



A Brief Overview

This paper provides research-based information on youth friendly clinical services – specifically for family planning clinicians and other professionals who provide health care for youth – and offers an overview of the recent medical and public health literature regarding key components of youth friendly clinical services. Confidentiality, respectful treatment, integrated services, culturally appropriate care, free or low cost services, and easy access: these are all widely recognized as important components of appropriate clinical services for adolescents and young adults. However, this section reviews and highlights aspects and nuances of these components that may be little known to clinicians and staff but that are essential to ensuring that services are youth friendly. As such, this information may challenge users to reflect on their personal knowledge, attitudes, and behaviors as well as on the protocols and practices in use at their clinic.

This section also considers the key components of youth friendly clinical services that are especially important to specific groups, including younger or older youth; pregnant and parenting adolescents; ethnic minority youth; gay, lesbian, and bisexual (GLB) adolescents; sexual assault survivors; and HIV-positive youth. In addition, one section specifically addresses reproductive and sexual health care. The final sections highlight recent research on: 1) providing services for young men; and 2) promoting parent-child communication on sexual health and other sensitive issues. Each of the nine sections concludes with recommendations derived directly from the research findings presented here.

Health Care Professionals' Core Values Promote Youth Friendly Clinical Services

Health care professionals, whether physicians, nurses, physician assistants, pharmacists, or allied health practitioners, all operate under certain core values:

- **Beneficence** means that the provider will: 1) act in the best interests of the patient and his/her welfare; and 2) fulfill the basic obligation to do no harm.
- **Justice** underlies the principle of nondiscrimination.
- **Respect for autonomy** is at the heart of the obligation to obtain informed consent and to respect the confidentiality of the client.¹

These three values are inherent in *everything* that contributes to youth friendly clinical services.

Confidentiality

Confidentiality means that the provider keeps an adolescent's sensitive health care issues in strict confidence between the adolescent and the provider. The imperative need to guard the adolescent's confidentiality extends, as well, to every member of the clinic's staff, including receptionists and technicians.

Minors' Rights to Confidential Services*

Even though laws guarantee minors' right to receive certain confidential services, adolescents (and health care providers) are not always clear about the extent of these rights.

- Every state and the District of Columbia guarantees confidentiality for adolescents seeking testing and treatment for sexually transmitted infections (STIs). Eleven states require that the minor be at least a certain age (generally 12 or 14). In addition, 31 states explicitly include HIV testing and treatment in the package of STI services to which minors may consent.²
- Twenty-five states and the District of Columbia allow **all** minors (ages 12 and older) to consent to contraceptive services. Twenty-one states allow only certain categories of minors to consent to contraceptive services. Four states

- have no relevant policy or case law.³
- Regardless of their age or state law, clients of clinics that receive funding through Title X of the Public Health Service Act have federally guaranteed confidentiality for contraceptive services.^{4,5}
- Some states give doctors the **option** of informing parents that their minor son or daughter is seeking health care related to sexual activity, substance use, or mental health. However, the laws in these states leave the decision to the physician.⁶
- Every jurisdiction requires clinicians to report to legal authorities when they believe that a minor has been sexually or physically abused. In a few jurisdictions, the fact that an underage client has had sex is considered proof of statutory rape, creating a serious dilemma for clinicians and their under-age patients.⁷
- All Planned Parenthood clinics provide confidential contraceptive and STI services for minors. When required by state law, some clinics must notify a parent or get parental consent before providing abortion services to minors.⁸

Adolescents' Understanding of Confidentiality

Studies show that teens have generally been unsure that their confidentiality will be guarded, even when it is guaranteed by law.

- One study found that adolescents knew far less about the **protections** than **the limits** of confidentiality. In fact, clinicians' explanations of the exceptions under which they would break confidentiality made adolescents wary of their assurances of confidentiality.⁹
- Adolescents usually trusted their doctor to maintain their confidentiality. However, many youth worried that receptionists, technicians, and nurse assistants might be careless with their medical records and, thus, their confidentiality.^{10,11}
- In one study, **88** percent of teens thought it was extremely important that clinic staff kept their business private from the teens' *acquaintances*. Far fewer, but still a majority, (**60** percent) thought it was extremely important that clinic staff kept their business private from parents and family. In fact some adolescents, especially young men, worried that faculty, staff, and other students might learn about it if they sought STI testing and treatment at a school-based health center (SBHC).¹¹
- Several studies found that adolescents trusted pharmacists to protect their privacy and to give them the information they needed.¹² Yet, a study in Indiana found that from nine to 11 percent of pharmacists would contact a **parent** before dispensing contraceptives, if the prescription was presented by a 14-year-old.¹³
- Nearly half (47 percent) of surveyed pharmacies lacked private space for confidential discussions with clients. Only 23 percent of pharmacists thought that they had been well trained on adolescent confidentiality. Only seven percent thought they had been well trained on adolescents' right to consent to services.¹³

Loss of Confidentiality Is Costly to Youth and Society

- One study in Texas found that the potential outcome of a loss of confidentiality could be an additional 11 pregnancies, seven births, and two abortions for every 100 teenage females currently receiving confidential reproductive health services. Researchers also predicted an additional three untreated cases of chlamydia, one untreated case of gonorrhea, and one additional case of pelvic inflammatory disease (PID) among every 100 adolescent females in the state.¹⁴
- Nearly one in four sexually active adolescents enrolled in one health maintenance organization (HMO) was likely to use out-of-plan care because of a desire for confidentiality. Teens who went out-of-plan for services were also more likely to be sexually active, use alcohol, and live outside their home. They were in more danger of serious negative health outcomes than were teens who used only in-plan services, both because of their risk behaviors and also because of the fragmented and non-comprehensive care they got by going out-of-plan.¹⁵
- One statewide study found that 86 percent of adolescent female family planning clients would be willing to use all the *confidential* sexual health services offered at local clinics. At the same time, 83 percent would stop using some or all sexual health services if their parents were to be notified. Some 57 percent would stop using prescription contraceptives and begin using condoms instead. Twenty-nine percent would have unprotected sex. About six percent

- would delay testing or treatment for HIV and other STIs. Only **one percent** would stop having sex.¹⁶
- A nationally representative study of foregone health care in adolescents found that 14 percent of youth did not get the care they needed out of concerns about confidentiality. These youth were at increased risk for real health problems because those who failed to get needed health care often also participated in health risking behaviors.^{17,18}
- Studies also found that teens who had no opportunity to talk alone with their provider (without their parents present) were *unlikely* to bring up sensitive concerns or to admit to risk-taking behaviors.¹⁹

