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Improving the Health of Adolescents & Young Adults: A Guide for States and Communities



National Adolescent Health Information Center
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Improving the Health of Adolescents & Young Adults: A Guide for States and Communities

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TABLE OF CONTENTS



Foreword

Acknowledgements

Preface

Section 1. Building National Efforts to Improve Adolescent Health

Chapter 1. The National Initiative to Improve Adolescent Health by the Year 2010

Chapter 2. Health Status of Adolescents and Young Adults

Chapter 3. Improving Adolescent Health

Section 2. Building State and Local Efforts to Improve Adolescent Health

Chapter 4. Using Data to Shape Your Adolescent Health Program

Chapter 5. Getting Started, Worksheets 1-5

Chapter 6. Taking Action, Worksheets 6-10

Chapter 7. Sustaining the Intervention, Worksheets 11-22

Closing

Section 3. Resources to Improve Adolescent Health

Chapter 8. Federal Resources

References

Foreword

Promoting the health and safety of adolescents is of critical importance to the future of the Nation. Adolescence represents a unique period in the life cycle. No longer children and not yet adults, adolescents make significant choices about their health and develop attitudes and health practices that affect their current safety and well-being as well as influence their risk for future serious chronic disease. Adolescence represents an opportunity for encouraging healthy choices and prosocial behaviors that will continue into adulthood. By investing in adolescent health today, we invest in the workforce, parents, and leaders of tomorrow.

Improving adolescent health, safety, and well-being is a complex endeavor that requires the collaborative efforts of a wide array of societal sectors and institutions including, for example, parents and families, adolescents themselves, schools and postsecondary institutions, health care providers, community organizations and agencies that serve youth, faith-based organizations, media, employers, and government agencies. Together, these entities are responsible for providing a nurturing structure and environment, as well as opportunities for growth that support and sustain the healthy development of youth.

Improving the Health of Adolescents & Young Adults: A Guide for States and Communities is a companion to *Healthy People 2010*, the U.S. Department of Health and Human Services' comprehensive, nationwide health promotion and disease prevention agenda. The document helps communities and individuals translate the *Healthy People 2010* objectives that are key to adolescent health and safety into a vision for improving adolescent health and well-being. It provides a framework for helping communities to establish priorities, take collective action, and measure progress toward the shared goal of improving the health, safety, and well-being of their adolescents and young adults. We believe this guide will serve communities and States and be an excellent starting point for new and evolving efforts that foster the healthy development of our Nation's youth.



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National Conference of State Legislatures

Society for Adolescent Medicine

State Adolescent Health Coordinators Network

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Office of Safe and Drug-Free Schools

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Office of Disease Prevention and Health Promotion

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Preface

Adolescence represents a unique period in the life cycle that brings special challenges and opportunities. No longer children and not yet adults, adolescents make significant choices about their health and develop attitudes and health practices that continue into adulthood. In this period of exploration, adolescents also consciously start to make choices about their future and develop ideas about their roles in society. Adolescence thus represents an opportunity to encourage healthy choices and pro-social behaviors. In creating safe and nurturing environments for today's adolescents—environments that build assets while minimizing opportunities for behaviors that endanger health and safety—we can help ensure that tomorrow's adults will be healthy and productive.

The national *Healthy People 2010* initiative presents a special opportunity to promote the health and well-being of adolescents. It is also an important element of the new prevention initiative—*Steps to a Healthier US*—from the U.S. Department of Health and Human Services. Serving as a blueprint for improving the health of all Americans, *Healthy People 2010* has two overarching goals: (1) to increase quality and years of healthy life and (2) to eliminate health disparities. These goals are operationalized through 467 health objectives. As part of the *Healthy People 2010* process, experts convened to select critical objectives that represented the most serious health problems among young people aged 10 to 24 years. Through this process, 21 Critical Health Objectives for adolescents and young adults were identified. The 21 Critical Health Objectives cover mortality, unintentional injury, violence, substance use and mental health, reproductive health, and the prevention of chronic disease during adulthood. These Objectives represent a framework for policy makers, professionals, and community members as well as adolescents and their families to collectively address the challenge and promise of improving the health of our nation's young people.

The efforts to develop the 21 Critical Health Objectives led to the creation of the National Initiative to Improve Adolescent Health by the Year 2010 (“The National Initiative,” or NIIAH 2010), which aims to attain all 21 Critical Health Objectives as it measures progress toward meeting them at the national and state levels. The 21 Critical Health Objectives will help establish priorities for improving adolescent health and provide a road map for monitoring progress toward those priorities at the national, state, and local levels. For the purposes of the National Initiative, adolescents and young adults are defined as persons aged 10-24 years including three subgroups: young adolescents, aged 10-14; older adolescents, 15-19; and young adults, 20-24. Focusing on these age group parameters is necessary to make consistent comparisons for this population and for tracking the *Healthy People 2010* objectives for adolescents and young adults over the next decade.

Using the National Initiative's framework to address adolescent health problems requires developing new approaches, working with a variety of partners, and conceptualizing adolescent health from a new perspective. This document departs from traditional approaches to adolescent health in at least three ways: it (1) de-emphasizes a categorical approach to addressing specific health problems, (2) emphasizes a multilevel approach rather than concentrating on changing the knowledge and behaviors of individual adolescents, and (3) simultaneously takes a youth development approach, one that embraces adolescents and young adults proactively as part of efforts to promote their health and safety rather than as “problems to be fixed”.

Relying on a categorical approach alone ignores the fact that there are many common antecedents to seemingly disparate health problems. Research has clearly shown that risk behaviors tend to cluster and that engaging in one risk behavior often contributes to other negative health outcomes. Although the 21 Critical Health Objectives present each



health outcome as a separate concern, we encourage interventions that address multiple health risk behaviors concomitantly.

Regarding our multilevel approach, we believe there is great danger in the common practice of emphasizing the personal attributes and behaviors of adolescents while neglecting the effects of the environments in which they live. This document stresses addressing adolescent health problems at the levels of individual/family, school/peers, community, and policy/society.

As for youth development, we believe in viewing adolescents and young adults as persons whose assets, if adequately nurtured, serve as a positive force. A youth development approach aims to enhance competence, capacities, caring, and citizenship among young people. Recent research, which later chapters describe in more detail, supports this approach. For example, some studies have demonstrated that programs and interventions that integrate youth development approaches are effective in protecting youth against engaging in health risk behaviors. Even so, prevention efforts should not focus on youth development to the exclusion of initiatives aimed at reducing health problems and risk behaviors. The National Initiative framework underscores that the two approaches must go hand-in-hand to effectively promote adolescent health.

The audience for this Companion Document includes people from a variety of backgrounds and sectors, including personal healthcare. This document provides a variety of strategies, tools, guiding questions, and additional resources to help interested agencies develop programs and interventions that can prevent adolescent health problems. It emphasizes collaborative program planning and maintaining a coalition. We encourage communities to prioritize a specific Critical Health Objective or set of Critical Health Objectives based on adolescent health issues of most concern to their particular community as well as their history, dynamics, leadership, and resources. The document highlights examples of various communities that have brought together different sectors of society to prioritize community action and that have developed mechanisms for implementing workable solutions. We could not, however, present instructions for every step necessary for communities to develop and implement adolescent health programs and initiatives.

This document is divided into three parts. Section 1: Building National Efforts to Improve Adolescent Health includes Chapters 1 through 3 and provides the background for the National Initiative. Chapter 1 describes *Healthy People 2010* as well as the development of the 21 Critical Health Objectives and the National Initiative. Chapter 2 provides an overview of the health status of U.S. adolescents and young adults. Chapter 3 presents the National Initiative's framework, which focuses on the antecedents of the 21 Critical Health Objectives and incorporates risk and resilience theory and youth development. Moving from the national to state and local levels, Section 2: Building State and Local Efforts to Improve Adolescent Health provides guidance for taking action to achieve the 21 Critical Health Objectives. Chapter 4 discusses how data can be used to shape a local adolescent health agenda, develop a local adolescent health profile, and identify priority objectives. Chapters 5, 6, and 7 provide guidance for communities on developing, enhancing, and/or expanding programs and interventions to meet the 21 Critical Health Objectives. Finally, Section 3 includes Chapter 8, which offers a list of federal resources, including manuals, Web sites, and best practices.

In summary, improving adolescent health and well-being is a complex undertaking. Program evaluation and research on antecedent factors of adolescent health risk behaviors have helped create a road map for improving adolescent health. Although all the pathways have not yet been clearly drawn, and the strategies needed to achieve the greatest success are still being developed and tested, this document serves as a starting

point for new and enhanced action. If the nation makes significant progress toward meeting the 21 Critical Health Objectives, substantial improvements in adolescent health will result. Meeting the 21 Critical Health Objectives will also lead to improvements in adult health, because adult health risk behaviors often develop during adolescence and young adulthood. In addition, adoption of healthy behaviors by adolescents helps prevent the development of many serious chronic diseases of later adulthood, including lung and heart disease, certain common types of cancer, and other chronic diseases. As adolescents represent the workforce, parents, and leaders of tomorrow, making concerted investments in their health becomes even more imperative today.

CHAPTER 1



The National Initiative to Improve Adolescent Health by the Year 2010

Contents

Healthy People 2010 **page 2**

Background on the National Initiative **page 3**

Current Strategies of the National Initiative **page 6**

Summary **page 9**

Appendix 1-1: National Initiative Steering Committee **page 10**

Appendix 1-2: All Healthy People 2010 Objectives for Adolescents and Young Adults **page 11**

Appendix 1-3: National Initiative Partners **page 17**



In this section, we review the origin of the National Initiative to Improve Adolescent Health by the Year 2010. First, we provide a brief history of Healthy People 2010, which is important for understanding the National Initiative; next, we elaborate on the National Initiative, the 21 Critical Objectives, and the strategies already in place to attain these objectives.

Healthy People 2010

Healthy People 2010 provides a comprehensive agenda for nationwide health promotion and prevention of disease, disability, and premature death; it serves as a road map for improving the health of all Americans during the first decade of the 21st century. A broad collaboration of governmental and nongovernmental organizations is committed to implementing *Healthy People 2010* at national, state, and local levels.

Healthy People 2010 builds upon initiatives pursued over the past two decades. In 1979, *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* provided national goals for reducing premature deaths and preserving independence for older adults. The following year, another report, *Promoting Health/Preventing Disease: Objectives for the Nation*, set forth 226 targeted health objectives to be achieved over the next 10 years.

Healthy People 2000: National Health Promotion and Disease Prevention Objectives, released in 1990, identified goals and objectives for health improvement to be reached by 2000. *Healthy People 2010* continues this tradition as an instrument to improve the health of the nation in the first decade of the 21st century. *Healthy People 2010* is fundamental to the new prevention initiative, *Steps to a Healthier US*, which aims to reduce the major health burdens created by poor nutrition, physical inactivity, and tobacco use, as well as the following diseases: obesity, diabetes, asthma, cancer, heart disease, and stroke.

The Development of Goals and Objectives

A diverse range of people and organizations offered ideas and expertise in the development of *Healthy People 2010*:

- The Healthy People Consortium—an alliance of more than 350 national organizations and 250 state public health, mental health, substance abuse, and environmental agencies—conducted three national meetings on the development of *Healthy People 2010*.
- Many individuals and organizations gave testimony about health priorities at five *Healthy People 2010* regional meetings in late 1998.
- More than 11,000 comments on draft materials were received by mail or via the Internet from persons in every state, the District of Columbia, and Puerto Rico.

The final *Healthy People 2010* objectives, 467 in all, were developed by teams of experts from a variety of federal agencies and were coordinated by the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services (DHHS).

A Systematic Approach to Health Improvement

Grounded in scientific and public health research, *Healthy People 2010* was built through public consensus and is designed to measure the Nation's progress. Simply put, *Healthy People 2010* is about improving health—the health of individuals, the health of communities, and the health of the nation. Its systematic approach to health improvement is founded on two goals:

Goal 1: Increase Quality and Years of Healthy Life

Goal 2: Eliminate Health Disparities

The Office of Disease Prevention and Health Promotion in DHHS will use the 467 objectives, which are grouped in 28 focus areas, to monitor the nation's progress in achieving these two overarching goals. The objectives include measures of health outcomes (e.g., number of deaths due to motor vehicle injury) and contributing behaviors (e.g., participation in regular physical activity). Others focus on broader issues, such as improving access to quality health care, strengthening public health services, and improving the availability and dissemination of health-related information. Each objective has a target for specific improvements to be achieved by the year 2010.

Healthy People 2010 Focus Areas

1. Access to Quality Health Services
2. Arthritis, Osteoporosis, and Chronic Back Conditions
3. Cancer
4. Chronic Kidney Disease
5. Diabetes
6. Disability and Secondary Conditions
7. Educational and Community-based Programs
8. Environmental Health
9. Family Planning
10. Food Safety
11. Health Communication
12. Heart Disease and Stroke
13. Human Immunodeficiency Virus
14. Immunization and Infectious Diseases
15. Injury and Violence Prevention
16. Maternal, Infant, and Child Health
17. Medical Product Safety
18. Mental Health and Mental Disorders
19. Nutrition and Overweight
20. Occupational Safety and Health
21. Oral Health
22. Physical Activity and Fitness
23. Public Health Infrastructure
24. Respiratory Diseases
25. Sexually Transmitted Diseases
26. Substance Abuse
27. Tobacco Use
28. Vision and Hearing

Background on the National Initiative

As part of the *Healthy People 2010* development process, an Adolescent Health Steering Committee was formed to provide expert guidance for developing and selecting objectives for adolescents and young adults (ages 10 to 24 years). The Steering Committee included experts in adolescent health from academic institutions, national and state professional organizations, and governmental agencies (see Appendix 1-1). The Steering Committee focused on accomplishing three main tasks: 1) to review and learn from the *Healthy People 2000* process; 2) to apply these lessons to the selection of the *Healthy People 2010* objectives for adolescents and young adults; and 3) to build a means for attaining critical *Healthy People 2010* objectives for adolescents and young adults.

By the conclusion of the *Healthy People 2010* development process, the Steering Committee had identified 107 of the 467 objectives as important for adolescents and young adults (see Appendix 1-2). A total of 21 were identified as Critical Health Objectives based on two criteria: they represented critical health outcomes or contributing behaviors, and state-level data were either available to measure them or soon would be. This second criterion was crucial because the active participation and leadership of states and local communities is needed if we expect to measure the progress they make in reducing adverse adolescent outcomes and health risk behaviors. The 21 Critical Health Objectives cover the areas of mortality, unintentional injury, violence, substance use and mental health, reproductive health, and the prevention of chronic disease during adulthood (see Table 1). These 21 Critical Health Objectives reflect the youth risk-taking behaviors addressed by *Steps to a Healthier US*, namely tobacco use, unhealthy dietary habits, inadequate physical activity, alcohol and other drug use, and behaviors that result in violence and unintentional injuries.



While developing and selecting the broader set of 107 objectives and identifying the 21 Critical Health Objectives, the Adolescent Health Steering Committee started developing a framework and coordinated approach to plan and implement activities we could pursue collectively as a nation to attain the 21 Critical Health Objectives; the National Initiative to Improve Adolescent Health by the Year 2010 was born of this dialogue. The National Initiative aims to achieve the 21 Critical Health Objectives at national, state, and local levels by mobilizing resources from public and private organizations. The Steering Committee envi-

Table 1

21 Critical Health Objectives for Adolescents and Young Adults*			
<i>Critical health outcomes are underlined, and behaviors that substantially contribute to important health outcomes are in normal font.</i>			
Obj. #	Objective	Baseline (year)	2010 Target
<u>16-03.</u> (a,b,c)	<u>Reduce deaths of adolescents and young adults.</u> 10- to 14-year-olds 15- to 19-year-olds 20- to 24-year-olds	21.5 per 100,000 (1998) 69.5 per 100,000 (1998) 92.7 per 100,000 (1998)	16.8 per 100,000 39.8 per 100,000 49.0 per 100,000
Unintentional Injury			
<u>15-15.</u> (a)	<u>Reduce deaths caused by motor vehicle crashes.</u> 15- to 24-year-olds	25.6 per 100,000 (1999)	[1]
<u>26-01.</u> (a)	<u>Reduce deaths and injuries caused by alcohol- and drug-related motor vehicle crashes.</u> 15- to 24-year-olds	13.5 per 100,000 (1998)	[1]
15-19.	Increase use of safety belts. 9 th -12 th grade students	84% (1999)	92%
26-06.	Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol. 9 th -12 th grade students	33% (1999)	30%
Violence			
<u>18-01.</u>	<u>Reduce the suicide rate.</u> 10- to 14-year-olds 15- to 19-year-olds	1.2 per 100,000 (1999) 8.0 per 100,000 (1999)	[1] [1]
18-02.	Reduce the rate of suicide attempts by adolescents that required medical attention. Grades 9-12	2.6% (1999)	1.0%
<u>15-32.</u>	<u>Reduce homicides.</u> 10- to 14-year-olds 15- to 19-year-olds	1.2 per 100,000 (1999) 10.4 per 100,000 (1999)	[1] [1]
15-38.	Reduce physical fighting among adolescents. Grades 9-12	36% (1999)	32%
15-39.	Reduce weapon carrying by adolescents on school property. Grades 9-12	6.9% (1999)	4.9%

Obj. #	Objective	Baseline (year)	2010 Target
Substance Use and Mental Health			
26-11. (d)	Reduce the proportion of persons engaging in binge drinking of alcoholic beverages. 12- to 17-year-olds	7.7% (1998)	2.0%
26-10. (b)	Reduce past-month use of illicit substances (marijuana). 12- to 17-year-olds	8.3% (1998)	0.7%
06-02.	Reduce the proportion of children and adolescents with disabilities who are reported to be sad, unhappy, or depressed. 4- to 17-year-olds	[2]	[2]
18-07.	(Developmental) Increase the proportion of children with mental health problems who receive treatment.	[3]	[3]
Reproductive Health			
09-07.	<u>Reduce pregnancies among adolescent females. 15- to 17-year-olds</u>	68 per 1,000 females (1996)	43 per 1,000
13-05.	(Developmental) <u>Reduce the number of new HIV diagnoses among adolescents and adults. 13- to 24-year-olds</u>	16,479 (1998) [4]	[3]
25-01. (a,b,c)	<u>Reduce the proportion of adolescents and young adults with <i>Chlamydia trachomatis</i> infections. 15- to 24-year-olds</u> females attending family planning clinics females attending sexually transmitted disease clinics males attending sexually transmitted disease clinics	5.0% (1997) 12.2% (1997) 15.7% (1997)	3.0% 3.0% 3.0%
25-11.	Increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active. Grades 9-12	85% (1999)	95%
Chronic Diseases			
27-02. (a)	Reduce tobacco use by adolescents. Grades 9-12	40% (1999)	21%
19-03. (b)	<u>Reduce the proportion of children and adolescents who are overweight or obese. 12- to 19-year-olds</u>	11% (1988-94)	5%
22-07.	Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion. Grades 9-12	65% (1999)	85%

[1] 2010 target not provided for adolescent/young adult age group.

[2] Baseline and target inclusive of age groups outside of adolescent/young adult age parameters.

[3] Developmental objective – baseline and 2010 target to be provided by 2004.

[4] Proposed baseline is shown, but has not yet been approved by the *Healthy People 2010* Steering Committee.

* Source: U.S. Department of Health and Human Services (2000). *Healthy People 2010*. (2nd ed.) Volume 1 and 2. Washington, DC: U.S. Government Printing Office. This information can also be accessed at <http://wonder.cdc.gov/data2010/>.



sioned a collaborative, multifaceted effort involving key individuals and societal institutions (e.g., parents and families, schools, health care providers, community agencies that serve youth, faith-based organizations, media, postsecondary institutions, employers, and government agencies) that strongly influence the behavior and health of young people. Among the key partners of the National Initiative are the State Adolescent Health Coordinators and their formal network, a national network of public health professionals working in or with state Title V Maternal and Child Health or family health programs, and the Maternal and Child Health Bureau's Leadership Education in Adolescent Health (LEAH) program, which includes seven advanced interdisciplinary training projects sponsored by academic medical centers for adolescent health. National professional membership associations and other university-based grantees, such as the National Adolescent Health Information Center at University of California, San Francisco and the Konopka Institute at University of Minnesota, are also instrumental players in the National Initiative. (See Appendix 1-3 for a complete list of current key partners involved in the National Initiative.)

The National Initiative initially identified broad national strategies to help states and communities engage the societal institutions in attaining the 21 Critical Health Objectives. These strategies can be organized in four main groups, which are briefly described below. In addition, many other organizations are actively engaged in programs and projects that contribute to the National Initiative's goal of achieving the 21 Critical Health Objectives. A few examples of these programs and projects (and related resources) are also presented below. These examples are meant to illustrate the variety of strategies being used to achieve the 21 Critical Health Objectives. Chapter 8 provides a comprehensive listing of Federal organizations and their resources.

Current Strategies of the National Initiative

Analysis, Synthesis, and Application

Strategies include researching, assessing, and producing policy statements on various health outcomes.

- **Identify best policies, practices, and partners to attain the 21 Critical Health Objectives**— Academic institutions, national organizations, professional membership associations, and governmental agencies frequently distribute information and other resources that can be of great value to proponents of adolescent health. This strategy aims to ensure that our adolescent health partners would be able to implement, for example, relevant *Best Practices for Comprehensive Tobacco Control Programs* (prepared by the Centers for Disease Control and Prevention's [CDC] Office on Smoking and Health, 1999 [www.cdc.gov/tobacco/bestprac.htm]) and recommendations from *The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity*, 2001 (www.surgeongeneral.gov/topics/obesity).
- **Integrate youth development efforts**— A growing body of literature about the theory and application of youth development principles is fueling a new generation of youth-focused programs. Findings from the *National Longitudinal Study of Adolescent Health* and the National Academy of Sciences' *Community Programs to Promote Youth Development*, for example, suggest that addressing young people's developmental needs is important to their successful transition from adolescence to adulthood. Integrating youth development efforts will ensure that the National Initiative is concerned not only with individuals' attributes (such as knowledge and attitudes) and behaviors, but also with the social and environmental contexts that influence developmental factors important for growing into healthy and productive adults. This strategy also includes the synthesis of research about the effects of schools' psychosocial climates on health and education outcomes and offers practical recommendations to school administrators.

- **Implement and apply findings from *Healthy Passages: A Community-based Longitudinal Study of Adolescent Health***—Currently in its first wave of data collection, *Healthy Passages* is designed to provide an empirical basis for the development of effective policies and programs to improve the health and development of children, adolescents, and adults. The hallmark of this study, which will identify factors that predict health risk behaviors and health outcomes by following a cohort of youth aged 10 to 20 years, will be the development of a knowledge base that can be used to translate research findings into intervention science for improving adolescent health across a broad range of societal institutions.
- **Work with the World Health Organization (WHO) to analyze and apply experience across nations to improve adolescent health**—As in the United States, nations around the world have been addressing adolescent health issues for many years. These international experiences will be very helpful to our understanding of effective programs, policies, and other strategies and, conversely, our experiences could be helpful to them. Several partners of the National Initiative have long-standing working relationships with WHO and will continue to stay apprised of relevant international adolescent health activities so that these efforts can inform the growth and development of the National Initiative.
- **Develop policy statements**—The American Academy of Pediatrics (AAP), the American Medical Association, the Society for Adolescent Medicine, and other professional societies have developed policy statements for many of the health issues addressed by the 21 Critical Health Objectives. These policy statements are research based and include the data that form the rationale for the stated policies. For example, the AAP policy statement *The Teenage Driver* provides data on teen motor vehicle-related injuries, describes the factors that put adolescents at greater risk for such injuries, and proposes strategies to prevent them. Such organizational strategies recommend educational, clinical, regulatory, and policy interventions. Most policy statements are available from organizational Web sites.

Enhancing Infrastructure

These activities are aimed at capacity building and promoting education and communication on adolescent health issues within National Initiative partner organizations.

- **Increase state core capacity in adolescent health program and service delivery**—The Maternal and Child Health Bureau developed a cooperative agreement program for a State Adolescent Health Resource Center for Maternal and Child Health (MCH) personnel to provide multidisciplinary training, technical assistance, and other resources for State Adolescent Health Coordinators and others at the state level involved in adolescent health program and service delivery. For example, in collaboration with the National Adolescent Health Information Center at University of California, San Francisco, the State Adolescent Health Resource Center for MCH Personnel* is writing a guidebook to help states develop strategic plans for adolescent health.
- **Convene all State Adolescent Health Coordinators every year**—The State Adolescent Health Coordinators Network has a leadership role in the National Initiative. The CDC has recently funded the annual meeting of the State Adolescent Health Coordinators to plan and implement programs and strategies for addressing the Critical Health Objectives. Along with regular meetings of the National Initiative's Steering Committee, this strategy allows for regular communication, updates, professional development, and strategic planning for attaining the 21 Critical Health Objectives.

* The grantee is the Konopka Institute for Best Practices in Adolescent Health (based at the University of Minnesota in Minneapolis).



- **Increase efforts of the nation's pediatricians**—The American Academy of Pediatrics focuses on increasing pediatricians' capacity to collaborate with other health care professionals, public health officials, and policy makers to achieve positive lifestyle behaviors among young people aged 10 to 24 by working with state chapters, other national organizations, and within the AAP internal structure to promote the National Initiative and increase awareness of the 21 Critical Health Objectives for adolescents and young adults.

Reporting on Progress Towards Improving Adolescent Health

These activities provide up-to-date information about indicators of adolescent health.

- **Publish the progress of states on the 21 Critical Health Objectives**—For this strategy, the CDC has taken the lead in developing and distributing a report presenting national- and state-level data on progress made toward achieving the Critical Health Objectives. These reports will be important for sustaining the attention and level of effort needed to achieve the Critical Health Objectives.
- **Publish state adolescent health performance measures**—The Maternal and Child Health Bureau has taken the lead in identifying the adolescent health performance measures used under the state Title V block grants and has started to align these measures with the 21 Critical Health Objectives. The potential reach and impact of the adolescent health performance measures and the Critical Health Objectives will be enhanced as they become more consistent and parallel over time.
- **Broadcast live to state departments of health the national *Healthy People 2010* progress reviews on adolescents and young adults**—As part of the *Healthy People* process, periodic progress reviews will be conducted during this decade to report progress in attaining all objectives for adolescents and young adults. As it did in 1998 for its review of the *Healthy People 2000* objectives, CDC will provide live satellite broadcasts to state departments of health and other adolescent health partners as a means to review objectives relevant to adolescents and young adults, with particular attention given to the 21 Critical Health Objectives. As before, participating sites will be encouraged to invite representatives from various sectors of societal institutions that are important to the support and development of healthy youth. Their participation will encourage the continued planning and implementation of actions needed to improve the health of young people.

Information and Resources

Information and resources include monographs and documents that summarize data, research, policies, programs, and other types of information relating to the 21 Critical Health Objectives.

- **Publish annual review of state health policies**—For the past 4 years, the National Conference of State Legislatures has produced a publication, *Adolescent Health Issues State Actions*, that reports legislative activities concerning adolescent health issues on a state-by-state basis. This document, which is a valuable policy-tracking tool for states and communities, is distributed to state government agencies and youth-serving organizations throughout the country.
- **Develop an online database of funding sources for adolescent health programs**—Formerly known as the *Adolescent and School Health Funding Database*, CDC's *Healthy Youth Funding Database (HY-FUND)* contains information on federal-, foundation-, and state-specific funding sources for adolescent and school health programs. The principal objective of the *HY-FUND* database is to share practical information with youth advocates and local communities about how they can acquire funds for developing and improving various components of adolescent and school health programs.

- **Develop a “Companion Document” on the National Initiative to Improve Adolescent Health by the Year 2010**—This document, which you are reading, provides an introduction and overview of adolescent health as well as background on the *Healthy People* initiative and the National Initiative to Improve Adolescent Health. It covers a variety of topics that are designed to provide concrete strategies and actions to achieve the 21 Critical Health Objectives. This document presents practical information that will help you begin, continue, and expand efforts to improve the health of young people in your community.
- **Produce resources for specific projects that may be useful to broader audiences**—The Association of State and Territorial Health Officials (ASTHO), for example, has an ongoing program to promote school health. Under this program, ASTHO has produced briefs summarizing research on the links between health status and academic performance. In addition, ASTHO has developed social marketing materials designed to engage more schools in health issues. Ready-to-use slide presentations have proven to be a particularly popular resource among health professionals working in schools. The American Medical Association (AMA) recently revised their publication of *Healthy Youth 2010: Supporting the 21 Critical Health Objectives*, which is a resource for physicians interested in actively supporting the national health objectives. The AMA has also developed many resources to support implementation of its Guidelines for Adolescent Preventive Services (GAPS). The preventive services outlined in GAPS pertain to many of the health issues addressed by the 21 Critical Health Objectives (e.g., pregnancy, substance abuse, and physical fitness). Among AMA’s resources are a “lessons learned” monograph, which offers guidance for implementing GAPS programs, and a discussion guide for parents of young teens. The National Adolescent Health Information Center, supported by the Maternal and Child Health Bureau, offers several resources related to the National Initiative’s goals. These include fact sheets on topics addressed by the 21 Critical Health Objectives (including violence, substance abuse, and injury), a monograph summarizing research and trends related to clinical preventive services, and the strategic plan guide book described earlier.

Summary

The National Initiative is an ambitious endeavor that challenges the nation to create new ideas, methods, and strategies to move forward in promoting adolescent health. To make improvements in the health of our nation’s young people, relevant agencies will need to nurture and expand their partnerships, especially at the state and local levels. In addition, we need to be creative in working with the various societal institutions that influence the behaviors and health of youth. Many individuals, agencies, and organizations, along with youth and their families, need to be a part of a long-term dialogue to incorporate the best science, effective strategies, and resources into the National Initiative to Improve Adolescent Health by the Year 2010.



Appendix 1-1

National Initiative to Improve Adolescent Health by the Year 2010

Steering Committee

Agency for Healthcare Research and Quality

American Academy of Pediatrics

American Medical Association

Association of Maternal and Child Health Programs

Association of State and Territorial Health Officials

Centers for Disease Control and Prevention—Division of Adolescent and School Health

Centers for Disease Control and Prevention—National Center for Health Statistics

Child Trends, Inc.

Health Resources and Services Administration/Maternal and Child Health Bureau—Office of Adolescent Health

Institute for Youth Development

National Academies/Institute of Medicine

National Association of County and City Health Officials

National Conference of State Legislatures

National Institute of Child Health and Human Development

Office of Assistant Secretary for Planning and Evaluation, DHHS

Office of Disease Prevention and Health Promotion, DHHS

Office on Minority Health, DHHS

Office on Women's Health, DHHS

Society for Adolescent Medicine

State Adolescent Health Coordinators Network

Substance Abuse and Mental Health Services Administration

U.S. Department of Education/Office of Safe and Drug Free Schools

United Nations Children's Fund

University of California, San Francisco
National Adolescent Health Information Center

University of Minnesota, Konopka Institute
State Adolescent Health Resource Center for MCH Personnel

University of Vermont

William T. Grant Foundation

World Health Organization

Appendix 1-2

All 107 Healthy People 2010 Objectives for Adolescents and Young Adults	
(Presented by Focus Area. Shaded rows indicate a Critical Health Objective.)	
1. Access to Quality Health Services	
01-04b.	Increase the proportion of persons who have a specific source of ongoing care. (baseline: 93%, target: 97% of 10- to 17-year-olds; baseline: not applicable, target: not applicable of 10- to 24-year-olds).
01-09a.	Reduce hospitalization rates for three ambulatory-care-sensitive conditions — pediatric asthma. (baseline: 23 per 100,000, target: 17 per 100,000).
3. Cancer	
03-09a.	(Developmental) Increase the proportion of adolescents who follow protective measures that may reduce the risk of skin cancer. Grades 9 through 12.
6. Disability and Secondary Conditions	
06-02.	Reduce the proportion of children and adolescents with disabilities who are reported to be sad, unhappy, or depressed. 4- to 17-year-olds (baseline: 31% and target inclusive of age groups outside of adolescent/young adult age parameters).
06-09.	Increase the proportion of children and youth with disabilities who spend at least 80% of their time in regular education programs (baseline: 45% of 6- to 21-year-olds; target: 60%).
7. Educational and Community-based Programs	
07-01.	Increase high school completion. 18- to 24-year-olds (baseline: 85%; target: 90%).
07-02.	Increase the proportion of middle, junior high, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol and other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; inadequate physical activity; and environmental health (baseline: 28% for all components; target: 70%).
07-03.	Increase the proportion of college and university students who receive information from their institution on each of the six priority health-risk behavior areas (baseline: 6%; target: 25%).
07-04a.	Increase the proportion of the nation's elementary, middle, and high schools that have a nurse-to-student ratio of at least 1:750 (baseline: 28% for all middle/junior, and senior high schools; target: 50%).
8. Environmental Health	
08-20.	(Developmental) Increase the proportion of the nation's primary and secondary schools that have official school policies ensuring the safety of students and staff from environmental hazards, such as chemicals in special classrooms, poor indoor air quality, asbestos, and exposure to pesticides.
9. Family Planning	
09-01.	Increase the proportion of pregnancies that are intended (baseline: 22% for 15- to 19-year-olds, 42% for 20- to 24-year-olds; target: not set for specific age group).
09-02.	Reduce the proportion of births occurring within 24 months of a previous birth (baseline: 9%, target: 6% for 15- to 19-year-olds, baseline: 14%, target: 6% for 20- to 24-year-olds).
09-03.	Increase the proportion of females at risk of unintended pregnancy (and their partners) who use contraception (baseline: 81%, target: 100% for 15- to 19-year-olds, baseline: 91% target: 100% for 20- to 24-year-olds).
09-07.	Reduce pregnancies among adolescent females (baseline: 68 per 1,000, target: 43 per 1,000 for 15- to 17-year-olds).



09-08.	Increase the proportion of adolescents who have never engaged in sexual intercourse before age 15 years (baseline: 81%, target: 88% for females aged 15 to 19 years, baseline: 79%, target: 88% for males aged 15 to 19 years).
09-09.	Increase the proportion of adolescents who have never engaged in sexual intercourse (baseline: 62%, target: 75% for females aged 15 to 17 years, baseline: 57%, target: 75% for males aged 15 to 17 years).
09-10.	Increase the proportion of sexually active, unmarried adolescents aged 15 to 17 years who use contraception that both effectively prevents pregnancy and provides barrier protection against disease (baseline: 7%, target: 9% for females, baseline: 8%, target: 11% for males).
09-11.	Increase the proportion of young adults who have received formal instruction before turning age 18 years on reproductive health issues, including all of the following topics: birth control methods, safer sex to prevent HIV, prevention of sexually transmitted diseases, and abstinence (aged 18 to 24 years) (baseline: 64%; target: 90%).
13. HIV	
13-05.	(Developmental) Reduce the number of cases of HIV infection among adolescents and adults.
13-06a.	Increase the proportion of sexually active persons who use condoms (aged 18 to 19 years) (baseline: 16%, target: 50% of unmarried Hispanic or Latina females, baseline: 31%, target: 50% of unmarried Black or African American females, baseline: 39%, target: 50% of unmarried White females).
14. Immunization and Infectious Disease	
14-03a.	Reduce hepatitis B (baseline: 24 per 100,000, target: 2.4 per 100,000 for 19- to 24-year-olds).
14-24b.	(Developmental) Increase the proportion of young children and adolescents who receive all vaccines that have been recommended for universal administration for at least 5 years. Data for specific population are not collected.
14-27 a,b,c,d.	Increase routine vaccination coverage levels of adolescents [13- to 1—years-old] (baseline: 48%, target: 90% for 3 or more doses hepatitis B, baseline: 89%, target: 90% for 2 or more doses MMR (measles, mumps, and rubella), baseline: 93%, target 90% for 1 or more doses tetanus-diphtheria booster, baseline: 45%, target: 90% for 1 or more doses Varicella).
15. Injury and Violence Prevention	
15-01.	Reduce hospitalization for nonfatal head injuries (baseline: 117.6 per 100,000, target: not applicable for male 15- to 24-year-olds).
15-05.	Reduce nonfatal firearm-related injuries (baseline: 143.8 per 100,000, target: not applicable for male 15- to 24-year-olds).
15-15a.	Reduce deaths caused by motor vehicle crashes (baseline: 25.6 per 100,000, target: not applicable for 15- to 24-year-olds).
15-16.	Reduce pedestrian deaths on public roads (baseline: 1.9 per 100,000, target: 1.0 per 100,000).
15-17.	Reduce nonfatal injuries caused by motor vehicle crashes (persons aged 16 to 20 years) (baseline: 3,116 per 100,000, target: not applicable for 16- to 20-year olds).
15-18.	Reduce nonfatal pedestrian injuries on public roads (baseline: 44 per 100,000 for 10- to 15-year-olds, 38 per 100,000 for 16- to 20-year-olds; targets: not applicable).
15-19.	Increase use of safety belts (baseline: 84%, target: 92% for 9 th - through 12 th - grade students).
15-21.	Increase the proportion of motorcyclists using helmets (baseline: 62%, target: 79% for 9 th - through 12 th - grade students).
15-22.	Increase the number of states (including District of Columbia) that have adopted a graduated driver licensing model law (baseline: 23 states; target: all states (including District of Columbia).

15-24.	Increase the number of states (including District of Columbia) with laws requiring bicycle helmets for bicycle riders baseline: 10 states; target: all states (including District of Columbia).
15-29.	Reduce drownings (baseline: 1.0 per 100,000 for 10- to 14-year-olds, 2.2 per 100,000 for 15- to 19-year-olds; targets: not applicable).
15-31.	Increase the proportion of public and private schools that require use of appropriate head, face, eye, and mouth protection for students participating in school-sponsored physical activities. (baseline: 39%; target: 43%).
15-32.	Reduce homicides (baseline: 1.2 per 100,000 for 10- to 14-year-olds, 10.4 per 100,000 for 15- to 19-year-olds; targets: not applicable).
15-35.	Reduce the annual rate of rape or attempted rape (data do not meet the criteria for statistical reliability, data quality, or confidentiality).
15-37.	Reduce physical assaults (baseline: 70.5 per 1,000 for 12- to 15-year-olds, 76.8 per 1,000 for 16- to 19-year-olds, 56.0 per 1,000 for 20- to 24-year-olds; targets: not applicable).
15-38.	Reduce physical fighting among adolescents (baseline: 36% of 9 th - through 12 th - grade students; target: 32%).
15-39.	Reduce weapon carrying by adolescents on school property (baseline: 6.9% of 9 th - through 12 th - grade students; target: 4.9%).
16. Maternal, Infant, and Child Health	
16-03 a,b,c.	Reduce deaths of adolescents and young adults (baseline: 21.5 per 100,000 for 10- to 14-year-olds, 69.5 per 100,000 for 15- to 19-year-olds, 92.7 per 100,000 for 20- to 24-year-olds; target: 16.8 per 100,000 for 10- to 14-year-olds, 39.8 per 100,000 for 15- to 19-year-olds, 49.0 per 100,000 for 20- to 24-year-olds).
18. Mental Health and Mental Disorders	
18-01.	Reduce the suicide rate (baseline: 1.2 per 100,000 for 10- to 14-year-olds, 8.0 per 100,000 for 15- to 19-year-olds; targets: not applicable).
18-02.	Reduce the rate of suicide attempts by adolescents that required medical attention (baseline: 2.6% of 9 th - through 12 th - grade students; target: 1%).
18-05.	(Developmental) Reduce the relapse rates for persons with eating disorders, including anorexia nervosa and bulimia nervosa. Data for specific population are not collected.
18-07.	(Developmental) Increase the proportion of children with mental health problems who receive treatment. Data for specific population are not collected.
18-08.	(Developmental) Increase the proportion of juvenile justice facilities that screen new admissions for mental health problems. Data for specific population are not collected.
19. Nutrition and Overweight	
19-03b.	Reduce the proportion of children and adolescents who are overweight or obese (baseline: 11% for 12- to 19-year-olds; target: 5% for 12- to 19-year-olds).
19-05.	Increase the proportion of persons aged 2 years and older who consume at least 2 daily servings of fruit (baseline: 23%, target: 75% for 12- to 19-year-old females; baseline: 22%, target: 75% for 12- to 19-year-old males).
19-06.	Increase the proportion of persons aged 2 years and older who consume at least 3 daily servings of vegetables, with at least one-third being dark green or orange vegetables (baseline: 2%, target: 50% for 12- to 19-year-old females).
19-07.	Increase the proportion of persons aged 2 years and older who consume at least 6 daily servings of grain products, with at least 3 being whole grains (baseline: 6%, target: 50% for 12- to 19-year-old females; baseline: 9%, target: 50% for 12- to 19-year-old males).



19-08.	Increase the proportion of persons aged 2 years and older who consume less than 10% of calories from saturated fat (baseline: 34% for 12- to 19-year-old females, 27% for 12- to 19-year-old males).
19-09.	Increase the proportion of persons aged 2 years and older who consume no more than 30% of calories from fat (baseline: 36%, target: 75% for 12- to 19-year-old females; baseline: 30%, target: 75% for 12- to 19-year-old males).
19-10.	Increase the proportion of persons aged 2 years and older who consume 2,400 mg or less of sodium daily (baseline: 29%, target: 65% for 12- to 19-year-old females; baseline: 4%, target: 65% for 12- to 19-year-old males).
19-11.	Increase the proportion of persons aged 2 years and older who meet dietary recommendations for calcium (baseline: 19%, target: 75% for 9- to 19-year-old females; baseline: 52%, target: 75% for 9- to 19-year-old males).
19-15.	(Developmental) Increase the proportion of children and adolescents aged 6 to 19 years whose intake of meals and snacks at schools contributes proportionally to good overall dietary quality. Data for specific population are not collected.
20. Occupational Safety and Health	
20-02h.	Reduce work-related injuries resulting in medical treatment, lost time from work, or restricted work activity (baseline: 4.8 per 100; target: 3.4 per 100 full-time adolescent workers).
21. Oral Health	
21-01c.	Reduce the proportion of adolescents who have dental caries experience in their permanent teeth (baseline: 61% of 15-year-olds; target: 51% for 15-year-olds).
21-02c.	Reduce the proportion of adolescents with untreated dental decay in their permanent teeth (baseline: 20% of 15-year-olds; target: 15% for 15-year-olds).
21-08b.	Increase the proportion of children who have received dental sealants on their molar teeth (baseline: 15% of 14-year-olds; target: 50% for 14-year-olds).
21-12.	Increase the proportion of low-income children and adolescents who received any preventive dental service during the past year (baseline: 20%; target: 57%).
21-13.	(Developmental) Increase the proportion of school-based health centers with an oral health component. Data for specific population are not collected.
22. Physical Activity and Fitness	
22-01.	Reduce the proportion of adults who engage in no leisure-time physical activity (baseline: 31%, target: 20% for 18- to 24-year-olds).
22-02.	Increase the proportion of adults who engage regularly, preferably daily, in moderate and/or vigorous physical activity for at least 30 minutes per day (baseline: 17% for 18- to 24-year-olds).
22-03.	Increase the proportion of adults who engage in vigorous physical activity that promotes the development and maintenance of cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion (baseline: 32%, target: 30% for 18- to 24-year-olds).
22-04.	Increase the proportion of adults who perform physical activities that enhance and maintain muscular strength and endurance (baseline: 28%, target: 30% for 18- to 24- year-olds).
22-05.	Increase the proportion of adults who perform physical activities that enhance and maintain flexibility (baseline: 36%, target: 43% for 18- to 24-year-olds).
22-06.	Increase the proportion of adolescents who engaged in moderate physical activity for at least 30 minutes on 5 or more of the previous 7 days (baseline: 27% for 9 th - through 12 th - grade students; target: 35%).
22-07.	Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion (baseline: 65% of 9 th - through 12 th - grade students; target: 85%).

22-08a,b.	Increase the proportion of the nation's public and private schools that require daily physical education for all students (baseline: 17% for middle/junior high schools, 2% for senior high schools; target: 25% for middle/junior high schools, 5% for senior high schools).
22-09.	Increase the proportion of adolescents who participate in daily school physical education (baseline: 29% of 9 th through 12 th grade students; target: 50%).
22-10.	Increase the proportion of adolescents who spend at least 50% of school physical education class time being physically active (baseline: 38% of 9 th - through 12 th - grade students; target 50%).
22-11.	Increase the proportion of children and adolescents who view television 2 or fewer hours per day (baseline: 57% of 9 th - through 12 th - grade students; target: 75%).
22-12.	Increase the proportion of the nation's public and private schools that provide access to their physical activity spaces and facilities for all persons outside of normal school hours (that is, before and after the school day, on weekends, and during summer and other vacations (baseline: 35%, target: 50%).
24. Respiratory Diseases	
24-01b.	Reduce asthma deaths (4- to 15-year olds per million population baseline: 3.1, target: 1.0).
24-02b.	Reduce hospitalizations for asthma. Baseline and target not applicable.
24-03b.	Reduce hospital emergency department visits for asthma. Baseline and target not applicable.
24-04b.	Reduce activity limitations among persons with asthma. Baseline and target not applicable.
24-05.	(Developmental) Reduce the number of school or work days missed by persons with asthma due to asthma. Data for specific population are not collected.
25. Sexually Transmitted Diseases (STDs)	
25-01b,c.	Reduce the proportion of adolescents and young adults with <i>Chlamydia trachomatis</i> infections (baseline: 5% for 15- to 24-year-old females attending family planning clinics, 12.2% for 15- to 24-year-old females attending STD clinics, 15.7% for 15- to 24-year-old males attending STD clinics; target: 3.0% for 15- to 24-year-old females attending family planning clinics, 3.0% for 15- to 24-year-old females attending STD clinics, 3.0% for 15- to 24-year-old males attending STD clinics).
25-02.	Reduce gonorrhea (baseline: 512 per 100,000 target: not applicable for 15- to 24-year-olds).
25-03.	Eliminate sustained domestic transmission of primary and secondary syphilis gonorrhea (baseline: 3.2 per 100,000 target: 0.2 per 100,000 for 15- to 24-year-olds).
25-04.	Reduce the proportion of adults with genital herpes infection (baseline: 6%; target: not applicable for 12- to 19-year-olds).
25-05.	(Developmental) Reduce the proportion of persons with human papillomavirus (HPV) infection. Data for specific population are not collected.
25-07.	Reduce the number of childless females with fertility problems who have had a STD or who have required treatment for pelvic inflammatory disease (PID) (baseline: 23%; target: not applicable for 15- to 24-year-olds).
25-08.	(Developmental) Reduce HIV infections in adolescent and young adult females aged 13 to 24 years that are associated with heterosexual contact. Data for specific population are not collected.
25-11.	Increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active (baseline: 85% of 9 th - through 12 th - grade students; target 95%).
25-14.	(Developmental) Increase the proportion of youth detention facilities and adult city or county jails that screen for common bacterial STDs within 24 hours of admission and treat STDs (when necessary) before persons are released. Data for specific population are not collected.
25-16.	(Developmental) Increase the proportion of sexually active females aged 25 years and under who are screened annually for genital chlamydia infections. Data for specific population are not collected.



26. Substance Use

26-01a,b.	Reduce deaths and injuries caused by alcohol- and drug-related motor vehicle crashes (baseline: 13.5 alcohol-related motor vehicle fatalities per 100,000; target: not applicable for 15- to 24-year-olds).
26-06.	Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol (baseline: 33% of 9 th through 12 th graders; target: 30%).
26-09 a,b.	Increase the age and proportion of adolescents who remain alcohol and drug free (alcohol baseline: 13.1 years for average age of first use in 12- to 17-year-olds; alcohol target: 16.1 years; marijuana baseline: 13.7 years for average age of first use in 12- to 17-year-olds; marijuana target: 17.4 years).
26-10b.	Reduce past-month use of illicit substances (marijuana baseline: 8.3% for 12- to 17-year-olds; marijuana target: 0.7%).
26-11d.	Reduce the proportion of persons engaging in binge drinking of alcoholic beverages (baseline: 7.7% for 12- to 17-year-olds; target: 2.0%).
26-14.	Reduce steroid use among adolescents (baseline: 1.7% for 12 th - graders; target: 0.4%).
26-15.	Reduce the proportion of adolescents who use inhalants (baseline: 2.9% of 12- to 17-year-olds; target: 0.7%).
26-16.	Increase the proportion of adolescents who disapprove of substance abuse (baseline: 69% for 12 th - graders; target: 83%).
26-17.	Increase the proportion of adolescents (aged 12 to 17) who perceive great risk associated with substance abuse (baseline: 47% for alcohol, 31% for marijuana, 54% for cocaine; target: 80% for alcohol, 80% for marijuana, 80% for cocaine).

27. Tobacco Use

27-02a.	Reduce tobacco use by adolescents (baseline: 40% for 9 th - through 12 th - grade students; target: 21%).
27-03.	(Developmental) Reduce initiation of tobacco use among children and adolescents. Data for specific population are not collected.
27-04.	Increase the average age of first use of tobacco products by adolescents and young adults (baseline: 12 years for 12- to 17-year-olds, 15 years for 18- to 25-year-olds; target: 14 years for 12- to 17-year-olds, 17 years for 18- to 25-year-olds).
27-07.	Increase tobacco use cessation attempts by adolescent smokers (baseline: 61% for 9 th - through 12 th - grade students; target: 84%).
27-10.	Reduce the proportion of nonsmokers exposed to environmental tobacco smoke (baseline: 87%; target: 45% for 12- to 17-year-olds).
27-11.	Increase smoke-free and tobacco-free environments in schools, including all school facilities, property, vehicles, and school events (baseline: 37% of middle, junior high, and senior high schools; target: 100% of middle, junior high, and senior high schools).
27-14.	Reduce illegal sales to minors through enforcement of laws prohibiting the sale of tobacco products to minors [baseline: 0 states; target: all states (including District of Columbia)].
27-15.	Increase the number of states (including District of Columbia) that suspend or revoke state retail licenses for violations of laws prohibiting the sale of tobacco to minors [baseline: 34 states; target: all states (including District of Columbia)].
27-16.	(Developmental) Eliminate tobacco advertising and promotions that influence adolescents and young adults. Data for specific population are not collected.
27-17c.	Increase adolescents' disapproval of smoking (baseline: 69% for 12 th graders; target: 95%).

Appendix 1-3

Partners in the National Initiative to Improve Adolescent Health by the Year 2010

American Academy of Pediatrics

Association of Maternal and Child Health Programs

Centers for Disease Control and Prevention—Division of Adolescent and School Health

Health Resources and Services Administration/Maternal and Child Health Bureau (MCHB)—Office of Adolescent Health

Leadership Education in Adolescent Health Program

Baylor College of Medicine

Children's Hospital/Harvard Medical School

Indiana University Medical Center

University of Alabama at Birmingham

University of California, San Francisco (UCSF), School of Medicine

University of Minnesota, School of Medicine

University of Rochester, School of Medicine

National Adolescent Health Information Center, UCSF

Partners in Program Planning for Adolescent Health Program

American Academy of Pediatric Dentistry

American Bar Association

American College of Preventive Medicine

American Dietetic Association

American Medical Association

American Nurses Association

American School Health Association

National Association of Social Workers

Public Policy Analysis & Education Center for Middle Childhood & Adolescent Health, UCSF

State Adolescent Health Resource Center for Maternal and Child Health Personnel/Konopka Institute, University of Minnesota

State Adolescent Health Coordinators Network

CHAPTER 2



Health Status of Adolescents and Young Adults

Contents

Demographic Profile **page 2**

Health Status of Adolescents **page 4**

 Mortality **page 4**

 Unintentional Injury **page 5**

 Violence **page 6**

 Substance Use **page 9**

 Mental Health **page 10**

 Reproductive Health **page 11**

 Chronic Disease Prevention **page 14**

 Special Health Care Needs **page 15**

Summary **page 15**

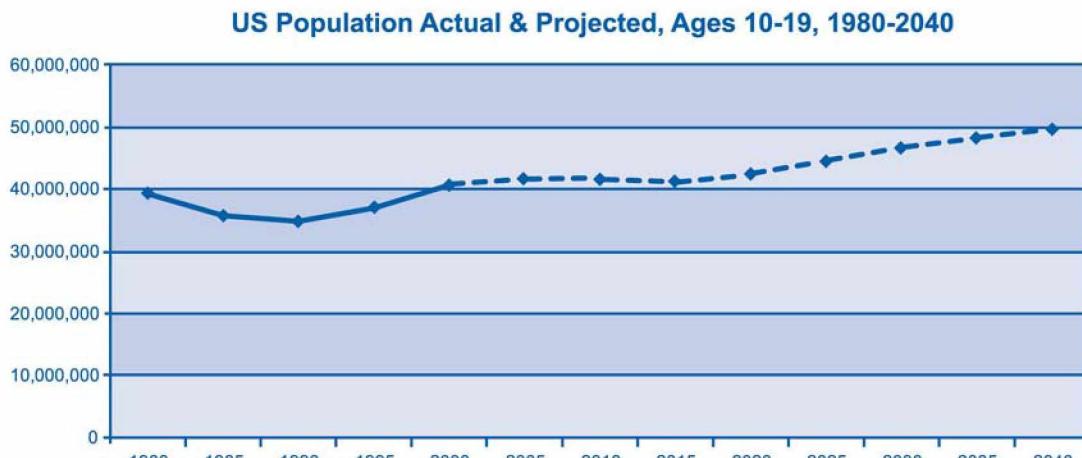


This chapter, which presents an overview of adolescent health status, is primarily organized around the focus areas of the 21 Critical Health Objectives (i.e., mortality, unintentional injury, violence, substance use and mental health, reproductive health, and the prevention of chronic disease during adulthood) and closes with a brief section on chronic conditions. We highlight trends and significant disparities in the health areas covered. Although the data on health status are organized by individual Objectives, it is important to keep in mind a comprehensive approach, that seemingly isolated adolescent problems are influenced by common antecedent factors—both those that protect and those that can jeopardize health and safety. This reality underscores the importance of improving adolescent health and safety through multiple societal institutions—this approach is needed to create healthy environments that promote positive youth development and discourage health risk behaviors. Before turning to the health status measures themselves, we present a demographic profile of the adolescent population. This profile supplements the overview of societal institutions that will be presented in Chapter 3.

Demographic Profile

The National Initiative comes at a critical time, with the number of adolescents in the United States expected to grow by almost 1 million by 2010. Although large in absolute size, this figure represents a much smaller percentage increase than that of the overall population. In particular, the size of the elderly population will swell as the “baby boomers” age. At the same time, however, an increasingly ethnically diverse group of young people will compete for limited resources at a time when the need for services responsive to the unique challenges facing adolescents and young adults is becoming more widely recognized.

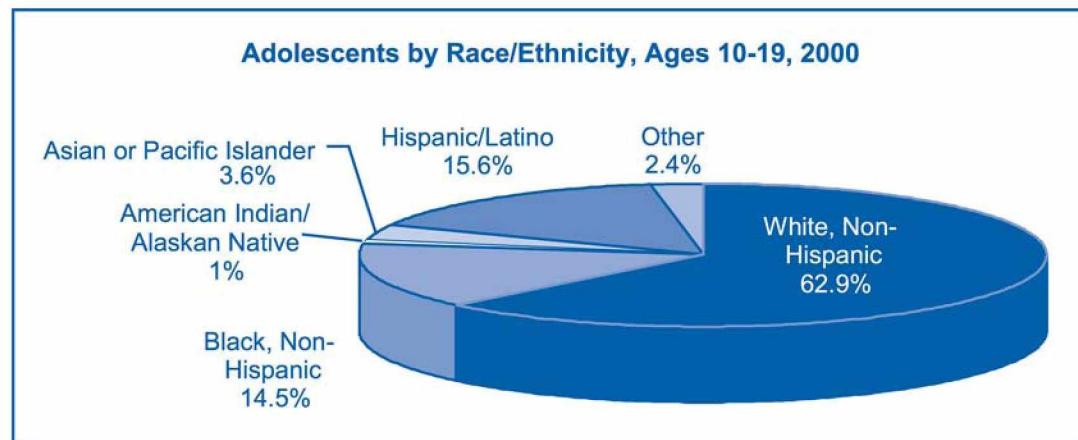
The size, average age, and racial and ethnic composition of the adolescent population all changed significantly during the 1990s, and its demographic composition is projected to continue changing through the next several decades. From 1990 to 2000, the number of adolescents aged 10-19 grew by 5.8 million, or 16.5% (US Census Bureau 2002a; US Census Bureau 2002b; US Census Bureau 1992), as the children of “baby boomers” reached toward maturity. Current projections show the population of adolescents aged 10-19 growing from 40.7 million in 2000 to 41.6 million in 2010. This represents a 2.0% increase, but is still much smaller than the expected 6.6% increase in the total U.S. population. By 2020, the adolescent population is projected to reach 42.4 million, and a record 50 million adolescents are projected by 2040. Meanwhile, the number of young adults aged 20-24 is projected to grow at a faster rate, an increase of 2.2 million, or 11.5%, over the next 10 years (US Census Bureau 2000a; US Census Bureau 2002b).



Sources: US Census Bureau 2000b; US Census Bureau 2002c

The western states have experienced the greatest growth among adolescents (ages 10-19), increasing 22.7% from 1990 to 2000. This growth rate compares to increases of 15.6% in the South, 8.8% in the Midwest, and 8.4% in the Northeast (US Census Bureau 2000a; US Census Bureau 2002b). In addition, more adolescents are living in the suburbs (Fields and Casper 2001).

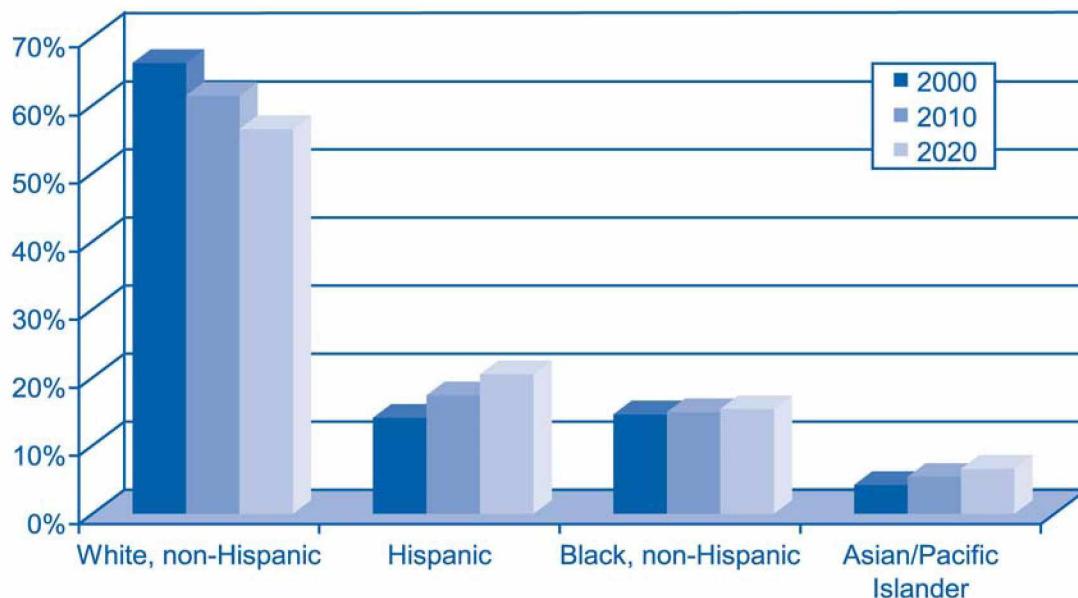
In the coming decades, the adolescent population will become even more racially and ethnically diverse. Key trends will include a decrease in Whites as a proportion of the overall adolescent population, a shift from Blacks to Hispanics as the second most populous racial/ethnic group, rapid increase of Asian Americans, and significantly more racial/ethnic diversity in the adolescent population than in the US as a whole (US Census Bureau 2000a).



Source: US Census Bureau 2000a; US Census Bureau 2002b

Non-Hispanic Whites accounted for only 63% of the adolescent population in 2000, compared to 76% in 1980 (US Census Bureau 2002c) and this figure is projected to fall to 56% in 2020. By 2040, non-Hispanic Whites are expected to no longer comprise the majority of the adolescent population. In 2000, non-Hispanic Blacks represented 14.5% of adolescents; Hispanics, 15.6%; and non-Hispanic Asian or Pacific Islanders, 4%. The Hispanic adolescent population is expected to nearly double in absolute terms by 2020, when it is anticipated to

**Proportion of Adolescent/Young Adult Population
by Race/Ethnicity, 2000-2020**



Source: US Census Bureau 2000a; US Census Bureau 2002b



include 23% of all adolescents. By comparison, the proportion represented by non-Hispanic Blacks will fall slightly to 14%, and non-Hispanic American Indians/ Alaskan Natives will remain at 1%. The non-Hispanic Asian or Pacific Islander population will also experience rapid growth, rising to 6.4% of the adolescent population by 2020 (US Census Bureau 2000a; US Census Bureau 2002b).

The shift in the racial/ethnic makeup of our youth stems from high immigration rates of Hispanics and Asian or Pacific Islanders. In addition, over the past two decades, birth and fertility rates have decreased among non-Hispanic Whites and Blacks, while these rates have increased among Hispanics (NCHS 2002). The number of adolescents who were foreign-born increased from 1.9 million in 1990 to 2.3 million in 2000. Among adolescents born in countries other than the United States in 2000, 55% were Hispanic and 22% were Asian or Pacific Islanders. In comparison, non-Hispanic White adolescents made up 16% of the foreign-born population, and Black adolescents only 8% of it (US Immigration and Naturalization Service 2000; Lollock 2000).

Health Status of Adolescents

In examining specific measures of adolescent health, the framework of the 21 Critical Health Objectives is used for each Objective, with a box showing the Objective name and number, baseline data, and the target for 2010. These boxes also indicate the national data source for the Objective as well as the age range (e.g., 15-19 or 12-17 years). For some Objectives, *Healthy People 2010* does not provide a target for specific age groups. Data issues are explained in more detail in Chapter 4 (see Table 4-1 for list of data sources).

Mortality

Healthy People 2010 Outcome Area: Mortality Objective 16-03: Reduce deaths of adolescents & young adults		
Age Group (years)	Baseline (per 100,000) (year)	2010 Target (per 100,000)
10-14	21.5 (1998)	16.8
15-19	69.5 (1998)	39.8
20-24	92.7 (1998)	49.0

Source: National Vital Statistics System-Mortality (NVSS-M), CDC, NCHS

The mortality rate is a key indicator of the health and safety of a population. Three-quarters of adolescent and young adult mortality is due to preventable causes, including motor vehicle crashes, homicide, and suicide. Overall mortality rates have consistently decreased and are now at or near historical lows for all racial/ethnic and age groups. Even so, the data show continued areas of concern, including unacceptably high mortality rates for older adolescents and young adults and significant disparities by sex and race/ethnicity.

Major differences in mortality rates exist between age groups, with rates increasing throughout adolescence and early adulthood and then throughout the life span. In 2000, young adolescents (10-14) had a mortality rate of 21.1/100,000; older adolescents (15-19) had more than triple this figure (69.8/100,000); while the rate for young adults (20-24) was 93.6/100,000 (Anderson 2002).

Analysis by sex reveals a significant disparity between males and females, with the mortality rate for males (10-24) over twice that for females (85.9/100,000 vs. 34.6/100,000). The difference increases with age: in 2000, the male mortality rate among 10-14-year-olds (25.0/100,000) was about 1.5 times the rate for females (16.6/100,000). For 15-19-year-olds, the ratio was 2.4:1 (94.9/100,000 vs. 40.0/100,000), and by age 20-24, males were 3 times as likely to die as their female peers (142.0/100,000 vs. 48.2/100,000) (Anderson 2002).

Mortality rates have fallen for all racial/ethnic groups and are now at or near all-time lows for each group. Even so, despite experiencing the steepest recent decline (47% since 1993), in 2000 15-24-year-old Blacks were still above their historic low of 111.9/100,000 reached in 1984 (NCHS 1991; NCHS 1994; Anderson 2002). In 2000, non-Hispanic Blacks (125.2/100,000) and American Indians (117.9/100,000) had the highest death rates among youth aged 15-24, nearly twice the rate for non-Hispanic Whites (72.1/100,000) and much higher than the 81.6/100,000 overall rate for this age group. Hispanics followed with a rate of 85.0/100,000, and Asian or Pacific Islanders had the lowest rate (44.3/100,000) (Anderson 2002).

