

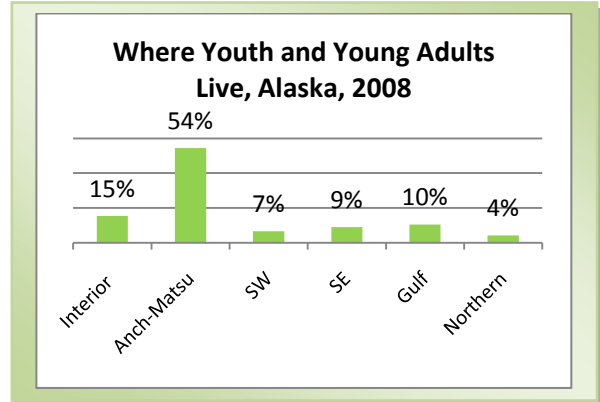


Focus: Adolescents and Young Adults (Ages 10 - 24 years old)

Could a systems approach improve adolescent and young adult health and well-being?

Adolescence is a time of physical and cognitive development when individuals are beginning to take on more responsibility for themselves and developing their own social and moral ideas. "There are multifaceted endocrine, neural, and social changes during and after the pubertal transition that make adolescents extremely susceptible to impulsive and risky behavior, as well as psychological, physical, and emotional challenges."¹

In 2008, there were **153,127** youth and young adults ages 10 through 24 years living in Alaska.² Seventy-nine percent lived in urban areas³ with more than half (54%) living in the Anchorage/Mat-Su Region.



In a recent needs assessment undertaken by the Adolescent Health Program, Alaska teens rated these topics, in priority order, as **the most important health problems** facing teens in their community: 1) Using drugs; 2) Using alcohol; 3) Smoking or using chew tobacco; 4) Teen pregnancy; 5) Being overweight and eating poorly.⁴ When asked the same question, adults listed these priorities: 1) Using alcohol; 2) Using drugs; 3) Feeling Hopeless or depressed; 4) Smoking or using chew tobacco; 5) Teen pregnancy.⁴

What Are Recent National Public Initiatives Around Adolescent Health?

In 2009, the Association of Maternal & Child Health Programs (AMCHP) advanced a proposal to define a comprehensive systems approach to adolescent health and well-being, similar to the approach being applied to early childhood health (Early Childhood Comprehensive Systems Initiative, or ECCS).

The systems approach may integrate elements composed of:

- physical health and medical care
- mental health
- social services
- education
- public safety
- family involvement
- substance abuse
- violence prevention
- job training and skills development.

What does a systems approach mean?

- Create partnerships among federal, state and community service providers to leverage resources and improve coordination and effectiveness
- Develop cross-service systems - break down silo effects, promote integration and multifaceted approaches
- Establish links within the lifespan health model so that the adolescent stage is viewed as part of a lifespan continuum rather than a separate point in time

What Do We Know About Adolescent and Young Adult Behavior?

Much of what we know about adolescent and young adult behaviors and attitudes are from Youth Risk Behavioral Surveillance System (YRBSS), a national school-based survey, and the Behavioral Risk Factor Surveillance System

