A UCSF/Kaiser Permanente Collaboration

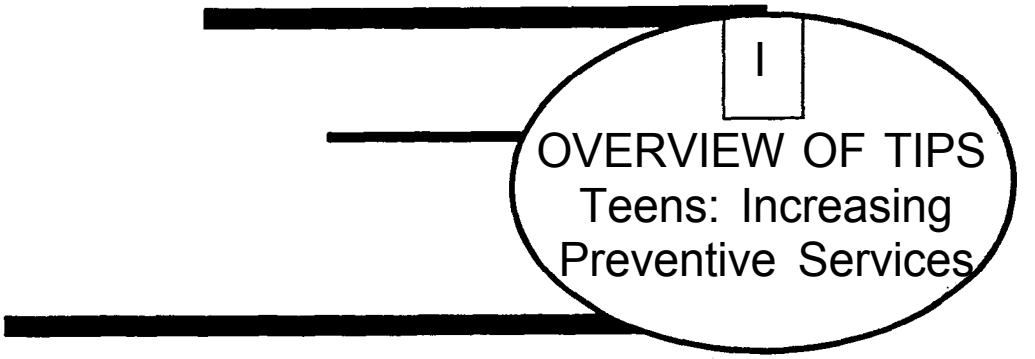
Supported by the Agency for Healthcare Research and Quality (AHRQ)
Department of Health and Human Services

Teens: Increasing Preventive Services

Provider Training Workshop

November 16, 2002

Kaiser Permanente, Fresno
Department of Pediatrics



Agenda

Acknowledgements

Panel Members

TIPS Study Team

Study Directory

Background of Study

TIPS Overview

A UCSF/Kaiser Permanente Collaboration

TIPS Provider Training Workshop
Kaiser Permanente, Fresno Pediatric Clinic
Agenda

Morning Session *8:30am-12:15pm*

Sign in and Refreshments

Welcome and Introductions

Background and Overview of TIPS Study

Adolescent Health Statistics in Kaiser, Permanente and the U.S.

Adolescent Development

Key Principles for Conducting a Clinical Interview with Adolescents

BREAK

Confidentiality

SUPPORT: Guidelines for Preventive Services Interview with Adolescents

Interviewing Adolescents About Substance Use

Group Practice Interviews

LUNCH *12:45pm-1:00pm*

EXAMPLE

TIPS
Teens: Increasing Preventive Services
A UCSF/Kaiser Permanente Collaboration

Afternoon Session *1:00pm-5:00pm*

Interviewing Adolescents About Safety

Interviewing Adolescents About Sexual Behavior

Putting it All Together: Prioritizing the Adolescent Visit
Educating Adolescents about Utilizing the Kaiser System

BREAK

Practice Adolescent Interviews

Wrap up and Question & Answer

EXAMPLE

A UCSP/Kaiser Permanente Collaboration

TIPS PROVIDER TRAINING WORKSHOP
KAISER PERMANENTE, FRESNO
NOVEMBER 16, 2002

FUNDED BY THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ), DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEVELOPED BY:

Julie L. Lustig, Ph.D.
Elizabeth M. Ozer, Ph.D.
Charles E. Irwin, Jr., M.D.
University of California, San Francisco School of Medicine
Department of Pediatrics
Division of Adolescent Medicine

WE APPRECIATE THE VALUABLE CONSULTATION, INPUT, AND INSIGHTS OF:

Sally Adams, Ph.D.
Andrea Garber, Ph.D., R.D.
Linda Rieder Gardner, M.P.H.
Susan Millstein, Ph.D.
University of California, San Francisco School of Medicine
Department of Pediatrics
Division of Adolescent Medicine

Robert Bonar, M.D.
Scott Gee, M.D.
Charles Wibbelsman, M.D.
Kaiser Permanente, Northern California

C. Daniel Fuster, M.D.
Kaiser Permanente, Southern California

FOR THEIR SKILLFUL WORK COORDINATING, EDITING, AND ORGANIZING MATERIALS FOR CURRENT AND PAST WORKSHOPS, WE GRATEFULLY APPRECIATE AND THANK

Andrea Garber, Ph.D., R.D.
Alison Goldberg, B.A.
Ilse Larson, B.A.
Anne Claiborne, B.A.
Denise Mailloux, B.A.
University of California, San Francisco School of Medicine
Department of Pediatrics
Division of Adolescent Medicine

WE ALSO ACKNOWLEDGE THE CONTRIBUTIONS OF THOSE WHO COLLABORATED ON EARLIER VERSIONS OF THESE TRAININGS

Carol Bandura Cowley, M.S.N., C.P.N.P.
Salud Family Health Center, Boulder, CO

Art Elster, M.D.
Missy Fleming, Ph.D.
Janet Gans-Epner, Ph.D.
Pat Levenberg, R.N., Ph.D.
Department of Adolescent Health, American Medical Association

EXAMPLE

TIPS
Teens: Increasing Preventive Services
A UCSF/Kaiser Permanente Collaboration

PROVIDER TRAINING PANELISTS:

University of California, San Francisco
Division of Adolescent Medicine:

Charles Irwin, Jr., M.D.
Elizabeth Ozer, Ph.D.

Kaiser Permanente, Northern CA:

Robert Bonar, M.D.
Charles Wibbelsman, M.D.

EXAMPLE

TIPS
Teens: Increasing Preventive Services
A UCSF/Kaiser Permanente Collaboration

University of California, San Francisco
Division of Adolescent Medicine
Department of Pediatrics
3333 California Street, Box 0503
San Francisco, CA 94143-0503

KAISER PERMANENTE
Stockton, Sacramento, Fresno & Oakland

TIPS Study Team

UCSF/KAISER PERMANENTE RESEARCH TEAM

Charles E. Irwin, Jr., M.D. – Co-Director
Elizabeth Ozer, Ph.D. – Co-Director
Scott Gee, M.D. – Raiser Permanente Investigator
Charles Wibbelsman, M.D. – Kaiser Permanente Investigator
Sally Adams, Ph.D. – Data Analyst
Andrea Garber, Ph.D., R.D. – Project Manager
Alison Goldberg, B.A. – Study Research Associate
Natalie Redmond, B.A. – Study Research Associate
Sheila Husting, B.A. – Study Research Associate

Pt. West, Sacramento

Jan Babb, M.S.N, N.P., R.N. – Site Research Associate

Stockton

Sherille Pedron, B.A. – Site Research Associate

Fresno

Martha Barbosa, B.A. – Site Research Associate

Oakland

Natalie Redmond, B.A. – Site Research Associate

EXAMPLE

TIPS
Teens: Increasing Preventive Services
A UCSF/Kaiser Permanente Collaboration

Background of Study

❶ Historical Absence of Prevention in Medical Settings

❷ Introduction of Clinical Guidelines to Facilitate Clinical Preventive Services (CPS)

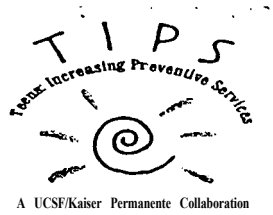
❸ Kaiser Issued Clinical Guidelines with Section on Adolescence

❹ HEDIS Guidelines

❺ Lack of Data on Implementation or Effectiveness of Guidelines

❻ UCSF/Kaiser Study of a Model for Implementing CPS Guidelines

❼ Agency for Health Care Research and Quality (AHRQ) Funds UCSF-Kaiser



BRIEF OVERVIEW OF TIPS—Teens: Increasing Preventive Services

- ❒ Goal: Integrate a system for implementing clinical preventive services with adolescents to make the brief clinical visit more efficient and effective for teens.

- ❒ 6 Target Areas: Sexual Behavior
  Substance Use: Tobacco
  Alcohol
  Drugs
  Safety: Seatbelts
  Helmets

- ❒ 13-17 Year Olds

- ❒ Training

- ❒ Tools

- ❒ 4 Clinics—2 Intervention & 2 Comparison

TIPS
Teens: Increasing Preventive Services
A UCSF/Kaiser Permanente Collaboration

TIPS Study Timeline

PHASES	INTERVENTION SITES	COMPARISON SITES
PHASE I BASELINE *(Sept. 2001-Dec. 2001)*	**SURVEY ADOLESCENTS**	**SURVEY ADOLESCENTS**
PHASE II TRAINING *(Dec. 2001)*	**TRAINING**	
(Dec. 2001-April 2002)	**SURVEY ADOLESCENTS**	**SURVEY ADOLESCENTS**
PHASE III TRAINING AND TOOLS *(May 2002)*	**TRAINING AND TOOLS**	
(June 2002-Oct. 2002)	**SURVEY ADOLESCENTS**	**SURVEY ADOLESCENTS**

This UCSF/Kaiser Permanente Collaboration is
Created by the Agency for Healthcare Research and Quality

Directors: Charles Irwin, Jr., M.D., and Elizabeth Ozer, Ph.D.
Study Project Manager: Andrea Garber, R.D., Ph.D.

For further information, please contact the Project Manager, Andrea Garber, R.D., Ph.D., at
415-514-2180, agarber@itsa.ucsf.edu
University of California, San Francisco, Division of Adolescent Medicine
3333 California St., Suite 245, San Francisco, CA 94143-0503

A UCSF/Kaiser Permanente Collaboration

OVERVIEW

We are excited to be collaborating with you on the TIPS–Teens: Increasing Preventive Services study! The goal of TIPS is to facilitate the implementation of clinical preventive services for adolescents in Kaiser Permanente pediatric clinics. We will be working with two pediatric clinics: Pt. West Sacramento and Stockton. We also have two clinics where we will not be facilitating the implementation of clinical preventive services with adolescents. The evaluation includes looking at changes in your clinic as you work with teens and address their risky behaviors.

Implementing clinical preventive services involves the whole system. Successful implementation will include increases in the delivery of preventive services for adolescents throughout the clinic. This will require the participation of clinicians, staff, adolescents, and their parents.

The Kaiser Clinical Practice Guidelines for adolescents target 9 content areas. TIPS will focus on the following 6 of the 9 Kaiser priority areas:

- **SUBSTANCE USE:**
  TOBACCO
  ALCOHOL
  DRUGS
- **SEXUAL BEHAVIOR**
- **SAFETY:**
  HELMETS
  SEATBELTS

What is included in TIPS?

- Provider Training Workshops
- Risk Assessment Tools
- Charting Tools

What is the goal of TIPS?

The goal is to increase your ability to integrate preventive services into adolescent patient visits as efficiently and effectively as possible.

Who participates in TIPS?

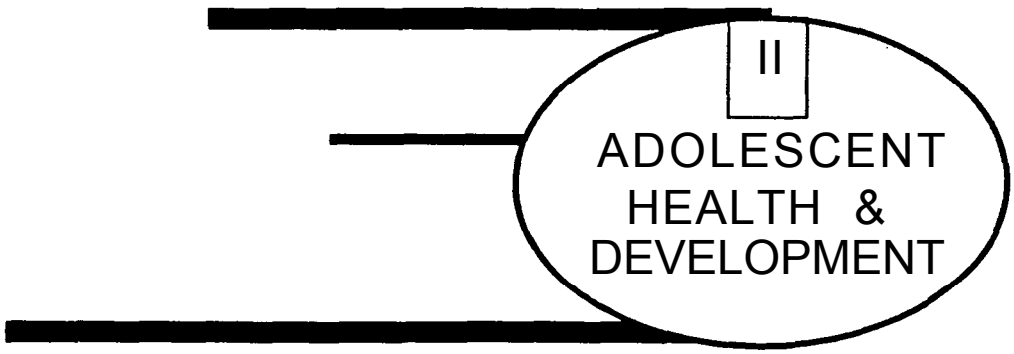
TIPS will be system-wide and will be for all providers who see teens in your clinic.

Which patients will participate?

All 13-17 year old patients seen in your clinics for well visits and sports physicals will benefit from the intervention.

TIPS
Teens Increasing Preventive Services
A UCSF/Kaiser Permanente Collaboration

NOTES



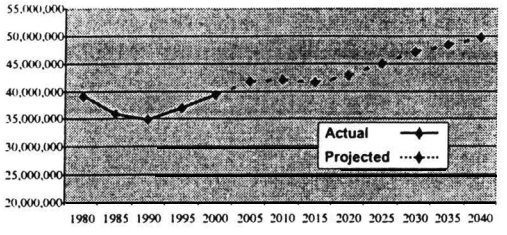
Adolescent Health Status

Adolescent Development

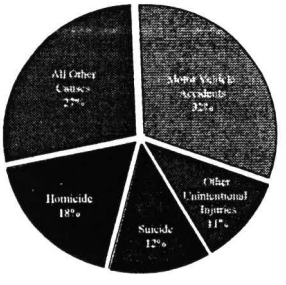
Adolescent Health in Kaiser Permanente, and the U.S.

Actual and Projected Population Ages 10-19

U.S. Census Bureau, 1999



Leading Causes of Mortality in Adolescents and Young Adults Ages 10-24 (1998)



- Accidents & injuries leading cause of death for both males and females.
- Many of these accidents involve alcohol & other substances.

TIPS Study
A UCSF/Kaiser Collaboration
Funded by AHRQ
November 2002

Adolescent Health in Kaiser Permanente, and the U.S.

- Sexually transmitted diseases are common infectious diseases among adolescents.
- Among adolescents ages 15-19, pregnancy and childbirth are the leading causes of hospitalization.

- Even if adolescents survive immediate hazards of risky behaviors, long-term health consequences of alcohol & drug use, smoking, physical inactivity, and risky sexual behavior contribute to major health problems in adult population.

Adolescent Substance Use

- Substance use has fallen over the past two decades.
- Use of most substances increases with age and peaks in late adolescence.
- Initiation of substance use most often between 7th and 10th grades.

Adolescent Health in Kaiser Permanente, and the U.S.

Substance Use (cont.)

- Rate of drug use is nearly equal for most racial/ethnic groups.
- Adolescents twice as likely to use marijuana as all other drugs. combined.

Substance Use (cont.)

- Substance use involved in 1 out of every 6 adolescent deaths.
- Over 30% of adolescents who use alcohol report driving after drinking.

Initiation of Substance Use

7^{th}-8^{th} Grade	9^{th} - 10^{th} Grade
• 20% - alcohol use	• 32% - alcohol use
• 13% - drug use	• 21% - drug use
• 25% - cigarette use	• 16% - cigarette use
• 10% - binge drinking	

Adolescent Health in Kaiser Permanente, and the U.S.

Adolescent Sexual Behavior

- After increasing for two decades, the proportion having sex has decreased.
- Contraceptive use has increased.
- Birth rates are declining.
- About 2/3 of students report having sex by senior year of high school.

National Adolescent Health Information Center

N A H I C

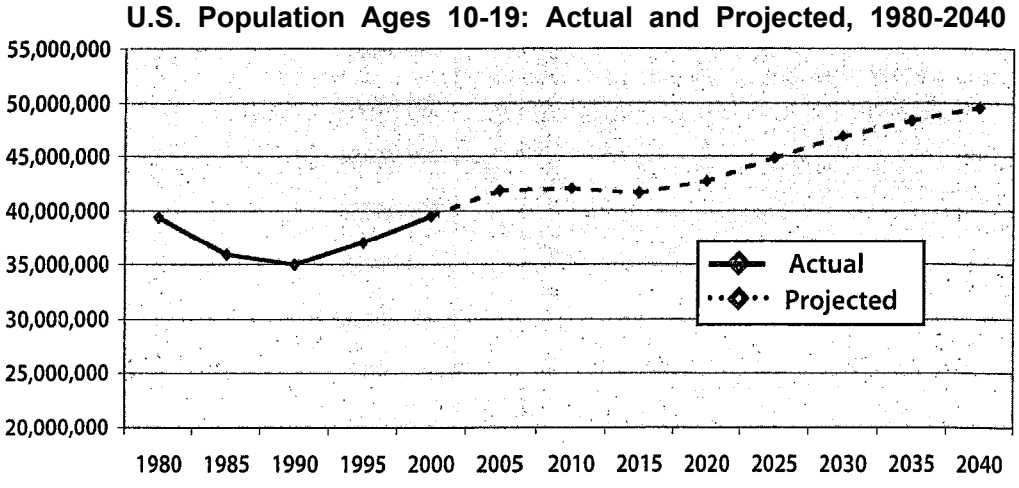
Fact Sheet on Demographics:

Children & Adolescents

Highlights:

- The U.S. adolescent population is growing, but is declining as a percentage of the total population.
- The adolescent population is more racially/ethnically diverse than the general population.
- Most adolescent minority populations are growing at a faster rate than White populations.
- Nearly one in five children/adolescents lives in poverty, but this varies widely by race/ethnicity.
- The percentage of children and adolescents living in two-parent households has decreased.

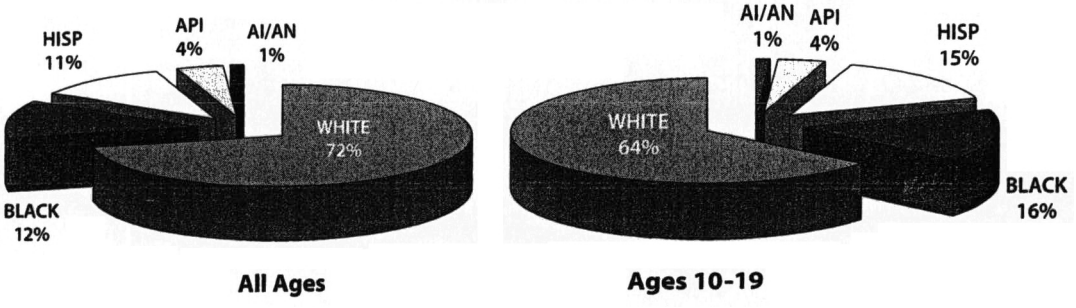
- **The U.S. adolescent population is growing, but is declining as a percentage of the total population.**



As of 1998, the population of adolescents ages 10-19 was 38.8 million. This population is expected to grow to nearly 50 million by the year 2040. However, as a proportion of the total population, adolescents are projected to comprise only 13.0% of the U.S. population by the year 2020, down from 14.5% in 2000 (U.S. Census Bureau, 1999).

The adolescent population is more racially/ethnically diverse than the general population.

U.S. Population by Race/Ethnicity, 1998



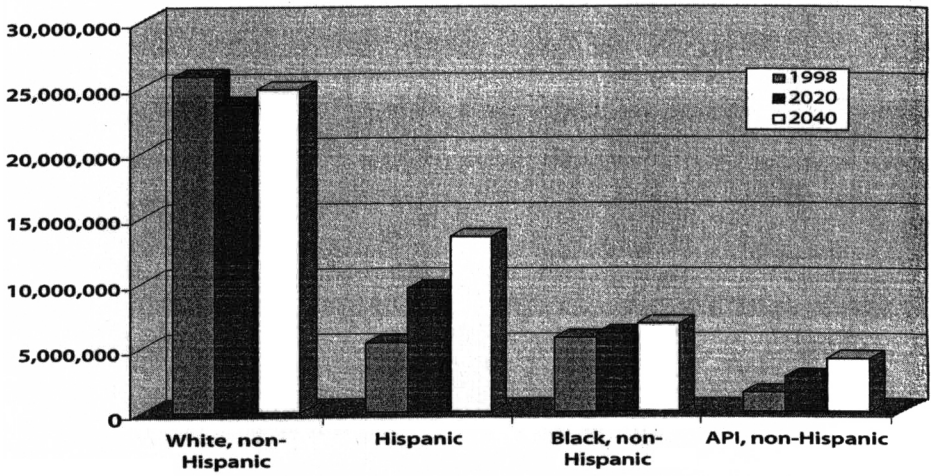
Whites comprise 72% of the general population, but only 64% of the adolescent population. Over the next several decades, the proportion of racial and ethnic minority adolescents ages 10-19 is expected to grow (U.S. Census Bureau, 2000).

HISP = Hispanic; API = Asian/Pacific Islander; AI/AN = American Indian/Alaska Native
HISP is the only category which includes those of Hispanic ethnicity.

Most adolescent minority populations are growing at a faster rate than White populations.

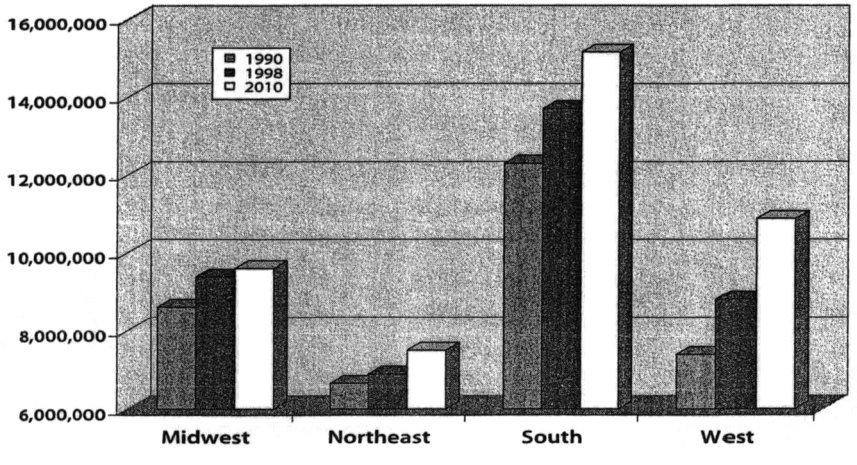
It is projected that by 2040 the percentage of non-Hispanic Whites in the adolescent population will drop below 50%. Hispanics are becoming the second most populous racial/ethnic group. Asian/Pacific Islanders, though small in number, have the fastest growth rate. The American Indian/Alaska Native population will remain largely unchanged (U.S. Census Bureau, 2000).

Actual and Projected Population by Race/ Ethnicity, Ages 10-19, 1998, 2020 & 2040



Most of the adolescent population growth is taking place in the South and West.*

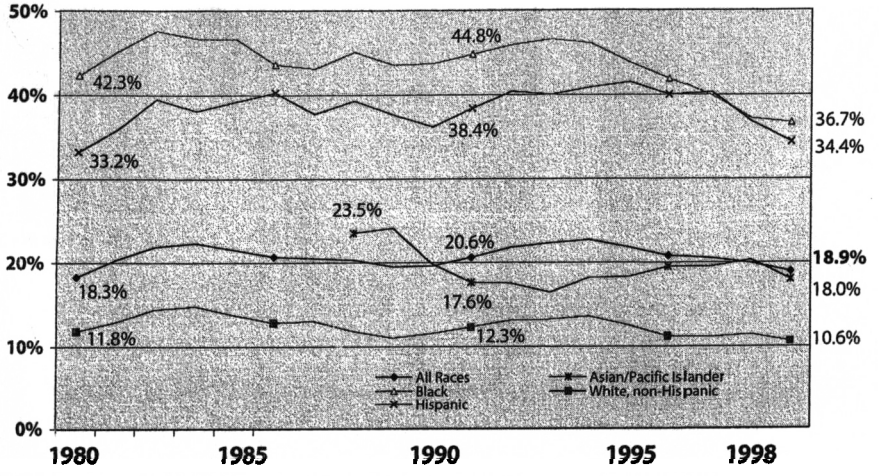
Actual and Projected Population Growth by Region, Ages 10-19, 1990, 1998 & 2010



The West is expected to experience the greatest growth in adolescent population, increasing 23.5% from 1998-2010, while the adolescent population in the South is expected to grow by 10.6%. In the Northeast and Midwest, the adolescent populations are expected to grow by 8.8% and 2.3%, respectively. In the ye-2000, adolescents will constitute 31% of the West's population, compared to 29% in both the South and Midwest, and 27% in the Northeast. (U.S. Census Bureau, 2000).

Poverty among children and adolescents varies widely by race/ethnicity.

Percent in Poverty by Race/Ethnicity, Under Age 18, 1980-1998

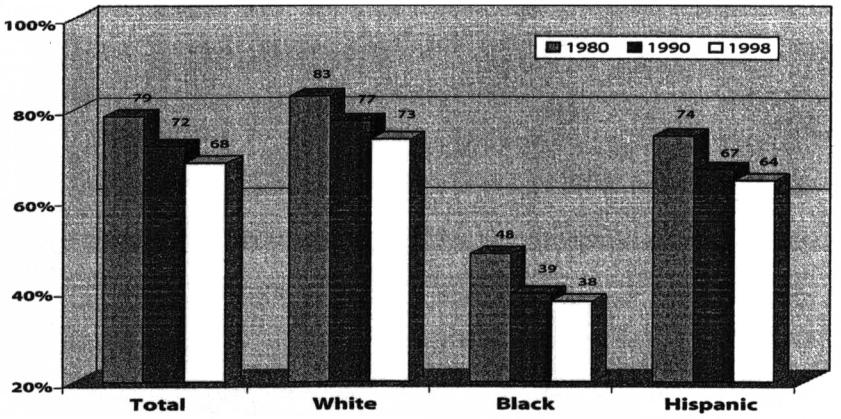


In 1998, 18.9% of all those under age 18 lived below the Federal Poverty Line (FPL)**. For Blacks and Hispanics, the figure was nearly twice as high. This racial/ethnic disparity held true among the near poor (income less than 200% FPL), and the very poor (income less than 50% FPL) (U.S. Census Bureau, 1998).

The percentage of children and adolescents living in two-parent households has decreased.

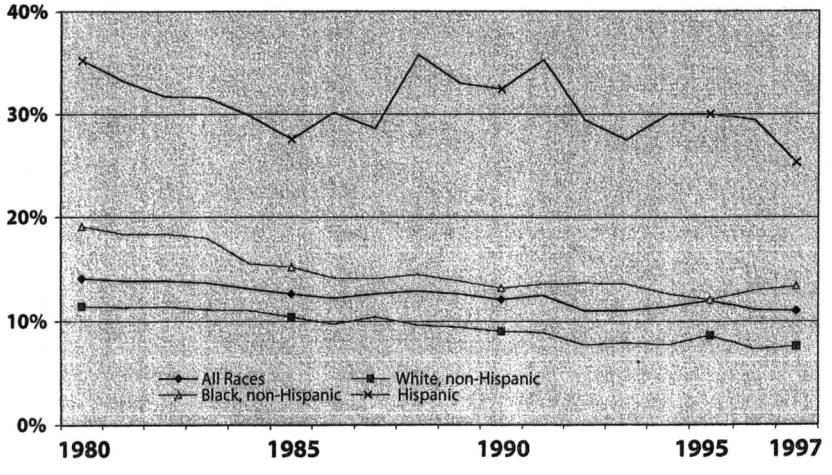
From 1980 to 1998 there was a dramatic decrease in the percentage of children and adolescents living In two-parent households. This decrease was even across racial and ethnic groups. Children and adolescents ages 6-17, living in households with only their mother present were 5 times as likely (42.2% vs. 8.5%) to be living in poverty than those living in two-parent households (U.S. Census Bureau, 1999).

Children/Adolescents Under 18 Living in Two-Parent Households by Race/Ethnicity, 1980, 1990 & 1998.



While high school drop-out rates have fallen, racial/ethnic disparities remain.

High School Drop-Out Rates, Ages 16-24, 1997



Educational attainment is a strong predictor of future economic status. Although Hispanic high school students have seen the greatest decline in drop-outs, they still have the highest drop out rates, more than four times that of Whites. Overall high school drop out rates have been falling consistently, and stood at 11.0% in 1997, down from 12.1% in 1990 and 14.1% in 1980. This overall decline is seen across all racial/ethnic groups (NCES, 1999).

Data Sources:

Dalaker, Joseph. U.S. Census Bureau Current Population Reports, Series P60-207, *Poverty in the U.S.: 1998,* U.S. Government Printing Office: Washington, DC, 1999.

U.S. Census Bureau Current Housing Reports, Series H150/97, *American Housing Survey for the United States: 1997,* U.S. Government Printing Office: Washington, DC, 1999.

U.S. Census Bureau Current Population Reports, Series P60-206, *Money Income in* the U.S.: *1998,* U.S. Government Printing Office: Washington, DC, 1999.

U.S. Census Bureau, Population Divisions, Populations Divisions Branch, *Population Estimates,* online data set: [www.census.gov].

U.S. Census Bureau, Population Divisions, Populations Divisions Branch, *Population Projections,* online data set: [www.census.gov].

U.S. Department of Education, National Center for Education Statistics, (1998). *Digest of Education Statistics 1998.* [http://nces.ed.gov/pubs99/digest98]

*** Regional Definitions are as follows:**

Northeast: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont.
Midwest: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin.
South: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia.
West: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming.

