Designing Health Promotion Approaches to High-Risk Adolescents Through Formative Research with Youth and Parents

This article describes findings of focus group research supported jointly by Public Health Service (PHS) Agencies and the Departments of Education, Justice, and Transportation. The research was conducted under contract No. 282-89-0021 by S. W. Morris. The findings are part of a larger project to help design health promotion strategies for high-risk youth. The project was directed by the PHS Office of Disease Prevention and Health Promotion with oversight by a Federal Advisory Panel. Panel members and their affiliations are listed in the accompanying box. Mary Jo Deering, PhD, Director, Health Communication Staff, Office of Disease Prevention and Health Promotion, chaired the Panel.

Synopsis

Young people who engage in multiple health risk behaviors such as alcohol and other drug use, unprotected sexual activity, smoking, and violence, are a serious public health concern. To help identify potential strategies for influencing these behaviors, focus groups were conducted with 160 youth ages 10–18 years. For additional insights, focus groups also were held subsequently with 70 parents and grandparents of youth of similar ages.

The youth participants were well-informed about most of the risky behaviors and their health consequences. Safe sex practices and the prevention of human immunodeficiency virus (HIV) infection were the exceptions. Despite this understanding, participants spoke of engaging in these behaviors as part of a lifestyle common to the high-risk environments where they live.

The youth said that knowing why these practices were harmful was not enough to help them change the behavior. The need for skills building and support systems to reinforce their generally high level of awareness was evident. Love, home, family, and safety were cited as very important. Many participants said they wanted to talk to someone they could trust, who knew what they were going through.

The groups of parents and grandparents were concerned about the physical dangers facing their adolescents and about peer influence. They also acknowledged their own mixed messages to their youth.

The focus group findings suggest that health promotion strategies for high-risk youth should be comprehensive rather than categorical, with nonjudgmental, interpersonal communication integrated into community-based programs. To be relevant, program strategies must reach outside the usual channels and incorporate the high-risk environment where these youth live.

ADOLESCENCE IS A TIME when young people—no longer children, not yet adults—experience new ideas, new relationships, and new activities. For some youth, the inherent difficulties of this transitional age, combined with high-risk environments, lead to experimentation and adoption of risky health behaviors and practices with lifelong consequences (1).

This article presents the findings of focus group research conducted to explore the attitudes and beliefs of adolescents (ages 10 to 18 years) in high-risk situations. The focus group findings are part of a project funded jointly by Public Health Service Agencies and the Departments of Education, Justice, and Transportation to help plan program approaches for youth in high-risk environments. Since these youth are not included in the usual school-based surveys, alternative methods for gathering information were needed. Focus groups were conducted with 160 high-risk youth and 70 parents and grandparents of high risk-youth in sites around the country. The health issues under study are smoking, human immunodeficiency virus and acquired immunodeficiency syndrome (HIV-AIDS), pregnancy, alcohol and other drug use, and violence.

Background

To help meet the health objectives for the adolescent population set in "Healthy People 2000," more attention must be given to adolescents whose lifestyles significantly increase short- and long-term health risks (2). Dryfoos (3) estimates that as many as one in four children in the United States, or 7 million of those ages 10 to 17 years, may not reach their full potential as workers, parents, and citizens. These young people often come from families struggling with their own problems and living in poor and increasingly violent communities. Their early experiences with unprotected sex, drugs, and violence put them at high risk for the physical and social morbidities, as well as mortality, that accompany these practices.

Federal Advisory Panel on Health Promotion Strategies for High-Risk Youth

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The tendency to engage in multiple problem behaviors characterizes adolescents at risk. Those who use alcohol, for example, are more likely to also use tobacco and other drugs, drive or ride under the influence of illicit substances, and be sexually active. At risk youth also are more likely to experience the so-called social morbidities of adolescence: victimization (including physical and sexual abuse), school problems, and delinquency. Generally, boys more than girls, and lower rather than higher income, youth show greater levels of overall risk (4,5).