Striking differences in mortality rates are apparent when race and sex are considered together (in this case for 15-24-year-olds in 2000). Versus all other age-sex groups, Black males have the highest mortality rates, and there is great variation in sex difference by race/ethnicity. The greatest difference is among Hispanics, where males die at 3.7 times the rate of their female counterparts (131.2 vs. 35.2 per 100,000). Among non-Hispanic Blacks, the male:female ratio is 3:1 (188.2 vs. 61.8 per 100,000). Among both American Indians and non-Hispanic Whites, the male:female ratio is 2.4:1 (167.0 vs. 68.4 per 100,000 for American Indians; 100.5 vs. 42.2 per 100,000 for non-Hispanic Whites), and among Asian or Pacific Islanders the ratio is 2.5:1 (63.6 vs. 25.1 per 100,000) (Anderson 2002).

Among young adolescents ages 10-14 years, motor vehicle crashes (MVCs) account for 22% of deaths (based on 2000 figures). Other leading causes of mortality in this age group include unintentional injuries other than MVCs (16.2%), malignant neoplasms (12.6%), suicide (7%) and homicide (5.6%). Among 15-19-year-olds, MVCs account for 37.8% of deaths (2000 data); homicide, 14%; suicide, 12%; other unintentional injuries, 12%; and malignant neoplasms, 5.5%. Among 20-24-year-olds, MVCs account for 29.3% of deaths; homicide, 17%; suicide, 13.4%; other unintentional injuries, 12.2%; and malignant neoplasms, 5.5% (Anderson 2002; NCIPC 2003).

Unintentional Injury

Healthy People 2010 Outcome Area: Unintentional Injury		
Objective 15-15: Reduce deaths caused by motor vehicle crashes		
Age Group (years)	Baseline (per 100,000) (year)	2010 Target (per 100,000)
15-24	25.6 (1999)	*
*Not Applicable		
Source: National Vital Statistics System - Mortality (NVSS-M), CDC, NCHS		

As discussed above, MVCs are the leading cause of death for adolescents and young adults, accounting for 31.7% of deaths. MVC-related mortality has fallen 36% over the past two decades, however, from 31.0/100,000 to 19.8/100,000. Males aged 10-24 are over two times more likely than same-age females to die from MVC injury; this statement holds true for all racial/ethnic and age groups (NCIPC 2003).

Using 2000 data, analysis by race/ethnicity and sex for adolescents aged 15-19 years shows that non-Hispanic American Indian/Alaskan Native males have the highest MVC mortality rates (71.6/100,000). This rate is twice that for non-Hispanic White males (37.2/100,000) and 2-5 times that for males who are Hispanic (34.5/100,000), non-Hispanic Black (23.6/100,000) or non-Hispanic Asian or Pacific Islanders (15.7/100,000). Since 1990, rates have declined for all males, except non-Hispanic Blacks. Among adolescent females in the same age group, non-Hispanic American Indians/Alaskan Natives also have the highest rate of MVC mortality (37.4/100,000), followed by non-Hispanic Whites (21.0/100,000), Hispanics (11.7/100,000), non-Hispanic Blacks (10.9/100,000), and non-Hispanic Asian or Pacific Islanders (7.0/100,000) (NCIPC 2003).



Healthy People 2010 Outcome Area: Unintentional Injury
Objective 15-19: Increase use of safety belts

Age Group	Baseline (per 100,000) (year)	2010 Target (per 100,000)
High school students (9 th -12 th Grades)	84% (1999)	92%

Source: *Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP*

Failure to use seat belts is a major cause of motor vehicle-related mortality. An analysis of 2001 data for fatal motor vehicle crashes among adolescents and young adults aged 16-24 years demonstrated that 62% of occupants were not wearing seat belts, and only about 30% were restrained (remaining 8%, unknown). Among crashes causing injury but not death, 75% of occupants used restraints and 17% did not (8%, unknown) (NHTSA 2001a). Adolescent seat belt use varies by sex but not by race/ethnicity. Male high school students (82%) are less likely to wear seat belts than are females their age (90%). Differences between racial/ethnic groups are negligible: non-Hispanic Blacks (84%), Hispanics (85%), and non-Hispanic Whites (86%). Between 1991 and 2001, high school students increased seat belt use overall from 74% to 86% (Grunbaum et al. 2002).

Healthy People 2010 Outcome Area: Unintentional Injury
Objective 26-01: Reduce deaths and injuries caused by alcohol- and drug-related motor vehicle crashes

Age Group (years)	Baseline (per 100,000) (year)	2010 Target (per 100,000)
15-24	13.5 (1998)	*

*Not Available

Source: *Fatality Analysis Reporting System (FARS), Department of Transportation (DOT); National Highway Traffic Safety Administration (NHTSA)*

Healthy People 2010 Outcome Area: Unintentional Injury
Objective 26-06: Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol

Age Group	Baseline (per 100,000) (year)	2010 Target (per 100,000)
High school students (9 th -12 th Grades)	33% (1999)	30%

Source: *Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP*

Other important strategies for preventing motor vehicle-related injury and death are reducing rates of driving under the influence of alcohol and riding with drivers who are under the influence. Although alcohol was involved in only 4.8% of all MVCs among adolescent and young adult drivers aged 16-24 years in 2000, 28.7% of motor vehicle fatalities in this age group involved a driver who had been drinking. In contrast, just 4.7% of nonfatal crashes with adolescent or young adult drivers involved alcohol (NHTSA 2001b). This indicator has improved significantly over the past decade. Based on self-reported data, the percentage of high school students who rode (in the previous 30 days) with a driver who had been drinking fell from 40% in 1991 to 31% in 2001. Male students (32%) are slightly more likely than female students (30%) and Hispanics (38%) are more likely than non-Hispanic Whites (30%) or non-Hispanic Blacks (28%) to engage in this behavior (Grunbaum et al. 2002).

Violence

Healthy People 2010 Outcome Area: Violence
Objective: 15-32: Reduce homicides

Age Group (years)	Baseline (per 100,000) (year)	2010 Target (per 100,000)
10-14	1.2 (1999)	*
15-19	10.4 (1999)	*

*Not Available

Source: *National Vital Statistics System - Mortality (NVSS-M), CDC, NCHS*

Violence accounts for a significant portion of morbidity and mortality among today's youth. Even so, most indicators show significant improvements since the mid-1990s; in addition to having dramatically lower homicide rates, youth are fighting less, perpetrating fewer violent crimes, and are less likely to carry a weapon.

Much violent behavior in the United States is perpetrated both by and upon young people, with arrests for violent crimes peaking at age 18 and declining thereafter. Between 1985 and 1993, arrests of 10- to 17-year-olds for murder rose 54%, from 5.7/100,000 to 14.5/100,000. By 1997, however, this trend had reversed, with a homicide arrest rate of 8.2/100,000 for this age group (Snyder and Sickmund 1999). The sharp decrease in homicide offense rates has been paralleled by similar drops in victimization rates for both sexes and all racial/ethnic groups. The decrease in the homicide offending rate among young Black males is particularly striking. In 1994, the homicide-offending rate among 14-to 17-year-old males was 22.4/100,000 for Whites and 226.7/100,000 for Blacks. In 2000, these rates had dropped dramatically, to 7.9/100,000 for Whites and 62.8/100,000 for Blacks. Sharp decreases in homicide offenses among Black males have also been seen among older adolescents and young adults aged 18 to 24 years: the homicide-offending rate for Black males in this age group dropped 38% from 329.8/100,000 in 1994 to 205.8/100,000 in 2000 (Fox and Zawitz 2002).

Healthy People 2010 Outcome Area: Violence Objective 15-38: Reduce physical fighting among adolescents		
Age Group	Baseline (per 100,000) (year)	2010 Target (per 100,000)
High school students (9 th -12 th Grades)	36% (1999)	32%
Source: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP		

Overall, physical fighting has decreased over the past decade. In 2001, 33% (by self-report) of high school students had been in at least one physical fight during the previous 12 months; this figure represents a 22% decrease from the 42.5% involved in fighting during 1991. Among all students, 4.0% had sustained a serious injury in a fight. Males (43%) were much more likely than females (24%) to have fought, while non-Hispanic Whites (32%) were less likely than either Hispanics (36%) or non-Hispanic Blacks (36.5%) to have done so. Much of this violence occurs on school property, with 12.5% of high school students involved in at least one fight on school grounds over the previous 12 months (Grunbaum et al. 2002).

Weapon carrying is also linked to violence. Based on self-report, in 2001, 17% of high school students had carried some type of weapon in the past 30 days, with males (29%) 5 times as likely as females (6%) to engage in this behavior. Analysis by race/ethnicity shows slightly higher weapon-carrying rates among non-Hispanic Whites (18%) than Hispanics (16.5%) or non-Hispanic Blacks (15%). Additionally, 6% of students had carried a weapon on school property during the past month, while 9% had been threatened or injured with a weapon on school property during the previous 12 months. In addition, 6% of students (10% of males, 1% of females) had carried a gun within the past month (Grunbaum et al. 2002). Still, the incidence of weapon carrying has fallen significantly over the past decade.

Homicide represents the second-leading cause of death in the U.S. for both the 15-19 and 20-24 age groups. There have been major swings in homicide rates for 15-19-year-olds, mostly among males, and Black males in particular. Homicide rates dropped to a record low in 1984, increased significantly until 1993, then started to fall again. Currently, homicide rates in the 15-19-year-old population are slightly lower than they were two decades ago (9.63/100,000 in 2000 vs. 9.96/100,000 in 1981). The decrease primarily reflects the decline in deaths caused by firearms. Overall, since 1981, homicide rates have increased by 4% for males, but have decreased 33% for females (NCIPC 2003).



Despite decreases in overall homicide rates, significant disparities by race/ethnicity and gender remain, with Black males affected more than any other population group. For example, among adolescents aged 15-19 years, the 2000 homicide rate of 60.2/100,000 for non-Hispanic Blacks represents a dramatic decline from the 1993 peak of 143.4/100,000, but homicide remains the leading cause of death for Black, non-Hispanic adolescent males. Per 2000 data, Black, non-Hispanic males are 17 times more likely to die from homicide than White, non-Hispanic males and more than twice as likely to do so compared with Hispanic/Latino males. Hispanic males had the second-highest homicide rate (29.3/100,000) in 2000, followed by non-Hispanic Whites, who had a much lower rate of 3.4/100,000. These figures also represent significant decreases from the high rates of the early or mid-1990s—60.4/100,000 in 1992 for Hispanic males and 15.0/100,000 in 1994 for White, non-Hispanic males (NCIPC 2003).

Among adolescent females aged 15-19 years, non-Hispanic Blacks also have homicide rates significantly higher than other female adolescents. The 2000 homicide rate of 8.9/100,000 for non-Hispanic Black females represents a significant decline from the 1993 high of 18.6/100,000, but it is 2 to 5 times that of Hispanic (3.1/100,000) or non-Hispanic White females (1.9/100,000) (NCIPC 2003).

Healthy People 2010 Outcome Area: Suicide Objective 18-01: Reduce suicide rate		
<u>Age Group (years)</u>	<u>Baseline (per 100,000) (year)</u>	<u>2010 Target (per 100,000)</u>
10-14	1.2 (1999)	*
15-19	8.0 (1999)	*

*Not Available
Source: Source: National Vital Statistics System - Mortality (NVSS-M), CDC, NCHS

Suicide represents the third-leading cause of death for adolescents and young adults. During the past 20 years, 10-14-year-olds were the only group to experience an increase in suicide rates, a rise of 39% (from 0.89/100,000 in 1981 to 1.5/100,000 in 2000), but suicide represents a small proportion of deaths for young adolescents. Suicide rates among 15-19-year-olds are below the 1981 level. After peaking in the early 1990s, rates for young adults have declined almost 20% during the past two decades (NCIPC 2003).

Suicide rates are far higher for males than females, and this difference increases with age. The ratios are 3.8:1 among 10-14-year-olds (2.3/100,000 vs. 0.6/100,000), 3.7:1 for 15-19-year-olds (9.7/100,000 vs. 2.6/100,000); and 6.7:1 among 20-24-year-olds (22.0/100,000 vs. 3.3/100,000) (NCIPC 2003). Although females attempt suicide more often than males, males complete suicide at a rate over five times that of females (12.3/100,000 vs. 2.2/100,000) (Grunbaum et al. 2002; NCIPC 2003).

It is critical to examine suicide data by race/ethnicity and gender. In the 15-19-year-old male population, non-Hispanic American Indians/ Alaskan Natives have the highest suicide rate: 33.3/100,000 (in 2000)—a rate over 2 times that of non-Hispanic Whites (14.6/100,000) and more than 3 times that of Hispanics (9.7/100,000), non-Hispanic Blacks (10.0/100,000), and non-Hispanic Asian or Pacific Islanders (8.9/100,000). Black male adolescents have shown the largest increase since 1981, almost doubling from 5.5/100,000 in 1981 to 9.7/100,000 in 2000 (the latter rate still represents a decrease from the peak of 16.5/100,000 reached in 1994) (NCIPC 2003).

Among females aged 15-19, non-Hispanic American Indians/ Alaskan Natives also have the highest rate of suicide. Their 2000 suicide rate was 9.1/100,000 in 2000—a rate more than twice that for non-Hispanic Asian or Pacific Islanders (3.6/100,000), non-Hispanic Whites (2.9/100,000), Hispanics (2.6/100,000) and non-Hispanic Blacks (1.6/100,000). Suicide data for American Indian/ Alaskan Native and Asian or Pacific Islander adolescents are considered unreliable, however, because of the absolute low number of cases (NCIPC 2003).

Substance Use

Using alcohol, tobacco, and other drugs during adolescence can have a lifelong impact on personal health. Many substances, including alcohol and tobacco, are addictive, and habits developed in the formative years are some of the most difficult to break (W.K. Kellogg Foundation 1998). Researchers conducting the Monitoring the Future Survey have noted that a change in these attitudes toward use of substances is usually a precursor to a change in actual use, with teens being less likely to use a drug if they perceive it as dangerous (Johnston, O'Malley, and Bachman 2002). Adolescents' perceptions of risk fell during the 1990s for many substances, but this low-key attitude appears to have recently leveled off. In 2002, 46% of 8th-graders and 23% of 12th-graders thought that occasionally smoking marijuana poses a "great risk" (Johnston, O'Malley and Bachman 2003). In addition, the percentage of 12th-graders believing their friends would disapprove of their regularly or occasionally using drugs increased after a decline in the early 1990s. The proportion of students perceiving daily drinking or "binge" drinking as dangerous or disapproving of it has remained stable over the past decade (Johnston et al. 2002).

Healthy People 2010: Substance Use		
Objective 26-10: Reduce past-month use of illicit substances (marijuana)		
<u>Age Group (years)</u>	<u>Baseline (per 100,000) (year)</u>	<u>2010 Target (per 100,000)</u>
12-17	8.3% (1998)	0.7%
Source: National Household Survey on Drug Abuse (NHSDA), SAMHSA		

Following declines during the 1980s, the prevalence of alcohol use among adolescents (defined as ages 12-17) and young adults (defined as ages 18-25) remained largely stable throughout the 1990s, with the exception of recent increases in binge drinking. Currently, past-month use of alcohol is at an all-time low for both adolescents and young adults; among adolescents this rate fell from 49.6% in 1979 to 20.9% in 1992, and then declined further to 17.3% in 2001. Past-month use among young adults followed a similar pattern, from 75.1% in 1979 to 58.8% in 2001 (SAMHSA 1999; SAMHSA 2002).

Healthy People 2010: Substance Abuse		
Objective 26-11: Reduce the proportion of persons engaging in binge drinking of alcoholic beverages		
<u>Age Group (years)</u>	<u>Baseline (per 100,000) (year)</u>	<u>2010 Target (per 100,000)</u>
12-17	7.7% (1998)	2.0%
Source: Monitoring the Future Study (MTF), NIH, NIDA.		

Based on self-report, the prevalence of binge drinking (consuming 5 or more drinks on one occasion) has recently increased. Among adolescents, the prevalence of past-month binge drinking fell sharply from 1985 (21.9%) to 1992 (10.0%) and remained at 7-8% from 1994 until 2001, when it increased to 10.6%. For young adults, binge use declined from 34.4% in 1985 to 29.1% in 1993 and remained stable until 2001, when it increased to 38.7% (SAMHSA 1999; SAMHSA 2002).

Males are more likely to binge drink than females; in 2001, 11.2% of 12-17-year-old males and 9.9% of females had at least one binge drinking episode during the preceding month. This gender gap widened among young adults (ages 18-25: 48.5% vs. 29.2%). There are also significant differences in binge drinking among racial and ethnic groups. Non-Hispanic American Indian/ Alaskan Native 12-17-year-olds had the highest prevalence (12.8%) in 2001 followed by non-Hispanic Whites (12.1%), Hispanics (9.8%), non-Hispanic Blacks (5.5%) and non-Hispanic Asians (4.6%). For young adults, non-Hispanic Whites were most likely to have engaged in binge drinking during the past month (43.7%), followed by



Hispanics (34.0%), non-Hispanic American Indians/ Alaskan Natives (29.6%), non-Hispanic Asians (25.0%), and non-Hispanic Blacks (24.3%) (SAMHSA 2002).

Trends in marijuana use by adolescents and young adults follow a pattern similar to that of illicit drugs overall. Among adolescents, past-month use fell from its peak in 1979 (14.2%) to 1991 (3.6%). After increasing in the mid-1990s, reaching 9.4% in 1997, marijuana use declined to 8.0% in 2001. Monthly use among young adults fell from 35.6% in 1979 to 10.9% in 1992 but has been slowly rising since, reaching 16.0% in 2001 (SAMHSA 1999; SAMHSA 2002).

Illicit drug use by adolescents and young adults remains well below levels seen in the late 1970s and 1980s. Rates have, however, increased from the lows reached in the early 1990s, especially among adolescents. In 2001, 10.8% of adolescents had used an illicit drug in the past month, well above 1992's low of 5.3% but still below the 1979 prevalence of 16.3%. Among young adults, 18.8% had used an illicit drug within the past month during 2001, an increase from 13.1% in 1992 but half the 1979 prevalence of 38.0%.

In 2001, adolescent males were slightly more likely than their female peers to have used illicit drugs in the past month (11.4% vs. 10.2%). Among young adults, however, males were more likely to be users than females (23.3% vs. 14.3%). These figures also varied by race/ ethnicity: among adolescents, non-Hispanic American Indians/ Alaskan Natives had the highest prevalence of use (22.1%), followed by non-Hispanic Whites (11.3%), Hispanics (10.1%), non-Hispanic Blacks (9.1%), and non-Hispanic Asians (8.0%). Among young adults, non-Hispanic Whites were most likely to have used illicit drugs in the past month (20.8%), followed by non-Hispanic Blacks (17.1%), non-Hispanic American Indians/ Alaskan Natives (17.0% in 2000), Hispanics (13.4%), and non-Hispanic Asians (10.6%) (SAMHSA 2002).

Overall, use of illicit substances among adolescents and young adults has fallen significantly over the past two decades, with a consistent decline from 1979 until the early 1990s, when use leveled off for adolescents and began rising slightly among young adults (Johnston et al. 2002). One notable exception has been MDMA, or Ecstasy, which had a significant increase among all age groups between 1996 and 2001 but a slight drop in use in 2002. Past-month use of alcohol is currently at historic lows for both adolescents and young adults, but binge drinking has recently been on the rise.

Mental Health

Healthy People 2010 Outcome Area: Mental Health
Objective 06-02: Reduce the proportion of children and adolescents with disabilities who are reported to be sad, unhappy, or depressed

<u>Age Group (years)</u>	<u>Baseline (per 100,000) (year)</u>	<u>2010 Target (per 100,000)</u>
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4-17	*	*
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*Baseline & target inclusive of age groups outside of adolescent/young adult age parameters.
Source: National Health Interview Survey (NHIS), CDC, NCHS.

Healthy People 2010 Outcome Area: Mental Health
Objective 06-02: Reduce the proportion of children and adolescents with disabilities who are reported to be sad, unhappy, or depressed

<u>Age Group (years)</u>	<u>Baseline (per 100,000) (year)</u>	<u>2010 Target (per 100,000)</u>
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4-17	*	*
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*Baseline & target inclusive of age groups outside of adolescent/young adult age parameters.
Source: National Health Interview Survey (NHIS), CDC, NCHS.

Currently, no national survey provides trends on the mental health status of adolescents, but the prevalence of mental health conditions can be examined through population-wide surveys as well as data accumulated from smaller studies. In addition, some national surveys on adolescent well-being include questions that reflect mental health status, such as suicidal behavior. Epidemiological surveys have found that about 20% of adolescents use mental health services (Leaf et al. 1996). The Surgeon General's Report on Mental Health estimates that nearly 21% of youth aged 9-17 have a diagnosable mental or addictive disorder associated with at least minimum impairment, while 11%, or 4 million, youth have a disorder that results in significant impairment (Shaffer et al. 1996, cited in DHHS 1999). Other studies indicate that mental health disorders among adolescents are underdiagnosed. In one study of 1,710 adolescents, 30% had at least one current symptom of major depression, but only 2.6% had received a diagnosis (Roberts, Lewinsohn, and Seeley 1995).

Suicidal behavior has been related to various mental health problems, including depression and adjustment or stress reactions (DHHS 1999). In 2001, 19% of high school students had seriously considered suicide over the previous 12 months, down from 29% in 1991. Ideation among females (24%) was more common than males (14%). This sex difference was identified for all grades and racial/ethnic groups (Grunbaum et al. 2002).

Healthy People 2010 Outcome Area: Mental Health		
Objective 18-02: Reduce the rate of suicide attempts by adolescents that require medical attention		
Age Group	Baseline (per 100,000) (year)	2010 Target (per 100,000)
High school students (9 th -12 th Grades)	2.6% (1999)	1.0%

Source: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP

As noted in the Mortality section of this chapter, males are more likely to commit suicide than females. In contrast, females are more likely to attempt suicide. Overall, in 2001, suicide was attempted by 9% of high school students, up slightly from 7% in 1991. Female students (11%) were almost twice as likely as male students (6%) to have attempted suicide at least once in the last 12 months. This sex difference held true across racial/ethnic groups. Hispanic females (15%) were most likely to have attempted suicide, followed by non-Hispanic White females (10%) and non-Hispanic Black females (10%). Among male high school students, Hispanics (8%) were more likely than non-Hispanic Blacks (7.5%) or non-Hispanic Whites (5%) to have attempted suicide. Although suicide attempts among female high school students have decreased in recent years, they have risen for males. Overall, in 2001, 3% of high school students reported requiring medical attention due to a suicide attempt in the previous 12 months (Grunbaum et al. 2002).

Reproductive Health

Compared to two decades ago, fewer adolescents are sexually active today, and sexually active adolescents are using condoms more often. Accordingly, pregnancy and birth rates are declining.

Healthy People 2010 Outcome Area: Reproductive Health		
Objective 25-11: Increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active		
Age Group	Baseline (per 100,000) (year)	2010 Target (per 100,000)
High school students (9 th -12 th Grades)	85% (1999)	95%

Source: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP



In 2001, 46% of high school students had ever had sexual intercourse, a decrease from 53% in 1993. Males (48.5%) were more likely than females (43%) to have had intercourse. Overall rates increased with age, with 60.5% of high school seniors having had intercourse at least once, versus 34% of 9th-graders. There were major differences by race/ethnicity: Black, non-Hispanics (61%) had the highest rate, followed by Hispanics (48%) and non-Hispanic Whites (43%). In addition, condom use has increased among adolescents, with 58% of sexually active high school students having used a condom at last intercourse, up from 53% in 1993. Black, non-Hispanic youth (67%) were most likely to use condoms, followed by non-Hispanic Whites (57%) and Hispanics (53.5%) (Grunbaum et al. 2002).

Healthy People 2010 Outcome Area: Reproductive Health Objective 09-07: Reduce pregnancies among adolescent females		
<u>Age Group (years)</u>	<u>Baseline (per 1,000) (year)</u>	<u>2010 Target (per 1,000)</u>
15-17	68 (1996)	43

Source: National Survey of Family Growth (NSFG), CDC, NCHS; National Vital Statistics System - Natality (NVSS-N), CDC, NCHS; Abortion Provider Survey, The Alan Guttmacher Institute; Abortion Surveillance Data, CDC, NCCDPHP.

Healthy People 2010 Outcome Area: Reproductive Health Objective 25-01: Reduce the proportion of adolescents and young adults with <i>Chlamydia trachomatis</i> infections		
<u>Sex and Age Group (years)</u>	<u>Baseline (year)</u>	<u>2010 Target</u>
Females, 15-24 (Family Planning clinics)	5.0% (1997)	3.0%
Females, 15-24 (STD clinics)	12.2% (1997)	3.0%
Males, 15-24 (STD clinics)	15.7% (1997)	3.0%

*Source: STD Surveillance System (STDSS), CDC, NCHSTP.
STD indicates Sexually Transmitted Disease*

Each year, almost 1 million adolescent females—10% of all females aged 15-19 and 19% of those who have had intercourse—become pregnant. Seventy-eight percent of these pregnancies are unplanned, and these early, unplanned pregnancies carry great costs, both social and economic, for the individual and for society (Henshaw 2001). Adolescent pregnancy rates have declined in recent years and are now at their lowest level since 1976. After peaking at 116.5 per 1,000 in 1991, the pregnancy rate among 15-19-year-olds fell to 94.3/1,000 in 1997. This trend occurred across all racial/ethnic groups, although Black, non-Hispanic (170.4/1,000) and Hispanic (148.7/1,000) adolescents continued to have pregnancy rates 2 to 3 times higher than non-Hispanic White adolescents (65.1/1,000) (Ventura, Mosher, Curtin, Abma and Henshaw 2001).

The three components of the pregnancy rate (births, abortions, and miscarriages) have all fallen. In 2001, the rate of births to adolescents aged 15-19 was 45.8/1,000, the lowest rate since 1988. Birth rates have decreased for all racial/ethnic groups, with Blacks experiencing the steepest decline. Between 1991 and 2001, the decrease in the birth rate was highest for non-Hispanic Black adolescents (36%), followed by non-Hispanic Whites (31%), Asian or Pacific Islanders (26%), American Indian adolescents (22%), and Hispanics/Latinos (13%) (Martin et al. 2002). Abortion rates have also fallen significantly among adolescents, from 40.3/1,000 in 1990 to 27.5/1,000 in 1997. Between 1990 and 1997, the percentage of adolescent pregnancies ending in abortion decreased from 40% to 21% (Ventura et al. 2001).

Of the 15 million new cases of sexually transmitted disease (STD) in the United States each year, one-fourth occur in teenagers (CDC 2000). Compared to older adults, adolescents and young adults (ages 10-24) are at higher risk for acquiring STDs because they are more likely to have multiple sexual partners, engage in unprotected intercourse, and may have higher-risk partners (CDC 2001). Infection rates for gonorrhea have decreased in recent years for all age, racial, and ethnic groups. Chlamydia infection rates increased among adolescents and young adults (10-24) 11%-68% from 1996 to 2001 (CDC 2002b, CDC 2001). The increase in reported chlamydial infections reflects the expansion of chlamydia screening and reporting.

Almost 40% of chlamydia cases occur among adolescents aged 15-19, with reported prevalence exceeding 30% for female adolescents and 5% for male adolescents in clinic-based studies. Among females, the highest age-specific rates of chlamydia in 2001 were among 15- to 19-year-olds (2,547.2/100,000) and 20- to 24-year-olds (2,466.9/100,000). Rates among males, while substantially lower than among females, were also highest in these age groups (383.9/100,000 and 623.5/100,000 respectively). Non-Hispanic, Black adolescents (15-19) are disproportionately affected by STDs. In 2001, this population had a chlamydia rate of 4,975.3/100,000 – a rate almost twice that of same-age American Indians/ Alaskan Natives (2,522.4/100,000), over 3 times that of Hispanics/Latinos (1,547.1/100,000), and more than 7 times the rate among non-Hispanic Whites (689.0/100,000) or Asian or Pacific Islanders (567.1/100,000) (CDC 2002b).

Cases of gonorrhea among adolescents (15-19) decreased by 5% from 1996 to 2001. Among all females in 2001, 15-19-year-olds had the highest rate (703.2/100,000); among males, 20-24-year-olds had the highest rate (563.8/100,000). Although the incidence of gonorrhea among Black adolescents declined from 1996 to 2001, this group still accounted for three-quarters of all reported cases. Black, non-Hispanic adolescents (15-19) experienced gonorrhea at a rate of 2,635.3/100,000, over 7 times the rate among same-age American Indian/ Alaskan Native (346.3/100,000), over 11 times the rate among Hispanic (223.7/100,000), and over 23 times that among non-Hispanic White (114.3/100,000) or Asian or Pacific Islander (93.2/100,000) adolescents (CDC 2002b, CDC 2001).

Healthy People 2010 Outcome Area: Reproductive Health		
Objective 13-05: Reduce the number of new HIV diagnoses among adolescents and adults		
Sex and Age Group (years)	Baseline (year)	2010 Target
Females and Males, 13-24	16,479 (1998)	*
<small>Source: Potential: HIV/AIDS Reporting System (HIV-AIDS), CDC, NCHSTP. Proposed baseline is shown, but has not yet been approved by the Healthy People 2010 Steering Committee.</small>		

Issues such as confidentiality, insurance coverage, and social stigma continue to make accurate data on HIV / AIDS difficult to obtain. Figures from states that report these data show that HIV infection rates continue to fall among adolescents, as do death rates from AIDS. Even so, AIDS cases, while still relatively rare among adolescents and young adults, are increasing in prevalence (CDC 2002a). Surveillance data from the states that report HIV / AIDS cases indicate that youth accounted for a higher proportion of HIV cases (13%) than of AIDS cases (3%) from 1996 to 1999. Black adolescents and young adults (ages 13-24) have accounted for over half of all HIV cases ever reported among youth. Among adolescents aged 13-19, females are more likely to become infected with HIV than their male counterparts, with females accounting for 57% of new cases of HIV infection. Among young adults (20-24), there has been a decrease in infection among males. In 2001, males accounted for 71% of cumulative AIDS cases in this age group but only 59% of new HIV infections and 59% of newly reported cases of AIDS (CDC 2002a).



Chronic Disease Prevention

Tobacco use can have serious negative health effects for adolescents, but the most severe consequences, such as cancer and chronic obstructive lung disease, are usually not realized until adulthood. The most common form of tobacco use, cigarette smoking, often begins in grade 6 or 7 (ages 11-13), with 16% of 8th-graders in 2001 having tried a cigarette by 5th grade. Cigarette smoking among adolescents peaked in the late 1970s, declined throughout the 1980s until the early 1990s, increased in the mid-1990s, and has declined again more recently (Johnston et al. 2002). Frequent cigarette use among high school students has risen slightly, from 13% in 1991 to 14% in 2001. In addition during 2001, 29% of high school students had smoked at least once within the past 30 days. Prevalence increases with age, with 24% of 9th-graders having smoked in 2001, compared with 35% of students in 12th grade. White, non-Hispanic high school students (32%) are more likely than Hispanic (27%) or non-Hispanic Black (15%) students to smoke. Male and female high school students are about equally likely to use cigarettes (Grunbaum et al. 2002).

Healthy People 2010 Outcome Area: Chronic Disease Prevention
Objective 27-02: Reduce tobacco use by adolescents

<i>Age Group (years)</i>	<i>Baseline (per 100,000) (year)</i>	<i>2010 Target (per 100,000)</i>
High school students (9 th -12 th Grades)	40% (1999)	21%

Source: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP.

Some important health problems of adulthood, such as certain types of heart disease and cancer, are linked to behaviors established during adolescence and young adulthood. Regular exercise and balanced eating patterns are known to promote health and a sense of well-being, and poor eating habits, as well as a lack of regular physical activity, can have severe health consequences later in life. The National Initiative focuses on diet and physical activity as ways to improve the health of the entire population.

Nutrition is a critical factor for lifelong health. In 2001, only 21% of high school students had eaten 5 or more servings of fruits and vegetables on the preceding day, down from 29% in 1997. Male students (23%) were slightly more likely than female students (20%) to meet this standard. A higher percentage of Black, non-Hispanics (24.5%) ate 5 or more servings of fruits and vegetables than did Hispanics (23%) or non-Hispanic Whites (20%) (Grunbaum et al. 2002). In addition, in 1997, 62% of students had eaten 2 or fewer servings of food high in fat content during the preceding day. Female students (71%) were significantly more likely than male students (55.5%) to consume 2 or fewer servings of such foods. Students in 9th and 10th grades were more likely to eat 2 or more servings of such foods than 11th- or 12th-graders (Kann et al. 1998).

Healthy People 2010 Outcome Area: Chronic Disease Prevention
Objective 19-03: Reduce the proportion of children and adolescents who are overweight or obese*

<i>Age Group (years)</i>	<i>Baseline (per 100,000) (year)</i>	<i>2010 Target (per 100,000)</i>
12-19	11% (1988-94)	5%

* Based upon 2000 CDC Body Mass Index for age-growth charts.

Source: National Health and Nutrition Examination Survey (NHANES), CDC, NCHS.

Overweight and obese adolescents are at high risk for being overweight adults, are relatively more likely to experience serious long-term morbidity, including coronary heart disease, diabetes, hypertension, and some cancers (Troiano et al. 1995). Data from the 1999-2000 National Health and Nutrition Examination Survey (NHANES) show an increase in the percentage of adolescents (ages 12-19) who are overweight. In 1976-1980, only 5% of adolescents were overweight but this increased to 11% in 1988-1994 and 16% in 1999-2000. The

1999-2000 NHANES found male and female adolescents equally likely to be overweight, but there were differential risks by race/ethnicity. For example, among males, Mexican Americans had the highest overweight prevalence (27.5%), followed by non-Hispanic Blacks (20.7%) and non-Hispanic Whites (12.8%). Among females, the highest rate was among non-Hispanic Blacks (26.6%), followed by Mexican Americans (19.4%), and non-Hispanic Whites (12.4%) (NCHS 2002).

According to the 2001 Youth Risk Behavior Surveillance System (YRBSS), 60% of students (68% of females and 51% of males) had exercised to lose weight or avoid gaining weight in the previous 30 days; 44% (59% of females and 28% of males) consumed less food, fewer calories, or foods low in fat to lose weight or avoid gaining weight. Female adolescents are apt to use potentially damaging measures to lose weight: in 2001, 13% used diet pills and 8% used laxatives or made themselves vomit to control their weight (Grunbaum et al. 2002).

Healthy People 2010 Outcome Area: Chronic Disease Prevention
Objective 22-07: Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion

<u>Age Group (years)</u>	<u>Baseline (per 100,000) (year)</u>	<u>2010 Target (per 100,000)</u>
High school students (9 th -12 th Grades)	65% (1999)	85%

Source: Youth Risk Behavior Surveillance System (YRBSS), CDC, NCCDPHP

Regular physical activity accords significant health benefits. The 2001 YRBS found that overall, 65% of high school students had engaged in vigorous physical activity 3 or more days per week. This level of physical activity decreased with age, however: 72% of 9th- graders but only 55.5% of 12th-graders met this standard. More males (73%) exercised than females (57%), and rates varied somewhat by race/ethnicity: non-Hispanic Whites had a rate of 66.5%; Hispanics 60.5%; and non-Hispanic Blacks 60% (Grunbaum et al. 2002).

Special Health Care Needs

Chronic conditions and disabilities can be measured according to limitations placed on activity. Adolescents with chronic conditions or disabilities have complex health care needs often requiring a constellation of services to ensure their optimal health and development. In 1997, 8.4% of adolescents aged 10-17 had activity limitations due to chronic conditions; males (10.7%) were more likely than females (5.9%) to be affected. Differences were found by race and ethnicity as well as socioeconomic status: White, non-Hispanics (9.0%) were most likely to have such limitations, followed by Black, non-Hispanics (8.9%) and Hispanics/Latinos (6.1%). Among poor youth, 12.3% had a chronic condition, versus 7.4% of those not living in poverty (NCHS 2000). Overall, children with special health care needs use health services at higher rates than their peers without these. For example, in 2002, 52.6% of children over 5 years of age with activity limitations had visited a doctor at least 4 times in the previous year, versus 23.6% of their peers without such limitations (MCHB 2002).

Summary

Current data show some promising trends, such as significant decreases in teen pregnancy rates as well as in homicide and other indicators of violence. Conversely, several areas warrant continued concern and attention, including the significant disparities highlighted throughout this chapter, the continued high rates of sexually transmitted infections, the increase in obesity, continued use of tobacco, alcohol and illicit drugs, and the decrease in vigorous physical activity. The health issues raised here warrant the concerted national effort of the National Initiative to Improve Adolescent Health by the Year 2010.

CHAPTER 3



Improving Adolescent Health

Contents

Risk, Resilience, and Youth Development as a Framework for the 21 Critical Health Objectives [page 3](#)

Strengthening Families: The Foundation for Raising Healthy Adolescents [page 6](#)

Expanding the Vision: The Role of Community Stakeholders in Improving the Health of Adolescents [page 6](#)

Schools [page 7](#)

Colleges and Universities [page 9](#)

Health Care [page 10](#)

Community Organizations that Serve Young People [page 11](#)

Faith-based Organizations [page 12](#)

Media [page 13](#)

Employers [page 14](#)

The Role of Law Enforcement, Corrections, and Juvenile Justice [page 15](#)

Government Agencies [page 15](#)

Academic Institutions [page 16](#)

Lessons Learned [page 17](#)

Summary [page 17](#)

Note: Citations are listed by chapter in the reference section at the end of the document.



Helping communities to meet the 21 Critical Health Objectives for adolescents and young adults requires an understanding of the many factors that influence adolescent health, safety, and well-being. Parents and other family members, peers, schools, health care providers, community agencies that serve youth, faith-based organizations, media, postsecondary institutions, employers, law enforcement, and government agencies all shape young people's development. Each individual and institution can play an important role in creating environments that support healthy development and encourage adolescents to make healthy decisions. To help young people establish healthy lifestyles, however, we need greater collaboration and commitment among multiple stakeholders. This chapter outlines the National Initiative framework for improving adolescent health and provides an overview for societal influences that shape adolescent lives.

In 1988, the Institute of Medicine published *The Future of Public Health*, an assessment of public health institutions. The report's major conclusions and recommendations remain salient today; in particular, improving public health requires developing partnerships among multiple societal institutions rather than depending solely on partnerships with traditional public health organizations. Although forming meaningful partnerships outside the public health sector may appear difficult, we have made progress in the past decade, as various sectors of society have more frequently fostered collaborative relationships to address public health and other social concerns. Still, a major challenge to achieving the 21 Critical Health Objectives for adolescents and young adults is forming these partnerships and collaboratively enacting prevention programs and interventions (Turnock 2001).

We must recognize that the 21 Critical Health Objectives represent complex health issues; achieving them requires a more complicated approach than simply assuming the issues are matters of individual behavior and personal lifestyle. In the past, many adults approached working with young people with an attitude of "What's wrong with these kids, and how can we 'fix' them?" This approach overemphasizes the personal attributes and behaviors of adolescents and families and overlooks the effects of their social and environmental contexts. For example, many young people know that tobacco and alcohol use and eating too much unhealthy food are harmful to their health, and yet they are surrounded by images of persons who smoke, drink alcohol, and eat unbalanced diets. Cigarettes and alcohol continue to be relatively accessible and widely promoted to young people. French fries, potato chips, candy, soda, and other processed foods high in fat and/or sugar are depicted as convenient and affordable options, and they are often more accessible than fresh fruits and vegetables. As a population with little political influence, adolescents can personally modify their lifestyles and health choices only to a limited extent. Societal institutions must also share responsibility for adolescent health promotion, as well as disease and injury prevention, by changing the environments that affect the daily lives of young people.

In a nation that highly values individualism, we must shift our frame of thinking by placing the responsibility for helping today's youth where it belongs—on society and its institutions, including families. We must recognize the value of defining potential roles and working collectively to improve adolescent health. Of course, focusing on the roles of societal institutions does not mean that the personal characteristics of individuals are unimportant, and it does not dismiss the importance of individual differences.

We have entered the new century with an increased awareness of the value of civic engagement and social capital, which together refer to the social networks, connectedness, norms, and social trust that facilitate coordination and cooperation for mutual benefit (Putnam 2000). Higher levels of civic engagement and social connectedness lead to better functioning schools, social services, government, and public health systems. To meet the

21 Critical Health Objectives, we encourage local agencies and communities to develop this sense of social connectedness through collaborative work. Partnerships, collective efforts, and institutional change are essential for substantially improving adolescent health.

This section examines the individuals and institutions that most affect adolescents' health, safety, and well-being. It provides examples of current collaborative projects that can guide future efforts for advancing and sustaining our progress in promoting adolescent health. We intend to acknowledge the role that institutions can play individually and also to affirm how bringing these institutions together enhances their collective strength. Collaboration and partnership can reinforce the efforts of different stakeholders and foster innovative approaches for improving adolescent health, safety, and well-being.

Communities and society at large incur significant costs from adolescent health problems that are frequently preventable. According to one estimate, federal and state governments annually spent \$33.5 billion (\$859 per adolescent) to address the effects of adolescent pregnancy, sexually transmitted diseases (STDs), mental disorders, alcohol and drug abuse, motor vehicle injuries, and other unintentional injuries (Gans, Alexander, Chu, and Elster 1995). Yet, U.S. adolescents fare worse on many measures of health than their peers in many other industrialized countries. For example, U.S. adolescents have high rates of injury mortality, pregnancy, STDs, and illicit drug use (Ozer, Macdonald, and Irwin 2002; Morrison and Stone 2000). These figures point to the need for a broad and coordinated effort to promote healthy adolescent development.

In a relatively short time, today's adolescents will be adults who will share responsibilities for addressing critical issues facing the nation and its states and communities. Adolescents who receive inadequate care and support from their families, schools, and communities are less likely to contribute positively to society as adults. On the other hand, youth supported throughout childhood and adolescence are more likely to become healthy, competent, skilled, and productive members of society.

Risk, Resilience, and Youth Development as a Framework for the 21 Critical Health Objectives

Before discussing societal institutions, we provide a brief background on risk and resilience. The public health field has traditionally focused on specific adolescent problem behaviors or issues in isolation, such as substance abuse, pregnancy, and violence. Yet, problem behavior theory (Donovan and Jessor 1985) has shown that health risk behaviors are interrelated and have similar root causes.

Resilience theory asks why some who grow up in adverse circumstances go on to lead healthy and productive lives when virtually all measures would have predicted otherwise. Resilience is the tendency for a child or teen to rebound from stressful circumstances or events, resume usual activity, and achieve success. Resilient youth do well despite facing multiple risk factors and activities.

Researchers have identified one set of factors that predisposes many adolescents to engage in health risk behaviors and another set that protects many young people from harm. Risk factors, which limit the likelihood of successful development, exist within various spheres: the individual, family, peer group, school, and community. The past 20 years of research have shown that many negative health outcomes are influenced by multiple factors and that many of these outcomes share the same risk factors. For example, antecedent risk factors such as poverty, trouble achieving academically, and access to alcohol and drugs at home, heighten the risk for multiple problems, such as pregnancy, substance use, and delinquent behavior.



To answer the question posed by resilience theory, researchers have identified a set of circumstances, experiences, and factors that seem to buffer young people from involvement in behaviors either harmful to themselves or others. These protective factors seem to moderate or ameliorate the effects of individual vulnerabilities or environmental hazards; they diminish the likelihood of negative health and social outcomes. Just like risk factors, protective factors (or assets) exist within the individual, family, peer group, school, and community and can also be clustered. For example, academic achievement protects against substance use, violence, and high-risk sexual behavior. Some risk and protective

Table 3-1: Examples of Risk and Protective Factors in the Lives of Youth

Domain	Risk Factors	Protective Factors
Individual	<ul style="list-style-type: none">• Biological vulnerability• Engaging in health-compromising behaviors• Intellectual impairment• Early or late onset of puberty• Aggressive temperament• Impulsivity• Affective disorder• Attention deficit hyperactivity disorder (ADHD)• Aggressive behavior• Stress reactivity	<ul style="list-style-type: none">• Spirituality/religiosity• Social skills• Normal intelligence• Late maturation• Higher self-image• Higher self-efficacy• Perceived importance of parents
Family	<ul style="list-style-type: none">• Low parental education• Family mental illness• Maternal stress• Large family• Overcrowding• Poverty• Access to weapons• Authoritarian or permissive parenting style• Exposure to family violence	<ul style="list-style-type: none">• Connectedness• Parental presence• Parental values<ul style="list-style-type: none">– Toward school– Toward risk behavior• Two parents• Fewer siblings/child spacing• Family cohesion• Authoritative parenting style
School	<ul style="list-style-type: none">• Retention in grade• Size of school• Absenteeism• Suspension	<ul style="list-style-type: none">• Connectedness to school• Improved academic performance• Consistency of schools attended• School policies
Peers	<ul style="list-style-type: none">• Prejudice from peers• Perception of threat• Social isolation• Participation in deviant culture	<ul style="list-style-type: none">• Being treated fairly by peers• Having low-risk friends• Peers with pro-social norms
Social Environment	<ul style="list-style-type: none">• Arrests by age, type• Community fertility rates by age• Rate of neighborhood unemployment• Single parent/female head of households• Age at migration• Exposure to violent media• Exposure to youth-oriented advertising• Access to tobacco, alcohol, drugs, firearms• Television/video watching	<ul style="list-style-type: none">• Educational attainment by age• School enrollment for those aged 16-19• Health care accessible• Health care utilization• Employment rates of adults• Positive support systems• Religious institution• Access to positive role models• Pro-social media

This table was developed by Dr. Robert Blum, based on a synthesis of available literature, 2002 (University of Minnesota).

Table 3-2: The Effects of Family Domain Risk and Protective Factors on Youth Behaviors for Grades 9-12

Risk or Protective Factor	Emotional Distress	Suicidal Thoughts or Attempts	Violence	Cigarette Use	Alcohol Use
Parent and Family Connectedness	Protective	Protective	Protective	Protective	Protective
Parental/Adolescent Activities	Neutral	Neutral	Not addressed	Protective	Neutral
Parental Presence	Protective	Neutral	Protective	Protective	Protective
Household Access to Guns	Neutral	Risk factor	Risk factor	Not addressed	Not addressed
Parental School Expectations	Protective	Neutral	Not addressed	Protective	Neutral
Household Access to Substances	Not addressed	Not addressed	Not addressed	Risk	Risk
Family Suicide or Attempts	Risk	Risk	Risk	Risk	Risk
Definitions:					
Parent and Family Connectedness: High degree of closeness, caring and satisfaction with parental relationship, whether resident or non-resident mother or father; feeling understood, loved, wanted, and paid attention to by family members.					
Parental/Adolescent Activities: Number of different activities engaged in with resident and/or nonresident parent and/or parents in the past 4 weeks.					
Parental Presence: Parent present before school, after school, at dinner, at bedtime.					
Household Access to Guns: Do or do not have easy access to guns at home.					
Parental School Expectations: Mother's or father's expectations for high school and college completion.					
Household Access to Substances: Do or do not have easy access to cigarettes, alcohol, and/or illegal drugs at home.					
Family Suicide or Attempts: Suicide attempts and/or completions by any family member in the past 12 months.					

(Resnick et al. 1997)

factors found to be empirically associated with either increased or diminished risk for a range of health and social outcomes, including several Critical Health Objectives, are shown in Table 3-1. Table 3-2 presents risk and protective factors within the family domain and their relationship with the following health outcomes and contributing behaviors: emotional distress, suicidal thoughts or attempts, violence, cigarette use, and alcohol use. These risk and protective factors can collectively be considered antecedent factors; in this document, we use the term “antecedent factors” to refer to both risk and protective factors that research has shown are linked to health risk behaviors.

This resilience framework complements a “risk reduction approach” that focuses on preventing health risk behaviors. Although risk reduction remains an important strategy for improving adolescent health, it should be combined with a focus on resiliency and youth development. A youth development approach emphasizes providing opportunities for young people to participate in challenging and engaging activities that build their skills and competencies.

Within a youth development framework, adolescents are seen as able to contribute to their community and participate in community decision-making. To recognize themselves as competent young adults and assets to their communities, young people need adult support and encouragement. A youth development framework turns our attention



to creating supportive environments for teens, rather than correcting their deficiencies. It calls for data collection efforts that can measure adolescents' strengths and assets as well as their problems. Building resilience and supporting protective factors are offered as promising strategies that complement, but do not replace, prevention efforts focusing on individual behaviors. Efforts that directly address negative health outcomes are still important, but these efforts are enhanced when blended with an approach that emphasizes youth development and resilience.

Strengthening Families: The Foundation for Raising Healthy Adolescents

Although this document emphasizes the importance of community mobilization and collaboration among societal institutions for addressing adolescent health problems, we also stress the important influence of family on adolescent health outcomes and adolescent development. The National Longitudinal Study on Adolescent Health (Add Health) found that young people who feel a strong sense of connectedness to (or feelings of love and caring toward) their parents or other family members are typically less likely to engage in health risk behaviors (Resnick, Bearman, Blum, et al. 1997). Conversely, adolescents with a lower sense of connectedness engage in higher levels of health risk behaviors. Such findings suggest that strategies designed to include and support families are needed to successfully address the health risk behaviors contained in the 21 Critical Health Objectives.

In view of the significant role the social environment plays in adolescent health and development, efforts to improve adolescent health can be strengthened by supporting familial involvement. For example, to achieve positive outcomes, communities may promote parental involvement in developing policies and programs that affect their teenagers and ensure that human service organizations provide an adequate mix of family support services. These strategies will promote safe and healthy environments for youth. For example, in 1992, the Chatham-Savannah Youth Futures Authority established the St. Pius X Family Resource Center (FRC) in Savannah, Georgia. In collaboration with the Chatham County Health Department, the Department of Family and Children Services, the Economic Opportunity Authority, Lutheran Ministries of Georgia, and the Second Harvest Food Bank, the FRC offers a range of services and activities, including after-school programs, public assistance, summer camp, employment services (for adults and youth), child care, and mental health services (Walsh 1998).

At a broader level, supporting families requires institutional changes that address socio-economic disparities. Almost 20% of adolescents in this country live in families with incomes below the federal poverty line. One-third of African-American and Hispanic children live in poverty, as do 13% of White children (U.S. Census Bureau 2001). The National Research Council Panel on High Risk Youth (1993) found that a combination of social factors, including inner-city deterioration, discrimination, deteriorating public schools, single-parent households, and low-paying jobs, make it difficult for families to rise out of poverty. Such adverse social factors have a negative impact on adolescent health (Rickel and Becker 1997). Poverty limits adolescents' access to health care and other community resources and negatively influences their perceptions of their futures. On the other hand, programs that assist poor and near-poor families contribute to the health and well-being of the young people in these families.

Expanding the Vision: The Role of Community Stakeholders in Improving the Health of Adolescents

Given the multiple dimensions of adolescent health, the numerous antecedent factors that contribute to health outcomes, and the complexity of health risk behaviors, our efforts to

improve adolescent health will benefit most from multi-pronged approaches that engage several community sectors. Traditionally, the clinical and public health communities have taken responsibility for adolescent health by developing educational and other program interventions that respond to such problems as substance use, injury, and the negative consequences of sexual behavior.

The audience for this Companion Document is very broad; it includes people from a variety of backgrounds and all sectors of society, including healthcare and public health, parents and families, schools, community agencies that serve youth, faith-based organizations, media, postsecondary institutions, employers, government agencies, and numerous others. In addition to parental and family relationships, personal factors such as aspirations for the future, educational achievement, religiosity, and ties to community are closely associated with health risk behaviors. Clearly, adolescents, families, schools, the faith community, businesses, the juvenile justice system, media, youth-serving organizations, and others can play significant roles in ensuring that all adolescents receive the supports they need for healthy development and a smooth transition to adulthood. We need social, political, educational, economic *and* health care-related strategies to improve adolescent development and behaviors.

To demonstrate the collaborative and broad vision of the National Initiative, we highlight how in Boston, Massachusetts, a broad coalition of federal, state, and local governmental agencies, nonprofit organizations, businesses, parents, community residents, churches, law enforcement, and the juvenile justice system reduced high rates of youth homicide and gang violence. The strategy consisted of action on multiple levels, including policy changes that required stricter responses to gang violence, creation of gun suppression and interdiction programs; and the development of new partnerships between probation officers and police officers for monitoring youth probationers. In addition, numerous prevention and intervention programs were strengthened or established in an effort to build on existing resources and create a more effective continuum of services. Because of the collaboration, integration of multiple key players, and implementation of an array of community-based strategies, the homicide and violence rates among adolescents dramatically decreased within 5 years of implementing this multifaceted intervention.

Since many adolescent risk behaviors mirror adult behaviors, there is a great need for broad positive adult involvement in, and responsibility for, adolescent well-being. Parents and families are lead members of a broad list of stakeholders and societal institutions with a vital role in assuring and improving the health of adolescents.

Schools

Academic settings have tremendous potential to reach young people. About 53 million youth attend primary and secondary schools each day, and 14 million students attend the nation's colleges and universities each year (US Department of Education 2002). In addition to providing academic knowledge and skills, schools are largely responsible for providing physical shelter, helping to establish social values, developing social skills, and, ultimately, preparing children and young people to become productive, contributing members of society.

Beyond their institutional functions, schools provide adult role models and are a source of peer influences, which have powerful effects on adolescent health, development, and well-being. Research indicates that school connectedness, or the establishment and maintenance of supportive relationships with teachers and peers, protects against a variety of health risk behaviors (Resnick et al. 1997). School connectedness is a parallel concept to family connectedness. From preschool through senior year in college, teachers and professors are often a source of guidance and support and serve as role models for



their students. Likewise, peer groups affect children's, adolescents', and young adults' perceptions of self and relations to others.

Academic institutions can provide opportune settings for comprehensive health education and life-skills development by employing such creative strategies as peer education, school-wide campaigns, and role plays. Although many schools strive to provide comprehensive, age-appropriate health education to young people on a range of health issues, schools can also serve as a central clearinghouse or coordinating entity where young people can obtain information about what resources are available in the community and obtain referrals to community-based programs.

Key Issues for School Health Programs

- **Health promotion is a priority.** Educators must make health education, the promotion of healthy lifestyles, and prevention of risk behaviors high priorities. Policy-makers need to be educated about the importance of comprehensive health promotion in schools and the link between health and the ability to learn.
- **Health education curriculum.** The health education curriculum should be comprehensive, providing a wide range of information related to adolescent health and health-related behaviors. It should also help students develop their skills in risk assessment, decision-making, and communication.
- **School environment.** In addition to offering a health education curriculum, schools promote healthy behaviors by operating a nutritious food service, maintaining clean and safe buildings, offering physical exercise through sports and physical education classes, and providing preventive health services.
- **Development of awareness and cultural competence.** Educators should be sensitive to diversity in experiences and environments with respect to students' cultural backgrounds, family structure and composition, socio-economic status, and social settings.
- **Professional training.** School personnel should receive in-service training regarding health promotion and social interactions with adolescents and their families.
- **Policies.** States and communities should establish policies that help local schools effectively implement school health programs and school health guidelines.

Adapted from: Elster, Panzarine, and Holt 1993.

Providing health education to children and young people represents just one of the responsibilities society looks to schools to fulfill. Increasingly, society views educational institutions almost as extensions of the family. Schools are often expected to feed students; provide health services; make referrals to community organizations for substance abuse, human services, and domestic violence; cooperate with law enforcement; provide comprehensive health education; and actively promote safety, social skills, physical activity, and overall healthy lifestyles (Dryfoos 1994). Meanwhile, schools continue to be accountable for their main role of preparing students for educational attainment and success in higher education and/or the work force.

Addressing adolescents' educational, health, and social needs through schools makes sense, but schools cannot be expected to meet these needs alone, especially with their accountability for higher academic standards and standardized test scores in the face of serious fiscal constraints. They can, however, provide a central facility in which many agencies can work together on these issues. Through partnerships and with strong community support, school-based collaborative programs have been successful in addressing

the health needs of children and adolescents. The CDC's Division of School and Adolescent Health (DASH) has developed and implemented a model for school health, the Coordinated School Health Program, which includes the following eight components: Health Education, Physical Education, Health Services, Nutrition Services, Health Promotion for Staff, Counseling and Psychological Services, Healthy School Environment, and Parent/Community Involvement. DASH currently monitors school health policies and programs across the country through its School Health Policies and Programs Study.

During the past decade, efforts have increased to link schools with community health and social services. Currently, there are some 1,500 school-linked or school-based health centers (SBHCs) in the U.S. providing elementary, middle, junior, and senior high school students with such services as preventive health care, health screenings, immunizations, counseling, and acute care (Making the Grade 1999; Schlitt, Santelli, Juszczak, et al. 2000; Snyder and Hoffman 2000). Studies indicate that SBHCs can be effective and responsive sources of health care (Kaplan et al. 1998).

A significant effort has emerged for linking a comprehensive array of health and social services through "full-service" or "beacon" schools. In addition to providing health care, full-service schools offer dental services, substance abuse treatment, mental health services, parent education and literacy, child care, employment training, case management, crisis intervention, community policing, and family welfare (housing, food, clothing) services (Dryfoos 1994).

Although every school in every community will not have the resources to incorporate all eight components of the Coordinated School Health Program or to create a full-service school, these models serve as examples of what is possible. Through such strategies as partnerships with community agencies and co-location of services, existing community resources can be maximized and a variety of resources made available to adolescents and their families. These models also facilitate the development of effective referral systems to larger and specialized systems of care.

Colleges and Universities

Colleges and universities can play a critical role in promoting the health of the young adult population. Many institutions use a variety of strategies that focus on changing the physical, social, legal, and economic environment on campus while acknowledging behavior influences at the personal, peer, institutional, community, and public policy levels.

Common health issues addressed on college campuses include alcohol and drug use, unsafe sexual activity and STDs, and violence. Many campuses have developed innovative programs that address these sensitive issues through strategies such as education to develop decision-making and communication skills; programs and policies to decrease alcohol abuse (including restrictions on alcohol marketing and promotion, stricter alcohol sanctions and discipline, and promotion of alcohol-free activities); student-led organizations and task forces that organize campus activities surrounding particular health issues; and curricular and extracurricular educational activities for students.

Examples include:

- Pennsylvania State University persuaded the Tavern Association of State College (Pennsylvania) to adopt a policy that the association's bars and taverns would wait to serve beer to consumers until 26 hours after their 21st birthday.
- Bowling Green State University (Ohio) surveyed students about attitudes and behaviors related to alcohol use and used the results to develop media campaigns that target misperceptions about drinking norms.



- Brown University (Rhode Island) sponsors the Sexual Assault Peer Education program, which mandates attendance for all first-year students.
- Ohio State University, in collaboration with the private sector, renovated areas with a high concentration of bars to provide positive places for student activities, including cafes and bookstores.
- Community College of Baltimore (Maryland) integrates a general wellness approach and making healthy life choices into its curriculum.
- Stanford University (California) launched the Stanford After Midnight program to provide students with late-night, alcohol-free activities.
- Administrations from seven Washington (D.C.) universities, law enforcement, non-profit organizations, and other agencies teamed up to enforce underage drinking laws, increase community involvement, and improve university programs and services through their Campus Alcohol Reduction Effort (CARE).

Health Care

The personal health care system has traditionally focused on treating illness and disease rather than preventing problems emanating from health-risk behaviors. However, it still acknowledges the critical importance of prevention. In particular, the health problems identified in the 21 Critical Health Objectives are largely preventable. Nearly three quarters (73%) of American adolescents see a physician at least once per year (Ziv et al. 1999), and 86% of youth have a regular clinician. These visits offer physicians and other clinicians the opportunity to provide preventive services. The medical setting allows multiple health factors to be addressed, including biomedical, behavioral, and emotional problems. Studies indicate that adolescents view their physicians as a trustworthy source of health information and that parents want clinicians to provide these services (Park et al. 2001).

Over the past decade, several national organizations and governmental agencies have developed practice guidelines to support the provision and expansion of clinical preventive services to adolescents. These guidelines define the content of comprehensive preventive health visits for adolescents and recommended intervals between visits. Major sources include the American Academy of Pediatrics, American Academy of Family Physicians, American Medical Association, Maternal and Child Health Bureau/Health Resources and Services Administration, and U.S. Preventive Services Task Force.

Despite the potential of clinical preventive services to improve adolescent health, research indicates that the delivery of these services lags well behind national recommendations. Barriers include financial constraints, with more than 15% of adolescents lacking health insurance (Newacheck, Brindis, Cart, Marchi, and Irwin 1999); a lack of confidentiality or ambiguity regarding confidentiality, which may limit adolescents' disclosure of potentially crucial information (Ford, Bearman, and Moody 1997); limited physician-patient interaction time (Elster, Panzarine, and Holt 1993); and a lack of confidence among clinicians in their ability to counsel on adolescent health risk behaviors. These factors often result in low levels of screening for health risk behaviors. Fortunately, new developments—including provider-focused interventions that aim to increase the delivery of preventive services and accountability initiatives designed to increase the quality of health care services—have the potential to improve the delivery of clinical preventive services (Park et al. 2001).

Key Issues in Health Care Services for Adolescents:

- **Access to services:** Adolescents and their parents need adequate outreach information on the availability of health services, and they require confidential care, flexible office hours, and transportation to the medical setting.
- **Important characteristics of the health visit include:** (1) systematic health promotion and prevention activities; (2) services tailored to the individual patient and family members; (3) screening for health risks; (4) treatment of the adolescent with dignity and respect; (5) teaching skills to the patient to enhance health; (6) provision of referrals; and (7) the creation of a working partnership among the adolescent health care professional and family.
- **Patient orientation:** Health promotion activities targeting the adolescent should consider personal health beliefs, familial factors, and developmental issues. Physicians should help patients appreciate that health education is a vital component of their overall care.

Adapted from: Elster, Panzarine, and Holt 1993.

Community Organizations that Serve Young People

Communities have the ability to influence youth on a wide scale. They can also target those young people who are not reached by school health activities (including classroom education), such as youth who have dropped out of school and those who are home-schooled.

Asset-Building Strategies

Many community programs offer asset-building opportunities for young people, opportunities that, while not necessarily labeled as health promotion, nonetheless contribute substantially to adolescent health and well-being. Such programs include mentoring, family education and support, extracurricular activities in schools, programs offered by clubs and congregations, and volunteer and employment initiatives. Asset-building programs can foster self-esteem, positive identity and pride among young people. They can also promote a commitment to education and promote values that help young people become productive members of society. To build youth assets, community organizations should involve young people as volunteers and leaders in their programs; provide asset-building skills to families as well as to youth; examine which program strategies and designs most effectively engage youth; integrate intergenerational perspectives; and provide leadership and financial assistance to programs with asset-building initiatives (Benson 1997).

Key Issues in Community Adolescent Health Programs

Communities need to develop comprehensive services for youth that address multiple health and safety issues. Categorical funding has often prevented communities from developing multifaceted programs, including “wraparound” services (such as case management, tutoring, and mentoring programs) that bridge the gaps in health care delivery systems (Brindis, Hughes, Newacheck, and Halfon 1998).

Key Issues in Providing Services to Youth at the Community Level:

- **Composition of services:** Community health promotion services targeting adolescents should be (1) affordable, (2) convenient, (3) confidential, (4) culturally aware, (5) communicative, and (6) compassionate.



- **Life span approach:** Health promotion programming should address multiple life stages, focusing on beliefs and behaviors that develop over time as well as the transitions into adolescence and into adulthood.
- **Family orientation:** Health activities should focus on adolescents in the context of their families.
- **Community orientation:** Adolescents, parents, and other community members should offer input regarding the types of health strategies implemented so as to develop the community's sense of ownership of these programs.
- **Involvement of the health sector:** Key professionals in the public and private sectors must become involved in setting the adolescent health agenda, including a comprehensive health approach.

(Elster, Panzarine, and Holt 1993).

