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Adolescent Health Care A Program Review and Descriptive Summary

Native American Management Services, Inc.

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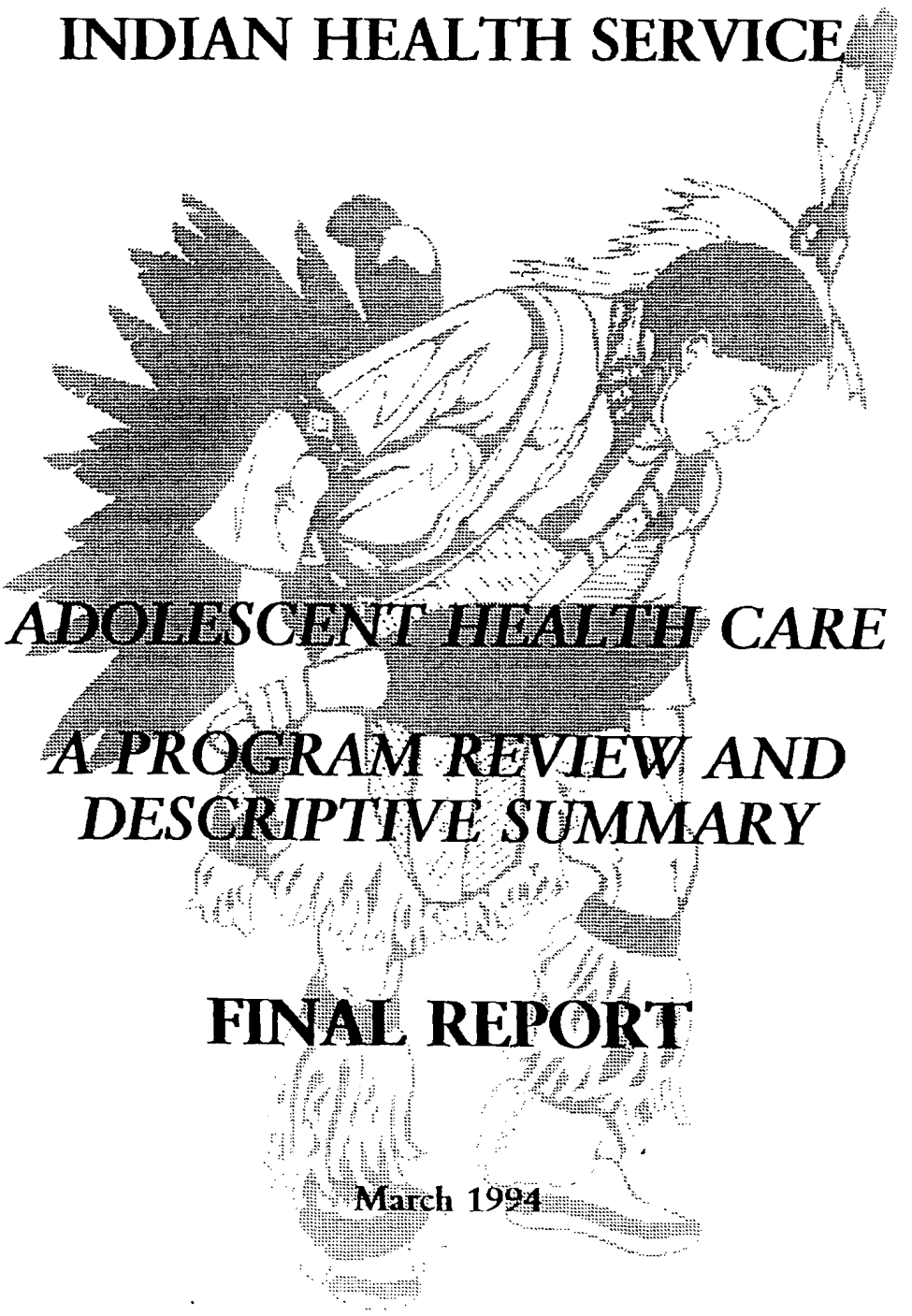
INDIAN HEALTH SERVICE



ADOLESCENT HEALTH CARE

A PROGRAM REVIEW AND DESCRIPTIVE SUMMARY

FINAL REPORT

March 1994

INDIAN HEALTH SERVICE

ADOLESCENT HEALTH CARE

FINAL REPORT

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INTRODUCTION

PURPOSE OF THE PROJECT:

The purpose of this project was two fold. First, was to conduct a review of the Indian Health Service (IHS) Health Promotion and Disease Prevention (HP/DP) Adolescent Health Centers Grants Program. The review was conducted by using the available data and reports contained in the grant files that are located in the Grant Management Branch, IHS Rockville. For this initial review, the scope of information collected and reviewed were limited to the grant files. However, telephone information queries were conducted with grantee project officers. The main objective of the grant program review was to examine the 14 grantee projects funded through this program and assess the grantees' progress toward meeting the grant program objectives. The next step was to analyze available program and cost data, and identify program accomplishments. The second purpose of the project was to compile information and describe American Indian/Alaska Native (AI/AN) adolescent health care in the IHS.

SCOPE OF THE REPORT:

This report is presented in two parts. Part One is the description and results of the IHS HP/DP Adolescent Health Centers Grant Program review. Part Two is the description of AI/AN adolescent health care in the IHS.

In Part One, information is presented in three sections. Section I describes the HP/DP grant program and Section II presents the findings from the program review. An additional outcome of this review was the development of program profiles on each of the 14 grantees. These profiles are presented in Appendix A and the budget data collected from the grant file review are in Appendix B. Recommendations are presented in Section III and are primarily based on the review findings and data gathered from the grant file review. However, some recommendations reflect a final analysis derived from all information gathered for this report. Finally, the data collection tools used in the grant file review are in Appendix C.

Part Two, of this report, has two sections. Section I describes an overview of adolescent and AI/AN adolescent health care and provides information on prevention strategies. Section II presents information about AI/AN adolescent health care in the IHS. Also, in this section are national strategies and directions for AI/AN adolescent health care based on a summary of the issues and recommendations from the first IHS Adolescent Health Conference. To complete the description of services and actions conducted by the IHS on AI/AN adolescent health, summaries of previous studies on adolescent health care are in Appendix D. Appendix E provides information on national resources available for AI/AN adolescent health care services.

PART ONE

THE HP/DP ADOLESCENT HEALTH CENTERS GRANT PROGRAM

SECTION I: DESCRIPTION OF THE GRANT PROGRAM

A. SCOPE AND PURPOSE OF THE GRANT PROGRAM

In fiscal year (FY) 1990, the Indian Health Service (IHS) Appropriations Act Public Law 101-121 authorized $3,000,000 for Health Promotion/Disease Prevention (HP/DP) initiatives. The IHS allocated $650,000 to the Cancer Prevention, $650,000 to Community Injury Control, $250,000 to Fetal Alcohol Syndrome, $450,000 to IHS Area HP/DP activities and special initiatives such as women's health, and $1,000,000 to the Adolescent Health Centers Grant Program. The three-year grant program was established to fund demonstration projects for adolescent health centers. The purpose of these demonstration projects was to address the specific health problems of AI/AN adolescents and emphasize health promotion and disease prevention with cultural relevance and sensitivity. Specific areas of special concern are:

- Teen Pregnancy
- Sexual Transmitted Diseases (STD)/Acquired Immune Deficiency Syndrome (AIDS)
- Mental Health
- Alcohol and Substance Abuse

The IHS offered the first three-year demonstration grant program beginning in FY 1990. The target population was ages 12 through 19. The Federal Regulations establishing this grant program, included three (3) main objectives. These were listed in the grantee application packets and represent the overall scope of the projects. The three main objectives were to:

1. Provide Indian adolescents with outreach programs of preventive education and counseling related to (a) accident prevention, (b) STDs, (c) AIDS, (d) suicide, (e) violence (f) substance use including tobacco, alcohol, other chemicals and drugs, and (g) fetal alcohol syndrome;

2. Provide Indian adolescents with outreach programs of health promotion education and counseling in a) teenage pregnancy, b) mental health, c) nutrition, d) physical fitness, e) health behaviors and the promotion of wellness, f) recreational therapy activities that enhance self-esteem, self-sufficiency and team building, and teach constructive use of leisure time, and g) preparation for adult role responsibilities, including parenting responsibilities; and

3. Ensure that Indian adolescents have access to age group and culture appropriate health care, particularly in the areas of special concern in adolescence including pregnancy, infant care, infectious diseases, mental health, tobacco alcohol, and substance abuse.

Fourteen (14) demonstration grant projects were funded in the FY 1990-1993 cycle. These demonstration projects were expected to develop program services and activities to address AI/AN adolescent health issues through culturally relevant education, counseling, and motivational techniques. In addition, an important aspect of the projects was to coordinate and promote access to culturally appropriate health care services for this age group. The expected outcome was the prevention or resolution of high risk behaviors and the development of healthful and responsible practices for AI/AN adolescents.

B. DEVELOPMENT OF GRANTEE PROFILES

An objective of this review was to develop individual grantee profiles that give a "snap shot" of each grant project. The other review objective was to collect information to assess grantee performance under this grant program. The assessment questions and findings are presented in Section III of this report.

The grantee profiles were developed from information contained in the 14 grant files located in the Grants Management Branch office in IHS Headquarters, Rockville and a review of summaries prepared from the *1993 IHS Adolescent Health Conference* held in Albuquerque, New Mexico. At this conference, a representative from each grant project presented a descriptive report of their demonstration project. Individual grantee profiles are found at Appendix A. These profiles present a summary of the information and data contained in the conference material and grant files. At Appendix B is the grantee budget data that was also extracted from the Headquarters grant files. The following is a brief narrative of some significant points included in these 14 profiles.

C. SUMMARY OF THE 14 ADOLESCENT HEALTH GRANT PROFILES

The 14 grantee projects were established in nine states with three-year funding provided by the IHS. Three projects were located in Washington State, two in Minnesota, Michigan, Wisconsin and one in each state of New Mexico, Oklahoma, Nevada, Arizona, and North Carolina.

The target population for each grant was Indian youth 12 to 19 years of age. Sometimes, the target population was scattered throughout many communities/reservations, counties, and school districts. For example, one project identified a service population in three different counties and nine schools.

The settings in which services were provided varied among projects. Projects ranged from stand alone centers and school classrooms to community outreach. Most projects set up teen health centers or resource centers.

METHODS FOR ACCOMPLISHING GOALS:

Based on the review of available data, the grantee demonstration projects planned, organized, and implemented programs that met the objectives identified in the scope of the demonstration project. The 14 grantees accomplished their program goals by establishing teen centers, providing outreach services, developing age and culturally relevant curricula and educational materials, conducting workshops, and offering group and individual counseling sessions.

Where centers were operated, centralized services were offered, including health screening and other clinical services with health care providers and counselors available. Some grant projects hired health care provider staff specifically to operate and manage their center; other grantees coordinated existing community service providers to be available on specific schedules. Many teen centers or resource centers were located in or near schools. Where teen centers were not established, the barrier often listed was the lack of a space or facility to provide centralized services.

All grantees included an evaluation component in their proposals and many reported data gathering efforts through administering Adolescent Health Risk Surveys to establish baseline data on their reservation's youths health and wellness. All 14 projects provided some "hands on" services and collected some data to assess and/or evaluate their program services.

It appeared that when a large service or target population (1000 plus) was identified, an emphasis was placed on data gathering such as the administering of the Adolescent Health Risk Surveys, developing curricula, and establishing networks to coordinate the communities youth programs and services. A common element across all projects was their communication efforts to keep the youth and community informed of project activity schedules and disease prevention/health promotion materials.

MAJOR ACHIEVEMENTS:

The grantee projects focused much of their efforts on creating change and increasing healthy behaviors with an integration of services approach. Grantees often took the lead in coordinating community youth program services and service providers, including those in the school system. They also stressed the role of the families in the network of support systems available to the AI/AN adolescent. Program objectives and activities frequently emphasized reestablishing traditional cultural values. Many notable achievements and/or innovative approaches incorporated AI/AN cultural enhancement projects (i.e., documenting elder's stories and other information, painting murals, making pow-wow outfits, etc.)

A significant success factor for some projects was the ability to get the support and commitment of the adolescent's family. For example, some grant projects organized and conducted activities involving entire families. These activities included group meeting sessions, week end retreats, camping and other recreational activities. It was reported that these activities were highly effective in team building and developing skills for conflict resolution, parenting, decision making and creating family unity and self-esteem.

IDENTIFIED BARRIERS:

Many grantees reported program start-up difficulties such as hiring staff; getting a site, space, or facility; and establishing and opening a center. A noted barrier for some grantees was the lack of participation and support of parents. The most frequently noted barrier was the lack of funds. Other barriers were the community's denial of problems, especially substance abuse, and/or lack of cooperation from school staff.

SECTION II: FINDINGS FROM THE GRANTEE DATA REVIEW

ASSESSMENT QUESTIONS AND THE GRANT REVIEW PARAMETERS

The review of the 14 grant files represents the major source of information used to develop this report. The review method focused on five questions that provided a reference point for each reviewers assessment. Those questions were: 1) How well did grantees perform against the program's objectives; 2) What program results and outcomes were realized; 3) What improvements are needed in program criteria and reporting; 4) What was the cost of the program and how were funds used; and 5) What community resources exist and how were they used?

QUESTION 1 - HOW WELL DID GRANTEES PERFORM AGAINST THE PROGRAM'S OBJECTIVES?

Factors and Data:

This review examined the performance of each grantee in achieving the following grant program objectives:

1. To provide Indian adolescents with outreach programs of preventive education and counseling related to (a) accident prevention; (b) STD; (c) AIDS; (d) suicide; (e) violence; (f) substance use including tobacco, alcohol, other chemicals, and drugs; and (g) fetal alcohol syndrome.

2. To provide Indian adolescents with outreach programs of health promotion education and counseling in (a) teenage pregnancy; (b) mental health; (c) nutrition; (d) physical fitness; (e) healthy behaviors and the promotion of wellness; (f) recreational therapy activities that enhance self-esteem, self-sufficiency and team building and teach constructive use of leisure time; and (g) preparation for adult role responsibilities, including parenting responsibilities.

3. To ensure that Indian adolescents have access to age group and culture appropriate health care, particularly in the areas of special concern in adolescence including pregnancy, infant care, infectious diseases, mental health, and tobacco, alcohol, and substance abuse.

Proposals and available progress reports were reviewed to assess grantee progress in achieving each of these objectives. In addition, direct telephone contacts were made with IHS Area project officers concerning the specific activities and outcomes of the grantee program. Standard data collection forms, see Appendix C, were used to document the methods used to achieve these objectives and the barriers that interfered with their achievement.

Findings and Explanations:

Program funding, through the HP/DP Adolescent Health Centers Grant Program, ended for the 14 grantee demonstration projects on October 1, 1993. However, all 14 have remained in operation and are continuing to provided services to their AI/AN adolescent population. Their continued operation is due, in part, to funding from each projects respective IHS Area Office. However, funding varied from 45 to 50 percent of the project's 1993 level of funding.

All 14 of the HP/DP Adolescent Health Centers Grant Program grantees achieved the Federal objectives. All of the grantees appear to have undertaken efforts that in one way or another provided outreach programs to educate and counsel AI/AN adolescents in the various health risks identified.

