



Monitoring Adolescents for High-Risk Behaviors

In this issue:

- 1** Introduction
- 3** Viewing Adolescent Health through a Primary Care Lense
- 9** Oregon's Adolescent Health Project
- 13** Adolescents in the Workplace
- 16** Eating Disordered Behaviors in Adolescents
- 20** Welcome New Students!
- 21** State Reports
- 26** Resources

This issue focuses on monitoring adolescents for high-risk behaviors. It is the second issue of a volume devoted to the public health function of monitoring health and development. Our previous issue focused on developmental screening of young children and the role of public health.

Who is an “adolescent” and who is a “young adult”? As Trina Anglin, Chief of the Adolescent Health Branch of the Maternal and Child Health Bureau, points out in her editorial, definitions are based on developmental stages but correspond roughly to ages 10 to 19 years for adolescence and 20 to 26 years for young adulthood. However, the age of legal majority is 18 years so that society regards 18- and 19-year-olds as young adults, even if they are still in high school. Dr. Anglin also observes that as the Affordable Care Act has expanded access to health care insurance, legal issues relating to the confidentiality of health data for adolescents and young adults, whose parents may add or keep their children on their health insurance policy through age 25 years, have become more complex. The article by Elizabeth Thorne describes Oregon's Adolescent Health Project, a state-wide effort to increase screening for alcohol, substance use, and depression in adolescents during annual well visits. The article by Catherine Karr and Mary Miller discusses current working conditions for adolescents. The authors recommend primary care providers ask and advise adolescents about workplace safety. The article by Alicia Dixon Docter discusses the latest on screening for and preventing eating disorders. She encourages readers to re-consider their food and nutrition messaging to avoid promoting disordered eating.

Reports from Region X states illustrate how each is using state-specific data to implement programs to identify and address adolescent risk-taking behaviors. The Alaska Division of Public Health is leading a grant-funded trial of a classroom-based curriculum to help youth learn healthy relationship and decision-making skills. In Idaho, the Children's Healthcare Improvement Collaboration is offering state-wide learning collaboratives, including one on adolescent depression screening. In Oregon, a collaboration to provide training and technical assistance has increased adolescent depression screening in primary care practices. The Washington State Department of Health has several multi-program and interagency projects to prevent sexually transmitted diseases and unintended pregnancies in youth.

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Updates

We would like to welcome Daniella DeLozier to the *Northwest Bulletin*. She is replacing Cheryl Prince on the editorial board as the representative for the State of Alaska. Daniella is a graduate of the Tulane University School of Public Health and Tropical Medicine, New Orleans, Louisiana. She is the public health specialist with the Maternal and Child Health Epidemiology Unit, Section of Women's, Children's, and Family Health, Alaska Department of Health and Social Services.

This year is the 30th anniversary of the Maternal and Child Public Health Leadership Training Program at the University of Washington. The program has been continuously funded with a grant from the Maternal and Child Health Bureau since 1984. The first issue of the *Northwest Bulletin* was published in 1987. It included a legislative report from Washington State, regional news and events, a literature review, and a guest editorial.

Reader Information

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Editorial . . .

Viewing Adolescent Health Through a Primary Care Lens

Trina Menden Anglin*

Adolescence comprises a complex set of biological, psychological, and social developmental changes that frame the transition between childhood and adulthood.

The [Second Decade Summit](#) helped Title V Region X staff enhance their understanding of adolescent health. This editorial provides another opportunity to examine adolescent health, this time from the perspective of primary care providers, who play a major role in the public health function of monitoring adolescent health and development.

How Do We Define “Adolescence” and “Young Adulthood”?

Adolescence comprises a complex set of biological, psychological, and social developmental changes that frame the transition between childhood and adulthood. It is divided into three developmental stages: early, middle, and late adolescence. Young adulthood is considered a separate life stage that bridges the developmental tasks of adolescence and the societal expectations of mature adulthood. While terminology and age-based definitions can vary, demonstrating the fluidity of transitions between each stage, the developmental tasks of each stage are clear and consistent.

Early adolescence starts with the onset of puberty and includes ages 10 to 14 years. Although most early adolescents are in middle or junior high school, both male and female ten-year-olds, still in elementary school, are likely to be in the early stages of puberty. Early adolescents are adjusting to a new body image, starting the process of separating from their parents, and recognizing that they have a separate identity. Their thinking and behaviors are strongly affected by peers. (1, 2) Evidence-based programs conducted by schools and

communities to prevent problem behaviors, such as tobacco and alcohol use, unprotected sex, and delinquency, are most effective when directed at early adolescents, when only a few have started to engage in risky behaviors.

Middle adolescence includes ages 15 to 17 years. Middle adolescents have mostly completed puberty and are in high school. They are

*The views expressed in this article are solely the opinions of the author and do not necessarily reflect the official policies of the U.S. Department of Health and Human Services or the Health Resources and Services Administration, nor does mention of the department or agency names imply endorsement by the U.S. Government.



starting to think abstractly and continuing to separate emotionally from their parents, frequently have romantic interests, and may engage in risky behaviors.

Late adolescence includes 18- and 19-year-olds. Late adolescents should be completing high school and starting post-secondary education or entering the labor market. They are establishing a sense of personal identity and social autonomy, further developing their ability to think abstractly, have better impulse control compared to younger adolescents, and have a more sophisticated understanding of intimacy.

Young adulthood includes ages 20 to 26 years. Until the Affordable Care Act allowed parents to add or keep their children on their health insurance policy until they turned 26 years, 24 years was usually considered the upper age for young adults. Young adults face major social transitions and are expected to be enrolled in college or vocational school, or are already working or in the military. *Young adulthood* may also be defined as starting at 18 years, the age of legal majority, when a person can consent for health care, vote, and serve in the armed forces; is considered an adult by the justice system; and is no longer eligible for many social supports provided to minors.

What National Recommendations and Legislation Will Increase Access to Preventive Health Care Services for Adolescents?

An annual visit for preventive services during adolescence promotes healthy development and prevents common health and behavioral problems. Recommendations that adolescents receive annual health supervision visits are included in *Bright Futures: Guidelines for Health*

Supervision of Infants, Children, and Adolescents (3), the Healthcare Effectiveness Data and Information Set (HEDIS), and the 2013 Core Set of Children's Health Care Quality Measures for Medicaid and the Children's Health Insurance Program (CHIP).

The Affordable Care Act (ACA) is expected to have a profound impact on the use of preventive health care services by adolescents and young adults. All states are now required to provide Medicaid coverage to children, aged 6 to 18 years, in families with incomes up to 133% of the federal poverty level. This provision will significantly increase the number and proportion of adolescents receiving health care, as lack of health insurance is a major barrier to receiving services. Medicaid coverage also provides access to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program for low-income children, adolescents, and young adults up to

The Affordable Care Act (ACA) is expected to have a profound impact on the use of preventive health care services by adolescents and young adults.

the age of 21 years. It allows them to receive preventive health, developmental, and specialty services; and to have physical, dental, and mental health problems identified and treated. (See page 5 for updates on Bright Futures and page 6 for updates on EPSDT.)

The 2012 National Health Interview Survey, conducted two years following the initiation of this provision of the Affordable Care Act, found that 74% of adolescents, aged 10 to 17 years, had a wellness checkup or preventive services visit, compared to 69% in 2008; however, rates varied by income and insurance status. Only 46% of adolescents without insurance had a preventive well visit, while 76% of adolescents with private insurance and 77% with public health insurance had a preventive well visit. (4) The Affordable Care Act mandates that commercial insurance plans cover a range of preventive health services, including those recommended by Bright Futures for children and adolescents (3), without cost sharing.

