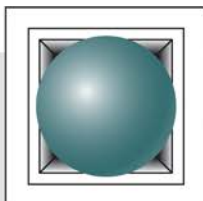


## **UTURE DIRECTIONS FOR THE OFFICE OF ADOLESCENT HEALTH**

In this report, clinical and policy experts offer their vision for the Office of Adolescent Health (OAH) in response to questions concerning potential new initiatives; interagency coordination of research, training, and programmatic activities; prevention of mental health disorders; promotion of improved models of care; and a national plan on adolescent health. The newly established office is charged with coordinating HHS activities and carrying out demonstration projects to improve the health of adolescents. How successful OAH ultimately will be in accomplishing this broad mission is unclear, but experts have high expectations for the office. Interviews with more than 30 leaders from key national organizations, academic institutions, and Congressional offices on future directions for OAH are summarized in this report.

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*By Harriette B. Fox and Bruce P. Frohnen*



*THE NATIONAL ALLIANCE  
TO ADVANCE ADOLESCENT HEALTH*

With the passage of the 2010 Appropriations Act,<sup>1</sup> Congress made a crucial step toward delivering on a promise made almost 20 years ago to America's adolescents: to provide strong federal support to study and coordinate solutions to the significant health issues they face. In 1992 Congress established the Office of Adolescent Health (OAH)<sup>2</sup> in response to an exhaustive federal study showing daunting health problems confronting adolescents -- low-income adolescents, in particular -- and critical failures in the health care system.<sup>3</sup> Unaddressed mental health, sexual health, and pregnancy and parenting issues along with chronic illness, obesity, drug and alcohol use, all were shown to seriously affect adolescents. As initially authorized, OAH was to receive adequate funding and a prominent place at the level of the Assistant Secretary for Health within the Department of Health and Human Services (HHS). Unfortunately, however, OAH never operated at that level, was severely underfunded at its inception, and soon had its budget eliminated entirely while the health problems articulated in the report continued to grow.

Congress recognized the need to reinvigorate OAH in 2010 through Appropriations Report language that re-established Congressional expectations for the placement of the office and for the leadership role it was to assume in coordinating Department activities with respect to adolescents, including coordinating programs, research projects, and training for healthcare professionals, and in undertaking demonstration projects to improve adolescent health. It also voiced its expectation that OAH would coordinate with the administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA) around the development and implementation of evidence-based programs to prevent mental, emotional, and behavioral disorders among adolescents. In addition, Congress placed OAH at the helm of a new, evidence-based Teen Pregnancy Prevention Initiative.

OAH has clearly gotten off to an excellent start, with considerable support from the Assistant Secretary. The office already has awarded \$75 million in grants to support a range of evidence-based programs that have been shown to reduce teen pregnancy and, in collaboration with the Agency for Children and Families (ACF) and the Centers for Disease Control and Prevention (CDC), awarded another \$35 million to support the development and testing of new pregnancy prevention models with promising outcomes. It also has entered into agreements with contractors to review the literature on evidenced-based pregnancy prevention programs, provide technical assistance to new grantees, evaluate program outcomes, develop a national communications strategy, and prepare a strategic plan for the office. In addition, an HHS interagency adolescent health workgroup has been formed under OAH's leadership and is meeting regularly. These

actions, along with the reaffirmation of the OAH Congressional mandate, have led leaders in the adolescent health community to hope that a number of pressing issues affecting young people's long-term health will now receive more coordinated attention.

To learn more about how these leaders would like to see OAH move forward, The National Alliance to Advance Adolescent Health conducted more than 30 interviews with adolescent health experts from national professional organizations, government and public health associations, advocacy organizations, and Congressional staff. (See Appendix.) The interviews were conducted in late summer and early fall of 2010 and typically lasted 30-45 minutes. Each interviewee was asked a series of seven questions intended to elicit his or her views regarding the optimal path for OAH to take in carrying out its mandate and achieving improved health outcomes for adolescents, in light of the limitations and challenges of budgetary, administrative, and political constraints. This report provides a summary of their responses to each question.

