Chapter 19

THE ROLE OF FEDERAL AGENCIES IN ADOLESCENT HEALTH

Contents

Box

Figures

Tables

Chapter 19

THE ROLE OF FEDERAL AGENCIES IN ADOLESCENT HEALTH

Introduction

The Federal Government has both direct and indirect involvement in providing services, developing policies, designing and implementing programs, and conducting research aimed at improving the health of adolescents. Some Federal efforts target adolescents specifically, and other Federal efforts are aimed at a more general population that includes adolescents. Because of the way funds are allocated, it is difficult to ascertain the extent to which the Federal Government supports activities designed to improve the health of adolescents.

As part of its adolescent health project, OTA surveyed Federal agencies that it identified as possibly having a role in adolescent health. The survey included agencies of the U.S. Department of Health and Human Services (DHHS) and of the U.S. Departments of Agriculture, Commerce, Defense, Education, Interior, Justice, Labor, and Transportation, and several independent Federal agencies such as ACTION (see table 19-1). Agencies were asked about the following:

- their definition of adolescence;
- current agency research priority areas;
- overall agency budgets for fiscal years 1979 through 1990;
- level of funding for adolescent initiatives for fiscal years 1979 through 1990;
- research activities and demonstration projects related to adolescents;
- participation in intra-agency and interagency coordination activities related to adolescents; and
- data collection activities related to adolescents.

The findings of OTA's survey clearly indicate that the Federal Government funds numerous activities aimed at improving the health of adolescents. This chapter analyzes the information sent to OTA in response to its survey questionnaire regarding Federal agencies' adolescent health initiatives. Unless otherwise indicated, the information in this chapter is from Federal agency responses to this questionnaire. Other sources of information are used to provide context to the discussion.

The Federal agencies that were sent OTA survey questionnaire were also invited to send representatives to OTA for a l-day discussion on the Federal role in adolescent health. OTA's workshop for Federal agencies was held in October 1989, and the discussions are summarized and incorporated into the conclusions of this chapter.

Federal Agencies' Definitions of the Adolescent Population

The Federal agencies responding to OTA's survey define adolescence inconsistently (see table 19-2). Definitions of adolescence or the ages it encompasses vary not only from one Federal department to another but also within departments and even within agencies.

The variation in definitions of adolescence is particularly evident within the Public Health Service of DHHS. Within the National Institutes of Health, for example, the National Institute of Child Health and Human Development defines adolescence as including, but not being restricted to, ages 12 and 19. Other institutes within the National Institutes of Health define adolescence very broadly. The National Institute of Neurological Disorders and Stroke, for example, defines adolescence as the period between late childhood and early adulthood.

Within the Centers for Disease Control, the definition of adolescence also varies. It is ages 10 to 19 in the Division of Adolescent and School Immunization and ages 10 to 18 in the National AIDS Information and Education Program. Further, within the Health Resources and Services Administration's Bureau of Health Care Delivery and Assistance, definitions of adolescence vary by program:

- community/migrant health centers programs, ages 10 to 19;
- homeless programs, ages 15 to 19;
- perinatal programs, under age 15 and ages 15 to 19; and
- substance abuse programs, ages 13 to 19.

A significant number of Federal agencies and programs do not define any particular age grouping as adolescence. These include the Family Support Administration of DHHS, the Bureau of the Census

Table 19-1-Primary Functions of U.S. Executive Branch Agencies With a Role in Adolescent Health[a]

Agency	Primary function(s)
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) .	Administers a wide range of programs related to health, welfare, and income security.
1. Family Support Administration (FSA)	Administers various programs intended to strengthen the American family.
A. Office of Family Assistance	Administers the Aid to Families With Dependent Children (AFDC) program and the Job Opportunities and Basic Skills Training (JOBS) program.
B. Office of Child Support Enforcement	Supports State efforts to enforce support obligations owed by absent parents to their children.
C. Office of Community Services	Administers the community services blockgrant and discretionary grant programs, which assist poor people.
2. Health Care Financing Administration (HCFA).	Administers the Medicaid[b] and Medicare programs.
3. Office of Human Development Services (OHDS)	Oversees various human services programs for the elderly, children and youth, families, Native Americans, persons living in rural areas, and people with disabilities.
A. Administration for Native Americans..	Advises the Assistant Secretary for Human Development Services on matters related to American Indians and other Native Americans. Administers a grant program and provides technical assistance to Native American organizations to help them implement locally determined social and economic development strategies.
B. Administration on Development Disabilities	Administers the Development Disabilities Act and supports the development and coordination of programs for developmentally disabled persons of all ages.
C. Administration for Children, Youth, and Families.	Funds comprehensive services for young children and their families through the Head Start program. Administers provisions of the Child Abuse Prevention and Treatment Act and manages a national clearinghouse on child abuse and neglect. Provides Federal support for child welfare services (including Federal funds for foster care maintenance). Administers the Runaway and Homeless Youth Act and a drug abuse prevention program for runaway and homeless youth.
4. Public Health Service (PHS)	Supports a wide variety of efforts to improve the physical and mental health of Americans.
A. Alcohol, Drug Abuse, and Mental Health Administration	Supports efforts to increase knowledge about and to prevent and treat alcohol and drug abuse and mental health disorders in the United States.
• National Institute on Alcohol Abuse and Alcoholism	Conducts and supports research on alcohol abuse and alcoholism.
• National Institute on Drug Abuse	Conducts and supports research on drug abuse.
• National Institute of Mental Health	Conducts and supports research on mental health and the prevention and treatment of mental illness.
• Office for Substance Abuse Prevention	Supports innovative prevention demonstration projects for individuals at high risk for drug or alcohol abuse; supports an information clearinghouse with drug and alcohol abuse prevention materials; provides technical assistance to States; supports training for substance abuse counselors.
•Office for Treatment Improvement	Supports efforts by States and communities to improve drug and alcohol abuse treatment programs; administers the alcohol, drug abuse, and mental health services block grant program.
B. Centers for Disease Control	Administers national programs for the prevention and control of communicable diseases; chronic diseases; and environmental health problems.
. Center for Chronic Disease Prevention and Health Promotion	Directs a national program aimed at the prevention of premature mortality, morbidity, and disability due to chronic illnesses.
—Division of Adolescent and School Health	Administers programs to reduce health risks to adolescents through comprehensive school health education and other means.
—Division of Reproductive Health	Administers programs and conducts research in areas related to contraception, pregnancy, human reproduction, and infancy.

[a]The Federal agencies listed in this table are primarily agencies that responded to a survey conducted by OTA in August 1989 to determine the scope and level of adolescent-health-related activity at the Federal level.
[b]Medicaid was established in 1965 under Title XIX of the Social Security Act to assist States in providing health care (e.g., inpatient and outpatient medical services, family planning services, prenatal care) to the poor.

Continued on next page

Table 19-1—Primary Functions of U.S. Executive Branch Agencies With a Role in Adolescent Health[a]—Continued

Agency	Primary function(s)
• Center for Environmental Health and Injury Control	Directs a national program aimed at promoting a healthy environment and preventing premature death, avoidable illness, and disability caused by environmental and related factors.
—Division of Injury Control	Administers and directs programs on the prevention and control of intentional and unintentional injuries.
—Division of Birth Defects and Developmental Disabilities	Administers programs directed toward determining the environmental causes of selected adverse reproductive outcomes and perinatal and childhood disabilities.
• Center for Infectious Diseases	Directs a national program aimed at improving the identification, investigation, diagnosis, prevention, and control of infectious diseases.
—Division of HIV/AIDS	Conducts studies, develops guidelines, evaluates programs and disseminates information on the prevention of human immmunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS).
• for Prevention Services	Directs national programs of assistance involving preventive health services to State and local health agencies.
—Division of STDs and HIV Prevention	Administers programs, in cooperation with other CDC components, for the prevention and control of sexually transmitted diseases (STDs), including HIV infection.
• National AIDS information and Education Program	Disseminates information about HIV infection and AIDS to the public through various means (mass media, national information hotline, and clearinghouse).
• National Center for Health Statistics	Collects, analyzes, and disseminates health statistics on activities that relate to health status, needs, and resources.
C. Health Resources and Services Administration (HRSA)	Oversees a number of programs on general health services and resource issues relating to access, equity, quality, and cost of care; helps coordinate government and private efforts on behalf of rural health facilities.
• Bureau of Health Care Delivery and Assistance	Supports States and communities in their efforts to plan, organize, and deliver health care services to medically underserved populations, and to special services populations such as migrants and homeless people. Administers the National Health Service Corps Program.
• Bureau of Health Professions	Undertakes efforts to improve the education, distribution, and quality of health care professionals in the United States.
• Bureau of M and Child Health[c]	Supports States and communities in their efforts to plan, organize, and deliver health care services to mothers and children. Awards maternal and child health block grants to States and discretionary grants for developing models of health care delivery to mothers and children, including adolescents.
D. Indian Health Service (IHS)	Provides health services for American Indians and Alaska Natives.
E. National Institutes of Health (NIH)	Conducts and supports biomedical research into the causes, prevention, and care of diseases.
• National Cancer Institute	Conducts and supports research on the causes, prevention, diagnosis, and treatment of cancer.
• National Eye Institute	Research on the eye and visual disorders.
• National Heart, Lung, and Blood Institute	Conducts and supports research on the causes, diagnosis, prevention, and treatment of heart, blood vessel, lung, and blood diseases. Conducts educational activities related to the prevention of these diseases.
• National Institute of Allergy and ec Diseases	Conducts and supports research on the causes, characteristics, prevention, control and treatment of a wide variety of diseases believed to be attributable to infectious agents, to allergies, or to other deficiencies or disorders in the responses of the body's immune mechanisms.
• National Institute of Arthritis and Musculoskeletal and Skin Diseases	Research on arthritis (including juvenile arthritis) and musculoskeletal and skin disorders (e.g., muscular dystrophies, acne).

[c]In 1990, the Bureau of Maternal and Child Health and Resources Development split into two separate bureaus: 1) the Bureau of Maternal and Child Health, and 2) the Health Resources Development Bureau.

Table 19-1—Primary Functions of U.S. Executive Branch Agencies With a Role in Adolescent Health[a]--Continued

Agency	Primary function(s)
• National Institute of Child Health and Human Development. .	Conducts and supports multidisaplinary behavioral and biomedical research on child health and maternal health, on problems of human development (e.g., mental retardation) and on family structure. Supports research on new contraceptives and AIDS.
• National institute of Dental Research	Research aimed at eliminating tooth decay and an array of other oral-facial disorders.
• National Institute of Diabetes and Digestive and Kidney Diseases	Conducts and supports research into the causes, prevention, diagnosis, and treatment of various metabolic and digestive diseases (e.g., juvenile diabetes, cystic fibrosis, sickle-cell anemia, hemophilia).
• National Institute of Environmental Health Sciences	Conducts and supports research to understand the effects of chemical, biological, and physical factors in the environment on health.
• National Institute of Neurological and Communicative Disorders and Stroke (NINCDS)[d]	Conducts and supports research on neurological disorders (e.g., head and spinal cord injury) and stroke.
• National Center for Nursing Research	Administers programs and research training programs aimed at promoting the quality of research in nursing and patient care, including care for adolescents.
F. Office of the Assistant Secretary of Health (OASH)	Aids the Secretary of Health with management responsibilities of the department.
• Office of Disease Prevention and Health Promotion	Supports and coordinates prevention programs within the Alcohol, Drug Abuse, and Mental Health Administration, the Centers for Disease Control, the Food and Drug Administration, the Health Resources and Services Administration, and the National Institutes of Health.
• Office of Minority Health	Ensures that DHHS funds are used to address minority health problems by organizing, and assessing current programs for minority health problems; provides technical assistance to States and local governments with respect to their efforts to address minority health issues.[e]
• Office of Population Affairs	Carries out Public Health Service Act Title X and Title XX programs related to adolescent pregnancy, family planning, and population research.
G. Social Security Administration	Administers the Old Age Survivors and Disability Insurance Program and the Supplemental Security Income Program.
ACTION	Administers several Federal domestic volunteer service programs, including VISTA, the Foster Grandparents Program, and Student Community Service Projects.[f]
NATIONAL SCIENCE FOUNDATION	Supports research in science and engineering through grants to universities and other research organizations.
U.S. CONSUMER PRODUCT SAFETY COMMISSION	Collects information on consumer-product related injuries, promotes research on the causes and prevention of such injuries, develops voluntary or mandatory standards for consumer products, and sometimes bans hazardous products.
U.S. DEPARTMENT OF AGRICULTURE (USDA)	Administers a wide range of programs related to farms, nutrition, food, hunger, rural development, and the environment.
1. Office of the Assistant Secretary, Food and Consumer Services	
A. Food and Nutrition Service	Administers several programs to make food assistance available to needy people, including the Food Stamp Program, the School Breakfast Program, the Food Distribution Program, and the Special Supplemental Food Program for Women, Infants, and Children. Also gives grants to States for disseminating nutrition information to children.
B. Human Nutrition Information Service	Performs research in human nutrition; monitors food and nutrient consumption in the United States; and disseminates information on nutrition.

[d] In 1990, the National Institute of Neurological and Communicative Disorders and Stroke split into two separate institutes: 1) the National Institute of Neurological Disorders and Stroke, and 2) the National Institute on Deafness and Other Communication Disorders.
[e] These were its functions prior to the passage of Public Law 101-527, which established separate funding for an Office of Minority Health in DHHS.
[f] These were its functions prior to passage of the National and Community Service Act (Public Law 101-610).

Table 19-1—Primary Functions of U.S. Executive Branch Agencies With a Role in Adolescent Health[a]—Continued

Agency	Primary function(s)
2. Office of the Assistant ec Science a×d E ca	
A. Extension Service	Serves as USDA's educational agency and is the Federal partner in the Cooperative Extension System, a nationwide educational network that provides access to food- and agriculture-related research, science and technology. Recent initiatives include programs on human nutrition, youth at risk, building human capital, and family and economic well-being.
U.S. DEPARTMENT OF COMMERCE	Administers a wide range of programs to promote the Nation's international trade, economic growth, and technical advancement.
1 Bureau of he Census .	Collects, tabulates, and publishes or otherwise makes available a wide variety of statistical data on the U.S. population and the economy.
U.S. DEPARTMENT OF DEFENSE	Oversees U.S. military forces and various civilian defense agencies.
1. Office of Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)	Administers a civilian health and medical program for retirees and spouses and dependents of active duty, retired, and deceased members of the military.
U.S. DEPARTMENT OF EDUCATION	Establishes policy for, administers, and coordinates most Federal assistance for education.
1. Office of the Assistant Secretary for Elementary and Secondary Education	Formulates policies for, directs, and coordinates programs for elementary and secondary education. Administers grants to States and local school districts for Indian and migrant education, as well as grants to help schools meet the educational needs of educationally disadvantaged children (e.g., neglected or delinquent children under State care).
2. Office of the Assistant Secretary for Educational Research and Improvement	Administers functions concerning research, statistics, demonstrations, and assessment. Administers discretionary grants to improve health education for elementary and secondary students.
3. Office of the Assistant Secretary for Special Education and Rehabilitative Service	Administers programs in special education and provides services designed to meet the needs and develop the full potential of handicapped children.
4. Office of Bilingual Education and Minority Languages Affairs	Provides support for programs to meet the special educational needs of minority languages populations.
5. Office of the Assistant Secretary for Vocational an= Adult Education	Administers programs of grants and assistance for vocational and technical education and coordinates rural education programs.
U.S. DEPARTMENT OF THE INTERIOR	Has responsibility for the stewardship of nationally owned lands and natural resources; has trust responsibilities for American Indian reservations.
Bureau of Affairs	Works with American Indian and Alaska Native people to develop and implement educational, social, and community development programs.
U.S. DEPARTMENT OF JUSTICE	Has broad responsibilities related to law enforcement, including oversight of the Federal Bureau of Investigation, the Drug Enforcement Administration, the Bureau of Prisons, the U.S. Marshals Service, the Immigration and Naturalization Service, and the Department's Civil Rights Division, Antitrust Division, Tax Division, Civil Division, Criminal Division, Environment and Natural Resources Division, etc.
. Office of Justice Programs[9]	
A. Bureau of Justice Assistance	Provides financial and technical assistance to States and local governments to control drug abuse and violent crime and improve the criminal justice system.

[9]The Office of Justice Programs was established by the Justice Assistance Act of 1984 and reauthorized in 1988 to help foster cooperation and coordination needed to make the criminal justice system function effectively.

Continued on next page

292-872 0 - 91 - 8 QL 3

Table 19-1—Primary Functions of U.S. Executive Branch Agencies With a Role in Adolescent Health[a]-Continued

Agency	Primary function(s)
6. Bureau of Justice Statistics	Collects, analyzes, and disseminates information about crime, and the operation of the criminal justice system at all levels of government.
C. National Institute of Justice	Works to improve the criminal justice system, address crime prevention and control, and enhance community safety and security.
D. Office of Juvenile Justice and Delinquency Prevention	Administers programs and policies intended to improve the juvenile justice system; assists communities in responding to the needs of juveniles; assesses the factors that contribute to juvenile delinquency; and informs practitioners about research findings and successful interventions.
E. Office for Victims of Crime	Carries out activities mandated by the Victims of Crime Act of 1984.
U.S. DEPARTMENT OF LABOR	Fosters U.S. workers' welfare, improves their working conditions, and promotes opportunities for employment.
1. Employment and Training Administration	Has responsibilities related to employment services, unemployment insurance, and job training. Administers the Job Training Partnership Act, which authorizes block grants to States for job training programs for economically disadvantaged individuals and provides authority for the Job corps.
U.S. DEPARTMENT OF TRANSPORTATION	Develops coordinated national transportation policies and oversees a wide variety of transportation programs carried out by nine operating administrations (aviation, highway, railroad; highway traffic safety; urban mass transportation, etc.).
1. Federal Highway Administration	Administers the Federal-aid highway program of financial assistance to the States for highway instruction and improvements, such as highway repairs and maintenance, which improve the safety of the roads; exercises jurisdiction over commercial motor carriers in interstate commerce.
2. National Highway Traffic Safety Administration	Carries out programs and research related to the safety and performance of motor vehicles, and related equipment.
NATIONAL TRANSPORTATION SAFETY BOARD	Conducts independent investigations of accidents and other safety problems, conducts studies, and makes recommendations to Federal agencies, the transportation industry, and others on safety measures and policies.

SOURCE: U.S. Congress, Office of Technology Assessment, 1991, based on National Archives and Records Administration, Office of the Federal Register, *The United States Government Manual 1990/91* (Washington DC: U.S. Government Printing Office, July 1, 1990).

Table 19-2—How Adolescence Is Defined by Different Federal Agencies and Their Components

Federal agency	Definition of adolescence	Distinctions between early, middle, and late adolescence	Reason(s) for definition or distinctions chosen
ACTION	10 to 19	None	Executive policy decision
U.S. CONSUMER PRODUCT SAFETY COMMISSION	None. Often, age groups are related to factors, such as product design or physical characteristics, of the population. Data are usually reported as ages 5 to 14 and 15 to 24.	None	Not applicable
U.S. DEPARTMENT OF AGRICULTURE Office of the Assistant Secretary, Science and Education • Extension Service's 4-H Program	Age guideline of 9 to 19. Most States have adopted an earlier age for participation.	Early: < 11. Middle: 11 to 14. Late: 15 to 19.	Lower age limit of 9 chosen because of the need to work with younger adolescents due to health-related issues.
Office of Assistant Secretary, Food and Consumer Services . Food and Nutrition Service	None. Some data are collected by single year of age or school grade. For example, the Food Stamp Program reports on children and adolescents ages 5 to 17 receiving food stamps.	None	Not applicable
U.S. DEPARTMENT OF COMMERCE Bureau of the Census	Not specified. Data are reported by single year of age and for various age groups (i.e., 10 to 14 and 15 to 19); data user can pay for other age breaks.	None. Data users can create their own age groups.	Requests from data users and the judgments of the Census Bureau's professional staff.
U.S. DEPARTMENT OF DEFENSE	Two military services use 10 to 18. Remaining two use 12 to 18.	*Yes*[a]	Programs are geared to adolescents based on their growth, development, and maturation levels.
Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)	None. Individuals less than age 21 are considered children, and those over 21 are considered adults. Data are collected for 10- to 14-year-olds and 15- to 19-year-olds.	None	Statutes determine age when it is a factor for eligibility.
U.S. DEPARTMENT OF EDUCATION	Although no Department-wide definition exists and definitions may vary by program, adolescents are generally considered to be in grades 7 through 12.	None	Traditional grouping
Office of Elementary and Secondary Education	None	None	Not applicable
. Office of Indian Education	None	None	Not applicable
. Office of Migrant Education	Unofficially, 10 to 21.	None	Not applicable
Office of Special Education and Rehabilitative Services	None		

[a]Definitions nOt provided.

Continued on *next* page

Table 19-2-How Adolescence Is Defined by Different Federal Agencies and Their Components-Continued

Federal agency	Definition of adolescence	Distinctions between early, middle, and late adolescence	Reason(s) for definition or distinctions chosen
• Office of Special Education Programs	None. Ages 12 to 17 and 18 to 21 are used in the *Annual Report to Congress.*	No specific distinctions. However, States report child data as 6 to 11, 12 to 17, and 18 to 21.	Legislatively mandated[b]
• National Institute on Disability and Rehabilitation Research	None. Age groupings may or may not be defined within project guidelines.	Not unless done within a specific project.	Legislatively mandated[b]
U.S DEPARTMENT OF HEALTH AND HUMAN SERVICES			
Assistant Secretary for Planning and Evaluation	10 to 18	Yes[a]	Age 10 generally marks the beginning of puberty, and at age 18 individuals are no longer eligible for ASPE social services.
Family Support Administration	Not specified. For recipient children under age 18, data are reported by year, and parent recipients are reported by age group 11 to 18.	Not provided	Not provided
Health Care Financing Administration	None. Eligibility for Medicaid includes individuals less than age 18.	None	Not applicable
Office of Human Development Services	Varies. Social services block grants: varies. Child welfare services: under 21. Child welfare research: not specified. Foster care: under 18. Independent living program: over 16. Runaway & homeless youth program: 10 to 18.	Sometimes made in discretionary priorities,	Required under legislative authority: Adoption Assistance Act (Public Law 92-272)--under age 18 except where mental or physical handicap warrants continuation until age 21, Child Abuse Prevention and Treatment Act (Public Law 93-247)--under age 18 or as specified by the State's child protection law.
Public Health Service			
A. Alcohol, Drug Abuse, and Mental Health Administration			
• National Institute on Alcohol Abuse and Alcoholism	13 to 21	None	Not applicable
. National Institute on Drug Abuse	None. Research projects target the range of 12- to 21-year-olds.	None. Studies test programs for adolescents of differing ages.	Determined by study questions and research subject eligibility.
• National Institute of Mental Health	No NIMH-wide definition, but the Child and Adolescent Disorders Research Branch defines adolescence as 10 to 18.	Does not code grants by these categories, but NIMH clinical investigators often use such categories- Early: 10 to 13. Middle: 14 to 17. Late: 18 to 24.	Age groups make sense developmentally in terms of psychosocial stressors and role transitions.

[a]Definitions not provided.
[b]Services maybe provided until age 22 under the Education for All Handicapped Children Act (Public Law 94-142). Title I of the Rehabilitation Act provides for delivery of service to individuals with potential vocational abilities with no set lower age limit. The Fair Labor Standards Act, however, established the age of 14 as appropriate for employment. Most school districts target the age of 16 as eligible for employment.

Table 19-2—How Adolescence Is Defined by Different Federal Agencies and Their Components—Continued

Federal agency	Definition of adolescence	Distinctions between early, middle, and late adolescence	Reason(s) for definition or distinctions chosen
. Office for Substance Abuse Prevention	Under age 21. Data age breaks include adolescent ages 10 to 12, 13 to 15, 16 to 18, 19 to 21.	Early: 10 to 14. Middle: 14 to 17. Late: 17 to 20.	Based on convenience of program administration, as with school-based programs, and on findings in developmental psychology literature. Under 21 age group defined by OSAP's authorizing legislation.
B. Centers for Disease Control			
. Center for Chronic Disease Prevention and Health Promotion			
—Division of Adolescent and School Health	10 to 19	*Yes*[c]	Uses the World Health Organization definition.
—Division of Reproductive Health	12 to 19	Early: 12 to 14. Middle: 15 to 17. Late: 18 to 19.	Very few births occur to adolescents under age 12. Fifteen to 17-year-olds may still be in school and the proportion married is different than the 18- to 19-year-olds.
• Center for Environmental Health and Injury Control	None	None	Not applicable
—Division of Injury Control	None	None	Not applicable
—Disabilities Prevention Program	None	None	Not applicable
. Center for Infectious Diseases			
—Division of HIV/AIDS	13 to 19	None	Children under age 12 unlikely to become infected with the AIDS virus through sexual contact. Age 19 is still considered an adolescent.
. Center for Prevention Services			
—Division of Immunization	10 to 24	Early: 10 to 14. Middle: 15 to 19. Late: 20 to 24.	Standard age groups of the Census Bureau.
—Division of STDs and HIV Prevention	10 to 19. Data provided for adolescents ages 10 to 14 and 15 to 19.	None	For STD morbidity purposes, there are differences in infection rates between 10- *to* 14-year-olds and 15- to 19-year-olds.
—Division of Tuberculosis Control	10 to 19. Data provided for adolescents ages 10 to 14 and 15 to 19.	None	Age groups used by other CDC surveillance programs.
—National AIDS Information and Education Program	10 to 18	None	Selected on the advice of the Division of Adolescent and School Health and the advice of national youth-serving organizations.
• National Center for Health Statistics	No uniform definition. NCHS does collect data on all age groups, by individual year.	None	Not applicable

[c]Although the Division of Adolescent and School Health does not have a standard definition for early, middle, and late adolescence, the Division does distinguish between age groups in particular cases. For example! the "Guidelines for Effective School Health Education To Prevent the Spread of AIDS" includes information appropriate for early elementary, late elementary/middle school, and junior/senior high school students (18).