Proposed changes to the Title V Maternal and Child Health (MCH) Services Block Grant include the draft performance measure "percent of adolescents with a preventive services visit in the last year." The National Survey of Children's Health, which uses



ages 12 to 17 years as its definition of adolescence, will serve as the data source for this draft performance measure. The survey's sampling frame is state-based, which allows states to use state-specific data to monitor progress toward goals.

What Ethical Issues Do We Need to Consider in Providing Health Care to Adolescents?

Consent and confidentiality represent the classic legal and ethical issues of adolescent health care. Although, in general, parents of minor adolescents are actively involved in their health care and sign consent for them to be seen by a health care provider and receive treatment, specific situations exist where an adolescent's right to privacy and confidentiality is respected and even legally recognized. Based upon federal regulations for certain

programs (e.g., Title X Family Planning program) and the laws of the state where the adolescent resides, an adolescent may give his or her own informed consent for health care for a number of specific conditions, such as sexually transmitted infections, contraception, pregnancy, sexual assault, substance use, and emergencies. (5)

Consent and confidentiality represent the classical legal and ethical issues of adolescent health care.

It is important to remember that laws allowing practitioners to provide confidential care vary across states and health care providers cannot always guarantee confidentiality of information to their adolescent patients. For example, health care providers must ethically disclose a situation where a patient is at serious risk for harming himself or others, or legally disclose a situation where child abuse is identified.

Through its privacy rule, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 provided clarification but also introduced additional complexity to the provision of confidential health care for adolescents. Although parents in general are entitled to full access to health information about their minor children, HIPAA specifies four sets of circumstances in which adolescent confidentiality is protected and parental consent is not required, including when the health care provider believes that the adolescent's safety would be jeopardized by providing information to the parent. (5)

Current billing mechanisms and procedures for processing insurance claims routinely violate the privacy and confidentiality of adolescent and young adult patients

Current billing mechanisms and procedures for processing insurance claims routinely violate the privacy and confidentiality of adolescent and young adult patients when named as dependents on a health insurance policy.

when named as dependents on a health insurance policy. A major problem occurs when Explanation of Benefits documents, as required by insurance companies and frequently by state law, are sent to commercial policy holders, no matter how sensitive the dependent's health issue. (6)

Providing confidential care encourages young patients to seek timely care for symptoms and to give full and

Updates. . .

Revised Bright Futures Guidelines for Preventive Care of Infants, Children, and Adolescents

The Affordable Care Act adopted *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, third edition, as the standard for pediatric preventive health insurance coverage, requiring all private plans to cover Bright Futures preventive services for infants, children, and adolescents, at no cost to the family.

In 2014, a revised [Recommendations for Preventive Pediatric Health Care](#) was released. The revised guidelines now include the recommendation for screening for depression at ages 11 through 21 years and the addition of a recommended screening tool for alcohol and drug use.

Bright Futures was founded in 1990 by the Maternal and Child Health Bureau, Health Resources and Services Administration. In 2002, the American Academy of Pediatrics was chosen to coordinate and implement Bright Futures activities.

truthful information to the health care provider, who then can partner with the patient on treatment decisions. Fear that their confidentiality will be violated is a major reason adolescents forego health care. (7)

In addition to providing confidential care, establishing trustworthy and honest relationships with patients is also important. This is an axiom for all health care providers but has especial importance in adolescent

health care, when communications are among the provider, the adolescent patient, *and* the parents. Ideally, all parties can agree on a common set of strategies, but the provider also needs to consider how to work effectively

Updates. . .

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Medicaid Benefit for Children and Adolescents

The Centers for Medicare and Medicaid Services (CMS) has released three guides to support states in implementing the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Medicaid benefit for children and adolescents. The EPSDT Medicaid benefit is a comprehensive set of benefits and services for children, different from adult benefits. Federal law requires Medicaid cover these benefits.

[EPSDT-A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents](#) provides an overview of benefits and summarizes CMS policy on screenings, diagnostic services, and treatment services.

[Keep Kids Smiling: Promoting Oral Health Through the Medicaid Benefit for Children and Adolescents](#) explains the dental and oral health benefit and explores a variety of ways states have improved delivery of dental and oral health services to enrolled children.

[Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits](#) lists approaches states can use to promote adolescent well-care visits.

The MCH Library also has available a knowledge path on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services in Medicaid at www.mchlibrary.info/KnowledgePaths/kp_EPSDT.html



with parents and the adolescent patient when there are disagreements. Providers also frequently need to assist and support adolescents in disclosing a stigmatizing condition, such as pregnancy, to parents and to help the family communicate constructively as they address the problem.

In general, adolescents should not be tested for illicit drug use in the primary care setting without their full knowledge and consent. (8) In addition, it is wise to ensure that parents acknowledge and accept a clinical practice's policy of providing confidential care to adolescent patients.

What Ethical Issues Do We Need to Consider in Screening?

The goal of screening adolescent patients in clinical settings is to decrease morbidity caused by preventable or treatable problems. Screening connects public health and clinical care functions. Clinical screening strategies may include use of a validated interview schedule or questionnaire to supplement the clinical history, a specific component of the physical examination, and a designated laboratory test. Some of the screening questions and laboratory tests recommended by Bright Futures are related to sensitive health issues, such as unprotected sex; use of alcohol, tobacco, and other substances; mental health; and exposure to, or participation in, violence. (3) The sensitivity of these issues creates important ethical

issues regarding confidentiality.

Another ethical issue is ensuring that an adequate system is in place for effective treatment of individuals who have positive results. (9) For example, the United States Preventive Services Task Force recommends screening adolescents (defined as ages 12 to 18 years) for a major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy, and follow-up. (10) But even with approximately 8% of adolescents having a major depressive disorder, primary care providers frequently do not have sufficient skills or self-efficacy to fully assess or manage these problems.

About 30 states, including Oregon and Washington, have recognized the need for effective follow-up and have developed access lines, frequently state-supported, through which primary care providers can receive same-day telephone consultation from child and adolescent psychiatrists and social workers regarding pediatric mental health and behavioral issues. Services may also include training, resources, and arranging for rapid referral to a mental health specialist. Alaska's primary care providers are supported by a tele-mental health partnership that provides free consultation for prescribing psychotropic medications to youth. (11)

Are Screening and Risk Reduction Efforts Sufficient to Assure Adolescents Are Healthy and Thriving?

Empirical evidence indicates that *both* traditional prevention strategies and promotion of positive development are needed to improve health outcomes for youth. (12) Positive or healthy youth development is an intentional, pro-social approach that promotes positive outcomes in young people by enhancing strengths, providing oppor-

tunities, fostering positive relationships, and building leadership skills. (13) Many state Title V MCH adolescent health programs incorporate the principles of positive youth development in their efforts to prevent problem behaviors and promote healthy, positive outcomes among young people.

Because they have regular contact with young people, health care providers are in an excellent position to teach young people how to recognize and build on their strengths and enhance their self-efficacy and autonomy. Using strength-based communication strategies to supplement standard inquiries into health risk behaviors, health care providers can help young people learn positive coping strategies and engage them in structured discussions that motivate them to take steps to change behaviors that compromise their health. (14) A strength-based approach helps create a working partnership between patient and provider and increases screening and health counseling rates by primary care practices. (15)

Conclusion

Adolescent health promotion requires the concerted efforts of both public health and primary care. The Affordable Care Act is expected to profoundly influence the use of health care services by adolescents because its provisions increase access to health insurance and promote receipt of preventive health services. As a key component of adolescent health care, preventive services visits by adolescents will be monitored by the Maternal and Child Health Bureau as a national performance measure of the Title V Maternal and Child Health (MCH) Services Block Grant.

