Handbook for Public Health Social Work

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CHAPTER 4

Adolescent Health

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INTRODUCTION

Adolescence is a particularly important transitional period for healthy development. During this period, youth begin to establish not only their self-identity, but also patterns of behavior that affect current and future health status. Many health conditions occurring in adolescence develop into chronic health problems during adulthood (e.g., obesity and type 2 diabetes). Also, the leading causes of death for adolescents (i.e., motor vehicle accidents, homicide, and suicide) are highly preventable. Therefore, in terms of public health interventions, adolescence is an opportune time not only to address the health problems that youth face, but also to prevent the onset of diseases and disorders that plague many Americans in their adulthood.

Although adolescence is generally a healthy period of life, a number of health problems begin, peak, or escalate during this period including obesity, unplanned pregnancy, sexually transmitted diseases (STDs), bullying and violence, psychological disorders, suicide, substance use, and motor vehicle injury. Adolescence is a vulnerable period of development for many youth. National mortality data show that from early adolescence (aged 10–14) to young adulthood (aged 20–24), the mortality rate increased by more than 400% (Xu, Kochanek, Murphy, & Tejada-Vera, 2010).

In this chapter, we provide an overview of major risks to adolescent health. Because adolescent health is significantly influenced by social and environmental factors, including family, peers, school, community, and culture, we examine health conditions emphasizing context. We also present the Healthy People 2020 objectives that relate to youth for each health issue and discuss adolescent health disparities. We use a case study to illustrate how a public health social worker could use the core public health functions of assessment, policy development, and assurance
to address an adolescent health problem at the community level. Finally, we conclude with a brief discussion of several emerging issues for public health social work practice with adolescents.

AN OVERVIEW OF MAJOR ADOLESCENT HEALTH PROBLEMS

Assessment, one of the core public health functions, requires that public health social workers understand the epidemiology of health problems and be able to identify protective and risk factors associated with these problems. The following section provides an overview of major adolescent health problems that public health social workers are likely to address in their practice with adolescents.

Overweight and Obesity

The proportion of adolescents who are overweight or obese has increased dramatically in recent decades and represents a serious public health threat for the 21st century. Since the late 1960s, the proportion of obese adolescents in the United States has more than tripled (Ogden & Carroll, 2010). Overweight is defined as a body mass index (BMI) at or above the 85th percentile and lower than the 95th percentile, and obesity is defined as a BMI at or above the 95th percentile for youth of the same age and sex (Barlow & Expert Committee, 2007). Recent national findings evidence that 16% of adolescents aged 12 to 19 are overweight, and an additional 18% are obese (Ogden, Carroll, Curtin, Lanab, & Flegal, 2010). Obesity can negatively affect youth in several ways as obese youth are more likely to have high blood pressure, high cholesterol, impaired glucose tolerance, type 2 diabetes, sleep apnea, asthma, bone and joint problems, fatty liver disease, gallstones, heartburn, and low self-esteem (Han, Lawlor, & Kimm, 2010). Obese youth are also more likely to be obese during adulthood (Biro & Wien, 2010).

Eating and drinking habits involving high-calorie, low-nutrient foods, as well as sedentary lifestyles, contribute to overweight and obesity. According to a national survey of dietary and activity behaviors, almost 30% of youth drank a nondiet soda at least once per day (Centers for Disease Control and Prevention [CDC], 2010). Additionally, 78% of youth did not eat fruits and/or vegetables 5 or more times per day. Likewise, 63% of youth did not engage in 60 minutes of physical activity per day for most days of the week (CDC, 2010). Conversely, adolescents spent an average of 7 hours and 38 minutes a day watching television, playing video games, using a computer, and talking on the phone (Rideout, Foehr, & Roberts, 2010).

Environmental factors play a role in adolescent obesity. Youth from low-income families and neighborhoods are at greater risk for obesity as healthy foods and opportunities for physical activity require financial resources (Lee, Harris, & Gordon-Larsen, 2009). Moreover, many youth live in neighborhoods without sidewalks, trails, parks, and recreation centers for physical activity (Singh, Siahpush, & Kogan, 2010). Likewise, only 22% of middle schools and 9% of high schools provided 45 minutes of physical education each day for at least 18 weeks of the school year (Lee, Burgeson, Fulton, & Spain, 2007). Similarly, only 4% of states required schools offer multiple servings of fruit and nonfried vegetables during lunch; 14% of states required that schools limit the availability of deep-fried foods; and 18% of states required that schools make healthy beverages, such as water or low-fat milk, available to students (O'Toole, Anderson, Miller, & Guthrie, 2007). Finally, portion sizes in vending machines, restaurants, grocery stores, and homes have increased significantly in recent decades (Rolls, 2003).