Continued on next page

Table 19-2-How Adolescence Is Defined by Different Federal Agencies and Their Components-Continued

Federal agency	Definition of adolescence	Distinctions between early, middle, and late adolescence	Reason(s) for definition or distinctions chosen
C. Health Resources and Services Administration			
. Office of Rural Health Policy	None. Does not collect data on adolescents.	None	Not applicable
. Bureau of Health Care Delivery and Assistance	Varies by program: Community/Migrant Health Center (C/M-HC): 10 to 19. Homeless: 15 to 19. Perinatal: <15 and 15 to 19. Substance abuse: 13 to 19.	None	C/MHC age grouping is based on those used by the Census Bureau. Others are program specific.
* Bureau of Maternal and Child Health and Resources Development@			
---Office of Maternal and Child Health	10 to 19	Distinguished only within program activities.	Based on Title V (Maternal and Child Health Services Block Grant) legislation and the recommendation of adolescent health professionals.
D. Indian Health Service	None. However, IHS health care providers accept the 10 to 19 definition. Data can be sorted by any age grouping.	None	Not applicable
E. National Institutes of Health			
• National Cancer Institute	12 to 19	Not provided	Not provided
• National Center for Nursing Research	13 to 18	Not provided	Not provided
• National Center for Research Resources	Puberty to maturity[a]	Not provided	Not provided
• National Eye Institute	Not provided	Not provided	Not provided
• National Heart, Lung, and Blood Institute	Generally, ages 12 to 18 for school-based programs. Ages 10 to 12 are considered preadolescents.	Not provided	Not provided
• National Institute of Allergy and Infectious Diseases	13 to 20	Not provided	Not provided
• National Institute of Arthritis and Musculoskeletal and Skin Diseases	12 to 21	Not provided	Not provided
• National Institute of Child Health and Human Development	Includes, but is not restricted to, ages 12 to 19.	Not provided	Not provided
• National Institute of Diabetes and Digestive and Kidney Diseases	12 to 21	Not provided	Not provided
• National Institute of Neurological and Communicative Disorders aid Stroke[e]	Period between late childhood and early adulthood. Most hospitals and other clinical centers conducting research supported by the institute consider those under 16 as children and those older than 16 as young adults.	Not provided	Not provided

[d] Following OTA's survey, the Bureau of Maternal and Child Health and Resources Development split into the Bureau of Maternal and Child Health and the Bureau of Health Resources Development (see fig. 19-1). Responses were received from the original Bureau.

[e] In 1990, the National Institute of Neurological and Communicative Disorders and Stroke split into two separate institutes: 1) the National Institute of Neurological Disorders and Stroke, and 2) the National Institute on Deafness and Other Communication Disorders.

Table 19-2-How Adolescence Is Defined by Different Federal Agencies and Their Components-Continued

Federal agency	Definition of adolescence	Distinctions between early, middle, and late adolescence	Reason(s) for definition or distinctions chosen
F. Off ice of the Assistant Secretary for Health			
* Office of Disease Prevention and Health Promotion	None	None	Not applicable
• Office of Population Affairs	None, but frequently targets 10- to 19-year-olds.	None, but recognizes that adolescents of different ages have varying degrees of need.	Uses data compiled by other agencies, such as the Census Bureau.
U.S. DEPARTMENT OF THE INTERIOR	Not provided	Not provided	Not provided
U.S. DEPARTMENT OF JUSTICE			
National Institute of Justice	None, but specific research projects may address issues relevant to particular groupings.	None	Not applicable
Office of Juvenile Justice and Delinquency Prevention	None[f]	None	Not applicable
U.S. DEPARTMENT OF LABOR			
Job Training Partnership Act Programs	Primarily ages 16 to 21. Limited programs for 14- to 15-year-olds.	Services for 14- and 15-year-olds are different than for 16- to 21-year-olds.	Legislatively mandated
Bureau of Apprenticeship and Training	Age 16 and over. Data can be obtained for different age groups, but is not routinely summarized in a report.	None	Not applicable
U.S. DEPARTMENT OF TRANSPORTATION			
Federal Highway Administration	Ages 10 to 20. Data stored by age so different age groupings possible.	Early: 10 to 14. Middle: 15 to 17. Late: 18 to 20.	Primarily because of driving/drinking cutoffs. The 15- to 17-year-olds are the learner/limited experienced drivers; the 18- to 20-year-olds are the more experienced drivers and before 1987 were often legal drinkers.
National Highway Traffic Safety Administration	None. Targets the 15- to 24-year-old group, especially those under 21. Age groups most frequently used in data collection, <15, 15 to 17, 18 to 20.	None	Ages 15 to 24 represent the most traffic fatalities, injuries, and years of life lost in almost every motor vehicle crash category.
NATIONAL TRANSPORTATION SAFETY BOARD	None	None	Not applicable

[f]Under Title II of the 1974 Juvenile Justice and Delinquency Prevention Act, as amended, the of fice relies on State laws to define the age of a juvenile for purpose of juvenile Or family court jurisdiction over delinquent conduct and noncriminal misbehavior (status offenses).

SOURCE: Office of Technology Assessment, 1991, based *on* Federal agency responses to the Office of Technology Assessment's 1989 questionnaire regarding adolescent health initiatives.

in the U.S. Department of Commerce, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) in the U.S. Department of Defense, the U.S. Department of Education, and programs within the U.S. Departments of Justice and Agriculture. Some Federal agencies that do not provide a specific adolescent defitition do collect data on various age groups, allowing outside researchers the opportunity to use their own adolescent age groups; these include the Bureau of the Census, the National Center for Health Statistics in DHHS, and the National Highway Traffic Safety Administration in the U.S. Department of Transportation.

Very few Federal agencies distinguish between early, middle, and late adolescence. Among those agencies that do have definitions, there appears to be greater agreement on the definition of early adolescence than on the definitions of middle and late adolescence (i.e., when one ends and the other begins). Federal agencies, including the Division of Immunization within the Centers for Disease Control of DHHS and the Office for Substance Abuse Prevention within the Alcohol, Drug Abuse, and Mental Health Administration of DHHS generally agree that early adolescence spans the ages of 10 to 14. For the Division of Immunization, late adolescence begins at age 20; for the Office for Substance Abuse Prevention, middle adolescence ends at age 17.

The reasons underlying Federal agencies' choice of definitions of adolescence (or lack thereof) are diverse. In some instances, State and Federal law require that adolescents of particular ages receive services. Thus, for example, the Bureau of Maternal and Child Health within the Health Resources and Services Administration of DHHS bases its definition of 10 to 19 years on Title V of the Social Security Act, which authorizes the maternal and child health block grant program.[1] Other Federal agencies, such as the Division of HIV/AIDS and the Division of Reproductive Health within the Centers for Disease Control, base their definitions of adolescence on their own practical experiences. The Federal Highway Administration of the U.S. Department of Transportation defines middle adolescence as ages 15 to 17 and late adolescence as ages 18 to 20, primarily because of the two age groups' differing driving experiences (i.e., 15- to 17-year-olds are considered inexperienced drivers).

The use of differing definitions of adolescence by Federal agencies is understandable and is not necessarily indicative of a problem. As discussed in Volume I, adolescence can be defined in physical, psychological, or social terms. In any event, chronological age is not necessarily consistent with any particular adolescent stage. Differing definitions of adolescence may be troublesome, however, if Federal agencies should be coordinating their efforts, or if some categories of adolescents (e.g., early adolescents, such as 10- and 11-year-olds) who should be receiving attention from a particular agency are excluded from their mission by definition.

Federal Programs and Expenditures for Adolescents

Given the various definitions of adolescence used by Federal agencies, and the way in which Federal funds are spent and distributed at the national, State, and local levels, determining the exact amount of money the Federal Government spends on adolescents is impossible. Some Federal agencies serve adolescents as part of a larger population group receiving Federal funds, so their expenditures on adolescents are unknown. The U.S. Consumer Product Safety Commission and the U.S. Department of Agricultures Food and Nutrition Service, for example, serve adolescents but do not have specific funds set aside for them. In order to give States greater control in planning, programming, and spending for programs, some Federal funds are distributed to States through block grants. Federal block grant funding is provided for maternal and child health services, social services, education, and alcohol, drug abuse, and mental health services. The provision of funding through block grant programs limits the Federal Government's ability to analyze expenditures on services or programs targeted to specific populations, such as adolescents.

Sometimes, Federal agency priorities are set by the U.S. Congress. Recently, for example, congressional funding decisions have led DHHS to increase its emphasis on activities related to the conse-

[1] *Block grants* are sums of Federal funds allotted to State agencies (e.g., education, health) which maybe passed onto local agencies. States determine the mix of services provided and the population served and are accountable to the Federal Government only to the extent that funds are spent in accordance with program requirements. Sometimes, however, set-asides are required for specific population groups.

quences of adolescent sexual intercourse and illicit drug use. Activities related to the prevention and control of other more prevalent conditions among adolescents, such as injuries, have received relatively little emphasis.

Federal programs and expenditures targeting adolescents within DHHS and other selected Federal agencies are discussed at greater length below. A summary of estimated expenditures by the agencies with the largest roles in adolescent health (broadly defined) can be found in figure 19-1.

U.S. Department of Health and Human Services: Programs and Expenditures for Adolescents

Many DHHS agencies assist or have the potential to assist adolescents through a wide range of social services, health services, and welfare programs, as well as through research and demonstration projects (see figure 19-2). In terms of expenditures for adolescents, however, the Office of Human Development Services and four agencies in the Public Health Service-the Alcohol, Drug Abuse, and Mental Health Administration, the Centers for Disease Control, the Health Resources and Services Administration, and the National Institutes of Health —provide the bulk of adolescent services and programs (see table 19-3).[2] Additional agencies within DHHS, some of which are discussed below, support activities that target or include adolescents.

Family Support Administration

The Family Support Administration of DHHS is responsible for programs intended to strengthen the American family. The Family Support Administration has six major programs, but the primary program affecting adolescents is Aid to Families With Dependent Children (AFDC).[3]

The AFDC program, established in 1935, is a cash assistance program serving needy families with children and is funded jointly by Federal and State governments. States administer the program within broad Federal guidelines, and the Federal Government provides quality control and compliance reviews. The fiscal year 1989 AFDC budget totaled $17.245 billion (103).

To help families meet financial needs and become self-sufficient, all States were required to implement a Job Opportunity and Basic Skills (JOBS) training program by October 1, 1990, under the Family Support Act of 1988. The program gives families receiving AFDC payments the opportunity to take part in education, job training, and work experience programs. As they do with AFDC, States have flexibility to determine the types of services they offer (59).

Under the Family Support Administration's discretionary community service grants program, the Office of Community Services provides an annual grant to the National Collegiate Athletic Association for the National Youth Sports Program, which is a summer recreational program for adolescents from low-income families (32).[4] Hygiene and nutritional information is presented as part of the program. In fiscal year 1990, over $27 million was expected to be awarded for new discretionary community service grants (55 FR 10297).5 Additionally, community food and nutrition programs include adolescents as part of their service group. Adolescents may also be included as recipients under the emergency community services of the homeless grant program, which distributes funds to 57 States and territories (60). Under this program, States award all funds to community agencies to meet the health needs (e.g., followup and long-term assistance and social services) of homeless individuals, including adolescents.

Health Care Financing Administration

One of the functions of the Health Care Financing Administration of DHHS is to administer the Medicaid program. Medicaid was established in 1965 under Title XIX of the Social Security Act to assist States in providing health care (e.g., inpatient and outpatient medical services, family planning services, prenatal care) to the poor (80,81).

---

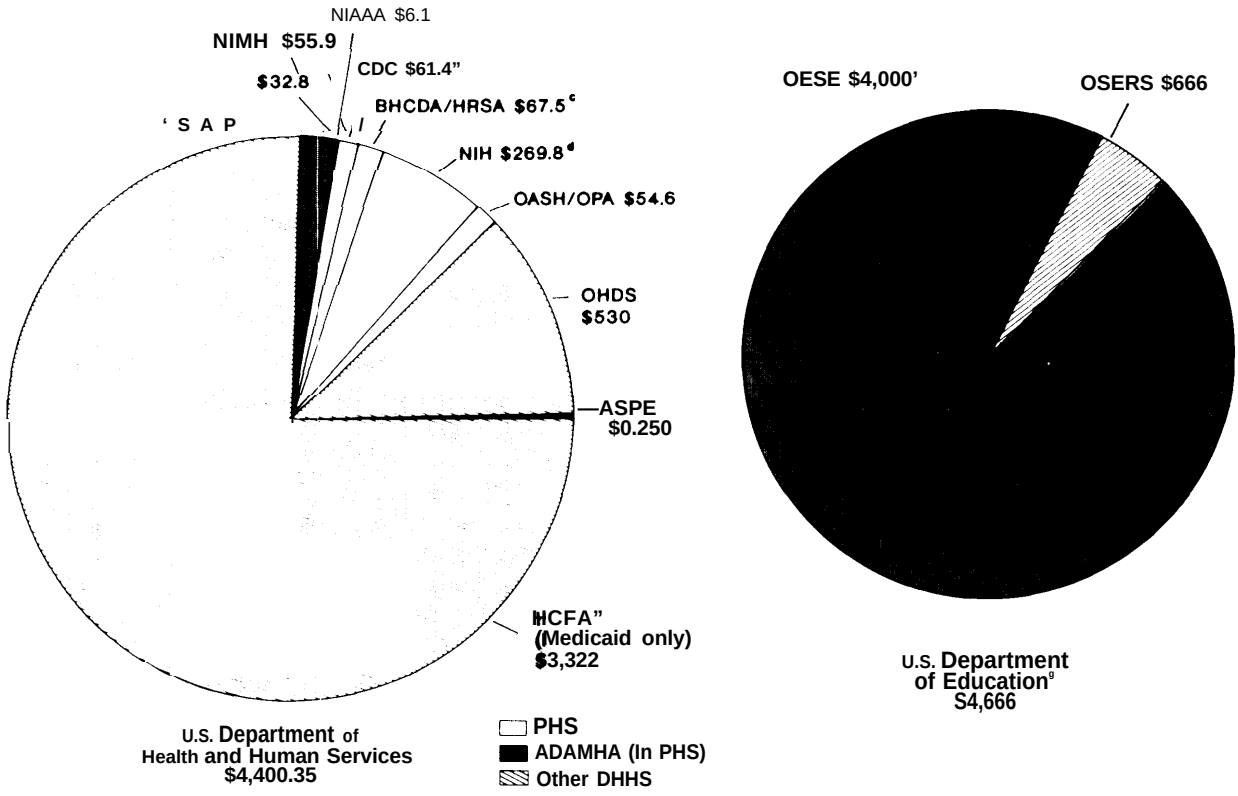
[2]Within these agencies are specific programs having adolescents as a primary focus. These include tbe Division of Adolescent and School Health within the Centers for Disease Control, the Bureau of Maternal and Child Health within the Health Resources and Services Administration, and the National Institute of Child Health and Human Development within the National Institutes of Health.

[3]The other five programs are Job Opportunity and Basic Skills (JOBS) Training, child support enforcement, refugee and entrant assistance, community services block grant, and low-income home energy assistance (59).

[4]Another grant program is the community services block grant program where grants are provided to States, territories, Indian tribes, and tribal organizations primarily for employment, education, housing, health, and the poor.

[5]This amount does not represent the amount being given to support continuation grants of past projects (103).

Figure 19-1—Estimated Adolescent-Specific Expenditures by U.S. Executive Branch Agencies Responding to OTA's 1989 Survey (dollars are In millions)



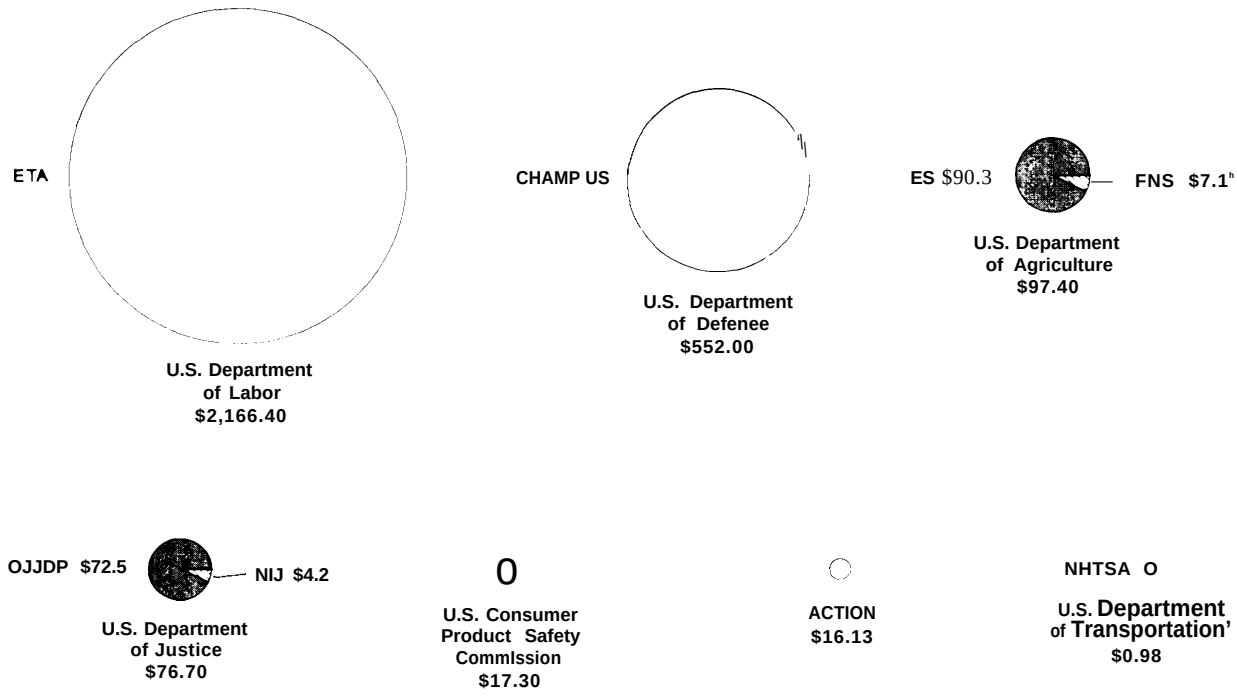
NOTE: Graphs are not drawn to scale. [differences in size are designed to provide rough estimates of differences in adolescent-specific expenditures only.

Key to abbrevations:

ADAMHA—Alcohol, Drug Abuse, and Mental Health Administration
ASPE—Assistant Secretary for Planning and Evaluation
BHCDA—Bureau of Health Care Delivery and Assistance
BMCH—Bureau of Maternal and Child Health
CCDPHP—Center for Chronic Disease Prevention and Health Promotion
CDC—Centers for Disease Control
CEHIC—Center for Environmental Health and Injury Control
CHAMPUS—Civilian Health and Medical Program of the Uniformed Services
CID—Center for Infectious Diseases
CPS—Center for Prevention Services
DI—Division of Immunization
DTC—Division of Tuberculosis Control
ES—Extension Service
ETA—Employment and Training Administration
FNS—Food and Nutrition Service
FSA—Family Support Administration
HCFA—Health Care Financing Administration
HRSA—Health Resources and Services Administration
IHS—Indian Health Service
NAIEP—National AIDS Information and Education Program
NIAAA—National Institute on Alcohol Abuse and Alcoholism
NIDA—National Institute on Drug Abuse
NIH—National Institutes of Health
NIJ—National Institute of Justice
NIMH—National Institute of Mental Health
NHTSA—National Highway Traffic and Safety Administration
OASH—Office of the Assistant Secretary for Health
ODPHP—Office of Disease Prevention and Health Promotion
OESE—Office of Elementary and Secondary Education
OHDS—Office of Human Development Services
OJJDP—Office of Juvenile Justice and Delinquency Prevention
OMH—Office of Minority Health
OPA—Office of Population Affairs
ORHP—Office of Rural Health Policy
OSAP—Office of Substance Abuse Prevention
OSERS—Office of Special Education and Rehabilitative Services
OSH—Office of Smoking and Health
OTI—Office of Treatment Improvement
PHS—Public Health Service
SSA—Social Security Administration

[a]The following agencies within DHHSwere unable to provideOTA with the amount spent on adolescents alone: Family Support Administration, Social Security Administration, Indian Health Service, National Institute on Drug Abuse(ADAMHA, PHS), Office of Treatment Improvement (ADAMHA, PHS), National AIDS Information Education Program (CDC, PHS), Office of Safety and Health (CCDPHP, CDC, PHS), Division of immunization (CPS, CDC, PHS), Division of Tuberculosis Control (CPS, CDC, PHS), Office of Rural Health Policy (HRSA, PHS), Bureau of Maternal and Child Health (HRSA, PHS), Bureau of Health Resources Development (HRSA, PHS), Office of Disease Prevention and Health Promotion (OASH, PHS), Office of Minority Health (OASH, PHS).

[b]This figure includes $33.3 million spent bythe Division of Adolescent and School Health (CCDPHP), $0.45 million spent bythe Division of Reproductive Health (CCDPHP), $23.7 million spent by the Division of STD/HIV Prevention (CPS), $0.525 million spent by the Division of HIV/AIDS (CID), $3.3 million spent by Division of Injury Control (CEHIC), and $0.156 spent by the Division of Prevention Programs (CEHIC).



cThis figure indudes expenditures by the Bureau of Health Care Delivery and Assistance only. Expenditures on adolescents by other subagencies (e.g., the Bureau of Maternal and Child Health) within HRSA were not provided to OTA.

dThisfigure indudes:$19.5 million spent by the National Cancer Institute, $0.148 million spent by the National Center for Nursing Research, $2.1 million spent by the National Center for Research Resources, $15.4 million spent by the National Heart, Lung, and Blood Institute, $98.2 million spent by the National Institute of Allergy and Infectious Diseases, $0.784 million spent by the National Institute of Arthritis and Musculoskeletal and Skin Diseases, $25.1 million spent by the National Institute of Child Health and Human Development, $26.6 million spent by the National Institute of Diabetes and Digestive and Kidney Diseases, $1.3 million spent by the National Institute of Neurological Disorders and Stroke. All are estimates.

eNote that the figure of &,322 millionincludes both Federal and State contributions to Medicaid spending for adolescents. At OTA's request, HCFA estimated the amount of Medicaid spending for adolescents in fiscal year 1988 (see app. C in this volume). However, HCFA did not calculate the Federal and State shares separately. As discussed in ch. 16 in this volume, many factors could affect estimates of the State share.

fThis is a very rough estimate by OTA. The Office of Elementary and Secondary Education dispenses most of the funds that are spent by the U.S. Department of Education. The Office has no specific line items for adolescents, because it distributes grants to schools and other organizations for various programs that are not aimed at a particular age group. In 1989, the Office of Elementary and Secondary Education disbursed $6.6 billion for all activities. OTA's estimate is based on the assumption that 10-to 1 8-year-olds are attending grades 5 through 12, which constitute 66.6 percent of elementary and secondary grades, not including kindergarten. Two-thirds of $6.6 billion is $4.4 billion. Since the percentage of adolescents attending school is likely to be lower than the percentage of younger children attending school, this estimate maybe too high. OTA estimates, therefore, that the Office of Elementary and Secondary Education spends about $4 billion on education of adolescents. However, this estimate does not take into account that the cost of adolescents' education may be higher than that of younger students (e.g. more highly trained teachers, more sophisticated lab equipment).

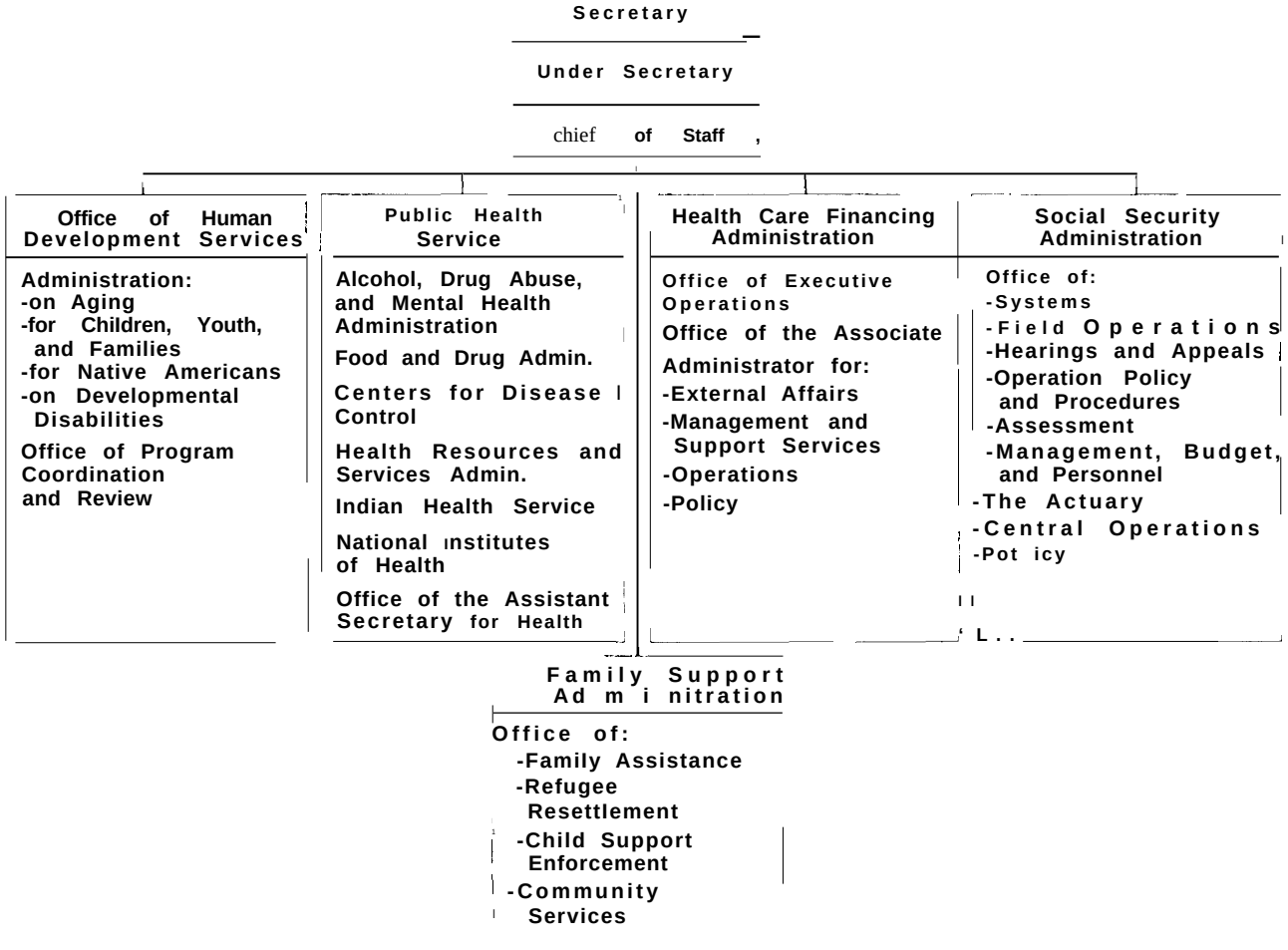
gThis figure does not indude spending by the following offices within the U.S. Department of Education that also serve adolescents: Office of Bilingual Education and Minority Languages Affairs, Office of Planning, Budget, and Evaluation, Office of Postsecondary Education, Office of Vocational and Adult Education. These offices were not able to provide OTA with estimates of spending on adolescents.

hThis is a very rough estimate by OTA. The figure was tabulated by using the following percentages on how many adolescents were served in the respective programs: 43 *percent of* the participants in the National School Lunch Program are in grades 7 through 12; 24 percent of those in the School Breakfast Program are in grades 7 through 12; 23 percent of those in the Summer Food Service Program are ages 13 to 18; 3 percent of those participating in the Supplemental Food Program for women, Infants, and Children are pregnant, breastfeeding, or postpartum females *underage 18;* and 34 percent of participants in the Food Stamp Program are between the ages of 15 and 17.

iThis figure does not include the Federal Highway Administration, which also serves adolescents.