Faith-based Organizations

Faith-based organizations can play a key role in promoting the health and well-being of adolescents for several reasons: they are instrumental in shaping the values of young people; they are trusted institutions with community credibility; they have a long tradition of offering community support services; and they have access to large numbers of young people, parents, and volunteers. Furthermore, research has identified an adolescent's attachment to faith communities as a protective factor; young people who identify religion and prayer as important to them are less likely to engage in certain risk behaviors (Resnick et al. 1997). Many churches and religious institutions are deeply involved in their communities and may be the only trusted institutions, especially in some communities of color or those with many undocumented residents.

As partners in adolescent health promotion initiatives, faith-based organizations can help facilitate access to young people and their families and lend credibility to groups from outside the community. Faith groups have partnered with many institutions and agencies in preventing violence, crime, and substance abuse. For example, in partnership with local juvenile justice systems, faith groups often provide mentoring and community service programs for court-diverted youth. Some urban schools welcome the support of faith-based institutions as both sources of volunteers and teachers of values. In Detroit, for example, the Second Ebenezer Church sends a youth worker to middle schools during the lunch hour to meet with young people who exhibit violent behavior and are at risk for suspension. The youth worker talks with students about life issues and choices, self-control, conflict resolution, and anger management. School and congregation officials are careful to avoid religious programming in the schools; they focus instead on modeling clear values.

Throughout the United States, faith-based organizations have initiated their own programs to assist persons in need. Ninety-one percent of congregations actively serve their community in one or more programs, such as day care, tutoring, after-school activities, and health-related issues. On average, these congregations provide 5,300 hours a year in community volunteer work. Eighty percent of the beneficiaries are not congregation members; most are neighborhood children. Faith-based groups have spearheaded initiatives on such health issues as violence prevention, substance use prevention, and nutrition and physical activity. For example, the Early Grove Baptist Church in Memphis, Tennessee, established Project Vision, a health promotion program designed to reduce risk factors for cardiovascular disease. Project Vision targets youth aged 5-18 and

adult women through health education, exercise classes (with child care provided), and blood pressure and cholesterol screenings.

Faith-based groups offering youth groups, after-school programs, and mentoring activities provide an excellent opportunity to incorporate health promotion in existing programs. Alternatively, they have value simply by offering safe and drug-free social events to young people, such as weekend dances and other structured recreational activities during after-school hours. Faith-based communities also serve as a support network for families in crisis, helping guide parents through difficult parenting issues and offering parent-child communication workshops.

By joining in interfaith or multi-congregation collaborations, many groups have been able to create new and separate organizations with not-for-profit status and develop clear missions to improve outcomes for young people. Such efforts help increase capacity for fundraising and mobilizing around adolescent health issues. Finally, many faith-based organizations advocate for health-related policies, which makes them valuable allies in policy-oriented interventions.

Media

The media are powerful influences in the socialization and cognitive development of youth (Brown and Cantor 2000). Advertising, television, movies, and other forms of media send a steady stream of messages to adolescents that portray adults as well as teens using tobacco, alcohol or other substances, and participating in sexual relationships, violence, and the unsafe operation of motor vehicles. Studies have shown an association between the media content to which young people are exposed and their attitudes and behavior related to substance use, violence, and sex. Since the 1950s, more than 1,000 studies have examined the effects of violence in television and movies; the majority have concluded that children who watch significant amounts of television and movie violence are more likely to exhibit aggressive behavior, attitudes, and values (National Institute on Media and the Family 2002). In addition, of the 40,000 commercials that children view each year, 2,000 are for beer and wine (Strasburger 2001; American Academy of Pediatrics 1995); advertisements also abound for processed and fast food, soda, and tobacco. Studies also show that television advertising changes young people's attitudes about engaging in unhealthy behaviors. For example, young people reported more positive feelings about drinking and their own likelihood of drinking after viewing advertisements for alcohol (Grube 1994).

Given their powerful influence, the media warrant substantial focus in any adolescent health initiative. It is important to work with the media to distribute healthy messages and to develop social marketing campaigns that promote healthy lifestyles. The National Campaign to Prevent Teen Pregnancy (The National Campaign) has co-developed successful efforts with several television shows as well as with Teen People magazine. As part of the Teen People partnership, an annual contest is sponsored to identify the best media messages aimed at reducing teenage pregnancy. The winning entries are highlighted in an article in the magazine and, in turn, The National Campaign uses the ads as part of its national efforts. In another effort to combine public health advocacy and popular culture, the CDC developed an anti-tobacco campaign featuring supermodel Christy Turlington as a prominent spokesperson.

Attempting to regulate the media remains a controversial issue. After a decade marked by several high school shootings, the level of violence and violent behaviors in television, movies, music, and video games remains high. In San Antonio, a youth-led movement to remove billboards advertising alcohol and tobacco products placed in low-income communities and near schools required more than advocacy. One clear-cut strategy, however, the use of media literacy education for children, youth and parents, appears to



be taking hold. The New Mexico Media Literacy Project, for example, is a public/private partnership that includes the Albuquerque Academy, the state departments of health and education, and the McCune Foundation. Among its activities, the Project provides curricula as well as tools on media literacy to schools, conducts workshops, and offers trainings to teachers in media literacy related to health.

Communities can also turn to media other than the entertainment industry to promote adolescent health. State health departments often invest in social marketing campaigns that promote healthy behavior messages on billboards and television commercials. Communities can also undertake local media projects; for example, young people can create their own health promotion messages in the form of television commercials and public service announcements aired on local television and radio. Communities can also organize health promotion events that attract media attention or write opinion pieces for the local newspaper (local media strategies are discussed in Chapter 7).

Employers

The number of adolescents entering the workforce is steadily increasing; by 2006, nearly 9 million workers will be aged 16 to 19. Research indicates that employment can promote healthy development, as it instills self-discipline, makes constructive use of time, and allows teens to make money. Employment has been associated with an increased sense of independence and responsibility, and teens with paid jobs are more likely to find employment once they graduate from high school (Brown 2001). In addition, working moderate hours is associated with higher educational attainment.

Unfortunately, working too many hours can have negative effects on a teen's health, education, and family relationships. The Add Health Study found that working more than 20 hours a week was associated with emotional distress, substance use, and earlier age of sexual debut (Resnick et al. 1997). Although teens who work can contribute to family income, they spend less time with their families (Steinberg, Greenberger, Garduque, Ruggiero, and Vaux 1982). Furthermore, working long hours is associated with poorer academic performance (Steinberg and Dornbusch 1991) and deficits in sleep, nutrition, and exercise (Bachman and Schulenberg 1993).

With these facts in mind, families and employers should be sensitive to the competing needs in young people's lives. Where possible, families can instill a commitment to education in their teens who have jobs by prioritizing their homework and limiting work hours. In addition, employers can promote health and safety in the workplace through employee training programs; by hanging posters with healthy messages; and by implementing work programs aimed at preventing substance abuse and injuries and promoting healthy nutrition. Employers can also contribute to positive youth development by offering internships and work programs to teens involved in community-based programs. For example, in San Francisco, a youth-focused nonprofit organization called Juma Ventures has partnered with food vendors and companies. It owns and operates concession stands at professional sports venues. Through the youth-run concessions, the organization provides jobs and job training for teens and young adults recruited from local low-income, at-risk neighborhoods. Juma Ventures also offers its young employees programs in saving money, writing resumes, and searching for jobs as well as referrals to other services.

Employment programs are also offered as rehabilitative programs or alternative sentencing options for youth in the juvenile justice system. For example, at the Avon Park Youth Academy (Florida), male repeat offenders aged 16-18 participate in a 9-month program that prepares them to hold jobs with living wages. Participants receive certification and wage-earning, work-based experience in the culinary arts, masonry, flooring, horticulture, plumbing, electricity, carpentry, building maintenance, landscaping, and auto

mechanics. The program has shown promising results, with a recidivism rate below 10%. Furthermore, 78% of students complete the program; 40% earn General Educational Development (GED) certificates or high school diplomas; 78% receive vocational certification; and 81% remain employed after 6 months.

The Role of Law Enforcement, Corrections, and Juvenile Justice

The federal Office of Juvenile Justice and Delinquency Prevention recommends a collaborative approach for preventing youth involvement in the justice system, an approach that focuses on youth development, addresses both risk and protective factors, and calls on different sectors to coordinate programming. The factors that place young people at risk for delinquent behaviors are the same that place them at risk for negative health outcomes and include poverty, family violence, lack of school connectedness, and access to drugs and firearms. Correspondingly, law enforcement and juvenile justice are natural allies for adolescent health promotion. Many of the efforts to prevent youth involvement in the juvenile justice system focus on such strategies as providing mentoring, employment training, and other youth development programs; increasing the number of recreation and after-school programs available to young people; providing mental health services; and offering support for the development of skills in anger management and conflict resolution.

Juvenile justice programs could benefit from partnerships with public health and human services programs addressing Critical Health Objectives in the areas of substance abuse, violence, and mental health. Court-involved and incarcerated youth face the same health issues as the general youth population but are often harder for community-based programs to reach. They may have been expelled from school or removed from their neighborhood or the community settings where most interventions take place. In some instances, young people involved in the juvenile justice system are among the groups at highest risk for such negative health outcomes as STDs, HIV infection, pregnancy, substance abuse, and other serious consequences from injuries sustained during fights and altercations with the police. Prevention programs, where they exist, take place in group homes, juvenile detention centers, and other correctional facilities using curricula specifically developed for incarcerated youth.

Community-based youth development programs are available for youth involved in the juvenile justice system as rehabilitative or court diversion programs. Local police departments frequently offer community programming in addition to their policing duties. Many officers arrange jobs for youth, create sports leagues and other recreation programs, and conduct violence prevention and mentoring programs. Local police are key partners for prevention programs seeking to expand their efforts into high-risk communities.

Government Agencies

Government agencies—at the federal, state, and local levels—play both direct and indirect roles in adolescent health by developing policies, implementing programs, and providing funding for research. Locally, such bodies and agencies as the city council, county commissioners, county departments of health, and school districts affect a community's awareness and its willingness to address the health needs of adolescents. Conversely, government agencies and policy makers can be encouraged to take action as a result of the advocacy efforts of individuals and communities. For example, after their 16-year-old son committed suicide in January 1992, Scott and Leah Simpson mobilized their community to increase its knowledge of suicide and mental health issues. By September of that year, the Simpsons had convinced their local legislator to sponsor a youth suicide prevention bill in the Washington State House of Representatives. The bill did not



pass, but as a compromise the legislature allocated funds for the development of a state-wide youth suicide prevention plan (<http://www.yspp.org/index.htm>).

Similarly, support from state government agencies often provides impetus for program and policy development; the assistance of these agencies in developing strategic plans or reports on adolescent health can help make adolescent health a priority. The California Adolescent Health Collaborative is a statewide partnership between public and private agencies aimed at promoting adolescent health (<http://www.californiateenhealth.org>). The collaborative created a comprehensive strategic plan for adolescent health that is multidisciplinary, noncategorical, and serves as a call to action to a broad array of stakeholders. The project was supported by the California State Department of Health Services, Maternal and Child Health Branch, and is now being put into action by county adolescent health coordinators throughout the state.

At the federal level, policies are set that affect how young people access health care and what type of health education they receive. Federal agencies also help set priorities and provide guidelines by disseminating research, information, and guidelines on best practices and program approaches. For example, the Center for Substance Abuse Prevention/Substance Abuse and Mental Health Services Administration (CSAP/SAMHSA) developed "SAMHSA Model Programs," which consist of curricula and other programs centered on preventing substance abuse (<http://www.modelprograms.samhsa.gov>). These types of tools elevate the government's role in community health promotion by facilitating dissemination of information on effective programs to greater numbers of communities.

Academic Institutions

Academic institutions can play many roles in promoting adolescent health that go beyond the campus-based health promotion programs described above under "Colleges and Universities."

First, they have the potential to train future leaders in the adolescent health field. Relatively few institutions of higher learning, however, offer comprehensive, practical programs that teach future health professionals how to address the many sensitive health topics important to adolescents. Thus, schools of public health, medicine, nursing, law, social work, education, and divinity as well as university departments of nutrition and psychology, have an important role in training practitioners about the specific health issues and concerns faced by adolescents. They can also train practitioners to deliver health care in a way that is youth-friendly and developmentally and culturally appropriate.

Schools of medicine, public health, and nursing, as well as other postsecondary institutions also have the resources and skills to conduct research that advances our knowledge about adolescent health. New research informs us about health behaviors, the underlying causes of important health issues, and the elements of successful health programs for young people. Academic institutions can also translate research into meaningful practice for a variety of health and youth-serving professionals through partnerships with non-profit organizations, hospitals, departments of public health, and other institutions providing direct services. In addition, university students can bring valuable skills and resources to communities through field experiences and internships. With appropriate supervision as well as community support, students and trainees can be placed as health providers in underserved communities, provide research and data collection services to communities that are conducting needs assessments or evaluating programs, and offer a wide range of affordable professional skills that are otherwise not easily available to community programs.

Lessons Learned

Many interventions have focused on providing information and skills so that young people develop a portfolio of knowledge, attitudes, and life skills that foster healthy decision-making. Research has clearly demonstrated that interventions focused only on providing knowledge have limited effectiveness. Program evaluations have also helped to create a scientific base for best practices and effective programs in numerous areas. A limited number of adolescents across the country have benefited from these model programs, but efforts to “go to scale” on most well-evaluated interventions have not occurred. Replication of best practices and model programs has been challenging for several reasons, such as dilution of program components and reduction in program time that are based on financial constraints. In Chapter 6, we discuss how to maintain a successful program’s core elements when adapting it to new groups of youth. Research on health risk behaviors indicates that different groups of adolescents may need different interventions. For example, some programs found to be effective in preventing use of tobacco or teen pregnancy have not yet been evaluated with certain subgroups, such as rural teens, some racial/ethnic groups, and youth with special needs. In addition, male and female teenagers may respond differently to some health promotion messages.

Lessons learned from past efforts offer valuable insights on the ingredients needed to meet the 21 Critical Health Objectives. To illustrate an effective “recipe” for success, we shall consider the issue of alcohol consumption in relation to motor vehicle crashes, which is directly related to 3 of the 21 Critical Health Objectives. First, widespread societal consensus needs to be reached about acceptable approaches to improving health needs. For example, public education campaigns with messages such as “If you drink, don’t drive” have helped to create strong support for the concept of “designated driver,” which, in turn, has contributed to a reduction in drunk driving among youth and adults. Second, to establish broader-level changes, there must be sound financial backing of policy and program initiatives. To curb driving under the influence of alcohol, policy makers have created policies to fund programs that increase penalties and fines for drunken drivers. Third, effective strategies must engage multiple stakeholders from a variety of perspectives. Involving bar owners in setting moderate drinking limits, creating Mothers Against Drunk Driving (MADD) and Students Against Destructive Decisions (SADD) chapters, and implementing media campaigns have all reinforced messages across multiple sectors about the consequences of drunk driving. Fourth, research-based, data-driven programs and policies are important to assure effective use of resources. For instance, federal policy has rewarded those states that have made penalties against drunk drivers more severe. Finally, clear professional commitment and advocacy play a role in assuring that a policy issue remains highly visible. For example, organizations such as MADD have continually educated the public about the societal impact of drunk driving and advocated for policies that will reduce the incidence of alcohol-related traffic deaths. This organization was instrumental in advocating for graduated driver licensing laws, which allow for better supervision of new and young drivers by regulating the time of day adolescents can drive, in stipulating the length of time an adult must accompany new adolescent drivers, and in limiting the number of passengers allowed in a vehicle operated by a new adolescent driver.

Summary

The lives of today’s adolescents cannot be neatly divided by health problem or risk behavior, or by topic and agency; instead, there is a continuum among home, school, community, and multiple additional influences. Because many societal factors contribute to adolescent health, safety, and well-being, health promotion and prevention strategies should not be implemented in isolation; a collaborative effort across multiple societal in-



stitutions is necessary. Coordination and cooperation across systems can strengthen efforts to address categorical health issues. Such joint efforts can also help to promote a more comprehensive approach to addressing adolescent health—an approach that views adolescents as whole persons who need many supports and opportunities for healthy development. By working across systems and health issues in a coordinated effort, individuals and institutions can together bring about significant positive changes. It is through this joint effort that the 21 Critical Health Objectives for adolescents and young adults can be achieved.

CHAPTER 4



Using Data to Shape Your Adolescent Health Program

Contents

How Data Can Shape a Community Adolescent Health Initiative **page 2**

Challenges in Using Data **page 3**

Using Data Sources to Create a Local Adolescent Health Profile **page 3**

Data Sources for the 21 Critical Health Objectives **page 6**

Broader Measures of Health and Well-Being **page 6**

Creating a Community Adolescent Health Profile **page 12**

Accountability to Funders **page 13**

Summary **page 15**



This chapter offers guidance for creating a local adolescent health profile. It introduces the reader to official data sources for the 21 Critical Health Objectives and to strategies for measuring the concepts of healthy environments and youth development. The chapter also discusses the importance of demonstrating responsible stewardship of the funding for an adolescent health program.

The first part of this document presented background information on adolescent health and the National Initiative, including the 21 Critical Health Objectives; the remaining chapters provide guidance to states and local communities for improving and promoting adolescent health. This chapter discusses the role of data in shaping adolescent health initiatives; subsequent chapters focus on recommended components of state and local action, such as coalition building and program planning, implementation, and evaluation.

The quality of data on adolescent health risk behaviors has advanced considerably over the past decade, and the 21 Critical Health Objectives themselves represent this progress. As noted in Chapter 1, the Critical Health Objectives all have (or will soon have) national- and state-level data. Chapter 3 described emerging approaches that define adolescent health broadly, complementing the traditional focus on “individual problem behaviors” with concepts of healthy adolescent development and health-promoting environments. Although there has been recent progress in measuring these last two concepts, no ongoing national and few state surveys exist that are comparable to efforts providing data on the 21 Critical Health Objectives. The present chapter attempts to balance the relative wealth of data on “problem behaviors” with promising, but less tested, strategies for measuring newer concepts of adolescent health. Most communities will need to work with data experts. To maximize effective use of the data, most states have data contacts within their Title V Maternal and Child Health Program which can provide technical assistance in measuring adolescent health at the state and community level.

How Data Can Shape a Community Adolescent Health Initiative

Data serve several purposes for policy makers and creators of health initiatives. First, data play an important role in ensuring accountability. Both public and private funders increasingly require organizations to evaluate their efforts so as to demonstrate both responsible use of the funds and programmatic effect. Evaluation requires the collection of data. At the local level, data provide benchmarks by which communities can measure their progress in improving adolescent health. Communities can set goals for two areas: (a) individual adolescent behavior change, such as reducing tobacco use; and (b) creating a social environment that fosters healthy adolescent development and supports adolescents in adopting healthy behaviors. Developing indicators for measuring progress toward individual and environmental goals can serve many purposes. For example, indicators that are easily understandable and readily communicated can motivate people and communities to mobilize around a health problem. By monitoring trends in these indicators, communities can begin to assess which of their efforts appear to have a positive influence and which seem less effective. Based on this assessment, communities can modify program priorities and resources as needed. Monitoring their efforts through repeated data collection will help them both to assess their progress and to demonstrate their accountability for adolescent health.

As an example, a community might respond actively to an increase in tobacco use among its teens, especially if its rate of adolescent tobacco use runs counter to a statewide decrease. As the community establishes its goals (e.g., decreasing the teen tobacco use rate from 40% to 20%), it can also define the ideal environment to reduce tobacco use by addressing its antecedents. One aspect of an ideal environment might be limiting exposure to tobacco advertising; another might be decreasing minors’ access to tobacco products. An ideal envi-

ronment might also foster healthy adolescent development through programs that create positive future expectations and promote academic achievement.

Developing indicators for, and monitoring progress toward, this ideal environment are both challenging yet crucial elements of using data to shape an adolescent health initiative. Communities can develop measurable indicators of this ideal environment and then measure their progress against their baseline. If teen tobacco use decreases more slowly than anticipated, communities can assess progress on individual and environmental factors antecedent to teen tobacco use. For example, data may indicate progress toward goals related to positive future expectations and school success but no changes in exposure to advertising. Or, the data may reveal a more complex picture. Progress on these variables may vary for different subpopulations (e.g., boys/girls, different racial/ethnic groups, students from different schools, or children of smokers vs. nonsmokers). Wherever the data show less progress, communities may want to redeploy resources to address those antecedent factors and subpopulations where more progress is needed. As part of this process, communities may consider whether new strategies are warranted. For example, a larger focus on families may be appropriate, especially if indicators do not improve among children of smokers (a group more likely to use tobacco). Using data in this way, a community can hold itself accountable for both creating a healthy environment for young people and reducing tobacco use. Communities may wish to use a quality improvement process (such as the rapid cycle described in Chapter 7) as part of their efforts to analyze why goals are not being reached.

Challenges in Using Data

Working with data poses significant challenges: communities may not be comfortable with statistics or may fear being labeled a “problem community” relative to some of the issues covered by the 21 Critical Health Objectives, such as adolescent alcohol, drug, tobacco use, or violence. To address these challenges, people playing leadership roles in adolescent health must work in close collaboration with their community; they need to engage a diverse range of stakeholders and develop a comprehensive strategy for communicating data to the public. These issues are addressed in more detail in Chapters 5 and 6. By using data to shape their programs, communities can develop strategies that make data more useful. For example, they might identify changes that need to be made in the data collection system, or they might need to stretch existing resources through creative collaboration.

Using Data Sources to Create a Local Adolescent Health Profile

Many communities will be able to focus on just one or two content clusters of the 21 Critical Health Objectives (e.g., objectives related to chronic disease prevention). This document presents a two-phase process for using data to drive an adolescent health agenda.

- First, communities can draw on the data sources in Table 4-1 (National, State, and Local Data Sources) to create an adolescent health profile based on the 21 Critical Health Objectives. This table includes major national sources of data, including the official *Healthy People 2010* data source for each Critical Health Objective, state-level sources, and suggested community-based sources. Communities may want to complement this profile by measuring antecedent factors of the health risk behaviors represented by the 21 Critical Health Objectives. Measures of antecedent factors provide a broader picture of adolescent well-being by addressing youth development and the status of the social environment. (There are often significant challenges in obtaining such data locally. The next section of this chapter offers more information about resources for measuring youth development and environmental factors.) Using this initial profile, community leaders can identify priority Critical Health Objectives that are adolescent health priorities for their communities.



Table 4-1: National, State, and Local Data Sources for the 21 Critical Adolescent Health Objectives

Critical Objective (Healthy People 2010 Objective Number)	Indicator	National Sources*	State Sources	Local/County Sources
Mortality				
Reduce deaths of adolescents and young adults. (16-03)	Rate per 100,000	NVSS ¹ ; NCIPC ² , CDC	State Department of Health, Vital Statistics; NCIPC	County Department of Health, Death Certificates (Note: large cities maintain registries)
Injury				
Unintentional Injury				
Reduce deaths caused by motor vehicle crashes. (15-15)	Rate per 100,000	NVSS ; FARS ³ ; NCIPC	FARS , NCIPC	County Department of Transportation; Coroners' office
Reduce deaths and injuries caused by alcohol- and drug-related motor vehicle crashes. (26-01)	Rate per 100,000	FARS	FARS ; State Traffic Record Systems	County Department of Transportation
Increase the use of safety belts. (15-19)	Percent	YRBSS ⁴	YRBSS	Local surveys of high school students
Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol. (26-06)	Percent	YRBSS	YRBSS	Local surveys of high school students
Violence				
Reduce homicides. (15-32)	Rate per 100,000	NVSS ; NCIPC	State Department of Health, Vital Statistics; NCIPC	State Department of Health Services, Vital Statistics, Coroners' offices, Police departments
Reduce physical fighting among adolescents. (15-38)	Percent	YRBSS	YRBSS	Local surveys of high school students
Reduce weapon carrying by adolescents on school property. (15-39)	Percent	YRBSS	YRBSS	Local surveys of middle and high school students
Reduce the suicide rate. (18-01)	Rate per 100,000	NVSS ; NCIPC	State Department of Health Services, Vital Statistics; NCIPC	CDC Wonder; County Department of Health
Reduce the rate of suicide attempts by adolescents that required medical attention. (18-02)	Percent	YRBSS	YRBSS	Local surveys of high school students
Substance Use				
Reduce the proportion of persons engaging in binge drinking of alcoholic beverages. (26-11)	Percent	NSDUH ⁵ ; YRBSS , Monitoring the Future (supported by NIDA)	YRBSS	Local surveys of middle and high school students
Reduce past-month use of illicit substances (marijuana). (26-10)	Percent	NSDUH ; YRBSS , Monitoring the Future (supported by NIDA)	YRBSS	Local surveys of middle and high school students
Mental Health				
Reduce the proportion of children and adolescents (with disabilities) who are reported to be sad, unhappy, or depressed. (06-02)	Percent	NHIS ⁶	State Department of Mental Health	Local surveys of middle and high school students

Critical Objective (Healthy People 2010 Objective Number)	Indicator	National Sources*	State Sources	Local/County Sources
(Developmental) Increase the proportion of children with mental health problems who receive treatment. (18-07)	Percent	<u>NSDUH</u> (proposed)		
Reproductive Health				
Reduce pregnancies among adolescent females. (09-07)	Rate per 1,000	<u>NVSS</u> ; <u>National Survey of Family Growth (NSFG)</u> ; <u>Abortion Provider Survey</u> , <u>Alan Guttmacher Institute</u> ; <u>CDC Abortion Surveillance</u>	State Department of Health, Vital Statistics	Local Department of Health; State Department of Health, Vital Statistics
Reduce the number of new HIV diagnoses among adolescents and adults. (13-05) (Developmental)	Number of Cases	<u>HIV/AIDS Surveillance System</u> (proposed)	NVSS; State Health Department HIV Office/Control Program	Local Health Department
Reduce the percent of adolescents and young adults with <i>Chlamydia trachomatis</i> infections. (25-01)	Rate per 100,000	<u>STD Surveillance System (STDSS)</u> ⁷	State Health Department STD Control Programs and Regional Infertility Prevention Programs	Local Health Department
Increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active. (25-11)	Percent of sexually abstinent youth, percent of condom use among sexually active youth	<u>YRBSS</u>	YRBSS	Local surveys of high school students
Chronic Disease Prevention				
Reduce tobacco use by adolescents. (27-02)	Percent	<u>YRBSS</u>	State Youth Tobacco Survey; YRBSS	Local surveys of high school students, State Youth Tobacco Survey
Reduce the proportion of children and adolescents who are overweight or obese. (19-03)	Percent	<u>NHANES</u> ⁸	YRBSS	Local surveys of middle and high school students
Increase the proportion of young persons who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 minutes or more. (22-07)	Percent	<u>YRBSS</u>	YRBSS	Local surveys of middle and high school students
Demographics				
	Population & Population Growth; Race/Ethnicity; Socioeconomic Status	U.S. Census Bureau	State Department of Finance; U.S. Census Bureau	County Department of Health, U.S. Census Bureau

KEY:¹ NVSS-National Vital Statistics System Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS)² NCIPC-National Center for Injury Prevention and Control, CDC³ FARS- Fatality Analysis Reporting System Department of Transportation (DOT), National Highway Traffic Safety Administration (NHTSA)⁴ YRBSS-Youth Risk Behavior Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, CDC⁵ NSDUH- National Survey on Drug Use & Health formerly called the National Household Survey on Drug Abuse (NHSDA)⁶ NHIS-National Health Interview Survey CDC, NCHS⁷ STDSS-STD Surveillance System CDC, National Center for HIV, STD and TB Prevention⁸ NHANES-National Health and Nutrition Examination Survey CDC, NCHS

* Note: The sources used to determine the national baseline and 2010 targets are underlined.



- In the second phase, community leaders can conduct a needs-and-assets assessment to examine community factors related to the selected objectives – including factors such as (a) existing programs and services and (b) attitudes and beliefs among different stakeholders and sectors of the community. This assessment process is described in Chapter 5.

Determining community priorities for adolescent health involves more than reviewing a list of indicators. Leaders must also weigh such issues as local values and the political will to address given topics. Thus, some communities may opt not to focus on an Objective that is likely to lead to divisiveness or controversy among community partners. Chapters 5 and 6 address issues related to community decision-making.

Data Sources for the 21 Critical Health Objectives

Healthy People 2010 identifies an official data source for each of its 467 objectives, including the 107 objectives related to adolescents and young adults and the subset of the 21 Critical Health Objectives. Additional data sources could be used at the state and local levels to monitor progress toward the 21 Critical Health Objectives. These data sources represent a variety of research methodologies, each having its advantages and disadvantages. For example, data from household interviews may underestimate the prevalence of particular behaviors, as some young people may not be candid when talking to a stranger, either on the telephone or face-to-face, with their parents in close proximity. An overview of the different types of data represented in the official data sources for the 21 Critical Health Objectives is presented in Table 4-2. To balance the limitation of any one source of data, communities can use multiple sources to develop an adolescent health profile. This table highlights advantages and disadvantages of the data sources. Communities can work with data experts to decide how best to use available sources in developing the most accurate measures.

Broader Measures of Health and Well-Being

Youth Development

As described in Chapter 3, research on broader measures of adolescent health and well-being has advanced considerably over the past decade, and there are now several approaches for measuring youth development. These approaches and their respective data collection instruments are listed in Table 4-3. Although the approaches differ in some aspects, such as the extent to which they emphasize community context versus individual traits, all share the following:

- a focus on fostering strengths and assets of youth
- recognition of the influence of community/environmental factors
- a philosophy that adolescents' assets can be fostered through programs, policies, and community efforts

In addition, there are several areas of convergence in the domains measured by the youth development approaches, including bonding with adults, social competence, and recognition of positive behavior. Although national consensus is still lacking on the best questions for measuring the domains of youth development, states and communities interested in these measures have several options to consider, and several states currently collect data on some aspects of youth development. For example, states are incorporating youth development measures in their ongoing statewide surveys of youth risk behaviors (see box about collecting youth development data). In addition, many communities are collecting data on positive youth development. Where state and local data are not available, communities may want to review national data sets for applicability. For example, if a community has a large Latino population, it may want to review research from the AddHealth study to see which risk and protective factors have the strongest relationships to adolescents' behaviors in this population.

Table 4-2: Description of Official Data Sources for the 21 Critical Health Objectives

Type of Data Official Data Source (Critical Objective)	Brief Description of Benefits and Limitations	Agency & Web Site
Vital statistics		
<ul style="list-style-type: none"> National Vital Statistics System - Mortality (NVSS-M), (births; overall mortality; mortality from homicide and suicide and motor vehicle crashes) 	<ul style="list-style-type: none"> Near-complete coverage of events (i.e., deaths and births). 	National Center for Health Statistics (NCHS)/Centers for Disease Control and Prevention http://www.cdc.gov/nchs/nvss.htm
Household interview surveys		
<ul style="list-style-type: none"> National Health Interview Survey (NHIS), (for adolescents who are sad, unhappy or depressed) National Health and Nutrition Examination Survey (NHANES), also includes clinical examinations (for obese/overweight adolescents) National Survey on Drug Use and Health (NSDUH), (for binge drinking, illicit substance use, and mental health treatment) 	<ul style="list-style-type: none"> Delay in availability; weighting software may be needed to obtain national estimates. Samples vary across time for a given survey in terms of size, age, and racial/ethnic diversity. Household surveys generally produce lower estimates of risk behaviors. Self-reported data may not be reliable. 	NHIS & NHANES are administered by NCHS/NHIS: http://www.cdc.gov/nchs/nhis.htm http://www.cdc.gov/nchs/products NHANES: http://www.cdc.gov/nchs/nhanes.htm NSDUH is administered by the Substance Abuse and Mental Health Services Administration NSDUH: http://www.samhsa.gov/oas/nhsda.htm
Anonymous school-based survey		
<ul style="list-style-type: none"> Youth Risk Behavior Surveillance System (YRBSS), (seat belt use, rode with drinking driver, binge drinking, fighting, weapon carrying, abstained from intercourse/ condom use, suicide attempts, exercise) 	<ul style="list-style-type: none"> School-based sample may not be representative in communities with large populations of adolescents not in school. Self-reported data may not be reliable. 	Division of Adolescent and School Health, Centers for Disease Control and Prevention YRBS: http://www.cdc.gov/yrbs
Disease surveillance		
<ul style="list-style-type: none"> Chlamydia Prevalence Monitoring Project 	<ul style="list-style-type: none"> Because data are gathered from testing of female clinic patients (from family planning clinics, some STD clinics, prenatal clinics, and jails and juvenile detention centers), they are not generalizable to entire population; different settings use different diagnostic tests. 	National Center for HIV, STD and TB Prevention, Centers for Disease Control and Prevention http://cdc.gov/std
Fatality Analysis Reporting System (FARS)		
<ul style="list-style-type: none"> Automobile crash reporting system 	<ul style="list-style-type: none"> No race/ethnicity data. 	National Highway Traffic Safety Administration, National Center for Statistics and Analysis http://www-fars.nhtsa.dot.gov

(Adapted from Family Health Outcomes Project, 2000).



Table 4-3: Overview of Approaches and Instruments that Measure Youth Development

Approach Name ▪ Researchers ▪ Name of Instrument ▪ Web Site	Features of Instrument
Community Change for Youth Development (CCYD) ▪ J.P. Connell, M.A. Gambone ▪ The Youth Survey ▪ http://www.ppv.org (Public/Private Ventures)	<ul style="list-style-type: none">includes measures of community support, attitudes, & risk behaviorsappropriate for culturally & socioeconomically diverse populationslength of survey requires individual interviews (extensive focus on how time is spent)
Communities That Care (CTC) ▪ J.D. Hawkins, R. Catalano ▪ The Youth Survey ▪ http://depts.washington.edu/sdrg (Social Development Research Group, University of Washington, Seattle)	<ul style="list-style-type: none">focus on adolescents' negative outcomes and their antecedentsmeasures have high predictive valueappropriate for culturally & socioeconomically diverse populationsrequires high reading levelmust purchase
Community Youth Development† (CYO) ▪ Pittman ▪ (no instrument) ▪ www.forumforyouthinvestment.org	<ul style="list-style-type: none">(no instrument)
Resilience ▪ B. Bernard et al. ▪ Healthy Kids Resilience Module (HKRM) ▪ http://www.wested.org	<ul style="list-style-type: none">most rigorously tested instrument focusing on resiliencyrelatively short, can be used with younger childrenappropriate for culturally & socioeconomically diverse populations
Search Institute ▪ P. Scales, D. Blythe ▪ Profiles of Student Life: Attitudes & Behaviors (PSL/AB) ▪ http://www.search-institute.org	<ul style="list-style-type: none">pioneering study, leading first efforts to measure external and internal assetslimited diversity in samples (primarily White, from Midwest)no published reports of psychometric propertiesmust purchase
National Longitudinal Study of Adolescent Health* (AddHealth) ▪ R. Udry et al. ▪ AddHealth ▪ http://www.cpc.unc.edu/addhealth/	<ul style="list-style-type: none">large national study examining the role of context in shaping adolescents' health and well-being (including health risk behaviors). Contexts examined include family, friends and peers, school, neighborhood, and community.

* We include AddHealth in this table because its findings have contributed significantly to our understanding of how context influences adolescents. Because of the complexity of the survey and study design, most communities cannot use the AddHealth approach. Adapted from Cagampang et al. 2001.

†Although no formal research instrument exists, the Forum has been a leader in the youth development field.

Table 4-4: Domains (External and Individual Assets) in Youth Development Instruments

Domain (General Term)	Approaches Incorporating the Domain: Specific Term(s)**†
External Assets:	
Safe Environment	CYD: Safe places; health; quality schools CCYD: Physical safety
Bonding	CYD: Healthy relationships with adults and peers; supportive community PSL-AB: Support CTC: Caring adult relationships CCYD: Connections with adults/peers HKRM: Caring adults in home, school, community Add Health: Support
High Expectations	CYD: High expectations and standards CTC: High expectations; home, school, and community peers CCYD: High, clear, fair expectations AddHealth: Expectations
Pro-social Involvement	CYD: Challenging experiences; participates, contributes PSL-AB: Empowerment CTC: Opportunities for involvement CCYD: Meaningful involvement; membership; challenge; engaged activities; learning experiences HKRM: Meaningful participation in a pro-social group
Autonomy	HKRM: Autonomy
Recognizes Positive Behavior	PSL-AB: Boundaries & expectations CTC: Monitoring, recognition of positive behaviors CCYD: Sense of boundaries AddHealth: Expectations; boundaries and expectations
Constructive Use of Time	CYD: Role models; resources; networks PSL-AB: Constructive use of time CCYD: Attention to activities; time AddHealth: Constructive use of time
Spirituality	CTC: Belief in moral order, religiosity CCYD: Connection—something larger than self HKRM: Belief system AddHealth: Religious belief
Individual Assets:	
Social Competence	PSL-AB: Social competence CTC: Communication & social skills CCYD: Social relationships HKRM: Cooperation; communications AddHealth: Social relations
Emotional Competence	CYD: Connectedness HKRM: Empathy
Moral Competence	CYD: Character
Cognitive/Behavioral Competence	CYD: Competence CTC: Discipline through problem solving CCYD: Coping positively with vicissitudes HKRM: Problem solving
	CYD: Confidence CCYD: Effectiveness HKRM: Self-efficacy



Domain (General Term)	Approaches Incorporating the Domain: Specific Term(s)**
Contribution	CYD: Contribution CCYD: Cares for self/others
Clear, Positive Identity	PSL-AB: Positive identity HKRM: Self-awareness AddHealth: Identity
Belief in the Future	HKRM: Goals & aspirations AddHealth: Schooling
Monitoring	CTC: Self-control CCYD: Avoids harm
Pro-social Norms	PSL-AB: Positive values; commit to learning CTC: School success

[†]Specific terms are the actual descriptive terms used by each instrument

^{**}Instrument Abbreviations:

CYD: Community Youth Development

CCYD: Community Change for Youth Development

CTC: Communities That Care

HKRM: Healthy Kids Resilience Assessment

PSL-AB: Profiles of Student Life: Attitudes & Behaviors

AddHealth: National Longitudinal Study of Adolescent Health

Collecting youth development data: State and local example

Vermont: The Agency of Human Services in Vermont has adopted an "outcomes-based" approach in many of its initiatives, including efforts to improve health. In collaboration with local communities and other state agencies, the state established 10 general outcomes it is committed to achieving, including "Youth choose healthy behaviors." For each outcome, there are specific indicators. The "Youth choose healthy behaviors" outcome includes several indicators that directly overlap with the 21 Critical Health Objectives, including pregnancy rates and past-month use of cigarettes, alcohol, and marijuana. The state also includes five questions on its Youth Risk Behavior Survey that measures positive youth development. These questions, taken from the Search Institute's Survey (Profiles of Student Life: Attitudes & Behaviors), include the percentage of students (a) participating in youth programs and (b) volunteering in their community. These measures are included in a comprehensive "Community Profile" that communities and the state use to monitor progress toward its 10 outcomes. When the Community Profiles show troubling trends, communities develop interventions to address the problem areas.

Source: Personal Communication, May 2002; Paula Duncan, M.D., formerly of the Agency of Human Services in Vermont, currently at the University of Vermont. Also see: <http://www.ahs.state.vt.us>.

Rochester, NY: Researchers from the University of Rochester teamed with the local United Way and the County Youth Bureau to develop the READY (Rochester Evaluation of Asset Development for Youth, 2002, 2003), a survey with questions related to youth development for youth-serving community agencies supported by the United Way. The agencies wanted to measure their progress toward youth development goals, but needed a survey that was both shorter than the major surveys and applicable to the goals of some 20 different agencies. In the first phase of the project, the researchers and the agencies' staff worked together to identify outcome areas of common interest. Initially, the team developed a list of 54 individual measures, covering 10 outcome areas. Through an iterative process, this list was eventually narrowed down to four outcome areas that were most important and most able to be affected by programs: productive use of leisure time, social skills, caring adult relationships, and decision making. After pilot-testing of the survey, a factor analysis confirmed the following constructs: basic social skills (self-control, empathy, and communication), caring adult relationships, and decision making. The final instrument is a pencil-and-paper survey consisting of 40 items measuring the four core outcomes along with program participation and sociodemographic information. READY is designed for use with program participants aged 13-19 and takes about 10-15 minutes to complete. More information about this tool is available at: <http://www.urmc.rochester.edu/gchas/div/adol/leah/resources.HTM>.

Source: "Building a Youth Development Outcome Measure," Klein, J.D., Matos, M. Smith, S.M., Lewis, K., Kodjo, C. Ryan, S. & Danbino, C. Division of Adolescent Medicine, University of Rochester, United Way of Rochester, and the Monroe County Youth Bureau, Rochester, New York. Society for Adolescent Medicine, Seattle, WA, March 2003.

Contextual Data

The past decade has also witnessed significant progress in the development of contextual data indicators. Research has demonstrated that the social context in which people live affects their health above and beyond the effects of individual and family factors. For example, adolescents who live in impoverished neighborhoods or neighborhoods with a high percentage of single-parent households are more likely to become pregnant, regardless of whether the individual teen is poor or lives in a single-parent household. The development of Geographic Information Systems (GIS) has driven progress in contextual data. GIS can provide neighborhood-specific data on a wide range of social indicators. National efforts to support local use of GIS to enhance community-building endeavors include the National Neighborhood Indicators Project (NNIP), spearheaded by the Urban Institute in Washington, DC. The Baltimore Neighborhood Indicators Alliance (BNIA), an NNIP partner, provides an example of the range of data that GIS can provide. Neighborhood data available from BNIA include demographic features such as income, age, sex, racial/ethnic composition, and household/family composition; education statistics such as high school dropout and graduation rates; and a wide range of health measures, including hospitalizations, teen enrollment in drug/alcohol treatment programs, births to teenagers, and age-specific homicide rates.

Communities can use these data for many purposes, such as identifying strategies to coordinate neighborhood services more effectively. In developing adolescent health profiles, communities can use these data to better understand the context in which adolescents make health-related decisions. Contextual factors complement individual- and family-level data.

Using data to improve mental health services: An example from Oakland, California

In 1990, the Urban Strategies Council (USC) and the superintendent of the Oakland Unified School District recognized a common challenge: the school system and the city's array of social service agencies were not dealing with children comprehensively. Students' difficulties at school often emanated from problems at home, but the efforts of the schools and other agencies to help were fragmented and sometimes contradictory. Agencies usually became involved only at times of crisis rather than working coherently to address root causes of problems.

Recognizing its advanced data processing capabilities and the fact that it already had some of the relevant information on hand, USC secured, processed, and linked school and social agency data files for the students of one elementary school and their families. The results were presented to agency representatives in a 1991 meeting called "The Same Client." The overlap of service provision was striking, and it motivated agreement to conduct a similar study for additional schools. In 1992, USC published the results in the report "Partnership for Change." It showed that almost 2 of 3 students used public services, and more than a third used at least two different services. The report also documented that the system was investing significantly more in crisis services than in prevention and that there were important differences between racial groups in service needs as well as in actual provision of these services.

Study findings were presented to the county's board of supervisors and other high-level officials, but their most important use was for the creation of Oakland's Interagency Group, which USC convened and facilitated. The process established new working relationships among representatives of different agencies, as it forced them to recognize common challenges. To move forward, they had to "acquaint themselves with agencies outside their normal scope of work," and together "discuss the kinds of joint action they might undertake, patterns of service use, relationship among agencies, and the ultimate effectiveness of existing programs".

This process resulted in the idea of deploying staff from different agencies to form family support teams for individual schools. The teams would "develop new collaborative strategies for working



with troubled families, taking on the crisis situations most taxing for schools, and leaving school resources to be focused on prevention, on establishing more positive activities, and on outreach to parents." This concept has since been tested in several schools, and wider implementation is underway. USC continues to be involved in monitoring performance and providing ongoing guidance and support.

Adapted from: Urban Institute 1999

Creating a Community Adolescent Health Profile

A comprehensive local adolescent health profile includes data for the 21 Critical Health Objectives as well as measures of youth development and the environmental context—measures that have a strong influence on the health issues addressed by the 21 Critical Health Objectives. Communities need to develop a realistic plan for creating an adolescent health profile that is feasible given existing resources. Because of the limitations in official data sources for the 21 Critical Health Objectives, health officials must be careful in interpreting the national- and state-level statistics and rates provided by these sources. It is even more important to use caution when drawing on these data sources to create a local adolescent health profile. These examples serve to familiarize the reader with data issues and are not intended as comprehensive guidelines for using data. It is important to emphasize that despite their limitations, current data sources represent a significant improvement over the data available a decade ago and permit a greater understanding of adolescent health.

A sample adolescent health profile based on the official data sources for the 21 Critical Health Objectives is presented in Table 4-6. This sample profile reflects the reality that in many communities local measures may not be available for all 21 Critical Health Objectives. Still, the profile serves as a useful starting point. In addition to presenting figures for the 21 Critical Health Objectives, the table suggests some measures (and presents data) for adolescents' feelings of connectedness to family, school, and community. These measures complement the traditional "problem-focused" measures represented by the 21 Critical Health Objectives.

Using data locally: Multiyear indicators for vital statistics

It is relatively easy to obtain data for the five Critical Health Objectives that are measured by vital statistics (overall mortality, motor vehicle crashes mortality, homicide, suicide, births). In some cases, however, these events are relatively rare among adolescents at the local and sometimes the state level, which results in misleading or unreliable indicators. Even small changes in the number of births or deaths in such cases can change a rate dramatically. To adjust for these distortions, states and communities can calculate multiyear rates.

- The small size of many Kentucky counties makes it difficult to calculate valid county-level teen birth rates. Many of the state's 120 counties have less than 20 births to teens aged 15-17 each year. To adjust for these small numbers, the state calculates 3-year averages. In one county, 11 births in 1998 translated into a birth rate of 39.4/1,000 females aged 15-17. The same county had 35 births for 1996-1998, for a 3-year average birth rate of 46.8/1,000. State officials use the latter figure as the official county rate. Former state adolescent health coordinator John Webb notes that sometimes, when there are two or three births in one high school, for example, he receives calls from local health officials inquiring about the county birth rate. With the 3-year averages, the state can provide accurate rates, which allows local health officials to assess the extent of teen births and establish priorities and allocate resources accordingly.

Source: Personal Communication, May 2003; John Webb, Kentucky Department of Health.

Because many communities can focus on only one cluster or just a few Critical Health Objectives, having a local profile can guide a community's initial decisions on which of the Objectives to address. Chapters 5 and 6 focus on developing and implementing a local initiative for the Objectives selected. In selecting priority Objectives, communities may want to consider different criteria after reviewing the profile itself. For example, a community's profile might suggest that five Objectives warrant further attention because of their prevalence. Communities may consider the following questions in prioritizing those five:

- Which Critical Health Objective(s) is/are most likely to engage the community?
- Which Critical Health Objectives have the most salience for the community?
- Which would be the least divisive?
- How many adolescents are affected by the health issue? (For example, although the community's suicide rate might be very high compared to the national average, physical fighting probably affects more adolescents, even if the community estimate for that behavior is relatively low.)
- For which Objectives are resources (e.g., funding, staff support) already available?
- Would it be logical to address two or three Objectives that cluster (e.g., binge drinking and alcohol-related motor vehicle accidents; or pregnancy, Chlamydia, and HIV prevention)?

Communities should also consider the extent to which a collaborative process might be used in selecting priority Objectives. Because the adolescent health profile can be created with just a few staff people in the local health department, some may prefer to have those people select the Objectives. Others may solicit guidance from a larger group, (e.g., by convening a meeting of key community stakeholders). The next chapter addresses the topic of working collaboratively.

Local health profiles: An example for the general population.

The Community Health Status Indicators (CHSI) project illustrates one approach to developing a community health profile. In response to requests from local health department officials for county-level data, the federal Health Resources and Services Administration funded the CHSI collaboration among the Association of State and Territorial Health Officials, the National Association of County and City Health Officials, and the Public Health Foundation. CHSI developed and published health profiles for all 3,082 U.S. counties (available at www.communityhealth.hrsa.gov). CHSI is based on the premise that "community health improvement begins with an assessment of needs, quantification of vulnerable populations, and measurement of preventable disease, disability, and death." The county profiles use a broad spectrum of health indicators in the following areas:

<ul style="list-style-type: none"> • Population Characteristics • Four Summary Measures of Health • Leading Causes of Death • Measures of Birth and Death • Vulnerable Populations 	<ul style="list-style-type: none"> • Environmental Health • Preventive Services Use • Risk Factors for Premature Death • Access to Care
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To help local health officials identify priority areas, the CHSI Web site allows counties to compare their health indicators with *Healthy People 2010* targets, 1997 U.S. rates, and peer counties – counties that share characteristics of population size, density, age distribution, and poverty. The health profiles include some local estimates based on national and state data, including estimates of risk behaviors among adults based on the Behavioral Risk Factor Surveillance System.

Accountability to Funders

Both public and private funders are increasingly requiring organizations to demonstrate progress toward program goals. Funders, often in collaboration with grantees, establish indicators to measure such progress. Where progress is slow, funders may provide support to help organizations address perceived barriers. In some cases, funders may reduce funding or take more direct control over programs. The types of data collection that funders require vary considerably, as do their responses to lack of progress. It is worth noting, however, that many community organizations receiving support from government agencies (or private funders) may already be required to collect data on measures related to the 21 Critical Health Objectives. One example of data and accountability, the Title V Maternal and Child Health Block Grant Performance Measures, is presented in the text box.



**Using data to promote accountability:
Performance measures for the Maternal and Child Health Block Grant.**

The Title V Maternal and Child Health Block Grant (MCHBG), a federal-state partnership administered by the Health Resources and Services Administration's Maternal and Child Health Bureau, focuses broadly on promoting the health of women, children, youth, and families. Within broad funding guidelines, states can use MCHBG funds to meet locally determined needs that are consistent with their priorities. To improve monitoring of state MCHBG-funded programs, the Maternal and Child Health Bureau, in collaboration with states, developed a system of performance measures. States are required to report on 18 national (or "core") performance measures as well as 7-10 state-specific (or "state-negotiated") performance measures. By monitoring progress on these measures, the Maternal and Child Health Bureau and state MCH programs can hold themselves accountable for MCHBG funds. In part, the performance measures were developed in response to the Government Performance and Results Act (passed by Congress in 1993). The national and state-negotiated MCHBG measures include some measures related to adolescents. The overlap between the 21 Critical Health Objectives and core and state-negotiated performance measures monitored by MCHBG is shown in Table 4-5. More detailed information about MCHBG and the performance measures is available at <http://performance.hrsa.gov/mchb/mchreports>.

Table 4-5: Comparison of the 21 Critical Health Objectives and Title V Maternal and Child Health Performance Measures (PMs) and Developmental Health Status Indicators (HSIs) in 2002.

21 Critical Health Objectives	MCH PMs		HSIs
	National	State-Negotiated	
Mortality			
Motor vehicle fatalities		✓ (8)*	✓
Alcohol-drug-related motor vehicle fatalities & injuries			
Safety belt use			
Riding with drinking driver			
Suicides	✓	✓ (2 - prevention)	
Injurious suicide attempts		✓ (1)	
Homicides		✓ (2)	
Physical fighting		✓ (6 - includes intentional injury)	
Weapon carrying			
Binge drinking		✓ (11 - alcohol use)	
Use of marijuana		✓ (1 - substance use)	
Feeling sad, unhappy, or depressed			
Youth with mental health problems who receive treatment		✓ (2)	
Pregnancies among 15-17-year-olds	✓	✓ (13 - some address repeat pregnancy)	
HIV infection			
Chlamydia		✓ (6)	✓
Abstinence or used condom at last intercourse		✓ (2)	
Used any tobacco product		✓ (15)	✓
Overweight/obese		✓ (13)	
Vigorous physical activity			

✓ Indicates the presence of the respective Title V MCH PMs and HSIs, 2002.

*The numbers in parentheses indicate the number of states with this measure.

Source: <http://performance.hrsa.gov/mchb/mchreports/search/neg/negmenu.asp>

Summary

This chapter introduced topics related to the use of data for shaping an adolescent health initiative, familiarized the reader with adolescent health data sources for both the 21 Critical Health Objectives and broader measures of health and well-being, and offered guidance for creating a community adolescent health profile. Chapters 5 and 6 discuss uses of data in specific processes, including a needs-and-assets assessment and evaluation. In developing their adolescent health profiles, communities may identify limitations in their ability to gather data, which may include monitoring too few indicators (e.g., if only risk behaviors are measured) or not enough diversity in the adolescents surveyed (e.g., if only one small high school conducts a survey). As communities begin planning their initiatives to improve adolescent health, it may be helpful to develop strategies for identifying or developing data sources to address these limitations. For example, a community with no local surveys addressing the 21 Critical Health Objectives may want to explore administering such a survey in local high schools. Or a community with a large out-of-school adolescent population may want to develop strategies to reach that population so that their behavior is included in the comprehensive community profile.

In planning for long-term data needs, communities can also develop strategies for measuring youth development and the contextual factors that shape adolescents' environment. This chapter has presented existing surveys and sources for these broader measures of health, including state and local examples. At a minimum, states may benefit from conducting this initial review of their adolescent profile and comparing it with national measures for the 21 Critical Health Objectives, which highlight health issues meriting consideration. This document is intended to support communities in their next wave of efforts—working collaboratively with stakeholders both to focus on specific areas of need and to build opportunities for young people. The next chapters present specific steps and tools to help communities move their data into action.



Table 4-6: Hypothetical Adolescent Health Community Profile

2010 Objective	U.S. Baseline	2010 Target	Example of State Measure	Example of Community Measure
Reduce deaths of adolescents and young adults. (16-03 a,b,c) - 10-to 14-year-olds - 15-to 19-year-olds - 20-to 24-year-olds	21.5/100,000 (1998) 69.5/100,000 (1998) 92.7/100,000 (1998)	16.8/100,000 39.8/100,000 49.0/100,000		19.3/100,000 (1999) 67.4/100,000 (1999) 90.6/100,000 (1999)
Unintentional Injury				
Reduce deaths caused by motor vehicle crashes. (15-15 a)	25.6/100,000 (1999)	[1]		34.5/100,000 (1999)
Reduce deaths and injuries caused by alcohol- and drug-related motor vehicle crashes. (26-01 a)	13.5/100,000 (1998)	[1]		17.2/100,000 (1999)
Increase the use of safety belts. (15-19)	84% (1999)	92%	78% (1999)	72%
Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol. (26-06)	33% (1999)	30%	29% (1999)	Data unavailable.
Violence				
Reduce the suicide rate. (18-01) - 10-to 14-year-olds - 15-to 19-year-olds	1.2/100,000 (1999) 8.0/100,000 (1999)	[1] [1]		1.0/100,000 (1997) 9.0/100,000 (1997)
Reduce the rate of suicide attempts by adolescents that require medical attention. (18-02)	2.6% (1999)	1.0%	8% (1999)	Data unavailable.
Reduce homicides. (15-32) - 10-to 14-year-olds - 15-to 19-year-olds	1.2/100,000 (1999) 10.4/100,000 (1999)	[1] [1]	34% (1999) 7% (1999)	1.2/100,000 (1999) 8.0/100,000 (1999)
Reduce physical fighting among adolescents. (15-38)	36% (1999)	32%		Data unavailable.
Reduce weapon carrying by adolescents on school property. (15-39)	6.9% (1999)	4.9%		Data unavailable.
Substance Use				
Reduce the proportion of persons engaging in binge drinking of alcoholic beverages. (26-11d)	7.7% (1998)	2.0%	30% (1999)	5.2% (1997)
Reduce past-month use of illicit substances (marijuana). (26-10b)	8.3% (1998)	0.7%	22% (1999)	8.0% (1997)
Mental Health				
Reduce the proportion of children and adolescents with disabilities who are reported to be sad, unhappy, or depressed. (06-02)	[2]	[2]		Data unavailable.

2010 Objective	U.S. Baseline	2010 Target	Example of State Measure	Example of Community Measure
Reproductive Health				
Reduce pregnancies among adolescent females. (09-07)	68/1,000 females (1996)	43/1,000 females		62/1,000 females (1998)
Reduce the number of new HIV diagnoses among adolescents and adults. (13-05)—Developmental	16,479 (1998) [4]	[3]		Data are from 25 states with confidential, name-based HIV reporting prior to 1994.
Reduce the proportion of adolescents and young adults with <i>Chlamydia trachomatis</i> infections. (25-01 a, b, c)				
Females attending family planning clinics	5.0% (1997)	3.0%		4.0% (1998) 11.1% (1998)
Females attending STD clinics	12.2% (1997)	3.0%		14.9% (1998)
Males attending STD clinics	15.7% (1997)	3.0%		
Increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active. (25-11)	85% (1999)	95%	85% (1999)	82% (1997)
Chronic Disease Prevention				
Reduce tobacco use by adolescents. (27-02 a)	40% (1999)	21%	29% (1999)	43% (1997)
Reduce the proportion of children and adolescents who are overweight or obese. (19-03 b)	11% (1988-1994)	5%		17% (1997)
Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiovascular fitness 3 or more times/week for 20 minutes/occasion. (22-07)	65% (1999)	85%	84% (1999)	50% (1997)
Suggested additional measures:				
contextual				
▪ poverty rate	16.9% (1999)		10.1% (1999)	
▪ family structure	63.6% (1999)		69.6% (1999)	
▪ high school graduation rate	5.1% (1998-99)		3.1% (1998-99)	
family & school*				
▪ engagement in school	40.1% (1999)		43.5% (1999)	
▪ parental stress	9.9% (1999)		11.7% (1999)	

[1] 2010 target not provided for adolescent/young adult age group.

[2] Baseline and target inclusive of age groups outside of adolescent/young adult age parameters.

[3] Developmental objective – baseline and 2010 targets will be provided by 2004.

[4] Proposed baseline is shown, but has not yet been approved by the Healthy People 2010 Steering Committee.

* These two measures come from the National Survey of American Families (NSAF) conducted by the Urban Institute. NSAF measures were selected as examples of indicators with state-level data. This survey contains numerous other indicators from which to choose. For more documentation on these two measures and others contained in this survey please see the following Web site: <http://www.urban.org/content/Research/NewFederalism/NSAF/Snapshots/Snapshots.htm>.

CHAPTER 5



Getting Started

Contents

Coalition Building **page 3**

 Nature and Types of Coalitions **page 5**

 Forming the Coalition **page 6**

 Inviting Members **page 10**

 Creating a Mission Statement and Goals **page 10**

 Coalition stages **page 12**

 Making Collaborations Work **page 13**

Needs-and-Assets Assessments **page 18**

 Overview of Assessment Steps **page 22**

 Collecting the Information **page 28**

 Analyzing the Information **page 30**

 Sharing the Results **page 31**

Appendix 5-1: Sources of Local Data **page 36**

Worksheets 1-5 **page 38-51**



Chapter 4 reviewed the use of data in developing an adolescent health intervention. The next three chapters are designed to guide communities through the planning and implementation processes needed to develop, enhance, and expand programs and interventions.

Numerous resources are available for addressing the community planning process. These chapters are meant to serve as a starting point for communities undertaking an adolescent health initiative; more detailed information about the specifics of each step of the community planning process can be found in the other publications and resources listed in Chapter 8.

Chapter 5 focuses on the initial steps of program planning: coalition building and assessing needs and assets. Chapter 6 covers program planning (prioritizing and developing an action plan and program model), program monitoring, and evaluation. Chapter 7 covers communication, fundraising, and evaluation. The organization of these chapters is not intended to suggest a strictly linear process in program development and evaluation. For example, the section on coalition building precedes the needs-and-assets assessment section, even though these processes are interrelated and may take place concurrently. Or, a coalition might come together after a needs-and-assets assessment has been conducted and publicized by an existing agency, such as a health department.

Improving adolescent health from multiple levels is essential and should be reflected in all stages of program development, monitoring, and evaluation. We have delineated four levels of influence:

1. Individual/Family
2. School/Peers
3. Community
4. Policy/Society

These levels constantly interact. This multifaceted approach tries to account for the many factors that influence adolescent health. This document is guided by the principle that efforts to address young people's needs are more likely to occur with broad support from a wide array of partners. As discussed in Chapter 3, these partners include parents and families, schools, health care providers, community agencies that serve youth, faith-based organizations, media, postsecondary institutions, employers, and government agencies.

A youth development framework is essential for ensuring that adolescents adopt health-promoting behaviors. Youth development strategies enhance young people's confidence, competence, capacities, and citizenship in addition to increasing collaboration between adults and youth. The following sections present examples of how youth development practices can be employed as part of an adolescent health initiative.

Throughout the process of implementing adolescent health programs, it is important to remain realistic about what can be accomplished with available resources, which include time, personnel, funding, and level of community engagement. Communities that use this guide will have different goals and levels of expertise and experience. Organizations will spend varying amounts of time in program planning, monitoring, and evaluation. There is no "right" starting point for initiating or expanding an adolescent health initiative. An organization may begin focusing on adolescents after having a long-standing, exclusive focus on younger children. Perhaps an existing collaborative seeking to prevent teen substance use wants to expand its efforts to include violence because of the connections be-

tween the risk behaviors. Or, a sentinel event such as a teen's fatal, alcohol-related car crash may generate community interest in motor vehicle crashes and teenage drinking.

Political will and strong leadership are essential to meeting the 21 Critical Health Objectives for adolescents and young adults. Political will encompasses the community's willingness to recognize an existing problem and the community's conviction that change must take place. Leadership entails having the necessary vision, skills, and commitment to bring about this change.

Throughout the process of defining and implementing an adolescent health agenda, both experienced and inexperienced coalitions will encounter challenges, including lack of expertise, data, or resources; a sense of the daunting tasks they must face in order to successfully address the issue and make a difference; and competing occupational and personal demands. The challenges may seem overwhelming, but throughout this chapter, we recommend ways to address them. Reaching the 21 Critical Health Objectives for adolescents and young adults requires initiative, commitment, and the mobilization of diverse stakeholders and resources.

Coalition Building

Working with a coalition to improve adolescent health offers many advantages. As many of the 21 Critical Health Objectives are interrelated, integrating health issues within a collaborative framework can increase the chances of achieving larger goals. Ideally, working together will result in the delivery of consistent messages through multiple channels, more comprehensively reaching adolescents and the broader community. Coalitions present valuable opportunities for sharing the resources possessed by various people and groups, for developing joint goals and objectives, and for learning from the experiences of other groups. Effective collaboration decreases the likelihood of either duplicating or leaving out services, using resources inefficiently, and coordinating programs and services ineffectively. It also raises the likelihood that member organizations will work concurrently, as a group, at the four primary levels of influence on youth: individual/family, school/peers, community, and policy/society. An additional benefit to collaboration across sectors is greater inclusion of different viewpoints, experiences, and perspectives, which may make the coalition stronger and better able to gain the community's respect and trust.

Working in a coalition is not easy, however, and there are inherent challenges in planning and implementing programs as a group. Disagreements often arise in establishing project goals or strategies. Other potential challenges include turf and boundary issues between agencies and the competing demands of other worthy projects in the community. Disparate opinions and perspectives can sometimes immobilize a project; thus, groups should strive to find the right balance between diverse representation and having people who work well together. A community leader or agency might decide that working in a coalition at a particular time might not be the most effective use of available time and energy. Bringing in a wider range of stakeholders may be more fruitful at a later stage.

In getting started, it is important to recognize other efforts that are already under way in a community. This knowledge might help determine whether a new coalition is necessary or whether such an initiative would be better incorporated by existing efforts. The community probably already has individuals, coalitions, and organizations working on adolescent health issues and focusing on one or more of the 21 Critical Health Objectives. Thus, individuals or groups may choose to join an existing coalition, expand work currently under way, or launch a new coalition. If a new coalition is considered



the best route, it is respectful, diplomatic, and strategic to acknowledge existing groups. Joint efforts should be explored that might further leverage the groups' respective agendas. In some situations, one or two people (or their agencies) might initiate the most effective and appropriate action, later joining forces with a broader group of professionals and community representatives.

In considering whether a community needs to form a new group or redirect an existing effort, key players and organizations, assets in the community, and lessons learned from past projects should be identified. This background information can help in understanding how existing groups might perceive a new coalition and determine what kinds of relationships and alliances would strengthen new initiatives and avoid conflict.

