

## Adolescent medicine

THE SPECIAL HEALTHCARE NEEDS of young people have long been recognised, but, before 1990, much of Australian adolescent medical practice was confined to small inpatient units in the major city paediatric hospitals. Other facets of adolescent healthcare — primary care, sexual and reproductive health, student health and mental health — operated independently. This was in stark contrast to North America, where the specialty of adolescent medicine had taken the lead in adolescent healthcare for three decades.

**Centres for Adolescent Health.** Much has now changed. The establishment of Centres for Adolescent Health in Melbourne, Sydney and Auckland has signalled a broader role for adolescent medicine. Shifting disease patterns lie behind these developments. Cancer, cardiovascular disease and neuropsychiatric disorders have become health priorities in an ageing population, highlighting the need for preventive and early interventions in younger people. Adolescent disease patterns have also shifted. Infectious diseases, both blood-borne (hepatitis C, HIV) and sexually transmitted (HIV, herpes, chlamydia), pose new threats. Drug dependence, eating disorders and depression have become common. Longer survival in young people with chronic illnesses and disabilities (eg, spina bifida, cystic fibrosis) has introduced complicating psychosocial and behavioural problems. In response to these trends, adolescent medicine has embraced preventive models of care, incorporating new clinical skills and building working relationships across the spectrum of health and welfare practice.

The role of specialist adolescent units has been questioned, but the number of young people admitted to hospital in the United Kingdom justifies regional adolescent inpatient units.<sup>1</sup> In Australia, their popularity with young people (and clinical staff) and their families is a strong endorsement.<sup>2</sup>

**Prevention and early intervention.** The care of adolescents with chronic physical illness extends beyond the acute problems (that trigger inpatient admission) to previously undiagnosed morbidities with longer-term health implications. It is now usual to screen for psychosocial and behavioural problems affecting adherence with therapeutic regimens and, in the case of tobacco and substance misuse, possibly causing early complications. Advances in other fields of medical practice have extended the scope for prevention, with simple immunological screens for hepatitis B and C, and HIV, and vaccination for hepatitis B. So too has the introduction of clinical tools such as HEADSS, a psychosocial screen covering an adolescent's Home life, Education, recreational Activities, Drugs, Sexuality and Suicide risk/depression.<sup>3</sup>

Prevention, early diagnosis and intervention have come to dominate the care of marginalised groups, such as young offenders and homeless youth, in whom risks for blood-borne and sexually transmitted infectious diseases, substance dependence and major psychiatric disorders are very high.

An emphasis on prevention and early intervention is also important in the common health problems of teenagers — depression, substance dependence, eating disorders and



obesity. The greatest barrier to effective early intervention is engagement with young patients. General practitioners are the healthcare providers most commonly accessed, but most consultations are for acne, respiratory and musculoskeletal problems rather than the major causes of disease burden in this age group. Practitioner lack of confidence, skills and training in dealing with adolescent mental health and behavioural problems explains some of the unmet need. To enhance competencies in adolescent healthcare, practitioners need well-designed training based on an understanding of adolescent development, a full risk assessment, sound communication skills and a respect for confidentiality.<sup>4</sup> With greater Medicare card ownership and the availability of longer GP consultations, adolescent access to healthcare, perhaps in the form of a “wellness” visit, would improve substantially.<sup>5</sup>

**Diagnosis and intervention.** New diagnostic concepts have also changed clinical practice and revealed previously under-recognised problems, such as adolescent depression and attention deficit hyperactivity disorder (ADHD) persisting beyond puberty. Prodromal and subsyndromal forms of less common disorders, such as schizophrenia and anorexia nervosa, have also been recognised. Interventions (pharmacological, educational and psychotherapeutic) used in other age groups have been adapted and shown to be efficacious in adolescents. Cognitive-behavioural treatments of depression and eating disorders, motivational interviewing for adolescent substance misuse, and pharmacotherapy for ADHD, depression or prodromal psychosis, have all shown promise in influencing short-term outcomes and even preventing the onset of fully-fledged disorders.

**Conclusion.** Australian adolescent medicine practice has moved from being a narrow specialty to a flourishing generality, dealing with common health problems and providing a point of convergence for disciplines such as paediatrics, primary care, psychiatry, and internal medicine. The potential for an integrative approach, emphasising prevention and early intervention, is clear, but is currently constrained by a disconnection in health policies for mental health, acute care, substance misuse and services for high risk groups. The need for a coherent adolescent and youth health policy across government has never been greater.

George C Patton,\* Lena A Sancı,† Susan M Sawyer‡

\* Director; † NH&MRC Post-doctoral fellow; ‡ Deputy Director  
Centre for Adolescent Health, Royal Children's Hospital, Parkville, VIC 3052  
gpatton@cryptic.rch.unimelb.edu.au

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