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001. paper	re: Attachment D Health Futures of Youth II [partial] (1 page)	n.d.	b(6)
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COLLECTION:

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Ann O'Leary
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FOLDER TITLE:

Researchers [1]

2013-0436-S

rc1278

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Ann O'Leary's Files
Office of Policy Development, Domestic Policy Council, First Lady's issues

BOX 8 of 23

Researchers
HEAP
Hispanic convening programs
Hispanic convening
Hispanic convening substance / themes
Facts Hispanic convening
Hispanic issues- Federal government
Bilingual Education ESEA
Hispanic education
Hispanic education
Hispanic education early childhood conference
Hispanic education
HRC requests
Infant screening
Juvenile justice
Issues updates
Juvenile justice briefing book

ENCLOSURES FILED OVERSIZE ATTACHMENTS

19582

NARA # 16786

Planners:

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March 28, 2000

Ann O-Leary and Heather Howard
Office of the First Lady
2nd Floor, West Wing
The White House
Washington, D.C 20500

Dear Ann and Heather:

It was very exciting to think through with you the possibilities for a White House conference on adolescent health. Common threads do, indeed, weave together the priorities you outlined for the May 2nd meeting. As I envision the strategies that need either launching or strengthening, I think about the diversity among the 43 million teenagers in our country – diversity of development, ethnicity, family structure, economics, and access to resources – all which create the marked disparities we see in indicators of health and well-being among teenagers in the U.S.

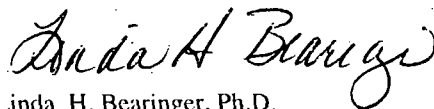
The common thread is about strengthening both the internal and external resources that make health and well-being a possibility, for all groups. Karen Pittman, who I recommended as a participant and possible speaker (see attachments) has described it this way, "Young people are resources to be developed, not problems to be solved." If we are to have 20/20 vision (which might make a good name for this meeting) we must consider that those in their adolescence now, are adults in 2020. Our vision now assures the capacity of the nation over the next decades.

I also appreciated the opportunity to speak on Saturday, not only as a researcher, but as a public health nurse. I have focused the last 20 years of my professional work on developing, designing, implementing, and evaluating interventions for promoting the health of adolescents. Most likely, more than physicians, nurses have had the opportunities to "meet" young people in home, school, and community-based settings. I believe we can provide a unique and rich perspective on the priorities that you outlined on Saturday.

I assembled materials that I thought would be of benefit in your planning. To ease the task of reviewing them, I provided a "table of contents." Please note that I enclosed a confidential description of some possible participants, whose names and addresses are included in Attachment D. I thought that a couple of hours invested at my end might save many hours for the two of you.

Tomorrow I will e-mail you a synopsis of what works and what doesn't, in terms of involving adolescents in the meeting. Please feel free to call or e-mail me, if I can be of further assistance.

Sincerely,



Linda H. Bearinger, Ph.D.

Associate Professor and Director

Table of Contents*

**Ann and Heather, note below (Attachment D) that I have include at list of participants at the Health Futures of Youth II national meeting (Fall 1998), with contact information and some descriptions of expertise for key persons.*

Attachment A:

Abstracts of Research Papers: Resilience and American Indian Adolescents

Attachment B:

Publication from the *Journal of Adolescent Health*

“The State of Adolescent Health: Looking Back and Planning Ahead”

Attachment C:

Health Futures of Adolescents II: A Call to Commitment and Action
Invitational Workshop Goals and Agenda

Attachment D:

Health Futures of Youth II: Pathways to Adolescent Health
Invitational Workshop Participants

Attachment E:

Pertinent White Papers Developed for Health Futures II

Attachment F:

Connections that Make a Difference in the Lives of Youth Attachment G

Attachment G:

The State of Native American Youth Health

Attachment A

Abstracts of Research Papers: Resilience and American Indian Adolescents

Attachment A includes a selection of abstracts drawn from the research team at the University of Minnesota which I direct. These papers together are representative of the array of research supporting the power of protective factors in promoting resilience among one of the most vulnerable, at-risk young people in the U.S. – American Indian adolescents. The conclusions quickly summarize the findings and their implications for where we should invest if we are to strengthen and improve health outcomes.

Each of these research papers have been supported by research grants (PI: Linda H. Bearinger, Ph.D) from the N.I.H. including the National Institute for Nursing Research and the National Institute of Mental Health.

Raph P, Bearinger LH, Erickson S, Skay C, Potthoff S, Stone S (2000). Conduct Disorder in American Indian Youth: What protects in urban settings? Journal of Adolescent Health, 26, (2), 99.

CONDUCT DISORDER IN AMERICAN INDIAN YOUTH: WHAT PROTECTS IN URBAN SETTINGS? Patricia Raph, MS; Linda Bearinger, PhD; Sandra Erickson, PhD; Carol Skay, PhD; Sandra Potthoff, PhD; Shirlee Stone, BA. School of Nursing and Carlson School of Management, University of MN, and Minneapolis American Indian Center, MN.

OBJECTIVE: Conduct disorder is characterized by delinquent/antisocial behaviors that result in impaired functioning in family, school, and community settings. Yet, conduct disorder in American Indian youth has been virtually unexamined. This analysis explored the prevalence of conduct disorder in a sample of urban Indian youth and identified salient protective factors amenable to intervention. It was hypothesized that positive affect, family caring as well as participation in Indian cultural activities and valuing Indian culture would be protective.

DESIGN: American Indian youth (N=318), ages 9-16, attending six urban public schools were surveyed in 1997-98 using a paper-pencil, self-report instrument that consisted of 243 forced choice questions related to health, culture, school, family, peers, values, and behaviors. Key study variables included conduct disorder, participation in Indian cultural activities ($\alpha=.82$), valuing Indian culture ($\alpha=.81$), positive affect ($\alpha=.61$), and family caring ($\alpha=.79$). Eleven of the 15 DSM-IV diagnostic criteria, included in the study instrument, were used to construct the conduct disorder variable. Descriptive statistics reported prevalence and Pearson's correlation coefficients examined bivariate relationships between study variables.

RESULTS: In this sample, 19.6% indicated a probable diagnosis of conduct disorder. Prevalence was higher for males (21.7%) than females (17.6%) and more common among older youth (31.4 %) as compared to the younger group (19.3%). Involvement in serious delinquent behaviors among this group was remarkable: in the past month, 22.4% carried one or more weapons (e.g., gun, knife, bat, razor); 6.7% had specifically carried a gun one or more days within the previous month. In the past year, 8.5% had shot at someone and 10.5% had stabbed someone. In addition, 36.2% had been suspended from school and 19.2% had been detained in a juvenile center. Considering protective factors, correlations of conduct disorder with positive affect ($r = -.28, p<.001$) and family caring ($r = -.29, p<.001$) were significant and negative. In contrast, the correlations between conduct disorder and cultural participation ($r = .21, p<.001$) and valuing Indian culture ($r = .12, p<.05$) were significant and positive.

CONCLUSIONS: Noteworthy is the high prevalence of conduct disorder in this group of urban American Indians, levels far exceeding prevalence figures for other adolescents in the U.S. Since conduct disorder is commonly co-morbid with more clinically treatable problems, such as ADHD, depression, and substance use, diagnosis of the disorder could alert providers to the need for expanded assessment. With regard to protective factors, positive affect and family caring were protective against conduct disorder as expected. In contrast, valuing Indian culture and participation in Indian cultural activities did not protect. Could immersion in a cultural group with a history of oppression create fear, self-doubt, anger, and hopelessness, all of which may lead to conduct disorder? Perhaps adolescents are especially vulnerable to cultural dissonance because of their developmental stage of identity formation. The role of cultural identity and participation, at least for urban American Indians, both in this study and extant research, is not yet fully understood. Clearly, interventions that promote positive affect and family caring are essential for young people whose emotional health is threatened.

CONDUCT DISORDER IN AMERICAN INDIAN YOUTH: WHAT PROTECTS IN URBAN SETTINGS?

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Erickson S, Bearinger LH, Skay C, Potthoff S, Resnick M, Stone S (2000). Violence perpetration among urban American Indian youth: Can risk be offset by protection? Journal of Adolescent Health, 26, (2), 98.

VIOLENCE PERPETRATION AMONG URBAN AMERICAN INDIAN YOUTH: CAN RISK BE OFFSET BY PROTECTION? Sandra Erickson, PhD; Linda Bearinger, PhD; Carol Skay, PhD; Sandra Potthoff, PhD; Michael Resnick, PhD; Shirlee Stone, BA. Schools of Nursing and Medicine and Carlson School of Management, University of MN; Minneapolis American Indian Center, MN.

OBJECTIVE: American Indian young people in urban settings live in a milieu of violence. Their perpetration of violence, including homicide, is among the highest in the U.S. Approximately 4 in 10 have perpetrated violence; of those, 16% have stabbed and/or fired a gun at someone. To determine priorities for clinical and programmatic prevention strategies, this analysis generated probability profiles of risk and protective factors for violence perpetration in a population of early and middle adolescents.

DESIGN: Between 1995-1998, 569 urban American Indian youths, ages 9-15, completed the Urban Indian Youth Health Survey, a confidential, self-report instrument tapping into dimensions of risk and protective factors, along with social, contextual, and demographic information. In this analysis, the youths reporting a history of violence perpetration against another person were compared to those without such a history. Probability profiles, based on odds ratios (OR) derived from logistic regressions, explain the likelihood of having perpetrated violence given various combinations of the most powerful risk and protective factors. Violence perpetration was defined as a mean score for 6 items that assessed individual and group fighting, shooting, cutting, or stabbing. The scale was, then, dichotomized (0=no or very low levels of violence perpetration [e.g., hitting someone 1-2 times in the past year]; 1=greater violence involvement [e.g., hitting someone repeatedly, involvement in group fights, shooting/stabbing someone 1+ times in the past year]).

RESULTS: Violence perpetration was reported by 37.5% of females and 43.2% of males, 35.7% of youth ages 9-12 years and 48.4% of those ages 13-15. Perpetrating violence was significantly ($p<.001$) associated with suicidal tendencies (OR=3.98) and alcohol, cigarettes, marijuana, or hard drug use (OR=6.95). Having a positive affect (OR=0.10), feeling connected to school (OR=0.01), and having peers with pro-social behavior attitudes (OR=0.19) were protective against perpetration of violence. Using multivariate logistic models, the likelihood of violence perpetration ranged from 10.3% of youth characterized by all three protective factors and no risk factors to 83.7% of youth with both risk factors and no protection. Most importantly, protective factors appeared highly effective in reducing the likelihood of violence perpetration even in the presence of risk, e.g., with both risk factors present, adding one protective factor reduced the odds of perpetration to as low as 65%; two protective factors lowered the probability to as low as 50%; and three protective factors reduced perpetration to 35%.