SOURCE: Office of Technology Assessment, 1991, based on various responses to the Office of Technology Assessment's 1989 questionnaire regarding adolescent health initiatives, Washington, DC, 1989.

Figure 19-2—U.S. Department of Health and Human Services[a]



[a]See text concerning April 1991 proposed reorganization.

SOURCE: Based on U.S. Department of Health and Human Services, organizational chart, Washington, DC, 1990.

In fiscal year 1988, Federal and State spending on Medicaid benefits was $48.4 billion, which includes expenditures for adolescents.[6] Adolescents ages 10 to 18 are eligible for Medicaid coverage if they meet the requirements for AFDC, if they are deemed ''medically needy" by their State, or if they meet other conditions outlined by their particular State. Therefore, which adolescents are eligible for Medicaid coverage varies a great deal from State to State. In fiscal year 1988, 4.58 million adolescents between ages 10 and 18 made up 17.1 percent of all Medicaid recipients; expenditures for adolescents in fiscal year 1988 represented 6.9 percent or $3.32 billion of Federal and State Medicaid expenditures (83).

Office of Human Development Services

The Office of Human Development Services of DHHS is the primary social service agency with programs for adolescents (see figure 19-3). In addition to administering Social Security Act Title XX social services block grants to the States,[7] the Office of Human Development Services supports activities that affect adolescents through its Administration on Children, Youth, and Families. This Administration provides Federal support for child welfare services and supports runaway and homeless youth centers.[8] In 1989, the amendments to the Drug Abuse Education and Prevention Act (Public Law 101-93) established and funded two new grant programs under the Office of Human Development Services for education and prevention efforts that target runaway and homeless youth and members of youth gangs.

The Office of Human Development Services' Administration for Native Americans has supported projects related to drug and alcohol abuse prevention among Native Americans. The Office of Human Development Services' Administration on Developmental Disabilities supports the development and coordination of programs for developmentally disabled persons, including adolescents. Recently, the Office of Human Development Services has used a portion of its discretionary money to support initiatives intended to help adolescents avoid alcohol and drug use, complete high school, and postpone pregnancy. In fiscal year 1989, the Office of Human Development Services spent approximately 7.7 percent ($530 million) of its total budget of $6.82 billion on adolescents.

Public Health Service

As noted earlier, four agencies within the Public Health Service of DHHS provide many of the services and programs for adolescents: the Alcohol, Drug Abuse, and Mental Health Administration, the Centers for Disease Control, the Health Resources and Services Administration, and the National Institutes of Health.

Alcohol, Drug Abuse, and Mental Health Administration—Within the Alcohol, Drug Abuse, and Mental Health Administration, five agencies fund diverse activities concerning adolescents (see figure 19-4):

- the National Institute on Alcohol Abuse and Alcoholism,
- the National Institute on Drug Abuse,
- the Office for Substance Abuse Prevention,
- the National Institute of Mental Health, and
- the Office of Treatment Improvement.

Although the priority areas of the agencies within the Alcohol, Drug Abuse, and Mental Health Administration address large societal problems (e.g., alcohol and drug abuse and mental health disorders), the prevention and treatment of these problems among adolescents is seen by the agencies as an important goal.[9]

The National Institute on Alcohol Abuse and Alcoholism, for example, has three priority areas specific to adolescents: defining sociocultural factors that promote adolescents' drinking, developing and testing preventive interventions, and assessing the impact of changes in the drinking age on alcohol consumption (39,65). In fiscal year 1989, the National Institute on Alcohol Abuse and Alcoholism

[6]For further *discussion* of Medicaid, see ch. 16, ''*Financial* Access to Health Services,'' in this volume.

[7]Services supported by social services block grants to States include protective and emergency services, employment, education, and training services for disabled adolescents, foster care and adoption services, and health related services (e.g., prevention, intervention, information, referral, and residential care and treatment). Although service recipients may be of any age group, adolescents receive a significant amount of these services (34).

[8]For further discussion of these centers, see ch. 14, "Hopelessness: Prevention and Services," in Vol. II.

[9]For a discussion of alcohol and drug abuse and mental health problems among adolescents, see ch. 12, "Alcohol, Tobacco and Drug Abuse: Prevention and Services," and ch. 11, "Mental Health Problems: Prevention and Services," in Vol. II.

Table 19-3-Components of the Expenditures on Adolescent Health by the U.S. Department of Health and Human Services

DHHS agency with actual or potential role in adolescent health	Total expenditures (most current fiscal year)	Estimated expenditures for adolescents (most current fiscal year)	Percent of expenditures for adolescents
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION	$12,000,000 (1989)[a]	$250,000 (1989)	2 percent
FAMILY SUPPORT ADMINISTRATION	Not provided	Not provided	Not provided
HEALTH CARE FINANCING ADMINISTRATION	$118,200,000,000 (1988)	$3,322,000,000 [b]	Not provided
OFFICE OF HUMAN DEVELOPMENT SERVICES	$6,817,162,000 (1989)'	$530,000,000 (1989)	7.7 percent
PUBLIC HEALTH SERVICE	Not provided	Not provided	Not provided
Alcohol, Drug Abuse, and Mental Health Administration	$2,700,000,000 (1990)	Not provided	Not provided
• National Institute on Alcohol Abuse and Alcoholism	$125,200,000 (1989)	$6,138,353 (1989)	4.9 percent
. National Institute on Drug Abuse	$379,000,000 (1990)	Not provided	Not provided
. National Institute of Mental Health	$454,604,000 (1989)	$55,947,000 (1989)	12 percent
• Office for Substance Abuse Prevention	$193,000,000 (1990)	$32,800,000 (1990)	17 percent[c]
• Office for Treatment Improvement	$1,268,700,000 (1990)[d]	Not provided	Not provided
Centers for Disease Control	$978,781,000 (1989)	$61,416,000 (1989)[e]	6.2 percent
. Center for Chronic Disease Prevention and Health Promotion	Not provided	Not provided	Not provided
—Division of Adolescent and School Health	$33,300,000 (1989)	$33,300,000 (1989)	100 percent
—Division of Reproductive Health	Not provided	$450,000 (1989)	10 percent[f]
~-Office on Smoking and Health	Not provided	Not provided	Not provided
• Center for Environmental Health and Injury Control	Not provided	Not provided	Not provided
—Division of Injury Control	$21,800,000 (1989)[c]	$3,270,000 (1989)[cg]	15 percent[c]
—Disabilities Prevention Program	Not provided	$158,000 (1989)	Not provided
• Center for Infectious Diseases	Not provided	Not provided	Not provided
—Division of HIV/AIDS	Not provided	$525,000 (1989)	Not provided
• Center for Prevention Services	Not provided	Not provided	Not provided
—Division of Sexually Transmitted Diseases and HIV Prevention	Not provided	$23,713,200 (1989)	Not provided
—Division of Immunization	Not provided	Not provided	Not provided
—Division of Tuberculosis Control	Not provided	Not provided	Not provided
. National AIDS Information and Education Program[g]	Not provided	Not specified	Not available

aA, additional $2 million is allocated every 2 years to the Institute for Research on Poverty (36). The money is appropriated from Congress to the Institute through the Assistant Secretary for Planning and Evaluation.
bFigure shorn is the proportion of Medicaid funding directed to adolescents only, as calculated for the Office of Technology Assessment by the Health Care Financing Administration. The figure includes both State and Federal Medicaid spending. For further discussion of Medicaid, see eh. 16, "Financial Access to Health Services," in this volume.
cEstimated amount.
dEighty-nine percent ($1.133 billion) of these funds are distributed to States as block grants.
eAdolescent expenditure total includes only those Centers for Disease Control agencies providing this information in response to the Off ice of Technology Assessment's survey. Several surveyed agencies did not provide adolescent-specific data, and the National AIDS Information and Education Program could not calculate an amount directed at adolescents.
fTen percent of the Division's staff time is being devoted to evaluation or analysis of adolescent data.
9No budget line item specific to adolescents.
h"Not specified" indicates that adolescents are included as part of a larger target group. Thus, expenditures cannot be separated out for that particular group.

spent over $6 million (under 5 percent) of its overall budget on activities aimed at adolescents. Current activities focus on adolescent risk-taking and alcohol abuse, the effects of parental and family influences, peer pressure, decisionmaking skills, and personality variables on high school and college students' drinking habits as well as preventive intervention efforts and the impact of parenting-skills training (65,68). Other efforts address the causes, consequences, and treatment of alcohol use (68).10

The National Institute on Drug Abuse studied the causes, consequences, and treatment of adolescent drug abuse throughout the 1980s and funded over

10The National Institute on Alcohol Abuse and Alcoholism recently announced its interest in funding an Adolescent Alcohol Research Center which would integrate identification of interactions between adolescent development and alcohol use and testing behavioral and other technologies alcohol problems. Any non-Federal public or private nonprofit organization could request up to $1.5 million to be awarded annually for 5 years (66). The starting date of the Center would be Dec. 1, 1990. Additionally, in 1988, the National Institute on Alcohol Abuse and Alcoholism announced interest in studying norm-setting related to alcohol use by parents and families, physicians and their staff, youth peer groups, schools, and co organizations, but did not allocate specific funds to this activity (64).

Table 19-3-Components of the Expenditures on Adolescent Health by the U.S. Department of Health and Human Services-Continued

DHHS agency with actual or potential role in adolescent health	Total expenditures (most current fiscal year)	Estimated expenditures for adolescents (most current fiscal year)	Percent of expenditures for adolescents
Health Resources and Services Administration	Not provided	Not provided	Not provided
• Office of Rural Health Policy	$1,400,000 (1988)	Not available	Not provided
. Bureau of Health Care Delivery and Assistance[i]	$397,058,800 (1989)[i]	$67,500,000 (1989)[j]	17 percent
• Bureau of Maternal and Child Health and Resources Development	Not provided	Not provided	Not provided
Office of Maternal and Child Health[k]	$573,848,000 (1989)[l]	Not available	Not provided
Indian Health Service[m]	$1 ,020,106,000(1 989)	Not specified	Not available
National Institutes of Health[n]	$7,144,764,000 (1989)	Not provided	Not provided
. National Cancer Institute	$1,468,435,000 (1988)	$19,490,000 (1988)	1.3 percent
• National Center for Nursing Research	$23,361,000 (1988)	$148,000 (1988)	0.6 percent
. National Center for Research Resources	$344,150,000 (1988)	$2,054,000 (1988)	0.6 percent
• National Heart, Lung, and Blood Institute	$965,283,000 (1988)	$15,464,000 (1988)	1.6 percent
. National Institute of Allergy and Infectious Diseases	$638,521,000 (1988)	$98,150,000 (1988)	15 percent
. National Institute of Arthritis and Musculoskeletal and Skin Diseases	$147,543,000 (1988)	$754,000 (1988)	0.5 percent
• National Institute of Child Health and Human Development	$377,167,000 (1988)	$25,093,000 (1988)	6.6 percent
• National Institute of Diabetes and Digestive and Kidney Diseases	$534,400,000 (1988)	$26,600,000 (1988)	5 percent
• National Institute of Neurological and Communicative Disorders and Stroke[p]	$458,792,000 (1988)	$1,327,000 (1988)	0.3 percent
Office of the Assistant Secretary for Health			
• Office of Disease Prevention and Health Promotion	$4,900,000 (1989)	Not provided	Not provided
• Office of Minority Health	$8,000,000 (1990)	Not provided	Not provided
• Office of Population Affairs[q]	$139,928,205 (1989)	$54,572,000 (1989)	39 percent
SOCIAL SECURITY ADMINISTRATION	Not provided	Not provided	Not provided

[i]These data were obtained from R. Abrams, Bureau of Health Care Delivery and Assistance (l).
[j]Although specific funding is not available for adolescent initiatives, the adolescent-specific amount is based on the average number of adolescent medical visits in community/migrant health center programs during 1988.
[k]Following OTA's survey in 1989, the Bureau of Maternal and Child Health and Resources Development split into the Bureau of Maternal and Child Health, formerly the office of Maternal and Child Health, and the Bureau of Health Resources Development (see fig. 19-1). Responses were reeeivedfromthe original Bureau.
[l]Approximately 80 percent of these funds are distributed to States as block grants.
[m]These data were obtained from G. Brenneman, Indian Health Service (11) and J.M. Lyle, Indian Health Service (23).
[n]The NIH total includes all NIH agencies, not just those able to estimate expenditures on adolescent health initiatives. The 1989 estimate for expenditures is from the Budget of the U.S. Government (102a).
[o]These data were obtained from D. Levenson, National Institute of Child Health and Human Development (21).
[p]In 1990, the National Institute of Neurological and Communicative Disorders and Stroke split into two separate institutes: 1) the National Institute of Neurological Disorders and Stroke, and 2) the National Institute on Deafness and Other Communication Disorders.
[q]These data were obtained from R. Scholle, Office of Population Affairs (37).

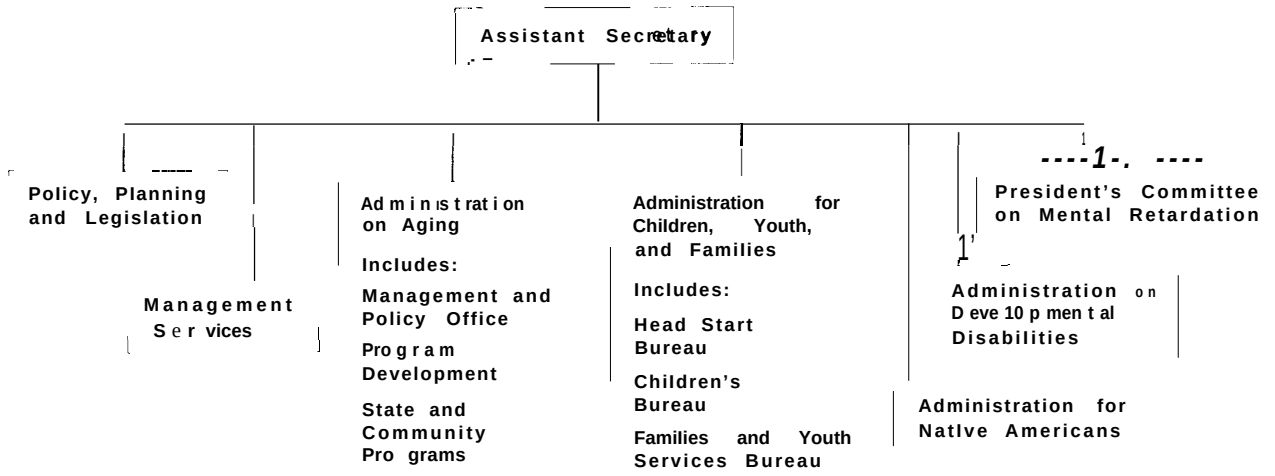
SOURCE: Office of Technology Assessment, 1991, based on Federal agency responses to the Office of Technology Assessment's 1989 questionnaire regarding adolescent health initiatives.

160 projects for 7- to 17-year-olds (68,70,73-75).[11] In fiscal year 1990, appropriations for the National Institute on Drug Abuse were $379 million (71). Information on the proportion being spent on adolescents was not available. Recently, the National Institute on Drug Abuse, in conjunction with the U.S. Department of Education, released a program announcement encouraging organizations to study innovative and theory-based drug abuse prevention programs in the schools or to evaluate currently ongoing school-based programs. Additionally, the National Institute on Drug Abuse is interested in granting money to a minority drug abuse prevention research center targeting high-risk children, adolescents, and young adults (74). Organizations can request support for up to 5 years. First-year awards were to be for $600,000, and $750,000 for each subsequent year.

Under the authority of the Anti-Drug Abuse Acts of 1986 and 1988 (Public Laws 99-570 and 100-

[11]The National Institute on Drug Abuse's overall priorities, mandated by Congress, for fiscal year 1991 are acquired immunodeficiency syndrome (AIDS) prevention improving drug abuse treatment and prevention, and studying maternal drug abuse and its effect on children.

Figure 19-3-U.S. Department of Health and Human Services, Office of Human Development Services[a]



[a]See text concerning April 1991 proposed reorganization.

SOURCE: *Federal Organization Service:* Civil(Washington DC: Carroll Publishing Co., February/March 1990).

690), the Office for Substance Abuse Prevention's general priority areas for the May 1989 review cycle (this includes fiscal year 1989 and the beginning of fiscal year 1990) were high-risk youth, pregnant and postpartum women and children, community youth activities, and a community partnership prevention program.[12] Office for Substance Abuse Prevention grants are designed to identify promising strategies for working with youth who are at high risk for alcohol and other drug use.[13] Forty-five percent ($5.6 million) of the high-risk youth grants focus on adolescents ages 12 to 20, and approximately 39 percent ($5.9 million) of the community youth activities grants focus on adolescents who are at risk of dropping out of school or being involved with gangs. The Office for Substance Abuse Prevention's budget increased substantially from about $69 million in fiscal year 1989 to $193 million in fiscal year 1990 (79).

The National Institute of Mental Health has several programs with an interest in adolescents. Two of the immediate goals of the National Institute of Mental Health's Division of Clinical Research are to address all of the major mental disorders of adolescents, such as affective and anxiety disorders, youth suicide, learning disorders, and mental illness/mental retardation, and to increase studies on the effectiveness of treatment, particularly in the area of adolescent depression. The Division also wants to expand the availability of manpower in the area of research on adolescent disorders by expanding research training and research career development support.[14] The National Institute of Mental Health's Child and Adolescent Service System Program (CASSP) under the Division of Applied and Services Research (formerly the Division of Education and Service Systems Liaison) tries to improve systems for service delivery to severely emotionally disturbed adolescents under age 18 by changing the way communities and States deliver services (e.g., improving the availability of continuums of care and involving parents and families) (76,78).[15] In 1989,

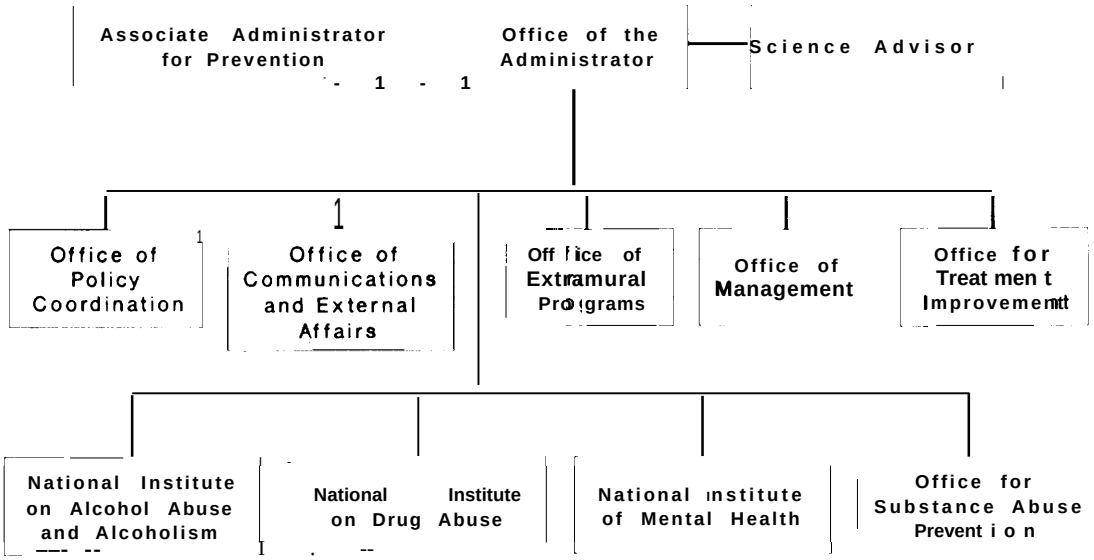
[12]The Office fo, Substance Abuse Prevention funds only demonstration projects. Individuals interested in research projects are encouraged to apply to other agencies.

[13]One Office for Substance Abuse Prevention program, the Community Partnership program, attempts to bring together all the knowledge gained from grant programs focused on individual target groups and apply this knowledge systematically to entire communities using public/private partnerships. Approximately $50 million was proposed in fiscal year 1990 for grants to 150 to 200 communities.

[14]The Antisocial and Violent Behavior Branch of the Division of Biometry and Applied Sciences has as a research priority the prevention of antisocial and highly aggressive behavior in childhood and adolescence. The Division of Education and Service Systems Liaison priorities included State-level service system development and service delivery to all children and adolescents.

[15]Demonstration projects under CASSP are funded under four types of grants: capacity building, State- and community-level system development, and strategy evaluation grants (77). In fiscal year 1989,$200,000 *was* available for 4 State capacity building projects, $2 million for 12 new State- and community-level projects, $300,000 for 10 Nate-level strategy evaluation grants, $1.3 million for 8 renewal projects, and $900,000 for 31 strategy evaluation supplements. No guarantee was available for funding beyond the first year (77).

Figure 19-4--U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration



SOURCE: U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, Rockville, MD, organizational chart, 1990.

CASSP projects were in 42 States and 11 localities for a total of $9.8 million, of which $1 million was targeted to services research for the homeless (78).

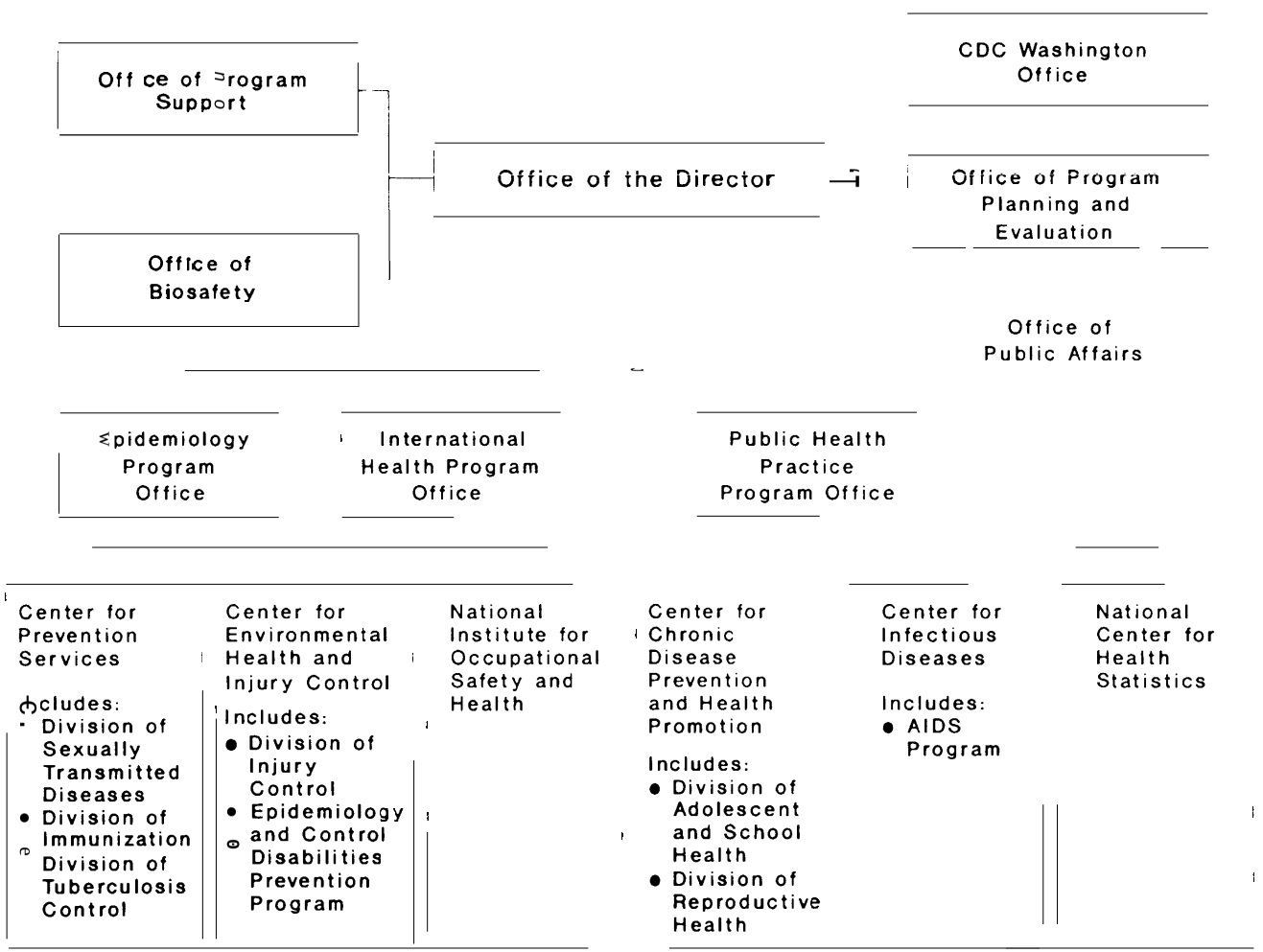
Finally, the new Office for Treatment Improvement within the Alcohol, Drug Abuse, and Mental Health Administration is responsible for improving the quality of treatment services for individuals suffering from drug abuse and other problems, such as alcoholism and physical and mental illness (72). The Office for Treatment Improvement administers alcohol, drug abuse, and mental health services block grants to States for application in the areas of mental health and substance abuse. In fiscal year 1990, Congress appropriated $1.133 billion for such block grants, $237.5 million for use in mental health and $895.6 million for use in substance abuse (17). Fiscal year 1990 appropriations for the Office for Treatment Improvement, apart from block grant funding, were $135.7 million. The Office is funding a grant demonstration program which targets three critical populations: adolescents, racial and ethnic minorities, and residents of public housing projects. The projects in this program are Model Comprehensive Treatment Programs for Critical Populations ($25 million in funding in 1990), cooperative Agreements for Drug Abuse Treatment Improvement Projects in Target Cities ($28 million in funding in 1990), and Model Drug Abuse Treatment Programs for Non-Incarcerated Criminal Justice Populations ($8 million in funding in 1990) (6).

