Towards Meeting the Needs of Adolescents: An Assessment of Federally Funded Adolescent Health Programs and Initiatives within the Department of Health and Human Services

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Table of Contents

Acknowledgements **3**
Executive Summary **4**
I. Introduction **10**
II. Methodology **14**
III. Results **19**
A. Health & Well-Being 24
B. Fitness 28
C. Family & Peer 30
D. School Environment 35
E. Smoking 39
F. Alcohol 41
G. Violence 45
H. Summary of Results 49
IV. Discussion **53**

Figures

Figure 1. Questions Addressed in Each Content Area of the U.S. Chartbook 12
Figure 2. Sources Used to Identify Potential Eligible Programs 15
Figure 3. Program Selection Process Within White House Report 16
Figure 4. Sources Used to Identify Potential Eligible Programs A2

Tables

Table 1. DHHS-funded Programs by Seven Content Areas 21
Table 2. DHHS-funded Health & Well-Being Programs by Seven Content Areas 25
Table 3. DHHS-funded Fitness Programs by Seven Content Areas 29
Table 4. DHHS-funded Family & Peer Relationship Programs by Seven Content Areas 32
Table 5. DHHS-funded School Environment Programs by Seven Content Areas 37
Table 6. DHHS-funded Smoking Programs by Seven Content Areas 40
Table 7. DHHS-funded Alcohol Programs by Seven Content Areas 43
Table 8. DHHS-funded Violence Programs by Seven Content Areas 47

Table 9. Total Number of Programs from the White House Task Force Report by, Federal Sponsoring Department, and Content Area A5

Appendices

Appendix A. Expanded Methodology A1
Appendix B. Tables B1
Appendix C. Program Resources C1
Appendix D. Bibliography D1
Appendix E. Program References E1

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The National Adolescent Health Information Center at the University of California, San Francisco and Child Trends are pleased to announce a new partnership. With support from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, our two institutions will collaborate to create resources and provide assistance to improve the health of young people and their families. This report is one of the first products of our collaboration.

Executive Summary

Why Adolescent Health?

The health and well-being of our country's adolescents have a major impact on the overall social and economic health of our nation. Today's adolescents are tomorrow's workforce, parents and leaders; and their future is shaped by the opportunities we create for them today. Adolescence represents a unique period of significant physical, cognitive and psycho-social development that brings with it special challenges and opportunities. Markers of overall child-wellbeing may require different assessments. Many adolescents may not seek care for chronic or persistent conditions because of lack of access to care or having irregular check-ups with medical visits used primarily for acute episodic issues such as respiratory infections or injuries. The US Teens in our World report shows that U.S. students rank at or among the highest of students in 29 countries in daily prevalence of backaches, stomachaches, headaches, difficulty sleeping, being tired in the morning and concurrent medication use for these problems, The clinical and public health community or parents may not be aware of the impact on youth well-being from these problems, particularly since they frequently occur as co-morbidities (Ghandour, Overpeck, & Huang, 2004). As with these conditions, adolescents face a variety of physical and behavioral choices that can impact their health, safety and well-being. As a result, adolescents do encounter significant health problems, many of which are attributable to risky behavior. Furthermore, the attitudes and health practices developed in adolescence often continue into adulthood and play a major role in the development of adult health problems (Ozer, Park, Paul, Brindis, & Irwin, 2003). Thus, the definition of adolescent health has expanded beyond the prevention and treatment of disease and disability and the prevention of risky behaviors among individuals to the establishment of healthy environments.

This broader definition of health has important implications for programs to improve adolescent health. Many of our traditional programmatic approaches have been directed primarily at changing individual behavior, often without considering the role of family, school, and community contexts in shaping individual behavior. An emerging consensus holds that without directing our efforts at each of these levels, we will continue to have limited success. An additional theme that emerges is that policy plays an important role in shaping adolescents' environments. Policy affects the types of resources made available to young people. Moreover, it reflects priority placed on investing in young people, for example, by having policies and practices that support youth and families.

Given the importance of this lifestage, it is important to assess where we are as a nation in terms of responding to the varied needs of adolescents. In 1982, an international research

study (coordinated with the World Health Organization) began to examine the influences of individual assets and contexts on adolescent health in different countries (Currie, Hurrelmann, Settertobulte, Smith, & Todd, 2000). Since the initial cross-national data collection in 1983/84, data have been collected every four years. Findings from that study supported the notion that family and school environments exert a strong influence on adolescent health and well-being. The study also provided prevalence data, showing cross-national comparisons across several health and environmental domains.

U.S. researchers prepared a special report, *U.S. Teens in Our World* (herein referred to as the *U.S. Chartbook*) (U. S. Department of Health and Human Services. Health Resources and Services Administration, 2003), that highlighted those areas showing "important differences" between U.S. adolescents and their counterparts in other countries. These differences spanned seven content areas: Health & Well-being, Fitness, Family & Peer Relationships, School Environment, Smoking, Alcohol Use, and Violence.

Goal of the Government Program Review

The overall goal of this project is to better understand the types of youth programs available that may influence the health measures presented in the U.S. Chartbook where American adolescents fare differently—sometimes better, sometimes worse—than their counterparts in other countries. In an effort to do so, we reviewed the existing "state of the state" of information available on adolescent health programs supported by the Department of Health and Human Services (DHHS) in seven content areas, and address four important questions regarding federal efforts to improve adolescent health:

- Is there a national policy that addresses the promotion of adolescent health?
- Is DHHS making an effort to create healthier environments for adolescents through a multi-level approach?
- What is the status of evaluations of federally funded adolescent health programs?
- What can we learn from existing evaluations of programs that seek to influence adolescent health outcomes?

The intent of this review is to provide a picture for policymakers and program managers and help shape future efforts as they make the most effective use of resources in meeting the varied needs of adolescents, their families, and the communities in which they live. As such, we have also provided implications for future endeavors.

We recognize that our review of adolescent health programs is not exhaustive. The reviewed programs provide a snapshot of the existing efforts at a given time. Due to the difficulties discussed within the full report regarding locating programs funded by federal agencies, we conclude that it would be near impossible to conduct a truly exhaustive review as there would be no way to know if any programs were being excluded.

Results

The results of this review clearly document the broad array of efforts underway, from direct service programs, research, educational campaigns, professional networks, to resource and technical assistance endeavors that help reach thousands of low income and underserved adolescents. In many of the content areas, such as health & well being and school environment, special groups of adolescents have also been included, including medically indigent, homeless, abused, Latino and Latina youth, and Native American youth. In selecting DHHS, we have spotlighted the efforts of the organization with the strongest portfolio and investment in the health arena, although we fully recognize that a number of other federal Departments, for example, the Department of Education and Department of Justice, also make strong investments on behalf of young people.

Building on the extensive data collected under the auspices of the White House Task Force on Disadvantaged Youth, this review utilizes the programs identified in its Final Report to frame our discussion on federal efforts to address adolescent health. The review points to the complexity of categorizing these diverse efforts within a specific content area. Within the seven content areas, topics such as health & well being, family & peers, and school environment represent multi-faceted programs and initiatives, many of which also overlap with specific content areas, such as violence, alcohol, and tobacco prevention. Furthermore, under the area of violence prevention, diverse efforts at reducing alcohol and tobacco use were often found to be included. The inclusion of these additional areas may not be readily apparent, but may reflect research findings pertaining to the clustering of adolescent risk-taking behaviors and the necessity of dealing with a variety of risk-taking behaviors simultaneously. Many of the content areas also include a great diversity of additional topics, for example, depression and mental health. In other words, overlapping programs within and across the seven areas appear to be occurring, but the level of cross-program communication and information sharing that might be in place was not easy to assess. One possibility is the ability of “resource centers” to play an intermediate role in helping programs become aware of each others’ efforts.

The challenge of narrowly categorizing existing programs within any one specific content area makes a financial analysis of federal investments in each of the content areas difficult. For

example, in the White House Report, the range of most investments made in each of the seven areas is from $100,000 to $1,700 million. Within specific content areas there is also a tremendous range of investments, with the average ranging from $13.9 to $50.7 million. There also did not appear to be any relationship between the number of programs within each content area and the amount of funding available.

It is also challenging to ascertain the relationship between program evaluation findings and current federal investments and service portfolios. This review found little information regarding current evaluation efforts underway within the seven content areas. In fact, it was unclear whether existing programs use previously evaluated curricula or other types of successful interventions. Analyzing whether research is being incorporated in new programmatic initiatives would be extremely useful in assuring that the next generation of Government-funded programs benefit from the lessons learned from well-evaluated programs, or at a minimum, best-practices.

Discussion

Based on these results and the program search process we provide a discussion of four important questions regarding federal efforts to improve adolescent health.

First, **is there a national policy that addresses the promotion of adolescent health?** Although there is significant investment in the area of adolescent health, no clearly articulated national policy pertaining to adolescent health was identified in this review. The review identified three implications for future work: 1.) Need for an articulated national policy on adolescent health; 2.) Need for inter-agency collaboration; and 3.) Need for a federal adolescent health program repository and technical assistance (TA) center. Easily accessible information allows those individuals designing or selecting programs to be able to determine what does and does not work with different populations, as well as to identify important lessons on how to implement a program to achieve the greatest results. Additionally, by making this information readily available, those looking for programs will be able to choose programs that have been shown to be effective and avoid programs which have been shown to be ineffective. At a minimum, information on programs that have recently undergone or are undergoing evaluation could be listed and highlighted on federal websites.

Second, **is DHHS making an effort to create healthier environments for adolescents through a multi-level approach?** Promising efforts appear to be made in using a multi-level approach to improve adolescent health, yet much work remains in this area. Available information suggests that DHHS has begun to take environmental factors into account

in program development, but additional systematic efforts are needed. Furthermore, available information indicates that there is strong commitment by DHHS to serve disadvantaged youth.

In response to these findings, we identify five implications for future work: 1.) Need to utilize a greater number of resources and approaches to help deliver messages on adolescent health; 2.) Need to share lessons learned across content areas; 3.) Need to incorporate "character development" in programming; 4.) Need to identify programming gaps across federal agencies; and 5.) Need to address adolescents' developmental stages in program development

Third, **what is the status of evaluations of federally funded adolescent health programs?** Our search for evaluations of federally funded adolescent health programs found that very few programs had been experimentally evaluated. Similarly, it was not apparent whether at a minimum, existing programs use previously evaluated curricula or other types of successful interventions. Analyzing whether in fact research is being incorporated in new programmatic initiatives would be extremely useful in assuring that the next generation of Government-funded programs benefit from the lessons learned from well-evaluated programs, or at a minimum, best-practices. However, it is extremely difficult to determine if current program practices are evidence-based or if rigorous evaluations have been conducted because of the disconnect between large grants, such as demonstration projects, and programs with a national scope. For example, sources such as the White House Report and the Catalog of Federal Domestic Assistance (CFDA) give grant information which can not necessarily be linked to the specific program level where evaluations are performed. Likewise, it is impractical to perform the converse search to determine whether programs receive any federal funding, and if so, under what mechanisms, and what types of evaluation reporting are required (if any). Two primary implications emerge from this review: 1.) Need for more program evaluations and 2.) Need for more readily available program information (including program evaluation reports).

Fourth, **what can we learn from existing evaluations of programs that seek to influence adolescent health outcomes?** Existing program evaluations can help decision-makers make better selections among available programs and strategies and as a consequence develop better policies. Our review identified two implications regarding future evaluations: 1.) Need for synthesis of knowledge in the field and 2.) Need for greater accountability.

Overview

The overall goal of this project is to better understand the types of youth programs available that may influence the health measures presented in the U.S. Chartbook where American adolescents fare differently—sometimes better, sometimes worse—than their counterparts in other countries. In an effort to do so, we answer four important questions regarding federal efforts to improve adolescent health:

- *Is there a national policy that addresses the promotion of adolescent health?*
- *Is Department of Health Human Services making an effort to create healthier environments for adolescents through a multi-level approach?*
- *What is the status of evaluations of federally funded adolescent health programs?*
- *What can we learn from existing evaluations of programs that seek to influence adolescent health outcomes?*

Thus, the intent of this review is to provide a picture for policymakers and program managers and help shape future efforts as they make the most effective use of resources in meeting the varied needs of adolescents, their families, and the communities in which they live. As such, we have also provided implications for future endeavors.

We recognize that our review of adolescent health programs is not in any way an exhaustive review. Due to the difficulties discussed within this report regarding locating programs funded by federal agencies, we conclude that it would be near impossible to conduct a truly exhaustive review as there would be no way to know if any programs were being excluded.

I. Introduction

The health and well-being of our country's adolescents has a major impact on the overall social and economic health of our nation. Today's adolescents are tomorrow's workforce, parents and leaders; and their future is shaped by the opportunities we create for them today. Adolescence represents a unique period of significant physical, cognitive and psycho-social development that brings with it special challenges and opportunities. No longer children and not yet adults, adolescents make significant choices about their health and develop health-related attitudes and practices that continue into adulthood. While most adolescents are considered healthy when assessed by traditional medical markers, such as mortality rates, incidence of disease, prevalence of chronic conditions, and health care utilization, adolescents face a variety of choices about their health, safety and well-being. As a result, adolescents do face significant health problems, many of which are attributable to risky behavior. Furthermore, the attitudes and health practices developed in adolescence often continue into adulthood and play a major role in the development of adult health problems (Ozer et al., 2003).

Thus, the definition of adolescent health has expanded beyond the prevention and treatment of disease and disability and the prevention of risky behaviors among individuals. This broader definition of health has important implications for programs to improve adolescent health. Many of our traditional programmatic approaches have been directed primarily at changing individual behavior, often without considering the role of family, school, and community contexts in shaping individual behavior. An emerging consensus holds that without directing our efforts at each of these levels, we will continue to have limited success. An additional theme that emerges is that policy plays an important role in shaping adolescents' environments. Policy affects the types of resources made available to young people. Moreover, it reflects priority placed on investing in young people, for example, by having policies and practices that support youth and families.

Given the importance of this lifestage, it is important to assess where we are as a nation in terms of responding to the varied needs of adolescents. In 1985, an international research study (coordinated with the World Health Organization) began to examine the influences of individual assets and contexts on adolescent health in different countries (Currie et al., 2000). Findings from that study supported the notion that family and school environments exert a strong influence on adolescent health and well-being. The study also provided prevalence data, showing cross-national comparisons across several health and environmental domains.

U.S. researchers prepared a special report, *U.S. Teens in Our World* (herein referred to as the *U.S. Chartbook*) (U. S. Department of Health and Human Services. Health Resources

and Services Administration, 2003), that highlighted those areas showing "important differences" between U.S. adolescents and their counterparts in other countries. These differences spanned seven content areas: Health & Well-being, Fitness, Family & Peer Relationships, School Environment, Smoking, Alcohol Use, and Violence. For further detail on the issues covered by each content area refer to Figure 1 below which lists the specific survey questions addressed in the Chartbook.

The overall goal of this project is to better understand the types of youth programs available that may influence the measures in the *U.S. Chartbook* where U.S. adolescents fare differently—sometimes better, sometimes worse—than their counterparts in other countries. It is noteworthy that numerous agencies within the federal government, as well as private regional and national organizations, already have developed and funded adolescent health programs that serve a broad spectrum of youth. These programs vary considerably, in terms of health issues addressed (e.g., substance use, violence), population of adolescents served, and the extent to which they incorporate youth development and environmental approaches.

The purpose of this assessment is to begin to ascertain what progress has been made at the federal level to meet the needs of adolescents in the aforementioned seven content areas. While the initial intent of this project was to review all federal programs, our initial search revealed a significant number of programs funded at the federal level. Through the initial search process a number of resources were found that identified hundreds of federal, state and private adolescent health programs. However, information available was largely inconsistent and often not verifiable. It was determined that the best available, most recent, and most reliable source of programs was the *Final Report of the White House Task Force for Disadvantaged Youth* (The White House Task Force for Disadvantaged Youth, 2003). Therefore, this review focuses on programs identified in that report *(See the methodology section for more details on the initial review).* Furthermore, discussion in this report is limited those programs funded by the Department of Health and Human Services (DHHS) given its large number of programs and its primary focus and responsibility for youth health and well-being. DHHS alone sponsors a wide range of activities. The majority of programs support grants for services or projects. Other funds support resource centers that provide in-depth information on specific content areas and broker information for professionals. Still other funds support research grants and informational campaigns to raise awareness on topics, such as mentoring, and violence prevention.

In the following review, we answer four important questions regarding federal efforts to improve adolescent health:

- Is there a national policy that addresses the promotion of adolescent health?

- Is DHHS making an effort to create healthier environments for adolescents through a multi-level approach?
- What is the status of evaluations of federally funded adolescent health programs?
- What can we learn from existing evaluations of programs that seek to influence adolescent health outcomes?

Thus, the intent of this review is to provide a picture for policymakers and program managers and help shape future efforts as they make the most effective use of resources in meeting the varied needs of adolescents, their families, and the communities in which they live.

Figure 1. Questions Addressed in Each Content Area of the U.S. Chartbook

Health & Well-being
How healthy do you think you are?
How do you feel about your life at present?
Do you ever feel lonely?
In the past six months, how often have you had a backache?
In the past six months, how often have you had a stomachache?
In the past six months, how often have you had a headache?
In the past six months, how often have you felt low?
In the past six months, how often have you had sleep difficulties?
How often do you feel tired when you got to school in the morning?
During the past month, have you taken medication for sleep difficulties?

Fitness
How often do you usually exercise in your free time so much that you get out of breath or sweat?
How many hours a day do you usually watch TV?
How often do you eat fruit?
How often do you eat French fries or fried potatoes?
How often do you eat candy or chocolate?
How often do you drink soft drinks?
Are you on a diet to lose weight?

Family & Peer Relationships
With whom do you live?
How easy is it for you to talk to your mother about things that really bother you?
How easy is it for you to talk to your father about things that really bother you?
How often do you spend time with friends right after school?

School Environment
How do you feel about school at present?
"My parents expect too much of me at school"
"My teachers expect too much of me at school"
How pressured do you feel by the school work you have to do?

"In our school the students take part in making rules"
"The students are treated too severely/strictly in this school"
"Most of the students in my classes are kind and helpful"

Smoking
Have you ever smoked tobacco?
How often do you smoke tobacco at present?

Alcohol Use
How often do you drink beer, wine, or spirits?
Have you ever had so much alcohol that you were really drunk?

Violence
Do you feel safe at school?
How often have you been bullied in school this term?
How often have you taken part in bullying other students in school this term?
During the past 12 months, how many times were you in a physical fight?
The last time you were in a physical fight, with whom did you fight?
During the past 30 days, on how many days did you carry a weapon, such as a knife or club for self-defense?

SOURCE: U. S. Department of Health and Human Services. Health Resources and Services Administration. (2003). *U.S. Teens in Our World*. Rockville, Maryland: Author.

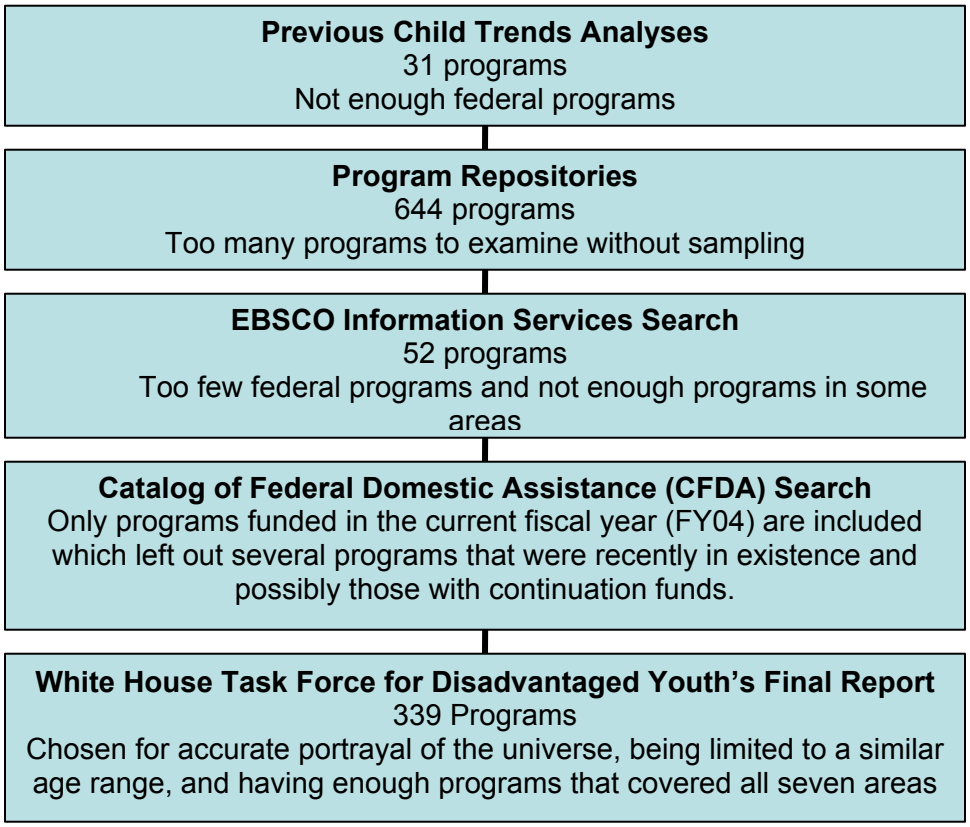
II. Methodology

While the original intent of the project was to review all federal adolescent health programs, an initial search revealed an extensive number of programs. Given the magnitude of programs, it was determined that this report would look in detail at only those programs funded by the U.S. Department of Health and Human Services. This section describes the process by which that determination was made.

The initial process to identify possible programs[1] for this report began by defining what a program entailed, the period of time in which the program operated, and the overall scope of the program reach and intent. Thus, all programs (excluding programs in the What Works section) that are presented in this report are mechanisms or initiatives officially funded by the federal government that address some dimension of health for adolescents. Following the definitional process, we developed a template with a number of program characteristics (e.g. type of approach, target audience, program summary, website, venue, etc.) to use as the basis for the review. We also worked to assure that there was inner-judge reliability in the type of information that was included in the grid by each member of the team. We examined multiple sources to gather information on federally funded programs. These sources included a review of previous Child Trends program review work, keyword searches of private and government program repositories available on the Internet, the EBSCO Information Services database, and the Catalog of Federal Domestic Assistance (CFDA), as well as a review The White House Task Force for Disadvantaged Youth's Final Report (White House Report). Figure 2, shows each of the potential sources that were reviewed, the number of programs that were found, and a brief justification for including or excluding the source in our final review. Ultimately, it was determined that the best resource of potential programs for this report was The White House Task Force for Disadvantaged Youth's Final Report. For more complete detail on this process, please see Appendix A.

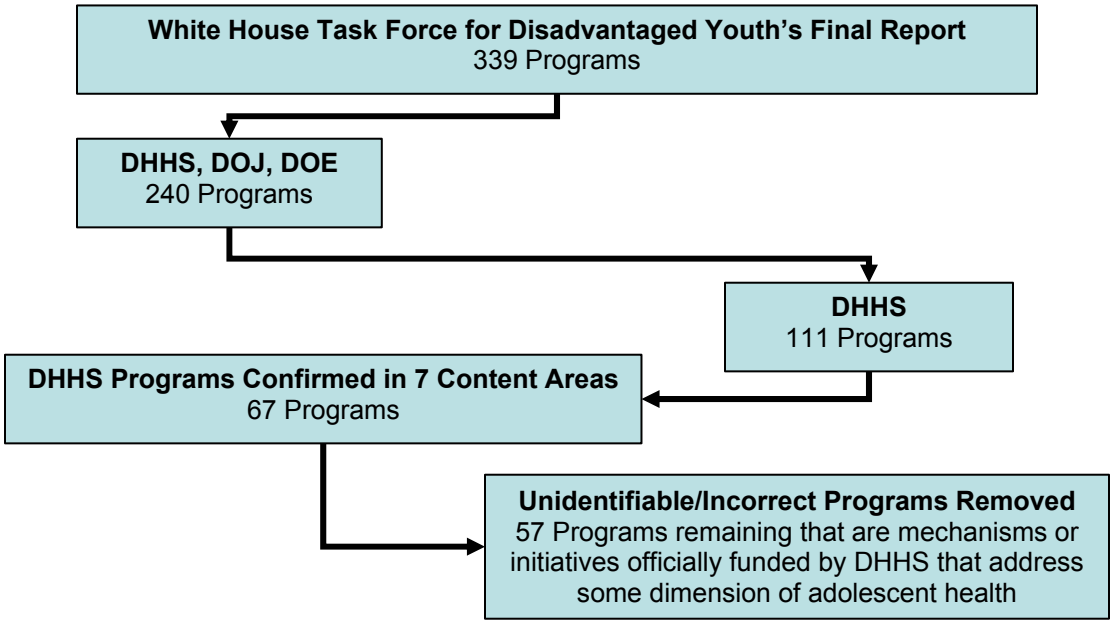
[1] The term program is used to refer to any mechanism, initiative, or program offered by the federal government. It does not imply only a "direct service" component.

Figure 2. Sources Used to Identify Potential Eligible Programs



In October of 2003, the White House Task Force for Disadvantaged Youth released its final report on the federal response to disadvantaged youth (White House Task Force for Disadvantaged Youth, 2003). The Task Force was created on December 23, 2002 and charged with assessing the effectiveness of existing programming efforts to address disadvantaged youth in the United States. The final report identified 339 programs and concluded that the best way to achieve the greatest outcomes for disadvantaged youth and utilize federal monies was to improve management, increase accountability, create better connections for and between the programs, and to give greater priority to the "neediest youth". Figure 3 shows the process by which we arrived at the 57 programs from the report to include in this review.

Figure 3. Program Selection Process Within White House Report



A detailed description of the process follows.

White House Task Force for Disadvantaged Youth's Final Report
339 Programs

First, we cross-referenced the 33 program goals cited in the White House Report with the seven content areas identified in the *U.S. Chartbook* (see Appendix B, Table 2). We then cross-referenced the list of programs in the White House Report against our seven content areas and found 313 programs which could potentially fall into one of the seven areas. Several content areas were more heavily addressed within the report than others. For example, there were 208 programs which potentially addressed the Health & Well-being area, 174 programs involving family and peer relationships, and 158 that possibly addressed the school environment. There were only 51 programs addressing youth fitness and 59 programs addressing youth smoking. Ultimately, the White House Report was chosen as the base for our program sample because it provided an up-to date list of highly-relevant federal programs that serve youth, and reflected recent efforts by specific federal program staff to identify and collect relevant program information. Admittedly, the report is geared towards direct service programs aimed only at disadvantaged youth, but it is as a good a catalog of adolescent programs as exists. Of the different departments covered in the report, the Department of Health and Human Services (DHHS) was selected as the single department which would be examined in this report

because of its large number of programs and its primary focus and responsibility for youth health and well-being.

DHHS
111 Programs

A general group screening of the 111 programs was then conducted to remove any programs that were known to not be age appropriate or that did not specifically deal with any of our seven content areas.

DHHS Programs Confirmed in 7 Content Areas
67 Programs

This screening left a sample of 67 potential programs. Additional determinations were then made to assess if the program was a service providing program, a funding stream which supported programming efforts, or a general effort (e.g. an educational campaign) to address one of the seven areas through non-program means. Four programs were then randomly selected for more in-depth examination to retrieve all the information provided in the Detailed Program Description Tables (see Appendix B, Table 1). General Internet searches on the program titles were performed and any available written reports were reviewed. The intent was to identify any preliminary problems in finding the information needed for all of the programs. Such problems as vague or incorrect program names were encountered, as well as problems finding reported evaluations and mention of cultural components of programs. However, enough information was collected on the selected programs that the grid was then filled out for all of the remaining programs. When information could not be found on a program or it was found to not address any of the seven content areas we excluded them from our list of DHHS programs.

Unidentifiable/Incorrect Programs Removed
57 Programs remaining that are mechanisms or initiatives officially funded by DHHS that address some dimension of adolescent health

This left 57 DHHS funded programs to be examined for this report. See Appendix B, Table 3 for a list of these programs cross-referenced by the 33 program goals in the White House Report and the seven content areas used in this report.

It should be noted that an attempt to crosscheck programs in the White House Report to other federal sources was made. In an effort to find additional or more recent program information on the 111 DHHS-funded programs listed in the White House Report, we searched the Catalog of Federal Domestic Assistance (CFDA) – a database of all Federal assistance programs – for each of the 111 programs. However, this process provided little information and only revealed additional difficulties in identifying accurate program information. Out of the 111

DHHS programs, 35 were found to have current CFDA numbers, meaning that they were currently (FY04) being funded under the name given in the White House Report. The large gap between DHHS-funded programs identified in the White House Report and those in the CFDA may be attributable to the difference in the fiscal year or differences in reporting between the two sources. The White House Report identifies programs funded in FY03 while the CFDA reports funding for the current fiscal year, which at the time of the search was FY04. As such, our search of the CFDA could not find programs that lost funding (even if the program was active in FY04 but was not receiving federal funds) or those that changed names between FY03 and FY04. In addition, since the CFDA does not necessarily show programs that receive continuation funding from previous years those programs did not show up in our search. Reporting differences may also contribute to the discrepancies between the two sources. For example, joint programs with other Departments may have been listed in the White House Report as DHHS programs but may be categorized under a different department (e.g., DOJ) by the CFDA. Similarly, a program may have been reported individually in the White House Report but funding may have come as part of a larger initiative or multiple programs that were named for the White House Report may be under a single grant. The inconsistency between the two sources led us to determine that all DHHS programs from the White House Task Force's final report would be reviewed.

III. Results

In this section, we present highlights from our review of programs funded by the Department of Health and Human Services, organized according to the content areas addressed in the *U.S. Chartbook*:

- health and well-being,
- fitness,
- family and peer relationships,
- school environment,
- smoking,
- alcohol use, and
- violence.

See Table 1 for a list of programs reviewed in this report and the content areas addressed within each program.[2] As noted in the table, a number of these programs, covered several content areas simultaneously based upon their description. For example, a program may focus on both family relationships and tobacco prevention. Although the programs were primarily classified within the seven content areas based on the goals stated in the White House Report (see Methodology Section), we also reviewed the program descriptions for anything indicating that the program could apply to other content areas included in this study. Within each content area, the review is organized in three sections: 1) summary of program types; 2) level of appropriations; and 3) summary of what works. Each of these is described in more detail below.

Summary of program types – identifies the number of programs identified and any overlap they have with other content areas, the type of programs offered (clearinghouses/resources, campaigns, collaboratives/networks, policy/associations, initiatives, or service delivery programs), and some specifics on what the programs offer. A number of Matrices are included in Appendix B, Table 1 to present a visual summary of the programs and their characteristics. These tables provide detailed information on each of the DHHS programs discussed in this review.

[2] Categorization within the seven content areas is primarily based upon the program goals cited in the White House Report. Therefore, imprecise categorization may be the result of reporting instruments and ambiguous definitions used for the compilation of that report. However, as noted previously, the White House Report has been determined to be the best available source of DHHS-funded adolescent health program information.

Level of appropriations – summarizes the level of federal FY03 funds identified in the White House Report as appropriated to programming in the content area.