CONCLUSIONS: These results can guide and improve practitioners' capacity to assess at-risk young people for violence involvement. Each of the risk and protective factors in this analysis, the first of its kind undertaken with urban American Indian youth, are amenable to intervention at both individual and population-based levels. Though not yet a norm in clinical practice, the study highlights the utility of including protective factors in comprehensive assessments with highly vulnerable populations. Programmatic, this analysis provides a guide for prioritizing violence prevention strategies with high risk youth.

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Derscheid DJ, Bearinger LH, Erickson SL, Blum RW, Resnick MD (1998). Social support as a modifier of depressive symptoms among American Indian adolescents with physical abuse histories. *Journal of Adolescent Health*, 22, (2), 130.

Social Support as a Modifier of Depressive Symptoms among American Indian Adolescents with Physical Abuse Histories Della Derscheid, RNC; , Linda H. Bearinger, Ph.D., M.S., RN, Sandra L. Erickson, B.A., Robert Wm. Blum, M.D., Ph.D., and Michael D. Resnick, Ph.D., Schools of Nursing, Medicine and Public Health, University of Minnesota, Minneapolis, Minnesota

Objective: To explore the impact of social support on the relationship between self-reported indicators of depression and history of physical abuse among American Indian adolescents. For Native American young people the questions around physical abuse and related emotional distress have gone largely unexamined. For this group, what is the role and what are the sources of social support?

Design: Secondary analysis of a national in-school survey of 13,454 American Indian/Alaskan Native reservation-based youths, grades 7-12. For this analysis, the final sample was 12,243 (51.6 % females). Cases were omitted for missing values on key variables. X² was used to assess bivariate relationships, including age and gender variation. A dichotomized scale of "depressive signs" was derived from two survey items with Likert response categories; one item explored self-reported feelings of sadness/discouragement/hopeless, the other item was a 1-7, depression-cheerful continuum. A social support scale was developed by trichotomizing ("none, some and very much") responses to perceived levels of caring from parents, adults, school people and tribal leaders.

Results: Of the total sample, 13.3% reported a history of physical abuse. More than twice as many females (18.7%, n=1182) as males (7.6% n=450) reported physical abuse histories. A significantly greater proportion of adolescents with physical abuse histories, compared to those without such a history, reported signs of depression (46.2% of males, 57.4% of females; p=.0000 for both genders). Across genders, older abused adolescents (ages 16-18) indicated more frequently feeling sad/discouraged/hopeless or depressed than younger teens (ages 12-15). In both age groups, depressive signs were more common for females than males, regardless of the presence of abuse.

For both younger and older groups of females and males, there was a consistent relationship between perceived social support and depressive signs. The lower the level of perceived support, the greater the proportion with depressive signs (males: X²=6.49, df=2, p<.05; females: X²=35.25, df=2, p<.0000). This modifying role of social support was significant across age x gender groups as well. Nearly half of physically abused respondents (48.3%) reported seeking help first for depression with "friends my age." The next most common persons sought first for support were parents/guardians (14.7%) and adult friends (7.1%). Responses to this question also indicated that 14.9% of those with abuse histories would not seek help from anyone at all if they felt depressed or sad.

Conclusion: Among American Indian youth with physical abuse histories, the high prevalence of depressive symptoms alerts professionals to the importance of assessing emotional distress among those at-risk. Encouraging though is that the presence of perceived social support was associated with fewer indicators of depression. What priorities and practices are needed to foster social support in the lives of these vulnerable young people? Furthermore, we must better understand patterns of help seeking, recognizing that parents/adults are not as likely to be the first consulted in times of need. The disturbing evidence that some teens who experience physical abuse would not turn to anyone for help when feeling depressed is a wake-up call to health and social service providers.

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Erickson S, Skay C, Bearinger, LH, Potthoff S, Eichhorn J, Stone S (1999). Probability profiling with American Indian youth: Determining priorities for suicide prevention. Journal of Adolescent Health, 24, (2), 111.

PROBABILITY PROFILING WITH AMERICAN INDIAN YOUTH: DETERMINING PRIORITIES FOR SUICIDE PREVENTION Sandra Erickson, MS; Carol Skay, PhD; Linda Bearinger, PhD. Sandra Potthoff, PhD; John Eichhorn, BA; Shirlee Stone, BA, School of Nursing and Carlson School of Management, University of Minnesota and Minneapolis American Indian Center, Minneapolis, Minnesota

OBJECTIVE: American Indian young people in urban settings are among the highest risk for suicide in the U.S., with overall rates as high as 1 in 5 who have attempted prior to age 18. It is the second leading cause of death for this population. The purpose of this analysis was to develop probability profiles of factors associated with increased or decreased suicidal involvement in a population of early and middle adolescents in order to determine priorities for suicide prevention in clinical and programmatic settings.

DESIGN: Between 1995 and 1998, 635 urban American Indian youths ages 9-18 were assessed using the Urban Indian Youth Health Survey, a confidential, self-report survey examining an array of health-compromising behaviors and protective factors, along with social, contextual, and demographic information. The responses of adolescents reporting a past suicidal attempt were compared to those without such a history. Separate analyses were conducted for males and females as well as younger versus older age groups. Using a methodology previously applied to reservation-based youths by Borowsky et al., probability profiles were created based on odds ratios (OR) derived from logistic regressions. These profiles predict the likelihood of a suicide attempt given various combinations of risk and protective factors.

RESULTS: In this sample, a history of ever attempting suicide was reported by 22.7% of females and 9.7% of males, 13.6% of younger and 19.7% of older youth. Suicide attempts were associated with having a friend or family member attempt suicide, past physical/sexual abuse, having health concerns, frequent alcohol, marijuana, or hard drug use, gang involvement, gun availability, and ever being in special education. Having a positive affect and sense of connectedness with family and school, discussing problems with friends or family members, and accessing health care within the year were protective against suicide attempts. Using logistic models to predict the probabilities of attempting suicide, the likelihood of attempting suicide increased dramatically as exposure to risk factors increased, i.e., up to an eight-fold increase with all risk factors present. More importantly, risk factors were more than offset by the cumulative effect of protective factors.

CONCLUSIONS: Previous research has demonstrated that the most accurate prediction of future suicide attempts is a history of previous attempts. This probability profiling approach, using retrospective reporting, can dramatically improve the capacity of practitioners to assess at-risk young people for suicidal involvement. Moreover, it identifies a set of risk and protective factors for suicidality in urban American Indian youth, most of which are amenable to intervention at both individual and population-based levels. Though not yet a norm in clinical practice, this analysis highlights the merits of including protective factors in comprehensive assessments, particularly with highly vulnerable populations such as urban American Indian young people. From a programmatic perspective probability profiling can provide a guide for prioritizing interventions most likely to succeed for young people most at risk for suicidal involvement.

Probability Profiling with American Indian Youth: Determining Priorities for Suicide Prevention

OBJECTIVE: American Indian young people in urban settings are among the highest risk for suicide in the US, with overall rates as high as 1 in 5 who have attempted prior to age 18. It is the second leading cause of death for this population. The purpose of this analysis was to develop probability profiles of factors associated with increased or decreased suicidal involvement in a population of early and middle adolescents in order to determine priorities for suicide prevention in clinical and programmatic settings.

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RESULTS: In this urban sample, a history of ever attempting suicide was reported by 22.7% of females, 9.7% of males, 13.6% of younger youth, and 19.7% of older youth. Suicide attempts were associated with having either a friend or family member attempt suicide, past physical or sexual abuse, having health concerns, frequent alcohol, marijuana, or hard drug use, gang involvement, gun availability, and ever being in

special education. Having a positive affect and sense of connectedness with family and with school, discussing problems with friends or family members, and accessing health care within the year were protective against suicide attempts. Using logistic models to predict the probabilities of attempting suicide, the likelihood of attempting suicide increased dramatically as exposure to risk factors increased, i.e., up to an eight-fold increase with all risk factors present. More importantly, risk factors were more than offset by the cumulative effect of protective factors.

CONCLUSIONS: Given that the most accurate prediction of future suicide attempts is a history of previous attempts, this probability profiling approach dramatically improves the assessment of at-risk young people. Moreover, it identifies a set of risk and protective factors for suicidality in urban American Indian youth, most of which are amenable to intervention at both individual and population-based levels. Though it is yet to become the norm in clinical practice, this analysis highlights the merits of including protective factors in comprehensive assessments, particularly with highly vulnerable populations such as urban American Indian young people. From a programmatic perspective probability profiling can provide a guide for prioritizing interventions most likely to succeed.

Bullerdick S, Bearinger, LH, Potthoff S, Skay C, Erickson S Eichhorn J, Stone S (1999). School and family matters, or do they? Patterns of social connections for Native American young people. Journal of Adolescent Health, 24, (2), 81.

SCHOOL AND FAMILY MATTERS, OR DO THEY? PATTERNS OF SOCIAL CONNECTIONS FOR NATIVE AMERICAN YOUNG PEOPLE Susan Bullerdick, MSW; Linda Bearinger, PhD, Sandra Potthoff, PhD; Carol Skay, PhD; Sandra Erickson, MS; John Eichhorn, BA; Shirlee Stone, BA, School of Nursing and Carlson School of Management, University of MN and Minneapolis American Indian Center

OBJECTIVE: Resiliency research has shown that strong social connections aid in buffering youth from adverse life circumstances and poor outcomes. But do they protect similarly for every group of teens? In this study we investigated whether connections to family, school, and friends played a similar role in promoting emotional well-being among the most at-risk young people in the U.S.--Native American youth living in urban settings. Specifically our goal was to understand the protective nature of these social connections as they differed among both boy and girls in early and mid-adolescence.

DESIGN: The study utilized data (1996-1998) from the Urban Indian Youth Health Survey designed for elementary and secondary school youth. The self-report survey, developed specifically for urban Native American youth, incorporated over 250 items on health/well-being, values, culture, and relationships. Study participants (N = 426; 49% females), ages 10-16, were primarily Chippewa/Ojibwa/Anishinabe or Lakota/Dakota Sioux. Scales for key variables were created using factor analysis: family ($\alpha=.78$), school ($\alpha=.65$), and friend ($\alpha=.43$) connectedness; emotional well-being ($\alpha=.62$) included eight items related to self-perceived stress, sadness, boredom, happiness and life satisfaction. The composite measure for friend connectedness was retained despite a low alpha to avoid repeated use of single item indicators. Following bivariate analysis, the relative contributions of independent variables to emotional well-being were tested using separate multiple regressions for each of four gender by age groups (early adolescence [ages 10-12] and middle adolescence [ages 13-16]).