### ***NEW INITIATIVES***

***Over the next few years, Congress could appropriate additional funds to demonstrate the effectiveness of new initiatives to improve adolescent health and place this responsibility with the OAH. If such funds were appropriated, what types of initiatives do you think OAH should undertake first?***

All but one of the interviewees was eager to see OAH be given responsibility for additional initiatives. Various suggestions were offered, with many wanting to see Congressional support for initiatives to address specific adolescent issues or problems, and many wanting support for initiatives to focus more broadly on systemic approaches to improve adolescent health. A few experts and a Hill staffer thought that before Congress acts, OAH should undertake an in-depth assessment of the greatest areas of need and "where adolescent health is right now," or, as one expert put it, "first get the lay of the land." One advocate cautioned, however, that to be successful, OAH will need to oversee existing program areas and over time to control more programmatic funds.

Interviewees offered many topics for OAH to address in a manner similar to the Teen Pregnancy Prevention Initiative. Interviewees commonly mentioned the need to get more evidence on adolescent risk-reduction strategies and to get the evidence that we do have, both

clinical and community-based, into practice. Behavioral health issues -- mental health, substance use, and co-occurring conditions -- were suggested most often, with some interviewees mentioning in particular the need to focus initiatives on addressing risks for clinical depression, suicide, and drug and alcohol abuse. Obesity and diabetes, eating disorders, and general sexual health issues including STI prevention, were also mentioned by a number of interviewees as topics for potential OAH initiatives. Other topics were oral health, violence and injury prevention, and health care for high-risk adolescent subpopulations such as gay and lesbian youth and those in foster care.

*Some interviewees want Congressional support for initiatives to address particular problems; others urge investments in more comprehensive approaches.*

Other interviewees wanted Congress to provide support for an OAH initiative that would be broader than a specific topic and envisioned OAH building an action plan for evidence-based practice in health care delivery or positive youth development. Among interviewees who spoke of an initiative addressing health care services, there was a strong interest in investing in comprehensive interdisciplinary approaches that address adolescents' multiple health needs concomitantly and learning how to better train health care providers to ask the right questions, to identify problems, and to get more adolescents in for care. They wanted OAH to examine which models work and how they work, and they wanted quality improvement in health care for all adolescents, not just those at highest risk. Among those interested in positive youth development, there was endorsement for research and demonstration projects focused on generating models for building self-esteem, delaying gratification, developing social relationships, and setting life goals. The need for models that build on strengths and support culturally responsive approaches was mentioned, as was the need to go back to the literature and see where there is promise. Prevention, as one interviewee suggested, could serve "as the umbrella to address a wide range of issues."

## ***MENTAL HEALTH***

***The Appropriations Report specified that the OAH work with the Substance Abuse and Mental Health Services Administration (SAMHSA) to implement the recommendations of the Institute of Medicine (IOM) report on preventing mental health problems among adolescents. How do you think OAH can support SAMHSA in this effort?***

Interviewees voiced strong consensus regarding the need for OAH to take on a leadership role in implementing the IOM's recommendations for prevention of mental, emotional, and behavioral health disorders among adolescents.<sup>4</sup> They saw OAH leadership needed to develop a "shared vision" for improving adolescent mental health within the Administration and working to achieve it. Comments such as OAH should be "very much tasked with being a leader" in mental health, should serve as a "federal catalyst for implementation," and should "assume the mantle of responsibility on mental health" were common. Interviewees underscored the need for a federal office that is capable of viewing an adolescent from a whole-person perspective, an outlook not typically taken on by individual federal agencies, and for promoting within SAMHSA an age-specific focus on adolescents. Several emphasized the need for significant federal funding for OAH to ensure that it can be effective. According to interviewees, SAMHSA historically has not had the resources or experience required to carry out such broad implementation recommendations as are contained in the IOM report.

*Interviewees see a critical need for OAH leadership in federal efforts to incorporate prevention and early intervention strategies across programs, taking a holistic view of adolescents.*

Interviewees wanted to see OAH integrate and coordinate initiatives across agencies and programs to better address adolescent mental, emotional, and behavioral health problems, infusing more creativity, reducing fragmentation, and blending resources to achieve better outcomes. OAH, as one interviewee commented, is in a unique position because "it carries the clout of the Office of the Secretary" to promote prevention and early identification strategies across the many agencies that serve children. Another concurred, saying OAH is best able to bring together different agencies and programs with expertise "to form real, bona fide partnerships" and "new collaborations in principle and practice." Many agencies were mentioned as essential players, including the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), the Maternal and Child Health Bureau (MCHB), the Bureau of Primary Health Care (BPHC), the Office of

Population Affairs (OPA), and the Office of Juvenile Justice and Delinquency Prevention (OJJDP).

