Adolescence on the Health Agenda

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Acting Director, Centre for Adolescent Health
Royal Children’s Hospital
Adolescent Health lectures

- March 1
  - Introduction (S Sawyer)
  - Eating disorders (M Yeo)
- March 15
  - Drug and alcohol (Y Bonomo)
  - Adolescent mental health (G Patton)
Resources

- Videotapes
  - Psychosocial history taking
- Adolescent Medicine clinics
- Team meetings
  - Wednesday 9-10 Healthy Eating Clinic
  - Wednesday 10 -11 Ward meeting
Adolescent health - Best practice framework

◆ Key concepts
  – Adolescent development
  – Burden of illness from psychosocial behaviours as much as physical health
  – Co-occurrence of health risk behaviours
  – Transition to adult health care

◆ Key clinical skills
  – Confidentiality
  – Psychosocial history taking (HEADSS)
  – Promoting adherence with the health care regimen
What is adolescence?

‘A period of personal development during which a young person must establish a sense of individual identity and feelings of self-worth which include an alteration of his or her body image, adaptation to more mature intellectual abilities, adjustments to society’s demands for behavioural maturity, internalising a personal value system, and preparing for adult roles’

Ingersoll, 1989
<table>
<thead>
<tr>
<th>Term</th>
<th>Age Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescence</td>
<td>10-19 years</td>
</tr>
<tr>
<td>Youth</td>
<td>15-24 years</td>
</tr>
<tr>
<td>Young people</td>
<td>10-24 years</td>
</tr>
</tbody>
</table>
Typical milestones for an adolescent girl in 1950’s:

- Menarche
- Finishing education
- Marriage - leaving home
- Parenthood

Ten years
Typical milestones for an adolescent girl in 2000:

- Menarche
- First sex
- Leaving home
- Finishing education
- ‘Marriage’
- Parenthood

20 years
Adolescent development

- Physical
- Cognitive
- Psychosocial
Developmental tasks

- Separate from parents
- Coherent sense of self
- Come to terms with physical self
- Come to terms with sexual self
- Provide for yourself financially
Youth development

- Ongoing
- Uneven
- Complex
- Influenced by the environment
- Mediated by relationships
- Triggered by participation
Self-assessed health status of 15-24 year olds

AIHW, 1999
Most often reported long term conditions (10-24 yrs)

Asthma
Hayfever
Allergy
Musculoskeletal
Bronchitis

AIHW, 1999
Leading causes of burden of disease (15-24 yr olds)

- Alcohol dependence
- Road Traffic Accidents
- Depression
- Bipolar affective disorder
- Suicide and self harm
- Social phobia
- Schizophrenia
- Borderline Personality Disorders
- Eating Disorders

DALYs (‘000)
Who is right?

- There is a wide discrepancy between the real health risks experienced by young people and the perceptions of health by themselves, their parents, by the media and by their health care professionals.
- This results in the relative invisibility of adolescent health as a concern.
Adolescent Health concerns

**Manifest Youth Health Problems**
Mental health problems, Substance abuse
Accidental injury, Antisocial behaviour,
Eating disorders

**Persisting Health Problems From Childhood**
Chronic illness, Survivors of prematurity & childhood cancer,
Behavioural disorders

**Risks for Later Disease**
Tobacco
Obesity
Inactivity
Poor diet
Substance use
Sexual behaviour
Mental health

Patton GC, 1999
Co-morbidity or co-occurrence

- Health compromising behaviours don't occur in isolation.
- Young people are variably vulnerable to physical, social and mental health issues and the range of associated health compromising behaviours.
- What behaviours are engaged in depend upon opportunity: community attitudes, parental values, peer practices, mental health of the adolescent, availability.
## Adolescent smoking status