RESULTS: The relationship between social connectedness and emotional well-being showed differing patterns by age and gender. For early adolescent males, family ($R^2=2.8\%$; $p<.05$) and school ($R^2=6.5\%$; $p<.001$) connectedness accounted overall for 16% of the variance ($p<.001$). In contrast, neither school, family, nor friend connectedness were significantly related to emotional well-being for the middle adolescent males. Among the females, school contributed more variance (12.6%; $p<.001$) than family (n.s.) among those in early adolescence compared to the role of family connectedness ($R^2=11.6\%$; $p<.01$) which weighed more heavily in emotional well-being than did school connectedness (n.s.) among middle adolescent females.

CONCLUSIONS: While connections with family and school as well as with friends are closely tied to self-perceptions of emotional well-being for urban Native Americans in early adolescence, their diminished importance in mid-adolescence, though differing by gender, is cause for serious concern. Given that the study sample did not include school dropouts ($\leq 90\%$ by 12th grade), the loss of a significant relationship between school connectedness and emotional well-being by the middle school years, for both boys and girls who are in school, suggests the need for significant investment in enhancing schools experiences for Native Americans. Moreover, the link between family connectedness and emotional well-being for two of the groups indicates that youth development efforts, particularly for these two groups, should be fostering family ties, even in the midst of overwhelming adversity that, at times, may face Native American families in urban settings.

School and Family Matters, or Do They?

Patterns of Social Connections for Native American Young People

OBJECTIVE: Resiliency research has shown that strong social connections aid in buffering youth from adverse life circumstances and poor outcomes. But do they protect similarly for every group of teens? In this study we investigated whether connections to family, school, and friends played a similar role in promoting emotional well-being among the most at-risk young people in the U.S.--Native American youth living in urban settings. Specifically our goal was to understand the protective nature of these social connections as they differed among both boy and girls in early and mid-adolescence.

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Attachment B

Publication from the Journal of Adolescent Health

“The State of Adolescent Health: Looking Back and Planning Ahead”

As I mentioned in the meeting on Saturday, in 1986 the Maternal and Child Health Bureau sponsored a consensus meeting of 200+ experts in adolescent health – Health Futures of Adolescents I. The goal was to set priorities in health services, research, and training of health professionals that would foster the well-being of adolescents. I served as a co-coordinator for this meeting. The attached paper reviews the impact of this national agenda-setting meeting 10 years subsequent. The article was a prelude for convening Health Futures of Adolescents II in 1999.

ADOLESCENT HEALTH BRIEF

The State of Adolescent Health: Looking Back and Planning Ahead

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CLAIRE D. BRINDIS, Dr.P.H., TRINA MENDEN ANGLIN, M.D., Ph.D.,
AND CHARLES E. IRWIN, JR. M.D.

Purpose: A decade has passed since the 1986 Health Futures of Youth policy-making conference was held. The present study aimed to examine perceived changes in the field of adolescent health since this conference, as a basis for further planning in adolescent health and consideration of a possible follow-up conference.

Methods: The study included two parts: (a) a mailed survey which was completed by 68 of 90 conference participants; and (b) telephone interviews with a sample of leaders from federal agencies and major foundations and one professional organization serving youth in the United States.

Results: Respondents perceived that small to moderate improvements have occurred for 10 key recommendations made at the 1986 conference. There appears to be increased recognition of the special needs of youth and a greater understanding of the period of adolescence. Improvements in health-related activities and in research of health behaviors have occurred. However, perceived setbacks have occurred at the intersection of health and social welfare. The conference was viewed by respondents as having had a moderate influence on the field of adolescent health and on the participants' own work and working relationships. In addition, policy-making con-

ferences were listed as the strongest source of influence on the agenda of national agencies and foundations serving youth.

Conclusion: A follow-up conference is recommended and should focus on both health-related topics and issues of social welfare. © Society for Adolescent Medicine, 1997

KEY WORDS:

Adolescent health
Evaluation
Conference
Health services
Health behaviors
Health concerns

In 1986, a national invitational conference, Health Futures of Youth, was held to: (a) identify the major health-related concerns facing youth through the year 2000; (b) delineate the state of knowledge regarding each of these major issues; and (c) develop a prospective action plan for the next 15 years for research, demonstration programming, and training (1-9). The Health Futures of Youth conference provided an opportunity for professionals concerned with the health and well-being of youth to meet and discuss the critical issues facing youth. The conference was unique in that it was one of the first national conferences on adolescent health to bring together leading experts from the fields of medicine, nursing, nutrition, public health, public policy, health education, psychology, social work, and sociology.

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A decade has passed since the Health Futures of Youth conference and the questions arise as to whether resources should be invested in another policy-forming conference, and if so, what the key issues are that need to be addressed. The present study aimed to examine perceived changes in the field of adolescent health since this conference as a basis for further planning in the field of adolescent health, and to determine the value of a follow-up Health Futures of Youth conference. In planning for the future, we need to explore the work that has been done in the field of adolescent health over the past decade, to assess the degree of progress which has been made, and to examine setbacks which may have occurred. In the present study, each of these points is examined from the perspectives of those who were conference participants.

Methods

A survey was mailed to the participants who attended the Health Futures of Youth conference. In addition, telephone interviews were completed with representatives currently involved with adolescent health from federal agencies and foundations that originally participated in the conference.

Mailed Survey of Adolescent Health Professionals

The survey population included all 110 adolescent health professionals who attended the Health Futures of Youth conference in 1986. Conference participants included national leaders from the areas of health promotion, biology and behavior, adolescent development, chronic and disabling conditions, health services delivery, and research and training. In addition, federal agencies and national foundations active in the field of adolescent health participated. Participants at the conference had been nominated based on expertise in one of the six areas under discussion (as noted above). The final study sample included 68 individuals who returned completed questionnaires. Five persons had died, nine had retired, and six were no longer working in the field of adolescent health. We had decided to limit the study to individuals still working in the field of adolescent health. Therefore, for eligible respondents ($n = 90$), we obtained an overall response rate of 75.5%.

Survey. Conference participants were mailed a questionnaire with a letter explaining the purpose of

the study. The questionnaire was developed by the research team and was pretested and further reviewed by three external experts in the field of adolescent health whose specialties are behavioral science, nutrition, and health policy. To enhance a high participation rate, three rounds of questionnaires were sent at intervals of approximately 3 weeks. The third round of questionnaires included a personal note stressing the importance of responding.

Measures. Perceived progress in achieving recommendations: Ten key recommendations were selected for inclusion in the study from the recommendations made within the study sections at the Health Futures of Youth conference (2-7) (Table 1). Respondents were asked to indicate, on a six-point scale, what progress had been made in reaching each goal over the past decade.

Perceived impact of conference: On a five-point scale, respondents indicated the extent to which they agreed that the conference had influenced their own work, health policy, the field of adolescent health, research, interventions, professional training, and adolescent health status. Each item was analyzed separately.

Effect of conference on working relationships: Participants were asked to identify any new collaborators or colleagues that they had met as a result of the meeting.

Relative effect of conference: Compared to other meetings they had attended, participants were asked to rate the extent that Health Futures of Youth helped to shape the research, training, program agenda and/or policy in the United States over the past decade. Six-point scales of response were used for each item.

Perceived future issues: Participants were asked to respond to the open-ended question, "Looking ahead, what do you think are the most pressing issues in adolescent health, social well-being, and development over the next decade? Please be as specific as possible."

Telephone Interviews With Federal Agencies and Foundations

Seven federal agencies and foundations were selected for telephone interview, since they were all originally involved in the Health Futures of Youth conference. If an original conference participant was still involved with adolescent health in the agency or

Table 1. Key Recommendations Made at the Health Futures of Youth Conference in 1986, and Progress From 1986 to 1995 as Perceived by Conference Participants ($n = 68$)

	% Participants Indicating					
	No Gain or Lost Ground	Small Improvement	Moderate Improvement	Substantially Advanced	Achieved	Don't Know
1. To develop a more precise conceptualization of risk taking and distinguish between constructive exploratory and potentially destructive behaviors.	7	29	31	19	2	12
2. There is a need for better research on communication and interactions between adolescents and their peers, parents, and health care providers.	2	44	38	10		6
3. To study development within the larger social context of the adolescent (i.e., impact of poverty, ethnicity, and family structure on adolescent development.)	4	28	37	24		7
4. Studies on adolescents with chronic physical or social conditions should focus on successful adaptation and coping (resiliency)	3	25	41	10		21
5. Studies on the impact of chronic physical and social conditions in families in terms of social functioning, communication, and physical and psychological health should be undertaken.	4	29	40	7		19
6. Each state health department needs to have (a) an interagency task force in adolescent health, and (b) at least one person responsible for adolescent health.	12	19	9	27	2	32
7. There is a need at both the national and state levels for expanded studies on adolescent health behavior and health status.	9	27	28	25	3	9
8. To ensure the promotion and maintenance of integrated community health delivery programs, systems are needed to provide interdisciplinary service and train service providers to work in a interdisciplinary clinical setting.	13	29	31	6		21
9. Service programs need to evaluate physical, social, and psychological outcomes (e.g., impact evaluation).	10	41	22	2		25
10. There is a need for clearly defined guidelines for training in adolescent health at the undergraduate, graduate, and postgraduate levels.	7	37	25	13	2	16

foundation, he or she was interviewed; if someone else had lead responsibility for adolescent health at the time of the study, he or she was interviewed. The rationale for this approach was that for federal agencies and foundations, participants were originally invited to the conference because of their

position; and on follow-up we were most interested in agency and foundation perspectives. Participating agencies and organizations included the Maternal and Child Health Bureau, the Centers for Disease Control and Prevention, the Robert Wood Johnson Foundation, the William T. Grant Foundation, the

Kellogg Foundation, the Carnegie Corporation of New York, and the Henry T. Kaiser Family Foundation. The American Medical Association (AMA) was added owing to its establishment of the National Coalition of Adolescent Health, which is a group of professional organizations, federal agencies, and private foundations working in adolescent health; its preparation of the *AMA Guidelines for Adolescent Preventive Services* (10); and its active role in adolescent health over the past decade.

