DOCUMENT RESUME

ED 345 153 CG 024 220

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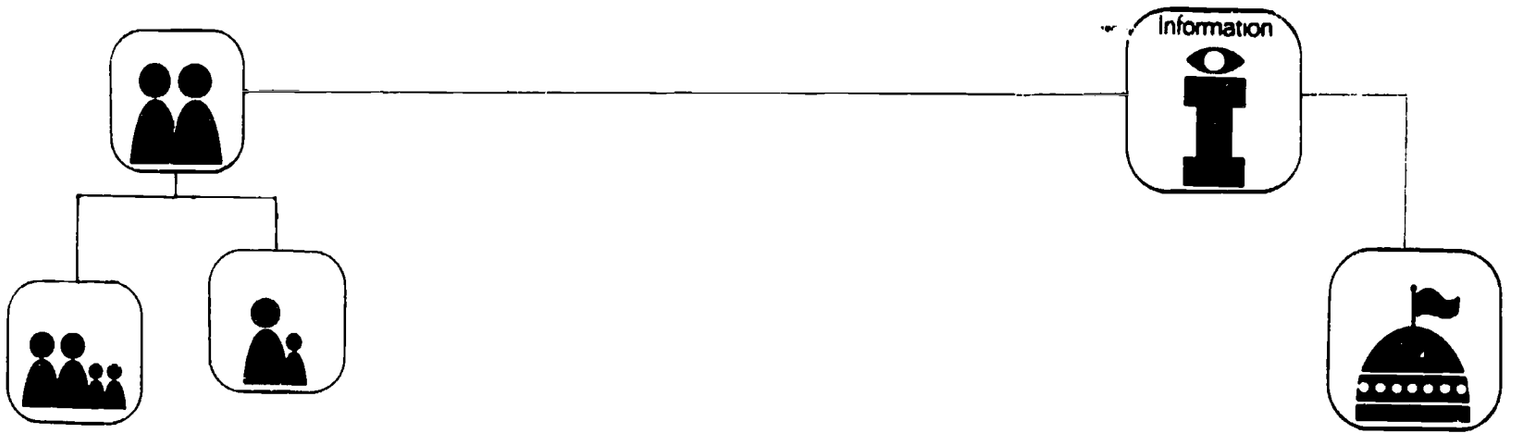
TITLE The Unique Health Needs of Adolescents: Implications for Health Care Insurance and Financing. Highlights and Background Briefing Report of a Meeting (Washington, D.C., February 24, 1989). Family Impact Seminars.
INSTITUTION Family Impact Seminar (FIS), The AAMFT Research and Education Foundation, Washington, DC.
SPONS AGENCY Consortium of Family Organizations.; Health Resources and Services Administration (DHHS/PHS), Rockville, MD. Bureau of Maternal and Child Health and Resources Development.
PUB DATE 90
NOTE 30p.
AVAILABLE FROM Family Impact Seminar, 1100 17th St., NW, Suite 901, Washington, DC 20036 ($10.00).
PUB TYPE Collected Works - Conference Proceedings (021)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Adolescents; *Child Health; Drug Abuse; Federal Programs; Health Insurance; *Health Needs; Trend Analysis

ABSTRACT

This report presents highlights of a seminar which focused on the unique health care needs of adolescents. Comments by the following panelists are summarized: Christine Winquist Nord, research associate at Child Trends Inc.; John Sargent, an adolescent psychiatrist, pediatrician and family therapist at the Philadelphia Child Guidance Clinic; and Peggy McManus, president of McManus Health Policy, Inc. Summaries of topics discussed at the seminar are provided. Topics are: (1) the idea that young people are basically healthy and getting healthier, although their high rates of death, injury, suicide, substance abuse, pregnancy, and sexually transmitted diseases cause considerable concern; (2) the need to study the health of youth at high risk, such as school dropouts, runaway youth, and youth in juvenile detention centers; (3) the goals of adolescent health care to promote and restore physical and emotional well-being, to enhance adolescent development for the adolescent and the family; to promote good habits that will continue later in life, and to reduce the negative consequences of high-risk behaviors; and (4) the severe and deteriorating health insurance picture for adolescents and young adults. A background report which discusses these topics as well as parents' role in the health of adolescents; a reference list of federal programs that fund health care for youth, including drug abuse and family planning programs; and a list of new national adolescent health projects are included. (ABL)

The Unique Health Needs of Adolescents: Implications for Health Care Insurance and Financing



The Unique Health Needs of Adolescents: Implications for Health Care Insurance and Financing

February 24, 1989, Mansfield Room (S.207), the U.S. Capitol

Panelists: **Christine Winquist Nord,** research associate, Child Trends Inc.
John Sargent, M.D. adolescent psychiatrist, family therapist, Philadelphia Child Guidance Clinic
Peggy McManus, M.H.S., health care specialist and President of McManus Health Policy, Inc.

Moderator: **Theodora Ooms**, Director, Family Impact Seminar

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The Unique Health Needs of Adolescents: Implications for Health Care Insurance and Financing

Background Briefing Report
and
Meeting Highlights

Theodora Ooms and Lisa Herendeen

This policy seminar is one in a series of monthly seminars for policy staff titled, *Family Centered Social Policy: The Emerging Agenda*, conducted by the **Family Impact Seminar**, American Association for Marriage and Family Therapy, Research and Education Foundation, 1100 Seventeenth Street, N.W., The Tenth Floor, Washington, D.C. 20036, 202/467-5114

This seminar was co-sponsored by the Consortium of Family Organizations (COFO) and funded by the Bureau of Maternal and Child Health and Resources Development, DHHS.

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The Unique Health Needs of Adolescents: Implications for Health Care Insurance and Financing

Highlights of the seminar meeting held on February 24, 1989, Mansfield Room (S. 207), the U.S. Capitol (a supplement to the Background Briefing Report).

While considerable concern has been voiced in the media and government over the 37 million Americans without health insurance, little attention has been paid to the group most likely to be uninsured—young people. To heighten awareness about the unique health needs of adolescents and the financing problems they face, this seminar, the first in a series of three, brought together three expert panelists to address questions such as: What are the unique health care needs of adolescents and young adults? To what extent is this age group covered by private or public health insurance? How does youths' transition from dependence to independence affect their ability to obtain health care?

Summary of Panelists' Presentations

Christine Winquist Nord, research associate at Child Trends Inc., substituting for James L. Petersen who was ill, reviewed the major causes of death among adolescents aged 15 to 24, as well as other indicators of adolescent health (see page 21 of the report). Basically young people are healthy and getting healthier. However, their high rates of death, injury, suicide, substance abuse, pregnancy, and sexually transmitted diseases cause considerable concern.

Nord pointed out that many of the major causes of death during late adolescence and early adulthood are rooted in behavior and are, therefore, largely preventable. Among such causes are motor vehicle accidents, other accidents, suicide, and homicide.

In 1985 there were 6.8 motor vehicle accidents per 100,000 children ages 5-14. The figure for youth 15-24 was 36.1, nearly 6 times as high. By ages 25-34, it dropped again to 22.8. The 36.1 figure is, however, an improvement over the 1980 death rate due to motor vehicle accidents which was 44.8 for youth 15-24 years old.

One cause of death that has not improved is the suicide rate among white males aged 15-24. In 1985 there were 27.4 deaths per 100,000 white males aged 20-24 and 17.3 per 100,000 white males aged 15-19 compared to 11.9 and 5.9, respectively, in 1960.

Homicide rates among young non-white males, although declining from highs recorded in the 1970s, also remain above their 1960 levels. In 1985 there were 72.8 homicide deaths per 100,000 non-white males aged 20 to 24 and 39.9 homicides per 100,000 non-white males aged 15 to 19, compared to 64.2 and 27.6, respectively, in 1960.