Recommendations on Confidentiality

1. Make sure that staff has a clear understanding of the state's laws on informed consent and confidentiality in regard to: a) contraceptive services; b) STI testing and treatment; c) HIV testing and treatment; d) substance abuse treatment; and e) mental health care. [Learn about consent and confidentiality laws in your state.](#)
2. Train **all** clinic staff about the importance of guarding adolescents' confidentiality. Make sure that receptionists, medical assistants, technicians, and clinicians understand how sensitive youth may be to any incident of carelessness with regard to their medical record, name, appointment, test results, and/or the reason they are seeking care.
3. Emphasize the protections of confidentiality. In focus group research, youth recommended that clinicians consider saying, "I promise ..." and that clinicians avoid using the word 'except'. They also recommended that clinicians explain the limits of confidentiality as a matter of caring rather than of law. For example, *"I hope you would discuss things like feeling suicidal or being abused with me because these are really serious and I would want to help you and get others to help you, too."*⁹
4. When any teenage client is accompanied to the clinic by a parent or guardian, make sure **always** to have counseling time **alone** with them. Experts suggest explaining to parents that: a) this time alone with the teen is necessary to ensure that he/she has no unaddressed health problems or concerns; and b) it is as important to guard the teen's confidentiality as to guard the parent's.
5. Be willing to treat unaccompanied minors (those who come into the clinic or practice without a parent).
6. Refer a minor to a pharmacy where her/his confidentiality will be respected and where the pharmacist will call the clinician (not the parents) with questions about a prescription.
7. Remember that some populations of youth need **extra assurances** of confidentiality:
 - **HIV-positive youth** have a critical need for assured confidentiality, especially in regard to their HIV status. They are often fearful of being rejected by family and friends if their status becomes known.^{20,21}
 - **Older youth** may be particularly concerned about confidentiality. For older adolescent females, this may relate to their increasing autonomy from the family. For older adolescent males, this may relate more to their need to conceal vulnerability from their peers than to concerns about their parents.
 - **Gay, lesbian, bisexual, and transgender youth** can be especially concerned about confidentiality regarding their sexual orientation or gender identity. They may be put in considerable danger by being deliberately or accidentally 'outed'.²²
 - **Pregnant and parenting teens** may worry that clinic staff isn't careful with their privacy. "They have your file just laying there. Anyone can read [it]."¹⁰ These young women are already under considerable stress and may discontinue or delay care if their confidentiality is not assured.
8. Some research has examined the value of involving young people in clinic operations. One study on "peer providers" in family-planning clinics showed that teens may feel more comfortable talking about reproductive health issues with other teens and may be more likely to absorb reproductive health messages from other teens. However, it is important to carefully weigh the benefits of having teens in a clinic environment, especially as it relates to preserving confidentiality.
9. In areas – both rural and urban – where clients may know peer educators, clinics could inadvertently compromise a client's confidentiality. Consider ways to involve teens through focus groups, as outreach workers, as members of advisory councils, and as media spokespeople.

Respectful Treatment

Adolescents are particularly sensitive to rude, judgmental, or overbearing attitudes and behaviors on the part of adults. In fact, such attitudes and behaviors can cause adolescents to:

- Leave the clinic before they get the care they need;
- Fail to comply with treatment requirements (such as taking medicine on time, getting physical therapy, etc.); and/or
- Refuse or forget follow-up care.

Disrespect Doesn't Help

Sometimes, well-meaning adults feel a need to express disapproval of adolescents' behaviors, even though such expression is entirely inappropriate in a health care setting. Any youth who has come in for health care deserves respectful treatment. As one teen said about rude comments, *Whether or not you approve, I'm still pregnant. So how is your disrespect going to help the situation?*¹⁰

- A qualitative study among pregnant and parenting teens found that they had a keen awareness of when they were being respected, listened to, and taken seriously. Some told about times when they were treated rudely by clinicians who dismissed their concerns, said highly inappropriate things, and/or failed to answer their questions.¹⁰
- Some studies reported "being afraid of what the doctor would say" as a barrier to care for adolescents. At least some of this fear was of being scolded, put down, or demeaned. In fact, studies showed that fear of being embarrassed was a major deterrent to teens' seeking important health care, including testing for STIs.^{17,23,24}
- Providers have often felt uncomfortable discussing sexual health with adolescents. Yet, studies have shown that youth **want** to discuss sexual health, STI prevention and testing, and/or birth control with their clinician.^{23,25} However in one study, only three percent of teens brought up a sensitive subject on their own if the provider did not do so.²⁶
- One study found that staff's judgmental attitudes about HIV-infected young women's not adhering closely to their treatment regimen created a significant barrier to the teens' continuing treatment.²¹
- Whereas youth in their early teens often preferred to have their parents present during a physical examination, high school youth were much more likely to prefer their parents' absence. In particular, teens with high stress or who used alcohol, tobacco, or other drugs usually preferred being examined alone. Young women who had been physically or sexually abused, were sexually active, or were seriously depressed were most likely to prefer being examined without a parent present.¹⁹
- In one study, 43 percent of women ages 25 and under said that they would be by the presence of a chaperone during a pelvic examination. Most did *not* want a chaperone present during examination by a female doctor. However, most *did* want a chaperone present during examination by a male doctor.²⁷
- For gay, lesbian, and bisexual youth, barriers to care included the fear that disclosing their sexual orientation would provoke judgment and discrimination from providers and staff.^{22,28}

Recommendations regarding Respectful Treatment

1. Make sure that every staff member – from clinicians to receptionists – receives training in adolescent development and in treating youth respectfully. Retrain anyone who treats adolescents and young adults with less dignity and respect than is shown to older clients.
2. Schedule slightly longer visits with adolescents than adults so youth have time to ask questions and to get answers to their questions. Remember that just because an issue is not clinically significant **doesn't** mean it is not important to the youth who is asking about it.
3. Train all clinicians in how to raise sensitive issues, such as sexual health, condom and contraceptive use, substance use, interpersonal violence, and mental health.
4. Treat every youth as a whole person. Involve the adolescent in his/her own health management. Remember that adolescence is a time when independence is increasingly important. Youth will appreciate and respond positively to being treated with dignity.
5. Always ask the adolescent if she/he wants a chaperone present during an examination.
6. Explain the reason for a particular test and what is involved. Be gentle when performing the test, whether it is a Pap smear, a testicular exam, drawing blood, or any other procedure that may make teens feel uncomfortable, wary, or

fearful.

7. Be aware that some populations of youth are particularly sensitive to disrespectful treatment:

- **Pregnant and parenting teens** have many fears and worries. They are often scared about: being examined; the pain of delivery; having a secure place to live with the baby; being a good parent; and finishing school, among other things. They need reassurance and emotional support from clinicians and staff.
- **Gay, lesbian, and bisexual youth** can be upset by heterosexist assumptions on the part of the clinician or staff. Avoid assuming that all youth are heterosexual. Train all clinicians regarding sexual orientation so that they know to **avoid**:
 - Saying that a teen who has acknowledged being gay, lesbian, or bisexual is ‘just going through a phase’;
 - Confusing sexual orientation with sexual behaviors;
 - Stigmatizing a teen’s sexual orientation; or
 - Associating sexual orientation with risk or safety regarding STIs or pregnancy, domestic violence, or any other issue that youth may face.[22,28](#)
- **HIV-positive youth** struggle with all the developmental issues facing any teen. In addition, they may be overwhelmed, when first diagnosed, with fears about the future, dying, maintaining relationships, establishing intimacy, being abandoned by family and friends, and being stigmatized.[20](#) Then too, taking a lot of medications is often difficult for youth who are balancing the normal developmental tasks of adolescence with social life and peer relationships. So being patient, positive, and nonjudgmental is particularly important to assuring they continue with the health care they need.[20](#)
- **Ethnic minority youth** are justly sensitive to discourtesy. A recent review found that providers may (intentionally or unintentionally) act differently according to the client’s ethnicity. These providers may base their actions on stereotyped beliefs about youth’s fundamental values, competence, and deservedness. Clinicians must question their own assumptions regarding youth of an ethnicity different to their own because there is substantial evidence that providers’ beliefs, expectations, diagnoses, and treatment are influenced by the race/ethnicity of clients.[29](#) [See the recommendations regarding cultural competence, later in this paper.]
- **Youth who are survivors of sexual or physical assault** are particularly vulnerable to any disrespect because of the traumatic event(s) they have endured. Young women may blame themselves. Young men may question their own masculinity. Respectful treatment is imperative at this time in the life of the adolescent or young adult survivor.