Research design. Key persons in each of these agencies or foundations were sent a letter explaining the purpose of the study and a copy of the questions which would serve as a guide for the telephone interviews. These individuals were then contacted to set up a convenient time period for the interview. Semistructured telephone interviews were conducted by the first author (DNS), who recorded, summarized and read the responses for relevant themes. The same questions and format were employed in each interview. Conversations ranged from 25 min to an hour, in accordance with the interviewee's responses.

Interviewees were asked a series of questions in the following seven areas:

Perceived major improvements: In what areas, if any, have we seen major improvements in adolescent health, development, or social welfare over the past decade?

Contributing factors to these improvements: What factors contributed to these improvements?

Perceived major setbacks: In what areas, if any, have we seen major setbacks in adolescent health, development, or social welfare over the past decade?

Contributing factors to these setbacks: What factors contributed to these setbacks?

Perceived future pressing issues: What do you think will be the major issues related to adolescent health, development, and social welfare over the next decade?

Themes/focal areas for follow-up conference: If there were to be a major national invitational conference on adolescent health and development, what do you think should be the organizing themes or major focal areas for such a meeting?

Results

Perceived Trends in the Field of Adolescent Health Over the Past Decade

Ten of the key recommendations made at the Health Futures of Youth conference are presented in Table 1.

Perceptions of conference participants as to the degree of progress made in achieving each recommendation over the past decade are also presented. For the majority of the recommendations, participants thought that small or moderate improvements had been made. Very few participants indicated that any of the recommendations had been achieved. Overall, the patterns suggest that participants thought that there had been more progress in the recommendations related to research than in the development of integrated services, evaluation of services, and training guidelines. For example, 60% perceived that there had been moderate or substantial improvement regarding the study of development within the larger social context of the adolescent (Recommendation No. 3). In contrast, only 24% perceived that there had been moderate or substantial improvement in the evaluation of health services for youth, and 37% in the promotion of integrated youth health services (Recommendation No. 8 and 9).

Representatives from federal agencies, foundations, and the Department of Adolescent Health of the AMA described their perceptions as to the major improvements and setbacks in adolescent health, development, or social welfare (Table 2). Major improvements include a greater understanding of the needs of youth and of the important issues and some positive changes in health services and in health behaviors related to unintentional injuries. Major setbacks include continued or increasingly high prevalence rates of numerous health behaviors such as violence, substance abuse, unsafe sexual practices, and suicide attempts. Factors viewed as contributing to these setbacks include: continued deterioration of support systems, changes in the family structure, economic upheavals, limited resources going to social issues, political conservatism, lack of recognition of the changes occurring in the lives of modern-day youth, failure of dialogue between subgroups of the population, and glorification of violence and of unprotected sex by the media.

Perceived Impact of Invitational Policy-Forming Conference Such as Health Futures of Youth

Conference participants were asked to describe their perceptions of the impact of the Health Futures of Youth conference on the field of adolescent health as well as on their own work (Table 3). Approximately 60% felt that the conference had influenced health policy initiatives and research in the field of adolescent health. Approximately half of the participants thought that the conference had an indirect positive

Table 2. Major Improvements and Setbacks in the Field of Adolescent Health From 1986 to 1995: Perceptions of Key Persons From Eight National Agencies and Major Foundations in the United States

Major Improvements	Major Setbacks
Increased integration of services	Increased violence (especially in inner cities)
Increased school-based clinics	Increased anxiety
Increased willingness to talk candidly about adolescent issues	Accent increases in substance abuse
Increased understanding about adolescent development	"Demonization" of teenage mothers
Increased understanding about high-risk behaviors	Dismal futures of youth owing to decrease of employment opportunities and violence
Increased useful interventions	Increased gangs
Increased emphasis on prevention	Decreased funding and resources for schools
Increased focus at national level regarding needs of youth	Increase of STDs
Increased screening	Increase of HIV/AIDS
Increased seatbelt use	Increased suicide rates
Increased strides toward decreasing drinking and driving	Continuation of high pregnancy rates
Decreased fatalities from motor vehicles and other unintentional injuries	

influence on adolescent health status and on professional training in the field, while 38% felt that the conference influenced interventions and programs for youth. One-third of the participants indicated that the conference had helped shape their own work. Forty-seven percent of the conference participants indicated that they had identified new collaborators or colleagues as a result of the meeting. Percentages of participants who indicated that the conference had a greater influence than other conferences on research, training, programming, and policy were 65%, 42%, 44%, and 51%, respectively.

Key Issues Within the Field of Adolescent Health to Be Addressed in the Upcoming Decade

Conference participants and key persons from federal agencies, major foundations, and professional organizations were also asked to predict the most pressing issues in adolescent health, social well-being, and development over the next decade. They raised a number of issues:

1. Health risk and behaviors [e.g., sexual behaviors related to pregnancy, sexually transmitted diseases, and human immunodeficiency virus/acquired immunodeficiency syndrome, sexual exploitation of young girls by adult men, violence within families, schools, and communities (and the effects of anxiety associated with violence), substance abuse, suicide, dietary and exercise behaviors, studying protective factors and prevention issues];
2. Health care (e.g., quality assessments, appropriateness for youth, access and barriers, access for minority populations, and cost reductions which may lead to cuts in interventions aimed at prevention);
3. Social awareness (e.g., ethnic differences, effects of poverty, and services for disadvantaged youth);
4. Economics (e.g., lack of higher education, uncertainty of future, job opportunities, dismal opportunities for African-American males);
5. Education for all youth and not just those going

Table 3. Impact of the Health Futures of Youth Conference on the Field of Adolescent Health: Perceptions of Conference Participants a Decade Later ($n = 68$)

Area of Impact	Extent of Agreement With Statement (% Conference Participants)			
	Disagree*	Neutral	Modestly Agree	Strongly Agree
1. The conference advanced health policy initiatives in the field of adolescent health	16	24	50	10
2. The conference influenced research in the field of adolescent health	13	27	48	12
3. The conference influenced professional training in adolescent health	14	33	47	7
4. The conference has indirectly had a positive influence on adolescent health status	21	26	35	18
5. The conference influenced interventions and programs for youth	19	43	36	2
6. The conference helped shape my work	23	44	16	17

* "Strongly" disagree and "modestly" disagree responses were combined.

to college, to help develop motivation, problem solving, and reasoning skills, for the workforce as well as citizenship;

6. Inadequate support of youth from families, adults, and communities.
7. Mental health (e.g., access to services, emotional development, emotion deprivation);
8. Chronic health problems;
9. Policy issues (e.g., funding issues and development of adolescent health databases at local, state, national, and international levels); and
10. Professional education (e.g., training in adolescent issues).

Those interviewed by telephone were asked to suggest organizing themes and major focal areas for a follow-up national invitational conference on adolescent health and development. Responses included the following:

1. Become action-oriented, to identify feasible actions which can be taken by organizations across the nation.
2. Focus on vulnerable populations.
3. Coalition-build with agencies not traditionally related to health (e.g., with those involved in economic/community development).
4. Focus on prevention and on looking ahead to the year 2050.
5. Involve teens.
6. Integrate health services, schools, and communities toward prevention.
7. Help adolescents deal with economic concerns in the face of less family and community support.
8. Look at the major problems of youth using an epidemiologic approach.
9. Examine issues of resiliency.
10. Identify and address the changing needs of adolescents (e.g., less family connectedness, less infrastructure, more economic concerns).

Discussion

This study provides a basis for future planning in the field of adolescent health. The ideas of professionals within the field can help in determining whether the investment of time and resources in policy-making conferences are worthwhile, and if so, what key issues should be addressed.

As far as can be determined (11), the present study represents the first long-term follow up of a major conference on adolescent health. The findings suggest that the Health Futures of Youth conference had

an effect on the field of adolescent health, in particular, compared to other conferences. The finding that many (47%) had identified new collaborators or colleagues as a result of the meeting is particularly important as cross-disciplinary and cross-regional collaboration is critical for the development of programs reaching youth.

In building an agenda for youth in the upcoming decade, the following issues should be addressed: (a) that the issues affecting the health of youth are multifactorial in their etiology as well as in their consequences; (b) that issues may differ substantially for ethnic, geographic, or gender subpopulations of the adolescent population; (c) that the importance of prevention be stressed as an integral part of health care and within the larger social arena of youth; and (d) that working with others who have not traditionally worked in the health arena is important. The importance of interdisciplinary work with youth has already been widely accepted in the area of health services with professionals from medical, nursing, nutritional, psychology, and social work fields working together. Interdisciplinary work now needs to extend to those working in a wider range of fields (e.g., economics, education, law enforcement, community organization) and to those working at both the micro and the macro levels if the needs of youth are to be met (12). Including these new fields will not be easy because of different languages, literatures, and traditions; yet, it does seem to be a necessary step.

The present study had a number of limitations which should be considered in drawing conclusions. Statements can be made regarding only respondents' perceptions of trends in the field of adolescent health in the decade since the Health Futures of Youth conference. The survey was limited to conference participants. We are not able to evaluate the direct impact of the conference on the field of adolescent health, as many factors have influenced the field over the past decade. We realize that participants may have avoided making negative comments. Finally, definitive statements cannot be made regarding the major issues that youth will face during the upcoming decade. Despite these limitations, this study is unique in that it provided an opportunity for professionals from different disciplines in the field of adolescent health to voice their opinions about past developments, about the impact of policy-making conferences, and about pressing issues facing youth which will need to be addressed over the upcoming decade.

In examining key recommendations made at the

Health Futures of Youth conference in 1986, considerable progress appears to have been made over the past decade in the field of adolescent health. Still, new challenges face the field which require comprehensive and integrated approaches. An expansion of interdisciplinary collaboration will enable the society to address the future and emerging health issues of youth. A Health Futures of Youth II conference should aim to address these issues.

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Attachment C

Health Futures of Adolescents II: A Call to Commitment and Action

Invitational Workshop Goals and Agenda

I attached the description of Health Futures of Adolescents II so that you could compare this national meeting of 200+ adolescent health experts convened in September 1998. As you can see, the work groups focused on individual, family, school, and community, not unlike you indicated for the White House meeting.

National Invitational Workshop
on the

**HEATH FUTURES OF ADOLESCENTS II:
A CALL TO
COMMITMENT AND ACTION**

"Safe passage, navigating into the next century, and securely anchoring
the future requires charting a course for life-saving, life-preserving,
and life-fulfilling action for America's youth."

Bill Clinton
President of the United States of America

Winter 1995
Washington, D.C.