The behavioral risk factors of high-risk youth are compounded by the environmental and social factors commonly associated with this population: poor communities, inadequate services, lack of adult support. Often the environment rewards the risky lifestyle and discourages efforts to change or excel (6–8). These factors tend to negate health promotion messages, making program planning difficult for this segment of the adolescent population.

Methods

Focus group methodology was used to collect information on attitudes, perceptions, and beliefs influencing the health behaviors and practices of the target group. The findings were intended for broad use in the design of programs for adolescents in high-risk situations.

As the first federally sponsored focus group study of this population, and because illegal behaviors might be

discussed by the participants, study protocols had to meet with human subject protection and confidentiality requirements of the Department of Health and Human Services before the groups could be convened.

High-risk adolescent focus groups. Twenty-four focus groups were conducted with a total of 160 youth from December 1990 to March 1991. Groups were held in community sites of Washington, DC, Chicago, Houston, Los Angeles, and rural Maryland.

Groups were held with African American, white, Hispanic, and American Indian youth. The groups were segmented by age, race and ethnicity, and sex. The three age divisions were 10–12, 13–15, and 16–18. The focus group design gave greater emphasis to those segments of the study population overrepresented in high-risk health behaviors, especially African Americans and Hispanic males, and to the 13–15 age group.

Leaders of community-based organizations were used to recruit the participants and serve as the focus group facilitators (for example, staff of inner city alternative schools and community youth organizations). Based on knowledge of their clients, these groups recruited youth already engaged in high-risk health practices who met the following criteria: were dropin-dropouts of school or were in alternative school programs, were involved in the juvenile justice system, were runaways, or were in drug or alcohol treatment.

According to the intermediary organizations,

- Approximately two-thirds lived in households which received public assistance.
- Nearly half lived with their mother alone.
- More than two-thirds were truant or school drop outs.
- More than 40 percent were involved with gangs.
- About one-third were engaged in alcohol abuse and drug use or had arrest records.

Equal or greater numbers of immediate family members also were reported to have been involved in alcohol abuse, drug use, gang violence, or had been arrested or incarcerated or both.

An Institutional Review Board, comprised of five local professionals involved in health communication, adolescent health and education, focus group research, and youth services and four representatives from the communities where the research would be conducted, approved the study design and content. One of the primary stipulations for confidentiality was that verbal consent would be obtained from parents or legal guardians and from the participants rather than written consent. A Certificate of Confidentiality was received from the Assistant Secretary for Health, protecting all those working on the study from having to reveal the identity or any information about the focus group participants in any Federal, State, or local civil, criminal, administrative, legislative, or other proceedings.

For additional protection of the youth, focus group meetings were not video taped nor was observation permitted. Sessions were audio taped, and only first names were used. To facilitate control over the groups, the number of participants was limited to seven.

The guide used for each of the focus groups opened with a discussion of life priorities, followed by questions about the youths' typical day; what "health" means to them; their knowledge, attitudes, and practices with respect to smoking, HIV-AIDS, pregnancy, alcohol, drugs, and violence; and their media habits.

Answers were sought to the following questions:

- To what extent is health a priority among high-risk youth? How does it compete with other needs and concerns?
- What do they know and how do they feel about smoking, HIV-AIDS, pregnancy, alcohol and other drugs, and violence? Do knowledge and attitude differ by age, race or ethnicity, and sex?
- What factors inhibit or promote the adoption of positive health practices?
- What opportunities are there for programs to address the problems that threaten the health prospects of this population?

Focus group moderators were, to the extent possible, of the same sex and race or ethnicity as the focus group participants. They received training on the study purposes, the discussion guide, appropriate ways of working with the participants, and issues of confidentiality and informed (verbal) consent. Moderators were responsible for preparing thorough reports on each focus group. These reports, along with the audiotapes, were subsequently used by project analysts to write a comprehensive report.

Parents of high-risk adolescents. In 1992, eight focus groups with parents and grandparents of high-risk youth were conducted to elicit feedback on the findings from the youth groups and to explore opportunities for involving parents in youth programs. The groups were held in four sites across the country: Washington, DC, Houston, Los Angeles, and rural Maryland. Some of the family groups were conducted in the same neighborhoods as the youth focus groups. However, the adult participants were not related to the youth participants in the 1990–91 focus groups.

