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**Interagency Working Group on Violence
Youth Development Final Draft**

I. Overview

In 1992, there were approximately 41 million young people between the ages of 14 and 24 in the United States. (U.S. Bureau of the Census, Population Projections, July 1992) In 1990 there were about 20 million young adolescents between the ages of 10 and 15. About 68% of young adolescents are non-Hispanic white, the remaining 32% are African-American (15%), Hispanic (12%), Asian/Pacific Islander (3%) and American Indian, Eskimo and Aleut (1%). By the year 2000, the number of young adolescents is expected to exceed 23 million, and its ethnic composition will change to approximately 66% non-Hispanic white and 34% other racial and ethnic groups. (U.S. Bureau of the Census 1990, cited in Carnegie Corporation, A Matter of Time: Risk and Opportunity in the Non-School Hours, 1992)

Most adolescents are on a healthy path towards productive adult lives. There is evidence, however, that 25% of adolescents are at significant risk of veering off that path because they engage in numerous behaviors with negative consequences, such as alcohol or other drug abuse, unprotected sexual activity, delinquency or violence. Another 25% of adolescents are at moderate risk because they engage in fewer of these behaviors. (Joy Dryfoos, Adolescents at Risk, Oxford University Press, 1989)

Deteriorating Neighborhoods and Limited Opportunities

Over the last 20 years, structural changes in the U.S. economy have combined with increases in the number of single-parent households over the last 20 years to cause a significant deterioration in the economic position of adolescents. While this decline affects youth of all races, sexes and levels of education, it is particularly acute for youth without a high school diploma and high school graduates who have not obtained a four-year college degree. (National Research Council, National Academy of Sciences, Losing Generations: Adolescents in High Risk Settings, 1993)

The statistics tell a dramatic story. The proportion of young adolescents (ages 10-15) who live in poverty rose from 14% in 1969 to 16% in 1978 to 20% in 1990. (Children's Defense Fund, 1991, cited in Carnegie) About 3 million young people between the ages of 10 to 18 and almost 1.2 million mothers younger than 26 (including 40,000 younger than 18) currently receive AFDC. (Children's Defense Fund, The Adolescent and Young Adult Fact Book, 1991) About one in four of the 30% of all adolescents in rural areas live in poverty, (Carnegie) and about 4 million of

the country's poor youth live in public and assisted housing projects (Pat Arnaudo, HUD). While children in single-parent families are most likely to be poor, many two-parent families have experienced a decline in their standard of living. Without the income provided by women entering the workforce and increasing the number of hours they work, incomes for 60% of two-parent families would have been lower in 1989 than in 1979. (National Research Council)

The number of poor neighborhoods has increased over the last decade. The incidence of neighborhoods in which at least 20% of families are poor has increased from 34% to 39% of cities' census tracts. During the same period, the proportion of extremely poor neighborhoods -- those with a poverty rate of 40% or more -- increased from approximately 10% to 14% of city census tracts. (William Julius Wilson, *The Truly Disadvantaged*, 1989)

The increase in poor neighborhoods is linked to a contraction of legitimate employment opportunities for youth. The shift to a service-oriented and high-technology economy and the loss of manufacturing jobs in central cities has reduced the number of job opportunities. These developments explain the loss of average real earnings for young adults between 1979 and 1988.

The increasingly limited economic opportunities for adolescents are also reflected in changes in the youth unemployment rate and the proportion of youth who are living at home with their parents. In 1991, about 15% of teenagers and 8%-9% of young adults in the labor force were officially unemployed. (Children's Defense Fund) Employment rates among African-American and other non-white youth ages 16-17 declined from 40% in 1954 to 15% in 1992. For African-American and other non-white youth ages 18-19, the employment rate dropped from 67% in 1954 to 34% in 1992.

Inability to find high-paying jobs without a college degree or specialized skills has made more adolescents dependent on their families longer. Over the past 15 years, the percentage of young people living with their families rose steadily to 54% at age 24 and 30% at age 29. (National Research Council)

For some youth who cannot rely on their families for economic support, lack education, and face discrimination in the job market, crime can appear to serve as a rational alternative to legitimate employment. The research suggests that some young men with few skills and limited legal work opportunities can earn up to 2 to 4 times as much in criminal activities than they are likely to earn in entry-level jobs. (National Research Council)

The significant increase over the last 20 years in the number of single-parent families is another reason for the large number of adolescents living in poverty. About one-half of all marriages now end in divorce, which is twice the divorce rate in 1960.

Approximately 25% of all births are to unmarried women. As a result, about 25% of all children live with only one parent, which represents a doubling of the rate since 1970. About 50% of all children will live in a single-parent home before they reach the age of 18 and will spend an average of 6 years with a single parent. (National Research Council)

Adolescent girls are becoming single parents in increasing numbers. While births to unmarried women made up only 15% of all births to adolescents in 1960, and 30% in 1970, by 1989 more than 67% of teen mothers were unmarried. (National Research Council) Families headed by a single parent, adolescent or not, are more likely to be poor. Poverty rates are almost six times higher for single-parent families than for two-parent families. About 87% of single parents are women. (National Research Council)

The growth in the number of youth living in non-traditional families, or without families at all, is significant. Drug abuse, sexual or physical abuse, and neglect have resulted in an increasing number of youth living in non-traditional arrangements, such as with non-parent relatives, in foster homes, in shelters or on the street. The total number of children in foster care rose from 273,500 in 1986 to 429,000 in 1991 (GAO, Foster Care: Federal Policy on the Title IV-E Share of Training Costs, November 3, 1993).] There are approximately 1.3 million youth today who are runaways or homeless, because their families have been evicted, their parents have pushed them out of the home, or abusive situations have made it impossible for youth to stay. Most of these youth live in shelters or on the street. These youth come from all socioeconomic strata and are at highest risk for involvement in violence and other risky behaviors like drug use and prostitution. (USDHHS, Administration for Children and Families, Runaway and Homeless Youth Program: Fiscal Year 1993 Final Priorities, Federal Register, May 18, 1993)

How Youth Spend Their Time

A 1992 study conducted by the Carnegie Corporation determined that 40% of the time adolescents are awake is discretionary time not taken up by school, homework, chores, meals or employment. It also found that many adolescents spend almost all of this time without adult companionship or supervision but alone, with peers, or with adults who may serve as negative or exploitive influences. (Carnegie) A recent study found that 27% of eighth graders spent two or more hours alone after school, and that low-income youth were more likely than higher income youth to be home alone for three or more hours. (U.S. Department of Education, Office of Educational Research and Improvement, National Center for Education Statistics, National Education Longitudinal Study of 1988: A Profile of the American Eighth Grader, 1990, cited in Carnegie)

In recent years, the infrastructure of America's low-income rural and urban communities has declined. Public schools in many areas have deteriorated and the quality of public education has fallen, city parks and recreation centers are in disrepair, and financial support for youth facilities and programs has decreased. (Carnegie) Thus, concentrated high risk environments for youth have formed.

While all young people can benefit from community supports, positive alternatives are especially important for youth who are not in school or who are at risk of dropping out. Approximately one quarter of all urban schools have dropout rates of around 50%. Dropouts are more likely to be from poor families and single parent households, have parents who are not heavily involved in their lives, and live in urban areas. Dropouts are also more likely to have a handicapping condition, engage in delinquent behavior, be retained in grade and truant from school, be pregnant or a parent, have poor grades, and work more than 15 hours a week. While dropout prevention programs have traditionally been geared to high school students, there is now a movement to begin dropout prevention programs in middle school or before. (National Research Council)

The importance of dropout prevention efforts is made clear from the fact that about one in three of the 400,000 young people who dropped out of high school between October 1989 and October 1990 were unemployed in 1991. Every year, high school dropouts "cost" this country approximately \$340 billion in lost productivity and tax revenue. That amount is 50% more than the United States' year expenditure on public and private education from preschool to postsecondary levels. It does not include the cost of welfare benefits that will be required for some dropouts, or the cost of prison for others. (Children's Defense Fund)

In addition to school dropouts, youth who are neither enrolled in school, employed, or serving in the military are need social supports and positive activities to prevent their involvement in risky behaviors. The research concerning these youth describes them in terms of labor market inactivity. A 1990 study showed that high inactivity rates begin soon after high school: after graduation 19.5% of African-Americans, 14.3% of Hispanics, and 32% of whites were not working or in school, and two years later 50% of African-Americans, 42% of Hispanics and 32% of whites who had been inactive remained inactive. (R.M. Fernandez, Structural Factors in Hispanic Youth Employment, 1990, cited in National Research Council)

Involvement in High Risk Behavior

The average young person is resilient enough to cope with the stressful transitions typical of adolescence. These include first sexual experiences and relationships, school transitions,

peer group pressures, changing relationships with parents, and defining identity. Youth in this age group must cope with the pressure of making decisions, often with considerable peer pressure, about illegal drugs, alcohol, smoking, and driving while intoxicated. Some also face parental divorce or separation, poverty, physical or sexual abuse, or discrimination at school or work. However, it is reassuring to note that only between 10 and 20% of adolescents--the same proportion as adults--exhibit severe emotional disturbance. (Stuart T. Hauser and Mary Kay Bowlds, "Stress, Coping and Adaptation," in At the Threshold: The Developing Adolescent, S. Shirley Feldman and Glen R. Elliott, eds., Harvard University Press, 1990).

A large number of adolescents engage in alcohol and other drug use, unprotected sexual activity and use of cigarettes. According to a 1991 National Institute on Drug Abuse survey of high school seniors, one-third of seniors reported having drunk at least five drinks in a row at least once during a 2-week period, 17% reported monthly use of marijuana, and about 19% reported smoking cigarettes on a daily basis. (Johnston and Bachman, Monitoring the Future: The National High School Senior Survey, 1992) About one-half of all sexually active teenagers have unprotected sexual intercourse, and about 2.5 million adolescents contract a sexually transmitted disease each year. (National Research Council) AIDS is the fast growing cause of death among young adults, and those most at risk of contracting it are runaways, those involved in prostitution, intravenous drug users, incarcerated youth, and those with homosexual experiences. (National Research Council)

The use of alcohol and other drugs is risky, especially because of its links to violent behavior. Alcohol is believed to lower inhibitions and is a factor in at least 55% of all fights and assaults in the home. In about 65% of all homicides, the perpetrator, victim, or both had been drinking. (American Psychological Association, Violence and Youth: Psychology's Response, Volume I: Summary Report of the American Psychological Association Commission on Violence and Youth, 1993) In addition, drugs that are addictive and expensive, such as heroin and cocaine, are linked to violent behavior. In 1984, the National Institute on Drug Abuse estimated that at least 10% of homicides occur during drug sales. Youth involved in the sale of drugs are at greater risk of becoming involved in violent acts. (American Psychological Association)

Despite concern about adolescent involvement in risky behavior, there is a difference between normal experimentation and enduring patterns. Experimentation with the use of alcohol, drugs and tobacco, sexual activity, and juvenile delinquency is widespread during adolescence. (Dryfoos; Terri Moffitt, "Adolescence-Limited and Life Course-Persistent Antisocial Behavior: A Developmental Taxonomy," Psychological Review, Vol. 100, No. 4,

1993) There has emerged a consensus in the research literature that problem behavior among adolescents are interrelated, so that many who engage in one type will also engage in others. (Dryfoos; National Research Council; Martha Burt, Gary Resnick, and Nancy Matheson, Comprehensive Service Integration Programs for At-Risk Youth, for the U.S. Department of Health and Human Services, 1992; D.W. Osgood, "Covariation of Risk Behaviors During Adolescence." Background paper for U.S. Office of Technology Assessment Study on Adolescent Health, U.S. Congress, 1989)

Determining those at highest risk of engaging in problem behaviors is complex and requires an understanding of the interplay between individual characteristics and environment. One group of researchers suggests that early indications of risk can be found in "risk markers"--such as involvement with the child welfare system. (Burt, Resnick and Matheson) This approach implies that environments can be viewed as "high risk" and vulnerable youth described as "youth in high risk situations." High risk environments can include the family, school, neighborhood, or larger community.

It is also possible to identify some youth who are inherently at risk of negative outcomes. Children who have suffered prenatal drug or alcohol exposure, exposure to parents who use alcohol or drugs, and physical or sexual abuse at young ages are examples of those who are "at risk" of negative outcomes. Sometimes intensive interventions or positive environmental influences can ameliorate the effects of early damage and enable the child to avoid later problems. Negative interventions or influences could have the opposite effect. (Doreen Koretz, National Institute of Mental Health, USDHHS)

Involvement in Violence

Young people are at risk of involvement in violence as participants, victims and witnesses; youth who live in low-income areas are at greater risk. Adolescents are 2 1/2 times more likely to be victims of violent crimes than those over age 20. (American Psychological Association) According to the Centers for Disease Control (CDC), the three leading causes of death for all youth ages 15-24 are unintentional injuries, homicide, and suicide. While homicide is the second leading cause of death for youth in this age group, it is the leading cause of death for African-American males and female of this age. (USDHHS, Centers for Disease Control, Youth Risk Behavior Survey, 1990) Rates of suicide for adolescents have almost tripled since 1960 and are now second only to the rates for persons over 65. More than 5,000 adolescents kill themselves each year, and approximately 400,000 attempt suicide. (National Research Council)

Firearms play a key role in the injury and death. CDC reports that guns are involved in about 75% of the killings by African-

American youth. (American Psychological Association) Between 1979 and 1989, there was a 61% increase in homicides by shootings by 15-19-year-old white and African-American youth. During the same period, the rate of homicides by objects other than guns declined 29%. (American Psychological Association) In 1987, firearms were involved in 68% of all murders of adolescents and 83% of all adolescent suicides. (National Research Council) In 1989, 80% of the homicide victims aged 10-19 years old were killed with guns. (Vital Statistics of the United States 1989, Vol. 2, Mortality, Part A, National Center for Health Statistics, 1992, cited in Daniel Webster, Patricia Gainer and Howard Champion, "Weapon Carrying among Inner-City Junior High School Students: Defensive Behavior vs. Aggressive Delinquency," American Journal of Public Health, Vol. 83, No. 11, November 1993)

Guns are available to adolescents both at school and at home. The 1991 National Youth Risk Behavior Survey (YRBS) conducted by CDC revealed that 20% of high school students (32% males, 8% females) reported carrying a weapon at least once during the past 30 days. In a 1993 Harris poll, 59% of the students surveyed said firearms were "easily obtainable" and 35% said that it would take them less than one hour to acquire a firearm. Approximately 50% of American households have guns, and half of these are handguns. (American Psychological Association) A recent study indicates that keeping a firearm in the home almost triples the chances that someone will be killed on the premises. (New England Journal of Medicine)

A small proportion of youth join gangs, and the absolute amount of violence committed by gang members is relatively small. Gang involvement is a concern, however, because of the increase in the amount and severity of gang violence during the past two decades. In addition, homicide and aggravated assault are three times more likely to be committed by gang members than by delinquents. (American Psychological Association)

Youths join gangs for a number of reasons, including the desire for connection, belonging, self-esteem, and self-definition. They also join to find friendship, pride, an identity separate from their families, status, excitement, and acceptance. All of these are normal developmental needs for adolescents. (American Psychological Association) While male gang members outnumber female gang members by 20 to 1, female involvement in gang violence is believed to be increasing. (American Psychological Association)

Adolescents who are not gang members may engage in less serious forms of violent activity, such as physical fighting with their peers. The YRBS reported that 8% of students surveyed had been in at least one physical fight that resulted in an injury requiring treatment by a doctor or nurse in the past 30 days.

(USDHHS, CDC, Youth Risk Behavior Survey, 1990)

Violence has psychological effects on young people, even if they are not the victims of the violent act. A recent survey of first and second graders in Washington, D.C. found that 45% of the children had witnessed muggings, 31% had witnessed shootings, and 39% had seen dead bodies. (American Psychological Association) Posttraumatic stress has been observed among children who witness violent acts. This syndrome includes sleep difficulties, anxiety, loss of interest in significant activities, and attention difficulties among its effects. (American Psychological Association) While there is no accurate measure of the number psychologically affected by violence, the proportion of children who received professional psychological help increased by 50% from 1981 to 1988. (American Psychological Association)

Paths to Violent Behavior

Factors affecting a child's engagement in violent behavior as a youth or young adult include childrearing conditions, emotional and cognitive development, sex role socialization, peer relationships, poverty, and media influences. According to the American Psychological Association, however, the strongest predictor of a child's involvement in violence is a history of previous violence, whether as a participant, victim or witness.