Sexually transmitted diseases and health problems due to the use of assorted addictive substances also contribute to health problems among older adolescents and young adults. Rates of sexually transmitted diseases, primarily gonorrhea, rose sharply during the 1960s, peaked in 1975, and have declined only slightly since. They remain higher among this age group than for any other age group. Studies conducted in the early 1980s found that about 25% of students had been infected with a sexually transmitted disease before graduating from high school.

Nord also pointed out that patterns of behavior are established during this age period that can have long-term health consequences. For example, cigarette smoking is a known precursor of heart disease and cancer in later life. In 1988, 16% of 8th graders and 26% of 10th graders reported having smoked in the previous month. And, according to data from the National Health Interview Survey, nearly one-third of all youth aged 20-24 smoke cigarettes. Other behaviors adopted during adolescence and young adulthood can also lead to chronic diseases and poor health in later life. Among such behaviors are lack of exercise, heavy drinking, and poor nutritional habits.

Because self-destructive behavior among adolescents and young adults accounts for a large share of the health problems that these youth experience, Nord commented that more needs to be done to educate youth about the consequences of their high-risk behaviors. One strategy, she said, might be to encourage counseling and education as part of basic health care for this age group.

Nord contends that it is difficult to get a well rounded picture of the status of adolescent health because studies tend to look at either health conditions or adolescent behavior and attitudes. In reality, however, many of the behaviors and outcomes are interrelated. Alcohol use, for example, is a contributing factor to motor vehicle accidents.

Nord also pointed out that in most national health surveys of adolescents and young adults, the surveys do not include samples of adolescents and youth at high risk (e.g. school drop outs, runaway youth, and youth in juvenile detention etc.). Efforts should be made to study the health status of these groups of youth.

John Sargent, an adolescent psychiatrist, pediatrician and family therapist at the Philadelphia Child Guidance Clinic, discussed what he, as a clinician, saw as the goals of health care for adolescents and what issues need to be considered in planning and providing health care services to this age group.

Sargent outlined the goals for adolescent health care as follows: to promote and restore physical and emotional well-being; to enhance adolescent development for the adolescent *and* the family; to promote good habits that will continue later in life, and to reduce the negative consequences of high-risk behaviors. He discussed some of the important issues in adolescent and family development including:

- Adolescence is a time of considerable flux and growth on several fronts at once: biological, emotional and social. Among the main features of adolescent development that are especially relevant to health are an increased ability to: use abstract reasoning in making decisions and judgements; to make plans for the future and to control impulses; to learn from the mistakes made when engaging in experimental and risk-taking behavior; and the development of a stronger sense of their identity as differentiated from their parents and peers.

- Adolescent development in all these areas is very uneven. It is not possible to know from a young person's age how well developed or mature he or she is on any of these dimensions.

- While developing more independence, adolescents remain very connected to their family and community and these connections are critical to their healthy development. This is often true even when adolescents present themselves as angry at, and alienated from, their family. Families influence their adolescent's health both positively and negatively and hence must be involved in health care delivery (see review of research p. 5-7). For example, stress and turmoil in the family can lead to neglect of adolescents health needs and exacerbation of problems. But when parents respond appropriately to their health problems adolescents gain increased self esteem and competence.

Sargent outlined the three basic groups of adolescents needing health care. First, there are those who are generally healthy and who need intermittent, short-term care for minor illnesses and accidents, who need preventive care, and/or assistance with a difficult family transition (such as parental divorce). Second, are those who are seriously emotionally troubled and engage in high-risk behaviors and need multiple, integrated services. The third group are those who are chronically, physically or mentally ill or handicapped. They need services to meet their emotional and physical needs and their families need a great deal of support both for effective treatment and to enhance their child's development and autonomy.

Sargent sketched some of the implications of his brief review of adolescent and family development for the delivery of health care to this age group.

- Health and social services must be integrated so as to recognize the connections between different aspects of adolescent needs and behavior.

- Health care practitioners must conduct broad assessments of different areas of adolescents' functioning, not simply focus on the presenting symptom or problem.

- Care for the disabled and chronically ill adolescent must help them assume increasing responsibility for their health care while maintaining support from their family and others.

- Policymakers and health care administrators must be clear about the goals of a particular service: for example, if the goal is basically concerned with public health, specific services can be directed at the general population of youth without directing attention to individuals range of needs. However, if the goal is to promote individual adolescents' health and well-being, narrowly targeted services are too limited and will be ineffective.

Peggy McManus, President of McManus Health Policy, Inc. discussed findings of a study she and her colleagues from the University of California, San Francisco (Paul Newacheck) and Fox, Inc. (Harriette Fox) are conducting on the health insurance problem of adolescents and young adults (see summary p. 8-10). This grant is funded from the Bureau of Maternal and Child Health of the Department of Health and Human Services.

Based on their examination of the 1984 National Health Interview Survey and the 1980 National Medical Care Utilization and Expenditure Survey (NMCUES), McManus summarized the characteristics of adolescents and young adults and their unique financing challenges.

The U.S. is faced with a severe and deteriorating health insurance picture for adolescents, ages 10-18, and young adults, ages 19-24. At least 11 million adolescents and young adults are uninsured. Taken together with all children, persons ages 0-25 account for over half of our nation's uninsured. Fourteen percent or 4.5 million 10-18 year olds, and 26 percent or 6.4 million 19-24 year olds had no health insurance in 1984.

McManus reported that the groups of adolescents and young adults at greatest risk for being uninsured are: males, poor and near poor, Hispanics, blacks, those whose parents have not completed high school, those young adults who do not have a high school diploma, those living in single-parent households, residents of the south and west, and unemployed young adults.

She also outlined why this population is unique and presents special challenges for public and private health care insurance programs:

—changes in their dependent status and continued eligibility;

—persistent shifts in residence, school, and work;

—likelihood of part-time work, short-term jobs and low-wage work;

—disinterest in and lack of knowledge of health insurance;

—low income;

—no single agent (adolescent/young adult, family, work, school) willing or able to assume full responsibility for purchasing insurance;

—need for confidential care;

—often independently seeking care yet without their own insurance or knowledge of their parents' insurance status;

—for young adults, difficulty in gaining eligibility if living at home;

Most of the dollars spent on adolescent health care is for a small minority who have very high health care costs. Ten percent of adolescents account for almost three quarters of all health care expenditures for adolescents. The average total health care expenditure for adolescents in 1988 was $525. The average out-of-pocket expenditure in 1988 was $150 or 29% of total expenditures. McManus cautioned using these expenditure figures because of the dramatic changes in health insurance since 1980. However, not until 1990 or 1991 will better estimates be available.

McManus noted that different policy options are required for these two population groups. For adolescents under 18 years of age who depend on their parents or guardians for insurance, policies aimed at improving parent's health coverage are the most effective. For young adults, many of who are purchasing health insurance for the first time, other approaches must be considered. She then discussed a table that outlined various policy options for uninsured adolescents and young adults and their likely impact in terms of reducing the largest numbers of uninsured adolescents and young adults (see Table I page vi).

Points made during discussion

- A questioner asked if employer mandates were passed what negative effects such as unemployment, would there be for young adults. McManus responded that this is an important issue since young adults are likely to be earning minimum or relatively low wages. She warned that employer mandated insurance was not a cure-all, but should be seen as part of a combination of financing strategies that could help this age group.

