



# State of Adolescent Health in Rhode Island Improving Access to Care



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## About this Report

Visionary and collaborative approaches can help ensure successful medical home models for adolescents to address their developmental needs. The research in this report was conducted to better understand how adolescents access medical services. There are four distinct components of the report. The first is the introduction and literature review. The second is a summary of recommendations for improving adolescent access from the Rhode Island Successful Start Adolescent Transition Group, the American Academy of Pediatrics, the Institute of Medicine, and the Society for Adolescent Medicine. The third is a qualitative study commissioned by the Rhode Island Department of Health (HEALTH) in partnership with Brown University. Jane Griffin of MCH Evaluation, Inc. conducted the research. The fourth component, also commissioned by HEALTH, in partnership with John Snow Institute, is a needs assessment and data analysis of a broad range of adolescent health concerns excerpted from the Rhode Island Maternal and Child Health Comprehensive Needs Assessment. This work was supported with federal funding from the Title V Maternal and Child Health Block Grant.

## Table of Contents

<b>Introduction and Literature Review .....</b>	<b>4</b>
<b>Recommendations for Improving Adolescent Healthcare Access in Rhode Island .....</b>	<b>7</b>
<b>Improving Access to Healthcare for Rhode Island Adolescents Results from Expert Interviews .....</b>	<b>15</b>
<b>Maternal and Child Health Needs Assessment Adolescents .....</b>	<b>55</b>
<b>References .....</b>	<b>81</b>

## Introduction and Literature Review

Although adolescence in general is a period of overall good health, it is also a period of high risk-taking behavior. This paradox has created disparities within the health-care system, particularly among racial and ethnic minority adolescents (The National Academies, 2008). Adolescents have morbidity and mortality rates twice that of younger children (National Center for Health Statistics, 2007). In Rhode Island, adolescents aged 10-17 comprise 46% of the childhood population (Rhode Island KIDS COUNT, 2011).

### Adolescent access to healthcare

Rhode Island has a low rate of uninsured children including adolescents. Only 6.3% of Rhode Island's children younger than age 18 were uninsured from 2008 through 2010. Health insurance provides access to care, but it does not guarantee that adolescents will use this care. Research presented in this report demonstrates that providing health insurance in and of itself does not increase access to care for adolescents.

In 2011, the aggregate percent of adolescents enrolled in Medicaid and private health plans who received a well-care visit was 63.5%. This measure ranged from a low of 57.2% to 67.6% among the four Rhode Island insurance providers. Health plans in Rhode Island report Healthcare Effectiveness Data and Information Set (HEDIS) measures for their enrolled populations. These measures describe performance on important dimensions of care and service, including adolescent well-care visits. There was no difference between private and public health insurance plans in terms of adolescent well-care visits. The HEDIS national benchmark measure for the percentage of adolescents who receive well-care visits is under 60%, which may explain why healthcare service use for adolescent well care is not better.

The National Adolescent Health Information Centers (2008) determined that the proportion of adolescents with private health insurance is declining. Almost three quarters of adolescents had a preventive care visit in the past year, yet almost half of adolescents reported visiting an emergency room in the past year. Finally, one in five youth with special healthcare needs goes without needed healthcare services. This information further underscores the need to support health insurance for adolescents as well as venues where adolescents can access care designed to address their developmental needs.

To increase the number of adolescents receiving well-child visits and develop supportive systems of care for adolescents, the following must be considered:

- Provider practices (e.g. Are practices adolescent-friendly? Do they provide wellness promotion/risk reduction services or traditional visits only?)
- Health plan incentives (e.g. Do enrolled members use the services?)
- Youth and parent engagement strategies (e.g. Do parents support visits? How do visits align with adolescent developmental needs?)
- Policies (e.g. required physical exams for high school students, more rigorous HEDIS measures)

Adolescents face many barriers to care. Medical office sites that have adolescent convenient locations, inviting waiting rooms, and staff trained to meet the multi-variate needs of adolescents, however, can help reduce those barriers. Co-location of services including physical, behavioral, and reproductive healthcare provides opportunities for clinicians to work together on behalf of their adolescent clients (Sandmaier, Bell, Fox, McManus & Wilson, 2007). Further, McManus and Fox (2007) advocate for establishing a more effective healthcare financing and delivery system that is more aligned to the needs of adolescents. They also assert that parents need skills and support to maintain close relationships with their adolescents.

### **Adolescent medical homes**

According to the National Center for Medical Homes Implementation, every child deserves a medical home. The American Academy of Pediatrics (AAP) describes the medical home as a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. Over the past year the AAP has been at the forefront of numerous initiatives to promote the adoption and growth of the patient-centered medical home.

Characteristics of successful medical home models for adolescents include: an inclusive wide range of services; a team approach to care; efficient division of responsibility designed to optimize physician time; staff sensitivity toward youth needs; a teen-friendly environment; and a youth development focus supporting health decision making, avoidance of high-risk behaviors, and development of healthcare consumer skills (Fox, Limb & McManus, 2007; Sandmaier et al., 2007).

Research involving medical home leaders across the country reveals the potential for medical home models to meet the needs of adolescents. Personal providers who understand adolescents, establish long-term relationships with them, and support them in taking ownership of their health and healthcare can improve the quality of care for adolescents. A physician-led, team-based approach can help focus attention on preventive services, care management, and holistic care. Medical homes may also improve coordination of care via health information exchange, develop systems of quality assurance, enhance access to care, and establish payment systems for achieving agreed-upon outcomes (Walker, McManus and Fox, 2011).

During 2006, the Rhode Island Department of Health created an Adolescent Medical Home Group to identify issues specific to adolescents accessing health care and define a “medical home” for teens. Data from the National Survey of Children’s Health (2007) indicate that 62.2% of Rhode Island adolescents aged 12-17 had a medical home. The medical home rate determined by the 2007 survey shows that a higher proportion of Rhode Island adolescents have a medical home compared to those nationwide (53.4%). Teens were less likely to have a medical home than children younger than age 6 (67.0%) and slightly more likely than children aged 6-11 (61.7%).

The current requirements for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) performance are an important foundation for medical homes, especially for children and adolescent services covered by Medicaid. Comprehensive guidance regarding the scope of EPSDT exams has been an important indicator of quality within state programs (Fox, Rogers, and McManus 2011). Rhode Island was recognized nation-

ally for its strategies for improving EPSDT performance. Health plans can earn payments over their capitation for improving performance, under the Performance Incentive Program. A well-child check-up must meet state EPSDT requirements by addressing the four domains of a well-child visit including physical health, developmental health, behavioral health, and health education to qualify for the additional payment. A structured exam using an age-specific form helps providers meet the comprehensive requirements of the EPSDT exam (Kaye and May, 2010).

## **Challenges and opportunities**

Challenges exist to ensuring high-quality medical homes for adolescents. These include: enrolling adolescents with appropriate primary care providers, addressing concerns about privacy protection, developing strategies to increase use of necessary services, and allowing adequate time and payments for providers to care for adolescents with complex needs (Walker, McManus and Fox, 2011).

Comprehensive primary care medical home models for adolescents sometimes seem financially unrealistic. If patients are privately insured, publicly insured, or uninsured, reimbursement rates usually do not cover the full cost of care. Both private and public insurance programs are not structured to support integrated primary care services for adolescents. Adolescents are underserved in Medicaid because payment policies discourage preventive counseling.

Minor consent to care and confidentiality laws are also necessary for adolescents to seek healthcare, especially pertaining to sensitive information. The purpose of these laws is to create access. Some adolescents may feel uncomfortable seeking the care that they need. Rhode Island offers confidential services for treatment of sexually-transmitted diseases. More states, including Rhode Island, could consider expanding confidential care to behavioral health, substance use, and family planning, because the data support a higher rate of mental, behavioral and emotional problems emerging in adolescence, as well as teen pregnancy rates that exceed rates in other industrialized countries. Aligning consent and confidentiality laws with Explanation of Benefits policies through health plans would also support access to confidential care (Fox and Limb, 2008).

The development of an adolescent vaccine platform can create opportunities to support access to immunizations and preventive care visits throughout adolescence (Kaplan, 2010). The National Foundation for Infectious Diseases (2004) asserts that the effect of vaccine-preventable disease would be diminished by widespread vaccination among 11-12 year olds. Rhode Island requires a preventive visit for students in grade 7; a new requirement for Meningococcal vaccine will support an additional state-required physical examination for adolescents by 16 years of age.

Finally, transition from adolescent to adult services is an ongoing issue. The American Academy of Pediatrics, the American Academy of Family Physicians, and the American College of Physicians all concur that all youth need education, guidance, and planning to prepare to assume appropriate responsibility for their health and well-being in adulthood (American Academy of Pediatrics 2011).

## Recommendations for Improving Adolescent Healthcare Access in Rhode Island

### Successful Start Adolescent Transition Group

#### Access to Care

- Engage and support providers in quality improvement for medical homes.
- Require a physical exam for all Rhode Island high school students linked to the last required dose in the meningococcal vaccine.
- Ensure comprehensive consent and confidentiality laws to support access to care.
- Advocate for laws that allow minors to consent to their own care.
- Develop family-community partnerships for prevention and community-based services including physical, behavioral, and oral healthcare.
- Invest in analysis of where adolescents receive their care and barriers to care.
- Plan for youth transitioning out of foster care; begin transition planning in middle school.
- Strengthen relationships among school and community providers related to physical and behavioral health services.

#### Access to Insurance

- Promote health insurance coverage which includes a comprehensive and coordinated benefits package.
- Identify gaps in insurance coverage.
- Advocate for policies and legislation that supports insurers in providing comprehensive and confidential access to care for adolescents.
- Balance high-cost treatment investments with prevention focused community investments in the work of the Office of the Health Insurance Commissioner.

#### Quality Assurance

- Identify HEDIS measures that support adolescent health such as preventive care, immunization schedule completion, and percent of sexually active teens with a Chlamydia test.
- Identify additional measures of adolescent health via HEDIS, KIDSCOUNT, and other data sources.

- Create a learning collaborative for providers. (Start with the toolkit described below.)
- Develop a provider toolkit based on a condensed version of Bright Futures.
- Develop a similar toolkit for youth and parents on adolescent transition resources from HEALTH.

## **Systems Development**

- Bring together providers interested in adolescent health.
- Develop a curriculum around adolescent health for use with providers and physician residents interested in developing expertise around adolescent health concerns.
- Expand the Ask a Doc website to answer youth health-related questions in a timely fashion.
- Link with the Rhode Island Department of Children, Youth, and Families system of care.
- Investigate Blue Cross Blue Shield and UnitedHealthcare performance benchmarks.
- Expand performance benchmarks to focus attention on adolescent health concerns.
- Ensure a voice for adolescents at healthcare reform discussions and in programs and policies.
- Cultivate youth development approaches in schools and communities.
- Support efforts to improve health education in school and community settings.
- Explore strategies to increase peer education efforts.

## Recommendations from the Experts

### **American Academy of Pediatrics, Achieving Quality Health Services for Adolescents – Policy Recommendations (June 2008)**

1. All children and adolescents should receive comprehensive, confidential (as appropriate) primary care as recommended by AAP guidelines, including screening, counseling, and physical and laboratory evaluations.
2. All children and adolescents should be covered by health insurance that provides benefits and care in accordance with AAP guidelines and that provides coverage and access to pediatric specialists for care identified as medically necessary during recommended screening and health supervision visits.
3. State governments should ensure that adolescent confidentiality is preserved and/or protected as HIPAA regulations and electronic health records undergo implementation.
4. Private-sector and government payers should develop policies and contract standards to promote access to adolescent care and availability of confidential services for adolescents and should provide other incentives for delivery of high-quality care to adolescents.
5. Public education should help parents and other consumers understand what constitutes high-quality adolescent primary care so that consumers can be better advocates for confidential and private screening and counseling in settings they can trust to help keep their children healthy.
6. Pediatricians and other adolescent health care clinicians should be provided professional education about effective strategies for delivery of high-quality adolescent primary care.
7. Feasible, valid, and reliable quality measures should be developed and implemented that use adolescent self-reported data to help assess the quality of preventive care provided to youth. In addition, existing measures that were developed in association with initiatives designed to improve the care delivered to adolescent patients should be catalogued and improved for use by external quality-measurement organizations.

**Institute of Medicine/National Research Council,  
Adolescent Health Services:  
Missing Opportunities - Policy Recommendations (2009)**

1. Federal and state agencies, private foundations, and private insurers should support and promote the development and use of a coordinated primary health care system that strives to improve health services for all adolescents.
2. As part of an enhanced primary care system for adolescents, health care providers and health organizations should focus attention on the particular needs of specific groups of adolescents who may be especially vulnerable to risky behavior or poor health because of selected population characteristics or other circumstances.
3. Providers of adolescent primary care services and the payment systems that support them should make disease prevention, health promotion, and behavioral health – including early identification, management, and monitoring of current or emerging health conditions and risky behavior – a major component of routine health services.
4. Within communities – and with the help of public agencies – health care providers, health organizations, and community agencies should develop coordinated, linked, and interdisciplinary adolescent health services.
5. Federal and state policy makers should maintain current laws, policies, and ethical guidelines that enable adolescents who are minors to give their own consent for health services and to receive those services on a confidential basis when necessary to protect their health.
6. Regulatory bodies for health professions in which an appreciable number of providers offer care to adolescents should incorporate a minimal set of competencies in adolescent health care and development into their licensing, certification, and accreditation requirements.
7. Public and private funders should provide targeted financial support to expand and sustain interdisciplinary training programs in adolescent health. Such programs should strive to prepare specialists, scholars, and educators in all relevant health disciplines to work with both the general adolescent population and selected groups that require special and/or more intense services.
8. Federal and state policy makers should develop strategies to ensure that all adolescents have comprehensive, continuous health insurance coverage.
9. Federal and state policy makers should ensure that health insurance coverage for adolescents is sufficient in amount, duration, and scope to cover the health services they require. Such coverage should be accessible, acceptable, appropriate, effective, and equitable.
10. Federal health agencies and private foundations should prepare a research agenda for improving adolescent health services that includes assessing existing service models, as well as developing new systems for providing services that are accessible, acceptable, appropriate, effective, and equitable.

11. The Federal Interagency Forum on Child and Family Statistics should work with federal agencies and, when possible, states to organize and disseminate data on the health and health services, including developmental and behavioral health, of adolescents. These data should encompass adolescents generally, with sub reports by age, selected population characteristics, and other circumstances.

## **Society for Adolescent Medicine Position Paper, Access to Health Care for Adolescents and Young Adults – Policy Recommendations (2004)**

### **Health insurance coverage**

All adolescents and young adults through age 24 should have access to affordable health insurance coverage. Insurance coverage should be continuous and not subject to exclusions based on pre-existing conditions. Eligibility for health insurance through public programs, particularly Medicaid and the State Children's Health Insurance Program (SCHIP), should be expanded to make coverage available to all uninsured adolescents and young adults who do not have access to affordable private insurance. Intensive outreach efforts should be undertaken to ensure that adolescents and young adults who are eligible for Medicaid and SCHIP actually enroll and benefit from these programs. Federal and state efforts to reduce eligibility levels, restrict benefits, or decrease funding for Medicaid and SCHIP should be opposed and, at a minimum, should not be allowed to affect adolescents disproportionately in comparison with other age groups.

### **Comprehensive, coordinated benefits**

Public and private health insurance coverage and public health programs should provide timely access to comprehensive, coordinated benefits that meet the physical, psychological, and developmental needs of adolescents, including preventive, primary, and specialty care services. Public and private health insurance coverage should provide for "equity" or "parity" in coverage of services that are often limited for adolescent enrollees, such as reproductive and sexual health services (including contraceptives), dental services, mental health, and substance abuse services. The principles of equity and parity should apply both to differences in coverage between adolescents and other age groups and among specific services.

### **Safety net providers and programs**

Adolescents and young adults receive care from a variety of health professionals and sites, including private offices, academic medical centers, school-based health centers, community health centers, family planning and STD clinics, mental health and substance abuse treatment centers, and other public health clinics that rely on public funding. These safety net providers represent a critical element of health care access and the health care delivery infrastructure for adolescents and young adults, particularly those from low-income families and those with special health care needs. Adequate funding should be provided to ensure the sustainability and financial viability of these safety net providers and sites.

### **Quality of care**

Health insurance plans and public health programs should implement quality assurance plans and goals that specifically address the needs of adolescents and young adults. Performance measures should include items of particular relevance and importance to adolescents and young adults, including prevention and health promotion. Quality and performance data should be collected, analyzed, and reported by age group, and data collection methods should incorporate input from a variety of sources, including adolescents and young adults themselves.

### **Affordability**

Health services should be affordable for adolescents and young adults and their families, and cost-sharing requirements such as premiums, co-insurance, deductibles, and co-payments should not hinder their utilization of health services. Co-payments, if required at all, should not be imposed for preventive services, family planning services, screening and treatment for sexually transmitted infections, substance abuse and mental health services, and other services that adolescents may seek on a confidential basis.

### **Consent and confidentiality**

Adolescents should be able to receive confidential services based on their own consent whenever limitations on confidentiality would serve as an obstacle impeding their access to care. Federal and state laws should support confidential access to health care for adolescents in these circumstances. Existing laws that provide for adolescents who are minors to give their own consent for health care and to receive services on a confidential basis should be maintained and fully implemented. Where additional protections are needed, they should be put in place. Health plans and providers should understand the relevant laws in their own jurisdictions, should implement administrative policies and procedures to maintain adolescents' confidentiality, and should inform adolescent patients and their parents about the scope and limitations of these protections. The existence of confidentiality protections for adolescents does not preclude, and sometimes helps to support, voluntary communication with parents, often with the assistance of a health care professional. Efforts to repeal minor consent laws or to place limits on the confidentiality of services for adolescents who are minors could undermine their access to essential services and should be opposed.

### **Compensation**

Health plans and providers will be able to deliver the full range of comprehensive, age-appropriate services needed by adolescents only if capitation rates, fee schedules, and other reimbursements paid to providers are established at a level that enables them to do so. Health care financing mechanisms, including risk adjustment and other mechanisms, should be sufficient to support the range and intensity of services needed by adolescents, including those with chronic illness or disabilities and those with other intense or specialized health care needs. Reimbursement rates for specific services should account for the time required to address the specific developmental needs of adolescents.

### **Availability of trained and experienced health care providers**

Health care providers who are appropriately trained and experienced in adolescent and young adult health should be available in all communities. Health plans should include health care providers with training, expertise, and experience in serving this population in their provider networks, both as primary care providers and specialists for referral. Adolescents and young adults should be offered maximum choice among providers and sites within health plans.

### **Visibility and flexibility of adolescent-oriented sites and services**

A number of features characterize adolescent-oriented sites, including locations and hours that are accessible to adolescents; age-appropriate settings; and multi-disciplinary clinical and administrative staff who are approachable and are able to address the cultural, linguistic, and developmental needs of adolescents from a variety of backgrounds. Information about adolescent-oriented providers and sites and the services they offer should be made available to adolescents and their families.

### **Coordination**

Local, state, and national health goals and objectives should include issues of particular importance and relevance to adolescents and young adults. Public health programs, including publicly funded health insurance, should be coordinated at local, state, and national levels to ensure that health services are financed and delivered in a way that addresses the needs of underserved adolescents, particularly those who experience disparities in access and health outcomes.

# **Improving Access to Healthcare for Rhode Island Adolescents: Results from Expert Interviews**

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## Acknowledgments

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Jane Griffin, MPH, Project Director conducted the expert interviews and wrote the final report. Holly Tartaglia set up and taped the interviews. Transcriptions were read and reviewed by Christine Payne, PhD, Jane Griffin, MPH, and Holly Tartaglia.

The most important contribution to this report came from the experts in adolescent healthcare that we interviewed. They were generous with their time and provided us with invaluable insights into the reasons teens do not get the healthcare they need.

## I. Purpose

The Rhode Island Department of Health's Adolescent Health Program was concerned about the low rate of teens in Rhode Island who had a preventive care visit in the past year as an indicator of medical home. When Rhode Island parents were asked as part of the national Survey on Children's Health, 2007, if their teen (ages 12 – 17) had the components of a medical home, only 62% said yes. Having a medical home meant the teen had primary care that was accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.

## 2. Methods

MCH Evaluation, Inc. met with two Department of Health advisory groups to select a list of Adolescent Experts to interview and to design the Access to Health Care Questionnaire. The group also agreed on the purpose and methods for the project (see Appendix 1).

In addition the questions addressed the key policy areas recommended by three expert groups including the Academy of Pediatrics, the Institute of Medicine, and the Society for Adolescent Medicine.

Six drafts of the questionnaire were designed to address the following issues:

- Medical Home
- Barriers to Providing Preventive Services
- Health Care Delivery Settings
- Provider Training
- Ideal Adolescent Health Visit
- Privacy and Confidentiality
- Barriers to Care from Adolescent Perspective
- Adolescents at Greater Risk for Poor Health

For a copy of the final questionnaire see Appendix 2.

Twenty-eight experts were sent an email from the Health Department explaining the project and inviting them to participate (see Appendix 3). Experts were sent up to three reminder emails and four reminder phone calls before they were considered non-respondents. Of the 28 experts who were contacted 21 completed the interview for a response rate of 75% (see Appendix 4).