Research on antisocial behavior indicates that, while the tendency of an individual to exhibit aggressive and antisocial behaviors shows a great deal of continuity over time, the prevalence of antisocial behavior temporarily increases almost tenfold during adolescence. (Doreen Koretz, National Institute of Mental Health, USDHHS; Moffitt) One researcher describes two distinct pathways to youth aggression and antisocial pathways that account for these seemingly incompatible facts. (Moffitt)

The first path, which involves a small group of children (between 4% and 9% of the population), begins early in life and persists over time. These children have serious motor and cognitive problems, poor impulse control, and exhibit problem behaviors before age 3, especially in high risk environments. They may begin life in very high risk environments and with physical damage due to a variety of factors such as poor prenatal nutrition, lead exposure, and maternal alcohol or drug abuse. They may also have difficult temperaments, making it difficult for caretakers to provide positive and loving care. A wide variety of risk factors may also contribute to parenting problems that lead to increasingly antisocial behavior by the young child. In turn, the child's acting out behaviors contribute to school failure and rejection by peers. The early adolescent who lacks positive bonds to family, school and prosocial peers may associate with antisocial peers. Behavior problems then increase in range, rate and seriousness, and associated problems including

alcohol and other drug abuse emerge. (Koretz; Moffitt)

The second path involves a much larger group of children who are antisocial only during adolescence. These children may mimic the behavior of the first group in order to achieve status, power, and privilege. For this group, adolescent acting out can be considered normative rather than deviant. Youth may cease engaging in this behavior when legitimate adult roles become available and the consequences of crime become too costly in terms of their futures. (Koretz; Moffitt)

Although both paths contribute to the prevalence of aggressive and antisocial behavior in adolescence, different prevention strategies are suggested. For the persistent, early starting group, sustained and coordinated interventions involving family, school, and peer group may be necessary to deal with the multitude of risk factors which they face. For the group beginning this behavior in adolescence, interventions may need to focus on providing opportunities for positive adult roles, such as mentoring, job skills training, and job placement. The effects of discrimination may be particularly damaging for the latter group. (Koretz)

II. Programs and Policies

There is no coherent Federal "youth policy". Federal programs addressing the needs of youth tend to be fragmented, housed within several different Federal departments and multiple offices within those Departments. Furthermore, most programs are designed to combat specific youth problems, rather than to prevent problems from occurring, improve the environments in which youth live and foster the overall positive development of youth. The majority of Federal dollars currently devoted to youth are spent on their incarceration.

Most people who work with youth directly agree that the categorical punitive, and crisis-oriented approach to youth policy has proven ineffective. A new, preventive approach that requires collaboration and coordination among existing Federal, State and local programs to provide comprehensive services and positive alternative activities for youth is needed. This approach would improve the environments in which youth live in addition to addressing their individual behavior. It will involve youth in the design and implementation of youth-serving programs. It will also require a significant amount of coordination between the public and private sectors. The development of youth policy must become the responsibility of all sectors of our society.

Promising Strategies

Discussions with representatives from youth programs,

foundations, research institutions and universities, and the experience of Federal policy analysts and program planners have indicated that there are a number

- Involving youth in the formation and development of policy and programs to focus on their strengths, address their needs and reduce their involvement in violence. We have begun to understand the great sense of alienation and disconnection that many youth (particularly those in high-risk areas) feel from their own communities in particular and society in general. Youth have indicated through their behavior and in their discussions with those in the field their need for opportunities to establish their self worth and receive affirmation of their importance to society. A number of successful programs have been able to use youth in the development and implementation of programs.

New York City's YOUTHLINE is a toll-free confidential hotline available 24 hours a day, every day, staffed entirely by trained and employed young people working under the supervision of experienced professionals. YOUTHLINE provides an outlet for young people to talk with their peers about their concerns and fears. In addition, with the assistance of a geographic-based computer system and an extensive database, YOUTHLINE is able to provide callers with detailed information about youth-related programs and services located as close as a block or two from their homes. The information is obtained by youth who live in the community.

- Developing, enhancing and promoting youth competence (in skills development), connection to their families, communities and society at large and fostering their ability to make positive contributions. The lack of self-esteem among many youth and the lack of a clear place and role in the community and society are seen as major factors contributing to the alienation of youth in society. Many programs attribute their success to the fact that they help youth to see and understand their own value in relation to others and to the fact that programs convey a sense of respect and pride in the positive contributions that youth can make.

The Teens as Resources Against Drugs (TARAD) program was created as a demonstration program by the National Crime Prevention Council, a nonprofit organization designed to enable people to prevent crime and build safe, caring communities. TARAD is funded by the Bureau of Justice Assistance in the U. S. Department of Justice to provide funds and technical assistance to three sites (New York City, Evansville, Indiana and communities in South Carolina) to demonstrate how

youth can be used to assist their communities in the fight against drug abuse. TARAD offers the opportunity to select a community drug prevention issue or situation, decide on action to address it, and obtain funds to implement the strategy. More than 3,000 youths developed nearly 100 projects in less than two years. Projects, on average, cost less than \$900 each and included the development of murals with anti-drug messages on corners formerly frequented by dealers, the development of teen helpers in elementary school, and community health fairs.

In the San Francisco Bay area of California, public libraries have involved youth in developing outreach programs. The San Lorenzo Branch Library of the Alameda County System sponsored youth forums on topics that teens identified as major needs (including jobs and job skills, multicultural relations, health and sexuality) and formed a teen advisory council to suggest ideas about materials the library should acquire for its collection.

- Intervening early in the lives of youth and providing sustained and involved contact with them over a long period of time. Programs that reach youth early and follow them into adulthood provide youth a stable force in their lives and give them a sense that the programs and their are invested in their growth and development.

The Futures Program of the Countee Cullen Beacon program, located in Central Harlem, New York, works with a small group of youths ages 11 -13 to provide job readiness and entrepreneurial training, computer programming, and sexuality awareness workshops. These services will be available to these young people through college.

- Responding in a way that treats youth as individuals, rather than treating them as a monolithic group. Programs and policies must understand, acknowledge, and respect the diversity among youth, and foster an acceptance for diversity in youth, their families, the community and greater society. Youth need to feel acceptance from many important sources as they struggle to explore issues about their own identity and to accept themselves. Programs must also acknowledge the many stressors that youth feel (including institutionalized racism and discrimination against youth of color, gay, lesbian and bisexual youth, and runaway and homeless youth).

This is a characteristic of all successful youth-serving programs.

- Empowering community leaders and institutions to play a more

active role in guiding and assisting youth. This fosters communities' ability to develop safe and acceptable recreational and leisure time activities for youth as well as connecting the community and its institutions to youth development. Community empowerment strategies that include methods of economically empowering communities are particularly effective, as they provide youth with the opportunity to acquire skills that will allow them to function within and contribute to the economies of their community and their nation. These also provide a socially acceptable alternative to involvement in gangs and drugs as a means of meeting youths' economic and social needs.

Texas City Action Plan to Prevent Crime (T-CAP) engaged seven of the most populous cities of Texas in producing long and short term comprehensive crime prevention action plans. In each city T-CAP aimed to create a comprehensive, citywide crime prevention plan spurred by the leadership of the mayor and grounded in a diverse citizens' coalition. The process was designed to include an assessment of city needs; development of both long- and short-term goals; use of task forces to involve residents and draw on specialized expertise; a process of official approval; and a specific blueprint for implementation. T-CAP's objective was to provide a blueprint help communities and neighborhoods reclaim themselves. Participating cities include San Antonio, Fort Worth, Houston, Dallas, Arlington and Corpus Christi. T-CAP is an initiative of the National Crime Prevention Council and is funded by the Bureau of Justice Assistance in the U.S. Department of Justice.

- Supporting families of youth and involvement of family members in programs that respond to youth issues. Programs that have been successful have indicated the great need to involve family members of youth in intervention and the great need for families to feel supported within their communities. Although, mentor programs have proven successful in providing youth with positive adult involvement, youth and program professionals have indicated that parents and other family members remain the most influential persons in the lives of most youth. Strategies that foster familial support and involvement in youth lives are extremely important.

The Runaway and Homeless Youth Basic Center model, for instance, follows this family support approach. While specifically addressing the needs of runaway and homeless youth, these centers have as their primary goal the effort to help families to succeed together.

The Challengers Boys and Girls Club of South-Central Los

Angeles provides another example of active and positive family involvement. More than 200 parents are involved in club activities every month, teaching arts and crafts skills, photography, sports and computer literacy or providing after school transportation and support services. On any given day 25 to 40 parents, grandparents, foster parents on-site at the club, so that youth can seek them out for discussion or guidance.

- Connecting youth services to existing institutions; particularly educational institutions. Improving the connection between youth and educational institutions enhances the ability of these institutions to provide comprehensive and responsive services to youth. Strengthening the learning environment is key to youth development, as educational institutions provide youth with the skills they need to become productive adults and provide them with a forum to explore social and emotional issues in a neutral and non-threatening environment.

The High Risk Youth Program of CSAP incorporates conflict resolution strategies into their programs that are often located within educational settings. These programs are culturally sensitive and offer developmentally appropriate activities that have been used with children as young as kindergarten age.

- Viewing youth development, violence and crime prevention as a community wide strategy. Linking law enforcement, social services and community policing together to ensure that youth developmental needs and community safety needs are attended to simultaneously have proven to be an effective method of bringing the community together on behalf of youth.

The Youth Gang Drug Prevention program, administered by the Administration for Children and Families, funds community based consortia which organize public and private community-based organizations in an effort to address the issues of gang involvement, violence and drug use. Their strategy is to allow the community to identify problems and plan and implement solutions to those problems.

Operation Weed and Seed is a multi-agency strategy headed by the Department of Justice designed to first "weed out" violent crime, gang activity, drug use, and drug trafficking in targeted high-crime neighborhoods and then to "seed" the target areas by restoring these neighborhoods through social and economic revitalization. The Weed and Seed strategy recognizes the importance of linking and integrating Federal, State, and local law enforcement and criminal justice efforts with Federal, State, and local social

services and private sector and community efforts to maximize the impact of existing programs and resources. It also recognizes the paramount importance of community involvement and empowerment. The United States Attorneys coordinate Federal involvement and funding with assistance from the Office of Justice Programs, the Departments of Health and Human Services, Housing and Urban Development, Labor, Education, Transportation, Agriculture, and Commerce and the Small Business Administration.

- Fostering community and systemwide collaboration for the development of policy, strategies and the integration of services to respond comprehensively to youth needs. Responding in a categorical, piecemeal way to youth problems has proven unsuccessful in curbing violence and/or meeting the real life needs of youth.

A program in Texas, San Antonio Fighting Back, is a comprehensive drug and crime prevention and community development program. The goal of the program is to establish a continuum of care to effectively address alcohol and other drug abuse through a comprehensive prevention, intervention, treatment and relapse prevention program. By consolidating resources and creating a single community-wide system of prevention, early identification, treatment and aftercare, the program seeks to achieve a reduction in the demand for and illegal use of alcohol and other drugs and, in so doing, to decrease violence.

New York City's Rheedlen Centers for Children and Families provide a variety of social, educational, cultural and employment programs and services that seek to involve the entire community in revitalizing the city's most devastated neighborhoods. Its programs include offering youth help with homework, opportunities for participation in sports and the arts, job readiness and employment training as well as family support and family preservation services for families in crisis.

III. Suggested Remedies

RECOMMENDATIONS

Factors influencing youth behavior are powerful, often long-term and pervasive. To be most effective, interventions should have similar characteristics. Efforts to change the environment should be concentrated and focused in intensity and geography to change daily experiences, decisions and behaviors. The goal of interventions should be to address the emotional, recreational, academic, mental and physical health and vocational needs of

youth and their families living in the targeted neighborhood or community.

To develop into productive, contributing members of society, young people need to be viewed as valued members of that society. Consequently, Federal, State and local governments, as well as youth-serving organizations, businesses and foundations, will have to make some fundamental shifts in the way that they view adolescents and address their needs.

Several actions can be taken to support American youth and prevent their involvement in violence. Among these actions are the recommendations of the other subgroups, particularly the subgroups on media violence, schools and firearms. Other steps include:

1. Establish a National Youth Policy.

The United States does not have a national youth policy. Youth issues are addressed on a "program by program" basis and many youth programs view youth as problems rather than people with talents and assets to be developed. The lack of a coherent policy that addresses the needs of adolescents in a comprehensive fashion has resulted in ineffective youth programs and policies.

If youth programs are to be effective, a comprehensive youth development policy must be developed. Such a policy should view all young people as resources to be developed and encourage communities to take responsibility for their youth by building on the inherent strengths of each young person. The policy should be designed to help youth build the skills and develop the healthy attitudes they will need to become productive and caring adults. It should recognize that all youth need the support of parents, communities and schools, and that youth functioning in high-risk environments need additional support. Additionally, a national youth policy should challenge all youth to take responsibility for their actions and the actions of their peers and to serve their communities.

First, the Federal Government should work with State and local governments and the private sector to bring national attention to adolescence as a critical time in children's development and to the need for a coherent youth policy based on the principles outlined earlier in this paper. Second, the Federal Government should facilitate the development of youth development initiatives at the Federal, State and local level — including the public and the private for-profit and not-for-profit sectors — that emphasize prevention rather than reaction and crisis response.

To support these efforts, the Federal Government can reallocate existing funds to programs that focus on prevention and on

meeting the developmental needs of youth in a comprehensive manner. It should also ensure that a significant portion of the resources for adolescents are targeted toward communities where youth are at highest risk.

2. Promote Youth Employment Opportunities.

Federal funds should be directed at providing support for a new youth community employment initiative to increase both short-term and long-term opportunities for youth and the employment rate for young adults in distressed communities. These new federal initiatives in high-poverty areas could include new funding for comprehensive youth employment development efforts such as school-to-work transitions, entrepreneurial businesses, community work improvement projects, sports and recreation programs, cultural activities, and other employment and training programs for youth and youth adults. These employment opportunities should provide young people with meaningful work experience and be fun.

3. Foster school reforms that are responsive to the changing needs of youth. Keep schools open after regular hours and on weekends, and offer programs for youth and their families.

Developing youth as resources for their communities while preventing them from engaging in violent behavior is contingent upon school reform. The challenge is to provide youth with the skills they need to function in society and simultaneously restructure schools so that they value youth and provide them with a safe and supportive learning environment. Reforms proposed by this Administration, such as the reauthorization of the Elementary and Secondary Education Act, Educate America: Goals 2000, the Safe Schools Act, and the School to Work Transition, are a starting place.

In addition, communities need to take steps to convert schools and other community centers into places where youth can gather for safe and enjoyable activities and obtain services — such as health screenings and job counseling — during the hours when they are neither in school or at work. Youth spend an enormous amount of time out of school, and that time should be spent in an environment free of violence, alcohol and other drugs, and other impediments to a positive life style. Programs like the Beacon Schools in New York City and the Safe Haven Program in Trenton, New Jersey are excellent examples of programs that locate health and social services in schools to reach youth attending after-school activities and their families.

The enhanced Social Service Block Grant funds provided by the Federal Community Enterprise Initiative could provide support for efforts to transform schools into community centers. More funds may be available through the "Community Schools Youth Services

and Supervision" program included in the Senate version of the crime bill.

4. Build youth into the design of youth programs.

Every community has resources. Youth and their families are potential resources in community efforts to eradicate crime and violence and provide meaningful activities for young people. Not all communities utilize the resources available to them, and too often youth are ignored or viewed as part of the problem rather than part of the solution.

The Federal Government should invest in the talents and capacities of youth by catalyzing public and private sector initiatives that build in high expectations, valuable roles and clear responsibilities for young people in the design and implementation, and where appropriate, delivery of youth programs. These programs should teach practical skills that young people can use to help others, themselves and their communities. Examples of such activities are peer counseling and mediation programs, in which youth resolve disputes among their peers and teach non-violent problem-solving techniques.

Federal, State and local governments can support youth-driven activities by providing applicants competing for youth program funds with additional "points" for plans to involve youth in program design, implementation or service delivery.

5. Involve youth, their families, and community stakeholders in community redevelopment efforts.

In highly distressed communities, the new Federal Community Enterprise Initiative could provide the catalyst for community redevelopment efforts. These efforts can include skills training, transportation services; job, housing and business counseling; and training and employment for disadvantaged youth and adults in construction, rehabilitation or improvement of affordable housing, public infrastructure, and community facilities. The Community Enterprise Initiative funds can also be used to support drug and alcohol prevention and treatment programs and programs to provide activities outside of school hours. All community redevelopment efforts should involve youth, their families, service providers, private and public agencies, and other community leaders in their design and implementation.

