1. PROJECT IDENTIFICATION

Project Title: Boys' Health Advocacy Program

Project Number: H17MC04352

Project Director: W. Burke Eilers

Grantee Organization: Youth & Family Services, Inc.

Address: PO Box 2813, Rapid City, SD 57709-2813

Phone Number: 605-342-4195

E-mail Address: soney@youthandfamilyservices.org

Home Page: www.youthandfamilyservices.org

Project Period: 3/1/05 - 2/28/10

Total Amount of Grant Awarded: Years 1-3 $50,000/year = $150,000

Years 4-5 $49,126/year = $ 98,252

TOTAL: $248,252

ABSTRACT

PURPOSE OF PROJECT AND RELATIONSHIP TO SSA TITLE V MATERNAL AND CHILD HEALTH (MCH) PROGRAMS: The Boys' Health Advocacy Program at Youth & Family Services, Inc., Rapid City, SD, was created to address the needs and problems of at-risk boys who have urgent or unmet health care requirements or do not receive routine health care by providing access to care. Contributing factors include challenging conditions in the home (addictions, abuse, neglect, etc.), poverty, lack of transportation, hardships related to minority status, chaotic lifestyles, lack of knowledge about the importance of health care checkups and how to get them, and/or lack of parent/caregiver involvement. The program was funded under the Healthy Tomorrows Partnership for Children and relates to the program priority to increase the number of children in low-income households who receive health assessments and follow-up diagnostic and treatment services.

GOALS AND OBJECTIVES: Goal 1.0: Access to health care services will be made available to Rapid City at-risk boys, ages 5-7, through the Boys' Health Advocacy Program. (During the 2009-2010 grant cycle, or Year 5, the Boys' Health Advocacy Program received permission to provide services to at-risk boys, ages 4-17, in the Healthy Tomorrows Program.) Objectives relating to Goal 1.0 are considerations of number of previously unserved boys, identification of needs, and provision of ongoing case management services from referrals.

Goal 2.0: The Boys' Health Advocacy Program will provide opportunities, encouragement, and support for parents and guardians to establish and maintain long-

term accessibility to health care services for their child(ren). Goal 2.0 objectives concern the establishment of a pattern of accessing health care and social services and increasing the level of parent/caregiver involvement in meeting their child(ren)'s health care needs.

Goal 3.0: Health Advocacy staff will continuously seek to improve program services. The objective establishes that Advocates will obtain feedback and guidance from service providers and referral sources regarding program services and recommended care and treatment for all boys participating in the program. Goal 4.0: Boys' Health Advocacy staff will advocate for boys on a systemic level. The objectives relating to Goal 4.0 describe the procedures that program and agency personnel will take to increase community awareness of the issues faced by high-risk boys, and institutional barriers for boys and their primary caregivers in accessing health care.

METHODOLOGY: The Boys' Health Advocacy Program provides health focused case management services designed to meet the needs of underserved boys. The program connects boys with unmet health needs to various area service providers; assists boys in learning and developing patterns of behavior that will enhance their health; works with boys to connect them with appropriate medical, dental, optical, and counseling services; and works closely with families and school personnel. Boys' Health Advocacy receives referrals from local school counselors, the Indian Health Service, South Dakota Department of Social Services, parents, juvenile justice programs, other agencies serving youth, and other YFS programs. Many organizations pass on information about the program to families who then request services directly.

Based on a Health Needs Assessment completed by the boy and his caregiver, the

Advocate draws up an individualized health care plan with each participating boy. The Advocate schedules appointments, as needed, with physicians, dentists, mental health counselors, and other connecting agencies, provides transportation, accompanies the boy to appointments with health care providers, and subsequently follows up with each boy and his family to address any treatment recommended by the health care provider. The cost per participant appears to be high because program provides comprehensive health-focused case management services that are highly time- and labor-intensive. Depending on the number and severity of needs, an individual boy may require multiple appointments with several service providers over an extended period of time.

EVALUATION: External evaluation of the Boys' Health Advocacy Program was conducted by the Institute for Educational Leadership and Evaluation®, an educational research and evaluation firm with a longstanding relationship with Youth & Family Services. The Boy's Health Advocacy Program Evaluation Plan utilized two evaluation models. The first model supports the continuous quality improvement of any program and serves as a quality control measure. The second model assesses the effectiveness of client services provided by the program through the measurement of process indicators, project outcomes, and impact. Both models serve to answer questions about achieving the goals and objectives formulated for the Boys' Health Advocacy Program.

RESULTS/OUTCOMES (POSITIVE & NEGATIVE): During the five years of the project, 87 boys (unduplicated) were enrolled in the program. The demographic distribution of participants was: 33% American Indian, 49.4% White, 8% Hispanic, 8% Other or Not Reported, and 1.14% Black. The boys were served with between 3,341 and

4,000 or more appointments with service providers. Of the 64 boys remaining in the program at the end of the grant period, approximately 10% entered between March 2005 and February 2006, 8% entered between March 2006 and February 2007, 17% entered between March 2007 and February 2008, 29% entered between March 2008 and February 2009, and 36% entered between March 2009 and February 2010. Social Networking demonstrated as the greatest need of participants, and this was addressed with mentoring activities. Additional program activities that support the health and well-being of the entire family were identified as considerations for meeting the challenges of the boys.

PUBLICATIONS/PRODUCTS: A doctoral dissertation, numerous presentations and newspaper articles, written materials and handouts, assessments and surveys, participant tracking system, a website, and a promotional DVD were developed for the program and are described in the final report.

DISSEMINATION/UTILIZATION OF RESULTS: Several presentations have been made at national conferences and community youth serving agencies and organizations. Detailed information has been sent to other agencies throughout the US who are exploring the possibility of replicating the program.

FUTURE PLANS/FOLLOWUP: Youth & Family Services (YFS) has been awarded a grant of $300,000 to support the Boys' Health Advocacy Program. YFS has also applied for funding to implement an evidence-based Teenage Pregnancy Prevention Project in four counties in western South Dakota. The proposed project contains a strong health advocacy component. Long term goals for the Boys' Health Program are to continue to meet the multi-dimensional and multi-layered health needs of "at-risk" boys.

FINAL REPORT AND ABSTRACT

Narrative:

1. PURPOSE OF PROJECT AND RELATIONSHIP TO SSA TITLE V MATERNAL AND CHILD HEALTH (MCH) PROGRAMS

In Rapid City, South Dakota, at-risk children and their families are a vulnerable group who often lack the skills, motivation, and opportunity to access and utilize basic and preventive health care services. Contributing factors include poverty, hardships related to minority status, challenging conditions in the home (addictions, abuse, neglect, etc.), chaotic lifestyles, lack of knowledge about the importance of health care checkups and how to get them, lack of transportation, and/or lack of parent/caregiver involvement. Even though the majority of these children are entitled to health care services through Medicaid, the State Children's Health Insurance Program (SCHIP), the Indian Health Service, or private insurers, few of them receive regular or preventive medical care. The Boys' Health Advocacy Program (as well as a similar program for girls) at Youth & Family Services, Inc., Rapid City, SD, was created to address these needs and problems by providing access to care for at-risk boys who have urgent or unmet health care needs or do not receive routine health care. This program was funded under the Healthy Tomorrows Partnership for Children and relates to the program priority to increase the number of children in low-income households who receive assessments and follow-up diagnostic and treatment services.

Dr. Willis Sutliff, a pediatrician at Black Hills Pediatrics & Neonatology, Rapid City, and a member of the local AAP chapter, served on the Boys' Health Advocacy

Program Advisory Board and has now become a member of the Board of Directors for Youth & Family Services, Inc. The Advisory Board has had a tremendous impact on the Boys' Health Advocacy Program services. Members of this board met quarterly throughout the project period to review program activities as well as obstacles and challenges encountered, discuss issues relevant to youth that they see in their professional and personal interactions, and offer suggestions on the future direction of the programming and the pursuit of funding. Referrals to the Boys' Health Advocacy Program also came from Dr. Sutliff and other pediatricians in the community.

2. GOALS AND OBJECTIVES:

Goal 1.0: Access to health care services will be made available to Rapid City at-risk boys, ages 5-7, through the Boys' Health Advocacy Program. (Please note: During the 2009-2010 grant cycle, or Year 5, the Boys' Health Advocacy Program received permission to provide services to at-risk boys, ages 4-17, in the Healthy Tomorrows Program.)

- **Objective 1.1:** Advocates will identify a minimum of 50 previously unserved boys, ages 5-7, from the Rapid City community who require health advocacy services.
- **Objective 1.2:** Advocates will assist all boys and parents/caregivers enrolled in the program to identify their needs through an initial assessment and throughout their enrollment in the program. Continuing identification of needs will also be accomplished through consultation with service providers and physicians in the community. These needs will be documented in the

following categories: (1) Abuse and/or Neglect, (2) Legal Involvement, (3) Substance Abuse, (4) Education, (5) Dental, (6) Medical, (7) Optical, (8) Home/Family, (9) Mental Health, (10) Wellness, (11) Social Network.

- **Objective 1.3:** Advocates will provide ongoing case management/advocacy services for all boys continuously participating in the program either directly through Health Advocacy or through referrals to other connecting agencies.

Goal 2.0: The Boys' Health Advocacy Program will provide opportunities, encouragement, and support for parents and guardians to establish and maintain long-term accessibility to health care services for their child(ren).

- **Objective 2.1:** Advocates will assist and encourage all boys continuously participating in the program and their families to establish a pattern of regularly accessing health care and social services.
- **Objective 2.2:** Advocates will assist in increasing level of parents/caregivers' involvement in meeting their child(ren)'s health care needs.

Goal 3.0: Health Advocacy staff will continuously seek to improve program services.

- **Objective 3.1:** Advocates will obtain feedback and guidance from service providers and referral sources regarding program services and recommended care and treatment for all boys participating in the program.

Goal 4.0: Boys' Health Advocacy staff will advocate for boys on a systemic level.

- **Objective 4.1:** Program and agency personnel will network within the community to increase understanding about the issues faced by high-risk boys and their families.
- **Objective 4.2:** Program and agency personnel will address institutional barriers for boys and their primary caregivers to access health care.

Through increasing access to health care services, assisting parents/caregivers to establish and maintain accessibility to health care services for their children, continuously improving program services, and addressing institutional barriers to health care access by low-income children and families, these goals and objectives directly relate to the Healthy Tomorrows priority to increase the number of children in low-income households who receive assessments and follow-up diagnostic and treatment services.

3. METHODOLOGY

The Boys' Health Advocacy Program, a unique program of Youth & Family Services (YFS), provides health focused case management services designed to meet the needs of underserved boys. The program connects boys with unmet health needs to various area service providers; assists boys in learning and developing patterns of behavior that will enhance their health; works with boys to connect them with appropriate medical, dental, optical, and counseling services; and works closely with families and school personnel.

Boys' Health Advocacy receives referrals from local school counselors, the Indian Health Service, South Dakota Department of Social Services, parents, juvenile justice programs, other agencies serving youth, and other YFS programs. While schools and

counselors may make direct referrals to the Boys' Heath Advocacy Program, many organizations pass on information about the program to the families, who then request services directly. The boys are selected to participate in this project precisely because they have an unmet health care problem or do not receive regular medical attention.

Based on a Health Needs Assessment completed by the boy and his caregiver, the Advocate draws up an individualized health care plan with each participating boy. Once the boy's need(s) have been identified, the Advocates assist in meeting these needs. The Advocate schedules appointments, as needed, with physicians, dentists, mental health counselors, and other connecting agencies, provides transportation, accompanies the boy to appointments with health care providers, and subsequently follows up with each boy and his family to address any treatment recommended by the health care provider.

Advocates also ensure that the boys have regular health care appointments even if the Advocate is not involved in the appointment. Advocates are in constant contact with the parents or guardians on various health issues, including annual physical examinations, dental, mental, and social health visits. Twice a year, the Boys' Health Advocacy Program, in collaboration with other Youth & Family Services programs, brings the Ronald McDonald/Delta Dental Care Mobile to their facility to address dental issues. During this time, the Advocates contact all the parents to ensure the boys are caught up on their dental appointments.

In many cases, transportation is a barrier to access to health care. The Advocate provides transportation to and from appointments in cases where the parent is working and cannot take time off work, does not have access to reliable transportation, or is

otherwise not able to take their child to appointments. The Advocate then works with the family to identify alternatives for transportation.

The cost of the health care for most of the boys is covered by Medicaid, SCHIP, the Indian Health Service (IHS), or private insurers. Many families are eligible for Medicaid or SCHIP but have not signed up due to the complexity of the paperwork. The Advocates assist these families with the paperwork and ensure that it is submitted in a timely fashion. The Advocates also teach program participants and their families the important skill of advocating for themselves.

Participating boys also spend time one-on-one with their Advocate. Additional health benefits are reaped from the encouraging and supportive personal relationship that develops between the Advocate, the boy, and his family. This mentoring and relationship building component is a pivotal part of the Boys' Health Advocacy Program. For boys participating in the program, the focus is on the prevention of bigger problems. According to the Advocates, mentoring is the key piece for these boys. It involves providing a positive male role model, working on their self-esteem, talking with them, building trust, asking what they can help them with, and getting them outdoors and involved in fun activities. A majority of these boys do not have a father or other significant male involved in their lives. Having a trusting adult in whom they can confide helps to keep the boys on track and deal with their family problems. The Advocates provide that trusting male role model for many of the boys in the program.

