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Problems and Help Seeking in High-Risk Adolescent Patients of Health Clinics

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In this study, 2787 adolescents between the ages of 13 and 18 years living in inner-city communities were interviewed about their mental and physical health and their clinic use. The patients used consolidated mental and physical health clinics located in neighborhoods, hospitals, or schools; or traditional neighborhood or hospital health clinics. Analyses of selected patient problems reveal that less than one third of adolescent patients with suicide ideation, conduct disorder, and substance abuse or dependency sought or received care for those problems. Only half of the adolescents with major depression sought or received care for depression, and only two thirds of the sexually active females sought or received help with birth control. A special effort needs to be made to attract troubled youth to clinics and to identify and treat their problems, particularly when those problems involve mental health concerns.

KEY WORDS:
Depression
Conduct disorder
Contraception
Substance abuse
Risk
Suicide
Clinics

A major concern of health providers is outreach to high-risk populations. Inner-city adolescents constitute such a group, as they tend to use health services infrequently but have high rates of mental and physical health problems (1–3). Health providers who wish to have the largest impact on adolescent health problems with the smallest expenditure must conserve their limited resources by developing effective services in areas known to have large, concentrated populations with health problems. Certain neighborhoods have demonstrably higher indicators of risk: adolescent pregnancy, low birth weight, homicide, suicide, and accidents (4).

This paper examines the problems and help-seeking behavior of patients using health clinics that provide care for adolescents living in such high-risk neighborhoods. We report the results of the first wave of a two-wave study that has an overall objective of examining health and psychosocial outcomes in consolidated and nonconsolidated programs. In the first wave we assessed what types of physical and mental health problems the high-risk patients report, and whether they use the clinics for those problems.

Methods

The data are derived from an evaluation of a program initiated in 1980 by the Robert Wood Johnson Foundation. The program was designed to develop models of health care delivery that would consolidate mental health and medical services for adolescents and young adults living in communities characterized by high rates of adolescent pregnancy, homicide, suicide, and substance abuse. Our sample was obtained from seven of the 20 consolidated programs (Boston, Chicago, Indianapolis, Jackson, MS, New Haven, Dallas, and Los Angeles) and three

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traditional health programs in similar communities (St. Louis, Buffalo, and New Orleans). The consolidated services are specifically designed to offer a full range of mental and physical health services to adolescents. In contrast, the traditional health services provide care based on medical needs such as gynecology, pediatrics, and dentistry, and provide care for all age ranges from child to adult.

The two-wave design will allow evaluation of the clinics' awareness and treatment of the problems reported by adolescents in the first wave, and of the impact of these different types of health services on their parents' mental and physical health in the second wave. This paper, based on data from the first wave, reports patterns of health problems and help seeking.

Table 1. Age, Sex, and Race Differences in Clinic Populations (n = 2,787)

	Percent
Age (yr)	
13–14	15
15–16	39
17–18	46
Sex	
Male	33
Female	77
Race	
White	22
Black	70
Hispanic/other	8

Sample

The adolescents participating were selected for interviews by the research team in the order that they presented to the clinics for care. The adolescents understood that these interviews were totally independent of their health care. Whenever possible, interviews were completed on site immediately before or after a clinic visit. Otherwise, an appointment for a future interview was arranged. Postponed interviews were usually completed within a few days of the clinic visit either on site or at a location mutually convenient for interviewer and respondent.

From November 1984 to June 1985, 2787 adolescents between the ages of 13 and 18 years were interviewed. The number varied across cities from 131 to 376 patients depending on the number of unduplicated patient visits during the period. No attempt was made to stratify by age. The clinic patients were predominantly female (77%), black (70%), and age 15 years or older (85%) (Table 1). Only 3.6% of the adolescents selected for interviews refused to participate; no reasons were specified.

