

CONNECTICUT DEPARTMENT OF PUBLIC HEALTH

ADOLESCENT HEALTH STRATEGIC PLAN

May 2005

SUBMITTED TO: CONNECTICUT DEPARTMENT OF PUBLIC HEALTH
AND THE ADOLESCENT HEALTH STRATEGIC PLANNING COMMITTEE

SUBMITTED BY: POLICY STUDIES INC. (PSI)



Keeping Connecticut Healthy

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Connecticut Adolescent Health Strategic Plan
May 2005



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SECTION 1: OUR APPROACH TO ADOLESCENT HEALTH IN CONNECTICUT

About the Strategic Plan

In the fall of 2004, the Connecticut Department of Public Health (DPH) embarked on a comprehensive and participatory long-range strategic planning process designed to establish a blueprint for improving the health of Connecticut youth over the next decade.

DPH hired Policy Studies Inc. (PSI) to facilitate the strategic planning process and to develop the Adolescent Health Strategic Plan. In addition to facilitating the strategic planning process with key stakeholders, PSI conducted an assessment of adolescent health needs in Connecticut, collected information about existing programs and assets serving youth in the state, and performed a best practices review. Detailed results of this assessment can be found in the document, *A Report on Adolescent Health Needs, Assets and Best Practices* (Companion Document to the Adolescent Health Strategic Plan).

DPH convened an Adolescent Health Strategic Planning Committee to participate in this process as a working group representing a range of key stakeholder perspectives. The Committee included representatives from state agencies that have a role in addressing adolescent health needs, from other organizations that serve adolescents, and from some healthcare providers. The Committee included representation from the following organizations and programs:

- Connecticut Children's Medical Center
- Connecticut Voices for Children
- Connecticut Dept. of Children and Families, Prevention Services (DCF)
- Connecticut State Dept. of Education (SDE)
- Connecticut Dept. of Mental Health and Addiction Services (DMHAS)
- Connecticut Dept. of Mental Retardation (DMR)
- Connecticut Dept. of Public Health, Tobacco Control
- Connecticut Dept. of Public Health, AIDS and Chronic Diseases
- Connecticut Dept. of Public Health, Family Health Division
- Connecticut Dept. of Public Health, Infectious Diseases
- Connecticut Dept. of Public Health, Health Education, Management & Surveillance Section
- Connecticut Dept. of Social Services, HUSKY Programs (DSS)
- Connecticut Dept. of Social Services, Social Work & Prevention Services
- Connecticut Primary Care Association

- Connecticut Parent Teacher Association (PTA)
- Fair Haven Health Center
- Greater Bridgeport Adolescent Pregnancy Program, Inc.
- Human Services Council, School-Based Health Program
- Legislative Medicaid Council
- Planned Parenthood of Connecticut
- St. Francis Hospital Medical Center

A list of Adolescent Health Strategic Planning Committee participants can be found in Appendix A.

In addition to receiving ongoing input from the Adolescent Health Strategic Planning Committee, PSI obtained input from adolescents on key health issues facing adolescents as well as on planning priorities. PSI developed a brief questionnaire that stakeholders distributed to adolescents whom they serve; PSI collected and analyzed over 170 surveys from a diverse group of adolescents across the state. In addition, PSI convened a discussion group of adolescents for additional insight into adolescents' priorities and concerns regarding their health.

This document presents Connecticut's Adolescent Health Strategic Plan, focusing on strategic directions and priorities. The Strategic Plan is organized as follows:

Section 1: Our Approach

This section provides a description of the strategic planning process, the framework for the plan, and the Committee's vision statement.

Section 2: A Starting Point

This section provides a brief summary of demographic information about Connecticut adolescents and a summary of key findings related to their health status and Connecticut's assets, programs and organizations serving adolescents.

Section 3: Trends Analysis

This trends analysis includes a list of trends which may impact the public health landscape in general and which may have an impact on Connecticut adolescent health.

Section 4: Priority Issues, Goals, and Strategies

This section contains descriptions of adolescent health strategic health priority issues. Following the descriptions are long-range goals and priority strategies/activities.

Section 5: From Planning to Action

This section includes recommendations for next steps for implementation.

Appendices

- A. Strategic Planning Committee Participants
- B. Critical 21 Health Objectives for Adolescents and Young Adults from the U.S. Healthy People 2010 Objectives
- C. Sources and Reports used in the Development of *A Report on Adolescent Health Needs, Assets and Best Practices*
- D. Connecticut Organizations and Services Serving Adolescent Health (Indicators & Assets)
- E. Adolescent Input Survey
- F. Summary of Adolescent Discussion Group Key Findings

About the Strategic Planning Process

The strategic planning process consisted of five meetings with the Adolescent Health Strategic Planning Committee.

- At the first meeting, held in December 2004, the Committee established a vision for adolescent health in Connecticut and provided comments on proposed data sources for the adolescent health needs assessment and best practices research.
- In the second meeting, the Committee gave feedback on the needs assessment, identified trends that are likely to impact Connecticut youth, and began to identify priority issues for the state's youth.
- In the third meeting, the Committee defined priority issues and ranked the issues based on feasibility of addressing the issue, the scope of the issue, whether services already existed addressing the issue, and the potential impact of not addressing the issue. For each issue identified, the Committee brainstormed goals and objectives for addressing the issue.
- In the fourth meeting, Committee members refined the goals for each issue and developed strategies to achieve the goals for each issue.
- In the fifth and final meeting, the Committee agreed on final changes to the strategies and discussed implementation of the plan.

Input from adolescents was collected through an informal survey process and a discussion group, and the feedback was added to the description and prioritization of the issues identified here.

The Framework for the Adolescent Health Strategic Plan

At the federal level, the Centers for Disease Control and Prevention's (CDC) Healthy People 2010 objectives are a set of indicators designed to assess progress in public health in a wide range of areas. These objectives define a subset of **21 critical indicators for adolescent health** (see Appendix B). The 21 critical indicators define adolescents as ages 10 to 24; however, most of the 21 indicators focus on specific age ranges. Connecticut's adolescent health strategic planning initiative adopted these objectives as a framework for measuring successes and identifying areas of concern for adolescents in this state. In addition, the plan includes other health issues that the Committee believes are of major concern to Connecticut adolescents but are not included in the 21 critical indicators.

The strategic plan also focuses on promoting opportunities for **positive youth development**, which is defined by the Search Institute (www.search-institute.org) as helping youth have a sense of competence, usefulness, belonging and power. The Strategic Planning Committee focused on the importance of youth empowerment as a critical component of improving adolescent health. Where possible, the Committee identified ways that this Strategic Plan could promote positive youth development.

The Connecticut Adolescent Health Strategic Plan At A Glance: Executive Summary

Overall, the Adolescent Health Strategic Plan emphasizes:

- Increasing access to healthcare for adolescents;
- Improving adolescent environments;
- Increasing the role of schools in improving adolescent health;
- Promoting positive adolescent health;
- Improving adolescent transition to adulthood; and
- Improving collaborative relationships.

Specifically, the Adolescent Health Strategic Planning Committee identified the following three priority issues and associated goals for supporting adolescent health and positive youth development in the coming decade.

Priority Issue #1: Provide adolescents with the support, options, and resources they need to successfully transition to healthy, empowered, and productive adulthood.

Goal 1.1: Connecticut adolescents are empowered to assume responsibility for their health and behavior.

Goal 1.2: Connecticut adolescents and their families and caregivers have access to timely and affordable health and mental health services that are culturally, medically, developmentally and linguistically appropriate.

Goal 1.3: Parents and guardians, providers and adolescents have meaningful opportunities to participate in policy decisions affecting adolescent health.

Priority Issue #2: Enhance communication, coordination and collaboration among stakeholders in adolescent health.

Goal 2.1: Programs and agencies serving youth (including efforts that are both public and private, and that are at the federal, state and local levels) have the mechanisms and opportunities to share data and information including best practices, challenges, and lessons learned in research and service delivery.

Goal 2.2: Adolescents receive coordinated, integrated physical health, oral health and mental health services.

Goal 2.3: Appropriate data are collected and available on adolescents to inform decision-making about adolescent health.

Priority issue #3: Improve adolescent health and well being.

Mental Health

Goal 3.1: Programs, services and information that create a culture of prevention and positive mental health are available to adolescents and their families and to healthcare providers and educators.

Goal 3.2: All adolescents who need mental health services have access to these services and utilize the services.

Obesity and Healthy Lifestyles

Goal 3.3: Adolescents achieve and maintain healthy nutrition and physical activity/fitness.

Substance Abuse

Goal 3.4: Adolescents abstain from using alcohol, marijuana, tobacco and other substances.

Goal 3.5: All adolescents who need substance abuse treatment have access to timely, affordable, and culturally, medically, developmentally and linguistically appropriate services.

Reproductive Health and Sexuality

Goal 3.6: Adolescents adopt behaviors that support healthy sexuality.

Violence

Goal 3.7: Adolescents live in neighborhoods and go to schools that are violence-free.

This plan also provides a general framework for implementation. There are two key actions that will set the framework for implementation of the Strategic Plan:

1. **Establish an implementation group and implementation structure**, including forming action teams to develop a plan for addressing each priority issue; and
2. **Communicate the plan**, including preparing and delivering presentations and written summaries appropriate to the needs of a range of audiences.

Ensuring the Success of the Strategic Plan

The Committee acknowledges the significant efforts already underway to support adolescent health in the state. With this document, the Committee presents a foundation for a coordinated, integrated and statewide effort to make progress in priority areas of adolescent health. By encouraging coordination among the many institutions, agencies and programs serving adolescents in the state, the Committee hopes to cultivate an environment in which adolescents develop healthy lifestyles, are fully engaged, and can reach their full potential.

The Committee also acknowledges that achieving our vision of healthy, productive and engaged youth requires the active participation and support of families, communities, healthcare and educational institutions, government, and businesses, in addition to teens.

The goals and strategies laid out in this plan must be addressed within the context of healthy families, communities and institutions. Part of our collective work in supporting positive youth development involves supporting the institutions and communities affecting adolescents' lives.

