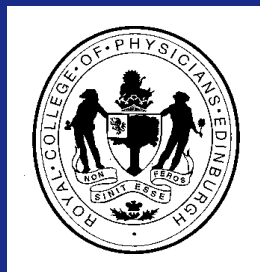


Bridging the Gaps: Health Care for Adolescents

June 2003



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Royal College of Paediatrics and Child Health

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on behalf of the participating organisations

Royal College of Psychiatrists Council Report CRI 14

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Health Services for Adolescents:

The Intercollegiate Working Party On Adolescent Health

The working party had representatives from:

Royal College of Paediatrics and Child Health (RCPCH)
Royal College of General Practitioners (RCGP)
Royal College of Nursing (RCN)
Royal College of Obstetricians and Gynaecologists (RCOG)
Royal College of Physicians (London) RCP(L)
Royal College of Physicians of Edinburgh (RCP(E))
Royal College of Physicians and Surgeons of Glasgow (RCPS(G))
Royal College of Psychiatrists (RCPsych)
Faculty of Public Health Medicine (FacPH, RCP(L))

And observers from:

The Association of Directors of Social Services (ADSS)
The Trust for the Study of Adolescence (TSA)
Young Minds (YM)
The Department of Health (DoH)
The Department for Education and Skills (DFES)

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FOREWORD

“I would there were no age between ten and three and twenty, or that youth would sleep out the rest; for there is nothing in the between but getting wenches with child, wronging the ancients, stealing, fighting”.

- William Shakespeare, c1611 – *The Winters Tale*, act III, scene iii.

The British stand accused of not liking children. They seem to like teenagers even less. They evidently had a bad press back in the reign of King James and now they are demonised in the media and portrayed as stropky, moody, turbulent, radical and rebellious. The approach of adolescence is viewed with trepidation by parents and teachers.

Why do successive generations of adults treat the adolescent as an alien species? Of course, it is partly envy of their youth, energy and apparent freedom. But perhaps they *are* alien to adults - and perhaps they *should* be. The fact that each new cohort of teenagers challenges the wisdom received from the older generation may be inconvenient, but from a Selfish Gene perspective it is surely a valuable, indeed essential, characteristic, ensuring that the human race does not rest on its laurels. And let's not forget that risk-taking behaviour, which we deplore from a public health angle, became a priceless asset when the nation's survival was threatened.

While it is readily accepted wisdom that we need to invest in tomorrow's adults, we seem peculiarly reluctant to do so. When it comes to health care, there is no room for complacency. More consultation, “involving young people in decision making”, is the politically correct thing to do but is often complete tokenism or, at worst, an excuse for not acting on the information we already have. Teenagers have specific and different needs of health care and when asked for their views have provided plenty of very clear answers – but not always the answers we wanted to hear or can be accommodated.

This report aims to remedy these past failings within the health care system. It is the product of an inter-disciplinary working group, expertly chaired by Dr John Tripp on behalf of the Royal College of Paediatrics and Child Health. It offers an overview of the health care of adolescents in the UK at the start of the 21st century and describes some of the deficiencies. One key message is that adolescent medicine is not so much about a particular set of diseases that afflict this age group, rather it is about the ways in which services are provided.

Key concerns for adolescents in primary care settings are about access, confidentiality, consent and privacy, as well as the expertise and continuity of professionals and the settings in which care is provided. Additional issues that must be addressed in hospital care include the need for separation of adolescents both from young children and older adults. It is not appropriate for teenagers either to be surrounded by the images, toys and paraphernalia that make youngsters in the pre-school age group feel at home or to be in an environment where the average age is over 60.

Above all, the various groups of professionals who deal with adolescents need to review training in this field. The process of arranging transition from paediatric to adult care networks must be co-ordinated and planned with due regard for the views and the maturity of the individual. An inter-Collegiate implementation group is proposed as the next step to ensure that the recommendations arising from this report are put into practice. We already know enough to make substantial improvements, but we still have much to learn. Experimentation and formal evaluation will be needed, to compare different models of care.

David Hall, President RCPCH

3rd December 2002.

Acknowledgements

Members of the working party are immensely grateful to the large number of individuals and organisations who have made critically important contributions to our deliberations and document. These include other Royal Colleges and Faculties as well as interested parties and individuals that have reviewed and commented on our “final” draft. We acknowledge with gratitude the hard work, unconditional support and commitment of Maureen Robinson, committee administrator at the RCPCH, and more than one secretary working in Exeter for the chairman.

Explanation of text

Standard endnotes give references at the end of the document (p.53).

References to examples of good practice that we could find described in an available form are referenced as [#] with capital letters [#A, #B etc] and are listed on p.51.

Additional supporting documents

Additional supporting documents are available on request from RCPCH (Maureen Robinson 020 7307 5649 <Maureen.Robinson@rcpch.ac.uk>)

Terminology

“Young people” is a phrase used as an alternative to “adolescents” and, in this document, has the same meaning. We have not defined adolescence by age because there would be difficulties in agreeing age limits, when adolescence is essentially a developmental stage. In this report we are particularly interested in the welfare of those young people on the cusp of adulthood, most of whom will be in the age range 13-18. We recognise that many young people can be properly thought of as adolescent before that age and similarly most professionals would agree that adult characteristics are often developing well into a person’s twenties.

Some terms describing provider and commissioning administrative units such as Primary Care Trusts are, strictly only applicable to England and Wales but have clear equivalents in Scotland and Northern Ireland, while others such as Strategic Health Authorities may not have exact comparability. Please interpret the text appropriately for the sake of simplicity of writing.

Primary and community care is taken to include all health care provided outside hospitals including that within the educational, social services or justice systems.

The authors have attempted to use the terms paediatric, child and children's services appropriately but they are to some extent used interchangeably as inclusive of all health services provided to children. Similarly we would like the document to be considered as applicable to all health services for young people though recognise that medicalisation may have crept in!

Glossary

CAMHS Child and Adolescent Mental Health Services

GP General Practice

GPs General Practitioners

HAs Health Authorities

ITU Intensive Therapy Unit

NGOs Non Government Organisations including local and national voluntary organisations

NHS National Health Service

PCOs Primary Care Organisations in any of the UK countries (PCTs, PCGs etc see above para on terminology)

SHAs Strategic Health Authorities (see above para on terminology)

WHO World Health Organisation

Executive Summary

- Adolescents between the ages of 10 and 20 make up 13-15% of the total population of the UK and among minority ethnic communities, the proportion is considerably higher.
 - Adolescence is a time when patterns of health behaviour and use of services are developed and these tend to be continued during adult life.
 - In contrast to all other age groups, mortality in this age group did not fall significantly in the second half of the twentieth century; the main causes of mortality are accidents and self-harm, with a recent rise in suicide among young men.
 - Morbidity mainly arises from chronic illness and mental health problems, with the likelihood of long-term adverse consequences, and a crucial relationship between physical, mental and social health.
- Young people have specific health needs, many of which remain unmet.
- For most adolescents their parents remain key providers of health care and require support in this task.
- Young people say that there are barriers to their effective use of both primary and secondary health care services including:
 - lack of information
 - difficulties in achieving low visibility access for confidential issues.
 - Services are not seen as youth friendly because of
 - concerns about confidentiality for those under 16 years old
 - lack of expertise and continuity of care by professionals
 - failure to respect the validity of young people's views
 - young people in hospital having to be accommodated either in a children's ward or with a population they regard as elderly.
 - Some groups of young people have particular difficulties with access to services associated with issues such as disability, poverty, ethnicity, being looked after and sexual orientation.
- Health services must pay greater attention to the special needs of young people if they wish to improve the emotional, psychological and physical health of the population.

- The views and needs of young people should be taken into account at all stages of planning and delivery of health services for adolescents.
 - Health strategies must address the particular needs of adolescents particularly in relation to sexual health, substance abuse, mental health and accident prevention.
 - Encouragement should be given to innovative strategies, which in turn need to be evidence based and/or evaluated.
- All health care providers should plan, support and monitor adolescent services within GP and other primary care, school based and secondary care services.
 - These services should enable all young people to have good information about and easy access to services of appropriate quality where consent and confidentiality issues have been resolved.
 - Effective provision requires co-ordination across different specialities specifically for young people.
 - Health commissioners should ensure that young people who are 'difficult to reach', such as those in pupil referral units or not in school, receive health services on an equitable basis.
 - Every healthcare organisation should have a policy for and identified lead professional for the provision of services for young people.
 - Good practice guidelines should be followed by all practitioners in relation to adolescents' rights and professionals' responsibilities in the areas of consent and confidentiality.