Also, all of the grantee projects made efforts to increase or improve adolescents' access to health care appropriate to their age group and culture. An emphasis was placed on adolescent pregnancy, infant care, infectious diseases, mental health, and tobacco, alcohol, and substance abuse.

The degree to which the grant program objectives were achieved becomes a critical and difficult question to resolve. A problem the reviewers encountered was a lack of many second and third year progress reports. Therefore, this review was unable to identify information or data that measured the specific degree to which project objectives were reached. Also, program standards were not available to the grantees. Therefore, the specific grantee program objectives on how and to what degree the overall grant program objectives were successfully met varied from grantee to grantee. Some grantees worked extremely hard and had considerable success at educating and counseling adolescents on their health risks. Many coordinated their activities with local clinics, schools, service agencies, tribal governments, and other organizations that could improve adolescents' access to appropriate health care.

Other grantees did not reach their full potential but they demonstrated successful implementation of activities that met the overall grant program objectives. Barriers were identified that slowed the grantees down or reduced their effectiveness. Some principle reasons for the reduced program effectiveness were:

- **Difficulty in recruiting and hiring qualified staff.**
- **Slow start-up caused by unexpected problems such as locating and acquiring facilities.**
- **Lack of support from the families of adolescents served.**
- **Lack of support from tribe or the community at large.**
- **Staff who lacked administrative skills.**

QUESTION 2 - WHAT PROGRAM RESULTS AND OUTCOMES WERE REALIZED?

Factors and Data:

All available progress reports were reviewed, and discussions conducted with IHS staff.

Findings and Explanations:

The grantee programs accomplished many positive results with the resources they had available in the three-year funding cycle. The knowledge, skills, and resourcefulness of grantee staff were probably the most significant factors that determined the quality of the program. A major program strength for some of the grantees was their staff's resourcefulness to organize and coordinate services and resources with other community youth programs and/or support systems including families and community members. Projects that were successful in integrating the existing health care systems and local community resources appeared to have a greater influence and affect on accomplishing their goals and maintaining an on-going program beyond the demonstration phase.

There was a broad range of program accomplishments.

HP/DP Outreach Services

Progress reports documented, in general, program activities that provided the following services, as required by the grant program.

- Provided health care services including health education, nutrition, family planning, physical exams, acute assessment, treatment of sexually transmitted diseases, prenatal care, mental health, substance abuse, and HIV/AIDS counseling and testing.

- Provided outreach services for disease prevention and health promotion in areas such as teenage pregnancy, mental health, nutrition physical fitness, healthy behaviors, the promotion of wellness, and recreational therapy.

- Provided structured recreational therapy and physical education (e.g., week end camping, river floats, field trips, cultural awareness and other age and culturally appropriate experiences) to increase self-esteem, self-sufficiency and teach team building and constructive use of leisure time.

Most reports documented the methods and activities developed to provide the HP/DP outreach services. The following is a summary list of grantee program activities and accomplishments.

Individual/Group Counseling

- Offered individual counseling.
- Conducted Teen Health Risk Appraisals to evaluate "level of wellness" of target population.
- Conducted group counseling and family counseling sessions, after school and evenings, that offered health promotion/disease prevention education and counseling on preparation for adulthood, Sexually Transmitted Diseases, HIV/AIDS, suicide, violent behavior, substance abuse, fetal alcohol syndrome, teen pregnancy, parenting, nutrition, wellness/self-esteem, and accident prevention.
- Conducted family oriented retreats for building self-esteem, communication skills, and family relations.

Development and Distribution of Education Materials

- Developed comprehensive health promotion and education, and disease intervention curricula in the areas of sex and sexuality, drug and alcohol abuse, and mental health.
- Developed, distributed, collected and tallied parent/teacher/student opinion surveys regarding perceived curricula needs and most useful information formats.
- Developed and distributed teacher and student resource handbooks and other information and educational materials.
- Implemented health care and disease prevention curricula through classroom and workshop sessions.
- Promoted the use of visual aids (films, slides, books/pamphlets) as learning and counseling tools.
- Designed brochures and posters, and distributed them throughout the community.
- Showed HP/DP videos in teen medical clinic.
- Designed and conducted innovative tribal cultural preservation projects.

Coordination and Integration of Services

- Coordinated activities and services with high schools, medical facilities, and teen health centers.
- Conducted open house events, and participated in health fairs.
- Coordinated with local health services and programs (e.g., Girl & Boy Scouts, C.A.R.E. Center, University, Alcoholics Anonymous, ALA-Teen, CAP, Students Against Drunk Driving, Rape Crisis Hotline.)
- Established network and referral systems with health and health related agencies.
- Established tribal youth advisory councils, elders advisory boards, work groups, and advisory groups with a mix of youth and adult membership.
- Provided in-school support staff.
- Coordinated with other agencies and programs on special needs projects, for example, one project was conducted with Johns Hopkins University for a HIV/AIDS prevention project.

QUESTION 3 - WHAT IMPROVEMENTS ARE NEEDED IN PROGRAM CRITERIA AND REPORTING?

Factors and Data:

Program criteria were reviewed and identified in the official Notice of Competitive Grant Applications for Adolescent Health Centers for American Indians/Alaska Natives. The Catalog of Federal Domestic Assistance description was also reviewed (13.228). Department regulations were also reviewed including Public Law 93-638 grants at 42 CFR 36.101 et seq. and applicable Office of Management and Budget Circulars. Executive Order 12372 requiring intergovernmental review was not applicable to this program.

Grant application review criteria were also reviewed as well as the special reporting requirements and other conditions required for grantees by the Grants Management Branch.

All available progress reports were reviewed as to their form, content, completeness and their ability to provide sufficient information to determine whether the program was or was not achieving its stated objectives.

Findings and Explanations:

The original grant application announcement provided an overview of the objectives of the program and the adolescent health risks to be addressed. The grant program criteria are generally good and provide the necessary information for a prospective applicant to prepare a successful application. However, guidelines are needed to describe program components, performance standards, and recommended approaches for operating effective centers to provide high quality health promotion and disease prevention services. In addition, a weakness noted in this particular grant program is in the application review, grantee reporting, and followup. [NOTE: The following observations are based on reviewing only one program of the IHS Grants Management Branch. It is acknowledged that there are staff limitations at the IHS Headquarters and the IHS Area Offices.]

In a sampling of the grant application reviews, there was a lack of substantial review comments on how the applicant's proposal showed evidence of meeting program criteria. The reporting requirements for the grantee were set forth in the special conditions clause of the grant. However, several grant files lacked the required reports and there was a wide range in the quality of reports reviewed. There was also no indication of followup on the missing reports. As required, the grantees would report areas of slippage, problems or barriers encountered toward accomplishing their objectives. Again, there was no indication in the file that followup to project officers or grantees was conducted. Improvements in grant application review, reporting, and IHS Headquarters and Area followup are needed.

<u>Improvements in Program Criteria</u>

The characteristics of each of the health risk categories should be thoroughly described in terms of their causal factors, the types of barriers and resistance to change that need to be overcome, and the principles that should be considered for planning and operating excellent HP/DP Adolescent Health Centers.

Guidelines are needed to help tribes and tribal organizations develop results oriented work plans; organize staff and operations; design innovative and culturally relevant strategies for change; establish meaningful cooperative relationships with local resources and service agencies; motivate parents, families, and communities to become more involved; and provide HP/DP services that can inspire AI/AN adolescents to change negative behaviors and support the practice of better health care. Guidance is also needed in how to collect, analyze, and report project data and determine if progress is being made in improving the health and wellness of AI/AN adolescents in local communities (see Section III Recommendations).

A Guide for HP/DP Adolescent Health Centers should be developed to provide more direction and guidance for operating effective HP/DP programs. At a minimum the guide should contain the following information:

- The mission of the HP/DP Adolescent Health Centers.
- National AI/AN adolescent health issues and priorities to be addressed, including a detailed description of each health issue; the rates of its incidence nationwide; the key reasons for the health issue; the results of recent research and/or projects that have dealt with the issue; and potential corrective actions.
- Project objectives to be achieved, program components to be established, and key activities to be accomplished.
- Core elements for organizing and operating a successful HP/DP Adolescent Health Center.
- Steps and procedures for preparing and supporting high-quality, culturally relevant, age-specific participant experiences.
- Procedures for establishing effective community partnerships and collaborations.
- Evaluation methods and tools for collecting, analyzing, and reporting project results.
- Examples of model projects, methodologies, and best practices that have a high potential for improving AI/AN adolescent health and wellness.

The guide should be provided to current and future grantees of the IHS as well as tribes, tribal organizations, or other parties interested in operating HP/DP Adolescent Health Centers with their own funds or other resources.

Improvements in Program Reporting

The IHS requires the following progress information to be reported by the HP/DP Adolescent Health Center grantees (as indicated in the IHS grant award documents):

"a. Provide a comparison of the actual accomplishments to the goals established for the period.

b. Describe the reasons for slippage in those cases where established goals were not met and a plan of action to overcome those slippages.

c. Indicate the number of Indians hired in the project and trained by the program.

d. Indicate the use of Indian business concerns.

e. Provide other pertinent data, especially regarding high costs and cost overruns."

This is the extent of the IHS program reporting requirements and in the opinion of the reviewers these report items are too general and do not provide the hard data needed to properly track and monitor the progress being made, both quantitatively and qualitatively, in improving AI/AN adolescent health.

More data should be obtained regarding the nature of the education, recreation, counseling, and other services being provided; the numbers and types of individuals contacted and involved; the collaboration and cooperation achieved identifying and obtaining resources; the creative approaches being used by the program; and the specific outcomes and results being achieved.

A new progress report form should be established and required by the IHS to assure the collection of more uniform and comprehensive HP/DP Adolescent Health Center data. At a minimum, the new progress report form should provide the following information:

- The nature and number of interventions for the project period.
- The number and type of participants involved.
- The type and length of services provided and method used to provide the services.
- Evaluations and recommendations of participants for the activities and services rendered.
- The degree to which local resources were employed and utilized.
- The degree to which families and local communities participated.
- The degree to which improvements were realized in base data statistics regarding the local community's rates of adolescent suicides, accidents, teenage pregnancies, substance abuse, STDs, HIV/AIDS, and other local AI/AN adolescent health problems.
- Unique and/or innovative approaches used to make services culturally relevant and age appropriate.

- The degree to which project objectives have been achieved and work plans completed.

- Problems and barriers encountered and strategies employed to overcome them.

- Plans and activities to be undertaken during the next project funded period.

A standardized progress report form is recommended to be completed and submitted to the IHS by each HP/DP Adolescent Health Center grantee. This will assure uniform reporting across all projects and provide a mechanism for easier extraction, comparison, and monitoring of program data.

QUESTION 4 - WHAT WAS THE COST OF THE PROGRAM AND HOW WERE FUNDS USED?

Factors and Data:

A special cost analysis form, see Appendix C, was prepared to record all grantee cost data. It was also used to analyze the IHS funds spent for particular budget cost categories, line items, certain program functions, and services such as education, counseling, recreation, transportation, and occupancy.

The specific budgets of each grantee for each fiscal year (1991, 1992, and 1993) were thoroughly reviewed and the costs were extracted and entered on the cost analysis form. All of the SF 269 Financial Status Reports were also examined to determine the amount of IHS funds totally expended by each program or carried over into the next funding period as unobligated balances.

Computer-based spreadsheets were used to organize and analyze the cost data and document the findings. Specific cost categories were defined for the cost findings report and all grantee cost data were organized to fit these categories. This provided a standard cost analysis report format for analyzing and presenting the cost data.

The data defines the amounts budgeted for each category by individual project and year of operation (1991, 1992, and 1993). The data also summarizes the total cost of the overall program and the percentages of total funds expended for each cost category within each year and for the entire three-year funding period.

Findings and Explanations:

Unfortunately, there was no mechanism for determining the actual costs of the program other than the SF 269 Financial Status Report that identifies only the gross amounts expended with no delineation of the costs by categories or line items.

The cost analysis focused on the budgets approved by the IHS Grants Management Branch for each project and year of operations. To make a comparative analysis, costs were classified by the following categories:

- Personnel
  - Direction
  - Education/Health
  - Secretarial
  - Other
- Fringe
- Consultants
- Travel
- Equipment
  - Office
  - Education/Health
  - Other
- Contractual
- Construction
- Trainee Costs
- Other
  - Occupancy
  - Communications/Meetings
  - Other
- Total Direct Costs
- Indirect Costs
- Total Budget

The amount and percentage of funds budgeted for each of these cost categories were determined for each year of operation and the total three-year funding period. The following findings were determined. See Appendix B for specific details concerning the overall costs of the program and the costs of each AI/AN Adolescent Health Center Project.

Most Expensive Cost Items

A total of $3,038,600 was budgeted for the entire three-year funding period. Some carry-over balances were used to offset this total. The rankings of the most expensive cost items for operating HP/DP Adolescent Health Centers during the three-year period were:

#1 -	Personnel -	48.2% of total funds
#2 -	Indirect Costs -	14.6% of total funds
#3 -	Fringe -	10.3% of total funds
#4 -	Contracts -	6.5% of total funds
#5 -	Travel -	5.0% of total funds

Personnel Costs

Personnel costs were the number one expenditure and accounted for 43.7% of the total 1991 funds, 51.8% of the total funds in 1992 and

49.9% of the total 1993 funds. This shows there was a slow startup in the staffing of programs during the first year of operation. This had a negative impact on some projects efforts to carry out their plans and achieve the program's objectives.

There was also a slight drop off of personnel costs in the third year of operation. This may indicate that some staff moved on to other projects and positions as the end of the three-year funding period approached. This drop of may also indicate that without the IHS funding, some projects may not continue to operate on their own.

The roles and responsibilities of the full and part-time personnel were related primarily to program functions and service delivery rather than administration and program management. Consultants comprised only 0.4% of the total cost of the program. The uses of consultants were mostly to conduct independent evaluations of the effectiveness of the local program and its operations.

Fringe Benefits

Fringe benefits were the third most expensive costs and their rates increased progressively over the 3-year funding cycle. In 1991 fringe benefits accounted for only 9.1% of the total cost but in 1992 the percentage increased to 11.5% of the total costs. In 1993, fringe costs dropped slightly to 10.7% of the total costs. However, there also was a similar drop-off of personnel salaries in the final year of funding which accounts for the slight decrease in the fringe benefit costs. Nevertheless, the rates charged for fringe benefits continued to increase in 1993.

Travel Costs

Only 5.3% of the total cost of the program (all three years) was spent for travel costs and ranks fifth in the expensive cost items category. Primarily, the travel costs were used for the transportation of youth and parents. Some out-of-town travel was needed to attend IHS meetings and conferences.

Equipment Costs

In 1991, equipment represented 7.7% of the total cost of the 1991 programs. However in 1992, the percentage of the total cost for the year was only 0.3% and in 1993 only 1.2% of the total costs. This indicates the first year in the funding cycle was the year in which most of the equipment purchases occurred. Much of the new equipment purchased was for computers, software, and computer peripherals and also for recreational and educational purposes.

Supply Costs

The costs of supplies represented only 3.9% of the total costs of the program (all three years). The largest percentage of these funds was spent for education, recreation, and other health related purposes. This included the development of presentations and educational materials for program participants.

Trainee Costs

Trainee costs also dropped over time. In 1991, these costs represented 1.9% of the total cost, in 1992 only 0.7%, and in 1993 0% (only $400 was expended nationally for trainee costs in 1993).