The basic message from interviewees was that OAH should lead efforts to incorporate strategies for identifying and serving adolescents who are at risk for or showing early symptoms of mental health disorders into existing state and local programs and sites of care for adolescents -- including its own Teen Pregnancy Prevention Initiative. All spoke about ensuring a holistic view of adolescent health, with some stressing the failure to recognize that substance abuse and mental health disorders are highly related, others talking about the failure to identify depression among pregnant teens, and still others expressing concerns about the lack of concerted efforts to treat the many problems of adolescents in foster care or juvenile justice facilities. Sentiments such as “so many things go hand in hand with substance abuse” and morbidities should not be treated individually “when they often travel in packs” were echoed in multiple interviews. Integrated approaches were encouraged, but so was the need for technical support by OAH in order to build competencies and fully implement the recommendations of the IOM report.

Finally, interviewees wanted OAH to play a major role in coordinating and advancing research on preventing adolescent mental health disorders. Many suggested that OAH identify and share research findings on best practices, particularly with regard to integrated approaches, while others advocated for continuing to develop the research base, concerned that clinicians and community program staff do not know whether their current practices are effective. Consistent with the recommendations of the IOM report, some interviewees spoke about the need to translate laboratory-based research into “real-world research in community settings” and to have OAH bring the relevant agencies and researchers together. As one expert commented, mental health researchers have not historically had “access to good practice settings where a community of practitioners can engage in ongoing practical laboratory-like demonstration projects.” Beyond generating additional evidence for the effectiveness of interventions, the need for research showing the potential cost savings associated with prevention and early identification was also mentioned. This, it was said, could be done through smaller demonstration projects that might involve CMS. Interviewees thought that bringing multiple research-funding agencies together to combine resources would be important: “If I’m working in the area of the relation between crime and drugs among teens, and I’m trying to put together funding for a study from SAMHSA and OJJDP, and neither of these agencies can afford to fund it themselves, OAH might bring together different agencies to focus on these issues for joint review.”

## PROGRAM COORDINATION

*It is clear from the recent appropriations language and the original authorizing legislation for the OAH that the office is charged with coordinating program design and evaluation within HHS. For what types of health programs would coordination have the greatest impact on adolescent health?*

Interviewees were eager to have OAH undertake its coordination function, believing, as several stated, that all “all adolescent programs need to be better coordinated.” “Health problems in adolescence,” as one expert stated, “cut across agencies.” Although beyond its legislative mandate, the hope that OAH would coordinate adolescent programs across numerous federal departments -- especially education, labor, and justice -- as well as within HHS was frequently expressed. Many interviewees envisioned OAH coordination of adolescent program design and evaluation leading to new ideas, a greater use of blended funding, more shared information, and less duplication of effort and resources. Advocates and others underscored the importance of breaking down existing compartmentalized approaches and taking a “whole-child perspective.” “As long as we stay siloed,” one said, “with teen pregnancy prevention in one place, substance abuse in another, not looking at adolescents as a whole, not looking at the context of their lives, we will be trying to fix kids one piece at a time.” But in coordinating adolescent programs the challenges the office faces were not ignored. Several noted the historic difficulty of bringing agencies together and the fact that “everybody else on the block has their own agendas.” Others stressed the need for funding to ensure that OAH can carry out its role.