ISSUE

Improving the health of the Nation's young people is our best investment to a secure America.

We can take great pride that most of America's young people have the opportunity to enjoy a quality of life that leads them toward positive health behaviors and health status. Many live where communities provide healthful supportive activities, and live with families that are understanding and supportive. Many benefit from an educational system that works and jobs that make it possible to look at the future with hope. However, we must take heed that many may only appear to be doing well and far too many youth in America do not experience the rich benefits seemingly available. If we as a Nation are to secure the future, we must renew our commitment, act decisively, and pay special attention to these young people. Most importantly we must appreciate and enjoy the specialness and vibrancy of all our young people.

CHALLENGE

The health status and unmet health needs of adolescents are well documented and are cause for extreme concern. Social and behavioral factors, in particular, rank high as the causes of mortality and morbidity among adolescents, e.g. injury and disability associated with the use of motor and recreational vehicles, the consequences of early and unprotected sexual activity, and the use of alcohol, tobacco, and other drugs. Moreover, outcomes associated with untoward behavior may not emerge until the adult years, thus may not appear in adolescent health status data or be viewed by adolescents and others as problems.

Adolescents' patterns of health system use compared to their actual health needs suggests the current system may not be meeting those needs. For example, adolescents visit private physicians at a lower rate than any other age group; 12% under 17 years report no regular source of care; in some communities as many as 44% reported no contact with the medical system in the prior 2-3 year period. Specific health services to meet reproductive and mental health needs are often not available and are underutilized. Only 57% of an estimated 5 million sexually active female adolescents receive any family planning services; fewer than one third of children needing mental health treatment receive any care.

Financial barriers and lack of health insurance keep adolescents from utilizing health services. Many are reluctant to use services covered by parental insurance fearing lack of confidentiality.

Yet there are models of comprehensive health care services programs which emphasize services to cover the range of health problems and satisfy important criteria

as confidentiality and accessibility. These programs may be based in schools and other community settings accessible to young people.

To date, evidence suggests that, across disciplines, the educational preparation of health professionals has not kept pace. There is a need to rethink traditional educational strategies in order to address the shift in the primary causes of morbidity and mortality in adolescents and the need for integration of comprehensive services in multiservice settings. One approach for better preparing health providers to work in such settings is to provide training in interdisciplinary programs to meet the unique health needs of adolescents.

ACTION

The Administrator of the Health Resources and Services Administration of the United States Public Health Service is calling together the Nation's best minds and talented scholars and people who work with youth everyday, as well as young people and parents to frame a national strategy and develop recommendations for action. Actions that federal, state, and local community governments and concerned groups can implement. The Workshop will be focused upon ensuring the safe passage of youth to adulthood by empowering them to chart a course to:

- enhance their resilience and life-saving skills needed to navigate in stormy seas;

- secure access to comprehensive health care and life-preserving and promoting care; and

- achieve their true potential and realize life-fulfilling aspirations.

The participants of this Workshop will include a broad array of experts from the health and social services systems, educators, legislators and key policy officials, business leaders and interested foundations, juvenile justice system, the media, parents and particularly young people for intense discussion of the subject issues and formulation of policy recommendations.

OBJECTIVE

The principal objective of the Workshop is to forge a consensus on a set of policy recommendations for a national social strategy that would assure the healthy passage of America's youth toward a promising and productive future with particular attention to youth at risk.

This will be accomplished by building upon the work of several recent efforts to call

national attention to the health status of the Nation's young people. For example, the reports from the Health Futures of Youth Symposium I, Bright Futures, OTA, Carnegie, IOM, AMA, and RWJ and WT Grant foundations, as well as *Healthy People 2000* will provide important background and context for synthesizing and analyzing recommendations from many scholarly works to create a state-of-the-art assessment, culminating in a draft/preliminary action plan. All of this work will be completed in advance of the Workshop.

The Workshop participants will then review this information, debate its merits, finalize the national plan of action focused upon problem solving, and suggest an implementation and dissemination strategy.

THEMES

The Workshop will fashion the action plan based upon one over-arching axiom: young people are special treasures possessing great strengths and resiliency while posing equally great challenges and opportunities. In addition the plan of action will be center on three basic themes:

assuring youth survival and protection from untoward threats by enhancing resilience and providing a healthy environment;

assuring the quality of life for young people growing up in America by securing their health; and,

assuring a future and achievement of optimal potential through a supportive family, education and jobs.

Three state-of-the-art "white papers", based upon the Workshop themes, will be prepared by experts selected for their knowledge in the area. The papers will serve several useful purposes for the workshop: (1) as an overview and synthesis of the theme area, (2) as background material and rationale for the preliminary action plan, and (3) as reference material for participants in the work/study groups preparing the final recommendations.

Each of the papers will be presented in a plenary session so that all participants will gain a common understanding and conceptual framework prior to working in groups. Each of the authors will prepare the papers in a coordinated manor with the development of the preliminary draft action plan.

One white paper, for example, will review and assess the status of youth violence, gun control, gangs, role of current justice systems and services and knowledge related to the issue, allocation of resources to improving survival of youth, injury prevention,

prevention of self-destructive behavior including pregnancy and suicide in particular, and identify protective factors such as resilience and other strengths that mediate the consequences of untoward threats.

Another essay will review and assess access issues and barriers to comprehensive health services focusing on innovative approaches, e.g. school based clinics, and other enabling services. This paper will examine health care issues related to personal care services, both publicly or privately financed, and the special need for a core public health system that focuses upon adolescent health. The focus of the paper will include specific attention to mental health, health promotion and prevention, including pregnancy prevention, highlighting strategies to improve services and what we know about utilization and the effect on health outcome. The paper will look at who provides what services; how effective are they; what new knowledge and leadership training is needed to improve capability to provide needed care.

A final paper and presentation will review and assess the environmental factors, system linkages, and nature of social institutions necessary to support youth healthy development, including family issues, education systems from preschool thru preparation for jobs, and the employment marketplace. The paper will highlight social strategies to strengthen families in their ability to support healthy growth and development of adolescents and partnerships that will improve their environment.

FORMAT

The conference will include a workshop format with plenary sessions and small workgroup breakout sessions. To enrich the plenary presentations, there will be added panels with adolescents and health professionals, educators, guidance counsellors, etc. to represent the breadth and depth of those concerned with the issues and their resolutions. These panels will act as responders to presented materials or be selected to bring in other views of the problems and their solutions. A "teleconferencing downlink" will be established with selected middle/high schools and colleges in order to invite national adolescent participation.

The plenary presentation on survival and resilience will lead off with a keynote presenter. A respondent panel for this theme will then make brief statements and will include individuals such as police, attorney, parent school administrator, media. Similarly, the plenary on health and quality of life responders will include school-based health center providers, Medicaid managed care administrators, health care reform experts, TV anchor, Girls/Boys clubs, school counselors, and coaches. Responders to the future plenary will include business leaders, employers, school principals, teachers, ministers/rabbis, and parents.

The proposed matrix organization of the Workshop builds the program content around

the three central workshop themes and provides for the exploration of these themes by participants in four dimensions:

- Research - the state of the art or what's known about key components of the theme topic;
- Services - description of programs that work;
- Education - who are the providers of the needed programs and how are they to be trained - what information and communication issues need to be covered - what health education is implied; and,
- Policy - specifying national, state, and local government topic-specific and cross-cutting roles and responsibilities those of public and private agencies, officials, and organizations; health care providers of both personal and public health services; and the development of partnerships and coalitions in meeting identified needs.

The action/policy recommendations will be developed from a matrix of twelve work groups:

THEME	RESEARCH	SERVICES	EDUCATION	POLICY
SURVIVAL/ RESILIENCE				
QUALITY/ HEALTH				
FUTURE/ ENVIRONMENT				

Chairpersons and recorders will be assigned to each workgroup and prepare a final recommendations for the action plan based on the draft plan, white papers, and group deliberations. The Chairpersons, recorders (and others to assist), will meet on the

evening of the second day to draft a final Workshop report/action plan.

In a final plenary session a reactor panel will respond to the action plan and provide an opportunity for interactive distant audience input to the Workshop from another set of selected classrooms around the country.

Finally, a medical writer will compose a Workshop draft report with a team of adolescent correspondents participating in preparation of the report.

SETTING

Selection of the setting for the Workshop should give consideration to keeping the participants engaged for the full time. A "cloistered" setting such as the Lansdown/Dulles Center would meet that goal.

HEATH FUTURES OF ADOLESCENTS II
WORKSHOP AGENDA

1st Day	AM	Welcome
		Charge to Participants* (*Video Teleconference)
		Keynote: Survival/Resilience
		Panel Response
		Discussion
		 BREAK
		Keynote: Quality/Health
		Panel Response
		Discussion
		 Keynote: Future/Environment
		Panel Response
		Discussion
		 LUNCH
	PM	Preliminary Action Plan workgroup charge
		 workgroup Session I
		 DINNER White House Speaker
2nd Day	AM	workgroup Session II
		 LUNCH
	PM	workgroup Session III
		 DINNER Meeting for group leaders
3rd Day	AM	Final Action Plan Report* Reactor panel
		 Closing Remarks
	NOON	Adjourn

Monday, September 14 continued

4:30 p.m.

Work Group Session A

**Work Group I:
Developing Models of Healthy Adolescent
Physical Development**

**East Chamber
(Governor Calvert
House)**

*Co-Chairs: Edward O. Reiter, M.D.
Baystate Medical Center*

*Elizabeth J. Susman, R.N., Ph.D.
The Pennsylvania State University*

**Work Group II:
Developing Models of Healthy Adolescent
Psychosocial Development**

**Calvert Chamber
(Governor Calvert
House)**

Co-Chairs: Dr. Charles Irwin

*Susan G. Millstein, Ph.D.
University of California San Francisco
School of Medicine*

**Work Group III:
Identifying Effective Strategies and Interventions
for Improving Adolescent Health at the Individual Level**

**Duke of Gloucester
(Maryland Inn)**

*Co-Chairs: Linda H. Bearinger, Ph.D., R.N.
University of Minnesota School of Nursing*

*James A. Farrow, M.D.
University of Washington*

*Jewelle Taylor Gibbs, Ph.D.
University of California at Berkeley
School of Social Welfare*

**Work Group IV:
Increasing the Capacity of Parents, Families, and
Adults Living with Adolescents to Improve
Adolescent Health Outcomes**

**West Chamber
(Governor Calvert
House)**

Co-Chairs: Dr. Paula M. Duncan

*Laurence Steinberg, Ph.D.
Temple University*

Monday, September 14 continued

**Work Group V:
Increasing the Capacity of Schools, Neighborhoods,
and Communities to Improve Adolescent Health
Outcomes**

**Crown & Crab
(Maryland Inn)**

*Co-Chairs: Peter L. Benson, Ph.D.
Search Institute*

*Robert Wm. Blum, M.D., Ph.D.
University of Minnesota*

*Karen J. Pittman, M.A.
International Youth Foundation*

**Work Group VI:
Exploring the Influence of Law and Public Policy
on Adolescent Health**

**Jonas Green Room
(Governor Calvert House)**

*Co-Chairs: Abigail English, J.D.
National Center for Youth Law*

*Brian L. Wilcox, Ph.D.
University of Nebraska*

5:45 p.m.