In addition to targeting its resources to the empowerment zones and enterprise communities designated by the Community Enterprise Initiative, the Department of Health and Human Services can work to improve opportunities for youth in low-income neighborhoods by coordinating its youth-serving programs in local communities with other multi-site initiatives such as DOL's new Youth Fair Chance program, DOJ's Weed and Seed program and HUD's Family Investment

Centers.

6. Challenge local communities to provide one million mentors for young people.

The Federal government should challenge local business and voluntary organizations to expand efforts to pair young people with adult role models. There are currently about 150,000 to 200,000 mentors around the country sponsored by organizations such as the Big Brothers and Big Sisters and smaller groups. There many more young people who could benefit from positive relationships with adults. This Administration should call on communities around the nation to put one million mentors to work with our nation's youth.

This effort would be a partnership between the government and communities. While mentors would be recruited, screened, trained, supervised, monitored, supported and provided with logistical assistance by businesses and community-based organizations, the Federal Government can provide support through grants from the mentoring program of the Office of Juvenile Justice and Delinquency Prevention in the Justice Department. Another source of support for these efforts is the provision in the Senate-passed crime bill that authorizes an Ounce of Prevention Council.

In addition to supporting the development of mentoring programs, Federal, State, local governments and private organizations should review and modify their personnel policies to encourage employees to serve as community volunteers with youth. Personnel policies could be modified to permit employees to volunteer several hours per week in youth-serving organizations and activities including schools. Employees could also be encouraged to visit and participate in activities sponsored by schools and day care facilities.

7. Establish a Federal interagency mechanism to coordinate the delivery of youth services and programs and promote comprehensive youth programs.

The design and development of effective youth development programs requires the coordination of many disparate programs and funding streams. Addressing the needs of youth means tying together programs from federal agencies such as Health and Human Services, Housing and Urban Development, Education, Labor, Justice and the Corporation for National and Community Service (which now includes ACTION). A formal mechanism is needed to facilitate the coordination of existing federal youth programs and promote an integrated, comprehensive and preventive approach to serving youth. The Ounce of Prevention Council, which is authorized in the Senate-passed version of the crime bill to bring these agencies together to plan prevention programs, would be the logical choice for such a coordinating body.

8. Establish a system to collect and disseminate information on model youth programs and policies at Federal, state, and local levels.

There are numerous innovative and effective violence prevention and youth development programs operating in every part of the country. Unfortunately, very little is known about these programs. In order to avoid "reinventing the wheel," information about these programs must be collected and disseminated to communities throughout the country. An example of the information that should be widely shared is an evaluation, recently launched by the Centers for Disease Control, of several programs designed to reduce interpersonal violence among high-risk youth. A potential starting point for developing such a system is the Department of Justice's current effort to link federal clearinghouses and databases to provide useful and easily accessible information to local communities.

9. Invest in well-planned, rigorous and longitudinal evaluations of intervention programs.

Currently, there is a great deal of research conducted on individual problems faced by youth, such as child abuse, suicide, alcohol and other drug use. Information on these issues is also collected, analyzed and disseminated on an individual, problem-by-problem basis. There is little research or data that describes the environments in which youth and their families live and the stress produced by living in deteriorating environments with few employment or safe recreation options. In order to serve youth most effectively, the research should begin to describe the context of youth behavior — including peer groups, families and community settings — rather than focusing exclusively on individual behaviors. It should also address a broad spectrum of areas associated with building healthy communities, such as economic opportunity, safety, recreational opportunities, health, and education.

IV. Research Agenda

The first principle of a youth development research agenda should be to move away from the "deficit model" that focuses on discrete problem behaviors, such as teen pregnancy, to a more comprehensive approach that describes experiences of youth in high risk situations who engage in negative behaviors. Research must describe youth in the context of peer group, family, neighborhood and community rather than individual behavior alone. Furthermore, we need to understand the adaptive and protective behaviors of youth in high stress environments and pay greater attention to positive developmental outcomes.

A research framework which considers the full contexts of youth development would:

- Identify the developmental needs of youth in general and within the context of distressed environments.
- Require attention to the interaction of risk factors and protective factors;
- Support studies that identify what needs are being met and which are not so that programs can identify appropriate and evaluable goals for youth ;
- Support long-term, longitudinal studies which examine processes of individual development and change, as well as change in communities and institutions; and
- Specify the most effective combination of community supports and opportunities necessary for youth to develop the skills and strengths they will need to become productive adults.

When developing any effort which aims for results large enough to be meaningful to both the individual and the community, attention must be paid to the circumstances in which youth live and grow. Efforts should address a broad spectrum of areas associated with a healthy community and healthy human development (e.g., economic opportunity, safety, health, education); therefore, research must allow understanding of the developmental needs of adolescents in relation to the environment.

Such a model for inquiry would move beyond measuring individual actions and circumstances to include obtaining data that illustrate the importance of positive developmental outcomes among youth. Rather than using research activities to focus simply on individual problem behaviors and the categorical funding streams by which most current programs are supported, this model would focus on the interaction of risk factors and normal processes of human development, positive adaptation and resilience among youth. Examples of areas for future research include:

- Availability of recreational and educational activities and employment opportunities;
- Existence of family and community supports;
- Developmental needs served by gang participation and other high risk behaviors;
- Cultural and ethnic characteristics as well as intergenerational influences on gang participation and other

high risk behaviors;

- Patterns of drug use and violent delinquency among youth to determine whether they are part of a single syndrome or whether there are developmental stages; and
- Correlation between family variables (e.g., parental supervision and/or involvement) and high risk behaviors to determine whether there is a concurrent or predictive relationship.

To be most effective, intervention efforts should consist of significant long-term investments. To insure the development and testing of new, high quality, scientifically-based prevention strategies, funding partnerships between service agencies and research institutes are needed. Since there are few credible evaluations of demonstrated intervention models, major investment in well-planned, rigorous evaluations is needed.

COMPREHENSIVE CHILD DEVELOPMENT CENTERS

Authorization. The Comprehensive Child Development Centers Act of 1988: Subchapter E, Chapter 8, Subtitle A of Title IV, Omnibus Budget Reconciliation Act of 1981, as amended by Title III, Part E of the Augustus F. Hawkins-Robert T. Stafford Elementary and Secondary School Improvement Amendments of 1988 and the Human Services Reauthorization Act of 1990; authorized through FY 1994.

Program Description. This program is administered by the Office of Human Development Services, the U.S. Department of Health and Human Services (DHHS). Model programs of comprehensive services to children from low-income families, from birth to the initial age of compulsory school attendance (usually 6 years), are authorized. Grants may be used either for planning or implementing such programs. The services provided by these centers are to be intensive as well as comprehensive, to foster the "physical, social, emotional, and intellectual development" of the children served, and to support their parents. Services provided are to include health care, early childhood development, day care, nutritional services, parenting education, and referral to other sources of social welfare assistance.

Agencies eligible to receive comprehensive child development center grants include head start agencies, community based organizations, institutions of higher education, community development corporations, or other public or private nonprofit agencies or organizations that specialize in delivering social services to infants or young children. Between 10 and 25 local agencies are to receive grants to operate comprehensive child development centers, while up to 30 local agencies may receive planning grants. Planning grants may be made only for 1 year, and may not exceed \$35,000. The Federal share for each type of grant is 80 percent. The programs are to be continuously evaluated by the Secretary of DHHS, and the Secretary is to submit an evaluation report to the Congress by October 1, 1993.

To the extent that services provided under this program are similar to those of the head start program, the head start program regulations are to apply to the comprehensive child development program.

Funding. Grantees are selected, on a discretionary basis, by the Secretary of DHHS.

FY 1992 Funding (Appropriations). \$44.4 million.

Participation Data. FY 1992: Twenty-four centers, serving approximately 2,600 families, including approximately 4,200 children under the age of 5 years.

TEMPORARY CHILD CARE FOR CHILDREN WITH DISABILITIES AND CRISIS NURSERIES GRANTS

Authorization. Children's Justice and Assistance Act of 1986 (Title II); authorized through FY 1995.

Program Description. This Act authorizes State demonstration grants for two programs that serve particular populations of children. One program provides temporary nonmedical child care (commonly referred to as respite care) to children with special needs to alleviate social, emotional, and financial stress among children and families with such children. Temporary nonmedical child care can be in the form of in-home or out-of-home care, and includes care for children with chronic or terminal illnesses. Such care is provided on a sliding fee scale with hourly and daily rates.

The second program provides crisis nurseries for abused and neglected children, children at risk of abuse or neglect, or children in families receiving protective services. The crisis nurseries provide temporary emergency services and care for children, and referral to support services. An individual may be provided services under this program without fee for a maximum of 30 days in any 1 year.

Under both of these programs, grants are awarded to public and private nonprofit agencies. These programs are administered by the Administration for Children, Youth, and Families, U.S. Department of Health and Human Services.

Funding. Funding for this Act is divided equally between the two programs, with consideration given to equitable geographic distribution. In awarding grants, preference is given to States in which such care is unavailable. In addition, State grantees must provide 25 percent of the total project cost. In FY 1992, a total of 60 grants were awarded under this Act.

FY 1992 Federal Funding (Appropriations). \$11.1 million.

Participation Data. No data are available on program participants.

INDEPENDENT LIVING

Authorization. Title IV-E of the Social Security Act; authorized through FY 1992.¹¹

Program Description. The independent living program provides grants to States for the provision of services to facilitate the transition of children aged 16 and older from foster care to life on their own. Services include those that would enable participants to seek a high school diploma or equivalent or to take vocational training; provide training in daily living skills; provide for counseling; coordinate otherwise available services; provide for the establishment of outreach programs; and/or provide each participant with a written plan for transitional independent living to be incorporated into the participant's case plan. Foster children age 16 and older who are eligible for Title IV-E foster care subsidies are eligible for independent living services. At their option, States also may serve individuals up to age 21 who had previously received Title IV-E foster care maintenance payments, and foster children who are not eligible for Title IV-E subsidies. Independent living is administered by the Administration for Children and Families, U.S. Department of Health and Human Services.

Funding. Independent living operates as a capped entitlement; i.e., States are entitled to receive their share of appropriated funds according to a formula, but subject to a nationwide ceiling. The ceiling was \$70 million in FY 1992. States receive their share of appropriations according to their percentage of Title IV-E foster children in FY 1984, and are required to provide a 50 percent match for Federal funds received above their share of the first \$45 million in appropriations.

FY 1992 Federal Funding (Appropriations). \$70 million.

Participation Data. The Administration estimates that 45,284 children participated in FY 1992.

¹¹Funds have been appropriated for this program for FY 1993, although the authorization has expired.

ADOPTION ASSISTANCE

Authorization. Title IV-E of the Social Security Act; permanently authorized.

Program Description. The adoption assistance program is an open-ended entitlement program required of States participating in aid to families with dependent children (AFDC) (all States participate). Under this program, States are required to develop adoption assistance agreements with parents who adopt supplemental security income (SSI-) or AFDC-eligible children with "special needs." States may claim Federal matching funds for adoption payments made under these agreements. In addition, the program authorizes Federal matching funds to States that reimburse the one-time expenses of parents who adopt a child with special needs who is covered by an adoption assistance agreement, whether or not the child is AFDC- or SSI-eligible. Children who have adoption assistance agreements and who are AFDC- or SSI-eligible children are deemed eligible for medicaid in the State where they reside, whether or not adoption assistance payments are being made.

A child with special needs is defined as one with a specific condition or situation, such as ethnic background, age, membership in a sibling group, or mental or physical handicap, which prevents placement without assistance. Before designating a child as having special needs, the State must determine that he cannot or should not be returned to his family and that reasonable efforts have been made to place the child without providing assistance. The adoption assistance program is administered by the Administration for Children, Youth, and Families, U.S. Department of Health and Human Services.

Funding. States are entitled to claim Federal matching funds for adoption assistance payments, based on the State's medicaid matching rate (which averages about 57 percent nationally). Adoption assistance payments are made to the parents in accordance with an adoption assistance agreement developed between the parents and the State agency. The agreement stipulates the amount of the payments to be made and additional services or assistance to be provided. The payment amounts are determined on the basis of the adoptive parents' circumstances and the needs of the child, but cannot exceed the amount the child would receive for maintenance in a foster family home under the Title IV-E foster care program. The payment amounts may be adjusted based on changed circumstances. The payments may continue until the child is 18; if the child is mentally or physically handicapped, payments may continue until age 21, at State option.

FY 1992 Federal Funding (Appropriations). \$201.9 million.¹²

Participation Data. FY 1992: 64,000 children (est.).

¹²States have up to 2 years to claim reimbursement for adoption assistance expenditures; in FY 1992 Congress appropriated funds to pay claims from prior years.

EDUCATION AND TRAINING PROGRAMS

EDUCATION FOR THE DISADVANTAGED--LOCAL EDUCATIONAL AGENCY GRANTS

Authorization. Title I, Chapter 1, Part A of the Elementary and Secondary Education Act of 1965 (ESEA), as amended by the Augustus F. Hawkins-Robert T. Stafford Elementary and Secondary School Improvement Amendments of 1988; authorized through FY 1993.

Program Description. The local educational agency (LEA) grant programs of chapter 1 serve educationally disadvantaged children attending public and private schools from the preschool through secondary education levels. The services provided are intended to meet the special educational needs of children whose academic achievement is below the level appropriate for their age. This program is administered by the Office of Elementary and Secondary Education, U.S. Department of Education (ED), as well as by State educational agencies (SEAs) and LEAs. There are no State or local matching requirements for chapter 1 programs.

According to the *Chapter 1 Implementation Study (1992)*, most elementary school chapter 1 programs offer supplementary instruction in reading (92 percent) or mathematics (66 percent). Many participating pupils are "pulled out" of their regular classroom to receive chapter 1 instruction, while others receive chapter 1 instruction in their regular classroom setting, or during summer or before-/after-school sessions.

Funding. Although all chapter 1 LEA grants may be combined and used for the same purposes at the local level, they are allocated under two separate formulas. The *basic* grant formula allocates funds to LEAs¹⁵ in proportion to counts of formula children multiplied by a cost factor. The children counted in the allocation formula are those aged 5-17: (a) in poor families; (b) in families receiving aid to families with dependent children payments in excess of the poverty level for a family of four; and (c) in local facilities for the neglected and delinquent. The cost factor is the State average per-pupil expenditure for public elementary and secondary education, limited to no more than 120 percent and no less than 80 percent of the National average, then further multiplied by .4. If grants are not fully funded at the level indicated by this formula, as has been the case for every year since FY 1966, they are reduced proportionately, with no LEA to receive less than 85 percent of its grant for the previous year; there is also a State minimum grant of approximately 0.25 percent of total grants. Most chapter 1 LEA grants are allocated under the basic grant formula (\$5.5 billion in FY 1992).

¹⁵Specifically, the ED allocates grants at the county level, then SEAs suballocate county totals to individual LEAs. In the future, grants may be calculated directly at the LEA level by the Federal Government after completion of a tabulation of the 1990 census by LEA.

The *concentration* grant formula (\$0.6 billion in FY 1992) is similar to that for basic grants, except funds are allocated only to LEAs in counties where the number of children counted in the basic grant formula for the previous year is at least 6,500 children, or at least 15 percent of the total population aged 5-17. There is also a concentration grant State minimum of, in general, the greater of 0.25 percent of total grants, or \$250,000.¹⁶ Beginning with 1993-94 grants, application of 1990 census data on the number of poor children will substantially change the share of chapter 1 LEA grants going to many States and localities, unless the formulas are revised in the meantime.¹⁷

Within LEAs, LEA grant funds are allocated to the school attendance areas with the greatest relative number or percentage of children from low income families.¹⁸ In these target attendance areas, the most educationally disadvantaged children are served, regardless of their individual family income or whether they attend public or private schools.

FY 1992 Federal Funding (Appropriations). \$6.1 billion.

Participation Data. FY 1992: 5.9 million students (est.).

¹⁶Annual appropriations legislation has increased this minimum to \$340,000 in recent years.

¹⁷For additional information on this topic, see U.S. Library of Congress. Congressional Research Service. *The Distribution Among the States of School-Age Children in Poor Families, 1990 Versus 1980: Implications for Chapter 1.* CRS Report for Congress No. 92-485 EPW, by Wayne Riddle. Washington. June 8, 1992.

¹⁸Schools may be ranked on the basis of their actual enrollments, rather than on the number of children residing in their attendance areas.

EDUCATION BLOCK GRANTS FOR STATES

Authorization. Elementary and Secondary Education Act of 1965, Title I, Chapter 2, Federal, State, and Local Partnership for Educational Improvement, Sections 1501-1542; authorized through FY 1993.