Another important mechanism for increasing use of health care services by adolescents, in addition to the expansion of health insurance, is the provision of confidential services. Fear that their confidentiality will be violated is a major reason adolescents forego health care.

Screening adolescents in clinical care settings for common health conditions and health risk behaviors can decrease morbidity caused by preventable and treatable problems, but systems need to be in place to provide appropriate follow-up. In response, many states have developed easily accessible, rapid, and free consultation services with child and adolescent psychiatrists and social workers for primary care providers seeking assistance for youth with mental health or behavioral problems.

Health care providers who incorporate positive youth development strategies, such as strength-based communication, achieve measurably higher quality in



the primary care of their adolescent patients. Positive youth development approaches are commonly used in many states' adolescent public health programs. ✂

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Oregon's Adolescent Health Project:

Increasing screening for alcohol, substance use, and depression during adolescent annual well visits

Elizabeth K. Thorne

Alcohol use among adolescents poses immediate and long-term health impacts. (See page 12.) In Oregon, 31% of 11th graders and 14% of 8th graders reported using alcohol in the past month in 2013. (1) Reducing alcohol exposure for youth, aged 14 years and younger, is a state-specific performance measure included in Oregon's Title V Maternal and Child Health Block Grant. The Oregon Public Health Division identified [screening, brief intervention, and referral to treatment \(SBIRT\)](#), conducted by adolescent primary care providers, as a central strategy for the Title V state performance measure. To increase screening for alcohol, substance use, and depression in adolescents during annual well visits, the Oregon Adolescent Health Project is assisting providers and their staff in implementing SBIRT into clinic settings.

The Adolescent Health Project

The Adolescent Health Project is a partnership between the Oregon Health Authority's Public Health and Addictions and Mental Health Divisions, the [Oregon Pediatric Society](#), and the [Oregon Pediatric Improvement Partnership](#). The project is funded by the Public Health and Addictions and Mental Health Divisions for the 2013-2015 biennium. Specific objectives of the project are to increase provider and staff awareness of risk of lifetime alcohol dependence among early alcohol initiators (younger than 14 years); standardized, universal screening with evidence-based screening tools; and provider and staff skills

and efficacy in providing brief intervention and referral to treatment

The first cohort (group of participating clinics) included a variety of settings where adolescents get health care, such as pediatric practices and school-based health centers, from diverse regions of the state. Each clinic participated in a training facilitated by the Oregon Pediatric Society's Screening Tools and Referral Training (START) Program and Oregon Pediatric Improvement Partnership. The day-long training covered best practices in delivering adolescent well visits, use and scoring of screening tools, brief interven-



tion techniques, billing, implementation strategies, and time with representatives from addictions and mental health providers in the community.

Clinics also will receive technical assistance through facilitated “learning communities” as they implement SBIRT into their clinic setting. The Adolescent Health Project is currently recruiting for the second cohort, which is planned for spring of 2015.

Screening at the Adolescent Well Visit

Screening, brief intervention, and referral to treatment (SBIRT) is a comprehensive public health approach to the screening and identification of individuals engaged in risky alcohol and drug use, and the delivery

of early brief interventions to reduce risky use. (2) The Substance Abuse and Mental Health Services Agency (SAMHSA) and the American Academy of Pediatrics recommend SBIRT within the context of routine adolescent health care, using developmentally appropriate tools and strategies. (3) The U.S. Preventive Services Task Force recommends SBIRT for adults, and the evidence of its effectiveness with adolescents continues to accumulate. (4)

Screening, brief intervention, and referral to treatment (SBIRT) is a comprehensive public health approach to the screening and identification of individuals engaged in risky alcohol and drug use, and the delivery of early brief interventions to reduce risky use.

Report. . .

A Snapshot of Current Title V Workforce Needs

The report, “A Snapshot of Current Title V Workforce Needs,” discusses the current challenges and opportunities facing the maternal and child health (MCH) work force and describes the training, tools, and guidance needed to advance the MCH agenda. The report synthesizes work force challenges and broad training and technical assistance needs, and cross-references them with existing or planned resources.

The National MCH Workforce Development Center at the University of North Carolina at Chapel Hill developed this report using a variety of data, including the Association of Maternal and Child Health Programs member surveys, Title V Block Grant applications, and key informant interviews with Title V and Maternal and Child Health Bureau staff.

The report is available at the Association of Maternal and Child Health Programs www.am-chp.org/Transformation-Station/Documents/National%20MCH%20WDC%20Needs%20Assessment%20Final.pdf

The adolescent well visit is a strong vehicle for the delivery of critical preventive services. Adolescent primary care providers are ideally situated to help prevent, identify, and aid in treatment of substance use issues. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* recommends that adolescent primary care providers discuss substance use as a part of a comprehensive preventive visit. (5)

Oregon’s transformation of its health system has added traction to and visibility of SBIRT in primary care in several ways. Integration of mental and physical health care is a component of Medicaid coordinated care organizations (CCOs) [transformation plans](#), which provide the framework for achieving Oregon’s health system goals. Additionally, coordinated care organizations are held accountable for [17 quality measures](#), including the adolescent well visit, SBIRT, and depression screening.

Key Findings

Initial findings and policy implications from the project include:

- ◆ While most participating clinics were aware of screening tools and had implemented them for some adolescent patients, **very few had standardized, universal screening procedures**. Consistent with research, the most often cited reasons for not screening included time limitations, lack of training, lack of knowledge of behavioral health services to refer to in the community, and concerns around confidentiality.
- ◆ **Confidentiality issues pose a major challenge.**

Many sites, with the exception of school-based health centers, did not have standardized policies or practices ensuring the provider and adolescent had private time together. Many sites were hesitant to bill for sensitive screenings or services, including substance use and mental health, for fear of confidentiality being abrogated via a bill, explanation of benefits, or communication through an online patient portal. Instead, sites absorbed the cost of services, limiting the use of claims data for evaluation and performance monitoring. Robust policies and protections of confidentiality are necessary to engage and empower youth as they transition to independent consumers of health services and to ensure they receive the care they need.

- ◆ **A majority of participating providers did not have standardized processes for tracking referrals** and reported that they rarely or never received a report back from the addictions and mental health provider after a referral was made. Many cultural, technical, and legal issues hinder communications between addictions and mental health providers and primary care providers. Solutions to these issues will be necessary in order to integrate physical and behavioral health services.

Future Directions

The Adolescent Health Project has created a platform for sharing best practices and aligning work that has implications beyond just this project. Looking to the future, the partnership will support more sites in implementing SBIRT within the context of an adolescent

well visit. More broadly, the partners will continue to inform strategies that address the policy implications of the project's key findings with the goal of ensuring adolescents in Oregon are receiving quality preventive services that support their healthy development and a healthy population. ✂

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RESOURCES

- Oregon Pediatric Improvement Partnership's policy briefs related to the importance of and strategies to improve the adolescent well visit. <https://projects.oregon-pip.org/resources/adolescent-care/adolescent-well-visits-and-claims/>
- Protecting Adolescent Confidentiality Under Health Care Reform: The Special Case Regarding Explanation of Benefits (EOBs). EOB Policy Brief June 2014. http://nahic.ucsf.edu/wp-content/uploads/2014/06/639265-0-000-00-020-EOB-Policy-Brief_FINAL.pdf



Adolescent Alcohol Use: A Public Health Challenge

Alcohol use among adolescents is common, exceeding tobacco and illicit drug use. (1) The 2013 Youth Risk Behavior Survey (YRBS) found that approximately 35% of youth, grades 9 to 12, reported using alcohol on at least one day during the 30 days before the survey. (2)

Alcohol use is a major contributor to the leading causes of death for adolescents: motor-vehicle crashes, suicides, and homicides. It is also associated with increased risk of death or serious injury due to alcohol poisoning, falls, burns, and drowning; unwanted, unplanned, and unprotected sexual activity; violence; and failing in school. (3)

Alcohol use during adolescence coincides with a critical period of brain development. Adolescents are more vulnerable to the negative effects of alcohol on the brain, especially in areas responsible for executive functioning and learning. Research has found that adolescents who abuse alcohol use fewer strategies to learn new information and demonstrate significantly reduced memory skills. (4) Substance abuse during adolescence can affect intellectual development, memory, and attention in adulthood. (5) In addition, individuals who drink alcohol before the age of 14 years are four times more likely to become alcohol dependent compared with those who report drinking at age 20 years and older. (6)

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Updates. . .

