

Adolescent Risk Behavior Screening

Discussion Date: May 2004
Discussion Moderator: Donna R. Perry, MD, FAAP, FSAM

During the month of May 2004 the combined IHS Primary Care Discussion Forum and the AAP Indian Health Special Interest Group listserv discussed:

- The presence or absence of culturally acceptable and useable screening tools to identify adolescent health risk behaviors
- Some strategies to use in the office or clinic setting
- A few issues unique to AI/AN communities

High risk behaviors of teenagers are responsible for the leading causes of mortality and morbidity during the adolescent years. They often are the starting points for adult morbidity and mortality. YRBSS data from the Navajo area and BIA schools compared to the US was an indicator that the AI/AN youth are participating in similar and sometimes greater reported risk taking behavior. If we want to prevent the short and long term morbidity and mortality, we have to identify the risk behaviors and have the resources and/or skills to intervene with best practices or evidence based treatment.

Sounds great, very tough to do.

Trigger questionnaires, either paper or computer-based, can be helpful. I suggested a few that are commonly used, including the GAPS from the AMA, the CAGE or CRAFFT questions for alcohol and substance abuse, a self esteem questionnaire, and the ACOG adolescent questions. Each has some problems: population and cultural appropriateness, reading level, and length.

Tuba City shared the questionnaire they have used which is an adaptation of the AMA's GAPS questionnaire.

Screening for resiliency at the same time as risk behaviors can help the provider identify if and where there are strengths on which a teen can rely. Providers rarely can 'fix' the issues which put the teen at risk, and it is more rewarding to support positive elements of relationships and environments if they are present.

What to do about the identified risk behaviors generated a lot of discussion because:

- most of our communities have limited behavioral health programs
- drug treatment programs for youth
- cultural support for ongoing counseling
- school based services to address mental health concerns
- neither the IHS or the 638 programs have enough mental health providers to provide the intervention
- most primary care providers have limited skills in providing short term office interventions

Providing confidential care for teens, its limits, and its impact on cultural family values concerned a number of our participants. The discussion pointed out the need to understand how

confidentiality is viewed in each AI/AN community, how to provide care to teens with some degree of privacy and the need for wisdom in applying guidelines for teen care. Teens are reluctant to discuss personal or risk behaviors when parents are present. However, family and extended family units for many AI/AN communities define “privacy” differently than the Euro-centric cultures around them. Unfortunately, these families may not feel comfortable talking about these ‘private’ matters until the behavior is out of control. Providing separate time for the parent and the teen has been used with some success, but doesn’t fit in most busy clinics. Providers also have to judge when the behavior constitutes a significant risk to life and therefore confidentiality must be breached for the patient’s safety.

Confidentiality also has limits defined by state laws on what medical information parents can access, and thereby thwart the efforts to provide confidential care while attempting to keep parents involved in their teens’ life. Options for resolving the conflict included:

- confidential files with information not put in the primary chart until teen is an “adult”
- shredding the questionnaires to avoid breaching confidentiality
- Use of a variety of abbreviations that would be harder for parents to decipher
- Setting up the ‘rules’ of the teen care to include parent and teen acknowledgment of the provision of confidential care and use of secondary records.
- Encouraging all patients to discuss risk behaviors with parents

We have some challenges. I would suggest we consider more adolescent topics at our local, regional and national meetings. This would be a place for dialog, increasing our skills, and planning more standardized approaches given our restraints on resources. We need to share programs that work in our communities. We can develop outcomes measures that will help us plan for improving care in our communities. A recent supplement to the journal *Pediatrics* discussed how to measure effectiveness of adolescent health care. How can we apply that to our communities? For those who have school based or school linked clinics, IHS headquarters is developing a discussion and work group in which we can participate. We can also commiserate in our struggle to provide increasingly accessible teen health care.

References

A January 2004 supplement to the journal *Pediatrics* 113(1) is focused on measuring the quality of children's health care as a key step in quality improvement. Extensive quality problems have been documented across all sectors of health services for children and adolescents. For example, problems persist in asthma care, well-child and adolescent care, childhood immunization rates, and sexually transmitted disease screening for adolescents. Many other problems in children's health care delivery are not being adequately measured and monitored.

<http://www.ahrq.gov/research/apr04/0404RA15.htm#head1>

Patient Education handouts on Reproductive Health

www.contraceptiononline.com

Updated consent and confidentiality and other adolescent health care related policy

www.guttmacher.org

School based health care and good evaluation of care suggestions and outcomes options

www.nasbhc.org