



UNDERSTANDING CONFIDENTIALITY AND MINOR CONSENT IN CALIFORNIA

An Adolescent Provider Toolkit



HOW TO OBTAIN A COPY OF THIS TOOLKIT MODULE

This module along with sample policies and handouts in Spanish and Chinese can be downloaded for free from the following websites:

Adolescent Health Working Group (AHWG) – www.ahwg.net

California Adolescent Health Collaborative (CAHC) – www.californiateenhealth.org

ADOLESCENT HEALTH WORKING GROUP

The Adolescent Health Working Group (AHWG) was formed in 1996 by a group of adolescent health providers and youth advocates concerned about the lack of age-appropriate health services in the city of San Francisco. Today, the AHWG remains the only group of its kind in San Francisco. The AHWG's vision is that all youth have unimpeded access to high quality, culturally competent, youth friendly health services. The AHWG's mission is to support and strengthen the network of providers working to improve adolescent health. The AHWG works to fulfill its vision and mission through the following core functions: 1) develop tools and trainings that increase providers' capacity to effectively serve youth, 2) advocate for policies that increase access to health insurance and comprehensive care, 3) convene stakeholders and coordinate linkages across systems to improve information sharing, networking and referral for youth services.

CALIFORNIA ADOLESCENT HEALTH COLLABORATIVE

California Adolescent Health Collaborative (CAHC), a project of The Public Health Institute, is a public-private statewide collaborative with the goal of increasing understanding and support for adolescent health and wellness in California. CAHC's vision is that adolescents and young adults from all California communities are living healthy lives and pursuing positive life options with resources, support, and opportunities from families, communities, schools, and service systems. Core functions include: 1) curriculum development, training, and technical assistance to strengthen the capacity of providers and systems; 2) publications to increase awareness of providers and policymakers and improve policy and practice; 3) advocacy to keep the health and well being of adolescents central to public debate and decision-making; and 4) collaborative development to strengthen partnerships between different disciplines through a common commitment to adolescent health.

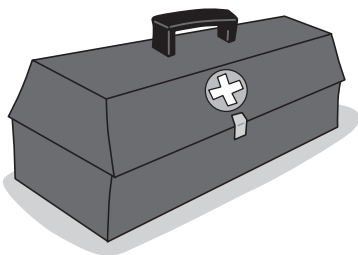
SUGGESTED CITATION

Second edition: Duplessis V, Goldstein S and Newlan S, (2010) *Understanding Confidentiality and Minor Consent in California: A Module of Adolescent Provider Toolkit*. Adolescent Health Working Group, California Adolescent Health Collaborative.

QUESTIONS ON TRAININGS

Contact CAHC: training@californiateenhealth.org

AHWG: info@ahwg.net





Adolescent Health Working Group

Dear Colleague,

We are pleased to present you with the second revised edition of **Understanding Confidentiality and Minor Consent in California**, a module of the Adolescent Provider Toolkit series, produced jointly by the Adolescent Health Working Group and the California Adolescent Health Collaborative.

During adolescence, youth confront new issues that affect their physical, reproductive, and mental health. At the same time, establishing autonomy is one of their most vital developmental tasks. As they face these changes, teens crave increased privacy and opportunities to make health-related decisions. This is an appropriate element of healthy development, which, if supported by involved parents and clinicians, can provide an important opportunity for maturation and independence. Youth list concerns about confidentiality as the number one reason they might forgo medical care. For this reason, youth need assurances of privacy and confidentiality with their healthcare providers. However, providers indicate that they are mystified and confused by the various confidentiality and minor consent laws, as well as their child abuse reporting responsibilities. This module, compiled by a multi-disciplinary group of health care providers, lawyers, health educators, social workers, with important input from parents and youth, strives to clarify these issues.

Designed for busy providers, the new **Understanding Confidentiality and Minor Consent in California** Module includes materials that you are free to copy and distribute to your adolescent patients and their families, or to hang in waiting and exam rooms. This module includes:

- Charts on minor consent and confidentiality
- Practice tools
- Screening, Assessment and referral tools
- Resource sheets
- Health education handouts for teens and their parents/guardians
- Online resources and research

Updates and additions in this new edition include:

- Updated legal information
- Added resources for youth
- A new section for parents/guardians
- Information addressing issues of HIPAA and FERPA

Our two websites have additional examples of forms and health education handouts in Chinese and Spanish for both youth and parents/guardians. This module can be downloaded for free in its entirety.

An interactive live training is also available to integrate the use of the module into clinical practice. Our evaluation data indicates that those who utilize our trainings find the materials richer, more salient, and are more likely to feel confident responding to minor consent and confidentiality concerns in their work with teens.

If you have questions regarding the Toolkit or its accompanying training and resources; please call the California Adolescent Health Collaborative at (510)285-5712 or Adolescent Health Working Group at (415)554-8429.

Regards,

Sandi Goldstein, MPH
Director, California Adolescent Health Collaborative

Alicia St. Andrews, MPH
Director, Adolescent Health Working Group

ACKNOWLEDGEMENTS

The California Adolescent Health Collaborative and Adolescent Health Working Group gratefully acknowledge The California Endowment and the Compton Foundation for generously supporting the production of the second edition of this toolkit module.

THE ADOLESCENT MINOR CONSENT and CONFIDENTIALITY PROVIDER TOOLKIT ADVISORY GROUP

We would like to extend our sincerest thanks to members of the Toolkit Advisory Group for their time, energy, dedication, and unwavering commitment to the health of adolescents.

Virginia Duplessis, MSW – California Adolescent Health Collaborative
Elizabeth Edwards, MPH, CHES – Alameda Alliance for Health
Sandi Goldstein, MPH – California Adolescent Health Collaborative
Rebecca Gudeman, JD, MPA – National Center for Youth Law
Amy Halio, MD – La Clínica de la Raza School Based Health Centers
Amanda Howell, The Permanente Medical Group, Inc
Robin Kirkpatrick, LCSW, MPH - California Adolescent Health Collaborative
David Knopf, LCSW, MPH – UCSF Division of Adolescent Medicine
Terrie Lind - Planned Parenthood Mar Monte
Erica Monasterio, MN, FNP – UCSF Division of Adolescent Medicine
Tomás Magaña, MD, MA, FAAP – Children’s Hospital and Research Center, Oakland
Sami Newlan, California Adolescent Health Collaborative
Janet Shalwitz, MD - Adolescent Health Working Group
Alicia St. Andrews, MPH - Adolescent Health Working Group

ORIGINAL AUTHORS

We would like to acknowledge the original authors of the Understanding Confidentiality and Minor Consent in California: An Adolescent Provider Toolkit Module, Marlo Simmons, Janet Shalwitz, Sara Pollack, and Allison Young.

YOUTH FOCUS GROUP PARTICIPANTS

We would like to thank students from: Alameda High School, Balboa High School (San Francisco), Manual Arts High School (Los Angeles), and San Luis Obispo Community School.

PARENT FOCUS GROUP PARTICIPANTS

We would like to thank parents from: Chinatown Child Development Center in San Francisco, Corcoran Family Resource Center, Riverside Community Health Foundation, and El Cerrito High School.

PROVIDER FOCUS GROUP PARTICIPANTS

We would like to thank providers from: Fresno, Alameda, and Riverside Counties.

OTHER CONTRIBUTORS AND REVIEWERS

Samantha Blackburn (California School Health Centers Association), Katie Hornung, and Christiana Macfarlane (National Center for Youth Law).



MODULE ONE: CONFIDENTIALITY

A. TIPS, TRICKS & TOOLS

California Minor Consent Laws	2
Snapshot: Who Can Consent for What	7
When Sexual Intercourse is Reportable as Child Abuse	8
Confidentiality and Minor Consent Q&A	9
Mandated Reporting Q&A.....	11
Is Your Office Confidentiality Conscious?	13
Confidentiality Conscious Back Office Recommendations	15
Balancing Act: Engaging Youth, Supporting Parents	16
Provider Tips for Discussing Conditional Confidentiality	17
Financing Sensitive Services: A Guide for Adolescent Health Care Providers.....	18

B. HANDOUTS FOR PARENTS AND YOUTH

Introduction.....	21
-------------------	----

FOR YOUTH

The Truth About Confidentiality	22
Youth-friendly Clinic Poster	23
Your Health Rights and Responsibilities	24
Quiz: How well do you know your health rights and responsibilities?	25

FOR PARENTS

Handouts from Providers to Parents Regarding Consent and Confidentiality	26
Your Teen is Changing!	28
Talking to Your Teen About Tough Issues	29
Helping Your Teen Take Responsibility for Their Health	30
Know Myself, Know My Teen	31
The 5 Basics of Parenting Adolescents.....	32
My Teen is Going to the Doctor and Not Telling Me!.....	33

C. FOR SCHOOL HEALTH PROVIDERS

What is FERPA?	34
How Does FERPA Differ From HIPAA?	36
What Do I Follow?	38
FAQs	40

D. RESOURCES

Confidentiality Literature Review Summaries	43
Federal Medical Privacy Regulations (HIPAA Rules): A Brief Overview.....	45
Confidentiality and Minor Consent-related Online Resources.....	48



CALIFORNIA MINOR CONSENT AND CONFIDENTIALITY LAWS: MINOR CONSENT SERVICES AND WHEN PARENTS MAY ACCESS RELATED MEDICAL INFORMATION

MINORS OF ANY AGE MAY CONSENT	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER IN RELATION TO PARENTS
PREGNANCY	<p>“A minor may consent to medical care related to the prevention or treatment of pregnancy,” except sterilization. (Cal. Family Code § 6925).</p> <p>A minor may receive birth control without parental consent. (Cal. Family Code § 6925).</p>	<p>The health care provider is not permitted to inform a parent or legal guardian without the minor’s consent. The provider can only share the minor’s medical information with parents with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).</p>
CONTRACEPTION	<p>A minor may consent to an abortion without parental consent. (Cal. Family Code § 6925; <i>American Academy of Pediatrics v. Lungren</i>, 16 Cal.4th 307 (1997)).</p>	<p>The health care provider is not permitted to inform a parent or legal guardian without the minor’s consent. The provider can only share the minor’s medical information with parents with a signed authorization from the minor. (<i>American Academy of Pediatrics v. Lungren</i>, 16 Cal.4th 307 (1997); Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).</p>
ABORTION	<p>“A minor who [may] have been sexually assaulted may consent to medical care related to the diagnosis, . . . treatment and the collection of medical evidence with regard to the . . . assault.” (Cal. Family Code § 6928).</p>	<p>The health care provider must attempt to contact the minor’s parent/guardian and note in the minor’s record the day and time of the attempted contact and whether it was successful. This provision does not apply if the treating professional reasonably believes that the parent/guardian committed the assault. (Cal. Family Code § 6928).</p>
<p>SEXUAL ASSAULT¹ SERVICES</p> <p>¹For the purposes of minor consent alone, sexual assault includes acts of oral copulation, sodomy, and other crimes of a sexual nature.</p> <p>³See also “Rape Services for Minors 12 and Over” on page 3 of this chart</p>	<p>A minor under 12 years of age who may have been raped “may consent to medical care related to the diagnosis, . . . treatment and the collection of medical evidence with regard” to the rape. (Cal. Family Code § 6928).</p>	<p>Both rape and sexual assault of a minor are considered child abuse under California law and must be reported as such. The child abuse authorities investigating the report legally may disclose to parents that a report was made.</p>
RAPE² SERVICES FOR MINORS UNDER 12 YRS³	<p>²Rape requires an act of non-consensual sexual intercourse.</p> <p>³See also “Rape Services for Minors 12 and Over” on page 3 of this chart</p>	

MINORS OF ANY AGE MAY CONSENT	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER IN RELATION TO PARENTS
<p>EMERGENCY MEDICAL SERVICES*</p> <p>*An emergency is "a situation . . . requiring immediate services for alleviation of severe pain or immediate diagnosis of unforeseeable medical conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death" (Cal. Code Bus. & Prof. § 2397(c)(2)).</p>	<p>A provider shall not be liable for performing a procedure on a minor if the provider "reasonably believed that [the] procedure should be undertaken immediately and that there was insufficient time to obtain [parental] informed consent." (Cal. Bus. & Prof. Code § 2397).</p>	<p>The parent or guardian usually has a right to inspect the minor's records. (Cal. Health & Safety Code §§ 123110(a); Cal. Civ. Code § 56.10. <i>But see exception at endnote (EXC).</i>)</p>
<p>SKELETAL X-RAY TO DIAGNOSE CHILD ABUSE OR NEGLECT*</p> <p>* The provider does not need the minor's or her parent's consent to perform a procedure under this section.</p>	<p>"A physician and surgeon or dentist or their agents . . . may take skeletal X-rays of the child without the consent of the child's parent or guardian, but only for purposes of diagnosing the case as one of possible child abuse or neglect and determining the extent of." (Cal. Penal Code § 11171.2).</p>	<p>Neither the physician-patient privilege nor the psychotherapist-patient privilege applies to information reported pursuant to this law in any court proceeding.</p>
<p>MINORS OF 12 YEARS OF AGE OR OLDER MAY CONSENT</p>	<p>LAW</p>	<p>CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER IN RELATION TO PARENTS</p>
<p>OUTPATIENT MENTAL HEALTH SERVICES⁴/SHELTER SERVICES</p> <p>⁴This section does not authorize a minor to receive convulsive therapy, psychosurgery or psychotropic drugs without the consent of a parent or guardian.</p>	<p>"A minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis, or to residential shelter services, if both of the following requirements are satisfied: (1) The minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services or residential shelter services. (2) The minor (A) would present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling or residential shelter services, or (B) is the alleged victim of incest or child abuse." (Cal. Family Code § 6924).</p>	<p>MENTAL HEALTH TREATMENT:</p> <p>The health care provider is required to involve a parent or guardian in the minor's treatment unless the health care provider decides that such involvement is inappropriate. This decision and any attempts to contact parents must be documented in the minor's record. Cal. Fam. Code § 6924; 45 C.F.R. 164.502(g)(3)(ii). While this exception allows providers to inform and involve parents in treatment, it does not give providers a right to disclose medical records to parents without the minor's consent. The provider can only share the minor's medical records with a signed authorization from the minor. (Cal. Health & Saf. Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11, 56.30; Cal. Welf. & Inst. Code § 5328. <i>See also exception at endnote (EXC).</i>)</p> <p>SHELTER:</p> <p>Although minor may consent to service, the shelter must use its best efforts based on information provided by the minor to notify parent/guardian of shelter services.</p>

CALIFORNIA MINOR CONSENT AND CONFIDENTIALITY LAWS: MINOR CONSENT SERVICES AND WHEN PARENTS MAY ACCESS RELATED MEDICAL INFORMATION, cont.

MINORS OF 12 YEARS OF AGE OR OLDER MAY CONSENT	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER IN RELATION TO PARENTS
<p>DRUG AND ALCOHOL ABUSE TREATMENT</p> <ul style="list-style-type: none"> This section does not authorize a minor to receive replacement narcotic abuse treatment without the consent of the minor's parent or guardian. This section does not grant a minor the right to refuse medical care and counseling for a drug or alcohol related problem when the minor's parent or guardian consents for that treatment. (Cal. Family Code § 6929(f)). 	<p style="text-align: center;">LAW</p> <p>“A minor who is 12 years of age or older may consent to medical care and counseling relating to the diagnosis and treatment of a drug or alcohol related problem.”(Cal. Family Code §6929(b)).</p>	<p>There are different confidentiality rules under federal and state law. Providers meeting the criteria listed under ‘federal’ below must follow the federal rule. Providers that don’t meet these criteria follow state law.</p> <p>FEDERAL: Federal confidentiality law applies to any individual, program, or facility that meets the following two criteria:</p> <ol style="list-style-type: none"> The individual, program, or facility is federally assisted. (Federally assisted means authorized, certified, licensed or funded in whole or in part by any department of the federal government. Examples include programs that are: tax exempt; receiving tax-deductible donations; receiving any federal operating funds; or registered with Medicare.)(42 C.F.R. §2.12); AND The individual or program: <ol style="list-style-type: none"> Is an individual or program that holds itself out as providing alcohol or drug abuse diagnosis, treatment, or referral; OR Is a staff member at a general medical facility whose primary function is, and who is identified as, a provider of alcohol or drug abuse diagnosis, treatment or referral; OR Is a unit at a general medical facility that holds itself out as providing alcohol or drug abuse diagnosis, treatment or referral. (42 C.F.R. §2.11; 42 C.F.R. §2.12). <p>For individuals or programs meeting these criteria, federal law prohibits disclosing any information to parents without a minor’s written consent. One exception, however, is that an individual or program may share with parents if the individual or program director determines the following three conditions are met: (1) that the minor’s situation poses a substantial threat to the life or physical well-being of the minor or another; (2) that this threat may be reduced by communicating relevant facts to the minor’s parents; and (3) that the minor lacks the capacity because of extreme youth or a mental or physical condition to make a rational decision on whether to disclose to her parents. (42 C.F.R. §2.14). STATE RULE: Cal. Family Code §6929(c). Parallels confidentiality rule described under “Mental Health Treatment” supra at page 2. See also exception at endnote (EXC).</p>



MINORS OF 12 YEARS OF AGE OR OLDER MAY CONSENT	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER IN RELATION TO PARENTS
DIAGNOSIS AND/OR TREATMENT FOR INFECTIOUS, CONTAGIOUS COMMUNICABLE DISEASES	<p>“A minor who is 12 years of age or older and who may have come into contact with an infectious, contagious, or communicable disease may consent to medical care related to the diagnosis or treatment of the disease, if the disease... is one that is required by law...to be reported....” (Cal. Family Code § 6926).</p>	<p>The health care provider is not permitted to inform a parent or legal guardian without the minor’s consent. The provider can only share the minor’s medical information with parents with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).</p> <p>Rape of a minor is considered child abuse under California law and must be reported as such. Even if health care providers cannot disclose to parents that they have made this report, adolescent patients should be advised that the child abuse authorities investigating the report legally may disclose to parents that a report was made.</p>
RAPE SERVICES FOR MINORS 12 AND OVER	<p>“A minor who is 12 years of age or older and who is alleged to have been raped may consent to medical care related to the diagnosis or treatment of the condition and the collection of medical evidence with regard to the alleged rape.” (Cal. Family Code 6927).</p>	
AIDS/HIV TESTING AND TREATMENT	<p>A minor 12 and older is competent to give written consent for an HIV test. (Cal. Health and Safety Code § 121020). A minor 12 and older may consent to the diagnosis and treatment of HIV/AIDS. (Cal. Family Code § 6926).</p>	<p>The health care provider is not permitted to inform a parent or legal guardian without the minor’s consent. The provider can only share the minor’s medical information with parents with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).</p>
DIAGNOSIS AND/OR TREATMENT FOR SEXUALLY TRANSMITTED DISEASES	<p>A minor 12 years of age or older who may have come into contact with a sexually transmitted disease may consent to medical care related to the diagnosis or treatment of the disease. (Cal. Family Code § 6926).</p>	

CALIFORNIA MINOR CONSENT AND CONFIDENTIALITY LAWS: MINOR CONSENT SERVICES AND WHEN PARENTS MAY ACCESS RELATED MEDICAL INFORMATION, cont.

MINORS OF 15 YEARS OF AGE OR OLDER MAY CONSENT	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER IN RELATION TO PARENTS
GENERAL MEDICAL CARE	<p>“A minor may consent to the minor’s medical care or dental care if all of the following conditions are satisfied: (1) The minor is 15 years of age or older. (2) The minor is living separate and apart from the minor’s parents or guardian, whether with or without the consent of a parent or guardian and regardless of the duration of the separate residence. (3) The minor is managing the minor’s own financial affairs, regardless of the source of the minor’s income.” (Cal. Family Code § 6922(a)).</p>	<p>“A physician and surgeon or dentist may, with or without the consent of the minor patient, advise the minor’s parent or guardian of the treatment given or needed if the physician and surgeon or dentist has reason to know, on the basis of the information given by the minor, the whereabouts of the parent or guardian.” (Cal. Family Code § 6922(c)). See also exception at endnote ^(EXC).</p>
MINOR MUST BE EMANCIPATED (GENERALLY 14 YEARS OF AGE OR OLDER)	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER IN RELATION TO PARENTS
GENERAL MEDICAL CARE	<p>An emancipated minor may consent to medical, dental and psychiatric care. (Cal. Family Code § 7050(e)). See Cal. Family Code § 7002 for emancipation criteria.</p>	<p>The health care provider is not permitted to inform a parent or legal guardian without minor’s consent. The provider can only share the minor’s medical information with parents with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).</p>

This chart may be reproduced for **individual use** if accompanied by an acknowledgement.

EXC: Providers may refuse to provide parents access to a minor’s medical records, where a parent normally has a right to them, if “the health care provider determines that access to the patient records requested by the [parent or guardian] would have a detrimental effect on the provider’s professional relationship with the minor patient or the minor’s physical safety or psychological well-being.” Cal. Health & Safety Code § 123115(a)(2). A provider shall not be liable for any good faith decisions concerning access to a minor’s records. Id.

© National Center for Youth Law, revision Feb. 2010. Available at www.teenhealthrights.org and www.youthlaw.org.



CALIFORNIA MINOR CONSENT LAWS

SERVICES YOUTH CAN RECEIVE WITHOUT PERMISSION FROM THEIR PARENT/GUARDIAN		CAN PROVIDER TELL YOUTH'S PARENT/GUARDIAN?
Birth Control <i>Except Sterilization</i>	Minors of any age	No Parental notification allowed only with consent of minor
Pregnancy (Prev, Dx, Tx) <i>Including inpatient care</i>	Minors of any age	
Abortion	Minors of any age	
STIs, Contagious and Reportable Diseases (Dx & Tx)	Minors 12 yrs or older	
HIV Testing	Minors 12 yrs or older and assessed as competent to give informed consent	
Sexual Assault Care	Minors of any age	Yes In most cases, an attempt to notify parent/guardian must be made. ^{1,2}
Alcohol/Drug Counseling by Federally Assisted Treatment Program <i>Including inpatient care</i>	Minors 12 yrs or older ^{3,4}	No Parental notification allowed only with consent of minor
Alcohol/Drug Counseling by Non-Federally Assisted Treatment Program	Minors 12 yrs or older ^{3,4}	Yes An attempt to notify parent/guardian must be made, except when provider believes it is inappropriate
Outpatient Mental Health Treatment	Minors 12 yrs or older ⁵	

DEFINITIONS

(with regard to minor consent)

Confidentiality: The provider can only share patient information with permission of patient. Note: Exceptions include reporting child abuse and insurance billing.

Consent: Giving permission to receive health services; or giving permission to share patient information with others.

Notification: The provider is required to tell a minor's parent/guardian that he/she received a specific health service. Note: Notification does not mean access to medical records.

Sexual assault: For the purposes of minor consent alone, sexual assault includes but is not limited to acts of oral sex, sodomy, rape, and other violent crimes of a sexual nature that occur without permission.

Note: Minors maintain the same right to consent for the above healthcare services upon entry into foster care and juvenile justice systems. For more detailed information on consenting for healthcare services for youth in the foster care and juvenile justice systems, see: *Consent to Treatment for Youth in the Juvenile Justice System: California Law and Consent to Medical Treatment for Foster Children: California Law* at www.teenhealthrights.org.

Adapted from: CA Minor Consent Laws Pocket Card, the Adolescent Health Working Group.

¹The law allows for some exceptions to parental notification. These exceptions include suspecting the parent of assault and certain cases of rape. See teenhealthrights.org for more information.

²Sexual assault requires a child abuse report in which case youth should be advised that parents may be notified by law enforcement or child protective services.

³However, parent/guardian can consent over the minor's objection.

⁴Parent/guardian's consent is required for methadone treatment.

⁵If (1) the minor is 12 years or older, is mature enough to consent AND (2) the minor is (A) the victim of incest or child abuse or (B) would present a threat of serious physical or mental harm to self or others without treatment.

KEY:

Pre=Prevention

Dx=Diagnosis

Tx=Treatment

STIs=Sexual Transmitted Infections



When Sexual Intercourse with a Minor Must Be Reported as Child Abuse: California Law*

In California, health care practitioners are mandated to report any reasonable suspicion of child abuse. Sexual intercourse with a minor is reportable as child abuse:

1. WHEN COERCED OR IN ANY OTHER WAY NOT VOLUNTARY

Mandated reporters must report any intercourse that was coerced or in any other way not voluntary, irrespective of the ages of the partners and even if both partners are the same age. Sexual activity is not voluntary when accomplished against the victim’s will by means of force or duress, or when the victim is unconscious or so intoxicated that he or she cannot resist. See Penal Code § 261 for more examples. Irrespective of what your patient tells you, treating professionals should use clinical judgment and “evaluate facts known to them in light of their training and experience to determine whether they have an objectively reasonable suspicion of child abuse.” 249 Cal. Rptr. 762.

2. BASED ON AGE DIFFERENCE BETWEEN PARTNER AND PATIENT IN A FEW SITUATIONS

Mandated reporters also must report based on the age difference between the patient and his or her partner in a few circumstances, according to the following chart:

KEY: M = Mandated. A report is mandated based solely on age difference between partner and patient.

CJ = Clinical Judgment. A report is not mandated based solely on age; however, a reporter must use clinical judgment and must report if he or she has a reasonable suspicion that act was coerced, as described above.

AGE OF PATIENT	AGE OF PARTNER										
	12	13	14	15	16	17	18	19	20	21	22 and older
11	CJ	CJ	M	M	M	M	M	M	M	M	M ⇒
12	CJ	CJ	M	M	M	M	M	M	M	M	M ⇒
13	CJ	CJ	M	M	M	M	M	M	M	M	M ⇒
14	M	M	CJ	CJ	CJ	CJ	CJ	CJ	CJ	M	M ⇒
15	M	M	CJ	CJ	CJ	CJ	CJ	CJ	CJ	M	M ⇒
16	M	M	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ
17	M	M	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ	CJ
18	M	M	CJ	CJ	CJ	CJ	Chart design by David Knopf, LCSW, UCSF. The legal sources for this chart are as follows: Penal Code §§ 11165.1; 261.5; 261; 259 Cal. Rptr. 762, 769 (3 rd Dist. Ct. App. 1989); 226 Cal. Rptr. 361, 381 (1 st Dist. Ct. App. 1986); 73 Cal. Rptr. 2d 331, 333 (1 st Dist. Ct. App. 1998).				
19	M	M	CJ	CJ	CJ	CJ					
20	M	M	CJ	CJ	CJ	CJ					
21 and older	M	M	M	M	CJ	CJ					

DO I HAVE A DUTY TO ASCERTAIN THE AGE OF A MINOR’S SEXUAL PARTNER FOR THE PURPOSE OF CHILD ABUSE REPORTING?

No statute or case obligates health care practitioners to ask their minor patients about the age of the minors’ sexual partners for the purpose of reporting abuse. Rather, case law states that providers should ask questions as in the ordinary course of providing care according to standards prevailing in the medical profession. Thus, a provider’s professional judgment determines his practice. 249 Cal. Rptr. 762, 769 (3rd Dist. Ct. App. 1988).

WHAT DO I DO IF I AM NOT SURE WHETHER I SHOULD REPORT SOMETHING?

When you aren’t sure whether a report is required or warranted, you may consult with Child Protective Services and ask about the appropriateness of a referral.

*This worksheet addresses reporting of consensual vaginal intercourse between non-family members. It is not a complete review of all California sexual abuse reporting requirements and should not be relied upon as such. For more information on other reporting rules and how to report in California and other states, check www.teenhealthrights.org



CONFIDENTIALITY AND MINOR CONSENT Q&A

<p>Q: What are the services a minor can consent to?</p>	<p>A: See pages 2-8 “CALIFORNIA MINOR CONSENT LAWS: Who can consent for what services and providers’ obligations.”</p>
<p>Q: If a minor cannot give consent to health care, who (besides a parent) can give it for them?</p>	<p>A: <i>Adult Caretaker:</i> With letter from parent, or with a caretaker consent affidavit; <i>Guardian:</i> With court order granting guardianship; <i>Court:</i> Minors 16 and over whose parents are unavailable; <i>Juvenile Court:</i> Minor who is a dependent of court; <i>Foster Parent:</i> In some cases.</p> <p><i>Emergency:</i> Consent not required in an emergency Note: For complete information, please refer to http://www.teenhealthrights.org/</p>
<p>Q: How far should I go when trying to reach a parent?</p>	<p>A: When parental consent is necessary in order to provide a service, the provider must obtain that consent. If the provider is unable to reach a parent and believes that treatment must be provided immediately, the provider should proceed if the youth’s medical condition qualifies as an emergency. The provider should clearly document his/her actions, decisions, and rationale for treatment or interventions.</p>
<p>Q: Can consent be given verbally?</p>	<p>A: California statutes do not specifically require that consent be written. Often, for routine uncomplicated care, providers feel comfortable with verbal consent. In these cases, it is clear that the person giving consent understands the risks and consequences of the procedure and that the verbal communication is documented in the medical record. If the treatment is more complicated, the provider may want a signed consent form to be sure that the person providing consent is providing “informed consent” and understands the ramifications of the procedures performed. Health care providers should establish an office policy to provide all staff guidance. (See Back Office Policies, p.15)</p>
<p>Q: If parents give consent to treatment, does that give them the right to look over medical records?</p>	<p>A: The general rule is that parents have a right to see medical records if the parents consented to the treatment. HOWEVER, California law gives health care providers the right to refuse access to records anytime the health care provider determines that access to the patient records would have a detrimental effect on the provider’s professional relationship with the minor patient or the minor’s physical or psychological well-being. (Cal. Health and Safety Code § 123115(a)(2)). The health care provider is not liable for denying access to records under this provision if the decision to deny access was made in good faith.</p>
<p>Q: When the youth has the right to confidential care, what do I do if I’m uncomfortable NOT telling parents?</p>	<p>A: If a minor has the legal right to confidential care, a provider must abide by that right or risk liability or other legal sanction. There are a few minor consent statutes that grant the health provider the right to decide whether contacting a parent is appropriate or necessary even over the minor’s objection. One example is the minor consent drug treatment statute. See the chart on pages 2-6 confidentiality column for statutes that allow providers to share with parents over the minor’s objection. In those cases and no others, a provider can rely on their professional judgment to decide whether to share information with parents. Providers are not legally obligated to provide services to which they are morally or ethically opposed. In such circumstances, the provider should refer the adolescent to another provider, clinic, or program who can better meet the teen’s health care needs.</p>

CONFIDENTIALITY AND MINOR CONSENT Q&A, cont.

Q: What if the minor does not SEEM competent to make his or her own decisions? (low IQ, drug use, adult influence, etc.)

A: A patient is competent if the patient (1) understands the nature and consequence of his/her medical condition and the proposed treatment, and (2) can communicate his/her decision.

Providers can make their own assessment of a patient's competency and do not need a judicial ruling or psychiatric diagnosis in order to find a patient incompetent. When assessing whether the patient understands the nature and consequences of his/her medical condition (and can communicate his/her decision) take into account the following:

- (1) Always start with the presumption that a patient is competent.
- (2) Minority age alone is not a sufficient basis for determining if someone is incompetent. The law specifically deems minors capable of providing consent in certain medical situations.
- (3) Physical or mental disorders alone are not a sufficient basis for finding incompetency.
- (4) The nature and consequence of the medical condition must be explained in terms a minor would understand.
- (5) Believing that the patient is making an unwise or "wrong" medical decision is not a sufficient basis for finding the patient incompetent.
- (6) Competency is situation specific. A minor deemed incompetent in one situation may not be considered incompetent in all situations.

Q: How can we provide confidential care when the patient's health plan sends Explanation of Benefits (EOBS), bills, or surveys home after a visit?

A: If you know that a health plan will automatically send out materials to your patient you can do the following:

- (1) Become a Family PACT provider and bill for services through this program.
- (2) Urge your patient to sign-up for the Medi-Cal Minor Consent program and bill for services through this program.
- (3) Refer your patients to Family PACT or Medi-Cal Minor Consent providers. See page A-18, "Financing Sensitive Services: A Guide for Adolescent Health Care Providers."
- (4) Contact the patient's health plan and let them know your concerns.
- (5) Urge your patients to request that their insurer not send an EOB or send it to a different address, although the insurer is not obligated to comply.

Q: I know that minors 12 and over can consent to their own mental health care when they are mature enough to participate in the service and the minor would present "a danger or serious physical or mental harm to self or others without the mental health treatment." But, what is "serious harm?"

A: There is no statute or regulation that defines the term "serious harm". The interpretation of this term is left to the discretion and professional judgment of the provider. For more detailed information, please refer to "Behavioral Health: An Adolescent Provider Toolkit" at www.ahwg.net.

MANDATED REPORTING Q&A

<p>Q: Who is a Mandated Reporter?</p>	<p>A: There is a list of 33 mandated reporters, but those pertaining to adolescent health services are: 1) Physicians, 2) Surgeons, 3) Psychiatrists, 4) Psychologists, 5) Psychological Assistants, 6) Mental Health and Counseling Professionals, 7) Dentists, 8) Dental Hygienists, 9) Registered Dental Assistants, 10) Residents, 11) Interns, 12) Podiatrists, 13) Chiropractors, 14) Licensed Nurses, 15) Optometrists, 16) Marriage, Family and Child Counselors, Interns and Trainees, 17) State and County Public Health Employees, 18) Clinical Social Workers, 19) EMT's and Paramedics, and 20) Pharmacists.</p>
<p>Q: Why and when am I required to make a report?</p>	<p>A: The California Child Abuse and Neglect Reporting Act created a set of state statutes that establish the whys, whens and wheres of reporting child abuse in California.</p> <p>“Mandated reporters” are required to make a child abuse report anytime, in the scope of performing their professional duties, they discover facts that lead them to know or reasonably suspect a child is a victim of abuse. Reasonable suspicion of abuse occurs when “it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect child abuse or neglect.”</p> <p>The Act requires professionals to use their training and experience to evaluate the situation; however, “nothing in the Act requires professionals such as health practitioners to obtain information they would not ordinarily obtain in the course of providing care or treatment. Thus, the duty to report must be premised on information obtained by the health practitioner in the ordinary course of providing care and treatment according to standards prevailing in the medical profession.” (People v. Stockton Pregnancy Control Medical Clinic, 203 Cal.App.3d 225, 239-240, 1988)</p> <p>The pregnancy of a minor in and of itself does not constitute a basis for a reasonable suspicion of sexual abuse. A child who is not receiving medical treatment for religious reasons shall not be considered neglected for that reason alone.</p>
<p>Q: What about the right of patient confidentiality?</p>	<p>A: Child Abuse reporting is one of the few exceptions to patient confidentiality. Reporters do not need the minor or parent’s consent to share the otherwise confidential information necessary to make a report. The Child Abuse Reporting Act specifically exempts reporters from any liability for breaching confidentiality if they make a good faith report of abuse.</p>
<p>Q: When does a mandated reporter have to report sexual activity?</p>	<p>A: See page A-8 “When Sexual Intercourse is Reportable as Child Abuse in California?”</p>
<p>Q: How do I make a report?</p>	<p>A:</p> <ol style="list-style-type: none"> 1. Reports should be made to any one of the following: <ul style="list-style-type: none"> • any police department or sheriff’s department, not including a school district police or security department; • the county probation department, if designated by the county to receive mandated reports; or • the county welfare department (often referred to as CWA or CPS). 2. You must make an initial report immediately or as soon as is possible by telephone. A written report (DOJ form SS 8572) must be sent, faxed, or electronically transmitted within 36 hours of the verbal report.

MANDATED REPORTING Q&A, cont.

Q: What will I report?	A: <ol style="list-style-type: none">1. Your name. Although this is kept confidential, there are exceptions in certain limited situations.2. The child’s name.3. The present location of the child.4. The nature and extent of the injury.5. Any other information requested by the child protective agency, including what led you to suspect child abuse.6. If the child does not feel safe returning to the place of abuse or if he or she is in immediate danger, report this information as well.
Q: What happens to the report?	A: <ol style="list-style-type: none">1. The report will be investigated either by the local law enforcement agency or by the child protective services agency.2. The report will be assessed as to whether there is a need for immediate action.3. High risk factors will be considered to determine whether immediate face-to-face contact is required (ex. Direct interviews with anyone who might provide more information on the situation).4. The report will be determined to be either:<ol style="list-style-type: none">a) Unfounded (false, inherently improbable, to involve accidental injury, or not to constitute child abuse);b) Substantiated (constitutes child abuse or neglect);c) Inconclusive (not unfounded, but the findings are inconclusive and there is insufficient evidence to determine whether child abuse or neglect has occurred).
Q: What happens if the report is not unfounded?	A: <ol style="list-style-type: none">1. It will be forwarded to the Child Abuse Central Index and investigation will continue.2. The child may be taken into protective custody.3. A dependency case may be opened.
Q: Will I be told about the status of the report?	A: The Child Protective Agency is required to provide mandated reporters with feedback about the report and investigation. It might be necessary to be proactive in this situation by calling the Department of Social Services.
Q: Is there a statute of limitations?	A: No. If an individual under 18 years old tells you about abuse, even if it occurred when he or she was a young child, you must report it. Other agencies will decide whether the case should be pursued.

**IS YOUR OFFICE CONFIDENTIALITY CONSCIOUS?
OFFICE SELF-ASSESSMENT CHART**

			YES	NO
STAFF	Knowledge	Staff are educated regarding the confidentiality laws that pertain to adolescents (p. 2-11 of toolkit). Reference materials are available for all staff.		
	Policies	When confidentiality cannot be maintained, adolescents are provided referrals to other practices where confidentiality will be safeguarded.		
	Practice	Charts and paperwork are securely placed or stored.		
Patient information is only discussed in private and never in elevators, hallways, parking lots, garages, waiting rooms, or other open spaces.				
WAITING ROOM	Privacy	Precautions are taken to ensure privacy when patients register at the front desk.		
		Patients can sit in visually obscured, private areas (i.e. a corner or alcove; behind a room divider), and are shielded from the view of people walking outside.		
		Waiting room signs assure confidentiality.		
	Environment	The atmosphere (pictures, posters, etc.) creates a safe and comfortable environment for adolescents to discuss private health concerns.		
		Patients are given as much privacy as possible when completing forms and paperwork.		
HAND OUTS AND MATERIALS	Discrete	Literature is small enough to fit into a purse or wallet.		
	Accessible	Educational materials on confidentiality for adolescent patients and their parents are displayed and/or offered.		
		Written materials have been translated to languages spoken by patients and families.		
		Written materials have been assessed for reading levels and some materials target adolescents with a reading level below 8th grade.		
EXAM	Informative	Adolescents and parents are provided with the opportunity to talk one-on-one with the health care provider about their concerns.		
		At the beginning of each appointment, the parameters of confidentiality are explained to patients and his/her parents.		
		Situations in which confidentiality may be breached are discussed.		
		A sign in the exam room encourages patients to ask questions.		
	Private	Patients are given privacy when changing clothes.		
		Doors are closed during history taking, counseling, and physical exams.		

**IS YOUR OFFICE CONFIDENTIALITY CONSCIOUS?
OFFICE SELF-ASSESSMENT CHART, cont.**

			YES	NO
IN-HOUSE RECORD KEEPING*	HIPAA Compliant	File cabinets, drawers, and file rooms are closed and locked when not in use.		
		Adolescent charts are flagged with a sticker stating “DO NOT COPY,” and staff are trained to separate out confidential materials when copying records.		
		Confidential visit information is filed in a separate or distinctly marked section of the medical record.		
	Electronic Records	Computer access is protected by passwords, and monitors are faced away from public view.		
PRE-VISIT AND FOLLOW UP	Phone Calls	New adolescent patients can join your practice without parental consent when legally possible.		
		Patients are asked at the time of scheduling if automated appointment reminder calls are ok.		
		At every visit, adolescent patients are asked where and how they can be contacted by phone or email for general and/or confidential matters.		
	Mail	Appointment reminders are only mailed to adolescent patients’ homes with permission from the adolescent. If the adolescent does not wish to receive mail at home or an alternate address, he or she is offered a time to pick up mail at the clinic.		
BILLING	Procedures	Special considerations are made to safeguard confidential visit information for adolescents with private insurance. Please see p. 15 of toolkit.		
		Payment for confidential services is collected at the time of service if possible.		

HOW DID YOU SCORE?

If you checked more than half of the boxes “yes” in each section, you’re on your way to having a confidentiality conscious office. Each section in which you checked only half or less of the boxes “yes” should be improved to better promote and protect confidentiality in your office. You can improve your office by implementing each piece that you checked “no.”

*While establishing confidentiality conscious guidelines in the front office is essential, it is also important to acknowledge that confidentiality can be breached through the systems that support your electronic record keeping, billing, insurance claims, and explanation of benefits (EOBs). See the Back-Office Policy Recommendations (p.15) for suggestions on confidentiality conscious policies for the systems in your type of practice.

CONFIDENTIALITY CONSCIOUS BACK-OFFICE POLICY RECOMMENDATIONS

The following administrative policies are necessary in any practice setting for the promotion and protection of adolescent confidentiality. Exemplary policies from various health care settings can be found at www.californiateenhealth.org.

COMMUNICATION AMONG FRONT AND BACK OFFICE STAFF

- Clinician/Provider: The clinician stamps or visibly marks the chart of each adolescent patient who receives minor consent services. Clearly marking charts that contain confidential information is imperative so that all personnel (including registration and lab) are aware that adolescents' confidentiality must be maintained.
- Front and Back Office Staff: All staff are trained to look for confidential charts and treat them accordingly.

SENSITIVE BILLING PRACTICES

- For confidential services, request any co-payment at the time of service. If the adolescent patient cannot pay at the time of visit, a balance is incurred that can be paid in person at a later date or alternately, waiving the fee.
- Electronic or automatic billing programs can be circumvented by using alternate programs or methods of record keeping for paying for confidential services.

DIFFERENT TYPES OF PRACTICES WILL REQUIRE ADDITIONAL OR SPECIALIZED POLICIES.

Special Considerations for Privately Insured Patients

While Medi-Cal and other types of public coverage generally avoid sending explanation of benefits (EOB) to patients' homes for confidential or sensitive services, private insurance companies are often required to send EOBs as a measure to avoid fraud. Even if billing to the home is avoided, an EOB sent home can breach confidentiality for adolescents who are insured through their parents. In general, *providers* have little to no control over how insurers will inform their beneficiaries of claims, but HIPAA allows *patients* to request that his or her insurance plan not send an EOB to the household if disclosing the information to another household member will "endanger" the patient.

POLICY RECOMMENDATIONS:

- Ensure that patients seeking confidential or sensitive services are aware that they may request that their insurer not send an EOB or send it to a different address if the disclosure would "endanger" the patient. Note that the insurer is not obligated to comply with the request. Adolescent patients may not know what type of insurance they have, so the following recommendation should be simultaneously implemented.
- Train billing, claims, or other appropriate staff to flag or contact privately insured patients receiving confidential care to warn them that an EOB containing information may be sent to their home address. Patients receiving confidential services who feel they would be endangered by receiving an EOB to the household should be encouraged to contact their health plan's HIPAA-required privacy officer for information on how to make a request.

ELECTRONIC RECORDS

- Face monitors away from public and other employee view, or use privacy screens, strategically placed objects, or timed screen savers and log-outs.
- Use passwords, and enforce no password sharing or accessible written passwords.
- When communicating between electronic systems, use a real or virtual cover sheet with a confidentiality notice and request to destroy if sent unintentionally.
- When disclosing medical records of a minor to the parent of that minor, confidential minor-consent services are NOT automatically printed or included.

PROMOTION OF SERVICES

- Advertisement wallet cards are adolescent-appropriate and state confidentiality practices.
- Publicize your services at local schools.

Balancing Act: Engaging Youth, Supporting Parents

Attempting to provide confidential services can cause great discomfort for adolescents, parents, and providers if it is not handled in a sensitive manner. The following are recommendations to ease the transition from the parent-accompanied visit to the confidential adolescent visit. The participation of a parent/caregiver in the adolescent's visit is invaluable and should be encouraged. That said, essential information may not be disclosed if the provider does not establish rapport and an alliance with the adolescent. When balancing the needs, concerns, and priorities of the parent with those of the adolescent, remember, the *adolescent* is your client, not the parent.

SEPARATING THE ADOLESCENT AND PARENT IN THE CLINICAL VISIT:

ROADMAP

- Lay out the course of the visit... *for example*, “We will spend some time talking together about Joseph’s health history and any concerns that you or he might have, and then I will also spend some time alone with Joseph. At the end of the visit, we will all talk to clarify any tests, treatments or follow-up plans.”
- Explain your office/clinic policy regarding adolescent visits.
Review your policy verbally early in the interaction with the adolescent and parent.
Normalize the reality that adolescents have an increased concern with and need for privacy.
Acknowledge that although the adolescent is a minor, they do have specific legal rights related to consent and confidentiality.
Introduce the concept of fostering adolescent self-responsibility and self-reliance.
Reinforce that this policy applies to all adolescents in your practice or clinic (in other words, this is not specific to a particular adolescent).
Validate the parental role in their adolescent’s health and well-being.
- Elicit any specific questions or concerns from the parent.
- Direct questions and discussion to the adolescent while attending to and validating parental input.

SEPARATE

- Invite the parents to have a seat in the waiting area, assuring them that you will call them in prior to closing the visit.

ESTABLISHING A RELATIONSHIP WITH THE ADOLESCENT:

REVISIT

- Once the parent is out of the room, revisit issues of consent and confidentiality with the adolescent, including situations when confidentiality has to be breached (suicidality, abuse, etc.).
- Revisit areas of parental concern with the adolescent and obtain the adolescent’s perspective.

EXAM

- Conduct the psycho-social interview and physical exam (ascertain whether the adolescent desires parent’s presence during PE and accommodate adolescent’s preference).
- Decide what to disclose and how; clarify what information from the psycho-social interview and PE the adolescent is comfortable sharing with parent.
- Encourage the adolescent to discuss issues with their parent or other responsible adult as appropriate to the individual circumstances.
- Explore approaches the adolescent might use to facilitate this discussion (how do they imagine the conversation).
- Offer support, tools and facilitation.

CONCLUDING THE VISIT WITH THE ADOLESCENT AND PARENT

REUNITE

- Invite the parent back to close the visit with both parent and adolescent.
- Focus on strengths and discuss concerns (with the adolescent’s permission).