As with the youth groups, the family groups were segmented by race or ethnicity. However, the family

Ranking of 12 life priorities by black, Mexican American, white, and American Indian participants

	African American		Mexican American		White		American Indian	
Rank	Male	Female	Male	Female	Male	Female	Male	Female
1	Being close to God	Being close to God	Having a family	Having a family	Having some place to call home[1]	Being loved	Having a family	Being loved
2	Having some place to call home	Being loved	Being close to God	Being close to God	Having enough to eat[1]	Having some place to call home	Being loved	Having a family
3	Being loved	Having a family	Being loved	Being loved	Being loved	Having a family	Feeling safe	Feeling safe
4	Having a family	Learning something	Feeling safe	Being healthy	Having money	Getting along with others	Having enough to eat	Being close to God[1]
5	Looking good	Having some place to call home	Having enough to eat	Feeling safe	Feeling important	Feeling safe	Feeling important	Having some place to call home[1]
6	Feeling safe	Being healthy	Feeling important	Looking good	Looking good	Having money	Being close to God	Getting along with others
7	Having enough to eat	Feeling safe	Being healthy	Having some place to call home	Being close to God	Feeling important	Having some place to call home[1]	Having enough to to eat
8	Having money	Having enough	Having some place	Feeling important	Having a family	Being healthy[1]	Being healthy[1]	Having money
9	Learning something	Having money	Learning something	Having enough to eat	Being healthy	Looking good[1]	Having money	Feeling important
10	Being healthy	Feeling important	Having money	Learning something	Getting along with others	Being close to God	Getting along with others	Being healthy
11	Feeling important	Getting along with others	Getting along with others	Having money	Feeling safe	Having enough to eat	Learning something	Looking good
12	Getting along with others	Looking good	Looking good others	Getting along with	Learning something	Learning something	Looking good	Learning something

1=tied.

groups were not further segmented by the age or sex of their children.

To open discussion, the parents and grandparents were asked what they liked best and least about their community and to list behaviors and influences that have an impact on youth. They then responded to a series of statements derived from the earlier focus groups with adolescents. These statements addressed youths' knowledge and practice of risk behaviors, their perceptions of conflicting messages about these behaviors, importance of family influences, availability of free time, need for adult support, and perceptions of racial and ethnic stereotypes.

Limitations of the research. Focus group studies such as these are essentially exploratory, seeking valuable impressions that can be used to help design, test, or assess materials and programs (9,10). When reviewing and interpreting the results of the groups, therefore, the limits of the method must be acknowledged. Focus groups do not use scientific sampling procedures; that is, the age, sex, and racial and ethnic mix of focus group participants are not representative of the study population. Therefore, the results are not statistically generalizable to any population.

Certain aspects of this study suggest that additional caution should be applied to the findings. First, white participants were from a rural community and the other participants were from cities, making it difficult to determine if differences between whites and other groups were due to urban-rural or racial-ethnic differences. Secondly, the information from the teens must be considered in light of the sensitivity of the issues, even more than in usual focus groups. Thirdly, available resources precluded inclusion of Asian-Pacific Islander groups.

Results

In general, there were more similarities than differences among youth of different ages and ethnicities-races. In the various cities and among the various groups, the youth gave similar responses again and again. Common responses are reported first and then the differences which may have emerged according to age, sex, site, or ethnicity-race.

The young people who participated in these focus groups discussed smoking and drinking, using drugs, having sex, and being victims or perpetrators of violence—all behaviors and practices that threaten their prospects for a long and healthy life. These activities were undertaken despite generally high levels of knowledge about the health consequences. As with most adolescents, giving up a practice one feels is enjoyable because of a health risk in the future was not compelling to this population. What seemed to make this concept even more irrelevant for these youth, however, is the volatility of their daily lives and their fatalism about the future.

Knowledge about the topics covered in this study frequently came from personal experiences. In their discussions, violent and dysfunctional behaviors seemed to be common in their environments. Home and family members were cited often as the source for drugs and weapons, verbal abuse, and, in some cases, violence. Participants seemed to accept the lack of structure in their daily lives. They described in a detached and dispassionate manner the killings, crimes, and fighting that touched their lives.