The Healthy People 2020 objectives to reduce adolescent obesity and overweight focus on improving diet via more fruits, vegetables, and whole grains, as well as less fat and added sugar (U.S. Department of Health and Human Services [DHHS], 2011). In addition, the objectives encourage more physical activity and muscle strengthening exercise, daily school-based physical education, and limited sedentary screen time.

Sexual and Reproductive Health Issues

Puberty, sexual identity development, and the expression of sexual feelings are hallmarks of adolescence. Rates of sexual activity increase significantly during adolescence. A national survey of high school students found that approximately 20% of 9th graders reported having sexual intercourse, whereas 50% of 12th graders reported having sexual intercourse (CDC, 2010). The median age at first sexual intercourse is 17 (Alan Guttmacher Institute, 2002).

Sexual behavior during adolescence can have lifelong implications in terms of pregnancy and STDs. Risky sexual behaviors include having unprotected sex, not using contraception, having multiple sexual partners, and using alcohol or drugs before sex. Among sexually active high school students, nearly 40% did not use a condom during last sexual intercourse, and 80% had not used birth control pills before last sexual intercourse (CDC, 2010). In addition, 21% of 12th graders had sexual intercourse with four or more partners (CDC, 2010). Though abstinence from sexual intercourse is the only 100% effective way to prevent pregnancy and STDs, research concludes that approximately 90% of youth have had sexual intercourse by the time they reach adulthood (aged 22–24; Mosher, Chandra, & Jones, 2005).

A sexually active female adolescent who is not using contraception has a 90% chance of getting pregnant (Harlap, Kost, & Forrest, 1991).
The unintended pregnancy rate is higher among adolescents than other age groups (Finer & Henshaw, 2006). Approximately 34% of female youth become pregnant before they reach age 20 (Henshaw, 2003). Teenage pregnancy is a problem because adolescent parents are often emotionally and financially unprepared for parenthood. Adolescent pregnancy and childbirth are linked to poor outcomes, such as inadequate prenatal care, low birth weight, single parenthood, poverty, and child maltreatment and neglect (Martin et al., 2010).

Researchers found that a majority of sexually active adolescents reported using some method of contraception at first sexual intercourse (79% for female adolescents and 87% for male adolescents) and at last sexual intercourse (84% for female adolescents and 93% for male adolescents; Abma, Martinez, & Copen, 2010). Methods of contraception varied as 95% of sexually experienced adolescents used condoms, 58% used withdrawal, 55% used the birth control pill, 17% used hormonal contraceptive injections, 17% used the calendar rhythm method, 11% used the transdermal contraceptive patch, 11% used the morning-after pill, and 7% used the vaginal contraceptive ring (Abma et al., 2010). In reality, most unintended teenage pregnancies occur because of inconsistent or incorrect use of contraception. Researchers found that the decline in the adolescent pregnancy rate since the 1990s was primarily due to increasing and consistent use of effective contraceptives as well as usage of multiple methods of contraception (e.g., condoms and birth control pills; Santelli, Lindberg, Finer, & Singh, 2007). Delaying sexual activity accounted for a small proportion of the reduction in adolescent pregnancy.

Adolescents are also disproportionately affected by STDs. Researchers have estimated that there are about 19 million new STD infections each year in the United States, and about half of them are among youth (Weinstock, Berman, & Cates, 2004). The most common STDs among youth are human papillomavirus (HPV), trichomoniasis, chlamydia, herpes, gonorrhea, HIV, syphilis, herpes, and hepatitis (Weinstock et al., 2004). STDs often go undiagnosed as many infections are asymptomatic. Nonetheless, infections can still be spread despite the absence of symptoms.

Adolescents are at increased risk of acquiring STDs because of barriers to accessing sexual and reproductive health services, including counseling on risky sexual behavior, contraception and STD prevention services, and STD testing (Rounds, 2004). Barriers to accessing care are due to lack of health insurance coverage, inability to pay, lack of transportation, discomfort with facilities and services designed for adults, fear of seeking care, concerns about confidentiality, and lack of information about services available (Hock-Long, Hercq-Baron, Cassidy, & Whittaker, 2003). In addition, female adolescents are at higher risk for certain STDs because of physiologically increased susceptibility to infection.