**** The Federal Poverty Line (FPL) was $16,660 for a family of four in 1998.**

In all cases, the most recent available data were used. Some data are released 1-3 years after collection. For questions regarding data sources or availability, please contact NAHIC. For racial/ethnic data, the category names presented are those of the data sources used.

2000 NAHIC Adolescent Fact Sheets

Fact Sheet on Adolescent Demographics

Fact Sheet on Adolescent Mortality

Fact Sheet on Adolescent Homicide

Fact Sheet on Adolescent Suicide

Fact Sheet on Adolescent Injury

Fact Sheet on Preventive Health Services for Adolescents

Fact Sheet on Adolescent Pregnancy Prevention

Fact Sheet on Adolescent Substance Use

Fact Sheet on Adolescent Sexuality

Fact Sheet on Adolescent Health Care Utilization

Fact Sheet on Out-of-Home Youth

National Adolescent Health Information Center

Division of Adolescent Medicine,
Department of Pediatrics &
Institute for Health Policy Studies,
School of Medicine,
University of California,
San Francisco

UCSF Box 0503
San Francisco, CA 94143-0503
ph. 415.502.4856, f. 415.502.4858
email: nahic@itsa.ucsf.edu
http://youth.ucsf.edu/nahic

Background on NAHIC

The National Adolescent Health Information Center (NAHIC) was established with funding from the Maternal and Child Health Bureau in 1993 (4H06 MC00002) to serve as a national resource center for adolescent health research and information to assure the integration, synthesis, coordination and dissemination of adolescent health-related information.

NAHIC Faculty and Staff

Charles E. Irwin, Jr., MD
Claire D. Brindis, DrPH
Susan G. Millstein, PhD
Elizabeth M. Ozer, PhD
David Knopf, LCSW, MPH
M. Jane Park, MPH
Scott Burg
Pamela S. Witt

Copies of any of the listed Adolescent Fact Sheets can be downloaded on the World Wide Web at http://youth.ucsf.edu/nahic. Hard copies can be requested at (415) 502-4856, or by email at: nahic@itsa.ucsf.edu.

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration
Maternal and Child Health Bureau

UCSF

Cite as: National Adolescent Health Information Center. (2000). Fact Sheet on Adolescent Suicide. San Francisco, CA: National Adolescent Health Information Center, University of California, San Francisco.

National Adolescent Health Information Center

N A H I C

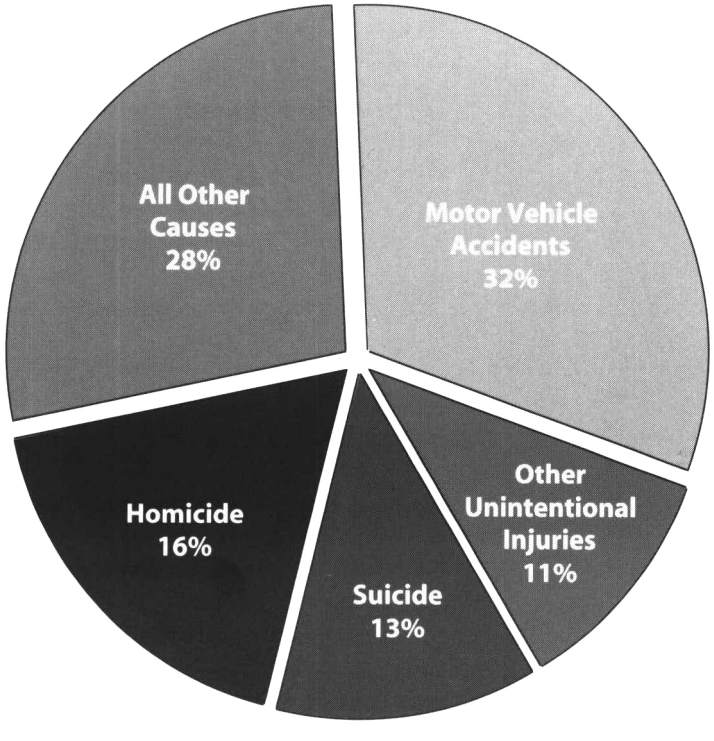
Fact Sheet on Mortality:

Adolescents & Young Adults

Highlights:

- Three-quarters of all adolescent/young adult mortality is preventable.
- Young adults ages 20-24 have four times the death rate of younger adolescents.
- The mortality rate for male adolescents/young adults is almost three times the rate for females.
- Adolescent and young adult mortality rates vary by race/ethnicity.
- Mortality rates are at or near all time lows for most racial/ethnic groups.

- **Three-quarters of all adolescent/young adult mortality is preventable.**

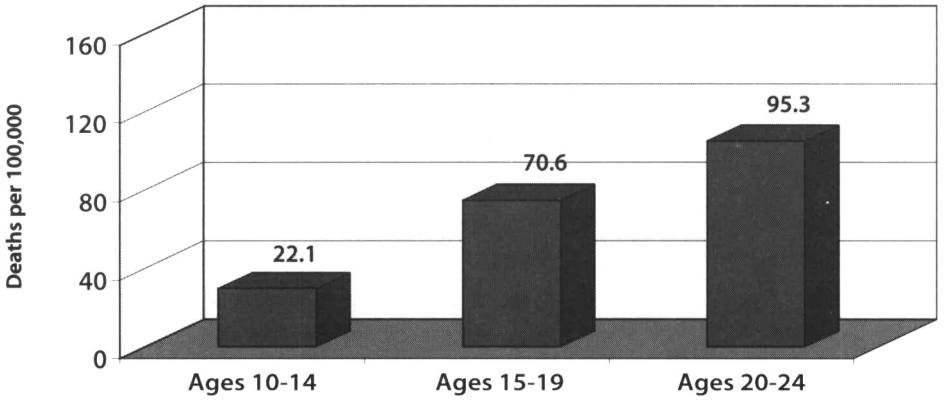


Leading Causes of Mortality: Adolescents/Young Adults Ages 10-24,1998

In 1998, the Centers for Disease Control and Prevention (CDC) reported 34,888 deaths among adolescents and young adults ages 10-24. With a total population of 56.5 million adolescents and young adults, this represents a death rate of 61.8 per 100,000 population. Of these deaths, 25,161, or roughly three-quarters, are due to preventable causes (NCIPC, 2000 & NVSS, 2000).

Young adults ages 20-24 have four times the death rate of younger adolescents.

Adolescent/Young Adult Mortality Rates by Age, 1998

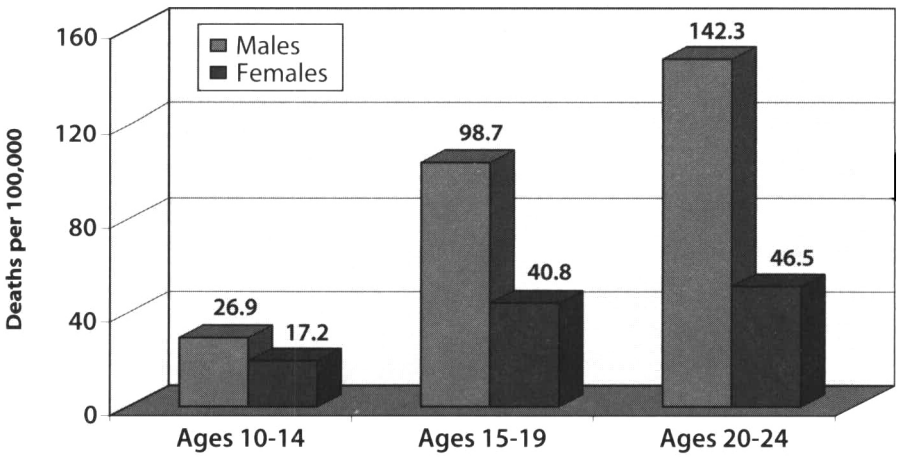


Mortality rates increase throughout adolescence and early adulthood. This trend continues throughout the lifespan (NVSS, 2000).

The mortality rate for male adolescents/young adults is almost three times the rate for females.

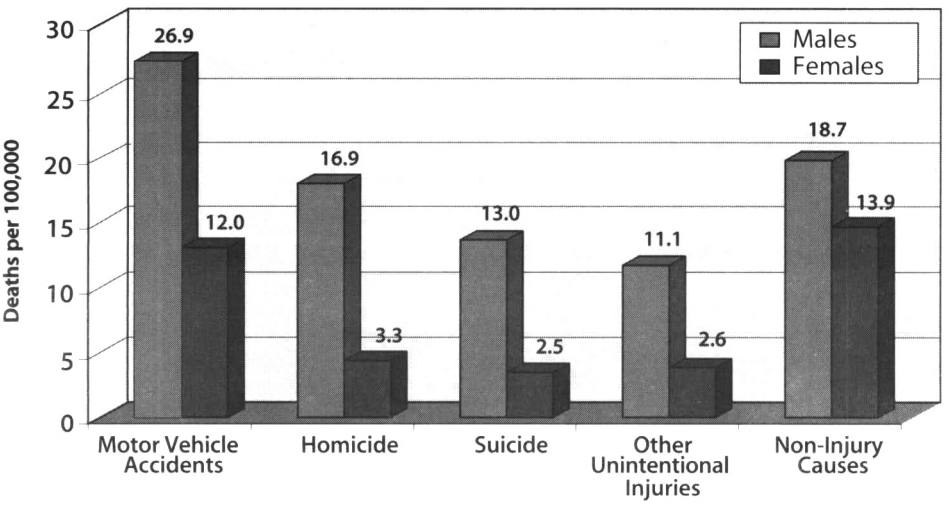
In 1998, adolescent males ages 10-24 had a death rate of 87.8/100,000, compared to 34.6/100,000 for same age females. This disparity is greater among older adolescents: For ages 10-14, the male death rate was 1.6 times that of females; at 15-19, males were 2.4 times more likely than females to die; and at ages 20-24, the male death rate was 3.1 times that of females (NVSS, 2000).

Adolescent/Young Adult Mortality by Gender & Age, 1998



Adolescent males are more likely than adolescent females to die from preventable causes.

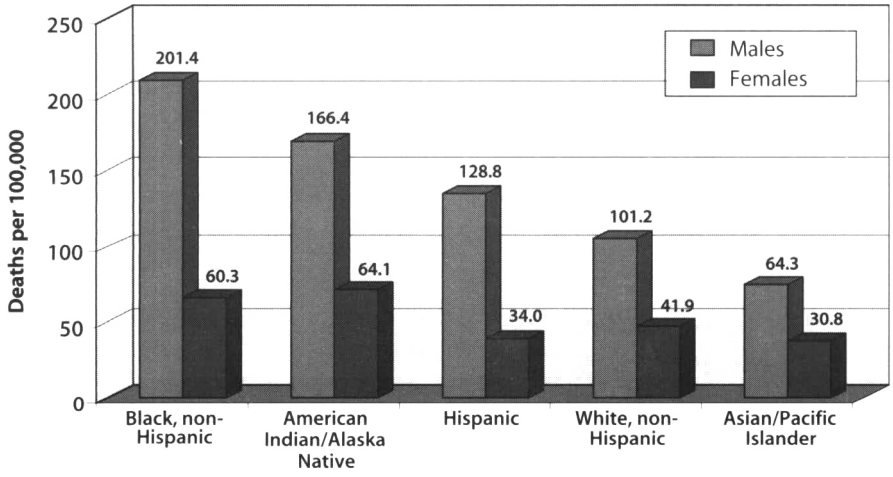
Causes of Mortality by Gender, Ages 10-24, 1998



In 1998,79% of deaths among males ages 10-24 were due to preventable, injury-related causes. In comparison, 60% of same-age female deaths were preventable. Motor vehicle accidents were the leading cause of death for both males and females. Among non-injury causes, malignant neoplasms were most prevalent, followed by diseases of the heart (NCIPC, 2000 & NVSS, 2000).

Adolescent and young adult mortality rates vary by race/ethnicity.

Mortality by Gender & Race/Ethnicity, Ages 15-24, 1998

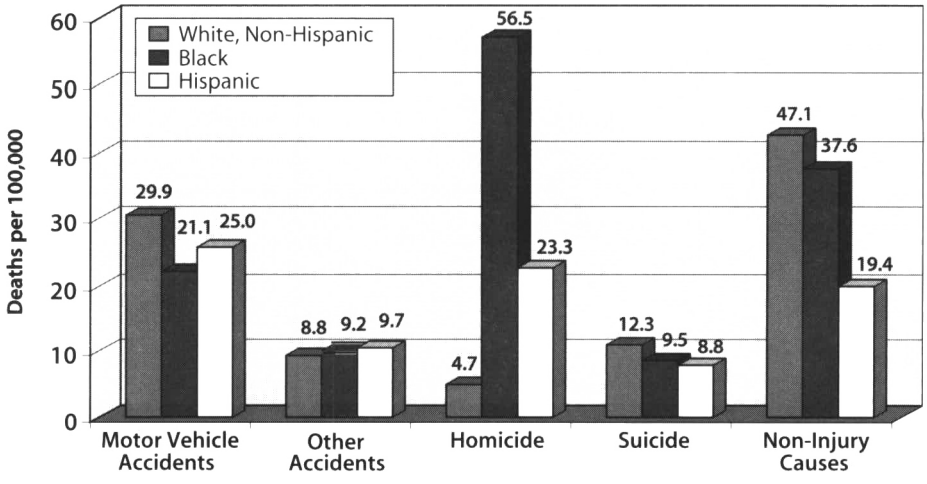


In 1998, the mortality rate for non-Hispanic Blacks ages 15-24 was 131.0/100,000, much higher than rates for the rest of this age group. Asian/Pacific Islanders had the lowest mortality rate: 47.6/100,000. Blacks ages 15-24 showed the greatest disparity in mortality rates across gender, with the male rate 3.3 times that of females. Asian/Pacific Islanders ages 15-24 had the least gender disparity: male death rates are just over twice that of females (NCHS, 1999).

Racial/ethnic disparity is primarily due to higher homicide rates among non-white adolescent males.

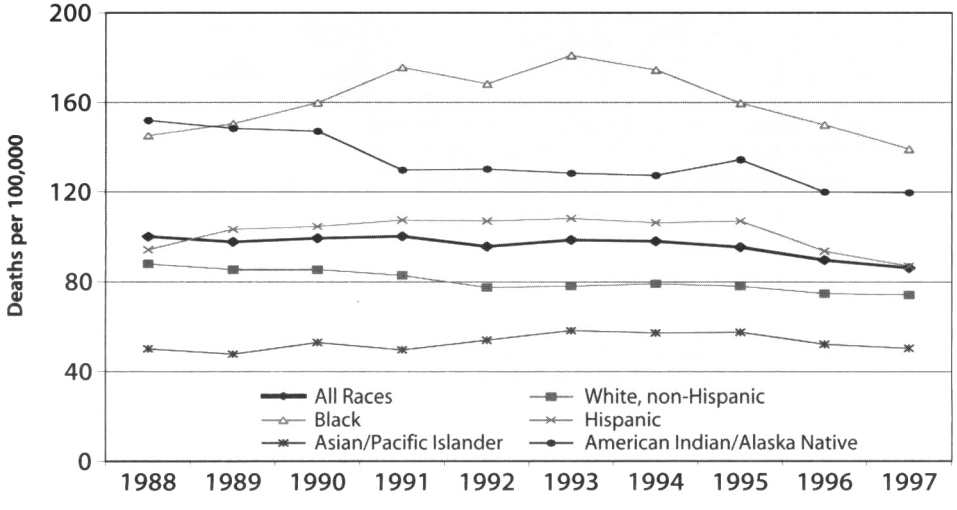
In 1998, homicide resulted in about half of all deaths among Blacks ages 15-24, and largely accounted for the higher mortality rate among this group. Homicide was also largely responsible for higher Hispanic mortality rates. High suicide and homicide rates among American Indian/ Alaska Natives are responsible for much of the higher mortality for that group (not shown). In each case, the higher rates are primarily due to males (NCHS, 2000).

Causes of Mortality by Race/Ethnicity, Ages 15-24,1998



Mortality rates are at or near all time lows for most racial/ethnic groups.

Mortality Trends by Race/Ethnicity, Ages 15-24, 1988-98



After peaking in the mid-1990s, mortality rates have fallen for all racial/ethnic groups, and are now at or near all time lows for most of these groups. Despite experiencing the steepest recent decline (30% since 1993) in mortality rates, Black rates are still above their historic low of 111.9 per 100,000, reached in 1984 (NCHS, 2000 & NVSS, 2000).

Data Sources:

Centers for Disease Control & Prevention, National Center for Health Statistics. (1999). CDC Wonder, Mortality (compressed) data set. [http://wonder.cdc.gov].

Centers for Disease Control & Prevention, National Center for Injury Prevention and Control. (2000). *United States injury Mortality Statistics.* [online database: http://www.cdc.gov/ncipc]

Peters, K. D., Kochanek, K. D., & Murphy, S. L. (2000). Deaths: Final Data for 1998. National Vital Statistics Reports 47(19). Centers for Disease Control & Prevention, National Center for Health Statistics, National Vital Statistics System.

Indian Health Service. (1998). Trends in Indian Health, 1997. Division of Program Statistics, Office of Planning, Evaluation and Legislation, Public Health Service, Department of Health and Human Services. [http://www.ihs.gov].

National Center for Health Statistics. (1996). Health, United States, 1995. Hyattsville, MD: Public Health Service.

National Center for Health Statistics. (1997). Report of Final Mortality Statistics, 1995. (DHHS Publication No. PHS 97-1220) Public Health Service, Department of Health and Human Services. Washington, DC: U.S. Government Printing Office.

National Center for Health Statistics. (1999). Health, United States, 1998. Hyattsville, MD: Public Health Service.

In all cases, the most recent available data were used. Some data are released 1-3 years after collection. For questions regarding data sources or availability, please contact NAHIC. For racial/ethnic data, the category names presented are those of the data sources used.

2000 NAHIC Adolescent Fact Sheets

Fact Sheet on Adolescent Demographics

Fact Sheet on Adolescent Mortality

Fact Sheet on Adolescent Suicide

Fact Sheet on Adolescent Injury

Fact Sheet on Adolescent Injury

Fact Sheet on Preventive health Services for Adolescents

Fact Sheet on Adolescent Pregnancy Prevention

Fact Sheet on Adolescent Substance Use

Fact Sheet on Adolescent Sexuality

Fact Sheet on Adolescent Health Care Utilization

Fact Sheet on Out-of-Home Youth

National Adolescent Health Information Center

Division of Adolescent Medicine,
Department of Pediatrics &
Institute for Health Policy Studies,
School of Medicine,
University of California,
San Francisco

UCSF Box 0503
San Francisco, CA 94143-0503
ph. 415.502.4856, f. 415.502.4858
email: nahic@itsa.ucsf.edu
http://youth.ucsf.edu/nahic

Background on NAHIC

The National Adolescent Health Information Center (NAHIC) was established with funding from the Maternal and Child Health Bureau in 1993 (4H06 MC00002) to serve as a national resource for adolescent health research and information to assure the integration, synthesis, coordination and dissemination of adolescent health-related information.

NAHIC Faculty and Staff

Charles E. Irwin, Jr., MD
Claire D. Brindis, DrPH
Susan G. Millstein, PhD
Elizabeth M. Ozer, PhD
David Knopf, LCSW, MPH
M. Jane Park, MPH
Scott Burg
Pamela S. Witt

Copies of any of the listed Adolescent Fact Sheets can be downloaded from the World Wide Web at http://youth.ucsf.edu/nahic. Hard copies can be requested at (415) 502-4856, or by email at: nahic@itsa.ucsf.edu.

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration
Maternal and Child Health Bureau

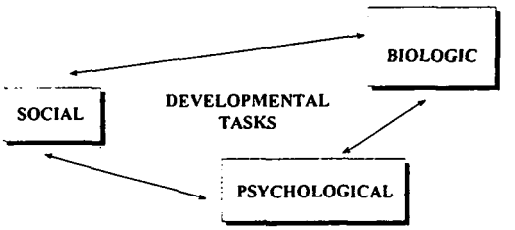
UCSF

Cite as: National Adolescent Health Information Center. (2000). Fact Sheet on Mortality: Adolescents and Young Adults. San Francisco, CA: National Adolescent Health Information Center, University of California, San Francisco.

ADOLESCENT GROWTH & DEVELOPMENT: IMPLICATIONS FOR CLINICAL CARE

Charles E. Irwin, Jr., M.D.
Professor of Pediatrics
Director, Division of Adolescent Medicine
Vice Chair, Department of Pediatrics
University of California, San Francisco
School of Medicine

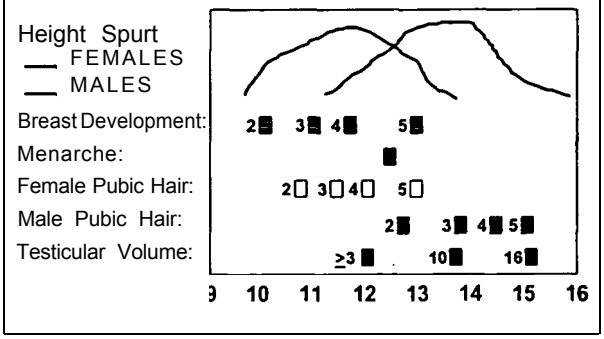
Major Biological, Psychological & Social Changes of Adolescents



Biological Changes

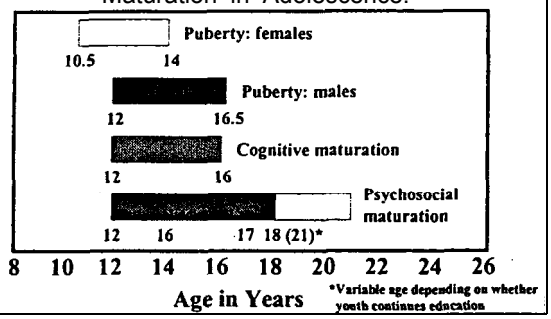
- Appearance of secondary sex characteristics.
- Emergence of sex drive.
- Transition to reproductive maturity.
- Dramatic changes in body size, shape & composition.

Sequence of Pubertal Events



TIPS Study
A UCSF/Kaiser Collaboration
Funded by AHRQ
Nov. 2002

Average Age Relationships Between Pubertal, Cognitive, and Psychosocial Maturation in Adolescence.



Behavioral Changes Associated with Biological Maturation

- Increased parent-child conflict
- Heterosocial/sexual behavior
- Decreased academic performance
- Gender differences regarding pubertal interest

Effects of Timing of Puberty *Early*

- Increased dissatisfaction with body image
- Lower self-esteem
- Identity crisis
- Problem behavior in school
- Greater social unhappiness
- Early sexual behavior

Effects of Timing of Puberty
Late

- increased dissatisfaction with body image
- Peer isolation
- Unathletic

Biopsychosocial Stages of Adolescence

- Early Adolescence Ages 10-13
- Middle Adolescence Ages 14-16
- Late Adolescence Ages 17-21

Early Adolescence (10 - 13)

GROWTH:	Initiation & rapid growth of secondary sexual traits.
SEXUALITY:	Self-exploration and evaluation. Limited dating and intimacy.
PSYCHO-SOCIAL:	Preoccupation with rapid body change. Former body image disrupted.

Early Adolescence (10 - 13)

COGNITION:	Concrete thought dominant. Cannot perceive long-range implications of current decisions.
FAMILY:	Define independence-dependence boundaries. No major conflicts over parental control.
PEER GROUP:	Seeks peer affiliation to counter instability. Compares own normality with same sex & age mates.

Middle Adolescence (14 - 16)

GROWTH:	Growth slowing, secondary sexual characteristics nearing completion.
SEXUALITY:	Multiple plural relationships. Increased sexual activity. Tests ability to attract opposite sex or same sex.
PSYCHO-SOCIAL:	Reestablishes body image. Preoccupation with idealism in exploring future options. Development of sense of invincibility.

Middle Adolescence (14 - 16)

COGNITION:	Rapidly gaining abstract thought. Can perceive future implications. Reverts to concrete thinking under stress.
FAMILY:	Major conflicts over control. Seeks freedom.
PEER GROUP:	Needs strong affiliation to affirm self-image. Peer group assumes role of behavioral example.

Late Adolescence (17 - 21)

GROWTH:	Physically mature.
SEXUALITY:	Forms stable relationships. Capable of caring reciprocally with others. Plans for future. Intimacy involves commitment.
PSYCHO-SOCIAL:	Emancipation continues to proceed with interdependence being goal. Intellectual and functional identity established.

Late Adolescence (17 - 21)

COGNITION:	Established abstract though processes Future oriented. Can act on long-range options.
FAMILY:	Parent-child dependency relationship changes to adult-adult model.
PEER GROUP:	Individual relationships take precedence.