Life priorities. Participants were asked to rank 12 different life priorities. The top choices across all groups were "being loved" and "having a family."

> "You need somebody to love you, to know that you're important. . . . Somebody's there to be with you through the bad times and the good times. It's important to be loved."

> "You need a family's support to do everything, you need help, their advice, you need somebody to run to."

These were followed closely by "being close to God."

> "God is your number one priority. Without God, you won't be able to breathe. . . . You wouldn't have none of the things on that list."

> "If you don't have friends, God's your friend."

> ". . . having someplace to call home."

> "Having a place to live, you won't be out in the street."

. . . and "feeling safe."

> "To feel like you can wear any color that you want, without somebody coming up to you."

Love, family, and God were discussed as fundamental concepts from which all other priorities evolved. "Being healthy" ranked 8 out of 12, on average. The table on page 71 summarizes how the ethnic-racial focus groups ranked their priorities.

Typical day. What emerged from the discussions of a

typical day was a picture of young people with lots of free time and little adult supervision or direction on how time is spent. Only a few reported job, family, and household responsibilities. Few mentioned any interactions with family members. More common activities reported were listening to the radio, playing Nintendo, talking with friends, doing simple chores (for example, cleaning their room), going to school, skipping classes, doing a "little homework," watching television, "getting high," and sleeping. None reported participation in extra curricular activities such as sports or school-based clubs.

Many of the parents agreed that the youth had little or no adult supervision and attributed the problem to a failure by communities, schools, and parents to meet the needs of young people. Barriers to community activities were raised by some, such as cost and transportation. The lack of community alternatives were cited by others. A few parents acknowledged the need for parents to get involved in creating programs for youth.

Parents reported more interactions with younger children than with their teenagers. The overall impression given was one of busy days, filled with work, in which most time with children was spent doing chores, watching television, and eating dinner.

Knowledge about health topics. In general, these youth knew about the issues discussed, often reporting what sounded like the curriculum from a health education class.

> About smoking: "Can give you cancer." "... heart problems." "Can kill you." "... hurt (your) baby."
>
> About alcohol: "Mess up your liver." "Makes you do things you don't want to do."
>
> About drugs: "Kills you." "Overdose" "Makes you want to do a crime."

HIV-AIDS misinformation. Misinformation was most notable about HIV-AIDS, a problem with which these youth had the least personal experience. Some of the adult participants thought the youth might know more now since the youth groups were held before Magic Johnson's announcement that he had HIV.

One area of misinformation for some participants was that safe sex and condom messages had been interpreted to mean that other forms of birth control (for example, birth control pills) would also protect them from AIDS.

> "Foams, jellies kill the AIDS virus."

There was also confusion about how it was transmitted (from saliva, a dentist's pick, sanitary napkins) and ways to prevent it (don't get tattoos, ingest bleach).

'The tendency to engage in multiple problem behaviors characterizes adolescents at risk. Those who use alcohol, for example, are more likely to also use tobacco and other drugs, drive or ride under the influence of illicit substances, and be sexually active.'

Confusion about birth control to prevent pregnancy. While nearly all participants could name various birth control measures, discussion yielded lots of questions and confusion about how to use many of them, including the pill. Many examples of failed methods were cited. Boys especially gave descriptions of sexual activity that would not result in pregnancy, some accurate and some not. Discussion of sex and birth control was more limited and abstract in the younger age groups.

Knowing and not believing. Parents noted that young people may have health information, but they don't believe it or don't believe it applies to them. This seemed to be particularly true when it came to HIV-AIDS.

> A parent:
> "Being aware and understanding are two different things. I think a lot of them know about Magic Johnson but they don't really understand it. They look at (him) and say, 'He's perfectly healthy.' My son asks, 'Is he going to die?'"
>
> The youth (why risky behaviors persist):
> "It always happens to somebody else." "They don't care."