TIPS

- Give parents and adolescents a heads up about confidential care. Send a letter to all adolescent patients and their parents who are new or between 10-11 years old explaining your policy. This will help prepare families for the adolescent visit.
- Explain the separation of the parent and adolescent by emphasizing that adolescents need to have increasing involvement in and **responsibility** for their health.
- A young person is more likely to disclose sensitive information to a health care provider if the adolescent is provided with confidential care, and has time alone with the provider to discuss his/her issues.
- Even when the presenting concern is acne or an earache, there may be other issues (such as the need for a pregnancy test or contraception), which will only surface when confidential care is provided.
- Display posters in the waiting area explaining adolescent consent and confidentiality and your office policy relating to the law. This can reinforce that you will be meeting alone with the adolescent.

Provider Tips for Discussing Conditional Confidentiality

Be direct

- Discuss confidentiality and the conditions under which it might be breached at the beginning of your interaction with a young person.

Keep it simple

- Tailor your discussion to the youth's age and context. For example, when presenting information about child abuse reporting related to age differences:

In California for the 13 year old client, it is important to emphasize that if they tell you that they are having sex with a partner who is older than they are, you would need to report that as child abuse, *even if they tell you they are having consensual sex, in order to assure that they can get help if they need it.*

In California for the 16 year old client, the focus would shift to a discussion of his or her risk of being reported as a perpetrator of child sexual abuse if they tell you that their partner is under 14 years old.

Communicate caring and concern

- Always frame information about your need to breach confidentiality (child abuse reporting, informing others about a youth's suicidality) in the context of "getting them the help that they might need", rather than using the law, policy, or phrase "I am a mandated child abuse reporter," as a reason to breach confidentiality.

Assure two-way communication

- Clarify that you will ALWAYS let the youth know if you are going to share information that they told you in confidence.

Know the law

- Be very familiar with California laws related to minor consent and confidentiality. In order to explain content clearly, you must first understand it yourself.

Check for understanding

- Ask the youth to explain what *they* understand about conditional confidentiality to avoid any misperceptions.
- If you're unsure about a situation or question that comes up about confidentiality, let the client know that you need to check out the facts and then get back to them in a timely fashion.

Document your communications, understanding and actions in the medical record

Financing Sensitive Services: A Guide for Adolescent Health Care Providers

Payment for sensitive services (i.e. STI testing and treatment, pregnancy related services, and behavioral health care) can pose an enormous barrier to youth seeking confidential care. Young people may not have enough money to pay for services that they need. Often, they are also worried that if they access services through their parent's insurance or free and low-cost programs, such as Family PACT (Planning, Access, Care and Treatment) and Minor Consent Medi-Cal, that their confidentiality will be compromised.

Use of Evidence of Benefits (EOB) Statements is another potential barrier that can affect billing choices for providers and use of services for adolescents. These statements, which typically list the type and nature of services billed for and reimbursed by the insurer, are generally mailed to the policy holder (parent). As a result, confidentiality may be violated. **Insurance company policies and state law, not individual provider preference, determine whether EOBs are sent to the policy holder.**

California has two unique programs that reimburse confidential health services for youth: Medi-Cal Minor Consent and Family PACT. Below you will find information on how to become a provider in each of these programs, how to determine youth eligibility, and how to receive payment for services rendered. These two programs do not send out EOB's.

KEY DIFFERENCES BETWEEN MEDI-CAL MINOR CONSENT AND FAMILY PACT (TITLE X):

1. While both programs cover pregnancy testing, Family PACT does not cover abortion or care once pregnant. Medi-Cal Minor Consent covers these services.
2. Family PACT covers females 55 and under and males 60 and under. Medi-Cal Minor Consent provides coverage for females and males up to age 21.
3. Clients must enroll in Family PACT at an FFACT provider's office. Clients can enroll for Medi-Cal Minor consent with an eligibility worker, who may or may not be located in a clinical setting.
4. For Family PACT, eligible clients are activated for one year following application and reconfirmed at each date of service; clients using Medi-Cal Minor Consent services must renew their eligibility every 30 days.

RESOURCE FOR ADDITIONAL INFORMATION

Fox, H. and Limb, S. "State Policies Affecting the Assurance of Confidential Care for Adolescents" (April 2008)
This fact sheet is a comprehensive overview of state's minor consent laws, explains how and why EOBs are used, and addresses implications of these policies for adolescents and providers. <http://www.thenationalalliance.org/jan07/factsheet5.pdf>

Financing Sensitive Services: A Guide for Adolescent Health Care Providers, cont.

	MEDI-CAL MINOR CONSENT	FAMILY PACT (Title X)
SERVICES COVERED	<ul style="list-style-type: none"> • Pregnancy and pregnancy-related services, including abortion • Family planning (birth control), including emergency contraception • Drug and alcohol counseling and treatment • Sexually transmitted infection testing and treatment • Sexual assault treatment 	<ul style="list-style-type: none"> • Pregnancy testing, counseling and referral • Family planning methods, including birth control and emergency contraception • Sexually transmitted infection testing and treatment • Education and counseling about reproductive health • HIV testing and counseling • Referrals for other services
CLIENT ELIGIBILITY (Age)	12 to 21	Females 55 and under; Males 60 and under
CLIENT ELIGIBILITY (Income)	Any income	200% of federal poverty level or less
CLIENT ELIGIBILITY (Citizenship)	Must be a California resident	Must be a California resident
INFORMATION REQUESTED FROM CLIENT	Name, phone number, address to which confidential mail can be sent. Social Security number is NOT requested.	Enrollment is by client report. Social Security number is NOT required.
CLIENT CO-PAY	None	None
HOW A YOUNG PERSON CAN UTILIZE THIS PROGRAM	Patient must visit the local county Social Services Office where eligibility is determined. Locations and phone numbers can be found at: www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx	Patient must visit a Family PACT provider, who will enroll the youth in the program. Services can be accessed immediately.
FOR MORE INFORMATION	Check the Medi-Cal website: www.medi-cal.gov or call the Medi-Cal Telephone Service Center (TSC) 1-800-541-5555.	The Family PACT website has comprehensive links to all aspects of the program: http://www.cdph.ca.gov/programs/FamilyPact/Pages/default.aspx A toll-free resource number provides information in both English and Spanish. 800-942-1054
HOW CAN A CLINIC BECOME A PROVIDER	Practitioner must be a Medi-Cal provider. Call 1-800-541-5555 or visit www.medi-cal.gov to download the provider application form.	A one page PDF on the Family PACT website includes phone numbers and resources for clinics and providers. A one-day orientation to the program is required. Contact the California Office of Family Planning at (916) 650-0414 for information. http://www.cdph.ca.gov/programs/FamilyPact/Documents/MO-AssistancePhoneCallAway07-08.pdf

Notes



The following pages consist of handouts for use with your adolescent patients and their parents. It is important to remember that these documents are intended to be used in conjunction with your visits—they are NOT a substitute for discussing these issues.

Youth materials are denoted with this symbol:



Parent materials are denoted with this symbol:



These handouts are also available in Spanish and Chinese on the websites of Adolescent Health Working Group (AHWG) www.ahwg.net and California Adolescent Health Collaborative (CAHC) www.californiateenhealth.org

We hope that these materials will offer guidance and spark discussion!

AHWG has additional materials for use with youth and parents in their other Toolkit modules. All toolkit modules can be downloaded from the website listed above.

The **TRUTH** ABOUT **Confidentiality**

Confidentiality means privacy.

Confidential health care means that information is kept private between you and your doctor or nurse.

Your doctor or nurse **CANNOT** tell your parents or guardians about your visits for:

- Pregnancy
- Birth control or abortion
- Sexually transmitted diseases (STDs)

For your safety, some things **CANNOT** stay confidential. Your doctor or nurse has to contact someone else for help if you say...

- You were or are being physically or sexually abused.
- You are going to hurt yourself or someone else.
- You are under 16 and having sex with someone 21 years or older.
- You are under 14 and having sex with someone 14 years or older.

CONFIDENTIALITY TIPS FOR TEENS

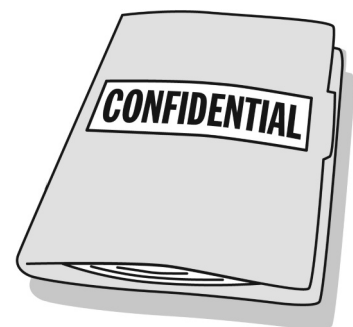
Ask questions about confidentiality. You can ask your doctor or nurse and health insurance plan what information will be shared with your parent/guardians.

Know your rights in the health care system and speak up.

Read and understand forms before you sign them.

*Even if you do **NOT** need permission from your parent/guardian to see a doctor, it's a good idea to talk with them or a trusted adult about the help you need.*

Every state has different confidentiality laws. This information applies **ONLY** to California. Visit www.teenhealthrights.org for more information about laws that protect your privacy when talking to your health care provider.





Teens... Did You Know?

Anything you say about sex, drugs and your personal feelings is confidential.*

There are some exceptions so ask your doctor about confidentiality rules.



*Visit www.teenhealthrights.org for more information about laws that protect your privacy when talking to your healthcare provider.

Teen Health Rights and Responsibilities



An Agreement Between You and Your Doctor

As a teen,

I have the RIGHT to:

- Be treated with respect.
- Be given honest and complete health information.
- Ask questions.
- Know how my health insurance and billing process works.
- Be able to look at my medical records.
- Ask for any of my family, friends, or partners to come into the exam room with me.
- See my doctor without my parent/guardian in the exam room.

I have the RESPONSIBILITY to:

- Give honest information and let my doctor know if my health changes.
- Follow the plan that I choose with my doctor or nurse, and tell him/her if I choose to change my plan.
- Treat staff, other patients, and the office with respect.
- Be on time for my appointments and call if I need to cancel or change an appointment.

When I have questions, I will **ASK!**

When I have concerns, I will **SPEAK UP!**

When I like what happens, I will **SMILE AND SAY THANKS!**

How Well do you Know Your Health Rights and Responsibilities?

TRUE OR FALSE:

A teen can see a doctor about birth control and pregnancy without their parent/guardian's consent.

TRUE: California has laws that let a person of any age make their own choices about birth control, pregnancy, abortion, adoption, and parenting.

Teens 12 and older can see a doctor about mental health issues, drug and alcohol use, or sexually transmitted diseases without their parent's consent.

TRUE: California laws let people 12 or older get care for mental health, drug and alcohol issues, or sexually transmitted diseases without parent consent.

Not all issues a teen might want to see a doctor for are considered confidential.

TRUE: Cases of abuse, assault, or possible suicide cannot remain confidential. Your doctor may have to contact others for help. Health services like treatment of injuries, colds, flu, and physicals are NOT confidential services. The doctor will need your parent/guardian's consent for these services.

A teen can ask a doctor about what will stay private in a visit, and what information will be shared with parents/guardians.

TRUE: There are many laws about what information your parent/guardian will be given. It is important to talk to your doctor about what will stay private. In some situations, you get to decide what is shared.

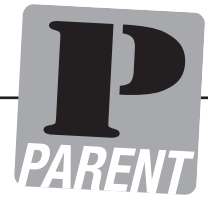
It is usually helpful for a teen to talk to an adult they trust about their health or changes in their life that they are worried about.

TRUE: It can be helpful to talk to an adult you trust such as a parent/guardian, teacher, family friend, counselor, or coach about your health. If there are health issues you have questions or concerns about, a trustworthy adult can give you important advice and opinions.

A teen being responsible for his or her health is an important part of growing up!

TRUE: Taking on more responsibility and wanting more privacy are a normal part of growing up for teens.





A Letter From Your Teen's Health Care Provider

Dear Parent or Guardian,

As teens become adults and take more control of their lives, our office will ask them to be more actively involved in their health and health care.

Some areas of teen health that we may talk about during an exam are:

- Eating and how to be active
- Fighting and violence
- Sex and sexuality
- Safety and driving
- Smoking, drinking, and drugs
- Sadness and stress

You should know . . .

We support teens talking about their health with their parents or guardians. But teens may be embarrassed to have an exam or talk about some things in front of their parents. This is a normal part of growing up. We give all teens a chance to be seen privately. During this time, you will be asked to wait outside of the exam room.

In order to best take care of your teen we offer some confidential services. "Confidential" means that we will only share what happens in these visits if the teen says it is okay, or if someone is in danger.

In California, teens can receive some types of health services on their own. We cannot share the content of these visits without your teen's okay. Ask us about what these health services include.

We are happy to talk to you about any questions or concerns you may have about this letter and your teen's health. Together, we can help keep your teen healthy.

Below, you will find some helpful websites about teen health and tips for parents of teens.

Sincerely,

Your teen's Health Care Provider

RESOURCES

Children Now and Kaiser Family Foundation
<http://www.talkingwithkids.org>

Advocates for Youth
<http://www.advocatesforyouth.org/>

SIECUS— Families are Talking
<http://www.familiesaretalking.org>

California Family Health Council—Talk with Your Kids
<http://www.talkwithyourkids.org/>

**US Department of Health & Human Services—
Parents Speak Up**
<http://www.4parents.gov/>

Nickelodeon—Parents Connect
<http://www.parentsconnect.com>



A Note to Parents from your Teen's Doctor

- Teens need to have more input in their health in order to build responsibility.
- I will give your teen a chance to talk to me alone during each exam.
- In California, teens can receive some services on their own. I cannot talk to you about your teen's use of these services without permission from your teen. Talk to me about what these services are.
- I encourage teens to talk about their health with their parents.
- I am happy to answer any questions or concerns you may have!





YOUR TEEN IS CHANGING!

The teen years are a time of growth and change as your teen moves from being a child to an adult.

As your teen changes, your role as a parent changes. You will relate to your 12 year old differently than your 18 year old. It is important to know what to expect, so that you can give your teen more responsibility and the best possible advice.

YOUR TEEN MIGHT:

- Become more independent
- Want more responsibility
- Push boundaries and test limits
- Want their relationship with you to change
- Need more privacy
- Have mood swings
- Think a lot more about their own personal concerns
- Place more importance on friends
- Feel that no one understands them
- Tryout new behaviors and activities – both healthy and risky
- Understand complicated concepts instead of just the here and now

YOUR TEEN STILL NEEDS YOU TO:

- Give them your time
- Give them a sense of connection or belonging
- Support them
- Provide for their basic needs
- Guide them
- Express your love
- Set limits
- Pay attention to their successes and behaviors
- Be involved and aware of what is going on in their lives

REMEMBER:

All of these changes are perfectly normal! Your teen still needs you, but may not always know how to communicate that. You are still the best person to guide your teen, and it is important to keep talking with them.

Talk to your teen’s doctor or nurse about these changes and any challenges you may have with your teen.

WEBSITES FOR PARENTS:

RESOURCES

Children Now and Kaiser Family Foundation
<http://www.talkingwithkids.org>

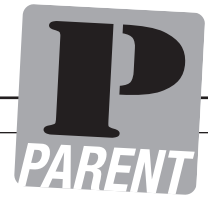
Advocates for Youth
<http://www.advocatesforyouth.org/>

SIECUS– Families are Talking
<http://www.familiesaretalking.org>

California Family Health Council–Talk with Your Kids
<http://www.talkwithyourkids.org/>

**US Department of Health & Human Services–
Parents Speak Up**
<http://www.4parents.gov/>

Nickelodeon–Parents Connect
<http://www.parentsconnect.com>



TALKING TO YOUR TEEN ABOUT TOUGH ISSUES

The natural changes that happen during the teen years can be hard for you and your teen. In many families, there may be disagreements as teens want more privacy and independence. Parents might feel that their teens are moody and disrespectful.

Teens make decisions about things like sex, smoking, alcohol and drugs. As an adult, you continue to make decisions about these things, too. As the parent of a teen, you have the opportunity and responsibility to help them learn how to make healthy decisions. Teens want information and a close relationship with their parents. Even though it can be hard, it is important to talk openly and often with your teen about these issues.

Tips for talking with your teen:

Talk:	Don't be afraid to talk about tough subjects like sex and drugs. Even if your child is only 10 or 11 years old, you can talk about puberty, peer pressure, and staying healthy. This will let your teen know that it is ok to talk with you about these issues.
Listen:	It is important to listen and be open to your teen's opinions. Try not to interrupt while they are telling you their point of view.
Be honest:	Give truthful answers when your teen asks for information. Don't worry if you don't have all the answers.
Share your ideas and opinions:	Teens want to hear about your values and beliefs.
Respect their opinions:	Teens become more mature and independent, and letting them make their own choices is an important part of growing up. Ask them for their ideas and opinions. Make sure to let them know you are always there to help, even if you do not agree with all of their decisions or behaviors.
Stay calm:	Try to stay calm if they come to you with a problem that is upsetting, so they will not be afraid to talk to you.
Keep talking:	Bring up subjects over and over again. Don't be afraid to bring up important topics that you have already talked about. Use movies, TV shows or news stories about teen health as a way to start discussions.
	Don't be afraid to ask for help!



HELPING YOUR TEEN TAKE RESPONSIBILITY FOR THEIR HEALTH

Raising teens can be tough. Sometimes they want you around and sometimes they don't. Sometimes they are responsible and sometimes they are not. Teens need involved parents, but they also need some privacy when it comes to their health. With privacy, they can talk openly to their doctor about their concerns. Without privacy they may avoid going for certain services. These may be called "confidential" or "sensitive" services.

For most types of medical care, parents need to give consent and they can get information about their teen's doctor's visits. But under California law teens can get private care without parent consent for some "confidential" or "sensitive" visits, such as those for:

- Birth control
- Pregnancy
- Sexually transmitted diseases (for ages 12 and older)
- Sexual assault services
- Mental health counseling (for ages 12 and older)
- Alcohol and drug counseling (for ages 12 and older)

Don't I have a right to know what medical care my teen is getting?

Why can my teen go to the doctor for these serious issues without me knowing about it?

Every state has laws for children under 18 to get certain kinds of health care without their parents' consent. Fortunately, MOST teens DO talk to their parents, and they want their parents' advice. You play an important role in helping them stay healthy! But even if the relationship between you and your teen is strong, there are some issues that your teen may want to get care for on his or her own. Teens may be embarrassed, ashamed, or scared to talk to parents about some issues. They may not go to the doctor unless they know the information would be kept private.

What will happen if my child is in danger?

There are some limits to confidentiality. If a doctor or nurse learns that a teen under 18 years is being abused, or is thinking about hurting him/her self or others, the proper authorities must be contacted for help.

Will my teen keep secrets from me since they can get confidential services?

Wanting privacy is a healthy and normal part of growing up. Even though teens are able to get some medical care without parent permission, doctors and nurses encourage them to talk to their parents or another trusted adult.

How can I let my teen know I want to talk to them about these kinds of issues?

As the parent of a teen, part of your job is helping them learn how to make healthy decisions. They are becoming more independent, and making their own choices is an important part of growing up. Make sure you let them know you are always there to help, even if you do not agree with all their decisions. Listen, and when possible, stay calm if they come to you with a problem that is upsetting, so they will continue to talk to you.



KNOW MYSELF, KNOW MY TEEN

Sometimes your opinions can stand in the way of listening to your teen with an open mind. If teens feel judged by their parents or guardians, they are less likely to share information that may be sensitive, embarrassing, or hard to talk about. Ask yourself these questions before you talk about sensitive issues with your teen.

How do I feel?

What is your mood? What are the memories that may shape your opinions? Keep in mind that what you went through as a teen may be different from what your teen is going through now.

What was I doing when I was 16?

Have you thought about what you want to share with your teen? Hold off on sharing sensitive information with your teen until he/she is in the middle teen years.

Are we finding some time together to enjoy each other?

It may be hard to believe, but most teens say they wish they had more time with their parents. Difficult topics may be easier to talk about when you spend enjoyable times together like going for walks, watching movies, doing projects, or sharing meals.

Am I listening to my teen?

Spend as much time listening as you do talking. Avoid making quick judgments. If you do not understand what your teen is trying to say, repeat what they have said back to them.

Do I judge too quickly?

Always ask your teen what she or he is doing rather than thinking the worst. Trust that he or she can make good decisions.

What are my rules about safety?

Tell your teen which rules must be followed for his or her safety. Follow through with consequences if your teen behaves in unsafe ways. Talk about the importance of safety on a regular basis, not only once. Get help immediately if your teen is in an unsafe situation.

Am I willing to get help for any problems I may have?

It is important to be an example for your teen. Seeing family members get help will encourage your teen to get help for his or her own problems.



Adapted with permission from "Are you An Askable Parent?" Advocates for Youth, Washington, DC. www.advocatesforyouth.org



THE 5 BASICS OF HOW TO PARENT TEENS

1. LOVE AND CONNECT

Support and accept your teen as she/he gets older. Their world is changing. Make sure your love doesn't.

Tips for Parents:

- Say good things about your teen when he or she does something well.
- Support your teen's interests, strengths, and talents.
- Spend time one-on-one and as a family.
- Get to know your teen's friends and their parents/caregivers.

2. WATCH AND OBSERVE

Find out what is going on by talking with your teen. Notice your teen's activities. Your interest matters to them.

Tips for Parents:

- Talk with the other adults in your teen's life.
- Be aware of your teen's classes, grades, job, and interests.
- Know where your teen is, what he or she is doing, and who your teen is with.

3. TEACH AND LIMIT

Limits protect your teen from unsafe situations and give him/her room to mature. Be firm, but also be willing to adapt and change your mind.

Tips for parents:

- Help teens make better choices by teaching them instead of punishing them.
- Stand firm on important issues such as safety, and let go of smaller issues.
- Be consistent and follow through with consequences you set up with your teen.
- Be firm about rules without turning to physical punishment.
- Give your teen more responsibility and more freedom to make their own choices as they grow into adults.

4. SHOW AND DISCUSS

Talk to your teen, support him or her, and teach by example!

Tips for Parents:

- Set a good example by behaving the way you want your teen to behave.
- Praise your teen's positive behaviors and habits.
- Give teens the chance to solve their own problems and make their own choices.

5. PROVIDE AND PROMOTE

Teens need parents to give them healthy food, clothing, shelter, and health care. They also need a caring home and loving adults in their lives.

Tips for Parents:

- Seek out good opportunities and activities for your teen.
- Make sure your teen gets checkups with his/her doctor every year, and any counseling that he or she needs.
- Reach out for support from other parents when you need it!

RESOURCES

Children Now and Kaiser Family Foundation

<http://www.talkingwithkids.org>

Advocates for Youth

<http://www.advocatesforyouth.org/>

SIECUS— Families are Talking

<http://www.familiesaretalking.org>

California Family Health Council—Talk with Your Kids

<http://www.talkwithyourkids.org/>

**US Department of Health & Human Services—
Parents Speak Up**

<http://www.4parents.gov/>

Nickelodeon—Parents Connect

<http://www.parentsconnect.com>

Adapted with permission from: Simpson AR. Raising Teens: A Synthesis of Research and a Foundation for Action. Center for Health Communication, Harvard School of Public Health. 2001, <http://hrweb.mit.edu/worklife/rpteens.html>

MY TEEN IS GOING TO THE DOCTOR AND NOT TELLING ME!



You just found out that your teen is getting medical services without telling you. As a parent you may be worried and upset when this happens. This is normal. But try thinking about it this way – your teen is being responsible for their health. This is something you can be proud of!

Remember:

- Your teen is becoming more independent. As teens get older they try out more adult behaviors, and may want to find help on their own. This is an important part of growing up.
- You are important to your teen and their health! But even when teens and parents have strong relationships, there are some issues that your teen may want to talk to their doctor about on their own.
- It is never too late to talk to your teen about tough subjects. Start by talking about your own values and expectations. It is important that you:
 - ✓ Stay calm
 - ✓ Listen
 - ✓ Respect their ideas
 - ✓ Share your thoughts and opinions
 - ✓ Do not lecture
- Doctors and nurses want to help and support you. Ask them for help if you have concerns or questions about your teen.

WHAT IS THE FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT (FERPA)?

The confidentiality rules described in other parts of this toolkit module apply when health and mental health services are provided in a traditional clinical setting. When services are provided on school grounds, however, there are additional federal and state laws that must be considered. One of the most important is the federal Family Educational Rights and Privacy Act (FERPA) and related state education law.

What is FERPA?

The Family Educational Rights and Privacy Act (FERPA) protects the privacy of students' personal information held by "educational agencies or institutions" that receive federal funds under programs administered by the U.S. Secretary of Education.

What is an educational agency or institution subject to FERPA?

"Educational agencies or institutions" are defined as institutions that provide direct instruction to students, such as schools; as well as educational agencies that direct or control schools, including school districts and state education departments.¹ Organizations and individuals that contract with or consult for an educational agency also may be subject to FERPA if certain conditions are met.² Almost all public schools and public school districts receive some form of federal education funding and must comply with FERPA.

What information does FERPA protect?

FERPA controls disclosure of written information maintained in the "education record." "Education records" are defined as written records, files, documents, or other materials that contain information directly related to a student and are maintained by an educational agency or institution, or a person acting for such agency or institution.³ "Information directly related to a student" means any information "that, alone or in combination, is linked or linkable to a specific student that would allow a reasonable person in the school community...to identify the student with reasonable certainty."⁴ Student health records maintained by a school nurse are "education records," as are immunization records housed in a student education file.⁵ Oral communications and "personal records,"⁶ as that is defined in FERPA, are not considered part of an education record. Personal records are notes kept in the maker's possession, used only as a memory aid, and not shared with anyone except a temporary substitute.

What are the general requirements of FERPA?

Generally, FERPA prohibits educational agencies from releasing any information in the education record unless they have written permission for the release. In most cases, a parent must sign that release. When students are eighteen years old or older, they sign their own release forms. FERPA also requires educational agencies to allow parents to access their minor children's education records.

There are exceptions to these rules, including exceptions that allow agencies and schools to disclose information without a written release in some circumstances. For example, schools may share "directory information"⁷ about students with the public if the school and district have first followed certain procedures defined in FERPA, including giving parents an opportunity to opt out. Another exception allows school staff to share information with "school officials"⁸ in the same school who have a

“legitimate educational interest” in the information.⁹ Certain policies must be in place at the district level in order to implement both exceptions. Additional exceptions also exist, including exceptions that allow sharing information in emergency situations and for school transfers, among others.¹⁰

Does California have state laws on this issue?

California has state laws that protect the confidentiality of information held by schools.¹¹ For the most part, the rules and exceptions in California law parallel those found in FERPA.¹²

i 34 C.F.R. § 99.1(a).

ii See e.g. 34 C.F.R. § 99.31(a)(1)(i)(B) (“A contractor, consultant, volunteer, or other party to whom an agency or institution has outsourced institutional services or functions may be considered a school official under this paragraph provided that the outside party-- (1) Performs an institutional service or function for which the agency or institution would otherwise use employees; (2) Is under the direct control of the agency or institution with respect to the use and maintenance of education records; and (3) Is subject to the requirements of § 99.33(a) governing the use and redisclosure of personally identifiable information from education records.”).

iii 20 U.S.C. § 1232g (a)(4)(A) (“... the term “education records” means, except as may be provided otherwise in subparagraph (B), those records, files, documents, and other materials which—(i) contain information directly related to a student; and (ii) are maintained by an educational agency or institution or by a person acting for such agency or institution.”).

iv 34 C.F.R. § 99.3.

v U.S. Dept. of Health and Human Services & U.S. Dept. of Educ. Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) To Student Health Records, November 2008, [hereinafter Joint Guidance], at page 2.

vi 34 C.F.R. § 99.3 (“‘Education Records’ ... (b) The term does not include: (1) Records that are kept in the sole possession of the maker, are used only as a personal memory aid, and are not accessible or revealed to any other person except a temporary substitute for the maker of the record.”).

vii The scope of the term ‘directory information’ will depend on district policy, but can include the following: the student's name, address, telephone listing, date and place of birth, major field of study, participation in officially recognized activities and sports, weight and height of members of athletic teams, dates of attendance, degrees and awards received, and the most recent previous educational agency or institution attended by the student. 20 U.S.C. § 1232g(a)(5)(A); Cal. Educ. Code §§ 49073; 49061(c).

viii The term “school official” includes school staff, such as teachers, counselors, and school nurses. A school or district may define this term more broadly in its School Board Policies so that it also includes outside consultants, contractors or volunteers to whom a school has outsourced a school function if certain conditions are met. See 34 C.F.R. § 99.31(a)(1)(i).

ix 20 U.S.C. § 1232g (b)(1) : 34 C.F.R. § 99.31(a)(1)(i)(A).

x See 34 C.F.R. §§ 99.31.

xi Cal. Civ. Code §§ 56-56.37; Cal. Welf. & Inst. Code §§ 5328-5329.

xii Cal. Ed. Code § 49060-49079.

©National Center for Youth Law 2010



©National Center for Youth Law 2010

HOW DOES FERPA DIFFER FROM HIPAA?

See pg.47 for HIPAA Overview See page 34 for FERPA overview.

In many ways, the two federal laws are similar.

- Both protect the privacy of personal information.
- Both require a signed authorization before records can be released.
- Both allow sharing of information with certain individuals and agencies without a signed release in certain situations.

Where FERPA and HIPAA differ is in the details. Here are just a few examples of those differences.

- **Signature for Release of Records**

Under FERPA, a parent must sign the release on behalf of his or her minor child.¹ Under HIPAA, a parent must sign for a minor in most cases; however the minor must sign if the records have to do with health care services for which the minor consented or could have consented under state law.

- **Parent access to records**

Parents have a right to access all records subject to FERPA regarding their minor child.² By contrast, parents do not have a right to access all medical records subject to HIPAA regarding their minor child.³ For example, parents cannot access those records if a provider determines that parent access would “have a detrimental effect on the provider's professional relationship with the minor patient or the minor's physical safety or psychological well-being,” or if the records relate to health care for which the minor consented or could have consented on his or her own.⁴ In the latter situation, parents must have the minor’s permission in order to inspect medical records.⁵ This distinction is particularly important to consider if a school health program is going to provide any “minor consent” services, such as reproductive health care, drug or alcohol abuse counseling, or mental health counseling, on the school site.

- **Exchange of Information without a signed consent**

A school health provider whose records are subject to FERPA, such as a school nurse or counselor, can share information with any school staff who have a “legitimate educational interest” in the information. This facilitates collaboration and communication with non-health personnel at the school, such as teachers and multidisciplinary teams. By contrast, a school health provider whose records are subject to HIPAA cannot disclose medical information to school staff who are not themselves health professionals unless there is a signed release form.

A school health provider operating under HIPAA may disclose information to any other health provider working with a student for purposes of treatment or referral, including professionals operating in and outside the school, without need of a signed release. A school health provider operating under FERPA cannot. This creates opportunities for referral and collaboration with the community at large that would be impossible under FERPA without a signed release.

Both laws also contain exceptions that allow disclosures for the purpose of research and in health emergencies, but each law defines these situations differently in a way that could impact how a school-based health program sets up its protocols. For example, under both FERPA and HIPAA, providers may disclose protected information when a youth is in danger, but to whom the provider may disclose that information varies under each law. (See section FAQs on Sharing Information pg.40 for more information.)

KEY POINTS about FERPA, HIPAA, and California Law:

Basics

- FERPA and HIPAA can never apply to the same records at the same time.
- FERPA and California medical confidentiality law can apply to the same records at the same time.
- HIPAA or FERPA may apply to control release of health records regarding services provided on a school campus.

FERPA or HIPAA?

- A school health program's records are subject to FERPA if the program is funded, administered and operated by or on behalf of a school or educational institution.
- A school health program's records are subject to HIPAA if the program is funded, administered and operated by or on behalf of a public or private health, social services, or other non-educational agency or individual.

Why does the distinction between FERPA and HIPAA matter?

A few examples:

- A parent's right to access health records is different under HIPAA and FERPA.
- The individuals and agencies with whom a school health provider can exchange health information without a release differ under HIPAA and FERPA.
- The administrative rules, including requirements for consent forms, are different.

i 20 U.S.C. § 1232g(b)(1).

ii 20 U.S.C. § 1232g(a)(1)(A).

iii See Gudeman, "*Minor Consent, Confidentiality and Child Abuse Reporting in California*" for detailed legal information on HIPAA and state medical confidentiality law, available at www.TeenHealthRights.org

iv Cal. Health & Saf. Code § 123115(a).

v See Gudeman, "*Minor Consent, Confidentiality and Child Abuse Reporting in California*" for detailed legal information on HIPAA and state medical confidentiality law, available at www.TeenHealthRights.org

What do I follow: HIPAA, FERPA or CALIFORNIA LAW?

Is it possible to operate under FERPA and HIPAA at the same time?

No. HIPAA explicitly states that its rules do not apply to health information held in an education record subject to FERPA.¹ Therefore, if FERPA applies, HIPAA does not. However, state medical confidentiality law does not have this same exception. Therefore, state medical confidentiality law can apply to health information held in an education record subject to FERPA.

Does FERPA or HIPAA or state law apply to the records of a district employed health provider, such as a school nurse or school mental health clinician?

Student health records maintained by a school nurse or by a licensed psychologist or counselor employed by the school typically are part of the education record subject to FERPA. In addition, California medical confidentiality law also may apply to health information held by a school nurse or psychologist, and in some cases, HIPAA.

Education records are covered by FERPA. In general, a school nurse's or clinician's records become part of the school's education record, as they contain information related to a student and are records maintained by a school employee or agent.² These records are not covered by HIPAA because HIPAA specifically states that it does not protect health information in an education record covered by FERPA. However, HIPAA may still apply to some information held by the nurse. Information held by the school nurse or counselor but not placed in the education record, such as health information in oral form or in personal notes, is not covered by FERPA and thus may be protected by HIPAA.

California medical confidentiality law also applies to the nurse's and psychologist's records, even those held in the education file. If FERPA and California law conflict regarding disclosure or protection, providers should seek guidance from their legal counsel about how to proceed.

Does FERPA or HIPAA apply to the records of a school-based health center (SBHC) or outside provider delivering services on school grounds?

It depends. Whether a school health program or provider is subject to HIPAA or FERPA will depend on the relationship between the school-based provider and the educational agency.

HIPAA Applies If: The U.S. Department of Education has said that the records of a SBHC are not subject to FERPA "if the center is funded, administered and operated by or on behalf of a public or private health, social services, or other non-educational agency or individual..."³ "In these circumstances, the records are not 'education records' subject to FERPA, even if the services are provided on school grounds, because the party creating and maintaining the records is not acting on behalf of the school."⁴ The records of a school based health center (SBHC) would be subject to HIPAA in these cases as long as the SBHC engages in any HIPAA covered transactions. (For example, the SBHC uses a billing service that transmits information electronically). (see page A-45 document in toolkit for more information.)

FERPA Applies If: The health provider’s records are considered “education records” subject to FERPA if the school-based health program or provider is funded, administered and operated by or on behalf of a school or educational institution. A school health program’s records also will be subject to FERPA if the program is administered by and under the direct control of an educational agency and providing what can be considered “institutional services” – even if those services are funded by a grant from an outside agency.

The federal Department of Education provided this example: “Some schools may receive a grant from a foundation or government agency to hire a nurse. Notwithstanding the source of the funding, if the nurse is hired as a school official (or a contractor), the records maintained by the nurse or clinic are ‘education records’ subject to FERPA.”⁵

In these cases, HIPAA would not apply. School-based health providers operating under FERPA, however, should remember that even if their records are not subject to HIPAA, in California, state confidentiality law nevertheless still may apply to their medical records. In some situations, federal FERPA rules and state confidentiality law may conflict. School-based health providers should seek advice from legal counsel should that occur.

If the relationship between the school health provider and the educational institution falls somewhere in between the scenarios presented above, the provider agency and educational institution should seek advice from their respective legal counsel on whether the records of the health program and its staff are subject to FERPA or HIPAA.

Is it possible for a school to contract with a provider and bring the provider under the auspices of FERPA?

FERPA says: “A contractor, consultant, volunteer, or other party to whom an agency or institution has outsourced institutional services or functions may be considered a school official [and therefore subject to FERPA]... provided that the outside party:

- (1) Performs an institutional service or function for which the agency or institution would otherwise use employees;
- (2) Is under the direct control of the agency or institution with respect to the use and maintenance of education records; and
- (3) Is subject to the requirements of § 99.33(a) governing the use and redisclosure of personally identifiable information from education records.”⁶

i 45 C.F.R. § 160.103 (“Protected health information excludes individually identifiable health information in: (i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. § 1232g;”).

ii 20 U.S.C. § 1232g(a)(4)(A).

iii U.S. Dept. of Educ., Family Policy Compliance Office, Letter to Ms. Melanie P. Baise, University of New Mexico, November 29, 2004, available at <http://www.ed.gov/policy/gen/guid/fpco/ferpa/library/baiseunmslc.html>

iv U.S. Dept. of Health and Human Services & U.S. Dept. of Educ. Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) To Student Health Records, November 2008, [hereinafter Joint Guidance] at page 5.v Joint Guidance at page 4.

vi 34 C.F.R. § 99.31(a)(1)(i)(B).

FAQs: Exchanging Information between Schools, Health Providers, and School Based Programs

1. May a school or district share information from the education record, such as schedule, attendance, discipline records or grades, with a school health provider for purposes of service provision?

FERPA: Yes, if the school health provider is a school employee or otherwise subject to FERPA. FERPA permits disclosure of information in the education record to other school officials with a legitimate educational interest in the information without need of parent consent.¹ Before exercising this disclosure option, schools must assure that the required annual notice to parents defines school official and legitimate educational interest in a way that would cover this type of disclosure to a school health program. The school health program will be required to protect the information by following FERPA requirements.²

HIPAA: For the most part, no, not without parent consent if the provider is subject to HIPAA. A school employee operating under FERPA may not provide detailed information from the education record to a non-FERPA provider without parent consent, though the school could release certain limited information. For example, the school could give the provider access to directory information about a specific student without needing parent consent. What that would include will depend on how directory information has been defined by that school district in its annual notice to parents and whether parents have opted out. In addition, the school also may disclose to the provider information that is not contained in the education record, such as information from oral communications or personal observation.³

2. May a school share information from the education record with a health provider if it is a health emergency?

Yes, any school employee may disclose information contained in the education record with appropriate parties in an emergency, without needing parent consent. However, the definition of emergency is strictly limited under FERPA. The U.S. Department of Education interprets emergency to be “a specific situation that presents imminent danger” or requires an immediate need for information to avert a serious threat. The emergency situation must be evaluated on an individual basis.⁴

3. May a school or district disclose information to an outside contractor or co-located program/service?

Yes, as long as the contractor or program is subject to FERPA. According to guidance from the U.S. Department of Education, “agencies and institutions subject to FERPA are not precluded from disclosing education records to parties to whom they have outsourced services so long as they do so under the same conditions applicable to school officials who are actually employed.” The guidance reminds districts that “an educational agency or institution may not disclose education records without prior written consent merely because it has entered into a contract or agreement with an outside party. Rather, the agency or institution must be able to show that:

- 1) The outside party provides a service for the agency or institution that it would otherwise provide for itself using employees;
- 2) The outside party would have “legitimate educational interests” in the information disclosed if the service were performed by employees; and
- 3) The outside party is under the direct control of the educational agency or institution with respect to the use and maintenance of information from educational records.”

The guidance reminds districts that they remain completely responsible for their contractor’s compliance with FERPA requirements in these situations and states “[f]or that reason, we recommend that these specific protections be incorporated into any contract or agreement between an educational agency or institution and any non-employees it retains to provide institutional services.”⁵

4. May a school or district share information from the education record about chronic disease, such as asthma and diabetes, with a health provider operating under HIPAA?

Yes, but only with a signed release or in an emergency. Disclosure of information in the education file about a student's chronic conditions to a school-based provider operating under HIPAA is not permitted without parent consent. Information from the education record may be disclosed without parent consent to protect the health or safety of a student or other individual.⁶ However, this exception has been strictly interpreted by the U.S. Department of Education. The emergency must be a specific situation that requires immediate need for disclosure of the information. For example, the emergency exception could not be used to send a list of all students with asthma or diabetes to the school-based health center. The school could provide the information about a specific student having a health emergency, including acute symptoms of asthma or diabetes.

5. May a school health program or provider disclose health information to school staff? For example, may a provider let a teacher know how a student is progressing in treatment?

FERPA: If the program or provider operates under FERPA, the program or provider may share health information in the education record with the teacher to the extent that the teacher has a “legitimate educational interest,” as that term is defined by the district, in the information disclosed.⁷

HIPAA: If the health provider or program operates under HIPAA, the provider can share if there is a signed release allowing the disclosure. If there is no release, the provider cannot. There is no exception under HIPAA that would allow a school health program to share protected health information with a teacher without an authorization. The student must provide the authorization if the information to be disclosed is about a minor consent service. The parent or guardian must provide the authorization in most other cases.

6. May a therapist disclose information obtained in the course of counseling a student on the school campus, regarding the student's threat to commit suicide?

Yes, FERPA, HIPAA, and state law all permit such disclosure without consent under certain “dangerous” conditions. If the therapist operates under FERPA, the therapist may disclose written education records to “appropriate parties” if the therapist reasonably determines that the student's statements indicate a serious and imminent threat to the student's health or safety.⁸

If the therapist operates under HIPAA, the therapist may disclose the relevant information to any person who is reasonably able to prevent a serious or imminent threat to the health or safety of a person.⁹ Therapists are even permitted to disclose psychotherapy notes without authorization under emergency circumstances.¹⁰

Under California law, a therapist may disclose medical information as necessary to prevent or lessen a threat to the health or safety of a reasonably foreseeable victim or victims. Exactly when and to whom such information can be disclosed will depend on which California law the therapist is providing services under. For example, if the therapist is subject to the Civil Code, disclosure of information may be to any person reasonably able to prevent or lessen the threat, including the target of the threat.¹¹ Therapists should consult their own legal counsel for more information and guidance on which California confidentiality law applies to their records.

7. May a school health program operating under FERPA promise students that their parents will not have access to their “minor consent” health records?

For the most part, no. The records of school health providers and programs operating under FERPA are part of the education record, and under FERPA, parents have a right to inspect the education record of their child if they choose to

do so.¹² There is no exception under FERPA that limits parent inspection rights simply because the information in the record pertains to health care services, or to “minor consent” services, with one caveat: Parents usually do not have the right to inspect health information in the education record of students eighteen and older, though there are exceptions to this rule as well.¹³

While parents cannot be prevented from viewing “minor consent” health information in the education record under FERPA, FERPA contains no affirmative obligation that requires schools to inform parents about “minor consent” health care services that a student may have received. Further, FERPA only allows parents a right to inspect “education records.” To the extent school health services providers hold information about minor consent services that is not recorded in the education record, (such as information in oral form or personal notes), the information would not be subject to FERPA.

It should be noted that this answer does not take into account state medical confidentiality law, which may apply to the same records at the same time as FERPA. Obligations under FERPA and state medical confidentiality law regarding parent access to minor consent records can conflict at times. Providers should seek guidance from their own legal counsel.

8. May a school health provider operating under HIPAA disclose protected health information to the school nurse or school therapist?

In most cases, yes. HIPAA and California law permit disclosures to other health care providers for “treatment” purposes. “Treatment” is defined broadly in this context and includes coordination or management of health care, consultation and referral as well as direct treatment.¹⁴ It is important to note that once disclosed to the school nurse, if the school nurse places the information in the pupil file, FERPA will apply when determining who controls access to the information in the file, not HIPAA.¹⁵

i 20 U.S.C. § 1232g(b)(1).

ii 34 C.F.R. § 99.33(a)(1).

iii 34 C.F.R. § 99.3 (“Education Records” ... (b) The term does not include: (1) Records that are kept in the sole possession of the maker, are used only as a personal memory aid, and are not accessible or revealed to any other person except a temporary substitute for the maker of the record.”).

iv U.S. Dept. of Educ. Family Compliance Policy Office, Letter to University of New Mexico re: Applicability of FERPA to Health and Other State Reporting Requirements, Nov. 29, 2004, available at <http://www.ed.gov/policy/gen/guid/fpco/ferpa/library/baiseunmslc.html>.

v U.S. Dept. of Educ., Family Policy Compliance Office, “Letter to Clark County School District (NV) re: Disclosure of Education Records to Outside Service Providers,” June 28, 2006, available at <http://www.ed.gov/policy/gen/guid/fpco/ferpa/library/clarkcty062806.html>

vi U.S. Dept. of Educ. Family Compliance Policy Office, Letter to University of New Mexico re: Applicability of FERPA to Health and Other State Reporting Requirements, Nov. 29, 2004, available at <http://www.ed.gov/policy/gen/guid/fpco/ferpa/library/baiseunmslc.html>.

vii 20 USC § 1232g(b)(1).

viii 34 C.F.R. §§ 99.31(a)(10)& 99.36(a); U.S. Dept. of Educ. Family Compliance Policy Office, Letter to University of New Mexico re: Applicability of FERPA to Health and Other State Reporting Requirements, Nov. 29, 2004, available at <http://www.ed.gov/policy/gen/guid/fpco/ferpa/library/baiseunmslc.html>.

ix 45 C.F.R. § 164.512(j).

x 45 C.F.R. § 164.508 (a)(2)(ii); 45 C.F.R. § 164.501.

xi Cal. Civ. Code § 56.10 (c)(19)(“The information may be disclosed, consistent with applicable law and standards of ethical conduct, by a psychotherapist, as defined in Section 1010 of the Evidence Code, if the psychotherapist, in good faith, believes the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a reasonably foreseeable victim or victims, and the disclosure is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.”).

xii 34 C.F.R. § 99.10.

xiii 34 C.F.R. § 99.5.

xiv 45 C.F.R. § 164.501.

xv U.S. Dept. of Health and Human Services & U.S. Dept. of Educ. Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) To Student Health Records, November 2008, at page 2.

CONFIDENTIALITY LITERATURE REVIEW SUMMARIES

- 1. Council on Scientific Affairs, American Medical Association 1993, “Confidential health services for adolescents,” *Journal of the American Medical Association*, vol. 269, no. 11, pp. 1420-1424.**

This report reviews adolescents’ need for confidential health services and major barriers to confidential care including the prerogative to provide informed consent for medical treatment and payment for health services. The article recommends that 1) providers reaffirm that confidential care for adolescents is critical to health improvement, 2) physicians involve parents in the medical care of their teens, 3) physicians discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated, 4) health care payers develop a method of listing of services that preserves confidentiality for adolescents, and 5) state medical societies review laws on consent and confidential care for adolescents and eliminate laws that restrict the availability of confidential care.

