ADOLESCENT CLINIC

BACKGROUND INFORMATION

Teenage pregnancy in Australia ranks high compared to other countries. While birth rates in the 15-19 year groups are declining in Australia in recent years the rate remains higher than numbers in comparable countries, with live birth rates in teenagers ranked fourth behind only the USA, Canada and New Zealand. However, this decline in birth rates is not reflected in rural teenagers, indigenous and socially disadvantaged teen groups. Teenagers have complex psychosocial issues and are more likely to live in unstable households or have no fixed address, have lower family incomes, are lacking social support networks, and are at higher risk for mental illness. Postnatal depression is a real risk for teenage mothers. Pregnancies are often unplanned or unwanted, and adolescents commonly face single parenthood.

A study in Western Australia (WA) found that risk factors in pregnancy increase in teenagers, and that they are more likely to come from a low socioeconomic background, smoke, have anaemia, urinary tract infections, and pregnancy-induced hypertension in pregnancy. The study also indicated that indigenous teenagers were more disadvantaged than non-Indigenous women with younger indigenous teenagers having increased risk factors leading to poor birth outcomes. Other reported pregnancy complications for teenagers include increased risk for preterm labour, intrauterine growth restriction (IUGR), and pre-eclampsia.

A recent study in WA of 137 adolescents attending KEMH found that 47% of teenage mothers recommenced sexual activity within 6 weeks postpartum, 9% wanted to become pregnant again, and two of the teenagers became pregnant again prior to the 6 week postnatal check. This indicates the importance of contraception counselling throughout pregnancy and again in the immediate postpartum period. Emphasis should be placed on reliable methods of contraception, such as long acting forms, which have fewer failure rates. The post partum follow up appointment may be more beneficial for some teenagers if arranged prior to 6 weeks postpartum and contraception can be arranged as an inpatient in the immediate postpartum period prior to discharge if appropriate (e.g. insertion of Implanon). Reducing risk for rapid-repeat pregnancies in teenagers can be facilitated by long-acting contraceptives, and by health workers gaining a clear understanding of their future intentions following birth so that the appropriate support and counselling can be provided.

Sexually transmitted infections (STIs) are prevalent among young adults, with Chlamydia being the most common reportable STI to the Department of Health WA. Over 25% of new notifications to the department of Chlamydia are in teenagers. Any medical appointment is an opportunity for screening for Chlamydia, and adolescents should be screened at the first antenatal appointment and again at 36 weeks routinely. If necessary, repeated screening can occur again at anytime during the pregnancy. Education on the importance of condom use to prevent infection should be stressed at the same time as contraception counselling. Given the higher failure rate of condoms for contraception, dual use of reliable contraception (particularly long acting hormonal contraception, implant or injectable) as well as condom use to prevent STIs should be encouraged.

REFERRALS

Referrals for the Adolescent Clinic are made by the ‘bookings clerk’ after the Patient Flow Co-ordinator liaises with the Co-ordinator for the Adolescent Clinic regarding the urgency/timing for the booking visit.
**TIME OF THE ADOLESCENT CLINIC**

The Adolescent Clinic is conducted on each Wednesday afternoon in the east wing clinic from 1300-1630.

**ADOLESCENT TEAM MEMBERS**

Staff attending the Adolescent Clinic include:

- Obstetric Consultant
- Obstetric registrar and resident
- Midwives
- Social Workers
- Parent Education Midwives
- Clinical Psychology
- Dietician (with referral)
- Adolescent Support Midwife