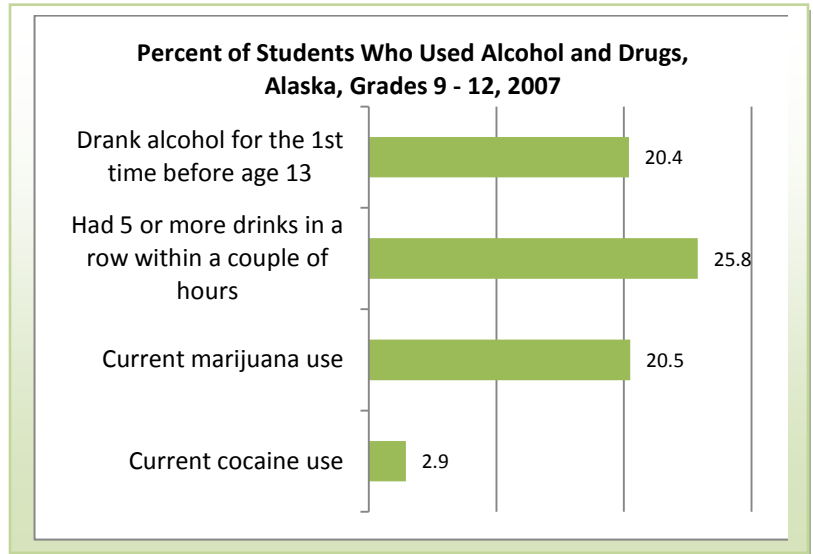


(BRFSS) which surveys adults over 18 years of age. Both are conducted by the Centers for Disease Control and Prevention (CDC) and the AK Dept. of Health and Social Services. Please consult YRBSS (<http://apps.nccd.cdc.gov/yrbss/SelHealthTopic.asp?Loc=AK>) on the exact wording of questions referred to in this sheet.

Substance Use

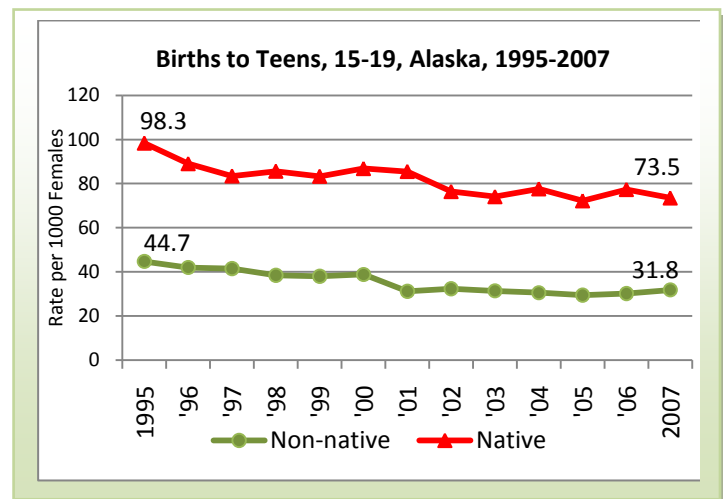
YRBSS data indicate that most behaviors among high school students related to **tobacco**, **alcohol and drug use** were significantly lower in 2007 compared to 1995 but about the same as for 2003.⁵

- The Alaska Interagency Coordination Committee on the Prevention of Underage Drinking prepared a Plan to Reduce & Prevent Underage Drinking. The plan states that "Interventions at the state and local level should include the university system as well as all of the school districts".⁶
- The Division of Public Health, Section of Chronic Disease Prevention and Health Promotion administers youth tobacco prevention programs while substance abuse prevention programs are coordinated through the Division of Behavioral Health .



Pregnancy & Sexual Behavior

Teenage mothers are less likely to receive adequate prenatal and postnatal care, and more likely to experience labor and delivery complications. They are more likely to drop out of high school, making it hard to find and keep a job. National studies demonstrate that communities with lower education levels, higher unemployment, and lower incomes have higher teen pregnancy rates.⁷ In 2007, birth rates among younger teens were lower than the national rate but higher among older teens. The National Campaign to Prevent Teen Pregnancy has identified 10 characteristics of effective sex education programs, including delivering clear and consistent messages, providing accurate information about risks of teen sexual activity and ways to avoid intercourse, and providing practice with communication, negotiation and refusal skills.⁷ National studies also show that teen pregnancy is linked with various types of **violence** including intimate partner violence and sexual abuse, and often leads to other risky behavior.⁸



- Alaska does not have statewide standards for comprehensive sexual health education.