Occupancy Costs and Other Costs

Like equipment, occupancy costs were also more expensive in 1991 (3.8% of the total funds) than for the next two years of funding (3.1% in 1992 and 2.5% in 1993). Most of the increased first-year expense was due to facility preparations and improvements. A significant amount of the "other" cost category was also used for communications, meetings, and other program related costs.

Indirect Costs

Indirect costs also increased progressively during the 3-year period. In 1991 the percentage projected for indirect costs were only 11.8% of the total costs of the program. However in 1992, the percentage was 14.6% of the total costs and in 1993 this percentage increased to 15.5% of the total costs. This resulted in Indirect Costs being the second most expensive project cost item.

The IHS may want to consider limiting the administrative costs of future HP/DP Adolescent Health Centers to 15% of their total cost. This would assure at least 85% of the funds are being used for program related purposes.

QUESTION 5 - WHAT COMMUNITY RESOURCES EXIST AND HOW WERE THEY USED?

Factors and Data:

In the grant application, a factor for consideration in preparing the application was to "demonstrate coordination with other agencies and organizations within and without the community who serve the target population." Grant proposals and grantee progress reports were reviewed to extract this information.

Findings and Explanations:

The coordination and integration of local community resources were key factors in determining the success of the grant demonstration projects. Most grantees identified the existing community resources in their proposals and progress reports. Some projects focused more efforts in this area than others. Those projects that did not provide services in a stand alone clinic setting, were especially involved in establishing networks of resources for accessing services and referral purposes. The coordination and integration of services are critical in that it prevents inconsistent, fragmented services. It also decreases the risk of duplicating services and prevents the waste of needed resources.

It appeared that those projects that were successful in gaining community and tribal support and integrating resources increased their changes of surviving beyond the three years funding cycle.

The types of resources identified were tribal, other Federal agencies, state, and county. For example, grantee projects demonstrated efforts in coordinating with other IHS programs, i.e., mental health; coordinating "in kind" services with tribes, i.e., office space, supplies, matching funds, etc.; and coordinating services with schools and county health programs.

SECTION III: RECOMMENDATIONS

1. **Establish an IHS Headquarters project officer for the HP/DP Adolescent Health Centers Grant Program.**

   All project officers for this grant program are located in the IHS Area Offices. The positive aspect of this arrangement provides a local project officer to the grantee. However, the scope of this program, and the expected outcomes and results are being viewed for a national perspective. Therefore, there is a need for a national focal point for information and guidance on the HP/DP Adolescent Health Centers Grant Program. A project officer at the national level could: 1) assure more uniform direction and control of the program; 2) function as a central point for communicating between IHS Headquarters and IHS Area Offices; 3) provide better monitoring and followup on information and reports collected and maintained at Headquarters; and 4) provide technical assistance to IHS Area project officers and grantees.

2. **Develop standardize reporting requirements and formats for the HP/DP Adolescent Health Centers Grant Program.**

   A standardized progress report form is recommended to be completed and submitted to the IHS by each adolescent health center grantee. This will assure uniform reporting across all projects and provide a mechanism for easier extraction, comparison, and monitoring of program data. At a minimum, the progress reports should include:

   - The nature and number of interventions for the period.
   - The number and type of participants involved.
   - The types and length of services provided and method used to provide the services.
   - Evaluations and recommendations of participants for the activities and services rendered.
   - The degree to which local resources were employed and utilized.
   - The degree to which families and local communities participated.
   - The degree to which improvements were realized in base data statistics regarding the local community's rates of adolescent suicides, accidents, teenage pregnancies, substance abuse, STDs, HIV/AIDS, and other local AI/AN adolescent health problems.
   - Unique and/or innovative approaches used to make services culturally relevant and age appropriate.

- The degree to which project objectives have been achieved and work plans completed.

- Problems and barriers encountered and strategies employed to overcome them.

- Plans and activities to be undertaken during the next project funded period.

Copies of the progress report should be supplied to both the IHS Headquarters and the IHS Area project officers. Headquarters should incorporate the data into its AI/AN adolescent health care services database (see recommendation 4).

3. **Develop program standards for the establishment and operation of HP/DP Adolescent Health Centers.**

Standards of performance should be defined to help local projects focus their plans and activities toward specific HP/DP objectives and to assure the operation of effective HP/DP Adolescent Health Centers. A team of AI/AN adolescent health care specialists should be convened to assist IHS to: 1) define the core elements of operating successful adolescent health care centers and 2) define the key principles for providing effective AI/AN adolescent HP/DP services.

The program standards should be organized according to logical program components, for example Administration, Education, Recreation, Counseling and Support Services, Transportation, Monitoring, and Evaluation. Each component should be further defined in terms of the standards to be met or addressed within the component. Guidelines and indicators of high quality performance should be defined or described.

These standards should serve as the basis for explaining "what" HP/DP Adolescent Health Centers should be doing. The plans, activities, and reports of local projects should, in turn, describe "how" the program's objectives and performance standards are being met, both qualitatively and quantitatively.

4. **Develop a standard data collection methodology for AI/AN Adolescent Health Care Services.**

Rather than relying exclusively on local projects to define their own data tracking and monitoring systems, the IHS should consider establishing a more collaborative approach. The IHS should use its Trends database and other available databases to define the current baseline data regarding specific health risks with the particular communities being served by adolescent health centers. Also, an analysis of all data collected by the 14 grantees should be conducted to assist in determining all available baseline data.

This baseline data could be provided by the IHS to local centers at their project start up period for their review, acceptance, and use as a monitoring mechanism. The baseline data could also be modified, with local participation, to reflect even more accurate data than was originally known or available to the IHS.

Once established and accepted by both the local projects and the IHS, the baseline data would serve as the focal point for measuring decreases (or increases) in the incidence of each AI/AN adolescent health care risk area. This data, in turn, would help both the IHS and local projects to know where to place their emphasis and where changes are needed in methods and procedures.

Standard data collection instruments should be designed and used to track the positive and negative changes in the baseline data for the local area during each year of operation. The instruments could also be automated but should be compatible with the software and data collection efforts currently being used by both the IHS and tribal programs.

5. **Conduct followup and technical assistance to the 14 original and the seven (7) newly funded grantees.**

The 14 original grantees are operational and are continuing to provide services to AI/AN adolescents in their communities. The IHS Areas where these programs are located are funding them at 45 to 50 percent of the program's FY 1993 funding level. Additional inquiries need to be made to determine to the extent of their data available since they now are going into their fourth year of operation. Technical assistance in the areas of strategic planning and operational needs assessment is recommended. It is also recommended that technical assistance materials be developed, i.e., "Mobilizing Local Resources for AI/AN Adolescent HP/DP" and/or "How to Provide Motivating, Culturally-Relevant, Age-Specific HP/DP Activities for AI/AN Adolescents." Every effort should be made to assist these programs.

Also, followup and technical assistance should be conducted with the seven new grantees before the end of their first year. The information and experience of the original grantees could be used to develop realistic program objectives for the remaining two funding years and provide technical assistance on data collection and other needs.

6. **Develop a manual guide for establishing and operating HP/DP Adolescent Health Centers.**

   A Guide for HP/DP Adolescent Health Centers should be developed to provide more direction and guidance for operating effective HP/DP programs. At a minimum the guide should contain the following information:

   - The mission of the HP/DP Adolescent Health Centers.
   - National AI/AN adolescent health issues and priorities to be addressed, including a detailed description of each health issue; the rates of its incidence nationwide; the key reasons for the health issue; the results of recent research and/or projects that have dealt with the issue; and potential corrective actions.
   - Project objectives to be achieved, program components to be established, and key activities to be accomplished.
   - Core elements for organizing and operating a successful HP/DP Adolescent Health Center.
   - Steps and procedures for preparing and supporting high-quality, culturally relevant, age-specific participant experiences.
   - Procedures for establishing effective community partnerships and collaborations.
   - Evaluation methods and tools for collecting, analyzing, and reporting project results.
   - Examples of model projects, methodologies, and best practices that have a high potential for improving AI/AN adolescent health and wellness.

   The guide should be provided to current and future grantees of the IHS, tribes, tribal organizations, and other parties interested in operating HP/DP Adolescent Health Centers with their own funds or other resources.

7. **Examine the possibility of using a cooperative agreement as the funding instrument for the HP/DP Adolescent Health Centers Program.**

   The use of a cooperative agreement may be a more effective method for assisting tribes and tribal organizations in developing their capacity to establish and operate an adolescent health center. The cooperative agreement is similar to a grant. However, a major difference between the two is that the cooperative agreement requires substantial involvement from the federal government to the recipient. It is recommended that the IHS be substantially involved with the

grantees because: 1) the IHS Adolescent Health Centers Grant Program is relatively new, 2) the grant program is for three years only and after that the grantee is on their own, and 3) the continuation of the grantee programs depends on identifying and coordinating resources at various funding levels, i.e., IHS, other Federal agencies and departments, Tribal, State, and County. The ability for grantees to access information and technical assistance at all phases of program development, implementation, and operation is critical to success. In addition, once base line data elements and reporting requirements are initiated, these programs will require substantial training and technical assistance for starting, operating, and maintaining their data systems.

8. **Develop a strategic plan for AI/AN adolescent health care in the IHS.**

   At the first IHS Adolescent Health Conference, many issues and recommendations were developed. Further steps should be taken to set priorities of the issues and recommendations and use this valuable information as part of a strategic plan for AI/AN adolescent health care.

   In addition, national strategy and direction need to be given for the continuation of the HP/DP Adolescent Health Centers Grant Program. Currently, the grant program is funded at approximately 1 million dollars a year. For the first three-year funding cycle, funds were distributed among 14 grantees. In the second cycle, the funds were split so that funding was made available to IHS Area Offices for funding the 14 grantees at less than their FY 1993 funding level. The remaining funds were made available to the grant program and seven new grantees were funded. National strategy and direction need to be developed by the IHS in consultation with tribal programs. The strategy would define a funds distribution process, and develop and document a process that shows a successful HP/DP Adolescent Health Center Program. The model process starts at the grant demonstration project level and shows the project's progression to an on-going operation that addresses the health care needs of AI/AN adolescents.

9. **Consider the establishment of a 15 percent limitation on administrative costs for AI/AN Adolescent Health Centers. This would assure that at least 85 percent of the total funds are being used for program related purposes and services.**

   Many Federally funded, service oriented programs are now limiting, through statutes and regulations, the amount of funds that can be expended for administrative purposes. For instance, Head Start projects (child development programs for disadvantaged children and families) are limited from spending more than 15 percent of the total cost of their program for administrative costs *regardless of the approved indirect cost rates of tribes, nonprofit organizations, and other grantees.* AmeriCorps and other projects established by the National and Community Service Trust Act of 1993 are being limited to a 5 percent administrative cost ceiling.

The IHS should similarly consider limiting the administrative costs of its HP/DP Adolescent Health Centers Grant Program. The Office of Health Programs staff and the IHS Grants Management Officer should examine the impact and feasibility of administrative cost ceilings in Public Law 93-638 grants. The costs analysis findings of this review indicate that on a nation wide basis the AI/AN Adolescent Health Center program is already operating near or beyond this level of limitation. The program may soon exceed this level given the percentage of increase in the indirect cost rates funded during the past three years. Without the administrative cost limitation the IHS may soon be using between 20 percent and 30 percent of its Federal funds for non program related purposes.

10. **An in depth evaluation of the HP/DP Adolescent Health Centers Grant Program should be conducted after baseline data and standardized reporting requirements are implemented.**

    An evaluation of the HP/DP Adolescent Health Centers Grant Program on a comprehensive level for comparable data, national statistical trends and specific measurable achievements is not recommended at this time. Before effective program evaluation can be conducted, baseline data elements, reporting requirements, and measurable program criteria must be established.

PART TWO

AMERICAN INDIAN AND ALASKA NATIVE ADOLESCENT HEALTH

SECTION I: OVERVIEW OF ADOLESCENT AND AI/AN ADOLESCENT HEALTH CARE

A. ADOLESCENT HEALTH CARE - DRAMATIC CHANGES IN THE PAST 20 YEARS

In the past two decades there has been a dramatic improvement in the morbidities and mortalities experienced by adolescents. Adolescents have also made significant gains in their legal status and the level of autonomy that they have within their families and communities. In spite of these gains, however, recent studies have concluded that for the first time in United States history, adolescents are beginning to regress in their health and social well-being.

For Native American youth the statistics are even more alarming. A recent University of Minnesota study found that "Native American youths experience stress and depression at alarming rates. Beyond the common concerns experienced by many teens in our society . . . significant numbers of Native teenagers experience profound stress such as extreme hopelessness (11.4%), worries about losing their mind (6.6%), and constant sadness (18.3%)."(1)

Overall Adolescent Health Is Relatively Good but Declining

When measured narrowly by traditional biomedical standards, adolescents appear to be relatively healthy. When measured broadly, however, by social, behavioral, and other standards, major adolescent health problems emerge.

Many adolescents have neither the maturity nor parental supervision to help them cope emotionally with the social and environmental influences that now surround their lives and are hazardous to their health.

Drug abuse, suicide, sexually transmitted diseases, pregnancy, hopelessness, delinquency, crime, and unintentional and violent deaths have increased among adolescents while healthy dietary and exercise habits, routine health care, and education have decreased.

Problems Occurring in Behaviors Pose Serious Health Threats

Statistically, there is a significant increase in health risk behaviors during the ages of adolescence, and for Native Americans and other minorities the health risks are two to three times larger than those of their white counterparts.

Native American adolescents have significantly higher risks for pregnancy, STDs, HIV infection and AIDS, chronic or other infectious diseases (such as hypertension, tuberculosis, and hepatitis), substance abuse, emotional problems, and violence (suicides and homicides). Researchers at the University of Minnesota have also found there is a strong relationship among Native American children between perceiving themselves as healthy and accessing health promotion services. Studies also indicate the health risk behaviors of adolescents are intricately tied to their self-esteem, competency, loss of control, and personality.

It is critical, therefore, that adolescent health promotion and prevention strategies address both the physical and psychological processes. The splitting of mind and body, which is common in American society and health interventions, is not working, especially in Native American communities.

Many experts are now beginning to reluctantly admit that the social, emotional, and physical health problems of adolescents are significantly interrelated, and that their associated diseases are co-morbid. This co-morbidity raises questions about the appropriateness of many of today's health promotion and disease prevention strategies. Many approaches are either too brief, too isolated from the developmental and environmental realities of adolescents, or too problem specific to have a significant impact on the multiple domains of adolescent health behavior.

B. PREVENTION STRATEGIES FOR NATIONAL ADOLESCENT HEALTH CARE

SUMMARY OF PROCEEDINGS OF THE AMERICAN MEDICAL ASSOCIATION "STATE OF THE ART" CONFERENCE ON ADOLESCENT HEALTH PROMOTION (2)

In May 1992 the American Medical Association convened a group of national experts to identify strategies for expanding comprehensive and multidisciplinary health promotion for adolescents. Participants included health professionals from the fields of medicine, school health, and community public health.

The goal of the conference was to develop a set of principles to guide policy makers and administrators to initiate, improve, and integrate adolescent health promotion and prevention strategies provided in medical, school, and community settings.

These experts have come to realize that preventive interventions provided in clinical settings are only a part of the strategy needed to improve the health of adolescents. The experts now agree that consistent health promotion messages need to come from a variety of environmental settings (medical, educational, judicial, religious, community, etc.) and that these settings must be mutually reinforcing.