Program Description. Grants support school improvement, educational innovation, and effective schools. Eligible activities include programs for students at risk of failure or dropping out, acquisition of educational materials, innovative programs for schoolwide improvement, training and professional development, and programs to enhance personal excellence. Local educational agencies (LEAs) design and implement programs; they receive at least 80 percent of each State allotment. State educational agencies (SEAs) use remaining funds for program administration, technical assistance to LEAs, and effective schools programs.

The U.S. Department of Education administers the education block grant program.

Funding. Grants are allotted by formula to SEAs in proportion to the population aged 5-17, with no State to receive less than 0.5 percent of the total allotment. Matching is not required.

FY 1992 Federal Funding (Appropriations). \$450 million

Participation Data. Data are not available.

STATE AGENCY NEGLECTED AND DELINQUENT EDUCATION PROGRAM

Authorization. Title I, Chapter 1, Part D, Subpart 3 of the Elementary and Secondary Education Act of 1965, as amended by the Augustus F. Hawkins-Robert T. Stafford Elementary and Secondary School Improvement Amendments of 1988; authorized through FY 1993.

Program Description. This program is administered by the Office of Elementary and Secondary Education, the U.S. Department of Education, as well as by State educational and other agencies. The chapter 1 neglected and delinquent program makes grants to State agencies for the education of children and youth (through age 21) in facilities for the neglected or delinquent, including adult correctional institutions. Services provided under chapter 1 are to be supplementary to basic educational programs funded by the State. Programs may be conducted directly by the State agencies, or through contract to local agencies or private, nonprofit organizations. Up to 10 percent of each State's grant may be used for services to facilitate the transition of students from State agency programs to regular, local elementary, and secondary schools.

Funding. Grants are made to the States in proportion to the number of children and youth in State agency programs for the neglected and delinquent, multiplied by a cost factor. The cost factor is the State average per-pupil expenditure for public elementary and secondary education, limited to no more than 120 percent and no less than 80 percent of the National average, then further multiplied by .4. If grants are not fully funded at the level indicated by this formula, as has been the case in recent years, they are reduced proportionately to the level of available appropriations. (The chapter 1 statute provides that this and other State agency programs are to be fully funded whenever total chapter 1 appropriations are below the authorized level. However, this provision has been overridden by appropriations statutes in recent years.) There is no matching requirement.

FY 1992 Federal Funding (Appropriations). \$36 million.

Participation Data. FY 1992: 52,400 pupils (est.).

EVEN START

Authorization. Title I, Chapter 1, Part B of the Elementary and Secondary Education Act of 1965, as amended by the Augustus F. Hawkins-Robert T. Stafford Elementary and Secondary School Improvement Amendments of 1988, and the National Literacy Act of 1991; authorized through FY 1993.

Program Description. This program is administered by the Office of Elementary and Secondary Education, U.S. Department of Education, as well as by State and local educational agencies. Under the even start program, the U.S. Secretary of Education makes grants to State education agencies (SEAs); SEAs then select local educational agencies (LEAs) to receive grants for joint programs of education for educationally disadvantaged children, aged 1-7, and their parents. To be eligible to be served, the children must reside in a school attendance area in which a chapter 1 basic grant program is conducted,¹⁹ and the parents must be eligible to be served under the Adult Education Act (AEA)--i.e., not enrolled in school and not a high school graduate (or equivalent).

The services provided under the even start program may include: identification of eligible participants; testing and counseling; adult literacy training; training of parents to aid in the education of their children; support services, such as child care and transportation, where unavailable from other sources; home-based education of parents and children; staff training; and coordination with other Federal programs (such as the AEA and head start).

Funding. Even start grants are made to the States in proportion to their grants under part A of chapter 1 (see separate entry on this program), with a State minimum of the greater of 0.5 percent of total grants or \$250,000. Even start programs may not receive grants for more than 4 years; the Federal share of program costs is limited to 90 percent for the first year of operations, declining to 60 percent for the fourth year. The programs must be independently evaluated; the U.S. Secretary of Education is to submit a summary and review of these evaluations to the Congress by September 30, 1993 (the first interim evaluation report was published in 1991).

FY 1992 Federal Funding (Appropriations). \$70 million.

Participation Data. In 1989-90, the only year for which participant data are currently available, even start projects served an estimated 2,800 families, including 4,500 adults and 4,800 children.

¹⁹These are school attendance areas with a relatively high number or percentage of children from low income families, compared to other school attendance areas in the LEA.

SCHOOL DROPOUT DEMONSTRATION ASSISTANCE

Authorization. Title VI of the Elementary and Secondary Education Act; authorized through FY 1993.

Program Description. The school dropout demonstration assistance program provides grants to local school districts and community-based organizations for dropout prevention and reentry demonstration programs. Recipients can use funds for a wide range of activities including identifying students who are at-risk of dropping out, encouraging dropouts to return to school, developing programs to address basic skill and other educational deficiencies, establishing or expanding work-study programs, educational partnerships, testing, training, and program evaluation.

Program grants are awarded by the U.S. Secretary of Education. Specified proportions of funds are reserved for school districts of different enrollment sizes; one-quarter to one-half of the funds for each category are to be used for partnerships between schools and businesses, colleges, private industry councils (established under the Job Training Partnership Act), community and other nonprofit organizations and others. Special emphasis is to be given to programs that include parental involvement and early intervention services, replicate successful programs, or serve high numbers or percentages of dropouts.

Funds are also used for a national evaluation of the demonstration projects.

Funding. This is a discretionary grant program that awards funds competitively to local school districts and community-based organizations. In 1991, recipients generally began 4 planned years of funding. The Federal share of dropout program costs may not exceed 90 percent the first year and 75 percent in subsequent years.

FY 1992 Federal Funding (Appropriations). \$40 million.

Participation Data. Data on the number of children served are not available.

EDUCATION FOR HOMELESS CHILDREN AND YOUTH

Authorization. Stewart B. McKinney Homeless Assistance Act, Title VII, Subtitle B, Education for Homeless Children and Youth, Sections 721-726; authorized through FY 1993.

Program Description. Grants are made to State educational agencies (SEAs) with the objective that each SEA assure access to a free, appropriate education for all homeless children and youth, as if they were residents of the State. Authorized activities include: (1) providing activities for and services to homeless children and youth to enable them to "enroll in, attend, and achieve success in school"; (2) establishing a State office of coordinator of education of homeless children and youth; (3) developing and implementing State plans for the education of each homeless child or youth; and (4) establishing programs for school personnel to increase awareness of the problems of homeless children and youth. Every 2 years, States must gather data on the number, location, and enrollment status of homeless children and youth, determine their special educational needs, and maintain school records on such children and youth. Whenever the appropriation exceeds the amount appropriated in FY 1990 and the grant to the SEA exceeds the FY 1990 award, the SEA must make grants to local educational agencies. Such grants must be used for facilitating the enrollment, attendance, and success in schools of homeless children and youth.

The U.S. Department of Education administers the homeless children and youth education program.

Funding. Grants are allotted by formula to States in proportion to grants made under Title I, Chapter 1, Part A of the Elementary and Secondary Education Act of 1965, except that no State is to receive less than \$50,000. Matching is not required.

FY 1992 Federal Funding (Appropriations). \$25 million.

Participation Data. Data are not available.

VOCATIONAL EDUCATION: BASIC STATE GRANTS

Authorization. Carl D. Perkins Vocational and Applied Technology Education Act, Title II, Basic State Grants for Vocational Education, Sections 201-240; authorized through FY 1995.

Program Description. According to an approved State plan, grants to States support the improvement of "educational programs leading to academic and occupational skill competencies needed to work in a technologically advanced society." Each State may reserve up to 25 percent of its grant for State programs, leadership activities, administration of the State plan, and corrections education. State programs include vocational education services for single parents, displaced homemakers, and single pregnant women, and programs to promote the elimination of sex bias. State leadership activities include professional development, curriculum improvement, and the assessment of programs. With certain exceptions, the remainder of each State grant must be distributed by formula for secondary school programs and for postsecondary and adult programs. Local recipients must use these funds for the improvement of vocational education programs, with the full participation of special populations.²⁰

The U.S. Department of Education administers the basic State grant program.

Funding. Grants are allotted by formula to States in proportion to populations in three age groups (15-19, 20-24, and 25-65), with an adjustment so that States with per capita incomes below average receive increased allotments. No State shall receive less than 0.5 percent of the total allocation, except that no State shall receive more than 150 percent of the national average per-pupil payment. Nevertheless, no State shall receive less than the FY 1991 allocation under this program. Matching is required only for the portion of the grant used for State administration.

FY 1992 Federal Funding (Appropriations). \$949.8 million.

Participation Data. Data are not available.

²⁰The Perkins Act defines special populations to include individuals with disabilities, educationally and economically disadvantaged persons (including foster children), persons with limited English proficiency, persons who participate in programs designed to eliminate sex bias, and persons in correctional institutions.

VOCATIONAL EDUCATION: CONSUMER AND HOMEMAKING EDUCATION

Authorization. Carl D. Perkins Vocational and Applied Technology Education Act, Title III, Part B, Consumer and Homemaking Education, Sections 311-313; authorized through FY 1995.

Program Description. States may use these funds for secondary and postsecondary vocational education programs to (1) prepare youth and adults for the occupation of homemaking and (2) provide instruction in the areas of food and nutrition, consumer education, family living and parenthood education, child development and guidance, housing, home management, and clothing and textiles. States are encouraged to use funds to conduct programs for the residents of economically depressed areas, encourage the participation of traditionally underserved populations, encourage the elimination of sex bias and stereotyping, and improve the quality and effectiveness of consumer and homemaking programs. At least one-third of each State allocation must be used in economically depressed areas or in areas with high rates of unemployment.

The U.S. Department of Education administers the consumer and homemaking education program.

Funding. Grants are allotted by formula to States in proportion to populations in three age groups (15-19, 20-24, and 25-65), with an adjustment so that States with per capita incomes below average receive increased allotments. No State shall receive less than 0.5 percent of the total allocation, and no State shall receive more than 150 percent of the national average per-pupil payment. Nevertheless, no State shall receive less than the FY 1991 allocation under this program. Matching is not required.

FY 1992 Federal Funding (Appropriations). \$35 million.

Participation Data. Data are not available.

VOCATIONAL EDUCATION: PROGRAMS FOR COMMUNITY-BASED ORGANIZATIONS

Authorization. Carl D. Perkins Vocational and Applied Technology Education Act, Title III, Part A, State Assistance for Vocational Education Support Programs by Community-Based Organizations, Sections 301-302; authorized through FY 1995.

Program Description. States use these grants to support projects operated jointly by eligible local recipients (local educational agencies and institutions of higher education) and community-based organizations. These projects provide a variety of special vocational education services and activities to economically or educationally disadvantaged youth and adults, as well as disabled persons, with special consideration given to severely disadvantaged youth aged 16-21. Services may include outreach programs, transitional services, prevocational preparation, career intern programs, model programs for school dropouts, assessments of student needs, and guidance and counseling.

The U.S. Department of Education administers programs for community-based organizations.

Funding. Grants are allotted by formula to States in proportion to populations in three age groups (15-19, 20-24, and 25-65), with an adjustment so that States with per capita incomes below average receive increased allotments. No State shall receive less than 0.5 percent of the total allocation, and no State shall receive more than 150 percent of the national average per-pupil payment. Nevertheless, no State shall receive less than the FY 1991 allocation under this program. Matching is required only for the portion of the grant used for State administration.

FY 1992 Federal Funding (Appropriations). \$12 million.

Participation Data. Data are not available.

VOCATIONAL EDUCATION: TECH-PREP EDUCATION

Authorization. Carl D. Perkins Vocational and Applied Technology Education Act, Title III, Part D, Tech-Prep Education Act, Sections 341-347; authorized through FY 1995.

Program Description. Funds are used at the local level by consortia of secondary and postsecondary schools. Awards must be used to develop and operate 4-year programs, under a formal agreement by the members of each consortia, consisting of 2 years of secondary education and 2 years of postsecondary education where the program has a common core of proficiency in mathematics, science, communications, and technologies. Programs must include inservice training of teachers and counselors, and provide equal access to all programs by special populations.

The U.S. Department of Education administers the tech-prep education programs.

Funding. At a funding level that is less than or equal to \$50 million, the U.S. Secretary of Education must make discretionary grants to local consortia of secondary and postsecondary schools; at higher funding levels, formula grants to States are required. Under the formula grants, funds are allotted to States in proportion to populations in three age groups (15-19, 20-24, and 25-65), with an adjustment so that States with per capita incomes below average receive increased allotments. No State shall receive less than 0.5 percent of the total allocation, and no State shall receive more than 150 percent of the national average per-pupil payment. Nevertheless, no State shall receive less than the FY 1991 allocation under this program. Matching is not required.

FY 1992 Federal Funding (Appropriations). \$90 million.

Participation Data. Data are not available.

VOCATIONAL EDUCATION: DEMONSTRATION PROGRAMS

Authorization. Carl D. Perkins Vocational and Applied Technology Education Act, Title IV, Part B, Demonstration Programs, Sections 411-420A; authorized through FY 1995.

Program Description. The U.S. Secretary of Education is authorized to make demonstration grants to a variety of recipients for a number of specified activities related to secondary and postsecondary vocational education. Priority is given to programs for (1) materials development in telecommunications and (2) demonstration centers for the training of dislocated workers. Other uses of funds may include demonstration activities related to professional development, blue ribbon vocational education programs, development of business and education standards, educational programs for Federal correctional institutions, dropout prevention, model programs of regional training for skilled trades, demonstration projects for the integration of vocational and academic learning, and cooperative demonstration programs.

The U.S. Department of Education administers national demonstration programs.

Funding. The U.S. Secretary of Education makes discretionary grants for vocational education national demonstration programs. Matching is not required, with the following exception: the Federal share is 50 percent for grants for materials development in telecommunications.

FY 1992 Federal Funding (Appropriations). \$13 million.

Participation Data. Data are not available.

IMPACT AID

Authorization. P.L. 81-874 and P.L. 81-815 relating to financial assistance for local school districts in areas adversely affected by Federal activities; authorized through FY 1993 by the Hawkins-Stafford Elementary and Secondary School Improvement Amendments of 1988.

Program Description. The impact aid program provides financial assistance to local school districts where action by the Federal Government has caused a financial burden to the district, such as the removal of land from the local tax base for a tax-exempt Federal facility, or the sudden influx of children into the school district due to the opening of a Federal facility. These school districts are often near Indian reservations, federally subsidized low-rent housing sites, or military bases or other defense-related installations.

Financial assistance primarily takes the form of per-pupil payments based partially on the amount the local school district contributes to a pupil's educational costs. Payments also vary according to the pupil's living circumstance (i.e., whether his or her parents live and/or work on Federal property) and educational needs. Since this program, in recent years, has not received its full authorized amount, the statute specifies the payment levels that school districts receive under the law. The impact aid program is administered by the Division of Impact Aid, the U.S. Department of Education, in cooperation with local educational agencies (LEAs).

Funding. The impact aid program under P.L. 81-874 (school maintenance and operation) provides financial assistance primarily through formula grants to public elementary and secondary school districts in federally affected areas. The impact aid program under P.L. 81-815 provides financial assistance usually through direct grants to LEAs for the construction and repair of school facilities for federally-connected children. Neither program requires matching funds.

Section 3 of P.L. 81-874 accounted for approximately 94 percent of the total FY 1992 impact aid appropriation. Each eligible school district's section 3 payment essentially represents a percentage of its local contribution rate, which is defined as the average amount of current educational expenditures derived from local revenue sources. The payment rates differ depending on the type of federally-connected child. The payment rate for 3(a) children is 100 percent. The payment rate for 3(b) children is 25 percent. The higher rate for section 3(a) children reflects the fact that their parents live *and* work on Federal property, which is not subject to local taxation; the lower rate for section 3(b) students reflects the fact that their parents live *or* work on such nontaxable Federal property resulting in less of a local revenue loss.

FY 1992 Federal Funding (Appropriations). \$771.7 million.

Participation Data. 1,400 LEAs received "3a" payments (estimate) and 2,400 LEAs received "3b" payments (estimate). In FY 1992, these districts served approximately 1.9 million "federally connected" students.

YOUTH TRAINING PROGRAM

Authorization. Title II-C of the Job Training Partnership Act (JTPA); permanently authorized.²²

Program Description. Funds are provided to States and localities for employment-related training and supportive services to economically disadvantaged youth. Some of these services include remedial education, institutional skills training, on-the-job training in the public and private sectors, work experience, skill assessment, job counseling, and job search assistance. The program is administered by the Employment and Training Administration, the U.S. Department of Labor (DOL).