The Physical Examination of Adolescents

HEIGHT, WEIGHT, & BLOOD PRESSURE:	◆ Temperature, pulse rate and respiratory rate if indicated by chief complaint
PHYSICAL & MENTAL STATUS:	◆ Apparent health, mental functioning, mood and affect

The Physical Examination of Adolescents

SEXUAL MATURATION RATING:
- Tanner Stage

SKIN:
- Acne commonly present
- Warts, fungal infections, rashes
- Lacerations

The Physical Examination of Adolescents

EYES, EARS, NOSE & MOUTH:
- Visual acuity
- Audiometric screening
- Dental carries, malocclusion

LYMPH NODES:
- Palpate

THYROID:
- Enlargement, nodules, bruit

The Physical Examination of Adolescents

BREASTS:
- Tanner stage
- Symmetry, masses (usually fibroadenoma or cysts)
- May teach Breast Self Exam

HEART:
- Functional murmurs common, mitral valve prolapse may be more apparent

The Physical Examination of Adolescents

MUSCULO-SKELETAL:
- Scoliosis assessment

RECTAL:
- If GI or GU symptomatology or engaging in receptive anal intercourse

The Physical Examination of Adolescents

GENITALIA:
- inspection and staging
- Boys should be taught testicular self-examinations
- Pelvic examination should be considered if necessary

ABDOMEN:
- inspect pubic hair escutcheon for Tanner stage

Specific Indicators of Possible Behavioral or Emotional Problems in Adolescents

APPEARANCE:
- Deterioration in Dress and Personal Hygiene

SCHOOL:
- Loss of Interest &/or Recurrent Truancy
- Disruptive Behavior

HEALTH:
- Chronic Illness or Handicap
- Illness Resulting in Prolonged Absence From School, Isolation From Peer Group

Specific Indicators of Possible Behavioral or Emotional Problems in Adolescents

HOME:
- Continual Disagreement & Acting Out
- Increase in Secretiveness and Isolation

PEERS:
- Lack of Involvement
- No Dating or Evident Interest
- Active Member in Peer Group Known to be Involved in Anti-social Behaviors

Specific Indicators of Possible Behavioral or Emotional Problems in Adolescents

FUNCTIONAL:
- Chronic Sleep Disturbances
- Major Shifts in Eating Patterns
- Psychosomatic Hypochondrial Complaints

MOOD:
- Chronic Depression
- Chronic & Unmitigated Hostility
- Chronic Anxiety or Nervousness
- Recurrent Hysterical Outbursts

Specific Indicators of Possible Behavioral or Emotional Problems in Adolescents

SEXUAL:
- Promiscuity and/or Unprotected Sex
- Sexual Abuse
- Gender Identity & Orientation Problems

SUBSTANCE USE:
- Use of Illicit Substances Esp. w/Regularity
- Drunk Driving or Riding w/Drunk Driver
- Smokes Cigarettes

Specific Indicators of Possible Behavioral or Emotional Problems in Adolescents

VIOLENCE:

- Witness to or Victim of a Crime
- Victim of Physical or Sexual Abuse
- Has Committed Abusive Acts
- Involved in Delinquent Acts

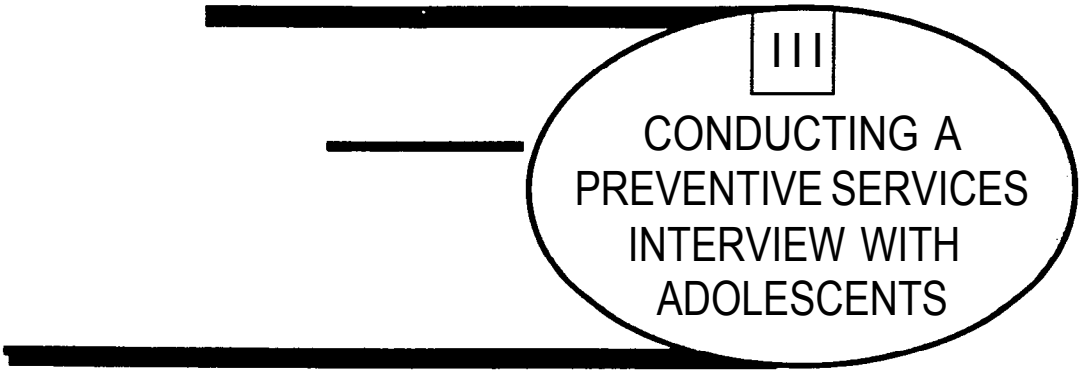
Adolescent Development

Approximate Age	Early Adolescence Females 11-14; Males 13-15	Middle Adolescence Females 15-17; Males 16-19	Late Adolescence Females 18-25; Males 20-26
Cognitive Thinking	Concrete Thinking: Here and no. Appreciate immediate reactions to behavior but no sense to later consequences.	Early Abstract Thinking: Inductive/deductive reasoning. Able to connect separate events, understand later consequences. Very self-absorbed, introspective, lots of daydreaming and rich fantasies.	Abstract Thinking: Adult ability to think abstractly. Philosophical. Intense idealism about love, religion and social problems.
Task Areas 1. Family Independence	- Transition from obedient to rebellious - Rejection of parental guidelines - Ambivalence about wishes (dependence/independence) - Underlying need to please adults - Hero worship ("crushes")	-I nsistance on independence, privacy - May have overt rebellion or sulky withdrawal Much testing of limits Roleplaying of adult roles (but not felt to be "real" -easily abandoned)	- Emancipation (leave home) - Re-establishment of amily ties - Assume true adult roles with commitment
2. Peer-Social/Sexual	- Same sex "best" friend - "Am I normal?" concerns - Giggling boy-girl fantasies - Sexual experimentation (inter-course) not normal at this age; Done to: - counteract fears of worthlessness - obtain friends - humiliate parents	- Dating, intense interest in "opposite sex" - Sexual experimentation begins - Risk-taking common - Unrealistic concept of partner's role - Need to please significant peers or either sex. For females, boyfriend alone may be "significant peer"	- Partner selection - Realistic concept of partner's role - Mature friendships - True intimacy possible only after own identity is established - Need to please self too ("enlightened self-interest")
3. School-Vocation	- Still need structured school setting - Goals unrealistic, changing - Grades often drop due to priority on socializing with friends	- More class choices in school setting - Beginning to identify skills, interests - Start part-time job - Begin to react to system's expectations: may decide to beat the establishment at its own game (super achievers) or to reject the game (drip-outs)	- Full time work or college - Identify realistic career goals - Watch for apathy (no future plans) or alienation, since lack of goal-orientation is correlated with unplanned pregnancy, juvenile crime, etc.
[illegible]ception [illegible]y Social Responsibility Values	- Incapable of true self-awareness while still concrete thinker - Losing child's role but not have adult role, hence low self-esteem - Tend to use denial - Stage II Values (back-scratching-good behavior in exchange for rewards	- Confusion/ flux about self-image - Very narcissistic - Impulsive, impatient - Stage III values (conformity-behavior that meets peer group values)	- Realistic, positive self-image - Able to consider other's needs, less narcissistic - Able to reject group pressure if not in self-interest - Stage IV values (social responsibility-behavior consistent with laws and duty)
Chief Health Issues [illegible]er than acute illness)	- Psychosomatic symptoms - Fatigue and "growing pains" - Concern about normalcy - Screening for growth and development problems	- Outcomes of sexual experimentation (STD, teen pregnancy) - Health-compromising behaviors (drugs, alcohol, driving) - Crisis counseling (runaways, acting out, family conflict)	Health promotion/healthy lifestyles - Contraception - Self-responsibility for health and health care
[illegible]rofessional Approach: To retain [illegible]ency, staff should: [illegible]like teenagers [illegible]understand development [illegible]be flexible [illegible]be patient [illegible]keep sense of humor	- Firm direct support - Convey limits - simple, concrete choices - Do not align with parents, but do be an objective caring adult - Encourage transference (hero-wroship) - Sexual decisions - directly encouraging to wait - Encourage parental presence in clinic, but interview teen alone	- Be an objective sounding board (but let them solve own problems) - Negotiate choices - Be a role model - Don't get too much history ("grandiose stories") - Confront gently about consequences, responsibilities - Consider: what gives them status in the eyes of peers? - Use peer group sessions - Adapt systems to crises, walk-ins, impulsiveness, testing - Ensure confidentiality - Allow teens to seek care independently.	- Allow mature participation in decisions - Act as a resource - Idealistic stage, so convey "professional" image - Can expect patient to examine underlying wishes, motives (e.g., pregnancy wish if poor compliance with contraception) -Older adolescents able to adapt to policies, needs of clinic system

Roberta K. Beach, M.D., Director of Adolescent Ambulatory Services, Denver Department of Health and Hospitals, Denver, CO.

A UCSF/Kaiser Permanente Collaboration

NOTES



Working with Adolescents

SUPPORT: Guidelines for Preventive Services Intervention with Adolescents

B-SAFE: Screening Guidelines for Adolescent Interview

KEY PRINCIPLES FOR WORKING WITH ADOLESCENTS

1. Develop an independent relationship with adolescent
2. include discussion about psychosocial issues in adolescent visit
3. Enhance adolescent's perceived control and responsibility over his/her own health and well-being
4. Increase adolescent's appropriate utilization of health care system to enhance his/her health and well-being

PRINCIPLE #1:

Develop an Independent Relationship with Adolescent

- Communicate clearly to adolescent and parents that the adolescent is your patient
- Meet alone with adolescent
- Address adolescent's concerns
- Ensure adolescent confidentiality as appropriate

TIPS Study
A UCSF/Kaiser Collaboration
Funded by AHRQ
Dec. 2001

PRINCIPLE #2

Include Discussion about Psychosocial Issues in Adolescent Visit

- Screen adolescent about important psychosocial issues including substance use, sexual behavior, and safety
- FocUS on health and safety of adolescent

PRINCIPLE #3:

Enhance Adolescent's Perceived Control & Responsibility Over His/Her Own Health & Well-Being

- Involve adolescent in the discussion
- Find out what is important to adolescent
- Link your comments to personal issues of adolescent
- Avoid judgmental or moralistic comments
- Reinforce adolescent's positive choices and behavior
- Support successes-large and small
- Emphasize adolescent's choices and personal responsibility regarding his/her health and safety

PRINCIPLE #4:

Increase Adolescent's Appropriate Utilization of the Health Care System to Enhance His/Her Health and We//-Being

- Link adolescent to helpful resources
- Facilitate adolescent's understanding and knowledge of how to use the health care system and community resources
- Create a supportive environment to facilitate adolescent's future disclosures and appropriate utilization of the system

A UCSF/Kaiser Permanente Collaboration

S U P P O R T

Guidelines for Adolescent Preventive Services Visit

Screen

Understand response

Positive reinforcement

Provide concern

Offer key messages

Resources/referrals

Telephone or visit follow-up

A UCSF/Kaiser Permanente Collaboration

B-SAFE

Screening Questions for Adolescent Visits

Behavior?

Start?

Amount?

Frequency?

Environment?

A UCSF/Kaiser Permanente Collaboration

ADDITIONAL CONSIDERATIONS/CONTEXT

When?

With Whom?

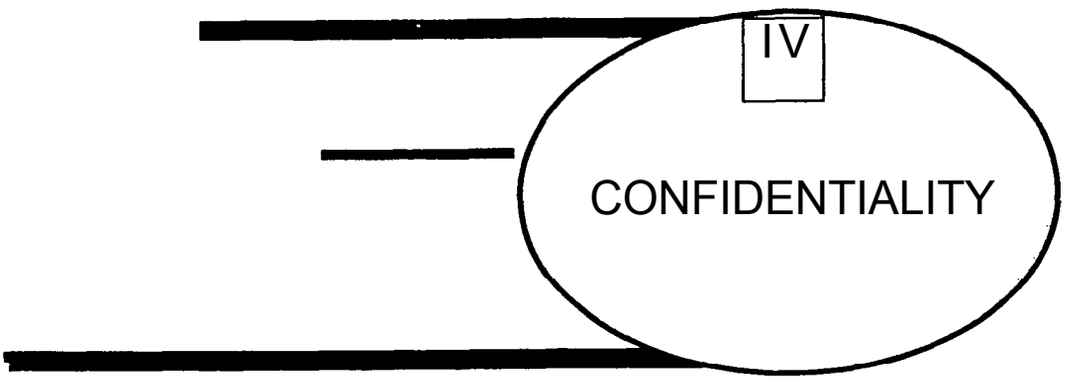
Where?

Additional History

Behavior-Specific Questions

A UCSF/Kaiser Permanente Collaboration

NOTES


IV
CONFIDENTIALITY

Adolescent Health Care
California Law

	REPORT TO STATE	MINOR CONSENT SUFFICIENT*	PARENTAL/ GUARDIAN CONSENT REQUIRED	CONFIDENTIAL CARE**	PARENTAL/ GUARDIAN NOTIFICATION
ABORTION (Family Code 6925)	**No**	**Yes**	**No**		**Not allowed without consent of minor**
BIRTH CONTROL (Family Code 6925)	**No**	**Yes** (except sterilization)	**No** (except sterilization)		**Not allowed without consent of minor**
PREGNANCY TESTING (Family Code 6925)	**No**	**Yes**	**No**		**Not allowed without consent of minor**
PRENATAL CARE (Family Code 6925)	**No**	**Yes** (including inpatient care)	**No** (including inpatient care)		**Not allowed without consent of minor**
STD DIAGNOSIS AND TREATMENT (Family Code 6926)	Syphilis: Gonococcus infection: Granuloma Inguinale: Lymphoganuloma Venereum: Chancroid	**Yes** (minors 12 years and older)	**Not needed** for minors 12 years and older (including inpatient care)	**Yes** (When minor consent is sufficient, or minors who legally can consent to care*)	**Not allowed without consent of minor**
TESTING (Family Code 6926)	**No**	**Yes** (minors 12 years and older, who are assessed as competent to give informed consent)	**Not needed** for minors 12 years and older, unless they are deemed incompetent to consent	**Yes** (when minor consent is sufficient, or minors who legally can consent to care*)	**Not allowed without consent of minor**
OTHER CONTAGIOUS DISEASES (Reportable) (Family Code 6926)	Hepatitis, Tuberculosis, etc.	**Yes** (minors 12 years and older)	**Not needed** for minors 12 years and older	Yes (When minor consent is sufficient, or minors who legally can consent to care*)	**Not allowed without consent of minor**
MENTAL HEALTH TREATMENT – OUTPATIENT (Family Code 6924)	**No**	**No** (except minors 12 years and older, if they are assessed to be mature and in danger of hurting self or others without treatment or the victim of incest or child abuse.) Minor cannot consent for convulsive therapy; psychosurgery, or psychotropic drugs	**Yes** (except when minor consent is sufficient or minors who legally can consent to care*)	**Yes** (except: 1. If minor is younger than 16, is the victim of a crime. and disclosure is assessed to be in the best interests of the minor. 2. Child Abuse Reporting is necessary; 3. Minor is danger to self or others)	An attempt should be made, except when deemed inappropriate
MENTAL HEALTH TREATMENT – INPATIENT	**No**	**No**	**Yes**	**Yes** (except 1. If the minor is younger than 16, is the victim of a crime, and disclosure is assessed to be in the best interests of the minor, 2. Child Abuse Reporting is necessary; 3. Minor is danger to self or others)	**Yes**

Kristin Chambers, Director, TPMG Compliance, 1/9/02

	REPORT TO STATE	MINOR CONSENT SUFFICIENT'	PARENTAL/ GUARDIAN CONSENT REQUIRED	CONFIDENTIAL CARE**	PARENTAL / GUARDIAN NOTIFICATION
ALCOHOL / DRUG ABUSE TREATMENT (Family Code 6929)	**No**	**Yes** (minors 12 years and older – except methadone treatment)	**Not needed** for minors 12 years and older (including inpatient care); except Methadone or LAAM treatment However, parents can consent over the child's objection	**Yes** (when minor consent is sufficient or minors who legally can consent to care*) [Code of Federal Regulations – 42 CFR 2.14(b)]	**Yes,** If appropriate
RAPE (Family Code 6927)	Child Abuse Reporting Law, when appropriate (Penal Code 11166)	**Yes** (minors 12 years and older)	**Not needed** for minors 12 years and older (including inpatient care)	**Yes** (when minor consent is sufficient, or minors who legally can consent to care*)	An attempt should be made, except when parent/guardian was responsible
SEXUAL ASSAULT (Family Code 6928)	Child Abuse Reporting Law, when appropriate (Penal Code 11166)	**Yes**	**No** (including inpatient care)	**Yes** (If appropriate, Child Abuse Reporting Law overrides physician-patient privilege)	An attempt should be made, except when parent/guardian was responsible
NON-SURGICAL CARE	**No**	**No** (except where minor is legally able to consent* - and in specific circumstances, e.g. sexual health, mental health, as listed above)	**Yes** (except when minor consent is sufficient, or minors who legally can consent to care*)	**No** (except when minor consent is sufficient, or minors who legally can consent to care*)	**Yes** (except when minor consent is sufficient, or minors who legally can consent to care*)
SURGICAL TREATMENT	**No**	**No** (except where minor is legally able to consent* - and in specific circumstances, e.g. abortion)	**Yes** except when minor consent is sufficient, or minors who legally can consent to care*)	**No** (except when minor consent is sufficient or minors who legally can consent to care*)	**Yes** (except when minor consent is sufficient or minors who legally can consent to care*)
EMERGENCY CARE	**No**	MD can proceed without consent if clinically or medically necessary	MD can proceed without consent if clinically or medically necessary		MD can proceed without consent if clinically or medically necessary

***Informed consent implies that the minor (or the parent or guardian) is sufficiently mature (i.e. understands the health professional and can make a clear choice between presented alternatives).**
In most cases, minors (people **younger than 18 years) do not have the legal capacity to consent to their own medical care. Consent of a parent, guardian, or the courts is required until the minor's 18 birthday.**
The exceptions:
1. **Emancipated minors (by marriage, those sewing in the Armed Forces. or 14 and older by court declaration) may consent to all forms of medical care.**
2. **Self-sufficient minors (minors 15 years or older, living on their own, managing their own finances) may consent to all types of health care**

Where minors have the legal right to consent to care, they also have the legal right to refuse care

****Where minors have the legal right to consent to care, they also generally have the legal right to control disclosure of medical information and assert the physician-patient privilege.**
In other cases, the provider can restrict parental access to medical records if it is determined that access would have a detrimental effect on the minor or on the provider's relationship with the minor. Confidentiality includes access to medical records

***In the case** of Self-Sufficient **minors, a provider may inform parents in some cases, before or alter treatment. whether or not the minor agrees.**

Kristin Chambers, Director, TPMG Compliance, 1/9/02

Topic: Confidentiality

Guideline: Confidential care must be provided to all teens.

Strength: suggested

Rationale:

- California law requires provision of confidential care to those who can consent for treatment. Minors can consent to the prevention or treatment of pregnancy, diagnosis and treatment of STDs, diagnosis and treatment of drug or alcohol related problems, and, in some circumstances, outpatient mental health treatment or counseling(1).
- There is a strong national consensus endorsing confidential health services for adolescents among national health organizations(2).
- Confidentiality emerges as a central theme in what adolescents consider important in the delivery of health care(3). Both physicians and adolescents believe uncertainty about confidentiality of health services leads some youths to suppress relevant information and to delay or avoid medical care. If parental notification were required, only 45% of adolescents reported in a study of suburban youth that they would seek services for depression, 19% for birth control, 15% for treatment for a STD, and 17% for treatment of drug use (4). If assured confidentiality, however, these figures rose substantially: 57% reported that they would seek care for depression, 64% for contraceptive services, 65% for STDs, and 66% for drug use. In a study of 1,295 students in the 9th through 12th grades, 58% of students stated they have health concerns that they would not want their parents to know about, and 25% of students reported that they would not seek health care because of fear their parents would find out (5).

Steps:

- Talk to adolescents alone to ensure their privacy. This is usually best accomplished by talking to the adolescent alone first, if the adolescent is accompanied to the visit by an adult.
- Communicate to adolescents that their care is confidential. Exceptions are legal requirements for disclosure if the teen is suicidal, the victim of abuse, a danger to others or has a gunshot wound. If possible, discuss this policy with the parents.
- Ensure that systems are in place in each facility that safeguard the confidentiality that has been promised to the teen. For teens who request confidentiality, there should be no appointment reminders, no satisfaction questionnaires and no information regarding the visit given over the phones.

References:

1. California Family Code
2. Gans JE. Policy Compendium on Confidential Health for Adolescents. Chicago: American Medical Association, 1993
3. Resnick MD, Blum RW, Hedin D. The appropriateness of health services for adolescents: youths' opinions and attitudes. J Adolesc Health Care 1980;1:137-141.
4. Marks A, Malizio J, Hoch J, Brody R, Fisher M. Assessment of health needs and willingness to utilize health care resources of adolescents in a suburban population. J Pediatr 1983;102:456460.
5. Cheng TL, Savageau JA, DeWitt TG. Confidentiality in health care: A survey of knowledge, perceptions, and attitudes among high school students. JA MA 1993;369: 1404- 1407.

STATUTORY RAPE AND REPORTING LAWS
WHAT YOU NEED TO KNOW

SUSAN POWERS
Assistant Head Deputy, Sex Crimes Division
Los Angeles County District Attorney
(213) 974-1611

I. THE LAW

In California. it is a crime to have sexual relations with a person under age 18. There are a variety of statutes that address this activity. The potential penalties generally increase as the age of the minor partner decreases. It is important to note that many of these crimes can be committed by minors upon minors.

Penal Code Section 261.5 -- Unlawful Sexual Intercourse With A Minor

- applies when at least one party is under age 18
- the parties are not married to each other
- the parties must engage in an act of sexual intercourse

Note: there are code sections which punish other sexual acts where at least one party is under age 18:
Penal Code Section 288a(b) -- oral copulation
Penal Code Section 286(b) -- sodomy
Penal Code Section 289(h) or (i) -- penetration with a foreign object (for instance a finger)

- less than a 3-year age difference between the parties = misdemeanor
  punishment = up to 6 months in jail & a fine of $1,000

- greater than a 3-year age difference between the parties = wobbler (can be either a felony or a misdemeanor)
  if it's a misdemeanor = up to 1 year in jail
  if it's a felony = up to 3 years in state prison

- victim under age 16 & defendant over age 21 = wobbler
  misdemeanor = up to 1 year in jail
  felony = up to 4 years in prison

Note: the penalty for the other sexual. acts. oral copulation. sodomy & penetration with a foreign object where the victim is under age 16 & the defendant is over age 21 is up to 3 years. In

addition. everyone convicted of one of these crimes (not sexual intercourse) with a person under age 18 must register as a sex offender for life unless the governor grants a pardon.

Penal Code Section 288(c) -- Lewd Act With a Child Age 14 or 15

- applies when victim is either age 14 or 15 & defendant is more than ten years older
- does not require sexual intercourse, just touching with a lewd intent

Penalties

- all 288(c)s are wobblers
  misdemeanor = up to 1 year in jail
  felony = up to 3 years in prison
- mandatory registration as a sex offender for life unless governor grants a pardon

Note: the penalty for oral copulation, sodomy & penetration with a foreign object where the victim is 14 or 15 & the defendant is more than 10 years older is up to 8 years in prison

Penal Code Section 288(a) -- Lewd Act With a child Under Age 14

- applies when victim is under age 14:
- can be any touching with lewd intent

Penalties

- all 288(a)s are felonies
  felony = up to 8 years in prison
- can get probation only under very limited circumstances
- mandatory registration as a sex offender for life unless governor grants a pardon

II. REPORTING CHILD ABUSE

Because children are among the most defenseless victims of crime, the law provides special protection for them. A key legal protection is the requirement that people involved in certain occupations must report suspected child abuse to authorities. The District Attorney gives the highest priority to child abuse reporting by professionals. Since so many incidents of abuse occur in the home and involve family & friends. it is incumbent on professionals to report suspected child abuse.

YOU ARE NOT REQUIRED TO REPORT EVERYTHING THAT COULD BE DEFINED AS A CRIME. ONLY CERTAIN INSTANCES OF CONDUCT THAT HAVE BEEN SPECIFIED BY THE LEGISLATURE.

MANDATORY REPORTER OCCUPATIONS:

Child Care Custodians (in any public or private school)
Health Practitioners
Child Visitation Monitor
Animal Control Officer
Humane Society Officer
Firefighters
Clergy Member

WHAT SHALL BE REPORTED:

- If you observe a child while in professional capacity or within the scope of the job

  -AND-

- know or reasonably suspect that the child has been abused

  reasonable suspicion means: it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position. drawing when appropriate on his or her training & experience. to suspect child abuse

  child means: any person under the age of 18

  child abuse means:
  - sexual abuse of a child
  - a physical injury that was not accidental
  - any act covered under PC§ 273(a) or (d)
  - neglect of a child or abuse in out-of-home care

  child abuse does not mean:
  - a mutual "affray" between minors
  - injury caused by reasonable & necessary force used by a peace officer during work

  sexual abuse means sexual activity or sexual exploitation:

  Sexual activity: (effective Jan 1, 1998)
  - rape (Penal Code Section [PC§] 261)
  - statutory rape where one party is under age 16 & the other is over age 21 (PC§ 261.5)
  - rape in concert (PC§ 264.1)
  - incest (PC§ 285)

- sodomy (PC§ 286)
- lewd act on a child (PC§ 288 (a), (b), or (c)(1)]
- penetration by a foreign object (PC§ 289)
- oral copulation (PC§ 288a)
- child molestation (PC§ 647.6)

Sexual exploitation:

- preparing, selling or distributing matter depicting a minor engaged in obscene acts
- coercing a child to engage in prostitution or coercing parental consent for a child to engage in prostitution
- depicting a child in or creating, developing or trading photos of minors engaged in obscene sexual conduct -

WHEN MUST YOU REPORT SEXUAL ABUSE?

Whenever you observe a child in your professional capacity or within the scope of your job and know or reasonably suspect that any of the following have occurred:

1. any forcible sexual act

2. any sexual activity where one parry is under age 16 and the other parry is over age 21 whether the conduct is consensual or not [a violation of either PC§ 261.5(d) or 288(c)] *This change was effective January 1, 1998*

3. any sexual activity where one party is under age 14 & the other party is over age 14 whether the conduct is consensual or not

4. a report is not mandatory if both parties are under age 14 and the conduct is consensual unless there is a significant difference in their ages/ development.

Pregnancy by itself does not trigger a mandatory report:

REPORT TO CHILD PROTECTIVE AGENCY IMMEDIATELY

- child protective agency means: a police or sheriffs department, a county probation department or a county welfare department. It does not include a school district police or security department.

CHILD ABUSE HOTLINE: (800) 540-4000
FAX: (213) 620-9525

- send written report within 36 hours

- must report even if the child has died whether or not the abuse contributed to the death

- there is no mandatory duty to report past incidents of child abuse if the victim is no longer under age 18

WHAT MAY BE REPORTED:

- when you reasonably. suspect that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way

- any "consensual" sexual act where one party is under age 18 and a mandatory report is not otherwise required

  Note: technically under the law, a person under age 18 is not capable of consenting. In actuality, however, we know that some people under age 18 do knowingly agree to have sex.

PROTECTING THE REPORTER'S IDENTITY:

- the reporter's identity will only be disclosed between child protective agencies. or to counsel representing a child protective agency, or to the district attorney in a criminal prosecution or to attorneys representing the child. or county counsel, or to licensing agencies when abuse is in out-of-home care, or when waived by the reporter, or when ordered by the court

- none of the agencies above may disclose the identity of the reporter without consent or by court order

IMMUNITY:

- mandated reporters are immune from civil or criminal liability for any report required or authorized by the code

- all other reporters are immune from civil or criminal liability unless the report was made with reckless disregard for the truth or falsity of the report & the person who reported knew it.

- if a reporter is sued, he or she may submit a claim to the State Board of Control for reasonable attorneys' fees

FAILURE TO REPORT IS A MISDEMEANOR AND IS PUNISHABLE BY 6 MONTHS IN COUNTY JAIL OR A FINE OF $1,000 OR BOTH

III. DISTRICT ATTORNEY STATUTORY RAPE FILING CRITERIA

The District Attorney's Office has a special unit dedicated solely to vertical prosecution of statutory rape. Vertical prosecution means that the same deputy district attorney handles all stages of the case from filing to sentencing. Non-vertically prosecuted cases are generally handled by different deputies at each stage.

There are many advantages to vertical prosecution, including:

1. Deputies specialize in. sexual assaults and are familiar with all aspects of these kinds of cases including the law and procedure unique to sex crimes. psychological evidence and the effects that sexual assault have on victims, serology, DNA, and medical evidence.

2. Victims are less traumatized by the system. They need fewer interviews and can develop a rapport with "their DA." It's important to note mat deputy DAs are not attorneys for the victim. they represent the state. But, they present the victim's testimony in court. Furthermore, victims of statutory rape seldom view themselves as victims of a crime but, of the system. Consistency with one attorney goes a long way to easing this problem.

3. Lower caseloads for the deputy DA which allows more time for case preparation and victim contact.

4. Vertical prosecution has been shown to improve conviction rates, reduce trauma to victims & provide more consistent, appropriate sentencing.

The Statutory Rape Vertical Prosecution Unit was created with the assistance of the State Office of Criminal Justice Planning (OCJP) as part of the Partnership for Responsible Parenting. The Partnership for Responsible Parenting is a four-part program designed to educate the public. assist adolescents and their partners and prosecute adults who continue to engage in sexual activity with underage minors. The four segments of the program include: community challenge grants to organizations throughout the state who target people who are likely to engage in sexual activity with minors to educate them to the dangers of such activity, mentoring programs to target at-risk youth, a media campaign Km by the State Department of Health to educate the public and the statutory rape vertical prosecution program.

All 58 counties in California were invited to participate in the program, 53 accepted the invitation. In Los Angeles, we have two deputy district attorneys dedicated full time to the project. We also have a district attorney investigator and a victim advocate. The program is

Appendix A: Child Sexual Assault Reporting Requirements

Activity	Report Required?	Source
Minor under age 14: Consensual sexual activity with minor partner under age 14 and of similar age, and additional facts do not suggest abuse. This includes minors under age 14 who seek medical treatment for STDs, pregnancy, or abortion, where practitioners believe these conditions are the result of consensual sexual activity, and additional facts do not suggest abuse.	NO	*Planned Parenthood Affiliates of CA v. Van de Kamp* *People v. Stockton Pregnancy Control Medical Clinic* 67 Ops.Atty.Gen. 235, 6-1-84
Minor under age 14: Consensual sexual activity with partner age 14 or over, and additional facts do 'not suggest abuse.	YES	Cal. Penal Code §288(a) Cal. Penal Code § 11165.1(a) *In re Paul C.*
Minor age 14 or 15: Consensual sexual activity with partner at least 10 years older, and additional facts do not suggest abuse.	YES	Cal. Penal Code § 288(a) Cal. Penal Code § 11165.1(a)
Minor age 14 or over Consensual sexual activity with minor partner age 14 or over and of similar age, and additional facts do not suggest abuse.	NO	Imputed from lack of requirement for younger minors, legislative silence on the issue, and holding in *People v. Stockton*
Minor under age 16: Consensual sexual intercourse (statutory rape) with partner age 21 or older, and additional facts do not suggest abuse.	YES	Cal. Penal Code § 261.5(d) Cal. Penal Code § 11165.1(a)
Minors age 14 or over but younger than age 16: Consensual sexual activity with person under 21, and additional facts do not suggest abuse.	NO	Not specifically mandated by new reporting law
Minor age 16 or over: Consensual sexual activity with adult of any age; and additional facts do not suggest abuse.	NO	Not specifically mandated by new reporting law
Other situations where provider knows or has a reasonable suspicion that there has been sexual assault, as defined in the statute.	YES	Cal. Penal Code § 11165.1(a)

Common Questions and Answers About Child Abuse Reporting Requirements for Health Practitioners

This information is intended to be a general reference guide to questions about mandatory reporting of child abuse. Information presented herein should not be construed as legal advice. Specific questions regarding interpretation of the law should be referred to your Medical-Legal Chief, Medical-Legal attorney, TPMG Compliance department or the TPMG Legal department.

1. **Who must report child sexual abuse?**

Health practitioners are required to report suspected cases of child abuse when they have knowledge of or observe a child in their professional capacity or within the scope of their employment whom they reasonably suspect has been the victim of child abuse.