Interviewees specified a number of areas that should be targets for OAH coordination. A Hill staffer suggested “any adolescent health program that would fall under the prevention umbrella,” and noted the importance of involving the Office of Minority Health (OMH). The prevention focus was reflected also in the suggestions of those who mentioned specific program areas. HIV, preconception health, and other sexual health issues were commonly discussed, and interviewees highlighted CDC, BPHC, OPA, the National Institute for Child Health and Human Development (NICHD), and the Administration for Children and Families (ACF) as agencies to involve. Injury and violence prevention, drug use prevention, and primary care and mental health integration were also identified as prime areas for OAH

*Eager to see OAH coordinate program designs and evaluations, interviewees envision OAH breaking down silos, developing new ideas, and promoting shared information and funding.*

coordination, involving agencies including CDC, SAMHSA, and the Health Resources and Services Administration (HRSA).

A few interviewees stressed in particular the need for OAH coordination of program evaluations, with one commenting that with more coordination, there are more opportunities to collaborate on a common set of outcome measures. Outcomes, it was said, should encompass a broad range of indicators including school performance and drop-out rates. Another emphasized the importance of outcome evaluations being rigorously designed, addressing the right questions, and using the right contractors, which requires individualizing requests for proposals (RFPs) and “not always using the master contractor approach.” It was also mentioned that OAH needs to work closely with CMS and the Assistant Secretary for Planning and Evaluation (ASPE) because there are well-funded activities in these agencies concerned with program design and measurement and adolescent health issues should be part of them.

Importantly, a number of interviewees indicated that greater coordination at the federal level was needed in order to build and support systems of care for adolescents at the state and local levels. In fact, one advocate urged OAH to look to states for lessons on how coordinated services and blended funding happens. MCHB’s Early Childhood Comprehensive Systems (ECCS) initiative was suggested as one effort that has forged a meaningful system of care at the state level and could offer guidance for the federal level. SAMHSA’s Comprehensive Community Mental Health Services Program, more commonly called the Child Mental Health Initiative (CMHI), was suggested as another. It was noted that increased federal coordination would enhance state-level efforts, so that at each level of government “we would be working toward a coordinated, integrated infrastructure.”

### ***RESEARCH COORDINATION***

***Another OAH area of coordination responsibility is research. Are there particular health research issues and agencies that you think OAH should be coordinating?***

Interviewees were generally consistent in their support for OAH leadership in shaping federal research activities on a range of adolescent health topics and interventions and saw the office taking on several different roles. Chief among these was advocacy with individual agencies to



encourage, where appropriate, separate analyses of impacts on adolescents in current research and also to promote new studies on “burning areas of need not being met.” There was concern that adolescent health issues are “underfunded and understudied.” Advocacy was seen by some as a particularly important role for OAH to play with agencies such as NICHD, the Food and Drug Administration (FDA), and the National Institute of Mental Health (NIMH). Another critical role seen for OAH was coordination of research on adolescent issues across HHS. Many interviewees wanted the office to encourage joint research projects and also to promote the use of common methods, age group definitions, and outcome measures among various federal programs. They envisioned OAH providing “guidance on integral partners” that might include SAMHSA, CDC, HRSA, and CMS, and the Agency for Healthcare Research and Quality (AHRQ), and getting “everyone speaking the same language” about the adolescent life stage. They also envisioned OAH engaging local and community-based organizations and provider communities in its research coordination efforts. Finally, a number of interviewees mentioned a need for OAH to support its own research, particularly in the area of implementation and evaluation, as previously discussed with respect to new initiatives. However, the significant challenges that OAH would face in carrying out these roles were also mentioned -- including lack of funding, entrenched agency fragmentation and Congressional mandates, and power and turf issues.

Interviewees actually focused most on recommendations for the essential research topics that OAH should promote. Some mentioned biomedical research areas. A few stressed the continued need for study of the safety and effectiveness of SSRIs and other psychotropic medications on adolescents. Others spoke of the need for new research on the psychobiological underpinnings of various risk-taking behaviors, with several health experts emphasizing obesity in particular and one noting the need to understand whether there is something about the adolescent psyche that causes young people to use food differently from others.

More commonly, though, interviewees wanted OAH to promote research addressing the individual and social determinants of health and focusing on ways to address multiple risk behaviors, rather than individual risks in isolation. They advocated for greater attention on positive youth development, strength-based interventions, and protective factors, supporting the need to build the evidence base for “fostering resiliency” and “promoting healthy youth development, beginning with those most vulnerable to adverse outcomes.” One comment was that we need to know more about the “combination of

*Interviewees want OAH to advocate for greater attention to adolescent health issues in existing research activities, encourage joint research projects, and even support its own research activities.*

events and opportunities and investments that help our young people to become competent, capable, caring human beings,” and another was that we need especially to know more about ways to support healthy development among adolescent males.