Integrated Services

Integrated care allows youth to obtain different services in a single location. Often known as ‘one-stop shopping’, integrated care is important to young men and women.

Adolescents Need Comprehensive Care

Ideally, integrated services offer a multidisciplinary, holistic approach, including primary care, reproductive and sexual health care, STI/HIV testing and treatment, substance abuse treatment, mental health care, and education and counseling.

- According to research, youth have often felt anxious to receive services in a setting that would not stigmatize them. Integrated service settings, such as school-based health centers, college and community health centers, and adolescent clinics, felt safe to these youth because just coming in did not expose what services they were seeking. This was a particular concern to young men and to youth in need of mental health care.[30,31,32](#)
- In studies, older adolescent males were less likely than their female peers or younger males to have a regular source of care, less likely to know where to go for health services, and more likely to be uninsured and to use the emergency department for urgent care.[33,34](#)
- Many urban minority youth utilized school-based health centers for medical and mental health care.[35](#) In fact, research showed that school-based health centers see the largest proportion of teenage males, far more than any other adolescent specific site.[32](#)
- Studies showed that young men have often gone without needed health care. In fact, male college students have

frequently presented to student health services for 'evaluation of acute conditions with alarming and long-neglected precursors'.³⁶

- The greatest barriers to male college students' seeking care have been their need to be independent and a need to conceal their vulnerability.^{30,36} Integrated services allow young men to seek care for sensitive issues without their peers' becoming aware of the specific service they sought.
- A nationally representative survey found that emotionally distressed black youth were significantly *less likely* to have received psychological counseling than their white or Hispanic peers.³¹ Another study found that suicidal adolescents, ages 18 and older, were significantly *less likely* to have received counseling than were youth ages 13 and younger.³⁷ Moreover, Asian youth were also *less likely* to have received counseling than were white youth.³⁷
- Analysis of data from the National Ambulatory Medical Care Survey found that U.S. adolescents received far less preventive counseling during office visits than has been recommended by prominent medical associations. On average, adolescent visits lasted only 16 minutes.
 - Sixty-one percent of visits included *no* preventive counseling.
 - Less than 15 percent included counseling on injury prevention.
 - Only eight percent included counseling on family planning or contraception.
 - Only five percent included counseling on preventing HIV and other STIs.³⁸
- For years, sexually active adolescent and young adult females (ages 15 through 24) have had the highest rates of chlamydia and gonorrhea of any age group in the United States. Yet, data have shown that only about 22 percent of female health plan members ages 16 to 20 received annual screening for chlamydia. Data also showed that only five percent of all U.S. women under age 25 and only four percent of all 15- to 19-year-old women have been screened for STIs.²³
- Several studies found that poor communication with providers kept adolescents from seeking or continuing the care they needed. Many clinicians' discomfort with and lack of training to address sexual health and other sensitive issues resulted in lost opportunities to discuss these issues openly and honestly with adolescents and, thus, in lost opportunities for testing and treatment as well.^{21,22,24,25,26,28,38,39,40,41}
- One study found that, among high school students who had a routine check-up, only 43 percent of females and only 26 percent of males had discussed STI or pregnancy prevention with their provider.⁴⁰
- Studies found that males generally received less information and fewer, briefer explanations at medical visits than did their female peers.^{34,38}
- One study found that, if the provider did not bring up a sensitive health topic, the adolescent would not bring it up either. Only three percent of adolescents raised the topics of sexual behavior, STIs, and/or contraception on their own.²⁶
- One study showed that teens felt that their clinician didn't care about them when he/she rushed through appointments, giving them no time to ask questions and get answers.¹⁰
- Studies showed that youth were willing and eager to use the Internet to learn more about conditions and issues. But, they had a hard time finding accurate information when they didn't know how to spell medical conditions or medications. Also, youth were often unable to assess the reliability and accuracy of Web sites.^{42,43}
- Adolescent males, rural youth, low-income adolescents, older youth, and African Americans often used the emergency room as their usual source of care. Although these youth were also more likely than their peers to report substance use, poor health, and mental health problems, ER visits rarely allowed for the comprehensive counseling or follow-up they needed.¹⁸
- A study of pregnant and parenting teens found that social workers usually did not approach the young women until after they had given birth. Many of the young mothers did not realize that they had to act quickly to ensure that they *and* the baby had Medicaid, WIC, and other social services. They needed a lot of practical assistance to ensure they would have food, safe housing, and other necessities.¹⁰
- Studies found that pregnant and parenting teens often benefited from tailored programs. In one, visiting nurses provided one-on-one case management that resulted in teenage mothers having fewer and better spaced subsequent births when compared to parenting teens who did not receive nurse home visiting.⁴⁴ Other studies found that teens who received prenatal care at their school's health centers gave birth to fewer infants of low birth weight and were less likely to drop out of school compared to teens receiving prenatal care at hospital-based clinics.^{45,46}

- A nationwide study of the prophylaxis offered to sexual assault victims who had come for care to an ED found **no** cases in which survivors were offered the full complement of medications recommended by the Centers for Disease Control & Prevention (CDC).⁴⁷
- One study found that young women's knowledge was poor regarding Papanicolaou (Pap) smears and when and why the test should be performed.³⁹