Integrated health behaviors and practices. In the discussions, the high-risk health behaviors were presented one at a time. But that is not how the teens talked about them. Discussions shifted frequently from one to another. It seems that one high-risk practice goes with another, such as using drugs, alcohol, and tobacco in conjunction with sex or before a fight. These youth did not make the same distinctions between categorical issues which agencies and organizations designing programs often do.

> "Drinking makes you want to use crack."
> "Some people can't fight unless they are drunk."

Levels of adolescents' knowledge, acceptance, and concerns about risk behaviors

Risk factor	*Knowledge*	*Acceptance*	*Concern*
Smoking	High	Low	Low
Violence	High	Medium	High
Drugs/alcohol	High	Medium	Medium
Sexual activity	High	High	Low
Pregnancy	Medium	Medium	Medium
AIDS	Low	Low	High

(What's the preferred drug?)
"Marijuana and beer."
"We discuss it every day. Sex, cars, drugs, and rock n' roll."

The parents strongly agreed with the teens that certain activities and behaviors go together:

"It's been like that since the 60s: sex and drugs and rock n' roll."
"Kids who are at risk in one area are very susceptible to be at risk in the others."

Violence. For inner city youth in Chicago and Los Angeles and to a lesser extent, Washington, DC, and Houston, violence was a part of daily life. Participants were skeptical that violence could be avoided or was something from which you could walk away. Some doubted they would survive their teenage years.

"If you try to avoid it, they'll sock you in the face. You don't want it, you ain't looking for it, it comes to you."

Weapons seemed to be readily accessible, especially guns. The availability of weapons, and violence itself, had become commonplace. This was reflected in the matter-of-fact discussions of personal experiences with violence.

"My uncle, he got shot. He was wearing the wrong color on the wrong street."

"My sister got shot in the head. She's still living."

"My brother, he robbed a pizza man, and he got 10 years in jail."

"This girl called me a fit and a half. . . .She hit me first so I beat her up."

Acceptable risk-taking. Participants were asked which of the topics that had been discussed were "okay for you to do." Most of the youth thought that sex was okay, except for some of the younger Mexican American girls and some of the American Indian participants who added caveats, that is, sex was okay with precautions, or pregnancy was okay if the baby was cared for. Many participants thought fighting was acceptable, especially in self-defense or to "establish your position." The white boys in rural Maryland talked about their support for fighting in the Gulf War. Smaller numbers felt that drinking alcohol and using drugs were okay for them to do. Cigarettes were least acceptable; the groups of white girls thought they were okay, as did several of the American Indian participants, but only one person in each of the other groups thought so.

Parental attitudes may contribute to perceptions of acceptable risk-taking. Parents talked about other parents who give their children alcohol and drugs to use at home because they feel it is safer there than on the streets. Others talked about their own adolescent experiences with alcohol and drugs. However, most parents did not agree that the risks discussed were acceptable. Many expressed concern that their children might not survive youthful experimentation in today's world of lethal drugs, weapons, and AIDS.

Issues of concern to youth. The teens also were asked which of the topics discussed concerned or bothered them the most. Using weapons and fighting were mentioned by many African Americans and Mexican American youth. White girls said "family problems." Pregnancy worried most of the girls, although concern among African American girls diminished in the older age groups. Many participants expressed concern about AIDS. One participant pointed out the discrepancy between the behaviors that they thought were okay and their worry about AIDS.

The box on this page summarizes youths' knowledge and attitudes about risk behaviors. They are ranked high, medium, and low in knowledge, acceptance, and concern.

Issues of concern to family members. Open-ended discussion yielded peer influences, poor schools, unresponsive school administrations, and aspects of pop culture as the greatest concerns of the adult participants. Their responses underscored how risk behaviors are perceived to be linked in a deadly and apparently inescapable pattern.

"Once you get started because of peer pressure...and you smoke weed and you take coke... it's not going to stop until something tragic happens. At an early age, you're not going to realize it. It's inherent that (young people) are not going to fear death."

Sources of health information. The youth's level of health information demonstrated that they have had a high level of exposure to information about the high-risk behaviors from many sources. Schools, television, radio, parents, friends, and firsthand experience were all mentioned in different contexts as sources of information. The family in general was also mentioned.