Many interviewees also emphasized OAH's role in securing a greater investment in research to increase the effectiveness of health care programs and services for adolescents. An advocate stressed the importance of implementation research, translating and testing findings from basic science to the service delivery settings. “The number of adolescent programs based on good intentions and bad evidence is huge.” Quality measures, financing and insurance, transition from pediatric to adult care, and assuring confidentiality were all mentioned as topics requiring further research to improve adolescent health care. The need for studies on getting adolescents into care and engaging them in preventive care was also mentioned several times. One Hill staff person argued further that “this all needs to be addressed in the context of health reform.” For example, community health center (CHC) funding has increased dramatically under the Affordable Care Act, and research regarding the CHC capacity and outcomes for adolescents served by CHCs is needed moving forward.

### ***TRAINING COORDINATION***

***OAH is also charged with coordinating health provider training throughout HHS to improve adolescent health outcomes. Which professions should OAH focus on and what should be its objective?***

Interviewees addressed that not only the coordination of health care provider training, they were passionate in pointing out the need for major improvements in the content of training as well. Many offered suggestions that envisioned OAH taking on a leadership role that likely would require new legislative and funding authority. They saw significant gaps in the training of future physicians and other health care professionals serving adolescents and also in the continuing education of the current workforce. They wanted OAH to play a major role in shaping training programs to address these problems, working with federal agencies -- HRSA most especially -- and with professional associations and state and local agencies as well. The general feeling was that there is a mismatch between the needs of the adolescent population and the number of professionals with training in adolescent health. One interviewee commented that OAH should evaluate adolescent components of relevant training programs and disseminate best practices;

another urged that because of the shortage of child and adolescent psychiatrists, OAH should examine alternative strategies to meet the mental health workforce needs for adolescents over the next 20 or 30 years; another stressed the need for OAH to look more broadly and assess workforce needs in primary and specialty care and identify mechanisms for incentivizing training in these areas. The concern, however, as one interviewee noted, is that “this will take much more in the way of resources than OAH has right now.”

Most interviewees offered comments regarding physician training. Some acknowledged the tension between focusing attention on training increased numbers of specialists and placing more emphasis on ensuring that generalists are better prepared to care for adolescents. Yet, while acknowledging the need for more child and adolescent psychiatrists and certain other subspecialists to provide clinical care and medical education, almost all interviewees came down on the side of enhancing adolescent health competencies among generalists. This, they believed, would have a greater impact on health outcomes for the adolescent population. They wanted OAH to promote improved training both on mental, behavioral, and emotional disorders and on reproductive care and sexual health. They spoke of the need for significant changes in residency training programs for pediatricians and family medicine physicians, but they also urged greater attention to the care of adolescents in training programs for OB/GYNs and psychiatrists. As a number of interviewees noted, most clinicians currently receive “at most a few weeks training regarding adolescents.”

*A major reshaping of physician and other health care provider training programs is needed to meet adolescents’ needs, according to interviewees.*

In addition to physician training, the vast majority of interviewees addressed the need for improved adolescent-specific training for other clinicians who interact regularly with adolescents -- nurse practitioners, nurses, health educators, psychologists, but especially, social workers. It was mentioned that leadership from OAH could help to minimize the professional turf issues, since “it’s about getting every possible clinician up to speed to provide care correctly and assure coordination... so that teens get appropriate, comprehensive, and culturally sensitive care.” More course offerings and optional adolescent training tracks were mentioned to increase trainees’ exposure to adolescent health issues and to equip them with the necessary skills to care for adolescents. Three clinical experts expressed the hope that OAH could work to expand the Leadership Education in Adolescent Health (LEAH) program which supports interdisciplinary training for clinical professionals across various disciplines.

