

Increasing Access to Program Information: A Strategy for Improving Adolescent Health

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Abstract *Objectives:* To identify existing programs serving 11- to 15-year-olds that aim to improve adolescent health in the areas of Health & Well-being, Fitness, Family & Peer Relationships, School Environment, Smoking, Alcohol Use, and Violence and to assess the utility of readily available resources in providing detailed program information. *Methods:* In Phase 1, publicly available program databases were searched to identify potential programs serving the target population. In Phase 2, an in-depth search of a limited sample of programs meeting the content and age criteria was performed to identify program descriptors. *Results:* Over 1,000 program names were identified in Phase 1. Information regarding programs is becoming more readily available through the internet; however, the program information that was publicly available only begins to draw the picture. Phase 2 revealed that a broad array of efforts are underway in all seven content areas, but found information on the program descriptors to be limited. *Conclusions:* Investment in programming is not enough; an upfront investment in communication and information sharing is critical in order to maximize the resources dedicated to the improvement of adolescent health. A well-publicized centralized program repository offered in conjunction with technical assistance would provide an efficient mechanism for this information sharing. We further suggest that the inherent gap between research and prac-

tice can be lessened by building a new body of practice knowledge. This would require improved program data collection by programs, the incorporation of program participation information in national surveys and enhanced evaluation efforts.

Keywords Adolescence · Health · Youth programs · Federal funding · Program information

Background

The International Health Behavior in School-aged Children (HBSC) study [1] has conducted periodic, nationally representative school-based surveys of teens living in 29 countries/regions since 1985. Under the auspices of the World Health Organization, the goal of the HBSC study is to understand the health and health-related behavior of young adolescents, ages 11–15 within the context of family, school, and peers. By using international comparisons, differences and similarities among youth in the industrialized world can be highlighted. This age group is noteworthy because it represents the transitioning from middle childhood into early and middle-adolescence, a period that has received little attention from policymakers, researchers, and service providers. Yet, this developmental period influences the behaviors and the health, educational, and social outcomes of older adolescents, and ultimately, adults [2, 3]. There is concern about how to intervene earlier with a number of risk-behaviors. For example, tobacco, alcohol, substance use, depression, and violence are often experimented with during this critical age period. In addition, there is research and programmatic interest in better understanding environmental influences, for example, the role of families and schools, on young adolescents' health and development.

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The HBSC report includes prevalence data, showing cross-national comparisons in several health and environmental domains. Reflecting the most recent data collection in the school year 1997–1998, U.S. researchers prepared a special report, *U.S. Teens in Our World* (hereafter referred to as *U.S. Chartbook*) [4] that highlighted those areas showing “important differences” – sometimes better, sometimes worse – between young U.S. adolescents and their counterparts in other countries. These comparisons spanned the following seven content areas that include both health problems and environmental factors. For each of these areas, we note key findings pertaining to American adolescents:

- **Health and Well-Being** covers indicators pertaining to physical or mental health. Young American adolescents are more likely to experience symptoms such as stomachaches, headaches, and difficulty sleeping than students in almost all other countries.
- **Fitness** covers indicators related to diet and exercise. American students are less likely to exercise regularly and more likely to eat french fries and soft drinks. They are also the most likely to be on a diet or feel they should be.
- **Family and Peer Relationships** covers indicators dealing with any aspect of a youth’s relationship with either family members or peers. American students are more likely to report communication problems with parents.
- **School Environment** pertains to indicators that address academic success or other factors that relate to the youth’s life as a student. American students are more likely to feel a lot of school pressure, but they rank comparatively high in feeling enthusiastic about school.
- **Smoking** covers indicators which address the use and frequency of smoking. American students are less likely to smoke than their international counterparts.
- **Alcohol Use** covers indicators which address the use of alcohol. There is great variation across countries in the proportion of students who reported “getting drunk twice or more”; American students ranked in the middle range.
- **Violence** involves indicators having to do with school violence. American students feel less safe at school and report frequently bullying others [4].

As we review this international data and identify differences in the behaviors and environments of American youth relative to their peers in other countries, questions arise as to why such patterns occur and what our response should be as a nation. It also raises questions as to whether the type of information program developers and managers can readily access provides them with the level of detail necessary to implement the most effective interventions.