- 2. Ford, C.A., Millstein, S.G., Halpern-Felsher, B.L. & Irwin, C.E., Jr 1997, “Influence of physician confidentiality assurances on adolescents’ willingness to disclose information and seek future health care,” *Journal of the American Medical Association*, vol. 278, no. 12, pp. 1029-1034.**

As part of a larger study on asymptomatic genital Chlamydia, Ford, et al. examines adolescents’ willingness to be tested for sexually transmitted diseases (STDs) under varying confidentiality conditions. Nearly all (92%) reported they would agree to STD testing if their parents would not find out. Significantly fewer would agree to testing linked to potential (38%) or definite (35%) parental notification. More male than female subjects were willing to agree to testing linked to potential or definite parental notification (49.5% vs. 33%). It is significant that the vast majority of sexually active adolescents report they would agree only to confidential STD testing.

- 3. National Association of School Nurses 2004, “Privacy Standards for Student Health Records.” Available: www.nasn.org/Default.aspx?tabid=277.**

School-Based Health Centers and other on-campus health services for students need more sufficient policies, procedures, and systems to ensure the privacy of students’ health information. This article outlines the complications caused by both HIPAA and FERPA with regards to school health records, and outlines the role of school nurses in promoting privacy of student health information. School nurses should educate themselves, administrators, students, and parents about health record laws. School nurses should ensure that health room procedures are conducive to maintaining health record privacy. School nurses should act as experts, collaborating with the other professionals around them to help develop supportive policies for privacy of students’ health information.

- 4. English, A. & Ford, C.A. 2007, “More evidence supports the need to protect confidentiality in adolescent health care,” *Journal of Adolescent Health*, vol. 40, no. 3, pp. 199-200.**

This editorial article outlines and summarizes some of the recent research that further supports the need for confidentiality in adolescent health care, and includes 20 references to the most important research on adolescent health care and confidentiality.

Continued next page



5. **Fox, H.B. & Limb, S.J. 2008, “Fact Sheet 5: State Policies Affecting the Assurance of Confidential Care for Adolescents” [Homepage of The National Alliance to Advance Adolescent Health], [Online]. Available: <http://www.thenationalalliance.org/jan07/factsheet5.pdf>.**

This fact sheet outlines state policies that aim to provide adolescents with certain confidential care, and how that confidentiality can be breached by public and private insurance practices such as sending explanation of benefit statements (EOBs) to the patient’s household. EOBs are an inexpensive way to comply with federal verification laws to combat fraud, but insurance companies can comply with the law in other ways that do not breach confidentiality. Furthermore, states can exclude sending EOBs for certain services, so they should exclude all family planning, STD, mental health, and substance abuse treatment services.

6. **Brown, J.D. & Wissow, L.S. 2009, “Discussion of sensitive health topics with youth during primary care visits: relationship to youth perceptions of care,” *Journal of Adolescent Health*, vol. 44, no. 1, pp. 48-54.**

This study examined whether the discussion of sensitive health topics such as sex, drugs, and mental health during primary care visits was associated with youth perceptions of care. Youth age 11-16 reported directly after a primary care visit whether the visit included discussion about sensitive health topics, and whether the provider understood their problems, eased their worries, allowed them to make decisions about treatment, gave them some control over treatment, and asked them to take some responsibility for treatment. The researchers found that youth has more positive perceptions of the provider and were more likely to report taking an active role in treatment when the visit included the discussion of a sensitive health topic.

7. **Ford, C.A., Davenport, A.F., Meier, A. & McRee, A.L. 2009, “Parents and health care professionals working together to improve adolescent health: the perspectives of parents,” *Journal of Adolescent Health*, vol. 44, no. 2, pp. 191-194.**

Investigators explored parent perceptions of the roles of parents, health care providers (HCPs), and parent-HCP partnerships in improving adolescent health and health care. When asked what parents can do to keep teens healthy, the most common themes reported were keeping teens busy, parental monitoring, and parent-teen communication. When asked what HCPs can do to keep teens healthy, the most common theme was teens being able to openly communicate with HCPs so that HCPs can accurately assess the teen’s health and behaviors. New ideas for improving parent-HCP partnerships emerged, including HCPs acknowledging the importance of normal parenting activities, HCPs assisting parents in recognizing when to ask for help (and encouraging parental acceptance of help when offered), and further investigation of the benefits of improved parent-HCP communication.

8. **Guttmacher Institute 2010, February 1st 2010-last update, “State Policies in Brief: An Overview of Minors’ Consent Law” Available: http://www.guttmacher.org/statecenter/spibs/spib_OMCL.pdf.**

Many states explicitly permit minors to consent to services for sexual and reproductive health care, including contraceptives, prenatal, and STI services without parental involvement. Conversely, parental involvement in a minor’s abortion is required in the majority of states. This overview of Minors’ Consent Law across the United States includes a chart outlining each state and what services minors can consent to in that state out of contraceptive services, STI services, prenatal care, adoption, medical care for minor’s child, and abortion services.

FEDERAL MEDICAL PRIVACY REGULATIONS (“HIPAA PRIVACY RULE”): A BRIEF OVERVIEW

What are the federal medical privacy regulations?

The “Standards for Privacy of Individually Identifiable Health Information” are federal medical privacy regulations (sometimes referred to as the “HIPAA Privacy Rule”) that broadly regulate access to and disclosure of confidential medical information. This summary provides a brief introduction to the provisions pertinent to adolescents, particularly those who are minors. Detailed information regarding those provisions and information regarding other provisions of the regulations is available from other sources.

How do the federal privacy regulations relate to state law?

The HIPAA Privacy Rule generally requires a uniform minimum standard of confidentiality protection. Federal privacy regulations under HIPAA supersede – or “preempt” – state laws, but with two important exceptions: state laws that are more stringent – i.e. more protective of individual privacy – are controlling; and on the question of parents’ access to their children’s protected health information, HIPAA defers to state and other applicable laws.

What is the scope of the regulations?

The regulations address a broad range of issues related to the privacy of individuals’ health information. They create rights for individuals to have access to their health information and medical records and specify when an individual’s consent is required for disclosure of their confidential health information. The regulations also contain provisions that are specific to the health information of minor children.

Who must comply with the regulations?

The regulations apply to “covered entities,” which include health insurance plans (including Medi-Cal and CHIP – Healthy Families in California), health care providers, and health care clearinghouses. According to the way each of these is defined in the regulations, the vast majority of health care professionals who provide care to adolescents are required to comply with the regulations.

What do the regulations mean for adolescents?

The HIPAA Privacy Rule contains numerous general provisions that affect the confidentiality of information about health care provided to adolescents as well as younger children and adults. The regulations also contain some provisions of particular relevance and importance for adolescents. Adolescents who are age 18 or older are adults and have the same rights under the regulations as other adults. Adolescents who are younger than age 18 are minors and the regulations establish special rules for the confidentiality of their protected health information.

Do adolescents control access to their own health information?

The HIPAA Privacy Rule establishes that when an individual provides consent for health care, that individual has specific rights to control access to the information about that care. Those rights are not absolute and are subject to certain exceptions. For example, an individual’s protected health information may be disclosed without the individual’s authorization for purposes of treatment, payment, and health care operations. Adolescents who are adults control access to their own health information on the same basis as other adults. However, different rules apply to adolescents who are minors. In particular, in certain situations, such as when minors consent for their own health care, the question of whether their parents have access to the information about the care is determined by state or “other applicable law.”

What is the role of parents for adolescents who are minors?

Parents (including guardians and persons acting in loco parentis) generally are considered the personal representatives of their unemancipated minor children, and as such, they have control over and access to their child's protected health information to the extent that the regulations provide individuals generally with such control and access. In specific circumstances, however, parents are not necessarily the personal representatives of their minor children.

When is a parent not the personal representative of his or her minor children?

A parent is not necessarily the personal representative of his or her minor child in one of three specific circumstances; (1) when the minor is legally able to consent for the care for himself or herself and has consented; or (2) the minor may legally receive the care without the consent of a parent, and the minor or someone else has consented to the care; or (3) a parent has assented to an agreement of confidentiality between the health care provider and the minor. In these circumstances, the minor is treated as the "individual" and may exercise many of the rights under the regulations. The minor also may choose to have the parent act as the personal representative or not.

What happens when a parent is not the personal representative?

When a parent is not the personal representative of the minor, the minor may exercise most of the same rights as an adult under the regulations. With respect to the question of whether a parent who is not the personal representative of the minor may have access to the minor's confidential information ("protected health information"), the regulations defer to state or "other law." If state or other law explicitly requires information to be disclosed to a parent, the regulations allow a health care provider to comply with that law and to disclose the information. If state or other law prohibits disclosure of information to a parent, the regulations do not allow a health care provider to disclose it. If state or other law permits disclosure or is silent on the question, a health care provider has discretion to determine whether to grant access to a parent to the protected health information.

What do the regulations mean for health care providers in California?

California has numerous laws that allow minors to give their own consent for health care. In addition, California has laws that specify the circumstances under which parents may or may not have access to information regarding the care for which minors may give their own consent. The federal privacy regulations would defer to those California laws. For adults, including adolescents age 18 or older, the federal regulations defer to state laws that provide stronger privacy protections than the federal rules do. Many other provisions of the regulations would remain applicable to health care providers in California.

What happens if a parent is suspected of domestic violence, abuse, or neglect?

When a parent is suspected of domestic violence, abuse, or neglect of a child, including an adolescent, a health care provider may limit the parent's access to and control over protected health information about the child by not treating the parent as the personal representative of the child.

When services are being provided in a school setting, do HIPAA or FERPA Regulations apply?

The interaction of school/healthcare setting regulations is very complex; please refer to our other documents on HIPAA/FERPA in the toolkit for more information.

How does a health care provider know what is required?

This overview does not provide legal advice. Health care providers should consult with legal counsel to be sure they are aware of the specific requirements of the regulations that apply to them and how to comply with those requirements. HIPAA serves as a reminder to organizations and health care professionals that adolescents are a group with distinct rights that must be respected. The HIPAA Privacy Rule makes clear that when adolescents have a right to give consent for their own care, organizations must honor their right to be treated as individuals. To understand what is required in any specific case or situation, organizations and health care professionals must consider not only the HIPAA Privacy Rule itself, but also relevant provisions of California laws, and other applicable laws, including other federal laws.

Where is additional information available that explains the regulations?

Implementation of the regulations is being overseen by the Office for Civil Rights (OCR) within HHS. OCR has established a web site with comprehensive information about the implementation of the regulations:
<http://www.hhs.gov/ocr/hipaa/>.

What are the official citations for the regulations?

Standards for Privacy of Individually Identifiable Health Information, 45 Code of Federal Regulations Parts 160 and 164. These regulations were originally promulgated at 65 Federal Register 82461 (Dec. 28, 2000) and Federal Register 53182 (Aug. 14, 2002).

Additional Resources

Office for Civil Rights (OCR).
<http://www.hhs.gov/ocr/hipaa>

Centers for Disease Control and Prevention (CDC)
<http://www.cdc.gov/privacyrule>

National Institutes of Health (NIH)
<http://privacyruleandresearch.nih.gov>

Based on information provided by:
Center for Adolescent Health & the Law
Chapel Hill, NC
<http://www.cahl.org>

CONFIDENTIALITY AND MINOR CONSENT-RELATED RESOURCES AVAILABLE ONLINE

National Center for Youth Law

<http://www.youthlaw.org>

See Articles and Analysis about Adolescent and Child Health

CA Minor Consent Laws – National Center for Youth Law, 8/01

http://www.youthlaw.org/fileadmin/ncyl/youthlaw/publications/minor_consent/Minor_Consent_Report_Download.pdf

CA Minor Consent Laws: Who can consent for what services and providers' obligations

http://www.youthlaw.org/fileadmin/ncyl/youthlaw/publications/minor_consent/CA_minor_consent_sep03.pdf

Center for Adolescent Health & the Law

<http://www.cahl.org/>

See Publications relating to Consent & Confidentiality Protections

<http://www.cahl.org/consentpubs.htm>

Society for Adolescent Medicine

<http://www.adolescenthealth.org>

See Publications

Confidential Health Care for Adolescents

[http://www.adolescenthealth.org/Content/NavigationMenu/Advocacy?PositionPapers/](http://www.adolescenthealth.org/Content/NavigationMenu/Advocacy?PositionPapers/PositionPaper_Confidential_Health_Care_for_Adolescents.pdf)

[PositionPaper_Confidential_Health_Care_for_Adolescents.pdf](http://www.adolescenthealth.org/Content/NavigationMenu/Advocacy?PositionPapers/PositionPaper_Confidential_Health_Care_for_Adolescents.pdf)

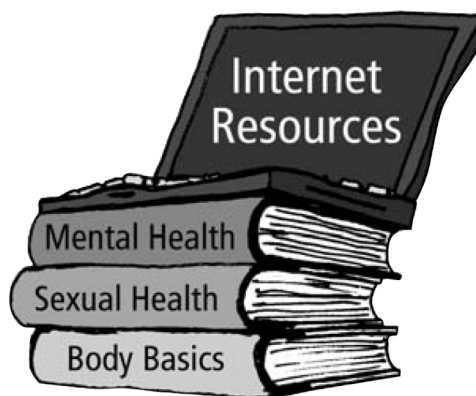
California Hospital Association

<http://www.calhospital.org/>

See Publications and Manuals

Minors and Health Care Law: A Handbook in Consent for Treatment of Infants, Children, and Adolescents (order form)

<http://www.calhospital.org/public/minors-health-care-law>



Notes



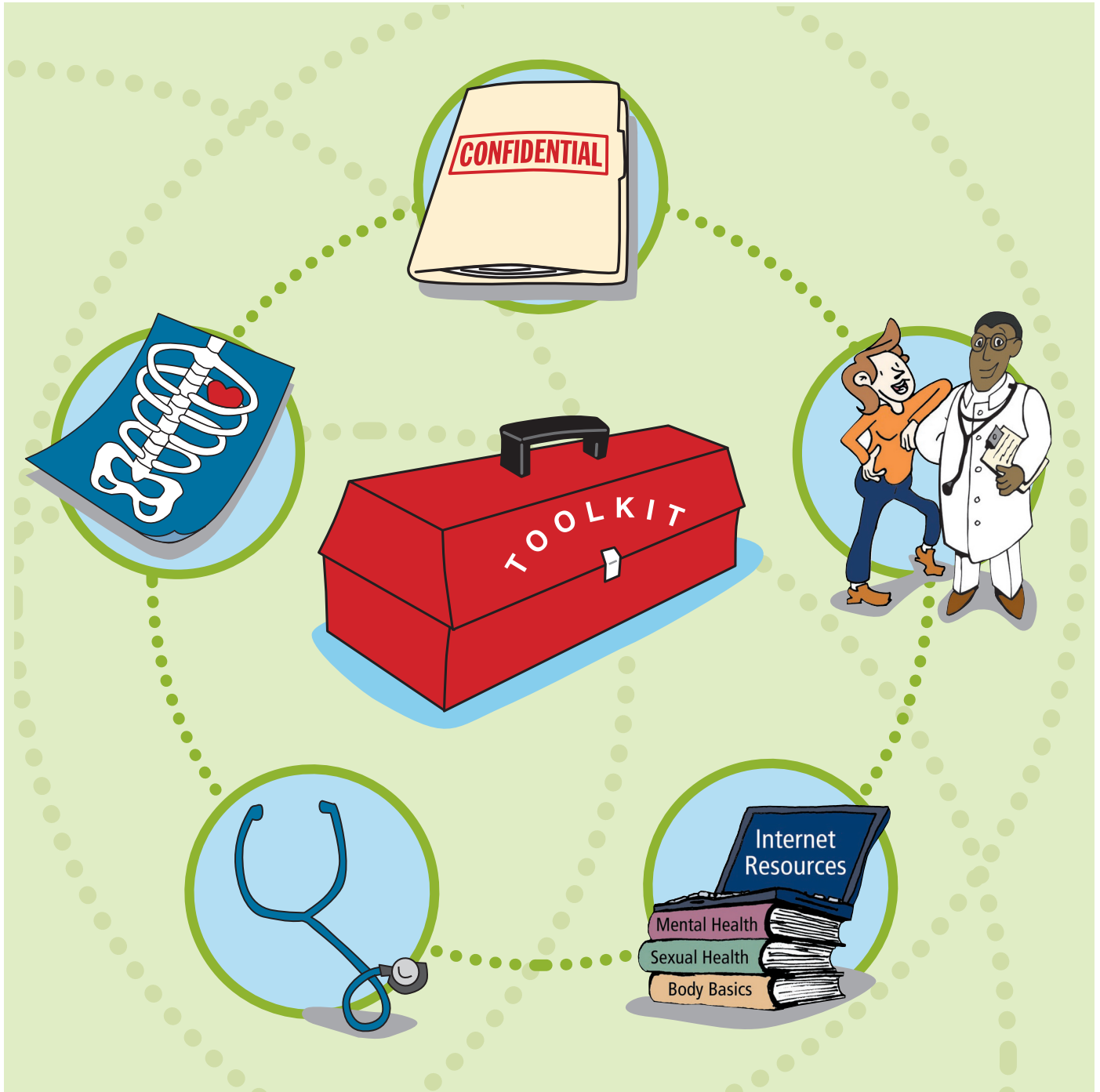


Adolescent Health Working Group



SEXUAL HEALTH

An Adolescent Provider Toolkit



HOW TO OBTAIN A COPY OF THIS TOOLKIT

The Sexual Health Module of the Adolescent Provider Toolkit can be downloaded for free from the following website:

Adolescent Health Working Group – www.ahwg.net

Please visit our website for information on purchasing hard copies of the Sexual Health Module.

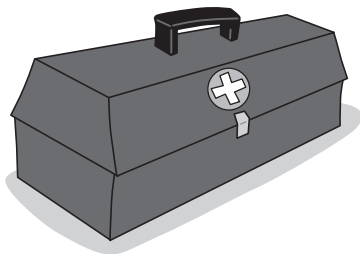
Additional AHWG materials including Chinese and Spanish handouts for youth and parents/care-givers are available for free download.

ADOLESCENT HEALTH WORKING GROUP

The Adolescent Health Working Group (AHWG) was formed in 1998 by a group of adolescent health providers and advocates concerned about the lack of age-appropriate health services for young people in the city of San Francisco. Today, the AHWG remains the only group of its kind in San Francisco. The AHWG's vision is that all youth have unimpeded access to high quality, culturally competent, youth friendly health services. The AHWG's mission is to support and strengthen the network of providers working to improve adolescent health. The AHWG works to fulfill its vision and mission through the following core functions: 1) develop tools and trainings that increase providers' capacity to effectively serve youth, 2) advocate for policies that increase access to health insurance and comprehensive care, and 3) convene stakeholders and coordinate linkages across systems to improve information sharing, networking, and referrals for youth services.

SUGGESTED CITATION

Monasterio E, Combs N, Warner L, Larsen-Fleming M, St. Andrews A, (2010). Sexual Health: An Adolescent Provider Toolkit. San Francisco, CA: Adolescent Health Working Group, San Francisco.





Adolescent Health Working Group
San Francisco, CA

Dear Colleagues:

We are pleased to present you with the new *Sexual Health Module* of the *Adolescent Provider Toolkit* series. The production of the new *Sexual Health Module* was made possible through the generous support of the San Francisco Department of Children, Youth, and Their Families, and through the UCSF University Community Partnership program.

The new *Sexual Health Module* is an updated and expanded version of the 2003 *Sexual Health-CA Version*. The new module champions a paradigm shift from a deficit/risk based perspective to one that embraces adolescent sexuality as a positive and normative in this stage of development. This comprehensive guide:

- ▶ Focuses on **healthy sexuality** and **healthy relationships**.
- ▶ Integrates information regarding the sexual health of all **young men and women, LGBT youth, and youth with disabilities**.
- ▶ Is designed for primary care providers and is applicable to many others including school-based and youth program providers.
- ▶ Is written from a **national perspective**.
- ▶ Is updated with links to the most **current evidence based research**.
- ▶ Includes many **unique resources** in the format of handouts for youth and families.

Designed for busy providers, the new *Sexual Health Module* includes materials that you are free to copy and distribute to your colleagues, adolescent patients, and their parents/caregivers. The new Sexual Health Module is not intended to replace clinical practice protocols. It does provide evidence based practice guidelines to enhance provider's ability to meet the sexual health needs of adolescents. This module includes:

- ▶ **Practice readiness tools**.
- ▶ **Screening, assessment, and referral tools** such as taking a client-centered sexual health history and screening for sexual dysfunction.
- ▶ **Resource sheets** on various sexual issues including menstrual suppression and male involvement.
- ▶ **Health education handouts** for teens and their parents/caregivers on topics including sex and technology and safer sex toy use.
- ▶ **Online resources and hotlines**.

We did not repeat information/tools that are included elsewhere in the *Adolescent Provider Toolkit* series. General screening and counseling techniques can be found in the *Adolescent Health Care 101 Module*. Information and treatment algorithms on California specific minor consent and confidentiality laws can be found in the *Understanding Minor Consent and Confidentiality in CA Module*. We have also opted to refer the reader to regularly updated website for information that changes frequently such as treatment protocols for STIs, etc.

We encourage you to visit our website, www.ahwg.net, for free downloads of the entire *Adolescent Health Toolkit* series, including **health education handouts for youth and parents/caregivers** available in **Chinese** and **Spanish**. We hope the *Adolescent Provider Toolkit* series will be a useful resource for you as you improve the health of adolescents.

Regards,

Erica Monasterio, MN, FNP
Alicia St. Andrews, MPH
Natalie Combs

ACKNOWLEDGEMENTS

The Adolescent Health Working Group has so many people to thank for their generous contributions of time, energy, expertise, encouragement, and financial support. The Sexual Health Module of the Adolescent Provider Toolkit has been made possible due to every individual and organization mentioned below. We are incredibly grateful to you.

THE ADOLESCENT PROVIDER TOOLKIT ADVISORY COUNCIL

Alicia St. Andrews, MPH – Adolescent Health Working Group
Amy Schalet, PhD – University of Massachusetts, Amherst, Department of Sociology
Arik Marcell, MD, MPH – Johns Hopkins University, Division of General Pediatrics and Adolescent Medicine
Carla Valdez, MPH – Planned Parenthood of Los Angeles
David Bell, MD, MPH – Columbia University, Mailman School of Public Health
Erica Monasterio, MN, FNP – University of California San Francisco, Division of Adolescent Medicine
Jeff Klausner, MD, MPH – San Francisco Department of Health, STD Prevention and Control Services
Kaiyti Duffly, MPH – PRCH, Physicians for Reproductive Choice
Leah Warner, RN, MPH – University of California San Francisco
Libby Benedict – PRCH, Physicians for Reproductive Choice
Mara Larsen-Fleming, MPP, MPH – Adolescent Health Working Group
Natalie Combs – Adolescent Health Working Group
Paul Gibson, MS, MPH – California Department of Public Health, STD Control Branch
Renata Arrington-Sanders, MD, MPH – Johns Hopkins University, Division of General Pediatrics & Adolescent Medicine
Tonya Chaffee, MD, MPH – University of California San Francisco, Department of Pediatrics

ORIGINAL AUTHORS

Guided by the expertise of the first Adolescent Sexual Health Advisory Toolkit Council, we would like to acknowledge the original authors of the Sexual Health Toolkit Module: Allison Young, Janet Shalwitz, MD, Sara Pollock and Marlo Simmons, MPH.

YOUTH FOCUS GROUP PARTICIPANTS

Alameda High School Peer Health Educators, Cole Street Youth Clinic Peer Educators, Students from LAUSD Taft High School courtesy of Bridget Brownell.

OTHER CONTRIBUTORS/REVIEWERS

Amal Kouttab, MA (SFWAR), Carmelius Quinn (Health Initiatives for Youth), Charlie Glickman, PhD (Good Vibrations), Deb Levine, MA (ISIS, Inc.), Heather Fels (University of California San Francisco), Janet Shalwitz, MD (Adolescent Health Working Group), Kara Rothenberg, Rebecca Gudeman, JD, MA (National Center for Youth Law), Rose Afriyie (Adolescent Health Working Group), Tina Mahle (Health Initiatives for Youth), Urooj Arshad (Advocates for Youth).

FINANCIAL SUPPORTERS/FISCAL SPONSOR

San Francisco Department of Children, Youth, and Their Families, San Francisco Maternal, Child, and Adolescent Health Department, the San Francisco Foundation, UCSF University Community Partnerships, The Yen Chuang Foundation, and our fiscal sponsor, the Tides Center.

Special mention goes to Amy Schalet, Arik Marcell, and Carla Valdez who contributed their many gifts of guidance, expertise, wisdom, and encouragement to the redesign and development of the updated edition of the Sexual Health Module of the Adolescent Provider Toolkit.



MODULE THREE: SEXUAL HEALTH

A. FOR PROVIDERS/CLINICS	
1. Practice Readiness	Are You Prepared to Address Adolescent Sexual Health?..... C-2
	Adolescent Sexual Development..... C-3
	Provider-Youth Communication..... C-5
	The Role of Providers in Parent-Child Communication..... C-7
	Minor Consent and Confidentiality..... C-8
	Healthy Relationships..... C-9
	Sexual Decision-Making..... C-10
	Male Involvement..... C-11
2. Screening, Assessment, and Referrals	Taking a Client-Centered Sexual History..... C-13
	STI Screening and Treatment..... C-16
	HIV Testing and Counseling..... C-18
	Human Papillomavirus (HPV) Related Cancers..... C-20
	Things to Consider When Prescribing Birth Control..... C-22
	Quick Start Algorithm..... C-24
	Emergency Contraception..... C-26
	Pregnancy Test Counseling..... C-28
	Teen Dating Violence/Intimate Partner Violence (IPV)..... C-30
	Sexual Assault..... C-33
	Sexual Dysfunction..... C-34
3. Resources	Counseling Youth About Sexual Function and Pleasure..... C-36
	Safer Sex and Lubrication..... C-37
	Safer Sex Toy Use..... C-38
	Pregnancy Prevention Options..... C-39
	Menstrual Suppression..... C-41
	Establishing Paternity and Paternity Laws..... C-43
	HPV Vaccine..... C-44
B. FOR YOUTH	
<i>Use these handouts as a guide for counseling your teen patients.</i>	Sex, Virginity & Abstinence..... C-45
	Having Sex on Your Own Terms..... C-46
	Healthy Relationships..... C-47
	The Relationship Spectrum..... C-48
	Love Shouldn't Hurt..... C-49
	Wetter Makes It Better..... C-50
	Be Safe With Sex Toys..... C-51
	Sex, Technology & You..... C-52
	Am I Normal? A Tour of The Female Genitals..... C-53
	Am I Normal? A Tour of Male Genitals..... C-54
	What to Expect at Your First Women's Health Exam..... C-55
	What to Expect at Your First Men's Health Exam..... C-56
	Your Safer Sex Options: Preventing Against Pregnancy and STIs..... C-57
	A Teen's Guide to Sexually Transmitted Diseases and Other Infections..... C-59
	Genital Warts and HPV-Related Cancer..... C-61
	What You Need To Know About Condoms..... C-62
	What You Need To Know About Female AKA Insertive Condoms..... C-63
	Do I Need a Period Every Month?..... C-64
	I'm Pregnant, What Should I Do?..... C-65
C. FOR PARENTS/ CAREGIVERS	
<i>Use these handouts as a guide for counseling parents/caregivers of your teen patients.</i>	How to Talk with Your Children and Teens about Healthy Relationships..... C-66
	Should I Worry About My Teen?..... C-67
	Parent-Child Communication..... C-68
	Sex, Technology & Your Teen..... C-69
	What Parents of Preteens/Adolescents Should Know About the HPV Vaccine..... C-70
	Supporting Your Pregnant and Parenting Teen..... C-71
D. INTERNET RESOURCES	
	Click on This!..... C-72

Are You Prepared to Address Adolescent Sexual Health?

Creating a safe, non-judgmental, and supportive environment can help teens feel more comfortable sharing personal information. There are many things that can be done to ensure that your practice is youth friendly. Here are some questions to consider as you read through Sexual Health Module of the Adolescent Provider Toolkit.

? Does your office/clinic have...

- Information on where and how to access condoms? While all clinic settings may not be appropriate for displays, having a small sign near the intake area is recommended.
- Teen-friendly sexual health education materials with age-appropriate language in your waiting room? Do these materials contain positive imagery of teen relationships which do not portray sex only in terms of the risks and negative consequences? Are your educational materials inclusive of a diverse audience including LGBT youth and youth with disabilities?
- Confidentiality policies posted in areas that can be viewed by both patients and their families?
- Gender inclusive language on intake/history forms and questionnaires?
- A procedure for dealing with emergency and crisis situations including rape, sexual assault, and intimate partner violence?
- A policy regarding teens scheduling their own appointments? Not all health services require consent from the parent/caregiver.
- Policies regarding talking to a teen alone without his/her parent/caregiver?
- Financing options for teens accessing confidential services under minor consent?
- Clinic/practice hours that are convenient for teens?
- A network of referrals for adolescent-friendly providers in the area?

? Is your staff...

- Friendly and welcoming toward teen patients?
- Knowledgeable about the laws of minor consent and confidentiality and consistent in upholding those laws?
- Aware of privacy concerns when adolescents check in?
- Careful to avoid making assumptions about gender or sexual orientation?
- Ready to maintain sensitivity for the age, race, ethnicity, gender, sexual orientation, disability, family structure, and lifestyle choices of your patients and their loved ones?

? Are you...

- Aware of your own biases toward sexual health and how your own experiences have shaped your opinions toward sexually active adolescents?
- Confident, comfortable, and non-judgmental when addressing adolescent sexuality?
- Prepared to take a strengths-based approach when working with youth?
- Aware of the characteristics/features of positive adolescent sexual development and relationships?
- Ready to provide medically accurate information about sexual and reproductive health while also emphasizing the importance of healthy relationships?
- Familiar with the legal and confidentiality issues dealing with teen sexual activity and reproductive health services including access to birth control options, STI testing, abortion, sexual assault services; parent/caregiver involvement; and releasing medical records?

Provider's role in providing adequate care for adolescents:

- Make every interaction an opportunity
- Support healthy relationships
- Provide a framework for positive adolescent sexual development
- Promote health and reduce risk



Sources:

- 1) California Adolescent Sexual Health Work Group (ASHWG). Core Competencies for Providers of Adolescent Sexual and Reproductive Health Programs/ Services. February, 2007.
- 2) Shalwitz J, Sang T, Combs N, Davis K, Bushman D, Payne B. *Behavioral Health: An Adolescent Provider Toolkit*. Adolescent Health Working Group. 2007: D-5. <http://ahwg.net/resources/toolkit.htm>.
- 3) Christner J, Davis P, Rosen D. Office-Based Interventions to Promote Healthy Sexual Behavior. *Adol Med: State of the Art Reviews*. 2007; 15(544-557).

Adolescent Sexual Development

STAGE	FACTS	TIPS
<p style="text-align: center;">EARLY ADOLESCENCE</p> <p>Females: 9-13 years Males: 11-15 years</p>	<ul style="list-style-type: none"> ▶ Puberty/Concern with body changes and privacy. ▶ Development of first crush as a milestone to sexual orientation. ▶ Concrete thinking, but beginning to explore new ability to think abstractly. ▶ Sexual fantasies are common. ▶ Masturbation is common. ▶ Movement towards defining sexual identity. ▶ Sexual intercourse is not common. 4.9% of high school females and 13.5% of high school males had first intercourse before the age of 13.¹ 	<ul style="list-style-type: none"> ▶ Begin discussing healthy relationships using examples from friendships or concepts such as, “what are you looking for in a friend?” ▶ Focus on current issues facing the teen instead of future possibilities. Relate decision-making techniques to everyday situations instead of having him/her visualize what may happen in the future. Avoid asking questions framed with “why.” ▶ Use health education materials with lots of pictures and simple explanations. Typically, males are not receiving as much information about puberty and body development as girls at this age. ▶ Focus on issues that most concern this age group (weight gain, acne, physical changes).
<p style="text-align: center;">MIDDLE ADOLESCENCE</p> <p>Females: 13-16 years Males: 15-17 years</p>	<ul style="list-style-type: none"> ▶ Increasing concern with appearance. ▶ Peer influences are very strong in decision making. ▶ Experimentation with relationships and sexual behaviors is common. ▶ Concerned about relationships. ▶ Sexual intercourse is increasingly common. 44% of high school tenth graders and 56% of high school eleventh graders have had sexual intercourse.² ▶ Increased abstract thinking ability. ▶ Full physical maturation is attained. ▶ Dating is common. ▶ Sexual behaviors do not always match sexual orientation. ▶ Often aware of theoretical risk but do not see self as susceptible. 	<ul style="list-style-type: none"> ▶ Listen more and talk less. ▶ Help teens identify the characteristics of a healthy relationship and assess their own relationship quality. ▶ Peer counseling can be effective with this age group. ▶ Focusing on health promotion, prevention and harm reduction is key. ▶ Avoid making assumptions about sexual orientation and behaviors. ▶ Help provide gay and lesbian youth with positive role models and support systems. Assess family response to youth’s sexual orientation. ▶ Be aware youth with disabilities, like their non-disabled peers, may be engaging in sexual behaviors and have questions around their sexual orientation ▶ Reinforce parent-child communication about sexual decision making and forming healthy relationships.
<p style="text-align: center;">LATE ADOLESCENCE</p> <p>Females: 16-21 years Males: 17-21 years</p>	<ul style="list-style-type: none"> ▶ Firmer and more cohesive sense of identity. ▶ Attainment of abstract thinking. ▶ Ability to establish mutually respectful/trusting relationships. ▶ Firmer sense of sexual identity. ▶ Concern for the future. ▶ Feelings of love and passion. ▶ Increased capacity for tender and sensual love. 	<ul style="list-style-type: none"> ▶ More abstract reasoning allows for more traditional counseling approaches. ▶ Acknowledge and support healthy relationships or the choice to not be in a relationship.

¹Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance-US 2007. *Morbidity and Mortality Weekly Report*. 2008; 55(SS-4).
²Ibid.

Adolescent Sexual Development *cont.*

The stages of adolescent development can be used as a guide to approaching counseling techniques in an age-appropriate/developmentally appropriate manner. Keep in mind that these age delineations are generalized and that actual development is affected by culture, abuse, and socialization.¹

When considering the stages of development, be sure to....

- ⇒ Appreciate that the transition from childhood to adulthood may be a difficult and overwhelming. Healthcare providers can make these transitions easier by providing guidance and information to teen patients and their parents. For example, research has shown that menarche is less stressful when the teen knows what to expect.
- ⇒ Assess social, biological, and cognitive stages of development. Keep in mind that physical development does not always match cognitive and social development. Asking a question like, “when do you think a person is ready to have sex,” can help identify where the teen is developmentally. When working with youth with disabilities be age appropriate unless cognitive delays are evident. Even if a person needs extra time to process information or has difficulty with language and expression, this does not mean he/she doesn’t understand at an age appropriate level.
- ⇒ Educate both adolescent girls and boys about the stages of development. Boys generally receive less information than girls about developmental changes and puberty can be a confusing, uncomfortable time for everyone.
- ⇒ Support your teen patients in developing healthy sexual relationships and healthy attitudes toward sex. Ensuring that teens have a supportive adult in their life who can guide the teen while he/she builds relationships is extremely important for their overall development into adulthood. The provider can help the teen identify adults they can turn to.
- ⇒ Pay attention to how a teen feels about his/her development. Teens that develop earlier or later than average are vulnerable to health and social problems. If you feel that a teen is developing faster/slower than average, provide anticipatory guidance.
- ⇒ Realize that social pressures surrounding development are a reality for many teens. Girls who mature earlier are at greater risk of becoming sexually active at a younger age than their female peers. Teen boys who develop later can be bullied and are at higher risk for substance and/or tobacco abuse problems than their peers who develop earlier.

¹Short MB, Rosenthal SL. Psychosocial Development and Puberty. *Ann. N.Y. Acad. Sci.* 2008; 1135:36-49.

Sources:

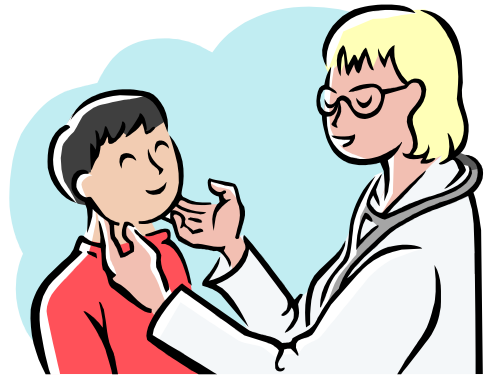
- 1) Neinstein, L. Adolescent Health Care: A Practical Guide, Philadelphia: Lippincott Williams and Wilkins, 2002.
- 2) Getting Organized: A Guide to Preventing Teen Pregnancy
- 3) Short MB, Rosenthal SL. Psychosocial Development and Puberty. *Ann. N.Y. Acad. Sci.* 2008; 1135:36-49.
- 4) Biro EM. Adolescent Sexuality: Puberty. *Adol Med: State of the Art Reviews.* 2007; 18:3.
- 5) Marcell AV, Monasterio EB. Providing Anticipatory Guidance and Counseling to the Adolescent Male. *Adol Med: State of the Art Reviews.* 2003; 14:3.
- 6) Facts for Families: Normal Adolescent Development. American Academy of Child and Adolescent Psychiatry. June 2001; 58.

Provider-Youth Communication

Providers play a critical role in encouraging healthy behaviors in adolescents. Encouraging teens to practice making healthy decisions requires clear, nonjudgmental, confidential guidance or communication.

↳ TIPS FOR TALKING TO TEENS

- ☑ **Remove distractions.** Spend part of every visit with adolescent patients alone. By asking teens in private if they want their parent and/or partner involved in their care, they will be more likely to give a comfortable answer. Also request that cell phones and pagers are turned off - both yours and the teen's.
- ☑ **Begin by discussing confidentiality and its limits.** This helps build trust and explains the basis for mandated reporting. These requirements differ by state; if you are unclear on the limits to confidentiality, contact your county's child protective services for more information.
- ☑ **Negotiate the agenda.** Make an effort to address the issue(s) that brought your patient through the door, and explain what you need to cover during the visit. You can address their concerns and yours while building trust along the way. Don't neglect to include a sexual history for a youth with a disability.
- ☑ **Avoid jargon or complex medical terminology.** Teens are often hesitant to ask for clarification. Simple, straightforward language ensures effective communication of important information. Check for mutual understanding by asking open-ended questions, and clarifying your patients' slang in a nonjudgmental manner (e.g., "Tell me what you know about how a person can get HIV?"; "I've never heard that term before, do you mind explaining what ___ means?") Unless it is natural for you, try to avoid using slang to relate.
- ☑ **Use inclusive language.** Language that includes LGBTQ or gender variant youth builds trust and indicates acceptance. Instead of 'do you have a boyfriend/girlfriend?' try saying 'are you seeing anyone?' or 'are you in a relationship?' The language we use when speaking of disabilities is important. For example, the term "disability" is preferred over "handicap" and "wheelchair user" over "wheelchair bound". Listen to the language your patients use and, when in doubt, ask what is preferred.
- ☑ **Listen.** This not only builds trust, but may give insight that affects the healthcare and advice you provide.
- ☑ **Respect an adolescent's experience and autonomy.** Many young people feel that adults and people in positions of authority discount their ideas, opinions and experiences. Health care providers, together with parents, can help patients make wise, healthy decisions.



RISK vs BLAME

Healthcare providers generally assess risk and protective factors when treating and providing guidance to teen patients. There are many factors that put an individual at risk of negative health outcomes including living in poverty, a violent neighborhood, a single parent home, etc. Many of these risks, however, are not by the choice of the individual. When assessing risk and counseling on behavior change, avoid communicating blame to the patient.

Provider-Youth Communication *cont.*

FRAMEWORKS FOR WORKING WITH YOUTH

Reinforcing Health Promoting Behavior (Harm Reduction)

While healthcare providers cannot control the decisions made by their patients, they do play an important role in encouraging and reinforcing healthy decision-making. For example, when teens are engaging in risky sexual behaviors, teach them to use a condom or other birth control methods correctly and consistently rather than solely focusing on trying to talk them out of a sexual behavior that is deemed as risky. When teens are having oral sex, encourage them to use protection and abstain from such an activity when they have a cold sore in their mouth, genital lesions or bleeding gums.

Motivational Interviewing

While many teens make healthy decisions, sometimes it's clear that teens would benefit from changing their behavior. Motivational Interviewing offers brief and effective methods for intervention and uses behavior change as a foundation for working with youth. Motivational interviewing techniques have been effective for alcohol or substance use counseling. There is increasing evidence of its usefulness for counseling around sexual health issues. For more information, see Behavioral Health Module of the Adolescent Provider Toolkit.

The basic framework for Motivational Interviewing is as follows:

1. **ASK PERMISSION** to engage in the topic of discussion.
2. **ASSESS READINESS** for change and the youth's belief in his/her ability to make a change.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

- ▶ On a scale of 0 to 10, how ready are you to get some help and/or work on this situation/ problem?
- ▶ Straight question: Why did you say a 5?
- ▶ Backward question: Why a 5 and not a 3?
- ▶ Forward question: What would it take to move you from a 5 to a 7?

3. RESPOND TO PATIENT'S READINESS

READY FOR CHANGE (0-3): Educate, Advise and Encourage

UNSURE (4-6): Explore Ambivalence

READY FOR CHANGE (7-10): Strengthen Commitment and Facilitate Action

4. KEEP "FRAMES" IN MIND when counseling for behavior change

- F:** Provide **FEEDBACK** on risk/impairment (e.g. it sounds like your fear of getting pregnant is causing you a lot of anxiety)
- R:** Emphasize personal **RESPONSIBILITY** for change (e.g. I'd like to help you, but it's also very important that you take responsibility for changing things. What steps can you take to help yourself?)
- A:** Offer clear **ADVICE** to change (e.g. I believe the best thing for you would be to...)
- M:** Give a **MENU** of options for behavior change and treatment (You could try...)
- E:** Counsel with **EMPATHY** (I know that these things can be very difficult...)
- S:** Express your faith in the adolescent's **SELF-EFFICACY** (I believe in you, and I know that you can do this, when you decide the time is right)

Resource

- ⇒ Motivational Interviewing – Resources for clinicians, researchers and trainers:
<http://www.motivationalinterview.org>

The Role of Providers in Parent-Child Communication

Providers play an important role in educating entire families on sexual health, sexual orientation and gender identity and facilitating communication between adolescent patients and their parents. Healthy communication about sex between parents and children is extremely important in ensuring that young people have the support and information they need to make healthy decisions about sex and sexuality. Although it may seem difficult to encourage communication while still respecting the teen's privacy, it is possible to maintain confidentiality and at the same time promote parent-child communication.

The Benefits of Parent-Child Communication

- ▶ Young people who feel connected to home and to their parent(s)/caregiver(s) delay initiation of sexual activity.¹
- ▶ Young people who have conversations with their parents about sex are also more likely to have conversations with their partners about sex.²
- ▶ Young people who regularly use contraception are more likely to report having had discussions about sex with their parents than sexually active young people who are not using contraception.³
- ▶ Young people whose parents talked to them about condoms are more likely to use a condom at first intercourse and more consistently thereafter.⁴
- ▶ Young people whose families and caregivers openly talk about their sexual orientation are at lower risk for health problems and risky sexual behavior.⁵

TIPS FOR ENCOURAGING PARENT-CHILD COMMUNICATION

With Youth:

- ⇒ Reiterate the importance of parent-child communication each time you talk with the teen.
- ⇒ Ask why they do not want to involve a parent and try and get a sense of what they are afraid of. You can't force a teenager to talk to their parents, but you can probe further when a young person says they don't want to or can't talk to their parent about sensitive issues.
- ⇒ Let LGBT teens know that families that reject their LGBT identity may be motivated by care and concern for their teen and can become more supportive when they learn how to provide support to their teen.⁵
- ⇒ Ask if they need help talking to their parent about a particular issue and offer to meet with the youth and their parent together.
- ⇒ If they feel uncomfortable talking to their parent, identify other caring adults in their immediate or extended family that they can talk to.
- ⇒ Offer examples of ways that talking to parents/caregivers can help to ensure that they get support. E.g., help getting to appointments or someone to talk to when confusing things happen with their peers.
- ⇒ Share examples of young people who were afraid to talk to their parent about a sensitive issue and how it went better than they expected.

With Parents:

- ⇒ Reiterate the importance of parent-child communication each time you talk with parents.
- ⇒ For parents of LGBT teens, tell them that family support decreases risk for HIV, STIs, suicide and promotes well-being while family rejection increases these risks.⁵
- ⇒ Teach them medically accurate information, so that they can reinforce this at home.
- ⇒ Ask if they need help talking to their children or if there are particular issues they find hard to discuss at home.
- ⇒ Remind parents that teens are often afraid of disappointing their parents.
- ⇒ Encourage taking advantage of teachable moments, such as when a young person asks a question or something is witnessed while watching TV together, for example, where a bigger discussion and line of communication can be opened up.
- ⇒ Help parents find ways to be involved while respecting a young person's privacy and confidentiality.
- ⇒ Encourage parents to initiate and sustain open dialogues about health and sexuality with their children. Help parents put themselves in the shoes of a young person, to understand how difficult it is for their child to open up about sexuality and health.
- ⇒ Offer educational materials and resources about parent-child communication. See pg. 66 and pg. 68.

Resources

- 🔗 Advocates for Youth - <http://www.advocatesforyouth.org/>
- 🔗 Guttmacher Institute - <http://www.guttmacher.org/>

¹Resnick, MD et al. Protecting Adolescents from Harm: Findings from the National Longitudinal Study on Adolescent Health. *JAMA*. 1997; 278:823-32.

²Whitaker, DJ et al. Teenage Partners' Communication About Sexual Risk and Condom Use: The Importance of Parent-Teenager Discussions. *Family Planning Perspectives*. 1999; 31(3): 117-21.

³Hacker, KA et al. Listening to Youth: Teen Perspectives on Pregnancy Prevention. *J of Adol Health*. 2000; 26:279-88.

⁴Miller, KS et al. Patterns of Condom Use Among Adolescents: The Impact of Mother-Adolescent Communication. *Amer J of Public Health*. 1998; 88: 1542-44.

⁵Ryan C. Supportive families, healthy children: Helping families with lesbian, gay, bisexual & transgender children. San Francisco, CA: Marian Wright Edelman Institute, San Francisco State University, 2009.

Minor Consent and Confidentiality

Adolescents list confidentiality concerns as the number one reason for delaying or forgoing medical care. During a visit, teens are more likely to disclose sensitive information if consent and confidentiality is explained to them and they have time alone with a provider. Providers should reclarify the laws and limits of confidentiality during each visit.