The Boys' Health Program is the only program in the Rapid City area that increases access to health care for at-risk boys. The cost per participant appears to be

high because the Boys' Health Advocacy Program provides comprehensive health-focused case management services that are highly time and labor intensive. Depending on the number and severity of needs, an individual boy may require multiple appointments with several service providers over an extended period of time. Most of the boys are on the Advocate's caseload for at least one year, some for as long as three years or more. A typical appointment for one boy may take up to three hours of the Advocate's time, including time providing transportation to and from the appointment, time waiting to see the service provider, and actual time with the service provider. In addition, for many of the boys whose families are in crisis, the Advocate spends additional time working with the entire family to help them find resources to meet their basic needs, including food and housing.

4. EVALUATION:

External evaluation of the Boys' Health Advocacy Program was conducted by the Institute for Educational Leadership and Evaluation®, an educational research and evaluation firm with a longstanding relationship with Youth & Family Services. The *Boy's Health Advocacy Program Evaluation Plan* utilized two evaluation models. The first model supported the continuous quality improvement of any program and served as a quality control measure. The second model assessed the effectiveness of client services provided by the program through the measurement of process indicators, project outcomes, and impact. Both models served to answer questions about achieving the goals and objectives formulated for the Boys' Health Advocacy Program.

5. RESULTS/OUTCOMES (POSITIVE & NEGATIVE):

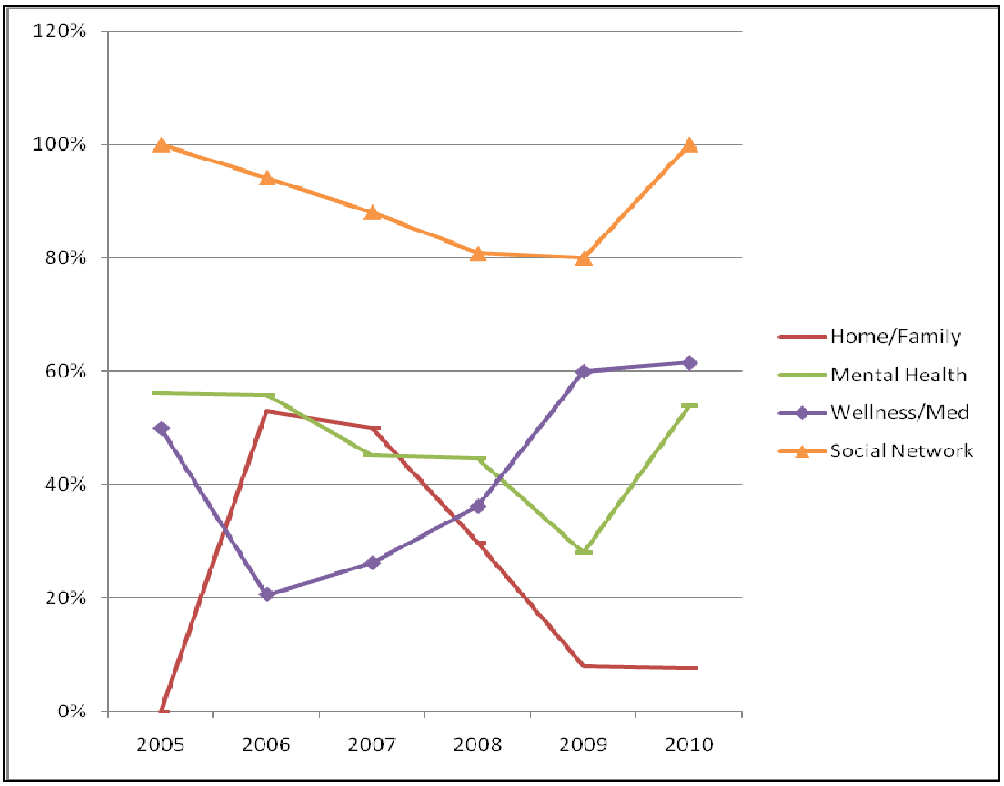
Youth & Family Services (YFS) was awarded the Healthy Tomorrows Partnership for Children grant effective March 1, 2005. The five-year funding period was completed February 28, 2010. YFS identified four goals and several related objectives for the grant. Each of these objectives has activities and strategies to be implemented during the five-year grant period. The original goal was to increase access to health care for boys, ages 5-7, in the Rapid City, South Dakota, area. In March 2007, the program was expanded to include 4-year-olds, and in March 2009, the program was expanded again to include older boys, ages 8-17. Previously, advocacy services for older boys, ages 8-17, were funded through a Title X Male Research project grant funded by the Office of Population Affairs, U.S. Department of Health and Human Services, which ended in September 2008.

During the five years of the project, 87 boys were enrolled in the program. The demographic distribution of participants was: 33% American Indian, 49.4% White, 8% Hispanic, 8% Other or Not Reported, and 1.14% Black. The boys were served with at least 3,341 appointments, but most likely more than 4,000 appointments, with service providers. (In Years 1-2, only referrals were tracked, not actual number of appointments.) These appointments addressed identified needs in eleven categories: Abuse/Neglect, Legal Involvement, Substance Abuse, Education, Dental, Medical, Optical, Home/ Family, Mental Health, Wellness, and Social Network.

The needs of boys entering the program have changed over the five-year period. In the first year of the program, more boys entered with medical, dental, and optical needs than in subsequent years. Social network has been a consistent need for almost all boys. Mental health and home/family issues have been a persistent need for more than half of

participating boys. Unlike the initial assumption that boys would be referred for physical health issues, most boys are now referred for mental health and behavioral issues. According to referral sources, boys are referred because of abuse situations (physical, mental, sexual, etc.), behavioral or social issues, health or mental health needs not being met, family issues, or need for relationship advice or knowledge. Service providers see these boys as having different needs than the boys that they usually serve. These boys are more likely to have mental health issues and live in difficult family situations.

The following graph shows changes in levels of needs over the five year period:



Greatest Percent of Boys with Need, Duplicated

Boys' needs fluctuated during the years of the grant period; however the greatest needs remained consistent throughout the program. Social Networking, Mental Health,

Wellness/Medical, and Home/Family needs were most frequently cited as shown in the table above. Although these greatest needs were consistently demonstrated and addressed, staff members also communicated their finding that academic support was a key ingredient in meeting the needs of boys with physical and emotional needs. The schools have communicated a great reception in relaying the need and value of the program. Academic needs have begun to be satisfied by the 21st Century Community Learning Centers grant through the SD Department of Education. This program provides academic enrichment, homework help and tutoring for the at-risk boys enrolled in the Boys' Health Advocacy Program.

Despite the best efforts of health care providers, preventive programs do not work if the families who need them cannot or do not access them. The Boys' Health Advocacy Program provides a primary mechanism for accessibility – transportation. Transportation has been and continues to be a primary obstacle for families to access health care. Other factors that impede access to health care include challenging conditions in the home (addictions, abuse, neglect etc.), a single caregiver with multiple children, inability to leave work for financial or security reasons, and a lack of knowledge about the importance of preventive health care check-ups.

The transportation provided by the Boys' Health Advocacy Program also ensures that clients will be present at appointments, which is important for service providers. Providers also cite consistency, coordination, and communication as benefits in working with the Boys' Health Project. These benefits ensure that services will be available to clients in the future. This includes the program's success in obtaining donated health care

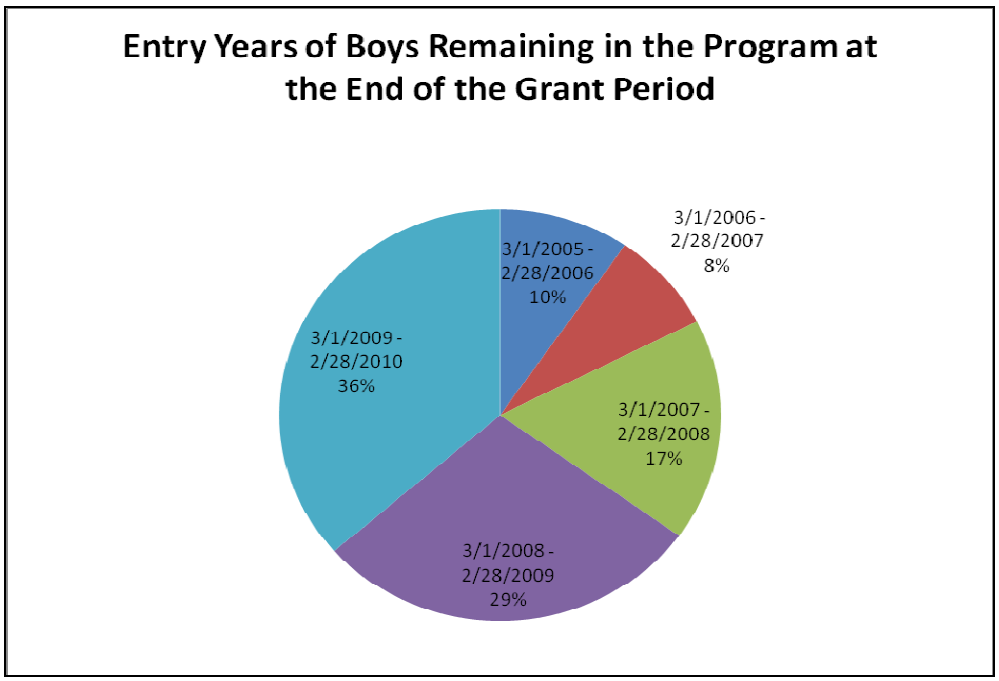
services for clients when no other resources exist. Without the existing relationships between service providers and the Boys' Health Advocacy Program staff, boys and their families may have increasing difficulties accessing needed health care services.

Advocates consistently interact with parents/caregivers about the outcome of appointments that they are unable to attend. Follow-up care is an integral part of overall health care and a step in the right direction for prevention. Advocates involve parents/ caregivers in every stage of the treatment process to assure that follow-up care is occurring and to answer any questions that they may have. In some instances, the parent/caregiver expressed interest in seeking similar care for themselves because the need was addressed for their child.

The Boys' Health Advocacy Program staff advocates for children and youth on individual, group and community levels. Active participation in community efforts is an important component of helping to address the needs of high-risk youth and their families. Advocates participate in community organizations and coalitions—the Youth Serving Organizations Alliance, Power Partners, Community Services Connection of the Black Hills, Youth 2 Youth, South Dakota Consolidated School Health Program, Youth & Family Services Team Wellness, Adolescent Substance Abuse Prevention Program, and the Advisory Committee for the Rapid City Community Health Center. The Boys' Health Advocacy Program staff's connections to the community are a continuing process in expanding potential resources and seeking alternative health care access.

Advocates also found parental involvement and family intervention to be challenges. Boys in need of the health program come from challenging home situations

and there are instances where the whole family is in need. Parents are invited to be involved, but there are complicating issues of child care, basic family needs, conflicts, and other challenging behaviors. Advocates have expressed a need to find a way to increase the participation and support from parents and enhance ways to assist parents in learning more about health advocacy for their families.



Of the 64 boys remaining in the program at the end of the grant period, approximately 10% entered between March 2005 and February 2006, 8% entered between March 2006 and February 2007, 17% entered between March 2007 and February 2008, 29% entered between March 2008 and February 2009, and 36% entered between March 2009 and February 2010.

6. PUBLICATIONS/PRODUCTS:

At Risk Boys' Perceptions of Manhood: A Descriptive Case Study, a doctoral

dissertation, was submitted in partial fulfillment of the requirements for the Degree of Doctor of Psychology from the University of Northern Colorado, Greeley, by Michael Joseph Huxford and published in January 2008. The dissertation is about the YFS Male Health Program, which includes Boys' Health Advocacy. Dr. Huxford is a former Health Advocate with the YFS Male Health Program. Contact information: Michael Huxford, 2424 9th Avenue, #4, Longmont, CO 80513, 303-859-4454, huxnbec@msn.com.

During the funding period, numerous presentations about the Boys' Health Advocacy Program were made to various audiences. These include:

- Youth & Family Services Male Advocacy Model, presented by Dr. Helen Jenkins, External Evaluator, and Burke Eilers, Project Director; *Men's Health Conference* sponsored by Morehouse School of Medicine, Atlanta, GA, October 2005
- Presentation by Burke Eilers to the 135th Annual Meeting of the American Public Health Association, Washington, DC, November 2007
- Presentation by Burke Eilers to the annual Male Health Research grantee meeting of the Office of Population affairs, Washington, DC, November 2007
- Presentation on KNBN newscast, Rapid City, SD, December 2007
- Numerous feature articles on Boys' Health Advocacy Program activities in the Rapid City (SD) Journal, 2005-2009

Other products and materials produced during the funding period are listed below.