Policy makers, program staff and researchers alike are asking similar questions, such as: What programs are we offering (or not offering) to positively influence these health and risk behaviors? Are we effectively implementing poli-

cies and programs that influence the areas where we are doing well? Are we failing to develop effective policies and programs in the areas where we fare worse? Are existing programs incorporating effective practices? A first step in answering these questions is assessing what program information is available.

Objective

Given the increased awareness to the differences highlighted in the *U.S. Chartbook*, it is important to understand what information is available to those who seek to improve adolescent health outcomes. The purpose of this review was to provide policymakers and program managers with a comprehensive snapshot of existing programs for 11- to 15-year-olds that aim to improve adolescent health in the seven content areas measured within the *U.S. Chartbook*. The review also assesses the utility of readily available resources (such as the Internet, Government-issued reports, and published articles and reviews) in providing detailed program information needed to shape future efforts, thus, allowing for the most effective use of resources in meeting the varied needs of younger adolescents, their families, and the communities in which they live.

For each program identified, we sought to collect information on the following topics: type of program, financial allocations, targeted population, program venue (i.e., school, community center), whether the program addressed issues of cultural relevance, type of approach (i.e., media campaign, policy directive, curriculum-based program), level of implementation (i.e., individual, family, community, school) and program evaluation results.

It should be noted that the seven content areas included in this review do not include ALL aspects of young adolescent health. Other important topics relevant to their health and well-being, such as injuries, use of illegal drugs, sexual activity, and family affluence were not presented in the *U.S. Chartbook*.¹ Therefore, programs that focus on those topics were not included in this review.

Methods

The study was completed in two phases, going through a funneling process. Phase 1 encompassed a broad search to identify information sources about programs serving adolescents in the 11–15 age range. Phase 2 encompassed an in-depth search of a limited sample of programs funded by the Department of Health and Human Services in an

¹ Some topics were not included in the HBSC survey by all countries and therefore did not allow for comparison.

attempt to identify more specific program descriptors. For both phases, we attempted to identify information sources that practitioners and policy makers would turn to in order to find the type of program and funding information they need. Therefore, multiple sources were used to gather information on programs, but individual programs were not directly contacted. The sources included a review of programs previously conducted by Child Trends, the EBSCO Information Services database, the Catalog of Federal Domestic Assistance (CFDA), The White House Task Force for Disadvantaged Youth's Final Report ("The White House Report") [5], and keyword searches of private and government websites or program databases available on the Internet. Keywords used included the seven content areas and general terms such as adolescent, health, and program. The websites and databases in this review included: Substance Abuse and Mental Health Services Administration, Office of the Surgeon General, U.S. Dept. of Justice, Coordinating Council on Juvenile Justice and Delinquency Prevention, U.S. Dept of Education, Maryland Blueprints, Child Trends What Works Series, Virginia Tobacco Settlement Foundation, Proven Practices Network for Children, Families, and Communities, Blue Prints for Violence Prevention, U.S. Office of Special Education Programs, Office of Safe and Drug Free Schools, Hamilton Fish Institute, and the Harvard Family Research Project. In total, the names of over 1,000 programs were identified from these sources. A description of each of these sources can be found at the end of this article. It should be noted that the sources used are "a moving target" as websites and databases may be updated on a regular basis.

While this initial search for adolescent health programs yielded a significant number of programs, it was challenging to locate specific information that would be useful to practitioners, policy makers, and community members. In some cases, little more than a program name and a short description were offered. Given the number of programs, it was not feasible to perform an in-depth search on all of the programs. When it became clear that the information we were seeking was not readily available for the majority of programs, we chose to evaluate a small sample of programs and map them back to the seven content areas as an illustrative example of the information that could be found through a more in-depth search. Specifically, we chose to do this in-depth search on programs from the Department of Health and Human Services (HHS) that were identified in the *White House Report*. Programs funded by HHS were chosen because of the Department's overall role in health and human development, as opposed to other agencies or organizations that may have health-related programs, but are not primarily health oriented, for example, Department of Education.