Healthy People 2020

Adolescent health is a new topic area in Healthy People 2020. Its objectives fill gaps pertinent to adolescent health, measure healthy development, and address social determinants of health. See www.healthypeople.gov/2020/topics-objectives/topic/Adolescent-Health

In addition, the Healthy People 2020 Core Indicators for Adolescent and Young Adult Health, drawn from all Healthy People topic areas, provide a snapshot of the health status of these age groups and a picture of how well the systems that support their health are functioning. They also offer a summary set of compelling indicators that states and communities can use to measure progress in addressing the needs of adolescents and young adults. See www.healthypeople.gov/sites/default/files/AYAHCoreIndicators.pdf and www.healthypeople.gov/2020/topics-objectives/topic/Adolescent-Health/objectives

Public Comment Period Open

The public comment period for Healthy People 2020 is officially open and live at www.healthypeople.gov/2020/about/history-development/Public-Comment

Comments will be accepted through November 7th. New objectives are proposed for both the maternal, infant, and child health; and early and middle childhood topic areas.

Please share with any and all relevant stakeholders and be sure to add your own comments as well.

Adolescents in the Workplace:

An Overlooked Environmental Health Problem

*Catherine Karr and
Mary E. Miller*

The role of the environment in influencing child health and safety is getting increased attention. However, much of the emphasis in research and intervention has been on environmental exposures of young children despite what we know about the unique vulnerabilities of adolescent developmental processes. In particular, public health and medical professionals typically do not consider the possible negative impact of the workplace environment on the health of young workers.

Youth at Increased Risk for Injury

In the United States, over one and half million youth, aged 15 to 17 years, are employed each year. The legal age for most work is 14 years and as young as 12 years in agriculture. Comprehensive surveillance is lacking for young workers, and data are most limited for the youngest workers. The National Institute for Occupational Safety and Health estimates that 160,000 American children suffer occupational injuries every year, with 54,800 of those injuries serious enough to require emergency room treatment. (1) The rate for emergency room treatment of occupational injuries of young workers is approximately twice that of workers, aged 25 years and older. (2)

Young workers are exposed to many of the same occupational risks as their adult counterparts. However, their developing cognitive skills, physical coordination, strength, and maturity place them at increased risk of injury. For instance:

- ◆ They have a reduced perception of danger and lack of a sense of vulnerability, which increases risk-taking behaviors
- ◆ Their lack of experience makes it difficult for them to speak to an adult or a person in authority about concerns or fears they may have when placed in a dangerous situation
- ◆ They seek increased responsibilities and do not want to appear to not know what they are doing, which makes them less inclined to ask questions (3)

Young workers are also at increased risk of injury because they often do not receive workplace health and safety training (4) and perform work activities



that they are prohibited by law from performing due to the hazards associated with the activities. For example, some young agricultural workers drive tractors and apply pesticides.

Young Agricultural Workers in the Northwest Region

In the Northwest Region, agriculture is an important industry and employer of youth. However, regulatory protections for youth are less stringent for agricultural work compared to other work, and fewer studies have been conducted on youth working in agriculture.

In 2012, through a University of Washington partnership with the [Yakima Valley Farmworkers](#) clinic and Heritage University, undergraduate students from Yakima interested in learning about environmental health research conducted a community survey to better understand young workers' perspectives and experiences regarding occupational health and safety. The survey included "field testing" of a new hazard assessment pictorial tool designed by the Migrant Clinicians Net-

work. The tool was designed for use in clinical settings to identify risks and prompt anticipatory guidance.

Among the 140 youth, aged 14 to 18 years, who reported working in agriculture, only half reported that they had received some type of job safety training,

Public health and medical professionals serving youth have a key role to play in identifying and reducing hazards encountered by young workers.

and a small minority (15%) reported having a medical provider ask them about their work. The survey also revealed a poor understanding of protections, such as restricted duties, and a lack of awareness of workers' compensation benefits. A high proportion of respondents found the Migrant Clinicians Network's [Rapid Clinical Assessment Tool](#) useful in identifying the tasks they perform (89%) and enhancing communication with their health professionals (77%).

Conclusion

Public health and medical professionals serving youth have a key role to play in identifying and reducing hazards encountered by young workers. A great start would be to include work history questions in routine screens at schools and clinics, including questions about work activities, hours of work, types of exposures, use of personal protective equipment, and availability of safety training.

Somatic health complaints, such as headache, fatigue, gastrointestinal disturbances, anxiety, and depression, should be assessed as possibly related to teens' attempt to do more than they can handle. Injuries must be evaluated for possible work-related causes, and workers' compensation claims should be filed, when appropriate. From a public health perspective, education and outreach to young workers and their families, in formats that are engaging and culturally appropriate, are needed in concert with regulatory approaches. ✂

Catherine Karr, MD, PhD, MS, is a pediatrician, environmental health researcher, member of the Pacific Northwest Center for Agricultural Safety and Health (PNASH), and director of the Northwest Pediatric Environmental Health Specialty Unit (PEHSU) at the University of Washington, Seattle. Her interests include community-based research, health of agricultural communities, and children's global environmental health.

Young Workers in Washington State

Identifying injuries through workers' compensation claims underestimates the scope of injuries to young workers, given that many youth, parents, and health care providers aren't aware that such claims can be filed for an young worker just as for any other worker. However, for the Washington State Department of Labor and Industries, compensation claims do provide one available approach to identifying injuries among teens in the absence of other, more comprehensive surveillance. The department is using claims data to pursue coordinated enforcement activities and provide outreach and education for prevention. (1) Resources for employers, health care providers, and working youth are available at [their website](#).

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She is a pediatric primary care provider and teaches residents at the University of Washington Pediatric Care Center. She is also an adjunct associate professor with the Department of Epidemiology, University of Washington School of Public Health.

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Mary E. Miller, MN, RN, is a child labor specialist with the Washington State Department of Labor and Industries. She has worked in the field of occupational safety and health for 30 years, mostly on issues regarding child labor and young worker health and safety. Since 1991, she has worked at the Department of Labor and Industries in the areas of research, policy development, outreach and education, and enforcement of child labor rules.

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RESOURCES

U.S. Department of Labor. Occupational Safety and Health Administration. Young Workers. www.osha.gov/youngworkers.



MCH Navigator

www.mchnavigator.org/

The MCH Navigator, housed at Georgetown University, is a learning portal for maternal and child health professionals, students, and others working to improve the health and well-being of women, children, and families.

MCH Navigator Training Spotlight on Access to Care

This compilation of trainings and resource guides is designed to help professionals facilitate access to quality health care for MCH populations. Content includes podcasts, webinar archives, video lectures, and video slide modules. Topics include eligibility and enrollment, coverage and insurance benefits, provider networks and network adequacy, continuity of care, partnerships, reimbursement, and monitoring and assessment. Also included are links to resource guides on topics such as children and youth with special health care needs, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), home visiting, the Affordable Care Act (ACA), and racial and ethnic disparities in health.

www.mchnavigator.org/trainings/access-to-care.php

Congratulations!

