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Despite our absence from these pages, we hope you will stay connected to the Forum!

— Karen Pittman, executive director of the Forum for Youth Investment

Health and Youth Development: Connecting the Dots

adolescence is a time of significant change in terms of physical, mental and social/emotional development. Implicit in the youth development approach is a recognition of health as an integral piece of adolescents' overall well-being. But while health shows up as an outcome area in most youth development frameworks and as a programming area for some youth organizations, informal polling suggests that basic health education and services are a priority for relatively few.

Behavioral health issues like substance abuse, teen pregnancy and violence prevention have long been priorities for the youth development field. In fact, the "life options" approach, the 1980s forerunner to many of the policy-related arguments for balanced investments in developing assets and reducing risks, grew directly out of efforts to identify new teenage pregnancy prevention strategies.

In the 1990s, the phrase "problem-free is not fully prepared" helped capture the need for both/and responses to risk reduction.¹ The corresponding "donut" image (see Figure 1) graphically depicts how at the core of successful efforts to address or prevent

specific youth problems sits a set of sustained efforts with supports and opportunities — the bread and butter of youth work.

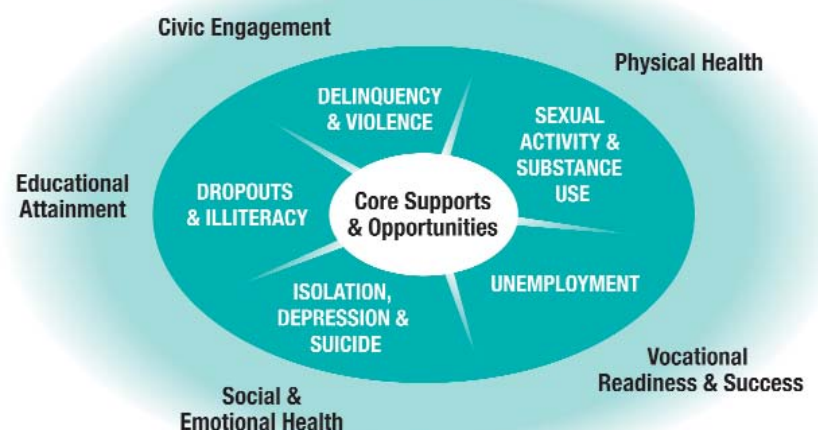
In 2000, we updated this image to reflect the overall progress that has been made to define youth outcomes not just as the absence of problems, but the presence of assets — vocational readiness, social and emotional health, physical health, civic engagement and educational attainment. Youth workers and youth organizations have long claimed some of these outcome areas (e.g., social, emotional and civic engagement issues) and are being pressed to take on more (e.g., academic education). The timing is right for the youth development field to turn its full attention to the basic health needs of America's youth.

WHAT YOUTH WORKERS CAN DO

For youth workers and youth-serving organizations, making a real commitment to improve adolescent health outcomes can be as complex as making a real commitment to improving academic achievement. Health, like education, has an entire system behind it. Given the data on gaps in access to health information and services, however, it is important for youth workers to have some immediate ways to respond. Aside from implementing specific health-related programs or curricula, or partnering with organizations in the community to provide specific health services or information, there are several ways organizations can modify their policies and practice, to promote health.

Organizations can create environments that reinforce good health habits. Providing healthy drinks and snacks, building in physical activity and exercise breaks and making health information easily accessible are several simple, but important

Figure 1: Youth Problem Reduction as a subset of Youth Goals



steps that any organization can take. Youth workers can go a step further by being explicit about the fact that the program has made intentional choices about these things; choices that young people will face at home, at school and with friends, and by helping youth build the skills, supports and confidence needed to make healthy choices outside of the program (e.g., providing nutrition and cooking classes, confidential health self-assessments, clinic links and referrals, discussion groups, family nights).

On the practice level, youth workers should recognize and capitalize on the power of positive relationships in promoting health. Not only are positive relationships themselves protective, they also put youth workers in a unique position to recognize and respond to signs of risky behavior or other health issues.

While youth workers should not be expected to personally advise teens about complex health issues, they are and always have been a critical link to necessary services in the community. Once teens are referred somewhere for help, youth

workers are often in a good position to a) make sure they get there; and b) to follow up afterward.