- How can health professionals be expected to provide comprehensive assessments of all adolescents given their very limited contact with them? John Sargent said that practitioners must first know what their goals are. If the goal is simply to decrease teen pregnancy, then giving birth control is adequate. But if the goal is to impact the general well-being of that adolescent then asking a few screening questions like: do you get along with your parents? do you like school? how much alcohol do you drink? etc. will help the practitioner determine if this adolescent is at risk and needs more intensive help. Sargent said he does *not* advocate giving intensive comprehensive assessments to every adolescent, only those who need such help.

- What kinds of health care services are needed for adolescents and young adults and what types are covered by public and private insurance? In general, many of the types of educational counseling and outpatient services youth need are not covered by insurance. McManus said that in the future and she and her colleagues (Harriette Fox and Paul Newacheck) will look at the specific benefits offered in state Medicaid programs. They will also be conducting an employer survey to analyze benefits covered by private insurers for adolescents. Kay Johnson of the Children's Defense Fund, she said, is currently studying what adolescent services are covered and what services need to be covered during screening visits in the Early Periodic Screening, Diagnosis and Treatment Program (see p. 11 for details on EPSDTP).

- Sargent confirmed the problem with public or private insurance is that it fails to cover many of the services adolescents need. For example, it funds in-patient hospitalization for mentally ill, but in order to get day treatment coverage the case has to be classified as a special education problem and these funds are not sufficient. Determining what kind of treatment an adolescent receives is often quite arbitrary and usually depends on what kinds of services are funded and available, not what is *needed*. Often multiple services are needed. In Philadelphia, between 10 to 50 percent of mental health care costs are covered by private insurance. When adolescents have a disorder requiring treatment over several years (eg. eating disorders) or the family has multiple emotional problems and several members need treatment they can go seriously in debt.

- Is lack of health insurance a more difficult problem for those with low incomes? Paul Newachek of the University of California is examining this problem in more detail and his report will be available soon, said McManus. McManus noted that adolescents whose family incomes are below poverty are three times as likely to be uninsured as adolescents whose family incomes are above poverty.

THE UNIQUE HEALTH NEEDS OF ADOLESCENTS:

IMPLICATIONS FOR HEALTH CARE INSURANCE AND FINANCING

Background Briefing Report

ADOLESCENT HEALTH: A NEW FOCUS

Until quite recently policymakers did not address the health status and health care needs of adolescents separately from those of children in general. National studies, task forces and special commissions on the status of child health paid scant attention to the special needs of teenagers. Teenage pregnancy was the sole exception: over a decade ago public concern about adolescent out-of-wedlock childbearing resulted in considerable policy debate, and many new private and publicly supported health and social service programs were established.

There is a growing public awareness of the many other special health problems and needs of teenagers and young adults. Many of these incur high personal, social and medical costs. Large proportions of young people do not have adequate access to needed health care due to lack of health care insurance. And questions are being raised about whether health care programs and services basically designed for young children or mature adults adequately meet the special needs and circumstances of those who are " in between" and whose health related problems are largely a consequence of behaviors rather than disease.

In this briefing report we summarize data and research about adolescents' health, psychological development and family context to provide the background for an examination of the current adequacy of health care insurance and financing for this age group. (In the second seminar in this series on adolescent health we plan to focus on models of comprehensive health care for adolescents.) In addition, we provide a preliminary summary of the major federal programs that fund health care for adolescents and young adults. And we include a list of new organizational initiatives that focus on adolescent health.

Note: The age categories used to define "adolescence" and "youth" vary widely. In this report we focus broadly both on dependent teenagers who are under 18 and the 19-24 year olds who are legally adult, but often remain economically dependent on their parents or public sources of support. We include the group of young adults because their mortality rates and health damaging behaviors are unacceptably high and because they are the age group least likely to have medical insurance.

OVERVIEW OF THE HEALTH STATUS OF ADOLESCENTS

(Sources: Child Trends, 1989; Dryfoos, 1987; Fingerhut 1989; Kovar, 1986; Irwin and Millstein,1986; NASHS, 1988; Newacheck, 1989; Smith, 1988)

As measured by death rates and prevalence of disease, young people are generally a healthy group and are getting healthier. Why then is there so much concern? The major reason is that current death and injury rates of youth are viewed as unacceptably high because the major causes are largely preventable; a result of health damaging behaviors rather than disease. In addition, there is growing awareness of the direct and indirect social costs involved in the high rates of teen child-bearing and substance abuse.

Morbidity: Physical health

Adolescents and young adults have lower rates of physical disease than every other age group except the 5-12 year olds. Since the fifties, polio, measles and tuberculosis, which once affected significant numbers of youth, have virtually disappeared. On the negative side, rates of sexually transmitted diseases, primarily gonorrhea, rose sharply, peaked in 1975, declined only slightly since and remain higher than any other age group. Studies in the early eighties found one-fourth of students infected with a sexually transmitted disease before graduating from high school. Serious eating disorders that are particularly prevalent for this age group, such as anorexia and bulemia, prevalence rates rose considerably but have recently leveled off. Cigarette smoking among teenagers has declined as it has among the population at large, but it still remains a serious problem with long-range consequences on health. In 1988, 16% of 8th graders, and 26% of 10th graders reported having smoked in the previous month.

In 1983, the average adolescent under 18 living in the community had 9.0 days of restricted activity, 4.9 days lost from school and spent 4.3 days in bed. On a five point scale, in 1983, parents reported that only 3.3% of 12-17 year olds were in fair or a worse state of health and 76% were in excellent or very good health. However, on various tests of the physical fitness of 17 year olds there has been only slight improvement over the past twenty years, more for girls than boys.

Morbidity: Injuries and other preventable health conditions

Injuries are a common cause of restriction of activity and utilization of health care for young people. Perhaps surprisingly few of these are associated with motor vehicle accidents. The majority of injuries are sustained at school, the next most common place is within the home. Injuries account for the largest number of hospital days among young males and females, even including pregnancy-related days.

Young people see doctors less often and have fewer and shorter hospitalizations on average than any other age group. This is usually taken as an indicator of their good health. However, a corollary is that too many youth do not get preventive care and there is evidence from school health surveys that many vision, hearing, nutritional and other treatable health problems go undetected. This is especially the case for dental care. Forty-nine percent of adolescents in families with incomes under $10,000 received no dental care in 1983. Youth in these low-income groups have high rates of dental disease.

Chronic illness and disability

Published studies of the prevalence of chronic illness and disability have not, to date, focused specifically on youth. Estimates are that perhaps 5-6% of youth have a significant, chronic condition. Several types of indicators can provide an estimate of the proportion of young people who are significantly handicapped by reason of physical, mental or emotional condition. For example, in 1988, a Census Bureau survey found that 3.8% of 16-24 year olds had some kind of disability that affected their employment. The Department of Education reported that in 1985 there were 8-12% of high school students receiving some kind of special education.

Attempts to estimate the prevalence of seriously emotionally disturbed children and adolescents in school have ranged from 1-3%. Surveys of children of all ages have reported an increase in disability and chronic illness since 1960. However, some proportion of this increase is undoubtedly due to better diagnosis and reporting resulting from a considerable expansion of special educational and health services.

A new examination of the prevalence and severity of disabling chronic conditions in adolescents, using National Health Interview Survey data collected in 1984, found that nearly 2 million

adolescents (6.2% of the total non-institutionalized adolescent population) suffered some degree of limitations in their activities due to chronic conditions (Newacheck, forthcoming 1989).

Five major causes of disability accounted for 77% of the disability. These leading causes are: mental and emotional disorders (including mental retardation) accounted for 32% of adolescent disability; chronic respiratory conditions for 21%; diseases of the musculoskeletal system (e.g. arthritis) for 15%; nervous system diseases for 6% (e.g. cerebral palsy, multiple sclerosis, epilepsy,) and diseases of the ear and mastoid processes account for 4% of adolescent disability. The prevalence of disability did not differ significantly by race or ethnicity but there were large differences according to poverty status and education of the family member respondent.