- Written materials/handouts:
  - *Study Smarter*
  - *Goals*

- *Moods and Feelings*
- *What is Self-Esteem?*

- Assessment surveys developed by Institute for Educational Leadership & Evaluation, 1641 Deadwood Avenue, Rapid City, SD 57702, 605-342-4311, husera@chiesman.org:
  - Service Provider/Referral Source Satisfaction Surveys
  - Parent/Guardian Surveys
  - Client Surveys
- Comprehensive Data Tracking System
- Developed website, www.teenhealthguide.org, for use by program participants.
- Boys' Health Advocacy Program promotional DVD

7. DISSEMINATION/UTILIZATION OF RESULTS

Several presentations about the Boys' Health Advocacy Program were made at national conferences. Detailed information was provided to other agencies throughout the US who were exploring the possibility of replicating the program. Information about the program was also shared with Beverly Duffel, Assistant Administrator of Office of Family Planning at SD Department of Health. A presentation was made to the South Dakota Consolidated School Health group. Locally, the SD Department of Social Services, Community Health Center, Club for Boys, YMCA, counselors at Rapid City Area Schools, and other entities are all well aware of the Boys' Health Advocacy Program and regularly make referrals. Information on the program is shared with Dexter Whitman at Pennington County Court Services/Diversion Program. A DVD on the

program was developed, distributed and used promotionally in presentations for YFS Annual Meetings and Board Meetings and also to local service clubs and United Way of the Black Hills.

8. FUTURE PLANS/FOLLOWUP

Youth & Family Services (YFS) has been awarded a Congressional Earmark of $300,000 to support the Boys' Health Advocacy Program. This funding is currently being processed through the Centers for Disease Control, which will administer the grant. The program will continue to serve boys, ages 4-17, who have unmet health care needs or do not receive routine medical care.

YFS has also applied to the US Department of Health & Human Services, Office of Adolescent Health, for funding to implement an evidence-based Teenage Pregnancy Prevention Project in four counties in western South Dakota. The proposed project contains a health advocacy component. If funded, this grant will provide approximately $100,000/year for five years for the Boys' Health Advocacy Program and will provide an opportunity to rigorously evaluate the effectiveness of evidence-based teen pregnancy prevention strategies with and without the case management/health advocacy component. (YFS has a similar health advocacy program for at-risk girls, which will also participate in the teen pregnancy prevention project, if funded.)

As a program within the YFS Counseling Center, the Boys' Health Advocacy Program receives a portion of the annual funding from United Way that supports the Counseling Center.

The program also formalized the homework help/academic enrichment/youth

development activities that have occurred alongside health care access and advocacy and now receives $35,000 annually as an out-of-school-time program from the 21st Century Community Learning Centers grant through the SD Department of Education.

Using a holistic approach to address the issues of a high-risk population, the Boys' Health Program works to promote preventive health care and positive physical and mental health lifestyles, reduce risky behavior, and improve decision-making and responsibility among boys and young men. Extensive experience with this type of programming indicates the following anticipated outcomes:

- Information about, values, peer pressure, goal setting, self concept, healthy relationships, human sexuality, and health care will reduce risky behaviors including substance use and abuse, violence/bullying, teen pregnancy, and sexually transmitted infections
- Improving access to health care services will contribute to the health of at-risk boys and reduce emergency-based medical care
- Mentoring of boys and young men will result in healthier decisions, self-efficacy, self-confidence, and more active and productive community youth

Long term goals for continuance of the Boys' Health Program are to persist in meeting the multi-dimensional and multi-layered health needs of participants. Program components will continue to have a positive impact on the health, wellness, and socialization skills critical to the success of each individual.

ANNOTATION

The Boys' Health Advocacy Program provides health-focused case management/ advocacy services for at-risk boys who have unmet health care needs and/or do not receive regular medical attention. The primary purpose is to increase access to health care through health promotion, prevention, and early intervention. Goals are to provide access to health care services; assist parents/guardians to establish and maintain long-term access to health care services for their children; improve program services continuously; and advocate on a systemic level for at-risk boys. During the funding period, 87 boys were served with 4,000 or more appointments. Materials developed include a doctoral dissertation, a comprehensive data collection system, a promotional DVD, and at least 26 presentations about the program.

KEY WORDS

Access to Health Care

Case Management

Community Based Health Services

Families, Health Education

Health Promotion

Indians/Native Americans

Males

Medicaid

Mental Health Services

Minority Health

Nutrition

Outreach

Preventive Health Care

Primary Care

Transportation

Youth & Family Services
Boys Health Advocacy

Program Evaluation Report

March 1, 2009 - February 28, 2010

Healthy Tomorrows Partnership for Children

Prepared By

Patricia Schulte, M.A.
John J. Usera, Ph.D.
Rebecca Almy, B.S.

Institute for Educational Leadership & Evaluation®
Chiesman Foundation For Democracy, Inc.
1641 Deadwood Avenue
Rapid City, SD 57702
Telephone: 605.341.4311
E-mail: pschulte@chiesman.org

Table of Contents

Acknowledgments

Youth & Family Services (YFS) would like to take this opportunity to thank the individuals who have assisted in the implementation of the Healthy Tomorrows Partnership for Children grant. The grant is funded through the U.S. Department of Health and Human Services, Maternal and Child Health Bureau. The following individuals are recognized for their specific contributions.

Boys Health Advocacy Advisory Board

Dr. Willis Sutliff . . . . . Black Hills Pediatrics and Neonatology
Heather Heynen-Cronin . . . . . LPC-MH, Private Counseling Service
Mark Klein . . . . . Program Director, The Club for Boys
Ben Geary . . . . . Teacher/Counselor, Behavior Management Systems
Leah Holt . . . . . Parent
Mary Boyer . . . . . Community Volunteer/Leader, Rapid City Soccer League
Michelle Brevik . . . . . Health Connections Advocate, YFS Girls Incorporated
Shawn Hayford . . . . . Program Director, Rapid City YMCA
Tim McGowan . . . . . Counselor, Rapid City Area Schools

The following persons are acknowledged for their special contributions to Youth & Family Services and the Boys Health Advocacy Program and its evaluation process.

Susan Fedell . . . . . Executive Director, Youth & Family Services
Burke Eilers . . . . . YFS Counseling Center/Male Health Program Director
Holli Vanderbeek . . . . . YFS Senior Program Director
Sharon Oney . . . . . YFS Grants Administrator
Crystal Mulloy . . . . . Health Educator, YFS Male Health Program
Mel Prairie Chicken . . . . . Advocate, YFS Male Health Program
Corey Kennedy . . . . . Advocate, YFS Male Health Program
Bob Burke . . . . . Former Advocate, YFS Male Health Program
Dace Price . . . . . Former Advocate, YFS Male Health Program
Mike Sehr . . . . . Former Advocate, YFS Male Health Program
Nancy Bertocchi . . . . . Office Manager, YFS Counseling Center

Youth & Family Services
Boys Health Advocacy

Introduction

The Boys Health Advocacy program, a unique program of Youth & Family Services (YFS), provides health focused case management designed to meet the needs of underserved boys. The Boys Health Advocacy Program connects boys with unmet health needs to various area service providers; assists boys in learning and developing patterns of behavior that will enhance their health and quality of life; works with boys to connect them with appropriate medical, dental, optical, and counseling services; and works closely with families and school personnel. Boys Health Advocacy receives referrals from local school counselors, the Indian Health Service, South Dakota Department of Social Services, parents, juvenile justice programs, other agencies serving youth, and other YFS programs. The boys are selected to participate in this project precisely because they have an unmet health care problem or do not receive regular medical attention. The Health Advocate draws up an individualized health care plan with each participating boy and his family. The Advocate schedules medical appointments, provides transportation, and accompanies the boy to appointments with health care providers. The Advocate subsequently follows up with each boy and his family to address any treatment recommended by the health care provider. The cost of the health care for most of the boys is covered by Medicaid, SCHIP, the Indian Health Service (IHS), or private insurers. Many families are eligible for Medicaid or SCHIP but have not signed up due to the complexity of the paperwork. The Advocates assist these families with the paperwork and ensure that it is submitted in a timely fashion. The Advocates also teach Health Advocacy participants and their families the important skill of advocating for themselves.

Additional health benefits are reaped from the encouraging and supportive personal relationship that develops between the Advocate, the boy, and his family. This mentoring and relationship building component is a pivotal part of the Boys Health Advocacy program. Research done on the Big Brothers/Big Sisters program showed the value of an intensive mentoring program where the mentor sustained a developmental one-on-one relationship with the child[1]. Boys and girls participating in the Big Brothers/Big Sisters program were more confident in their performance at school, had a better relationship with their families, and were :

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[1] Tierney J; Grossman, J.; and Resch, N.. (1995). *Making a Difference: An Impact Study of Big Brothers/Big Sisters*. Philadelphia: Public/Private Ventures.

- 46% less likely to use drugs
- 27% less likely to begin using alcohol
- 52% less likely to skip school
- 37% less likely to skip a class
- 33% less likely to hit someone

YFS was awarded the Healthy Tomorrows Partnership for Children grant effective March 1, 2005. The five-year grant was completed February 28, 2010. The purpose of this report is to inform the stakeholders about progress made towards meeting the goals and objectives identified by YFS for this Healthy Tomorrows project in the fifth and final year of the grant. YFS identified four goals and several related objectives for the grant. Each of these objectives has activities and strategies to be implemented during the five-year grant period. The original goal was to increase access to health care for boys, ages five to seven, in the Rapid City, South Dakota area. In March 2007, the program was expanded to include four-year-olds. In March 2009, the program was expanded again to include older boys, ages eight through 16. Previously, advocacy services for older boys between the ages of eight and 16 were funded through a Title X Male Research project grant funded by the Office of Population Affairs, U.S. Department of Health and Human Services, which ended in September 2008.

The data collected for each participant includes demographics, program participation, and responses to a series of questions about risky behaviors and self-perception. The evaluation design provides a means for obtaining information about all the boys during the reporting period from March 1, 2009 to February 28, 2010.

Methodology

Twenty-three (23) boys, ages five to 16, from the Rapid City area entered the Boys Health Advocacy Program between March 1, 2009 and February 28, 2010. Referrals to the Boys Health Advocacy program were made through schools, counselors, Department of Social Services, and other nonprofit agencies.

Upon entering the program and after the parents of participating boys completed required permission forms, each boy was administered the Boys Health Advocacy Assessment. From this assessment, each boy's needs were ascertained and appropriate services were identified. Each boy's assigned advocate tracked the number of referrals, the type of referrals, and maintained a log on each boy's progress. The information and data was stored on the *YFS Information Network System* using the KidTrax Case Management System to track each boy's progress. Currently, the Boys Health Advocacy staff are still working out the most effective way to use this system.

Goal 1.0 Access to health care services will be made available to Rapid City at-risk boys ages 4 - 7 through the Boys Health Advocacy Program.[2]

Objective 1.1 Advocates will identify a minimum of 50 previously unserved boys ages 4 to 7 from the Rapid City community who require health advocacy services.

At the beginning of the current grant year, there were 46 boys actively participating in the Boys Health Advocacy Program. These boys entered the program between March 1, 2003 and February 28, 2009. Between March 1, 2009 and February 28, 2010, an additional 23 boys entered the program. At the end of the grant year (February 28, 2010), there were 64 boys still actively participating in the program. Of the 64 boys remaining in the program at the end of the grant period, 9.4% entered between March 2005 and February 2006, 7.8% entered between March 2006 and February 2007, 17.2% entered between March 2007 and February 2008, 28.1% entered between March 2008 and February 2009, and 35.9% entered between March 2009 and February 2010. Table 1.0 shows program participation by year entering the program.

Table 1.0
Program Participation

	In program on Mar 1, 2009	In program on Feb 28, 2010		
Year Entered			**% of Boys in Program**	**% Remaining**
Mar 2003 - Feb 2004	2	1	1.6%	50.0%
Mar 2004 - Feb 2005	1	0	0.0%	0.0%
Mar 2005 - Feb 2006	6	6	9.4%	100.0%
Mar 2006 - Feb 2007	5	5	7.8%	100.0%
Mar 2007 - Feb 2008	13	11	17.2%	84.6%
Mar 2008 - Feb 2009	19	18	28.1%	94.7%
Mar 2009 - Feb 2010	0	23	35.9%	100.0%
Total	**46**	**64**	**100.0%**	**139.1%**

[2] For the 2009 - 2010 program year, the Boys Health Advocacy Program received permission to serve boys older boys through age 16 as well as 4 - 7 year olds.

During the current grant year, the Boys Health Advocacy program funded by Healthy Tomorrows expanded to include older boys ages 8 - 16 due to completion of the Title X grant which had previously funded advocacy services for boys in this age range. Of the 23 boys who entered the program in 2009 - 2010, 30.6% were ages 5 - 8, 30.4% were ages 9 - 11, 21.7% were ages 12 - 14, and 15.4% were ages 15 - 16. Table 2.0 shows the age distribution by year entered.