Integration of Strategies for Clinical/School/Community:

To have healthy lifestyles, adolescents need factual information and guidance, protection from physical harm, and appropriate role models. These needs are being increasingly provided by schools, churches, and community groups.

Some form of health education is now present in all schools. Many schools have expanded their health education to more specifically address sexuality education. As of 1992, 47 states and the District of Columbia recommend or require HIV and AIDS education.

School health programs have also been developed for the prevention of smoking, alcohol and drug abuse, and for improving diet and exercise. Some beneficial results have been noted, especially in the reduction of smoking by boys and drug use by all adolescents. Nevertheless, the desired improvement in adolescent health has not been forthcoming. There are several reasons for this but one important finding is that the efforts have been too fragmented and uncoordinated.

School health education programs are rarely integrated or coordinated. There is also a lack of consensus by experts on how to approach preventing many health problems of adolescents. This diffusion of efforts, especially at the local level, may lead to mixed or inconsistent health messages provided to adolescents; inefficient use of human and financial resources; and an inability to sustain a prevention strategy over a prolonged period.

Successful adolescent health promotion efforts need to go beyond what can be offered in any single setting or by any single discipline. Collaboration among medical, school, and community groups is crucial to the prevention of the complex, interrelated problems that youth face, and to promoting lifestyles that are healthy and productive in the broadest sense.

Need for a More Integrated Approach:

While the expectations and goals of schools, clinics, and communities seem to differ, there is in reality a large overlap in what each is trying to achieve. Educators are increasingly aware of the interconnectedness between learning and health -- students must be healthy to be ready to learn and must learn how to be healthy.

Physicians are increasingly aware that adolescents who do poorly in school are vulnerable to a variety of health problems and that successful interventions frequently require that adolescents be involved with parents or other community adults. Community leaders are increasingly aware of the need to insure access to health care and quality education as ways to

improve the health and well-being of adolescents. Also business leaders know that the quality of their future work force depends on adolescents being healthy and receiving quality education. Now that society is waking up to these facts, a more concrete approach is needed to deal effectively with the problem.

Universal Concepts for Health Promotion/Disease Prevention:

Guidelines for adolescent health promotion and disease prevention services were defined by the participants of the AMA State-Of-The Art Conference on Adolescent Health Promotion. Although the application of these principles might differ across school, medical, and community locations, the following concepts appear to be universal for adolescent HP/DP:

- efforts should be broadly based and include both health promoting and disease preventing activities;
- strategies should build on adolescent strengths and positive outcomes rather than weaknesses and negative outcomes;
- programs should be relevant, both developmentally and culturally, and involve adolescents and parents in the planning process;
- efforts should be coordinated between various settings and disciplines and health messages should be consistently reinforced;
- health promotion must become a societal priority and be led by physicians, educators, and community adolescent advocates;
- more emphasis should be given to evaluation research to determine the effectiveness of preventive interventions; and
- health providers and educators need more training in adolescent health education.

The participants of the AMA Adolescent Health Promotion Conference expressed a strong opinion that greater emphasis must be placed on preventing adolescent health problems and promoting healthy lifestyles. They stated that this will require changes in the way the health business is currently being conducted. They also emphasized that professionals from medical, educational, and community settings should work together more closely as partners, supporting and coordinating each other's efforts to promote this change and improve the health of our nation's adolescents.

C. PREVENTION STRATEGIES EMPHASIZED BY THE PUBLIC HEALTH SERVICE AND AMERICAN INDIAN AND ALASKA NATIVE (AI/AN) COMMUNITIES SINCE THE EARLY 1980S

THE PUBLIC HEALTH SERVICE (PHS)

In 1974, the LaLonde Report was published in Canada. This report outlined a new model for improving the health of Canadians that focused not only on health services and biology, but also on the effects of environment and lifestyle. The report expanded the notion of health by pointing out that a simple increase in the number of physicians and hospitals would not be enough. The environment and lifestyle of Canadians also needed to be addressed.

In 1979 the United States Surgeon General took up this challenge and published the report, Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention. The report presented the health profile of the American people and identified the need to look at broader definitions for improving health, including lifestyle and the environment.

The Surgeon General's Office then published a document containing 226 objectives in 15 health areas developed by Public Health Service experts (Promoting Health, Preventing Disease: Objectives for the Nation). These objectives were to serve as the foundation for public health improvements over the decade of the 1980's.

Ten years later, while many original objectives were obtained, many also fell short of their goals. In particular, as the decade progressed, the disparities in reaching health goals in minority communities as compared to Euro-American communities became painfully obvious. A report released in 1985, the Report of the Secretary's Task Force on Black and Minority Health, outlined the health status of minorities and found many problems, not only in health status but also in the lack of good data. Because of this, an emphasis on reducing health differences among Americans was promoted in the campaign, *Healthy People 2000.*

Three overall health goals are the foundation for the Healthy People 2000 campaign: 1) increase the span of healthy life for Americans; 2) reduce health disparities among Americans; and 3) achieve access to preventive services for all Americans.

For Indian communities, these goals have special meaning. The span of healthy life for AI/AN continues to be considerably lower than that of the general public, and even other minorities, despite continued efforts by the IHS to bring the health of AI/AN "to the highest possible level."

Many unique strategies have been employed to establish viable adolescent health programs that achieve this harmony and wellness:

- Mobilizing and coordinating other funding resources.
- Promoting and establishing school-based health clinics.
- Developing and providing culturally-specific educational materials.
- Targeting and involving male youths.
- Providing culturally relevant family-life education curriculum materials.
- Empowering youth and women and consulting them in the planning and development of health promotion programs.
- Promoting activities that build self-esteem.
- Promoting activities that nurture adolescents to become administrators teachers, and health professionals.
- Promoting adolescent decision-making skills.
- Providing alternatives to having sex.
- Providing culturally relevant health promotion activities.
- Lobbying tribal leaders to promote adolescent health-related issues.
- Making birth control alternatives accessible.
- Promoting sexual practices that deter the spread of STDs and HIV/AIDS.
- Promoting positive role models for Native American youth.
- Initiating preventive health education at the elementary school level.
- Promoting traditional cultural values and skills.
- Focusing on teen pregnancy from a woman's health perspective (i.e., cervical cancer).
- Developing and implementing adolescent pregnancy prevention policies and programs.
- Increasing tribal interest in giving adolescent health issues appropriate interest and program funding.

Access to preventive health services, especially for adolescents, continues to be a compelling need for Indian communities, particularly in urban and underserved rural areas. Although the Indian Health Service has made a commitment to providing health promotion and disease prevention programs, continuing budget crises and a lack of resources for basic health care has limited the resources available for preventive services.

The concept of wellness is based on the Indian belief that the mind, the body, and the spirit are all connected to a person's health. One cannot be separated from the other. A harmony and balance must exist between the physical, spiritual, mental, and emotional health of adolescents before true wellness can be achieved.

SECTION II: ADOLESCENT HEALTH CARE IN THE INDIAN HEALTH SERVICE

A. THE IHS RECOGNITION AND RESPONSE TO INDIAN ADOLESCENT HEALTH CARE

Over the past decade, the IHS has recognized the need to target resources specifically addressing the health care needs of AI/AN adolescents. In response to a Teen Pregnancy Task Force in the IHS Albuquerque Area, the IHS contracted with the University of New Mexico, in 1983, to operate Teen Centers at Acoma-Laguna and Bernalillo High Schools. In 1986, alcohol and substance abuse was identified as the most significant problem affecting Indian communities. At this time, the IHS launched a major campaign to combat this problem and identified a major component of this campaign to target AI/AN adolescents.

As the emphasis on adolescent health services and activities increased, the IHS recognized the need to evaluate the effectiveness of those programs and services. Also, the need for current data on health care needs of AI/AN adolescents was critical to plan for services and programs.

B. IHS STUDIES AND RESEARCH ON ADOLESCENT HEALTH

In the fall of 1986, the IHS conducted THE SCHOOL/COMMUNITY-BASED ALCOHOLISM/SUBSTANCE ABUSE PREVENTION survey.(3) The purpose of the survey was to: 1) determine the extent to which the schools/communities were involved in prevention activities, 2) seek vital information in areas regarding curricula, student/community/agency participation, intervention programs, and mass media programs, and 3) provide a foundation document to enhance and promote prevention activities tailored especially to Indian youth to reduce the risks of alcohol/substance abuse.

A major theme throughout all the findings and recommendations of the report was the need to coordinate efforts between communities, tribes, and schools. Also, a major emphasis was placed on the importance of community involvement in prevention and intervention activities. Another important recommendation was the need for evaluation outcome measures relative to risk reduction and the need to develop standard (IHS, BIA, and tribes) evaluation tools for local program use.

In 1991, the IHS, Office of Policy, Evaluation, and Legislation conducted an evaluation of the Albuquerque Area Teen Centers Demonstration Project.(4) This study provided information that showed the effectiveness and need for teen center programs for AI/AN adolescents. The study also revealed that the teen center projects performed at a satisfactory level and teen center services were viable and being used. The study pointed out the need for measurable objectives, standard reporting, and evaluation methods. A major component to

the effectiveness and success of the teen centers focused on the involvement of the community and parents. The study sites, "The relationship with the community represents both one of the greatest potential strengths and one of the greatest potential weaknesses of TCs[Teen Centers]."

The following year, in 1992, a joint effort between the University of Minnesota, the IHS, the Bureau of Maternal and Child Health, and the Robert Wood Johnson Foundation resulted in the conduct of an adolescent health survey that produced a national report on the state of Native American youth health.(1) This report provided status and information on the attitudes, social behaviors, and health issues of AI/AN adolescents. Also, the report found that respecting and using culture and traditions in developing program and community activities to be very important. At appendix A, there is a summary of each studies' findings and recommendations.

An overriding subject, in all three studies, is the involvement of community. Community includes aspects of family, cultural traditions, values, and beliefs. In recognizing the role of community in the providing health care to AI/AN and especially AI/AN adolescents, the IHS promotes tribes and communities to take the lead in the development and implementation of prevention and intervention programs and activities. The establishment of the HP/DP Adolescent Health Care Grant Program was among the first actions taken in response to recommendations from the research and studies.

C. CURRENT IHS PROGRAMS AND SERVICES

The IHS provides comprehensive multi disciplined health care to eligible American Indian and Alaska Natives. While there is not a specific program identified as the IHS adolescent health care program, the IHS provides services to AI/AN adolescents through clinical services, preventive health, contract health care, and urban programs.

For program planning purposes, the IHS collects and uses statistical data based on standard age groupings. For AI/AN adolescents the standard age grouping is 15 to 24 years of age. Current statistical information, as presented in the 1992 IHS Trends report reflects that this group has an estimated user population rate of 18.6 percent. This group also accounts for 14.5 percent of the outpatient clinical impressions, 19.8 percent of the inpatient discharges, and 14 percent of the inpatient days. While the adolescent years usually represent good general health, health problems do occur and represent a significant portion of the IHS

workload. Chart 1.1 on page 33 shows the patient care workload for the age group of 15 to 24 years. Also, on page 33 is chart 1.2 that shows the top five leading causes of death for AI/AN youth, ages 15 to 24 years old. As chart 1.2 reflects, the first two leading causes of the death for AI/AN ages 15 to 24 are accidents and suicide. In response to these statistics, the IHS has targeted specific programs and services to place a special emphasis on adolescent health care needs.

THE ALCOHOL AND SUBSTANCE ABUSE PROGRAM

The IHS funds approximately 350 AI/AN alcohol and substance abuse programs that provide treatment and prevention services to rural and urban communities. Services specifically targeted the AI/AN adolescents began with the Anti-Drug Abuse Act of 1986, Public Law 99-570. As part of this legislation, resources were targeted for the development and programs and services for Indian youth and community education and training. With the passage of the Omnibus Drug Act, and the subsequent mandate, a youth services' system was authorized for community-based services and regional residential treatment centers. In FY 1993, approximately $12 million was appropriated for the Regional Treatment Centers (5).

THE MENTAL HEALTH PROGRAM

The IHS Mental Health Program provides clinical and preventive services that are community oriented. The program continues to implement the child abuse prevention initiative, and update the AI/AN Mental Health Plan. Another important component of the program is to provide technical assistance and community education on suicide and family violence prevention, quality assurance, and child and adolescent programs. In response to the Office of Technology's Report on Indian Adolescent Health, the IHS stated, "Children and adolescents are already identified as the highest priority populations for increased mental health services in the National Plan for Native American Mental Health Services."(6)

Other IHS programs and services with a special emphasis toward adolescent health are the HIV/AIDS, Health Education, and Public Health Nursing. In addition to these prevention programs, a major emphasis of adolescent health care is directed toward health promotion and disease prevention activities.

Chart 1.1

Percent Distributions For Populations
And Patient Care Workloads, FY 1990 Data
15 to 24 Years of Age

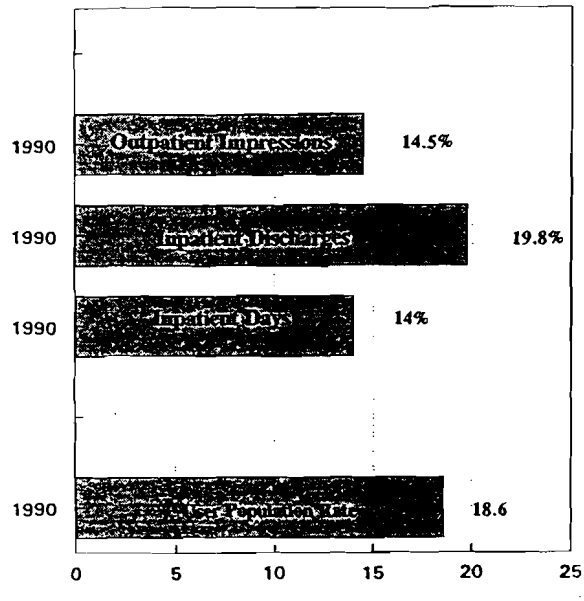
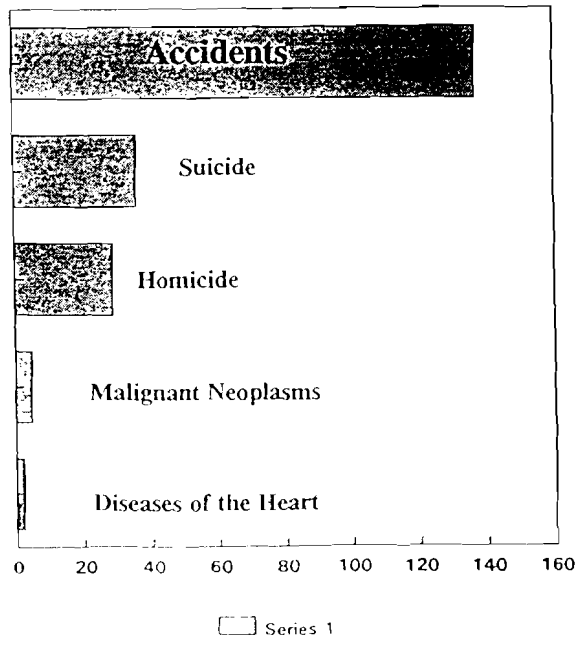


Chart 1.2

Leading Causes of Death
American Indian/Alaska Natives
15 to 24 Years of Age



Rate Per 100,000 Population

HEALTH PROMOTION/DISEASE PREVENTION ACTIVITIES

Health Promotion/Disease Prevention activities that are specifically targeted to adolescent health care are provided through the tribally operated HP/DP Adolescent Health Centers Grant Program. This program and all HP/DP activities are integrated into the overall comprehensive health program and the funding of these activities are derived from the various program budgets. Therefore, not only do IHS programs provide specific services to Indian adolescents but they also contribute funds to implement the HP/DP Adolescent Health Grant Centers Program.

