

Closing the Gap

A newsletter of the Office of Minority Health, U.S. Department of Health and Human Services



OFFICE OF
MINORITY
HEALTH

Ensuring Healthy Development: A Proposal for Young Americans

By Houkje Ross

“When it comes to adolescent health we need to start emphasizing the positive,” said Gordon Raley, executive director of the National Assembly of Health and Human Services Organizations. “In the past there has been too much emphasis placed on the negative. We tell them they need to stop smoking, stop drinking, and stop dropping out of school,” he said. “Instead, we should be talking about what we need to give them for positive health and well-being,” said Raley.

Younger Americans Act

Raley is part of a coalition of more than 40 youth organizations, including General Colin Powell’s America’s Promise organization, that is supporting the National Collaboration for Youth’s (NCY) proposal for a Younger Americans Act (YAA). In September 2000, Senator James Jeffords (R-VT), Chairman of the Health, Education, Labor and Pensions Committee, introduced the Act to Congress, along with Senator Edward Kennedy (D-MA).

YAA would authorize funds to local communities to ensure that youth have access to five resources for positive youth development that the President’s Summit for America’s Future and other experts say adolescents need for healthy development. These qualities include: ongoing relationships with caring adults; safe places with structured activities during non-school hours; marketable skills and

competencies through education and youth development and opportunities for community service and civic participation. The President’s Summit for America’s Future was held in Philadelphia in 1997 with the goal of increasing civic participation and to help solve the common problems



that communities face. Particular emphasis was placed on the issues and problems facing youth.

Modeled after the Older Americans Act, YAA would provide incentives for communities to plan, implement, and be accountable for strategies that link existing community-based organizations, businesses, and other segments of the community in ensuring that youth have access to the things they need for healthy development.

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Many Health Problems are Preventable

With its emphasis on linking communities, resources, and institutions together, the YAA could be a powerful factor in improving adolescent health. Most teen health issues are social and behavioral in nature—and stronger communities could promote healthy activities while curbing many negative health behaviors teens are now engaging in.

The Centers for Disease Control and Prevention noted that six categories of behavior are responsible for 70 percent of adolescent mortality and morbidity. These are: unintentional and intentional injuries, drug and alcohol abuse, sexually transmitted diseases and unintended pregnancies, diseases associated with tobacco use, illnesses due to inadequate physical activity, and health problems due to inadequate dietary patterns.

Minority adolescents, many of whom live in or near poverty, are at a further disadvantage for good health when compared to their white counterparts due to a variety of factors. “We know that poor environments, where parents don’t have access to medical care, good preschools, and neighbors that can monitor a child’s behavior, can negatively impact a child’s health and well-being,” said Jacqueline Eccles, PhD, from the Institute for Social Research at the University of Michigan. According to the Society of Adolescent Medicine, a lack of health care early on can have life-long effects because part of being a teen means forming attitudes and behaviors.

Many low-income minority children and adolescents face a disproportionate array of problems. For example, American Indian/Alaska Native adolescents continue to struggle with high rates of substance abuse, according to the National Institutes of Health. Homicide rates for African American teenagers ages 10 to 14 are three to four times greater than for whites. Older Hispanic and African American teens have much higher rates of HIV/AIDS compared to other groups.

Following the Lead

The YAA program could be a healthy push in the right direction. But getting local communities to work with federal and state governments, schools and health clinics, and other institutions may take a while. The idea has been around for a number of years.

“There are lots of programs—ranging from prevention programs, YMCAs, or Boys and Girls Clubs—that have a positive influence on the health and well-being of teens,” said Dr. Eccles. For example, a program for AI/AN youth that is run through the Anchorage Boys and Girls club is helping to curb adolescent substance abuse by teaching the life skills and strategies to stay healthy. Other programs, like the Across Ages program in Philadelphia, involve Hispanic, Asian, and African American youth in community service and elder mentoring activities. The program aims to improve social competence.

“To provide some continuity in a youth’s life, these programs need to coordinate and work together,” said Dr. Eccles. For example, if a community program is teaching youth about science or health, it should be coordinating with the local school system. “But our communities and our institutions are not designed to work that way,” said Dr. Eccles. We don’t yet know how to effectively design and plan schools and other programs that can work together,” she added.

Researchers are just beginning understand and explore adolescent behavior—especially risk related behaviors—in terms of communities, not just families. “Although we don’t yet know the specifics, certain factors can play a role in ensuring a positive development of teens,” said Reed Larson, PhD, a human development professor at the University of Illinois. Like Gordon Raley, Dr. Larson also addresses the need to emphasize the positive when it comes to youth. “Programs that try to fix problems are less effective than those that address the entire youth and stress involvement, positive motivation, and goal setting,” noted Dr. Larson.

In January of 2001, the National Academy of Science’s (NAS) Committee on Community-Level Programs for Youth will introduce a report that will discuss what is known about adolescent well being, factors/influences (including individual, familial, and neighborhood) that promote adolescent well-being, and how community-level programs can support adolescent health, development, and well-being.

For more information about the upcoming NAS report, contact Michele Kipke at: mkipke@nas.edu. For more information on the progress of the Younger Americans Act, contact Gordon Raley, National Collaboration for Youth, (202) 347-2080. ❖

Teens Having Sex: Teaching About Risks and Consequences

Editorial by Nathan Stinson, Jr., PhD, MD, MPH

Deputy Assistant Secretary for Minority Health, U.S. Department of Health and Human Services

One of the biggest threats to young people today is their sexuality. Sexually transmitted diseases, teen pregnancy, HIV and AIDS, and economic disability are only some of the risks associated with sexual activity among teenagers. For young people to become adults, they need to be capable of weighing choices and making good decisions. Teaching boys to become men and girls to become women means teaching them that everything they do has consequences.

However, too many young people think they are invincible. We know this because we were once young. Teenagers think consequences are for someone else. They often fail to realize that some consequences are permanent. Teens need to know and understand that failure to negotiate the risks of premature sex exposes them to consequences that last forever. Just ask them to consider this:

- Having sex puts people at risk of contracting herpes simplex virus, a sexually transmitted disease (STD) for which there is no cure. The rate of herpes infection is highest among teenagers. The herpes virus is extremely contagious, which means it is easy to catch and easy to spread to someone else. Intimate contact with someone who has herpes can cause pain, discomfort, inconvenience, and shame for a lifetime.
- There is also teen pregnancy. Avoiding pregnancy is not only the girl's responsibility; it is also the boy's. All it takes is one sexual encounter, and dreams of having a normal teen life—like taking part in extra curricular activities, going out with friends, even attending the senior prom—can all be shattered. Instead, a young person may have to work at some menial task to earn money for pampers and formula. Chances of going to college can even be compromised; their future is put in jeopardy.
- Perhaps the biggest risk in having sex is HIV/AIDS—the number one killer of young African American men ages 25–44. Many of these adults were infected as teenagers. Having sex with someone who is infected HIV but who does not look, act, or feel sick puts one at great risk of catching this deadly disease that has no cure.



When teaching our teens to manage risks and understand consequences, it is important to conduct those instructions in an environment that empowers. Although our society focuses much attention on sexual activity, minority communities can and should focus their attention on healthful behavior.

In many minority communities, girls are taught from an early age to value their virginity. At the same time, our boys are taught that the loss of their virginity is a sign of manhood. There is something wrong with this picture. If waiting until marriage is the best and only way to go for girls, then boys too might benefit from waiting.