Centers for Disease Control—Within the Centers for Disease Control, numerous programs, particularly the Division of Adolescent and School Health within the Center for Chronic Disease Prevention and Health Promotion, respond to various health needs of adolescents (see figure 19-5).[16] The Centers for Disease Control agencies responding to OTA's survey[17] indicated that for fiscal year 1989, approximately $61 million was targeted specifically for

[16]Originally, the Division of Adolescent and School Health was the Office of School Health and Special Projects whose mission was to develop a national school health program for the prevention of human immunodeficiency virus (HIV)/AIDS. In October 1988, the Center for Chronic Disease Prevention and Health Promotion was created, and the Office of School Health and Special Projects was elevated to become the Division of Adolescent and School Health.

[17]Centers for Disease Control agencies that responded to OTA'S questionnaire included the Center for Chronic Disease Prevention and Health Promotion, Center for Environmental Health and Injury Control, Center for Infectious Diseases, Center for Prevention Services, and the Deputy Director, HIV.

Figure 19-5—U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control



SOURCE: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, organizational chart, Atlanta, GA, Aug. 1, 1990.

adolescents, representing about 6 percent of the Centers for Disease Control's total budget.[18]

Major adolescent-health related programs administered by the Centers for Disease Control include the following:

- the Youth Risk Behavior Surveillance System that provides national, State, and local data about the incidence and prevalence of risk behaviors (e.g., behaviors resulting in unintentional injuries, human immunodeficiency virus (HIV) infection and other sexually transmitted diseases (STDs), alcohol and drug use, tobacco use, improper diet, and insufficient physical activity) among students in 9th to 12th grade;
- reimmunization programs for the prevention of measles, mumps, and rubella in junior high and high school students;
- initiatives for injury prevention and control;
- activities to prevent or minimize complications for adolescents with diabetes;
- water fluoridation activities (not limited to adolescents);
- funding of the Southwest Center for Prevention Research at the University of Texas at Houston, focusing on the physical and psychological health of children and adolescents;
- support for the 1987 National Adolescent Student Health Survey, which assessed 8th and 10th grade students' knowledge, attitudes, and behaviors related to health (e.g., nutrition, alcohol and tobacco use, STDs, injury prevention, suicide, violence) (5);[19]
- National Health and Nutrition Examination Survey and the National Health Interview Survey, which incorporate nutrition and health data on adolescents (18);
- cooperative agreements with national, State, and local education agencies to implement HIV education for in- and out-of-school adolescents;
- adolescent health data collection by the National Center for Health Statistics;
- HIV seroprevalence surveys to determine the magnitude of infection within the adolescent population; and
- the phase of the 'America Responds to AIDS multimedia campaign targeting parents and youth.

The Centers for Disease Control appears to be spending most of its adolescent health-related money addressing health problems associated with sexual intercourse (e.g., pregnancy and the transmission of HIV and STDs). For example, although the mission of the Division of Adolescent and School Health is to identify, monitor the prevalence of, and implement interventions to reduce health risks[20] among adolescents, most of the Division's funding has been provided to prevent HIV infection. Therefore, its current priority area is to help schools develop effective educational programs to prevent the spread of HIV. On the other hand, in 1989 the Division of Injury Control within the Centers for Disease Control's Center for Environmental Health and Injury Control was allocated much less money, only $3.27 **million** (approximately 15 percent of the Centers for Disease Control's injury budget), for the prevention and control of injuries among adolescents (e.g., youth suicide, homicide, and motor-vehicle related injuries), by far the largest killer of adolescents (24).

Health Resources and Services Administration—The Bureau of Maternal and Child Health (formerly the Office of Maternal and Child Health[21]), within the Health Resources and Services Administration, administers the maternal and child health block grant program authorized by Title V of the Social Security Act (see figure 19-6).[22] Eighty-five percent of the $526.6 million appropriation for the program in fiscal year 1988 was allocated to States for

[18]Proportion is based only on those agencies within the Centers for Disease Control responding to OTA's survey. These are the Division of HIV/AIDS, Division of Adolescent and School Health, Division of Reproductive Health, Division of Injury Control, Disabilities Prevention Program, and the Division of Sexually Transmitted Diseases and HIV Prevention. Several surveyed agencies did not provide adolescent-specific data.

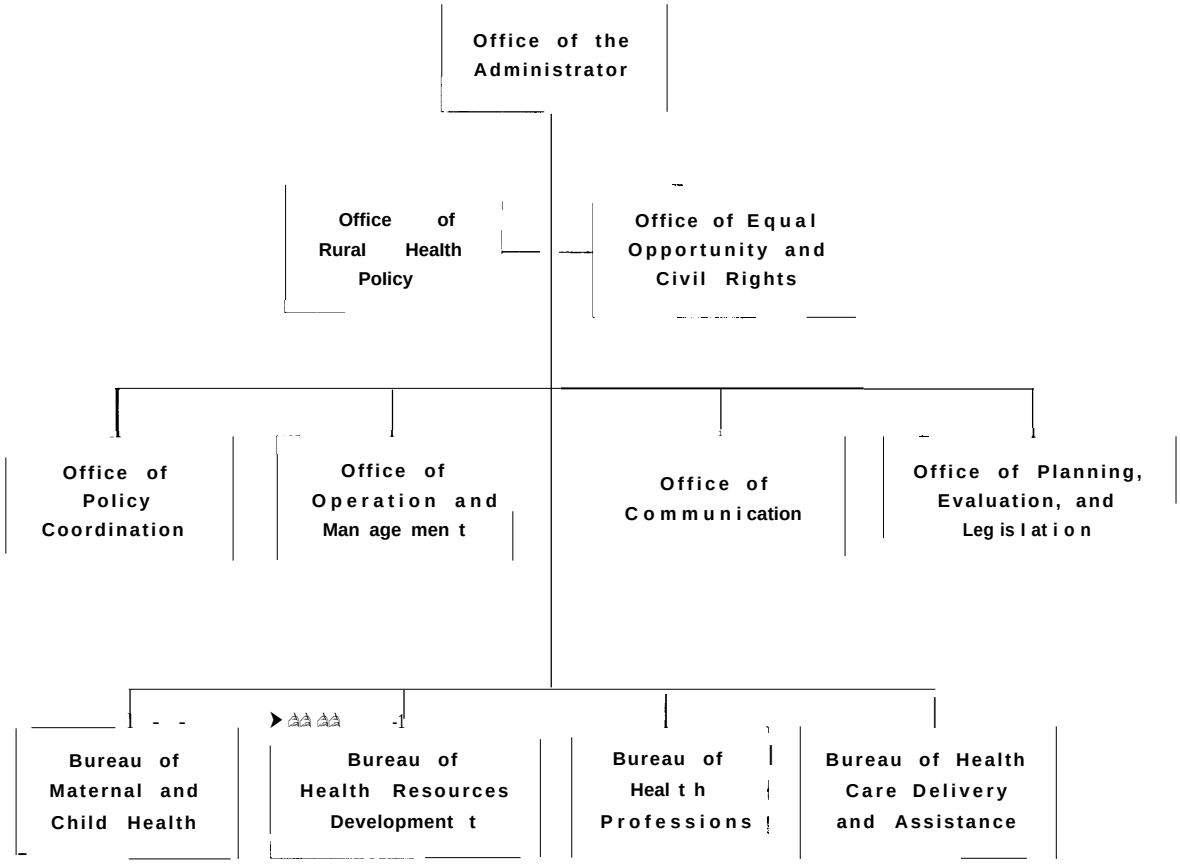
[19]The National Adolescent Student Health Survey was supported by the Office of Disease prevention and Health Promotion within the Office of the Assistant Secretary of Health, with additional support from the Centers for Disease Control and the National Institute on Drug Abuse within the Alcohol, Drug Abuse, and Mental Health Administration.

[20]Priority risks are those behaviors resulting in unintentional and intentional injuries, alcohol and drug abuse, tobacco use, improper diet, insufficient physical activity, and HIV infection and other STDs.

[21]In May 1990, the Bureau of Maternal and Child Health and Resources Development split into two bureaus: the Bureau of Maternal and Child Health and the Bureau of Health Resources Development. When expenditures made prior to May 1990 are discussed here, the term ''Office' will be used.

[22]Established in 1987, the Health Resources and Services Administration's Office of Rural Health Policy's role in rural adolescent health has been limited. The Office targeted adolescent suicide, pregnancy, and lack of access for health and mental health services in its Work Group on Health Services of the National Advisory Committee on Rural Health.

Figure 19-6--U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration



SOURCE: U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, organizational chart, no date.

programs to improve the health status of mothers and children, especially those with low incomes and living in areas with limited availability of health services (85).[23,24] Approximately 21 States have a designated adolescent health care coordinator (16, 26).[25,26]

Fifteen percent of the $526.6 million appropriation for the maternal and child health block grant program in fiscal year 1988 was set aside to support Special **Projects** of Regional and National Significance (SPRANS) (86).[27] In fiscal year 1988, 57 projects addressed the health needs of adolescents and children in various areas (e.g., research, training, genetics, hemophilia) (86). Twenty-three of these projects dealt specifically with injury prevention. In 1989,36 projects[28] included adolescents specifically or as part of a larger group (26). Although no new projects targeting adolescents were begun in fiscal

[23]These State programs are sometimes called the Consolidated State Programs (86).

[24]In fiscal year 1987, States transferred over 30 percent of their maternal and child health block grant funds to local health departments (31).

[25]Information on the proportion of Title v maternal and child health services allocated specifically to adolescents is not available.

[26]The 21 are Arizona, Colorado, Connecticut, District of Columbia, Delaware, Florida, Hawaii, Iowa, In&~ Massachusetts, Maine, Michigan, Mississippi, Minnesota, New Hampshire, Ohio, Oklahoma, Oregon, South Carolina, Washington and Wisconsin (26). Preliminary survey results indicate that two or three more States may have such a coordinator (16). It is unclear how States are paying for adolescent health care coordinator positions. Because the position is typically located within a State's Office of Maternal and Child Health, it may be that many, if not most, States are funding the position with block grant funds (16).

[27]These projects are sometimes called Consolidated Federal Programs (86).

[28]Of these projects, 23 were demonstration projects, 7 were research related, and 6 were training projects (26).

year 1990, approximately three new projects were scheduled to begin in fiscal year 1991 (16).

The Health Resources and Services Administration's Bureau of Health Care Delivery and Assistance supports the provision of primary health care services to medically underserved populations by providing Federal finds for community and migrant health centers, as well as for comprehensive perinatal care programs for low-income women and children, health care for the homeless programs, and health care for substance abusers. In 1989, 814,000 adolescents received medical care in the community and migrant health centers; of these adolescents 117,000 females ages 10 to 14 received family planning services.[29] At least 121,000 adolescents received dental care. During 1988, the comprehensive perinatal care programs provided perinatal services to 6 percent of all U.S. pregnant adolescents under age 20 and to 29 percent of pregnant adolescents 15 years of age and under (l).

Indian Health Service---The Indian Health Care Improvement Act of 1976 (Public Law 94-437) gave funding to the Indian Health Service for a 7-year period to elevate the health status of American Indians and Alaska Natives. Recently, amendments (Public Law 100-713) to the Indian Health Care Improvement Act were passed that extended this funding. In fiscal year 1989, the Indian Health Service spent over $1.02 billion on health services (primarily clinical care for acute and chronic physical problems) to assist American Indians and Alaska Natives. No specific funds of the agency are allotted for adolescents, so it is difficult to assess the amount spent by the Indian Health Service on health care for adolescents.

In 1989, the Indian Health Service conducted an Adolescent Health Survey to obtain a database on adolescents for use in local programs. The Alcohol and Substance Abuse Programs Branch of the Indian Health Service funds three regional adolescent treatment centers for substance abuse, which cost a total of $2.4 million per year. The Indian Health Service also helps to support adolescent health centers in or near four schools in the Albuquerque, New Mexico area (44a).

In fiscal year 1989, the Indian Health Service targeted Indian adolescents as a priority group for prevention efforts, planning to specifically emphasize prevention of teen pregnancy, alcohol/substance abuse, mental health, violence, and suicide. However, only 7 percent of the *total Indian* Health Service budget was devoted to preventive health in fiscal year 1988 (44a).

National Institutes of Health—In fiscal year 1989, the various institutes and divisions of the National Institutes of Health spent $7.1 billion (8) to fulfill their mission of improving the health of individuals through advancement of the state of knowledge in biomedical science and health care (see figure 19-7).

Within the National Institutes of Health, the National Institute of Child Health and Human Development, established in 1963, is the institute most identified with behavioral and biomedical research on adolescent development (e.g., cognitive, emotional, and social development) and with research on reproduction, sexual behavior, the effects of nutrition on development, and patterns of adolescents' interaction with family, peers, and school (see table 19-4).[30]

In fiscal year 1988, the National Institute of Child Health and Human Development funded 147 projects (21). Between fiscal years 1980 and 1990, however, approximately 7 percent of the National Institute of Child Health and Human Development budget was spent on research specific to adolescents (see table 19-3). In fiscal year 1990, the Institute estimated that $25.5 million will be spent on adolescents, focusing on the physiological, psychological, endocrinological aspects of puberty,[31] the nutritional needs of adolescents, adolescent pregnancy, and acquired immunodeficiency syndrome (AIDS) (21). As does the Division of Adolescent and School Health in the Centers for Disease Control, the National Institute of Child Health and Human Development places heavy emphasis on research dealing with adolescent sexual behavior and its consequences (see table 19-4).

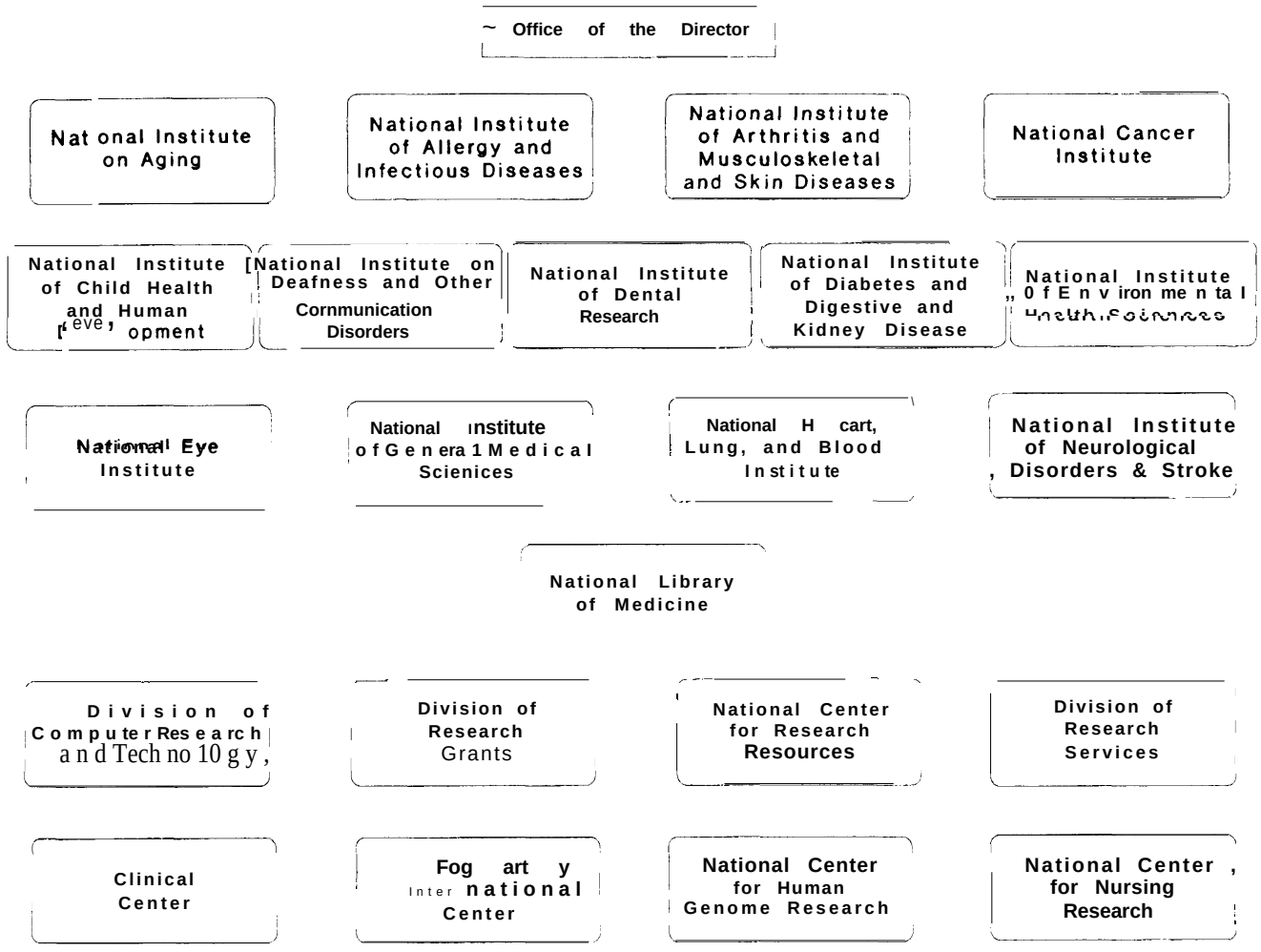
Eight other institutes within the National Institutes of Health sponsor research that pertains to

[29]The Bureau of Health Care Delivery and Assistance does not collect data on usage of community and migrant health centers by adolescents, ages 15 to 19. Data on this age group was collected eight years ago, but since then it has been discontinued.

[30]The National Institute of Child Health and Human Development does not deliver services to adolescents.

[31]Endocrinological aspects of puberty are those related to the functions of the endocrine glands (e.g., thyroid or pituitary gland).

Figure 19-7—U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health



SOURCE: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, organizational chart, Bethesda, MD, no date.

Table 19-4-Adolescent Research Priority Areas of the Components of the National Institutes of Health

NIH agency	Adolescent research priority areas	Selected adolescent project descriptions
National Cancer Institute	Cancer prevention and control, improving the health of minorities and the underserved, and increasing patient accrual to clinical trials.	Smoking cessation interventions (e.g., school-based intervention research studies and a public information campaign to prevent adolescents from racial and ethnic minority groups from using tobacco); influence of smoking and drinking by families on Hispanic youth; adolescent v. adult diets on breast cancer risk; association of adolescent alcohol consumption, oral contraceptive use, dietary patterns, hormonal levels with breast cancer risk; school-based nutrition education project; adolescents' risk of developing Leukemia; therapies for sarcomas; improving the survival of adolescent cancer patients through clinical studies by expanding eligibility criteria; improving adolescent cancer patients' psychological well-being (e.g., stress reduction, increasing school attendance).
National Center for Nursing Research	Nursing care of prospective mothers at risk of having low birth-weight babies, focusing on preventing pregnancy complications and care of low birth-weight babies. Prevention and physiological/psychosocial factors relating to the care of individuals with human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS).	Causes, consequences, and patterns of loneliness during adolescence; personality and environmental aspects of health compromising behaviors (e.g., cigarette smoking, drug and alcohol use, early sexual activity, eating behaviors, and excessive caffeine consumption) among young adolescents; improving communication within families of early adolescents using parenting styles and knowledge about adolescent and adult growth and development.
National Center for Research Resources	Does not set priorities in specific research areas as do the other institutes. The Center ensures availability of resources to the NIH community.	Hormonal aspects of growth and sexual maturation, psychosocial aspects of adolescence (e.g., effects of the government school breakfast program v. short-term fasting on adolescent cognition, behavior, and exercise; depression in adolescent males focusing on endocrine responses), diabetes and obesity (i.e., appropriate insulin levels), renal disease, urethritis, adolescent development using nonhuman primates, role of ethnicity in adolescent identity development, relationship of depression in children and adolescents, treatment program for adolescent substance abusers, aggressive conduct disorder, street youths' knowledge and attitudes toward AIDS prevention, history of immunization as a predictor of measles.
National Eye Institute	Research is not specifically targeted to adolescents.	Not provided
National Heart, Lung, and Blood Institute	Risk factors for cardiovascular disease, particularly hypertension, smoking, and blood cholesterol levels. Programs for adolescents with cystic fibrosis and sickle cell anemia	Not provided
National Institute of Allergy and Infectious Diseases	Sexually transmitted diseases (STDs), AIDS, type I diabetes mellitus, asthma and allergy, chronic granulomatous disease.	Vaccine development for chlamydia, gonorrhea, syphilis, and herpes simplex virus type 2; diagnostic and therapeutic approaches for pelvic inflammatory disease and understanding the natural history of human papillomavirus; various aspects (e.g., epidemiologic and clinical) of individuals with AIDS, including prevention and treatment; mechanisms in the development of type I diabetes mellitus and chronic granulomatous disease; Self-Management of Asthma Educational Programs.

Continued on next page

Table 19-4-Adolescent Research Priority Areas of the Components of the National Institutes of Health-Continued

NIH agency	Adolescent research priority areas	Selected adolescent project descriptions
National Institute of Arthritis and Musculoskeletal and Skin Diseases	Systemic lupus erythematosus, particularly in minority populations, Lyme disease, juvenile arthritis, and osteoporosis (i.e., impact of diet and exercise during adolescence).	Pain treatment for adolescents with juvenile arthritis; psychological effects of pain on adolescents with juvenile arthritis; risk factors (e.g., diet, exercise, scoliosis development) during adolescence for the onset of osteoporosis .
National Institute of Child Health and Human Development	Physiological, psychological, and social consequences of adolescent pregnancy for mothers, their children, and other family members; endocrinological aspects of puberty, nutritional needs of the adolescent, and adolescent AIDS.	New contraceptives development (e.g., skin patch, implanted drug delivery system); preventing sexually transmitted diseases; understanding the transmission of HIV and its natural history in mothers and their children to prevent AIDS as well as developing age-appropriate educational strategies; investigation of the molecular basis for normal and abnormal male development and reproduction; role of genetics and environment (e.g., early family experiences) in development; female reproductive cycle disorders (e.g., pelvic inflammatory disease, severe premenstrual syndrome, interrelationship of nutrition and exercise with ovulation); sexual behavior and contraceptive use for contraception and disease prevention among adolescent females and their partners; consequences of adolescent childbearing; relationship between sexually transmitted diseases, including AIDS, and fertility-related behavior.
National Institute of Diabetes and Digestive and Kidney Diseases	Not planning specific initiatives on adolescent health.	Treatment of diseases (e.g., juvenile diabetes (insulin-dependent diabetes), cystic fibrosis, juvenile liver disease, inflammatory bowel disease, Cooley's and sickle cell anemia, hemophilia and growth abnormalities) often diagnosed and treated initially during adolescence.
National Institute of Neurological Disorders and Stroke	Head and spinal cord injury, stroke, juvenile epilepsy, lipid storage diseases, Tourette's syndrome, muscular dystrophies, autism, ataxias, Batten Disease, Reye's syndrome, tuberous sclerosis, learning disorders/attention deficit disorders, Charot-Marie-Tooth syndrome, spinal muscular atrophies, juvenile myasthenia gravis, neurofibromatoses-	Incidence and duration of loss of consciousness in newly injured patients; natural history of adolescents following first epileptic seizure and risk factors for reoccurrence; development of skills (e.g., gestures) in developmentally disordered adolescents.

SOURCE: U.S. Department of Health and Human services, Public Health Service, National Institutes of Health, unpublished data provided in response to the Office of Technology Assessment's questionnaire regarding adolescent health initiatives, 1989.

adolescent health. In general, their emphasis tends not to be related to adolescent sexual behavior but on various aspects of specific diseases. Although it is important to note that it is difficult for these institutes to disaggregate adolescent-specific research because of their disease-specific approach, the institutes were only able to identify a research budget of 2 percent ($1 14.93 million) that was clearly specific to adolescents in fiscal year 1989.

It appears that the National Institute of Allergy and Infectious Diseases places a greater emphasis on adolescents than do the other Institutes and divisions, including the National Institute of Child Health and Human Development. In fiscal year 1988, for example, the National Institute of Allergy and Infectious Diseases estimates that it spent approximately 15 percent of its overall budget on adolescents, as compared with only about 7 percent of the National Institute of Child Health and Human Development's budget. Like the National Institute of Child Health and Human Development, however, the National Institute of Allergy and Infectious Diseases primarily studies consequences of adolescent sexual behavior (i.e., STDs and AIDS).