Recommendations on Integrated Services for Youth

1. Establish protocols to ensure that youth receive preventive counseling as recommended by GAPS (the American Medical Association's *Guidelines for Adolescent Preventive Services*).^{**} Set up protocols so clinicians will remember to ask about risk-taking behaviors, including unprotected sex, substance use, and violence as well as about issues like depression, suicidal thoughts, and violence victimization.
2. Make sure that staff understands that some teens, including teen parents and those in foster care, homeless shelters, juvenile detention centers, and substance abuse programs, have higher rates of risk-taking than other teens. Set up strong referral systems, co-locate services, and/or establish collaborative partnerships with agencies who serve these youth.
3. Develop links with school-based health clinics, which are especially effective in serving teens but are often unable to provide contraceptive and family planning services.
4. Many youth use the hospital emergency department as their usual source of care and, thus, may not receive comprehensive care. Connect with local emergency rooms so they can refer youth to the clinic for family planning and other care.
5. To the extent possible, ensure continuity of care by making every effort to have teens see the same counselor and/or clinicians at every appointment.
6. Widely advertise the breadth of the clinic's services. If youth, males and females, know that the clinic offers primary care and general and sports physicals as well as care for more sensitive issues like reproductive and sexual health, STIs, substance abuse, and/or mental health, they can come in for care related to a sensitive issue without worrying that others will know why they are in the clinic.
7. Try 'in-reach' as well as outreach. Excellent ways to reach young men include their girlfriends and other males who have used the clinic and been satisfied.^{30,48}
8. Since adolescents often have difficulty negotiating complex medical systems, make referral appointments for them and ensure that they know exactly where and when to go. Give them clear directions, assurances of continuing confidentiality, and information about fees, if any. Knowledge can help lessen their anxiety so they will be more likely to keep the referral appointment.
9. Before an adolescent leaves the clinic, provide a slip of paper with his/her correctly spelled diagnosis and medications, if any. The same paper can include reliable, accurate Web sites that offer consumer health information. This is easy. Clinicians can have ready a sheet of paper with the Web addresses of organizations that offer consumer health information: two each on reproductive and sexual health, substance use, mental health, violence, and general health. All the clinician has to do is to add any diagnosis and medications, clearly printed, on the paper before handing it to the client.
10. Remember that integrated care is especially important to some populations of youth:
 - **Young men** may be particularly drawn to integrated services that allow them to seek care for sensitive issues without exposing their vulnerability.
 - **Young women** need proactive health care. Sexually active young women need annual screening for *Chlamydia trachomatis* and *Nisseria gonorrhoeae*, regardless of whether or not they are symptomatic.
 - **Pregnant teens** need more than just prenatal care. They need to know that their clinician cares as much about them as about the fetus they carry. They often need assistance to get publicly funded health insurance and social services.
 - **Gay, lesbian, and bisexual youth** have the same physical and psychosocial needs as their heterosexual peers and need the same comprehensive services.
 - HIV-positive youth need coordinated care that provides a range of services, including case management,

comprehensive medical care, and social services to ensure that their fundamental needs, such as food and housing, are met.[20.21.49.50](#)

- **Sexual assault survivors** need immediate prophylaxis for STIs. Women of reproductive age need immediate prophylaxis to prevent pregnancy. CDC recommends a variety of antibiotics for preventive therapy against gonorrhea, chlamydia, trichomoniasis, and bacterial vaginosis. CDC also recommends emergency contraception (EC) for sexual assault survivors at risk of pregnancy. Youth need clear, gentle explanations of why the medications are important. And they need to be treated gently and respectfully during the examination.[47.51](#)

Cultural Competence (Diverse, Well Trained Staff)

Cultural competence in health care: acknowledges and incorporates the importance of culture(s); assesses cross-cultural relations; is vigilant regarding dynamics that result from cross-cultural differences; expands cultural knowledge; and adapts services to meet the culturally unique needs of clients.[52](#)

Culturally Competent Staff Is Critical to Quality Services for Youth

Studies show that humans universally process information in ways that include social categorizing and stereotyping. All humans share this highly adaptive cognitive strategy because it makes massive amounts of data more manageable by using categories to simplify what is taken in. But, the process also leads each of us to develop beliefs and expectations about *groups* of people. Then, when we mentally assign someone to a particular group, we unconsciously and automatically assign the 'group' characteristics to that person. Studies show that "patients' sex, age, diagnosis, marital status, sexual orientation, type of illness, and race / ethnicity can influence providers' beliefs and expectations."[29](#)

The issue becomes critical when, for example, clinicians do not counsel some youth about health risk behaviors because they have unconsciously assigned them to a particular stereotype and made assumptions (positive *or* negative) about their health risks or behaviors based on that stereotype.

- When students were recruited as members of an advisory board for a school-based health center, they identified: obstacles to youth's coming in for care; positive and negative aspects of students' experiences at the school-based health center; and important gaps in services.[53](#) Despite some people's prior assumptions that youth would not know enough to inform the protocols of the school-based health center, the study showed that they made highly relevant and helpful recommendations.
- According to one study, Hispanic clinicians believed that some of their most important skills for treating adolescents included the abilities to: 1) understand because they were from a similar background and culture; and 2) communicate well with the adolescent's family.[54](#)
- Another study found that connectedness to their community, including health care providers, helped Hispanic young women to decide to come in for care.[24](#)
- A study among African American youth found that they rated providers' attributes as even more important than confidentiality when they sought care for STIs. The specific attributes these youth viewed as most important were that clinicians: 1) said exactly what was wrong; 2) answered teens' questions about STIs; 3) knew a lot about youth's medical issues; and 4) explained everything they did during an examination.[11](#)
- A study of gay, lesbian, and bisexual youth found that the most important provider attributes to them were cleanliness, trust, respect, and understanding. GLB youth had the same health care needs as their peers. At the same time, they also wanted clinicians to understand how sexual orientation can affect emotional health. And, they wanted clinicians to avoid assumptions of heterosexuality and to distinguish sexual orientation from sexual behavior.[22](#)
- Lack of interpreter services and of culturally and linguistically appropriate health education materials has been associated with patient dissatisfaction, poor comprehension, inadequate compliance, and ineffective or low quality health care. For example, when Spanish-speaking patients were discharged from an emergency room, they were less

likely than English-speaking patients to understand their diagnosis, prescribed medications, special instructions, and plans for follow-up care. As a result, they were also less likely to have been satisfied with their care and were often unwilling to return.⁵²

- An Hispanic, bilingual doctor said, *It's important to use the [person's] language around sexuality and prevention... [It's] most important is to speak the language the client is most comfortable in.*⁵⁴ Nevertheless, a review of publicly funded family planning agencies nationwide found that less than one-fourth offered tailored services for non-English speaking clients.⁴¹