LEARN THE MINOR CONSENT AND CONFIDENTIALITY LAWS IN YOUR STATE

Every state has different minor consent, confidentiality and mandated reporting laws. Almost all states allow teens to consent to STI testing and treatment, as well as medical care for a minor’s child. Contrarily, most states require some form of parental consent or notification before a minor can obtain an abortion.

Below is a link to an overview of minor consent laws for each state. This chart is updated regularly, but should only be used for a quick reference. More specific information about the laws in each state can be found in the resources and links listed at the bottom of this section.

 **OVERVIEW OF MINOR CONSENT LAWS**
http://www.guttmacher.org/statecenter/spibs/spib_OMCL.pdf

ENSURE CONFIDENTIAL BILLING FOR ADOLESCENT SEXUAL HEALTH SERVICES¹

- ▶ Most private health insurance plans send home an explanation of benefits (EOB) to the primary policy holder detailing services that have been received by the minor. Confidentiality may be breached if a parent/caregiver receives an EOB detailing their child’s reproductive or sexual health services.
- ▶ City, county, and/or state low- or no-cost family planning programs and Title X clinics do not send EOBs therefore disclosures regarding confidential care are avoided. Many of these programs cover services for to males too.
- ▶ **Sometimes a referral to a Title X clinic is most appropriate if confidentiality can’t be ensured through insurance billing.**

TIPS

- Be clear with minor patients up front about confidentiality and its limits. Be as specific as possible, so that they know what to expect and do not feel betrayed if something needs to be reported to a parent or child protective services.
- Explain that mandated reporting exists. Though it can cause confusion at times, it is ultimately for their protection.
- Explain early on the importance of confidentiality between providers and minor patients to parents. Rather than adversaries, parents can be allies in the provision of confidential healthcare for adolescents.²



RESOURCES

- ▶ **Office of Population Affairs**
Lists all Title X clinics by city, state, and zip code
http://www.opaclearinghouse.org/db_search.asp
- ▶ **National Center for Youth Law**
Minor Consent and Confidentiality Information (AZ, CA, HI, IL, MI, NV, OH)
http://www.youthlaw.org/publications/minor_consent/

¹Billing for Confidential Adolescent Health Services. Society for Adolescent Medicine. <http://www.adolescenthealth.org/clinicalcare.htm>

²Hutchinson, J. Stafford, E. Changing Parental Opinions About Teen Privacy Through Education. *Pediatrics*. 2005; 116(4): 966-971.

Healthy Relationships

The physiologic and cognitive impacts on romantic interest make adolescence an optimal time for providers to begin conversations about trust, communication, and respect. Regardless of whether a teen looks mature or displays a rebellious attitude towards authority, teens need to hear positive messages reinforced by adults who demonstrate an interest in their health and wellbeing. An assessment of relationships may also serve as a vehicle for exploring topics such as sexual activity, condom and birth control use, and intimate partner violence.



DISCUSSING HEALTHY RELATIONSHIPS WITH ADOLESCENTS:

Using the Healthy Relationships Wheel as a visual tool, ask the following four open-ended questions to begin a conversation about Healthy Relationships:



1. Can you find any areas on the wheel that match what your relationship with your girlfriend/boyfriend/partner is like?
2. Which areas on the wheel are the most important to you when you think of respect? Why?
3. How do you handle a disagreement in your relationship? Which ideas on the wheel can help you deal with conflict?

MESSAGES FOR HEALTHY RELATIONSHIPS

- ⇒ *The two people are equal in the relationship.*
- ⇒ *Each shows some flexibility in role behavior.*
- ⇒ *Each avoids assuming an attitude of ownership toward the other.*
- ⇒ *They encourage each other to become all that they are capable of becoming.*
- ⇒ *Each avoids manipulation, exploiting and using the other.*

RESOURCES

- ▶ SIECUS: <http://www.sexedlibrary.org/index.cfm?pageId=740>
This site contains links to a variety of healthy relationship publications and data.
- ▶ <http://www.cdc.gov/Features/ChooseRespect/>
The CDC's issue brief on healthy relationships.

¹Hedberg VA, Bracken AC, Stashwick CA. Long-term consequences of adolescent health behaviors: Implications for adolescent health services. *Adol Med: State of the Art Reviews*. 1999; 10(1): 137-151.

²Karney BR, Beckett MK et al. Relationships as Precursors for Healthy Adult Marriages: A Review of Theory, Research, and Programs. Rand Corporation, 2007.

Sexual Decision-Making

Healthcare providers play an important role in influencing the decisions that teens make surrounding sex. However, adolescents are equally as likely to get information on sexual decision-making from television than from providers (60% and 62% respectively).¹ By encouraging communication between teens and their parents and educating youth about the responsibilities, benefits, and risks involved with sexual activity, healthcare providers can facilitate healthy choices. Some of these choices may include initiating sexual activity at an appropriate time or using condoms consistently.

THEMES INFLUENCING ADOLESCENT SEXUAL- DECISION MAKING ²	PROVIDER INTERVENTION STRATEGIES
<p>1. Desire for Intimacy - Teens frequently report that desire for intimacy/love and sexual attraction significantly influence sexual decisions.</p> <p>2. Perceived Relationship Safety – Teens equate longer term relationships with trust and safety. This often results in the use of hormonal methods for pregnancy prevention and decreased or inconsistent condom use.</p> <p>3. Problem Solving and Cognitive Ability – Higher cognitive and reasoning ability may imply the ability to be more thoughtful and mature with decision-making. Lower problem-solving skills and cognitive ability is associated with earlier age of sexual debut. 50% of females with learning disabilities will be mothers within 3-5 years of leaving high school.³</p> <p>4. Family and Peer Influence – The decision to initiate sexual intercourse is often influenced by parents, peers and sexual partners. For example, teens who talk to their parents about sex are more likely to have conversations with their partners about sex.⁴</p> <p>5. Concern for Pregnancy or STI – Many teens underestimate their personal vulnerability for pregnancy and STIs.</p>	<p>1. Encourage thinking about sexual intimacy in the context of healthy relationships and suggest using experience of pleasure (or lack there of), level of partner communication, and the importance of safer sex as measures of sexual readiness.</p> <p>2. Raise the issue of consistent condom use if there is risk for STIs. Discuss approaches to STI risk reduction (condom use, condom use with side partners, limiting number of partners, etc.) as well as pregnancy risk reduction.</p> <p>3. Drugs and alcohol can impair decision-making skills. Encourage teens to: discuss sexual decisions with their partners before drinking; go to parties with a friend and designate one to stay sober for the night; watch their drinks to avoid date rape drugs.</p> <p>4. Identify peer and parent attitudes toward sex. Affirm positive influences and dispel myths. For example, “it is great that you and your friends always use condoms. However, using two condoms at the same time does not increase your safety and can cause condoms to break.”</p> <p>5. If not using contraceptives, explore why. Identify barriers to use and try to identify solutions. For example, if a teen is worried about confidentiality, revisit confidentiality with the teen.</p>

🔑 TIPS

- ▶ Revisit the teen’s sexual history during each visit. Try and understand the social, cultural and cognitive circumstances of the sexual activity. Use this as an opportunity to either educate or remind the teen of safer sexual behaviors and risk reduction strategies.
- ▶ Acknowledge and reaffirm positive behaviors and choices. Whenever possible, deliver some positive feedback to the teen.
- ▶ Applaud teens for making an informed decision to remain abstinent or become sexually active.
- ▶ Use harm reduction and motivational interviewing techniques to encourage behavior change. For more information on motivational interviewing, refer to pg. 6.
- ▶ Encourage parent child communication. For more information on parent-teen communication, refer to pg. 7.
- ▶ Discuss the importance and meaning of healthy relationships. For more information on healthy relationships, refer to pg. 9.
- ▶ Keep in mind that some teens may be having sex for reasons not outlined about (sex to get pregnant or test fertility, survival sex). Use motivational interviewing and harm reduction techniques to explore these issues.

¹SexSmarts Survey. Kaiser Family Foundation, 2001.

²Fantasia HC. Concept Analysis: Sexual Decision-Making in Adolescence. *Nursing Forum*. 2008; 43(2).

³Washington Summit on Learning Disabilities. 1994.

⁴Whitaker, DJ et al. Teenage Partners’ Communication About Sexual Risk and Condom Use: The Importance of Parent-Teenager Discussions. *Family Planning Perspectives*. 1999; 31(3): 117-21.

Sources:

- 1) Weiss UJA. Let us talk about it: Safe adolescent sexual decision-making. *J of the Amer Acad of Nurse Practitioners*. 2007; 450-458.
- 2) Fantasia HC. Concept Analysis: Sexual Decision-Making in Adolescence. *Nursing Forum*. 2008; 43(2).
- 3) Planned Parenthood. Sex and Alcohol: Some Sobering Thoughts.

Male Involvement

Young men are often not actively included in pregnancy and parenting discussions. They are sent the message early and often by friends, parents, and healthcare providers that their role is fairly limited when it comes to pregnancy prevention and parenting. Though there are realistic and legal limits to the role of young men in terms of decision-making about birth control and pregnancy options, the provider plays an important role in helping young men (and young women) understand the responsibilities and rights of fathers.

FAST FACTS

- ▶ Teen boys and girls whose fathers are involved in their lives do not initiate sexual activity as early and are less likely to get pregnant.
- ▶ Children who live with their fathers are 5 times less likely to live in poverty than children who live separately from their fathers.
- ▶ Young people without involvement of their fathers are twice as likely to drop out of school, twice as likely to abuse alcohol and other drugs, twice as likely to serve time in jail, and two to three times as likely to need support for behavioral and emotional problems.

Source:
National Campaign to Prevent Teenage Pregnancy

MALE INVOLVEMENT IN PREGNANCY PLANNING

Healthcare providers can help young men understand their role in pregnancy prevention. Encourage male adolescents to:

- 1. Take responsibility to prevent pregnancy.** Help him learn how to use condoms correctly through a condom demonstration in the office or other resources (video, handouts). Teach him what to do if the condom breaks. Specifically, explain that he should tell his partner if the condom breaks and share with her information about EC, if she is not on a hormonal birth control method. If he is 17 or older, he can buy EC over the counter.
- 2. Learn about hormonal birth control methods including Emergency Contraception (EC) using supportive handouts or other resources.** See pg. 26 for more information on EC and pg. 22 for information on hormonal birth control options.
- 3. Talk about pregnancy and pregnancy prevention with his female partner(s).** Provide the consistent message that using both condoms and hormonal contraception is the best way to prevent pregnancy and getting STIs. If the young man is interested in having children, ask him how he will determine when the time is right to become a father. Encourage him to have these conversations with his partner and intentionally plan for pregnancy.
- 4. Understand that he is in control regarding when and how his sperm is released.** Explain that he can choose not to have sex if he does not want to and that there are alternatives to penetrative sex. Masturbation on one's own or together with a partner are additional ways to avoid pregnancy and/or STI risk. Advise him that once his sperm has left his body, he may not be able to control the outcome if a condom was not used. Remind him that outcomes from unprotected sex, e.g., pregnancy, may be associated with unexpected legal and economic responsibilities.



Male Involvement *cont.*

5. **Estimate the costs of being a parent**, especially for young men who are ambivalent about condom use and fatherhood timing, using established worksheets or web-based resources. The following website, <http://www.babycenter.com/babyCostCalculator.htm>, provides an estimate for first year baby costs.

ADDITIONAL STEPS PROVIDERS CAN TAKE INCLUDE:

1. **Review condom use barriers** – e.g. why is it difficult to use, issues related to sensation, knowledge about various condom shapes and sizes and that not one condom is made for all, variation by partner in use and suggestions how to reintroduce condoms in relationships without impacting trust issues.

MALE INVOLVEMENT IN PARENTING

Assist young men who are fathers to understand their role in parenting. Providers should:

- Ask all young men whether they have ever made someone pregnant and if they are a father.
- Assess the degree to which they are involved in their child(ren)'s life including emotional, physical, financial support and barriers/facilitators to involvement.
- Identify community resources such as parenting classes geared to young men, educational support, job training, etc. that can positively assist young men in the parenting role.

Tips For Encouraging Male Involvement:

- Approach young men as partners and assets rather than adversaries.
- Conduct education with female clients to encourage them to involve their partners in reproductive health and family planning, as well as pregnancy options.
- Increase 'male-friendliness' of clinics and medical offices. For example, display posters with images of young men, use language that is inclusive of young men in pregnancy prevention educational materials.

PATERNITY LAWS

For information on paternity and paternity laws, please see pg. 43.

Taking a Client-Centered Sexual History

At a teen's first visit or at ages 11-12, it is important to initiate discussion about sexuality. Teens want their healthcare providers to ask these questions!

↳ General Tips

- ▶ Begin the sexual history AFTER you have established rapport with the adolescent.
- ▶ Think about taking the sexual history in the context of a HEADSSS assessment: Home, Education/ Employment, Activities, Drugs, Sexuality/ Suicide/ Depression/Self-Image, Safety.
- ▶ Remember! Restate the parameters of confidentiality before you take a sexual history.
- ▶ Use open ended questions that start with “what,” “how,” “when,” or “tell me”.
- ▶ Be aware of judgmental questions (ex. “you don’t have unprotected sex, do you?”) and behaviors (ex. shaking your head as you ask questions).
- ▶ Frame some questions in the third person. (ex. Are you noticing that your peers/friends are starting to have sex?)
- ▶ Use understandable language - avoid clinical terms. (e.g. substitute “having sex” for “intercourse”)
- ▶ Ask adolescents for clarification when they say things you don’t understand.
- ▶ Use reflective listening. Paraphrase what the young person has said and repeat it back to him/her.
- ▶ Do not make any assumptions, particularly about initiation of sexual activity, type of activity, gender identity, and sexual orientation.
- ▶ Always acknowledge positive behaviors and assets particularly establishing healthy relationships, proper use of contraceptives and safer sex methods, etc.
- ▶ Educate teens about their options so they are in a position to make informed choices.
- ▶ Refer teens to other resources based on their individual needs.

Guidelines For Sexual History Taking

The following is an outline for taking a sexual health assessment based on the Five P’s Assessment (Partners, Prevention of Pregnancy, Protection from STIs, Practices, and Past History of STIs). Taking a sexual history should always be embedded in a general psycho-social assessment like “Annotated HEADSSS”.¹ Consider these statements, questions, and tips as a guide to assessing your teen patients.

INTRODUCTION

I'm going to take a few minutes to ask you some sensitive questions. This information is important and will help me provide better health care to you. Let's first discuss what information will be kept private and what information I might have to share with other people (see pg. 8 for information on minor consent and confidentiality).

STAGES OF DEVELOPMENT

Initial Questions

- Do you have any questions or concerns about your looks or appearance?
- Do you have any questions or concerns about your sexual development?
- Do you have any questions, thoughts, or rules about masturbation?

Tips

- ▶ During the onset of puberty, advice about hygiene can become very important. Include discussions on bathing, deodorant, and proper shaving techniques.
- ▶ Normalize the changes that happen during puberty. Assure patients that they shouldn’t feel ashamed about having wet dreams and masturbation.
- ▶ See pg. 3 for more information on the stages of adolescent sexual development

¹Simmons M, Shalwitz J, Pollack S, Young A. *Adolescent Health Care 101: The Basics*. Adolescent Health Working Group. 2003. http://www.ahwg.net/assets/library/74_adolescenthealthcare101.pdf.

Sources:

- 1) Cavanaugh RM. Screening Adolescent Gynecology in the Pediatrician’s Office: Have a Listen, Take a Look. *Pediatrics in Review*. Sept 2007; 28(9).
- 2) Marcell AV, Bell DL. Making the most of the adolescent male health visit Part 1: History and anticipatory guidance. *Contemp Pediatrics*. 2006;23:6(38-46)

Taking a Client-Centered Sexual History *cont.*

SEXUAL ORIENTATION/SEXUAL ATTRACTION

Initial Questions

- Some of my teen patients are exploring new relationships. Do you have a crush on anyone? Are you dating or seeing anyone?*
- Are you attracted to guys, girls, or both?

Follow-Up Questions:

- How long have you been dating this person?*
- Are you having sex with anyone else?*
- Is your partner having sex with anyone else?*
- Have you thought about having sex with him or her?*
- Who do you talk to about sex?*

Follow-Up Questions for Lesbian/Gay/Bisexual Teens:

- Who have you told about your sexual orientation?*
- What are your family's reactions to your sexual orientation/identity?*

Tips

- ▶ Use gender neutral terms until the teen has established a preference for male/female sexual partners.
- ▶ Become familiar with resources for LGBT youth in your area. Refer to community support programs for supportive counseling as needed.
- ▶ Provide anticipatory guidance to LGBT teens who report family rejection.
- ▶ With younger teens, start by asking questions in the 3rd person, ie. Are any of your friends...?
- ▶ Sometimes teens, especially young teens, don't use the word dating. Keep this in mind when discussing their relationships.
- ▶ Don't forget to address these issues with teens with disabilities.

SEXUAL ACTIVITY

Initial Questions:

- Sexuality and relationships are things that many teens are dealing with; and different people are at different points in exploring these issues. Have these issues come up for you? How?*

Follow-Up Questions:

- What do you consider "having sex?"*
- When do you think it is OK to have sex?*
- Have you ever had sex? (intercourse/outercourse)?*

If yes:

I'm going to ask you several questions about your experiences with sex, so that I can help you in making/keeping these experiences positive and healthy.

- ⇒ How old were you the first time you had sex?
- ⇒ Do you have sex with guys, girls or both?
- ⇒ Do you want to be having sex right now?
- ⇒ How often do you have sex?
- ⇒ How many people have you had sex with in the last 3 months? In your life?
- ⇒ For some people sex is generally a fun experience, for others it is not all that fun and may even hurt most of the time? What is usually your experience with sex?
- ⇒ Has there ever been a time that you had sex but didn't want to?
- ⇒ Have you ever had sex when you were high on drugs or alcohol?

If no:

- ⇒ When do you see yourself making the decision to have sex?*

- Who do you talk to about sex?*
- How do feel about having sex? Is it a good thing or bad thing for you?*

Tips

- ▶ Use the follow-up questions to determine if STI/pregnancy prevention methods have been used and which methods might be most appropriate for him or her.
- ▶ When sex is not enjoyable, assess whether this is because they *don't want to be sexually active*, have a physical problem, or are having problems with sexual function, as the counseling messages are different.

Protective Factors

- ▶ Sexual debut after 15 years of age.
- ▶ Has a trusted adult to talk to about sexual issues.
- ▶ For LGBT youth, have parents/caregivers/families that support their LGBT identity.²

*Ask every adolescent patient regardless of sexual activity.

²Ryan C. Supportive families, healthy children: Helping families with lesbian, gay, bisexual & transgender children. San Francisco, CA: Marian Wright Edelman Institute, San Francisco State University, 2009.

Taking a Client-Centered Sexual History *cont.*

SAFER SEX PRACTICES

Initial Questions:

- Tell me some of what you know about STIs and HIV.*

Follow-Up Questions:

- Have you or your partner ever been tested for STIs/HIV? Had an STI?*
- Does your partner have other sexual partners that you know of? Do you?
- What questions do you have about STIs and HIV?

Initial Questions:

- Are you doing anything to protect yourself against STIs/HIV and pregnancy? What are you doing?

Follow-Up Questions:

If the teen indicates that he/she has not been using protection, ask:

- ⇒ Have you used some sort of protection in the past?
- ⇒ What keeps you from using protection now?

If the teen indicates that he/she sometimes uses protection, ask:

- ⇒ With whom and when do you use protection?
- ⇒ What would help you to always use protection?

Tips

- ▶ Use this opportunity to counsel teens about methods. Congratulate those who are using contraception for doing so, and encourage those who are not to initiate use.
- ▶ Remind them that condoms are most effective when they are used correctly with every sexual encounter.
- ▶ Teens may be more likely to use protection with casual rather than steady partners. Remind them to use STI and pregnancy protection with all partners.
- ▶ Screen for other risks, such as alcohol and substance use and sexual abuse.
- ▶ Refer teens to health education materials.

Protective Factors:

- ▶ Discussing contraception with partner before first sex
- ▶ Not currently sexually active or using reliable methods to reduce pregnancy/STI/HIV risk
- ▶ Using dual methods – condoms in addition to a contraceptive method dedicated to the prevention of pregnancy (IUD, birth control pills, etc.).

SEXUAL ASSAULT AND INTIMATE PARTNER VIOLENCE

Introduction:

Teens usually form healthy relationships. Unfortunately, some teens are hurt by strangers, people they know or the people they date. I am going to ask you a couple questions to make sure that you are safe.

Initial Questions:

- Have you ever been hurt in a sexual way or forced to have sex when you didn't want to?*
- Have you ever traded sex for money, drugs, a place to stay or other things that you need?
- Do you feel safe in your relationships?

Follow-Up Questions:

- There are things people can do that may reduce their risk of sexual assault. Do you know how to reduce your risk of sexual assault?*

Tips

- ▶ Remind teens that you ask these questions because you're concerned about their safety. As a mandated child abuse reporter you must report abuse to your county child protective services or law enforcement agencies.
- ▶ Be aware that youth with disabilities (particularly non-verbal and intellectually disabled youth) report higher incidence of sexual abuse.⁴
- ▶ For more information on healthy relationships, see pg. 9.
- ▶ For more information on intimate partner violence, see pg. 30.
- ▶ For more information on sexual assault, see pg. 33.

CLOSURE

At the end of the conversation, review what you learned and what you discussed.

For Example:

So, you've just told me that you're taking birth control pills to prevent pregnancy with your partner. And that you two have talked about using condoms if either of you have side partners. You're making really good decisions and I encourage you to continue this smart behavior.

*Ask every adolescent patient regardless of sexual activity.



³The American College of Obstetrics and Gynecologists suggests screening all patients at every visit for sexual assault. This following questions should be asked of all patients whether or not they are currently sexually active.

⁴Horner-Johnson W, Drum CE. Prevalence of maltreatment of people with intellectual disabilities: A review of recently published research. *Mental Retardation and Developmental Disabilities Research Reviews*. 2006; 12: 57–69.

Source:

Ryan C. Supportive families, healthy children: Helping families with lesbian, gay, bisexual & transgender children. San Francisco, CA: Marian Wright Edelman Institute, San Francisco State University, 2009.

STI Screening and Treatment

An Overview

SCREENING

A complete and accurate sexual history is needed to determine sexual risk based on practices and gender of partners. Because STIs and HIV can remain asymptomatic, it is imperative that providers assess all sexually active teens for risky sexual and drug-use behavior at health maintenance visits. For guidance on assessing risk and taking a sexual health history, please refer to pg. 13.

✓ Screening for Chlamydia and Gonorrhea (CT and GC)

- ▶ Annual screening for CT in all sexually active females 25 years of age and younger and men who have sex with men is recommended by the Center for Disease Control and Prevention (CDC).
- ▶ Annual screening for GC in all sexually active females 25 years of age and younger is recommended by the U.S. Preventive Services Task Force, and supported by the CDC. Annual screening of men who have sex with men is also recommended by the CDC. Screening in very low prevalence populations (<1%) is generally not indicated.
- ▶ More frequent screening based on sexual risk. For adolescents, screening every 6 months in young women and every 3-6 months for men who have sex with men may be indicated. CT and GC screening can be performed at any visit type, regardless of reason for visit.
- ▶ If the test is positive for either CT or GC, repeat screening 3-4 months after treatment.

✓ Screening for HIV

- ▶ The CDC currently recommends an HIV test for all persons aged 13-64 once, and periodic testing for those with on-going behavioral risks. See pg. 18 for more information on HIV testing and counseling recommendation.

✓ Screening for HPV

- ▶ See pg. 20 for more information on HPV and HPV-related cancer screening recommendations.

✓ Screening for other STIs

- ▶ Any positive test for an STI is an indication to screen for all other STIs. For example, if a patient has trichomoniasis, he/she should be screened for CT, GC, syphilis and HIV.
- ▶ Men who have sex with men should be screened annually for syphilis.

Screening at the Discretion of the Provider

Currently, there are no screening guidelines for Chlamydia and gonorrhea (CT and GC) for men who only have sex with women (MSW) and women who only have sex with women (WSW).

- ▶ Providers may screen MSW selectively for the following high-prevalence settings:
 - ⇒ Correctional facilities
 - ⇒ STI clinics
 - ⇒ Adolescent-serving clinics
 - ⇒ Individuals with multiple partners
- ▶ Young WSW engaging in sexual behaviors involving shared vaginal or anal penetrative items (digital, sex toys, etc.) are at risk of CT/GC and should be screened at the discretion of the provider.
 - ⇒ For more information see the ARHP WSW fact sheet:
 - 📄 www.arhp.org/factsheets

Sources:

- 1) STI Epidemiology, Testing and Treatment Strategies. Adolescent Reproductive Health Education Project, PRCH, 2009.
- 2) Center for Disease Control. Sexually Transmitted Diseases Treatment Guidelines 2006. Special Populations. <http://www.cdc.gov/STD/treatment/2006/specialpops.htm>. Accessed 1/29/10.

TREATMENT



- ◆ For the most up-to-date treatment recommendations, refer to the CDC's guidelines:
 - 📄 <http://www.cdc.gov/STD/treatment/default.htm>
- ◆ Chlamydia, gonorrhea, and syphilis are reportable STIs in every state. Other reportable STIs vary by state and sometimes by county. See the CDC's Fastats from A to Z for individual state data:
 - 📄 http://www.cdc.gov/nchs/FASTATS/map_page.htm

¹Youth Risk Behavior Survey, National Youth Behavior Survey: 2007.

²Kaiser Family Foundation U.S. Teen Sexual Activity: Source footnote 7.

STI Screening and Treatment *cont.*

TIPS

- ▶ Contact your local health department for prevalence rates and trends to help you tailor STI screening. STI trends can vary significantly by state and county.
- ▶ Keep in mind patient consent/confidentiality and let the patient know that you are screening him/her for STIs. This is a great opportunity to educate teens about common STIs and safer sex methods.
- ▶ Be aware that patient confidentiality may be compromised by mandated reporting of STIs. Even if the healthcare provider does not file a report, laboratories will report any positive Chlamydia, gonorrhea or syphilis test. Become familiar with local reporting practices around contacting patients and partners and advise patients accordingly.
- ▶ Be aware of billing practices. Insurance claims sent home may breach confidentiality especially if tests for STIs are listed.
- ▶ Nucleic acid amplification tests (NAATs) are recommended for screening, and can be used on urine and self-collected vaginal swab specimens, making a pelvic exam unnecessary.
- ▶ NAATs can also be used on pharyngeal and rectal specimens.

EXPEDITED PARTNER THERAPY (EPT) AND PARTNER NOTIFICATION

- ⇒ Expedited partner therapy (EPT) is the empirical treatment of sexual partners of an individual who tested positive for a sexually transmitted disease without provider evaluation. Under most circumstances, the patient will deliver the medication to his/her sexual partners.
- ⇒ Partner notification is the act of informing one's sexual partner(s) that he/she has potentially been exposed to an STI. There are three routes of partner notification: provider, patient, or contact referral.
- ⇒ EPT has been shown to be more effective than referring sexual partners for treatment of Chlamydia and gonorrhea and has reduced rates of persistent or recurring infections in individuals including adolescents.
- ⇒ EPT for gonorrhea and Chlamydia is safe, effective and should be considered standard medical practice.
- ⇒ Providers need to consider the issues surrounding EPT use and partner notification in adolescents. Dispensing EPT can breach patient confidentiality via insurance billing for medication and both EPT and partner notification can result in mandated reporting if the partner's birth date is required for prescriptions.

Resources:

- **CDC's full review of EPT:** <http://www.cdc.gov/std/EPT/>. Guidance for use of EPT can be found on page 34.
- **InSpot.org:** This website allows individuals who have tested positive for an STI to anonymously tell their sexual partners through an ecard. The ecard then links the individual to resources for STI testing and treatment in their area. Currently, InSpot is only available in 10 states and 9 metropolitan areas.

Sources:

- 1) Centers for Disease Control and Prevention. Expedited partner therapy in the management of sexually transmitted diseases. Atlanta, GA: US Department of Health and Human Services, 2006.
- 2) Golden MR, Whittington WLH, Handsfield HH, et al. Effect of Expedited Treatment of Sex Partners on Recurrent or Persistent Gonorrhea or Chlamydial Infection. *N Engl J Med.* 2005; 352(7): 676-685.
- 3) Hogben M, Burstein GR. Expedited Partner Therapy for Adolescents Diagnosed with Gonorrhea or Chlamydia: A Review and Commentary. *Adol Med Clinics.* 2006; 17: 687-695.
- 4) CDC: Program Operations Guidelines for STD Prevention: Partner Services.

RESOURCES

Centers for Disease Control and Prevention

- ▶ *Sexually Transmitted Diseases Treatment Guidelines, 2006:* <http://www.cdc.gov/STD/treatment/2006/toc.htm>
- ▶ *Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings, 2006:* <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>

US Preventive Services Task Force

- ▶ *Screening for Chlamydia Infection:* <http://www.ahrq.gov/clinic/uspstf/uspshlm.htm>
- ▶ *Screening for Gonorrhea:* <http://www.ahrq.gov/clinic/uspstf/uspsgono.htm>

HIV Testing and Counseling

Background

BASIS FOR UNIVERSAL HIV TESTING

Up to 30% of all new HIV infections occur in adolescents and young adults 13 to 25 years old.¹ 25% of individuals with HIV are unaware of their HIV diagnosis and account for approximately 54% of new infections.² The Centers for Disease Control and Prevention recommend that all persons ≥13 years of age be tested for HIV at least once during their lifetime.³ More frequent testing is recommended based on risk for acquiring HIV.

HIV TESTING METHODS

Usually, HIV infection is screened for by an EIA (enzyme immunoassay), from a blood sample, to look for HIV antibodies. A positive or reactive EIA requires a confirmatory test (such as the Western blot) to make the diagnosis of HIV. Depending on the lab, it may take up to 2 weeks to receive results. There are limitations to this option. First, it may limit the ability to counsel patients. Second, because the patient must return in person, it may limit some people in receiving results.

ANONYMOUS TESTING

Anonymous testing is offered in some states at community based organizations or clinics. Clients may feel more at ease with anonymous testing. Refer to your state laws for more information.

RAPID TEST

Rapid Tests are screening tests available at many community or STI clinics and testing centers. Results are generally given within about 20 minutes of processing and clients receive results before they leave, enabling a built-in counseling and referral session. All reactive/positive rapid test results must be confirmed by a blood test which will require a follow-up visit. To find local testing resources go to: www.hivtest.org.

HIV Counseling

The 2006 CDC guidelines recommend that HIV testing should be: 1) opt-out, with the opportunity to ask questions and the option to decline testing; 2) performed without a separate written informed consent for HIV testing; and 3) prevention counseling should not be required with HIV diagnostic testing or part of HIV screening programs in health-care settings. The CDC does recommend counseling in nonclinical settings, such as at community-based organizations. There continues to be controversy around these areas and many state laws are incongruous with the recommended guidelines.

The ACTS⁴ (Advise, Consent, Test, Support) program can be used to prepare an adolescent to have an HIV test, receive results and elicit discussion around ways to prevent HIV quickly and efficiently. For more information about ACTS go to www.adolescentaids.org.

Adolescents may also be referred out to receive pre-test counseling using www.hivtest.org.

TO COUNSEL OR NOT TO COUNSEL?

While the CDC does not recommend counseling in health-care settings, there are times or situations that may warrant counseling.

REASONS FOR COUNSELING

- ▶ Adolescents prefer to receive STI/HIV information from their provider and studies have demonstrated that provider recommendation remains one of the strongest predictors of testing.^{5,6}
- ▶ Identifies personal risk of HIV infections.
- ▶ Reduces anxiety by preparing client for a positive diagnosis.
- ▶ Decreases cost of repeat testing and stress for clients with no or low risk for HIV.
- ▶ Opens discussion for additional testing and counseling
- ▶ Assesses social support.

REASONS AGAINST COUNSELING

- ▶ Routine or universal HIV testing (by itself without counseling) was cost-effective even in low prevalent settings (prevalence >0.1%).^{7,8}
- ▶ Normalizes HIV and makes it a part of regular STI screenings.
- ▶ Time constraints for primary care physicians
- ▶ Counseling for HIV can be integrated into risk-reduction counseling for all clients when discussing other STIs and drug use.
- ▶ Client has already been counseled before and does not need more information.

¹Morris M, Hancock MS, Miller WC, et al. Prevalence of HIV infection among young adults in the United States: results from the Add Health study. *Amer J Pub Health*. 2006; 96(6): 1091-1097.

²Marks G, Crepez N, Janssen RS. Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA. *AIDS*. 2006; 20:1447-50.

³MMWR Morb Mortal Wkly Rep 2006; 55:1-17.

⁴Developed by the Adolescent AIDS Program at Montefiore Medical Center.

⁵Goodman E, Tipton AC, Hecht L, Chesney MA. Perseverance pays off: health care providers' impact on HIV testing decisions by adolescent females. *Pediatrics*. Dec 1994; 94(6 Pt 1):878-82.

⁶Samet JH, Winter MR, Grant L, Hingson R. Factors associated with HIV testing among sexually active adolescents: a Massachusetts survey. *Pediatrics*. Sept 1997;100(3 Pt 1):371-7.

⁷Sanders GD, Bayoumi AM, Sundaram V, et al. Cost-effectiveness of screening for HIV in the era of highly active antiretroviral therapy. *N Engl J Med*. Feb 2005; 352(6):570-85.

⁸Paltiel AD, Weinstein MC, Kimmel AD, et al. Expanded screening for HIV in the United States--an analysis of cost-effectiveness. *N Engl J Med*. Feb 2005; 352(6):586-95.

HIV Testing and Counseling *cont.*

WHEN A CLIENT DECIDES TO TEST

- **Praise client for considering HIV testing**
 - ☑ “It is great that you are being proactive about your health and taking the initiative to test for HIV today.”
- **Remove distractions** (cell phones, partners, parents, etc.).
- **Discuss confidentiality laws** specifically pertaining to testing, results, and parental/partner notification. Check for testing site and state specific protocols and laws.
- **Assess risk** (intravenous drug users, men who have sex with men, anal sex, inconsistent condom use, sex with a known positive, history of STIs, sex in high prevalence community/network) and ways to reduce risk – this can be included in discussing ways to reduce risk for other STIs; Hepatitis and HIV.
 - ☑ “What types of sex are you having? What are some ways that you could have safer sex in your relationships?”
- **Discuss the window period.** HIV antibodies take anywhere from 2 weeks to 6 months to be detected with the majority being detected at 3 months. Depending on risk level and state of exposure, retesting may be indicated.
- **Prepare for a positive or negative diagnosis.** Discuss the meaning (from patient’s perspective) of a positive or negative test, what their life looks like moving forward, and who they can talk to when the appointment is over.

AFTER TESTING

In some states, giving HIV screening results over the phone is illegal, even in the case of a negative screening. Providers should refer to state laws for more information.

If **NEGATIVE**, review the risk reduction plan, window period, and need to retest. Answer any questions the client may have.

If **POSITIVE**, refer to state-specific laws for follow-up. Many states require additional screening before diagnosis, and reporting laws vary by state. Review the results, allowing additional time if the result is positive. You may want to have a social worker, counselor, or nurse provider available to assess the client and assist with post-test counseling and link to HIV/AIDS services. Discussion of partner notification and a risk reduction plan may need to be performed during a follow up visit. The first visit should be used to repeat HIV testing, and give the client time to receive their result, to process and to assess the client’s safety.

Giving HIV results can be stressful. Make sure to take a break to clear your mind and talk with another health care provider about the experience.

Resources



Image reproduced with permission by Pro-Choice Public Education Project. Copyright © 2005.

- 🔗 <http://www.adolescentaids.org>
HIV educational materials for youth.
- 🔗 <http://www.thebody.com>
Online resource for HIV/AIDS.
- 🔗 <http://www.hivplus.com>
Discusses issues related to HIV/AIDS.
- 🔗 <http://www.poz.com>
Popular magazine catered to HIV positive individuals.
- 🔗 <http://www.mpowrplus.com>
Popular magazine for HIV positive LGBT community.
- 🔗 <http://www.hivtest.org>
CDC sponsored website that provides information on HIV test centers by going to the website or texting a zip code to KnowIt or 566948.

Human Papillomavirus (HPV) Related Cancers

Screening and Follow-Up

BACKGROUND

The new recommendations for cervical cancer screening are based on a growing understanding about the Human Papillomavirus (HPV) and its causal relationship to 99% of cervical cancer.¹ However, the actual incidence of the virus causing neoplastic cervical lesions, particularly in young, healthy women, is extremely low. While over 80% of sexually active people have the virus, most young women will clear the virus before pre-cancerous cervical lesions occur.² With this understanding the new recommendations are endorsed by the American Society of Colposcopy and Cervical Pathology (ASCCP) and include new management guidelines specific to adolescent women age 20 and younger with abnormal cervical cytology and histology.

¹American College of Obstetrics and Gynecology (ACOG), Committee on Adolescent Health Care. Evaluation and management of abnormal cervical cytology and histology in the adolescent. ACOG. 2006; 107(4): 963-8.

²Ibid

Screening

WHEN TO START SCREENING FOR CERVICAL CANCER^{1,2}:

All women should begin Pap tests at the age of 21. All women, regardless of sexual orientation should undergo pap test screening using current national guidelines.³ The data on cervical cancer incidence and the natural history of HPV infection and of low- and high-grade cervical lesions suggest that a cervical lesion significant for neoplasm would take 5 to 10 years to develop after initial exposure to HPV.

- ▶ **Victims of sexual abuse:** little to no data is available on victims of sexual abuse, however, no evidence suggests that earlier screening would be beneficial, however abuse victims who have had vaginal intercourse, especially post puberty, may be at increased risk of HPV infection and cervical lesions and should be referred for screening once they are psychologically and physically ready (i.e., postpuberty) by a provider who has experience and sensitivity working with abused adolescents.
- ▶ **Adolescents engaging in sexual activities excluding vaginal intercourse:** the risk of HPV transmission to the cervix is low for other types of sexual activity.
- ▶ **Concurrent STIs:**
 - ⇒ HIV infection: obtain two Pap tests in the first year after initial diagnosis of HIV infection and if results are normal, annually thereafter.
 - ⇒ All other STIs including genital warts: follow 2002 ACS recommendation
- ▶ **Anal HPV infection or anal cancer:** precancerous lesions and HPV infection are common in HIV-positive individuals and MSM. Because these populations may be at higher risk of developing anal cancer, some health care providers recommend yearly anal pap tests. Currently, however, the CDC does not recommend anal pap tests due to lack of evidence supporting their use in preventing anal cancer. HPV tests have not been approved for either anal use or use in men and are likely not to be clinically helpful.^{4,5}

¹2002 American Cancer Society Recommendations can be accessed from the CDC's website at <http://www.cdc.gov/std/hpv/ScreeningTables.pdf>.

²ACOG Practice Bulletin: Clinical Management Guidelines for Obstetrician-Gynecologists. Cervical Cytology Screening. Dec 2009; 109.

³Center for Disease Control. Sexually Transmitted Diseases Treatment Guidelines 2006. Special Populations. <http://www.cdc.gov/STD/treatment/2006/special-pops.htm>. Accessed 1/29/10.

⁴<http://www.cdc.gov/std/hpv/stdfact-hpv-and-men.htm>

⁵Evans, D. Pap Smears for Anal Cancer? Poz Magazine. June 2008.

Human Papillomavirus (HPV) Related Cancers *cont.*

SCREENING FOR CERVICAL CANCER⁶:

Screening Intervals for normal cervical cytology and histology:

- ▶ **Conventional cervical cytology smears:** After the initiation of cervical cancer screening, continue with Pap tests every two years until the age of 30.
- ▶ **Liquid-Based Cytology (Thin Prep):** After the initiation of cervical cancer screening, continue with Pap tests every two years until the age of 30.

Intervals for screening women under 30 are more frequent due to the increased likelihood of high-risk HPV acquisition.⁷

In women 20 or younger, HPV testing is not recommended due to the likelihood of this population clearing the virus.

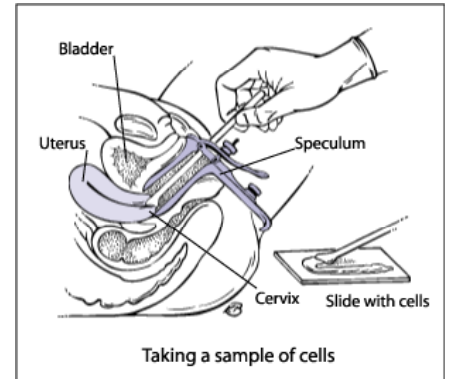


Image taken from "FamilyDoctor.org: Pap Smear": <http://familydoctor.org/138.xml>

Follow-Up⁸

Recommendation for management of abnormal cervical cytology and histology in the event that the provider decides to screen a young woman under 21

DIAGNOSIS	RECOMMENDATIONS FOR ADOLESCENTS (AGED 20 OR YOUNGER)
Atypical Squamous Cells of Undetermined Significance (ASC-US) or Low-grade Squamous Intraepithelial Lesion (LSIL)	Repeat Pap test in 12 months for up to two years; then, if remains abnormal or HSIL at any visit refer to colposcopy
Atypical Squamous Cells, Cannot Exclude High-grade Squamous Intraepithelial Lesion (ASC-H)	Colposcopy
High-grade Squamous Intraepithelial Lesion (HSIL)	Colposcopy
Atypical Glandular Cells* (AGC)	Colposcopy, endocervical assessment, possible endometrial evaluation
Cancer	Colposcopy, endocervical assessment
Cervical Intraepithelial Lesion - mild cervical dysplasia (CIN I)	Repeat Pap at 12 month intervals, if HSIL or greater, refer back to Colposcopy.
Cervical Intraepithelial Lesion - moderate cervical dysplasia (CIN II)	Close follow-up at 4-6 month intervals, with cytology and colposcopy; treatment is recommended if CIN II remains at two years
Cervical Intraepithelial Lesion - severe cervical dysplasia (CIN III)	Ablative or excision therapy

*Associated with malignant or pre-malignant lesions in up to 40% of women (age over 35 confers greater risk)

For further recommendations regarding management of colposcopy results and/or the management of pregnant adolescents with abnormal cervical cytology and histology refer to CDC website at <http://www.cdc.gov/std/hpv/default.htm#resources> and refer to the "Clinician's Resources" section.

⁶ACOG Practice Bulletin: Clinical Management Guidelines for Obstetrician-Gynecologists. Cervical Cytology Screening. Dec 2009; 109.

⁷Center for Disease Control and Prevention (CDC) (2007). Human papillomavirus (HPV): Prevalence of high-risk and low-risk types among females 14 to 59 years of age reported from a national survey, 2003–2004. Accessed from <http://www.cdc.gov/std/stats07/figures/43.htm> on May 12, 2009.

⁸ASCCP Recommendations for the Management of Women with Abnormal Cervical Cancer Screening Tests which can be accessed at <http://www.asccp.org/consensus.shtml>.

Things to Consider When Prescribing Birth Control

WHEN COUNSELING ABOUT CONTRACEPTION OPTIONS:

- | | |
|---|---|
| <ul style="list-style-type: none"> ☑ First ascertain what methods the teen knows about and is interested in. ☑ Briefly describe all options. Guide them in their decision based on their comfort level, needs and behaviors. ☑ Describe the chosen method in greater detail to ensure that the teen knows how to use it effectively. | <ul style="list-style-type: none"> ☑ Have the teen repeat back and demonstrate the correct use of the method. ☑ Schedule a future visit to ensure that the method is working right for him/her. ☑ Always re-emphasize the importance of condom use to prevent STIs in addition to choosing an alternative method of birth control. ☑ Suggest ways to include the teen's partner in discussions about contraception. |
|---|---|

IS THE INTRAUTERINE DEVICE (IUD) AN OPTION FOR YOUTH?

Health care providers trained since the 1970's have generally considered IUDs to be contraindicated in adolescents. The Dalkon Shield, a popular IUD with young women in the 1960's and early 70's was associated with severe pelvic infections, ectopic pregnancies and infertility and effectively created an association between any IUD and poor outcomes in adolescents. Recent data shows that the association between IUD's and pelvic infections is primarily related to infections in the first few weeks after insertion and likely reflects insertion in women already infected with Gonorrhea or Chlamydia.



Contraindications for IUD initiation: World Health Organization medical eligibility criteria¹



- ▶ Current purulent cervicitis, chlamydia or gonorrhea infections
- ▶ History of an STI in the past three months
- ▶ Very high individual likelihood of chlamydial and gonorrhea exposure
 - ⇒ More than 1 sexual partner in past 3 months
 - ⇒ Partner who has multiple sexual partners
 - ⇒ Partner who has been diagnosed with an STI or has STI symptoms in past 3 months

Some, but not all, adolescents have these risks; therefore this method should not be categorically considered inappropriate for all adolescents. Even in the presence of an STI, currently available IUCs are not independently associated with pelvic infections or tubal infertility.²

The following are NOT IUD contraindications:



- ▶ Remote history of STI if no longer at increased risk
- ▶ Nulliparity
- ▶ History of PID
- ▶ History of ectopic pregnancy

Although the expulsion rate of recently inserted IUCs is slightly higher in women who have never borne a child, nulliparity is not a contraindication.³ IUDs are highly effective, long acting (5 years for the levonorgestrel intrauterine system, Mirena; 10 years for the intrauterine copper contraceptive, Paragard), invisible, reversible and easy to maintain – all attractive characteristics for adolescents. In particular, adolescent mothers, a group at very high risk for repeat pregnancy, may benefit from this contraceptive option.⁴

¹World Health Organization. Medical Eligibility Criteria for Contraceptive Use. 3rd ed. Geneva: WHO; 2004 (Update, 2008). Available at <http://www.who.int/reproductive-health/publications/mec>. Accessed 7/23/08.

²Toma A, Jamieson MA. Revisiting the intrauterine contraceptive device in adolescents. *J Ped Adol Gynecol*. Aug 2006;19(4):291-296.

³World Health Organization. Medical Eligibility Criteria for Contraceptive Use. 3rd ed. Geneva: WHO; 2004. Available at <http://www.who.int/reproductive-health/publications/mec>. Accessed 7/23/08.

⁴Toma A, Jamieson MA. Revisiting the intrauterine contraceptive device in adolescents. *J Ped Adol Gynecol*. Aug 2006;19(4):291-296.