<table>
<thead>
<tr>
<th></th>
<th>Year 7</th>
<th>Year 9</th>
<th>Year 11</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (n=479)</td>
<td>Female (n=477)</td>
<td>Male (n=437)</td>
</tr>
<tr>
<td><strong>Never Smoked</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>85</td>
<td>82</td>
<td>68</td>
</tr>
<tr>
<td><strong>Ex Smoker</strong></td>
<td>4</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td><strong>Occasional smoker</strong></td>
<td>10</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td><strong>Regular smoker</strong></td>
<td>1</td>
<td>3</td>
<td>13</td>
</tr>
</tbody>
</table>

Patton et al, 1996
## Smoking and mental health

<table>
<thead>
<tr>
<th>Year</th>
<th>Males</th>
<th></th>
<th>Females</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Low</td>
<td>High</td>
<td>OR</td>
<td>Low</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>7</td>
<td>8.5</td>
<td>2</td>
</tr>
<tr>
<td>(n=956)</td>
<td>15</td>
<td>19</td>
<td>1.3</td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>17</td>
<td>24</td>
<td>1.5</td>
<td>18</td>
</tr>
<tr>
<td>(n=911)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>17</td>
<td>24</td>
<td>1.5</td>
<td>18</td>
</tr>
<tr>
<td>(n=658)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patton et al, 1996
Co-occurrence of health risk behaviours

- A regular smoker in adolescence is:
  - 2 times more likely to diet severely
  - 3 times more likely to have psychiatric morbidity
  - 7 times more likely to be heavy alcohol drinker
  - 9 times more likely to have unprotected sexual intercourse
  - 19 times more likely to use Marijuana weekly

The Health of Young People in Victoria Centre for Adolescent Health, 1996
Substance use (30 day)

Adolescent Health and Wellbeing Survey, 2000
Risk factors for substance use

- Alcohol
- Cigarettes
- Marijuana
- Other drugs

Risk factors range from 0-1, 2-3, 4-6, 7-9, and >=10.
Protective factors for substance use

![Graph showing protective factors for substance use.](image)
Transition to adult health care

- The movement from child to adult health care systems for young people with chronic illness is known as ‘transition to adult health care’
  - Transition - gradual *process*
  - Transfer - physical *event*
- Includes primary, secondary and tertiary care
Principles of successful transition

- In whatever setting, services need to be developmentally appropriate
- Services must be able to address the common health issues facing young people generally in addition to aspects specific to the chronic illness
- Transition is most successful when there is a designated professional who, together with the young person and family, takes responsibility for the process
RCH Adolescent Admissions 1990-2001

Lam, Yeo & Sawyer 2003
Over 18 yr old admissions by surgical units

- Plastic Surgery: p=.02
- Orthopaedic Surgery: p<.0001
- Cardiac Surgery: p=.001
- General Surgery: p=.02
Results: Complexity

- 34% ≥ 2 allied health units
- 33% ≥ pre-existing diagnoses
- 64% ≥ 2 complications from pre-existing diagnoses
- Mean length of stay
  6 days (hospital mean 4)
<table>
<thead>
<tr>
<th>A framework for working with young people</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Be empathic, respectful and non-judgemental</td>
</tr>
<tr>
<td>- Understand confidentiality and consent issues</td>
</tr>
<tr>
<td>- Understand adolescent development</td>
</tr>
<tr>
<td>- Recognise the importance of privacy</td>
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<tr>
<td>- Be vigilant with boundaries</td>
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<tr>
<td>- Provide a safe environment</td>
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<tr>
<td>- Understand the link between physical &amp; emotional well-being</td>
</tr>
<tr>
<td>- Understand that family, school and peers are key agents of socialisation</td>
</tr>
<tr>
<td>- Have good communication skills</td>
</tr>
</tbody>
</table>

Sawyer & Bowes, Lancet 1999
An integrated approach to clinical skills development for adolescent health
Adolescent health - Best practice framework

◆ Key concepts
  – Adolescent development
  – Burden of illness from psychosocial behaviours as much as physical health
  – Co-occurrence of health risk behaviours
  – Transition to adult health care

◆ Key clinical skills
  – Confidentiality
  – Psychosocial history taking (HEADSS)
  – (Promoting adherence with the health care regimen)
## Confidentiality: young people’s perspective