Terms of Reference

The terms of reference of the working party were:

“To describe the health needs that young people⁺ should expect to be met by health service providers and to propose a strategy to meet them.”

It is hoped that this report will provide a source of advice from a group of health professionals and other experts that will be useful to those planning and commissioning health services for adolescents. It recommends appropriate standards for health services for adolescents and identifies the training needs of professionals.

The working party had its first meeting on 24th May 1999, and has met on 5 further occasions. We have received written material covering a number of topics relevant to its work, including a definition of adolescence, reasons for considering the health of and services for adolescents as a substantive issue at this time, data on the health needs of young people and details of some specific services for adolescents.

Two sub-groups, with additional co-opted members, met twice during the process of producing this combined working party report for wider consultation. One, chaired by Chris Donovan, considered the needs of young people and services in primary and community care*, prevention and health promotion. The other, chaired by Russell Viner, considered acute secondary and tertiary care. Both were concerned that young people’s views of their needs and how they can best be met adequately should inform health promotion policies and healthcare practices of health authorities.

A consultation document in the form of a draft report was circulated to a number of interested individuals and groups, including disease and speciality groups, consumer organisations, service commissioners and providers. Representatives from among those consulted were invited to, and many participated in, a lively, stimulating and useful working day-seminar. The day began with keynote presentations from a child and adolescent psychiatrist (Dr Sue Bailey), an adolescent physician (Dr Russell Viner), a well known advocate for young people (Mr John Coleman) and a commissioner (Professor Aynsley Green). During the day a number of questions posed in the consultation document were discussed in working groups with summarising sessions chaired by Professor Philip Graham and Professor David Hall.

⁺ Please see “Terminology”, p. 11, for discussion of terminology for Adolescence, adolescents and young people

*Ibid for primary and community care.

The aim of this report is to state general principles whenever possible in the expectation that these can be applied by individual patient and professional groups and disciplines. References have been used liberally because we believe strongly that the best possible evidence base is important, but this is not a systematic review. Where possible we have included illustrative examples of good practice.

The final purpose of this report is to influence all those who we believe should be actively commissioning, providing and supporting excellent health services for our young people. These persons and organisations will include the Government and the Department of Health, those creating the National Health Service Framework for Children and Young People, those responsible for commissioning and providing services at National, Regional, NHS Trust and PCO levels and the Royal Colleges. The latter have the critically important role to move this agenda forward by establishing training and setting standards for provision of these services.

The working party accepts that in order to achieve progress it is essential to concentrate on proposals that are affordable, or even no-cost improvements to services which will have real benefits for the young people. Realising change will require both administrative and professional flexibility to significantly improve current practice, training and standards. Proposed improved services should have the effect of raising significantly the health status of young people whether they are perceived as healthy or having short or long term health problems.

1. Young people have major health needs

Adolescents make up a significant proportion of the population; in the UK, along with most developed countries, young people between the ages of 10 and 20 account for 13-15% of the total. Projections suggest that the adolescent population will grow by 8.5% between 1998 and 2011.

Mortality among adolescents, in contrast to almost all other age groups, did not fall during the second half of the twentieth century.¹ The main causes of mortality in this age group are accidents and self harm.^{2 3 4} Adolescents' health needs appear to be greater than those of children in the middle childhood (from 5 to 12 years) or of young adults. Morbidity mainly arises from chronic illness and mental health problems;⁵ Child and Adolescent Mental Health Services (CAMHS) are often both seen as, and are, the poor relation of other services in terms of resources.⁶ This in spite of the fact that long term morbidity and mortality among young people with mental health problems is among the highest of any group of patients. The peak age of onset of type 1 diabetes is during adolescence and its control is poorer than at any other age⁷. The main concerns of young people in relation to health are focused on issues of immediacy that impact on their relations with peers and include problems with skin, weight, appearance, emotions and sexual health including contraception.^{5 8} Young people whose childhood or adolescent illness has impacted significantly on their appearance or expectations for sexual and reproductive function face particularly intense problems as they approach adulthood.

Attendances for health care by young people aged 12 to 19 years are about half those of the traditional 'child' population aged 0 to 14 years but their use of hospital beds increases during adolescence, particularly in females and without inclusion of obstetric admissions.⁹ Nearly all have seen a GP within the previous twelve months, though there is evidence that their consultations are shorter than average; many will have seen other health professionals.^{10 11 12 13 14} They report concerns about how services are currently provided.^{15 16 17 18 19 20 21 22}

Adolescents' health and better ways to meet their physical and mental health needs are matters of national²³ and international concern.^{24 25 26 27 28} The brief of this report was addressed succinctly in the USA context over 20 years ago by Charles Irwin,²⁹ who reached very similar conclusions to those we reach below. Nearly a decade ago the President of the Society for Adolescent Health in her presidential address emphasised the importance of adolescent health practitioners recognising their role in advocacy for, rather than didactic interaction with, young people.³⁰

Adolescence is a developmental phase of significant positive change and maturation and is by no means universally problematic. Nevertheless because of the rapid emotional, social and psychological changes occurring during adolescence, together with pubertal changes in growth and strength, a number of problems may become apparent which may earlier have been “masked”. Thus, acting out behaviours tend to be contained during primary school years but become problematic during adolescence especially in boys, while affective disorders may similarly become apparent in adolescence, particularly among girls.^{31 32} A young person who is being “looked after” and therefore, by definition, experiencing significant “disconnectedness”³³ with family is associated with dramatically higher prevalence of mental health disorder, teenage pregnancy and involvement in crime.³⁴

Young people are not a homogeneous group but have diverse special needs associated, for example, with gender, ethnicity, social and educational disadvantage, family breakdown and sexual orientation. A significantly larger proportion of people among the minority ethnic groups in the UK is under 20 than in the host population, particularly among the Bangladeshi and Pakistani groups.^{35 36} These young people have particular health needs associated with their increased risk of certain health problems, and because they are over-represented among families who suffer socio-economic and health disadvantage.³⁷

It is clearly important that young people are nurtured so that they may become healthy adults and contributors to society. This is increasingly important for sound economic reasons in an ageing society. The high rates of sexually transmitted infections among young people, particularly, teenage girls are a significant cause of physical health problems^{38 39} and the recent rise of suicide among young men gives grave concern for psychological health.⁴⁰ There is strong and growing evidence for the fundamental inter-relationship between physical, mental and social health.^{41 42 43} Problems in adolescence in any of these areas indicate the likelihood of long term adverse health and social consequences.⁵ The fact that the UK has the highest rate of teenage pregnancy in western Europe is one instance of the way that many of our young people will start their adult lives at significant disadvantage.⁴⁴

There is evidence that patterns of health behaviours established in adolescence are maintained through adult life (e.g. smoking⁴⁵, substance abuse^{46 47}, eating disorders^{46 48} physical activity⁴⁹, obesity⁵⁰ and sexual risk taking⁵¹). Contextual factors associated with higher risks of unhealthy behaviours in adolescence and higher risks to health, such as living in relative poverty, poor parenting, family breakdown and being looked after by the local authority are often present in the childhood years.

2. Existing health services

In dramatic contrast to the numbers of adolescents using services and their perceived special needs as described above, there is a relative dearth of specific or discrete services for young people within all our health services. A recent formal survey of primary health care services conducted by this working party suggests that dedicated services for young people within GP primary based care are rare.⁵² There are a number of existing specialist adolescent clinic provisions outside of general practice. Most offer confidential and user-friendly services for sexual health,⁵³ less frequently for mental health,⁵⁴ and there are also some generic adolescent services some of which are school based.[#A] Only half of all responders were aware of a specific person responsible for taking a lead in adolescent service provision in their PCO.