IN THIS ISSUE

This issue of *Forum Focus* attempts to bring together the youth development and adolescent health perspectives, with an emphasis on helping youth workers identify concrete ways to turn their attention to health issues. In **research update**, we attempt to answer some basic questions about access to health care and coverage for teens. In **on the ground**, we describe two programs that integrate health education and health access issues into their programming by doing what youth development organizations do best — letting young people take the lead. In **voices from the fields** we talk with Claire Brindis, director of the National Adolescent Health Information Center and Kristin Teipel of the Konopka Institute for Best Practices in Adolescent Health about opportunities for alignment between the youth development and adolescent health fields. **key resources** includes our best picks of health-related Web sites that youth workers might benefit from, as well as an overview of the National Initiative to Improve Adolescent Health by the Year 2010.

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¹ Phrase was coined by the Forum's executive director, Karen Pittman, and originally used in *A New Vision: Promoting Youth Development*, Testimony before the House Select Committee on Children, Youth and Families (1991, September).

research update TEENS AND ACCESS TO HEALTH SERVICES

an observant youth worker is likely to know something about the behavioral health status of the young people they serve. They may know, for example, which young people they work with are using drugs, or whether any are pregnant or parenting. They may know which youth smoke and may have explored various options with them for cutting back or quitting. A well-informed youth worker may also keep up with national trends related to adolescent risk behaviors, and may know, for example, that while rates have been declining steadily for over a decade, the United States still leads the industrialized world in teen births and pregnancies.

Youth workers may be less able to answer some questions related to basic health service. What percentage of young people has medical insurance? Do most teens go to the emergency room or to a doctor when they get sick? How regularly do they see a doctor or a dentist? What do they tend to seek health services for? Do gender, race or socio-economic status influence access to services? How many youth have access to school-based health clinics? What are the barriers to accessing services, and what factors increase the likelihood that youth will take advantage of them? Having answers to these questions could inform the day-to-day practice of youth work in important ways.

Adolescents and health insurance. Medicaid and the State Children's Health Insurance Program (SCHIP) are the two most significant sources of public health insurance for low-income teens. While there has been a sharp decline in terms of private health coverage for children and youth during the past two decades, policy expansions during the late 80s and early 90s increased eligibility for public insurance cover-

age. By September of 2001, 46 states offered Medicaid or SCHIP coverage to all poor adolescents under age 19, and in 2002, 88 percent of youth ages 10–18 had some form of coverage. There are lots of “buts,” however. Coverage varies by state; preventive/mental health coverage is limited; access to particular benefits varies by state and by type of program for which young people are eligible, and being eligible is not the same as being enrolled (Newacheck et al. 2004; Brindis et al. 2003a). For example, in 2000, 2.3 million adolescents were eligible for Medicaid or SCHIP but not enrolled (Driscoll, A. et al. 2004).

ADOLESCENTS	PERCENT UNINSURED IN 2002
All adolescents 10–18	12
Age	
Ages 10–14	11
Ages 15–18	14
Race/Ethnicity	
Black	12
White	8
Hispanic	28
Poverty Status	
Below 200% Poverty Line	20
Above 200% Poverty Line	6
Family Education	
Guardian < High School	23
Guardian has some college	7
Source: Newacheck et al. 2004.	

There are also important differences in coverage based on age, race and poverty status (see Table 1). Older teens (15–18) are more likely to be uninsured than younger adolescents (10–14). Young adults ages 18–24 are the most likely of any age group to be uninsured (English et al. 2003). Black adolescents are more likely to be uninsured than whites, and when insured, are more likely to have public coverage. Hispanic adolescents are more than twice as likely as blacks and more than three times

as likely as whites to be uninsured, and foreign-born Latinos are twice as likely as those born in the United States to lack insurance. Poor adolescents are three times more likely to be uninsured than those living at above 200 percent of the federal poverty line (Newacheck et al. 2004; Brindis et al. 2003a).²

Having health insurance significantly influences health outcomes. Uninsured youth are more likely to have unmet health care needs, to go without physician contact and to lack a usual source of care or “medical home” as it is sometimes referred to. Having health insurance increases medical care use by 50% (Driscoll et al. 2004).

Accessing care. Where and how often do young people access health care services? In 1998, 85 percent of teens ages 12–17 reported seeing a health care professional, and four fifths saw a dentist during the past year (Ozer et al. 2003). While compared with other groups, adolescents under-use office visits and over-use emergency department care. Doctor's offices and HMOs are the most common sources of care. Not surprisingly, this varies by poverty status. Eighty-one percent of nonpoor adolescents and 67 percent of poor adolescents rely primarily on doctor's offices; the remainder of poor adolescents visited clinics or the emergency room. Poor teens are also four times as likely as middle and high income teens to report being without a “usual source of care” (Newacheck et al. 2003).