The success of this plan also requires nurturing and sustaining close working relationships with key adolescent stakeholders including those represented by the Committee, but especially the State Department of Education (SDE). Moving towards implementation of this plan, the Committee recognizes the significant role that SDE plays in the health and well being of adolescents in the state. In addition to key partnerships and participation from a range of other stakeholders, it is critical that the SDE is an active partner in the implementation of the strategies in this plan.

Ultimately, the success of this plan depends on our collective efforts. This plan is a starting point for a wide range of agencies and individuals to continue and focus their work in improving and supporting adolescent health and well-being.

Vision Statement

A vision statement is a description of the ideal future for adolescents in the state. It describes what adolescent health *should* be in Connecticut and provides a firm direction for the strategic plan. Early in the strategic planning process, the Strategic Planning Committee developed a vision statement for adolescent health in Connecticut, below.

Our Vision for Healthy Adolescents in Connecticut

The Connecticut Adolescent Health Strategic Planning Initiative is working toward an environment for Connecticut adolescents in which:

- All adolescents value health, are empowered to make healthy decisions, and are adequately prepared to thrive during adolescence.
- All adolescents have easy, affordable access to confidential physical, mental and oral healthcare, substance abuse services, and health information and resources that are accurate and appropriate to their age, cultural and linguistic background, geographic location, and developmental stage.
- All adolescents, including those with disabilities or those who are chronically ill, are offered adequate opportunities and resources that allow them to achieve their levels of optimal health and well being.
- Programs serving adolescents are appropriately funded and facilitate communication, collaboration and coordination with one another.
- Adolescents' environments – including their home, school and community – are safe, supportive, and promote health and well-being.
- Adults, families, communities and institutions provide consistent and scientifically accurate messages on health promotion.
- All adults have earned adolescents' trust, are equipped to nurture adolescents, and have access to appropriate networks that support adolescents' health and well-being.
- All adolescents have hope for their future.

SECTION 2: A STARTING POINT

A Demographic Snapshot of Connecticut Adolescents

Approximately 13.5% of Connecticut's population is aged 10 to 19 years and 6.4% of the population is aged 20 to 24 years (U.S. Census 2000). About 77% of Connecticut's population is white, 10% is Hispanic, 9% is African American, and 4% is from other racial/ethnic groups (Kaiser Family Foundation, 2002-2003).

CT Voice's for Children's report called *Immigration in Connecticut* (2005) notes the significant expected growth of the immigrant population residing in Connecticut. Currently 11% of Connecticut residents were born outside the United States with an additional 2.7% born in Puerto Rico. The report notes that between 1995 and 2025, the number of immigrants in CT is expected to double, with an additional 337,000 immigrants residing in the state by the end of that time period.

As noted in CT Voices for Children's *The State of Connecticut Youth 2003*, Connecticut compares favorably with national health and social factors, yet, it is a state of key disparities. For example, poverty rates are disproportionately high among minority residents, with 28% of African Americans residents and 32% of Hispanic residents living at or below the poverty level, compared to 7% of White residents.

In Connecticut, there are also significant disparities by geography. "A Tale of Two Connecticut," an essay in the KIDS COUNT 2002 data book, notes that economic, educational and health disparities are most severe in four of Connecticut's large cities: Bridgeport, Hartford, New Haven and Waterbury. The KIDS COUNT 2004 data book also shows that these cities have the largest racial/ethnic minority populations.

The State of Connecticut Youth 2003 notes significant differences between the 6% of youth living in Connecticut's most affluent communities and the 20% living in the states poorest communities. Indicators that CT Voices for Children reviewed on school poverty rates, academic achievement levels, high school drop-out rates, crime rates and teen birth rates show major differences between the experiences of wealthy and poor youth in the state.

Connecticut Adolescents: A Summary of Health Status and Available Resources

As part of the needs assessment, PSI collected and analyzed health status data for Connecticut adolescents and collected information about available services addressing adolescent health. A detailed report of this assessment can be found in *A Report on Adolescent Health Needs, Assets and Best Practices*, a companion document to the Adolescent Health Strategic Plan.

Data Sources

No single data source captures all 21 critical objectives for adolescent health. Therefore these data were reported from a variety of sources. Primary sources included:

- Chlamydia in Connecticut 1999-2002 (DPH publication)
- Connecticut Childhood Injury Prevention Center at CT Children’s Medical Center
- Connecticut Department of Public Health, Office of Policy, Planning and Evaluation, Vital Statistics (CT DPH OPPE)
- CT DPH HIV/AIDS Surveillance Program: HIV diagnoses since 2002
- CT DPH Family Health Division: CT Teen Pregnancy Facts, Statistics and Programs
- Governor’s Prevention Initiative for Youth 2000 Student Survey (Connecticut Department of Mental Health and Addiction Services)
- Governor’s Blue Ribbon Commission on Mental Health (2000)
- KIDS COUNT Databook (Annie E. Casey Foundation, 2004)
- Motor Vehicles Fatality Report, CT Department of Transportation
- School Based Health Center Utilization by Diagnosis Code
- YRBS: Youth Risk Behavior Survey

Additional national data sources were utilized as well as a wide range of reports and data summaries compiled by various organizations addressing adolescent health in Connecticut. Refer to Appendix C for a complete list of data sources.

Data Limitations

While the information in this section provides a general picture of the health status of adolescents in the state, certain limitations to the data should be noted. These include:

- The last representative sample for the YRBS in Connecticut was in 1997. The 2003 CT YRBS data achieved a 58% response rate, rather than 60% required in order to be representative. Therefore data from the 2003 CT YRBS cannot be used to represent adolescents across the state, and differences in 2003 data cannot be statistically compared to 1997 data. Noting these limitations, we have used both 1997 and 2003 YRBS data to provide a general picture of the state’s trends in health risk behaviors.
- The needs assessment report, along with others (notably *The State of Connecticut’s Youth 2003* from Connecticut Voices for Children), identifies the need to collect data on adolescent health more frequently, broadly and efficiently. For example, there are very little data describing the adolescent mental health indicators as well as positive or protective youth behaviors. The needs assessment completed as part of this initiative should be considered a reflection of the most current data where available, which is sometimes very limited.

Key Findings

Detailed information can be found in the *A Report on Adolescent Health Needs, Assets and Best Practices* (Companion Document to the Adolescent Health Strategic Plan). Key findings related to Connecticut's adolescent health are summarized below.

- **Overall, Connecticut's adolescents do well on many health factors** compared to the nation, with trends generally improving. The Annie E. Casey KIDS COUNT Databook for 2004 ranked Connecticut as 7th in the nation for overall health measures.
- **Significant disparities exist for youth of specific racial and ethnic groups, age groups, or gender** for particular health issues, suggesting that there are important opportunities to improve adolescent health within the state.
- Connecticut adolescents have **lower rates of unintentional injury** compared to the nation. Their seat belt use is higher than the national rate, and they have met the Healthy People 2010 target for decreasing the rate of riding in motor vehicles with drivers who have been drinking. However, Hispanic/Latino youth have the lowest rate of seat belt use and the highest rate of riding with a driver who has been drinking.
- Adolescent **tobacco use has declined** in CT since the 1990s, but a **significant number of high school students continue to smoke**, and CT's rates are comparable to the national rate of smoking for adolescents.
- Connecticut youth have **lower rates of fighting and weapon** carrying than the nation. Adolescent **homicide** rates have declined in recent years and are close to the national rate. Males have much higher rates than females for suicide, homicide, weapon carrying and physical fighting, and Hispanic/Latino and African American students have higher rates of carrying weapons than White students.
- Connecticut youth use **marijuana at higher rates** than youth nationwide. White students have the highest rate of **binge drinking**, while **marijuana use** is similar across racial and ethnic groups. Use of inhalants, hallucinogens, and ecstasy by Connecticut youth exceeds the national rates.
- Connecticut's **teen pregnancy rates are decreasing**, a trend that is also occurring nationally. The number of youth who abstain from sexual intercourse or use a condom is lower among Hispanic/Latino and African American youth, and Hispanic/Latino youth have a considerably higher pregnancy rate. **Chlamydia** cases in Connecticut youth have increased dramatically. Hispanic/Latino and African American youth have the highest number of **HIV** cases in the state.
- For all Connecticut youth, **rates of overweight and obesity are increasing while physical activity is decreasing**. The lowest rates of physical activity are among Hispanic/Latino and African American youth as well as female youth.
- **Data are limited regarding mental health needs** of adolescents in general and those with disabilities in particular. Mental health data are difficult to collect and are not aggregated

across agencies and private practitioners. Yet the Governor’s Blue Ribbon Commission on Mental Health estimated that approximately one-fifth of youth in Connecticut have mental health needs in a given year, while only half of these youth receive treatment.

- Connecticut has a **wide range of programs and services** addressing adolescent health—both in direct services and in collaborations across agencies. Appendix D lists many of the programs and organizations that serve Connecticut adolescents.

Input from Adolescents

As part of the strategic planning process, we solicited input from adolescents to help inform the priorities, goals and strategies developed in this planning process. Input was collected through: 1) an informal survey process and 2) one discussion group. While the information collected as part of this process cannot be interpreted as representative of the views of adolescents across the state, it provides key insight into adolescents’ understanding of what is important to address in the strategic plan.

Adolescent Input Survey

The adolescent health survey was a one-and-a-half page survey that asked respondents to:

- Describe (via write-in responses) areas of health that are going well for them and their friends;
- Describe (via write-in responses) areas of health that are the biggest problems in their communities; and
- Rank, from one to ten, the most important health issues that should be addressed in the final strategic plan. These choices included: motor vehicle crash related injuries, violence, suicide, mental health, alcohol use, drug use, pregnancy, sexually transmitted diseases, tobacco, and obesity.

See Appendix E for the survey instrument.

