Highlights
Chapter I – Fostering Healthy Teens

Between the ages of 10 and 20, youth make transitions through pre-, early, middle and late stages of adolescence, and each stage brings with it a new set of physical, mental and emotional challenges. While most adolescents successfully navigate this transition, a significant proportion take unhealthy or dangerous risks and initiate habits that may lead to chronic illnesses in adulthood.

This chapter explores the characteristics of adolescence and the factors that contribute to or detract from a successful transition from child to adult, and introduces the concept of "best practices."

Colorado Trends

Population

- In 2000, the population of adolescents, ages 10-19, was 622,823, or 14.4 percent of Colorado's total population.
- From 1990 to 2000, Colorado's population of high school-aged children increased by 43 percent, compared with the state's total population growth of 32 percent.
- In 2000, 31.1 percent of adolescents, ages 10-19, were of minority racial/ethnic descent, compared to 24.8 percent in 1990.

Economic Status

- Between 1999 and 2000, in Colorado, an estimated 29,251 adolescents (about 10 percent of the population) lived in families with income below the federal poverty level.
- An estimated 25 percent of adolescents 12-17 lived in families considered to be "near poor," with incomes below 200 percent of the federal poverty level.

Education

- In 2000, there were an estimated 149,000 adolescents enrolled in middle or junior high schools, and an estimated 222,000 adolescents enrolled in high school.
- Colorado ranks a dismal 48th out of the fifty states in the percentage of teens that are high school dropouts (14 percent in 1999).
- About 10 percent of older teens (25,372 teens, ages 16 through 19) are neither enrolled in school nor high school graduates. Almost half of these teens are unemployed.

Best Practices

Best practices are those strategies, activities or approaches that have been shown through research and evaluation to be effective at preventing and/or delaying a risky/undesired health behavior or conversely, supporting and encouraging a healthy/ desired behavior.

- Parent-child relationships are vital to adolescent development and well-being.
- Peer influences are important and can be positive.
- Siblings, teachers and other adults and mentors can provide important support.

Best Practices for Programs

- Young people engaged in programs that build relationships and provide structured activities participate in fewer behaviors that place their health at risk.
- Successful programs target specifically desired outcomes, start early and maintain the effort and implement their services with fidelity to research-tested strategies.
- A positive approach is more likely to engage adolescents and help them to realize their potential and avoid negative influences.

Best Practices for Community Planning

Addressing the health needs of adolescents is best done within the context of community collaboration and planning. These steps assume community and youth involvement.

1. Conduct a community-based assessment and planning process to be sure that you're addressing the adolescent issues that are most appropriate and pressing for the community.
2. Decide whether you'll address the issue directly, or whether you'll try to change the conditions that make it possible.
3. Locate practices or interventions that have successfully addressed the issue in the way you want to address it.
4. Determine what elements of a promising intervention will work in your community, and which ones need to be changed.
5. Implement the intervention, making adjustments as you go along.
6. Evaluate your work and results regularly, understanding that no matter how well any intervention works, it can always be improved.

Websites

Annie E. Casey Foundation
www.aecf.org

Assets for Colorado Youth
www.buildassets.org

Center for Adolescent Health and Development
www.allaboutkids.umn.edu/cfahad

Child Trends
www.childtrends.org

Children Now
www.childrennow.org

Colorado Center on Law and Policy
www.cclponline.org

Community Toolbox
www.ctb.lsi.ukans.edu

Division of General Pediatrics and Adolescent Health
www.allaboutkids.org

Forum on Adolescence, National Research Council and Institute of Medicine
www.nas.edu/nrc

Johns Hopkins Center for Adolescent Health Promotion and Disease Prevention
www.jhsph.edu/hao/cah

Latin American Research and Service Agency (LARASA)
www.larasa.org

Manpower Demonstration Research Corporation
www.mdrc.org

National Coalition of Hispanic Health and Human Service Organizations
ftp://ftp2.smart.net/pub/cossmho

National Institute of Mental Health
www.nimh.nih.gov

Office of Homeless Youth
www.cdphe.state.co.us/ps/pp/tony/homeless/homelesshom.asp