"Health practitioner" means a physician, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, or any other person who is licensed under Business and Professions Code section 500 et seq.[1] Other health care professionals covered by mandatory child abuse reporting laws include, but are not limited to paramedics, psychological assistants, and coroners.

Mandated reporters have absolute immunity from civil or criminal liability for reporting and/or providing CPS access to the victim

2. **Are others permitted to report?**

The law permits, but does not require, reporting from any other person who has knowledge of or observes a child whom he or she knows or reasonably suspects has been a victim of child abuse. Under the law, no one can prevent you, whether a licensed or unlicensed healthcare professional, from filing a report.

The TPMG Compliance Department recommends that MAs or other professionals forward questions or cases to their supervisor and/or treating physician or nurse practitioner who enjoy absolute immunity. Voluntary reporters do not enjoy "absolute immunity" – if an intentionally false report is filed, the reporter could be found civilly and criminally liable.

3. **What is reportable child abuse?**

Penal Code § 11165.6 Child abuse
"As-used in this article, 'child abuse' means a physical injury which is inflicted by other than accidental means on a child by another person. Child abuse also means the sexual abuse of a child or any act or omission proscribed by Section 273a (willful cruelty or

[1]Other persons include lab technicians, speech pathologists, audiologists, occupational therapists, physical therapists, dietitians, pharmacists, psychiatric technicians, acupuncturists, social workers, marriage, family and child counselors, physician assistants, registered nurses, and licensed vocational nurses.

(3) Reportable under PC § 288(a), lewd and lascivious acts upon a minor under 14. The court in People v. Stockton Pregnancy Control found that Planned Parenthood's rationale does not apply to situations in which one party is under 14 and the other is over 14.[2]

(4) Reportable as statutory rape, PC §261.5(d), *if they had sexual intercourse.* ("Any person 21 years of age or older who engages in an act of unlawful sexual intercourse with a minor who is under sixteen years of age is guilty of either a misdemeanor or a felony...." §26l.5(d)). But remember, pregnancy alone "does not, in and of itself, constitute a basis of reasonable suspicion of sexual abuse." PC§11166

(5) Also reportable under PC §288(c)(1), lewd and lascivious acts upon a minor 14 or 15 if the partner/perpetrator is at least 10 years older than the minor. ("Any person who commits an act described in subdivision (a) with the intent described in that subdivision, and the victim is a child of 14 or 15 years, and that person is at least 10 years older than the child, is guilty of a public offense...." PC §288(c)(1))

5. Do I have to ask my patient his or her partner's age?

No.

6. Must I report a minor patient's request for birth control?

No. Regardless of the patient's age, a request for birth control is not reportable.

7. What happens when a report is made?

(taken from "An Analysis of Assembly Bill 327; New California Child Abuse Reporting Requirements for Family Planning Providers," Catherine Teare and Abigail English, JD, National Center for Youth Law, May 1998)

It depends. The response to reports of child abuse varies greatly by location. The law says that, after receiving a report of child abuse, a county welfare or probation department must immediately make a cross-report to the law-enforcement agency having jurisdiction over-the case. Similarly, law enforcement agencies must cross-report to the county welfare department and to the district attorney's office. (Cal. Penal Code §11166 (i))

The risks and benefits of reporting to the welfare department (CPS) or the police also vary by location, as do these agencies' responses. In some places, providers feel that CPS rarely follows up on any abuse reports regarding adolescents, especially if they are related to consensual sexual activity. In other communities, CPS and law enforcement agencies are aggressive in pursuing these investigations. It is important that providers understand

[2] Penal Code §288(a) – "Any person who willfully and lewdly commits any lewd or lascivious act, ...upon or with the body, or any part or member thereof, of a child who is under the age of 14 years, with the intent of arousing, appealing to, or gratifying the lust, passions, or sexual desires of that person or the child, is guilty of a felony...."

the philosophies and practices of their local agencies. Providers are encouraged to consult with their local CPS agencies, police departments, and district attorney's offices.

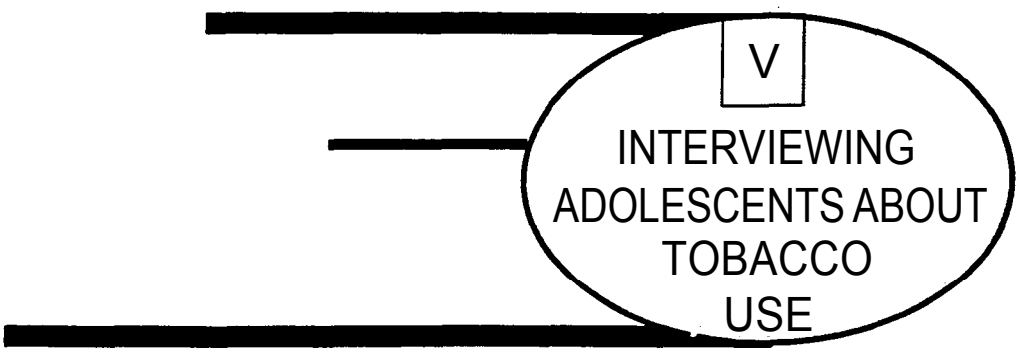
8. What happens if I don't report?

Failure to report is a misdemeanor, punishable by imprisonment in the county jail for up to six months, or by a fine of up to $1,000, or both. (Penal Code §11172(e))

In addition, courts have found health care practitioners civilly liable for failure to report when additional abuse was inflicted after the date when a report should have been made.

9. What should I tell my patient about confidentiality and mandatory reporting?

Minors have the right to receive some confidential medical services such as reproductive services, drug and alcohol treatment, etc. However, it is important to remember that you cannot guarantee confidentiality for all services all the time — for example, telling a minor patient "Everything you tell me is confidential," could be misleading. You may want to alert your minor patients that 1) only certain medical services to minors can be kept confidential from their parents; and 2) you are obligated to report suspicions of child abuse.



Screening Questions

Key Messages for Tobacco Use

Message Tips for Tobacco Use

Background Articles

TIPS
Teens: Increasing Preventive Services
A UCSF/Kaiser Permanente Collaboration

SCREENING QUESTIONS FOR TOBACCO

Behavior?

- Have you ever smoked cigarettes?

Start?

- How long have you been smoking/chewing?
- When was the last time you smoked/chewed tobacco?
- Has a doctor ever told you that you have asthma?

Amount?

- How many cigarettes (or snuff) do you usually smoke (or chew) in a day?

Frequency?

- How often do you smoke/chew tobacco?

Environment?

- Do your friends use tobacco?
- Does anyone in your family or household use tobacco?

A UCSF/Kaiser Permanente Collaboration

ADDITIONAL TOBACCO SCREENING QUESTIONS

- When do you smoke/chew?
- With whom do you smoke/chew?
- How do you get your cigarettes/chewing tobacco?

ADDICTION QUESTIONS:

- Have you ever tried to quit smoking/chewing tobacco? When? How? What happened?
- Is it extremely difficult for you to go a half-day without using tobacco?
- Do you have strong cravings for tobacco (nic fits)?
- Do you feel a need to smoke a certain number of cigarettes each day?
- Do you think you could quit at any time?

A UCSF/Kaiser Permanente Collaboration

KEY MESSAGES FOR TOBACCO

Message 1

♦Avoiding tobacco is very important for your health

Message 2

♦Smoking/Chewing tobacco becomes a habit that is hard to break

Message 3 – for teens who smoke/chew only

♦When you decide to stop using tobacco, I can help you and there are resources here at Kaiser to help you

A UCSF/Kaiser Permanente Collaboration

TIPS PREVENTIVE SERVICES VISIT — SAMPLE INTERVIEW FOR *TOBACCO USE*

FOR NON-SMOKERS/NON-CHEWERS

SCREEN

Do you smoke/chew?
(Start, Amount, Frequency, Environment)

UNDERSTAND RESPONSE

It sounds like you do not smoke/chew. Although most people don't smoke/chew, some adults and teens tell us it is really hard to keep from smoking/chewing – how have you been able to keep from smoking/chewing?

POSITIVE REINFORCEMENT

It is great that you have made the choice to avoid smoking/chewing. Because you've decided not to smoke/chew, you're making one of the smartest and most important decisions about protecting your health. Smoking/chewing causes cancer and kills millions of people each year. It is great that you are taking responsibility for your health and well-being.
I know it can get harder to not smoke/chew when you get older, but it is very important for your health that you continue to make the good choice you have made in not smoking/chewing.

As you get older, you may find that some people say they use cigarettes to reduce stress and to reduce the amount of food they eat. But cigarettes are not a good way to reduce stress or to reduce the amount of food you eat. If you ever want to talk more about these things, please get in touch with me and we can talk.

FOR NON-SMOKERS WHOSE FRIENDS SMOKE/CHEW

SCREEN

(Environment)
Do your friends smoke/chew?

UNDERSTAND RESPONSE

You said that some of your friends smoke. Sometimes friends can pressure their friends to smoke/chew even when they don't want to. Does this ever happen to you?

How are you able to make the responsible choice not to smoke/chew when some of your friends are smoking/chewing?

POSITIVE REINFORCEMENT

It is more difficult to choose not to smoke/chew if friends pressure you to smoke, and it is great that you have chosen not to smoke/chew even though some of your friends are smoking/chewing.
I know it can get harder to not smoke/chew when you are in high school, but it is very important for your health that you continue to make the good choice you have made in not smoking/chewing. If you ever want to talk more about these things, please get in touch with me and we can talk.

FOR SMOKERS/CHEWERS

SCREEN

Do you smoke/chew?
(Start, Amount, Frequency, Environment)

UNDERSTANDING RESPONSE

It sounds like you smoke a few cigarettes once a week. Tell me about the times when you have made the choice *not* to smoke.

POSITIVE REINFORCEMENT

I am glad there are times when you have chosen to not smoke. You've used great self-control during these times.

PROVIDE CONCERN

As your doctor caring for your health, I aim glad you don't smoke/chew (amt/frequency), and I am very concerned that you do smoke/chew (amt/frequency). Choosing whether or not to smoke/chew is one of the most important decisions you will make about your health. It is important for you to take responsibility for your own health and think seriously about the effect smoking/chewing is having on your health now and as you get older.

Just like the decision to start smoking/chewing, the decision to quit or cut down on smoking is yours to make. Quitting or cutting back on smoking/chewing now, while you're young, can protect you from many of the dangerous effects of smoking/chewing on your health.

Sometimes a good first step in thinking about quitting or cutting back is to think about why smoking/chewing is important to you, and about whether there are any reasons you might want to consider cutting back or quitting. Have you thought about cutting back/quitting? What are some reasons you might want to cut back/quit?

(Add to adolescent's response as appropriate)
Some of the reasons other adolescents give for deciding to quit or cut back are things like:

- noticing that smoking is interfering with sports
- coughing
- trouble breathing
- being bothered by frequent colds/coughs
- their breath/clothes smell like smoke
- cigarettes cost a lot of money
- boyfriend/girlfriend doesn't want to kiss them
- fear of lung cancer

OFFER KEY MESSAGES

For teens who have not yet considered quitting:

I know quitting or even cutting back is not easy. I want you to know that as your doctor, I think it is extremely important for your health to consider quitting or at least to begin cutting back on smoking/chewing. I would like you to think about it and let me know if you want some help getting started when you are ready to cut back or quit.

RESOURCES/REFERRALS

For teens who are considering quitting:

It is great that you are interested in quitting smoking/chewing and that you are taking responsibility for your own health and well-being. Although quitting smoking/chewing can be difficult, there are lots of different approaches that have worked for people (e.g., going "cold turkey," gradually cutting back, giving up the least important cigarette of the day first, etc.). I can work with you, or we have people here at Kaiser who can help you since you are ready to quit. Here is a card with my name and some information about making appointments at Kaiser.

TELEPHONE/VISIT FOLLOW-UP

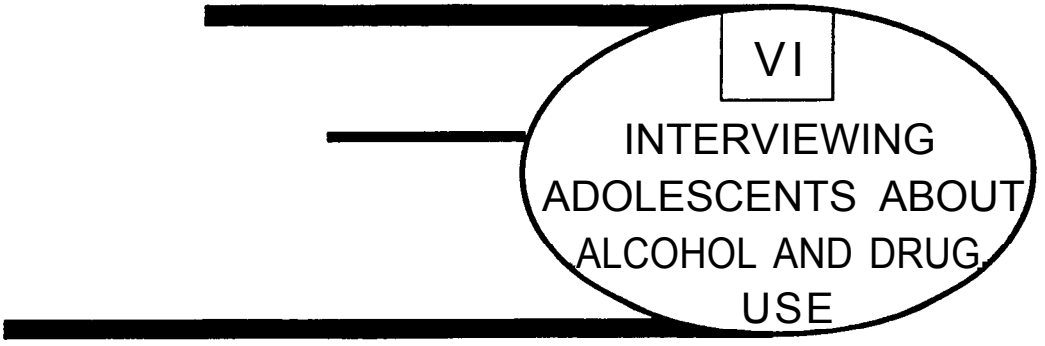
Schedule follow-up sessions if working with the teen to quit smoking or facilitate referral.

A UCSF/Kaiser Permanente Collaboration

NOTES

Please refer to the following publication:

John Kulig (2011) “Substance Use and Abuse” (chapter 172) in Textbook of Adolescent Health Care. American Academy of Pediatrics



Screening Questions

Key Messages for Alcohol and Drug Use

Message Tips for Alcohol and Drug Use

Background Articles

A UCSF/Kaiser Permanente Collaboration

SCREENING QUESTIONS FOR ALCOHOL/DRUGS

Behavior?

- Have you ever drunk alcohol/used drugs?
- What kind of alcohol/drugs do you use?

Start?

- How long have you been using alcohol/drugs?

Amount?

- How much do you usually drink?
- How much (quantify for specific drug) do you usually use/take/smoke?
- Have you ever had 5 or more drinks of alcohol in a row or engaged in binge drinking?

Frequency?

- How often do you drink/use drugs?

Environment?

- Do any of your friends or family drink alcohol/use drugs?
- Have you ever been in a car with a driver after he/she was drinking/using drugs?
- Have you ever driven after drinking/using drugs?

A UCSF/Kaiser Permanente Collaboration

ADDITIONAL ALCOHOL/DRUGS SCREENING QUESTIONS

- When do you drink/use drugs?
- With whom do you drink alcohol/use drugs?
- How you do get your alcohol/drugs?

TIPS
Teens: Increasing Preventive Services
A UCSF/Kaiser Permanente Collaboration

KEY MESSAGES FOR ALCOHOL AND DRUGS

Message 1

- Avoiding alcohol and drugs is very important for your health and safety

Message 2

- Avoid driving a car, riding a bike, skateboarding, swimming, boating, riding a scooter, or doing any activity that is dangerous under the influence of alcohol/ drugs or with someone who is under the influence

A UCSF/Kaiser Permanente Collaboration

TIPS PREVENTIVE SERVICES VISIT—SAMPLE INTERVIEWS FOR ALCOHOL *USE*

FOR NON-DRINKERS

SCREEN

Have you ever drunk alcohol?
(Start, Amount, Frequency, Environment)

UNDERSTAND RESPONSE

You said that you have never tried alcohol. Although most teens don't drink, some teens your age have tried alcohol at least once. How have you been able to keep from trying it?

At some point, you may find yourself around other people or older teens who are drinking. Drinking alcohol interferes with people's judgment and ability to control their behavior. It is important to avoid situations where their drinking might hurt or injure you, like being in a car with a driver who has been drinking, being at a party where you don't know many people or don't have a ride home, and being in other dangerous situations. Have you ever been in any of these types of situations?

How do you handle it when other people are drinking and you are not?

POSITIVE REINFORCEMENT

It is great that you have made the choice not to drink. Drinking can lead to car accidents, injuries, poor decisions, and many other problems. Deciding not to drink is a very smart and important decision about protecting your health. It is great that you are taking responsibility for your health and well being by not drinking.

Most teens your age also do not drink. I know it can get harder to not drink as you enter high school, but it is very important for your health that you continue to make the good choice you have made to avoid alcohol.

FOR TEENS WHO DRINK

SCREEN

Have you ever drunk alcohol?
(Start, Amount, Frequency, Environment)

A UCSF/Kaiser Permanente Collaboration

UNDERSTAND RESPONSE

It seems like you occasionally drink alcohol.

POSITIVE REINFORCEMENT

I am glad that you have found ways to make the choice not to drink sometimes. It is sometimes hard to avoid alcohol when friends are drinking.

How have you been able to avoid alcohol during these times when you chose not to drink?

PROVIDE CONCERN

It's great that you were assertive in the situation where you decided not to drink. Still, as your doctor, I am very concerned about the times when you are drinking. Choosing whether or not you drink is an important decision about your health and safety. It is important for you to take responsibility for your own health and think seriously about the effect that alcohol has on you. To protect yourself, it is helpful to think about when, how much and under what circumstances you choose to drink. Many accidents that injure or harm teens your age involve alcohol.

Lots of things can influence the way alcohol affects your body and your ability to make a decision that can keep you safe:

- How tired you are
- How much you weigh
- How long it's been since you ate anything
- The amount and kind of alcohol you're drinking
- If you're also taking any other drugs or medicines

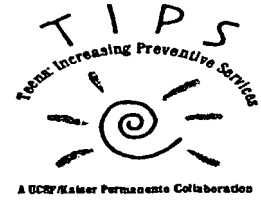
Sometimes a first step in thinking about not drinking is to think about why you drink and whether there are some reasons why you might want to cut back or stop.

Have you thought about stopping or cutting back on your drinking?

Have you thought of some reasons to stop/cut_ back on drinking?

Some of the reasons other teens have given for deciding to quit or cut back were things like (Add some that seem relevant to the teen's list of reasons):

- alcohol can interfere with school and athletic performance
- alcohol can impair judgment and lead to accidents while driving
- alcohol can increase unsafe sexual practices, increasing risk of pregnancy and STDs (including HIV)
- you can become addicted



- alcohol can cost a lot of money
- alcohol can taste bad
- alcohol can cause family fights
- alcohol can cause liver cancer
- alcohol can cause heart disease

OFFER KEY MESSAGES

Avoiding alcohol is very important for your health and safety.
Avoid driving a car, riding a bike, skateboarding, swimming, boating, riding a scooter, or doing any activity that is dangerous under the influence of alcohol or with someone who is under the influence.

For all teens who are drinking or whose friends are drinking:

There are some things you can do to keep yourself safe:

If you hang around friends who drink, always have a designated driver when you will need a ride home. If you think that the person driving has been drinking, find another way home (call a taxi, your parents, another friend or relative).

For teens who have not considered stopping/cutting back on drinking:

I understand that you have not thought about stopping drinking at this time, but I want you to know that I think it is very important for your health and well-being to consider stopping drinking or at least cutting down on your drinking. Sometimes, without really realizing it, alcohol can begin to have a very negative effect on your life, and start to cause problems for you and people you love.

For teens who have considered stopping/cutting back on drinking:

I am glad to hear that you have thought about stopping/cutting back on your drinking. It is great that you are thinking about ways to take responsibility for your own health and well being. One good way to take responsibility is to talk to someone who can help you make changes that you want to make.

RESOURCES/REFERRALS

We have people here at Kaiser who can help you quit (or when you are ready to quit). I'd like you to look over this brochure. Here is a card with my name and some information about. making an appointment at Kaiser.

TELEPHONE/VISIT FOLLOW-UP

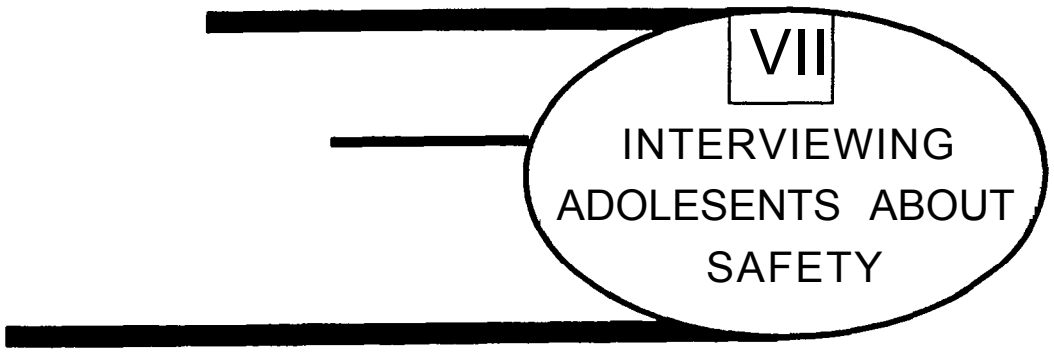
Schedule follow-up sessions if working with teen to avoid alcohol, or facilitate referral.

A UCSF/Kaiser Permanente Collaboration

NOTES

Please refer to the following publication:

Werner MJ, Hoover A Jr: Early identification and intervention for adolescent alcohol use. Adolescent Health Update (American Academy of Pediatrics) 10(1): 1-8,1997



Screening Questions

Key Messages for Seatbelt & Helmet Use

Message Tips for Seatbelt & Helmet Use

Background Articles

TIPS
Teens: Increasing Preventive Services
A UCSF/Kaiser Permanente Collaboration

SCREENING QUESTIONS FOR HELMET/SEATBELT

Behavior?

- Do you use a seatbelt when riding in/driving a car?
- Do you wear a helmet when riding/biking/ skateboarding/blading/using a scooter?

Start?

- Have you ever driven/biked/skateboarded/ bladed/scooted after drinking or using drugs?

Amount?

- Do you own a helmet?

Frequency?

- How often do you use your seatbelt when riding in a car?
- How often do you wear your helmet when riding/biking/skateboarding/blading/using a scooter?

Environment?

- Do your friends wear seatbelts?
- Do your friends wear helmets?

TIPS
Teens: Increasing Preventive Services
A UCSF/Kaiser Permanente Collaboration

KEY MESSAGES FOR SEATBELT USE

Message 1

- Wear a seatbelt every time you ride in a car (for teens 15 ½ and older add: and every time you, drive a car)

KEY MESSAGES FOR HELMET USE

Message 1

- Wear a helmet every time you blade/board/ bike/scooter

Message 2

- If you don't have a helmet, don't blade/ board/bike/scooter until you get one

TIPS PREVENTIVE SERVICES VISIT-SAMPLE INTERVIEWS FOR *SEATBELT USE*

FOR TEENS WHO WEAR A SEATBELT ALL THE TIME

SCREEN

Do you use a seatbelt when riding in a car?
(Start, Amount, Frequency, Environment)

UNDERSTAND RESPONSE

It sounds like you wear your seatbelt every time you ride in a car. Some people find it hard to wear a seatbelt all the time. How are you able to do it?

POSITIVE REINFORCEMENT

It is great that you wear your seatbelt *every time* you ride in a car. Car accidents injure and kill more people your age than anything else and wearing a seatbelt can save your life. You are making a smart and important decision by wearing your seatbelt *every time* you ride in a car.

I know that it is hard to wear a seatbelt when you have so much to do. Even adults sometimes find it hard to wear a seatbelt *every time* they ride in a car. It is great that you are taking responsibility for your health and safety. I hope you continue to make the good choice you have made to keep wearing a seatbelt *every time* you ride in a car.

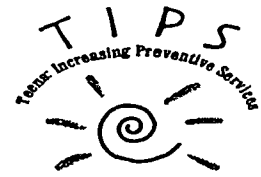
FOR TEENS WHO DO NOT WEAR A SEATBELT ALL THE TIME

SCREEN

Do you wear a seatbelt every time you ride in a car?
(Start, Amount, Frequency, Environment)

UNDERSTAND RESPONSE

You said that you wear your seatbelt some of the time.



A UCSF/Kaiser Permanente Collaboration

POSITIVE REINFORCEMENT

Most people find it hard to wear a seatbelt every *time* they ride in a car. How often would you say you *do* wear your seatbelt when you ride in a car?

I am glad there are some times when you are able to wear your seatbelt.

PROVIDE CONCERN

Wearing a seatbelt is important for your safety. It is good that you wear a seatbelt (once in a while/some/most) of the time, and I am concerned about the times that you are not wearing your seatbelt.

OFFER KEY MESSAGES

Even though you may ride with excellent drivers, there are lots of situations one cannot predict, such as irresponsible and careless drivers and unpredictable obstacles on the roads/ paths you may be on. Wearing your seatbelt is also protection against them.

Most people think that car accidents don't happen on short trips. But most accidents happen close to home and while traveling short distances, so it's important to wear your seatbelt every *time* you ride in a car, even for just a quick trip.

As your doctor, I strongly advise you to wear a seatbelt every time you ride in a car.

RESOURCES/REFERRALS

What would help you remember to wear your seatbelt every time you ride in a car?

Here's a "buckle-up" sticker to help you remember.

TELEPHONE/VISIT FOLLOW-UP

As needed.

A UCSF/Kaiser Permanente Collaboration

TIPS PREVENTIVE SERVICES VISIT—SAMPLE INTERVIEWS FOR *HELMET USE*

FOR TEENS WHO WEAR A HELMET ALL THE TIME

SCREEN

Do you wear a helmet when riding/biking/skateboarding/blading/using a scooter?
(Start, Amount, Frequency, Environment)

UNDERSTAND RESPONSE

It sounds like you always wear your helmet when biking/riding/skateboarding/blading. Some teens have a hard time wearing their helmet *every time.* How are you able to do it?

POSITIVE REINFORCEMENT

It is great that you wear your helmet *every time you* (bike/skateboard/rollerblade). Bike/skateboard/rollerblade accidents injure and kill a lot of people every day. You are making a smart decision by wearing your helmet *every time* you (bike/skateboard/rollerblade). It is great that you are taking responsibility for your health and safety.

I know that it can get harder to wear a helmet when you are in high school and have so much to do. Even adults sometimes find it hard to wear a helmet *every time* they bike/skateboard/rollerblade. It is important for your health and safety that you continue to make the good choice you have made to keep wearing a helmet.

FOR TEENS WHO DO NOT WEAR A HELMET ALL THE TIME

SCREEN

Do you wear a helmet when riding/biking/skateboarding/blading/using a scooter?
(Start, Amount, Frequency, Environment)

UNDERSTAND RESPONSE

It seems like you wear a helmet some of the time. Most people find it hard to wear a helmet *every time* they bike/skateboard/rollerblade.

POSITIVE REINFORCEMENT

When *are* you able to wear a helmet?

I am glad there are some times when you are able to wear your helmet.

PROVIDE CONCERN

Wearing a helmet is important for your health and safety. It is good that you wear a helmet (once in a while/some/most) of the time, and I am concerned about the times that you are not wearing your helmet.

OFFER KEY MESSAGES

Even though you may be an excellent (biker, skater or rollerblader), there are lots of situations one cannot predict, such as irresponsible and careless drivers and unpredictable obstacles on the roads/paths you may be on. Wearing your helmet is protection against them, more than anything else.

It can be hard to wear a helmet when friends or other people you're with don't care enough to protect their heads. I know everyone is in a hurry and it can be a hassle to put on a helmet, but wearing a helmet when you (bike, skateboard or rollerblade) will greatly reduce the chance that you will get a serious head injury. This is why helmets are even required for professional bikers or other athletes. So, I want *you* to *wear a helmet every time you blade/board/bike/scooter. If you don't have a helmet, don't helmet/board/bike/scooter until you get one.*

RESOURCES/REFERRALS

I would like to help you remember to wear it all of the time. Here is a brochure that lists places to get helmets, and some information about bike safety. I would also like to give you a card with my name on it and instructions for making an appointment here at Kaiser. Please use this if you would ever like to discuss these issues with me.

TELEPHONE/VISIT FOLLOW-UP

As needed.