Summary of what works – provides an evidenced-based summary of programs that work within each content area. It should be noted that the programs summarized here are not necessarily federally funded or national in scope. Appendix B, Table 4 presents a cross-index of evaluated programs and the characteristics that work for a given content area. Throughout the Summary of What Works sections, applicable programs are denoted with abbreviated program names. Refer to Appendix E, Program Reference List for complete program evaluation references.

This evaluation review includes experimental, quasi-experimental and non-experimental studies. The review of studies included experimental program evaluations that had been through peer review or that were included in official Government reports. The evidence-based best practice guidelines include experimental studies presented in three columns: "What Works," that is, studies that have shown positive impacts on the adolescent outcome in question; "What Doesn't Work," that is, studies that have shown no impact or a negative impact on the adolescent outcome in question; and "Mixed Findings." The best practice guidelines include "Best Bets"– or promising practices – from non-experimental studies, including quasi-experimental studies and multivariate, longitudinal research, in addition to wisdom from the practice field.

There are several reasons for this differentiation. One reason is that there are so few experimental studies at this point in time that it is difficult to be useful if we limit our knowledge base solely to experimental studies. The second reason is that, while there is a lot of "poor" research that does not meet the methodology selection criteria, there exist strong multivariate, longitudinal research that can inform policy and practice. Thirdly, there are intelligent people working in programs and policy fields who have good ideas that deserve consideration although this information represents a different type of knowledge than the knowledge that results from experimental studies. Evaluation results are separated into columns labeled: Experimental and Non-experimental. (To view the full series of What Works tables visit the Child Trends website http://www.childtrends.org).

We additionally recognize that our review of adolescent health programs is not in any way an exhaustive review. Due to the difficulties discussed within this report regarding locating programs funded by federal agencies, we conclude that it would be near impossible to conduct a truly exhaustive review as there would be no way to know if any programs were being excluded.

Table 1. DHHS-funded Programs by Seven Content Areas

	Seven Content Areas						
Program Name	**Health and Well Being**	**Fitness**	**Family & Peer**	**School Environment**	**Alcohol**	**Smoking**	**Violence**
Alcohol Research Center Grants					X		
Alcohol Research Programs					X		
Circles of Care	X		X				
Community Based Family Resource and Support Program	X		X				X
Community Initiated Interventions	X	X	X	X	X	X	X
Community Services Block Grant	X	X	X	X	X		X
Community Youth Mental Health Promotion and Violence/Substance Abuse Prevention	X		X	X	X		X
Comprehensive Community Mental Health Services Program for Children and Their Families	X		X				
Consolidated Health Centers	X	X	X	X			
Cooperative Agreements for Strengthening Communities in the Development of Comprehensive Drug and Alcohol Treatment Systems for Youth	X		X		X		X
Development of Comprehensive Drug/Alcohol and Mental Health Treatment Systems for Persons Who Are Homeless	X		X		X		
Drug Abuse Research Programs					X		
Family Support (PNS)	X		X				
Girl Power!	X				X		
Grants to Improve the Quality and Availability for Residential Treatment and its Continuing Care Component for Adolescents	X		X		X		X
Healthy Schools Healthy Communities	X	X	X	X	X		X
Hispanic Latino Boys and their Fathers			X		X		
Hotline Evaluation and Linkage Program	X						
Injury Prevention and Control Research	X		X	X			X
Integrated health and behavioral health care for children, adolescents, and their families	X		X		X		

Table 1. DHHS-funded Programs by Seven Content Areas (Cont.)

	Seven Content Areas						
Program Name	**Health and Well Being**	**Fitness**	**Family & Peer**	**School Environment**	**Alcohol**	**Smoking**	**Violence**
Maternal and Child Health Block Grant	X		X				
Mental Health Block Grant	X						
Mental Health Research Grants	X						
Mentoring and Family Strengthening	X		X	X	X		X
National Academic Centers for Excellence on Youth Violence Prevention	X		X	X			X
National Adolescent Health Information Center; Adolescent Health Center for State Maternal and Child Health Personnel	X		X		X	X	X
National Association for Children of Alcoholics	X		X		X		
National Bone Health Campaign	X	X	X	X			
National Clearinghouse on Alcohol and Drug Information	X		X	X	X	X	
National Suicide Prevention Resource Center	X		X	X			
National Youth Sports Program	X	X	X	X	X	X	X
National Youth Violence Prevention Resource Center	X		X	X			X
Parenting is Prevention/National Families in Action	X		X	X	X		X
Policy Research and Evaluation Grants	X	X	X	X			X
Practice Improvement Collaborative	X		X		X		X
Prevention of Underage Alcohol Use	X		X	X	X	X	X
Prevention Research Centers Program	X	X	X				
Projects of National Significance	X		X				
Promoting Safe and Stable Families	X		X		X		X
Regional Alcohol and Drug Awareness Resource Network (part of NCADI contract)					X		
Runaway and Homeless Youth - Basic Center program	X		X	X	X		X

Table 1. DHHS-funded Programs by Seven Content Areas (Cont.)

	Seven Content Areas						
Program Name	**Health and Well Being**	**Fitness**	**Family & Peer**	**School Environment**	**Alcohol**	**Smoking**	**Violence**
Runaway and Homeless Youth - State Collaboration/Demonstration Grants for Positive Youth Development	X	X	X	X	X		X
Runaway and Homeless Youth - Transitional Living Program and Maternity Group Homes	X	X	X	X	X	X	X
Runaway and Homeless Youth/Education and Prevention Grants to Reduce Sexual Abuse of Runaway, Homeless and Street Youth: Street Outreach Program	X	X	X	X	X		X
Rural Health Outreach Grant Program	X		X				
School Guidelines and Related Activities of National Strategy for Suicide Prevention	X		X	X			X
Social Economic Development Strategies	X		X				
Social Services Block Grant	X		X				X
Social Services Research and Demonstration program	X		X				
Soy Unica Soy Latina Hispanic Initiative	X		X	X	X	X	X
State Incentive Grants Discretionary Program	X		X	X	X	X	
Statewide Family Networks	X		X				
Substance Abuse Prevention and Treatment Block Grant	X	X	X	X	X	X	X
Substance Abuse Prevention and Treatment Block Grant/Prevention Set-Aside	X		X	X	X	X	
Targeted Capacity Expansion - Prevention and Early Intervention	X		X	X			
Tobacco Control Program	X		X	X		X	
Youth Violence Prevention Program	X		X	X			X
Totals	**52**	**12**	**49**	**28**	**31**	**11**	**27**

NOTE: Categorization within the seven content areas is primarily based upon the program goals cited in the White House Report. Therefore, imprecise categorization may be the result of reporting instruments and ambiguous definitions used for the compilation of that report. However, as noted previously, the White House Report has been determined to be the best available source of DHHS-funded adolescent health program information.

A. Health & Well-Being

Summary of Program Types:

Programs categorized as **Health & Well-Being** include any program trying to influence the physical or mental health of the youth. As shown in Table 2, 52 of the 57 DHHS funded programs analyzed are categorized as focusing on **Health & Well-Being,**[3] the most out of any other category. Refer to Appendix B, Table 1 for a detailed description of these programs. Nearly all (48) of these programs were also categorized as **Family & Peer**; 28 as **School Environment,** 27 as **Violence**; 26 as **Alcohol;** 12 as **Fitness,** and 11 as **Smoking**. All serve disadvantaged youth, though some target specific populations (e.g., adolescents with a drug problem, abused youth, medically underserved youth, adolescent Latinas, adolescent Latino boys and their fathers, homeless youth and Native American youth).

Programs fund a wide range of services, such as mental health research grants, residential treatment services for youth with alcohol/drug problems, transitional living projects for homeless and runaway youth, the support of health centers (e.g. community based, school based), the promotion of health access in rural areas, and the promotion of a stable family unit (e.g. preventing unnecessary separations and promoting adoption or permanent placements).

Six programs are clearinghouse/resources, four are campaigns and the rest are a combination of collaboratives/networks, policy/associations, initiatives and service delivery programs. The clearinghouse/resources provide information on violence, substance abuse prevention and treatment, suicide prevention and general adolescent health. The campaigns focus on alcohol prevention, the promotion of bone health for girls, health messages targeted to the unique needs, interests and challenges of adolescent females, as well as a bilingual educational campaign aimed at increasing the self-esteem of adolescent Latinas. The rest address culturally appropriate mental health services for Native American youth, advocacy for children and families affected by alcoholism, a service delivery program which combines physical fitness activities, nutritional teaching and academic services for low-income youth, and a collaborative that promotes effective community based alcohol treatment.

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[3] From White House Report Appendix G; Federal Youth-serving Program with Program Goals: Address homelessness/runaway youth; Prevent and/or reduce neglect/abuse/exploitation; Promote healthy development of children/families; Provide after-school care; Provide character education; Provide day care; Provide mentoring services; Provide social services (foster care, adoption); Provide youth developmental activities; Reduce juvenile delinquency or gang participation; Reduce juvenile delinquency or gang participation; Reduce/eliminate poverty; Serve victims of child abuse and neglect.

Table 2. DHHS-funded Health & Well-Being Programs by Seven Content Areas

	Seven Content Areas						
Program Name	**Health and Well Being**	**Fitness**	**Family & Peer**	**School Environment**	**Alcohol**	**Smoking**	**Violence**
Circles of Care	X		X				
Community Based Family Resource and Support Program	X		X				X
Community Initiated Interventions	X	X	X	X	X	X	X
Community Services Block Grant	X	X	X	X	X		X
Community Youth Mental Health Promotion and Violence/Substance Abuse Prevention	X		X	X	X		X
Comprehensive Community Mental Health Services Program for Children and Their Families	X		X				
Consolidated Health Centers	X	X	X	X			
Cooperative Agreements for Strengthening Communities in the Development of Comprehensive Drug and Alcohol Treatment Systems for Youth	X		X		X		X
Development of Comprehensive Drug/Alcohol and Mental Health Treatment Systems for Persons Who Are Homeless	X		X		X		
Family Support (PNS)	X		X				
Girl Power!	X				X		
Grants to Improve the Quality and Availability for Residential Treatment and its Continuing Care Component for Adolescents	X		X		X		X
Healthy Schools Healthy Communities	X	X	X	X	X		X
Hotline Evaluation and Linkage Program	X						
Injury Prevention and Control Research	X		X	X			X
Integrated health and behavioral health care for children, adolescents, and their families	X		X		X		
Maternal and Child Health Block Grant	X		X				
Mental Health Block Grant	X						
Mental Health Research Grants	X						

Table 2. DHHS-funded Health & Well-Being Programs by Seven Content Areas (Cont.)

	Seven Content Areas						
Program Name	**Health and Well Being**	**Fitness**	**Family & Peer**	**School Environment**	**Alcohol**	**Smoking**	**Violence**
Mentoring and Family Strengthening	X		X	X	X		X
National Academic Centers for Excellence on Youth Violence Prevention	X		X	X			X
National Adolescent Health Information Center; Adolescent Health Center for State Maternal and Child Health Personnel	X		X		X	X	X
National Association for Children of Alcoholics	X		X		X		
National Bone Health Campaign	X	X	X	X			
National Clearinghouse on Alcohol and Drug Information	X		X	X	X	X	
National Suicide Prevention Resource Center	X		X	X			
National Youth Sports Program	X	X	X	X	X	X	X
National Youth Violence Prevention Resource Center	X		X	X			X
Parenting is Prevention/National Families in Action	X		X	X	X		X
Policy Research and Evaluation Grants	X	X	X	X			X
Practice Improvement Collaborative	X		X		X		X
Prevention of Underage Alcohol Use	X		X	X	X	X	X
Prevention Research Centers Program	X	X	X				
Projects of National Significance	X		X				
Promoting Safe and Stable Families	X		X		X		X
Runaway and Homeless Youth - Basic Center program	X		X	X	X		X
Runaway and Homeless Youth - State Collaboration/Demonstration Grants for Positive Youth Development	X	X	X	X	X		X
Runaway and Homeless Youth - Transitional Living Program and Maternity Group Homes	X	X	X	X	X	X	X

Table 2. DHHS-funded Health & Well-Being Programs by Seven Content Areas (Cont.)

	Seven Content Areas						
Program Name	**Health and Well Being**	**Fitness**	**Family & Peer**	**School Environment**	**Alcohol**	**Smoking**	**Violence**
Runaway and Homeless Youth/Education and Prevention Grants to Reduce Sexual Abuse of Runaway, Homeless and Street Youth: Street Outreach Program	X	X	X	X	X		X
Rural Health Outreach Grant Program	X		X				
School Guidelines and Related Activities of National Strategy for Suicide Prevention	X		X	X			X
Social Economic Development Strategies	X		X				
Social Services Block Grant	X		X				X
Social Services Research and Demonstration program	X		X				
Soy Unica Soy Latina Hispanic Initiative	X		X	X	X	X	X
State Incentive Grants Discretionary Program	X		X	X	X	X	
Statewide Family Networks	X		X				
Substance Abuse Prevention and Treatment Block Grant	X	X	X	X	X	X	X
Substance Abuse Prevention and Treatment Block Grant/Prevention Set-Aside	X		X	X	X	X	
Targeted Capacity Expansion - Prevention and Early Intervention	X		X	X			
Tobacco Control Program	X		X	X		X	
Youth Violence Prevention Program	X		X	X			X
Totals	**52**	**12**	**48**	**28**	**26**	**11**	**27**

NOTE: Categorization within the seven content areas is primarily based upon the program goals cited in the White House Report. Therefore, imprecise categorization may be the result of reporting instruments and ambiguous definitions used for the compilation of that report. However, as noted previously, the White House Report has been determined to be the best available source of DHHS-funded adolescent health program information.

Level of Appropriations as Identified in the White House Report:

FY 2003 appropriations range from $100,000 per program (Girl Power! and Soy Unica, Soy Latina Hispanic Initiative) to $1700 million (Social Services Block Grant), with a median of $13.9 million dollars. Appropriations were unavailable for 10 of the programs.

Summary of What Works for Health & Well-Being:[4]

Past evaluations of programs pertaining to Health & Well-Being reveal several important lessons on what works. Among experimentally evaluated programs that significantly improved Health & Well-Being, policy directives and curriculum-based programs seemed to most reliably produce positive change in adolescents' lifestyles [MTO, PYDP, MTO, WTE]. Programs which were generally more intensive Government- or community-funded programs tended to also produce more positive outcomes for adolescents [CAS-Carerra, MTO, PYDP, RY, WTE]. School and community programs which addressed the individual (even if it was as a member of a family or a school) were generally successful in making gains on indicators of both physical and mental health [AA, BBBS, CAS-Carrera, RY]. Some indicators of health & well-being which evaluated programs have been shown to affect include: fewer depressive symptoms [MTO, RY], lower levels of eating disorders [WTE], lower levels of problem behaviors [MTO, RY], better coping skills [PYDP], and improved mental health [MTO].

B. Fitness

Summary of Program Types:

Programs categorized as **Fitness** address nutrition, diet and exercise. As shown in Table 3, of the 57 DHHS funded programs analyzed, 12 are categorized as focusing on **Fitness**[5], though there is overlap with other program categories. Refer to Appendix B, Table 1 for a detailed description of these programs. All of these programs were also categorized as **Health & Well-being**; as well as **Family & Peer**; 11 as **School Environment**; 8 as **Alcohol** and 9 as **Violence**; and 4 as **Smoking**. All serve disadvantaged youth, though some specifically target medically underserved, at risk, or homeless youth.

The programs fund a wide range of services, including community health centers, school-based health centers, youth development strategies and service delivery to runaway and homeless youth, and two support research/research centers (e.g. policy and chronic health research). One is a social marketing campaign aimed at improving optimal bone health among

[4] Throughout the Summary of What Works sections, applicable programs are denoted with abbreviated program names. Refer to Appendix E, Program Reference List for complete program evaluation references.

[5] From White House Report Appendix G; Federal Youth-serving Program with Program Goals: Prevent/treat chronic diseases; Promote good nutrition/address obesity.

females aged 9-12. Two are service delivery programs that combine physical fitness activities, nutritional teaching and academic services (e.g. education and career planning) for older children and low-income youth (requiring that 90 percent of participants meet U.S. poverty guidelines).

Table 3. DHHS-funded Fitness Programs by Seven Content Areas

	Seven Content Areas						
Program Name	**Health and Well Being**	**Fitness**	**Family & Peer**	**School Environment**	**Alcohol**	**Smoking**	**Violence**
Community Initiated Interventions	X	X	X	X	X	X	X
Community Services Block Grant	X	X	X	X	X		X
Consolidated Health Centers	X	X	X	X			
Healthy Schools Healthy Communities	X	X	X	X	X		X
National Bone Health Campaign	X	X	X	X			
National Youth Sports Program	X	X	X	X	X	X	X
Policy Research and Evaluation Grants	X	X	X	X			X
Prevention Research Centers Program	X	X	X				
Runaway and Homeless Youth - State Collaboration/Demonstration Grants for Positive Youth Development	X	X	X	X	X		X
Runaway and Homeless Youth - Transitional Living Program and Maternity Group Homes	X	X	X	X	X	X	X
Runaway and Homeless Youth/Education and Prevention Grants to Reduce Sexual Abuse of Runaway, Homeless and Street Youth: Street Outreach Program	X	X	X	X	X		X
Substance Abuse Prevention and Treatment Block Grant	X	X	X	X	X	X	X
Totals	**12**	**12**	**12**	**11**	**8**	**4**	**9**

NOTE: Categorization within the seven content areas is primarily based upon the program goals cited in the White House Report. Therefore, imprecise categorization may be the result of reporting instruments and ambiguous definitions used for the compilation of that report. However, as noted previously, the White House Report has been determined to be the best available source of DHHS-funded adolescent health program information.

Level of Appropriations as Identified in the White House Report:

FY 2003 appropriations range from $1.6 million (State Youth Development Collaboration Projects) to $1504.8 million (Consolidated Health Centers), with a median of $21 million dollars Appropriations were unavailable for three of the programs.

Summary of What Works for Fitness:[6]

Past evaluations of programs pertaining to fitness reveal several important lessons on what works. Curriculum-based programs have been shown to be effective in promoting physical fitness and good diets among adolescents [CATCH, MHHP, SAHHP, WTE]. Programs that were provided in schools and encouraged physical exercise and the selection of healthy foods and snacks as part of a nutritious and regular diet were found to improve such indicators as adolescent heart rates [CATCH, SAHHP], hours of weekly exercise [SAHHP, MHHP], eating habits [SAHHP, WTE], rates of eating disorders [WTE].

C. Family & Peer

Summary of Program Types:

Family & Peer Relationships address programs dealing with aspects of the youth's relationship with family members and/or peers, as well as family functioning as a whole. As shown in Table 4, of the 57 DHHS funded programs analyzed, 49 are categorized as focusing on **Family & Peer**[7], though there is overlap with other program categories. Refer to Appendix B, Table 1 for a detailed description of these programs. Nearly all (48) of these programs were also categorized as **Health & Well-Being**; 28 as **School Environment,** 27 as **Violence**; 26 as **Alcohol;** 12 as **Fitness,** and 11 as **Smoking**. All serve disadvantaged youth, though some target specific populations (e.g., adolescents with a drug problem, abused youth, medically underserved youth, adolescent Latinas, adolescent Latino boys and their fathers, homeless youth and Native American youth).

Programs fund a wide range of services, such as systems of care to meet the needs of children with serious emotional disorders and their families, the promotion of a stable family unit (e.g. preventing unnecessary separations and promoting adoption or permanent placements), the expansion or enhancement of comprehensive state-wide systems of family resource and support systems (to prevent child abuse and neglect), to increase the financial self-sufficiency of families, and to provide support and assistance to families of youth with serious emotional disturbances. Six programs are clearinghouse/resources, three are campaigns and the rest are a combination of collaboratives/networks, policy/associations, initiatives and service delivery

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[6] Throughout the Summary of What Works sections, applicable programs are denoted with abbreviated program names. Refer to Appendix E, Program Reference List for complete program evaluation references.

[7] From White House Report Appendix G; Federal Youth-serving Program with Program Goals: Address homelessness/runaway youth; Prevent and/or reduce neglect/abuse/exploitation; Promote healthy development of children/families; Provide after-school care; Provide character education; Provide day care; Provide mentoring services; Provide social services (foster care, adoption); Provide youth developmental activities; Reduce juvenile delinquency or gang participation; Reduce juvenile delinquency or gang participation; Reduce/eliminate poverty; Serve victims of child abuse and neglect.

programs. The clearinghouse/resources provide information on violence, substance abuse prevention and treatment, suicide prevention and the traumatic impact of suicide on family and friends, and general adolescent health. The campaigns focus on the promotion of bone health for girls, alcohol prevention, as well as a bilingual educational campaign aimed at adolescent Latinas and their caregivers to increase self-esteem, mental health, decision-making and assertiveness skills. The rest address culturally appropriate mental health services for Native American youth, advocacy for children and families affected by alcoholism, substance abuse prevention for Latino boys and their fathers, a service delivery program which combines physical fitness activities, nutritional teaching and academic services for low-income youth, and a collaborative that promotes effective community based alcohol treatment.

Table 4. DHHS-funded Family & Peer Relationship Programs by Seven Content Areas

	Seven Content Areas						
Program Name	**Health and Well Being**	**Fitness**	**Family & Peer**	**School Environment**	**Alcohol**	**Smoking**	**Violence**
Circles of Care	X		X				
Community Based Family Resource and Support Program	X		X				X
Community Initiated Interventions	X	X	X	X	X	X	X
Community Services Block Grant	X	X	X	X	X		X
Community Youth Mental Health Promotion and Violence/Substance Abuse Prevention	X		X	X	X		X
Comprehensive Community Mental Health Services Program for Children and Their Families	X		X				
Consolidated Health Centers	X	X	X	X			
Cooperative Agreements for Strengthening Communities in the Development of Comprehensive Drug and Alcohol Treatment Systems for Youth	X		X		X		X
Development of Comprehensive Drug/Alcohol and Mental Health Treatment Systems for Persons Who Are Homeless	X		X		X		
Family Support (PNS)	X		X				
Grants to Improve the Quality and Availability for Residential Treatment and its Continuing Care Component for Adolescents	X		X		X		X
Healthy Schools Healthy Communities	X	X	X	X	X		X
Hispanic Latino Boys and their Fathers			X		X		
Injury Prevention and Control Research	X		X	X			X
Integrated health and behavioral health care for children, adolescents, and their families	X		X		X		
Maternal and Child Health Block Grant	X		X				
Mentoring and Family Strengthening	X		X	X	X		X
National Academic Centers for Excellence on Youth Violence Prevention	X		X	X			X

Table 4. DHHS-funded Family & Peer Relationship Programs by Seven Content Areas (Cont.)

	Seven Content Areas						
Program Name	**Health and Well Being**	**Fitness**	**Family & Peer**	**School Environment**	**Alcohol**	**Smoking**	**Violence**
National Adolescent Health Information Center; Adolescent Health Center for State Maternal and Child Health Personnel	X		X		X	X	X
National Association for Children of Alcoholics	X		X		X		
National Bone Health Campaign	X	X	X	X			
National Clearinghouse on Alcohol and Drug Information	X		X	X	X	X	
National Suicide Prevention Resource Center	X		X	X			
National Youth Sports Program	X	X	X	X	X	X	X
National Youth Violence Prevention Resource Center	X		X	X			X
Parenting is Prevention/National Families in Action	X		X	X	X		X
Policy Research and Evaluation Grants	X	X	X	X			X
Practice Improvement Collaborative	X		X		X		X
Prevention of Underage Alcohol Use	X		X	X	X	X	X
Prevention Research Centers Program	X	X	X				
Projects of National Significance	X		X				
Promoting Safe and Stable Families	X		X		X		X
Runaway and Homeless Youth - Basic Center program	X		X	X	X		X
Runaway and Homeless Youth - State Collaboration/Demonstration Grants for Positive Youth Development	X	X	X	X	X		X
Runaway and Homeless Youth - Transitional Living Program and Maternity Group Homes	X	X	X	X	X	X	X
Runaway and Homeless Youth/Education and Prevention Grants to Reduce Sexual Abuse of Runaway, Homeless and Street Youth: Street Outreach Program	X	X	X	X	X		X

Table 4. DHHS-funded Family & Peer Relationship Programs by Seven Content Areas (Cont.)

	Seven Content Areas						
Program Name	**Health and Well Being**	**Fitness**	**Family & Peer**	**School Environment**	**Alcohol**	**Smoking**	**Violence**
Rural Health Outreach Grant Program	X		X				
School Guidelines and Related Activities of National Strategy for Suicide Prevention	X		X	X			X
Social Economic Development Strategies	X		X				
Social Services Block Grant	X		X				X
Social Services Research and Demonstration program	X		X				
Soy Unica Soy Latina Hispanic Initiative	X		X	X	X	X	X
State Incentive Grants Discretionary Program	X		X	X	X	X	
Statewide Family Networks	X		X				
Substance Abuse Prevention and Treatment Block Grant	X	X	X	X	X	X	X
Substance Abuse Prevention and Treatment Block Grant/Prevention Set-Aside	X		X	X	X	X	
Targeted Capacity Expansion - Prevention and Early Intervention	X		X	X			
Tobacco Control Program	X		X	X		X	
Youth Violence Prevention Program	X		X	X			X
Totals	**48**	**12**	**49**	**28**	**26**	**11**	**27**

NOTE: Categorization within the seven content areas is primarily based upon the program goals cited in the White House Report. Therefore, imprecise categorization may be the result of reporting instruments and ambiguous definitions used for the compilation of that report. However, as noted previously, the White House Report has been determined to be the best available source of DHHS-funded adolescent health program information.

Level of Appropriations as Identified in the White House Report:

FY 2003 appropriations range from $100,000 per program (Soy Unica, Soy Latina Hispanic Initiative) to $1700 million (Social Services Block Grant), with a median of $13.9 million dollars. Appropriations were unavailable for nine of the programs.

Summary of What Works for Family & Peer Relationships:[8]

Past evaluations of programs pertaining to family & peer relationships reveal several important lessons on what works. Among experimentally evaluated programs that significantly

[8] Throughout the Summary of What Works sections, applicable programs are denoted with abbreviated program names. Refer to Appendix E, Program Reference List for complete program evaluation references.

improved family & peer relationships, mentoring and curriculum-based programs [AA, BBBS, CA], programs which provide parent training [ATP, LIFT], or programs that provide adolescents with situations in which they can practice their social skills [CDP, SDP], have been shown to be effective. Non-experimental evaluations indicate that service learning/civic engagement programs may also have positive effects on attitudes towards working with others and on being more accepting of cultural diversity [LSA, PWMP]. Programs that address family & peer relationships included federally funded, regional/state funded and privately funded programs. Programs ranged in size and were offered in a variety of locations including schools, program sites, and as part of community wide initiatives. Programs with large minority populations (over 50 percent) [AA, ACP, BBBS, CA] or special culturally related features (such as bilingual lessons [SS] or specific versions of the program targeted at specific minority populations [ISFP]) have also been tried in the field and found to be capable of producing significant effects on family & peer relationships.

D. School Environment

Summary of Program Types:

School Environment pertains to programs that address academic success and other contributing factors related to the youth's life as a student. As shown in Table 5, of the 57 DHHS funded programs being analyzed, 28 are categorized as focusing on **School Environment**[9], though there is overlap with other program categories. Refer to Appendix B, Table 1 for a detailed description of these programs. All of these programs were also classified as **Family & Peer** and **Health & Well-Being**, 20 were categorized as **Violence**, 17 as **Alcohol**, 11 as **Fitness** and 10 as **Smoking**. All serve disadvantaged youth, though some target specific populations (e.g. high-risk youth, Latinas, adolescent females, runaway/homeless youth and their families, medically underserved youth).

The programs fund diverse projects, including the development and operation of school based health centers, a national network of health centers (including community and school based health centers) and the identification and development of youth development strategies for states, coalition based mental health programs, street based services to runaway/homeless youth subjected to sexual exploitation, and the implementation of evidence based youth violence prevention. Five of the programs are clearinghouse/resources, three are campaigns and one is a service delivery program. The clearinghouse/resources provide information on violence, suicide prevention and the traumatic impact it has on family and friends, and tools and

[9] From White House Report Appendix G; Federal Youth-serving Program with Program Goals: Improve academic performance; Provide after-school care; Provide youth developmental activities; Reduce the dropout rate; Reduce/eliminate school violence.

information geared towards parents/caregivers to strengthen families (e.g. adoption, permanent living situations). The campaigns focus on the promotion of bone health for girls, the development alcohol prevention strategies and programs, as well as a bilingual educational campaign aimed at increasing the self-esteem of adolescent Latinas. The service delivery program combines physical fitness activities, nutritional teaching and academic services for low-income youth.

Table 5. DHHS-funded School Environment Programs by Seven Content Areas

	Seven Content Areas						
Program Name	**Health and Well Being**	**Fitness**	**Family & Peer**	**School Environment**	**Alcohol**	**Smoking**	**Violence**
Community Initiated Interventions	X	X	X	X	X	X	X
Community Services Block Grant	X	X	X	X	X		X
Community Youth Mental Health Promotion and Violence/Substance Abuse Prevention	X		X	X	X		X
Consolidated Health Centers	X	X	X	X			
Healthy Schools Healthy Communities	X	X	X	X	X		X
Injury Prevention and Control Research	X		X	X			X
Mentoring and Family Strengthening	X		X	X	X		X
National Academic Centers for Excellence on Youth Violence Prevention	X		X	X			X
National Bone Health Campaign	X	X	X	X			
National Clearinghouse on Alcohol and Drug Information	X		X	X	X	X	
National Suicide Prevention Resource Center	X		X	X			
National Youth Sports Program	X	X	X	X	X	X	X
National Youth Violence Prevention Resource Center	X		X	X			X
Parenting is Prevention/National Families in Action	X		X	X	X		X
Policy Research and Evaluation Grants	X	X	X	X			X
Prevention of Underage Alcohol Use	X		X	X	X	X	X
Runaway and Homeless Youth - Basic Center program	X		X	X	X		X
Runaway and Homeless Youth - State Collaboration/Demonstration Grants for Positive Youth Development	X	X	X	X	X		X
Runaway and Homeless Youth - Transitional Living Program and Maternity Group Homes	X	X	X	X	X	X	X
Runaway and Homeless Youth/Education and Prevention Grants to Reduce Sexual Abuse of Runaway, Homeless and Street Youth: Street Outreach Program	X	X	X	X	X		X

Table 5. DHHS-funded School Environment Programs by Seven Content Areas (Cont.)

	Seven Content Areas						
Program Name	**Health and Well Being**	**Fitness**	**Family & Peer**	**School Environment**	**Alcohol**	**Smoking**	**Violence**
School Guidelines and Related Activities of National Strategy for Suicide Prevention	X		X	X			X
Soy Unica Soy Latina Hispanic Initiative	X		X	X	X	X	X
State Incentive Grants Discretionary Program	X		X	X	X	X	
Substance Abuse Prevention and Treatment Block Grant	X	X	X	X	X	X	X
Substance Abuse Prevention and Treatment Block Grant/Prevention Set-Aside	X		X	X	X	X	
Targeted Capacity Expansion - Prevention and Early Intervention	X		X	X			
Tobacco Control Program	X		X	X		X	
Youth Violence Prevention Program	X		X	X			X
Totals	**28**	**11**	**28**	**28**	**17**	**10**	**20**

NOTE: Categorization within the seven content areas is primarily based upon the program goals cited in the White House Report. Therefore, imprecise categorization may be the result of reporting instruments and ambiguous definitions used for the compilation of that report. However, as noted previously, the White House Report has been determined to be the best available source of DHHS-funded adolescent health program information.

