Utah
Adolescent Reproductive Health Report
2010

UTAH DEPARTMENT OF HEALTH
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Overview

The Utah Department of Health is pleased to release this report on the reproductive health of adolescents in Utah. The focus of this report is adolescent pregnancy and how certain behaviors can increase the risk of youth engaging in unsafe practices. For the purposes of this report, adolescence is defined as ages 11-24. The authors and contributors represent an interdisciplinary group of researchers, health educators, clinicians, and other advocates for the health and well being of Utah adolescents.

This report consists of the following three sections:

Introduction: Defining adolescents and identifying behaviors that place today's youth at an increased risk for pregnancy and sexually transmitted diseases.

Utah Data: Various tables and charts that provide the most current data for adolescent births, pregnancies, and related factors.

Topical Reports: This section consists of a variety of reports related to adolescent reproductive health. Topics include, but are not limited to: repeat teen births, sexually transmitted diseases, substance abuse, gang activity, and adolescent mental health. Each of the eight topical reports follows the same format and provides the following information:

- Problem Statement
- Background
- Utah Data
- National Data
- Who is at Risk
- What is Being Done
- Local Resources
- National Resources
- Recommendations
- References

Authors and Contributors

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Introduction

Adolescent pregnancy is a persistent health and social problem that has serious consequences at the individual, family, and community levels. Pregnancy during the teen years poses health problems for mothers and their infants. Teen pregnancy increases a family's chances of living in poverty (especially compared with married adults who start families after age 20), and results in high social costs for health care and public assistance. Teen pregnancy may result in: induced abortions, inadequate prenatal care, repeat births before age 20, proportionally higher rates of low birth weight infants and infant mortality, subsequent infant illnesses and/or disabilities, low educational attainment and low marriage rates.

Birth Rate: Teen births (ages 15-19) in Utah account for approximately 7% of all births in the state. In 2008, 3,745 adolescents ages 15-19 gave birth. More than a thousand (1,122) children were born to adolescents 15 -17 years of age. The 2008 birth rate for Utah teens ages 15-19 was 34.4 per 1,000 females in this age group compared to the national rate of 42.5 per 1,000. For data comparison purposes, Utah divides the state into 62 small areas. Of these small areas, 18 have teen birth rates higher than the nation. When Utah's teen population is broken down by race and ethnicity, the highest birth rates occur among Hispanic girls aged 15–19. Black, Native American and Pacific Islander adolescents had higher birth rates in Utah than White adolescents. Teen birth rates in both Utah and the United States are significantly higher than the rates for many Western European nations.

The Utah Department of Health, Maternal and Infant Health Program continues to work on improving the health of Utah adolescents. The Adolescent Health activities are guided by the Utah Adolescent Health Network, a group of diverse stakeholders from government, academic, non-profit and community organizations. While the mission of the Adolescent Health Network is to improve the overall health and well being of Utah adolescents, the current focus of the Network is adolescent reproductive health. The Network was a key player in the development of this Utah Adolescent Reproductive Health report.

Utah's teen birth rate has been declining steadily since the early 1990s. It is slightly lower than the U .S. teen birth rate. Low socioeconomic status (SES) and ethnically diverse populations are overrepresented in Utah's teen pregnancy rates. Utah's teen mothers suffer more poor outcomes than older mothers, such as low birth weight births and infant mortality. In addition, children of teen mothers are more likely to encounter other health risks than children of older mothers. Examples of these risks include exposure to environmental tobacco smoke and infrequent seatbelt use.

Although the rate of teen births in Utah is declining, there is concern about the rising rate of repeat teen births. Also, due to the poor pregnancy and economic outcomes for teen mothers and their children, there continues to be great concern about teen pregnancy, despite the decline in rates. The following recommendations are identified as priority interventions that could be useful in continuing to decrease the trend of teen births in Utah and improving outcomes for teens and their children.

- Continue the promotion of sexual abstinence among teens through innovative programs

that educate teens about the importance of remaining abstinent until marriage

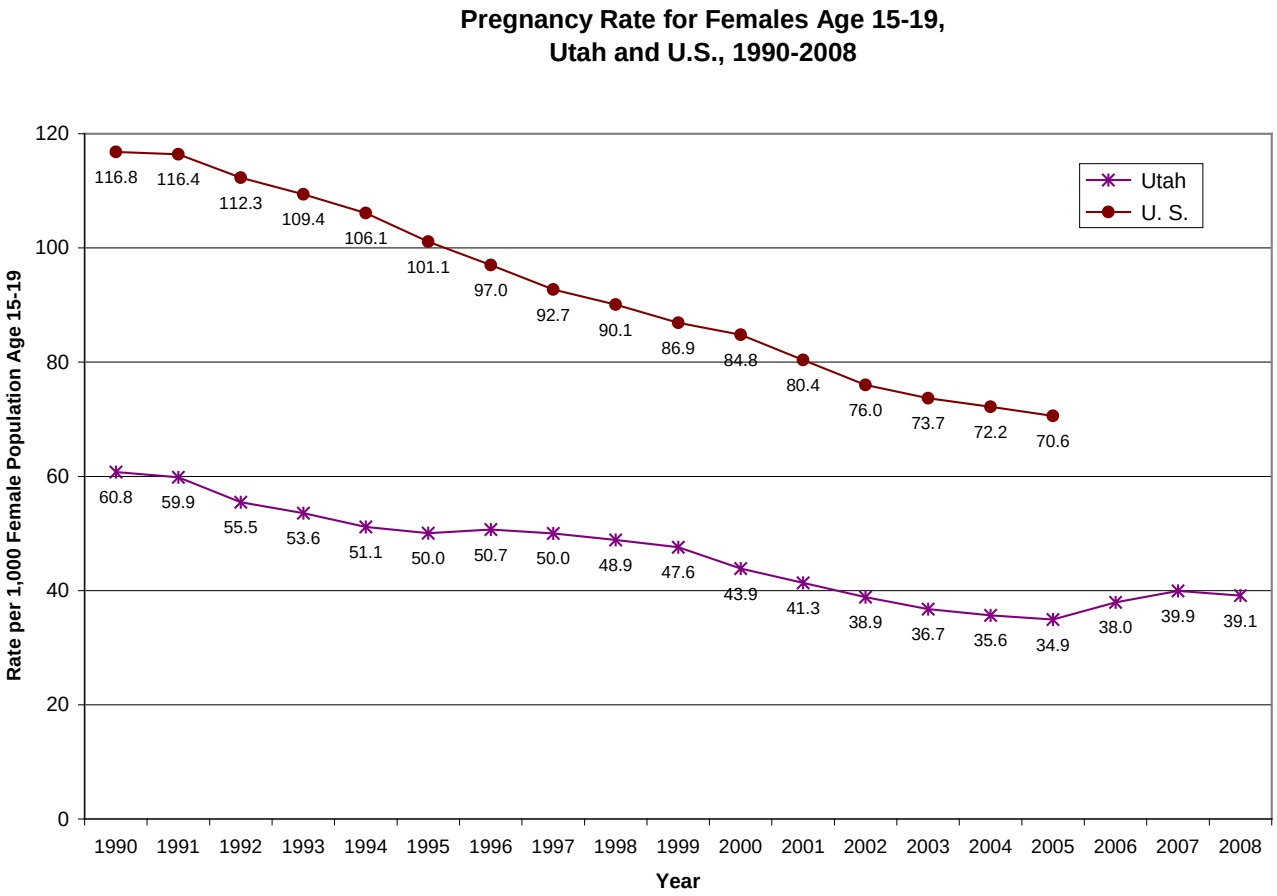
- Assure access to contraceptive education and services for those teens who are sexually active
- Facilitate prevention of repeat teen pregnancies by assuring optimal perinatal healthcare for pregnant teens
- Encourage policies that promote completion of high school for pregnant teens
- Assure access to early and continuous prenatal care for pregnant teens

UTAH DATA

Pregnancy Rates for Utah Teens

The reported pregnancy rate includes live births, fetal deaths and abortions.

Figure1



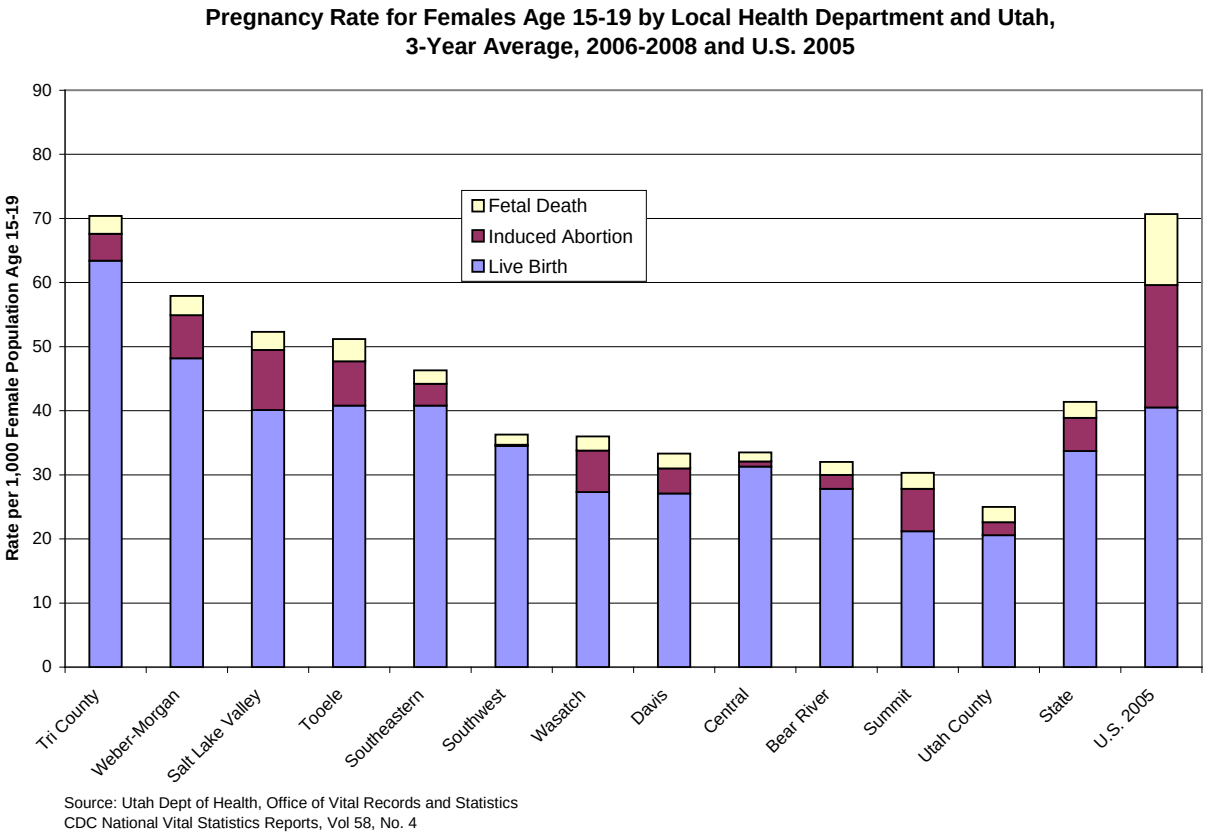
Source: Utah Dept of Health, Office of Vital Records and Statistics
CDC National Vital Statistics Reports, Vol 58 No. 4

- The rate of reported pregnancies for Utah females 15-19 years of age (per 1,000 population) declined 43% between 1990 and 2005, with a slight rise in 2006 and 2007.
- The rate of reported pregnancies for U.S. females 15-19 years of age is significantly higher than Utah's rate; however, it has also steadily declined since 1990.

Local Health Department Teenage Pregnancy Rates

The reported pregnancy rate includes live births, fetal deaths and abortions.

Figure 2

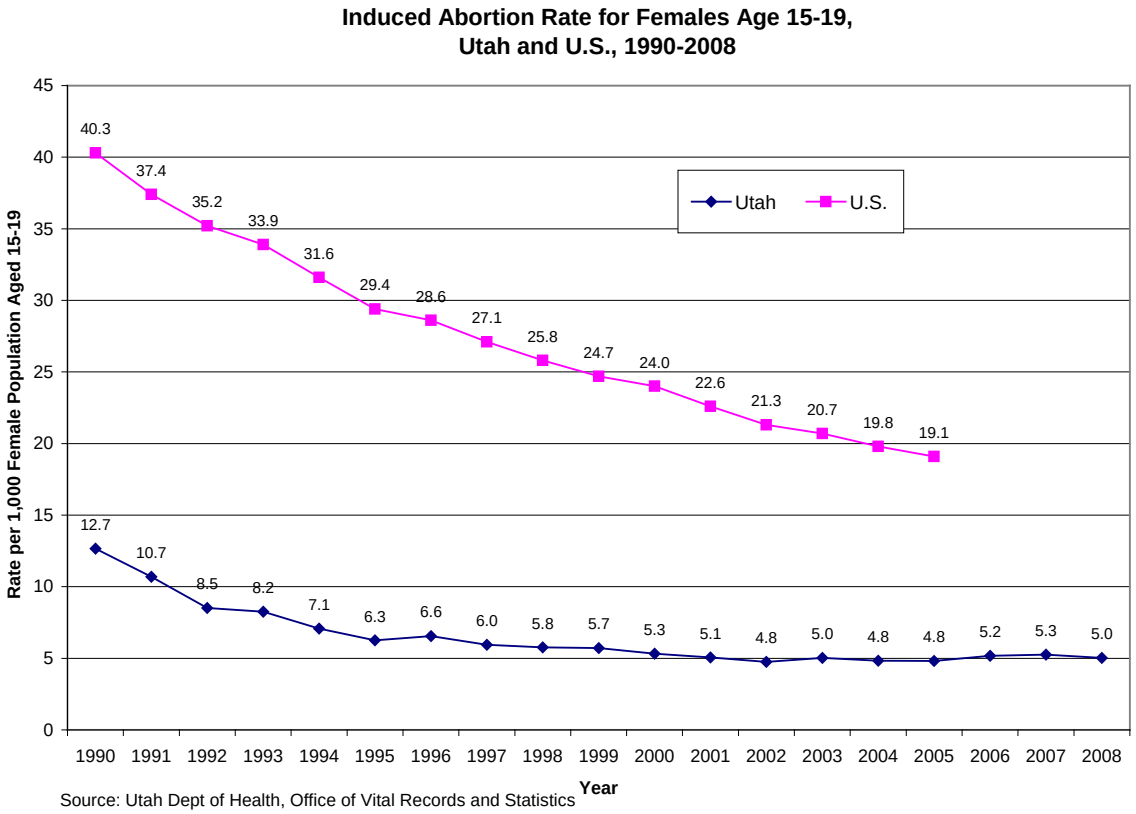


- The three-year average pregnancy rate for Utah teens 2006-2008 was 41.3 (per 1,000 females age 15-19).
- TriCounty, Weber-Morgan, and Salt Lake Valley Health Districts (LHDs) led the state in the reported pregnancy rate for 2006-2008.

Induced Abortions

Utah teens tend to have difficulty accessing abortion services since state law requires parental notification. Teens tend to wait to have their pregnancy diagnosed, thus delaying the timing of abortion. Abortion is a safer procedure when performed early in pregnancy.

Figure 3



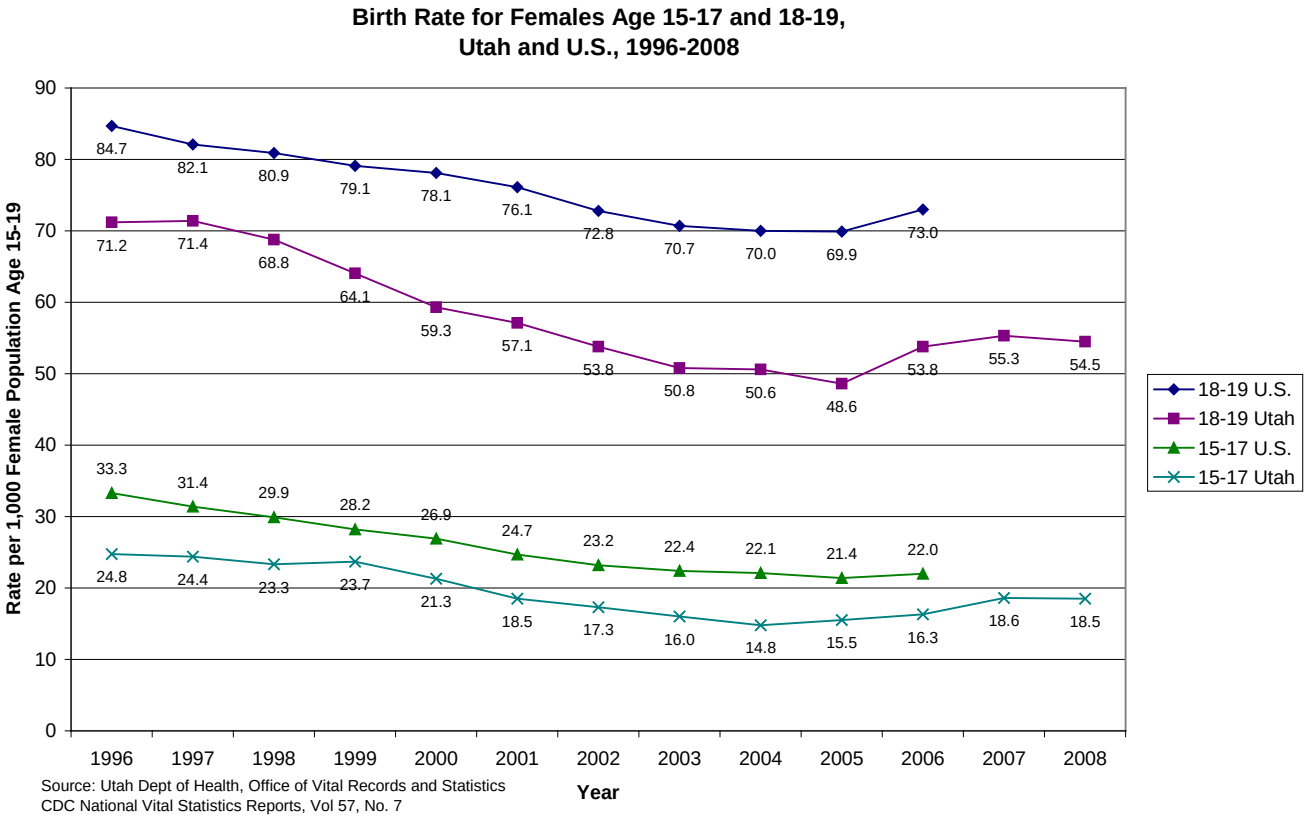
Source: Utah Dept of Health, Office of Vital Records and Statistics
CDC National Vital Statistics Reports, Vol 58, No. 4

- Since 1990, abortion rates have declined among Utah women 15-19 years of age.
- Additional data from Vital Records indicated in 1997, 36% of teens ages 15-19 who had abortions reported no contraception use during the year before conception, while in 2008, 58% of teens ages 15-19 reported not using contraception during the year prior to having an abortion.

Maternal Age

Over the past 13 years, among Utah women there has been a larger change in live birth rates over time for women 15-17 years of age than for women 18-19 years of age.

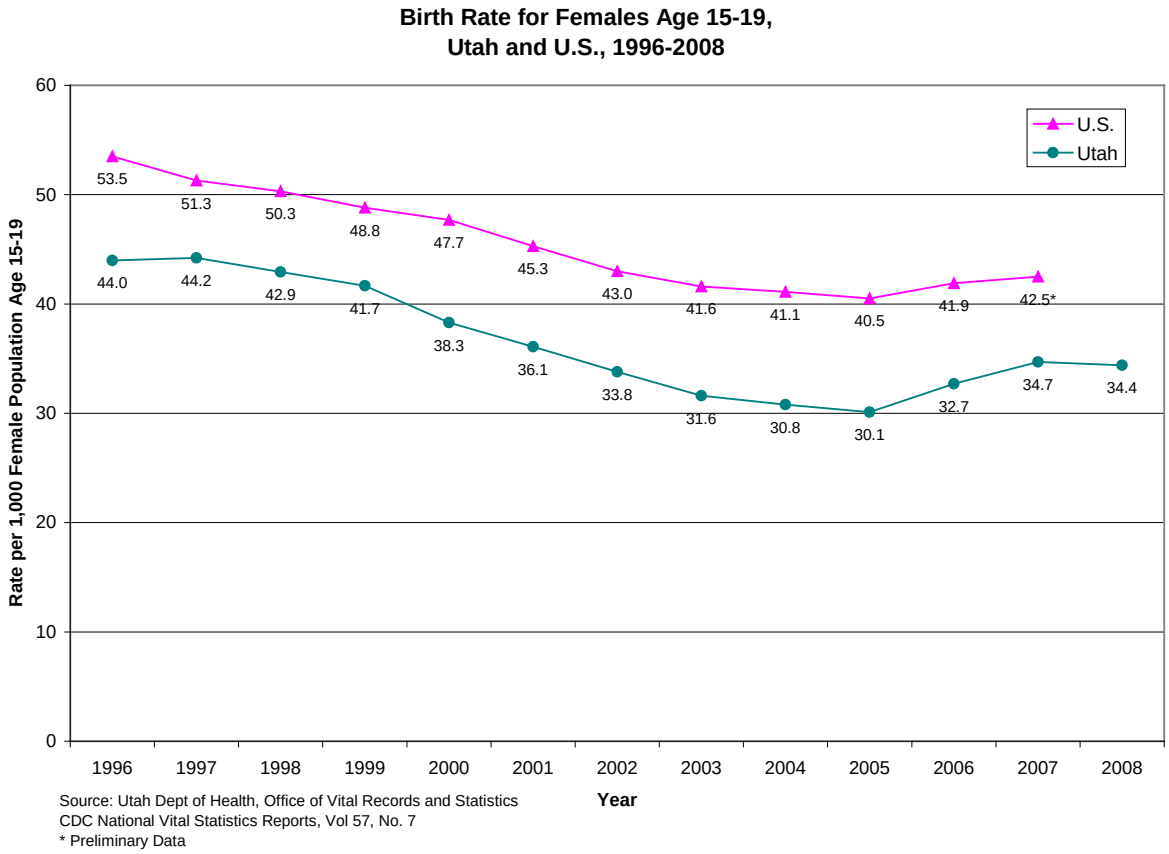
Figure 4



- Birth rates for Utah females 15-17 years of age remained relatively stable at around 24 to 26 births per 1,000 teens until 2000, when they began decreasing to the rate of 14.8 in 2004.
- Since 2004, the birth rate for females 15-17 years of age increased slightly to the current rate of 18.5 births per 1,000 teens.
- For Utah women 18-19 years of age, the teen birth rate peaked in 1997 at 71.4 births per 1,000 teens, and has since declined to the 2008 rate of 54.5.