D. IHS NATIONAL STRATEGIES AND DIRECTIONS

In March 1993, the IHS conducted the first Adolescent Health Conference to bring together members of the IHS Headquarters and Areas, as well as, the local participants of the IHS Adolescent Health Centers Grant Program. The purpose of this conference was to discuss and exchange ideas learned from the first three-year cycle of the IHS grant program. The following is a summary of the issues and recommendations from that conference.

SUMMARY OF ISSUES AND RECOMMENDATIONS

Workshop Issue: Substance Abuse/Mental Health

Interactive review of process of integrating mental health and substance abuse services in residential and outpatient settings.

Conference Recommendations

- The adolescent population needs timely access to persons/providers who can listen and understand that each individual's needs are vitally important.

- The IHS needs to appreciate that food is an integral ingredient in Native American gatherings and needs to consider the importance of allowing money to be spent on it.

Workshop Issue: Teenage/Unplanned Pregnancies and Sexually Transmitted Diseases

Discussion of adolescent/unplanned pregnancies and sexually transmitted diseases and the difficulties with and solutions to preventing these problems.

Conference Recommendations

- Develop creative strategies for funding resources.
- Promote/establish school-based health clinics.
- Provide culturally specific educational materials.
- Target and involve Native American male youth.
- Provide culturally relevant family life education curriculum materials.
- Consult with youth and women in planning and developing health programs.
- Promote activities that build self-esteem and decision making skills.
- Promote activities that nurture future Native American youth to become administrators, teachers, and health professionals.
- Provide alternate activities to sexual activities.
- Lobby tribal leaders to promote adolescent health related issues.
- Promote sexual habits that deter the spread of AIDS/STDs.
- Give adolescent health issues appropriate emphasis and program funding.
- Develop and implement adolescent pregnancy prevention policy and programs.
- Develop inter-generational gatherings/support groups.
- Develop materials that provide adequate sex education.
- Promote parental involvement with adolescent health programs.
- Simplify parental releases for adolescent's access to school's adolescent programs.
- Promote Magic Johnson's video on AIDS.
- Revise Beauty Way curriculum for family life health education program.
- Provide counseling to pre-sexual activity programs.
- Develop topic specific videos.
- Develop mentor/mentee relationships between adults and adolescents.

Workshop Issue: Abuse/Neglect/Violence: Teens as Victims: Family and Provider Issues

Discussion of community programs and supportive resources necessary to help families rear children well.

Conference Recommendation

- Develop IHS training programs that assist perpetrators in a culturally relevant way. Many Indians believe that the Indian way is to regard that the perpetrator as needing healing rather than deserving a punitive response.

Workshop Issue: Funding

Participants share funding experience/problems, brainstorm possible alternative sources, and suggest how IHS might be more responsive to future programs.

Conference Recommendations

- **Place adolescent health as a high priority at Headquarters, Areas, and Service Units.**
- **Focus health promotion/disease prevention efforts on adolescents.**
- **Break down barriers between departments.**
- **Coordinate between IHS and BIA programs.**
- **Develop and implement Memorandum of Agreements between Medicare/Medicaid/3rd Party coverage for adolescent health programs.**

Workshop Issue: Evaluation

Brief review of evaluation terminology/options. Participant discussion of evaluation topics and methods.

Conference Recommendations

- **Decide at the onset of a program what you will want to evaluate.**
- **Decide what you would like to have happen as a result of your program.**
- **Decide how to measure process effectiveness.**
- **Decide how to measure impact outcomes.**
- **Be impartial - accurately reveal how well the program provided the services to the target population and use valid measurement tools.**

Workshop Issue: Data Collection

Review of adolescent health data gathered from the IHS Grant Program. The session will focus on what has been learned and what on-going efforts in data and epidemiology are needed.

Conference Recommendations

The IHS should:

- Provide training with on-site Technical assistance on data collection for adolescent health programs.
- Provide clear direction for standardized data collection methodology.
- Provide standard data collection forms.
- Establish effective communications from the IHS.

Workshop Issue: Quality Assurance

Examination of the quality assurance process and how it can apply to adolescent health care programs.

Conference Recommendation

- **Establish a Quality Assurance program for adolescent health programs.**

Special Conference Recommendations

- **Establish an adolescent health newsletter.**
- **Establish an Adolescent Health Care Advisory Committee**

APPENDIX A

GRANTEE PROFILES

PROGRAM DATA

Grantee Profile - Cherokee Band of Indians

Name: Cherokee Band of Indians
Location Cherokee, North Carolina

Funding: 1991 $71,800 -- 1992 $73,000 -- 1993 $64,648

Target Population: 600 - 1500 Adolescents

Major Program Objective(s):

- Establish and staff a clinic to provide for the medical and psychological needs of adolescents.
- To reduce teen pregnancy by 40 percent.
- To increase birth control by 20 percent.
- To increase drug awareness by 60 percent.
- To decrease drug use by 20 percent.
- To increase healthy dietary practices by 20 percent.
- To increase regular exercise by 20 percent.
- Decrease hospitalizations/emergency visits for suicide attempts by 20 percent.
- Increase safe sex knowledge by 20 percent.

Methods for Accomplishing Objectives:

- Counseling
- Workshops
- Field Trips

Accomplishments:

- Started Tribal Working Club for regular exercise.
- Provided job Interview and resume writing skills workshops for High School students
- Developed peer teaching program in making health related videos
- Conducted field trips for students interested in pursuing careers in the health occupations.
- Established an advisory board.

- Administered an Adolescent Health Risk Appraisal
- Provided regular counseling sessions.
- Provided health screening services.

Notable Achievements/Innovative Approaches:

- Established a teen health clinic providing confidential medical services and counseling in a relaxed atmosphere.

Barriers in Meeting Objectives:

- Space was not remodeled in time due to flooding
- Slow hiring of staff - not hired until the 4th quarter of 1st year.

Grantee Profile - Grand Traverse Band

Name: Grand Traverse Band of Ottawa and Chippewa
Location: GTB Reservation and Outlying Counties (Peshawhestown Village)

Funding: 1991 $71,106 -- 1992 $70,000 -- 1993 $61,055

Target Population: 274 Adolescents in Four Community Sites

Major Program Objective(s):

- To develop a five-year plan for Alt Promotion.
- To establish the Indian youth power center as the core facility.
- To realign tribal service systems within the division of youth services.
- To ensure that Indian Adolescents have access to age groups and culturally appropriated health care.
- To interface with non-tribal resources including other tribes nationally and other service delivery systems locally.
- To provide leadership to the IHS project from the tribal council - through council liaison.
- To capture internal funding from the tribal tax base for on-going supplemental funding for youth services.

Methods for Accomplishing Objectives:

- Youth Center
- Workshops
- Recreational Activities

Accomplishments:

- Provided health promotion and disease prevention workshops.
- Developed and established a teen-parent program.
- Developed a resource network of tribal and non-Indian agencies.
- Conducted outdoor skill building and cultural awareness projects

Notable Achievements/Innovative Approaches:

- Conducted a family Olympics and cultural enhancement workshops

Grantee Profile - Hope Tribe

Name: The Hopi Tribe
Location: Box 123
Kykotsmovi, AZ 86039

Funding: 1991 $71,799 -- 1992 $70,000 -- 1993 $112,700

Target Population: 550 Adolescents

Major Program Objective(s):

- To provide space which belongs to the youths. Will promote healthy life styles, encourage normal physical, mental and social development and prevent unnecessary illness or accidents in an organized coordinated manner.

- To build a firm base of support from the various Hopi communities, government agencies and drawing upon the rich cultural heritage of the Hopi is crucial to formation of a strong program foundation. The village leaders, parents, tribal, BIA and IHS agencies will be used as resources in planning and implementing programs at the high school.

- To provide a multi disciplinary approach integrating services provided by the IHS, BIA, Hopi Health Department, Hopi Guidance Center, Hopi Education Department, Law Enforcement, Courts and Educational services. Direction and input in implementing this approach will be provided by a teen center advisory council.

- To formalize the teen center/clinic as the major "hub" through which adolescent programs can be coordinated and publicized in a professional and confidential manner.

Methods for Accomplishing Objectives:

- Teen Center Approach
- Integrate and Coordinate Local Services

Accomplishments:

- The total number of participants were 550.

- Teen Center was located in a room at the Hopi Jr./Sr. high school. It is separated from the Teen Clinic.

- Resources and equipment is available - VCR, monitor, and video recorder

- Most services were offered during lunch and study hall.

- Weekly schedule of services: Mondays - Health presentation by the Community - Tuesdays - Groups and individual counseling - Wednesdays - The JTPA program provides intake services for youth and summer programs and information about opportunity for employment and career Enhancement - Thursdays - Alateen - Fridays - reserved for recreational.

- The teen clinic is adjacent to the student bathroom - open 4 hours in the afternoon one to two times per week - over 400 visits a year.

- Developed a strong base of support from the consortium of communities, governmental agencies, etc.

- Served 100 percent of service population.

Notable Achievements/Innovative Approaches:

- Counseling services provided both formally and informally.

Barriers in Meeting Objectives:

- Need more support and involvement of parents.

Grantee Profile - Leech Lake Reservation

Name: Leech Lake Reservation Business Committee
Location: Route 3, Box 100
Cass Lake, Minnesota 56633

Funding: 1991 $78,846 -- 1992 $76,150 -- 1993 $83,997

Target Population: 234 Students

Major Program Objective(s):

- To open a health center in the Chief Bug-O-Nay-Ge-Shig School (Bug School). The program will operate 5 days a week bringing health services and development and delivery of health curricula to the students of the Bug School.

- To increase the general level of health of the adolescent students at the Bug School. This will be accomplished by providing comprehensive health services, including preventative education and counseling, health promotion and counseling and health care services in the areas of: 1) sex and sexuality - special emphasis on teen pregnancy and sexually transmitted diseases; 2) alcohol and drug abuse - special emphasis on abusive behavior caused or aggravated by substance abuse and fetal alcohol syndrome; and 3) mental health - special emphasis on suicide, physical and sexual abuse, and on an Ojibwe mental health/psychology component.

Methods for Accomplishing Objectives:

- Health Center Setting

- Individual and Group Counseling

- Develop and Distribute Educational Materials

- Coordinate Services with Other Local Programs

Accomplishments:

- Seventy five percent of the target population was reached (150 Students per quarter).

- Developed and distributed educational and health promotion materials.

- Provided Medical services and referrals through a drop-in clinic located at the Bug School. The clinic was staffed by a nurse practitioner, who was also the director.

    - A Nurse Practitioner was hired and clinic was opened.

    - At least 190 Students now using the clinic. A minimum of 136 students had family planning and STD counseling.

- Developed a comprehensive health promotion and education and disease intervention curriculum in the areas of sex and sexuality, drug and alcohol abuse, and mental health.
    - Materials and resources gathered to develop a curricular.
    - Developed, distributed, collected and tallied parent/teacher/student opinion surveys regarding perceived curriculum needs and most useful information format.
    - The teacher's resource book was developed.
- Implemented health care and disease prevention curricula through small group sessions of five (5) to 15 students.
    - Classes were given to students in the 7th through 12th grades. There were approximately 247 that students participated.
    - The Mental Health Specialist is available for individual counseling.
- Developed curricula for a health and wellness handbook to be used by students in the Bug School.
    - Developed a plan for curriculum format and developed the topical outline.
    - Reviewed existing curricular and resources and contacted area service providers for additional resources.
    - Developed a philosophy for the curriculum, as well as, background information for 10 topics/issues to be included in the curriculum for the student handbook.
    - Collected, developed and categorized student activities and lesson plans to be included in the curriculum.
    - A consultant was hired to provide an objective evaluation on both the process of curriculum development and on the content of the curriculum.
    - The student handbook was typed and reviewed.
- Provided one opportunity each year through the Leech Lake Reservation health fair to bring parents and students together to share information and values about health and wellness and disease prevention.
    - A student advisory committee was organized.
    - "Non-acholic party drinks" was the booth topic. 500 visitors came to booth. Students also prepared the non-acholic drinks at Senior Prom.

Notable Achievements/Innovative Approaches:

- Established a program that would allow them in the 3rd year to: Disseminate the completed health and wellness curriculum to 1) the secondary schools serving Leech Lake Reservation (there are six in addition to the Bug School), 2) the Health Division of the five other Chippewa Reservations, which are members of the Minnesota Chippewa Tribe, 3) the health division of the Red Lake Nation in Minnesota, and others 4) copies were made available to other reservations at cost of reproduction.

- Teen pregnancies in the first dropped by approximately 80 percent.

Barriers in Meeting Objectives:

- The accomplishments in the first quarter of the grant were hampered by the need to hire the staff. The drop-in clinic in the first quarter was not opened due to the Nurse Practitioner vacancy.

Grantee Profile - Menomiee Tribe

Name: Menominee Indian Tribe
Location: Keshena, Wisconsin

Funding: 1991 $53,307 -- 1992 $73,770 -- 1993 $94,490

Target Population: 108 Adolescents on Four Reservations

Major Program Objective(s):

- To establish a comprehensive health care delivery system on the Menominee Indian Reservation
- To provide National American Adolescents with outreach preventive education and counseling

Methods for Accomplishing Objectives:

- Communication Activities
- Recreational Outings
- Coordination of Services
- Weekly Sessions

Accomplishments:

- Coordinated services with the Meahnowesekiyah Treatment Center on the Menominee Indian Reservation.
- Exceed goals in reaching additional adolescents in education/counselling and individual counselling.
- Developed pamphlets and newsletters.
- Conducted retreats with 30 family units.
- Retreats were evaluated and determined to be effective in building self-esteem and communication skills and family relations.
- Integrated services with other programs.

Notable Achievements/Innovative Approaches:

- Projects involved entire families.

Barriers in Meeting Objectives:

- Community denial and fear of association with substance abuse programs

Grantee Profile - Northwest Indian College

Name: Northwest Indian College
Location: 2522 Kwina Road
Bellingham, WA 98226-9217

Funding: 1991 $114,262 -- 1992 $114,620 -- 1993 99,526

Target Population: 1,227 Adolescents

Major Program Objective(s):

- To provide Indian adolescent ages 12 to 19 years of age with age and culture appropriate health assessment, education information, prevention activities and resource referral service to two center based locations.

Methods for Accomplishing Objectives:

- Referral Services
- Health Promotion and Disease Prevention Education
- Emphasis Traditional Values and Culture

Accomplishments:

- Completed all of year ones objectives.
- Developed an advisory committee.
- Identified Indian adolescent health curricula which can be modified and included in the service delivery methods of the two center based locations.
- Provided initial health screening assessments and enrolled all youth participating in the project at the two center based locations and referred those classified as high risk for further and more intensive health related services.
- Identified and developed activities which support culturally appropriate holistic health life styles.
- Assisted and supported tribal education.
- Created a daily health class.
- Developed and refined the student/client record keeping assessment and follow-up system. These systems are applicable to all Indian adolescent youth as a basis for setting goals and referring specific youth to appropriate health services

Notable Achievements/Innovative Approaches:

- A community focus was very successful in developing a comprehensive and effective youth program.