Interviews were conducted from April 4, 2011 – June 27, 2011. There were 14 face-to-face interviews and 7 phone interviews completed. Professions of the 21 experts who were interviewed included:

- Pediatricians (5)
- Nurse Practitioners (2)
- Health Educators (2)
- Family Physicians (2)
- Social Workers (2)
- Health Administrators (2)
- School Nurses (2)
- Community Advocates (2)
- Principal (1)
- Mediator (1)

The time range of interviews was 54 minutes to 128 minutes. The average time for an interview was 71 minutes.

All interviews were taped and transcribed. Three reviewers read the experts' transcripts and highlighted barriers to care and promising strategies. The highlighted narrative from each transcription was assigned an issue and a count of each issue was tallied. Issues that had supporting narrative from at least three experts were included in the final list of barriers and strategies.

In addition to barriers and strategies there were also several mental health issues that were noted by at least three experts. These mental health issues were separated into their own section.

### 3. Results

Following is a list of the seven mental health issues, ten major barriers to healthcare, and seven promising strategies that were illustrated with supporting narrative from at least three experts. The number of experts who identified this issue as a barrier or strategy is listed in parenthesis next to the issue.

#### **Mental Health**

1. Stress, Anxiety, and Depression (n=12)
2. Violence (n=6)
3. Cyberbullying (n=5)
4. Addicted to Facebook, other social media (n=5)

5. Low Self-esteem (n=4)
6. Obesity (n=4)
7. Cutting (n=3)

### **Barriers to Health Care**

1. Privacy and Confidentiality (n=11)
2. Annual Visit too short (n=8)
3. Pediatricians need to learn communications skills (n=8)
4. Low reimbursement rate for care (n=6)
5. Meeting State Health Education Requirements (n=6)
6. Intermittent Health Insurance (n=5)
7. Teens uncomfortable going to “baby doctor” (n=3)
8. Teens’ healthcare is not a priority for parents (n=3)
9. Shortage of Child Psychiatrists (n=3)
10. Equity and Poverty (n=3)

### **Promising Strategies**

1. Components of Ideal Adolescent Health Visit (n=5)
2. Peer (adolescents) Education (n=4)
3. Preventive Care at 7th grade Physical (n=4)
4. Multiple Short Visits, Not One Annual Exam (n=4)
5. Middle School are Best Years to Provide Preventive Programs (n=4)
6. Provide Preventive Care and Counseling in Small Groups before Exam (n=3)
7. After School 2-6 pm is Best Time of the Day to Provide Program Interventions (n=3)

## A. Mental Health Issues are the Major Challenges Teens Face

### 1. Stress, anxiety and depression have reached epidemic proportions among teens.

Many experts were concerned about the high rate of depression in teens and the number of antidepressants. Some estimated 25% of teens were on antidepressants. They felt we needed to look at the pressures parents and society puts on teens.

*"I would say certainly there's a huge increase in population of kids with depression. Depression and anxiety is huge and those kids' needs are not necessarily being met."*

*"We have so many young people who are struggling with depression, anxiety, and post-traumatic stress, who have never really been adequately treated in part because our mental health system does not really even diagnose those issues in children as much, but also it is not part of their traditional health so to talk to someone about the fact that they are not sleeping, or they are not enjoying life much."*

*"There is something that we are fundamentally doing wrong that all of these kids need to be medicated, and whether it is what we are doing to our kids, which I think is a bigger part of it. So I think that we are putting a lot of our kids at risk. Part of this comes to as why are all of these kids on medications? Why are 25 % of college kids on some type of medication? They do not do well. They are not doing well with stress. They are not doing well with anxiety. They do not make decisions well at all."*

*"I was amazed at how many teens were on antidepressants. I was amazed by how many. I wouldn't be surprised at how many kids were worried about it. At the intake in the beginning of school you have to know what medications and so forth that people are on, in the school record. I was absolutely amazed at how many were on anti-depressants. That's why I say no one is dealing with the underlying issue or asking what their hopes and dreams are."*

*"I think there is a lot of medication being used and there are a lot of expectations for these kids to behave in ways that they simply cannot behave in. They cannot get it all together. They need somebody with patience and kindness who is just going to be their parent and hang in there and that is really hard for a lot of people who work hard and who really do not have the wherewithal to do this."*

**One expert said today's teens do not have enough "downtime," and we need to "slow them down."**

*"With technology and the activity issues, they have no down time. The single most identified issue by incoming students is stress when we send out our surveys. They do not know how to have down time. They are so oversubscribed. They get dropped off at a daycare when they are little kids, now they are bused directly from the daycare to school, then they have a sport activity or something after that, then they go home to dinner, and maybe there is a parent there or not, and then it is time to go to bed. This is not parent judgment,*

*parents are working, but the part of it is, everything is so tightly structured. They do not interact, they do not have to work things out for themselves, and then with the technology issues they are connected all of the time. People are now talking about how every student should have a computer because those are the new teaching techniques because we can do more. Oh my God, as it is we are not giving them individual attention, now a machine is going to give them individual attention, not a human voice or human touch. We have to find a way to get kids interacting with each other and learning the skills that go along with that. That does not mean they cannot be technologically savvy, but they have no down time as a result. How do you enforce down time, I mean how do you do that? Are they going to put up with that? I do not have an answer yet, but we have got to slow them down.”*

## **School is a place where the unmet mental healthcare needs of teens are seen by teachers and school nurses.**

*“The American high school particularly is full of kids with unrecognized and even fuller with kids of unsupported mental illnesses of various kinds and depression is probably the most common of them and if we could broaden the focus again from highly controlled test grubbing and focus on sports and a few other things, the real issues of adolescent development. The place to start that I think would be in school and kids would tend to stay in school much more if they felt that the school counselors or some kind of mental health person was at the school health center.”*

*“Mental health is definitely a huge problem I see in my practice and so many of the students I see that come into my office most of them are there for psychosocial. My stomach hurts, my head hurts but it’s the underlying thing that is going on that has brought them to my office, either they are being bullied in class or a teacher is giving them a hard time about something. They’re just not able to cope with the environment of the classroom so they come out of the classroom into my office.”*

## **Experts thought that mental health resources were not aimed at prevention.**

*“I think my big issue with mental health is that there is no preventive mental health. We do not connect teens with mental health resources until there is a diagnosis or a big problem. I say this all the time, when you are 14-years-old and you have a baby, what more crisis do you need? Shouldn’t we have a mental health component to what we do? Shouldn’t we think differently about mental health and prevention or good mental health habits? It is the same thing. We do not have a health care financing system that pays for prevention.”*

## 2. Violence is an integral part of teens' lives.

Teens face violence in some of their most intimate relationships. This violence affects their sense of security and well being. Many times violence stems from unhealthy relationships.

*“It’s knowing the difference between a good and bad relationship. It is the same with girls and dating violence, I tell the girls you don’t have to take that so I think a lot of what is the key to this is really understanding relationships. What’s a good friend? What’s not a good friend? How do you help yourself? These are basic things about how not to get involved. Have a dream, have something you’re focusing on and enjoying some place where there’s that safe time after school.”*

*“When young women don’t have a father in the house and don’t have any vision of what a healthy relationship is. Many young men and women only see single household and have never seen a healthy relationship between a male and female, so how would we expect them to do that? The truth is 80% of kids in some neighborhoods have never seen what a healthy relationship looks like. Then we wonder why they get in unhealthy relationships and don’t protect themselves and don’t know how to tell their partner they want to use a condom or they have sex just to keep the guy who is totally abusive to them because that’s what they’ve seen on TV.”*

*“One girl literally told me she knew she shouldn’t be with this boy. There was a situation where he essentially raped her but she didn’t know that it was rape. She didn’t know what rape was to know that she basically got raped, what happened was she was basically angry at herself because she froze and let him do it. She didn’t even know to name it rape. She did not know that what happened was rape. I kept trying to separate her and to talk to her about this young man. I was talking to her about it and she said “I know what you’re saying, I know, but you can’t give me what he gives me” and she was right, I couldn’t give her the validation she wanted. She had a terrible relationship with her mother and there was no father.”*

**Violence is also a pervasive part of their homes, schools, and communities. Many experts suggested that the peer model practiced by The Institute for the Study and Practice of Nonviolence was extremely effective.**

*“It’s so hard when you live in a neighborhood where violence is. They come to school and may have seen something the night before, or heard gunshots. We had a girl in the school whose father was in prison for murder. A darling kid who loved her dad and he called her on her cell phone just before he was going to kill himself. Can you imagine a sixth grade child getting that kind of a call and having that relationship? So therefore there is a lot of violence and maybe not necessarily within that particular home itself but in the neighborhood. They see a lot.”*

*“I’ve brought the Institute for The Study and Practice of Nonviolence into my school to do non-violence training for the last seven or eight years just because of what I saw in the hallways of my school, it was like “oh my god, you guys need to come.” Then I’ve sat in on different classroom visits when they’ve come and it’s unbelievable, like raise your hand if someone you know has been murdered and all these hands go up. How many of you have seen other acts of violence happen in your neighborhood? It is unbelievable, so these kids certainly need some support or whatever regarding violence.”*

*“The other reason that kids are getting hurt and killed in our community is because they are shooting each other. Then you need an approach like the Institute for Nonviolence. They are extremely effective, what they do is hire former gang members to work with kids who are in gangs right now, to try and help them see a better way. Then they give those kids opportunities. There is no way a pediatrician can make a difference like that. What are they going to say? “It’s really dangerous to be out with a gun and do revenge killing.” They are not going to say anything but the Institute has the right approach. When there is an incident, they get right in, they infiltrate. They get to know all the kids from all the different entities that are shooting at each other. They infiltrate those entities and they talk to those kids and they help them see another way. Then they provide them with jobs, opportunities, and school. When you look at it, that’s a major way we lose kids – homicide. There is nothing that a pediatrician or media campaign or anybody’s going to do that is going to make more of a difference than The Institute for Nonviolence.”*

### **3. Cyberbullying has replaced face-to-face bullying.**

Many experts said today’s cyber bullying was much more powerful because the perpetrator and the victim never face each other and it is impossible to escape from its hold. Following are several examples of cyber bullying,

*“The kids do not work things out anymore, and when they do work it out, it is in an anonymous way online and in a very dysfunctional way. So those interpersonal skills that used to develop are different now. It is more throwing a bomb and then running. It is a different situation now. It is a lot of internet stuff where you put something out there, but you are not in front of the person anymore. You know before when you had a fight with somebody, your hands hurt, you saw the blood, somebody cried, and maybe somebody showed up to break it up. Now, bam, you just send off that bomb. You do not see their face, you do not have to deal with them being in front of you, you do not get that immediate feedback, the bystanders are not there and if they are they are chuckling on the outside because they are witnessing it but they are not part of it, and I think there is a lot of frightening ramifications about that.”*

*“It’s easy to bully people from behind a computer. When you didn’t have it, you were on a playground and you had a big bad bully and everybody at one point ganged up on him and put him in his place. You don’t have that now. It’s easy to do it hiding behind electronics.”*

*“I was talking to the chief of police this morning about bullying. When we were kids you might have gotten bullied but eventually at some point you were going to have to stand up. For one thing the bully had to face you and confront you in order to bully you. At some point you had to decide whether or not you were going to stand up for yourself or not, but it sort of ended there. Home was safe. Everywhere else was generally safe other than that interaction that you had with the bully, but now with technology like cell phones, Twitter, Facebook, the bullying can take on a whole new level, a whole new scale that makes it impossible for kids to escape from it.”*

### **Schools play an important role in recognizing and preventing cyber bullying, as this expert states:**

*“Its very bad this whole internet stuff where they use phones, they videotape fights and stuff and then they post them to YouTube. A lot of stuff goes back and forth on Facebook over the weekend and whatever happens it then gets brought to school and then we have problems in school with fights. A big issue is peer relations and rumors, especially in middle school, Oh my God, it’s huge. If you don’t have a good system in place in the school, like if the administrators haven’t laid down the ground rules or whatever, then it can be a huge problem and you get lots of fights and lots of hurt feelings.”*

#### **4. Teens are addicted to Facebook, texting, and other social media.**

Many of the experts who were healthcare providers said teens were on the internet or cell phone around the clock. They need to be constantly connected even during their doctor visits.

*“They’ll stand three feet across from each other and text I mean I have kids that I have to physically walk up to and take their cell phone away from them and put it on the desk in the office because they cannot resist the temptation to be texting while they’re at a medical visit. I only get to see them for fifteen minutes a year and they’re texting the whole time.”*

*“The whole cell phone and internet and Facebook—they’re always distracted. I think they try to sit down and get their homework done and somebody is messaging them or their Facebook account gets updated or somebody is texting them. They’re addicted to this kind of stuff. There are a lot of good things about technology, but I see it as a huge distraction for a lot of teenagers that you just can’t draw the line anymore. They can’t say, “Okay, I’m going to turn off my phone so I can get my work done.” They never turn off their technology. It’s hard to get them to give up their phone, to turn their phone off when they come in for an exam. You can hear the messages coming in and they really want to see. Some of them just answer the phone and you have to tell them, “Listen, this is not appropriate” I’m doing an exam here and you’re on the phone. I think it is a big distraction.”*

*“They do not sleep. They are up all of the time, and part of that is their “in touchness.” One of the things about adolescents is their need for affiliation and they have got this belief that they cannot miss something, or if they are not present at something they are going to be talked about, so they feel this need to be constantly connected and in touch, and these new tools that have become available to them have just sucked up their idle time because*

*they are afraid if they do not participate it is going to be about them instead of with them. When they do attend, either online or in person, there is really not a lot to these. They would not have missed anything, but their perception is that they will. So, their phones are on around the clock. They can be IM'd around the clock, so there is that constant connectivity, yet at the same time they do not seem to be aware of boundaries. If something pops into their head at two in the morning they will call somebody. Yet when you get that call that wakes you up at two in the morning, maybe you're not crazy about it, but they do not seem to make that link, so part of it is that they do not sleep, and they are online a lot at night whether it is porn, whether it is gambling, or whether it is just communicating. They are awake at night. Sleep is markedly diminished and that increases stress and it decreases learning."*

*"I think the whole media thing and the internet and texting and sexting these issues are huge. It's a whole new way of communicating and I think in some respects we need to think about utilizing some of them to communicate if we want to be engaged with our adolescents and I'm not saying go to their level and do whatever, but we need to incorporate some of that into what we do, especially in the classroom and making them engaged. You can't sit there and just lecture them, that's not going to work anymore. They're playing games, they're doing that at home and they function in a different way than they did thirty years ago and I think we need to look at some of that."*

### **5. Teens have low self-esteem. These negative attitudes need to be addressed.**

Experts believed that many times we see teens as a bundle of risks rather than valuing their positive attributes.

*"I think it is culturally that we see them as risky people instead of promising individuals. I think adults tend to fear adolescents or disparage adolescents as a time of life rather than really valuing adolescents."*

### **In order to build self-esteem parents and communities need to encourage teens to dream, engage them in their passion, and help them to see they have a future.**

*"Parents are key, home is key and dreams are key. I think getting from the youths even if you do it...I always remember when I was a teacher, I would say to the kids, "Just list five things for me. What do you wonder about?" It's amazing what they come up with. I ask them what they would like to know about."*

*"Teens need safe, dynamic learning opportunities. We need to engage them in their passions and help them discover who they are. I think this self-esteem thing is a lot of code for nonsense unless you feel like you are worth something, but you have to express yourself. You have to build something or interact or be in a place, be involved in a student demonstration. You need to actually be active and engaged in something in order to discover you're good or you have the potential to get better at it. It all boils down to keeping them*

*constructively busy. So when they are not busy we don't know what to do with them, we blame them and start looking into dissecting all of the aberrant behavior which is a result of them just wanting to do something."*

*"Young women that feel that they have a future that they are excited about delay getting pregnant. It is very clear and it is also really clear to me, after all these years of doing sexual health work that it has almost nothing to do with information, almost nothing. It has to do with how a young person feels about themselves, feels about their sexuality and feels about their body. It just does. Risky behaviors have very, very little to do with knowing it's risky. Kids know. Who doesn't know that drugs are risky or smoking gives you cancer? Who doesn't know if you have unprotected sex that you could get pregnant? Yes, there is the invincibility piece but that's not about facts because you can present all of the facts and then they say, "It's not going to happen to me." There's very, very little chance that the presentation of facts is going to make any difference whatsoever. Dealing with the whole individual and helping them get a context, helping them look at it differently, helping them feel that they have something to, that they have a future is what we have to do."*

## **6. Obesity is related to depression and bullying.**

Many experts talked about the emotional and psychological side of obesity. They felt obesity was highly correlated to depression and bullying.

*"A lot of them use food as an emotional thing. The number of girls that come in and admit that they're either eating and purging or not eating at all, or eating constantly and therefore are obese. There's stuff going on up there that you need the time to be able to figure out. So it all sort of goes to mental and psychological."*

*"We see that the one thing we are missing that we need to add to that is the mental psychological aspect because a lot of these kids have their current mental psychological issues that are very closely related to their body image and their health and weight."*

*"We had a kid in our obesity program that got beat up while waiting for a ride outside the YMCA. Now here's a kid who is trying to better himself, is going twice a week to engage in some activity and have his blood work monitored with his pediatrician, taking it upon himself to do this and he gets beat up outside the building by school bullies. We reported it to the police. The YMCA reported it to the police. We let the school know but that's the kind of thing that happens. We see kids come in here as well that get bullied and it affects them mentally. It's related to the obesity thing and a lot of the weight problems create a self-image problem."*

*"We do not have a healthcare financing system that pays for prevention. It is the same thing with obesity. I can get some services. I could probably get surgical bariatric surgery for obese teenagers if they are fat enough, but I cannot get programming that is intensive outpatient focusing the family and child around diet and exercise. It is ridiculous. It is not a system that makes sense to me in that regard. We want to keep people healthy. We do not want to wait until they have a BMI of 45 before we make services available to them."*

## **Pediatricians face barriers when they treat obesity, because health insurance pays for bariatric surgery, not preventive counseling.**

*We say, "Gee, you have a BMI of 23, isn't that great? How do you do you keep that? This is why it is important. This is what you do and it is right. These are the things that worry me a little bit. Is there an alternative to that one and how much are you getting out?" I think, again, it is a resource alignment in some ways and a reimbursement issue, but is the doctor's office the best place to do that work? I do not know. I would love to be able to say, "No, we have this yoga class for your health. You need to be doing yoga." Because you need your 20 minutes a day that you just are contemplative and take a deep breath and learn some coping skills for destressing."*

### **7. Cutting is used by teens to relieve stress.**

Experts said that more teens were cutting themselves as a way to relieve all the stresses in their lives. It has become very common.

*"Something that I was actually very surprised finding out is that amongst this age group there is a lot of cutting to relieve stress. It's an anxiety releaser and that sort of thing."*

*"They deal with a lot of stress, there is stress at home, and stress at school, there is violence in the community. All of those things are just stresses that young people are dealing with. There's cutting, that's a pretty common thing that comes up, there's relationship stress – choosing the not so great partners, that creates stress in their lives and us trying to coach them through healthier relationships. That's not always easy. A lot of it is typical teenage stuff, but a lot of it is typical urban teenage stuff. It's how you handle those things in life and that is what we struggle with. If you find yourself in a situation where you're falling off balance we try our best to coach young people through that. It's difficult depending on how involved the parent is."*

*"We've had a least four or five students hospitalized this school year either at Bradley or at Butler, just for cutting."*

## B. Barriers to Healthcare for Teens

### 1. Privacy and confidentiality are the major barriers to healthcare from a teen perspective.

Both healthcare providers and teens are confused about when a parent will be notified about what services a teen receives and which types of health services need a parent's consent. In fact, when the experts were asked to pick major reasons teens do not go for healthcare, the majority answered "Teens are worried that their parents will find out something that they do not want them to know."

**Most of the experts stressed the importance of respecting the teen's privacy, creating a trusting relationship, and keeping open communication with parents.**

*"I'm very up front with my kids that anything they tell me stays between us and that the only time I would break that trust was if they were going to do something very dangerous like kill themselves or somebody else. Then we'll talk about ways to tell other people about it. Those are the words I use. I spend a lot of time over the years to try and develop a relationship with kids and so I think they feel pretty comfortable that there's confidentiality and privacy here. That being said, I'm an adult and if they don't trust me they lie to me. So I'm not feeling that there is some systemic thing here that there's this perception that in Rhode Island the system is set up so that it's open and that kids are at high risk to have their information shared. I just think that kids just have an inherent distrust of adults, which I don't blame them."*

*"In general, most primary care physicians will take anybody over 16 and basically have a conversation that goes, "I will keep what you tell me confidential and I will begin treatment for a condition that exists and I encourage you to tell your parents, but whether it's legal or not, I'm going to take care of you and be respectful of your privacy."*

*"Any good person taking care of adolescents in my view needs to spend five minutes with the parents on the front end and then five to ten minutes with the teen and the parent getting basic history and then you kick the parent out of the room and find out the truth."*

*"Most of my families I have known for a long time, and even with the ones I have only known for a short time, I tend to be very clear that at some point I intend to throw the parent out. I will let the parent stay while we are talking about their health history and then I will throw them out. I will say something like, "usually at this age, I would like to examine your son or daughter by themselves," and then I can talk about other things and see if there is any other agendas that they think they need to be seen for. Sometimes that is very useful, sometimes not. I think most of my colleagues do similar stuff. We will see the kids by themselves sometimes too, and we will provide STD and birth control care sometimes without the parent's permission. The state law is pretty murky about it."*

*"If a teenager has a relationship that he or she can trust, much of this goes away and a part of that will be asking "are you going to tell my parents or are you going to tell my*

*teacher?” and them believing you’re going to give a decent answer that they can believe. I think rationalizing this sort of crazy quilt of different rules, Title X Family Planning versus non-Title X Family Planning and HIV versus other sexually transmitted diseases, like does Chlamydia count and all that kind of stuff...would be nice to straighten out. Just make a rule. From a teenager’s point of view, I think it is much more about whether or not they trust the person they are talking to and is it a relationship that they can count on.”*

However even if the doctor does not share confidential information with the parent, the health insurance company many times sends an explanation of benefits (EOB) to the parents. Reporting the EOB to parents makes parents aware that their teen has seen the doctor and causes problems, as these experts state.