In Phase 2, general internet searches on the 111 HHS program titles were performed and any available written reports were reviewed. The program information was evaluated to

determine whether any of the seven adolescent health content areas were addressed by the program and whether the program served 11- to 15-year-olds. Ten of the programs yielded such limited information that it could not be determined whether any of the seven content areas were addressed by the program. Forty-four either did not serve the age group or did not address any of the seven content areas. Fifty-seven of the 111 programs were determined to address at least one of the seven content areas and serve the target age group. Those programs were further researched to collect information on program descriptors such as: type of program, financial allocations, targeted population, program venue, whether the program addressed issues of cultural relevance, type of approach, level of implementation and program evaluation results. A more detailed description of the methods used can be located in the full report [6]. The report is available at: http://nahic.ucsf.edu/index.php/publications/article/towards_meeting_the_needs_of_adolescents1.

Results

Phase 1 – broad search for potential programs

The results of the broad search for several information sources are shown in Table 1. For each potential source, we present the number of programs that were found (fiscal year 2003–2004) and a brief justification for choosing or not choosing the source for the in-depth review. The results of this first phase points to the challenges in identifying relevant and readily available information on the range of services and funding streams that have been established to promote adolescent health. While over 1,000 program names were found, basic information on program descriptors proved more difficult to locate. When information could be located, there was no consistency in the amount or type of information available. Some databases provided a lot of detailed information on programs, while others included very little. Some programs had their own websites, although most did not. Some databases included vague program names that made it difficult (if not impossible) to find information pertaining to the program. Additionally, there was often no way to determine if information was up-to-date, which made matching program names from reports or databases with individual program websites much more difficult.

In general, websites were more likely to provide background information regarding traditional health topics (e.g., smoking, fitness, violence) and less information on relationship or contextual factors that contribute to adolescent health (e.g., school, family, and peers). Several websites did provide links to information on most of the seven topics, although the links often connected to broad information/research web sites (e.g., Healthfinder or Medline) rather than specific program information. It is worth noting that while the databases

Table 1 Sources used to identify potentially eligible programs in initial search

Source	Number of programs	Reason for inclusion/exclusion
Program websites and databases	675	Inconsistency in the level of program information
EBSCO information services	52	Inconsistency in the level of program information
Catalog of federal domestic assistance (CFDA) search	300	Inconsistency in level of program information. Not limited to programs. Also included large funding mechanisms. Only programs funded in the current fiscal year (FY04) are included which left out several programs that were recently in existence and possibly those with continuation funds
White house task force for disadvantaged youth's final report	339 funded by 3 agencies	Programs served a consistent age range similar to the US Chartbook. Provided a snapshot of programs within a given time period. More consistent information across programs provided

searched in this review did not provide the program specific information we were seeking they can serve as complementary resources to help the capacity of providers to put better programs into practice.

Phase 2 – in-depth search of limited sample

The second phase of this search – the in-depth review of 57 HHS programs that were determined to serve 11- to 15-year olds and address at least one of the seven adolescent health content areas – documents the broad array of programs underway in just one, albeit the largest, agency. Programs ranged from direct service programs, research, educational campaigns, and professional networks, to resource and technical assistance endeavors and project grants that help reach thousands of low-income and underserved adolescents. The majority of HHS-sponsored activities sampled support service or project grants, while others support resource centers that provide in-depth information on specific content areas and broker information for professionals. Still other funds support research grants and informational campaigns to raise awareness on topics, such as mentoring and violence prevention, and direct services, although it is difficult to ascertain the proportion devoted to these types of programs. For example, the individual investments made in each of the seven areas vary greatly, from \$100,000 for small direct service programs to \$1.7 billion for the Block Grants [5]. Of the sampled programs, those in the content area of tobacco had the largest amount of funding, which may be attributed to the increased attention to the issue in recent years.

Information on cultural relevance was particularly difficult to locate. However, in many of the content areas, such as Health & Well-Being and School Environment, programs

for specific groups of adolescents have been included, such as medically indigent, homeless, abused, Latino and Latina, and Native American youth.