A UCSF/Kaiser Permanente Collaboration

NOTES

National Adolescent Health Information Center

N A H I C

Fact Sheet on

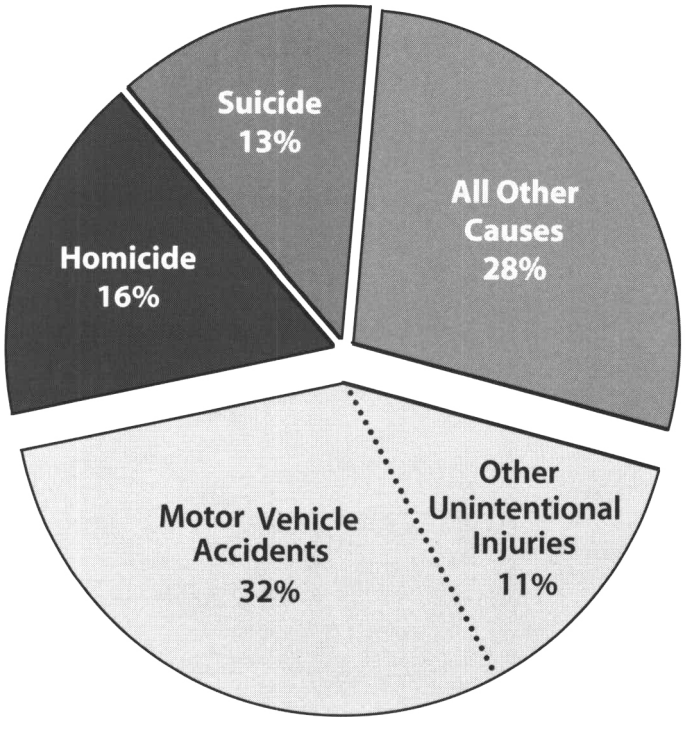
Unintentional Injury:

Adolescents & Young Adults

Highlights:

- Unintentional injury is the leading cause of death for adolescents and young adults.
- Motor vehicle accidents account for 74% of unintentional injury deaths to adolescents/young adults.
- More than 1 million adolescents/young adults are injured in motor vehicle accidents each year.
- The unintentional injury mortality rate for 10-24 year-old males is almost three times that of females.
- Adolescent and young adult unintentional injury mortality rates have been falling steadily.

- Unintentional injury* is the leading cause of death for adolescents and young adults.



Leading Causes of Mortality:
Adolescents/Young Adults Ages 10-24, 1998

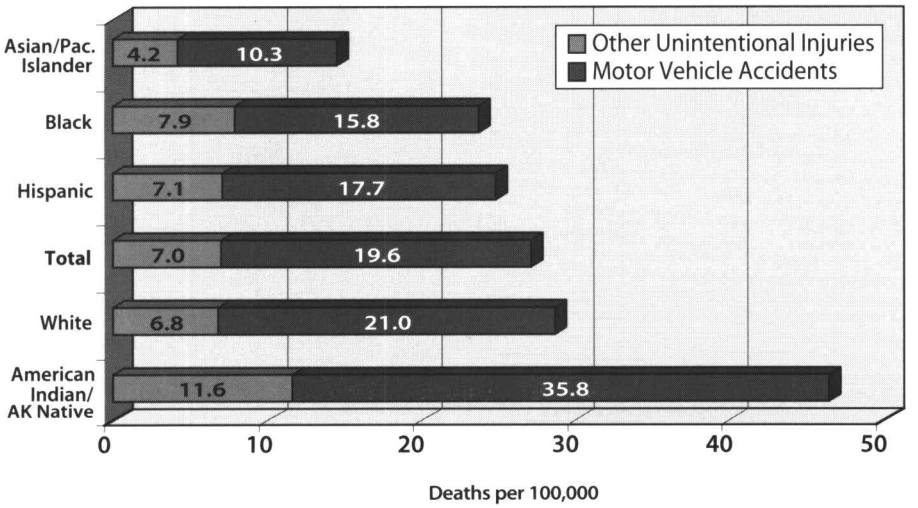
In 1998, 43% (14,991) of all deaths among adolescents and young adults ages 10-24 resulted from unintentional injury causes (26.6 per 100,000). Of these deaths, three-quarters (11,060) were caused by motor vehicle accidents (19.6 per 100,000). Drowning (2.9% of all deaths), poisoning (2.5% of all deaths), fire (0.9%) and falls (0.7%) accounted for much lower percentages (NCIPC, 2000).

***Unintentional Injuries:**

This fact sheet focuses on unintentional injuries as distinct from those defined as intentional, whether self or externally inflicted. information about intentional injury is available in the National Adolescent Health Information Center's Violence and Suicide Fact Sheets.

▸ Motor vehicle accidents account for 74% of unintentional injury deaths to adolescents/young adults.

Unintentional Injury Mortality by Race/Ethnicity, Ages 10-24,1998

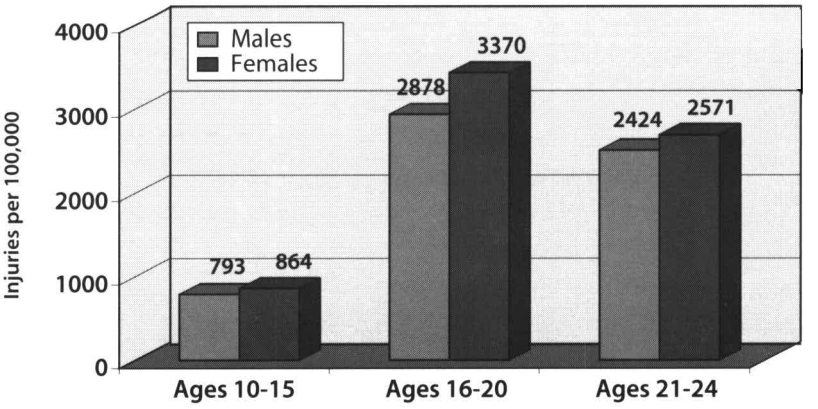


Among adolescents/young adults ages 10-24, motor vehicle accidents (MVAs) are the leading cause of death, accounting for 74% of all unintentional injury (UI) deaths and 32% of all mortality. In this age group, American Indians/Alaska Natives (AI/AN) have the highest UI death rate, followed by Whites. Greater rates among these groups are largely due to higher MVA death rates, which account for 76% of UI deaths among AI/ANs and Whites. Among other racial/ethnic groups, this percentage ranges from 62% for Blacks to 74% for Hispanics (NCHS, 2000).

▸ More than 1 million adolescents/young adults are injured in motor vehicle accidents each year.

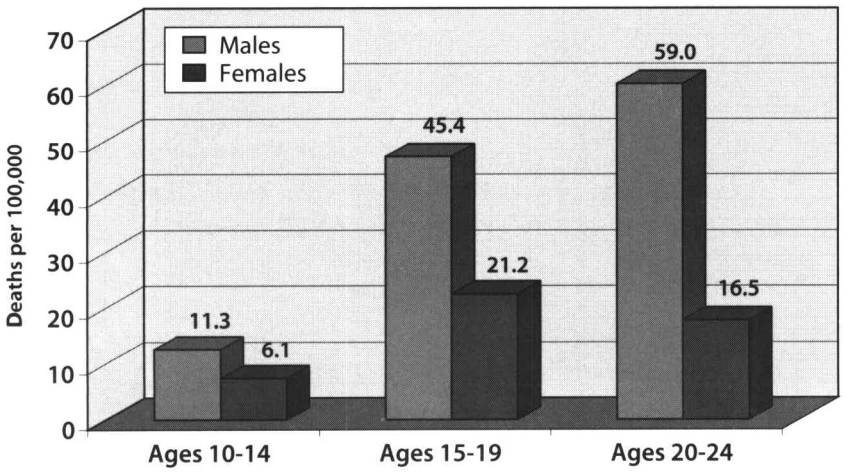
While motor vehicle accidents are the leading cause of death for adolescents and young adults, far more are injured. In 1997, 1% of the 1.12 million motor vehicle-related injuries among 10-24 year-olds resulted in death. Older adolescents have the highest rates of both motor vehicle-related injury and mortality of any age group (NHTSA, 1998). In addition, data show that unintentional injury accounts for 13.6% of all hospitalizations among adolescents/young adults (excluding pregnancy) (NHDS, 1997).

Non-Fatal Motor Vehicle Injuries by Age & Gender, 1997**



▸ The unintentional injury mortality rate for 10-24 year-old males is almost three times that of females.

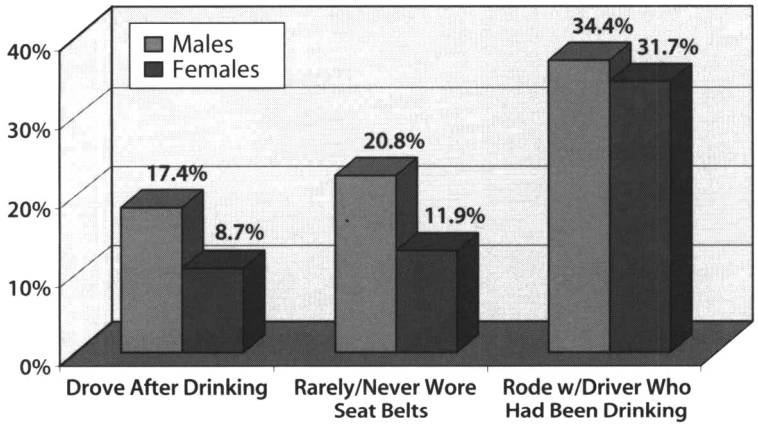
Unintentional Injury Mortality by Age and Gender, 1998



Adolescent males have a consistently higher rate of death due to unintentional injury, averaging almost three times the rate of adolescent females (38.0 vs. 14.6/100,000, ages 10-24). A major difference between male and female patterns is that the male injury death rate increases through early adulthood, while it declines for females. Although mortality rates for most causes of death increase throughout the lifespan, injury-related deaths peak during late adolescence/early adulthood (NCIPC, 2000).

▸ Male adolescents engage in behaviors which put them at risk for injury more often than females.

Injury Risk-Behaviors by Gender, High School Students, 1999

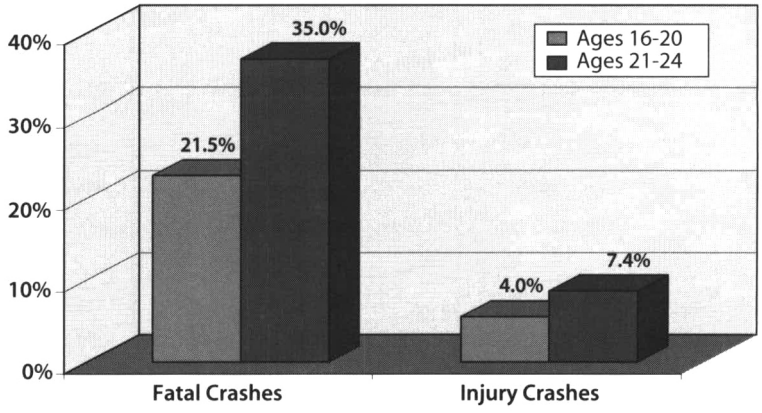


Among high school students, males were more likely than females to report engaging in behaviors which put them at risk for injury. These behaviors also varied by race/ethnicity: Blacks (22.5%) were more likely than Whites (15.5%) or Hispanics (14.4%) to have rarely or never worn seat belts. Hispanics (39.5%) were more likely than Blacks (34.4%) or Whites (32.4%) to have ridden with a driver who had been drinking. Whites (14.6%) were more likely than Hispanics (12.7%) or Blacks (7.9%) to have driven after drinking alcohol (YRBSS, 2000).

Motor vehicle accident severity increases when adolescents and young adults drink and drive.

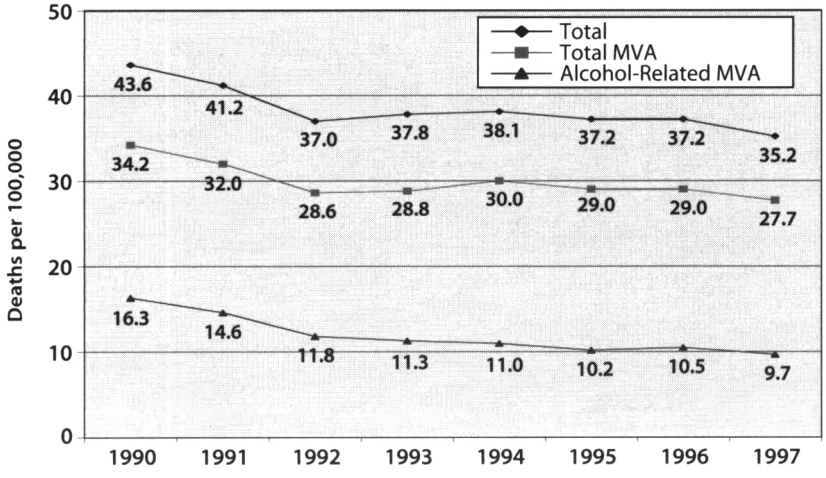
Accidents involving adolescent and young adult drivers ages 16-24 tend to be more severe when the driver is under the influence of alcohol. In 1997, 27.2% of all fatal motor vehicle accidents with adolescent or young adult drivers involved alcohol use by the driver. In contrast, alcohol was rarely involved in non-fatal crashes. Adolescents and young adults were under the influence of alcohol in only 5.4% of accidents resulting in non-fatal injury (NHTSA, 2000).

Percent of Motor Vehicle Accidents with Drinking Driver, by Severity & Age of Driver, 1997**



▸ Adolescent and young adult unintentional injury mortality rates have been falling steadily.

Mortality Trends in Unintentional Injury & MVAs, Ages 16-20, 1990-97**



From 1990 to 1997, there was a 19% decline in both total unintentional injury and motor vehicle accident (MVA) mortality rates among adolescents ages 15-20 (NCIPC, 2000). This was largely driven by a 40% reduction in alcohol-related MVA mortality rates over the same period (NHTSA, 1997). This is a continuation of a longer trend: unintentional injury mortality rates among adolescents and young adults ages 10-24 have fallen 43% since 1980 (from 47.7 to 27.3 deaths/100,000), with the MVA component falling 40% (from 33.8 to 20.4 deaths/100,000) over the same period (CDC Wonder, 2000).

Data Sources:

Centers for Disease Control & Prevention, National Center for Injury Prevention and Control. *(2000). United States injury Mortality Statistics.* [online database: http://www.cdc.gov/ncipc]

Centers for Disease Control & Prevention, National Center for Health Statistics. (2000). *CDC Wonder, Mortality (compressed) data set.* [online database: http://wonder.cdc.gov]

Kann, L., Kinchen, S.A., Williams, B.I., Ross, J.G., Lowry, R., Hill, C.V., Grunbaum, J., Blumson, P.S., Collins, J.L., & Kolbe, L.J. (2000). *Youth Risk Behavior Surveillance,* 1999. Surveillance and Evaluation Research Branch, Division of Adolescent and School Health. Atlanta, GA: Centers for Disease Control and Prevention.

National Center for Health Statistics. (1997). *Report of Final Mortality Statistics,* 1997. (DHHS Publication No. PHS 97-1220). Public Health Service, Department of Health and Human Services. Washington, DC: U.S. Government Printing Office.

National Center for Health Statistics. (1999). *1997 National Hospital Discharge Survey. (Private data run).* Public Health Service, Department of Health and Human Services. Washington, DC: U.S. Government Printing Office.

National Highway Traffic Safety Administration. (1998). *Traffic Safety Facts 1997.* Washington, DC: U.S. Department of Transportation.

National Highway Traffic Safety Administration. (2000). *1998 Youth Fatal Crash and Alcohol Facts.* Washington, DC: U.S. Department of Transportation.

**Age groups used were those provided by NHTSA.

In all cases, the most recent available data were used. Some data are released 1-3 years after collection. For questions regarding data sources or availability, please contact NAHIC. For racial/ethnic data, the category names presented are those of the data sources used.

2000 NAHIC Adolescent Fact Sheets

Fact Sheet on Demographics: Children and Adolescents

Fact Sheet on Mortality: Adolescents and Young Adults

Fact Sheet on Adolescent Violence

Fact Sheet on Suicide: Adolescents and Young Adults

Fact Sheet on Injury: Adolescents and Young Adults

Fact Sheet on Preventive Health Services for Adolescents

Fact Sheet on Adolescent Pregnancy Prevention

Fact Sheet on Adolescent Substance Use

Fact Sheet on Adolescent Sexuality

Fact Sheet on Adolescent Health Care Utilization

Fact Sheet on Mental Health

National Adolescent Health Information Center

Division of Adolescent Medicine,
Department of Pediatrics &
Institute for Health Policy Studies,
School of Medicine,
University of California,
San Francisco

UCSF Box 0503
San Francisco, CA 94143-0503
ph. 415.502.4856, f. 415.502.4858
email: nahic@itsa.ucsf.edu
http://youth.ucsf.edu/nahic

Background on NAHIC

The National Adolescent Health Information Center (NAHIC) was established with funding from the Maternal and Child Health Bureau in 1993 (4H06 MC00002) to serve as a national resource center for adolescent health research and information to assure the integration, synthesis, coordination and dissemination of adolescent health-related information.

NAHIC Faculty and Staff

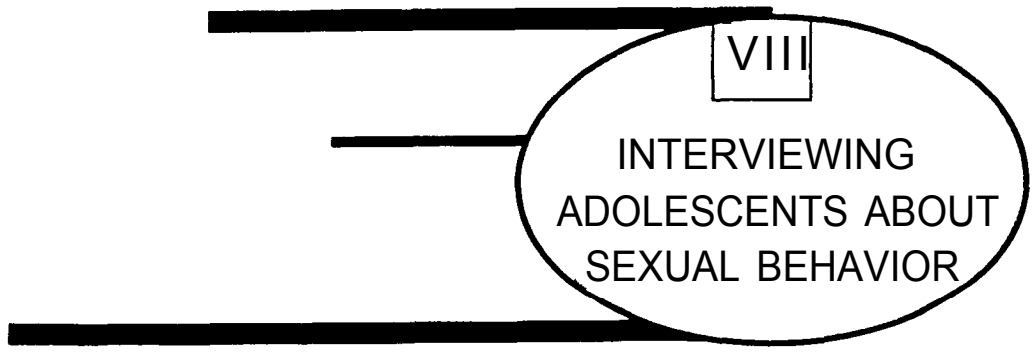
Charles E. Irwin, Jr., MD
Claire D. Brindis, DrPH
Susan G. Millstein, PhD
Elizabeth M. Ozer, PhD
David Knopf, LCSW, MPH
M. Jane Park, MPH
Scott Burg
Pamela S. Witt

Copies of any of the listed Adolescent Fact Sheets can be downloaded from the World Wide Web at http://youth.ucsf.edu/nahic. Hard copies can be requested at (415) 502-4856, or by email at: nahic@itsa.ucsf.edu.

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration
Maternal and Child Health Bureau

UCSF

Cite as: National Adolescent Health Information Center. (2000). Fact Sheet on Unintentional injury: Adolescents and Young Adults. San Francisco, CA: National Adolescent Health Information Center, University of California, San Francisco.



Screening Questions

Key Messages for Sexual Behavior

Message Tips for Sexual Behavior

Background Articles

A UCSF/Kaiser Permanente Collaboration

SCREENING QUESTIONS FOR SEXUAL BEHAVIOR

Behavior?

- Have you had vaginal sex? Oral sex? Anal sex?
- Have you had sex with guys, girls, or both?

Start?

- When did you most recently have sex?
- Do you think you or your partner could be pregnant?
- Have you ever been pregnant or had a partner who became pregnant?
- Do you think you or your partner could have a sexually transmitted disease/infection or STD?
- Have you ever had an STD?
- Has a partner of yours ever had an STD?

Amount?

- Have you had sex with anyone other than your current/most recent partner? When?
- How many sexual partners have you had?

Frequency?

- How often do you have sex?

Environment?

- Do you use any form of birth control/std prevention when having sex?
- If yes: What type of birth control/std prevention do you use?

- How often do you use (fill in) method of birth control/std prevention?
- Have you ever felt pressure to have sex?
- Were you using alcohol/drugs when you had sex?

ADDITIONAL SEXUALITY SCREENING QUESTIONS

SEXUAL ORIENTATION:

- Do you feel sexually attracted to girls, boys, or both?

A UCSF/Kaiser Permanente Collaboration

KEY MESSAGES FOR SEXUAL BEHAVIOR

Message 1

- Avoiding sex is the safest way to prevent pregnancy and sexually transmitted diseases or AIDS

Message 2

- If you choose to have sex, be responsible:
  - Use a condom every time you have sex
  - If you don't have a condom, don't have sex
  - To ensure you don't get pregnant or get your partner pregnant, and as a backup to a condom, use another form of birth control such as oral contraceptives or Depo Provera
  - If you have unprotected intercourse, you may obtain emergency contraception

A UCSF/Kaiser Permanente Collaboration

TIPS PREVENTIVE SERVICES VISIT-SAMPLE INTERVIEWS FOR *SEXUAL BEHAVIOR*

FOR NON-SEXUALLY ACTIVE TEENS

SCREEN

Have you had vaginal sex? Oral sex? Anal sex?
(Start, Amount, Frequency, Environment)

UNDERSTAND RESPONSE

You said that you have never had sex. Most teens your age have not started to have sex. Although sex is a very positive thing when adults are physically and emotionally ready and in a loving relationship, teens your age are not usually ready to have sex, and most wait until they are older. *By 11th or 12th grade, almost half of teens have still chosen not to be sexually active.*

POSITIVE REINFORCEMENT

Like most teens your age, by choosing not to start having sex, you are protecting yourself from things like pregnancy; infections that are sexually transmitted (including HIV); and the emotional pain that often goes along with having sex before you are emotionally ready, in the right relationship, and making a clear choice to have sex. It is great that you are taking responsibility for your health, your body, and your well being by waiting so that when you have sex it is right for you and your partner.

I know that it can get harder to continue not having sex when you get in high school and some of your friends may start having sex. It is important that you continue to make the best and healthiest choices for yourself.

As your doctor, *I feel it is very important for you to continue to wait to have sex until you are really ready emotionally and in the right relationship with a responsible partner.* When you begin to think about it, I want you to get in touch with me so we can talk more about this and make sure you are prepared with birth control, etc.

FOR TEENS WHO HAVE HAD SEX

SCREEN

Have you ever had vaginal sex? Oral sex? Anal sex?
(Start, Amount, Frequency, Environment)

Do you *ever* use contraception? Do you *ever* use condoms?

A UCSF/Kaiser Permanente Collaboration

UNDERSTAND RESPONSE

It sounds like you have had sex, and that you use contraception some of the time.

POSITIVE REINFORCEMENT

I'm glad you have made the good choice to use contraception/condoms (sometimes/once in a while/etc.). Let's talk about how to help you be sure to use contraception/condoms every *time* you have sex. How are you able to use contraception/condoms (sometimes/once in a while/etc.)?

PROVIDE CONCERN

Sex can be a positive thing for adults who are physically and emotionally ready, in a loving and responsible relationship, and prepared to be safe and to keep from getting pregnant. Decisions about sex, using birth control, pregnancy, and STDs can be difficult and confusing. The decisions you make about these things are some of the most important ones you'll ever make. It is very important that you are prepared when you choose to have sex. I am concerned that you are having sex and not being as safe as you could be. I think it is important to talk to someone about these difficult choices and decisions. It is important for you to take responsibility for your own health, body, and well being and discussing your decisions about having sex is one good way to be responsible for your own health.

I want to begin talking to you about things like STDs, pregnancy, and birth control to make sure that when you have sex it is right for you and you are prepared to protect yourself from infections and pregnancies.

OFFER KEY MESSAGES

There are many options for you at this point. Even if you have had sex already, the *most safe thing to do to not get pregnant or get a disease is to avoid sex.* It is not too late to wait to have sex again even if you have had sex already. If you choose to keep having sex, let's talk about your options for staying safe, keeping you from getting pregnant, and making sure it is right for you.

If you choose to stop having sex for now, do you have any concerns about how to say no or not have sex?

If you choose to continue to have sex, let's talk about ways to prevent infections and pregnancy.

A UCSF/Kaiser Permanente Collaboration

You can decrease your chances of getting pregnant or getting an STD through lots of different actions/decisions: (tailor to each teen)

- Deciding not to have sex again for a while
- Having sex with just one partner who is faithful to you (not having sex with anyone else other than you)
- Using condoms every time you have sex to prevent STDs
- Also using birth control like the pill or the Depo shot to avoid pregnancy
- Avoiding mixing alcohol or drug and sex
- Avoiding situations where you feel you can't control what might happen (e.g., parties with alcohol, guys older than you [if female], not having a reliable ride home, etc.)
- Sometimes, people have unprotected sex when they didn't expect to. *If that happens to you or your partner, Emergency Contraceptive Pills can decrease your chances of getting pregnant by 75%, if taken within three days of when the unprotected intercourse occurred.*

RESOURCES/REFERRALS

If you have had sex and have never had a pelvic exam, I want you to schedule an appointment for an exam. Do you know what a pelvic exam is? (Explain as needed) You can start on birth control without getting the exam right away, but it is important for you to know that you have been checked for infections and to find out if everything is OK.

Because some infections don't cause any symptoms, the exam can also pick up things that can be treated – before they can cause any problems or be spread to other people.

Here is a card with my name on it and some instructions about how to make a confidential appointment here at Kaiser. There are also some phone numbers on the back that you may find useful.

TELEPHONE/VISIT FOLLOW-UP

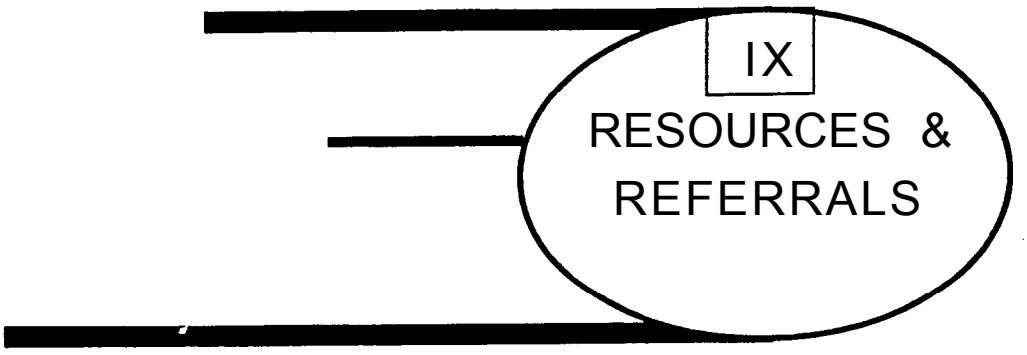
Schedule follow-up as needed or facilitate referral.

A UCSF/Kaiser Permanente Collaboration

NOTES

Please refer to the following publication:

Ellen J, Boyer C, Tschann J, et al. Adolescents' perceived risk for STIs and HIV infection. J Adolesc Health 1996; 18: 177-81.