Level of Appropriations as Identified in the White House Report:

FY 2003 appropriations range from $100,000 per program (Soy Unica, Soy Latina Hispanic Initiative) to $1504.8 million (Consolidated Health Centers), with a median of $15.4 million dollars. Appropriations were unavailable for five of the programs.

Summary of What Works for the School Environment:[10]

Past evaluations of programs pertaining to the school environment reveal several important lessons on what works. Programs related to the school environment are extremely varied. Though most programs are offered on an individual or school-wide basis, there are no uniquely targeted population of adolescents and no particular approach that seems to work better than another. Perhaps one of the more surprising factors of what makes a program successful in effecting the school environment is that the program does not necessarily have to take place in a school or be a school-based program [BBBS, CAS-Carerra, UB]. In fact, one-on-one

[10] Throughout the Summary of What Works sections, applicable programs are denoted with abbreviated program names. Refer to Appendix E, Program Reference List for complete program evaluation references.

mentoring programs have been shown to be successful at increasing such indicators as school attendance and academic outlook for the future [AA, BBBS, BGCA]. Other outcomes which were positively influenced by school environment programs were: perceived scholastic competence [BBBS, CAS-Carerra], greater school engagement [BELONG, CA], fewer problem behaviors [BELONG], less disciplinary problems [BELONG], lower dropout rates [CAS-Carerra, RY], increased academic course taking [CA], higher standardized test scores for some subjects [BGCA, CAS-Carerra,] and lower class failure rates [BELONG, TO]. Program participants were not found more likely to participate in extracurricular activities in high school or have significantly higher grades (with only one exception [BBBS]) [CAR, CA, STEP, UB]. Non-experimentally evaluated programs show that strongly focused, long-term academic-oriented programs, high quality mentoring and tutoring programs, and programs which provide service and/or vocational learning to adolescents seem to be best bets for improving the school environment [STEP, SAS, K-12, LAB, CA, AA, BBBS]. Ultimately, the common characteristic which most of the successful programs in this content area shared is a relationship with an adult where the adolescent felt supported in their academic endeavors [AA, BBBS, BGCA, BELONG, RAISE, RY, SAS, STEP, UB, WYDP].

E. Smoking

Summary of Program Types:

Programs categorized as **Smoking** address tobacco use prevention, including delayed initiation programs, resistance skills programs, and programs aimed at altering use patterns. As shown in Table 6, 11 federally funded programs are categorized as focusing on **Smoking**.[11] Refer to Appendix B, Table 1 for a detailed description of these programs. Many of these programs address other content areas. All of the programs were also categorized as **Health & Well-Being** and **Family & Peer.** Ten of the 11 programs were classified as **School Environment** and **Alcohol**. Seven programs overlapped with **Violence** and 4 overlapped with **Fitness**. All serve disadvantaged youth, though some populations are more specifically targeted (e.g. older youth, homeless youth, Latina youth and their caregivers).

Funding areas for the programs vary, including funding and technical assistance for state and territorial health departments which aim to reduce tobacco-related diseases and deaths, development, field-testing and implementation of substance abuse/tobacco prevention, transitional living programs for homeless youth, and treatment and rehabilitation activities directed towards substance abuse. Two of the programs are campaigns, one is a clearinghouse/resource, and the other is a service delivery program. One campaign is a science

[11] From White House Report Appendix G; Federal Youth-serving Program with Program Goals: Reduce/eliminate youth smoking.

based public information initiative that works with communities to develop and conduct underage alcohol prevention programs. The other campaign targets Latina girls and their caregivers to build and enhance decision-making and assertiveness skills and prevent the harmful consequences of alcohol, tobacco and illicit drugs. The clearinghouse/resource provides information (via information services staff, documents and media) about alcohol, tobacco and drug prevention and addiction treatment. The service delivery program combines physical fitness activities, nutritional teaching and academic services (e.g., education and career planning) for older children and low-income youth (requiring that 90 percent of participants meet U.S. poverty guidelines).

Table 6. DHHS-funded Smoking Programs by Seven Content Areas

	Seven Content Areas						
Program Name	**Health and Well Being**	**Fitness**	**Family & Peer**	**School Environment**	**Alcohol**	**Smoking**	**Violence**
Community Initiated Interventions	X	X	X	X	X	X	X
National Adolescent Health Information Center; Adolescent Health Center for State Maternal and Child Health Personnel	X		X		X	X	X
National Clearinghouse on Alcohol and Drug Information	X		X	X	X	X	
National Youth Sports Program	X	X	X	X	X	X	X
Prevention of Underage Alcohol Use	X		X	X	X	X	X
Runaway and Homeless Youth - Transitional Living Program and Maternity Group Homes	X	X	X	X	X	X	X
Soy Unica Soy Latina Hispanic Initiative	X		X	X	X	X	X
State Incentive Grants Discretionary Program	X		X	X	X	X	
Substance Abuse Prevention and Treatment Block Grant	X	X	X	X	X	X	X
Substance Abuse Prevention and Treatment Block Grant/Prevention Set-Aside	X		X	X	X	X	
Tobacco Control Program	X		X	X		X	
Totals	**11**	**4**	**11**	**10**	**10**	**11**	**7**

NOTE: Categorization within the seven content areas is primarily based upon the program goals cited in the White House Report. Therefore, imprecise categorization may be the result of reporting instruments and ambiguous definitions used for the compilation of that report. However, as noted previously, the White House Report has been determined to be the best available source of DHHS-funded adolescent health program information.

Level of Appropriations as Identified in the White House Report:

FY 2003 appropriations range from $100,000 per program (Soy Unica, Soy Latina Hispanic Initiative) to $1403.1 million (Substance Abuse Prevention and Treatment Block Grant), with a median of $50.7 million. Appropriations were unavailable for two programs.

Summary of What Works for Smoking:[12]

Past evaluations of programs pertaining to smoking reveal several important lessons on what does and does not work. Curriculum-based programs that specifically target risky behaviors such as smoking, drug, and alcohol use have been shown to be effective at reducing the delay the onset of smoking and decrease the amount that adolescents smoke AAPT, LST, ALERT, NORTHLAND, PTNTU, PTNDU. Programs which are solely designed to counteract social influences by enhancing resistance skills and correcting exaggerated perceptions on how common the use of tobacco is were found to be ineffective in combating actual adolescent smoking habits HSPP. Programs that address smoking included federally funded, regional/state funded and privately funded programs. Most programs were Government funded school-based programs which were curriculum-based.

F. Alcohol

Summary of Program Types:

Programs categorized as **Alcohol** address alcohol use, including delayed initiation programs, resistance skills programs, and programs aimed at altering use patterns. As shown in Table 7, 31 DHHS funded programs were categorized as focusing on **Alcohol**.[13] Refer to Appendix B, Table 1 for a detailed description of these programs. A majority of programs also were categorized as **Health & Well-being** (26) and **Family & Peer** (26); 19 were categorized as **Violence;** 17 as **School Environment**. Ten overlapped with **Smoking**, and 8 with **Fitness**. All serve disadvantaged youth, though some have specific target populations (e.g. adolescents with drug and alcohol problems, runaway and street youth, medically underserved youth, Latino males and females).

The program fund a variety of projects, including alcohol and drug related research, the field-testing of substance abuse prevention interventions, cooperative agreements that assist communities to strengthen their drug and alcohol identification, referral and treatment systems for youth, youth development strategy development and promoting stable environments for at-

[12] Throughout the Summary of What Works sections, applicable programs are denoted with abbreviated program names. Refer to Appendix E, Program Reference List for complete program evaluation references.

risk youth. Three programs are campaigns, and the rest are a combination of clearinghouse/resources, collaborative/networks, initiatives, policy/associations, and programs. The campaigns focused on developing and implementing communication strategies to combat misinformation about alcohol use youth get from peers, role models and the media, targeting health messages to the unique needs, interests and challenges of females, and preventing harmful consequences of alcohol, tobacco and other drugs among adolescent Latinas. The clearinghouse/resource programs provide information about substance abuse prevention and addiction treatment, as well as resources to assist caregivers in raising healthy and drug-free adolescents. The collaborative/networks support and promote effective and efficient community-based treatment for substance abuse, and strengthen the substance abuse prevention organizational network. The initiative addressing substance abuse prevention for Latino males and their fathers; the policy/association advocates for all children and their families affected by alcoholism and other drug abuse; and the service delivery program combines physical fitness activities, nutritional teaching and academic services for older children and low-income youth.

[13] From White House Report Appendix G; Federal Youth-serving Program with Program Goals: Eliminate or reduce substance abuse; Enforce underage drinking laws; Prevent substance abuse; Treat substance abusers.

Table 7. DHHS-funded Alcohol Programs by Seven Content Areas

	Seven Content Areas						
Program Name	**Health and Well Being**	**Fitness**	**Family & Peer**	**School Environment**	**Alcohol**	**Smoking**	**Violence**
Alcohol Research Center Grants					X		
Alcohol Research Programs					X		
Community Initiated Interventions	X	X	X	X	X	X	X
Community Services Block Grant	X	X	X	X	X		X
Community Youth Mental Health Promotion and Violence/Substance Abuse Prevention	X		X	X	X		X
Cooperative Agreements for Strengthening Communities in the Development of Comprehensive Drug and Alcohol Treatment Systems for Youth	X		X		X		X
Development of Comprehensive Drug/Alcohol and Mental Health Treatment Systems for Persons Who Are Homeless	X		X		X		
Drug Abuse Research Programs					X		
Girl Power!	X				X		
Grants to Improve the Quality and Availability for Residential Treatment and its Continuing Care Component for Adolescents	X		X		X		X
Healthy Schools Healthy Communities	X	X	X	X	X		X
Hispanic Latino Boys and their Fathers			X		X		
Integrated health and behavioral health care for children, adolescents, and their families	X		X		X		
Mentoring and Family Strengthening	X		X	X	X		X
National Adolescent Health Information Center; Adolescent Health Center for State Maternal and Child Health Personnel	X		X		X	X	X
National Association for Children of Alcoholics	X		X		X		
National Clearinghouse on Alcohol and Drug Information	X		X	X	X	X	
National Youth Sports Program	X	X	X	X	X	X	X
Parenting is Prevention/National Families in Action	X		X	X	X		X

Table 7. DHHS-funded Alcohol Programs by Seven Content Areas (Cont.)

	Seven Content Areas						
Program Name	**Health and Well Being**	**Fitness**	**Family & Peer**	**School Environment**	**Alcohol**	**Smoking**	**Violence**
Practice Improvement Collaborative	X		X		X		X
Prevention of Underage Alcohol Use	X		X	X	X	X	X
Promoting Safe and Stable Families	X		X		X		X
Regional Alcohol and Drug Awareness Resource Network (part of NCADI contract)					X		
Runaway and Homeless Youth - Basic Center program	X		X	X	X		X
Runaway and Homeless Youth - State Collaboration/Demonstration Grants for Positive Youth Development	X	X	X	X	X		X
Runaway and Homeless Youth - Transitional Living Program and Maternity Group Homes	X	X	X	X	X	X	X
Runaway and Homeless Youth/Education and Prevention Grants to Reduce Sexual Abuse of Runaway, Homeless and Street Youth: Street Outreach Program	X	X	X	X	X		X
Soy Unica Soy Latina Hispanic Initiative	X		X	X	X	X	X
State Incentive Grants Discretionary Program	X		X	X	X	X	
Substance Abuse Prevention and Treatment Block Grant	X	X	X	X	X	X	X
Substance Abuse Prevention and Treatment Block Grant/Prevention Set-Aside	X		X	X	X	X	
Totals	**26**	**8**	**26**	**17**	**31**	**10**	**19**

NOTE: Categorization within the seven content areas is primarily based upon the program goals cited in the White House Report. Therefore, imprecise categorization may be the result of reporting instruments and ambiguous definitions used for the compilation of that report. However, as noted previously, the White House Report has been determined to be the best available source of DHHS-funded adolescent health program information.

Level of Appropriations as Identified in the White House Report:

FY 2003 appropriations ranged from $100,000 per program (Girl Power!, and Soy Unica, Soy Latina Hispanic Initiative) to $1403.1 million (Substance Abuse Prevention and Treatment Block Grant), with a median of $12.1 million. Appropriations were unavailable for seven of the programs.

Summary of What Works for Alcohol:[14]

Past evaluations of programs pertaining to alcohol reveal several important lessons on what works. Curriculum-based programs that specifically target risky behaviors such as smoking, drug, and alcohol use have been shown to be effective at delaying the initiation of drinking [AA, AAPT, BBBS, CLC, NORTHLAND], decreasing drunk driving behaviors [AMPS, CMCA,] reducing the frequency and amount of alcohol minors consume [AAPT, CLC, PTNDU, RY], and reduce other risky behaviors associated with alcohol consumption [AA, LST, PIP]. Non-experimental programs found that high involvement with mentors and programs which incorporate cultural enrichment, health and physical education, social recreation, personal and educational development, citizenship, and leadership development may also help to prevent alcohol abuse [AA, BGCA]. Mentoring, community service, policy directives, and media campaigns were also methods used with some success to address adolescent alcohol use. Evaluated programs that address alcohol included federally funded, regional/state funded and privately funded programs. Most programs were Government funded school-based programs which were curriculum-based.

G. Violence

Summary of Program Types:

Programs categorized as **Violence** focus on any aspect of violence prevention and awareness, including juvenile delinquency, child abuse and neglect, bullying, and gang participation. As shown in Table 8, 27 of the DHHS funded programs were categorized as focusing on **Violence**.[15] Refer to Appendix B, Table 1 for a detailed description of these programs. All of the programs were also categorized as **Family & Peer** and **Health & Well-being**; 20 were categorized as **School Environment**; 19 as **Alcohol**; 9 as **Fitness** and 7 as **Smoking**. All serve disadvantaged youth, though some specifically target underserved youth (e.g. those who are low income, medically underserved, at risk, or homeless).

The programs fund a variety of projects, including academic centers that work with communities to address youth violence, the prevention of child abuse and neglect, promoting stable environments for at-risk youth, providing transitional housing for homeless youth, youth development strategy development, and the implementation of evidence based violence prevention, intervention and treatment services. Two are campaigns, three are

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[14] Throughout the Summary of What Works sections, applicable programs are denoted with abbreviated program names. Refer to Appendix E, Program Reference List for complete program evaluation references.

[15] From White House Report Appendix G; Federal Youth-serving Program with Program Goals: Address crime and disorder problems; Prevent and/or reduce neglect/abuse/exploitation; Provide treatment for

clearinghouse/resources, one is a collaborative/network, and one was a service delivery program. One campaign is a bilingual public education campaign directed towards Latina girls and their caregivers to build and enhance mental health and decision making skills and prevent harmful consequences of alcohol, tobacco and other drugs. The clearinghouse/resource programs provide information regarding violence prevention and intervention programs, publications and statistics, how to raise healthy and drug-free children, and suicide prevention.

juvenile offenders; Reduce juvenile delinquency or gang participation; Reduce/eliminate school violence; Serve victims of child abuse and neglect.

Table 8. DHHS-funded Violence Programs by Seven Content Areas

	Seven Content Areas						
Program Name	**Health and Well Being**	**Fitness**	**Family & Peer**	**School Environment**	**Alcohol**	**Smoking**	**Violence**
Community Based Family Resource and Support Program	X		X				X
Community Initiated Interventions	X	X	X	X	X	X	X
Community Services Block Grant	X	X	X	X	X		X
Community Youth Mental Health Promotion and Violence/Substance Abuse Prevention	X		X	X	X		X
Cooperative Agreements for Strengthening Communities in the Development of Comprehensive Drug and Alcohol Treatment Systems for Youth	X		X		X		X
Grants to Improve the Quality and Availability for Residential Treatment and its Continuing Care Component for Adolescents	X		X		X		X
Healthy Schools Healthy Communities	X	X	X	X	X		X
Injury Prevention and Control Research	X		X	X			X
Mentoring and Family Strengthening	X		X	X	X		X
National Academic Centers for Excellence on Youth Violence Prevention	X		X	X			X
National Adolescent Health Information Center; Adolescent Health Center for State Maternal and Child Health Personnel	X		X		X	X	X
National Youth Sports Program	X	X	X	X	X	X	X
National Youth Violence Prevention Resource Center	X		X	X			X
Parenting is Prevention/National Families in Action	X		X	X	X		X
Policy Research and Evaluation Grants	X	X	X	X			X
Practice Improvement Collaborative	X		X		X		X
Prevention of Underage Alcohol Use	X		X	X	X	X	X
Promoting Safe and Stable Families	X		X		X		X
Runaway and Homeless Youth - Basic Center program	X		X	X	X		X

Table 8. DHHS-funded Violence Programs by Seven Content Areas (Cont.)

Program Name	Seven Content Areas						
	Health and Well Being	Fitness	Family & Peer	School Environment	Alcohol	Smoking	Violence
Runaway and Homeless Youth - State Collaboration/Demonstration Grants for Positive Youth Development	X	X	X	X	X		X
Runaway and Homeless Youth - Transitional Living Program and Maternity Group Homes	X	X	X	X	X	X	X
Runaway and Homeless Youth/Education and Prevention Grants to Reduce Sexual Abuse of Runaway, Homeless and Street Youth: Street Outreach Program (SOP)	X	X	X	X	X		X
School Guidelines and Related Activities of National Strategy for Suicide Prevention	X		X	X			X
Social Services Block Grant	X		X				X
Soy Unica Soy Latina Hispanic Initiative	X		X	X	X	X	X
Substance Abuse Prevention and Treatment Block Grant	X	X	X	X	X	X	X
Youth Violence Prevention Program	X		X	X			X
Totals	**27**	**9**	**27**	**20**	**19**	**7**	**27**

NOTE: Categorization within the seven content areas is primarily based upon the program goals cited in the White House Report. Therefore, imprecise categorization may be the result of reporting instruments and ambiguous definitions used for the compilation of that report. However, as noted previously, the White House Report has been determined to be the best available source of DHHS-funded adolescent health program information.

Level of Appropriations as Identified in the White House Report:

FY 2003 appropriations ranged from $100,000 per program (Soy Unica, Soy Latina Hispanic Initiative) to $1700 million (Social Services Block Grant), with a median of $15.4 million Appropriations were unavailable for five of the programs.

Summary of What Works for Violence:[16]

Past evaluations of programs pertaining to violence reveal several important lessons on what works. Programs related to youth violence are extremely varied. They are offered in a variety of settings including schools, program sites, and even visits to nursing homes. Most programs have been offered at the individual or school-wide level and were curriculum-based or

mentoring based programs. Funding came from a variety of federal, regional/state, and private mechanisms and no particular populations seemed to be more heavily targeted than others. Programs that were found to work tended to focus on increasing social problem solving, conflict resolution, and general social skills amongst adolescents [ACP, BELONG, PYDP, QOP, RY, SDP]. Outcomes that were affected by violence programs included: increased social skills [ACP, PYDP], increased conflict management [ACP, PYDP], increased anger control [RY], less date violence [SDP], and fewer problem behaviors [BELONG]. Programs varied in producing effects on interactivity with police (arrests, committing crimes, being involved in delinquent activities, etc.). Some programs did not impact interactions with police [CAR, BBBS] while others showed both short- and long-term decreases in the amount of misdemeanors and felonies committed by adolescents [BELONG], as well as other contact with police [QOP].

H. Summary of Results

In this section, we present key findings regarding federally-funded programs and initiatives in seven key content areas that significantly impact adolescent health. In selecting DHHS, we have spotlighted the efforts of the organization with the strongest portfolio and investment in the health arena, although we fully recognize that other federal Departments, for example, the Department of Education and Department of Justice, also make strong investments on behalf of young people. It is important to recognize the contributions of these other Departments, along with DHHS, in improving adolescent health. For example, efforts to reduce violence are noted within DHHS, but are also supported by the Department of Justice. Furthermore, concerns regarding the impact of bullying (an antecedent to violence) and other forms of school violence on educational outcomes have also increased the level of program activity regarding violence prevention by the Department of Education. A broader array of strategies sponsored and funded by different stakeholders is especially timely as emerging research documents the inter-related nature of social, health, educational, economic, and cultural factors that all impact adolescent health and well-being.

The results of this review document the broad array of efforts underway, from direct service programs, research, educational campaigns, professional networks, to resource and technical assistance endeavors that help reach thousands of low-income and underserved

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[16] Throughout the Summary of What Works sections, applicable programs are denoted with abbreviated program names. Refer to Appendix E, Program Reference List for complete program evaluation references.

adolescents. In many of the content areas, such as health & well being and school environment, special groups of adolescents have also been included, including medically indigent, homeless, abused, Latino and Latina, and Native American youth.

An important finding is the combination of activities sponsored by the federal government within each of the content areas. The majority of programs support grants for services or projects. Other funds support resource centers that provide in-depth information on specific content areas and broker information for professionals. Still other funds support research grants and informational campaigns to raise awareness on topics, such as mentoring, and violence prevention. Within the portfolio, there is also a commitment to direct service provision, although it is difficult to ascertain the proportion devoted to these types of programs.

Building on the extensive data collected under the auspices of the White House Task Force on Disadvantaged Youth, this review utilizes the programs identified in its Final Report to frame our discussion on federal efforts to address adolescent health. The review points to the complexity of categorizing these diverse efforts within a specific content area. Within the seven content areas, topics such as health & well being, family & peers, and school environment represent multi-faceted programs and initiatives, many of which also overlap with specific content areas, such as violence, alcohol, and tobacco prevention. Furthermore, under the area of violence prevention, diverse efforts at reducing alcohol and tobacco use were often found to be included. The inclusion of these additional areas may not be readily apparent, but may reflect research findings pertaining to the clustering of adolescent risk-taking behaviors and the necessity of dealing with a variety of risk-taking behaviors simultaneously. Many of the content areas also include a great diversity of additional topics, for example, depression and mental health.

We also found that even under more specific content areas, such as smoking, funding for programs such as transitional living services for homeless youth would also be included, although the relationship to the specific topic area was often difficult to discern. Based on information available through written reports and the Internet descriptions of the programs, the level of coordination and communication across the content areas (even within specific topic areas) is not easily apparent. In other words, overlapping programs within and across the seven areas appear to be occurring, but the level of cross-program communication and information sharing that might be in place was not easy to assess. One possibility is the ability of “resource centers” to play an intermediate role in helping programs become aware of each others’ efforts.

The challenge of narrowly categorizing existing programs within any one specific content area makes a financial analysis of federal investments in each of the content areas difficult. For

example, the range of most investments made in each of the seven areas is from $100,000 to $1,700 million. Within specific content areas there is also a tremendous range of investments, with the average ranging from $13.9 to $50.7 million. There also did not appear to be any relationship between the numbers of programs within each content area and the amount of funding available. For example, in the area of health & well-being, there were 52 different programs in place that pertained to this topic, with an average of $13.9 million dollars per initiative. In contrast, there were fewer programs (11), but higher funding levels (an average of $50.7 million) in the area of smoking. Furthermore, as Health & Well-Being, Family & Peer, and School Environment have such a broad and overlapping mandate with the other content areas, it makes it difficult to comment on the specific dollars devoted to any one topic. For example, 49 of the 57 programs are rated as working in the area Family & Peer programs. Of the 49 programs, over half address school environments and many pertain to violence and alcohol. Far fewer programs are noted as dealing with fitness (12) and smoking (11). Establishing reasonable parameters as to the aim and scope of federally-funded programs in each of these categories is thus challenging, as the "subject content" (e.g. smoking prevention) and the setting (e.g. schools) overlap with relationships, such as family and peers. Thus, while a program's focus may be specifically on the topic of tobacco reduction, clearly many of the programs may be incorporating the issue of relationships, for example, helping young people examine the influence of peer pressure, as well as conducting the programs in a variety of settings, including schools.

It is also often challenging to ascertain the relationship between program evaluation findings and current federal investments and service portfolios. A clear strength of existing programs is the extensive use of school settings where curriculum based initiatives directed at changing individual level behavior has been shown to be effective. This is particularly true of efforts to decrease smoking, alcohol, and violence which appear to have been topics that lend themselves to successful individual level interventions. An interesting finding is that some interventions, such as mentoring programs, appear to have an impact on academic outcomes, even when they are not offered in school settings.

Far less evaluation information is available in terms of initiatives directed at multiple levels - the individual, their family, peers, school and community setting. Some evaluation information, for example, in the area of health & well-being points to the importance of policy directives, yet evaluations that review the impact of supportive federal and state policies have rarely been reported in the literature. Another important finding is the lack of information regarding current evaluation efforts underway within the seven content areas, and whether at a

minimum, existing programs use previously evaluated curricula or other types of successful interventions. Analyzing whether in fact research is being incorporated in new programmatic initiatives would be extremely useful in assuring that the next generation of Government-funded programs benefit from the lessons learned from well-evaluated programs, or at a minimum, best-practices.

IV. Discussion

In this report we review and summarize the available information on adolescent health programs funded by DHHS in seven content areas: health and well-being, fitness, family and peer relationships, school environment, smoking, alcohol use, and violence. Programs reviewed included not only direct service programs but any mechanisms or initiatives officially funded by DHHS that address some dimension of health for youth. The extensive range of programs currently in place under the auspices of different agencies within DHHS clearly demonstrates a strong federal commitment to addressing adolescent health on several levels. Resource allocation and distribution channels, including grants that support direct service programs, funding for national campaigns, resource centers, technical assistance providers, and professional membership and other types of collaboratives focused on specific needs reflect a strong commitment to identifying and prioritizing adolescents at risk and providing them with the necessary information and services.

Although these national efforts are noteworthy and represent an important investment of national resources, we found it difficult to readily access available information on the range of services and funding streams that in fact have been established to promote adolescent health. While our initial search for adolescent health programs yielded a significant number of programs supported by various Government agencies as well as private funders, it was also challenging to ascertain the type of specific information on these programs that would be useful to practitioners, policy makers, and community members. One source that attempts to catalogue the myriad of available information on Government funding of programs is the Catalog of Federal Domestic Assistance (CFDA). However, the CFDA was found to be limited in assessing the level of effort put forth by DHHS to meet the needs of adolescents across the seven content areas for the following reasons:

- The CFDA is intended to track funding, not program implementation.
- Information in the CFDA provides only general program information and does not include information on evaluated outcomes.
- The CFDA only shows recently funded programs. Clearly the Government/DHHS has a long history of funding programs and initiatives pertaining to adolescent health. Using the CFDA, only programs funded in the current year are readily accessible without having to scan thousands of programs for each previous fiscal year. In assessing the level of effort dedicated in a given content area, it is important to have access to previous activities as well as current ones. In addition, it is important for program providers to have access to the history of programs so as to learn from previous efforts.

These difficulties in finding documentation of the existing programs and initiatives within the federal government led us to choose the program information provided in the *White House Task Force for Disadvantaged Youth: Final Report* (White House Task Force for Disadvantaged Youth, 2003) as the basis for review, the source identified as the most comprehensive, best available source of federally funded youth programs. However, efforts to map program information onto the federal financial information contained in the CFDA were problematic. For example, out of the 111 DHHS programs listed in the White House Report, only 35 were found to have current CFDA numbers.

It is true that information regarding the specific programs that receive funding is becoming more readily available through the internet; however, the program information that was publicly available online only begins to draw the picture. Given the current information available, we conclude that it would be near impossible to conduct a truly exhaustive review as there would be no way to know if programs were being excluded. The development of a system to share more specific information about federally funded programs would be a service to the field on several levels – the federal government, state and local governments, program funders, program practitioners, and even program participants. It is important to consider that the information in this report was located after extensive effort by experienced researchers and therefore would likely be more difficult for communities and program professionals to locate.

DHHS, as a whole, has adopted an expanded definition of adolescent health. This is apparent in the diverse topics covered in objectives pertaining to adolescents and young adults set forth in *Healthy People 2010* – a set of 467 national disease prevention and health promotion objectives (U. S. Department of Health and Human Services, 2000). As such, many DHHS programs have adopted a broad approach to adolescent health. While the majority of programs still focus on the health and well-being content area, there is evidence that DHHS has expanded its program funding outside of the traditional vision of health as physical health and illness to encompass a broader definition, including other content areas such as violence prevention or improving school environment. Although DHHS programs are limited by mandates, efforts are being made to put programs in a greater family and community context than was done many years ago. Indeed, all seven content areas reviewed in this report had at least some program coverage. For example, there are programs, such as those in the school environment content area that serve adolescents directly without specifically focusing on health. These programs promote adolescent health in the broader sense, by promoting psychosocial well-being and strong connections with adults and other youth which in turn help adolescents make wiser decisions regarding risk-taking behaviors that directly impact their health. As

program information becomes more readily available, it will assist the government and the community in identifying and filling in gaps in all of the content areas. For instance, future grantees would be able to see more readily the content areas that have been, and currently are, addressed and those that need more coverage.

Although the program information currently available is not ideal, this review provides a general picture of adolescent health programs and the role of the federal government. In this section, we discuss the major underlying questions that emerged in this review and implications for future work in this area. Specifically, we address the following questions:

- Is there a national policy that addresses the promotion of adolescent health?
- Is DHHS making an effort to create healthier environments for adolescents through a multi-level approach?
- What is the status of evaluations of federally funded adolescent health programs?
- What can we learn from existing evaluations of programs that seek to influence adolescent health outcomes?

Is there a national policy that addresses the promotion of adolescent health?

Although there is significant investment in the area of adolescent health, no clearly articulated national policy pertaining to adolescent health was identified in this review. For the purpose of this report, policy is used broadly to define a mission that shapes the kind of activities the federal government funds to promote an agenda, in this case, adolescent health and well-being. Such a mission helps to prioritize the funding of these activities and identify the target audiences for the activities. In general, advancements in the research arena and existence of documents addressing adolescent health policy reflect a growing concern for, and a more comprehensive approach to, adolescent health. For example, researchers conducted an extensive review of 1,000 health policy recommendations proposed in 36 blue-ribbon commissioned documents and reports (Brindis et al., 1997). There also exist a wide range of documents containing recommendations for programs that directly serve adolescents (Irwin & Duncan, 2002; National Research Council and Institute for Medicine [NRC/IOM], 2002; Zaff & Moore, 2002). It is difficult, however, to identify clearly articulated national policy in the seven content areas included in this review. Although policy is not explicitly stated, the existence of significant levels of funding indicates that these areas are important to the federal government and other stakeholders. Along with the federal government, the initial search also revealed that investments are being made at the state and local level, as well as by the private sector.

Though there is no clearly articulated single policy pertaining to adolescent health, the National Initiative to Improve Adolescent Health by the Year 2010 (The National Initiative) represents an important step in the right direction to develop a coherent, comprehensive policy aimed at affecting the health of youth aged 10 to 24 (Centers for Disease Control and Prevention - Division of Adolescent and School Health (CDC-DASH), Health Resources and Services Administration - Maternal and Child Health Bureau (HRSA-MCHB), Office of Adolescent Health - National Adolescent Health Information Center (NAHIC), & University of California - San Francisco, 2004). The National Initiative was launched in 2003 and is led by two federal agencies – the Centers for Disease Control and Prevention's Division of Adolescent and School Health and the Health Resources and Services Administration's Maternal and Child Health Bureau/Office of Adolescent Health – in collaboration with 21 national organizations and academic institutions. At the heart of the National Initiative are the 21 Critical Health Objectives derived from Healthy People 2010, a comprehensive set of

national disease prevention and health promotion objectives that measure the nation's progress over time.