From other studies, there is some speculation that the numbers of severely handicapped infants and children are rising as a function of improved medical care and technology. As more and more of these children survive into adolescence, the special problems of disabled youth will require more attention and resources. In addition, youth survivors of motor vehicle accidents are sometimes severely disabled and while very small in number require intensive and long-term health, rehabilitation and social services.

Mortality

Overall death rates for this age group are very low compared with other age groups (except for 5-12 year olds) and have been steadily declining since 1970. Yet there is a great deal of concern about the causes of youth mortality and about specific trends within the overall totals.

In 1983, the mortality rate for 15-24 years old was 95.8 per 100,000. Rates vary considerably by age, gender and race. Death rates are twice as high for males than females, are considerably higher for minority youth than white youth, and rise with age. The 1983-85 death rate for 15-19 year olds was 81.3, nearly three times as high as for the 10-14 year olds. This is the only age group for which death rates are the same for blacks and whites. However, the causes of death are very different for the two races (Fingerhut, 1989). Table 1. (p. 21) illustrates some of these key concerns about adolescent and young adult mortality rates as follows.

- The chief threats to adolescents' lives are external: motor-vehicle accidents, other accidents and deaths by violence (murder and suicide) are the four leading causes of death among 15-24 year olds. Deaths from cancer and heart disease rank fifth and sixth and are few in number.

- The leading cause of death for 15-19 year olds are motor vehicle injuries for whites and homicide for blacks. Among whites, in this age group 46% of all deaths are from motor vehicle injuries. Among blacks 33% are from homicides and another 17% from motor vehicle injuries.

- White males are more likely to commit suicide, yet minority males in 1985 were four to five times as likely to die as a result of homicide than white males. While mortality rates overall have declined since 1970, suicide rates have tripled for those 15-19 years, and more than doubled for the 20-24 year-olds.

- In a 1987 survey, 41% of high school boys and 24% of girls reported that they had access to a handgun. About 64% of boys and 19% of girls report having used a gun in the past year (including recreational use).

- Deaths by homicide among black males peaked in the seventies and have declined somewhat in recent years. However, the chances of a young black male being murdered during his lifetime are 1 in 30. (For white males the chances are 1 in 178). There appears

to be a recent escalation of death rates of young black males in certain urban communities (such as Washington, D.C.).

The "New Morbidity": Health compromising behaviors

Experimentation with sex, alcohol and drugs and occasional reckless driving of automobiles and motorcycles are a relatively normal part of adolescent development. But such behaviors are becoming called the "new morbidities" because of the new recognition that they too often lead to socially and health damaging consequences. When they engage in these behaviors repeatedly, without taking precautions and/or in combination adolescents place themselves and others at risk of disease, injury and death, or, through unwed childbearing, serious social handicap. In addition to these risk taking behaviors the new morbidity includes acts of violence such as suicide and homicide.

In the late sixties and early seventies, increasing proportions of adolescents at younger and younger ages engaged in these high-risk behaviors. While these trends have for the most part declined or leveled off in the eighties, the public is becoming more aware of their prevalence, serious consequences and their interrelatedness. In addition, sub-groups of the youth population engage in a combination of these high-risk behaviors placing them at especially high risk.

One estimate suggests that about one-quarter of all adolescents 10-17 years of age behave in ways that place them at moderate risk, another quarter (7 million) are in serious jeopardy, and 1 in 10 are already in dire straits (Dryfoos, 1987): those engaging in high-risk behavior are usually also in trouble at school, may drop out of school, and are often involved in delinquency.

- **Adolescent sexual activity, and unwed pregnancy and parenthood.** Since the early 1970s sexual activity among teenagers and young adults has increased, placing many more at risk of pregnancy, parenthood, and sexually transmitted diseases (including AIDS). While pregnancy rates for this age group have also increased, birth rates have declined for 15 to 19 year olds. This is due in part to somewhat more effective contraceptive use and to increased rates of abortion.

  The trend to delay marriages has resulted in a steep rise in out-of-wedlock childbearing. In 1985, 45% of births to white teenagers (including Hispanics) and 90% of births to black teens were out-of-wedlock. Children born out-of-wedlock comprise the largest subgroup of the welfare population, nearly one-half.

- **Substance Use and Abuse.** Alcohol and drug use was at its highest among high school seniors in 1980 when 72% reported using alcohol within the previous 30 days, and 37% reported using some kind of illicit drug (about 19 % marijuana only). In 1986 these percentages had fallen to 65% (alcohol), 27% (any illicit drug) and 13.9% (marijuana only). However, the prevalence of drug and alcohol use is not known for those who drop out of high school and is, presumably, considerably higher. Moreover, there are no national studies among young people of the use of the new cocaine derivative "crack" which is highly addictive and quite inexpensive.

- **Reckless Driving.** More than 50% of high school students reported not wearing seat belts on their most recent ride; 40% of motorcyclists rarely or never wear a helmet. Speed is a factor in greater than 50% of the accidents among adolescents as compared to only about 30% adults' accidents. Alcohol was a contributing factor in 42% of the fatal motor vehicle accidents among 16-24 year olds. And between 30-40% of high school students report having recently ridden in a car when the driver had used drugs or alcohol.

Interrelationship between risk behaviors
(Sources: Dryfoos, 1987; Irwin and Millstein, 1986)

Most of the surveys monitoring these trends collect information about only one type of behavior which makes it very difficult to understand how they are related to one another. Similarly, most of the programs and services developed to prevent or treat these behaviors are categorical, directed toward particular solutions for one type of problem. For example, in any one school (or community) there may be quite separate programs addressed to prevention of drug abuse, suicide, school drop out, pregnancy prevention, and to encourage safe driving. Similarly, community-based family planning or teen parent programs very rarely assess their teenage clients use of alcohol or other drugs. Substance abuse programs do not address the teens' sexual behavior and other health issues and so forth.

Yet a growing body of research confirms what many practitioners have known for years, namely that young people's behaviors are interrelated. These interrelations seem to be of several types. Engaging in one type of high-risk behavior may lead to another, such as teenagers who have been drinking or taking other drugs then engaging in unprotected sex, or reckless driving. Another pattern is to begin with taking a minor risk such as smoking marijuana which then leads to taking a more serious risk such as using "hard" drugs. Finally, it seems clear that there is a sub-group within the youth population which has multiple educational, personal and family problems and who engage in a cluster of high risk behaviors though the direction of cause and effect is rarely clear or simple.

One result of program specialization is that the process of labeling or making a diagnosis of a troubled adolescent may be somewhat arbitrary. An adolescent exhibiting certain behavior may be assessed as needing either treatment for a psychiatric disorder, or as a juvenile offender, or as learning disabled student depending on who is doing the assessment, what kinds of services are available in the community as well as other factors, such as race.

DEVELOPMENTAL AND FAMILY CONTEXT OF ADOLESCENT HEALTH
(Sources: Baumrind, 1987; Campbell, 1986; Combrinck- Graham, 1988; Doherty and Campbell, 1988; Gilligan, 1987; Hill, 1987; Lerman and Ooms, 1988; Millstein, Irwin, & Brindis forthcoming; Schorr, 1980; Smollar, Youniss and Ooms, 1986; Steinberg, forthcoming)

Adolescent Development

When they reach 18, American youth become adults in the eyes of the law and health care professionals and policymakers. And by this age most are biologically mature. However, psychologically, socially and economically most are still in a state of transition to independent, adulthood. Some reverse the usual sequence and become parents themselves before they leave their parental home, become employed and marry. Certain characteristics of this transitional stage of the life cycle have strong salience for the focus, organization and delivery of health care to this age group.