Alaska has had the first or second highest **chlamydia** infection rate in the U.S. each year since 2000. In 2008, 67% of the cases (3,154) occurred in females.⁹ The highest documented infection rates were among females 15-19 and 20-24 years.⁹ Up to 40% of females with untreated chlamydia infections develop pelvic inflammatory disease, which can lead to infertility, pelvic abscesses and chronic pelvic pain.⁹

- Title V funds nurse practitioners to provide reproductive health services (including education and counseling) at the Kodiak Public Health Center and the Juneau High School Teen Health Center.
- Title V staff administers 2 Title X Family Planning grants serving the Mat-Su and lower Kenai Peninsula regions.
- The Adolescent Health Program collaborates with the Division of Public Assistance to provide training, presentations, media campaigns and overall education on teen and non-marital pregnancy prevention and healthy relationships promotion.
- The Reproductive Health Partnership provides reproductive health services (including long acting reversible contraceptives at no cost) in regional areas with high rates of teen and non-marital births.

Injury and Mental Health

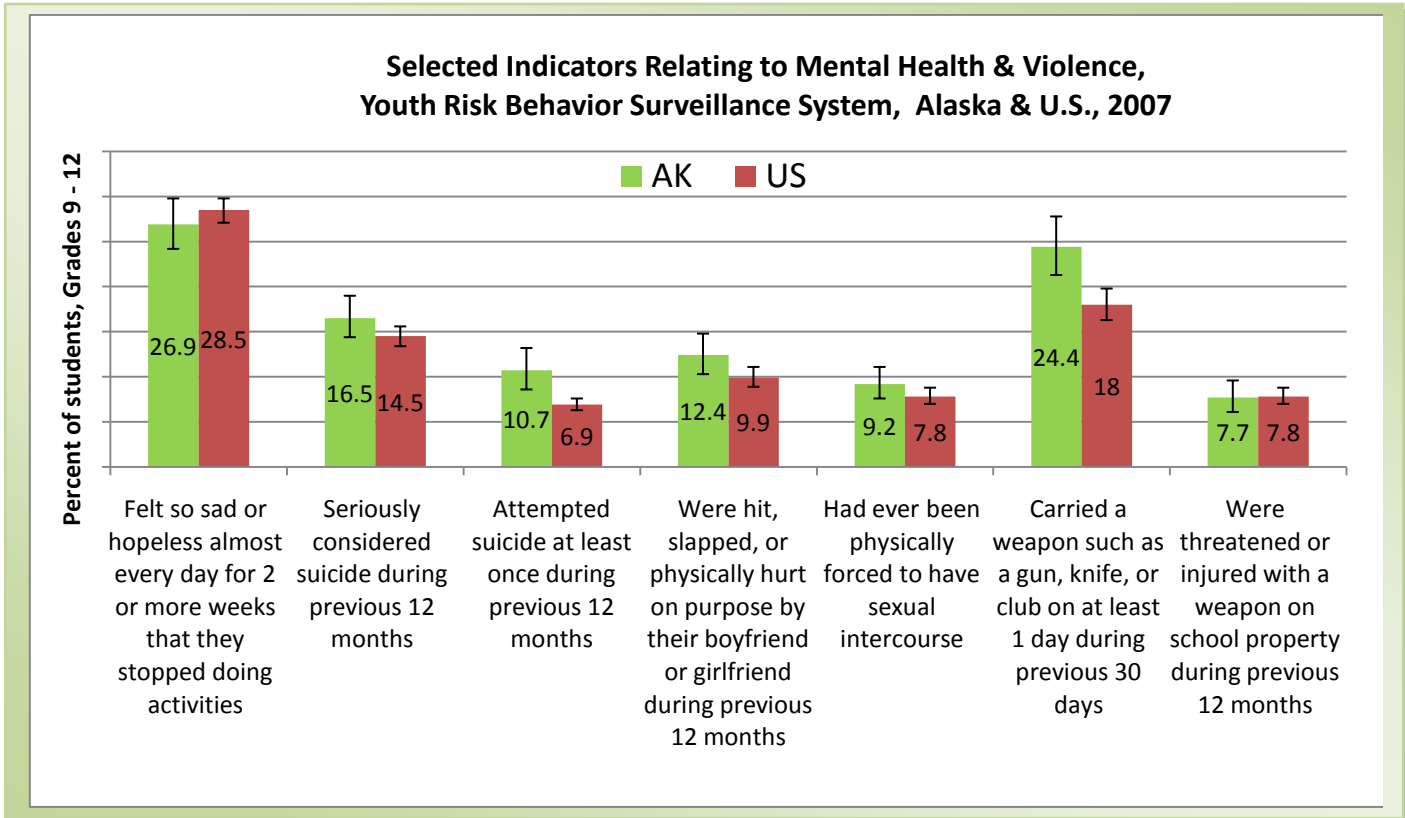
During 1996 - 2005, 82% of deaths among Alaskan teens (ages 15 - 19) were due to three preventable causes of death: **unintentional injury, assault and suicide**.¹⁰ There is a consistent and significant difference in the teen mortality rate for Alaska Native and non-Native teens. During 2003-2005 the Alaska Native teen mortality rate was more than three times the non-Native teen rate (234.2 compared to 69.5 per 100,000 respectively).¹⁰ Risk factors related to unintentional injury include age, male gender, rural residence, poverty, prevalence of risk-taking behavior, and life-styles that involve firearms, use of off-road vehicles, and sports. Behavioral traits such as hyperactivity and aggression are also associated with increased injury risk.¹¹

