

Adolescence: Forgotten Age, Forgotten Problems

Adolescence is a forgotten age, its problems largely ignored in the clamor for attention to competing societal concerns. So argues Phyllis Ellickson, the originator of Project ALERT and a senior RAND analyst who has devoted much of her career to the study of young people in the years between childhood and maturity.

"Perhaps that is because adolescents are so often perceived as troubled kids or troublemakers," she observes, "unlike younger children for whom it is easy to get a sympathetic hearing." A worry to their parents and teachers, teenagers are often touchy, obsessed with the approval of their peers, and seemingly indifferent - or downright hostile - to the views and values of adults. Ellickson's research has shown that even good students from financially secure homes can go off track when they reach junior high school.

Ellickson, a social policy analyst, finds the years between 12 and 18 are an "extremely vulnerable" time in the lives of young people. "They desperately want the approval of their friends, to be perceived as 'cool,' and they will do dangerous and just plain dumb things to gain that status." Unfortunately, temptations to drink, take drugs and engage in precocious sex arise long before adolescents have developed skills to cope with the forces that are whipsawing them. Violent behavior and emotional problems, such as depression, which may be the precursor of a lifelong disability, may worsen during this period as well.

It may seem odd to think of adolescence as a major public health issue, but that is exactly how I believe that adolescent health encompasses far more than the absence of physical disease or disability. It includes mental and social, as well as physical, wellbeing."

A Disturbing Portrait

In a recent report, Ellickson and colleagues Maria Elena Lara, Cathy D. Sherbourne and Bonnie Zima unveil a disturbing portrait of the adolescent condition. Adolescents start out in good health relative to the rest of the population: Expected deaths for 10- and 11-year-olds are lower than those for any other age. As adolescents grow older, however, their risk of dying increases; the mortality rate for 15- to 19-year-olds is three times that for 10- to 14- year-olds. These differences reflect the fact that more older adolescents engage in high-risk behavior and are the victims of violence.

Seventy-five percent of all adolescent deaths are due to three causes: unintentional injuries (particularly from automobile accidents), homicide and suicide. Each is more likely to occur among older adolescents. Each is also linked to various risk-taking activities, such as drug use or drinking and driving, or to negative emotional states, such as depression or conduct disorders, or to some combination of these.

Other threats to the health of American adolescents arise from what scholars are calling the "new morbidity." By this they mean illness associated with drug use (including alcohol and cigarettes), violent behavior, unsafe sexual activity, and mental disorders. Such problems often go together: Drug use raises the risk of unsafe sexual behavior, teens with mental health problems often use drugs, and teens who use drugs are often violent or have mental health problems.

More than one-fifth of the nation's high school seniors smoke every day, and about 30 percent are binge drinkers - practices that put them at risk of developing long-term addictions to tobacco and alcohol.

Over half of the nation's high schoolers are sexually active, but few use condoms consistently. As a result, about one million teenage girls become pregnant each year and the risk of contracting AIDS or other sexually transmitted diseases (STDs) is rising.

In addition, about one in five adolescents suffers from a diagnosable mental disorder, which can develop into life-threatening problems or severely impede the young person's ability to negotiate the shoals that separate adolescence from adulthood.

Young people from all ethnic and demographic groups are prey to the new morbidity, but its consequences are particularly severe for teenagers who lack the resources to get help. About one-third of poor and near-poor adolescents have neither Medicaid nor private health insurance coverage. A surprisingly large portion of middle-income teenagers also lack coverage - almost 30 percent of uninsured adolescents live in families with incomes 200 percent or more above poverty levels.

The ABC's of Sex

Access to medical help for teenagers is further restricted by limitations on coverage (particularly for preventive and mental health services), by payment policies that promote expensive hospitalization over less costly community- or family-based treatment, and by adolescent concerns about confidentiality. The frequent failure of physicians to identify emotional and behavioral problems in adolescents, plus the adolescents' own failure and that of their parents to seek help, are also factors.

Doctors also need to be more aggressive in discussing sexual matters with teenagers. A RAND survey of 2,000 high school students found that about half of the physicians who treat these adolescents do not discuss sex and sexual risk prevention with them.

This is the case even though professional medical organizations uniformly urge such counseling and an overwhelming majority of the young people say they would find such discussion helpful.