Things to Consider When Prescribing Birth Control *cont.*

FDA BLACK BOX WARNINGS AND OTHER SAFETY INFORMATION

Depo-Provera – Depot medroxyprogesterone acetate (DMPA)

- ▶ In 2004, the FDA placed a black box warning label on the Depo-Provera Contraceptive Injection concerning the risk of bone density loss after prolonged use. The warning states that “Depo-Provera CI should be used as a long term birth control only if other birth control methods are inadequate.”¹
- ▶ The Society for Adolescent Medicine recommends that providers continue prescribing DMPA to adolescent girls along with providing an explanation of both the benefits and risks.² Evidence has shown increased bone mass accrual after discontinuing use of DMPA and therefore, the benefits prescribing an effective contraception can outweigh the risk of bone density loss.
- ▶ For teens receiving DMPA, the Society for Adolescent Medicine recommends daily calcium supplements, vitamin D and daily exercise. While calcium and vitamin D have not been proven to offset bone density loss, these supplements are known to have broad health benefits for this population. Estrogen supplementation may be considered in girls with osteopenia.³

¹ U.S. Food and Drug Administration. Black box warning added concerning long-term use of Depo-Provera Contraceptive Injection. Available from: <http://www.fda.gov/bbs/topics/ANSWERS/2004/ANS01325.html>. Accessed 8/19/08.

² Tolaymat LL, Kaunitz AM. Long-acting contraceptives in adolescents. *Curr Opin Obstet Gynecol.* 2007; 19:453-460.

³ Society for Adolescent Medicine. Depot Medroxyprogesterone Acetate and Bone Mineral Density in Adolescents – The Black Box Warning: A Position Paper of the Society for Adolescent Medicine. *J of Adol Health.* 2006; 39:296-301.

Ortho Evra and the birth control patch

- ▶ In 2006, the FDA amended the label for Ortho Evra to warn women of potential increased risk for venous thromboembolism (VTE) when using the patch. The warning was based on the results of two epidemiological studies with conflicting data on potential for increased risk for VTE.
- ▶ Given the lack of substantive safety data for the use of the birth control patch, the World Health Organization Medical Eligibility Criteria for Contraceptive Use (WHOMEC) suggests using the same guidelines for combination oral contraceptives when prescribing the birth control patch.

Sources:

1) Burkman, RT. Clinical Opinion: Transdermal hormonal contraception: benefits and risks. *Amer J of Obstetrics and Gynecology.* August 2007; 134:e1-6.

2) Elliott TC, Montoya CC. How does VTE risk for the patch and vaginal ring compare with oral contraceptives? *The Jof Family Practice.* October 2008; 57: 10.

QUICK START ALGORITHM

Initiation and continued use of hormonal contraception is more likely if a teen can initiate the method right away, rather than waiting for her next menses.¹ Providers can feel reassured regarding the safety of this approach, as studies have shown the inadvertent exposure to the hormones used in combined oral contraceptives early in pregnancy has no detrimental effect on the developing fetus.² This approach, known as “Quick Start” has been evaluated for a variety of hormonal methods, including OCPs, DMPA, the transdermal contraceptive patch and the contraceptive ring.^{3,4,5,6}

The principles of quick start regimens are to:

1. Rule out a detectable pregnancy prior to method initiation
2. Provide Emergency Contraception if indicated
3. Initiate the method immediately
4. Counsel the youth to use condoms for 1 week and obtain a follow-up pregnancy test in 2 weeks if the method was initiated after day 6 of the menstrual cycle.

This approach is easily followed using the very clearly outlined “Quick Start Algorithm” on the next two pages.

¹Zurawin RK, Ayensu-Coker L. Innovations in contraception: a review. *Clin Obstet Gynecol.* June 2007;50(2):425-439.

²M.B. Bracken, Oral contraception and congenital malformations in offspring: a review and meta-analysis of prospective studies. *Obstet Gynecol.* 1990; 76:552-557.

³Westhoff C, Heartwell S, Edwards S, et al. Initiation of oral contraceptives using a quick start compared with a conventional start: a randomized controlled trial. *Obstet Gynecol.* June 2007; 109(6):1270-1276.

⁴Nelson AL, Katz T. Initiation and continuation rates seen in 2-year experience with Same Day injections of DMPA. *Contraception.* Feb 2007; 75(2):84-87.

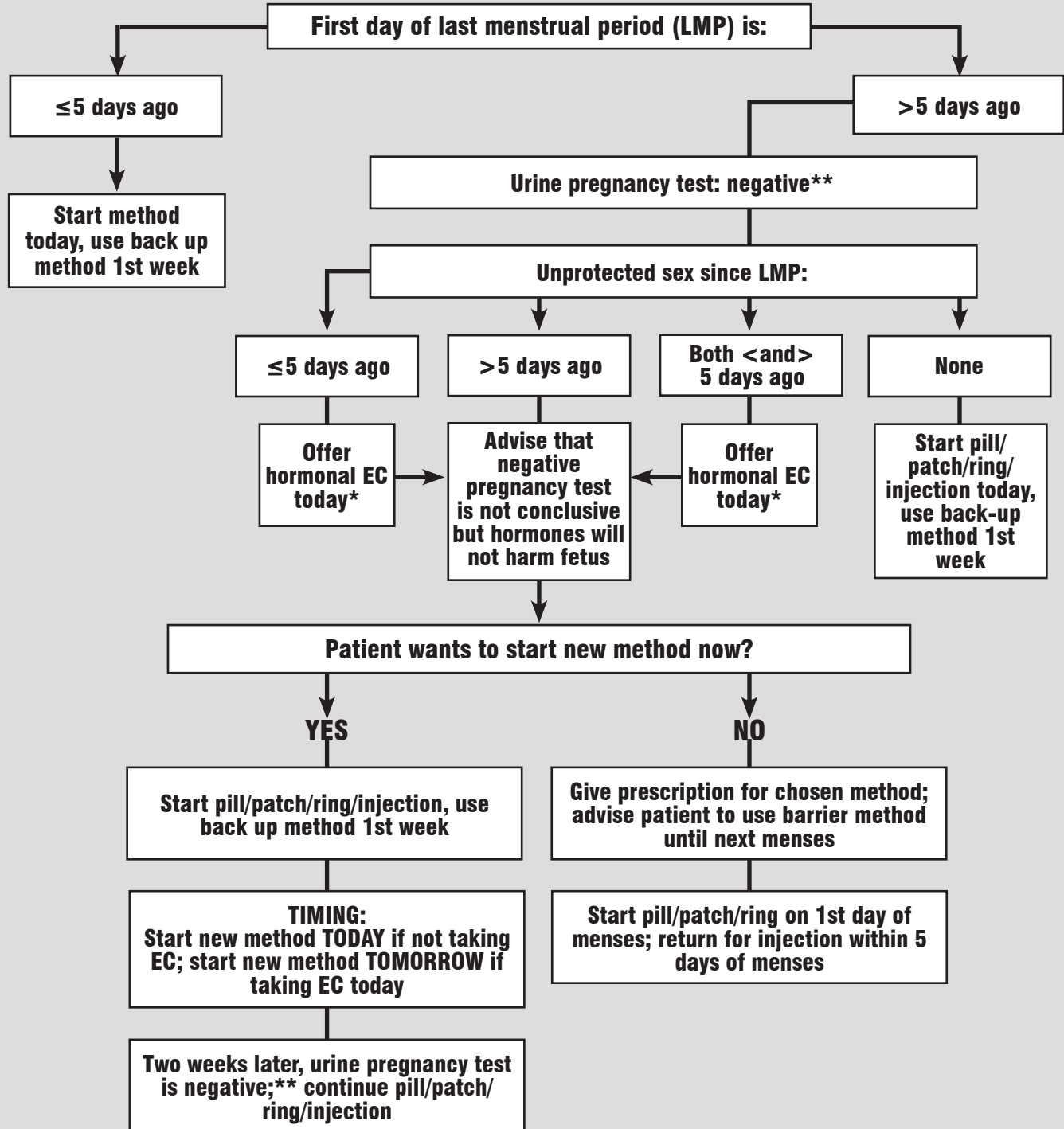
⁵Murthy AS, Creinin MD, Harwood B, Schreiber CA. Same-day initiation of the transdermal hormonal delivery system (contraceptive patch) versus traditional initiation methods. *Contraception.* Nov 2005; 72(5):333-336.

⁶Schafer JE, Osborne LM, Davis AR, Westhoff C. Acceptability and satisfaction using Quick Start with the contraceptive vaginal ring versus an oral contraceptive. *Contraception.* May 2006; 73(5):488-492.

Quick Start Algorithm

Woman requests a new birth control method

1. PILL, PATCH, RING, INJECTION



* Because hormonal EC is not 100% effective, check urine pregnancy test 2 weeks after EC use.

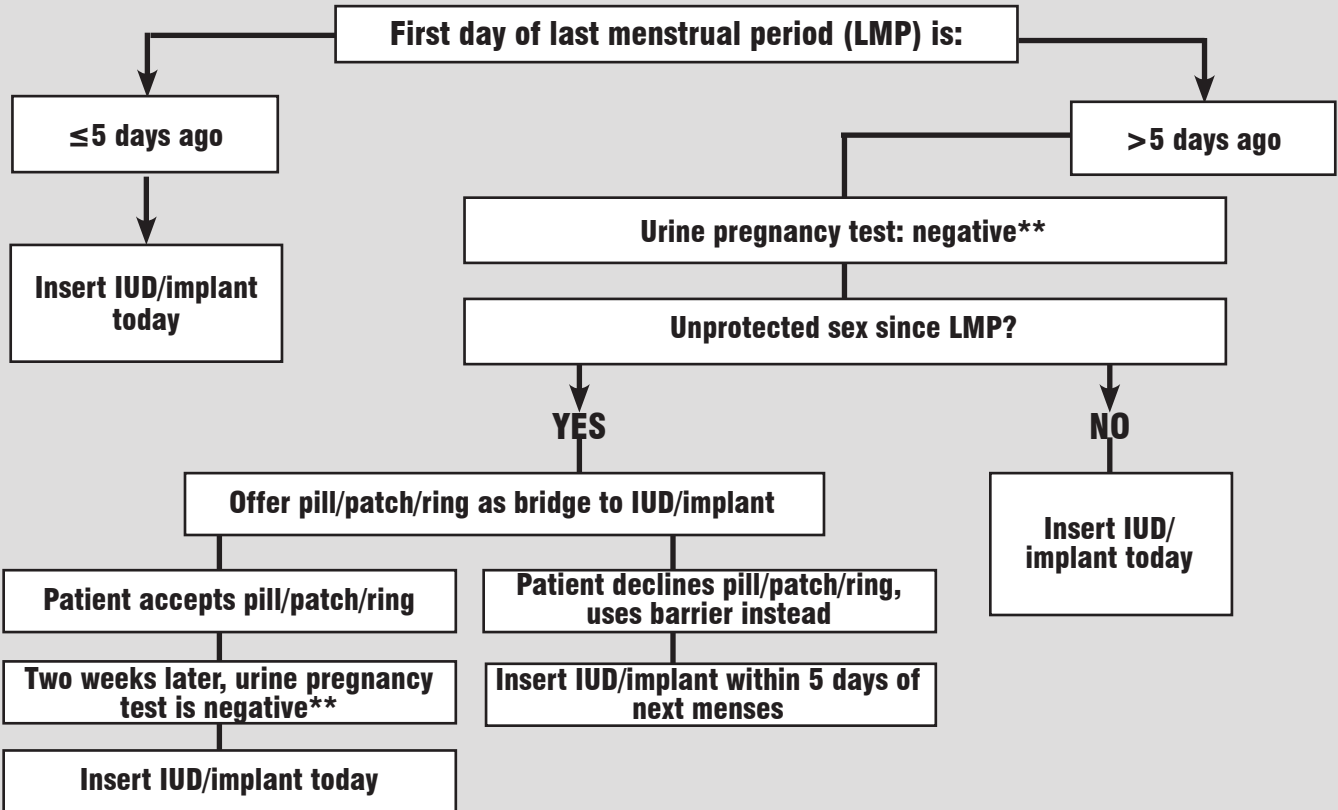
**If pregnancy test is positive, provide options counseling.

Source:

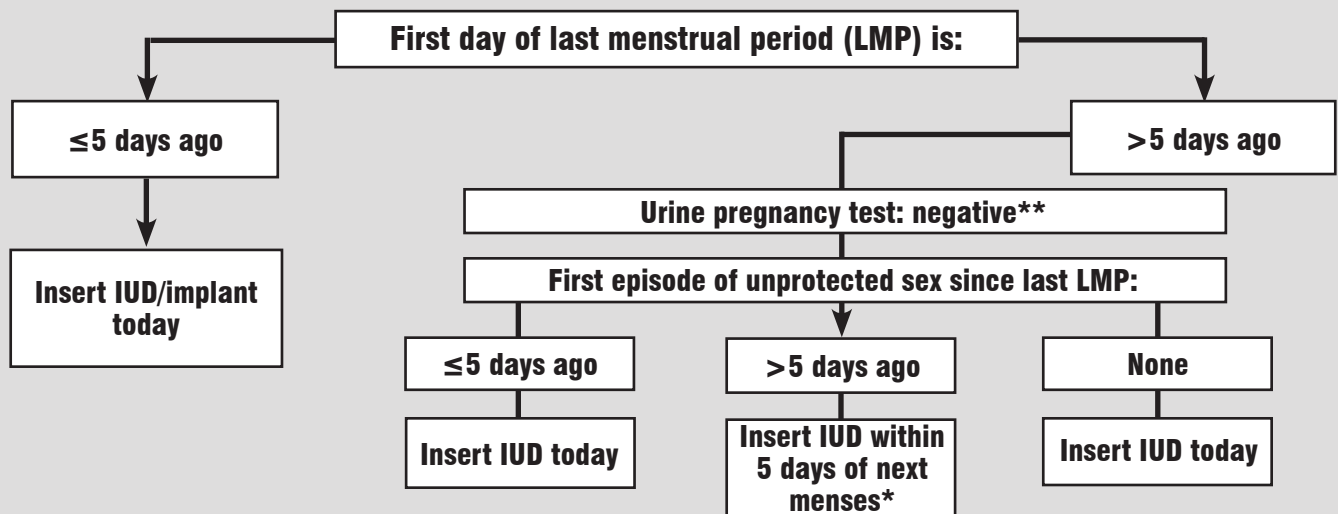
2005 Pocket guide to Managing Contraception by Hatcher RA, Ziemann M et al, page 135. Reproduced with permission from RHEDI/The Center for Reproductive Health Education in Family Medicine.

Quick Start Algorithm

2. PROGESTIN IUD OR IMPLANT



3. COPPER IUD



* Pill/patch/ring may be started as a bridge to copper IUD.

**If pregnancy test is positive, provide options counseling.

Source:

2005 Pocket guide to Managing Contraception by Hatcher RA, Ziemann M et al, page 135. Reproduced with permission from RHEDI/The Center for Reproductive Health Education in Family Medicine.

Emergency Contraception

FAST FACTS

- ▶ **EC is safe and effective birth control** that can be used after unprotected intercourse (including sexual assault) or underprotected sexual intercourse.
- ▶ **EC comes in the form of pills** which are most effective when taken immediately, but reduce the risk of pregnancy when taken within 120 hours. EC also comes in the form of a copper IUD, which must be inserted within 5 days of unprotected intercourse.* (Please refer to pg. 22 for recommendations for use of IUDs with adolescents).
- ▶ **EC pills work by** delaying or inhibiting ovulation, inhibiting fertilization, or preventing implantation of a fertilized egg (although this mechanism has never been clinically demonstrated). It will not interrupt a pregnancy that has already begun, like RU-486, “the abortion pill”. This is an important point for many teens!
- ▶ **EC pills significantly reduce the risk of pregnancy** after one instance of unprotected intercourse and are more effective the sooner they are taken.
- ▶ **EC pills may cause side effects** such as nausea, vomiting, and breast tenderness. If a patient vomits within one hour of taking EC, the dose should be repeated. Levonorgestral only products generally cause less side effects than the combined estrogen-progestin EC.
- ▶ **There are no state or federal laws that require parental consent or parental notification for the provision of EC.** Some healthcare providers, however, have their own parental notification policies for prescribing EC to patients under 18. Patients should ask their healthcare provider about these policies before receiving care.
- ▶ **Think about prescribing EC in advance with refills** to all of your sexually active teen patients. Educate them about its use, so they are prepared for an emergency.

*Currently, the efficacy of progesterone receptor modulators as an alternate form of EC is being studied.



TYPES OF EMERGENCY CONTRACEPTIVE PILLS

	TYPE OF PILL	PRODUCTS	DOSAGE
DEDICATED PRODUCTS	Progestin-only (Levonorgestral)	Next Choice (Generic EC)	1 pill each dose ¹ (Repeat in 12 hours)
	Progestin-only (Levonorgestral)	Plan B One Step	1 pill
The dedicated Levonorgestral products are generally the most appropriate form of EC for teens. The side effects are usually minimal and dosing instructions are simpler than with other EC methods.			
ORAL CONTRACEPTIVES USED AS EC	Progestin-estrogen combined (in 28 day packs, only the first 21 pills can be used)	Various combined birth control pills ²	Dosage depends on type of pill ²
	Only 16% of self-identified sexually active students nationwide reported use of oral contraceptive (OC) pills by themselves or their partner, therefore, use of OCs as EC is less utilized in teens. ³ For teens that need EC while using OCs, this may indicate that they are on the wrong contraceptive method. This is a great opportunity to discuss alternate contraceptive options.		

¹Although it conflicts with instructions on the box, current practice also includes administering 2 pills at one time up to 5 days after unprotected sex, but sooner is always better: Allen RH, Goldberg AB. Emergency Contraception: A Clinical Review. *Clin Obstet and Gynecol.* Dec 2007; 50(4).

²Refer to NOT-2-LATE.com: <http://ec.princeton.edu/questions/dose.html> for specific dosages for common birth control pills.

ACCESS TO PLAN B

- ⇒ **Over the counter:** In 2009, the FDA approved Plan B for over the counter use by men AND women 17 years and older. In the future, the generic product may be available for over the counter use.
- ⇒ **Prescribing EC pills:** Women under 17 can access Plan B with a prescription from a healthcare provider. Women under 18 can access the generic product with a prescription. *Counsel young men about EC even though they cannot receive a prescription.*
- ⇒ **Pharmacy Access:** In nine states (AK, CA, HI, MA, ME, NH, NM, VM, WA) women of any age can obtain Plan B directly from a pharmacist. Patients should be advised to call their local pharmacy to see if they participate in the Pharmacy Access Program. Access without a prescription can be limited due to pharmacists’ willingness or unwillingness to dispense Plan B. Pharmacy Access may increase the cost of Plan B because an extra “counseling fee” is added onto the cost.
- ⇒ **Cost:** The average cost of Plan B without insurance is \$31 per package*. This cost may vary and patients should contact their insurance companies to find out whether or not it is covered. Many states also have family planning funding programs that subsidize the cost of Plan B and other contraceptives. However, the generic product may be the least expensive option.

* Allen RH, Goldberg AB. Emergency Contraception: A Clinical Review. *Clin Obstet and Gynecol.* Dec 2007; 50(4).

Emergency Contraception *cont.*

When assessing a patient for emergency contraception, ask:

- ❶ When was the last time you had unprotected intercourse? Was in it the last 3-5 days?
- ❷ Why do you think you need EC?
 - ☑ **If the teen's last unprotected intercourse happened in the last 3-5 days**, prescribe EC pills.
 - ☑ **If the response to the first question indicates increased likelihood of pregnancy**, or you question the accuracy of the history, you can still prescribe the pills, but there is a greater chance the patient might be pregnant. (Run a preg test to assure appropriate care.)

If you prescribe EC pills,

YOUR PATIENT SHOULD BE AWARE THAT:

- ▶ She might still get pregnant.
- ▶ She might experience side effects such as nausea, vomiting, and breast tenderness.
- ▶ If she vomits within an hour of taking EC, she should repeat the dose. Side effects are less common with Plan B or generic.
- ▶ EC will not protect against pregnancy related to unprotected intercourse occurring after she takes the pills.
- ▶ Her next menstrual period might not start at the expected time or be of the usual flow or duration.
- ▶ ECPs do not protect against STIs.
- ▶ ECP should not be used as a regular form of birth control because they do not prevent pregnancy as effectively as other forms of contraception.

CONSIDER THE FOLLOWING:

- ▶ Patients should be counseled further about consistent and reliable birth control use.
- ▶ Patients should be counseled further about the risks of STIs involved with unprotected sex.
- ▶ Patients should return for a follow-up appointment to confirm they did not become pregnant, if they do not get their period within two weeks of the expected date. Use this as an opportunity to reinforce regular contraceptive practices.

If you prescribe the copper IUD

CONSIDER THE FOLLOWING:

- ☑ Ascertain if the patient desires long term contraception (method is effective up to 10 years)
- ☑ Rule out Chlamydia or gonorrhea infection.
- ☑ Rule out other contraindications for use of the IUD.
- ☑ If a patient does not have health insurance, the cost of the IUD may be prohibitive unless the teen is in a locale with a public family planning program.
- ☑ Refer to pg. 25 for the quick start algorithm for the copper IUD.

Resources:

- ⇒ <http://www.not2late.com>
- ⇒ <http://www.go2planb.com>
- ⇒ <http://www.ec-help.org>

Tips and Follow-Up Questions

- ▶ **Have you been screened recently for Chlamydia and gonorrhea?** If not, offer screening. See pg. 16 for STI screening guidelines.
- ▶ **Was this a sexual assault?** If so, see pg. 33 for more information on sexual assault and abuse.
- ▶ **How often are you having unprotected sex?** If unprotected sex is frequent, counsel on different methods and see pg. 39 for more information on BC.



¹Youth Risk Behavior Surveillance, United States, 2007.

²Allen RH, Goldberg AB. Emergency Contraception: A Clinical Review. *Clin Obstet and Gynecol.* Dec 2007; 50(4).

Sources:

- 1) Allen RH, Goldberg AB. Emergency Contraception: A Clinical Review. *Clin Obstet and Gynecol.* Dec 2007; 50(4).
- 2) What You Need to Know: The Facts about Emergency Contraception. Association of Reproductive Health Professionals (ARHP). Updated January 2008.
- 3) Emergency Contraception: A Practitioner's Guide. Physicians for Reproductive Choice (PRCH), 2008.
- 4) What Consumers Need to Know about Obtaining Plan B® Over-the-Counter in Pharmacies. Pharmacy Access Partnership. Rev Aug 2009.

Pregnancy Test Counseling

BEFORE DELIVERING THE TEST RESULTS:

- What brings you here today?
- How would you feel if you were pregnant?
- I know you're sexually active right now. Is this something you are enjoying? Do you feel comfortable with your partner?
- What are you hoping the test result will be?
- Are you doing anything to prevent getting pregnant or getting STIs? Are you happy with this method?

If last incidence of unprotected or under-protected sex occurred in the **past 3-5 days**, assess appropriateness of emergency contraception.

IF THE TEST IS NEGATIVE:

Explore personal beliefs and attitudes about pregnancy:

- ▶ How would you have felt if the test were positive?
- ▶ What do you think is the best age to get pregnant?
- ▶ What are your goals and ideas for the next year? For the future?

Screen for risks of unprotected sex including pregnancy, STIs and forced sex:

- ▶ Conduct a HEADSSS¹ assessment.

Discuss relationships and support of family/friends/partners:

- ▶ Who knows you came here today? Who knows that you think you might be pregnant?
- ▶ How would/do your parents feel about your sexual activity?
- ▶ How does your partner/boyfriend feel about pregnancy, birth control and safer sex?
- ▶ Do you have friends or family members who are pregnant or have babies?

TIPS

- ▶ Remind her that just because she did not become pregnant this time, it does not mean she will never get pregnant. Identify successful female role models and goals and plans for the near and distant future.
- ▶ Use these responses to assess contraceptive methods that would work best for the teen given her readiness, motivation and method of choice. It may help to role-play scenarios to deal with this issue. For example, if she begins oral contraceptives, act out how she might handle her mother finding her pills. Role-play discussing contraceptives with her partner/boyfriend.
- ▶ Based on her answers, counsel on consistent and effective contraceptive use, and/or the realities of pregnancy (financial, physical, personal, emotional). Write her an advance prescription for emergency contraception and discuss its effects and uses (see pg. 26 for more details on EC).
- ▶ Contact your patient by phone to see how things are going if she does not return for a follow-up. 56% of teens with a negative pregnancy test become pregnant in the next 18 months, so follow up care is vital.²

IF THE TEST IS POSITIVE:

Explore knowledge and beliefs about parenting, abortion, and adoption:

- ▶ Did you plan to get pregnant?
- ▶ How do you feel about being pregnant?
- ▶ What options have you considered (adoption, abortion, etc.)?
- ▶ What does your family, religion or culture think about pregnancy? abortion?
- ▶ What is your experience with pregnancy and parenting?
- ▶ Have any of your friends or relatives been pregnant recently? What did they decide to do about their pregnancies?

Assess social and family history:

- ▶ Who do you confide in?
- ▶ Who knows that you might be pregnant?
- ▶ How are you doing in school?
- ▶ What do you want to do in 1 year? 5 years?
- ▶ Do you have insurance? Can you use it without worries of confidentiality?

¹For a full HEADSSS Assessment refer to the Basics of Adolescent Health Toolkit Module: Adolescent 101.

²Vyas S. Adolescent Pregnancy: A Pediatric Resident's Perspective. *Ped Annals*. 2002; 31(9).

Pregnancy Test Counseling *cont.*

Conduct medical history:

- ▶ Do you have any medical problems or are you taking any medications?
- ▶ What methods have you used to prevent pregnancy or STIs?
- ▶ Have you had a pregnancy test before?
- ▶ Have you been pregnant before? Do you have children? What did you do about your past pregnancies?
- ▶ Have you had any STIs before?
- ▶ Have you had any bleeding/spotting or abdominal pain since your last period?

Discuss family/friends/partner influences:

- ▶ What adults in your life will be supportive?
- ▶ Does anyone know you came for a pregnancy test today?
- ▶ What is your relationship with the man you are pregnant by? Are you still seeing him? Do you think he will be supportive?
- ▶ How would/do your parents feel about your sexual activity?
- ▶ How does your partner/boyfriend feel about pregnancy, birth control and safer sex?
- ▶ How do you think your family and friends will react?
- ▶ Do you have friends or family members who are pregnant or have babies?

Discuss concrete options including health risks and costs of the options.

- ▶ Who will you talk to about this?
- ▶ Do you need any help in talking about your pregnancy plans with your boyfriend, parent(s), or other significant adults?
- ▶ Do you have someone to accompany you to your appointments? (prenatal or abortion)
- ▶ Do you know what your options are? What do you think you would like to do?

TALKING POINTS

Parenting	Abortion	Adoption
<ul style="list-style-type: none"> ▶ Emphasize the importance of prenatal care ▶ Medicaid enrollment/health coverage options ▶ Impact on finishing school ▶ Finances ▶ Relationship with father of the baby ▶ Social support 	<ul style="list-style-type: none"> ▶ Medical ▶ Surgical ▶ Access to abortion ▶ Timing ▶ Cost 	<ul style="list-style-type: none"> ▶ Closed adoption Birth mother and father remain anonymous to adoptive parents ▶ Open Adoption Birth mother chooses the adoptive parents and they may stay in touch

Schedule follow up appointment(s), as needed, for physical exam, additional counseling and referrals.

Medical v. Surgical Abortion: Which is more appropriate for teens?

MEDICAL ABORTION		SURGICAL ABORTION	
PROs	CONs	PROs	CONs
<ul style="list-style-type: none"> ▶ Doesn't require surgery ▶ Can be more private ▶ Can feel more "natural" 	<ul style="list-style-type: none"> ▶ Requires a follow-up appointment ▶ Causes heavy bleeding for several hours and bleeding may continue for ~2 weeks ▶ Bleeding timing and duration is unpredictable ▶ Limited to weeks 4-9 of pregnancy 	<ul style="list-style-type: none"> ▶ Usually requires only one appointment ▶ Immediate results ▶ Performed at weeks 6-23 of pregnancy ▶ Procedure does not take a long time ▶ Minimal bleeding after procedure ▶ Is more effective than medical abortion 	<ul style="list-style-type: none"> ▶ Can cause minimal cramping during or after the procedure ▶ Light bleeding may last up to two weeks after the procedure

Resources:

- 🔗 http://gutmacher.org/statecenter/spibs/spib_PIMA.pdf
State policies on parental involvement in the abortion of minors.
- 🔗 http://gutmacher.org/statecenter/spibs/spib_MAPC.pdf
State policies on minor's access to prenatal care.

Safe Haven Laws

Safely Surrendered Baby Law allows parents to confidentially give up their baby, 72 hours or younger. As long as the baby has not been abused or neglected, parents may give up their newborn without fear of arrest or prosecution.
<http://www.nationalsafehavenalliance.org>

Sources:

- 1) Utilizing Decision: Pregnancy Options Counseling. Physicians for Reproductive Choice and Health.
- 2) Thinking About Adoption. Planned Parenthood. <http://www.plannedparenthood.org/health-topics/adoption-4261.htm>
- 3) Medical vs. Surgical Abortion. UCSF Medical Center. Updated 05/2007. <http://www.ucsfhealth.org/adult/edu/abortion.html>

Teen Dating Violence/Intimate Partner Violence (IPV)

Adolescents should be routinely screened for dating violence; and, providers should help youth/parents understand and develop healthy relationships. By learning about local resources and how to support victims, healthcare providers can ensure that their patients are safe and/or have a strategy to deal with partner violence or abuse.

FAST FACTS

- ▶ Intimate partner violence is defined as the intentional violent or controlling behavior by a person who is currently or was previously in an intimate relationship with the victim. Sexual abuse or assault can be associated with intimate partner violence but is not always an issue.
- ▶ 1 in 3 teens experience some kind of abuse in their romantic relationships, including verbal and emotional abuse.¹
- ▶ 1 in 5 female students report physical and/or sexual abuse by “dating partner.”²
- ▶ Teens in same sex relationships are just as likely to experience dating violence. Studies show that 20%-50% of same sex relationships may be abusive.³
- ▶ A recent study found significant levels of abusive behavior in “tween” (ages 11-14) dating relationships, and teens report that abusive behavior increases dramatically in the later teen years.⁴
- ▶ Youth perpetrators are equally likely to be female or male: girls more likely to be victims of physical abuse and boys victims of psychological abuse and mutual aggression is common.⁵

RISK FACTORS FOR VICTIMS

- ▶ Poor self-esteem
- ▶ Younger age with older partner(s)
- ▶ History of prior IPV
- ▶ Substance abuse
- ▶ Initiation of sex before 15 years old
- ▶ Multiple partners
- ▶ Pregnancy

RISK FACTORS FOR PERPETRATORS

- ▶ Aggressive behavior, jealous, blaming
- ▶ Poor interpersonal skills/problem solving
- ▶ Substance abuse
- ▶ Personal history of physical abuse
- ▶ Growing up in a household where DV is occurring

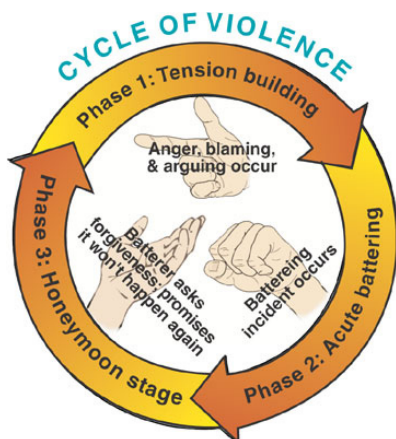


Image taken from <http://extension.missouri.edu/publications/DisplayPub.aspx?P=GH6608>

The Cycle of Violence

Intimate partner violence generally follows a progression that is referred to as the cycle of violence. The cycle usually starts with the tension phase followed by a violent or abusive episode followed by the honeymoon or apology phase. With each repetition of the cycle, the acts of violence/abuse tend to escalate and transition time between episodes decreases. It is important to explain this cycle when you are counseling a youth who may be involved in IPV.

¹Halpern CT, et al. Partner Violence Among Adolescents in Opposite-Sex Romantic Relationships: Findings From the National Longitudinal Study of Adolescent Health. *Amer J of Pub Health*. 2001; 91:1680.

²Silverman JG, Raj A, Mucci LA, Hathaway JE. Dating Violence Against Adolescent Girls and Associated Substance Use, Unhealthy Weight Control, Sexual Risk Behavior, Pregnancy, and Suicidality. *J of the Amer Med Assoc*. 2001; 286(5).

³National Coalition of Anti-Violence Programs. Lesbian, Gay, Bisexual and Transgender Domestic Violence in 2001. New York, NY; 2002.

⁴Liz Claiborne Inc. study on teen dating abuse conducted by Teenage Research Unlimited, Feb 2008.

⁵Mulford C, Giordano, PC. Teen Dating Violence: A Closer Look at Adolescent Romantic Relationships. *NIJ Journal*. Oct 2008; 261.

Teen Dating Violence/Intimate Partner Violence (IPV) *cont.*

Screening Tips and Guidelines

It is important to look for signs and symptoms of IPV. Many of these signs and symptoms may surface during a HEADSSS assessment.¹

SIGNS OF POSSIBLE IPV		
Clinical Complaints	Behavioral	Partner Behaviors
<ul style="list-style-type: none"> ▶ Chronic complaints of abdominal pain, headaches, vaginitis, fatigue, pelvic pain ▶ Acute complaints genital urinary/gynecological (vaginal bleeding, STIs, UTI, vaginitis, amenorrhea) ▶ Sleep problems, anorexia, anxiety symptoms (shortness of breath, chest pain, palpitations, hyperventilation, syncope) ▶ Injuries not consistent with history and at different stages of healing ▶ Psychiatric: depression, PTSD, anxiety disorders, suicidal ideation/attempts and substance abuse 	<ul style="list-style-type: none"> ▶ Hostile and secretive ▶ Moody, withdrawn, or depressed ▶ Has stopped seeing friends or has given up favorite activities ▶ School problems ▶ Frequent cancelled appointments ▶ Delayed care for injuries ▶ Seems afraid of partner and fears breaking up with him/her 	<ul style="list-style-type: none"> ▶ Is possessive, jealous of others, including friends and family ▶ Uses alcohol or other drugs ▶ Sabotages birth control methods/use ▶ Refuses to leave the room during health exams

Tools for Screening

While there are many IPV screening tools, none are adolescent focused or appropriate. Asking questions within HEADSSS can help identify signs/symptoms to elucidate IPV:

HEADSSS

Ask questions related to teen’s relationships (under “Sex” or “Safety”)⁶

- “I ask all my patients about their relationships. Are you now, or have you ever been in a relationship with a person who physically hurts or threatens you?”
- “What happens when you and your partner disagree? Does it ever get physical?”
- “Do you feel safe in your relationship/at home?”

ADDITIONAL SCREENING QUESTIONS FOR SUSPECTED IPV

- Does your partner get jealous when you go out or talk with others?
- Does your partner put you down, but then tell you he/she loves you?
- Have you been held down, shoved, pushed, hit, kicked, or had things thrown at you by your partner?
- Does your partner frighten or intimidate you?
- Does your partner make you choose between him/her, or family and friends?
- Has your partner forced or intimidated you into having sex?
- Are you afraid to break up with your partner because you fear for your personal safety?

⁶For a full HEADSSS Assessment refer to the Basics of Adolescent Health Toolkit Module: Adolescent 101

Teen Dating Violence/Intimate Partner Violence (IPV) *cont.*

What is the provider’s role once IPV has been identified?

ASSESS SAFETY	INTERVENTION AND REFERRAL
<ul style="list-style-type: none"> ▶ “Are you currently safe where you are now?” ▶ “What has been the worst fight? Were weapons used?” ▶ “Have you thought about hurting or killing yourself or others?” ▶ “Do you have an adult you can confide in?” ▶ “Have you tried to leave your relationship before? If so, what happened?” ▶ “In a crisis/unsafe situation, where would you go/who could you turn to for help?” ▶ See safety Plan Checklist below. 	<ul style="list-style-type: none"> ▶ Convey Key Messages. <ul style="list-style-type: none"> ⇒ No excuse for violence ⇒ Not the victim’s fault ⇒ You are not alone ⇒ Changing a relationship can be difficult ⇒ We can find you help and support ▶ Utilize a harm reduction approach. ▶ Inform on resources/safety plan (see resources and safety plan below). Empower the youth, point out strengths. ▶ Respect what they want to disclose and how (while considering legal issues re: reporting). ▶ Educate the victim about IPV (i.e. the cycle of violence).
REPORTING	DOCUMENTATION
<ul style="list-style-type: none"> ▶ Reporting depends on state laws. ▶ Consider contacting CPS if parents are unwilling to protect teen (possible neglect). ▶ Reporting mandates are based on age of victim. <ul style="list-style-type: none"> ⇒ 17 and younger - child abuse report ⇒ 18 and older - domestic violence report mandated in some states 	<ul style="list-style-type: none"> ▶ Safeguard confidentiality. ▶ Document physical injuries (take photographs or describe in detail). ▶ Detailed documentation is important in case there are court proceedings but evidence collection can only be done by a certified examiner ▶ Abuse Centers can help with evidence collection if reporting/pressing charges (e.g. DNA of bite marks, sexual abuse exams photo documentation).

Safety Plan Checklist

- Ensure immediate safety
- File necessary reports
- Discuss notifying parents (if they don’t already know).
- Know shelters that take teens
- Discuss considering a temporary restraining order (TRO). In most states a minor cannot request a TRO independently.
- Be familiar with counselors knowledgeable with trauma and conflict resolution to help teen negotiate out of a relationship safely
- Advise changing locks/alarms
- Urge removing/safeguarding weapons

Resources

- ▶ The Safe Space teen safety plan worksheet:
<http://www.thesafespace.org/pdf/handout-safety-plan-workbook-teens.pdf>
- ▶ National Domestic Violence Hotline 1-899-SAFE

Sources:

- 1) Foshee VA, Linder GF, Bauman KE, et al. The Safe Dates project: theoretical basis, evaluation design, and selected baseline findings. *Amer J of Preventive Med.* 1996; 12(Suppl 2):39–47.
- 2) Avery-Leaf S, Cascardi M, O’Leary KD, Cano A. Efficacy of a dating violence prevention program on attitudes justifying aggression. *J of Adol Health.* 1997; 21:11–7.
- 3) Centers for Disease Control and Prevention. Physical dating violence among high school students—United States, 2003. *MMWR* 2006;55:532-535.

Sexual Assault

Adolescents and young adults are the primary age group at risk for sexual violence.¹ Providers play an important role in identifying instances of sexual abuse or violence experienced by their teen patients. Routine screening for sexual assault should be done at every visit and providers need to be knowledgeable about the steps to take if a sexual assault is reported by one of their patients.

Fast Facts

- ▶ Sexual assault is defined as any non-consensual sexual contact that may or may not include rape. This includes sexual touching and fondling. The exact definition varies from state to state.
- ▶ 44% of rape victims are under the age 18²
- ▶ 2/3 to 3/4 of victims of sexual assault knew the perpetrator³
- ▶ More than 40% of adolescent victims report using drugs or alcohol before the assault⁴
- ▶ 80% of rape victims experience post-traumatic stress disorder⁵

Recommendations for the Care of Adolescent Sexual Assault Victims⁶

Providers should:

1. Be familiar with the epidemiology of sexual assault in adolescents.
2. Be familiar with local reporting requirements for sexual assault. Keep in mind that survivors may not want to file a police report, and the law may mandate filing a child abuse report if they are a minor.
3. Learn about community sexual assault resources and where to refer teen patients for a forensic examination/evidence collection. Hospitals that have Level 1 trauma units, a rape treatment center, or SANE (Sexual Assault Nurse Examiners), are usually set up to handle a thorough examination.
4. Screen for a history of sexual assault and potential sequelae
5. Be ready to provide psychological support or counseling referrals to the teen that has been assaulted.
6. Provide preventative counseling to adolescents regarding avoidance of high-risk situations that could lead to sexual assault. Emphasize the difference between risk and blame, (i.e. even if an individual engages in high-risk situations, it does not mean they are responsible for being assaulted).

Evidence Collection and Prophylaxis

If patients report sexual assault in the last 72 hours, advise them not to bathe and refer for a forensic examination immediately. Evidence can only be collected within the first 72 hours. Depending on the jurisdiction, evidence collection will not automatically result in a police report. Most hospitals will hold the evidence for a few months to give survivors time to decide whether or not they want to file criminal charges. Prophylactic treatment for Chlamydia and Gonorrhea is recommended and emergency contraception is recommended for female victims when indicated. HIV prophylaxis may be provided with mucosal exposure (oral, vaginal, anal).

Resources

- ☞ Rape, Abuse & Incest National Network (RAINN), local rape crisis centers and comprehensive information on statistics and related articles
<http://www.rainn.org>
- ☞ National Sexual Violence Resource Center, sexual violence organizations in each state
<http://www.nsvrc.org/organizations>

Tips for Supporting Victims of Assault:⁷

- ▶ Validate survivors' feelings. Explain that what they are feeling and experiencing is completely normal, acceptable and that what happened was not their fault.
- ▶ Listen non-judgmentally. Ask survivors what kind of support they want and need. Honor and respect these needs.
- ▶ Make sure the survivors are safe and physically well. If there is an immediate concern for well-being, create a safety plan and/or refer to temporary emergency housing (particularly when domestic violence/intimate partner abuse is also present).
- ▶ Suggest medical, psychological and/or other assistance, but let them decide which action to take.

¹Lessing JE. Primary Care Provider Interventions for the Delayed Disclosure of Adolescent Sexual Assault. *J of Ped Health Care*. Jan 2005.

²U.S. Department of Justice. 2004 National Crime Victimization Survey. 2004.

³U.S. Department of Justice. 2005 National Crime Victimization Study. 2005.

⁴American Academy of Pediatrics. Care of the Adolescent Sexual Assault Victim. *Pediatrics*. 2001; 107(6).

⁵Ibid.

⁶Ibid.

⁷San Francisco Women Against Rape. How to Support a Survivor. <http://www.sfwar.org/emergency.html>.

Sexual Dysfunction

It is important to consider the implications of sexual dysfunction in teens. While data on sexual dysfunction in teens is scarce, teens experience erectile dysfunction, loss of desire, pain with penetration and other problems that affect sexual function. Sexual function and dysfunction is a topic area that is often overlooked and it is important to be prepared to provide adequate guidance to teens who report sexual concerns.

Sexual Dysfunction in Adolescent Females

Forty-three percent of women report experiencing some sort of sexual concern in their lifetime.¹ Among these concerns, younger women report higher frequencies of orgasmic disorders and sexual pain disorders including vaginismus and dyspareunia, particularly vulvodynia. Change or decrease in libido is a known and common listed adverse reaction to hormonal contraception, including all combination and progestin-only methods.

FEMALE ORGASMIC DISORDER (FOD) ²	VAGINISMUS ³	VULVODYNIA (AKA VULVAR VESTIBULITIS DISORDER) ⁴
<ul style="list-style-type: none"> ▶ Persistent or recurrent delay in, or absence of orgasm following a normal sexual excitement phase. ▶ 29% of women aged 18-73 reported difficulty with orgasm. ▶ Can be caused by drugs that increase serotonergic activity: antidepressants, antipsychotics. ▶ Younger women report higher instances of delayed or absent orgasm. ▶ Factors associate with FOD include age, education, religion, personality, and relationship issues. 	<ul style="list-style-type: none"> ▶ Recurrent, involuntary spasm of the outer third of the vagina which interferes with entry of a penis, finger, tampon, etc into the vagina. ▶ Estimated 1-6% of women report symptoms of vaginismus. ▶ Sexually abused females are more likely to develop vaginismus ▶ The gynecological exam can be a source of extreme anxiety and discomfort for women with this disorder. 	<ul style="list-style-type: none"> ▶ Chronic discomfort and burning of the vulva not attributable to infection or neurological disorder. ▶ Etiology linked to pro-inflammatory response of the vestibular mucosa. ▶ Women who report symptoms of vulvodynia range from 16-80 years old. ▶ 50% of women with vaginismus are also diagnosed with vulvodynia. ▶ Common co-morbidities include fibromyalgia, irritable bowel syndrome and interstitial cystitis.

Sexual Dysfunction in Adolescent Males

Despite a lack of data, sexual dysfunction in adolescent males appears to be common and is generally caused by performance anxiety and in some cases, condom use.⁵ Common dysfunctions include premature ejaculation and erectile dysfunction. Delayed ejaculation is a less common disorder; and is most likely to be caused by psychoactive drugs (see Antidepressant/SSRI-induced Sexual Dysfunction in Teens on the next page).⁶

PREMATURE EJACULATION ⁷	ERECTILE DYSFUNCTION ⁸
<ul style="list-style-type: none"> ▶ Persistent or recurrent ejaculation with minimal sexual satisfaction before, or shortly after penetration and before the person wishes. ▶ 31% of American men aged 18-59 reported premature ejaculation at least once in the last 12 months. ▶ Can be caused by psychological factors or underlying medical conditions such as pelvic injury, neurological disease, prostatic hypertrophy and hypogonadal hypertrophy. 	<ul style="list-style-type: none"> ▶ The inability to achieve or maintain an erection. ▶ Caused by common substances of abuse, many psychoactive medications, mental health issues and/or physical illness. ▶ 12-32% of college students report erection loss associated with condom use. ▶ Most cases of erectile dysfunction in teens are transient.

¹Meston CM, Bradford A. Sexual Dysfunctions in Women. *Ann Review of Clin Psych.* 2007; 3:233-56.

²Ibid.

³Ibid.

⁴Damsted Peterson C, Lundvall L, Kristensen E, Giraldi A. Vulvodynia. Definition, diagnosis and treatment. *Acta Obstetrica et Gynecologica Scandinavica.* 2008; 87:9(893-901).

⁵Marcell AV, Bell DL. Making the most of the adolescent male health visit Part 1: History and anticipatory guidance. *Contemp Pediatrics.* 2006; 23:6(38-46).

⁶Richardson D, Goldmeier D. Recommendations for the management of retarded ejaculation: BASHH Special Interest Group for Sexual Dysfunction. *International J of STD & AIDS.* 2006; 17(7-13).

⁷Richardson D, Goldmeier D, Green J, Lamda H, Harris JRW. Recommendations for the management of premature ejaculation: BASHH Special Interest Group for Sexual Dysfunction. *International J of STD & AIDS.* 2006; 17:1-6.

⁸Graham CA, Crosby R, Yarber WL, Sanders SA, McBride K, Milhausen RR, Arno JN. Erection loss in association with condom use among young men attending a public STI clinic: potential correlates and implications for risk behavior. *Sexual Health.* 2006; 3(255-260).