Despite the existence of efforts such as The National Initiative, it is still difficult to ascertain how some of the investment areas are developed and prioritized. It is not clear how much research and evaluation drives initiatives as compared to efforts that emerge because of public concern. For example, media focus on violence appears to have led to a wide variety of programs being implemented, but it is not clear how many are shaped by specific policy goals and outcomes that can be achieved. Similarly, it is difficult to determine where public policy is heading, in terms of addressing adolescent health, given the current lack of a true national policy and uncertainty as to what agency is really responsible for this area of domestic policy.

Implications

1. Need for an articulated national policy on adolescent health. While there is clearly significant interest in the adolescent health arena, the topic could benefit from a more structured approach. By clarifying the national policy in this area, the Government as whole will become better organized to truly promote change in adolescents and will be able to be more responsive to their needs. Once a national policy on adolescent health is articulated, every agency can understand its potential contribution to this larger policy objective and activities can be streamlined and coordinated across agencies.

As this national policy is articulated, it is important that it be driven by research. In particular, findings from a report that examined antecedents for successful development of adolescent programs can help guide the development of The National Initiative (Zaff & Moore, 2002). Among the messages that emerged in this report, the following four are particularly salient in developing a national policy on adolescent health. *First, adolescent behaviors often cluster.* Non-experimental research confirms that teens that show one positive or negative characteristic are more likely to have other positive or negative characteristics. This clustering effect highlights the importance of addressing adolescent health from a comprehensive perspective and supports the notion that programs focused on changing one outcome (e.g., violent behavior) can effect other characteristics of adolescent life (e.g., health).

Second, teens should be viewed as whole people, more than just students, patients, or delinquents. Schools, communities, families, the media, and public policies, all have implications for adolescent development and should be considered when trying to use a holistic approach. In developing a national policy it is important to recognize that youth often need a set of services that address the whole person, not just programs that target one or two aspects of (such as eating healthy or exercising). *Third, engage young people.* Experimental evaluations have

shown repeatedly that lectures do not change adolescent behavior, in regard to pregnancy, drug use, alcohol use, and tobacco use. The evaluations indicate that adolescents who take part in programs that build relationships, truly involve teens, and provide well-implemented and structured activities tend to have lower rates of pregnancy and drug, alcohol and tobacco use.

Fourth, it helps to start early and sustain the effort. Many problems which begin in childhood continue through adolescence and adulthood. A national policy should take this into account, recognizing that development is a continuum that does not end when adolescents reach a certain age. *Finally, think positively about teens.* Polls show that many adults see teens as having a high potential for problems. Thus, many youth programs focus almost exclusively on preventing specific problems from occurring. However, an accumulating body of research suggests that taking a positive approach with teens by promoting their skills and assets may be a more effective way to avoid negative outcomes and help teens realize their potential.

2. Need for inter-agency collaboration. As recommended in the White House Report, the federal agencies should "maximize interagency collaborations". Our initial search for adolescent health programs included agencies outside of DHHS and revealed an extensive amount of program activity related to the seven content areas in other Government agencies. It is important that similar ongoing efforts in multiple government agencies not operate in independent silos, but that there is collaboration between them. Through such collaboration (e.g., DHHS working with ED and DOJ), programs can truly address the "whole adolescent". For example, the establishment of the interagency working groups in the seven content areas would foster shared resources and assure appropriate reinforcement of major focus areas and policies across agencies. Efforts in this review to identify interagency working groups revealed little information on formal relationships and joint projects. While it is likely that informal relationships among individuals in different departments exist, the establishment of formal work groups would help to form a more coherent, single, overarching federal policy on adolescent health for each of the seven areas. It is important that these collaborations go beyond the top level of the organizations and include collaboration of program staff between agencies.

3. Need for a Federal Adolescent Health Program Repository and Technical Assistance (TA) Center. Given the need for a centralized repository of program information on adolescent health, it would be useful to establish an adolescent program repository and technical assistance center (repository) that provides basic information on direct-service programs funded by DHHS. A repository would provide a much needed investment in capacity

building. Ideally, the repository would manage a general program compendium that tracks basic program information (age of program participants, topic areas covered, funding level, location, outcomes, etc.). This center would allow for the pooling of resources, evaluation and research information, and sharing of lessons learned.

Such a repository would not only be useful to the Government in assessing and monitoring the current support offered in a given topic area, but would also be useful to program managers and providers, as well as their community. Program providers would have an easily accessible database of programs to serve as a single point to access information for establishing new programs and also improving existing programs. Furthermore, such a repository would allow those working with youth to identify programs that meet the needs of the youth they are working with and potentially help to get them involved with such programs. Such an arrangement would also help to ensure that programs are reaching their intended recipients. For example, guidance counselors working with youth may identify a youth's needs, then identify programs that meet those needs and work with the youth to enroll in the program.

Yet another critical component of a repository and TA center would be to provide viable models and methods by which other program providers could incorporate key programs ingredients into their programs. A "what works" component of the TA Center could assist in translating evaluation findings into program practice, ensuring that program funders and program developers are building on the large base of program knowledge that already exists. As with any database, the quality of such a repository would be dependent on the quality of data entered into the system and therefore it would be necessary that the federal government require that information be supplied as part of the grantmaking process.

The aforementioned concepts would build or enhance current efforts to collect information, including the use of government clearinghouses that have been established in some areas of adolescent health, such as the National Clearinghouse on Alcohol and Drug Information and the National Suicide Prevention Resource Center. While these clearinghouses help to increase access to useful research reports and other materials, there is no clear, in-depth repository of government-funded program information on a wide variety of health-related topics. Furthermore, the compilation of information, while clearly an important core function, would not be sufficient without some concurrent effort to assure that the information was made available in an easy to use format, with the provision of some technical assistance to support communities' use of the information.

The proposed repository would also build upon the DHHS website, which provides direct links to information on most of the seven topics, with more available information regarding the

more traditional health topics (e.g. smoking, fitness, violence) than relationship or contextual factors that contribute to adolescent health (e.g. school, family, and peers). Most of the links on the DHHS website connect to Healthfinder or Medline information web sites, though in some cases they do link to government organizations and programs (e.g. Substance Abuse and Mental Health Services Administration, National Institute of Mental Health). Other federal websites, particularly those related to the Centers for Disease Control and Prevention, provide more specific information about all seven program areas, including information related to data, funding, technical support and programs. The CDC, HRSA, and NAHIC's recent publication on the CDC and NAHIC website, "Improving Adolescent Health: A Guidebook for States and Communities", provide this information in a readily available format (Centers for Disease Control and Prevention - Division of Adolescent and School Health (CDC-DASH) et al., 2004). So while federal clearinghouse information on the seven topic areas exists (and some are in fact included in our program search, such as the National Clearinghouse on Alcohol and Drug Information and the National Suicide Prevention Resource Center), they are not easily navigated on federal web sites. The development of a centralized, easy to use, cross-referenced DHHS resource that links specific government-funded program information and existing clearinghouses would significantly advance efforts in the field.

One very recent effort by DHHS appears to follow this concept of a repository on a smaller scale for only one content area. As this report was being finalized, DHHS issued a Request for Proposals (RFP) titled "Cooperative Agreement Program for the National Academic Centers of Excellence on Youth Violence Prevention." As stated in the RFP, the purpose of the Centers is to " to promote a stable, long term focus on the complex problem of youth violence, fostering multidisciplinary and multi-sectoral interactions that can stimulate scientific creativity, speed new developments in youth interpersonal violence research and practice, and hasten translation of knowledge into health and community practice. Centers are expected to actively foster an environment conducive to reciprocally beneficial collaborations among health scientists, social scientists and the affected communities with the common goal of reducing youth interpersonal violence." This is a major endeavor and points out that costs and resources may not allow for any one repository across all youth programs to exist unless it were somewhat limited in scope. However, if separate repositories in each content area were to be established, they could at a minimum include cross-references to other major topics (chronic health conditions, mental health and substance abuse, reproductive health).

Is DHHS making an effort to create healthier environments for adolescents through a multi-level approach?

Promising efforts appear to be made in using a multi-level approach to improve adolescent health, yet much work in this area remains. Developing developmentally appropriate programs that address multiple environments –individual and family, school and peer, community, and policy – has been identified as an important step in assuring the health of adolescents (Centers for Disease Control and Prevention - Division of Adolescent and School Health (CDC-DASH) et al., 2004). Adopting a broad definition of what constitutes adolescent health and addressing the needs of special populations, for example, adolescents living in foster care settings, juvenile justice, migrant adolescents, are essential ingredients in achieving this step. The program information available varied considerably in the way and extent to which environmental influences were addressed in the type of programs currently being funded. In reviewing program language, there appears to be some indication that a number of the programs are reaching out to parents and families. However, it is less clear whether programs are linked to the larger community and policy arena, representing important social contexts in which adolescent health issues must be addressed. Similarly, there is some indication that programs are addressing the needs of special populations, although there were no consistencies in the populations found across program domains.

Additional efforts to broaden the definition of what constitutes adolescent health are needed. The last decade has witnessed significant changes in the field of adolescent health. While risky behaviors among individuals remain a concern, new approaches have broadened the definition of adolescent health to include concepts such as environmental context. Behaviors of individual adolescents are shaped in large part by the environment in which health-related decisions are made. Factors such as family, school, and community contexts influence behavior. To be comprehensive, a definition of adolescent health and well-being should incorporate environments that support healthy development and healthy choices (Burt, 2002; Centers for Disease Control and Prevention - Division of Adolescent and School Health (CDC-DASH) et al., 2004; Mortimer & Larson, 2002).

In addition to a new focus on adolescents' environments, the field has also increasingly adopted a youth development approach (Hair, Moore, Hunter, & Kaye, 2001). Where an emphasis on individual problem behaviors can engender a view of young people as problems to be fixed, a youth development approach views young people as individuals whose assets, if adequately nurtured, can be a positive force. A youth development approach aims to enhance

competence, capacities, caring, and citizenship among young people. This approach also recognizes the need to better understand different stages of adolescent development and create health promotion strategies that recognize these stages.

Research in this area has clearly identified the importance of environmental factors in adolescent development (Zaff & Moore, 2002). *First, parent-child relationships are vital to adolescent well-being.* Multiple non-experimental research studies consistently show that teens who have warm, involved and satisfying relationships with their parents are more likely to do well in school, have better social skills, have lower rates of risky sexual behavior, and demonstrate a lower frequency of engaging in risky behavior (including tobacco, alcohol and other substances) than those who do not. In addition, parent-youth relationships are a protective factor for school suspension, delinquent activities, substance abuse, and alcohol use (Hair, Moore, & Garrett, 2004). *Second, peer influences are important and can be positive or negative*. Again, non-experimental evidence suggests that by modeling behaviors and pressuring each other to behave in certain ways or to adopt certain attitudes and goals, adolescents play roles in each others' development. Several experimental studies also indicate that interventions can improve peer interactions. *Third, siblings, teachers, and other adults and mentors can provide additional support*. Similar to peers, brothers and sisters can act as models for positive behaviors, such as not smoking and avoiding drug use. Sibling relationships also serve as good training ground for developing conflict resolution and negotiation skills. Experimental studies also indicate that mentors can have a positive impact on adolescent outcomes, similar to parents. Non-experimental analyses suggest that long-term mentors, with whom an adolescent develops a positive relationship, can offer guidance, friendship and assistance, and serve as positive role models for positive behaviors. Given the strong evidence base for taking a multi-level approach, it would follow that DHHS would strive to create healthy environments for adolescents by taking a multi-level approach to address the many factors that play a role in adolescent development.

Demographics will shape future program endeavors. As the field has broadened its approach to adolescent health, it is important to note that the U.S. adolescent population itself continues to undergo major demographic changes (Ozer et al., 2003). To be successful, any adolescent health programming must acknowledge these changes. The population of young people ages 10-24 is expected to increase in the coming decades (U.S. Census Bureau, 2002). The population will grow more slowly than the total U.S. population, however, and will represent a decreasing proportion of the total population. In addition, the racial/ethnic makeup of the population ages 10-24 continues to change rapidly, with Hispanics replacing Blacks as the

second largest racial/ethnic group (U.S. Census Bureau, 2000, 2002). It is projected that the proportion of Whites in the adolescent population will fall below 50 percent by 2040 (U.S. Census Bureau, 2000)

Another important factor influencing adolescent health is family composition. One-third (32 percent) of youth under age 18 live with either a single parent or no parent (Federal Interagency Forum on Child and Family Statistics, 2003). Trends in family structure have implications for children's poverty status because single-parent families are more likely to be poor than married-couple families. While 8 percent of youth under age 18 in married-couple families live below 100 percent of the federal poverty level, youth living in female headed households are five times as likely (39 percent) to live in poverty (Federal Interagency Forum on Child and Family Statistics, 2003). This disparity in income is largest among black children: almost half (47 percent) of those in female-householder families live in poverty, compared to one tenth (10 percent) of those in married-couple families. Among Hispanic children, having married parents offers less protection against poverty: 20 percent of children in married-couple families live in poverty compared to 49 percent in female-householder families.

Available information suggests that DHHS has begun to take environmental factors into account in program development, but additional systematic efforts are needed. Contextual issues such as the larger community, policy, schools and peers are an integral component in approximately one-fifth (12) of the programs. Among these are the recognition of residential services (particularly in regards to homeless youth), the integration of community contexts in design and practice in health access and treatment, and the targeting of youth through school networks. For example, the Practice Improvement Collaborative focuses on community based substance abuse treatment and is governed by community stakeholders; Targeted Capacity Expansion focuses on meeting the needs for urgent mental health services in communities in a variety of settings (e.g. criminal justice and foster care systems); Healthy Schools Healthy Communities establishes comprehensive School Based Health Centers targeted towards medically underserved youth populations, and Community Initiated Interventions field test substance abuse and tobacco interventions in local community outposts (e.g. schools, health care provider, workplace).

Many programs recognize the importance of including families and caregivers in addressing the health needs of adolescents. Given the research findings that indicate that adult-youth connectivity are key to protect young people from engaging in high-risk behaviors, information collected regarding the role of parents is important to consider. Of the 57 programs reviewed, one-quarter (14) specified their efforts were directed at both adolescents and their

families and/or caregivers. A majority of these programs target both the adolescent and the family/caregiver; for example, Hispanic/Latino Boys and their fathers addresses substance abuse prevention for boys and fathers; The Prevention of Underage Alcohol Use uses input from adolescents and parents to develop communication strategies regarding alcohol use; and Circles of Care, Comprehensive Community Mental Health Services Program for Children and their Families and Stateside Family Networks all focus on serving children with Serious Emotional/Behavioral Disturbances and their families. One program, Parenting is Prevention, specifically targets families of the adolescent in providing information, support and resources to raise healthy, drug-free children.

Available information indicates that there is strong commitment by DHHS to serve disadvantaged youth. A number of programs specify particular populations of youth, including adolescents with a drug problem, abused youth, medically underserved youth, adolescent Latinas, adolescent Latino boys and their fathers, homeless youth and Native American youth. These specific types of populations identified as "target populations" reflect sensitivity to the emerging needs of different segments of the adolescent population and the importance of tailoring interventions to meet both their universal (e.g., safe environments), as well as the unique needs (e.g., language, risk factors).

The recognition of special groups of adolescents is especially timely given that historically many of these populations have not been the recipients of specific programs and policy focus. A challenge is to consider whether there are additional groups of adolescents whose profile places them at a particularly high risk of poor outcomes, but who are currently not being served. Furthermore, many of these populations may represent more than one special population – for example, medically underserved homeless youth who have a substance abuse problem. Available program information does not allow the reader to ascertain whether the opportunities to serve special groups of youth are maximized across programs.

Implications

1. Need to utilize a greater number of resources and approaches to help deliver messages on adolescent health. Using a multi-level approach when creating programs has been shown to have some promising results, but current efforts are too often not linked to communities or to the policy area. To truly address the needs of teens, it is necessary to utilize a greater number of resources and approaches to help deliver messages on adolescent health across different systems that interact with youth and their families, including schools, faith-based organizations, community-based organizations, parks and recreation (Centers for Disease Control and Prevention - Division of Adolescent and School Health (CDC-DASH) et al.,

2004). Thus, it is important to work with other systems not traditionally viewed as public health in a more integrated fashion. Bringing in other stakeholders can help promote the health and wellbeing of teens by allowing greater access to programs, as well as giving more people a vested interest in making sure that adolescent health programs are successful. For example, by working with school administrators, teachers, and staff, DHHS can describe the multiple ways that schools contribute to the health of adolescents and the manner in which health contributes to adolescents' academic achievements. As mentioned earlier, an important element of this collaboration would be the greater availability of program information to all of these stakeholders, as well as funding initiatives shaped by a clearly articulated policy. Furthermore, while DHHS has made efforts to shift from single focus silo programs, it still could to do more to address youth in a holistic manner by using various delivery approaches and addressing the many contributing factors to adolescent health. (See section on repository and technical assistance center(s))

2. Need to share lessons learned across content areas. Successful multi-level efforts within one of the content areas have implications for future programmatic efforts in other areas. For example, the multi-level approach (from individual to policy level) to the prevention of alcohol abuse has decreased the incidence of mortality related to drinking and driving (Ozer et al., 2003). Such efforts may likely have implications for other areas, such as physical activity, where enhancing individually-focused approaches to include school (e.g. requiring physical exercise throughout high school) and community context (e.g. safer streets, lighting on playgrounds, etc.) will likely lead to far greater success. The multi-level approach supports the development of the next generation of programs and interventions that tie these levels together.

3. Need to incorporate "character development" in programming. In addition to incorporating environmental factors into program development, incorporating the emerging focus on "character development" is also important and has likely implications for the health of young people (Seligman & Csikszentmihalyi, 2000). For example, improving social skills and relationships through mentoring can help adolescents to negotiate and navigate through adolescence and avoid risks (Jekielek, Moore, & Hair, 2002). This approach may do as much to prevent violence as curricula efforts but research is not available to compare these different types of efforts to ascertain which ones are most effective.

4. Need to identify programming gaps across federal agencies. In order to truly determine how thoroughly each of the seven content areas is addressed, greater efforts should be made to identify gaps which may exist across agencies. For example, this review found that DHHS seems to have focused less on violence prevention programs than other areas of

adolescent health, such as health and well-being. It is possible that other agencies, such as the Department of Justice, cover violence with their programming efforts. Thus a more extensive review across agencies could determine the full measure of programs being used to address adolescent health. More information on how community programs receive guidance and funding is also needed. Currently, it is difficult to determine the multiple sources of funding that support governmental activity within a specific topic and consequently how program assistance is provided to potential grantees.

5. Need to address adolescents' developmental stages in program development. A greater emphasis could be placed on addressing adolescents' developmental stages within programs and articulating how programs could adapt in serving younger (10-14), middle (15-17) and older adolescents (18-19). This assessment found few programs (5) explicitly stating the age groups they were serving, with the majority focused on females between the ages of 9 and 14 (younger adolescents). Only one, Runaway and Homeless Youth – Transitional Living Program and Maternity Group Homes, focused on older adolescents aged 16-21. The lack of information on age groups suggests that developmental stages may not be receiving adequate attention in the process of program development. It would be important to require information on how programs have been designed or adapted to be developmentally appropriate during the funding as well as in the implementation process. Furthermore, individual programs need to focus on the whole adolescent, rather than specific components, such as separating physical health and well being from potential risk behaviors, such as substance use. While the availability of several concurrent DHHS programs may be "combined" to deal with the whole adolescent, it is not clear from available information how often such strategic funding is occurring, let alone how many individual adolescents are exposed to a comprehensive "package" of programs that may be available in the community. Clearly, this level of data gathering would require an even greater level of coordination.

What is the status of evaluations of federally funded adolescent health programs?

Our search for evaluations of federally funded adolescent health programs found that very few programs had been experimentally evaluated. In fact, very few programs were found to have publicly available evaluations of any type or to even mention them in any documents which were readily accessible through internet searches (which included program and departmental web sites, as well as searches of the World Wide Web using the Google search engine). Without program evaluations, it is very difficult to draw conclusions about the state of federally funded programs for adolescents. Likewise, without experimental evaluations it is impossible to determine cause and effect relationships. For example, the percentage of teens who smoke has been dropping for several years, but without experimental studies to help isolate possible causes, it is not possible to precisely determine what has caused this change (Child Trends, 2004).

It is noteworthy that federal funding efforts have begun to require procedures be "evidence-based." As such, programs where information was found that resembled an evaluation usually presented a collection of indicators on participation rates, participant characteristics, and a handful of outcomes. These social indicators can be very useful to policy makers as they can serve as an early warning system for problems so that quick action can be taken to address problems (whether that be a trend in the general populace or a specific concern with a program) (Moore, Brown, & Scarupa, 2003). These indicators can be used by program practitioners to provide descriptive data, monitor programs, set goals, track accountability, or even for reflective practices. When well-conceived and used in this way, social indicators help to measure a specific population. It is important to note, however, that indicators can be misused if they are applied to broader populations than the indicator actually measured, if they are used to determine cause and effect (positively or negatively for program or societal change), or if they are used to evaluate the performance of individuals or programs without considering the larger societal and environmental context. If indicators are used in any of these manners, they are taken to represent more than they actually measure which can lead to false conclusions (Moore et al., 2003). While the collection of indicators by programs is a step in the right direction, it should not be confused with the performance of experimental program evaluations that can definitively determine whether or not a program is having its desired effect.

Although this review found it difficult to identify explicit evaluation information, research may have likely driven the development of funded initiatives and represents the underlying

framework for these efforts. This more explicit research-link is often included as background information in Request for Proposals (RFPs) and other program announcements in which government agencies provide the parameters for new funding initiatives. It thus may be useful to include this background information as a first step in clearly articulating the research base for new funded efforts.

As with the general search for federal programs, our search for evaluation information presented several problems. Due to the difficulties discussed within this report regarding locating programs funded by federal agencies, we conclude that it would be near impossible to conduct a truly exhaustive review as there would be no way to know if programs were being excluded. This predicament makes it even more difficult to determine if practices are evidence-based or if rigorous evaluations have been done because of the disconnect between large grants, such as demonstration projects, and programs with a national scope. For example, sources such as the White House Report and the CFDA give grant information which can not necessarily be linked to the program level where evaluations are performed. Likewise, it is impractical to do the reverse search for all programs to determine if they receive any federal funding, if so, under what mechanisms, and what type of evaluation reporting is required (if any).

Implications

1. Need for more program evaluations. Based upon the strengths and weaknesses identified in existing programs, it will be important to make strengthening the evaluations in less researched content areas (such as fitness) a priority. As noted previously, smoking-related programs have a longer history of more rigorous evaluations than fitness and nutrition programs for which the impact on adolescent health may have been considered a secondary gain. Furthermore, research is needed that emphasizes a developmental lens, the role of multiple influence models for understanding and improving adolescent health and development; and that provides additional information on the diversity of the adolescent population (Millstein, Ozer, Brindis, Knopf, & Irwin, 1999).

2. Need for more readily available program information (including program evaluation reports). Easily accessible information allows for people designing, or choosing, programs to be able to determine what does and does not work with different populations, as well as important lessons on how to implement a program to achieve the greatest results. Additionally, having this information readily available allows for people looking for programs to choose a program that has been shown to be effective and avoid programs which have been shown to be ineffective. Finally, it will be important for federal websites to include information on

programs which have recently undergone or are undergoing evaluation.

What can we learn from existing evaluations of programs that seek to influence adolescent health outcomes?

Existing program evaluations can help decision-makers make better selections among available programs and strategies and as a consequence develop better policies. The past decade has witnessed an ongoing devolution of responsibility from the federal government to states and communities. This has been accompanied by greater emphasis on program accountability, with more funders requiring evaluation to provide evidence that their grantmaking is effective. While evaluations have their challenges, this has led to the growth of the evidence base and best practices in adolescent health, as well as other areas.

The review of "what works" provided in the Results section of this report helps to identify a number of promising directions for programs, including incorporating key ingredients, such as parents, positive peer influences, sibling support, treating youth as "whole people", engaging young people, and providing early and sustained efforts. Specific evaluation findings within each of the seven content areas point to additional components, for example, the positive role of mentors, the benefit of teaching young people new skills, and the value of specific curriculum-based programs.

Program evaluations also help to provide information on how to implement a program. For example, research has found that programs benefit from having staff that have been trained to work with certain age groups and by providing a program that is both intensive and long lasting. Likewise, interactive approaches (as opposed to information-only approaches) seem to best communicate and teach lessons to children and youth. These program implementation considerations are important factors in determining how and why some programs work while others do not. It is therefore important that such information continue to be collected so that more lessons involving how to properly implement different types of programs, including replications of well-evaluated programs, for different populations can be learned (Garrett, McKinney, Kinukawa, Redd, & Moore, 2003).

Implications

1. Need for synthesis of knowledge in the field. Agencies need to better synthesize existing literature in the field of adolescent health. By examining program evaluations and exploring the current body of literature, model programs and practices can be established. SAMHSA has done this previously (http://modelprograms.samhsa.gov/) in order to create a "comprehensive resource for anyone interested in learning about and/or implementing these

programs". Evaluated programs that share similar program components can be used to help glean lessons on the effectiveness of those components. Additionally, development of more mechanisms, such as working groups or reports which synthesize multiple research findings, would help those concerned with adolescent health to discuss changes the field as well as stay up-to-date on what does and does not work for affecting change in the lives of adolescents.

2. Need for greater accountability. Greater accountability, for both programs and agencies, is needed to advance the knowledge base.

a. More information on program participation and interest in various types of adolescent programs could be collected through major national surveys. For example, the National Longitudinal Study of Adolescent Health (AddHealth) has been groundbreaking in assessing the influence of several individual, family, and social context variables (Harris et al., 2003). An initial review of the questionnaire finds that relatively few items ask adolescents about their experiences participating in specific types of programs. This level of specificity in the future would help provide additional information regarding the impact of program participation on health outcomes, including the effect of intervening factors, such as community context.
b. It is important that agencies not only establish best practices and model programs, but should also encourage people to use these resources to help find better ways of delivering services to adolescents. For example, All Stars, a school-based intervention program aimed at reducing substance use, violence, and sexual activity, utilizes elements of two other programs (Project STAR and the Adolescent Alcohol Prevention Trial) that have previously been shown to be successful in reducing some of these behaviors (Child Trends, in press).
c. Programs need to collect and make publicly available more indicators on program effects. To adequately monitor programs it is necessary to not only collect basic demographic information on participants and a few measures on their participation rates and outcomes, but multiple measures on outcomes for adolescent participants (possibly from multiple sources).
d. Programs need to collect and make publicly available information on how their program is operated. Information, such as staff turnover rates, adolescent to class or group size ratios, and staff education and salaries, can often help to establish why some programs are effective when other similar projects are not (Child Trends & SRI International, 2002).

In summary, evaluations that help to determine if programs are effective are needed in order to help establish model programs and practices that can be used to guide program development and to enhance the field of adolescent health.

Summary

Adolescents make choices about their future and develop ideas about their role in society that impact not only themselves, but society in general. Thus, adolescence represents a unique opportunity to encourage healthy choices and pro-social behaviors. Improving the health of adolescents will likely continue to be a complex, but important endeavor requiring changes in individual behavior, as well as the creation of environments that foster healthy decision-making. Adult supervision and parental monitoring have been shown to influence the health and development of adolescents (Fletcher, Darling, Steinberg, & Dornbusch, 1995; Galambos & Maggs, 1991). While efforts to address specific health areas have been successful, improving adolescent health requires a holistic approach to complement categorical approaches (Brindis et al., in press). Seemingly isolated adolescent problems are influenced by common antecedent factors—both those that protect and those that can jeopardize health and safety. In short, adolescents need multiple supports to successfully navigate the transition from childhood to adulthood. Addressing health issues requires involvement at multiple levels— parents and other adults, service delivery systems, funding priorities, community resources and supportive environments (Brindis et al., in press). Enhancing the involvement of these important stakeholders reflects important next steps and an opportunity where the federal government can provide key leadership

This review has helped to assess the many and varied federal efforts that have been made to develop and fund programs to improve adolescent health, so many in fact, that it was decided that only programs funded by DHHS would be presented here. However, this review also revealed that efforts in this area need to be strengthened and made more visible, both within DHHS and across the federal agencies. These goals can be reached by addressing the areas of need identified in this report. First, by articulating a national policy on adolescent health and improving inter-agency collaboration, the federal government can design a more comprehensive approach and avoid duplicating efforts. An essential product of this streamlined effort would be a federal adolescent health program repository and technical assistance center (repository) that would improve accessibility to information on programs for a wide variety of audiences, from program practitioners to policy makers.

Second, DHHS can take more steps to ensure that their efforts are creating healthier environments for adolescents through a multi-level approach. Doing so will require DHHS to employ a greater number of resources and approaches to help deliver messages on adolescent health. It will be important to share lessons learned across content areas and incorporate “character development” in programming, as well as to address adolescents’ developmental

stages in program development. Additionally, in order to accurately assess whether programs are addressing all of the content areas, it will be critical to identify programming gaps not only within DHHS but across federal agencies.

Third, more evaluations of federally funded programs can help to identify programs and program characteristics that work in order to ensure that funded programs are actually achieving desired results. In particular, new evaluations should focus on those content areas that have been less thoroughly researched. At the same time, it is essential that program information and evaluations become more readily available

Fourth, in the absence of federally funded evaluations, the DHHS and other agencies can use existing evaluations to help shape programming efforts. It will also be important for current knowledge in the field to be synthesized and shared in more user-friendly formats. Finally, DHHS can use the available information to meet the need for great accountability across programs.

Ultimately, there are multiple efforts underway to address adolescent health, reflecting this complex, multifaceted issue. More can be done, however, to help guide and improve these efforts. Greater collaboration across federal agencies, and accessibility to and visibility of program information will aid the process of creating programs to improve adolescent health and collect better information on the state of adolescent health. Greater accessibility to information allows for program practitioners to find better program models to follow when implementing programs and also allows for collaboration and collective learning. Publicly available program evaluations allow for program practitioners to learn from other programs and avoid “reinventing the wheel” when implementing new programs or adapting current programs. Additionally, shared information allows for a collective approach to addressing difficult questions about adolescent health, such as “Which approaches to adolescent health have the greatest effects?” and “How do you get a child’s family and community involved to help create a comprehensive approach for addressing adolescent health?”

The aforementioned repository could also be used to create stronger adolescent health programs. Such a resource center could serve as a collection and distribution point for program evaluations that could then be used to create best practices and model programs. Such resources could help to cut down on trial and error, as well as help to focus federal money at more productive efforts. At the research level, having a single collection and dissemination point would allow for a single entry point for accessing information on adolescent health. Having one access point would make finding gaps in available programs and their research more accessible and allow for quicker scans on the state of adolescent health programs.