Barriers in Meeting Objectives:

- Positions took a long time to fill.

Grantee Profile - Otoe Tribe

Name: Otoe - Missouria Tribe
Location: Red Rock, Oklahoma

Funding: 1991 $71,495 -- 1992 $70,000 -- 1993 $65,659

Target Population: 183 Adolescents

Major Program Objective(s):

- Establish a functional referral/information - exchange network with other internal/external service agencies
- Negotiate/initiate services agreements with other internal/external service agencies.
- Develop information package detailing services available through the center.
- Hold nine support group meetings for clients in area of need.
- Hold 18 adult responsibilities training classes.
- Have 18 organized recreational activities.

Methods for Accomplishing Objectives:

- Health Center
- Community Education
- Counseling
- Referral Network and Crisis Intervention

Accomplishments:

- There were 129 participants recorded.
- Opened Health Center
- Provided outreach and "after-care" services.
- Coordinated services with the school system.
- The program served 129 youths.
- By the end of the first year - all objectives (37) were met.
- Numerous programs and for youth and parents were provided.

- Attended the outdoor production of the "Trail of Tears" and floated down the Illinois river.
- Conducted summer youth retreats.
- Provided daily activities during summer, spring break and Christmas holidays.
- All activities were designed to help the individual increased his/her social skills, job skills, and educational opportunities.
- Used age/cultural relevant health information and curriculum.

Notable Achievements/Innovative Approaches:

- Teens painted a culturally relevant mural.
- Involved parents and elders on task force.

Grantee Profile - Pueblo of Zuni

Name: Pueblo of Zuni
Location: P.O. Box 339
Zuni, NM 87327

Funding: 1991 $50,245 -- 1992 $50,245 -- 1993 $43,837

Target Population: 1,800 Adolescents

Major Program Objective(s):

- Reduce teen pregnancy, substance abuse and school drop outs through a "coordinate effort" with Zuni Public Schools (2) and other Community Programs (specifically Zuni Health Teen Center). This program will offer outreach, prevention and health promotion activities.

- A focus will be placed on services that are not currently available through other local agencies and programs to:
  -Reduce teen pregnancy by 50% by 1992.
  -Reduce juvenile arrest for alcohol and other drug abuse reduced by 30% by 1992.
  -Increase use of Teen Health Center by 25% by 1992.
  -Reduce teen suicides to zero by 1991.
  -Reduce teen incidence of VD by 50% by 1992 and maintain HIV/AIDS infection.
  -Reduce school drop out by 25% by 1992.

Methods for Accomplishing Objectives:

- Class room presentations
- Community outreach
- Conducted Workshops
- Local Program Coordination
- Communication Projects

Accomplishments:

- Served ages 11 to 20: 1990-91: 1,818; 1991-92: 968; 1992-93: 1,297.

- Brochures and posters were designed and distributed throughout the community.

- Videos were shown in teen medical clinic.

- Coordinated activities and services with two high schools, medical facilities, and teen health center.

- Provided outreach services for disease prevention and health promotion.

- Sponsored six students to participate in three day conference "Empowering Families and Teens for Success".
- Set up and managed a booth at the health fair.
- Developed materials and conducted workshops.
- Conducted two open house events.
- Established a data base for measuring changes in health behaviors.
- Statistics collected from program and other related agencies indicate slight decrease in high school drop-outs by 2 - 3 percent.

Notable Achievements/Innovative Approaches:

- Established a teen advisory board

Grantee Profile - Puyallup Tribe

Name: Puyallup Tribe of Indians
Location: 2002 East 28th St
Tacoma, WA 98404

Funding: 1991 $62,248 -- 1992 $62,248 -- 1993 $68,867

Target Population: 1,911 Adolescents

Major Program Objective(s):

- To identify of Adolescent Health risk youth.
- Development of Curriculum to provide prevention/intervention information.
- Evaluation and modification of the curriculum.
- Conduct overall Program Evaluation.

Methods for Accomplishing Objectives:

- Health screening
- Curriculum development
- Resource Coordination
- Outreach Services

Accomplishments:

- Adolescent Risk Appraisal was administered to 76 percent of middle and high school students.
- Gathered information and community networking to create a resource center.
- Provided outreach services.
- Conducted program evaluation.

Notable Achievements/Innovative Approaches:

- Conducted a Johns Hopkins University HIV/AIDS prevention project. It was implemented in March 1993. Baseline assessments were given to all 7 - 12 grades and all students completed a six week course.

Barriers in Meeting Objectives:

- Program Director had resigned in March of 1992.

Grantee Profile - Sault Ste. Marie

Name: Sault Ste. Marie - Chippewa Tribe
Location: 206 Greenough Street
Sault Ste. Marie, MI 49783

Funding: 1991 $72,923 -- 1992 $73,300 -- 1993 $63,007

Target Population: 1,083 Adolescents

Major Program Objective(s):

- To provide services for the Chippewa youth, including health education, nutrition, family planning, physical exams, acute assessment, treatment of sexually transmitted diseases, prenatal care, mental health, substance abuse, and HIV/AIDS counseling and testing.

Methods for Accomplishing Objectives:

- Preventive Education and Counseling
- Teen Health Nights
- Self-Learning Computer Programs on Sexuality, Parenting, Health Risks, etc.
- Close Coordination with other Community Agencies.

Accomplishments:

- Coordinated local adolescent health services for adolescents (Girl & Boy Scouts, C.A.R.E. Center, University, AA, ALA-Teen, CAP, SADD, Rape Crisis Hotline.)

- Increased use of health services by youth, especially for:
  - Pregnancy
  - Infant Care
  - Infectious Diseases
  - Mental Health
  - Tobacco, Alcohol Abuse
  - Drug Abuse

- Provided outreach programs and services for health promotion/disease prevention education and counseling (i.e., Preparation for adulthood, STD, HIV/AIDS, suicide, violent behavior, substance abuse, FAS, teen pregnancy, nutrition, wellness/self-esteem, and accident prevention.

- Program assessments and an evaluation was performed.

- Used self-learning computers for subject areas such as sexuality, parenting, health risk, etc.

- Promoted the use of visuals (films, slides, books/pamphlets) as learning and counseling tools.

Notable Achievements/Innovative Approaches:

- Teen Health Risk Appraisals were done to evaluate "level of wellness" of the local adolescent target population (approximately 300 teens).

Barriers in Meeting Objectives:

- Lack of funding for advertisement, purchasing materials and transportation to outlying sites.

Grantee Profile - Shoshone-Paiute

Name: Shoshone - Paiute Tribes of Duck Valley
Location: P.O. Box 219
Owyhee, NV 89832-0219

Funding: 1991 $75,110 -- 1992 $75,110 -- 1993 $80,182

Target Population: 250 Adolescents

Major Program Objective(s):

- To provide educational and therapeutic presentations.
- To establish an Adolescent Health Center in perpetual service to the Duck Valley Reservation through the utilization of a new facility.
- Implement an educational and screening process to identify target youth gender - groups, problems, and some needs with intent to refine effectiveness and efficiency of program.

Methods for Accomplishing Objectives:

- Screening
- Coordination of local youth services

Accomplishments:

- Youth advisory board established.
- Staff work hours are continuously adjusted to meet adolescent needs
- Program is accepted and supported by the community.

Notable Achievements/Innovative Approaches:

Barriers in Meeting Objectives:

- Lack of support and involvement of parents
- Lack of facility

Grantee Profile - St. Croix Band

Name: St. Croix Band of Lake Superior Chippewa
Location: St. Croix Band - Lake Superior Chippewa Reservation

Funding: 1991 $73,744 -- 1992 75,865 -- 1993 68,202

Target Population: 160 Adolescents in a Three County Area - Nine Schools/Four with Large Indian Youth Population

Major Program Objective(s):

- To reduce the high incidence rate of health problem behaviors. School age parents, AODA related problems, delinquency and out of home placements.

- To reduce stress and increase coping skills.

Methods for Accomplishing Objectives:

- Establish networks and referral systems
- Develop Data Collection System
- Develop Orientation and Training for Staff

Accomplishments:

- Recruited and trained part-time home-school coordinators for role of Adolescent Health Facilitators (AHF).

- Adolescent Health Facilitator provided education and supported adolescents in developing and using bon adaptue health behaviors.

- Integrated current health services through referral and networking between school, community, and family.

- Developed a video taped of initial training sessions for adolescent health facilitators that address staff turnover concerns.

- Collected data on delinquency, out of home placements, early pregnancy, stress related disorders, AODA inpatient and outpatient treatment, mental health treatments, accident rates, STDS.

- Supported and integrated local adolescent services.

- Services were provided to support adolescent decision making process for healthy behaviors.

Notable Achievements/Innovative Approaches:

- Supplemented the hours of the in-school support staff to offer services in the schools located in the target area. It was reported that this process proved so successful that it will be continued and expanded to other programs.

Grantee Profile - Tulalip Tribe

Name: The Tulalip Tribe
Location: 6700 Totem Beach Road
Marysville, WA 98270

Funding: 1991 $68,722 -- 1992 $67,372 -- 1993 $72,699

Target Population: 312 Adolescents - 159 Female - 153 Male

Major Program Objective(s):

- Establish an outreach program of preventive education and counseling related to all urgent areas of need such as:
  -accident prevention -STD
  -HIV/AIDS -Suicide/violence
  -substance abuse/FAS

- Provide education and counseling in areas such as:
  -nutrition -teenage pregnancy
  -Physical Fitness -parenting

Methods for Accomplishing Objectives:

- Counseling
- Recreational Therapy
- Reestablishment of Traditional Values (including language)

Accomplishments:

- Staff took extensive training to educate youth.
- Evaluations were completed every three months.
- Program moved into its own building.
- Obtained information on changes in attitude and behavior among the target population through a survey.
- Questionnaires were completed by the teen who took part in the project act
- Provided disease prevention and health promotion activities.

Notable Achievements/Innovative Approaches:

- Incorporating traditional values into the adolescent programs.

Grantee Profile - White Earth

Name: White Earth Reservation
Location: P.O. Box 418
White Earth, MN 56591

Funding: 1991 $63,398 -- 1992 $66,398 -- 1993 $74,543

Target Population: 120 Adolescents on Five Reservations

Major Program Objective(s):

- Provide counseling services for youth.
- Implement recreational activities for youth.
- Give reservation youth an organized voice through implemention of tribal youth advisory council.
- Enhance base line data system to evaluate negative youth behaviors, including suicide.
- Improve referral system between schools, Indian Health Service and tribal agencies.

Methods for Accomplishing Objectives:

- Individual Counseling
- Recreational Activities
- Coordination of Community Youth Services
- Data System Development

Accomplishments:

- Suicide intervention project was put to action.
- Provided reservation youth with structured recreational activities in 3 reservation communities with at least 40 participants from each community.
- Enhanced system for evaluating negative behaviors.
- Established a network with agencies by Mental Health Practitioners and Youth Activity Coordinators.
- Established tribal youth advisory council.
- Provided training to reservation communities regarding the establishment of community watch programs.

- Provided counseling services for at least 50 reservation youth and their families.

Notable Achievements/Innovative Approaches:

- Established a Cultural Preservation Project. Examples of activities are: pot luck feast, making their Pow - Wow outfits, youth interviewing elders and documenting information in books and on computers.

Barriers in Meeting Objectives:

- Lack of parental participation.
- Lack of facility.
- Difficulty in accessing information from other similar projects in other area or locations.

APPENDIX B

GRANTEE BUDGET DATA

SUMMARY
Adolescent HP/DP Grantees
Budgeted Costs - All Prgrams

	FY 1991		FY 1992		FY 1993		TOTAL	
	$	%	$	%	$	%	$	%
Personnel								
Direction	189,638	19.0	257,006	25.2	269,951	26.4	716,595	23.6
Education/Health	136,063	13.6	182,044	17.9	154,314	15.1	472,421	15.5
Secretarial	43,209	4.3	48,485	4.8	46,239	4.5	137,933	4.5
Other	67,684	6.8	40,576	4.0	39,500	3.9	147,760	4.9
Subtotal	436,594	43.7	528,111	51.8	510,004	49.9	1,474,709	48.5
Fringe	90,693	9.1	117,198	11.5	109,048	10.7	316,939	10.4
Consultants	6,420	0.6	1,000	0.1	5,400	0.5	12,820	0.4
Travel	57,877	5.8	50,801	5.0	51,984	5.1	160,662	5.3
Equipment								
Office	23,298	2.3	1,500	0.1	1,300	0.1	26,098	0.9
Education/Health	9,875	1.0	1,802	0.2	7,300	0.7	18,977	0.6
Other	43,346	4.3			4,108	0.4	47,454	1.6
Subtotal	76,519	7.7	3,302	0.3	12,708	1.2	92,529	3.0
Supplies								
Office	14,838	1.5	13,459	1.3	13,312	1.3	41,609	1.4
Education/Health	17,907	1.8	17,908	1.8	11,574	1.1	47,389	1.6
Other	11,557	1.2	5,865	0.6	11,082	1.1	28,504	0.9
Subtotal	44,302	4.4	37,232	3.7	35,968	3.5	117,502	3.9
Contractual	74,141	7.4	67,910	6.7	44,533	4.4	186,584	6.1
Construction (A/R)								
Trainee Costs	19,148	1.9	6,921	0.7	400	0.0	26,469	0.9
Other								
Occupancy	38,329	3.8	32,067	3.1	25,693	2.5	96,089	3.2
Communications/Meetings	23,031	2.3	9,124	0.9	8,422	0.8	40,577	1.3
Other	13,600	1.4	16,642	1.6	57,287	5.6	87,529	2.9
Subtotal	74,960	7.5	57,833	5.7	92,602	9.1	225,395	7.4
Total Direct Costs	880,654	88.2	870,308	85.4	862,647	84.5	2,613,609	86.0
Indirect Costs	117,846	11.8	148,369	14.6	158,776	15.5	424,991	14.0
Total Budget	998,500	100.0	1,018,677	100.0	1,021,423	100.0	3,038,600	100.0

Adolescent HP/DP Grantees
Budgeted Costs

	Eastern Band of Cherokee Cherokee, NC				Otoe-Missouri Tribe Red Rock, OK			
	1991	1992	1993	Total	1991	1992	1993	Total
Personnel								
Direction	11,087	35,000	35,473	81,560		34,902	19,781	54,683
Education/Health						4,202	15,413	19,615
Secretarial	9,914	11,500	11,655	33,069				
Other					29,350			29,350
Subtotal	21,001	46,500	47,128	114,629	29,350	39,104	35,194	103,648
Fringe	2,200	9,517	10,737	22,454	5,283	9,170	6,236	20,689
Consultants								
Travel	1,000	2,091	2,500	5,591	4,095	2,161	2,697	8,953
Equipment								
Office					4,421			4,421
Education/Health	3,510			3,510				
Other	33,951		1,500	35,451				
Subtotal	37,461		1,500	38,961	4,421			4,421
Supplies								
Office		1,000	5,007	6,007	648	1,452	240	2,340
Education/Health						407	720	1,127
Other	2,500			2,500	1,528	350		1,878
Subtotal	2,500	1,000	5,007	8,507	2,176	2,209	960	5,345
Contractual					1,811	1,000	1,000	3,811
Construction (A/R)								
Trainee Costs	400			400	1,247	600		1,847
Other								
Occupancy					5,098	3,636	2,400	11,134
Communications/Meetings					4,570	600	540	5,710
Other	1,500	1,500	3,000	6,000			110	110
Subtotal	1,500	1,500	3,000	6,000	9,668	4,236	3,050	16,954
Total Direct Costs	66,062	60,608	69,872	196,542	58,051	58,480	49,137	165,668
Indirect Costs	5,739	12,392	14,497	32,628	13,444	11,520	16,523	41,487
Total Budget	71,801	73,000	84,369	229,170	71,495	70,000	65,660	207,155