Data for secondary care services are more robust, with literature about use of services from health authority statistics published in a recent review⁵⁵, with more recent data from Suresh et al⁵⁶ and Viner.⁹ Outpatient clinics specifically for adolescents are often linked to transition from paediatric* to adult secondary care, e.g. for epilepsy or diabetes. National data held by the RCN shows that there are presently 13 dedicated adolescent medicine wards (plus 5 dedicated adolescent oncology wards) 16 units with limited facilities, usually attached to children's wards.⁵⁷ The experience in the USA is that in spite of the development of the speciality of adolescent medicine, dedicated inpatient units are not the norm in general hospitals. There are 40-60 inpatient adolescent units in the USA (population about five times that of the UK) and some hospitals have closed existing units.⁵⁸ However, in Australia, the Scandinavian countries and much of Europe, adolescent wards are being developed in most children's hospitals and many adult hospitals. A report of a survey of directors of units in the USA describes the clear rationale for such units and the advantages, but also the difficulties of establishing and maintaining them. This is particularly problematic outside tertiary units.⁵⁹

As far as members of the working party could judge, services for young people with psychological and mental health problems have changed little since their deficiencies were clearly identified by a statutory authority review in 1986.⁶⁰ Funding and resources appear on a balance of gains and losses, not to have been increased in spite of the high and increased morbidity evident to professionals and NGOs discussed in the preceding section.

* See terminology section in introductory pages.

Qualitative analysis of the data from our own survey⁶¹ suggests a variety of reasons as to why district general hospital units have not developed specialist adolescent inpatient facilities. Few perceived that there would be sufficient demand for a separate unit, although this is in contrast to published data showing that units could be established in most districts and would achieve high occupancies.⁹ Financial constraints were clearly important, as were concerns that separate adolescent units would be opposed by some adult disciplines who regularly admit older teenagers to their adult wards. Many children's units recognised that the case mix of young people in such units would be quite different to the case mix of admissions in an average children's ward; there are larger numbers of patients with psychiatric or psychological disorders, including patients admitted after self-harm, and significant numbers of trauma patients, particularly among males. Most units recognised the potential importance of separate adolescent services and particular skills needed by staff, but had failed to achieve them.

3. The need for service development

Article 12 UN Convention on the Rights of the Child states:

'State parties shall assure to the child who is capable of forming his or her own views, the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child'

'What should I be doing for the sake of my own health?' is hardly the first thing that young people wake up thinking about in the morning, nor should it be! – Nevertheless they do have definite concerns, needs and views about health services and health promotion.

Approaches to health promotion in young people must be different to that provided for adults and be appropriate for their stage of cognitive and social development. They may fail to appreciate long term consequences of poor health or even regard it as someone else's problem.

Young people require special consideration as users of health services (see above and section 9 on Consent and Confidentiality, p.45). As long ago as 1959, the Platt report recognised the need for specialised healthcare facilities for young people⁶² and in 1976 the Court Report recognised that Adolescents should be considered as a group having needs distinct from those of either adults or children.⁶³ Failure to develop a good relationship between professional and adolescent may set patterns for long term poor use of services.

Adolescents can be considered as "new" users of healthcare services with the corollary that they need information, support and encouragement to access and use them effectively. Until young people reach adolescence they are presented to health services by their parents and have not had to access these services for themselves. The developing autonomy of young people needs to be encouraged by professionals enabling them to spend part of a consultation without their parents present, and offering encouragement to discuss lifestyle and psychological issues. While parents may need significant support and reassurance to let young people take charge of their health, particularly if a chronic long term condition that has been present throughout childhood, some adolescents will demand or be given autonomy but neglect their health, sometimes with severe adverse outcomes. Young people may be on a steep learning curve about how to use services appropriately and have different perceptions to professionals or their parents of health care.⁶⁴ Some young men have different attitudes to their health, tending to access services only when they are desperate.⁶⁵

A different sort of service is required to attract and retain young people's engagement with health service providers than for adults, who have already experienced and used services either for themselves or for their children. If appropriate use is considered to lead to health benefit, then services require marketing e.g. practice leaflets, telephone advice lines, websites etc.[#G] A young person's first contact with a service may be their last, if it is not perceived by them to be appropriate.

Adolescents, in establishing their own self-identity, lack confidence to challenge services, or to develop ways of using them that meet their needs or to persist in access. The onus is therefore on health care providers, both clinicians and administrators to engage with young people to develop services which meet their needs.

Some young people may be less inclined or able to access services successfully than others and these may include those with the greatest needs. Young people who are members of ethnic minority groups may experience difficulties,⁶⁶ because of cultural and language differences and prejudice.^{14 16 68 69}

The need for services to be co-ordinated and for information about different health interventions and treatments being received by an individual raises important issues: first the co-ordination of services at strategic planning and delivery levels and second the co-ordination of services to meet the needs of the individual adolescent. The strategic co-ordination of services for adolescents has to be considered both within and between services and includes services provided by NGOs, health, social, educational and legal services. Information sharing between services about an individual young person has to take into account issues of 'confidentiality'. This problem might be overcome by the development of proper health records kept by the individual themselves: patient held records (which could be duplicated on electronic or written files by the main services involved).

Almost as important for young people is having services delivered by someone who has good communication skills, who respects and listens, is non judgmental or over paternalistic, and gives sound clinical advice based on the best available evidence using understandable language.^{8 16 18 70} Many young people want to be able to choose the sex of the health professional that they see. By the age of fifteen, half want to see the doctor or nurse alone, just under a quarter with their parents and just over a quarter with a friend.⁷¹

Professionals providing health services for young people at primary, secondary and tertiary levels need to be aware firstly that young people have specific health needs of their own;

second that the style in which health professionals care for young people is all-important; third, of the importance of offering services when they are needed but not to over-medicalise young people's lives. Health professionals need specific training to perform this role.

Nearly all primary care providers in our survey (95%) believed that there should be dedicated or special services for young people. Over 95% also supported development of services in schools or the community and a significant minority (25%) stating that they should not be in GP primary care premises.

Similarly nine out of ten young people who had been in hospital and more than eight of every ten nurses believed that there should be specific units for adolescent patients in all hospitals admitting young people.¹⁹

An extensive manual on consultation with young people in relation to health services has recently been published by the Health Development Agency,⁷² as have illustrative reports of using participatory approaches to improve health,⁷³ and a book giving examples of positive health benefits associated with Participatory Learning Approaches in improving sexual health services in non-OECD countries is to be published in 2002.⁷⁴ A useful guide to consultation and participation in CAMHS has been published by the Trent Region, [#B] and to counselling and information services by Youth Access. [#C]

There are a multitude of reports available to commissioners and providers emphasising the need^{6 75 76} and resources to support the development^{77 78 79 80} [#D, #E] of improved clinical services.

Recommendations for policy

3.1 *That national, regional and local health commissioners examine the consequences of not investing to a higher than present level in services for adolescents, particularly mental health and health promotion services.*

3.2 *That the government recognises the need for specific planning of health services for young people and ensures that appropriate guidance is included in the National Service Framework for Children's Services, with cross reference to other major policies such as the National Sexual Health and HIV Strategy.*

3.3 *That Regional and local commissioners plan services for young people which have appropriate links between health, social, and education services, and encourage the use of Health Act Flexibilities to achieve this.*

3.4 *That PCOs, as the lead commissioners for health services, develop mechanisms for identifying local adolescent health needs (perhaps jointly with neighbouring PCOs) and monitoring the impact of local service provision in effectively meeting these needs.*

4. Do we need a speciality of adolescent health care?

The development of a speciality of adolescent healthcare at first appears attractive, and is a norm in many industrialised countries. Additionally, American studies suggest that only around a third of physicians and paediatricians actually like working with adolescents and that another third have very little interest in adolescent care.^{81 82 83} It is not clear that a speciality of adolescent medicine would necessarily be the best solution in our current health system. In many countries where adolescent medicine has developed, the patient will choose their primary care practitioner on the basis of professional expertise and special interest. In these countries there are primary care paediatricians, adolescent physicians, psychologists and psychiatrists, gynaecologists, etc. This is not the case in the UK where the risk of developing specialist adolescent medicine is that it may fragment rather than improve care for the majority of young people. Outcomes are not necessarily better in countries where there are developed adolescent services than they are in the UK⁸⁴. Both Youth Matters,⁵⁵ a collation of the limited evidence base available to guide the care of young people in hospital, and Macfarlane and Blum⁸⁵ in a recent leading article, emphasise the dearth of evidence in relation to outcomes as a result of the type of services provided. Within the primary sector there may be few GPs willing to give up seeing their current adolescent patients to a sub-specialist. This might be more acceptable when teenagers are seen in a clinic led by a range of nurse professionals (school, practice, specialist nurses or health visitors). In secondary care provision professional expertise in a sub-speciality appears to be a more important criterion in setting up a service than special expertise in managing young people. We predict that there would likely be benefits for some professionals in larger hospital specialities developing particular interests in the care of young people within their speciality.