Parents thought that youth listened most closely to their peers and were concerned about the misinformation that they may be getting. The parents also acknowledged that the information youth received from their families "could be good information or bad information," that is, information gained by witnessing family members who are abusive, use drugs, smoke, or engage in other risk behaviors.

> "They learn what they see."

Television was popular with all the participants, with sports, soaps, music shows, situation comedies, and action movies the programs most commonly viewed. Few of the participants viewed news programs or read newspapers or magazines for health information.

Asked specifically about public service announcements, youth rated their impact between 5 and 50 on a scale of 1 to 100. One youth said that change comes from "the commercial in combination with other things."

Conflicting messages. While not all participants could think abstractly about what could be done to curtail risky behavior, some simply stated it should not "be allowed." For example, they perceived the conflict in the message "don't smoke" and the legal sale of cigarettes. These youth did not make distinctions between public service announcements and paid commercials seen on television, adding to the confusion. A few acknowledged the conflicting messages that come from the home.

Parents were concerned not only about commercials targeting young people but also about how their own behavior sends mixed messages.

Racial and ethnic stereotypes. In some of the African American, American Indian, and Mexican American groups, the youth expressed a negative response to messages aimed at specific racial-ethnic populations. Some felt these reinforced negative stereotypes and reinforced racist messages about their ethnicity-race. The adult participants generally agreed with the youth, although some thought they were simply repeating what they had heard from adults. One woman did say that the groups portrayed in the public service announcements were meant to capture the attention of a specific audience, not to perpetuate stereotypes. Another said that stereotypes were "everywhere you look."

Change. Although a fair amount of information about health appears to be reaching this population, what seems lacking is both the motivation to act on that information and the skills and resources to make the changes. When asked what it would take to get people to change, the youth suggested interpersonal strategies which offered skills and support for changing behavior and stressed social over medical consequences.

> "I care about my friends but if they do drugs and alcohol, I won't tell them to stop. I'll just help them to stop. I'll talk to them."

> "I would tell that drugs, AIDS, or whatever there is . . . it would ruin their life and they can't get no girlfriend because their breath is always stinking and their clothes look dirty because they smoke."

Many participants thought hearing it from a trusted source, with firsthand experience, would be helpful.

> "I like to sit down and have a long talk with somebody who knows. Individually."

> "You have to see someone have these experiences to listen to them. Your friends, if it happens to them, then they tell you."

> "Get ex-gang bangers, get ex-convicts, they have changed their lives."

> "It should be someone who is straight with you and someone who understands . . . Someone who will be honest. Someone you know you can trust. Someone to take the time and not just read it (health information). Someone who lets you understand it."

Discussion

Given the complex and compelling needs which emerged from the focus group discussions, it is evident that health cannot be addressed in isolation from the daily threats of the environment in which these youth live. Rather, information that addresses health matters must fit the context of daily life. The motivation to do something now to safeguard the future first must be sparked by a belief that there will be a future.

Despite the odds, the youth displayed the resilience characteristic of their age group. In many ways, they sounded like their larger adolescent peer group. Love, home, family, and safety were cited as important priorities—the need for someone and somewhere to feel safe. They wanted someone to talk to whom they could trust.

Many of the parents seemed to understand the youths' need to talk to someone who was not judgmental. Most seemed to find it hard to be both parents and "buddies" to their children. Sex was the most difficult health topic to discuss with their children. For many parents, talking about their children's friends presented the most frequent problem.

In a way not anticipated, simply going through the focus group process provided an opportunity for open discussion and critical thinking which has not been available to these youth. The participants were eager to talk. There appeared to be a benefit in having the opportunity to explore these topics in the absence of directive, judgmental input from adults. These findings suggest that effective communication can occur in a "safe haven" in the midst of what were reported to be violent and unpredictable lives.

Attracting these youth to participate in program activities will be a challenge. Time will not be the barrier; it seemed to be in plentiful supply. But building trust and making a youth program attractive and relevant to their lives will be difficult. And, according to some of the parents, the cost of programs may be a barrier for low-income families.