Public/Private Ventures
www.ppv.org

Search Institute
www.search-institute.org

Urban Institute
www.urban.org

Western Regional Center for Drug-Free Schools and Communities
www.wested.org

Youth Development and Research Fund
www.ydrf.com

Chapter I
Fostering Healthy Adolescent Development

Adolescence is a heady time. Exasperatedly dealing with parents; negotiating the complexity of peer pressure; doggedly flaunting (or embracing) convention; surviving hormonal shifts and discovering one's sexuality; struggling with issues about emancipation and independence . . . these are milestones that mark a teen's progress from childhood to adulthood.

KidSpeak

"Teens face these issues each day yet the answers do not get any easier."
Boy, age 16, Adams County

Every domain – family, school and community – influences the developmental process during adolescence. During the second decade of life, between the ages of 10 and 20, youth make transitions through pre-, early, middle and late stages of adolescence within each of these domains. Each transition or stage brings with it a new set of physical, mental and emotional challenges.[1] Fortunately, most adolescents successfully navigate this seeming maelstrom to become healthy, productive adults.

What factors contribute to or detract from a successful transition from child to adult? Are all adolescents alike? When should adults become concerned about a teen's development, and what can they do about these concerns?

How the developmental needs of adolescents are best met within the context of health care delivery is covered in Chapter X — Accessing Health Care: Maintaining Healthy Adolescents.

Population

- In 2000, the population of adolescents, ages 10-19, was 622,823, or 14.4 percent of Colorado's total population. Boys slightly outnumbered girls. (See Figure 1.) An estimated 385,529 adolescents (62 percent) live in the Front Range counties of Adams, Arapahoe, Boulder, Denver, Douglas, El Paso, Jefferson, Larimer, Pueblo, and Weld.[2]
- From 1990 to 2000, Colorado's population of middle school-aged children (ages 12-14) increased by 41 percent; the population of high school-aged children (ages 15-17) increased by 43 percent, compared with the total population growth of 32 percent.[3]
- The population of adolescents as a percent of the total population is projected to stay relatively stable in Colorado over the next decade.[4]
- In 2000, 31.1 percent of adolescents, ages 10-19, were of minority racial/ethnic descent, compared to 24.8 percent in 1990. In 2000, 68.9 percent of adolescents were white non-Hispanic, 20.8 percent were white Hispanic; 5.1 percent were African American; 3 percent were Asian; and 2.2 percent were American Indian.

Colorado Adolescents as Percent of Population, 2000

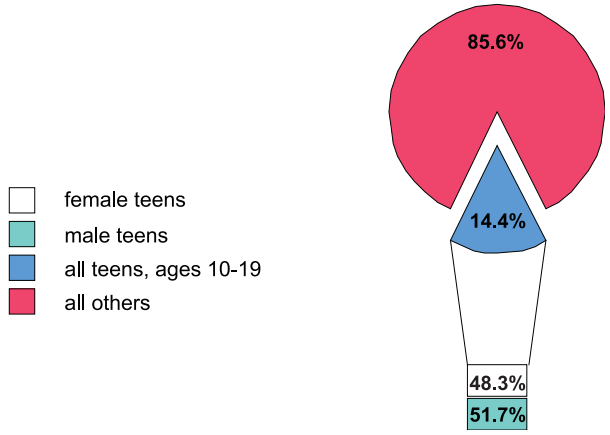


Figure 1: Source: Colorado Department of Local Affairs

This chapter explores answers to these questions in four major sections:

- A thumbnail demographic sketch of Colorado adolescents
- A short description of adolescent development
- The risks adolescents run and the resiliency they need to make a successful transition to adulthood
- Common elements of best practices for programs serving adolescents

You can get more data for your county at the U.S. Census website, Quick Facts for Colorado, at: www.quickfacts.census.gov/qfd/states/08000.html.

Adolescents In Colorado: A Demographic Picture

Economic Security

How well are adolescents doing in terms of living in families who can meet basic economic needs?