5. Health promotion for adolescents

The main rationales behind health promotion for adolescents are:

- That biological and psychological development during adolescence, including the development of abstract thinking capacities, means that adolescence is a time of search for identity, meaning and ideology.
- This means that health promoting behaviours beginning in childhood and established during adolescence usually persist into adult life though they may or may not have a profound effect on health during adolescence itself. These behaviours include smoking, diet, exercise, substance use, offending behaviour, contraception and the use of medical services.^{45 46 47 48 49 50 51}
- Another approach/rationale of 'health promotion' is based around the increasing research evidence that better mental health outcomes for adolescents may be achieved through early parenting interventions.⁸⁶

The main strategic approaches are:

- Health promotion carried out by society as a whole on behalf of young people e.g. banning cigarette advertising, making emergency contraception available 'over the counter' etc.
- Systemic "whole school" approaches to improving well-being and health e.g. the 'Healthy Schools Standard'⁸⁷
- Health promotion carried out as health education assisting young people to behave in healthy ways e.g. not smoking, practising safer sex, eating a balanced diet, taking regular exercise etc. This includes opportunistic health promotion to individual young people when attending health services facilities e.g. primary care, offering opportunities for general advice, active listening and education for parents of young people
- A review of community approaches to health promotion for young people in the UK has recently been published.⁸⁸

The evidence on the effectiveness of health promotion for young people suggests that:

- The most effective health promoting intervention for young people would be to create greater socio-economic equality.⁸⁹
- Early 'parenting' interventions improve long term outcomes for adolescents in several areas of their functioning.⁸⁶
- Simultaneous interventions at governmental, community, media, family and individual levels increase the chances of effectiveness of health promotion interventions.⁹⁰

- In some cases effective health promotion interventions for adolescents carried out at national level on behalf of young people (e.g. to reduce adolescent smoking by increasing the price of cigarettes and banning cigarette advertising) may be more effective than direct health education messages to young people.
- School environments and ethos are recognised as being important factors impacting on the likelihood of children and young people benefiting from health behaviour messages in school since ‘connectedness’ with the source of information²⁹ is important in the impact of social influences.⁹¹ The Healthy Schools initiative in the UK recognises the opportunity for inputs from health staff in this area, particularly in the promotion of mental health.
- There is some evidence that interventions promoting general self empowerment are more effective than interventions dealing with single health issues.⁹²
- There is also evidence that to be effective specific interventions designed to reduce unhealthy behaviours need to be targeted at specific behaviours, employ intensive and expensive interventions based on social influence theories^{93 94} and use peer assisted programs.^{95 96} [#N, #O]
- Parents continue to play a key role in adolescent behaviours, and the role of the parent and parenting styles and how they can best be supported in this role needs to be further researched.
- For young people with diabetes interventions may show small to medium effects on health outcomes if they demonstrate the inter-relatedness of the various aspects of diabetes management.⁹⁷

Overall there is insufficient research into the effectiveness of health promotion for young people either to be totally nihilistic about its effectiveness or to be totally clear about how it is best carried out.

Recommendations for promoting better health

5.1 *Governments must continue to recognise and act on the fact that for young people, like all other age groups, socio-economic circumstances and inclusion have a profound effect on health and emotional wellbeing.*

5.2 *The main strategic emphasis should be on health promotion for young people rather than health education to young people.*

5.3 *Couple support programmes and early ‘parenting’ programmes’ which have been shown to be effective should be considered for certain disadvantaged groups within society.*

5.4 *Young people's views of their needs and how they can best be met must inform health promotion policies and practices.*

5.5 *More research is required on the effectiveness of interventions before large scale projects are developed for health promotion to this age group.*

5.6 *The relative merits of health promotion interventions aimed at increasing the overall self esteem and self empowerment of young people, those directed at single health issues and those using combined approaches should be formally investigated using appropriate research methodologies.*

5.7 *Health promotion interventions for young people should be carried out simultaneously at government, community, school and local level. This will necessitate co-ordination and commissioning at supra- PCO level.*

5.8 *Health promotion such as that directed to the reduction of the major mortality and morbidity suffered by young people from trauma may require even wider community interventions.*

5.9 *The Healthy Schools initiative, if found to be effective, should be further developed as 'Healthy Communities'.*

5.10 *Educational providers should take up the opportunity offered by the inclusion of Citizenship in the National Curriculum to provide additional and evidence based health promotion in schools, including how to access and use health services.*

5.11 *More research into the effective roles of specific health professionals in the field of health education should be undertaken but at the present time the main roles of health professionals in health promotion should include:*

- acting as advocates for the health of young people*
- utilising all clinical contacts with young people as health promotional opportunities - while remembering the possibility of damaging relationships by providing gratuitous advice!*
- providing young people and their carers with the most relevant and most up-to-date evidence based information*
- informing all relevant stakeholders of the major known research facts concerning the effectiveness of health promotion so that resources can be used effectively.*

6. Primary care services

Some of the issues that most concern young people in their contact with primary health care services include (a) the privacy/visibility of the visit and trust in the confidentiality of all the staff involved. (Confidentiality issues are so important that they are dealt with separately in a later section.) (b) the overall friendliness of professional and other staff including the receptionists (c) the gender of the doctor who they wish to see (d) non-judgemental attitudes of all staff and their ability to listen (e) the timing of surgeries and ease of access via public transport (f) having access to primary health care information without actually consulting the doctor face to face. The latter can be done in a variety of ways using leaflets, letters, telephone contact, text messaging or internet access to their local practice, community or national resources. Other professional groups, for example pharmacists, are increasingly important in the provision of direct health care services.

The Teenage Pregnancy Strategy⁹⁸ and the National Sexual Health and HIV strategy⁹⁹ both encourage primary care services particularly General Practice to provide more comprehensive sexual health services.

The case for specifically designed health services for adolescents is made in the preceding section – “The need for service development”. Young people require a variety of primary health care clinical services to meet their needs. These may include (a) an overall user friendly general practice (which includes the requirement that professionals dealing with young people are appropriately trained) (b) specific adolescent clinics (c) clinics run in premises other than a general practice surgery or health centre (e.g. schools, centre of town etc). All such service developments should take not only the needs and views of young people into account but also the resources of other supporting services e.g. those provided by NGOs and other local organisations. They should be well advertised.

Examples of good practice are available in this area.¹⁰⁰ [#A, #F]

Recommendations for the Health Care of Adolescents in Primary Care

6.1 *The views and needs of both the majority of young people and of sub-groups of young people with particular requirements, should be taken into account at all stages of planning and delivery of primary health services for young people.*

6.2 *The National Service Framework for Children’s Services to include specific standards for adolescent health services. Such standards should take into account the views of the various Colleges and other organisations involved.*

6.3 The strategic planning of primary health services for young people should be carried out jointly by the relevant organisations concerned including the health services, NGOs, social services, education services, and legal services.

6.4 Options for providing health care for young people should be considered alongside other provisions which they may need including information about 'housing', 'jobs', 'social services provision', 'further education' etc. e.g 'One Stop Shops' should be further developed and formally piloted.

6.5 Issues surrounding the question of 'confidentiality' when sharing information between services for the benefit of young people need to be carefully examined, and the use of 'adolescent held' health records further developed.

6.6 At the present state of provision of services for adolescents, the primary aim is to improve the service provision for all teenagers. The additional needs of certain subgroups of young people such as those from ethnic minority groups, those with long term handicapping conditions, those who are looked after etc. need to be further considered as the overall services are developed.

6.7 When at the planning and development stage of adolescent health services at a local level consideration should be given as to how such services can be adequately resourced and supported by all stakeholders.