Break

6:15 p.m.

Maryland Crab and Chicken Feast

Atrium

Tuesday, September 15, 1998

8 a.m.

Continental Breakfast
(Provided in Work Group Rooms)

8:30 a.m.

Work Group Session B - Maryland Crab and Chicken Feast

10:15 a.m.

Break

10:30 a.m.

Work Group Session B Continued

12 p.m.

Luncheon

Atrium

1:30 p.m.

Plenary Session II:

Governor's Hall

*Facilitator: Trina Menden Anglin, M.D., Ph.D.
Medical Officer, Office of Adolescent Health*

"Reasons to Invest in Adolescents"

*Martha R. Burt, Ph.D.
The Urban Institute*

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*From the Office of Linda H. Bearinger, Ph.D.
beari001@tc.umn.edu*

Attachment D

Health Futures of Youth II: Pathways to Adolescent Health

Invitational Workshop Participants

I thought it would be most helpful if you received the list of participants at the Health Futures of Youth II invitational workshop. (As you can see, as we moved from conception to implementation there was a shift in the name of the national event.)

I have boldly gone through and asterisked the names of those who for a variety of reasons you might want to consider for the White House meeting. I am certain that some of the names have already come to your attention. [REDACTED] (b)(6)

[REDACTED] (b)(6) Otherwise, there are a number of exceptional persons who contributed to the Health Futures meeting.

[0061]

HEALTH FUTURES OF YOUTH II: PATHWAYS TO ADOLESCENT HEALTH



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Public Health Service
HRSA
Health Resources & Services Administration
Maternal & Child Health Bureau
Office of Adolescent Health

September 14-16, 1998

**Historic Inns of Annapolis
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Participant and Speaker Recommendations drawn from the Health Futures II conference.

Overall, I know that you are seeking persons representing a diversity of disciplines, perspectives, and ethnicity. For this convening to have lasting impact, you are also seeking opinion leaders, many of whom should ~~be~~ have their views grounded in research, i.e., evidence-based perspectives and insights.

Let me summarize some rationale for the asterisks for a few of those I noted on the attached list. Of course, I would ask that these perspectives from me remain confidential to the two of you.

Trina Anglin: the head of the Office of Adolescent Health of the Federal Maternal and Child Health Bureau (MCHB) and the 2000-2001 President of the Society for Adolescent Medicine. She is not a dynamic contributor, nor has she done research or clinical work that has a psycho-social emphasis, but she heads up the Office that holds much of the MCHB resources focused on adolescent health.

Peter Benson: as I indicated on Saturday, Peter Benson (who I know is on your planning committee) has taken a lead in identifying the many "assets" that strengthen young people's ability to resist harm and be resilient. His work is most applicable to community perspectives, as exemplified in his most recent book. Though this work contributed to further study of resilience, the Search Institute has not moved forward in scientific analysis of findings and publication in scientific, peer-reviewed journals (with few exceptions). In other words, Peter's contributions at the meeting would be excellent, but would not include strengths in presenting research-based perspectives.

→ **Claire Brindis:** can provide rich perspectives on delivery of services to young people at the individual (clinical) and population-focused (community-based) levels. Her research is highly regarded and applicable to many of us in the field of adolescent health.

Debra Delgado: an African American woman who, to say simply, was quite impressive in workgroup at the Health Futures II meeting. Her experiences at Annie E. Casey Foundation give her a breadth of perspective on "what works" and "what doesn't" with young people who are most vulnerable.

Joy Dryfoos: I mentioned her book at the meeting on Saturday, "Full Service Schools." She gave an excellent keynote address at the Society for Adolescent Medicine meeting several years ago. I imagine she would be close to retirement at this point, but very persuasive in her perspectives grounded in an ethnographic approach.

Lloyd Kolbe: of the CDC, he has been the head of the Division of School Health for many years. Yet, he is a motivator as well as innovator in supporting research that might lead to meaningful applicable interventions for young people. He has been collaborating with a consulting team of researchers who are attempting to launch what has been called a "Framingham II" longitudinal study of children that will hopefully track over a 20+ year time period.

(**Julia Graham Lear:** who has spent many years of her career at the Robert Wood Johnson Foundation literally launching the first school-based health clinics. She continues to be one of the most insightful and experience persons in the country, in terms of school-based health services.

(**Karen Pittman:** In an e-mail to you, I am putting her on the list of potential speakers. Though I haven't heard her speak recently, she is a very knowledgeable African American woman who has set the standards for effective community-based interventions with vulnerable youth. She coined the phrase the many of us use:

"Adolescents are not problems to be solved, but resource^s to be developed."

Laurence Steinberg: Also, a potential speaker that we mentioned in the Saturday meeting. He gave a stunning keynote at the Society for Adolescent Medicine meeting two years ago. His focus is on youth and families, being a development psychologist in his training.

Attachment E

Pertinent White Papers Developed for Health Futures II

I gleaned through the set of papers that were commissioned for Health Futures II. A number of them (about half) were not applicable to the set of objectives for the White House meeting that you outlined on Saturday.

I didn't mention **Martha (Marty) Burt** as a potential participant in the White House meeting. As you can see, she authored one of the white papers. I just met with her a week ago while in Washington DC. She has been instrumental in arguing the worth of investing in adolescents and she presents the research-based evidence to support her perspectives. She lives in Washington DC and works at the Urban Institute. I think she would make a valuable contribution to the meeting.

REASONS TO INVEST IN ADOLESCENTS

July 1998

By:

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Paper prepared for the "Health Futures of Youth II: Pathways to Adolescent Health" September 14-16, 1998. sponsored by the Maternal and Child Health Bureau, DHHS, Washington, DC.

REASONS TO INVEST IN ADOLESCENTS

Martha R. Burt, Ph.D.
Urban Institute, Washington, D.C.

I. Framework for Understanding Initiatives toward Adolescents

Too often in the past, public policy has either ignored adolescents or focused on them only when they behave in ways that trouble their elders. Compared to very young children and to the elderly, adolescents suffer from few life-threatening conditions. The formation in adolescence of certain health habits with long-term negative consequences (such as smoking tobacco products, use of other addictive substances, or sexual activity without protection from STD and AIDS) often does not produce morbidity or mortality *in adolescence itself*. Rather the effects, and the costs, develop over a lifetime. Thus, when societies face decisions about where to invest significant health and other supportive resources, attention to adolescents often receives short shrift, despite the fact that after early infancy, adolescence is the period of greatest vulnerability until one gets to the diseases of old age.

Need for Future Health and Productivity

In 1996, youth made up about 1 in every 7 people in the United States population, whether the focus is on the younger end of the age spectrum (10-19 year olds are 14.2 percent) or the older end (14-24 year olds are 15.1 percent). These are the individuals on whom the future of this country rides. A strong argument can be made that we need *all* of our youth to develop into productive adults, with skills and attitudes ready to cope with 21st century work, politics, and community and interpersonal relationships. The evidence suggests that for significant portions of our youth, seriously inadequate educational achievement, life-threatening habits such as addictions, risky sexual behavior, involvement in crime and violence, and too-early childbearing foreclose the possibility that they will become contributing members of society. Being both well-educated and healthy contributes to potential economic productivity, but of course does not guarantee it. It is also essential that communities create increasingly broad and rewarding economic opportunities. There is an important interaction between economic opportunity and the readiness of today's youth to take advantage of it. Without the realistic hope of getting ahead economically, there is little incentive for youth to invest in education or protect themselves from some of the less healthy habits they may acquire during adolescence. But without the expectation that there will be a qualified workforce to fill newly-created jobs, many employers will send jobs overseas or fill them with people trained outside the United States, while the jobs that remain will be the least challenging, interesting, and rewarding ones. To the extent that the youth of today and tomorrow are not prepared for the future (and many are not, as will be documented below), expectations for the country's continued economic prosperity are open to question.

Problem-Focused Versus Holistic Programming

Another critical issue has to do with the programs that *do* exist to serve adolescents. The types of attention that adolescents usually *do* receive, when they receive any, too often is focused on

adulthood or to stay a child; or (3) the consequences of their perception that they may never complete the tasks successfully.

Addressing Symptoms, or Underlying Conditions. As has already been noted, most programs serving adolescents focus on specific conditions and usually do not intervene until the conditions have reached the level of "problems." Thus we have programs dealing with teenage childbearing, programs dealing with failure to complete secondary school, programs dealing with substance abuse among youth, and programs trying to reduce youth violence and criminal behavior. To a large extent this compartmentalized pattern of services reflects the narrow focus of many government agencies, so that even when service agencies want to treat youth holistically, their sources of funding often get in the way. However, a great deal of research on the factors contributing to the development of these problems reveals that they have common antecedents—the same underlying conditions are identified time and again.

In a recent summary of research on risk factors, Catalano and Hawkins (1995) identify the following as common antecedents for most or all of substance abuse, delinquency, teenage pregnancy, school dropout and violence: extreme economic deprivation, family conflict, family history of the problem behavior, and family management problems. Further, substance abuse, delinquency and violence all have as antecedents neighborhood characteristics that suggest the neighborhood offers pervasive opportunity to engage in problem behaviors, and little to help youth resist them. These include community laws and norms favorable toward drug use and crime, availability of firearms, friends who engage in the problem behaviors, parental attitudes favorable to the problem behavior, and low neighborhood attachment and community disorganization. Under these circumstances, youth striving to achieve identity, skills, and a livelihood may have ready access to problem activities (from the society's point of view) and little access to positive ones.