Instrument

The interview asked about the youth's social environment, health, lifestyle, and help seeking. The questions about the social environment concerned household members, employment, school, and stressful events. Those about physical health concerned chronic and acute illness, injuries, sexually transmitted diseases, pregnancy, and somatic symptoms. Those about mental health included depression, anxiety, suicide ideation, behavior problems, posttraumatic stress disorder, and substance use and abuse. Questions about lifestyle related to sexual, social, academic, and work behaviors. The interview, which averaged 50 minutes in length, was administered individually to the respondents by trained professional interviewers.

Psychiatric diagnoses were based on computer algorithms that combined symptoms according to the positive criteria in DSM-III (5). With the exception of conduct disorder, questions to elicit symptoms came from the National Institute of Mental Health's Diagnostic Interview Schedule (DIS) (6). Studies of the reliability and validity of the DIS have been conducted by comparing DSM-III diagnoses of lay interviewers' versus psychiatrists' interviews in clinical and general population adult samples (7,8). The modified version of the DIS used for our study allows lifetime and current diagnoses of major depression, dysthymia, and drug and/or alcohol abuse and dependence. The DIS depression section also provides information about suicide ideation and behavior. Youths whom we consider suicide ideators had one or more of the following symptoms: frequent thoughts of death, 2 weeks or more of wanting to die, thinking of committing suicide, or a history of attempting suicide.

The diagnosis of conduct disorder is based on questions from the Diagnostic Interview for Children and Adolescents (DICA). The DICA is a structured interview protocol designed to diagnose psychiatric disorders occurring in individuals under the age of 18 years according to DSM-III criteria. Levels of parent–child agreement for the DICA have been established for individual symptoms and di-

Table 2. Health and Behavior Problems of Youths Using Clinics

	Percent with problems
Physical health problems	
Any chronic illness	23.4
Asthma	8.9
Injury in last year	4.2
Sexually active	79.0
If female, if sexually active, ever pregnant	46.7
If sexually active, had sexually transmitted disease	6.5
Mental health behavior problems (past year)	
Three or more depressive symptoms	20.5
Jailed	5.6
Drunk three or more times	7.7
Substance use	24.8
Suicidal attempt	4.4
Physical fights	25.7

agnostic categories (9,10) and for test–retest reliability (11).

Results

Although the rates of physical and mental health problems are known to be high among inner-city populations, unless patients using clinics evidence those problems, clinic personnel have little opportunity to intervene to lower the rates. Our adolescent patients evidenced high rates of many pertinent physical, behavioral, and mental health problems (Table 2).

Physical problems or health care needs were largely confined to care for chronic illness and problems associated with sexual activity. Almost one quarter of the patients reported having some chronic illness; 9% had asthma. Only 4% had had a serious injury in the last year. Seven percent of the sexually active patients reported having a sexually transmitted disease. The highest risk rates were for child bearing, with 79% of the patients being sexually active, and 47% of the female patients having had a pregnancy.

Need for the care of mental health and behavioral problems was striking. One fifth of all the youths interviewed reported three or more symptoms of depression within the last year, and 4% had made a suicide attempt in the last year. More than one quarter had engaged in physical fights, and almost 6% had been jailed in the last year. In the last year, a quarter of the patients had used illicit substances, and 8% had been intoxicated three or more times.

Table 3. Clinic Use for Target High-Risk Conditions

	Percent of patients with this condition in the last year (n = 2,787)	Percent of these patients who sought or received care within the last year
Patients who met criteria for depression	6.1	48.5
Patients with suicide ideation	24.3	31.3
Patients with a diagnosis of conduct disorder	11.5	25.9
Patients with substance abuse/dependence	5.8	22.2
Sexually active females (n = 2,149)	74.4	63.1[a]

[a]Care for birth control needs.

Use Patterns for Five Target Conditions

Although a detailed research interview may reveal that patients have high rates of problems, these patients may not reveal these problems to the clinic staff. This is particularly likely when crowded clinics must perform a series of time-efficient intakes that focus on the treatment of the presenting problem, and when the general clinic is perceived by youth as an inappropriate place to bring a psychologic problem.

Uncontracepted Sexual Activity. Although preventing teenage pregnancy was a major goal of the health care professionals involved, many of these sexually active youngsters had not sought birth control information or supplies from a medical source in the current year. Only 63% of the sexually active female patients obtained help at a clinic for birth control needs (Table 3).