As Dr. Catherine D. DeAngelis, editor of the Archives of Pediatric and Adolescent Medicine, puts it, "Discussing the B's (birds and bees) with adolescents was never easy for physicians or parents. Now that we've added the A's (AIDS), C's (condoms) and D's (diseases of sexual transmission), it's even more challenging and important."

Too Little Known

To overcome these barriers to care, a number of systems that specialize in adolescent health have sprung up across the country. Comprehensive health care centers that provide multiple services at a single site ("one-stop shopping") have been the most thoroughly studied. While they appear to be an effective strategy for reaching poor teenagers and for getting them needed care, the researchers observe, not much is known about their effect on improving adolescent health over the long term.

Against this backdrop of rising need and limited access, Ellickson worries that too little is known about the effectiveness of intervention programs. Evaluations of drug treatment programs have largely ignored adolescents; they have also focused on such substances as heroin, which few adolescents use. Moreover, studies of mental health services for teenagers have been plagued by methodological flaws that make it difficult to identify program-induced gains.

"We still lack solid evidence about what treatment regimes work, how long the effects last, and which problems and which adolescents are helped," she says.

Drugs and Other Risky Business

Studies by Ellickson and others have found that school-based prevention programs can curb drug use in middle school. The programs are more effective at delaying or reducing cigarette and marijuana use than drinking; they also work better for nonusers and experimenters than for committed users. Once the lessons stop, however, program effects begin to wear off. Thus discontinuing these programs in high school is a big mistake.

"We need to keep these programs going after kids make the transition to high school," Ellickson argues. "Each year that we hold off initiation buys kids more time to get some life experience under their belt. And if they do experiment later on, they are much less likely to become addicted or to mess up their lives because of drug use. The name of the game in prevention is delay, delay, delay."

Programs aimed at reducing sexual activity and teenage pregnancy have modest influence, she acknowledges, but those that provide condoms and foster their use may be more successful at curbing both pregnancy rates and the spread of STDs.

The relatively modest results of treatment and prevention efforts should come as no surprise. Ellickson blames them, in part, on the complex nature of the problems and on the blurring of cause and effect. Drug and alcohol use are linked to risky driving, death by accident, violence, suicide and unsafe sex, while poor mental health and violent behavior may be either the cause or the consequence of drug use. Added to that are influences on teenagers as diverse as belief in their own invincibility, difficulties at school, societal and parental attitudes that condone high-risk behavior, family problems and genetic vulnerability.

Risk factors that are bound up with family dynamics, community and social norms, or school experience are difficult to modify, Ellickson notes. Certainly, sorting out these tangled influences is beyond the province of health care providers, who see adolescents only when they happen to show up in their office or clinic.

That is why viewing the new morbidity as a public health problem is important, she maintains. Only then can the door be opened to coordinated prevention and treatment efforts that involve families, schools, community agencies, and the media, as well as health professionals.

"Rather than fostering hospitalization as the dominant strategy for treating teenagers with mental health or substance abuse problems," she says, "we need to promote community-based or school-linked systems of care that recognize the interrelatedness of many adolescent problems."

Including schools in a coordinated program is particularly important, she adds. Schools are where most children can be found and where problems can be identified before they become critical. Moreover, some school environments exacerbate emerging problems, whereas others provide countervailing mores or rewards for productive behavior. Hence, efforts to modify school practices and norms may help curb high-risk behavior.

Better training in adolescent medicine, including how to communicate with teenagers, would go a long way toward improving health professionals' ability to identify and cope with mental disorders, sexually at-risk teens, and drug abuse. Being able to see the doctor in a friendly and familiar setting (teen clinics, school-linked health clinics, community-based centers) clearly helps teens talk more freely about personal matters, respond more positively to the doctor and feel more satisfied with the quality of care they receive.

If they lack the insurance coverage to get through the door, however, few teens will benefit from greater professionalism and more coordinated services. Although removing cost barriers to care is not a panacea, expanded insurance coverage is an important piece of the mosaic. Ellickson recommends that current efforts to reform the health care

system should aim at both reducing the number of uninsured and underinsured adolescents and providing a basic floor of preventive and mental health services for this group.

"I'm not arguing that children can be protected forever. They can't. But there are things we as a society can and should do to help them through the high school years," Ellickson contends, "before their horizons close down and mistakes like pregnancy or trouble with the law cut them off from a good job or college."

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