Birth Rate for Teens

Figure 5



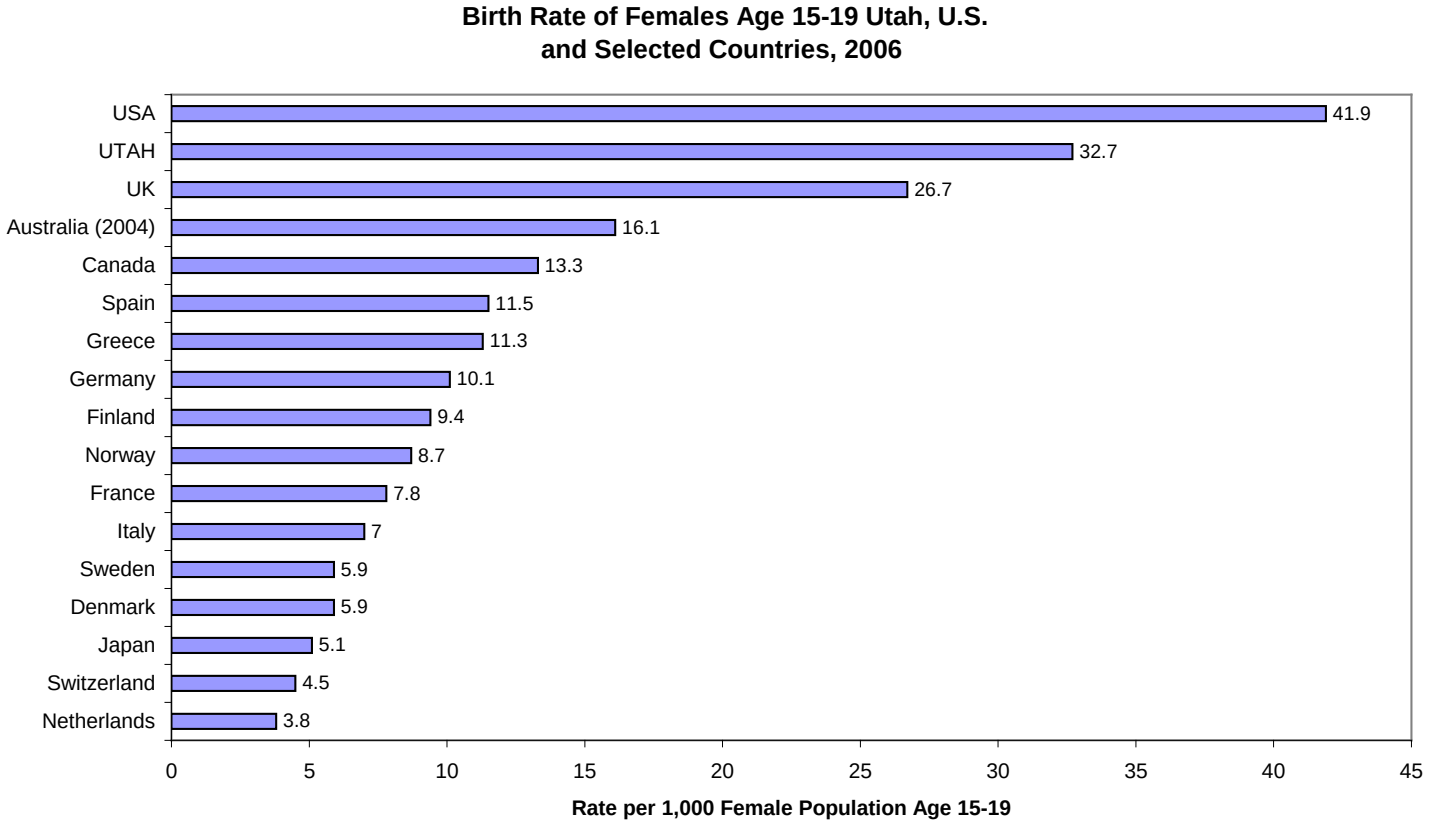
Source: Utah Dept of Health, Office of Vital Records and Statistics
CDC National Vital Statistics Reports, Vol 57, No. 7
* Preliminary Data

- From 1996-2005, the overall Utah teen birth rate among 15-19 year old females declined, followed by a slight increase in 2006 and 2007.
- Utah teens experienced lower birth rates than rates recorded for teens nationally.

International Birth Rates

Although Utah's teen pregnancy rate is among the lowest in the United States, the U.S. rate is much higher than other industrialized nations.

Figure 6

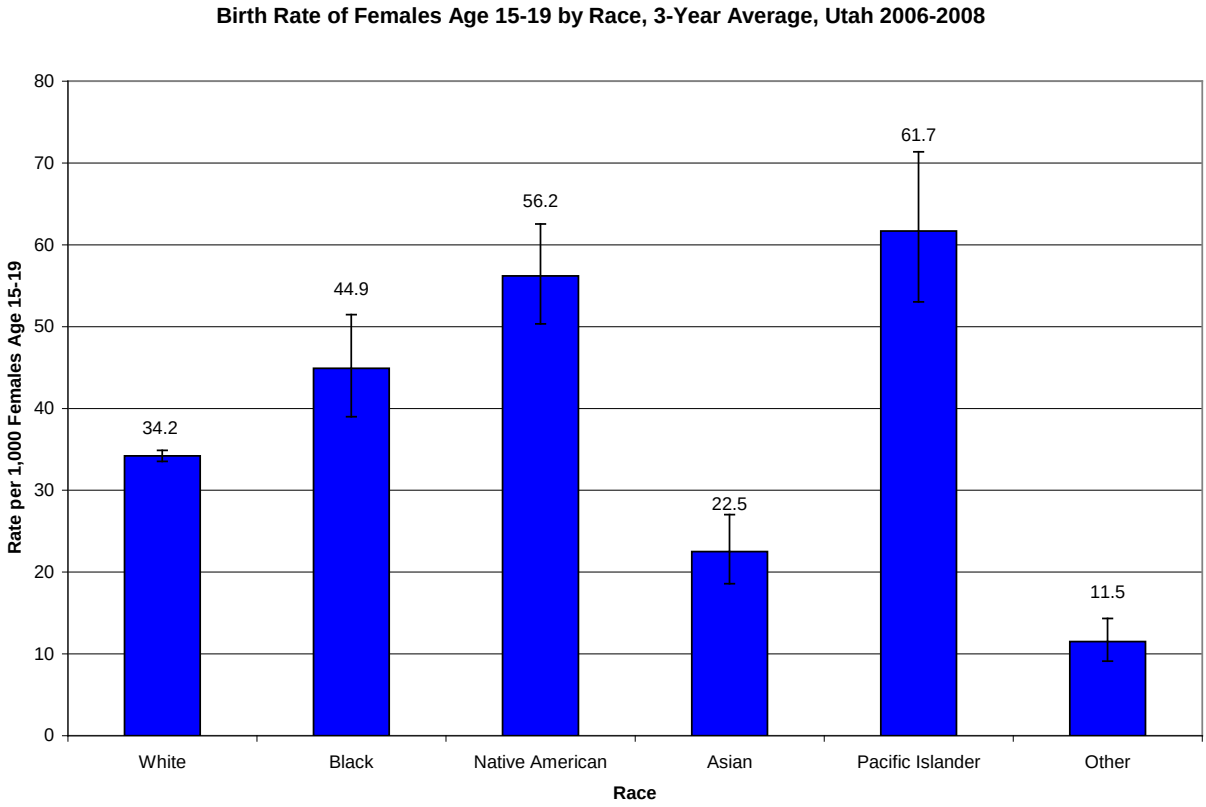


Source: Teen Birth Rates: How Does the United States Compare? National Campaign to Prevent Teen and Unplanned Pregnancy. http://www.thenationalcampaign.org/resources/pdf/TBR_InternationalComparison2006.pdf. Accessed 7/12/10.
United Nations Statistics Division. Demographic Yearbook 2006.
Utah Dept of Health, Office of Vital Records and Statistics

- Despite a one-third decline since the early 1990s, the United States still has the highest rates of teen pregnancy and birth among comparable countries.
- By way of comparison, the U.S. teen birth rate is **1.5** times higher than that of the United Kingdom, which has the highest teen birth rate in Europe; more than **3** times higher than the teen birth rate in Canada; more than **8** times higher than the teen birth rate in Japan; and **7** times higher than Denmark and Sweden.
- Data are for 2006, the most recent year for which comparable information is available from all countries, unless otherwise noted.

Race

Figure 7

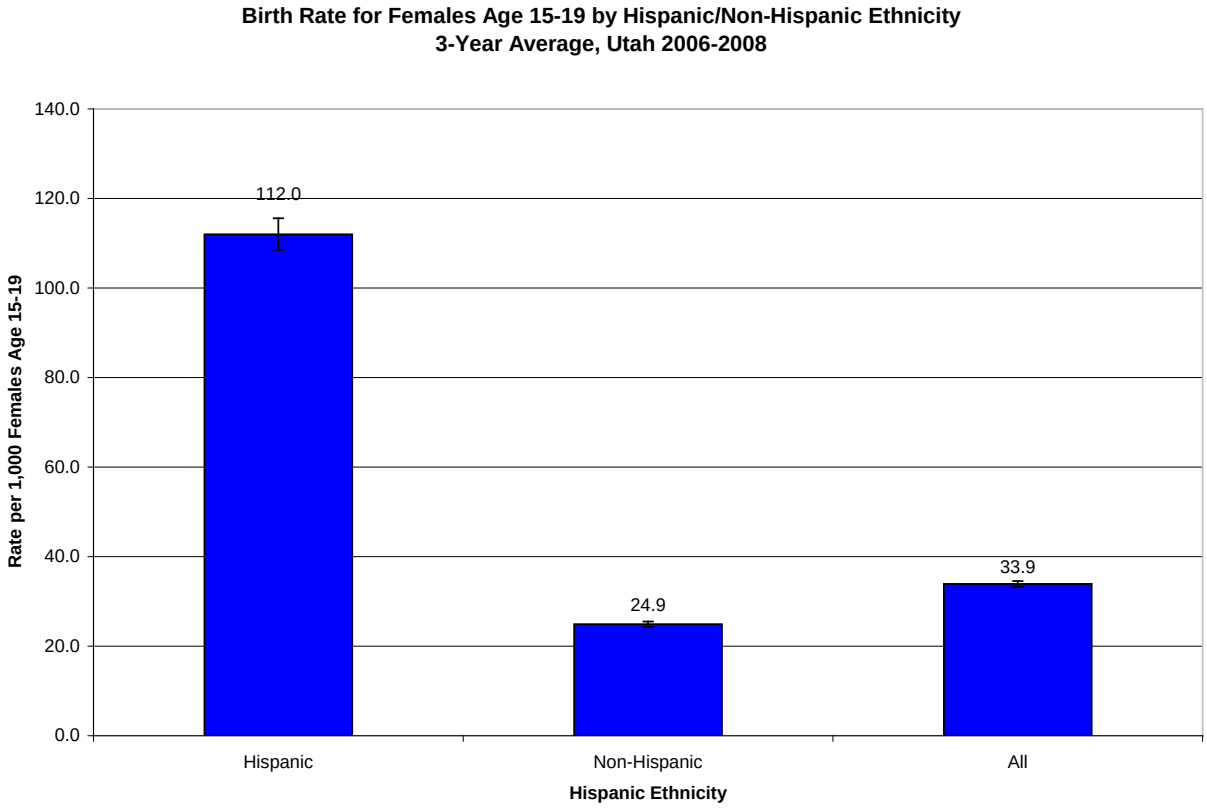


Source: Utah Department of Health, Office of Vital Records and Statistics

- Teen birth rates are higher among Black, American Indian, and Pacific Islander teens in Utah than among White teens.
- Asian teens have the lowest birth rates among all racial groups in Utah.

Ethnicity

Figure 8



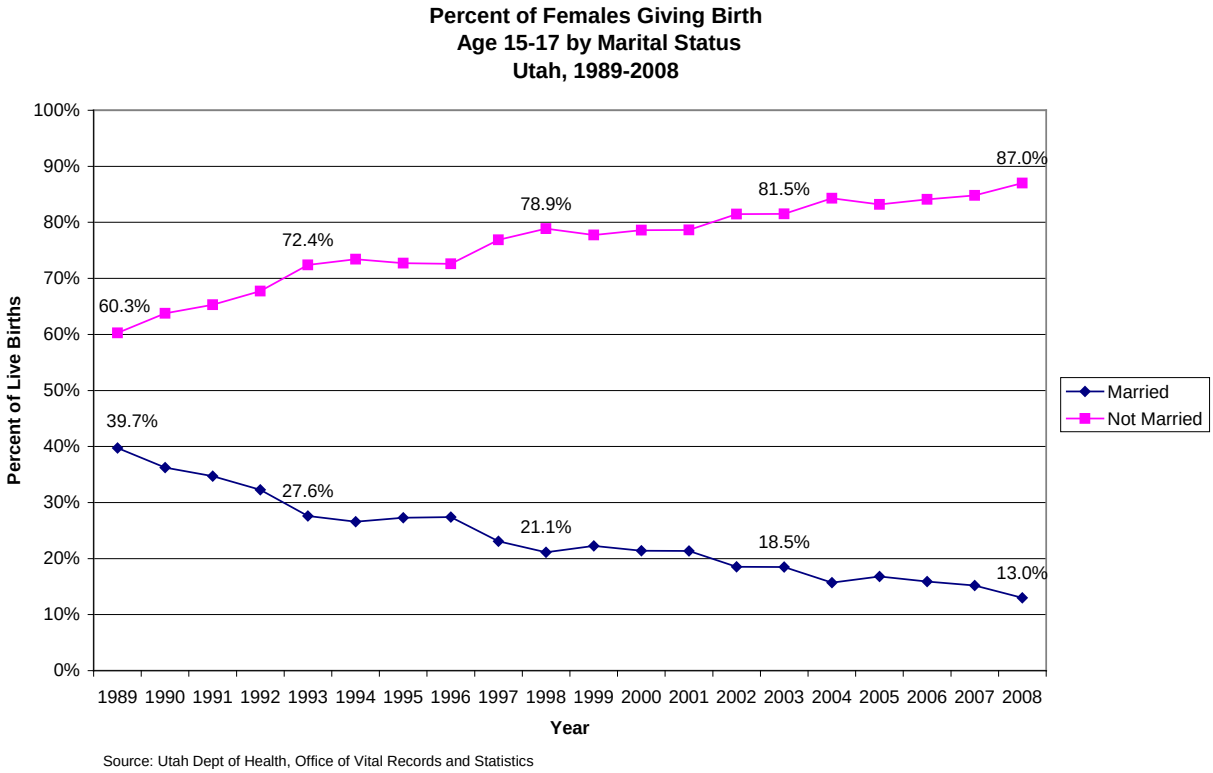
Source:
Utah Dept of Health, Center for Health Data , Indicator Based Information System for Public Health Web site (http://ibis.health.utah.gov)
Retrieved Wed, 23 June 2010 10:17:53.

- Birth rates for Hispanic teenagers 15-19 years of age are 4.5 times greater than for Non-Hispanic teenagers.

Marital Status Age 15-17

In Utah, births to unmarried women have become a larger proportion of births to Utah teens.

Figure 9



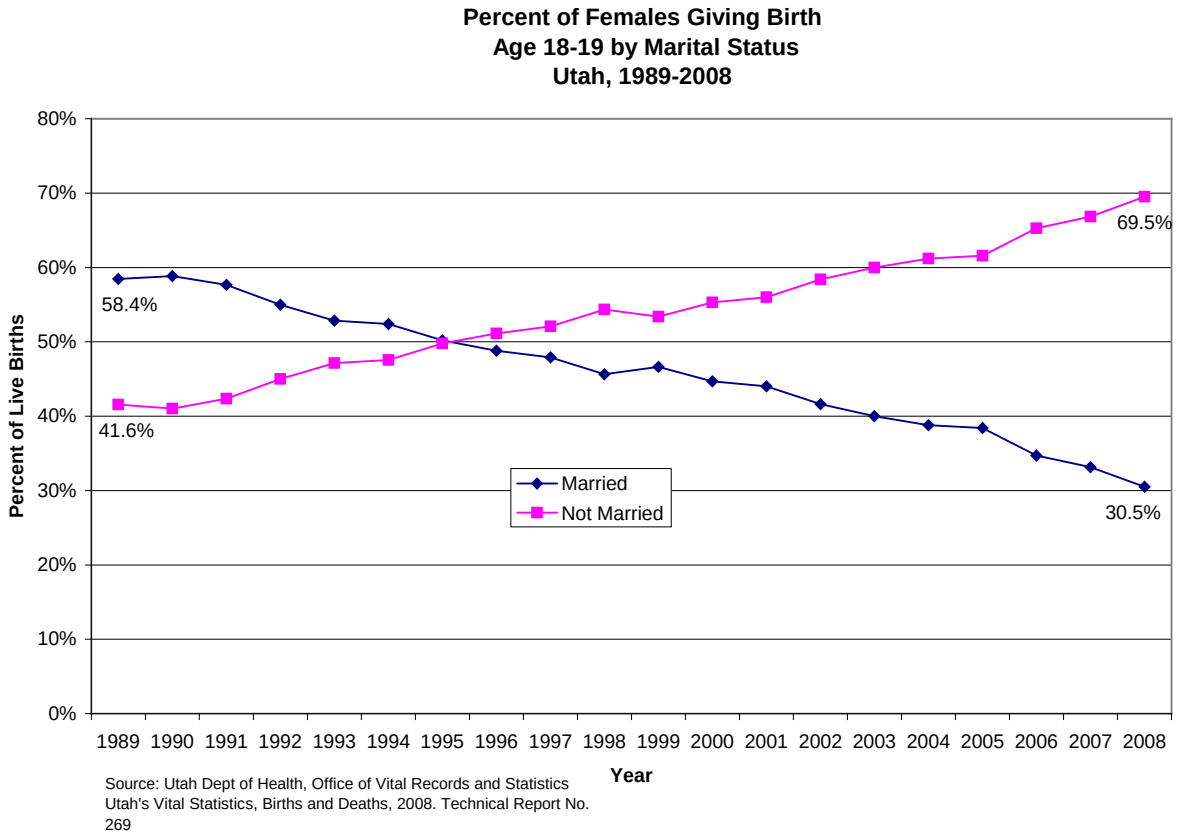
Source: Utah Dept of Health, Office of Vital Records and Statistics

- Among females ages 15-17 who gave birth in Utah during 2008, 87% were not married.

Marital Status Age 18-19

In Utah, births to unmarried women have become a larger proportion of births to Utah teens.

Figure 10

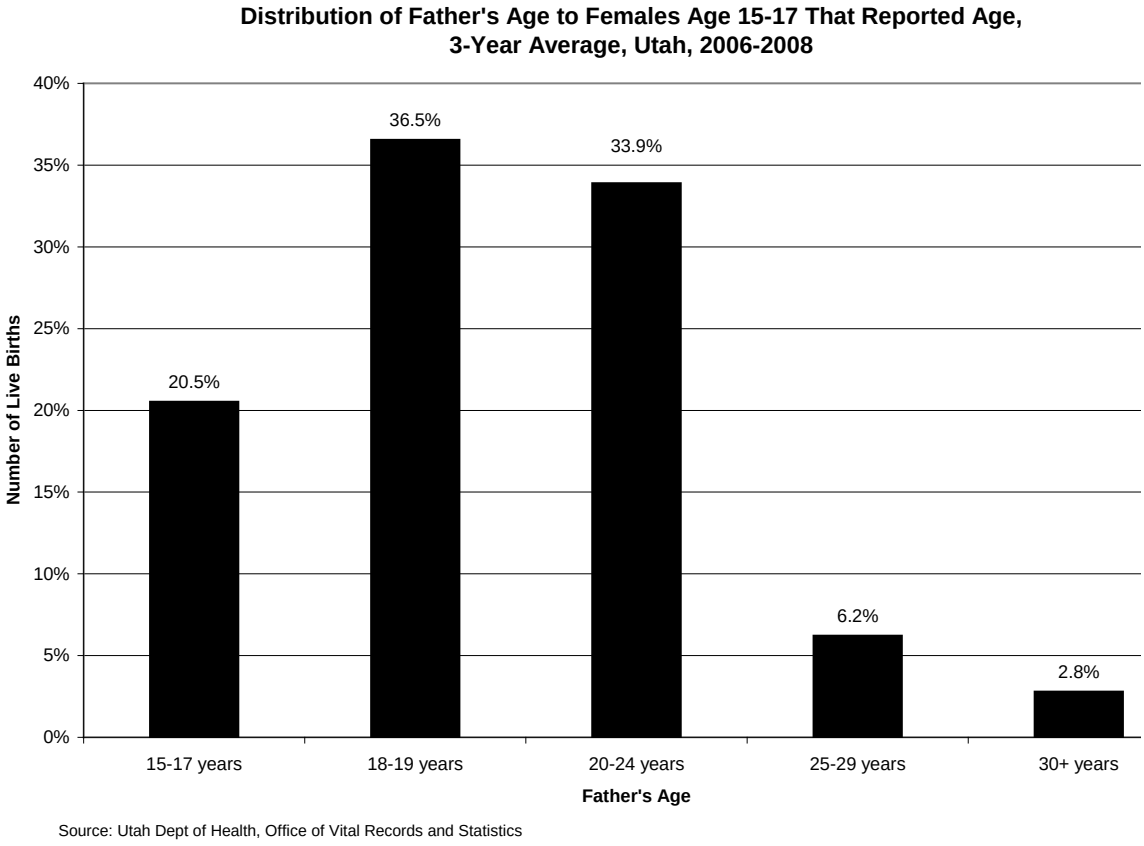


Source: Utah Dept of Health, Office of Vital Records and Statistics
Utah's Vital Statistics, Births and Deaths, 2008. Technical Report No. 269

- Among females ages 18-19 who gave birth in Utah during 2008, 69.5% were not married.