Consider the following questions to help decide whether working as a coalition is the right choice and how best to proceed in meeting the needs of adolescents (see Worksheet 1 at the end of this chapter):

- What is the history and status of the 21 Critical Health Objectives for adolescents and young adults in the community?
- How does the community view these Objectives? What is the current political and social context in relation to the health issues covered by the Objectives?
- Who is concerned about and affected by these issues? Who has participated in the past? Who has not participated, and why haven't they been involved?
- What existing youth-focused groups or efforts address these issues? With which, if any, could we collaborate?
- Do we have sufficient information and resources?
- What information and resources (administrative, financial, and structural) do we currently have to work on this issue?
- What resources are we lacking?
- Does a current needs-and-assets assessment exist in the community?
- Do we need to conduct a needs-and-assets assessment specific to our selected Critical Objectives?
- Is working as a coalition the optimal option?
- Will working as a coalition help achieve goals that cannot be achieved independently?
- What are the pros and cons of working in a coalition or a collaborative right now?
- How official or formal do we want to be?
- Do we want to be identified with another organization working in this or a parallel area? Why or why not?
- What do we want to accomplish in the short term?
- Do we have a long-term goal? What do we want to accomplish in the future?

Note that various sources and groups define the terms "collaborative" and "coalition" differently. Throughout this guide, the terms are used interchangeably to mean a multisector group (consisting of private, public, and nonprofit organizations and community residents) that has come together to plan for community action toward meeting one or more of the Critical Objectives. Coalitions vary in size, duration, and activity. Ideally, the aims of a coalition are to plan, to bring new programs and activities to the community, to participate in evaluation, and to create longer-lasting, systems-level changes that encourage different sectors to better communicate and coordinate their work.

Nature and Types of Coalitions

Coalitions can take many forms, varying in such characteristics as structure and duration. The following list may help communities determine the form that best fits their needs.

Temporary Group

A temporary group may be an attractive solution if a relatively small task is to be accomplished and group leaders want the flexibility to decide later whether the group will become more permanent. This type of group might be convened solely to conduct a needs-and-assets assessment, or it might be convened as an advisory group for creating an action plan. Having the group be temporary may attract members who are apprehensive about committing to long timelines or intensive activities but who are able and willing to provide their expertise on a short-term basis. This type of group also allows for the composition of the group to change as the tasks change.

Subcommittee of an Existing Organization

A larger organization working on a wide set of issues might create a subgroup on adolescent health; in this arrangement, the parent organization exercises oversight. In some cases, the subgroup will develop activities to be carried out by the larger organization. Being part of the larger organization may give the group additional influence and resources, but it might also limit the activities it can undertake.

Expansion in Scope of an Existing Group

An already established group that is focused on youth (or the critical health issue the group wishes to address) and wants to expand its activities might represent an ideal platform from which to launch new adolescent health activities.

Agency- or Organization-based Coalition

A formally designated lead agency may establish a special coalition whose members include a diverse group of agencies and organizations. The coalition might have one primary sponsor or it may share sponsorship. Activities might include joint fundraising and collective policy development. One challenge with this type of structure might be the necessity of requiring individual members to obtain approval from their parent organizations to proceed—a process that may cause delays. Shared decision-making between organizations could also present complications. On the other hand, having multiple agencies work under one structure can facilitate the joint planning of new programs and better coordination of existing efforts.

Independent Coalition

An independent, private sector coalition is a more formal structure. It will likely include its own coordinator and staff to assure that the goals of the coalition emphasize convening a variety of individuals and community groups. Funding an independent coalition often depends on in-kind contributions and external fundraising. This type of coalition has the flexibility to implement a variety of strategies outside the purview of any one agency.

Government-mandated Group

Sometimes a legislature or governor decides on the type of group to establish. A government-initiated structure tends to be more formal than the other models and is generally created to carry out a specific set of goals and objectives. A group such as a governor's task force has specific responsibilities and often needs to report its results to a



governing organization. Timelines and funding for such efforts often depend on the elected leadership. Potential benefits stem from the highly visible nature of this structure and the public power and influence it wields because of its government sponsorship.

Forming the Coalition

The membership of the coalition should be designed strategically. Those responsible for this task should be mindful of the four levels in which change is desired: individual/family, school/peers, community, and policy/society. The coalition will benefit from having members who address or represent each of these areas. Correspondingly, it is important to maintain communication with teens and families, school administrators, the city council or board of supervisors, and any individuals involved in defining agency or community policies that affect adolescent health (see Figure 3 in Worksheet 1 at the end of the chapter).

Determining the most feasible group size, given a community or group's resources, and recognizing that the size of a coalition may change over time is also important. In the early stages of coalition development, it is common for a small steering committee to convene and formally consider the membership of the coalition (and how the coalition can complement other efforts under way in the community). It is helpful to first define the skills and resources needed to reach project goals, then develop a list of individuals who can contribute those skills and resources. For example, to complete the needs-and-assets assessment, it might be useful to have someone from a local university or research institute with data collection experience.

Members of the steering committee should determine whether they have existing relationships with people they would like to recruit or whether they will need to forge new connections. Individuals and agencies already working on the issue of interest, or those with a stake in adolescent health, are natural partners. Making master lists of the names of people who are already working on this issue as well as related networks and re-

CASE STUDY: *Working with diverse local partners can often yield innovative, mutually beneficial solutions.*

It is important to form partnerships with community stakeholders, including those not specifically focused on youth health.

The Chula Vista school district; the city of Chula Vista, California; the Sharp Chula Vista Medical Center (SCVMC); and another local hospital have teamed together to sponsor a mobile health clinic at five area schools with high absenteeism. The mobile clinic treats asthma and other health problems that have often kept pupils at home. The mobile clinic began after the assistant superintendent of schools found that certain schools with poor test scores also had poor attendance. He met the chief executive of SCVMC at a local Human Services Council meeting and found him concerned about uncollected medical bills for children without regular sources of health care; these children were using emergency rooms for nonurgent care. The two decision makers jointly created the mobile health clinic plan. The mobile clinic is tied to family centers (also located on school grounds) that help mothers learn English, enroll eligible children in various health plans, and work with families to maintain regular preventive health care for their children. In one participating school, three-quarters of the students now have health insurance, and the rest get free care at the mobile clinic. The mobile clinic is staffed by nurse practitioners and other nursing personnel who dispense medications and consult with the children's regular health care providers. The assistant superintendent believes that the mobile clinic has contributed to test score increases and other improvements in student learning, as well as yielding increases in attendance.

sources will be helpful. Similarly, it is helpful to consider who could extend the coalition's network to reach teens and families. To include teens, consider inviting members from a youth commission, a Boys and Girls Club, youth sport teams, and student government associations. Ideas for recruiting families include the school health councils, PTA/O, adult service clubs, and in small communities, notices posted in local food stores and libraries. Recruiting policy makers and representatives of any local philanthropic foundation is important for the coalition; their membership increases credibility and enhances potential funding opportunities once an intervention has been selected.

The following questions are useful for determining the composition of the coalition:

- What skills, information, and resources do we need?
- What assets already exist in the community?
- How are stakeholders reached?
- What services and expertise can other groups offer that this coalition cannot?
- What members of the community would help get the message across or bring credibility to the cause?

The committee should consider who has not been involved previously but would be an asset to the collaborative. It might think about how the health issue relates to other

CASE STUDY: *Involving youth in the coalition has numerous advantages.*

By encouraging youth involvement, a coalition can gain substantial credibility among various sectors of the community, especially young people themselves. Moreover, youth may provide valuable insights into how a particular problem manifests itself and devise effective, innovative solutions. Youth can improve a coalition's outreach and allow it to make inroads that may otherwise have been impossible. Finally, the process of involvement can be tremendously empowering to youth and provide them with leadership and advocacy skills that will benefit them in their future occupations and experiences.

The Coalition for a Drug-Free Greater Cincinnati (<http://www.drugfreecincinnati.org/>) is involved in promoting drug-free environments for youth and supporting anti-drug coalitions. It brings business leaders, parents, schools, law enforcement officials, and young people together to work on preventing substance abuse among youth. The coalition works through several task forces, such as the Media/Public Awareness Task Force and the Parent School Youth Task Force. The latter group directs the Student Congress, a 75-member body representing 23 communities. After monthly meetings, individual members return to their communities to try to implement environmental initiatives concerned with substance abuse prevention programs and policy development. In 1999, the Congress produced a Parents Survival Kit that included guides such as *The Top Ten Ways Teens Trick Their Parents*, *What Are the Signs and Symptoms?*, and *Teen Parties and the Law*. Finally, the Congress educated law enforcement officials about inconsistent enforcement of substance abuse laws.

Besides this task force involvement, local youth are able to participate in coalition activities by completing the Personal Drug Use Survey, which compares findings from previous local and national surveys. In 2002, almost 67,000 youth were surveyed to examine whether coalition activities are leading to decreases in substance abuse. The survey results were also used to show that parents can have a strong effect in preventing youth drug use. Potential of parental influence has helped launch the Strong Voices, Smart Choices campaign to help adults have age-appropriate conversations with young people about the dangers of substance use and abuse.



Forming a Coalition on Adolescent Mental Health (Illustrative Example)

A group in a university town decides to work towards **Critical Health Objective 18-07: Increase the proportion of children with mental health problems who receive treatment.** It has already conducted a needs-and-assets assessment and decided to develop a media campaign to both increase awareness and reduce stigma about mental health issues among adolescents in the community. Using the four-level framework of influences (individual/family, school/peers, community, and policy/society), it brainstorms answers to the following questions:

What skills, information, and resources do we need in our collaborative?

- Knowledge about different categories of mental disorders, and how they affect adolescents and families
- Information about the experiences and perspectives of youths with mental health disorders and their families
- Knowledge of mental health services in the community
- School time and access to students and families
- Social marketing media skills and access to different media channels
- Funding

What assets already exist in the community?

- Teachers
- Students at junior high schools, high schools, and universities
- Parent Teacher Associations
- School clubs and counselors
- Mental health care providers
- Health care providers
- Teen centers
- Local media
- Local chapter of National Mental Health Association

Which stakeholders need to be reached?

- Youth and parents
- Health care providers
- Teachers and school support staff
- Faith-based communities
- Media
- Social and community service clubs
- Youth-serving organizations

What services or options can other groups offer that this coalition cannot?

- Knowledge of mental health care policy (e.g., access to care, school funding for mental health programs)
- Connections with larger professional societies (e.g., medical and mental health associations) and academic institutions
- Marketing experience
- Funds
- In-kind staff (e.g., university and high school students interested in psychology, health, or journalism)

social systems (e.g., faith, business, juvenile justice, foster care) and invite representatives from these sectors to join. For example, it might consider recruiting members from the local business association if a goal is to prevent teen smoking and tobacco sales to minors.

Because of limited time or other constraints, some members will be more symbolic than active. Therefore, the committee needs to be creative in maximizing the time and resources that different people bring to the coalition. The committee might keep a list of potential

members and maintain regular communication with them, involving them at different stages. Project updates could be e-mailed periodically to interested and relevant parties to keep these key stakeholders involved.

To be inclusive, the committee might consider everyone who expresses an interest in joining. Understanding who they are, their perspectives and goals, and the compatibility of these goals with the coalition's mission is important. The committee might also consider the possible consequences of not including someone, such as alienating members of the community.

Finally, the committee might consider that when it extends an invitation to an organization it must accept the organization's choice for a representative.

Once specific people are identified to participate in the collaborative, the committee might consider:

- What can each potential member contribute? What unique perspective, resource, or experience does the person bring (e.g., staff time, money, space, allies, data, media relations, credibility, skills, community appeal)?
- Do individuals represent different constituent groups that can work towards strategies at the individual/family, school/peers, community, and policy/society levels?
- Is each potential member committed and able to work on the issue?
- Is the committee interested in the agency or the individual member? Is the member limited by agency obligations?
- Does the person representing each organization have the power to act on behalf of that organization? Does he/she need to get formal approval for major decisions made by the coalition? (If so, this step should be incorporated in the timeline.)
- Will certain organizations or individuals need incentives to join? What do they gain by joining the effort (e.g., increased skills, networking, access to policy makers)?
- What constitutes membership within the collaborative (are there different levels of membership, options of membership dues or in-kind contributions)?

Tips for Involving Youth:

- Include partners who respect youth and are willing to work with teens to sustain their engagement.
- Train adults in the skills needed to work with young people.
- Involve youth early in the planning of program goals and activities (e.g., creating a mission statement, conducting focus groups).
- Let teens guide the coalition's understanding of how young people think and feel about an initiative or strategy being developed.
- Provide youth with the training and guidance necessary to promote meaningful participation in the group.
- Encourage and train youth to be media and community spokespersons.
- Offer incentives, awards, salary, or recognition for the work teens do for the organization or collaborative.
- Consider what specific strategies young people can undertake that affect their peers (e.g., being a peer educator), their families, and their schools and communities (e.g., working on policy changes).

Adapted from National Campaign to Prevent Teen Pregnancy 2000



Once a list of members has been compiled, the committee can consider the overall mix of the coalition. It is important to have diversity in individuals, backgrounds, and perspectives while ensuring that the group will be able to work well together. The involvement of young people and families is highly valuable. Involving youth will strengthen the coalition's understanding of youth perspectives on programs, projects, and strategy development. It is important not to underestimate the knowledge, experience, and ideas of young people and their potential contributions.

Inviting Members

When extending an invitation to join the coalition, meeting with potential members individually provides those persons with an opportunity to share their concerns and priority issues. It also presents an opportunity to express the importance of the collaborative, the timeliness, and relevance of the issue of interest and what the group has accomplished or aims to accomplish. Good relationships are often instrumental in gaining support—whether in the form of coalition membership, political support, or funding. When approaching individuals who may be reluctant to join, come prepared with talking points that clearly state why adolescent health should be a priority and how the health of the community's adolescents directly affects that stakeholder. Another option is to have a well-respected or well-known person (e.g., local elected official, advocate or concerned celebrity) write or sign an invitational letter.

Invitation Strategies

The coalition could also do the following:

- Plan an exciting introductory meeting that will motivate people to attend (e.g., kick off luncheon, inspirational speaker, panel discussion).
- Send an invitational letter to potential members. This letters should:
 - Be explicit about the goals of the first meeting and include the agenda.
 - Incorporate a local case study or local statistics to illustrate the impact of the adolescent health issues in the community. Include a youth perspective.
 - Include background information on the issue(s) (e.g., fact sheets, results of a needs assessment, other community data).
 - Include a short biographical paragraph about each current coalition member.
 - Emphasize why the coalition wants the potential members' involvement and why they are important.
- If invitees do not accept at first, the coalition could ask if someone else in the organization is interested. If the invitees would like to be on the mailing list, the coalition could offer to check on their availability and interest later (perhaps after a plan of action has been established).

Creating a Mission Statement and Goals

A mission statement broadly describes a coalition's core principles and purpose. The goals and objectives identified for the coalition's specific intervention should be consistent with its overall mission. Group leaders may decide that all members should be involved in creating a mission statement or may find it more effective to have a group draft one for others to review. Youth should always be involved when drafting or revising the group's mission statement.

Collaborative Decision-making Processes

To assure that the coalition will work effectively as a group, members must establish governance and decision-making processes. Aim to create an open environment that engenders trust and makes people feel comfortable expressing themselves. Early on, establish processes to reach resolution and address disagreements. Neglecting to formalize decision-making processes from the start will likely cause problems later. Depending on the size and diversity of opinion among the group, decision-making processes can range from informal to very formal; possibilities include decision by majority rule and consensus.

Majority Rule

When using majority rule, decisions are made by voting or polling after some discussion. If the majority is in favor, its vote is accepted as a decision. The facilitator must allow adequate time for discussion from a variety of viewpoints. The group may adopt formal rules of conduct, such as *Robert's Rules of Order*, if desired.

- Simple majority: a vote of more than 50% of those present is required to pass a motion.
- Super majority: a vote of either 60% or two-thirds of those present is required to pass a motion.

Consensus

Consensus is not the same as unanimity; it is the arrival at a decision that each member can accept. This is one of the most time-consuming methods because it involves every member. It is also an approach for exposing and exploring conflicting viewpoints before making a decision.

- General consensus: almost everyone has to agree, but there may be one or a very small number of people who are not completely comfortable with the decision.
- Total consensus: absolutely everyone has to agree. A single person can be a “holdout,” and here the group must continue to discuss the matter until the person agrees with the decision or until changes are made that make the outcome acceptable to the holdout. This method requires a high level of trust within the group and a very skilled facilitator.

Brindis 1991

When defining their mission statements, coalitions can be encouraged to:

- Be inclusive and encourage all members to contribute.
- Allow a generous amount of time to brainstorm and discuss thoughts and ideas.
- Identify common themes and combine ideas.
- Refine the statement until there is consensus among the group.
- Finalize the statement after sharing it with other coalition members or partners.

A coalition's mission is distinct from its individual goals. Goals help to lay a strong organizational foundation. More challenging and long-term goals may need to be broken down into smaller steps. Due to the nature of collaborative work, it is likely that goals for the coalition will change over time. For example, simply establishing a coalition might be an immediate goal. The next goal might be to conduct a comprehensive needs-and-assets assessment—its findings will help the coalition decide on its next steps. It is important to note that the coalition's goals at this point are different from its goals and objectives developed



Creating a Mission Statement for the “Coalition for Active Youth”

(This is a fictitious scenario for illustrative purposes.)

The mission of the Coalition for Active Youth is to reduce obesity and increase physical activity among young people in the community. This example refers to the following Critical Health Objectives:

- Reduce the proportion of children and adolescents who are overweight or obese. (Critical Health Objective 19-03)
- Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion. (Critical Health Objective 22-07)

(Note: As many of the Critical Health Objectives are closely related, it often makes sense to focus on a cluster of objectives. The Coalition for Active Youth example focuses on two Critical Health Objectives because they are interrelated: An integral aspect of reducing the number of teens who are overweight or obese is increasing physical activity levels among young people.)

A sample mission statement for the Coalition for Active Youth would be:

- Finalize the statement after sharing it with other coalition members or partners.
- “The Coalition for Active Youth supports adolescents and their families in achieving a healthy weight and increasing participation in physical activities.”

The Coalition for Active Youth will later develop its goals, which are more specific:

Long-term goals:

- Implement a community-wide health education campaign focused on improving teens’ and adults’ knowledge levels on healthy eating and the importance of regular physical activity.
- Create environments that encourage and support physical activity among community members by, for example, improving the safety and facilities at a centrally located park.
- Collaborate with schools to offer affordable low-fat snacks and lunch items, including fresh fruits and vegetables.

Short-term goals:

- Conduct a needs-and-assets assessment to help determine what strategies should be implemented to address high obesity rates and low physical activity levels among teens.
- Hold teen focus groups to discuss their concerns regarding body image and obesity, their needs, and the services they desire for the community.
- Survey teens and their families on their eating and exercise habits.

(Note: It is important for a coalition to be aware of overloading itself with too many goals and spreading itself too thinly. Coalitions may want to decide on a realistic, but comprehensive, set of short- and long-term goals instead of taking on a larger set of goals.)

later. At this early stage the coalition’s goals should refer to the activities it will undertake to keep its efforts focused.

Coalition Stages

Once membership and operational issues (e.g., frequency of meetings, decision-making processes, and governance structures) are established, the coalition will likely undergo a natural progression in its development. The following paragraphs briefly discuss these stages.

Coalitions may be advised to plan for dealing with the possible challenges inherent in each phase.

Understanding the stages of a coalition can assist members in addressing challenges when they arise. Coalitions rarely proceed through these stages sequentially, and aspects of each stage may need to be revisited at any given time. Strong coalitions will have the flexibility to respond rapidly to changing realities, and they should recruit new members as appropriate (e.g., when new resources such as individual and organizational skills are needed).

Early Stage: Initial mobilization and establishment of organizational structure

In this stage, generally a group of people come together who share common beliefs and goals. At first, the group may function informally in terms of goals, agenda, and membership. Challenges often encountered include insufficient staff or resources, limited power and authority, and struggle over which directions to pursue. At the end of this stage, the coalition has generally begun to establish the structure needed to proceed.

Middle Stage: Building capacity for action and implementation of interventions

During this stage, the coalition establishes a sense of stability, with some staff and other resources available on a more regular basis. The coalition further defines its committee structure, and membership may be expanded. Challenges can emerge as the initial euphoria of finding a common cause gives way to the reality of the size and complexity of the task. Other problems might include insufficient resources, burnout and frustration of key players, and disagreements about policies and activities.

Late Stage: Refinement of interventions and possible institutionalization of coalition

The coalition establishes a relatively permanent staff and secures financial resources during this stage. Membership also becomes more stable, and a more elaborate organizational structure may develop. A broad recognition of the coalition as a major stakeholder within the community is also established. This phase is difficult to achieve, and a fully developed coalition needs relatively stable sources of funds to sustain and pursue its goals. It also needs to be independent enough to pursue its own agenda. Challenges encountered at this point include obtaining the necessary resources, gaining access to and influencing other key decision makers, sustaining the enthusiasm of the stakeholders, and maintaining the effort. For coalitions that do not want to be institutionalized, this stage would mean completing the final project and dissolving the coalition.

Making Collaborations Work

Coalitions will undoubtedly encounter challenges in trying to achieve the 21 Critical Health Objectives. To overcome them, a coalition should continually re-evaluate its structure, implementation of the project, and group processes and dynamics. When challenges arise, the coalition should examine the root of the problem. Revisiting the mission statement, action plan, and other accomplishments may be required. Focusing on ways to maintain the group's initial momentum and energy and not fearing the restructuring of the coalition or its work are crucial to success. For an example of an assessment form that can be used to evaluate the coalition and how it functions, see Worksheet 2 at the end of this chapter.

The following nine items are important ingredients for managing and maintaining a healthy and productive coalition:



1. Create a positive and motivating mission.

A motivating mission or vision for what the coalition wants to accomplish will help the group when challenges arise (e.g., a feeling that project work is stagnant or frustrating). Having an unclear purpose, goal, or vision might send the coalition in unplanned and unwanted directions. For instance, if the initial goal was to implement action, but recent meetings seem to have turned the coalition into simply a discussion group, there may be a disconnect between the original mission and current action.

The mission statement may need to be refined as time goes on. For example, once work begins on the issue, the coalition may find that what it originally believed to be the most effective course of action or focus has changed. Working in a coalition is a continual process of action and reflection, and there should be flexibility to restructure and change focus as knowledge and experience are gained.

2. Establish strong management and leadership.

Selecting a leader or a core group that will initiate coalition processes, such as a steering committee or a lead agency with a coordinator, is crucial. This action is especially important for larger groups and helps in establishing responsibilities, timelines, and next steps. Unclear and unrealistic expectations often result in frustration, lost motivation, and miscommunication. Over time, leadership can be defined and consistent or it may be shared and rotated.

Leadership roles include:

- Encouraging participation and contributions from all members.
- Structuring fair and productive group interactions.
- Negotiating among organizations and individuals with diverse agendas.
- Maintaining enthusiasm through good and bad times.

3. Respect the community.

Respect for the community norms, trying to understand the community, and involving its members are all critical in advancing the National Initiative. Not involving key community members and appearing exclusive will likely create distrust and cause alienation. The coalition should determine how community interest and support can be garnered and how controversial issues can be handled in a respectful manner. It will take time to establish credibility and gain the trust of the community. If the coalition encounters conflict and resistance, it should not lose sight of the young people and the health issue at the heart of its work.

4. Establish clear ground rules and policies.

Generally, establishing ground rules (e.g., how to conduct meetings, create records/minutes, make decisions, and work with media) will avoid future confusion. Members of the coalition can take turns leading, facilitating, or hosting meetings if appropriate. They might also consider rotating meeting places and times. Over time, the group will integrate what works best for coalition members.

Differences in views are inevitable, and thus it is important to create an open environment where people feel comfortable expressing themselves. Early on, the group should establish processes for reaching resolution and addressing disagreements. Neglecting to formalize decision making processes from the start will likely cause later problems. The coalition can review these processes as time moves forward and adjust them as necessary.

5. Create a clear action plan.

Once an action plan has been developed to reach the 21 Critical Health Objectives for adolescents and young adults, it is important to be explicit about who will do what, how it will be done, and by when. Not assigning responsibilities or deadlines for action will likely cause confusion and project delays. Building in predetermined evaluation processes (e.g., biyearly reviews of progress made) is beneficial in monitoring accomplishments.

The coalition should address the planned agenda and analyze the effectiveness of its actions. If a review demonstrates little action, the coalition can consider what factors have contributed to the limited success and rethink future strategies. If work has been successful, it is also important to assess what factors contributed to this success.

6. Validate and respect members and staff.

As in all group processes, interpersonal relationships are critical. Common challenges include the politics/territoriality of individual group members, conflicting loyalties, vested interests, and difficult past or current relationships (organizational or personal). Respecting the familial, personal, and professional obligations of each member of the coalition is vital, as is working to ensure that coalition roles and obligations are appropriate.

Common mistakes when organizing a coalition:

- Neglecting to involve (or at least advise) key people in the community about the group.
- Spending too long (e.g., 6 months) trying to define the group's purpose.
- Beginning with a needs assessment study that takes a year, precluding other decisions or actions from taking place.
- Becoming preoccupied with organizational structure, including bylaws, without working on the actual agenda of the group.
- Developing a great plan but neglecting to assign responsibility for carrying it out.
- Neglecting to assign deadlines or at least target dates.
- Failing to develop the ability to deal with hard issues, such as group leadership and agency "turf."
- Turning into a discussion rather than an action group.
- Failing to build in a process for self-evaluation.
- Losing sight of the young people the group is supposed to serve.
- Allowing only a vocal minority to dictate policy or action; in other words, failing to engage all sectors of the community.
- Taking on a highly controversial strategy before developing credibility in the community.
- Allowing one agency to dominate or control the group.
- Failing to rotate members off the board of directors.
- Failing to establish decision-making rules.
- Trying to achieve 100% agreement on every decision or issue.



It is important to allow time for meaningful discussion so that people feel they are being heard. Responding actively to concerns when issues are raised and determining what needs to be done next are all crucial to maintaining a healthy coalition. Validation of members' feelings and beliefs will help sustain motivation. Even if there are no obvious communication or interpersonal problems, evaluating the coalition from time to time using a process perspective is important (Are the group members feeling validated, useful, and respected? Do they understand their and others' roles? How often are group meetings held? Who decides? How well is information being shared? Do members feel a sense of ownership?).

7. *Address administrative barriers.*

Administrative barriers such as inadequate staff support or funding may cause tension or stagnation, making the coalition less productive. It is important to recognize the relationship between administrative barriers and project work, discuss these barriers, and do what is possible to address them.

There may be times when the coalition needs outside guidance or resources to address issues or problems; it is important to ask for and accept help when necessary.

8. *Encourage group cohesion.*

The coalition should encourage the formation of relationships both within the coalition and in the community. Keeping people motivated about the project and the coalition's efforts is important. Failing to have fun and celebrate successes will increase the chances of coalition work feeling like "just another meeting."

9. *Set realistic expectations and goals.*

Frustration and impatience in meeting short- or long-term goals is a common problem. It might be better to successfully meet smaller goals than to set coalition goals extremely high. Build on successes as the coalition strives to achieve the next set of goals and objectives. Conducting periodic reviews of accomplishments (e.g., semiannually) is important, as is having explicit, achievable goals for each meeting so that accomplishments are easy to measure.

Summary

There are significant challenges in establishing a collaborative effort that focuses on specific aspects of adolescent health. The sheer complexity of meeting any of the 21 Critical Health Objectives for adolescents and young adults requires a concerted effort to mobilize a wide variety of community resources. By bringing together a diverse, representative group of committed individuals and agencies that can work in concert, a community can increase its likelihood of success, especially if the coalition adopts multi-level strategies.

This overview raises some of the issues to be considered in developing a new collaborative structure or building on an existing one. Coalition leaders may wish to explore these topics further with others in their community to increase the likelihood of success for their collaborative efforts.

Once the coalition's membership has been established, processes have been identified to support effective group functioning, and a mission and goals have been identified, the group is ready to move to the next step. If a needs-and-assets assessment has not already been completed in the community, the coalition will need to conduct one to guide its future efforts. The following section describes how to assess community needs and

assets and how to use this information to further mobilize the community and create an effective action plan.

EAT RIGHT COALITION CASE STUDY

(This fictitious example is woven into the document for illustrative purposes.)

How Coalitions Are Formed

The Eat Right Coalition (ERC) was formed when local public health department officials in a predominantly poor, rural town of 40,000 received numerous comments from area family practice physicians about an alarming increase in the number of overweight and obese adolescents in their practices. These physicians estimated that the number of overweight children attending their practice had doubled during the past 5 years. When six popular practitioners were asked by the health department to perform an informal inventory from their patient records, they found that the number of overweight adolescents in their practice had increased by 30% over the past 3 years. After informally speaking with area teachers, religious leaders, and police, health officials found that those groups, too, had made these observations. Teachers had noticed fewer youth engaging in outdoor activities and instead playing video games; clergy had noticed more overweight teens attending Sunday morning services; and police had seen fewer children playing outside and more young people “hanging out” at local fast-food restaurants. The combination of these different indicators reflecting the same theme convinced the health department of the need to create a community coalition that would address the issue of childhood obesity. It decided to form the ERC.

Before moving further, health department personnel believed it would be best to invite local residents to be involved in the coalition. They decided not to have restrictive criteria for involvement, instead accepting everyone who wanted to be included and permitting them to participate according to their interest, ability, and availability. Over the next several months, they targeted businesses, local policy makers, parents, schools, youth-serving organizations, the media, health care personnel, and youth themselves to attend introductory meetings. In making these overtures, several strategies were employed:

- All community members perceived as vital to the coalition received formal invitation letters; these persons included the mayor, local school board members, local physicians and health officials, PTA leaders, business leaders, clergy, and members of teachers' unions. After explaining the coalition's background, the invitation implored potential participants to help create and guide the coalition's activities. It stressed that the coalition was in its inception and stated that reducing childhood obesity was its only goal. Most importantly, it emphasized how relevant the issue of childhood obesity was to all community residents. It asked them to pass the invitation to other people they believed would also be important to involve.
- Whenever possible, influential community leaders and decision makers were called personally and invited to attend the introductory meetings.
- Advertisements for the meetings were published in local newspapers, and the local news station ran a story about childhood obesity that mentioned ERC as a contact. In addition, numerous flyers were posted around the town, many near schools, library branches, and area businesses.
- Young people perceived as leaders or as influential (e.g., members of student councils, sports teams, and various school groups) in each of the town's high schools and middle schools received formal invitations. Coalition members also asked physical education teachers, health teachers, and school counselors to recommend students.

Two months later, the first meeting took place at a local high school cafeteria. Among the approximately 80 attendees were clergy, school principals, youth, school board



members, health care personnel, and many parents. The mayor sent a letter expressing support. Several members of the initial start-up group (e.g., physicians, members of the health department) had prepared a slide presentation detailing their findings and concerns. Numerous teachers and several prominent officials had been asked to offer their personal perspective about how the community had been affected by this problem. After the presentations, a spirited town meeting took place about the next course of action. Some speakers thought that steps must be taken immediately to restrict the amount of unhealthy snack food in schools. Others believed a community-wide exercise campaign would be the best course. Many attendees were not even convinced there was a real problem and argued that community efforts should be focused on the larger socioeconomic issues affecting the entire area.

Through a series of discussions, it was decided that the most appropriate course of action would be to form a grants committee that would seek funds to perform a local needs assessment. Because the health department director had experience with nutritional programs, she wanted the needs assessment and the coalition's other activities to focus initially on addressing healthy eating, adding an exercise component later. The needs assessment would detail the number of obese schoolchildren and what they ate, what they wanted to eat, where they are, and what they knew about healthy eating. It would also look at the number and types of existing programs working to alleviate the obesity problem, factors that promoted this problem, and best practices and strategies employed elsewhere to address the issue. The health department formed a grants committee of existing personnel that would be involved in applying for grant funds.

Another small committee, the assessment group, was formed to spearhead the needs-and-assets assessment process. It would focus on general community assessment and research. It was charged to design the needs-and-assets assessment and to formulate the specific questions. It was composed of volunteer health department staff, local researchers with experience in data collection, and other interested individuals. Community youth were also invited to be trained for the information gathering process (e.g., interviewing, data collection). They were to receive extra credit for participating as they learned these research skills. All other audience members would be kept on a mailing list and regularly updated on the coalition's activities. Another series of meetings were to be held after the completion of the needs assessment for presenting the key findings, considering what priorities to establish, and deciding what types of intervention strategies should be pursued.

Needs-and-Assets Assessments

Before conducting a needs assessment, a community should have already determined which clusters of the 21 Critical Health Objectives for adolescents and young adults it wishes to address. To further refine its efforts, the coalition will need to gather more in-depth information related to those Critical Health Objectives. A needs-and-assets assessment can help the coalition have a clearer understanding of what antecedent factors are related to its selected Critical Health Objectives, how the community perceives the problems, and what resources and assets exist within the community to help address the problems.

Conducting a needs-and-assets assessment is the process of gathering and analyzing information to better understand the context surrounding specific health issues. More specifically, this process examines the social, environmental, and political factors that contribute to the health issues prevalent among a defined population or in a geographic area. The assessment forms the basis for program planning, monitoring, and evaluation. It yields specific information about the health status and resources in a community—information that can help communities use resources most effectively. The assessment is

also a way to engage communities in defining their own health agenda and shaping solutions.

A community-oriented assessment emphasizes a community's assets, not just its needs. **Assets** are resources available to individuals, groups, and communities that improve the health of a designated population. People, places, organizations, funding, and material goods are all community assets. Communities might already have many assets and resources that can be mobilized to address the 21 Critical Health Objectives. For example, existing PTA groups, teachers' associations, and youth councils can participate in or offer resources to an adolescent health initiative. A **need** is a problem or lack of resources that either indicates or leads to negative outcomes for a community or group. A need can exist at the individual, institutional, or community level. For example, adolescents in a community might be engaging in very little physical activity, schools might lack funding to offer adequate physical education, or neighborhoods might lack parks and recreation facilities.

A needs-and-assets assessment encourages community involvement in designing, implementing, analyzing, and presenting the information gathered about the community. Ideally, a community invested in long-term change will conduct a needs-and-assets assessment every 3 to 5 years to gauge its progress and identify emerging needs.

Purpose

The needs-and-assets assessment is a multistage process of collecting, analyzing, and presenting information. Its purpose is to answer the following questions:

- What are the extent and scope of a problem in a community?
- Are there demographic groups and geographic areas with relatively greater need around selected problems?
- What are local perceptions of the problem?
- What causes the problem, and how might it be prevented?
- What is the current knowledge about "what works" in addressing a particular health issue?
- What current efforts are under way to address that problem?
- What gaps are there in existing services?
- What community capacities and strengths exist, and how can they be mobilized?

With this information, practitioners, policy makers, and community members can identify priority issues and measure how well the community is meeting the needs of its young people. The assessment can also point toward areas for improvement and effective strategies and interventions.

Using data and quantifiable information, the needs-and-assets assessment helps provide an objective picture of a community's health status. Perhaps teens in the community are becoming involved in alcohol-related traffic crashes more frequently; an assessment showing that the rate of drinking and driving among community adolescents is higher than state and national rates establishes the existence of a problem and helps mobilize the community. Such data also demonstrate to potential funders the extent of need in the community. Similarly, a needs-and-assets assessment can quantify the types and amount of services available and the extent to which those services are meeting the needs of adolescents. Collecting data on the health of adolescents and available resources can also serve as a baseline from which progress can be measured after an intervention has been implemented.



The needs-and-assets assessment also provides a subjective view of the community and its health concerns from the perspectives of many stakeholders, including families, policy makers, school officials, the medical community, and adolescents themselves. Gathering these multiple perspectives sheds light on how the community defines the problem and what factors affect the Critical Health Objectives being assessed. Knowledge gained about these factors will help the coalition determine which strategies are most appropriate for addressing its selected Critical Health Objectives. Furthermore, stakeholders are more likely to “buy in” to an adolescent health initiative if they can provide input, ideas, and opinions.

Tips for Conducting a Needs-and-Assets Assessment

Carefully define the parameters of the community:

Before getting started, it is important to define the community that will be assessed. A community can be defined along political, geographic, or social boundaries. Groups undertaking an assessment might define their community by school district or county but make comparisons across zip codes, race/ethnicity and age groups. However narrow or broad the definition of the community, those conducting the assessment must be clear about its parameters from the outset.

Involve young people in the assessment process:

It is important to give youth an opportunity to create their own definitions of the problems they face and identify their own assets and priorities. When adults speak for teens without soliciting their input, they risk designing interventions that do not resonate with youth. Involving young people in the assessment helps recognize and mobilize their strengths and assets. Youth can help design the questions or data collection instruments, collect and interpret data, and present the findings. By participating, they learn important skills in research, community organizing, public speaking, and community planning.

Actively engage community members:

The coalition should establish a “learning community” environment in which communities affirm and celebrate their strengths and assets while recognizing their responsibility to address problems and lessen any disparities. Involving community members and groups in the data-gathering process helps create a sense of ownership, which will likely encourage mobilization and stir positive excitement. Active community representation is integral to creating a successful intervention and makes its sustainability more likely. The adolescent health issue must be “owned” by the community and not be seen as a problem manufactured by outsiders. Conducting an assessment presents a real opportunity to develop a trusting relationship between a coalition and the community, as it demonstrates and reinforces the coalition’s dedication and interest. Involving a diverse group of community members and stakeholders is also an excellent opportunity to inform and educate one another regarding the community’s needs, gaps in services, and available assets.

Emphasize community assets:

Emphasizing community assets helps to avoid “reinventing the wheel” and engages people and resources that may be undervalued or underused. Focusing on assets also encourages residents to take pride in improvements. This approach also treats residents as agents in control of issues faced by the community and active shapers of solutions rather than passive clients or receivers of services.

Obtain the cooperation of key stakeholders:

Gaining the support of key stakeholders in the assessment can help build consensus around an adolescent health initiative. With the cooperation of stakeholders such as parents, school administrators, and other formal and informal community leaders, the coalition will gain better access to important data and information. Involving stakeholders in the assessment process also helps forge relationships that will be important in the planning and implementation phase.

Collect data at each of the four levels:

The coalition is encouraged to structure its assessment according to the four levels of influence: individual/family, school/peers, community, and policy/society. The assessment should determine the scope of the problem at each level and how it is viewed there. The assessment should also examine current efforts to address the problem at each level and how those efforts can be improved. Representatives from each level should be on the coalition or actively engaged in conducting the assessment.

Determine what data are already available:

Before beginning data collection, it is important to determine whether other groups have conducted an assessment in the community. If the information is still current and has been collected and reported accurately, it can be used. Groups can then focus on supplementing the information with new data. This step also helps avoid surveying community members and health care providers repeatedly about an issue.

Be prepared to spend a fair amount of time:

Communities should be prepared to spend a fair amount of time on the project. The coalition must collect enough data and engage enough stakeholders to obtain meaningful findings, but it should be realistic about what can be accomplished with the time, staffing, funding, and other resources available. Partnering with other organizations or local universities is a way to maximize resources. Coalitions might also consider conducting the assessment in a specific neighborhood, with a specific population, or on a specific health issue. It is much better to scale back and undertake a manageable project than to try to accomplish an enormous amount in a little time.

Be sensitive to community reaction:

Because communities can feel as though they are under a microscope during a needs-and-assets assessment, it is important to frame the assessment in terms of its ultimate benefits to the community, including its value in helping the community's voice be heard. All communities include groups with diverse interests and perspectives, so that the coalition should frame findings in an objective and noninflammatory way. Still, the coalition should not shy away from important issues simply because of disagreement; debate can lead to innovative solutions. "Hot" issues uncovered by a needs assessment might provide the coalition with a focus for its adolescent health initiative.

Consider using consultants:

For a thorough community assessment, a coalition may want to consider hiring an outside consultant, which might make the assessment seem more objective. On the other hand, an outside consultant will have less knowledge of the community's history, politics, and important contacts. If resources allow, the coalition can hire a consultant to coordinate the data gathering or needs assessment processes; assist in determining the scope of the needs assessment and research questions; select methodologies; review existing guidelines, best practices and evidence-based programs; train and supervise community members to collect data; and analyze data and present the results. It may



not be necessary to hire a consultant if the community decides to conduct a brief needs assessment or if there are alternatives, such as partnering with a university, community, or agency representatives.

Overview of Assessment Steps

Recruiting Team Members

The National Initiative encourages people to build partnerships within their communities, and joining with a variety of stakeholders. Having broad partnerships will help yield more meaningful and comprehensive findings, because the persons involved in data collection influence the scope and depth of the assessment. Involving community leaders as well as experts in data collection broadens the scope of the persons who commit themselves to the assessment process and the action plan that will follow.

It is important to be strategic when assembling the assessment team by thinking about the tasks to be completed, the skills (e.g., survey design, data analysis, report writing) and resources (e.g., access to young people and community residents) necessary, and whether current coalition members bring these skills and resources. The coalition might begin by developing a list of individuals and organizations that can provide these skills and resources (see Worksheet 3 at the end of this chapter). These individuals and organizations might bring strengths to a range of tasks, such as obtaining permission to survey young people at school, designing interview questions, photocopying the report, or publishing an article about the assessment in the newspaper. Clearly, the assessment team must be a diverse group, composed, for example, of a school board member, graduate students from a local university, a reporter, and a local businessperson.

Involving community residents, both young people and adults, can benefit the community by affirming their diverse assets and teaching them about the principles and techniques of social inquiry. By participating in the assessment, community members learn to collect, interpret, and use data to support their perceptions and ideas for future efforts on behalf of the community. Involving community members also facilitates data collection by increasing access to, and building trust within, the community. For example, a community leader might be more successful than a service provider in convening a group of parents for a focus group. Inclusiveness also strengthens coalitions and helps them develop relationships with others interested in the Critical Health Objectives. Individuals involved in the data gathering will likely need training in conducting interviews and focus groups, ensuring confidentiality, interpreting data, and presenting findings.

It is important to “get the team on board” before starting the assessment. Convening small meetings with key stakeholders or conducting one-on-one interviews with them will help the coalition build relationships and get a sense of how it wants to focus the assessment. These meetings might also shed light on potential community politics around adolescent health and on turf issues concerning resources for young people. Names of key informants and key sources of data may emerge from these meetings. This initial relationship building will also be a first step in defining the scope of the needs assessment, as those conducting it start to learn what data have already been gathered and what other assessments related to adolescent health have been completed.

Once recruited, community members and stakeholders should participate in the entire process, from defining the scope of the assessment to collecting the data, presenting the findings, and translating findings into actions. Once the assessment team takes shape, it is advisable for the group to work out certain logistics and understand the roles and responsibilities of team members. For example:

- Who will contact schools, program directors, city or county officials, and other sources of information or possible partners?
- Who will head the data collection process, either as an internal expert or by finding and hiring a consultant?
- What level of funding is necessary to conduct the assessment? What in-kind contributions can be used (for example, existing staff)?
- If necessary, who will manage or seek funding to carry out the assessment process?
- What types of training or skills development are needed to conduct this assessment?

In addition to assessing these roles, it is important to determine how often the group should discuss progress, obstacles, and any changes in initial goals and timelines. For example, how much in-person communication is desired or necessary, and how much can be done electronically, through conference calls, or in face-to-face meetings?

Determining the Goals and Scope of the Assessment

The coalition should start by deciding what it hopes to accomplish by completing a needs-and-assets assessment. Establishing goals will guide the assessment, determining the questions to ask and the types of data to be collected. Thus, by deciding what it hopes to achieve through a needs-and-assets assessment, the coalition will create a road map to keep the project on course.

Needs assessments can be performed for a variety of reasons. They can provide baseline data that can be revisited after an intervention has been implemented. They can be very focused, looking at a specific community or health issue, or more comprehensive, exam-

CASE STUDY

Needs assessments can vary in size and scope. Important factors for deciding such issues include who is conducting the assessment (e.g., the public health department or a specialized agency such as a university's community health program?), its purpose (e.g., is it primarily focused on trying to change existing programs or trying to create new programs) and what time and funding constraints it faces. The following example describes a needs assessment that is more limited in size and scope. It is important to remember that the structure and administration of an assessment has as much to do with surrounding circumstances as with prevailing needs.

In December 2000, the North Carolina Title V Program, the Special Services Unit of the Division of Public Health, and the North Carolina Office on Disability and Health produced a report titled "Assessing the Health-related Needs of Youth with Disabilities and Chronic Health Conditions in North Carolina" (<http://www.fpg.unc.edu/~ncodh/execsum.pdf>). The report, based on focus groups and individual interviews held with disabled youth and their parents, focused on responses to several key health issues, including barriers to maintaining a healthy lifestyle, satisfaction with the health care environment, suggestions for improving the health care environment, and concerns regarding transitions from pediatric to adult health care. Teens reported forming new provider relationships and finding providers with adequate disability knowledge who could interact in an age-appropriate way as major concerns. The participants also completed a health survey that assessed insurance coverage, health conditions, health status, and plans for the future, and they were asked to prioritize particular health-related information needs and transition supports. Using the assessment responses, suggestions were made for improvements in schools, health care, the community, and the State Title V Program. Sample suggestions included having transition-related programs contain opportunities for adolescents with special health care needs to have meaningful interaction with positive adult role models who themselves have special health care needs. It was hoped that these suggestions would be used to formulate a comprehensive plan that was developed with the input of all relevant stakeholders.



ining a region of several counties or looking at several health issues simultaneously. Some communities might use their assessment to focus on specific levels of intervention. For example, a community might have adequate individual-level interventions under way but want to assess what can be done on other levels (individual/family, school/peers, community, and policy/society). Another community might want to engage a particular sector, such as the business community, and focus its assessment on how to involve that community on all four levels.

The following questions might help the coalition focus its assessment:

- Which questions do we want to answer?
- What do we already know about these issues?
- What outside resources can we tap to help us understand these issues?
- Which forms of data collection are feasible?
- What is a realistic timeline for completing the assessment?
- How much staff time, funding, and other resources do we have right now to conduct the assessment?

The scope and depth of the assessment partly depends on how much time, staffing, and funding are available. These constraints notwithstanding, it is important to conduct some assessment, even if small. The coalition can always build upon existing assessments. Or, one piece of a larger assessment can be done first, with a more comprehensive assessment at a later time.

The type of information often collected for a needs-and-assets assessment, organized by the four levels, is presented in the box. Guided by the goals of the assessment, communities should determine the most important data to collect for each level. For example, does the coalition want to focus on a specific aspect of service delivery such as service coordination or after-school programs? The coalition also needs to consider what types of information will help it understand the different topics. For example, would rosters of existing services help assess the availability of services? Identifying whether any of this information has already been collected in the community is also an important step.

Sample Needs-and-Assets Outline

- I. Individual/Family
 - A. Socioeconomic status
 - B. Family structure/composition
 - C. Family connectedness within or to external community
 - D. Development
 - E. School performance
 - F. Attitudes and knowledge
- II. Schools/Peers
 - A. School connectedness among students, teachers, and parents
 - B. School services/classes/programs
 - C. School environment
- III. Community
 - A. Community attitudes and perceptions of adolescent health
 - B. Availability of health and social services/programs
 - C. Safety
 - D. Opportunities for community services and employment
- IV. Policy/Society
 - A. Policies and regulations
 - B. Funding
 - C. Media

A literature review may help coalition members gain a better sense of the questions they should ask when gathering information for the assessment; it should familiarize them with the antecedent factors linked to the Critical Health Objectives being addressed. Antecedent factors either put young people at risk for negative outcomes or provide protection from these outcomes (e.g., observable behavior) (see Figures 1 & 2). A review of literature on teen suicide, for example, would show connection to others as protective and school failure and substance abuse as risks. When collecting data and interviewing community members, the coalition may want to examine school success and interview teens about what helped them feel connected to their peers, family, school and the community. The more a coalition understands a particular health issue, the better equipped it will be to address it. A careful consideration of antecedent factors can suggest effective intervention strategies. Furthermore, it can help identify groups of young people who are at particular risk. Antecedent factors may differ among groups of young people; these differences may point to the need for tailored interventions.

Traditionally, public health models have focused on changing individual behaviors by addressing risk factors without also supporting and enhancing protective factors (e.g., assets and strengths). By focusing on individual health risk behaviors, these models also ignore larger environmental and societal issues. It is important to recognize that risk factors and protective factors can exist at multiple levels, including individual/family, school/peer, community, and policy/society, and that interventions need to operate at multiple levels.

Literature reviews (and summaries of literature reviews) are available for many of the health areas addressed by the 21 Critical Health Objectives. The coalition may choose to appoint a special ad hoc group or task force to read these literature reviews and examine the existing knowledge base (see the box below). Information from a literature review will also be helpful when the coalition is ready to design the intervention. Once priority health issues have been identified, knowledge of antecedent factors related to the health issue will indicate points for intervention. The information should be revisited when the coalition reaches the action plan/prioritization phase (see Chapter 6).

How to conduct a literature review

1. Review public health search engines and databases for referrals to relevant journal articles and information:
 - Healthfinder: www.healthfinder.gov
 - PubMed: www.ncbi.nlm.nih.gov/PubMed/
 - Medline Plus: www.medlineplus.gov
2. Consult recognized experts in the field:
 - Ask them whether they know of literature reviews, publications, or program evaluations that might be relevant to the selected Critical Objectives.
3. Contact national organizations that have expertise regarding the issue.
4. Search the World Wide Web:
 - Enter key phrases in established search engines (e.g., www.google.com).
 - Be aware of the sources of information and make sure they are credible.

Specifying Questions

Determining the scope and depth of the assessment sets the stage for specifying the questions the coalition would like it to answer. Using the sample needs-and-assets out-



Figure 1: Observable Behaviors—Antecedent Risk and Protective Factors at Four Contextual Levels

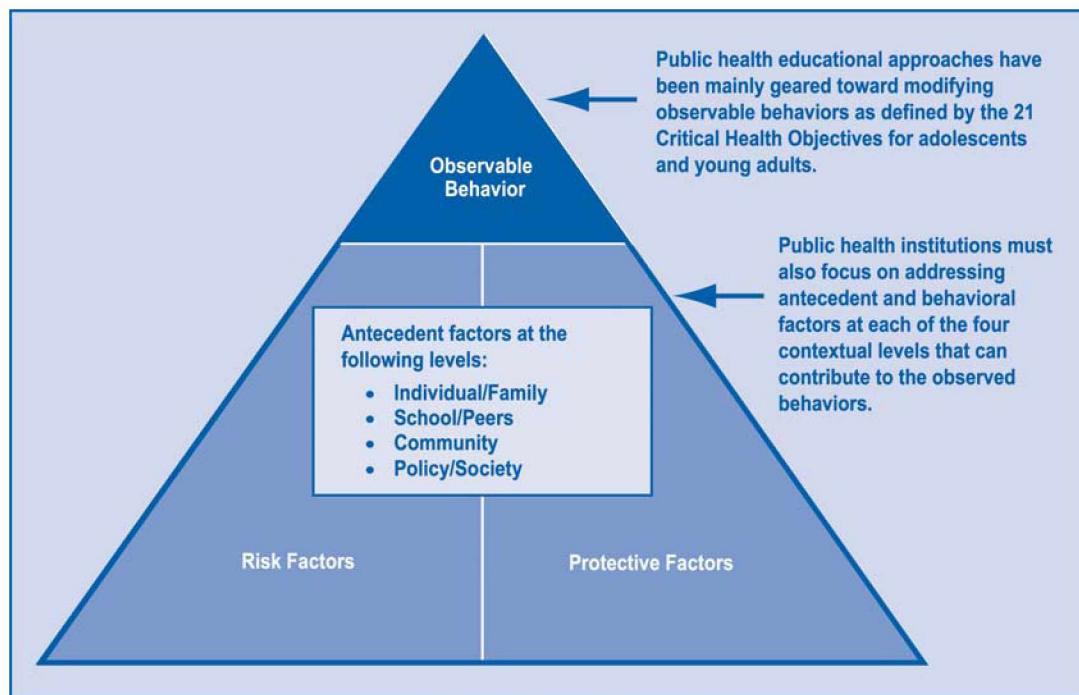
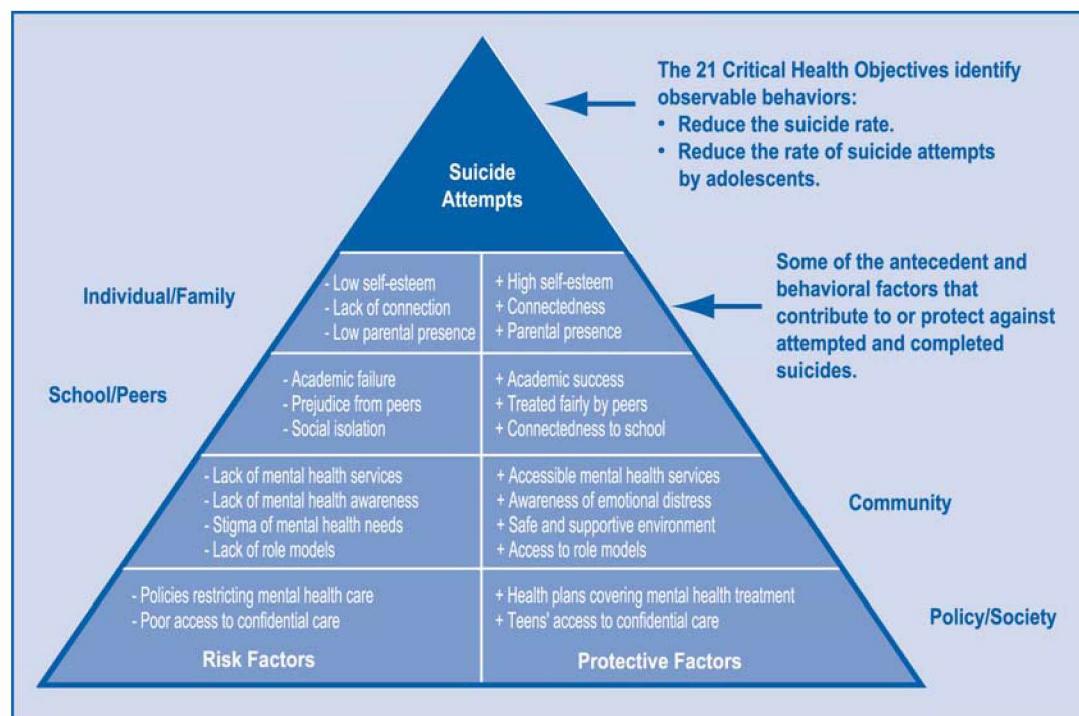


Figure 2: Suicide Attempts and the Antecedent Risk and Protective Factors at Four Contextual Levels



line, the coalition can further refine the aims of the assessment by determining questions for each section (see Worksheet 4 at the end of this chapter). When designing the questions, it is important to keep in mind the goals for the assessment and the different audiences for its results. The answers to the questions can serve several purposes: guiding the design of the action plan, creating support for the plan among community residents, and demonstrating need for action to potential funders. In this section, we outline some of the larger questions communities might want their assessment to answer.

Needs-and-assets assessments for adolescent health have often focused primarily on risk factors related to the health issues of interest and the services available for those problems. These foci provide useful information for developing an action plan. In the area of risk factors, for example, one might look at the social and demographic characteristics of the community to obtain insights on teens' quality of life. Some useful variables include the number of teens living in poverty, the percent of single-parent households, rates of unemployment, educational attainment of adults and teens, percent of teens graduating from high schools, and the relative number of recreational facilities for youth. In looking at services, the coalition might document the range of services related to the 21 Critical Health Objectives being addressed, including services from different sectors: community-based organizations, health care, schools, the faith-based community, juvenile justice, and other key players specific to the community. The coalition may look at gaps and duplications in services, barriers teens face in accessing services, or barriers and opportunities related to coordination between agencies.

Although information about individual risk factors and community services is needed, this document encourages coalitions to go beyond these two areas, guided by the four levels presented at the beginning of this chapter. One important area of inquiry is community environment and norms (e.g., how parents, teens, policy makers, practitioners, and other stakeholders perceive teens and the selected Objectives). Assessing community norms may help the coalition understand what interventions would best motivate community involvement.

In summary, the collaborative needs to develop a deeper understanding regarding the issues it is addressing to determine which directions to take and to frame a realistic timeline. It is important to identify positive as well as negative indicators in the community. Important questions that any needs-and-assets assessment should answer include:

- What is the scope of the problem?
- What are the ranges and profiles of the problem at the individual/family, school/peers, community, and policy/society levels?
- What are the antecedent factors influencing the outcomes reflected in the selected Critical Health Objectives? What does the literature review tell us about antecedent factors on all four levels?
- How ready are people to prioritize and act on the selected Critical Health Objectives? What types of actions would they most likely support?
- Do different sectors of the community view the problem differently? If so, how?
- What efforts are already in place?
- What is the range of current activities related to the Critical Health Objective(s) at each of the four levels? What, if any, gaps exist in these efforts (e.g., lack of programs, lack of policies)?
- Should we expand or enhance existing efforts? If so, how?
- Does the issue require creating new interventions; for example, should we develop an intervention for a level not previously addressed?
- What additional resources do we need, and how can we pursue them?
- What funding sources already support these activities, and which funding resources might be used for future support? How can current resources be redeployed for more effective or efficient use?



Collecting the Information

Now that the coalition has decided which persons/groups to involve in the assessment, defined the assessment's goals and scope, and developed a prioritized list of questions, it is time to determine the types of data to collect and to identify the sources of these data. The coalition needs to consider the resources and time available in selecting the range of questions, the data collection tools, the numbers of key persons to interview, and the size of the survey sample.

It may be useful to begin by gathering existing data from a variety of sources, including state and county health departments and the US Census. To fill in gaps and confirm conclusions drawn from existing data, the coalition will want to collect new data using tools such as surveys of representative samples of individual respondents, focus groups, and interviews of key informants. Worksheet 5 can help determine sources of necessary existing data, new data the coalition needs to collect, collection methods, persons responsible, and timelines. This section describes different types of data, sources of data, and suggestions for ways to collect new data.

To compensate for the inherent limitations of a given data source, it is important to employ multiple sources (sometimes called "data triangulation"). The more varied the sources, the more likely the needs-and-assets assessment will accurately reflect the factors that influence the selected Critical Health Objectives. Focus groups and interviews can provide qualitative information that rounds out a quantitative description of the health issue. For example, data indicating high rates of substance use can be supplemented by information on contextual factors from focus groups and interviews.

Coalitions might choose to create an advisory group to ensure that the data collected accurately represents the community. This group can convene periodically throughout the data collection process to review findings and ensure that the assessment gives equal consideration to assets and needs. The advisory group can also review survey instruments and other data collection tools to ensure they are clear and culturally appropriate, and can point out additional questions to ask.

Types of Data

This section very briefly describes types of data and their potential uses in a needs-and-assets assessment. The coalition will likely collect both primary and secondary data as part of the assessment and should seek a balance of quantitative and qualitative data, which can be either primary or secondary.

Primary: Original data the coalition collects and analyzes (e.g., responses from a parent focus group, results from key interviews or a community survey). It is desirable to reach a variety of stakeholders from different sectors of society (e.g., youth, parents, staff working in such areas as health and social services, education, law enforcement, community agencies, business) to gain a sense of the community's awareness regarding the selected Critical Health Objectives.

Secondary: Data that others have previously collected but which the coalition can analyze or reanalyze (e.g., statistics from state and local health departments, government or local agency reports). The coalition must be selective with secondary data because the information may not be specific to its community. To note any trends and changes, it is advantageous to compile data over a 5-10-year period.

Qualitative: Data presented in narrative form that usually cannot be expressed numerically. Examples include information gathered from focus groups, key informant interviews, community forums, and public hearings. Gathering qualitative primary data:

- Brings in community perceptions of adolescent health.

- Helps provide a context for the collection and analysis of quantitative data.
- Provides a better understanding of health behaviors and attitudes.

Quantitative: Data presented in numerical terms (e.g., vital statistics, responses to closed-ended questions on surveys). Gathering quantitative data:

Where to gather data?

Schools and households represent convenient settings to conduct research. Conducting surveys in schools offers a broad demographic range of adolescents. Drawbacks include needing to gain access to schools, time involved in obtaining parental consent, potential bias, and administering a questionnaire in a restricted amount of time. It is generally easier to obtain parental consent for household surveys, but teens may be more reluctant to discuss risk behaviors when at home. Several strategies can be used to address this problem, including the use of individualized tape recorders or laptop computers to protect confidentiality. To study select populations, you may want to conduct research in out-patient health care settings, juvenile justice facilities, inpatient psychiatric hospitals, and community agencies that serve troubled youth.

For further information, review Gans, J.E., & Brindis, C.D. Choice of research setting in understanding adolescent health problems: *Journal of Adolescent Health*. 1995; 17(s): 306-313.

CASE STUDY

Comparing national and state data

In January 2001, the California Adolescent Health Collaborative (AHC) — a collaborative involving more than 40 public and private organizations committed to improving the health and well-being of adolescents throughout California — released *Investing in Adolescent Health: A Social Imperative for California's Future*.* This strategic plan makes policy recommendations for improving health outcomes. The plan uses national and state data to profile seven action areas: injuries, mental health and suicide, nutrition and physical activity, substance use, teen pregnancy and STDs, oral health, and environmental and occupational health.

To ascertain the prevalence of adolescent health problems, the AHC reviewed data that assessed how California compares to the rest of the US. The review included the effects of various car and road safety programs. In the 1990's, California implemented a variety of programs, including having police officers stop drivers if they were not wearing a seat belt (failure to use a seat belt is an important antecedent to vehicle injuries and deaths). Other strategies included a graduated driver's license program (which places restrictions on young drivers) and programs aimed at reducing drinking and driving, another major cause of highway fatalities.

Trends in Motor Vehicle Death Rates Among Youth 15-19 in the U.S. and California (Deaths per 100,000)

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
U.S.	34.0	32.8	30.4	27.5	27.8	28.5	27.9	27.9	27.0	26.0
CA	33.0	27.6	27.6	23.5	21.7	21.5	20.2	18.5	18.5	17.5

Source: National Highway Traffic Safety Administration, Fatal Analysis Reporting System, 1989-1998

*(Clayton et al. 2001). To view or download the entire strategic plan, please go to: <http://www.california-teenhealth.org/strategic.html>

Note: Please see Appendix 5-1 for examples of Sources of Local Data



- Can provide information about a large population sample.
- Allows tracking of trends and changes within a population.
- Is necessary to determine and monitor health indicators.

Coalitions can gather secondary and qualitative data from local and state reports, newspapers, journals, and data gathered by local branches of government (e.g., health, education, law enforcement) and planning commissions.

Analyzing the Information

Careful analysis of the information gathered in the needs-and-assets assessment will help the community develop a more effective intervention. It may be helpful to prioritize the information obtained, identifying what will most interest the various stakeholders and audiences. This section provides a brief description of considerations for analyzing data; several available resources provide more detailed information and instruction. If funds allow, the collaborative may wish to work with a consultant to analyze its data. It might also task a subcommittee to conduct initial analyses, interpret the data, and provide ideas for presenting key findings to various audiences.

Quantitative data can be analyzed with computerized data analysis packages [e.g. Statistical Package for the Social Sciences (SPSS) or Statistical Analysis System (SAS)]. The findings can be summarized using such statistics as percentages, averages, and differences among different demographic groups or geographic areas. An analysis of quantitative data can yield information about changes in health indicators over time and provide comparisons across groups. Creating charts and graphs helps to interpret the data and illustrate trends and differences.

Analyzing qualitative data involves organizing ideas and information captured in notes from meetings, focus groups, interviews, and site visits. Information might also be recorded on audiotapes or videotapes. The information is organized around topics, themes, observations, descriptions, and conclusions. It is very easy to interpret qualitative data subjectively, and thus several people should review the data to guard against bias. Qualitative data analysis programs such as Ethnograph and Atlas can be helpful for presenting the information objectively.

It is important to consider the Critical Health Objectives not only in terms of individual problems but also as issues affected by events at the individual/family, school/peers, community, and policy/society levels. One way to organize the analysis follows:

1. Provide an epidemiological profile of the problem, using both primary and secondary data (e.g., hospital discharge data). The “who, what, where, and when” framework is useful (e.g., who is affected? where is the problem most evident?).
2. The profile of the problem should examine the existing observable behavior and how it is affected by the four levels of influence (individual/family, school/peers, community, and policy and society). It should also consider any information pertaining to antecedent factors—for example, families who drink and drive, or lax enforcement of laws regarding the sale of liquor to minors could affect rates of injury.
3. A summary should be made of the perspectives of both adolescents and adults (e.g., parents, teachers, other community stakeholders, policy makers) regarding the Critical Health Objectives of concern, including whether the issue is perceived to be a problem in the community, perceptions regarding its causes and potential solutions, and interest in and willingness to “adopt” this issue as a policy priority.
4. The community’s assets should be described, including programs, strategies, policies, and funding currently in place to deal with the specific Critical Health Objectives. The needs-and-assets analysis should also review community resources that could potentially be directed to the issue.