Kaiser and Community Resources for Target Risk Behaviors

TIPS Card

Teen Resource Card

A UCSF/Kaiser Permanente Collaboration

Resources and Referrals for Teens: Fresno Pediatrics

SAMPLE

GENERAL INFORMATION

Kaiser Appointment and Advice Line: (559) 448-4555
General Health Education: (559) 448-4415

Kaiser Permanente's Website for Members:
www.kponline.org

SAFETY

Kaiser Resources

- Health Education Department: (559) 448-4415

TOBACCO

Kaiser Resources

- Single Session Quit Smoking Workshop (4 hours)
  Cost: Free (559) 448-4415

Community Resources

- California Smokers Helpline: 1(800) 7 NOBUTTS or 1(800) 45-NO FUME
- California Tobacco Helpline: 1(800) 844-CHEW
- CDC Tobacco Information and Prevention Source 1(800) 232-1311

ALCOHOL/DRUGS

Kaiser Resources

- Adolescent Chemical Dependency Recovery Program: (559) 448-4620

Community Resources

- Alcoholics Anonymous: (559) 221-6907

TIPS Study
A UCSF/Kaiser Collaboration
Funded by AHRQ
November 2002

- Narcotics Anonymous: (559) 255-5881
- Al-Anon Alateen Family Groups: (559) 239-5433
  After hours information line (559) 265-3560

SEXUAL BEHAVIOR

Kaiser Permanente

Kaiser Confidential Services for Teens
(STDS, Birth Control, Pregnancy Tests, Medical Advice,
Confidential Teen Visits available): (559) 448-4957

Community Resources

- **Lyric Lavender Youth Talk Line: (800) 246-7743**
  Peer support for gay/lesbian teens.
- **RAINN (Rape, Abuse, Incest National Network): (800) 656-HOPE**
- **Rape Counseling Service of Fresno (559) 222-7273**

OTHER RELEVANT SERVICES

Kaiser Resources

- **Mental Health Department Member Line (559) 448-4260**

Community Resources

- **Youth Crises Hotlines**
  - **California Youth Crisis Hotline: (800) 843-5200**
  - **National STD Hotline: (800) 227-8922**
  - **HIV/AIDS Hotline: (800) 342-AIDS**
  - **Sanctuary Safe Place Youth Shelter: (559) 498-8543**

EXAMPLE

Internet Resources for Teens, Parents and Providers

General Information

www.kponline.org
Kaiser Permanente's Website for Members

Safety: Bike Helmets and Seat Belts

www.bhsi.org
Bicycle Helmet Safety Institute
www.nsc.org/airbag.htm
National Safety Council Air Bag & Seatbelt Safety Campaign

Tobacco

www.cdc.gov/tobacco
Centers for Disease Control tobacco information
www.quitnet.org
On-line smoking cessation program
www.ymn.org
Youth Media Network; communication network providing tobacco information

Alcohol & Drugs

www.alateen.org
Support organization for family and friends of alcoholics
www.drugfreeamerica.org
Alcohol and drug information for parents and teens
www.health.org
Prevention information presented by the Substance Abuse and Mental Health Service Administration
www.saddonline.com
Students Against Driving Drunk

Sexual Behavior

www.siecus.org
Sexuality Information and Education Council of the United States
www.cfoc.org
Campaign for Our Children
www.pflag.org

EXAMPLE

Parents and Friends of Lesbians and Gays
www.noappp.org/home/overview.htm
National Organization on Adolescent Pregnancy, Parenting and Prevention

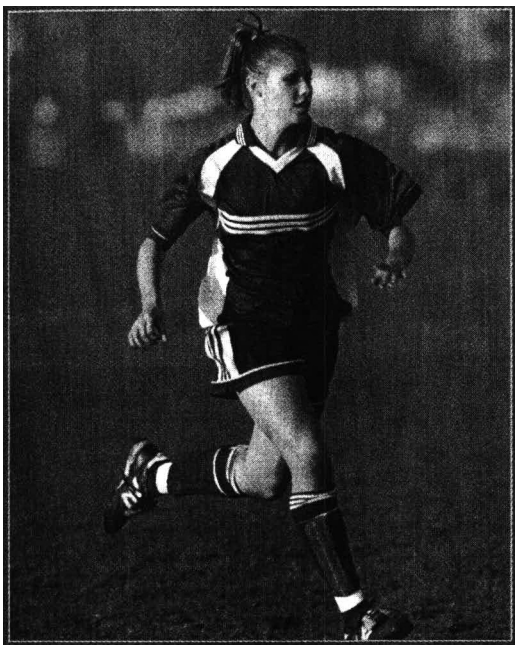
Other Relevant Topics

www.advocatesforyouth.org
Supports policy and programs that help youth make informed and responsible decisions about sex
www.goaskalice.columbia.edu
This site is designed to answer questions about health posed by the on-line audience
www.kidshealth.org/teen/
Offers a variety of helpful information regarding all aspects of teen growth.
www.pavnet.org
Partnership Against Violence Network
www.edap.org
Eating Disorders Awareness and Prevention

EXAMPLE

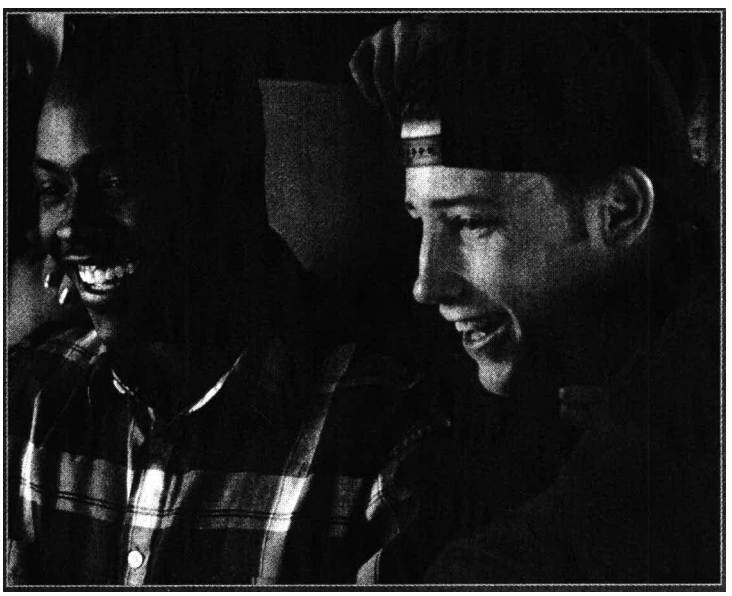
A UCSF/Kaiser Permanente Collaboration

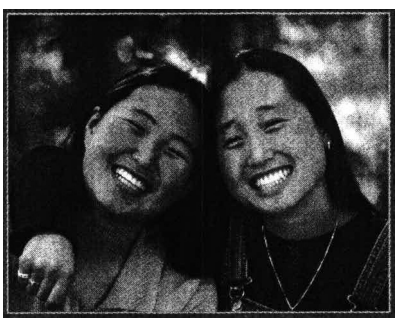
NOTES



Investing in

Clinical Preventive Health Services for Adolescents





M. Jane Park
Tracy M. Macdonald
Elizabeth M. Ozer
Scott J. Burg
Susan G. Millstein
Claire D. Brindis
Charles E. Irwin, Jr.

Policy Information and Analysis Center for
Middle Childhood and Adolescence
and
National Adolescent Health Information Center

Division of Adolescent Medicine, Department of Pediatrics
and Institute for Health Policy Studies
School of Medicine
University of California, San Francisco

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration
Maternal and Child Health Bureau

Healthy Teens Healthy Futures

Next check up 1 to 3 years.

KAISER PERMANENTE

PREVENT INJURY & VIOLENCE

Did you know...Murder is the #1 killer of teens.

- Do not carry or use a weapon of any kind. Learn how to solve conflicts without violence. Talk it over. Walk away.
- Learn how to protect yourself from violence, intimidation, harassment and rape (including date rape).
- Seek help (from a parent, teacher or doctor) if you are physically or sexually abused, or fear that you are in danger.

Car accidents are the #2 killer of teens.

- Always wear a seat belt while driving or riding in a car, Drive carefully, follow the speed limit and use good judgment.
- Never drive after drinking alcohol. Designate a driver or call a friend or family member for a ride.
- Always wear a helmet when riding a motorcycle, bike or skateboard.

A HEALTHY MIND & BODY

- Learn how to deal with stress. Exercising daily, eating regular meals and getting enough sleep will help. For more ideas, talk to your doctor.
- Take on new challenges: it increases your self-confidence.
- Own up to your actions (at school, at home, with friends).
- Find at least one adult you can trusr and can talk to. Speak with him or her regularly about friends, sex, growing up or anything else you have questions or worries about.
- Accept who you are. Focus on your strengths.
- Respect the rights and needs of others (even if you don't agree).
- To have a healthy smile, white teeth and fresh breath...brush your teeth and floss every day.
- If you feel angry, depressed, or hopeless, talk to a friend or trusted adult. Don't keep it to yourself.
- Cover up and use sunscreen (SPF 15 or higher) for sun exposure (helps prevent skin cancer).
- Try to exercise every day. Exercise includes walking, bike riding and roller blading.

HEALTHY EATING

- Eat 3 healthy meals daily. Don't forget breakfast!
- Eat meals with your family as often as possible.
- The healthier your food, the better you will feel. Try it!
- Girls should take a multivitamin with folate and iron, and drink 3 glasses of milk every day.
- If you are always "on the run", try grabbing:
  - Bread, bagels or crackers with peanut butter or cheese
  - Bananas, apples or oranges "to go"
  - Mini bags of carrots or pre-cut veggies
  - Milk. yogurt and juice boxes
  - Healthy frozen dinner entrees

EXAMPLE

94834 (1-99)

Healthy Teens

Healthy Futures

Next check up 1 to 2 years.

Tips for Parents of Teenagers

PARENTING

- Try to accept the natural changes in your relationship with your teen—your new role is to help your child make wise decisions.
- Recognize that your teen may be less willing to be involved in some family activities and may suddenly challenge your authority.
- Decide, with your teen, which things he/she can do on his/her own-including straying home alone or going out with friends who drive.
- Accept your teen's need for privacy
- Establish realistic family rules, giving your teen more responsibility as he/she seems ready. Set clear limits and consequences when rules are broken. To avoid power struggles, pick your battles.
- Enhance your teen's feelings of self-worth by paying attention to what he/she says, and by recognizing and acknowledging positive behavior and achievements. Minimize put-down, nagging and yelling.
- Spend personal, fun time with your son or daughter.
- You may want to talk with other parents or to a counselor about all the changes in your family.

SAFETY

- Unload guns and lock them up.

TALKING ABOUT SEXUALITY

- Talk with your teen about sexuality. Share your views with him/her about teen sex and discuss the emotional and physical consequences (pregnancy, sexually transmitted diseases, guilt, and anxiety).
- Even if you don't want your teen to be sexually active, stress the reasons for practicing safe sex.

SCHOOL

- Show interest in your teen's school life, and pay attention to grades and attendance problems (cuts).
- Work with school staff and your teen to find out what's wrong if there are problems.
- Tell your teen why you think education is important and how it could help him/her in the future.

ROLE MODELING

- Be a good role model:
- Eat and buy healthy foods.
- Don't smoke. Don't use drugs.
- Get regular physical exercise.
- Use your seat belt.
- Don't drive after drinking alcohol; have a designated driver.

SUGGESTED READING:

"Caring for Your Adolescent" - Greydanus

"Surviving your Adolescents" - Phelan

EXAMPLE

91263 (1-99)

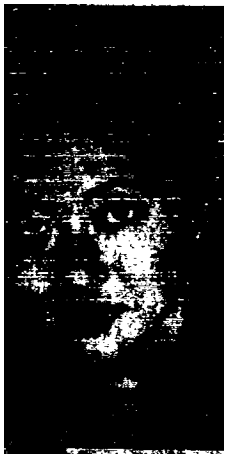
© 1991 Bright Systems - Used with permission from the Permanente Medical Group Inc., Northern California Regional Health Education

Partners in Prevention

Are Emergency Contraceptive Pills for you?

WHAT ARE EMERGENCY CONTRACEPTIVE PILLS?

Emergency contraceptive pills can prevent pregnancy AFTER you have had sex and didn't use birth control. Emergency contraceptive pills are also called ECPs. The brand name for these pills is "planB." ECPs are made of a hormone called progestin. If you take ECPs within 72 hours (3 days) after having unprotected sex, the risk of getting pregnant is reduced by 89%. This means that only 1 out of 100 women using ECPs will get pregnant compared to 8 out of 100 women who do not use ECPs. The sooner you take ESPs after having sex, the more effective they are in preventing pregnancy.



How do emergency contraceptive pills work?

Doctors and researchers are unsure exactly how emergency contraceptive pills work. However, studies suggest that ECPs prevent pregnancy in 3 ways:

1. ECPs may cause your body to delay releasing an egg *(ovulation).*
2. ECPs may stop the sperm from penetrating the egg *(fertilization).*
3. ECPs may prevent implantation of a fertilized egg into the uterus.

ECPs will NOT cause an abortion if you are already pregnant. ECPs are NOT the RU-486 or French abortion pill.

What are the advantages of emergency contraceptive pills?

- ECPs help prevent unwanted and mistimed pregnancies and abortions.
- ECPs are very safe. Even if you can't take birth control pills for medical reasons, you can usually use ECPs.
- You can ask for an ECP prescription *before* you need them so that you will have them just in case of an emergency.
- ECPs are *not* abortion pills and will not hurt a fetus if you are already pregnant.

What are the disadvantages of emergency contraceptive pills?

- After taking ECPs, you may feel sick to your stomach, dizzy, or have a headache.
- You could have menstrual spotting or bleeding. Your breasts may feel tender.
- ECPs are not as effective as a regular birth control method such as birth control pills, Norplant, or the Depo-Provera shot
- ***You should not use ECPs over and over as your regular birth control, because they will not work as well as other methods. But if you need to use ECPs more than once, they are not dangerous.***
- If you do not already have a supply of ECPs, you will need to call Kaiser Permanente or your doctor or nurse practitioner to ask for a prescription. *Call as soon as possible after having unprotected sex:*

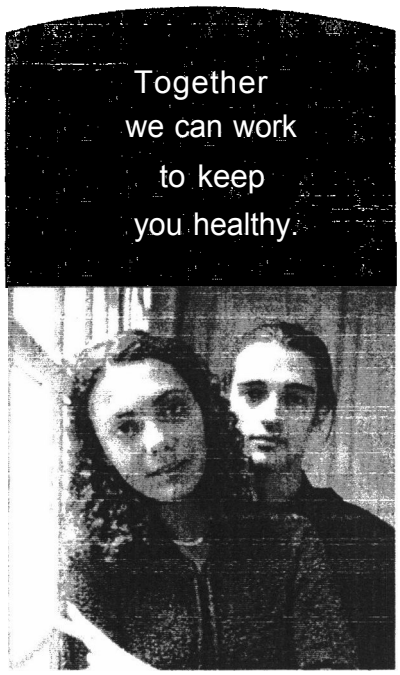
CONSIDER EMERGENCY CONTRACEPTION IF YOU HAVE...

- Made love unexpectedly without birth control
- Had a condom break, slip or come off
- Awakened to realize you were having sex
- Forgotten several birth control pills
- Had your diaphragm or cervical cap slip out of place
- Been forced to have sex

EXAMPLE

Tips for Teens

Healthy **teens**
Healthy Futures



Did you know... most teens only get 7 hours of sleep when they really need at least 9?

We know that you already know this stuff, It can't hurt to hear it again... Right?

- It's simple. Don't drive drunk or with anyone who has been drinking. Choose a sober driver or call for a ride.
- B-Ball. Hiking. Dancing. Exercising 30-60 minutes every day will help you relax and handle stress.
- Try cutting back to one hour of TV/video games a day
- Munch at least 5 helpings of fruits and veggies. A helping is a piece of fruit or ½ cup of vegetables.
- Cut back to one can or small cup of soda or juice drink a day. Try water and milk instead.
- Cheese, yogurt, milk ... get 'em four times a day for the calcium you need.
- Take a multivitamin with folate and iron. Make it a part of your day.
- The decision to have sex is a serious one that only you can make. Not having sex is the best way to prevent HIV, STDs, and pregnancy.
- If you do choose to have sex, condoms and birth control can increase your chances of protection against STDs and pregnancy.
- All Kaiser Permanente offices have doctors. nurse practitioners (NPs), and counselors you can talk with confidentially. Choose a regular doctor or NP to see every one to two years.
- Drugs like alcohol and marijuana make it hard to think clearly. You need a clear head to make good choices.
- Yellow teeth, smelly clothes-tobacco stinks! Smoking harms the health of you and everyone around you. Call your doctor or NP for help quitting.

  If you smoke and are thinking of quitting, call the California Smokers' Helpline. A free service designed for teens, 1-800-NO-BUTTS helps people kick the habit.

Got the blues?

Break-ups, fights with friends, problems at home—it's normal to feel sad. Exercising, being with friends, or a good night's sleep can help lift your mood. When sad feelings last for a long time, it may be more serious.

Am I depressed?

If you have any of the following feelings every day for more than two weeks, talk to a counselor or doctor. Do you ...

- ❑ feel sad a lot or cry all the time?
- ❑ have trouble sleeping or sleep too much?
- ❑ find it hard to concentrate, make decisions, or remember things?
- ❑ change how you normally eat?
- ❑ feel guilty for no reason?
- ❑ feel life is meaningless?
- ❑ think about killing yourself (suicide)?

Even if you feel as if no one can understand, help is available. Start by talking to someone you trust or call one of the phone numbers listed.

EXAMPLE

Tips for Teens

Keep it cool.

Stress is your body's natural reaction to strong feelings and changes. School, parents, friends, work—you have a lot on your mind.

You may be stressed out if you have:

- headaches
- neckaches
- backaches
- an upset stomach
- crabby feelings

Healthy ways to deal with stress:

- get 9 - 10 hours of sleep every night
- eat healthy meals
- go for a long walk
- shoot hoops
- talk with someone you trust
- laugh, cry, sing, write in a journal

Know that you deserve to feel safe in your relationships.

A good relationship does not include hitting, threatening, put-downs or trying to control the other person. If you fear that you are in danger, get help now. **Keep in mind:**

- You always have the right to say "no," even to something you've done before.
- Trust your "gut feelings." If someone is making you feel uneasy or uncomfortable, get out of the situation.
- Date rape is not about love or passion. It's about power and control.
- Don't pressure your partners. If someone says "no," respect his/her decision.
- Date rape can happen to anyone. If it happens to you, it's not your fault. Talk to a friend or relative and get medical help right away.

What's new for sexually active teens?

You probably know abstinence is the best way to protect yourself from STDs, HIV, and unwanted pregnancy and that condoms can reduce your risk. But you might not know...

- **Chlamydia is a very common sexually transmitted disease.** Most young women and some young men have no symptoms, so you can have it and not know. All sexually active young women should be tested for chlamydia every year.
- **Oral sex confuses a lot of teens.** Although you can't get pregnant from having oral sex, you can catch some STDs—especially herpes. Using an unlubricated latex condom to cover the penis or a dental dam (flat, square piece of latex) to cover the vagina or anus can make oral sex safer. Know that stopping before ejaculation isn't safe sex. Pre-ejaculation fluid can still carry STDs.
- **Emergency Contraceptive Pills: (ECPs) can prevent pregnancy if you've had sex without birth control.** Since ECPs work best within 72 hours, call your doctor or NP as soon as possible after having unprotected sex. ECPs are for emergencies only. Talk to your doctor or NP about your choices for regular birth control.

Talk to your doctor, NP, or trusted adult if you have any questions.

Gay. lesbian, bisexual, or unsure ... you are not alone if you are questioning your sexuality. Talking with someone you trust can help you feel safe and accepted. For more information, call the National Gay/Lesbian/Bisexual Youth Hotline at 1-800-347-TEEN.

One last thing ...

We just loaded you with a million things to stay safe, healthy and happy. Being a teen isn't easy.

Just remember . . .

You are loved.

•Sometimes your parents might forget to show it, but they do love you. Don't forget, your being a teen is new for them, too. Also, remember that you are loved by others—grandparents, cousins, friends, and neighbors. Who else?

You are doing all right.

•So you're only getting 3 out of 5 fruits and vegetables a day? We all have stuff to work on. This is a time to find out who you are, set some goals, learn, and have fun.

You are who you are.

•With so many changes, it's normal to look to friends and see how they're acting. Try your best to accept who you are and focus on your strengths.

Other Resources

Web sites

Kaiser Permanente
www.kaiserpermanente.org

KidsHealth Teen Page
www.kidshealth.org/teen/index.html

Planned Parenthood's Teen Page
www.teenwire.com

Phone numbers

California Youth Crisis Hotline
1-800-843-5200

Child Abuse Hotline
1-800-4 A CHILD

National STD Hotline
1-800-227-8922

National Alcohol/Drugs Helpline
1-800-662-HELP

Emergency Contraception Hotline
1-888-NOT-2-LATE

Kaiser Permanente Healthphone
1-800-33-ASK ME.

Kaiser Permanente Healthwise Handbook

Visit your local **Health Education Department or Center**

EXAMPLE

The information presented here is not intended to diagnose health problems or take the place of the information or medical care you receive from your medical professional. If your teen has persistent health problems, or if you have additional questions, please consult your physician or other medical professional.

© 2002 The Permanente Medical Group, Inc. All rights reserved. Regional Health Education

Emergency Contraceptive Pills

How do you take emergency contraceptive pills?

Your package of emergency contraception contains 2 pills. Take each emergency contraceptive pill exactly 12 hours apart. Before you take the first dose, think ahead about where you will be 12 hours later. Make sure you will be awake and in a convenient place in 12 hours when it is time for the second dose. Remember that you must take the first pill within 72 hours after unprotected sex. Eat something with the pills to help prevent nausea. Nausea is usually mild and should stop in a day or so. If you vomit within 1 hour after taking a dose, call your doctor or nurse practitioner for an extra dose.

Write down the time that you take the first pill here: ☐

Then, take the second pill exactly 12 hours later at: ☐

What happens next?

NOW is the time to plan a regular, more effective method of birth control. Talk to your doctor or nurse practitioner about your birth control choices as soon as possible. Use condoms every time you have sex until you are able to get your regular birth control prescription. If you were using birth control pills, or want to start using them, it is best to start taking them the day after your last dose of Emergency Contraceptive Pills. Some birth control methods need to be started during your next period, so it is important to your doctor or other health care professional AS SOON AS POSSIBLE.

Your next menstrual period may start a few days earlier or later than usual. Menstrual bleeding may be heavier or lighter than usual. If your period doesn't start within 3 to 4 weeks, get a pregnancy test. You may be pregnant.

If you are having any unusual pain, bleeding, or vaginal discharge call your doctor or nurse practitioner. These could be signs of an infection or other medical need.

What a relief?

You got your period. Now what?

Again, make sure you ***always*** use an effective birth control method.

And remember to protect yourself against sexually transmitted diseases (or STDs), AIDS and pregnancy by using condoms correctly every time you have sex. You may have been exposed to a sexually transmitted disease from having unprotected sex. A common STD, chlamydia, may have no symptoms. Chlamydia can be cured. But if left untreated, it can cause internal scarring and possibly keep you from having a normal pregnancy in the future. Make an appointment for a private exam to check for STDs.

- For more information, call the Emergency Contraceptive Pill hotline at 1-888-NOT-2-LATE.
- Visit the Emergency Contraception website at ***http://opr.princeton.edu/ec/***
- Look in your Kaiser Permanente Healthwise Handbook.
- Call the Kaiser Permanente Healthphone at 1-800-33-ASK-ME. Listen to message #2714.
- Visit our website for Kaiser Permanente members at ***www.kponline.org***

The information presented here is not intended to diagnose health problems or take the place of medical core or information you receive from your physicion or health core professional. If you hove persistent health problems, or if you hove further questions, please consult your physician or other health professional.

KAISER PERMANENTE

© 2000, The Permanente Medical Group
All rights reserved. Regional Health Education. Northern California

90316
(6/00)

EXAMPLE

HOW TO PREVENT SUBSTANCE USE & ABUSE

- Think about not using drugs.
- Avoid situations where drugs or alcohol are easily available. Find ways to enjoy life without drugs.
- Be aware of the consequences of using alcohol, tobacco, drugs, diet pills and steroids.
- Ask your doctor if you have questions about any substances. If you smoke and would like to quit, talk with your doctor.
- Respect the decision of others to stay drug-free.
- Know that unwanted sex (and sexual abuse) is more likely to happen after drinking.
- Remember that selling drugs has serious consequences.
- Most schools have adult or peer counselors you can talk to.

SEXUALITY

The choices you make about your sexual behavior are important. Sex has potential consequences (pregnancy, HIV/AIDS, sexually transmitted diseases, guilt, depression). The decision to have sex is a serious decision that only you can make.

- Talking with your parents or trusted adult about sex and sexuality can be helpful.
- If you choose not to have sex, you are not alone. Many teens choose not to have sex.
- Show your affection by hugging, kissing and touching.
- Be clear in your own mind what you will and will not do. If any part of you says NO—pay attention to it.
- If you are having sex, make sure you come in for check-ups at least once a year. If you have had sexual intercourse and did not use any birth control, call your doctor for emergency birth control right away.

- Safer sex includes: wearing a condom or using a dental dam AND using other forms of birth control (like the pill or Depo-Provera). Ask your doctor if you have any questions about safer sex or birth control. Masturbation is also safe.
- Unsafe sex includes: ANY unprotected contact between genitals (including intercourse); ANY contact between genitals and the mouth (oral sex); or ANY contact between genitals and the anus (anal sex) or the mouth and the anus.
- Even condoms and birth control cannot guarantee safety from pregnancy or sexually transmitted diseases-but you must always use them to increase your chances of protection.

IMPORTANT PHONE NUMBERS

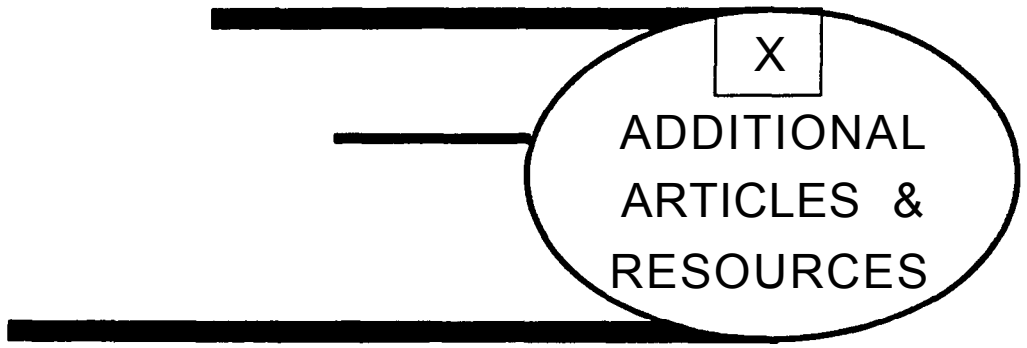
California Youth Crisis Hotline 1-800-843-5200
(Call this number for questions about friends, family, school, pregnancy. rape, violence, depression, suicide, sexual issues, or running away.)

Child Abuse Hotline 1-800-422-4453

Sex and AIDS Hotline 1-800-227-8922

National Alcohol / Drugs Helpline 1-800-662-HELP

EXAMPLE



UCSF Adolescent Medicine References

Background Articles

General Adolescent Medicine

Charles E. Irwin, Jr., M.D.
Professor of Pediatrics
Director, Division of Adolescent Medicine
Vice Chairman for Academic General Pediatrics
Department of Pediatrics, School of Medicine
University of California, San Francisco

1. Adams GR, Montemayor R, Gullotta TP, editors: *Biology of Adolescent Behavior &* Development, Newbury Park, CA: Sage, 1989.
2. American Academy of Pediatrics: *Guidelines for Health Supervision III,* 3rd edition, Elk Grove Village, IL: American Academy of Pediatrics, 1997.
3. American College of Physicians: Health care needs of the adolescent, *Annals of Internal Medicine* 110: 930, 1989.
4. American Medical Association: *AMA Guidelines for Adolescent Preventive Services (GAPS),* Chicago, Illinois: American Medical Association, Division of Adolescent Health, 1994.
5. Backous DD, Farrow JA, Friedl KE: Assessment of pubertal maturation in boys, using height and grip strength, *Journal of Adolescent Health* 11: 497, 1990.
6. Balk DE: *Adolescent Development: Early Through Late Adolescence,* Pacific Grove, CA: Brooks/Cole Publishing Company, 1995.
7. Bancroft J, Reinisch JM, editors: *Adolescence & Puberty,* New York: Oxford University Press, 1990.
8. Biro FM, Lucky AW, Huster GA, et al: Pubertal staging in boys, *J Pediatr* 127: 100,1995.
9. Blum RW, Beuhring T, Wanderlich M, Resnick MD: Don't ask, they won't tell: the quality of adolescent health screening in five practice settings, *American Journal of Public Health* 86: 1767, 1996.
10. Blum RW, Rhinehart PM: Reducing the risk: connection that makes a difference in the lives of youth, Minneapolis, MN: Division of General Pediatrics and Adolescent Health, University of Minnesota, 1997.
11. Blum RW, Stark T: Cognitive development in adolescence: clinical cues and implication, *Semin Adolesc Med* 1: 25, 1985.
12. Bremberg S, Andersson R: Medical vocational guidance for adolescents - is it effective? *Acta Paediatric* 81: 253, 1992.
13. Brindis CD, Ozer EM, Handley M, Knopf DK, Millstein SG, Irwin CE Jr: Improving adolescent health: an analysis and synthesis of health policy recommendations, full report, San Francisco, CA: National Adolescent Health Information Center, University of California, San Francisco, 1998.
14. Brown BB, Mounts N, Lamborn SD, et al: Parenting practices and peer group affiliation in adolescence, *Child Dev* 64: 467, 1993.