*“If you have a Blue Cross Policy and it’s in your name, when you go in for a service you get a notice sent to your home that tells you that services were rendered, sometimes they’re detailed things, sometimes they’re not but it says that on May 5th you went to the doctor for such and such... If your sixteen-year-old daughter goes and you’re the policyholder, you’ll get a notice saying that she went. Again, it may not say she had a pregnancy test but now the horse is out of the barn and so she is going to come home and you’re going to accost her and there will be a difficult conversation. If she’s fast enough on her feet, she’ll invent something. This is what the commercial insurers do because they feel that you’re entitled, since you’re a paying customer. I get it, but it creates a problem.”*

*“The biggest issue we run into is a barrier—privacy and confidentiality. The first question a teen might ask, especially if it is a sensitive issue, is “Is my insurance company going to hear about this and as a result, my parents and what can I do to prevent this from happening?” This is one of the barriers, the issues that we see frequently.”*

*“I think a lot of kids are still worried about what they can tell their pediatrician and then the insurance companies with EOB’s make it really difficult. I can never ensure that there is not going to be something sent to the home that says, “Your lab was just paid \$300 for lab testing on such and such a date.””*

*“Somebody needs to come out and say “These are the things we do and these are the rules, we might need to bill your insurance company, or your parents’ insurance company or whoever owns that insurance plan.” That’s a big issue because when that happens there’s that EOB that goes to whoever owns that insurance plan. It may not say STD testing, it may just say lab services, but if the parents get a \$300 EOB they are going to ask some questions about what this lab bill was all about. We really need to stop doing that with teenagers or anyone. We ought to be able to request that we want a service to be private and don’t send anything to my home. That EOB is a big barrier.”*

Not only do teens have to worry about health insurance companies sending an EOB, but they also have to be aware that healthcare providers send appointment reminders and make reminder phone calls.

*“You have to be careful about sending a bill out. We have to adjust our processes so when we identify someone as being a confidential patient in our electronic health tracker it stays confidential. When we print out the receipt for a patient, the receipt normally has the date and time of their next visit. We had to stop giving the date and time of their next visit because we realized, for example, that if a 15-year-old pediatric patient comes in with their mother for their annual wellness visit and when they leave are given a printed receipt out listing their next appointment, which is not their next pediatric visit but their next women’s health visit for their birth control, which is confidential. So the electronic system wasn’t smart enough to prevent that from happening. We have regular processes set up for 72 hours, like having staff call to confirm their next appointment. They need to be aware when they pull up that record and before they dial that phone number that this may be a confidential patient and if so they can’t confirm that appointment. This is also true when bills go out and if there is a balance. So there are points in the process that we have to be aware of and consciously sort of create alternatives to prevent disclosure of that confidentiality.”*

### **Experts also pointed out some of the frustrations they have experienced with confidentiality rules and non-minor teens.**

*“Confidentiality becomes a much bigger issue when you are dealing with a 20-year-old. A 20-year-old, my God, we are sending them to war and they are doing all kinds of adult things, but the industry seems to think that since somebody is paying the bill, they need to know what they are getting and I think we need to say no. That is not the way health insurance should work. People want confidentiality. Now with my insurance, I do get an Explanation of Benefits (EOB) so I do know if somebody sees someone, but any pharmaceutical information or things like that, I need to get that person’s permission to know about, so that is a little bit of a step. So, if my daughter is filling her birth control on my policy, I cannot know unless she gives me her permission. Why cannot we just extend that to the other stuff as well?”*

*“Once you have a kid that turns 18, you now have an actual adult and there is no requirement to share any information. In fact, there may be prohibitions. So, you could have, for instance an 18- or 19-year-old admitted to a psychiatric facility and as a parent you could be handed back this kid with very little idea of what is going on unless the adult child agrees to share that information. I think there is this kind of rub and I do not know how you deal with it exactly because I do think that people need to have some level of confidentiality, but on the other hand we all know that there are not so many kids on their own at age 18 anymore. So if those kids who just had a psychiatric hospitalization come back into your house and you do not have a clue of what is actually going on with them, how supportive can you be? Or are you continuing to do things that are just making things worse?”*

*“Teens cannot even consent to deliver their own baby. I do not think they can consent for any treatment that is not emergent. For instance, if I have a 17-year-old pregnant patient in my office, I have to have parental consent for her delivery because there is no emancipated minor law in Rhode Island, but yet once the baby is born, she can consent for her own baby’s care which is fascinating. She still cannot consent for her own, but she can consent for her child’s care.”*

## 2. The 15-minute annual visit is too short to provide preventive services.

Several physicians said the traditional “15-minute slot” for a visit was too short to provide care for an adolescent who said “yes” to any of the screening questions. However, in order to pay for office overhead, staff salaries, malpractice, and student loans they needed to schedule as many patients as possible.

Following are experts’ opinions about the inadequacy of the “15-minute slot.”

*“I guess there are a couple of main barriers to providing preventive services. One is just time. It’s tricky because to cover all the bases with a teen probably takes more time than the slot you’re allotted with them.”*

*“A typical visit slot is about 15 minutes. To see an adolescent and to talk about every single thing in detail takes much longer than that, particularly if the answer is yes to anything. So just the time is a barrier. I try to touch base on every single thing at all of my visits and understand that I need to make up that lost time in other areas. But I think that a lot of doctors are reluctant to even ask the questions because they might get a positive answer and they aren’t going to have the time or expertise to do anything about it.”*

*“The number of patients you are supposed to see every day just seem to go up and up. I feel fortunate in this particular position that I sort of dictate my schedule and I’m salaried and it doesn’t matter how many people I’m seeing. I kind of control that myself, but in a private office where you’re supporting a big staff and you have a big overhead and your malpractice rates are high and all the other things, you really need to crank out the visits. I hear people bragging all the time about how many visits they can do in one day and I’m thinking, you divide that into an eight- or nine-hour day and that doesn’t leave much time for each visit.”*

*“I go to a doctor all the time for all kinds of health issues and she’s only got like 15 minutes. She is running all day. It’s a medical sweat shop. So she only has a very short period of time to see me. What she can do in that period of time or what’s reasonable is going to be very low and if you’re a sexually active teen and maybe your parents are in the room, how much can the doctor really do.”*

*“It sometimes takes 15 minutes just to get them to say anything or to develop a level of comfort. So if it is a regular patient maybe it is a little different. Maybe they’ve already developed a level of comfort, but with some of the newer patients it takes a significant amount of time. The real issues do not come out until late in the visit after they’ve scoped you out and decided whether or not they could talk to you about some of those things, so time is definitely an issue.”*

*“We already know that very few teens say that they have a medical home, so I do not know whether in a yearly preventive visit a physician or provider has the time to actually go through these things in detail with an adolescent. Then let them know what really is risky behavior and what is not, and how to advocate for themselves and their health. I do not know that our half-an-hour yearly visit with our teens is actually enough to do that.”*

*“The reality is you’ve got 15 minutes with the doctor. I would be asking you what you would take seriously if your doctor told you this. When would you start to take this person seriously? At what point in this conversation? How would you approach preventive topics as opposed to like if you have 15 minutes with an adolescent, how are you going to even approach these topics. A good mental health screening takes 45 minutes. You’ve got 10, 15 minutes so how are you going to introduce any of these topics? In what areas do you make and how do you make a connection with youth when you have such a short period of time? You know like what would be the way to ask questions. It might be like if you were going to change your behavior, what behavior would you like to work on the most? How can I help you as opposed to barraging you with a litany?”*

### **3. Healthcare providers need to take a positive approach to communication with teens and to really listen to their concerns.**

Many experts said professionals who work with teens need training in how to talk with teens. It is important to make them feel comfortable and to stress the positives in their lives.

*“We need to do a better job of training people in how to talk to teenagers and how to discuss confidentiality with parents and teens. I think this is a big piece. I think this is also a fault of the traditional medical approach but too many adults including pediatricians and family doctors see teenagers as vehicles of risk, like here is this walking risk. Shaking the finger, don’t have sex, don’t drive too fast, don’t drink, and don’t get into fights. Don’t, don’t, don’t, don’t because you are at risk, but we do not do enough of working with teenagers to point out, “Wow that is really excellent decision-making. Tell me how you thought about that” or “Boy it sounds like you make really strong relationships. Have you ever thought about that? Tell me something about your relationships and what part they play in your life?” or “Wow that was a really generous thing you did.” That giving back is really important. We do not recognize, empower, and celebrate youth. We walk around as if they are a bunch of walking risks. Oh my God, I have to put you in your closet until you’re 18 because somehow magically at 18 you are going to walk out of that door and be an adult.”*

*“Listen to really what the teens’ concerns are because they may be very different from what you see, but you really have to take that into consideration, and if you do not address the concern that they came in for, even though you feel like you have done such a marvelous job on all of the other things, you are not going to get very far. The other thing is I always feel like I do not have to do everything in one visit. I used to think that I had to cure the world in 30 minutes, but you cannot, and realizing that what is most important is mainly just establishing some sort of rapport with the patient, or the family that you are working with, so that they would be willing to come back and work with you on stuff. Otherwise, you can write them out a long list of whatever and they are just going to throw it in the trash can when they go.”*

*“I don’t want to be negative about the pediatrician thing. I know they see a lot of kids but I have to tell you that young people don’t really like to talk more and more and are less and less interested in sharing things that they consider personal with adults. I have seen that shift and it seems more than ever now, more than it was 10 years ago. Where it is like “I don’t ever want to talk to you about this topic. Don’t ever bring this up”. So there are very*

*few adults that can talk to youth about sexual behavior. That's part of the problem. I could see a doctor asking them and them really freezing up and being uncomfortable and either saying nothing or lying. It's very hard to make a difference in these areas."*

*"Teenagers may be clueless about some things but they are much attuned to whether people are paying attention to them or not and whether they are getting authentic communication. So if you aren't comfortable having open-ended conversations with teenagers and if you're not comfortable with some of the health and other sorts of problems that come up in that line of work, I don't think that more education or other traditional incentives are going to make much difference."*

*"Provider training is about how to more holistically approach these kids and how to have those conversations, as opposed to teaching them. You do not need to teach a doctor about cigarette use, I mean you do not. You may need to give them some help around doing a behavioral health assessment. That is possible. I think the way physicians are trained is to look for problems. They are not trained to look at this holistic soul, that has been my experience. I think it is more about transforming the practice than it is about, "This is easy to do." If you meet a lot of doctors, and I see some of the young ones and I see some of the older doctors. I still have doctors that are running around pulling index cards out of their pockets because that is how they do business. They write down on their index card what the problems are and then they cross them off as they take care of them. Some of the younger physicians, I think, are still being trained in this, "What is the presenting problem?" Do we still need to do that? I'm not suggesting that you do not do that, but you have to look more broadly at what the presenting problem is."*

#### **4. Healthcare providers are not reimbursed adequately for teen office visits.**

Several healthcare providers said the number-one barrier to providing healthcare to teens was that they were not reimbursed for their time spent with teens.

*"The number-one barrier to providing healthcare in pediatrics is that we don't get paid enough for what we do. We're trying to cut corners and slide more kids in and use our time in a super efficient way so that we can pay our staff and pay back our student loans. I'm telling you, I don't know how many interviews you've conducted so far, but that's where we're stuck. We're expected to do more in less time for less money. Not to mention, I haven't even gotten to the point that yes I would like to have a schedule where I only had 10 or 15 kids on it for the day but 1) I would go broke and 2) who is going to see the rest of the kids that I'm not seeing because I've limited my schedule. I guess that is another barrier, the number of providers out there. We just don't have enough primary care providers. In Rhode Island the reimbursement rates also affects us in particular because we can't recruit help. People do not want to practice in RI because they don't get paid enough, especially when compared to going 10 minutes away and practicing in Massachusetts. The reimbursement could be up to 50 percent more for doing the same exact thing."*

*"I think in our traditional setting, certainly it is finances. I could do a well-baby visit in probably fifteen minutes pretty nicely if that six-month-old was doing well and everything*

*was going great. To really sit down with a teenager who is 13 or 14, who is starting to bump up against rules and restrictions, and starting to have some trouble in school, or trouble with peers then you need more time. Once you start down that road with teenagers, you need time and that is not always reimbursed.”*

**Although many healthcare providers thought highly of the new Bright Futures Guidelines for Adolescent Health Care, they saw it as an unfunded mandate for additional screening.**

*“Well to me payment is the big thing with Bright Futures. Bright Futures is AAP-approved, but nowhere in the law does it say that it has to be paid for. Now the trick is going to be really looking at what is Bright Futures, really when it comes down to implementing it, and how do we make sure this is not just one more burdensome unpaid mandate being put on top of pediatricians, but that we pay for the screening test. The teen screen is done in the waiting room before they come in. Also, that we pay for counseling. The big issue that came up was around the postpartum depression screening in the mothers of infants and the ones that come in. That is part of Bright Futures, to include a depression screening for mom at the one, two, and four-month screening. It was really interesting to hear discussion around, “Well wait a minute, first of all who is going to pay me for that?” The payers did not want to pay the pediatrician to be doing work on mom, and even though we said the whole reason was that in Bright Futures the mom’s mental wellness impacts the infant. “Well that is fine; she can go to her own doctor. We are not going to pay you to do the screen there.”*

## **5. Some schools struggle to meet State health education requirements.**

Health education in the schools is not a priority in Rhode Island. Experts shared that principals, teachers, and parents have to work together to ensure that teens receive the health curriculum. If teens do not receive sex education there are negative consequences, as these expert opinions show.

*“At this point there is not a consistent enforcement of health/sex education in the high school or school system in general. Health education is left to individual teachers as far as how they deliver that education, whether or not they deliver that education. We need to be a lot stronger or more consistent in delivering it by people who feel comfortable with the content. We’re not doing ourselves any favors. We have girls come into our agency saying, “I went out last night with my boyfriend and this is what we did, but I think I’m okay because I borrowed birth control pills from my girlfriend around the corner.” She borrowed one birth control pill and thought she was safe for the night. So I think there’s a great deal of room for improvement around education in the schools.”*

*“Within the school, the health classes are terrible. There is an example in my school, it’s not like that everywhere, but we have P.E. teachers who want to be teaching P.E., they don’t want to be teaching health. So they’re not happy when they have to and then do a*

*terrible job at it. So these kids aren't getting information about risky behaviors and other health issues."*

*"I think that health education is a big issue in this state. I don't know if it's as big a problem in other states, but I don't think we have the consistency here with health education that younger adolescents should be getting in school. I'm seeing college students who still think that withdrawal is a good method of birth control, or don't understand when their most fertile time of the month is. I think those things should be taught at a middle school level or even younger. I'm still dismayed at the number of college students I see who, and these are the most educated adolescents in our population, still don't understand normal physiology. I think that that is one area that we really could improve on, I think every high school student and every middle school student should have a good health education available to them in their school."*

*"I think there are lots of problems with health education in schools. There is a parental opt-out of sex education, and it is a limited curriculum that I do not think is very well supervised at schools. It would seem to me from just my experience with my own children in schools that access to the information that they are getting is sort of just scratching the surface. It is not really digging down deep into what kids' thoughts are and trying a peer educator, I do not know people that adolescents will really listen to. I think that if you bring in the school nurse, who is the same person you see when you scrape your knee, it may not be sort of as legitimate to them as bringing in a peer educator."*

*"A lot of not offering a health curriculum in the school is principals and teachers not wanting to deal with what it would take to get us to be in there. Not getting the consent forms—that's them being afraid of what parents might say. We've found in our experience that parents want this; they want schools to be more active in making sure that kids are safe and so I think it's just fear and not actually rational fear. It's been an ongoing struggle. We know the curriculum works, we know that when our educators go to school their health teachers are not teaching anywhere near what they're teaching and when they try to speak up and say "Actually here is the information I know," teachers say to be quiet and not to say that because we can't talk about those things here. So we're frustrated that we've come so far as a country but as a state we are very far behind in terms of what we actually implement. What the lawyers that we are working with have found out is that the statutes are there, the law says we're supposed to be teaching this in schools but it is just not enforced by the schools themselves."*

## **6. Lack of health insurance coverage stops teens from getting healthcare.**

Many teens lose health coverage when their parents leave a job or if their parents do not fill out applications for insurance. Experts agreed that lack of health insurance was one of the major barriers to teens having a medical home.

*"I think some of teens' not having a medical home has to do with the parent's insurance. A lot of parents lose jobs. I see that happening a lot. They may have had insurance six*

*months ago and then when you ask them next they're like "We don't have health insurance right now." Another reason is when people move, even if it's just from one community to another. They are not apt to travel from Pawtucket to Woonsocket. They are like okay I've left there so now I have to find a new place. I think that for the most part parents do want their children to have medical care. It's not like they don't want them to, but there are barriers and I guess some of it's due to lack of health insurance or their employment. Parents are not so compliant either with appointments. They will blow off an appointment if they don't feel like going out or if it's raining. I have heard all kinds of excuses as to why they haven't gone to an appointment."*

*"I think why they don't come for healthcare is really mostly because mom or dad lost their job and there is no health coverage. Sometimes they've forgotten to reapply for their RIte Care or RIte Share, and so they are out of the system. What usually happens is that eventually somebody gets some health insurance and then they come back."*

*"So one being able to afford it, or the perceived ability to be able to afford it, is a big barrier. People just feel like they can't afford healthcare. Even if I'm on public assistance, even through whatever resources the Department of Health is making available to people, even if I only have to pay a little bit of something, I can't pay that little bit of something, not right now when there are to many other things that are more important. So honestly unless it is absolutely free I think that it is not a priority, so affordability is I think the number-one issue."*

*"Access to insurance is probably the reason teens don't have a medical home. Certainly the only reason why my patients do not come to see me is because they cannot afford to. They have lost their insurance. Sometimes they will still come and we will work on some payment plan. I think most of the people who I have taken care of over the years know that I will continue to see their kids. I am very clear about that. I see them for sprains, strains, rashes, STDs, everything. They do not have to go to an emergency room; they can always come and see me."*

## **7. Teens are not comfortable continuing to see their "baby doctor."**

Many adolescents are reluctant to go to the same pediatrician they saw as a child. It is difficult for them to sit in a waiting area with babies, and many of them leave their medical home during their teen years.

*"Some pediatricians are very engaged with shots and earaches and nutrition and safety and such in the prepubescent years but are okay with kids kind of drifting away once they get into "sex, drugs and rock and roll" and they are not as comfortable as you might hope with talking to teens about that stuff or dealing with those issues. So you've got sort of a double problem in that adolescents often don't feel they want to go back and take a new set of problems back to their old baby doctor and the baby doctor sometimes doesn't want to deal with those adolescent issues either even though he or she knows that they are supposed to. So it's not a surprise that a lot of kids leave their medical homes in middle or high school."*

*“Even among teens who have the same pediatrician, if your pediatrician has Donald Duck on the walls and does not ask your parent to leave during the exam and is really geared toward a well-baby visit, I’m not sure I would feel comfortable going there as a teenager.”*

*“I think kids are reluctant to go to the same place that their parents brought them to as a baby. I think they also get to a point where they are reluctant to tell the doctor who has seen them since they were “this high” that now they’re doing something that the doctor is not necessarily going to condone or that they are worried they are going to be judged. He saw me in diapers, he can’t possibly understand that now I want to have sex or whatever, nor can they deal with the fact that the doctor is going to ask them questions.”*

*“Most practices are ones or twos and sometimes pediatric practices are like good family practices in that way but many adolescents age out of pediatric practices by the time they are 14 or 15. They don’t want to be with the babies and you will hear that. That’s what people will say, “I didn’t go because I don’t want to sit in the waiting room with the babies.” The babies don’t bite. You see babies in family practices as well, but there are only a couple and the mix is different and the waiting room and the exam rooms are designed for all ages. They don’t feel talked down to. Toys and blocks are there in quite the same way they are in pediatric practices.”*

## **8. Teens’ healthcare is not always a priority for parents.**

Many parents see the seventh grade physical as the last required health visit for their teen so they stop bringing them for care. If their child is not having any health problems it is easy for some parents to not make an appointment for an annual exam.