Provision of birth control devices or information to patients who seek such help is only one step in reducing adolescent pregnancy. But it was apparent that at least 36% of the patients who might use such help were not requesting or receiving it. By their own admission, only 60% of the sexually active youths *ever* used birth control, let alone used it regularly.

Depression. Six percent of the patients at the clinics met DSM-III criteria for a diagnosis of a major depression, meaning that they had had 2 or more weeks of dysphoria and four other symptoms such

as loss of appetite, fatigue, and sleep disturbance clustered together in time during the last year. Yet less than half of these patients sought or received help for their depression.

Suicide Ideation and Behavior. Although there is an association between depression and suicide, the overlap is far from complete. Many depressed adolescents are not suicidal, and some suicidal adolescents do not have symptoms of depression. Of the 677 sampled youths who reported suicide ideation, only 18% met the criteria for a diagnosis of major depression.

One fourth of all patients reported having had suicide thoughts or behaviors within the last year. Nevertheless, the treatment gap was substantial as only one third of the patients with suicide ideation or behavior had sought help during the year.

Conduct Disorder. Eleven percent of the patients met criteria for a DSM-IIl diagnosis of a conduct disorder within the last year. Nevertheless, only 26% of those conduct-disordered youths sought or received help for their behavior problems. Thus, less than one in three of the patients displaying behaviors directly related to high community rates of morbidity and mortality received an intervention for those behaviors.

Substance Abuse or Dependency. Much of the morbidity and mortality in inner-city communities may be associated with high rates of alcohol or drug abuse and dependence. Although there was a heavy use of alcohol and drugs (Table 2) in our population, the number of patients with alcohol or drug abuse or dependence (by DSM-III diagnostic criteria) was too low for separate analyses. The overlap was considerable. Only 61 youths had a diagnosis of alcohol abuse or dependence, and only 11 had a diagnosis of substance abuse or dependence. Therefore, the youths with a diagnosis of alcohol abuse/dependence and illicit drug abuse/dependence were combined. Six percent of the patients had substance abuse behavior in the year, but only one in five sought or received help for their substance abuse.

Discussion

The problems that we have singled out for discussion are important because they put youth at a high risk for death. Depression and suicide ideas increase the risk for suicide; conduct disorder and substance abuse increase the risk for homicide and accidental death. These causes claim many more lives of youngsters than do physical illness or unwanted pregnancy. It seems clear that the health clinics have the opportunity to provide help for these problems because the frequency is high among their patients. However, our findings suggest that high-risk adolescents typically do not seek help for these problems. The highest rate of help seeking occurred for the physical care needs of sexually active females, such as securing a contraceptive, but even then it did not exceed two thirds. Thus, even in the current national climate in which considerable attention is being given to the prevention of adolescent pregnancy, a substantial number of sexually active girls who are in contact with a medical clinic are not asking for or being offered contraceptive help. Although considerable variation in help seeking for the other four mental health conditions was found, in each case less than half of those identified by the interview as having a high-risk condition sought or received help. The rates of care for suicide ideation, conduct disorder, and substance abuse were particularly low, with less than a third of those youths identified by the research interview as having the problem seeking or receiving help.

These less than satisfactory rates of help seeking are important, given that the sample youths had already elected to visit a clinic for some type of help, and at least some of them had had multiple clinic contacts. This finding suggests that, during intake procedures with adolescents, clinic staff may need to increase the amount of probing or questioning, particularly in the area of mental health problems, which adolescents tend to perceive as inappropriate problems to discuss with health care professionals in this setting. It can be reasonably assumed that nonpatients, or nonclinic attenders, may have even lower rates of help seeking. The relatively low proportion of help seekers suggests that much work is still needed in the area of outreach to youths not using health services, as well as to youths who are using health clinics but are not seeking care for the types of conditions we examined. The predominance of females at our clinics further illustrates that a major problem exists in attracting at-risk males.

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