Age of Father of Infants Born to Adolescent Mothers

Figure 11



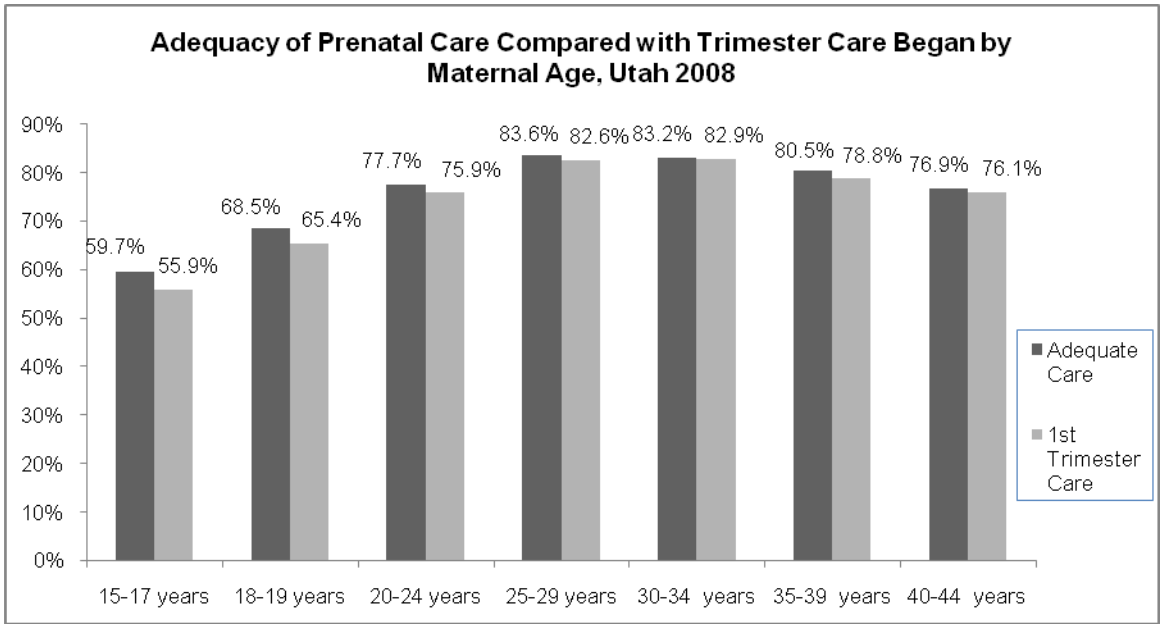
Source: Utah Dept of Health, Office of Vital Records and Statistics

- 43% of Utah teen births to females age 15-17 reported no information about the father.

Prenatal Care

Prenatal care has long been recognized as an important contributor to ensuring the health of mothers and infants. Prenatal care should consist of early and ongoing risk assessment to identify and intervene with factors that may have an impact on pregnancy outcomes.

Figure 12



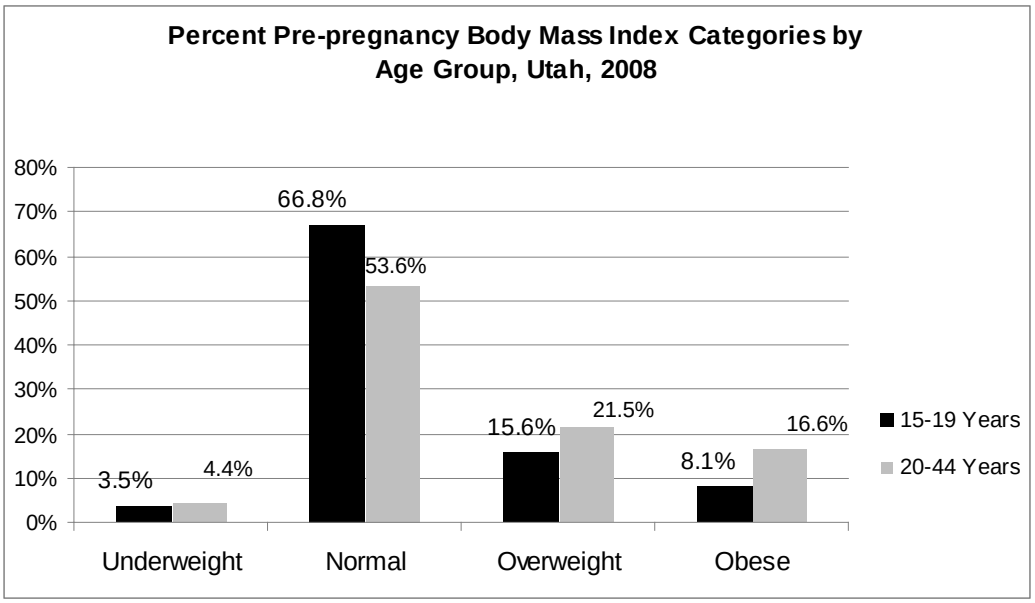
Source: Utah Department of Health, Office of Vital Records and Statistics, obtained via IBIS 4/23/10
Adequate prenatal care is based on the Kotelchuck criteria

- Only 56% of females 15-17 years of age entered care in the first three months of pregnancy.
- Only 60% of pregnant 15- to 17-year-old teens had an adequate number of prenatal care visits during their pregnancies.

Body Mass Index

Pre-pregnancy Body Mass Index (BMI) is an indicator of the overall health of women that can affect pregnancy outcomes. Women who are underweight prior to pregnancy have been reported to be at higher risk for low birth weight births and women who are overweight or obese have been reported to be at higher risk for diabetes and cesarean section delivery.

Figure 13



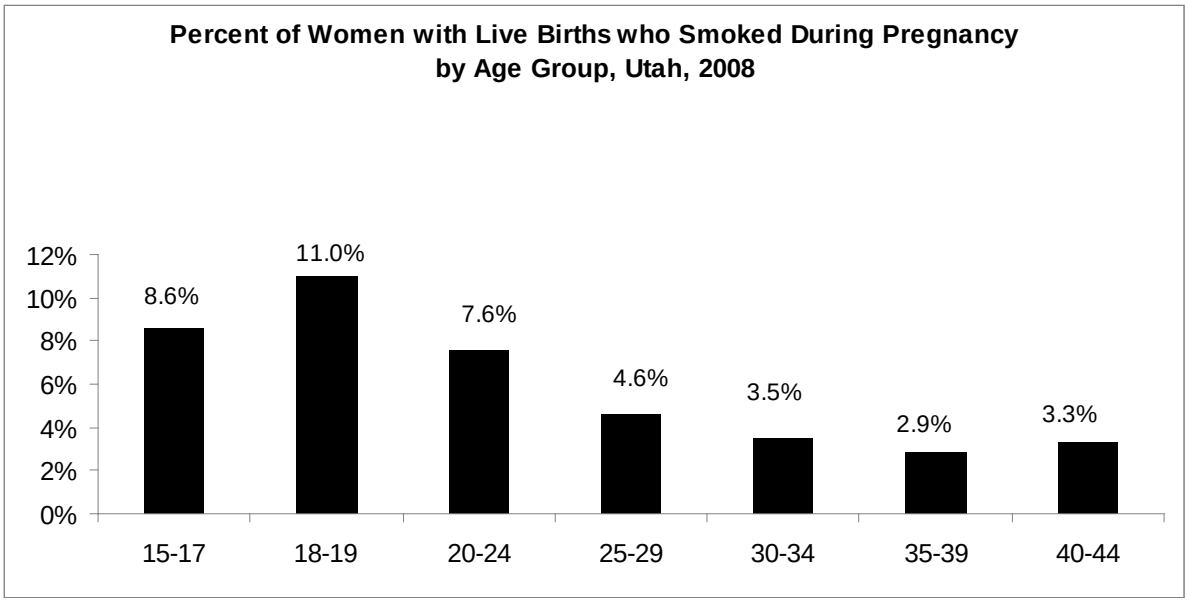
Source: Utah Department of Health, Office of Vital Records and Statistics, obtained via IBIS 4/23/10

- The largest percentage of Utah teens who delivered live born infants during 2008 had a normal pre-pregnancy BMI; in fact, a significantly higher percentage of teens than adult women had a normal BMI prior to pregnancy.

Smoking During Pregnancy

Tobacco use during pregnancy can lead to low birth weight infants. While Utah reports low smoking rates among pregnant women in general, rates among Utah teen mothers are disproportionately high.

Figure 14



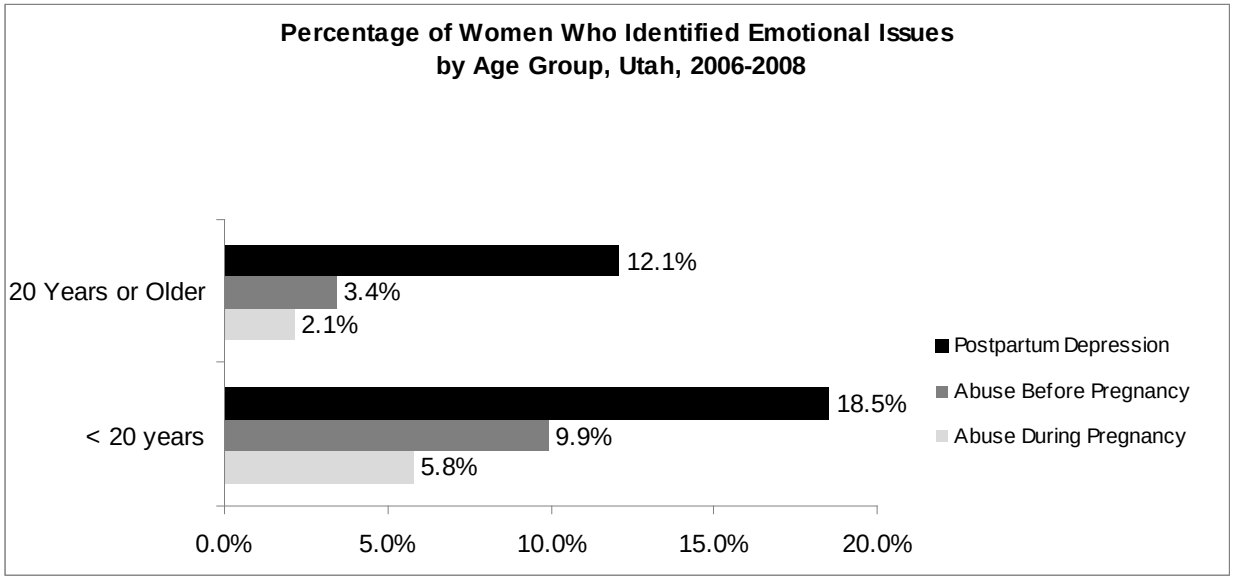
Source: Utah Department of Health, Office of Vital Records and Statistics, obtained via IBIS 4/23/10

- Teens and women in their early twenties are significantly more likely to smoke during pregnancy than adult pregnant women.

Depression and Abuse

Selected emotional indicators related to teen mothers were analyzed from Utah Pregnancy Risk Assessment Monitoring System (PRAMS) data. These data were compared to that of older mothers. Abuse is defined as a husband or partner pushing, hitting, slapping, kicking, choking, or physically hurting a girl or woman in any other way, with 'before pregnancy' being defined as the 12 months prior to pregnancy.

Figure 15



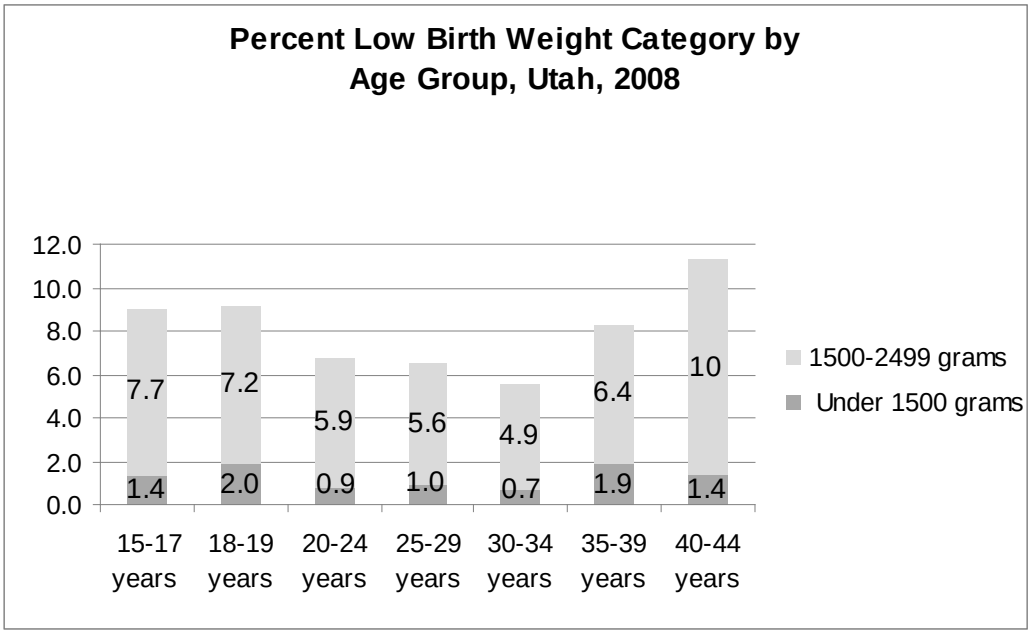
Source: Utah Department of Health, Utah PRAMS data, obtained via IBIS 7/6/10.

- Postpartum depression was higher for teens who delivered a live birth compared to adult women.
- Abuse both before and during pregnancy was higher for teen mothers. Abuse decreased for both adult and teen mothers during pregnancy compared to before pregnancy.

Low Birth Weight

Infants born to teen mothers are at greater risk for low birth weight, preterm delivery, and other complications. Low birth weight (infants born weighing less than 2,500 grams or 5.5 pounds) is related to poor infant health, such as respiratory distress, newborn anemia, neurological problems, and even death.

Figure 16



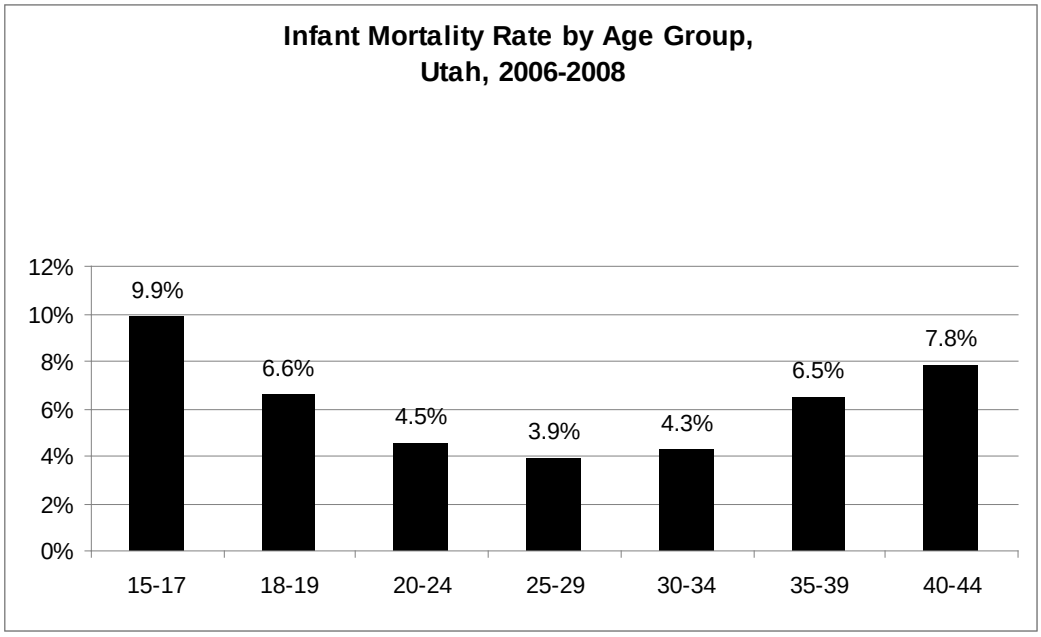
Source: Utah Department of Health, Office of Vital Records and Statistics, obtain through IBIS 4/23/10

- Compared to women ages 25-29, teen moms had significantly higher rates of low birthweight babies (.0001).

Infant Mortality

Infant mortality is often used as an indicator of the health of a population. Utah's infant mortality rate has ranked as one of the lowest in the U.S. for a number of years. However, there are subpopulations in Utah at higher risk for infant mortality, including adolescent mothers.

Figure 17



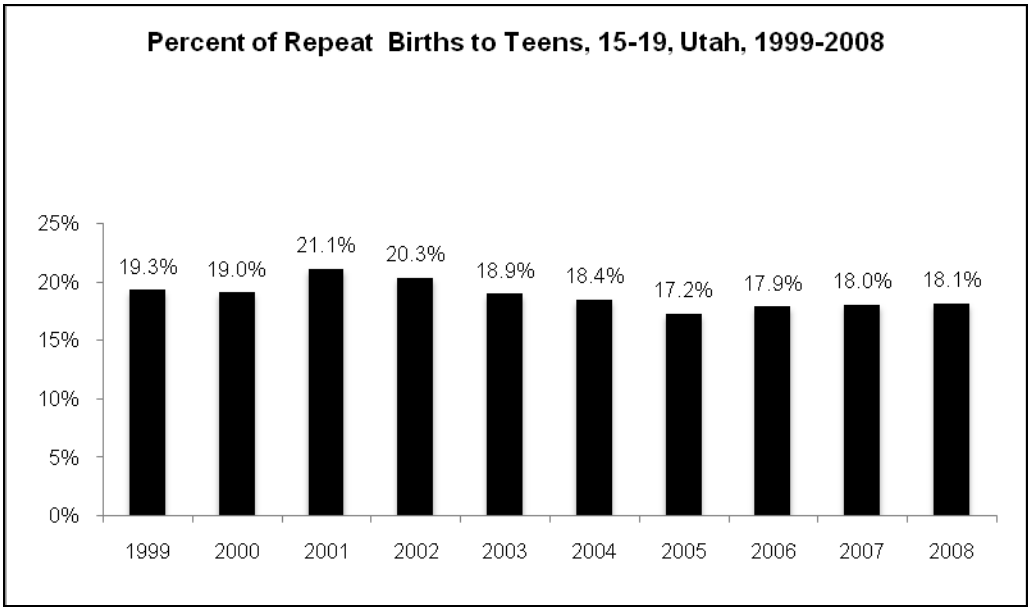
Source: Utah Department of Health, Office of Vital Records and Statistics, obtain through IBIS 7/6/10

- Compared to women ages 25-29, babies born to teen moms ages 15-17 ($p < .0001$) and to teen moms ages 18-19 ($p < .001$) had significantly higher rates of infant mortality.

Repeat Pregnancies

Teens who have previously given birth are at high risk of having another birth during their adolescent years. These mothers may incur compounded physical and psychological risks with more than one birth during their teen years.

Figure 18



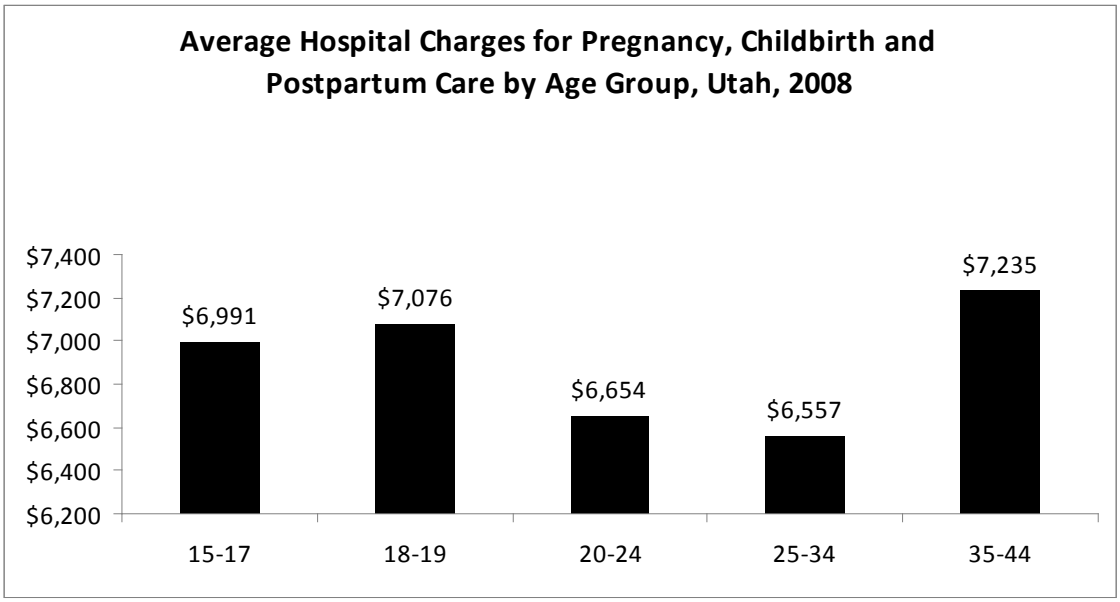
Source: Utah Department of Health, Office of Vital Records and Statistics, obtain through IBIS 7/6/2010

- Data for 2008 indicate that about 18% of births among teens 15-19 years of age were to adolescents who had given birth previously.
- There was a slight decrease in the percent of repeat teen births during 2001 and 2005, when the trend began to stabilize.