- The years 10-18 are a time of rapid growth and intense physical change, yet there is an enormous degree of individual variation in both the onset and duration of this growth spurt. And the development of the ability to think abstractly and rationally about risks and responsibilities also proceeds very unevenly. These facts pose problems for policies and programs based on chronological age and for the definition of legal maturity.

- A certain amount of experimentation and risk taking is normal and to be expected and, although not without danger, can result in increased psychological maturity and confidence.

But the self-centered absorption and belief in personal invulnerability characteristic of early adolescence can, especially if it persists, obstruct a realistic understanding of the degree of risk involved and be highly dysfunctional and destructive.

- Adolescence is a time of rapid and uneven vacillation between steps towards independence and back to dependence. One moment a teenager will demonstrate the tones and actions of an independent adult, a few hours later he or she will seek the comfort and security needed by a child.

Adolescents' Relations with the Family

The American tradition of rugged individualism, and psychoanalytic theories have forged an image of adolescence in the public mind that bears little resemblance to the common experience. This image emphasizes the inevitability of turmoil, rebellion and considerable conflict with parents during this period; the rejection of parental values, and the necessity of achieving physical separation, autonomy and detachment from parents to achieve full adulthood.

In the past few decades a growing body of psychosocial research has examined the relationship of adolescents and their parents. Some of the major findings include the following.

- There is no evidence for an increase in conflict from childhood to adolescence; that "storm and stress" are not normal; and that when conflicts occur they are about mundane matters (chores, bedtimes, personal appearance, etc.) and not about fundamental values. Such mundane conflicts are a normal healthy part of the process of individuation and are often constructive. In fact, adolescents agree with their parents on most basic value issues and while peers and other adults are a growing influence teenagers still turn to their parents for guidance about most major concerns. The adolescent years can be tense and stressful for both parents and teenagers, largely due to external pressures and dangers, but serious conflict is not inherent in the development of their relationship.

- Instead of becoming psychologically detached, rejecting and separate from them, adolescents transform their perceptions of their parents and learn to individuate themselves. They renegotiate their relationship with their parents on terms of greater equality and mutual respect and friendship. Parents in turn do not sever their bonds with their teens but gradually give them more freedom and autonomy.

- Typically, parents and teenagers avoid explicit communication about sex, alcohol and drugs. Consequently parents show much denial about the extent to which their own adolescents are engaging in any of these activities.

- In the last decade youth have delayed leaving home in increasing numbers. Until their mid-twenties more than half of young men and women continue to live in their parental homes or with other relatives. Three-quarters of minority, jobless youth live with their parents or other relatives. Many young people are not in steady, full-time employment. Yet when they live at home they are often economically dependent upon their parent(s) for shelter and food. (There are many reasons for this delayed nest-leaving: postponement of marriage, higher costs of housing and college education, smaller families leaving more space in the parental home, etc.)

- Teenagers who engage in persistent, destructive high-risk behavior and become emotionally distraught are usually alienated and distant from their families psychologically. Emotional distance and lack of connectedness to parents or other adults heightens their susceptibility to negative peer and other influences. While there may have been serious problems within the family for years, sometimes the family dysfunction is of recent origin

and may reflect the family's difficulty with renegotiating the parent-teen relationship, and/or other life-cycle issues.

Parents' Role in Health

"While the family is, and will remain the primary source of health care for children, the current health care system insufficiently recognizes or supports this role" (Schorr, 1980 p. 3). Numerous research studies have identified the complex pathways through which families influence the health of their members, and the ways in which illness can affect family patterns and relationships. While the ability of parents to directly influence their children's health diminishes somewhat in adolescence, it remains significant. And parent involvement remains critical to their teenager's recovery from illness, trauma or emotional breakdown or their ability to cope with handicap and chronic illness. Some of the major findings of this research are as follows.

- Families' genetic inheritance, cultural background and income level affect an individual's disposition to certain diseases, degree of health and access to health care. The well documented association between poverty and health status means that youth in future decades are likely to have poorer general health status and more chronic limitations on their activities (due to the projected increase in the proportion of children and youth living in poor, minority households).

- Parents and other family members help promote good health and avoid risk through health education, modeling healthy life styles, providing a safe home environment and a good diet.

- Stressful family events and relationships such as death, divorce, or serious illness have been found to predispose some family members---including adolescents---to become ill or act out in destructive ways.

- When children are young, parents are the organizers of health care, the central depository of health history and information and the key intermediary with health care professionals. This role will diminish as the adolescent takes on more responsibility for initiating and keeping appointments etc. In some sensitive areas, such as reproductive care, many parents have no involvement.

- Parents and other family members affect the course of a child or teenager's illness or condition through their initial response to the symptoms, their role in obtaining medical assistance, their role in ensuring compliance with prescribed medication or regimens and their general assumption of caretaking for an acute or chronic condition. When physical or emotional illness is severe or prolonged the family becomes reorganized and stressed in various ways that can be either adaptive or maladaptive.

- When a teenager or young adult has a serious illness, accident or behavioral or emotional crisis the family must usually be involved in the treatment to sustain recovery. There will be very few exceptions to this general presumption. If the parent/family is quite unavailable or it is considered unwise to invite them, then some other adult is usually needed to act as a surrogate parent.

- For children under 18, parent's health care insurance (or lack of it), and extent of the dependent coverage, affects their access to needed health care. After 18, as long as a young adult attends school full-time, their parent's plan often will continue coverage. Others students may participate in a college health plan. However, when they are not regularly attending school, they can only obtain insurance in their own right, not as members of the parental household.

QUESTIONS FOR POLICY ANALYSIS

The following conclusions and questions emerge from this overview of the data and research on adolescent health:

1. Effective prevention and treatment of these new morbidities of adolescents and young adults cannot rely on traditional public health methods and clinical diagnostic and treatment procedures such as immunization and information, drugs, diet and surgical and other interventions used for physical illness and disability. Thus, efforts to prevent or change specific behaviors will need to include a variety of psychological, behavioral and educational approaches and provide a variety of specific social and support services. *The question is whether existing or proposed health care insurance and program financing pay or reimburse for these kinds of non-traditional services that adolescents and young adults need?*

2. Services that target only one kind of behavior or illness without assessing its relationship to other aspects of the teenager's behavior are likely to be very ineffective. *The question is how can the current fragmented and categorical organization of programs and services to youth be changed to develop integrated systems of care that meet their multiple needs in a wholistic fashion?* (This question will be addressed in our second seminar.)

3. Disabled and chronically ill youth confront an especially complex challenge as they strive to accomplish the developmental tasks of adolescence---increased competence, autonomy and strong peer relations while continuing to be dependent on medical regimens and technology, family members and others. *The question is how can programs be designed to assist disabled youth gradually learn to assume increasing responsibility for their own care while accepting their continued limitations and dependence upon others?*

4. Health care policy and programs cannot make assumptions about adolescents' needs, capacities and maturity based on chronological age alone. *How can policies and programs assure that assessments of adolescents' psycho-social-familial functioning become an integral part of health care delivery to this age group?*

5. The family's role in health promotion and health care of adolescents' needs to be recognized and supported as for other ages. Yet, the strategies to accomplish these general goals, while still respecting adolescents' needs for privacy and increased autonomy, seem elusive. *How can health policies and programs best encourage adolescents to gradually assume increasing responsibility for their own health care without alienating them unnecessarily from the support and assistance they still need from their families?*

STATUS OF HEALTH INSURANCE COVERAGE FOR ADOLESCENTS (AGES 10-18) AND YOUNG ADULTS (AGE 19-24)

(Sources: McManus, Greaney, & Newacheck, forthcoming, 1989; Newacheck, forthcoming, 1989; Newacheck and McManus, forthcoming, 1989)

The first national examination of the health insurance status of adolescents and young adults is being conducted by the Institute of Health Policy Studies (IHPS), University of California in San Francisco, in collaboration with McManus Health Policy Inc. and Fox Health Policy Consultants with funding from the Bureau on Maternal and Child Health of DHHS. (See New Adolescent Health Projects below.)