*“When the kid looks old enough to be an adult, even though the kid isn’t an adult and the kid wants to be treated as an adult and the parent is kind of tired of parenting the kid—and I’m not saying that they’re being neglectful—but that annual physical that you were so good about until you got to seventh grade, now you’re not quite so worried about it or you might put it off for a year or whatever. I think there is a temptation on everybody’s part to just sort of slack off a little bit. He looks healthy, he’s more able to take care of himself, his asthma doesn’t seem to be acting up, it’s inconvenient to pull him out of school and bring him there.”*

*“I think frequently low income families who are excessively mobile in comparison to other demographics may lose touch with a primary care home. I think it is not just the kids. I think it is the parents as well sometimes. I think adolescents are developmentally in a place where they are trying to differentiate from home and so maybe being seen by the same family practitioner that is seeing mom is also not comfortable and I think it relates to some of the conversation about confidentiality and privacy that is starting to develop. I think that this is an area of real conflict for the parents and the kids as well as providers. At the end of the day, these young people are still children under the law. Parents are responsible for them and if there are some risky behaviors or other significant issues going on, I think there is a real question about how does that get most effectively shared with a parent so that a parent becomes part of the solution and not the one who is blindsided by the issue.”*

*“When people move, even if it’s from one community to another, they’re not apt to travel from Pawtucket to Woonsocket. They are like okay now I’ve left there so I have to find a new place for medical care. I think that for the most part parents want their children to have medical care, it’s not like they don’t want them to but there are barriers and I guess some of it’s due to lack of health insurance or their employment. Parents are not so compliant either with appointments. They will blow off an appointment if they don’t feel like going out or if it’s raining. I have heard all kinds of excuses as to why they haven’t gone to an appointment. I have heard parents question whether or not the kid can just go by themselves to the doctor.”*

## **9. There is a shortage of child psychiatrists in Rhode Island.**

Several physician experts said that Rhode Island had a severe shortage of child psychiatrists. Due to this shortage many pediatricians have to prescribe medications. They are not always comfortable with this practice.

*“In RI you could have a force of 50 psychiatrists and they would all be full tomorrow. The psychologists try to manage them. The pediatricians are trying to manage them. You have no idea how many kids I prescribe Prozac and Zoloft and all those other medicines for because there is no psychiatrist to do that for them. Even kids that have psychiatrists get turned over once they’re in a relatively stable place. They are turned back over to me to manage their needs so when the next crisis comes along they don’t have a psychiatrist. It’s horrible.”*

*“It is pretty hard to find mental health people so it falls in the laps of pediatricians. Actually if you have RIte Care there are some options. There are the local mental health community health centers or whatever they are called now and there are some pretty decent people there particularly where I am. The access to psychiatrists is dreadful. It is really impossible. What happens is those of us who are willing to end up doing medications. I certainly feel comfortable with some of them, but not with some of these antipsychotic ones that they are putting kids on all the time now. We will give them enough prescription medication until hopefully they can get hooked up with a therapist who will then hook them up with a psychiatrist. There are just not enough child psychiatrists in this state. It is partly because of the way that they are paid. They are not reimbursed well enough. They cannot survive on what they are paid.”*

*“I have a ton of trouble finding a psychiatrist who will see teenagers. They have to be down and out and sent to the Bradley ER sometimes before I can get somebody within a two to three-month period of time to see a patient. I was hoping to get them into care before that need that kind of acute intervention, so I think it is tough. I even am somewhat reluctant in terms of using medication for teenagers just because I think you have to be careful about dosing parameters. I think it is something I do not necessarily feel as well trained in as I do in other parts of preventive care.”*

## 10. Equity issues need to be addressed because there is not equal access to healthcare for Rhode Island teens.

Access to healthcare for Rhode Island teens has improved with RItE Care, but still private doctor offices are not accessible to teens living in poverty areas.

*“There are two Americas when it comes to healthcare. What are the issues? It’s the issue that RI Hospital is on another planet for the young people that we work with. The East Side is another planet. Social workers come from another world. There are two Americas. Every student at Moses Brown sees the same doctor every year. All students living on the south side of Providence should get the same. America can do this.”*

*“One wonders about the effectiveness of the service and to how much morbidity is determined or influenced by medical care and how much of it is socially determined. In general the value of access to medicine in population health is way overestimated with social detriments being the most significant influence. The barriers to care practically are socially determined. You don’t see kids in adolescence and the kids who are likely to indulge in risky behavior aren’t coming through the door. I’m not convinced what a physician says or what a nurse practitioner says is likely to be anywhere near as powerful as what their friends say. If you grow up in a culture of poverty you’re not as likely to have a regular doctor any way and you’re more likely to use a health center and see somebody different all the time. So when you come in and if somebody asks you about a behavior it’s like “Who the heck are they?” You don’t have a relationship to connect to and even if you did like the sword or the street it is much sweeter than the whimpering of some weird looking doctor.”*

### C. Promising Strategies

#### 1. Components and descriptions of the ideal adolescent health visit

The priority components for an “ideal adolescent health visit” suggested by experts include:

- Provide access to mental health services.  
There needs to be the ability to screen for mental health issues and provide services as soon as possible.
- Make the teen comfortable at the visit.  
Right person at front desk
  - Make teens feel welcome
  - Find out what they want out of visit
  - Sit down and talk to teens at eye level
- Administer pre-visit questionnaire (ideally electronically) so you are aware of teens’ needs before the visit.

Following are some innovative descriptions of the ideal adolescent visit by experts:

*“For the ideal adolescent visit, I would include doing some screen questionnaires before they come in to see me. Again, almost to say these are issues that I think are important about your health. These are issues that we can talk about on this visit, but if there are other things, I want you to be able to talk about them as well. So I think that a visit starts with some information gathering before the visit that is centered on the teen’s agenda, and I have to be flexible and fit my agenda around that. I think a visit should certainly screen for risky behaviors, but should also acknowledge the strength of teenagers as well. A visit is also a place to talk about what they are doing right. I think it is ideal if a visit that has enough time and perhaps the resources available onsite. If it was my dream, I would have a psychologist or a mental health counselor working with me that I could call in and say “Gee, this is Johnny and we have just been talking about some things, and these are the things he has told me, and these are the things I worry about, and he is willing to have a conversation with you so why don’t you guys go down the hall and have a talk.” I would love to have a nutritionist. Again, I have so many of these patients and getting a nutritionist who is culturally sensitive to adolescents and gets that there is a social mandate to stop at McDonald’s. To have nutrition resources and mental health resources, and I would love to have a dental hygienist. I have teenagers that have never seen a dentist.”*

*“There may be potentially an adolescent center type of thing, but it would be a medical office. If money or time were no object then I think getting good tools in place for kids to do kind of a pre-visit questionnaire and things like that to kind of highlight some of the potential behaviors and other things that they are doing. That type of situation has been shown to elicit more information so to have somebody show up and have some type of technologically based system in place where kids could fill out a questionnaire asking specific questions like have you ever done this or that would allow that information to come forward in the visit so you can address each situation head on. Then making sure you have the capacity and the training and the resources so that if you do uncover something that you can actually spend a little time and talk about it. Then if you need to call in any help from somebody else, ideally to have it on site, but certainly have an easy way to say that this is something that a lot of kids are dealing with, these are your options. You can talk with this person, a psychologist or maybe we can get you into a group with kids your own age or we can arrange to see how you do and see you back in a few weeks and talk about it again, that kind of stuff.”*

*“I think a sort of comprehensive Bright Futures check up kind of model probably makes the most sense. I suspect that like most other things there is no single model that makes the most sense. Adolescents at different stages and different cultural backgrounds and the like may have different needs but if you could create an environment in which there was some clear expectation by everybody that the adolescent was going to be asked some questions and then have an opportunity to ask some questions themselves and that all of that would be safe and managed appropriately by someone who actually would care and follow up and keep in touch and had access to a dermatologist, gynecologist or whatever might be needed. If you could sustain that long enough to be credible and could reinforce that then I think that would probably work pretty well. It would also be best if that could happen in a place that was easily accessible to the average teen, not at a hospital or at two in the afternoon. Make it so that kids could actually go there and reinforce it by actually following up with them. The kids do have insurance giving them their parents’ clear message*

*that we want you to do this every year or every other year, something reasonable like that. I think it would eventually work. It would take a while before people would begin to believe it was true and some folks have other ideas. You could do it in private practices or a health centers if they wanted to set aside Thursday evenings to just do routine comprehensive check ups.”*

*“I actually think the ideal visit is a continuous process. You do not all of a sudden become an adolescent one day. I think the best way to do it is in a practice where there is a lot of continuity and where you as the physician feel comfortable moving from one kind of relationship to another with your families, and just have everything available that you need. We have all of the stuff to do all of the testing, all of the paps if you need one, we give HPV vaccines, and I talk about it for boys as well. I think they are just glad to have somebody who is willing to talk to them about the things they need to talk about. It is about the comfort level. You could make a brand spanking new beautiful adolescent setting and have people there who would make you feel uncomfortable, so I think it is really once you get in there how you were made to feel. Not making them sit up on a table but sitting in the chair opposite them to talk to them first about what is going on. We don’t have a ton of baby toys but we do have some wall paper borders in the rooms that are kind of childlike, but I think it has more to do with how you behave towards people rather than anything else.”*

## **2. Peer educators**

Many of the experts had peer educators working in their agencies and highly recommended this type of program intervention. Peer counselors have the unique ability to understand instead of judge.

*“I think for the most part teens are not receptive to hearing about preventive services, so in some ways they are their own barriers. They think it’s not going to happen to them. They think they have it all under control. I think for a lot of teens their adult role models necessarily ones that would encourage them to change their habits. I think there’s a lot of preaching to kids and that their gut reaction is to go in the other direction. I think it works much better if the kids are talking to each other like peer-to-peer support groups.”*

*“We need someone who comes from their culture who understands it and understands why kids do what they do and not just blame them. So you are able to pressure all the decision-making points and at the same time you’ve seen that all those good reasons of slavery, racism, and poverty are just not enough reason for you as an individual to make poor choices. You’ve got to make better choices even though you might have succumbed to an environment.”*

## **3. Seventh grade physical as the last required exam and a good time to focus on preventive care**

In Rhode Island there is a requirement that seventh graders have a physical before they enter school. This is a time when the school nurse, teen, parent, and pediatrician could communicate in the best interest of the teen. It would be an ideal time for preventive counseling and follow-up.

*“There are multiple visits up to age four but after age four right on through adolescence the recommendation is a yearly health maintenance visit. So how it works just in terms of requirements for school there’s a requirement to have a physical before you enter seventh grade, but after that there is really no high school requirement. So my sense is that a lot of folks once they have that final seventh grade physical don’t necessarily feel they have to go to the doctor.”*

*“They have to have a seventh grade physical, it is required by the state so all of my incoming seventh graders are supposed to come to school with proof of that, including documentation that they had the three required vaccines. We can’t exclude them from school for not having the physical. We can for not having the immunizations. So most of them do get the physical not all of them I tell you I am still missing about 10.”*

#### **4. Teens need multiple short visits, not one annual exam.**

Many experts thought one annual visit was not enough for teens. Multiple short visits were better suited for the types of health problems teens have.

*“I think for an initial visit it’s nice to have a full hour. I don’t think most practices are able to devote that kind of time. I think longer than that is way too much overload and you kind of lose the teen. Seeing them a bit more regularly for shorter visits I think is always more helpful than doing a really long visit. Initially I think you can get at least an hour especially if it’s a new patient to your practice.”*

*“The ideal time for a visit is five minutes like three times a week or five minutes once or twice a week or month. The idea of having somebody sit there for an hour and get a whole spiel makes a doctor feel righteous and I think the kids stop listening after about two seconds. Teens need multiple brief encounters with lots of repetition and checking in so the adolescent knows that he or she is thought of as important and valuable. That’s why it’s important to check in with them.”*

*“If a physician was caring for a teenager who had a serious health problem and was seeing them periodically to take care of whatever that problem was, it might enable them to start or build a conversation around other stuff because they’re seeing that kid every two weeks or once a month. Unless it’s a repeat interaction like that there’s absolutely no way to really build a relationship through one visit a year.”*

#### **5. Middle school years are the best time to provide preventive programs for preteens.**

Experts believed that there were not many programs for middle school youth and that it was an ideal time for program interventions. It is a time when you can reach the highest-risk teens and provide innovative programs.

*“I think the pity is that middle school and high school years are probably the most fluid and dynamic of the human development. It is the brightest time for us a society to be stimulating and invigorating and connecting some knowledge with them about health-care and healthy habits and letting kids discover and model them for each other. They can*

*really influence their peers when they're in a successful mode. The fact that we actually as a society let that period go dormant, let it actually burn out and discourage it, is a shame. They are looking at us wide eyed to give them a leg up and a pathway on how to get there and what we as adults do is negate them. We're afraid of it and we actually try to box it in narrowly based on our narrow adolescent experiences or what we were afraid to deal with in our adolescence. We actually strangle it. It's really quite sad as a society.*

*"I think cities are starting to realize that research has triggered this realization that we really need to be more concerned about connecting to middle school youth and we can't wait till high school. So I think that a lot of the behavioral research is pointing to that. If kids don't have constructive things to do they're striving toward, have adventure and learning about their community, and if there aren't safe places for them to discover stuff then they are going to discover the bad stuff. We really need to present a very age-appropriate set of offerings for them."*

*"Developmentally middle school is probably the most at-risk time. Kids' brains developmentally aren't attached to whatever and they're not making any critical decisions at all. They are just hormonally tracking all of their peers and pretty much trying not to pay attention to adults. So developmentally it is a time when kids start to thrive on adrenaline and risk, so they really need a structure that allows them choice and an opportunity to choose. It's a time when kids in fact need to be given a lot more freedom and then responsibility within a safely defined structure around them. They can experiment, but safely. It's a community-based organization that has elementary school kids doing art and then you switch to sports all in the same room, most middle school kids have had it. By the time they get to sixth grade, especially if they've been in child care, they're like "I don't need any more child care for the rest of my life, thank you very much." They don't want to be stuck at the same community center where they already were for four or five years. They need to sort of experiment with sports now. They don't necessarily want to be super competitive but they like a challenge, so developmentally it's a challenging time for community-based organizations. There is almost no funding or subsidy for that. It's when if you look at test scores grades drop from fourth grade to eighth grade dramatically in our public school systems across the country. The leading predictor for ninth grade dropout, of which we have fifty percent in two of our high schools, stems from poor attendance in sixth and seventh grade, poor math and literacy scores and bad behavior. I think we're pretty convinced that if you're going to stem the drop-out problem you need to get at it in middle school."*

## **6. Provide education or preventive services in small groups before the exam.**

Many experts found that a group education visit with teens before they see the doctor is very effective. The interaction among teens helps to facilitate learning and is cost effective.

*"Initially we started out at the clinic with a scheduled template and you had a scheduled time and that probably lasted about three days because teenagers don't work that way so we've really pretty much evolved into a revolving door walk-in kind of thing, there are scheduled appointments for physicals and to come back for refills on medications and stuff but the door is always open and they can come in when its convenient for them.*

*Somehow at the end of the day it all works out and you're never quite sure how. At this age they come in groups. Often it'll be a girl who will drag her friend over and say "Okay, tell her what's going on," or three girls will come over and they all know each others' business so confidentiality amongst them is almost non-existent. They're not malicious at all. They're really trying to protect each other as best they know how to keep an eye on each other and as they'll walk out I'll say, "Now you make sure you bring her back next week," and they take on some level some kind of responsibility for each other."*

*"For an adolescent visit I would use more of a group approach followed by individual sessions. I think there is a lot to the peer interaction and the kids playing off each other. If they are interested it takes a dynamic person, you cannot just sit there and show them a PowerPoint presentation and expect them to be part of it. It would take a dynamic person. Getting the kids in a room together would be ideal. First from a cost perspective you can get more information to more people instead of trying to say the same thing to each kid in an individual appointment. It has got to be small enough that people can interact. I do not think it should be above 20, probably below that even. It does not have to be a physician. The guys in private practice will probably crucify me over this, but it does not have to be a physician. It needs to be a person who is knowledgeable in the area that is being presented and has the ability to get across and connect. "*

*"I think the ideal adolescent visit would be one where a group of teens, whether it is boys or girls, could come in with their peers, but not a huge group. I would say a small group of like three people at the same time could meet with one staff member or healthcare provider who's very comfortable with teens. This person can provide a very comforting environment where it's more like chatting with them on a level that is resonating with them. It's about how you make them feel comfortable. Then doing a brief intro to whatever setting they are at and provide a comfortable environment where they might ask some questions."*

## **7. After school from 2-6 pm is a prime time to offer program interventions to teens.**

Many teens are out of school at 2 pm and their parents are not home until 6 pm. Experts agree that we need innovative programs for teens during this time or even to keep schools open until 5 pm.

*"School gets out too early in this state. Most high schools are out by two o'clock but parents are not home until six o'clock. Nothing good is happening between two and six in the afternoon, nothing. There are kids getting together unsupervised and nothing good will come out of that. They are kids. They do not know what they are doing. They do not have the brain capacity to handle being responsible and we are leaving them to their own devices, and hoping we taught them well enough in their young years, hoping that they are going to be strong and not have sex, or not do drugs. That is ridiculous—the expectations we have for them. I think school needs to go to five pm. We are dumber than every other country in the world. We really are. Think of China, any country, you name it. They are all smarter than us because we do not educate our children well enough."*

*“It’s in grades four through eight, if you look at test scores in school, that grades drop dramatically in our public school systems across the country. After school is the time when kids need something, it’s when we see the highest teen pregnancy, substance abuse and all the rest of the bad indicators. It all happens between three and six in the afternoon. That is when you need to keep kids busy.”*

## Appendix 1

### Key Informant Interviews—Purpose and Methods

**Purpose:** To determine barriers to healthcare for Rhode Island adolescents and to design strategies to improve their access to care.

**Method:** Conducted 30 key informant interviews with Rhode Island experts in adolescent health. Ten questions were developed with two health department advisory groups and policy recommendations on how to improve access to care from the American Academy of Pediatrics, Institute of Medicine, and Society for Adolescent Medicine. These ten questions address the following areas:

1. Expert's Background
2. Medical Home
3. Barriers to Providing Preventive Services to Adolescents
4. Healthcare Delivery Settings
5. Provider Training
6. Ideal Adolescent Health Visit
7. Privacy/Confidentiality
8. Barriers to Care—Adolescent Perspective
9. Adolescents at Greater Risk for Poor Health
10. Final Thoughts

Experts included healthcare providers, teachers and educators, professional organizations, and community agencies and groups.

Interviews were taped and transcribed. Transcriptions were reviewed separately by three researchers to identify common themes and select quotations to illustrate these themes. All transcriptions are confidential.

## Appendix 2

### Key Informant Interview Questions for Adolescent “Experts”

#### Access to Healthcare for Rhode Island Adolescents Project

#### Final Survey—March 30, 2011

##### 1. Expert’s Background

You have been identified as a RI “Expert” in adolescent health. What do you think are the reasons you were suggested as an Expert? Tell me about your work with adolescents. What do you enjoy the most? What are the qualities someone needs to work effectively with adolescents?

##### 2. Medical Home

Only 62% of RI teens have a medical home. “A medical home is a model of delivering primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate and culturally effective”. What are the factors that make the RI medical home rate for adolescents so low? What are some ways we could improve this rate?

##### 3. Barriers to Providing Preventive Services to Adolescents

70% of adolescent morbidity and mortality involves consequences of such behavior as unsafe sexual activity, violence, substance abuse, tobacco use, poor nutrition, and risky driving. What are the barriers to providing preventive services to teens? What are some ways we can eliminate these barriers?

##### 4. Healthcare Delivery Settings

There are four settings where RI adolescents receive primary care – private physician offices, community health centers, hospital clinics, and school based health centers. What are the strengths and weaknesses of these models? What do you think is the best model for RI? What are the characteristics of an “adolescent friendly” model of care?

## 5. **Provider Training (Attachment 1)**

Many health care providers working with adolescents believe they are inadequately trained in preventive services for adolescents (some areas include sexual/reproductive health, eating/weight problems, psychological problems, substance abuse, oral health, sports medicine, and violence). Attachment 1 on page 3 shows a list of recommended preventive services for adolescents. Select the three preventive services that you believe should be the top priority for training. What are the barriers to providing this training?

Is it your sense that providers want this additional training or would they rather refer to someone who specializes in these areas?

## 6. **Ideal Adolescent Health Visit**

If money or time was no object, how would you design the ideal adolescent health visit? What services would be available on site? Tell me about the setting. How would adolescents find out about this service?

## 7. **Privacy/Confidentiality**

At the state level there is broad variation with respect to confidentiality protection offered to adolescents. How do privacy and confidentiality issues affect the way providers deliver care to adolescents? What are some ways privacy and confidentiality issues affect the way adolescents seek and use health care? Are adolescents in RI able to consent for their own Substance abuse treatment? Pregnancy testing? Sexually transmitted infections?