- Between 1999 and 2000, in Colorado, an estimated 29,251 adolescents (about 10 percent of the population of teens ages 12-17) lived in families with income below the federal poverty level. (The federal poverty level for a family of one adult and three children is $14,603; to qualify for "welfare" the income level is $8,364.[5])
- An estimated 25 percent of adolescents 12-17 lived in families with incomes below 200 percent of the federal poverty level.
- From October 1, 1999 to September 30, 2000, approximately 24 percent of children receiving "welfare" (Temporary Assistance to Needy Families, or TANF) assistance in Colorado were adolescents between the ages of 12 and 19.[6]
- A variety of state and local programs provide services for low-income adolescents. Safety net supports include cash assistance (Supplemental Social Security Income); nutrition programs (food stamps; Special Supplemental Nutrition Program for Women, Infants, and Children [WIC]; free and reduced price school lunch); health care (Medicaid; Colorado Child Health Plan *Plus;* Title X Family Planning; and federal mental health and substance abuse block grants); housing; childcare; and employment and training programs.

Find out what level of income families need to make ends meet in your county. Check out The Self-Sufficiency Standard for Colorado: A Family Needs Budget at: www.cclponline.org/cfpi/fullreport.pdf.

There is emerging evidence that welfare reform has had some unexpected negative impacts on the well-being of adolescent children of adult recipients, even with family income increases and favorable effects on younger children. Three rigorous experimental evaluations of welfare-to-work programs conducted by the Manpower Demonstration Research Corporation revealed several findings. While these effects were not dramatic, they were worrisome, and call for continuing assessment of the effects of welfare reform on adolescents.

- Decreased academic achievement
- Increases in troublesome behavior, such as drinking, smoking and delinquency
- Increases in harsh or negative parenting behavior
- Decreases in parental supervision[7]

Education

- In 2000, there were an estimated 149,000 adolescents enrolled in middle or junior high schools, and an estimated 222,000 adolescents enrolled in high school (public, private and alternative schools).[8]
- Colorado ranks a dismal 48th out of the fifty states in the percentage of teens that are high school dropouts (14 percent for Colorado in 1999, compared to 10 percent for the United States as a whole).[9]
- About 10 percent of older teens (25,372 teens, ages 16 through 19) are neither enrolled in school nor high school graduates. Almost half of these teens are unemployed.[10]

Find out how many adolescents are in your school district by going to: www.dola.state.co.us/demog/CensusData/SchoolDistricts.htm.

Runaways and Homeless Youth

An unknown, but significant, number of Colorado youth are homeless. A homeless youth lacks a fixed, regular and adequate residence, or has a primary nighttime residence that is in a supervised shelter for temporary accommodations, an institution providing temporary residence or a public or private place not designated for, or ordinarily used as, a regular sleeping accommodation for human beings.[11] While the specific number of homeless youth in Colorado is

unknown, the Colorado Department of Human Services estimates that the number of homeless youth has risen by 39 percent since 1998.[12] This increase is significant because homeless youth are especially vulnerable to health-compromising behaviors and poor health and educational outcomes.[13]

A new opportunity was recently created by the Colorado General Assembly to learn more about, and address the needs of, this vulnerable population. Effective July 2002, an Office of Homeless Youth was created in the Division of Prevention and Intervention Services for Children and Youth at the Colorado Department of Public Health and Environment. The office will provide information, coordination and support services to public and private entities serving the homeless youth of Colorado. It will identify procedural and substantive obstacles to the provision of services and make recommendations for procedural, regulatory or statutory changes to remove them; and it will develop and maintain a clearinghouse of information on services and funding sources available for services to homeless youth.