Hospital Charges for Infants

Some teens' hospital costs for pregnancy, delivery and postpartum care are covered through their parents' private health insurance, while others are covered by Medicaid. Some teens may not have any health insurance coverage at all.

Figure 19



Source: Utah Department of Health, Office of Health Care Statistics, obtained through IBIS 4/23/10

- State average charges in 2008 for all ages were $6,680.44.
- Average hospital charges are highest among women in the oldest categories, followed by teen mothers.

TOPICAL REPORTS

Repeat Adolescent Births

Submitted by: Joni Hemond, Teen Mother and Child Program

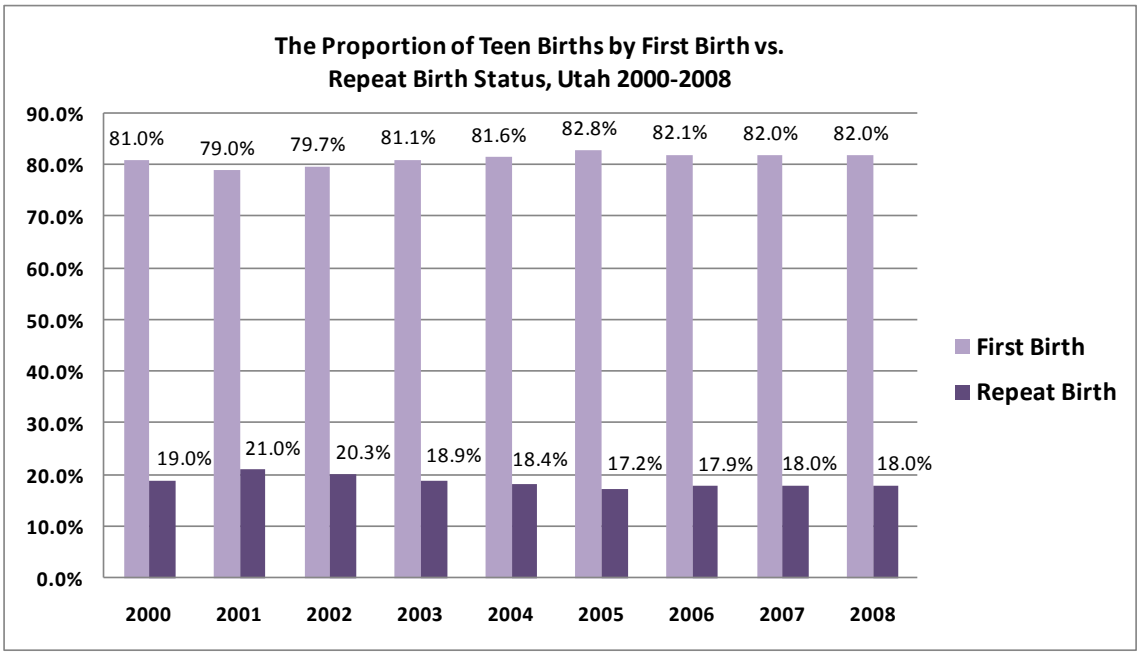
Problem Statement and Background

This report focuses on repeat teen childbearing, which refers to births to teen mothers who already have a child. Teen mothers tend to be from disadvantaged backgrounds, even before giving birth, and they and their children face poorer educational, economic, health, and developmental outcomes compared to women who delay childbearing beyond their teenage years.[1,2] Repeat birth compounds problems resulting from a first teen birth.[1,2] Additionally, teenagers who experience a rapid subsequent pregnancy are less likely to complete high school compared to teenage mothers who avoid a repeat pregnancy.[2]

Utah Data

Utah's overall teen birth rate (ages 15-19) in 2008 was 33.8 per 1,000 females.[3] Teen births represented 6.7% of all births in Utah in 2008.[4] There were 3,745 teen births in 2008, of which 677 (18%) were repeat births (second, third, or higher order births).[4] Among all Utah teen births, the proportion of repeat teen births has remained relatively unchanged since 2000.[1]

Figure 1



Source: Utah Health Status Update: The Utah All Payer Database (APD), "Spotlights for June 2009" *Repeat Births Among Adolescents*, Utah Department of Health, July 2009.

National Data

According to preliminary national data, teenagers aged 15-19 gave birth to 445,045 babies in 2007.[5] This represents 10.3% of all total births in the U.S. Of those births, 86,226 were repeat births (second, third, or higher order births). This represents 19.4% of teenage births. In other words, approximately one-fifth of teenage births were repeat births. The overall national birth rate for teenagers aged 15-19 (in 2007) was 42.5 per 1,000 women.[5] The overall repeat teen birth rate was 8.2 per 1,000.[5] Of note, in 2007, the repeat birth rate for Hispanic teens was 18.0 per 1,000, for non-Hispanic black teens it was 13.7 per 1,000, and for non-Hispanic white teens it was 4.5 per 1,000.[5]

Who is at Risk?

Risk factors for repeat teen childbearing include: lower cognitive ability, being non-Hispanic black or Hispanic, and wanting the first teen birth.[2] Protective factors include: delaying first sexual intercourse, use of a long-acting contraception, continuing to attend school after the first teen birth, both parents of the teenager having greater than 12 years of education, the teen mother living alone or with a parent versus living with her partner, and the teen's involvement with a nurse home visiting program.[2]

What is Being Done?

At the state level, the Utah Department of Health (UDOH) and its partners continue their work to prevent both initial and repeat teenage pregnancies. The Utah Adolescent Health Network meets regularly to discuss community programs targeting high-risk teenagers and their families.

The University of Utah's Teen Mother and Child Program provides medical care and social support to teenage mothers and their families. The program assists adolescent mothers in their efforts to continue their education, offers affordable long-acting contraception, and gives them access to mental health services.

The Nurse Family Partnership (NFP) provides high-risk mothers with home visits through their child's first two years. Patients can be referred to this program by their physicians, and nurses meet with participants at some time before their third trimester of pregnancy. The NFP has studied outcomes with longitudinal, randomized trials and found both fewer subsequent pregnancies and increased intervals between births as effects of this program across multiple trials.[6]

Local Resources

- Utah Department of Health, Maternal and Infant Health Program. Jenny Mayfield, Adolescent Health Coordinator. Phone 801-538-9317. E-mail: jmayfield@utah.gov

- Teen Mother and Child Program. 3690 South Main Street, Salt Lake City, UT 84115. Phone 801-468-3279. E-mail: joni.hemond@hsc.utah.edu

- Nurse Family Partnership. Supervisor. Sue Nicodemus. Phone 801-468-3873.

- Y Teen Home. Director, Bree Murphy. 322 East 300 South, Salt Lake City, UT 84111. Phone 801-537-5510

- School Programs for Young Mothers (contact local school district)

National Resources

- The National Campaign to Prevent Teen and Unplanned Pregnancy. http://www.thenationalcampaign.org/

- Advocates for Youth. http://www.advocatesforyouth.org/

- Centers for Disease Control and Prevention, Adolescent Reproductive Health. http://www.cdc.gov/reproductivehealth/AdolescentReproHealth/index.htm

- Nurse Family Partnership national website: www.nursefamilypartnership.org

Recommendations

- Continue to seek funding to provide programs to prevent teen pregnancy and delay first sexual intercourse

- Continue to seek funding to provide programs that support teenage mothers (particularly programs that offer affordable, long-acting contraception and help the mother stay in school)

- Continue to educate legislators, educators, the general community, and Utah adolescents on the importance of preventing teen pregnancies and repeat teen pregnancies

References

1. Utah Health Status Update: The Utah All Payer Database (APD), "Spotlights for June 2009" *Repeat Births Among Adolescents,* Utah Department of Health, July 2009.
2. Child Trends (2007). *Repeat Teen Childbearing: Differences Across States and by Race and Ethnicity.* Research Brief, Publication #2007-23. www.childtrends.org
3. Utah Department of Health, Center for Health Data, Indicator-Based Information System for Public Health Website (IBIS): http://ibis.health.utah.gov/home/Welcome.html, accessed October 29, 2009.
4. Utah Department of Health, Center for Health Data, Office of Vital Records and Statistics, 2008
5. NVSS (2009). *Births: Preliminary Data for 2007.* National Vital Statistics Reports, Volume 57, Number 12, NCHS.http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_12.pdf
6. Nurse-Family Partnership, www.nursefamilypartnership.org

Sexually Transmitted Diseases Among Utah Adolescents

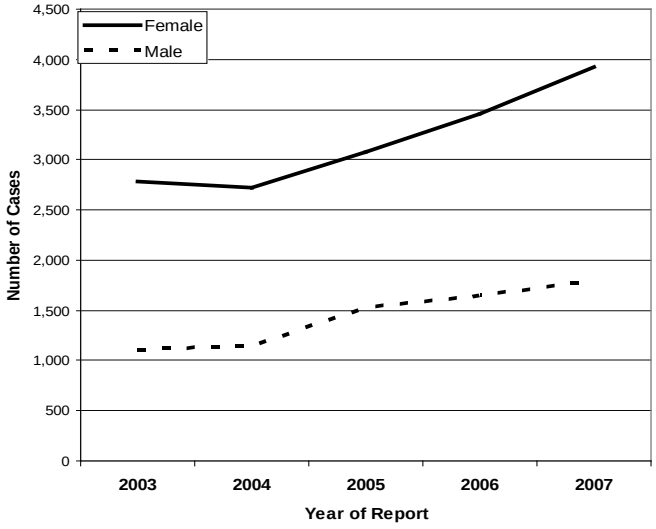
Submitted by: Emily Holmes, HIV/STD/HepC Prevention Program, Utah Department of Health

Problem Statement and Background

Chlamydia is the number one reported communicable disease in Utah, with gonorrhea being number four. These infections are most often "silent" and go undetected without regular testing. Chlamydia and gonorrhea usually cause no or nonspecific symptoms, but untreated chlamydia and gonorrhea infections can cause serious reproductive and other health problems. In females, the bacteria can spread into the uterus and fallopian tubes causing pelvic inflammatory disease (PID), leading to infertility, chronic pelvic pain, and ectopic pregnancy (pregnancy outside the uterus).

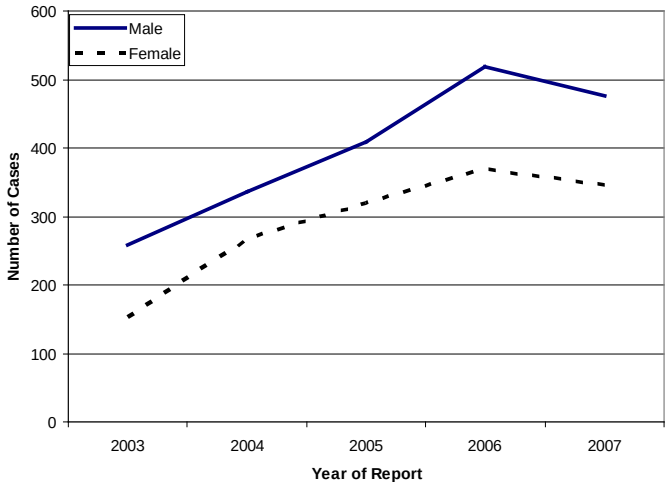
In recent years, cases of chlamydia and gonorrhea among U.S. and Utah adolescents have continued to climb. More and more adolescents are diagnosed with these reportable sexually transmitted diseases (STDs), and many others are estimated to be infected with unreportable STDs, including genital herpes and human papillomavirus (HPV). More cases of chlamydia are reported in females than males because testing is more often performed among females.

Numbers of Male and Female Chlamydia Cases by Year
Utah, 2003 – 2007



Source: Utah 2003-2007 Chlamydia and Gonorrhea Epidemiological Profile
Utah Department of Health, Bureau of Epidemiology, Communicable Disease Analysis and Reporting Program
http://health.utah.gov/cdc/sp.htm

Male and Female Gonorrhea Cases by Year
Utah, 2003 – 2007



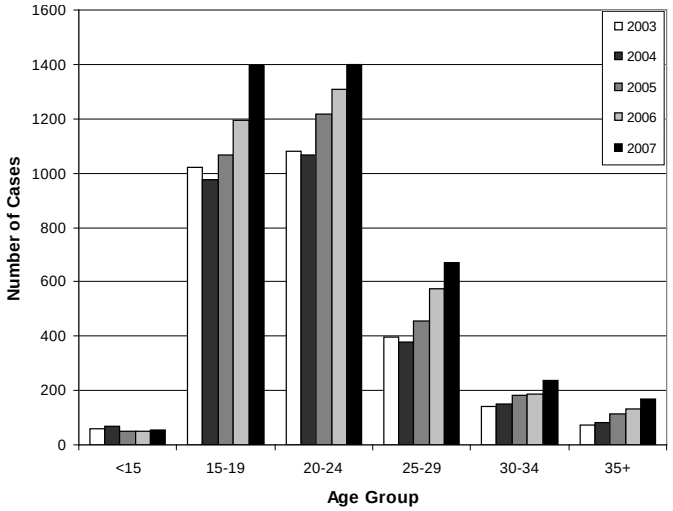
Source: Utah 2003-2007 Chlamydia and Gonorrhea Epidemiological Profile
Utah Department of Health, Bureau of Epidemiology, Communicable Disease Analysis and Reporting Program
http://health.utah.gov/cdc/sp.htm

New cases of HIV/AIDS continue to be diagnosed in teenagers and young adults in the U.S. and in Utah. In recent years, there has been an increase in cases among younger age groups. Data suggest that infection with one or more STDs can increase the risk of HIV infection if exposed. It is expected that the number of new HIV diagnoses would increase if testing was routinely offered by medical providers to all sexually active individuals. Targeted education and testing services for at-risk populations are essential in order to identify new infections and provide risk-reduction education.

Utah Data

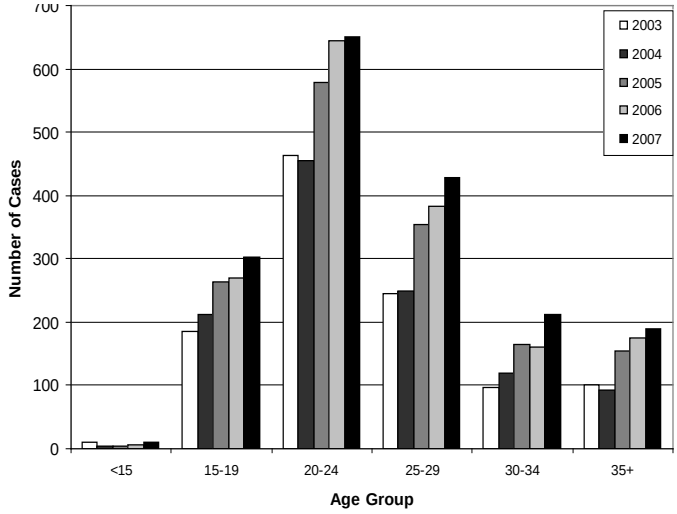
In Utah, approximately two-thirds of chlamydia cases are diagnosed in 15-24-year-olds. During the 2003-2007 time period, adolescent and young women ages 15-24 accounted for 51% of all reported chlamydia cases and also had the highest re-infection rates.[1] In 2007, among 15-19-year-olds, the rate of chlamydia per 100,000 was 797.0 (1,724 cases) and among 20-24-year-olds, the rate of chlamydia per 100,000 was 861.6 (2,091 cases). In 2007, 793 (20%) women who tested positive for chlamydia indicated they were pregnant at the time of testing. Of those 793 cases, 612 (77%) were below the age of 25. In 2007, 76% (3,001 cases) of women diagnosed with chlamydia had an unknown pregnancy status at time of diagnosis/interview. Of all individuals reported with chlamydia during 2008, 66% (4,078 cases) were in the 15-24 age group.[2] In 2008, among 15-19-year-olds, the rate of chlamydia per 100,000 was 819.6 (1,805 cases). In 2008, among 20-24-year-olds, the rate of chlamydia per 100,000 was 937.0 (2,273 cases).

Chlamydia Cases Among Females by Age Group
Utah, 2003 – 2007



Source: Utah 2003-2007 Chlamydia and Gonorrhea Epidemiological Profile
Utah Department of Health, Bureau of Epidemiology, Communicable Disease Analysis and Reporting Program
http://health.utah.gov/cdc/sp.htm

Chlamydia Cases Among Males by Age Group
Utah, 2003 – 2007

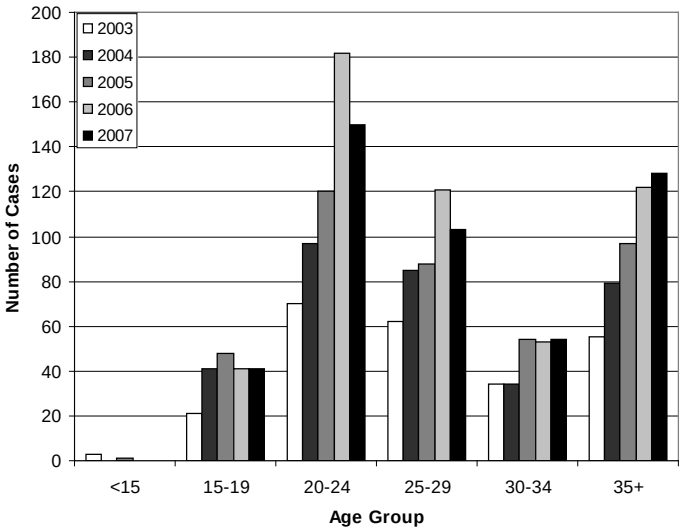


Source: Utah 2003-2007 Chlamydia and Gonorrhea Epidemiological Profile
Utah Department of Health, Bureau of Epidemiology, Communicable Disease Analysis and Reporting Program
http://health.utah.gov/cdc/sp.htm

In Utah, nearly half of gonorrhea cases are diagnosed in 15-24-year-olds. During the 2003-2007 time period, adolescent and young women ages 15-24 accounted for 64% of all reported gonorrhea cases.[3] In 2007, among 15-19-year-olds, the rate of gonorrhea per 100,000 was 69.3

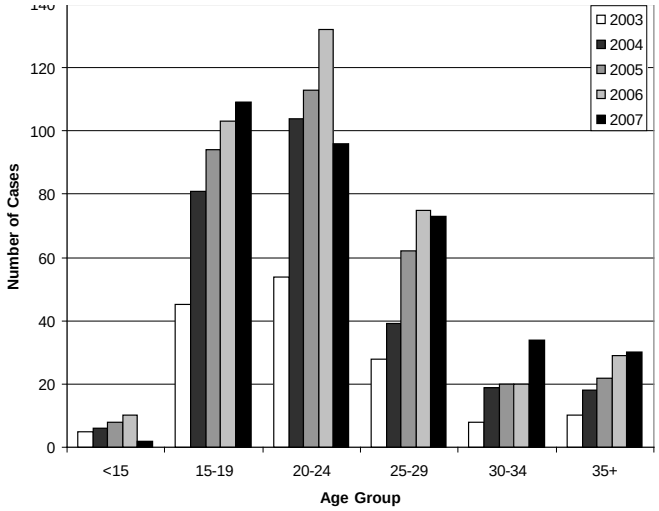
(150 cases). In 2007, among 20-24-year-olds, the rate of gonorrhea per 100,000 was 100.5 (244 cases). Of all individuals reported with gonorrhea during 2008, 46% (218 cases) were in the 15-24 age group.[4] In 2008, among 15-19-year-olds, the rate of gonorrhea per 100,000 was 31.8 (70 cases). In 2008, among 20-24-year-olds, the rate of gonorrhea per 100,000 was 61.0 (148 cases).

Gonorrhea Cases Among Males by Age Group
Utah, 2003 – 2007



Source: Utah 2003-2007 Chlamydia and Gonorrhea Epidemiological Profile
Utah Department of Health, Bureau of Epidemiology, Communicable Disease Analysis and Reporting Program
http://health.utah.gov/cdc/sp.htm

Gonorrhea Cases Among Females by Age Group
Utah, 2003 – 2007

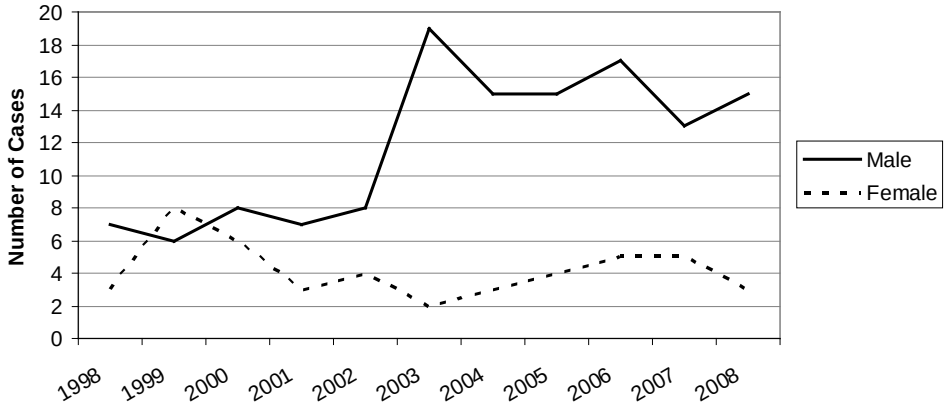


Source: Utah 2003-2007 Chlamydia and Gonorrhea Epidemiological Profile. Utah Department of Health, Bureau of Epidemiology, Communicable Disease Analysis and Reporting Program. http://health.utah.gov/cdc/sp.htm

During 2008, 66 AIDS cases were documented in Utah. The majority of these cases (71%) met the AIDS case definition based on low CD4 T-lymphocyte counts. Sixty-six AIDS cases were also reported in 2007. Twenty-four AIDS deaths were reported through December 2008 compared to 23 deaths reported in 2007 through December. During 2008, 106 HIV-positive individuals were reported compared to 91 the previous year, a 16% increase. After a review of previous trends, it is anticipated that between 85-115 HIV infections and 45-75 AIDS cases will be reported during 2009. In Utah, two teenagers (ages 13-19) and 18 young adults (ages 20-24) were reported with HIV/AIDS during 2008. Cumulative data show 54 teenagers and 275 young adults have been reported in Utah with HIV/AIDS. The distribution by risk exposure for teens and young adults remains consistent with that of older adults.

