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Adolescent Health

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What's Inside...

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Adolescence: A Critical Period for Public Health Intervention

By Lori Tremmel Freeman, Chief Executive Officer, NACCHO

Adolescence is a critical period of human development—marked by significant biological, cognitive, social, and emotional changes in which young people prepare for adulthood by engaging in new experiences and taking on new responsibilities. As adolescents explore their burgeoning independence, they navigate new social, economic, and educational environments, and develop stronger relationships with peers and others outside of the home. Universally, there is no standard definition of what ages comprise "adolescence," but the World Health Organization states that the most consistent range is between the ages of 10–19 years, with further divisions for early adolescence (10–14 years), and late adolescence (15–19 years).[1]

Although adolescence typically represents a healthy stage of life, with 83% of adolescents ages 12–17 described as being in "excellent or very good health" by their parents, the health risks for adolescents are closely linked to the biological, neurological, and hormonal changes they experience. While exploration is a natural part of adolescent development, these risk-taking behaviors are also linked to the leading causes of adolescent morbidity and mortality.[2,3] Young people age 15–24 account for half of all new STI infections.[4] Suicide rates among 12–19-year-olds have increased 87% between 2007–2017.[5] Though rates of illicit and prescription drug use and alcohol use have decreased among teens, e-cigarette use is skyrocketing, with a 78% increase among high school students in just one year.[6] Many of these negative health outcomes and the behaviors that contribute to them often begin or worsen in adolescence; thus, adolescence is a critical point for health promotion and

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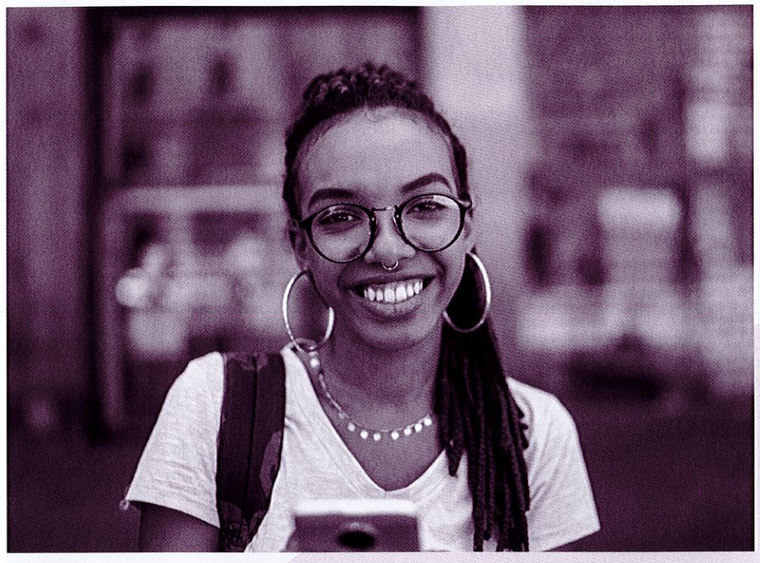

intervention. Conversely, adolescence provides a unique opportunity to recover from adverse childhood events, strengthen resiliency, and develop healthy lifestyle habits resulting in positive outcomes. While the implementation of the Affordable Care Act led to an increase in well-visit rates among adolescents, with the greatest increases among minority and low-income groups, adolescent preventive care rates remain low,[7] and further efforts are needed to ensure that this critical checkpoint is available to adolescents.

Despite adolescence being a critical time for intervention, adolescents are rarely prioritized in public health initiatives. This oversight is due to several factors, including a lack of designated funding at federal, state, and local levels and a hesitancy to engage with controversial topics such as adolescent sexual health or harm reduction. Additionally, while many conditions emerge in adolescence, outcomes are typically worse among adults, thus treatment is prioritized over prevention. Where adolescent health efforts exist, they are often top-down initiatives developed without adolescent input, resulting in programs and services that are ineffective or underutilized. Often, practitioners and decision-makers scorn adolescents for their poor health-seeking behavior and choices, rather than question how programs and services might have missed their mark.

Adolescence: Reframing the Narrative

Attitudes regarding adolescents are typically negative. In popular culture, they are often depicted as apathetic, entitled, risky, and lazy. However, these perspectives miss critical context, for example, that real or perceived apathy may result from a failure to effectively engage young people in decisions that impact them, or that risk-taking is developmentally appropriate and often even advantageous. Communities across the country are being ravaged by an opioid crisis that is overshadowing a worsening stimulant epidemic, grappling with school and other mass shootings, and coping with the aftermaths of natural disasters of increasing frequency. Adolescents are growing up in a turbulent time without the certainty of stability and consistency due to situations beyond their control. Furthermore, they are at the mercy of policy decisions for which they are deemed too young to vote. Yet some of the greatest social changemakers in recent years have been adolescents, such as Marjorie Stoneman Douglas students in Parkland, FL, galvanizing the gun control movement and Greta Thunberg of Sweden demanding action against climate change. When adolescents are empowered to act, people take notice.

Meaningful Youth Engagement

Effective youth engagement requires that adolescents are meaningfully involved in all levels of planning and decision-making and share authority with adults. Engagement means more than hosting a single focus group—it requires adults to recognize that young people have expertise and competence. Different levels of youth engagement are described in Roger Hart's seminal "Ladder of Participation," the eight rungs of which range from manipulation, decoration, and tokenism as examples of non-participation to youth-initiated, shared decision-making with adults as the highest degree of participation. While most youth engagement efforts tend to fall between "tokenism" (rung #3) and "consulted and informed" (rung #5), the most effective efforts include the highest levels of participation.[8]

Local health departments (LHDs) are uniquely positioned to promote adolescent health and well-being in their communities. LHDs have strong and diverse cross-sector partnerships, are experienced at identifying and engaging priority populations, and recognize the critical importance and opportunity of prevention. These characteristics are critical for a comprehensive approach that centers young people and effectively addresses upstream factors that impact health across the lifecourse.

LHDs most frequently work on adolescent sexual, mental, and behavioral health, including substance use; however they often face barriers to this work, including inadequate or inflexible funding, insufficient prioritization of adolescent health, and challenges related to strengthening partnerships with schools and mental and behavioral health providers. LHDs and other stakeholders are often hesitant to engage in adolescent health initiatives due to real or perceived backlash from parents and other community members, and while these

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challenges are real, most families are overwhelmingly supportive of efforts to improve adolescent health outcomes.

While many LHDs engage adolescents in this work, sustained, meaningful youth engagement requires transformative approaches, including establishing infrastructure or changing protocols and procedures to ensure that young people are engaged at all stages, from planning to implementation to evaluation, and that their expertise and input are not merely collected, but reflected in decision-making. While this work can be time and resource intensive, it is critical to the success of adolescent health initiatives and represents an investment in the health of the community for decades to come.

This issue of *NACCHO Exchange* will highlight how adolescents' engagement in LHD public health efforts has led to positive health outcomes and successful policy change. Each story is an example of meaningful youth engagement, in which adolescents and adults are allies in seeking positive change for various public health issues.

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Helpful Practices for Involving Youth in Public Health Advocacy

By Whitney Greger, MPH, CHES®, Health Education Program Coordinator, Champaign-Urbana Public Health District; Talia Shaw, Health Educator II, C-UPHD; Kami Lafoon, LSW, Special Projects Coordinator C-UPHD

Program History

As part of their Illinois Tobacco-Free Communities grant from the Illinois Department of Public Health, the Champaign-Urbana Public Health District (CUPHD) collaborates with local schools to implement a curriculum called *Engaging Youth for Positive Change* (EYPC). EYPC is a program for ages 13–18 that teaches the importance of advocacy and civic engagement, and provides a framework for youth to learn about, participate in, and change a local health-related policy. By engaging youth directly in a collaborative, community-based change effort, EYPC aims to give young people the skills, confidence, and experience they need to become effective advocates for positive social change.