Sexual Dysfunction *cont.*

Assessment

Include sexual function in a thorough sexual health assessment (see pg. 13). The extended PLISSIT model is useful for screening for sexual problems. Conduct a thorough medical history and medication history. Alcohol, tobacco, recreational drugs, some psychotropic medications, and β blockers and many others are all associated with sexual dysfunction in both females and males (see insert). Review the sexual side effects of medications when prescribing them and assess medication use in the sexual dysfunction work up.

Interventions

- ⇒ Reassurance
- ⇒ Stress reduction techniques
- ⇒ Refer the teen to appropriate local resources

Ex-PLISSIT⁹

The extended PLISSIT model takes a stepwise approach to addressing sexual health concerns. Permission-giving is part of each step and reflection and self-awareness are key skills for the provider. When going beyond levels one and two (Permission and Limited Information) a greater level of expertise may be required. If this level of care is outside the comfort zone of the provider, a referral should be made to someone more knowledgeable about sexual dysfunction.

P PERMISSION GIVING: Creates a safe environment to address sexual health concerns by screening for a problem.

Ex. Young men and women often have questions and concerns about sex and how their bodies are functioning during sex—do you have any?”

LI LIMITED INFORMATION: Gives the patient limited information about the sexual problem. This is a great opportunity to discuss causes, normalize and dispel myths about the dysfunction.

Ex. “Many young men may have trouble getting or maintaining an erection at some point. Sometimes it can happen if a man is having problems with his relationship or if he is nervous about having sex with someone. Sometimes men lose their erection when they put on a condom.”

SS SPECIFIC SUGGESTIONS: Take a problem-solving approach and make specific suggestions in response to problems discussed.

Ex. If the teen reports loss of erection with condom use, suggest adding a couple drops of lubricant inside the condom before putting it on.

IT INTENSIVE THERAPY: Assess whether or not the primary care provider can effectively treat the health concern and offer referrals as required.

Resources for Female Sexual Dysfunction

☞ http://www.obgyn.net/women/women.asp?page=/CPP/articles/Cracchiolo_0499

Symptoms, causes, treatment options, and resources for vulvodynia.

☞ <http://www.nva.org/>

National Vulvodynia Association. Has links to research articles related to vulvodynia.

☞ <http://www.vaginismus-awareness-network.org/index.html>

Vaginismus Awareness Network. Has information geared toward providers, partners, and women.

For resources for teens, refer to Click on This, pg. 72.

ANTIDEPRESSANT/SSRI-INDUCED SEXUAL DYSFUNCTION IN TEENS

SSRI induced sexual dysfunction is not as well documented in teens as it is in adults. The low number of cases, however, may be attributed to discomfort surrounding reporting dysfunction to the prescribing health care provider or clinicians failing to ask the teen about sexual side-effects.

Tips:

- ▶ Be aware of the side effects of all the medications the teen may be taking.
- ▶ Always reassure patients of confidentiality and let them know that they can feel comfortable discussing sexual function at any time.
- ▶ Incorporate questions that address sexual function into assessment tools and questionnaires.
- ▶ Refer to the Ex-PLISSIT model for guidance surrounding sexual interventions.

Resources for teens:

☞ <http://www.teenwire.com/infocus/2007/if-20071106p509-orgasm.php>

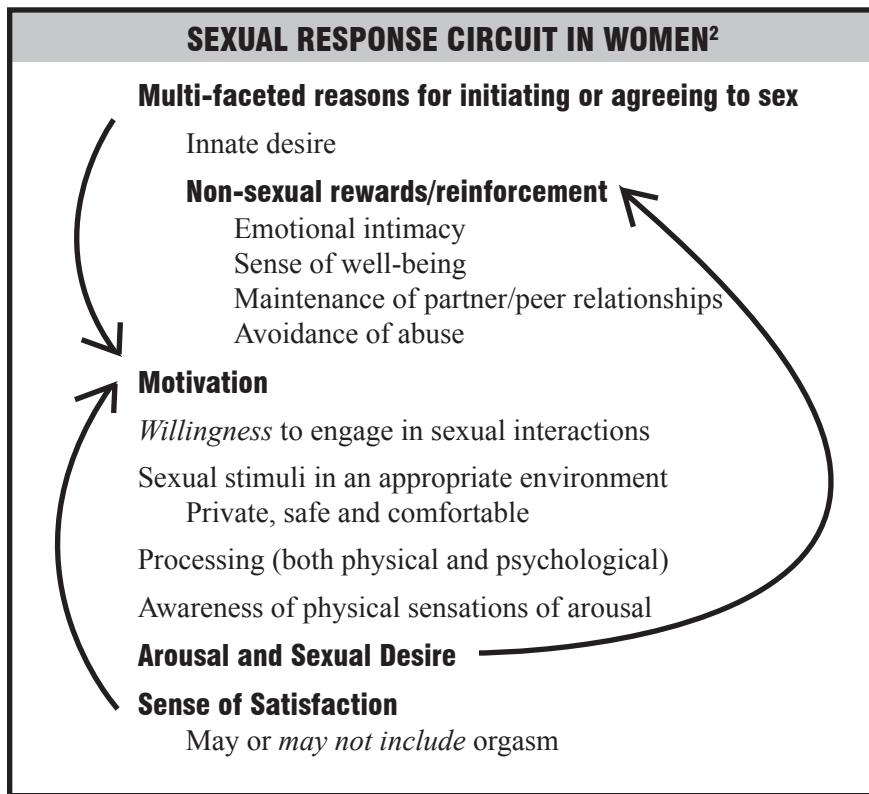
An article geared toward mid to late adolescents about sexual dysfunction caused by antidepressants.

Source:

- 1) Scharko AM. Selective Serotonin Reuptake Inhibitor – Induced Sexual Dysfunction in Adolescents: A Review. *J of the Amer Acad of Child and Adol Psych.* September 2004; 43:9.

⁹Taylor B, Davis S. Using the Extended PLISSIT Model to Address Sexual Health Needs. *Nursing Standard.* 2006; 21(11):35-40.

Counseling Youth About Sexual Function and Pleasure



Sexual pleasure is an integral part of sexual function and behavior and is often not discussed by healthcare providers. While some providers may feel uncomfortable discussing the details of sexual pleasure and function, it is an important topic that should be discussed with all teen patients. For example, discussing pleasure promoted with condom use in addition to safer sex messaging results in increased condom use and safer sex.¹

Lack of sexual enjoyment may indicate that a teen is not ready to be sexually active. Encourage teens to think about how comfortable they are with their current sexual behaviors. If a sexual function problem persists, you may need to evaluate whether a patient is experiencing sexual dysfunction. (See pg. 34).

TIPS

Improving Female Satisfaction	Postponing Male Ejaculation
<ul style="list-style-type: none"> ▶ Encourage use of lubrication as it improves the quality of sex. Refer her to over-the-counter, water-based lubricants. ▶ Educate young women about their erogenous zones. Encourage female patients to explore their bodies and seek stimulation from erogenous zones: nipples, clitoris, vagina, arms, back, buttocks, ears, feet, fingers, legs, and neck. ▶ Suggest using adequate stimulation. Longer foreplay, oral or manual stimulation of clitoris and other erogenous zones improves a woman’s chances of orgasm and/or satisfaction. ▶ Promote condom use. Females report added clitoral stimulation when using the female condom and increased relaxation when stress of potential STIs or pregnancy is reduced. ▶ Recommend finding a safe, private environment and comfortable sexual position. Position is an important factor to consider in maximizing pleasure and minimizing discomfort. Often youth may be in an awkward environment, may be rushed or afraid of discovery which can reduce pleasure and satisfaction. 	<ul style="list-style-type: none"> ▶ Reassure that this problem diminishes with time. Premature ejaculation is very common in adolescent boys, but decreases with age. ▶ Suggest using adequate stimulation. If males perform longer foreplay on partner, they are more likely to reach orgasm simultaneously during sex. ▶ Promote condom use. Condom use for hyper-sensitive males may postpone ejaculation. ▶ Recommend finding a safe, private environment and comfortable sexual position. Awkward environments may negatively impact male performance. ▶ Advise trying kegel exercises. Not all young men know about their pubococcygeus (PC) muscles and how exercising them can postpone ejaculation. Inform males about anatomy and advise that squeezing PC muscles for seconds at a time will help postpone ejaculation. ▶ Suggest using the “Stop and Start” method. This involves temporarily pulling out and resuming sex when feelings of imminent ejaculation subside.

¹Pleasure and Prevention: When Good Sex is Safer Sex. *Reproductive Health Matters*. 2006; 14(28): 23-31.

²Basson R. Women’s sexual dysfunction: revised and expanded definitions. *CMAJ*. May 2005;172(10):1327-33.

Safer Sex and Lubrication

FAST FACTS

- ▶ **Lubrication promotes a safer sex experience by decreasing abrasive friction.**
 - ⇒ Abrasive friction, the result of dry penetration (can include a sex toy) can cause condom breakage or vaginal and anal tears increasing the chances of transmitting an STI.
 - ⇒ Abrasive friction also increases the risk for Herpes outbreaks in those infected.
- ▶ **Using lubrication enhances pleasure during sex.**
 - ⇒ Lubricants makes sex feel wetter and better.
 - ⇒ Dropping a little lubricant in the condom increases sensitivity and erections in adolescent males who have difficulty maintaining an erection when using condoms.
 - ⇒ Dropping a little lubricant outside the condom promotes pleasure for the receptive partner.
 - ⇒ Adding flavored lubricant to the outside of condoms promotes a pleasant oral sex experience for both the giver and the receiver.¹
- ▶ **Additives in lubricants such as glycerin can create an environment that is friendlier to yeast infections.**
 - ⇒ If a teen reports recurring yeast infections, ask about lubricant use and advise to avoid glycerin-based lubricants.

A Note on Benzocaine: Benzocaine lubricant may have clinical indications (i.e. vulvodynia) but it is not advisable for anal sex or anal stimulation as it masks the body’s signals of pain and use can result in fissures and other anal tears.

TYPE OF LUBRICATION	PROS	CONS
Water-Based Lubricant <i>Astrolide, KY Jelly, etc.</i>	<ul style="list-style-type: none"> ▶ Latex, polyurethane, and nitrile friendly ▶ Female condom friendly ▶ Easily washes off skin, clothes or sheets ▶ Easy to rinse off with water ▶ Sex toy friendly 	<ul style="list-style-type: none"> ▶ Can contain parabens and glycerin ▶ Cannot be used in water ▶ Can vary in how long it stays slippery
Oil-Based Lubricant <i>Baby oil, Vaseline, hand lotion and men’s cream (designed for male masturbation), etc.</i>	<ul style="list-style-type: none"> ▶ Polyurethane or nitrile friendly (i.e. female or Avanti condom)¹ ▶ Particularly effective for male masturbation 	<ul style="list-style-type: none"> ▶ Cannot be used with latex condoms ▶ Not as easy to wash off with soap and water, leaving one susceptible to bacterial infection
Silicone-Based Lubricant <i>Wet Platinum, Eros Body- glide, etc.</i>	<ul style="list-style-type: none"> ▶ Latex, polyurethane, and nitrile friendly ▶ Stays slippery for a long period of time ▶ Can be used in water 	<ul style="list-style-type: none"> ▶ Can be expensive ▶ Must be washed off with soap and water ▶ Harder to remove from clothes or sheets ▶ Can’t be used with some silicone sex toys
Saliva	<ul style="list-style-type: none"> ▶ Latex, polyurethane, and nitrile friendly ▶ Free ▶ Easily washes off skin, clothes, or sheets. 	<ul style="list-style-type: none"> ▶ Cannot be used in water ▶ Usually doesn’t stay slippery for long

Resource

- 🔗 <http://www.plannedparenthood.org/teen-talk/sex-masturbation/vaginal-oral-anal-sex/got-lube-25408.htm>
 Planned Parenthood’s informational handout for teens on lube.

¹Pleasure and Prevention: When Good Sex is Safer Sex. *Reproductive Health Matters*. 2006; 14(28): 23 -31.

Safer Sex Toy Use

When addressing the sexual behaviors of adolescents use of sex toys is often not taken into consideration. The use of sex toys can increase the sexual pleasure of the user, but the different sex toy materials may have implications for the spread of sexually transmitted infections. For example, porous toys retain bacteria and can transmit infections when used without a condom while non-porous toys can be thoroughly cleaned and do not retain bacteria.

FAST FACTS¹

- 53% of women and almost half of all men have used a vibrator.
- Late adolescent women (age 18-22) represented 15.5% of vibrator users and 30% of women in that age group have used a vibrator to masturbate.
- 81% of women and 91% of men who have used a vibrator used it with a partner.
- More lesbian and bisexual identified women have used vibrators and dildos compared to heterosexual women.
- Vibrator users scored higher on measures of positive sexual function, reporting higher rates of sexual pleasure and fared better than their counterparts when considering natural lubrication, pain and erectile function.

Sex Toy Guidelines for Safety and Minimizing Infection of Viruses, Bacteria, or Yeast:

- ▶ Sex toys should be thoroughly cleaned and dried after each use.
- ▶ Condoms should be used when sex toys are:
 - Shared between partners.
 - Used vaginally and anally and the condom should be changed when switching from anal to vaginal penetration.
 - Made out of porous materials such as jelly rubber and “soft skin.”
- ▶ Some silicone and silicone blend toys are porous and cannot be used with silicone lube. Advise patients to read labels to be sure.
- ▶ If recurring infections occur, ask about sex toy use and advise on safer practices.
- ▶ **ANAL TOYS SHOULD ALWAYS HAVE A FLARED BASE TO PREVENT IT FROM GETTING STUCK IN THE RECTUM.**

MATERIAL OF TOY	CLEANING RECOMMENDATIONS	SAFER SEX TIPS
Glass <i>Non-porous</i>	Mild liquid soap and warm water	Use a condom when sharing the toy or when using the same toy vaginally and anally.
Silicone <i>Usually non-porous (can vary in porosity the product is if it is not 100% silicone)</i>	<ul style="list-style-type: none"> ▶ Anti-bacterial soap and warm water; rinse well and dry thoroughly <i>or</i> ▶ Dishwasher <i>or</i> ▶ Boil to disinfect 	Use a condom when sharing the toy or when using the same toy vaginally and anally.
Elastomer and Vinyl <i>(Less Porous)</i>	Mild liquid soap and warm water	Always use a condom whether or not the toy is being shared.
Jelly Rubber, Polyvinyl Chlorides <i>(Porous)</i>	Mild soap and hot water or a washcloth for non-waterproof vibrators; remove soap residue before next use	Always use a condom whether or not the toy is being shared.

¹Herbenick D, Reece M, Sanders S, et al. Prevalence and Characteristics of Vibrator Use by Women in the United States. *J of Sex Med.* 2009; 6(7): 1857–1866.

Pregnancy Prevention Options

METHOD	PROS	CONS
Abstinence	<ul style="list-style-type: none"> ▶ Requires no supplies. ▶ Natural. ▶ Only definite way to prevent pregnancy/STIs. 	<ul style="list-style-type: none"> ▶ Requires motivation and self-control from both partners.
Withdrawal	<ul style="list-style-type: none"> ▶ Requires no supplies. ▶ Natural. 	<ul style="list-style-type: none"> ▶ Unreliable. ▶ Requires motivation and self-control from both partners. ▶ Difficult for male to predict ejaculation ▶ No control by women – need to rely completely on men to prevent pregnancy. ▶ Poor protection against STIs.
Condoms	<ul style="list-style-type: none"> ▶ Immediate protection. ▶ Easily accessible. ▶ Protects against pregnancy/STIs. ▶ Male partner can “last longer” when using a condom. 	<ul style="list-style-type: none"> ▶ Requires planning. ▶ Both partners must be cooperative. ▶ Partner may be allergic to latex.
Cervical Cap/ Diaphragm	<ul style="list-style-type: none"> ▶ Some protection against STIs. ▶ Non-visible. 	<ul style="list-style-type: none"> ▶ Requires fitting and continued use. ▶ Can be expensive if not covered by insurance. ▶ Best used when intercourse can be predicted. ▶ Must be comfortable inserting/removing. ▶ Not usually popular among teens.
Spermicides	<ul style="list-style-type: none"> ▶ Easily accessible. 	<ul style="list-style-type: none"> ▶ Much more effective with condom or diaphragm use. ▶ Requires planning. ▶ No protection against STIs. ▶ May increase risk of contracting Gonorrhea or HIV through irritation of vaginal mucosa.
Emergency Contraception (not intended to be a regular form of birth control)	<ul style="list-style-type: none"> ▶ Effective and safe for teenagers. ▶ Back-up method for unprotected intercourse. ▶ Reduces pregnancy risk after unprotected or under-protected intercourse. 	<ul style="list-style-type: none"> ▶ Side effects such as nausea and vomiting if using OCPs, but levonorgestrel only (Plan B) is well tolerated. ▶ Should be taken ASAP, but reduces pregnancy risk up to 120 hours after intercourse. ▶ Menstrual period is disrupted (may come earlier or later than usual). ▶ No protection against STIs. ▶ Less effective than regular hormonal contraception.
Progestin only Injectables (Depo- Provera)	<ul style="list-style-type: none"> ▶ Non-visible. ▶ Only requires injection every 12 weeks. ▶ Many stop getting their period during use. ▶ Helps protect against uterine cancer. ▶ Highly effective with proper user 	<ul style="list-style-type: none"> ▶ Side effects such as thinning hair, depression, weight gain and irregular periods may be especially bothersome to teens. ▶ Impacts bone mineral density with use over time (see pg. 23). ▶ Can be costly without insurance coverage. ▶ Re-injection must be timely. ▶ No protection against STIs.

Pregnancy Prevention Options *cont.*

METHOD	PROS	CONS
Oral Contraceptives (Birth Control Pills)	<ul style="list-style-type: none"> ▶ Few contraindications. ▶ Safe use after menarche. ▶ May improve acne, dysmenorrhea and cycle control. ▶ Highly effective with proper use. 	<ul style="list-style-type: none"> ▶ Requires consistent daily use. ▶ Forgetfulness increases failure. ▶ Break through bleeding worries and upsets many teens. ▶ No protection against STIs. ▶ Might cause nausea, breast tenderness, moodiness, and weight gain. ▶ Contraindicated for migraines with auras. ▶ Can be costly if not covered by insurance.
Vaginal Ring (Nuva Ring)	<ul style="list-style-type: none"> ▶ Non-visible. ▶ Highly effective with proper use. ▶ Does not require consistent daily use. 	<ul style="list-style-type: none"> ▶ Requires inserting new ring every 4 weeks. The ring stays in for 3 and is taken out for 1 week. ▶ Must be comfortable inserting/removing ring. ▶ Contraindicated for migraines with auras. ▶ No protection against STIs.
Birth Control Patch (Ortho Evra)	<ul style="list-style-type: none"> ▶ Highly effective with proper use. ▶ Does not require consistent daily use. 	<ul style="list-style-type: none"> ▶ Requires applying a new patch once a week for 3 out of 4 weeks. ▶ Visible – particularly on people of color. ▶ Side effects include breast tenderness and nausea. ▶ Contraindicated for migraines with auras ▶ No protection against STIs.
Hormonal Implant (Implanon)	<ul style="list-style-type: none"> ▶ Good for 3 years. ▶ Barely visible. ▶ Highly effective. ▶ Capsule can be removed any time. ▶ May cause light to no periods. 	<ul style="list-style-type: none"> ▶ Must be inserted/removed by a provider. ▶ Side effects may include headaches, irregular bleeding patterns and arm discomfort (initially post-insertion). ▶ No protection against STIs.
Intra-Uterine Device (IUD)	<ul style="list-style-type: none"> ▶ Non-visible. ▶ Minimal maintenance is needed. ▶ Very effective against pregnancy. ▶ Levonorgestrel IUD lasts for 5 years, the copper IUD lasts for 10 years. ▶ Levonorgestrel IUD lessens menstrual flow and can be used to treat heavy periods. 	<ul style="list-style-type: none"> ▶ Slightly higher expulsion rate in nulliparas. ▶ Not recommended for teens with a high risk for contracting CT/GC. ▶ Must be screened for STIs prior to insertion. ▶ Copper IUD sides effects include menstrual cramping, longer and/or heavier menstrual periods and spotting between menstrual periods. ▶ No protection against STIs.

Pg. 57 includes a brief chart to distribute to teens about different types of contraceptives. See pg. 22 for tips for talking with teens about contraception and sexual health.

Menstrual Suppression

As dedicated products for menstrual suppression become more available and gain popularity, more women are interested in learning how they can suppress menstruation. Extended cycling of the combined hormonal birth control methods to suppress menstruation is comparable in safety and effectiveness as the traditional birth control regimen.¹

FAST FACTS

- The average modern women will have four times as many lifetime periods as pre-agricultural women.¹
- Monthly bleeding with combined hormonal contraceptive use is not a “true” period. This “withdrawal” bleeding is the body’s reaction to not having a sustained level of hormones.
- “Off label” extended cycling was used for years before the first dedicated product was approved by the FDA in 2003.³
- Most adult women consider menstruation to be an inconvenience.⁴

¹Clinical Proceedings: Extended and Continuous Use of Contraceptives to Reduce Menstruation. ARHP/NPWH. September 2004.

²New Yorker, 2000

³Steinauer, et al 2007

⁴Clinical Proceedings: Extended and Continuous Use of Contraceptives to Reduce Menstruation. ARHP/NPWH. September 2004.

Extended Hormonal Contraception

Extended hormonal contraception used to delay or eliminate menstruation provides many menstrual and non-menstrual benefits to users.²

MENSTRUAL BENEFITS	NONMENSTRUAL BENEFITS
Reductions in: <ul style="list-style-type: none"> ⇒ Dysmenorrhea ⇒ Menorrhagia ⇒ Premenstrual syndrome ⇒ Irregular monthly periods 	Reductions in: <ul style="list-style-type: none"> ⇒ Menstrual migraines ⇒ Endometriosis ⇒ Acne Improved sense of well-being

Extended cycling is most often recommended in adult women and teens for:³

- ▶ Inducing amenorrhea for a specific event
- ▶ Women in the military
- ▶ Accommodating patient preference for fewer menses
- ▶ Managing menses related problems such as dysmenorrhea, menorrhagia, cyclic headaches
- ▶ Managing problematic menses in women with developmental and/or physical disabilities or behavioral problems

Extended Methods⁴

METHOD	USE
Combined oral contraceptives	Extended or continuous use with elimination of the placebo pills Can use multiple packs or dedicated products
Vaginal contraceptive ring*	Extended or continuous use
Transdermal contraceptive patch*	Extended or continuous use

*Currently, there are no FDA recommendations for the use of the vaginal ring or transdermal patch.

¹Anderson FD, Hait H. A multicenter, randomized study of an extended cycle oral contraceptive. *Contraception*. 2003; 68:89-96.

²Sulak PJ, Kuehl TJ, Ortiz M, Shull BL. Acceptance of altering the standard 21-day/7-day oral contraceptive regimen to delay menses and reduce hormone withdrawal symptoms. *Amer J Obstet Gynecol*. 2002; 186:1142-1149.

³Gerschultz KL, Sucato GS. Eliminating monthly periods with combined hormonal contraception. *Womens Health*. Sept 2007; 3(5):541-5

⁴Anderson FD. *Contraception*. 2003. Kaunitz AM. *Contraception*. 2000. ARHP. 2003. NuvaRing Product Information. 2001. Stewart FH. *Obstet Gynecol*. 2005. Kwiecien M. *Contraception*. 2003. Sulak PJ. *Amer J Obstet Gynecol*. 2002.

Menstrual Suppression *cont.*

Menstrual suppression can also occur with long term use of progesterone contraceptive methods including the levonorgestral intrauterine system (Mirena) and the depot medroxyprogesterone injection (Depo-Provera). For more information on prescribing considerations for these methods, see pg. 22.

PRESCRIBING CONSIDERATIONS^{1,2}

- ▶ Clarify client's expectations for withdrawal bleeding
 - ⇒ Frequency
 - ⇒ Predictability
- ▶ Use monophasic pills or dedicated products
- ▶ Keep it simple and straightforward
- ▶ Start with 3 21/7 (conventional) cycles if history of heavy bleeding
- ▶ Discuss cost of extra pills (up to 4 cycles extra per year); most insurance plans will not cover extra cycles
- ▶ Extended regimen as effective in preventing pregnancy as conventional OCs
- ▶ Withdrawal bleeding is comparable to a conventional withdrawal bleed
 - ⇒ Frequency of breakthrough bleeding (unscheduled bleeding episodes) initially higher with extended OC regimen but declines over time
 - ⇒ One study has shown that frequency of sustained amenorrhea may be lower in patients using the extended use of the transdermal contraceptive patch³
- ▶ No endometrial pathology noted
- ▶ Nonmenstrual side effects are comparable to conventional dosing

¹Sucato GS, Gold MA. Extended cycling of oral contraceptive pills for adolescents. *J Ped Adol Gyn.* Dec 2002;15(5):325-7.

²Anderson FD, Hait H. A multicenter, randomized study of an extended cycle oral contraceptive. *Contraception.* 2003; 68:89-96.

³Stewart FH, Kaunitz AM, LaGuardia KD, et al. Extended Use of Transdermal Norelgestromin/Ethinyl Estradiol: A Randomized Trial. *The Amer College of Obstetricians and Gynecologists.* 2005; 105(6).

Common Patient Questions and Concerns⁵

- ***Is it safe to use hormonal birth control continuously?***

Taking the birth control pill continuously is not any riskier than taking monthly birth control pills. Studies have also shown that use of Seasonale, the dedicated product, did not cause any health problems in users. If you have high blood pressure or a history of problems with blood clots you may not be able to use birth control pills.
- ***How often do I need a period?***

Women who are on hormonal birth control pills do not need to get a period ever. In fact, the bleeding that occurs when you are on the pill isn't even a real menstrual period.
- ***What should I do if I have spotting?***

Spotting is normal as your body gets used to the new hormone levels. Spotting can happen on and off in the first months, sometimes longer. If your spotting becomes heavy or doesn't stop after the first few months, call your healthcare provider.
- ***How will I know if I am pregnant?***

If you take your birth control pills correctly, pregnancy is very rare. If you start to feel any abnormal symptoms like breast tenderness, feeling overly tired, and nauseated, you may want to take a pregnancy test. You can either schedule an appointment for a pregnancy test with me or buy one from the drug store.

⁵Clinical Proceedings: Extended and Continuous Use of Contraceptives to Reduce Menstruation. ARHP/NPWH. Sept 2004.

Establishing Paternity and Paternity Laws

Many teens do not know the laws about paternity or what paternity implies. Generally, paternity is presumed if the parents are married. However, if the parents are not married, paternity needs to be established. Paternity can legally impact a lot of things; and, depending on the relationship between the mother and the father, establishing paternity can either be an appropriate or inappropriate choice.

Pros and Cons to Establishing Paternity

PROs	CONs
<ul style="list-style-type: none"> ▶ Can request custody ▶ Can request child support ▶ Inheritance ▶ Eligibility for father’s insurance benefits ▶ Can obtain father’s medical history ▶ Usually a child wants to know the identity of his/her father. 	<p>Establishing paternity may compromise the safety of the mother and the child in the following situations:</p> <ul style="list-style-type: none"> ▶ If physical, emotional or sexual abuse of the mother is suspected ▶ If the pregnancy is a product of rape ▶ If coercion is suspected ▶ If the father is involved in criminal activity

Despite the fact that unmarried parents are not legally required to establish paternity, young parents may be inappropriately pressured to establish paternity before leaving the hospital or in order to be eligible to file for social services. Encouraging both married and unmarried teen patients to think about paternity before the child is born can help prevent teens from making uninformed decisions about paternity and long-term implications if established. Refer teen parents to local legal counsel organizations to receive guidance on paternity laws.

Testing Paternity: Blood and DNA Testing



A parent may request blood or DNA testing when paternity is ambiguous or being contested. In other situations, if the mother is applying for social services or benefits, the state may require that paternity be determined with a DNA test before benefits are awarded. When faced with the question of paternity testing, however, it is often unclear who is financially responsible for the test and this responsibility can vary state to state.

TIPS:

While the healthcare provider’s role may be relatively limited in this matter, it is important to know the correct referrals and resources in your area.

- ▶ Contact local legal aid or other public counsel option.
- ▶ Contact the local court. Generally it is the court that may force paternity testing and often determine who will pay for the test.

RESOURCE:

🔗 <http://family.findlaw.com/paternity/paternity-tests.html>
 This site outlines basic information on paternity testing.

Sources:

- 1) <http://family.findlaw.com/paternity/chronology-establishing-paternity.html>
- 2) Weisz AG, Gudeman R, Sartell M, Ramos A. Legal Issues for Pregnancy and Parenting Teens in California. Stuart Foundation; 1997.

HPV Vaccine

The quadrivalent HPV vaccine types 6, 11, 16, 18 (GARDASIL™, manufactured by Merck and Co., Inc.) is licensed for use among females and males aged 9–26 years for prevention of vaccine HPV-type–related cervical cancer; cervical, vaginal and vulvar cancer precursors; and anogenital warts. Currently its use in males is optional and at the discretion of providers. The bivalent HPV vaccine types 16, 18 (Cervarix™, manufactured by GlaxoSmithKline) was recently licensed for use among females aged 10–25 years for prevention of vaccine HPV-type–related cervical cancer; and cervical, vaginal and vulvar cancer precursors.

Recommendations for use of HPV Vaccine:

OPTIONAL VACCINATION OF MALES AGED 9-26 YEARS

- ◆ Currently (10/2009) the HPV quadrivalent vaccination in males is optional and at the discretion of providers. There are no recommendations for the use of the bivalent HPV vaccine in males.

ROUTINE VACCINATION OF FEMALES AGED 11–12 YEARS

- ◆ Ideally, the vaccine should be administered before sexual debut and subsequent potential exposure to HPV through sexual contact.
- ◆ Advisory Committee on Immunization Practices (ACIP) recommends routine vaccination of females aged 11–12 years with 3 doses of quadrivalent or bivalent HPV vaccine.
- ◆ The quadrivalent vaccination series can be started as young as age 9 years and the bivalent as young as 10 years.

CATCH-UP VACCINATION OF FEMALES

- ◆ The quadrivalent is also recommended for females aged 13–26 years who have not been previously vaccinated or who have not completed the full series, the bivalent is recommended for females aged 13–25 years who have not been previously vaccinated or who have not completed the full series. The American Cancer Society states there is no evidence of benefit for vaccinating the general population after the age of 19 years.
- ◆ Sexually active females who have not been infected with any of the HPV types included in the vaccine would receive full benefit from vaccination.
- ◆ Vaccination provides less benefit to females if they have already been infected with one or more of the HPV types included in the vaccine. However, females in this age bracket should still receive the vaccine regardless of potential exposure since there is no cost effective way to determine previous exposure to the different HPV types.

DOSAGE AND ADMINISTRATION

- ◆ The vaccine should be shaken well before administration.
- ◆ The dose of quadrivalent HPV vaccine is 0.5 mL, administered IM, preferably in the deltoid muscle.

RECOMMENDED SCHEDULE

- ◆ Both the bivalent and quadrivalent HPV vaccines are administered in a 3-dose schedule.
- ◆ The second and third doses should be administered 2 and 6 months after the first dose.

MINIMUM DOSING INTERVALS AND MANAGEMENT OF PERSONS WHO WERE INCORRECTLY VACCINATED

- ◆ The minimum interval between the first and second doses of vaccine is 4 weeks.
- ◆ The minimum recommended interval between the second and third doses of vaccine is 12 weeks.
- ◆ Inadequate doses of quadrivalent or bivalent HPV vaccine or vaccine doses received after a shorter-than-recommended dosing interval should be readministered.

INTERRUPTED VACCINE SCHEDULES

- ◆ If the quadrivalent or bivalent HPV vaccine schedule is interrupted, the vaccine series does not need to be restarted.
- ◆ If the series is interrupted after the first dose, the second dose should be administered as soon as possible, and the second and third doses should be separated by an interval of at least 12 weeks.
- ◆ If only the third dose is delayed, it should be administered as soon as possible.

Resources for Patient & Parent Education:

The Center for Disease Control (CDC) has excellent handout resources that explain the current understanding about HPV and cervical cancer, the function of Pap screening tests, HPV prevention, and information about the HPV vaccine.

HPV: Prevention & Abnormal Pap Results PDF Handouts

📄 <http://www.cdc.gov/std/hpv/common>

HPV Vaccine: Fact sheets & Information

📄 <http://www.cdc.gov/std/hpv/>

📄 <http://www.cdc.gov/std/hpv/common-clinicians/InsertParents.pdf>

Sex, Virginity & Abstinence

People have sex for many reasons – to feel close to their partner, to show and receive affection, and to experience the physical pleasure of sex. There are also many reasons that people choose not to have sex – religious beliefs, they don't feel ready, or they have not found the right person yet. In the end, it is always your decision to have sex or not have sex, the first time and every time after.

Here are some Common sexual Behaviors...

- ☆ **Masturbation** - touching yourself in a sexual way. Partners can masturbate together and watch each other.
- ☆ **Finger Sex** - touching your partner's sexual organs with your hands.
- ☆ **Sex talk** or “talking dirty” - people saying things to each other about sexual feelings, fantasies, and acts. Sex talk can be used during sexual touching or intercourse.
- ☆ **Phone sex** - people talk sexually to each other over the phone.
- ☆ **Anal intercourse** - a penis, finger, sex toy, or other object is put inside the anus.
- ☆ **Vaginal intercourse** - a penis, finger, sex toy, or other object is put inside the vagina.
- ☆ **Oral sex** - a mouth or tongue is used to sexually stimulate someone. The tongue is used on the penis, scrotum, clitoris, vagina, anus, etc.

Other Important Terms

Abstinence – some people use the word “abstinence” to refer to not having sex. They may mean that they are not doing any sexual activities with another person at all. It can also mean that they are doing some sexual activities, just not having vaginal intercourse.

Periodic Abstinence – when someone decides to take a break from sex. People can decide to take a break from sex for a few days or a few years.

Sexual Self-Reliance – when you rely on yourself to make yourself feel sexually satisfied. This is often through masturbation. Relying on yourself is different from relying only on a partner for sexual pleasure. You can use self-exploration and masturbation to get to know your body and show your partner what you like. Being sexually self-reliant can also make sex with someone else better.

Am I a Virgin?

Virginity refers to never having had sex. For some people, being a virgin means someone has not done any sexual activities with another person. For others, being a virgin just means that someone has not had vaginal intercourse.

Myths and Facts about Virginity

- ☆ There is a virginity test.
myth! There is no medical test to tell if you are a virgin.
- ☆ If a girl breaks her hymen, she can still be a virgin.
Fact! The hymen, also known as “the cherry,” is a thin tissue that covers the vaginal opening. This tissue can break from sexual or non-sexual activities. These non-sexual activities could be riding a bike or climbing a tree.
- ☆ You can tell if someone has had sex by the way he or she looks or acts.
myth! You cannot tell if someone is sexually active by how he or she looks or acts. Everyone is different.

Having Sex on Your Own Terms

QUIZ: Do You Have to Say Yes to Sex If...

- | | |
|--|--|
| <input type="checkbox"/> you have already <i>lost</i> your virginity? | <input type="checkbox"/> someone is a teacher, policeman, or boss at your job? That person has power over you? |
| <input type="checkbox"/> you have had sex with someone before? | <input type="checkbox"/> someone is in your family? |
| <input type="checkbox"/> someone spends money on you? | <input type="checkbox"/> someone is really popular and wants to have sex? |
| <input type="checkbox"/> you are a female and your cleavage is showing? your clothes are tight fitting? you are wearing a short skirt? | <input type="checkbox"/> someone is older than you and wants to have sex? |
| <input type="checkbox"/> you are a male and want to be a real man? your friends say you need to have sex to be a man? | <input type="checkbox"/> you are a female and it is late at night? |
| <input type="checkbox"/> your partner is really horny? | <input type="checkbox"/> you are a female and you are naked in bed with your partner? |
| <input type="checkbox"/> you want someone to like you? | <input type="checkbox"/> you are a male and a 15-year-old virgin? 17? 19? |
| <input type="checkbox"/> you are a female and you have been called a ho? whore? slut? | <input type="checkbox"/> you have been raped, or forced to have sex before? |
| <input type="checkbox"/> you are a straight male and a female is offering? | <input type="checkbox"/> you are at a place you shouldn't be? |
| <input type="checkbox"/> someone is your boyfriend or girlfriend? | <input type="checkbox"/> you have been drinking or smoking? |
| | <input type="checkbox"/> you love sex and think it feels good? |

The answer to all of these questions is NO.

YOU NEVER HAVE TO SAY YES to sex. Sex is always a choice, the first time and every time!

AND REMEMBER: Sex is something YOU CAN SAY YES to when you and your partner are ready, feel safe and comfortable with each other, and are using protection against pregnancy and STIs

Thinking about having sex? Ask yourself these questions...

- ✓ Am I in a healthy, trusting, respectful and honest relationship? Do we treat each other as equals and communicate well?
- ✓ Do my partner and I agree on the nature of our relationship (friendship, steady romantic relationship, etc.?)
- ✓ Do we have the same ideas about sex and love?
- ✓ Can I explain my decision to have sex if parents or friends ask why?
- ✓ Is having sex my idea, or am I being pressured? Is having sex something my partner really wants, or am I pressuring him or her?
- ✓ Am I OK talking with my partner about what I do and don't want to do sexually?
- ✓ Do I know how to use birth control and condoms to prevent pregnancy and STIs?
- ✓ If sex leads to pregnancy or getting an STI: Do I know where to get treated for an STI? Do I feel ready to make decisions about a pregnancy? Will my partner be there for me?

TIPS for Having Sex on Your Own Terms:

- ✓ **Always have a safe way to get home** when on a date or out with friends.
- ✓ **Pick friends you can trust.** A true friend will respect your sexual decisions.
- ✓ **Be prepared with a safer sex method.** Get condoms or talk to your provider about picking a birth control method before you start having sex.
- ✓ **Get tested for STIs.** Go to the clinic with your partner before you have sex.
- ✓ **Ask your partners about their sexual desires.** Be sure to share your own desires, too. Your sexual decisions should be what you both want, every time.
- ✓ **Pay attention to your partner.** If he or she seems unsure always stop and ask, "Is this OK?"

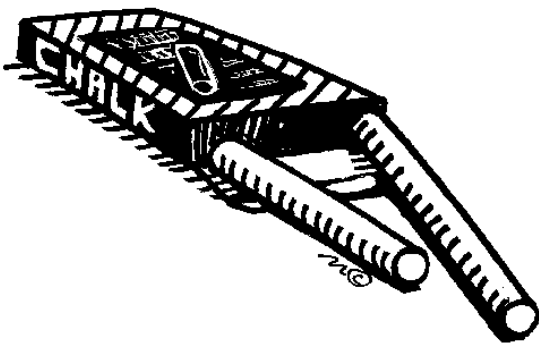
Healthy Relationships

The following are some tips for deciding what you should look for in a relationship. These should also help you know when you are in an unhealthy relationship. Healthy dating and sex habits now lead to healthy sex and dating habits in the future. If you think you might be in an unhealthy or abusive relationship, talk to a trusted and caring person in your life. Most people need support when they are in these situations.

THE RELATIONSHIP BILL OF RIGHTS

I HEREBY DECLARE THAT I HAVE THE RIGHT TO...

- TRUST MY FEELINGS.
- BE WITH WHO I WANT, WHEN I WANT, AND HOW I WANT.
- SAY NO OR LEAVE A SITUATION IF I FEEL UNCOMFORTABLE.
- DISAGREE WITH MY PARTNER.
- HAVE SEX WHEN MY PARTNER AND I BOTH WANT TO.
- HAVE SEX THAT FEELS GOOD TO ME.
- FEEL GOOD ABOUT MYSELF WHETHER I AM IN A RELATIONSHIP OR NOT.
- ACCUSE SOMEONE OF HURTING ME PHYSICALLY OR SEXUALLY.
- RECEIVE EMOTIONAL SUPPORT AND UNDERSTANDING.
- CONTROL MY OWN FUTURE.



Resources/Links:

- Advocates for Youth: <http://www.advocatesforyouth.org/youth/health/relationships/index.htm>
- Planned Parenthood: <http://www.plannedparenthood.org/health-topics/relationships-4321.htm>
- Planned Parenthood's Teenwire: <http://www.teenwire.com/topics/relationships-friends-and-family.php>

The Relationship Spectrum

Healthy	Unhealthy	Abusive
<p style="text-align: center;">A HEALTHY RELATIONSHIP</p> <p><i>A healthy relationships means that both you and your partner are...</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Communicating - You talk openly about problems and listen to one another. You respect each other's opinions. <input type="checkbox"/> Respectful - You value each other as you are. <input type="checkbox"/> Trusting - You believe what your partner says. <input type="checkbox"/> Honest - You are honest with each other but can still choose to keep certain things private. <input type="checkbox"/> Equal - You make decisions together and hold each other to the same standard. <input type="checkbox"/> Enjoying personal time - You both enjoy spending time apart and respect when one of you needs time apart. <input type="checkbox"/> Making mutual sexual choices. You talk openly about sexual choices together. You both consent to sexual activity and can talk about what is ok and what isn't. You discuss using condoms or other birth control methods. 	<p style="text-align: center;">AN UNHEALTHY RELATIONSHIP</p> <p><i>You may be in an unhealthy relationship if one of you is...</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Not communicating - When you talk about problems you fight, or you don't talk about them at all. <input type="checkbox"/> Disrespectful - One or both of you is not considerate of each other. <input type="checkbox"/> Not trusting - You don't believe what your partner says. <input type="checkbox"/> Dishonest - One or both partners is telling lies. <input type="checkbox"/> Trying to take control - One or both partners feel their desires and choices are more important. <input type="checkbox"/> Feeling crowded or not spending time with others - Only spending time with your partner. <input type="checkbox"/> Pressured by the other into sexual activity - One partner tries to convince the other that they should have sex, or more sex. <input type="checkbox"/> Ignoring the consequences of sex - The partners are having consensual sex with each other but are not talking about possible consequences. 	<p style="text-align: center;">AN ABUSIVE RELATIONSHIP</p> <p><i>An abusive relationships starts when one of you...</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Communicates in a way that is hurtful or insulting. <input type="checkbox"/> Mistreats the other - One or both partners does not respect the feelings and physical safety of the other. <input type="checkbox"/> Accuses the other of flirting or cheating when it's not true - The partner that accuses may hurt the other in a physical or verbal way as a result. <input type="checkbox"/> Denies that the abusive actions are abuse - They may try to blame the other for the harm they're doing. <input type="checkbox"/> Controls the other - There is no equality in the relationship. What one partner says goes. <input type="checkbox"/> Isolates the other partner - One partner controls where the other one goes, and who the other partner sees and talks to. <input type="checkbox"/> Forces sexual activity - One partner forces the other to have sex.

Love Shouldn't Hurt

Dating and being in a romantic relationship can be fun and exciting. Unfortunately, too many teens are hurt by the people they date. Dating or relationship violence is a pattern of violence someone uses against their boyfriend, girlfriend, or date and it includes emotional, verbal, physical, and sexual abuse.

Quiz: Are you In an ABusive Relationship?

1. Are you afraid of your partner or afraid of what your partner will do if you end your relationship?
2. Does your partner call you names, make you feel stupid, or tell you that you can't do anything right?
3. Is your partner extremely jealous?
4. Does your partner try to limit where you go or who you talk to?
5. Do you feel cut off from your friends or family because of your partner?
6. Do you feel threatened by your partner if you say no to touching or sex?
7. Has your partner ever blamed you for his/her violent actions?
8. Has your partner ever shoved, hit, kicked, held you down, or physically hurt you on purpose?
9. Is your partner really nice sometimes and really mean other times as if she/he has 2 different personalities?
10. Does your partner make frequent promises to change and never hurt you again?

If you answered "YES" to any of the above questions, your partner is being abusive towards you. It is very important for you to be safe and reach out for help.

Safety Tips:

- ⇒ Do not meet or hang out with the abusive person by yourself. Go to a public place or a location where your family or friends are nearby.
- ⇒ Avoid being alone at school, at work, or on the way to and from places.
- ⇒ Always tell someone you trust where you are going and when you will be back.
- ⇒ Make sure you can get home or get to a safe place on your own. Bring your own car, money for the bus or taxi, or go to a public place and call friends/family for a ride.
- ⇒ Memorize the addresses and phone numbers of people you trust. Go to these people for help if your date or partner becomes violent or abusive. Call 911 if you are in an emergency situation.

You Deserve healthy relationships!

Where to Go for Help:

- ⇒ Educate yourself about dating/relationship violence. Search for information on the internet or at your local public library.
- ⇒ Talk with your parent, family member, teacher, counselor, doctor/nurse, clergy member, or other trusted adult. The less isolated you are, the less opportunity the abusive person has to hurt you.
- ⇒ Seek help from professionals. Go to places such as school health centers or counseling offices, clinics, youth or faith-based organizations, community centers and/or call a hotline.

Resources:

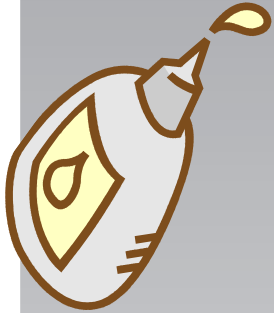
- ◆ National Teen Dating Abuse Helpline: 1-866-331-9474
- ◆ Rape Abuse Incest National Network: 1-800-656-HOPE
- ◆ Love is Not Abuse: www.loveisnotabuse.com

Source:

Washington State Office of the Attorney General. Teen Dating Violence Brochure. 2004, <http://www.atg.wa.gov/violence>. Adapted and reproduced with permission.

Wetter Makes It Better

Did You Know???



- ☆ Lube can make condom use more pleasurable for both sexual partners
- ☆ Lube can decrease pain and discomfort from dryness and friction during sex
- ☆ Lube can prevent condoms from breaking
- ☆ **LUBe Can Be Put on the inside of a Condom Before rolling it Down the Penis, and on the outside of a Condom Before having sex**

Got LUbe?

VAGINAL LUBRICATION:

- ⇒ The vagina gets wet or lubricated when sexually stimulated
- ⇒ If the vagina does not get wet enough before a finger, penis, or sex toy is inserted, it can be painful or irritating
- ⇒ Lube can be put on the opening of the vagina and on the outside of a finger, penis, or sex toy before inserting into the vagina to increase pleasure during sex
- ⇒ Sometimes you need to reapply lube

ANAL LUBRICATION:

- ⇒ The anus does **NOT** get wet or lubricated when sexually stimulated
- ⇒ Lube should **always** be applied to the opening of the anus and on the finger, penis, or sex toy that is inserted into the anus to increase pleasure and decrease pain, friction, and tearing of the anus
- ⇒ Sometimes you need to reapply lube

What Type of LUbe Should I Use?