The team that developed the MCH Navigator was awarded the American Public Health Association's 2014 Effective Practice Award. The team included Colleen Huebner, PhD, MPH, (Region X) a faculty member of the UW MCH Leadership Training Program.

Eating Disordered Behaviors in Adolescents:

Reconsidering Food and Nutrition Messages

Alicia Dixon Docter

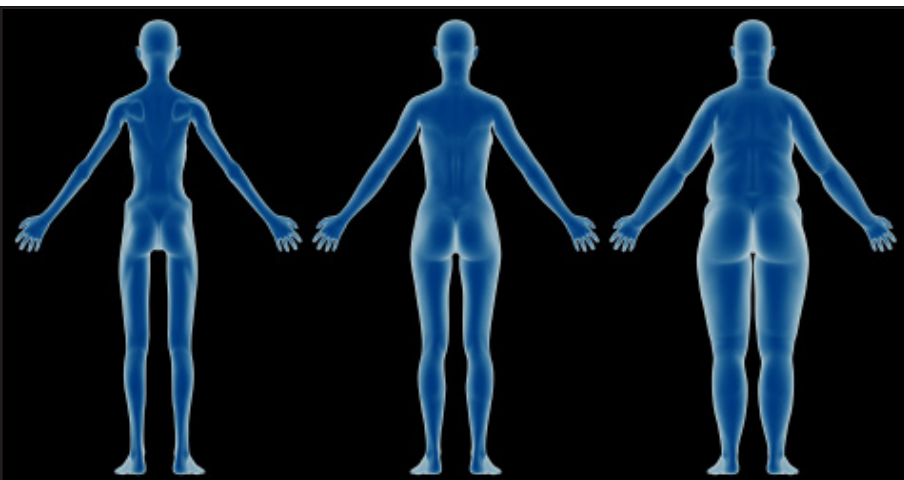
The importance of disordered eating to physical health and development is underscored by the choice to include the topic in national youth risk behavior surveys. Results of the 2013 Youth Risk Behavior Surveillance (YRBS) survey indicate 13.0% of high school students did not eat for 24 hours in order to lose weight (18.7% of females and 7.4% of males); 5% of students took diet pills, powders, or liquids to lose weight in the 30 days prior to the survey (6.6% of females and 3.4% of males); and 4.4% vomited or took laxatives to lose weight or keep from gaining weight in the 30 days prior to the survey (6.6% females and 2.2% of males). (1)

The lifetime prevalence of anorexia nervosa is 0.5% to 2%, with a peak age of onset of 13 to 18 years. (2) The lifetime prevalence of bulimia nervosa is higher at 0.9% to 3%, with an older age of onset of 16 to 17 years. The most common diagnosis, based upon the fourth edition of the *Diagnostic and Statistical Manual*, is eating disorders not otherwise specified. This group of heterogeneous disorders is composed primarily of sub-threshold anorexia nervosa or bulimia nervosa. The estimated lifetime prevalence of eating disorders not otherwise specified in adolescents is 4.8%. Although female patients account for most diagnoses of eating disorders, males have accounted for 10% of cases of eating disorders over the past years, with some studies reporting up to 25% of cases being male. (2)

This article describes the prevalence and types of eating disordered behaviors in adolescents, provides guidance on screening and diagnosis, suggests directions for prevention, and lists resources. It is not an exhaustive review—the reference list has additional readings and websites.

What is an Eating Disorder?

According to the Society for Adolescent Medicine (now the Society for Adolescent Health and Medicine), a diagnosis of an eating disorder should be considered when an adolescent engages in potentially unhealthy weight-control practices; demonstrates obsessive thinking about food, weight, shape, or exercise; or fails to attain or maintain a healthy weight,



height, body composition, or stage of sexual maturation for gender and age. The threshold for intervention in adolescents should be lower than in adults because of the potentially irreversible effects of an eating disorder on physical, psychological, and emotional growth and development; the high mortality; and the evidence suggesting improved outcome with early treatment. (3)

Younger patients are likely to have atypical presentations: instead of rapid weight loss, they may present



with failure to make expected gains in weight or height and may not endorse body image concerns or engage in binge eating or purging behaviors. Boys and children and adolescents who are overweight or obese are at risk for delayed diagnoses and significant complications. These populations require heightened vigilance by providers. Adolescents with chronic illnesses, especially insulin-dependent diabetes mellitus, are also at higher risk of developing eating disordered behaviors and should be screened regularly. (2) Eating disordered behaviors, such as bingeing, even can show up in well-designed weight management efforts (4).

New diagnostic criteria for eating disorders were released in the fifth edition of the *Diagnostic and Statistical Manual*. Significant changes were made in an effort to improve the accuracy and precision of eating disorder diagnoses. The fifth edition broadens the inclusion criteria for both anorexia nervosa and bulimia nervosa, includes binge-eating disorder as a formal diagnosis, and further clarifies other eating disorders. (5)

Screening for an Eating Disorder

Initial evaluation of the child or adolescent with a suspected eating disorder includes establishment of the diagnosis; determination of severity, including evaluation

of medical and nutritional status; and performance of an initial psychosocial evaluation. Each of these steps can be performed in a primary care setting. (3)

The assessment and treatment of adolescents with an eating disorder should be inter-disciplinary and, under ideal circumstances, is best accomplished by a team consisting of a medical doctor (or advanced practice nurse or physician's assistant), nurse, registered dietitian (RD) or registered dietitian nutritionist (RDN), and mental health professional. The providers need to have expertise in managing the complexities of adolescent eating disorders and need to be knowledgeable about normal adolescent physical and psychological growth and development. (3)

The dietitian's (RD) role in the nutrition care of individuals with eating disorders is unique and supported by the American Psychological Association, the Academy for Eating Disorders, and the American Academy of Pediatrics. Dietitians trained to successfully work with adolescents with eating disorders and their families have a good understanding of developmental needs, the psychodynamics of eating disorders, need for professional boundaries, and appropriate individualized food and nutrition intervention. An experienced dietitian may be the first to recognize an individual's symptoms or be the first health care professional consulted by a patient for this condition and thus be a key participant in screening. (6) A fellowship in Leadership Education

The threshold for intervention in adolescents should be lower than in adults because of the potentially irreversible effects of an eating disorder on physical, psychological, and emotional growth and development; the high mortality; and the evidence suggesting improved outcome with early treatment.

in Adolescent Health (LEAH) is an excellent multi-disciplinary training opportunity for developing in-depth skills in working with adolescents (see page 19 for more information about this program).

Screening tools, such as the brief SCOFF questionnaire (see page 18) (7), although only validated in adults, are used in the primary care setting for screening for eating disorders in adolescents. In addition, providers should evaluate all patients for high-risk behaviors, such as dieting or excessive exercise, and track their growth trajectories and body mass index (BMI) to assess for

weight loss or failure to make appropriate gains. If an eating disorder is suspected, it is important to obtain a comprehensive medical, family, and social history and a complete review of systems and to perform a thorough physical examination to evaluate for physical stigmata and medical complications of eating disorders. Obtaining a history from both the patient and caregiver(s) is important. Although time alone with the adolescent is standard practice, a history from a caregiver can be crucial in elucidating behaviors or cognitions that the adolescent may not report. As with any condition, a complete differential diagnosis is recommended when evaluating a patient with a potential eating disorder. (3)

SCOFF Questionnaire

- ◆ Do you make yourself Sick because you feel uncomfortably full?
- ◆ Do you worry that you have lost Control over how much you eat?
- ◆ Have you recently lost more than 14 pounds (One stone) in a three-month period?
- ◆ Do you believe yourself to be Fat even though others say you are too thin?
- ◆ Would you say that Food dominates your life?
- ◆ One point for every “yes;” a score of > 2 indicates a likely case of anorexia nervosa or bulimia

Prevention of Eating Disorders

It is well known that obesity continues to be a major public health issue. There are growing concerns that an anti-obesity focus in pediatric public health may result in an increase in eating disorders (3). One study found that the use of dieting practices also considered disordered eating behaviors (skipping meals, eating very little, using diet pills) can predict weight gain over time. (8) One recommendation is that health professionals be vigilant about the possibility of promoting eating disordered thinking as they develop new content and programming for obesity prevention and treatment (3).