Champaign-Urbana Public Health District has implemented the EYPC curriculum in area schools since 2014. For the past two years, CUPHD has worked with high school seniors in government classes at Centennial High School in Champaign, Illinois. Visiting health educators from CUPHD facilitated the curriculum throughout the semester, during which students learned about a local tobacco-related issue, examined government systems and their role in communities, researched and collected data, and developed an advocacy message. The goal of EYPC is for students to finish the program with a youth-powered presentation to a council or board advocating for policy change.

In May 2018, Centennial students presented to the Champaign City Council during audience participation, advocating for e-cigarettes to be prohibited anywhere smoking

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is prohibited under the Smoke-Free Illinois Act. The Council determined this was a proposal worth further consideration and conducted a study session on the topic in January 2019. Council opinion following the study session was favorable and another study session was discussed. CUPHD staff are currently determining the best way to re-introduce this topic to the city council, as the issue of e-cigarette-free public spaces is now working its way through the state legislature.

In May 2019, another class of EYPC participants at Centennial presented to their school administrators and other school staff about the discipline schedule for vaping-related offenses. They proposed to change their school's policy to be more education-focused and assist students with accessing cessation resources. Following the presentation, staff determined that prevention education regarding e-cigarettes should be added to the freshmen health curriculum.

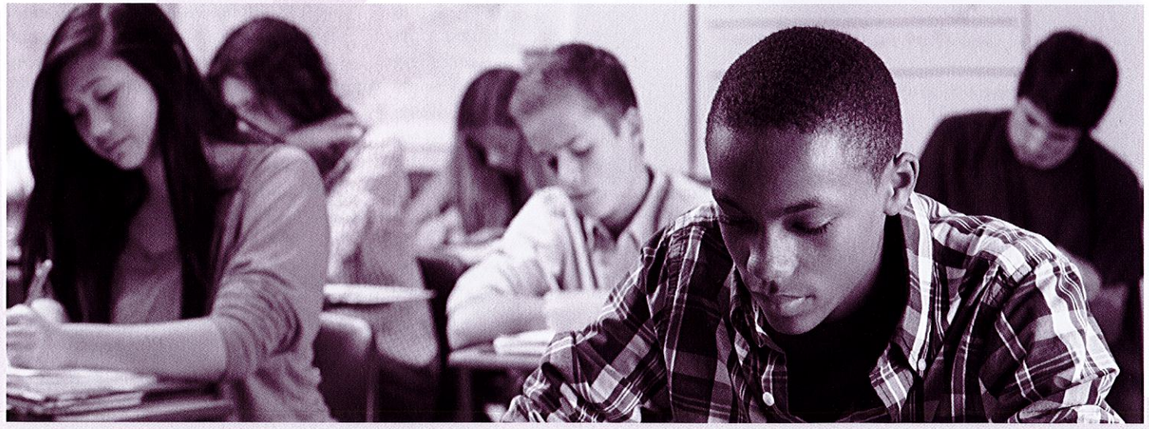
Prior to working with Centennial High School, CUPHD implemented EYPC at JW Eater Junior High School in Rantoul, Illinois, first as an after-school program and later as a project for the school's National Junior Honor Society group. These groups advocated for smoke-free parks, tobacco counter-marketing, and Tobacco 21 policies in Rantoul. In fact, it was an EYPC group's presentation to the Rantoul Park District Board that led to Rantoul passing a smoke-free playgrounds policy.

In recent fiscal years, CUPHD has been involved in more macro policy work through their Tobacco-Free Communities grants with a targeted emphasis on preventing youth use of e-cigarette products, allowing for a great opportunity to implement the EYPC programming.

Why This Work Is Important

With the continued rise in popularity of e-cigarette devices being used by youth, CUPHD views the EYPC programming model as an integral tool in creating change throughout the community to address this public health concern. CUPHD staff can work directly with teens who have first and second-hand knowledge of youth vaping practices, which can allow for a more personal development and delivery of policy initiatives. During the 2017–2018 school year, local health department staff were able to come to the classroom to discuss relevant health information on the dangers of e-cigarette use, which was then combined with the student's personal experiences and knowledge to form the best advocacy message to present to the city council. By having youth at the forefront of this civic engagement process, decision-makers

Without educational cessation-based interventions, a student is not likely to quit vaping after being caught on school premises, so school policies should better reflect that notion.



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are better able to understand health policy issues from the perspective of a young person and how such laws affect their lives.

It would be no surprise to a city councilperson that a professional in the public health field is in support of prohibiting the use of e-cigarettes in public spaces, but that city councilperson may feel more affected by groups of teens supporting the same mission. In May 2018, EYPC participants were able to articulately discuss to the city council their experiences with vaping, and how the use of e-cigarettes had become a social norm in their high school. Through this process, city council was better able to understand the daily lives of high schoolers and the ways the rampant use of e-cigarette devices is negatively affecting them and their classmates.

Similarly, in the 2018–2019 school year, EYPC participants advocated for a change in their school policy to be less punitive towards student caught vaping on campus and shift towards a more restorative approach to better instill healthy behaviors and coping skills. Best practices show that suspending or expelling a student for vaping in school does not improve behaviors, and this was not being administered in a fair or just process. Without educational cessation-based interventions, a student is not likely to quit after being caught vaping on school premises, so school policies should better reflect and support that concept.[1]

After LHD staff provided evidence and further information to their EYPC group on alternative measures to suspension, those participants created marketing and survey materials to gather opinions from students, staff, and the administration on its current punitive processes that were translated into presentation materials to the school administration. The ethos of EYPC is to have program participants be fully involved in defining their issue, determining the important decision-makers, discovering relevant data, and then delivering their message. During their presentation to the school administration, EYPC students showcased just how much effort and thought they put into their advocacy message to improve the school environment. With this presentation, the school administration recognized that this project was more personal to the students and went beyond receiving a grade, because it was going to create a longer-lasting legacy for future school cohorts.

Through the EYPC programming model, decision-makers see that young people are in fact invested in the betterment of their communities and want to live and thrive in a community where those in power are listening to and respecting the views of its younger generations.

How Local Health Departments Can Use EYPC

The EYPC curriculum is designed to prepare youth to be advocates for change; it can easily be used as a guide for any advocacy initiative. If used specifically for a health-related concern, the program can be an incredibly useful tool for LHDs involved in policy work. In fiscal year 2019, EYPC was implemented across 13 counties in Illinois, many by LHDs, and served over 630 youth. LHDs that are Tobacco-Free Communities grantees are limited to collaborating on a tobacco-related policy with youth participants, but other EYPC sites in the state have been successful in advocating for healthier food options in schools, more accessible bus stops,

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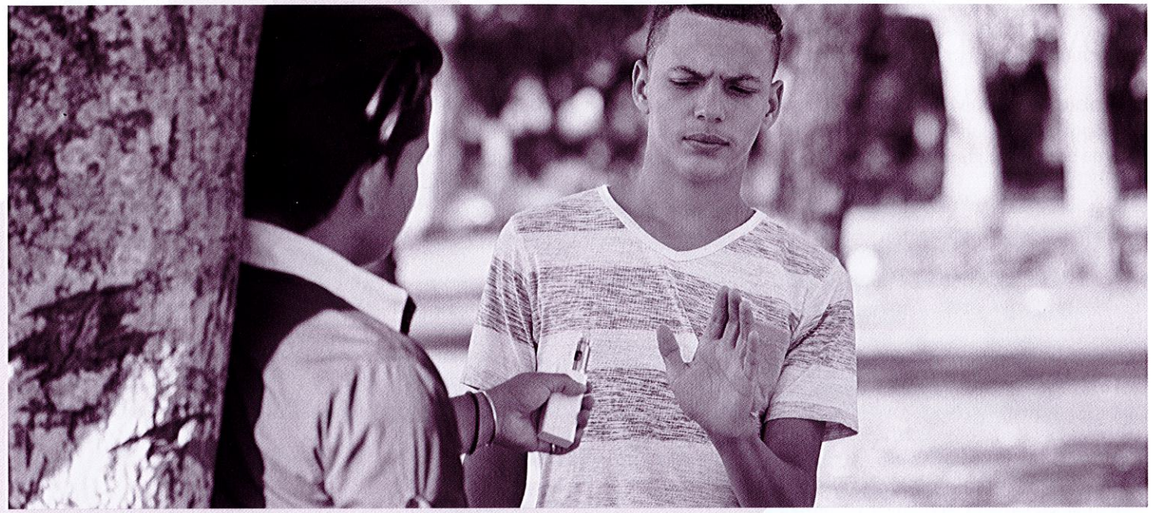

cleaning up a neglected bridge, limiting the use of single-use plastics, and various other community restoration projects. At CUPHD and other LHDs implementing the EYPC curriculum, bringing youth to the table is a unique and impactful way to bolster in-progress policy change initiatives.