Encouraging boys to be sexually active while teaching girls to wait, sends conflicting messages that can lead to unintended and permanent consequences. If boys, as well as girls, waited until marriage to become sexually active, we would likely see reductions in teen pregnancy, STD's, and HIV/AIDS in minority communities.

Abstinence is not a popular point of view today. In fact, many experienced and well-meaning adults question abstinence as a realistic point of view.

However, in this environment of permanent and deadly sexually transmitted diseases, it is time for a radical change in our approach to sexuality. Abstinence should be promoted as an acceptable choice.

Informing our sons and daughters of the consequences of having sex can help them make the right choices. In addition, we must keep young people busy and help them to develop the strength to conquer peer pressure, resist temptation, and pave their own paths. We must engage ourselves in our teenagers' lives and preoccupy them with after school and weekend activities. And, we must know who their friends are, where they hang out, and what they are doing when they are not in our presence.

Finally, with young people being young people, they need to know—and be reminded frequently—that life is more than the moment. Talk to young people. Teach them how to be responsible adults. Be to them what you want them to be to society. ❖

Many Teens, Families Unaware They Qualify for Insurance

By Houkje Ross

Teenagers and young adults are the least likely of any age group to have health insurance coverage, according to U.S. Census Bureau statistics. Approximately 14 percent of adolescents ages 10 to 18—4.2 million teens—are not covered by any form of health insurance. That's about 1 in 7 uninsured adolescents. For low-income and minority adolescents, the proportion is even higher.

In 1997, President Clinton signed into law the State Children's Health Insurance Program (SCHIP), which provides health insurance to uninsured children of low-wage working parents. All states now have an SCHIP plan in place and are working to expand the program to reach more children and teens. Health and Human Services Secretary Donna E. Shalala recently approved a proposal by Hawaii to further expand its program and provide health insurance through the Hawaii SCHIP program to thousands of additional children. State officials expect this expansion of their SCHIP program to cover nearly 5,300 children by September 2001. But recent reports indicate that many parents still are not aware of the program and states have been working hard to promote the program.

"Most of the promotion for SCHIP is for younger children. Here in California I see a lot of advertisements for SCHIP that have pictures of small children, not teens" said Claire Brindis, DrPH, executive director of the National Adolescent Health Information Center. As a result, many families may not know their teen qualifies for insurance under the program.

Dr. Brindis, along with the Association of Maternal and Child Health Programs, co-authored the 1999 report, *Adolescents and the State Children's Health Insurance Program: Healthy Options for Meeting the Needs of Adolescents*. The study highlighted programs that are working to increase teen awareness of SCHIP. Outreach efforts in Alabama show that using adolescents to increase awareness to their uninsured peers can be a great way to get more teens insured.

Alabama Targets Adolescents for SCHIP

In 1998 local pediatrician Dr. Marsha Raulerson worked with seven local teens to conduct outreach to other teens in Escambia County, Alabama. In six months, Raulerson and her group were able to decrease the uninsured rate of those using the emergency room at the local hospital from 25 percent to 11 percent. "It was really their project," said Dr. Raulerson. "They decided what kind of outreach they wanted; we just acted as mentors," she added. Dr. Raulerson, an administrative assistant, and three medical students met with the teens to make sure they did things ethically.

"They were given a list of all the teens who had been to the emergency room in the last six months that were uninsured," said Dr. Raulerson. The teens mailed information about Alabama's SCHIP program, ALL Kids, to everyone on the list. Other activities included: wearing tee shirts with information about ALL Kids to school; hold-

ing meetings with local counselors, encouraging them to spread the word about ALL Kids to other adolescents; and setting up a table at a local high school that was conducting sports physical exams.

The program not only increased the number of adolescent enrollees in ALL Kids, but also enticed several teens into health care careers. "One of the students who was involved in the project is now a third year pre-med student at Alabama State University. Another student is in a physical therapy program at Alabama A&M," said Dr. Raulerson. Both students are African American.

This is important, because as the minority population increases the health care industry needs to ensure an ethnically diverse health care workforce. "So far, we have done a dismal job in ensuring this," says Dr. Brindis. "Role-modeling opportunities like this can have a positive impact," she said.

*For more information on adolescents and health care or to obtain a copy of *Adolescents and the State Children's Health Insurance Program (CHIP): Healthy Options for Meeting the Needs of Adolescents*, contact Dr. Claire Brindis, National Adolescent Health Information Center (NAHIC) at (415) 502-4856. The CHIP report is also available through NAHIC's website at <http://youth.ucsf.edu/nahic>.*

Opportunities for Minorities in Health Care

- **National Institutes of Health (NIH)** sponsors several programs to expand the participation of underrepresented minorities in all aspects of biomedical and behavioral research. The programs focus on pre-college, undergraduate, and pre-doctoral training. For more information, contact NIH's Office of Research on Minority Health, (301) 402-1366 or visit its web site at <http://www.1.od.nih.gov/ormh/main.html>.
- **Minority Health Professions Foundation** works to facilitate an increase in the representation and recognition of blacks and other underrepresented minorities in the health professions of medicine, dentistry, pharmacy, and veterinary medicine. For more information, call the Minority Health Professions Foundation, (404) 634-1993.
- **CDC Public Health Fellowship Program.** The Public Health Summer Fellowship Program is a collaboration between CDC, Emory University's School of Public Health, and Morehouse School of Medicine. The program is directed toward rising junior and senior undergraduate students of African American, Hispanic, and Native American descent to encourage and prepare these students to pursue graduate degrees and careers in public health. For more information call (404) 639-3316.

Overcoming Common Barriers to Treating Adolescents

By Houkje Ross

“Too often, when a teen obtains health services, it’s like two ships passing in the night,” Claire Brindis, DrPH, said of the exchange between physician and patient. Dr. Brindis is a pediatrics professor and executive director of the National Adolescent Health Information Center at the University of California at San Francisco.

“When it comes to treating adolescents, physicians, nurses, and other health care workers need to take a comprehensive approach,” said Dr. Brindis. “This means assessing psycho-social as well as physiological factors, like mental health, family structure, and socioeconomic status.”

Adolescents and young adults are the least likely of any age group to be insured, according to statistics. But even teens with insurance aren’t receiving the services they need to ensure a smoother transition into adulthood, said Dr. Brindis. Because most of the health risks for teens are more social in nature, rather than medical, unhealthy behaviors can be prevented or reduced if recognized and caught early on, according to many professional associations, including the American Academy of Family Physicians.

Guidelines for Services

Guidelines for Adolescent Preventative Services (GAPS) provide physicians with recommendations to help prevent unhealthy behaviors in teens. Supported by the Centers for Disease Control and Prevention and the American Medical Association, GAPS are designed to help busy physicians identify at-risk adolescent patients and provide them with information about preventing and changing unhealthy behaviors.

“Many doctors and other medical staff are missing opportunities for prevention,” said Dr. Brindis. GAPS can help health care workers learn what types of questions to ask regarding social and emotional development, physical development and health habits, sexual development, and family and school concerns of adolescents. Examples of GAPS

questions include: *Has anyone talked to you about what to expect as your body develops? How do you feel about the way you look? Have you started dating? What do you do with your friends?* “When a student comes in for a sports exam, this is an opportunity to learn what else is going on in the student’s life and to intervene early,” said Dr. Brindis.