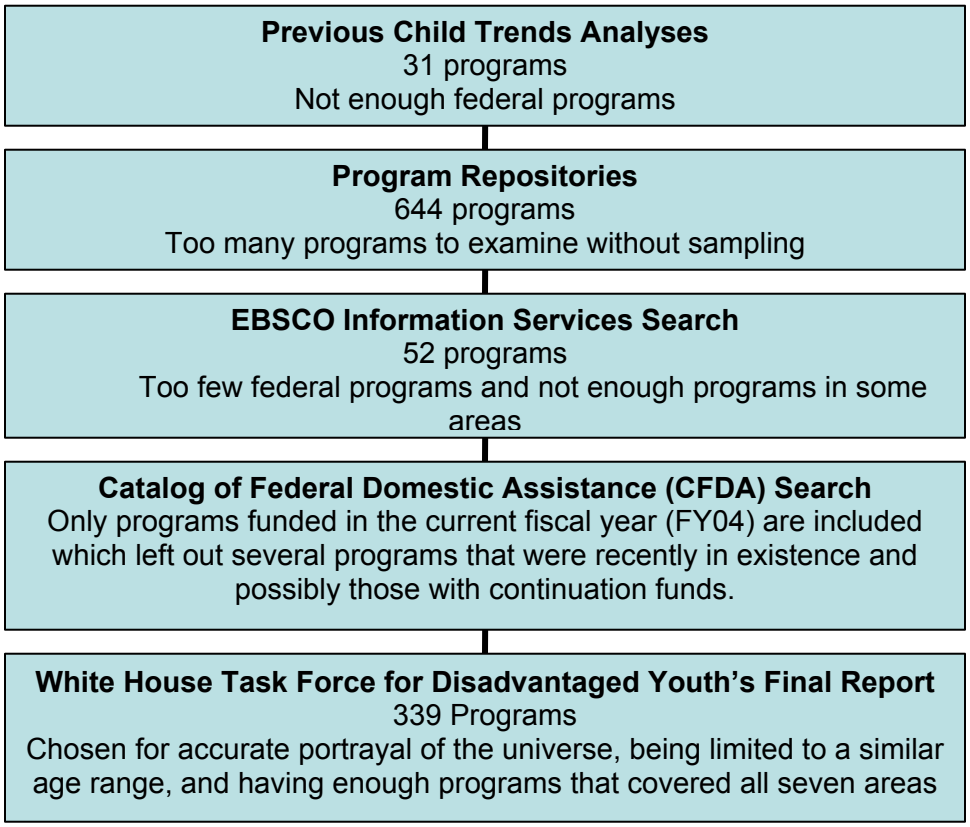
Clearly, the scope of reviewing even one federal agency among several that touch the lives of adolescents and their families demonstrates the complexity of conducting such a synthesis and analysis. We encourage others within the federal government, as well as stakeholders concerned with adolescent health at the state and community levels, to consider such an analysis of their own endeavors.

Appendix A. Expanded Methodology

The initial process to identify possible programs[17] for this report began by defining what a program entailed, the period of time in which the program operated, and the overall scope of the program reach and intent. Thus, all programs that are presented in this report are mechanisms or initiatives officially funded by the federal government that address some dimension of health for youth. Following the definitional process, we developed a template with a number of program characteristics (e.g. type of approach, target audience, program summary, website, venue, etc.) to use as the basis for the review. We also worked to assure that there was inner-judge reliability in the type of information that was then included in the grid by each member of the team. We examined multiple sources to gather information on federally funded programs. These sources included previous Child Trends program review work, private and government program repositories available on the Internet, the EBSCO Information Services database, the Catalog of Federal Domestic Assistance, and The White House Task Force for Disadvantaged Youth's Final Report. Ultimately, it was determined that the best resource of potential programs for this report was The White House Task Force for Disadvantaged Youth's Final Report. Figure 4, shows each of the potential sources that were reviewed, the number of programs that were found, and a brief justification for including or excluding the source in our final review.

[17] The term program is used to refer to any mechanism, initiative, or program offered by the federal government. It does not imply only a "direct service" component.

Figure 4. Sources Used to Identify Potential Eligible Programs



Initially, we examined programs that Child Trends had previously reviewed in other reports that might be applicable to the seven content areas (i.e. adolescent Health and well-being, family and peer relationships, school environment, youth fitness, smoking, alcohol and violence) found in *U.S. Teens in Our World: Understanding the Health of U.S. Youth in Comparison to Youth in Other Countries* (U. S. Department of Health and Human Services. Health Resources and Services Administration, 2003) and covering our target age range of 11 to 15 years old. Specifically, two previous Child Trends projects were utilized: five syntheses developed for the Edna McConnell Clark Foundation and a series of seven reports produced for the John S. and James L. Knight Foundation. From these reports, 31 programs were identified as relating to the seven content areas. Using the search engine "Google", additional information was gathered on the 31 programs, including how the programs were funded, specifically whether they were federally funded, and whether they qualified as being national in scope. Additionally, in those cases where it was not apparent, program directors were called to determine whether the program was still operating or if no longer available, when the program ended.

An additional search for programs which were potentially applicable to the seven content areas was then conducted by reviewing the federal resources identified in the resource chapter of *Improving the Health of Adolescents & Young Adults: A Guide for Communities and States* Lists of potential eligible programs were also identified and reviewed from several other sources: the Substance Abuse and Mental Health Services Administration (SAMSHA), the Office of the Surgeon General, the US Department of Justice Coordinating Council on Juvenile Justice and Delinquency Prevention (OJJDP), the US Department of Education, the US Office of Special Education Programs, and the Office of Safe and Drug Free Schools (See Appendix C). Programs were selected from these repositories if they appeared to be aimed at youth and responded to at least one of the seven content areas.

Federal repositories often mentioned other non-federal repositories which caused an expansion of the search to include prominent non-federal resources to ascertain if they identified programs funded by the federal government. This process served as a triangulation process which assured the assessment team that all potentially eligible programs had been identified. Repositories included: the Harvard Family Research Project, Maryland Blue Prints, the Proven Practices Network for Children, Families, and Communities, Virginia's Best Practices in School-Based Violence Prevention, the Virginia Tobacco Settlement Foundation, The Hamilton Fish Institute, and Blue Prints for Violence Prevention (See Appendix C). Programs chosen from these repositories were based on the age range served and if they appeared to address at least one of the seven content areas. The federal and non-federal repository lists were then combined and obvious duplicates were removed so that a single list of programs was compiled. The list consisted of over 600 unique programs aimed at youth that also addressed at least one of the seven areas. A detailed “Google” search of a sample of these programs was then conducted to determine if it was feasible to examine all the programs on the list for each of the defining characteristics which were being examined. It was determined that it would be time and cost prohibitive to pursue examining all of these programs to assess whether or not they were linked to federal initiatives or funding.

In an attempt to select the most effective programs, in other words, programs that had withstood some measure of evaluation, other options for identifying programs were examined. This was considered to be a crucial step in program identification because the intent of this project is to assure that programs available for youth be of the highest quality and that they are able to demonstrate some level of impact. Thus, we sought experimentally evaluated programs specifically pertaining to the seven areas and our age range that could be found using the EBSCO search engine (an online database of published articles). This search yielded 52

possible programs within any of the seven areas that had conducted some level of experimental or quasi-experimental evaluation. Program evaluations were then located and gathered for possible future use. Ultimately, these programs were not chosen for the sample because few federal programs were found to exist within this sample which also occurred within the seven content areas. Programs that were located, however, ranged in size from small, localized programs, funded through local, state, and/or federal funds, to large national programs funded through federal grants and private donations.

Another approach was to utilize the Catalog of Federal Domestic Assistance (CFDA) in an attempt to do a general search for Government programs pertaining to the seven areas. The CFDA is an up-to-date database of all Federal programs available to state and local governments (including the District of Columbia); federally-recognized Indian tribal governments; territories (and possessions) of the United States; domestic public, quasi-public, and private profit and nonprofit organizations and institutions; specialized groups; and individuals. Searches of the CFDA, however, did not yield results which accurately portrayed the universe of Governmental programs addressing the seven content areas. This inaccurate portrayal exists, in part, because programs which are not being funded in the current fiscal year are placed into the CFDA archives -- there is no quick and efficient way to search for programs that have recently been in operation, but might not have funding at the time of this review. Furthermore, the database for the current funding year does not reflect programs that receive continuation funding from previous years. Therefore existing programs initially funded in previous years will not show up on a search. Similarly, programs funded in previous years that are current and active but do not currently receive federal funding will not show up.

Another resource with a potentially useful list of programs was also identified at this point. In October of 2003, the White House Task Force for Disadvantaged Youth released its final report on the federal response to disadvantaged youth (White House Task Force for Disadvantaged Youth, 2003). The Task Force was created on December 23, 2002 and charged with assessing the effectiveness of existing programming efforts to address disadvantaged youth in the United States. The final report identified 339 programs and concludes that the best way to get the greatest outcomes for disadvantaged youth and best utilize federal monies were to improve management, increase accountability, create better connections for and between the programs, and to give greater priority to the “neediest youth”. We cross-referenced this list of programs against our seven content areas and found 313 programs which could potentially fall into one of the seven areas. Several areas were more heavily addressed within the report than others. For example, there were 208 programs which potentially addressed the Health and well-

being area, 174 programs involving family and peer relationships, and 158 that possibly addressed the school environment. There were only 51 programs addressing youth fitness and 59 programs addressing youth smoking. As noted in the grid, a number of these programs addressed several content areas simultaneously based upon their description. For example, a program may focus on both family relationships and tobacco prevention. In the White House Report, the category selected was the prime one identified by the program or funder themselves. We reviewed the program descriptions for any anything indicating that the program could also apply to other topics included in this study. Ultimately, the White House Report was chosen as the base for our program sample because it provided an up-to date list of highly-relevant federal programs that serve youth and reflected recent efforts by specific federal program staff to identify and collect relevant program information.

Table 9. Total Number of Programs from the White House Task Force Report by, Federal Sponsoring Department, and Content Area

Source	Total Programs	Program Areas						
		Health and Well Being	Fitness	Family and Peer Relations	School	Alcohol	Smoking	Violence
DHHS	111	79	15	78	28	59	28	37
DOJ	72	40	5	35	35	33	7	63
ED	58	42	5	18	58	11	6	14
Entire Report	339	208	51	174	158	130	59	137

At this point, a decision was made to narrow the departments which we would examine. To do this, the three federal departments with the largest number of programs for disadvantaged youth [Department of Health and Human Services (DHHS) (111), Department of Justice (DOJ) (72), and Department of Education (ED) (58)] were chosen for further examination (See Table A-1). All three departments had their websites reviewed for additional program information. The Department of Education has a convenient, single centralized list for its funded programs that allows users to click on a program name to get more information about the program. The Department of Justice and Department of Health and Human Services do not have similar centralized lists. In order to further narrow the field of programs, however, DHHS was selected as the single department which would be examined in this report because of its large number of programs and its primary focus and responsibility for youth health and well-being.

In an effort to find additional or more recent program information on the 111 DHHS-funded programs listed in the White House Report, we searched the Catalog of Federal Domestic Assistance (CFDA) – a database of all Federal assistance programs – for each of the

111 programs. However, this process provided little information and only revealed additional difficulties in identifying accurate program information. Out of the 111 DHHS programs, 35 were found to have current CFDA numbers, meaning that they were currently (FY04) being funded under the name given in the White House Report. Of this total, 14 of the programs (two per content area) were randomly selected to undergo a "Google" search to try and locate any published evaluation articles or reports that might fit the seven areas that are the focus of this study. Only a handful of programs appear to have been evaluated. Those were examined for further characteristics, such as the targeted age for the program, the population served, and how it was funded. While it was possible that more programs may have undergone an evaluation and the relative timeline of the programs being reviewed might have precluded the publication of evaluation results in peer-reviewed journals, it was hoped that at a minimum there would be information on federal web sites that at a minimum evaluations were underway or had been recently completed.

The preceding process yielded too few results so it was determined that all DHHS programs from the White House Task Force's final report would be reviewed. A general group screening of the 111 programs was then conducted to remove any programs that were known to not be age appropriate or that did not specifically deal with any of our seven content areas. This screening left a sample of 67 potential programs. Additional delineations were then made to determine if the program was a service providing program, a funding stream which supported programming efforts, or a general effort (e.g. an educational campaign) to address one of the seven areas through non-program means. Four programs were then randomly selected for more in-depth examination to retrieve all the information provided in the Detailed Program Description Tables (see Appendix B, Table 1). General Internet searches on the program titles were performed and any available written reports were reviewed. The intent was to identify any preliminary problems in finding the information needed for all of the programs. Such problems as vague or incorrect program names were encountered, as well as problems finding reported evaluations and mention of cultural components of programs. However, enough information was collected on the selected programs that the grid was then filled out for all of the remaining programs. When information could not be found on a program or it was found to not address any of our seven areas we excluded them from our list of DHHS programs.

Appendix B. Tables

Table B-1. Detailed Program Description Tables

Table B-2. White House Report Program Goals by US Chartbook Content Areas

Table B-3. DHHS Programs by White House Program Goals and US Chartbook Content Areas

Table B-4. What Works Tables (summary of previous CT work)

B1: Detailed Program Description Tables

Name of Program				Program Characteristics				
Name	Acronym/ Other names	FY 03 Appropriation (Millions)*	CFDA Number	Summary	Targeted Populations	Cultural Relevance	Type of Approach	Notes
Alcohol Research Center Grants		NA	93.891	The National Institute on Alcohol Abuse and Alcoholism (NIAAA) provides grant support for Alcohol Research Centers and fosters interdisciplinary research on alcoholism and alcohol abuse. The programs of research include the nature, causes, and consequences of alcohol abuse and alcoholism, including diagnosis, treatment, prevention, and health services research related to prevention and treatment of alcoholism. Centers are designed to stimulate and encourage application of multiple perspectives and approaches to alcohol related problems.			Grant: Research	All proposed research to be conducted within a Center must be clearly directed toward one or more of the following goals: prevalence, etiology, diagnosis, prediction, clinical course, management or treatment of alcohol abuse, alcoholism, or alcohol-related health problems; health services research; consequences of alcoholism or alcohol abuse; factors that relate to prevention of alcohol abuse, alcoholism, or other problems associated with alcohol consumption. On a rotating basis, program evaluations will be conducted to validate the performance monitoring data and to extend our understanding of the impacts of the activities on the adoption of best practices.
Alcohol Research Programs		NA	93.273	These programs are designed to develop a sound fundamental knowledge base which can be applied to the development of improved methods of treatment and more effective strategies for preventing alcoholism and alcohol-related problems. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) supports research in a broad range of disciplines and subject areas related to biomedical and genetic factors, psychological and environmental factors, alcohol-related problems and medical disorders, health services research, and prevention and treatment research.			Grant: Research	Example programs: (1) Alcohol use during pregnancy and pregnancy outcome; (2) studies of alcoholic hepatitis; (3) physical dependence on ethanol; and (4) alcohol and alcohol-drug interactions.
Circles of Care	Circles of Care Initiative	2.4		The *Circles of Care* initiative provides funding to plan, design, and assess the feasibility of implementing a culturally appropriate mental health service model for American Indian/Alaska Native children with Serious Emotional/Behavioral Disturbances (SED) and their families. This program is funded by the Federal Center for Mental Health Services (CMHS, part of the Substance Abuse and Mental Health Services Administration, or SAMHSA) with additional support from the Indian Health Service and the National Institute of Mental Health.	American Indian/Alaska Native children with SED and their families.	American Indian/Alaska Native children with SED	Grant: Services/ Project	With this three year planning and assessment grant, grantees will plan, design, and assess the feasability of implementing a culturally appropriate mental health service model for American Indian and Alaska Native children. The Circles of Care initiative requires an evaluation plan that both informs and assesses the strategic planning process. The overarching goals of the Circles of Care Evaluation Plan are to: 1) to provide a knowledge base for the planning effort; 2) to facilitate the process for developing the capacity for ongoing evaluation efforts; 3) to examine the feasibility of the service system models; and 4) to document and disseminate the results of the initiative. Evaluation activities are designed to assure that the final service delivery models developed through the Circles of Care initiative are consistent with community needs, developed through community consensus building, and practical and feasible given the resources available.
Community Based Family Resource and Support Program	Community Based Family Resource and Support Grants	33.2	93.590.	This program is designed to assist States in their development and implementation (or expansion and enhancement) of a comprehensive, statewide system of community-based family resource and support services; to prevent child abuse and neglect.	Abused/neglected youth		Grant: Range	To receive funds, States must meet eligibility requirements by using funds to develop, operate, expand, and enhance community-based, prevention focused programs and activities designed to strengthen and support families to prevent child abuse and neglect.
Community Initiated Interventions	Community Initiated Prevention Interventions	NA		The purpose of these interventions is to field-test effective substance abuse prevention interventions that have been shown to prevent or reduce, tobacco, alcohol, or illegal drug use and/or associated social, emotional, cognitive or behavioral issues among high-risk populations in local communities.	At risk populations		Grant: Services/ Project	The purpose of Community-Initiated Prevention Interventions is to support knowledge development by soliciting applications for studies that field test effective substance abuse prevention interventions that have been shown to prevent, delay or reduce alcohol, tobacco, or other illegal drug use and/or associated social, emotional, behavioral, cognitive and physical problems among at-risk populations in their local community(ies) and /or other domains. These other domains include the individual, the family, the school, the health care provider and the workplace.
Community Services Block Grant	CSBG	645.8		The Community Services Block Grant program provides states, territories, and federally and state-recognized Indian tribes/tribal organizations with funds to provide a range of services to address the needs of low income individuals to ameliorate the causes and conditions of poverty.			Grant: Services/ Project	Community Service Block Grants are run by ACF and monitored by the CSBG Information System. The CSBGIS survey, which is administered by the National Association for State Community Services Programs, is used to collect program level information for annual statistical reports. CSBG funds many local agencies (over 1,100) most of which are Community Action Agencies. Grantees use the funds to support a variety of activities that help low-income people. Services typically assist with childcare, employment, education, health care, housing, nutrition, transportation, youth development, and coordination or resources and encouraging community participation.

*Total appropriations may overlap and also serve other age groups

B1: Detailed Program Description Tables

Name of Program				Program Characteristics				
Name	Acronym/ Other names	FY 03 Appropriation (Millions)*	CFDA Number	Summary	Targeted Populations	Cultural Relevance	Type of Approach	Notes
Community Youth Mental Health Promotion and Violence/Substance Abuse Prevention	Community Youth Mental Health Promotion and Violence/Substance Abuse Prevention Partnership Program	NA		The Coalitions for Prevention Grants seek to promote mental health and to prevent violence and substance abuse among youth. The grants provide 2 types of funding: 1). Planning and Partnership Development Grants for States and tribes to develop new coalitions with community service organizations; 2). Partnership Resources and Infrastructure Support Monies for existing coalitions to develop resources and infrastructures to support program implementation and evaluation.			Grant: Range	This program is administered by SAMHSA and currently the Center for Substance Abuse Treatment has not developed any evaluations explicitly within the GPRA framework.
Comprehensive Community Mental Health Services Program for Children and Their Families		98.1		The Comprehensive Community Mental Health Services Program for Children and Their Families provides grants for the improvement and expansion of systems of care to meet the needs to the estimated nationwide 4.5-6.3 million children with serious emotional disturbances and their families.	Children with serious emotional disturbances and their families		Grant: Services/ Project	The Center for Mental Health Services (CMHS), administers 6-year Federal grants to implement, enhance, and evaluate local systems of care. The Child, Adolescent and Family Branch of CMHS manages the program and receives and evaluates the competitive grant applications. The program utilizes a service delivery approach which includes families in the designing and partnership stages of the program
Consolidated Health Centers		1504.8		This grant is designed to fund the creation (and expansion) of a national network of community health centers, migrant health centers, health care for the homeless centers, public housing primary care centers and school-based health centers.	People without health insurance		Grant: Services/ Project	These grants are aimed at creating comprehensive health care centers that will provide health services to hundreds of thousands of people (many of whom do not have insurance.)
Cooperative Agreements for Strengthening Communities in the Development of Comprehensive Drug and Alcohol Treatment Systems for Youth	Strengthening Communities – Youth	8.8	93.243 (This is part of a larger grant (SAMHSA-PRNS))	The program funds cooperative agreements to assist communities strengthen their drug and alcohol identification, referral and treatment systems for youth.	Services must be directed to youth who are identified as experiencing substance abuse problems or who are at risk of problem behavior related to substance abuse.		Grant: Services/ Project	This program is administered by the Substance Abuse and Mental Health Services Administration and is primarily targetted at youth. However, services may also be provided to the youth's parents, legal guardians or significant adults in their lives.
Development of Comprehensive Drug/Alcohol and Mental Health Treatment Systems for Persons Who Are Homeless	Treatment for Homeless	28.5	93.243 (This is part of a larger grant (SAMHSA-PRNS))	The purpose of Treatment for Homeless grants is to enable communities to expand and strengthen their treatment services for homeless individuals with substance abuse disorders and/or mental illness.	Homeless persons who have a diagnosable substance abuse disorder, diagnosable mental illness, or a co-occurring substance abuse disorder and mental illness.	Intervention must be culturally competent	Grant: Services/ Project	This program began in FY01 and is run by the Substance Abuse and Mental Health Services Administration. Funds must be used to provide substance abuse treatment and/or mental health services. Funds may also be used to promote entry to and maintenance in stable housing or educate the community about homelessness. Applicants for this grant must state if their proposed intervention approach is an evidence-based practice, best practice, or promising practice (see Appendix D. Definitions). Additionally, applicants must demonstrate that their proposed intervention is culturally competent supported by evidence from current research or from locally conducted evaluations.

*Total appropriations may overlap and also serve other age groups

B1: Detailed Program Description Tables

Name of Program				Program Characteristics				
Name	Acronym/ Other names	FY 03 Appropriation (Millions)*	CFDA Number	Summary	Targeted Populations	Cultural Relevance	Type of Approach	Notes
Drug Abuse Research Programs		NA	93.279	These programs are supposed to provide epidemiologic, basic, clinical, and applied research to develop new knowledge and approaches related to the prevention, treatment, etiology, and consequences of drug addiction, including HIV/AIDS.			Grant: Research	This program is administered by the National Institutes of Health. The purpose of the grant is to: (1) provide support for clearly defined projects or a small group of related research activities, and when appropriate, support of research conferences; (2) support large-scale, broad-based programs of research, usually interdisciplinary, consisting of several projects with a common focus; (3) support newer, less experienced investigators; investigators at institutions without a well developed research tradition and resources; the testing of new methods or techniques; small-scale exploratory and pilot studies, or exploration of an unusual research opportunity; (4) to establish the technical merit and feasibility of a proposed research or research and development efforts to determine the quality of performance of the small business grantees. Examples of funded projects: (1) Kinetics of Morphine and its Derivatives; (2) Epidemiology of drug abuse among minority populations; (3) Studies of AIDS among IV Drug Abusers; (4) Studies of Narcotic- Induced Respiratory Depression; and (5) Maternal/Paternal Effects of Drugs of Abuse.
Family Support (PNS)	Projects of National Significance Family Support Program	NA		This particular Project of National Significance is designed to support the development of state policies that reinforce and promote the development of family support activities contributing to the self-determination, independence, productivity, and integration and inclusion in all facets of community life of children with disabilities.	Unserved and underserved populations	Race/ethnic minorities are one of the targeted groups	Grant: Services/ Project	This program is part of the larger Projects of National Significance grant program. This particular program not only tries to support state development of family services but also seeks to increase services to those that have traditionally not received enough services (minorities, econ. disadvantaged, limited-English proficiency, underserved geographic areas, etc.).
Girl Power!		0.1		Girl Power! is a national public education campaign to help encourage and motivate 9- to 13- year-old girls to make the most of their lives by targeting health messages to the unique needs, interests, and challenges of girls.	Girls ages 9-13		Campaign	Girl Power! provides opportunities for girls to increase their competence in decision making, problem solving, and communication. National, State, and local organizations across the country implement the skill-building programs. Girl Power! has hundreds of private and public partners who are dedicated to making regular, sustained efforts to teach girls the skills they need to make positive decisions in their lives. As a public awareness campaign, Girl Power! informs the public about the importance of supporting girls as they grow into adolescence. Information can be found at: http://www.girlpower.gov/
Grants to Improve the Quality and Availability for Residential Treatment and its Continuing Care Component for Adolescents		8.1		These grants are to enhance and/or expand residential treatment services for youth (aged 21 and under) referred for treatment of a drug or alcohol problem.	Adolescents with drug or alcohol problem		Grant: Services/ Project	Run by The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT)
Healthy Schools Healthy Communities	HSHC	21	93.302	Healthy Schools, Healthy Communities provides support for the development and operation of centers that provide preventive and comprehensive primary health care services to children at risk for poor health outcomes and other medically underserved populations.	High risk, medically underserved children and adolescents		Grant: Services/ Project	The mission of the HSHC program is to promote and establish comprehensive school-based health centers which improve the health of vulnerable children and adolescents through treatment and services such as: counseling, mental and dental health services, nutrition, and health education. Using a multi disciplinary staff and a family-centered approach to care, HSHC projects deliver comprehensive primary care services to over 160,000 at-risk school aged children. Targeted education programs are an integral part of each project
Hispanic Latino Boys and their Fathers	SAMHSA's Hispanic/Latino Initiative	0.4		The Substance Abuse and Mental Health Services Administration developed a three phase Hispanic/Latino Initiative. Phase III, which will address substance abuse prevention for Hispanic boys and their fathers, was under development in FY04.	Latino boys and their fathers	Latino boys and their fathers	Initiative	In the Spring of 1995, the Secretary of the Department of Health and Human Services authorized the establishment of the Departmental Working Group on Hispanic Issues. The Hispanic/Latino Initiative has released two sets of materials. Phase I is aimed at parents, children and community leaders, and Phase II (the Soy Unica component) is targeted to Latinas ages 9-14 and their mothers and caregivers.Phase III will address substance abuse prevention for Hispanic boys and their fathers, is currently under development and promises to be equally successful.
Hotline Evaluation and Linkage Program	Hotline Evaluation and Linkage Project – HELP	3		HELP seeks to improve the quality and accessibility of suicide prevention services and to evaluate those services; to increase knowledge of basic biological and behavioral processes that underlie mental and behavioral disorders, and contribute to maintaining mental health; to improve methodologies for research relevant to these disorders; and to conduct research on mental health services.			Grant: Range	HELP is intended to improve the quality and accessibility of suicide prevention services and to evaluate those services. The program is a collaborative effort between researchers at Rutgers and Columbia Universities and will hopefully evaluate the services of over 200 crisis centers. This is the first federal funding for suicide prevention given since former U.S. Surgeon General Dr. David Satcher released the National Strategy for Suicide Prevention: Goals and Objectives for Action. More information can be found at: http://www.hopeline.com/5/HELP.asp

*Total appropriations may overlap and also serve other age groups

B1: Detailed Program Description Tables

Name of Program				Program Characteristics				
Name	Acronym/ Other names	FY 03 Appropriation (Millions)*	CFDA Number	Summary	Targeted Populations	Cultural Relevance	Type of Approach	Notes
Injury Prevention and Control Research	Injury Prevention and Control Research and State and Community Based Programs	10.1	93.136	These grants are given to support improvements in injury control programs, to integrate aspects of other disciplines in order to prevent and control injuries more effectively, to stimulate and support Injury Control Research Centers (ICRC), and to help improve the knowledge base on injury prevention and control in general.			Grant: Research	Research grants are given to: (1) support injury control research on priority issues (2) integrate aspects of multiple disciplines in order to prevent and control injuries more effectively (3) rigorously apply and evaluate current and new interventions, methods, and strategies that focus on the prevention and control of injuries (4) stimulate and support Injury Control Research Centers (ICRC) in academic institutions which will develop a comprehensive and integrated approach to injury control research and training (5) bring the knowledge and expertise of ICRC's to bear on the development of effective public health programs for injury control. State and regional grants are to help develop and evaluate new methods or evaluate existing methods and techniques used in injury surveillance by public health agencies; to develop, expand, or improve injury control programs to reduce morbidity, mortality, severity, disability, and cost from injuries.
Integrated health and behavioral health care for children, adolescents, and their families	Integrated Health and Behavioral Health Care for Children, Adolescents and Their Families Grant Program	0.8		These grants are designed to assist community health care organizations develop and formalize working relationships for planning a program of health service delivery for children, adolescents and their families that integrate physical and psychosocial primary care, comprehensive mental health services, and substance abuse prevention and treatment services.	Children, adolescents and their families.		Grant: Other	These two-year planning grants will provide start-up support for grantees to initiate and formalize working relationships with public and private community organizations/agencies/ programs and/or State agencies and other key stakeholders to establish a blueprint for the integration of primary health care and behavioral health services for children, adolescents and their families in a targeted area with a total population of about 100,000, which includes an estimated minimal population of children and adolescents of 25,000. (Rural areas may contain a smaller target population.)
Maternal and Child Health Block Grant	MCH Block Grants; MCHBG	730	93.994	The purpose of the MCHBGs is to enable states to maintain and strengthen their leadership in planning, promoting, coordinating and evaluating health care for pregnant women, mothers, infants and children, and children with special health care needs. To assist states in providing health services for mothers and children who do not have access to adequate health care; to improve the health of all mothers and children, reduce infant mortality, provide access to comprehensive prenatal and postnatal care, and increase the number of children receiving health assessments.	Mothers, infants and children, and children with special health care needs particularly those in low-income families		Grant: Range	Beginning in FY 1991, States have been required to use at least 30 percent of their Federal allotment for preventive and primary care services for children, and at least 30 percent for services for children with special health care needs. In addition, each State must establish and maintain a toll-free information number for parents on maternal and child health (MCH) and Medicaid providers. No more than 10 percent of each State's allotment may be used for administration. Funds are allocated among the States and jurisdictions in proportion to their relative shares of funds received under eight antecedent programs in fiscal year 1981. When funding exceeds the amount appropriated in fiscal year 1983, the additional funds are allocated in proportion to the poverty population under age 18. States must assure that $3 of State or local funds will be expended for Maternal and Child Health purposes for every $4 of Federal funds allotted through the formula mechanism.
Mental Health Block Grant	Block Grants for Community Mental Health Services; CMHS Block Grant, MHBG. Was previously (until 1992) the Alcohol, Drugs, and Mental Health Services (ADMS) Block Grant.	437.1	93.958	The purpose of the MHBG is to provide financial assistance to States and Territories to enable them to carry out the State's Plan for providing comprehensive community mental health services to adults with a serious mental illness and to children with a serious emotional disturbance; monitor the progress in implementing a comprehensive community based mental health system; provide technical assistance to States and the Mental Health Planning Council that will assist the States in planning and implementing a comprehensive community based mental health system.			Grant: Range	Because what is effective in one State may not be effective in another, the Community Mental Health Services Block Grant works in close collaboration with each State or Territory to develop and implement its own State Mental Health Plan for improving community-based services and reducing reliance on hospitalization. The program stipulates that case management be provided to individuals with the most serious mental disorders and encourages appropriate partnerships among a wide range of health, dental, mental health, vocational, housing, and educational services. The program also promotes partnerships among Federal, State, and local government agencies. This program is run by the Substance Abuse and Mental Health Services Administration. The State must provide for independent peer review to assess the quality, appropriateness and efficacy of treatment services provided in the State to individuals under the program involved, ensuring that not fewer than 5 percent of the entities providing services in the State under the program are reviewed and that the 5 percent are representative of the total population of such entities.
Mental Health Research Grants		NA	93.242	These grants are aimed at increasing knowledge of basic biological and behavioral processes that underlie mental and behavioral disorders and of processes that contribute to maintaining mental health; to improve methodologies for research relevant to these disorders; and to conduct research on mental health services			Grant: Research	Examples of Funded Projects: (1) Basic and clinical neuroscience approaches to normal and disordered behavior; Genetic studies of depressive disorders; (2) prospective study of children of schizophrenic parents; (3) neural bases of major psychiatric disorders; (4) genomic control of CNS development; (5) Psychosocial interventions in senile dementia; (6) legal impact on mental health practice; (7) processes in learning and behavioral change; (8) prevention of high-risk AIDS behavior; and (9) antibodies to rationally modulate specific neurotransmitter receptors.