Establishing Partnerships with Schools

A vital, and often challenging, element of getting a new EYPC program off the ground is selecting a group of youth to work alongside. The curriculum allows for flexibility of use with any group of teens ages 13–18—for example, a Boys and Girls Club, a scout troop, a church group, or an after-school program. CUPHD has found success implementing the program in established clubs and classrooms in a school setting. They piloted EYPC as an after-school program, followed by two years of working with that same school's National Junior Honor Society. The most recent two years of the program were implemented in a government and civics class with high school seniors.

CUPHD found it beneficial to pilot EYPC in a school where they had already formed a partnership. The program was proposed to a health teacher the facilitators had worked with previously; the rapport that existed likely boosted the school's buy-in for the new program. After completing the first year (and passing a smoke-free playgrounds ordinance), CUPHD had the evidence needed to improve implementation and hone the ideal group and setting. The first year's success was touted when new program sponsors were sought in the years to follow.

If an LHD is interested in partnering with a school on a program like EYPC, there are several ways to make the connection. First, use the partnerships that already exist with schools or teachers through other public health initiatives. Teachers whose classes or clubs are related to health or civics are great places to start, such as PE/health, student council, key club, and social studies. Explain the program in detail to the teacher so they understand how it relates to their students, what the time commitment will be, and how it can be implemented seamlessly into their plans. If a LHD does not have any connections within the schools, draft an "invitation" that includes how the program could satisfy community service hours, a civic engagement project, or other education mandate. Send the invitation through mail or e-mail to school administrators and teachers who may benefit. Expect that finding a group may take some time and effort initially, but once a solid foundation is formed, the program can become an ongoing component of that class or club.

Impact

The benefits of a youth advocacy program like EYPC are many. It is a creative and impactful way for a health department to strengthen in-progress policy change initiatives and make new connections with local governing bodies, schools, and youth-serving organizations. Moreover, it is a fresh way to empower young people to be change agents. The program asks teens to think about what matters to them in their community and how their voice is unique. Additionally, it gives them the information, resources, and encouragement to turn those thoughts into action they are able to build on throughout their lives.

For more information on EYPC, visit https://eypc.cprd.illinois.edu/.

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Engaging Youth to Assess Their Own Health: A Novel Approach to Health Assessment in Denver

By Abbie Steiner, MS, MPH, Epidemiologist, Denver Public Health and Denver Department of Public Health & Environment

Denver Public Health (DPH), a department within the Denver Health and Hospital Authority, and the Denver Department of Public Health & Environment (DDPHE), a charter department of the City and County of Denver, work collaboratively to provide public health services that promote, improve, and protect the health and well-being of its residents. Through the combined programs of these two public health agencies, Denver residents have easy access to high quality public health services in community, clinical, and environmental settings.

DPH and DDPHE collaborate on the essential public health function of community health assessment. These resources, designed to provide a comprehensive and clear understanding of the health status of Denver residents, have been produced every three to five years since they were mandated by state law in 2008. Health assessments have helped to shape community health improvement plans, and have supported organizational efforts to achieve and maintain public health accreditation.

Past health assessment efforts, especially the *2014 Health of Denver Report*, placed a high priority on health equity and the social and economic barriers to health by measuring the link between determinants such as income, education, housing, and transportation and health outcomes.[1] In highlighting disparities in health outcomes for Denver residents, these assessments help stakeholders understand how health is affected by socio-economic status and events both inside and outside of a medical

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office. They also shed light on how much health varies based on where one lives.

Previously published health assessments provided a large amount of useful data; however, there were some limitations to the way they were developed and how the information was presented. Specifically, past health assessments in Denver missed the opportunity to:

- Take a sufficiently deep dive to explore health issues facing a specific group.
- Engage community members to actively participate in and lead the assessment process.
- Ask the target population to define assets and protective factors for success.

While DPH and DDPHE were reflecting on the limitations of previous assessment efforts, the organizations were considering how they could better understand the needs of young people in Denver when designing the programs and initiatives meant to serve this population. To develop a solution both to limitations of previous health assessment processes and to the dearth of information available to better understand the health experience of Denver's youth, DPH and DDPHE committed to conduct a different type of health assessment implemented by and focused on Denver's young people. This Youth Health Assessment (YHA) model and report was developed, conducted, drafted, published, and disseminated over the course of two years, from August 2016 through August 2018.

To most effectively empower young people to collaborate on all aspects of the assessment process, DPH and DDPHE adopted a community-based participatory research (CBPR) framework. Using CBPR requires the participation of community in all aspects of the work. Typically focused on research, CBPR identifies a community, builds on its strengths and assets, facilitates collaboration, seeks mutual benefit and well-being, promotes iterative co-learning, recognizes multiple factors affecting health, and shares ownership of findings with all participants.[2] It was decided that a team of young people who either live, learn, or work in Denver would be employed to drive the health assessment process. Recognizing the unique strengths and perspectives that youth offer and to uphold the commitment to CBPR, it was decided that this group of young people would share decision-making power with public health staff for each component of the project.

The YHA model was divided into six phases. The first phase focused on youth leader recruitment and training. To implement this phase, DPH and DDPHE recruited a group of youth from across Denver to participate in a Youth Leadership Team (YLT) and lead this work. More than 100 young people applied to participate. Thirty were interviewed at two group interview sessions and nine were then hired based on their:

- Ability to think critically about what shapes health;
- Ability to connect with a wide range of youth communities from many backgrounds and parts of the city; and
- Capacity to actively participate on a team with young people and professionals from a wide variety of backgrounds.

Once hired, the YLT met regularly from January 2017 through August 2018 and guided this work as paid consultants and subject matter experts. Before beginning the formal assessment process, the YLT was trained in assessment research and on the social and economic barriers to health. Time was also spent setting expectations, building trust,

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By engaging young people directly, this YHA ensured that identified issues and opportunities aligned with youth-defined needs and desires for improvement and change.

and establishing the youth-adult partnership based on principles of Positive Youth Development.[3]

The next phase focused on data collection. The youth leaders worked together to decide that they wanted to learn more from their peers about how to better understand issues facing youth health in Denver and how young people in Denver define youth success. The team decided to conduct a paper survey that they distributed to their peers at school, during extracurricular activities, at the community spaces where they gather regularly, and at community events focused on teens. Halfway through data collection, they realized that they wanted to hear more from young people that they were otherwise not hearing from; most notably, young people touched by the criminal justice system, and young people from immigrant or refugee families. To do this, DPH set up listening sessions with organizations serving those populations, and YLT members engaged in more open conversation about the survey questions. To complement the data collection effort conducted by the youth leaders, the public health staff supporting this project interviewed leaders from youth-serving organizations around Denver to garner their thoughts on the two main questions asked of youth, along with a question about how a report about youth health could be most useful to them.

In the third phase, both the youth team and the public health staff team engaged in analysis of the qualitative data that each collected, first independently and then collaboratively. Using grounded theory, both teams reviewed their data and allowed themes to arise through group discussion. Following these efforts, youth leaders led a conversation with public health staff to synthesize key strengths and challenges in youth health. After crystallizing the key themes, in the fourth phase, public health staff identified quantitative data that could help complement the stories told through the thematic analysis of the qualitative data, and relevant sources were analyzed and organized for further interpretation by the youth leaders.