Recommendations on Cultural Competence

1. Establish continuous, ongoing training regarding:
 - Cultural diversity;
 - Sexual orientation and gender identity; and
 - Cultural norms particular to the cultures of the clients.
2. Establish clear, unambiguous policies against discrimination on the basis of sex, age, race/ethnicity, sexual orientation, religion, and gender identity. Make sure that the clinic or practice is a safe place for **all** clients and staff.
3. Hire diverse staff, in regard to both ethnicity and gender. Pay attention to gender role dynamics between staff and clients.
4. Ensure that staff can communicate with clients in their own language(s). This may mean hiring bilingual and multilingual staff and/or generously compensating staff who learns one or more additional languages.
5. Depending on the demographics of the clinic's clientele, be sure that bilingual staff is available, either during all operating hours or at set times and on set days. Remember that critical misinformation may be exchanged if the clinician and the client do not speak the same language. Language clarity is vitally important during discussions of diagnoses, treatment, and medications, and also of sensitive subjects like violence victimization, substance use, and sexual risk-taking.
6. Ensure that high quality consumer health education materials are available in *all* the languages that clients speak and for various reading levels, including low literacy.
7. Involve young people in assessing the policies and services offered by the clinic. Take their recommendations seriously.
8. Choose a gender neutral décor for waiting rooms to provide reassuring visual cues that both young men and young women belong there and are welcome.
9. Remember that cultural competence is highly important to particular populations of youth:
 - **Young lesbians** want clinicians to be respectful. Clinicians who show sensitivity and respect can have a highly positive impact on young lesbians' willingness to seek and receive care.²⁸ Be aware that sexual orientation does not preclude either pregnancy or STIs among lesbian women.
 - **Gay and bisexual men** often rely heavily on the experiences and recommendations of their gay peers. Good client-staff interactions with one young man will be likely to come to the attention of other gay and bisexual young men. Be aware that young gay and bisexual males have the same need as their heterosexual peers to be treated holistically and to receive optimal care that addresses their physical, emotional, and psychosocial health.³⁰
 - **Ethnic minority youth** need to know that they are seen as individuals, not as someone's stereotype of their race/ethnicity. Remember that any individual adolescent is no more and no less likely than any other to participate in or to avoid risk-taking behaviors. *All* need the same individual counseling and care.

Easy Access to Care

Easy access to health services is important to youth. Access issues may include: lack of transportation; difficulties making appointments; not knowing where to go; hours and days when services are available; and requirements to return for follow-up. [Access issues related to culture and language are discussed in the preceding section on cultural competency.]

Access Is Critical to Youth

Although access issues can be important to adults as well, they pose especially significant barriers to youth's ability to get the health care services they need.

- Lack of transportation to health care settings has been a significant barrier for many young people, especially for: HIV-positive youth²⁰; urban, ethnic minority youth, African Americans and Latinos¹⁷; and emotionally distressed adolescents.³¹
- Difficulties making an appointment was a reason given in a national survey by nine percent of adolescents who failed to get needed health care.¹⁷
- In a study of emotionally distressed adolescents, black and Hispanic youth were significantly less likely than their white peers to know where to go.³¹ At the same time, a study of Hispanic adolescents found that one in five reported they 'had nowhere to go' for health care.²⁴
- One study found that adolescents were 21 times more likely to come for mental health care to school-based health centers than to community health centers. Schools, school counselors, and school health services were more likely than other venues to identify youth in need of mental health care. Equally important, care at school-based health centers was much easier for youth to access.³² And in another study, longer clinic hours were associated with teen males' increased use of school-based health center services.³⁵
- Studies showed that adolescents often failed to return for STI test results and follow-up care – a failure that could have serious repercussions. For example, up to four percent of women who developed PID did so *after* testing and *before* they received treatment.⁵⁵

Recommendations on Improving Access to Care

1. If possible, offer transportation vouchers or bus tokens to youth who need them. If this is not possible, link with community health clinics around the county or geographic area so that you can offer youth the option of using a clinic closer to their home, school, or work.
2. Offer a special help-line that adolescents can use to inquire about services, make appointments, and request follow-up care.
3. Offer flexible hours for adolescents. Offer appointments in the evening and on weekends. At the same time, accept walk-in appointments during those evening and weekend hours that have been set aside especially for youth.
4. Be sure to get a cell or pager number and/or private e-mail address for youth. For youth in need of follow-up care, such those who have tested positive for STIs, clinics may be able to contact youth much more quickly and reliably through text messaging, paging, or e-mail than through more traditional methods. Contact youth within 24 hours with their test results. Keep a confidential log book to document follow-up, treatment, and partner notifications.⁵⁵

Free or Low Cost Services

Fear about Costs Is a Major Barrier to Health Care for Youth

Poor and uninsured adolescents worry a lot about whether they can afford the care they need. Youth who have health insurance often worry about confidentiality, for example, about information forms going to their parents. So, whether youth have insurance or not, cost can be a major factor in whether they even attempt to get medical care. Clinics should offer free services and/or use sliding fee scales to ensure that young people get the services they need.

- In a national survey, uninsured adolescents were more likely to report foregone care than were adolescents with continuous private or public insurance (24 percent versus 17 and 16 percent, respectively). Fourteen percent of youth who neglected to get necessary care cited cost as the reason.¹⁷
- One study found that confidential accounts worked well for youth who needed sensitive health care, including

laboratory tests. The lab fees were billed to the practice and the adolescent agreed to pay a nominal fee as reimbursement. At the same time, the practice used non-confidential codes to bill youth's insurance for the provider's time.⁵⁶

- A nationally representative survey found that adolescents with fewer financial resources and those without insurance were more likely than other youth to use the emergency room as their only source of care. In busy emergency rooms, they were unlikely to get the comprehensive care they needed.¹⁸
- A study of client visits before and after the imposition of a co-payment in an STI clinic found a 29 percent decline in the number of visits. The proportion of STI diagnoses declined by 40 percent among all women and by 42 percent among women under age 20. The researchers found that even a modest fee for service appeared to have a large **negative** impact on the use of STI clinic services and significantly reduced the community's ability to identify and treat chlamydia and gonorrhea cases, especially among those most at risk.⁵⁷

Recommendations on Cost

1. Offer free or greatly reduced-fee services to adolescents. This can be especially important for STI testing and treatment.
2. Set up private billing accounts for adolescents who seek confidential services. Arrange for laboratory fees for confidential tests to be billed directly to the clinic or practice. Work out a nominal payment plan with the adolescent. At the same time, bill the adolescent's insurance for provider time, using non-confidential codes, so that information forms sent to the parents will not betray youth's confidentiality.
3. Where permitted by state law, dispense free or low cost prescriptions to adolescents.
4. Stock exam rooms (not the waiting room) with baskets of condoms along with signs saying that youth are free to take as many as they feel they need, at no charge.

Reproductive & Sexual Health Services

Reproductive and sexual health services can include education and counseling, contraceptive services, STI/HIV testing and treatment, in addition to prenatal and obstetrical care, abortion services, and fertility counseling and treatment. Most of these services are important to adolescents and young adults.

Adolescents Often Need Sexual Health Services

The statistics released each year by the Centers for Disease Control and Prevention (CDC) indicate that adolescents are in serious need of reproductive and sexual health care. In addition, other studies highlight youth's need for these services.