## 8. **Barriers to Care—Adolescent Perspective (Attachment 2)**

In a recent national Harris Poll of 1,200 adolescents who said they faced barriers to care, the top three barriers to health were: 1st – cost too much, 2nd – has no health insurance and 3rd – hard to get appointment. Attachment 2 on page 4 shows the list of barriers. Choose the top three barriers you think adolescents in RI would list. What can be done to eliminate these three barriers?

## 9. **Adolescents at Greater Risk for Poor Health (Attachment 3)**

Several groups of vulnerable adolescents have been identified in research and policy reports as at risk for poor health. Attachment 3 on page 5 shows this list. From this list which are the three groups you believe are most in need of services. How can we meet the needs of these vulnerable groups? What kind of services do we need to provide? Where and how should these services be delivered?

## 10. **Final Thoughts**

Are there other areas or issues we have not talked about that are important to improve access to health care for adolescents? Besides access to health care what other major issues and problems do adolescents face?

## **Attachment 1 Provider Training**

### **Select three priorities for provider training**

- Sexual Activity/Reproductive Health
- Nutrition – Eating/Weight
- Mental/Psychological
- Alcohol/Drug Use
- Cigarette Use
- Family Violence
- Oral Health
- Life Style
- Physical/Sexual/Emotional Abuse
- Injury Prevention

## Attachment 2

### Barriers to Care—Adolescent Perspective

Select top three reasons RI adolescents would say they do not get healthcare

- Costs too much.
- Has no health insurance.
- Too hard to get to appointments that fit my schedule.
- No way to get to appointments.
- Not sure the visits are private or confidential.
- Medical staff does not understand my ethnic or cultural background.
- Medical staff is not interested in listening to my concerns.
- Not being treated with respect.
- Worried that parents will find out information they don't want them to know.

**Attachment 3**  
**Adolescents at Greater Risk for Poor Health**

**Select three groups that you believe are the most in need of services in RI**

- Adolescents with Depression
- Adolescents using Drugs or Alcohol
- Adolescents not in School/Not Working
- Lesbian, Gay, Bisexual or Transgender Adolescents
- Adolescents in Foster Care
- Adolescents involved with Judicial System
- Homeless/Runaway Adolescents
- Adolescents in Immigrant Families
- Pregnant/Parenting Adolescents
- Adolescents with Disabilities or Chronic Conditions
- Adolescents in Violent Relationships

## Appendix 3

### Interview Invitation Email to Adolescent Health Experts

From: Rosemary Reilly-Chammat  
To:  
Sent: Monday, May 23, 2011  
Subject: Adolescent Health in Rhode Island

Good Morning:

I am pleased to inform you that you have been selected as an “Expert” in adolescent health in Rhode Island. The RI Department of Health needs your help to see what the supports and barriers to care are for Rhode Island adolescents. As reported from the 2007 National Survey on Children’s Health, only 62% of Rhode Island adolescents said they had a medical home. We need your unique perspective to guide the development of adolescent medical homes in Rhode Island and increase access to preventative care for this population.

Over the next few months the RI Department of Health is conducting key informant interviews with 30 Rhode Island experts. The survey is ten questions and will take about an hour and a half.

We are collaborating with MCH Evaluation, Inc. to conduct these in-depth interviews. Holly Tartaglia, Research Assistant will be calling you to set up an interview. Jane Griffin, MPH, will be conducting the interviews. If you have any questions or would like to call to set up an interview time then please call MCH Evaluation at 431-6290.

We look forward to working with you and designing strategies to improve access to care for Rhode Island adolescents.

Sincerely,

Rosemary Reilly-Chammat, Ed.D.  
Adolescent Health, Manager  
Perinatal and Early Childhood Team  
Division of Community, Family Health and Equity  
RI Department of Health  
3 Capitol Hill  
Providence, RI 02908-5097  
401-222-5922 ph  
401-222-1442 fax

thrive-strong minds, strong bodies, strong schools

## Appendix 4

### List of Experts Interviewed for Improving Access to Healthcare for Rhode Island Adolescents Project

1. Bethany Baker, Nurse Practitioner, The Met School
2. Karen Feldman, Co-Director, Young Voices
3. Michael Fine, MD, Rhode Island State Training School
4. Patricia Flanagan, MD, Hasbro Children's Hospital
5. Gregory Fox, MD, Pediatrician
6. Teny Gross, Executive Director, Institute for the Study & Practice of Nonviolence
7. Jane Hayward, President, Rhode Island Health Center Association
8. Bill Hollinshead, MD, American Academy of Pediatrics
9. Chuck Jones, SBHC, Executive Director, Woonsocket Thundermist
10. Amanda Laramie, Director of Teen Clinic, Planned Parenthood
11. Susanna Magee, MD, Family Practice
12. Yvette Mendez, Grant Programs Officer, The Rhode Island Foundation
13. Linda Mendonca, Director, National Association of School Nurses/Joseph Jenks
14. Adeola Oredola, Director, Youth in Action
15. Susan Pakula, MD, Anchor Medical Group
16. Fortunato Procopio, MD, Director, Medical Services, University of Rhode Island
17. Sister Mary Reilly, Sophia Academy
18. Hillary Salmons, Executive Director, Providence After School Alliance (PASA)
19. Janet Sheehan, Principal, East Providence High School
20. Marianne Soscia, President, School Nurse, Captain Isaac Paine, Foster
21. Lynn Wachtel, Director/Nurse Practitioner, Rhode Island College



# Maternal and Child Health Needs Assessment Adolescents

## Adolescent Medical Home

Although adolescence in general is a period of overall good health, it is also a period of high risk taking behavior. This paradox has created disparities within the health care system particularly among racial and ethnic minority adolescents (The National Academies, 2008). Adolescents have morbidity and mortality rates twice that of younger children (National Center for Health Statistics, 2007). In Rhode Island, adolescents aged 10-17 comprise 45% of the child-hood population (Source: 2009 Rhode Island KIDS COUNT) Health plans in Rhode Island report HEDIS measures including adolescent well child visits for their enrolled populations.

National research demonstrates that whether patients are privately insured, publicly insured, or uninsured, reimbursement rates usually do not cover the full cost of care. Both private and public insurance programs are not structured to support integrated primary care services for adolescents. Adolescents are underserved in Medicaid because payment policies discourage preventive counseling. This information further underscores the need to support health insurance for adolescents as well as venues where adolescents can access care designed to address their developmental needs. Studies have demonstrated that providing health insurance in and of itself does not increase access to care for adolescents. Visionary and collaborative approaches can help ensure successful medical home models for adolescence to address their developmental needs.

According to the National Center for Medical Homes Implementation, every child deserves a medical home. The American Academy of Pediatrics (AAP) describes the medical home as a model of delivering primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. Over the past year the AAP has been at the forefront of numerous initiatives to promote the adoption and spread of the patient-centered medical home.

In March 2007, the AAP joined with the American Academy of Family Physicians (AAFP), American College of Physicians (ACP), and the American Osteopathic Association (AOA) to publish the Joint Principles of the Patient-Centered Medical Home.

During 2006, the Rhode Island Department of Health created an Adolescent Medical Home Group to identify issues specific to adolescents accessing health care and define a “medical home” for teens. Data from the 2007 National Survey of Children’s Health indicate that 62.2% of Rhode Island adolescents aged 12-17 had a medical home. The medical home rate determined by the 2007 survey show that a higher proportion of Rhode Island adolescents have a medical home compared to those nationwide (53.4%). Teens were less likely to have a medical home than children aged less than 6 (67.0%) and slightly more likely than children aged 6-11 (61.7%).

## Teen Risk Behaviors

### Alcohol, Drugs and Cigarettes

Substance use and/or abuse of alcohol, tobacco, and other drugs by children and youth poses health and safety risks not only to those who use them but also to their families, schools, and communities. Rhode Island ranks among the states with the highest percentages of adolescents and adults reporting use of illicit drugs and alcohol (Source: *2010 Rhode Island KIDS COUNT Factbook*).

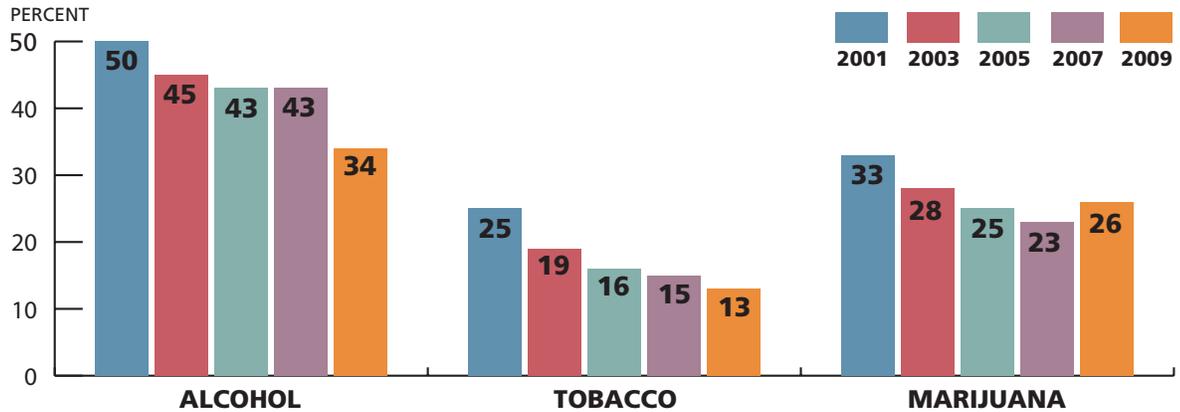
Research shows that children and youth are at highest risk for alcohol, cigarette, and other drug abuse during major transitions in children's lives. These include major transitions to middle school and high school where there are new academic, social, and emotional challenges. There is greater exposure to drugs, to peers who abuse substances, and to social activities involving drugs and alcohol at the high school level (Source: *2010 Rhode Island KIDS COUNT Factbook*).

Nationally, approximately one in 10 adolescents meet standard diagnostic criteria indicating the need for treatment for an illicit drug use problem; however, only one in 14 in need actually receive specialty treatment. This on-going trend indicates a need to expand the continuum of care for increased access to specialty treatment programs (Source: *2010 Rhode Island KIDS COUNT Factbook*).

According to the *2009 Rhode Island Youth Risk Behavior Survey (YRBS)*, 39.9% of high school students reported ever having used marijuana and 8.3% of high school student reported ever using marijuana prior to the age 13. Nearly one in ten (8.7%) high school students in 2009 reported ever using inhalants (sniffing glue, breathing the contents of an aerosol spray can, and/or inhaling paints or sprays), 5.9% reported ever using ecstasy, and 5.4% reported ever using any form of cocaine.

Data from the YRBS also indicate that substance abuse among high school students has declined during 2001-2009 (Figure 1). The one exception in the data shows a 13.4% increase in students who report smoking marijuana within the past 30 days between the 2007 and 2009 surveys, up from 23.2% to 26.3%, respectively. However, the overall trend in marijuana use (past 30 days) among high school students between 2001 and 2009 shows a 20.8% decrease, from 33.2% in 2001 to 26.3% in 2009. Between 2001 and 2009, the percentage of students surveyed who reported they had drunk alcohol in the past 30 days decreased by 32.4%, from 50.3% to 34.0%. A sharper decline of 46.4% was seen in tobacco use, where 13.3% of students reported they had smoked cigarettes in the past 30 days on the 2009 survey compared to 24.8% on the 2001 survey.

**FIGURE 1**  
**CURRENT SUBSTANCE ABUSE AMONG HIGH SCHOOL STUDENTS**  
**RHODE ISLAND, 2001-2009**



NOTE: Current = used substance in the past month

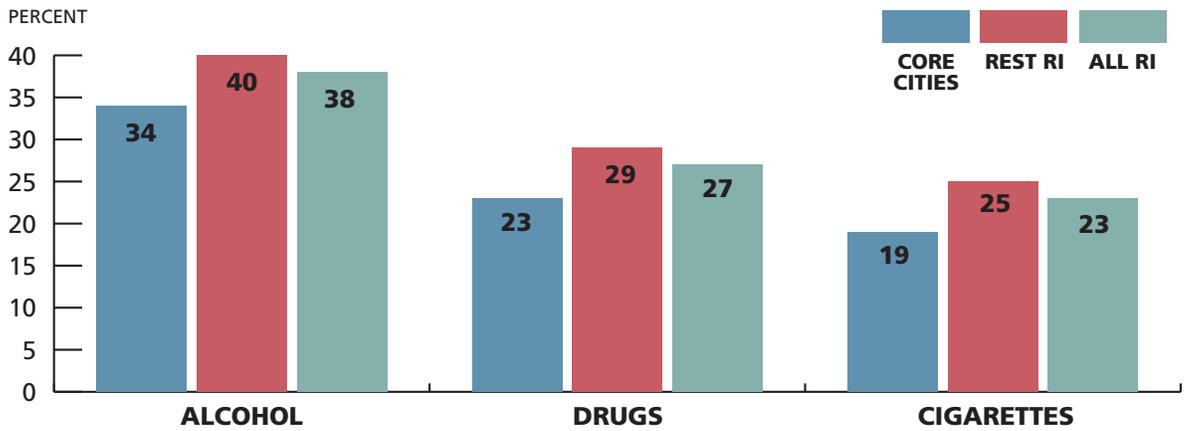
SOURCE: Rhode Island Youth Risk Behavior Survey, Rhode Island Department of Health

For the first time in 2007, the Rhode Island YRBS survey was administered to middle school students (grades 6-8). Data show that 4.1% of students currently (in the past 30 days) smoked cigarettes; 27.8% ever had a drink of alcohol (other than a few sips); and 10.0% had ever used marijuana. Data for 2009 show that 5.0% of students currently (in the past 30 days) smoked cigarettes; 26.0% ever had a drink of alcohol; and 10.2% had ever used marijuana.

Data from the 2006-2007 School Accountability for Learning and Teaching (SALT) survey indicate that 17% of middle school students and 42% of high school students reported they used alcohol in the past month; 8% of middle school students and 27% of high school students reported having used drugs in the past month; and 8% of middle school students and 22% of high school students reported smoking cigarettes in the past month. Rates of substance use among middle school students living in the core cities were higher compared to rates among middle school students living in the rest of the state. However, rates among high school students living in the core cities were lower than rates among high school students living in the rest of the state (Figures 68 and 69).

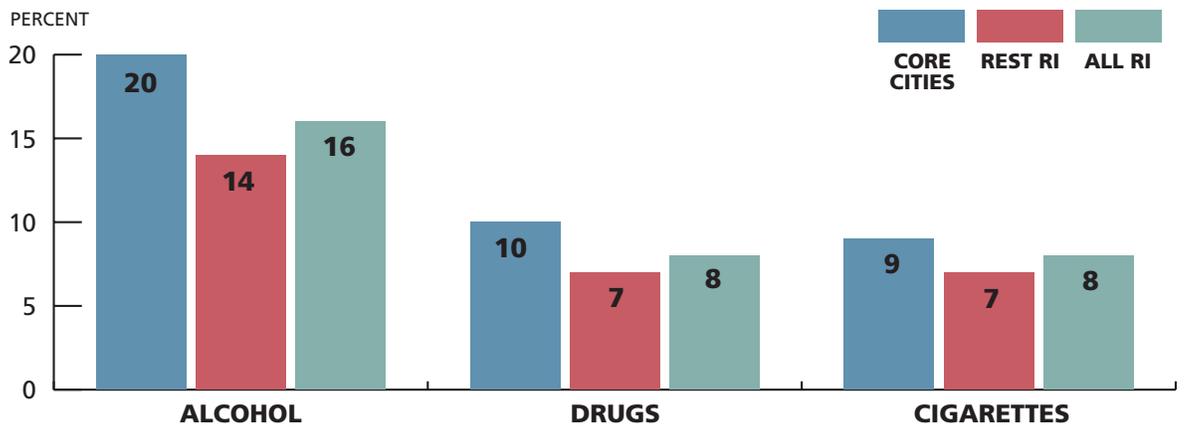
Data from the 2007-2008 SALT survey indicate a decrease in alcohol consumption among high school (38%) and middle school (27%) students. Substance use continues to be lower among core cities in Rhode Island than the rest of the state among high school students, but it remains higher among middle school students.

**FIGURE 2**  
**SUBSTANCE ABUSE AMONG HIGH SCHOOL STUDENTS BY SELECTED GEOGRAPHIC AREA**  
**RHODE ISLAND, 2007-2008**



NOTE: Data are for students reporting use in the 30 days prior to the SALT Survey  
 SOURCE: Rhode Island SALT Survey as reported in the 2008 Rhode Island KIDS COUNT Factbook

**FIGURE 3**  
**SUBSTANCE ABUSE AMONG MIDDLE SCHOOL STUDENTS BY SELECTED GEOGRAPHIC AREA**  
**RHODE ISLAND, 2007-2008**



NOTE: Data are for students reporting use in the 30 days prior to the SALT Survey  
 SOURCE: Rhode Island SALT Survey as reported in the 2008 Rhode Island KIDS COUNT Factbook

### Sexual Behavior

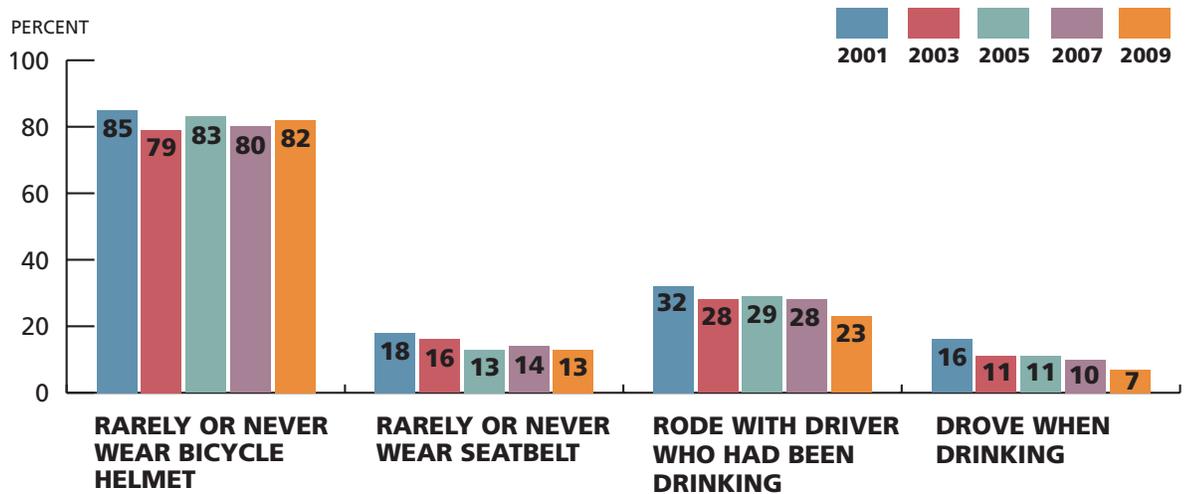
High school students (grades 9-12) are not only taking risks in the areas of tobacco, alcohol, and drugs, but they are also taking risks with sexual intercourse and behaviors that may result in unintentional and intentional injuries. According to the 2009 YRBS, 45.6% of respondents indicated they had sexual intercourse. Of the students who had sexual intercourse in the past three months, 68.2% reported they had used a condom. This represents a 22.2% increase from 1997, when 52.4% reported condom use. Additionally, among students who had sexual intercourse during the past three months, the percentage who drank alcohol or used illicit drugs before the last time they had sexual intercourse was 20.5%, down 44% from 2001 when 36.6% reported using alcohol or drugs prior to intercourse.

### Behaviors Related to Unintentional Injuries

Figure 70 summarizes the responses to YRBS questions pertaining to behaviors that result in unintentional injuries, such as bicycle helmet use, seatbelt use, riding with a driver that has been drinking alcohol, and driving a car when drinking alcohol. Data from the 2009 YRBS indicate that the percentage of students who never or rarely wear a bicycle helmet increased to 82.1% from 80.4% in 2007. However, seatbelt use decreased slightly, where 13.1% of students reported that they rarely or never wore a seatbelt. This represents an increase from the 2005 figure of 12.5%; however, it was still down from 13.7% in 2007. The percentage of students who reported they rode in a car driven by someone who had been drinking alcohol decreased to 23.1%, and the percentage of students who reported they had driven a car while they had been drinking alcohol decreased to 7.2%.

According to the 2009 YRBS middle school survey, 62.3% of students in grades 6-8 reported they never or rarely wore a bicycle helmet (among students who rode a bicycle); 9.0% never or rarely wore a seatbelt when riding in a car; and 24.3% ever rode in a car driven by someone who had been drinking alcohol.