The Adolescent: A Work In Progress

Adolescence starts somewhere around 10 years of age and continues into the early 20s, depending on who is doing the counting.[14] Whatever the age grouping, adolescence is an explosive period, as both body and mind go though the complex changes necessary to make the successful transition from childhood to adulthood. Youth experience change in three major dimensions: physical change and maturation; development of thinking skills; and psychosocial and emotional growth.[15] Adolescence is also commonly divided into three developmental

Table 1: Stages of Adolescent Development

Stage of Adolescence	Developmental Task	Description
EARLY Ages 10-14	Adjusting to physical and biological changes	• Positive and negative changes in self-image and self-esteem as physical appearance changes; different for boys and girls • Responding and reacting to others' perceptions of them as physical changes occur • Comparing self to peers and worrying about being different
	Developing independence from parents	• Changing relationships with caregivers and other adults • Increased need to have an identity apart from family
MIDDLE Ages 15-17	Developing a new appreciation for peer relationships	• Increased focus on peers for support, companionship and feedback • Adoption of peer lifestyles and codes, including language and dress • Use of peer group as safe haven for testing out decision- making skills, building intimacy and reinforcing self-confidence • Dating begins, and experimentation with risk-taking behavior
	Developing a sense of belonging	Greater need for: • *Physical belonging*, or feeling connected to home, school, neighborhood and/or workplace • *Social belonging* or feeling accepted by family, friends and neighbors by taking part in activities and being useful to others • *Community belonging*, or having access to resources, e.g., social and health services, educational programs and community activities
LATE Ages 18-20+	Achieving a sense of independence or autonomy	• Ongoing effort to define themselves and become individuals with their own perspectives • Development of individual values and beliefs, with the ability and interest to think abstractly and plan for the future
	Beginning to master work and life skills for adulthood	• Participation in challenging, skill-building activities to boost self-esteem, as well as to enhance employment opportunities and a sense of connection to the larger world

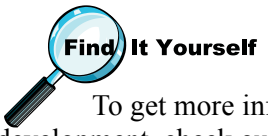
Source: Parents Matter: A Caregiver's Guide to Adolescent Health and Development, Johns Hopkins Center for Adolescent Health Promotion and Disease Prevention (1999)

stages: early, middle and late. At each stage, characteristic changes take place that are essential to understand when helping youth and developing programs to serve them. Table 1 presents a partial summary of some of the characteristics of adolescent development.

Adolescent brain development

"The teen-age years are a kind of critical time to optimize the brain,'' Child psychiatrist Jay Giedd of the National Institutes of Health. *Source: "*Growth patterns in the developing human brain detected by using continuum mechanical tensor maps," *Nature* 404(3):190-193 (2000).

Perhaps surprisingly, adolescence is a critical time for brain development. Experts used to think this just happened in very young children. New research has revealed that teen's brains "grow" predominately in the brain "wiring" for planning, associative thinking, impulse control and reasoning – areas very much at the heart of keeping adolescents safe and healthy.[16]



To get more information on adolescent development, check out this adolescent directory online: www.education.indiana.edu/cas/adol/adol.html.

Adolescence: Risky Business

All adolescents take chances – it's how they learn. Not all risks are potentially health-compromising. Adolescent experiences cover a wide range of risk – from spiking one's hair, to learning how to rock climb, to experimenting with tobacco, alcohol or other drugs. The trick is ensuring that adolescents and their families know the difference; and if the behavior is health-compromising, supports and services exist to avert long-lasting adverse consequences. Vulnerability may increase with the number and intensity of the risks and risks done in combination. Multiple risk behaviors, such as drinking and driving, increase the odds of poor outcomes.[17] "Gateway" behaviors, such as tobacco use, initiated in early adolescence, may lead to riskier behaviors with more serious consequences during later adolescence.[18] (See Chapters II through IX for specific risk behaviors and Colorado statistics.)

Every American child will face a conscious choice whether to smoke, drink, use drugs, engage in risky sexual behavior or put him or herself in a potentially injurious situation before they graduate from high school. "What each chooses will be related to a host of factors, including parent and family engagement, religious and moral values, genetics, learning disabilities and psychological factors."

Source: National Center on Addiction and Substance Abuse, *Malignant Neglect* (2001), p. ii.

What is a risk factor?

A characteristic of school, community and family environments, and of individuals and their peer groups, that is known to predict an increased likelihood of engaging in problem behaviors such as substance abuse, delinquency and violent behavior among youth.

What is a protective factor?

Any personal or environmental factor that exerts a positive influence that reduces the likelihood that a youth will engage in problem behaviors such as substance abuse, delinquency and violence. Protective factors identified through research include certain individual characteristics; social bonding to family, school, community and peers; healthy beliefs; and clear standards of behavior.