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B1: Detailed Program Description Tables

Name of Program				Program Characteristics				
Name	Acronym/ Other names	FY 03 Appropriation (Millions)*	CFDA Number	Summary	Targeted Populations	Cultural Relevance	Type of Approach	Notes
Mentoring and Family Strengthening	Dissemination of Effective Mentoring and Family Strengthening Programs for High Risk Youth.	6.9		The Center for Substance Abuse Prevention proposes to reach a greater number of youth and families in two separate program areas: (1) Science-based family strengthening program models and (2) youth only or youth and family mentoring approaches. Both program areas have well-experienced and active communities implementing these practices. This money will provide for expanding family strengthening and mentoring activities beyond their original target groups, settings, or sites.	High risk youth		Grant: Services/ Project	Program seems to be part of the Consolidated Knowledge Development and Application (KD&A) Program which is run by SAMHSA and tries to provide substance abuse and mental health services in crucial selected areas. The grant requires that a cross site evaluation will be done which "will give a better understanding of the process and outcomes of widespread implementation".
National Academic Centers for Excellence on Youth Violence Prevention	Academic Center of Excellence	9.2		Ten colleges and universities work with communities to address the public health problem of youth violence. Five centers focus on developing and implementing community response plans, training health care professionals, and conducting small pilot projects to evaluate effective strategies for preventing youth violence. The other five centers conduct more comprehensive activities, including researching risk factors for youth violence and evaluating prevention strategies.	Communities and Youth		Grant: Range	The purpose of the centers is to: Develop and evaluate youth violence prevention and intervention strategies, and carry them out in cooperation with agencies and experts in the fields of medicine, epidemiology, legal and criminal justice, behavioral and social science, and public health; Develop and help to implement a youth violence community response plan; Develop, deliver, and maintain a training curriculum for health care professionals; Research youth violence risk and protective factors; Work with other youth violence prevention programs, organizations, and individual leaders, especially in communities where there is much youth violence. Currently there are 10 Centers located at: Columbia; Harvard; Johns Hopkins; University of Alabama/Birmingham; University of California/Riverside; University of California/San Diego; University of Hawaii/Manoa; University of Michigan; University of Puerto Rico; Virginia Commonwealth University. For more information please see: http://www.safeyouth.org/scripts/ace/index.asp
National Adolescent Health Information Center; Adolescent Health Center for State Maternal and Child Health Personnel	NAHIC	2.3		The goal of NAHIC is improve the health of adolescents by serving as a national resource for adolescent health information and research; and to assure the integration, synthesis, coordination and dissemination of adolescent health-related information.			Clearing-house/ Resource	NAHIC works to promote collaborative relationships; collect, analyze and disseminate information; provide technical assistance, consultation and continuing education to states, communities and providers in content areas that emphasize the needs of adolescents. For more information please see: http://nahic.ucsf.edu/index.php/about/index/
National Association for Children of Alcoholics		NA		The purpose of the National Association for Children of Alcoholics is to advocate for all children and families affected by alcoholism and other drug dependencies.	All children and families affected by alcoholism and other drug dependencies.		Policy/ Association	Affiliate organizations exist throughout the country and Great Britain. The program publishes a bi-monthly newsletter; creates videos, booklets, posters and other educational materials to assist natural helpers to intervene and support children; host web site with information about and ways to help children of alcoholics and other drug dependent parents; information packets, and maintain a toll-free phone available to all. For more information please see: http://www.nacoa.org/
National Bone Health Campaign		1.7		The National Bone Health Campaign is a social marketing campaign that promotes optimal bone health among girls aged 9–12 years in an effort to reduce their risk of osteoporosis later in life; to establish lifelong healthy habits, focusing on increased calcium consumption and weight-bearing physical activity to build and maintain strong bones.	Girls ages 9-12		Campaign	Resources for this campaign include a Web site for girls, and print materials, radio and print advertisements for girls and parents. This campaign is a result of a partnership between two agencies of the U.S. Department of Health and Human Services (the Centers for Disease Control and Prevention and the Office on Women's Health), and the National Osteoporosis Foundation. For more information please see: http://www.cdc.gov/nccdphp/dnpa/bonehealth/
National Clearinghouse on Alcohol and Drug Information (NCADI)		7.1		Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Clearinghouse for Alcohol and Drug Information (NCADI) is the Nation's one-stop resource for information about substance abuse prevention and addiction treatment.			Clearing-house/ Resource	NCADI services include an information services staff equipped to respond to the public's alcohol, tobacco, and drug (ATD) inquiries; the distribution of free or low-cost ATD materials, including fact sheets, brochures, pamphlets, monographs, posters, and video tapes from an inventory of over 1,000 items; a repertoire of culturally-diverse prevention, intervention, and treatment resources tailored for use by parents, teachers, youth, communities and prevention/treatment professionals; customized searches in the form of annotated bibliographies from alcohol and drug data bases; access to the Prevention Materials database (PMD) including over 8,000 prevention-related materials and the Treatment Resources Database, available to the public in electronic form; rapid dissemination of Federal grant announcements for ATD prevention, treatment, and research funding opportunities.

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B1: Detailed Program Description Tables

Name of Program				Program Characteristics				
Name	Acronym/ Other names	FY 03 Appropriation (Millions)*	CFDA Number	Summary	Targeted Populations	Cultural Relevance	Type of Approach	Notes
National Suicide Prevention Resource Center (NSPRC)		3		The goal of the Resource Center is to facilitate the implementation of the goals and objectives of the National Strategy for Suicide Prevention through the identification, translation, and culturally appropriate delivery of best practices for all aspects of suicide prevention.			Clearing-house/ Resource	The Resource Center's goals is to provide technical assistance to national, regional, state, tribal, and local organizations, develop and disseminate suicide prevention information, identify, document, and disseminate best practices in suicide prevention, develop and deliver training on suicide prevention topics, and conduct policy activities. The Education Development Center will collaborate with the American Association of Suicidology, the American Foundation for Suicide Prevention, and the Suicide Prevention Advocacy Network to bring this project to fruition.
National Youth Sports Program (NYSP)		16.9		The program tries to teach physical fitness, form friendships, teach useful skills (e.g., swimming), teach nutrition, and improve academic interest and abilities.	Older children and Youth; Low income youth: NYSP requires 90% of participants at each site to meet U.S. poverty guidelines.		Program	The five-week program conducted at over 200 colleges and universities makes an unprecedented effort to combine the promotion of athletic know-how and life skills that can bring participants closer to equality. Looking to the future needs of students, NYSP has implemented a senior-phase program to focus on the needs of the 13-16 year old participant. Placing an emphasis on achieving higher-level education and test taking skills, 25 sites are being used to evaluate teaching methods and needs for launching the concept nationally. NYSP enhances participants' chances of achieving higher educational standards by helping students prepare for the rigors of standardized-testing methods and reinforcing reading, writing and computer skills. For more information please see: http://www.nyscorp.org/nysp_overview.htm
National Youth Violence Prevention Resource Center		25.5		The Resource Center serves as a central source of information on prevention and intervention programs, publications, research, and statistics on violence committed by and against children and teens; a single point of access to federal information on youth violence; provides current information developed by Federal agencies and the private sector pertaining to youth violence; includes tools to facilitate discussion with children, to resolve conflicts nonviolently, to stop bullying, to prevent teen suicide, and to end violence committed by and against young people.			Clearing-house/ Resource	Developed by the Centers for Disease Control and Prevention and other Federal partners, the Resource Center provides current information developed by Federal agencies and the private sector pertaining to youth violence. A gateway for professionals, parents, youth and other interested individuals, the Resource Center offers the latest tools to facilitate discussion with children, to resolve conflicts nonviolently, to stop bullying, to prevent teen suicide, and to end violence committed by and against young people. Resources include fact sheets, best practices documents, funding and conference announcements, statistics, research bulletins, surveillance reports, and profiles of promising programs. For more information please see: http://www.safeyouth.org/scripts/index.asp
Parenting is Prevention/National Families in Action		0.4		Parenting is Prevention/National Families in Action strive to provide accurate information, support, and resources to assist parents and others in raising children to be healthy, drug-free, productive adults	Parents and caregivers		Clearing-house/ Resource	The program's internet website provides tips, informational resources, links to local and national organizations, a focus on what other parents are doing in their communities, and opportunities to ask questions and have them answered by parents whose children have become healthy, drug-free, productive adults. For more information please see: http://www.parentingisprevention.org/about.html
Policy Research and Evaluation Grants		NA	93.239	The goal of these grants is to support research that is relevant to policy development and evaluation of current and proposed programs of interest to the Secretary, the Administration, and the Congress that pertain to welfare reform outcomes and policies affecting children and youth..			Grant: Research	Priorities for the grants include: (1) Issues of long-term care, disability, and personal assistance services, including informal care giving; (2) health care delivery issues including health care financing; (3) welfare reform outcomes and policies affecting children and youth; (4) community development; (5) science policy development; and (6) the reduction of poverty.
Practice Improvement Collaborative		5.6		The Practice Improvement Collaboratives (PIC) program was initiated by the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (CSAT) in 1999 to support and promote effective and efficient community-based treatment.	Ethnic and cultural minorities, clients involved with the criminal justice system, clients with co-occurring mental health and substance use disorders, adolescents, and women with children.		Collaborative/ Network	Each PIC program has a formally established organizational structure and is governed by community stakeholders, including substance abuse treatment providers, researchers, policymakers, educators, and members of the recovery community. Each PIC also evaluates the process of implementation and the effectiveness of its implementation strategies.

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Name of Program				Program Characteristics				
Name	Acronym/ Other names	FY 03 Appropriation (Millions)*	CFDA Number	Summary	Targeted Populations	Cultural Relevance	Type of Approach	Notes
Prevention of Underage Alcohol Use	Too Smart to Start (Underage Alcohol Use Prevention Initiative)	NA		Too Start to Smart uses Input from pre-teens and their parents to help develop and implement communication strategies to combat misinformation and conflicting messages about alcohol use that 9- to 13-year-olds get from their peers, role models, and the media.	9- to 13- year-olds and their parents/caregivers.		Campaign	Too Smart to Start is a science-based public information initiative that helps communities to develop and conduct underage alcohol prevention programs. This is done through providing strategies and materials to these communities. The Center for Substance Abuse Prevention along with University Research Co. are working together to help communities build and mobilize networks to change norms that encourage underage drinking and decrease risk factors while increasing protective factors related to underage alcohol use. The program has a large and diverse group of partners and currently has programs underway in multiple states.
Prevention Research Centers Program		NA		The Prevention Research Centers Program enables CDC to fund extramural research centers that add to knowledge about preventing and controlling chronic disease.	People at risk for disease and disability, especially people affected by adverse socioeconomic conditions.		Program	These centers are housed within schools of public health, medicine, or osteopathy and are managed as CDC cooperative agreements. The centers try to add to the knowledge about preventing and controlling chronic disease by incorporating families in many interventions; striving to develop communities' long-term capacity, and by conducting research projects on health- or population-specific issues.
Projects of National Significance (PNS)		12.4		PNS funds are awarded to public or private, non-profit institutions to enhance the independence, productivity, integration and inclusion into the community of people with developmental disabilities. Monies also support the development of national and state policy.	Focus on the most pressing issues affecting people with developmental disabilities and their families.		Grant: Range	PNS address issues transcend the borders of states and territories, but must be addressed in a manner which allows for local implementation of practical solutions. Examples include: Data collection and analysis; Technical assistance; Projects which enhance participation of people with developmental disabilities from minority and ethnic groups; Projects which explore the transition of youth with developmental disabilities from school to work; Projects which develop strategies for self-advocacy and leadership skills among people with developmental disabilities and their families; Projects which develop training and ongoing programs for inclusion of children with developmental disabilities in child care settings.
Promoting Safe and Stable Families		404.4		This money is used to prevent the unnecessary separation of children from their families, improve the quality of care and services to children and their families, and ensure permanency for children by reuniting them with their parents, by adoption or by another permanent living arrangement. The programs include: family support, family preservation, time-limited family reunification and adoption promotion and support services.	Children and Families		Grant: Range	Most grant funds go directly to State governments or certain eligible Indian tribes for expenditure in accordance with their 5-year plans. Other grant funds are set aside for nationally-funded evaluation, research, and training and technical assistance projects. In addition, State courts receive grants to improve foster care and adoption proceedings.
Regional Alcohol and Drug Awareness Resource Network (part of NCADI contract)	Radar Network	0.2		The goal of the RADAR Network is to strengthen communication, prevention, and treatment activities among a broad range of organizations to address problems related to substance abuse. RADAR Centers are committed to keeping the national and international community informed about the latest regulations, scientific findings, campaigns and materials, and other resources related to alcohol and drug use.			Collaborative/ Network	The RADAR Network consists of State clearinghouses, prevention resource centers, and national, international, and local organizations supporting substance abuse prevention activities. For more information please see: http://www.health.org/radar/about.aspx
Runaway and Homeless Youth - Basic Center program		49.5	93.623	The purpose of these grants is to establish or strengthen locally controlled community-based programs that address the immediate needs of runaway and homeless youth and their families. Services must be delivered outside of the law enforcement, child welfare, mental health and juvenile justice systems. The goals and objectives of the Basic Center Program are to: 1) Alleviate problems of runaway and homeless youth; 2) reunite youth with their families and encourage the resolution of intrafamily problems through counseling and other services; 3) strengthen family relationships and encourage stable living conditions for youth; and 4) help youth decide upon constructive courses of action.	Runaway and homeless youth and their families.		Grant: Services/ Project	This program is run by the Family and Youth Services Bureau. Each Basic Center program is required to provide outreach to runaway and homeless youth; temporary shelter for up to fifteen days; food; clothing; individual, group and family counseling; aftercare and referrals, as appropriate. Basic Center programs are required to provide their services in residential settings for at least four (4) youth and no more than twenty (20) youth. Some programs also provide some or all of their shelter services through host homes (usually private homes under contract to the centers), with counseling and referrals being provided from a central location. Basic Center programs offer shelter to youth who are less than 18 years of age and who are at risk of separation from their family. Basic Center must provide age appropriate services or referrals for homeless youth ages 18-21. Examples of funded projects: Funded projects include local centers for runaway and homeless youth, Youth Development State Collaboration Programs, Training and Technical Assistance grants, and a toll-free National Communications System.

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Name of Program				Program Characteristics				
Name	Acronym/ Other names	FY 03 Appropriation (Millions)*	CFDA Number	Summary	Targeted Populations	Cultural Relevance	Type of Approach	Notes
Runaway and Homeless Youth - State Collaboration/Demonstration Grants for Positive Youth Development	State Youth Development Collaboration Projects	1.6		The grants enable the States to identify and develop new or strengthen existing effective youth development strategies. Each State has designed a unique plan for implementing the demonstration project on the basis of identified youth needs and prior State activities with regard to youth development. The states meet from time to time to share information on their work in progress	All youth, including those in at-risk situations such as runaway and homeless youth, youth leaving the foster care system, abused and neglected children, and other youth served by the child welfare and juvenile justice systems.		Grant: Services/ Project	This program is run by the Family and Youth Services BureauEach State has designed a unique plan for implementing the demonstration project on the basis of identified youth needs and prior State activities with regard to youth development. States have planned evaluations: http://www.acf.dhhs.gov/programs/fysb/State-YD2.htm Topics that states have identified as being of concern or interest include: youth participation, marketing and message development, collaboration, and project evaluation. Most of the states seem to have used the money for surveys on youth development, creating task forces on youth development, and creating clearinghouses on youth development.
Runaway and Homeless Youth - Transitional Living Program and Maternity Group Homes	Transitional Living Program (TLP)	40.5	93.557	The overall purpose of the Transitional Living Program (TLP) for Homeless Youth is to establish and operate transitional living projects for homeless youth, including pregnant and parenting youth. This program is structured to help older homeless youth achieve self-sufficiency and avoid long-term dependency on social services.	Homeless youth, ages 16 through 21		Grant: Services/ Project	This program is run by the Family and Youth Services Bureau. In response to the growing concern for these youth, Congress determined that many young people need long-term, supportive assistance that emergency shelter programs were not designed to provide. As a result, Congress created the Transitional Living Program for Older Homeless Youth (TLP) as part of the 1988 Amendments to the Runaway and Homeless Youth Act. Transitional Living Programs are required to provide youth with stable, safe living accommodations and services that help them develop the skills necessary to move to independence.
Runaway and Homeless Youth/Education and Prevention Grants to Reduce Sexual Abuse of Runaway, Homeless and Street Youth: Street Outreach Program (SOP)		15.4	93.550	This program makes grants available to nonprofit agencies for the purpose of providing street-based services to runaway, homeless and street youth, who have been subjected to, or are at risk of being subjected to, sexual abuse, prostitution, or sexual exploitation; to provide education and prevention services to runaway, homeless and street youth that have been subjected to or at risk of sexual exploitation or abuse; to establish and build relationships between street youth and program outreach staff to help youth leave the streets.	Runaway and homeless street youth.		Grant: Services/ Project	This program is run by the Family and Youth Services Bureau with the goal of providing street-based outreach and education for runaway and homeless youth and youth on the streets who have been, or are at risk of being, sexually abused and/or exploited, and to provide them with services that help them leave the streets. Example projects: In fiscal year 2002, 149 projects provided services for street-based education and outreach, emergency shelter, survival aid, individual assessment, treatment and counseling prevention and education activities, information and referral, crisis intervention, and follow-up support.
Rural Health Outreach Grant Program		NA		The purpose of the Rural Health Care Services Outreach Grant Program is to promote rural health care services outreach by expanding the delivery of health care services to include new and enhanced services in rural areas.	Rural populations		Grant: Services/ Project	This program is run by the Health Resources & Services Administration. This grant program supports projects that demonstrate creative or effective models of outreach and service delivery in rural communities. Applicants may propose projects to address the needs of a wide range of population groups including, but not limited to, low-income populations, the elderly, pregnant women, infants, adolescents, rural minority populations, and rural populations with special health care needs. Applicants may propose to deliver many different types of service, including: primary care, dental care, mental health services, home care, emergency care, health promotion and education programs, outpatient day care, and other services not requiring inpatient care. The program will not support services provided in an inpatient setting such as hospital inpatient units and nursing care facilities. For more information please see: http://ruralhealth.hrsa.gov/

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Name	Acronym/ Other names	FY 03 Appropriation (Millions)*	CFDA Number	Summary	Targeted Populations	Cultural Relevance	Type of Approach	Notes
School Guidelines and Related Activities of National Strategy for Suicide Prevention	The National Strategy for Suicide Prevention: Goals and Objectives for Action NSSP or National Strategy	NA		The goal of the National Strategy is to prevent premature deaths due to suicide across the life span; to reduce the rates of other suicidal behaviors; to reduce the harmful after-effects associated with suicidal behaviors and the traumatic impact of suicide on family and friends; to promote opportunities and settings to enhance resiliency, resourcefulness, respect, and interconnectedness for individuals, families, and communities			Clearing-house/ Resource	As conceived, the National Strategy requires a variety of organizations and individuals to become involved in suicide prevention and emphasizes coordination of resources and culturally appropriate services at all levels of government–Federal, State, tribal and community–and with the private sector. The NSSP represents the first attempt in the United States to prevent suicide through such a coordinated approach. For more information please see: http://www.mentalhealth.samhsa.gov/suicideprevention/strategy.asp
Social Economic Development Strategies (SEDS)		45.5		The goal of SED grants are to provide services that safeguard the health and well-being of people.			Grant: Services/ Project	SEDS are competitive financial assistance grants that support locally determined and designed projects to address community needs and goals promoting self-sufficiency.
Social Services Block Grant	SSBG	1700	93.667	To enable each State to furnish social services best suited to the needs of the individuals residing in the State. Federal block grant funds may be used to provide services directed toward one of the following five goals specified in the law: (1) To prevent, reduce, or eliminate dependency; (2) to achieve or maintain self-sufficiency; (3) to prevent neglect, abuse, or exploitation of children and adults; (4) to prevent or reduce inappropriate institutional care; and (5) to secure admission or referral for institutional care when other forms of care are not appropriate.			Grant: Services/ Project	This program is run by the Administration for Children and Families . As a condition of the grant an annual report is required. The report must include the services provided in whole or in part with block grant funds; the number of children and the number of adults receiving each service; expenditure data for both children and adults for each service; the criteria applied in determining eligibility for each service, including fees; and the method(s) by which each service was provided. States must provide DHHS with an annual report also. States and other eligible jurisdictions determine their own social services programs. Examples of funded services include child day care, protective and emergency services for children and adults, homemaker and chore services, information and referral, adoption, foster care, counseling, and transportation.
Social Services Research and Demonstration program		34.7	93.647	This program strives to promote the ability of families to be financially self-sufficient, and to promote the healthy development and greater social well-being of children and families	Families		Grant: Research	Example Programs: New Hampshire Employment and Training Program Process and Outcome Study: (New Hampshire Department of Health and Human Services) - The overall objectives of this study are to examine the planning, funding, and implementation of the state's welfare program and its different components at the state and local level. This examination will include documenting the organization and staffing of New Hampshire's program and observing and documenting service delivery processes; describing client flow and participation; and analyzing participant outcomes in terms of key variables such as employment and earnings and family structure and stability. Youth Employment and Training Initiative: (Illinois Department of Human Services) - This project involves the state completing an evaluation of the Youth Employment and Training Initiative (YETI) which operated as a welfare reform demonstration from November 1993 until July 1997 when Temporary Assistance to Needy Families (TANF) was implemented in the state.
Soy Unica Soy Latina Hispanic Initiative		0.1		The ¡Soy Unica! ¡Soy Latina! bilingual public education campaign is designed to assist Hispanic/Latina girls ages 9-14, and their mothers and other caregivers, to build and enhance their self-esteem, mental health, decision-making and assertiveness skills, and to prevent the harmful consequences of alcohol, tobacco and illicit drugs.	Latina girls ages 9-14 and their mothers/caregivers	Latinas	Campaign	The Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention (SAMHSA/CSAP) established the Hispanic/Latino Steering Committee to recommend and guide SAMHSA's Working Gropu on Hispanic Issues. The goal of the committee is to help the department reach out to the growing Hispanic/Latino population using culturally and language appropriate techniques. The Hispanic/Latino Initiative has released two sets of materials (Activity books, posters, bookmarks, stickers, T-shirts, and lanyards, and a Web site). Phase I is aimed at parents, children and community leaders, and Phase II (the Soy Unica component) is targeted to Latinas ages 9-14 and their mothers and caregivers. For more information please see: http://www.soyunica.gov/
State Incentive Grants Discretionary Program	State Incentive Grants	60.8		There are quite a few State Incentive Grants within DHHS. None of them are specifically referred to as being for discretionary programs. They exist for Strategic Prevention Frameworks, Building Alternatives to Restraint and Seclusion, Co-Occurring State Incentive Grants, State Incentive Grants for Prevention, Special Education, for Substance Abuse Prevention, etc.			Grant: Other	The SIG program is administered by the federal Center for Substance Abuse Prevention (CSAP), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) at the U.S. Department of Health and Human Services.

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Name of Program				Program Characteristics				
Name	Acronym/ Other names	FY 03 Appropriation (Millions)*	CFDA Number	Summary	Targeted Populations	Cultural Relevance	Type of Approach	Notes
Statewide Family Networks	The Family Network and Support Program	3.4		The purpose of the Family Network and Support Program is to provide families of children and adolescents with serious emotional disturbances (SED) the support and assistance needed to contribute to the development of effective Statewide Family Networks.	Families of children and adolescents from birth to 18 years of age with a serious emotional disturbance.		Grant: Range	The Family Network and Support Program : 1) fosters collaboration among key stakeholders (i.e. families, advocates, networks, etc...) 2) promotes skills development of family-controlled organizations, and 3) identifies and implements a strategy to address technical assistance needs for family-controlled organizations. Network activities include developing support groups; disseminating information and technical assistance through clearinghouses; maintaining toll-free telephone numbers, information and referral networks, and newsletters; sponsoring conference and workshops; outreach activities; serving as a liaison with various human service agencies, developing skills in organizational management and financial independence ; training and advocacy for children's services. Several of the projects sites in the Statewide Family Network Program specifically focus on the needs of ethnic minorities and rural families' issues. For more information please see: http://www.mentalhealth.samhsa.gov/cmhs/childrenscampaign/statewide.asp
Substance Abuse Prevention and Treatment Block Grant	SAPT	1403.1	93.959	To provide financial assistance to States and Territories to support projects for the development and implementation of prevention, treatment and rehabilitation activities directed to the diseases of alcohol and drug abuse.			Grant: Services/ Project	The grants have built in set-asides for: Programs to educate and counsel individuals who are not substance abusers and to provide for activities to reduce the risk of such abuse by developing community-based strategies for prevention of such abuse, including the use of alcoholic beverages and tobacco products by those that are underage; Increasing the availability of treatment services designed for pregnant women and women with dependent children (either by establishing new programs or expanding the capacity of existing programs); and for providing tuberculosis services such as counseling, testing, treatment, and early intervention services for substance abusers at risk for the human immunodeficiency virus (HIV) disease. Additional information on that can be found at: http://aspe.hhs.gov/pic/perfimp/1995/chap-01.htm
Substance Abuse Prevention and Treatment Block Grant/Prevention Set-Aside	SAPT Prevention Set-aside	350.8	93.959	To provide financial assistance to States and Territories to support projects for the development and implementation of prevention, treatment and rehabilitation activities directed to the diseases of alcohol and drug abuse.			Grant: Range	The grants require that not less than 20 percent of the funds shall be spent for programs for individuals who do not require treatment for substance abuse, but to educate and counsel such individuals and to provide for activities to reduce the risk of such abuse by the individuals by developing community-based strategies for prevention of such abuse, including the use of alcoholic beverages and tobacco products by individuals to whom it is unlawful to sell or distribute such beverages or products.
TCE (Targeted Capacity Expansion) - Prevention and Early Intervention	TCE Prevention and Early Intervention	1		This program is designed to meet the need for emerging and urgent mental health services in communities. A fundamental objective of the program is to provide resources to non-mental health service systems that provide treatment to the vast majority of persons who receive mental health care. For example, physicians' offices, nursing homes, the criminal justice system, and the foster care system are just a few of the settings where care is typically provided.	There are special program set-asides for programs that serve individuals who are at risk, or in the early stages of mental illness, in non-mental health settings with a special emphasis will be placed on targeting at-risk children and adolescents and projects that target a reduction in racial and ethnic disparities in mental health.		Grant: Services/ Project	The grant program provides funds and technical assistance to enable grantees to better reach their communities and fill the gaps in substance abuse treatment within the three-year period of the grant. Grantee programs are located throughout the United States including Puerto Rico and the U.S. Virgin Islands. The program provides funding for both prevention and early intervention programs as well as local service expansion programs.

*Total appropriations may overlap and also serve other age groups

B1: Detailed Program Description Tables

Name of Program				Program Characteristics				
Name	Acronym/ Other names	FY 03 Appropriation (Millions)*	CFDA Number	Summary	Targeted Populations	Cultural Relevance	Type of Approach	Notes
Tobacco Control Program	National Tobacco Control Program (NTCP)	99.9		CDC's Office on Smoking and Health (OSH) created the National Tobacco Control Program (NTCP) to encourage coordinated, national efforts to reduce tobacco-related diseases and deaths. The program provides funding and technical support to State and territorial health departments. The four goals of NTCP are to: 1) Eliminate exposure to environmental tobacco smoke; 2) Promote quitting among adults and youth; 3) Prevent initiation among youth, and 4) Identify and eliminate disparities among population groups.			Grant: Range	The four components of NTCP are 1) Population-based community interventions, 2) Counter-marketing, 3) Program policy/regulation, and 4) Surveillance and evaluation. NTCP-funded programs are working to achieve the objectives outlined in OSH's Best Practices for Comprehensive Tobacco Control Programs. For more information please see: http://www.cdc.gov/tobacco/ntcp_exchange/about.htm
Youth Violence Prevention Program	Youth Violence Prevention Grant Program	10		Through its Youth Violence Prevention Grant Program, CMHS continues to provide support to grantees to implement evidence-based prevention, intervention, and treatment services to reduce violence and to enhance pro-social development and positive mental health in children and youth. The program is built upon a public health framework that emphasizes a strength-based, prevention-oriented approach that involves an array of stakeholders who can have a positive impact upon at-risk youth at the individual, family, and/or community levels.			Grant: Services/ Project	The Coalition for Youth Violence Prevention Program Grantees help to foster collaborative efforts to prevent or reduce youth violence. Through leveraging resources, engaging community stakeholders and facilitating a wide variety of efforts they have tried to meet the complex and diverse needs within their communities. These grantees have had a significant role in building the capacity needed across communities to sustain comprehensive and complex efforts that can improve the lives of youth, promote youth development, as well as reduce and prevent youth violence. The structure of this grant program is consistent with the recommendations of the President's New Freedom Commission to expand the availability of model community-based programs for at-risk youth and their families.

*Total appropriations may overlap and also serve other age groups

B3: DHHS Programs by White House Program Goals and US Chartbook Content Areas

	Address crime and disorder problems	Address homelessness/runaway youth	Collect and/or evaluate data/conduct research	Eliminate or reduce substance abuse	Eliminate/reduce teen pregnancy/STDs/HIV	Enforce underage drinking laws	Help developmentally disabled children	Improve academic performance	Prevent and/or reduce neglect/abuse/exploitation	Prevent substance abuse	Prevent/treat chronic diseases	Promote good nutrition/address obesity	Promote healthy development of children/families
Alcohol Research Center Grants										A			
Alcohol Research Programs										A			
Circles of Care													H, FA
Community Based Family Resource and Support Program							H		H, FA, V				H, FA
Community Initiated Interventions	H, V			A			H	SCH	H, FA, V	A	H, FI		H, FA
Community Services Block Grant	H, V	H, FA		A			H	SCH				H, FI	H, FA
Community Youth Mental Health Promotion and Violence/Substance Abuse Prevention	H, V							SCH	H, FA, V	A			H, FA
Comprehensive Community Mental Health Services Program for Children and Their Families													
Consolidated Health Centers											H, FI		H, FA
Cooperative Agreements for Strengthening Communities in the Development of Comprehensive Drug and Alcohol Treatment Systems for Youth	H, V			A									H, FA
Development of Comprehensive Drug/Alcohol and Mental Health Treatment Systems for Persons Who Are Homeless		H, FA		A									
Drug Abuse Research Programs										A			
Family Support (PNS)							H						H, FA
Girl Power!				A						A			

H = Health and Well-Being; FI = Fitness; FA = Family and Peer Relationships; SCH = School Environment; A = Alcohol; SM = Smoking; V = Violence

B3: DHHS Programs by White House Program Goals and US Chartbook Content Areas

	Promote mental health	Provide after-school care	Provide character education	Provide day care	Provide institutional systems support	Provide mentoring services	Provide self-sufficiency skills	Provide service learning opportunities	Provide service opportunities	Provide social services (foster care, adoption)	Provide treatment for juvenile offenders	Provide workforce preparation/job training	Provide youth developmental activities	Reduce juvenile delinquency or gang participation	Reduce the dropout rate	Reduce/eliminate poverty
Alcohol Research Center Grants																
Alcohol Research Programs																
Circles of Care	H															
Community Based Family Resource and Support Program	H			FA			H			H, FA						
Community Initiated Interventions	H		H, FA				H						H, FA, SCH	FA, V	SCH	H, FA
Community Services Block Grant	H	FA, SCH	H, FA			H, FA	H			H, FA			H, FA, SCH	FA, V	SCH	H, FA
Community Youth Mental Health Promotion and Violence/Substance Abuse Prevention	H		H, FA			H, FA	H				V		H, FA, SCH	FA, V	SCH	
Comprehensive Community Mental Health Services Program for Children and Their Families	H															
Consolidated Health Centers																
Cooperative Agreements for Strengthening Communities in the Development of Comprehensive Drug and Alcohol Treatment Systems for Youth	H										V			FA, V		
Development of Comprehensive Drug/Alcohol and Mental Health Treatment Systems for Persons Who Are Homeless	H						H									
Drug Abuse Research Programs																
Family Support (PNS)																
Girl Power!																