Schools play a major role in adolescent sexual and reproductive health. While almost all adolescents in the United States receive formal sex education before 18 years of age, 32% had not received instruction on methods of contraception, 7% had not been taught about STDs, and 11% had not learned how to prevent HIV/AIDS (Martinez, Abma, & Copen, 2010). A national survey of school-based health education courses found that 76% of middle schools and 87% of high schools taught abstinence as the most effective way to avoid pregnancy, HIV, and other STDs; 42% of middle schools and 65% of high schools taught about condom efficacy; and 21% of middle schools and 39% of high schools taught how to use a condom (Kann, Tejlojohann, & Woolley, 2007). Most schools do not provide sexual and reproductive health services, and only 5% of high schools made condoms available to students (Jones, Purcell, Singh, & Finer, 2005).

The Healthy People 2020 objectives to reduce the adolescent pregnancy rate focus on increasing access to sexual/reproductive health care services, abstinence among adolescents, use of condoms and hormonal or intrauterine contraception, receipt of formal education on reproductive health and discussion of sexual/reproductive health topics with parents or caregivers (DHHS, 2011). The STD objectives aim at reducing youth infections of chlamydia, pelvic inflammatory disease, gonorrhea, HPV, and herpes. Finally, the objectives to reduce HIV/AIDS among adolescents relate to increasing usage of condoms, encouraging testing for HIV and increasing receipt of health care and treatment for adolescents with HIV.

**Bullying and Violence**

Youth violence involves a range of harmful behaviors, such as harassment and homicide, which can result in physical injury, psychological distress, and death. Youth are most frequently victimized by their peers. According to data from the National Survey on Health Youth Risk Behavior Survey, 20% of high school students reported being bullied at school, and 5% missed at least one day of school in the past month because they felt unsafe (CDC, 2010). Bullying or harassing behaviors can be physical (e.g., hitting or pushing), verbal (e.g., name calling or threatening), social/relational (e.g., spreading rumors or excluding others), or sexual (e.g., unwanted touching or offensive gesturing). One of the fastest growing forms of bullying is cyberbullying, in which electronic communication technologies such as e-mail, instant messaging, text messaging, and websites are used to harm others (Kowalski, Limber, & Agatston, 2008).

Violence-related behaviors are not confined to schools. Approximately one-third of youth had been in a physical fight in the past year, and 4% of these youth required medical attention (CDC, 2010). In 2009, over
650,000 youth aged 10 to 24 were treated in emergency departments in the United States for injuries caused by violence (National Center for Injury Prevention and Control [NCIPC], 2010). Injuries due to violence frequently involve weapons. Approximately 18% of youth reported carrying a weapon such as a gun or knife at least once in the past month (CDC, 2010). Homicide due to gun violence ranks as the second leading cause of death among adolescents (NCIPC, 2010).

Research demonstrates that environmental factors associated with youth violence include family, peer, school, and community factors (DHHS, 2001; Resnick, Ireland, & Borowsky, 2004). Family risk factors include low parental socioeconomic status, poor family functioning, low parental involvement and attachment, and exposure to family conflict and violence. Being socially rejected by peers, associating with delinquent peers, and gang involvement are also risk factors for violence. Educational risk factors include low academic achievement and school failure. Youth living in socially disorganized neighborhoods, high poverty communities, and areas with limited economic opportunities are at increased risk for violent behavior.

The Healthy People 2020 objectives related to youth violence focus on improving school safety as well as reducing bullying, fighting, and weapon-carrying (DHHS, 2011). Because youth who are lesbian, gay, bisexual, transgender, or queer (LGBTQ) are frequently harassed, one objective advocates that schools prohibit bullying and harassment based on sexual orientation and gender identity.

**Mental Health Problems**

Adolescence is a stressful stage with many psychosocial challenges. Although most youth are able to successfully navigate these challenges and effectively cope, many others experience mental health disorders. Lifetime prevalence data from a nationally representative survey showed that 28% of adolescents aged 13 to 18 had a mental health disorder that severely impaired functioning (Merikangas et al., 2010). Psychological disorders rank as the most costly health problem among youth in the United States (Soni, 2009). If left untreated, mental health problems can lead to school failure, violence, juvenile incarceration, family dysfunction, social isolation, and suicide. Mental health disorders that are of special concern during adolescence include depression, suicide, anxiety, eating disorders, attention-deficit/hyperactivity disorder (ADHD), disruptive behavior disorders, and schizophrenia.