For the fifth phase, public health staff drafted report text and worked with the youth team to edit and revise each version until it represented their voice and best conveyed the key findings of the research. At the same time, the youth leaders partnered with members from an external graphic design firm to collaborate on the look and feel for the final report product as well as a video that shared the key messages in a more dynamic format. Once both the report and video were completed, the youth leaders presented their work and the key findings from the research in a final phase focused on dissemination. They shared their experience at a formal launch

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event, in which over 100 individuals from youth-serving and public health organizations across the Denver metro region joined in to learn about this work and brainstorm about their experience. They then presented to the Denver Board of Health, to the boards of multiple foundations, and then at several conferences focused on advancing public health practice.

By engaging young people directly, this YHA ensured that identified issues and opportunities aligned with youth-defined needs and desires for improvement and change. The YHA highlights ways in which young people described success, while illuminating some key challenges facing Denver's youth that differ from Denver's adult experience. To uphold the organizational commitment to CBPR, the YLT played an equal role in all decisions made about how to conduct and finalize this project. The YHA effectively tested a model for health assessments focused on a specific population or health issue and that engage relevant community members directly in the process of assessment creation. Since the publication of the YHA in January of 2018, many aspects of the model have informed other efforts implemented by the public health agencies in Denver, and both organizations have made a stronger commitment to engaging people from communities of interest or with lived experience with specific health issues to help shape how they do their work.

The 2017 Denver Youth Health Assessment can be found online at https://bit.ly/2vuJEsC and the Youth Health Assessment video can be viewed online at https://youtu.be/aLF_Bkz7byc.

For more information about the YHA model or about this approach to health assessment in Denver, please contact Abbie Steiner at abigail.steiner@dhha.org.

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DuPage County Health Department Offers Teens Sex Education and STD Awareness: Utilizing Teen Pregnancy Prevention Grant, Local Resources to Develop "The Ask"

By Rebecca McFarland, MA, Community Initiatives Coordinator, DuPage County Health Department

In 2015, the DuPage County Health Department (DCHD) began efforts to improve the sexual health of adolescents. DuPage County is one of the "collar counties" of the Chicago Metropolitan area and has many unique challenges and opportunities when it comes to teens accessing sexual healthcare and information related to sexually transmitted diseases (STDs) and pregnancy.

As part of the federally-funded Teen Pregnancy Prevention grants from the Health and Human Services' Office of Population Affairs, DCHD began to work on projects designed to decrease the unintended teen pregnancy rates and the STD rates among young people ages 12–17. These efforts included an in-school evidence-based curriculum implementation, a communications campaign to educate young people on pregnancy and STDs, and promotion of Title X clinics and other sexual healthcare services.

In the first year of the grant, DCHD focused on promoting the curriculum in the schools during health class. Many schools in the area do not provide a fully comprehensive sexual health curriculum, so it took several conversations before the schools felt comfortable allowing DCHD and a partner organization's sexual health educators in the classroom. To establish buy-in in a local municipality, DCHD worked with the local library to pilot the curriculum before implementing it in schools. DCHD and the library asked volunteer students and library interns to audit the curriculum

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by taking the class and then providing feedback after each session. The pilot class met during the summer of 2016 and had an average of 13 participants per session ranging in age from 12–17.

This pilot session was helpful for the library, the health department, and the young people. The library has a strong relationship with the school and the teen librarian became an advocate for the curriculum after observing the library sessions. The health department was able to gain experience with and feedback on the new curriculum. The sessions were also helpful for the students; they realized that they could influence the content of their health class and told their friends about various sexual health resources in the community. Moreover, the library pilot session with students led to the creation of one of our most successful community programs: The Ask.

"Can you still get pregnant if you do it in a pool? What are crabs? How do I clean my vagina?" These are just a few of the real questions that teens submitted anonymously to The Ask.

After working with the teens and a teen librarian for several weeks, DCHD learned that one of the frustrating things for teens was about what information librarians could give them. When teens would ask about sexual health topics, they could not get direct answers due to how librarians can ethically and legally answer health-related questions. Instead of using the resources librarians directed them to, teens were discouraged from reaching out at all. The library recognized that by partnering with the health department, the library could connect teens directly to the resources they needed while staying within the ethical and legal bounds of the profession.

Using this information, DCHD and the library asked teens about what resources they used for health information, who or what they trusted, and what they thought would be effective in fighting teen pregnancy and STDs. The answers were often surprising. Students did not want resources online and had a strong preference for face-to-face contact. They also said they were most likely to trust medical professionals but felt uncomfortable going to a healthcare provider. They wanted information, but they preferred learning through games and discussion. Recognizing a unique opportunity, the library and DCHD used the final sessions of the class to design a resource responding directly to this feedback.

Together, the group built a program called The Ask. Inspired partially by the popular TV program Loveline, the program allows teens to ask anonymous questions of a panel of experts that mix humor, advice, and accurate health information. The Ask not only provides information, but also puts a face to local organizations and resources. The library and DCHD reached out to local health care providers like the Title X clinic, Teen Parent Connection, and other social service organizations for panelists that could form personal connections with teens. These organizations also provide free condoms to participants in discreet bags with informational pamphlets.

Each program begins with a statement

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from the librarian about anonymity, inclusiveness, and the use of words like "vagina," "anal," and "masturbation." The librarian explains that teens are welcome to leave at any time if they are uncomfortable. The panelists are introduced, along with the organizations they represent. The list of questions asked are generated from the Google forms students use to anonymously submit questions. Generally, questions are first asked of the general audience and then turned over to the panel for accuracy and commentary. Participants are given a chance to ask follow-up questions or comment, and discussion sometimes continues among participants, especially if the question is about family or relationships. Periodically, the librarian asks participants to get up and answer a question by walking to an area of the room. This provides an opportunity to move and often sparks further discussion, because attitudes are visible to the entire group. About half-way through, the program breaks for pizza, soda, and cookies. Recently, a final game was added to the end of the program, testing participants' knowledge of the information covered at the event. The teen with the most correct answers wins a gift card to a local fast food restaurant. The tone of the entire program is intentionally kept light, encouraging laughter and informal talk between participants and panelists.

Initial outcomes have been extremely promising. From September 2016 through May 2018, 19 sessions of The Ask had been hosted at the library with an average of 20 participants per session. Between January 1 and June 30, 2017, use of the local Title X clinic featured on the panel doubled. The clinic attributes this increase to its new outreach at the library.

In the summer of 2017, the library and the health department hosted a second pilot of the sex education curriculum at the library, this time with participants receiving school credit for the class at the junior high. In part because of the two successful sessions at the library, the district administration agreed to integrate the curriculum into 8th grade health classes in fall 2017. The partnership has also sparked a broader collaboration among the school districts, the library, healthcare providers, and local social services. Because of their partnership on The Ask, the library was invited to join the Information and Education Council hosted by the local Title X clinic. The library helped the clinic redesign its website, handouts, and other outreach efforts to be more teen-friendly. Representatives from the clinic set up tables during the library's busiest times with games and incentives to draw teen

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participants. Most importantly, the pilot classes and The Ask broke the silence on teen sexual health and sparked a culture shift in the community.

Through the experience of the library pilot and development of The Ask, partners also learned that many people do not understand which sexual healthcare services teens can access without parental consent. The health department set out to educate young people directly, as well as social workers, school nurses, medical students, and other youth-serving professionals. DCHD created a healthcare center handout and poster, which outlined all the services teens could consent to and links to organizations offering those services. Local Title X clinics and pediatricians' offices hung the posters on the back of exam room doors so teens could read them while they waited for a provider. DCHD also held trainings for physician office front desk and support staff on LGBTQ+ inclusivity, confidentiality best practices and laws, and healthcare rights for teens.