- One recent study found that almost one in 12 (eight percent) of young adults ages 18 through 35 in one city had *untreated* gonorrhea, chlamydia, or both. Nearly all of these cases were **asymptomatic**.⁵⁸
- According to experts, every year about half of all pregnancies in the United States are unintended and the proportion of unintended pregnancies is highest among U.S. women under age 20. Among teenage women, about 85 percent of pregnancies are unintended.⁵⁹
- Rates of unintended pregnancy have been highest among women ages 18 and 19 and ages 20 through 24. Rates of unintended pregnancy have also been much higher among:
 - Unmarried women compared to married or cohabiting women;
 - Black and Hispanic women compared to white women; and
 - Women whose income is at or below the federal poverty level compared to those whose income is at least twice the federal poverty level.⁵⁹
- According to data from the National Survey of Family Growth, half of all unintended pregnancies have occurred among contraceptive users. Moreover, 90 percent of these pregnancies resulted from inconsistent or incorrect method use rather than from method failure.⁶⁰
- Research showed that women with ambivalent attitudes toward pregnancy used contraceptives less continuously and

less effectively than women with clearly defined, firm motivation to avoid pregnancy.⁶¹

- Research also showed that women who switched methods were at higher risk of unintended pregnancy than were women who used the same method over time. Experts attributed this increased risk to the difficulty that women often had in adjusting to a new method or in restarting use after a period of nonuse.⁶¹
- Overall, studies indicated that, the less familiarity adolescents felt with a prospective partner, the less likely they were to use contraception, possibly because they felt less comfortable discussing sex, sexual histories, and contraception.⁶²
- Research has identified some characteristics that may indicate a lower likelihood of adolescents' using contraception:
 - For males, not having used contraception during a first sexual relationship was associated with 66 percent reduced odds of ever using contraception in a current relationship.⁶²
 - Males who had suffered sexual abuse had a greatly reduced likelihood of using contraception compared to those who never suffered such abuse.⁶¹
 - Females were less likely to have ever used contraception in their most recent or current relationship if they never used contraception in a first relationship.⁶²
 - If females' most recent partner was initially a stranger to them, they were less likely to have used contraception than if he had been previously known to them.⁶²
 - For females, the likelihood of using contraception was reduced by 20 percent for each additional partner they had ever had.⁶²
- Studies showed that pelvic examinations posed a barrier to STI screening. In focus group research, young women suggested that clinicians provide clear, one-on-one information as to when and why a pelvic exam and/or Pap smear was needed.^{23,40}
- In a survey of lesbians, over 77 percent reported sexual intercourse with one or more males during their lifetime.⁶³ In fact, one study showed that lesbian and bisexual adolescent females had twice the rate of pregnancy as their heterosexual peers.⁶⁴

Current Practices Offer Youth More Options than in the Past

- Over 40 years of research regarding oral contraception has proven that the pills, used as regular birth control or as emergency contraception, will **not** harm an established pregnancy, will **not** cause birth defects, and will **not** cause abortion. The American College of Obstetricians & Gynecologists, Society for Adolescent Medicine, and American Academy of Pediatrics assert that EC is entirely safe for adolescents.^{65,66,67}
- A recent study found that many clients responded well to computer-assisted sexual history screening. In particular, young women were more likely to acknowledge oral sex, transactional sex, and methamphetamine use when filling out the form by computer than through personal interview. On the other hand, they were less likely to report STI symptoms by computer than by interview.⁶⁸
- Another study found that asking about sexual contacts during the past two weeks or one month was **insufficient** for identifying partners infected with some viral and bacterial pathogens.
 - **Two weeks to one month** identified contacts during the infective period for genital herpes and some bacterial STIs.
 - The past **60 days** was important to identifying those who may have been infected with chlamydia or gonorrhea.
 - A **12-month** time-frame was best for identifying partners at risk for HIV.⁶⁹
- For many years, family planning experts considered intrauterine contraception (IUC) or intrauterine devices (IUD) to be inappropriate for young women who had never given birth. Today, experts say differently. They now say that young women can use the IUD or IUC even though insertion is somewhat more difficult in women who have never given birth and the expulsion rate is slightly higher. These disadvantages are offset by intrauterine contraception's superior efficacy in preventing pregnancy and its ease of compliance.⁷⁰
- Experts now recommend a quick start regimen for adolescent and young adult women to begin hormonal contraception. Under this method, a young woman can start birth control pills, the patch, or the ring at any point in her menstrual cycle. If she starts it later than the sixth day of her cycle, she also needs to use condoms for the next seven days. Moreover, she should consider using EC if she has had unprotected sex anytime after day six of the cycle in which she began the pills, patch, or ring.⁷⁰

Recommendations for Reproductive and Sexual Health Clinical Practices

1. Use a standardized form for eliciting sexual history. Whether the clinic uses computer technology or clinician interviews or both, it is critically important to obtain a sexual history from every client using standardized forms. This will help to ensure that clinicians can adequately and appropriately address each client's sexual risk.
2. Offer adolescent females a wide array of hormonal contraceptive methods. Do not hesitate to offer intrauterine contraception and contraceptive injections as well as the patch, the ring, or birth control pills. A client cannot make an informed choice unless she knows the benefits and drawbacks of all her contraceptive options. If she chooses the pill, patch, or ring, encourage her to begin her method immediately, regardless of where she is in her menstrual cycle. At the same time, advise her of the importance of using condoms for additional protection against pregnancy in the first seven days after she has begun her chosen method of hormonal contraception.
3. Explain the difference between the relative risks and the absolute risks associated with contraceptive options, especially since media usually highlight relative risks and ignore absolute risks. Take for example, oral contraceptives and the risks of heart attack: among one million non-smoking women ages 30 to 34 who use oral contraceptives, about four experience a heart attack each year, compared to two who do not use oral contraceptives. Thus the relative risk has doubled; but the absolute risk has remained quite low.⁷¹
4. Advise all adolescent and young adult female clients about the importance of using dual protection, regardless of their sexual orientation. Most sexually active young women are able to use hormonal contraception to prevent pregnancy. All sexually active youth—male and female—should use condoms or dental dams at every act of sex, to prevent or lessen the risk of infection with STIs, including HIV.
5. **Don't** require a pelvic exam before prescribing or dispensing hormonal contraception to adolescents. Also be sure that young women know, in advance, when a pelvic exam will not be necessary and when it will be needed. Many experts now recommend that the first Pap test should occur three years after the first episode of vaginal intercourse or at 21 years of age, whichever comes first. Thereafter, women under age 30 should be screened once each year with conventional cervical cytology or every two years, using liquid based tests.⁷⁰
6. **Don't** require a pregnancy test before offering EC. A pregnancy test is entirely unnecessary before a young woman uses EC because the medication will not harm an established pregnancy and will have **no** effect if the woman taking it is already pregnant. Remember that EC is **entirely safe** for adolescent women.^{65,66,67}
7. For purposes of partner notification, be sure to ask about sexual partners: in the previous two weeks to one month (for herpes and most bacterial infections); in the past two months (for chlamydia and gonorrhea); and in the past year (for HIV).
8. Screen consistently for chlamydia and gonorrhea, using urine based testing. Experts suggest that, whenever possible, clinicians offer urine-based STI screening, using sensitive nucleic acid amplification techniques, for the diagnosis of most STIs.²³
9. Screen **all** sexually experienced females, ages 25 and under, annually for chlamydia AND for gonorrhea unless the prevalence of gonorrhea in your client population is known to be less than two percent. Do **not** limit screening to symptomatic clients.²³
10. Screen **all** young men under age 25 for chlamydia and gonorrhea, unless prevalence in your client population is known to be less than two percent. For purposes of assessing prevalence, consider separately the populations of young men who do and do not have sex with other men. Do **not** limit screening to symptomatic clients.²³