Office of the Assistant Secretary for Health—Three agencies within the Office of the Assistant Secretary for Health are involved in matters related to adolescents and their health:

. the Office of Disease Prevention and Health Promotion,
. the Office of Minority Health, and
. the Office of Population Affairs (see figure 19-8).

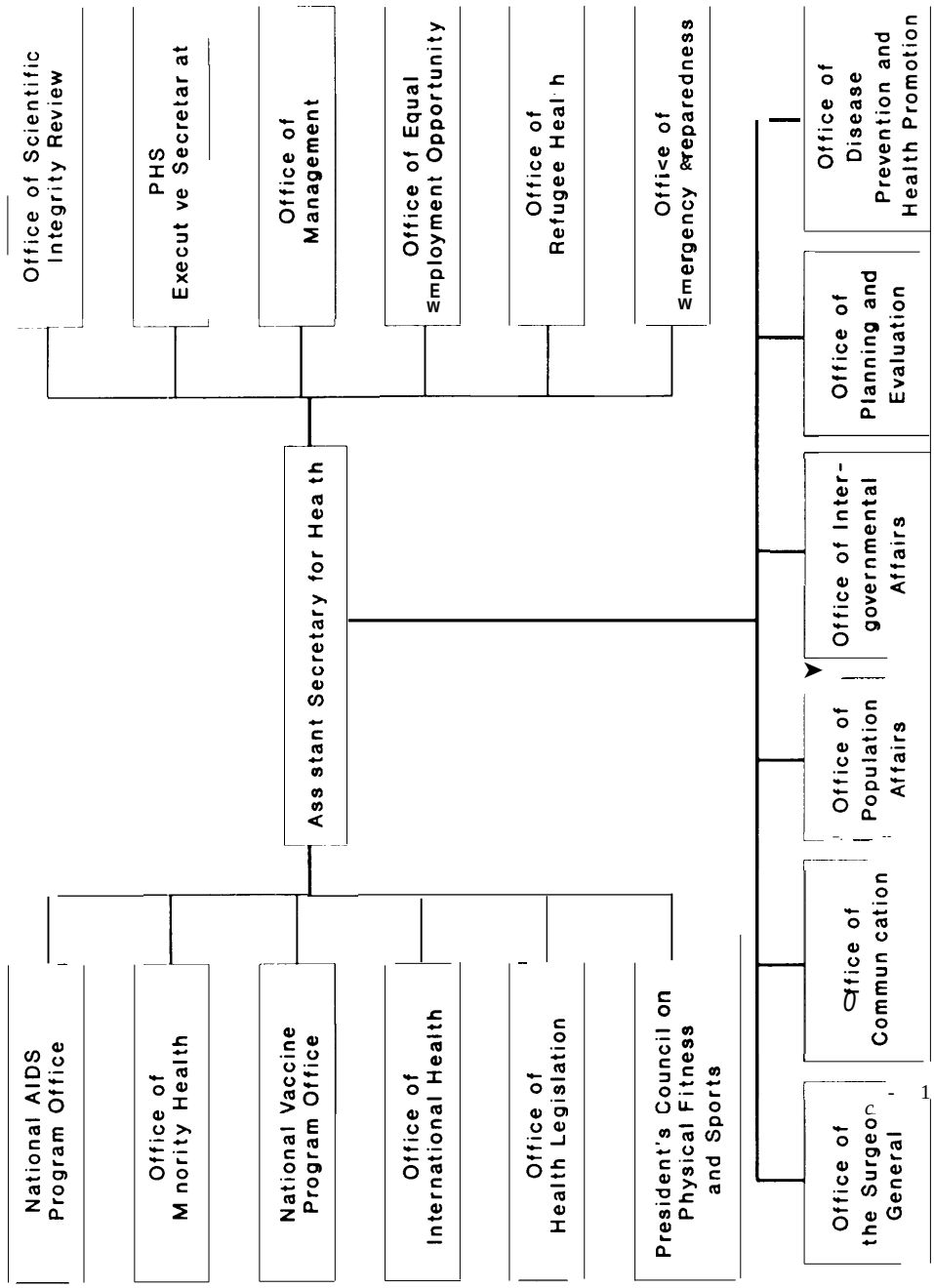
Office of Disease Prevention and Health Promotion—Established by the National Consumer Health Information and Health Promotion Act of 1976 (Public Law 94-3 17), the Office of Disease Prevention and Health Promotion is responsible for supporting and coordinating prevention programs within the Alcohol, Drug Abuse, and Mental Health Administration, the Centers for Disease Control, the Food and Drug Administration, the Health Resources and Services Administration, and the National Institutes of Health (89).

The overall budget of the Office of Disease Prevention and Health Promotion in fiscal year 1989 was close to $5 million. Although the amount spent on adolescents is not known, the Office of Disease Prevention and Health Promotion has several ongoing activities that affect adolescents. Examples include awarding grants to national private sector organizations under the National Health Promotion Cooperative Agreements Program and the coordination of a broad-based public service initiative to develop the agenda for "Healthy People 2000: National Health Promotion and Disease Prevention." This initiative developed objectives targeted to adolescents.[32] The Office of Disease Prevention and Health Promotion has cooperative agreements with the Association of American School Administrators, as well as the American Medical Association to help promote the "Healthy People 2000: National Health Promotion and Disease Prevention' objectives as they relate to adolescents.

Office *of Minority Health—The* Office of Minority Health is the agency within DHHS which was originally established to be responsible for coordinating and monitoring the implementation of the recommendations from *The Report of the Secretary's Task Force on Black and Minority Health.* That report identified six health priority problem areas among minorities: cancer, cardiovascular disease and stroke, chemical dependency, diabetes, homicide and accidents, and infant mortality. In 1988, the Office of Minority Health added AIDS to the list of major health problems. Three major demonstration grant programs funded by the Office of Minority Health directly address the seven minority health priority areas. The Minority Community Health Coalition Program provides grants to develop community health coalitions which can effectively demonstrate risk reduction efforts among minority populations (91). In 1989, the Office of Minority Health awarded seven demonstration grants of approximately $200,000 each, two of which were directed at adolescent minorities. In addition, the HIV/AIDS Education and Prevention Grant Program awarded 24 grants of approximately $50,000 each in 1989 to both national and community-based minority organizations that provided education and information to minorities on the prevention of the spread of HIV (91). Three such grants on HIV/AIDS education and prevention directly affect adolescents (93). In 1990, the Office of Minority Health announce a three-part grant program to address the health and human service needs of

[32]Healthy People 2000 objectives pertinent to adolescents are discussed in *Volume I—Summary and Policy Options* of this Report (44b).

Figure 19-8—U.S. Department of Health and Human Services, Public Health Service, Office o the Assistant Secretary for Health



SOURCE: U.S. Department of Health and Human Services, Public Health Service, Office of the Assistant Secretary for Health, organizational chart, Washington, DC, 990.

minority males of all ages. One program, funded at $450,000, was to support meetings and conferences on problems confronting high-risk minority males; a second, funded at $1.05 million, was to provide limited resources to plan and develop community coalitions to address the needs of high-risk minority males in specific communities; and the third, funding for which had not been announced, was intended to demonstrate methods of implementing community coalition intervention activities involving multiple organizations (55 FR 22312). In early 1990, a report by the U.S. General Accounting Office criticized the Office of Minority Health and later in 1990, the potential role of the Office was expanded when the U.S. Congress statutorily established such an Office, to be headed by a Deputy Assistant Secretary for Minority Health (Public Law 101-527, the "Disadvantaged Minority Health Improvement Act of 1990," section 2). Public Law 101-527 also authorized an increase in funding for the Office of Minority Health, to $25 million per year for fiscal years 1991 through 1993. The potential role of the Off-ice in the health of minority adolescents is as yet unknown.

Office *of Population Affairs-Within the* Public Health Service's Office of the Assistant Secretary for Health, the Office of Population Affairs carries out activities related to adolescent pregnancy, family planning, and population research. The Office of Population Affairs has responsibility for administering Title X (Family Planning Services and Research Program) and Title XX (Adolescent Family Life Program) of the Public Health Service Act.[33]

The Office of Population Affairs provides Title X funds to public or private nonprofit organizations operating family planning projects for low-income families and encouraging family participation when possible. There are currently approximately 86 States, organizations, or independent family planning agencies receiving Title X moneys throughout the country (37). Services they provide include education, counseling, and medical services related to contraception as well as training for family planning personnel in general and nurse practitioners in particular to help improve the delivery of family plannin g services. Organizations which receive Title X money may not provide counseling and referral for abortion services except in medical emergencies.[34] In fiscal year 1990, $130 million was available for family planning service grants, 22 of which were awarded competitively (54 FR 35440); the remaining 64 awards represented continuations of projects which had competed in one of the prior 2 years. Current Title X priority areas are:

- the involvement of families of adolescent clients in Title X clinics,
- infertility services,
- natural family plannin g services,
- male involvement,
- sexually transmitted diseases,
- AIDS, and
- sexual abstinence for adolescents.

Approximately one-third of all Title X money is specific to adolescents. The last new reauthorization of funds for Title X was in 1984 (Public Law 98-512) (19). However, organizations continue to receive Title X funds through congressional appropriation acts.

The Office of Population Affairs provides Title XX (Adolescent Family Life Program) funds to support research and demonstration projects aimed at the alleviation, elimination, or resolution of negative consequences of adolescent premarital sexual intercourse. Specifically, abstinence from premarital sexual intercourse and adoption as an alternative to abortion are encouraged. Additionally, demonstration projects under the Adolescent Family Life Program attempt to establish innovative, comprehensive, and integrated health care services for pregnant and parenting adolescents under age 19. As with Title X funds, Title XX money cannot be used to provide abortions, abortion counseling, or abortion referrals, and adolescents must obtain parental consent before participating in any Title XX program (94). An average of 60 demonstration grants are funded under Title XX each year. In fiscal year 1986, Title XX demonstration projects served approximately 60,000 adolescents in both prevention and care programs. In addition, Title XX funds supported research on adolescent sexual activity and

[33]For a more in-depth discussion of services provided to pregnant and parenting adolescents by the Office of population Affairs under Titles X and XX of the Public Health Service Act, see ch. 10, "Pregnancy and Parenting: Prevention and Services," in Vol. II.

[34]In a 5-4 decision on May 23, 1991, the U.S. Supreme Court upheld this regulation, despite&e concern of some dissenting judges that the regulation ''raises serious First Amendment [free speech] concerns' (The New *York Times*, ''*Excerpts* From Court Ruling Curbing Family Planning Clinics, ' May 24, 1991, p. A19; L. Greenhouse, ' 'Five Justices Uphold U.S. Rule Curbing Abortion Advice, " *The New York Times,* p. A19, May 24, 1991).

the effectiveness of available services. The funding for Title XX in 1990 was $9.5 million, all of which was for adolescents.

Agencies Other Than DHHS: Programs and Expenditures for Adolescents

There are agencies other than those in DHHS that provide funding aimed at improving the lives of adolescents (see table 19-5). Many of these agencies, such as the U.S. Consumer Product Safety Commission and the U.S. Departments of Agriculture, Defense, Education, and Transportation, do not provide set-asides for adolescents but do include adolescents as a subgroup of larger populations served. Again, this factor makes determining expenditures for adolescents difficult.

ACTION

ACTION administers several Federal domestic volunteer service programs that provide human services to disadvantaged, poor, and elderly Americans.[35] Within ACTION, the Office of Domestic Operations administers several programs that affect adolescents. These include the Retired Senior Volunteer Program, the Foster Grandparent Program, Volunteers in Service to America (VISTA), the Student Community Service Program, and the Office of Program Demonstration and Development. The Foster Grandparent Program provides direct benefits (e.g., stipend, transportation, meal assistance, annual physical examination) to low-income individuals ages 60 and over who work 20 hours a week with children and adolescents with special needs (2). In fiscal year 1988, the Foster Grandparent Program sponsored 252 projects with a budget of $57.4 million. That year, it served about 70,000 young people, including about 25,500 ages 6 through 12 and 15,400 ages 13 through 20 (4). Typically, the young people assisted are at risk of drug or alcohol use, are in the delinquent detention system, are pregnant or parenting, or are mentally, physically, or emotionally disabled (2).

The VISTA program tries to help low-income people become self-sufficient by supporting projects sponsored by local public and private nonprofit organizations (2). In fiscal year 1988, 244 VISTA projects focused on youth (2). As of August 31, 1989, 66 VISTA volunteers were involved in 15 projects focusing on juvenile health, including the prevention of adolescent pregnancy, substance abuse, suicide, and violence (3). The Student Community Service Program funds projects that enable high school and college student volunteers to work as volunteers to help eliminate poverty-related problems. The estimated budget for the Student Community Service Program for fiscal year 1990 was $893,000 (7). In 1988, an estimated 28,000 students provided more than 850,000 hours of community service in various settings, such as Head Start programs, juvenile diversion programs, shelters, and soup kitchens (2).

The program Demonstration and Development Division within the Office of Domestic Operations was created, in part, to award demonstration grants to organizations that have the potential to generate volunteer activity within a community and have the ability to serve as a model for other organizations. In fiscal year 1988, the Division awarded $2.6 million in demonstration and other grants for 79 projects (2).[36] Because Congress earmarked all fiscal year 1990 demonstration grants for illicit drug use prevention activities (7), ACTION gave top priority to drug prevention initiatives for at-risk youth in fiscal year 1990. These grants ($1.3 million for 1990), handled through the Office of Program Demonstration and Development's Drug Alliance Office, are awarded to community drug prevention projects that include enlisting volunteers from corporations to serve as mentors and organizing parent groups to prevent drug abuse.

U.S. Consumer Product Safety Commission

The U.S. Consumer Product Safety Commission typically does not focus on adolescents as an age group, but focuses on product-related hazards. For example, priority areas in fiscal year 1990 include indoor air quality, playground surfacing, diving injuries, choking hazards, and lead in water coolers. Although no projects are specifically aimed at adolescents, some projects do have a direct impact

[35] The role of ACTION in organizing and coordinating domestic volunteer service activities may have been affected by passage in late 1990 of the Nationat and Community Service Act of 1990 (Public Law 101-610). While the law intended to "build on the existing organizational framework of Federal, State, and local programs and agencies to expand full-time service opportunities for all citizens. . . .", it also established a Commission on National and Community Service to administer most of the programs established by the act. The programs established by the act are described briefly in *Volume I---Summary and Policy Options* and more fully in ch. 4, ''Schools and Discretionary Time, " in Vol. II.

[36] These projects were supported with $1.074 million in non-Federal contributions.

Table 19-5-Expenditures on Adolescent Health by Federal Agencies Other Than the U.S. Department of Health and Human Services

Agency with actual or potential role in adolescent health	Total expenditures (most current fiscal year)	Estimated expenditures for adolescents (most current fiscal year)	Percent of expenditures for adolescents
ACTION	$170,417,000 (1990)'	$16,127,000 (1990)"	9.4 percent
U.S. CONSUMER PRODUCT SAFETY COMMISSION	$34,500,000 (1989)	Not provided	Estimated at 50 percent for all children.
U.S. DEPARTMENT OF AGRICULTURE	Not provided	Not provided	Not provided
Extension Service	$361,370,000 (1989)	$90,342,500 (1989)"	25 percent
Human Nutrition Information Service	Not provided	Not provided	Not provided
Food and Nutrition Service	$21,264,955 (1989)	No specific line items for adolescents.	Not provided[b]
U.S. DEPARTMENT OF DEFENSE[c]	Not provided	Not provided	Not provided
Force Management and Personnel	Not provided	Not provided	Not provided
Office of Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)	$2,400,000,000 (1989)	$552,000,000 (1989)"	23 percent of CHAMPUS benefit costs are provided to adolescents ages 10 to 19.
U.S. DEPARTMENT OF EDUCATION	$22,467,400,000 (1989)	No specific line items for adolescents.	Not provided
Office of Planning, Budget, and Evaluation	Not provided	Generally, no specific line items for adolescents. Adolescents receive Federal money through funds provided to State and local educational agencies and other organizations.	Not provided
Office of the Assistant Secretary for Elementary and Secondary Education	$6,600,886,000 (1989)	No specific line items for adolescents.	Not provided
--Office of Indian Education	$71,553,000 (1 989)	Not provided	Not provided
--Office of Migrant Education	$269,029,000 (1988)	$123,193,500 (1986-87)	45 percent
Office of the Assistant Secretary for Educational Research and Improvement	$78,200,000 (1989)	Not provided	Not provided
Office of the Assistant Secretary for Special Education and Rehabilitative Services	$3,558,500,000 (1988)	Not provided	Not provided
--Office of Special Education Programs	$2,109,982,000 (1988)	Not provided	Not provided
-National Institute on Disability and Rehabilitation Research	$53,525,000 (1989)	$17,461,006 (1989)[d]	32 percent
Office oft he Assistant Secretary for Vocational and Adult Education	$1,080,614,000 (1989)	Not provided	Not provided
Office of Bilingual Education and Minority Languages Affairs	$197,394,000 (1989)	Not provided	Not provided
Office of the Assistant Secretary for Postsecondary Education	$5,814,320,000 (1989)	Not provided	Not provided
U.S DEPARTMENT OF JUSTICE	Not provided	Not provided	Not provided
National Institute of Justice	$21,000,000 (1989)	$4,200,000 (1989)'	20 percent
Office of Juvenile Justice and Delinquency Prevention	$72,482,000 (1990)	$72,482,000 (1990)	100 percemt
U.S. DEPARTMENT OF LABOR	*$24,900,000,000 (1990)*	No line items specific for adolescents.	Not provided
Employment and Training Administration[e]	$3,728,431,000[f]	$2,166,367,000 (1989)[g]	58 percent
U.S. DEPARTMENT OF TRANSPORTATION	Not provided	Not provided	Not provided
Federal Highway Administration	$13,308,000,000 (1988)	No line items specific for adolescents.	Not provided
National Highwav Traffic Safety Administration	$103,500,000 (1989)	$975,000 (1989)"	1 percent

[a]Estimated amount.
[b]Forty-three percent of the participants in the National School Lunch program are in grades 7 through 12; 24 percent of those in the School Breakfast Program are in grades 7 through 12; 23 percent of those in the Summer Food Service Program are ages 13 to 18; 3 percent of those participating in the Supplemental Food Program for Women, Infants, and Children are pregnant, breastfeeding, or postpartum females less than age 18; and 34 percent of those in the Food Stamp Program are between the ages of 15 and 17.
[c]Questionnaire is from the perspective of the youth activities programs which are part of the Morale, Welfare, and Recreation Division. However, the Department's commitment to adolescents is not limited to these programs. Other agencies, such as Medical Programs, Mental Health Division, Drug and Alcohol Abuse Programs, and Chaplains Programs, sponsor activities for military youth.
[d]Adolescent projects are included within larger research efforts and are not specifically for adolescents.
[e]These data were obtained from E. Kolodny, U.S. Department of Labor (20).
[f]Funds are allocated for program year July 1, 1989—June 30, 1990 and not for the fiscal year (20).
[g]Forty percent of Title II-A, all of Title II-B, and all of Job Corps funding is allotted to youth, primarily ages 16 through 21 (20).

SOURCE: Office of Technology Assessment, 1990, based on Federal agency responses to the Office of Technology Assessment's survey on adolescent health, 1989.

on adolescents. These include projects related to all-terrain vehicles, fireworks, bicycles, lawn darts, water coolers with lead components, amusement rides, diving injuries, and playground surfacing. It is estimated that about 50 percent ($17.3 million) of the Commission's budget in fiscal year 1989 went toward activities that protected children[37] (40).

U.S. Department of Agriculture

Four of the U.S. Department of Agriculture Extension Service's nine priority areas include substantial adolescent cornponents.[38] These initiatives are human nutrition, youth at risk, building human capital, and family and economic well-being. More specifically, building human capital involves helping adolescents develop self-confidence and the ability to think independently as well as helping communities accept adolescents as responsible and valuable members of society (45). Youth-at-risk research and demonstration projects include a model youth-at-risk program with the University of Arizona and adolescents as advocates for youth with Colorado State University. Within the Extension Service's 4-H program, adolescents ages 10 to 18 make up 66 percent of those individuals enrolled in the program, with 10- to 13-year-old adolescents making up 50 percent of those enrolled (45). In fiscal year 1989, approximately 25 percent of the Extension Service's budget of" over $361 billion was dedicated to programs devoted to adolescent issues.[39]

The U.S. Department of Agriculture's Human Nutrition Information Service conducts and interprets applied research in food and nutrition (35). Other responsibilities include monitoring the food and nutrient content of diets, assessing dietary status and trends in food consumption, increasing understanding of the factors that influence consumer food choices, providing appropriate dietary guidance for the public, and developing techniques to help people make informed food choices.

The U.S. Department of Agriculture's Food and Nutrition Service administers several programs that provide food assistance to low-income individuals and families, including the Food Stamp Program, various child nutrition programs, and the Special Supplemental Food Program for Women, Infants, and children (WIC) (22). Adolescents ages 15 to 17 make up an estimated 34 percent of the participants in the Food Stamp Program (22).[40] Child nutrition programs, such as the National School Lunch and School Breakfast Programs, and the Summer Food Service Program, provide food services to children and adolescents in public and nonprofit, private schools. Adolescents in grades 7 through 12 makeup an estimated 24 percent of the participants in the School Breakfast Program and 43 percent of the participants in the National School Lunch Program (22).[41] Pregnant, breastfeeding, or postpartum adolescents make up an estimated 2.8 percent of WIC participants (22).

U.S. Department of Defense

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is a health benefits program provided by the Federal Government under public law primarily to dependents and retirees of the Air Force, Army, Coast Guard, Marine Corps, Navy, Public Health Service, and the National Oceanic and Atmospheric Administration (49). CHAMPUS covers residential treatment for certain mental disorders, family planningservices,[42] general inpatient and outpatient care that is considered medically necessary, and general treatment for alcohol/drug abuse or dependency and detoxification, without complications or comorbidity. In addition, the program for the Handicapped provides benefits for individuals, who are primarily adolescents, with moderate or severe mental retardation or serious physical disabilities. Under CHAMPUS, adolescents are covered if they are unmarried and under age 21, full-time students under age 23, or age 21 and over and severely disabled (49). In fiscal year 1989, $2.4 billion was spent on CHAMPUS (36).

37The Consumer product and Safety Commission does not specify what age groups this term encompasses.

38The priority areas are determined by executive and legislative directives with local and State input.

39Most projects are limited to a single year of funding.

40The Food Stamp Program supplements household income by improving families' food purchasing power.

41Participants are those children and adolescent students who ate a breakfast or lunch at least once during a week as determined by a 1-week survey (47).

42CHAMPUS covers measurement for contraceptive diaphragms and birth control pills but does not cover abortions except in very limited circumstances (49).

CHAMPUS estimates that approximately 23 percent of CHAMPUS benefit costs are provided to adolescents ages 10 to 19.

U.S. Department of Education

Generally, the U.S. Department of Education does not administer educational programs targeted specifically to adolescents but includes adolescents as part of the school-aged population. For example, the Education of the Handicapped Act programs provide special education and related services for children and adolescents with disabilities, and programs authorized by the Drug-Free Schools and Communities Act target high-risk youth, many of whom are adolescents. For most programs, counts of individuals served with U.S. Department of Education funds are done by grade level rather than by age.

In 1989, the Department had a budget of approximately $22 billion and was responsible for 187 programs spanning six different offices (figure 19-9). It is impossible to determine total adolescent expenditures, because U.S. Department of Education funds are distributed to State and local educational agencies that determine their own priorities. The U.S. Department of Education's own priority areas are determined through legislative mandates, reviews of current literature, and State-identified needs. Priorities include increasing educational services to economically and educationally disadvantaged children.

In terms of research and demonstration projects, the U.S. Department of Education programs are currently interested in dropout prevention, secondary education and transitional services for disabled youth, bilingual aid, compensatory education, Indian youth, homeless youth, and drug abuse prevention. Funding for compensatory education, Indian education, and education of homeless children and adolescents is estimated to account for 21 percent of the U.S. Department of Education's budget (34), but only selected programs could specify funds for adolescents.

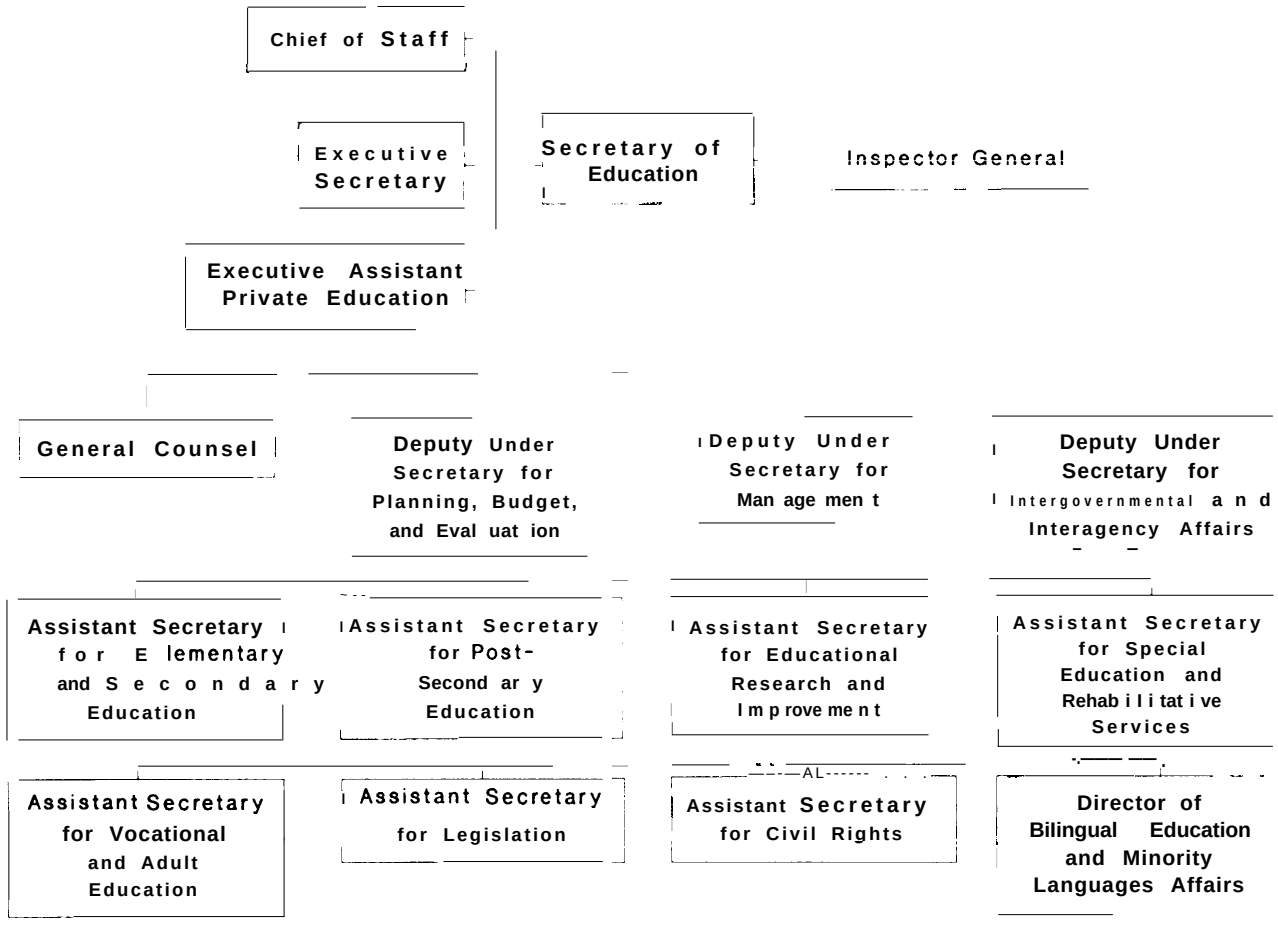
Within the Department, three offices fund more projects and activities for adolescents than do the others (table 19-5). These are the Office of the Assistant Secretary for Educational Research and Improvement, the Office of the Assistant Secretary for Elementary and Secondary Education, and the Office of the Assistant Secretary for Special Education and Rehabilitative Services.