Diane Neumark-Sztainer, School of Public Health, University of Minnesota, Minneapolis, recommends the following to help prevent eating disorders and obesity:

- ◆ Inform adolescents that dieting, and particularly unhealthy weight-control behaviors, may be counterproductive. Instead, encourage positive eating and physical behaviors that can be maintained on a regular basis.
- ◆ Do not use body dissatisfaction as a motivator for change. Instead, help teens care for their bodies so that they will want to nurture them through healthy eating, activity, and positive self-talk.
- ◆ Encourage families to have regular and enjoyable family meals.
- ◆ Encourage families to avoid weight talk. Talk less about weight and do more to help teens achieve a weight that is healthy for them.
- ◆ Assume overweight teens have experienced weight mistreatment and address this with teens and their families. (9)

To help with food and nutrition messaging, consider an approach to healthy eating in which the total diet or overall pattern of eating is the most important focus. This approach recognizes that eating practices are dynamic and influenced by multiple factors. It also recognizes that an overly simplistic classification of food as good versus bad can foster unhealthy or disordered eating behaviors. (10)

Conclusion

Eating disorders can be devastating and can lead to a lifetime of frustration for teens, families, and even health care providers. Moreover, disordered eating may get in the way of the success of a perfectly planned obesity intervention. As a clinician in the field, I encourage all readers, regardless of discipline, to re-consider their food and nutrition messaging in a way that avoids promoting disordered eating. ✂

Alicia Dixon Docter, MS, RDN, is an adolescent medicine dietitian at Seattle Children's Hospital. She also is core faculty member of the University of Washington Leadership Education in Adolescent Health (LEAH) Program and clinical instructor with the University of Washington School of Nursing. Currently, she manages key pediatric weight management clinics at Seattle Children's Hospital and has been instrumental in the development of the Adolescent Wellness Intensive Program, which is evaluating outcomes of the weight management clinics.

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RESOURCES

Academy for Eating Disorders
www.aedweb.org/web/index.php
Eating Disorder Referral and Information Center
<http://edreferral.com>
Motivational Interviewing
www.motivationalinterviewing.org
National Eating Disorders Association
www.nationaleatingdisorders.org
National Association of Anorexia Nervosa and Associated Disorders
www.anad.org
Society for Adolescent Health and Medicine
www.adolescenthealth.org



UW LEAH

The University of Washington's Leadership Education in Adolescent Health Program (UW LEAH) trains future leaders in adolescent health in five key health disciplines: medicine, nursing, nutrition, psychology and social work. Fellows in the program participate in mentored clinic and research experiences. They also receive advanced didactic training in interdisciplinary practice, leadership skills, research, public health, advocacy, public policy, health disparities, and health services delivery.

The program's curriculum and conceptual framework highlights the life course perspective and relationships between social and environmental determinants of health, risk and protective factors, and adult outcomes.

The Maternal and Child Health Bureau funds UW LEAH, in addition to four other leadership and clinical training programs at the University of Washington: Leadership Education in Neurodevelopmental and Related Disabilities (LEND), Maternal and Child Public Health Leadership Training Program, nutrition, and Pediatric Pulmonary Training Center (PPC).

The UW LEAH is located in the [Division of Adolescent Medicine](#) at Seattle Children's Hospital, the major pediatric teaching hospital affiliated with the University of Washington.

More information about UW LEAH can be found at <http://depts.washington.edu/uwleah/frontpage>



Maternal and Child Public Health Leadership Training Program

Welcome New Students!

The Maternal and Child Public Health Leadership Training (MCH) Program welcomes the 2014 incoming class. They will be looking for professional networking opportunities, and practica and thesis projects. Please contact Melissa Schiff, Director, at mschiff@uw.edu if you would like to be introduced to a specific student. The program is now accepting applications for fall 2015 for the two-year, in-residence interdisciplinary Master in Public Health degree program. For more information, go to <http://depts.washington.edu/mchprog/admissions>.

Vivian Lyons (epidemiology) has a Bachelor of Science degree in public health from the University of Washington, Seattle. She was the lead domestic violence advocate for the DoVE Project, where she created a program to provide services to Spanish-speaking women by training local Latina women to be certified advocates within their own communities. For her undergraduate honors thesis, she designed and implemented a primary data collection research project that resulted in increased enforcement of Vashon Island School District's policy on vaccinations.

Jovana Martin (epidemiology) has a medical degree from the Case Western Reserve University School of Medicine, Cleveland, Ohio. She is a fellow in gynecologic oncology at the University of Washington School of Medicine. Jovana was course leader for the SMART Girls Program for the King Kennedy Boys and Girls Club in Cleveland, Ohio, and an academic mentor for the Children's Restoration Network in Atlanta, Georgia. She plans to use her training in gynecologic oncology along with her Master of Public Health degree to perform disparities, epidemiological, and outcomes-based clinical research in gynecological cancers.

Jennifer Mueller (epidemiology) received a Bachelor of Arts degree in anthropology and biology from the University of Virginia, Charlottesville. Prior to coming to the University of Washington, she coordinated gynecologic oncology clinical research trials at the University of Virginia Health System, Charlottesville, and conducted research on access to maternal and reproductive health

care in rural Appalachia. With a Master of Public Health degree in maternal and child health epidemiology, she hopes to improve the health of vulnerable and chronically underserved women in the United States by increasing the use of contraceptives and family planning. She is also interested in maternal depression.

Priya Patel (health services) has a Master of Education degree in early childhood education from the University of Nevada, Las Vegas. While obtaining her degree, she also was teacher for a Head Start program and a corps member for Teach for America. Her work with young children and their families and her work with communications and advocacy within the World Health Organization has strengthened her belief that investments in maternal and child health are crucial to the overall success of communities. After graduating, she anticipates a career in program management and advocacy.

Olivia Vargas (health services) has an undergraduate degree in the History, Philosophy, and Social Science of Medicine (HiPSS) from the University of Chicago. She was a research assistant with the "Finding Answers: Research for Change," a national program of Robert Wood Johnson Foundation. For her undergraduate thesis, she chose to study disparities in cervical cancer outcomes between Hispanic and white women and the social determinants of cervical cancer. With her Master of Public Health degree, she hopes to work directly with Hispanic mothers and children to help them gain access to needed medical care.

Ying Zhang (epidemiology) has a Doctorate in Medicine from the Brody School of Medicine, Greenville, North Carolina. She was a family medicine resident at Harborview Family Medicine Center, Seattle. She is interested in reproductive health and helped expand contraception services to uninsured and charity care patients while at the Harborview Family Medicine Center. She is also interested in evaluating and improving reproductive health in underserved populations. After additional training as a clinical research fellow and Master of Public Health student, she hopes to be a leader in the field of women's reproductive health and family planning. ❧

State Reports . . .