How do protective factors help protect against risks?

By reducing the impact of risks, or by changing the way a person responds to risk factors in his or her life. However, increasing protective factors without also attempting to reduce elevated risks may not be sufficient to decrease problem outcomes.

Source: Colorado Youth Survey (2000)

What are "assets?"

In the 1990s, a youth development research organization identified 40 building blocks of healthy development that help young people to grow up healthy, caring and responsible.

- External assets pertain to a teen's environment: family, neighborhood and school
- Internal assets develop within a young person and reflect values, competencies and motivation.

Source: Assets for Colorado Youth, www.buildassets.org

Resiliency and Assets: The Flip Side of Risk

Most youth deal successfully with the risk-taking elements of adolescence, protected by varying influences. A teen's particular genetics, brain maturation and learning styles may allow him or her to make good decisions. Gender, age, race/ethnicity, religious and cultural identity and family and community values all impact adolescents' behavior.[19] Teens' resiliency is influenced by the settings in which they live; their connections to family and friends; and support from community institutions. This concept of resiliency – or protective factors – is also known as developmental assets.[20] Many protective factors are the "flip side" of risks. (See Table 2.) Surveys of thousands of adolescents, both nationally and in Colorado, reveal that the more protective factors, or assets, a young person has, the more likely it is that he or she will do well in school and the less likely he or she will be to engage in risk-taking behaviors.

For information on the Search Institute's 40 Developmental Assets, go to: www.search-institute.org.

Table 2: Resilience Factors that Protect Youth from Negative Life Experiences[21]

Internal Factors

- Social Competence – responsiveness, cultural flexibility, empathy, caring, communication skills and sense of humor
- Problem Solving – capacity for planning, help-seeking and critical and creative thinking
- Autonomy – sense of identity, self-efficacy, self-awareness, task-mastery and adaptive distancing from negative messages and conditions
- Sense of Purpose and Belief in a Bright Future – goal directed, educational aspirations, optimism and tendency to have faith and spiritual connectedness
- Educational Commitment – achievement motivation, school performance and homework
- Positive Values – ideals such as helping people, concern for world hunger, caring about people's feelings and sexual restraint
- Social Competencies – skills such as assertiveness, decision-making, friendship-making, planning; self esteem; and a positive view of the future

Environmental Factors

- Caring Relationships – relationships that convey compassion, understanding, respect and interest, that are grounded in listening
- Messages Conveying High Expectations – firm guidance, structure and challenge, belief in the youth's innate resilience and recognition of strengths as opposed to problems and deficits
- Opportunities for Meaningful Participation and Contribution – involvement in valued responsibilities, making decisions, giving voice and being heard and contributing talents to the community
- Strong, Positive Relationship with Father – significant for both genders, but especially females
- Ability to Seek Reassurance from Peers – able to use friends as a support for dealing with difficulties and as a sounding board for other possible points of view
- Support – family and parents communicate and serve as social resources, parent involvement in school and positive school climate and adult relationships
- Boundaries – parental standards, discipline and monitoring of time at home, at school and with peers
- Structured Time Use – involvement in school, community and religious activities

Recent issues have emerged from studies of risks and resiliency. Overall, teen risk-taking has declined during the past decade with fewer teens engaging in multiple risk behaviors.[22]

- Risk-taking youth may not be the stereotypical "social misfits." Research has shown that many engage in positive behaviors by participating in family, school, religious and community activities. Long-term studies of individual resilience among risk-taking teens consistently identify caring relationships, high expectations and opportunities for participation and contribution as strong protective factors. Evidence of these positive connections presents opportunities for parents, educators, policymakers and health care providers to help teens lead healthier lives.[23]
- Strong family communication and involvement emerge as some of the most protective assets to reduce dangerous adolescent risk-taking.

Myths & Facts

Myth: Multiple risk takers are disconnected from their communities.