1982 survey of 180 NY adolescents

<table>
<thead>
<tr>
<th></th>
<th>Parents involved</th>
<th>Confidential</th>
</tr>
</thead>
<tbody>
<tr>
<td>STD</td>
<td>15%</td>
<td>65%</td>
</tr>
<tr>
<td>Drug Use</td>
<td>17%</td>
<td>66%</td>
</tr>
<tr>
<td>Depression</td>
<td>45%</td>
<td>57%</td>
</tr>
</tbody>
</table>

Suggested age to begin spending time alone with the CF clinician

Zack et al, 2003
The young person’s perspective

- 9% had not sought health care because of fear their parents would find out
- Students who knew the physician’s stance on confidentiality were more likely to discuss pregnancy, contraception and sexually transmitted diseases with the physician

Thrall et al J Adolesc Health, 1997
Confidentiality

Increased Comfort
Less Anxiety
Increased Trust
Feeling of connectedness with physician

More willing to disclose information*
More honest about disclosure*
Increased likelihood of future visits*

*P<0.001

Ford et al. JAMA, 1997
Confidentiality exclusions

- Young people have the legal right to obtain confidential health care unless:
  - They cannot be considered a ‘mature minor’ and/or
  - There is significant concern of ‘risk’
    » sexual abuse
    » suicide or self harm
    » threat of homicide
HEADSS: a psychosocial history

- Home
- Education
- Activities
- Drugs and alcohol
- Sexuality
- Suicide, depression and self-harm
Why take a psychosocial history?

- Strategy to engage with young people
- Clarify stage of adolescent development
- Identify level of health risk
- Identify protective behaviours
- Help formulate intervention
Doctor-adolescent discussions: reported vs preferred

Zack et al, 2003
RCH adolescent HEADSS screening

None

Inadequate (1-4 areas screened)

Thorough (5-6 areas screened)

Completed (7 areas screened)
## RCH adolescent admissions

### Documentation, Risk identification and Actions

<table>
<thead>
<tr>
<th></th>
<th>Adolescent Med (n=20)</th>
<th>Medical units (n=40)</th>
<th>Surgical units (n=40)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>D  Risk  Act</td>
<td>D  Risk  Act</td>
<td>D  Risk  Act</td>
</tr>
<tr>
<td>Home</td>
<td>15 12 10</td>
<td>5 6 0</td>
<td>6 2 1</td>
</tr>
<tr>
<td>Education</td>
<td>14 2 1</td>
<td>0 1 0</td>
<td>1 0 0</td>
</tr>
<tr>
<td>Activities</td>
<td>10 0 1</td>
<td>0 0 0</td>
<td>1 0 0</td>
</tr>
<tr>
<td>Tobacco</td>
<td>12 10 8</td>
<td>0 0 0</td>
<td>5 2 1</td>
</tr>
<tr>
<td>Marijuana</td>
<td>10 0 1</td>
<td>0 0 0</td>
<td>0 1 0</td>
</tr>
<tr>
<td>Alcohol</td>
<td>11 0 1</td>
<td>0 0 0</td>
<td>0 1 0</td>
</tr>
<tr>
<td>Other drugs</td>
<td>10 11 8</td>
<td>0 1 1</td>
<td>2 1 1</td>
</tr>
<tr>
<td>Sexual activity</td>
<td>8 1 4</td>
<td>0 0 0</td>
<td>0 0 0</td>
</tr>
<tr>
<td>Suicide risk</td>
<td>8 1 4</td>
<td>0 0 0</td>
<td>0 0 0</td>
</tr>
</tbody>
</table>
Interviewing tips

- Developmental stage
  - early: biological focus
  - middle: peer focus
  - late: educational/vocational, intimate relationships
Achieving behaviour change

- Identify how ‘the problem’ affects them
- Help build motivation to change
- Help build routines around the new behaviour
- Review regularly
- Positively reinforce positive change
Remember to:

- See young people ALONE for at least part of the consultation
- Talk about confidentiality
- Identify risk and protective factors through taking a psychosocial history
- Develop a formulation or plan of action