Trust and Confidentiality

Getting teens to talk at the doctor’s office can be difficult if teens don’t feel safe. Health care providers need to consider trust and confidentiality when working with teens.

“When it comes to treating adolescents, physicians, nurses, and other health care workers need to take a comprehensive approach.”

An increased desire for privacy and autonomy is a normal part of adolescent development and teens may be unwilling to seek health care without confidentiality protection, according to Abigail English, executive director of the Center for Adolescent Health and the Law in Chapel Hill, North Carolina.

“A provider should set up a policy within his or her practice to address confidentiality,” said Dr. Brindis. “This can prevent things like sending lab results for a pregnancy test home to parents,” she said. The Society for Adolescent Medicine advises health professionals to encourage adolescents to involve their families in health decisions whenever possible. However, when such involvement is not in the best interest of the adolescent or when parental involvement may prevent the adolescent from seeking care, confidentiality must be assured.

“There are a range of legal protections at the state and federal level to ensure that minors who are unable to involve their parents have access to essential health care. Health care providers need to understand these protections and explain them clearly to adolescent patients. When parents are involved, physicians should explain the importance of confidentiality to them as well,” said English.

Other factors physicians and health care workers need to consider when treating adolescents, from the 1999 report *Adolescents and the State Children’s Health Insurance Program: Healthy Options for Meeting the Needs of Adolescents*:

- **Expand Service Hours.** Most teens have to rely on parents or family, public transportation, or walking to reach health care services. When different services are in two locations, teens may be deterred by the inconvenience, according to a recent study. Clinics should consider location and hours of service to meet the needs of teens. Long waiting times for teens, who don’t perceive a problem as urgent, may also deter them from treatment.
- **Provide community referrals.** Making teens aware of their options can maximize health outcomes. “They need more than one gateway for health services,” said Dr. Brindis. Consider referring teens to school-based or school-linked health care centers, community-based organizations, health department clinics, Planned Parenthood, hospitals, and other neighborhood resources.
- **Be Sensitive.** Adolescents are sensitive to the attitudes of the individuals to whom they turn to for advice and care. Providers need to consider teen feelings of insecurity, conflict about dependency, and the age difference between provider and teen.

For more information on confidentiality laws, e-mail: info@adolescenthealthlaw.org, or call (919) 968-8850. GAPS are available from the Adolescent Health Department of the American Medical Association at <http://www.ama-assn.org/adolhlth/adolhlth.htm>. Contact the National Adolescent Health Information Center at <http://youth.ucsf.edu>. ❖

What You Need to Know About Today's Teenage Girls

By Kendra Lee

So what's it like to be a teenage girl these days? It's not much different than a half generation ago. "Boys, parents not understanding them, race issues, sex, drugs, alcohol, pregnancy, sexually transmitted diseases, boys—in that order," said Stacie Wright, a sociologist in Roanoke, VA. There is, however, one notable exception: "They just start so much earlier," Wright said. "Issues we dealt with as older teens, 17 and 18, they're dealing with at 11, 12, and 13."

Recent studies bear this out. One survey, by the Kaiser Family Foundation and *YM* magazine for teens, found that teen girls as young as 13 struggle with complex sexual situations involving pressure, drinking and drug use, or with relationships that are moving too fast for them to handle. Teens in the study also reported worrying a lot about HIV/AIDS and other sexually transmitted diseases, as well as unwanted pregnancy.

A large-scale study—*The Girls Report: What We Need to Know About Growing Up Female*—by the National Council for Research on Women (NCRW), found that although adolescent girls are doing better in school and having fewer babies than several years ago, they are smoking more, suffer depression twice as frequently as boys, and often are the victims of rape and other forms of violence.

"Despite some progress, in many areas girls remain victimized, harassed, and diminished and face very real risks that threaten their healthy development," wrote NCRW Executive Director Linda Basch in the report's introduction. The report concluded that a growing number of programs directed at girls' needs and an increased effort by girls themselves to overcome challenges notwithstanding, recent research reveals little or no progress on many indicators, and even a turn for the worse in some areas:

- Smoking among teenage girls is on the rise. In 1991, one in eight girls in eighth grade reported smoking (13 percent); by 1996 the number had jumped to more than one in five (21 percent).

- Girls ages 12–18 are now as likely as boys to drink alcohol and use illegal drugs.
- Girls are twice as likely as boys to experience depression during adolescence, and are more likely to consider and attempt suicide.
- A disproportionate percentage of reported rape victims are adolescent girls. In 1992, 62 percent of all reported forcible rape cases involved victims who were younger than 17.
- Girls frequently are denied access to reproductive information, products and services.
- Recent changes in welfare laws threaten the well-being of teen mothers and their children, children living in single-parent households, and children from immigrant families.
- Participation in sports is linked with numerous health and social benefits. Yet despite Title IX and the increasing popularity of women's collegiate and professional sports, the percentage of high school sophomore girls who participated on athletic teams continues to fall.
- High school girls who say they have experienced sexual or physical abuse are more likely to smoke, drink and use illegal drugs.
- Teen mothers under age 20 comprised seven percent of all adult female recipients of Aid to Families with Dependent Children in 1995.

In addition, peer pressure—especially among the younger set of adolescents—is strong. "There's a lot of pressure to do drugs. There's pressure about that all the time," said Meredith Howard, an 11 year-old African American.

Signs of the results of that pressure show up in the latest results from the Monitoring the Future study, conducted at the University of Michigan Institute for Social Research. The most recent study showed that drug use among American adolescents held steady in 1999. "We are down some from the recent peak levels in overall illicit drug use by American teenagers, which were reached in 1996 and 1997," said Lloyd D. Johnston, one of the study's researchers. "I am hopeful that

this is just a pause in a longer-term decline. In fact, we saw such a pause in the '80s, in the middle of what turned out to be a continuing decline in drug use." The one exception to the illegal drug standstill is ecstasy; use of that by teens increased in 1999.

Girl Power! Campaign

In 1998, HHS Secretary Donna Shalala launched *Girl Power!*, a national public education campaign to help encourage and empower 9 to 14 year-old girls to make the most of their lives. "Too many girls are taking dangerous chances with the only lives they will ever have," Shalala said during the program's kickoff. "We

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hope to reach girls at this key transitional age when they are forming their values and attitudes. Our job as caring adults is to help girls build confidence and pursue opportunity.”

Phase one of the project focused on preventing alcohol, tobacco and illicit drug use among girls. Subsequent phases have addressed premature sexual activity, physical activity, nutrition and mental health. Three aspects of this public education campaign set it apart from other government efforts:

- It recognizes that while some health messages work equally well for boys and girls, girls require health messages targeted to their unique needs, interests and challenges.
- It takes a comprehensive approach, addressing not only a range of health issues but

also the erosion of self confidence, motivation and opportunity that is all too typical for many girls during the transitional period of 9-14 years of age.

- It is based on research indicating that girls at the age of 8 or 9 typically have very strong attitudes about their health. The Partnership for a Drug-Free America's 1995 Partnership Attitude Tracking Study found the majority of girls and boys in grades 4-6 believe that “using drugs is dangerous.”

Girl Power! also enlists the aid of parents, schools, communities, religious organizations, health providers and others to give girls the support and encouragement they need. “We are challenging caring adults to reach out to young girls in their lives,” Shalala said. “De-

spite the aura of independence they project so well, adolescent girls look to their parents and other adults for everyday love, attention, involvement and discipline.”

The Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention developed *The Girl Power! Community Education Kit* designed to help coaches, teachers, business leaders and others help girls make the most of their lives.

The kit can be previewed and downloaded from the Girl Power! Web site at <http://www.health.org/gpower>. The kit can also be ordered by calling SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) at (800) 729-6686. ❖

Teen Pregnancy Rates

Despite a decline in teen pregnancy and abortion rates during the 1990s, unwanted pregnancy and abortion still pose a major problem for adolescent females, according to CDC's National Center for Health Statistics, 1999.

- More than 800,000 teens become pregnant each year.
- Four in 10 young women become pregnant at least once before age 20.
- From 1995 to 1997, among females aged 15--19 years, the national pregnancy rate declined by 7.8 percent.
- The largest decline in teen births since 1991 has been in black teens age 15-19. The rate dropped 38 percent.
- From 1994-1998, Hispanic teen birth rates fell 13 percent, but this group still has the highest teen birth rates.
- Adolescent pregnancy rates were higher for blacks than for whites in every state except one.
- An estimated 65-86 percent of teen pregnancies are unintended and nearly two-thirds of children born to teenage girls are fathered by men at least four years older than their teen mothers.
- 70 percent of African-American teenagers reported that lack of communication between a girl and her parents is often a reason teenage girls have babies.
- From 1995 to 1997, the abortion rate for adolescents aged 15 to 19 fell by 7.5 percent nationally.
- Still, the U.S. has the highest teen pregnancy rate among developed countries.

Teen Sexuality

According to CDC's 1998 Youth Risk Behavior Surveillance System Summary:

- In 1995, of girls age 15-19, 53 percent of Hispanic girls, 49 percent of non-Hispanic white girls, and 67 percent of African American girls had sexual intercourse.
- Most sexually experienced teens are also sexually active, having had sex in the last 12 months. The majority of sexually experienced teens have had one or two partners, but many have had three or more.
- The primary reason teenage girls who have never had intercourse give for abstaining from sex is that having sex would be against their religious or moral values.
- Three of four girls report that girls who have sex do so because their boyfriends want them to.
- At age 16, 22 percent of girls from intact families and 44 percent of other girls have had sex at least once.
- One of every 3 girls has had sex by age 16, 2 out of 3 by age 18.
- More than six percent (6.5 percent) of ninth-grade girls first had sexual intercourse before age 13.

Sexuality Transmitted Diseases

Although STDs affect people of all ages, the epidemic disproportionately impacts young people:

- Roughly four million teens get an STD every year.
- Experts estimate that as many as one in three sexually-experienced young people will have an STD by age 24.

- American teens 15-17 underestimate the incidence of non-HIV STDs in the U.S. AIDS tops the list when teens are asked to name sexually transmitted diseases. Even the more commonplace non-HIV STDs, like gonorrhea and herpes, trail behind AIDS in mentions.
- A quarter of new STD cases in the U.S. occur among 15-19 year olds.
- Few 15 to 17 year olds say they worry about getting an STD.
- Many teens assume because they have no symptoms or that their health care provider has never mentioned a problem or that they do not know about any of their partners having been infected they do not need to be concerned.
- Teens underestimate the national incidence of STDs, and many are misinformed or uninformed about treatment options and health consequences.
- Most teens know STDs can be spread despite the absence of symptoms and that some STDs may be symptom-free for an extended period. Many, however, are unaware about other transmission facts and most know little about the prognosis of specific non-HIV STDs.
- Teenage girls are more likely than teenage boys to have been tested for both HIV and other STDs.
- Many teens think only of AIDS when they talk about STDs. ❖

—Kendra Lee

Fitness Program Helps Keep Teens Out of Trouble

By Houkje Ross

Teens need physical fitness for more than just a healthy heart. Exercise can keep teens out of trouble, off drugs and alcohol, and away from other harmful activities, according to Thomas Collingwood, PhD. Dr. Collingwood is a nationally known sport physiologist and psychologist who developed a fitness program for teens called First Choice.

Dr. Collingwood developed First Choice 10 years ago with a small grant that aimed to decrease the use of drugs among teens. He was then working as the director of education for the Cooper Institute for Aerobics in Dallas, Texas.

Developed specifically for at-risk youth, the First Choice curriculum teaches health as a life skill and aims to prevent substance abuse, delinquency, violence, school drop-outs, and mental health problems. Kids have formal gym time where they learn to assess themselves physically and plan and develop goals, says Dr. Collingwood.

The program also uses formal instruction with a workbook entitled *Taking Charge* that reinforces what the kids learn on the gym floor. The skills they learn can be applied to other areas of their lives, like dealing with stress, substance abuse, nutrition, or violence, said Dr. Collingwood. Additional skills kids learn include self-discipline, responsibility, and respect.

Versatility and Leadership are Key

Dr. Collingwood designed the program so that it could be used in a variety of institutions like community service or recreation agencies, community-based organizations, schools, rehabilitation settings, and substance abuse and mental health agencies. The program is individually tailored to fit within a specific organization and the existing community is trained on how to implement the program to its teens.

"This is a leadership-driven program and can't be done without the people who are out on the gym floor working with the kids," said Dr. Collingwood, who provides a standard 40-hour training to those who will deliver the program. There are basic requirements of an institution. It must dedicate staff to the program, staff must come to the training, agree to run the program for one year, and collect data.

About 80 percent of those institutions he trains are successful in implementing the program, said Dr. Collingwood. Often, other priorities or trouble with funding get in the way. He estimates that about 120 to 150 people have been trained at about 80 different sites and approximately sixty percent of the 10,000 teens who have gone through the program are minorities.

The program has had dramatic effects on the teens that have gone through the program. Data collected by First Choice shows dramatic changes in teen health behaviors:

- 60 percent decrease in multiple drug use;
- 60 percent decrease in alcohol use;
- 38 percent decrease in anxiety and depression;
- 60 percent decrease in marijuana use;
- 30 percent decrease in cigarette use;
- 40 percent increase in drug and alcohol abstinence;
- 23 percent increase in school attendance;
- 20-27 percent increase in levels of physical fitness; and
- 10 percent increase in grade averages.



Teens Need Structure

"I think it's really the structure of the program that separates it from other programs. The kids really crave it because they're not getting it anywhere else. Many of the kids come from one-parent households with a mom who may be working two or three jobs. Typically these kids would be home alone watching TV. We've never had a problem getting the kids involved," said Capt. Bob Cockrell, from the Illinois National Guard. The Illinois National Guard provides technical assistance to the community-based organizations that have been trained to use First Choice. There is a one year waiting list for the program in our area, according to Cockrell. Another reason the program is so popular is because it isn't perceived as "wimpy," said Cockrell. "That makes it okay with the kids' peers."

"Most people would disagree with me on this, but I don't think we have a substance abuse problem in our country. We are just not developing strong kids that can make good choices. The program gives kids the skills they need to set goals and make choices," said Dr. Collingwood. "When they begin to see improvements on the physical level, their self-esteem goes up and they realize that they can succeed. And once you get them into a positive, active lifestyle, negative behaviors like smoking or drinking don't seem to fit anymore."

For more information on First Choice, contact Fitness Interventions Technologies, Dr. Thomas Collingwood, (972) 231-8866. ❖

OMHRC Seeks Applicants for Resource Persons Network

By Houkje Ross

It's not news that many community-based organizations are strapped for resources. That's why the Resource Persons Network (RPN) is such an important part of the Office of Minority Health Resource Center's (OMHRC) mission. The RPN's slogan is *Connecting with Communities*. "The Network is a great way we at the federal level can connect those working at the community level to the expertise and resources they need," said Lisa E. Williams, RPN coordinator.