Data for the two initial studies of health insurance among adolescents (age 10-18) and young adults (age 19-24) comes from a 1984 National Health Interview Survey, a nation wide, cross-section

survey of households conducted by the Census Bureau and sponsored by the National Center for Health Statistics. Also presented below are findings on medical expenditures for adolescents from their analysis of the 1980 National Medical Care Utilization and Expenditures Survey.

Selected Findings

Overview. Fourteen percent of adolescents and 26% of young adults were without insurance coverage. Eighty-four percent of adolescents 10-18 years old had some form of private or public health coverage during 1984 (76% private and 12% public, of these 2% had a combination). Only 74% of young adults had private or public coverage (66% private, 8% public, of these 1% had a combination).

Aside from using age as a factor in predicting absence or presence of health insurance, both studies examined the relationship of gender, race/ethnicity, income, youth's occupation/education, parent's education, living arrangements and geographic factors on insurance coverage.

Gender Differences. Gender was a stronger indicator of presence or absence of insurance for young adults than for adolescents. Young adult women were 9% more likely than men to have some form of insurance coverage, presumably because women can be insured through Medicaid if they have children.

Race and Ethnicity. Both analyses found large differences in insurance coverage by race and ethnicity. But when income was taken into account, race and ethnicity played a much smaller role in determining whether a young adult or adolescent would be insured. Black adolescents were 63% more likely to be uninsured and over four times as likely to be covered by public programs when compared to their white counterparts. Hispanic adolescents were nearly three times as likely to be uninsured as white adolescents.

Only half of black young adults were privately insured compared to nearly three-fourths of whites aged 19-24. Hispanic young adults suffered from even greater insurance disparities than black young adults. Forty-four percent of the Hispanic young adult population lacked health insurance coverage. While the extent of private insurance among black and Hispanic young adults was identical, Hispanics were only about half as likely to be publicly insured.

Income. As expected, rates of insurance rose as family income rose, except for the two lowest income brackets. Adolescents from the lowest income group (less than $5,000) were more likely to have health insurance than those from working poor families ($5,000 - $10,000). Thus, 73% of the very poor were insured compared to 67% of the working poor. This is largely attributable to the fact that many "working poor" families are not provided insurance through their work and can't afford to purchase private insurance, but are ineligible for Medicaid coverage because their incomes exceed state set eligibility thresholds.

Parents' or Guardians' Education. The most powerful predictor of insurance coverage for adolescents was parents' education. Adolescents residing in families where the person interviewed had completed fewer than 9 years of formal education were 11 times more likely to be uninsured than their counterparts in families where the reference person had completed some post-baccalaureate training.

Young Adults' Education and Occupation. Only 50% of young adults with a grade school education were insured as compared to 88% among those with a college education. Still, 12% of college graduates were uninsured in 1984. Young adults in college were the most likely to have health insurance, more likely than young adults who were working. Only 75% of employed young adults were insured.

Living Arrangement. Young adults living with others were more likely to be uninsured as compared to those who lived on their own. Almost 30% of young adults who lived with their relatives, for example, were uninsured. As many as one out of four married young adults who lived with their spouse was uninsured.

Geographic Region. Adolescents and young adults living in the Northeast and Midwest were more likely to have some type of coverage than those living in the South or West. The difference can be attributed to broader public health insurance in the Northeast and Midwest. Region may also play a role in whether insurance is provided by an employer. Jobs in the Northeast and Midwest are more likely to be unionized, while jobs in the South and West tend to be in agricultural or service industries jobs which often do not provide benefits like health insurance.

Reason Given for Absence of Coverage

The primary reason given for why adolescents were without coverage was that it was "too expensive" (seven out of ten respondents). Another one in ten respondents indicated that they lost health care coverage for their dependents following loss of employment.

Six out of ten young adult respondents stated that they could not afford health insurance. Almost two in ten young adults cited unemployment as the major reason for lack of coverage.

Adolescents' Health Care Expenditures

Newacheck and McManus also analyzed the 1980 National Medical Utilization and Expenditure survey and found that average, total health care expenditures of adolescents ages 10-18 were $525 in 1988 dollars (updating the 1980 data using the medical care component of the CPI). Of these, average out-of-pocket expenses were $151. But these averages mask enormous variation in use of services. Nearly one fourth of adolescents had no health care expenditures at all. In contrast, 10% of adolescents accounted for 74% of all expenditures for this age group. (Note: health insurance premiums were not counted in this survey, nor is dental care.)

Having insurance does not guarantee that family's medical bills will be covered. The quality of coverage and degree of financial protection depends on various provisions regarding type of services covered, co-payments and deductibles, etc. In general, insurance offers relatively good protection for hospital-based services, but comparatively poor coverage for ambulatory services that adolescents typically need, such as preventative or health supervision visits, mental health services, substance abuse treatment, nutritional counseling, dental care, and reproductive care. Typically these services, when provided at all, are either covered by direct grant programs (e.g. community health clinics) or written off by the provider as bad debt or charity.

FEDERAL PROGRAMS THAT FUND HEALTH CARE FOR YOUTH

(Sources: CASSP, 1988; Johnson, K., 1986; Congressional Research Service, 1988 and 1989; Democratic Study Group, 1988; Knitzer, 1982; Office of Technology Assessment, 1988 and 1986)

We have compiled this list simply to illustrate the range and variety of sources of public funding of health care for adolescents and young adults. Detailed descriptions and analyses of these programs are needed to assess the degree to which they currently serve young people and how adequately they meet their complex and special needs. For some programs this examination is already underway (see below New Adolescent Health Projects). This listing is very preliminary. [Please inform us of any errors of commission or omission.]

With two small exceptions---The Adolescent Family Life Program and the OSAP High Risk Youth grant program---there are no federal health programs that specifically target adolescents or young adults. Basically, adolescents are served as part of the overall population of children under 18. And young adults receive care as part of the general adult population although sometimes services for children can be extended up through 21 years of age. Generally, the federal health dollar goes either to reimburse health care providers for services for eligible individuals in various entitlement programs or to provide grants to states or community-based organizations for a variety of health related activities.

However, within the broad parameters set by the federal government, the extent and type of services paid for, or offered to, youth will depend considerably on the degree to which the states give this population priority. States vary a great deal in the extent of their efforts to target the health needs of adolescents and youth. For the most part it is not possible to say how many adolescents or young adults are served by these public programs nor how much of federal and state health dollars are spent on this population.

Medicaid

Medicaid is a federally aided, state-administered program that pays providers for a range of medically related services to low-income adults and children. It is the largest single source of public funding of medical care for mothers and children. At least 50% of each state's Medicaid expenditures are paid by the federal government under matching formulas. States operate under broad federal guidelines, but each state designs and administers its own Medicaid services. Thus eligibility requirements, services offered and methods and level of payments vary a great deal from state to state.

A range of inpatient and outpatient services are federally required, as is the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT) program services. At state option, a number of other services may be provided including psychiatric, inpatient, hospitalization, and upon receipt of a state waiver, home-based services for the chronically ill and disabled who would otherwise have to be hospitalized. When such services are offered to adults, children and adolescents may also participate. States may also extend their Medicaid services to the "medically needy," those whose incomes are too high to qualify but when their medical bills are discounted their incomes do make them eligible.