Although this review included a small sample of programs, the program information available suggested that all seven content areas of young adolescent health were being addressed in some form. Overall, there is significant overlap between the seven content areas in many of the programs. Table 2 provides a summary of the number of programs that addressed each of the seven content areas. These categorizations are not mutually exclusive and the table should be read both horizontally and vertically. For example, 28 of the 57 programs addressed the School Environment content area. The 28 programs addressing the School Environment also addressed the content areas of Health and Well-Being as well as Family & Peer. Of those 28 programs, 11 also addressed Fitness, 17 addressed Alcohol, 10 addressed Smoking, and 20 addressed Violence. As shown, programs in specific content areas, such as Violence, Alcohol, and Smoking often cover broad topics as well, such as Health & Well-being, Family & Peers, and School Environment, suggesting that many of the initiatives are multi-faceted. In other words, while aiming to improve specific health areas, such as tobacco prevention, programs also focus on the overall health and well-being of adolescents. Specific information on the programs reviewed can be found in the full report available on the aforementioned website.

Categorizing programs was difficult because many addressed multiple “subject content” simultaneously. For example, the “subject content” (e.g., smoking prevention) could also overlap with relationships with family and peers. A program’s focus may be specifically on the topic of tobacco reduction, but program activities may incorporate the issue of relationships, such as helping young people examine the

Table 2 Adolescent health content areas of 57 HHS-funded programs

Adolescent health content areas	Adolescent health content areas						
	Health and well-being	Fitness	Family & peer	School environment	Alcohol	Smoking	Violence
Health and Well-being	52						
Fitness	12	12					
Family & Peer relationships	48	12	49				
School environment	28	11	28	28			
Alcohol	26	8	26	17	31		
Smoking	11	4	11	10	10	11	
Violence	27	9	27	20	19	7	27

Note. Highlighted cells indicate the total number of programs within a content area. Non-highlighted cells indicate the number of those programs that also fall within one other category. The table can be read vertically or horizontally. A vertical example is reflected in the 52 programs that addressed health and well-being. Of those 52, 12 also addressed fitness, 48 addressed family and peer relationships, 28 addressed school environment, etc. A horizontal example is noted in the area of alcohol (31 programs). Of these programs, 26 dealt with the issue of health and well-being, 8 pertained to fitness, 26 pertained to family and peers, while 17 also dealt with issues related to the school environment.

Source. http://nahic.ucsf.edu/index.php/publications/article/towards_meeting_the_needs_of_adolescents1.

influence of peer pressure on their own smoking practices. Many of the programs reviewed also include additional services and topics not covered by the seven content areas. For example, within the smoking content area, one program provided smoking prevention classes, but also provided support for transitional living services for homeless youth.

Although overlapping programs within and across the seven areas appear to be in place, it is not clear whether there are efforts to coordinate activities or engage in cross-program or agency communication and information sharing. For example, there were few examples of cross-referencing to other web sites that might have useful information relevant to the program.

Furthermore, it was challenging to determine the relationship between program evaluation findings and the sampled federal investments and service portfolios. Our review yielded minimal information regarding current evaluation efforts underway within the sampled programs. In addition, it was not evident whether these programs use previously evaluated curricula or other types of successful interventions to create or guide their programs. While it may be true that some evaluation material exists, for example, the number of program participants and a description of their characteristics, and those close to the program may be aware of it, the information was not made readily accessible to others who may be interested in garnering from the program experience.

Discussion and implications

The large number of programs found in Phase 1 and the range of programs identified in Phase 2 clearly demonstrate a strong national commitment to addressing adolescent health on several levels. Resource allocation and distribution

channels – including grants that support direct service programs, national campaigns, resource centers, technical assistance providers, and professional memberships – reflect a strong commitment to identifying and prioritizing a broad spectrum of youth, with a special emphasis on adolescents at risk. It is also true that information regarding the specific programs that receive funding is becoming more readily available through the internet; however, the program information that was publicly available online only begins to draw the picture. Given the progress that has been made in the field, it is important not only to identify areas of need, but to be able to reflect on the lessons learned.