Funding. DOL allocates funds to States according to a three-part formula, based on unemployment and poverty. States keep a percentage of the funds, as specified by statute, for statewide activities and allocate the remainder according to the same three-part formula to local service delivery areas.²³ No match is required except for a limited amount of the State funds set aside for education coordination activities.

FY 1992 Federal Funding (Appropriations). \$1.8 billion for the Title II-A program for training disadvantaged adults and youth. (For FY 1993, \$696.7 million has been appropriated for the new Title II-C youth training program.)

Participation Data. 230,800 individuals younger than 22 completed the program in 1990 (of which 61 percent were younger than 19).

²²Legislation amending JTPA was passed by the 102d Congress, and signed into law on Sept. 7, 1992 (P.L. 102-367). The amendments will be effective July 1, 1993, the beginning of the 1993 program year. The amendments create a new Title II-C to provide year-round services to economically disadvantaged youth. These services have been provided in the Title II-A program for economically disadvantaged adults and youth. Local service delivery areas receiving funds under Title II-A have been required to spend at least 40 percent of their funds on eligible youth, ages 16-21. (As of July 1, 1993, the Title II-A program will only serve adults age 22 and older.)

²³Currently, States keep 22 percent of the funds for statewide activities. As of July 1, 1993, States will keep 18 percent of the funds for statewide activities.

JOB CORPS

Authorization. Title IV-B, Job Training Partnership Act; permanently authorized.

Program Description. The Employment and Training Administration, the U.S. Department of Labor (DOL), contracts directly with private and public organizations to operate job corps centers, which are residential programs providing intensive remedial education and skill training for economically disadvantaged individuals, aged 14-21, whose home environments are extremely disruptive and who could benefit from a residential program.

Funding. Funds are provided from DOL to job corps sponsors through contracts. No match is required.

FY 1992 Federal Funding (Appropriations). \$955.1 million.

Participation Data. FY 1990: 99,703 participants aged 16-21.

SUMMER YOUTH EMPLOYMENT AND TRAINING PROGRAM

Authorization. Title II-B of the Job Training Partnership Act; permanently authorized.

Program Description. Localities use funds provided under this program for employment and training activities, during the summer months, for economically disadvantaged 14- to 21-year-olds. Remedial education also is provided. The program is administered by the Employment and Training Administration, the U.S. Department of Labor.

Funding. The Federal Government allocates funds to States according to a three-part formula based on unemployment and poverty. States in turn allocate funds to local service delivery areas according to the same formula. No match is required.

FY 1992 Federal Funding (Appropriations). \$682.9 million for the summer of 1993.²⁴

Participation Data. FY 1992: 565,000 individuals aged 14-21 (est.).

²⁴The summer youth program is forward funded. For example, FY 1992 appropriations are for the summer of 1993. The total funding available for the summer of 1992 was the FY 1991 appropriation of \$682.9 million and the \$500 million appropriated by the Dire Emergency Supplemental Appropriation Act, 1992.

EDUCATION, WORK, AND TRAINING PROGRAM FOR RECIPIENTS OF AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)

Authorization. Title IV of the Social Security Act.

Program Description: Since October 1990, the Family Support Act of 1988 has required States to establish a job opportunities and basic skills (JOBS) training program for AFDC recipients. To the extent resources permit, States must require JOBS participation by all welfare mothers with no child under age 3. At the Federal level, JOBS is administered by the Administration for Children and Families, U.S. Department of Health and Human Services; State and local welfare offices are responsible for local administration.

Each State JOBS program *must* require most young AFDC mothers who failed to complete high school to participate in an "educational activity," even if their youngest child is an infant. Teen parents aged 16 through 19 may be required to attend school full time in pursuit of a high school diploma or its equivalent. State JOBS programs also may assign some relatively young unemployed AFDC fathers (under age 24) who have not completed high school to basic education part time. In addition, States *must* require JOBS participation by AFDC children 16-18 who are not attending school on a full-time basis.

The law requires each State's JOBS program to include high school or equivalent education, basic and remedial education, education for persons with limited English proficiency, jobs skills training, jobs readiness activities, and job development and placement. States also must offer two of these four program components: community work experience (work relief), work supplementation (in which a person's AFDC grant is used to subsidize a job), on-the-job training, and job search. The law permits States to enroll AFDC recipients in postsecondary education in "appropriate cases." During FY 1991, the first year when all States operated JOBS, 44.8 percent of the participants were engaged in education (including 8.4 percent in postsecondary education and 10.9 percent in "self-initiated" schooling); some of these persons also engaged in a nonschool component of the JOBS program. **Note:** The food stamp program has similar employment and training programs for food stamp recipients operated by the States.

Funding. The law authorizes \$1 billion annually (more in FY 1994-95), but States have not used their full allotments. The Federal matching rate for JOBS activities and costs of full-time JOBS personnel is inversely related to State per capita income and now generally ranges from 60 to 80 percent. The matching rate is a flat 50 percent for other administrative expenses. JOBS funds may be used to pay educational expenses of AFDC parents assigned to schooling.

FY 1992 Federal Funding (Obligations). \$750 million (est.).

Participation Data. FY 1991 (preliminary estimate): 465,000 persons (monthly average). An age breakdown of participants is not available.

HEALTH PROGRAMS

MEDICAID

Authorization. Title XIX of the Social Security Act; permanently authorized.

Program Description. Medicaid is a Federal-State matching program providing medical assistance for certain low-income persons. At the Federal level the program is administered by the Health Care Financing Administration in the U.S. Department of Health and Human Services. Each State designs and administers its own program within broad Federal guidelines. As a result, there is substantial variation among States in groups covered, services offered, and amount of payment for services. For children (and pregnant women), recent Federal medicaid legislation reduces the variation.

Eligibility for medicaid benefits has traditionally been linked to actual or potential receipt of cash assistance under either of two programs: aid to families with dependent children (AFDC), or supplemental security income (SSI) for the aged, blind, and disabled. States must provide medicaid to all persons receiving cash assistance under AFDC, and to additional AFDC-related groups who are not actually receiving AFDC. The latter include children for whom adoption assistance agreements are in effect, or for whom foster care payments are made under Title IV-E of the Social Security Act. Families who lose AFDC benefits as a result of increased employment income, working hours, or child support payments may continue medicaid eligibility for various periods, depending on the reason for the loss of AFDC benefits.

Some children (and pregnant women) are eligible for medicaid due solely to their poverty status. All States must cover pregnant women and children to age 6 in families with incomes up to 133 percent of the Federal poverty level (FPL). States may cover pregnant women and infants to age 1 with household incomes up to 185 percent of the FPL. Medicaid eligibility for older children is being phased in: States must cover children to age 19, born after September 30, 1983, in families with incomes under 100 percent of the FPL. Thus, in 2002, all poor children can be covered by medicaid.

In addition to groups that States *must* cover, there are groups that States *may* cover. States may extend medicaid coverage to children to age 18, 19, 20, or 21 (at the option of the State) whose income and resources do not exceed the State's AFDC eligibility thresholds. Also, States may cover disabled children who are not in an institution but who would be eligible if they were in an institution.

For children who are not receiving cash assistance, some States are extending coverage under Section 1902(r)(2) of the Social Security Act. Enacted in 1988, the provision specifies that the income and resource methodology used in determining eligibility of pregnant women and children may be less restrictive, and shall be no more restrictive than the methodology used under the most closely related category (for children, this is usually the AFDC category). By using more liberal methodologies than would otherwise be

applied, States may determine children eligible for medicaid even though gross household income is higher than the Federal eligibility standard.

Federally required medicaid benefits for children include inpatient and outpatient hospital services; laboratory and x-ray services; home health services; family planning services and supplies; rural health clinic services; physician services; certified nurse midwife services; nurse practitioner services; and services of federally qualified clinics. States may choose to provide a wide range of optional services. Among the more important of these are prescription drugs and care in intermediate care facilities for the mentally retarded (ICFs-MR).

States are required to furnish early and periodic screening, diagnosis, and treatment (EPSDT) services to beneficiaries under age 21. EPSDT services include periodic health screenings, and services necessary to treat conditions identified in those screenings. States must provide needed services to EPSDT participants (such as dental, vision, and hearing care) even if the services are not ordinarily covered for other medicaid beneficiaries. Each State must also develop an outreach program to inform eligible beneficiaries that EPSDT services are available and assist in scheduling and transportation.

Funding. The Federal Government's share of medicaid is tied to a formula which is inversely related to the per capita income of the State. Current Federal matching rates range from 50 to 80 percent. Administrative costs are generally matched at 50 percent except for certain items which are subject to a higher matching rate.

FY 1992 Federal Funding (Outlays). \$68 billion Federal outlays (est.); \$120 billion combined Federal and State outlays.

Participation Data. FY 1991: over 13 million children accounted for 46 percent of the medicaid population.

MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT

Authorization. Title V of the Social Security Act; permanently authorized.

Program Description. The maternal and child health (MCH) services block grant provides health services to mothers and children, particularly those with low income or limited access to health services. The purposes of the block grant include reducing infant mortality; reducing the incidence of preventable disease and handicapping conditions among children; and increasing the availability of prenatal, delivery, and postpartum care to low-income mothers. MCH is administered at the Federal level by the Health Resources and Services Administration, the U.S. Department of Health and Human Services (DHHS).

States are required to use 30 percent of their MCH allotments for preventive and primary care services for children, and 30 percent for services for children with special health care needs. Otherwise, States determine the services to be provided under the block grant. Services can include prenatal care, well-child clinics, immunizations, vision and hearing screening, dental care, and family planning. They may also include inpatient services for crippled children, screening for lead-based poisoning, or counseling services for parents of sudden infant death syndrome victims.

Individual eligibility criteria are set by the States themselves. States are allowed to charge for services provided; however, mothers and children whose incomes fall below the poverty level may not be charged for services.

Funding. Most of the MCH block grant appropriation is allotted among the States. Each State's individual allotment is based on (1) the proportion of total funding it received in FY 1981 for certain categorical programs that were consolidated under the block grant beginning in 1982, and (2) the number of low-income children in the State. States must contribute \$3 of their own funds for each \$4 in Federal funds. Not more than 10 percent of grant funds may be used for administrative expenses. In addition, States are required to maintain at least the State's 1989 level of funding for maternal and child health programs.

There are various set asides with which the Secretary may contract to fund special projects of regional and national significance, and to expand and develop certain other programs. Set-asides may be used for training, research, genetic disease and hemophilia projects, screening of newborns for sickle cell anemia and other genetic disorders, primary care services, and community-based services for children, and for community-based service networks and case management services for children with special health care needs.

FY 1992 Federal Funding (Appropriations). \$649.7 million. Spending is for children and adults; percentage of funds that goes to children is not available.

Participation Data. FY 1991: over 4.5 million children and adolescents received Title V-supported preventive and primary care.

COMMUNITY HEALTH CENTERS

Authorization. Section 330 of the Public Health Service Act; authorized through FY 1994.

Program Description. Federal grants may be made to public or nonprofit private organizations to plan and develop, or operate, community health centers (CHC) in areas designated as medically underserved. Each CHC provides:

- primary health services, including physician services, diagnostic laboratory and radiologic services, and preventive services;
- referrals for supplemental health services;
- environmental health services which may include alleviation of unhealthful conditions associated with sewage treatment or water supply;
- patient case management services;
- health education.

As appropriate for the area, a center may provide translation services, or supplemental health services which may include dental, vision, home health, or other services. At the Federal level, the CHC program is administered by the Bureau of Health Care Delivery and Assistance, Health Resources and Services Administration, Department of Health and Human Services (DHHS).

Funding. Funds for are allocated to the 10 regional offices of DHHS which award the grants to the public and nonprofit entities which operate the CHCs. No matching is required. However, the level of Federal grant support is based on the difference between a center's operating costs and anticipated revenues. Federal grant funds are estimated to provide less than one-half the operating costs of CHCs.²⁵ Centers collect fees from third-party payors such as medicare, medicaid, or private insurers. Individuals who have incomes under the Federal poverty level and no insurance coverage may receive services free of charge. For families with incomes up to 200 percent of the poverty level, fees are charged according to sliding fee scales based on income and family size. CHCs may receive some support from State and local governments, or from philanthropic organizations.

In FY 1992, 375 centers received supplemental grants authorized to provide services for reducing the incidence of infant mortality and to coordinate services for infants and pregnant women.

FY 1992 Federal Funding (Appropriations). \$536.6 million. Spending is for all services: portion of funds spent on services to children is not available.

Participation Data. FY 1992: 5.4 million participants of whom approximately one-third are children.

²⁵U.S. Congress. Senate. Committee on Finance. Subcommittee on Health Care for Families and the Uninsured. Testimony presented by Julio Bellber on behalf of the National Association of Community Health Centers, Inc., Apr. 10, 1992.

CHILDHOOD IMMUNIZATION

Authorization. Section 317(j)(1) of the Public Health Service Act; authorized through FY 1995.

Program Description. The Centers for Disease Control awards grants to State and community health agencies to help them establish and maintain immunization programs for the control of vaccine-preventable childhood diseases, including measles, rubella, poliomyelitis, diphtheria, pertussis (whooping cough), tetanus, and mumps.

Grant funds may be used for costs of planning, organizing, and conducting immunization programs, and for the purchase of vaccine. Grant applicants may receive vaccine or personnel in lieu of cash under the program. The amount of assistance is determined by the Secretary of the U.S. Department of Health and Human Services and is based on need and availability.

Funding. State and local agencies may apply for project grant assistance to the appropriate regional office of the U.S. Department of Health and Human Services. During FY 1992, 63 grants were awarded. No matching is required.

FY 1992 Federal Funding (Appropriations). \$296 million. Spending is for children and adults.

Participation Data. There are no data on participants in this program.

HEALTHY START

Authorization. No specific authorization. Funds first appropriated in the U.S. Department of Health and Human Services Appropriations Act for FY 1991.

Program Description. The healthy start program has provided grants to 15 urban and rural communities with exceptionally high infant mortality rates. The demonstration program is intended to fund new and innovative ways of delivering care to pregnant women and infants with the goal of reducing infant mortality in the grant areas by 50 percent in 5 years. The grantees are expected to demonstrate effective techniques that can be applied in other communities. The program is administered by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

Healthy Start communities are expected to ensure access to a comprehensive package of family planning counseling, pregnancy testing, prenatal care, pediatric care for infants, and social services. Other services appropriate to a community's needs may include outreach, home visits, child care, transportation, dental care, nutrition counseling, mental health, and substance abuse services. There are no Federal eligibility requirements for participation in healthy start projects.

Funding. From appropriated funds, Federal grants were awarded based on the applicant's plans and, in part, on the level of community commitment to the project and involvement with local providers of health care and public health services. There are no matching requirements for healthy start awards.

FY 1992 Federal Funding (Appropriations). \$64.3 million.

Participation Data. There are no data on participants.

CHILDHOOD LEAD POISONING PREVENTION PROGRAM

Authorization. Section 317A of the Public Health Service Act; authorized through FY 1997.

Program Description. The childhood lead poisoning prevention program is a program of project grants to initiate and expand State and community-based lead poisoning prevention programs that (1) screen large numbers of infants and young children and identify those with lead poisoning; (2) identify possible sources of lead exposure; (3) monitor medical and environmental management of lead poisoned children; (4) provide information on childhood lead poisoning, its prevention and management, to the public, health professionals, and policy- and decisionmakers; and (5) encourage community action programs directed to the goal of eliminating childhood lead poisoning. Grant funds may not be spent for medical care and treatment or for environmental remediation of lead sources. The applicant, however, must provide an acceptable plan to ensure that these program activities are appropriately carried out. The program is intended to serve areas with a high incidence of elevated blood lead levels in infants and children.

The program is administered by the Lead Poisoning Prevention Branch, Division of Environmental Hazards and Health Effects, National Center for Environmental Health and Injury Control, Centers for Disease Control.

Funding. Project grants are awarded to State health departments or other State health agencies or departments deemed most appropriate by the State to lead and coordinate the State's childhood lead poisoning prevention program, and to agencies of units of local government that serve jurisdictional populations greater than 500,000. The program has no matching requirements, but grant funds cannot supplant existing funding for childhood lead poisoning prevention programs or activities.

FY 1992 Federal Funding (Appropriations). \$21.3 million.

Participation Data. No participation data are available.

FAMILY PLANNING

Authorization. Title X of the Public Health Service Act; funded through FY 1993 (under the authority of the U.S. Departments of Labor, Health and Human Services, and Education Appropriations Act for FY 1993).