Early Periodic Screening, Diagnosis and Treatment Program (EPSDT)

The EPSDT program is a special program within Medicaid aimed at providing preventive care to poor children. It requires states to provide comprehensive medical examinations at periodic intervals, follow up treatment and case management for all Medicaid eligible children and youth up to age 21. A 1985 CDF report concluded that, in general, states had underutilized EPSDT as a vehicle for delivering effective health services to poor teenagers, but some states were doing so creatively. For example, Maryland uses EPSDT to expand and strengthen health services in Baltimore city high schools serving large proportions of low-income youth.

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

CHAMPUS is the largest single health insurance program in the country and provides health care benefits to military dependents and retirees who are unable to receive services through the uniformed services medical treatment facilities. CHAMPUS is known as one of the most generous third-party payers for mental health care, although up to 75% of these benefits are spent on inpatient and residential treatment center care for adults, adolescents and children.

Maternal and Child Health Services Block Grant

The MCHS Block Grant was created under the OBRA legislation of 1981. It consolidated a number of federal categorical health programs authorized under Title V of the Social Security Act.

(Title V was originally established in 1935 as a federal grant-in-aid program). The Title V Block Grant program provides funds to state health agencies for a variety of services to improve the health of mothers and children, including children with special health needs. Many state programs accomplish their goals through collaborative efforts with other agencies and resources. A 1985 survey of fifty state MCH agencies found most states using Title V and other monies to fund adolescent health services. In 1988, around twenty states had designated adolescent health coordinators at state level who promoted the development of community-based, comprehensive health programs for youth.

Under a 15% set aside, the Block Grant funds a program of special projects of regional and national significance (SPRANS) including a number of special programs devoted to adolescent health with an emphases on service delivery to high-risk and low-income youth. Of particular interest are grants that focus on training of adolescent health care professionals, research in relation to high-risk behaviors and demonstrations for improved services for youth. The MCH Block Grant is administered by the Health Resources and Services Administration which also administers the Community Health Centers and Migrant Health programs, and other programs.

Community Health Centers (CHC)

The goal of the CHC grant program, which funds over 1,200 centers and satellite clinics is to provide primary health care services to medically underserved areas. A wide range of services is provided under a sliding fee pay scale with 60% of the recipients under the federal poverty level and an estimated 50% of the patients carrying no health insurance. There is no data about the percentage of patients who are adolescents or young adults.

Title X, Family Planning Program, Office of Population Affairs

Title X of the Public Health Services Act is the major federal program that provides family planning services to low-income women through grants to public and private non-profit organizations. Many of the programs have made special efforts to focus their services on adolescents. The program is administered by the Office of Population Affairs, Assistant Secretary for Health.

Title XX, Adolescent Family Life Act (AFL) Program

The AFL program, in the Office of Population Affairs, is authorized by Title XX of the Public Health Services Act. It funds community-based programs that aim to prevent adolescent pregnancy and provide comprehensive, coordinated health education and social services to teenage mothers and their babies. It was the first federal health program to target adolescents. It received $9.6 million in FY '88 of which $6.5 million was for the demonstration programs. In recent years the program has placed special emphasis on promotion of chastity, adoption and involving families in the services to teenage mothers. The programs give priority to school-age adolescents, but may provide services up to age 21.

Alcohol, Drug Abuse and Mental Health Services (ADMS) Block Grant

The ADMS Block Grant authorized under Title XIX of the PHS Act provides grants to states for alcohol and drug abuse, treatment and prevention activities, and community mental health services. This grant program, created by the Omnibus Reconciliation Act of 1981, consolidated a number of categorical programs within the Public Health Services Act and required that the monies be allocated in certain proportions between alcohol, drug abuse, and mental health. Inpatient and outpatient services to children and adolescents were permitted, at state option, but not required. In 1985, Congress required that 10% of the mental health portion of the block grant funds be set aside for new programs for children and other special populations.

Office of Substance Abuse Prevention: High Risk Youth Program, ADAMHA

This program was initially established in 1987 as part of the ADMS Block Grant to provide a variety of public education and community prevention services for both alcohol and drug abuse.

These include a clearinghouse, a grants program for projects for pregnant and post-partum women and their children, a program for training counselors and health care personnel, and a High Risk Youth Model Projects Program. This High-Risk Youth program has funded projects to community based programs for preventive education, ea 'y intervention, treatment and rehabilitation services for high-risk youth.

The Anti-Drug Abuse Act of 1988 (H.R. 5210) increased the funding for OSAP from $34 million to $64 million and established the Office as a fourth, separate Institute within ADAMHA (though it will retain its current name). OSAP's purpose and activities are different from the other Institutes, whose primary purpose is to fund research.

Child and Adolescent Service System Program (CASSP), National Institute of Mental Health, ADAMHA

In 1984 Congress mandated a new federal initiative to help states improve their existing systems for delivering services to severely emotionally disturbed youth. CASSP currently funds grants to two-thirds of the states and various communities, and provides a variety of technical assistance activities in addition. The major focus of these activities is to develop leadership capacity and foster interagency coordination to develop integrated, community-based systems of care for children and youth in need of services. CASSP, initially funded at $1.5 million, received $7.4 million in FY '88.

The target population of the CASSP program is quite broad and includes children up to age 18 (at state discretion this may extend to age 21) who are not functioning in the family, school and community; who rec 'ire multiple agency services (e.g. from mental health, educ ation, juvenile justice, substance abu e etc); whose difficulties have been or are expected to be present for at least one year; and who are diagnosed with a mental, or emotional, psychiatric disorder (DSM-III-R). It is believed that in many communities a large majority of the children assisted by this program are seriously troubled adolescents. There is a strong emphasis on involving the families in the planning and delivery of services.

Anti Drug-Abuse Act of 1988, H.R. 5210

This omnibus bill, enacted in the 100th Congress, addresses illegal drug use in two ways: roughly half of the $2.7 billion authorized dollars are allocated to enhancing law enforcement and increasing penalties and the other half to expanding prevention and treatment activities. A down payment of close to $1 billion was actually provided in supplemental appropriations for FY '89.

Of these monies, roughly $48 million are specifically targeted on anti-drug youth programs including the increased monies for the OSAP High Risk Youth grants program, grants to prevent drug abuse among runaway and homeless youth, grants for anti-drug abuse activities targeted to youth gangs, and educational and recreational, community-based drug abuse prevention activities for youth.

In addition, the Act includes other provisions for the general population that may be expected to provide some additional direct or indirect services to youth, if the states choose to do so, namely substantial additional monies to the ADMS Block Grant program to be used solely for substance abuse programs; a new direct grants program to successful drug abuse programs, and substance abuse education for participants in the Women, Infants and Children (WIC) food and nutrition programs.

NEW NATIONAL ADOLESCENT HEALTH PROJECTS

American Medical Association, (AMA) Department of Adolescent Health

In 1988, the AMA established a new Department of Adolescent Health within its Division of Health Sciences. Its mission is to improve the health of adolescents by providing education and developing new research information. Among its activities are an Awards program provided for Excellence in Intervention, Education and Prevention, Use of Volunteers, and Distinguished Service on Behalf of America's Youth. It holds an annual National Congress on Adolescent Health. Its Center for Adolescent Health Analysis plans to develop a set of adolescent health profiles, and identify, analyze and disseminate models of comprehensive prevention strategies for the transition into adolescence.

Contact: Arthur B. Elster, M.D., Director , and Dale Blyth, Senior Scientist, Department of Adolescent Health, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610, (312) 645-5530 or 5540.