**Depression**

Many youth experience some symptoms of depression. However, depression is not a normal part of adolescents’ psychological experience. Research shows that 12% of adolescents aged 13 to 18 experienced a depressive disorder (Merikangas et al., 2010). The age of onset for adolescent depression ranges from 11 to 14 years, and rates of depression increase significantly from early to late adolescence (Lewinsohn, Rohde, & Seeley, 1998; Merikangas et al., 2010). The course of depressive disorders varies; some youth may only experience one episode of major depression, while others experience chronic low-grade depression or recurrent depressive episodes into adulthood.

**Suicide**

Mental illness is the leading risk factor for youth suicide, with depressive disorders being the most common (Achilles, Gray, & Moskos, 2004). Data indicate that between early adolescence (aged 10–14) and young adulthood (aged 20–24) the suicide rate increased by 10-fold (NCIPC, 2010). Data from the CDC’s Youth Risk Behavior Surveillance 2009 study found that approximately 14% of high school aged adolescents had seriously considered attempting suicide (CDC, 2010). In 2009, over 130,000 youth aged 10 to 24 intentionally harmed themselves to the point that they needed medical attention (NCIPC, 2010). Suicide is the third leading cause of death for youth (NCIPC, 2010).

**Anxiety disorders**

Momentary experiences of fear, worry, shyness, nervousness, and anxiety are normal during adolescence; however, excessive and debilitating anxiety is a symptom of an anxiety disorder. Anxiety disorders are the most prevalent mental health problem among adolescents; 32% of youth aged 13 to 18 have an anxiety disorder (Merikangas et al., 2010). The most common anxiety disorders among adolescents include a specific phobia (e.g., fear of heights), social anxiety disorder, separation anxiety disorder, and posttraumatic stress disorder. Most cases of anxiety disorders during adolescence began during childhood and often persist into adulthood, as anxiety disorders tend to be chronic.

**Eating disorders**

The average age of onset for eating disorders (i.e., anorexia and bulimia) occurs during late adolescence (Hudson, Hiripi, Pope, & Kessler, 2007). Research also shows that 3% of youth aged 13 to 18 have an eating disorder, and female youth are disproportionately affected (Merikangas et al., 2010). If left untreated, eating disorders can become chronic and pose serious threats to health and well-being. Anorexia has the highest mortality rate of any psychological disorder (Hudson et al., 2007).
ADHD

ADHD is often viewed as a childhood disorder; however, a majority of youth diagnosed with ADHD in childhood will continue to meet diagnostic criteria into adolescence (Wolraich et al., 2005). ADHD is characterized by (1) inattention, poor concentration, and disorganization, and/or (2) hyperactivity and impulsive behavior. A nationally representative survey reported that 9% of youth aged 13 to 18 had ADHD (Merikangas et al., 2010).

Although most mental health disorders entail a genetic predisposition, environmental stressors often trigger their onset. Environmental risk factors for adolescent mental health problems include family, peer, school, and situational factors (DHHS, 2000a). Family risk factors include family dysfunction and conflict, poor parent-child relationship, parental history of psychopathology or criminality, and coming from a low socioeconomic background. Peer and school risk factors include bullying or peer harassment, peer rejection, association with delinquent peers, frequent change in school, and low academic achievement. Exposure to traumatic and/or acute stressful life events, such as the death of a family member or friend, divorce, child abuse/maltreatment, exposure to violence, and natural disasters also put youth at risk for mental illness.

The Healthy People 2020 objectives related to adolescent mental health problems aim at reducing depressive episodes, disordered eating behavior, and suicide attempts (DHHS, 2011).

Substance Use

Experimentation with alcohol, tobacco, and drugs is fairly common among adolescents. However, while some youth only experiment with or occasionally use various substances, others use substances on a regular basis and may develop dependence or addiction. Rates of drinking alcohol, smoking cigarettes, and using illicit drugs more than double between 8th and 12th grade (Johnston, O'Malley, Bachman, & Schulenberg, 2011). Indeed, substance use rates climb dramatically during adolescence and peak between late adolescence and early adulthood (aged 18 to 25; Substance Abuse and Mental Health Services Administration [SAMHSA], 2008).

Alcohol

Alcohol is the most commonly used substance among adolescents. According to a national survey of high school aged youth, 73% had drunk alcohol and 24% reported binge drinking (i.e., consumed five or more drinks of alcohol during a single occasion; CDC, 2010). Alcohol use among youth is associated with accidental injuries, academic problems, delinquency, and violence (SAMHSA, 1999).