During 2008, male-to-male sexual contact was the most common means of HIV/AIDS exposure reported among men of all races. Men who have sex with men and inject drugs was the second highest means of exposure followed by injecting drug use. Fifteen percent of men reported with HIV/AIDS during 2008 did not disclose a risk. The racial breakdown of men with HIV/AIDS in 2008 shows that 73% were White, 17% were Hispanic, 4% were Black, 1% were Native American, 1% were Asian/ Pacific Islander, and for 4%, race was unknown. Twenty-two women were reported with HIV/AIDS during 2008. Heterosexual contact was the most common means of HIV/AIDS exposure reported. Injecting drug use was the second highest means of exposure. Eighteen percent of women reported with HIV/AIDS during 2008 did not disclose a risk. The racial breakdown of women shows that 59% were White, 23% were Hispanic, 14% were Black, and 5% were Asian/Pacific Islander. Seventy-seven percent of these women were of childbearing age (15-44).

HIV/AIDS Cases Among Teenagers and Young Adults Ages 13-24
by Year of Diagnosis for All Risk Groups
Utah, 1998-2008



Source: Utah HIV/AIDS Epidemiological Profile-Update 2009. Utah Department of Health, Bureau of Epidemiology, Communicable Disease Analysis and Reporting Program. http://health.utah.gov/cdc/sp.htm

National Data

In 2007, 1,108,374 chlamydial infections were reported to the Centers for Disease Control and Prevention (CDC) from 50 states and the District of Columbia.[5] In 2007, the reported number

of cases of chlamydial infection was more than three times greater than the reported cases of gonorrhea (355,991). Among women, the highest age-specific rates of reported chlamydia in 2007 were among 15-19-year-olds (3,004.7 cases per 100,000 females) and 20-24-year-olds (2,948.8 per 100,000).

According to the CDC's 2006 report, "Sexual and Reproductive Health of Persons Aged 10-24 Years", approximately 1 million adolescents and young adults aged 10-24 years were reported to have chlamydia, gonorrhea, or syphilis.

In 2006, 15% of new HIV diagnoses were in 13-24-year-olds. Among new nationwide HIV diagnoses, 49% were in African-American/Black individuals, 30% were in White individuals, and 18% were in Hispanic/Latino individuals. Asians/Pacific Islanders and American Indians/Alaska each accounted for 1% or fewer diagnoses.

Who is at Risk?

Any sexually active person is at risk for chlamydia and gonorrhea infection. The CDC reports that many adolescents and young adults in the United States engage in sexual risk behaviors and experience negative sexual and reproductive health outcomes.[6]

In Utah, as two-thirds of chlamydia and nearly half of gonorrhea cases are diagnosed in 15-24-year-olds, it is clear that our sexually active youth are at greatest risk of infection. Early sexual activity among teens may be influenced by many complex factors such as substance/alcohol use, peer pressure, self-esteem issues, media/societal influences, religious beliefs, and cultural factors.

In Utah, among males diagnosed with HIV in 2008, 60% of cases were diagnosed in men who have sex with other men, followed by men who have sex with men and inject drugs (17%). Among females diagnosed with HIV in 2008, 50% of cases were diagnosed in heterosexual women, followed by injection drug use (32%).

What is Being Done?

Beginning in 2009, the state-funded Catch the Answers Campaign was implemented to target at-risk youth, parents, and medical providers, as a result of House Bill 15, "The Control and Prevention of Sexually Transmitted Diseases." This campaign was created to increase awareness among the general public, as well as specific populations in need of targeted education and better access to resources. Catch the Answers includes a website for young adults, parents, and health care providers and is publicized via billboards, bus/train signs (interior and exterior), posters, magnets, and cards. The chlamydia and gonorrhea-focused website features an interactive question and answer section, public testing resources, and links to other health-related websites.

In May 2009, the Utah Department of Health organized the STD Community Coalition, comprised of policy-makers, community-based organizations, local health departments, family planning facilities, community health centers, the private medical sector, and influential community members. The purpose of the STD Community Coalition is to promote awareness of

STDs in Utah's youth population (15-24) and collaborate to support reproductive health. As a result of this Coalition, new collaboration among agencies is occurring, with the goal of expanding and improving targeted awareness, education, testing, and disease intervention services aimed at the targeted at-risk population.

The Utah Department of Health collaborates with Local Health Districts and community based organizations to provide HIV prevention services to at-risk populations, including adolescents and young adults.

Local Resources

- Utah Department of Health, HIV/STD/Viral Hepatitis Prevention Program. STD Prevention Coordinator, Emily Holmes, 801-538-6701, eholmes@utah.gov
- Catch the Answers campaign, www.CatchTheAnswers.net
- Utah Association of Local Health Districts, www.ualhd.org
- Association for Utah Community Health, www.auch.org
- Planned Parenthood Association of Utah, www.plannedparenthood.org/utah

National Resources

- Centers for Disease Control and Prevention, Division of STD Prevention, www.cdc.gov/std
- Planned Parenthood Federation of America, www.plannedparenthood.org
- Youth Risk Behavior Surveillance System, www.cdc.gov/HealthyYouth/yrbs
- National Association of Community Health Centers, www.nachc.com
- National Association of County and City Health Officials, www.naccho.org
- National Infertility Prevention Program, www.cdc.gov/std/infertility/ipp.htm
- National Chlamydia Coalition, www.prevent.org/ncc
- National Coalition of STD Directors, www.ncsddc.org
- Association of Reproductive Health Professionals, www.arhp.org
- Society for Adolescent Medicine, www.adolescenthealth.org
- National Network for STD/HIV Prevention Training Centers, http://depts.washington.edu/nnptc
- US Department of Health and Human Services, Office of Population Affairs, Office of Family Planning, www.hhs.gov/opa/familyplanning

Recommendations

Many young people in the U.S. engage in sexual risk behaviors that can result in unintended health outcomes, including sexually transmitted diseases, HIV/AIDS, and pregnancy. Services to promote adolescent reproductive health, including evidence-based prevention education, counseling, testing, and referral, are essential and should be delivered so all youth can benefit.

In Utah, legislators, educators, medical providers, the general public, and adolescents need continuous education on the importance of preventing chlamydia, gonorrhea, HIV, and other sexually transmitted infections. Collaboration should continue with a variety of agencies in order to best reach all at-risk populations. Additionally, funding should be sought to create/support programs that increase awareness of the prevalence of sexually transmitted diseases among Utah youth.

References

1. References Utah Department of Health, CHLAMYDIA AND GONORRHEA EPIDEMIOLOGICAL PROFILE, 2003-2007.
2. Utah Department of Health, Bureau of Epidemiology, HIV/STD/Viral Hepatitis Prevention Program.
3. Utah Department of Health, CHLAMYDIA AND GONORRHEA EPIDEMIOLOGICAL PROFILE, 2003-2007.
4. Utah Department of Health, Bureau of Epidemiology, HIV/STD/Viral Hepatitis Prevention Program.
5. Centers for Disease Control and Prevention. *Sexually Transmitted Disease Surveillance 2007 Supplement, Chlamydia Prevalence Monitoring Project Annual Report 2007*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; January 2009.
6. Centers for Disease Control and Prevention. Sexual and Reproductive Health of Persons Aged 10-24 Years. Surveillance Summaries, MMWR 58;(No. SS-6).

Hepatitis B

Submitted by: Nasrin Zandkarimi, Immunization Program, Utah Department of Health

Problem Statement and Background

Hepatitis B is a contagious liver disease which is caused by infection with hepatitis B virus and can be acute (lasting a few weeks) or chronic (a serious, lifelong illness). Chronic hepatitis B can lead to liver disease or liver cancer and even death. Hepatitis B may be spread through sexual activity or contaminated blood such as sharing needles, syringes, or other drug-injection equipment. Hepatitis B can also spread through close household contact and from infected mothers to their infants at birth. Infants infected during pregnancy are at increased risk for developing chronic liver disease, such as cirrhosis (liver scarring) or liver cancer later in life. Up to 25% of infants infected prenatally will die of chronic liver disease as adults.[1]

National Data

In the United States, an estimated 1.5 million people are chronically infected with the hepatitis B virus. Twelve million Americans have been infected with hepatitis B (1 out of 20 people). Hepatitis B is the underlying cause of an estimated 2,000–4,000 deaths each year in the United States.[2] As many as 100,000 people will become infected with the hepatitis B virus each year.[3] Furthermore, 90% of infants and up to 50% of young children infected with hepatitis B will develop chronic infections. [3] Clearly, this is a significant public health and medical problem and vaccination is essential to protect infants and children.

Utah Data

In 2008, Utah reported 45 cases of chronic hepatitis B with 11 cases occurring in adolescents 11-24 years of age. In the same year, 13 cases of acute hepatitis B were reported with 2 cases in adolescents 11-24 years of age.[4] The 2008 school audits indicated that 98% of 7th grade students completed their hepatitis B series. In 2008, there were 85 cases of pregnant women with positive hepatitis B surface antigen (HBsAg). Fifteen of those cases occurred in adolescents.[1]

In 2007, Utah had a total of 71 chronic hepatitis B cases. Eleven of those were among adolescents 11-24 years of age. In the same year, there were also 15 confirmed cases of acute hepatitis B and five of those were among adolescents 11-24 years of age.[4]

Who is at Risk?

Anyone can get hepatitis B. However, certain groups have a greater chance of becoming infected. These include: infants born to infected mothers, IV drug users, sexual partners of infected people, people with many homosexual or bisexual partners, certain populations with high rates of hepatitis B infection, health care and public safety workers, and anyone who has frequent contact with blood. Clients and staff of institutions for people with developmental disabilities, and housemates of chronically infected people are at higher risk than the general population, but lower risk than those listed above.

A highly effective vaccine is available for persons at high risk of being infected with hepatitis B. The vaccine is a three-dose series and is usually given over a period of six months. Testing all pregnant women for the hepatitis B surface antigen is recommended to prevent spread from infected mothers to their infants. Donated blood should be tested for HBsAg, and individuals who test positive should be rejected as donors. Syringes, acupuncture and tattooing needles should never be reused.

What is Being Done?

Hepatitis B vaccine is promoted through the Vaccines for Children (VFC) program at youth correctional facilities and participating health care provider offices. Also, sexually transmitted infection clinics throughout the state promote the hepatitis B vaccine to adolescents. These clinics also provide print materials to adolescents who visit their clinics. Beginning in the 2006-2007 school year, hepatitis B became a requirement for students entering the seventh (7^{th}) grade.[1]

Through the Utah Immunization Program, the Prenatal Hepatitis B Prevention Project provides case management and follow-up for pregnant women and their infants who are positive for the hepatitis B virus. Infants and all household members can receive free hepatitis B vaccine and blood testing after administration of the vaccine.

Prenatal testing for the HBsAg is recommended for all pregnant women to identify newborns at risk for prenatal hepatitis B virus infection. This testing should be conducted during an early prenatal visit in every pregnancy. Prenatal testing can identify hepatitis B carriers and ensure their infants receive appropriate medical attention (hepatitis B immune globulin and hepatitis B vaccine). Children born to hepatitis B infected mothers who are not previously identified are at high risk for infection through person-to-person transmission during the first five years of their lives.[1]

Local Resources

- The Utah Department of Health, Bureau of Epidemiology (801) 538-6191
- Utah Immunization Program: www.immunize-utah.org

National Resources

- Centers for Disease Control and Prevention, Viral Hepatitis: http://www.cdc.gov/hepatitis/
- Hepatitis B Foundation: http://www.hepb.org/
- Immunization Action Coalition: www.immunize.org

Recommendations

- Continue to seek funding to promote hepatitis B vaccination among teens.

- Continue to educate parents, teens, legislators, and the general community on the importance of vaccinating adolescents with hepatitis B vaccine.

- Continue working with Juvenile Justice System, Planned Parenthood Association of Utah, and other facilities that provide services to high-risk adolescents and promoting the VFC Program at these facilities.

References

1. Utah Department of Health Immunization Program: www.immunize-utah.org accessed August 27, 2009.
2. Morbidity and Mortality Weekly Report (MMWR) September 19, 2008/Vol.57/No.RR-8.
3. Hepatitis B Foundation: www.hepb.org accessed July 2009
4. Utah Department of Health, Communicable Disease Epidemiology

What is HPV?

Submitted by: Nasrin Zandkarimi, Immunization Program, Utah Department of Health

Problem Statement and Background

The human papillomavirus (HPV) is the most common sexually transmitted infection in the U.S. There are currently more than 100 known strains of HPV. About 30 of these strains affect both male and female genitalia, causing conditions like genital warts and, more seriously, cervical cancer. It is estimated that at least 50% of sexually active people will get HPV at some time in their lives. HPV is a serious but preventable cancer of the cervix. HPV may also play a role in cancers of the anus, vulva, vagina and penis, and some cancers of the oropharynx. HPV is spread through any type of skin-to-skin genital contact with a person who has HPV.

Utah Data

Although the majority of the HPV infections cause no symptoms, 99.7% of cervical cancers are caused by HPV. On average, 60 Utah women are diagnosed and 17 die each year from cervical cancer.[1] Locally, there are no data available on adolescents and HPV infection.[1] There were an insufficient number of Utah girls age 13-17 included in the 2009 NIS-Teen survey to calculate a state level vaccination rate, but Utah Immunization Program data indicate that Utah coverage is most likely below the national level.

National Data

Approximately 20 million people are currently infected with HPV in the United States, and another 6.2 million people become newly infected each year.[1] The majority of these cases (74%) occur in 15- to 24-year-olds.[2]

The Centers for Disease Control and Prevention (CDC) estimates that 8 out of 10 women will become infected with genital HPV in their lifetime. Every day, 30 women are diagnosed with cervical cancer and about 12,000 people ages 15 to 24 are infected with HPV. According to the CDC, every year about 10,000 women will be diagnosed with cervical cancer and about 3,000 will die from the disease.

The following numbers indicate the number of U.S. women diagnosed with cervical cancer in 2005, the most recent year for which data are available: 11,999 women overall; 1,973 Hispanic women; 1,794 African-American women; 501 Asian/Pacific Islander women; and 85 American Indian/Alaska Native women.

The following numbers of U.S. women who died from cervical cancer in 2005, the most recent year for which data are available: 3,924 women overall; 2,982 white women; 783 African-American women; 447 Hispanic women; 125 Asian/Pacific Islander women; and 34 American Indian/Alaska Native women.[3]

Who is at Risk?

HPV is a serious but preventable cancer of the cervix. Men and women are more likely to get the infection if they: 1) have sex at an early age (16 years or younger); 2) have or have had intimate sexual contact with multiple partners, and 3) have or have had intimate sexual contact with a sex partner who has had many partners.

The best way to prevent genital HPV infection is to not have genital contact with another individual. Even when you don't have sex, any contact with the genitals can spread HPV. Limiting the number of sexual partners one has in his/her lifetime and using a condom are the best ways to reduce the risk of contracting HPV. In addition to getting a regular Pap test, the HPV vaccine provides another layer of protection against cervical cancer. The HPV vaccine will not eliminate the need for screening because it does not protect women from all types of HPV that cause cancer. The best time to vaccinate is before a woman becomes sexually active. However, women who are sexually active may also benefit from the vaccine.

What is Being Done?

In June 2006, the Food and Drug Administration (FDA) approved an HPV vaccine that is effective against four strains of the virus for use among females ages 9-26 years. Currently, Gardasil® is the only FDA-approved vaccine for use against HPV types 6, 11, 16 and 18. HPV types 16 and 18 cause 70% of all cervical cancers. Gardasil® is between 95-100% effective against the HPV types it is approved for.[1]

This vaccine is given in a series of three injections over a six-month period. Vaccination is not a substitute for routine screening with Pap tests because the vaccine does not protect against all HPV types that cause cervical cancer.

In 2007, Utah industrialist Jon Huntsman, Sr. donated $1 million to the Utah Department of Health (UDOH) to begin a cervical cancer prevention and awareness campaign and to provide low-cost HPV vaccines to eligible women 19-26 years of age. Through this program, many Utah women received life-saving education and vaccines to prevent the HPV infection. Women 19-26 years of age who had no insurance or whose insurance did not pay for the HPV vaccine were able to receive the vaccine at low cost in designated locations throughout Utah.

In June 2009, the Utah Cancer Control Program completed its HPV campaign with the Cervical Cancer Prevention Contest to virally spread messages about cervical cancer prevention. Participants had the opportunity to win prizes by blogging or tweeting to their friends and family about how to prevent cervical cancer. The contest ran through June 29, with one winner chosen each week. Funding for the campaign ended June 30, 2009.

HPV vaccine is available through the Vaccines for Children (VFC) Program at participating provider offices. Informational materials for the public and health care providers about HPV are available from the Utah Immunization Program and the Utah Cancer Control Program. These materials can be viewed at http://www.cancerutah.org/prevent.

Local Resources

- Utah Cancer Control Hotline: 1-800-717-1811
- Utah Cancer Control Program: http://www.utahcancer.org/
- http://www.health.utah.gov/nomorecancer/
- Utah Immunization Hotline 1-800-275-0659
- Utah Immunization Program: http://www.immunize-utah.org

National Resources

- American Society of Colonoscopy and Cervical Cancer Pathology: http://www.asccp.org/pdfs/patient_edu/women_should_know.pdf
- Centers for Disease Control and Prevention http://www.cdc.gov/std/HPV/default.htm and www.cdc.gov/cancer/cervical
- Cervical Cancer Vaccine Basics www.cervicalcancercampaign.org/faqs
- National HPV and Cervical Cancer Prevention Resource Center, created by the American Social Health Association: http://www.ashastd.org/hpvccrc/
- U.S. National Library of Medicine and National Institutes of Health: Medline Plus http://medlineplus.gov/
- http://hpv.com/

Recommendations

- Continue to work with facilities that provide health care for high-risk adolescents such as sexually transmitted disease (STD) clinics, youth correctional facilities, primary care physicians, and Utah Planned Parenthood clinics and encourage them to promote and provide the HPV vaccine to adolescents.
- Continue to educate legislators, parents, the general community, and Utah adolescents on the importance of preventing cervical cancer among Utah youth.

References

1. Utah Cancer Control Program: www.cancerutah.org
2. http://www.vaccinesforteens.net or CDC. Genital HPV infection: CDC fact sheet. http://www.cdc.gov/std/hpv/stdfact-hpv.htm
3. CDC. Cervical Cancer www.cdc.gov/cancer/cervical accessed July 31, 2009.

Access to Family Planning

Submitted by: Debby Carapezza, Maternal and Infant Health Program, Utah Department of Health

Problem Statement

Over the past several decades, political debate has raged over the rights of adolescents to receive confidential reproductive health care vs. parents' rights to control their teens' reproductive health care decisions. This chapter will examine the public policies and professional opinions involved in this complex issue.

Background

Since its inception in 1970, the Federal Title X Program of the Public Health Service Act has required that family planning services be provided confidentially to low income women regardless of age. Federal Medicaid regulations also mandate confidential provision of family planning services to sexually active minors.[1] In 1988, the Utah legislature passed a law that states, "No funds of the state or its political subdivisions shall be used to provide contraceptive or abortion services to an unmarried minor without the prior written consent of the minor's parent or guardian."[2] Since that time, the Utah Department of Health has been unable to apply for Title X funds for family planning services since the state law now requires the department, including local health departments, to obtain parental consent for family planning services to unmarried minors - a direct conflict to Title X requirements. As a result, the Federal Title X Grant Funds passed to Planned Parenthood Association of Utah which currently administers this funding stream in Utah.

An issue that also impacts teen access to family planning services is the teen's perception of confidentiality of her/his medical records. The impact of loss of confidentiality of a teen's medical record was the subject of a 2003/2004 study published in the *Journal of the American Medical Association*. Sixty percent of minor teens surveyed reported that their parents or guardians were aware of their use of publicly funded family planning clinics to access sexual health services. Among these respondents, 79% indicated they would continue to use the clinic for prescription contraception if parental notification were mandated. Of the 40% of minors reporting that their parents or guardians did not know they were accessing sexual health services at participating clinics, only 29.5% indicated they would continue clinic use if parental notification were mandated. Among these teens, if parental notification were instituted, 63% indicated they would use an over-the-counter method of birth control but only 1% of minor females indicated that their only response would be to stop having sex. Among both groups, 18% of teenagers reported they would engage in risky sexual behavior if parental involvement were to be mandated and 5% would not seek services for sexually transmitted diseases (STDs).[3]

As noted above, a teen attempting to access family planning services may encounter laws that require health care providers to notify her parents in writing of attempts to obtain prescription contraceptives. While Utah law does not currently mandate parental notification prior to providing contraceptives to a minor, legislation had previously been introduced that would have mandated such a law. This law was struck down by the courts.