**FIGURE 4**  
**SELECTED BEHAVIOR AMONG ADOLESCENTS THAT CAN RESULT IN UNINTENTIONAL INJURIES**  
**RHODE ISLAND, 2001-2009**



SOURCE: Rhode Island Youth Risk Behavior Survey, Rhode Island Department of Health

### Violence among Adolescents

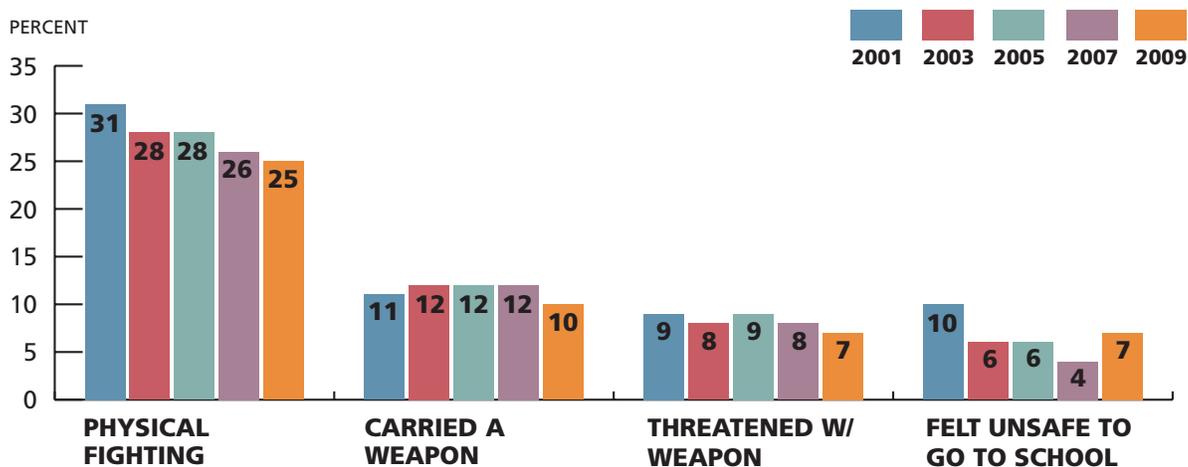
Youth violence refers to a range of negative behaviors that youth can experience as victims, witnesses, or offenders that can cause emotional harm, injury, disability, or even death. Violence and the threat of violence can impact the well-being of youth, families, schools, and communities (Source: *2010 Rhode Island KIDS COUNT Factbook*).

Nationally in 2008, almost two-thirds (61%) of children under age 18 reported being exposed to violence as a victim or witness during the previous year, almost one in five (19%) youth ages 14 to 17 reported being injured by a physical assault in the previous year, and 71% of youth reported having ever been assaulted (Source: *2010 Rhode Island KIDS COUNT Factbook*).

In 2008, juveniles made up 16% of all serious violent crime arrests in the U.S. The 2008 Rhode Island juvenile arrest rate for serious violent crimes was 186 per 100,000 youth ages 10 to 17, compared to the U.S. rate of 306 per 100,000 youth. During 2008, there were 814 juvenile arrests for assault offenses and 161 juvenile arrests for weapons offenses. In 2009, violent crimes made up 5% (359) of the 7,829 juvenile offenses referred to Rhode Island Family Court (Source: *2010 Rhode Island KIDS COUNT Factbook*).

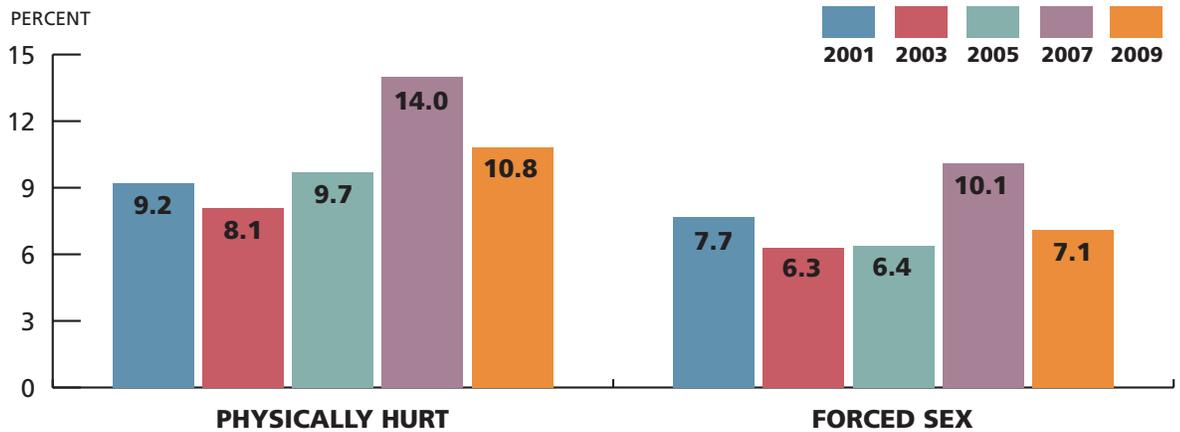
Data from the 2009 YRBS (Figure 5) indicate the percentage of students who were in a physical fight during the past year declined to 25.1%, and the percentage of students who reported they carried a weapon in the past month (10.4%) also decreased. The percentage of students who reported they had been threatened or injured with a weapon on school property decreased to 6.5%, while the percentage of students who reported they did not go to school because they felt unsafe increased to 7.4%. It should also be noted that the percentage of students reporting having ever been physically hurt by a boyfriend or girlfriend in the past year decreased to 10.8% after a high of 14.0% in 2007 (Figure 6). Additionally, 7.1% of students reported they had ever been physically forced to have sexual intercourse when they did not want to, down from a high of 10.1% in 2007.

**FIGURE 5**  
**VIOLENCE AND SAFETY AMONG ADOLESCENTS**  
**RHODE ISLAND, 2001-2009**



SOURCE: Rhode Island Youth Risk Behavior Survey, Rhode Island Department of Health

**FIGURE 6**  
**INJURY AND VIOLENCE AMONG ADOLESCENTS**  
**RHODE ISLAND, 2001-2009**



SOURCE: Rhode Island Youth Risk Behavior Survey, Rhode Island Department of Health

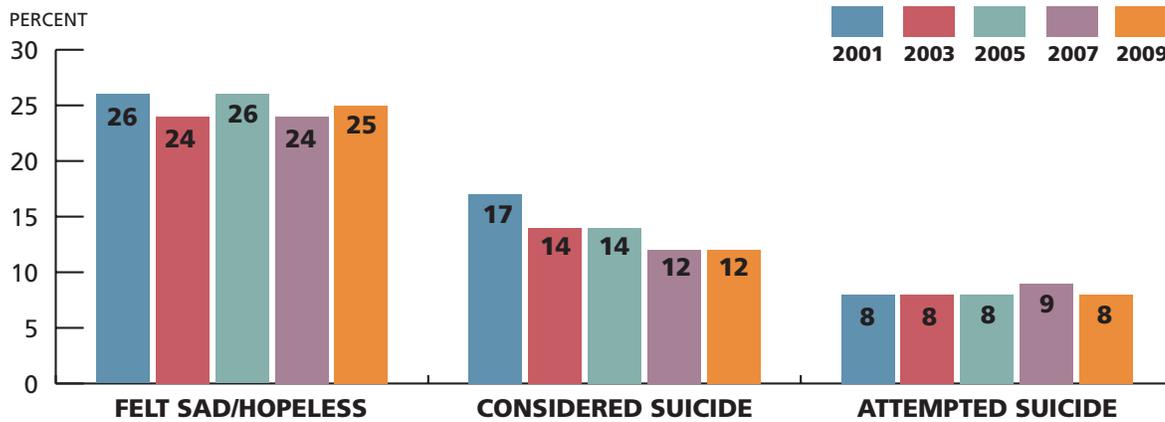
### Mental Health Issues among Adolescents

Mental health in childhood and adolescence is fundamentally important to health and well-being. It is defined as “the achievement of expected developmental, cognitive, social and emotional milestones and by secure attachments, satisfying social relationships and effective coping skills.” In Rhode Island, one in five children ages six to 17 has a diagnosable mental or addictive disorder; one in ten is functionally impaired (Source: *2010 Rhode Island KIDS COUNT Factbook*).

Behavioral and mental health problems affect children of all backgrounds. Children most at risk for mental disorders are those with prenatal exposure to alcohol, tobacco, and other drugs; children born with low birth weight, difficult temperament, or an inherited predisposition to a mental disorder; children living in poverty; those suffering abuse and neglect; children exposed to traumatic events; and children of parents with a mental health disorder (Source: *2010 Rhode Island KIDS COUNT Factbook*).

According to the 2009 Rhode Island Youth Risk Behavior Survey, approximately one out of four adolescents (25.0%) report they have felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities. However, the percentage of high school students who seriously considered attempting suicide during the past 12 months has been decreasing. In 2001, 16.5% of YRBS respondents reported they had considered suicide compared with 11.8% in 2009. The percentage of respondents who attempted suicide declined by 5% from 8.1% in 2001 to 7.7% in 2009 (Figure 7).

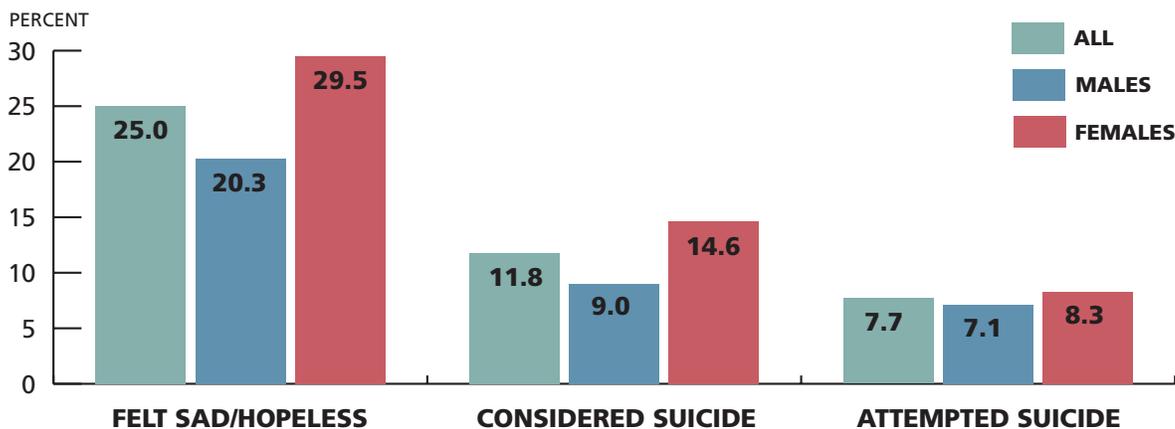
**FIGURE 7**  
**MENTAL HEALTH ISSUES AMONG ADOLESCENTS**  
**RHODE ISLAND, 2001-2009**



SOURCE: Rhode Island Youth Risk Behavior Survey, Rhode Island Department of Health

Figure 8 reflects the differences among male and female adolescents regarding feeling sad or hopeless, considering suicide, and attempting suicide. YRBS data indicate that higher percentages of female respondents reported having these feelings compared to their male counterparts. In 2009, 29.5% of female YRBS respondents reported feeling sad or hopeless compared to 20.3% of males; 14.6% of females had considered suicide compared with 9.0% of males; and approximately one in twelve (8.3%) females had attempted suicide in the past 12 months compared with 7.1% of males.

**FIGURE 8**  
**MENTAL HEALTH ISSUES AMONG ADOLESCENTS**  
**RHODE ISLAND, 2009**



SOURCE: Rhode Island Youth Risk Behavior Survey, Rhode Island Department of Health

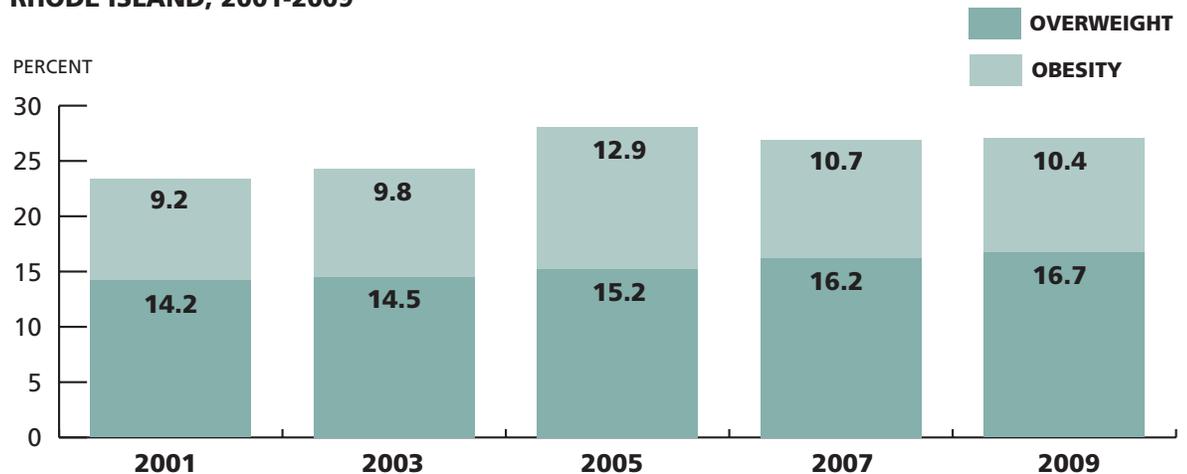
## Obesity and Adolescents

Children and adolescents who are overweight and obese are at increased risk for type 2 diabetes, asthma, heart disease, and other acute and chronic health problems throughout the life course. Aside from obesity's physical consequences, obese children and youth are susceptible to mental health and psychological conditions such as depression and low self-esteem, and they may experience social stigmatization and discrimination.

In Rhode Island in 2007, 14.4% of children ages 10 to 17 were obese, and 15.8% were overweight. In the U.S. in 2007, 16.4% of children ages 10 to 17 were obese and 15.3% were overweight, with significant disparities for racial and ethnic minorities. Nationwide, 41.1% of Black children and 41.0% of Hispanic children ages 10 to 17 were overweight or obese in 2007, compared to 26.8% of White, non-Hispanic children (Source: *2010 Rhode Island KIDS COUNT Factbook*).

According to the 2009 YRBS, the percentage of high school students who were obese (i.e. at or above the 95th percentile for body mass index, by age and gender) decreased to 10.4%, while the percentage that were overweight (between the 85th percentile and the 95th percentile for BMI by age and gender) rose to 16.7% (Figure 9) Teenagers who are obese have an 80% chance of being obese as an adult (Source: *2010 Rhode Island KIDS COUNT Factbook*).

**FIGURE 9**  
**OVERWEIGHT AND OBESITY\* AMONG ADOLESCENTS**  
**RHODE ISLAND, 2001-2009**



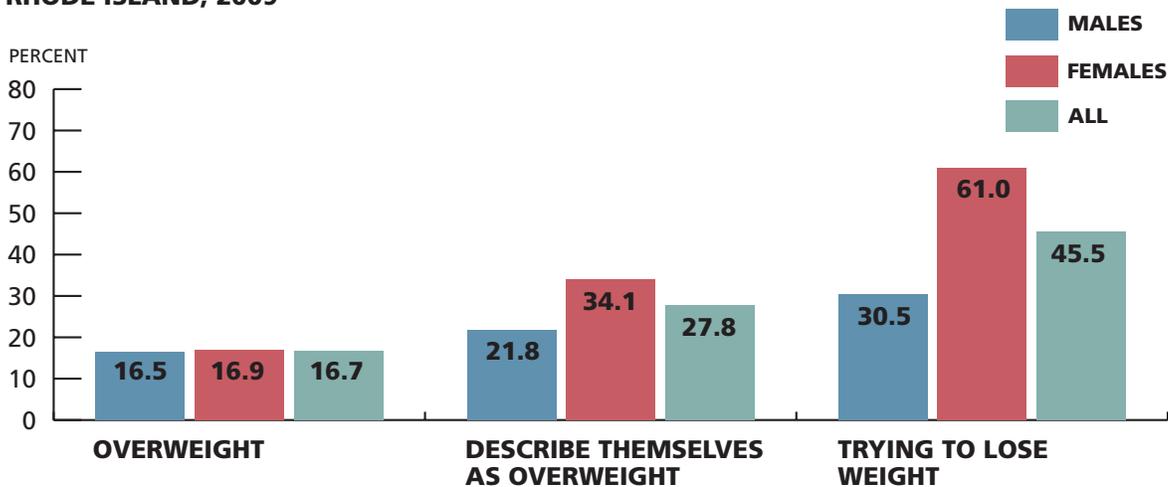
**\*NOTES:**

Overweight = between the 85th and 95th percentile for body mass index by age and sex;  
Obesity = at or above 95th percentile for body mass index by age and sex based on reference data from the National Health and Nutrition Examination Survey I

SOURCE: Rhode Island Youth Risk Behavior Survey, Rhode Island Departments of Health and Education

Based on reported heights and weights from 2009 YRBS data, males were one and a half times as likely to be obese (12.4%) than females (8.2%); similar percentages of males and females were overweight, 16.5% and 16.9%, respectively. However, females were more likely to describe themselves as overweight (34.1%) compared to males (21.8%). Female students were also twice as likely to report they were trying to lose weight (61.0%) compared to their male counterparts (30.5%) (Figure 10).

**FIGURE 10**  
**SELECTED INDICATORS OF OVERWEIGHT AMONG HIGH SCHOOL STUDENTS**  
**RHODE ISLAND, 2009**



\*Note: Overweight = BMI > 95th percentile based by age and sex based on reference data from the National Nutrition and Health Examination Survey I.

Source: Rhode Island Youth Risk Behavior Survey, Rhode Island Department of Health

Data from the 2009 YRBS indicate that 44.0% of high school students in Rhode Island participated in vigorous activity compared to 29.1% who watched three or more hours per day of TV on an average school day. Twenty-eight percent also reported using computers for non-school work three or more hours on an average school day. Rhode Island public high school students reported eating increased amounts of fruits and vegetables between 2007 and 2009, but only one in eight (13%) reported drinking recommended amounts of milk daily in 2009.

## **Sexually Transmitted Diseases (STDs)**

### **Chlamydia**

During 2004, the chlamydia rate for all teens aged 15-19 (male and female) was 14.2 per 1,000. The rate among females (23.5) was 4.6 times that for males (5.1). The chlamydia rate among teens increased between 2000 and 2004, the rate rose by 16.3%, from 12.2 to 14.2. Although rates are higher among females, the chlamydia rate rose more sharply among males (28.1%) than females (13.6%). Specifically, during 2000, there were 152 cases (3.9 per 1,000) among males and 771 cases (20.1 per 1,000) among females. By 2004, these figures increased to 195 cases (5.1 per 1,000) and 876 cases (23.5 per 1,000) for males and females, respectively.

Data for 2008 indicate that the number of cases of Chlamydia among teens aged 15-19 remained level at 916 cases among males and 2,399 cases among females compared to 2007 data where there were 892 cases among males and 2,282 among females. The number of cases (2,399) and rate of Chlamydia among female teens ages 15-19 (22.2 per 1,000) decreased slightly (4.3%) from 2005, when there were 873 cases and a rate of 23.2.

### **Gonorrhea**

Between 2000 and 2004, the number of cases of gonorrhea among Rhode Island teens aged 15-19 decreased slightly, from 206 (27.3 per 10,000) to 197 (26.1 per 10,000), a 4.4% decrease. Rates are three times higher among females than males; during 2004, the gonorrhea rate was 39.5 among females and 13.1 among males. The number of case of gonorrhea among teens aged 15-19 continued to decrease in 2005, with 29 cases among males and 73 among females.

Data for 2008 show that there were 71 cases of gonorrhea among Rhode Island teens aged 15-19, or a rate of 8.8 (per 10,000). Rates are 1.7 times higher among females than males; during 2008, the gonorrhea rate was 11.1 among females and 6.7 among males.

### **Teen Family Planning**

The Family Planning Program provides affordable, confidential family planning and related preventive health services in accordance with nationally recognized standards where evidence exists that these services should lead to improvement in the overall health of individuals with a priority for services to low-income individuals. The program expands access to a broad range of acceptable and effective family planning methods and related preventive health services that include HIV counseling, testing, and referral services and services for adolescents, including adolescent abstinence counseling.

The broad range of services provided does not include abortion as a method of family planning. With respect to adolescent clients, the program encourages participation of families, parents, and legal guardians in the decision of adolescents to seek family planning services and provides adolescents with counseling on how to resist attempts to coerce them into engaging in sexual activities. The program also assures compliance with state laws requiring the reporting of child abuse, child molestation, sexual abuse, rape, and incest.

According to Rhode Island Department of Health Program data, in 2008, the Family Planning Program served 2,677 adolescents less than 18 years of age. Of the 2,677 adolescents served, 73% were females and 24% were males. Twenty-one percent (21%) belonged to a racial minority group, and 34% reported themselves as Latino. Seventy-four percent (87%) had incomes at or below 200% of the federal poverty level.

## Teen Pregnancy

Poor school achievement, attendance and involvement are predictors of teen pregnancy and childbearing. Childbirth is the leading cause of dropping out of school among teen girls. Nationally, fewer than half of teen mothers (40%) ever graduate from high school and fewer than 2% earn a college degree before age 30. Reduced educational attainment among teen parents puts them at increased risk of unemployment, low-wage jobs, and poverty (Source: 2010 Rhode Island KIDS COUNT Factbook).

Based on 2006 data when Rhode Island's teen birth rate was 27.8 per 1,000, Rhode Island is ranked 9th in the country (1st is best) for teen birth rates and 6th (6th is worst) among the six New England states. The national rate in 2006 was 41.9 (Source: *2010 Rhode Island KIDS COUNT Factbook*).