Tobacco

Every day in the United States, about 4,000 adolescents try their first cigarette (SAMHSA, 2007). Among high school students, 46% had tried cigarette smoking, 14% had smoked cigars, and 9% had used smokeless tobacco (i.e., chewing tobacco, snuff, or dip; CDC, 2010). Youth make up the largest proportion of new smokers, and the younger people begin smoking, the more likely they are to become addicted to nicotine (DHHS, 2000b).

Drugs

Many adolescents experiment with and use drugs. Marijuana is the most commonly used illicit drug among youth. Among high school aged youth, 37% had used marijuana, 7% had used ecstasy, 6% had used cocaine, 4% had used methamphetamine, 3% had used heroin, and 3% had used steroids not for medical reasons (CDC, 2010). Nearly one-quarter (23%) of high school students were offered, sold, or given illegal drugs by someone at school (CDC, 2010). While rates of illicit drug use among youth have dropped slightly in the past decade, illicit use of prescription drugs increased slightly (Johnston et al., 2011). Approximately 15% of adolescents reported that they had used a prescription drug without a doctor's permission. The most commonly abused prescription medications among youth include pain relievers, sedatives, tranquilizers, amphetamines, narcotics, stimulants, and depressants. Adolescents also misuse over-the-counter medications, such as cold and cough medicines (National Institute on Drug Abuse, 2005).

The Healthy People 2020 objectives related to adolescent drug use aim at reducing use of illicit drugs, prescription drugs, steroids, and inhalants as well as broadening perceptions about the risks of substance abuse and increasing disapproval of substance abuse among adolescents (DHHS, 2011). The alcohol objectives focus on reducing binge drinking and riding with drivers who had been drinking. The tobacco-related goals for adolescents intend to reduce tobacco use, initiation of tobacco use, exposure to secondhand smoke, exposure to tobacco advertisements, and sale of tobacco products to minors. Objectives concerning schools advocate for tobacco-free schools and reducing drug exchanges at school.

Motor Vehicle Injury

Motor vehicle accidents are the leading cause of death for adolescents (NCIPC, 2010). The risk of having a motor vehicle accident is higher among adolescents than any other age group (Insurance Institute for
Highway Safety [IIHS], 2009). In 2009, over 430,000 youth aged 15 to 20 were treated in emergency departments in the United States for injuries caused by motor vehicle accidents (NCIPC, 2010). In addition, recent mortality data indicate that every day in the United States there are about a dozen motor vehicle-related deaths among adolescents.

High rates of motor vehicle injury among youth are attributed to lack of driving experience and lack of maturity. Adolescents’ lack of driving experience makes it difficult for them to recognize, assess, and respond to dangerous or hazardous situations (McCarr, Mayhew, Braitman, Ferguson, & Simpson, 2009). The risk of motor vehicle crash is particularly high during the first months that adolescents are licensed to drive (Mayhew, Simpson, & Pak, 2003; McCarr, Shabanova, & Leaf, 2003). Peer influences are also significant. Research shows that the presence of other adolescent passengers increases the risk of motor vehicle accident, and risk increases with the number of adolescent passengers (Chen, Baker, Braver, & Li, 2000). Finally, motor vehicle-related injury and death among youth are highest during the summer months, the weekend (Friday, Saturday, and Sunday), and nighttime (6:00 p.m. to 3:00 a.m.; IIHS, 2009).

Risky driving behaviors are also associated with motor vehicle accidents. Compared to other age groups, adolescents have the lowest rate of seat belt use; in one survey, 20% of drivers aged 16 to 24 were observed not wearing a seat belt (National Highway Traffic Safety Administration [NHTSA], 2009). Similarly, 10% of high school-aged youth never or rarely wore a seat belt when riding in a car (CDC, 2010). Adolescent drivers are also more likely to speed and tailgate (McCarr et al., 2009). Emerging research on distracted driving among youth showed that cell phone use increased the likelihood of motor vehicle injury (Neyens & Boyle, 2008), and 82% of adolescent drivers surveyed reported driving while using a cell phone (Allstate Foundation, 2009). There is also a strong connection between alcohol use and motor vehicle injury. In 2009, approximately one-quarter of adolescent drivers aged 15 to 20 involved in fatal car crashes had been drinking alcohol (NHTSA, 2011).

The Healthy People 2020 objectives related to motor vehicle accidents intend to reduce injuries and deaths as well as increase use of restraints (DHHS, 2011). The objectives also advocate for effective statewide graduated drivers’ licensing programs.