Table 2.0
Age

Year Entered	n	5-8	9-11	12-14	15-18
Mar 2003 - Feb 2004	2	0.0%	0.0%	50.0%	50.0%
Mar 2004 - Feb 2005	1	0.0%	0.0%	100.0%	0.0%
Mar 2005 - Feb 2006	6	0.0%	16.7%	33.3%	50.0%
Mar 2006 - Feb 2007	5	20.0%	60.0%	0.0%	20.0%
Mar 2007 - Feb 2008	13	23.1%	46.2%	15.4%	15.4%
Mar 2008 - Feb 2009	19	52.6%	15.8%	15.8%	15.8%
Mar 2009 - Feb 2010	23	30.4%	30.4%	21.7%	15.4%
Total	**69**	**30.6%**	**29.2%**	**20.8%**	**19.4%**

Participating boys are referred from local school counselors, the Indian Health Service, South Dakota Department of Social Services, parents, juvenile justice programs, other agencies serving youth, and other YFS programs. While schools and counselors may make direct referrals to the Boys Heath Advocacy Program, many organizations pass on information about the program to the families, who then request services directly.

Unlike the initial assumption that boys would be referred for physical health issues, most boys are referred for mental health and behavioral issues. According to referral sources, boys are referred because of the following:

- abuse situations (physical, mental, sexual, etc.)
- behavioral or social issues
- health or mental health needs not being met
- family issues
- relationship advice or knowledge

Service providers see these boys as having different needs than the boys that they usually serve. These boys are more likely to have mental health issues and live in difficult family situations.

Table 3.0 shows the initial referral source that was recorded for the boys who entered into the program between March 2005 and February 2009. The Kid Trax system did not track this information for the 2009 - 2010 program year. Detailed information is available for 64 boys who entered the program between March 2005 and February 2009. Of these boys, 21.9% were referred by a counselor, 9.4% were referred by their school, 6.3% were referred by other local organizations, and 40.6% were self-referred. The initial referral source was not reported for 21.9% of the participants.

Table 3.0
Initial Referral

Year Entered	n	Counselor	Other Organization	School	Self	Not Reported
Mar 2005 - Feb 2006	24	12.5%	8.3%	16.7%	45.8%	16.7%
Mar 2006 - Feb 2007	19	31.6%	5.3%	0.0%	36.8%	26.3%
Mar 2007 - Feb 2008	12	16.7%	8.3%	16.7%	50.0%	8.3%
Mar 2008 - Feb 2009	9	33.3%	0.0%	0.0%	22.2%	44.4%
Total	**64**	**21.9%**	**6.3%**	**9.4%**	**40.6%**	**21.9%**

Table 4.0 shows the ethnicity distribution of the boys that participated in the program by the year in which they entered. Overall, 36.1% of the boys were White, 44.4% were American Indian, 12.5% were Hispanic, and 6.9% were Black. This mix has changed over the five years of the grant with more American Indian boys participating over time.

Table 4.0 Ethnicity					
Year Entered	**n**	**Black**	**Hispanic**	**American Indian**	**White**
Mar 2003 - Feb 2004	2	50.0%	0.0%	50.0%	0.0%
Mar 2004 - Feb 2005	1	0.0%	0.0%	100.0%	0.0%
Mar 2005 - Feb 2006	6	16.7%	33.3%	33.3%	16.7%
Mar 2006 - Feb 2007	5	0.0%	20.0%	40.0%	40.0%
Mar 2007 - Feb 2008	13	0.0%	0.0%	38.5%	61.5%
Mar 2008 - Feb 2009	19	5.3%	10.5%	57.9%	26.3%
Mar 2009 - Feb 2010	23	4.3%	17.4%	34.8%	43.5%
Total	**69**	**6.9%**	**12.5%**	**44.4%**	**36.1%**

Table 5.0 shows the age distribution of the boys by the year in which they entered the program. Overall, 30.6% of the boys enrolled between the ages of five and eight, 29.2% enrolled between the ages of nine and eleven, 20.8% enrolled between the ages of twelve and fourteen, and 19.4% enrolled between the ages of fifteen and eighteen. This mix varied by year. In the current grant year, 30.4% of the boys entering the program were ages 5-8, 30.4% were ages 9-11, 21.7% were ages 12-14, and 19.4% were ages 15-18.

Table 5.1 shows the number of boys, ages 4 -7, enrolled in the program by the year entered. During the reporting period, 60.0% of the boys (n = 5) were age 5, 20.0% were age 6, and 20.0% were age 7. No four-year-olds were enrolled in the program during the reporting period. Table 5.2 shows the distribution of ages for all boys, ages 4 - 16, who enrolled in the program during the reporting period. The highest percentage of boys who entered the program during the current year were age 11.

Table 5.0 Age					
Year Entered	**n**	**5-8**	**9-11**	**12-14**	**15-18**
Mar 2003 - Feb 2004	2	0.0%	0.0%	50.0%	50.0%
Mar 2004 - Feb 2005	1	0.0%	0.0%	100.0%	0.0%
Mar 2005 - Feb 2006	6	0.0%	16.7%	33.3%	50.0%
Mar 2006 - Feb 2007	5	20.0%	60.0%	0.0%	20.0%
Mar 2007 - Feb 2008	13	23.1%	46.2%	15.4%	15.4%
Mar 2008 - Feb 2009	19	52.6%	15.8%	15.8%	15.8%
Mar 2009 - Feb 2010	23	30.4%	30.4%	21.7%	17.4%
Total	**69**	**30.6%**	**29.2%**	**20.8%**	**19.4%**

Table 5.1 Ages 4 - 7					
Year Entered	**n**	**4**	**5**	**6**	**7**
Mar 2005 - Feb 2006	24	12.5%	20.8%	33.3%	33.3%
Mar 2006 - Feb 2007	19	31.6%	0.0%	21.1%	47.4%
Mar 2007 - Feb 2008	12	16.7%	16.7%	25.0%	41.7%
Mar 2008 - Feb 2009	9	55.6%	33.3%	11.1%	0.0%
Mar 2009 - Feb 2010	5	0.0%	60.0%	20.0%	20.0%
Total	**69**	**30.6%**	**29.2%**	**20.8%**	**19.4%**

Table 5.2 Age Entered March 2009 - February 2010		
Age	**n**	**%**
4	0	0.0%
5	3	13.0%
6	1	4.3%
7	1	4.3%
8	2	8.7%
9	1	4.3%
10	1	4.3%
11	5	21.7%
12	2	8.7%
13	3	13.0%
14	0	0.0%
15	3	13.0%
16	1	4.3%
Total	**23**	**30.6%**

Objective 1.2 ***Advocates will assist all boys and parents/caregivers enrolled in the program to identify their needs through an initial assessment and throughout their enrollment in the program. Continuing identification of needs will also be accomplished through consultation with service providers and physicians in the community.***

Objective 1.3 ***Advocates will provide ongoing case management/advocacy services for all boys continuously participating in the program either directly through Health Advocacy or through referrals to other connecting agencies.***

Upon entering the program, an advocate schedules a meeting with the boy and his family. At this meeting, the advocate explains the Boys Health Advocacy Program and answers

any questions and concerns regarding the program. The primary caregivers are encouraged to participate in the program and provide the necessary support to both the boy and the advocate.

If the primary caregiver and the youth elect to participate in the program, a health care assessment is completed by both the boy and his primary caregiver within 30 days of enrollment. The primary caregiver also signs release forms, which provide the advocate permission to go forward with the program, access to the boy's health records, and release from any liability. Table 6.0 shows the number of boys with needs identified by the health care assessment for the reporting period of March 1, 2009 - February 28, 2010. Needs were documented for 45 boys actively participating in the program during the current program year. The greatest needs were in the areas of mentoring (93.3%), mental health (53.3%), transportation (37.8%), social network (35.6%), education (31.1%), and wellness (26.7%). Eighteen percent (17.8%) of the boys had dental needs, 11.1% had medical needs, and 15.6% had home/family needs. The needs of the boys entering the program have changed over the five year period. In the first year of the program more boys entered with medical, dental, and optical needs than in subsequent years. Mentoring has been a consistent need for almost all boys (93.3% in the current year), while social network and mental health issues have been consistent needs for one-third to one-half of the boys.

Table 6.0 also documents the number of visits associated with each need and shows the number of visits made with an advocate during the duration of the current reporting period. A visit could be anything from an appointment with a health care provider, interaction with the family or school, or time spent with the advocate in physical activity or relationship building. Forty-five (45) boys received a total of 1,357 visits during the reporting period with an average of 30.2 visits per boy. The highest percentage of visits was for mentoring (43.7%, n = 593) for the 42 boys with an identified need, mental health (24.1%, n = 327) for the 24 boys with an identified need, and transportation (17.3%, n = 235) for the 17 boys with an identified need.

Table 7.0 shows the number of visits per boy. Of the 45 boys receiving services in the reporting period, 46.7% received between one and 10 visits, 35.6% received over 31 visits, and 17.8% received between 11 and 20 visits.

Table 6.0 Number of Needs and Visits to Service Providers, Unduplicated					
	Reporting Period 3/1/09 - 2/28/10				
Need	Number of Boys with Need	% of Boys with Need	Number of Visits	% of Visits	Avg # of Visits per Boy
Legal Involvement	3	6.7%	5	0.4%	1.7
Substance Abuse	3	6.7%	7	0.5%	2.3
Education	14	31.1%	44	3.2%	3.1
Dental	8	17.8%	11	0.8%	1.4
Medical	5	11.1%	14	1.0%	2.8
Optical	1	2.2%	2	0.1%	2.0
Home/Family	7	15.6%	18	1.3%	2.6
Mental Health	24	53.3%	327	24.1%	13.6
Mentoring	42	93.3%	593	43.7%	14.1
Transportation	17	37.8%	235	17.3%	13.8
Wellness	12	26.7%	73	5.4%	6.1
Social Network	16	35.6%	28	2.1%	1.8
Total	45		1357		30.2

Table 7.0 Number of Visits per Boy		
	Frequency	Percent
1 - 10	21	46.7%
11 - 20	8	17.8%
21 - 30	0	0.0%
31+	16	35.6%
Total	45	100.0%

For the boys participating in the program, the focus is on the prevention of bigger problems. According to the advocates, mentoring is the key piece for these boys. It involves providing a positive male role model, working on their self-esteem, talking with them, building

trust, asking what they can help them with, and getting them outdoors and involved in fun activities. A majority of these boys do not have a father or other significant male involved in their lives. Having a trusting adult to confide in helps to keep them on track and deal with their family problems. The advocates provide that trusting male role model for many of the boys in the program.

Once the boy's need(s) have been identified, the advocates assist in meeting these needs. Boys have appointments with physicians, dentists, mental health counselors, and other connecting agencies as well as time with their advocate. Advocates also ensure that the boys have regular health care appointments even if the advocate is not involved in the appointment. Advocates are in constant contact with the parents or guardians on various health issues, including annual exams, dental, mental, and social health visits. Twice a year, the Boys Health Advocacy Program, in collaboration with other Youth & Family Services programs, brings the Delta Dental/Ronald McDonald Care Mobile to their facility to address dental issues. During this time, the advocates contact all the parents to ensure the boys are caught up on their dental appointments.

Transportation is another service the advocates provide. In many cases, transportation is a barrier to access to health care. The advocate provides transportation to and from appointments in cases where the parent is working and cannot take time off work, does not have access to reliable transportation, or is otherwise not able to take their child to appointments. The advocate then works with the family to identify alternatives for transportation.

Evaluative Case Studies

Evaluative case studies involve description, explanation, and judgement. Much has been written about naturalistic evaluation, responsive evaluation, and qualitative evaluation. Guba and Lincoln (1981) review the kinds of reports that might be produced in naturalistic evaluations, and they conclude that case studies are the best reporting form[3]. Their rationale is that evaluative case study methods are grounded, holistic, and lifelike. It simplifies data to be considered by the reader, illuminates meanings, and can communicate tacit knowledge. This type of case study weighs information to produce judgment. Judgment is the final and ultimate act of evaluative case study.

The evaluative case study has the ability to explain the causal links to real-life interventions that are too complex for many other experimental strategies. A second application is to describe the real-life context in which an intervention has occurred. Third, an evaluation can benefit, again in a generative mode, the intervention itself. Finally, the case study strategy

[3] Guba, E.G. and Lincoln, Y.S. (1981). *Effective Evaluation*. San Francisco: Jossey-Bass

may be used to explore those situations in which the intervention being evaluated has no clear, single set of outcomes[4].

The evaluative case studies performed by the Boys Health advocates identified three clients which represented the range of services made available through the program. Each case study provides the reader with an overview of the barriers and strategies undertaken to assist the boys in attaining a healthy quality of life. Some of the major elements addressed in the case studies include:

- Background and demographics of a client;
- Sensory and descriptive observations by advocate;
- Knowledge based on factual information;
- Experiences;
- Behaviors and actions of a client;
- Opinion and value input by provider or advocate; and
- Feeling observations by peers, adults, and advocate.