H = Health and Well-Being; FI = Fitness; FA = Family and Peer Relationships; SCH = School Environment; A = Alcohol; SM = Smoking; V = Violence

B3: DHHS Programs by WH Program Goals and US Chartbook Content Areas

	Reduce/eliminate school violence	Reduce/eliminate youth smoking	Serve victims of child abuse and neglect	Treat substance abusers
Alcohol Research Center Grants				
Alcohol Research Programs				
Circles of Care				
Community Based Family Resource and Support Program			H, FA, V	
Community Initiated Interventions	SCH, V	SM	H, FA, V	
Community Services Block Grant			H, FA, V	
Community Youth Mental Health Promotion and Violence/Substance Abuse Prevention	SCH, V		H, FA, V	
Comprehensive Community Mental Health Services Program for Children and Their Families				
Consolidated Health Centers				
Cooperative Agreements for Strengthening Communities in the Development of Comprehensive Drug and Alcohol Treatment Systems for Youth				A
Development of Comprehensive Drug/Alcohol and Mental Health Treatment Systems for Persons Who Are Homeless				A
Drug Abuse Research Programs				
Family Support (PNS)				
Girl Power!				

B3: DHHS Programs by White House Program Goals and US Chartbook Content Areas

	Address crime and disorder problems	Address homelessness/runaway youth	Collect and/or evaluate data/conduct research	Eliminate or reduce substance abuse	Eliminate/reduce teen pregnancy/STDs/HIV	Enforce underage drinking laws	Help developmentally disabled children	Improve academic performance	Prevent and/or reduce neglect/abuse/exploitation	Prevent substance abuse	Prevent/treat chronic diseases	Promote good nutrition/address obesity	Promote healthy development of children/families
Grants to Improve the Quality and Availability for Residential Treatment and its Continuing Care Component for Adolescents	H, V			A									H, FA
Healthy Schools Healthy Communities	H, V			A		A	H	SCH	H, FA, V	A	H, FI	H, FI	H, FA
Hispanic Latino Boys and their Fathers				A						A			
Hotline Evaluation and Linkage Program													
Injury Prevention and Control Research									H, FA, V				
Integrated health and behavioral health care for children, adolescents, and their families													H, FA
Maternal and Child Health Block Grant							H						H, FA
Mental Health Block Grant													
Mental Health Research Grants													
Mentoring and Family Strengthening				A				SCH	H, FA, V	A			H, FA
National Academic Centers for Excellence on Youth Violence Prevention									H, FA, V				
National Adolescent Health Information Center; Adolescent Health Center for State Maternal and Child Health Personnel													H, FA

H = Health and Well-Being; FI = Fitness; FA = Family and Peer Relationships; SCH = School Environment; A = Alcohol; SM = Smoking; V = Violence

B3: DHHS Programs by White House Program Goals and US Chartbook Content Areas

	Promote mental health	Provide after-school care	Provide character education	Provide day care	Provide institutional systems support	Provide mentoring services	Provide self-sufficiency skills	Provide service learning opportunities	Provide service opportunities	Provide social services (foster care, adoption)	Provide treatment for juvenile offenders	Provide workforce preparation/job training	Provide youth developmental activities	Reduce juvenile delinquency or gang participation	Reduce the dropout rate	Reduce/eliminate poverty
Grants to Improve the Quality and Availability for Residential Treatment and its Continuing Care Component for Adolescents	H										V			FA, V		
Healthy Schools Healthy Communities	H						H			H, FA	V					
Hispanic Latino Boys and their Fathers																
Hotline Evaluation and Linkage Program	H															
Injury Prevention and Control Research																
Integrated health and behavioral health care for children, adolescents, and their families																
Maternal and Child Health Block Grant																
Mental Health Block Grant	H															
Mental Health Research Grants																
Mentoring and Family Strengthening	H															
National Academic Centers for Excellence on Youth Violence Prevention			H, FA			H, FA							H, FA, SCH			
National Adolescent Health Information Center; Adolescent Health Center for State Maternal and Child Health Personnel																

H = Health and Well-Being; FI = Fitness; FA = Family and Peer Relationships; SCH = School Environment; A = Alcohol; SM = Smoking; V = Violence

B3: DHHS Programs by WH Program Goals and US Chartbook Content Areas

	Reduce/eliminate school violence	Reduce/eliminate youth smoking	Serve victims of child abuse and neglect	Treat substance abusers
Grants to Improve the Quality and Availability for Residential Treatment and its Continuing Care Component for Adolescents				A
Healthy Schools Healthy Communities	SCH, V		H, FA, V	A
Hispanic Latino Boys and their Fathers				
Hotline Evaluation and Linkage Program				
Injury Prevention and Control Research	SCH, V			
Integrated health and behavioral health care for children, adolescents, and their families				
Maternal and Child Health Block Grant				
Mental Health Block Grant				
Mental Health Research Grants				
Mentoring and Family Strengthening	SCH, V			
National Academic Centers for Excellence on Youth Violence Prevention	SCH, V			
National Adolescent Health Information Center; Adolescent Health Center for State Maternal and Child Health Personnel				

B3: DHHS Programs by White House Program Goals and US Chartbook Content Areas

	Address crime and disorder problems	Address homelessness/runaway youth	Collect and/or evaluate data/conduct research	Eliminate or reduce substance abuse	Eliminate/reduce teen pregnancy/STDs/HIV	Enforce underage drinking laws	Help developmentally disabled children	Improve academic performance	Prevent and/or reduce neglect/abuse/exploitation	Prevent substance abuse	Prevent/treat chronic diseases	Promote good nutrition/address obesity	Promote healthy development of children/families
National Association for Children of Alcoholics				A						A			H, FA
National Bone Health Campaign											H, FI	H, FI	
National Clearinghouse on Alcohol and Drug Information (NCADI)										A			H, FA
National Suicide Prevention Resource Center (NSPRC)													H, FA
National Youth Sports Program (NYSP)				A				SCH				H, FI	H, FA
National Youth Violence Prevention Resource Center													
Parenting is Prevention/National Families in Action	H, V			A				SCH		A			H, FA
Policy Research and Evaluation Grants	H, V	H, FA					H		H, FA, V		H, FI	H, FI	H, FA
Practice Improvement Collaborative				A									
Prevention of Underage Alcohol Use	H, V	H, FA		A		A		SCH	H, FA, V	A			H, FA
Prevention Research Centers Program											H, FI		
Projects of National Significance (PNS)							H						H, FA
Promoting Safe and Stable Families							H		H, FA, V	A			H, FA
Regional Alcohol and Drug Awareness Resource Network (part of NCADI contract)				A						A			

H = Health and Well-Being; FI = Fitness; FA = Family and Peer Relationships; SCH = School Environment; A = Alcohol; SM = Smoking; V = Violence

B3: DHHS Programs by White House Program Goals and US Chartbook Content Areas

	Promote mental health	Provide after-school care	Provide character education	Provide day care	Provide institutional systems support	Provide mentoring services	Provide self-sufficiency skills	Provide service learning opportunities	Provide service opportunities	Provide social services (foster care, adoption)	Provide treatment for juvenile offenders	Provide workforce preparation/job training	Provide youth developmental activities	Reduce juvenile delinquency or gang participation	Reduce the dropout rate	Reduce/eliminate poverty
National Association for Children of Alcoholics	H						H									
National Bone Health Campaign													H, FA, SCH			
National Clearinghouse on Alcohol and Drug Information (NCADI)																
National Suicide Prevention Resource Center (NSPRC)	H	FA, SCH														
National Youth Sports Program (NYSP)						H, FA	H						H, FA, SCH	FA, V	SCH	H, FA
National Youth Violence Prevention Resource Center														FA, V		
Parenting is Prevention/National Families in Action	H					H, FA	H						H, FA, SCH	FA, V	SCH	H, FA
Policy Research and Evaluation Grants	H					H, FA	H						H, FA, SCH	FA, V	SCH	H, FA
Practice Improvement Collaborative	H													FA, V		
Prevention of Underage Alcohol Use	H						H						H, FA, SCH	FA, V	SCH	
Prevention Research Centers Program																
Projects of National Significance (PNS)																
Promoting Safe and Stable Families				FA		H, FA				H, FA						
Regional Alcohol and Drug Awareness Resource Network (part of NCADI contract)																

H = Health and Well-Being; FI = Fitness; FA = Family and Peer Relationships; SCH = School Environment; A = Alcohol; SM = Smoking; V = Violence

B3: DHHS Programs by WH Program Goals and US Chartbook Content Areas

	Reduce/eliminate school violence	Reduce/eliminate youth smoking	Serve victims of child abuse and neglect	Treat substance abusers
National Association for Children of Alcoholics				
National Bone Health Campaign				
National Clearinghouse on Alcohol and Drug Information (NCADI)				
National Suicide Prevention Resource Center (NSPRC)				
National Youth Sports Program (NYSP)		SM		
National Youth Violence Prevention Resource Center	SCH, V			
Parenting is Prevention/National Families in Action				
Policy Research and Evaluation Grants			H, FA, V	
Practice Improvement Collaborative				
Prevention of Underage Alcohol Use	SCH, V	SM	H, FA, V	
Prevention Research Centers Program				
Projects of National Significance (PNS)				
Promoting Safe and Stable Families			H, FA, V	A
Regional Alcohol and Drug Awareness Resource Network (part of NCADI contract)				

H = Health and Well-Being; FI = Fitness; FA = Family and Peer Relationships; SCH = School Environment; A = Alcohol; SM = Smoking; V = Violence

B3: DHHS Programs by White House Program Goals and US Chartbook Content Areas

	Address crime and disorder problems	Address homelessness/runaway youth	Collect and/or evaluate data/conduct research	Eliminate or reduce substance abuse	Eliminate/reduce teen pregnancy/STDs/HIV	Enforce underage drinking laws	Help developmentally disabled children	Improve academic performance	Prevent and/or reduce neglect/abuse/exploitation	Prevent substance abuse	Prevent/treat chronic diseases	Promote good nutrition/address obesity	Promote healthy development of children/families
Runaway and Homeless Youth - Basic Center program		H, FA		A			H		H, FA, V	A			H, FA
Runaway and Homeless Youth - State Collaboration/Demonstration Grants for Positive Youth Development		H, FA		A			H		H, FA, V	A	H, FI		H, FA
Runaway and Homeless Youth - Transitional Living Program and Maternity Group Homes		H, FA		A			H	SCH	H, FA, V	A		H, FI	H, FA
Runaway and Homeless Youth/Education and Prevention Grants to Reduce Sexual Abuse of Runaway, Homeless and Street Youth: Street Outreach Program (SOP)				A			H		H, FA, V	A	H, FI		H, FA
Rural Health Outreach Grant Program													H, FA
School Guidelines and Related Activities of National Strategy for Suicide Prevention													H, FA
Social Economic Development Strategies (SEDS)													
Social Services Block Grant									H, FA, V				
Social Services Research and Demonstration program													
Soy Unica Soy Latina Hispanic Initiative								SCH		A			

H = Health and Well-Being; FI = Fitness; FA = Family and Peer Relationships; SCH = School Environment; A = Alcohol; SM = Smoking; V = Violence

B3: DHHS Programs by White House Program Goals and US Chartbook Content Areas

	Promote mental health	Provide after-school care	Provide character education	Provide day care	Provide institutional systems support	Provide mentoring services	Provide self-sufficiency skills	Provide service learning opportunities	Provide service opportunities	Provide social services (foster care, adoption)	Provide treatment for juvenile offenders	Provide workforce preparation/job training	Provide youth developmental activities	Reduce juvenile delinquency or gang participation	Reduce the dropout rate	Reduce/eliminate poverty
Runaway and Homeless Youth - Basic Center program	H		H, FA			H, FA	H			H, FA			H, FA, SCH	FA, V	SCH	
Runaway and Homeless Youth - State Collaboration/Demonstration Grants for Positive Youth Development	H		H, FA			H, FA	H			H, FA			H, FA, SCH	FA, V	SCH	
Runaway and Homeless Youth - Transitional Living Program and Maternity Group Homes	H		H, FA	FA		H, FA	H			H, FA			H, FA, SCH	FA, V	SCH	
Runaway and Homeless Youth/Education and Prevention Grants to Reduce Sexual Abuse of Runaway, Homeless and Street Youth: Street Outreach Program (SOP)	H		H, FA			H, FA	H			H, FA			H, FA, SCH	FA, V	SCH	
Rural Health Outreach Grant Program																
School Guidelines and Related Activities of National Strategy for Suicide Prevention																
Social Economic Development Strategies (SEDS)						H, FA	H									
Social Services Block Grant							H									
Social Services Research and Demonstration program										H, FA						H, FA
Soy Unica Soy Latina Hispanic Initiative	H					H, FA							H, FA, SCH	FA, V	SCH	

H = Health and Well-Being; FI = Fitness; FA = Family and Peer Relationships; SCH = School Environment; A = Alcohol; SM = Smoking; V = Violence

B3: DHHS Programs by WH Program Goals and US Chartbook Content Areas

	Reduce/eliminate school violence	Reduce/eliminate youth smoking	Serve victims of child abuse and neglect	Treat substance abusers
Runaway and Homeless Youth - Basic Center program			H, FA, V	
Runaway and Homeless Youth - State Collaboration/Demonstration Grants for Positive Youth Development				
Runaway and Homeless Youth - Transitional Living Program and Maternity Group Homes		SM	H, FA, V	A
Runaway and Homeless Youth/Education and Prevention Grants to Reduce Sexual Abuse of Runaway, Homeless and Street Youth: Street Outreach Program (SOP)			H, FA, V	
Rural Health Outreach Grant Program				
School Guidelines and Related Activities of National Strategy for Suicide Prevention				
Social Economic Development Strategies (SEDS)				
Social Services Block Grant				
Social Services Research and Demonstration program				
Soy Unica Soy Latina Hispanic Initiative				

B3: DHHS Programs by White House Program Goals and US Chartbook Content Areas

	Address crime and disorder problems	Address homelessness/runaway youth	Collect and/or evaluate data/conduct research	Eliminate or reduce substance abuse	Eliminate/reduce teen pregnancy/STDs/HIV	Enforce underage drinking laws	Help developmentally disabled children	Improve academic performance	Prevent and/or reduce neglect/abuse/exploitation	Prevent substance abuse	Prevent/treat chronic diseases	Promote good nutrition/address obesity	Promote healthy development of children/families
State Incentive Grants Discretionary Program				A						A			
Statewide Family Networks													H, FA
Substance Abuse Prevention and Treatment Block Grant				A						A	H, FI		
Substance Abuse Prevention and Treatment Block Grant/Prevention Set-Aside				A						A			
TCE (Targeted Capacity Expansion) - Prevention and Early Intervention													H, FA
Tobacco Control Program													H, FA
Youth Violence Prevention Program													H, FA

B3: DHHS Programs by White House Program Goals and US Chartbook Content Areas

	Promote mental health	Provide after-school care	Provide character education	Provide day care	Provide institutional systems support	Provide mentoring services	Provide self-sufficiency skills	Provide service learning opportunities	Provide service opportunities	Provide social services (foster care, adoption)	Provide treatment for juvenile offenders	Provide workforce preparation/job training	Provide youth developmental activities	Reduce juvenile delinquency or gang participation	Reduce the dropout rate	Reduce/eliminate poverty
State Incentive Grants Discretionary Program													H, FA, SCH			
Statewide Family Networks	H					H, FA										
Substance Abuse Prevention and Treatment Block Grant			H, FA								V		H, FA, SCH			
Substance Abuse Prevention and Treatment Block Grant/Prevention Set-Aside													H, FA, SCH			
TCE (Targeted Capacity Expansion) - Prevention and Early Intervention	H															
Tobacco Control Program													H, FA, SCH			
Youth Violence Prevention Program	H															

B3: DHHS Programs by WH Program Goals and US Chartbook Content Areas

	Reduce/eliminate school violence	Reduce/eliminate youth smoking	Serve victims of child abuse and neglect	Treat substance abusers
State Incentive Grants Discretionary Program		SM		
Statewide Family Networks				
Substance Abuse Prevention and Treatment Block Grant		SM		A
Substance Abuse Prevention and Treatment Block Grant/Prevention Set-Aside		SM		
TCE (Targeted Capacity Expansion) - Prevention and Early Intervention				
Tobacco Control Program		SM		
Youth Violence Prevention Program	SCH, V			

B2: White House Report Program Goals by US Chartbook Content Areas

	Health and Well-Being	Fitness	Family and Peer Relationships	School Enviroment	Smoking	Alcohol	Violence
Address crime and disorder problems	X						X
Address homelessness/runaway youth	X		X				
Eliminate or reduce substance abuse						X	
Enforce underage drinking laws						X	
Help developmentally disabled children	X						
Improve academic performance				X			
Prevent and/or reduce neglect/abuse/exploitation	X		X				X
Prevent substance abuse						X	
Prevent/treat chronic diseases	X	X					
Promote good nutrition/address obesity	X	X					
Promote healthy development of children/families	X		X				
Promote mental health	X						
Provide after-school care			X	X			
Provide character education	X		X				
Provide day care			X				
Provide mentoring services	X		X				
Provide self-sufficiency skills	X						
Provide social services (foster care, adoption)	X		X				
Provide treatment for juvenile offenders							X
Provide youth developmental activities	X		X	X			
Reduce juvenile delinquency or gang participation			X				X
Reduce the dropout rate				X			
Reduce/eliminate poverty	X		X				
Reduce/eliminate school violence				X			X
Reduce/eliminate youth smoking					X		
Serve victims of child abuse and neglect	X		X				X
Treat substance abusers						X	

B4: Evaluated Programs: Health and Well-Being

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
Across Ages	6th graders at high risk for substance abuse	individual	school, nursing home, community, program site	52.2% African American, 15.8% White, 13.9% Other, 9.1% Asian Americans, 9.0% Hispanics. (LoSciuto et al., 1996) Original project and two replications were designed and tested on African American, Hispanic/Latino, White, and Asian American middle school students (sixth grade) living in a large urban setting. 30 replications have since been designed for Native American, White, Hispanic/Latino and African American youth.	federal, regional/state	Mentoring, community service, curriculum-based program
Big Brothers/Big Sisters	N/A	individual	community/ program site	34.1% minority boys, 28.3% white boys, 22.7% minority girls, 14.9% white girls (Tierney et al., 2000)	private, regional/state	Mentoring
Children's AID Society - Carrera (CAS-Carrera) Program	At-risk high school students between 13 and 15 years of age	Individual	Multiple	47% black (Philliber, 2001)	federal, regional/state, private	Holistic approach that tailored services to the participant
Moving to Opportunity	Volunteer families living in low-income neighborhoods already receiving vouchers from HUD	family	Baltimore, Boston, Chicago, Los Angeles, and New York City	N/A in evaluation	federal	policy directive
Positive Youth Development Program	Middle school students	School	School	N/A in evaluation	Regional/state, private	Curriculum-based

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: Health and Well-Being

Name of Program	CT evaluation Criteria			
	What works	**What doesn't work**	**Mixed reviews**	**Best bets**
Across Ages			Compared to non-participants, those participating in mentoring programs had: - better sense of well-being - greater sense of self-control BUT not different levels of: - Harter self-perception - self confidence	
Big Brothers/Big Sisters			Compared to non-participants, those participating in mentoring programs had higher self-esteem levels	The following practices are best bets for improving self-perception: - Mentoring programs that improve parent-child relationships - Mentor relationships lasting 12 months or more
Children's AID Society - Carrera (CAS-Carrera) Program	Participants were found to have better health habits.			
Moving to Opportunity	Families moving from high-poverty neighborhoods to low-poverty neighborhoods resulted in improved parent and child mental health, and lower rates of youth delinquency and problem behaviors. In New York, the experimental boys were more happy, less depressed, and had fewer instances of arguing. In Boston, the experimental boys had fewer behavior problems (e.g. disobedience at home, bullying others, inability to sit still, depression).			
Positive Youth Development Program	Participants had better coping, stress management, problem-solving, and conflict resolution skills			

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: Health and Well-Being

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
Quantum Opportunities Program	Disadvantaged Youth	individual	program site	75% African Americans, 14% Caucasian, 7% Hispanic, 2% Other, 1% Asian (Hahn et al., 1994). Has a developmental component which may include cultural enrichment activities.	Regional/state, private	community service, curriculum-based program
Reconnecting Youth	High-risk students in 9th through 12th grades who exhibit multiple problems such as depression aggression, and substance use.	individual	school	N/A in evaluation	federal, regional/state	curriculum -based program
The Weigh to Eat	Teenage girls	School	School	Program was done in all-girl high schools in Jerusalem. Racial breakdown was fairly representative of the Jewish population on the whole.	regional/state (Senate of the Hebrew University in Jerusalem, Israel)	Curriculum-based. Discussion on issues surrounding societal pressures to be thin.

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: Health and Well-Being

Name of Program	CT evaluation Criteria			
	What works	**What doesn't work**	**Mixed reviews**	**Best bets**
Quantum Opportunities Program			Program participants showed no difference in high school grades, although academic skills increased significantly. Program participants were less likely to drop out of high school and more likely to graduate from high school one year after the end of the program. Program participants were more likely to be attending a two-year or four-year post-secondary school one year after the end of the program. Program participants reported higher educational expectations. Program participants had fewer arrests.	
Reconnecting Youth	At 5 and 10 month follow-ups, the treatment group has lower rates of school drop-out, a decreased use of alcohol and drugs, decreased drug use control problems, decreases in anger control problems and aggressive tendencies, and a significant decrease in depressive symptoms.		The program did not affect suicidal behaviors.	
The Weigh to Eat	6 and 24 month follow-up surveys showed that participants had improved nutritional knowledge and more regular eating patterns. Additionally, participants had lower levels of binge eating and excessive dieting.			

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: Fitness

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
Child and Adolescent Trial for Cardiovascular Health	N/A	school	school	74.25% Caucasian, 14.41% Hispanic, 11.34% African-American (Nader et al., 1996).	federal, regional/state, private	hybrid (policy directive/curriculum-based program)
Minnesota Heart Health Program / Class of 1989 Study	N/A	community/school	community/school	N/A in evaluation	N/A in evaluation	curriculum-based program
Stanford Adolescent Heart Health Program	N/A	school	school	69% white, 13.1% Asian, 9.6% other, 6.4% Latino, 2% black (Killen et al., 1989).	federal, private	curriculum-based program
The Weigh to Eat	Teenage girls	School	School	Program was done in all-girl high schools in Jerusalem. Racial breakdown was fairly representative of the Jewish population on the whole.	regional/state (Senate of the Hebrew University in Jerusalem, Israel)	Curriculum-based. Discussion on issues surrounding societal pressures to be thin.

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: Fitness

Name of Program	CT evaluation Criteria			
	What works	**What doesn't work**	**Mixed reviews**	**Best bets**
Child and Adolescent Trial for Cardiovascular Health	Program showed long-term positive effects on physical activity and nutrition.			
Minnesota Heart Health Program / Class of 1989 Study	Significant effects on weekly hours of exercise, especially amongst adolescent girls., notably, outside of school.			
Stanford Adolescent Heart Health Program	Treatment group students were more likely to become regular exercisers and experienced improvements in heart rates. Students in the treatment group were also more likely to select healthy foods for snacks.			
The Weigh to Eat	6 and 24 month follow-up surveys showed that participants had improved nutritional knowledge and more regular eating patterns. Additionally, participants had lower levels of binge eating and excessive dieting.			

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: Family and Peer Relationships

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
Across Ages	6th graders at high risk for substance abuse	individual	school, nursing home, community, program site	52.2% African American, 15.8% White, 13.9% Other, 9.1% Asian Americans, 9.0% Hispanics. (LoSciuto et al., 1996) Original project and two replications were designed and tested on African American, Hispanic/Latino, White, and Asian American middle school students (sixth grade) living in a large urban setting. 30 replications have since been designed for Native American, White, Hispanic/Latino and African American youth.	federal, regional/state	Mentoring, community service, curriculum-based program
Adolescent Social Skills Effectiveness Training	N/A	parent/child pairs	community/school	N/A in evaluation	federal, regional/state	curriculum-based program
Adolescent Transitions Program	10 - 14 year olds and their parents	parent/child pairs	school	95% European- American	national organization	intervention
Anger Coping Program	highly aggressive and disruptive pre-adolescent boys	individual	school	47.36% White, 52.6% Black	federal, national/state, private	intervention

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B4: Evaluated Programs: F B4: Evaluated Programs: Family and Peer Relationships

Name of Program	CT evaluation Criteria			
	What works	**What doesn't work**	**Mixed reviews**	**Best bets**
Across Ages	Participants in a mentoring and community service learning program had increased positive attitudes toward the future and older people			
Adolescent Social Skills Effectiveness Training				Social Skills training program aimed at reducing parent-child conflict. (Adolescents experienced improved problem-solving and negotiation skills. Parents perceived changes, in the expected directions, of warmth and hostility in the relationships, and both parties reported increases in their ability to give and receive negative feedback.)
Adolescent Transitions Program	Program that focuses on both improving parent management skills and developing the adolescent's goals/limit setting ability, peer supports, and problem solving ability			
Anger Coping Program	A program designed to increase adolescent perspective taking, social problem solving, and social skills for managing conflict situations.			

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B4: Evaluated Programs: Family and Peer Relationships

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
Big Brothers/Big Sisters	N/A	individual	community/ program site	34.1% minority boys, 28.3% white boys, 22.7% minority girls, 14.9% white girls (Tierney et al., 2000)	private	Mentoring
Career Academies	N/A	school	school, place of employment	56.2% Hispanic, 30.2 % Black, 7.2% Asian or Native American, 6.4% White (Kemple & Snipes, 2000).	federal, regional/state, private	curriculum-based program
Child Development Project	School-age children	School	School, Community	N/A in evaluation	Private	Curriculum-based
Children at Risk	Middle school students living in disadvantaged neighborhoods	Community	Community	58% black, 34% Hispanic, 8% white or Asian	Regional/state	Policy directive. Whole-community approach involving school services, community and social services, and out-of-school activities.
Creating Lasting Connections	N/A	individual	church	2/6 program sites were from African American communities. And 29/189 overall participants were from those African American communities (Johnson et al., 1996).	federal, regional/state	hybrid (policy directive, curriculum-based program)

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B4: Evaluated Programs: F B4: Evaluated Programs: Family and Peer Relationships

Name of Program	CT evaluation Criteria			
	What works	**What doesn't work**	**Mixed reviews**	**Best bets**
Big Brothers/Big Sisters	Participants felt that they communicated better with their parents (especially white males). Emotional support at outcome was higher among Little brothers and Little Sisters compared to controls (especially true for minority males). Program participation was found to be positively associated to changes in trust, communication, and anger/alienation (all measures of the parent-child relationship). Additionally, BBBS was found to improve male minority participants' feelings that they received emotional support from their peers.			
Career Academies	Program youth were also more likely to believe that their peers were supportive.			
Child Development Project	A program targeted at improving youth's prosocial behavior and moral reasoning through cooperative activities, social skills practice, and practice with helping others.			
Children at Risk			Program participants reported fewer peers involved in delinquent activities. Program participants showed no difference in gang membership. Program participants took part in more positive social activities (clubs, religious groups, sports, community programs, etc.).	
Creating Lasting Connections	From increased engagement in church activities and greater levels of communication skills, family bonding and use of community services.			

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B4: Evaluated Programs: Family and Peer Relationships

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
Expect Respect Elementary School Project	N/A	school	school	58% white/American Indian/Asian, 26% Hispanic, 16% African American (Sanchez et al., in press)	federal, regional/state, private	hybrid (policy directive/curriculum-based program)
Iowa Strengthening Families Program	N/A	parent/child pairs	program site	Program has been tailored to work with specific ethnic populations.	federal, regional/state, private	curriculum-based program
Learn and Serve America	School-age children	school	school	N/A in evaluation	federal, regional/state	Community service, curriculum-based program
Linking the Interests of Families and Teachers	high juvenile crime neighborhoods	school	school	12% minority	private	curriculum-based program
Public Works Mapping Project	Students at St. Bernard's Elementary School in St. Paul, Minn.	School	School/Community	N/A	N/A	Curriculum -based program/Service Learning
Safe Dates Project	adolescents in relationships ages 12- 17	individual	school	75.9% White, 20.2% African American, 3.9% other racial/ethnic groups	federal, national/state	curriculum-based program
Sembrando Salud	N/A	family	N/A	Has bilingual lessons.	N/A	curriculum-based program

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: F B4: Evaluated Programs: Family and Peer Relationships

Name of Program	CT evaluation Criteria			
	What works	**What doesn't work**	**Mixed reviews**	**Best bets**
Expect Respect Elementary School Project				The program yielded promising results: increases in treatment participants' ability to identify sexual harassment, knowledge of and awareness of bullying, and proactive reactions to bullying situations by intervening or telling an adult
Iowa Strengthening Families Program				Separate and joint social skills training sessions over 14 weeks between adolescents and their parents were shown to be effective in improving relationships. (Strong parent-child relationships continued to develop over time.)
Learn and Serve America				Participants in a service learning program were significantly more accepting of cultural diversity than nonparticipants
Linking the Interests of Families and Teachers	This intervention which involved parent training, and child-behavior modification program was found to be effective in improving familial relationships.			
Public Works Mapping Project				Participants in a school-based civic engagement program had improved attitudes toward working with others.
Safe Dates Project	This intervention was found to be effective and consisted of role-playing, a poster contest, and a curriculum on violence, gender stereotyping and conflict management, as well as the development of victim services in the community.			
Sembrando Salud	Hispanic adolescents from families with fewer children experienced notable improvements in parent-child communication.			