Comorbidity

Health risk behaviors and problematic outcomes are not isolated phenomena in the lives of adolescents. Researchers have demonstrated the interrelatedness of many adolescent health problems. For example, adolescent obesity is associated with both depression and oppositional defiant disorder (Mustillo et al., 2003). Risky sexual behavior among youth is associated with psychological problems and substance use (Elkington, Bauerschmeier, & Zimmerman, 2010). Approximately 22% of sexually active youth had used alcohol or drugs before last sexual intercourse (CDC, 2010). There are also relationships between violence and sexual/reproductive health. For one, sexual assault is a form of violence, and 11% of young women and 5% of young men reported that they had been forced to have sexual intercourse (CDC, 2010). Violence also often occurs in the context of a romantic relationship, as 10% of youth reported that their boyfriend or girlfriend had physically abused them (CDC, 2010). Youth violence is associated with psychological problems, risky sexual behavior, substance use, and risky driving behavior (DHHS, 2001). The co-occurrence of mental health disorders and substance use is also common. It is also not uncommon for youth to have co-occurring psychological disorders, as 40% of adolescents with a psychological disorder reported more than one class of disorder (Merkangas et al., 2010). Finally, the causal relationship between substance use and motor vehicle injury is substantial. Understanding the relationships among adolescent health problems and shared risk factors will assist public health social workers in the development of comprehensive and effective prevention and intervention programs.

ADOLESCENT HEALTH DISPARITIES

Health disparities are significant differences in health risk factors, rates of disease prevalence, and mortality among population groups. These disparities may vary by many factors. By understanding health disparities, public health social workers can design and target interventions that are evidence-based and culturally appropriate for those who are most at risk.

Although biological factors may account for some differences in health conditions for certain population groups, the socioecological systems model emphasizes understanding the interactions among individual and environmental factors in determining health status. Health disparities among minority groups, including racial/ethnic minorities, women, sexual minorities, and gender minorities may be due to sociocultural forces such as historical and continuing patterns of disenfranchisement and institutional discrimination. Minority groups not only systems of oppression not only at the societal level, such as racism, ethnocentrism, classism, sexism, and heterosexism, but other prejudice, biases, and stereotypical assumptions held by individuals, including health providers. In addition, the stress of belonging to a socially stigmatized group may affect well-being.
American Indians, African Americans, and Hispanic/Latino Americans are disproportionately at risk for obesity, STDs, teen pregnancy and childbirth, violence, mental health problems, substance use, and motor vehicle injury. Many of these youth live in communities with few resources but numerous environmental hazards. Disparate health outcomes exist for refugee and immigrant youth, which may be due to stressful migration journeys, acculturation, citizenship status, poverty, and lack of culturally sensitive services.

Differences in health outcomes among population groups are often mediated by socioeconomic status. Youth from families and communities with low socioeconomic status likely have more limited access to health insurance, preventive services, and treatment. In addition, the stress associated with living in poverty and in unsafe and hazardous environments likely threatens well-being.

In terms of gender, young women are disproportionately at risk for sexual and reproductive health issues, as well as internalizing psychological problems. This may be due to sociocultural gender stereotypes. On the other hand, male youth experience disparate levels of violence, externalizing psychological problems, and motor vehicle injury, which may be due to higher levels of risk taking among male youth and sociocultural gender expectations.

Geographic differences in health outcomes also exist which may be related to regional culture or to state-level policies and programs. For example, youth living in rural and urban areas often experience more health problems than their suburban counterparts. These disparities may be attributed to poverty, environmental hazards, and barriers to accessing health care services. Health disparities exist among states as well as geographic regions (i.e., the North, South, Midwest, and West), which may be due to state-level policies and programs impacting health as well as sociocultural factors. Indeed, one's culture has a significant influence on health in terms of sociocultural ideals and preferences, as well as normative behaviors and activities.

**PUBLIC HEALTH SOCIAL WORK PRACTICE IN ADDRESSING ADOLESCENT HEALTH PROBLEMS**

Public health social workers use a preventive, evidence-based, socioecological systems approach to develop, deliver, and evaluate interventions at the program, community, and policy levels to address adolescent health problems. This approach aligns with the core public health functions of assessment, policy development, and assurance (Institute of Medicine, 2002). In order to fulfill these functions, public health social workers perform the following services (Core Public Health Functions Steering Committee, 1994): (1) monitor, identify, and investigate community health problems; (2) mobilize community partnerships to understand and solve health problems; (3) advocate for policies that promote health and well-being; (4) provide health services and implement intervention programs; (5) promote access to health care services; (6) inform, educate, and empower individuals, groups, and communities about health issues; and (7) evaluate the efficacy, accessibility, compatibility, and quality of health services, programs, and policies. Social workers participating in core public health functions need to master a range of competencies. These include having knowledge and skills in collecting, analyzing, and interpreting epidemiology and other data; designing and conducting needs assessments; program planning, implementation, and evaluation; and critically assessing the impact of policies and developing and advocating for policies that promote the health of the public. Equally important are competencies in leading, partnering, and communicating with multiple disciplines and community stakeholders, working in a culturally competent manner, and building coalitions among diverse groups. Public health social workers are guided in their practice by the National Association of Social Workers’ Code of Ethics and the American Public Health Association Creed.