School-based health centers. In response to the increasing number of children and youth lacking access to care — particularly age-appropriate, culturally sensitive, confidential, safe and accessible care — school-based health centers (SBHCs) emerged in the 1970s and have grown exponentially since then. There were approximately 1,400 centers across 45

different states in 2001 (Geierstanger et al. 2005). Roughly half of those centers are located in schools that include high school grades; 56 percent are in urban districts, 30 percent in rural and 14 percent suburban (Brindis et al. 2003b).

Barriers to health care and services. While SBHCs have increased access for many adolescents who are lucky enough to attend schools that have them, there remain significant financial, physical, psychological and cultural barriers to health care for many teens. Financial barriers, delivery system fragmentation, the types of services available (or not available), and legal restrictions (e.g., confidentiality) are common barriers. In addition, transportation, hours of operation and language barriers present challenges for many teens. Finally, adolescents' own perceptions of restricted access may also be a challenge. Advocates argue that several strategies increase the likelihood that teens access the services they need — expanding service locations, engaging adolescents in planning and shaping responsive services, improving outreach and improving coordination and continuity of care (Brindis et al. 1997; Brindis et al. 2003a).

For youth workers, the most basic and important lesson from this compilation of data may be this: Never assume that young people you work with have regular access to quality health services. Use the strong relationships you have with youth to help ensure their health-related needs are being met. There are things you can do in terms of your own practice and programming, as well as strategies for creating a healthy environment within your organization. But in addition, it is important that you develop an awareness of the local health services landscape and consider yourself a critical link between those resources and the young people you serve.

² In 2005, the federal poverty line is \$19,350 for a family of four.

Brindis, C.D., Morreale, M.C., & English, A. (2003a). The Unique Health Care Needs of Adolescents. *The Future of Children*, 13(1), 117–135. Retrieved March 16, 2005, from www.futureofchildren.org/usr_doc/tfoc13-1h.pdf.

Brindis, C.D., Klein, J., Schlitt, J., Santelli, J., Juszczak, L., & Nystrom, R.J. (2003). School-Based Health Centers: Accessibility and Accountability. *Journal of Adolescent Health*, 32(6), 98–107.

Brindis, C.D., Ozer, E.M., Handley, M., Knopf, D.K., Millstein, S.G., & Irwin, C.E., Jr. (1997). *Improving Adolescent Health: An Analysis and Synthesis of Health Policy Recommendations*. San Francisco, CA: National Adolescent Health Information Center. Retrieved March 16, 2005, from http://nahic.ucsf.edu/index.php/recommendations/article/improving_adolescent_health_1997

Driscoll, A.K., Brindis, C.D., Biggs, M.A., & Valderrama, L.T. (2004). *A Future with Promise: A Chartbook on Latino Adolescent Reproductive Health*. San Francisco, CA: Center for Reproductive Health Research and Policy and the Institute for Health Policy Studies. Retrieved March 16, 2005, from http://crhrp.ucsf.edu/resources/files/Driscoll_04_Chartbook-LatinoAdolescent_v2.pdf.

English, A., Morreale, M.C., & Larsen, J. (2003). Access to Health Care for Youth Leaving Foster Care: Medicaid and SCHIP. *Journal of Adolescent Health*, 32(6), 53–69.

Geierstanger S.P., & Amaral, G. (2005). *School-Based Health Centers and Academic Performance: What is the Intersection?* Washington, DC: National Assembly on School-Based Health Care. Retrieved March 16, 2005, from www.nasbhc.org/EQ/Academic_Outcomes.pdf.

Newacheck, P.W., Wong, S.T., Galbraith, A.A., & Hung, Y. (2003). Adolescent Health Care Expenditures: A Descriptive Profile. *Journal of Adolescent Health*, 32(6), 3–11.

Newacheck, P.W., Park, M.J., Brindis, C.D., Biehl, M., & Irwin, C.E., Jr. (2004). Trends in Private and Public Health Insurance for Adolescents. *Journal of the American Medical Association*, 291(10), 1231–1237.