Carnegie Council on Adolescent Development

The Council is composed of 26 distinguished national leaders from the fields of education, law, health, science, religion, business, media, youth serving agencies and government. It was established by the Carnegie Corporation of New York in June 1986 for the purpose of placing the challenges of the adolescent years higher on the nation's agenda.

The Council has four integrative functions: to synthesize existing knowledge, to identify gaps in knowledge and in the effectiveness of supportive programs, and to make recommendations for needed programs and policies at different levels of government and sectors concerned about adolescents. The efforts of the Council are focused primarily on the early adolescent years. Its activities include working meetings of the Council, special task forces, working groups, workshops and publications. The Council is chaired by David Hamburg, M.D., President of the Carnegie Corporation.

Contact: Ruby Takanishi, Ph.D., Executive Director, Carnegie Council on Adolescent Development, 11 DuPont Circle, N.W., Suite 900, Washington, D.C. 20036. (202) 265-9080.

General Accounting Office (GAO), U.S. Congress

GAO has initiated an exploratory study of adolescent access to health care. The study will initially focus on Medicaid. Its first task will be the preparation of an issue paper documenting state variation in Medicaid benefits, and various factors that encourage or discourage utilization of Medicaid by adolescents.

Contact: Charles Reisz or Mary Brecht, GAO, Human Resources Division, Room 1126 Switzer Building, 330 C Street, S.W., Washington, D.C. 20201. (202) 426-5246.

Institute for Health Policy Studies, University of California, San Francisco (IHPS)

Paul Newacheck, M.D. of the Institute of Health Policy Studies, in collaboration with Peggy McManus and Harriette Fox, health policy consultants in Washington, D.C., is conducting a three-year project designed to improve health insurance coverage for adolescents and young adults. The project is funded by the Bureau of Maternal and Child Health, DHHS. The project involves three principal activities:

1. Analyses of several national data sets to examine and assess the health insurance status of adolescents and young adults as a group and specific sub-populations with unique access problems such as low-income teenagers, chronically ill and disabled youth, and substance abusers.

2. A review and assessment of the adequacy of private and public health insurance programs and policies to meet the needs of adolescents.

3. Identification and evaluation of various alternative mechanisms and policy options that would remove or alleviate existing barriers to the appropriate use of health care for this age group.

Throughout the study, which is expected to be completed by the end of 1990, project staff will prepare several articles for publication and issue a series of fact sheets and memoranda for wide distribution.

Contact: Peggy McManus, McManus Health Policy Inc., 4801 Massachusets Avenue, N.W., Suite 400, Washington, D.C. 20016. (202) 895-1580.

Office of Technology Assessment (OTA), U.S. Congress

The OTA, at the request of 37 members of Congress in July 1988 launched a study on adolescent health. OTA is to report to the Congress on the status and well-being of adolescents and propose options for policy development, recommendations for future research and data collection efforts. The study will pay special attention to the needs of rural youth and racial and ethnic minorities. The study is broad in scope. It is guided by a national Advisory Panel and will be assisted by the Carnegie Corporation under a cooperative agreement. The final report is due in December 1989.

Contact: Denise Dougherty, Project Director, Health Program, Office of Technology Assessment, Washington, D.C. 20510. (202) 228-6590.

University of Minnesota, Adolescent Health Database Project

The University of Minnesota Database Project was funded in 1984 by a four-year Maternal and Child Health grant to establish a model database on adolescent health. It has approached this challenge in two ways: 1. Conducted an adolescent health survey of over 36,000 7th-12th graders from around the state. 2. Established a computer database drawing on data from a variety of state agencies. The data was put on DATANET, an online computer network at the State Planning Agency. The network of users planned for the database includes health researchers and planners, and the myriad of agencies and programs that deal with young people.

Contact: Laura Hutton, Adolescent Health Programs, University of Minnesota, Box 271, Harvard Street at East River Road, Minneapolis, Minnesota 55455. (612) 626-2807.

University of Minnesota, National Resource Center for Youth with Disabilities

The National Center for Youth with Disabilities is a collaborative project of the University with the Society for Adolescent Medicine, and is supported through a grant from the Bureau of Maternal and Child Health Resource Development, Division of Services For Children with Special Needs. The Center sponsors the National Resource Library (which functions as a clearinghouse of information on youth disabilities), workshops, conferences, publications and technical assistance. The Center was initially established in 1986, the Resource Center became operational in 1988.

The Center works to expand the knowledge and involvement of individuals, agencies and programs providing services to youth with chronic illness/disabling conditions and to demonstrate service system models which enhance the ability of adolescents to grow, develop, work and

participate in community life to their fullest capacity. The Center is committed to an interdisciplinary perspective and to fostering collaboration between and among professionals, parents and youth.

Contact: Nancy Okinow, M.S.W., Ex. Director, National Center for Youth with Disabilities, Adolescent Health Program, University of Minnesota, Box 721-UMHC, Harvard Street at East River Road, Minneapolis, MN 55455. 1-800-333-NCYD or (612) 626-2825.

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Indicator 45. Causes of Death

Annual number of deaths among 15- to 24-year-olds, by age and cause of death: 1960 to 1985

[Number of deaths per 100,000 persons in each specified group]

Age and cause of death	1960	1965	1970	1975	1980	1985
15 to 19 years old						
All causes	92.2	95.1	110.3	101.5	97.9	81.2
Motor vehicle accidents	35.9	40.2	43.6	38.4	43.0	33.9
All other accidents	16.8	16.5	20.3	19.0	14.9	10.3
Suicide	3.6	4.0	5.9	7.6	8.5	10.0
Males, white	5.9	6.3	9.4	13.0	15.0	17.3
Females, white	1.6	1.8	2.9	3.1	3.3	4.1
Males, all other races	3.4	5.2	5.4	7.0	7.5	10.0
Females, all other races	1.5	2.4	2.9	2.1	1.8	2.2
Homicide	4.0	4.3	8.1	9.6	10.6	8.6
Males, white	3.2	3.0	5.2	8.2	10.9	7.3
Females, white	1.2	1.3	2.1	3.2	3.9	2.7
Males, all other races	27.6	30.6	59.8	47.8	43.3	39.9
Females, all other races	7.0	7.1	10.1	14.6	10.1	9.4
Cancer	7.7	7.6	7.3	6.0	5.4	4.6
Heart disease	6.2	5.3	3.9	3.4	2.3	2.2
Pneumonia/influenza	2.8	2.1	2.1	1.5	0.6	0.5
20 to 24 years old						
All causes	125.6	127.3	148.0	138.2	132.7	108.9
Motor vehicle accidents	42.9	49.3	51.3	40.1	46.8	38.1
All other accidents	19.6	18.7	22.9	23.5	18.8	14.1
Suicide	7.1	8.9	12.2	16.5	16.1	15.6
Males, white	11.9	13.9	19.3	26.8	27.8	27.4
Females, white	3.1	4.3	5.7	6.9	5.9	5.2
Males, all other races	7.8	13.1	19.4	23.6	20.9	20.2
Females, all other races	1.6	4.0	5.5	6.0	3.6	3.5
Homicide	8.2	10.0	16.0	18.3	20.6	15.1
Males, white	6.0	7.4	11.1	14.5	19.9	14.6
Females, white	1.9	2.3	3.5	4.8	5.4	4.3
Males, all other races	64.2	80.5	136.3	124.9	109.4	72.8
Females, all other races	16.3	17.3	23.9	23.6	23.3	15.2
Cancer	9.2	9.0	9.4	7.6	7.2	6.1
Heart disease	11.3	9.3	6.2	5.4	3.5	3.3
Pneumonia/influenza	3.2	2.3	2.8	1.9	1.0	0.8

SOURCE: U.S. Department of Health and Human Services. *Vital Statistics of the United States*, various years.