The survey was distributed to Adolescent Health Strategic Planning Committee participants, who were asked to administer the survey to adolescents with whom they work. Surveys were completed by youth in a number of different settings including a local youth agency, a school-based health center, medical clinics, several programs offered by the CT Department of Children and Families and the CT Department of Mental Health and Addiction Services, and community-based organization peer education programs.

Approximately 170 surveys were completed and returned as part of this effort. Of this group:

- 107 respondents are female, 57 are male, and 6 are unspecified; and
- 55 are White, 44 are African American, 42 are Hispanic, 16 are of mixed race or from other racial or ethnic groups, and 13 are unspecified.

Of the 170 surveys completed, 102 were completed according to the standard directions of ranking priority health issues on a scale of 1 (most important) to 10 (least important). Findings from this group include:

- The areas of **highest overall concern** are drug use (average score of 3.74), STDs (4.06), and alcohol use (4.43).
- The areas of **lowest overall concern** are mental health (7.24), obesity (6.95), and motor vehicle crash related injuries (6.67).
- Among respondents that used a modified ranking system (i.e., did not rank issues from one to ten), top concerns were drug use, STDs and alcohol use, closely followed by pregnancy prevention.
- For African American and Hispanic/Latino respondents, STDs are identified as the highest area of concern, with an average score of 3.06 and with 69% of this group identifying STDs as one of their top 3 concerns. For this group, drug use and pregnancy were also identified as areas of concern, with 50% of adolescents identifying both issues as one of their top 3 areas of concern.
- For White respondents, drug use and alcohol were identified as top areas of concern. Of the White youth, 64% identified alcohol as one of their top areas of concern and 62% identified drug use as their top area of concern.
- Male respondents ranked STDs as their highest area of concern, followed by drug use and alcohol.
- Female respondents ranked drug use as their highest area of concern, followed by STDs and alcohol.

Respondents' write-in comments indicated several areas that respondents felt were positive in their lives, including avoiding smoking, drinking and drugs. In many cases, the areas of concern highlighted in the write-in comments indicated concern related to weight, smoking and violence, in addition to areas of concern identified through the ranking exercise. Other topics of concern that were identified include: eating disorders, self-mutilation, diabetes, asthma, and gangs.

Adolescent Discussion Group

For more in-depth input on these issues of concern to adolescents, PSI conducted a discussion group with six adolescents who receive services from a Greater Bridgeport area youth-focused, community-based agency. The group was held on March 30, 2005, between the fourth and fifth Adolescent Health Planning Committee meetings. The discussion lasted for one hour. Of the participants, 4 were peer educators at the agency. The participants ranged from age 15 to age 20; four respondents were female and two were male.

Questions for the discussion group focused on understanding the participants' concerns about specific health issues including violence, suicide, mental health, alcohol use, drug use, pregnancy,

sexually transmitted diseases, tobacco, and obesity, and on what they think needs to be done in order to address these issues. See Appendix F for a detailed summary of discussion group themes.

In general, discussion group participants reported:

- Feeling comfortable seeking health services that are **confidential** (“your parents won’t find out”), which they feel is critical.
- Being concerned about **unintended pregnancy**. They said that unintended pregnancy is common in high school and that many teens do not think through the repercussions of pregnancy in advance. In addition, they said that many teens make decisions about sexual activity “in the moment” and do not have information about the seriousness of **STDs**.
- That the **most effective information about preventing pregnancy and STDs comes from peer educators**. They suggested having regular peer education groups in schools to address these issues.
- That **self-esteem** is an important issue. Participants felt that many teens focus excessively on their appearance and that many develop eating disorders. They also said that teens are trying to dress and act much older than they really are.
- Having considerable **stress** in their lives from trying to balance academics, sports, social lives, jobs and other activities. When asked how they deal with stress, they described taking time to read, do homework, listen to music or sleep. They said that many teens deal with stress by smoking, using drugs and drinking.
- **Having major concerns about violence** including fighting and weapons at school, and shootings and homicides in their community. They noted that they do not feel safe at school and feel that the schools do not have adequate security systems. Their suggestions about how to decrease violence focused on making schools safer with metal detectors, buzzers, locked doors, providing identification before entering the school, and additional security guards.
- Considerable **drug and alcohol use and smoking at school**. They noted that they receive inconsistent messages from teachers on this issue and that school security guards do not deal effectively with these problems.
- Feeling strongly about the importance of **families** and the importance of adolescents being taught **values, morals and manners** in the home. They also talked about the importance of having the opportunity “to be a kid,” to enjoy childhood and to enjoy being young.

SECTION 3: TRENDS ANALYSIS

As part of the development of the strategic plan, the Committee identified important social, technological, economic and social trends shaping the health and well-being of Connecticut adolescents. These “forces of change” are used to describe events and trends that are generally measurable over time but are beyond the control of stakeholders to influence. It is important to understand the potential implications of these trends for the final strategic plan.

The Strategic Planning Committee identified the following trends that could have an impact, some positive and some negative, on Connecticut adolescent health.

Social Trends

- People live in a society of fear; youth spend less time out in their neighborhoods.
- Youth spend increased amounts of time playing video games after school.
- Adolescents have more unstructured and/or unsupervised time.
- Trends show an increase in youth gambling.
- Obesity starts at an early age for many children and carries over into adolescence.
- Children are sexualized at a younger age.
- It is difficult for parents and guardians to communicate with teens about sex, and this may be further complicated by diverse cultural values about sexuality.
- New drugs such as ecstasy have become popular.
- Adolescents experience increasing amounts of peer pressure.
- In many communities, there is a lack of available transportation.
- Many youth and families experience a lack of community.
- Connecticut has increased numbers of undocumented people residing in the state.
- There is an increased need for interpreters, particularly in medical settings.
- Emergency contraception may become available over the counter.

Social Trends – Implications and Assumptions: The implications of social trends noted above might include:

- A decrease in physical activity due to less time spent out in the neighborhood and more time playing video games.
- More fragmentation of communities with increasing isolation for adolescents out of school.
- A need to target anti-obesity efforts to younger children.
- A need to provide support to parents and guardians on how to provide information to teens and younger children about sex using strategies that acknowledge cultural differences.

Political Trends

- Legislation to weaken or rescind the smoking ban in restaurants is being proposed.
- Increasing numbers of citizens and business owners are supporting smoking restrictions while opponents are making great efforts to be heard on this issue.
- Legislation to strengthen gun registration requirements and to require reporting of lost or stolen guns is being proposed.
- Development of Connecticut Community KIDCARE ASO will help DCF and DSS develop a common administrative infrastructure to improve access, coordination and quality of behavioral healthcare.
- Federal funding for abstinence-only education is increasing and funding for comprehensive sex education is decreasing.
- Legislation requiring schools to implement strategies to address physical needs of children is being proposed. Strategies include appropriate allocation of time for meal consumption and physical activity, identification of appropriate types of food and drink that may be available to children while in school, and inclusion of Body Mass Index ("BMI") evaluations as part of required school health assessments.

Political Trends – Implications and Assumptions: The implications of political trends noted above might include:

- Efforts to rescind the smoking ban will continue.
- Continued community-based education about the health effects of second hand smoke will help improve the likelihood of maintaining the restrictions.
- Changes in gun legislation may make it more difficult for youth to get access to guns.
- The ASO structure may provide a vehicle for DCF and DSS to collaborate effectively across agencies to provide and coordinate access to behavioral health services to youth.
- Schools may modify food offerings to include healthier options and may modify school schedules to offer more opportunities for physical activity.
- The use of BMI in evaluations may identify more youth who are overweight or obese and may increase awareness of the magnitude of this problem.

Economic Trends

- Budget cuts are being made across state agencies.
- There is a lack of affordable healthy food in inner city grocery stores.
- School gym classes are decreasing due to budget cuts.
- Teen work options are decreasing due to budget cuts.
- Youth are homeless, especially among foster care youth.
- The numbers of the under-insured are increasing among low-income people.

- Funding across agencies is increasingly blended.
- There is a lack of funding to support comprehensive health education and health promotion efforts at the school and community levels.
- Tobacco companies continue to increase spending on marketing strategies to target youth.

Economic Trends – Implications and Assumptions: The implications of economic trends noted above might include:

- The state’s budget constraints currently impact several important areas of adolescent health and development.
- Some youth in low-income families may lack access to all services they need through public or private insurance.

Technology Trends

- Use of video games, particularly point-and-shoot games, is increasing.
- Use of cell phones and pagers is increasing.
- The Internet provides access to an enormous range of messages and information.
- Use of electronic medical records is increasing.
- New web-based linguistic technology (translations) is being utilized.
- Ability to support and sustain children and youth with special healthcare needs in family or community settings is increasing.

Technology Trends – Implications and Assumptions: The implications of technology trends noted above might include:

- Decrease in physical activity due to more time spent playing video games and surfing the Internet
- The Internet can pose both risks and opportunities. It can expose youth to risks, such as dangerous contacts through chat rooms and inaccurate health information. At the same time, it can provide youth direct access to helpful and high quality information from respected sources.
- Electronic medical records can improve how healthcare is provided to adolescents by enabling providers to have a more comprehensive understanding of a patient’s health information. It can also raise concerns about confidentiality and appropriate access to medical information.
- Increases in motor vehicle crash related injuries, related to use of cell phones and pagers while driving.
- Better access to healthcare services and information by people of diverse linguistic backgrounds.
- Children with special needs living longer and in better health.

SECTION 4: PRIORITY ISSUES, GOALS, AND STRATEGIES

Identifying priority issues and developing comprehensive plans to respond to these issues are at the heart of the strategic planning process. *Priority issues* are fundamental issues that affect the state's ability to achieve its vision of adolescent health. Priority issues are usually large, encompassing issues that comprise what appear to be numerous unrelated or loosely related problems. They are fundamental to the strategic planning effort and must be addressed over the long term in order to make progress in a desired direction.