Alaska's Fourth R for Healthy Relationships Program

Alaska Department of Health
and Social Services

Katie Reilly

Alaska has the highest rates of domestic violence and sexual assault in the United States. In 2012, the rate of rape in Alaska was more than twice the national rate. (1) In 2013, among high school students, 11.4% reported experiencing sexual violence (compared to 10.4% nationally), 38.6% reported ever having sexual intercourse, and 10.5% reported having four or more sexual partners. Among students who were sexually active, 39.6% did not use a condom, and 15.3% had consumed alcohol or used drugs before their last sexual intercourse. (2)

The Fourth R Program has been adapted for use in Alaska to reduce high rates of dating violence, risky sexual behaviors, and substance abuse among youth.

The Fourth R Program

Developed in Canada by the Centre for Addiction and Mental Health, the [Fourth R Program](#) is a comprehensive, school-based program designed to reduce violence, substance abuse, and other risky behaviors. The program is based on the premise that relationship skills (R = Relationships) are as important to learn in school as the other three Rs (Reading, wRiting, and aRithmetic).

The program uses interactive teaching methods, such as role play, to help youth learn healthy relationship and decision-making skills. Listed on the Substance Abuse and Mental Health Services Administration's [National Registry of Evidence-based Programs and Practices](#), the program has been shown to reduce violence and improve decision-making and communication skills, and prevent first-time perpetration of dating violence. (3)

The classroom-based curriculum for grades seven to nine is taught by health and physical education teachers trained in the Fourth R. The Alaska Division of Public Health manages the grant and coordinates teacher trainings. The curriculum is composed of 21 lessons, each taking 75 minutes to complete. Age-appropriate lessons focus on subjects such as the impact of bullying and harassment, developing skills for healthy relationships, developing skills to avoid the pressure to use substances, and positive coping strategies. The curriculum takes four to six weeks to complete although that time can be shortened by integrating the curriculum into other health education classes.

Since 2011, when the program began in Alaska, 63 schools from 21 school districts have received Fourth R curricula materials, with more than 300 school staff and community partners throughout the state trained to teach the program. ✂

Katie Reilly, MPH, is the adolescent health project coordinator with the Section of Women's, Children's, and Family Health, Alaska Division of Public Health. Her public health experience includes educating people about HIV/AIDS in East Africa, conducting substance abuse research in New York City, and assessing social norms related to intimate partner violence in North Carolina.

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Learning Collaboratives: A Whole Practice Approach

Idaho Department
of Health and Welfare

Melissa Carico

The “learning collaborative” approach, which implements and tests repeated cycles of change to meet quality improvement goals, is recognized by many leading health care organizations as an effective way to bring together health care groups to improve health care practices. In Idaho, Medicaid and maternal and child health (MCH) programs are using this approach in projects designed to narrow the gap between actual and best practices.

One example of such a project is the [Children’s Healthcare Improvement Collaboration](#) (CHIC), funded by the Centers for Medicare and Medicaid Services through the Children’s Health Insurance Program Reauthorization Act. This project offered six learning collaboratives, with an emphasis on children with special health care needs, from September 2011 to September 2014. Topics were asthma, the patient-centered medical home, immunizations, adolescent depression screening, childhood obesity, and health care transitions. During this three-year period, 134 providers (pediatricians, family physicians, specialty nurse practitioners, and physician assistants) from more than 25 practices participated in at least one learning collaborative.

The goal of the learning collaborative on adolescent depression screening was to increase early detection and initiation of treatment for adolescent depression by implementing universal depression screening with a validated tool, the [Patient Health Questionnaire-9](#) (PHQ-9), and educating providers about appropriate treatment strategies and referrals.

The learning collaborative focused on four core health care measures for adolescents, aged 12 through 17 years, and established baseline data and project completion goals for each:

- ◆ Percentage screened for depression with a validated tool (baseline 2%; project completion 51%)
- ◆ Percentage with documentation of screening results (baseline 30%; project completion 95%)

- ◆ Percentage screened for substance use and abuse (baseline 18%; project completion 58%)
- ◆ Percentage with a positive depression screen who had an appropriate follow-up plan documented (baseline 0%; project completion 88%)

The learning collaborative on adolescent depression screening lasted nine months, with six active data collection months. Sixty providers from eighteen clinics across the state participated. The activities included multiple “Plan-Do-Study-Act” submissions and onsite coaching visits. At the end of the six-month period, all clinics reported that they had significant changes in processes to identify, document, and treat adolescent depression.

An advantage of the learning collaboration approach and its use of repeated cycles of change was evident early on and led to a change in screening. Most clinics began screening at all well-child visits but quickly realized the need to screen at all visits. As one provider explained, “A child was being seen with a complaint of headaches and was mistakenly given a PHQ-9 at check-in. That child had a positive screen. That was the “a-ha!” moment to screen on all visits.”

Generally, participating providers reported better patient care and outcomes through this learning collaborative. All clinics made improvements in at least three of the four core measures, as evidenced by a random sampling of chart reviews. At the final conference call, clinics reported what they found most valuable and ways their practice would sustain change. As a requirement for participation, each clinic also wrote and submitted reports for sustaining change. ✕

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Investing in Behavioral Health Services for Youth

Oregon Health Authority

Brooke Rizor

In 2013, Governor Kitzhaber and the Oregon State Legislature made an unprecedented investment in behavioral health services, with almost \$40 million going to the community mental health system. The legislation focuses on promoting community health and wellness, keeping children healthy, and helping adults with mental illness live successfully in the community.

During the September 2013 special session, the Legislature increased the cigarette tax to fund community mental health services by an additional \$20 million during the 2013-2015 biennium. Much of the funding was directed towards the needs of youth and young adults, encouraging a dynamic and multifaceted system that focused on prevention, early detection, treatment, and recovery by strengthening partnerships, expanding services, and supporting innovation.

Many of these services were chosen for implementation and funding because of data demonstrating they improved client outcomes and reduced high-cost practices, such as psychiatric acute care. The Addictions and Mental Health Division will continue to monitor the return on investment by carefully analyzing outcome and claims data. Below are listed highlights of this new investment.

[Adolescent Depression Screening](#), a collaboration between the Addictions and Mental Health Division, the Public Health Division, and the Oregon Pediatric Society, provides statewide outreach, training, and technical assistance to:

- ◆ Increase adolescent depression screening in primary care practices
- ◆ Improve primary care clinicians' understanding of assessment and treatment of depression
- ◆ Increase provider awareness and effective use of local community resources

[Oregon Psychiatric Access Line about Kids](#) (OPAL-K) expands the availability of high-quality

mental health treatment to youth by providing timely psychiatric consultation, provider education, recommendations for primary care treatment, and connections with mental health professionals. The program offers free, same-day psychiatric phone consultation for primary care providers. More than 600 primary care providers have registered.

[Trauma Informed Oregon](#) was created in recognition of the impact of adverse experiences in childhood on long-term health outcomes. It is committed to promoting prevention while bringing health care policies and practices into better alignment with the principles of trauma-informed care. The program is a collaboration between public and private organizations, consumers, youth, and family members.

Additional investments expand and establish programs to reach vulnerable populations at crucial developmental stages. Parent-Child Interaction Therapy programs address early childhood mental health and attachment needs. [Early Assessment and Support Alliance \(EASA\)](#) and [Young Adult Hubs](#) target youth and young adults with comprehensive, developmentally appropriate, and flexible services.

In collaboration with the Public Health Division, the Addictions and Mental Health Division has allocated resources to increase access to mental health services in a school-based setting, support initiatives to address bullying in schools, and reach youth who may not obtain care in typical outpatient settings.

A complete list of new investment projects can be found [here](#). ❀

Brooke Rizor, LCSW, is a program and policy development specialist for the Addictions and Mental Health Division, Oregon Health Authority. Her career has focused on children's mental health and integrated behavioral health initiatives.