Office of the Assistant Secretary for Educational Research and Improvement—Under the Secretary's Fund for Innovation in Education (Public Law 100-297), the Office of the Assistant Secretary for Educational Research and Improvement administers funds to both public and private institutions to improve health education for elementary and secondary students. In 1989, 18 projects were funded with approximately $3 million. The projects funded included various health education programs (on nutrition, fitness, disease prevention), State and local education reform models, and evaluations of health education programs. In 1990, $4 million was allotted to the Comprehensive School Health Education Programs, with a primary emphasis on models of health education programs and training needed to implement such programs (55).

Office of the Assistant Secretary for Elementary and Secondary Education—For the past two decades, the primary Federal vehicle for helping schools meet the educational needs of educationally disadvantaged children (i.e., children performing below their appropriate grade level, children of migrant workers, children with physical disabilities, and neglected or delinquent children under State care) has been the Grants for the Disadvantaged programs authorized by Chapter 1 of the Education Consolidation and Improvement Act of 1981 under the Office of the Assistant Secretary for Elementary and Secondary Education (53). In 1988, the Education Consolidation and Improvement Act was repealed and replaced by Title I of the Elementary and Secondary Education Act of 1965, enacted as part of the Augustus F. Hawkins-Robert T. Stafford Elementary and Secondary School Improvement Amendments of 1988 (Public Law 100-297). The purpose of the amendment was to strengthen parental involvement and to improve access to high quality education for adolescents in areas with a high proportion of low-income families and for neglected or delinquent adolescents in State institutions (53,54 FR 21752).

The Office of the Assistant Secretary for Elementary and Secondary Education has one of the largest appropriations in the U.S. Department of Education, approximately $6.6 billion in fiscal year 1989 (56). Although the proportion allocated to adolescents cannot be precisely determined, major programs that provide adolescent-related efforts include the following:

Figure 19-9--U.S. Department of Education



SOURCE: U.S. Department of Education, organizational chart, Washington, DC, Sept. 15, 1989.

- Chapter 1 grants to provide financial assistance to State and local educational agencies to meet the special educational needs of disadvantaged children and adolescents;[43]
- education of homeless children and youth, as authorized by the Stewart B. McKinney Homeless Assistance Act;
- Indian education programs, as authorized by the Indian Education Act of 1988;
- training for elementary and secondary school teachers in math and science, as authorized by the Dwight D. Eisenhower Mathematics and Science Education, Hawkins-Stafford Amendments of 1988;
- migrant education program to address the educational needs of migratory agricultural workers and fishers ages 3 to 21, as authorized by Chapter 1 of Title 1 of the Elementary and Secondary Education Act of 1%5;
- drug abuse education and prevention coordination in States and communities, as authorized by the Drug-Free Schools and Communities Act of 1986;
- dropout prevention demonstration projects conducted by local education agencies, educational partnerships, and community-based organizations to increase the number of children and adolescents remaining in school, as authorized by Title IV-A of the Elementary and Secondary Education Act of 1965 (56); and
- distribution of books to high school students under the Inexpensive Book Distribution Program to encourage adolescents to read, as authorized by the Education Consolidation and Improvement Act of 1981 and Chapter 2 of Title 1 of the Elementary and Secondary Education Act of 1965 (34).

Office of the Assistant Secretary for Special Education and Rehabilitative Services-Under the authority of Part B of the Education of the Handicapped Act (Public Law 94-142) and Chapter 1 of the Education Consolidation and Improvement Act as part of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35), the Office of Special Education Programs (within the Office of the Assistant Secretary for Special Education and Rehabilitative Services) supplies funds primarily to State education agencies to provide special education and related services to children and adolescents ages 3 through 21 with disabilities (57).[44] In 1987-88, a total estimate of $574.14 million or 44 percent of the total appropriation of approximately $1.3 billion was spent to reach close to 1.7 million students ages 12 to 17 (13).[45]

Under Chapter 1 Handicapped Programs (of the Education and Consolidation Improvement Act), State-operated programs provide special education to children and adolescents with disabilities who are in or have transferred from State-operated or State-supported programs. Over 83,000 students ages 12 to 17 received services through this program at an estimated cost of $48 million in the 1987-88 school year.[46]

One priority area within the Office of Special Education Programs is secondary education and transitional services for handicapped youth. This activity assists adolescents with disabilities and their families in making the adolescents' transition from secondary school to work life or postsecondary education settings. About $7.3 million was spent on this program in fiscal year 1988. Further, the Program for Severely Handicapped Children attempts to involve families in the planning and delivery of services and increase the number of children and adolescents with severe disabilities being served in regular school settings (54 FR 3945). Finally, the Office of Special Education Programs is supporting research projects for interventions to retain junior-high-school-aged students with disabilities, who are at risk of dropping out of school (54 FR 30642).

[43]No age breakdowns are available for current funding of Chapter 1. However, in the 1987-88 school year, 21 percent (1,037, 127) of the population served were students in grades 7 through 12 in both public and private schools, with funding for these adolescents totaling $3.8 billion (56).

[44]The Education of the Handicapped Act (Public Law 94-142) requires that all children and adolescents between the ages of 3 through 21 be served. However, States are not required to serve 3- to 5-year-olds or 18- to 21-year-olds if the service is inconsistent with State law or practice (57). Additionally, the statute requires that at least 75 percent of the funds must be passed through State education agencies to local education agencies and other agencies seining children directly. Up to 25 percent of the funds may be spent on direct and support services and administration at the State level.

[45]In fiscal year 1989, of the $2.1 billion appropriated to the Office of Special Education Programs, 93 percent of the funds ($1 .94 billion) were awarded to State education agencies under five grant programs (57).

[46]In the 1987-88 school year, approximately 40 percent of children and adolescents with disabilities served were between the ages of 12 and 17. Most of these adolescents had 1earning disabilities (50).

292-872 0 - 91 - 9 QL 3

Another branch of the Office of the Assistant Secretary for Special Education and Rehabilitative Services, the National Institute on Disability and Rehabilitation Research, administers a number of research activities that affect adolescents, although adolescents are not specifically targeted. For fiscal year 1989, $17.46 million was spent on initiatives that would affect adolescents. The priority areas for fiscal years 1989 and 1990 include research on children with severe emotional problems, a pediatric center for study of children's needs, spinal cord injury centers, and persons with orthopedic disabilities.

U.S. Department of Justice

Office of Juvenile Justice and Delinquency Prevention—The Office of Juvenile Justice and Delinquency Prevention was created under the Juvenile Justice and Delinquency Prevention Act (Public Law 93-415) and was authorized to administer programs and policies to improve the juvenile justice system, assist communities in responding to the needs of juveniles, assess the factors that contribute to juvenile delinquency, and inform practitioners about research findings and successful interventions (see figure 19-10). Additionally, the Office provides support and assistance to State and local juvenile justice agencies and delinquency prevention programs and facilitates cooperation and coordination among the Federal agencies funding juvenile delinquency programs. In fiscal year 1989, the office's budget was $66.69 million. The Office's fiscal year 1990 priorities are serious juvenile crime, illegal drug use, youth gangs, and missing and exploited children. Additionally, Congress mandated the following studies:

- determination of the extent to which confinement conditions in juvenile detention and correctional facilities comply with national standards;
- obstacles to legal custodians' recovery of children who have been removed by a noncustodial parent;
- village and tribal justice systems' treatment of American Indian and Alaska Native juveniles accused of committing crimes on or near reservations, and the availability of community-based alternatives to incarceration for these youth;
- extent to which minority juveniles are disproportionately detained or confined in secure juvenile detention or correctional facilities, jails or lockups; and
- improvement of national statistical data on juveniles taken into custody.

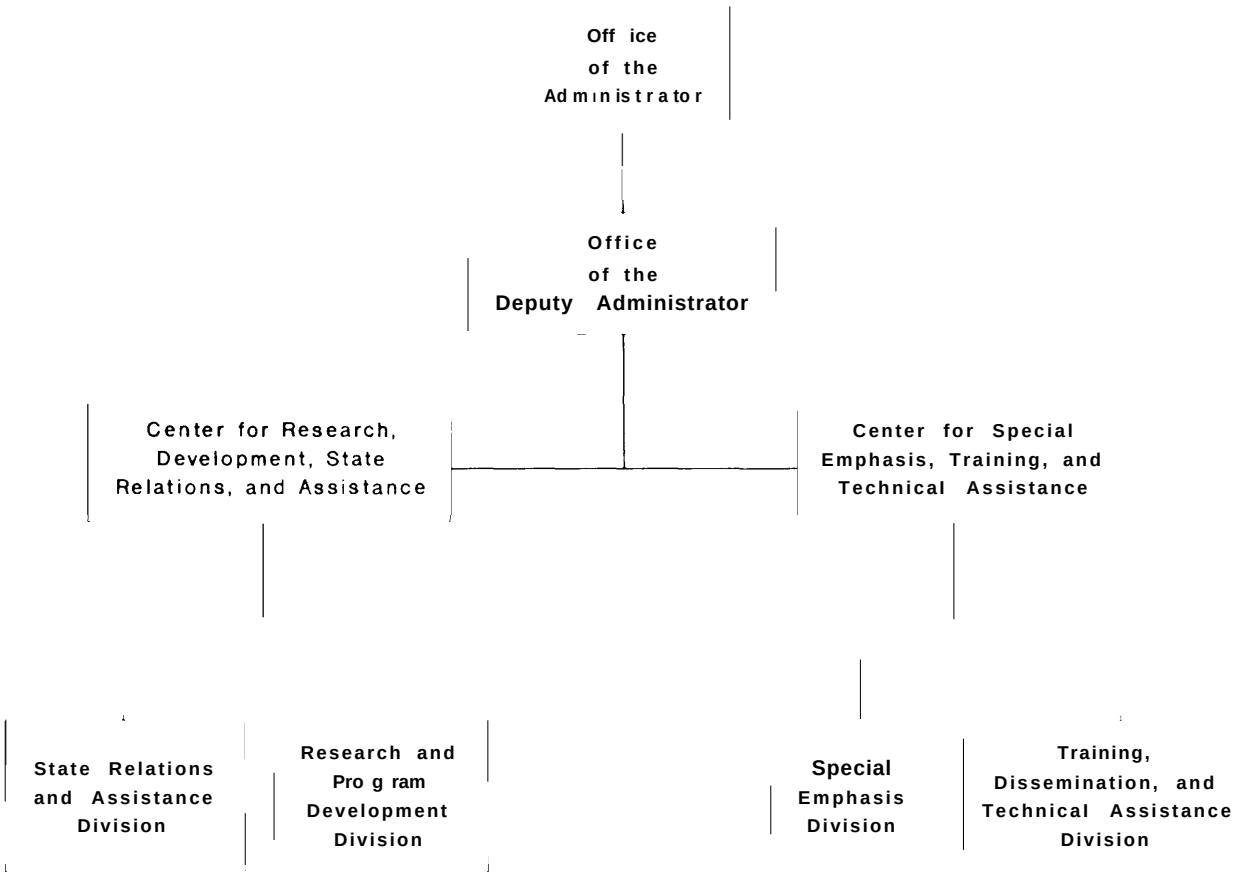
The Office of Juvenile Justice and Delinquency Prevention awards an estimated 115 to 120 discretionary grants each year, ranging from $15,000 to $4 million, with an average of approximately $215,000 per award in fiscal year 1989.[47] In 1988, Congress authorized that substantial portions of discretionary funds be shifted from discretionary to formula grants to States (34).[48] In fiscal year 1989, the funds allocated to States totaled $45.75 million.

National Institute of Justice—The National Institute of Justice within the U.S. Department of Justice works to improve the criminal justice system, addresses crime prevention and control, and enhances community safety and security. Although approximately 20 percent ($4.2 million) of the National Institute of Justice's overall budget of $21 million is spent on research and demonstration projects that include adolescent components, the National Institute of Justice generally does not target adolescents specifically. Its fiscal year 1990 priorities include examining drug marketing and associated crime, violent crime, effective policing strategies, white-collar and organized crime, and the prosecution and incarceration of offenders. Current adolescent projects include grants on drug use patterns of inner-city youth, drug testing of juvenile offenders, and helping fund the National Academy of Sciences Panel on Understanding and Controlling Violence which will examine adolescent data on violence. Additionally, the program of research on Human Development and Criminal Behavior will examine developmental factors that influence delinquency, crime, and other antisocial behavior.

[47] In fiscal year 1988, 86 initiatives were funded, including 24 on illegal drug use, 18 on missing and exploited children, 6 on violence in the schools, and 3 on juvenile gang violence (97).

[48] In order to be eligible for these grants, States must comply with section 223(a)(12)(A)(13) and (14) of the Juvenile Justice and Delinquency Prevention Act requiring the deinstitutionalization of status offenders and nonoffenders, the separation of juveniles from adults within secure confinement facilities, and the removal of juveniles from adult jails and lockups.

Figure 19-10--U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention



SOURCE: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, *Twelfth Analysis and Evaluation: Federal Juvenile Delinquency Programs 1988* **(Washington, DC: 1988).**

U.S. Department of Labor

Within the U.S. Department of Labor, the Employment and Training Administration is the agency most directly supporting activities affecting adolescents. In program year 1989, funding for youth was estimated to account for 58 percent ($2.2 billion) of the budget. Employment and Training Administration projects for youth typically focus on adolescents and young adults ages 16 and over. The Employment and Training Administration supports employment and training programs for economically disadvantaged youth under the 1982 Job Training Partnership Act. Three sections of the Job Partnership Training Act affect adolescents ages 16 to 21: Titles 11-A, II-B, and IV.

Titles H-A and II-B of the Job Training Partnership Act authorize block grants to States. Under Title II-A, training services are offered throughout the year to economically disadvantaged adults and youth. Forty percent ($715.1 million) of the total budget in program year 1989 for Title II-A was earmarked for adolescents.[49] Title II-B establishes a summer employment program for low-income youth. All of the funding for Title II-B, $709.4 million for summer 1990, was designated for adolescents, and $12.9 milllon of this total was used to Support

[49] States are required to allocate funds according t. a set formula, so that 78 percent of the funds are distributed to service delivery areas (designated by **Governors)** and **[he** remaining 22 **percent** is for **State** set-asides.

summer employment opportunities for Native American youth (99).

Title IV authorizes various federally administered programs affecting adolescents, such as Job Corps and programs designed for Native Americans and migrant workers. Job Corps, a joint venture between the U.S. Department of Labor, private corporations, and nonprofit organizations, provides employment and training in primarily residential centers for disadvantaged adolescents and young adults ages 16 to 21 (100). The U.S. Department of Labor provides funding for the centers, which totaled $741.8 million in program year 1989, and corporations and nonprofit organizations organize and manage the centers under a contractual agreement. In program year 1989, there were 100,000 participants in Job Corps. After completing the program, 66.9 percent of the participants were placed in jobs and 16.7 percent went on for further education.

In addition, Title IV establishes funding for research, which is administered by the Division of Research and Demonstrations in the Office of Strategic Planning and Policy Development. One of the primary goals is to address the problem of unemployed youth or those at risk of becoming unemployed. Specific programs include grants for the following: to integrate Federal, State and local services; to investigate patterns of youth achievement; to link school and employment with apprenticeships; to evaluate demonstrations providing alternative education to at-risk youth; and to analyze interagency demonstrations *(98).* Currently, 35 such research projects are underway, and the average cost per project is approximately $275,000.

Under the Employment and Training Administration's Office of Work-Based Learning, the Bureau of Apprenticeship and Training administers various apprenticeship programs authorized by the National Apprenticeship Act of 1937. Federal staff from the Bureau of Apprenticeship and Training, as well as State personnel in some States, assist in providing technical assistance to *the* apprenticeship programs, which are sponsored by industry. The average age of most apprentices is about 29, and about 17 percent of apprentices are between the ages of 16 and 22 (25). There is one type of apprenticeship program designed specifically for adolescents. The School-to-Apprenticeship Program, which makes up less than 1 percent of all apprenticeship programs, provides adolescents with the opportunity to attain valuable job skills in an apprenticeship when they are high school seniors (101).

U.S. Department of Transportation

Federal Highway Administration—The Federal Highway Administration does not typically target individuals of any age group, but supports programs, such as highway repairs and maintenance, which improve the safety of the roads for everyone. Within the Federal Highway Administration, however, the Office of Highway Safety sponsors a number of research and demonstration projects that indirectly affect both adolescent drivers and pedestrians. For fiscal years 1987-91, $10 million was allocated for safety research and development, which includes research on accidents among young drivers, pedestrians, and bicyclists (102).

National Highway Traffic Safety Administration-Although the National Highway Traffic Safety Administration does not have any adolescent-specific priorities for fiscal years 1989 and 1990, the agency does fired several programs that include adolescents. Because motor vehicle accidents are the greatest cause of death for adolescents and young adults ages 15 to 24, this age group is targeted by the National Highway Traffic Safety Administration. Activities for adolescents and young adults under age 21 include alcohol and drug accident prevention, passenger protection, and motorcycle safety; these activities take place in a variety of settings, such as schools, offices, and other places in the community. In addition, within the National Highway Traffic Safety Administration, the Office of Traffic Safety Programs has formed a Youth Committee to coordinate its highway safety activities for young adults. The National Highway Traffic Safety Administration also supports workshops in colleges and media announcements dealing with alcohol and drug and highway safety policies. Research priorities include accident prevention techniques for use by States and communities.

The National Highway Traffic Safety Administration also funds activities aimed at individuals younger than age 15, which primarily affect adolescents in the 10- to 14-year-old age group. These activities include pedestrian safety programs, a bicycle education program, dissemination of educational kits for schools and communities, and informational guides related to car air bags, alcohol, and safety belt use. As an example, ''The Car Club,' an instructional kit for junior high and middle school

students, provides information on car occupant protection.

In 1989, the National Highway Traffic Safety Administration programs were estimated to reach over 30 million elementary, junior high, and high school adolescents. But in 1989, less than 1 percent ($975,000) of the Adrninistration's budget was estimated to target adolescents. Estimates for research programs targeting adolescents are not available; however, total research funding is estimated at $775,000 for 1989.

Coordination at the Federal Level

Currently no one agency, department, or executive office formally coordinates Federal activities related to adolescents, but some coordination does take place within and between organizations in the form of Committees and memoranda of agreement.[50] For example, within the Alcohol, Drug Abuse, and Mental Health Administration, the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse together fund grants for drug and alcohol abuse prevention research. The U.S. Department of Justice's National Institute of Justice and the Office of Juvenile Justice and Delinquency Prevention fund a project on Drug Use Patterns of Inner City Youth. Examples of current efforts between agencies are listed below.

- The Ad Hoc Committee on Health Promotion Through the Schools, which is coordinated through the Office of Disease Prevention and Health Promotion and involves about 10 Federal agencies (e.g., U.S. Environmental Protection Agency, the Indian Health Service, Bureau of Maternal and Child Health, and the U.S. Departments of Agriculture, Defense, Education, Health and Human Services, and Transportation) (14).
- The multi-agency collaboration with the Centers for Disease Control's Division of Adolescent and School Health in the development of a Youth Risk Behavior Surveillance System.
- * The Coordinating Council of Juvenile Justice and Delinquency, created by Section 206 of the Juvenile Justice and Delinquency Prevention Act, coordinates Federal juvenile delinquency Programs[51] and is composed of cabinet-level representatives from 18 member Federal agencies. In fiscal year 1988, Coordinating Council agencies supported 72 initiatives to prevent juvenile delinquency (97).
- The Ad Hoc Federal Interagency Working Group, which was developed to bring about a more coordinated governmental response to the drug problems within individual communities. Agencies include the National Highway Traffic Safety Administration, and the U.S. Departments of Education, Health and Human Services, Housing and Urban Development, Justice, and Labor.
- The Interagency Panel on Children and Adolescents meets monthly to share information and coordinate research efforts on issues affecting children and adolescents. Member agencies report on current research, demonstration projects and various programs; in addition, they discuss interagency joint research. The panel

[50]In April 1991, the Secretary of Health and Human Services announced a reorganization of some DHHS programs for children and families within DHHS (61a). The purpose of the reorganization was 'to place greater emphasis and greater focus on the needs of America's children and families" (61a). The reorganization would combine all programs of the Family Support Administration and the Office of Human Development Services, and the maternal and child health block grant program in the Health Resources and Services Administration of the Public Health Service, into a new '' Administration for Children and Families.' The new Administration for Children and Families would be on an@ level with the Public Health Service, the Health Care Financing Administration, and the Social Security Administration. Programs in the new operating division would include programs such as Head Start, Job Opportunities and Basic Skills, Aid to Families With Dependent Children, Child Support Enforcement, Adoption Assistance, Foster Care, the Social Services Block Grant, Child Care and Development Block Grant, and child abuse programs, as well as the maternal and child health block grant (61a). The combined budget of the new Administration was estimated by DHHS to be $27 billion and the size of the staff 2,000. According to the announcement, no funding or staff cuts will take place as a result of the change. Although the reorganization was said to be effective immediately, the DHHS announcement indicated that the change will involve extensive followup implementation. Consequently, a task force to direct the implementation had been formed (61 a). Thus, although one of the intended divisions of the new Administration for Children and Families was an office of 'Children, Youth and Families,' the role of adolescent health issues in the new Administration was not immediately clear. It is important to note that many of the approximately 60 U.S. executive branch agencies with a role in adolescent health (some of them in departments other than DHHS; see figure 19-1) were not included in the reorganization.

[51]Coordination occurs among the U.S. Department of Justice [National Institute of Justice and the Office of Juvenile Justice and Delinquency Prevention], U.S. Department of Health and Human Services [Administration for Children, Youth and Families; Family and Youth Services Bureau; Office of Community Services; Alcohol, Drug Abuse, and Mental Health Administration], U.S. Office of National Drug Control Policy, U.S. Department of Education, U.S. Department of Transposition [National Highway Traffic Safety Administration], U.S. Department of Labor, U.S. Department of the Interior [Bureau of Indian Affairs] , U.S. Department of Housing and Urban Development ACTION, and the U.S. Environmental Protection Agency (97).

also conducts an annual conference to discuss topics in depth, inviting experts from outside the Federal government. Twenty-eight government agencies are represented at the monthly panel meetings. Agencies include ACTION and the U.S. Department of Agriculture, Defense, Education, Health and Human Services, Justice, Labor, State, and Transportation (12).