5. The coalition might revisit its literature review to ascertain how well existing community efforts are matched with what the research base indicates would work. If such information is not readily available or documented (e.g., prevention of adolescent depression and suicide attempt), communities may consider reviewing more general data on adolescent risk behaviors, as many of the behaviors are interrelated and cluster.
6. The analysis should also include suggestions or recommendations for action. This approach provides an opportunity to incorporate voices and perspectives from different perspectives and helps illustrate areas of consensus and divergence of opinions.

A report summarizing each component of the assessment becomes a powerful tool in planning for action. The collaborative may use it to broaden the community's knowledge regarding the Critical Health Objectives by widely disseminating the results. From this effort, additional members may be attracted to working with the collaborative to develop an action plan.

Sharing the Results

Widespread and effective dissemination of findings from the needs-and-assets assessment lays the foundation for action. A special effort should be made to make the findings accessible, both to the larger community and to special groups. The findings should be organized around a few key points and presented clearly and simply. Graphs, charts, and other visual representations can make the information more easily understandable. It might help to work with a public relations or media consultant to create a dissemination plan that involves different stakeholders and creates media attention.

The coalition should identify different audiences for the assessment, including community residents, potential funders, policy makers, other agencies and collaborators, and the coalition itself. The coalition should also decide who will present the information to each audience as well as the format for each presentation. For example, it might be more appropriate to have a young person and a community resident present findings to the community at large, while someone from a lead agency involved in the assessment might present the findings to potential funders. The information can be presented as a formal written report, or it might be condensed into an executive summary, fact sheet, press release, or a slide presentation. These documents can be tailored to different audiences. Effective presentation strategies might also include creative forms such as skits, theater, and video. Sharing the assessment findings offers an opportunity to incorporate youth development activities in the coalition's efforts. For example, the coalition might provide young people with training and support to present results through community forums, legislative briefs, and letter-writing campaigns.

If the coalition decides to produce a report, its members should work on and review all the drafts. Obtaining feedback from the coalition and various stakeholders helps people feel included in the process and helps to ensure that the report is inclusive and comprehensive. It also enhances relationships with agencies and individuals who might be important partners for creating and implementing an action plan. Lastly, when people are involved in the process they are more interested and engaged when it comes time to shape solutions.

Information gathered from the needs-and-assets assessment serves several purposes:

- Findings may be used within the coalition as baseline data against which to monitor progress after a program or series of interventions have been implemented.
- Findings can be shared with other community organizations and stakeholders working on relevant issues, especially those involved in the assessment process. Interested parties can join the coalition or use the findings independently to address related health issues.
- Findings, conclusions, and recommendations can be distributed (in the form of reports, summaries, or related fact sheets) to local and state policy makers, program planners and



Table 5-1: Eat Right Coalition Case Study (continued) Partial Analysis of the Needs and Assets Assessment by Level of Intervention

Needs/Assets Question(s)	Individual/Family	Schools/Peers	Community	Policy/Society
What is the scope of the problem? (e.g., How many teens are overweight or obese? Which populations are most affected?)	Thirteen percent of teens are overweight or obese.	Only 35% of surveyed teens report participating in physical activities.	Females report low physical activity levels. Males, African Americans, and Latinos have high rates of obesity.	There are few sources of affordable fresh fruits and vegetables.
What are the perceived causes for overweight or low levels of physical activity among teens?	Many families have parents who work and do not prepare meals for their children. Many adults and youth have very sedentary lifestyles.	Physical education (PE) is not required throughout high school. Females are less likely to participate in PE classes and after-school sports.	There are many fast-food establishments, which are perceived as offering convenient meals. Fresh fruits and vegetables are not readily available.	No existing policies regulate cafeteria food or vending machine sales in middle and high schools.
How ready are people to prioritize and act on the selected Critical Objectives? What types of actions would they more likely support?	Parents don't want their teens to watch so much TV and want them to be more physically active (but in a safe environment).	Many teachers want students to eat better and exercise more but feel constrained by pressures to improve academic outcomes.	Many people recognize that few stores offer affordable quality produce. They say they would buy (and eat) more fruits and vegetables if available.	There are not many efforts or incentives in place for grocery stores to carry more fresh fruits and vegetables.
What recommendations have we found in the literature review?	Reduce intake of high-fat and caloric-dense fast food. Increase exercise. Reduce soda consumption.	Increase students' level of physical activity through PE class. Reduce access to soda.	Encourage more walking, bike riding, and more active lifestyles overall.	Provide safe and well-lit parks and walking and bike paths. Reduce access to soda.
What efforts are already in place?	Don't know. Requires further investigation.	Few teens participate in nonteam sports.	Some community agencies have youth sports programs, but many families can't afford the fees.	Policy makers assume that low-income students are well-served by free or reduced-price breakfast and lunch programs.
Should we expand or enhance existing efforts? If so, how? (ideas suggested by participants)	Screen and recruit teens to participate in supportive and existing group activities aimed at decreasing the prevalence of overweight.	Better publicize school sports programs. Provide better health education. Engage youth in developing strategies. Institute cooking clubs, food preparation, demonstration of, and supporting groups for parent-child weight reduction.	Increase community health education about diet and exercise.	Support family-focused weight control efforts.
Does the situation require creating new interventions?	Review existing school-based programs to assess whether new programs need to be initiated or existing programs can be further developed.	Create policy to enforce regular physical education for students up to the 12th grade, emphasizing individual lifelong sports.	Assess the gap between existing need and current programs and resources.	May need to get additional information.
What additional resources do we need, and how can we pursue these?		Identify funds or invite community agencies (e.g., parks and recreation) to provide support to interested teens who cannot afford to join high school sports programs.	Cross-train teachers, providers, and others who work with youth in the areas of diet and nutrition and physical activity and show them how to integrate these messages in existing programs.	Identify federal and state demonstration funds to support testing of new programs.

managers, and funding sources to garner more support among key players in the community who may not be formally involved.

- Findings can be shared with the media and be publicized in a variety of ways (e.g., as a newspaper article or editorial, as a fact sheet distributed with the newspaper).
- A working group can be convened to put the plan into action.

Keep in mind how coalition members and the larger community may interpret the assessment findings, particularly regarding the needs of the community. It is important to anticipate how to present the assessment findings thoughtfully and delineate next steps to encourage mobilization and avoid feelings of being overwhelmed, should the information from the assessment appear daunting.

CASE STUDY: Report on the Status of Children, Youth, and Families, Alameda, California 2000-2001.

The Alameda Collaborative for Children, Youth and Their Families, formed in 1996, was composed of community-based service providers, public officials, citizens, parents, and youth. The collaborative undertook a needs-and-assets assessment with data from the City of Alameda, Alameda County, the State Department of Justice, the State Department of Education, standardized test scores, and focus groups. The data were compiled over 3 years. The Collaborative wrote a report summarizing its findings and also wrote a **Report Card** on the status of programs and resources for youth in Alameda. It ranked ("A" to "F") child care, safety, education, basic needs (housing and transportation), maternal and child health, teen services and activities, and community resources for similar programs and services in Alameda County and in the state. The end result was an interesting and easy way to illustrate the needs and assets of services for youth in its community.

(Alameda Collaborative for Children, Youth and Their Families 2001). The Report Card can be viewed at: <http://www.alamedayouth.org/REPORTsm.pdf>

EAT RIGHT COALITION CASE STUDY (continued)

The ERC's assessment group started doing some background research for the assessment using existing community data, including information from sources such as the health department and the Youth Risk Behavior Survey (YRBS). It also researched best practices regarding obesity and nutrition to learn what had and had not worked in other communities. During this time, the grants committee also applied for assessment funding from several community foundations.

Six months later, the coalition received a foundation planning grant of \$75,000 to conduct a needs assessment. A consultant familiar with nutritional needs assessments/surveys was hired who subsequently trained several health care personnel, parents, and youth in specific techniques of survey questionnaire administration, literature review, and focus groups. The training took longer than expected and delayed the needs assessment by nearly 6 weeks. Finally, however, a survey was conducted that obtained information on weight, height, and nutrition for 2,000 area high school and middle school students, and several focus groups were held with parents, policy makers, business leaders, teachers, physicians, dieticians, and youth to identify what factors promoted or hindered a healthy diet within the town.

Concurrently, to more specifically identify best practices related to improving childhood diet, one member of the group was assigned to perform literature reviews, while another three members conducted expert interviews and site visits. Specific attention was focused on program implementation in towns that resembled the coalition's in terms of socioeconomic status, race, industry, and surrounding farmland.



After almost 9 months, the results were compiled and analyzed by the consultant and the grants committee. They were shared with community members for review and feedback. A 10-page summary report was compiled and mailed to the persons on the coalition's list, local and state policymakers, principals and teachers, physician practices, the chamber of commerce, and student leaders who had been targeted for the coalition's introductory meeting. A press release was sent out to the local newspaper, to TV and radio stations, and to area school newspapers. This media outreach resulted in a short piece on the local evening news and several articles in community and school newspapers. Simultaneously, a flyer was sent out publicizing the coalition's next meeting.

The needs-and-assets assessment showed numerous areas for both concern and hope. In particular, the results illustrated challenges in students' nutritional knowledge and habits:

- 30% were obese according to their body mass index (BMI).
- 70% had misconceptions about a healthy diet.
- 60% received at least one of their daily meals from a restaurant or vending machine.
- 20% "almost never" ate a meal that was cooked in the home.
- 50% felt they were not eating very healthfully during the school day.
- 70% felt there were not many healthy and appetizing food options in the schools.
- 50% cited their willingness to try healthier foods if they were made available at schools and if they were appetizing.

The focus groups also yielded many interesting results:

- Most parents spoke of time constraints that limited their ability to cook even 3 days a week.
- Teachers, parents, and physicians cited the proximity of fast-food restaurants to schools and the availability of unhealthy snack foods and sodas on school grounds.
- Community parents and adults remarked on the lack of accessible grocery stores in their neighborhoods that sold quality produce.
- Business leaders and principals cited the lost revenue if soda and candy were disallowed for competitive sale.
- Members of advocacy groups and the clergy spoke of how unhealthy eating behaviors and food choices had become part of the town's social fabric. They detailed how restaurants sponsored town events, the media promoted consumption of foods high in fat and sugar, and town citizens had made many aspects of poor eating habits a part of social ritual ("Chili Dog Nite" at Frank's was specifically cited).

Despite these findings, it was clear there were many pathways by which the problem could be addressed:

- 80% of students received the majority of their nutritional influence from their home environment, peers, the media, sports coaches, or physicians.
- 60% of the students wanted more nutrition information provided at school.
- Most teachers and parents were very supportive of school nutrition and cooking classes.
- Many parents supported school policies that would prohibit students from leaving the school campus for meals and that would require the removal of unhealthy snacks and sodas from school vending machines.

- Many parents wanted affordable healthy school lunches to be more available.
- Most parents wanted affordable grocery stores that provided quality food and produce.
- Principals and teachers supported healthy food options in the schools as well as restrictions on access to nearby restaurants during school hours.

The needs assessment also revealed many challenges standing in the way of change:

- 85% of students felt that healthy foods “were not as appetizing.”
- 40% of students said that nutrition wasn’t important to them.
- Students, policy makers, and business leaders heavily opposed restrictions on access to unhealthy snacks in school vending machines and area fast-food restaurants.
- Many principals were opposed to competitive food restrictions that might affect school revenues/budgets.

Finally, the research on best practices yielded numerous avenues to approach the problem including:

- Providing comprehensive nutrition education.
- Creating a supportive school food service environment.
- Involving communities and family members in supporting and reinforcing nutrition education.

With all of this information, the ERC needed to decide its priorities.

Summary

The needs assessment process, however, can seem very long, involved, and complex. It can also be expensive. Still, communities can tailor a needs assessment to fit their goals and resources. It is much better for a community to conduct a scaled-down needs assessment than not to do one at all or to take on a large project without adequate resources. Regardless of the size of the assessment, it is important to involve young people, community members, and stakeholders early on. The coalition should also have clearly defined goals and a well-thought-out plan. By engaging young people and the larger community in an assessment process, a coalition can create a great deal of energy and momentum around adolescent health. It can also strengthen relationships that are instrumental for taking action to improve supports and opportunities for young people once the coalition has decided on a plan of action. Ultimately, the needs-and-assets assessment provides information essential for prioritizing action and identifying resources for improving adolescent health. Once the coalition has conducted the needs-and-assets assessment, it is ready to move on to the next steps, which are outlined in Chapter 6.



APPENDIX 5-1: Sources of Local Data

The following resources are possible sources of local data.

Department of finance or municipal planning publishes population data providing information on such areas as poverty levels, expected population growth, racial groups, and foster care youth.

State and county departments of health (and programs supported by them) collect data on types of unintentional and intentional injuries and their rates, vital statistics, suicide rates, the prevalence of violence, mental health, pregnancy or birth rates, and rates of HIV and other STDs.

Hospital discharge data, available from the county department of health, include emergency room visits and the causes of hospitalization. This information may be valuable in determining and monitoring levels of violence and mental health diagnoses as well as the rates and causes of intentional and unintentional injuries.

School districts have data on school attendance, dropout and graduation rates, which are useful for demographic profiling. Identifying both struggling students and those who excel may offer insight on what types of programs and supports are successful and where to focus additional efforts. In addition, school districts may have administered surveys assessing the health behaviors and attitudes of students.

Clinics, youth-serving agencies, and youth programs may have conducted their own needs-and-assets assessments. These data may be useful in identifying where services are located (or are in need), what types of youth services exist, the populations served, and how many persons have access to services.

Juvenile justice/youth authority institutions may provide data on crimes, the prevalence of violence and arrests for driving under the influence, or use of alcohol or other illicit substances. Police reports and court records are also valuable sources.

Community assessments, annual reports, and report cards from community agencies (e.g., United Way) and governmental institutions may already contain significant amounts of information related to any of the Critical Health Objectives or special populations, such as youth with disabilities or homeless youth. (*Many of the agencies listed in Chapter 8 publish reports on adolescent health that use national and state data.*)

Journals, newspaper articles, reference manuals, clearinghouses, and online literature may provide background information (and potential solutions) pertinent to the adolescent health concerns in the community. It is important to be aware of any biases and to know the data source, especially for information found online.

Survey questionnaires allow data collection for large numbers of respondents on a wide variety of health behaviors and young people's perceptions of these behaviors. Generally, administering surveys at schools, school-linked services, community-based organizations, and teen health centers is effective for collecting data on youth behaviors and attitudes. Surveys of adults are useful for documenting their perceptions of youth issues and strategies that adults might accept. Community settings, such as the work site, and parks and other recreation sites, as well as door-to-door or telephone data collection, are useful for obtaining data.

Interviews can complement questionnaire data by eliciting more in-depth responses from youth, parents, providers, teachers, and other stakeholders. Carefully selecting persons for interview is important, as this method may be more time-consuming. It provides an opportunity for building relationships with community members most heavily affected by the issue being studied. Bias can be introduced by using a non-representative, convenience sample.

Focus groups are selectively held with target populations to gain better insight into their perceptions of the issues of concern and how to address them. Sessions usually involve a facilitator, note taker, and 8-10 participants. Special consideration of who leads the group is necessary; ideally, the skilled facilitator is matched by sex and ethnicity/racial background to the groups being led.

Observational appointments (site visits) help coalition members better understand the scope of the problem by transforming statistics and numbers into real people, and real organization providing services to community members. Visits to schools, community centers, health centers, and other sites provide invaluable insights into their efforts to better meet the needs of adolescents.

Brindis 1991



Worksheet 1: A Coalition Planning Tool

This form should be completed by a steering committee, a community group, or others who have come together to start an adolescent health initiative. Completing this form will help the group begin to shape the initiative and determine who should be involved. In the spaces provided, please answer the questions listed, which are about history, norms, and politics around the Critical Health Objectives; which key stakeholders should be involved; what resources are needed; what other efforts are taking place in the community; and what is the best course of action for engaging the community to meet the needs of adolescents. This form can also be used to facilitate a group discussion.

What are the history and status of adolescent health and the Critical Health Objectives in the community?

How does the community view these issues? What is the current political and social climate in relation to these issues?

Who is concerned about and affected by these issues? Who has participated in the past? What is their relation to these issues?

Who has not participated, and why haven't they been involved in these issues?

What existing youth-focused groups or efforts address these issues? With which, if any, could we collaborate?

Do we have sufficient information and resources?

What information and resources (administrative, financial, and structural) do we have right now to work on this issue?

What resources are we lacking?

Does a current needs-and-assets assessment exist in the community?

What are the advantages or disadvantages of using this assessment?

What are the possible benefits and challenges of conducting a new needs-and-assets assessment?

Is working as a collaborative or a coalition the optimal option?

Will working as a group help achieve goals that cannot be achieved independently?

What are the pros and cons of working in a coalition or a collaborative right now?

How official or formal do we want to be?

Do we want to be identified with another organization working on this issue or in a parallel area? Why or why not?

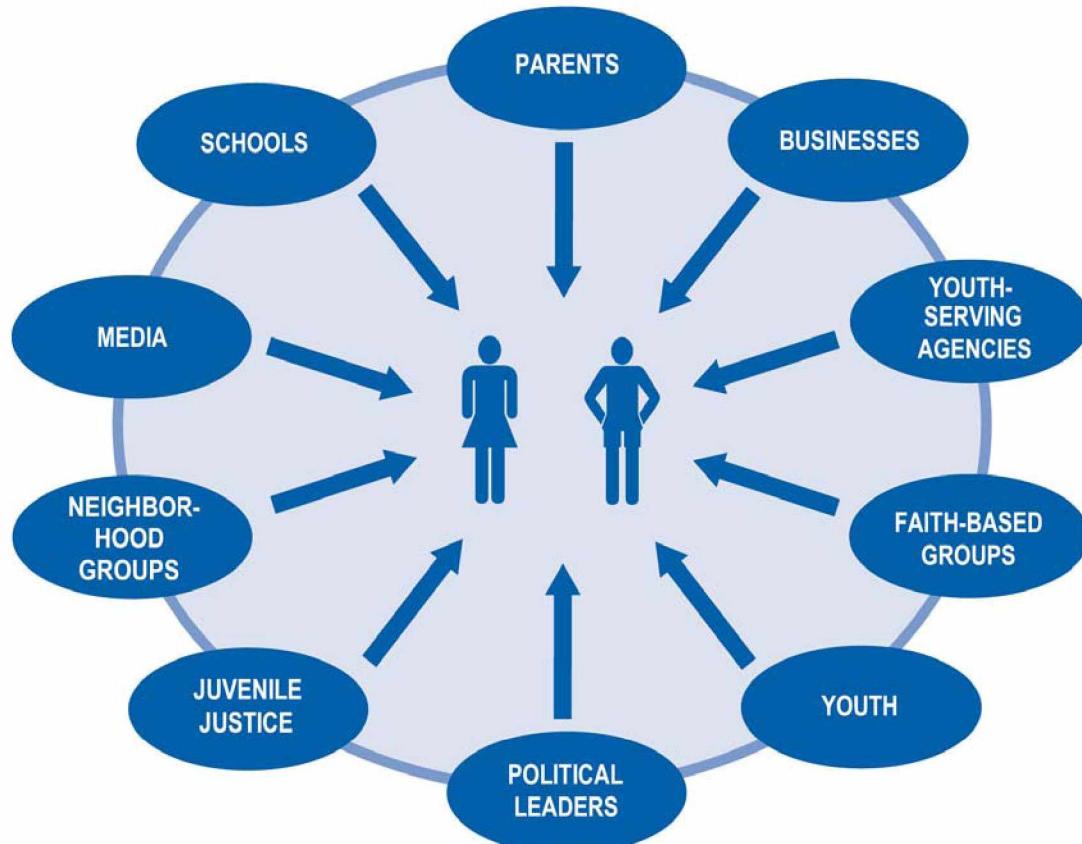
What do we want to accomplish in the short term?



Do we have a long-term goal? What do we want to accomplish in the future?

Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health; Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health; National Adolescent Health Information Center, University of California, San Francisco. *Improving the Health of Adolescents & Young Adults: A Guide for States and Communities*. Atlanta, GA: 2004.

Figure 3: Community Partnership For Youth



Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health; Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health; National Adolescent Health Information Center, University of California, San Francisco. *Improving the Health of Adolescents & Young Adults: A Guide for States and Communities*. Atlanta, GA: 2004.

Worksheet 2: Coalition Self-Assessment

This form should be completed by coalition members to assess how the group is functioning. Answers will be used to determine areas in which the coalition can improve. Respondents should rate how well the coalition measures up to each statement below. Using a scale of 1 to 5, circle the number that best fits your opinion. Please answer each question as honestly as possible. Your name will not appear anywhere on this form.

Staffing and Resources					
	Not At All		Somewhat		Outstanding
The coalition has stable staff.	1	2	3	4	5
The coalition has a designated person to serve as the coordinator of the coalition.	1	2	3	4	5
The coalition has secured diverse funding streams.	1	2	3	4	5
The coalition has secured needed in-kind contributions (meeting space, volunteer time, supplies, etc.).	1	2	3	4	5
The coalition uses existing resources.	1	2	3	4	5
Leadership					
	Not At All		Somewhat		Outstanding
The coalition leadership is committed to the coalition's mission.	1	2	3	4	5
The coalition leadership has knowledge in the content area.	1	2	3	4	5
The coalition leadership promotes equal status and collaboration among members.	1	2	3	4	5
The coalition leadership provides an opportunity for different points of view to be heard.	1	2	3	4	5
The coalition leadership is competent in negotiation, problem solving, and conflict resolution.	1	2	3	4	5
The coalition leadership is effective in managing meetings.	1	2	3	4	5
The coalition leadership values members' input.	1	2	3	4	5
The coalition leadership celebrates accomplishments of the coalition and its members.	1	2	3	4	5
Structure					
	Not At All		Somewhat		Outstanding
The coalition provides a forum for joint planning.	1	2	3	4	5
The coalition has bylaws/rules of operation.	1	2	3	4	5
The coalition has a clear mission statement in writing.	1	2	3	4	5
The coalition has goals and objectives in writing.	1	2	3	4	5
The coalition has an action plan.	1	2	3	4	5
The coalition has regular, structured meetings.	1	2	3	4	5
The coalition has a process for decision making.	1	2	3	4	5
The coalition has a mechanism for holding members accountable for completing tasks in a timely manner.	1	2	3	4	5
Membership					
	Not At All		Somewhat		Outstanding
The coalition has been successful in bringing together people with different views about how to approach adolescent health.	1	2	3	4	5



Members share the coalition's mission.	1	2	3	4	5
Members actively plan, implement, and evaluate coalition activities.	1	2	3	4	5
Members regularly attend meetings.	1	2	3	4	5
The coalition includes key players in the community.	1	2	3	4	5
The coalition includes young people in planning and decision making in a meaningful and substantive way.	1	2	3	4	5
The coalition includes members who are knowledgeable about the adolescent health issue being addressed and ways to prevent it.	1	2	3	4	5
Function		Not At All	Somewhat	Outstanding	
The coalition has conducted a needs assessment/drawn up a resource map to establish areas of need.	1	2	3	4	5
The coalition has established a formal, comprehensive plan of action.	1	2	3	4	5
The coalition has engaged diverse partners to take part in implementing the action plan.	1	2	3	4	5
The coalition has been successful in instituting new programs in the community.	1	2	3	4	5
The coalition has been successful in getting new policies implemented.	1	2	3	4	5
The coalition has been successful in getting stakeholders to work together more effectively.	1	2	3	4	5
Community		Not At All	Somewhat	Outstanding	
The coalition is able to obtain political support at the community level.	1	2	3	4	5
The coalition has credibility within the community.	1	2	3	4	5
The coalition engages the community as its partner with decision-making power.	1	2	3	4	5

Currently, how involved are each of the following groups in your coalition?

		Not At All	Somewhat	Very Much	
Youth	1	2	3	4	5
Parents	1	2	3	4	5
Business leaders	1	2	3	4	5
School administrators and school board members	1	2	3	4	5
Teachers	1	2	3	4	5
Grassroots or neighborhood groups	1	2	3	4	5
Youth-focused organizations	1	2	3	4	5
Health care providers	1	2	3	4	5
Juvenile justice	1	2	3	4	5
Social service providers	1	2	3	4	5
Media	1	2	3	4	5
Political leaders	1	2	3	4	5
Clergy/religious leaders	1	2	3	4	5

Do you have any comments on how to improve the coalition's functioning?

Any other comments?

Thank you!

Adapted from: Brindis, C.D., & Davis, L. (1998). Mobilizing for action. In Advocates for Youth, *Communities responding to the challenges of adolescent pregnancy prevention*, Vol. 1. Washington, DC: Advocates for Youth. North Carolina Department of Health and Human Services, North Carolina Diabetes Prevention and Control Unit. (2000). *Coalition self-assessment tool*. Retrieved September 23, 2002, from http://www.ncdiabetes.org/WhatWeDo/pdf/Coalition_Self-Assessment_Tool.pdf



Worksheet 3: Needs Assessment Team Planning Tool

Use this worksheet to identify the skills, resources, and expertise the coalition will need to conduct a needs assessment; how to access those resources within the community; and who should serve on the needs assessment team. The list of resources will most likely include items such as research and data skills, expertise in the area of best practices, entrée into the schools, and funding. In creating such a list, the coalition may find that many of the resources it needs can be found within the coalition. For missing resources, this tool can help the group identify organizations with which it might want to partner or contract, and people it might recruit to participate in the needs-and-assets assessment process.

Skills Resources, or Expertise Needed (e.g. in-kind, technical expertise, skills, funds)	Individual, Organization, or Institution That Can Provide Resources	Contact Information	Person Willing to Contact

Source: Card, J., Brindis, C.D., Peterson, J., & Niego, S. (2001). *Guidebook: Evaluating teen pregnancy prevention programs* (2nd ed, Chapter 4). Los Altos, CA: Sociometrics.

Worksheet 4: Needs Assessment Questions

Use this worksheet to brainstorm a list of questions to guide the needs-and-assets assessment. You may find that, depending upon the topic the community is exploring, all the questions may not be relevant. After brainstorming, the coalition will need to narrow the list by prioritizing questions. Prioritizing should be guided by the resources available to the coalition, the previously agreed-upon scope and depth of the assessment, and the relevancy of the questions.

Youth Profile Questions

Our top three questions about the demographics and socioeconomic status of young people in our community are:

1. _____

2. _____

3. _____

Our top three questions about [insert adolescent health issue being addressed] and its antecedent factors are:

1. _____
2. _____
3. _____

Our top three questions about school-related issues are:

1. _____

2. _____

3. _____



Our top three questions about other related health and social issues facing young people are:

1. _____
2. _____
3. _____

Community Resources Questions

Our top three questions about health and social services available to young people in the community are:

1. _____
2. _____
3. _____

Our top three questions about best practices are:

1. _____
2. _____
3. _____

Our top three questions about school resources in our community are:

1. _____
2. _____
3. _____

2. _____

3. _____

Our top three questions about youth development efforts in our community are (for example, volunteering, employment, civic engagement, mentoring, and relationships with adults):

1. _____

2. _____

3. _____

Our top three questions about adolescent health and youth development initiatives in our community are:

1. _____

2. _____

3. _____

Environment and Norms Questions

Our top three questions about community attitudes and perceptions of [insert adolescent health issue being addressed] are:

1. _____

2. _____



3. _____

Our top three questions about Federal, State, and city/county policies and laws related to [insert adolescent health issue being addressed] are:

1. _____

2. _____

3. _____

Our top three questions about funding are:

1. _____

2. _____

3. _____

Sources: Card, J., Brindis, C.D., Peterson, J., & Niego, S. (2001). *Guidebook: Evaluating teen pregnancy prevention programs* (2nd ed, Chapter 4). Los Altos, CA: Sociometrics. Brindis, C.D., Card, J.J., Niego, S., & Peterson, J. L. (1996). *Assessing your community's needs and assets: A collaborative approach to adolescent pregnancy prevention*. Los Altos, CA: Sociometrics.

Worksheet 5: Needs Assessment Data Chart (Youth Profile)

Use these worksheets (5, 5.1, 5.2) to map out what information is needed to answer each needs-and-assets assessment question, the sources of data, how data will be collected, who will collect it, and the time frame. Complete the applicable worksheet for each segment of the assessment (youth profile, community resources, environment and norms).

Needs Assessment Question	Information Needed to Answer Questions	Sources of Existing Data	Data to be Collected (if existing data are not available)	How Data Will Be Collected	Persons/ Group Responsible	Time Frame
Question 1: Example: What is the economic profile of young people and their families in our community?	% adolescents living in poverty by race/ ethnicity	US Census			Graduate student intern	2 weeks
	% adolescents living in single-parent Households by race/ethnicity	US Census			Graduate student intern	2 weeks
	% adolescents receiving free or reduced-cost lunch	US Department of Agriculture, School district			Graduate student intern	2 weeks
Question 2:						
Question 3:						

Source: Card, J., Brindis, C.D., Peterson, J., & Niego, S. (2001). *Guidebook: Evaluating teen pregnancy prevention programs* (2nd ed, Chapter 4). Los Altos, CA: Sociometrics.



Worksheet 5.1: Needs Assessment Data Charts (Community Resources)

Needs Assessment Question	Information Needed to Answer Questions	Sources of Existing Data	Data to be Collected (if existing data are not available)	How Data Will Be Collected	Persons/Group Responsible	Time Frame
Question 1: Example: Are teen-friendly clinical services available to adolescents in the community?	Are there health care centers that serve teens?		No. of health care centers that serve teens	Survey of health care centers	Dr. Smith, with assistance from other Needs Assessment team members	2 months
	Do health care centers have policies and procedures that reduce barriers for teens to access care?		No. of teen-friendly practices implemented by health care centers	Survey of health care centers	Dr. Smith, with assistance from other Needs Assessment team members, including two youth	2 months
Question 2:						
Question 3:						

Source: Card, J., Brindis, C.D., Peterson, J., & Niego, S. (2001). *Guidebook: Evaluating teen pregnancy prevention programs* (2nd ed, Chapter 4). Los Altos, CA: Sociometrics.

Worksheet 5.2: Needs Assessment Data Charts (Environment and Norms)

Needs Assessment Question	Information Needed to Answer Questions	Sources of Existing Data	Data to be Collected (if existing data are not available)	How Data Will Be Collected	Persons/Group Responsible	Time Frame
Question 1: Example: Why is there low utilization of health services among young people?	What are the attitudes and perceptions of young people when it comes to accessing health care?		<ul style="list-style-type: none"> ▪ Perceived barriers to accessing health care ▪ Perceived benefits of seeking health care 	Focus groups	Superintendent Jones; Boys and Girls Club staff	2 months
Question 2:						
Question 3:						

Source: Card, J., Brindis, C.D., Peterson, J., & Niego, S. (2001). *Guidebook: Evaluating teen pregnancy prevention programs* (2nd ed, Chapter 4). Los Altos, CA: Sociometrics.

CHAPTER 6



Taking Action

Contents

Using Information from the Needs-and-Assets Assessment [page 2](#)

The Prioritization Process [page 4](#)

Developing an Action Plan [page 7](#)

Defining Goals and Objectives [page 8](#)

Designing an Intervention [page 10](#)

Creating an Action Plan [page 15](#)

Creating a Mission Statement and Goals [page 10](#)

Coalition Stages [page 11](#)

Developing a Logic Model [page 19](#)

Developing a Theory of Change [page 21](#)

Developing indicators [page 21](#)

Implementing an Action Plan [page 23](#)

Appendix 6-1: Force Field Analysis [page 28](#)

Worksheets 6-10 [page 32-38](#)



Meaningful information and insight about youth in the community have been gained through the processes of coalition building and needs assessment. The next step in the planning process is for the coalition to decide how it will use this information and how it will work towards addressing the selected Critical Health Objectives for adolescents and young adults. At this point, the coalition should consider the following questions:

- *On which aspect of the issue should the group focus?*
- *How can the assessment and available data be used to direct efforts?*
- *How can research guide the effort?*

The needs-and-assets assessment yields information about many aspects of the problem, suggesting several possible solutions or strategies as well as potential challenges in responding to the four levels of intervention (individual/family, school/peers, community, and policy/society). With limited resources, most communities cannot address every risk and protective factor, but it is important to be as comprehensive as possible. In some cases, findings from the needs-and-assets assessment point to a clear strategy from which to develop a detailed program plan. More often, however, coalitions will need an intermediate step before selecting strategies. This section aims to help communities identify priority issues and determine the most feasible strategies to pursue. The strategies will guide the development of the next stages of planning. Some questions to consider when prioritizing strategies include:

- *Which strategies reflect a sound understanding of the problem and its causes as identified by the needs assessment?*
- *Do the strategies reach teens and young adults most at risk?*
- *Do the strategies focus on reducing risk factors and promoting protective factors?*
- *Are the strategies consistent with community values and priorities?*
- *Do the strategies draw on the strengths of the community and the coalition?*
- *Do the strategies complement rather than duplicate concurrent efforts that address the same issue?*
- *Do the strategies draw on readily available resources?*
- *Will the strategies be likely candidates for funding?*
- *Do the strategies address levels of influence not being addressed by current community efforts?*

Although not meant to be a strict guideline for prioritization, this list may help coalitions consider important factors related to the strategies they choose. It is most important for the coalition to respect the community and choose strategies that reflect local priorities. An intervention is destined to backfire if outsiders impose it on a community.

Using Information From the Needs-and-Assets Assessment

Findings from the needs-and-assets assessment should help inform the prioritization process. The coalition should assess both quantitative data about the Critical Health Objectives and qualitative data about community perceptions.

CASE STUDY

As with needs assessments, the prioritization process comes in numerous shapes and forms. Regardless of the method chosen, the process should take into account financial and human resources, likelihood of success, timeline, and community interest and acceptance. Every prioritization process should have a well-defined system that all participating members understand, deem fair, and follow. Here is how one coalition decided to prioritize its problem areas:

Mason Matters (<http://www.masonmatters.org/>) is a nonprofit organization consisting of community citizens and health care providers concerned with addressing the health and social needs of Mason County, Washington—a small county of approximately 47,000 persons. This coalition strives to develop local solutions for local problems using the strengths of all sectors of the community. In January 1998, 30 community members representing diverse interests convened to decide upon the health and social issues most affecting county residents. Using a previous assessment, the *1997 Mason County Health Profile*, the members highlighted 25 issues of general importance, including teen pregnancy, teen smoking, cancer, child abuse, domestic violence, and HIV/AIDS. In May 1998, these issues were further prioritized by Mason Matters using five criteria:

1. How many people in Mason County are affected?
2. Is Mason County faring less well than the rest of the state on this issue?
3. How severe is the impact on individuals or the community?
4. Is this an issue that can be addressed through community action? (Would an intervention make a difference?)
5. Will there be community support?

The top seven issues were prioritized as follows:

1. Teen pregnancy.
2. Drug and alcohol use.
3. Domestic violence.
4. Water quality.
5. Community support for schools.
6. Economic opportunities.
7. Dental access.

Teen pregnancy and domestic violence were selected as the first two foci because both received the highest rating on the “community support” question. Two work groups addressing these issues were formed in May 1998. Since that time the teen pregnancy work group has conducted teen focus groups, increased the availability of medical services, and created an information package for parents titled “T.I.P.S.: Teen Information for Parenting Success.”

The remaining high-priority issues underwent another prioritization process in September 2000. The issues of water quality and community support for schools were ranked highest in the areas of “impact on individuals and the community,” “impact of community action on the problem,” and “community support.” Two work groups were formed to address these issues.

Who is most affected by the problem?

A good way to use limited funds is to focus on the young people who are most at risk. The needs-and-assets assessment should indicate whether specific geographic clusters, age or income classifications, or ethnic or racial groupings are associated with particularly high rates of the problem. The communities identified by these variables, however, may already be saturated with programs. The assessment will also indicate gaps in services that may be better points of intervention for the coalition. By concentrating on a specific group or area of service delivery, the coalition can prioritize appropriate strategies. Alternatively, a broader approach may be appropriate.



What factors contribute to the problem?

The needs-and-assets assessment will uncover a host of contributing factors that could be the focus of an intervention. The coalition should take into account what experts, parents, and teens themselves have to say about the factors that matter most. Ultimately, the coalition should target those risk factors known to be related to the issue that are the most prevalent and that the community will support addressing. Harder issues can be addressed after the coalition has laid the groundwork and gained more support. The coalition should also address the protective factors that are most lacking in the community.

What strategies will the community support?

The needs-and-assets assessment should have shed light on where the community stands on the selected Critical Health Objectives and what strategies it would support. The coalition may want to garner more input from community members, other stakeholders, and the coalition itself on how to proceed through a process of participatory planning and prioritization.

The Prioritization Process

The prioritization process consists of brainstorming which antecedent factors might be addressed, determining feasible strategies given current resources and community support, and coming to consensus about strategies to pursue. The initial prioritization process allows the group to creatively brainstorm all ideas without worrying about what resources it actually has. Fine-tuning will occur later in the action planning process. Although all the strategies brainstormed will not be used, discussing each of them encourages the group to assess its options. One prioritization process a coalition might use is the “Force Field Analysis” (adapted from Kurt Levin, see Appendix 6-1). Some coalitions may elect to work with a steering committee to draft priorities and then present them to the coalition for decision-making. Other coalitions might distribute a questionnaire to community members, the coalition, and other stakeholders, asking them to rank the strategies on their effectiveness and level of community support (see Worksheet 6 at the end of this chapter). Another option is to hold community forums where the results of the needs-and-assets assessment are presented and community input is sought.

Prioritization processes such as the Force Field Analysis provide a logical and structured framework for defining how to reach the selected Critical Health Objectives. They also help when the coalition is having difficulty reaching consensus. The process can also initiate dialogue about other logistical issues, including how to involve other groups and organizations in the process of meeting the Critical Health Objectives. For example, a group may rank a media literacy campaign about tobacco use as its highest-priority strategy but not have any relevant expertise. The prioritization process may lead it to involve new partners from the media, marketing, and education sectors.

During the prioritization process, it will be helpful to consider several questions about the coalition:

- How can the roles and resources of the group be maximized?
- Who will be important allies in the implementation phase?
- How can the multiple ongoing efforts be connected with new ones?
- Should some existing members take a stronger role and commit more of their resources?
- Is this the right time to expand or change group membership?

- Should the coalition apply for a planning grant to obtain sufficient time and money to focus on specific Critical Health Objectives?
- What are the strengths and assets of our community and how can we best use them in our new efforts?
- How can we engage youth in the prioritization process?

Once the group has established how it will focus its intervention(s), it also needs to consider at what levels it plans to direct its initial energy. Ideally, the collaborative will adopt strategies at the four levels (individual/family, schools/peers, community, and policy/society). In considering each of these primary strategies, the coalition needs to consider who else can assist, what resources are available, and in what time sequence the actions should be completed. If the group believes it has reached consensus, it is ready to proceed to the next step, creation of a logic model.

EAT RIGHT COALITION (ERC) CASE STUDY (continued)

Approximately 60 people attended the second ERC meeting, which included attendees from the previous meeting as well as newcomers. The meeting had been designed to decide on a course of action for the coalition, but because of the many possible avenues for action as well as the numerous persons supporting each avenue, criteria had to be set for prioritizing each proposed area for change. The director of the health department, who was serving as the moderator of the meeting and the “de facto” leader of the coalition, proposed several statements that could help decide which strategy should be chosen. The statements were prioritized by the attendees according to their perceived value (1-7, with 7 being the most highly valued):

1. The community will support any changes in this area.
2. The community has resources available for these changes.
3. Addressing this area will improve the problem.
4. Changes in this area are financially viable.
5. It will not take a long time to create changes in this area.
6. The coalition is prepared to commit for a substantial length of time.
7. Addressing this area is a long-term solution.

Each question could be answered on a scale of 1 to 5 (5=strongly agree; 1=strongly disagree). Thus, the total score received for a particular question was the result of multiplying each attendee's rating (1-5) by the average, or mean, priority score and then deriving a group average, or mean.

After hearing a presentation about the needs assessment and the best practice findings, the attendees split into small groups and were asked to think of three ways to approach the problem. After a short discussion, each group gave a brief presentation of its ideas.

The proposals, by level, included:

Individual:

- Offer free local community nutrition and cooking classes.

School:

- Offer comprehensive cooking and nutrition classes where students have a role in developing and selecting the menus.
- Add healthy options to the breakfast and lunch menus that students help to select.



- Prohibit sodas and snacks devoid of nutritious value other than calories from being sold on the campus.
- Limit access to area restaurants during school hours.
- Integrate nutrition information in academic classes (e.g., health, math, science).
- Develop healthy-eating campaigns.
- Have health clinic personnel plan individualized strategies to address nutrition.
- Use subsidies to lower the price of healthy foods.

Family:

- Offer free cooking and nutrition classes and cookbooks for parents and adults.
- Provide healthy food coupons to parents.

Community:

- Provide local physicians and health care workers with ready-made materials on nutrition and physical activity to give to their patients.
- Restrict the placement and operating hours of restaurants near area schools.
- Work with restaurants to add healthy options to their menus.
- Restrict sponsorship of school events by area restaurants (or at least the type of food they offer).
- Increase the accessibility of grocery stores, particularly those with quality produce.
- Reduce the presence of fast-food restaurants in low-income neighborhoods.
- Develop a cooking club for families to share responsibilities for healthy meals.
- Develop community gardens.

After hearing the various proposals, each attendee selected the two proposals that scored the best (i.e., had the highest numerical scores) according to the criteria outlined earlier. The two proposals that received the higher rankings from the average scores of individual attendees, were chosen as the direction/strategy the coalition would use to achieve its goals:

- Have a supportive school food service environment (e.g., conduct healthy-eating campaigns and offer healthier, appetizing options in the cafeteria).
- Offer comprehensive school nutrition and cooking classes.

Two school-based approaches, lowering the price of healthy foods and restricting sales of unhealthy foods, were seen as very important, but most attendees felt that other, more amenable issues should be addressed before moving on to such emotionally charged concerns. Many attendees felt that these two proposals, while useful, did not address enough parental, community, or policy issues.

Because schools were heavily involved in each of the proposals and because many principals and teachers already supported the coalition's efforts, the school board chief decided to take the lead in the coalition's activities along with the health department. Most attendees, however, felt it was important not to create a formal power structure, so as to foster collaboration both within and outside the coalition and avoid power struggles.

Developing an Action Plan

The 21 Critical Health Objectives reflect complex health issues that can be approached in a variety of ways (e.g., outreach services, policy change). In the prioritization process, the coalition should have identified general strategies from which to create a specific action plan. Action plans include goals and objectives, program components, action steps, timelines, and resources; in brief, the plan guides future actions. The coalition should involve various stakeholders in developing the intervention in order to foster a sense of commitment to the community and vision among key players. Furthermore, bringing in diverse backgrounds and viewpoints helps elicit underlying assumptions early, when they can be more easily addressed. There are a variety of ways to carry out this process – an organization may decide, for example, to have a smaller group develop the plan and then bring it back to the larger group for discussion, suggestions, and adaptations. This strategy can be helpful especially when too many diverse opinions stagnate the group.

Action planning consists of a three-stage process that will be described in this section:

1. Defining goals and objectives.
2. Designing an intervention.
3. Creating an action plan.

Creating an action plan has many advantages: First, following this systematic method will allow the coalition to lay the groundwork for evaluation of the program it designs. The action plan will also help the coalition stay on track as it begins to implement the program and will allow members to communicate one clear message when communicating their work to others. An action plan can also help by clarifying partners' time and energy commitments, thereby promoting partner understanding and accountability. Developing an action plan will also illustrate to the community, funders, and partners that the coalition is organized.

Benefits of developing an action plan include:

- **Developing understanding and consensus** among the coalition members regarding strategies, role expectations, and the selection of indicators to measure effectiveness.
- **Developing strategies at each of the four levels** (individual/family, school/peers, community, and policy/society) that focus on observable behavior and antecedent factors.
- **Ensuring that the program goals and objectives and the resulting intervention flow directly from the needs-and-assets assessment data.**
- **Imparting a realistic view** of what the program can achieve. With an action plan, program planners must think about the limits and potential of their proposed strategies given the resources available, timelines, and the magnitude of the health problem.
- **Facilitating possible replication of effective programs and best practice approaches.**

There are a variety of ways to organize the action planning process. The coalition may want to consider forming workgroups for different activities, creating one smaller planning committee, or restructuring the composition of the coalition to be sure the right people are at the table when creating the action plan. It is likely that different members within the coalition may take on stronger roles at this time (e.g., if a strategy involves developing a media campaign to create awareness of teenage depression and suicide, a member with journalism skills or media connections may increase his/her level of involvement).



Examples of Strategic Efforts: Case Study

Action plans frequently take the shape of strategic plans, incorporating discussions on the current state of affairs and proposing principles for action. In such documents, many aspects of the prioritization and needs assessment process are incorporated. In contrast, other action plans take the shape and form of a goal-oriented timeline, providing more specifics about what is to be done and when. Clearly, one of the driving forces behind the structure of an action plan is what type of organization constructs it. Here are some examples of the shapes the action plan can take:

In the Federal Office of Juvenile Justice and Delinquency Prevention's 1996 report entitled "Combatting Violence and Delinquency: The National Juvenile Justice Action Plan" (<http://ojjjp.ncjrs.org/action/>), the agency outlined eight objectives that would help strengthen state and local efforts to reduce juvenile delinquency and increase the effectiveness of the juvenile justice system. One objective was "to provide immediate interventions and appropriate sanctions and treatments for delinquent juveniles." Under each objective, an overview and current analysis of the problem was provided. In addition, each objective contained a discussion of effective and promising strategies and programs as well as recommended federal, state, and local action steps (U.S. Department of Justice, et al. 1996).

In "Being, Belonging, Becoming: Minnesota's Adolescent Health Action Plan" (<http://www.health.state.mn.us/divs/fh/mch/adolescent/exec-summ/exec-summ.pdf>), an overview of adolescent health is provided, followed by a discussion of the health status of Minnesota adolescents. General recommendations to improve adolescent health are given, followed by more specific descriptions of how to develop the recommendations. For example, under the general recommendation to "build the capacity of adolescents to become productive adults" there are more specific proposals to "strengthen schools for students of all ages" and "strengthen opportunities to connect teens to the world of work." A description of state resources for adolescent health concludes the document (Minnesota Department of Health 2002).

In contrast to these documents, the "Master Action Plan for Youth" developed by The Youth Service Action Team (YSAT) of FACES—Family Action Collaborative, Olmsted County (<http://www.cnetcf.sitehosting.net/www/area1/MAP/>), contains more specific community goals. Examples of suggested future steps for YSAT include:

1. Create an integrated, developmentally appropriate playground at the elementary school for all community members and their children to be open by June 2001.
2. Create and maintain a book-and-toy lending library for children from birth to 8 and their parents by February 2001.
3. Begin a Byron Day Care Association by planning an organization meeting and offering three training sessions in the first quarter of 2001.
4. Provide transportation to and from childcare or home to School Readiness, Byron Playgroup, and Head Start beginning September 2000.
5. Make family-based activities available, with three activities set up by November 2000 and offered in January, February, and March of 2001.

Defining Goals and Objectives

Goals and objectives should flow directly from the prioritization process, which identified the most effective and feasible strategies. They should also be consistent with community values and priorities, which should have been clarified by the needs assessment. The goals and objectives selected by the coalition should address the antecedent

factors of the selected Critical Health Objectives as well as the Objectives themselves. For example, the prioritization process may identify eating fast food as an important behavioral cause of obesity among adolescents. The intervention should take into account antecedent factors—such as lack of funding in schools for healthy lunch options, an absence of affordable healthy restaurants in certain neighborhoods, and parents' lack of knowledge or sufficient time to prepare home-cooked healthy meals—that influence adolescent obesity. If a needs-and-assets assessment confirms that these factors are present in the community, the coalition should include objectives that target school, business, and family environments to reduce adolescent obesity.

The terminology for goals and objectives varies (e.g., short-term outcomes, long-term outcomes, action steps, strategies). Coalitions should not get discouraged by the different terms. What matters is the meaning behind them. For our purposes, goals and objectives are defined as follows:

Goals are *long-term outcomes* a community hopes to achieve over a significant period of time. A typical intervention has only one or two major goals, which may be pursued through multiple objectives. For example, goals may be to decrease binge drinking among high school students or motor vehicle injuries among teenagers across the state. Measuring change in these outcomes will require significant time between the completion of the intervention and follow-up measurements.

Objectives are *short-term outcomes* that are pathways to goals. They can be measured at the completion of a program or several months afterward. For example, as a pathway to reducing motor vehicle injuries, a short-term outcome may be increasing proper seat belt use.

Worksheet 7 (at the end of this chapter) can be used to help create goals and objectives. When developing goals and objectives for an action plan, it is important to:

- Clearly link each objective to a goal.
- Be sure that both goals and objectives are measurable.
- Be specific about the geographic area, target population, and time frame of each goal and objective.

When developing objectives, consider:

- What (if any) baseline data are available to effectively monitor change over time as the strategies are implemented?
- According to the needs-and-assets assessment, how should the interventions be tailored for different groups (e.g., as defined by age groups, sex or race/ethnicity)?
- What are realistic time lines and financial parameters for the strategic plan? What resources are already in place that can be incorporated as part of the effort? What additional, crucial resources are needed to fill gaps?
- What are realistic short-term outcomes and long-term impacts?
- How can implementation of efforts be monitored (e.g., documenting activities, number of persons participating, trainings held), and what indicators can be used to measure success?

It is important to be as realistic as possible when writing goals and objectives. The coalition should consider whether the goals and objectives it has identified are achievable based on the severity of the problem and the resources available in the community. The group should be careful not to shy away from addressing issues that have a critical impact on the health of adolescents simply because they may be difficult or controversial.



EAT RIGHT COALITION CASE STUDY (continued)

The director of the health department and school board chief decided to form an action plan committee that would consult with all current members of the coalition to officially set out the mission, goals, and objectives of the coalition's first intervention. Proposals already decided upon by ERC members would serve as a foundation. The committee would also conduct an initial analysis and form a prospective timeline for the planned activities. Several parents, teachers, principals, government officials, youth, and physicians volunteered for the committee. The committee was given 6 weeks to create a comprehensive action plan. To be officially accepted, the plan would need to gain majority approval at the next meeting.

The action plan committee first decided to develop the mission, goals, and objectives for the coalition's efforts. After numerous conversations with various coalition members, these guiding principles were drafted:

Mission: To decrease obesity in youth in order to lessen the risks of such conditions as heart disease and diabetes.

Goals: To reduce obesity in middle/high school students, increase their awareness of healthy eating practices, and promote such practices in their schools.

Selected Objectives:

- By the end of year 2, all area middle and high schools should have taken steps to create a supportive school food service environment.
- By the end of year 3, 85% of middle and high school students should demonstrate their understanding of core nutritional concepts.
- By the end of year 3, there should be a 15% increase in the number of middle and high school students who purchase healthy food items at school.
- By the end of year 4, obesity prevalence should have dropped to 20% among area high school and middle school students.

Once this basic outline had been created, it was necessary to look at each program component more intensively. Specifically, the action plan committee needed to look at each program component from the standpoint of who would carry out its duties, what the deadline would be for full implementation of program activities, what barriers and collaborators might be present, what resources would be required for the program, and what indicators would be necessary to evaluate the program.

Designing an Intervention

After the coalition writes goals and objectives, its next step is to construct a set of program components that will constitute the intervention. Program components should address the antecedent factors of the Critical Health Objectives being addressed as well as the health outcomes. As part of the needs-and-assets assessment, the coalition should have researched the antecedent factors associated with these Critical Health Objectives. Now is the time to revisit that information to determine the most logical and effective interventions for the goals and objectives developed by the coalition. The coalition should link each program component to the objectives and goals it has selected. Those planning the intervention should be sure to match the intervention to the population with which it is working and be as specific as possible about the content, level of exposure, and resources needed that are necessary to accomplish the coalition's goals.

Coalitions can take a variety of approaches to designing an intervention. For example, they may use a single strategy, such as launching a major health education campaign,

and implement it at each of the four levels of influence. An anti-tobacco project might raise awareness of the risks of smoking among individual teens and their family members; provide informational brochures to medical providers; implement a public education campaign using billboards, television, radio, and bus ads; and educate policy makers about the issue of teen smoking and the need for policy changes, such as restricting tobacco sales to youth and regulating tobacco companies' advertising at the local, state, and national levels. Alternatively, the coalition might implement different strategies at each level. For example, a teen smoking prevention project might consist of a health education program for middle and high school students, a family-based intervention to increase communication about smoking, and a youth advocacy program in which young people persuade business owners to limit sales to minors and lobby policy makers to support anti-tobacco legislation. Both approaches recognize that the complex health problems represented by the Critical Health Objectives require multilevel interventions.

As the collaborative begins to map out the selected program components, it might find that one strategy can be used to achieve several objectives. Linking program components with goals and objectives will help streamline activities and help the coalition determine how to make the most effective use of limited resources (see Worksheet 8).

Best Practices and Model Programs

When considering program components, the coalition should research "best practices" and model programs related to its selected Critical Health Objectives. Lessons learned from what has worked in the past can provide a valuable foundation for future work. Those strategies, activities, and approaches that research and evaluation have found to be effective in promoting public health are called "best practices." Programs and strategies that have some quantitative data showing positive outcomes for the behavior but do not have enough research or replication to support generalizable outcomes are called "promising practices." "Guiding principles" are recommendations on how to create effective prevention programs. When a community already has a prevention program or strategy in place, the guiding principles can be used to gauge the program's potential effectiveness. They can also be used to design an innovative program/strategy when none or only a few of the best practices are appropriate to the community's needs. In addition, many professional associations have published clinical guidelines and recommendations for providers (Park et al. 2001).

Reviewing model programs saves communities from "reinventing the wheel" and gives immediate direction to program planning. Using best practices in combination with program evaluation contributes to further testing of effective strategies. In addition, funders are more likely to fund programs that use strategies shown to be effective. Information about best practices and model programs can help the coalition determine how to proceed with the specifics of developing its interventions (e.g., whom to involve, which levels should be targeted first, sequence of events, and possible curricula). Existing research can provide a foundation for creating new interventions, or the coalition may decide to replicate an existing successful program or project.

Federal agencies and organizations such as the U.S. Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention and the National Campaign to Prevent Teen Pregnancy publish information about best practices for addressing various adolescent health issues (see Table 6-1: Guidelines and Best Practices).

The coalition can search Web sites that specialize in research on best practices and evaluation research:

- Best Practices Web Site Resource Guide: http://www.asu.edu/aprc/Pages/Best_Practices/Website%20guide.htm



- Center for Effective Collaboration and Practice: <http://www.air.org/cecp/>
- Center for Substance Abuse Prevention Model Programs: <http://www.samhsa.gov/centers/csap/modelprograms/programs.cfm>
- Center for Substance Abuse Prevention's Western Center for the Application of Prevention Technologies Best and Promising Practices: <http://casatweb.ed.unr.edu/cgi-bin/WebObjects/Step6.woa/wa/getList>
- Western Regional Center for the Application of Prevention Technologies Best Practice Resource Materials: <http://www.open.org/~westcapt/bpresrce.htm>

Coalitions can ask youth or family-serving organizations that focus on the selected Critical Health Objectives if they have more information on program planning and developing interventions.

Overview of Guidelines

Critical Health Objective	Guideline(s)
Nutrition and Physical Activity	Promoting Lifelong Healthy Eating (CDC) http://www.cdc.gov/mmwr/preview/mmwrhtml/00042446.htm Promoting Lifelong Physical Activity (CDC) http://www.cdc.gov/mmwr/preview/mmwrhtml/00046823.htm
Injury and Violence Prevention	Injury and Violence: Guidelines to Prevent Unintentional Injuries and Violence (CDC) http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5022a1.htm Blueprints for Violence Prevention http://www.colorado.edu/cspv/blueprints/index.html
Tobacco Use Prevention	Guidelines to Prevent Tobacco Use and Addiction (CDC) http://www.cdc.gov/mmwr/preview/mmwrhtml/00026213.htm
Substance Abuse Prevention	Center for Substance Abuse Prevention (CSAP) http://www.samhsa.gov/centers/csap/modelprograms
HIV/AIDS Prevention	Guidelines for Effective School Health Education to Prevent the Spread of AIDS (CDC) http://wonder.cdc.gov/wonder/prevguid/p0000217/p0000217.asp
Teen Pregnancy Prevention	Program Archive on Sexuality, Health and Adolescence (Sociometrics, www.socio.com) No Easy Answers: Research Findings on Programs to Reduce Teen Pregnancy, ETR Associates http://www.teenpregnancy.org/resources/data/report_summaries/no_easy_answers/default.asp
Suicide Prevention	National Institute of Mental Health (NIMH) http://www.nimh.nih.gov/ Department of Health and Human Services (DHHS): National Strategy for Suicide Prevention http://www.mentalhealth.org/suicideprevention/strategy.asp

Questions to consider:

- What effective strategies have been identified for each of the four levels: individual/family, schools/peers, community, and policy/society?
- What strategies have been shown to be effective for the sociodemographic profile of our community?
- What critical components from evaluated programs can we commit ourselves to incorporating?

- What financial resources does the coalition have right now? Do we need to focus on fundraising efforts at this stage?
- What resources can be redeployed to support the implementation of best practices and strategies within existing programs? For example, what staff training and resources may be necessary to incorporate a well-tested curriculum in existing school health education programs?

CASE STUDY

Communities searching for best practices to address an adolescent health issue have many possible avenues. Consulting literature reviews, government and private documents, speaking with experts in the field, and studying the success of similar communities can all yield valuable information on the creation and implementation of a particular intervention and its associated strategies.

The Department of Children, Families, and Learning, the Minnesota Coordinated School Health and States Incentive Grants, the Department of Public Safety's Office of Drug Policy and Violence Prevention, and the University of Minnesota's Konopka Institute for Best Practices in Adolescent Health have worked together to produce an adolescent health document entitled "Growing Absolutely Fantastic Youth: A Guide to Best Practices in Healthy Youth Development" (<http://allaboutkids.umn.edu/kdwbvfc/Fantastic%20Youth%20Book.pdf>). The document, released in spring 2000, highlights the latest research and theories behind youth development, risk factors, protective factors, and resiliency. It showcases the various roles that schools, families, and communities can play in promoting healthy adolescent development. The document also contains numerous examples of successful youth programs within Minnesota. Most importantly, the document dispels various myths about adolescent health and adolescent health programs so that persons interested in creating their own youth interventions are guided by research rather than negative, stereotypical images. Lastly, the document places its information about seven problem areas (alcohol/tobacco/other drugs, motor vehicle crashes, violence, suicide, risky sexual behavior, nutrition, and physical activity), in the context of a community youth development framework so that communities can see how many research principles apply to community youth problems. The document serves as a valuable resource to Minnesota parents, policy makers, youth, grantees, and service providers for improving the health and well-being of youth.

Challenges: When Models Are Not Available

Throughout this document, the importance of addressing the Critical Health Objectives from a multilevel approach has been emphasized. In addition, we strongly recommend applying evidence-based research and best practices when developing a plan of action. Still, there are gaps in our knowledge about what is effective. Few evidence-based programs address critical health issues at the four levels discussed in this document. Communities may find there is much more knowledge about what works at the individual level, because it is generally harder to measure the impact of interventions designed to produce changes in the environment, such as policy-level interventions. Because interventions operating at multiple levels are more likely to be successful, however, as in the case of "designated drivers," communities should not forgo interventions at the school, community, and policy levels.

Some health issues addressed by the 21 Critical Health Objectives, such as teenage pregnancy, have more available research on best practices and effective programs than others, such as mental health. Where there is less research, communities need to examine best practices and evidence-based research for other health issues addressed by the 21 Critical Health Objectives to review whether parallel findings in those content areas



have implications for their own efforts. No matter what health issue is being addressed, adolescents need specific knowledge regarding the issue; a specific set of skills that enable them to adapt and apply that knowledge to their own behavior; a family, school, and community environment in which the requisite knowledge and skills can be used and supported; and a policy environment that provides sufficient resources and political commitment to support improved adolescent health and changes in social norms.

Communities may also find that existing program evaluations and research have been conducted with certain ethnic groups but not with those in their own communities. Much of the existing research has been conducted on non-Latino white and African American youth; less research has involved Latinos, Asians/Pacific Islanders, Native Americans or adolescents representing multi-ethnic groups. For the latter populations, the coalition will need to consider what cultural adaptations, if any, are necessary. A coalition might, for example, aim to reduce teen pregnancy among Latino youth and decide to tailor an existing program to work with this group. It may help to research the types of general interventions that have been effective in reaching Latino communities, especially Latino youth. It is also advisable for a subcommittee to work with parents, youth, and teachers to consider what cultural adaptations are needed. When incorporating interventions with demonstrated effectiveness, the coalition should keep the tailored program as true as possible to the original model with respect to factors such as classroom hours and learning objectives.

Choosing Program Components

After reviewing best practices about its selected health issue, the coalition may have difficulty deciding which components to incorporate. It should take the time to research and consider a variety of options, paying attention to what has worked and what has not. A common pitfall is combining interesting elements from several model programs. For example, a teen drug prevention coalition might mix components from three such programs, but this is a “hybrid” intervention, which changes the core of the program and essentially defeats the purpose of using evaluated programs. Coalitions are better off staying true to one model’s core evaluated curriculum, adding components only after the core program has been fully implemented. Mixing and matching components from model programs makes evaluation more difficult and may prevent the coalition from using previously developed evaluation measures.

The following principles can guide planners in selecting, replicating, and adapting model programs:

- **Select and adapt programs based on the unique needs of youth participants:** Choose programs that serve similar populations. Once a program is selected, consider how it may be applied more effectively to the background and experience of youth in the community. If possible, conduct focus groups to test the acceptability and relevance of the model.
- **Plan for evaluation of the program from the outset:** Keeping evaluation in mind during program planning will help guide implementation efforts.
- **Seek outside assistance:** Establish contact with people who have used the program to find out about potential challenges or pitfalls and to learn from their experiences. Consult a researcher or statistician on the best way to evaluate the program.
- **Consider resources and training:** Ensure that there are adequate resources (e.g., staffing, training) to implement the program model.

- **Replicate evaluation criteria:** Replicate evaluation procedures used in the model program so that the effectiveness of your program can be compared among different sites and populations. Use programs with goals and objectives that are similar to those of the coalition.
- **Adhere to the model:** When adapting an already tested program, do not let changes compromise the goals or objectives of the original. If necessary, supplement evaluated materials to tailor the program to a specific audience, but these supplemental materials must not change the core elements of the original materials.

(Adapted from Brindis and Davis 1998).

Creating an Action Plan

Now that the coalition has decided on the program components of the intervention, it is time to plan how it will be put into action (see Worksheet 10). Creating an action plan includes determining the steps involved in implementing each program component, assigning responsibility for them, determining what resources are necessary, and creating a timeline.

An action plan should incorporate:

- *Actions that must take place to accomplish the objectives.* For example, if a coalition chooses to create a peer education program as a component of an intervention to prevent drunk driving, its action steps might include hiring a program coordinator, securing or developing a training curriculum, recruiting young people, and training the peer educators.
- *Groups and individuals who will perform these actions.* These people should understand what the goals are; be given tasks that match their capabilities, available time, and spheres of influence; and be provided with relevant training and resources.
- *Anticipated time for implementing the action and the sequence in which the actions will be implemented.* Make sure to incorporate enough time to accomplish the goals. Be sure to consider trainings that need to be given, staff that need to be hired, and funds that need to be raised.
- *Requisite resources to carry out these changes.* Whether through funding or redeployment, those carrying out the plan need to have access to proper resources.
- *Potential barriers to completing program activities.* Identifying potential barriers in advance will help the coalition be prepared to deal with roadblocks as they arise.
- *Agencies and individuals that can be collaborative partners.* Working in collaboration with others to implement program strategies that maximize resources can help forge important relationships between organizations and can increase the likelihood of a program's sustainability.