Studies show parental notification laws can affect teen use of reproductive health care. One such study conducted in 2002 explored parents' attitudes toward such laws. The results indicated mixed feelings on the issue. Forty-nine percent of parents surveyed felt a minor's right to obtain contraceptives without parental consent is a good idea. Overall, 55% of surveyed parents of adolescents indicated that parental notification laws are a good idea. However, 96% of parents expected there to be at least one negative consequence, such as teens using methods not requiring a clinic visit (condoms and foam), more teens having unprotected sex and more teen pregnancies and STDs as a result of passage of parental notification laws. The more negative consequences the parent anticipated such laws could generate, the less likely they were to favor them. Conversely, the more positive consequences of enactment of parental notification laws the parent noted, the more favorably they viewed the laws.[4]

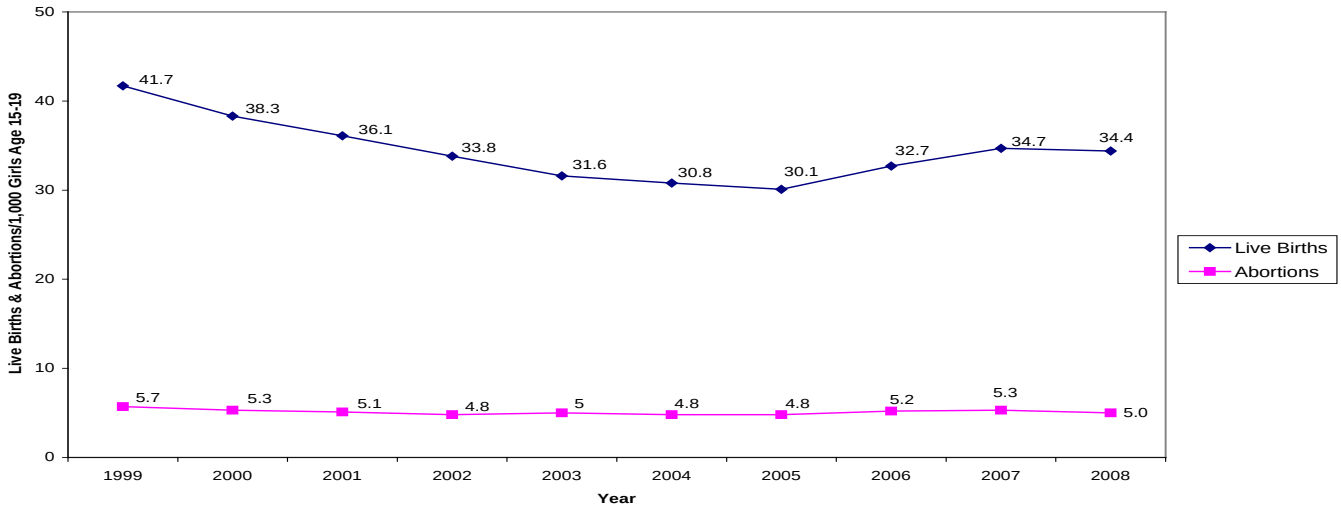
The Federal Food and Drug Administration (FDA) decreased minors' access to family planning services in 2006 when it ruled that emergency contraception (Plan B®), while available without prescription to adults, would require a prescription for teens under age 18 despite a lack of science-based evidence documenting increased risk or side effects related to the use of emergency contraception among young teens. In 2009, the FDA extended the right to obtain emergency contraception without prescription to 17-year-olds.[5]

While adults continue to debate the need/advisability of teen access to family planning services, teens continue to become pregnant at great personal and societal cost. According to The National Campaign to Prevent Teen and Unintended Pregnancy, a November 2006 report stated that between 1991 and 2004, there were more than 56,200 teen births in Utah. This cost Utah taxpayers $1.3 billion dollars in that time period. The cost to the child born to a teen mother is also high. In 2004, the Utah taxpayer's bill for the associated costs of teen childbearing included: $13 million for Medicaid and CHIP-covered health care; $13 million for child welfare; and $21 million in lost tax revenue due to decreased earnings and spending. Of these 2004 expenses, 45% were federal costs and 55% were state and local costs.[6]

Utah Data

Abstinence from sexual activity until marriage has been the national and state standard of expected behavior for teens since 1998. Despite efforts to promote this standard and regulate access to family planning, many Utah teens are sexually active. The Utah teen birth rate (the number of live births per 1,000 girls ages 15 through 19) declined from a high of 41.7 in 1999 to a low of 30.1 in 2005. Since that time the rate has increased to 34.7 in 2007 (see Chart #1). In 2008 there was a slight decrease to 34.4 live births per 1,000 girls ages 15-19. It is too early to determine if the increase between 2005-2007 represents a new upward trend of teen births.[7] The abortion rate for Utah teens ages 15-19 from 1999 through 2008 remained relatively static, with the highest rate of abortions among teens occurring in 1999 with a rate of 5.7 (the number of abortions per 1,000 teens ages 15 through 19). The lowest rate of 4.8 occurred in 2002, 2004 and 2005. In 2008, the last year for which data are available, the rate increased slightly to 5.0.[8]

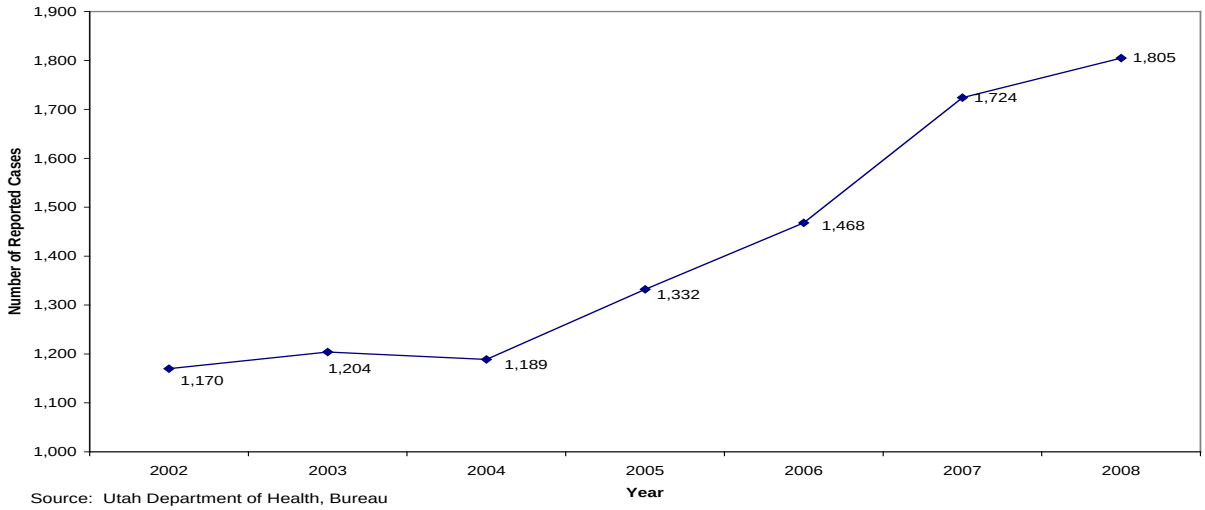
Chart #1: Live Births and Abortions Among Utah Teens Ages 15-19, 1999-2008



Source: Utah Department of Health, Office of Vital Records and Statistics, Utah's Indicator-Based Information System for Public Health (IBIS). Available online @ http://ibis.health.utah.gov Utah Department of Health. Center for Health Data, Office of Vital Records and Statistics. *Utah's Vital Statistics" Abortions, 2008.*

Another indicator also points to continued teen sexual activity – the increasing number of cases of the STD chlamydia. In 2002, the number of chlamydia cases reported among 15-19-year-old teens was 1,170. By 2008 (the last year for which data are available), the number of reported cases was 1,805 (see Chart #2).[9] Clearly, many Utah teens are sexually active.

Chart #2: Number of Chlamydia Cases Among Utah Teens Ages 15-19, 2002- 2008



Source: Utah Department of Health, Bureau of Communicable Disease Control, STD Control Program

National Data

Birth rates for teens ages 15 through 19 in the United States fell steadily since the early 1990s to a low of 41.1 live births per 1,000 in 2004. Since that time, the U.S. rate has climbed with the last year of final data indicating a birth rate of 41.9 in 2006. [10] Provisional data for 2007 reveal another increase in the rate to 42.5. [11] Despite this overall trend in the decline of teen births, the U.S. birth rate for teens is higher than other developed countries and even many less-developed countries In Canada, the teen birth rate in 2004 was 13.6 per 1,000 teens (age of teens not specified) compared to 41.1 in the U.S. that same year.[12]

What is Being Done?

Of Utah's 12 local health districts, in state fiscal year 2008 (July 1, 2007 through June 30, 2008), 10 offered some form of family planning services. Some local health departments offer financial assistance, education and referral of clients to local providers of family planning services. Others provide family planning examinations and prescriptions for contraceptive methods. All local health departments require written parental consent for contraceptive services to teens. Among them, the 10 local health districts providing some form of family planning services served a total of 5,377 women in FY08. Of these, only 823 (15.3%) were under the age of 20.[13] In contrast, at Planned Parenthood of Utah Clinics during FY2008, a total of 13,389 women under the age of 20 were seen, representing 32.5% of their total clients. The percentage decreased from 35% in FY2007 to 27% in FY2009.[14]

Family planning services may also be provided to teens via private providers throughout the state. Access to these providers may be limited due to financial constraints as most teens do not have sufficient income to afford services from private providers. Statistics regarding family planning services provided to teens are not available from private providers because there are no requirements for this group to report these data to state and local agencies. Also, family planning visits may be billed under a number of different codes making tracking of these services difficult.

National Programs

In 2009, The Task Force on Community Preventive Services, an independent, nonfederal group of health care experts appointed by the Centers for Disease Control and Prevention, recommended "group-based comprehensive risk reduction (CRR) be delivered to adolescents to promote behaviors that prevent or reduce the risk of pregnancy, HIV and other sexually transmitted infections (STIs)." This recommendation was issued after a systematic review of all available studies. In their review, no evidence was found that CRR interventions result in increased sexual activity. To the contrary, evidence was found that CRR interventions reduce the prevalence and frequency of sexual activity.[15]

Over the past several years, many professional health organizations have issued statements on the importance of adolescent access to confidential reproductive health care. Among them is a May, 2009 news release by the American College of Obstetricians and Gynecologists. The news release contains the following[16]:

> "The American College of Obstetricians and Gynecologists (ACOG) reaffirms its position that every teen should be provided with comprehensive, scientifically accurate sex education and that access to contraception services should be available to all teens."

In the same release, included in the discussion regarding STDs is the following:

> "…access to a full spectrum of confidential reproductive health services-including family planning and services for the prevention, diagnosis and treatment of STDs-is imperative."

And finally:

> "Parental involvement also makes a difference in teen attitudes toward sexuality and pregnancy."

Other national organizations have also advocated for teen access to reproductive health services. They include the National Family Planning and Reproductive Health Association (NFPRHA) and Planned Parenthood.

Local Resources

- Utah Department of Health, Division of Family Health and Preparedness, Maternal and Infant Health Program: www.health.utah.gov/rhp
- Local health departments throughout Utah. Listing of locations available online @ http://www.ualhd.org/Department/Department.htm
- Planned Parenthood Association of Utah: http://www.plannedparenthood.org/utah/

National Resources

- The National Campaign to Prevent Teen and Unplanned Pregnancy: www.thenationalcampaign.org
- The Alan Guttmacher Institute: http://www.guttmacher.org/
- The Youth Risk Behavior Surveillance System (YRBSS): http://www.cdc.gov/HealthyYouth/yrbs/index.htm

Recommendations

Evaluating the impact of teen access, or lack of access, to family planning services is difficult due to a lack of appropriate data. Information related to teen sexual activity, use of reproductive health care services and other important aspects of adolescent sexual behaviors are generally available through the Youth Risk Behavior Surveillance System (YRBSS), a Centers for Disease Control and Prevention national surveillance system. The YRBSS is a school-based survey. In Utah, questions related to teen sexual behavior are not included in the YRBSS. As a result, there is no consistent source of information on current Utah teen sexual behaviors, risk factors specific to Utah teens and the impact of interventions on these behaviors. This limits the ability to develop effective, science-based programs for teens that target appropriate population groups and deal with issues specific to Utah teens, including access to reproductive health care services. However, a resolution entitled "Additional School Strategies to Address Teen Sexual

Involvement" made by the Utah Parent Teacher Association (PTA) states, "…That the Utah PTA encourage local districts to allow one student survey for grades 8-12 with parental permission which includes limited questions about sexual intercourse and associated protective and risk factors of early sexual involvement..".[17]

In a study by Santelli, et al, in discussing the public policy implications of behavioral risks for pregnancy among high school students, the following statement is made: "If the U.S. wants to effectively address teen pregnancy rates, reinvigorated efforts are needed at a state and national level to promote contraceptive use among teens through sex education and health services.[18]

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Teen Pregnancy and Sexually Transmitted Diseases Among Foster Care Youth

Compiled by: Christie Kinghorn, Utah Department of Child and Family Services

Problem Statement and Background

By age 20, approximately 1 in 3 girls nationwide become pregnant.[1] Females served in the foster care system are at even higher risk of pregnancy, with one study showing that females served in foster care are 2.5 times more likely to become pregnant by age 19 and are 1.5 times more likely to have a subsequent pregnancy compared to their non-foster care peers.[2]

Further, a July 2009 national report indicates a significant difference between the reproductive health behaviors and outcomes of youth who have ever been in foster care compared to the general population of the same age. Youth who have ever been served in foster care are more likely to have sex for the first time under the age of 16, are less likely to use contraception the first time they have sex, and have higher rates of sexual experience than their non-foster care peers.[3] In addition, youth who have been served in foster care are nearly twice as likely to have a sexually-transmitted infection, at a rate of 13% compared to 7%.[4]

Utah Data

The Utah Department of Human Services collects data on the overall reproductive health of youth served in foster care. A number of children in foster care have reported sexually related health conditions* such as abortion, cervical dysplasia**, childbirth, chlamydia, gonorrhea, hepatitis**, herpes, HIV, HPV, miscarriage, pelvic inflammatory disease, and pregnancy. The below chart indicates the reproductive health of youth, ages 11 to 21, served from fiscal years 2005 to 2008.[5]

Reproductive Health of Utah Youth Served in Foster Care

Utah Youth ages 11 and older served in Foster Care	FY05	FY06	FY07	FY08
Total Youth served	2092	2120	2159	2258
Youth with one or more sexually-related health conditions	210	193	185	176
Percent of Youth with one or more sexually-related health conditions	10%	9%	9%	8%

* Please note that pregnancy or STDs may occur prior to the child's entry into foster care.

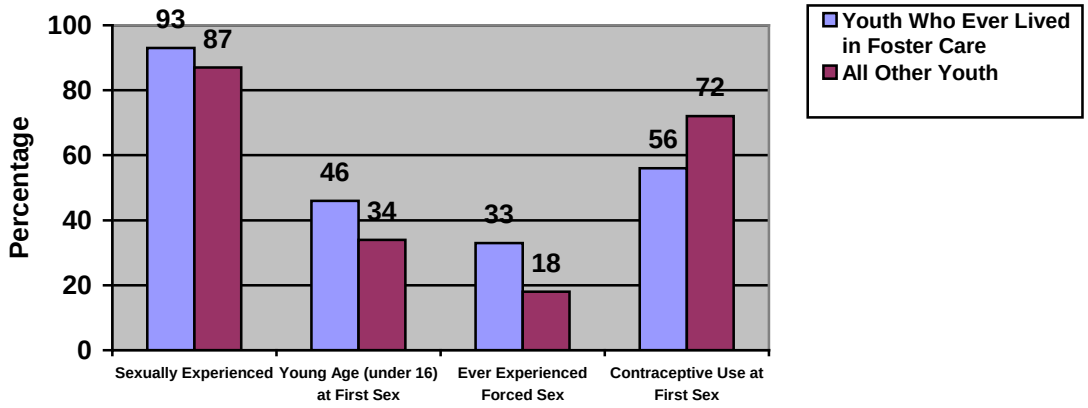
** Please note that hepatitis and cervical dysplasia may be caused by means other than sexual intercourse.

In addition to the above data, the Utah Department of Human Services released a report in 2006 which detailed well-being indicators of more than 900 youth who had transitioned out of the foster care system between 1999 and 2004. The study found that females ages 18 to 24 who had transitioned out of foster care had a birth rate within three years of leaving care that was 2.74 times higher than females of the same age group in the general statewide population.[6]

National Data

In July 2009, the National Campaign to Prevent Teen and Unplanned Pregnancy reported that youth who have been served in foster care are nearly twice as likely to have a sexually-transmitted infection as their non-foster care peers. The report also details the marked differences between the reproductive health behaviors of these two groups as indicated in the chart below. Youth were ages 18–26 at time of interview.[7]

Reproductive Health Behaviors Among U.S.Young Adults (Age 18-26)



Further, another recent study indicates that nearly 50% of females served in foster care reported ever having been pregnant by the age of 19 compared to 20% of their non-foster care peers.[8]

What are the Risk Factors?

The National Campaign to Prevent Teen Pregnancy and the Uhlich Children's Advantage Network (UCAN) collaborated on a 2005 qualitative study to gain a deeper perspective of teen pregnancy from the viewpoint of youth in foster care, as well as that of foster parents. By conducting a series of focus groups, the study concluded that youth in foster care may face the following risk factors:

- Lack of key relationships with parents and others
- Perception of benefits in having a baby, such as creating a family of their own
- Social pressure to have sex
- Inadequate or untimely information on sex and contraception
- Impulsive decision-making in regard to sex, even if long-term goals include waiting to have children[9]

What is Being Done?

The Division of Child and Family Services (DCFS) of the Utah Department of Human Services provides Transition to Adult Living (TAL) services for youth transitioning from foster care to

adulthood. The TAL curriculum has been approved for high school credit by the Utah Department of Education and is organized into 13 modules, one of which provides information on prevention, teen pregnancy, and parenting.[10]

In addition, the Utah Department of Human Services administers www.justforyouth.utah.gov, with information specifically targeting the needs of youth in foster care, including a *Guide to Medicaid After Leaving Foster Care*. This guide, in part, describes medical benefits for which the youth may be eligible, including birth control, Pap smear and pelvic exam.[11]

DCFS solicits input from foster care youth through a Youth Leadership Council, as well as an annual Youth Leadership Summit. During the Summit, the youth are given an open forum to provide feedback on the usefulness of services and information provided to them. Plans are in development for this feedback from the youth, entitled *Youth Speak Out*, to be printed and distributed to community partners.

Local Resources

- www.justforyouth.utah.gov: Just For Youth. Provides resources for youth on a variety of issues including education, employment, housing, finances, and health.
- www.ufostersuccess.org: Led and driven by the alumni and youth of foster care, empowering each other and the community to contribute and succeed in life.
- Tanya Albornoz, Program Administrator, Department of Human Services, DCFS, talborno@utah.gov
- Jode Littlepage, Transition to Adult Living (TAL) Liaison, Department of Human Services, DCFS, jode.littlepage@gmail.com
- Chris Chytraus, Program Manager, Fostering Healthy Children, Department of Health, chrischytraus@utah.gov

National Resources

- www.cdc.gov: Centers for Disease Control and Prevention
- www.fosterclub.com: The National Network for Young People in Foster Care
- http://www.thenationalcampaign.org/fostercare/default.aspx: The National Campaign to Prevent Teen and Unplanned Pregnancy

Recommendations

Policies and procedures should be developed for foster care in order to provide youth with access to information and services that will promote reproductive health among this target population.

Receiving and implementing feedback from youth served in Utah's foster care system continues to be a key goal. Some recommendations to be implemented include:

- Developing and distributing *Youth Speak Out*, an informative pamphlet stemming from the annual Youth Leadership Summit
- Updating www.justforyouth.utah.gov so that the site is more engaging and user-friendly to the target audience
- Revising the exit interview form, to be given to youth exiting foster care, so that it better describes the Transition to Adult Living resources available to them
- Planning a discussion forum on cultural awareness to be held at the next annual Youth Leadership Summit, which includes information on dating, prevention, and pregnancy

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Male Focused Reproductive Health Education

Submitted by: Annabel Sheinberg, MM, Planned Parenthood Association of Utah

Problem Statement

Adolescent males initiate risk-taking behaviors, including sexual intercourse, earlier than their female counterparts. Reproductive Health education includes teaching about reproductive anatomy, prevention of pregnancy and sexually transmitted infections and healthy relationships. Effective health education has been shown to increase condom usage at first intercourse and consistency of usage by adolescent males, thereby decreasing the likelihood of unintended pregnancy and sexually-transmitted infections.[1] Teens who engage in conversations with their parents about sexual decision-making are more likely than their peers to act responsibly. Across all ethnic groups, parents are more likely to talk to their daughters than their sons. Reproductive health education has been shown to improve sex role attitudes.

Background

Data from the 2002 National Survey of Family Growth indicate that condom use among teen males ages 15-19 is fairly high. Yet, one out of three are not using a condom the first or most recent time they have sex. Furthermore, one out of two are not using condoms consistently in their most recent sexual relationship. When comparing Black, White and Latino adolescent males, Latino teen males are least likely to use condoms at first intercourse.[2] Reproductive health education prior to first intercourse has been shown to be effective in increasing condom utilization, yet one in five males has not received any formal reproductive health education prior to first intercourse.

Adolescent males today often lack role models who display and discuss self-responsibility, particularly in the area of sexual development and sex roles. Sexuality is still a taboo subject in many U.S. families, and teens often fear asking questions at home. In some families there are expectations that daughters remain abstinent and avoid dating while there is a sentiment that sexual activity, aggressive behavior and dating are part of a teen male's 'coming of age'.[3] Effective interventions assist young males in developing a broader vision of masculinity than that provided by mainstream culture and traditional sex roles.

Utah Data

Planned Parenthood Association of Utah (PPAU) administers Title X Family Planning funds which support both reproductive education and clinical services. The largest age group served at family planning clinics is 20-24-year-olds with 15-19-year-olds being the second largest group. For education classes, the majority of participants are ages 14-19.

Table 1 illustrates 3-year trend data for male participation in education and family planning.

Table 1.