Examples of past and current Memoranda of Agreement follow:

- Parent education to low-income parents (including adolescents), expectant parents, and care givers of children ages O to 36 months in at-risk families: Office of Human Development Services, U.S. Department of Health and Human Services; Extension Service, U.S. Department of Agriculture;
- Community-based mental health services for youth: National Institute of Mental Health, Alcohol, Drug Abuse, and Mental Health Administration; Bureau of Maternal and Child Health, Health Resources and Services Administration;
- Assignment of medical students to youth shelters to help enhance coordination of health services: Bureau of Health Care Delivery and Assistance, Health Resources and Services Administration; Office of Human Development Services, U.S. Department of Health and Human Services;
- Demonstration projects in consumer education for public housing residents on nutrition and decisionmaking in eight sites: U.S. Department of Agriculture, Extension Service's 4-H Youth Development Program; U.S. Department of Housing and Urban Development; Kraft General Food Foundation (48);
- Support for the Cities in School project: U.S. Department of Health and Human Services, U.S. Department of Labor, U.S. Department of Justice, U.S. Department of Education;
- Programs for American Indian youth related to alcohol and drug abuse: education and prevention services for Indian children and adolescents attending elementary and secondary schools on reservations: U.S. Department of Education, U.S. Department of the Interior (14);
- Supporting and mobilizing national resources for young children and youth with HIV infection and AIDS-related complex: Office of Human Development Services, U.S. Department of Health and Human Services; Public Health Service, U.S. Department of Health and Human Services;
- Conducting 1988 National Health Interview Survey's Child Health Supplement; National Health and Nutrition Examination Survey III Child Health Component: National Center for Health Statistics, Centers for Disease Control; Health Resources and Services Administration;
- Conducting National Adolescent Student Health Survey: Centers for Disease Control; National Institute on Drug Abuse, Alcohol, Drug Abuse, and Mental Health Administration; Office of Disease Prevention and Health Promotion, Office of the Assistant Secretary for Health;
- National Longitudinal Survey of Youth: U.S. Department of Labor; U.S. Department of Defense; National Institute of Child Health and Human Development, National Institutes of Health; National Institute on Alcohol Abuse and Alcoholism and National Institute on Drug Abuse, Alcohol, Drug Abuse, and Mental Health Administration (30);
- Plan and implement cooperative program activities related to the provision of services, education, and treatment to pregnant and postpartum women and to infants in the area of drug abuse prevention, education, and treatment via women in the Special Supplemental Food Program for Women, Infants, and Children (WIC) program: Office for Substance Abuse Prevention, Alcohol, Drug Abuse, and Mental Health Administration; Food and Nutrition Service, U.S. Department of Agriculture;
- Market research study conducted by S.W. Morris & Co. to determine what high-risk adolescents know about certain issues, such as AIDS, teenage pregnancy, and substance abuse, and how they received this information: Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services; U.S. Department of Education; U.S. Department of Justice; U.S. Department of Transportation (29);
- Demonstration grant program to develop model programs for pregnant and postpartum women (including adolescents) and their infants: Office for Substance Abuse Prevention, Alcohol, Drug Abuse, and Mental Health Administra-

tion; Bureau of Maternal and Child Health, Health Resources and Services Administration;

- Supporting the reduction of crime in schools, Drug Prevention Education in the Schools, and D.C. Drug Free School Zone (Z-1000 Program: Office of Juvenile Justice and Delinquency Prevention, and National Institute of Justice, U.S. Department of Justice; U.S. Department of Education (54);
- Children in Custody Census of Juvenile Detention, Correctional and Shelter Care Facilities: Office of Juvenile Justice and Delinquency Prevention, and National Institute of Justice, U.S. Department of Justice; Bureau of the Census;
- Wilmington Delaware Public Housing Initiative: Office of Juvenile Justice and Delinquency Prevention, and National Institute of Justice, Bureau of Justice Assistance, U.S. Department of Justice; U.S. Department of Housing and Urban Development;
- Supporting programs on military installations: Extension Service, U.S. Department of Agriculture; U.S. Department of Defense;
- Improve breastfeeding promotion: Food and Nutrition Service, U.S. Department of Agriculture; Office of Maternal and Child Health, Health Resources and Services Administration, in the U.S. Department of Health and Human Services;
- Identification of ways to integrate food assistance services into migrant health care programs: Food and Nutrition Service, U.S. Department of Agriculture; Migrant Health Programs;
- Smoking Cessation in Pregnancy demonstration project: Food and Nutrition Service, U.S. Department of Agriculture; Centers for Disease Control, U.S. Department of Health and Human Services;
- Facilitating the transfer of nutrition education to American Indian households: Food and Nutrition Service, U.S. Department of Agriculture; Indian Health Service, Public Health Service, U.S. Department of Health and Human Services;
- Cooperation on bicycle safety issues: U.S. Consumer Product Safety Commission; National Highway Traffic Safety Administration, U.S. Department of Transportation.

In addition, some Federal agencies have become involved in promoting coordination at the local level. These efforts include the following:

- Division of Children, Youth, and Families within the Office of the Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services.

  The Division has undertaken a study that will evaluate the feasibility of reorganizing local existing social services for at-risk children, youth, and families into a comprehensive community-based system. This effort, funded at $135,000, ties into local initiatives sponsored by the Annie E. Casey Foundation.
- Regional Offices of the Employment and Training Administration within the U.S. Department of Labor and the U.S. Department of Health and Human Services.

  These offices coordinate Youth 2000, a project designed to mobilize local efforts to address problems with at-risk youth, including illiteracy, incompletion of high school, teenage pregnancy, and alcohol and drug abuse (98).
- Child and Adolescent Service System Program within the National Institute of Mental Health.

  The Child and Adolescent Service System Program tries to promote change in the ways in which communities and States deliver health services to severely emotionally disturbed children. Two Research and Training Centers under the Child and Adolescent Service System Program are funded through an interagency agreement with the U.S. Department of Education's National Institute on Disability and Rehabilitation Research, and a Technical Assistance Center is funded through an agreement with the Health Resources and Services Administration's Bureau of Maternal and Child Health and Resources Development (76).
- High Risk Program within the Child and Family Support Branch of the National Institute of Mental Health.

  The High Risk Program is helping to integrate HIV-infected children and adolescents into State service networks for children and adolescents with severe emotional disturbance (78).

Additionally, several agencies have agreements with private businesses. For example, through the national Cooperative Extension System, the U.S. Department of Agriculture and professionals at

land-grant universities are trying to extend research and technology into the communities (45). Additionally, discussions are being conducted with the U.S. Department of Housing and Urban Development's Division of Indian and Low Income Housing, the U.S. Department of Agriculture's Extension Service, and private industry to target youth programs in selected locations of high-risk factors.

A common theme among the reports reviewing Federal policies toward children and adolescents and among representatives at OTA's meeting with representatives of U.S. executive branch agencies with a role in adolescent health is the need for leadership and coordination at the Federal level, although the mechanism to provide for this coordination is not uniformly agreed upon.

In 1980, a report from the National Commission on Youth recommended the development of a comprehensive national youth policy at the Federal level to serve the needs of all young persons rather than targeted segments of the population (26a). Furthermore, the Commission suggested that the policy should be long-term with a startup period to build experienced personnel for program supervision. In addition, the Commission recommended both a presidential commission to study youth problems and the establishment of a White House youth office to coordinate policies and programs.

Given the gaps in and between adolescent services, fragmentation and duplication in both programs and services, and conflicts among various levels of government and among a variety of programs, the 1981 report *Better Health for our Children (96)* recommended that an Administration on Maternal and Child Health be created that would have abroad role in coordinating programs for youth and children.

In 1988, the National Commission to Prevent Infant Mortality recommended that a permanent national council on children's health and well-being be established to provide coordination and collaboration among Federal agencies to promote the health of both pregnant women and children (27).

In both 1987 and 1989, the W.T. Grant Foundation stated that the Federal Government has not provided a ''coordinated, comprehensive direction for youth" ages 16 through 24 (33,34).

Most recently, the Institute of Medicine reviewed the level of implementation of recommendations by over *20* major commission and panel studies on children, youth and families published between 1983 and 1988. The review, *Social Policy for Children and Families,* noted that 'there is no entity taking responsibility or catalyzing the nation into action. No coordinating mechanisms exist to ensure that the necessary services are provided effectively and efficiently to those in need. . ..[There is] no public leadership on children's issues" (28). The history of the Children's Bureau provides an illuminating example of the way Federal policy on children and youth has developed in the past (see box 19-A).

Most of these reports have not distinguished between children and adolescents. The Federal agency representatives who came to OTA for discussion in October 1989 agreed that there was little coordination on adolescent issues. Some of the responsibility for the isolation and fragmentation these representatives experienced was attributed to the legislation that guides executive branch programs. In fact, the fragmentation of services maybe due in part to the many authorizing congressional committees from which agencies take direction (table 19-6). As just one example, 53 House committees and subcommittees and 21 Senate committees and subcommittees exercise some jurisdiction over controlling drug use in the general population (41). Still, the U.S. Executive Branch representatives did not believe that an agency devoted specifically to adolescent issues would be the preferred method to improve adolescent health, especially in these times of fiscal restraint. They favored incentives to increase cooperation and coordination among the current Federal agencies.

Conclusions and Policy Implications

The response to OTA's August 1989 survey of Federal agencies suggest that many Federal agencies support a range of activities directed toward improving the health of adolescents. As reflected in Federal agency budgets, however, adolescent health issues generally do not receive much emphasis. Among DHHS agencies, for example, it is rare for an agency to devote more than 10 percent of its expenditures specifically to adolescents (see table 19-3). DHHS agencies responding to OTA's survey that do devote more than 10 percent of their expenditures to adolescents were the Centers for Disease Control's Division of Adolescent and School Health (100 percent), the Health Resources and Services Admin-

Box 19-A—History of the Children's Bureau

The idea of a central **coordinating body** for programs and policies related to children and youth in the United States is not new. The Children's Bureau was established in 1912. The issues surrounding the development of the Bureau are not at all dissimilar to some of the issues facing the Nation today.

In the late 1800s, with the rapid growth of industrialization and migration to cities, communities were faced with a lack of foster care for abandoned children, high infant mortality rates, problems of gangs of homeless youth roaming the streets, juvenile delinquency, education, and child labor. It was becoming more and more critical that both national and local policies relating to children be developed. There was also the need for more accurate information on the condition of children.

The editors of a multi-volume history of children and youth in America noted that the Children's Bureau was:

> The single most important development in the public provision of services to children during the early 20th century. . . The founding of this agency signified acceptance by the Federal government of responsibility for promoting health and welfare of the young. The Bureau was not organized as a reearch and information center and did not initially perfom any child welfare services. Its function was to investigate and report upon all matters pertaining to the welfare of children and child life among all classes of our people including questions of infant mortality, the birth rate, orphanage, juvenile courts, desertion, dangerous occupation, accidents and diseases of children, employment, and legislation affecting children in the several states and territories (10).

Grace Abbott, a former director of the Children's Bureau, noted that "the whole child was made the subject of the research. " The interrelated problems of child health, dependency, delinquency, and child labor were to be considered and interpreted in relation to the community program for all children" (10). This theme is one heard time and again in relation to the health problems of today's adolescents.

The development of the Children's Bureau from its initial conception in 1903 until it was signed into law in 1912 was not without controversy. The themes expressed by opponents of the Bureau seem remarkably familiar today. Opposition to the 1909 bill was in part based on the view that such a bureau would be unconstitutional as it purported to exercise jurisdiction over State and local agencies concerned with child welfare. It was also felt that such programs in the children's Bureau would be duplicative of efforts by either the Department of Census or the Department of Education. Surprisingly, opposition was also expressed by the New York Society for the Prevention of Cruelty to Children which felt that the Bureau would 'inevitable interfere with the work of our Societies where they exist through the entire United States" (10). One senator speaking out against the Bureau noted that". . .While upon the face of this measure it merely provides for the taking of statistics, the accumulation of knowledge, yet we know from other measures which have been introduced, some from the same source, that it contemplates the establishment of a control, through the agencies of government, over the rearing of children" (10).

Despite these objections, a Children's Bureau was signed into law. In its first 10 years, the activities of the Bureau resulted in an increase in the number of States with special units concerned with child health from 1 to 46. Some of the issues brought to the fore by the Children's Bureau and localbureaus again are germane today. A report in 1927 by the Children's Bureau of Cleveland indicated that" . . .no other dependency of children is so great a tax on the financial resources and on the skill of the staffs of social welfare agencies as that of divorce, separation and desertion. The difficulties in families broken by divorce or desertion are so complex that the work of medical and social agencies of community must be well coordinated in order to salvage as many of these wrecked families as possible" (10).

In 1934, a report by the Bureau to the Committee on Economic Security on the impact of the depression noted that ".. among adolescents were found evidences of increasing mental instability and inability to meet the problems that arise from unemployment and depleted family resources."

And finally, in 1938, Grace Abbott, then director of the Bureau, noted that "programs should be tailored for children and they cannot be merely an adaptation of the program for adults. . nor should the programs for children be curtailed during periods of depression or emergency expansion of other programs" (10).

Organizationally, the children's Bureau was initially placed in the U.S. Department of Labor. In 1930, the Preliminary Committee Reports of the White House Conference on Child Health and Protection recommended that the Division of Child Hygiene and Maternity and Infancy of the Children's Bureau be moved to the Public Health Service (10). In 1946, the Children's Bureau was moved from the U.S. Department of Labor to the Federal Security

Continuedon next page

Box 19-A—History of the Children's Bureau—Continued

Agency, then responsible for Social Security programs. In 1953, the Family Support Administration was absorbed by the U.S. Department of Health, Education and Welfare, and the Children's Bureau became part of the Social Security Administration. In 1963, the Bureau was moved from the Social Security Administration to the Welfare Administration, and again in 1967, the Bureau was further assigned to Social and Rehabilitation Services. The medical services component, maternal and child health, was subsequently moved to the Public Health Service in the Health Services and Mental Health Administration. The social services component remained in the U.S. Department of Health, Education, and Welfare and then became part of the U.S. Department of Health and Human Services, Office of Human Development Services, Administration for Children, Youth, and Families.

The Children's Bureau exists today. However, its function is much changed from the broad charge given it in 1912. Today, its responsibilities focus primarily on administering child welfare grants. Other child related programs in the U.S. Department of Health and Human Services are now found in the Administration on Children, Youth, and Families, Bureau of Maternal and Child Health, National Institute of Child Health and Human Development and other Institutes within the National Institutes of Health, Centers for Disease Control, and agencies within the Alcohol, Drug Abuse, and Mental Health Administration. No single unit within the U.S. Department of Health and Human Services at this time serves as a central coordinating or clearinghouse for the department's adolescent initiatives.

istration's Bureau of Health Care Delivery and Assistance (17 percent), the National Institutes of Health's National Institute of Allergy and Infectious Diseases (15 percent), the Alcohol, Drug Abuse, and Mental Health Administration's National Institute of Mental Health (12 percent).

In non-DHHS agencies responding to OTA's survey, adolescents tend to receive a larger proportion of appropriated money, although the total amounts are small (see table 19-5). The U.S. Department of Justice, for example, directs approximately 20 percent of its National Institute of Justice funds and all of its Office of Juvenile Justice and Delinquency Prevention funds to adolescents. In addition, the U.S. Department of Agriculture's Extension Service, and the U.S. Department of Education's National Institute on Disability and Rehabilitation Research direct over 20 percent of their funds specifically to adolescents.

A very rough estimate by OTA, based on data able to be provided by the range of U.S. executive branch agencies with a role in adolescent health, is that, in fiscal year 1988, adolescent health initiatives accounted for perhaps 2 percent of the $533 billion in Federal expenditures (102a) for domestic "human resources' or ''social welfare' programs.[52]

Most Federal agencies surveyed by OTA do not provide specific set-asides for adolescents. Instead, they often include adolescents as part of a larger, more general, research or service focus. Because adolescents require comprehensive, continuous, developmentally appropriate, labor-intensive interventions, they may not receive the services they need when they are included as part of populations serving children in general or adults.

Federal agency priorities are often determined by authorizing legislation or executive directive. In some cases, the result is that resources available to serve the needs of adolescents are quite limited. Federal agency representatives at OTA's meeting indicated that direction for changing agencies' short- and long-term priorities must come from the President or Congress. To make adolescent health a priority, Federal agency representatives expressed the need for additional appropriated funds or for current funds to shift from other areas and suggested Congress could heighten awareness of adolescents and their health needs through a series of hearings.

Currently, the Federal Government places heavy emphasis on supporting programs and projects related to the consequences of adolescent sexual

52 ''Human resources'' or ''social welfare'' programs include the budget ''functions'' of education, training, unemployment, and social services; health; Medicare; income security; social security; and veterans benefits and services (414102a), Recent changes in the Federal budget as they pertain to domestic spending, and the potential consequences for adolescent health initiatives, are discussed more fully in *Volume I—Summary and Policy Options* of this Report (44b). The budget share would be higher if the adolescent share of AFDC payments were known.

Table 19-6-Congressional Committees With a Role in Adolescent Health[a]

AP = Handles appropriations
B = Sets fundinga guidelines
AU = Authorizes major program areas
A = Authorizes specific programs
O = Oversight of programs
T = Jurisdiction over funding sources such as trust funds

Congressional committees and subcommittees	Families	Schools and education	Work, recreation, and fitness	Nutrition	Special groups	Health and related services (delivery and access)	Financial access to health services	Future competitiveness and defense readiness	Other
Senate committees									
Agriculture, Nutrition, and Forestry				AU/O	A/o				
Nutrition and investigations									
Appropriations[d]	AP/O	AP/O	AP/O	AP/O	AP/O	AP/O	AP/O	AP/O	AP/O
Armed services[e]						A/o	A/O	A/o	
Banking, Housing, and Urban Affairs[f]	A/o				A/O				
Housing and Urban Affairs									
Budget	o	0	0	0	0	0	0	0	0
Commerce. Science. and Transportation[g]			AU/O						AU/O
Environment and Public Works[h]			A/o					AU/O	
Finance[i]	T/O					T/O	AU/T/O		
Social Security and Family Policy									
Health for Families and the Uninsured									
Governmental Affairs[j]	o	0	0	0	0	0	0	0	AU/O

[a] Except where noted, the congressional committees shown in this table are standing committees. *Standing committees are* committees that are permanent bodies of either the House or the Senate, have responsibility for broad areas of legislation (e.g., agriculture), and are responsible for most of the legislation considered by Congress. The Senate has 16 standing committees, and the House has 22 standing committees. *Select committees* are committees created to study particular problems or concerns (e.g., Select Committee on Children, Youth, and Families). These committees make recommendations but are usually not permitted to report legislation to congress (the one exception is the Select Intelligence Committee). Joint committees are committees composed of members from both the House and the Senate. The Joint Economic Committee is the only joint committee which has a policy roie v. an administrative role, and reports its findings to Congress.

[b] Only subcommittees that deal extensively with legislation related to adolescent health are noted. A *subcommittee* is an offshoot of a standing or joint committee and deals with a particular area covered by the full committee. There are usually a number of subcommittees within a particular comm ittee. Members of the subcommittee are also members of the full committee. Subcommittees hoid hearings and amend bills relating to their particular topic area. The amendments must be voted on in the full committee before returning to the House or Senate floor.

[c] The Senate Agriculture, Nutrition, and Forestry Committee authorizes and exercises oversight over numerous programs administered by the U.S. Department of Agriculture, including food and nutrition programs (e.g., the Food Stamp Program, school nutrition programs) and programs related to rural development.

[d] The following subcommittees of the Sanate Appropriations Committee deai with programs relevant to adolescent healt h: Agriculture, Rural Development, and Related Agencies ;Commerce, Justice, and State, the Judiciary, and Related Agencies; Defense; interior and Related Agencies; Labor, Health and Human Services, Education and Related Agencies; and Transportation and Related Agencies.

[e] The Senate Armed Services Committee authorizes and exercises oversight over numerous programs administered by the U.S. Department of Defense, including the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), a civilian health and medical program for retirees and the spouses and dependent children of active duty, retired, and deceased m ilitary personnel.

[f] The Senate Banking, Housing, and Urban Affairs Committee authorizes and exerases oversight over programs administered by the U.S. Department of Housing and Urban Development, including public and private housing programs and community development block grants.

[g] The Senate Commerce, Science, and Transportation Committee authorizes and exercises oversight over programs administered by the U.S. Department of Transportation, including programs related to highway and motor vehicle transportation safety.

[h] The Senate Environment and Public Works Committee authorizes and exercises oversight over programs administered by the Environmental Protection Agency that alleviate or reduce noise, water, and air pollution.

[i] The Senate Finance Committee authorizes health programs under the Social Security Act. including Medicaid.

[j] The Senate Governmental Affairs Committee has jurisdiction over programs of the Census Bureau, and over the organization of Congress and the U.S. executive branch.

Continued on next page

Table 19-6-Congressional Committees With a Role in Adolescent Health[a]-Continued

AP = Handles appropriations
B = Sets funding guidelines
AU = Authorizes major program areas
A = Authorizes specific programs
O = Oversight of programs
T = Jurisdiction over funding sources such as trust funds

Congressional committees and subcommittees[b]	Families	Schools and education	Work, recreation, and fitness	Nutrition	Special groups	Health and related services (delivery and access)	Financial access to health services	Future competitiveness and defense readiness	Other
Judiciary[k]					AU/O				AU/O
Labor and Human Resources[l]	AU/O	AU/O	AU/O	AU/O	AU/O	AU/O	AU/O	AU/O	AU/O
Labor									
Education, Arts, and Humanities									
Employment and Productivity									
Disability Policy									
Children, Family, Drugs, Alcoholism									
Select Committee on Indian Affairs					o	0	0		
House committees									
Agriculture[m]				A/O	AU/O				
Conservation, Credit, and Rural Development									
Domestic Marketing, Consumer Relations, and Nutrition									
Appropriations[n]	AP/O	AP/O	AP/O	AP/O	AP/O	AP/O	AP/O	AP/O	AP/O
Armed Services[o]						A/O	A/O	A/O	
Banking, Finance, and Urban Affairs[p]	A/o				A/o				
Housing and Community Development									
Budget	o	0	0	0	0	0	0	0	0

[k]The Senate Judiciary Committee authorizes and exercises oversight over programs administered by the U.S. Department of Justice, including Office of Justice and other programs related to juvenile justice and delinquency prevention.

[l]The Senate Labor and Human Resources Committee authorizes and exercises oversight over a wide range of programs related to health, education, labor, and public welfare. It has jurisdiction over the Public Health Service Act, substance abuse programs, education programs, and numerous other programs related to children and families.

[m]The House Agriculture Committee authorizes and exercises oversight over programs administered by the U.S. Department of Agriculture, including food and nutrition programs (e.g., the Food Stamp Program, school nutrition programs) and programs related to rural development.

[n]The following subcommittees of the House committee on Appropriations deal with programs relevant to adolescent health: Commerce, Justice, and State, the Judiciary, and Related Agencies; Defense; Interior and Related Agencies; Labor, Health and Human Services, Education, and Related Agencies; Rural Development, Agriculture, and Related Agencies; and VA, HUD, and independent Agencies.

[o]The House Armed Services Committee authorizes programs administered by the U.S. Department of Defense, including CHAMPUS (see Senate Armed Services Committee above).

[p]The House Banking, Finance, and Urban Affairs Committee authorizes and exercises oversight over programs administered by the U.S. Department of Housing and Urban Development, including housing and community development programs.

Table 19-6-Congressional Committees With a Role in Adolescent Health[a]—Continued

AP - Handles appropriations
B - Sets funding guidelines
AU = Authorizes major program areas
A = Authorizes specific programs
O = Oversight of programs
T = Jurisdiction *over* funding sources such as trust funds

Congressional committees and subcommittees	Families	Schools and education	Work, recreation, and fitness	Nutrition	Special groups	Health and related services (delivery and access)	Financial access to health services	Future competitiveness and defense readiness	Other
Education and Labor[q]	AU/O	AU/O	AU/O	A / O	A / o				AU/O
Elementary, Secondary, and Vocational Education									
Health and Safety									
Employment Opportunities									
Select Education									
Energy and Commerce[r]	AU/O		AU/O	AU/O	AU/O	AU/O	A / O		A / o
Health and the Environment									
Government Operations[s]	o	0	0	0	0	0	0	0	AU/O
Interior and Insular Affairs[t]	AU/O		AU/O		AU/O	AU/O	AU/O		
Judiciary[u]	AU/O				AU/O				AU/O
Post Office and Civil Service[v]	A/O				A/o	A/o	A/o		A/O
Science, Space, and Technology[w]		A/O						AU/O	AU/O
Ways and Means[x]	AU/O			A/O		AU/O	AU/O		
Health									
Human Resources									
Select Committee on Children, Youth, and Families	O	0	0	0	0	0	0	0	0
Select Committee on Hunger	o	0		0	0	0	0		
Select Committee on Narcotics Abuse and Control[y]	O	0	0			0	0		0
Joint committee									
Joint Economic Committee		o				0		0	0
Economic Resources and Competitiveness									
Education and Health									

[q]The House Education and Labor Committee authorizes and exercises oversight overa wide range of programs related to education, labor standards, human resources programs for the elimination of poverty and the care and treatment of children (e.g., Head Start, community services block grants, juvenile justice and delinquency prevention, and programs for runaway youths), and job training.
[r]The House Energy and Commerce Committee authorizes and exercises oversight over a wide range of programs related to health and the environment. It has jurisdiction over the Public Health Service Act and biomedical programs and health protection in general (including Medicaid and national health insurance). it also has jurisdiction over the Clean Air Act and the Safe Drinking Water Act.
[s]The House Government Operations Committee has oversight responsibilities related to the organization and reorganization of the U.S. executive branch.
[t]The House Interior and Insular Affairs Committee authorizes and exercises oversight over programs administered by the U.S. Department of the Interior, including programs that deal with national parks and several programs that affect Native Americans.
[u]This House Judiciary Committee authorizes and exercises oversight over programs administered by the U.S. Department of Justice, including Office of Justice and other programs related to juvenile justice and delinquency prevention.
[v]The House Post Office and Civil Service Committee has jurisdiction over programs of the Census Bureau and authorizes programs that deai with health and related services for Federal employees and their families.
[w]The House Science, Space, and Technology Committee authorizes research and development in science and technology.
[x]The House Ways and Means Committee authorizes and exercises oversight over numerous programs of the Social Security Act, including AFDC.
[y]The House Select Committee on Narcotics Abuse and Control investigates issues relating to substance abuse and the criminal justice system.

SOURCE: Office of Technology Assessment, based on material from U.S. Congress, Library of Congress, *Congressional Yellow Book* 16(3) (Washington, DC: Monitor Publishing Co., Fall 1990).

intercourse, especially focusing on AIDS and HIV infection and on adolescents' use of illicit drugs. The Division of Adolescent and School Health, for example, spends most of its $33 million on HIV education. The National Institute of Allergy and Infectious Diseases, which spends about $98 million on adolescents, is concentrating primarily on research related to vaccine development and therapeutic approaches for sexually transmitted diseases and AIDS.

With the Federal Government's heavy emphasis on efforts related to adolescent sexual activity and drug use, other more prevalent health problems, such as unintentional injuries, the greatest killer of adolescents, receive less attention.[53] The Centers for Disease Control's Division of Injury Control, for example, targets just over $3 million on injury control for adolescents, less than a tenth of the funds that the Centers for Disease Control spends on HIV education. Adolescents' own subjective distresses are also little attended to.