Services for Young Men

Young Men's Confidentiality Concerns Are Somewhat Different than Young Women's

- While studies showed that many young men were as concerned about confidentiality as their female peers, the focus for the young men was frequently somewhat different. Young men, especially older adolescents and young adults, were often less concerned than their female peers about confidentiality with regard to their parents.^{17,19,25} But, young

men expressed considerable concern about whether their peers would learn that they were seeking care and why.[19.26.30.32](#)

- In one study, some young men worried that faculty, staff, and other students would learn about it if they sought STI testing and treatment at their school-based health center. Their fear prevented many of these young men from using the school-based health center for this important health care service.[11](#)

Young Men Need Integrated Care

- In focus group research, male college students said that men's socialization to conceal their vulnerability and to be independent was by far the greatest barrier to visiting health care providers.[30.36](#) They indicated that the male socialization process, maintained and strengthened by peer pressure, was a powerful deterrent to seeking help, especially to seeking any kind of counseling.[30](#)
- Thus, young men's concerns about confidentiality *vis-à-vis* their peers made them anxious to receive services in a setting that would not expose their vulnerability. Integrated service settings, such as school-based health centers, college and community health centers, and adolescent clinics, felt safer because just coming in wouldn't relay to anyone else what services the young man sought. This was a particular concern to males needing mental or sexual health care or substance abuse services.[11.30.33.34.36](#)
- Young men often fail to get needed health care. In one study, male college students frequently presented to student health services for 'evaluation of acute conditions with alarming and long-neglected precursors'.[34](#)
- Research has shown that school-based health centers (which offer a wide variety of services) served the largest proportion of teenage males, far more than any other adolescent specific site. In fact in one study, males who used both community health clinics and school-based health centers were 45 times more likely to visit the school-based health center than a community health clinic for mental health services. School-based health centers were also particularly strong at delivering health care to ethnic minority males.[32](#)
- "Effective programs appeal to men in ways that increase their knowledge and skills, support positive actions to improving physical and psychological health, and foster better communication with intimate partners."[36](#) In fact, focus group research showed that young men recognized connections between physical, emotional, and social health. Thus, they preferred integrated care that understood and fostered these connections.[30](#)
- One study identified characteristics of clinics that attracted a higher proportion of young male clients. Overall, school-based health centers provided the most equally balanced care and attracted the closest proportion of males to females. At other types of clinics, characteristics that attracted more young men included:
 - Longitudinal care;
 - Alcohol abuse treatment;
 - Drug abuse treatment;
 - Psychological counseling;
 - Treatment for injuries from accidents;
 - Life skills training; and
 - A higher proportion of male health care providers.[33](#)
- Research showed that most males under age 18 preferred a female clinician to a male clinician (51 versus 40 percent, respectively), even for a genital checkup (49 versus 39 percent, respectively). African American males had the strongest preference for a female clinician.[72](#)

Young Men Need Counseling and Education from Providers

- Several studies found that poor communication with providers kept young men from seeking or getting the care they needed.[22.25.26.38](#) Clinicians' discomfort with and lack of training to address sexual health and other sensitive issues resulted in lost opportunities to discuss these issues openly and honestly with young men.[25](#) In fact, one study found that, among high school students who had a routine check-up, only 26 percent of males had discussed STI or pregnancy prevention with their provider.[40](#) In another study, only 16 percent of sexually experienced males reported being counseled about birth control.[73](#) In a third study, only 18 percent had this discussion.[26](#)

- Studies found that males generally received less information and fewer, briefer explanations at medical visits than did their female peers.^{34,38} Also, if the provider did not bring up a health topic, the adolescent male seldom brought it up either.²⁶

Access and Cost of Care Affect Young Men's Use of Services

- Studies found that older adolescent males were: less likely than their female peers or younger males to have a regular source of care; less likely to know where to go for health services; and more likely to be uninsured.^{32,33}
- In studies, access had a strong effect on whether young men sought needed care. One study of emotionally distressed adolescents found that those who had a physical examination in the previous year were 1.5 times more likely to have received psychological counseling than those who had no physical exam. Further, young men's most frequent access to care was at school, through school counselors and school-based health centers.³⁷
- Cost of care was the sixth most frequently listed reason that male college students failed to get needed health care. (Their top reasons included a need to conceal vulnerability, lack of knowledge about services, lack of time, lack of faith in the health care provider, and uncertainty that the provider would meet their needs.)³⁰
- One study found that young males often used the Emergency Department as their usual source of care. Although youth who used the Emergency Department as their usual source of care were also more likely than their peers to report substance use, poor health, and mental health problems, Emergency Department visits rarely allowed for the comprehensive counseling or follow-up necessary to address the young men's problems effectively.¹⁸
- A recent study found that many clients responded well to computer assisted sexual history screening. Among young men, those who had sex with other men were equally likely to report this behavior by interview with a clinician or through a computer assisted interview.⁶⁸

Recommendations on Services for Young Men

1. To draw young men as clients, offer integrated care so they can seek services for sensitive issues without their peers learning why they came in. Offer what they want: holistic care that addresses their physical, emotional, and social health and that increases their knowledge and skills, supports positive behaviors, improves physical and psychological health, and fosters better communication with intimate partners.^{30,36}
2. If the clinic is unable to offer a full breadth of services, link with other community health clinics and agencies so that the clinic can easily and readily refer young men to nearby care, preferably to venues where they will feel that their peers will not know *why* they are there.
3. Train **all** clinic staff about the importance of guarding male adolescents' confidentiality, especially with regard to their peers. Medical staff at school-based health centers should be pro-active in assuring male students that their confidentiality will be guarded, especially with regard to their medical records and conversations that might be overheard by other students, faculty, or school staff.
4. Create links between the clinic and area emergency rooms and school-based health centers. Young men who use the emergency room as their usual source of care may need referral to your community-based clinics for reproductive and sexual health care and other services, such as mental health care, substance use treatment, and/or primary care. Young men who use school-based health centers may also need referral to local family-planning or STI clinics, especially for sexual health care.
5. Advertise the breadth of the clinic's services, especially in venues where young men congregate. If young males know that the clinic offers primary care and general and sports physicals as well as reproductive and sexual health care, STI testing and treatment, substance abuse treatment, and/or mental health care, they can come in for care related to sensitive issues without worrying that their peers, advisors, coaches, etc., will know why they are in the clinic.
6. Try 'in-reach' as well as outreach. Studies suggest that an excellent way to reach young men is through their girlfriends. Young men also listen to the recommendations of other males who have used the clinic and been satisfied.^{30,48}
7. Treat young gay and bisexual males holistically and assure that they receive optimal care that addresses their physical, emotional, and psychosocial health.³⁰ Gay and bisexual men often rely on the experience and

recommendations of their gay peers. So, good client-staff interactions with one young man will be likely to come to the attention of other gay and bisexual young men.

8. Screen *all* young men under age 25 for chlamydia and gonorrhea, unless the prevalence in your client population is known to be less than two percent. For purposes of assessing the prevalence, consider separately the populations of young men who do and do not have sex with other men. Do **not** limit screening to symptomatic males.