In addition to educating teens about their healthcare rights, DCHD also sought to help teens learn how and where to find confidential sexual health services. During the 2018–2019 school year, DCHD held focus groups and surveyed teens to see which social media platforms were most popular in their area. Based on that feedback and supported by funding from the Teen Pregnancy Prevention Grant, DCHD launched a SnapChat and YouTube campaign educating young people on where they could get tested for STDs. Young people helped to develop and approve key messages and graphics used in the campaign. From May to August 2019, over 5 million impressions were served to teens, 12–17, in DuPage County on SnapChat. A total of 28,000 young people swiped up on the video, indicating that they took some action to seek additional information; in this case, they entered their zip code to find a testing center near them. This is a swipe rate of 0.93%—outperforming the healthcare/public health media industry average of 0.2 to 0.55%. It was the health department's first time using SnapChat as a media channel to reach young people, and now DCHD has used SnapChat, Instagram, Spotify, and YouTube with great success for various youth-directed campaigns.

For health departments just beginning work on creating an adolescent-friendly community, there are several helpful resources available. The goal of any public health project should be to use best practice interventions, and Adolescent Health Initiative at University of Michigan and the Healthy Teen Network have been invaluable resources. There are also many sexual health organizations such as SIECUS, Advocates for Youth, and AMAZE that have informative newsletters and easily shareable social media content.

When serving the adolescent population, ask for youth feedback or involvement at every opportunity. Never assume health department staff are cool, hip, or "with it", because they aren't! Involve young people when designing teen interventions, if possible. If you cannot access young people in your community, try to find national, state, or local resources that can at least lend a youth voice to your project. With accurate information and the right resources, young people can be empowered to take charge of their sexual health. Health departments can play an important role in facilitating young peoples' access to information and resources.

For more information about the DuPage County Health Department, visit https://www.dupagehealth.org//.

IDecide Detroit: Empowering Detroit Teens

By Megan Boyce, MPH, Reproductive Health Program Manager, Detroit Health Department

The Detroit Health Department (DHD) is the public health authority in the City of Detroit and serves the nearly 700,000 residents in the city. DHD frequently serves as a convener for residents' most pressing health concerns, including infant mortality, childhood lead poisoning, and access to social services. As the DHD has grown over the last several years, a priority to address unintended teen pregnancy emerged in conjunction with programming aimed at social support for pregnant women and their families.

Each year, over 1,600 Detroit teens ages 15 to 19 become pregnant. Teen pregnancy is 2.5 times more common in Detroit than in the rest of the state of Michigan.[1] This disproportionate burden is driven by several factors, including lack of access to reproductive healthcare and poor awareness of contraceptive options.

The aim of iDecide Detroit is to reduce unintended teen pregnancy by reducing barriers to accessing adolescent-friendly care, including long-acting reversible contraception (LARCs), increasing knowledge in the community around adolescent reproductive health, and strengthening the existing healthcare system. This program uses three strategies that are interconnected and mutually reinforcing. Public acceptance of LARCs must be established to make clinical engagement or access points worthwhile. Similarly, without access through clinicians or unconventional access points (including a clinic in a recreation center), demand for these services cannot increase LARC use.

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Public Awareness

Engage community in candid discussions on teen pregnancy to develop a targeted public relations campaign

Clinician Engagement

Establish and grow a network of adolescent-friendly LARC providers through medical education and training

Improved Access

Open reproductive health clinics in repurposed public spaces and mobile unit to circumvent traditional access barriers

Laying the Foundation for iDecide Detroit

Planning and implementation for iDecide Detroit was a two-year process, emphasizing youth engagement and inclusion. We held focus groups with youth across Detroit, then used that feedback to shape the standards for those we selected as healthcare partners. The feedback from the focus groups impacted our own clinical practice, including our clinic hours and walk-in availability. Additionally, the youth shaped the messaging of the campaign and served as the faces in the campaign. They also acted as youth ambassadors for the program.

To address barriers to healthcare, it was critical to gain insight from a provider perspective. We also conducted focused interviews and surveys of medical providers in Detroit to understand their attitudes and behaviors towards adolescent reproductive health. We learned there were challenges with being able to provide services to underinsured and uninsured patients, and that availability was often limited to regular business hours.

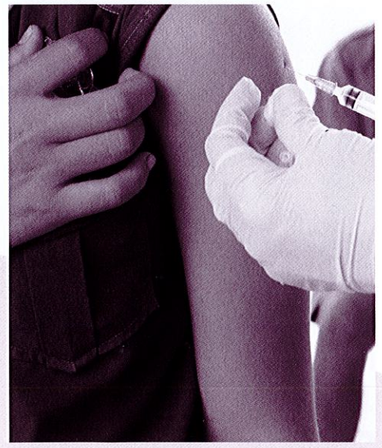
To reduce barriers and align already existing partners, we convened and established a network of 23 healthcare partners across Detroit. These partners include obstetrics and gynecology departments in major health systems, family medicine providers, Planned Parenthood, and multiple federally qualified health centers. Each network provider offers a unique perspective of care and ensures that client needs can be met through our own clinic or connection to care with one of the partners. All of the iDecide Detroit network partners agreed to provide adolescent-friendly, high-quality, low-barrier care based on best practice and the youth feedback we received. This iDecide Detroit network creates a coordinated system of care for our youth, and allows sharing of best practices and problem solving across providers in a supportive environment. Data sharing agreements with providers in the network ensure we will be able to consistently engage our stakeholders and align goals and strategies.

To circumvent traditional barriers and expand access, DHD established a new clinic inside a city recreation center that offers services during non-traditional hours, walk-in appointments and same day LARC placement. In addition to clinical services, DHD has a central phone number to navigate young people to our clinic or a network provider near them, and we have partnered with a transportation service to provide free transportation to and from appointments, as we know transportation can be a significant barrier to accessing care.

Operation of iDecide Detroit

Prior to launching iDecide Detroit, in October 2018, a multidisciplinary team was hired to serve the residents of Detroit. The program is currently staffed by an MPH-prepared program manager, a nurse practitioner, a certified nurse midwife, a licensed social worker, and medical assistants. The inclusion of a licensed social worker on our clinical team offers young Detroiters the opportunity to have their needs beyond reproductive health addressed while they access the tailored care that they may need. Our social worker has connected clients with behavioral health services, primary care, and food and housing resources among, many others.

Within our clinic, our services include sexually transmitted infection testing and treatments, HIV testing, pregnancy testing, same-day contraceptive care, and preventative reproductive healthcare services. In 2019, we also became a Pre-exposure prophylaxis (PREP) and Post-exposure prophylaxis (PEP) provider for HIV prevention. Since our launch, young people have accessed all these important services and often return to our care for



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IDecide Detroit: Empowering Detroit Teens

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follow-up with our social worker.

Some of our successes include:

- Within first week of operation, iDecide navigated an HIV-positive patient to care within 24 hours.
- 43% of patients served have been uninsured and may not have had access to this care prior to our launch.
- 75% of patient visits included testing for sexually transmitted infections (STIs).
- 99% of clients who tested positive for an STI have been successfully treated for infection.
- Over 4 million impressions through social media and other digital advertising.

In addition, iDecide Detroit won a 2019 Model Practice Award from the National Association of County and City Health Officials (NACCHO), recognizing iDecide Detroit as an exemplary model program to replicate.

Looking to the Future for iDecide Detroit

After almost 18 months of operation, the iDecide Detroit initiative has laid a strong foundation to grow and serve young Detroiters. As we continue operation in our second year of service, we look to build connections with the community and our clinical partners. The DHD is looking to use innovative approaches to reach young people and ensure that alternative access points in the health care system can result in connections to the reproductive health services that iDecide Detroit offers.

To ensure that our messaging and services reach young people in the public school system, iDecide Detroit will offer school-wide STI screening and treatment events in partnership with the state health department, a model that is being expanded to serve more students. These testing events will allow us to provide limited services in the schools, while complying with the state legislation that prevents distribution of contraception on school grounds. The hope is that through these events, iDecide Detroit can become a bridge for students to access the care that they may need.

Additionally, iDecide Detroit plans to continue to strengthen our partnerships within the community. By ensuring that youth organizations and community groups are well-versed in our services and know how to connect young people to us, we hope to create trusted adults throughout the community that support our young people and reduce the barriers that they often face when accessing this kind of care.