There are **three priority issues** of critical importance to adolescent health stakeholders in CT. These issues affect a broad range of institutions, policies and services, as well as health issues affecting adolescents directly. To identify these priorities, the Committee discussed cross-cutting issues affecting the state's ability to achieve adolescent health and well being. In addition, Committee members considered the CDC's Critical 21 Objectives and identified other issues of concern for the Connecticut adolescent population. The Committee evaluated priority issues in terms of: 1) feasibility of addressing the issue; 2) consequence if not addressed; 3) frequency of the issue; and 4) whether the issue is being adequately addressed by other organizations or initiatives.

Following are the **most critical issues** defined by CT DPH and the Adolescent Health Strategic Planning Committee.

Priority issue #1:	Provide adolescents with the support, options, and resources they need to successfully transition to healthy, empowered, and productive adulthood.
Priority issue #2:	Enhance communication, coordination and collaboration among stakeholders in adolescent health.
Priority issue #3:	Improve adolescent health and well being.

For each priority, described below in detail, we present: 1) a description of why this is an issue; 2) goals for addressing the issue; and 3) steps for taking action to address the issue. **It is important to note that there are many additional issues facing adolescents in the state.** We have described these later in this section. While these other issues have not been identified as the most critical issues in this strategic plan, CT DPH and the Adolescent Health Strategic Planning Committee present them for consideration in future and ongoing efforts to address adolescent health and well being in the state. Additionally, we have identified strategies and priority projects to address these other issues where possible.

PRIORITY ISSUE #1: Provide Adolescents With the Support, Options, and Resources They Need to Successfully Transition to Healthy, Empowered, and Productive Adulthood.

Traditional approaches to supporting adolescent health focus on identifying and reacting to problems in adolescent populations. While this approach is important for managing emerging issues in adolescent health, it is inadequate for supporting positive youth development (as defined by the Search Institute and others).

DPH and other adolescent health stakeholders are challenged to provide the support, options and resources necessary for equipping adolescents with what they need to transition to healthy adulthood. This is particularly true for adolescents with chronic illness or disabilities, or those who are in the foster care system. Increasing amounts of unstructured and/or unsupervised time for adolescents, increasingly disengaged parents and communities, and inadequate access to preventive health and mental health services undermine adolescents' ability and motivation to take responsibility for their health and behavior choices.

Many adolescents do not have access to appropriate primary care or behavioral health services, including mental health and substance abuse treatment. In many parts of Connecticut, adolescents do not have adequate public transportation, influencing their ability to participate in after school or community activities, jobs, or other activities that may be important to their development.

Many adolescents do not have access to high quality and comprehensive before- and after-school programs. As a result, many adolescents experience increased amounts of unsupervised and unstructured time. This may result in inactive time spent playing video or computer games, and it may lead to more opportunities for participating in risky behaviors.

Therefore CT DPH and other adolescent health stakeholders are challenged to develop and support a comprehensive health education agenda that addresses these issues. This sometimes results in conflicting messages about appropriate protective health strategies and services for adolescents.

Goal 1.1: Connecticut adolescents are empowered to assume responsibility for their health and behavior.

Goal 1.2: Connecticut adolescents and their families and caregivers have access to timely and affordable health and mental health services that are culturally, medically, developmentally and linguistically appropriate.

Goal 1.3: Parents and guardians, providers, and adolescents have meaningful opportunities to participate in policy decisions affecting adolescent health.

Priority Issue #1 Cross-Cutting Strategies

1. Promote positive communication between adults and adolescents in family, school, community and healthcare settings.
2. Promote workforce development for adolescents, including workforce skill development.
3. Promote regular and ongoing adolescent participation in community service.

Priority Issue #1 Specific Strategies

1. Increase awareness among adolescents and their families and guardians about how to obtain health coverage in Connecticut by distributing this information through schools, health professionals, and the media.
2. Provide educational programs and tools to support health professionals in being more culturally sensitive and more aware of cultural influences that can lead to disparities in health-seeking behaviors and medical conditions.
3. Promote adolescent-friendly healthcare environments by developing recommended protocols for pediatricians and primary care providers regarding optimal adolescent healthcare practice.
4. Invest in video technology and make this available in order to provide appropriate linguistic support for adolescents during visits to their healthcare providers.
5. Activate the legislated Adolescent Health Council (Section 19a-125) to coordinate with the Implementation Group (see Specific Strategy #2.1) and provide feedback on policy issues that impact adolescent health.
6. Promote models for evidence-based, medically accurate educational programs and tools for teachers, providers and parents/guardians to help them empower adolescents, including those with special healthcare needs, to engage in health-positive behaviors and lifestyles.
 - a. For schools, these programs should be based on the State Department of Education's Health Education and Physical Education Curriculum framework.
 - b. For other community-based providers and parents/guardians, this might include tools for more effective screening, referrals, and training in anticipatory guidance. An evaluation component should be developed for each program/tool to evaluate its use and effectiveness.
7. Further develop the infrastructure and resources for care coordination to effectively transition adolescents with complex chronic conditions to adult health systems of care by assessing resources that are currently available and building support for their use by payers and healthcare professionals.

PRIORITY ISSUE #2: Enhance Communication, Coordination and Collaboration Among Stakeholders in Adolescent Health.

Appropriate communication, coordination and collaboration among stakeholders in adolescent health has a major impact on the state's ability to effectively support adolescent health and development. Currently, stakeholders face several challenges in this area. First, programs serving adolescents (both in the public and private sectors) often function without meaningful communication and collaboration with one another. Often, this is because programs have limited opportunities for exchanging information or collaborating on service delivery. This is also due to the lack of appropriate mechanisms for sharing confidential information among healthcare providers. At times there may also be confusion about the specific services that different state agencies provide to adolescents.

Second, while there are significant efforts underway to collect and share information about the state's youth, much of the data describing adolescent health are incomplete, outdated, and not representative. For example, the most recent collection of YRBS data did not meet the requirement of 60% participation and may under-represent some geographic areas. In addition, because the YRBS is collected through school-based efforts, data are useful for monitoring general trends but do not reflect youth who are out of school or homeless. As a result, there are few (if any) data collected systematically reflecting the state's most at-risk youth.

There is also no centralized "data warehouse" of adolescent health and well being in the state. In addition, much of the information collected throughout the state focuses on problems in adolescent health. There is very little information describing youth assets. This is a challenge for adolescent health stakeholders because there is only a partial understanding of the ongoing needs of adolescents in the state.

Another real challenge is that while there are many programs serving adolescents, there is not a centralized process for monitoring these programs' effectiveness. It is important for ongoing improvement (and sometimes funding) to understand how programs are meeting their goals, lessons learned in the field, and their outcomes.

Goal 2.1: Programs and agencies serving youth (including efforts that are both public and private, and at the federal, state and local levels) have the mechanisms and opportunities to share data and information with each other, including best practices, challenges, and lessons learned in research and service delivery.

Goal 2.2: Adolescents receive coordinated, integrated physical health and mental health services.

Goal 2.3: Appropriate data are collected and available on adolescents to inform decision-making about adolescent health.

Priority Issue #2 Cross-Cutting Strategies

1. Promote positive communication between adults and adolescents in family, school, community and healthcare settings.
2. Promote workforce development for adolescents, including workforce skill development.
3. Promote regular and ongoing adolescent participation in community service.

Priority Issue #2 Specific Strategies

1. DPH should establish and facilitate an implementation group to assist with the implementation of the strategic plan. The group, which should hold ongoing meetings, should consist of key stakeholders including adolescents and their families and healthcare providers as well as representatives from state and community organizations, universities, the media, faith-based organizations, schools and law enforcement. As part of its activities, the implementation group should review data that measure the 21 Critical Health Objectives to monitor progress on these key health areas over time.
2. DPH and the implementation group should assess available data that are collected by stakeholders across the state on adolescent risk/protective factors.
 - a. Develop a tool to assess the existing data collection infrastructure, to identify capacity, cross-cutting data elements, outcomes measured, and gaps.
 - b. Develop a plan to improve current data collection and to address key gaps in data.
3. DPH should strengthen surveillance activities in order to successfully receive, integrate and make available statewide data on adolescent health to inform decision-making and public awareness.
4. DPH and the Implementation Group should establish standard indicators to determine whether adolescents are receiving coordinated integrated physical, mental and oral health services.
5. DPH and the Implementation Group should create mechanisms for documenting and distributing evidence-based best practices for adolescent health, such as conferences, websites, learning communities, forums based on a “grand rounds” approach, or newsletters.

PRIORITY ISSUE #3: Improve Adolescent Health and Well Being.

CT DPH and the Adolescent Health Strategic Planning Committee defined “health and well being” broadly, identifying several health areas that are of particular concern for adolescents in the state. These include mental health, obesity, substance abuse, reproductive health and sexuality, and violence. Goals and strategies are proposed in each of these areas. The Committee also noted several other important areas of concern, which are described at the end of this section.

A. Mental Health

The Committee identified mental health as one of the most critical health issues for adolescents in CT. Limited data are available on the extent of Connecticut adolescents’ mental health needs, including how Connecticut adolescent mental health compares to the nation and specific groups that may be at particular risk. Several agencies have responsibilities for overseeing or providing mental health services to adolescents and have applicable utilization data, but there is no centralized collection of information across agencies and private practitioners, which limits the ability to understand adolescent mental health experience broadly.

However, estimates suggest that only a portion of the population of adolescents who need mental health services receive them. *The Governor’s Blue Ribbon Commission on Mental Health* (2000) estimates that 21% of Connecticut adolescents have a mental health disorder in a single year, but that only about half of them receive any form of public or private treatment.

There are several factors that may contribute to adolescents not receiving services. There is limited availability of mental health providers treating adolescents. The availability of providers who can provide culturally or linguistically appropriate services or who can treat adolescents with disabilities is even more limited. Adolescents who are gay, lesbian, bisexual or transgendered, who may be at particular risk for having mental health related problems, may not feel comfortable seeking care. This relates to a general stigma surrounding mental health treatment.

Further, according to a 2004 Candidate Briefing by Connecticut Voices for Children (*Reforming Our Juvenile Justice System*), adolescents with untreated mental health needs sometimes end up in the juvenile justice system as a first resort instead of receiving earlier and better mental health screening. Vanessa Burns, Executive Director of the African-American Affairs Commission, testified in 2005 that minority youth are more likely than other youth to become involved in juvenile justice system.