Case Study #1: Jack

Jack is a 12-year-old Native American boy that lives with his mother and four siblings in Section 8 (public) housing. The father has been absent for many years due to physical abuse to the mother and son. Jack is friendly and always has a smile which has not been the case all the time. Jack has lived through poverty, alcoholism, abuse, and low self-esteem. The family is on welfare and receives food stamps. Jack has been a part of the Boys Health Program for approximately three years. Jack is an enrolled member of the Rosebud Sioux Tribe. He was born and raised on the reservation and attended school there for awhile. The transition from reservation life to city life has been difficult mentally, emotionally, and socially. Jack encountered racism at school and in the community. He was able to open up to the advocate and counselor at Youth & Family Services about the racism incidents. He has a mother that has a strong background in values about their Native American culture. One of their values is that all people are created by the Creator. Their belief is that the four races - white, black, red, and yellow - are all related. That belief helped Jack to forgive the people that were racists and know that they are out of balance. Jack has adapted to school and the community.

Jack attends middle school and is in the sixth grade. He is struggling in math and reading. He is receiving help at school with these courses. The Boys Health Program assists him after school with tutoring at the Boys Health Program facility. Jack has difficulty concentrating and he has been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD).

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[4] Yin, R.K. (1984). *Case Study Research: Design and Methods.* Newbury Park, CA: Sage Publishing.

His condition has been helped with medication. Jack's behavior is good at school. He is interested in girls and talks about dating. The Boys Health Program utilizes the *Wise Guys* curriculum which teaches lifeskills. Jack has learned about values, self-esteem, decision-making, responsibilities, and age appropriate sex education. The Wise Guys class taught him about relationships with girls and how to treat them respectfully. It also taught him about teen pregnancy, abstinence, and safe sex.

Jack's diagnosis of ADHD has been an issue for him at home and school. Sometimes, he forgets to take his medication which creates a hyperactivity scene for him at school and home. Jack's attention span is short, and he loses interest in his studies at school. When this happens he falls behind in school and homework. He makes an effort to stay after school and get caught up. The Boys Health Program assists him with after school tutoring in math or reading. He has a friendly, happy attitude and gets along okay with his peers at school. His relationship with teachers and administrators is respectful. His behavior at home is challenging for his mother. He has rules to abide by at home and when they are broken, he has consequences to address. The rules are enforced by his mother. Jack has been in counseling the past two years. He resolves his issues with his counselor.

The advocate is a vital part of the Boys Health Program. The advocate fills a role as a mentor and male role model in the lives of these boys. About 75% of the boys that are in the program are without a father. The mother is stressed out trying to fulfill her role as a mother. She needs a male role model in her boy's life; the Boys Health Advocacy Program fills that role. Jack fell into this category and did not know how to relate to men. The advocate had to build a trusting relationship with him for one year before he began to open up and express his feelings. The Boys Health Advocacy Program serves all the needs of the boy. It serves the physical, mental, and social needs of all boys. The boys come from single-parent homes and show signs of emotional or behavioral problems. They lack the support to navigate developmental tasks successfully.

Jack came to the program because he was in need of support and guidance. Teachers were not able to give him individual attention because of crowded classrooms. Guidance counselors were busy too, because they are dealing with the whole population of the school. An advocate assists at-risk children in setting up their goals and ambitions, resolve their personal problems, and make appropriate decisions and choices in life. Advocates are not there to replace what parents can give to their children. Advocates are simply there to give help and be role models for at-risk boys. Simple and easy activities like doing school assignments and projects, going to parks and museums, engaging in some sports and playing games, and doing art and craft projects is enough for a boy who is more than eager to be guided and to feel a sense of security that he is protected from the evils that lurk in the dark. This is what the Boys Health Program has brought to Jack. There is hope for Jack.

Case Study #2: Chauncey

Chauncey is an eight year-old Native American/Caucasian boy that lives with his grandparents. He had been living with his mother and father in another state but was placed with his grandparents because of physical abuse by his biological father. He is in the second grade and rides a bus to a local elementary school. Chauncey was referred to the Boys Health Advocacy Program by his grandparents for behavior problems at school and home.

The Boys Health Advocacy Program assists boys ages four through 16 to attain improved health care. The majority of the boys referred to the program are at-risk youth. The boys come from single-parent homes and they show signs of emotional or behavioral problems. The boys lack the support to achieve developmental tasks successfully. The advocate maintains a caseload of 20 - 30 boys and they vary in age from five to 16 years old. Chauncey has been on the advocate's caseload for two years. When he initially entered the Boys Health Advocacy Program he had abandonment and physical abuse issues.

The Boys Health Advocacy Program is unique in that it meets all the needs of the boys. After an application process, the advocate, parent, and boy develop a plan to address the mental, physical, and social needs of the boy. The adovcate met with Chauncey and his grandmother to develop a plan to address all his needs. Chauncey was referred to counseling to deal with his abandonment and physical abuse issues. The advocate made appointments for his dental and vision visits. At these appointments, the advocate provided transportation and accompanied Chauncey to the doctor's offices. Boys Health Advocacy referred him to the Wise Guys Program which teaches boys about life living skills. Wise Guys is an afterschool program which taught Chauncey about self-esteem, values, decision-making, responsibility, and age-appropriate sex education.

Mentoring these boys makes a difference in their lives. A boy yearns for adult support when faced with parents' divorce, family heartbreaks, and financial troubles. These boys need mentoring with their family problems, school work, and peer pressure . They need someone who will listen and give unwavering support. It took approximately one year for Chauncey and his advocate to develop trust with each other. Soon, Chauncey was able to open up and talk about his personal life.

Case Study #3: Josh

Josh was a participant in Camp Bob Marshall last summer. The camp was located in the Black Hills and lasted for one–and-one-half weeks. It was a coed camp and Josh made many friends. After he came back from camp the advocate taught him about relationships with girls. A few months ago, Josh entered into the world of underage drinking. Josh, his sister, and a friend obtained alcohol from an adult and partied at a house. As a mentor, the advocate

cautioned him on the dangers of binge drinking, accidents, addiction, and unlawfulness. Afterwards, they viewed a 30 minute DVD on underage drinking and discussed it. He is in counseling for his ADHD and drinking of alcohol.

Josh's relationship at home with his mother and siblings is erratic. When he violates his mother's authority, he is given "time out," with consequences. As the oldest, he is expected to be a role model for his siblings. He takes that position seriously and attempts to fulfill that responsibility most of the time. His relationship with his peers at school is puzzling to him. He has been teased and bullied about his hair and being a Native American. The advocate reported those incidents to his school counselor and they resolved it.

Josh and his family were evicted from their Section 8 rental home last summer because of an unkempt yard. The family moved back to the Reservation for several months. Josh was unhappy on the Reservation because it was unlike Rapid City. Josh was eager to move back to Rapid City. When the family moved back to Rapid City, Josh enrolled in the Boys Health Advocacy Program. He got back into counseling. The advocate began mentoring with him immediately. Josh informed his advocate he was happy to be back in the program. Sometimes, it is a culture shock for children who live on the Reservation to migrate to the cities and experience discrimination, poverty, alienation, and differences in values. Josh proved he was adaptable by transitioning from Reservation life to City life. He had made this trip many times during his ten years of life.

The Boys Health Advocacy Program uses a holistic approach in serving the needs of the boys. The advocates address the mental, physical, and emotional needs of the boys. The advocates mentor the boys to be a positive role model in their lives. A majority of the boys come from one-parent families. The father has abandoned and neglected his role in the family. Josh has never had a positive role model in his years growing up. His father physically abused him, and boyfriends of his mother did not accept him. The advocate believes that mentoring has made a difference in Josh's life. Josh had his dental, vision, and physical needs met through referral to medical providers in the community. Josh was in need of addressing his ADHD and abandonment issues, so the advocate referred him to counseling. The advocate has accompanied Josh to movies, swimming, hiking, and community events. There are studies that indicate that boys who have had some mentoring are more apt to be successful in life than boys who have had no mentoring. The advocate believes that the Boys Health Advocacy Program is fulfilling a role in the community by supporting boys like Josh.

Goal 2.0 The Boys Health Advocacy program will provide opportunities, encouragement, and support for parents and guardians to establish and maintain long-term accessability to health care services for their child(ren).

Objective 2.1 Advocates will assist and encourage all boys continuously participating in the program and their families to establish a pattern of regularly accessing health care and social services.

As part of the advocacy program, the advocate develops a relationship with the child's parent or caregiver. In most cases, the child is picked up or dropped off from appointments at the child's home, which gives the advocate an opportunity to visit with the parent about the child's needs. Advocates discuss how the child's immediate needs can be addressed as well as ensure that the child is receiving ongoing care, including annual medical, dental, and vision exams. In most cases, annual medical, dental, and vision exams are handled by the parent.

The boys complete a survey about their practices and beliefs regarding risky behaviors, character development, healthy practices, peer influence, and parental influence. The current survey was revised in 2007 to tailor the questions to the 5 - 7 age range. The Advocate assists the respondent by reading the questions. The data from these surveys was compiled and tabulated into a statistical software program. Because of the small sample sizes, no statistical tests were performed during this reporting period. During the fifth and final grant year, five boys completed the current survey.

Tables 8.0 and 9.0 show the grade and age distribution of the respondents. At the time of the survey the respondents were in grades 1st through 3rd grade, with 40.0% in 1st grade, 40.0% in 2nd grade, and 20.0% in 3rd grade. There were no respondents in Kindergarten. The majority of the respondents were ages 6 and 9 (40.0% each).

Table 8.0
Grade Level of Respondents
2009 - 2010

Grade Level	n	%
Kindergarten	0	0.0%
1st Grade	2	40.0%
2nd Grade	2	40.0%
3rd Grade	1	20.0%
Total	**5**	**100.0%**

Table 9.0 Age of Respondents 2009 - 2010		
Age	**n**	**%**
5	0	0.0%
6	2	40.0%
7	0	0.0%
8	2	40.0%
9	1	20.0%
Total	**5**	**100.0%**

The behavioral survey contains 23 items related to four categories: behaviors, beliefs, interactions with peers, and perceived parental reaction to behaviors. Table 10.0 shows the distribution of responses over the past three years for the behavioral questions, including diet and physical activity.

The USDA Dietary Guidelines for Americans 2005 provides science-based advice to promote health and to reduce risk for major chronic diseases through diet and physical activity. Their recommendations include specific diet and physical activity guidelines for children and adolescents, including that children and adolescents engage in at least 60 minutes of physical activity on most, preferably all, days of the week, as well as consume two cups of fruit, two and a half cups of vegetables, and three cups of fat free or low fat milk per day.[5]

Most boys indicated that they are meeting the majority of these guidelines, as well as participating in other healthy behaviors. In 2009 - 2010 and 2008 - 2009, 100.0% of the boys indicated that they exercised and played with friends compared to 88.9% in 2007 - 2008; 100.0% of the boys in 2009 - 2010 and 2007 - 2008 ate breakfast every day compared to 94.7% in 2008 - 2009; 100.0% drank milk every day compared to 89.5% in 2008 - 2009 and 88.9% in 2007 - 2008; 100.0% ate fruit every day compared to 73.7% in 2008 - 2009 and 83.3% in 2007 - 2008; 80.0% ate vegetables every day compared to 73.7% in 2008 - 2009 and 44.4% in 2007 - 2008. However, 100.0% in 2009 - 2010 said they watched TV every day compared to 89.5% in 2008 - 2009 and 72.2% in 2007 - 2008; 40.0% in 2009 - 2010 said they ate junk food every day compared to 36.8% in 2008 - 2009 and 55.6% in 2007 - 2008. All of the boys in the program (100.0%) in 2009 - 2010 also reported that they are reading and doing homework every day compared to 84.2% in 2008 - 2009 and 83.3% in 2007 - 2008.

[5]Dietary Guidelines for Americans 2005 (www.health.gov/dietaryguidelines/dga2005)

Table 10.0 Behavioral Questions				
	Item	**n**	**Yes**	**No**
2007 - 2008	I eat fruit every day.	18	83.3%	16.7%
2008 - 2009		19	73.7%	26.3%
2009 - 2010		5	100.0%	0.0%
2007 - 2008	I eat vegetables every day.	18	44.4%	55.6%
2008 - 2009		19	73.7%	26.3%
2009 - 2010		5	80.0%	20.0%
2007 - 2008	I eat breakfast every day.	18	100.0%	0.0%
2008 - 2009		19	94.7%	5.3%
2009 - 2010		5	100.0%	0.0%
2007 - 2008	I eat junk food every day.	18	55.6%	44.4%
2008 - 2009		19	36.8%	63.2%
2009 - 2010		5	40.0%	60.0%
2007 - 2008	I watch TV every day.	18	72.2%	27.8%
2008 - 2009		19	89.5%	10.5%
2009 - 2010		5	100.0%	0.0%
2007 - 2008	I eat fast food every day.	18	44.4%	55.6%
2008 - 2009		19	42.1%	57.9%
2009 - 2010		5	100.0%	0.0%
2007 - 2008	I read / do homework every day.	18	83.3%	16.7%
2008 - 2009		19	84.2%	15.8%
2009 - 2010		5	100.0%	0.0%
2007 - 2008	I play with friends every day.	18	88.9%	11.1%
2008 - 2009		19	100.0%	0.0%
2009 - 2010		5	100.0%	0.0%
2007 - 2008	I exercise every day.	18	88.9%	11.1%
2008 - 2009		19	100.0%	0.0%
2009 - 2010		5	100.0%	0.0%

Table 10.0 Behavioral Questions				
2007 - 2008	I drink milk every day.	18	88.9%	11.1%
2008 - 2009		19	89.5%	10.5%
2009 - 2010		5	100.0%	0.0%
2007 - 2008	I get enough sleep every day.	18	72.2%	27.8%
2008 - 2009		19	63.2%	36.8%
2009 - 2010		0	no data	no data
2007 - 2008	I play video games every day.	18	44.4%	55.6%
2008 - 2009		19	63.2%	36.8%
2009 - 2010		0	no data	no data

The belief questions included topics such as perceived harm of drugs and alcohol (Table 11.0). In 2009 - 2010 and 2007 - 2008, all the boys (100.0%) agreed that smoking cigarettes is not good for their health compared 89.5% in 2008-2009. In 2009 - 2010, 100.0% of the boys agreed that there are both good and bad drugs compared to 88.9% in 2008 - 2009 and 77.8% in 2007 - 2008. Eighty percent (80.0%) of the boys in 2009 - 2010 agreed that drinking alcohol now will hurt their health compared to 73.7% in 2008 - 2009 and 73.7% in 2007 - 2008. In 2009 - 2010, only one of the boys (20.0%) said that they were sad most of the time compared to 35.3% in 2008 - 2009 and 61.1% in 2007 - 2008.