- ☆ **Always use water-based lubricants with pre-lubricated latex condoms.** Common types of water-based lubes include Astroglide and K-Y Jelly
- ☆ **If you or your partner are irritated by a lubricant, stop using it and try one that does not contain parabens or glycerin. Check the labels!**
- ☆ **If you or your partner are irritated by latex condoms, try using polyurethane condoms instead**
- ☆ **Do NOT use oil-based lubricants (Baby oil, lotion, Olive oil, or Vaseline) with latex condoms.** Oil-based lubricants can cause condoms to break

Forgot To Pick UP The LUbe?

Use plenty of saliva (spit)! It's free and always available!

Be Safe With Sex Toys

- KEEP them Clean.** Toys are made from all different types of materials. They can be really hard to clean or really easy to clean. Follow the directions on the labels for cleaning and storing. Dry your toys well after you clean them.
- Know the Difference Between sex toy materials:**



- ▶ **100% silicone** - Can be washed with antibacterial soap or in a dishwasher.
- ▶ **Glass** - Can be washed in mild liquid soap and warm water.
- ▶ **Elastomer and Vinyl** - Bacteria remain after it's washed in mild liquid soap and warm water.
- ▶ **Jelly RUBBER and Polyvinyl Chlorides (PVC)** - Bacteria remain after it's washed in mild liquid soap and warm water.

- Always use a Condom when using sex toys with a Partner and when they are hard to Clean.**
- Remember to Put on a new Condom when you are:**
 - ✓ Done using a toy and want to share it with a partner
 - ✓ Going from one hole to another (especially from anus to vagina)
- Read labels.** Avoid toys that have substances like “phthalates.” Look for phthalate-free toys. They are safer for your health.
- only use toys that are flared at the Bottom for anal sex.** This way, it won't get stuck.



What if you Don't have time or money to Buy sex toys?

Cucumbers, carrots, and bananas (with the peel) make great dildos. Just remember to use a condom!



Sex, Technology & You

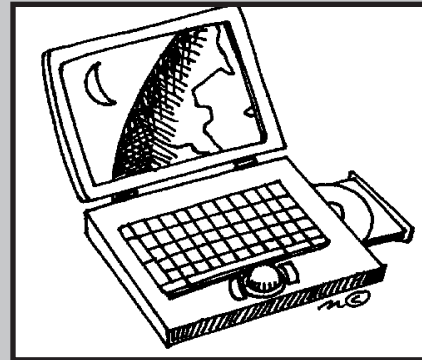
So, You Met Someone Online...

Some questions to ask yourself are:

1. Does their story stay the same about their age and background?
2. If sex is brought up, are they respectful about it?
3. Are they ok when you say you don't want to give out personal information? Are they ok when you say you don't want to meet face to face?

If **YES**, these are some of the signs of a healthy relationship - online.

If **NO**, then you may want to consider meeting other new people.



DID YOU KNOW... sending a naked picture can be illegal?



This includes pictures you post online and text messages. You can get in trouble with the law for sending or receiving a sexual text message. You may send your picture to someone you trust. But some pictures are forwarded during a break up or an argument. Think about where your picture might end up before you press SEND.

TIPS for Keeping Your Information Private

- ✓ Make sure your messages are private. Add this at the end of your e-mail: "This email message and any files transmitted with it are private and intended only for the individual to whom they are addressed."
- ✓ Prevent IM forwarding. Set your chats to "off the record." This means no record of your conversation will be saved. Keep in mind that a text can still be copied and pasted.
- ✓ If you want to make sure that your text is private, send anonymous messages through services such as www.anontxt.com.
- ✓ Use a screen name different from your real name when in chat rooms.
- ✓ Check out the privacy settings for your social networking site. You can control who can see your profile. Also, never post your phone number or address so it can be seen publicly.



Am I Normal? A Tour of The Female Genitals

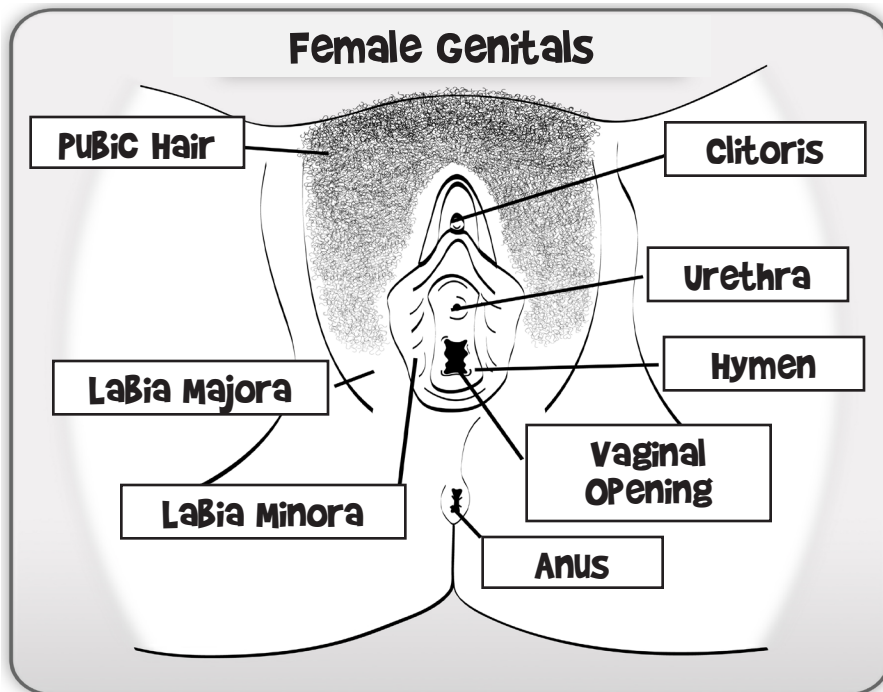


Diagram reproduced with permission from www.Avert.org

KEY TERMS

- ☆ **PUBic Hair** - hair that surrounds the sex organs for protection.
- ☆ **LaBia Majora** - also called the outer lip. Pubic hair grows here.
- ☆ **LaBia Minora** - also called the inner lip. It may vary in texture, size and color. It covers the urethra and vaginal opening.
- ☆ **clitoris** - the pleasure center of the vulva. It is a tissue that fills with blood and becomes erect when sexually aroused.
- ☆ **urethra** - a tube that carries your urine, or pee, to your urethral opening. It is a tiny hole under the clitoris.
- ☆ **Hymen** - the thin layer of tissue that covers the vaginal opening. The hymen can break at any time in many different ways.
- ☆ **vaginal opening** - the passage from the uterus to the outside of the body. Contains the pleasure center called the g-spot.
- ☆ **ANUS** - the opening of the rectum where waste leaves the body.

Fact check: Female Genitals

- ✓ Female genitals come in different sizes, colors and shapes.
- ✓ The vagina releases discharge to keep itself clean and healthy. Everyone has a natural smell that is different.
- ✓ Some families decide to circumcise (remove parts of the female sex organs). Some people think this is OK for cultural reasons. Others think it's violent and should be stopped. This practice can cause problems with sex, hygiene, and childbirth.

How to Keep your genitals healthy:

- ✓ Wear cotton underwear and change them every day.
- ✓ Wipe from front to back.
- ✓ Wash with warm water and mild soap.
- ✓ Avoid douching.
- ✓ Try to learn what your genitals look like. If you notice anything that's not normal (lumps, bumps, changes in discharge) let your healthcare provider know.

Resources

- 🔗 http://www.scarleteen.com/article/body/anatomy_pink_parts_female_sexual_anatomy
- 🔗 http://www.advocatesforyouth.org/storage/advfy/documents/leaders_hygiene.pdf

Am I Normal? A Tour of Male Genitals

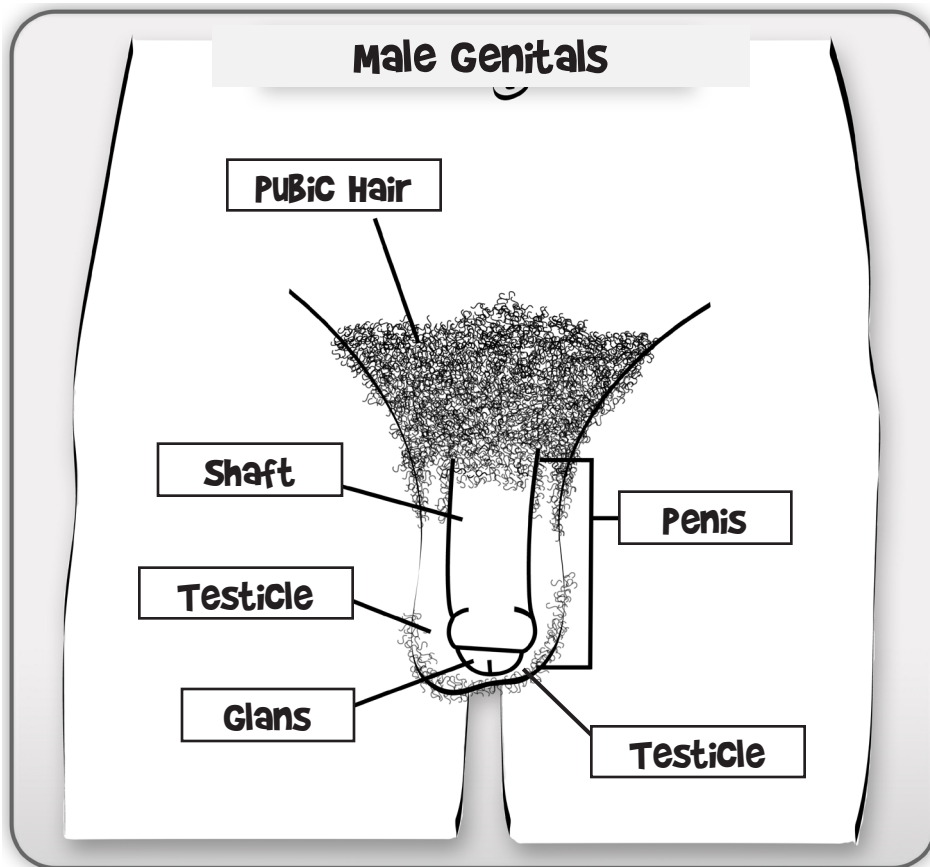


Diagram reproduced with permission from www.Avert.org

KEY TERMS

- ☆ **PUBic Hair** - hair that surrounds the sex organs.
- ☆ **Penis** - the male sex organ that is made up of the glans and the shaft.
- ☆ **Shaft** - the long part of the penis below the glans. It grows longer when sexually aroused.
- ☆ **Glans** - the tip or head of the penis. At the tip of the glans is the urethral opening. The urethral opening is a small opening that releases urine, semen, and pre-ejaculate fluid..
- ☆ **Testicles** - reproductive glands that make sperm and testosterone. They are covered by a loose skin called the scrotum.

Fact Check: The Male Genitals

- ✓ Male genitals come in different sizes, colors and shapes.
- ✓ Penises can change a lot in size. They can go from flaccid (soft) to erect (hard).
- ✓ Some penises are circumcised. Circumcision is when the foreskin or loose skin that covers the glans of the penis is cut. Parents often decide whether or not to circumcise their boys.

How to Keep Your genitals Healthy:

- ✓ Wear clothes that fit loosely. This prevents Jock Itch, irritation or chapping in the genital area.
- ✓ If you play sports, wear an athletic supporter to protect your sex organs.
- ✓ Wear cotton underwear and change them every day.
- ✓ Wash with warm water and mild soap.
- ✓ If you are uncircumcised, gently pull back the skin on the head of your penis. Wash that area with soap and water.
- ✓ Try and learn what your genitals looks like. If you notice anything that's not normal (lumps, bumps, changes in discharge) let your healthcare provider know.

What to Expect at Your First Women's Health Exam....

As you get older, your provider may tell you that you need a gynecological or pelvic exam. This means that he or she will take closer look at your reproductive system. You may need this exam if you...

- ⇒ are sexually active and have symptoms of an infection
- ⇒ have any changes or questions about your sexual health
- ⇒ have never had a gynecological exam and are 21 years of age or older
- ⇒ you are pregnant
- ⇒ don't start your period or stop having your period

- 1** **Your provider will ask questions** about your period. He or she will also ask about sex, pregnancy and STIs. It's important to answer these questions truthfully. The provider will not tell anyone what you tell him or her unless he thinks that someone has hurt or abused you.
- 2** **You will undress and cover up.** You will probably be left alone in the room to undress and cover up with a sheet or a gown.
- 3** **You will lie on the exam table and will be asked to scoot to the edge of the table and open your legs. Usually you will be asked to put your feet in foot rests that will help keep your legs apart while the exam is done. *If you have mobility problems, use a wheelchair, or have tight legs, your provider will work with you to find a comfortable position.*** There are usually three parts of the exam:
 - **External Exam** — The provider looks at the outside of your vulva for bumps or other problems.
 - **Speculum Exam** — A tool called a speculum is inserted into your vagina. The speculum is used to look at your vagina and cervix. The cervix is the opening to your uterus. Samples of vaginal or cervical discharge will be taken with a large Q-tip. These samples are used to check for vaginal infections, STIs and cancer.
 - **Bimanual Exam** — Your provider will put one or two gloved fingers inside your vagina. He or she will then press with the other hand on the outside on your lower belly. This is to check the size and position of your cervix, uterus and ovaries. Sometimes the provider will also perform a rectal exam and insert a finger in your anus. This is to check for tumors, and is not usually done on teens.
- 5** **The provider will let you ask any questions** and then leave the room so you can change. If the results of the test are normal you won't hear anything. If the results of the tests are not normal, someone from your provider's office will contact you within a week.

Some Tips

- ☑ Come prepared to this visit by knowing the dates of your very first period and your last menstrual period.
- ☑ Do not come when you are on your period unless you are having a discharge, burning when you pee, abdominal pains or irregular bleeding.
- ☑ It is your right to ask for a different provider if you do not feel comfortable with the one you have, or ask for a female to be in the room if you have a male provider.
- ☑ It is almost always ok to bring someone into the exam room with you, like a relative or a friend.
- ☑ The exam might be uncomfortable but shouldn't hurt. The best way to deal with this discomfort is to take some slow deep breaths. Breathe in through your nose and blow out through your mouth. If you feel any pain during the exam, tell your provider.
- ☑ If you want, ask for a mirror during the exam so you can see what's happening.
- ☑ Be familiar with your body so you know when anything changes.
- ☑ Ask questions! This is an especially great opportunity to ask about your body, sex, STIs and birth control.
- ☑ If you don't want to be contacted at your home with your test results, make sure you speak up about this!
- ☑ You can call your provider to find out the results of your tests.

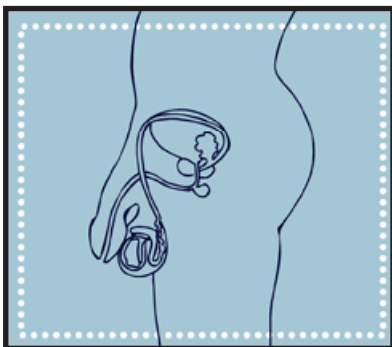
What to Expect at Your First Men's Health Exam....

To make sure that you are healthy, your healthcare provider will check your genitals. This can seem uncomfortable or embarrassing, but exams are important for your health. A provider needs to check your anatomy to make sure you are developing normally. If you are sexually active they will check for sexually transmitted diseases. They may also check your testicles for signs of testicular cancer, which is rare but can effect young men.

- 1** Your health care provider will ask you some questions about your body. He or she will ask if you have noticed any changes, and if you are sexually active. It is important to tell the truth when you answer the questions. The provider will not tell anyone what you tell him or her unless he thinks that someone has hurt or abused you.
- 2** You will be asked to undress and put on a gown. You will probably be left alone in the room to change your clothes.
- 3** Your provider will start by looking at your genital hair. He or she will then gently touch your testicles, penis and the surrounding areas. He or she is looking for anything that looks or feels unusual. Your provider may also teach you how to give yourself a testicular exam
- 4** You may be asked to “turn your head and cough.” This is to check for hernias.
- 5** Your provider might perform a rectal exam. This is done by inserting a gloved finger in your anus. This is not usually performed on teens.
- 6** Your provider may test for sexually transmitted infections. He or she will test you if you are sexually active or if you have STI symptoms. You can also ask for STI tests. This may be done by asking you to pee in a cup. Sometimes this is done by inserting a Q-tip into the small hole at the tip of your penis, the urethra and in the anus if you have anal sex. If you are worried about the Q-tip exam, ask if they offer a urine test when you schedule the appointment.
- 7** Your provider will usually leave the room so you can change. Ask your provider any questions about the exam and your health.

SOME TIPS...

- It is your right to ask for a different health care provider if you do not feel comfortable with the one you have.
- It is almost always ok to bring someone, like a relative or a friend, into the exam room with you.
- The exam might be uncomfortable but it shouldn't hurt. If you feel any pain during the exam, tell your provider.
- Be familiar with your body so you know when anything changes.
- Ask questions! This is a great opportunity to ask about your body, sex, STIs and birth control.
- If you don't want to be contacted at your home with your test results, make sure you speak up about this!
- You can call your provider to find out the results of your tests.



Other Resources/Links:

⇒ Sexual Health Exams

http://www.youthresource.com/health/features/what_to_expect.htm

<http://www.youngmenshealthsite.org>

<http://www.teenwire.com/infocus/2003/if-20031015p199-gyno.php>








⇒ Self-Testicular Exams

http://www.kidshealth.com/teen/sexual_health/guys/tse.htm






http://www.usrf.org/video_tomgreen/tcexam.html

Your Safer Sex Options: Preventing Pregnancy & Protecting Against STIs

- ⇒ Depo-provera (the hormonal injection) and the IUD are the most effective types of birth control.
- ⇒ It is best to use condoms and another method that protects against pregnancy (birth control pills, IUD, depo-provera, etc.).
- ⇒ Condoms come in many shapes, sizes, colors, flavors and varieties. Try a different shapes or styles if a condom feels uncomfortable. Check out condomania.com for different options.
- ⇒ New birth control products come out all the time. To learn about new methods, ask your health care provider.

METHOD	HOW IT WORKS	PROS	CONS
Male Condom 86-97% effective 	Piece of plastic/rubber covers penis and stops cum from entering vagina or anus.	Protects against STIs (latex are the best) and pregnancy. Don't need a prescription.	You have to be prepared. A new one is needed after every act of sexual intercourse.
Female Condom 79-95% effective 	Piece of plastic shaped like a sock that goes in the vagina or anus and stops cum from entering.	Provides protection against STIs and pregnancy. Can be use by people with latex allergies. Don't need a prescription.	Condom can be noisy or feel uncomfortable.
Cervical Cap 82-94% effective 	Rubber cup that covers the opening to the womb or uterus and blocks sperm.	Can put it in several hours before sexual intercourse.	No protection against STI and has to be fit by a health care provider. It can cost a lot without insurance.
Diaphragm 80-94% effective 	Dome shaped rubber cup that covers the cervix and blocks sperm.	Don't have to take it out between acts of sexual intercourse. Works for about 6 hours, but need to reapply spermicide.	No protection against STIs and can be messy or awkward to use.
Spermicides 74-85% effective 	Gel that is put in vagina before intercourse and kills the sperm.	Don't need a prescription.	It's messy. Not the best protection against STIs.
Injection (Depo-Provera) 99% effective 	A hormone shot taken every 3 months	Can't see it. You don't have to worry about birth control for 3 months once you get the shot. Can stop periods.	No STI protection and need to go to see a provider every 3 months for next shot. Can stop periods.
Oral Contraceptives (Birth Control Pills) 95-99% effective 	Hormone pills taken everyday that stops release of egg from ovary	24/7 protection. Can make periods lighter and more regular	Need to remember or remind your partner to take the pill everyday. No STI protection.

Your Safer Sex Options *cont.*

METHOD	HOW IT WORKS	PROS	CONS
Vaginal Ring (Nuva Ring) 99% effective 	Plastic ring that's put inside the vagina and left in for three weeks. A new ring is reinserted 1 week later.	Can't see it. You only have to insert and remove it once a month.	No protection against STIs. Have to feel comfortable putting in and taking out the ring or help your partner put it in and take it out.
Birth Control Patch (Ortho Evra) 99% effective 	A patch that is worn on the skin in a certain area that must be changed every week.	Does not require taking a pill. Can be hidden by clothing.	No protection against STIs. Must change it every week. Can cause side effects like breast tenderness and nausea.
Hormonal Implant (Implanon) 99% effective 	A small tube with hormones is inserted in the women's upper arm.	Barely visible and works for 3 years.	No protection against STIs. Can cause irregular periods.
Emergency Contraception 75-88% effective 	Hormone pills taken 3-5 days after unprotected sex. Stops ovulation or prevents egg from being fertilized.	Can be taken after intercourse.	Not a regular form of birth control. Does not protect against STIs.
Intra-uterine Device (IUD) 97-99% effective 	A plastic device is put in the woman's uterus.	Hormonal IUD is good for 5 years. The copper IUD is good for 10 years.	No protection against STIs. Risk of serious infection shortly after insertion. Can make your periods irregular.
Withdrawal 81-96% effective	During intercourse, the man pulls his penis out of the vagina or anus before he cums.	Is natural and no supplies are needed.	Pulling out in time can be difficult to predict. Pre-ejaculation fluids can transfer HIV and other STIs.
Abstinence 100% effective	A couple does not have sex.	Only definite way to prevent pregnancy and STIs.	Requires motivation, self-control and communication from both partners. Only works if it is used 100% of the time.

FOR MORE INFORMATION ON ANY OF THESE METHODS, CHECK OUT THESE WEBSITES:

 **Young Women's Health:**

<http://www.youngwomenshealth.org/contra.html>

 **Teen Talk**

<http://www.plannedparenthood.org/teen-talk/birth-control-25029.htm>

A Teen's Guide to Sexually Transmitted Diseases and Other Infections

Infection	What are the symptoms?	How is it spread?	Is it curable?
Chlamydia <i>Bacterial</i>	Most often there are NO SYMPTOMS. Yellowish discharge, burning with urination, bleeding between periods, swollen or tender testicles.	Through unprotected vaginal, oral, or anal sex.	Yes, but it must be treated to prevent Pelvic Inflammatory Disease (PID), or damage to the reproductive organs.
Gonorrhea <i>Bacterial</i>	Most often there are NO SYMPTOMS in women. Yellowish discharge, burning with urination, stomach pain.	Through unprotected vaginal, oral, or anal sex.	Yes, but it must be treated to prevent other problems, like PID, or damage to the reproductive organs.
Genital Herpes <i>Viral</i>	Blister-like sores in the genital region or mouth.	By touching an infected area (which may not be noticeable), or having unprotected vaginal, oral, or anal sex.	No. Herpes is treatable, but does not go away. People with herpes can be contagious even if they are not having an outbreak.
Human Papillomavirus (HPV or Genital Warts) <i>Viral</i>	One type of HPV causes genital warts. Another type can cause cervical and anal cancer.	By touching or rubbing an infected area (which may not be noticeable), or having unprotected vaginal, oral, or anal sex.	No. HPV is treatable but does not go away. The most common types of HPV can be prevented by a vaccination of three doses. Make sure you're up to date!
Pubic Lice (CraBs) <i>Parasite</i>	Severe itching, small red bumps.	Through any direct physical contact and rarely through indirect contact such as a shared object.	Yes. Clothes and bedding must also be cleaned to get rid of the bugs.
Trichomoniasis <i>Parasite</i>	Most often there are NO SYMPTOMS in men. Itching, irritation, redness, discharge, bad smell, frequent and/or painful urination, discomfort during intercourse, stomach pain.	Through unprotected vaginal sex.	Yes.
Syphilis <i>Bacterial</i>	First stage: painless open sore on the penis, vagina, or mouth. Second stage: rash, fever, swollen lymph glands, sore throat, muscle aches. Final stage: damaged internal organs and central nervous system.	Through unprotected vaginal, oral, or anal sex, and also through kissing if there is a lesion on the mouth.	Yes.

A Teen's Guide to Sexually Transmitted Diseases and Other Infections *cont.*

Infection	What are the symptoms?	How is it spread?	Is it curable?
Hepatitis A <i>Viral</i>	Poor appetite, nausea/vomiting, headaches, fever, jaundice (yellow skin), dark urine, light-colored bowel movements. Sometimes there are no symptoms.	Through oral contact with feces. Through unprotected anal/oral sex, drinking contaminated water or eating contaminated food.	Does not cause a long-term infection, but symptoms can last 6-9 months. Once you have had Hepatitis A you cannot get it again. It can be prevented by two doses of a Hepatitis A vaccine.
Hepatitis B <i>Viral</i>	Poor appetite, nausea/vomiting, headaches, fever, jaundice (yellow skin), dark urine, light-colored bowel movements. Sometimes there are no symptoms.	Through unprotected vaginal, oral, and anal sex and through sharing dirty needles. It is spread by blood, semen, vaginal secretions and breast milk.	No highly successful treatment, but can be prevented by a Hepatitis B vaccination of three doses. Make sure you're up to date!
HIV/AIDS <i>Viral</i>	Weight loss, fatigue, night sweats/fever, dry cough, diarrhea, swollen glands, memory loss/confusion, depression. Sometimes there are no symptoms.	Through unprotected vaginal, oral, and anal sex, and dirty needles. Can also pass from mother to child during pregnancy or child birth, or breast-feeding.	No. Although there are many treatments which have greatly improved the health and survival of people with HIV. No proven vaccine at the current time.
Bacterial vaginosis (BV) <i>Bacterial</i>	Fishy or unpleasant vaginal odor, milky-white or gray vaginal discharge, vaginal itching and burning. Sometimes there are no symptoms.	The cause of BV is not completely understood. Having multiple sex partners and douching increases your risk.	Yes, but it must be treated to prevent increased risk of other pelvic illnesses or chance of having problems with a pregnancy.
Vaginal Yeast Infection <i>Fungal Overgrowth</i>	Thick curd-like vaginal discharge (like cottage cheese), vaginal itching and burning, redness and irritation.	Through an imbalance of the healthy organisms in the vagina. May occur while on antibiotics.	Yes.
Urinary Tract Infection (UTI) <i>Bacterial</i>	Burning or pain during urination, urge to urinate frequently or after you've just urinated, fever, lower abdominal or back pain.	Through bacteria coming in close contact to the vulva or urethra. It can also be caused by an STI.	Yes, it must be treated to prevent kidney infection.

From <http://www.iwannaknow.org>, <http://www.mtv.com/onair/ffyr/protect/guide.pdf>, <http://www.youngwomenshealth.org>, <http://plannedparenthood.org/teen-talk>.

Genital Warts and HPV-Related Cancer

What is HPV?

- Human Papillomavirus (HPV) is a common virus that infects men and women. It is passed through sexual contact.
- The body usually fights off HPV before it causes any health problems.
- There are two types of the virus: wart-causing HPV and cancer-causing HPV. You can get one or both.
- Cancer-causing HPV can cause cervical cancer in women and anal cancer in both men and women.
- Warts caused by HPV may look like bumps of varying shapes and colors. The warts may disappear or return.

📢 HPV can be **Prevented** by getting vaccinated. **Using Condoms helps Prevent HPV** but not 100%.

At least **50%** of sexually active men and women will be infected with HPV.

How Can I Prevent HPV and its effects?

- There are vaccines that can prevent some of the common types of HPV. They are approved for both men and women. Ask your provider about it.
- Using condoms and other latex barriers every time you have sex helps lower chances of HPV exposure.
- Women over 21 should get regular pap tests to check for cervical cancer. If you're 21 talk to your provider about getting a pap test.
- If you have HPV, smoking can increase your risk of developing cervical cancer.

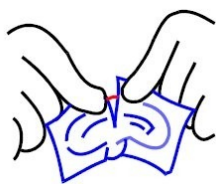
I might have HPV. What now?

- If you have what look like genital warts, get checked by your provider. If you have warts, your provider can recommend treatments to remove them from your genital area. **DO NOT TRY TO REMOVE THEM BY YOURSELF!**
- If you have one type of HPV you can still get other types. Keep using condoms to lower your chance of getting other types of HPV.
- Many people who have HPV want to know who gave it to them. There is no way to know for sure unless a person has had only 1 sexual partner.

📢 **Ask your Provider for more information on how you can Prevent or treat HPV.**

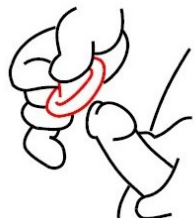
What You Need To Know About Condoms...

How to Put on a Condom



1 Before having sex...

- Discuss using condoms with your partner
- Buy latex or polyurethane condom
- Check the expiration date. Do not use an expired condom!
- Open condom package carefully. Don't use your teeth.



2 When the Penis is erect...

- Squeeze the air out of the tip of the condom and place rolled condom on the tip of the penis or dildo. If you use lube, add a couple drops of water-based lube inside the tip of the condom.
- Leave a half inch space at the tip of the condom to collect semen.
- Hold the tip of the condom and unroll it until the penis or dildo is completely covered.
- Smooth out the air bubbles and put more lube on the outside of the condom after putting it on.



3 After Ejaculation and when the Penis is still erect...

- Hold the condom at the base of the penis.
- Carefully remove the condom without spilling any semen.
- Wrap up the condom in tissue and throw it away. (Don't flush condoms down the toilet - the toilet might clog.)
- Use a new condom every 20 minutes or for every act of vaginal, oral, and anal intercourse from start to finish.



Condom Talk

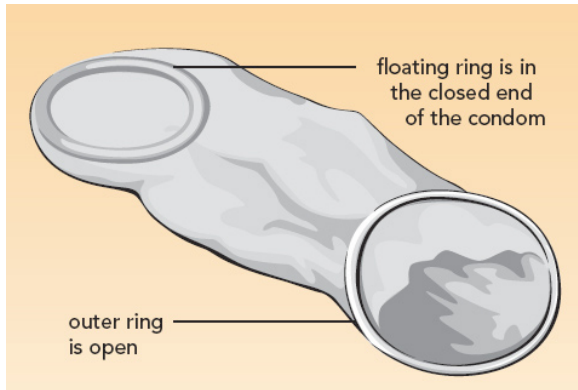
Talking about condoms can be a lot harder than learning how to use a condom. Here are some tips on how to bring up condoms with your partner:

- ★ Don't be shy. Be direct about your feelings. There's no reason to be embarrassed!
- ★ Don't wait until the heat of the moment to bring it up. Talk about condom use before you are in a situation where you might need one.
- ★ Don't be afraid of rejection. If a partner doesn't care enough about you to use a condom and protect your health, then she or he probably isn't worth your time. As 18-year-old Ari says, "If your partner turns condom use into a trust issue instead of a health issue, why would you want to have sex with that person anyway?"
- ★ Be positive! Many people find sex more enjoyable when they're protected because they don't have to worry about pregnancy and infections.
- ★ Talking about condom use is easier if you are in a healthy relationship that makes you feel good about yourself. And it gets easier with time, as well. But no matter what, it's very important to communicate with partners about condoms. It's all about protecting your health!

Reprinted with permission from Planned Parenthood® Federation of America, Inc. © 2009 PPFA. All rights reserved.

What You Need To Know About Female AKA Insertive Condoms...

How to Use a Female Condom



1 Before having sex...

- Talk to your partner about using a condom.
- Buy a female condom.
- Check the expiration date. Do not use an expired one!
- Carefully tear at the top right of the package. Never use scissors or your teeth.

2

When you are wet...

- Get into a comfortable position: sit, squat, lie down or raise one leg.
- Add extra lubrication inside condom so it will stay in place during sex.
- Grab the inner floating ring and squeeze it with the thumb and pointer finger.
- Take one hand and spread out the lips of your vagina.
- Put the pointer finger of your other hand in the condom push the inner ring in your vagina as far as it will go. You can also use a sex toy to insert the condom.
- Make sure the condom is not twisted. The outer ring should be sticking outside of the vagina.
- Hold onto the outer ring while having sex to make sure the condom doesn't get pushed into the vagina.



3

After sex while you are lying Down

- Twist the outer ring and carefully pull it out.
- Put it in the wrapper and throw away, but don't flush — toilet will get clogged.
- Use a new condom for every act of vaginal and anal intercourse.

A Word About the Female Condom...

- ✦ Is also called the “insertive condom” because it is used internally.
- ✦ Can be used in the anus. The ring can be taken out or left in for prostate stimulation.
- ✦ Can be used by people with latex allergies because it is made out of polyurethane.
- ✦ During vaginal sex, the outside ring rubs against the clitoris. This can make having an orgasm easier.

Do I Need a Period Every Month?

Sometimes, your period can come at the worst times, like before a sporting event, party, or night out with your boyfriend/girlfriend. For years, women have used birth control pills to stop their periods for important events and vacations.

Most forms of hormonal birth control (the pill, patch or ring) can be used to stop a women's period, but it is **VERY IMPORTANT** that you talk with your healthcare provider before making any changes in the way you use your birth control. There are even brands of birth control pills packaged to take for 3 months or even a year without having a period. For more information about stopping your periods, talk to your health care provider.

What are the Benefits of Skipping your Period?

- ✓ Less pain with monthly bleeding
- ✓ Less heavy bleeding
- ✓ Fewer PMS symptoms
- ✓ Reduced menstrual migraines and acne
- ✓ An increased feeling of well-being

Do I have to Bleed every month?

There is no evidence that shows women need to bleed monthly. Studies have found that using the pill for two or more cycles in a row without taking the sugar pills is safe and effective. It prevents pregnancy just as well as taking the pill in the usual way.

What are the side effects or Disadvantages of skipping your Period?

Some women have breakthrough bleeding or spotting in the first few months. This is less common once your body has gotten used to the new routine. Blood from spotting may be dark brown from being in the uterus longer.



Just like when you take Pills in the usual way, you should Contact a health Care Provider if you experience ACHES— ABDominal Pain, Chest Pain, Heavy Bleeding, Eyesight or vision Changes, or Severe leg Pain.

Adapted with permission from ARHP Health Matters Fact Sheet: Understanding Menstrual Suppression

I'M PREGNANT, WHAT SHOULD I DO?

Choosing what to do when you are pregnant is difficult and none of the options is the “easy” or “right” choice. Each choice comes with its own set of challenges. Consider all your options and how each one will fit with your life and beliefs. When possible, talk this over with your parent(s) or another trusted adult. Your health care provider can also assist you in learning about and discussing your options.

WHAT ARE YOUR CHOICES?

1. Parenting

Being a parent is a hard job for anyone. It can be even harder if you are a young parent. It is a 24-7 responsibility for at least 18 years. These questions may help you think about whether or not you want to be a parent at this time in your life:

- Where will you live?
- What will you do about money? How will you support yourself and your child?
- What will you do about school?
- Who will provide childcare while you are at work or school?
- What do you want out of life for yourself? What do you think is important?
- What are your goals and how will you meet them? (a college degree, a job, a family?)
- How will having a baby change your social life?
- How will the baby’s father be involved in your pregnancy and parenting?

2. Abortion

If you are not ready to be a parent or go through a pregnancy, abortion might be something to consider. An abortion is a medical procedure that ends a pregnancy. Your health care provider can tell you the names of providers and



Image reproduced with permission by Pro-Choice Public Education Project. Copyright © 2005

clinics that are covered by your insurance plan. You can also call Planned Parenthood to discuss this option further or visit their website (see the resources box above).

If you have had an abortion, you may consider calling Exhale, a counseling service for women who have experienced abortions, at 1-866-4-EXHALE. Visit their website at www.4exhale.org.

3. Adoption

Adoption is another choice if you do not want an abortion but are not ready to become a parent. There are a lot of different types of adoption. In an open adoption, you know who the adoptive parents are. In a closed adoption, you do not know who they are. For more information about adoption, call the National Council for Adoption hotline, 1-866-21-ADOPT. Also check out <http://www.childwelfare.gov/adoption/> for more information and resources.

RESOURCES

For even more information about your options and the experiences of other teens who have gotten pregnant, visit or call:

- Stay Teen
<http://www.stayteen.org/>
- Planned Parenthood
<http://www.plannedparenthood.org/teen-talk/>
800-230-PLAN
- Sex, Etc.
<http://www.sexetc.org/>

Safe Haven Laws

The Safely Surrendered Baby Law lets you confidentially give up you baby. The baby must be 72 hours old or younger. As long as the baby has not been hurt, parents may give up their newborn and not get in trouble or arrested.

<http://www.nationalsafehavenalliance.org>

How to Talk with Your Children and Teens about Healthy Relationships

- ◆ Talk to your children and teens about friendship, dating, and love *before* they start to ask questions about these important issues.
- ◆ Listen to your children and teens and try to understand their point of view.
- ◆ If you can't answer a question, help your children talk to other trusted adults.
- ◆ Use daily experiences like watching TV, to talk with your children and teens. It is a chance to share your values and messages with them.
- ◆ Find out what schools are teaching your children and teens about these topics.
- ◆ Stay active in the lives of your children and teens and help them plan for the future.



Know and practice the messages that you want to share with your children and teens.

Use the information below to make your messages clear.

Message Information For Ages 12-15:

- ◆ Friends can influence each other in positive and negative ways.
- ◆ People can be friends without being sexual.
- ◆ People are ready to start dating at different times.
- ◆ When couples spend a lot of time together alone, they are more likely to become sexually involved.
- ◆ If someone pays for a date or gives gifts, it does not mean that they are owed sexual activity.
- ◆ In a love relationship, people help each other to grow as individuals.
- ◆ People may mix up love with other strong emotions like jealousy and control.

Message Information For Ages 15-18:

- ◆ Dating can be a way to learn about other people and what it is like to be in a love relationship. It is also a way to learn about romantic and sexual feelings.
- ◆ Being honest and open can make a relationship better.
- ◆ Both people in the relationship are responsible for it.
- ◆ A dating partner cannot meet all of the needs of another person.
- ◆ A lot of time, love changes during a long term relationship.

Keep these talks going! When you talk about relationships with your teen, you can hear about what is going on in your teen's life. You can also teach your teen about your family's values and beliefs.

Adapted from SEICUS. Families Are Talking; Volume 3, Number 1, 2004.

Should I Worry About My Teen?

The Facts about Teen Dating Violence:

Teen dating violence is when a teen:

- ⇒ Hits, punches, slaps, or kicks their partner.
- ⇒ Forces or pressures their partner to have sex.
- ⇒ Teases, controls, or intimidates their partner.
- ⇒ Isolates their partner from friends and family.
- ⇒ Stops their partner from doing normal activities.

⚡ Warning signs for Teen Dating Violence ⚡

Know the warning signs of when a teen is being abused or is abusing others. Ask yourself the following questions:

Has your teen or your teen's dating partner...

- ▶ Lost interest in activities that used to be enjoyable?
- ▶ Stopped hanging out, talking on the phone, or staying in contact with friends?
- ▶ Acted extremely jealous?
- ▶ Violently lost their temper and hit or broke objects?
- ▶ Tried to control their partner's behavior?
- ▶ Check up constantly on their partner and demand to know who their partner is with?
- ▶ Had a sudden change in weight, appearance, or school performance?
- ▶ Had injuries that cannot be explained, or gave an explanation that did not make sense?

If you notice any of the above warning signs, talk with your teen about his/her relationship. Try and stay supportive and non-judgmental. Contact a domestic violence agency or call 1-800-799-SAFE for advice on the situation.

Did you know there are ways to prevent teen dating violence? Here are some of the things that help:

- Talk to your teen about their friends and relationships.
- Listen to your teen and be open to their experiences.
- Support your teen in pursuing their interests.
- Help your teen get involved in school and after school programs such as clubs and sports.
- Encourage your teen to join religious, spiritual, or community groups.
- Assist your teen with volunteering in the community.

Source:

Liz Claiborne, Inc, National Teen Dating Violence Helpline, Love Is Respect.org: A Parent's Guide to Dating Violence: Questions to Start the Conversation.

Parent-Child Communication

Many parents freeze when they are faced with talking to their children about sex.¹ Many teens prefer to talk to their parents rather than doctors about sex. It can feel awkward, but you can help your child make healthy choices. They need you, and if you are not talking to them, somebody else will. Think about what you want them to know.

Why should you talk to your child about sex?

- ▶ Teens who feel connected to their home and families wait to have sex.²
- ▶ Teens whose parents talk to them about condoms are more likely to use them.³
- ▶ Teens who said they talked to their parents about sex are more likely to use contraception.⁴
- ▶ Teens who have talks with their parents about sex are more likely to have talks with their partners about sex.⁵
- ▶ Teens whose parent talk to them about their sexual orientation have lower risk for STIs, including HIV.⁶

It's not just what you say, but how you say it. Healthy communication means:

- ▶ Openness to all topics and ideas.
- ▶ Each party talks and also listens.
- ▶ Being warm and caring.
- ▶ Trying not to fight.



↳ Tips for Talking with Your Teen

- ☑ Even if your teen does not want to talk, let them know there is an open door if and when they do.
- ☑ Many teens are afraid that they will disappoint their parents. Praise your teen's healthy choices. This may lessen these fears.
- ☑ If your teen comes to talk to you about something, as scary as it may be, do not run away or simply tell them not to have sex. This may be perceived as uncaring or discomfort and can set the stage for how they think you will respond every time.
- ☑ Make the most of 'learning moments'. Learning moments are when something you and your child see can be used as a chance to start a talk. For example:
 - ▶ When you and your child see a sex scene in a movie or on television, or when you see a sexual advertisement
 - ▶ When a young person or adult you both know gets pregnant.

¹The Media Project, a project of Advocates for Youth. Parent-Child Communication: Helping Teens Make Healthy Decisions about Sex. 2002.

²Resnick, MD et al. Protecting Adolescents from Harm: Findings from the National Longitudinal Study on Adolescent Health, JAMA; 1997; 278:823-32.

³Miller, KS et al. Patterns of Condom Use Among Adolescents: The Impact of Mother-Adolescent Communication. American Journal of Public Health 1998; 88: 1542-44.


⁴Hacker, KA et al. Listening to Youth: Teen Perspectives on Pregnancy Prevention. Journal of Adolescent Health 2000; 26: 279-88.

⁵Whitaker, DJ et al. Teenage Partners' Communication About Sexual Risk and Condom Use: The Importance of Parent-Teenager Discussions. Family Planning Perspectives; 1999; 31(3): 117-21.

⁶Ryan C. Supportive families, healthy children: Helping families with lesbian, gay, bisexual & transgender children. 2009; San Francisco, CA: Marian Wright Edelman Institute, SF State University.

Sex, Technology & Your Teen

Technology	Sexual Use	Privacy Tips
<p>E-mail <i>Electronic letters that are sent with computers or cell phones. Pictures and other files can be attached to an email.</i></p>	<p>Emails can have sexual content. This content can either be sexual language or attached sexual pictures.</p>	<p>Email and all attachments can be widely forwarded, or sent to others. Talk to your teen about this privacy risk.</p>
<p>Instant Message (IM) <i>Real-time messages sent back and forth between two people with computers or cell phones.</i></p>	<p>IMs can have sexual content. This content can be sexual language.</p>	<p>To prevent forwarding IMs, your teen can set chats “off the record.” This means no record of the conversation will be saved. Text can still be copied and pasted.</p>
<p>Text Message <i>Short messages sent to someone’s cell phone from another cell phone. Pictures can also be sent through text messages.</i></p>	<p>Text messages can have sexual content. This content can be sexual language or attached sexual pictures.</p>	<p>Your teen can send anonymous text messages through services such as www.anontxt.com. This will keep their identity private.</p>
<p>Chat Rooms <i>A virtual room that allows people to chat back and forth in real-time.</i></p>	<p>Chats can have sexual content. Users can also be invited to chat in a private room.</p>	<p>Remind your teen to keep his/her identity private by choosing a screen name. A screen name is an alias or name different from your real name.</p>
<p>Social Networking Websites <i>Online websites that allow users to build a customized “profile” webpage. Profiles contain short biographical information along with pictures and interests. Users can become friends with other users and share information.</i></p>	<p>Social networking sites can be used to meet people for sexual relationships.</p>	<p>Your teen can control what profile information is viewed by the public. Talk to your teen about changing the privacy settings to limit viewers of their site. Remind your teen not to post phone numbers or home addresses publicly.</p>



An Update on Text Messaging:

Sexual text messaging (sending naked and partially naked pictures through texts) can be illegal in the US for minors. Some teens who have sent or received sexual text messages have been charged with child pornography. This can lead to expulsion from school, possible jail time or getting registered as a sex offender. Talk to your teen about the legal consequences of sexual text messaging.

Chart adapted from: Subrahmanyam, Kaveri and Patricia Greenfield. 2008. “Online Communication and Adolescent Relationships.” *The Future of Children*, 18(1), 119-146.

What Parents of Preteens/Adolescents Should Know About the HPV Vaccine

There are now vaccines that protect against some types of the human papillomavirus (HPV). HPV is the common virus that causes most cervical cancers and genital warts. The vaccine is a series of three shots.

- ☆ **The HPV vaccine is safe for males and females between the ages 9 to 26.** The HPV vaccine is usually given when girls are 11- or 12-years old. Currently, one of the vaccines is optional for boys.
- ☆ **It is best to get vaccinated before becoming sexually active.** This vaccine works best in girls/women who have not been exposed to HPV.
- ☆ **The vaccine work against certain types of HPV.** It is nearly 100% effective in girls/women who have not been infected with any of those types of HPV. It works by preventing precancers of the cervix, vulva, and vagina. It also prevents genital warts.
- ☆ **The vaccine is a series of three shots over a six-month period.** It is very important that she/he receive all three shots. It is not yet known how much protection she would get from receiving only one or two shots of the vaccine.
- ☆ **The vaccine causes no serious side effects.** The most common side effect is soreness where the shot was given.
- ☆ **The HPV vaccine costs about \$120 per dose (\$360 for the series).** You may be able to get it for free or at low-cost. Check with your health insurance plan or federal or state programs. The vaccine is free through the Vaccines for Children (VFC) program. You can also get more information about these programs at your provider's office or the local health department.

What Is HPV and What Are Its Health Effects?

HPV is passed on during sex. There are about 40 types of HPV that can infect the genital areas of men and women. Most sexually active adults get HPV at some time in their lives. Most never know it because HPV usually has no symptoms and goes away on its own. But:

- ⇒ Some types of HPV can cause cervical cancer in women.
- ⇒ Other types of HPV can cause genital warts.



Adapted with permission from What Parents of Preteens/Adolescents Should Know About the HPV Vaccine, CDC.