These factors result in an inability to get mental healthcare when needed. Adolescents may feel that providers do not understand their needs or they can’t find appropriate mental health services, and this is a serious impediment to appropriate treatment. In addition, providers and researchers are not always in agreement about what constitutes appropriate treatment for adolescents.

In addition, inadequate health coverage to support ongoing mental health treatment has an impact on some youth seeking mental health services.

Adolescents surveyed as part of this planning process raised several mental health issues they considered important, such as problems accessing mental health services, including dealing with stress, family relationships, and eating disorders.

Goal 3.1: Programs, services and information are available to adolescents and their families, healthcare providers and educators that create a culture of prevention and positive mental health.

Goal 3.2: All adolescents who need mental health services have access to and utilize them.

Priority Issue #3 Cross-Cutting Strategies

1. Promote positive communication between adults and adolescents in family, school, community and healthcare settings.
2. Promote workforce development for adolescents, including workforce skill development.
3. Promote regular and ongoing adolescent participation in community service.

Priority Issue #3 Mental Health Specific Strategies

1. Participate in and inform the implementation of Recommendations of the Lieutenant Governor's Mental Health Cabinet in areas of outreach, best practices, and children's mental health. This could include supporting initiatives providing timely and accessible information and referral to consumers, and appropriate training for healthcare professionals.
2. In coordination with the Interagency Suicide Prevention Network and others, develop public education materials to de-stigmatize mental health treatment and to promote mental health among adolescents and their families, educators, and healthcare providers. This includes training educators on how to apply consistent and appropriate disciplinary and referral techniques for students with mental health needs.
3. Create a more detailed assessment of specific adolescent mental health needs. This can be done in part by:
 - a. Assessing current resources and data sources within Connecticut focused on mental health prevention and treatment, and identifying potential strengths and gaps.
 - b. Work with the Lieutenant Governor's Mental Health Cabinet and other stakeholders to identify key indicators related to mental health to incorporate into the statewide data tracking efforts described in the strategies under Priority Issue #2.
4. Work towards assuring adequate adolescent mental health provider capacity.
5. Increase routine mental health screening by primary care providers, school-based health and mental health staff, and other healthcare providers to detect early signs of depression and other mental health issues and make appropriate referrals for treatment.

B. Obesity and Healthy Lifestyles

Rates of overweight and obesity are increasing among adolescents across Connecticut, affecting all adolescent population groups. Tied to the increase in obesity is an increase in obesity-related illnesses such as diabetes, high blood pressure and high cholesterol, psychological effects such as depression and low self-esteem, and respiratory problems such as asthma and sleep apnea.

At the same time, levels of physical activity are decreasing. Data show that for Connecticut youth, females have lower rates of physical activity than males and that African-American and Hispanic/Latino students have lower rates of physical activity than White students. Rates of physical activity decrease for students in higher grades.

Approximately 30% of the adolescents who were surveyed as part of this planning process identified issues related to overweight teens and physical activities as areas of concern.

Goal 3.3: Adolescents achieve and maintain healthy nutrition and physical activity/fitness.

Priority Issue #3 Cross-Cutting Strategies

1. Promote positive communication between adults and adolescents in family, school, community and healthcare settings.
2. Promote workforce development for adolescents, including workforce skill development.
3. Promote regular and ongoing adolescent participation in community service.

Priority Issue #3 Obesity and Healthy Lifestyles Specific Strategies

1. Partner with schools to develop and implement a policy that recommends that all schools offer a range of physical activity options every day to all students in grades preK-12. Provide appropriate incentives and support to schools that implement this policy.
2. Partner with schools to assess the physical education curriculum to ensure that the curriculum is based on SDE Curriculum Frameworks and that it encourages all students—including those who are inactive, overweight and obese— to be physically active.
3. Provide schools with resources to identify opportunities for providing healthy meals and snacks at schools and eliminating junk food vending machines.
4. Develop and provide parent/guardian and teen education focused on healthy nutrition, including the importance of nutritional habits established in early childhood, and the importance of physical activity. Information should be provided by respected adults, such as coaches, and other trusted authorities.
5. Identify interventions to increase the number of adolescents who participate in before- and after-school activities that may include positive youth development, arts, music, and physical activity/sports programs.
6. Provide information and access to healthy nutritional options for adolescents and their families.

C. Substance Abuse

Connecticut adolescents' rates of alcohol and marijuana use are comparable to national rates but are higher than the national Healthy People 2010 targets. Binge drinking has decreased over recent years, but 27% of students in grades 9-12 report recent binge drinking. This suggests significant opportunities for improvement. White students in grades 9-12 have the highest rate of binge drinking, followed by Hispanic/Latino students.

Connecticut adolescent marijuana use has increased slightly over recent years and is higher than the national level and much higher than the Healthy People 2010 target. There are no large disparities by

racial/ethnic group or gender for marijuana use. Therefore, interventions should be focused broadly across these groups.

Use of other drugs is also of concern. For example, Connecticut adolescents' use of inhalants and ecstasy exceeds national rates (*Governor's Prevention Initiative for Youth 2000 Student Survey*). In addition, steroid use is increasing among both male and female adolescents. The use of steroids and other performance-enhancing drugs in the state has become so problematic that the state is considering random steroid testing in high schools. The state's Regional Action Councils (see Appendix D) are important sources of information on substance abuse trends and interventions and should be an important partner in prioritizing and implementing strategies in this area.

In Connecticut, tobacco use has declined among adolescents, as it has in national trends. However, there are still opportunities for improvement, with a higher percentage of females reported smoking cigarettes than male students. White and Hispanic/Latino students in CT have higher rates of smoking cigarettes than African-American students. *The State of Connecticut Youth 2003* (Connecticut Voices for Children) points out "smoking appears to begin later in affluent suburbs than in small urban cities in Connecticut. However, by grades 9 and 10, students in the suburbs are smoking as much as, and perhaps even more than, urban counterparts."

Substance abuse is an area of major concern for adolescents who gave input in this process. Approximately 58% and 63% of the adolescents identified alcohol and drugs respectively as one of their top three concerns. Approximately 37% of them thought that tobacco was one of the main concerns for adolescents.

Goal 3.4: Adolescents abstain from the use alcohol, marijuana, tobacco and other substances.

Goal 3.5: All adolescents who need substance abuse treatment have access to timely, affordable, and culturally, medically, developmentally and linguistically appropriate services.

Priority Issue #3 Cross-Cutting Strategies

1. Promote positive communication between adults and adolescents in family, school, community and healthcare settings.
2. Promote workforce development for adolescents, including workforce skill development.
3. Promote regular and ongoing adolescent participation in community service.

Priority Issue #3 Substance Abuse Specific Strategies

1. Ensure that adolescents are screened for substance abuse by their healthcare providers using appropriate screening tools.
2. Promote local “operation storefront” projects, in which youth assess tobacco advertising in their communities and share findings with other youth.
3. Increase networking opportunities for Regional Action Councils across the state (see Appendix D), enabling them to share information, experiences, and best practices.
4. Promote use of clinical practice guidelines for tobacco prevention.
5. Increase enforcement efforts focused on preventing sale of tobacco and alcohol to under-age youth.
6. Encourage all schools to implement research-based substance abuse prevention programs within the context of comprehensive school health education.
7. Increase awareness of evolving substance abuse issues.

D. Reproductive Health and Sexuality

The number of Connecticut teens who report having been pregnant has decreased, reflecting national trends. Hispanic female students have a much higher pregnancy rate than White female students. A lower percentage of African American and Hispanic/Latino students either abstain from sexual intercourse or use condoms if sexually active than White students. *The State of Connecticut Youth 2003* (Connecticut Voices for Children) points out that “important racial and geographic disparities in the teen birth rate remain in the state,” with a much higher birth rate for Hispanic/Latino and African American teens and a higher teen birth rate in Connecticut’s largest cities.

Sexually transmitted diseases (STDs) have increased significantly in Connecticut. Chlamydia cases in Connecticut youth ages 15-24 have increased noticeably, particularly for males. STDs have a heavy impact on Connecticut’s minority youth. African American and Hispanic/Latino adolescents and young adults ages 15-24 have higher HIV rates than White adolescents. The state’s 2002-2004 HIV Prevention Plan (DPH Division of HIV/AIDS Prevention) describes the high rates of reportable STDs among young people demonstrate continued risky sexual behavior among youth.

Adolescents reported a high level of concern about pregnancy and STDs through the survey administered for this project. Approximately 40% identified pregnancy as one of their top three areas of concern, and approximately 50% identified STDs as one of their three areas of concern. The surveys showed that these areas are especially of concern to minority youth; 76% of the youth who identified pregnancy as a concern were African American or Hispanic, and 73% of the youth who identified STDs as a concern were African American or Hispanic.

Goal 3.6: Adolescents adopt behaviors that support healthy sexuality.

Priority Issue #3 Cross-Cutting Strategies

1. Promote positive communication between adults and adolescents in family, school, community and healthcare settings.
2. Promote workforce development for adolescents, including workforce skill development.
3. Promote regular and ongoing adolescent participation in community service.

Priority Issue #3 Reproductive Health Specific Strategies

1. Educate stakeholder agencies on evidence-based, culturally appropriate approaches to sexuality education and the curriculums that have been developed—through the implementation group described in Priority Issue #2. Work toward using a consistent curriculum across the state.
2. Support School-Based Health Centers, Community Health Centers, and other community based organizations to offer comprehensive reproductive health services.
3. Increase adolescents' access to screening for HIV, STDs and pregnancy.
4. Support parents/guardians in efforts in talking to adolescents about sexuality, by providing culturally appropriate information and materials, and supporting improved outreach efforts from schools, community organizations and peer educators.

E. Violence

While overall Connecticut adolescents have a low violence rate – including homicide, physical fighting and weapon carrying – compared to the nation, there is still considerable room for improvement and some disparities exist regarding youth experience in this area.