Table 11.0 Belief Questions				
	Item	**n**	**Yes**	**No**
2007 - 2008	Smoking cigarettes is good for your health.	18	0.0%	100.0%
2008 - 2009		19	10.5%	89.5%
2009 - 2010		5	0.0%	100.0%
2007 - 2008	If I drink alcohol now it will hurt my health.	18	88.9%	11.1%
2008 - 2009		19	73.7%	26.3%
2009 - 2010		5	80.0%	20.0%
2007 - 2008	There are good drugs and bad drugs.	18	77.8%	22.2%
2008 - 2009		19	88.9%	11.1%
2009 - 2010		5	100.0%	0.0%
2007 - 2008	I am sad most of the time.	18	61.1%	38.9%
2008 - 2009		19	35.3%	64.7%
2009 - 2010		5	20.0%	80.0%

The respondents were asked about their feelings of safety. In 2009 - 2010 and 2007 - 2008, all the boys (100.0%) reported feeling safe at home and at school compared to 94.7% in 2008 - 2009. All of the boys (100.0%) in 2009 - 2010 reported feeling safe at school compared to 83.3% for both 2008 - 2009 and 2007 - 2008. In 2008 - 2009, 50.0% of the boys reported being picked on at school compared to 44.4% in 2007 - 2008. This question was not asked in 2009 - 2010. Twenty-six percent (26.3%) of the boys in 2008 - 2009 reported that the friends they spent time with encouraged them to do bad things compared to 5.6% in 2007 - 2008. This question was not asked in 2009 - 2010.

Table 12.0 Safety				
	Item	**n**	**Yes**	**No**
2007 - 2008	The friends I spend time with encourage me to do bad things.	18	5.6%	94.4%
2008 - 2009		19	26.3%	73.7%
2009 - 2010		0	no data	no data
2007 - 2008	I have been picked on at school.	18	44.4%	55.6%
2008 - 2009		18	50.0%	50.0%
2009 - 2010		0	no data	no data
2007 - 2008	I feel safe at home.	17	100.0%	0.0%
2008 - 2009		19	94.7%	5.3%
2009 - 2010		5	100.0%	0.0%
2007 - 2008	I feel safe at school.	18	83.3%	16.7%
2008 - 2009		18	83.3%	16.7%
2009 - 2010		5	100.0%	0.0%

Table 13.0 shows the distribution of responses to questions about perception of parental reaction. In 2009 - 2010 and 2008 - 2009, all the respondents (100.0%) believed that their parents' reaction to the use of tobacco would be unfavorable compared to 94.4% in 2007 - 2008. All the boys (100.0%) in 2009 - 2010 reported that they would be in big trouble with their parents if they drank alcohol compared to 94.7% in 2008 - 2009 and 88.9% in 2007 - 2008. In 2009 - 2010, only one boy (20.0%) believed that he would not be in big trouble with his parents if he cheated compared to 0.0% in 2008 - 2009 and 16.7% in 2007 - 2008. All of the boys in 2009 - 2010 (100.0%) reported that they would be in big trouble with their parents if they lied, stole, or hit someone. Close to 90.0% of boys in 2008 - 2009 and 2007 - 2008 responded the same (lying: 89.5% and 88.9% respectively; stealing: 94.4% each year; hitting: 94.7% and 88.9% respectively). All of the boys (100.0%) in 2009 - 2010 and 94.7% in 2007 - 2008 reported that they only used drugs given to them by their parents or a doctor. There was no data for this question in 2008 - 2009. All of the boys (100.0%) in 2009 - 2010 and 2007 - 2008 said that they can talk with their parents or another safe adult about things that concerned them compared to 94.7% in 2008 - 2009.

Table 13.0 Parental Reaction Questions				
	Item	**n**	**Yes**	**No**
2007 - 2008	If I cheat I will be in big trouble with my parents.	18	83.3%	16.7%
2008 - 2009		19	100.0%	0.0%
2009 - 2010		5	80.0%	20.0%
2007 - 2008	If I lie I will be in big trouble with my parents.	18	88.9%	11.1%
2008 - 2009		19	89.5%	10.5%
2009 - 2010		5	100.0%	0.0%
2007 - 2008	If I steal I will be in big trouble with my parents.	18	94.4%	5.6%
2008 - 2009		18	94.4%	5.6%
2009 - 2010		5	100.0%	0.0%
2007 - 2008	If I hit someone I will be in big trouble with my parents.	18	88.9%	11.1%
2008 - 2009		19	94.7%	5.3%
2009 - 2010		5	100.0%	0.0%
2007 - 2008	If I smoke I will be in big trouble with my parents.	18	94.4%	5.6%
2008 - 2009		19	100.0%	0.0%
2009 - 2010		5	100.0%	0.0%
2007 - 2008	If I drink alcohol I will be in big trouble with my parents.	18	88.9%	11.1%
2008 - 2009		19	94.7%	5.3%
2009 - 2010		5	100.0%	0.0%
2007 - 2008	I only use drugs given to me by my parents or a doctor.	19	94.7%	5.3%
2008 - 2009		0	No Data	No Data
2009 - 2010		5	100.0%	0.0%
2007 - 2008	I can talk with my parents or a safe adult about things that concern me.	18	100.0%	0.0%
2008 - 2009		19	94.7%	5.3%
2009 - 2010		5	100.0%	0.0%

For the fifth and final year of the Healthy Tomorrows program, Boys Health Advocacy expanded to serve older boys, ages 8 - 16, in addition to serving boys ages 4 - 7. Seven boys in

this age range completed the Youth Development Survey for older boys, a 33-item questionnaire that asks about risky behaviors, beliefs, peer influence, and parental perception.

Tables 14.0 - 17.0 show the grade level, age, ethnicity, and household composition of respondents. The majority of the boys were in the seventh grade (42.9%), were age 13 (42.9%), and did not report their ethnicity (57.1%). Forty-three percent (42.9%) of the boys reported they were American Indian. Seventy-one percent (71.4%) of the boys reported they lived with their mother only; only one boy (14.3%) lived with both parents together.

Table 14.0
Grade Level of Respondents

Grade Level	n	%
4th Grade	2	28.6%
5th Grade	1	14.3%
6th Grade	1	14.3%
7th Grade	3	42.9%
Total	**7**	**100.0%**

Table 15.0
Age Level of Respondents

Age	n	%
9	1	14.3%
10	2	28.6%
11	0	0.0%
12	1	14.3%
13	3	42.9%
Total	**7**	**100.0%**

Table 16.0 Ethnicity		
	n	**percent**
White (Caucasian)	0	0.0%
Black (African American)	0	0.0%
American Indian	3	42.9%
Hispanic (Latino)	0	0.0%
Asian	0	0.0%
Not Reported	4	57.1%
Total	**7**	**100.0%**

Table 17.0 I live with . . .		
	n	**percent**
Mother only	5	71.4%
Father only	0	0.0%
Both parents together	1	14.3%
Grandparents	0	0.0%
Relatives	0	0.0%
Not Reported	1	14.3%
Total	**7**	**100.0%**

Table 18.0 shows the distribution of responses to questions about behavior in the past 30 days. In the past 30 days, the majority of respondents had not used tobacco (85.7%), alcohol (71.4%), other drugs (71.4%), and marijuana (85.7%). Eighty-six percent (85.7%) of the boys reported they had not had sex or unwelcome or bad touch in the past 30 days. Seventy-two percent (71.4%) of the boys reported they had not ridden in the past 30 days with someone who

had been drinking or was intoxicated. However, one boy (14.3%) reported that he had ridden one time in the past 30 days with someone who was intoxicated, and one additional boy (14.3%) reported that he had ridden two times in the past 30 days with someone who was intoxicated.

Table 18.0
Behavioral Questions

Item	n	Zero times	One time	Two times	Three times	Four or more times
In the past 30 days, I have used tobacco.	7	85.7%	14.3%	0.0%	0.0%	0.0%
In the past 30 days, I have used alcohol (do not include religious practices).	7	71.4%	28.6%	0.0%	0.0%	0.0%
In the past 30 days, I have used other drugs (cocaine, crack, LSD, ecstasy, dust, etc.)	7	71.4%	14.3%	14.3%	0.0%	0.0%
In the past 30 days, I have used marijuana.	7	85.7%	14.3%	0.0%	0.0%	0.0%
In the past 30 days, I have had unwelcome or bad touch.	7	85.7%	14.3%	0.0%	0.0%	0.0%
In the past 30 days, I have had sex (sexual intercourse).	7	85.7%	14.3%	0.0%	0.0%	0.0%
In the past 30 days, I have ridden with someone who has been drinking alcohol or is intoxicated.	7	71.4%	14.3%	14.3%	0.0%	0.0%

Table 19.0 lists the distribution of responses to belief questions regarding substance use. Fifty-eight percent (57.2%) of respondents disagreed with the statement that smoking tobacco only once in awhile would not harm their health. Sixty-seven percent (66.6%) disagreed with the statement that marijuana is a harmless substance. Over half the boys (57.2%) disagreed with the statement that there is a safe level for drinking alcohol for each individual under the age of 21. However, 57.1% strongly agreed with the statement that only regular use of drugs can harm their health; 28.6% disagreed with this statement.

Table 19.0 Belief Questions						
Item	n	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
I believe if I smoke tobacco only once in awhile it will not harm my health.	7	14.3%	0.0%	28.6%	28.6%	28.6%
Marijuana is a harmless substance.	7	16.7%	0.0%	16.7%	33.3%	33.3%
Only regular use of drugs can harm my health.	7	57.1%	0.0%	14.3%	28.6%	0.0%
There is a safe level for drinking alcohol for each individual under the age of 21.	7	14.3%	0.0%	28.6%	28.6%	28.6%

Table 20.0 shows the distribution of responses for questions about peer influence. Overall, the majority of boys were not encouraged by their friends to drink alcohol (85.7%) or use drugs (100.0%). The majority of the boys also reported that the friends they spend time with did not regularly use marijuana (71.4%), use drugs (74.1%), or drink alcohol (71.4%).

Table 20.0 Peer Influence					
Item	n	Yes	Some-times	Not Sure	No
The friends I spend time with encourage me to drink alcohol.	7	0.0%	0.0%	14.3%	85.7%
The friends I spend time with encourage me to use drugs.	7	0.0%	0.0%	0.0%	100.0%
The friends I spend time with use marijuana regularly.	7	0.0%	14.3%	14.3%	71.4%
The friends I spend time with use drugs regularly.	7	0.0%	0.0%	28.6%	71.4%
The friends I spend time with drink alcohol regularly.	7	0.0%	0.0%	14.3%	85.7%

The boys were also asked about how their parents would feel if they found out that they were drinking alcohol, using marijuana, or using illegal drugs. All of the boys stated that their

parents would be either extremely concerned or upset if they found out they were drinking alcohol (57.1% and 42.9% respectively), using marijuana (57.1% and 42.9% respectively), or using illegal drugs (71.4% and 28.6% respectively). Table 21.0 shows the distribution of responses to these questions.

Table 21.0
Parental Perception

Item	n	Extremely Concerned	Upset	Concerned	Not Upset
How would your parents feel if they learned that you were drinking alcohol?	7	57.1%	42.9%	0.0%	0.0%
How would your parents feel if they learned that you were using marijuana?	7	57.1%	42.9%	0.0%	0.0%
How would your parents feel if they learned that you were using illegal drugs?	7	71.4%	28.6%	0.0%	0.0%

In addition, 28 boys in this age range also completed the Youth Service Questionnaire, a 25-item retrospective post questionnaire comparing the boys' perceptions and feelings prior to working with an advocate and after working with an advocate. Tables 22.0 - 35.0 list the distribution of responses to this questionnaire.

Tables 22.0 and 23.0 show the grade and age level distribution of respondents. Most of the respondents were in 2nd grade, 3rd grade, and 6th grade (17.9% each) and were eight and 11 years old (25.0% and 17.9% respectively).