Fact: Probably not. A survey of risk-taking teens found that they participated in in-school and out of school team sports (90%), faith institutions (67%), school clubs (45%), and workplace (90% for out of school youth); and that many (63%) were receiving regular health care
Source: LD Lindberg et al.,*Teen Risk-Taking: A Statistical Portrait*, The Urban Institute (2000).

Best Practices

How do parents, educators, and policymakers, teens, and program providers support the positive behaviors of non-risk-taking *and* risk-taking teens? It is precisely because of the powerful influence of both risk and resiliency factors that services for any particular group of adolescents must be thoughtfully designed. Scattered programs, limited funds, complex issues demanding complex solutions and lack of a "silver bullet" for any one teen health issue make this a challenge.

To get the "best bang for the buck," funders favor "model" or "promising" programs that use "best practices." This holds true whether the programs are focused on prevention, intervention or treatment.

- *Best practices* are those strategies, activities or approaches that have been shown through research and evaluation to be effective at preventing and/or delaying a risky/undesired health behavior or conversely, supporting and encouraging a healthy/desired behavior.
- *Model programs* are programs and strategies that credible research illustrates are effective in improving the program's stated outcomes.
- *Promising programs or strategies* are those that have data (preferably quantitative) showing positive outcomes in attaining the goals of the program over a period of time, but do not have enough research data to support generalized outcomes.[24]

Successful programs are specifically tailored to a target audience (e.g., males of color, ages 10-13 in small schools in suburban locations, delivered by males of the same racial or ethnic background). A "model" program may become only a "promising strategy" when even one variable, such as the age of the target group, is changed. It may not work at all if there are too many changes from the original design or implementation of the program. What may be a model program in one set of circumstances

Facts for Families: Thirteen essential rules of thumb for talking with teens about anything

- Create an open environment
- Consider your teen's temperament
- Respect your child's feelings
- Understand the question
- Always be honest
- If you don't know something, admit it
- Don't leave big information gaps
- Use age-appropriate language
- Get feedback
- Be patient
- Say it again and again
- Give them your undivided attention
- Speak separately to kids of different ages

Source: Talking with Kids about Tough Issues, www.talkingwithkids.org

may be best used as just part of a multi-faceted strategy in another.[25]

Should we wonder about some of our expectations? The excitement and challenge of adolescence is that it is transient; the child we spoke to last year is not the emerging adult we are facing today and will not be the young adult we encounter two years from now. . .Why would we expect that the effects of an intervention that "made sense" at age 12 ... would remain compelling at age 19...?

Source: BF Stanton and M Gibson, "The questions we need to ask now," *Archives of Pediatrics and Adolescent Medicine* 155(10):1093-1097(2001).

Improving Outcomes for Teens

In its American Teens series, Child Trends, a non-profit, non-partisan research organization, undertook a comprehensive review of the many contributing influences and programs that lead to positive behavior in seven areas of functioning: mental health, emotional well-being, educational adjustment and achievement, physical health and safety, reproductive health, social competency and citizenship. Based on over 1,100 research articles, the findings identified several characteristics for health program designers, policymakers and parents to use to promote positive adolescent development. Overall, these findings suggest that *relationships* are key to adolescent well-being.[26]

- Adolescent behaviors often cluster. Teens with one positive or negative characteristic have other corresponding characteristics. For example, young people who drink alcohol, take drugs and smoke cigarettes are also more likely to engage in risky sexual behaviors.
- Parent-child relationships are vital to adolescent well-being. Teens who have warm, involved relationships with their parents are more likely to do well in school, have better social skills and have lower rates of risky sexual behavior than their peers. Teens whose parents demonstrate positive behaviors are more likely to engage in those behaviors themselves. Parents who know about and monitor their teen's activities in age-appropriate ways have teens with lower rates of risky behaviors. Teens whose parents are caring and supportive, but who also consistently monitor them and enforce family rules, are more likely to be successful in school and to be psychologically and physically healthy.
- Peer influences are important and can be positive. Adolescents often influence each other positively by modeling behaviors or pressuring each other to behave in certain ways.
- Siblings, teachers and other adults and mentors can provide important support. Siblings can serve as positive models. Mentors can offer friendship, guidance and assistance, and serve as positive role models. Teachers and other adults can serve as surrogate family members and role models.
- Young people engaged in programs that build relationships and provide structured activities participate in fewer behaviors that place their health at risk. Activities that take place during the high-risk hours of 3 p.m. to 8 p.m. give teens something positive to do and leave less time for getting into trouble.
- Successful programs target specifically desired outcomes, start early and maintain the effort, and implement their services with fidelity to tested strategies.
- Thinking positively about teens promotes skills and assets instead of preventing deficits. A positive approach is more likely to engage adolescents and help them to realize their potential and avoid negative influences.