Promoting Parent-Child Communication

Today, many clinicians work to promote parent-child communication about sexuality, drug use, and other critical health issues. Studies have shown that adult-focused programs and workshops can greatly strengthen parents' skills, willingness, and determination to have conversations with their teens about sex and other important health issues. Studies showed that parents' improved communication skills resulted in better communication with their teens and improved behavioral health outcomes for youth.^{[74,75,76,77,78,79,80](#)}

Parent-Child Communication Positively Affects Adolescents' Behaviors

A significant body of research has shown that discussions between parents and their children can have a highly positive impact on adolescents' behaviors.

- Many studies have found that adolescents who felt connected to parents and family were more likely than other youth to delay initiating sexual intercourse. Teens who said their families were warm and caring also reported less marijuana use and less emotional distress than their peers.^{[74,81,82,83](#)}
- Teens whose parents were warm and firm and also granted the adolescent the right to make decisions also achieved more in school, reported less depression and anxiety, and scored higher in self-reliance and self-esteem than adolescents whose parents did not exhibit these parenting traits.^{[84](#)}
- In one study, sexually experienced African American female teens who lived with a supportive mother were *half as likely* as their peers in non-supportive families to report having had unprotected sex in the previous month or to report sex with a casual partner in the previous six months.^{[85](#)}
- In one study, when mothers discussed condom use before teens initiated sexual intercourse, the youth were three times more likely to use condoms than were teens whose mothers never discussed condoms or discussed condoms only after the youth initiated sex.^{[86](#)} Moreover, studies have shown that condom use at first sexual intercourse or in a first sexual relationship predicted regular condom use in adolescents' most recent sexual relationship.^{[62,86](#)}

Clinics Promote Parent-Child Communication regarding Sexuality

Many family planning clinics encourage adolescents to talk with their parents about contraception.

- Clinics receiving funding through Title X of the Public Health Service Act have been mandated since 1981, "to the extent practical ... to encourage family participation in the decision of minors to seek family planning services."^{[3,87](#)}
- Recent research showed that nearly all Title X funded clinics engaged in at least one activity to promote parent-child communication. Most (from 73 to 94 percent of clinics, depending on the reason for the visit) routinely counseled minors to talk with their parents.^{[87](#)}
- In the same research, 84 percent of clinics distributed pamphlets on how to talk about sexuality. Seventy percent provided social events, like health fairs. Over 50 percent offered a library of instructional materials, posters, and/or a Web site with information about parent-child communication regarding sexual health. Forty-three percent offered or referred interested individuals to educational programs designed to improve communication.^{[87](#)}

Parental Rights and Confidentiality

- Conservative efforts to undercut minors' rights to confidential reproductive health care have usually been billed as safeguarding parental rights. Yet, studies have shown that, for up to 55 percent of adolescents, at least one parent knew beforehand about their teen's visit to a family planning clinic. By 15 months after the first visit, the proportion of adolescents whose mother knew about their clinic visit had risen to 78 percent. In fact, many parents not only were aware that their daughter was using contraception, but also were involved in and supportive of the family planning visits.⁴
- Fear of a breach of confidentiality is a serious barrier to health care for adolescents. [4.7.9.10.11.14.15.16.19](#) For example, one study found that, if faced with a requirement for clinics to notify their parents, many minors would switch to having unprotected or less well protected sex.¹⁶ One statewide study found that 86 percent of adolescent female family planning clients would be willing to use all the *confidential* sexual health services offered at local clinics. At the same time, 83 percent would stop using some or all sexual health services if their parents were to be notified. Some 57 percent would stop using prescription contraceptives and begin using condoms instead. Twenty-nine percent would have unprotected sex. About six percent would delay testing or treatment for HIV and other STIs. Only **one percent** would stop having sex.¹⁶
- Clinics that receive funding through Title X are required to promote parent-child communication about contraception. Yet no research has been published documenting a positive effect (or any effect for that matter) arising from clinicians' encouraging minors to talk with their parents about contraception.

Parents Can Have Difficulty Discussing Sensitive Subjects with Teens

- Studies have shown that parents want to be able to discuss sex and other sensitive subjects with their adolescents and that discomfort often prevents them from having discussions.^{75,88}
- Studies have also shown that parents need help to begin and continue positive conversations with their children about sex. For example, focus group research found that adolescents said their parents often made false assumptions about their sexual activity if the teens asked about sex.⁷⁵
- One study showed that immigrant Muslim girls felt that school-based sex education did not fit their lives and culture. At the same time, however, they and their mothers had great difficulty discussing sexuality.⁸⁹
- Other research showed that people (both adolescents and adults) differed greatly in their understanding of 'openness'. Aspects of this complicated concept included: being willing to answer questions without harping on the topic; being open-minded with regard to questions asked; balancing openness with privacy; and being responsive to the individual characteristics of the particular adolescent.⁹⁰

Recommendations on Parent-Child Communication

1. To encourage parent-child communication about sensitive health issues, advertise and offer workshops for **parents** on how to talk with their children. Several programs have been evaluated and found to be effective.
2. If you cannot offer workshops directly, find out what other agencies in your community are doing to promote parenting skills or to prevent teen pregnancy or adolescent substance use and other adolescent risk behaviors. Consider collaboration with these agencies in sponsoring workshops that will improve parents' skill in having positive, healthy, two-way discussions with their adolescents.
3. Offer pamphlets, Web information, and other passive materials, in a variety of languages and reading levels, to help parents talk with adolescents about sexuality and other sensitive health issues.
4. When counseling adolescents to talk with their parents.
 - First, ascertain whether the adolescent has already talked with a parent.
 - If the adolescent has not talked with his/her parent(s) about sexual health, be sure that the adolescent lives in a safe environment before counseling her/him to do so.
 - Finally, be very clear with adolescents that you will **not** break their confidentiality, regardless of what they decide about talking with their parents.

Researched and written by Sue Alford, MLS, on behalf of Advocates for Youth, © 2009

Programs and Workshops that Help Parents to Talk with Their Children about Sexual Health & Other Sensitive Issues

1. Plain Talk / Hablando Claro^{82,83} – For more information on this community-based program to encourage and support parents and other adults in talking with teens about responsible sexual behavior, please visit: <http://www.plaintalk.org/>. To read about one of the Spanish language Plain Talk sites, please visit: <http://www.advocatesforyouth.org/storage/advfy/documents/plaintalk.pdf>
2. Informed Parents and Children Together (ImPACT)⁷⁸ – For more information on this program, please visit: <http://www.cdc.gov/hiv/topics/research/prs/resources/factsheets/FOK-ImPACT.htm>
3. Parent Peer Education⁸¹ – For more information on this program, please visit: <http://www.familiesaretalking.org/approaches/aprch0006.html>

* For information regarding specific laws in your state or jurisdiction, please visit Guttmacher Institute, www.guttmacher.org or Center for Reproductive Law & Policy, www.reproductiverights.org.

** Other appropriate guidelines include, but are not limited to, those by the Society for Adolescent Medicine and the American Association of Family Physicians.

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