Too often, public policies and programs address youth problems as if each one happens in a vacuum. A more apt metaphor for youth problem behavior would be a volcano. The volcano has a seething, molten inner core, and a number of potential fissures through which the pressure building up at the core may be relieved. One fissure may be risky sexual behavior; another may be involvement with drugs; a third may be criminal behavior; a fourth may be school dropout. If we focus on the symptom emerging from a particular fissure and try to fix it, say by plugging the fissure, the underlying pressure from the life conditions of high risk youth will simply find another way to escape. Perhaps this will be as another problem behavior. Perhaps, with proper guidance and intervention to help youth achieve developmental tasks in a constructive manner, it could be legitimate entrepreneurial activity or community service. The important point is that, to change the fate of youth in these circumstances, we have to find ways to reduce the pressure or turn down the heat at the base of the volcano and, in addition, channel energies into productive activities. This means addressing the underlying causes or conditions of adolescent lives, at the same time we think about how to help youth toward successful completion of their fundamental developmental tasks.

Risk and Resiliency. Just as there are factors in a youth's environment and background that condition the probability that the youth will get into trouble, there are also factors that may be able to protect youth from their influence. The idea of protective factors grows out of work that

Exhibit 1

RISK ANTECEDENTS, MARKERS, BEHAVIORS, AND OUTCOMES: A CONCEPTUAL FRAMEWORK FOR THINKING ABOUT YOUTH

ANTECEDENTS	PROTECTIVE FACTORS	SYSTEM MARKERS	PROBLEM BEHAVIORS	POSITIVE BEHAVIORS	NEGATIVE OUTCOMES
Family Dysfunction	Individual competencies/abilities Parental competencies, resources	Poor school performance Child protection/ out of home placement	School-related problem behaviors (truancy, absenteeism, violence) Early sexual behavior	Good school attendance, attachment to school, good performance Postponing sexual behavior	Dropping out of school, poor credentials for economic self-sufficiency Pregnancy, too-early parenthood, poor pregnancy outcomes Sexually-transmitted diseases, including chlamydia and AIDS
Poverty			Use of tobacco, alcohol, other drugs		Abuse of or addiction to alcohol or other drugs, and associated health problems
Neighborhood and Local Institutions	Other adults Neighborhood resources Effective schools and other institutions with responsibility for children and youth		Running away from home, foster home Associating with delinquent peers	Positive interactions with family Participation in community and religious institutions Social, problem-solving and peer skills High self-esteem and achievement motivation	Homelessness Physical abuse, battering Prostitution Sexual abuse, rape, incest Death or permanent injury from guns, knives, and other violent behavior, automobile accidents, other accidents Other morbidity/mortality outcomes (e.g., hepatitis, tuberculosis, pneumonia, AIDS complications) Depression, suicide Criminal convictions

percent reporting truancy from some classes (Resnick, Chambliss & Blum, 1993). Resnick, Harris & Blum (1993) report that school absenteeism was a problem strongly associated with other acting out behaviors (poly-drug use, pregnancy risk, delinquency risk, and risk of unintentional injury). In addition, data from the 1988 National Survey of Adolescent Males indicates that 36 percent of non-poor and 42 percent of poor males age 15-19 had been suspended from school at least once. In the 1990 follow-up of this cohort, 6 percent of non-poor and 13 percent of poor males had been suspended at least once during the two years since their first interview (Chaplin & Merryman, 1996). Finally, data for 1993 from the Youth Risk Behavior Surveillance System show that 12 percent of respondents to this school-based survey reported carrying a weapon to school at least once during the 30 days before the survey. Males were much more likely to do so than females (18 and 5 percent, respectively) (Centers for Disease Control, 1991).

A number of correlates of poor school performance appear to make the difference between staying in or dropping out of school for young at-risk adolescents. Dryfoos (1990) estimates that the children at highest risk are those who live in disadvantaged families in impoverished neighborhoods and communities, get little support and encouragement from parents or other family members, and belong to a peer group whose members are also at risk for dropping out and serve as negative models. At the same time, the schools in these communities are under considerable stress, and do not have sufficient resources to assist these children. In addition, they have relatively low expectations of success for these students, and thus may not offer effective help even though there is some evidence that early interventions can succeed (see Sonenstein et al., 1991, for a review of programs to prevent school failure during children's first years in school).

Health and Adolescent Pregnancy

Ample documentation exists that teenage childbearing has negative consequences for both mothers and children (Brown & Eisenberg, 1995). Yet although only 1 in 100 sexually active teenagers 17 years or under wanted a pregnancy to occur (this was true for both males and females, and for both African-Americans and whites; Moore & Peterson, 1989), close to one in four sexually active teens (23 percent) experience a pregnancy during the year. Among sexually experienced teenagers, approximately 9 percent of 14-year-olds and 18 percent of 15-17-year-olds become pregnant each year. Nineteen percent of African-American teenage women aged 15-19 become pregnant each year compared to 13 percent of Hispanics and 8 percent of whites (Alan Guttmacher Institute, 1994).

The chain of events for early adolescents at highest risk for childbearing starts with early intercourse, followed by nonuse of protection at first intercourse, a long delay prior to obtaining contraception, and finally, an unplanned, out-of-wedlock pregnancy. Although the scope of the problem for the population of 10-15 year olds is considerably smaller than for older adolescents, the consequences are more serious. Moreover, pregnancies during early adolescence may signal non-voluntary intercourse, sexual abuse, and rape (Moore, Nord & Peterson, 1989). Among sexually active teens, African-American males and males living in poverty are likely to have a higher number of partners than females from the same groups. The earlier the age at first

Pastore, 1993). According to the Federal Bureau of Investigation's 1993 Uniform Crime Reports, juvenile arrests between 1984 and 1993 rose 40 percent for robbery, 98 percent for aggravated assault and 106 percent for motor vehicle theft (Federal Bureau of Investigation, 1993). According to some estimates, approximately 20 percent of adolescents commit muggings, robbery or gang assaults, but only a small minority (5-8 percent of males and 3-6 percent of females) are responsible for most of these acts (Elliott et al., 1983; Elliott, Huizinga & Menard, 1989; Tracy, Wolfgang & Figlio, 1990).

Combined Prevalence

A relatively strong research literature now exists that explores the co-occurrence of multiple problems in adolescence (Allen, Leadbeater & Aber, 1994; Botvin, 1990, 1986; Elliott, Huizinga & Menard, 1989; Fergusson, Horwood & Lynskey, 1994), as well as studies that look at the co-occurrence of many aspects of risk, including antecedent conditions, protective factors, and problem behaviors (Garmezy, 1991; Harrell et al., 1997; Hawkins, Catalano & Miller, 1992; Paternoster & Mazerolle, 1994; Resnick, Harris, & Blum, 1993; Werner, 1989). This research supports earlier findings that many problem behaviors share common antecedent characteristics, and makes a strong case that a common dynamic probably precedes engagement in the many potential problem behaviors of youth. Therefore different levels of risk can be defined according to the number and seriousness of multiple problem behaviors that a youth exhibits (e.g., school failure, substance abuse, delinquency, or pregnancy).

Resnick, Harris and Blum (1993), using data from a school-based survey with more than 30,000 youth throughout Minnesota, find very high rates of participation in at least one problem behavior, but relatively low proportions of youth who participate in many. Their analysis of nine types of problem behaviors found two clusters. The first cluster, *acting out behaviors*, includes: poly-drug use, school absenteeism, unintended injury risk such as drinking and driving, not wearing seatbelts, not using a helmet on a motorcycle, risk of becoming pregnant or causing a pregnancy, and delinquency risk. That these serious behavior problems cluster so strongly gives ample evidence that youth in serious trouble are probably in trouble in a lot of ways. The second cluster, *quietly disturbed behaviors*, includes: poor body image, disordered eating including bingeing, bulimia, chronic dieting; fear of loss of control over eating; emotional stress; and suicidal ideation or attempts. These authors also note that "some 80 percent of students fell into the high-risk category for at least one of the behaviors, with about 10 percent at high risk for four or more behaviors."

The National Survey of Adolescent Males also provides some sense of overlapping problem behaviors and the counteracting influence of protective factors for young men aged 15-19 in 1991. Pleck, Sonenstein, Ku & Burbridge (in press) report the following:

- 21 percent —sexual intercourse at age 14 or earlier;
- 43 percent—first use of alcohol at age 15 or earlier;
- 20 percent—first use of marijuana at age 15 or earlier;
- 30 percent—ever retained in grade;
- Multiple risk markers: 0—33 percent; 1—34 percent; 2—22 percent; 3—10 percent; 4—2 percent.

adolescent risk behaviors with respect to a variety of topics including youth smoking and substance abuse, teenage pregnancy and childbearing, educational completion, and juveniles likely to become career criminals. This section describes some of these studies with two purposes in mind. The first purpose is to present a variety of ways that analysts have tried to conceptualize the ideas of investment, payoff, costs, and social and personal consequences. A number of approaches exist, and there may be reasons for choosing one or the other of them depending on what you are trying to do. The second purpose is to give some concrete examples of analyses that may stimulate the reader to think about how similar investigations could be undertaken in their own states and communities. The end of this section includes the results from several studies that examined the effects of holistic, integrated service and support systems designed to help high risk youth.

Statements about costs that could have been prevented with appropriate interventions make very powerful arguments. For instance, the Carnegie Council on Adolescent Development (1993) recently presented some telling calculations for the United States:

- Each year's class of high school dropouts will, over their lifetime, cost the nation \$260 billion in lost earnings and foregone taxes.
- Over a lifetime, the average high school dropout will earn \$230,000 less than a high school graduate and contribute \$70,000 less in taxes.
- Each added year of secondary education reduces the probability of public welfare dependency in adulthood by 35 percent (with associated reductions in public costs).
- Each year, the U.S. spends roughly \$20 billion in payments for income maintenance, health care, and nutrition to support families begun by teenagers.

When thinking about justifying investments in public support and services to adolescents, there is some pressure to try to quantify the results, and also to monetarize them if possible. People usually approach the job of justifying investments by asking, "What is the cost of *not* helping high risk youth—that is, suppose we did nothing and the youth went ahead and pursued high risk behaviors, what would be the consequences? And, are those consequences sufficiently disastrous, for a youth, for a community, or for society as a whole, that we should seriously consider putting some public resources (money, programs, attention) into trying to prevent them and into promoting their opposite?"

Several components of cost have been investigated, including:

- *Things of value to the individual*, that he or she is less likely to attain if he or she indulges in risky behavior—the most obvious monetary example is income that might have been earned if the individual had completed high school rather than dropping out, or had lived rather than died of a drug overdose, or had not had a baby at the age of 14. "Years of life foregone" is a quantified but not monetarized measure often used to assess the seriousness of various causes of death.