Under the leadership of Williams, the Network has undergone some changes that have improved the current process of matching minority health experts with organizations. Ms. Williams has updated the database, which lists current members, their locations across the country, and their focus of expertise. "We now have almost 200 mem-

bers in the Network. Our goal is to reach approximately 500 members by the end of fiscal year 2001," said Williams. Ms. Williams has also set up an electronic listserv for RPN members, to encourage networking with colleagues.

What is a Resource Person?

Duties of RPN members vary, depending on an organization's needs. Typically a member will be asked to review grant proposals, speak at conferences and workshops; serve on committees and workgroups; serve as a subject expert for the media; provide advice on developing, implementing, and evaluating health programs; or offer guidance on preparing papers and speeches.

OMHRC is looking for volunteers with

expertise in all areas of minority health, including HIV/AIDS. Candidates must have a strong commitment to improving racial and ethnic minority health status, and proven experience with issues related to at least one of OMHRC's target populations: African Americans, Hispanics/Latinos, American Indians/Alaska Natives; Asian Americans; and Native Hawaiians and other Pacific Islanders.

"Our RPN members volunteer out of a desire to make a difference in minority health," Williams said. OMHRC values members and supports them with additional benefits, including an RPN newsletter called *Minority Health Update*. This quarterly newsletter supports work in minority health by providing information on grants and awards, announcements for upcoming conferences, and new publications. "The newsletter is a great resource for our members who need quick and easy information," said Williams.

The newsletter also gives information to members on the best ways to carry out volunteer activities on behalf of OMHRC. In the latest issue, for example, members are given advice on how to deal with media calls. "This is extremely important because when someone from the press calls they usually need information fast," said Williams. "Our article helps RPN members know how to be prepared for these situations."

OMHRC is a nationwide service of the Office of Minority Health, U.S. Department of Health and Human Services. To request an RPN application, call 1-800-444-6472. ❖

Minority Health and Fitness

Diseases directly related to a lack of exercise, such as obesity and diabetes, are more prevalent in many minority teens. Type II diabetes is reaching epidemic proportions among American Indians and Alaska Natives (AI/ANs), according to the National Institutes of Health. Diet and physical activity play a significant role in reducing the risk of developing the disease, but many AI/AN populations are eating high fat diets and not getting enough exercise.

Other minority groups, like African American teenage girls have higher rates of obesity than white teenage girls do. A recent study conducted at the University of North Carolina (UNC) at Chapel Hill found that minority teens, including African Americans, Hispanics, and Asian Americans, are less active than whites and face greater health risks from being overweight.

A May 2000 UNC study notes that adolescents living in high crime and poverty areas, or those without neighborhood

support systems like community recreation centers, are more likely to be inactive. "Many of these youth have lost their sense of hope and they feel separated from mainstream society," said John Studach, of the National Center for Health and Fitness at American University in Washington, DC. "They often ask themselves 'Why should I invest in becoming more healthy when I don't think I'm going to live past high school,'" said Studach.

Studach also said that if kids don't see the hope, health care workers should, because programs that work to increase physical activity among teens also can help curb substance abuse and other problems like smoking or quitting school.

For more information on the North Carolina studies, contact: David Williamson, UNC Chapel Hill, (919) 962-8596. For information on the National Center for Health and Fitness at American University, contact John Studach, (202) 885-6275. ❖

Did You Know?

According to the National Center for Health Statistics, in 1999:

- 14 percent of the total U.S. population—40 million residents—were adolescents between the ages of 10 and 19.
- One-third of the adolescent population represents racial and ethnic groups.
- By 2050 Hispanic, African American, American Indian, and Asian American adolescents will constitute 56 percent of the total adolescent population. ❖

Teen Violence: Schools are not Immune

By Kendra Lee

For the past 5 or 6 years, it's been hard to turn on the television without seeing a teenager at school with a gun, shooting fellow classmates or teachers, or holding someone hostage. During the past decade there have been stabbings, shootings, brutal rapes, gang-related incidents—not in a back alley in the inner city (though these crimes are happening there, too)—but in the place parents once thought was safe: an educational institution.

How Safe are Schools?

Despite recent Justice Department figures showing school was a safer place than the street or the home, youth violence is still occurring. And it's happening in a big way in our schools nationwide. The Justice Department figures show that incidences of violence in the schools is half as great as these incidences away from schools.

According to a 1997 Youth Risk Behavior Survey done by the Centers for Disease Control and Prevention, the Department of Education, Department of Justice, and the National School Safety Center, the facts bear this out:

- 65 percent of school-associated violent deaths involved students;
- 28 percent of fatal injuries occurred inside the school building;
- 18.3 percent of high school students carried a gun, knife or club to school during the 30 days preceding the survey;
- 7.4 percent were threatened during the previous 12 months;
- 4 percent felt unsafe either at school or on while traveling to school and missed one or more days because of fear; and
- 32.9 percent had property stolen or destroyed on school grounds.

A separate CDC study on youth violence found that the majority of violent incidents were homicides and involved firearms. That same study found that though the number of violent school-associated incidents had decreased since 1993, the number of inci-

dents involving multiple victims has increased. The National School Safety Center reports that students in higher grades are more likely to be victims of violent death than are younger students. The Center also found that black students are more likely to be victims than their counterparts from other racial-ethnic groups. School-associated violent death is also nine times more likely to happen in urban schools—the recent mass shootings in rural and suburban areas such as Paducah, Kentucky, and Columbine notwithstanding.

The idea behind the project is to catch the students early...and train them to create a “culture of peace” within the school environment.

Clearly, the youth crime statistics could go on and on. The question is why this violence is happening in the first place. The Office of Juvenile Justice and Delinquency Prevention has assessed the risk factors for youth violence. They include:

- Poor interactions between mother and child at 1 year-old;
- An emotionally distressed parent;
- Marital conflict and lack of communication between parents;
- Criminal or violent behavior of a parent;
- Alcohol or other drug abuse by a parent;
- Child abuse or neglect;
- Harsh or inconsistent discipline;
- Lack of parental supervision;
- Living in violent neighborhoods;
- Rough or antisocial peers;
- Learning problems;
- A history of absenteeism from school; and
- A lack of social problem-solving skills.

Creating “Cultures of Peace”

But there are organizations doing something about the problem. Fourteen youth violence prevention evaluation projects are underway in 11 cities nationwide, under the

sponsorship of the CDC's National Center for Injury Prevention and Control. The goal of these projects is to determine which interventions are effective in preventing and reducing aggressive and violent behavior. The majority of the projects emphasize primary prevention and are cooperative efforts between schools, health departments and community partners. Four of the projects (Tucson; Chicago; Richmond, Virginia; Portland, Oregon) will be extended three years to assess whether initial intervention effects continue after the program has ended.

The idea behind the projects is to catch the students early—some programs begin with students as young as 5 years of age—and train them to create a “culture of peace” within the school environment. The projects teach students to understand other cultures as well as their own and to develop an appreciation for their communities and families. Other cities' projects, for example, Chicago and Aurora, Illinois' Cognitive/Ecological Approach to Preventing Violence, are aimed specifically at African-American and Hispanic youth (ages 7-13) who are at high risk for violence. These at-risk youth are taught to recognize and better manage aggression.