For example, CT's YRBS data shows that physical fighting has increased sharply among high school students. Hispanic/Latino students and African American students have higher rates of weapon carrying than White students, and Hispanic/Latino students have higher rates of physical fighting. Overall, males have higher rates of violence than females, including homicide, weapon carrying, and physical fighting.

The State of Connecticut Youth 2003 (Connecticut Voices for Children) points out that “Connecticut leads the nation in the number of juveniles under 18 years in adult jails and prisons” and that “minority youth are disproportionately represented in our state's juvenile justice system.”

Input from adolescents suggests that violence is a key area of concern for them. Almost half of adolescents who were surveyed identified violence as one of their top three areas of health concern, with several specifically citing concerns about fighting and bullying.

In addition, dating and domestic violence was identified as an emerging area of concern among stakeholders and adolescents.

Goal 3.7: Adolescents live in neighborhoods and go to schools that are violence-free.

Priority Issue #3 Cross-Cutting Strategies

1. Promote positive communication between adults and adolescents in family, school, community and healthcare settings.
2. Promote workforce development for adolescents, including workforce skill development.
3. Promote regular and ongoing adolescent participation in community service.

Priority Issue #3 Violence Specific Strategies

1. Create opportunities for teen employment and workforce skill development.
2. Increase opportunities and venues where adolescents can learn and practice positive social-emotional skills.
3. Increase the number of schools that have peer mediation/conflict resolution and social development programs.
4. Improve availability and accessibility of education and support on violence prevention and non-violent behaviors for parents/guardians, families and caregivers of adolescents.
5. Support efforts to reduce availability of weapons.
6. Provide schools with resources to address violence in schools, such as support for peer mentoring programs, lesson plans addressing positive social-emotional skills and conflict resolution, and support for increased security on school grounds.
7. Reduce demand for drugs through substance abuse prevention and treatment strategies described in this section.
8. Support efforts at the community level to reduce violence.

F. Other Key Adolescent Health Issues

There are several other important adolescent health issues in Connecticut, which may be of special concern for specific groups of adolescents. These are not the primary focus of this strategic health plan, in some cases because there are extensive programming and services addressing these areas, by

organizations listed in Appendix D. However, these are important issues that should continue to be monitored and included in future planning as appropriate.

Other key adolescent health issues include:

Suicide: Connecticut's rates of suicide and suicide attempts requiring medical attention have not changed dramatically in recent years. However disparities do exist. Males aged 15-19 have a significantly higher suicide rate than females in the same age range. Hispanic/Latino and African American students have a higher rate of suicide attempts than White students.

Motor vehicle crash related injuries: Overall, Connecticut compares well to other states on motor vehicle crash related injuries. It has surpassed the Healthy People 2010 target for reducing the number of adolescents who report they rode with a driver who had been drinking alcohol. The state is above the national rate on seat belt use but has not met the national target. Connecticut has a lower rate of adolescent deaths caused by motor vehicle crash related injuries than the national rate. However, disparities do exist and there are opportunities for improvement. Male adolescents have a much higher rate of death due to motor vehicle crash related injuries and lower rates of seat belt use than female adolescents. Hispanic/Latino students have the lowest rate of seat belt use of all races, followed by African American students. Hispanic/Latino students have the highest percentage of all races of driving with someone who has been drinking. *The State of Connecticut Youth 2003* (Connecticut Voices for Children) underscores these disparities by pointing out that while the rate of preventable deaths among youth (including injuries) is declining, "the rate of preventable teen deaths was higher in urban cities than in affluent suburbs." Adolescent input surveys indicate that many consider motor vehicle crash related injuries as an important area of concern.

Oral health: The Connecticut Oral Health Initiative describes in its website that there is a crisis in oral health in Connecticut. Tooth decay remains the most common chronic childhood disease in Connecticut. Over 84% of children have had dental decay by age 17. Oral disease could be significantly decreased with improved dental care from an early age. Instead, children miss hundreds of thousands of hours of school annually due to tooth decay and oral infection. Access to oral healthcare is impacted by the low percentage of Connecticut dentists who accept Medicaid/ Husky clients. Seventy-one percent of children enrolled in Connecticut's Medicaid Program do not receive any dental care and there are long waiting lists to receive services.

Gambling: The Connecticut Council on Problem Gambling (CCPG) describes how youth are growing up in a society where legalized gambling is a socially acceptable, widely promoted, and highly visible recreational activity. In this context, it is not surprising that many young people in Connecticut under the age of 18 are gambling. CCPG conducted a prevalence study among Connecticut high school students (1996-1997), which yielded the following results:

- The rate of gambling among the high school students in this survey exceeds the rate of substance use.
- Students who gamble excessively are more likely to abuse substances and vice versa.
- Males and minority group members are at greater risk for problem gambling.
- A history of problem gambling among family members is significantly related to problem gambling among students.
- There is widespread gambling among underage students in the lottery.
- Students with a gambling problem are gambling on school grounds and absent from school in order to gamble.
- Problem gambling has significant negative affects on students' family, school, and community life.
- The rate of problem gambling among high school students (11.3%) significantly exceeds the rate for adults.

Stress: Both agencies and programs serving adolescents, as well as adolescents themselves, identified stress as an issue affecting adolescent health. Stress can be experienced in a range of environments and in relation to a number of different issues. It can include stress from living in communities or attending schools where adolescents encounter violence and drugs. It can be stress from experiencing too much pressure academically. Stress is not addressed separately in this strategic plan, but it can be related to substance abuse, mental health, suicide, violence and a number of other themes.

Economic conditions: *The State of Connecticut's Youth 2003* notes that:

Policymakers in Connecticut have long recognized this dichotomy in the state, a state that boasts the highest per capita income in the nation, yet whose capital city has the second highest poverty rate among US cities. One of the greatest challenges in Connecticut is to eliminate the gaps between these groups by providing equal opportunities for success to all children, youth and families in the state.

While addressing the impact of economic disparities is beyond the scope of the strategic plan, these issues impact the state's ability to address adolescent health. Indicators such as income and employment are important for consideration in setting priorities for action, and in evaluating the effectiveness of programs and strategies.

SECTION 5: FROM PLANNING TO ACTION

After finalizing the Adolescent Health Strategic Plan, it will be critical to take action to begin to address the identified issues. There are two key actions that will set the framework for implementation of the Strategic Plan: 1) Establish an Implementation Group and Implementation Structure, and 2) Communicate the Plan. Each is described in detail below.

Key Action #1: Establish an Implementation Group and Implementation Structure

One of the primary factors for the ongoing success will be the implementation of an Implementation Group to sustain the work initiated by this adolescent health plan. This Group will provide the basis for sharing information, identifying priorities, and initiating and sustaining action to achieve the goals outlined in this plan.

The Implementation Group will meet regularly, and have representation from DPH, other key agencies including but not limited to Department of Labor (DOL), DSS, DCF, DMAHS, SDE, Department of Transportation (DOT), Department of Justice (DOJ), and DMR, healthcare providers, key community-based organizations, adolescents and families. This group should have representation from appropriate state-level task forces and councils also addressing adolescent health, including but not limited to the Governor’s Behavioral Health Task Force, Coordinated School Health Partnership, and the Governor’s Prevention Partnership.

With leadership from DPH, the Group’s activities will include:

- **Organizing for Success**
 - ✓ Appoint a **Strategic Planning Coordinator** to coordinate and facilitate implementation efforts. This person has responsibility for tracking progress, documenting results, communicating progress, and alerting the Monitoring/Oversight Team to problems, delays, and successes.
 - ✓ Form a **Strategic Planning Monitoring/Oversight Team** that reviews progress on each strategic issue, helps to remove barriers, and maintains focus on the strategic plan. This Team may be a subset of the Implementation Group, and should include representation from DPH and key agencies.
 - ✓ Form an **Action Team** for each priority issue, including each priority health area identified in Section 4. Each Action Team should consist of 3-4 members, including people with relevant expertise and/or from stakeholder agencies. Action Team members will be responsible for developing a plan to achieve the issue’s goals and strategies.

- **Creating Implementation Plans**

- ✓ Have the Action Teams complete **Implementation Plans** that lay out their work plan (what they intend to do), timelines, expected outcomes, and who is responsible.
- ✓ Ensure that Action Teams **include partner agencies** when funding or seeking for funding for initiatives in order to encourage collaboration, coordination and effective use of resources.
- ✓ Set a high priority for initiatives that promote **blended funding streams** across agencies that provide services to overlapping adolescent populations.
- ✓ **Set a target for six months from now.** That is, define what the Strategic Planning Monitoring/Oversight Team hopes to accomplish in six months and set up a meeting date to discuss results.
- ✓ Define **short-term and long-term evaluation criteria** to measure progress.

Key Action #2: Communicate the Plan to Stakeholders, Adolescents and Families

With input and direction from the Implementation Group, communicate the plan to stakeholders in adolescent health. Once the plan is finalized, this is an important component in order to gain necessary support for implementing the plan. Communicating the plan also serves the important purpose of uniting and aligning stakeholders under a single vision for healthy, empowered and productive adolescence. It will also help to hold the group responsible for working towards the goals outlined in the plan.

Communicating the plan could involve several activities, including:

- Convening a statewide conference to announce the launch of the plan.
- Holding regional forums with stakeholders around the state to introduce the plan as well as agree on key goals and strategies for potential collaboration.
- Developing and distributing a summary of the plan to professional audiences, including state employees.
- Developing a summary of the plan to distribute to adolescents and their families, perhaps through community agencies and healthcare providers.
- Developing a mechanism for regular communication to key stakeholders about the ongoing implementation of the plan, including its successes.

When preparing to communicate the plan, it is essential to consider the needs and interests of the target audiences. While one audience (e.g., state agency staff) may want detailed information and data, other audiences (e.g., community providers) may appreciate a higher-level summary of the

key points. The Implementation Group will be responsible for developing a range of communication approaches to satisfy the needs of a range of stakeholders.