Community Planning and Best Practices

Selecting a best practice, identifying a model or promising program or applying guiding principles takes thought. Those who are funding the program need to know their community

KidSpeak

If teens are heard then assumptions can't be made about us, and people won't be scared that the future is in our hands.
Girl, age 15, Arapahoe County

context. This involves an environmental scan and a needs assessment. What are the community demographics?

- What is it like for an adolescent to live in the community? An adolescent of color?
- What are the risk and protective factors that need to be addressed in the community?
- Who already provides services?
- Who are potential partners? Stakeholders? Allies? Opponents?
- How will the program fit with other activities in the community?

Choosing a Promising Practice or Intervention for Adolescents: 6 Basic Steps

All of these steps assume community involvement, ideally in both planning and implementing an intervention.

1. Conduct a community-based assessment and planning process to be sure that you're addressing the adolescent issues that are most appropriate and pressing for the community.
2. Decide whether you'll address the issue directly, or whether you'll try to change the conditions that make it possible.
3. Locate practices or interventions that have successfully addressed the issue in the way you want to address it.
4. Determine what elements of a promising intervention will work in your community, and which ones need to be changed
5. Implement the intervention, making adjustments as you go along.
6. Evaluate your work and results regularly, understanding that no matter how well any intervention works, it can always be improved.

Source: Community Toolbox, Designing Community Interventions (Part F, Chapter 18, Section 1), http://ctb.lsi.ukans.edu/tools/EN/section_1140.htm

There are many sources of information on best practices in youth prevention activities, both specific and general. Resources on best practices for specific issues are listed in each of the following 10 chapters. Additional information may also be obtained on the Best Practices webpage of the Colorado Department of Public Health and Environment's website at www.cdphe.state.co.us.

End Notes

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9. AECF, *KidsCount 2000*, see note 3.
10. The U.S. Census uses 16 to 19 as its age breakdown for older adolescents. US Census. QT-03. Profile of Selected Economic Characteristics: 2000; Data Set: Census 2000 Supplementary Survey Summary Tables, Geographic Area: Colorado.
11. Colorado Department of Education, *Who Is Homeless?* (2000).
12. The Metropolitan Denver Homeless Initiative and the Colorado Department of Human Services Supportive Housing and Homeless Programs, *Homelessness in the Denver Metropolitan Area – The Changing Face of Homelessness: Third Annual Point in Time Survey*: *Executive Summary* (2001).
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14. For example, researchers from the Colorado Department of Public Health and Environment use 19 as a cut-off point for adolescent health, but they may use age 24 when

looking at injury prevention. Administrators for the Child Health Plan *Plus*, the state's child health insurance program, use 18 as the cut-off.