Continuing education and professional development of the existing workforce was stressed as well, and here the focus was on the broader range of professionals coming into contact with adolescents. Many interviewees mentioned teachers, school nurses, school administrators, and juvenile justice staff in addition to clinicians. They saw OAH playing a leadership role in encouraging pre-service and in-service training programs to help professionals identify high-risk populations and arrange for appropriate treatment, using its influence to ensure that training reflects innovations and best practices. Some interviewees commented that OAH could work to ensure that effective training methods are used, noting also that without ongoing reinforcement and supervision, practice patterns will not change. Interestingly, also, two respondents specifically underscored the importance of training for peer health educators, commenting that teens can be “more effective than professional counselors.”

### ***SYSTEMS OF CARE***

***The IOM report on adolescent systems of care offered a number of recommendations related to improved preventive services and improved models of care and payment. Do you think that these recommendations should be addressed by the OAH and, if so, what should its role be?***

Not all interviewees were familiar with the recommendations of this IOM report, but among those who were, nearly all saw the report as an important source of guidance for OAH in advocating within the Administration for adolescent-focused models of service delivery and payment approaches.<sup>5</sup> Many commented that the IOM report recommendations should be taken very seriously and should at least serve as the starting point for OAH in convening federal agencies and creating an actionable agenda. Interviewees wanted OAH to be the “national focal point” for the promotion of improved delivery and payment arrangements for adolescent health services. “Systems change,” it was said, “requires national leadership,” and the expectation of many interviewees was that only OAH was in a position to provide it. Several interviewees emphasized the opportunities and new resources available as a result of the health reform legislation and urged OAH to address adolescent health objectives through the new model building and reimbursement structures being put into place. There are now significant opportunities for demonstrations and experimentation. A suggestion offered by one expert was that OAH and AHRQ create a joint working group to ensure that reviews of evidence-based practice in delivery and payment “give adequate attention to the needs of adolescents.”

Interviewees wanted to see OAH take up the report's recommendations by promoting effective adolescent health services and models of care and advocating for additional research to provide evidence on promising approaches. Consistent with the report, one expert emphasized that "we have shining examples of coordinated, high-quality health care that must be replicated" to reach more of the adolescent population. Others, echoing the report's research recommendations, underscored the need to generate a greater knowledge base, especially as new funding for primary care innovations is available. They urged that adolescent health topics such as complex and interrelated health needs, effective screening instruments, confidentiality protections, and adolescent-friendly environments be adequately studied. With expansions in school-based health centers and community health centers programs, interviewees wanted OAH to assure that new programs are implemented in a way that meets adolescents' unique health needs and that existing programs are strengthened. In addition, it was suggested that additional funding would be needed but also that OAH could pursue these objectives by identifying opportunities for joint funding.

*Interviewees hope OAH will assert its leadership to promote adolescent-focused models of primary care and payment in the context of health reform.*

Interviewees also stressed the need for OAH to work with CMS and other payers to advocate for payment approaches that can improve adolescents' access to appropriate, quality health care. As the IOM recommendations were published prior to health reform, interviewees expected that OAH would need to revisit the payment recommendations, but they generally endorsed the report in calling for comprehensive coverage and adequate payment for services that adolescents require. One expert said "what is needed is a payment system that creates huge incentives for prevention and health promotion;" another commented that something should be done to address the fact that for adolescents "billing codes often don't cover the problem or the costs involved;" and still another stressed the need to have payment for physicians' cognitive services and not just for tests and procedures. In addition to addressing the adequacy of coverage, a few interviewees spoke about wanting OAH to address the types of adolescent health providers able to receive payment, mentioning that allowing multiple access points that include OB-GYNs and school clinic providers is essential. Several spoke about the need to address the insurance barriers to confidentiality. Regarding Medicaid, one Hill staffer noted that Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) has not been re-examined in many years and suggested that, based on the IOM recommendations, OAH should begin working with CMS to redesign this

important preventive benefit for adolescents. “To the extent that we’ve got evidence on what works, we should use it.”