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APPENDIX A: STRATEGIC PLANNING COMMITTEE PARTICIPANTS

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Martha Okafor	CT Dept. of Public Health, Family Health Division
Donna Heins	CT Dept. of Public Health, Family Health Division
Vincent Sacco	CT Dept. of Public Health, Infectious Diseases
Heidi Jenkins	CT Dept. of Public Health, Infectious Diseases
Terri Foster	CT Dept. of Public Health, Tobacco Program
Rose Ciarcia	CT Dept. of Social Services, HUSKY Programs
Lisa Rau	CT Primary Care Association
Peg Perellie	CT PTA
Susan Peters	Fair Haven Health Center
Rudy Fuedo	Greater Bridgeport Adolescent Pregnancy Program, Inc.
Carla Gisolfi	Human Services Council, School Based Health Program
Mariette McCourt	Legislative Medicaid Council
Susan Lane	Planned Parenthood of Connecticut
Aric Schichor	St. Francis Hospital Medical Center

APPENDIX B: CRITICAL 21 HEALTH OBJECTIVES FOR ADOLESCENTS
AND YOUNG ADULTS FROM THE U.S. HEALTHY PEOPLE 2010
OBJECTIVES

16-03 (a, b, c)	Reduce deaths of adolescents and young adults
UNINTENTIONAL INJURY	
15-15 (a)	Reduce deaths caused by motor vehicle crashes.
26-01 (a)	Reduce deaths and injuries caused by alcohol- and drug-related motor vehicle crashes.
15-19	Increase use of safety belts.
26-06	Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol.
VIOLENCE	
18-01	Reduce the suicide rate.
18-02	Reduce the rate of suicide attempts by adolescents that required medical attention.
15-32	Reduce homicides.
15-38	Reduce physical fighting among adolescents.
15-39	Reduce weapon carrying by adolescents on school property.
SUBSTANCE USE AND MENTAL HEALTH	
26-11 (d)	Reduce the proportion of persons engaging in binge drinking of alcoholic beverages
26-10 (b)	Reduce past-month use of illicit substances (marijuana)
06-02	Reduce the proportion of children and adolescents with disabilities who are reported to be sad, unhappy, or depressed.
18-07	(Developmental) Increase the proportion of children with mental health problems who receive treatment.
REPRODUCTIVE HEALTH	
09-07	Reduce pregnancies among adolescent females.
13-05	(Developmental) Reduce the number of new HIV diagnoses among adolescents and adults.
25-01 (a, b, c)	Reduce the proportion of adolescents and young adults with <i>Chlamydia trachomatis</i> infections among 15- to 24-year-olds. <ul style="list-style-type: none"> • Females attending family planning clinics • Females attending sexually transmitted disease clinics • Males attending sexually transmitted disease clinics
25-11	Increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active.
CHRONIC DISEASES	
27-02 (a)	Reduce tobacco use by adolescents.
19-03 (b)	Reduce the proportion of children and adolescents who are overweight or obese.
22-07	Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 minutes or more minutes per occasion.

APPENDIX C: SOURCES AND REPORTS USED IN THE DEVELOPMENT
OF A REPORT ON ADOLESCENT HEALTH NEEDS, ASSETS AND BEST
PRACTICES

Connecticut data:

- Connecticut Department of Public Health, Office of Policy, Planning and Evaluation, Vital Statistics (CT DPH OPPE)
- Motor Vehicles Fatality Report, CT Department of Transportation
- YRBS(S): Youth Risk Behavior Surveillance System or Youth Risk Behavior Survey
- DPH HIV/AIDS Surveillance Program: HIV diagnoses since 2002
- CT Childhood Injury Prevention Center at CT Children's Medical Center
- DPH Family Health Division: CT Teen Pregnancy Facts, Statistics and Programs
- Chlamydia in CT 1999-2002 (DPH publication)
- School Based Health Center Utilization by Diagnosis Code
- HUSKY Utilization Data for Behavioral Health Services

National data:

- APS: Abortion Provider Survey
- ASD: Abortion Surveillance Data
- CDC: United States Centers for Disease Control and Prevention
- CT OPPE: Connecticut Office of Policy, Planning, and Evaluation
- NCCDPHP: National Center for Chronic Disease Prevention and Health Promotion
- FARS: Fatality Analysis Reporting System
- NCHS: National Center for Health Statistics
- NHANES: National Health and Nutrition Examination Survey
- NHSDA: National Household Survey on Drug Abuse
- NSFG: National Survey on Family Growth
- NVSS-M: National Vital Statistics System- Mortality
- NVSS-N: National Vital Statistics System- Natality
- SAMHSA: Substance Abuse and Mental Health Services Administration
- YRBS(S): Youth Risk Behavior Surveillance System or Youth Risk Behavior Survey

APPENDIX D: CONNECTICUT ORGANIZATIONS AND SERVICES SERVING ADOLESCENT HEALTH

This list of programs and services supporting adolescent health was developed from a range of sources including interviews with DPH staff, a review of research reports produced by a range of organizations, input from the Adolescent Health Strategic Planning Committee members, and an in-depth web-based review of Connecticut organizations. This list should not be viewed as complete or exhaustive but rather as an identification of the many organizations supporting adolescent health in Connecticut.

INDICATOR	CONNECTICUT ASSETS
<p>YOUTH LEADERSHIP AND DEVELOPMENT</p>	<ul style="list-style-type: none"> • American Red Cross, Greenwich, Connecticut Chapter • Anti-Defamation League • Boys and Girls Club of America • Boy Scouts of America • Bridgeport Health Department, Youth as Resources • Connecticut Forum, CT Youth Forum • Department of Children and Family Services Youth Advisory Boards • FBI National Academy Associates, Connecticut Chapter • 4-H • Girl Scouts of America • Institute for Community Research • Neighborhood Youth Centers • Roots and Shoots Youth Leadership Council • Stratford Youth and Family Advisory Board • True Colors • Valley United Way Youth Leadership Program • Waterbury Foundations Program • Youth Development Training and Resource Center/Consultation Center • Youth as Philanthropists, Fairfield County • Youth Service Bureaus
<p>INFORMATION AND RESOURCES FOR PARENTS</p>	<ul style="list-style-type: none"> • Anti-Bullying Program, Department of Education • Birth to Three Program • Children's Health Infoline • Children's Trust Fund: Help Me Grow, Nurturing Families Initiative • Connecticut Clearinghouse • Connecticut Community Health Centers • Connecticut Parent Teacher Association • Connecticut Parents As Teachers Association • Emergency Mobile Psychiatric Services • Fatherhood Website, Department of Social Services

INDICATOR	CONNECTICUT ASSETS
	<ul style="list-style-type: none"> • Parent Education and Assessment Centers, Department of Children and Families • Parent Leadership Training Institute • Parent Support Information, The Wheeler Clinic • 2-1-1 Infoline • Young Families Program, Department of Social Services • Youth Service Bureau
HEALTHCARE SERVICE AND HEALTH ACCESS	<ul style="list-style-type: none"> • Advisory Commission on Multicultural Health • Child Guidance Clinics • Children, Youth & Family AIDS Network • Connecticut Commission on Children • COMADRONA, Department of Public Health • Commission on Deaf and Hearing Impaired • Community Health Center Program, Department of Public Health • Connecticut Community Health Centers • Connecticut Voices for Children • Connecticut Clearinghouse • Connecticut Community KIDCARE • DCF Office of Multicultural Affairs Website • DCF Psychotropic Medication Advisory Committee • Emergency Mobile Psychiatric Services • HUSKY Program • Maternal Child Health Information and Referral Services (MCHI&R) Infoline, Department of Public Health • Medicaid Managed Care Council • Mental Health Clinics • Multicultural Health Resource Directory, Department of Public Health • Planned Parenthood of CT • School nurses, social workers, and psychologists • School-Based Health Centers (SBHCs), Department of Public Health • Sickle Cell Disease Association of America/Connecticut Chapter
UNINTENTIONAL INJURY	<ul style="list-style-type: none"> • Connecticut Children’s Medical Center Injury Prevention Program • Drink-drive-lose.com • Mothers Against Drunk Driving (MADD) • Students Against Drunk Driving (SADD) • School-Based Health Centers (SBHCs), Department of Public Health • Unintentional Injury Program, Department of Public Health
VIOLENCE	<ul style="list-style-type: none"> • Safe and Drug-Free Schools and Communities Grant, Department of Education • Connecticut Community Health Centers

INDICATOR	CONNECTICUT ASSETS
	<ul style="list-style-type: none"> • Governor’s Prevention Partnership – Safe Schools and Communities Coalition • Hispanic Health Council, The Center for Youth & Families • School-Based Health Centers (SBHCs), Department of Public Health • New Haven Gang Task Force • Project One Voice • Youth Violence Firearms Initiative • Center for Violence Reduction, University of CT • Positive Youth Development Initiative, Department of Children and Families • Reconnecting Youth, Bridgeport SBHC • Promoting Alternative Thinking Strategies, Bridgeport SBHC • Connecticut Coalition Against Domestic Violence (services addressing dating violence) • Connecticut Sexual Assault Crisis Services (CONNSACS)
SUICIDIDE	<ul style="list-style-type: none"> • Connecticut Community Health Centers • Connecticut Youth Suicide Advisory Board, Department of Children and Families • Intentional Injury Program, Department of Public Health • School-Based Health Centers (SBHCs), Department of Public Health • 2-1-1 Infoline and Youth Yellow Pages • Reconnecting Youth, Bridgeport SBHC • Teen Screen • Connecticut Committee for Youth Suicide Prevention
SUBSTANCE ABUSE	<ul style="list-style-type: none"> • CT Assets Network • Connecticut Clearinghouse • Connecticut Coalition to Stop Underage Drinking Youth Council (CCSUD) • Connecticut Council on Problem Gambling • Connecticut Department of Children and Families (DCF) • Connecticut Community Health Centers • Connecticut Prevention Network (CPN) • Connecticut Renaissance, Inc. • The Governor’s Prevention Partnership • Hartford Youth Project, Department of Children and Families • Local Prevention Councils • Mobilize Against Tobacco for Children’s Health (MATCH), Inc. • Mothers Against Drunk Driving (MADD) • Multicultural Leadership Institute • Safe and Drug-Free Schools and Communities Grant, Department of Education • School-Based Health Centers (SBHCs), Department of Public Health