Alaska's teen suicide and homicide rates did not improve during the decade spanning 1996 - 2005. The suicide rate among Alaska Native teens during 1996 - 2005 was more than 8 times higher than for non-Native teens (110.8 compared to 13.1 per 100,000).¹⁰ The impact of **violence** in adolescence is substantial - victimization during these years is more deleterious than at other times of life.¹ Violence that begins in adolescence can carry forward to adulthood.

- The Division of Behavioral Health, Prevention and Early Intervention Services (DBH) has the primary responsibility for mental health programs. The Division is in the second cycle of a 3-year grant for a Comprehensive Prevention & Early Intervention Services program in FY08. Sixteen community-based grantees typically run programs such as healthy recreation activities, teen centers, sports activities, mentoring and cultural activities. Suicide prevention is integrated with other behavioral health prevention strategies.
- In FY09, DBH received a \$1.5 million, 3-year grant from the federal agency SAMHSA (Substance Abuse and Mental Health Services Administration) to implement the Alaska Youth Suicide Prevention Project. Regional suicide prevention teams will be developed to implement a community-based planning model, the Strategic Prevention Framework. Special emphasis will be placed on high risk youth populations. The UAA's Behavioral Health Research Services will conduct program evaluation.¹²



- There has been an overall decrease in teen mortality due to unintentional injury during 1996 - 2005. Injury prevention programs implemented to date include the graduated driving license, a bike helmet and seatbelt laws, and enforcement of alcohol laws.



Education

Research has shown that higher education attainment is a protective factor across the entire health spectrum. Alaska's high school drop-out rate is one of the highest in the nation. In the 2007-2008 school year there were 61,823 children enrolled in grades 7 - 12. Five percent, (3,283) dropped out. Alaska Native students had the highest drop-out rate (8.5%) and black students had the second highest dropout rate (7.1%).¹³ Many improvements to the state's educational system have been made since statehood, yet many challenges remain. About 39% of K-12 students are considered low income based on how many receive free or reduced price school lunches.¹⁴

- State school aid peaked in 1983. Almost all increases in state aid have gone to rising costs of employee retirement and medical plans.¹⁵
- High-risk students are less likely to drop out if enrolled in career and technical education (CTE), but Alaska has fewer high-school CTE teachers and courses than it used to.¹⁵
- UA has a scholars program that awards free tuition to high school graduates in the top 10% of their class. Alaska is one of only two states that does not have a needs-based student aid program.¹⁵



Related Title V State Priorities, 2005-2010

- Reduce the rate of child abuse and neglect.
- Reduce the rate of unplanned and unwanted pregnancies including teen pregnancies.
- Reduce the rate of teen suicide.
- Increase awareness around mental health issues in the MCH population.