6.8 Primary care services for young people should:

- be based on a mapping of service need for young people within defined areas
- be readily accessed geographically and by times of availability
- be well advertised with confirmation of their confidentiality
- be supported by a local strategy group for commissioning of adolescent services with involvement of all the stakeholders
- have high profile amongst adolescents but be of low visibility to other members of the community.
- The essential role of parents in the provision of primary health care to their young people should be taken into account at all stages of service development.
- offer active sympathetic listening opportunities.
- enable engagement at different levels according to the needs of the individual.
- liaise with parents, other primary care, social, youth and educational services within the bounds of confidentiality
- address the provision of sexual health and psychological/psychiatric services
- have staff who have been trained to work with young people and work to specified standards [#D]

Within General practice

Many practices fail to achieve even basic standards of provision for their adolescent services as a result of a lack of recognition of both the actual health concerns and needs of young people as well as their concerns about the kind of service provided – e.g.. siting, timing etc. Furthermore there is a belief that adolescents are low users of the primary health care services, there are few resources to provide services and there is a lack of training in adolescent health. Recognition of mental health problems and their contribution to physical symptoms is limited.¹⁰¹

In the overall planning of primary health care services for adolescents, the Primary Health Care teams (including General Practitioners, receptionists, managers, therapists, nurses etc) are now responsible for commissioning the majority of primary and secondary health care services via the Primary Care Organisations (PCOs). For adolescents at a local level, PCOs are therefore of major importance in the development of appropriate health services, for all but the most specialist services. Some of the services developed will require new resources. Some practices may take on more responsibility for adolescent health services than others and will require additional resources, with the agreement of other practices that do not.

Although it will be the responsibility of PCOs to provide local clinical governance in the area of adolescent health, *nationally* agreed standards for such governance need to be developed, agreed and disseminated. The initiative for developing such national standards should be undertaken by relevant Colleges and government bearing in mind existing good practice and guidelines.^{100 102} [#A, #D, #K]

Remembering that young people should be regarded as new users of health services it is desirable to give them the opportunity to re-negotiate their general practice service. A specific appointment, perhaps offered annually, from the age of 14 or 15 until taken up, could provide a number of opportunities. These include a meeting with their general practitioner in their own new persona, having the opportunity to decide whether they wish to continue with their parent's GP or choose their own. Making a choice might be influenced by gender, age, ethnicity and perceived appropriateness of the service and gives the professional an opportunity to discuss the ways in which they can offer services.

Recommendations for the Health Care of Adolescents within the GP practice

6.9 *Primary Health Care Organisations (PCOs) should plan, support and monitor adolescent services within GP primary care.*

6.10 *National standards for provision of adolescent health services in primary health care require development and implementation.*

6.11 *Relevant members of the primary health care team, (from senior GP partner to receptionist) should consider additional training in adolescent health and communication with young people.*

6.12 *General practice partnerships should consider the appointment of a lead professional to take responsibility for the development of services and the maintenance of standards in adolescent care.*

6.13 *That there should be development and evaluation of more specialised services within primary care services (level 2 services e.g. ⁹⁹) to be run or supported by nominated and interested GP teams working in defined geographical areas.*

6.14 *That the issue of having GP specialists in Adolescent health – both men and women with appropriate training – should be further examined.*

6.15 *That general practices should routinely offer a specific review appointment or re-registration in primary care to all young people, on or before their 16th Birthday.¹⁰³*

Outside General Practice Premises

There are situations where running specialist clinics for young people outside general practice may be advantageous to both young people and services. Achieving physical access to services, with low visibility to parents, and the community as a whole, often poses unique problems to young people because of timing of clinics, transport and cost; these problems are particularly acute for adolescents in rural areas or with disability who are reliant on school or parent transport.¹⁰⁴

A single style of service such as might be provided within a general practice, is unlikely to be attractive to young people from widely varying backgrounds; the provision of choice should encourage use. General practice based primary care services may remain the predominant service for most young people's health needs but the provision of drop-in services, for example school- or high street- based services is predicted to attract a different group of

young people. Other drop-in services such as family planning services, particularly the Brook Advisory Service, GUM clinics etc. may provide a style of service that could increase adolescent access to, and use of, healthcare. Complementary therapies may also provide an additional access route to orthodox health services.

Against this increased access to care it may be important to balance the loss of continuity of health records which will inevitably occur if these contacts are regarded as confidential to the service and client so that information is not passed to the general practitioner. There appears to be an increasing tendency towards episodic, rather than continuity of GP centred care and this is particularly apparent among adolescent healthcare episodes. If patient well being is not to be compromised by insufficient information being available to their primary medical carers (including parents) then patient held records may assume a greater importance.¹⁰⁵ This issue may also be addressed by guidelines which mandate copying clinical letters to patients.¹⁰⁶

Specifically designated services for young people may not always be either practical in terms of people, resources or affordability. Where such services for adolescents are provided it is essential that the staff involved are appropriate professionals, are trained to take into account the specific needs of young people and that quality controls are in place as for other statutory services. [#C]

Recommendations for health care facilities outside of Primary Health Care premises

6.16 *That the commissioner for children's services in PCOs and SHAs should also be responsible for the planning, development and implementation of these adolescent services.*

6.17 *Provision of primary care clinics outside of practice premises should be decided on the basis of the needs of the local population of young people.*

6.18 *Specific local health service provision should take into account ALL other relevant service provision for young people including those provided by other health services (including primary and secondary care, community children's nursing services and school based services, see below) as well as provision by NGOs, social services and justice services.*

6.19 *It is essential that the staff involved in such facilities are trained to take into account the specific needs of young people.*

6.20 *'Quality control' standards should be maintained.*

School Health Services

School health services need specific comment. They are seen by parents and children as important places for young people to obtain health information, advice and support.⁵ School provides an environment where initiatives designed to support young people are deliverable on a relatively even playing field and without the need for labelling; nearly all children attend regularly until the age of around 14, after which those most in need may attend less or not at all. Pupils and parents value information given in school by health professionals who may have special knowledge, credibility and skills different to those of teachers, who themselves value health support in helping young people, particularly those experiencing emotional, psychological and mental health problems.

A recent review of School based drop-in services in secondary schools carried out for an NGO in the UK concluded that such a service should be universally available to students within or close to all secondary schools.¹⁰⁷ A recent report on good practice in sex and relationships education highlights how access to individual advice from specialist professionals can underpin effective delivery of school SRE programmes¹⁰⁸ and includes a school based clinic as an example of good practice. The report recommends local education and health authorities to consider how more pupils in secondary schools can have better access to individual advice including through centres on school sites.

Recommendations for School-based Health Services

6.21 *That the commissioners of children's services should, with PCOs review school health services in secondary schools, FE colleges, universities and similar institutions to ensure that their provision is optimised to provide appropriate, readily accessed physical and mental health services for young people.*

6.22 *That health commissioners should ensure that young people who are 'difficult to reach', such as those in pupil referral units or not in school, receive health services on an equitable basis.*

6.23 *Ways of including appropriate health education provision within the standard school curriculum, and supported by the appropriate health services – should be examined and developed.*

6.24 *Involvement of the health services advice in the prevention and management of bullying in schools should be considered.*

7. Special healthcare situations

Young offenders, rough sleepers, those involved in drug use, care leavers and other marginalised young people present unique challenges in the provision of health care, particularly in terms of access. While acknowledging the difficulties of engaging these young people in regular health service provision because of their social exclusion, the subsequent health and social needs and costs to society may mandate the provision of highly specialised services. Successful treatment of such young people is notoriously difficult and even retention of young people and their families for a course of treatment is problematic. Effective treatments must be multi-modal and link health with education and social services. Treatment programmes based on Multi Systemic Therapy appear to be the most promising.¹⁰⁹ As might be predicted they are relatively expensive and logistically complex¹¹⁰ and need to be weighed against the likely cost savings of early intervention.¹¹¹

Recommendations relating to young people in special circumstances

7.1 Government to continue to develop, support and rigorously evaluate technologies that aim to reverse cycles of social exclusion.

7.2 Economic cost-benefit models for expensive, preventative interventions should be realistically costed in multiple dimensions including not only health but social, judicial and societal terms.

7.3 Health care provided within prisons/youth offender units should reach standards at least equivalent to those normally available in the NHS and should be the subject of rigorous monitoring/audit.

8. Secondary care

The RCPS(G) pointed out that in cities where children's services are centralised in one children's hospital special arrangements may need to be commissioned to deal with many of the issues discussed in this section which presume child and adult services are geographically proximate.

Accident and Emergency services

Increasing numbers of adolescents access accident and emergency departments rather than primary health care facilities¹¹² especially for issues of sexual health (notably for emergency contraception), mental health, self harm and substance abuse. However, few if any A&E departments currently have specific provision (either trained staff or separate facilities) for young people.¹¹³

Young people with substance use, self-harming or behavioural problems and rough sleepers pose particular management challenges for busy A&E staff, either when presenting for outpatient treatment or requiring admission. Adolescents may also pose particular problems where hospitals separate children's from adult A&E services, as neither service may take lead responsibility for young people. Most children's services see new patients only under 14 or 16 years depending on local circumstances, with young people above this age being treated in adult services where multi-disciplinary team working and links with CAMHS are less well developed. Strong links between ward teams and A&E staff are essential for managing such young people. Consideration should be given to the development of liaison posts (e.g. social work or nurse specialist posts) between inpatient services for young people and A&E and the community.