Although this review did identify many programs serving young adolescents within the seven content areas, it is worth noting the limitations of the review. While the internet is an easily accessible, user-friendly resource with a significant amount of information, it is also a constantly changing resource that can not be frozen in time. As such, replication of the search results may be difficult and may yield more or less information on any given day. Therefore, the results presented within provide a snapshot in time of what was available at the time of this review. Additionally, the sample of programs used for the in-depth review is relatively small and limited to programs offered by HHS. As such, the findings of this review are not comprehensive; however this sample does provide an illustrative example of programs offered by one of the largest agencies dedicated specifically to health. Thirdly, the focus of the review was on seven content areas related to health. While areas such as tobacco, violence, and alcohol use are extremely relevant to this age group, other areas that were not included in this review, for example, adolescent sexual behavior, may have much more readily available information. Other areas, such as family and peer relationships and school environment have thus far

not traditionally been included and recognized as topics that have a strong influence on the health and well-being of adolescents. Thus, this limitation may reflect the “state of the state” in terms of emerging fields. Finally, interviews with program managers were not feasible given the resources for this review. Undoubtedly, additional programmatic information would have been made available through such means. However, it was the intent of this review to access information that would be readily available to program providers, funders and policy makers. The study team did not consider telephone interviews with program managers to be “easily accessible” information.

Given the current information available, we conclude that it is difficult to answer a variety of questions policy makers, program staff and researchers are asking about the availability and effectiveness of programs designed to address adolescent health. Based upon our research findings, we propose a series of future directions that will help to answer the questions about the availability and effectiveness of adolescent health programs that have arisen as a result of the differences highlighted in the *U.S. Chartbook*. Our research suggests that in addition to investing in the programs, it is equally important to have a system in place to communicate basic program information and quality evaluation information. Specifically, we suggest developing a centralized program repository with technical assistance, and building a new body of practice knowledge through improved data collection and program evaluations.

Sharing knowledge through a centralized program repository

The development of a centralized, easy-to-use, up-to-date, cross-referenced repository that links specific program information and existing clearinghouses would significantly advance efforts in the field. This centralized source could also provide an important link between research and programming implementation and help to identify programming gaps across federal agencies and other funding sources. Such a system would be useful for all parties involved – the federal government, state and local governments, program funders, program practitioners, and even program participants.

The challenges encountered through this research project suggest the difficulties that may be faced by program practitioners, policy makers or funders who may not have the resources or time to dedicate to such an in-depth search. As a single point of access, users would have a centralized database to refer to when establishing new programs and improving existing programs. Ideally, the repository would manage a general program compendium that tracks basic program information (i.e. age of program participants, topic areas covered, funding level, location, outcomes, etc.), as well as information on any evaluation activities. A “what

works” component of the repository could assist in translating research findings into program practice, ensuring that program funders and program developers are building on the large base of program knowledge that already exists and that continues to grow. For example, Child Trends’ What Works series summarizes available research and program evaluations to determine what works, what doesn’t work, and what are some “best bets” in program design in a variety of areas relevant to adolescent health, including tobacco use and physical activity.

Making user-friendly and applicable information more easily accessible would allow people who are designing, or choosing, programs to determine what does and does not work with different populations, as well as learn important lessons (where available) on how to implement a program to achieve the greatest results. Additionally, a repository would provide the opportunity to incorporate contextual factors, such as family and peer relationships and school environment, into general program descriptions and design. These factors were largely missing in our program search. Such a repository would also be useful in assessing and monitoring the current level of effort dedicated to a given topic area. For example, it would allow comparisons between the number of programs in one area (e.g., violence) versus the number of programs addressing another area (e.g., fitness).

As with any database, the quality of a repository would be dependent on the quality of data entered into the system and therefore it would be necessary that the federal government and other funding organizations require that information be supplied as part of the grant-making process. Furthermore, the compilation of information, while clearly an important core function of a repository, would not be sufficient without some concurrent effort to assure that the information was made available in an easy-to-use format, with the provision of technical assistance to support communities’ use of the information.

The creation of a centralized repository would undoubtedly be a major endeavor requiring a large investment of both money and resources. As such, it may be difficult to create one repository across all youth programs. As an alternative, if separate repositories in specific content areas using the same format were established, they could, at a minimum, include cross-references to other major health topics. To ensure that such an investment delivers the maximum benefit it would be important to publicize the repository across several groups including funders, policymakers, program developers and other key stakeholders.