Are these programs—and others like them—working? Only time will tell, since most of them are ongoing. Fernando Soriano, Ph.D., principal investigator of the Santa Cruz, California, Cultures and Communities program, says so far, the results are promising. “The responses from young participants are favorable, with youth indicating a positive experience. Many of the participants want to continue with the program after its 16-week term. And teachers appear to observe positive changes among participants,” he said.

For more on youth violence and risk factors, you can download CDC's booklet, Best Practices in Youth Violence Prevention, at <http://www.cdc.gov/ncipc/dvp/bestpractices.htm> or call CDC at (770) 488-4362. ❖

Asthma: HHS, Federal Agencies Focus on Awareness

By Kendra Lee

Black children are significantly more likely than whites to suffer from childhood asthma, a chronic lung disease characterized by temporary obstruction of airflow that causes breathing difficulty, coughing and inflammation of the airways. A 1998 CDC survey found that black children were 31 percent more likely than white children to have had an episode of asthma or an asthma attack during the previous year. "In 1998, 68 out of 1,000 black children had asthma versus only 52 out of 1,000 white children," says Lara Akinbami of the CDC's National Center for Health Statistics. "And black children are much more likely to be hospitalized or die from asthma."

The racial disparity has grown steadily since 1980 when black children had only a 15 percent higher asthma rate than whites. Several studies have also shown an increase in asthma among Hispanic children, as well as in asthma-related conditions in Asian/Pacific Islander and American Indian/Alaska Native children.

Big City Living to Blame?

While the CDC survey did not identify the reasons for the racial gap, previous studies have shown the illness disproportionately affects minorities and people living in poverty. A new study out of Rochester General Hospital in Rochester, New York, places the

blame on big city living. The study, which was published in the September issue of the *American Journal of Respiratory and Critical Care Medicine*, found that black children who did not live in big cities were at no greater risk of asthma than white children. "These results suggest that the higher prevalence of asthma among black children is not due to race or to low income per se," said Dr. C. Andrew Aligne, chief researcher of the study, "and that all children living in an urban setting are at increased risk of asthma."

Whatever the reasons for the increasing numbers of asthma cases in minority youth, several federal agencies are trying to make it easier for sufferers to breathe. The Environmental Protection Agency (EPA) supports education and outreach programs in schools and communities related to environmental aspects of asthma through such programs as Childhood Champions and Tools for Schools. The EPA, together with the Department of Education, this year expanded school-based programs teaching parents and children how to identify and avoid allergens that trigger asthma attacks.

Several HHS agencies, including the CDC, the Administration for Children and Families, and the Office of Minority Health, have programs designed reduce the disproportionate impact of asthma on minorities. The National Institute of Allergies and Infectious Diseases (NIAID) sponsored the

National Cooperative Inner-City Asthma Study, which found that empowering families to increase their asthma self-management skills was an important way to improve quality of care and reduce asthma symptoms. Both NHLBI and the National Institute of Nursing Research (NINR) sponsor research on the effectiveness of asthma education and self-management programs, targeting African Americans and Mexican Americans in urban and rural areas.

Surgeon General Dr. David Satcher and the Asthma & Allergy Foundation of America have teamed up, using rapper Coolio (who suffers from asthma) as a spokesperson to bring greater awareness about asthma management to minority communities. Dr. Satcher said research indicates far too many minority, inner-city families are exposed to asthma risk factors, such as high levels of indoor allergens and pollutants, including those borne by cockroaches, tobacco smoke, dust mites and nitrogen dioxide.

"We have to improve awareness within these communities about eliminating the risk factors," Dr. Satcher says. "At the same time, health care institutions must find ways to offer more accessible and appropriate asthma treatment to minority communities."

For more information on asthma, contact AAFA at (800) 727-8462. To subscribe to AAFA's teen newsletter, Healthlines SAY contact: Elizabeth Hunter at elizabeth@aafa.org or call (202) 466-7643, ext 230.

A Research Program Open to Investigators from All Fields

The Sandler Program for Asthma Research (SPAR) was founded in 1999 by Marion and Herbert Sandler and is sponsored by The Sandler Family Supporting Foundation. The mission of SPAR is to develop important new pathways of investigation in basic research regarding asthma. The program therefore encourages investigators from all fields to consider how their work may apply to the study of asthma. Innovation and risk are encouraged. Awards will be given to investigators at two levels:

Senior Investigator \$250,000/year for three years
Junior Investigator \$125,000/year for three years

The next application deadline is *February 15, 2001, for funding July 1, 2001*.
Information about the program can be found at <http://www.sandlerresearch.org/general.html>

New Surgeon General's Report Provides Strategies for Halving U.S. Smoking Rates by Year 2010

In August 2000, Surgeon General David Satcher announced that smoking rates among teens and adults could be cut in half within the decade if the nation would fully implement anti-smoking programs using effective approaches that are already available.

Dr. Satcher released the Surgeon General's report on "Reducing Tobacco Use." It is the first-ever report to provide an in-depth analysis of the effectiveness of various methods to reduce tobacco use—educational, clinical, regulatory, economic, and social.

"During the past four decades we have made unprecedented gains in preventing and controlling tobacco use," Dr. Satcher said. "However, the sobering reality is that smoking remains the leading cause of preventable death and disease in our nation, and those who suffer the most are poor Americans, minority populations, and young people. Although our knowledge remains imperfect, we know more than enough to address the tobacco control challenges of the 21st century," he said.

Health and Human Services Secretary Donna E. Shalala noted, "This report offers a science-based blueprint for achieving our Healthy People 2010 objectives to reduce tobacco use and its health impact in this country."

Key actions that Dr. Satcher outlined to reduce tobacco use, supported by evidence in the report, include:

- Implementing effective school-based programs, combined with community and media-based activities, which can prevent or postpone smoking onset in 20 to 40 percent of U.S. adolescents. Unfortunately, fewer than 5 percent of schools nationwide are implementing the major components of school guidelines recommended by the federal Centers for Disease Control and Prevention (CDC).
- Changing physician behavior, medical system procedures, and insurance coverage to encourage widespread use of state-of-the-art treatment of nicotine addiction. The report shows that brief physician advice to

quit smoking can double or triple normal quit rates, while a combination of behavioral counseling and pharmacological treatment can boost success up to 10 times.

- Passing and enforcing strong clean indoor air regulations, which contribute to changing social norms and may decrease tobacco consumption among smokers and increase smoking cessation. The report calls on states to pass laws that will not restrict local governments from passing even stronger measures to protect their citizens from second-hand smoke.
- Improving tobacco warning labels in the U.S., which are weaker and less prominent than those required in other countries such as Canada and Australia. The report shows that consumers receive very little information regarding the ingredients, additives, and potential toxicity of tobacco products.
- Increasing tobacco prices and excise taxes. Evidence presented in the report suggests that a 10 percent increase in price will reduce overall cigarette consumption by 3 to 5 percent. However, both the average price of cigarettes and the average cigarette excise tax in the United States are well below those in most other industrialized countries.
- Changing many facets of the social environment to reduce the broad cultural acceptability of tobacco use. The report concludes that comprehensive approaches combining community interventions, mass media campaigns, and program policy and regulation are most effective in changing social norms and reducing tobacco use.