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B4: Evaluated Programs: School Environment

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
Across Ages	6th graders at high risk for substance abuse	individual	school, nursing home, community, program site	52.2% African American, 15.8% White, 13.9% Other, 9.1% Asian Americans, 9.0% Hispanics. (LoSciuto et al., 1996) Original project and two replications were designed and tested on African American, Hispanic/Latino, White, and Asian American middle school students (sixth grade) living in a large urban setting. 30 replications have since been designed for Native American, White, Hispanic/Latino and African American youth.	federal, regional/state	Mentoring, community service, curriculum-based program
Big Brothers/Big Sisters	N/A	individual	community/ program site	34.1% minority boys, 28.3% white boys, 22.7% minority girls, 14.9% white girls (Tierney et al., 2000)	private, regional/state	Mentoring

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: School Environment

Name of Program	CT evaluation Criteria			
	What works	**What doesn't work**	**Mixed reviews**	**Best bets**
Across Ages	Program participation is effective at increasing positive attitudes toward school/future/elderly/helping Participants in a mentoring and community service learning program had higher rates of school attendance than youth in the control group		Participants did not have significantly different GPA	High involvement and high frequency of contact with mentors may decrease school absence rates
Big Brothers/Big Sisters	Program participants had fewer unexcused absences from class or school One-to-one mentoring led to improvements in perceived scholastic competence		Participants experience modest gains in GPA overtime BUT, program participation did not impact behaviors such as: number of times youth sent to office and doing risky things, fighting, cheating	Mentoring programs that improve parental relationships and scholastic competence may improve attitudes about school

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: School Environment

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
Boys and Girls Clubs of America	Teens	Individual	Program sites	32% African American, 6% white, 26% Hispanic, 24% Asian, 12% Other	Federal, private	Mentoring

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B4: Evaluated Programs: School Environment

Name of Program	CT evaluation Criteria			
	What works	**What doesn't work**	**Mixed reviews**	**Best bets**
Boys and Girls Clubs of America			- Program participants showed no difference at final follow-up evaluation in English, writing, and geography grades. - Program participants had higher grades in reading, spelling, history, science, and social studies and in overall GPA than control and comparison groups. Teachers reported higher reading, verbal and writing skills and overall performance in program group participants at the 18 month follow-up. Program youth did not differ empirically from "comparison" group youth at the 30-month follow-up. Program youth showed higher verbal skills and completion of homework than comparison and control group youth at the 18 month follow-up, but did not differ from the "comparison" group youth at the time of the 30-month follow-up. Program participants had a higher mean school attendance rate than "comparison" and control groups.	Programs which incorporate cultural enrichment, health and physical education, social recreation, personal and educational development, citizenship, and leadership development may help to prevent drug and alcohol abuse.

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B4: Evaluated Programs: School Environment

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
Building Essential Life Options through New Goals (BELONG)	At risk youth	school	school, nursing home, community	49.4 % White, 27.8% African-American, 22.9% Hispanic (Blakely et al., 1995)	Regional/state, federal	hybrid (policy directive, curriculum-based program)
Career Academies	N/A	school	school, place of employment	56.2% Hispanic, 30.2 % Black, 7.2% Asian or Native American, 6.4% White (Kemple & Snipes, 2000).	federal, regional/state, private	curriculum-based program

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: School Environment

Name of Program	CT evaluation Criteria			
	What works	**What doesn't work**	**Mixed reviews**	**Best bets**
Building Essential Life Options through New Goals (BELONG)	Participants were viewed by their teachers as placing a higher value on school Participants were rated by their teachers as more engaged in the classroom than youth in the control group Teachers were less likely to report behavior problems for mentored students The percentage of mentored youth referred to school administrators for a severe discipline infraction decreased from pre to post intervention		Mentored youth were less likely to be receiving a failing grade in Math. But they were not less likely to be receiving a failing grade in English, Reading, or Social Studies	
Career Academies	Substantially improved attendance and decreased dropout rates among youth at high risk of dropping out Substantially increased academic course-taking among youth at high risk of dropping out, and also increased the likelihood of earning enough credits to graduate on time Compared to control youth, program youth were more likely to report: - They were motivated to attend school - Their classmates are highly engaged in school and work with them on school projects Program youth more likely to report that teachers give them personalized attention and have high expectations of them Program youth more likely to perceive a strong connection between what they learned in school and their longer-term education and career interests		Did not improve standardized reading or math achievement test scores Have an improved chance of graduating from high school	Integrating vocational components into an academic curriculum enhances school attendance, even compared to youth in a highly structured JROTC program seems to help decrease school absences and increase school grades High levels of support from teachers and peers in the 9th or 10th grade reduced school dropout and chronic absenteeism, even among high-risk youth

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: School Environment

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
Children at Risk	Middle school students living in disadvantaged neighborhoods	Community	Community	58% black, 34% Hispanic, 8% white or Asian	Regional/state	Policy directive. Whole-community approach involving school services, community and social services, and out-of-school activities.
Children's AID Society - Carrera (CAS-Carrera) Program	At-risk high school students between 13 and 15 years of age	Individual	Multiple	47% black (Philliber, 2001)	federal, regional/state, private	Holistic approach that tailored services to the participant
Fifth Dimension	Older elementary school students	Individual	program site	Has a component on cultural systems	federal, regional/state	Curriculum

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B4: Evaluated Programs: School Environment

Name of Program	CT evaluation Criteria			
	What works	**What doesn't work**	**Mixed reviews**	**Best bets**
Children at Risk			Program participants showed no difference in grades. Program participants were less likely to repeat a grade. Program participants showed no difference in the likelihood of having dropped out of high school. Program participants showed no difference in school attendance. Program participants showed no difference in educational or work expectations.	
Children's AID Society - Carrera (CAS-Carrera) Program	Participants were found to have better health habits and to have improved academic outcomes (higher test scores, feel better about school work, and made more college visits).			
Fifth Dimension				After-school program offering educational computer games and activities, board games, and recreational activities.

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B4: Evaluated Programs: School Environment

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
K-12 Service Learning in California	Rural, urban, and suburban neighborhoods; students in elementary, middle, and high school	School	School/Community	N/A	N/A	Curriculum -based program/Service Learning

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: School Environment

Name of Program	CT evaluation Criteria			
	What works	**What doesn't work**	**Mixed reviews**	**Best bets**
K-12 Service Learning in California				Involvement in a program with a school-based curriculum on service learning may increase academic performance Involvement in a program with a school-based service learning curriculum may increase engagement with school Involvement in a program with a school-based service learning curriculum may increase educational competence Involvement in a program with a school-based service learning curriculum may increase homework completion rates Involvement in a program with a school-based service learning curriculum may increase educational aspirations

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B4: Evaluated Programs: School Environment

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
LA's Best	N/A	school	community/school	Includes cultural activities. 26.6% African American, 4.4% Asian, 57.1% Latino, and 11.8% white.	federal, regional/state, private	curriculum-based program
Learn and Serve America	N/A	school	school	N/A in evaluation	federal, regional/state	Community service, curriculum-based program
Project RAISE (Raising Ambition Instills Self-Esteem)	At-risk adolescents and teens	Individual	community/ program site	N/A in evaluation	Regional/state	Mentoring
Public Works Mapping Project	Students at St. Bernard's Elementary School in St. Paul, Minn.	School	School/Community	N/A	N/A	Curriculum -based program/Service Learning

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: School Environment

Name of Program	CT evaluation Criteria			
	What works	**What doesn't work**	**Mixed reviews**	**Best bets**
LA's Best				Strongly academic-focused after-school programs providing recreational, tutoring, homework assistance, sports, and cultural activities and trips are found to improve school grades, improve attitudes about school, and increase educational expectations. - Academic-oriented programs lasting for two years seem to help improve grades.
Learn and Serve America				Involvement in a service learning program had significantly better math grades than nonparticipants did Participants in a service learning program were significantly more engaged with school than nonparticipants
Project RAISE (Raising Ambition Instills Self-Esteem)			Program was found to improve certain educational outcomes, such as higher English grades and school attendance. Program did not significantly affect GPA, math grades, or standardized test scores.	
Public Works Mapping Project				Participants in a school-based civic engagement program had improved attitudes toward working with others.

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: School Environment

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
Reconnecting Youth	High-risk students in 9th through 12th grades who exhibit multiple problems such as depression aggression, and substance use.	individual	school	N/A	federal, regional/state	curriculum -based program
Sponsor-a-Scholar	Program open to motivated, low-income students with average grades.	Individual	School	75% black, 10% Hispanic, 7% white, and 7% Asian.	Private	Mentoring

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: School Environment

Name of Program	CT evaluation Criteria			
	What works	**What doesn't work**	**Mixed reviews**	**Best bets**
Reconnecting Youth	At five and 10 month follow-ups, the treatment group has lower rates of school drop-out.			
Sponsor-a-Scholar				High-quality mentoring and academic tutoring and educational assistance seem to improve grades and college attendance rates. More frequent visitation and contact with mentor may improve high school grades Mentors knowing a youth's parents well may also help to improve high school grades for the youth and improve later college attendance rates College tuition assistance may improve college attendance

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: School Environment

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
The Summer Training and Education Program	Low-achieving adolescents from poor families	Individual	Schools and places of employment/training agencies	19% Asian, 49% black, 18% Hispanic, 14%white/other Minority participants were found to have a much higher change in college graduation rates compared to the national average for their respective minority groups.	federal, private	hybrid (policy directive, curriculum-based program)
Teen Outreach	High school students	School	School/Community	68% black, 17% white, 13% Hispanic, 2% other (Allen, 1997)	private	Curriculum -based program/Service Learning

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: School Environment

Name of Program	CT evaluation Criteria			
	What works	**What doesn't work**	**Mixed reviews**	**Best bets**
The Summer Training and Education Program		Compared to control group program youth do not have significantly higher grades	Program participants showed no difference in grades. Program participants had higher test scores for reading and math soon after the summer program ended; no impact was found on standardized scores in long-term report, however. Program participants showed no difference in college enrollment/ attendance rate. Program participants showed no difference in the likelihood of having dropped out of high school. In long-term, program youth not significantly different from control group	Academic-oriented programs lasting for two years may help to improve grades.
Teen Outreach	Participants in a national volunteer service program were less likely to fail in school than youth in the control group Participants in a national volunteer service program were less likely to get suspended from school than youth in control group			

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B4: Evaluated Programs: School Environment

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
Upward Bound	Two-thirds of the students in each project must be low-income and first-generation college prospects; the remainder must have one of the characteristics, but not both.	Individual	Program sites	50% African American, 21% white, 23% Hispanic, 6% other (Myers, 1999)	federal	Curriculum-based
Woodrock Youth Development Project	At-risk elementary and middle school minority students	Individual	School	19% Latino, White 12%, African American, 10% Asian, 2% American Indian (Lo Sciutto, 1997)	federal	Curriculum-based program, mentoring, family participation

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: School Environment

Name of Program	CT evaluation Criteria			
	What works	**What doesn't work**	**Mixed reviews**	**Best bets**
Upward Bound	Program participants earned more high school credits. Program participants had higher levels of engagement in college activities.	Program participants showed no difference in participation in extracurricular activities in high school.	Program participants showed no difference in GPA. Program participants showed no difference in the likelihood of having dropped out of high school. Program participants showed no difference in college enrollment/ attendance rate. Program participants reported higher educational expectations.	
Woodrock Youth Development Project	Multi-component program was found to create both short- and long-term increases in school attendance.			

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: Smoking

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
Adolescent Alcohol Prevention Trial	N/A	school	school	N/A	N/A	curriculum-based program
Big Brothers/Big Sisters	N/A	individual	community/ program site	34.1% minority boys, 28.3% white boys, 22.7% minority girls, 14.9% white girls (Tierney et al., 2000)	private	curriculum-based program
Hutchinson Smoking Prevention Project	N/A	school	school	N/A	federal	curriculum-based program
Life Skills Training	N/A	school	school	Hispanic or black. 55.6% Hispanic, 18.7% black, 14.2% white, 11.6% other (Botvin et al., 1992). Program has shown marked success in a diversity of settings including urban schools that are primarily	regional/state	curriculum-based program

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: Smoking

Name of Program	CT evaluation Criteria			
	What works	**What doesn't work**	**Mixed reviews**	**Best bets**
Adolescent Alcohol Prevention Trial	Program participants showed a significantly reduced use of alcohol and cigarettes at a two-year follow-up, demonstrating a medium term delay of substance use initiation among adolescents.			
Big Brothers/Big Sisters			Program participation did not impact using tobacco	
Hutchinson Smoking Prevention Project		Pure "social influences" programs, designed to counteract the social influences to use tobacco by enhancing resistance skills and correcting exaggerated perceptions of how common tobacco use is.		
Life Skills Training	School-based drug prevention program in which students are taught to resist the pressures of advertisements, build self-esteem, manage anxiety, communicate effectively, and develop interpersonal relationships resulted in reduced use of drugs, alcohol, and cigarettes.			

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: Smoking

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
The Midwestern Prevention Project	N/A	parent/child (school based population)	school	81.13% of program cigarette users vs. 85.64% of control cigarette users were white, 85.76% of program alcohol users vs. 87.93% of control alcohol users were white, and 72.73% of program marijuana users vs 82.05% of control marijuana users were white (Chou et al., 1998)	federal	curriculum-based program
Project ALERT	Middle school students	School	School	Program effects were similar for schools with high minority populations and those without.	Federal, Regional/state	Curriculum-based program
Project Northland	N/A	school	school	94% white, 5.5% Indian (Perry, et al., 1996)	federal, regional/state	curriculum-based program
Project Toward No Tobacco Use	N/A	school	school	60% were White, 27% were Hispanic, 7% were Black, and 6% were Asian or "other (Dent et al., 1995).	federal, regional/state	curriculum-based program
Project Towards No Drug Use	Youth at general high schools	school	school	34% white, 38% Latino, 26% African American, and 2 % other.	N/A	curriculum- based program

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: Smoking

Name of Program	CT evaluation Criteria			
	What works	**What doesn't work**	**Mixed reviews**	**Best bets**
The Midwestern Prevention Project			Cigarette smoking and alcohol use were reduced at the 2.5 year follow-up but by the 3.5 year follow-up there were no significant effects on use.	
Project ALERT			Program produced short-term decreases in alcohol and cigarette use. Effects were not long-term, however.	
Project Northland	Community-based alcohol prevention programs that include an in-school curriculum, parent education, and participation by youth in alcohol-free activities outside of school. Intervention students were less likely to start drinking or smoking and those who did were engaged in those activities less often.			
Project Toward No Tobacco Use	School-based drug prevention program in which students are taught to resist the pressures of advertisements, build self-esteem, manage anxiety, communicate effectively, and develop interpersonal relationships resulted in less participants increasing their use of tobacco products. The physical consequences curriculum was found to be effective in reducing the use of smokeless tobacco.			
Project Towards No Drug Use	School-based programs that teach youth coping and self-control skills, teach youth about the myths of drugs and alcohol, and teach youth about the consequences of drug and alcohol use results in the reduced use of alcohol and illicit drugs. Program was found to effect tobacco usage rates in addition to alcohol use.			

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: Alcohol Use

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
Across Ages	6th graders at high risk for substance abuse	individual	school, nursing home, community, program site	52.2% African American, 15.8% White, 13.9% Other, 9.1% Asian Americans, 9.0% Hispanics. (LoSciuto et al., 1996) Original project and two replications were designed and tested on African American, Hispanic/Latino, White, and Asian American middle school students (sixth grade) living in a large urban setting. 30 replications have since been designed for Native American, White, Hispanic/Latino and African American youth.	federal, regional/state	Mentoring, community service, curriculum-based program
Adolescent Alcohol Prevention Trial	N/A	school	school	N/A in evaluation	N/A	curriculum-based program
Alcohol Misuse Prevention Study	N/A	school	school	N/A in evaluation	federal	curriculum-based program
Big Brothers/Big Sisters	N/A	individual	community/ program site	34.1% minority boys, 28.3% white boys, 22.7% minority girls, 14.9% white girls (Tierney et al., 2000)	private	curriculum-based program
Boys and Girls Clubs of America	Teens	Individual	Program sites	32% African American, 6% white, 26% Hispanic, 24% Asian, 12% Other	Federal, private	Mentoring

B4: Evaluated Programs: Alcohol Use

Name of Program	CT evaluation Criteria			
	What works	**What doesn't work**	**Mixed reviews**	**Best bets**
Across Ages	Mentoring programs are shown to make participants less likely to initiate drug and alcohol use (especially minority youth). Participants also had better reactions to situations involving drugs and alcohol			High levels of involvement with a mentor may help to reduce drug and alcohol use
Adolescent Alcohol Prevention Trial	Program participants showed a significantly reduced use of alcohol and cigarettes at a two-year follow-up, demonstrating a medium term delay of substance use initiation among adolescents. Programs that use adult-taught curriculum, peer leaders, and parental involvement in order to create no-drug norms and develop drug resistance strategies seems to work in preventing alcohol and drug use.			
Alcohol Misuse Prevention Study	During first year of licensure participants had fewer serious offenses (which included those where alcohol was involved). The program affect was stronger among students who reported drinking less than one drink per week at baseline.			
Big Brothers/Big Sisters	Mentoring programs are shown to make participants less likely to initiate drug and alcohol use (especially minority youth).			
Boys and Girls Clubs of America				Programs which incorporate cultural enrichment, health and physical education, social recreation, personal and educational development, citizenship, and leadership development may help to prevent drug and alcohol abuse.

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B4: Evaluated Programs: Alcohol Use

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
Communities Mobilizing for Change on Alcohol	N/A	community	community	N/A in evaluation	federal, regional/state	hybrid (media campaign, policy directive, curriculum-based program)
Creating Lasting Connections	N/A	individual	church	2/6 program sites were from African American communities. And 29/189 overall participants were from those African American communities (Johnson et al., 1996).	federal, regional/state	hybrid (policy directive, curriculum-based program)
Life Skills Training	N/A	school	school	Hispanic or black. 55.6% Hispanic, 18.7% black, 14.2% white, 11.6% other (Botvin et al., 1992). Program has shown marked success in a diversity of settings including urban schools that are primarily	regional/state	curriculum-based program
The Midwestern Prevention Project	N/A	parent/child (school based population)	school	81.13% of program cigarette users vs. 85.64% of control cigarette users were white, 85.76% of program alcohol users vs. 87.93% of control alcohol users were white, and 72.73% of program marijuana users vs 82.05% of control marijuana users were white (Chou et al., 1998)	federal	curriculum-based program
Peer Intervention Program	N/A	individual	community/ school	N/A in evaluation	regional/state	curriculum-based program
Project ALERT	Middle school students	School	School	Program effects were similar for schools with high minority populations and those without.	Federal, Regional/state	Curriculum-based program
Project Northland	N/A	school	school	94% white, 5.5% Indian (Perry, et al., 1996)	federal, regional/state	curriculum-based program

B4: Evaluated Programs: Alcohol Use

Name of Program	CT evaluation Criteria			
	What works	What doesn't work	Mixed reviews	Best bets
Communities Mobilizing for Change on Alcohol	Program communities saw a decrease in drunk driving arrests among young people ages 18 to 20 years and among adolescents between the ages of 15 and 17 years			
Creating Lasting Connections	From increased engagement in church activities and greater levels of communication skills, family bonding and use of community services, the treatment group had a significant decrease in the age of onset and frequency of alcohol and drug use.			
Life Skills Training	School-based drug prevention program in which students are taught to resist the pressures of advertisements, build self-esteem, manage anxiety, communicate effectively, and develop interpersonal relationships resulted in reduced use of drugs, alcohol, and cigarettes.			
The Midwestern Prevention Project			Cigarette smoking and alcohol use were reduced at the 2.5 year follow-up but by the 3.5 year follow-up there were no significant effects on use.	
Peer Intervention Program	Students in program showed a sustained increase in self-reported intervention in drinking and driving situations.			
Project ALERT			Program produced short-term decreases in alcohol and cigarette use. Effects were not long-term, however.	
Project Northland	Community-based alcohol prevention programs that include an in-school curriculum, parent education, and participation by youth in alcohol-free activities outside of school. Intervention students were less likely to start drinking or smoking and those who did were engaged in those activities less often.			

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

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B4: Evaluated Programs: Alcohol Use

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
Project Towards No Drug Use	Youth at general high schools	school	school	34% white, 38% Latino, 26% African American, and 2 % other.	N/A	curriculum- based program
Reconnecting Youth	High-risk students in 9th through 12th grades who exhibit multiple problems such as depression aggression, and substance use.	individual	school	N/A in evaluation	federal, regional/state	curriculum -based program
The Saving Lives program	N/A	community	community	N/A in evaluation	regional/state	hybrid (media campaign, policy directive, curriculum-based program)
Students Against Drunk Driving	N/A	school	school	California = 93% white in program school vs. 89% white in control school. New Mexico = 67% in program school and 62% in control school (Klitzner et al, 1994)	private	hybrid (media campaign, curriculum-based program)
Youth Corps	Educationally and economically disadvantaged participants	community	community	46% African-American, 28% White, 19& Hispanic, 3% Asian, 3% American Indian/Alaskan Native, 1% Other (Jastrzab et al., 1996)	regional/state, private	community service, curriculum-based program

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: Alcohol Use

Name of Program	CT evaluation Criteria			
	What works	What doesn't work	Mixed reviews	Best bets
Project Towards No Drug Use	School-based programs that teach youth coping and self-control skills, teach youth about the myths of drugs and alcohol, and teach youth about the consequences of drug and alcohol use results in the reduced use of alcohol and illicit drugs.			
Reconnecting Youth	At 5 and 10 month follow-ups, the treatment group has decreased use of alcohol and drugs.			
The Saving Lives program				Program communities saw a decline, relative to rest of Massachusetts, in the percentage of 16- to 19- year-olds who reported drinking and driving in the previous month. There were also overall decreases in fatal crashes involving alcohol.
Students Against Drunk Driving		No measurable effect on drinking and driving behavior or other related measures.		
Youth Corps			White female program participants are less likely to consume five or more alcoholic drinks per sitting (3 percent vs. 32 percent). Other subgroups of participants are not significantly less likely to use alcohol or drugs.	

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: Violence

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
Across Ages	6th graders at high risk for substance abuse	individual	school, nursing home, community, program site	52.2% African American, 15.8% White, 13.9% Other, 9.1% Asian Americans, 9.0% Hispanics. (LoSciuto et al., 1996) Original project and two replications were designed and tested on African American, Hispanic/Latino, White, and Asian American middle school students (sixth grade) living in a large urban setting. 30 replications have since been designed for Native American, White, Hispanic/Latino and African American youth.	federal, regional/state	Mentoring, community service, curriculum-based program
Anger Coping Program	highly aggressive and disruptive pre-adolescent boys	individual	school	47.36% White, 52.6% Black	federal, national/state, private	intervention
Big Brothers/Big Sisters	N/A	individual	community/ program site	34.1% minority boys, 28.3% white boys, 22.7% minority girls, 14.9% white girls (Tierney et al., 2000)	private	curriculum-based program

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: Violence

Name of Program	CT evaluation Criteria			
	What works	**What doesn't work**	**Mixed reviews**	**Best bets**
Across Ages			Mentored youth were less likely to engage in problem behavior	
Anger Coping Program	A program designed to increase adolescent perspective taking, social problem solving, and social skills for managing conflict situations.			
Big Brothers/Big Sisters			Mentored youth were less likely to hit someone BUT, program participation did not impact behaviors such as: stealing or damaging property, number of times youth sent to office, doing risky things, fighting, cheating	

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: Violence

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
The Buddy System	Multi-ethnic adolescents with academic or behavioral problems	Individual	Program and Activity sites	N/A in evaluation	Federal	Mentoring/Monetary Incentives
Building Essential Life Options through New Goals (BELONG)	At risk youth	school	school, nursing home, community	49.4 % White, 27.8% African-American, 22.9% Hispanic (Blakely et al., 1995)	Regional/state, federal	hybrid (policy directive, curriculum-based program)
Children at Risk	Middle school students living in disadvantaged neighborhoods	Community	Community	58% black, 34% Hispanic, 8% white or Asian	Regional/state	Policy directive. Whole-community approach involving school services, community and social services, and out-of-school activities.

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: Violence

Name of Program	CT evaluation Criteria			
	What works	**What doesn't work**	**Mixed reviews**	**Best bets**
The Buddy System			Youth without a prior major offense were more likely than a control group to commit a major offense in the program year (16% vs. 7%), or in the program year or two years later (23% vs. 16%) Mentored youth were less likely to commit a major offense in the program year (37.5% vs. 64%), or in the program year or two years later (56% vs. 78%), (only for mentored youth with a history of committing major offenses)	
Building Essential Life Options through New Goals (BELONG)	Teachers were less likely to report behavior problems for mentored students The percentage of mentored youth referred to school administrators for a severe discipline infraction decreased from pre to post intervention		Mentored youth were less likely to commit misdemeanors or felonies and were also less likely to commit less serious offenses	
Children at Risk			Program participants reported fewer peers involved in delinquent activities. Program participants showed no difference in gang membership. Program participants showed no difference in contact with juvenile justice system agencies, based on police and court records. Program participants took part in more positive social activities (clubs, religious groups, sports, community programs, etc.).	

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: Violence

Name of Program	Program Characteristics					
	Targeted Populations	Youth Context	Venues	Cultural Relevance	Sponsor Level	Type of Approach
Learn and Serve America		school	school	N/A in evaluation	federal, regional/state	Community service, curriculum-based program
Positive Youth Development Program	Middle school students	School	School	N/A in evaluation	Regional/state, private	Curriculum-based
Quantum Opportunities Program	Disadvantaged Youth	individual	program site	75% African Americans, 14% Caucasian, 7% Hispanic, 2% Other, 1% Asian (Hahn et al., 1994). Has a developmental component which may include cultural enrichment activities.	Regional/state, private	community service, curriculum-based program
Reconnecting Youth	High-risk students in 9th through 12th grades who exhibit multiple problems such as depression aggression, and substance use.	individual	school	N/A in evaluation	federal, regional/state	curriculum -based program
Safe Dates Project	adolescents in relationships ages 12- 17	individual	school	75.9% White, 20.2% African American, 3.9% other racial/ethnic groups	federal, national/state	curriculum-based program

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

B4: Evaluated Programs: Violence

Name of Program	CT evaluation Criteria			
	What works	**What doesn't work**	**Mixed reviews**	**Best bets**
Learn and Serve America				Middle school participants in a service learning program were less likely to be arrested than nonparticipants
Positive Youth Development Program	Participants had better coping, stress management, problem-solving, and conflict resolution skills			
Quantum Opportunities Program	Participants in a community-based service learning program were less likely than youth in the control group to become involved with police			
Reconnecting Youth	At 5 and 10 month follow-ups, the treatment group has lower rates of school drop-out, a decreased use of alcohol and drugs, decreased drug use control problems, decreases in anger control problems and aggressive tendencies, and a significant decrease in depressive symptoms.			
Safe Dates Project	Intervention consisted of role-playing, a poster contest, and a curriculum on violence, gender stereotyping and conflict management. Development of victim services available in the community.			

NOTE: Due to the lack of evaluation information on the programs cited in the WH report, we rely on evaluation information from programs that may not be federally funded or national in scope. Findings from these evaluations however, are important to consider and can help to shape the development of future federal programs.

Appendix C. Program Resources

Federal Resources

Substance Abuse and Mental Health Services Administration

http://modelprograms.samhsa.gov/template_cf.cfm?page=model_list

SAMHSA has collected and created an online database of evidence-based programs on substance abuse and mental health services. Programs which were conceptually sound and internally consistent, reasonably well implemented and evaluated, and had activities related to conceptualization were selected for the database.

The Office of the Surgeon General

http://www.mentalhealth.org/youthviolence/default.asp

The Surgeon General's Report on Youth Violence identifies science-based strategies that can be implemented by parents, schools, and communities to decrease the risk of youth violence. The report looks at violence from a developmental perspective to try and understand why some youth engage in violence and also suggests several programs which have been shown (to some extent or another) to be effective in combating the spread of youth violence.

The US Department of Justice Coordinating Council on Juvenile Justice and Delinquency Prevention

http://ojjdp.ncjrs.org/programs/index.html

The OJJDP maintains an online database with program descriptions, funding mechanisms, and contact information for all 27 of their current programs. The programs involve a wide array of topics ranging from youth courts to delinquency prevention to tribal programs to mental health initiatives.

US Department of Education

http://www.ed.gov/programs/find/title/index.html?src=ov

The Department of Education keeps a main database of all of its programs linked within their homepage. The list is extensive and every program has a program description and other relevant information listed.

US Office of Special Education Programs

http://cecp.air.org/preventionstrategies/Default.htm

The US Office of Special Education's page on Prevention Strategies That Work is an electronic guide of programs and practices which K-8 public school administrators have found to be effective in accelerating school performance, increasing readiness for learning, and reducing problem behaviors. Creating a safe school environment requires, among other things, preventive measures for children's behavioral and emotional problems." The page links to an OSE report, as well as links to several of the programs discussed within the report.

Office of Safe and Drug Free Schools

http://www.ed.gov/admins/lead/safety/exemplary01/index.html

In 2001 the Office of Safe and Drug Free School (part of the Department of Education) released *Exemplary and Promising Safe, Disciplined and Drug-Free Schools Programs 2001.* The OSDFS has multiple other lists of programs which effect students and the school environment.

Non-Federal Resources

Harvard Family Research Project

http://www.gse.harvard.edu/hfrp/projects/afterschool/mott/mott6.html

The Harvard Family Research Project has targeted programs that involve child development, student achievement, healthy family functioning, and community development for inclusion in their database. Their program profiles include very detailed information on both the program and the evaluations that were done of the program. New profiles are added and existing profiles are updated quarterly.

Maryland Blue Prints

http://www.marylandblueprints.org/

The Maryland Blueprints web site contains youth-focused programs shown by research to be effective at reducing or preventing substance use, crime, delinquency and anti-social behavior. Program descriptions and evaluation information are given in addition to other factors such as cost and program contact information.

Proven Practices Network for Children, Families, and Communities

http://www.promisingpractices.net/programlist.asp

The Colorado Foundation for Families and Children, the Family and Community Trust (Missouri), the Family Connection Partnership (Georgia), and the Foundation Consortium for California's Children & Youth (California) created this project which is currently administered by the RAND Corporation. Publicly available information is used to report on the effectiveness of programs, both program designs and evaluations. Programs are listed according to benchmarks for both children and families.

Virginia Tobacco Settlement Foundation

http://www.vtsf.org/compendium.asp

The Virginia Tobacco Settlement Foundation's Compendium of Tobacco Use Prevention Programs for Youth includes 30 programs which have been identified by national, state, and non-profit organizations as effective tobacco prevention and/or cessation programs for youth. The online database of programs also includes 8 supplemental programs and thorough descriptions of all programs. The descriptions include evaluations of the programs, as well as program goals, features, costs, and other associated information.

Hamilton Fish Institute

http://www.hamfish.org/programs/all.html

The Hamilton Fish Institute on School and Community Violence at George Washington University seeks to synthesize and analyze existing models and research on school violence prevention to examine their effectiveness. The Institute has identified 12 Effective and 11 Noteworthy programs thus far which have been rigorously evaluated. Program descriptions are provided for all programs which they have evaluated.

Blue Prints for Violence Prevention

http://www.colorado.edu/cspv/blueprints/index.html

Blueprints for Violence Prevention has identified 11 prevention and intervention programs that meet a strict scientific standard of program effectiveness. The 11 model programs and 21 promising programs have been identified as being effective (or showing signs of being effective) in reducing adolescent violent crime, aggression, delinquency, and substance abuse. So far, more than 600 programs have been reviewed and the Center continues to look for programs that fit within either their model or promising programs sections.

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