### *NATIONAL PLAN*

***Under its original authorization, the OAH was charged with developing a national plan for improving adolescent health. Do you think this task should still be carried out by the OAH?***

Nearly all interviewees were enthusiastic about having OAH prepare a national plan to improve adolescent health. Comments were made about how neglected the needs of the adolescent population have been and about how important it is for OAH to pursue its leadership and coordination functions within the framework of a strategic national plan. Many spoke about the value of having a blueprint or roadmap to guide all OAH discussions and actions, noting that it could make government efforts less “ad hoc” and more “intentional” and “synergistic.” One expert commented that a plan is “a way to develop a basic infrastructure for care, for research, for advocacy, and for education.” Others spoke of the benefit that a national plan to improve adolescent health could have to the nation as a whole, making us a healthier and more productive society. Several interviewees urged that OAH begin work on the plan immediately; one said that it “should have started yesterday.” The few interviewees who recommended against the plan basically took the position that a plan was not necessary.

Among those who wanted a national plan, though, the need to focus on adolescent issues broadly and go beyond targets for reducing specific risks and conditions was emphasized often. And just as interviewees wanted the plan to take a holistic view of adolescents and their developmental needs, they wanted OAH to “provide strong, integrative leadership across federal agencies.” As one expert said, “it is timely and important to have some branch of the federal government saying that we should not be treating adolescent problems in isolation, that they are connected.” Another commented that the plan should focus across agencies on three or four major areas that can have maximum impact on promoting healthy development in the second decade of life and setting adolescents on a course for successful life outcomes.

*Most interviewees wanted OAH to prepare a blueprint for integrated action to achieve healthy adolescent development and successful life outcomes but urged the involvement of all relevant stakeholders and adequate funding for implementation.*

Several interviewees mentioned the existence of *Healthy People 2020*<sup>6</sup> and wanted OAH to consult this and also reports from the IOM and the Surgeon General as a starting point for planning and identifying effective interventions. Before bringing together disparate agencies, an advocate said “OAH will first need to figure out the logic model based on desired outcomes.” For one interviewee working on the Hill, though, the real opportunities were in health reform implementation and developing a plan “that could be meaningfully integrated into larger national strategies” involving Medicaid, CHCs, and prevention activities.

Still, many supporters of the plan voiced a few clear caveats. First, to be successful, the plan must be developed with key stakeholders. OAH should reach out to various types of state and community agencies, health care providers, and national experts as well as adolescents and their families, which would help OAH in understanding local differences and the importance of building on existing community strengths. “A lot of voices need to be heard.” Second, OAH must have authority and demonstrate leadership. It needs to assign responsibilities to appropriate federal agencies and show people in the field that there is a plan that everyone is working to implement. The plan itself must be part of a more sophisticated strategy that can engage adolescent health leaders and the public. Third, and probably most important, OAH must have adequate funding, not just for developing the plan, but for implementing it, “because without money not much will happen.” One advocate captured the general sentiment well: “This can’t be just be something that sits on a shelf -- which is too common -- and frustrates people by taking their time, raises their hopes, and then accomplishes nothing.”

## Conclusion

Several themes emerge from the responses of adolescent health leaders to our interview questions. Clearly, clinical and policy leaders in adolescent health see an urgent need for OAH leadership in coordinating HHS activities to improve the health of our nation’s adolescents. Whether in program design and evaluation or in research, they have high expectations that leadership at the level of the Office of the Assistant Secretary for Health can result in greater attention to adolescent health issues, a more targeted and blended use of resources to achieve improved health outcomes, and a stronger focus on building and disseminating evidence for effective interventions. Not surprisingly, almost all interviewees want OAH to prepare with relevant stakeholders a national plan or blueprint to chart a course of action for health care delivery, for research, for training, and for advocacy.

From their responses it is also evident that interviewees want OAH to use its position to help redefine many of our current approaches. Although the need to address many specific health care issues, particularly mental health issues, was mentioned frequently, the need to move HHS agencies to view adolescents holistically and address their problems through comprehensive interventions was emphasized even more, as was the challenge of breaking down existing programmatic silos. Similarly, interviewees stressed the need not only for OAH to coordinate training programs for health providers serving adolescents, but for it to promote changes in content of training to ensure that providers are able to identify, counsel, and treat adolescents effectively. Interviewees acknowledge the challenges facing OAH but believe that with sustained leadership and an adequate budget the office can fulfill its mission and, in so doing, guide HHS agencies in the development of new knowledge and innovative programs that will help to ensure the health and future success of adolescents.