Reproductive Health Care and Education Services to Males at Planned Parenthood Association of Utah

Year	Unduplicated Male Clinic Patients	Percentage of All Family Planning Patients	Male Education Participants	Percentage of All Education Participants
2006	2645	8.25%	1850	30%
2007	3127	10.5%	2416	48%
2008	3323	10.4%	3115	49%

Source: Title X FPAR Report

National data

Title X is the Federal Family Planning Program for men, women, and teens that expands access to reproductive health care that helps prevent unintended pregnancy and abortions, and curbs the spread of Sexually Transmitted Infections. The return on investment for dollars spent on Title X is $3.80 for each $1.00[4] (Alan Guttmacher Institute). Nationwide, only 5% of Title X patients are males.

Who is at Risk?

Young males are much less likely than girls to access health care in general, or reproductive health care specifically (Armstrong et al., 1999). This is in part because there are so few services crafted specifically to meet their needs. Adolescents who are risk takers are multiple risk takers. Teens who engage in alcohol or drug use, acts of violence, or sexual intercourse are more likely to exhibit additional risk behaviors than their peers. Teen males who are out of school and or who are involved in the criminal justice system are most at risk.[5]

Protective Factors

Programs seeking to reduce the prevalence of isolated risk behaviors, such as sexual intercourse, smoking or violence, cannot address each behavior in isolation. Success with adolescent males requires changing behavior of multiple risk takers. Directly addressing the relationship between substance abuse and risky sexual behavior can encourage teens to resist pressure to conform to peer norms, real or perceived. Developing communication skills in adolescent males has been shown to be a protective factor. Teen couples with open communication are more likely to discuss contraception and are more likely to use it.[6] This same review showed that the programs most likely to prevent unplanned pregnancy were programs that empowered youth in their communities and provided them with social competencies such as communication skills, refusal skills, and the ability to resist peer pressure to engage in risky behavior. More and more efforts are being made to reach boys in effective ways that build on their strengths and develop them more holistically. The values and outlook of the program are important to adolescent males. Armstrong et al. (1999) found that young men are more likely to access reproductive health care

clinics when the social, economic, cultural, and health needs they consider to be important are addressed as well.[7]

What is Being Done?

PPAU has spearheaded a collaborative effort to bring the Wise Guys™ Male Responsibility Curriculum listed in the National Campaign to Prevent Teen and Unplanned Pregnancy's *What Works* category to Utah. In 2007 and 2008, PPAU hosted Wise Guys program staff to conduct trainings in Salt Lake City. Utah now has a team of skilled trainers in the Spanish and English versions of the program. Through partnerships with Midvale City and Centro de la Familia de Utah and other agencies, PPAU has reached 262 youth with the Wise Guys curriculum. Pre-and post-test data from a cohort of 50 rural, migrant and immigrant Utah Latino youth with an average age of 12.4 years who attended Wise Guys/*Jovenes Sabios classes* indicated 14% gains in knowledge about Sexually Transmitted Infections. Increases in participant communication with parents and adults about sex are highlighted in Table 2 below.

Table 2. Increases in Wise Guys participants communication with adults about sex

	Pre Wise Guys	**Post Wise Guys**	**% Change**
Participants reporting talking with their parents about sex			
Never	22/51 (43.%)	20/51 (39%)	- 4%
Sometimes	22/51 (43%)	27/51 (53%)	+ 10%
Often	7/51 (14%)	4/51 (8%)	- 6%
Participants reporting talking with their parents about dating			
Never	18/47 (38.%)	13/51 (26%)	- 12%
Sometimes	22/47 (47%)	28/51 (55%)	+ 8%
Often	7/47 (15%)	10/51 (20%)	+ 5%
Talked with someone about sex			
	42/55 (76%)	41/49 (84%)	+ 8%
Talk with adults about sex			
	28/55 (51%)	36/49 (73%)	+ 22%

Local Resources

- Centro de la Familia de Utah, Phone: 801- 521- 4473, G.palza@cdlfu.org
- Midvale City, Midvale Community Building Corporation, Phone 801-566-6191, Email: magramont@midvale.com
- Planned Parenthood Association of Utah, State Administration and Education Offices 801-532-1586, www.ppau.org, E-mail: Annabel.sheinberg@ppau.org
- Utah Department of Health, Maternal and Infant Health Program. Adolescent Health Coordinator. Phone 801-538-9317. E-mail: jmayfield@utah.gov
- Weber Morgan County, Community Based Abstinence Education Manager, Phone: 801-399-7188, Email: npalacios@co.weber.ut.us

National Resources

- Wise Guys Program, Family Life Council of Greater Greensboro, Rick Brown, Director Tel: (336)333-6890
- Best Practices in Adolescent Pregnancy Prevention Male Involvement, Cicatelli Associates Incorporated, 505 E. Eighth Ave., Suite 1600, New York, NY 10018, Phone 212-629-3231, www.cicatelli.org
- Centers for Disease Control and Prevention, Rape Prevention and Education Grants. 1600 Clifton Rd, Atlanta, GA 30333, U.S.A. http://www.cdc.gov/ViolencePrevention/RPE/index.html

Recommendations

- Conduct male focused outreach and education programs to males before first intercourse.
- Seek out partners in rape prevention, drug and alcohol prevention and crime prevention to collaborate efforts in reducing risky behaviors among male adolescents.
- Use reproductive health education curricula designed for adolescent males that have been validated for target populations (i.e., Caucasian, Hispanic and other groups as desired).
- Increase the number of male sexual health visits at Family Planning Centers, Private Health Care Providers and Public Health Clinics.

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Date Rape and Teen Violence

Submitted by: Katie McMinn, Violence and Injury Prevention Program, Utah Department of Health

Problem Statement and Background

According to the 2009 Youth Risk Behavioral Surveillance System, 10.9% of Utah students indicated they were hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend.[1] Dating violence encompasses verbal, emotional, psychological and sexual abuse. These types of abuse can escalate over time and may even lead to death. From 2005-2008, dating partners accounted for 10.5% of homicide victims in the state. [2]

Utah Data *

- National Incident-based Reporting System (NIBRS) data, which provide information on victim-offender relationship, shows a rising trend of violent crime committed by dating partners. In Utah, over the past eight years, incidents of assault and forcible sex involving dating partners have increased (49% and 147% respectively) while spousal violence trends have remained relatively stable.

Assaults and Sex Offenses Committed in Utah by a Dating Partner or Spouse, All Ages, 2001-2008

	Relationship	2001	2002	2003	2004	2005	2006	2007	2008
Assault (All Types)	Overall NIBRS	17,381	19,563	20,245	19,987	20,371	22,212	24,306	24,513
	Dating	2,359	2,390	2,508	2,468	2,835	3,079	3,396	3,518
	Spousal	2,864	2,659	2,717	2,468	2,565	2,733	2,902	2,713
Sex Offenses (Forcible)	Overall NIBRS	1,859	2,294	2,567	2,671	2,579	2,683	2,878	2,683
	Dating	68	96	120	140	76	153	173	168
	Spousal	32	32	40	38	33	41	48	35

NOTE: Incident-based reporting does not cover all offenses in the state, only those from reporting agencies (~75%).

Homicide in Dating Relationships

- A separate study by the Utah Commission for Criminal and Juvenile Justice for the years 2000-2008 showed that 13% of homicides in Utah were committed by spouses or ex-spouses and 6.7% by boyfriends/girlfriends or ex-boyfriends/girlfriends.
- From 2000-2004, dating partners accounted for 3.7% of homicide victims in Utah, whereas from 2005-2008, this percentage had grown to 10.5%.[2]

Homicides Committed in Utah by a Dating Partner or Spouse 2000-2008

Source: Analysis of data from Utah NIBRS, FBI Supplemental Homicide Reports, and the Utah Domestic Violence Fatality Review Committee

Sex Offenses in Dating Relationships

- According to the 2007 Rape in Utah survey, 15.7% of rapes and 17.8% of attempted rapes (10.6% of overall sexual assaults) against Utah women are committed by boyfriends or ex-boyfriends.

National Data*

- National data show that unmarried individuals experience non-lethal intimate partner violence (i.e., assault) at rates surpassed only by individuals who were separated or divorced from their partners.[3] In recent years, women were just as likely to be murdered by dating partners as spouses.[4]
- According to the 2009 Youth Risk Behavioral Surveillance System, 9.8% of U.S. students indicated they were hit, slapped, or physically hurt on purpose by their boyfriend or girlfriend during the 12 months before the survey. [1]
- Women ages 16 to 24 experience the highest per capita rates of intimate violence at nearly 20 per 1000 women.[5]

Who is at Risk?

Dating violence in the United States and Utah is experienced by adolescents, young adults, and older adults in dating relationships, though the dynamics may differ according to age group. Studies show that people who harm their dating partners are more depressed, have lower self-esteem, and are more aggressive than their peers. Other warning signs for dating violence include: use of threats or violence to solve problems; alcohol or drug use; inability to manage anger and conflict; poor social skills; association with violent friends; problems at school; lack of parental supervision, support, or discipline; and witnessing abuse at home.[6]

What is Being Done?

The Centers for Disease Control and Prevention funds a Rape Prevention and Education (RPE) Grant program through the Utah Department of Health Violence and Injury Prevention Program. The program goal is to strengthen sexual violence prevention efforts in states. Most RPE grant programs focus on teaching adolescents how to develop healthy relationships.

Primary prevention is the cornerstone of the RPE program. Program activities are guided by a set of prevention principles that include:

- Preventing first-time perpetration and victimization;
- Reducing modifiable risk factors while enhancing protective factors associated with sexual violence perpetration and victimization;
- Using the best available evidence when planning, implementing, and evaluating prevention programs;
- Incorporating behavioral and social change theories into prevention programs;
- Using population-based surveillance to inform program decisions and monitor trends; and
- Evaluating prevention efforts and using the results to improve future program plans.

In addition to the RPE program, advocates in Utah are also trying to pass legislation that would provide for the issuance, modification, and enforcement of protective orders between parties who are, or have been, in a dating relationship when:

- The parties are emancipated or 16 years of age or older;
- The parties are, or have been, in a dating relationship with each other; and
- A party commits abuse or dating violence against the other party. [7]

Currently, Utah law provides protective orders only to individuals who are or were married, and to individuals who have children together, regardless of marital status.

Local Resources

- Utah Coalition Against Sexual Assault 801-746-0404 info@ucasa.org
- Utah Department of Health Violence and Injury Prevention Program 801-538-6141 www.utah.gov/vipp
- Utah Domestic Violence Council 801-521-5544 www.udvc.org/home
- Utah Office on Domestic and Sexual Violence 801-538-1945 nsearle@utah.gov
- Utah Men's Anti-violence Network www.manutah.org

National Resources

- Choose Respect www.chooserespect.org
- Family Violence Prevention Fund http://endabuse.org/section/programs/teens
- Men Can Stop Rape www.mencanstoprape.org
- My Strength www.mystrength.org
- National Sexual Violence Resource Center www.nsvrc.org
- National Teen Dating Abuse Hotline http://www.loveisrespect.org/

Recommendations

- Continue to provide primary prevention and education in regard to dating and sexual violence.
- Redraft the protective order bill that will enable individuals who are in a dating relationship and are 18 years of age and older to obtain a protective order.

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*Prepared by Ben Peterson, PhD, and Chris Mitchell, PhD, Utah Commission on Criminal and Juvenile Justice

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Gang Involvement and Sexual Activity

Submitted by: Ken Roach, Salt Lake County Youth Services

Problem Statement and Background

Several studies suggest that teens who belong to gangs are more likely to have sex, have more sexual partners, and become pregnant. It is not clear whether these consequences are the result of gang membership or other risk factors.[1] What is clear, however, is that not enough is known about the problem. Some of the reasons for the lack of information are mentioned below.

Gang involvement is difficult to measure. [6] To the extent that there is a relationship between gang involvement and sexual activity, the research hasn't been able to determine what "dose" (or level) of gang involvement affects sexual activity.[7] Another reason it is difficult to measure gang involvement is that gang members may not always be trustworthy. Some gang members may exaggerate their antisocial behaviors to intimidate others. Other gang members may deny, or minimize, their gang involvement for fear of attracting the attention of anti-gang resources. Another difficulty is that research about gang members is potentially dangerous. Finally, it may be that the gang members who participate in research are different from other, more dangerous, gang members. Generalizations about gang members, when based on information gained from those who participate in research, may be skewed.

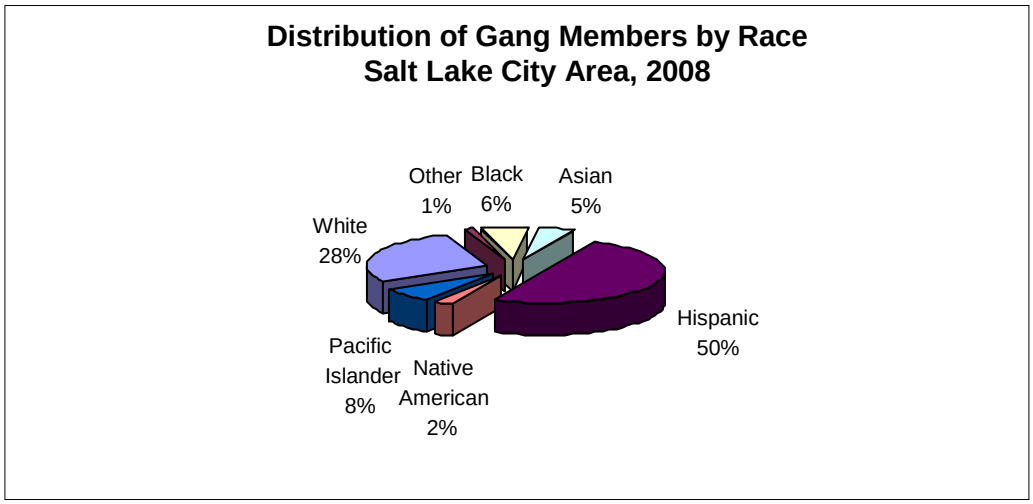
Notwithstanding the challenges, there is a growing body of research suggesting a relationship between gang involvement and sexual activity.[7,8,9,10] The findings of some of this research will be discussed in the national data section of this report.

Utah Data

There may be more than 4,500 documented gang members in Utah. However, actual numbers may be higher, as documenting gang members has become more difficult in recent years.[11, 12] Some reports indicate that Utah gangs are more "mobile" than their counterparts elsewhere.[12] The average gang member in Utah is 18 to 24 years old.[12]

Gangs in Salt Lake County are influenced primarily by two areas of the country: Los Angeles and Chicago. The Salt Lake metropolitan area could be referred to as a "Secondary Gang City" because it has the same affiliations as these other influential gang cities, but with local adaptations. In fact, the gang culture found in Salt Lake is one of the most diverse in the western United States. Major California affiliations include the Surenos, Nortenos, Crips, and Bloods. Chicago affiliations include both the Folks and the People. Additionally, the Salt Lake metro area has Southeast Asian gangs, Polynesian gangs, racist and non-racist skinheads, motorcycle gangs, Straight Edgers, and other groups such as the Animal Liberation Front.[22]

The following chart shows the distribution of gang members by race in the Salt Lake City area for the 2008 calendar year.



Source: Salt Lake Area Gang Project, 2008 End of Year Statistics

National Data

The Federal Bureau of Investigation (FBI) estimated in 2008 that there were at least 20,000 gangs in the United States with a total of 1 million members.[11] There is no agreement on how many youth gang members there are, in part because there is no accepted definition of youth gangs.[2] Some estimates are that half of all gang members are juveniles.[17] A 1998 study reported that Hispanics accounted for 46% of all gang members, Blacks 31%, Whites 13%, and Asians 7%.[3]

A 2008 Seattle study of adolescent girls who worked as prostitutes concluded that many were either gang-involved or were being exploited by gang-involved pimps.[13] A 1999 New York Times story reported that gang-involved boys were forcing adolescent girls, some of whom were also gang-involved, to work as prostitutes to make money.[14]

A 2007 study in Los Angeles concluded that about half of the gang-involved adolescent boys in the study had engaged in unprotected sex or used drugs or alcohol during sex. About 25% had gotten someone pregnant. The mean number of sex partners was nine, and about 25% had engaged in group sex, usually involving multiple males and a single female.[15]

A 2008 study in San Francisco concluded that gang-involved girls (14-19 years old), three quarters of whom were Latinas, were about twice as likely as their non-gang involved peers to become pregnant if, but only if their partners were also gang-involved. On the other hand, gang-involved girls whose partners were not gang-involved were no more likely to become pregnant.[8]

A large, well-controlled 2004 study involving detained adolescent males in Georgia found that gang-involved boys (14-18 years old) were 5.7 times more likely than their peers to have had

sex, 3.2 times more likely to have impregnated a girl, and almost 4 times more likely to have been high on alcohol/other drugs during sex or have had sex with multiple partners.[7]

A 2002 study of African American adolescent females (14-18 years old) in the South concluded that gang-involved girls were more than twice as likely as their non-gang involved peers to have had a nonmonogamous sexual partner. The gang-involved girls also had significantly higher rates of sexually transmitted infections (STIs).[10]

There have been numerous allegations that gang membership for girls requires being "sexed in," or having sex with male gang members to demonstrate loyalty.[3] The reports of this practice are as convincing as the reports that deny the phenomenon[16]. In some gangs, girls are regarded as property, in other gangs the girls are genuine colleagues, and in yet other gangs the girls are the ones who actually run the gang. Some girls are undoubtedly "sexed in," others are not.[16] It is not clear how prevalent the practice is, nor are many of the characteristics of the gangs/girls who engage in the practice.

Who is at Risk?

Some influences place both girls and boys at risk for gang involvement while others are gender-specific. For example, both girls and boys are more likely to become gang-involved if they experienced peer rejection, academic failure, and/or antisocial behavior. Other factors that predict gang involvement include delinquent peers, delinquent beliefs, lack of parental supervision, and negative life events. Additional risk factors are peer pressure, protection of one's status, the desire for acceptance, and problems at home; Such as, lack of parental warmth and higher levels of family conflict. Finally, a lack of maternal attachment, social isolation, impulsivity, risk-seeking, poor refusal skills, and low empathy also predict gang involvement.[17,18,19,20]

Adolescent boys sometimes join gangs because they have a friend who is a gang member or because they're looking for friends. Other boys join to get away from their families. Still others join for attention and affection.[17,18,19,20]

Adolescent females are more likely to become gang-involved if they are risk-seeking, have low school commitment, lack pro-social peers, experience neighborhood disorganization, have poor problem-solving skills, suffered from physical and/or sex abuse, witnessed domestic violence, or had a parent(s) with a substance abuse/mental health problem. The desire for friends and lack of a father affect girls more than boys.[17,18,19,20]

Protective factors include college aspirations, teacher attachment, community sports, school successes (e.g., awards), and the presence of a caring adult.[17,18,19,20]

What is Being Done?

Primary prevention programs focus on keeping adolescents out of gangs. Examples of primary prevention programs include parent education and school-based gang prevention programs.[21]

Secondary prevention programs focus on keeping at-risk youth out of gangs. Examples include certain Juvenile Justice Services programs and school-based programs.[21]

Tertiary prevention programs attempt to help gang-involved youth exit the gang, or reduce their level of involvement.[21] Examples of these programs include Colors of Success and Project 180.

Law enforcement also plays a significant role in trying to thwart gang activities.

Utah has also incorporated some of the Office of Juvenile Justice and Delinquency Prevention's (OJJDP) Best Practices in its programs.[21]

Local Resources

- Cedar City Police Department, 10 N. Main, Cedar City, UT 84720, 435-865-5139, http://www.cedarcity.org/index.aspx?NID=136
- Iron/Garfield County Narcotics Drug Task Force: 435-586-2651.
- Ogden Metro Gang Unit: Ogden City Police Dept. 801-395-8221 http://www.ogdencity.com/en/public_safety/police_department/gangs.aspx
- Salt Lake Area Gang Project: 3365 S 900 W, Salt Lake City, UT 84119. 801-743-5864. http://www.slsheriff.org/lawenforcement/investigations/metrogang/index.html
- Salt Lake County Sheriff's Office: Admin. 801-468-3900, Gang Hotline 801-743-5864, http://www.slsheriff.org/contactus.html
- St. George Police Department, http://www.sgcity.org/police/indexmain.php
- Washington County Narcotics Drug Task Force, Sheriff's Office Main Number: 240-313-2100, http://www.washcosheriff.com/ntf.html
- Colors of Success: 1747 South 900 West, Ste 200, Salt Lake City, Utah 84104, 801-596-9081, http://www.colorsofsuccess.com/,
- Project 180, http://www.westvalleycommunitycenter.com/project180.html, 801-654-0446

National Resources

- National Gang Intelligence Center, http://www.justice.gov/criminal/ngic/, 703-414-8600
- Federal Bureau of Investigation (FBI), http://www.fbi.gov/
- National Major Gang Task Force, http://www.nmgtf.org/
- National Gang Center, http://www.nationalgangcenter.gov/

Recommendations

- Continue funding primary, secondary, and tertiary prevention programs
- Expand initiatives in schools to educate parents about signs of gang involvement, prevention strategies, and treatment resources

- Expand the number/quality of treatment programs
- Endorse initiatives to make schools the "frontline" resource in identifying at-risk youth and intervening to the extent possible

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Substance Abuse Among Young Adults

Submitted by: Ben Reeves, Utah Division of Substance Abuse and Mental Health

Problem Statement

Alcohol use and binge drinking among young adults is a public health concern across the nation. While Utah has the lowest alcohol use rates compared to other states, these rates have an impact on the increasing rates of high-risk behavior associated with drinking. National and state data show a correlation between rates of alcohol use and the increase in sexually transmitted diseases (STDs), the practice of unsafe sex, and unplanned pregnancies.