"Failure to effectively use every intervention strategy at our disposal could mean turning back the clock on the efforts we've made since the 1960s to reduce cigarette smoking, one of the most notable public health accomplishments of this century," Dr. Satcher said. "We must respond aggressively to the serious challenges we still face: most importantly, the tobacco industry's continuing campaign to advertise and promote tobacco products. We need fair but aggressive measures to regulate these marketing activi-

ties, especially those that influence young people." He noted that the industry spent \$6.7 billion in 1998 or more than \$18 million a day to market cigarettes, despite the overwhelming evidence of the harm they cause.

A detailed summary of the Surgeon General's report, "Reducing Tobacco Use," and other related information is available on the CDC's web site: http://www.cdc.gov/tobacco/gr_tobacco_use.htm. ❖

Facts About Minority Teens and Smoking

- The decline of smoking among African American young people during the 1970s and 1980s was widely viewed as a great public health success. Unfortunately, recent national surveys have shown that smoking rates among African American high school students are starting to increase, although those rates are still lower than those of other students.
- Research shows an association between cigarette smoking and acculturation among Asian American and Pacific Islander adults from Southeast Asia. Those who had a higher English-language proficiency and those living in the United States longer were less likely to be smokers.
- Studies have found a higher density of tobacco billboards in racial/ethnic minority communities. For example, a 1993 study in San Diego, California found the highest proportion of tobacco billboards were posted in Asian American communities and the lowest proportion were in white communities.

Source: Tobacco Use Among U.S. Racial/Ethnic Minority Groups: A Report of the Surgeon General. (July 2000).

- **Mental Health: A Report of the Surgeon General.** (1999) The first Surgeon General's Report on Mental Health asserts that mental illness is a critical public health problem that must be addressed by the Nation. The Surgeon General urges people to seek help if they or their family members have symptoms of mental health problems. Call toll free (877) 9-MHEALTH for a free copy of the Executive Summary and other information.
- **Mental Health and Substance Abuse Spending.** In July 2000, the Substance Abuse and Mental Health Services Administration (SAMHSA) announced the results of its study, *National Expenditures for Mental Health and Substance Abuse Treatment, 1997*. The study revealed a decline in the percentage of spending on mental and addictive illnesses and treatment. Spending for the sector represents 7.8 percent of the more than one trillion dollars in all U.S. health care expenditures for 1997. *The report can be ordered through the National Clearinghouse for Alcohol and Drug Information at (800) 729-6686.*
- **Resource Guides for Minority Populations.** SAMHSA's Center for Substance Abuse Prevention (CSAP) has several resource guides available for those working with minority populations. The guides include listings of: prevention materials such as fact sheets, booklets, and brochures; articles and reports; organizations and programs; and Internet sites and resources. The guides are entitled:
 - ˆ *Substance Abuse Resource Guide: Asians/Pacific Islanders* (MS408)
 - ˆ *Substance Abuse Resource Guide: American Indians/Alaska Natives* (MS419)
 - ˆ *Substance Abuse Resource Guide: Hispanic/Latino Americans* (MS441)
 - ˆ *Alcohol, Tobacco, and Other Drugs Resource Guide: African Americans* (MS449)
- **National Clearinghouse for Alcohol and Drug Information publications:**
 - ˆ *Communicating Appropriately with Asian and Pacific Islander Audiences* (MS701)
 - ˆ *CSAP Cultural Competence Series: A Guide for AOD Abuse Prevention Practitioners Working with Ethnic/Racial Communities* (BKD 79)
 - ˆ *CSAP Cultural Competence Series: The Challenge of Participating Research: Preventing Alcohol-Related Problems in Ethnic Communities* (BKD 177)
 - ˆ *Making Prevention Work: Actions for Asian/Pacific Islander Americans* (MPW017)
 - ˆ *Making Prevention Work: Actions for American Indians/Alaska Natives* (MPW017)
 - ˆ *Breaking New Ground for American Indians and Alaska Natives: Program Summaries.* (BK174)

To order, call NCADI at (800) 729-6686.
- **Asian Americans and Pacific Islanders.** A September 2000 report from SAMHSA's Center for Mental Health Services. CMHS recently awarded a contract to the Child and Adolescent Services Asian Pacific Development Center. The Center will develop a strategic plan to address the mental health needs of AAPIs. The plan will connect experts from AAPI communities to develop a strategy that will build and sustain culturally competent services for these populations. *For more information, contact CMHS at (800) 789-2647 or visit <http://www.mentalhealth.org/cmhs/index.htm>.*
- **American Indians/Alaska Natives**
 - **Tribal Communities Receive Grants.** The Office of Juvenile Justice and Delinquency Prevention (OJJDP) recently announced an award of \$8 million in grants to 34 Native American and Alaska Native tribal communities. The Tribal Youth Program grants are intended to assist tribal communities in preventing youth violence and substance abuse. *For more information on the program, view OJJDP's press release online at <http://www.ojjdp.ncjrs.org/about/press/ojp991216.html>.*
 - **Evaluation of the Indian Health Service Adolescent Regional Treatment Centers.** (1998) Through funding from the Indian Health Service (IHS), this report evaluates the nine Regional Treatment Centers which provide alcoholism and substance abuse rehabilitation treatment to American Indian/Alaska Native youth. *For more information about the report, contact Walter Hilabrant, PhD, Support Services International, Inc., (301) 587-9000 or e-mail ssix@email.msn.com*
 - **Circles of Care.** SAMHSA's Child, Adolescent, and Family Branch (CAFB) has a program entitled *Circles of Care*, which provides grants to nine tribes and urban Native American programs to plan and evaluate systems of mental health care for the children and families. The program collaborates with IHS, the National Institute of Mental Health, and the OJJDP. *For more information about Circles of Care, call the CAFB at (301) 443-2940.*
 - **The Diineegwahshii project.** Developed by the Fairbanks Native Association in Alaska, the Diineegwahshii project is a prevention program for Alaska Native girls that builds on Native culture, works to develop the connections between self, family, and community through home visits and case management with teens and their mothers. The program was successful in decreasing alcohol, marijuana, and cigarette use among participants. The project was featured in an OJJDP 1998 publication entitled, *Guiding Principles for Promising Female Programming: An Inventory of Best Practices.* *For more information, contact Sandra Deaton, Fairbanks Native Association, (907) 452-1608. To obtain a copy of the OJJDP publication, call (800) 638-9736. ❖*

Resources

Administration for Children and Families
370 L'Enfant Promenade SW
Washington, DC 20447
<http://www.acf.dhhs.gov>
(202) 401- 9215

Office of Juvenile Justice and Delinquency Prevention
Office of Justice Programs
810 Seventh Street, NW
Washington, DC 20531
<http://ojjdp.ncjrs.org>
(202) 307-5911

Federal Interagency Forum on Child and Family Statistics (ChildStats)
<http://www.childstats.gov>
e-mail childstats@ed.gov

Health Care Financing Administration Children's Health Insurance Program
7500 Security Blvd.
Baltimore, Maryland
<http://www.hcfa.gov/init/children.htm>
(877) KIDS - NOW

Substance Abuse and Mental Health Services Administration (SAMHSA)
5600 Fishers Lane Rm 10-75
Rockville, Maryland 20857
<http://www.samhsa.gov>
(301) 443-7265

- **Center for Mental Health Services**
<http://mentalhealth.org>
301-443-0001
- **Center for Substance Abuse Prevention**
<http://samhsa.gov/csap>
301-443-0365
- **Center for Substance Abuse Treatment**
<http://www.samhsa.gov/csap>
302-443-5700