INDICATOR	CONNECTICUT ASSETS
	<ul style="list-style-type: none"> • Students Against Drunk Driving (SADD) <p>Regional Action Councils</p> <ul style="list-style-type: none"> • Birmingham Group/Valley Substance Abuse Action Council, Ansonia • Business and Industry/Middlesex, Middletown • Capitol Area Substance Abuse Council, Bloomfield • Citizen’s Task Force, New London • City of Waterbury/Central Naugatuck Valley RAC, Waterbury • Lower Fairfield County RAC, Stamford • ERASE, East Hartford • Housatonic Valley Coalition Against Substance Abuse, Bethel • Human Services Council/Mid Fairfield, Norwalk • Meriden/Wallingford RAC • Northeast Communities Against Substance Abuse (NECASA), Dayville • Regional youth/Adult Substance Abuse Project, Bridgeport • Regional Substance Abuse Action Council (SAAC), Bristol • South Central CT RAC, New Haven <p>DMHAS Funded Community-Based Substance Abuse Programs</p> <ul style="list-style-type: none"> • Alcohol Services Organization of South Central CT • Bridges a Community Support System • Central CT State University • Child and Family Agency of SE CT • The Consultation Center • Community Prevention and Addiction Services, Inc. • Courage to Speak Foundation • Institute for Community Research • McCall Foundation • Midwestern CT Council on Alcoholism • New Directions • Positive Directions (formerly Alcoholism and Drug Dependency Council) • Rushford Center • Wheeler Clinic
MENTAL HEALTH	<ul style="list-style-type: none"> • Big Brother/Big Sister • Bridges: A Community Support System, Inc. • Connecticut Clearinghouse • Connecticut Community KIDCARE • Connecticut Community Health Centers • Connecticut Renaissance, Inc. • Emergency Mobile Psychiatric Services • FAVOR (Family Advocacy Organization for Children’s Mental Health) • The Mental Health Association of CT

INDICATOR	CONNECTICUT ASSETS
	<ul style="list-style-type: none"> • Mental Health – AIDS Program, Department of Public Health • Mental Health Clinics • One to One Mentoring, Department of Children and Families • Primary Mental Health Programs, Department of Education • School-Based Health Centers (SBHCs), Department of Public Health • School Guidance Clinics • School social workers and psychologists • Young Adult Services, Department of Children and Families
REPRODUCTIVE HEALTH	<ul style="list-style-type: none"> • Abstinence-Only Education, Department of Public Health • Adolescent Pregnancy Prevention/Young Parents Program (APP/YPP) • AIDS Surveillance and Viral Hepatitis Surveillance and Prevention Programs, Department of Public Health • Break the Cycle, Hartford • Child and Family Agency of Southeastern CT • Children, Youth & Family AIDS Network • CT Community Health Centers • HIV/STD Prevention, Department of Education • Planned Parenthood of CT • School-Based Health Centers (SBHCs), Department of Public Health • Sexually Transmitted Disease Program (STD), Department of Public Health
CHRONIC DISEASES	<ul style="list-style-type: none"> • Connecticut Community Health Centers • Connecticut Team Nutrition • Hispanic Health Council, The Center for Community Nutrition • Local Prevention Councils • MATCH Coalition (Mobilize Against Tobacco for Children’s Health) • Safe and Drug-Free Schools and Communities Grant, Department of Education • School-Based Health Centers (SBHCs), Department of Public Health • Statewide Oral Health Promotion and Disease Prevention Program, Department of Public Health
ORAL HEALTH	<ul style="list-style-type: none"> • Connecticut Community Health Centers • Connecticut Oral Health Initiative • Oral Health Promotion and Disease Prevention Program, Department of Public Health

APPENDIX E: ADOLESCENT INPUT SURVEY

1. Thinking about your health, and the health of your friends and other adolescents in your area, describe some areas you think are going really well. (This could include being a healthy weight, not smoking, and avoiding fights in school.)

2. What health issues do you think are the biggest problems for adolescents in your community today?

3. *At the state level, we're working on a project to improve adolescent health across Connecticut. We would like your input on which health issues you think we should focus on. Please rank the following health issues in order of importance to be addressed, when you think about yourself, your friends and other adolescents in your community. (1 = most important and 10 = least important)*

- Motor vehicle accidents
- Violence (physical fighting, weapons carrying)
- Suicide
- Getting mental health and/or counseling services
- Alcohol use
- Drug use
- Pregnancy prevention
- Sexually transmitted diseases (such as HIV or chlamydia)
- Tobacco use
- Overweight and obesity

3. What other health concerns do you have that are not on this list?

4. Please give us some basic information about you.
 Male Female

Age range:

10-12 16-18 13-15 18+

What is your racial/ethnic group?

What city or town do you live in?

APPENDIX F: SUMMARY OF ADOLESCENT DISCUSSION GROUP KEY FINDINGS

For more in-depth input on issues addressed in the Adolescent Health Strategic Plan, PSI conducted a discussion group with six adolescents who receive services from a Greater Bridgeport area youth-focused, community-based agency. The group was held on March 30, 2005, between the fourth and fifth Adolescent Health Planning Committee meetings. The discussion lasted for one hour. Of the participants, 4 were peer educators at the agency. The participants ranged from age 15 to age 20, with four females and two males. Questions for the discussion group focused on understanding the participants' concerns about specific health issues, including violence, suicide, mental health, alcohol, drug use, pregnancy, sexually transmitted diseases, tobacco, and obesity, and what they think needs to be done in order to address these issues.

When asked about what is going well in their lives related to health issues, group participants said that when teens need services, they feel comfortable going to the local health center and Planned Parenthood of Connecticut. They said that teens feel comfortable going for health care at these locations because services are **confidential** ("your parents won't find out"), which they feel is critical. They noted that most teens know where to go to get health care services. For teens that don't know where to go, they may ignore a problem. The peer educators also noted that many teens come to them with questions about where to get services.

The participants expressed concern about **unintended pregnancy**. They said that unintended pregnancy is common in high school and that many teens do not think through the repercussions of pregnancy in advance. They feel that an important problem for teens is that they **do not have accurate information** about preventing pregnancy and the consequences of early pregnancy, and that information presented through health education classes has not taught them enough on these issues. They feel that the **most effective information comes from their peers**. To address this issue, one respondent suggested convening a summit of teenage mothers to talk to other teens about how pregnancy has affected them. In addition, they suggested that peer education programs are an effective means of talking about pregnancy prevention. The participants also expressed concern that for teens that do become pregnant, many do not receive adequate **prenatal care** or preparation on how to care for a baby.

Participants said that many teens make decisions about sexual activity "in the moment" and do not have information about the seriousness of **STDs**. They suggested peer education groups in schools to address these issues and feel that groups should be conducted more often.

One participant described that for many adolescent girls, **self-esteem** is an important issue. Participants felt that many teens focus excessively on their appearance and that many develop eating disorders. Some said that teen girls who lack self-esteem sometimes want to be loved and cared for by a boy, which they said leads some girls into relationships where girls feel pressured into early sexual activity. They also said that teens are trying to dress and act much older than they really are (e.g., 15-year-olds that dress and act like they are 20). One participant said that he felt teens are beginning to become sexually active at earlier ages, sometimes as early as nine years old.

Participants feel that they have considerable **stress** in their lives from trying to balance academics, sports, social lives, jobs and other activities. Several describe pressure to do too much. Many agreed that they couldn't do all they wanted to do, and some were forced to quit activities they enjoyed (e.g., gospel choir). When asked how they deal with stress, they described taking time to read, do homework, listen to music, or sleep. They said that many teens deal with stress by smoking, using drugs and drinking. They feel that **programs that allow teens to talk to peers** provide an effective way for them to deal with stress, allowing teens to talk about issues that they would not be comfortable raising with adults.

Violence is an area of major concern for this group. They described situations involving fighting and weapons at school, and shootings and homicides in their community. They noted that they do not feel safe at school and feel that the schools do not have adequate security systems. Their suggestions about how to decrease violence focused on making schools safer with metal detectors, buzzers, locked doors, providing identification before entering the school, and additional security guards. While they feel that teens make suggestions regarding school safety, their concerns are not implemented because of school budget constraints.

Alcohol and drug use are also of concern. Group participants described considerable **drug and alcohol use and smoking** at school. They feel that there are inconsistent messages from teachers on this issue and that school security guards do not deal effectively with these problems. For example, they are not consistent about how they treat students who have been drinking or using drugs at school. They feel that there should be more programs to address substance abuse, but also feel that it is difficult to get youth to change these behaviors.

Some of the participants feel that **nutrition** is also an important issue. While they note that there are now some healthier food choices at school, there are still many unhealthy food options (for example, french fries offered with every meal, including breakfast). They also described how many teens do not know what a healthy diet is and they need more information about food groups and healthy eating. Some participants noted that teens want to eat food that tastes good, and that this may be a higher priority than making healthy food choices.

They talked about the importance of **families**. One teen noted that “everything starts in the home.” In some cases, participants said that parents do not know how to treat teens, either treating them as a friend or not providing adequate support. He described how sometimes in a single parent home, if a teen’s mother develops a new relationship and shifts her attention away, the teen may try to raise her self esteem and confidence through a relationship with a boy, which can lead to unintended pregnancy and STDs.

Several noted that some parents make the mistake of being too strict, which can lead to an adolescent rebelling. They emphasized that once a parent has provided a strong foundation of values, manners and morals, that the adolescent should have room to make decisions for him or herself, including making mistakes and learning from those mistakes.

Several participants in the group described the importance of adolescents being taught **values, morals and manners** in the home. They emphasized the importance of this foundation. They also talked about the importance of having the opportunity “to be a kid”, to enjoy childhood and to enjoy being young.