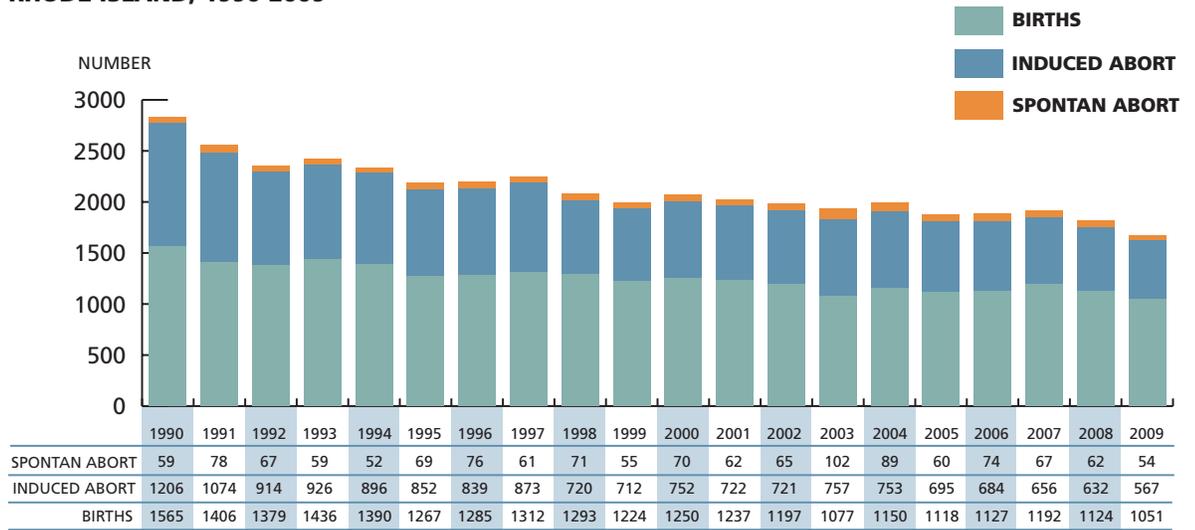
A repeat birth during adolescence compounds educational, economic, developmental, and health problems for both the mothers and their children. Once a teenager has a baby, she is at increased risk of having another baby as a teen. In 2006, Rhode Island ranked 8th nationally (tied with Louisiana, New Mexico, and Alaska) for the highest percentage of repeat teen births. Between 2004 and 2008, 18% of the births to teens 15-19 were repeat births (Source: 2010 Rhode Island KIDS COUNT Factbook). It important to note that while RI does a good job preventing first time teen births, repeat births are high. RI needs to do a better job at preventing repeat births.

In 2009 in Rhode Island, there were 1,051 babies born to mothers under age 20, accounting for 9% of all babies born in the state. Researchers estimate that approximately 11% of Rhode Island girls (vs. 18% of all girls in the U.S.) will become teen mothers (Source: *2010 Rhode Island KIDS COUNT Factbook*).

While teen pregnancy occurs in families of all income levels, teen pregnancy and childbearing are strongly associated with poverty. As many as 83% of teen mothers are from poor or low income families. There is a strong inter-generational pattern of early childbearing. At least one-third of teen parents (both teen mothers and fathers) were the children of adolescent mothers themselves (Source: *2010 Rhode Island KIDS COUNT Factbook*).

Since 1990, the number of pregnancies (live births, spontaneous abortions, and induced abortions) among Rhode Island teens aged 15-19 has been declining. In 1990, there were 2,830 pregnancies, and by 2000 this number had decreased by 26.8% to 2,072. Between 2005 and 2009, the number of teen pregnancies continued to decline to 1,672 pregnancies (Figure 11). During this same period, the outcomes of teen pregnancies have changed, resulting in more births and fewer abortions. In 1990, 1,565 (55.3%) of the pregnancies resulted in live births, 1,206 (42.6%) induced abortions, and 59 (2.1%) spontaneous abortions. Provisional data indicate that during 2009, 1,051 (62.9%) of the pregnancies were live births, 567 (33.9%) were induced abortions, and 54 (3.2%) were spontaneous abortions.

**FIGURE 11**  
**NUMBER OF PREGNANCIES AMONG TEENS\* BY OUTCOME**  
**RHODE ISLAND, 1990-2009\***

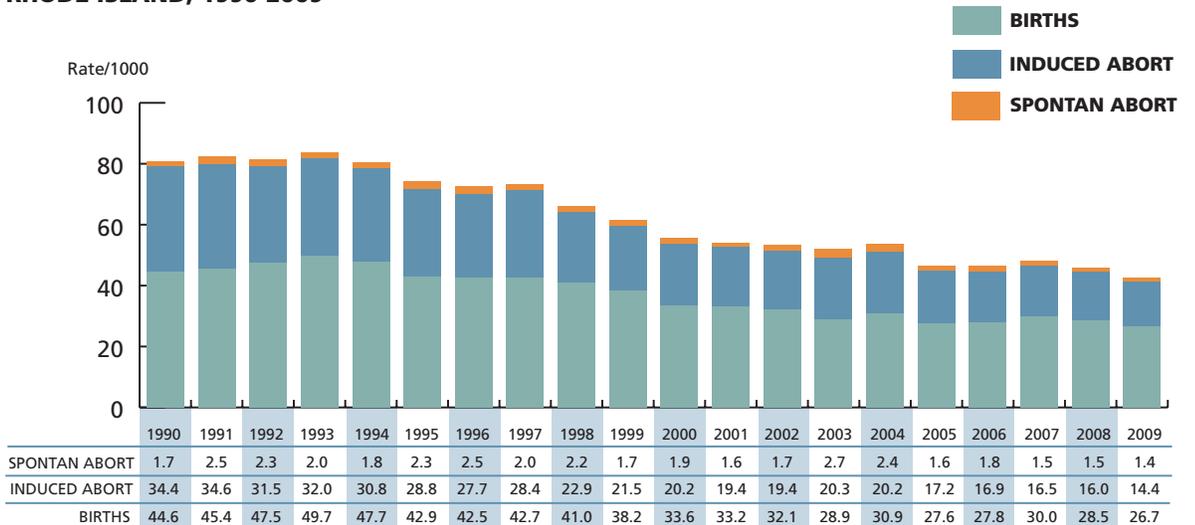


\*Notes: Teens aged 15-19; 2009 data are provisional

Source: Maternal and Child Health Database, Rhode Island Department of Health

Rates of teen pregnancies have also declined during the past 15 years. The teen pregnancy rate is the number of pregnancies among teens aged 15-19 per 1,000 female teens aged 15-19. Rates presented are calculated using U.S. Census Population (2000). In 1990, the teen pregnancy rate among 15-19 year-olds was 80.6, and by 2009 the rate dropped to 42.5 (provisional), representing a 47.4% decrease (Figure 12). During this period, the birth rate decreased by 59.9% from 44.6 in 1990 to 26.7 in 2009, and the induced abortion rate fell by 58.1% from 34.4 in 1990 to 14.4 in 2009.

**FIGURE 12**  
**PREGNANCY RATES AMONG TEENS\* BY OUTCOME**  
**RHODE ISLAND, 1990-2009\***



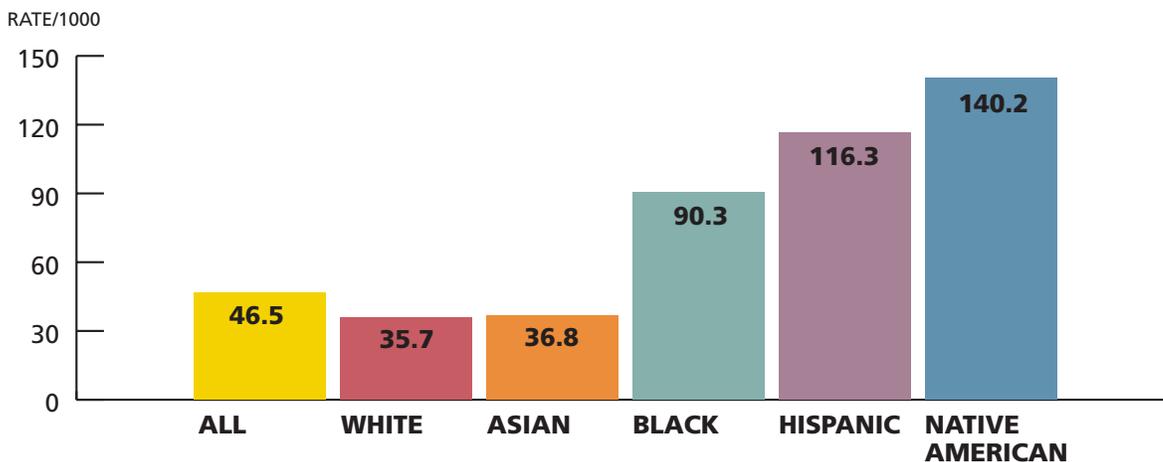
\*Notes: Teens aged 15-19; Rates are calculated using US Census data; 2009 data are provisional

Source: Maternal and Child Health Database, Rhode Island Department of Health

## Racial Disparities

Although teen pregnancy rates have been decreasing, there is much variation among racial/ethnic groups. Figure 13 illustrates the differences in teen pregnancy rates by race/ethnicity during 2005-2009. Whites (35.7) and Asians (36.8) had the lowest teen pregnancy rates, while Native Americans (140.2), those of Hispanic/Latino ethnicity (116.3), and Black/African Americans (90.3) had the highest rates. As previously stated, rates for Native Americans are not considered to be statistically reliable due to the relatively small population of Native American females aged 15-19 (n = 251). These rates are based on 2006 U.S. Census projections.

**FIGURE 13**  
**TEEN PREGNANCY RATES BY RACE/ETHNICITY**  
**RHODE ISLAND, 2005-2009**



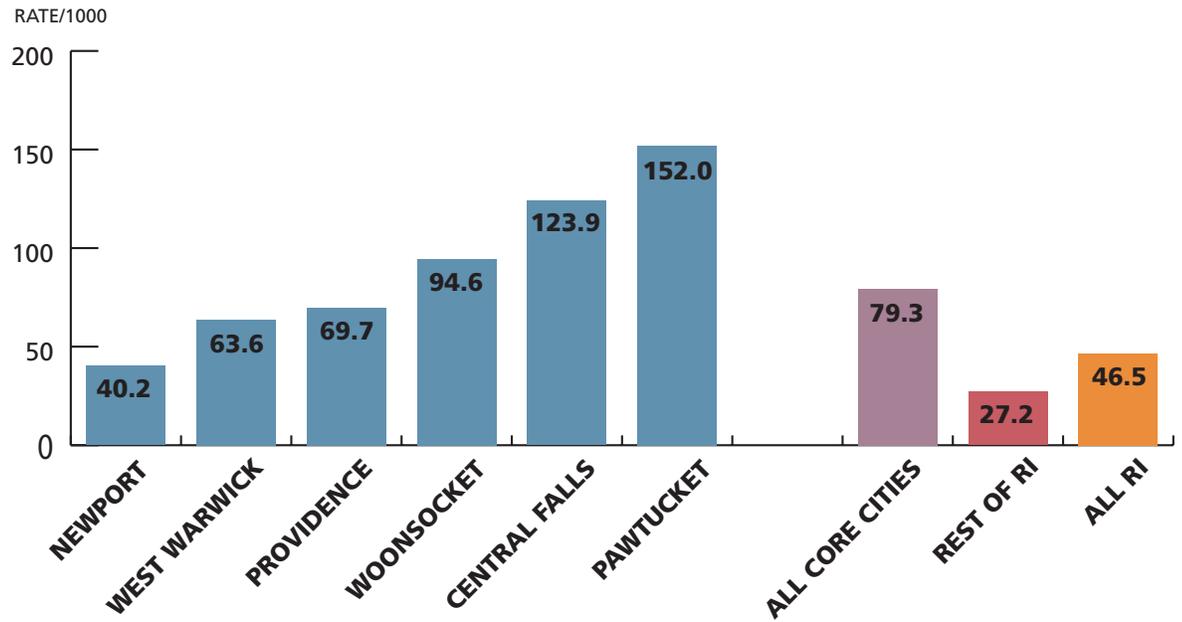
\*Notes: Teens aged 15-19; Rates are calculated using 2006-2008 US Census data; data are provisional; Native American rate based on small numerator and denominator

Source: Maternal and Child Health Database, Rhode Island Department of Health

## Geographic Disparities

Nearly three-quarters or 3,903 (69.5%) of the 5,612 Rhode Island teenagers aged 15-19 who became pregnant during 2005-2009 lived in the core cities. Teens residing in the core cities (79.3) were three times more likely to become pregnant compared to teens living in the rest of the state (27.2). Teens living in Central Falls (123.9) and Pawtucket (152.0) had the highest pregnancy rates, which were of four to six times the rate of the rest of the state. Teen pregnancy rates were also 2-3 times higher among those living in Woonsocket (94.6), Providence (69.7), and West Warwick (63.6) than those living in the rest of the state (Figures 14 and 15). Compared to the other core cities, teens residing in Newport had the lowest pregnancy rate (40.2), which was nearly half of the overall core city rate (79.3) and lower than the statewide average (46.5).

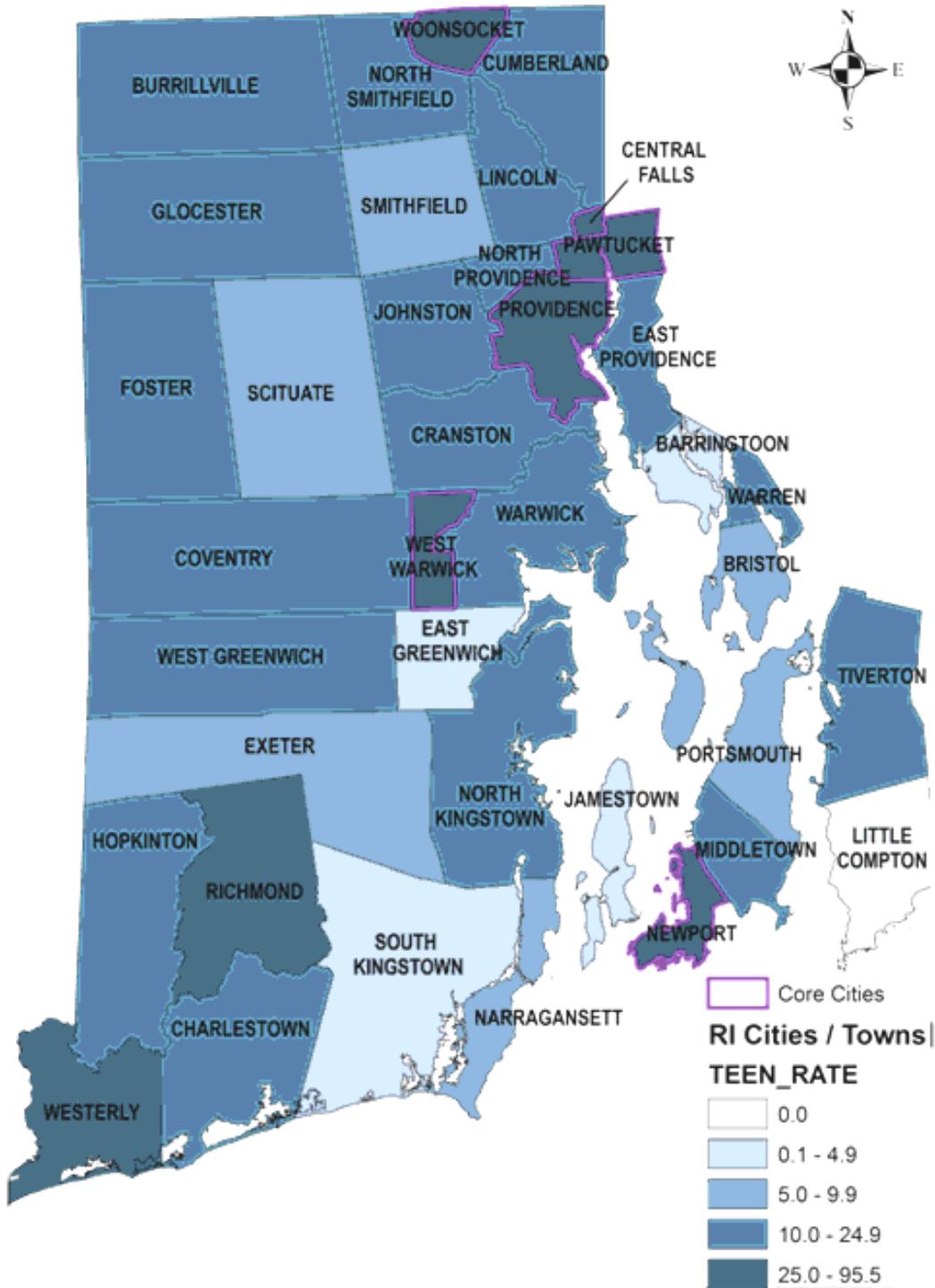
**FIGURE 14**  
**TEEN PREGNANCY RATES BY SELECTED CITY/TOWNS**  
**RHODE ISLAND, 2005-2009**



\*Note: Teens aged 15-19

Source: Maternal and Child Health Database, Rhode Island Department of Health

**FIGURE 15**  
**BIRTH RATE (PER 1000) FOR TEENS (15-19) BY CITY/TOWN**  
**RHODE ISLAND, 2004-2008**



## **Adolescent Self Sufficiency Collaborative**

The Adolescent Self Sufficiency Collaborative (ASSC), which is funded by the Rhode Island Department of Human Services, is a statewide network of social service and community health agencies providing services to pregnant and parenting teens aged less than 20 in Rhode Island. Each teen is provided with a case manager who provides information and helps with accessing services, such as Family Independence Program cash assistance, RIte Care Medical Assistance, Food Stamps, WIC, educational requirements and services, employment and training opportunities, childcare assistance, etc. During FY2006, the ASSC provided 5,655 case management services to 1,376 pregnant or parenting teens. More than half (58.6%) of ASSC pregnant and parenting teens were in school, GED or an ESL program, and 22% had graduated high school. Among the teens served, 44.6% were White, 15.6% were Black/African American, and 34.8% were of Hispanic/Latino ethnicity (Source: *“Teen Births in Rhode Island: An Evaluation of the RI Department of Human Services Adolescent Self Sufficiency Collaborative”*).

## **Youth in Out-of-Home Placement**

Youth in out-of-home care regularly experience multiple placements, lose contact with family members, and often have overlooked or neglected educational, physical, and mental health needs. Children in out-of-home care suffer more frequent and more serious medical, developmental, and mental health problems than their peers most likely due to their lack of consistent guardianship (Source: *2010 Rhode Island KIDS COUNT Factbook*).

Research shows that racial and ethnic minorities are over-represented at all points in the child welfare system, including reporting, investigation, substantiation, placement, and exit from care. Minority children in child welfare systems experience significantly worse outcomes, have more placement changes, receive fewer supports, stay in care longer, are less likely to be adopted or reunited with their families, have fewer contacts with caseworkers, have less access to mental health and substance abuse services, and are placed in detention or correctional facilities at higher rates than White children (Source: *2010 Rhode Island KIDS COUNT Factbook*).

Youth who age out of foster care experience high rates of poverty, homelessness, unemployment, and incarceration. They are also at increased risk for early parenthood and becoming a victim of a violent crime. In 2009 in Rhode Island, there were 1,056 youth ages 13 to 17 and 237 youth ages 18 to 21 who were in the care or custody of the Rhode Island Department of Children, Youth and Families (DCYF). Beginning at age 16, youth develop a transitional living plan that helps to identify services and supports their need to move toward self-sufficiency. In Rhode Island in Federal Fiscal Year 2009, 151 youth aged out of foster care to emancipation never having gained permanent placement through reunification, adoption, or guardianship (Source: *2010 Rhode Island KIDS COUNT Factbook*).

## **Homeless Youth (Aged 13-17)**

According to the 2010 Rhode Island KIDS COUNT Factbook, in Rhode Island between July 2008 and June 2009, 248 youth between the ages of 13 and 17 received shelter through the emergency shelter system in Rhode Island. This is a 3.5 fold increase since

1998, when 68 youth entered the Rhode Island Emergency Shelter System. These youth are vulnerable to being separated from their families due to shelter or State child welfare policies. Since many of the emergency and domestic violence shelters do not accept unaccompanied children over the age of twelve, this figure is most likely an underestimation of the number of youth in need of shelter.

On December 31, 2009, there were 69 youth in the care of the Rhode Island DCYF who were classified as unauthorized absences/runaways (AWOL), 31 of whom were female and 38 of whom were male. These youth were AWOL from either foster care or juvenile justice placements (Source: *2010 Rhode Island KIDS COUNT Factbook*).

One emergency shelter in Rhode Island meets the needs of unaccompanied and runaway homeless youth. During 2009, there were 14 unaccompanied youth ages 12 to 18 who received emergency shelter for up to 21 days, and five youth ages 17 and 18 who received long-term residential and supportive services. These programs are funded through the federal Runaway and Homeless Youth Program (Source: *2010 Rhode Island KIDS COUNT Factbook*).

In 2009, the National Runaway Switchboard handled 193 crisis-related calls from Rhode Island regarding youth ages 21 and under who were homeless, runaways, or at risk of homelessness. Nationally, in 2009, 50% of callers to the hotline were youth, and the rest were friends, family, and other adults (Source: *2010 Rhode Island KIDS COUNT Factbook*).