Finally, we hope to educate and foster strong referrals from medical partners that may not provide reproductive health services, but are still caring for young people on a consistent basis. These providers include emergency departments, pediatricians, family medicine, and school-based health centers. By strengthening these referral pathways, we hope to ensure access to services and strengthen the public health system that serves Detroiters.

iDecide Detroit exemplifies a useful strategy for successfully engaging youth in health initiatives, aligning healthcare providers, and addressing social determinants of health and barriers to healthcare.

For more information visit www.idecidedetroit.com or contact Megan Boyce boycem@detroitmi.gov.

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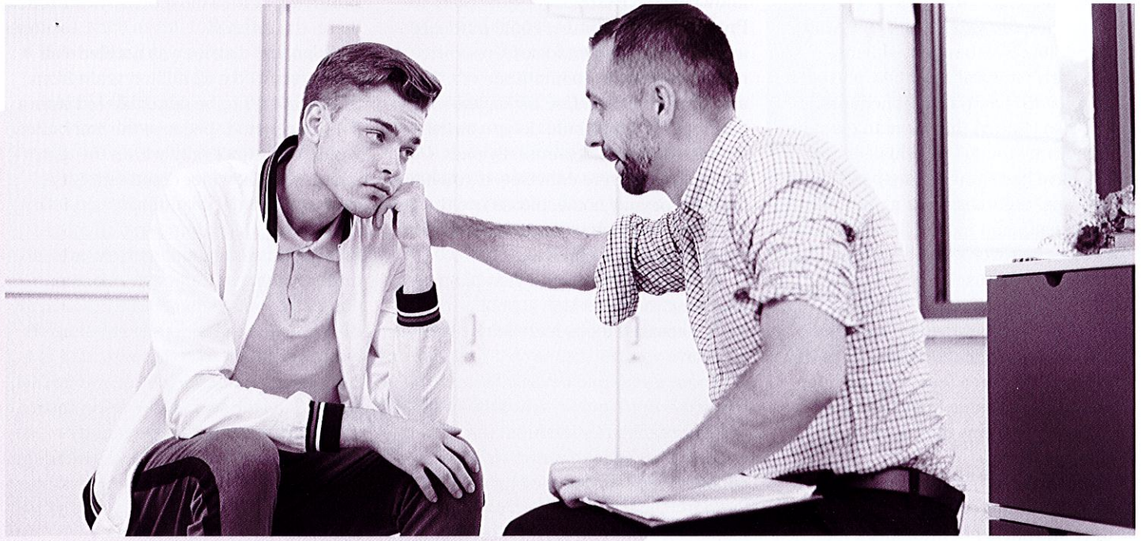
Butte-Silver Bow Suicide Prevention

By Karen Sullivan, MA, Health Officer, Butte-Silver Bow Health Department



Just prior to the 2013 Thanksgiving holiday in Butte, MT, a 17-year-old boy died by suicide, using a firearm. About five weeks later, early on New Year's Day, another young male, age 15, died by suicide in Butte—also by firearm. Four days later, a 14-year-old girl died in Butte by suicide, also using a firearm.

I was one month into my tenure as health officer for Butte-Silver Bow, a combined city-county jurisdiction of a little more than 34,000 residents. After the death of the third teen, my supervisor at the time, the county's chief executive (our city-county strong mayor) called together a group of people to discuss what we had on our hands. I remember that initial meeting very well—community leaders sitting in a room looking at each other, very scared.

Our kids were dying.

Six years later, we have learned so much as a community—about kids, about suicide, and about the steps required to become a healthier community.

It has been an exhausting, invigorating, and somewhat triumphant journey.

At that initial meeting of people called together to discuss the deaths of three teenagers, it was decided that we—public health officials, school administrators, law enforcement, government representatives, and other community partners—would collaborate to take a public health approach to quickly devise a mission for the group, which was to prevent other kids from dying by suicide, and to hopefully have a positive impact on the adult demographic.

The newly formed Butte-Silver Bow Suicide Prevention Committee quickly learned that all three teenagers attended the same public high school, and so we readily determined that we had a prospective cluster, and we wanted first and foremost to prevent contagion of suicidal acts.

We invited the state's suicide prevention coordinator, Karl Rosston, to Butte High School to speak to parents and other concerned residents. About 400 people attended.

We met with media representatives, and shared with them evidence-based toolkits on how to report on suicidal events.

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Butte-Silver Bow Suicide Prevention

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We learned that Montana's suicide rate for the past many years has been among the nation's top states per capita. We further learned that the state's large geographic expanse lends toward an incredible isolation of residents, particularly for rural residents, and such isolation can lead to deep loneliness.

We also learned that Montana, a state known for its tough individualism and a collective "pull-yourself-up-by-the-bootstraps" mentality, was a place where mental health and mental illness were not issues that were widely discussed. Additionally, we discovered that many people felt stigmatized when they reached out for therapy or medication.

We pondered the commonality of the suicides of the three teens—in addition to attending the same high school, all had died by firearms that were readily available to them.

Montana's culture is rooted in the outdoors; hunting wild animals, such as deer and elk is not only sport, it is a way for many families to put food on their tables. Our 2014 Community Health Needs Assessment provided the following statistics: more than one-half of adults in our county (55.5%) had a firearm kept in or around their home, much higher than the national prevalence. Among households with children, 71.4% had a firearm kept in or around the house, nearly twice the reported national findings.

Two physicians in the community stepped up and donated $5,000 each so that our group, which was now known as the Butte-Silver Bow Suicide Prevention Committee, could purchase an abundance of gun locks. Committee members attended a multitude of events and distributed the free locks, knowing that locking guns could delay a suicidal impulse that would eventually pass. Our talking points were concise—if you have firearms in your home, please use the gun lock and also lock your guns away from the reach of your children.

On April 5, 2014, an 18-year-old male attending the same high school as the three deceased teens had died by suicide. A firearm was the means.

About a year and a half into our work, the Butte public school district was approached by the Montana Office of Public Instruction (OPI) to consider applying for the Montana Support, Outreach and Access for the Resiliency of Students (SOARS) grant, monies made available to OPI by the Substance Abuse and Mental Health Services Administration (SAMHSA). The school district's curriculum director, Jim O'Neill, set to work on the grant application, illustrating that the district had many interventions for the bulk of its students and for students in crisis, but very few interventions for students at risk of entering into crisis. O'Neill also noted that the district would often refer students to community services, only to learn that many of those referrals were unsuccessful. Families facing a variety of health disparities most often didn't follow up on the referral.

Soon, the district was notified that it had received a $2 million grant from SAMHSA/OPI to be administered over a five-year period. Because the work ahead would center not only within the district but also in the wider community, the district needed a coalition.

The Suicide Prevention Committee was that coalition, and with the school district taking a leadership role, the committee was renamed the Community Action Team, to reflect the committee's collective intent to collaborate and to act. A retained focus was suicide prevention, but CAT, as the team came to be known, evolved into a healthy community coalition, believing that work centered on building a healthier community certainly would have a positive impact on suicide rates.

CAT developed four primary goals—to develop a resilient, trauma-informed community; build a system in which referrals to community services for students and families could be more robust; assist the school district with its student attendance campaign; and advocate for policies and legislation prompting healthier communities and suicide prevention.

With the SOARS grant funding

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Butte-Silver Bow Suicide Prevention

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received, the Butte school district immediately looked inward. It went to its best resource for baseline information—its kids. Students were surveyed with questions, such as the following:

- How often they enjoyed being at school (with a range of "never" to "almost always")
- Did they have at least one adult at school they could approach with a problem
- Did teachers inform them when they'd done a good job
- Did everyone know what the school rules were and whether those rules were applied equally
- Had they been bullied
- Had they ever felt so sad or hopeless that they stopped doing some usual activities
- Had they ever attempted suicide
- Did they feel safe at school

As the SOARS project launched, O'Neill wrote in a project summary, "Butte did not have in place systematic programs or initiatives to address school safety or school climate, with limited … interventions available."