The following case study illustrates how a social worker could use the public health social workers standards and competencies to actualize core public health functions to address teen pregnancy. Discussion questions are listed at the end of the case study. A number of websites that provide current data and statistics on adolescent health as well as effective, evidence-based health interventions for youth are listed in Appendix B at the end of this book.

**Case Study**

The health director at the Sunny County public health department has asked the lead public health social worker to develop a project to address the county's teen pregnancy problem. The county reportedly has one of the highest teen pregnancy rates in the state. To initiate this project the public health social worker examines the most recent teen pregnancy statistics for the county and finds that in 2010 there were 110 pregnancies for every 1,000 young women aged 15 to 19, that the county had the third highest teen pregnancy rate in the state, and that the rate has been trending upward. Through her initial fact finding, she discovers that for the past 3 years, the county public health department has missed the opportunity to apply for and receive $225,000 of funding ($75,000 per year) from the state department of health and human services. These grants could have
been used for pregnancy prevention awareness campaigns, as well as programs to deliver direct services to prevent teenage pregnancy. In addition, she learns that the school district for the county has an abstinence-only until marriage sex education policy.

The public health social worker creates a teen pregnancy prevention task force composed of colleagues at the health department and community stakeholders who provide services to teens. She contacts a number of community-based organizations that work with teens to ask for representatives to serve on the task group. These organizations include a youth development organization serving at-risk teens, a nonprofit organization that provides family planning and reproductive health care services, parent-teacher associations and the school board, the department of social services, the local association of family and pediatric physicians, and faith-based organizations in the area. The group is tasked with investigating the problem and developing a plan for reducing adolescent pregnancy in the county. The public health social worker's role is to facilitate meetings, staff the task force, and keep the health department director and board updated on the group's findings and progress.

In the initial meetings of the task force, members produce a plan to systematically collect data to better understand the underlying risk factors contributing to the rate of teen pregnancy, as well as protective factors that may prevent teen pregnancy in their community. The task force decides to conduct a needs and resource assessment with the community. Given the resources available and the sensitive nature of the problem, the task force decides to design a series of focus groups composed of stakeholders to assess needs and resources. For maximum participation, stakeholders are invited to attend groups based on commonality (e.g., there is a focus group for youth, one for parents, one for educators, health care providers). Participants in the focus groups are asked about their concerns regarding the high teen pregnancy rate; the effects of teen pregnancy on teens, families, and their community; their theories about causes of the high teen pregnancy rate; ideas as to how to reduce the teen pregnancy rate; and strengths and resources in the community for designing interventions to address this problem.

Following the conclusion of the focus groups, the public health social worker analyzes and summarizes the data and presents them to the task force. After several meetings, during which the task force members discuss and interpret the findings, the public health social worker leads the group in identifying intervention targets. The task force members decide to focus on advocating for changes in policy on sex education in the schools, developing a community awareness campaign, and seeking funds for a pilot program targeted at teens at high risk for becoming pregnant. Because the task force has identified the school district's outdated abstinence-only sex education policy as one of the risk factors, the public health social worker researches laws and policies related to school-based sex education in the state. She contacts the statewide adolescent pregnancy prevention coalition to learn about existing efforts to advocate for comprehensive sex education policies for schools. She invites the coalition to meet with the task force to present available resources for a community awareness campaign and to discuss ways that the two groups might partner to maximize resources.

The public health social worker researches and identifies effective, feasible, and compatible evidence-based program interventions to prevent adolescent pregnancy, which she presents to the group. To identify intervention programs, the public health social worker searches a number of websites cataloging effective adolescent pregnancy prevention programs: Advocates for Youth, National Campaign to Prevent Teen and Unplanned Pregnancy, Teen Pregnancy Prevention Programs for Replication, and Resource Center for Adolescent Pregnancy Prevention. The public health social worker facilitates meetings and works with the task force to come to a group consensus concerning programmatic recommendations for implementation.

