NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

17-03

STATEMENT OF POLICY

Comprehensive Adolescent Health

Policy

The National Association of County and City Health Officials (NACCHO) supports national, state, and local public health approaches that promote the health of individuals across the lifespan and affirms the need for a comprehensive approach to health for adolescents, who face unique needs and barriers during the course of their transition to young adulthood.

NACCHO recommends that local, state, and federal public health agencies do the following:

- Ensure access to timely, confidential, affordable, and equitable healthcare services aligned with evidence-informed or evidence-based practices that respond to adolescents' physical, mental, and psychosocial development, while supporting adolescent skill-building related to managing their own health and healthcare needs.
- Educate providers, caregivers, and adolescents regarding minor consent laws that enable mature adolescents under the age of 18 to make informed decisions regarding their healthcare, specifically for services related to contraception, prenatal care, HIV/STI testing and treatment, substance use treatment, and outpatient mental health services. (While statutes vary by jurisdiction, mature minor rules enable the medical provider to deem an adolescent under the age of 18 mature enough to consent to medical services without parental consent by considering factors such as age, intelligence, marital and parental status, economic independence, and decision-making skills.)
- Consider confidentiality concerns when providing billable services and implement alternative billing structures, such as self-pay or sliding fee scales, for adolescents with confidentiality concerns.
- Utilize Positive Youth Development (PYD) approaches to improve the health and well-being of adolescents by enhancing positive youth assets and resiliency.
- Collaborate with youth-serving entities and organizations, such as schools, community-based organizations, juvenile detention facilities, and social service organizations, to ensure access to comprehensive services that support health and facilitate referrals to youth-friendly healthcare.

Justification

Adolescence is a transitional period in which young people experience biological and neurological changes, explore gains in independence, and learn to engage in responsibilities of adulthood; it is marked by significant cognitive, social, and emotional changes.[1] Universally, there is no standard definition of what ages comprise "adolescence," but the World Health

Organization states that the most consistent range is 10-19 years, with further divisions for early adolescence (10-14 years) and late adolescence (15-19 years).[2]

Biological, hormonal, and physical changes during adolescence, such as growth in height and muscle mass or puberty, are marked by rapid developmental spurts, lack of coordination between processes (e.g., physical changes preceding neurologic maturation), and dependence on a complex interplay between external and internal factors.[3] Research highlights the role of understanding neurodevelopmental changes, including unique neural plasticity, as a key factor in developing programs to effectively meet adolescent needs.[4] This data contextualizes common "risky" behaviors associated with adolescence and situates them within the processes of limbic and pre-frontal cortex development influencing pleasure-seeking, emotional responses, sleep regulation, impulse control, and both short- and long-term decision-making.[5] Additional developments in research highlight the roles that social, cultural, economic, and educational environments play in influencing adolescent health decision-making and health outcomes, illustrating the need for cooperative efforts by families, peers, schools, neighborhoods, and health programs.[6,7]

Although adolescence typically represents a healthy stage of life, with 83% of adolescents ages 12-17 described as being in "excellent or very good health" by their parents, the health risks for adolescents are closely linked to the very processes of biological, neurological, and hormonal changes they experience. [8,9] While exploration is a natural adolescent process, risk-taking remains closely linked to the leading causes of adolescent morbidity and mortality including unintentional injury, substance abuse, and sexually transmitted infections (STIs). Behaviors that contribute to health outcomes such as obesity, substance abuse, and HIV and STIs, and those that can exacerbate chronic conditions and mental health issues, often begin or worsen in adolescence; thus, adolescence is a critical point for health promotion and intervention. Conversely, adolescence provides a unique opportunity to recover from adverse childhood events, strengthen resiliency, and develop healthy lifestyle habits resulting in positive outcomes. U.S. adolescents comprise 42 million diverse individuals who represent all races, socioeconomic backgrounds, geographic areas, as well as sexual and gender identities.[10,11] Adolescents experience significant disparities in health outcomes based on race and ethnicity; young Blacks, Latinos, and American Indians/Alaskan Natives experience worse outcomes in a variety of areas, such as obesity, unintended pregnancy, and oral health.[12] Socioeconomic status also plays a significant role in adolescent health outcomes, and the most current available data from 2014 indicates that the number of adolescents living in households considered low-income (21%) or below poverty-level (19%) has been rising. [13] Despite challenges in data collection related to sexual orientation and gender identity, current estimates indicate that 8-10% of adolescents identify as lesbian, gay, bisexual, or questioning, while 0.7% or 150,000 youth identify as transgender. [11,14] Lesbian, gay, bisexual, transgender, and queer (LGBTQ+) adolescents experience higher rates of depression, suicidal ideation, and substance use than their heterosexual peers, and are more at risk for HIV and other STIs.[15] Each of these demographic characteristics represents adolescent populations with specific health needs that necessitate cultural responsiveness and awareness of health-related disparities across adolescent populations. [16] Adolescent perception of stigma from medical providers or health centers regarding behaviors or conditions reduces the likelihood that an adolescent will engage in care; research illustrates that adolescents may experience stigma with regard to a range of health issues, including mental

health, sexual health, and obesity, which are often associated with social determinants of health.[17,18,19]