EAT RIGHT COALITION (ERC) CASE STUDY (continued)

Program Component #1: Offer comprehensive middle/high school nutrition and cooking classes that will increase individual understanding of core nutritional concepts.

This coalition activity required several considerations. Would existing teachers be used or would new teachers need to be hired? Which model nutrition curriculum would be chosen, and would it be adapted to meet the local community's needs? From where would funding for the teacher training/curriculum come? Would parent and student



associations help to choose a curriculum and consider any possible modifications? How would possible conflicts between principals and teachers be resolved? What indicators would be necessary to monitor how well students learn nutritional concepts?

The committees responsible for carrying out the action steps would focus more specifically on these issues. In preparation, however, the action planning committee deliberated on some of these issues to create an action plan template.

Action Step	Persons Responsible	Resources Required	Potential Collaborators	Indicator(s)	Potential Barriers	Potential Solutions
To implement a comprehensive nutrition and cooking class in all area middle and high schools at the beginning of year 2.	Teachers; principals to guide implementation process	Model curriculum; classroom/time availability in schools; funding for teacher salaries/overtime and school supplies	PTA; student associations; teachers unions; school board/ principals; local physicians; mayor	Percentage area middle and high school students understanding core nutritional concepts (Percentage may come from baseline survey accompanying curriculum)	Principals/school board worried about time constraints on teachers; lack of interest shown by students; lack of funding; inability to recruit existing teachers for program	Work closely with school officials Engage youth in coalition work; take their input seriously Provide incentives for teachers to engage them in the project

Program Component #2: Create a supportive food service environment in area middle/high schools by offering more healthy, appetizing options on school menus and conducting healthy-eating campaigns.

This program component had a myriad of questions to be considered. What food options would be chosen for the school menus? How much would they cost and for what price would they be sold? How would their use be tracked? Who would lead healthy-eating campaigns in school cafeterias?

Action Step	Persons Responsible	Resources Required	Potential Collaborators	Indicator(s)	Potential Barriers	Potential Solutions
Create a supportive food service environment in area middle/high schools by offering more healthy, appetizing options on school menus and designing healthy-eating campaigns by the end of year 2.	Principals to guide implementation process (purchase food); food service staff to prepare/ publicize healthy food options, conduct healthy-eating campaigns, and coordinate school nutrition activities	Healthy, appetizing foods; school supplies (flyers, table settings, etc.) for campaigns; improved cooking equipment; time for campaign activities; increased funding for food service staff	PTA, student associations, school board/ principals, area food businesses	Number of area middle/ high schools that have added three healthy, appetizing items to each school meal; number of area schools conducting healthy-eating campaigns	Principals opposed to expense of adding healthier foods to school menus; food service staff inexperienced in preparing/ publicizing healthy food options and conducting healthy-eating campaigns; student apathy; tracking student use of healthy foods; making time for campaign activities	Work closely with school officials to engage their support Work with local food businesses and restaurants for the mutual benefit all parties Have recommendation box for student menu suggestions and use them

The deliberations that went into creating these templates helped the action planning committee form a hypothetical timeline for the ERC's activities. These timelines would necessarily undergo future revisions, especially by the individual committees handling the implementation of various program components, but they provided a useful benchmark to gauge the pace and success of the coalition's efforts. Here is an example of the timeline used for **Program Component #1**:

Partial ERC Timeline: Program Component 1, Year 1

	Jan	Feb	March	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Research and select appropriate curriculum.	X	X										
Secure grant money for instructor salaries and purchase of curriculum/school supplies.	X	X	X	X								
Create official curriculum proposal to be approved by school board.			X	X	X	X	X					
Work with area schools to find instructors for curriculum.			X	X	X	X	X	X				
Train teachers with curriculum (use paid/ free consultant for this).					X	X	X	X	X			
Adjust school schedules, and class teaching schedules to incorporate more nutrition information.						X	X	X				
Urge all area middle and high schools to introduce class.								X	X	X	X	X
Publicize the program in the community and provide necessary information to school staff.								X	X	X	X	X



Time Sequencing

Some objectives need to be met before others are put into place, while others can be met concurrently. It is essential to consider the relationships between activities when creating the action plan. A timeline allows for the organization and efficient use of resources and serves as a guide for gauging progress and realistic goal setting. Some questions to consider when creating a timeline are:

- What is the necessary sequence for introducing different activities? What critical tasks need to be accomplished first, second, third, etc? What activities can occur concurrently?
- What are the critical dates (e.g., when do the tasks have to be accomplished to meet the projected implementation deadlines)?
- What other interim tasks have to be accomplished for the community-wide plan to be implemented?
- What concrete benchmarks will indicate progress made toward meeting the goals and objectives?
- When should the project be completed?

It may be helpful to designate a subgroup of persons to write the plan, which should be written in clear, accessible language that makes sense to the community and the people who will be carrying it out. Once the plan is developed, with the responsibilities of each partner clearly defined, it can be distributed by the coalition to the partners. Realistic timelines are needed to ensure timely progress. It is wise to build in a cushion of time while maintaining a set of clearly defined benchmarks to measure timely completion of tasks.

Evaluating Community Resources: Revisiting the Needs-and-Assets Assessment

An understanding of community resources is instrumental in deciding which strategies to pursue at this time and how to pursue them. Although additional funds will probably be necessary to support some of the plan's components, there are numerous ways to be creative with available resources.

Based on the needs-and assets assessment, consider what resources exist:

- What resources does the community (and the coalition) already have in place? For example, who or which groups/agencies are working on the issue, what facilities exist; what activities are already in place?
- How can other community sectors be best incorporated and involved?
- What resources are lacking? How can these be secured?
- What skills need to be developed? Who can help develop them?
- How can all the existing resources be coordinated and better aligned so that simultaneous efforts are under way at each major level of effort (i.e., from the individual/family to school/peers to community to policy/society)?

One of the most important outcomes of a needs-and-assets assessment is gaining an understanding of which existing resources and groups are related to the Critical Health Objectives. Restructuring staff and resources or using money in creative ways can be as useful as seeking new funds. Many resources can be redeployed without using additional funds. For example, two schools in a community that want to reduce the number

of adolescents injured or killed in car crashes involving alcohol might provide free weekend transportation to teens. The two schools can pool their resources (e.g., developing joint grant applications, purchasing of vans, and asking members of Parents and Students Against Destructive Decisions to drive on weekends).

Once completed, assess your action plan:

- Is it based on the needs-and-assets assessment?
- Does it have activities geared to specific individuals, agencies, and community-wide efforts?
- Does it set up specific steps?
- Does it include age-appropriate activities for adolescents?
- Does it include multiple strategies that operate at multiple levels?
- If it involves a coalition, does it coordinate program activities and encourage joint planning among partners?
- Does it incorporate support from multiple funding sources?
- Is it based on best practices?
- Does it clearly delineate who will be involved and responsible for carrying out different components?

(Adapted from Brindis 1999b).

Developing a Logic Model

Using a Logic Model Approach

A logic model is a visual representation that illustrates how an intervention will achieve its intended outcomes by clarifying the links among the needs and the target populations, the goals and objectives, and the intervention strategies. The logic model establishes measurements that will be used for the evaluation and can also be used to facilitate program planning and implementation. The logic model synthesizes all the planning steps presented in this document.

Although a logic model may sound intimidating, it is just another tool for describing how an intervention is intended to work. Laying out intervention components visually can clarify the links among the target population, program activities, and the desired outcomes, and can help communicate the concepts and assumptions supporting the coalition's belief that its intervention will work.

Groups often do not want to create a logic model because they do not see its value and believe it differs little from narrative descriptions of the intervention. Some may not think it necessary to map out what seems obvious. However, there are many ways in which a logic model will ultimately improve the implementation and evaluation of an intervention. A logic model:

- Helps build understanding about what the program is, what it expects to do, and what measures of success it will use.
- Helps monitor progress and track changes during implementation so that successes can be replicated and mistakes can be avoided in the future.



- Serves as an evaluation framework by clarifying evaluation questions and the data needed to answer them.
- Helps reveal assumptions that need validating.
- Provides a clear mechanism to communicate information about the intervention, its goals, and expected outcomes.

Logic models are typically developed by workgroups of program planners, evaluators, and other stakeholders who are knowledgeable about both the issue and the community. Using such a workgroup promotes stakeholder involvement, greater commitment, and a shared vision of the project.

There are many ways to construct a logic model. The coalition can use the template described here or research other logic model templates (Worksheet 10 provides a template for the method used in this guide). With the exceptions of identifying indicators and data sources as well as constructing a theory of change, the coalition should have defined most of the logic model's components during the action-planning phase. The group will simply need to insert the goals, objectives, antecedent factors being addressed, and program components into the logic model format. Although other logic models may label the components differently, it is important not to be deterred by different terminology. What is important is considering how each component fits in a logical progression of steps toward the goal.

A logic model has the following components:

- **Antecedent Factors:** These factors, which are based on research, either place people at risk for, or protect them from, the health issue being addressed. The antecedent factors should have been identified by the needs-and-assets assessment as relevant to the community.
- **Theory of Change:** This theory explains the underlying assumptions and constructs for why the chosen strategies are expected to create positive change.
- **Program Components:** This set of strategies constitutes the intervention. Individually, strategies may operate on different levels; together they create a comprehensive, multifaceted approach to the problem. Curricula, public education campaigns, drafts of recommendations for policy changes, and service coordination are examples of components that together form a strategy set.
- **Process Indicators:** These measures determine whether the program is being implemented as planned (e.g., training conducted, educational materials handed out, number and types of people reached).
- **Short- and Long-Term Outcomes (From Goals and Objectives):** These outcomes, which are short- and long-term changes expected to result from program activities and components, flow directly from the goals and objectives of the intervention. They can be at the level of individual/family, school/peers, community, or policy/society. Examples include changes in knowledge, skills, attitude, behavior, policies, and programs. Outcomes can be related to such areas as building the capacity of individuals or organizations, reducing underlying risk factors, increasing protective factors, or decreasing risk behaviors.
- **Outcome Indicators:** These measures determine the degree to which an outcome objective has been met. They are usually expressed as increases or decreases in the numbers or percentages of something. One example is an increase in the percentage of persons who, after participating in a program on injury prevention, have increased their knowledge of the subject.

- **Data Sources:** Sources of the data, which can either be readily available from existing sources, or can be collected to measure the process and outcome indicators, can range from state statistics to medical records reviews to surveys of program participants (Western Regional Center for the Application of Prevention Technologies 2003).

Developing a Theory of Change

A very common problem in prevention programs is that program strategies and activities do not lead to the desired outcomes. Thinking through assumptions about why a program should work will help to increase the likelihood that the program will be effective and resources will be put to good use. One approach is to create a series of “if...then” statements.

Example: Theory of Change

If a program invests time and money to develop a directory of drug-free summer activities, then youth will be more informed about what is available in the community. If youth know what is available, then they will be more likely to participate in these programs. If youth participate in alternative activities, then they will be more likely to develop friendships with non-drug-using peers and less likely to use alcohol, tobacco, and other drugs.

In this series of if...then statements, several assumptions are being made about the problem being addressed and what the program can achieve.

- Youth do not currently know what is available.
- The collaborative will have the time, money, expertise, and other resources needed to create the directory.
- Once the directory has been developed, people will receive and use it.
- The people who use the directory will be from the target population.
- Knowing about available activities will lead youth to participate in them.
- The activities will support the development of positive peer relationships.

Taking the time to understand assumptions will help the coalition clarify the logic behind its intervention, highlight assumptions that may be incorrect, and identify additional steps to be taken. In the example shown in the box, the coalition might discover the need to develop a strategy for publicizing the directory in a way that ensures that the target population will be reached. The coalition might also realize that it needs to create a referral system for increasing the likelihood that young people who need the programs will actually enroll.

Developing a theory of change is another tool for ensuring that resources are used wisely and that an intervention is based on sound logic. It will also help the coalition communicate about the program more effectively to colleagues, community members, and potential funders.

Developing Indicators

Indicators can be thought of as markers toward achieving its goal that help the collaborative know whether it is on the right path. They are essential for evaluating a program’s effectiveness. Many of the health issues addressed by the 2010 Critical Health Objectives are caused by an array of complex, multifaceted factors, and thus programs addressing the Critical Health Objectives may take several years to produce results. Identifying realistic indicators, which can be assessed at periodic intervals, will help the collaborative and its funders know if the intervention is making progress.



Indicators help measure progress in quantifiable ways. For example, the percentage of adolescents who exercise 3 to 5 times per week for 30 minutes or more serves as an indicator for the goal “teens are physically active.” The percentage of adolescents who wear seat belts is a possible indicator for “teens are safe.” The coalition needs to consider, in both its action plan and the logic model, the indicators that will help determine whether it is meeting its goals. Coalitions should make sure that their indicator set includes measures at the four levels of action: individual/family-, schools/peer-, community, and policy/society-.

Indicators can be used to gauge progress only if they are compared to baseline measures. Once collaborative members have decided on their indicators, they must collect data to determine the community’s current status as measured by them. Data from the needs-and-assets assessment or from state or national sources can serve as a baseline. Data will be collected again at intervals throughout implementation and after program completion to measure the impact of the intervention. The Evaluation section of this document provides further discussion.

Example: Outcome Indicator Inventory Tool: UNHEALTHY DIETARY BEHAVIOR

Type of Indicator	Indicator	Method and Source	Availability (City, County, State, National, or Not Available)
Risk factor	Poor body image	Minnesota Student Survey	City, county, and state
Protective factor	Parental nutrition behavior	CDC Behavioral Risk Factor Surveillance System	State
Youth risk behavior	Fast or skip meals to lose or control weight	Minnesota Student Survey	City, county, and state
Youth risk behavior	Few or no servings of fruits, fruit juices, and vegetables yesterday	Minnesota Student Survey	City, county, and state
Consequence of youth risk behavior	Overweight	Minnesota Health Profile	County and state
Consequences of youth risk behavior	Type 2 Diabetes	Minnesota Health Profile	County and state
Capacity building	Policies regarding nutritional content of school meals	School district records	County and state

(Source: Minnesota Youth Risk Behavior Endowment 2003).

As program accountability becomes increasingly important to potential funders, greater emphasis is placed on measuring the “results” of an intervention, which makes the need for program indicators clear. In addition, with the relatively new emphasis on youth development and asset building as prevention strategies, it is important that programs measure asset- or resiliency-based indicators. Although measures of resiliency are still in development, there is already a strong body of evidence supporting this new approach. See Chapter 4 for more information on measuring assets and possible indicators of this concept.

Once the coalition has created a logic model, the members should check their logic: is each element of the model causally linked to the next? Are causal linkages realistic? Are both outcomes and activities clear and measurable? The time invested in developing the logic model is well spent, as it enables the group to address potentially troublesome issues in advance so that less time is diverted during implementation to

working on such problems. It is important to schedule sufficient time to develop the logic model; working through assumptions and reaching consensus will ultimately benefit the resulting intervention.

Celebrate a job well done. To keep partners motivated and inspired, it is a good idea to plan informal get-togethers (e.g., on a semi annual basis) to celebrate group accomplishments, however “small.” Do not wait until the broader goals are attained, as they are harder to meet. Instead, celebrate the attainment of immediate objectives, which will show appreciation to partners and also draw attention to the progress being made.

EAT RIGHT COALITION SAMPLE LOGIC MODEL

Antecedent Factor	Theory of Change	Program Component	Process Indicator	Outcome(s)	Indicator(s)	Method/Data Source
Knowledge about nutrition and physical activity.	What youth eat in school affects their eating habits outside of school.	Offer comprehensive middle/high school nutrition and cooking classes that will increase individual understanding of core nutritional concepts.	Increase in number of healthier food options on menu.	Short-term: Selling healthier food options will be sustainable for school cafeteria.	Improved availability of healthy food choices and increased use by students.	Review of school and district policies.
Eating habits established by parents and/or at home (e.g., sit-down dinners, parent/child cooking).	Some youth will change their eating habits if given healthier, appetizing, inexpensive options.		Increase in number of healthier foods, items sold.	Schools/school board will adopt policies that promote healthier eating through school cafeterias.	Strong policies in place that promote healthy food choices.	Survey data of youth and cafeteria workers.
Access to fast food vs. healthier selections at school.	Publicizing changes in menu along with information on eating healthfully will encourage students to eat healthier if given options.	Create a supportive food service environment in area middle/high schools by offering more healthy, appetizing options in school menus and conducting healthy-eating campaigns.	Decrease in number of fast-food items sold.	Improved dietary lifestyle of teens (at school and at home).	Increased numbers of youth eating more fresh fruits and vegetables and fewer calorie-dense foods.	Medical records of youth.
School funding (uses funds generated by calorie-dense competitive foods to fund lunch service program, sports, etc.).				Long-term: Reduction in the proportion of teens who are overweight or obese.	Decreased proportion of teens who are overweight or obese.	

*** Sources consulted for Best Practices and Guidelines include:*

American Academy of Family Physicians, American Academy of Pediatrics, American Dietetic Association, Centers for Disease Control and Prevention, National Hispanic Association, National Medical Association, Office of the Surgeon General, U.S. Department of Agriculture, U.S. Department of Health and Human Services.

Implementing an Action Plan

Implementation of Previously Evaluated Programs

When following an intervention program that has been previously evaluated, it is advantageous to implement as many of the components as possible. Maintaining the integrity of the approach will maximize the potential for achieving results similar to the original, although adaptation may be necessary to make the intervention relevant and meaningful to new communities.

For any prevention or intervention program at the individual level to be successful, the targeted youth must find the activities interesting and want to participate in them.



As the coalition plans to implement its model, it must consider the adaptations necessary to match the needs and demographics of the selected populations. However, it is vital to adhere to the model program (the concept of “fidelity”) while making necessary adaptations based on such differences as culture and age of target population.

Adhering to the model entails maintaining the standards of previously evaluated programs. Compare the original community (from the evaluated model) and its resources to the target populations or community and available resources. Consider how the coalition can expand or modify the evaluated model for the population of interest (e.g., group with a different culture, youth with special needs). The coalition should take care, however, not to change the components that make an intervention successful. In brief, it is acceptable to add elements, but unadvisable to dilute critical aspects of any model or promising program. The Center for Substance Abuse Prevention provides instructions or tools for achieving program fidelity when applying model programs.

Communication Within the Collaboration and the Community

As the program gets under way, it is important for the coalition to keep relevant partners and community members informed about its progress. The coalition should communicate to partners how their input was incorporated and check in regularly with the persons carrying out the action. It is important to be accessible to partners and open to their concerns on what is needed to fulfill goals. Collaborative members could be asked to report on how they are accomplishing their tasks and be given an opportunity to communicate any questions, concerns, or suggestions that they may. Communication strategies could include in-person meetings, conference calls, e-mail or fax. Regular updates, such as a quarterly newsletter or a monthly group e-mail, are useful for synthesizing and celebrating the implementation efforts under way.

More formal partners, such as project funders, should receive a semi-annual or annual report covering the progress of the coalition. It is critically important to be accountable to those connected to the coalition’s work. It is also important to get the word out to the community about the coalition’s accomplishments and progress. It is also helpful to maintain relationships with the media, send them press releases, and invite them to community events. These efforts will also raise awareness about the issue and build support in the community.

Community Involvement and Staying Consistent With the Action Plan

Community members and youth need to be actively involved throughout the implementation of the action plan; there are several ways to achieve this aim. The highest degree of community involvement means that young people, community residents, coalition members, and partner organizations are actively involved in carrying out components of the action plan. For example, young people and parents might be trained as peer educators or members of a speakers’ bureau. A partner organization might expand its existing mentoring program to serve a new group of young people recruited through the coalition’s new intervention. An example of a less-involved form of inclusion is asking community members to serve on an advisory board of young people, parents, teachers, health care providers, and other relevant stakeholders. Such a group might meet monthly or quarterly to hear updates about the intervention, help troubleshoot challenges to the implementation, and plan additional activities.

The action plan is a work in progress, and the coalition should be open to suggestions for making it stronger and more complete. Although an advisory board can make helpful recommendations and bring to light some ways the intervention could be modified to better meet the needs of the community, there are serious risks to modifying the intervention partway through implementation. As outlined previously, changing or

eliminating components of a model program can weaken its effects. In addition, groups often miscalculate the time and resources necessary to implement a program, and activities can take longer than expected to get off the ground. The coalition also might find that certain organizations or institutions previously identified as collaborating partners are now unwilling to work with it. In reality, timelines and strategies will need to be continually reassessed, and the coalition will need to troubleshoot a variety of issues throughout the implementation process.

EAT RIGHT COALITION (ERC) CASE STUDY (continued)

Now that the action planning committee had formed an initial plan, it sent out flyers to all ERC members and posted them around the town. The flyers publicized the plans for the next meeting to adopt the action plans formulated by the action planning committee and work committees, etc. Approximately 100 persons attended the meeting, and they overwhelmingly approved the action plans. There was some disagreement about whether the timelines could be met, with many attendees believing there was not enough time for such activities as recruiting instructors for nutrition classes, but most attendees felt the timelines represented a good starting point.

The director of the health department and the school board chief decided to form two committees to oversee implementation of the agreed-upon program components. A moderate number of parents, principals, teachers, health care professionals, clergy, and youth volunteered, but there were not enough to truly implement coalition activities. Also, the volunteers did not possess sufficient expertise to manage the program components effectively. Thus, the audience members, especially educators and influential persons in the community, were urged to use the next month to actively recruit other principals, teachers, lawmakers, and parents into the coalition so that ERC's efforts would have more community support, expertise, and a better likelihood of success. A follow-up meeting was planned for the next month.

The next meeting had approximately 50 attendees, which included influential local citizens, such as prominent lawmakers, school board members, clergy, physicians, and principals, teachers, as well as some parents. These persons had been recruited by previous ERC members and offered general support for what the ERC was trying to achieve. Again, volunteers for the two program component committees (PCCs) came forward, and several additional persons volunteered to serve. This group appeared to have significantly more influence in the community and direct knowledge of what was being attempted. To supplement the volunteers, the health department director assigned several departmental employees to the various committees. It was unclear, however, how many of the new recruits would consistently participate in the coalition's efforts. The director of the health department stated that even though no formal governing structure had been adopted by the ERC, there should be a structure for managing funds, keeping track of progress, addressing needs, and so forth. The attendees decided that the director and the school board chief should remain the informal heads of the coalition, and two volunteers agreed to act as treasurer and secretary. Each PCC was asked to form its own governing structure and was required to send a progress report every month to the action planning committee. The various committees were expected to start meeting within a month. An advisory board of several volunteers was formed to help the PCCs troubleshoot problems.

Implementation

While the director of the health department concentrated on securing stable funding, the PCCs tried to follow the directives of the action planning committee and set tasks for individual members. Tasks included deciding upon and purchasing materials (e.g., the nutrition curriculum); deciding how to find and use



necessary labor; advocating in front of school board members, policy makers, and principals; and tracking project indicators.

The PCC in charge of implementing the school nutrition and cooking class worked with area principals and the school board to find a curriculum that would suit the needs of the community. Initially, it found many curricula that were either geared toward urban communities or were not particularly useful for racially diverse communities (this town had large African-American and Hispanic populations). When the committee discovered a curriculum that appeared responsive to the town's needs, the price was prohibitively high. Finally, using input from local PTA groups, youth, and teachers, the committee settled on a curriculum that had served rural communities. Even though it was not as comprehensive as desired, the curriculum had been used in similar towns around the country with good results. It taught basic nutrition education and incorporated physical activity education, which was useful for schools desiring to form a coordinated "nutrition web" among physical education, nutrition, health, and food service staffs. The school board approved the curriculum.

The committee's biggest obstacle was achieving consolidated support for the program among the teachers and principals of area high schools and middle schools. Although schools were not responsible for purchasing the curriculum or paying the teachers extra for their additional efforts (this would be accomplished with grant funds), they still had to adjust student schedules, implement evaluation and tracking measures, and make sure the curriculum was integrated with the changes being requested by the other PCCs. To achieve this goal, the PCC charged with implementing the nutrition and cooking class worked with the school board and a popular health class teacher to create a detailed presentation that spelled out the important points of the curriculum intervention, its successful implementation elsewhere, how in other school districts health teachers participated, and where funding would be obtained. This presentation was given to area educators at a school board meeting. Concurrently, sympathetic influential parents, teachers, and youth activists lobbied for the curriculum at area schools, and youth activism was employed. The PCC then worked with school principals and teachers to create a class schedule and course content that would minimally disrupt the existing school environment; it also scheduled time for pretraining teachers in the curriculum. Subsequently, a final curriculum proposal incorporating all salient points was presented to the school board and received majority approval. The proposal's open support from the school board had significant impact not just on its passage but also on its acceptance by area middle/high schools; the school board's participation and involvement in the intervention had been central to the PCCs' success. Although the school district was careful not to dilute the curriculum, it did make additions felt to be relevant to the local community (e.g., it emphasized food enjoyed by its African-American members). Interestingly, the curriculum had been developed to be part of an existing health course, but some PCC members and other educators thought it merited a separate class. To maintain fidelity to the curriculum's intended use as well as to conserve funds, however, it was kept as part of a larger school health course.

The PCC charged with creating a more supportive school food service environment faced several difficult tasks. First, it needed to work with food service staff members, dieticians, and youth to come up with a list of foods that would meet three criteria: healthy, low cost, and appetizing. After the list was compiled, the PCC worked with principals, youth, and food service staff to develop ideas for healthy-eating campaigns that promoted the new foods. This task required speaking to other communities that had implemented similar programs and working with the other PCCs to ensure that their activities were properly coordinated. Such coordination involved offering the same foods cafeteria that were discussed in nutrition classes, allowing nutrition classes to meet in cafeterias to learn how to prepare healthy meals, and posting the nutritional contents of various school meals. Constant reinforcement of principles of healthy nutrition was a central aim.

As in other PCCs, youth activism played a prominent role in shaping these efforts. As part of its efforts, the PCC concerned with a supportive food service environment gave a detailed presentation to the school board and area educators about this program component; it specified what foods could be purchased, how coalition money would be used to purchase these foods as well as improved cooking equipment for needy schools. It also gave a preview of the planned healthy-food campaigns. The proposal received majority approval by the board. Two principals were not convinced, however, that they were not already providing healthy foods. They adopted a wait-and-see approach to see how successful other schools were with the program; they committed to joining the program the following year if there were noticeable results.

Youth Involvement

Youth had helped administer the needs-and-assets assessment and had voted in the prioritization process, but they had not taken an active role in the action planning committees. One concern was that the high school youth who had been specifically invited to the initial meeting made up the majority of those participating. Few middle school youth were participating, and few new high school students had been recruited. To address this problem, both PCCs elicited ideas from youth members on new ways to recruit other youth. The youth already involved were asked to take one month to focus solely on recruiting other youth. Specific attention was focused on having high school youth recruit middle school youth; recruiting more peer leaders; and letting youth know they would be valued active members of the coalition. The start of PCC activities was delayed until the process was finished. The process took longer than expected, but 15 more youth were recruited. Six youth were assigned to each PCC. The other youth chose to participate by helping out with administrative duties, including preparing progress reports and recording minutes at coalition meetings. The youth received modest stipends for their work.

The youth involved in the PCCs were quite active in planning the coalition's activities. The youth in the nutrition curriculum committee helped to select the final curriculum, interviewed officials from other towns to see how similar programs had been implemented, conducted literature searches on making health and nutrition materials engaging for youth, interviewed youth to find out what things they wanted in a nutrition class, added to the curriculum to meet students' desires, and worked with health teachers during the pretraining period to make nutrition classes engaging and interesting. Very importantly, these youth worked with principals and school board members to convince them of the necessity of nutrition and cooking classes. These youth were not only a prominent voice in the curriculum PCC, they were oftentimes the *dominant* voice in this PCC. They effectively represented the concerns of the curriculum's intended target population.

The youth working in the PCC concerned with making healthy additions to school menus and conducting healthy-eating campaigns in cafeterias were also heavily involved. Their input led to decisions to reject or accept certain healthy foods: They interviewed officials in other communities who implemented similar measures; they worked with educators and food service staff to create exciting, relevant healthy-eating campaigns; and they took inventories of the food equipment needs of area high and middle schools. These students were integral to the PCC's operation.

Despite the efforts of these 15 students, it was still unclear whether their enthusiasm would catch on with all the students. Many who had been interviewed for recruitment seemed skeptical of the program in spite of peer involvement. In fact, three students dropped out of the coalition because they felt "it was a waste of time" and because "no kids wanted it." The coalition appreciated that it would need to work harder if it were going to improve general student support for its activities.



APPENDIX 6-1: Force Field Analysis

This appendix outlines the basic process of a **Force Field Analysis**. Consider how the information gathered through the needs-and assets-assessment can be used to fill in the steps of a Force Field Analysis.

1. State the goal(s) you want to accomplish.
2. List all **supporting forces** (i.e., positive forces currently in place that can help reach Critical Health Objective goals).
3. List the **blocking forces** (i.e., conditions currently in place that may prevent you from reaching your goal).
4. Examine the lists of supporting and blocking forces. Assess the strength of each force with respect to fulfilling or limiting your goals.
 - **Significance:** First, rate each supporting and blocking force (on a scale of 1- 3) in terms of its degree of significance. The number “1” represents a factor that is vitally important; the number “3” signifies the least significant force, either in a positive or negative sense. (Significance rankings are listed under the letter “S” in the table.)
 - **Changeability:** Next, rate each force (on a scale of 1- 3) to reflect the difficulty or ease of changing that force, either to increase supportive forces or decrease blocking forces. The number 1 represents a force that is relatively easy to change; the number 3 represents a major barrier that is difficult to overcome. (The ease of changing forces is listed under the letter “C” in the table.)

Sample Force Field Analysis Worksheet

Supporting Forces (+)	S*	C**	Blocking Forces (-)	S	C	Goals
Individual/Family Teens responded that if offered a wider range of food options that were healthier, they would choose those.	1		Individual/Family Fast food is cheap and teens like it.	1	3	Individual/Family Offer nutrition education for students and parents that teaches how to prepare delicious, low-fat meals that are just as tasty as fast food and can be prepared quickly.
60% of teens would like to increase their level of physical activity.	1		Bag lunches are neither convenient nor cool to students.	1	2	
School/Peers Teens believe there are few healthy fast food options.	1		Teens may not buy healthier foods, such as quality fruits and vegetables, because they may cost more than fast food.	1	2	School/Peers Offer more affordable low-fat and low-calorie options in the school cafeteria.
More than 50% of high schools surveyed offer healthier food options (e.g., fruit, packaged salad, yogurt, bagels). ¹	1		School/Peers 85% of school districts that sell fast food as a la carte items use profits from these sales to support food service operations. ³	1	3	Community In partnership with the local youth organization that has funding for chronic disease prevention, form a youth development program. Activities may include engaging young people to advocate that local
Some schools that sell only healthy competitive food modify them to be healthier and sell them under the school name. ²	1		Some school districts also use these profits to	1	3	

Supporting Forces (+)	S*	C**	Blocking Forces (-)	S	C	Goals
Community Several sports and recreation programs are available through the schools, the city's Parks and Recreation Department, and community based organizations.	1		fund other functions, e.g., athletics, education programs, and extracurricular activities. ⁴			restaurants add low-fat options to their menus. The program can also help enroll young people in existing sports and recreation programs.
A local youth organization recently received a grant for chronic disease prevention activities.	1		At least 72% of responding school districts allow fast food and beverage advertising (e.g., posters, advertisements on scoreboards, other signage). ⁵	1	3	Policy/Society With the participation of young people, develop a public education campaign about healthy eating to counteract the impact of advertising and the media.
Policy/Society CDC guideline: Increase availability of and accessibility to healthy foods to reinforce better eating.	1		Community There are an abundance of fast food restaurants in the community, especially near the schools.	1	3	
The Surgeon General's Call to Action: Include new foods and foods prepared in new ways and sufficient choices to better meet the taste preferences of a diverse student population.	1		Policy/Society Adolescents are exposed to hundreds of advertisements for fast foods and other unhealthy foods that make poor dietary behaviors seem attractive.	1	3	
CDC guideline: Implement a change in eating habits in schools because it is an opportunity to reinforce healthy eating.	1					

*S = Significance of force (1= most important; 2 = moderately important; 3 = least important)

**C = Ability to change the force (1 = easy for change; 2 = moderate effort required for change; 3 = challenging for change)

¹ Public Health Institute, "California High School Fast Food Survey: Findings and Recommendations." (2000) Author: Berkeley, California.

² Ibid

³ Ibid

⁴ Ibid

⁵ Ibid



Force Field Analysis Blank Worksheet

Supporting Forces (+)	S*	C**	Blocking Forces (-)	S	C	Goals
1. Individual/Family			1. Individual/Family			1. Individual/Family
2. School/Peers			2. School/Peers			2. School/Peers
3. Community			3. Community			3. Community
4. Policy/Society			4. Policy/Society			4. Policy/Society

*S = Significance of force (1 = most important; 2 = moderately important; 3 = least important)

**C = Ability to change the force (1 = easy for change; 2 = moderate effort required for change; 3 = challenging for change)

After rating the strength of each supporting and blocking force, the following steps will help determine the most appropriate strategies.

1. Brainstorm strategies to diminish or remove the strongest blocking force(s).

List what the group can do to weaken or eliminate blocking forces. In the example provided, schools are very resistant to giving up contracts with fast food and soda vendors as profits from their sales support school programs. However, students indicate that there are few healthy food options in the school cafeteria and the options that are available are more expensive than fast food. Offering a wider variety of healthy foods at affordable prices may diminish the appeal of fast food.

2. Brainstorm strategies to strengthen the strongest supporting force(s).

List what the community can do to strengthen these forces, combining strong positives if possible. For example, 60% of the teens surveyed would like to increase their levels of physical activity and there are several already existing after school sports programs. Perhaps the coalition can identify ways to involve teens in these sports programs or expand or enhance the programs.

3. Try to reverse a strong blocking force into a strong supporting force.

This requires ingenuity and creativity! For instance, the media is a powerful influence on young people. Advertising sends a strong message to young people that eating unhealthy foods is positive and cool. However, the coalition can decide to use the media to their advantage by creating counter-messages that show healthy eating and exercise as the more positive option.

4. Research best practices to help identify promising strategies.

If the coalition has done some research on best practices for the health issue they are addressing, they can plug in the strategies that seem most appropriate based on the specific characteristics of their community that have been identified in the Force Field Analysis.

Addressing the strongest blocking forces generally has the greatest impact. However, sometimes the energy and resources required to change these forces may be too big a strain on existing resources. Instead, choose to work on a factor that is easier to change. Starting small and succeeding creates a sense of success and lends credibility to the coalition. It is much easier to build on smaller successes than to reach too high and fail, especially if resources are limited. For example, in the Force Field Analysis, extending the health education curricula on dietary and exercise habits in high schools appears to be extremely challenging, often due to the constraints schools face such as academic accountability and limited funding. It may be more realistic to try to limit teens' access to foods high in fat and sugar, by, for instance, regulating vending machines and advocating that school cafeterias offer low-fat snacks and fruit. This is not to say that the easiest strategy is always the best, especially if it has little potential to make an impact. The coalition should weigh each strategy and employ the one that seems both feasible and effective.

Keep in mind the four levels of influence when brainstorming strategies, so that the group can work toward a multi-level approach. Using the Force Field Analysis model should facilitate the prioritization process by helping the group choose where they want to focus next steps and which levels they would like to focus on first.

Selected Forces for Change

Diminish/Remove Strongest Blocking Force(s)		Who can help with this strategy?	Other available resources:	Implementation priority:	Action Steps
	Potential Strategies				
Individual/Family					
School/Peers					
Community					
Policy/Society					
Strengthen Strongest Blocking Force(s)					
	Potential Strategies				
Individual/Family					
School/Peers					
Community					
Policy/Society					



Worksheet 6: Prioritization

On a scale of 1-5, please indicate the degree to which you think each proposed strategy will be effective and supported by the community. All answers will be averaged and used to help prioritize strategies for the community action plan.

Proposed Strategy	Community Support					Effectiveness				
	Weak	Strong	Low	High						
	1	2	3	4	5	1	2	3	4	5
	1	2	3	4	5	1	2	3	4	5
	1	2	3	4	5	1	2	3	4	5
	1	2	3	4	5	1	2	3	4	5
	1	2	3	4	5	1	2	3	4	5
	1	2	3	4	5	1	2	3	4	5
	1	2	3	4	5	1	2	3	4	5
	1	2	3	4	5	1	2	3	4	5

Source: Adapted from: Wadud, E. (2002). Rating community goals. In *Community Toolbox: Part J, Chapter 38, Section 3*. Retrieved September 29, 2002, from http://crb.lsi.ukans.edu/tools/en/sub_section_main_1365.htm

Instructions for Using the Prioritization Survey

- Use this survey with a group that offers broad representation of community stakeholders and viewpoints.
- Results may be used to prioritize strategies, or they may indicate a need to revise strategies and survey the group again.

1. Distribute the survey and describe to respondents what is meant by community support and effectiveness:
 - Community Support—Will the community find this strategy controversial, culturally appropriate, or a necessary expense? Will it consider the strategy a priority? These are examples of what respondents should consider when ranking each strategy for community support.
 - Effectiveness—Respondents should consider whether each strategy is based on best practices, whether the strategy will target young people most at risk, and whether the community has the resources to implement it.
2. Review survey responses: Someone will need to average the ratings for community support and effectiveness for each strategy. The results can be summarized in a table similar to this one:

Strategy	Community Support	Effectiveness
1. Change school lunch menus	3.7	4.5
2. Do away with candy machines on school grounds	1.8	3.9

3. The coalition will need to decide what strategies constitute higher and low priority for community members based on these ratings. One way to use this information to prioritize strategies is to create a ranking system similar to this one:

High Priority = high community support, high effectiveness

Priority = low community support, high effectiveness

Low Priority = high community support, low effectiveness

Last Resort = low community support, low effectiveness



Worksheet 7: Writing Goals and Objectives

Use this worksheet to create goals and objectives for your intervention. Copy extra sheets as needed.

Goals are *long-term outcomes* of an intervention that a community hopes to achieve over a significant period of time. A typical intervention has only one or two major goals, which may be pursued through multiple objectives.

Objectives are *short-term outcomes* and should be thought of as pathways to goals. They can be measured at the completion of a program or several months afterward.

When developing goals and objectives for an action plan, it is important to:

- Clearly **link** each objective to a goal.
- Be sure that both goals and objectives are **measurable**.
- Be specific about the **geographic area**, **target population**, and **time frame** of each goal and objective.

Goals	Objectives
By 2006, motor vehicle injuries among teenagers living in the state aged 16–19 will decrease by 20%.	By 2003, there will be a 25% decrease in the number of adolescents aged 16–19 who have ridden in a car with someone who has been drinking.
	By 2004, 75% of adolescents will be able to identify at least four strategies for preventing motor vehicle injuries.
	By 2005, the number of adolescents aged 16–19 who wear a seatbelt will increase by 25%.

Source: Card, J., Brindis, C.D., Peterson, J., & Niego, S. (2001). *Guidebook: Evaluating teen pregnancy prevention programs* (2nd ed, Chapter 4). Los Altos, CA: Sociometrics.

Worksheet 8: Linking Program Components with Goals and Objectives

Once goals and objectives have been identified, use this worksheet to link them with program components or activities. If matching a particular component to your goals and objectives seems difficult, you may need to abandon this approach and find a more appropriate strategy. Completing this worksheet will help the coalition focus its efforts. Complete the table from right to left by first filling in the Goals and Objectives columns, then filling in the program components that relate to them. It may help to draw arrows between program components and the goals and objectives to which they correspond, as some components will address more than one goal and objective.

Level	Program Component	Objectives	Goals
Individual/Family			
School/Peers			
Community			
Policy/Society			

Source: Card, J., Brindis, C.D., Peterson, J., & Niego, S. (2001). *Guidebook: Evaluating teen pregnancy prevention programs* (2nd ed, Chapter 4). Los Altos, CA: Sociometrics.



Worksheet 9: Action Plan Worksheet

Use this worksheet to create an action plan, or work plan, that will guide implementation efforts. A separate sheet can be completed for each program component. Make copies as needed.

Program Component:

Action Step	Person(s) Responsible	Date to be Completed	Resources Required	Potential Barriers or Resistance	Collaborations
Example Recruit, train, retain, and supervise a youth advisory board to assist in the development of a campaign.	Adult leaders, college mentors, Emilio, Cathy.	April 30, 2007.	Transportation, handouts, easel, paper, food, supervision, stipend.	Transportation, inability to recruit interested youth, parents concerned about their children participating.	Principal, PTA, student council, minority student union, business leaders (to pay stipends).

Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health; Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health; National Adolescent Health Information Center, University of California, San Francisco. *Improving the Health of Adolescents & Young Adults: A Guide for States and Communities*. Atlanta, GA: 2004.

Worksheet 10: Creating a Logic Model

This worksheet will help you create a logic model, which clarifies the links among the antecedent factors of the health issue, the intervention's goals and objectives, and the intervention strategies. Complete the worksheet from left to right, listing the following: 1) Antecedent Factors identified in your assessment process, 2) your theory of change (explaining why program components will bring about change), 3) program components, 4) indicators that will help monitor whether program components are being implemented as planned, 5) short- and long-term outcomes that the intervention is expected to bring about (short-term outcomes should correspond to objectives and long-term outcomes to program goals), 6) indicators that will serve as benchmarks of progress toward outcomes, and 7) sources of existing data or methods for collecting data to measure indicators.

Example: Sample logic model to reduce overweight and obesity rates among youth in the community.

Antecedent Factors	Theory of Change	Program Components	Process Indicators	Outcomes	Outcome & Impact Indicators	Methods/Data Source
Knowledge levels about nutrition.	What youth eat in schools affects their eating habits outside of school.	Provide nutrition and cooking classes for students and parents.	No. of nutrition and cooking classes offered.	Short-term Students and parents have increased knowledge of good nutrition practices and how to cook nutritious foods.	Outcome Increased knowledge of good nutrition practices and how to cook nutritious foods.	Pre- and post-tests administered to nutrition/cooking class participants.
Eating habits established by parents and/or at home (e.g., sit-down dinners, parent/child cooking).	Some youth will change their eating habits if given healthier, appetizing, inexpensive options.	Offer more healthy food options on school lunch menu and in school vending machines.	No. of people attending cooking classes.	No. of healthier food options on menu.	Policies regarding nutritional content of school meals.	School district records.
Access to fast food vs. healthier selections at school.	Publicizing changes in menu along with information on eating healthy will encourage students to eat healthier.		No. of healthier food options in vending machines.	Schools/ school board will adopt policies that promote healthier eating through nutrition classes, school cafeteria, and vending machines.	Cafeteria and vending machine sales.	School food service sales receipts.
School funding (uses funds generated by sales of fast foods to fund lunch service program, sports, etc.).			No. of parents involved in cooking meals with their teens.	No. of healthier foods, items sold increases.	Servings of fruits, fruit juices, and vegetables yesterday.	Student food logs.
				Decrease in No. of foods sold with high-fat, calorie, and sodium contents.	Servings of foods high in fat, sugar, and sodium.	
				Increase in number of students who eat recommended daily amounts of fruits and vegetables.	No. of times a student ate a meal at a restaurant.	
				Decrease in students' daily intake of foods with high-fat, calorie, and sodium contents.	No. of meals from fast food restaurant.	

Source: Western Regional Center for the Application of Prevention Technologies. (2003). *Building a successful prevention program: Step 7, Evaluation*. Retrieved May 23, 2003, from <http://www.unr.edu/westcapt/bestpractices/eval.htm>.



Antecedent Factors	Theory of Change	Program Components	Process Indicators	Outcomes	Outcome & Impact Indicators	Methods/Data Source
				Long-term Reduce the proportion of teens who are overweight or obese.	Impact % Overweight.	

CHAPTER 7



Sustaining the Intervention

Contents

- Communication and Dissemination **page 2**
 - Communication Strategies **page 2**
 - Determining the Target Audience **page 4**
 - Developing a Clear Message **page 5**
 - The News Media **page 7**
- Fundraising and Redeployment of Resources **page 11**
 - Determining Development Strategies **page 11**
 - Understanding and Developing a Budget **page 13**
 - In-Kind Services and Redeployment of Resources **page 15**
 - Fundraising **page 16**
- Program Monitoring and Evaluation **page 20**
 - Documenting Implementation **page 21**
 - Assessing a Program's Readiness for Evaluation **page 21**
 - Why Evaluate? **page 24**
 - Determining the Scope of the Evaluation **page 25**
 - Process Evaluation **page 26**
 - Outcome and Impact Evaluations **page 28**
 - Evaluation Design: Data Sources and Collection **page 29**
- Worksheets 11-22 **page 32**

Note: Citations are listed by chapter in the references section at the end of the document.



Communication and Dissemination

A major goal of this document is to increase community interest in adolescent health in general and the 21 Critical Health Objectives in particular. Communicating what a coalition does will help accomplish this goal. Most coalitions incorporate some communication strategies in their interventions, whether through relatively small-scale activities (such as publicizing events or recruiting members) or larger activities (such as a comprehensive media campaign). Regardless of the scope of communication efforts, an intervention to achieve any of the 21 Critical Health Objectives will be enhanced by knowing how to frame messages, communicate information, and work effectively with the news media.

The communications arena provides a wonderful opportunity for increasing the involvement of coalition members. For example, members with experience or connections in journalism, media, event planning, or social marketing can be very creative. Youth involvement can be especially powerful in disseminating meaningful messages (e.g., through youth-specific message development, media interviews). Expanding coalition membership or partnering with other agencies may provide communication other routes. Community groups who are working on related issues may want to cosponsor campaigns or events (e.g., Students Against Destructive Decisions (SADD) and the PTA could sponsor a forum on decision-making strategies to prevent drunk driving). Depending on the communications experience within the coalition and the type of strategy, it may be wise to seek professional help from public relations firms.

Communication Strategies

Communication strategies benefit the work of the coalition in many ways. They can:

- Increase or create awareness about the health issue (e.g., increase media awareness about bullying and fighting in local elementary, middle, and high schools).
- Increase or create awareness about the group, available services, programs or projects (e.g., use a newspaper ad to publicize a free youth sports program that reflects the goal of increasing physical exercise among community teens).
- Motivate people to use program services, attend events, or change behavior (e.g., hold a health fair to promote the use of mental health screening services and treatment for youth).
- Recruit members, allies, or potential funders (e.g., e-mail fact sheets or promotional information to other organizations working on related issues to help introduce the coalition to the public).

General Kinds of Information Dissemination

In choosing the most appropriate strategy for dissemination of information, it is important to consider the message, target group, and timing of delivery. For example, a group focusing on reducing HIV infection may first try to recruit members by posting an introduction in e-mails, list servs, and established newsletters, and wait until later to hold a press conference for local media that discusses how the issue affects youth in the community. The requirements of communication strategies vary widely, with some options involving substantial time, training, and resources. Worksheets 11 and 12 are designed to help plan and evaluate communications efforts.

CASE STUDY: Communication

Attracting community interest in an organization is vital to its sustainability. Being creative in how youth are approached and engaged can yield substantial benefits to an organization's functioning, reach, and objectives. Essentially, a coalition must have a strong understanding of its target population in order to effectively galvanize it for organizational activities.

Yo! Memphis is dedicated to youth development in Memphis, Tennessee (<http://www.yomemphis.org/>). More specifically, this organization attempts to help teens stay in school, learn job skills, earn a GED, and obtain long-term employment. In an effort to encourage community support for the organization and to promote organizational objectives, *Yo! Memphis* and its partners held a teen music video contest that encouraged participants to showcase videos addressing social issues such as AIDS and crime. Entries were judged according to talent, social content, and originality. In 2001, citywide winners were selected. To assist their efforts, contestants received video resources from community sponsors as well as from *Yo! Memphis* and they could take media classes if they needed technical assistance.

When developing communication strategies, consider:

- Is the strategy realistic within the designated time frame?
- Is the strategy financially feasible at this time?
- Does the coalition have the capacity and experience to use this strategy effectively?
- What, if any, additional resources and support are necessary to use this strategy?
- How can the impact on the target audience be measured?

Potential dissemination approaches include:

- **Paid Advertising and Public Service Announcements (PSAs).** Effective paid advertising can be very expensive, but the coalition can maintain control over the timing and placement of paid ads. PSAs are free, but timing and placement are out of the group's control.
- **Entertainment and Events.** Examples include live theatre, music, and poster contests. Entertainment strategies can be very effective with teens, but they take a lot of creative energy and effort to be done well.
- **Non-Media Public Relations.** Public speaking (conferences, special events) and publications (classroom materials, newsletters, community, school and faith-based publications, posting of notices in libraries, and supermarkets) are examples. These can be very effective and have a wide reach; they can be very targeted or very broad.
- **Electronic.** Web sites, e-mails, list servs are examples of easy, fast ways to "get the word out."
- **Sales.** T-shirts, bumper stickers, calendars and other items could be sold. If done creatively, sales can be a good strategy and a great way to involve teens.
- **Media Relations.** TV, newspapers, radio are possibilities. Generating news coverage by the media is largely free or inexpensive, reaches a large, diverse audience, and has high credibility. It takes a lot of effort, however, to establish and maintain relationships, and there is a lot of competition with other stories.

Although many of the strategies and information discussed below are applicable to all modes of communication, the next section focuses primarily on the news media.



CASE STUDY: Media

In addition to drawing on the power of such traditional media outlets as television, radio, print media, and billboards to effect change, coalitions should explore nontraditional media, such as photography. Finding a medium that is heavily used by youth can increase their exposure to and use of a coalition's resources. Before undertaking any communications strategy, the coalition should study the media habits of its target population. Communications specialists and teen volunteers could provide valuable assessment assistance as part of this research project. Here are examples of organizations that used less traditional methods of getting their message across:

The Alameda County (California) Public Health Department (<http://www.co.alameda.ca.us/publichealth/>) planned to use photographs taken by a group of teenage youth, known as the Town Criers, to increase local awareness of AIDS. The pictures were taken within the county and depicted HIV-infected and AIDS-affected persons in various situations, such as relaxing at home, visiting relatives, or seeing the doctor. The photographs, which were accompanied by captions that describe the essence of AIDS as well as various perspectives on the disease, were designed to increase the visibility of AIDS in a county that has been severely affected by it.

As part of the CDC's "Choose Your Cover" initiative to prevent skin cancer (<http://www.cdc.gov/ChooseYourCover/>), Ogilvy Public Relations Worldwide worked with local restaurants to develop a "Choose Your Cover"-themed tray liner.

The Truth, an anti-tobacco organization, has created the "INFKT truth tour 2002"—a tour of U.S. cities that showcases DJs, oversees rap contests, and holds free giveaways—to go along with its core task of providing anti-tobacco information (http://www.thetruthpress.com/press_release.html).

Determining the Target Audience

In developing the action plan, the coalition should choose very specific strategies and groups on which to focus. It is very important to define the target audience as specifically as possible. Perhaps the strategy focuses on individuals (such as youth who carry weapons), or, if the intervention operates on multiple levels, aims various components at different populations (e.g., youth who carry weapons, their parents, local stores that sell weapons). Perhaps the strategy is geared to people familiar with the issue; perhaps it targets people not yet involved. In any case, the strategy needs to be tailored both to the audiences the coalition is trying to reach and to the message it seeks to convey.

To determine optimal ways to reach its target population, the coalition should consider the following (also see Worksheet 13):

1. Target Audience:

Age, sex, race/ethnicity, culture, location.

2. Information Sources:

Where do audience members get their information? Whom do they trust or respect? Who are their role models? What radio stations do they listen to? What TV shows do they watch? What other media do they use?

3. Perception of Issue:

What do audience members think about this issue? Do they know the consequences or realities of the health issue? Have they been personally affected by the issue?

4. Places to Reach:

Where do audience members spend their time? What are their hobbies? What transportation do they use? What are their travel routes?

5. Cultural Issues/Languages:

Are there cultural aspects to the message that must be considered? Is it necessary to publicize the message in more than one language?

6. Research Shows:

What does research show about the issue? What best practices have been found to be effective?

Example: Message Development Worksheet for Smoking Intervention Geared at Latina Youth (See Worksheet 13)

Target Audience	Information Sources	Perception of Issue	Places to Reach	Cultural Issues/Languages	Research Shows
Latina females, ages 10-17 years, living in predominantly Latino neighborhoods	Spanish-speaking and hip-hop radio stations, Spanish-speaking local television stations	Focus group with Latina youth in the neighborhood where smoking was common	City subways, particularly in certain neighborhoods, local park where Latina youth hang out	Language, smoking common in this target group	Targeted interventions specifically focused on different segments of the population are more effective

Developing a Clear Message

The message the coalition promotes should conform to its action plan. To develop an effective message, the coalition first has to know what the target audience thinks or knows about the issue, and needs to be clear about the behavior or actions it wants to encourage. Focus groups, surveys, and key informant interviews are excellent ways to learn what types of messages the target group will respond to as well as how and where the group gets its information. It is extremely important to have members of the target group involved in the working group that develops and tests messages. It is best to test and refine the message until the target group finds it effective. The impact of an effective message can be enhanced by placing it in the media channels most frequently used by the target group.

Developing a clear message is extremely important. The message should be so straightforward that there is virtually no chance of misunderstanding it. It should stress a few key points and be honest and simple, yet complete. The message can be delivered in a variety of tones (e.g., reassuring, serious, emotional) as long as it is expressed in a way the target group will relate to and respect.

Once the core messages for the intervention or program are developed, they can be adapted for different audiences. All related communication activities regardless of vehicle (e.g., flyers, commercials, news media interviews) should reinforce the same message.



Targeting Young People

When developing messages targeted to youth, research has shown:

- Teens do not respond to scare tactics and negative images.
- Teens are more likely to respond to messages from people 2 or 3 years older than themselves.
- Immediate consequences are far more real to teens than long-term ones. Messages that focus on the short term have the most impact.
- Glamorizing the positive behavior being promoted is effective.

(National Campaign to Prevent Teen Pregnancy 1997)

EAT RIGHT COALITION (ERC) CASE STUDY (continued)

Many of the ERC's communication efforts had already taken place through numerous presentations prepared by the individual program component committees (PCCs) for area educators. Moreover, joint publicity events were being planned with other organizations. Still, it was imperative that the coalition assign several persons to handle its essential communication duties. The coalition's communications committee was composed of students, parents, business professionals, and teachers. These persons decided to develop a coherent media strategy that focused on three groups: youth, parents, and teachers.

The committee realized it may be difficult to gain the acceptance and approval of youth while simultaneously exciting and motivating them. Therefore, it was especially important to obtain feedback from student members. First, the committee tried to organize events in which youth would participate. Thus, talent shows (including one Latin talent show catering to the community's Hispanic population), food tastings showcasing some of the new healthy/appetizing foods to be offered, and basketball tournaments were held at various schools, and high school seniors were recruited to organize events and encourage other youth to participate. In addition, the committee attempted to sponsor events and have booths and presentations at relevant events. The committee used a variety of communication strategies, including school flyers, youth speakers in local classrooms, and short speeches at sponsored events. In each setting the committee explained in basic terms the activities the coalition intended to offer and how youth could take advantage of them, while emphasizing the impact that healthy eating could have on a person's energy level and self-esteem. In fact, the committee created a slogan that promoted such a message: "Eat Right, Feel Good!"

To target parents and teachers, the committee tried to employ different methods. It had learned from many of the coalition's initial meetings that these groups were fairly supportive. Thus, it felt its goal should be to explain how parents and teachers could involve themselves in the various interventions. It gave short presentations at PTA meetings, teacher meetings, the work sites of large employers, and to faith-based groups. Its presentations clearly explained what the coalition was doing, and audience members received a flyer entitled "How You Can Help." These flyers gave suggestions to teachers on how to coordinate health messages in their classes with healthy-eating campaigns taking place around the schools. The campaigns' purposes were to help students make healthy food choices, as well as to promote healthy-cooking classes and contests. Flyers encouraged parents to familiarize themselves with healthy food options at schools and to conduct healthy-eating campaigns in their own homes that dovetailed with what was going on in the schools. Presentations emphasized that the interventions would have minimal impact on the school teaching environment, and would not consume a large part of the school's resources. Finally, all teachers and parents were given healthy-food vouchers that students could use in the cafeteria.

The committee also tried to publicize the coalition's message to the greater community. For example, it held a joint press conference with the school board superintendant and health department director to announce the project. Coalition members wrote editorials and placed ads in local newspapers, and they developed "sound bites" in preparation for subsequent interviews. Press kits were sent to area newspapers, radio, and television stations, as well as to the mayor and other prominent community figures. In addition, one committee member worked extensively with a local television station to plan a series of youth health reports that corresponded with National Physical Fitness and Sports Month.

Finally, the coalition sponsored a community-wide healthy cooking competition in which local businesses and residents set up booths at an area park, showcased healthy foods, and vied for the first prize, the "Scrumptious and Healthy" award.

The committee's activities required more expenditures than initially anticipated. The expense of printing various items and sponsoring events was quite large, so that this committee had to coordinate with the resource committee to ensure that funds were available. These extra cost placed considerable strain on the resource committee's ability to maintain adequate funds for the coalition. Some of the expenditures were recovered by selling ERC T-shirts, which proved to be exceptionally popular and were sold at each of the community events.

The News Media

There are many benefits to working specifically with the news media which has the capacity to reach a large audience, offers free exposure, and specializes in communication. It takes significant time and effort, however, to work with the news media effectively. In addition, what the news media views as "newsworthy" changes constantly, and many issues compete for daily coverage.

Strengths of the news media:

- Informs the public on a broad scale about health issues.
- Informs policy and decision makers and influences them to take action.
- Gives community members who might not otherwise be heard a stronger voice and a sense of empowerment and importance.
- Gives exposure to stories and issues that will help a community mobilize its members.

There are **three main approaches** to working with the media:

- **Proactive:** A member of the group approaches the media to propose a story about an issue, service, or event.
- **Reactive:** The media asks the group to respond to an issue or statement currently in the news.
- **Self-defense:** The media asks the group to respond to a crisis or negative press regarding the organization or the issue at hand.

Working with the media proactively is usually the best approach. By building a relationship with media representatives, the coalition can initiate dialogue and present stories and efforts strategically. Correspondingly, most media opportunities can be used to the group's advantage.

Certain times are especially strategic and appropriate for collaborating with the media:

- During the announcement of a new project or new development (e.g., the results of a community needs-and-assets assessment)



- When the coalition has information that can be tied to current community events or recent news (e.g., injuries in the national news can be tied to local adolescent profiles), and
- When opportunity for publicity could mean the difference between meeting coalition goals and having an alternative (or opposing) view of the problem receive attention (e.g., directing attention to rates of youth depression when a mental health bill is being considered).

Relationships with the Media

Making friends with, and becoming a credible source for, the media takes a lot of time and effort, but it is well worth expending this energy. Developing this relationship illustrates to media representatives that the coalition respects the role they play in making its message visible, and it will build their trust in the coalition as a respected source for health information.

Tips for developing a relationship with the media:

- Research the types of articles or topics covered by local or other media sources, and examine which reporters and newspaper sections cover the issues related to the Critical Health Objectives the coalition is addressing. Be creative, perhaps approaching the sports editor, for example, to focus on unintentional injuries that affect youth.
- Designate media contacts (or a group) within the coalition. These persons should introduce themselves to the media, follow up on all calls, and keep the media informed of group activities or relevant developments on the issue.
- Research and connect with a variety of media organizations, such as local, ethnic, faith-based, and educational resources, including ethnic-specific newspapers or radio stations.
- Keep a current media contact file that is easily accessible and well organized.
- Share new information, related news, and important contacts as they come up, not just when the coalition has an upcoming event or services to publicize.
- Put together a press kit that contains background information on your organization, including its accomplishments, current projects, and, possibly, staff biographies. Send the press kit to media contacts to introduce the coalition and include it with any topical information the group sends out.
- Keep a media “hit file,” which includes the actual piece if possible (e.g., newspaper article or online printout) as well as how many individuals it reached (e.g., Web hits, newspaper circulation, presentation audiences). This information will help assess how well the group is working with the media and will prove useful when applying for funds or conducting an evaluation.

Connecting with the Media

Establishing connections with the media can take numerous forms based on the specific purpose—to inform about events, to initiate ideas, and to present information to the general public. These opportunities are excellent for local youth to offer their perspectives and experiences regarding the Critical Health Objectives. Strategies for contacting the media are described below:

- Pitch letters—Short, concise letters to propose ideas for a story or to spark media interest.

- Media advisories—Announce the particulars of an upcoming press event in bullet form (often sent a few weeks before an event).
- Press releases—Short, concise memos that describe the “who, what, when, where, how, and why” of an upcoming event. Should be written so they can be printed “as is” and easily distributed; should be sent to the media approximately a week before an event.
- Press conferences and briefings/community forums—Events the coalition can sponsor that provide opportunities to discuss the issue the media is invited to explore.
- Press/media kits—These kits, which should be assembled and ready to go at a moment’s notice, can contain fact sheets about the organization, supporting documents (reports, informational flyers, or brochures), and fact sheets about the issue, including sources for all facts.
- Opinion pieces (op-eds)—Most op-eds are 500-1000 words. Because newspapers have different policies, check with the local paper about how to submit an opinion piece so that it is published at the correct time.
- Letters to the editor—Shorter than op-eds, these letters are usually written in response to a newspaper article and should be submitted as soon as possible after that article appeared.

Framing Messages for the Media

Because exposure from the media is often limited, it is important to make the message as compelling as possible and to frame it in a manner that is easy for the media to communicate.

Prepare a Media Bite

Oftentimes, regardless of the amount of time spent with a reporter or information offered to this person, only one or two sentences see print or are broadcast. Therefore, it is a good idea to incorporate a media bite – the core message in a quick and succinct form – that the media can easily use. Once the coalition knows the core message it wants to deliver, the following strategies can help:

- Keep it short and simple – 15 seconds maximum.
- Communicate shared values – Stress themes that appeal to the general public (e.g., safety, education).
- Communicate what is at stake – Who is affected? Why is it important?
- Use reasonable language easy for the public to understand – Avoid jargon or acronyms.
- Present a solution to the problem or concern of interest.
- Frame the problem and solution in terms of institutional accountability – if appropriate, name the body the coalition holds responsible for taking action.

Make the issue “newsworthy”

As media reporters have so many potential stories and issues to cover, consider framing the issue in a manner they will find attractive and “newsworthy.” Some possibilities are:

Local angles to national news information—statistics or trends

Personal stories—especially of interesting events, personalities, achievements against great odds, or racial or socioeconomic inequalities



Quotable people—celebrities and policy makers

Seasonal/anniversaries—a critical objective can be tied to a holiday or an annual or historic event

Some examples include:

- *A popular young celebrity discloses a history of drug abuse and a stay in rehabilitation. This can be related to drug use among the community's youth and efforts to work with adolescents and their families on this problem.*
- *Bringing attention to drinking and drug use on prom night can serve as a tie to community programs for youth that are drug and alcohol free.*
- *A teen suicide in national headlines can prompt a report on suicide and depression among youth in the community.*
- *Cuts in funding for physical education classes could be an opportunity to highlight the need for physical activity.*

(Hutchins 1999; Wallack et al. 1999; Whitman 2002a)

Communicate the Meaning Behind the Statistics

Many of the statistics behind the Critical Health Objectives have striking implications. Even so, when a powerful statistic is shared with the community, its meaning can be lost because the public cannot relate to its significance. Expressing a statistic in a context that is easy to understand can help provide the desired effect.

- Break down numbers by time – how many teens a day, per hour, every weekend. For example, every weekend, more than 1,000 teenagers will be involved in a car accident due to drinking.
- Break down numbers by place – how many classrooms of students every year or day, the size of a city.
- Provide comparisons with familiar entities – the number of kindergarten classrooms needed every year because of teenage births, for example.
- Provide ironic comparisons – money spent on violence prevention vs. juvenile halls vs. college tuition.
- Personalize the statistic – what it means for each child, adolescent, and family.