Adolescent HP/DP Grantees

Budgeted Costs

	Chippewa Tribe Sault Ste. Marie, MI				Grand Traverse Band			
	1991	1992	1993	Total	1991	1992	1993	Total
Personnel								
Direction	18,196	28,988	25,841	73,025	14,238	10,847	17,784	42,869
Education/Health	17,533	21,907	19,529	58,969				
Secretarial								
Other					7,134	9,214		16,348
Subtotal	35,729	50,895	45,370	131,994	21,372	20,061	17,784	59,217
Fringe	7,086	7,480	7,367	21,933	5,984	5,617	4,980	16,581
Consultants							2,000	2,000
Travel	4,804	1,400	500	6,704	3,600	3,878	2,377	9,855
Equipment								
Office	2,550			2,550				
Education/Health								
Other								
Subtotal	2,550			2,550				
Supplies								
Office	4,373	1,495	800	6,668	480	480	480	1,440
Education/Health	1,302	500		1,802	680	2,400	1,520	4,600
Other								
Subtotal	5,675	1,995	800	8,470	1,160	2,880	2,000	6,040
Contractual					2,500	3,500		6,000
Construction (A/R)								
Trainee Costs	930	500		1,430	1,101			1,101
Other								
Occupancy					18,731	18,731	18,731	56,193
Communications/Meetings	5,948	600		6,548	2,220	900	2,100	5,220
Other								
Subtotal	5,948	600		6,548	20,951	19,631	20,831	61,413
Total Direct Costs	62,722	62,870	54,037	179,629	56,668	55,567	49,972	162,207
Indirect Costs	10,200	10,430	8,970	29,600	14,433	14,433	11,083	39,949
Total Budget	72,922	73,300	63,007	209,229	71,101	70,000	61,055	202,156

Adolescent HP/DP Grantees

Budgeted Costs

	Pueblo of Zuni				Hopi Tribe			
	1991	1992	1993	Total	1991	1992	1993	Total
Personnel								
Direction	1,756	1,756		3,512	27,500		24,750	52,250
Education/Health	22,000	22,000	22,000	66,000				
Secretarial	4,130	6,307	6,812	17,249	11,000	15,225	13,171	39,396
Other								
Subtotal	27,886	30,063	28,812	86,761	38,500	15,225	37,921	91,646
Fringe	3,545	4,254	4,254	12,053	6,160	2,741	7,584	16,485
Consultants					6,120			6,120
Travel	978	1,657	1,280	3,915	8,969	9,302	11,928	30,199
Equipment								
Office	3,923			3,923	5,000			5,000
Education/Health								
Other	645			645				
Subtotal	4,568			4,568	5,000			5,000
Supplies								
Office	1,542	2,100	513	4,155	2,820	1,482	522	4,824
Education/Health								
Other								
Subtotal	1,542	2,100	513	4,155	2,820	1,482	522	4,824
Contractual	1,813	2,000	500	4,313		40,650	2,500	43,150
Construction (A/R)								
Trainee Costs	1,700	400	400	2,500	3,570			3,570
Other								
Occupancy	600	800	362	1,762				
Communications/Meetings	1,883	2,285	1,030	1,883	660	600	600	1,860
Other	400	400	400	1,200				
Subtotal	2,883	3,485	1,792	8,160	660	600	600	1,860
Total Direct Costs	44,915	43,959	37,551	126,425	71,799	70,000	61,055	202,854
Indirect Costs	5,330	6,286	6,286	17,902				
Total Budget	**50,245**	**50,245**	**43,837**	**144,327**	**71,799**	**70,000**	**61,055**	**202,854**

Adolescent HP/DP Grantees
Budgeted Costs

	Leech Lake Chippewa Reservation				Menominee Indian Tribe			
	1991	1992	1993	Total	1991	1992	1993	Total
Personnel								
Direction	16,300	16,000	16,800	49,100	1,688	18,000	20,225	39,913
Education/Health	6,500	34,000	32,760	73,260	19,320	14,500	16,300	50,120
Secretarial			3,360	3,360	1,587	1,899	1,881	5,367
Other								
Subtotal	22,800	50,000	52,920	125,720	22,595	34,399	38,406	95,400
Fringe	6,156	13,500	12,610	32,266	7,682	11,352	13,058	32,092
Consultants								
Travel	840	420	1,750	3,010	2,767	1,000	2,516	6,283
Equipment								
Office					1,604	1,500		3,104
Education/Health								
Other	4,750			4,750			2,608	2,608
Subtotal	4,750			4,750	1,604	1,500	2,608	5,712
Supplies								
Office		1,000	1,750	2,750	1,000			1,000
Education/Health					2,000			2,000
Other	3,129			3,129		4,315	9,495	13,810
Subtotal	3,129	1,000	1,750	5,879	3,000	4,315	9,495	16,810
Contractual	25,837		1,000	26,837	7,700	1,720	2,533	11,953
Construction (A/R)								
Trainee Costs	4,000			4,000		3,321		3,321
Other								
Occupancy					2,500			2,500
Communications/Meetings	3,200	1,939	4,152	9,291	850			850
Other	900	1,000	1,590	3,490		9,749	18,685	28,434
Subtotal	4,100	2,939	5,742	12,781	3,350	9,749	18,685	31,784
Total Direct Costs	71,612	67,859	75,772	215,243	48,698	67,356	87,301	203,355
Indirect Costs	5,234	8,290	8,225	21,749	4,609	6,414	7,189	18,212
Total Budget	76,846	76,149	83,997	236,992	53,307	73,770	94,490	221,567

Adolescent HP/DP Grantees

Budgeted Costs

	Puyallup Tribe of Indians				Shoshone-Paiute Tribe			
	1991	1992	1993	Total	1991	1992	1993	Total
Personnel								
Direction					12,946	14,988	15,724	43,658
Education/Health					20,288	23,488	23,820	67,596
Secretarial								
Other	31,200	31,362	39,500	102,062				
Subtotal	31,200	31,362	39,500	102,062	33,234	38,476	39,544	111,254
Fringe	6,864	6,900	8,000	21,764	6,394	6,774	4,840	18,008
Consultants					300	1,000	3,400	4,700
Travel	3,500	2,500	3,000	9,000	2,000	2,000	3,003	7,003
Equipment								
Office								
Education/Health								
Other					4,000			4,000
Subtotal					4,000			4,000
Supplies								
Office					300	300	700	1,300
Education/Health					6,000	6,624		12,624
Other	2,200	1,200	1,587	4,987	200			200
Subtotal	2,200	1,200	1,587	4,987	6,500	6,924	700	14,124
Contractual	1,200			1,200				
Construction (A/R)								
Trainee Costs	1,500	1,500		3,000	1,400			1,400
Other								
Occupancy					7,200	4,700		11,900
Communications/Meetings					3,700	2,200		5,900
Other	6,700	1,001	3,007	10,708			13,543	13,543
Subtotal	6,700	1,001	3,007	10,708	10,900	6,900	13,543	31,343
Total Direct Costs	53,164	44,463	55,094	152,721	64,728	62,074	65,030	191,832
Indirect Costs	9,084	17,785	13,773	40,642	10,382	13,036	15,152	38,570
Total Budget	62,248	62,248	68,867	193,363	75,110	75,110	80,182	230,402

Adolescent HP/DP Grantees
Budgeted Costs

	White Earth Reservation				Northwest Indian College			
	1991	1992	1993	Total	1991	1992	1993	Total
Personnel								
Direction	13,364	13,364	13,364	40,092	22,600	30,000	25,500	78,100
Education/Health	23,400	23,400	24,492	71,292	11,400	21,590		32,990
Secretarial					10,858	7,842		18,700
Other								
Subtotal	36,764	36,764	37,856	111,384	44,858	59,432	25,500	129,790
Fringe	7,820	7,987	8,173	23,980	10,284	13,668	6,000	29,952
Consultants								
Travel	6,760	7,360	8,460	22,580	11,868	11,200	4,800	27,868
Equipment								
Office					2,400		900	3,300
Education/Health	1,200	1,000	3,000	5,200	3240		4,300	7,540
Other								
Subtotal	1,200	1,000	3,000	5,200	5,640		5,200	10,840
Supplies								
Office	1,075	1,700	3,000	5,775	600	1,200		1,800
Education/Health	1,075	1,627	5,960	8,662	2,250	2,000		4,250
Other					2,000			2,000
Subtotal	2,150	3,327	8,960	14,437	4,850	3,200		8,050
Contractual	2,000			2,000	15,600	4,000	31,000	50,600
Construction (A/R)								
Trainee Costs	1,500	600		2,100				
Other								
Occupancy								
Communications/Meetings								
Other							7,000	7,000
Subtotal			1,200	1,200			7,000	7,000
Total Direct Costs	58,194	57,038	67,649	182,881	93,100	91,500	79,500	264,100
Indirect Costs	8,204	9,960	8,237	26,401	21,162	23,120	20,026	64,308
Total Budget	66,398	66,998	75,886	209,282	114,262	114,620	99,526	328,408

Adolescent HP/DP Grantees

Budgeted Costs

	St. Croix Band of Chippewa				Tulalip Tribe			
	1991	1992	1993	Total	1991	1992	1993	Total
Personnel								
Direction	27,300	28,560	29,120	84,980	22,663	24,601	25,589	72,853
Education/Health					15,622	16,957		32,579
Secretarial	5,720	5,712	9,360	20,792				
Other								
Subtotal	33,020	34,272	38,480	105,772	38,285	41,558	25,589	105,432
Fringe	7,578	7,848	8,812	24,238	7,657	10,390	6,397	24,444
Consultants								
Travel	2,016	1,200	1,493	4,709	4,680	4,632	5,680	14,992
Equipment								
Office					3,400		400	3,800
Education/Health	1,925	802		2,727				
Other								
Subtotal	1,925	802		2,727	3,400		400	3,800
Supplies								
Office	2,000	1,250	300	3,550				
Education/Health		750		750	4,600	3,600	3,374	11,574
Other								
Subtotal	2,000	2,000	300	4,300	4,600	3,600	3,374	11,574
Contractual	15,680	15,040	1,200	31,920			4,800	4,800
Construction (A/R)								
Trainee Costs					1,800			1,800
Other								
Occupancy					4,200	4,200	4,200	12,600
Communications/Meetings								
Other					4,100	2,992	9,952	17,044
Subtotal					8,300	7,192	14,152	29,644
Total Direct Costs	62,219	61,162	50,285	173,666	68,722	67,372	60,392	196,486
Indirect Costs	10,025	14,703	16,508	41,236			12,307	12,307
Total Budget	72,244	75,865	66,793	214,902	68,722	67,372	72,699	208,793

APPENDIX C

DATA COLLECTION FORMS

Grantee: _____

Director: _____

Phone # _____ Fax: _____

Location: _____

Characteristic's _____

Population Served: _____ Age Range: _____

Total Funding For:

1991	Over/Short	1992	Over/Short	1993	Over/Short
$	$	$	$	$	$

Were "other resources" identified in the proposal? _____ Yes _____ No

Type: _____ Tribal _____ Federal _____ Other (please specify) _____

_____

	1991		1992		1993	
	Yes	No	Yes	No	Yes	No
Did they get all their quarterly reports in?						
Did they meet conditions of program year progress format?						
Content of Progress Reports (Very Good, Good or Poor)						

Did the initial proposal include an evaluation plan? _____ Yes _____ No

Is there evidence (in reports and year 2 and 3 proposals) that the evaluation plan was used to measure program progress for effectiveness? _____ Yes _____ No

Actual Number of Clients Served:

Quarter	1991	1992	1993
First			
Second			
Third			
Fourth			

Program Objectives:

Year One

Program Objectives:

Year Two

Program Objectives:

Year Three

Misc. Information - Such as Unique Features - Services and Methods , etc.

Grantee Name/Location: _____

Budgeted _X_ Actual ___ Costs

Cost Categories and Line Items	BUDGET	COST ANALYSIS	
		%	$
D. TRAVEL			
1. Out-of Town (Staff)			
2. Local (Staff)			
3. Out-of-Town (Youth)			
4. Local (Youth)			
5. Other Travel			
TOTAL TRAVEL			
E. EQUIPMENT			
1. Office			
2. Educational			
3. Recreational			
4. Equip./Maint./Repair			
5. Other Furniture/Equip.			
TOTAL EQUIPMENT			
F. SUPPLIES			
1. Office/Copying/Postage			
2. Cleaning/Maintenance			
3. Education			
4. Recreational			
5. Kitchen			
6. Special Awards			
7. Other Supplies			
TOTAL SUPPLIES			

Grantee Name/Location: _____

Budgeted _X_ Actual ___ Costs

Cost Categories and Line Items	BUDGET	COST ANALYSIS	
		%	$
G. CONTRACTUAL			
1.			
2.			
3.			
4.			
5.			
TOTAL CONTRACTUAL			
H. PATIENT CARE			
1.			
2.			
TOTAL PATIENT CARE			
I. CONSTRUCTION (A & R)			
1. Alterations			
2. Renovations			
3. Space Maint./Repair			
4. Other Construction			
5.			
TOTAL CONSTRUCTION			
J. TRAINEE COSTS			
1. Trainee Expenses			
2. Trainee Stipends			
3. Trainee Tuition/Fees			
4. Trainee Travel			
TOTAL TRAINEE COSTS			

Grantee Name/Location: _____

Budgeted _X_ Actual ___ Costs

Cost Categories and Line Items	BUDGET	COST ANALYSIS	
		%	$
K. OTHER			
1. Rent			
2. Depre./Use Allowance			
3. Building/Liability Insur.			
4. Theft Bond			
5. Pubs./Subscriptions			
6. Printing/Advertising			
7. Telephone			
8. Utility - Gas/Fuel Oil			
9. Utility - Electricity			
10. Other			
TOTAL OTHER			
L. TOTAL DIRECT COSTS			
Direct Costs			
TOTAL DIRECT COSTS			
M. INDIRECT COSTS (Rate _____ % of ___ S & W ___ TADC)			
Indirect Costs			
TOTAL INDIRECT COSTS			
N. TOTAL BUDGET			

APPENDIX D

PREVIOUS STUDIES

SUMMARY OF FINDINGS AND RECOMMENDATIONS

The following information was taken from the Indian Health Service ***School/Community-Based Alcoholism/Substance Abuse Preventy Survey*** report.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

SCHOOL BASED SURVEY RESULTS

Subject Area Surveyed: Issues for Curriculum Planning

Findings:

Overall, the alcohol/substance abuse curriculum was developed based on concern regarding issues dealing with student's low self-concept, alcoholism, attendance problem/low academic achievement, disciplinary problem/marijuana, and inhalants. In 1986, the use of marijuana and inhalants among Indian youth was a serious problem and was projected to continue.