Ozer, E.M., Park, M.J., Paul, T., Brindis, C.D., & Irwin, C.E., Jr. (2003). *America's Adolescents: Are They Healthy?* San Francisco, CA: National Adolescent Health Information Center. Retrieved March 16, 2005, from http://nahic.ucsf.edu/downloads/AA_2003.pdf.

on the ground **YOUNG PEOPLE TACKLING HEALTH ISSUES**

Selecting programs to highlight for this issue proved difficult. There are organizations like El Puente in New York City that have delivered fully on their commitment to a holistic approach, and as a result, have integrated a range of health services into the menu of supports they offer. But the average youth program, reeling from demands that they improve academic achievement, may be understandably leery of taking on the tasks of another large public system.

We focus here on programs that integrate health education and health access issues into their programming by doing what youth development organizations do best — letting young people take the lead. In the first example, young people are involved in systemic change as evaluators of school based health centers. In the second, young people are engaged as conveyors of health-related information using the media. Both strategies, which young people can do and youth workers can support, are powerful ways to get young people talking and thinking about basic health issues and services.

Youth In Focus is an intermediary organization serving Northern California that provides training and support to groups of young people as they engage in youth-led action research designed to promote social justice. Youth In Focus has helped thousands of young people become agents of social change by helping them assume key roles in the design and implementation of research and evaluation projects connected to organizations, initiatives, campaigns or policies that affect them and their peers.

Drawing on 15 years of national and international field experience, Youth In Focus has a comprehensive, youth-centered curriculum — for building the capacity of young people and adults in community-based action research and capacity building. Through a variety of initiatives

focused on a range of topics (adolescent health, public education, youth justice, community development), youth action researchers become catalysts for civic change through skill building and connections with adult partners. In turn, partner organizations build their capacity to support, sustain and benefit from this critically informed youth leadership.

In 2003, Youth In Focus began partnering with the University of California San Francisco Institute for Health Policy Studies to involve young people in an evaluation of school-based health centers (SBHCs) throughout Alameda County. The purpose was to determine the quality and extent of each SBHCs existing services and programs. Young people were engaged around specific health topics they identified as important (i.e., contraception, depression, sexual harassment) that connected in some way (or could connect) to SBHC services. Each youth-led project lasted for approximately eight months and was conducted during the academic school year.

Student research teams were compensated for their efforts and met with an adult facilitator at least weekly for training and support. Organizers anticipated and planned for various challenges, including working within the limitations of an academic calendar and potential backlash from administrators, teachers and parents regarding controversial topics students were addressing. This allowed adults and students to make practical adjustments as needed and gave young people the opportunity to set realistic goals and examine power structures in their school and community from a social change perspective.

Students at Berkeley High School selected depression and suicide as the issue they wanted to address. After surveying their peers and finding that 22 percent of respondents had thought about death or suicide in the past two weeks, student

researchers made two recommendations related to the SBHCs. First, they argued that counseling for depression should be integrated as a service because depression is difficult to detect among teens. Second, they recommended implementing a community education campaign about teen depression because of the stigma about depression in both the school and community.

Engaging young people as leaders in this evaluation effort helped draw attention to the health status of youth in the community, and led to concrete improvements in services at several schools. For more information, see www.youthinfocus.net.

Spirit of Youth (SOY) is an organization dedicated to promoting and recognizing youth engagement across Alaska. Its mission is to recast the public's image of young people as trouble makers to young people as problem solvers. To accomplish this ambitious mission, the organization receives "story leads" from parents, schools, youth advocates, faith leaders, etc. that illustrate the many ways that youth are contributing to their communities. SOY's teen action council reviews all leads and shares the best stories with its local and statewide media partners. In addition, the teen council interviews top nominees, summarizes and presents the most inspiring stories at their annual youth banquet. As a result, hundreds of positive stories make their way onto the radio, TV and local newspapers.

Every year SOY learns about many health-related efforts in which young people have played leadership roles. For example, one of the stories it received and successfully disseminated to a range of media outlets documented the work of a team of young people from a Native village in Alaska that decided they wanted a Girl Scout badge related to their strong interest in traditional foods. The girls conducted research and developed a badge with ten corre-

sponding activities related to in-depth traditional foods found across Alaska for other Girl Scouts to learn about and study. They then developed a series of PSAs to advertise the badge.