Table 22.0 Grade Level of Respondents		
Grade Level	**n**	**%**
Kindergarten	0	0.0%
1st Grade	0	0.0%
2nd Grade	5	17.9%
3rd Grade	5	17.9%
4th Grade	3	10.7%
5th Grade	3	10.7%
6th Grade	5	17.9%
7th Grade	3	10.7%
8th Grade	2	7.1%
9th Grade	1	3.6%
Not Reported	1	3.6%
Total	**28**	**100.0%**

Table 23.0 Age of Respondents		
Age	**n**	**%**
5	1	3.6%
6	0	0.0%
7	0	0.0%
8	7	25.0%
9	4	14.3%
10	2	7.1%
11	5	17.9%
12	4	14.3%
13	3	10.7%
14	1	3.6%
15	1	3.6%
Total	**28**	**100.0%**

Tables 24.0 and 25.0 show the ethnicity and household composition of the respondents. The majority of the boys were white (35.7%), American Indian (25.0%), and Hispanic (21.4%). The majority of respondents (60.7%) lived with their mother only.

Table 24.0 Ethnicity		
	n	**percent**
White (Caucasian)	10	35.7%
Black (African American)	0	0.0%
American Indian	7	25.0%
Hispanic (Latino)	6	21.4%
Asian	0	0.0%
Other	1	3.6%
Not Reported	4	14.3%
Total	**28**	**100.0%**

Table 25.0 I live with . . .		
	n	**percent**
Mother only	17	60.7%
Father only	0	0.0%
Both parents together	4	14.3%
Grandparents	1	3.6%
Relatives	1	3.6%
Other	5	17.9%
Total	**28**	**100.0%**

One-quarter of the respondents (23.1%) had worked with an advocate/counselor for six months, 30.8% had worked with an advocate 12 months, and another 23.1% had worked with an advocate 30 months or longer. Table 26.0 shows the distribution of responses to this question.

Table 26.0 Working with an advocate/counselor at least . . .					
n	**6 months**	**12 Months**	**18 Months**	**24 Months**	**30 Months or longer**
26	23.1%	30.8%	11.5%	11.5%	23.1%

Tables 27.0 and 28.0 list the distribution of responses to questions about school. Over half of the boys (59.3%) reported that the Boys Health Program has made a difference in their school attendance, 14.8% said it had not made a difference, and 25.9% said that their school attendance had remained the same. Over half of the respondents (57.1%) reported they missed school zero times per month after working with an advocate compared to 40.7% before. Fifty-nine percent (59.3%) reported they were tardy for school zero times per month after working with an advocate compared to 39.3% before. There was not much change in reported run-ins with law enforcement or the school liaison officer before and after working with an advocate. Eighty-nine percent (88.9%) of the boys reported they had no run-ins with law enforcement before working with an advocate compared to 92.6% after.

Table 27.0 The Boys Health Program has made a difference in my school attendance			
n	**Yes**	**No**	**Has remained the same**
27	59.3%	14.8%	25.9%

Table 28.0 Before and After Working With an Advocate . . .							
		n	Zero (0) times per month	One (1) times per month	Two (2) times per month	Three (3) times per month	Four (4) or more times per month
I missed school at least	Before	27	40.7%	14.8%	11.1%	22.2%	11.1%
	After	28	57.1%	10.7%	21.4%	7.1%	3.6%
I was tardy for school at least	Before	28	39.3%	28.6%	10.7%	14.3%	7.1%
	After	27	59.3%	18.5%	7.4%	7.4%	7.4%
I had run-ins with law enforcement or the school liaison officer	Before	27	88.9%	7.4%	3.7%	0.0%	0.0%
	After	27	92.6%	3.7%	0.0%	3.7%	0.0%

Prior to working with an advocate, 33.3% of the boys reported very rarely feeling sad or depressed compared to 71.4% of the boys after working with an advocate. Over half of the boys (55.6%) reported very rarely feeling sick prior to working with an advocate compared to 59.3% after working with an advocate. When asked if their parents or guardians cared about what they were doing, 63.0% responded that parents/guardians cared about what they were doing most of the time before working with an advocate compared to 70.4% after. Table 29.0 lists the distribution of responses to these questions.

Table 29.0 Before and After Working With an Advocate . . .					
		n	Most of the time	Sometimes	Very Rarely
I felt depressed or sad	Before	27	11.1%	55.6%	33.3%
	After	28	10.7%	17.9%	71.4%
I felt sick	Before	27	7.4%	37.0%	55.6%
	After	27	3.7%	37.0%	59.3%
My parents or guardians cared about what I was doing	Before	27	63.0%	29.6%	7.4%
	After	27	70.4%	25.9%	3.7%

Table 30.0 lists the distribution of responses to questions about communication. One-third of the respondents (33.3%) reported talking with an adult daily before working with an advocate. This percentage decreased to 25.9% after working with an advocate. However, the percentage of respondents reporting that they talked to an adult weekly increased from 14.8% prior to working with an advocate to 22.2% after working with an advocate. The percentage of boys (29.6%) reporting that they talked to their parents daily increased from 29.6% before working with an advocate to 40.7% after working with an advocate.

Table 30.0 Before and After Working With an Advocate . . .						
		n	Daily	Weekly	Sometimes	Very rarely
I talked to an adult	Before	27	33.3%	14.8%	44.4%	7.4%
	After	27	25.9%	22.2%	40.7%	11.1%
I talked to my parents or guardian	Before	27	29.6%	14.8%	48.2%	7.4%
	After	27	40.7%	11.1%	37.0%	11.1%

Tables 31.0, 32.0, and 33.0 show the distribution of responses to medical questions. Thirty percent of the boys (29.6%) reported that they took their medication as directed and 18.5% said they took their medication sometimes before working with an advocate compared to 22.2% each after working with an advocate. Half the boys (48.2% before and 51.9% after) reported they were

not on medication (Table 31.0). There was little change reported from before to after working with an advocate for the frequency of visits to a physician or dentist. Fifty-eight percent (57.7%) of the boys reported seeing a dentist every six months before working with an advocate compared to 55.6% after. Fifty-four percent (53.9%) of the boys reported seeing a physician once a year before working with an advocate compared to 50.0% after. One-third of the boys (37.0%) reported seeing an eye doctor once a year both before and after working with an advocate. Twenty-two percent (22.2%) of the boys reported that they saw an eye doctor only in emergencies both before and after working with an advocate, and 29.6% reported that they never saw an eye doctor before working with an advocate compared to 22.2% after. (Table 24.0). Two-thirds of the boys (65.4% before working with an advocate and 66.7% after) reported that they did not wear glasses.

Table 31.0
Before and After Working With an Advocate . . .

		n	As directed	Sometimes	Very rarely	I am not on medication
If I am on prescribed medication, I took my medication	Before	27	29.6%	18.5%	3.7%	48.2%
	After	27	22.2%	22.2%	3.7%	51.9%

Table 32.0
Before and After Working With an Advocate . . .

		n	6 months	Once a year	In emergencies	Never
I saw a dentist every	Before	26	57.7%	30.8%	7.7%	3.9%
	After	27	55.6%	29.6%	7.4%	7.4%
I saw a physician (doctor) every	Before	26	23.1%	53.9%	19.2%	3.9%
	After	26	23.1%	50.0%	23.1%	3.9%
I saw an eye doctor every	Before	27	11.1%	37.0%	22.2%	29.6%
	After	27	18.5%	37.0%	22.2%	22.2%

Table 33.0 Before and After Working With an Advocate . . .								
		n	Immediately	Within a week	Within a month	Within a year	Never	I do not wear glasses
I would get my broken glasses repaired	Before	26	19.2%	0.0%	3.9%	0.0%	11.5%	65.4%
	After	27	22.2%	0.0%	0.0%	0.0%	11.1%	66.7%

Ninety-two percent (91.7% and 92.0% respectively) of the boys reported they were able to get to their appointments both before and after working with an advocate (Table 34.0). Ninety-six percent (96.2%) of the respondents reported feeling safe at home. Ninety-six percent (96.0%) also reported they were still in the Boys Health Program (Table 35.0).

Table 34.0 Before and After Working With an Advocate . . .				
		n	Yes	No
I was able to get to my appointments	Before	24	91.7%	8.3%
	After	25	92.0%	8.0%

Table 35.0			
	n	Yes	No
I feel safe at home	26	96.2%	3.9%
I am still in the Boys Health Program	25	96.0%	4.0%

Objective 2.2 Advocates will assist in increasing the level of parents/caregivers' involvement in meeting their child(ren)'s health care needs.

Following each appointment, the advocate discusses the appointment and the results of the appointment with the parent/caregiver. Additionally, the advocate has constant contact with parents to ensure that the child is receiving ongoing care, including annual medical and dental

exams. Based on a parent survey, over half (57.9%) of parents said that they were now more involved in getting their child the health care he needs.

Parents of participants were given surveys to determine their level of satisfaction with the Boys Health program and to understand their perception of the program's impact on their child(ren). Eight parents returned the survey. The majority of respondents had a long relationship with the Boys Health Program, with half participating for either 24 months (25.0%) or 30 or more months (25.0%). Half of the respondents (50.0%) of the respondents had two or more children involved in the program. Tables 36.0 and 37.0 list the distribution of responses.

Table 36.0
Child has been working with an advocate for at least . . .

	Number	Percent
6 months	2	25.0%
12 months	1	12.5%
18 months	1	12.5%
24 months	2	25.0%
30+ months	2	25.0%
Total	8	100.0%

Table 37.0
Number of children Participating in the Boys Health Program

	Number	Percent
1	4	50.0%
2	3	37.5%
3	1	12.5%
Total	8	100.0%

Tables 38.0 - 40.0 the household composition and ethnicity of the respondents. Only one respondent (12.5%) resided in a traditional two parent household, while almost two-thirds (62.5%) were households headed by a single mother. One in four respondents (25.0%) was a relative. Most of the respondents were American Indian (62.5%) and lived in a household with four or more people (87.5%).

Table 38.0 Number of People in Household		
	Number	Percent
2	0	0.0%
3	1	12.5%
4	4	50.0%
5+	3	37.5%
Total	8	100.0%

Table 39.0 Head of Household		
	Number	Percent
Mother Only	5	62.5%
Father Only	0	0.0%
Both Parents	1	12.5%
Relatives	2	25.0%
Other	0	0.0%
Total	8	100.0%

Table 40.0 Ethnicity		
	Number	Percent
White	1	12.5%
Hispanic	2	25.0%
American Indian	5	62.5%
Total	8	100.0%

Twenty-nine percent (28.6%) of parents said that after working with an advocate, their child communicated about their problems daily compared to 25.0% prior to their entry into the program (Table 41.0). Twenty-five percent of parents (25.0%) said that before working with an advocate, their child very rarely communicated with them about their problems or other issues compared to 0.0% after working with their advocate. Three-fourths of the parents (75.0%) felt that their child

had shown improvement in their behavior and their academic achievement, and all parents (100.0%) felt that their child had shown improvement in their behavior (Tables 42.0 - 43.0).

Table 41.0
My child communicated about their problems or other issues . . .

	Daily	Weekly	Sometimes	Very Rarely
Before working with the advocate	25.0%	12.5%	37.5%	25.0%
After working with the advocate	28.6%	28.6%	42.9%	0.0%

Table 42.0
I have noticed an improvement in my child's academic progress since he has been a part of the Boys Health Program.

	Number	Percent
Yes	6	75.0%
No	1	12.5%
No difference	1	12.5%
Total	8	100.0%

Table 43.0
I have noticed an improvement in my child's behavior since he has been a part of the Boys Health Program.

	Number	Percent
Yes	8	100.0%
No	0	0.0%
No difference	0	0.0%
Total	8	100.0%

After participating in the Boys Health Program, most parents (87.5%) were more aware of the resources available to their child, and 85.7% said that they had increased access to resources and assistance for their child or themselves (Tables 44.0 and 45.0). Parents said that they were very satisfied with the Boys Health Program, with 87.5% giving it a rating of excellent and one person (12.5%) rating it average (Table 46.0). All respondents (n = 6) reported that the advocate transported their child to and from appointments (Table 47.0).

Table 44.0 I am more aware of the variety of resources available to my child after participating in the Boys Health Program.		
	Number	**Percent**
Yes	7	87.5%
No	1	12.5%
Total	8	100.0%

Table 45.0 I have increased access to resources and assistance for my child and / or myself due to my involvement with the Boys Health Program.		
	Number	**Percent**
Yes	6	85.7%
No	0	0.0%
No difference	1	14.3%
Total	7	100.0%

Table 46.0 My level of satisfaction with the Boys Health Program and the work they do for my child.		
	Number	**Percent**
Excellent	7	87.5%
Above Average	0	0.0%
Average	1	12.5%
Below Average	0	0.0%
Not Sure	0	0.0%
Total	8	100.0%

Table 47.0 The advocate transported my child to and from his appointments.		
	Number	Percent
All appointments	6	100.0%
Some appointments	0	0.0%
I transported or made other arrangements	0	0.0%
Transportation was not required	0	0.0%
	0	0.0%
Total	6	100.0%

When asked "What areas was the advocate helpful," comments included:

- Providing other outside activities. Advocate is very helpful in a lot of things that are helpful to my children.
- I think you all have been great for my son.