Adolescents experience high levels of health insurance coverage, and the majority have access to a regular source of care.[20] Despite coverage, access, and a clear need for preventive and clinical services, adolescents' receipt of healthcare is suboptimal; in 2011, the rate of adolescents who attended an annual healthcare visit ranged from 43% to 74%.[21] Receipt of specific, recommended services is even lower; in 2015, only about 10% of high school students were tested for HIV.[15] Confidentiality concerns are key factors in access to and quality of care for adolescents, impacting whether they will seek care and how openly they will communicate with healthcare professionals.[22] The importance of providing confidentiality protections for adolescents seeking healthcare services, particularly those for sensitive services related to HIV and STI testing and treatment, contraception, substance use, and mental health, is well-established among healthcare professional organizations, including the American Academy of Pediatrics,[23] the American Academy of Child and Adolescent Psychiatry,[24] the Society for Adolescent Health and Medicine,[22] and the American Medical Association.[26] States recognize the importance of confidential health services for adolescents through minor consent laws, providing adolescents under the age of 18 the legal ability to consent to the aforementioned range of sensitive healthcare services. All states and the District of Columbia allow minors to consent to STI services; however, 18 of those states allow, but do not require, a physician to inform a minor's parents that the adolescent is seeking or receiving STI services when the doctor deems it in the minor's best interest.[27] Forty-four states and the District of Columbia have laws or policies that authorize a minor who abuses drugs or alcohol to consent to counseling and medical care.[28] Twenty-six states and the District of Columbia have laws or policies that explicitly give minors (12 and older) the authority to consent to contraceptive services (not including abortion).[27] Importantly, though some states do not have laws or policies in place specifically authorizing minor consent to these services, in many cases, there are also no laws or policies that explicitly require parental consent for services. The age at which minors may consent to services varies by state and service. When stated, the age of minor consent for contraceptive services may range from 12 to 16 years, or require a referral, or rely on the "mature minor" rule, which allows a minor who is sufficiently intelligent and mature to understand the nature and consequences of a proposed treatment to consent to medical treatment without consulting their parents or obtaining permission. However, in many states that allow minor consent to sexual and reproductive healthcare services, medical providers are allowed, but not required, to inform a minor's parents that they are seeking care if they deem it in the best interest of the child.[27]

Despite legal protections for confidentiality in health services, billing, and health insurance documentation may lead to breaches. Most private insurance plans send an Explanation of Benefits form to the primary insurance holder, typically the parent, describing services received. The possibility of parental notification, through provider or insurance disclosures, contributes directly to forgoing or delaying healthcare. According to a national study, 35% of students who did not seek care reported one reason as "not wanting to tell their parents"[29] Another study found that the prevalence of several risk characteristics, including depression, unwanted pregnancy, and STIs, were significantly higher among both boys and girls who reported concerns about confidentiality than among those who did not.[30] A recent analysis of results from the National

Survey of Family Growth shows an association between confidentiality concerns and a lower prevalence of chlamydia screening for young women. HIPAA privacy rules allow for special confidentiality provisions that can be used to protect the health or safety of an individual, including minors who have consented to their own care, though insurers are not obligated to adhere to these requests.[23] Additionally, individuals who are deterred from using private insurance due to confidentiality concerns often turn to publicly funded clinics and services, placing additional strains on under-resourced, over-utilized systems when alternative resources are available. [23]

Evidence-based guidelines indicate multiple ways to serve adolescents in ways that support their physical, mental, and psychosocial development, while promoting principles of youth-friendliness: accessibility, acceptability, equity, appropriateness, and effectiveness. [33,34,21] The Interagency Working Group on Youth Programs, a collaboration of 20 federal departments and agencies that support youth, has created the following definition of Positive Youth Development (PYD):

"PYD is an intentional, prosocial approach that engages youth within their communities, schools, organizations, peer groups, and families in a manner that is productive and constructive; recognizes, utilizes, and enhances young people's strengths; and promotes positive outcomes for young people by providing opportunities, fostering positive relationships, and furnishing the support needed to build on their leadership strengths."[35]

Providers should engage adolescents in assessing and implementing services to meet their needs and adopt PYD approaches to healthcare that focus on strengths and assets, rather than risks.[36, 37] Meeting these needs requires addressing barriers on multiple fronts, including system-level changes (e.g., expanding health insurance coverage, increasing community-clinic linkages, and improving health equity) and improvements to clinical care (e.g., improving clinician knowledge and competency and increasing parental engagement).[21]

Improving adolescent health also requires structural designs that meet young people where they are. School-based or school-linked health centers are critical to increasing access to care, and schools should have formalized referral processes with community health providers, including mental health providers. Local health departments play an important role in providing that care directly or in leading or supporting processes to ensure adolescents have access to community providers across a range of health services. Furthermore, local health departments can establish or provide professional development and technical assistance to existing school-based health centers and other youth-serving providers and organizations to ensure services are being provided in accordance with the policy recommendations listed.

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Record of Action

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