Supporting Your Pregnant and Parenting Teen

Finding out that your child is pregnant or made someone pregnant can cause you to feel a wide range of emotions. If your teen has made the decision to become a parent, the following tips raise considerations to help you and your family through the challenges that lie ahead.

- **It is normal to feel angry, disappointed and overwhelmed.** Just remember that your teenager needs you now more than ever. Being able to communicate with each other – especially when emotions are running high – is essential to the health of your teen.
- **Explore resources available to your son or daughter and your family.**
- **Stay involved with the pregnant teen’s medical treatment.** The earlier your teen gets prenatal care, the better her chances are for a healthy pregnancy.
- **When the baby is born, remember you are the grandparent to that child, not the parent.** This may be especially difficult if they live with you, but it is important to support your son or daughter in parenting the newborn.
- **Help financially if you are able to, but also remember that as a parent, you are not financially responsible for the child.** Encourage your son or daughter to find a part-time job and be as financially responsible for the child as possible. This is sometimes very difficult for a full-time student and parent, but in the long run it will be best for the new family.
- **Communicate with your other children early about sexuality, pregnancy and STIs.** Sisters of teenage parents are more likely to become pregnant at a young age.
- **Find someone outside the situation that you can talk to.** This is a difficult situation, and you will be a better parent and grandparent if you have your own support system for handling the issues involved.



Image reproduced with permission by Pro-Choice Public Education Project. Copyright © 2005

SUPPORTING YOUR TEEN DAUGHTER

- ▶ Keep in mind that this is the pregnant teen’s decision. Do your best to respect the decisions that she makes.
- ▶ Encourage the involvement of the baby’s father and his family.
- ▶ If your daughter decides to continue the pregnancy, encourage and help her to stay in school so that she can secure a better job and create a better life for herself and the baby. Go to the school and assist your daughter if there are school related issues. Explore school and community programs that offer special services for teen mothers, such as child care, rides, or tutoring.

SUPPORTING YOUR TEEN SON

- ▶ Support him in taking responsibility for his actions, both financially and emotionally.
- ▶ Encourage your son to take interest in the pregnancy. Encourage your son to be available for appointments and read about pregnancy. Encourage him to also set aside time for the weeks leading up to the birth.
- ▶ Encourage your son to understand his legal rights and responsibilities surrounding fatherhood.

INTERNET RESOURCES: Click on This!

GENERAL SEXUAL HEALTH

- ★ **Association of Reproductive Health Professionals (ARHP)**, www.arhp.org/
 - 🏠 Contains information on many sexual health topics. Also has a section on adolescent sexual health.
- ★ **Go Ask Alice**
www.goaskalice.columbia.edu
 - 👂 Provides extensive information on sexual health and relationships.
- ★ **Kaiser Family Foundation (KFF)**
www.kff.org
 - 🏠 Contains general health information and also provides fact sheets and summaries on adolescent sexual health.
- ★ **Physicians for Reproductive Choice and Health (PRCH)**
www.prch.org
 - 🏠 Provides information on sexual health care for providers in the form of minor access cards, policy statements and fact sheets.
- ★ **Planned Parenthood**
www.plannedparenthood.org, www.plannedparenthood.org/teen-talk
 - 🏠 👂 👤 Provides healthcare, sex education and advocates for sexual and reproductive health. Teen-Talk is the youth-oriented version of the site.
- ★ **Scarleteen**
www.scarleteen.com
 - 👂 👤 Provides information about sexual health based on requests from youth.
- ★ **Sex, Etc.**
www.sexetc.org
 - 👂 Provides informal information about sexual health online. They also have a large glossary on many different sex terms.
- ★ **Sexuality Information and Education Council of the United States (SIECUS)**
www.siecus.org
 - 🏠 👂 Provides resources for providers and youth on adolescent sexuality, STIs and reproductive health. They focus on sexual and reproductive health research and policy analysis.

- ★ **Young Women's Health**
www.youngwomenshealth.org
 - 👂 Comprehensive website addressing female sexual and general health issues.
- ★ **Young Men's Health**
www.youngmenshealthsite.org
 - 👂 Comprehensive website addressing male sexual and general health issues.



HEALTHY RELATIONSHIPS

- ★ **CDC, Healthy Relationship Website**
<http://www.cdc.gov/Features/ChooseRespect/>
 - 👂 👤 Contains fact sheets and an article on aspects of a healthy relationship and identifying when intimate partner violence is taking place.
- ★ **Choose Respect**
www.chooserespect.org
 - 👂 👤 Contains articles on building a healthy relationship and understanding the difference between a healthy and unhealthy relationship.
- ★ **Love is Respect**
www.loveisrespect.org
 - 👂 Contains interactive quizzes, an application that allows teens to make movies on healthy relationships and other resources on dating and violence.

🏠 = Resource for Providers 👂 = Resource for Youth 👤 = Resource for Parents

INTERNET RESOURCES: Click on This!

TEEN DATING VIOLENCE

- ★ **Teen Relationships**
<http://www.teenrelationships.org/>
👂 Provides informal resources on building a healthy relationship in the form of quizzes and forums that provide advice.
- ★ **Break the Cycle: Empowering Youth to End Domestic Violence**, www.breakthecycle.org
👂 Provides domestic violence and dating violence facts as well as information on the warning signs of abuse.
- ★ **Family Violence Prevention Fund**
www.endabuse.org/programs/teens
👂 👂 👂 Provides facts for teens and immigrant women on intimate partner violence, resource lists, and safety planning.
- ★ **Love is Not Abuse, Liz Claiborne Inc.**
www.loveisnotabuse.com
👂 👂 Contains informative handbooks, wallet cards, links to online resources and quizzes on teen dating violence.
- ★ **National Youth Violence Prevention Resource**
www.safeyouth.org
👂 👂 👂 This sector of the CDC provides fact sheets and information on violence in English and Spanish.

SEXUAL ABUSE

- ★ **Rape Abuse and Incest National Network**
www.rainn.org
👂 👂 👂 Provides information about sexual assault and abuse. Find information here on domestic violence, abuse, prevention, how to seek counseling, legal rights, and state and local sexual assault organizations.

SEXUAL PLEASURE AND FUNCTION

- ★ **Sexuality and U: What Is Sex?**
www.sexualityandu.ca/teens/what-5.aspx
👂 This site outlines different aspects of sexuality and sexual function.
- ★ **Good Vibes**
www.goodvibes.com
👂 Toy distributor that offers educational information about sex toys and lubricant ranging from cleaning recommendations to how toys can best be used for pleasure.

CIRCUMCISION

- ★ **Guttmacher Institute**
www.guttmacher.org
👂 Contains research articles on female circumcision and male circumcision.
- ★ **Kids Health**
www.kidshealth.org/parent/system/surgical/circumcision.html
👂 Provides information on the pros and cons of male circumcision. They also provide information on caring for circumcised and uncircumcised penises.

PREGNANCY PREVENTION

- ★ **The National Campaign to Prevent Teen and Unplanned Pregnancy**
www.thenationalcampaign.org/
👂 👂 The National Campaign provides resources on potentially negative adolescent sexuality outcomes in the form of reports and resources. They have an entire section of their website in Spanish.
- ★ **Stay Teen**
www.stayteen.org
👂 Sponsored by the National Campaign to Prevent Teen Pregnancy and offers informal information on building self-confidence, questions to ask yourself when falling in love and sexual decision-making.
- ★ **The Emergency Contraception Website**
www.not-2-late.com
👂 👂 Information about Emergency Contraception and where to obtain it.



👂 = Resource for Providers 👂 = Resource for Youth 👂 = Resource for Parents

INTERNET RESOURCES: Click on This!

PREGNANCY OPTIONS

- ★ **Backline**
www.yourbackline.org/
👂 This site provides information for pregnant women who need support making a decision to either abort or continue the pregnancy. Contains a pregnancy options workbook to assist in the decision-making process.
- ★ **Abortion Access**
www.abortionaccess.org
🏠 Abortion Access provides resources and information on challenges to accessing abortion in various states.
- ★ **Exhale**
www.4exhale.org
👂 This is a national organization that provides non judgmental post-abortion counseling through a nationwide, multilingual talkline.
- ★ **Planned Parenthood**
www.plannedparenthood.org
🏠 👂 🏠 Provides information of pregnancy options including details on the different types of abortion.

MALE INVOLVEMENT

- ★ US Dept of Health and Human Services
<http://fatherhood.hhs.gov/>
👂 🏠 Provides a list of resources spanning from pregnancy to legal services to promote responsible fatherhood regardless of the socioeconomic background.
- ★ The National Campaign to Prevent Unplanned Pregnancy
www.thenationalcampaign.org/resources/males.aspx
🏠 🏠 Contains policy briefs, and fact sheets on the importance of male involvement in pregnancy prevention and parenting.



STI/HIV INFORMATION

- ★ **Center for Disease Control (CDC)**
www.cdc.gov
🏠 👂 🏠 Contains STI screening and treatment protocols, fact sheets and resources in English and Spanish on various sexual and reproductive health topics.
- ★ **Iwannaknow.org**
www.iwannaknow.org
👂 🏠 Provides information to youth, parents and providers about STIs.
- ★ **American College of Obstetricians and Gynecologists (ACOG)**, www.acog.org
🏠 Provides screening recommendations and educational resources on sexual health for women and adolescent girls.
- ★ **American Society for Colposcopy and Cervical Pathology (ASCCP)**, www.asccp.org
🏠 Provides educational resources and materials on HPV and cervical cancer screenings for women and girls.
- ★ **U.S. Preventive Services Task Force (USPSTF)**
<http://odphp.osophs.dhhs.gov/pubs/guidecps/uspstf.htm#USPSTF>
🏠 Website for a government appointed panel that provides recommendations on testing and screenings. Their recommendations cover adolescent sexual health.
- ★ **Adolescent AIDS**
www.adolescentaids.org
👂 HIV educational materials for youth.
- ★ **The Body**
www.thebody.com
🏠 👂 🏠 Contains online resource for HIV/AIDS.

YOUTH OF COLOR

- ★ **MySistahs**
www.mysistahs.org
👂 This site is created by and is for young women of color. Contains information and support on sexual and reproductive health issues.
- ★ **Ambiente Joven**
www.ambientejoven.org/
👂 A bilingual web site for gay, lesbian, bisexual, and transgender Latino/a youth. Provides resources and other aid to an underrepresented community.

🏠 = Resource for Providers 👂 = Resource for Youth 🏠 = Resource for Parents

INTERNET RESOURCES: Click on This!

LGBT YOUTH

- ★ **Gay, Lesbian and Straight Education Network**
www.glsen.org
🏠 🎧 👥 Provides news, resources and links aimed at promoting school and community safety and respect for youth regardless of sexual orientation or gender identity.
- ★ **Youth Resource**
www.youthresource.com
🎧 A web site by and for gay, lesbian, bisexual, transgender and questioning (LGBTQ) young people, takes a holistic approach to sexual health and overall wellness.
- ★ **OutProud**
www.outproud.org
🎧 Offers tons of resources for queer youth including links to current relevant news headlines, support groups, online brochures, literature, magazines, and more.

YOUTH WITH DISABILITIES

- ★ **National Dissemination Center for Children with Disabilities**, www.nichcy.org
🏠 🎧 👥 A site maintained by the National Information Center for Children and Youth with Disabilities to help disabled youth learn from and connect with each other.
- ★ **Common Thread**
www.commonthread.org/home.html
🎧 👥 Provides community and support for young adults dealing with disability or illness and their parents, siblings and friends.
- ★ **The Adolescent Health Transition Project**
http://depts.washington.edu/healthtr/Teens/intro.htm
🎧 👥 Provides information and resources to help adolescents with special health care needs, chronic illness, physical and developmental disabilities become informed participants in their health care.
- ★ **Sexual Health Network**
www.sexualhealth.com/channel/view/disability-illness/
🏠 Provides information on how sexual health is impacted by a variety of disabilities both developmental and physical.

SEXUAL HEALTH ADVOCACY

- ★ **Advocates for Youth**
www.advocatesforyouth.org
🏠 🎧 👥 Provides act sheets are in English and Spanish. They have a sexual education center for parents and tip sheets for providers.
- ★ **Pro-Choice Public Education Project (PEP)**
www.protectchoice.org/
🎧 👥 Offers advocacy, and information on HIV-positive youth, in the form of an informal question and answer section on HIV and AIDS.
- ★ **Guttmacher Institute**
www.guttmacher.org
🏠 Provides resources on adolescent sexual and reproductive health. They focus on sexual and reproductive health research, policy analysis and public education. They provide fact sheets in English, Spanish and French and information on healthcare policies in each state.

TALKLINES AND HOTLINES

- ☎ **Planned Parenthood**
1-800-230-PLAN
Planned Parenthood Clinic locator.
- ☎ **Gay, Lesbian, Bisexual, Transgender (GLBT) National Youth Talkline, GLBT National Help Center**
1-800-246-PRIDE
Mon to Fri 5-9 PM (Pacific Time), English
Confidential peer counseling on coming-out issues, relationships concerns, school problems, HIV/AIDS anxiety, and safer sex.
- ☎ **National Teen Dating Abuse Helpline**
1-866-331-9474 (TTY: 1-866-331-8453)
24/7, English
Free and confidential helpline and online chat room for teens (13 to 18 years old) who experience dating violence or abuse.
- ☎ **RAINN: Rape, Abuse & Incest National Network**
1-800- 656- HOPE
24/7, English and other languages
Connects callers to their nearest rape crisis center to speak with a counselor.
- ☎ **National AIDS Hotline**
1-800-342-AIDS (Spanish: 1-800-344-SIDA)
24/7, English; 8AM-2AM, Spanish
Information and referrals to local hotlines, testing centers, and counseling

🏠 = Resource for Providers 🎧 = Resource for Youth 👥 = Resource for Parents



©Adolescent Health Working Group, 2010



Sexual and Reproductive Health Care for Foster Youth: Minor Consent Law in California

FOSTER YOUTH OF ANY AGE MAY CONSENT	LAW/DETAILS	MAY/MUST THE HEALTH CARE PROVIDER INFORM A SOCIAL WORKER OR CAREGIVER ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?
PREGNANCY	“A minor may consent to medical care related to the prevention or treatment of pregnancy,” except sterilization. (Cal. Family Code § 6925).	The health care provider is not permitted to inform a social worker or caregiver without the minor’s consent. The provider can only share the minor’s medical information with them with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).
CONTRACEPTION	“A minor may consent to medical care related to the prevention or treatment of pregnancy,” except sterilization. (Cal. Family Code § 6925).	
ABORTION	A minor may consent to an abortion. (Cal. Family Code § 6925; <i>American Academy of Pediatrics v. Lungren</i> , 16 Cal.4 th 307 (1997)).	The health care provider is not permitted to inform a social worker or caregiver without the minor’s consent. The provider can only share the minor’s medical information with them with a signed authorization from the minor. (<i>American Academy of Pediatrics v. Lungren</i> , 16 Cal.4 th 307 (1997); Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).
SEXUAL ASSAULT¹ SERVICES and RAPE² SERVICES FOR MINORS UNDER 12 YRS³ <p>²Rape is defined in Cal. Penal Code § 261. ³See also “Rape Services for Minors 12 and Over” on page 3 of this chart ¹For the purposes of minor consent alone, sexual assault includes acts of oral copulation, sodomy, and other crimes of a sexual nature.</p>	<p>“A minor who [may] have been sexually assaulted may consent to medical care related to the diagnosis,...treatment and the collection of medical evidence with regard to the ...assault.” (Cal. Family Code § 6928).</p>	<p>The health care provider must attempt to contact the minor’s guardian and note in the minor’s record the day and time of the attempted contact and whether it was successful. This provision does not apply if the treating professional reasonably believes that the parent/guardian committed the assault. (Cal. Family Code § 6928).</p> <p>Both rape and sexual assault of a minor are considered child abuse under California law and must be reported as such to the appropriate authorities by mandated reporters following mandated reporting procedures. Reporting to a youth’s child welfare case worker does not satisfy this obligation. (See Cal. Penal § 11167 and 11167.5.)</p>

MINORS 12 YEARS OF AGE OR OLDER MAY CONSENT	LAW/DETAILS	MAY/MUST THE HEALTH CARE PROVIDER INFORM A SOCIAL WORKER OR CAREGIVER ABOUT THIS CARE OR DISCLOSE RELATED MEDICAL INFORMATION TO THEM?
<p align="center">SEXUALLY TRANSMITTED DISEASES (PREVENTIVE CARE, DIAGNOSIS, TREATMENT)</p>	<p>A minor 12 years of age or older who may have come into contact with a sexually transmitted disease may consent to medical care related to the prevention, diagnosis or treatment of the disease. (Cal. Family Code § 6926).</p>	<p>The health care provider is not permitted to inform a social worker or caregiver without the minor’s consent. The provider can only share the minor’s medical information with them with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).</p>
<p align="center">RAPE SERVICES FOR MINORS 12 and OVER</p>	<p>“A minor who is 12 years of age or older and who is alleged to have been raped may consent to medical care related to the diagnosis or treatment of the condition and the collection of medical evidence with regard to the alleged rape.” (Cal. Family Code § 6927).</p>	<p>The health care provider is not permitted to inform a social worker or caregiver without the minor’s consent. The provider can only share the minor’s medical information with them with a signed authorization from the minor. (Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).</p> <p>Both rape and sexual assault of a minor are considered child abuse under California law and must be reported as such to the appropriate authorities by mandated reporters following mandated reporting procedures. Reporting to a youth’s social worker does not satisfy this obligation. (See Cal. Penal § 11167 and 11167.5.)</p>

Provider Bias in Long-Acting Reversible Contraception (LARC) Promotion and Removal: Perceptions of Young Adult Women

Jenny A. Higgins, PhD, MPH, Renee D. Kramer, MPH, and Kristin M. Ryder, MA, MPH, CHES

Long-acting reversible contraception (LARC) is effective and acceptable. However, concern exists about potential provider bias in LARC promotion. No study has documented contraceptive users' attitudes toward or experiences with provider influence and bias regarding LARC.

We collected qualitative data in 2014 to address this gap. Participants were 50 young adult women with any history of contraceptive use (including LARC) in Dane County, Wisconsin. Women often described providers as a trusted source of contraceptive information. However, several women reported that their preferences regarding contraceptive selection or removal were not honored. Furthermore, many participants believed that providers recommend LARC disproportionately to socially marginalized women.

We encourage contraceptive counseling and removal protocols that directly address historical reproductive injustices and that honor patients' wishes. (*Am J Public Health*. 2016;106:1932–1937. doi:10.2105/AJPH.2016.303393)

One of the most significant reproductive health developments of the past decade is the rise in use of long-acting reversible contraception (LARC). For at least 3 reasons, LARC methods, which include intrauterine devices (IUDs) and implants,¹ can be welcome options for many people who wish to prevent pregnancy. First, people who use contraception tend to prefer IUDs and implants at higher rates than they do other methods.² Second, IUDs and implants are much more effective than other contraceptive methods.³ Third, LARC methods are also cost-effective.⁴ These benefits mean that increasing knowledge of and access to these methods is both a public health and a social justice imperative. Across age groups, racial/ethnic groups, and social classes, many people still do not know about or have access to these methods.^{5–8}

However, it is critical to take a user-centered approach to increasing LARC knowledge and access. Reproductive justice supporters have described a variety of ways LARC methods might be promoted or practiced in socially unjust ways, particularly among poor women of color. Some argue that policymakers' enthusiasm about LARC may pertain more to lowering certain groups' birth rates than to improving women's lives.^{9,10} Others fear that promoting LARC over all other methods could threaten the reproductive

autonomy of the most socially marginalized women.¹¹ (A recent analysis by Kavanaugh et al. showed that 11% of Whites, 9% of Blacks, 15% of Hispanics, and 11% of women of other races were using LARC as their current contraceptive method; in multivariate models, Black women were significantly less likely to have used LARC than White women.¹² However, the authors did not have sufficient power to run separate regressions by race. More complicated racial patterns may emerge when race is treated not as a control variable, but as a potential context in which people use or do not use LARC.)

Although outright coercion may be unlikely, subtler biases shape the ways in which race and class influence women's contraceptive decision-making and patient-provider interactions.¹³ For example, evidence suggests that providers recommend IUDs and implants more to poor women of color than to poor White women and more to poor White women than middle-class women.¹⁴ Finally, historical reproductive injustices—from forced sterilizations to Norplant

insertion in exchange for welfare benefits—could lead communities of color to perceive well-intended IUD and implant programs as engaging in racial targeting.^{15,16}

Despite these concerns, no study to our knowledge has documented contraceptive users' perspectives on LARC-related provider influence and potential bias. To bridge this gap, we use qualitative data to describe 50 contraceptive users' perceptions of provider influence and bias, mostly in relationship to LARC but also (when relevant) to other contraceptive experiences.

METHODS

We derived our data from a qualitative study of IUD and implant use among 18- to 29-year-old women³ in Dane County, Wisconsin, a semiurban area of approximately 500 000 inhabitants and home to the University of Wisconsin–Madison. (Although all of the participants in our study identified as women, we recognize that not all

ABOUT THE AUTHORS

Jenny A. Higgins is with the Department of Gender and Women's Studies, University of Wisconsin–Madison. Renee D. Kramer is with the Department of Population Health Sciences, University of Wisconsin–Madison. At the time of the study, Kristin M. Ryder was with the Department of Health Behavior and Health Education, University of Michigan, Ann Arbor.

Correspondence should be sent to Jenny A. Higgins, PhD, MPH, 3309 Sterling Hall, 475 North Charter St, University of Wisconsin, Madison, WI 53706 (e-mail: jenny.a.higgins@wisc.edu). Reprints can be ordered at <http://www.ajph.org> by clicking the "Reprints" link.

This article was accepted July 14, 2016.

doi: 10.2105/AJPH.2016.303393

contraceptive users do so. We encourage the development of LARC programs and services that are inclusive of transgender and gender-queer individuals.) Approximately 13% of the county's residents live below the federal poverty level (compared with 15% nationally), and 19% are people of color (compared with 23% nationally).¹⁷ The purpose of the larger study was to assess barriers to and facilitators of LARC use among young adult women in Dane County and at the university. Because the role of providers emerged so strongly over the course of the study, we conducted a closer analysis of the data pertaining specifically to provider influence and bias.

In phase 1 of the larger study, investigators conducted focus groups with women who had any history of contraceptive use. These focus groups were designed to explore young adult women's LARC-related knowledge and attitudes, as well as various factors associated with LARC acceptability and access.¹⁸ We also conducted 12 one-on-one interviews with former or current LARC users to more deeply explore personal experiences with these methods (phase 2).

To ensure socioeconomic diversity among participants, we designed a stratified sampling frame: one third of focus groups and interviews were conducted with current university students, and two thirds were conducted with women from the community who were currently receiving at least 1 form of public assistance. We were interested in lower-income individuals given their increased likelihood of unintended pregnancy,¹⁹ whereas university students were of interest for a related research project. We selected a participant age range of 18

to 29 years given this group's disproportionate burden of unintended pregnancy¹⁹ and comparatively low likelihood of using LARC.²⁰ Although race and ethnicity were not part of our sampling frame, we strove for racial/ethnic diversity among both the university and community respondents.

Recruitment and Data Collection

The study's data collection and recruitment procedures have been described in detail elsewhere²¹; what follows is a brief summary. To recruit participants, study team members posted and distributed flyers in university buildings, public libraries, health clinics, bus shelters, and Job Corps offices. Recruitment e-mails were circulated to public health departments and other pertinent health and social organizations. Information about the study also appeared in the Craigslist community volunteer and "etc." jobs sections. Some participants were referred by friends or family members who qualified for the study. All of the participants were screened via telephone.

Data collection took place between January and June 2014. We conducted 6 focus groups with 40 women who had any history of contraceptive use; of these women, 8 had used an IUD and 2 had used an implant. Focus groups included 4 to 10 participants and were between 1.5 and 2.5 hours in duration. Interviews, which were conducted with women who had any history of LARC use, were between 25 and 55 minutes in duration, with a mean length of about 50 minutes. At the conclusion of the focus group or interview, university participants received \$20 gift cards

and community participants received \$30 gift cards. All focus group sessions and interviews were audio-recorded and transcribed.

Analysis

We used an inductive, modified grounded theory approach in analyzing the data, meaning that we drew on preexisting themes from the literature and research questions as well as themes arising from the data. For the purposes of our analysis, study team members applied a "provider" code to all sections of the transcripts pertaining to health care professionals who provide contraceptive services. The first and second authors reviewed the coding reports and met to compare and confirm a list of subthemes, which became the basis of the results described subsequently.

To conduct descriptive and analytic cross-case analyses,²² the second author reviewed the coding reports a second time and created a theme-based matrix to assess differences, if any, across the following groups: LARC ever users versus never users, White respondents versus respondents of color, and university students versus women in the community currently receiving public assistance. Because we found few differences between groups, we largely describe commonalities across respondents. We draw distinctions between racial groups only in 2 relevant cases (under the first and third themes described subsequently).

RESULTS

Table 1 provides an overview of the 50 women who participated in the study: 23 current

university students and 27 women from the community who were currently receiving at least 1 form of public assistance. About two fifths ($n = 21$) had had any prior experience with LARC methods. About three fifths ($n = 32$) identified as White alone, and 18 women identified as Black, Latina, Asian, Native American, or biracial.

In the sections to follow, we present 4 themes related to provider influence and bias that emerged from the analyses. Although all of the data derived from the study focused specifically on LARC, some participants also shared relevant stories related to experiences with other patient-provider interactions associated with contraceptive use. Quotations from focus groups are not fully comparable to quotations from interviews as units of analysis, given the inherently different dynamics of these two data collection mechanisms. However, given the exploratory nature of our study, as well as the fact that focus group participants did share both personal and anecdotal stories (as opposed to merely attitudes and larger social norms), we mix both interviewee and focus group data in our presentation of results. All participant names are pseudonyms.

Providers as Trusted Source of Information

Many women, especially White respondents, described health care providers as a trusted source of information regarding contraceptives and LARC methods in particular. For example, when asked "Whose opinion matters most to women as they choose contraceptive methods, including IUDs and

TABLE 1—Overview of Participant Characteristics: 18–29-Year-Old Women in Dane County, Wisconsin, With a History of Contraceptive Use, 2014

Characteristic	Focus Group Participants (n = 40), No.	Interview Participants (n = 12), No.	Total ^a (n = 50), No.
Status			
Current university student	19	4	23
Community resident receiving at least 1 form of public assistance	21	8	27
Race/ethnicity^b			
White	22	10	32
Black	5	1	5
Latina	6	...	6
Asian	3	...	3
Native American	2	...	2
Biracial	3	1	3
Highest level of education attained^c			
High school	2	...	2
Some college	24	6	29
College or more	12	4	15
Any history of intrauterine device or implant use	9	12	21

^aTwo focus group participants also participated in interviews, and thus the total sample size is 50 rather than 52.

^bTwo participants self-identified as being of more than 1 race.

^cFour participants omitted educational information.

implants?” most focus group participants mentioned providers first:

Certainly my doctor I would trust.

—Christy, White, never user, community focus group participant)

I feel like I would talk to a doctor. . . . I'd rather trust somebody who had a lot of experience.

—Suzanne, White, never user, university focus group participant

Trust could strongly influence women’s willingness to try IUDs and implants and could ameliorate concerns about these methods for potential users. For example, Madeline, a White LARC user and community interviewee, said that she initiated IUD use because her provider suggested it to her, even though she at first was wary about certain aspects of the device. “I trust him,” she said. “My provider is awesome.”

A minority of participants indicated that they were reluctant to trust health care providers regarding LARC recommendations. These participants were disproportionately women of color. For example, Sandra, a Latina university focus group participant who had not used an LARC method, said, “I actually really don’t trust providers. . . . So I go through other means of finding out what [contraceptive method] I want to be on.”

Removal and Other Patient Preferences Sometimes Unheeded

Despite the trust described by a number of participants, women also reported that their own preferences could be undervalued by providers when it came to contraception. Here we highlight 2 issues in particular: contraceptive selection and provider minimization of side effects,

especially in relationship to desired LARC removal. The former could pertain to contraceptive methods more broadly, whereas the latter was more specific to LARC methods.

In terms of the contraceptive decision-making process, some women said that providers’ preferences for particular methods could outweigh patients’ desires. For example, Josie, a White university interviewee and current IUD user, reported,

I was pressured to use NuvaRing a long time ago. And I hated it. And I knew I was going to hate it and I told them [my providers] I was going to hate it. But they were like “No, it’s the greatest thing ever. You’re never ever going to have a problem with it.” And I used it for a week and I absolutely hated it and took it out.

In Josie’s case, the stage may have been set for dissatisfaction given her provider’s singular promotion of a method she was

not interested in. Such an experience could also potentially undermine future trust in her care providers or lead to contraceptive decisions independent of a provider. (Josie made her own decision to initiate an IUD prior to any interaction with a care provider: “I Googled . . . kinds of birth control and then narrowed from there because I wanted to look into everything before I decided.” In a qualitative study of approaches to contraceptive counseling, Dehlendorf et al. found that women aged 25 years or younger were more likely than women aged 35 years or older to receive such “foreclosed” contraceptive counseling; that is, the provider discussing only those methods brought up by the patient and leaving decision-making to the patient.²³)

Some women reported feeling disrespected or patronized during provider–patient interactions regarding contraception. For example, Latina focus group participant Sandra, whose distrust of providers was just described, reported the following patient–provider interaction:

I went to the doctor and I didn’t even bring up the pill, and she was like “You know, you have to take it at the same time every day,” and I said “yeah.” “You have to take it at the same time every day at the same time, like not an hour after.” And I was like “yeah.” And she was like “same time every day.” Like she told me four times and I got so upset that I wanted to walk out. I was like “Are you kidding me? I’m not stupid. Stop it.”

Such experiences could undermine provider–patient trust and decrease women’s receptiveness to LARC recommendations from providers.

A substantial number of women reported provider minimization of side effects such as heavy cramping and bleeding, particularly if those side effects led

women to request the removal of the LARC device. For example, Dawnesha, a Black community interviewee and current implant user, reported several months' worth of difficult bleeding and cramping with her implant. She said,

I was telling the nurse how I been on my period for like 3 weeks now, and I'm having bad cramps, and I'm even having them in my back, which I never had before. And she was saying, "Just give it another month or so and see how it goes." . . . I was mad, but then I'm like, I'm just going to give it another try. They know best because they go to school for this stuff.

At the time of her interview, Dawnesha was still hoping to have her implant removed if her care providers would agree to it.

Heather, a White community interviewee who was a satisfied IUD user at the time of the interview, said that she had faced provider resistance when she wanted her IUD removed a month or slightly more after its insertion. She said,

I told them that I wanted it out and they said that it's really expensive and that the IUD's the best option. I got some resistance there. . . . I was a little emotional at the time and she [the provider] didn't even care, it seemed.

On one hand, Heather was a satisfied IUD user at the time of the study, so her symptoms had improved; on the other hand, she felt frustrated and disrespected during that particular patient-provider interaction.

Elizabeth, a White community interviewee, encountered similar resistance when seeking the removal of her first IUD, ParaGard, after experiencing significant bleeding and cramping. She reported,

My provider was really hesitant to remove the ParaGard. She kept

telling me, "Well, we should wait 3 months and see if your symptoms have worsened." And I waited 3 months and she's like "Well, you should wait some more." And I'm like "No. So take it out or I'm going to a different doctor. Those are your options."

Elizabeth was finally able to get her ParaGard removed, and she went on to get a Mirena, with which she was satisfied at the time of the interview. However, she reflected that many patients may not be able to harness as much agency or "feistiness" when pushing back on providers' recommendations. She also reflected on institutional or peer pressures that might shape providers' LARC practices. She said,

I don't know if it makes them [providers] look bad if you have an IUD removed and they're the one who placed it, or I don't know if they have some stat chart somewhere, like a contest board in the breakroom.

By contrast, some women received assurances from their provider about LARC removal. For example, Kelli, a White IUD user and community interviewee, reported that "I remember my providers saying, 'You know, if you do want it out any time before the 5 years, just make an appointment and we can take it out.'" Such assurances from providers appeared to increase women's willingness to try LARC methods. They could also help women "stick it out" with side effects such as bleeding and cramping, which are likely to decrease over time.

Prior Reproductive Injustices' Role

Women shared their personal experiences with provider pressure regarding LARC but also identified the potential for provider bias based on social and

reproductive factors. When asked "Do you think providers are more likely to recommend IUDs and implants to some groups more than others?" a number of participants, especially White participants, mentioned clinical or reproductive characteristics, particularly multiparity (i.e., a history of 2 or more full-term pregnancies). However, participants across racial groups also cited the potential for racial and socioeconomic bias in provider recommendations. Women expected that providers would be more likely to recommend IUDs and implants to women of color, poor women, and women deemed uneducated or unintelligent by providers. For example:

Young African American women are more pressured [to use LARC] from my point of view. Even if they're in a responsible relationship or state of mind or set of circumstances, or even if they're just going in for education, providers can be very judgmental.
—Loretta, African American, IUD user, community focus group participant

I can definitely see providers maybe pushing for the long-term method more with poorer women.
—Kelli, White, IUD user, community interviewee

I think probably minorities and lower-income people could be more likely to be pressured [to use LARC].
—Marissa, White, IUD user, community interviewee

Women across racial groups, both from the community and from the university, linked these potential biases to historical reproductive injustices such as forced sterilizations and eugenic social policies. For example, when asked about whether providers might recommend LARC

methods more to some women than others, White community interviewee Elizabeth responded,

Historically there have been government efforts to actually sterilize Native Americans and Black women because they didn't want those populations growing. There's this sort of idea, "because you're poor we can't trust you to make good decisions about birth control and so we're going to make that decision for you."

One participant linked historical injustices to her own unwillingness to try a particular LARC method:

In school, we learned a lot about the Norplant implant and how women of color were specifically targeted for that. I don't know if that's still the case, or what happened with that, but because of that I'm really anti-implant.
—Heidi, White, never user, community focus group participant

As these examples suggest, White women cited historical reproductive injustices and then linked these injustices to LARC promotion. However, women of color were more likely to describe prior injustices in a way that personally affected them and their communities and that increased their wariness of LARC recommendations as a result. For example, African American focus group participant Loretta, quoted earlier, described how she had seen cousins and nieces "lectured to" about birth control by providers "even when they were responsible." And Sandra (the Latina university focus group participant quoted earlier), who had never used an LARC method, reported,

Birth control in general makes me really wary because it was meant

to keep people like me from procreating and having more of us, right? . . . I don't really trust doctors because I don't know what subconscious things are going on when certain methods are being recommended to me.

Larger Influences on Providers

A final salient theme pertained to participants' identification of larger influences that may shape providers' contraceptive recommendations, including those relating to LARC. Some respondents contextualized providers within larger institutional cultures, often sympathetically. For example, rather than singling out providers for being uniquely biased, several women argued that everyone in American society is affected by racial and social class biases. Some used the term "unconscious." As Mary, a White focus group participant who had never used LARC, said,

I don't think doctors are really exempt from being prejudiced. I mean, we're all still human, so I think it's silly to say definitely that providers will recommend LARC methods in an unbiased way.

A few participants seemed sympathetic to the stresses placed on health care providers, particularly in resource-deprived settings. For example, Elizabeth reported,

I mean [providers] see a huge volume of people, and after you see your thousandth pregnant 14-year-old, you're probably like "This is ridiculous. These people are clearly not smart enough to handle this. So [LARC] is what my policy is going to be moving forward."

This respondent reflected that she, too, could make internal judgments about how other women should use contraception:

If someone's not capable of . . . remembering to take her pill or

insisting on using a condom or whatever, then it would be in her best interest to use something that she can't mess up or forget or lose or break.

In summary, some respondents admitted that they, too, thought that they knew best when it came to (some) others' contraceptive use, even as they criticized the same paternalism exhibited by providers.

DISCUSSION

Despite public health enthusiasm about LARC, a number of reproductive justice proponents have been concerned about how LARC methods might be promoted by health practitioners.^{9–11} One central worry has been the role of bias in shaping contraceptive recommendations,¹³ a concern upheld in a trial documenting that providers were in fact more likely to recommend IUDs to poor women of color than to poor White women.¹⁴ In this exploratory study of 50 contraceptive users, we found that patients have the same expectations for provider bias in terms of LARC recommendations. We also found evidence of provider resistance to removal. Although women of all races reported prior reproductive injustices, women of color were especially likely to experience LARC promotion as racialized and to express a personal connection to such injustices. By contrast, at least some contraceptive users expressed sympathy toward the larger forces that may shape providers' LARC recommendations, from deep-set racism and cultural bias to high-pressure health care systems.

On the basis of these findings and the growing momentum of

reproductive justice approaches to LARC, we propose several strategies that might improve future provider–patient interactions. We champion contraceptive counseling and practice protocols that support both patients and providers in offering patient-centered care.

Professionals who offer contraceptive care are strongly encouraged to educate themselves about prior reproductive abuses in socially marginalized communities (if they are not deeply aware already). (A variety of helpful resources have been compiled at the University of California's Reproductive Justice Virtual Library.²⁴) These histories are known and remembered by contraceptive users and patients; they should be on professionals' minds as well. Even well-intentioned practitioners may hold deep-set judgments about whether (more) children are a good idea for certain women. Rather than pretending such implicit biases do not exist, we would be better served by acknowledging them and identifying techniques to actively challenge and undermine dominant stereotypes. Patient-centered practices such as values clarification²⁵ and cultural humility^{26,27} have been encouraged in related health care domains, and they could be helpful in relationship to LARC as well. Providers need and deserve tools to better cope and respond when patients make different choices than they might want them to.

Aligning with exciting new work in this area,^{11,28–30} we also encourage contraceptive counseling and marketing that adopt a user-centered framework that supports clients in identifying their family planning priorities. As argued by Gomez et al.,¹¹ we need to attend to users' individual preferences and

circumstances, particularly in the case of groups whose fertility has been historically devalued. We also need to temper enthusiasm that LARC is the best option for all contraceptive users.¹¹ Even briefly acknowledging historical racial injustices during contraceptive counseling sessions may be important as well. For example, counselors may wish to say something along the lines of

I want you to know that I recommend these methods to all of my patients, regardless of their race, social class, or number of children; however, these methods might not be right for everyone, and I want to make sure we find the one that works best for you.

Patients should also be offered thorough information about potential side effects so that they are empowered to better manage these effects if they occur. Skillful "expectation management" can ease women's insertion fears and help them better weather unpleasant bleeding and cramping. In addition, practitioners should emphasize to contraceptive patients that they will support them whenever they decide to discontinue an LARC method. Finally, providers may wish to consider a developmental approach to these issues, as patients' ages and life stages are likely to influence their willingness to consider LARC as well as the kind of reproductive health care they receive.²³

Limitations

Our findings should be considered in the light of the study's limitations. Most centrally, the original study goals were to assess general barriers to and facilitators of increased LARC use among young adults, not specifically the issue of provider influence.

Although race could be an important factor, the sampling frame was not perfectly designed to assess racial differences. For example, we would have likely received different input from a focus group composed completely of African American women than from a group including 6 White women and 2 women of color.

Furthermore, our sample contained a considerable number of relatively socially advantaged women. For example, the 12 interviewees (all former or current LARC users) included only 2 non-White women, and all had at least a high school diploma. LARC trajectories among women of color with comparatively less formal schooling may differ with regard to provider influence. Such women's perspectives and experiences are invaluable and should be included in future research in this area. We may have also garnered different results if we had conducted a study in a large, urban area with more socioeconomic and racial diversity.

Conclusions

A user-centered approach to LARC could serve to increase people's access to LARC methods if they wish to use them, could improve their ability to have LARC devices removed if they so choose, and could help them feel respected and cared for by their providers. System- and provider-level changes can help facilitate access to unbiased and noncoercive information through patient-centered contraceptive counseling. **AJPH**

CONTRIBUTORS

J. A. Higgins originated the study design, oversaw the data collection and analyses, and wrote the majority of the article. R. D. Kramer conducted the analysis and contributed to the writing and editing of the

article. K. M. Ryder collected and coded the majority of the original data and contributed to the editing of the article.

ACKNOWLEDGMENTS

Jenny A. Higgins was supported by an award (K12 HD055894) from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD) and an NICHD Population Dynamics Research Infrastructure Program grant (P2C HD047873). We acknowledge a pair of internal grants from the University of Wisconsin–Madison, one from the Obstetrics and Gynecology Intramural Research Fund and one from the Graduate School.

We thank Grace Skarda and Erica Koepsel for their invaluable research assistance.

Note. The content of this article is solely the responsibility of the authors and does not necessarily represent the official views of the funding organizations.

HUMAN PARTICIPANT PROTECTION

The University of Wisconsin–Madison institutional review board reviewed this study and waived the protocol. Participants were not required to provide written consent to take part in the study. However, prior to data collection, all participants received and reviewed a cover sheet that described the study and the human participant procedures, risks and benefits, voluntariness, and their ability to withdraw from the study at any time without penalty.

REFERENCES

- American Academy of Pediatrics. Policy statement: contraception for adolescents. Available at: <http://pediatrics.aappublications.org/content/pediatrics/early/2014/09/24/peds.2014-2299.full.pdf>. Accessed August 12, 2016.
- Peipert JF, Zhao Q, Allsworth JE, et al. Continuation and satisfaction of reversible contraception. *Obstet Gynecol.* 2011; 117(5):1105–1113.
- Trussell J. Contraceptive failure in the United States. *Contraception.* 2011;83(5): 397–404.
- Trussell J, Henry N, Hassan F, Prezioso A, Law A, Filonenko A. Burden of unintended pregnancy in the United States: potential savings with increased use of long-acting reversible contraception. *Contraception.* 2013;87(2):154–161.
- Kavanaugh ML, Jerman J, Ethier K, Moskosky S. Meeting the contraceptive needs of teens and young adults: youth-friendly and long-acting reversible contraceptive services in US family planning facilities. *J Adolesc Health.* 2013;52(3): 284–292.
- Greenberg KB, Makino KK, Coles MS. Factors associated with provision of long-acting reversible contraception

- among adolescent health care providers. *J Adolesc Health.* 2013;52(3):372–374.
- Spies EL, Askelson NM, Gelman E, Losch M. Young women's knowledge, attitudes, and behaviors related to long-acting reversible contraceptives. *Women's Health Issues.* 2010;20(6):394–399.
- Teal SB, Romer SE. Awareness of long-acting reversible contraception among teens and young adults. *J Adolesc Health.* 2013;52(suppl 4):S35–S39.
- Gubrium AC, Mann ES, Borrero S, et al. Realizing reproductive health equity needs more than long-acting reversible contraception (LARC). *Am J Public Health.* 2016;106(1):18–19.
- Higgins JA. Celebration meets caution: LARC's boons, potential busts, and the benefits of a reproductive justice approach. *Contraception.* 2014;89(4): 237–241.
- Gomez AM, Fuentes L, Allina A. Women or LARC first? Reproductive autonomy and the promotion of long-acting reversible contraceptive methods. *Perspect Sex Reprod Health.* 2014;46(3): 171–175.
- Kavanaugh ML, Jerman J, Finer LB. Changes in use of long-acting reversible contraceptive methods among U.S. women, 2009–2012. *Obstet Gynecol.* 2015;126(5):917–927.
- Gilliam ML. Beyond coercion: let us grapple with bias. *Obstet Gynecol.* 2015; 126(5):915–916.
- Dehlendorf C, Ruskin R, Grumbach K, et al. Recommendations for intra-uterine contraception: a randomized trial of the effects of patients' race/ethnicity and socioeconomic status. *Am J Obstet Gynecol.* 2010;203(4):319.e1–8.
- Gold RB. Guarding against coercion while ensuring access: a delicate balance. *Guttmacher Policy Rev.* 2014;17(3):8–14.
- Roberts DE. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty.* New York, NY: Pantheon Books; 1997.
- US Census Bureau. State and country quick facts Available at: <http://quickfacts.census.gov/qfd/states/00000.html>. Accessed August 12, 2016.
- Ulin PR, Robinson ET, Tolley EE, McNeil ET. *Qualitative Methods: A Field Guide for Applied Research in Sexual and Reproductive Health.* Research Triangle Park, NC: Family Health International; 2002.
- Finer LB, Zolna MR. Shifts in intended and unintended pregnancies in the United States, 2001–2008. *Am J Public Health.* 2014;104(suppl 1):S43–S48.
- Daniels K, Daugherty J, Jones J. Current contraceptive status among women aged 15–44: United States, 2011–2013. *NCHS Data Brief.* 2014;173:1–8.
- Higgins JA, Ryder K, Skarda G, Koepsel E, Bennett EA. The sexual

- acceptability of intrauterine contraception: a qualitative study of young adult women. *Perspect Sex Reprod Health.* 2015; 47(3):115–122.
- Miles MB, Huberman AM. *Qualitative Data Analysis: An Expanded Sourcebook.* 2nd ed. Thousand Oaks, CA: Sage Publications; 1994.
- Dehlendorf C, Kimport K, Levy K, Steinauer J. A qualitative analysis of approaches to contraceptive counseling. *Perspect Sex Reprod Health.* 2014;46(4): 233–240.
- Center on Reproductive Rights and Justice. Reproductive Justice Virtual Library. Available at: <https://www.law.berkeley.edu/centers/center-on-reproductive-rights-and-justice/crrj-reproductive-justice-virtual-library>. Accessed August 12, 2016.
- Upadhyay UD, Cockrill K, Freedman LR. Informing abortion counseling: an examination of evidence-based practices used in emotional care for other stigmatized and sensitive health issues. *Patient Educ Couns.* 2010;81(3):415–421.
- Borkan JM, Culhane-Pera KA, Goldman RE. Towards cultural humility in healthcare for culturally diverse Rhode Island. *Med Health R I.* 2008;91(12): 361–364.
- Waters A, Asbill L. Reflections on cultural humility. Available at: <http://www.apa.org/pi/families/resources/newsletter/2013/08/cultural-humility.aspx>. Accessed August 12, 2016.
- Dehlendorf C, Henderson JT, Vittinghoff E, et al. Association of the quality of interpersonal care during family planning counseling with contraceptive use. *Am J Obstet Gynecol.* 2016;215(1):78.e1–9.
- Dehlendorf C, Levy K, Kelley A, Grumbach K, Steinauer J. Women's preferences for contraceptive counseling and decision making. *Contraception.* 2013; 88(2):250–256.
- Donnelly KZ, Foster TC, Thompson R. What matters most? The content and concordance of patients' and providers' information priorities for contraceptive decision making. *Contraception.* 2014; 90(3):280–287.