As with outpatient and inpatient services for young people, the provision of separate facilities for young people is less important than development of staff skills in communicating with and dealing with challenging young people. All those who work in A&E will see young people from time to time, and therefore should have some basic training in adolescent health. The development of adolescent lead professional roles amongst A&E staff should be considered as a way of improving health care delivery to hard to reach young people.

Recommendations for Accident and Emergency departments

8.1 All A&E departments should identify a lead professional to take responsibility for developing policies and services for young people.

8.2 Training for all A&E staff in communicating with and treating young people should be strongly encouraged.

8.3 PCOs and secondary care providers should ensure that if A&E departments are used as a significant resource by young people that there is an appropriate built environment, they are seen by trained staff and that formal arrangements for liaison with specialist services such as CAMHS exist.

Specialist Outpatient services & Transition

Classic paediatric or adult outpatient services often poorly serve young people with acute or chronic illnesses. Adolescents sit poorly between the family centred, developmentally focused paediatric paradigm (which frequently ignores their growing independence and increasingly adult behaviour) and the adult medical culture, which acknowledges patient autonomy, sexual health, and employment issues but may neglect growth, development, and family concerns. Adult services may better address confidentiality and individuation issues, but be less supportive generally, due to different financial constraints; they may rely heavily on services from relatively under-supported primary care services. Additional time for appointments may be needed as compared to adult services. In both services consideration should be given to non-traditional ways of patient-professional communication including web-sites, email and text messaging.

Transition issues can be particularly acute in mental health, with some CAMHS services expecting to transfer young people to adult services at age 16, yet adult services not taking patients until they are 18 years. Developments are being explored between adolescent and adult mental health services to fill this gap.¹¹⁴

Transition has been defined by the Society for Adolescent Medicine (USA) as “the purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centred to adult-oriented health care systems.”¹¹⁵ The requirement for improved transitional care during this period of transfer between child and adult services has been emphasised by numerous reviews and governmental documents e.g. the Select

Committee on Health. Improved transitional care has recently been mandated as a standard for quality care for young people by the Diabetes National Service Framework:

*“All young people with [diabetes] will experience a smooth transition of care from paediatric diabetes services to adult [diabetes] services, whether hospital or community-based, either directly or via a young people’s clinic”.*¹¹⁶

Where there are large numbers of young people requiring transition the requirements for adequate transition planning are often best met by the development of dedicated adolescent or “handover” clinics in various specialities. Such clinics allow carers to focus on meeting the developmental needs of young people while the clinic provides a more adult model of medical and nursing service. These clinics may be within either child or adult services, but with input from both, and should provide multi-disciplinary input including psychological services. Support should be provided for the family during the process of transition.¹¹⁷ The age range of such a clinic is most appropriately determined by local need, however young people might remain in such a clinic for 3 or more years. These clinics should be multi-disciplinary, may be led by non-medical professionals, and consideration should be given to late afternoon/evening clinics. Educational, vocational, youthwork and sexual health services may also be provided.

If dedicated adolescent clinics are not developed, handover clinics between child and adult professionals should be developed to provide an introduction for young people to adult services and clinicians. In conditions where new complications arise in adulthood (eg diabetes) children’s health professionals would benefit from experience in an adult speciality clinic.

The need for wider-scale planning regarding transition is particularly important in those illnesses once considered to be confined to childhood but where modern treatment advances have led to longer-term survival into adult life. In the past a lack of adult expertise in conditions such as cystic fibrosis and congenital heart disease led to the development of new specialist units (adult cystic fibrosis units; grown-up congenital heart disease services).¹¹⁸ These services were set up in collaboration between child and adult services, and include a significant training component for adult physicians. Similar young adult services have been developed for the survivors of childhood cancer (late-effects of childhood cancer) and for Intersex conditions. However, adult services do not exist for sufferers of many less common conditions. It is not appropriate for paediatricians, or other child specialists such as paediatric surgeons, to continue to follow-up adults simply because they have had a childhood illness. Where no adult speciality or service is active in providing long-term care for young people with specific health needs,

new services should be developed to provide ongoing health care. This may require specialist commissioning support for regional services.¹¹⁹

Conversely where conditions are rare in childhood, joint clinics with adult and child specialists working together in a DGH may provide a high quality service, facilitate the care of young people and a learning environment for child specialists. Examples include rheumatology, haematology, physical disability/orthopaedic clinics.

New referrals to secondary care services

During consultation the RCP(L) pointed out that we had not dealt with appropriate ages to decide referral to a child or adult specialist. The most important factor is the referrer's judgement as to the socio-psychological maturity of the patient but the decision will also be influenced by others such as the nature of the complaint and its likely time course. For example a sixteen year old with delayed puberty or suspected functional pain of childhood might be referred to a child specialist while another with inflammatory bowel disease, rheumatic disease or epilepsy might be referred to an adult specialist. Where joint or handover clinics exist they facilitate a dual approach.

Genetic counselling in the transition to adulthood

Young people at risk from genetic diseases should have access to genetic counselling in adolescence before they begin reproduction.

Generic adolescent clinics

Consideration could be given to the development of general adolescent clinics in secondary care, analogous to general paediatric or general medicine clinics. Such clinics might particularly benefit young people with acute or self-limiting medical problems as well as chronic illnesses (e.g. eating disorders, chronic fatigue syndrome, functional syndromes etc) who are not well served by speciality clinics. An alternative might be to hold relevant specialist clinics for young people (eg diabetes, cystic fibrosis, epilepsy and sexual health) at the same time and place, facilitating multiple attendance.

Disability

Transition planning is the key issue in services for those with physical disability. Expert and extensive support is provided from both health and education services until age 19 years, with care thereafter often poorly co-ordinated and patchy or provided only from primary care.¹²⁰ Consultant led services should be developed for young adults with physical disability.

Evaluation

While it is accepted that transition planning is now an essential part of quality care for young people, direct evidence of the benefit of adolescent clinics is lacking. In diabetes, the planned transfer of the care of young people promotes diabetes self-care and improves outcomes.¹²¹ Anecdotal evidence of the benefit of transition programmes for self-esteem and self-management skills are available in other specialities such as cystic fibrosis and arthritis. Further evidence on the benefits of transition will be available from a forthcoming systematic review.¹²²

Recommendations for good practice in outpatient care and transition^{123 124}

8.4 Individual disciplines should develop clear protocols of good practice for the management of young people's health during adolescent transfer to adult care. This is important in all specialities, particularly diabetes,¹²⁵ terminal illness,¹²⁶ epilepsy,¹²⁷ respiratory disease, physical disability,¹²⁸ rheumatic disease,¹²⁹ substance users,¹³⁰ congenital heart disease¹³¹ and metabolic disease.

8.5 Where appropriate there should be shared care guidelines for young adults who will be transferred from secondary paediatric care to adult primary care.¹³²

8.6 In either model

- Young people should not be transferred fully to adult services until they have the necessary skills to function in an adult service and have finished growth and puberty.
- An identified person within the paediatric and adult teams must be responsible for transition arrangements. The most suitable persons may be nurse specialists or other health care professionals.
- Longer consultation times are required than for either children's or adult clinics.
- Evaluation of transition arrangements must be undertaken.
- A planned review by a clinical geneticist should be considered.

8.7 Every children's general and speciality clinic should have a specific transition policy.

8.8 For young people with mental health problems specific services should be available for those in the 16-19 gap, linking to drug and alcohol services, early intervention (in psychosis) and youth offender teams.