Program Description. Title X provides support for family planning clinics, training of family planning personnel, and development and dissemination of family planning and population growth information to all persons desiring such information.

Title X grants are awarded by the Office of Family Planning, within the U.S. Department of Health and Human Services (DHHS), to State and territorial health departments, hospitals, universities, and other public and nonprofit agencies that may support other organizations and clinics. In FY 1991, over 4 million clients received services through 4,000 clinic sites operated by 85 service grantees. Participating clinics are required to offer a broad range of acceptable and effective methods and services to all persons desiring such services--including natural family planning methods, nondirective counseling services, physical examinations (including cancer detection and laboratory tests), infertility services, pregnancy tests, contraceptive supplies, periodic followup examinations, referral to and from other social and medical service agencies, and ancillary services.

There is no statutorily mandated target population under Title X, although regulations require that priority in the provision of clinic services be given to persons from low-income families. Clinics must provide services free of charge to low-income persons, who are defined by Federal regulation as persons whose income does not exceed 100 percent of the poverty level.

Funding. Grants and contracts are available to public or nonprofit private entities to establish and operate family planning clinics. The Office of Family Planning allocates funds to the regional DHHS offices which then determine which family planning projects should be funded. No specific matching requirements exist for these grants. However, Federal regulations specify that no family planning clinic project grant may be fully supported by Title X funds.

FY 1992 Federal Funding (Appropriations). \$150 million. Spending is for children and adults. The percentage of funds that goes to younger persons is not available.

Participation Data. FY 1992: 4.3 million (est.); the Office of Family Planning estimates that approximately one-third of all clients served at Title X clinics. 1.3 million per year, are adolescents.

PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT

Authorization. Title XIX, Part A of the Public Health Service Act; authorized through FY 1997.

Program Description. The Preventive Health and Health Services Block Grant authorizes grants to State governments for preventive health and health services programs and activities. States may use allotments under this block grant for:

- rodent control programs;
- community- and school-based fluoridation programs;
- detection and prevention of hypertension;
- health education and risk reduction programs, including activities designed to deter smoking and the use of alcoholic beverages among children and adolescents;
- comprehensive public health services;
- emergency medical services systems;
- home health services;
- rape crisis and prevention services;
- immunization services;
- serum cholesterol control projects;
- programs to reduce the incidence of chronic diseases; and
- preventive programs for screening, diagnosis, and treatment compliance related to uterine and breast cancer.

Eligibility requirements, when appropriate, are determined by States. The block grant is administered by the Centers for Disease Control of the Public Health Service, the U.S. Department of Health and Human Services.

Funding. Except for a special allotment for rape crisis programs, each State's allotment is based on the proportion of total funding it received in FY 1981 under the formerly categorical programs that were consolidated into the block grant. The rape crisis allotment, which by law must total \$3.5 million out of the total block grant appropriation, is distributed to States on the basis of population. No matching is required.

FY 1992 Federal Funding (Appropriations). \$135 million. Spending is for all services. The portion of funds spent on services for children is not available.

Participation Data. No participation data are available.

PROPOSED INITIATIVES

health care
education
crime
welfare

MEMORANDUM:

Fr: Christine Heenan / Sara Toomey
To: Deputy Secretary Kunin
Elaine Holland
Date: April 8, 1994
Re: School-Based Initiatives and Teen Pregnancy Prevention

Health Care Reform -- The Health Security Act

Comprehensive School Health Education

- School-based health education that focuses on health-risk behaviors such as substance abuse, behavior resulting in sexually-transmitted disease and unintended pregnancies. (III, G, 1, 3601)
- Support for the establishment of health education programs that are age and developmentally appropriate. These programs should be designed to address not only issues of prevention, but also issues such as environmental, personal health, family life, nutritional health and safety. (III, G, 1, 3601)
- \$50,000,000 has been appropriated to support school health programs and research, evaluation, training and technical assistance for each of the fiscal years 1995 through 2000. This money should be allocated at the state and local levels. (III, G, 2, 3611)

School-Related Health Services

- Support local community partnerships to encourage broad participation from families, health and social service providers, educational personnel and other local organizations. Priority for grants will be given to medically underserved populations that have a high incidence of high-risk behaviors. (III, G, 5, 3683, 3684)
- \$100,000,000 (FY 1996), \$275,000,000 (FY 1997), \$350,000,000 (FY 1998), \$400,000,000 (FY 1999 and 2000) has been appropriated to support local community partnership programs designed to help underserved areas including: furnishing health services; outreach services to at-risk youth and parents; and prevention and support services. (III, G, 5, 3681)

Education Reform -- Goals 2000 / ESEA

Substance Abuse Prevention

- Support for local educational agencies to develop comprehensive drug and alcohol prevention programs. (I, 102,7B)
- Support for research of the impact of such activities as substance abuse on learning through the National Institute of Early Childhood Development and Education. (VIII, C, 931)

- Require local educational agencies to submit plans for drug and violence prevention. (ESEA - IV)
- Support the Midnight Basketball League Training and Partnership that targets youths in high-risk neighborhoods where there is a high incidence of high-risk behaviors. (X, D, 1052)

Health Care Services

- Improve efforts to provide students and families with appropriate social services, health care, nutrition and other preventable barriers to learning. (III, 301,7) Provide grants to address these issues surrounding school readiness. (III, 309,3)
- The National Institute on Early Childhood Development and Education promotes health services integral to learning such as prenatal care, nutrition and other relevant health services. (VII, 931,2)
- Integration of Title I ESEA programs with other educational programs such as Head Start and with health and social services. (ESEA - Title I)
- Expand the Women's Educational Equity Act to implement programs to address the needs of pregnant and parenting teens to help them to remain in school, graduate, and prepare their children for preschool. (ESEA - Title V)
- Transfers the Office of Comprehensive School Health Education from under the control of the Office of Educational Research Improvement into ESEA. (XI, G, 971) -- According to Elaine Holland at the Education Department, the money will be available for the Secretary of Education to allocate.

Community Partnerships

- Establishes an integrated service delivery system to promote linkages and communication between different agencies such as local educational agencies, health and social service agencies and providers, juvenile and criminal justice agencies, providers of employment training, and early childhood agencies. (VIII, D)

Health Screenings

- Require local educational agencies to provide health screening in high-poverty elementary schools. (ESEA - Title I)
- "Ready to Learn: Title I Health Screening in the Improving America's School Act" -- Require schools to ensure that all students in elementary schools would have at a minimum of two health screenings during the elementary school years at appropriate intervals. These screenings should include hearing, vision and other relevant physical screening.

Surgeon General's Office

Office of Adolescent Health

- Support grants to fund projects which include reducing the incidence of violence and substance abuse, preventing adolescent pregnancy and sexually transmitted disease, and provide health education and services such as contraceptive and mental health services.
- Coordination of other PHS adolescent health programs. Also, funding of research to demonstrate the successful outcomes of emerging programs.
- An estimated \$6,825,000 will be appropriated to fund these programs in 1995.

Crime Reform

Ounce of Prevention Program

- Allows communities to put together flexible coalitions of local residents, neighborhood groups and community-based organizations to develop positive out-of-school activities for young people. Applicants must involve local residents, young people, community-based organizations, private-sector representatives, youth-serving organizations, schools, law enforcement professionals, employers, and health and social service providers.
- Funding for this program is \$75 million per year.

**SUBTITLE G - COMPREHENSIVE SCHOOL HEALTH EDUCATION;
SCHOOL-RELATED HEALTH SERVICES
(H.R. 3600 and S. 1757 p. 627)**

PART 1 - GENERAL PROVISIONS

Section 3601. Purposes. The purposes of activities authorized in this subtitle are to:

- (1) support, in kindergarten through grade 12, sequential, age appropriate comprehensive health education programs that address locally relevant priorities;
- (2) establish a national framework for comprehensive school health education programs, focused on such health-risk behaviors as drug abuse, sexual behavior resulting in HIV and other sexually-transmitted diseases, unintended pregnancy, injuries and other unhealthy lifestyles; the framework must also allow for integration of the school health plans with state plans for achieving national education and health goals for the year 2000;
- (3) support planning and establishing the school health programs;
- (4) support research, evaluation, training and technical assistance;
- (5) motivate youth to stay in school and strive for success;
- (6) improve the knowledge and skills of children by integrating academic, experiential learning with other elements of comprehensive health education; and
- (7) further national education and health goals for the year 2000.

Section 3602. Definitions. (a) Comprehensive school health education programs means programs that address locally relevant priorities and that meet the following conditions:

- (1) the program is sequential and age and developmentally appropriate;
- (2) the program is provided every year for every student from kindergarten through grade 12;
- (3) the program provides comprehensive health education that addresses community, environmental, personal health, family life, substance abuse, growth and development, nutritional health, prevention and control of disease, safety and prevention of injuries, consumer health and health education;
- (4) the program promotes personal responsibility for a healthy lifestyle;
- (5) the program is culturally sensitive in the content of its instructional materials and approaches;
- (6) the program includes activities that support instruction;
- (7) the program involves families, community organizations and other appropriate entities;
- (8) the program is coordinated with other Federal, state and local programs; and
- (9) the program focuses on the health concerns of students in the state, school district or school.

(b)(1) The term local education agency has the meaning given under section 1471 (12) of the Elementary and Secondary Education Act;

(2) the term state education agency has the meaning given under section 1471(23) of the Elementary and Secondary Education Act.

PART 2 - SCHOOL HEALTH EDUCATION; GENERAL PROVISIONS

Section 3611. Authorization of Appropriations. (a) For purposes of carrying out parts 3 and 4 (grants to states and local education agencies respectively), the following amounts are authorized: \$50,000,000 for each of fiscal years 1995 through 2000.

(b) Of amounts appropriated under subsection (a) the Secretary may allocate up to \$13,000,000 of appropriated funds for local education agency grants under part 4, and up to \$5,000,000 for such national leadership activities as research and demonstration, evaluation, and training and technical assistance in comprehensive school education. The Secretary may use up to five percent of the funds for administrative expenses of carrying out parts 3 and 4.

(c) Funds authorized under this part are in addition to other authorizations.

Section 3612. Waivers of Statutory and Regulatory Requirements. (a) (1) The Secretaries of Health and Human Services and of Education may waive restrictions on the use of funds under the Federal programs identified below, if the following conditions are met:

(A) the requirement to be waived impedes achievement of the purposes of parts 3 and 4;

(B) the Secretary determines that the requested use (requiring the waiver) would be consistent with parts 3 and 4;

(C) a state education agency making the request has provided for notice to and comment on the waiver request by local education agencies;

(D) a local education agency or other entity making a waiver request has submitted the request to the state education agency for review;

(2) The programs subject to waiver are: (i) Prevention, Treatment and Rehabilitation Model Projects for High Risk Youth under section 517 of the Public Health Service Act; (ii) State and Local Comprehensive School Health Programs to Prevent Important Health Problems and Improve Educational Outcomes under Section 517 of the Public Health Service Act; (iii) Part B programs under the Drug Free Schools and Communities Act of 1986.

(b) A waiver may not exceed 3 years but may be extended if the waiver has been effective in the purpose for which it was granted, and if the extension is in the public interest.

(c) The Secretaries may not waive statutory and regulatory requirements relating to the following:

- (1) comparability of services;
- (2) maintenance of effort;
- (3) equitable participation of students in private schools;
- (4) parental involvement;
- (5) distribution of funds;
- (6) maintenance of records;
- (7) civil rights; and
- (8) the requirements of sections 438 and 439 of the General Education Provisions Act.

PART 3 - SCHOOL HEALTH EDUCATION; GRANTS TO STATES

SUBPART A - PLANNING GRANTS FOR STATES

Section 3621. Application for Grants. (a) A state education agency shall submit a planning grant application in the form and manner prescribed by the Secretary.

(b) An application must be developed jointly by state health and education agencies and must include:

- (1) an assessment of the state's need for comprehensive school health education, as measured by goals established by the departments of Health and Human Services and Education and state goals;
- (2) a description of how the state education and health agencies will collaborate in the development of a comprehensive school health education program in the state, including coordination of existing programs and resources;
- (3) a plan to build capacity at the local level to provide for staff development and technical assistance for local education agency and health agency staff;
- (4) a preliminary evaluation plan;
- (5) information demonstrating that the state has established an advisory council with representation from state agencies with principal responsibilities for health, education and mental health;
- (6) a timetable and proposed budget; and
- (7) such other information and assurances as the Secretary may require.

(c) A state agency may receive one planning grant annually, and no more than two such grants may be awarded to a state.

Section 3622. Approval of the Secretary. The Secretary may approve the applications that meet the statutory requirements of subpart A that are likely to result in a program meeting the requirements of subpart B.

Section 3623. Amount of Grant. A planning grant may not be less than the amount necessary for the state planning process (as determined by the Secretary), nor more than \$500,000.

Section 3624. Authorized Activities. States may use grants under this subpart only to:

- (1) carry out the planning process;
- (2) carry out state and substate collaboration and coordination activities;
- (3) conduct activities to build capacity to provide staff development and technical assistance to local education and health agencies;
- (4) develop student learning objectives and assessment instruments;
- (5) work with state and local health and education agencies to reduce barriers to implementation of school health education;
- (6) to prepare applications for implementation grants; and
- (7) to adopt, validate and disseminate curriculum models.

SUBPART B - IMPLEMENTATION GRANTS FOR STATES

Section 3631. Application for Grant. (a) A state must submit an application for an implementation grant in the form and manner specified by the Secretary.

(b) The application for an implementation grant must be developed jointly by state education and health agencies and must include descriptions of:

- (1) state program goals and objectives;
- (2) the state formula for allocating grant funds to local education agencies;
- (3) how the state will coordinate programs funded under this subpart with other local, state and Federal health education programs;
- (4) how the comprehensive school health education programs will be coordinated with other local, state and Federal programs;
- (5) how the state has worked with state and local health and education agencies;
- (6) how the state will monitor implementation;
- (7) professional capacity development plans;
- (8) staff development and technical assistance plans;
- (9) the respective roles of state and local education and health agencies;
- (10) how programs will be tailored to be responsive to students, including those with disabilities and from disadvantaged backgrounds; and
- (11) the state's evaluation and reporting system.

Section 3632. Selection of Grantees. The Secretary shall establish award criteria for competitive award of implementation grants; the Secretary may give additional planning funds (if any are available) to an unsuccessful implementation grant applicant that could benefit from additional planning.

Section 3633. Amount of Grant. The Secretary shall establish grant award criteria that take into account such factors as the numbers of children enrolled in school and of school-age children living in poverty, and also the scope and quality of a state's plan.

Section 3634. Authorized Activities; Limitation on Administrative Activities. (a) State education agencies receiving grants may retain up to 75 percent of funds in the first year, 50 percent in the second year, and 25 percent in the third year. Funds not retained shall be granted to local education agencies.

(b) States must use retained grant funds for specified purposes, including the following:

- (1) statewide and regional coordination activities;
 - (2) adapting, validating or disseminating models for comprehensive school health education;
 - (3) building capacity for staff development and technical assistance;
 - (4) promoting involvement of families and coordinating program activities with community groups and agencies;
 - (5) evaluating program performance and reporting thereon to the Secretary;
- and
- (6) other activities approved by the Secretary.

(c) States may use up to 10 percent of the retained funds for administrative costs.

Section 3635. Sub-grants to Local Educational Agencies. (a) Local educational agencies may apply to states for implementation grants, and must furnish specific information including

- (1) goals and objectives;
- (2) how the local agency will target schools with a high need for comprehensive health education, monitor program performance, and ensure cultural and linguistic suitability of the education programs;
- (3) monitoring activities;
- (4) how the agency will assure that programs are appropriate for students, including those with disabilities and from disadvantaged backgrounds; and
- (5) how the local educational agency will evaluate and report on attaining the goals and objectives of (1).

(b) States must select grantees on the basis of evidence of need, as shown by high rates of poverty, births, sexually-transmitted disease, drug and alcohol use, violence among adolescents, and other factors.

(c) Grants must be used for comprehensive school health education programs.

SUBPART C - STATE AND LOCAL REPORTS

Section 3641. State and Local Reports. State agency grant recipients must submit information as required by the Secretary; and local grant recipients must submit required information to the state agency.

PART 4 - SCHOOL HEALTH EDUCATION; GRANTS TO LOCAL EDUCATIONAL AGENCIES

SUBPART A - ELIGIBILITY

Section 3651. Substantial Need of Area Served by Agency. A local educational agency is eligible for a grant under this part if the agency enrolls at least 25,000 students and serves an area that shows a high need for the program, compared to other areas in the United States.