## Appendix: List of Interviewees

### National Professional Organizations

Lawrence D'Angelo, Society of Adolescent Health and Medicine  
 Lisa Goldstein, American College of Obstetricians and Gynecologists  
 Micah Haskell-Hoehl, American Psychological Association  
 Jonathan Klein, American Academy of Pediatrics  
 Kristin Kroeger Ptakowski, American Academy of Child and Adolescent Psychiatry  
 Leslie Walker, Society of Adolescent Health and Medicine

### Adolescent Health Experts

Claire Brindis, National Adolescent Health Information Center  
 Gale Burstein, SUNY Buffalo School of Medicine and Biomedical Sciences  
 Angela Diaz, Mount Sinai Adolescent Health Center and Mount Sinai School of Medicine  
 Sybil Goldman, The National Technical Assistance Center for Children's Mental Health  
 Robert Lawrence, IOM Committee on Adolescent Health Care Services and Models of Care for  
 Treatment, Prevention, and Health Development  
 Kristin Moore, Child Trends  
 Michael Resnick, University of Minnesota School of Public Health  
 Mark Schuster, Children's Hospital Boston and Harvard Medical School  
 Laurence Steinberg, Temple University  
 Kenneth Warner, IOM Committee on the Prevention of Mental Disorders and Substance Abuse  
 among Children, Youth, and Young Adults

### Government, Public Health, and Advocacy Organizations

Tasha Akitobi, National Association of City and County Health Officials  
 Sophie Arao-Nguyen, Family Voices  
 Anne-Marie Braga, National Network of State Adolescent Health Coordinators  
 Sarah Brown, The National Campaign to Prevent Teen and Unplanned Pregnancy  
 Clare Coleman, National Family Planning and Reproductive Health Association  
 Michael Fraser, Association of Maternal and Child Health Programs  
 Linda Juszczak, National Assembly on School-Based Health Care  
 Bruce Lesley, First Focus  
 Carla Plaza, Voices for America's Children  
 Patricia Paluzzi, Healthy Teen Network  
 David Shern, Mental Health America  
 Sandra Spencer, National Federation of Families for Children's Mental Health

### Congressional Staff

Debbie Jessup, Congressional Hispanic Caucus, Task Force on Health and the Environment  
 Andrew Schneider, House Energy and Commerce Committee  
 Britt Weinstock, Congressional Black Caucus Health Braintrust

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## Endnotes

<sup>1</sup> Committee on Appropriations, U.S. Senate. *Report on H.R. 3293: Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill 2010*. 2009.

<sup>2</sup> 42 U.S. Code § 300u-7.

<sup>3</sup> U.S. Congress, Office of Technology Assessment. *Adolescent Health – Volumes I, II and III*. Washington, DC: U.S. Government Printing Office, 1991. Available at [http://www.princeton.edu/~ota/ns20/topic\\_f.html](http://www.princeton.edu/~ota/ns20/topic_f.html). Accessed on December 5, 2010.

<sup>4</sup> National Research Council and Institute of Medicine. *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Washington, DC: The National Academies Press, 2009.

<sup>5</sup> National Research Council and Institute of Medicine. *Adolescent Health Services: Missing Opportunities*. Washington, DC: The National Academies Press, 2009.

<sup>6</sup> Office of Disease Prevention and Health Promotion. *Healthy People 2020 Framework*. Washington, DC: ODPHP, U.S. Department of Health and Human Services, 2009. Available at <http://www.healthypeople.gov/hp2020/objectives/framework.aspx>. Accessed on January 3, 2011.

The National Alliance to Advance Adolescent Health provides education, research, policy analysis, and technical assistance to achieve fundamental improvements in the way that adolescent health care is structured and delivered in the United States. Its mission is to enhance the physical and emotional well-being of adolescents, especially those who are low-income and minority, by improving the health care delivery model for adolescents and achieving the infrastructure changes needed to support it. The National Alliance seeks to promote comprehensive, interdisciplinary models of physical, mental, behavioral, and reproductive health care that incorporate a youth development philosophy and operate in collaboration with schools and other community-based programs. It also seeks to ensure that all adolescents have health insurance coverage for the services they require.

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