(Wallack et al. 1999)

General Interview Tips

- ***Timing is everything***

If a conversation with a reporter is proactive, asking if it is a good time to talk and offering to call back at a later time if needed might be useful. If journalists or reporters call, respond promptly, as they may be working to meet a deadline. A delayed response might tempt journalists to find someone else, who may not present the perspective of the coalition. Be prepared to respond immediately to breaking news, which is often the priority for news media.

- ***Only discuss issues when ready—if not ready, refer to someone who is***

If reporters call the organization to request an interview or information, first determine the specific issues about which they want to know. This will help to decide who in the coalition the reporters should be interviewing. If they should be speaking to

someone else or the information is not available, inform the reporters that the necessary information will be gathered and delivered to them as soon as possible.

- ***Prepare for anticipated questions***

Draw on the core message and mission of the coalition to determine what messages need to be stressed, and how. Generally, it is wise to prepare answers to questions like:

- Why is this issue important to the community?
- What is the solution to the problem?
- How can community members become involved?

- ***Say only what you are willing to see in print***

Speak positively and remain as friendly and relaxed as possible. Understand the reporter's perspective, answer directly and honestly, and maintain control of the interview by focusing on the topic to be discussed. If the reporter phrases the issue negatively or is trying to steer the conversation in a different direction, you might have to reframe the issue and bring it back to the core message (e.g., "What is really important is..."). If you do not know the answer to a question, it is okay to say so and promise to get back to the reporter as soon as possible. As the interview is closing, summarize key points and the take-home message. Finally, if the reporter misrepresents what was said in the interview, or related facts – ask for a correction in print or on the air.

- ***Develop a group of credible community members who can speak on the topic***

Have a prepared contact list of community members who can discuss how this issue affects them personally and professionally (e.g., community youth, parents, teachers, physicians) to make it easy for reporters to obtain the quotes and information they are seeking (National Campaign to Prevent Teen Pregnancy 1997; Wallack et al. 1999).

Disseminating messages to the community, both through media and non-media approaches, calls for initiative and perseverance. The options for disseminating information can seem overwhelming, and first steps such as determining the target audience and developing clear messages require time and careful consideration. Developing relationships with the media also entails significant energy and commitment. Although challenging, all of these efforts are integral to reaching the 21 Critical Health Objectives for adolescents and young adults in a meaningful way. Communication strategies shape the environment and influence teens on a variety of levels. Thus, working to transform key messages into health-promoting influences is an effort well spent.

Fundraising and Redeployment of Resources

Regardless of the direction in which the coalition has decided to channel its Critical Health Objective efforts, additional resources will probably be needed to carry out these strategies. The resource development process depends on many factors (e.g., the coalition's age and structure, current financial standing, and potential strategies) that must be addressed prior to or concurrent with putting the Critical Health Objective strategies into action. For certain strategies, some resources can be redeployed or donated; for others, substantial funds must be raised.

Determining Development Strategies

There are a variety of approaches for acquiring necessary resources. The route the group takes will depend on such factors as timing, the stage of the coalition, findings from the needs-and-assets assessment, and strategies in the action plan.



The coalition might consider the following questions to help determine appropriate resource development strategies:

Financial Standing

- What is the current financial situation of the coalition? Does it have a tax-exempt or nonprofit status?
- What are the current sources of funding? How are funds currently being allocated?
- Can any of the existing sources be further increased?
- What is the fundraising goal at this time? What are future goals? What kind of funding will be needed in the future to maintain the interventions?

Current and Future Strategies

- Which, if any, current activities/components are to be maintained? Which activities can be eliminated if funding is not available?
- Are more staff and positions needed to implement strategies effectively?
- What may not be absolutely necessary but would facilitate meeting objective goals (e.g., space, supplies, essential equipment, transportation)?

Available Resources

- To what resources (e.g., staff, space, board members) does the coalition have access?
- Are there more effective ways to use existing facilities and resources? How can resources from members of the coalition be pooled to maximize their potential?
- Are additional funds really needed at this time, or could the needed services or personnel be redeployed, provided in-kind, or obtained voluntarily from existing resources?
- How much money is already dedicated by the community to the issue? What other groups are working on similar issues? Is there potential for collaboration?
- What funding/resources are generally available in the community? (This information may be available from the needs-and-assets assessment).

Approaches to Resource Development

The coalition can choose from several approaches to resource development. The majority of these strategies can be carried out at different times or in conjunction with each other. Youth can be creatively involved in all these approaches.

- **Collaboration with Other Organizations**

Collaborate with other organizations to work towards meeting needs together (e.g., applying for joint funding) or sharing resources with each other.

- **Events (e.g., Fundraisers, Conferences)**

Hold events that draw attention to the issue. Charge registration or admission fees, or request donations.

- **Fees or Dues**

Develop a fee-for-service structure or membership fees.

- **Sales**

Sell products (e.g., greeting cards, T-shirts related to the issue and the target population) that contribute to youth development.

- **In-Kind Support, Volunteers, or Donations**

Seek donations, obtain in-kind support, or use volunteers to meet administrative or program needs.

- **Resource Use and Redeployment**

Use resources more fully and redeploy existing resources (personnel and administrative).

- **Submission of Funding Proposals**

Submit proposals to governmental (federal, state, local) or private (e.g., philanthropic) funding sources.

CASE STUDY: Fundraising

Despite having multiple funding sources, an organization can find itself struggling to make ends meet. To raise funds effectively, it is necessary to know what resources are available, to be efficient and creative, and always to be prepared.

LA Youth (<http://www.layouth.com>) is a countywide, independent, teen-written newspaper with a readership of over 300,000. Among the newspaper's many goals are to give youth a voice in civic life as well as a forum to discuss relevant subjects and ideas. The organization has several funding streams but is primarily supported by grants from such foundations as the Irvine Foundation, the Ford Foundation, and The California Endowment. Although the newspaper receives funds from 25 to 50 foundations overall, no one foundation accounts for more than 20% of the total funds received. Besides this source of income, the newspaper receives small amounts of revenue from advertising, subscriptions, and donations. Despite having developed such innovative and diversified strategies to create income, the organization still does not always feel financially stable; thus, it has developed a strong appreciation for all the monetary support it receives.

Understanding and Developing a Budget

Before adopting any fundraising options, the coalition needs to understand its current financial standing and be able to anticipate future expenses required to implement the intervention. A clear understanding of where its money is going, how it is coming in, and how it can be used will help determine realistic goals for the present and provide a base from which to determine future development needs. Understanding the financial status of the coalition is essential to all fundraising work, including more formal fundraising efforts such as grant proposals.

Budgeting may be particularly complicated if the coalition has operated rather informally. The development of present and future budgets may bring to the surface such issues as salaries, job stability, long-term commitments, and sponsorship. For example, determining whether assurance of fiscal responsibility is the coalition's job or something for individual agencies (many of them are also concerned about their own long-term sustainability) to provide could be a point of contention. Redefining roles and commitments may be necessary in developing a clear understanding of what is expected of those involved. (*Note: Refer to Coalition Building section for more information on the challenges of collaboration.*)

There are different ways to organize a budget. For example, it can be broken down by organizational and activity expenses, personnel and non-personnel costs, or other categories required by a funder. Approaches used to facilitate this process can range from using computer software programs to working formally with an accountant. A



budget typically has two core components: **Current Financial Standing** and **Future Expenses and Income** (see Worksheets 14 and 15).

Current Financial Standing – integrates the costs associated with components, activities, and funding streams currently in effect.

Example: Current Financial Standing (see Worksheet 14)

	Department of Public Health	United Way	Membership	Totals
Salaries				
Supplies				
Equipment				
Totals				

(Rabinowitz 2002a)

Future Expenses and Income – incorporates projected expenses (the amount of money the coalition expects to spend in the coming fiscal year) in established categories, projected income by source (the amount of money the coalition expects to take in for the coming fiscal year, broken out by sources such as fundraising, memberships, and sales), and the interaction of expenses and income. Funding sources can be broken out in general categories (e.g., fundraising, memberships, donations) or more specifically (e.g., the department of public health, the community health foundation). Make sure to build in the flexibility to make adjustments as the year goes on. Plan for unexpected expenses!

Potential expenses include:

- Salaries, wages, and fringe benefits for employees, listed separately by position
- Rent and utilities for organizational space
- Phone and Internet service
- Insurance (e.g., liability, fire, and theft)
- Taxes (these can reach 15% of the total payroll)
- Consultants (e.g., accountant, marketing)
- Transportation expenses/travel allowances
- Administrative costs (e.g., printing, postage)
- Program/office supplies (e.g., pens, paper, software)
- Program/office equipment and repairs (e.g., fax machine, copier)
- Training/professional development costs
- Program/strategy costs

Estimating expenses can be difficult, especially for expenses with which the coalition has no experience. Expenses can be estimated based on previous years' figures, from general research, or by asking other agencies. For supplies and equipment, look through a store catalog and create budget items based on coalition needs. In general, it is wise to estimate high when estimating expenses and low when estimating income. The group needs to be able to defend the reasons and costs behind all estimates (formal grant proposals usually include a budget justification).

Example: Future Expenses and Income (see Worksheet 15)

Expenses		
	Salaries	\$XXX
	Supplies	
Total Expenses		
Income		
	Department of Public Health	
	Membership dues/fees	
Total Income		

(Rabinowitz 2002a)

In-Kind Services and Redeployment of Resources

Although traditional fundraising is a valuable strategy, there is also a potential for donations and for redeployment (redistribution of available resources to use them more effectively) at structural, organizational, and individual levels. Donations, in-kind services, and redeployment can advance both individual and collective organizational goals. Review the needs-and-assets assessment to determine possible contributors. After reviewing the needs-and-assets assessment, consider how community resources can be used to fill project needs through partnerships or shared resources (e.g., using schools and houses of worship as program space). Such sharing of resources assists the coalition by helping it reach its goal, and at the same time avoids duplication of services while effectively meeting community needs. Worksheet 16 can help identify available in-kind and redeployment options.

Consider:

- What exists that can be used for the intervention?
- Are there better ways to use existing facilities?
- Who else is serving the same population or working on the same issues?
- Can resources be pooled to maximize their potential?
- What does the coalition have to offer other groups?

Possible In-Kind or Redeployable Services

- Space, including maintenance and utilities for that space
- Professional staffing, including counselors and school nurses
- Health professionals or university students in training
- Administrative assistance
- Services



- Equipment/furniture
- Construction and renovation

CASE STUDY: Redeployment

Using existing community resources or getting in-kind support can provide substantial financial savings to a coalition. The advantages of such a structure are more than monetary, however. Using existing resources can allow a program to be more heavily used because it takes place in a setting with which local constituents are already familiar. It also allows a program to be better integrated in the daily life of the local community and improves its chances for sustainability. Finally, by taking advantage of existing capabilities, coalition activities take on the feel of a community-run program and increase their public acceptance.

The “Teachers and Health Plans for Healthy Kids” program, which has been initiated throughout the state of California relies on teachers to inform the families of uninsured children about their eligibility for medical insurance (<http://www.calendow.org/news/NewsReleases/2002/09/090402catpressrelease.htm>). Forged from a partnership between the California Teachers Association and the California Association of Health Plans, and using grant money from The California Endowment, the program aims to insure the 656,000 uninsured children who are currently eligible for low-cost Healthy Families or no-cost Medi-Cal coverage. The program is attempting to have more than 330,000 teachers hand out information and hang posters saying “You Can’t Help Kids Learn When They Aren’t There.” Teachers will be given leeway to inform families about their insurance options in the manner they find most suitable. A previous pilot version of the program was very successful—on just one day, 489 families and their children signed up for health care insurance.

Fundraising

Fundraising needs and sources vary according to the stage of coalition development. In the beginning, funding may be needed for administrative purposes, such as conducting the needs-and-assets assessment. In the middle and end stages, funds are likely to be needed for sustaining or enhancing the intervention. The activities to be funded may dictate the funding sources. For example, a planning grant from a philanthropic foundation may be necessary to conduct the needs-and-assets assessment. Once the data are available, collaborative members may be able to write grant proposals to the federal and state governments in order to fund the program intervention itself.

There are a variety of avenues from which to secure funds; the coalition needs to decide which type of funding is appropriate and most accessible at particular times. A combination of funding sources is recommended; the coalition should not depend on any one source. Because donors prefer to give in different ways, having diversified funding strategies offers a greater opportunity for attracting contributors.

Personal Connections

When seeking funding, do not underestimate the importance of personal connections. Does anyone in the coalition know a potential funder (e.g., from the public or private sector, a foundation, an agency)? If possible, propose a meeting to discuss the coalition’s mission and action plan in more detail.

The following persons and groups are potential sources of program funding:

- Coalition and board members
- Current staff and volunteers
- Individuals/community members who use the services

- People who have volunteered or donated in the past
- People who are interested and involved in the field
- Family and friends

The three main sources for grants are government, private business, and philanthropic foundations.

Government: National, State, or Local

The coalition may be eligible for funding from federal, state, or local governmental agencies. At the federal level, a wide variety of funding programs exist both within health and in related areas such as education, human services, justice, and labor (for more information on government and funding sources, see Chapter 8). However, the coalition will need to demonstrate its capabilities and experience in order to receive competitive funding.

Private Businesses or Corporations

Businesses and corporations can be a valuable resource for community organizations, and the reverse can be true as well. Businesses can benefit in terms of tax relief, community involvement, and demonstrating their investment in the community. Finding a set of champions from the business community can be invaluable to the coalition.

Local, State, and National Philanthropic Foundations

Foundations are an indispensable source of funding. Foundations rarely support ongoing program and service delivery, however. It is important to research and make sure they match the goals of the coalition. In addition, try to determine what aspects of grant-making are of most interest (e.g., start-up funds). Because local foundations generally invest in local communities and are likely to provide planning grants or fund demonstration projects, they are a good place to start. Securing local funding can also help attract state and national funding. National foundations generally have certain priorities or areas they fund (e.g., innovative models) that address a specific health issue or population group.

Narrowing the Field—Determining Where to Focus Efforts

With so many options, it is important to focus on realistic chances for securing funds. Eligibility, particularly for government grants, should be the first consideration. Review a potential source's funding history (e.g., its Web page or annual report) and ask for its grant or grantee list. Find out how and why the organization was created, its areas of interest, general types and amounts of past grants, and application procedures.

Worksheet 17 can be used to compare potential funders and identify the best matches.

Consider:

History—In what areas has the funder given in the past? Are they relevant to what the coalition is working towards?

Purpose—What purposes does the funder support (e.g., start-up, administrative, program related)?

Size—What size grants has it given in the past? Are these amounts useful to the organization, given the effort it will take to apply and the chances of acceptance?

Location—In what areas of the country has the funder given in the past? Does it seem to support cities more than rural areas?

Considering all this information, what are the chances the funder is a good match for the coalition's work and interest?



CASE STUDY: Fundraising

Simply learning about a foundation can provide important clues for the grant proposal process. It is important to consider the foundation's primary focus, the awards usually given, where its activities are concentrated, what types of proposals are eligible or ineligible, and the length of the review process (if funds are needed immediately). Even modest research can save valuable time and help pinpoint foundations worth targeting. Quick research can yield facts such as these examples:

(Note: Names are not those of actual foundations)

- The Health Foundation's awards are primarily focused on health care and only support domestic efforts. In general, many grantees' projects appear to focus on children and adolescents.
- The Northwest Foundation's Pacific Northwest Division is involved in supporting nonprofit organizations in Washington and Oregon, including organizations supporting the civic engagement of youth.
- The Helpful Foundation does not generally award grants for annual fund drives, building campaigns, major equipment, or biomedical research. It prefers to fund organizations attempting to improve human services.

Basic clues such as these can go a long way in deciding which foundations to approach, how to shape a proposal, and even how to figure out a funding focus for a coalition.

Federal Tax-Exempt and Nonprofit Status:

The coalition status (e.g., whether it is a certified nonprofit organization or the subset of a lead agency) influences the manner in which funds can be acquired. If the group has federal tax-exempt status (e.g., 501[c][3]), potential donors can make tax-deductible contributions, which is very important for groups that rely primarily on grants. The group can also apply for grant funds directly. Certified nonprofit organizations can also assume fiduciary responsibility for themselves. If the group does not have either of these classifications, however, it will need a fiscal sponsor to receive the funds. In turn, the fiscal sponsor (potentially a lead agency within the coalition) will support the coalition's activities.

After determining the best match (or matches) for its fundraising efforts, the coalition can examine its specific grant-making processes. Funding sources range widely in their application processes, and it is extremely important to follow application procedures carefully and completely, and be courteous and businesslike in all communication and correspondence.

The request should clearly demonstrate: (see Worksheet 18)

- A clear representation of the coalition's mission and goals and the program the group plans to carry out with the requested funds.
- Past accomplishments (e.g., needs-and-assets assessment, youth development work) and the group's ability to carry out the proposed program.
- Why the targeted Critical Health Objective is important—to the coalition, the community, and the potential funder.
- Why the approach was selected. How is it known to be effective (e.g., it is based on a successful model, or is linked to research)? How is it innovative? Make sure it is realistic—be reasonable and establish specific criteria by which to measure success.

- Strong commitment to the community. This illustrates to potential funders that the coalition is dedicated to working with the community to effect change.
- A clear justification of the request, its purpose, and cost. Do not ask for more funds than needed—they can be hard to justify and the request may illustrate poor planning.
- Why the group is interested in this particular funder. How does the coalition's project relate to the funder? What benefits will involvement in this project offer the funder? For example, will it help it demonstrate its connection to the community; does it fit its mission?

Following Up

Regardless of outcome, follow up with the potential funder. If funding is obtained, immediately call and thank the funder and send a formal thank-you letter as well. Deposit the money as soon as possible. Keep in contact and complete any requested progress reports in a timely manner, clearly illustrating what the support is helping the coalition accomplish. Add the funder to the coalition's mailing list, invite your program officer to events, and acknowledge the funders support at any public events or in published materials as appropriate.

- If funding is not obtained, send a formal thank-you letter for the time the funder spent considering the application. The four most common reasons proposals are not funded are that:
 1. the funder does not believe the applicant understands the problem;
 2. the funder does not believe the applicant's proposed solution provides an adequate response;
 3. the organization's qualifications are considered insufficient;
 4. the proposed budget is considered inadequate.

(Brindis & Davis 1998)

If interested in this funder, ask the program officer or representative how to improve the proposal for future applications (for example, what was missing), and when the next funding cycle begins. It is important and valuable to learn from rejection. Sometimes, however, the foundation will ask for more information or justifications. Make these proposed changes and resubmit if appropriate.

EAT RIGHT COALITION (ERC) CASE STUDY (continued)

The implementation phase of the coalition was filled with a multitude of activities. One of the primary activities was to establish a budget committee that would oversee the financial management of the organization. A group of three volunteers, one an accountant, agreed to serve in this capacity. Their first order of business was to establish the coalition as a nonprofit 501(c)(3) entity. This step would allow donors to make tax-deductible contributions and permit the coalition to apply directly for funds. Second, the committee needed each program component committee (PCC) to formulate initial 1-year and 3-year maintenance budgets based on expected costs for labor, materials, administration, program/office supplies, consultants, transportation, and training. The PCCs, taking into account labor, material, and administrative costs, requested \$100-125,000 for the first year and a 3-year maintenance budget of \$120,000. The committee then began a series of discussions with coalition leaders and other members to review various methods for obtaining funds. A minimal membership fee was discussed but rejected because it would likely generate few funds



while dampening member enthusiasm for the coalition's activities. Other ideas, however, such as event fundraisers, local concerts, and sales of ERC T-shirts (designed by youth), were discussed as powerful ways of raising funds while making inroads into the community. It was imperative that the coalition make use of redeployed and in-kind resources. The curriculum PCC's budget projections were based on using existing teachers who teach the nutrition curriculum as well as the schools' offer to provide more in-kind support in the form of classroom space and some program materials in exchange for the benefits of the intervention itself. Several organizations in nearby communities that focused on improving nutrition offered to provide additional materials for school health campaigns. The committee also received commitments from several fitness organizations to hold joint fundraising events and promotions.

The committee realized that the bulk of its resources, especially funding, would have to come from multiple large sources, including the government, private corporations, and foundations. The committee sent out grant applications to several large local and national foundations focused on youth health. In addition, several coalition members with prominent positions in local corporations/businesses presented the ERC at meetings to stimulate further financial support from the business community. A total of \$35,000 was received from local businesses.

Applications were sent to the state and federal governments requesting for program implementation funds. One foundation cited lack of detail about how the funds would be used as its primary reason for not offering funds. ERC provided more detail and reapplied. In the end, the community foundations that historically had supported child issues and education provided a total of \$100,000. These foundations were generally satisfied with ERC's plans for documenting progress and asked that they also be informed of major coalition activities. The funds were provided for 2 years, to be reevaluated after that time based on the intervention success and efficiency of implementation, etc. State and federal grants amounted to another \$100,000. Overall, although adequate sources of initial funding had been found, the budget committee would need to maintain vigilance for seeking future sources. Moreover, it would have to work with the PCCs to keep detailed spending accounts that verified that money received was being used efficiently.

The resource development process needs to address many issues before undertaking formal fundraising (e.g., determining current financial standing, and evaluating potential strategies, resources, and type of development approach). The resource development process can also prove beneficial in unexpected ways; as it facilitates greater communication and collaboration with other community groups, and offers an opportunity for the coalition to evaluate itself in terms of where it is and where it wants to go.

Program Monitoring and Evaluation

The groundwork undertaken to develop an intervention focused on improving the health and well-being of a community's adolescents and young adults requires a substantial investment of time and effort from community members, project staff, and other stakeholders. Such groundwork includes building a coalition, conducting a needs-and-assets assessment, and developing an action plan. Assuring that the resulting intervention is as effective as possible requires evaluation. Any evaluation relies heavily on ongoing documentation during implementation; it could cover how the intervention is proceeding and the challenges that arise during implementation. Documentation can also provide feedback that will allow the coalition to change how the intervention is being delivered before a more formal evaluation takes place.

Documenting Implementation

The logic model, with its indicators, provides a framework for documenting a program's progress. Information from the model reveals whether the intervention is serving the target population and helps bring about any necessary modifications (a process sometimes called program monitoring).

Collecting data requires a well-organized information system that allows staff to track and manage the activities of participants and other items or events. Staff must be trained and supported in data collection, and the group must agree on data collection procedures, especially if numerous people are involved. To facilitate this process, it is important to give the staff resources for documenting project information.

There are many ways to collect program data (e.g., observations, questionnaires, sign-in sheets). The types of data collected depend on the indicators the coalition selected as part of the action plan (e.g., how many participants enter or participate in each component of a program per week, participants' ethnicity or neighborhood). Coalition meetings provide wonderful opportunities for program staff to offer feedback as well as to discuss and document program status. Although it requires time and effort, it is much easier to document project information as the effort moves forward than to recall it after some time has passed.

Assessing a Program's Readiness for Evaluation

Even with a very thorough planning process, it often takes time and adjustments during implementation before key program elements run smoothly. Unexpected events and other hurdles (such as staff turnover, lack of community or administrative support) affect the quality and quantity of programs implemented. Because of these challenges, participants may not be receiving the actual intervention that the coalition set out to implement. An evaluation at this point would reflect the effect of these challenges, not the intervention as it was meant to be delivered. Thus, for programs still in the early stages of implementation, conducting an evaluation may not be a strategic use of time, funding, and other resources. Before it undertakes any type of evaluation, the coalition should feel confident that the program is running smoothly and that it has sufficient time and resources to plan for the evaluation.

The questions listed below can help a coalition determine if it is ready to invest in an evaluation. Most programs will need to collect information about implementation for at least one program cycle before answering these questions. This process gives the coalition information needed to make changes *before* substantial time and financial resources are invested in an evaluation. Consider these questions and discuss whether more time and effort need to be spent in any of these areas before embarking on a comprehensive program evaluation. Worksheet 19 can be completed by coalition members and staff or used as a discussion guide to help the group work through some of these questions.

- What proportion of staff have been retained for at least a year?
- Do staff know the program's goals, objectives, and target group?
- Do staff have all the skills they need to implement the program?
- Do staff feel supported by management?
- Are staff given the opportunity to suggest program changes?
- Are staff enthusiastic about the program?
- To what extent was the community involved in developing the program?



- How frequently does the program seek input from community members in revising the program?
- To what extent were youth involved in program development?
- How frequently does the program seek input from participants in revising the program?
- Is sufficient time available to deliver each program component?
- Are adequate supplies/physical resources available to deliver each component?
- How often is each component delivered as planned?

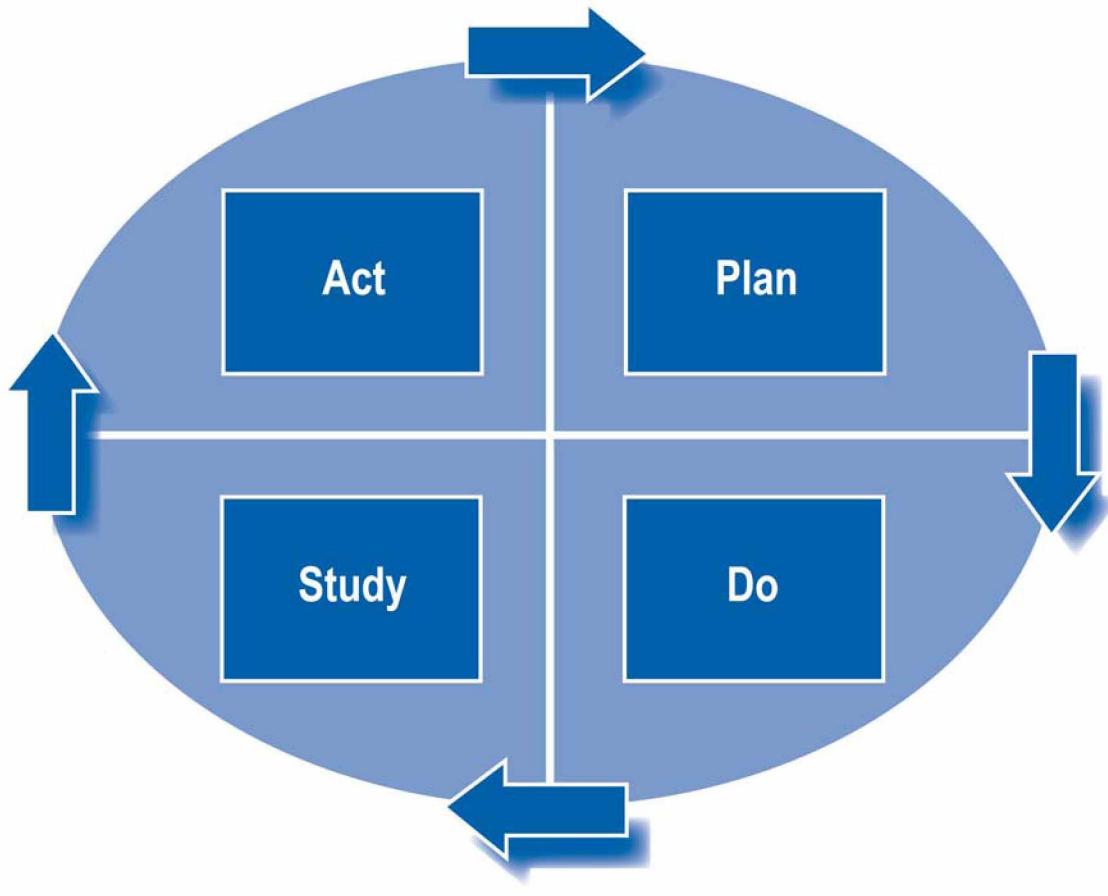
(Source: Sedivy & Brindis 2001).

If, after discussing these issues, the group is ready to move into a formal evaluation, it should proceed. Many programs, however, will benefit from at least minor adaptations to better reach their goals before committing to an evaluation. The information uncovered during program monitoring may reveal potential adjustments needed to help the intervention run more smoothly and effectively.

Program Adaptations: The Plan-Do-Study-Act Cycle

One strategy that may help the coalition reassess its intervention in an on-going way is the Plan-Do-Study-Act (PDSA) model, a tool for continuous quality improvement that employs a trial-by-learning approach. This approach can be used for the whole intervention, employed for individual strategies, used to test small changes, or employed to pilot-test a larger program.

Figure 1: Plan-Do-Study-Act Model for Continuous Quality Improvement



The PDSA model's four steps are as follows:

- **Plan:** Plan for change (e.g., develop an action plan, modify the existing program).
- **Do:** Carry out the strategies or desired change in strategies. Collect program monitoring data while testing out the action plan or selected changes.
- **Study:** Analyze the data to determine the effectiveness of strategies.
- **Act:** Based on the analysis, collaborate with others to discuss which steps to take next. For example, if the change in the plan improved program implementation, consider how the coalition can implement this change in the original program model.

EAT RIGHT COALITION (ERC) CASE STUDY (continued)

To illustrate how the PDSA cycle might work, consider the Eat Right Coalition's intervention to offer healthy food options on the school cafeteria menu. Knowing that pizza is a popular item and profitable to food services, the Coalition convinces the school to sell pizza that meets USDA dietary guidelines (e.g., fat accounts for 30% or fewer calories in the item).

- The **Plan** stage involves determining how to make pizza meet these guidelines. The Coalition suggests selling cheese and vegetarian pizzas made with reduced-fat cheese.
- During the **Do** stage, the Coalition monitors pizza sales and collects students' feedback through brief questionnaires asking how satisfied they are with the pizza.
- The **Study** stage entails analyzing the data collected during the 6 weeks of selling the healthier pizza.
- For the **Act** stage, the Coalition presents findings from the data – students were satisfied with the healthier pizza – and convinces the high school to make the reduced-fat pizza a permanent addition to the menu (replacing the pizza previously sold). The Eat Right Coalition also contacts other schools in the district to implement a similar change in their cafeterias.

After the intervention has been adapted, strengthened, and is running smoothly, the time may be right to invest in a formal evaluation. (Keep in mind that program monitoring and changes the group has made as part of the PDSA cycle are forms of process evaluation, which is discussed later in this section.)

Documenting Implementation: Creative Uses of Participant Data

Using a computer to create participant profiles by address, age, sex, and race helped the Mary Ryan Center, one of five Milwaukee Boys and Girls Club neighborhood centers, with its program planning decisions (<http://www.boysgirlsclubs.org/>). With the assistance of the Nonprofit Center of Milwaukee, the Mary Ryan Center conducted a geographic analysis of these data. It found that although the Center was in a racially integrated area, its participants were predominantly African American and that more than 20% of participating youth lived within a few blocks of the Center. Using these findings, the Center modified the original intervention model so that programs better matched actual participants' characteristics. In addition, results from the analysis raised the following questions: How should the Center reach out to youth from other ethnic backgrounds? How should the Center facilitate transportation for youth who lived beyond walking distance?



Why Evaluate?

Being able to demonstrate program effectiveness has become increasingly important – especially for potential funders and stakeholders who want to ensure that their investments (of money or time) are worthwhile. Even though program evaluation requires substantial time and effort, it is extremely valuable. The feedback allows the program planners, funders, and community at large to consider the program’s effectiveness, strengths, and weaknesses. It can demonstrate the need for continued funding, and programs found effective can serve as models for other communities. Even if project goals are not reached or findings are disappointing, evaluations offer valuable information about how interventions can be improved.

Evaluation is an ongoing process; planning for it should be incorporated in earlier group processes, such as coalition building, the action plan, and the logic model. For example, responsibility for data collection should be written into job descriptions, and grant proposals should incorporate time and financial estimates for planning and implementing evaluation (even as placeholders for evaluations to be conducted in the future). The evaluation will rely on the indicators developed for the logic model and the program monitoring data collected by the coalition.

A comprehensive evaluation requires significant time and financial resources. Build sufficient time for the evaluation into the timeline (e.g., for gaining approval for surveys of participants and pilot testing). In general, it is good to designate 10-15% of the overall program budget for evaluation. Although this figure may seem expensive, evaluations are well worth the investment. Well-done evaluations that demonstrate successful programs increase funding opportunities and foster support within the community.

The coalition can choose varying levels of complexity for the evaluation. Many factors – such as the scale of a program or initiative, availability of resources, budgets, and timelines – shape the type of evaluation that may be appropriate. Be realistic yet thorough in evaluation planning. It is usually better to plan a small but complete evaluation than to invest in a complex evaluation at an early stage.

Evaluation Resources Within the Coalition and the Community

Strong leadership is crucial to conducting a meaningful evaluation. It is advisable for a subset of the larger group to focus on different aspects of the evaluation process. As planning and conducting an evaluation requires a wide range of skills and resources, there are many opportunities to involve coalition and community members throughout the evaluation process. Using the needs-and-assets assessment as a guide, the coalition could examine the resources within the community that are available for an evaluation. A good idea is to make a list of the skills necessary for the evaluation, then recruit people who may be able to provide them. For example, partnering with psychology or sociology departments at local colleges can be a mutually beneficial collaboration for data collection and analysis. As with all processes related to the intervention, everyone involved needs a clear understanding about timelines and deadlines as well as roles and expectations (see Worksheet 20).

Because evaluation can be an intimidating term to people unfamiliar with it, working closely with community and coalition members to plan the evaluation process is important. If coalition members are not experienced in evaluation, it may be useful to have an outside evaluator or consultant (e.g., someone from a university or a consulting firm) provide assistance. An outside evaluator who has the additional benefit of maintaining objectivity regarding the results, which may increase credibility.

Tips for hiring an evaluator:

- Determine the specific reasons you want to evaluate; share this information with the potential evaluator.
- Select an evaluator who has worked directly with programs, preferably in your field.
- Determine appropriate audiences for the evaluation findings, and decide whether you want the results to be made public (even if unfavorable).
- Ask the evaluator for a sample report/presentation and references.
- Have a clear idea of your resources.
- Ask the evaluator what s/he will require of your staff/program.
- Make sure you're comfortable with the evaluator's design/techniques.
- Determine deliverables, timelines, and costs ahead of time.

(Adapted from the Institute for Program Development and Evaluation 2001).

Involving Youth in Evaluation

Involving youth and incorporating the perspective of young people participating in the program can help assure that the evaluation findings are used in meaningful ways. If properly trained, youth can be employed as interviewers, focus group facilitators, and analysts. They can also be instrumental in modifying and field-testing evaluation tools, such as questionnaires, to ensure their validity and appropriateness (e.g., How do you interpret these questions? Do they make sense? How would you reword questions to make sense?).

Teens can also be very effective in presenting evaluation findings because they provide a unique perspective and can offer personal insight about how the intervention affected them. This personal perspective can be very powerful.

Determining the Scope of the Evaluation

Planning an evaluation can be intimidating. Given the wide range of evaluation choices, the coalition should determine which type of evaluation is most appropriate now and what may be appropriate in the future. The following questions may help the coalition decide on the evaluation's purpose, which data to collect, and the level of community participation:

- Which aspects of the initiative do you want to evaluate?
- What is the purpose of the evaluation? To whom is it geared?
- How will the evaluation's findings be shared?
- Who will oversee the evaluation? Will you use a consultant or another resource person to help?
- How will data be collected? From which data sources?
- By what time does the data need to be collected?
- What information or training is needed to design the evaluation and analyze its results?
- How can youth, parents, and the greater community be involved in planning and implementing the evaluation?



There are three types of evaluation—process, outcome, and impact—that may be relevant to the coalition’s needs.

Process Evaluation

A process evaluation compares actual implementation of the program with the original action plan. That is, it examines how closely the program has adhered to its design and the extent to which it is producing all the materials and services promised. It may uncover challenges that occurred during implementation (e.g., tensions among staff, lack of administrative support) and potential ways to overcome them (e.g., through processes such as the previously described Plan-Do-Study-Act model). If the project seems to have gone off course, a process evaluation might identify changes that can refocus it. The ongoing program monitoring conducted by the coalition throughout implementation will prove highly valuable.

A process evaluation addresses these questions:

- Are appropriate personnel, equipment, and financial resources available in the right quantity, in the right place, and at the right time to meet program needs? If not, what are the barriers?
- Is the program providing the expected services and reaching the target population?
- What key ingredients contribute to the results being achieved?
- Are the activities being completed on time? Does the timeline allow sufficient time to reach the selected objectives?

Worksheet 21 can help the coalition determine the kind of data and record keeping that will help answer the questions above. Process evaluations can be conducted for the intervention as a whole or for particular components. If time, personnel, funding, or other resources are lacking, the coalition should conduct a process evaluation for the most important components of an intervention. For each activity to be evaluated, the group should ask questions that relate to the indicators selected during the action plan, such as:

- How will we know if we reached our target population?
- How will we know that the program delivered an appropriate quantity of services?
- How will we know that the program was implemented as planned?

To facilitate this discussion, the group should list each program activity as written in the action plan and then discuss how each activity was actually implemented. Explain why any program changes (e.g., additions, deletions, modifications) were made. Focus on aspects that could have strong effects on teens; findings of the needs-and-assets assessment are very important.

It is also essential to describe how actual participants compare to the program audience described in the action plan. In addition, describe the organizational, community, and social context for the program, which also may differ from the coalition’s initial impressions. All of this information may help explain differences between the original program model and how it is being implemented. For example, what are the physical conditions of the program’s facilities, such as a clinic or community center? Do teens in the program depend on public transportation or their parents to participate? Are there other programs in the community that focus on the issue? Are there any community factors that make implementation especially difficult or easy?

Comparing Process vs. Outcome and Impact Evaluations

It can be difficult for a coalition to distinguish between process and impact evaluations. Process evaluations represent how well the “game plan” of an organization is/was followed—how many seminars were conducted, how many Public Service Announcements (PSAs) were run, how many pamphlets were developed, etc. That is, process evaluations look at how well a program was implemented (i.e., what was done in relation to what was supposed to be done). Their primary value is in assessing the overall functioning of the intervention. Impact and outcome evaluations assess whether an organization actually “won the game” once an intervention was fully implemented. They answer the central question of “did the organization’s activities have the expected impact on the target population?” Outcome evaluations tend to focus more on short-term objectives (e.g., did teens talk to their parents more about depression and suicide after exposure to a suicide reduction campaign?). In contrast, impact evaluations focus on long-term objectives (e.g., did suicide ideation and suicide attempts decrease as a result of the campaign?). The value of each type of evaluation is in showing how useful the intervention is to a community. Using these different types of evaluations can help an organization determine how well its activities are conducted and whether it is worthwhile conducting them.

Case Study

“Not Me, Not Now” (<http://www.notmenotnow.org/welcome.cfm>) is an abstinence-based adolescent pregnancy prevention program in Monroe County, NY. The program which focuses mostly on youth aged 9 to 14, was started in 1994 to reduce the county’s teen pregnancy rate. The program is based on several goals, including promoting parent-child communication about sexuality and relationships and raising awareness of adolescent pregnancy. An analysis of its accomplishments provides a useful example of the distinction between process and impact evaluation measures:

“Not Me, Not Now”

Process Evaluations

1. Developed a parent’s guide, “Unlocking the Secret—A Parent’s Guide to Communication with Your Kids.” Over 50,000 copies of the parent packet were distributed to parents in Monroe County.
2. Each year printed and distributed 5,000 posters in schools, community centers, and pediatricians’ offices.
3. Sponsored a school-based educational series presented in Monroe County elementary and middle schools: Postponing Sexual Involvement.

Impact Evaluation

1. According to the Monroe County Youth Risk Behavior Survey, the percentage of students who reported having had sexual intercourse by age 15 fell from 46.6% in 1992 (before the program was started) to 37.8% (the second year of the program) to 31.6% (the fourth year).
2. The decline in teen pregnancy rates between 1993 and 1996 was faster in Monroe County than in four comparison areas (New York state, upstate New York, and two large counties in western New York).



Outcome and Impact Evaluations

While a process evaluation helps determine whether the intervention is *doing* what it set out to do, outcome and impact evaluations indicate whether it has *accomplished* its goals and objectives. Process evaluations also contrast with outcome and impact evaluations by beginning during implementation and continuing throughout the intervention. It is important to conduct a process evaluation before committing to an outcome or impact evaluation. Conducting outcome and impact evaluations demands significant time and resources as well as careful planning.

Outcome and impact evaluations address the following types of questions:

- What was the impact of the intervention on participants' subsequent behavior, skills, knowledge, or attitudes?
- How did the intervention compare to other model programs?
- How did teens in the evaluated program compare to those in the comparison or control group who did not receive an intervention?
- For whom did the program work and under which circumstances?

Outcome evaluations emphasize the immediate results of program efforts; they specifically address the following questions:

- Did the program meet its stated objectives?
- What were the short-term results of the interventions?
- Can the results of the program be attributed to the program itself (as opposed to other factors and influences)?

Impact evaluations help determine whether the program ultimately had the desired long-term effect. Measures are more related to achievement of goals than are outcome evaluations. Impact evaluations address the following questions:

- Did a particular program produce the desired effect? For example, was weapon carrying reduced in the school?
- Could these effects have occurred in the absence of the program or in the presence of an alternative program?

To conduct an outcome or impact evaluation, a comparison group—persons who did not receive the intervention—is necessary. Comparison and control groups strengthen evaluations because they help determine whether participants improved as a result of the program rather than for some other reason. A control group is established by random assignment of the entire pool of subjects into participant and control groups prior to the intervention. A comparison group is selected to be as similar as possible to the “experimental” group, but random assignment is not used. Control/comparison groups are especially relevant when working with young people, who change overtime by normal growth and maturation.

An outcome evaluation might continue for 6 months or so after the intervention ends, but it might be longer or shorter based on program goals. An impact evaluation requires data collection for 1 to 5 years (or more) after the intervention has been completed. Because long-term follow-up with teens can be difficult, consider the stability of the populations you are measuring and the resources (both money and time) that will be required to maintain contact with them. What proportions of program participants and members of the comparison groups can be followed at least 12 months?

The following questions can help determine the evaluation areas and the indicators that can be used to measure the answers. Worksheet 22 can be used to plan for data collection once indicators are selected.

- How will we know if the quality of services was adequate?
- How will we know if the program met its outcome objectives?
- How will we know if the program made a difference?
- How will we know what happened as a result of the program that would not have happened had we not implemented it?

CASE STUDY: Impact Evaluation

Impact evaluations are vitally important to the function of all service-oriented coalitions, including those operating in youth health. Not only do they measure a coalition's adherence to its mission, but they can also provide the needed credibility to justify its work to funding agencies and the local community.

When the Montana Social Norms Project, a project of Montana State University's Health and Human Development Department, started its teen tobacco reduction project in September 2000, it was venturing into uncertain territory. The campaign, "MOST of US Are Tobacco Free" (<http://www.socialnorm.org/montanatobacco.html>), was the first state use of social norms theory on a region-wide basis. This project attempted to prevent unhealthy behaviors and dispel common myths by promoting the fact that most people actually engage in healthy activities. During the 8-month tobacco awareness campaign, which took place in seven counties, the project employed a variety of media, including television and billboard, to popularize such messages as "70% of Montana teens are tobacco free." An evaluation of teens in the pilot area at the conclusion of the campaign showed that only 10% who had never before tried cigarettes reported a first-time use of cigarettes in the academic year 2000-2001, versus 17% in the parts of the state that did not receive the campaign. Such results were not only a local success, but were also a boon to statewide officials, who wanted to see state dollars supporting successful programs. As Joe Mazurek, former Montana Attorney General, said, "With \$932 million being awarded to Montana in the Master Tobacco Settlement, the people of our state deserve to have their money invested in a comprehensive prevention program, including efforts like those of Montana State University's MOST of US campaign that can demonstrate effectiveness in saving money and lives."

Evaluation Design: Data Sources and Collection

Evaluation designs determine when and from whom data are collected. There are several possible designs (e.g., post-assessment only, one group pre-assessment and the other post-assessment, and time series), and there are various ways of establishing comparison groups if the coalition is conducting outcome or impact evaluations. (Note: Detailed information regarding evaluation design is beyond the scope of this document; refer to the References of this section and Chapter 8 for more information.)

Possible data sources include teenage participants, their parents, and program staff, as well as program records. Baseline and comparison data can be drawn from existing national and state data sources, such as those reviewed in Chapter 4. The needs-and-assets assessment also provides some baseline data, but much information will need to be gathered during the implementation process itself. There are many ways to measure the attitudes, intentions, and behaviors that the intervention aims to affect. Tools for data



collection include existing databases, questionnaires, interviews, pre- and post-tests, observations, and focus groups.

Maintaining confidentiality is important in any data collection. The group should establish guidelines and procedures regarding how to collect the data and how the data can be accessed. Before giving “informed consent,” potential participants should be told the purpose of the data collection and how the information will be used. They should also be told that data will be kept confidential and in many cases will be collected anonymously, that data from all interviews or questionnaires will be summarized rather than reported for specific persons, and that they have the right to refuse participation or not to answer any particular question without jeopardizing their right to receive any services.

Informing people of the evaluation’s findings is an important step in making the evaluation count. As with the needs-and-assets assessment, the data need to be summarized in a meaningful way after being reviewed by the intended audience (e.g., program staff, funders, community members, and media).

EAT RIGHT COALITION (ERC) CASE STUDY (continued)

The ERC worked hard to maintain a record of what happened during the implementation process. Each program component committee (PCC) met every 2 weeks, and both PCCs met with each other and the informal administrative committee (health director, school board chief, secretary, and others) every month. The meetings served as a way to gauge progress, discuss funding and administrative issues, and consider what adjustments needed to be made to the timeline. Minutes were taken at every meeting and maintained in an archive file of ERC documents. ERC members, area educators, and local media outlets received quarterly progress reports from each PCC detailing what had/had not been achieved to date and what adjustments were being made. In addition, meetings with all ERC members were held every 4 months to discuss member concerns and note progress. Because the coalition had no real governing structure, ERC members felt free to contact PCC members and the informal administrative structure directly to relay their concerns. Through these series of meetings, calls, and reports, the ERC achieved the multiple goals of maintaining written records of the implementation process, keeping coalition members and partners informed and interested in coalition activities, measuring the progress of the coalition, and making necessary adjustments.

For a project of this nature, evaluation was deemed central to success. The ERC needed to document that the curriculum was having the expected effect and that the changes in food environment were in place. Thus, within each PCC, one person was assigned the task of coordinating the evaluation. These representatives came together during the monthly group PCC meetings and decided upon the type of evaluative structure to put in place. The first decision was to create a logic model that would provide the theoretical underpinnings of the project and highlight necessary evaluation measures (see logic model section in Chapter 6).

The logic model pointed out several needs for evaluation. First, the coalition needed to develop survey instruments that would track the progress of area schools in implementing these measures and the overall effect the project was having on students and educators. Definitions of measures and concepts were a specific concern. For example, the following terms would need to be defined: “full implementation of a nutrition curriculum,” “more healthy, appetizing foods in school menus” and “healthy-eating campaigns.” Moreover, a survey of educators and students would need to include questions that would measure whether they felt that the food service environment had improved and whether students were making healthier food choices at

school. In addition, the questionnaire would have to be administered before implementing of the intervention and periodically thereafter to judge its progress. This questionnaire would also have to be administered alongside a survey that tested students' understanding of basic nutritional concepts as well as their general feelings about the nutrition curriculum. Such a tool had been included in the curriculum package, and it was believed by the evaluation volunteers to be a good yardstick of nutritional knowledge. Beyond the administration of surveys measuring the progress of the coalition, ERC needed to create project feedback forms that could be answered by students, parents, teachers, and educators so that appropriate changes could be made during and after the implementation process. Finally, the evaluation process would require a timeline so that various instruments would be administered on schedule. If the effort of developing and conducting the evaluation proved too arduous for the PCC members, the coalition would have to consider forming an evaluation committee or hiring an outside consultant.

Although their complexity can feel overwhelming, program evaluations play a crucial role in programmatic interventions designed to improve adolescent health and safety. The information they provide can help new programs modify their interventions to enhance effectiveness as well as inform other communities seeking to apply similar interventions.

The coalition should not be discouraged if evaluation results do not reflect the intervention's intended impact on some key players and participants. Some results of the intervention are difficult to measure – the influence of working closely with youth and the community, capacity building for individuals, bringing certain stakeholders together. Through the relationships the intervention helped facilitate – both personal and professional – its actual effects and ramifications may last a long time and lay a foundation for a new generation of programming.



Worksheet 11: Communications Work Plan

Use this worksheet to create a plan, or road map, for the coalition's media and communications activities. Start by listing the different messages the coalition has developed in the left-hand column. For each message, list the target audience, strategy for communicating the message, and time frame for it. Some messages may be used for more than one target audience or communicated using several different strategies. It may be necessary to use arrows when completing the first three columns. In the Resources Available section, try to identify coalition members or other colleagues who might be able to connect the group with in-kind services or free advertising. Lastly, identify resources that need to be obtained (Resources Needed), such as supplies, specific expertise, and skills. These items should be factored into the cost. Some research may be needed to complete the cost column. For example, the coalition should research the cost of creating printed materials, placing a print ad, or running a radio spot.

Message	Target Audience	Strategy	Time Frame	Cost	Resources Available	Resources Needed

Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health; Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health; National Adolescent Health Information Center, University of California, San Francisco. *Improving the Health of Adolescents & Young Adults: A Guide for States and Communities*. Atlanta, GA: 2004.

Worksheet 12: Communications Evaluation

Use this worksheet to plan the coalition's evaluation of its media and communications strategy. This exercise will help to identify benchmarks of success for each strategy and sources of data for measuring the benchmarks.

Message	Target Audience	Strategy	Evidence of Success*	Data Source†

*Examples:

- Increase in people enrolled in program
- Increase in knowledge
- Increase in coalition members

†Examples:

- Enrollment forms
- Surveys/Questionnaires
- Membership lists

Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health; Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health; National Adolescent Health Information Center, University of California, San Francisco. *Improving the Health of Adolescents & Young Adults: A Guide for States and Communities*. Atlanta, GA: 2004.



Worksheet 13: Message Development

Use this worksheet to help develop media messages for different target populations. By identifying where the target group is most likely to seek health information, and how it currently perceives the health issue, as well as identifying best practices for communicating health messages, the coalition can tailor its media messages and determine the best communication channels for reaching its intended audience. Some research (e.g., conducting focus groups or literature reviews) may be necessary to complete this worksheet.

Target Audience	Information Sources	Perception of Issue	Places to Reach	Cultural Issues/Barriers	Research Shows

Source: Hutchins, J. (1999). Working with the media to promote teen pregnancy prevention. In T. Kreinin, S. Kuhn, A.B. Rodgers, & J. Hutchins (Eds). *Get organized: A guide to preventing teen pregnancy*: Vol. 3. Washington, DC.: The National Campaign to Prevent Teen Pregnancy.

Worksheet 14: Current Financial Standing

Use this form to allocate expenses to your various funding sources. The left-hand column should list all expenses, including salaries, supplies, space rental, utilities, etc. Under each funding source, list either the dollar amount or percentage that is going toward each budget item.

Source: Rabinowitz, P. (2002a). Planning and writing an annual budget. In *Community Toolbox: Part L, Chapter 43, Section 1*. Retrieved September 29, 2002, from http://ctb.lsi.ukans.edu/tools/en/sub_section_main_1303.htm



Worksheet 15: Future Expenses and Income

Use this table to list projected expenses (the amount of money the coalition expects to spend in the coming fiscal year, broken down into established categories), projected income by source (the amount of money the coalition expects to have for the coming fiscal year, broken down by sources such as fundraising, memberships, and sales), and the interaction of expenses and income. Funding sources can be separated into general categories (e.g., fundraising, memberships, donations) or into more specific categories (e.g., the department of public health, the Health Foundation). Also, make sure to build in flexibility to make adjustments as the year goes on.

Expenses		Amount
	Salaries	
	Supplies	
Total Expenses		
Income		Amount
	Grants	
	Membership	
	Donations	
	Other	
Total Income		

Source: Rabinowitz, P. (2002a). Planning and writing an annual budget. In *Community Toolbox: Part L, Chapter 43, Section 1*. Retrieved September 29, 2002, from http://ctb.lsi.ukans.edu/tools/en/sub_section_main_1303.htm

Worksheet 16: Assessing availability of in-kind contributions and redeployment options

What in-kind resources exist that can be applied to the coalition's/project's strategies?

Are there better ways to use existing resources and facilities?

Who else is serving the same population or working on the same issues?

What resources can be pooled to maximize their potential?



What does the coalition have to offer other groups?

Source: Brindis, C.D., & Davis, L. (1998). Building strong foundations, ensuring the future. In *Communities responding to the challenges of adolescent pregnancy prevention: Vol. 2*. Washington, DC: Advocates for Youth.

Worksheet 17: Grantwriting Grid

Use this grid to gather information about potential funders. Completing this form will help determine which funders are strong matches and help you create a timeline or work plan for writing proposals based on their funding cycles. It is helpful to have information on hand as the funding needs change across time. List the name of the funder in the top row and fill in answers in the columns below.

Potential Funder				
	#1	#2	#3	#4
Applied to this source in the past?(Y/N, date, result)				
Funder's priority area(s) that match coalition goals				
Has funder made awards to similar projects in the recent past?				
Areas funder tends to support (start-up, capacity building, etc.)				
Average award				
Proposal due dates				
Dates awards are made				
Name of coalition member who has a personal contact				
Name of contact person at funding organization				
Contact information				

Source: Berkowitz, B. (2002). Applying for a grant: The general approach. In *Community Toolbox: Part L, Chapter 42, Section 4*. Retrieved September 29, 2002, from http://ctb.lsi.ukans.edu/tools/en/sub_section_main_1300.htm



Worksheet 18: Background for Writing a Grant Proposal

Provide a clear description of the coalition's mission and goals and the project the group hopes to carry out with the requested funds.

List past accomplishments (e.g., needs-and-assets assessment, youth development work) that provide proof of the coalition's ability to carry out the proposed project.

List at least three reasons why the targeted Critical Health Objective (or cluster of objectives) is important – to the coalition, the community, and the potential funder.

Describe why the approach was selected. How is it known to be effective (e.g., it is based on a successful model, is it supported by research)? How is it innovative? What criteria will be used to measure success?

List at least three reasons why the coalition's project demonstrates a strong commitment to the community (i.e., that the coalition is dedicated to working with and within the community to effect positive change).

Provide at least three clear reasons why the approach will be effective for the population and community.

Provide three reasons why the group is interested in this particular funder. How does the coalition's project relate to the funder? How will involvement in this project benefit the funder? For example, will it help it demonstrate its connection to the community? Does it fit its mission?

Source: Butts, D. (1999). Raising funds for teen pregnancy prevention. In T. Kreinin, S. Kuhn, A.B. Rodgers, & J. Hutchins, *Get organized: A guide to preventing teen pregnancy: Vol. 3*. Washington, DC.: The National Campaign to Prevent Teen Pregnancy.



Worksheet 19: Assessing Program Readiness for Evaluation

The purpose of this form is to assess whether a program is ready to conduct a formal evaluation or whether additional program changes are needed. This form should be completed by program managers and staff and by coalition members. The assessment can be completed as part of a staff meeting or coalition meeting. After compilation, the answers will be used to help decide which aspects of the program need work to improve its readiness for a more thorough assessment.

Answer the following questions using a scale of 1-5. Space is provided below each question and at the end of the form to list suggestions for improving the program. Respondents are encouraged to answer questions as honestly as possible. The forms can be completed anonymously.

	Not at All	Somewhat	Outstanding		
The program/agency has been successful in retaining staff for 1 year or longer.	1	2	3	4	5
If not, why?					
Staff know the program's goals, objectives, and target group.	1	2	3	4	5
If not, why?					
Staff have all the skills they need to implement the program.	1	2	3	4	5
If not, why?					
Staff feel supported by management.	1	2	3	4	5
If not, why?					
Staff are given the opportunity to suggest program changes.	1	2	3	4	5
If not, why?					
Staff are enthusiastic about the program.	1	2	3	4	5
If not, why?					
The community is involved in developing the program.	1	2	3	4	5
If not, why?					

The coalition seeks input from community members in revising the program.	1	2	3	4	5
If not, why?					
Youth are involved in program development.	1	2	3	4	5
If not, why?					
The coalition seeks input from participants in revising the program.	1	2	3	4	5
If not, why?					
Sufficient time is available to deliver each program component.	1	2	3	4	5
If not, why?					
Supplies/physical resources are available to deliver each component.	1	2	3	4	5
If not, why?					
Each component is delivered as planned.	1	2	3	4	5
If not, why?					

The following steps can improve staff retention:

- 1) _____

- 2) _____

- 3) _____

The following steps can improve staff understanding of the program's goals, objectives, and target population:

- 1) _____

- 2) _____



3) _____

List three skill areas where staff capacity building is necessary and steps the program can take to ensure improved staff capacity:

<u>Skill</u>	<u>Action Step</u>
1) _____	1) _____
2) _____	2) _____
3) _____	3) _____

Management can take the following steps to be more supportive of staff:

- 1) _____
- 2) _____
- 3) _____

The following steps can give staff more opportunities to provide input on program operations and suggest program changes:

- 1) _____
- 2) _____
- 3) _____

The following steps can improve community input into the program:

- 1) _____
- 2) _____
- 3) _____

The following steps can improve youth input into the program:

- 1) _____
- 2) _____

3) _____

The following steps can improve participant input into the program:

1) _____

2) _____

3) _____

The following steps can ensure that sufficient time is available to deliver each program component:

1) _____

2) _____

3) _____

The following steps can ensure that supplies/physical resources are available to deliver each program component:

1) _____

2) _____

3) _____

The following steps can ensure that each program component is delivered as planned:

1) _____

2) _____

3) _____

Thank you!

Source: Sedivy, V., & Brindis, C. (2001). Minimizing the Risk of Premature Evaluation: Lessons from an Evaluation of Seven Adolescent Pregnancy Prevention Programs. Manuscript submitted for publication.



Worksheet 20: Evaluation Timeline/Work Plan

Complete this timeline to determine what resources are available and what people, organizations, tools, etc. will be needed to conduct a program evaluation. Examples of tasks this timeline/work plan might include are to: decide on evaluation design, create/research data collection tools, recruit comparison/control group, train staff/community members in evaluation skills, obtain consent, pilot tools, collect data, analyze data, present findings.

Task	Time Frame	Resources Needed (e.g. staff time, school approval, specific skills)	Persons Responsible

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health; Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health; National Adolescent Health Information Center, University of California, San Francisco. **Improving the Health of Adolescents & Young Adults: A Guide for States and Communities.** Atlanta, GA: 2004.

Worksheet 21: Process Evaluation Planning Tool

The purpose of a process evaluation is to determine how well the program was actually implemented by comparing it with the original action plan. It examines whether a program has stayed true to its design and the extent to which it is producing all the materials and services promised. The left-hand column lists several questions that process evaluations often seek to answer. First select the questions to be used in the process evaluation, then use the subsequent columns to list the data the coalition can collect to answer the questions, sources of that data, and baseline measures that help gauge whether the program is achieving what it set out to do. The form is partially completed to provide examples of possible data and baseline measures.

Evaluation Question	Data Needed to Answer the Question	Data Source	Baseline Measure
Are appropriate personnel, equipment and financial resources available in the right quantity, in the right place, and at the right time to meet program needs? If not, what barriers exist?	<ul style="list-style-type: none"> • Staff skills, education, and training • Staff productivity • Perceived barriers 	<ul style="list-style-type: none"> • Resumes • Staff activity logs • Schedules of program activities • Interviews with managers and staff 	<ul style="list-style-type: none"> • Job descriptions • Staff work plans • Program activities
Is the program providing the expected services and reaching the target population?	<ul style="list-style-type: none"> • No. of program components implemented (No. of classes implemented, No. of events held, etc.) • Participant characteristics (age, sex, race, neighborhood of residence, etc.) • No. of sessions in which persons participate 	<ul style="list-style-type: none"> • Program activity logs • Participant registration forms • Participant sign-in sheets for each activity 	<ul style="list-style-type: none"> • Action plan/program plan • Grant proposal or program plan
How well is the program meeting the needs of participants, their families, and staff?	<ul style="list-style-type: none"> • Participant, parent, and staff satisfaction with the program 	<ul style="list-style-type: none"> • Interviews with participants, parents, and staff • Client satisfaction forms 	<ul style="list-style-type: none"> • Needs-and-assets assessment data
Are the activities being completed on time? Was sufficient time given in the timeline to reach the selected objectives? Are we reaching our target population?			



Is the program delivering an appropriate quantity of services?			
Is the program being implemented as planned?			

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health; Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health; National Adolescent Health Information Center, University of California, San Francisco. **Improving the Health of Adolescents & Young Adults: A Guide for States and Communities. Atlanta, GA: 2004.**

Worksheet 22: Evaluation Data Planning Tool

Outcome and impact evaluations indicate whether an intervention or initiative has accomplished its short- and long-term goals, respectively. This form helps identify what data need to be collected for the evaluation. List short- and long-term outcomes in the left-hand column, then list indicators for each outcome, sources of existing data, and the method that will be used to collect new data. Much of the information needed for this worksheet can be taken directly from the logic model worksheet.

	Indicators	Data Source	Data Collection Method
Short-Term Outcomes: Example: Schools/school board will adopt policies that promote healthier eating through enhanced nutrition curriculum, as well as changes in the schools' Good Service program and foods sold through vending machines.	Policies regarding nutritional content of school meals	School district records	Records review
Long-Term Outcomes: Example: Reduce the proportion of teens who are overweight or obese.	% of overweight teens (ages 10-19)	County health profile	

Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health; Health Resources and Services Administration, Maternal and Child Health Bureau, Office of Adolescent Health; National Adolescent Health Information Center, University of California, San Francisco. **Improving the Health of Adolescents & Young Adults: A Guide for States and Communities. Atlanta, GA: 2004.**



Closing

The 21 Critical Health Objectives for adolescents and young adults, which were identified as part of the *Healthy People 2010* process, provide a framework that unifies the efforts of different stakeholders to collectively address the health of our nation's young people. These objectives can serve as guideposts to help communities establish priorities and measure progress toward the goal of improving the health and well-being of adolescents. In this document we present guiding principles, effective strategies, and practical tools that should be helpful in working towards this goal. We hope this document will serve as an important resource for local communities as they embark on a new initiative or enhance an existing one.

The National Initiative to Improve Adolescent Health by the Year 2010 has put forth new approaches to adolescent health that are woven throughout this document. These approaches depart from a sole focus on preventing negative behavior and outcomes among individual adolescents. Instead, they emphasize focusing on young people's assets, promoting healthy development, and adopting noncategorical, ecological strategies that address the multi-level influences on adolescent health, such as family, community, schools, society and policy. These approaches require new strategies and engagement of nontraditional partners. This document is meant to support efforts to test and promote these new approaches. The strategies, worksheets, and resources presented here are tools you can use throughout your adolescent health initiative, from building a coalition, to conducting a needs assessment, to planning programs, to evaluating progress.

Improving adolescent health is a complex endeavor. This document serves as a starting point for new and evolving efforts to support the healthy development of young people. By making investments in adolescent health today we are investing in the workforce, parents and leaders of tomorrow.

CHAPTER 8



Federal Resources

Contents

General Adolescent Health [page 3](#)

Unintentional Injury [page 8](#)

Violence [page 11](#)

Substance Use [page 17](#)

Mental Health [page 20](#)

Reproductive Health [page 25](#)

Chronic Disease Prevention [page 30](#)



This chapter lists and describes federal resources (documents, organizations, and Web sites) to assist you in developing interventions for the 21 Critical Health Objectives. The seven topic areas are: general adolescent health, unintentional injury, violence, substance use, mental health, reproductive health, and chronic disease prevention. Under each of these headings, we organize the resources into nine subcategories:

- **Background/General**
- **Partnerships and Coalition Building**
- **Needs-and-Assets Assessment, Planning, & Using Data**
- **Programs and Interventions**
- **Management and Media Relations**
- **Evaluation**
- **Funding**
- **Policy**
- **Other**

Acronyms

To avoid repetition, the following acronyms are used for commonly listed agencies/sources:

ACF	Administration for Children and Families
CDC	Centers for Disease Control and Prevention
CSAP	Center for Substance Abuse Prevention (SAMHSA)
DASH	Division of Adolescent and School Health (CDC)
DHAP	Division of HIV/AIDS Prevention (CDC)
DHHS	Department of Health and Human Services
DSTD	Division of STD Prevention (CDC)
HRSA	Health Resources and Services Administration
MCHB	Maternal and Child Health Bureau (HRSA)
MMWR	Morbidity and Mortality Weekly Report, (CDC)
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion (CDC)
NCHS	National Center for Health Statistics (CDC)
NCHSTP	Natural Center for HIV, STD, and TB Prevention (CDC)
NCIPC	National Center for Injury Prevention and Control (CDC)
NHTSA	National Highway Traffic Safety Administration (Department of Transportation)
NIMH	National Institute of Mental Health
NVSR	National Vital Statistics Reports, (CDC)
OJJDP	Office of Juvenile Justice and Delinquency Prevention (Department of Justice)
SAMHSA	Substance Abuse and Mental Health Services Administration
YRBSS	Youth Risk Behavior Surveillance System

General Adolescent Health

Background/General

DHHS. Healthy People 2010

<http://www.healthypeople.gov/>

This Web site has general background regarding *Healthy People 2010* (HP 2010), information on Leading Health Indicators, and links to data, companion Web sites, documents, and other relevant *HP 2010* publications.