15. Brown RT, Henderson PB: Treating the adolescent: the initial meeting, *Semin Adolesc Med* 3: 79, 1987.
16. Carnegie Council on Adolescent Development: Great Transitions: Preparing Adolescents for a New Century, New York: Carnegie Corporation of New York, 1995.
17. Cavanaugh RM, Jr., Hastings-Tolsma M, Kennan D, et al: Anticipatory guidance for the adolescent, parents' concerns, *Clin Pediatr* 32: 542, 1993.
18. Chassin L, Presson CC, Sherman SJ: "Constructive" vs. "destructive" deviance in adolescent health behaviors, *Journal of Youth and Adolescence* 18: 245, 1989.
19. Cheng TL, Savageau JA, Sattler AL, et al: Confidentiality in health care: a survey of knowledge, perceptions and attitudes among high school students, *JAMA* 269: 1404, 1993.
20. Cohn LD, Mcfarlane S, Yanez C, et al: Risk-perception: differences between adolescents and adults, *Health Psychol* 14: 217, 1995.
21. Cohn LD, Schydlower M, Foley J, et al: Adolescents' misinterpretation of health risk probability expressions, *Pediatrics* 95: 713, 1995.
22. Collins JK: Future challenges for behavioral research in adolescent health, *J Paediatr Child Health* 29: S66, 1993.
23. Commission on Behavioral Social Sciences and Education, National Research Council: Losing Generations: Adolescents in High Risk Settings. Washington, DC: National Academy Press, 1993.
24. Conger JJ, Galambos NL: Adolescence and Youth: Psychological Development in a Changing World, Fifth edition. New York Addison Wesley Longman, 1997.
25. Copeland KC, Brookman RR, Rauh JL: Assessment of pubertal development, *Pediatr Rev* 2: 1, 1986.
26. Cromer BA, McLean CS, Heald FP: A critical review of comprehensive health screening in adolescents, *J Adolesc Health* 13: 1S, 1992.
27. Cur-ran PJ, Stice E, Chassin L: The relation between adolescent alcohol use and peer alcohol use: a longitudinal random coefficients model, *J Consul Clin Psychol* 65: 130, 1997.
28. Daniel WA, Jr: Growth at adolescence: clinical correlates, *Semin Adolesc* 1:15, 1985.
29. DiClemente RJ, Hansen WB, Ponton LE., editors *Handbook of Adolescent Health Risk Behavior.* New York: Plenum Press, 1996.
30. Dryfoos JG. *Adolescents At Risk.* New York: Oxford University Press, 1991.
31. Elster AB, Kuznets NJ, editors: *AMA Guidelines for Adolescent Preventive Services: Recommendations & Rationale,* Baltimore, MD: Williams & Wilkinson, 1994.
32. Emans SJ, Laufer MR, Goldstein DP, editors: *Pediatric and Adolescent Gynecology,* 4th Edition Philadelphia, Pennsylvania: Lippincott-Raven Publishers, 1998.
33. Feldman SS, Elliott GR, editors: *At the Threshold: The Developing Adolescent.* Cambridge, Massachusetts: Harvard University, 1990.
34. Ford CA, Millstein SG, Eyre SL, Irwin CE, Jr.: Anticipatory guidance regarding sex: views of virginal female adolescents, *Journal Of Adolescent Health* 19: 179, 1996.

35. Ford CA, Millstein SG, Halpern-Felsher B, Irwin CE, Jr: Influence of physician confidentiality assurances on adolescents' willingness to disclose information and seek future health care - a randomized controlled trial, *Journal of the American Medical Association* 278: 1029, 1997.
36. Franzgrote M, Ellen JM, Millstein SG, Irwin CE, Jr.: Screening for adolescent smoking among primary care physicians in California *American Journal of Public Health* 87: 1341, 1997.
37. Freed LH, Ellen JM, Irwin CE, Jr., Millstein SG: Determinates of adolescents' satisfaction with health care providers and intentions to keep follow up appointments. *Journal of Adolescent Health* 22:475-479, 1998.
38. Friedman SB, Fisher M, Schonberg SK, Alderman EM, editors: *Comprehensive Adolescent Health,* 2nd edition. St. Louis, Missouri: Mosby, 1998.
39. Gabel LL, Siegal HA, Hostetler J: Preventing substance abuse, an interview paradigm, J Fam Practice 37: 503, 1993.
40. Gans JE, Alexander B, Chu RC, Elster AM: The cost of comprehensive preventive medical services for adolescents, *Archives of Pediatrics & Adolescent Medicine* 149:1226, 1995.
41. Ginsburg KR, Slap GB, Cnaan A, et al: Adolescents' perceptions of factors affecting their decisions to seek health care, *JAMA* 273: 1913, 1995.
42. Gotlieb EM, editors: *Practicing Adolescent Medicine: A Collection of Resources. Section on Adolescent Heath.* Elk Grove, Illinois: American Academy of Pediatrics, 1994.
43. Green M, editors: *Bright Futures: Guidelines for Health Supervision of Infants, Children & Adolescents.* Arlington, Virginia: National Center for Education in Maternal & Child Health, 1994.
44. Haggerty RJ, Sherrod LR, Garmezy N, Rutter M: *Stress, Risk, and Resilience in Children and Adolescents: Process, Mechanisms, and Interventions.* New York: Cambridge University Press, 1994.
45. Harlan WR, Grillo GP, Coroni-Huntley J, et al: Secondary sex characteristics of boys 12 to 17 years of age: the U.S. health examination survey, *J Pediatr* 95: 293, 1979.
46. Harlan WR, Harlan EA, Grillo GP: Secondary sex characteristics of girls 12 to 17 years of age: the U.S. health examination survey, *J Pediatr* 96: 1074, 1980.
47. Hendee WR editor: *The Health of Adolescents.* San Francisco: Jossey-Bass, 1991.
48. Herman-Giddens ME, Slora EJ, Wasserman RC, Bourdony CJ, Bhapkar MV, Koch GG, Hasemeier CM: Secondary sexual characteristics and menses in young girls seen in office practice: a study from the Pediatric Research in Office Settings network, *Pediatrics* 99: 505, 1997.
49. Hirsch M, Lunenfeld B, Modan M, et al: Spermarche: the age of onset of sperm emission, *J Adolesc Health Care* 6: 35, 1985.
50. Hofmann AD, Becker RD, Gabriel HP: The *Hospitalized Adolescent.* New York: Free Press, 1977.

51. Hofmann AD, Greydanus DE, editors: *Adolescent Medicine,* Stamford, Connecticut: Appleton & Lange, 1997.
52. Hofmann AD: Managing adolescents and their parents: avoiding pitfalls and traps, *State Art Rev: Adolescent Medicine* 3: 1, 1992.
53. Holmbeck GN, Paidoff RL, Broks-Gunn J: Parenting adolescents. In Bornstein MH, editor: *Handbook of Parenting: Children and Parenting,* Mahwah, NJ: Lawrence Erlbaum Associates, 1995, pp. 91-118.
54. Igra V, Irwin CE, Jr.: Theories of adolescent risk taking behavior. In: DiClemente RJ, Hansen WB, Ponton LE , editors: *Handbook of Adolescent Health Risk Behavior.* New York: Plenum Press, 1996, pp. 35-51.
55. Igra V, Irwin CE, Jr.: Risk and risk-taking behaviors in adolescents. In: Spencer N & Lindstrom B , editors: *European Textbook of Social Pediatrics.* London: Oxford University Press, 1995, pp. 225-256.
56. Institute for Social Research, University of Michigan: *National Survey Results on Drug Abuse from the Monitoring the Future Study,* 1975-97. Rockville, MD: National Institute on Drug Abuse, U.S. Department of Health and Human Services, 1998.
57. Irwin CE, Jr.: Adolescent development and driving: does driving differ from other health damaging behaviors. In: Simpson H, editors: *New to the Road: Reducing the Risks for Young Motorists.* Los Angeles: Youth Enhancement Service, pp. 5l-70, 1996.
58. Irwin CE, Jr., editor: *Adolescent Social Behavior and Health.* San Francisco: Jossey-Bass, 1987.
59. Irwin CE, Jr., Orr D: Future directions of health research in adolescence. In: Lerner R, Petersen AC, Brooks-Gunn J, editors: *Encyclopedia of Adolescence.* New York: Garland Publishing, Inc., pp. 934-943, 1991.
60. Irwin CE, Jr., Brindis C, Holt KA, Langlykke K, editors: *Health care reform: Opportunities for improving adolescent health.* National Center for Education in Maternal and Child Health, Arlington, Virginia, 1994.
61. Irwin CE, Jr., Millstein SG: Biopsychosocial correlates of risk-taking behaviors during adolescence, *Journal of Adolescent Health Care* 7: 82S, 1986.
62. Irwin CE, Jr., Shafer MA, Ryan SA, editors: The adolescent patient. In: Rudolph A (ed.). *Rudolph's Pediatrics,* 20th edition. East Norwalk, Connecticut: Appleton & Lange, pp. 37-67, 1996.
63. Irwin CE, Jr., Shafer MA: Adolescent health problems. In: Isselbacher KJ, Brunwald E, Wilson J, et. al., editors: *Harrison's Principles of Internal Medicine,* 14th edition. New York: McGraw Hill, pp. 30-37, 1998.
64. Irwin CE, Jr., Vaughan E: Psychosocial context of adolescent development, *Journal of Adolescent Health Care* 9: 11, 1988.
65. Irwin, CE, Jr., Cataldo MF, Matheny AP, Peterson L. Health consequences of behaviors: injury as a model. *Pediatrics* 90:798, 1992.
66. Jackson S, Rodriquez-Tomes H, editors: *Adolescence & Its Social Worlds.* United Kingdom: Hove, 1993.

67. Jacobsen LD, Wilkinson C, Owen PA: Is the potential of teenage consultations being missed? A study of consultation times in primary care, *Fam Pract* 11: 296, 1994.
68. Jensen LC, De Gaston JF, Weed SE: Societal and parental influences on adolescent sexual behavior, *Psychol Rep* 75: 928, 1994.
69. Jessor R, Donovan JE, Costa FM: *Beyond Adolescence.* Cambridge, England: Cambridge University Press, 1991.
70. Joffe A, Radius S, Gall M: Health counseling for adolescents: what they want, what they get, and who gives it, *Pediatrics* 82: 481, 1988.
71. Joffe A, Radius SM: Health counseling of adolescents, *Pediatr Rev* 12: 344, 1991.
72. Johnson J, editor: *Adolescent Medicine Residency Training Resources.* Section on Adolescent Health. Elk Grove, Illinois: American Academy of Pediatrics, 1995.
73. Kann L, Kinchen SA, Williams BI, Ross JG, Lowry R, Hill CV, Grunbaum JA, Blumson PS, Collins JL, Kolbe L: *Youth Risk Behavior Surveillance - United States,* 1997, In: CDC Surveillance Summaries, August 14, 1998. MMWR 1998: 47 (No, SS-3). Atlanta: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.
74. Ketterlinus RD, Lamb ME, editors: *Adolescent Problem Behaviors: Issues & Research.* Hillsdale, New Jersey: Lawrence Earlbaum & Associates, Inc., 1994.
75. Langer LM, Zimmerman RS, Warheit GJ, et al: Decision-making orientation and AIDS-related knowledge, attitudes, and behaviors of Hispanic, African-American, and white adolescents, *Health Psycho1* 12: 227, 1993.
76. Lerner RM, editor: Early Adolescence: Perspectives on Research, Policy, and Intervention. Hillsdale, New Jersey: Lawrence Erlbaum Associates, Inc., 1993.
77. Litt IF: The interaction of pubertal and psychosocial developmental during adolescence, *Pediatr Rev* 12: 249, 1991.
78. Lopez RI: Role of the primary care pediatrician in adolescent psychological assessment and intervention, State *Art* Rev: *Adolesc Med* 3: 147, 1992.
79. Lynch, BS, Bonnie RJ, editors: *Growing Up Tobacco Free: Preventing Nicotine Addiction in Children and Youths.* Washington, D.C.: National Academy Press, 1994.
80. Mahon NE, Yarcheski TJ: Future time perspectives and positive health practices in adolescents, *Percept Mot Skills* 79: 395, 1994.
81. Males MA: The Scapegoat Generation: *America's War on Adolescents.* Monroe, ME: Common Courage Press, 1996.
82. Marks A, Fisher M: Health assessment and screening during adolescence, *Pediatrics* 80: 135, 1987.
83. McAnarney ER, Kreipe RE, Orr DP, Commerci GD, editors: *Textbook of Adolescent Medicine.* Philadelphia, PA: W.B. Saunders, 1992.
84. McFarlane AH, Bellissimo A, Norman GR: Family structure, family functioning and adolescent well-being: the transcendent influence of parental style, *J Child Psychol Psychiatry* 36: 847, 1995.

85. Millstein SG, Igra V, Gans J. Delivery of STD/HIV preventive services to adolescents by primary care physicians. *Journal of Adolescent Health* 19:4 249, 1996.
86. Millstein SG, Irwin CE, Jr., Adler NE, et. Al: Health-risk behaviors and health concerns among young adolescents. *Pediatrics* 89:422, 1992.
87. Millstein SG, Petersen AC, Nightingale EO, *editors: Promoting the Health of Adolescents: New Directions for the Twenty-first Century,* New York: Oxford University Press, 1993.
88. Mortimer JT, Finch MD, Ryu S, Shanahan MJ, & Call KT: The effects of work intensity on adolescent mental health, achievement, and behavioral adjustment: new evidence from a prospective study, *Child Development* 67: 1243, 1996.
89. Muus RE: Theories of Adolescence, 6th edition. New York: McGraw Hill, 1996.
90. Neinstein LS: *Adolescent Health Care: A Practical Guide,* 3rd edition. Baltimore, Maryland: Williams & Wilkins, 1996.
91. Neumark-Sztainer D, Blum RW, Brindis CD, Anglin TM, Irwin CE, Jr.: The state of adolescent health: looking back and planning ahead. *Journal of Adolescent Health* 21: 280, 1997.
92. Offer D, Marcus D, Offer JL: A longitudinal study of normal adolescent boys, *Am J Psychiatry* 127: 917, 1970.
93. Offer D, Schonert-Reichl KA: Debunking the myths of adolescence: findings from recent research, *J Am Acad Child Adolesc Psychiatr* 31: 1003, 1992.
94. Orr DP, Brack CJ, Ingersoll G: Pubertal maturation and cognitive maturity in adolescents, *Journal of Adolescent Health Care* 9:273-279.
95. Orr DP, Ingersoll GM: Adolescent development: a biopsychosocial review, *Curr Probl Pediatr* 8:443, 1988.
96. Orr DP, Ingersoll GM: The contribution of level of cognitive complexity and pubertal timing to behavioral risk in young adolescents, *Pediatrics* 95: 528, 1995.
97. Orr DP: Helping adolescents toward adulthood, *Contemporary Pediatrics* 15: 55, 1988.
98. Orr DP: The contribution of level of cognitive complexity and pubertal timing to behavioral risk in young adolescents, *Pediatrics* 95: 528, 1995.
99. Ozer EM, Brindis CD, Millstein SG, Knopf DK, Irwin CE, Jr. *America's Adolescents: Are they Healthy?* Revised edition. San Francisco, CA: University of California, San Francisco, National Adolescent Health Information Center, 1998.
100. Petersen AC, Leffert LL: Developmental issues influencing guidelines for adolescent health research: a review, *J Adolesc Health* 17: 323, 1995.
101. Petersen AC: Adolescent development. *Annual Review of Psychology* 39:583, 1988.
102. Platt FW, Keller VF: Empathic communication: a teachable and learnable skill, *J Gen Intern Med* 9: 222, 1994.
103. Proos LA: Anthropometry on adolescence - secular trends, adoption, ethnic and environmental differences, *Horm Res* 39: 18, 1993.
104. Resnick MD, Beat-man PS, Blum RW, Bauman KE, Harris KM, Jones J, Tabor J, Buehring T, Sieving RE, Shew M, Ireland M, Bearinger LH, Udry JR: Protecting

adolescent from harm: findings from the National Longitudinal Study on Adolescent Health, *JAMA* 278: 823, 1997.

105. Resnick MD, Harris LJ, Blum RW: The impact of caring and connectedness on adolescent health and well-being, *J Pediatr Child Health* 29: S3, 1993.
106. Rickert VI, Graham CJ, Fisher R, et al: A comparison of methods for alcohol and marijuana anticipatory guidance with adolescents, *J Adolesc Health* 14: 225, 1993.
107. Roberts RE, Lewinsohn PM, Seeley JR: Symptoms of DSM-II-R major depression in adolescence: evidence from an epidemiological survey, *Journal of the American Academy of Child and Adolescent Psychiatry* 34: 1608, 1995.
108. Roche AF, Wellens R, Attie KM, et al: The timing of sexual maturation in a group of U.S. white youths, *J Pediatr Endocrinol Metab* 8: 11, 1995.
109. Rodriguez-Tome H, Bariaud F, Zardi MF, et al: The effects of pubertal chances on body image and relations with peers of the opposite sex in adolescence, *J Adolesc* 16: 421, 1993.
110. Rogers DE, Ginzberg E., editors: *Adolescents at Risk.* Boulder, Colorado: Westview Press, 1992.
111. Rohde P, Lewinsohn PM, Seeley JR: Psychiatric comorbidity with problematic alcohol use in high school students, *Journal of the American Academy of Child & Adolescent Psychiatry* 35: 101, 1996.
112. Ryan S, Millstein SG, Irwin CE, Jr.: Pubertal concerns of early adolescents, *Journal of Adolescent Health* 19:145, 1996.
113. Ryan SA, Irwin CE, Jr: Risk behaviors. In: Friedman SB, Fisher MM, Schonberg SK, Alderman EM, editors: *Compendium of Adolescent Health,* 2nd edition, St Louis, Missouri, pp. 848-57, 1998.
114. Scheer SD, Unger DG: Parents' perceptions of their adolescent: implications for parent-youth conflict and family satisfaction, *Psychol Rep* 76: 131, 1995.
115. Schubiner H, Tzelepis A, Wright K, et al: The clinical-utility of the Safe Times Questionnaire, *J Adolesc Health* 15: 374, 1994.
116. Simpson H, editor: *New to the Road: Reducing the Risks for Young Motorists.* Los Angeles: Youth Enhancement Service, 1996.
117. Singer MI, Singer LT, Anglin TM, editors: *Handbook for Screening Adolescents at Psychosocial Risk.* New York: Lexington Books, 1992.
118. Slap GB, Khalid N, Paikoff RL, et al: Evolving self-image, pubertal manifestations, and pubertal hormones: preliminary findings in young adolescent girls, *J Adolesc Health* 15: 327, 1994.
119. Smetana JG: Parenting styles and conceptions of parental authority during adolescence, *Child Dev* 66: 299, 1995.
120. Society for Adolescent Medicine: Guidelines for adolescent health research: a position paper, *J Adolesc Health* 17: 270, 1995.
121. Solloway MR, Budetti PP. *Child Health Supervision: Analytical Studies in the Financing, Delivery, and Cost-Effectiveness of Preventive and Health Promotion Services for Infants, Children, and Adolescents.* Arlington, Virginia: National Center for Education in Maternal and Child Health, 1995.

122. Steinberg L, Fletcher A, Darling N: Parental monitoring and peer influences on adolescent substance use, *Pediatrics* 93: 1060, 1994.
123. Steinberg LD: *Understanding Families with Young Adolescents,* Carrboro, NC: Center for Early Adolescence, 1980.
124. Strasburger VC. *Adolescents and the Media: Medical and Psychological Impact.* Newbury Park, California: Sage, 1995.
125. Strasburger VC, Brown RT: *Adolescent Medicine: A Practical Guide,* 2nd edition. Philadelphia, Pennsylvania: Lippincott-Raven, 1998.
126. Susman EJ, Dorn LD, Fletcher JC: Participation in biomedical research: the consent process as viewed by children, adolescent, young adults, and physicians, *J Pediatrics* 121: 547, 1992.
127. Sussman S, Dent CW, Stacy AW, et al: Psychosocial predictors of health risk factors in adolescents, *J Pediatr Psychol* 20: 91, 1995.
128. Takanishi R, Hamburg DA, editors: *Preparing Young Adolescents for the 21st Century: Challenges facing Europe and the United States.* New York: Cambridge University Press, 1996.
129. Tanner JM, Davies PS: Clinical longitudinal standards for height and height velocity for North American children. *Journal of Pediatrics* 107: 317, 1985.
130. Tanner JM: Issues and advances in adolescent growth and development, *Journal of Adolescent Health Care* 8: 470, 1987.
131. Tschann JM, Adler NE, Irwin CE, Jr., et al: Initiation of substance use in early adolescence: the role of pubertal timing and emotional distress, *Health Psychol* 13: 326, 1994.
132. Turner RA, Irwin CE, Jr., Tschann JM, Millstein SG: Autonomy, relatedness and the initiation of health risk behaviors in early adolescence, *Health Psychology* 12: 200, 1993.
133. US. Congress, Office of Technology Assessment: *Adolescent Health- Volume 1: Summary and Policy Options,* OTA-H-468 (Washington, DC: U.S. Government Printing Office, April 1991).
134. U.S. Congress, Office of Technology Assessment: *Adolescent Health- Volume 2: Background and the Effectiveness of Selected Prevention and Treatment Services,* OTA-H-466 (Washington, DC: U.S. Government Printing Office, November 1991).
135. U.S. Congress, Office of Technology Assessment: *Adolescent Health- Volume 3: Crosscutting Issues in the Delivery of Health and Related Services,* OTA-H-467 (Washington, DC: U.S. Government Printing Office, June 1991).
136. U.S. Preventive Services Task Force: *Guide to clinical preventive services,* 2nd edition, Baltimore, MD: Williams & Wilkins, 1996.
137. Wasson, JH, Kairys SW, Nelson EC, et al: Adolescent health and social problems. A method for detection and early management. The Dartmouth Primary Care Cooperative Information Project (COOP), *Arch Fam Med* 4: 51, 1995.
138. Weiler RM, Sliepcevich EM, Sarvela PD: Development of the Adolescent Health Concerns Inventory, *Health Educ Q* 20: 569, 1995.

139. Weiner IB: *Psychological Disturbance in Adolescence.* New York: J. Wiley & Sons, 1992.
140. Wells CW, Blum RW: Morbidity and mortality among US adolescents: an overview of data and trends, *Am J Public Health* 86: 513, 1996.
141. West KK, Hauser RM, Scanlan TM: *Longitudinal Surveys of Children,* Committee on National Statistics, Board on Children Youth and Families, Commission on Behavioral and Social Sciences and Education, National Research Council, Institute of Medicine, Washington D.C.: National Academy Press, 1988.
142. Wheeler MD. Physical changes of puberty, *Endocrine and Metabolism Clinics of North America* 20: 1, 1991.

PERIODICALS & JOURNALS FOR PROFESSIONALS

Adolescent Health Update <since 1988>

Three issues published yearly by The American Academy of Pediatrics. Covers topics relevant to adolescent health. Available through The American Academy of Pediatrics: 141 Northwest Point Blvd., Elk Grove Village, Il. 60007- 1098, Attention: Publications Department. Fax: (847) 228-1281

Adolescent Medicine: State of the Art Reviews <since 1990>

Official Journal of Section on Adolescent Health of The American Academy of Pediatrics. Published three times per year on a state-of-the-art topic. Available through Hanley & Belfus, Inc. 210 South 13th Street, Philadelphia, PA 19107

Journal of Adolescent Health <since 1980>

Official Journal of the Society for Adolescent Medicine, published monthly. Available through Elsevier Science Inc. 655 Avenue of the Americas, New York, N.Y. 10010

Journal of Research on Adolescence <since 1992>

Official Journal of Society for Research on Adolescence, published four times a year. Available through Lawrence Earlbaum Associates, Inc. Journal Subscription Department, 10 Industrial Avenue, Mahwah, N.J. 07430-2262

PROFESSIONAL ORGANIZATIONS IN THE UNITED STATES OF AMERICA

American Academy of Pediatrics (AAP) Section on Adolescent Health

The AAP is an organization committed to the attainment of optimal physical, mental, and social health for all infants, children, adolescents and young adults. The Section on Adolescent Health enables members who are primarily interested in adolescent health to meet for the purpose of developing ideas and programs which will improve the health care of young people in their second decade of life and to provide an educational forum for the membership at large in expanding their basic pediatric knowledge and skills to include the adolescent patient. **For information regarding the American Academy of Pediatrics (AAP) Section on Adolescent Health, please contact:**

The American Academy of Pediatrics
Section on Adolescent Health
141 Northwest Point Boulevard
Elk Grove Village, IL 60007- 1098
Phone: (847) 228-5005
Fax: (847) 228-5097
E-mail: section@aap.org
Home Page: http://www.aap.org/sections/adol/

American Medical Association (AMA), Department of Adolescent Health

The American Medical Association's (AMA) Department of Adolescent Health is a resource for information on adolescent health issues. A major AMA adolescent health initiative is called Guidelines for Adolescent Preventive Services (GAPS). GAPS is based on a set of recommendations that describe the content and delivery of comprehensive clinical preventive services for adolescents between 11-21 years of age. **For information regarding the AMA Department of Adolescent Health, please contact:**

American Medical Association
Department of Adolescent Health
515 North State' Street
Chicago, IL 60610
Phone: (3 12) 464-5570
Fax: (3 12) 464-5842
E-mail: gaps@ama-assn.org
Home Page: http://www.ama-assn.org/ama/pub/category/l947.html

Society for Adolescent Medicine (SAM)

The Society for Adolescent Medicine, a multidisciplinary organization, is devoted to the development of comprehensive acute, chronic, and preventive health care delivery to youth and to the institution of imaginative scientific research regarding all aspects of adolescence. SAM has an annual meeting in March. **For information regarding, SAM please contact:**

Society for Adolescent Medicine
1916 Northwest Copper Oaks Circle
Blue Springs, Missouri 64015
Phone: (816) 224-8010
Fax: (816) 224-8009
E-Mail: sam@adolescenthealth.org
Home Page: http://www.adolescenthealth.org

Society for Research on Adolescence (SRA)

The Society for Research on Adolescence is a multidisciplinary society devoted to research on the second decade of life. SRA has a biennial meeting in the spring. **For information regarding SRA, please contact:**

Society for Research on Adolescence
Department of Psychology
University of Michigan
505 East Huron Street #301
Ann Arbor, MI 48104-1522
Phone: (734) 998-6567
Fax: (734) 998-9586
E-mail: socresadol@umich.edu
Home Page: http://www.s-r-a.org/

BOOKS FOR ADOLESCENTS & PARENTS

1. Elkind D: *Parenting Your Teenager,* New York: Ballentine Books, 1993.
2. Greydanus DE, editor: *Caring For Your Adolescent: Ages 12 to 21,* Elk Grove Village, Illinois: American Academy of Pediatrics, 1991.
3. Madaras L, Madaras A: My *Body, Myself for Boys,* New York: Newmarket Press, 1995.
4. Madaras L, Madaras A: My *Body, Myself for Girls,* New York: Newmarket Press, 1993.
5. McCoy K, Wibbelsman *C: The New Teenage Body Book,* New York: The Body Press/Perigee Books, 1992.
6. Slap GB, Jablow MM: *Teenage Health Care,* New York: Pocket Books, 1994.
7. Steinberg L: *Crossing Paths: How Your Child's Adolescence Triggers your Own Crisis,* New York: Simon & Schuster, 1994.

REFERENCES:

Increasing the Delivery of Adolescent Preventive Services within Clinical Practice

American Academy of Pediatrics. (1999). An analysis of the costs to provide clinical preventive services to adolescents. Elk Grove Village, IL: Author.

American Academy of Pediatrics, Department of Research. (1999, March). Providing health care to adolescents: Pediatricians' attitudes and practices (Periodic Survey of Fellows No. 42). Elk Grove Village, IL: Author.

Bandura, A. (1997). Self-efficacy: the exercise of control. New York: W.H. Freeman.

Bero, L. A., Grilli, R., Grimshaw, J. M., Harvey, E., Oxman, A. D., & Thomson, M. A.(1998). Closing the gap between research and practice: an overview of systematic reviews of interventions to promote the implementation of research findings. The Cochrane Effective Practice and Organization of Care Review Group. BMJ (Clinical Research Ed.), 317(7156), 465-468.

Biskupiak, J., (1997). Disease management in managed care organizations. In W. Todd & D. Nash (Eds.), Disease management: a systems approach to improving patient outcomes. (pp. 207 - 233). Chicago, IL: American Hospital Publishing.

Blum, R. W., & Bearinger, L. H. (1990). Knowledge and attitudes of health professionals toward adolescent health care. journal of Adolescent Health Care, 11(4), 289-294.

Blum, R.W., Beuhring, T., Wunderlich, M., Resnick, M.D. (1996). Don't ask, they won't tell: the quality of adolescent health screening in five practice settings. American Journal- of Public Health. 86, 1767-1772.

Bodenhorn, K. A., & Kemper, L. D. (1997). Spending for health: Californians speak out about priorities for health spending. Sacramento: California Center for Health Improvement.

Brindis, C. D., Irwin, C. E., Jr., Ozer, E. M., Handley, M., Knopf, D. K., & Millstein, S. G. (1997). Improving adolescent health: An analysis and synthesis of health policy recommendations. San Francisco: University of California, National Adolescent Health Information Center.

Brindis, C. D., Morales, S., McCarter, V., Dobrin, C., & Wolfe, A. (1993). An evaluation study of school-based clinics in California: Major findings, 1986-1991. San Francisco: University of California, Center for Reproductive Health Policy Research, Institute for Health Policy Studies.