Goal 3.0 Boys Health Advocacy staff will continuously seek to improve program services.

Objective 3.1 Advocates will obtain feedback and guidance from service providers and referral sources regarding program services and recommended care and treatment for all boys participating in the program.

Service providers and referral sources are surveyed every year to determine their level of satisfaction with the program and learn how the program can be improved. For the 2009 - 2010 reporting period, one referral source and two service providers responded to the survey. The referral source had referred eight boys during the reporting period and felt that the Boys Health Advocacy program was effective in increasing client access to physical, mental, and social health services.

Comments include :

- *What are the primary reasons you refer boys to the Boys Health Program?* Body health, relationship advice, or knowledge.

- *How effective do you feel Male Health is in increasing client access to physical, mental, and social health services?* Lets the boys know what's out there and that they are not the only ones going through these changes and feelings.
- *What are the barriers that boys and their families face when they have physical, mental, and social health needs?* Pride.
- *What can advocates do to provide further assistance to you?* Maybe run one for my older boys: the 15 - 17 age group.

The service providers views reflected those of the referral source. They also all felt that the Boys Health Advocacy program was effective in increasing client access to physical, mental, and social health services.

Some comments include :

- *How effective do you feel Male Health is in increasing client access to physical, mental, and social health services?* Very effective.
- *What can advocates do to provide further assistance to you as a service provider?* [Advocate] is doing a wonderful job and we look forward to working with him for many years to come.

Goal 4.0 Boys Health Advocacy staff will advocate for boys on a systemic level.

Objective 4.1 Program and agency personnel will network within the community to increase understanding of the issues faced by high-risk boys and their families.

Advocates participate in several community coalition meetings. Currently, they participate in the following community organizations and coalitions: Power Partners, Community Services Connection of the Black Hills, South Dakota Consolidated School Health Program, Youth & Family Services Team Wellness, the Advisory Committee for the Rapid City Community Health Center, Adolescent Substance Abuse Prevention Program, Youth 2 Youth, and the Youth Serving Organizations Alliance.

Objective 4.2 Program and agency personnel will address institutional barriers for boys and their primary caregivers to access health care.

Advocates are continuously reaching out to service providers to expand their resource list. In addition, through program staff's connections in the community, the program is able to work with other agencies to seek alternative methods for accessing health care.

Successes and Challenges

Interviews and focus groups were conducted with supervisory staff, advocates, former advocates, and program participants to determine both successes of the program and potential areas for improvement.

Successes

Mentoring and Relationship Building

All staff members emphasized the value of the mentoring aspect of the Advocacy program and felt that it was the key component to the success of the program. Mentoring creates a bond between the advocate and the child that allows the child to experience positive relationships with adults, especially males, and creates a situation in which the child is receptive to the lessons being taught by the advocate. Most of the health, wellness, and socialization skills that are critical components of the Advocacy program are taught in the mentoring environment. The mentoring relationship also creates a comfort level that supports the children in going to their advocates when issues arise at home or at school.

Some staff comments included:

- As the program has evolved over the last five years, mentoring is a bigger component than we originally anticipated.
- The biggest need we see is for the mentoring.
- We have a lot of single mother families. The boys don't have a positive male adult role model. We provide that role model.
- The boys are hungry for the mentoring.
- The protective factors in the mentoring are more powerful than we thought.
- Even after boys leave the program, they are coming back to talk to us because we are the trusting adult they can confide in.
- When mentoring, I think how do I work this lesson in? I'm creating a context from which greater good can happen.

- The success of the kids is more important than anything else. Kids need this. We are not their dad but give them the challenges they need. Without that, they would not be successful.
- Now that we have the older boys, whenever we have group activities, I incorporate the older boys with the younger boys. The teens start mentoring the younger kids. It's really cool to watch.
- One of the greatest successes is the mentoring. I ran into a mom the other day who told me what a difference it has made with her son.
- Some of our former boys are young adults now. They still come back to see us. They come back because they are proud of their successes.
- Two of our former boys are in their early 20s and now they are participating in our Fatherhood Program.
- We have a young man who just entered the military. If not for this program, he would probably be in prison.

Three focus groups were conducted with participants in the Boys Health Program. The boys talked a lot about the positive relationships they have with their advocates and how it has improved their lives. Play is an important aspect of the program for these boys which helps them to learn socialization skills and improve their behavior. Some comments from the boys include:

- Things have gotten better for me. My advocate helped me out a lot. I'm definitely calmer. I have a better relationship with my mom.
- We talk about health, healthy snacks, exercise, school, how to organize classes, different things I can do to help around the house and have a better relationship with my mom. We talk about staying away from drugs and alcohol.
- My advocate is the only guy in my life that listens - my dad is in Alaska.
- I didn't have any male adults to talk to. My mom and dad got divorced when I was a baby and my mom and stepdad got divorced awhile ago.
- I feel good with my advocate. Everyone pushes me around at school. I can talk to my advocate about it.
- My advocate makes me feel happy. He helps me learn how I can't control what the other person does. We talk about what I can do. He really helps me.
- I feel differently about myself since I've been here. I get along better with my brothers. We stopped yelling at each other.
- We get to go places and do stuff. I like that we get to hang out.
- My advocate gives me advice about what to do. It helps but it doesn't make the problem go away. We talk about what I could do about the problem.

Other Comments

Staff members talked about other dimensions of the program. Comments included:

- The boys' issues are multi-dimensional and multi-layered.
- The mental/behavioral health needs are disproportionate to the physical health needs.
- Our approach is very holistic and all encompassing.
- We do whatever is needed for the overall health of the boys.
- There is a greater need for academic support than we thought. If kids are not doing well emotionally and physically, they act out and get in trouble in school.
- We always have boys waiting to get into the program. Once the word got out about our program, we did not need to promote the program. We always had full caseloads.
- Our reception at the schools is great. They really see the need for and the value of our program. If a boy has an IEP, we are involved in it.
- Another very important aspect of our program is the transportation we provide. A lot of our families don't have reliable transportation and can't get their kids to appointments.

Challenges

Parental Involvement

All staff members indicated that parental involvement was an area that was challenging and could be improved upon. In most cases, the dad is absent and the mom has problems of her own; she might have substance abuse problems, job issues, transportation issues, etc. One of the goals for the advocates is to model for the parents and to encourage the parents to take responsibility for their own child. However, in many cases the parents are not taking on this responsibility. Advocates mentioned that parents expected more from the program than what was intended. They sometimes used the program as day care and were not always home when they tried to drop off the child. The advocates indicate that they need to deal with the whole family and not just the child. In many cases, this assistance takes the form of providing basic necessities such as food and clothing and assisting with finding housing as well as helping families to move residences. The advocates expressed a need to find a way to increase the participation and buy-in from the parents.

Some comments from the supervisory staff and advocates included:

- There is a lot more family intervention than we anticipated. We have to take care of the whole family.
- A lot of the boys have issues with their home life. We do home visits to try to help with these issues.
- One of the biggest struggles is parental involvement. They think someone else will take care of it. The parents look to us to do it all without their involvement.
- Most boys come from families that depend on the system. It is like a training wheel program, but the training wheels never come off.
- We have to teach the parents and kids to do things themselves.
- Childcare is an issue. I think more people would participate in parenting classes if there was childcare.
- We always invite the parents whenever they can be involved.
- We encourage parents to get involved. We teach classes like Love and Logic. Parenting is 90% motivation and 10% learning.
- We need to start talking about expectations on the part of the parents. We don't hold parents accountable. The majority of boys would not get to appointments if not for us.
- I would like to see a program with more accountability for the parents. I want to see some follow-through with the parents. Right now there are no expectations on the parents.

Funding

The Boys Health Advocacy Program does not charge for services, and sustainability is an issue. The program staff would like to be less dependent on grants because when the grant funding ends, they have to cut back on services unless another funding source can be found.

Conclusion

The Youth and Family Services Boys Health Advocacy program serves as a mechanism to increase boys' access to health care and provide advocacy and mentoring to disadvantaged youth. The purpose of this grant was to expand advocacy services to include four to seven year old males. For the fifth and final program year, older boys ages eight to 16 were included in the program. From March 1, 2009 through February 28, 2010, 23 boys entered the program. Needs assessments were conducted for each of the boys. The boys also completed surveys regarding their behaviors, beliefs, peers, and parental influence. The following is a summary of the objectives evaluated during the reporting period (March 1, 2009 through February 28, 2010).

Objective 1.1 ***Advocates will identify a minimum of 50 previously unserved boys ages 5 to 7 from the Rapid City community who require health advocacy services.***

At the beginning of the current grant year, there were 46 boys actively participating in the Boys Health Advocacy Program. These boys entered the program between March 1, 2003 and February 28, 2009. Between March 1, 2009 and February 28, 2010, an additional 23 boys entered the program. At the end of the grant year (February 28, 2010), there were 64 boys still actively participating in the program.

Objective 1.2 ***Advocates will assist all boys and parents/caregivers enrolled in the program to identify their needs through an initial assessment and throughout their enrollment in the program. Continuing identification of needs will also be accomplished through consultation with service providers and physicians in the community.***

Objective 1.3 ***Advocates will provide ongoing case management/advocacy services for all boys continuously participating in the program either directly through Health Advocacy or through referrals to other connecting agencies.***

Needs were documented for 45 boys actively participating in the program during the current program year. The greatest needs were in the areas of mentoring (93.3%), mental health (53.3%), transportation (37.8%), social network (35.6%), education (31.1%), and wellness (26.7%). Eighteen percent (17.8%) of the boys had dental needs, 11.1% had medical needs, and 15.6% had home/family needs. The needs of the boys entering the program have changed over the five year period. In the first year of the program more boys entered with medical, dental, and optical needs than in subsequent years. Mentoring has been a consistent need for almost all boys (93.3% in the current year), while social network and mental health issues have been consistent needs for one-third to one-half of the boys.

Forty-five boys received a total of 1,357 visits during the reporting period with an average of 30.2 visits per boy. A visit could be anything from an appointment with a health care provider, interaction with the family or school, or time spent with the advocate in physical activity or relationship building. The highest percentage of visits was for mentoring (43.7%, n = 593) for the 42 boys with an identified need, mental health (24.1%, n = 327) for the 24 boys with an identified need, and transportation (17.3%, n = 235) for the 17 boys with an identified need. Of the 45 boys

receiving services in the reporting period, 46.7% received between one and ten visits, 35.6% received over 31 visits, and 17.8% received between eleven and 20 visits.

Objective 2.1 Advocates will assist and encourage all boys continuously participating in the program and their families to establish a pattern of regularly accessing health care and social services.

The number of visits (n = 1,357) indicate that the boys are regularly accessing health care and social services. The advocates ensure that the boys attend appointments by providing transportation to and from appointments.

Objective 2.2 Advocates will assist in increasing the level of parents/caregivers' involvement in meeting their child(ren)'s health care needs.

Following each appointment, the advocate discusses the appointment and the results of the appointment with the parent/caregiver. Additionally, the advocate has constant contact with parents to ensure that the child is receiving ongoing care, including annual medical and dental exams. Based on a parent survey, 87.5% of parents rated the services of the Boys Health Advocacy program as excellent.

Objective 3.1 Advocates will obtain feedback and guidance from service providers and referral sources regarding program services and recommended care and treatment for all boys participating in the program.

Service providers and referral sources are surveyed annually about the collaboration with the Boys Health Program. Service providers and referral sources felt that the program was effective in increasing access to physical, mental, and social health services, and wanted to see the program continue or expand.

Objective 4.1 Program and agency personnel will network within the community to increase understanding of the issues faced by high-risk boys and their families.

Advocates participate in several community coalition meetings. Currently, they participate in the following community organizations and coalitions: Community Services Connection of the Black Hills, South Dakota Consolidated School Health Program, Youth & Family Services Team

Wellness, the Advisory Committee for the Rapid City Community Health Center, Adolescent Substance Abuse Prevention Program, and the Youth Serving Organizations Alliance.

Objective 4.2 Program and agency personnel will address institutional barriers for boys and their primary caregivers to access health care.

Advocates are continuously reaching out to service providers to expand their resource list. In addition, through program staff's connections in the community, the program is able to work with other agencies to seek alternative methods for accessing health care.

Recommendations

The collected data and its analysis assist the evaluation team in determining areas for the program director and staff to consider for program improvement. The following recommendations are being made as the program continues beyond the end of the Healthy Tomorrows grant.

- Continue to plan for sustainability of the program.
- Explore utilizing a data collection system that more systematically tracks participation data.
- Add a parent component to the database so parent participation can be tracked.
- In order to more effectively measure program outcomes, ensure that participant, parent, service provider, and referral source satisfaction surveys are administered as outlined in the evaluation plan.
- Review the parent component of the program and develop ways to improve parent participation, including increased childcare options for parents participating in Boys Health Advocacy programs (i.e., parenting classes, counseling, etc.).