Spirit of Youth also provides real-life journalism training through its Alaska Teen Media Institute program (ATMI). Youth develop and practice skills by writing, editing and filing stories in local and statewide media. Nearly every story has made its way into either local radio, newspapers, or the statewide public radio network. Director Shana Sheehy explains the process. "It's up to the students to decide what subject they will research and cover ... teens naturally find ways to address health issues on their own terms. As adults we don't need to push it, we just create a supportive environment for natural inquiry."

Examples of health-related topics that have been addressed by youth include teen marriages (this piece received a statewide Press Club award in competition with adult reporters; teen views on nutrition, body art and piercings; the effect of high caffeine consumption and lack of sleep; coping with a chronic condition; fighting measles in Africa; relieving boredom (safe, places to hang out).

Health promotion takes place within the organization informally, through basic team building and support as well as the following:

- Meetings are held in safe places where parents and youth are comfortable being after dark;
- Healthy snacks are served at meetings;
- Check-ins and ice breakers include sharing your favorite sport, exercise, stretch or way to de-stress;
- When staff sense an individual is having a problem they inquire privately. Sometimes this leads to a specific referral.

For more information, see www.spiritofyouth.org.

voices from the fields **AN INTERVIEW WITH CLAIRE BRINDIS AND KRISTIN TEIPEL**

We talked with Claire Brindis, director of the National Adolescent Health Information Center at the University of California, San Francisco and Kristin Teipel of the Konopka Institute for Best Practices in Adolescent Health, about opportunities for alignment between the youth development and adolescent health fields.

Forum: Why do you think it's important to strengthen connections between the health and youth development fields?

CB: One of the most revolutionary

findings of recent years is the National Longitudinal Study of Adolescent Health data showing that adult/child connections play an important role in supporting young

people and protecting them from engaging in a lot of risky behaviors. The youth development field has had as its core philosophy the idea that positive relationships are critically important in helping to maximize opportunities for positive development and successful navigation through adolescence into adulthood.

Research from the health sector now says these connections also have ripple effects on health outcomes and risk behaviors. That nexus point brings these two fields together like never before.

Another timely, relevant body of research highlights the important role

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voices from the fields

continued from page 3

that social and community context play in influencing individual behavior. This country was built on the Horatio Alger model, focused on individual behavior, and yet it has become clear that unless our strategies address not only the individual, but also family, peers, schools, community organizations, neighborhoods and policies, our ability to change behaviors is very limited.

KT: Collectively, we are addressing the needs of the same young people and we have the same long-term goals. Adolescents are whole beings, with their own complex set of issues. Health is only one piece. The health field in part views youth development as a means to an end in helping young people achieve better health. But we also work to ensure that youth develop in healthy ways so that they are productive, happy human beings. Research has helped health professionals understand that young people who are supported and have meaningful opportunities are more likely to do well in lots of areas of their life, including their health.

Forum: Where do you see synergy between the fields?

CB: I see great opportunities for synergy. Youth workers play integral roles in the lives and contexts of adolescents, and they can play an integral role in reinforcing positive, affirming behaviors that help protect young people from risky behaviors like violence, drugs and early unprotected sexual activity.

KT: The public health perspective, which is one piece of the larger health field, focuses less on individual youth and more on populations

of young people, with a focus on building supportive environments that nurture health and well-being. This perspective resonates with youth development. Programs may be unique, but in terms of the policy and philosophy conversations, there's real synergy.

Forum: Where do you see disconnects?

KT: The obvious disconnect is health's attention to problem prevention. Public health and health care have historically been problem-focused. In the last 20 years or so, a broader focus on health improvement and quality of life has emerged, which is more inclusive of notions of development and well-being. Yet, some health professionals still don't quite know what to do with this shift. They know how to deal with substance abuse or pregnancy, but struggle to define their role in supporting and nurturing the healthy development of youth. And while plenty of people working in health embrace the youth development approach, the systems they are working in still focus on problems.

Another challenge is language. The outcomes we each talk about sound different, but are actually very similar. Because of this, we lose the forest for the trees. Health people are definitely focused on health issues — reducing certain problems or improving certain outcomes as a means to helping youth to achieve optimal health, and we see youth development as a means toward this end. Youth development folks think about outcomes in terms of young people who are thriving, and sometimes feel that any other focus is a constraint.

CB: I agree. Many funding streams,

in both health and youth development, continue to support an individual problem approach, and we have federal and state agencies focusing on specific behaviors such as substance abuse, teenage pregnancy or violence prevention. People in both fields know that if we strengthen certain factors, such as academic success and personal opportunities for all youth, all of these problems would be diminished.