Brindis, C. D., VanLandeghem, K., Kirkpatrick, R., Macdonald, T., & Lee, S. (1999). Adolescents and the state Children's Health Insurance Program (CHIP)! Healthy options for meeting the needs of adolescents. Washington, DC: Association of Maternal and Child Health Programs, & San Francisco: University of California, Policy Information and Analysis Center for Middle Childhood and Adolescence, & National Adolescent Health Information Center.

Cabana, M. D., Rand, C. S., Powe, N. R., Wu, A. W., Wilson, M. H., Abboud, P. A., & Rubin, H. R. (1999). Why don't physicians follow clinical practice guidelines? A framework for improvement. JAMA, 282(15), 1458-1465.

Campbell, J. (1999). Health insurance coverage: Consumer income (Current Population Report No. P60-208). Washington, DC: U.S. Census Bureau. Retrieved from the World Wide Web: http://www.census.gov/hhes/hIthins/hIthin98.html

Centers for Disease Control and Prevention. (1998). Tracking the hidden epidemics: Trends in the STD epidemics in the United States. Atlanta, GA: Centers for Disease Control and Prevention.

Centers for Disease Control and Prevention. (1999). CDC Wonder online database. Atlanta, GA: Centers for Disease Control and Prevention [http:wonder.cdc.gov].

Chabra, A., Chavez, G. F., Harris, E. S., & Shah, R. (1999). Hospitalization for mental illness in adolescents: Risk groups and impact on the health care system. Journal of Adolescent Health, 24(5), 349-356.

Chan, C., & Witherspoon, J. M. (1988). Health risk appraisal modifies cigarette smoking behavior among college students. Journal of General internal Medicine, 3(6), 555-559.

Cheng, T. L., Dewitt, T. G., Savageau, J. A., & O'Connor, K. G. (1999). Determinants of counseling in primary care pediatric practice: physician attitudes about time, money, and health issues. Archives of Pediatrics and Adolescent Medicine, 153(6), 629-635.

Children Now. (2000). Partners in transition: Adolescents and managed care. Oakland, CA: Author.

Coveny, J. L., & Wilson, T. (1998, July). SBHC middle school initiative: Early adolescent screening and prevention project (GAPS Update Vol. 1, Issue 2, pp. 3). Chicago: American Medical Association.

Cross, M. (1998). Cultivating better relationships with teens. Healthplan, 39(3), 63-7 1 .

Davis, D. A., Thomson, M. A., Oxman, A. D., & Haynes, R. B. (1995). Changing physician performance. A systematic review of the effect of continuing medical education strategies. JAMA, 274(9), 700-705.

Downs, S.M. & Klein, J.D. (1995). Clinical preventive services efficacy and adolescents' risky behaviors. Archives of Pediatrics and Adolescent Medicine, 149, 374-379.

Durant, R. (1991). Overcoming barriers to health care access. In W. Hendee (Ed.), The health of adolescents (pp. 431-452). San Francisco: Jossey-Bass.

Ellen, J. M., Franzgrote, M., Irwin, C. E., Jr., & Millstein, S. G. (1998). Primary care physicians' screening of adolescent patients: a survey of California physicians. Journal of Adolescent Health, 22(6), 433-438.

Ellrodt, A. G., Conner, L., Riedinger, M., & Weingarten, S. (1995). Measuring and improving physician compliance with clinical practice guidelines: A controlled interventional trial. Annals of Internal Medicine, 122(4),. 277-282.

Elster, A. B., & Kuznets, N. J. (1994). AMA guidelines for adolescent preventive services (GAPS): Recommendations and rationale. American Medical Association.

English, A., Kapphahn, C., Perkins, J., & Wibbelsman, C. J. (1998). Meeting the health care needs of adolescents in managed care: A background paper. Journal of Adolescent Health, 22(4), 278-292.

English, A., & Knopf, D. (1999). HEDIS 3.0 and adolescents: An overview. Chapel Hill, NC: Center for Adolescent Health and the Law, & San Francisco: University of California, National Adolescent Health Information Center.

Ferris T. G., Dougherty, D., Blumenthal, D., Perrin, J. M. (2001). A report card on quality improvement for children's health care. Pediatrics, 107(1), 143-155.

Feuer, E. J., & Kessler, L. G. (1989). Test statistic and sample size for a two-sample McNemar test [published erratum appears in Biometrics 1989 Sep;45(3):1039]. Biometrics, 45(2), 629-636.

Fisher, M. (1992). Parents' views of adolescent health issues. Pediatrics, 90(3), 335-341.

Fogle, S. (1991). Pitching prevention: will doctors listen? J NIH Res, 3, 90-92.

Ford, C.A., Millstein, S.G., Halpern-Felsher, B., Irwin, C.E., Jr. (1997) Influence of physician confidentiality assurances on adolescents' willingness to disclose information and seek future health care: a randomized controlled data. JAMA, 278, 1029-1034.

Foundation for Accountability. (2000). The Child and Adolescent Health Measurement Initiative. [http//:www.facct.org].

Franzgrote, M., Ellen, J. M., Millstein, S. G., & Irwin, C. E., Jr. (1997). Screening for adolescent smoking among primary care physicians in California. American Journal of Public Health, 87(8), 1341-1345.

Freed, L.H., Ellen, J.M., Irwin, C.E., Jr., Millstein, S.G. (1998) Determinants of adolescents' satisfaction with health care providers and intentions to keep follow up appointments. Journal of Adolescent Health, 22, 475-479.

Gans, J.E., Alexander, B., Chu, R. & Elster, A.B. (1995). The cost of comprehensive preventive medical services for adolescents. Archives of Pediatrics and Adolescent Medicine, 149, 1226-1234.

Goodwin, M. A., Flocke, S. A., Borawski, E. A., Zyzanski, S. J., & Stange, K. C. (1999). Direct observation of health-habit counseling of adolescents. Archives of Pediatrics & Adolescent Medicine, 153(4), 367-373.

Greco, P. J., & Eisenberg, J. M. (1993). Changing physicians' practices New England Journal of Medicine, 329(17), 1271-1273.

Green, L. W., Eriksen, M. P., & Schor, E. L. (1988). Preventive practices by physicians: behavioral determinants and potential interventions. American Journal of Preventive Medicine, 4(4 Suppl), 101-7; discussion 108-110.

Green, L.W. & Kreuter, M.W. (1999). Health promotion planning: an educational and ecological approach. Mountain View, CA. Mayfield Publishing Co.

Green, M. E.; & Palfrey, J. S. (2000). Bright futures: guidelines for health supervision of infants, children, and adolescents (2nd ed.) Arlington, VA: National Center for Education in Maternal and Child Health.

Grimshaw, J. M., & Russell, I. T. (1993). Effect of clinical guidelines on medical practice: a systematic review of rigorous evaluations Lancet, 342(8883), 1317-1322.

Grossman, D. C., Mang, K., & Rivara, F. P. (1995). Firearm injury prevention counseling by pediatricians and family physicians. Archives of Pediatrics and Adolescent Medicine, 149(9); 973-977.

Halpern-Felsher, B. L., Millstein, S. G., & Ellen, J. M. (1996). Relationship of alcohol use and risky sexual behavior: a review and analysis of findings. Journal of Adolescent Health, 19(5), 331-336.

Halpern-Felsher, B. L., Ozer, E. M., Millstein, S. G., Wibbelsman, C. J., Fuster, C. D., Elster, A. B., & Irwin, C. E., Jr. (2000). Preventive services in a health maintenance organization: how well do pediatricians screen and educate adolescent patients? Archives of Pediatrics and Adolescent Medicine, 154(2), 173-179.

Hayward, R.S.A. (1997) Clinical practice guidelines on trial. CMAJ, 156, 1725-1727.

Health Care Financing Administration (HCFA). (1998). National summary of Medicaid managed care programs and enrollment. [http:www.hcfa.gov/medicaid/trends98.htm].

Hedberg, V. A., Bracken, A. C., & Stashwick, C. A. (1999). Long-term consequences of adolescent health behaviors: Implications for adolescent health services. Adolescent Medicine: State of the Art Reviews, 10(1), 137-151.

Hedeker, D., & Gibbons, R. D. (1994). A random-effects ordinal regression model for multilevel analysis. Biometrics, 50(4), 933-944.

Henry, R. C., Ogle, K. S., & Snellman, L. A. (1987). Preventive medicine: physician practices, beliefs, and perceived barriers for implementation. Family Medicine, 19(2), 110-113.

Howell, M. R., Quinn, T. C., & Gaydos, C. A. (1998). Screening for chlamydia trachomatis in asymptomatic women attending family planning clinics. Annals of Internal Medicine, 128(4), 277-284.

Iglehart, J. K. (1994). Physicians and the growth of managed care. New England Journal of Medicine, 331(17), 1167-1171.

Igra, V., & Millstein, S. G. (1993). Current status and approaches to improving preventive services for adolescents. Journal of the American Medical Association, 269(11), 1408-1412.

Irwin, C. E., Jr. (1993). The adolescent, health, and society: From the perspective of the physician. In S. G. Millstein, A. C. Peterson, & E. O. Nightingale (Eds.), Promoting the health of adolescents (pp. 146-150). New York: Oxford University Press.

Irwin, C. E., Jr., Cataldo, M. F., Matheny, A. P., Jr., & Peterson, L. (1992). Health consequences of behaviors: injury as a model. Pediatrics, 90(5 Pt 2), 798-807.

Irwin, C. E., Jr., & Millstein, S. G. (1982). Predictors of tampon use in adolescents after media coverage of toxic shock syndrome. Annals of Internal Medicine, 96(6 Pt 2), 966-968.

Irwin, C. E., Jr., & Millstein, S. G. (1986). Biopsychosocial correlates of risk-taking behaviors during adolescence. Can the physician intervene? Journal of Adolescent Health Care, 7(6 Suppl), 82S-96S.

Irwin, C. E., Jr., Millstein, S. G., & Ellen, J. M. (1993). Appointment-keeping behavior in adolescents: factors associated with follow-up appointment-keeping. Pediatrics, 92(1), 20-23.

Irwin, C. E., Jr., Millstein, S. G., & Shafer, M. A. (1981). Appointment-keeping behavior in adolescents. Journal of Pediatrics, 99(5), 799-802.

Joffe, A., Radius, S., & Gall, M. (1988). Health counseling for adolescents: what they want, what they get, and who gives it. Pediatrics, 82(3 Pt 2), 481-485.

Joffe, A. (1995). Prevention dollars and sense. Archives of Pediatrics and Adolescent Medicine, 149(11), 1203-1204.

Johnston, L. D., O'Malley, P. M., & Bachman, J. G. (2000). The Monitoring the Future national results on adolescent drug use: Overview of key findings, 1999. Bethesda, MD: National Institute on Drug Abuse. Retrieved from the World Wide Web: http://monitoringthefuture.org/pubs.html

Kanouse, D. E., Winkler, J.D., Kosecoff, J., (1989) Changing medical practice through technology assessment: an evaluation of the NIH consensus development program, Association of Health Services Research, Washington, D.C.; and Health Administration Press, Ann Arbor, MI, 1989; also The RAND Corporation, R-3452-NIH, March 1989.

Kaplan, D. W., Calonge, B. N., Guernsey, B. P., & Hanrahan, M. B. (1998). Managed care and school-based health centers: Use of health services. Archives of Pediatrics and Adolescent Medicine, 152(1), 25-33.

Klein, J. D., Allan, M. J., Elster, A. B., Stevens, D., Cox, C., Hedberg, V. A., & Goodman, R. A. (in press). Improving adolescent preventive care in community health centers. Pediatrics.

Klein, J.D., Allan, M.J., Hedberg, V.A., Stevens, D.A., Elster, A.B. (1997) Implementing the guidelines for adolescent preventive services (GAPS) in community and migrant health centers (CHCS) Ambulatory Child Health, 3, 166.

Klein, J. D., Graff, C. A., Santelli, J. S., Hedberg, V. A., Allan, M. J., & Elster, A. B. (1999). Developing quality measures for adolescent care: validity of adolescents' self-reported receipt of preventive services. Health Services Research, 34(1 Pt 2), 391-404.

Knopf, D., & Gordon, T. E. (1997). Adolescent health. In J. B. Ketch (Ed.), Maternal and child health: Programs, problems, and policy in public health (pp. 173-225). Gaithersburg, MD: Aspen Publishers, Inc.

Kokotailo, P., Langhough, R., Neary, E., Matson, S., & Fleming, M. (1995). Improving pediatric residents' alcohol and other drug use clinical skills: use of an experiential curriculum. Pediatrics, 96(1), 99-104.

Kolbe, L. (1998). Draft background document to develop year 2010 adolescent and young adult objectives. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, DASH.

Lawrence, R. S. (1990). Diffusion of the U.S. Preventive Services Task Force recommendations into practice. Journal of General Internal Medicine, 5(5 Suppl), S99-103.

Levenson, P. M., Morrow, J. R., Morgan, W. C., & Pfefferbaum, B. J. (1986). Health information sources and preferences as perceived by adolescents, pediatricians, teachers and school nurses. Journal of Early Adolescence, 6(2).

Lindberg, L. D., Boggess, S., Porter, L., & Williams, S. (2000). Teen risk-taking: A statistical portrait. Washington, DC: Urban Institute.

Lomas, J., & Haynes, R. B. (1988). A taxonomy and critical review of tested strategies for the application of clinical practice recommendations: from "official" to "individual" clinical policy. American Journal of Preventive Medicine, 4(4 Suppl), 77-94; discussion 95-97.

Lurie, N., Manning, W. G., Peterson, C., Goldberg, G. A., Phelps, C. A., & Lillard, L. (1987). Preventive care: Do we practice what we preach? American Journal of Public Health, 77(7), 801-804.

Lustig, J. L., Ozer, E. M., Adams, S. H., Wibbelsman, C. J., Fuster, C. D., Bonar, R. W., & Irwin, C. E., Jr. (2001). Improving the delivery of adolescent clinical preventive services through skills-based training. Pediatrics, 107(5), 1100 - 1107.

Malus, M., LaChance, P. A., Lamy, L., Macaulay, A., & Vanasse, M. (1987). Priorities in adolescent health care: the teenager's viewpoint. Journal of Family Practice, 25(2), 159-162.

Mangione-Smith, R., Mcglynn, E. (1998). Assessing he quality of healthcare provided to children. Health Services Research. 33, 1059-1090.

Marcell, A. V., & Millstein, S. G. (2000). Prevalence and quality of adolescent alcohol screening and education among primary care providers [Abstract]. Journal of Adolescent Health, 26(2), 88.

McManus, M. A., Graham, R. R., Fox, H. B., Mercil, C. M., & Irwin, C. E., Jr. (2000). How far have state Medicaid agencies advanced in performance measurement for children? Archives of Pediatrics and Adolescent Medicine, 154(7), 665-671.

Mellin, L. M., Irwin, C. E., Jr., & Scully, S. (1992). Prevalence of disordered eating in girls: a survey of middle-class children. Journal of the American Dietetic Association, 92(7), 851-853.

Mellin, L. M., Slinkard, L. A., & Irwin, C. E., Jr. (1987). Adolescent obesity intervention: validation of the SHAPEDOWN program. Journal of the American Dietetic Association, 87(3), 333-338.

Millstein, S. G. (1989). Adolescent health. Challenges for behavioral scientists. American Psychologist, 44(5), 837-842.

Millstein, S. G. (1993). A view of health from the adolescent's perspective. In S. G. Millstein, A. C. Peterson, & E. O. Nightingale (Eds.), Promoting the health of adolescents (pp. 97-118). New York: Oxford University Press.

Millstein, S. G. (1996). Utility of the theories of reasoned action and planned behavior for predicting physician behavior: a prospective analysis. Health Psychology, 15(5), 398-402.

Millstein, S. G., Adler, N. E., & Irwin, C. E., Jr. (1984). Sources of anxiety about pelvic examinations among adolescent females. Journal of Adolescent Health Care, 5(2), 105-111.

Millstein, S. G., & Halpern-Felsher, B. L. (1998). Adolescent Sexuality. In E. A. Blechman & K. D. Brownell (Eds.), Behavioral medicine and women: a comprehensive handbook (pp. 59-63). New York: Guilford Press.

Millstein, S. G., & Igra, V. (1995). Theoretical models of adolescent risk-taking behavior. In J. L. Wallander & L. J. Siegel (Eds.), Adolescent health problems: behavioral perspectives (pp. 52-71). New York: Guilford Press.

Millstein, S. G., Igra, V., & Gans, J. (1996). Delivery of STD/HIV preventive services to adolescents by primary care physicians. Journal of Adolescent Health, 19(4), 249-257.

Millstein, S. G., & Irwin, C. E., Jr. (1983). Acceptability of computer-acquired sexual histories in adolescent girls. Journal of Pediatrics, 103(5), 815-819.

Millstein, S. G., Irwin, C. E., Jr., Adler, N. E., Cohn, L. D., Kegeles, S. M., & Dolcini, M. M. (1992). Health-risk behaviors and health concerns among young adolescents. Pediatrics, 89(3), 422-428.

Millstein, S. G., & Litt, I. (1990). Adolescent health and health behaviors. In S. S. Feldman & G. R. Elliott (Eds.). At the threshold: the developing adolescent (pp. 431-456). Cambridge, Mass.: Harvard University Press.

Millstein, S. G., Ozer, E. J., Ozer, E. M., Brindis, C. D., Knopf, D. K., & Irwin, C. E., Jr. (1999). Research priorities in adolescent health: An analysis and synthesis of research recommendations. San Francisco: University of California, National Adolescent Health Information Center.

Millstein, S. G., Petersen, A. C., & Nightingale, E. O. (1993). Promoting the health of adolescents: new directions for the twenty-first century. New York: Oxford University Press.

Nader, P. R., Taras, H. L., Sallis, J. F., & Patterson, T. L. (1987). Adult heart disease prevention in childhood: A national survey of pediatricians' practices and attitudes. Pediatrics, 79(6), 843-850.

National Committee for Quality Assurance. (1997) HEDIS 3.0. Washington, D.C.

National Governors' Association, & The National Conference of State Legislators. (1999). State Children's Health Insurance Program: 1999 annual report. Washington, DC: Author.

Newacheck, P. W., Brindis, C. D., Cart, C. U., Marchi, K., & Irwin, C. E. (1999). Adolescent health insurance coverage: recent changes and access to care. Pediatrics, 104(2 Pt 1), 195-202.

Olson, K., Perkins, J., & Pate, T. (1998). Children's health under Medicaid: A national review of Early and Periodic Screening, Diagnosis and Treatment. Los Angeles: National Health Law Program.

Orleans, C. T., George, L. K., Houpt, J. L., & Brodie, K. H. (1985). Health promotion in primary care: a survey of U.S. family practitioners. Preventive Medicine, 14(5), 636-647.

Oxman, A. D., Thomson, M. A., Davis, D. A., & Haynes, R. B. (1995). No magic bullets: a systematic review of 102 trials of interventions to improve professional practice. CMAJ, 153(10), 1423-1431.

Ozer, E. M. (1995). The impact of childcare responsibility and self-efficacy on the psychological health of professional working mothers. Psychology of Women Quarterly, 19(3), 315-335.

Ozer, E.M., Adams, S.H., Lustig, J.L., Millstein, S.G., Camfield, K., El-Diwany, S., Volpe, S., Irwin, C.E., Jr. (In Press). Implementing Adolescent Preventive Services. Health Services Research, 36(6) Part 2.

Ozer, E. M., & Bandura, A. (1990). Mechanisms governing empowerment effects: a self-efficacy analysis. Journal of Personality and Social Psychology, 58(3), 472-486.

Ozer, E. M., Brindis, C. D., Millstein, S. G., Knopf, D. K., & Irwin, C. E., Jr. (1998). America's adolescents: Are they healthy? University of California, San Francisco, National Adolescent Health Information Center.

Ozer, E. M., Macdonald, T., & Irwin, C. E., Jr. (in press). Adolescent health care: Implications and projections for the new millennium. In J. Mortimer & R. Larson(Eds.), The future of adolescent experience: Social trends and the transition to adulthood. New York: Cambridge University Press.

Paperny, D. M., & Hedberg, V. A. (1999). Computer-assisted health counselor visits: a low-cost model for comprehensive adolescent preventive services. Archives of Pediatrics and Adolescent Medicine, 153(1), 63-67.

Park, M. J., Macdonald, T. M., Ozer, E. M., Burg, S. J., Millstein, S. G., Brindis, C. D., & Irwin, C. E., Jr. (2001). Investing in clinical preventive services for adolescents. San Francisco, CA: University of California, San Francisco, Policy Information and Analysis Center for Middle Childhood and Adolescence, & National Adolescent Health Information Center.

Perry, C. L., Kelder, S. H., Murray, D. M., & Klepp, K. I. (1992). Communitywide smoking prevention: Long-term outcomes of the Minnesota heart health program and the class of 1989 study. American Journal of Public Health, 82(9), 1210-1216.

Potosky, A. L., Breen, N., Graubard, B. I., & Parsons, P. E. (1998). The association between health care coverage and the use of cancer screening tests: Results from the 1992 National Health Interview Survey. Medical Care, 36(3), 257-270.

Rosen, D. S., Elster, A., Hedberg, V., & Paperny, D. (1997). Clinical preventive services for adolescents: position paper of the Society for Adolescent Medicine. Journal of Adolescent Health, 21(3), 203-214.

Rosenbach, M. L., & Gavin, N. I. (1998). Early and Periodic Screening, Diagnosis, and Treatment and managed care. Annual Review of Public Health, 19, 507-525.

Rosenbaum, S., Smith, B. M., Shin, P., Zakheim, M. H., Shaw, K., Sonosky, C. A., & Repasch, L. (1998). Negotiating the new health system: A nationwide study of Medicaid managed care contracts (2nd ed.). Washington, DC: The George Washington University Medical Center, Center for Health Policy Research.

Schlitt, J., Santelli, J., Juszczak, L., Brindis, C., Nystrom, R., Klein, J., Kaplan, D., & Seibou, M. D. (2000). Creating access to care: School-based health center census 1998-99. Washington, DC: National Assembly on School-Based Health Care.

Schoen, C., Davis, K., Collins, K. S., Greenberg, L., Des Roches, C., & Abrams, M. (1997). The Commonwealth Fund survey of the health of adolescent girls. New York: Commonwealth Fund.

Schuster, M. A., Bell, R. M., Petersen, L. P., & Kanouse, D. E. (1996). Communication between adolescents and physicians about sexual behavior and risk prevention. Archives of Pediatrics and Adolescent Medicine, 150(9), 906-913.

Schuster, M., McGlynn, E., Brook, R. (1998). How good is the quality of care in the United States? Milbank Quarterly. 76, 517-563.

Scutchfield, F. D., & Hartman, K. T. (1995). Physicians and preventive medicine [editorial]. JAMA, 273(14), 1150-1151.

Simpson, L. (2001). Quality of care: time to make the grade. Pediatrics. 107(1), 171.

Snyder, T., & Hoffman, C. (2000). Digest of Education statistics, 1999 (NCES Publication No. 2000-031). Washington, DC: National Center for Education Statistics. Retrieved from the World Wide Web: http://nces.ed.gov/pubs2000/digest99.

Srinivasan, S., Levitt, L., Lundy, J. (1998). Wall street's love affair with health care. Health Affairs. 17(4), 126-131.

Stein, M. (Ed.). (1997). Guidelines for health supervision (3rd ed.). Elk Grove, IL: American Academy of Pediatrics.

Steiner, B.D. & Gest, K.L. (1996) Do adolescents want to hear preventive counseling messages in outpatient settings? Journal of Family Practice, 43(4), 375-381.

Thrall, J. S., McCloskey, L., Spivak, H., Ettner, S. L., Tighe, J. E., & Emans, S. J. (1998). Performance of Massachusetts HMOs in providing pap smear and sexually transmitted disease screening to adolescent females. Journal of Adolescent Health, 22(3), 184-189.

Tschann, J. M., Adler, N. E., Irwin, C. E., Jr., Millstein, S. G., Turner, R. A., & Kegeles, S. M. (1994). Initiation of substance use in early adolescence: the roles of pubertal timing and emotional distress. Health Psychology, 13(4), 326-333.

Turner, R., Irwin, C. E. J., & Millstein, S. G. (1991). Family structure, family processes and experimenting with substances during adolescence. Journal of Research on Adolescence, 1, 93-106.

Turner, R. A., Irwin, C. E., Jr., Tschann, J. M., & Millstein, S. G. (1993). Autonomy, relatedness, and the initiation of health risk behaviors in early adolescence. Health Psychology, 12(3), 200-208.

U.S. Census Bureau. (1999). Resident population estimates of the United States by age and sex: April 1, 1990 to September 1, 1999. Washington, DC: Population Estimates Program, Population Division, U.S. Census Bureau. Retrieved from the World Wide Web: http://www.census.gov/population/estimates/nation/intfile2-1.txt

U.S. Congress, Office of Technology Assessment. (1991). Adolescent health l volume I: Summary and policy options (Report No. OTA-H-468). Washington, DC: Government Printing Office.

U.S. Preventive Services Task Force (1996). Guide to clinical, preventive services (2nd ed.). Alexandria, VA: International Medical Publishing.

U.S. Public Health Service. (1998). Clinician's handbook of preventive services: Put prevention into practice (2nd ed.). Alexandria, VA: International Medical Publishing.

Walsh, J. M., & McPhee, S. J. (1992). A systems model of clinical preventive care: an analysis of factors influencing patient and physician. Health Education Quarterly, 19(2), 157-175.

Wechsler, H., Levine, S., Idelson, R. K., Rohman, M., & Taylor, J. O. (1983). The physician's role in health promotion - a survey of primary-care practitioners. New England journal of Medicine, 308(2), 97-100.

Weiss, K. (1997). Improving asthma care in children and adults. Boston, MA: Institute for Healthcare Improvement.

Winter, L., & Breckenmaker, L. C. (1991). Tailoring family planning services to the special needs of adolescents. Family Planning Perspectives, 23(1), 24-30.

Woolf, S.H., (1993) Practice guidelines: a new reality in medicine, III impact on patient care. Archives of Internal Medicine, 153, 2646 - 2655.

Zabin, L. S., Hirsch, M. B., Smith, E. A., Streett, R., & Hardy, J. B. (1986). Evaluation of a pregnancy prevention program for urban teenagers. Family Planning Perspectives, 18(3), 119-126.

Ziv, A., Boulet, J. R., & Slap, G. B. (1999). Utilization of physician offices by adolescents in the United States. Pediatrics, 104(1), 35-42.

Please refer to the following publication:

E.M. Ozer, S.H. Adams and J.L. Lustig, et al. Can it be done? Implementing adolescent clinical preventive services. Health Serv Res, 36 6 (2001), pp. 150-165

Please refer to the following publication:

Lustig et al., 2001 J.L. Lustig, E.M. Ozer and S.H. Adams, et al. Improving the delivery of adolescent clinical preventive services through skills-based training. Pediatrics, 107 (2001), pp. 1100-1107

Please refer to the following publication:

Halpern-Felsher B, Ozer E, Millstein S, et al. Preventive services in a health maintenance organization: how well do pediatricians screen and educate adolescent patients? Arch Pediatr Adolesc Med. 2000; 154(2): 173-179.

Please refer to the following publication:

American Medical Association's (AMA) Guidelines for Adolescent Preventive Services (GAPS) - monograph

Please refer to the following publication:

A. Rudolph, C. Rudolph, L. First, G. Listner, & A. Gershon (2010) “The Adolescent Visit” (chapter 67) in Rudolph’s Pediatrics. Twenty-Second Edition. McGraw-Hill Companies

Please refer to the following publication:

Orr, D.P. (1998). Helping adolescents toward adulthood. Contemporary Pediatrics 15(5), 55-76.

Please refer to the following publication:

Long Jr., William A., et al. Practice Management and the Teenage Patient. Adolescent Health Update (American Academy of Pediatrics) 2(2): l-7,1990

Please refer to the following publication:

Goldenring JM, Lohen E. Getting into adolescent heads. Contemp Pediatr 1988; 00:75-90.

Please refer to the following publication:

Blum R, Beuhring T, Wunderlich M, Resnick M. Don’t ask, they won’t tell: the quality of adolescent health screening in five practice settings. Am J Public Health. 1996; 86(12): 1767-1772

Please refer to the following publication:

Hedberg V, Klein J, Andresen E. Health counseling in adolescent preventive visits: effectiveness, current practices and quality measurement. J Adolesc Health 1998; 23: 344-353