The district realized it had some interventions for the estimated 85% of students who abided by societal and school norms, and interventions for the 5% of students in crisis. Administrators realized that they had developed no interventions for the 10% students at risk for being in crisis.

The district started developing and enhancing a multi-tiered system of support for students in each category, adding evidence-based interventions, such as the PAX Good Behavior Game in the first tier (85%) of students, the Zones of Regulation program fostering self-regulation and emotional control in the second tier (10%) of students, and the Check and Connect program for the 5% of students in the third tier. The program works with K–12 students who show signs of disengagement and dropping out of school.

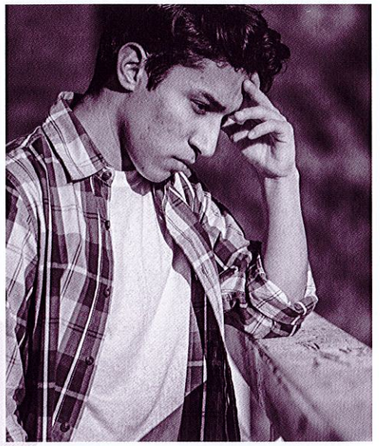
In addition to the tiered interventions, the district implemented other initiatives. O'Neill mentioned, "… Butte implemented training and initiatives to increase safety, created an emergency operations plan, formed a district safety team, and trained key personnel in crisis response."

O'Neill, along with myself, became a co-facilitator of the CAT team, continually seeking members' input and insight. CAT members used their own circles of influence to promote school attendance, using talking points from the Attendance Works program (www.attendanceworks.org)—on the fact that students, especially those in K–3, greatly benefit from attending school all day, every day.

The school district and CAT worked with the California-based Noble Software Group to develop an online referral system allowing schools and agencies to easily and securely transfer people to other providers for care and treatment. The SOARS grant paid for early initial costs, but the need for a system coordinator became readily apparent. The school district and Butte-Silver Bow County partnered to pay for the position, with the county taking on long-term sustainability post-SOARS. The position now resides within the Butte-Silver Bow Health Department.

The Montana Legislature convenes biennially, and CAT members traveled to Montana's capital city of Helena to be present at hearings where suicide prevention and health promotion bills were debated.

We worked collectively to make our community more empathetic and trauma-informed. SOARS paid for school district personnel and others to be taught to train in the evidence-based programs called Youth Mental Health First Aid, Adult Mental Health First Aid, and Signs of Suicide. Fourteen community members were trained to present on adverse childhood experiences (ACEs). Our mission was to eliminate stigma around mental illness and train people on how to interact with someone who is ill, and help to get them the assistance they needed. In our ACEs training, we expressed that early-childhood trauma has an incredibly negative impact, and that people who are mentally and emotionally scarred may have had early-childhood experiences that resulted in lifelong repercussions.



Instead of asking the members of our community "what is wrong with you?", we attempted to reframe the question to "what happened to you, and how can I help?"

Last September, the Butte school district wrapped up the SOARS grant by re-surveying students with the questions previously asked. The district found a 31% decrease in bullying and a 36% drop in cyberbullying. There was a 32% decrease in the number of students who felt unsafe.

The data also showed a 51% increase in the number of students who enjoy school, a 23% increase in the belief that school rules are applied equally, and a 23% decrease in K–6 suspensions and expulsions. There was also a 41% decrease in students who felt sad or hopeless, and a 30% decline in students attempting suicide.

Over the five-year grant period, 732 community members were taught to train in Youth Mental Health First Aid, and 1,028 public school students were referred to the services they needed.

The CAT team is now working to replicate the school district's multi-tiered system of support for the county's adult demographic.

Fortunately, our impact has been proven, which energizes our collaborative efforts that will take place in the years to come.

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Butte-Silver Bow Suicide Prevention
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Butte Montana SOARS

Goal	Areas	2014 Pre-Grant Status	Work Accomplished During Grant				2019 End-of-Grant Status
Build and expand capacity at the state and local levels to make schools safer and improve school climate	MTSS Infrastructure, Safety Initiatives	Emergency Plan: None Bullying Prevention: None Students Feel Unsafe: 18% Students Bullied: 32% Students Cyberbullied: 24% MBI/MTSS Teams: 2 Schools Referral Protocols: None Resource Map: None Data Collection: None	Emergency Operations Plan	Olweus Bullying Prevention Program		District Safety Team	31% Decrease in Bullying
			MTSS Teams K-12	School & Community Resource Map		MTSS Training & Summer Institute	36% Decrease in Cyberbullying
			Tiered Referral Processes	CSCT Coordination	Case Managers at each School	Grade-Level Data Folders	32% Decrease in Students Feel Unsafe
	Tier 1 Supports, Behavior Policies	Tier 1 Support: Limited Punitive Disciplinary Policy Students Enjoy School: 29% Rules Applied Equally: 55% Suspensions/Expulsions: 291	Universal Expectations	Positive Behavior Club	Strong Kids	Attendance Matters	51% Increase in Students who Enjoy School
			PAX Good Behavior Game	Trauma-Informed Classroom Supplies		Morning Meetings	23% Increase Rules Applied Equally
			Zones of Regulation	Home Visiting Program	Adopting Restorative Practices & Trauma- Informed Policies		23% Decrease in K-6th Suspens/ Expulsions
Increase awareness of mental health issues	Trauma-Informed Community	Trauma-Informed Training: None Mental Health Awareness Training: None	Overcoming ACEs	Question Persuade Refer (QPR)	Trauma-Informed Parent Night		732 YMHFA Trainees
			Youth Mental Health First Aid (YMHFA)	Signs of Suicide (SOS)	Applied Suicide Intervention Skills Training		1028 Youth Referred to Services
Connect children and youth with behavioral and mental health issues with needed services	Tier 2 Services	Tier 2 Supports: Very few Community Referrals: Not Coordinated Students Receiving Tier 2 Services: 1.5%	FBA Plans	Check & Connect	Check In/ Check Out	Small Groups	956% Increase in students receiving Tier 2 Services
			Meaningful Work	Truancy Court Diversion		Second Step	~20 Providers & All Schools on CONNECT
	Youth Mental Health Supports	Mental Health: No programs Substance Use Support: None Suicide Protocols: None Crisis Response Team: None Felt Sad or Hopeless: 35% Attempted Suicide: 17%	Youth Awareness of Mental Health	Crisis Response Team	Youth Mental Health First Aid Training	Signs of Suicide (SOS)	41% Decrease in Feeling Sad or Hopeless
			Badges w/ Hotline	Suicide Risk Protocols	In School Addiction Recovery & Treatment Services	Substance Abuse Screening	30% Decrease in Suicide Attempts

Butte Results Summary

Before Project AWARE initiatives began, Butte did not have in place systematic programs or initiatives to address school safety or school climate, with limited tiered interventions available. During the five grant years, Butte implemented training and initiatives to increase safety, creating an Emergency Operations Plan, formed a district safety team, and trained key personnel in crisis response. By the end of the grant, Butte showed a 9% decrease in number of students missing school due to not feeling safe. Throughout the grant, Butte worked to create Multi-Tiered Systems of Support (MTSS) infrastructure. MTSS teams were created for each school and the Butte School District staff attended MTSS training and worked with an MBI Coordinator to improve school environments. As of Year 5, each school except the high school, used the Tiered Fidelity Inventory (TFI) regularly to evaluate progress in MBI/MTSS implementation and make school-specific plans to make implementation progress throughout the school year.