- **DHHS, Public Health Foundation. Healthy People 2010 Toolkit**

<http://www.healthypeople.gov/state/toolkit/>

The toolkit walks the reader through the steps of developing an intervention, program, or service. It provides instructions and worksheets on building leadership and organizational structure, identifying and securing resources, identifying and engaging community partners, setting health priorities, assessing and evaluating progress, sustaining a program, and communicating health goals to the community. The toolkit also lists literature and online resources, including each state's *Healthy People* Web site.

- **DHHS. Understanding and Improving Health, Volumes 1 & 2**

<http://www.healthypeople.gov/Document/tableofcontents.htm>

This Web site and its links provide background information regarding the *Healthy People 2010* initiative and information on all the leading health indicators (e.g., Physical Activity, Tobacco, Mental Health).

CDC, NCCDPHP, Division of Adolescent and School Health

<http://www.cdc.gov/healthyyouth/>

This Web site provides information on and links to national school health strategies, research and evaluation tools, YRBSS data on risk behaviors, health-related guidelines, resources and tools, and project partners of the Division.

DHHS, HRSA, MCHB

<http://www.mchb.hrsa.gov/>

This Web site links to several MCHB resources, including information regarding grant guidelines and assistance. Within MCHB, there is the Division of Child, Adolescent and Family Health. The Division lists the MCHB adolescent health programs in each state. Use the Internet to order National Maternal and Child Health Clearinghouse publications. MCHB provides state resource sheets with MCHB contact information for each state and territory. There are also links to MCHB-funded related sites.

DHHS, ACF, Family & Youth Services Bureau (FYSB)

<http://www.acf.dhhs.gov/programs/fysb/>

FYSB provides national leadership on youth issues and assists individuals and organizations in providing effective, comprehensive services for youth in at-risk situations, particularly runaway and homeless youth and their families. FYSB funds programs that support communities in helping young people and their families. Available at this Web site are links to information about youth and youth development (for youth, policy makers, professionals, parents and community members), including a *National Blueprint for*



Youth. The FYSB Web site also provides information on children's health insurance, funding and policy announcements, and publications.

DHHS, ACF, National Clearinghouse on Families & Youth (NCFY)

<http://www.ncfy.com>

The NCFY Web site offers a library on family and youth issues, special-issues forums, and outreach services. The library contains free or low-cost publications, abstracts, and information on national organizations that address youth issues. NCFY offers information and resources specific to policy makers, parents, community members, researchers, young people, and youth services.

U.S. Department of Justice, Coordinating Council on Juvenile Justice and Delinquency Prevention. Parenting Resources for the 21st Century

<http://www.parentingresources.ncjrs.org/index.html>

This Web site links parents and other adults responsible for the care of a child with information on issues covering the full spectrum of parenting. This site, federally sponsored through the Coordinating Council on Juvenile Justice and Delinquency Prevention, helps families meet the formidable challenges of raising a child today by addressing topics that include school violence, child and youth development, child care and education, health and safety, out-of-school activities, the juvenile justice system, and other family concerns.

CDC, NCHS. Fast Stats A-Z

<http://www.cdc.gov/nchs/fastats/Default.htm>

This Web site provides links to a substantial number of health topics/state information (A-Z), which provide quick access to statistical information and data.

- Fast Stats: Child Health**

<http://www.cdc.gov/nchs/fastats/children.htm>

CDC, 2000. Surveillance for Characteristics of Health Education Among Secondary Schools—School Health Education Profiles, 1998. MMWR. 49(SS-8):1-41

<http://www.cdc.gov/mmwr/preview/mmwrhtml/ss4908a1.htm>

The School Health Education Profiles monitor characteristics of health education in middle or junior high schools and senior high schools. This report summarizes results from 36 state surveys and 10 local surveys conducted among representative samples of school principals and lead health education teachers during February-May, 1998.

Partnerships and Coalition Building

(No Entries)

Needs-and-Assets Assessment, Planning, & Using Data

CDC, NCHS. "DATA2010"

<http://wonder.cdc.gov/data2010/>

DATA2010 is an interactive database system developed by staff of the Division of Health Promotion Statistics of the National Center for Health Statistics, and contains the most recent monitoring data for tracking *Healthy People 2010*. Data are included for all the objectives and subgroups identified in the *Healthy People 2010: Objectives for Improving Health*. DATA2010 contains national and some State data. All data in DATA2010 are

the most recent available and may include revisions or corrections. Therefore, some data may differ from data previously shown.

CDC, NCHS. Healthy People 2010 Homepage

<http://www.cdc.gov/nchs/lphome.htm>

The NCHS *Healthy People 2010* homepage contains links to several critical *Healthy People 2010* publications including the *Healthy People 2010* volumes, and Tracking *Healthy People 2010* (technical guidebook on tracking the *Healthy People 2010* objectives). Data tables, PowerPoint slides, and executive summaries from the Progress Reviews with the Assistant Secretary for Health and Human Services are also available.

National Library of Medicine, National Institutes of Health. PubMed

<http://www.ncbi.nlm.nih.gov/PubMed>

PubMed, a service of the National Library of Medicine, provides access to over 12 million MEDLINE citations and life science journals.

NIH, HRSA, CDC. Combined Health Information Database (CHID)

<http://chid.nih.gov/>

CHID, a bibliographic database produced by health-related agencies of the federal government, provides titles, abstracts, and availability information for health and health education resources. The Web site lists several health promotion and education materials and program descriptions not indexed elsewhere. New records are added quarterly, and current listings are checked regularly to help ensure that entries are up to date and still available from their original sources. Some older records are retained for archival purposes.

CDC, NCCDPHP, DASH. State-by-State Information

http://www.cdc.gov/nccdpHP/dash/state_info/index.htm

This Web site lists information for each state, such as available data (e.g., State Youth Risk Behavior Survey, School Health Policies and Programs Study), School Health Profiles, and CDC project partners.

HRSA, MCHB. Child Health USA: 2002

http://mchb.hrsa.gov/chusa02/main_pages/page_03.htm

<ftp://ftp.hrsa.gov/mchb/chusa02.pdf>

This report covers population, health status, health services and state and city data regarding infants, children, and adolescents.

DHHS, CDC. Fact Book: 2000/2001

<http://www.cdc.gov/maso/factbook/Fact%20Book.pdf>

This general resource about CDC projects includes a profile of the nation's health and a chapter on adolescent health (e.g., mortality, access to care, smoking, violence, and suicide).



CDC, NCHS. Adolescent Health Chartbook: Health, United States, 2000

<http://www.cdc.gov/nchs/data/hus/hus00cht.pdf>

The Adolescent Health Chartbook presents data on the current health status of adolescents aged 10 to 19. There are 32 figures and accompanying text that encompass injury, mortality, reproductive health, health care utilization, and risk behaviors by age and sex. Many charts also describe racial, ethnic, and socio-demographic differences. The 146 trend tables are organized around four major subject areas: health status and determinants, health care utilization, health care resources, and health care expenditures. Trend tables were developed from data spanning several years.

CDC, NCHS, Division of Data Services. Healthy People 2000 Statistical Notes #19: Healthy People 2000: An Assessment Based on the Health Status Indicators for the United States and Each State

<http://www.cdc.gov/nchs/products/pubs/pubd/hp2k/statnt/20-11.htm>

For this report, health status indicators (HSIs) were developed as part of the *Healthy People 2000* process to facilitate the comparison of health status measures at national, state, and local levels. The number of HSIs for which the national target has been attained and the number of HSIs that have improved significantly are enumerated for the United States as a whole, the District of Columbia, and each state. Data from this assessment facilitates national, state, and local comparisons of health status measures as well as evaluation of progress since the *Healthy People 2000* objectives were published in 1991.

CDC. MMWR

<http://www.cdc.gov/mmwr/>

This is the Web site for the Morbidity and Mortality Weekly Report (MMWR). The data presented in this publication are based on reports to the CDC from state health departments. On this Web site, you can search for reports regarding various health areas, and it provides links to publications and media relations.

CDC. YRBSS

<http://www.cdc.gov/yrbs/>

YRBSS includes a national survey and surveys conducted by state and local education and health agencies. It provides vital information on risk behaviors among young people, health, and has links to questionnaires, information, and results from current and past years (including trend data).

- **CDC. YRBSS. Assessing Health Risk Behaviors Among Young People: At A Glance, 2002**

http://www.cdc.gov/nccdphp/aag/aag_yrbss.htm

This article offers a general background on the purposes of YRBSS and highlights trend data regarding health risk behavior of high school students between 1991 and 2001.

Programs and Interventions

(No Entries)

Management and Media Relations

DHHS, ACF, Family and Youth Services Bureau (FYSB), National Clearinghouse on Families & Youth (NCFY). Covering Youth and Family Issues: A Guide for the Media

<http://www.ncfy.com/media1.htm>

Although aimed at the media, this resource is useful for learning how to effectively communicate health issues through the media. It also provides resources for youth data and lists corporate, national, and federal organizations working on youth issues.

DHHS, SAMHSA, CSAP. Developing Effective Messages and Materials for Hispanic/Latino Audiences

<http://www.health.org/govpubs/MS703/>

This document discusses the six-stage health communication process and how to draw on Latino community-based values and traditions to promote health messages.

Funding

CDC, NCCDPHP, DASH. Healthy Youth Funding Database (HY-FUND)

<http://www2.cdc.gov/nccdpHP/shpfP/index.asp>

This online database contains information on federal and state-specified funding sources for school health programs.

CDC, NCCDPHP, DASH. Funding Resources

<http://www.cdc.gov/nccdpHP/dash/funding/index.htm>

This Web site contains information on federal, foundation, and state-specific funding sources for school health programs. Users may search by geographic region, key word, and specific school health component (e.g., nutrition, health education, counseling services).

DHHS. GrantsNet

<http://www.hhs.gov/grantsnet>

GrantsNet is an Internet application tool created by the DHHS, Office of Grants Management for finding and exchanging information about federal grant programs in DHHS and elsewhere. GrantsNet serves the general public, the grantee community, and grant-makers. GrantsNet provides a variety of department-wide policies governing the awarding of grants and the administration of grant activities, publishing these in policy directives, regulations, and manuals.

Policy

Centers for Medicare and Medicaid Services (CMS). State Children's Health Insurance Program (SCHIP)

<http://cms.hhs.gov/schip/>



This Web site on the State Children's Health Insurance Program (SCHIP) is intended to provide materials of interest to various audiences regarding the passage of SCHIP, also known as Title XXI, as part of the Balanced Budget Act of 1997. Listed are SCHIP state plan submissions, regulations and allotment notices, and Title XXI legislations. There is also a link to the outreach information clearinghouse on how to improve SCHIP enrollment.

Other

DHHS, SAMHSA, White House Council on Youth Violence. Helping Your Children Navigate Their Teenage Years: A Guide for Parents

<http://www.mentalhealth.org/publications/allpubs/SVP-0013/default.asp>

This resource provides tools for improving communication between parents and their teenagers. It addresses how to handle a teenager's desire for increasing responsibility and freedom, anger management, and getting help for a teen. The main health outcomes covered are youth violence, mental health, and alcohol and substance abuse. It does not delve into these issues but provides helpful, general background and tips as well as national resources available online or by calling toll-free.

DHHS. Office of Minority Health (OMH)

<http://www.omhrc.gov/OMH/sidebar/aboutOMH.htm>

The mission of OMH is to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs that address health disparities. The Web site provides links to initiatives, grants, data and resource links to federal/nonfederal organizations. Some resources are specifically geared towards youth/young adults.

U.S. Department of Justice. Children with Disabilities

<http://www.childrenwithdisabilities.ncjrs.org/>

This Web site offers information about advocacy, education, employment, health, housing, recreation, technical assistance, and transportation covering a range of developmental, physical, and emotional disabilities. It provides links to federal/local/national resources, grants, and data.

Unintentional Injury

Background/General

CDC, NCIPC

<http://www.cdc.gov/ncipc/>

The NCIPC works to reduce morbidity, disability, mortality, and costs associated with injuries. Research includes motor vehicle safety and youth violence. This Web site provides information and links to data sources, news items, and other resources related to preventing unintentional injury. For example, for bicycle-related injuries, the NCIPC links directly to the National Bicycle Safety Network. This CDC site features state injury profiles for all types of injury for all ages.

CDC, NCHS. Fast Stats A-Z

<http://www.cdc.gov/nchs/fastats/Default.htm>

This Web site provides links to a substantial number of health topics/state information (A-Z), which provide quick access to statistical information and data.

- **Accidents/Unintentional Injuries**

<http://www.cdc.gov/nchs/fastats/acc-inj.htm>

- **Injuries**

<http://www.cdc.gov/nchs/fastats/injury.htm>

CDC, NCIPC. Injury Fact Book: 2001 – 2002.

http://www.cdc.gov/ncipc/fact_book/Index.htm

This fact book offers injury data and descriptions of CDC research and prevention programs for many injuries, ranging from those related to alcohol use to those resulting from youth violence.

CDC, NCCDPHP, DASH. School Health Policies and Programs Study (SHPPS) 2000. Fact Sheet: Accident and Unintentional Injury Prevention.

http://www.cdc.gov/nccdpHP/dash/shpps/factsheets/fs00_injury.htm

SHPPS is a national survey conducted to assess school health policies and programs at the state, district, school, and classroom levels. This fact sheet discusses school policy and environment as well as health education.

CDC, MMWR December 6, 2002. 51 (48). 1089 – 1091. Involvement by Young Drivers in Fatal Alcohol-related Motor-Vehicle Crashes – United States, 1982-2001

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5148a2.htm>

CDC analyzed data from the Fatality Analysis Reporting System (FARS) to characterize the rate of alcohol-related fatal crashes among young drivers. This publication summarizes these data.

U.S. Department of Transportation, NHTSA. Traffic Safety Programs

<http://www.nhtsa.dot.gov>

NHTSA is responsible for reducing deaths, injuries and economic losses from motor vehicle crashes. The mission of the Impaired Driving Division is to develop partnerships for cooperatively saving lives, preventing injuries, and reducing traffic-related health care and economic costs resulting from driving impaired by alcohol or other drugs.

- **Saving Teenage Lives – The Case for Graduated Driver Licensing**

<http://www.nhtsa.dot.gov/people/injury/newdriver/SaveTeens/toc.html>

- **Issues Affecting Teens (e.g., graduated license and alcohol-impaired teen driving)**

<http://www.nhtsa.dot.gov/people/injury/newdriver/>

CDC, NCIPC. Injury Fact Sheets: Teen Drivers

<http://www.cdc.gov/ncipc/factsheets/teenmwh.htm>

This fact sheet discusses injury occurrence, costs, at-risk groups, and risk factors for teen injury.



CDC, NCIPC. Injury Fact Sheets: Adolescent Injury

<http://www.cdc.gov/ncipc/factsheets/adoles.htm>

This fact sheet discusses basic facts about adolescent injury.

Partnerships and Coalition Building

(No Entries)

Needs-and-Assets Assessment, Planning, & Using Data

Programs and Interventions

CDC. 2001. School Health Guidelines to Prevent Unintentional Injuries and Violence. MMWR, 50(22):1-46.

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5022a1.htm>

This report summarizes school health recommendations for preventing unintentional injury, violence, and suicide among young persons. CDC developed these guidelines in collaboration with specialists from universities and national, federal, state, local, and voluntary agencies and organizations. They are based on an in-depth review of research, theory, and current practice in preventing unintentional injury, violence, and suicide; health education; and public health. Schools should determine which recommendations have the highest priority based on their needs and available resources.

Guidelines to Prevent Unintentional Injuries and Violence. Summary

<http://www.cdc.gov/nccdphp/dash/healthtopics/injury/guidelines/summary.htm>

- **CDC. 2001. Appendix A: Selected Healthy People 2010 Objectives Related to Child and Adolescent Unintentional Injury, Violence, and Suicide Prevention. MMWR. 50(22):65-66.**

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5022a2.htm>

- **CDC. 2001. Appendix C: Sources of Model and Promising Strategies and Programs. MMWR. 50(22):71-73.**

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5022a4.htm>

CDC, 1995. Recommendations and Reports: Injury-Control Recommendations: Bicycle Helmets. MMWR. 44(No. RR-1):1-18

<ftp://ftp.cdc.gov/pub/Publications/mmwr/rr/rr4401.pdf>

These guidelines were developed for state and local agencies and organizations that are planning programs to prevent head injuries among bicyclists through the use of bicycle helmets. The guidelines are based on a review of literature on bicycle-related injuries, bicycle helmets, and the evaluation of legislation and community programs. The guidelines have been reviewed and approved by the Advisory Committee for Injury Prevention and Control and by other experts in the prevention of bicycle-related injuries.

CDC, NCIPC. Community-Based Interventions to Reduce Motor Vehicle-related Injuries: Evidence of Effectiveness from Systematic Reviews

<http://www.cdc.gov/ncipc/duip/mvsafety.htm>

This Web page discusses useful interventions for increasing safety belt use and reducing drinking and driving.

Management and Media Relations

(No Entries)

Evaluation

CDC, NCIPC. Demonstrating Your Program's Worth: A Primer on Evaluation for Programs to Prevent Unintentional Injury

<http://www.cdc.gov/ncipc/pub-res/dypw/>

This guide was written to enable program managers to demonstrate the value of their work to the public, peers, funding agencies, and people served. The document explains why evaluation is necessary and worth the resources and effort. It instructs on how to conduct simple evaluations, how to hire and supervise consultants for complex evaluation, and how to incorporate evaluation activities in the injury prevention program itself.

Funding

NCIPC: Research Grants and Funding Opportunities

<http://www.cdc.gov/ncipc/res-ops/grants1.htm> or <http://www.cdc.gov/ncipc/res-ops/funding.htm>

This Web site has links to research grants and funding opportunities concerning injury prevention.

Policy

(No Entries)

Other

CDC. 2001. Appendix B: Child and Adolescent Unintentional Injury, Violence, and Suicide-Prevention: Resources. MMWR. 50(22):67-70

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5022a3.htm>

This appendix provides resources of model policies and materials for preventing unintentional injury, violence, and suicide.

Violence

Background/General

CDC, Federal Working Group on Youth Violence, National Youth Violence Prevention Resource Center (NYVPRC)

<http://www.safeyouth.org/home.htm>

NYVPRC is a clearinghouse of user-friendly, single-point-of-access federal information about preventing youth violence. The site lists citations on causes, risk and protective factors, interventions and preventions, and epidemiology as well as links to other resource sites on the Web.

U.S. Department of Justice, Executive Office for Weed and Seed (EOWS)

<http://www.ojp.usdoj.gov/eows/>



Operation Weed and Seed is a multi-agency strategy that “weeds out” violent crime, gang activity, and drug trafficking in targeted neighborhoods and then “seeds” the area by restoring these neighborhoods through social and economic revitalization. This strategy links and integrates federal, state, and local law enforcement and criminal justice efforts with social services and private sector and community efforts. The Web site has links to funding resources, publications, and technical assistance.

U.S. Department of Justice. National Criminal Justice Reference Services

<http://www.ncjrs.org/>

The Office of Juvenile Justice and Delinquency (OJJDP) is dedicated to a comprehensive approach to preventing youth violence and strengthening the juvenile justice system. The OJJDP can be accessed from the Justice Information Center Web site and provides information on upcoming conferences, funding opportunities, new publications, and contact lists for state agencies and organizations. The OJJDP also publishes full-text links to Adolescent Violence Fact Sheets that the public is invited to copy and use. Finally, OJJDP publishes JUVJUST, an electronic newsletter.

CDC, NCHS. Fast Stats A-Z

<http://www.cdc.gov/nchs/fastats/Default.htm>

This Web site provides links to a substantial number of health topics/state information (A-Z), which provide quick access to statistical information and data.

- **Firearms**

<http://www.cdc.gov/nchs/fastats/firearms.htm>

CDC. 2001. Temporal Variations in School-associated Student Homicide and Suicide Events – U.S., 1992-1999. MMWR;50(31).

<http://www.cdc.gov/mmwr/PDF/wk/mm5031.pdf>

The CDC, US Department of Education, and US Department of Justice analyzed data regarding student homicide and suicide events in elementary and secondary schools for 1992-1999. This article discusses their findings.

DHHS, CDC, NCIPC, SAMHSA, NIH, NIMH. Youth Violence: A Report of the Surgeon General

http://www.mentalhealth.org/youthviolence/surgeongeneral/SG_Site/home.asp

This report reviews existing knowledge, and provides background on trends and risk and protective factors for youth violence. It highlights 27 successful and cost-effective programs to prevent youth violence. The report concludes with policy recommendations and courses of action intended for policy makers, service and treatment providers, researchers, and persons involved in the juvenile justice system.

SAMHSA, CSAP. National Clearinghouse for Alcohol and Drug Information. Substance Abuse Resource Guide: Violence in Schools

<http://www.health.org/govpubs/ms713/>

This guide, which focuses on violence in schools, includes a variety of publications and data bases and represents the most current information to date. The listing of books, booklets, brochures, fact sheets, reports, magazines, newsletters, videos, curricula, and journal articles provides depth and a breadth of information related to school violence. Community leaders, teachers, parents, and individuals involved in violence prevention should find this guide valuable.

U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. Female Gangs: A Focus on Research, 2001

<http://www.ncjrs.org/pdffiles1/ojjdp/186159.pdf>

This bulletin considers the underlying reasons for female gang membership, assesses the delinquency and criminal activity of female gang members, examines the influence of ethnicity and gender norms on female gang behavior, and discusses the long-term consequences of gang membership for females. It concludes with proposals for future research.

U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. Preventing Adolescent Gang Involvement, 2000

<http://www.ncjrs.org/pdffiles1/ojjdp/182210.pdf>

This bulletin provides information on the history of American youth gangs and current knowledge about gangs. It provides information that communities can use to build a comprehensive strategy to prevent youth gang involvement, as it examines the problem within the larger context of juvenile violence.

Partnerships and Coalition Building

(No Entries)

Needs-and-Assets Assessment, Planning, & Using Data**CDC, NCIPC. Measuring Violence-related Attitudes, Beliefs, and Behaviors Among Youths: A Compendium of Assessment Tools**

<http://www.cdc.gov/ncipc/pub-res/measure.htm>

This compendium provides researchers and prevention specialists with tools to evaluate programs to prevent youth violence. The measures, directed toward youth aged 11-20, assess factors such as attitudes toward violence, aggressive behavior, conflict resolution skills, self-esteem, self-efficacy, and exposure to violence.

DHHS, HRSA. Youth Violence Prevention in Latino Communities: A Resource Guide for MCH Professionals

<http://www.ask.hrsa.gov/detail.cfm?id=MCHL107>

This guide is directed at Maternal and Child Health (MCH) professionals, public health researchers, policy makers, and practitioners. It provides national demographic information, lists risk factors for violence, and offers program development and policy recommendations related to better serving Latino communities.

Programs and Interventions**CDC. 2001. School Health Guidelines to Prevent Unintentional Injuries and Violence. MMWR. 50(22):1-46.**

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5022a1.htm>

This report summarizes school health recommendations for preventing unintentional injury, violence, and suicide among young persons. CDC developed these guidelines in collaboration with specialists from universities and national, federal, state, local, and voluntary agencies and organizations. They are based on an in-depth review of research, theory, and current practice in preventing unintentional injury, violence, and suicide.



- **School Health Guidelines to Prevent Unintentional Injuries and Violence – Summary**
<http://www.cdc.gov/nccdpHP/dash/healthtopics/injury/guidelines/summary.htm>
- **Appendix A: Selected Healthy People 2010 Objectives Related to Child and Adolescent Unintentional Injury, Violence, and Suicide Prevention**
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5022a2.htm>
- **Appendix C: Sources of Model and Promising Strategies and Programs**
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5022a4.htm>

U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. Reducing Youth Gun Violence: An Overview of Programs and Initiatives

<http://www.ncjrs.org/pdffiles/readyouth.pdf>

This report discusses strategies to prevent gun violence, from school-based prevention to gun market interception.

CDC, DASH. 2000. Federal Activities Addressing Violence in Schools: A Special Report

<http://www.cdc.gov/nccdpHP/dash/violence/index.htm>

This special report is an inventory of federal activities that address violence in schools. Topics include surveillance, evaluation research, research synthesis, and programmatic and resource development activities and resources as well as technical assistance centers.

CDC, NCIPC. Best Practices of Youth Violence Prevention: A Sourcebook for Community Action

<http://www.cdc.gov/ncipc/dvp/bestpractices.htm>

This sourcebook combines expert opinions, interviews with individuals invested in youth violence prevention, and an extensive review of scientific literature on youth violence. The document focuses on the planning, implementing, and evaluating of an intervention and on strategies to prevent youth violence. The strategies fall under four categories: parent and family based, home visit, social cognitive, and mentoring.

U.S. Department of Education, Department of Justice. Safe and Smart: Making the After-School Hours Work for Kids

<http://www.ed.gov/pubs/SafeandSmart/>

This report presents research and examples supporting the potential of high-quality after-school activities. It identifies key components of high-quality programs and effective practices. The report showcases exemplary after-school programs and an extended-learning models from across the country and provides a brief description and contact information for over 20 programs.

U.S. Department of Education. Safeguarding Our Children: An Action Guide

<http://cecp.air.org/guide/actionguide.htm>

The guide expands on three levels of interventions to address violence in schools: school-wide, early, and intensive efforts (e.g., how to develop program evaluations and referral systems; identify warning signs of violence, intervention strategies). It refers to

model programs throughout the U.S. and provides contact information for them. It also offers an online resource list about the following topics: school safety, student support and classroom management, federal and organizational sites, and family information.

CDC, DHHS. Federal Activities Addressing Violence in Schools

http://www.cdc.gov/nccdp/dash/00_pdf/violenceactivities.pdf

This document provides an inventory of federal activities addressing violence in schools. It is designed to facilitate the coordination of federal activities in the prevention of school violence and enhance collaboration on future projects. This inventory will be updated semi-annually.

Office of Juvenile Justice and Delinquency Prevention. Youth Gang Programs and Strategies, 2000

<http://www.ncjrs.org/pdffiles1/ojjdp/171154.pdf>

http://www.ncjrs.org/html/ojjdp/summary_2000_8/contents.html

This OJJDP Summary describes youth gang programs and strategies used to break the appeal of gangs and reduce gang violence. It includes seven sections: Prevention Programs, Intervention Programs, Suppression Programs, Strategies Using Multiple Techniques, Multi-agency Initiatives, Comprehensive Approaches to Gang Problems, and Legislation. In addition, it assesses youth gang programs and stereotypes of youth gang members.

U.S. Department of Education. Wide Scope, Questionable Quality: Three Reports from the Study on School Violence and Prevention

<http://www.ed.gov/offices/OUS/PES/studies-school-violence/3-exec-sum.pdf>

<http://www.ed.gov/offices/OUS/PES/studies-school-violence/wide-scope.pdf>

This report summarizes findings from the Study on School Violence and Prevention. The study was funded by the U.S. Department of Education (and conducted in collaboration with the National Institute of Justice, U.S. Department of Justice) to investigate the extent of problem behavior in schools nationally and to examine several aspects of delinquency prevention efforts in schools, such as the types and quality of prevention efforts, how schools plan and use information about prevention options to improve their own efforts and school management, and sources of funding for prevention activities.

U.S. Department of Education. Exemplary and Promising Safe, Disciplined, and Drug-Free Schools Programs, 2001

<http://www.ed.gov/offices/OSDFS/exemplary01/> or

<http://www.ed.gov/offices/OSDFS/exemplary01/exemplary01.pdf>

This report describes exemplary and promising programs regarding safe and drug-free schools.

CDC, NCIPC, Division of Violence Prevention. Best Practices of Youth Violence Prevention: A Sourcebook for Community Action

<http://www.cdc.gov/ncipc/dvp/bestpractices/Introduction.pdf>

This source book discusses best practices for four promising strategies: parent and family based, home visiting based, social cognitive and mentoring to prevent youth violence. It provides many resources on preventing youth violence.



U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. Blueprints for Violence Prevention

<http://www.ncjrs.org/pdffiles1/ojjdp/187079.pdf>

This report provides information to communities on a variety of evidence-based, effective programs in violence prevention and intervention.

U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. Promising Strategies To Reduce Gun Violence

http://ojjdp.ncjrs.org/pubs/gun_violence/contents.html or

http://ojjdp.ncjrs.org/pubs/gun_violence/173950.pdf

This document provides information about strategies to reduce gun violence.

U.S. Secret Service, U.S. Department of Education. Final Report and Findings of the Safe School Initiative: Implications for the Prevention of School Attacks in the United States

http://www.secretservice.gov/ntac/ssi_final_report.pdf

This publication presents an extensive examination of 37 incidents of targeted school violence that occurred in the U.S. from December 1974 through May 2000.

Management and Media Relations

(No Entries)

Evaluation

National Institute of Justice. National Evaluation of the Gang Resistance Education and Training (GREAT) program

<http://www.ncjrs.org/pdffiles/167264.pdf>

This research brief discusses the early findings of a national evaluation of the Gang Resistance Education and Training (GREAT) program.

Funding

NCIPC. Research Grants and Funding Opportunities

<http://www.cdc.gov/ncipc/res-ops/grants1.htm>

This Web page provides links to funding opportunities, extramural grants, state cooperative agreements, and state injury profiles.

CDC, Federal Working Group on Youth Violence, National Youth Violence Prevention Resource Center. Funding Sources

<http://www.safeyouth.org/resources/index.htm>

This Web page provides links to federal funding resources. Soon it will link to research, funding, educational materials, model programs, and other resources related to youth violence prevention.

Policy

(No Entries)

Other

CDC. 2001. Appendix B: Child and Adolescent Unintentional Injury, Violence, and Suicide-Prevention Resources. MMWR. 50(RR-22):67-70.

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5022a3.htm>

This appendix provides sources of model policies and materials for (a) responding to emergencies and crises and (b) preventing unintentional injury, violence, and suicide.

SAMHSA, White House Council on Youth Violence. Helping Your Children Navigate Their Teenage Years: A Guide for Parents

<http://www.mentalhealth.org/publications/allpubs/SVP-0013/default.asp>

This resource provides tools for improving communication between parents and their teenagers. It discusses how to address a teenager's desire for increasing responsibility and freedom, when parents need help, getting help for a teen, and anger management. The main health outcomes covered are youth violence, mental health, and alcohol and substance abuse. The guide is succinct, reads easily, provides helpful, general background information, and tips as well as national resources.

Substance Use

Background/General

DHHS, CSAP

<http://www.samhsa.gov/centers/csap/csap.html>

CSAP's mission is to provide national leadership in the federal effort to prevent problems with alcohol, tobacco, and illicit drugs. CSAP connects people and resources to innovative ideas and strategies, and it encourages efforts to reduce and eliminate problems with alcohol, tobacco, and illicit drugs both in the United States and internationally. CSAP fosters the development of comprehensive, culturally appropriate prevention policies and systems that are based on scientifically defensible principles and target both individuals and the environments in which they live.

DHHS, SAMHSA. National Clearinghouse for Alcohol and Drug Information (NCADI)

<http://www.health.org>

NCADI is the world's largest resource for up-to-date information and materials concerning alcohol and substance abuse prevention, intervention, and treatment. The Clearinghouse is a service of CSAP, which is part of SAMHSA.

- **Publications and resources related to youth**

<http://www.health.org/features/youth/>

- **Publications and resources related to schools**

<http://www.health.org/features/school/>



CDC, NCHS, Fast Stats A-Z

<http://www.cdc.gov/nchs/fastats/Default.htm>

This Web site provides links to a substantial number of health topics organized alphabetically (A-Z), which provide quick access to statistical information and data.

- **Alcohol**

<http://www.cdc.gov/nchs/fastats/alcohol.htm>

- **Drug Use**

<http://www.cdc.gov/nchs/fastats/druguse.htm>

Partnerships and Coalition Building

U.S. Department of Transportation, NHTSA. Community How to Guides on Underage Drinking Prevention: Coalition Building

http://www.nhtsa.dot.gov/people/injury/alcohol/Community%20Guides%20HTML/Book1_CoalitionBldg.html

This guide includes tips on how to form coalitions, recruit participants, involve youth, maintain the coalition, overcome obstacles, and market the coalition.

Needs-and-Assets Assessment, Planning, & Using Data

U.S. Department of Transportation, National Highway Traffic Safety Administration (NHTSA). Community How to Guides on Underage Drinking Prevention

http://www.nhtsa.dot.gov/people/injury/alcohol/Community%20Guides%20HTML/Guides_index.html

The *Community How To Guides* series addresses the fundamental components of planning and implementing a comprehensive underage drinking prevention program. The Guides are brief and contain a resource section to assist readers in obtaining additional, detailed information about the topics they cover. The appendices include useful tools for each topic area that provide coalitions and organizations a jump-start in their planning and implementation activities. Topics covered in the *Guides* include coalition building; needs assessment and strategic planning; evaluation; prevention and education; underage drinking enforcement; public policy advocacy; media relations; self-sufficiency; and resources.

U.S. Department of Transportation, NHTSA. Community How to Guides on Underage Drinking Prevention: Needs Assessment and Strategic Planning

http://www.nhtsa.dot.gov/people/injury/alcohol/Community%20Guides%20HTML/Book2_NeedsAssess.html

This guide discusses barriers to conducting a needs assessment, integral elements of an assessment, and data collection.

Programs and Interventions

National Institute on Drug Abuse (NIDA), NIH. Preventing Drug Use Among Children and Adolescents: A Research-Based Guide

<http://www.nida.nih.gov/Prevention/Prevopen.html>

This guide provides research-based concepts and information for developing and carrying out effective drug abuse prevention programs. The question-and-answer format is the result of a collaboration involving NIDA staff, drug abuse prevention leaders, and NIDA-supported prevention scientists. This guide presents an overview of research on the origins and pathways of drug abuse, the basic principles derived from research in effective drug abuse prevention, and the application of research results to the prevention of drug use among young people.

SAMHSA, CSAP.

<http://www.samhsa.gov/centers/csap/csap.html>

<http://www.samhsa.gov/csap/modelprograms/nominatenew.htm>

This Web site and its links present real-life examples of seven model programs throughout the country. For each model program, CSAP lists a description, the target domains, objectives and activities, how to get started, the program history, contact information, and evaluation methods. CSAP's National Prevention System and National Registry of Effective Prevention Programs (NPS/NREPP) is an ongoing repository of model programs. For those wishing to nominate their program (as a model program), a list of 15 criteria that define a model program is provided. The criteria are good general structural references for those implementing new programs in their communities.

SAMHSA, CSAP. Underage Drinking Prevention Action Guide and Planner

<http://www.health.org/govpubs/phd858/index.pdf>

This guide assists prevention professionals in their efforts to address underage drinking. It is organized as a monthly calendar, with each month focusing on different aspects of underage drinking (e.g., alcohol and relationships, alcohol and youth culture, drinking and driving). It provides ideas and suggestions for activities that target teens and the community.

Management and Media Relations

U.S. Department of Transportation, NHTSA. Community How to Guides on Underage Drinking Prevention: Media Relations

http://www.nhtsa.dot.gov/people/injury/alcohol/Community%20Guides%20HTML/Book7_MediaRelations.html

This guide discusses basic principles of media relations, communication tools, ideas for coverage, and developing a media relations plan.

Evaluation

U.S. Department of Transportation, NHTSA. Community How to Guides on Underage Drinking Prevention: Evaluation

http://www.nhtsa.dot.gov/people/injury/alcohol/Community%20Guides%20HTML/Book3_Evaluation.html

This guide discusses purposes of evaluation; how to conduct formative, process, outcome, and impact evaluations; quantitative and qualitative methods; how to plan an evaluation; and how to hire an evaluator.

U.S. Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. Enforcing the Underage Drinking Laws (EUDL) Program

http://www.udetc.org/NationalOverv/ojjdp_report_pdf2.pdf



The Enforcing the Underage Drinking Laws (EUDL) program tracks information on how states define and address underage drinking. This document discusses findings from analysis of data concerning proposed activities for year 3 of the program.

Funding

U.S. Department of Transportation, NHTSA. Community How to Guides on Underage Drinking Prevention: Self Sufficiency

http://www.nhtsa.dot.gov/people/injury/alcohol/Community%20Guides%20HTML/Book8_SelfSufficiency.html

This guide discusses various forms of resource development, including government funding, private sector funding, and in-kind contributions as well as how to become a nonprofit organization.

SAMHSA

<http://www.samhsa.gov/funding/funding.html>

This Web site is linked to information about SAMHSA grant funding, which includes discretionary grant funding as an important component. The primary source of funds is the Knowledge Development and Application program, which seeks to develop new ways to improve the treatment of mental disorders and substance abuse. Notices of Funding Availability (NOFAs) are officially published in the Federal Register. The title, grant number, and receipt date are posted on this Web site under List of Grant Funding Opportunities. SAMHSA provides online tips on how to apply for its grants.

Policy

U.S. Department of Transportation, NHTSA. Community How to Guides on Underage Drinking Prevention: Public Policy

http://www.nhtsa.dot.gov/people/injury/alcohol/Community%20Guides%20HTML/Book6_PublicPolicy.html

This guide discusses guidelines for effective advocacy, advocacy tools, and underage drinking laws and regulations.

Other

U.S. Department of Transportation, NHTSA. Community How to Guides on Underage Drinking Prevention: Resources

http://www.nhtsa.dot.gov/people/injury/alcohol/Community%20Guides%20HTML/Book9_Resources.html

This guide lists federal and national resources, including state highway safety offices, and the Enforcing Underage Drinking Laws Program Contact list.

Mental Health

Background/General

DHHS, SAMHSA

<http://www.samhsa.gov/>

SAMHSA is the federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitative services so as to reduce illness, death, disability, and societal costs resulting from substance abuse and mental illnesses. SAMHSA's main Web site has links to programs, centers, data, funding, and publications related to mental health and substance use.

NIMH

<http://www.nimh.nih.gov/>

This Web site has links to breaking news and events, information on mental disorders, information in Spanish, and information regarding funding opportunities. You can also sign up for a list serv to receive information directly.

- [Link to Child and Adolescent Mental Health \(e.g., research, reports, and collaborations\)](#)
- [Link to Selected Bibliography on Suicide Research - 1999](#)

SAMHSA, CDC, NIH, HRSA, Indian Health Services. National Strategy for Suicide Prevention - State Prevention Programs

<http://www.mentalhealth.org/suicideprevention/strategy.asp>

The National Strategy for Suicide Prevention (NSSP) represents the combined work of advocates, clinicians, researchers and survivors around the nation. It lays out a framework for action to prevent suicide and guides the development of services and programs. It is designed to be a catalyst for social change with the power to transform attitudes, policies, and services. The NSSP Goals and Objectives for Action was published by the DHHS in May 2001, with leadership from the Surgeon General.

- [National Strategy for Suicide Prevention](#)

<http://www.mentalhealth.org/suicideprevention/>

CDC, NCHS. Fast Stats A-Z

<http://www.cdc.gov/nchs/fastats/Default.htm>

This Web site provides links to a large number of health topics/state information (A-Z), which provide quick access to statistical information and data.

- [Mental Health](#)
<http://www.cdc.gov/nchs/fastats/mental.htm>
- [Suicide](#)
<http://www.cdc.gov/nchs/fastats/suicide.htm>

DHHS, SAMHSA, NIMH, Office of the Surgeon General. Mental Health: A Report of the Surgeon General

Chapter three of this extensive report is devoted to children and adolescents—it reviews theories of development, risk factors for mental disorders, and service interventions and delivery. The last three chapters focus on general policy and institutional changes, including organizing and financing mental health services, confidentiality of mental health information, mental health service delivery and accessibility, treatment quality, and public awareness.

- [Mental Health: A Report of the Surgeon General](#)

<http://www.surgeongeneral.gov/library/mentalhealth/home.html>



- **2001 Supplement. Mental Health: Culture, Race, and Ethnicity**

<http://www.surgeongeneral.gov/library/mentalhealth/cre/>

DHHS. The Surgeon General's Call To Action To Prevent Suicide, 1999

<http://www.mentalhealth.org/suicideprevention/calltoaction.asp>

This call to action introduces a blueprint for addressing suicide – Awareness, Intervention, and Methodology (AIM). As a framework for suicide prevention, AIM includes 15 key recommendations that were developed from consensus and evidence-based findings. These public health recommendations address the problems of undetected and undertreated mental and substance abuse disorders. These recommendations and their supporting conceptual framework are essential steps toward a comprehensive National Strategy for Suicide Prevention.

CDC, NCCDPHP. Mental Health Work Group

<http://www.cdc.gov/mentalhealth/>

The CDC Mental Health Workgroup includes over 85 members representing multiple disciplines, divisions, and centers within CDC and the Agency for Toxic Substances and Disease Registry. The overall goal of the work group is to foster collaboration and advancement in the field of mental health in support of CDC's commitment to promote health, prevent disease and injury, and improve quality of life. The Web site links to state mental health organizations, publications, and resources.

President's New Freedom Commission on Mental Health

<http://www.mentalhealthcommission.gov/>

The President's New Freedom Commission on Mental Health was established as part of the President's agenda to ensure that Americans with mental illness will not "fall through the cracks," that lives will not be lost, and that recovery will be a realistic goal of treatment. President George W. Bush asked the Commission in April 2002 to recommend improvements in the U.S. mental health service system for adults with serious mental illness and for children with serious emotional disturbances. He requested a review of both public and private sectors to identify policies that could be implemented by federal, state, and local governments to maximize the utility of existing resources, to improve coordination of treatments and services, and to promote successful community integration. The Commission's recommendations were presented in its final report in April 2003.

CDC. The National Youth Violence Prevention Resource Center (NYVPRC): Fact Sheet: Youth Suicide.

<http://www.safeyouth.org/topics/suicide.htm>

This fact sheet provides an overview of youth suicide, including information regarding demographics, risk and protective factors, approaches to prevention, and federal resources.

NIMH. Depression in Children and Adolescents: A Fact Sheet for Physicians

<http://www.nimh.nih.gov/publicat/depchildresfact.cfm>

This fact sheet summarizes the latest scientific research on child/adolescent depression and provides resources geared specifically to physicians (e.g., clinical characteristics, screening tools, treatment, and prevention programs).

Partnerships and Coalition Building

SAMHSA, CDC, NIH, HRSA, IHS. National Strategy for Suicide Prevention – State Prevention Programs

<http://www.mentalhealth.org/calendar/suicide.asp>

This Web site has a calendar of upcoming suicide prevention events (users can submit items).

Needs-and-Assets Assessment, Planning, & Using Data

SAMHSA, CDC, NIH, HRSA, IHS. National Strategy for Suicide Prevention – State Prevention Programs: Data Collection Systems and Interactive Databases

<http://www.mentalhealth.org/suicideprevention/surveillance.asp>

This Web site provides links to data collection systems and interactive databases (e.g., the National Injury Data Technical Assistance Center, YRBSS, and CDC Wonder).

Programs and Interventions

SAMHSA, CDC, NIH, HRSA, IHS. National Strategy for Suicide Prevention: Goals and Objectives for Action

<http://www.mentalhealth.org/publications/allpubs/SMA01-3517/SMA01-3517.pdf>

These goals and objectives provide a road map for dealing with suicide. Objectives include increasing awareness; reducing stigma; developing community-based suicide prevention programs, training for the recognition of at risk behavior; developing clinical/professional practices, increasing access to mental health/substance abuse treatment services; increasing research, and improving and expanding the surveillance system.

Management and Media Relations

SAMHSA, CDC, NIH, HRSA, IHS. National Strategy for Suicide Prevention – State Prevention Programs: Newsroom/Media

<http://www.mentalhealth.org/suicideprevention/newsroom.asp>

This component of the National Strategy Web site lists articles on mental health that have appeared in the U.S. media. It also includes resources on how to cover mental health in the media.

Evaluation

DHHS, SAMHSA, Center for Mental Health Services. Annual Report To Congress on the Evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program, 1998

<http://www.mentalhealth.org/publications/allpubs/CB-E198/default.asp>

The Comprehensive Community Mental Health Services for Children and Their Families Program provides grants to states, communities, territories, and Native American Tribes and tribal organizations to improve and expand local systems of care designed to meet the individualized needs of the estimated 4.5 to 6.3 million children and adolescents with a serious emotional disturbance and their families. The report presents data from the third year of the evaluation of the children's services program, which is based on information collected through August 1998 from 22 grantees funded initially in fiscal year 1993 or 1994.



SAMHSA, CDC, NIH, HRSA, IHS. National Strategy for Suicide Prevention – State Prevention Programs: Resources for Researchers and Program Evaluators

<http://www.mentalhealth.org/suicideprevention/research.asp>

This page from the National Strategy Web site provides links to resources regarding suicide evaluation and research.

Funding

SAMHSA

<http://www.samhsa.gov/funding/funding.html>

This site is linked to information about SAMHSA grant funding, which is largely discretionary. The primary source of funds is the Knowledge Development and Application program, which seeks to develop new knowledge and ways to improve the treatment of mental illness and substance abuse. Notices of Funding Availability (NOFAs) are officially published in the Federal Register. The title, grant number, and receipt date are posted on this Web site under List of Grant Funding Opportunities. SAMHSA also provides online tips on how to apply for its grants.

SAMHSA, CDC, NIH, HRSA, IHS. National Strategy for Suicide Prevention – State Prevention Programs: Funding Opportunities

<http://www.mentalhealth.org/suicideprevention/funding.asp>

This page from the National Strategy Web site provides links to federal and non-federal funding sources relating to suicide prevention.

Policy

SAMHSA, CDC, NIH, HRSA, IHS. National Strategy for Suicide Prevention – State Prevention Programs: Policy and Legislation

<http://www.mentalhealth.org/suicideprevention/policy.asp>

This page from the National Strategy Web site provides links to policy and legislative documents relating to suicide. It also provides searchable legislative Web sites and U.S. Senate testimonies.

Reproductive Health

Background/General

CDC, NCCDPHP. Unintended Pregnancy: Adolescent Pregnancy and Births

http://www.cdc.gov/nccdphp/drh/up_adolpreg.htm

This Web site provides links to information, data, and programs relating to adolescent unintended pregnancy.

National Institutes of Health, National Library of Medicine. Medline Plus: Teenage Pregnancy

<http://www.nlm.nih.gov/medlineplus/teenagepregnancy.html>

This informational Web site has links to the latest news, research, publications, data, and research articles relating to teenage pregnancy.

CDC, National Center for HIV, STD and TB Prevention, DHAP.

<http://www.cdc.gov/hiv/dhap.htm>

This Web site contains basic science, surveillance, prevention research, vaccine, prevention tool, treatment, funding, testing evaluation, and training information about HIV, Sexually Transmitted Diseases (STDs), and tuberculosis.

CDC. The CDC National Prevention Information Network (NPIN)

<http://www.cdcnpin.org/>

This Web site contains information, facts, databases, services, and publications about HIV/ AIDS, STDs, and tuberculosis. The CDC MMWRs are also available through NPIN.

- **Youth-specific materials**

<http://www.cdcnpin.org/topic/youth.htm>

CDC, National Center for HIV, STD and TB Prevention, Division of Sexually Transmitted Disease Prevention (DSTDp).

<http://www.nchstp.cdc.gov/std/>

This Web site provides current information about the transmission, treatment, and prevention of sexually transmitted diseases.

<http://www.cdc.gov/std/commdata/>

This Web site provides easy access to population-specific communication information for specific STDs.

CDC, NCHS. Fast Stats A-Z

<http://www.cdc.gov/nchs/fastats/Default.htm>

This Web site provides links to a substantial number of health topics organized alphabetically (A-Z), which provide quick access to statistical information and data.

- **AIDS/HIV**

<http://www.cdc.gov/nchs/fastats/aids-hiv.htm>

- **Contraception Use**

<http://www.cdc.gov/nchs/fastats/usecontr.htm>

- **Reproductive Health**

<http://www.cdc.gov/nchs/fastats/reproduc.htm>

- **Sexually Transmitted Infections**

<http://www.cdc.gov/nchs/fastats/stds.htm>

- **Teen Birth Rates**

<http://www.cdc.gov/nchs/fastats/teenbrth.htm>

DHHS, Office of the Surgeon General. The Surgeon General's Call to Action to Promote Sexual Health and Responsible Sexual Behavior

<http://www.surgeongeneral.gov/library/sexualhealth/default.htm>



This document complements *Healthy People 2010* by encouraging a national dialogue and action steps to promote responsible sexual behavior, particularly for young people. It describes the public health approach to addressing problems of sexual behavior. It also reviews risk and protective factors for sexual health, many of which relate to young people. The report summarizes research findings on different types of interventions (community, school, clinic, and faith-based). The document is directed toward a wide, diverse audience, including parents, teachers, and social service professionals as well as health care professionals and policy makers.

CDC. 2002. Trends in Sexual Risk Behaviors Among High School Students – U.S., 1991-2001. MMWR. 51(38): 856-859

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5138a2.htm>

To examine changes in sexual risk behavior that occurred among high school students in the United States during 1991–2001, CDC analyzed data from six national Youth Risk Behavior Surveys (YRBS). This report summarizes the results of this analysis.

CDC, NCCDPHP, DASH. School Health Policies and Programs Study (SHPPS) 2000. Fact Sheet: HIV Prevention, Sexually Transmitted Disease Prevention, Pregnancy Prevention

<http://www.cdc.gov/nccdphp/dash/shpps/index.htm>

SHPPS is a national survey conducted to assess school health policies and programs at the state, district, school, and classroom levels. This fact sheet discusses school policy and environment and health education relevant to the prevention of HIV, STDs, and pregnancy.

CDC, NCCDPHP, DASH. Publications on Adolescent Sexual Behavior, HIV/AIDS and Sexually Transmitted Diseases: 1996-2002

<http://www.cdc.gov/nccdphp/dash/publications/publications.htm#stds>

This Web page provides links to materials published by and available from the CDC.

CDC, DHAP. Fact Sheet: Young People at Risk: HIV/AIDS among America's Youth

<http://www.cdc.gov/hiv/pubs/facts/youth.htm>

This fact sheet provides an overview and statistics on HIV in young people as well as information on how to improve prevention efforts. It also has links to resources.

CDC. 2002. Sexually Transmitted Diseases Treatment Guidelines 2002. MMWR. 51(6):1-84

<http://www.cdc.gov/std/treatment/TOC2002TG.htm> or <http://www.cdc.gov/std/treatment/rr5106.pdf>

Included in these updated guidelines are new alternative regimens for early syphilis, an expanded section on the diagnosis of genital herpes, new recommendations for treatment of recurrent genital herpes among persons infected with HIV, and inclusion of hepatitis C as a sexually transmitted infection. In addition, these guidelines emphasize education and counseling for persons infected with human papillomavirus, clarify the diagnostic evaluation of congenital syphilis, and present information regarding the emergence of quinolone-resistant *Neisseria gonorrhoeae* and implications for treatment. Recommendations are provided for vaccine-preventable STDs, including hepatitis A and hepatitis B. It includes a specific section on adolescents.

CDC. Program Operations: Guidelines for STD Prevention: Leadership and Program Management

<http://www.cdc.gov/std/program/Leadership.pdf>

This CDC document includes information on leadership, strategic planning, program management, resource development, advocacy, media relations, legislation, partnerships, and collaborations.

Partnerships and Coalition Building

(No Entries)

Needs-and-Assets Assessment, Planning, & Using Data**CDC, DHAP. Software, Data Access on HIV/AIDS**

<http://www.cdc.gov/hiv/software.htm>

This Web site provides links to software that offers HIV / AIDS data and analysis for the general public and state and local health department staff.

CDC, DHAP. Suggested Guidelines for Developing an Epidemiologic Profile for HIV Prevention Community Planning

<http://www.cdc.gov/hiv/pubs/suggguid.htm>

These guidelines include the kinds of questions to ask and techniques for gathering data in preparation for an epidemiologic profile for HIV prevention planning at the community level.

CDC. 2002. Teenage Births in the United States: State Trends, 1991–2000, An Update. National Vital Statistics Reports. 50(9)

http://www.cdc.gov/nchs/data/nvsr/nvsr50/nvsr50_09.pdf

This report provides state-specific birth rates for teenagers between 1991 and 2000 and the percent change for 1991–2000.

CDC, DHAP. Fact Sheet: Basic Statistics of HIV/AIDS

<http://www.cdc.gov/hiv/stats/hasr1402.htm>

These data come from the CDC semiannual *HIV/AIDS Surveillance Report*. Numbers are based on AIDS cases reported to CDC through December 2002. The fact sheet includes information about HIV / AIDS rates among adolescents.

CDC, DHAP. Fact Sheet: Comprehensive HIV Prevention Messages for Young People

<http://www.cdc.gov/hiv/pubs/facts/compyout.htm> or <http://www.cdc.gov/hiv/pubs/facts/compyout.pdf>

This fact sheet discusses abstinence and condom-use promotion messages supported by scientific reviews.



Programs and Interventions

CDC, NCCDPHP, DASH. 1988. School Health Program Guidelines: Guidelines for Effective School Health Education to Prevent the Spread of AIDS. MMWR. 37(2); 1-14

http://www.cdc.gov/nccdpHP/dash/healthtopics/sexual_behaviors/aids_guidelines/index.htm

These guidelines include specific recommendations to help states, districts, and schools implement those programs and policies in HIV / AIDS health education that have been found to be most effective in promoting healthy behaviors among youth. Recommendations include teacher preparation and qualification guidelines, program assessments, and the main messages students should learn in elementary, junior high, and high school.

CDC, Division of STDs. Program Operations, Guidelines for STD Prevention: Areas of Special Emphasis

<http://www.cdc.gov/std/program/SpecialEmph.pdf>

This series of guides was developed by the CDC to assist in the design, implementation, and evaluation of STD prevention and control efforts. This guide provides information on program development in areas such as adolescents, other high-risk populations, managed care, STD/HIV interaction, and syphilis elimination.

CDC, DHAP. Replicating Effective Programs Plus

<http://www.cdc.gov/hiv/projects/rep/default.htm>

This Web site helps users identify and implement HIV / AIDS prevention programs that have been shown to work. It lists model HIV / AIDS prevention programs and other relevant resources.

CDC, NCCDPHP. CDC's Reproductive Health Information Source. Teen Pregnancy: Community Coalition Partnership Programs for the Prevention of Teen Pregnancy

<http://www.cdc.gov/nccdpHP/drh/tPartner.htm>

The Community Coalition Partnership Programs for the Prevention of Teen Pregnancy are based on a youth development framework. In 1995, CDC awarded funds to 13 communities to demonstrate that community partners can mobilize and organize community resources to prevent teen pregnancies through programs that are community wide, comprehensive, effective, and sustainable.

Management and Media Relations

(No Entries)

Evaluation

CDC, Division of STDs. Program Operations: Guidelines for STD Prevention: Program Evaluation

<http://www.cdc.gov/std/program/ProgEvaluation.pdf>

This document gives a brief description of program evaluation and ways evaluation can be used to achieve program goals and objectives.

CDC, DASH. The Handbook for Evaluating HIV Education

http://www.cdc.gov/nccdpHP/dash/publications/hiv_handbook/index.htm

The CDC and its contractor, IOX Assessment Associates, developed this handbook to support the efforts of educators to evaluate the quality of their HIV prevention programs. The handbook includes evaluation designs and measurement tools necessary to collect data on such basic program components as policy development, curriculum design, teacher training, and student outcomes. Although the handbook cannot serve all evaluation purposes, it reflects the need to evaluate the basic, most central aspects of HIV prevention programs.

Funding**CDC, National Center for HIV, STD and TB Prevention, Division of Sexually Transmitted Diseases. Federal Funding Links**

<http://www.cdc.gov/nchstp/dstd/funding.htm>

This Web site links to other federal funding resources, including CDC funding, CDC grants forms, the Federal Register, HIV / AIDS funding, and NPIN Funding Databases.

Policy

(No Entries)

Other

(No Entries)

Chronic Disease Prevention**Background/General****DHHS. Nutrition**

<http://www.nutrition.gov/home/index.php3>

This Web site provides access to all online federal government information on nutrition. This national resource makes government information on nutrition, healthy eating, physical activity, and food safety easily accessible. The Web site has links to food facts, research, funding, and other resources relating to nutrition.

CDC, NCCDPHP, Division of Nutrition and Physical Activity (DNPA). Nutrition and Physical Activity

<http://www.cdc.gov/nccdpHP/dnpa/>

This Web site provides the following information relevant to nutrition and physical activity: general information, data, and statistics, recommendations, reports and other publications.

CDC, NCHS. Fast Stats A-Z

<http://www.cdc.gov/nchs/fastats/Default.htm>

This Web site provides links to numerous health topics organized alphabetically (A-Z), which provide quick access to statistical information and data.



- **Smoking**
<http://www.cdc.gov/nchs/fastats/smoking.htm>
- **Diet**
<http://www.cdc.gov/nchs/fastats/diet.htm>

CDC, NCCDPHP. The Surgeon General's Report on Physical Activity and Health

<http://www.cdc.gov/nccdpHP/sgr/contents.htm>

This Surgeon General's report is the first to address physical activity and health. The main message is that Americans can substantially improve their health and quality of life by including moderate amounts of physical activity on a daily basis. The information in this report summarizes a diverse literature from the fields of epidemiology, exercise physiology, medicine, and the behavioral sciences. The report highlights what is known about physical activity and health as well as what is being learned about promoting physical activity among adults and young people.

- **Surgeon General's Report Fact Sheet: Adolescents and Young Adults**
<http://www.cdc.gov/nccdpHP/sgr/adoles.htm>

DHHS. The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity

<http://www.surgeongeneral.gov/topics/obesity/default.htm>

This call to action includes general information about obesity as a public health problem in the U.S., basic epidemiology, and strategies to confront this issue that involve families and community, schools, health care, media, and work sites.

- **Call to Action Fact Sheet: The Problem of Overweight in Children and Adolescents**
http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact_adolescents.htm

CDC, NCCDPHP, DASH. Guidelines for School and Health Programs Promoting Lifelong Healthy Eating

<http://www.cdc.gov/nccdpHP/dash/healthtopics/nutrition/guidelines>

The *Guidelines for School Health Programs to Promote Lifelong Healthy Eating* was developed by CDC in collaboration with experts from other federal agencies, state agencies, universities, voluntary organizations, and professional associations. These guidelines identify strategies most likely to be effective in promoting lifelong healthy eating among young people.

CDC. 2002. Trends in Cigarette Smoking Among High School Students – U.S. 1991-2001. MMWR. 5 (19):409-412

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5119a1.htm>

To examine changes in cigarette smoking among U.S. high school students during 1991-2001, CDC analyzed data from the national Youth Risk Behavior Survey (YRBS). This report summarizes the results of the analysis, which found that although cigarette-smoking rates increased during most of the 1990s, they have declined significantly since 1997.

CDC, NCCDPHP, DNPA. State-based Physical Activity Program Directory

<http://apps.nccd.cdc.gov/DNPAProg/>

This Web site provides information about physical activity programs involving state departments of health. Programs can be searched by state and key words.

Partnerships and Coalition Building

(No Entries)

Needs-and-Assets Assessment, Planning, & Using Data**CDC, DASH. School Health Index (SHI) for Physical Activity, Healthy Eating, and a Tobacco Free Lifestyle: A Self-Assessment and Planning Guide**

http://www.cdc.gov/nccdpHP/dash/SHI/middle_high.htm

This tool helps schools assess their physical activity and nutrition policies and programs compared to national standards and guidelines. It may be used as part of a school improvement plan. Specifically, the index helps schools to 1) identify strengths and weaknesses of school health promotion policies and programs, 2) develop action plans for improving school health, and 3) involve teachers, parents, students, and the community in improving school health services. The CDC developed SHI in partnership with school health experts, school administrators and staff, parents, and national and health education organizations.

CDC, NCHS. Prevalence of Overweight among Children and Adolescents: United States, 1999-2000

<http://www.cdc.gov/nchs/products/pubs/pubd/hestats/overwght99.htm>

This document discusses results from the 1999-2000 National Health and Nutrition Examination Survey (NHANES).

Programs and Interventions**CDC, NCCDPHP. Effective Population-Level Strategies to Promote Physical Activity**

<http://www.cdc.gov/nccdpHP/dnPA/physical/recommendations.htm>

This Web site provides a summary of the findings from the *Guide to Community Preventive Services*, which reports evidence-based recommendations on effective population-level interventions for promoting physical activity.

CDC, NCCDPHP, DASH. Guidelines for School Health Programs

<http://www.cdc.gov/nccdpHP/dash/guide.htm>

- **Guidelines to Promote Lifelong Physical Activity**
- **Guidelines to Prevent Tobacco Use and Addiction**

The guidelines include specific recommendations to help states, districts, and schools implement the health programs and policies found to be most effective in promoting healthy behaviors among youth. Recommendations cover topics such as policy development, curriculum development and selection, instructional strategies, staff training, family and community involvement, evaluation, and linkages between different components of coordinated school health programs. Each Web site also has links to related reports, summaries, fact sheets, and resource lists.



Management and Media Relations

(No Entries)

Evaluation

DHHS, CDC. Physical Activity Evaluation Handbook

<http://www.cdc.gov/nccdphp/dnpa/physical/handbook/pdf/handbook.pdf>

This resource outlines the six basic steps of program evaluation and illustrates each step with examples of physical activity programs. Appendices provide information about physical activity indicators, practical case studies, and additional evaluation resources.

Funding

(No Entries)

Policy

CDC. Preventing Tobacco Use among Young People: A Report of the Surgeon General

- The **complete version** of “Preventing Tobacco Use among Young People - A Report of the Surgeon General” provides scientific and technical details about its six major conclusions.

<http://www.cdc.gov/tobacco/sgryth2.htm>

- The **executive summary** presents major conclusions from the Surgeon General’s Report on the health consequences and epidemiology of adolescent tobacco use, psychological risk factors for using tobacco, advertising and promotion by the industry, and efforts to prevent tobacco use among young people.

<ftp://ftp.cdc.gov/pub/Publications/mmwr/rr/rr4304.pdf>

CDC, NCCDPHP, DASH. Promoting Better Health for Young People Through Physical Activity and Sports: A Report to the President from the Secretary of Health and Human Services and the Secretary of Education

http://www.cdc.gov/nccdphp/dash/healthtopics/physical_activity/promoting_health/

This report contains national data on the amount of physical activity among youth and discusses health risks and societal factors related to physical inactivity and obesity. Targeting federal, state, and community institutions, the report outlines general strategies and reasons for families, schools, communities, and after-school and sports recreation programs to increase the amount of physical activity in which adolescents and children participate.

CDC, NCCDPHP, Office on Smoking and Health. State Tobacco Industries Activities and Evaluation System

http://www2.cdc.gov/nccdphp/osh/state/browse_index.asp#Legislation

This Web site lists policies related to tobacco (such as restricting youth access or advertising) by state.

Other

The President's Council on Physical Fitness and Sports

<http://www.fitness.gov/>

This Web site describes such Council programs as The President's Challenge and The Presidents Sports and Fitness award as well as links to programs, publications, and resources regarding physical activity and nutrition.

REFERENCES



Contents

Chapter 1 **page 2**

Chapter 2 **page 2**

Chapter 3 **page 5**

Chapter 4 **page 7**

Chapter 5 **page 7**

Chapter 6 **page 8**

Chapter 7 **page 9**



Chapter 1

U.S. Department of Health and Human Services. (2000). *Healthy People 2010. (2nd ed.) Understanding and Improving Health and Objectives for Improving Health. Volume 1 and 2*. Washington, DC: U.S. Government Printing Office.

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