Health Resources and Services Administration, Maternal and Child Health Bureau, Division of Child, Adolescent and Family Health
5600 Fishers Lane, Room 18A-39
Rockville, MD 20857
<http://www.mchb.hrsa.gov>
(301) 443-2250

America's Promise: The Alliance for Youth
909 N. Washington Street, Suite 400
Alexandria, VA 22314

<http://www.americaspromise.org>
(703) 684-4500

The American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Ave., NW
Washington, DC 20016
<http://www.aacap.org>
(202) 966-7300

Association of Maternal & Child Health Programs
1220 19th Street NW Suite 801
Washington DC 20036
<http://www.amchp.org>
(202) 775-0436

Academy for Educational Development Center for Youth Development and Policy Research
1825 Connecticut Ave. NW, Ninth Floor
Washington DC 20009
<http://www.aed.org>
(202) 884-8267

American Youth Policy Forum
1836 Jefferson Place, NW
Washington DC 20036
<http://www.aypf.org>
(202) 775-9731

Boys and Girls Clubs of America
1230 W. Peachtree Street, NW
Atlanta, GA 30309
<http://www.bgca.org>
(404) 815-5700

Child Welfare League of America
440 First Street, NW, 3rd Floor
Washington, DC 20001
<http://www.cwla.org>
(202) 638- 2952

Center for Adolescent Health & the Law
211 North Columbia Street
Chapel Hill, NC 27514
<http://www.adolescenthealthlaw.org>
(919) 968-8870

The Center for Youth Studies
130 Essex Street
South Hamilton, MA 01982
<http://www.gcts.edu/cys/>
(978) 468-7111

Campaign for Tobacco-free Kids
1707 L Street NW, Suite 800
Washington, DC 20036
<http://www.tobaccofreekids.org>
(800) 284-5437

Children's Defense Fund
25 E Street NW
Washington, DC 20001
<http://www.childrensdefense.org>
(202) 628- 8787

Department of Adolescent Health American Medical Association
515 N. State Street
Chicago, IL 60610
(312) 464-5570
<http://www.ama-assn.org>

National Youth Development Information Center
1319 F Street NW, Suite 601
Washington, DC 20004
<http://www.nydic.org>
(877) 693-4248

National Institute on Out-of-School Time Center for Research on Women
106 Central Street
Wellesley, MA 02181
<http://www.wellesley.edu/WCW/CRW/SAC>
(781) 283-2547

National Collaboration for Youth
The National Assembly
1319 F Street NW, Suite 601
Washington, DC 20004
<http://www.nassembly.org>
(202) 347-2080

National Resource Center for Youth Services
The University of Oklahoma College of Continuing Education
4502 E 41st Street, Building 4 West
Tulsa, OK 74135
<http://www.nrcys.ou.edu>
(918) 585-2986

National Network For Youth
1319 F Street NW Ste 401
Washington DC 20004
<http://www.nn4youth.org>
(202) 783-7949

National Adolescent Health Information Center

University of California San Francisco
3333 California Street, Suite 245
San Francisco Ca. 94143-0503
<http://youth.ucsf.edu/nahic>
(415) 502-4856

National Clearinghouse for Alcohol and Drug Information

P.O. Box 2345
Rockville, MD 20847
(800) 448-0440
<http://www.health.org>

National Technical Assistance Center for Children's Mental Health

Georgetown University
3307 M Street NW Suite 401
Washington DC 20007
<http://www.dml.georgetown.edu/gucdc>
(202) 687-5000

Policy Information and Analysis Center for Middle Childhood and Adolescence

3333 California Street, Suite 245
San Francisco, CA 94143
<http://youth.ucsf.edu/policycenter>
(415) 502-4856

New reports available to the public

- *The State of Hispanic Girls*, which details alarming trends in health risk behaviors among Hispanic girls, is available from the National Alliance for Hispanic Health (NAHH). It analyzes current research, presents findings from focus groups with girls, and offers recommendations. Call NAHH at (202) 387-5000, or send an e-mail to: publications@hispanichealth.org Ask for publication number 3310.
- *Adolescents in Public Health Insurance Programs: Medicaid and CHIP* (1999) is available from the Center for

Adolescent Health and the Law. To obtain a copy, send an e-mail to info@adolescenthealthlaw.org or call (919) 968-8854.

- The Center on Budget and Policy Priorities has available a June 2000 report entitled, *Conducting Children's Health Insurance Outreach in African American Communities*. The report is available on CBPP's website at <http://www.cbpp.org/6-26-00health.htm> or by calling Jacqueline Patterson at (202) 408-1080.

Society for Research on Adolescence

Loyola University Chicago
6525 N. Sheridan Road
Chicago, IL 60626
<http://www.sra-newsletter.ucsd.edu>
(773) 508-3007

Youth Law Center

1010 Vermont Ave NW Suite 310
Washington DC 20005
<http://www.buildingblockforyouth.org>
(202) 637-0377



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Public Health and Science
Office of Minority Health Resource Center
P.O. Box 37337
Washington DC 20013-7337

Official Business
Penalty for Private Use \$300

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DHHS/OPHS
PERMIT NO. G-280



Closing the Gap

Conferences: 2001

Jan. 22–25: *Healthy Kids—Healthy Communities: We Can Make a Difference!* CDC National Leadership Conference to Strengthen HIV/AIDS Education and Coordinated School Health Programs. Renaissance Hotel, Washington, DC. Contact the Society of State Directors of Health, Physical Education and Recreation. Contact: (703) 476-3403. Registration forms are available online at <http://www.cdc.gov/nccdphp/dash>.

Feb. 18–21: *Youth and Adults Uniting for Community Change.* Grand Hyatt Hotel, Washington, DC. Sponsored by the National Network for Youth, Brandeis University Center on Youth and Communities, Southeastern Network of Youth and Family Services, Western State Youth Services Network. To register, e-mail: NN4Youth@worldnet.att.net, or call (202) 783-7949.

Feb. 25–28: The 14th Annual Research Conference. *A System of Care for Children's Mental Health: Expanding the Research Base.* Tampa, Florida. Sponsored by the Research & Training Center for Children's Mental Health, Department of Child and Family Studies, Louise de la Parte Florida Mental Health Institute, University of South Florida. For more information, call (813) 974-4649 or e-mail kutash@fmhi.usf.edu.

February 25–28: *Strengthening Families and Youth: Strategies for Success.* Will highlight best practices—from national, state, regional and local levels—that have improved the quality of life for families and youth. Sponsored by Clemson University Cooperative Extension, Myrtle Beach SC. Contact: (864) 656-5721 or (864) 656-5717.

March 7–9: *The Child Welfare League of America (CWLA) National Conference.* Grand Hyatt Hotel, Washington, DC. Will examine whether current federal laws, policies, and resources promote safe and healthy children, families, and communities. To highlight collaboration, cultural competence and diversity, integrating systems of care, expanding organizational missions, technology and research, advocacy, and more. For conference brochures and registration information, send e-mail to: register@cwla.org or call the CWLA at (202) 942-0289.

May 7-9, 2001: *Finding Better Ways 2001, Confronting the Workforce Crisis: Finding and Keeping Competent Employees.* Dallas, Texas. Westin Park Central Hotel. Sponsored by the Child Welfare League of America (CWLA), the conference will focus on the workforce crisis in human service agencies. Hear from those doing exemplary work. Contact: CWLA at (202) 638-2952.