The systemic embedding of tiered services is one of the major accomplishments during the Project AWARE grant for Butte. Butte created universal expectations and incentives for positive behaviors and attendance, as well as grade-level folders for teachers to find students' information on behavior, attendance, grades, and scores in one place to target student needs. Multiple Tier 1 programs were implemented including a Home Visiting Program, PAX Good Behavior Game, Zones of Regulation, Strong Kids, and Morning Meetings. Implemented Tier 2 programs included Check In/Check Out, 2X10, Meaningful Work, Check & Connect, and Second Step. Butte provided Tier 2 services to 14% of the student population in Year 5, a 956% increase in students served from Year 1. Butte also implemented the Olweus Bullying Prevention program in K-12th grades and demonstrated a 31% decrease in the number of students who were bullied and a 36% decrease in the number of students who were cyberbullied from grant Year 1. Additionally, Butte showed a 51% increase in the number of students who indicated they enjoyed being at school. Now at the end of the grant, Butte elementary schools have worked to adopt trauma-informed behavior policies, resulting in a 23% decrease in suspensions and expulsions compared to grant Year 1.

At the beginning of the grant, Butte did not have trauma-informed training in the community. By Year 5, Butte provided training in Youth Mental Health First Aid (YMHFA), Overcoming Adverse Childhood Events (ACEs), Question Persuade Refer (QPR), and Applied Suicide Intervention Skills Training (ASIST). By the end of the grant, Butte had trained 732 individuals in YMHFA and trainees referred 1028 youth to mental health services.

Butte worked throughout the grant to create the youth mental health supports and suicide prevention programs initially lacking in the district. Butte middle and high school students had access to in-school substance abuse screening and treatment and received Signs of Suicide (SOS) training. Butte established a Crisis Response Team and assigned a case manager to students identified at risk. Further, a community-wide rollout of the CONNECT referral system increased the efficiency of referring students to needed community services. The number of students who felt sad or hopeless decreased by 41% from the beginning to the end of the grant. Importantly, the number of students who attempted suicide decreased by 30% by the end of the grant.

For more information, contact Karen Sullivan at ksullivan@bsb.mt.gov.

Exploring the Role of Local Health Departments in Youth Sexual and Intimate Partner Violence

By Kat Kelly, Program Analyst, HIV, STI, & Viral Hepatitis, NACCHO

Sexual and intimate partner violence are critical, but often neglected, public health concerns, resulting in long-term mental, physical, and reproductive health consequences. In the United States, 44% of women and 25% of men have experienced sexual violence (SV), which includes any unwanted, coerced, or alcohol and drug-facilitated sexual contact. Additionally, 37% of women and 34% of men have experienced intimate partner violence (IPV), which includes sexual, physical, or psychological aggression and stalking committed by a current or former romantic or sexual partner.[1] Research indicates that rates of SV and IPV victimization are even higher among transgender and gender-nonconforming people.[2,3] While violence has traditionally been addressed as a criminal justice issue, there is increasing recognition of the importance of a public health approach: from defining and monitoring SV and IPV, to exploring risk and protective factors, to developing, evaluating, and scaling up prevention strategies.[4]

Rates of SV and IPV are high among young people: 10% of high school students reported SV victimization in the past year, with rates higher among female students, and of those who reported at least one recent dating partner, 7% reported sexual IPV and 8% reported physical IPV.[5] There is also a strong association between exposure to SV and IPV in adolescence and subsequent revictimization or perpetration.[6] Additionally, adolescence is a consequential period for educational attainment, sexual initiation, and the onset of mental health and substance use disorders—an important consideration as the trauma associated with SV and IPV victimization can have a negative impact on academic achievement, future job stability and earnings, and mental, behavioral, and sexual health outcomes.[7,8,9] These trends demonstrate the importance of targeting adolescents in efforts to prevent and mitigate the harms associated with SV and IPV.

Local health departments (LHDs) are well-positioned to lead the public health approach to SV and IPV at the local level, mobilizing their cross-sector and community partners, using data to inform priorities and planning, and identifying and addressing the upstream factors contributing to violence. NACCHO's 2018 *Forces of Change* survey found that one in four LHDs conduct activities to address violence in their communities, but limited information is available on their violence portfolios, including their work to address SV and IPV.

To address this gap, NACCHO recently distributed a survey to LHDs that reported working on violence in the 2018 *Forces of Change* survey and is conducting key informant interviews with LHDs leading in the field. The goal of these activities is to develop a deeper understanding of what LHDs are doing to prevent and respond to SV and IPV, including their activities, resources, and partnerships and the barriers, challenges, and needs that affect this work. This project will culminate in recommendations for LHDs, NACCHO, and other entities that fund or provide support to LHDs, with the goal of making the case for this work, highlighting best practices, and determining what NACCHO and others can do to support and advance LHD engagement in this space.

For more information, contact Kat Kelley, Program Analyst, at kkelley@naccho.org.

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Student Health: Current Snapshot

By Kathleen Ethier, PhD, Director, Division of Adolescent and School Health, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Centers for Disease Control and Prevention

Data from the Centers for Disease Control and Prevention's (CDC's) 2018 *Youth Risk Behavior Survey* show that fewer high school students are engaging in health behaviors that put them at risk for HIV and sexually transmitted diseases (STDs). But although many adolescents are making better decisions about their health, far too many are still at risk.

The percentage of students who used a condom the last time they had sex decreased significantly to 54%. Illicit drugs were used by 14% of high school students. Unfortunately, the number of high school students who experienced persistent feelings of sadness or hopelessness increased significantly to a ten-year high of 32%.[1] These experiences put youth at risk for a variety of negative health outcomes including HIV and STDs.

School-Based HIV and STD Prevention: CDC's Approach

CDC's Division of Adolescent and School Health (DASH) has established an evidence-based approach to school-based HIV and STD prevention. It includes providing:

- Quality sexual health education;
- Connecting students to sexual health services; and
- Establishing safe and supportive school environments.

Activities related to health education and health services can be tailored to address health outcomes and other behaviors, including high-risk substance use, violence victimization, and mental health. Safe and supportive school environments, particularly those in which students feel connected to their peers and adults, can have broad and substantial impact on a wide array of health issues, including violence victimization, substance use, and mental health.

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Sexual Health Education

Quality sexual health education is a systematic approach to preparing students with the knowledge and skills needed to make informed decisions to prevent HIV, STDs, and unintended pregnancy. Programs should:

- Include planned, progressive learning objectives and outcomes across grade levels.
- Address knowledge and skills students need before risk behaviors and health issues emerge.

Effective programs:

- Are taught by qualified, trained teachers;
- Connect students to health services;
- Engage parents and community partners; and
- Foster positive relationships between students and trusted adults.

Students who receive quality sexual health education can reduce health risk behaviors and experiences and may improve their academic performance.

Sexual Health Services

Sexual health services give students access to preventive health care, such as STD and HIV testing, contraception and condoms, and referrals to appropriate treatment.

- Students can gain access to broad preventive health services, such as sexual risk assessments and counseling on healthy decision-making.
- Schools can provide services on site or refer students to youth-friendly healthcare providers in the community.

These services can provide students with information, education, support, referrals, and counseling for a broad range of health behaviors and experiences that can affect healthy development.

Safe and Supportive School Environments

Creating safe and supportive environments emphasizes aspects of school settings and family relationships that can protect adolescents and reduce their risk for HIV, STDs, and unintended pregnancy.

- These protective factors include school connectedness, parental monitoring, and parent-adolescent communication (both generally and specifically about sex).
- Safe and supportive environments connect adolescents to a network of caring peers and adults, including parents, other primary caregivers, and teachers.
- Improving environments can have a broad and lasting positive impact on health. It also establishes a context for sexual health education and sexual health services to be effective.

Schools, communities, families, and youth can work together to create school environments that protect students' health and improve academic performance. Teens can especially play a vital role in school connectedness by establishing, leading, or participating in clubs that support LGBT youth.

What Works: How DASH Helps

DASH is a unique source of support for HIV, STD, and pregnancy prevention efforts in the nation's schools. DASH works to protect youth by:

- Collecting data that drive action;
- Translating science into innovative programs and tools that work to protect youth; and
- Supporting a network of leaders in primary prevention by funding education agencies that reach nearly 2 million students.

DASH is committed to preventing HIV, STDs, and pregnancy among all youth. Taking a school-based health promotion and disease prevention approach, the division works to prepare healthy youth for a successful future.

Read more about what works in schools at https://www.cdc.gov/healthyyouth/whatworks/.

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