Forum: What can be done to address these challenges?

KT: I think we still need basic discussions about who we are. There are all sorts of other fields that youth development brings in, like youth employment and education. What do we all stand for? What are our holistic goals for and with young people? And how do we put all those pieces together? Where to they mesh, and where there are differences?

CB: A lot of health messages are already being given by the youth development field, but youth workers may not always realize they're giving a health message. Violence prevention is about health. A community clean-up campaign is about health. If you have a program that integrates physical activity, you are contributing to the obesity challenge. What tools do you need from us to expand your capacity — information, speakers, training, joint projects? This should not be about adding responsibilities.

Forum: What kinds of policy change needs to happen related to adolescent health?

CB: We need to assure public and political will around making adolescents and young adults, and their needs, a societal priority, recognizing that they represent our future. I'd like to see much more of a lifespan

focus, so that work that has occurred in the birth-to-five age group connects to a commitment to the full life trajectory.

KT: I'd like to see policies that encourage and require all of the agencies that address youth issues to come together and look at young people holistically. We need to bring together labor, parks and recreation, juvenile justice, education, health, youth development and others to identify what we're each doing, how this contributes to an overall goal of helping young people to succeed and how we can integrate our work. This requires support at a policy level. Youth development is a lens that can help weave this integration together.

Forum: What should youth workers and advocates know about the National Initiative to Improve Adolescent Health by the Year 2010?

CB: This is the first time that both the Centers for Disease Control and Prevention and the Bureau of Maternal and Child Health have partnered with over 20 national organizations to advance a comprehensive adolescent health agenda. By coming together and joining forces with states and local communities, we can focus on priority areas where we can make a huge difference. We've identified areas of focus, we've incorporated a youth development perspective and identified ways we can work at the individual, family, peer, community and policy levels to assure that the contexts in which young people live support their ability to make healthy decisions. The initiative also recognizes that there are significant disparities within the youth population — related to ethnicity, poverty, and gender — and also disparities between adolescents and other age groups that need our prioritization.

key resources WHAT'S HEALTH GOT TO DO WITH IT?

The following are our best picks of general health-related Web resources for youth advocates. Visit our Web site for additional resources organized by specific health topic.

TOPIC	ORGANIZATION	WEB SITE
General adolescent health sites	National Health Information Center, HHS	www.healthfinder.gov
	American Medical Association	www.ama-assn.org/ama/pub/category/1947.html
	National Adolescent Health Information Center	http://nahic.ucsf.edu
	Child Trends	www.childtrends.org
Adolescent health sites for youth	Columbia University Health Services	www.goaskalice.columbia.edu/about.html
	The Nemours Foundation	www.kidshhealth.org/teen
	U.S. Centers for Disease Control and Prevention, HHS	www.bam.gov/flash_elli.html
Adolescent health sites for parents	National Youth Anti-Drug Media Campaign	www.freevibe.com/index.asp
	National Library of Medicine and National Institutes of Health	www.nlm.nih.gov/medlineplus/teenhealth.html
	Substance Abuse and Mental Health Services Administration, HHS	www.mentalhealth.org/15plus/default.asp www.family.samhsa.gov/talk

National Initiative to Improve Adolescent Health by the Year 2010

The National Initiative was created by the Centers for Disease Control and Prevention and the Bureau of Maternal and Child Health, in partnership with more than 20 national organizations to elevate the national focus on the health and well-being of young people ages 10–42. To address the most serious health and safety issues facing this population, the National Initiative encourages strategies that: 1) emphasize multi-level approaches involving the individual/family, school/peers, community, and policy/society; 2) de-emphasize categorical approaches to specific health problems; 3) integrate youth development to enhance health. The Initiative also recognizes that there are significant disparities within the youth population — related to ethnicity, poverty, gender and age, that need prioritization.

To learn more about the National Initiative:

- Improving the Health of Adolescents & Young Adults: A Guide for States and Communities* provides tools and frameworks for planning and implementing health and safety initiatives and programs for young people aged 10–24 years. www.cdc.gov/HealthyYouth/NationalInitiative/order/index.htm
- The 21 Critical Health Objectives for Adolescents* represents the most serious health and safety issues facing adolescents and young adults. http://nahic.ucsf.edu/downloads/21_Crit_Obj_0304.pdf



The National Initiative to Improve Adolescent Health by the Year 2010