15. See, generally, Johns Hopkins Center for Adolescent Health Promotion and Disease Prevention, *Parents Matter: A Caregiver's Guide to Adolescent Health Development* (1999); K Soren, "The adolescent years," in *Complete Home Medical Guide*, 3rd rev. ed., Columbia University College of Physicians and Surgeons (1995).
16. See, e.g., Zero to Three, *Brain Development: Frequently Asked Questions* (no date); National Institute of Mental Health, *Teenage Brain: A Work in Progress* (NIH Pub. No. 01-4929) (2001); P Thompson et al., "Growth patterns in the developing human brain detected using continuum-mechanical tensor mapping," *Nature* 404(3):190-193 (2000).
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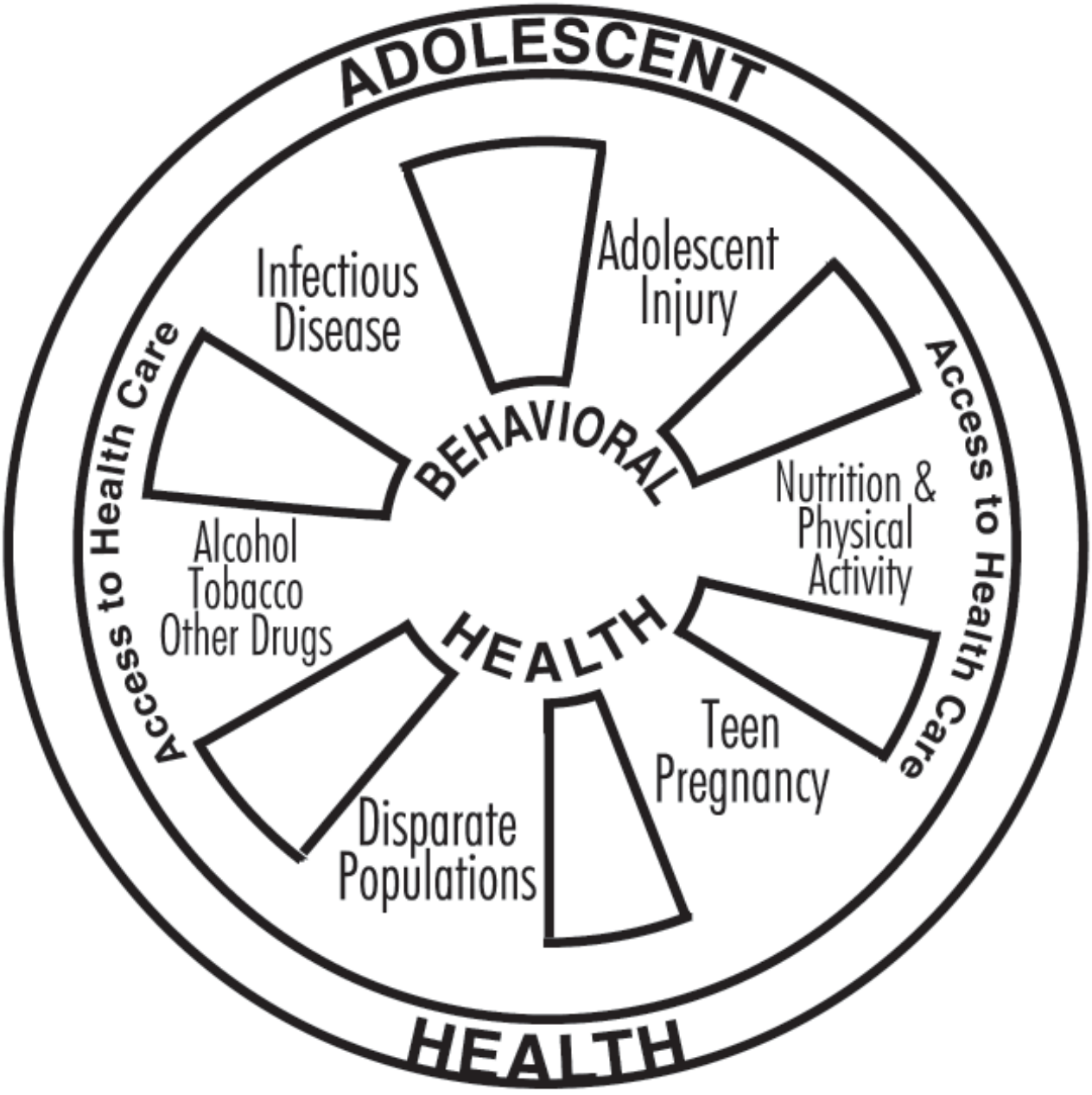
ADOLESCENT
HEALTH
BEHAVIORAL
HEALTH
Infectious Disease
Adolescent Injury
Nutrition & Physical Activity
Teen Pregnancy
Disparate Populations
Alcohol Tobacco Other Drugs
Access to Health Care
Access to Health Care