## **Academic Performance and Health Risks**

### **Middle School Students**

According to 2007 Youth Risk Behavior Survey (YRBS), data show that 7% of Rhode Island public middle school students report receiving mostly D and F grades. This represents about 2,300 students statewide. Another 19% received mostly C's. Students in 8th grade vs. 6th grade, those that speak primarily non-English at home, and those with emotional or learning disabilities were more likely to report mostly D's and F's. Compared to students receiving high grades (mostly A's and B's), students receiving low grades (mostly D's and F's) were at greater risk for 25 of the 28 behaviors listed in this report. Prevalence rates among "C" students were generally between those with higher and lower academic achievement.

Students with low grades were over four times more likely than students with high grades not to wear a seatbelt and two times more likely to have ever carried a weapon. They were also at increased risk for other injury related activities (e.g. not wearing helmets, riding with a driver who has been drinking, physical fighting). Students with D and F grades were much more likely to engage in tobacco use behaviors, especially current cigarette smoking (nine times greater) and current smokeless tobacco use (11 times greater).

Students with low grades were five times more likely to have ever used marijuana and three to four times more likely to have ever tried alcohol, cocaine, inhalants, steroids, and painkillers. Students with D and F grades were also more likely to fast in order to lose or maintain weight, watch TV for 3+ hours daily, play video games or use a computer for 3+ hours daily, and not play on sports teams. There was no difference between

students with high and low grades for self-perception of overweight, purging to lose or maintain weight, and insufficient physical activity.

### **High School Students**

According to 2007 YRBS, data show that 7% of Rhode Island public high school students received mostly D and F grades. This represents nearly 3,500 students statewide. Another 25% received mostly C's. 9th graders, non-heterosexuals, and students with emotional/learning disabilities were more likely to report D's and F's. Compared to students receiving high grades (mostly A's and B's), students receiving low grades (mostly D's and F's) were at greater risk for 27 of the 30 behaviors listed in this report. Prevalence rates among "C" students were consistently between those with higher and lower academic achievement.

Students with low grades were five times more likely than students with high grades not to wear a seatbelt and four times more likely to drive after drinking alcohol or to carry a weapon. They were also at increased risk for other violence related behaviors (e.g. not going to school due to unsafe feelings, threatened/injured at school, physical fighting, dating violence, forced sexual intercourse, sad/hopeless feelings, considering suicide). Students with D's and F's had a higher prevalence for ever trying cigarettes and currently smoking and, especially, for trying cigarettes at any early age.

Students with low grades were more likely to have tried alcohol or to be current alcohol drinkers. The same was true for marijuana use and having ever taken painkillers. They were also four to five times more likely to have used cocaine or inhalants. More students with low grades had ever had sex or were currently sexually active, and six times as many initiated sex very young. Obesity and nutritional risks were similar for the two groups, but students with low grades were more likely to have insufficient physical activity.

### **Implications for Middle School and High School Students**

Academic success depends on healthy students learning in safe and caring schools. The YRBS data show that students who struggle academically are much more likely to engage in risky behaviors. Research demonstrates that schools that focus on health and safety can profoundly impact academic achievement. School and community efforts should concentrate on the following activities in order to support positive health and academic outcomes:

- Empower local District Health and Wellness subcommittees to adopt policies, strategies and plans to strengthen the connection between health and wellness and academic achievement in the school community.
- Integrate the relationship between healthful behavior and academic achievement within school improvement and district strategic plans.
- Encourage school nurse teachers, health and physical education teachers, social workers, guidance counselors, school psychologists, and all teachers and administrators to identify and act on opportunities to promote health.
- Create interventions to address youth behavioral & mental health care needs.

- Form partnerships with health and local organizations, after school providers, and others that can provide resources and support to schools.
- Provide professional development that meets all student needs.
- Promote the link between health and academic achievement among educational leaders.

### **Sexual Orientation and Health Risks among High School Students**

According to 2007 YRBS data, 10% of students (representative of 5,000 statewide) identified themselves as Lesbian, Gay, Bisexual, or Unsure (LGBU). Females and students with physical or emotional/learning disabilities were more likely to be LGBU. Compared to heterosexuals, LGBU students had a greater risk for 27 of 30 behaviors listed in this report and a similar risk for the other three behaviors (weapon carrying, condom use, and overweight/obesity).

LGBU students were more likely to engage in risky safety behaviors (e.g. not wearing a seatbelt, riding in a vehicle with a driver who has been drinking). They were also at increased risk for violent behaviors (e.g. being threatened or injured with a weapon at school, physical fighting, dating violence, sad and hopeless feelings). They were much more likely to skip school due to unsafe feelings, be forced to have sexual intercourse, or attempt suicide. LGBU students had a higher prevalence for ever trying cigarettes or alcohol and for being current users of cigarettes, any tobacco product, or alcohol.

LGBU students were more likely to have ever used marijuana or taken painkillers and much more likely to have ever used cocaine, inhalants, or ecstasy. More LGBU students were sexually active, initiated sex at an early age, had multiple sex partners, or had not had AIDS/HIV education. They engaged in fasting more often and were more likely to get insufficient physical activity. Emotional and learning disabilities were also much more prevalent among LGBU students.

### **Implications for High School LGBU Students**

2007 YRBS data provide an opportunity to identify the impacts of sexual orientation on youth behavior and outcomes. Although all students participate in some risky behaviors, the data indicate that students who identify as LGBU engage in these behaviors more consistently and to a more unhealthy level. LGBU youth need targeted school and community programs to support and promote more positive outcomes, such as:

- Programs and policies that support self-esteem and diversity.
- Connections to LGBU knowledgeable and supportive adults.
- Interventions addressing youth behavioral and mental health care needs.
- Increased emphasis on creating and maintaining safe schools for LGBU youth.
- Academic intervention that ensures the integration of LGBU related issues.
- Professional development for teachers/administrators on LGBU issues.
- Support for the development of gay/straight alliances in schools.

## School Attendance/Suspensions

### School Attendance

Poor school attendance affects school achievement and can lead to school failure. Research has shown that having established relationships between students and their teachers and their classmates can positively impact attendance. Students are more likely to stay in school if they are engaged and have a sense of belonging. According to the 2010 Rhode Island Kids Count Factbook, in Rhode Island, during the 2008-2009 school year, 94% of middle school students and 91% of high school students enrolled in public schools attended school, based on average daily attendance. Additionally, almost half (47%) of middle and high school students in Rhode Island were absent for five or fewer days. Nearly a quarter (24%) of middle school students and 33% of high school students were absent for 12 days or more.

Attendance rates were lower among students residing in the core cities (87%) compared to students residing in the rest of the state (93%). Students enrolled in Providence schools had the lowest attendance rate of 85%. Improving the core cities' high school attendance rate from the current rate of 87% to 93% (the rate in the remainder of the state) would mean that on average 890 more students would be attending high school in the core cities each day of the school year (Source: *2010 Rhode Island KIDS COUNT Factbook*).

Truancy is defined as ten or more unexcused absences in a school year by the U.S. Department of Education and the Rhode Island Department of Elementary and Secondary Education. When a student in Rhode Island is truant s/he may be referred to the Rhode Island Truancy Court by school administrators. The goal of the Truancy Court is to work with families, schools, and communities to address the individual causes of truancy through monitoring, counseling, tutoring, and other support services for students. The number of Rhode Island students charged with truancy more than quadrupled between 1997 and 2008, from 265 students to 1,214 students (Source: *2010 Rhode Island KIDS COUNT Factbook*).

### Suspensions

According to the 2010 Rhode Island KIDS COUNT Factbook, during the 2008-2009 school year there were 42,714 disciplinary actions. These disciplinary actions were attributed to 15,829 students, an average of 2.7 actions per student. Over half (59%) of the disciplinary actions were out-of-school suspensions. The number of actions per 100 students residing in the core cities (46) was more than twice that among students in the rest of the state (22). Woonsocket students had the highest rate of disciplinary actions, 81 per 100 students.

Attendance-related offenses were the leading type of infraction and accounted for 14,405 (34%) of the disciplinary actions. Disorderly conduct (16%), insubordination/disrespect (16%), and fighting (6%) were other major causes for the actions. During 2008-2009, almost one-third, or 13,272 (31%), of the disciplinary actions in Rhode Island public schools were attributed to 4,450 students enrolled in special education, accounting for 28% of the total number of students disciplined (Source: *2010 Rhode Island KIDS COUNT Factbook*).

## High School Graduation

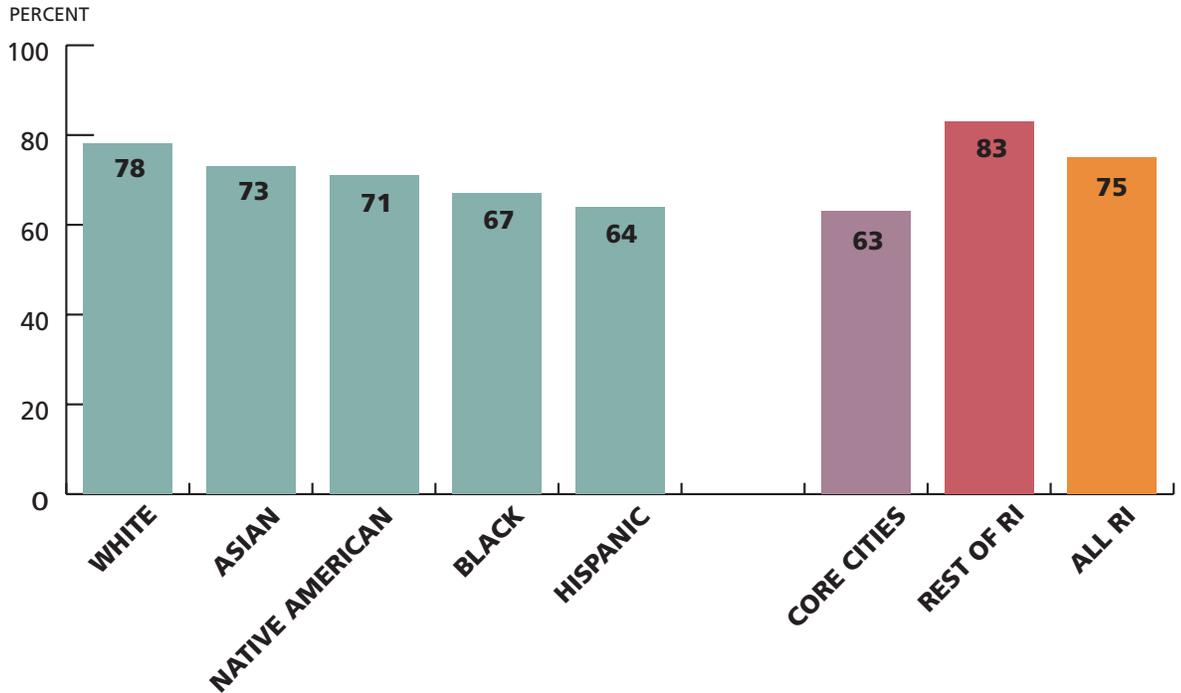
High school graduation rate is defined as the number of graduates divided by the estimated size of the 12th grade class had no one dropped out. In Rhode Island during 2009, the high school graduation rate was 75%, the dropout rate was 14%, 5% of students completed their GEDs within four years of entering high school, and 6% were still in school in the fall of 2009.

High school graduation rates varied by gender, race/ethnicity, and geographical areas (Figure 16). The Rhode Island four-year graduation rate for the class of 2009 was 71% for males and 80% for females. While female students have lower dropout rates than males, national data show that female dropouts are significantly more likely to be unemployed and earn less on average than male dropouts from the same racial and ethnic group.

Poverty is strongly linked to the likelihood of dropping out. Students in the core cities in Rhode Island are more than twice as likely to drop out of high school as students in the remainder of the state. Minority students also are more likely than White students to drop out of school. However, lower graduation rates in minority communities mainly are driven by higher poverty rates and lower rates of educational attainment among adults in the community. Graduation rates were highest among White students (80%) and lowest among students of Hispanic/Latino ethnicity (64%). Asian students (73%), Black students (67%) and Native American students (71%) also had graduation rates that were lower than the rate for Whites. Students living in the core cities had the lowest graduation rates (63%) compared to students living in the rest of the state (83%). Specifically, students living in Central Falls (47%), Pawtucket (55%), Woonsocket (62%), Providence (66%), and West Warwick (69%) had the lowest graduation rates in the state (Source: *2010 Rhode Island KIDS COUNT Factbook*).

According to the 2010 Rhode Island KIDS COUNT Factbook, in 2006, Rhode Island was ranked 24th (1st is best) in the country for the percentage of teens who were high school graduates (73%). The national high school graduation rate for 2006 was 69%.

**FIGURE 16**  
**HIGH SCHOOL GRADUATION RATES BY RACE/ETHNICITY**  
**AND SELECTED GEOGRAPHICAL AREAS**  
**RHODE ISLAND, 2009**



Source: 2010 Rhode Island KIDS COUNT Factbook, RI KIDS COUNT, Providence, RI

### Teens Not in School and Not Working

Teens who are not in school and not working are at especially high risk for teen parenting, crime, risk behaviors, and limited economic prospects. Between 2006 and 2008, an estimated 4,323 (7%) youth ages 16 to 19 were not in school and not working in Rhode Island. Of the youth who were not in school and not working, 48% were females and 52% were males. Forty-five percent (45%) of these youth were high school graduates, and 55% percent had not graduated from high school. Rhode Island is ranked 7th (1st is best) in the country for the percentage of teens not in school and not working. This ranking is based on an average of 2002-2007 data (*Source: 2010 Rhode Island KIDS COUNT Factbook*).

Education has an impact on the likelihood of finding and maintaining employment, regardless of race or ethnicity. In 2008, people with less than a high school diploma in Rhode Island were nearly twice as likely to be unemployed as those who attained a high school degree or equivalent and were almost five times as likely to be unemployed as those who received a bachelor's degree (*Source: 2010 Rhode Island KIDS COUNT Factbook*).

Identifying successful strategies to connect youth to school and work is fundamentally important to long-term economic and physical well-being. These strategies must be broad and include reform and redesign of community systems, community engagement in schools, early identification of youth at risk of dropping out of school, targeted

workforce development programs, and multiple pathways to high school graduation and employment. A key indicator of youth connectedness to school and work is high school graduation. Programs and alternative schools that enable students to earn college credits while working towards their high school degree can improve high school graduation rates and better prepare students for high-skill careers (Source: *2010 Rhode Island KIDS COUNT Factbook*).

### **Juveniles Referred to Family Court**

Many risk factors discussed previously such as, poverty, family violence, substance abuse, mental health problems, poor school performance, etc. can lead to juvenile involvement with the justice system. Programs that focus on prevention, early intervention, and positive youth development have been shown to be the most cost-effective approaches to reducing juvenile delinquency.

According to the *2010 Rhode Island KIDS COUNT Factbook*, the Rhode Island Family Court has jurisdiction over all juvenile offenders referred for wayward and delinquent offenses. All referrals to Family Court are from state and local law enforcement agencies, with the exception of truancy cases, which are referred by local school departments.

In 2009, 4,825 juveniles aged 10-17 were referred to Juvenile Court for 7,829 offenses, down from 5,242 youth and 8,790 offenses in 2008. Of the 7,829 juvenile offenses, 24% were for property crimes. The next most frequent types of offenses are disorderly conduct (19%), status offenses (19%), simple assault (10%), alcohol and drugs (9%), motor vehicle offenses (5%), violent offenses (5%), and weapon offenses (3%).

### *Disparities*

Juveniles living in Providence account for over one-fourth (27%) of all juvenile offenses referred to Family Court. Over half (51%) of the juvenile offenses were committed by teens aged 16 and 17, 34% were by teens aged 14 and 15, 14% were by teens aged 13 or younger, and only 1% was by teens aged 18 or older. Less than half (44%) of the juvenile offenders were White, 18% were Black/African American, 12% were of Hispanic/Latino ethnicity and 2% were Asian.

### **Juvenile Offenders and Mental Health**

According to the *2010 Rhode Island KIDS COUNT Factbook*, youth in the juvenile justice system experience higher rates of mental health disorders than youth in the general population. Two-thirds of youths in juvenile justice custody in the United States meet the criteria for one or more mental disorders, and at least one in five has mental health problems that are serious enough to interfere with their functioning.

During 2008, all youth adjudicated to the Training School received counseling services as part of their service plans, and 156 youth received mental health services for psychiatric diagnoses other than conduct and substance abuse disorders; 54 males participated in the residential substance abuse treatment program. During the week of January 10, 2008, half of the youth in the Training School were receiving outpatient substance abuse treatment. (Source: *2010 Rhode Island KIDS COUNT Factbook*)

## Juveniles at the Rhode Island Training School

Risk factors for youth being incarcerated in the Training School include school failure, mental health problems, substance abuse, learning disabilities, and family violence. In 2008, 1,084 youth were in care and custody at the Rhode Island Training School. Among these youth, 21% were aged 13-15, 56% were aged 16-17, and 24% were aged 18-21. One quarter, 258 (25%) had been admitted previously, 64 of whom had been at the Training School three or more times. On January 1, 2009, there were 305 youth adjudicated at the Training School (Source: *2009 Rhode Island KIDS COUNT Factbook*).

## Teen Deaths

As discussed earlier, individual, family, community, and environmental factors can protect teens from the effects of risk behaviors and can reduce the teen death rate. Protective factors such as parental involvement, feeling connected to adults in the community, having high self-esteem, access to and participation in extracurricular activities, and access to mental health services can help teens to manage their response to conflict and stress.

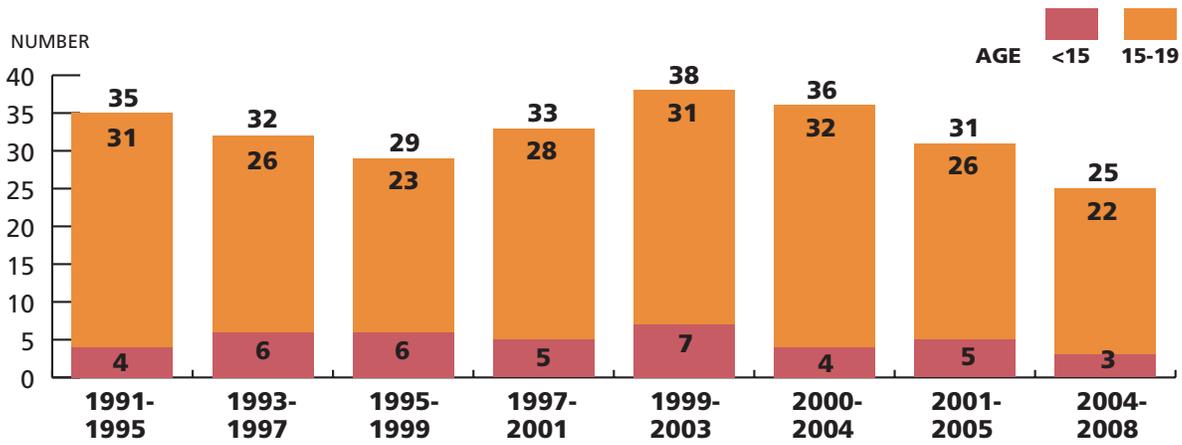
During 2004-2008, there were 153 (38.5 per 100,000) teens aged 15-19. Among these deaths, 39 (25%) were due to disease, 39 (25%) were due to intentional injuries, 72 (47%) were due to unintentional injuries, one (1%) was due to undetermined injuries, and two (1%) were due to unknown causes. In total, 112 of the 153 teen deaths were caused by unintentional injuries, with half involving motor vehicles (n=56, 50%). Of the teens ages 15 to 19 who died between 2004 and 2008, 57 (37%) lived in the core cities and 96 (63%) lived in the remainder of the state.

Among the intentional injury deaths, 20 were homicides and 19 were suicides (three females and 16 males). According to the 2009 Rhode Island Youth Risk Behavior Survey, 7% of male high school students and 8% of female high school students in Rhode Island reported having attempted suicide in the previous year, and 9% of male high school students and 15% of female high school students reported seriously considering suicide in the previous year. Female middle school students in Rhode Island (8%) were twice as likely to report having ever attempted suicide compared to their male peers (4%).

## Gun-Related Deaths and Hospitalizations

Guns are the leading cause of fatal teen violence and are used in more than three-quarters (82%) of teen homicides in the U.S. In Rhode Island between 2004 and 2008, there were 46 gun-related hospitalizations of youth ages 15 to 19 and 22 deaths of youth ages 15 to 19 attributed to firearms. Figure 83 shows the number of gun deaths among children and youth during 1991-2008 in five-year periods. Children living in states with the highest levels of gun ownership are 16 times more likely to die from unintentional firearm injury, seven times more likely to die from firearm suicide, and three times more likely to die from homicide than children living in the states with the lowest levels of gun ownership (Source: *2010 Rhode Island KIDS COUNT Factbook*).

**FIGURE 17**  
**GUN DEATHS AMONG CHILDREN AND YOUTHS**  
**RHODE ISLAND, 1991-2008**



SOURCE: Hospital Discharge Database, Rhode Island Department of Health

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