After considering several intervention programs, the task group decides that a community-based health center intervention that is educational, behavioral, and psychosocial would be best for the county given the nature of the community, resources available, and level of intervention. The public health social worker recommends adapting the program slightly so that it is developmentally and culturally appropriate for the target population in the county. The task force decides to implement the program as a pilot for 1 year, with the possibility of extension if it is feasible and effective. Once the task force has agreed upon an approach, the public health social worker takes the lead in writing a teen pregnancy prevention grant proposal to obtain funding from the state department of health and human services. If funded, the public health social worker will take the lead in coordinating the design, implementation, and evaluation of the program. This will involve extensive partnering with community partners and stakeholders, many of whom serve on the task force or have been involved in the initial focus groups.

Questions for Discussion:

1. Identify the core public health functions and services that the public health social worker in the above case is involved in providing.
2. What public health social workers competencies (knowledge, skills, and values) does the public health social worker need to successfully engage the community in addressing the rising teen pregnancy rates in the county?
3. Select another adolescent health issue discussed in this chapter. Using websites listed at the end of the chapter, describe the prevalence of the problem nationally and in your geographic area. Are there disparities among groups in the prevalence of this problem? If so, describe what they are. What Healthy People 2020 objectives address this problem? If you were the public health social worker assigned to address this problem in your community, what steps would you take? Be specific in identifying community stakeholders that you would involve and how you would partner with these groups; how you would collect data to adequately describe the problem and the risk and protective factors associated with the problem; and sources for evidence-based interventions at the policy, community, and programmatic level.

EMERGING ISSUES IN ADOLESCENT HEALTH

There are a number of unfolding issues that will affect adolescent health in the coming decades. Unlike previous generations, today’s youth are growing up in a media-saturated age. While traditional forms of media (i.e., television, video games, movies, and magazines) will continue to influence adolescents, newer forms of media (i.e., smartphones and the Internet) increasingly play a major role in the everyday lives of youth in the United States. These technologies will affect the physical, mental, social, and sexual health of adolescents. In terms of health promotion, public health social workers can use these technologies to provide health education and to design interventions that are innovative and appealing to youth.

The adolescent population is also becoming increasingly diverse, underscoring the importance of culturally competent health professionals and interventions. According to population projections, Hispanic/Latino, African American, Asian, and multicultural populations will increase their proportions of the total population in the coming decades (U.S. Census Bureau, 2008). In addition, the decrease in sexual stigma in the United States has corresponded with more youth coming out as LGBTQ. Also, research findings report that the average age of coming out as gay or lesbian has fallen in recent decades, from 16 to 21 years of age (Savin-Williams, 2006). Recently, there has been growing attention focused on transgender and intersex youth. Although the research literature on these populations is scant, evidence exists that these youth face a number of problematic physical and mental health challenges.

Finally, there has been a dramatic increase in the rate of autism since the 1990s. Research shows that on average one in 110 children has an autism spectrum disorder (Autism and Developmental Disabilities Monitoring Network Surveillance Year 2006 Principal Investigators, 2009). After completing high school, support services for many adolescents with autism are dropped (Taylor & Seltzer, 2011). Public health social workers can help ensure that this growing population receives needed services to transition from adolescence into adulthood, including case management, mental health and medical services, and vocational and housing support.

SUMMARY

In this chapter we provided an overview of critical health problems and issues that public health social workers need to know in order to effectively promote adolescent health in their communities. For each critical health issue, we examined the prevalence, health disparities, and risk factors and discussed Healthy People 2020 objectives that address the health problem or issue. We presented a case study that illustrates the use of core public health functions by a public health social worker addressing an adolescent health issue at the county level. We concluded by presenting emerging issues, such as the influence of new media technologies on adolescent health behavior and the growing diversity in the adolescent population that are shaping public health social workers practice with adolescents.

INTERNET RESOURCES FOR EFFECTIVE ADOLESCENT HEALTH INTERVENTIONS

Advocates for Youth
(www.advocatesforyouth.org/for-professionals/programs-that-work)

Center for Mental Health in Schools
(http://smhp.psych.ucla.edu/)

Centers for Disease Control and Prevention Violence Prevention
(www.cdc.gov/ViolencePrevention/suicide/prevention.html)

Guide to Community Preventive Services
(www.thecommunityguide.org/adolescenthealth/index.html)

Konopka Institute for Best Practices in Adolescent Health
(www.med.umn.edu/peds/ahm/programs/konopka/konopkapubs/home. html)