Recommendation:

Schools together with tribal groups should clearly provide priority considerations to include meaningful curricula that address issues and concerns in ways that can enhance and facilitate joint community efforts for education and intervention approaches. Technical assistance from IHS, BIA and tribal groups should be offered to schools in developing appropriate and acceptable Head Start to 12th grade health education emphasizing youth alcohol/substance abuse, teenage pregnancy, child sexual abuse, coping skills, and family relationships.

Subject Area Surveyed: Networking

Findings:

There were strong indications of excellent agency networking with community groups in school sponsored alcohol/substance abuse prevention programs under the umbrella of health promotion/disease prevention activities.

Recommendations:

Based on a successful public health demonstration project targeted to Indian adolescents and youth in the Pueblo and Navajo communities, serious consideration for replication should be made by school/community groups. The centerpiece was the use of a Teen Advisory Group to develop program ownership and implementation.

Subject Area Surveyed: School Programs

Findings:

It is significant to note that positive inroads are being made of the utilization of model programs such as Here's Looking at You, Project Charlie, BABES, and Dare to be You.

Recommendation:

Every school, Head Start through 12th grade, should develop and establish appropriate prevention and intervention programs on alcohol/substance abuse as part of its health program.

Subject Area Surveyed: Mass Media

Findings:

The majority of the schools use posters and pamphlets to disseminate information on alcohol/substance abuse to large segments of the student population and to a lesser degree used TV/cable TV and radio.

Recommendation:

Increasing attention should be given to the "packaging" of mass media (videotapes, cassettes, poster, radio, national public service announcements) to supplement educational programs on alcohol/substance abuse. Community health educator, together with media experts, BIA, IHS, and school systems, should develop special work group to develop these essential tools.

Subject Area Surveyed: Outcome Indicators and Evaluation

Findings:

Based on their prevention program activities, schools reported positive outcome indicators in the following major areas: increased self-esteem, decreased disciplinary problems, and increased attendance.

Recommendation:

To determine outcome measures relative to risk reduction, knowledge transfer, attitudinal changes, decision making, etc., evaluation must become an integral program component to justify program support. Evaluation relative to process and outcome should provide the following data: 1) specific target groups to which the program has been addressed, 2) knowledge level at start and end of program documenting the degree of change, 3) attitudinal changes documented before and after, and 4) other pertinent indicators to strengthen evaluation.

Subject Area Surveyed: Areas for Program Concern

Findings:

Of the 1,580 responses, program planning and development were based on the following evenly distributed areas of concern: alcohol/substance abuse related morbidity and mortality, alcohol/substance abuse related accidents, alcohol/substance abuse related family violence and child abuse/neglect, and fetal alcohol effect and syndrome.

Recommendation:

Because each community is unique, prevention/intervention program activities should fit the priority needs and concerns of the specific target groups.

Subject Area Surveyed: Program Content

Findings:

Content areas used in the community-based prevention programs appear to be fairly evenly distributed among the following: alcohol/substance abuse education, building self-esteem and coping skills decision making skills , awareness of community resources, creating health promotion/disease prevention activities, and developing mutual-help and self-help support groups.

Recommendation:

While there is a continuing need to stress the problems of youth alcohol/substance abuse, fetal alcohol syndrome cause and effect't child abuse problems, etc., there is a need to balance community-based prevention programs with topics such as promoting a healthy lifestyle as contrasted to a destructive lifestyle, promoting self-esteem, family bonding, etc.

Prevention/intervention services should be provided by community-based health agencies complementing age-specific prevention programs in Head Start to 12th grade.

Subject Area Surveyed: Mass Media

Findings:

In contrast to the school population , there is greater use of TV, cable TV, and radio by community groups in seeding information on the major topics above,

However, there is similarity with the school-based programs on the greater use of posters and pamphlets for the dissemination of factual information regarding the major topics mentioned.

Recommendation:

In order to extend community-based outreach capabilities, especially to the vast majority of the Indian population who wish to remain anonymous, who do not want to participate face to face, and lack transportation, and taking into account the need to reach large audiences, the mass media approaches should be expanded and supported, A Center for Media Prevention and Intervention should be developed to produce films, video documentaries, and brochures and pamphlets for wide dissemination and utilization. The IHS health educators should play an integral role in developing such a center.

Subject Area Surveyed: Intervention Activities

Findings:

Nationally, the intervention activities receiving the highest percentages were alcohol/substance abuse counseling/referral, workshops/training, self/help and support groups, and education.

Recommendation:

In general, intervention in alcohol and substance abuse should focus on the targeted high risk group(s) rather than the individual. Intervention approaches should embrace the efficacy of coping skills training, social support systems, and community involvement, particularly in providing followup care, including "booster" sessions on critical prevention and intervention activities.

Subject Area Surveyed: Outcome Indicators and Evaluation

Findings:

The program evaluation instruments/techniques utilized prominently among community groups were interviews and conversations, questionnaires, active participation and participant observer, and pre/post tests.

Recommendation:

There is a great need for community-based agencies to develop evaluation tools for ensuring that local program efforts are planned and managed with clear objectives and that those objectives are realistic and achievable.

Subject Area Surveyed: Positive Outcome Indicators

Findings:

Community education/workshops/training and increased participation in outreach programs achieved the highest percentages on positive outcome indicators as the result of intervention program activities. Only minimal positive outcomes were indicated in areas such as reduced alcohol/substance abuse in accidents, teenage pregnancies, and homicide.

Recommendation:

The tripartite (IHS, BIA, tribes) should develop a task force to develop and disseminate guidelines and /or standards for evaluation and outcome measures of local programs, The tripartite should make technical assistance and evaluation consulting services available to local providers.

The following information was taken from the Indian Health Service ***Evaluation of the Albuquerque Area Teen Centers*** report.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Finding:

There is a clear need for the services provided by the TCs, the existing programs are viable, and the services are being used. The average cost of operation of a TC is $48,196 per year or $38,141 per year depending on the contractor. A TC probably costs less to operate for one year than the costs associated with the treatment of one teenager who contracts AIDS.

Recommendation:

The IHS should continue to fund Teen Centers (TCs) in the Albuquerque Area.

Finding:

These demonstration TC programs should incorporate sound evaluation methods and should utilize the model developed in this evaluation so that the impact and cost-efficiency of the TC model can be better established.

Recommendation:

The IHS should fund TCs in other Areas, but only on an experimental basis as demonstration projects.

Finding:

Examination of six years of TC operation revealed that IHS and the TC contractors are performing at a satisfactory level.

Recommendations:

The following activities and approaches should be replicated in new TCs.

- Support from high levels in the Area Office.
- Contract out the operation of TCs to tribes or community-based organizations.
- Team with other funding sources.
- Expand on the model provided in this study by creating a TC developers handbook.
- Procure TC services by three year contracts.

Recommendations:

The following changes in TC programming should be instituted.

- Make contract awards only to offerors who submit technically acceptable proposals and who provide evidence of successful operation.
- Require the TC proposals include measurable objectives.
- Develop standard reporting forms.
- Develop a standard evaluation form and procedures to guide IHS project officers' of TC operations.
- Provide technical assistance for the evaluation of TC impact.
- Determine the return on investment.

Finding:

Problems to be solved and barriers to overcome. Prepare for negative publicity and opposition before in happens.

Recommendation:

TCs deal with controversial and emotionally charged issues such as teen sexual behavior and pregnancy. The key to success involves presentation of the facts of the crisis in adolescent health and the TC model so that key supporters are not surprised should heated controversy occur.

Finding:

TC funding has been variable, uncertain and unequal.

Finding:

TCs have been cost-efficient; however, they perform at different levels of efficiency.

The following information was taken from the University of Minnesota, *The State of Native American Youth Health* report.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

1. Youth Involvement

While the intent of this [State of Native American Youth Health] report is to highlight the major health issues and concerns confronting Native American teenagers there are many areas where their strength and resilience shine. It is evident that most teenagers are not depressed, not chemically dependent and have not been pregnant. Most are happy, have supportive families, like school and live in nurturing environments. Most Native teenagers do not engage in delinquent acts, have not experienced abuse and have not attempted suicide.

Challenge #1:

The challenge is to recruit teenagers into being active players in improving their own health care, in developing health promotion strategies and in serving as peer teachers and educators. In addition, there is need to recruit adults throughout the community to work with youth as empathetic and supportive role models.

2. The Family

Native American youths have a familiarity and intimacy with death and loss within families comparable to few other young people in our society. Far fewer teens growing up in Native households live with two parents compared with other groups we have surveyed. Poverty is more common; unemployment is more prevalent; and both physical and sexual abuse are reported with greater frequency by Native youths than by other groups.

While the family is a source of concern and worry so, too, is it the source of heritage, culture and hope. As one Native community leader said, "Basic to the problems of Native American adolescents are the problems of cultural disintegration threatening the fundamental existence of many Indian communities. Strengthening Indian communities and families...is critical to attacking the social blight which exists in so many Indian communities."

Challenge #2:

There is need to support and strengthen Native American families so they can serve as a source of spiritual and cultural strength and economic security for their children.

3. Stress and Depression

Native American youths experience stress and depression at alarming rates. Beyond the common concerns experienced by many teens in our society. Significant numbers of Native teenagers experience profound stress such as extreme hopelessness, worries about losing their mind and constant sadness.

Challenge #3:

There is need to acknowledge the profound stress experience by a significant minority of Native American youths and to develop community-wide interventions grounded in the culture and customs of the tribe. In doing so, support are the natural resources for troubled teens: parents, family, spiritual leaders and peers.

4. Violence and Drugs

Native American mortality is persistently associated with violence and violence is far in excess of other populations. In 1986, actual deaths for Native teenagers exceeded anticipated deaths by 55%. Most deaths are related to unintentional injuries, homicides and suicides.

Challenge #4:

Given that early patterns of use for males parallel that of their female counterparts there is a window of opportunity in those years - the 6th through 8th grades - to

develop culturally appropriate interventions in support of chemical health especially for Native American males. Success in reducing drug use particularly among males will lower every major cause of mortality for Native youth.

5. Access to Health Services

Despite the fact that treaties more than a century old have assured health care services on all the reservations we surveyed, Native American youth access health care services far less than other American teenagers. Compared with Minnesota youth for example, Native teens are far less likely to have had a physical exam in the last two years, to have had with their vision or hearing checked or to have had a dental exam in the past year.

Challenge #5:

While it is clear that Native American youth have major health needs it is likewise evident that services are frequently unavailable or inaccessible. Innovative youth specific, community based health services need to be developed which better meets the needs of teenagers. Services need to be integrated between physical and mental health and those, in turn, need to be coordinated with the education system.

6. Native Cultures and Traditions

While not a major focus of this survey, one is struck by the strong cultural values and heritage which transcend the poverty and negative statistics we have confronted. In many communities there is an orientation to collective values over individual decisions - a strong cultural base for prevention programs. In many homes, cultural values and spirituality buffer youth from the often brutal economic realities which surround them. Language, arts, music and religion can serve as the basis for building common values.

Challenge #6:

The challenge is to build on the cultures, religions and traditions of the American Indian and Alaskan Native communities in addressing the problems which face their youth. Then and only then can we be assured that the solutions sought will be rooted in community values so critical to their success.

RESOURCE INFORMATION

The following information is presented to assist AI/AN communities identify sources that provide technical assistance, funding, or other informational resources for the continuation or development of AI/AN adolescent health services.

FUNDING OPPORTUNITIES

Public Health Service (PHS)
Profiles of Financial Assistance Programs

This book is a compendium of PHS financial assistance programs compiled from the Catalog of Federal Domestic Assistance. The program assistance descriptions are presented agency by agency and include: 1) Catalog of Federal Domestic Assistance Number, 2) Authorization for Program, 3) Program Objectives, 4) Assistance Uses and Use Restrictions, 5) Eligibility Requirements, and 6) Information Contacts. To obtain a copy of this book, interested parties should call the Division of Grants and Contracts, PHS at (301) 443-1832.

RESOURCE CENTERS

National Adolescent Health Resource Center (NAHRC)

NAHRC is housed in the Division of General Pediatrics and Adolescent Health, School of Medicine, at the University of Minnesota. Our center is devoted to providing resource materials, network referrals, technical assistance and consultation on research studies related to adolescent health issues. For more information about NAHRC's services call (612) 627-4488.

Resources for Enhancing Adolescent Community Health (REACH)

REACH is housed in the Colorado Department of Health. The mission of this center is to provide technical assistance to enhance the ability of states to improve adolescent health through dissemination of information on model programs, and through the development of community and statewide adolescent health coalitions. This center maintains a database and resource library of model programs. To learn more about REACH's resources call (303) 692-2328.

The Center of Continuing Education in Adolescent Health (CCEAH)

CCEAH is located in the Division of Adolescent Medicine at Cincinnati's Children's Hospital Medical Center. This center was established to develop materials that could be used to sensitize and train health professionals to work with adolescent more effectively. CCEAH is developing and pilot-testing an extensive training curriculum, in various media formats, for a range of health professionals. For more information about this project and the future availability of these exciting materials call (513) 559-4681.

CHILD WELFARE
NATIONAL RESOURCE AND RESEARCH CENTERS

Robert Horowitz
National Legal Resource Center for Child Welfare
American Bar Association
1800 M Street, NW
Suite S-300
Washington, DC 20036
(202) 331-2250 FAX (202) 331-2220

Marcia Allen
National Resource Center on Family Based Services
Room 112 North Hall
University of Iowa
Iowa City, IA 52242
(319) 335-2200 FAX (319) 335-2204

Brenda S. Lakin
National Resource Center for Special Needs Adoption
16250 Northland Drive
Suite 120
Southfield, MI 48075
(313) 443-7080 FAX (313) 443-7099

Patricia Ryan
National Foster Care Resource Center
Institute for the Study of Children and Families
Eastern Michigan University
Yosilanti, MI 48197
(313) 487-0372 FAX (313) 487-0284

Helaine Hornby
Director, Management and Administration Resource Center
University of Southern Maine
96 Falmouth Street
Portland, ME 04103
(207) 780-4436 FAX (207) 780-4417

Tom Joe
Center for Child Welfare Policy Research
The Center for the Study of Social Policy
1250 Eye Street, NW
Suite 503
Washington, DC 20005
(202) 371-1565 FAX (202) 371-1472

Robert George
Child Welfare Research Center
Chapin Hall Center for Children
1155 E. 60th Street
Chicago, IL 60637
(312) 753-5958 FAX (312) 753-5940

Jill Duerr Berrick
Berkeley Child Welfare Research Center
1950 Addison Street
Suite 104
Berkeley, CA 94704
(510) 643-7016 FAX (510) 642-1895

James M. Walker
The University of Oklahoma
National Resource Center for Youth Services
202 West 8th Street
Tulsa, OK 74119-1419
(918) 585-2986 FAX (918) 592-1841

Lynn E. Pooley
National Resource Center for Family Support Programs
200 S. Michigan Avenue
Suite 1520
Chicago, IL 60604
(312) 341-0900 FAX (312) 341-9361

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3. Indian Health Service, School/Community - Based Alcoholism/Substance Abuse Prevention Survey, Indian Health Service, Rockville, 1987.

4. Indian Health Service, Final Report, Evaluation of the Albuquerque Area Teen Centers, Indian Health Service, Rockville, 1991.

5. Indian Health Service, Justification of Appropriation Estimates for Committee on Appropriations, Indian Health Service, Rockville, FY 1993.

6. Indian Health Service, IHS Comments on the Executive Summary and Policy Options, Indian Health Service, Rockville, 1992.