Following are several principles from the focus group findings that could be applied to the design of outreach efforts for this population.

Concepts of "risk" and "risky behaviors" are not appropriate to these youth and their parents. The discussions suggest that the public health community's emphasis on "risk" and "risky behaviors" is not an effective communications approach for these youth or their parents. While parents as well as adolescents are aware of the consequences of "high-risk behaviors," they see many of them as part of a "good time." Youth named as many "good" things as "bad" about the individual behaviors. Both youth and parents also see teens' risk-taking as both normal and inevitable, a view supported by empirical evidence. However, parents did not think, like youth, that this meant that the behaviors were acceptable. Parents felt that this generation of youth has no margin of safety for risk-taking. Since some of the behaviors had immediate life-threatening consequences, they merited even stronger labels. They suggested words such as "dangerous," and "the don'ts."

The communications challenge will be to address these behaviors in ways that are congruent with the reality that they are both pleasurable and deadly for youth. The program challenge will be to provide attractive activities that help adolescents develop their sense of competence through safe experiences with alternative risk-taking.

Adolescents need skills and services as well as information. The focus group participants supported a basic tenet of health communication practice: messages alone cannot make people change their health behaviors. These youth recognized the need for individualized support when making difficult changes. They wanted to be able to talk to people whom they could trust; people who had experienced the same problems they did. They also were enthusiastic about the focus group process itself, suggesting that holding discussion groups with a similar format might be a good method of promoting change.

The youth also recognized that they needed skills and services if they were to make the types of changes which were discussed—how to quit using drugs, avert violence, prevent AIDS-HIV—not just information about the harmful effects of these practices.

Youth need clear, specific information about HIV-AIDS, safe sex practices, and birth control. Confusion was greatest in these areas. Since sexual activity is prevalent, it is especially important that sound information about safer sex practices which prevent pregnancy and HIV-AIDS be accessible to these youth. It also is important to recognize that the age of initiation of sexual activity is dropping, especially for this population. Information about these topics needs to be developmentally appropriate.

The parents and grandparents expressed difficulty in discussing sex with the youth. Information to help them communicate with the adolescent would be helpful.

Multiple risk factor approaches are needed. For this population, who engage in multiple risk behaviors, a multiple risk factor approach is crucial. Not only must the combination of high-risk practices (such as using drugs and alcohol combined with sex) be acknowledged in program design, but the different types of approaches needed, that is, services, programs, and information must be addressed.

Involve the family in promoting change. Youth cited family as an important source of support for keeping youth "in school . . . off drugs . . . off crack." While parents agreed that families could be important positive influences, particularly with younger adolescents, they expressed more reservations. This apparent difference between youth and parent perceptions bears further exploration.

Families were also cited by both youth and adult participants as examples and sources of many of the risks under study, for example, alcohol and drug use, smoking, and violence.

Strengthening family support should be an important

element of any outreach strategy for this population. Since the adults also liked the focus groups as a means of talking through their concerns, discussion groups of a similar format may be a possible strategy for involving parents.

Make activities safe and accessible. These youth do not attend school regularly and do not seem to be engaged in other traditional adolescent group activities, such as sports or church groups. Programs will need to recruit participants from this population, not expect members to join. Cost may be an issue; it was raised by parents as a barrier to sports and other community programs.

Media use should focus on music and entertainment programming. Mass media for this population means music and other youth-oriented entertainment programming, on cable and network television and radio. Media strategies which rely on news programming will not reach this audience. Furthermore, programs which rely heavily on mass media will not influence this population for whom firsthand experience and interpersonal contact is so important.

Develop appropriate messages. Youth are sensitive to subtle cultural messages and racial stereotyping. They do not like only negative images and messages about people of their own ethnic or racial group. To ensure the relevancy of programs and messages, careful testing should be done. Furthermore, youth's developmental stages are important in determining the type of information required.

In conclusion, these discussions show that to significantly improve the health prospects of this segment of the adolescent population, they must be offered the means and opportunity for change. The changes required are complex; the level of effort enormous. But if these challenges are not met, morbidity and mortality will continue to increase for these youth, and our national objectives cannot be met.

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