Inpatient services

Specialist practitioners in the USA, Australia and Europe are of the opinion that dedicated adolescent units are essential for the best management of young people in hospital.⁵⁸ In the UK there is agreement among children's service providers on the need to provide separate inpatient facilities for adolescents. Around 90% of UK paediatric clinical directors surveyed by this Working Party agreed that dedicated adolescent inpatient facilities were required in their Trust⁶¹ and nurses agree.¹⁹ However, there are only around 15 - 20 adolescent wards in the UK, with another 20 or so hospitals having an adolescent area (e.g. a bed bay) contained within their children's ward. Young people themselves repeatedly voice the opinion that they desire separate wards to very young children and the elderly.¹⁹ In contrast to guidance on ward arrangements for adults, young people prefer mixed gender wards as long as adequate privacy is available.^{19 55} During consultation, the RCP(E) expressed reservations about mixed sex wards, pointing out that adequate privacy is hard to define. It is often believed that there are insufficient numbers of adolescents in many DGHs to justify the provision of a separate ward, although published national data show that most DGHs have adolescent activity that would require around 15 beds at any one time.⁹ It is clear that in most hospitals, adolescents are spread between children's wards and a number of adult wards, lowering their visibility and giving an impression, largely false, of a paucity of inpatient numbers. It is generally recognised that young people need to be physically separated with their own facilities even if sharing a staff complement with the children's ward or an adult ward.^{19 55 133} Adolescent units or areas should, like children's wards and other specialist services, such as Infectious diseases wards, be able to accommodate the needs of virtually all disciplines. Such units appear to work well in both tertiary and DGH facilities. During consultation, the RCP(E) and RCPATH believed that the need for appropriate medical and nursing care should be the first consideration and that separate adolescent wards should only be provided where this criteria had been met first. The RCP(E) also believed that separate facilities might be impractical or unnecessary in some hospitals, particularly small or rural hospitals.

Shortage of designated resources and under-funding of paediatric developments are often cited as reasons for failure to achieve ambitions for inpatient adolescent facilities. In some instances pressure on beds has resulted in annexing of proposed or actual facilities planned for use by young people by other specialities. However, with accurate mapping of adolescent activity, bringing together of young people into an adolescent inpatient facility may be made cost-neutral to the provider as a whole.

Local Adolescent leads

A lead health care professional should be identified to manage the development of protocols and services and usually a medical professional (most often this will be a paediatrician) should be identified to advise on clinical care for young people. This person might provide advice to specialist colleagues dealing with young people on both adult and paediatric wards as well as in A&E. Where numbers of young people are seen within an adult speciality, it would be beneficial for one or more professionals (nurses or doctors) to develop a special interest in adolescent care.

Multi-disciplinary working

Young people with chronic illness can experience high levels of social exclusion, educational and vocational failure and psychological morbidity. Input from professionals from education, youth work and mental health professionals as part of a multi-disciplinary team is essential to allow young people to achieve their potential and maximise disease control. Strong links with CAMHS services, including good emergency cover, is essential for the management of young people with chronic illness and those with acute problems including self-harming.

Nursing skill-mix

Fifty percent of nurses in a recent survey believed that they had difficulty meeting the needs and demands of adolescent patients.¹⁹ Diploma and certificate level courses in nursing young people have been developed in a number of UK universities. Both children's and adult nurses contribute significant skills to the management of young people in hospital, and the nursing skill-mix for dedicated adolescent inpatient units should include nurses from both branches. Skill-mix must also take account of existing requirements on the provision of registered children's nurses where nursing young people under 16¹³⁴ years. Mental health nurses are also highly desirable as part of the adolescent ward skill-mix, and have a particular role in the management of behaviourally challenging and/or self-harming young people.

Self-harming and challenging young people

Young people admitted with self-harming or substance use problems present a significant management problem, and can present a perceived barrier to the development of adolescent inpatient areas. These patients require initial treatment on a medical ward, and are rarely subsequently admitted to acute CAMHS beds (either because these beds are unavailable or because these young people largely do not have specific mental health problems). Management of these patients requires good links with CAMHS liaison services including social work, strong nursing skills/ training in mental health issues and effective community follow-up. New joined-up inter-agency methods of working with young people with acute

behavioural or mental health problems are being developed.¹³⁵ There are specific adolescent in-patient facilities in place for young people with medium to long term episodes of mental illness but often these are not available when adolescents with mental health disorders require admission as emergencies.¹³⁶ Adolescent medical beds may provide a local alternative for the acute admission of young people with less intrusive mental health problems or no clearly psychiatric diagnosis .

Hospice & palliative care

While excellent hospice and respite facilities exist for children and adults, poor provision is available for young people in respite and palliative care. A lack of facilities, shortage of trained staff, and inadequate psychological and educational support for young people have been identified as significant issues that need to be urgently addressed.¹³⁷

Evaluation

The evidence is strong that both health professionals and young people themselves perceive a benefit from dedicated adolescent inpatient facilities, particularly in terms of self-esteem and emotional well-being.¹³⁸ These are clearly linked to better health outcomes. There is little direct evidence of benefits for disease-based outcomes and expenditure; this benefit will be difficult to quantify. Further evaluation of adolescent inpatient facilities should be undertaken.

Recommendations for inpatient care

8.9 *Every hospital should have a policy on the care of young people in hospital and one or more professionals with special responsibility for young people.*

8.10 *Every hospital with a paediatric unit should have designated inpatient facilities for young people.*

- At the minimum, this should be a separate facility on a children's or adult ward. Mixed gender wards are preferred. Interview facilities should be provided for private discussions with patients and ward rounds.

- It should be managed jointly by lead nurses and a designated doctor with responsibility to ensure that there are appropriate facilities and that standards of confidentiality, consent and privacy are met for all patients admitted under any clinician.

- All young people who are clearly adolescent (as defined by age, physical or psychological maturity) should have the opportunity to be looked after in such a unit and by an appropriate specialist clinician when inpatients, unless medical/

nursing needs require a different clinical environment (e.g. ITU, HDU, neurosurgery etc).

- All such units should be provided with appropriate education facilities and access to transition to employment schemes.

- Nurse staffing must include a lead appropriately qualified in adolescent mental health.

- Each of these units should have emergency access to CAMHS services for support of young people admitted, or seen in A & E after self-harming episodes as well as dedicated liaison sessions from CAMHS professionals.

8.11 *Each DGH should be able to acutely admit certain young people with mental health problems locally (e.g. to adolescent medical beds) as well as into supra-district specialist psychiatric units.*

9. Consent, confidentiality and rights

Maintenance of confidentiality is one of the key issues that young people report influences their use of health services.¹⁵ Legally and historically, confidentiality has been assumed to be linked to personal competence to make important decisions regarding health care. Young people of 16 years or over are competent even while still under the legal age of majority (18 years), and thus should be assured of confidentiality in clinical consultations. Under this age, young people are assumed to be competent for consent/confidentiality purposes if the clinician can be confident that they can give informed consent and understand the consequences of their decision (Fraser guidelines).^{139 140 141 142 143} This area remains controversial, and some have suggested that young people's rights might have been taken too far.¹⁴⁴

Individual practice must ensure the best interests of young people, as required by children's rights legislation, while meeting their expressed wishes. There is general acceptance by professionals that young people presenting for contraception should routinely be afforded complete confidentiality in terms of informing their parents only with their express consent. However competence is a matter of professional judgement with no formal lower limit and informed by the clinical presentation so that advance undertakings are problematic. It is not clear whether this confidentiality should be extended to, for example a 10 year old asking for contraception, or whether in different circumstances perhaps with equivalent health risk, it would be extended to a 15 year old for intravenous heroin prescription. The distinction does not appear to be related to the legality of the activity; the sexual activity of many younger teenagers is, within the letter of the law, illegal.¹³⁹ An authoritative book has recently been published that provides robust guidance.¹³⁹

Concern about the confidentiality of their family doctor, together with lack of immediate access to family doctor services for those at school, college or work may lead young people to use a range of primary care providers (e.g. walk-in medical centres, school health nurses, family planning services, community clinics etc.). This raises issues of continuity of care, co-ordination and safety, particularly in those with chronic conditions or on medication. These can be minimised by making GP practices "friendly" for young people, addressing issues of family doctor confidentiality^{145 146} copying young people in on clinical correspondence¹⁰⁶ and perhaps the holding of personal health records by young people.

Whatever the conclusion of this debate good practice guidelines and information on this subject should be readily available to all professionals working in this field.^{139 143 147} [#G, #L, #M]

Specific issues concerning consent arise in regard to mental health treatment and the use of the Mental Health Act for compulsory treatment. Compulsory treatment is rarely necessary with young people and the provisions of the Children Act should be prioritised.

Within the Mental Health Act there is little reference to the special circumstances of young people. However it is generally agreed that the least restrictive options should be chosen where compulsory treatment is being considered for young people.