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Promoting Adolescent Sexual Health through Provider Training

Washington State
Department of Health

Cynthia Morrison

Rates for many sexually transmitted infections (STIs) are highest among adolescents. In Washington State, for example, the reported rates for chlamydia and gonorrhea are highest among young women, aged 15 to 24 years. (1) Many people acquire the human papilloma virus (HPV) during the teen years; however, medical providers often do not inquire about sexual behavior, assess STI risk, and screen for asymptomatic infections during office visits. The Centers for Disease Control and Prevention (CDC) recommends annual screening for both chlamydia and gonorrhea in sexually active young women and for young men with more risk factors. (2)

The Washington State Department of Health has several multi-program and interagency projects to prevent sexually transmitted diseases and unintended pregnancies in youth by training the professionals who work with them. Washington State law allows minors to consent to health care for STIs without parent approval.

To promote more screening, the Department of Health partners with the [Seattle STD/HIV Prevention Training Center](#) at the University of Washington, Seattle, to offer training to those providing health care to teens and young adults. Department of Health staff coordinates with local health jurisdictions, hospitals, and major medical centers to schedule and promote these trainings, as well as frequently serving as faculty. The Department of Health also sponsors a series of lectures on STIs at nursing schools throughout the state. In the past five years, approximately 800 nursing students have received information on prevalence, transmission, testing, and treatment of STIs in adolescents and young adults.

The goal of the Washington Personal Responsibility Education Program (WA PREP) is **to reduce unintended**

pregnancies and STIs among at-risk youth in middle and high schools. Staff from community partners¹ are trained to use evidence-based interventions to educate teens on abstinence and contraception. Led by the Department of Health, the program works closely with the Office of the Superintendent of Public Instruction, Department of Social and Health Services, and [Cardea Services](#). The program is funded by the Administration for Families and Children, Administration on Children, Youth and Families, and Family and Youth Service Bureau through the Affordable Care Act.

The Department of Health's Immunization Program received a grant from the CDC **to develop a large education campaign to encourage providers to talk to parents and patients about HPV and the HPV vaccine**. The CDC named HPV "one of top five health threats for 2014." It is the most common STI in the United States and causes 26,000 new cancers annually. The HPV vaccine is highly effective against the strains that cause cervical and other cancers, such as anal, penile, and some head and neck cancers. The CDC [recommends](#) vaccination for both boys and girls, aged 11 to 12 years. ✨

Cynthia Morrison, MA ABS, is the manager for the Adolescent Health Program at the Washington State Department of Health. She is a former professor of psychology and human sexuality.

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1. Washington State Department of Health. STI Fast Facts: Washington State 2012. www.doh.wa.gov/Portals/1/Documents/Pubs/347-350-FastFacts2012.pdf
2. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2010. *MMWR*. 2010;59(RR12):1-110.

¹ Partners include the Juvenile Rehabilitation Authority, Boys and Girls Clubs, White Salmon School District, Planned Parenthood of the Greater Northwest, and Walla Walla and Grant County Health Departments.

State Title V Adolescent Health Coordinators and Contacts as of September 1, 2014*				
State	Name	Title	Agency	Email/Phone
Alaska	Mollie Rosier	Adolescent Health Program Manager	Alaska Division of Public Health, Section of Women's, Children's and Family Health	mollie.rosier@alaska.gov 907-269-3466
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Idaho	Mercedes Munoz	Manager, Sexual Violence Prevention Program, Adolescent Pregnancy Program	Idaho Department of Health and Welfare, Bureau of Community and Environmental Health	MunozM1@dhw.idaho.gov 208-334-4970
Oregon	Jessica Duke (main contact)	Manager, Adolescent and School Health Program	Oregon Public Health Division	jessica.duke@state.or.us 971-673-0242
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Washington	Sharon L. McAllister	Manager, Reproductive Health and Wellness	Washington State Department of Health Prevention and Community Health	Sharon.McAllister@doh.wa.gov 360-236-3403
*State adolescent health coordinators are responsible for coordinating adolescent health program in their state Title V/maternal and child health (MCH) programs and other programs in state public health agencies. Source: http://nnsahc.org/images/uploads/StateAHCwebroster.pdf				

On-Line Training Opportunity. . .

Maternal and Child Public Health Webinar Series

These quarterly webinars provide up-to-date information on topics related to maternal and child health (MCH) and the Title V MCH national performance measures.

The October 2014 webinar was on “The Invincibles: Teens, Risk Taking, and the Role of Health Professionals.” This webinar can be accessed at www.nwcphp.org/training/opportunities/maternal-child-health/index.html

The June 2014 webinar was on “Developmental Screening for All Children: Alaska’s Experience with Implementing Statewide the Ages and Stages Questionnaire Online.”

You can access an archive of all past webinars at www.nwcphp.org/training/opportunities/maternal-child-health/archive

Resources . . .

- ACT for Youth Center of Excellence, New York State.
www.actforyouth.net/
- Adolescent Health Transition Project.
<http://depts.washington.edu/healthtr/>
- Bright Futures.
<http://brightfutures.aap.org/>
- Centers for Disease Control and Prevention.
Adolescent and School Health.
www.cdc.gov/healthyyouth/
- Centers for Disease Control and Prevention.
Children's Food Environment State Indicator Report, 2011.
www.cdc.gov/obesity/downloads/childrensfood-environment.pdf
- Centers for Disease Control and Prevention. 2010 Sexually Transmitted Disease Guidelines. (Includes screening guidelines for adolescents.)
www.cdc.gov/std/treatment/2010/default.htm
- Child Trends. Five Things to know about LGBTQ Youth.
<http://archive.constantcontact.com/fs177/1101701160827/archive/1118489371597.html>
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents. www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/EPSDT_Coverage_Guide.pdf
- Health, Mental Health, and Safety Guidelines for Schools. American Academy of Pediatrics.
www.nationalguidelines.org/
- Health Resources and Services Administration, Maternal and Child Health. Adolescent and Young Adult Health Program.
<http://mchb.hrsa.gov/programs/adolescents/>
- HealthyPeople.gov 2020 Topics and Objectives. Adolescent Health.
www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=2
- Institute of Medicine and National Research Council. Improving the Health, Safety, and Well-being of Young Adults: Workshop Summary. Washington, DC: The National Academies Press; 2013.
www.nap.edu/catalog.php?record_id=18340
- Maternal and Child Health Library at Georgetown University. Adolescent Health Resource Brief.
www.mchlibrary.info/guides/adolescent.html
- Maternal and Child Health Library at Georgetown University. Social and Emotional Development in Children and Adolescents Knowledge Path.
www.mchlibrary.org/KnowledgePaths/kp_Mental_Healthy.html
- National Adolescent and Young Adult Health Information Center
<http://nahic.ucsf.edu/>
- National Adolescent and Young Adult Health Information Center. A Guide to Evidence-Based Programs for Adolescent Health: Programs, Tools, and More. August 2014.
<http://nahic.ucsf.edu/download/evidence-based-program-guide/>
- National Campaign to Prevent Teen and Unplanned Pregnancy.
<http://thenationalcampaign.org/>
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www.nimh.nih.gov/health/publications/the-teen-brain-still-under-construction/index.shtml
- Oregon Pediatric Society. Screening Tools and Referral Training (START) Program.
<http://oregonpediatricsociety.org/programs/ops-programs/start/>
- Stang J, Story M. Guidelines for Adolescent Nutrition Services.
www.epi.umn.edu/let/pubs/adol_book.shtml
- U.S. Department of Health and Human Services. Office of Adolescent Health.
www.hhs.gov/ash/oah/
- U.S. Preventive Services Task Force. Child and Adolescent Recommendations.
www.uspreventiveservicestaskforce.org/tfchild-cat.htm
- U.W. LEAH: Leadership Education in Adolescent Health.
<http://depts.washington.edu/uwleah/links>