During the early 1980s, several pioneering attempts were made in the United States to estimate various aspects of the costs of teenage childbearing. Among the most sophisticated were Wertheimer and Moore (1982), who used dynamic simulation computer modeling to estimate lost earnings, lost work years, lost taxes, and probable use of public benefits such as welfare (Aid to Families with Dependent Children) and public medical care (Medicaid); and SRI International (1979), who developed a 20-year projection of the public welfare, medical, housing and social services costs of a family begun by a first birth to a teenager. Both studies controlled for the age at first birth, and assumed higher costs the younger the mother at first birth.

Burt (1985, 1986) took the findings from these studies and developed two simple cost-estimating methods that could be conducted in any jurisdiction of interest (county, state, or for the whole country). The first method calculates the money spent through the three biggest public assistance programs in the United States during a single calendar year that went to families begun by a teen first birth.² It uses public records of the totals spent on these programs during the year of interest within the jurisdiction being studied, and takes a percentage of these total funds equivalent to the proportion of families receiving them in which the mother had her first child as a teenager (some states collect this information, and an estimate of the correct proportion was also available from other research). The total national expenditure for 1985 calculated by this method was \$16.65 billion through the three programs. Advocates for Youth (then Center for Population Options), which commissioned the development of this method, published annual updates through the mid-1990s indicating that these costs rose a small amount every year during that period.

The second method follows the SRI International model, and estimates the cost to the public over a 20-year period, in welfare, medical care, housing, and social services, of each family begun by a birth to a teen younger than 15, 15 to 17, and 18 to 19. To learn the total public cost for an entire calendar year's cohort of first births to mothers 19 or younger, these calculated costs are then multiplied by the actual number of first births to teens in those age groups as recorded in vital statistics. All out-year costs are then discounted to future value. These costs are compared to the probable public costs for families in which the mother waited until she was at least 20 before having her first child; the difference is the possible public savings of helping teens delay first births until the age of 20 or later. Results indicated that for each first birth to a teen mother in 1985, public costs averaged almost \$14,000 over the next 20 years, and would be \$5.16 billion over 20 years for the entire cohort of families begun by a first birth to a teen during 1985. Each subsequent year's cohort of new families would cost the same or more. These costs include only the outlays of the major public programs that existed up through the major national welfare reform effort initiated by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which eliminated Aid to Families with Dependent Children along with the entitlement to welfare, and substituted Temporary Assistance to Needy Families. One could add to them the costs of earnings and taxes foregone for each new teen mother who failed to complete high school, as reported below.

Burt and Levy (1987) used these cost analyses as the basis of a model for assessing cost-benefits and the cost-effectiveness of services to adolescents. The reasoning they followed is similar to

² Income assistance (Aid to Families with Dependent Children), health care (Medicaid), and nutrition (Food Stamps).

- Victim costs including tangible ones (lost productivity, medical expenses), intangible ones (pain, suffering, and reduced quality of life), and probability of death;
- Criminal justice costs, including police, investigative, court, and imprisonment costs;
- Foregone earnings of the youth while incarcerated.

He makes these calculations for each type of crime, calculates the probable number and mix of crimes perpetrated by the average career criminal, adds up all of these over the course of a criminal career, discounts the total for present monetary value, and arrives at a sum of \$1.0 to \$1.3 million *per career criminal*. Similar calculations (with somewhat different components of cost) for chronic drug abusers and high school dropouts produce estimates of \$333,000 to \$809,000 for the former and \$291,000 to \$466,000 for the latter. Eliminating duplication (many career criminals are also high school dropouts and heavy drug users), he arrives at an overall estimate of the "monetary value of saving a high risk youth" of \$1.5 to \$2.0 million. It should be apparent to the reader that even if these estimates are ten times too high, they could still justify a great deal more assistance to high risk youth than currently is being offered.

IV. What Evidence Do We Have that a Holistic Approach Works?

In deciding *what to do* to assist youth, past efforts have focused largely on youth who have already exhibited behaviors considered undesirable by society (e.g., dropping out of school, engaging in illegal activities, engaging in violent activities, having babies without being able to support them, abusing drugs and alcohol). Programs addressing these issues typically work with youth to try to stop them from continuing these behaviors, and to reduce the consequences of these behaviors. Thus they are engaging in either secondary prevention or tertiary attention (Barker & Fuentes 1995).

There is ample evidence that programs of this type cannot and do not bring about a significant reduction in negative behaviors for the youth population as a whole (Barker & Fuentes 1995; Dryfoos 1990; Burt, Resnick & Novick, 1998). The major explanations for the failure of most programs of this type are that: (1) they are single focus (they focus only on a single problem, not on the youth's whole life circumstances, and the single problem cannot be solved without "solving" the youth's life circumstances); (2) they are too short-term; (3) they start too late (after the problems are already apparent and the behavioral patterns are set); (4) they focus only on preventing negative behavior, not on promoting positive behaviors. Dryfoos (1990) summarizes the characteristics of single-focus programs with the highest records of *success*; her findings are reproduced in Table 1.

The evidence is very strong that the successful programs, even though nominally single-focus, in reality treat children and youth (and their families) holistically, start young, offer many enrichment, growth and development activities, and stick with youth for a long period of time.

Recent research results support the importance of an integrated approach to helping youth, both in terms of the issues addressed in the youths' lives and in terms of the structure of services and activities available to them through the intervention program. In New Jersey, a high school that put in place an integrated services program described as "convenient, sensitive, non-stigmatizing, and holistic." The program offers services such as individual and family counseling, primary and

neighborhoods in the same cities that had neither the community policing or the Children at Risk Program. Not only were juvenile arrests significantly lower in the demonstration than in the comparison neighborhoods, but so were *all* criminal offenses, both serious and less serious.

Mid-term results from CAR, which included information about problem behaviors obtained directly from youth, were disappointing, but results from follow-up interviews conducted with CAR and comparison youth one year after the end of the program are more encouraging (Harrell, Cavanagh & Sridharan, 1998). In comparison with non-CAR youth, CAR youth were less likely to have used gateway drugs or stronger drugs in the past month, less likely to have sold drugs in the past month and in their lifetime, more likely to be promoted in school, and had committed fewer violent crimes. A most interesting result was that when CAR youth *did* get into trouble, the supports offered by the program helped to resolve the situations before they escalated into permanent difficulties for the youth.

A final U.S. success story is the Quantum Opportunities Program (Hahn 1994; 1995). The evaluation for this program also involved random assignment. The program offered integrated services, enrichment activities, and a community service and development focus. Participants, who were recruited in 9th grade (at about age 14) and followed for four years, received tutoring and other educationally oriented assistance, mentoring (association with compassionate, caring, competent adults), and financial incentives, and also were involved in numerous community-oriented activities, services, and developmental projects. Over the four years during which the study followed the participants, youth participating in the program experienced significantly better outcomes than those in the control group. The results were consistently in the right direction; however, as a warning to those who might hope for "instant," or at least "quick," impact, the differences did not reach the level of statistical significance until the third or fourth year of program participation (some results reached significance sooner than others). These findings suggest that it is important for both program and researchers to be in the picture for an extended period of time, and for the evaluation design to include indicators of early signs of progress, as well as indicators of achievement on the ultimate outcomes toward which the program is targeted.

These results indicate that integrated services addressing the complex needs of youth in a compassionate way with a positive outlook can make a significant difference on important youth outcomes that are likely to affect the future life chances and productivity of youth. The importance of an integrated, holistic approach has now reached the point of acceptance at the level of federal agencies. For instance, the Office of Juvenile Justice and Delinquency Prevention (1995a,b) in the U.S. Department of Justice has recently issued two reports that accept and strongly promote the holistic approach of involving many other service sectors, families, and communities. OJJDP recognizes that its strictly "justice" goals will not be reached without broader-based interventions, both for primary prevention and for interventions with criminally-involved youth. OJJDP goes so far as to include adequate prenatal care and parenting education as effective strategies for preventing *adolescent criminal behavior*, both because they can help prevent disabilities that may leave a youth few positive alternatives and because they prevent child abuse that can perpetuate another violent generation. The U.S. Department of Health and Human Services also take this view.

get some help in protecting themselves from negative family influences. Many programs also try to offer sympathetic and supportive adults with whom youth can bond, in order to supply this relationship as an additional protective factor. This is especially important when familial problems and difficulties with parents are among the chief risk factors in the lives of youth.

Use a Holistic Approach

It is a strong recommendation of this paper that programs structure themselves so they can serve youth in a holistic manner. The keys to doing so are to take a long-range approach, to offer positive developmental opportunities to youth appropriate to their age and experience, to pay attention to family and neighborhood issues, and to recognize that healthy behaviors (and unhealthy behaviors) happen in a context which must be addressed if programs are to be successful in changing the lives of youth. This may be a new way of thinking for many readers of this paper, but the evidence is coming in from many directions to suggest that the payoffs are worth the effort. In thinking about the value of the holistic approach, one needs to think about the reasons why youth may *not* benefit from your program, and determine to help them overcome these barriers. The barriers may be those of knowledge and access, but they may also be those of motivation, of seeing no realistic future that is worth the effort to take care of themselves, of other pressing priorities, of no resources to follow the advice of the program on health issues, of family or peer interference, or of other neighborhood influences. If 90 percent of the youth in your catchment area experience one or more of these barriers to the extent that they are prevented from using your program, it may be wise to develop ways to reach this 90 percent, rather than working exclusively with the 10 percent who are able to find their way to your door.

In the pursuit of a more holistic approach, it is not necessary, and may not even be desirable, for a particular program to try to do everything itself. More and more, programs addressing different needs and providing different skills and knowledge are forming networks that help them meet the multiple needs of youth in a flexible and efficient manner. This may involve co-locating services from different agencies in an attractive and easily accessible youth center, or it may involve developing a network of service providers who are very familiar with each other's work and make a lot of referrals among network agencies. It certainly involves listening to the needs and issues of youth, the needs and issues of service providers, and creating new and flexible structures that are responsive to both sets of needs.

Need for Information for Making Decisions

Enough evaluation evidence exists to support the recommendation of a holistic approach to helping at-risk youth, along with advice to intervene earlier rather than later and to offer youth long-term involvement with your program. However, many questions remain about which we have little or no information on which to base program decisions. Some of these questions may be answerable either through meta-analysis of existing evaluations or through carefully designed new research. These questions include:

- I am committed to a holistic approach, but is there a "best," or a "better," way to structure my program offerings? Should I try to get everything under one roof, or will I succeed

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