Recommendations in relation to confidentiality and rights issues

9.1 *Training for all health professionals should include information and practical training on managing consent and confidentiality with young people.*

9.2 *Good practice guidelines should be followed by all practitioners in relation to adolescents' rights and professionals' responsibilities in the area of consent, and confidentiality.*

9.3 *All services for young people should produce an explicit confidentiality policy which makes clear the duty of confidentiality and care to young people and prominently advertise to young people through posters and leaflets that the service is confidential.*

9.4 *All professionals should be aware of local policies and sources of advice in relation to child protection issues.*

9.5 *The least restrictive and least stigmatising options must be used for young people who are subject to compulsory mental health treatment.*

9.6 *Professionals should investigate mechanisms to allow copying of clinic correspondence to young people, while maintaining confidentiality.*

9.7 *That the use of patient held records for young people should be evaluated.*

9.8 *Those responsible for developing information strategies for the health services should make special reference to the needs of young people.*

10. Training in adolescent health care

There is presently no formal clinical training in any area of adolescent health in the UK outside of mental health (Child & Adolescent Psychiatry training). A small number of short-courses on adolescent health exist for nurse training in universities, but no formal practical nursing training has been developed. This is starkly deficient in contrast to the USA, Australia and European countries such as Sweden, France or Switzerland, where medical training programmes in adolescent health exist or are being developed.

Some training in adolescent health is needed for all professionals who see young people, not merely those who specialise in adolescents. American data suggests that only one third of physicians enjoy looking after young people, and Australian data shows clearly that most GPs (analogous to the UK situation) feel that their skills are deficient in dealing with this age group.¹⁴⁸ Nurses working in children's and adolescent wards in the UK report that although they spend one fifth of their time working with this age group only a small minority have had any specific training, while four out of five feel that specialist training is vital.¹⁹

Evidence from randomised controlled trials shows that the necessary skills for helping GPs and other health care professionals deal with young people can be taught, and that skills persist over time.¹⁴⁹ Some training in adolescent health should be included in medical curricula at undergraduate and post-graduate levels as well as in continuing professional development.^{149 150 151 152}

Because of the multiple services and therefore different professional groups who are critical to the care of young people, multi-disciplinary training in adolescent health will be advantageous and should be carried out where possible.

Curriculum

The key question as to what training programmes in adolescent health and medicine there needs to be is 'What health and medical problems are specific to adolescents, and what methods of prevention, treatment and management are significantly different for adolescents, rather than for children or adults'?

The main general subject areas that need to be covered are:

- definition of adolescence and bio-psychosocial development during adolescence
- the setting and family influences and dynamics

- epidemiology and priorities, including needs assessment
- confidentiality, consent, rights, access and personal advocacy
- communication and clinical skills such as conflict resolution,
- multidisciplinary working & networking, transfer from child to adult services
- the impact of the environmental context: socio-economic, cultural, ethnic and gender issues
- issues concerning resources, resilience, exploratory and risk behaviours
- health education and promotion, including school health

And the key physiological and medical areas that need to be covered are:

- growth and puberty
- nutrition, exercise and obesity
- sexual and reproductive health including STIs
- common medical conditions of adolescence
- chronic conditions that commonly bridge adolescence
- mental health including eating disorders.
- substance use and misuse
- injuries and violence, including accidents, self-harm, abuse, etc.

Recommendations for professional training:

10.1 *Training in adolescent health should be mandatory for both for undergraduates and the trainees of all the Royal Colleges whose members may be involved with the care of young people.*

10.2 *Multi-disciplinary modular training programmes in general and specific aspects of adolescent health should be developed for allied health professionals.*

10.3 *All those working in the field of adolescent health and medicine should be encouraged to obtain a relevant qualification.*

10.4 *The European wide training programme for trainers in adolescent health (European training in Effective Adolescent Care and Health or EuTEACH) is available free on the internet at www.euteach.org. This should be reviewed by the relevant UK training organisations and adapted for use in their training programmes, together with other existing resources. [#G, #H, #I]*

10.5 *Existing nurse training modules in adolescent health be developed and made available throughout the country. Practical training in nursing young people should also be developed.*

Appendix A: Crucial Interfaces

Crucial interfaces between adolescent health services and other services outside of the National Health Service:

The range of other services that may be useful for those working in the health services to be aware of is extensive, and it is impossible to be totally comprehensive.

Relevant national organisations which may also have local services include:

- Health Development Agency
- Department for Education and Skills
- Youth Services
- Youth Justice Board
- The Juvenile Court
- Connexions
- Local Youth Access
- Prison Services
- Community Safety Teams
- Drug Action Teams
- Refugee networks
- NGOs offering support for specific groups of patients e.g. Brook Advisory Centres, Family Planning Association, Diabetes UK, Cancer and Leukaemia in Childhood, Samaritans, British Epilepsy Association, British Paediatric Rheumatology Group (an excellent Adolescent Resource Newsletter # P) Papyrus (supports sibs/parents where there has been a death)

Local Authority Services That May Be Relevant

- Local Education Authorities
- Social Services
- Care Leaver Services
- Housing Agencies
- Youth Offending Teams
- Local probation services
- Local drug services
- Family court service committees

Other Local Services

- Young Offender Institutions (YOI)s (HM prison service)
- Youth clubs
- Counselling services
- Local youth drop-in centres

Appropriate Websites for Young People

General health and specific conditions:

- <http://www.mindbodysoul.gov.uk>
- <http://www.teenagehealthfreak.org>
- HDA Young peoples health network directory of databases networks and directories <http://www.hda-online.org.uk/yphnnews>
- Childline: <http://www.childline.org.uk>
- Trust for the Study of Adolescence, Professionals/parents: <http://www.tsa.uk.com/>
- Eating disorders: <http://www.gurney.org.uk/eda>

“Agony aunts”

- <http://www.bbc.co.uk/so/agony/kate/index.shtml>
- <http://www.doctorann.org>

Sexual Health

- Sexwise: <http://www.thesite.org.uk>
- Are you thinking?: <http://www.ruthinking.co.uk>
- Europeer HIV/AIDS : <http://www.europeer.lu.se>
- A PAUSE <http://www.ex.ac.uk/sshs/apause>

Mental Health

- Young Minds <http://www.youngminds.org.uk>

Appendix B: Identified examples of Good Practice

- A Personal communication. Tilbury J Primary care in the school grounds in Cornwall. Tic-Tac. Also described in Kurz and Thornes.⁵
- B Hedges C and Mckeown C. Give us a voice: Consultation and participation in child and adolescent mental health services within the Trent region. 2000, NHSE Trent and Save the Children.
- C Youth Access. National quality standards – for young people’s counselling , advice and information services. Youth Access 1998.
- D Young people’s health service standards. Tyne and Wear 2000. www.haz.co.uk (follow Programme to Child Health to Young People, to award and toolkit)
- E Rogstad KE Ahmed-Jushuf IH and Robinson AJ. Standards for comprehensive sexual health services for young people. MSSVD Adolescent Special Interest Group, 2001, London.
- F Getting it right for teenagers in your practice. 2002, RCN & RCGP, London.
- G The health of adolescents in primary care: How To Promote Adolescent Health In Your Practice’. (2nd edition) Radcliffe Medical Press, 2001 Abingdon.
- H Confidentiality and People Under 16: Guidance issued jointly by the BMA, GMSC, HEA, Brook, fpa and RCGP. 1994. British Medical Association.
- I Two training videos for primary health care workers – ‘Clueless’ and ‘Trust’ – from the Royal College of General Practitioners.
- J Best Practice Guidance on the Provision of Effective Contraceptive Contraception and Advice Services for Young People. Teenage Pregnancy Unit, Department of Health. 2000.
- K Confidentiality and People Under 16: Guidance issued jointly by the BMA, GMSC, HEA, Brook, fpa and RCGP. 1994. British Medical Association.
- L General Medical Council. Confidentiality, protecting and providing information. GMC, London, 2000.
- M General Medical Council Seeking patients consent: the ethical considerations. GMC, London, 2000.
- N European guidelines for youth AIDS peer education. Gary Svenson and collaborators. European Commission 1998 www.europeer.lu.se

- Involving young people in in peer education: a guide to establishing sex and relationships education projects. Teenage Pregnancy Unit, Department of Health, London 2002.
- P Adolescent resource Newsletter. Institute of Child Health, Princess of Wales Children's Hospital, Birmingham B4 6NH
- Q Adolescent units - in tertiary hospitals: Middlesex Hosp (London), Bristol, Oxford;
- in DGHs: Numerous

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