Perhaps one reason health issues, other than those related to sexual intercourse and substance use, receive relatively little Federal funding is the current lack of data on adolescent health defined broadly and the limited availability and dissemination of data that are both relevant and timely.[54]

The Office of Treatment Improvement, the U.S. Departments of Education and Justice, the Health Resources and Services Administration, and the Family Support Administration award most, if not all, of their physical and mental health education, prevention, and social service activities funds through block grants. Because the Federal Government does not determine the mix of services that States provide under block grant programs (except within broad guidelines), the Federal Government's ability to affect the health of adolescents is limited. States receiving block grant awards, even maternal and child health block grants, do not necessarily choose to allocate funds to adolescents and their health problems. The Federal Government could earmark funds to adolescents within block grants, but the procedure has the disadvantage of limiting States' ability to control services.

The other primary way the Federal Government provides funding related to adolescent health also presents a dilemma. Funds are often limited to research or demonstration projects awarded on a competitive basis.[55] As with block grant programs, it is often difficult to know whether those adolescents most in need of will be reached by the demonstration projects that survive the Federal grantmaking process. However, there is reason to believe that the needs of adolescents may not be adequately met by such a relatively passive approach, for several reasons. The overall grant amounts are generally small; adolescents are not specifically mentioned in many authorizing legislation or grant announcements; and the most adept at writing grant proposals, rather than those most in need, are most likely to receive funding.

This limited Federal role is a consonant with the overall current Federal approach to domestic issues,

---

[53] See ch. 5, "Accidental Injuries: Prevention and Services," in VO1. II.

'*Volume I—Summary and Policy Options* includes discussions of crosscutting issues in the definition of adolescent health (box A) and in the collection and dissemination of data on adolescent health and health services (app. C) (44b). Further, data collection issues related to specific adolescent health concerns (e.g., accidental injuries, chronic physical illness, mental health, delinquency, hopelessness) are discussed in the chapters in Volume II of this Report, to be released later in 1991.

[55] Recent examples include:

- Grants authorized under the Education of the Handicapped Act Amendments of 1990 (Public Law 101-476) to institutions of higher education and local educational agencies (acting in collaboration with mental health entities) to improve services to students who are in special education programs as a consequence of having a serious emotional disturbance; this program is designed to address the longstanding need of such students for the mental health services that are not explicitly mandated by the original Education for All Handicapped Children Act (Public Law 94-142). For further discussion see ch. 11, "Mental Health Services: Prevention and Services," in Vol. II.
- Grants authorized by the National and Community Service Act of 1990 to States or local applicants for: the creation or expansion of service opportunities for students (Title 1, Subtitle B); and the creation or expansion of full-time or summer youth service corps programs focusing on conservation and human resources (Title I, Subtitle C), among other provisions. These programs are designed to fill several purposes, including: build self-esteem; teach teamwork, decisionmaking, and problemsolving; and tap youth as a resource for community service. For further discussion see ch. 4, "Schools and Discretionary Time," in Vol. II.
- Grants authorized by Title V of the Stewart B. McKinney Homeless Assistance Amendments Act of 1990 (Public Law 101-645) to support demonstration projects regarding outreach and comprehensive primary health services for homeless children. For further discussion, see ch. 14, "Hopelessness: Prevention and Services, " in Vol. II.

which is far less active than it has been at other times.[56] Further, with limited direct Federal involvement in social programs, a competitive approach to grantmaking helps to ensure that Federal dollars are well spent. Given the critical needs of adolescents, however, it is not clear that such an approach is sufficient.

Certain Federal policies specific to adolescents have the effect of limiting the types of services adolescents receive. For example, the Government emphasis on abstinence from sexual intercourse provides important limitations to the type of services that adolescents engaging in these activities can receive (67). If pregnancy occurs and an abortion is desired, no Title X or Title XX funds can be used to provide abortions, education and counseling for abortion services, or abortion referral (54 FR 35440) (19,94).

Given Federal agencies' limited ability to fund activities and the potential for duplication of or gaps in efforts, many Federal representatives expressed their desire to collaborate and coordinate more frequently with other agencies serving adolescents. Although there is some coordination ongoing within and between Federal agencies through interagency agreements, particularly in the areas of drug education and juvenile justice issues, many representatives were unaware of other Federal agencies' projects and programs. Barriers to collaboration include constraints inherent in congressional enabling legislation, the lack of a consistent definition of adolescence, agencies' disagreement as to what is needed to improve the health of adolescents, lack of incentives to cooperate, and lack of leadership on adolescent issues.

Currently, there are no incentives or rewards for Federal agencies to collaborate, and no mechanism has been established through which information is shared. There are several ways in which greater collaboration could be encouraged. First, Congress could establish a reward structure to encourage collaboration or could set up a separate fund for collaborative efforts. Additionally, an individual in each Federal agency could be responsible for coordinating adolescent issues within and between agencies. In fact, the idea of having an adolescent health coordinator is not a new one. Some State governments recognize the need to have a health coordinator for adolescents. The Bureau of Maternal and Child Health within the Health Resources and Services Administration supports coordination among the various State adolescent health care coordinators, although it does not directly support the coordinating function in any one State. However, no such level of coordination exists between Federal agencies. Instituting one Federal adolescent coordinator responsible for coordination across all agencies could improve adolescent services and programs as well as create a strong national advocate for addressing the health needs of adolescents.

Mere coordination may not be sufficient. In fact, several observers suggested that a new Federal agency may be needed to organize the resources necessary to improve the health of adolescents.

Clearly, the Federal Government has an important role in improving the health of adolescents. Although funding research and demonstration projects is an essential component of that role, the coordination of Federal efforts is and can be a more important component of the Federal Government's responsibility to approximately 12 percent of the Nation's population. Specific policy options on the Federal role in adolescent health-across a broad range of issues-can be found in Volume I of OTAs *Adolescent Health Report.*

Chapter 19 References

1. Abrams, R., Director, Office of Program and Policy Development, Bureau of Health Care Delivery and Assistance, Health Resources and Services Administration, Public Health Service, U.S. Department of Health and Human Services, Rockville, MD, personal communication, June 4, 1990.
2. ACTION, *ACTION Annual Report 1988* (Washington DC: 1988).
3. ACTION, "VISTA Juvenile Health Projects, " unpublished memo, Aug. 31, 1989.
4. ACTION, "Summary 1988 FGP Program: Project Profile and Volunteer Activity Survey,' unpublished mimeo, Sept. 7, 1989.

[56] As summarized by Brindis and Lee in their discussion of public policy issues affecting the health care delivery system for adolescents,". . the United States evolved from a pattern of *dual federalism, with* a limited role in domestic affairs for the federal government, to *cooperative federalism, with* a strong federal role in the 1930s. . .The term *creative federalism was* applied to policies developed during [the early and middle 1960s] that extended the traditional federal-state relationship to include direct federal support for local governments (cities and counties), nonprofit organizations, and private business and corporations to carry out health, education, training, social services, and community development programs. During the 1970s, President Richard M. Nixon coined the term *new federalism* to describe his efforts to move away from the categorical programs of the Johnson years. . .President Reagan extended the idea in the 1980s to limit further the role of government, transferring authority and responsibility to the States, with a reduction in federal funding. . ." *(italics added) (1* la). For further discussion, see *Volume I—Summary and Policy Options* (44b).

5. American School Health Association% Association for the Advancement of Health Education, Society for Public Health Education, Inc., *The National Adolescent Student Health Survey: A Report on the Health of America's Youth,* a cooperative project of the National Institute on Drag Abuse, Alcohol, Drug Abuse, and Mental Health Administration; Centers for Disease Control; and Office of Disease Prevention and Health Promotion, Public Health Service, U.S. Department of Health and Human Services (Oakland, CA: Third Party Publishing CO., 1989).
6. Berger, J., Adolescent Specialist, Office of Treatment Improvement, Alcohol, Drug Abuse, and Mental Health Administration, Public Health Service, U.S. Department of Health and Human Services, personal communication, July 17, 1990.
7. Berrett, B., Public Information Specialism ACTION, Washington, DC, personal communication July 7, 1990.
8. Blue Sheet, "Conference Agreement on NIH FY 1990 Budget" *Blue Sheet 3,* Oct. 11, 1989.
9. Bowles, J., and Robinson, W.A., "PHS Grants for Minority Group HIV Infection Education and Prevention Efforts, " *Public Health Reports* 104(6):552-559, *1989.*
10. Bremner, R.H. (cd.), *Children and Youth in America, Vol. II* (Cambridge, MA: Harvard University Press, 1971).
11. Brenneman, G., Branch Chief, Maternal-Child Health, Indian Health Service, Public Health Service, U.S. Department of Health and Human Services, Rockville. MD, personal communication May 29, 1990.

1 la. Brindis, C.D., and Lee, P.R., ''Public Policy Issues Affecting the Health Care Delivery System of Adolescents," *Journal of Adolescent Health Care* 11:387-397, 1990.

12. Brown, B., Special Assistant to the Director, National Center of Child Abuse and Neglect, Administration for Children, Youth, and Families, Office of Human Development Services, U.S. Department of Health and Human Services, Washington, DC, personal communication, Jan. 11, 1991.
13. Cook, L.H., Research Analyst, Division of Innovation and Development Office of Special Education programs, U.S. Department of Education, Washington, DC, personal communication, June 20, 1990.
14. DeGraw, C., Coordinator, Children and School Program, Office of Disease Prevention and Health Promotion, Public Health Service, U.S. Department of Health and Human Services, Washington DC, personal Communication May 9, 1990.
15. *Federal Organization Service: Civil* (Washington, *DC:* Carroll Publishing Co., 1990).
16. Gephart, J., Nurse Consultant, Child and Adolescent Health Branch, Bureau of Maternal and Child Health, Health Resources and Services Admistration, Public Health Service, U.S. Department of Health and Human Services, Washington DC, personal communications, Apr. 18 and June 1, 1990.
17. Kanuk, G., Public Health Advisor, Office of Treatment Improvement, Alcohol, Drug Abuse and Mental Health Administration, Public Health Service, Department of Health and Human Services, personal communication, 1990.
18. Katz, M., Director, Office of Program Planning and Evaluation, Office of Program Planning and Evaluation, Centers for Disease Control, Public Health Service, U.S. Department of Health and Human Services, Atlanta, GA, personal communication, May 31, 1990.
19. Klebe, E., Specialist in Social Legislation, Congressional Research Service, Library of Congress, U.S. Congress, Washington, DC, personal communication July 6, 1990.
20. Kolodny, E., Chief of Technical Assistance and Clearinghouse Programs, Employment and Training Administration, U.S. Department of Labor, Washington, DC, personal communication, June 4, 1990.
21. Levenson, D., Chief, Program Analysis, National Institute of Child Health and Human Development, National Institutes of Health, Public Health Service, U.S. Department of Health and Human Services, Bethesda, MD, personal communication June *7,* 1990.
22. Lilja, J.G., Director, Office of Analysis and Evaluation, Food and Nutrition Service, U.S. Department of Agriculture, Alexandria V! personal communication, June 13, 1990.
23. Lyle, J.M., Coordinator, Program for Children with Special Needs, Maternal-Child Health, Indian Health Service, Public Health Service, U.S. Department of Health and Human Services, Rockville, MD, personal communication May 29, 1990.
24. Mercy, J.A., Chief, Epidemiology Branch, Division of Injury Control, Center for Environmental Health and Injury Control, Centers for Disease Control, Public Health Service, U.S. Department of Health and Human Services, Atlanta, GA, personal communication, June 22, 1990.
25. Moore, J.P., Executive Assistant, Office of Work Based Learning, Employment and Training Administration Bureau of Apprenticeship and Training, U.S. Department of Labor, personal communication July 1990.
26. National Center for Education in Maternal and Child Health, *Adolescent Health: SPRANS Abstracts FY 1989* (Washington DC: 1989).

26a. National Commission on Youth, *The Transition of Youth to Adulthood: A Bridge Too Long: A Report to Educators, Sociologists, Legislators, and Youth Policymaking Bodies (Boulder,* CO: Westview Press, 1980).

27. National Commission to Prevent Infant Mortality, *Death Before Life: The Tragedy of Infant Mortality* (Washington, *DC:* August 1988).
28. Nationat Research Council, Institute of Medicine, National Forum on the Future of Children and Families, Social *Policy for Children and Families: Creating an Agenda: A Review of Selected Reports (Washington DC:* National Academy Press, 1989).
29. Norris, P., Community Health Promotion Specialist, Office of Disease Prevention and Health Promotion Public Health Service, Department of Health and Human Services, personal communication, July 23, 1990.
30. Ohio State University, Center for Human Resource Research, *The National Longitudinal Surveys of Labor Market Experience Handbook: 1988* (Columbus, OH: 1988).
31. Public Health Foundation, 1989 *Public Health Chartbook* (Washington, DC: May 1989).
32. Reed, J., Chief, Division of Discretionary Grants, Office of Community Services, Family Support Administration, U.S. Department of Health and Human Services, Washington, DC, personal communication, May 9, 1990.
33. Reingold, J.R., and Associates, Inc., *Current Federal Policies and Programs for Youth,* prepared for the William T. Grant Foundation, Commission on Work, Family and Citizenship, August 1987.
34. Reingold, J.R., and Associates, Inc., *Current Federal Policies and Programs for Youth,* prepared for the William T. Grant Foundation, Commission on Work, Family and Citizenship, August 1989.
35. Ritchko, S.A., Administrator, Human Nutrition Information Service, U.S. Department of Agriculture, Hyattsville, MD, personal communication, June 12, 1990.
36. Sabo, R. M., Health Care Policy Analyst, CHAMPus, Us. Department of Defense, personal communication Sept.21, 1990.
37. Scholle, R., Policy Analyst, Office of Population Affairs, Office of the Assistant Secretary for Health, Public Health Service, U.S. Department of Health and Human Services, Washington, DC, personal communication, May 9, 1990.
38. Segal, A., Division Director for Children, Youth, and Family Policy, Office of Social Services Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington DC, personal communication, March 1990.

39. Taylor, J. A., Deputy Director, Division of Program Analysis, Office of Extramural Programs, Alcohol, Drug Abuse, and Mental Health Administration, Public Health Service, U.S. Department of Health and Human Services, Rockville, MD, personal communication, May 31, 1990.
40. Tomey, D., Program Manager, Emerging Hazards and Vulnerable Populations, U.S. Consumer Product Safety Commission personat communication, Sept. 26, 1990.
41. U.S. Congress, Library of Congress, Congressional Research Service, "House and Senate Standing Committees and Subcommittees With Jurisdiction Over National Drug Abuse Policy, " Sept. 27, 1988.

41a. U.S. Congress, Library of Congress, Congressional Research Service, "Federal Spending for Social Welfare Programs in Fiscal Year 1990, " CRS Issue Brief prepared by G. Falk, Washington, DC, Nov. 28, 1990.

42. U.S. Congress, Library of Congress, Congressional Research Service, *Medicaid: FY 91 Budget and Child Health Initiatives* (Washington, DC: U.S. Government Printing Office, Feb. 12, 1990).
43. U.S. Congress, Office of Technology Assessment, responses from various Federal agencies to 1989 Office of Technology Assessment questionnaire regarding adolescent health initiatives, Washington, DC, 1989.
44. U.S. Congress, Office of Technology Assessment, Adolescent Health Project, Adolescent Health Advisory Panel, meeting in Washington DC, Jan. 8, 1990.

44a. U.S. Congress, Office of Technology Assessment, *Indian Adolescent Mental Health,* OTA-H-446 (Washington DC: U.S. Government Printing Office, January 1990).

44b. U.S. Congress, Office of Technology Assessment, *Adolescent Health-Volume I: Summary and Policy Options, OTA-H-468* (Washington DC: U.S. Government Printing Office, April 1991).

45. U.S. Department of Agriculture, Extension Service, *Annual 4-H Youth Development Enrollment Report: 1988 Fiscal Year* (Washington, DC: U.S. Government Printing Office, January 1989).
46. U.S. Department of Agriculture, Extension Service, "Building Human Capital: Educating People for Positive Living, " Washington, DC, June 1989.
47. U.S. Department of Agriculture, Food and Nutrition Service, Office of Analysis and Evaluation *Characteristics of the National School Lunch and School Breakfast Program Participants* (Washington, DC: U.S. Government Printing Office, January 1988).
48. U.S. Department of Agriculture, Office of Public Affairs, Office of Press and Media Relations, News Division, "New Consumer Education Program Established for Public Housing Residents, " News, p. 1, June 21, 1990.
49. U.S. Department of Defense, Office of the Civilian Health and Medical Program of the Uniformed Services, *CHAMPUS Handbook* (Washington DC: U.S. Government Printing Office, January 1986).
50. U.S. Department of Education, *Eleventh Annual Report to Congress on the Implementation of the Education of the Handicapped Act* **(Washington DC: U.S. Government Printing** Office, 1989).
51. U.S. Department of Education, *1989 Guide to Department of Education Programs* (Washington, DC: U.S. Government Printing Office, **1989).**
52. U.S. Department of Education, organizational chart, Washington, DC, Sept. 15, 1989.
53. U.S. Department of Education, Office of the Assistant Secretary for Elementary and Secondary Education, "Compensatory Education for the Disadvantaged: Account Summary,' Washington DC, 1988.
54. U.S. Department of Education, Office of the Assistant Secretary for Elementary and Secondary Education, ''Application for Cooperative Agreements Under the Drug-Free Schools and Communities Act of 1986 Regional Centers Program," Washington, DC, Aug. 7, 1987.
55. U.S. Department of Education, Office of Education and Research and Improvement Fund for the Improvement and Reform of Schools and Teaching, "National Program for Comprehensive School Health Education,'' Washington DC, 1990.
56. U.S. Department of Education, Office of the Assistant Secretary for Elementary and Secondary Education, "Overview: Fiscal Year 1989," Washington, DC, 1990.
57. U.S. Department of Education, Office of the Assistant Secretary for Special Education and Rehabilitative Services, Office of Special Education Programs, "Education of the Handicapped: Program-Funded Activities Fiscal Year 1989," unpublished mimeo, Washington, DC, Nov. 17, 1989.
58. U.S. Department of Health and Human Services, organizational chart, Washington DC, 1990.
59. U.S. Department of Health and Human Services, Family Support Administration Office of Communications, "Job Opportunities and Basic Skills (JOBS) Training Program,' Washington, DC, no date.
60. U.S. Department of Health and Human Services, Family Support Administration, Office of Community Services, ''Emergency Community Services Homeless Grant Program,'' Washington, DC, no date.
61. U.S. Department of Health and Human Services, Family Support Administration "Fact Sheet: Family Support Administration,'' Washington DC, no date.

61a. U.S. Department of Health and Human Services, Office of Human Development Services, Administration for Children, Youth, and Families, *HHS News,* Apr. 15, 1991.

62. U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute on Alcohol Abuse and Alcoholism, ''Alcohol Research Grants,' program announcement, Rockville, MD, January 1987.
63. U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute on Alcohol Abuse and Alcoholism, *Alcoholism: The Search for Solutions* (Rockville, MD: 1988).
64. U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute on Alcohol Abuse and Alcoholism, ''Research on the Prevention of Alcohol Abuse Among Children, Adolescents, and Young Adults, ' program announcement, Rockville, MD, October 1988.
65. U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute on Alcohol Abuse and Alcoholism, "Research on Economic and Socioeconomic Issues in the Prevention Treatment, and Epidemiology of Alcohol Abuse and Alcoholism" program announcement, Rockville, MD, December 1988.
66. U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute on Alcohol Abuse and Alcoholism, "Alcohol Research Center Grants, " request for application% Rockville, MD, May 1989.
67. U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute on Alcohol Abuse and Alcoholism, ''Legal Minimum Age for Sale/Purchase, Possession and Consumption of Beverage Alcohol, " unpublished mimeo, Rockville, MD, 1990.
68. U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute on Alcohol Abuse and Alcoholism, National Institute on Drug Abuse, "Drug and Alcohol Abuse Prevention Research Grant Announcement, " special grant announcement, Rockville, MD, January 1987.

69. U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute on Drug Abuse, ''Drug Abuse Treatment Research Grant Announcement,' special grant announcement, Rockville, MD, January 1987.
70. U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute on Drug Abuse, "Research Demonstration Grants on Drug Treatment(1) With Public Service, or (2) for Pregnant Women,'' request for applications, Rockville, MD, February 1989.
71. U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute on Drug Abuse, "NIDA's FY 1990 Budget Tops $379 Million,'' *NIDA Notes* 5(1):8-9, Winter 1989/1990.
72. U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute on Drug Abuse, 'ADAMHA Gets Record Budget Increase, " *NIDA Notes* 5(1):9, Winter 1989/1990.
73. U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute on Drug Abuse, ''Research Demonstration Applications on Drug Abuse Treatment for Women of Child-Bearing Age and Offspring," request for applications, Rockville, MD, January 1990.
74. U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute on Drug Abuse, ''Minority Drug Abuse Prevention Research Centers,' request for applications, Rockville, MD, January 1990.
75. U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute on Drug Abuse, "Projects Involving Adolescents (7-17): 1980-1990,'' unpublished table, Rockville, MD, Feb. 21, 1990.
76. U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute of Mental Health, Division of Education and Service Systems Liaison, "The Child and Adolescent Service System Program—FY '88 Report," Rockville, MD, May 12, 1988.
77. U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute of Mental Health, ''Mental Health Services Demonstration Grants: Child and Adolescent Service System program, " request for applications, Rockville, MD, January 1989.
78. U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, National Institute of Mental Health, "Update on CASSP," Rockville, MD, June 1989.
79. U.S. Department of Health and Human Services, Public Health Service, Alcohol, Drug Abuse, and Mental Health Administration, Office of Substance Abuse Prevention, Office of Planning, Budget and Evaluation, Dear Colleague letter from M.G. Dana, Deputy Associate Director, Washington, DC, June 1990.
80. U.S. Department of Health and Human Services, Health Care Financing Administration, "Medicaid: A Brief Summary of Title XIX of the Social Security Act," Baltimore, MD, September 1989.
81. U.S. Department of Health and Human Services, Health Care Financing Administration ''HCFA Fact Sheet: Medicaid, " Baltimore, MD, Apr. 15, 1989.
82. U.S. Department of Health and Human Services, Health Care Financing Administration organizational chart, Baltimore, MD, Aug. 1, 1989.
83. U.S. Department of Health and Human Services, Health Care Financing Administration Office of the Actuary, unpublished data on Medicaid expenditures and enrollment in fiscal year 1988, Baltimore, MD, June 1990.
84. U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Bureau of Maternal and Child Health and Resources Development organizational chart, Rockville, MD, no date.
85. U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Bureau of Maternal and Child Health and Resources Development "Understanding Title V of the Social Security Act: A Guide to the provisions of Federal Maternal and Child Health Services Legislation' no date.
86. U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, Bureau of Maternal and Child Health and Resources Development, ''Fifth Report to the Congress on the Consolidated Federal Programs Under the Maternal and Child Health Block Grant,'' Rockville, MD, May 1989,
87. U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, organizational chart, Bethesda, MD, no date.
88. U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, unpublished data, provided in response to the U.S. Congress, Office of Technology Assessment's questionnaire regarding adolescent health initiatives, 1989.
89. U.S. Department of Health and Human Services, Public Health Service, Office of the Assistant Secretary for Health, Office of Disease Prevention and Health Promotion, ''ODPHP: A Decade of Progress," Washington, DC, December 1986.
90. U.S. Department of Health and Human Services, Public Health Service, Office of the Assistant Secretary for Health, Office of Disease Prevention and Health Promotion, Prevention '89/' 90: *Federal Programs and Progress* (Washington, DC: U.S. Government Printing Office, 1990).
91. U.S. Department of Health and Human Services, Public Health Service, Office of the Assistant Secretary for Health, Office of Minority Health, ''OfIlce of Minority Health,'' Washington DC, no date.
92. U.S. Department of Health and Human Services, Public Health Service, Office of the Assistant Secretary for Health, Office of Minority Health, "Minority Community Demonstration Grants," Washington, DC, 1989.
93. U.S. Department of Health and Human Services, Public Health Service, Mice of the Assistant Secretary for Health, office of Minority Health, "HIV/AIDS Education and Prevention Grants," June 24, 1990.
94. U.S. Department of Health and Human Services, Public Health Service, Office of the Assistant Secretary for Health, Office of Population Affairs, Deputy Assistant Secretary for Population Affairs, ''Family Planning and Five Year Plan,'' memorandum to the Assistant Secretary for Health, Planning, and Evaluation, Washington, DC, Sept. 9, 1988.
95. U.S. Department of Health and Human Services, Public Health Service, Office of the Assistant Secretary for Health, Office of Population Affairs, *The Adolescent Family Life Research Project Summaries,* Washington DC, 1989.
%. U.S. Department of Health and Human Services, Public Health Service, Office of the Assistant Secretary for Health, Office of the Surgeon General, *Better Health for Our Children: A National Strategy, Vol. I,* DHHS (PI-IS) Pub. No. 79-55071, (Washington DC: 1981).
97. U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention *Twelfth Analysis and Evaluation: Federal Juvenile Delinquency Programs 1988* (Washington, DC: 1988).
98. U.S. Department of Labor, Employment and Training Administration, *Training and Employment Report of the Secretary of*

Labor, DOL Pub. No. 209- 109-814/'94907 (Washington, DC: Us. Government Printing Office, 1988).

99. U.S. Department of Labor, Employment and Training Administration, Budget Office, Washing-tom DC, personal communications, Sept. 13 and 14, 1990.
100. U.S. Department of Labor, Employment and Training Administration, Office of Job Training Programs, Office of Job Corps, "Job Corps in Brief," Washington, DC, 1987.
101. U.S. Department of Labor, Employment and Training Administration, Office of Job Training Programs, Bureau of Apprenticeship and Training, "The Bureau of Apprenticeship and Training: A Brief Overview,'' Washington DC, August 1989.
102. U.S. Department of Transportation, Federal Highway Administration, Office of Highway Safety, *An Overview of FHWA Highway Safety Programs*, Pub. No. FI-IWA-SA-89-047 (Washington DC: U.S. Government Printing Office, April 1989).

102a. U.S. Executive Office of the President, Office of Management and Budget, *Budget of the U.S. Government, Fiscal Year 1991* (Washington, *DC:* U.S. Government Printing Office, 1990).

103. Washnitzer, M., Family Support Administration, U.S. Department of Health and Human Services, Washington DC, personal communication% May 9, 1990.