Building a new body of practice knowledge

The past decade has witnessed an ongoing devolution of responsibility from the federal government to states and communities. This has been accompanied by greater emphasis on

program accountability, with more funders requiring evaluations to provide evidence that their grantmaking is effective. Unfortunately, however, this assessment found few efforts to make information, such as program documents (e.g., evaluations, annual reports, etc.) or previous research findings that may have shaped the program readily available. At the same time, there is a gap between the availability of research and evaluation findings and their incorporation into programmatic efforts and policy. The call for more program evaluations and the need to incorporate research findings into practice present an opportunity to build a new body of practice knowledge. Doing so through several mechanisms at once will help to close the gaps between research, practice and policy, ultimately indicating whether programs are functioning as well as they can. The overall intent is to strengthen the quality and availability of programs that serve young people. Programs are one of the nation's strategies for not only promoting the health of adolescents, but also diminishing the health status gaps identified by international comparisons.

One step in providing the information that providers, policy makers and researchers are seeking is to adequately monitor programs, through the collection of information at several levels and from several sources. Clearly, at the program level it is important to collect basic demographic information on participants and participation rates, but it is equally important to include multiple measures on short and long term outcomes for participants. We suggest moving beyond client satisfaction surveys to collecting information on adolescent outcomes from both the adolescent's and parent's perspective. Additionally, we encourage the collection of information on what the program model is and how it functions. For example, information on the type of curriculum and/or other interventions being used, the length and intensity of the program, as well as its overarching goals and objectives is as important to collect as program staff turnover rates, adolescent to class or group size ratios, and staff education and salaries. Such information can often help to establish why certain programs are effective, when other similar programs are not [7]. Simultaneously, data from major national surveys could enhance the knowledge base by providing general program information on a national scale. In particular, information on program participation and interest in various types of adolescent programs could help to articulate the utility of programming to adolescents and identify gaps in programming. While such data would not provide information on effectiveness, it would provide the unique perspective of the adolescent as the "consumer," including both adolescents that are involved in programs and those that are not.

At the same time, more rigorous evaluations of programs can help to identify programs and program characteristics that work in order to ensure that funded programs are ac-

tually achieving desired results. Evaluated programs that share similar program components can be used to help glean lessons on the effectiveness of those components. Without program evaluations, it is very difficult to draw conclusions about the state of programs for adolescents. Likewise, without experimental evaluations it is impossible to determine cause and effect relationships. For example, the percentage of teens who smoke has been dropping for several years, but without experimental studies to help isolate the effects of separate and/or multi-sectoral factors, it is not possible to precisely determine what has caused this change [8]. In particular, more evaluations should focus on content areas that have been less thoroughly researched and that affect the most adolescents—both in terms of protective factors, as well as risk behaviors.

Articulating research findings and other "Best Practices" may become increasingly important in future efforts, given the need to use available resources judiciously. While research findings are often noted in Requests for Proposals, their absence in available program information represents a lost opportunity to help programs understand the theoretical and research underpinnings of their efforts. Assessing whether in fact new programs incorporate research findings would be extremely useful in assuring that the next generation of programs benefit from the lessons learned from well-evaluated programs, or at a minimum, "Best-Practices" [9]. In order to be particularly useful, such evaluation information should be presented in a readily understood rating system, ranging from best practices to evaluation results from randomized studies.

Summary

The *U.S. Chartbook* highlighted areas of adolescent health where we as a nation are doing better or worse compared to our counterparts. These findings underscore the need to define what contributes to these differences from an analytical perspective.

A first step in understanding the nation's potential contribution to improving adolescent health outcomes in these areas is ascertaining what policies and programs are in place. This review identified multiple efforts underway, reflecting this complex, multifaceted issue. More can be done, however, to help guide and improve these efforts. Greater accessibility to information will: aid in creating programs that aim to improve adolescent health; allow program practitioners to find better program models to follow when implementing programs; and allow for collaboration and collective learning. Publicly available program evaluations permit program practitioners to learn from other programs and avoid "reinventing the wheel" when implementing new programs or adapting current programs. Additionally, shared information

allows for a collective approach to addressing difficult questions about adolescent health.