SUBPART B - PLANNING GRANTS FOR LOCAL EDUCATION AGENCIES

Section 3661. Application for Grant. (a) A local education agency must submit a planning grant application to the Secretary in the form and manner required by the Secretary.

(b) Before submitting an application to the Secretary, a local education agency must first submit it for comment to state education and health agencies.

(c) Applications must include the following:

- (1) a needs assessment, using Federal and state health and education goals;
- (2) information showing that the local agency has established or selected a community-level advisory council, with representation from community health, education, child nutrition and mental health agencies;
- (3) a description of expected collaboration among state education and health agencies and local health and education agencies;
- (4) a plan to build capacity in the local agency for staff development and technical assistance;
- (5) a preliminary evaluation plan;
- (6) a planning and budget timetable; and
- (7) other information and assurances required by the Secretary.

(d) A local education agency may not receive more than two annual planning grants.

Section 3662. Selection of Grantees. (a) The Secretary must establish criteria for competitive selection of grantees.

(b) The Secretary may not approve a local grant application unless the Secretary determines that the local plan is consistent with the state plan, if any.

Section 3663. Amount of Grant. In any fiscal year, the minimum amount for a local agency planning grant is the amount determined by the Secretary to be needed for agency planning. The maximum amount of a grant in any year is \$500,000.

Section 3664. Authorized Activities. Local agencies may use grant funds only for the following purposes:

- (1) planning;
- (2) joint training, staffing, administration and other coordinating activities among local education, health and other appropriate agencies;
- (3) building capacity for staff development and technical assistance;
- (4) developing student learning objectives;
- (5) reducing barriers to implementing comprehensive school health education;
- (6) preparing an implementation plan.

SUBPART C - IMPLEMENTATION GRANTS FOR LOCAL EDUCATIONAL AGENCIES

Section 3671. Application for Grant. (a) A local education agency must submit an implementation grant application to the Secretary of Health and Human Services in the form and manner, and including information and assurances as required by the Secretary.

(b) The application must be submitted to state education agency for comment.

(c) The application must include specified information:

- (1) local agency goals and objectives for the program;
- (2) how the program will be coordinated with other state and Federal health education programs;
- (3) how the program will be coordinated with other state and Federal education programs;
- (4) how the agency will reduce barriers to school health education;
- (5) how the program will be monitored;
- (6) how the agency will build professional development capacity;
- (7) how the agency will provide staff development and technical assistance;
- (8) the respective role of state and local health and education agencies in implementing comprehensive school health education programs;
- (9) how programs will be tailored to meet the needs of students, including those with disabilities and from disadvantaged backgrounds;
- (10) evaluation and reporting plans.

Section 3672. Selection of Grantees. (a) The Secretary must establish criteria for the competitive selection of grantees.

(b) The Secretary may not approve a local education agency implementation grant that is not consistent with a state plan.

(c) The Secretary must offer planning grants to local education agencies whose implementation grants have been denied, if there are funds available and if the local agency could benefit from planning.

Section 3673. Amount of Grant. (a) The minimum amount of a grant is the amount necessary for implementation of the program, as determined by the Secretary.

(b) In determining the minimum grant, the Secretary must take into account factors such as the number of children in the schools, the numbers of school-age children living in poverty in the area served by the local agency, and the scope and quality of the plan.

Section 3674. Authorized Activities. An implementation grant may be used for the following purposes:

- (1) implementing comprehensive school health education programs;
- (2) coordinating local or regional activities;
- (3) providing staff development and technical assistance to schools;
- (4) administering and monitoring the program;
- (5) evaluation and reporting;
- (6) other activities authorized by the Secretary.

Section 3675. Reports. Local education agencies that receive implementation grants must submit reports required by the Secretary.

PART 5 - SCHOOL-RELATED HEALTH SERVICES

SUBPART A - DEVELOPMENT AND OPERATION OF PROJECTS

Section 3681. Authorization of Appropriations. (a) For developing and operating school-related health services, the following amounts are authorized: \$100,000,000 for fiscal year 1996; \$275,000,000 for fiscal year 1997; \$350,000,000 for fiscal year 1998; and \$400,000,000 for each of fiscal years 1999 and 2000.

(b) Funds appropriated under this section are in addition to other funds available for developing and operating school-related health services.

Section 3682. Eligibility for Development and Operation Grants. (a) Entities

eligible to apply are state health agencies that apply on behalf of local community partnerships, and such local partnerships in states where state health agencies have not applied.

(b) Local partnerships are entities that at a minimum include a local health care provider delivering services to adolescents, one or more public schools, and at least one community based organization. Partnerships shall encourage broad participation from parents and youth, health and social service providers, teachers and school personnel, the regional alliance serving the area in which schools participating in the partnership are located, and other organizations and business leaders.

Section 3683. Preferences. (a) In making grants, the Secretary must give priority to communities with highest level of need among 10 to 19-year-olds as measured by poverty, the presence of a medically underserved population, a health professions shortage area, and a high proportion of children with special health care needs such as disability, adolescent pregnancy, sexually transmitted disease, injuries and gang violence, and exposure to drugs and alcohol.

(b) The Secretary shall give preference to applicants demonstrating a link to qualified community health plans and community networks under subtitle E of title III.

Section 3684. Grants for Development of Projects. (a) The Secretary may make development grants to state health agencies or local community partnerships.

(b) Permissible uses of planning funds include planning for the provision of school health services; staff recruitment, compensation and training; developing agreements with alliance health plans; acquiring equipment and information services, establishing local partnerships (in the case of state applications), and other activities necessary to achieve operational status.

(c) Applications shall be submitted in a form and manner specified by the Secretary. A state agency application must include assurances that the agency is applying on behalf of at least one local community partnership and at least one other community in need of services (as identified by the state) but without a local partnership. In the latter case, the application must also describe how the state will aid the community to develop a partnership. No more than 10 percent of grant awards may be used for administrative activities.

(d) The application shall contain the following contents:

- (1) a plan for assessing need;
- (2) a description of how the proposed services will reach the maximum number of school-aged children and youth at risk for poor health outcomes;
- (3) an explanation of how services will be integrated with other community health and social service programs;

- (4) an explanation of how services will be linked to health plans;
- (5) evidence of program linkages to regional and corporate alliances; and
- (6) a description of quality assurance plans.

(e) No more than one planning grants may be made to an applicant.

Section 3685. Grants for Operation of Projects. (a) The Secretary may make grants, for the cost of operating school health service sites, to state health agencies or local partnerships.

(b) The purposes for which an operating grant may be used include:

- (1) furnishing health services;
- (2) furnishing enabling services (as defined under section 3461(b));
- (3) training, recruitment and compensation of staff;
- (4) outreach services, to at-risk youth and parents;
- (5) prevention and support services;
- (6) linkage of individuals to health plans and community and social services;
- (7) other activities authorized by the Secretary.

(c) Applications shall be submitted in a form and manner approved by the Secretary and must include information on the services to be furnished, the amount and sources of funds the applicant will spend, and such other information as the Secretary requires.

(d) The applicant must also meet the following conditions:

- (1) the applicant will furnish the following:
 - (A) diagnosis and treatment of minor illness and injury;
 - (B) preventive services;
 - (C) enabling services;
 - (D) referral and follow up for illness and injury;
 - (E) health and social services, counseling and referrals, including referrals regarding mental health and substance abuse;
 - (F) other services the Secretary specifies.
- (2) the applicant maintains agreements with all regional and corporate alliance health plans offering services in the applicant's service area;
- (3) the applicant participates in Medicaid;
- (4) the applicant does not charge for services;
- (5) the applicant will periodically review the needs of populations served and will remove barriers to the use of services;
- (6) the applicant will provide a plan to meet the needs of non-English speaking populations;
- (7) the applicant will provide non-Federal contributions; and
- (8) the applicant will operate a quality assurance program consistent with section 3684(d)(6).

(e) Grants will be for periods determined by the Secretary. A grant recipient must provide reports and information required by the Secretary.

Section 3686. Federal Administrative Costs. The Secretary may retain up to five percent of funding for development and operation grants for administrative costs.

SUBPART B - CAPITAL COSTS OF DEVELOPING PROJECTS

Section 3691. Loans and Loan Guarantees Regarding Projects. (a) The Secretary may make loans to and guarantee loans to state health agencies and local partnerships for capital costs of developing school-related health services.

(b) The provisions of section 3441 (loans to develop community health plans and networks) shall apply to loans and loan guarantees under this subpart.

Section 3692. Funding. Amounts made available to the Secretary to carry out subparts B and C of part 2 of subtitle E may be used not only for purposes there authorized but also for school-related health services under this part.

CHRISTOPHER J. DODD
CONNECTICUT

United States Senate

WASHINGTON, DC 20510

Subcommittee on Children, Family, Drugs, and Alcoholism Committee on Labor and Human Resources

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FROM: Jorge B. LOPEZ

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FYI. PLEASE CALL ME
IF YOU HAVE ANY QUESTIONS.

**SENATOR CHRISTOPHER J. DODD AMENDMENT
OUNCE OF PREVENTION PROGRAM
SUMMARY**

General Information

Establishes the Ounce of Prevention Council to coordinate federal youth violence efforts and provide one-stop shopping for community-developed programs. Assists communities in providing alternatives to violence for their youth.

Program Structure

Helps communities cut through government red-tape by establishing the Ounce of Prevention Council. Communities apply directly to the Ounce of Prevention Council which coordinates various departments and offices within the federal government. Includes the Departments of Justice, Education, Health and Human Services, Agriculture, Housing and Urban Development, Labor and the Office of National Drug Control Policy.

Allows communities to put together flexible coalitions of local residents, neighborhood groups and community-based organizations to develop positive out-of-school activities for young people. Applicants could be municipalities, school boards, colleges, nonprofit corporations, or consortia of eligible applicants. Applicants must involve local residents, young people, community-based organizations, private-sector representatives, youth-serving organizations, schools, law enforcement professionals, employers and health and social service providers.

Use of Funds

Funds may be used for summer and after-school recreation, academic enrichment or workforce preparedness programs.

Authorization

Funding is \$75 Million per year.



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
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Office of Adolescent Health

Authorizing Legislation - Title XVII of the Public Health Service Act

	FY 1993 Actual		FY 1994 Appropriation		FY 1995 Estimate		Increase or Decrease	
	FTE	BA	FTE	BA	FTE	BA	FTE	BA
AFL	11	\$7,598,000	13	\$7,000,000	--	---	-13	-\$7,000,000
OAH	--	---	--	---	13	\$6,825,000	+13	+\$6,825,000
Total	11	7,598,000	13	7,000,000	13	6,825,000	--	-175,000

1995 Authorization Indefinite

Purpose and Method of Operation

The Office of Adolescent Health (OAH) is administered and directed by the Office of Population Affairs. The OAH focuses on improving adolescent health by supporting demonstration grants, including projects to: train health professionals; reduce the incidence of violence and substance abuse among youth; prevent adolescent pregnancy and sexually transmitted diseases; encourage comprehensive health education and the provision of contraceptive information and services to adolescents; provide attention to the mental health needs of adolescents.

The legislation for the Office of Adolescent Health supports a broad definition of "adolescent health." The definition includes all diseases, disorders, and conditions (including mental health) that are unique to adolescents, or more serious or more prevalent in adolescents; for which the factors of medical risk or types of medical intervention are different for adolescents; and for which there is insufficient clinical research involving adolescents as subjects or insufficient clinical data on adolescents.

P.L. 102-531 authorizes \$5 million for fiscal year 1993 and "such sums as necessary" for fiscal years 1994-1997 for the office to make demonstration grants for the improvement of adolescent health. The OAH is specifically charged with the following responsibilities:

- coordination of all activities within the Department related to adolescent health;
- operation of a clearinghouse on adolescent health;
- development of a national plan to improve adolescent health which is to be consistent with the Healthy People 2000 objectives; and
- administration of a demonstration grant program, including grants to train health professionals and to reduce the incidence of violence among adolescents, particularly among minority males.

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Rationale for Budget Request

The request of \$6,825,000 and 13 FTEs in Fiscal Year 1995 will provide funds to support the OAH demonstration grant and contract program as authorized by P.L 102-531. In advancing a more comprehensive public health response to the special health problems of adolescents, adolescent pregnancy prevention and care will continue to be a priority for the Office of Adolescent Health. However, future OAH grants will be more broadly focused than they were under the Adolescent Family Life (AFL) program. All AFL grantees will be eligible for funding to complete their current project periods during the FY 1994 funding cycle, and it is likely that many will be eligible to compete for funding under the OAH demonstration grant program in FY 1995.

A comprehensive range of health, educational and social services is needed to protect and improve the health of adolescents. And, in light of the increasing rates of morbidity and mortality among adolescents, it is imperative that new and effective approaches to the prevention of adolescent health problems be developed and evaluated. The health problems of adolescents present a formidable public health challenge: one in five adolescents suffers at least one serious health problem; the three leading causes of death among adolescents are injury, suicide and homicide; nearly 1 million teens become pregnant each year; up to 25 percent of all adolescents will have had at least one sexually transmitted disease before leaving high school; and 35 percent of high school seniors report binge drinking within the last two weeks.

The OAH provides leadership, planning, and coordination support for existing and new PHS adolescent health activities. In general, OAH coordinates in the design, support and evaluation of existing and emerging adolescent health programs; monitors trends in adolescent health; provides support for multidisciplinary projects on adolescent health; operates a clearinghouse for the collection and dissemination of adolescent health information; and provides support for special training projects for health providers who work with adolescents. Much of this is done through demonstration grant projects that attempt to close the gap between research findings and practice.

The OAH seeks to demonstrate successful outcomes for emerging programmatic efforts directed at adolescents, and to strengthen links among existing public health activities related to adolescents. A major study by the Office of Technology Assessment of existing adolescent-related programs within the Federal government showed that over 75 different departments and agencies are responsible for providing care to adolescents. Most of the public health programs are targeted at a particular health problem -- e.g., drug abuse, substance abuse or pregnancy -- rather than on the adolescent population in general. Unfortunately, few of these programs have been adequately linked to each other, and the piece-meal manner in which they have been developed have often prevented clear coordination of efforts.

Funding at the requested level would improve the ability of the Public Health Service (PHS) to enhance adolescent health by: (a) allowing for the development of more comprehensive public health strategies; (b) complementing

current efforts in health care reform which propose expanded school-linked health services for adolescents who represent an underserved population, and comprehensive school health education for children in grades K-12; and (c) enabling improved program and policy coordination of a wide range of PHS prevention and services programs that address adolescents.

Program Data

	<u>Adolescent Family Life</u>		<u>Adolescent Health</u>
	<u>FY 1993</u>	<u>FY 1994</u>	<u>FY 1995</u>
	<u>Actual</u>	<u>Estimate</u>	<u>Request</u>
Programs:			
Demonstration Grants	\$4,729,000	\$4,404,000	\$5,000,000
Research grants	<u>994,000</u>	<u>952,000</u>	<u>---</u>
Total	5,723,000	5,356,000	5,000,000
Contracts	313,000	348,000	477,000
Support Costs	<u>1,582,000</u>	<u>1,296,000</u>	<u>1,348,000</u>
Total Funds	\$7,598,000	\$7,000,000	\$6,825,000
FTEs	11	13	13



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Washington DC 20201

DEC 16 1993

Programs to prevent adolescent pregnancy have generally fallen into two categories--those that provide information/services on sexuality and contraception and those that promote abstinence. Convincing evidence of their effectiveness is quite limited.

A number of studies have been done to determine the effectiveness of sexuality education programs in schools. The consensus seems to be that, while there is a gain in knowledge, there is no consistent and measurable impact on attitudes or behavior with respect to initiation of sexual activity, contraceptive use or pregnancy.

Evaluations of programs that provide contraceptive services have shown that adolescents who use clinic services are more likely to use contraceptives than those who do not use the services. In addition, these programs appear to have some effect in reducing births, although it is not clear whether this is through preventing conceptions or through terminating unwanted pregnancies.

During the past decade, the primary Federal focus on adolescent pregnancy prevention has been abstinence education. Despite the requirement that such programs be evaluated, there is, again, little evidence of their success or failure--with the exception of apparent increases in knowledge among those who participate in the programs.

A major impediment in the evaluation of all these programs has been that measuring the outcome variable of most interest--incidence of unplanned pregnancy--remains elusive. A count of pregnancies includes births, abortions and an estimate of fetal deaths. Births are relatively easy to verify because they are tabulated by the vital registration system. Abortions, however, are not uniformly reported and direct inquiry through survey mechanisms is subject to underreporting. In addition, adolescents--especially the low-income minorities most at risk--can be difficult to locate for follow-up purposes.