Background

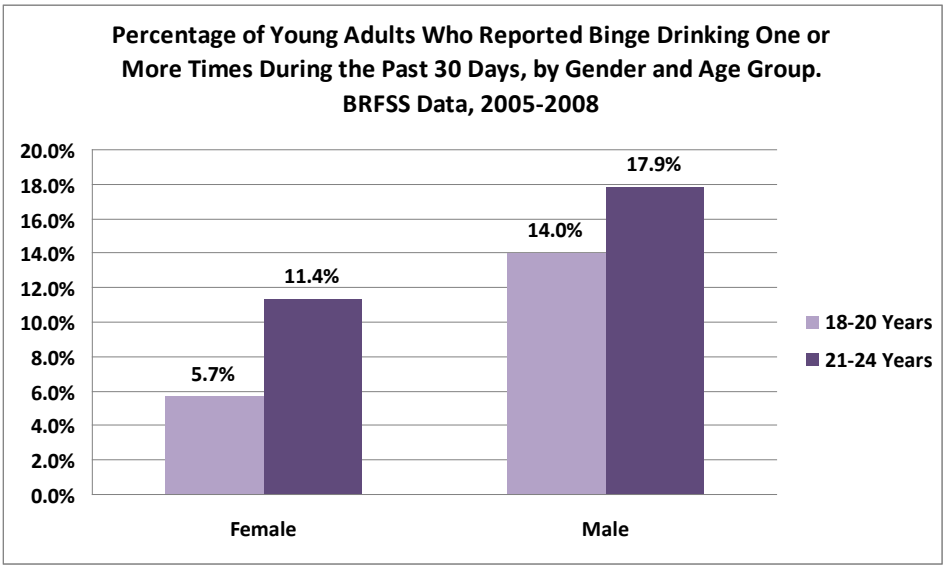
Young adults who engage in sex when making high-risk choices are more likely to have unprotected sex, and as a result, experience higher rates of sexually transmitted diseases and infections such as genital warts, herpes, and hepatitis. It has long been known that young men are more likely to engage in aggressive behavior when impaired. Young men also seek predatory opportunities to seduce young women during these high-risk drinking episodes. Research now shows that on days when women have five or more drinks, their risk for experiencing sexual aggression increases nine times; their risk for experiencing physical aggression increases seven times.[1]

When looking at binge drinking among young adults from 1979-2006, Gruzca et al found that the risk of binge drinking had increased among young women overall. Furthermore, binge drinking had increased most dramatically among 21- to 23-year-old female college students compared to their non-student counterparts. Gruzca et al also reported that during this time period, the risk of binge drinking among 18-20 year old non-student males had declined; however this decrease was not seen among college students the same age.[2]

Utah Data: How is Utah Doing?

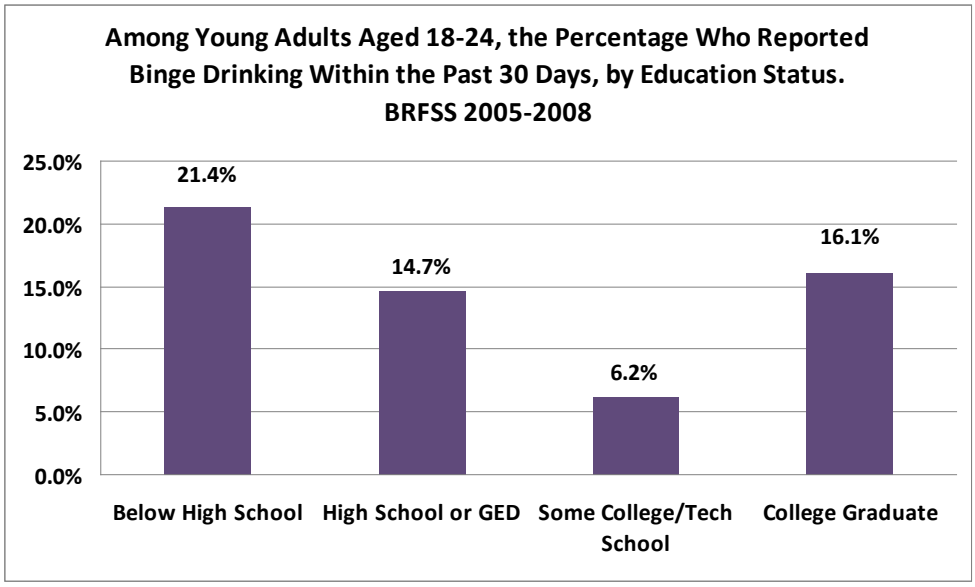
Data from the Utah Behavioral Risk Factor Surveillance System (BRFSS) indicate that 14.0% of males aged 18-20 reported binge drinking one or more times during the past 30 days compared to 5.7% of females ages 18-20. Binge drinking rates increased dramatically for both males and females ages 21-24 compared to 18- to 20-year-olds.[3] (See Graph 1)

Graph 1



While the data presented in Graph 2 do not depict current college student status among young adults who report binge drinking, it illustrates that those with a high school education or less report higher rates of binge drinking in Utah.[3]

Graph 2



National Data

Results from the 2007 National Survey on Drug Use and Health show that 35.7% of 18 to 20-year-olds reported binge drinking, as did 45.9% of young adults aged 21-25.[4]

Findings from this survey also suggested that full time college students aged 18-22 were more likely to use alcohol in the past month, binge drink, and drink heavily compared to their counterparts not enrolled in college. Specifically, 43.6% of college students (aged 18-22) reported binge drinking compared to 38.4% of non-students from the same age group.[4]

Who is at Risk?

Risk factors are characteristics of individuals, their families, schools, and community environments that are associated with increases in alcohol and other drug use. The following factors increase the likelihood that young adults may develop the above mentioned problem and may include:

-Availability of alcohol/other drugs
-Transitions and mobility
-Low neighborhood attachment and community disorganization
-Extreme economic deprivation
-Family history of the problem behavior
-Family management problems
-Family conflict
-Favorable parental attitudes and involvement in problem behaviors
-Academic failure beginning in late elementary school
-Lack of commitment to school
-Early and persistent antisocial behavior
-Rebelliousness
-Friends who engage in the problem behavior
-Favorable attitudes toward the problem behavior (including low perceived risk of harm)
-Early initiation of the problem behavior
-Gang involvement
-Constitutional factors (a type of mental disadvantage or learning disability)

What is Being Done?

Many of the colleges and universities in Utah provide substance abuse prevention and/or awareness services for their students. The following is a brief description of a few of those programs and services:

University of Utah: The University of Utah has a number of activities related to high-risk drinking. The campus is "dry" and violations of policy are not tolerated. There are also very few alcohol outlets along the perimeter of campus, which one might call environmental management. The school offers an evidence based curriculum for students who feel their drinking is high-risk

or for students who have been sanctioned because of a policy violation. Since research shows parents have a significant effect on choices students make with respect to drinking, a letter and information booklet is sent to the parents of incoming first year students who reside on campus and are under 21. They also offer, by request, lectures and presentations related to high-risk drinking [6]. Additional information about the University's prevention services can be found on the following website: http://www.wellness.utah.edu/wellness_as_prevention.htm

Weber State University (WSU): The Health Education/Drug and Alcohol Office at Weber State University established the ATOD (Alcohol, Tobacco, and Other Drug) Advisory Board. This board has developed the Code 411 campaign to keep WSU students informed about substances that impact their lives. Informational ads have been placed in the school newspaper and are available for viewing at http://departments.weber.edu/heda/[7].

Utah State University:
The Student Wellness Center at Utah State University (USU) provides access to health and wellness educational programs and presentations to all student organizations around such topics as decision-making, conflict resolution, coping techniques, relationship and people skills, alcohol and other drug use/abuse, sexuality, sexual assault, date/acquaintance rape, HIV/AIDS and STDs. Substance abuse messages, services and programs are also offered through student peer education and mentoring groups, referral services, support groups, and in-service training for students, faculty and staff. Each year, the college sponsors various programs and awareness campaigns including National Collegiate Alcohol & Drug Awareness Week, National Drunk and Drugged Driving Week, National Safe Spring and Summer Breaks, National Red Ribbon Week, and National AIDS Day[8]. Additional information about the USU Wellness Center can be found at: http://www.usu.edu/health/services/.

Local Resources

- **The Utah Division of Substance Abuse and Mental Health (DSAMH)** is the State agency responsible for ensuring that prevention and treatment services for substance abuse and mental health are available statewide. If you, a friend, or family member is struggling with a mental health problem or a problem with alcohol, tobacco, or other drugs there is help available. Hope and recovery are possible. For more information: http://www.dsamh.utah.gov/

- **NAMI Utah**: The National Alliance on Mental Illness. NAMI Utah's mission is to ensure the dignity and improve the lives of those who live with mental illness and their families through support, education and advocacy. For more information: http://www.namiut.org/

National Resources

- The National Institutes of Health, http://www.nih.gov/
- The National Institute of Drug Abuse and Health, http://www.drugabuse.gov/
- Department of Health And Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, http://prevention.samhsa.gov/

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Adolescent Mental Health in Utah

Submitted by: Lori Smith, LCSW, Utah Department of Health, and Kristen Reisig, LCSW, Utah Department of Human Services

Problem and Background

Research has shown that an estimated 21% of children and adolescents (11 million) in the United States have a diagnosable mental health or substance abuse disorder (U.S. Department of Health and Human Services, 1999). Further, it is estimated that 1 in 5 children and adolescents has a mental health disorder and that 1 in 10 (about 6 million) people has a serious emotional disturbance (Office of the Surgeon General, 2000). Unfortunately, nearly 80% of children and adolescents with mental health problems do not receive behavioral health services and only 21% of children needing a mental health evaluation received services (Kataoka, Zhang & Wells, 2002). Other estimates indicate that fewer than one in five children and adolescents receive needed treatment (Office of the Surgeon General, 2000) which is often provided by a variety of systems including school, primary health care, human services and juvenile justice. This emphasizes the need for strong interagency collaboration which can offer a vehicle for combining expertise and resources as well as program coordination among partners throughout a state.

Utah Data

According to 2009 Youth Risk Behavior Survey (YRBS) data, which is representative of 9th through 12th grade students in public schools in Utah, 26% of students reported symptoms of depression. According to Utah Department of Health Office of Vital Records and Statistics data, the rate of suicide deaths among adolescents aged 12-19 years of age declined from 9.8 to 7.5/100,000 population between 2003 and 2008. However, while the rates may have declined, Utah continues to rank among the highest in the nation, at 12th highest from 2003 to 2006 (CDC, WISQARS).

In Utah the use of alcohol and other drugs of abuse is typically low. However, there is some concern about adolescent use of alcohol and other drugs and the relationship to antisocial behavior. The Utah Prevention Needs Assessment (PNA) Survey, conducted by the Student Health and Risk Prevention (SHARP) Project under the direction of the State Office of Education, queries students in grades 6, 8, 10 and 12 in all Utah public schools. The 2009 survey found little increase in the use of substances over the last two-year period and that 11.2% of 12th grade students reported binge drinking behaviors. The study also found a high correlation between substance use and antisocial behavior among boys and girls and a strong link between students who report depression and use of alcohol and other drugs of abuse. For example, students who report being depressed are five times more likely to have used drugs within the past 30 days than students who are not depressed (Utah SHARP Report, 2009).

The 2008 U.S. Census Bureau population estimate for Utahns aged 11 to 20 is 426,749. Utah Medicaid records indicate that there are currently 124,373 children aged birth to 17 enrolled in Medicaid (data are not broken down by age and children age out of Medicaid at age 20), 40,028 enrolled in the Children's Health Insurance Program (CHIP) and 18,827 families enrolled in CHIP. Of these, 69% are from the Wasatch Front and 34% are residents of the remaining counties, 27% of the families have at least one other child enrolled in Medicaid and 22% have a

parent enrolled in the Primary Care Network (PCN), an entitlement program for families who would not otherwise qualify for Medicaid or who have no employer-provided health care. (Source: Utah Department of Health Medicaid Data Warehouse).

U.S. Data

2009 YRBS data indicate that:

- Nationally, 24.2% of youth report having had five or more drinks of alcohol in a row on at least one day during the past 30 days compared to 11.5% of Utah youth;
- Nationally, 26.1% of youth reported feeling depressed vs. 26.0% of Utah youth;
- Nationwide, 6.3% of youth had attempted suicide one or more time during the past 12 months compared to 9.6% of Utah youth, and;
- Nationally, 4.8 per 100,000 12- to 19-year-olds committed suicide (2007 WISQARS data) compared to 7.6 per 100,000 Utah youth (2008 Utah Vital Statistics data).

Risk Factors

The following table provides a list of mental health and substance abuser risk factors (Source: Utah DSAMH 2008 Annual Report, 2008):

Communities That Care

Risk Factors	Adolescent Problem Behaviors: Substance Abuse	Delinquency	Teen Pregnancy	School Dropout	Violence	Depression and Anxiety
Community						
Availability of Drugs	✓				✓	
Availability of Firearms		✓			✓	
Community Laws and Norms Favorable Toward Drug Use, Firearms, and Crime	✓	✓			✓	
Media Portrayals of Violence					✓	
Transitions and Mobility	✓	✓		✓		✓
Low Neighborhood Attachment and Community Disorganization	✓	✓			✓	
Extreme Economic Deprivation	✓	✓	✓	✓	✓	
Family						
Family History of the Problem Behavior	✓	✓	✓	✓	✓	✓
Family Management Problems	✓	✓	✓	✓	✓	✓
Family Conflict	✓	✓	✓	✓	✓	✓
Favorable Parental Attitudes and Involvement in the Problem Behavior	✓	✓			✓	
School						
Academic Failure Beginning in Late Elementary School	✓	✓	✓	✓	✓	✓
Lack of Commitment to School	✓	✓	✓	✓	✓	
Individual/Peer						
Early and Persistent Antisocial Behavior	✓	✓	✓	✓	✓	✓
Alienation and Rebelliousness	✓	✓		✓		
Friends Who Engage in the Problem Behavior	✓	✓	✓	✓	✓	
Gang Involvement	✓	✓			✓	
Favorable Attitudes Toward the Problem Behavior	✓	✓	✓	✓		
Early Initiation of the Problem Behavior	✓	✓	✓	✓	✓	
Constitutional Factors	✓	✓			✓	✓

Utah's Mental Health System

Mental health services in Utah may be provided through contract with private medical insurance, private pay or fee-for-services. Utah Medicaid enrollees living in specific counties are required to obtain services from a community mental health center under contract with Utah Medicaid. Nine community mental health centers contract through a Prepaid Mental Health Plan (PMHP) and two fee-for-service centers provide services to Utah Medicaid enrollees throughout the state. Of the nine pre-paid plans, four provide services in the large urban areas along the Wasatch Front and the remaining five are in the rural or frontier areas in eastern, central and southern Utah. The two fee-for-service centers provide care to children in a small northern county and the southeastern counties surrounded by the Navajo and Ute Indian Reservations.

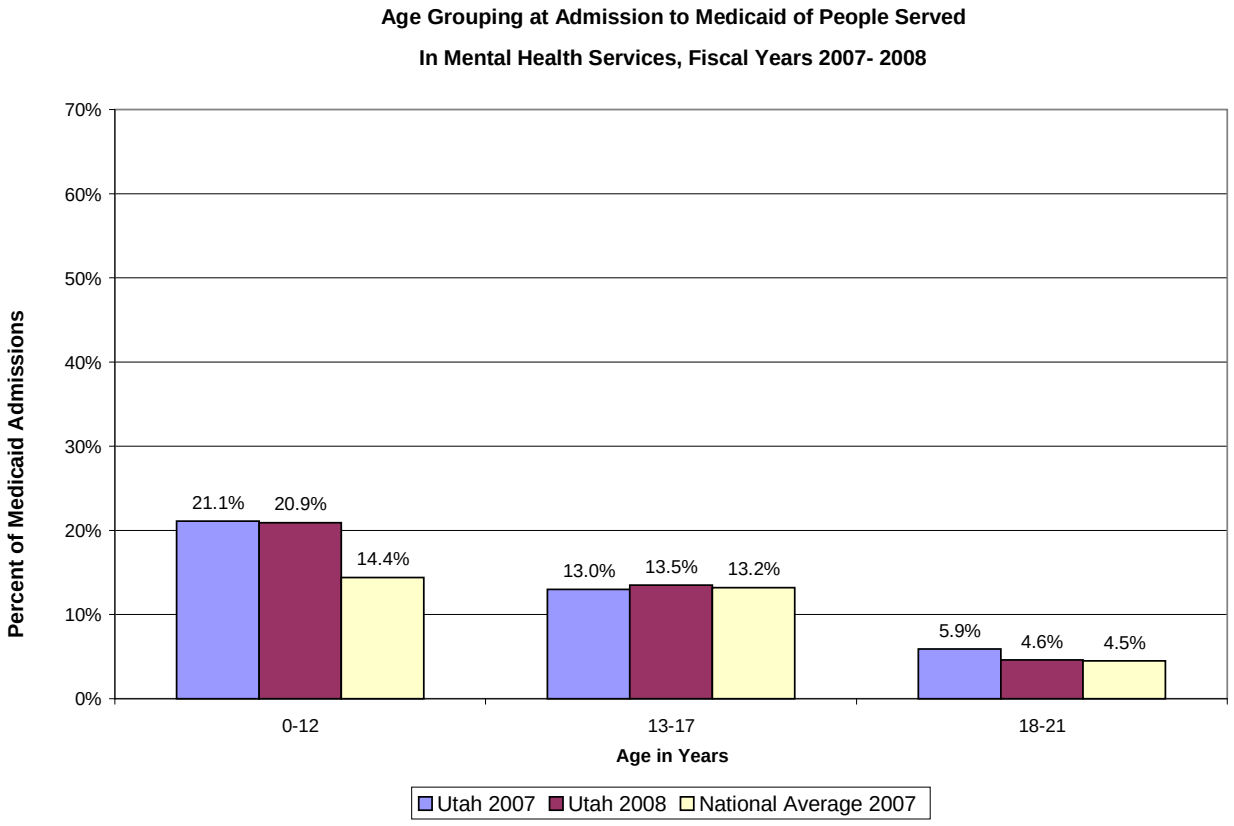
The Division of Substance Abuse and Mental Health (DSAMH) is the Single State Authority for public substance abuse and mental health programs in Utah and is charged with ensuring that prevention and treatment services are available throughout the State. As part of the Utah Department of Human Services (DHS), DSAMH receives policy direction from the State Board of Substance Abuse and Mental Health, which is appointed by the Governor and approved by the Utah State Senate. DSAMH contracts with the local county governments statutorily designated as local substance abuse authorities and local mental health authorities to provide prevention and treatment services. The Board of Substance Abuse and Mental Health and DSAMH provide oversight and policy direction to these local authorities. DSAMH monitors and evaluates mental health services and substance abuse services through an annual site review process, the review of local area plans, and the review of program outcome data. DSAMH also provides technical assistance and training to the local authorities, evaluates the effectiveness of prevention and treatment programs, and disseminates information to stakeholders. In addition, DSAMH supervises administration of the Utah State Hospital.

Under Utah law, local substance abuse and mental health authorities are responsible for providing services to their residents. A local authority is generally the governing body of a county. Some counties have joined together to provide services for their residents. There are 29 counties in Utah, and 13 local authorities. By legislative intent, no substance abuse or community mental health center is operated by the State. Some local authorities contract with community substance abuse centers and mental health centers, which provide comprehensive substance abuse and mental health services. Local authorities not only receive state and federal funds to provide comprehensive services, they are also required by law to match a minimum of 20% of the state general funds. However, counties statewide overmatch and contribute approximately 44% for substance abuse and mental health combined.

Utilization of Mental Health Services in Utah

Data obtained from the DSAMH indicate that the number of Medicaid enrolled children birth to 21 who have received mental health services has increased by over 900 from 2007 (15,462) to 2008 (16,373). Further breakdown indicates that the number of youth and young adults who have received services has increased by over 700 (8809 in 2007 and 9562 in 2008). The following graph provides a snapshot of the increase over the past two years. (Source: Utah Division of Substance Abuse and Mental Health data records).

The following graph reflects the age at admission of adolescents and young adults during 2007 and 2008 (Source: DSAMH 2008 Annual Report):



What are we doing?

The Division of Substance Abuse and Mental Health (DSAMH) is committed to the principles of recovery, systems of care, and full integration of family involvement at all levels of service and policy delivery. To promote these principles, DSAMH, through the Utah's Transformation of Child and Adolescent Network (UT CAN) project, created and developed a program that would: 1) have at least one Family Resource Facilitator (FRF); and 2) at least one clinician trained in assessing and treating youth at each of the 13 community mental health centers (CMHCs) throughout Utah. The primary job components of each FRF are:

- Resource Coordination: Provide local resource information to any family requesting assistance.
- Family Advocate/Advisor: Develop working partnership with CMHC staff, to represent the family voice at the service delivery, administration, and policy levels.
- Develop local Family Support & Information Group: This group will provide information and support to all families regardless of funding.

- Family Wrap-around Facilitation: Work with families and youth who have complex needs to build a plan that incorporates necessary formal supports (e.g., mental health/substance abuse treatment, educational assistance, juvenile court engagement, etc.) and informal supports (family members, Boy Scouts, clergy, etc.) to help the child and his/her family exit the mental health system and live full and productive lives.

Future Plans

The DSAMH, in partnership with the Utah Department of Health, the Utah Chapter of the National Alliance for the Mentally Ill (NAMI), Intermountain Healthcare and Utah's Parent Center are developing a comprehensive Children's Mental Health Plan. This plan will guide future efforts using a public health approach of promotion, prevention and intervention in providing mental health services to all children from birth to age 21.

The Utah Technical Assistance Center for Children's Services (UTACCS) is engaged in providing support to the mental health community in the implementation of evidence-based practices. The Center hosted a State of Utah Policy Summit: Supporting Effective Programs for Intersecting Youth in Utah on July 27, 2009. The goal of the summit was to align high level policymakers, funding partners and program leaders in implementing evidence-based practices in children's mental health.

Resources and Selected References

- *A Culture of Wellness: Utah Division of Substance Abuse and Mental Health 2008 Annual Report.* Utah Department of Human Services, 2008.
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