Our assessment revealed that program information needs to be articulated and made more visible between the government, private funders, practitioners, researchers, policy makers, and the general public in order for all parties to get the best value from the resources that are already being spent in this area. Investment in programming is not enough; it is critical that an investment in communication and information sharing be made in order to maximize the resources we as a nation are dedicating to the improvement of adolescent health. Integral steps in the process include collecting more program specific information, synthesizing available evaluation information, sharing both in more user-friendly formats, and requiring programs to incorporate evidence-based research findings to improve their service delivery. A centralized program repository offered in conjunction with technical assistance would provide an efficient mechanism for this information sharing. We further suggest that the inherent gap between policy, research, and practice can be lessened by building a new body of practice knowledge. This new body of practice knowledge would require improved data collection by programs, the incorporation of program participation information in national surveys and enhanced evaluation efforts. These strategies also point to the importance of collecting comprehensive, ongoing national and international comparison data that can help track changes over time, and fuel the commitment and efforts of multiple stakeholders to improve the health and well-being of adolescents.

Websites and databases containing program information

Federal resources

The Office of Safe and Drug Free Schools

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

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

The Office of the Surgeon General

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

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

have been shown (to some extent or another) to be effective in combating the spread of youth violence.

Substance Abuse and Mental Health Services Administration

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

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

US Department of Education

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

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

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

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

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

US Office of Special Education Programs

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

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

Non-federal resources

Blue Prints for Violence Prevention

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

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

that fit within either their model or promising programs sections.

Child Trends' What Works Series

[http://www.childtrends.org/_docdisp_page.cfm?LID = F1B8BA1C-D733-4500-A294FA13E8DC5DBB](http://www.childtrends.org/_docdisp_page.cfm?LID=F1B8BA1C-D733-4500-A294FA13E8DC5DBB)

Child Trends' "What Works" series summarizes available program evaluations to determine what works, what doesn't work, and what are some "best bets" in program design. The "What Works" series consists of interactive tables that are linked to relevant research and program descriptions.

Hamilton Fish Institute

<http://hamfish.org/cms/view/9>

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

Harvard Family Research Project

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

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

Maryland Blue Prints

<http://www.jhsph.edu/preventyouthviolence/Resources/blueprints.sect2.pdf>

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

Proven Network for Children, Families, and Communities

<http://www.promisingpractices.net/>

The Colorado Foundation for Families and Children, the Family and Community Trust (Missouri), the Family Connection Partnership (Georgia), and the Foundation Consortium for California's Children & Youth (California) created this project which is currently administered by the RAND

Corporation. Publicly available information is used to report on the effectiveness of programs, both program designs and evaluations. Programs are listed according to benchmarks for both children and families.

Virginia Tobacco Settlement Foundation

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

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

References

1. Currie C, Hurrelmann K, Settertobulte W, Smith R, Todd J. Health and health behavior among young people. Health Behavior in School-aged Children: A WHO cross-national study (HBSC) international report. Copenhagen, Denmark: Health Promotion and Investment for Health, World Health Organization Regional Office for Europe, 2000.
2. Biehl MC, Park MJ, Brindis CD, Pantell RH, Irwin CE, Jr. The health of America's middle childhood population. San Francisco, CA: University of California, Public Policy Analysis and Education Center for Middle Childhood and Adolescent Health, 2002.
3. Brindis CD, Biehl MC, Park JM, Pantell RH, Irwin CE, Jr. Building a Strong Foundation: Creating a health agenda for the middle childhood Years. San Francisco, CA: University of California, Public Policy Analysis and Education Center for Middle Childhood and Adolescent Health, 2002.
4. U. S. Department of Health and Human Services. Health resources and services administration. U.S. Teens in Our World. Rockville, Maryland: Author, 2003.
5. White House Task Force for Disadvantaged Youth. White House Task Force for Disadvantaged Youth: Final report. Washington, DC: Author, 2003.
6. Brindis CD, Hair EC, Cochran SW, Cleveland K, Valderrama LT, Park MJ. Towards Meeting the Need of Adolescents: An Assessment of Federally Funded Adolescent Health Programs and Initiatives within the Department of Health and Human Services. San Francisco CA: University of California, National Adolescent Health Information Center, 2004.
7. SRI International. First 5 California: Child, family, and community indicators. Sacramento, CA: California Children and Families Commission, 2002.
8. Child Trends. Daily cigarette use. (2004). Retrieved December 2, 2004, from <http://www.childtrendsdatbank.org/indicators/3Smoking.cfm>.
9. Moore KA, Zaff JF. Building a better teenager: A summary of "what works" in adolescent development. Washington, DC: Child Trends, 2002.