-2-

In general, the methodologies for evaluating pregnancy prevention programs have not been adequately developed. The absence of matched comparison groups in most studies is striking. Frequently, the data necessary for appropriate controls, such as the level of sexual activity in the populations being studied or, adequate data on the content, length and quality of programs, are not available. Random assignment of treatment and comparison groups is rare, often because programs do not want to deny services. Also, the questions asked of program clients for evaluation purposes are often sensitive--such as their attitudes about sex, whether or not they are sexually active, if they have ever been pregnant, etc. In addition to the error introduced by self-report, schools and parents often object to the personal nature of these questions and will not permit them to be asked.

Evaluations of a few programs, however, have yielded some promising results. The Postponing Sexual Involvement (PSI) curriculum, developed at Emory University and the Reducing the Risk (RTR) curriculum, developed by ETR Associates, combine sexuality education, including delaying sexual involvement, social skills training and practice in applying skills with comprehensive information about contraceptives. These programs have shown positive effects on delaying first intercourse, increasing the use of effective contraception at first intercourse and decreasing the frequency of unprotected intercourse. Another program, a school linked clinic affiliated with the Johns Hopkins University, provided reproductive health and pregnancy prevention services to students in two nearby schools. Evaluation results indicate that in addition to increasing contraceptive use and decreasing pregnancy, initiation of sexual activity was delayed an average of seven months.

In addition, a study recently released by the World Health Organization found that prevention programs which combine information about contraceptives and postponement of sex were more effective than those that promoted only abstinence. The WHO study also corroborated findings from both PSI and RTR--programs are more effective when given before a young person becomes sexually active.

Background

3. Summary of teenaged pregnancy and child bearing trends of the 1980s and early 1990s, including assigning relative importance to demographic trends, age at initiation and frequency of intercourse, contraceptive practices, abortion practices and marriage decisions.

Between 1980 and 1986, birth rates for adolescents continued the decline that began in the 1970s. In 1986, these rates began to rise--as did birth rates for all age groups--and, by 1990, had reached a level not seen since the early 1970s. Most of this change occurred among younger adolescents; the birth rate for 15-17 year olds increased by 23 percent between 1986 and 1990 as compared to an 11 percent increase for 18-19 year olds.

Data on adolescent pregnancy lags behind that for births with 1988 being the most recent year for which adolescent pregnancy rates are available. The number of pregnancies is constructed by summing births, abortions and an estimate of fetal deaths. Births, collected through the national vital registration system, are available on a more timely basis than abortions which are not subject to the same mandatory reporting system.

Pregnancy rates for adolescents remained fairly stable during the 1980s--declining slightly through 1986 and then increasing to the 1980 level by 1988. This pattern varied by age with most change attributable to fluctuations in birth rates for those aged 15-17 years and in increasing abortion rates for those aged 18-19 years.

Levels and changes in adolescent pregnancy and birth rates depend on a number of factors, as well as the interrelationships between them. The rapid increase in adolescent sexual activity during the past two decades is probably the most important. The proportion of adolescent women who are sexually experienced has increased steadily since 1970--from 29 to 52 percent. The same holds for young men (aged 17-19 years); the proportion sexually active increased from 66 to 76 percent between 1979 and 1988. In addition, sexual initiation is occurring at younger ages; young women aged 15 years show the largest increase in the proportion sexually active--slightly less than 5 percent in 1970 to nearly 26 percent in 1988.

Although adolescents may not be particularly good contraceptors, their increased use of contraceptives has kept their pregnancy rates relatively level despite large increases in the proportion sexually active. During the 1980s, the proportion using a contraceptive method at first intercourse increased from 53 percent to 65 percent. If pregnancy rates are calculated for sexually active adolescent women only, there is a 20 percent

decrease between 1980 and 1988--sexually experienced adolescents were less likely to become pregnant in 1988 than they were in 1980.

The decline in adolescent birth rates, beginning in the early 1970s, corresponded with the legalization of abortion. The abortion rate for adolescents increased sharply during the latter half of the 1970s, but has increased only slightly since. Similarly, after the increases observed during the 1970s, the proportion of adolescent pregnancies terminated by abortion has remained at about 40 percent since 1980.

Although data by age and race are limited, they do indicate some important differences. While the pregnancy rate decreased somewhat between 1980 and 1988 for white adolescents, it rose for all other adolescents; the pregnancy rate is nearly twice as high for all other adolescents as for whites. The same difference applies to childbearing; the birth rate for black adolescents has always been substantially higher than for white adolescents. In 1990 it was 98.8 births per 1,000 young black women aged 15-19 years compared to 49.3 for whites.

Young black women are more likely to be sexually active than their white counterparts. The difference between the two races is narrowing, however, as the increases in adolescent sexual activity observed during the past decade are much greater for whites. Nevertheless, improved contraceptive use by adolescents is also largely for white adolescents--the proportion of all other adolescents using a contraceptive method at first intercourse changed little during the 1980s. Thus, while the pregnancy rate per 1,000 sexually experienced white adolescents fell 20 percent between 1980 and 1988, the corresponding rate for all others did not change.

Marriage as a determinant of adolescent fertility has become largely irrelevant. During the 1980s, marriage rates for adolescents steadily decreased as adolescent fertility began to increase by mid-decade. Moreover, adolescent nonmarital childbearing has been increasing steadily since the 1970s. Black adolescents are far more likely to have an out-of-wedlock birth than are white adolescents. In 1990, 92 percent of births to black adolescents were out-of-wedlock as compared to 56 percent of births to white adolescents. The gap between black and white adolescents is narrowing, however, as the increase in nonmarital childbearing has been far greater for white adolescents.

Although not well quantified, social factors must also be considered as having an effect on adolescent fertility. It is speculated that many adolescent pregnancies and births are intended, or at least that the adolescent is indifferent when an unplanned pregnancy occurs. When life opportunities are limited, an early pregnancy may not be viewed as an obstacle nor a child as much of an additional burden. Some researchers are suggesting that, among low-income families, early parenthood may not have

the deleterious effects on education and income levels once thought. Instead, a family background of low educational attainment, low-income or welfare dependency may be more of a predictor; policy measures designed only to delay childbearing may not do much to improve the status of poor women and their children.

6. (a) Summary of effectiveness (especially impacts on unwanted pregnancies and welfare receipt) of family planning and other social and medical services aimed at teenage pregnancy prevention.

Programs to prevent adolescent pregnancy have generally fallen into two categories--those that provide information/services on sexuality and contraception and those that promote abstinence. Convincing evidence of their effectiveness is quite limited.

A number of studies have been done to determine the effectiveness of sexuality education programs in schools. The consensus seems to be that, while there is a gain in knowledge, there is no consistent and measurable impact on attitudes or behavior with respect to initiation of sexual activity, contraceptive use or pregnancy.

Evaluations of programs that provide contraceptive services have shown that adolescents who use clinic services are more likely to use contraceptives than those who do not use the services. In addition, these programs appear have some effect in reducing births, although it is not clear whether this is through preventing conceptions or through terminating unwanted pregnancies.

During the past decade, the primary Federal focus on adolescent pregnancy prevention has been abstinence education. Despite the requirement that such programs be evaluated, there is, again, little evidence of their success or failure--with the exception of apparent increases in knowledge among those who participate in the programs.

A major impediment in the evaluation of all these programs has been that measuring the outcome variable of most interest--incidence of unplanned pregnancy--remains elusive. A count of pregnancies includes births, abortions and an estimate of fetal deaths. Births are relatively easy to verify because they are tabulated by the vital registration system. Abortions, however, are not uniformly reported and direct inquiry through survey mechanisms is subject to underreporting. In addition, adolescents--especially the low-income minorities most at risk--can be difficult to locate for follow-up purposes.

In general, the methodologies for evaluating pregnancy prevention programs have not been adequately developed. The absence of matched comparison groups in most studies is striking. Frequently, the data necessary for appropriate controls, such as the level of sexual activity in the populations being studied or adequate data on the content, length and quality of programs, are not available. Random assignment of treatment and comparison groups is rare, often because programs do not want to deny services. Also, the questions asked of program clients for evaluation purposes are often sensitive--such as their attitudes

about sex, whether or not they are sexually active, if they have ever been pregnant, etc. In addition to the error introduced by self-report, schools and parents often object to the personal nature of these questions and will not permit them to be asked.

Evaluations of a few programs, however, have yielded some promising results. The Postponing Sexual Involvement curriculum, developed at Emory University and the Reducing the Risk curriculum, developed by ETR Associates, combine sexuality education, including delaying sexual involvement, social skills training and practice in applying skills with comprehensive information about contraceptives. These programs have shown positive effects on delaying first intercourse, increasing the use of effective contraception at first intercourse and decreasing the frequency of unprotected intercourse. Another program, a "school linked" clinic affiliated with the Johns Hopkins University, provided reproductive health and pregnancy prevention services to students in two nearby schools. Evaluation results indicate that in addition to increasing contraceptive use and decreasing pregnancy, initiation of sexual activity was delayed an average of seven months.

(b) Description of current programs and planned initiatives in family planning and social and medical services to prevent teenaged pregnancies.

Several Federal programs provide family planning services. They are primarily targeted to low-income women; adolescents are included in this population but counts are not available. Medicaid, a Federal/State program that reimburses health care providers for medical services to the poor, provides more than \$200 million annually to support family planning services. Community Health Centers, Migrant Health Centers, the Maternal and Child Health Block Grant and the Social Services Block Grant also provide family planning services to the populations they serve. However, only two Federal programs focus directly on adolescent pregnancy prevention--the Title X Family Planning Program and the Title XX Adolescent Family Life Program.

The Title X program was enacted in 1970 to provide support for public and private nonprofit agencies in the provision of voluntary family planning services for low-income individuals. With a \$173.6 million budget in FY 1993, more than 4 million clients will receive services through a network of over 4,000 clinics. The majority of Title X clients are low-income women and approximately one-third are adolescents.

Title X clinics provide contraception, infertility services, basic gynecologic care and counseling and referral on a broad range of reproductive health matters, as well as screening for ancillary health problems such as hypertension and diabetes. Projects are required to give priority to clients who are members

of low income families. They provide free care to low-income clients and charge fees according to a sliding scale for those with higher incomes. In addition to the services program, Title X also supports a program of training for medical, professional, administrative and clerical clinic personnel, an information and education program and a research program which focuses on family planning service delivery improvements.

For many clients the family planning clinic has been the primary, or sole, point of contact with the health care system. Rising sexual activity rates among adolescents, recent increases in the number who need subsidized services and concerns about prevention of sexually transmitted diseases (including HIV) have increased the need to expand family planning services, particularly for low income women and adolescents. Planned initiatives for the Title X program include:

- o outreach to low-income women, adolescents and persons at high risk of unintended pregnancy or infection with STD not now receiving family planning services;
- o increased focus on quality and completeness of services including treatment of STDs, screening for cervical cancer and breast cancer, substance abuse counseling and counseling on avoidance of high risk behavior which may place clients at risk of STD and HIV;
- o more emphasis on prevention of adolescent pregnancy, including enhanced counseling as well as new service arrangements for providing services to adolescents;
- o expansion of current clinic sites and development of clinics in high need areas to provide services to an additional 500,000 clients per year;
- o more emphasis on training and retention of Family Planning nurse practitioners and those working in clinics that serve high need populations.

The Title XX Adolescent Family Life program was enacted in 1981. With a FY 1993 budget of \$7.8 million, it is the only Federal effort focused exclusively on the issues of adolescent sexuality, pregnancy and parenting. The program provides funding in three areas: (1) care demonstration projects that serve pregnant and parenting adolescents, their infants and their families; (2) prevention demonstration projects that provide educational services to preadolescents, adolescents and their families; and (3) research projects on the issues of adolescent sexuality, pregnancy and childbearing.

Title XX care projects provide comprehensive health, education and social services, as well as test new approaches for their delivery. Most projects are either hospital or agency based and many provide home visiting services. A major focus is a case

management approach where each adolescent works one-on-one with a case manager throughout the pregnancy and early parenting period. An independent evaluation is required of each project which incorporates a process evaluation of program implementation and operation, as well as an outcome evaluation of the impact of the program on the health and life outcomes of adolescent parents and their children.

The major focus of Title XX prevention projects has been to develop and test programs to delay the onset of sexual activity and thus reduce the incidence of pregnancy and STD transmission. Projects are either school or community based and generally provide basic sexuality education, as well as training in life skills, social skills and resistance skills in various combinations. Discussion of contraception has not been included. Some projects provide information on contraceptive methods to parents. An independent evaluation is also required of each project which incorporates a process evaluation of program implementation and operation and an outcome evaluation that attempts to measure changes in knowledge, attitudes and behavior.

Thus far, the Title XX program remains as originally legislated and the prevention component is focused on abstinence. However, with the new Administration's much broader perspective on the issue, any program dealing with adolescent pregnancy prevention will take a more comprehensive approach than that of the past decade. New initiatives are likely to include:

- o sexuality education, beginning in the early grades, as part of a comprehensive health education program;
- o contraceptive information, education and services, as well as abstinence education, especially for younger adolescents;
- o information and education on avoiding other risky behaviors such as consumption of alcohol, tobacco and drugs;
- o availability of health services based in schools or other sites easily accessible to adolescents.

Adolescent Pregnancy and Childbearing: International Comparisons

Although international comparisons are always problematic because of data limitations, data for the U.S. and some highly developed countries are extensive and reliable enough to discern obvious patterns. When adolescent birth rates in the U.S. are compared with those for Western European countries similar in culture and level of economic development, it is clear that U.S. rates are substantially higher. Induced abortion rates for adolescents and, by extension, pregnancy rates follow the same pattern.

These differences cannot be attributed to the extremely high birth and pregnancy rates for U.S. black adolescents, nor can they be explained by differential rates of induced abortion. Even though rates for U.S. black adolescents are twice as high as for whites, the rates for U.S. white adolescents are still substantially higher than those for adolescents in Western European countries. As already stated above, abortion rates are much higher in the U.S. than other industrialized countries.

Levels of sexual activity are similar in the U.S. and other countries used for comparison. However, available data indicate that rates for younger adolescents in the U.S. tend to be slightly higher. Age at initiation of sexual activity is important because contraceptive use is positively associated with age and commitment of relationship. Where first intercourse is early, contraceptive use is likely to be lower and pregnancy risk higher.

In Western Europe, the governments are the principal funders and providers of health services. In addition, governments have recognized the need for adolescent contraceptive services and have acted accordingly. Contraceptive services tend to be more accessible to adolescents in Western European countries, as well as confidential and low cost. In some cases, there are clinics set up specifically for adolescents and young adults. Subsidized services are available to U.S. adolescents but they are targeted to low-income women of all ages. Contraceptive services from private physicians are more expensive and many will not provide such services without notifying parents.

Not surprisingly then, contraceptive use among Western European adolescents is higher than among adolescents in the U.S. In addition, the use of more effective methods, in particular oral contraceptives, is higher in Western European countries than in the U.S.

Social factors also seem to have a role. Western European populations by country are more homogeneous, both socially and economically. There appears to be less ambivalence about sexuality and, in contrast to the U.S., there is an absence of religious fundamentalism and highly restrictive moralistic attitudes about sexuality. There is also less of a class

Crime Prevention and Youth Development Strategy

I. The separate categorical targeted programs (Ounce of Prevention, YES, Model Intensive Prevention/Schumer grants) should be used together as a coherent crime prevention and youth development strategy. We plan to saturate distressed, high crime, high poverty areas (particularly areas with public housing) with positive interventions that work together to improve the life prospects of youth and young adults in these areas. The key problems are social isolation (lack of positive adult contacts and role models), poor skills, and lack of connection to jobs with a future. Our approach will be to use the funds together to create a coherent strategy of interventions that will follow youth from ages 10 to 18 and then into the labor market (up to their early 20s in some cases).

In each targeted community, we will allow flexibility but expect a concrete strategy to accomplish the five following goals:

- increase adult contacts for youth and increase duration of such contacts (mentors, coaches, group situations)
- increase activities in after-school and weekend hours
- improve skills by increasing the availability of work-based, experience-based learning activities.
- improve connections to jobs throughout metropolitan area
- employment guarantee for those that play by the rules (YES)

This approach deals directly with the problems associated with high crime and other social problems (social isolation and poor labor market prospects).

Collaboration among agencies at Federal and Local level is key. This can be viewed as a single coherent crime prevention and youth development strategy not just a bunch of categorical programs.

II. Conyers Local Partnership Act

1. Try to get the maximum targeting possible to high poverty, high crime areas.
2. Encourage collaborative efforts and links to other prevention programs in the crime bill.