Related Title V State Performance Measures, 2005-2010¹⁶

4. Rate of substantiated reports of harm to children per one thousand children age 0 to 18.
 FFY 2007 - 15 per 1,000 FFY 2008 - 18 per 1,000

Related Title V National Performance Measures, 2005-2010¹⁶

8. Rate of birth (per 1000) for teenagers aged 15 through 17 years.

Year	Rate	Number
2001	19.1	301
2002	19.8	316
2003	20	320
2004	17.6	286
2005	17.3	289
2006	18.6	315
2007	16.0	271

10. Rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

Year	Rate	Number
2003-2005	6.5	31
2004-2006	5.0	24
2005-2007	4.1	20

#13. % of children (0-18 years) without health insurance.
 2005 - 9.2% 2006 - 9.4% 2007 - 11.2%

#16. Rate (per 100,000) of Suicide deaths among youths aged 15 through 19.

Year	Rate	Number
2003-2005	32.6	53
2004-2006	28.5	47
2005-2007	22.9	38

References

¹ Association of Maternal & Child Health Programs. Make the Case: A Comprehensive Systems Approach for Adolescent Health & Well Being". Summary Document. May 27, 2009.



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- ² AK Dept of Labor, population estimates, July 1 2008. Chart based on ages 10 - 24 years.
- ³ Urban area is defined here as Municipality of Anchorage, Mat-Su Borough, Fairbanks North Star Borough, Kenai Peninsula Borough, and City/Borough of Juneau.
- ⁴ correspondence, S Wenzel, AK DHSS, Section of WCFH, 9/14/2009.
- ⁵ AK DHSS, Section of Women's Children's and Family Health. Youth Risk Behaviors in Alaska -Tobacco Use, Alcohol Use, Drug Use. Vol 2 No 37, Aug 2008.
- ⁶ AK Interagency Coordinating Committee on the Prevention of Underage Drinking. Plan to Reduce & Prevent Underage Drinking. November 2007. Available at http://www.hss.state.ak.us/dbh/PDF/Underage_Drinking_Plan_11-07.pdf.
- ⁷ Kirby D, Trocoli, K.(2003). Progress Pending: How to Sustain and Extend Recent Reductions in Teen Pregnancy Rates. Washington, DC: National Campaign to Prevent Teen Pregnancy.
- ⁸ National Campaign to Prevent Teen Pregnancy. Why It Matters: Teen Pregnancy and Violence. Available at <http://www.thenationalcampaign.org/why-it-matters/pdf/violence.pdf>.
- ⁹ Centers for Disease control and Prevention. Sexually Transmitted Disease Surveillance. Atlanta, GA: US Dept of Health and Human Services, Division of Sexually Transmitted Diseases. November 2006.
- ¹⁰ Schoellhorn KJ, Perham-Hester KA, Goldsmith YW. AK Maternal and Child Health Data Book 2008: Health Status Edition. Anchorage, AK. Maternal and Child Health Epidemiology Unit, Section of Women's Children's and Family Health, Division of Public Health, AK Dept of Health and Social Services. December 2008.
- ¹¹ AK Adolescent Advisory Committee. Adolescent Health Research Updates, Supplement No 2, January 1997. Available at http://www.hss.state.ak.us/dbh/prevention/publications/resiliency/update_UIAA.pdf.
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- ¹⁵ Hill A, Gorsuch L, Killoran M, Cravez P. The Case for Strengthening Education in Alaska. UA Policy Brief, November 2006. Institute for Social and Economic Research, UAA, Anchorage.
- ¹⁶ State of Alaska, Section of Women's Children's and Family Health. FY 2010 Title V Block Grant application.