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<thead>
<tr>
<th>PROCEDURE</th>
<th>ADDITIONAL INFORMATION</th>
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<tbody>
<tr>
<td><strong>1</strong> Routine antenatal care</td>
<td>Routine antenatal visits should be conducted, however frequency of visits and additional tests are required for the adolescent woman.</td>
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<tr>
<td>See Clinical Guideline Antepartum Clinic Visits – Initial visit</td>
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<td><strong>2</strong> Initial visit</td>
<td>Allows early interventions to link women with welfare assistance and social services.</td>
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<td>At the initial visit women shall be assessed by the:</td>
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<tr>
<td>• Midwife or doctor</td>
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<tr>
<td>and</td>
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<tr>
<td>• Social worker</td>
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<td>Additional referrals may be made depending on psychosocial and fetal/maternal needs.</td>
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<tr>
<td><strong>2.1</strong> Additional screening and blood tests</td>
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<td>• PAP smear for those fitting the screening guidelines (i.e. 18 years or older and 2 years or more since first sexual intercourse)</td>
<td>Unless contra-indicated encourage collection of a pap smear at the booking visit if appropriate according to the current screening guidelines. Pregnancy provides an opportunity to screen teenagers.</td>
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<tr>
<td>See Clinical Guidelines Papanicolaou (Pap) Smear</td>
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</table>
## PROCEDURE

- Symptomatic patients should be tested for sexual transmitted infections (STI's) by taking the following swabs via speculum examination. Those patients requiring a PAP smear can also have the following swabs collected at the same time:
  - High vaginal swab (for MC&S)
  - Endocervical swab for chlamydia/gonorrhoea PCR

- Screening in asymptomatic patients can be via a self obtained low vaginal swab (SOLVS) and a first void urine for chlamydia and gonorrhoea PCR

### NOTE: adolescents are at high risk for STI's should be re-screened at 36 weeks gestation.

- Screen for iron and vitamin D levels if current results are unavailable.

### If an STI is diagnosed:

- Complete the Health Department Notification form
- Advise the partner they will need to be screened and treated as appropriate, and that the Health Department will be notified.
- A ‘proof of cure’ test should be performed with repeat SOLVS and first void urine at 6 weeks following treatment. See Chlamydia guideline
- First void urine: the patient should not have passed urine in the previous hour. The initial 20-30mL of urine is collected in a sterile specimen container.

## ADDITIONAL INFORMATION

Adolescents in industrialised countries often have micro-nutrient poor, energy-dense diets with deficiencies in iron and Vitamin D. Adolescents who smoke are at increased risk for lower concentrations of folate which can be associated with fetal growth restriction in adolescents. They have a higher likelihood of anaemia which increases in the third trimester, and also may be at higher risk for Vitamin D deficiency especially in the darker skinned groups.

### 2.2 Dental hygiene

- Recommend a dental check in pregnancy.
- Refer to Perth Public Dental Clinics if financial restrains are present.

### 3 Subsequent antenatal visits

#### 3.1 Frequency of antenatal visits

Frequency of visits recommended are:

- 2 weekly from 32 – 36 weeks gestation
- weekly from 36 weeks gestation

**However, antenatal visits should be adjusted according to the individual maternal and fetal needs.**

Undiagnosed dental infections and poor dental hygiene in teenagers may increase risk the risk of pre term birth. Urgent dental problems are given priority at the public dental clinics, and appointments for routine dental checks are placed on the ‘waiting list’.

Shared care with a consistent GP may be an option if the Adolescent team decide this is feasible (e.g. transport, distance issues).
### PROCEDURE

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<th>3.2 Assessment each visit</th>
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<td>3.3 Blood</td>
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<tr>
<td>4 Social work assessment</td>
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</table>

### ADDITIONAL INFORMATION

- **Dietary habits/patterns**
  
  Adolescents are high risk for anaemia during pregnancy\(^2\), therefore assessment of their dietary habits is essential at each visit. When anaemia is diagnosed and iron supplementation is instigated the health practitioner needs to confirm compliance with medication use at each visit.

- **Social Issues:**
  - Home environment/accommodation
  - Financial issues
  - Support network
  
  At each visit the midwife/doctor will assess the woman’s psychosocial situation, and refer to the social worker or psychological services as required.

- **Psychological well-being**
  
  Teenage mothers are at higher risk of mental health and related problems compared to other groups of antenatal women.\(^2\) Refer to the Department of Psychological Medicine as required.

- **Smoking habits /illicit drug use**
  
  Pregnant teenagers have been found to be less likely to quit smoking during pregnancy than other antenatal women.\(^2\) Adolescents who continue to smoke in the second half of pregnancy are more likely to have low birth weight neonates.\(^10\) Emphasis on this modifiable risk factor should be monitored and interventions offered at each visit to the woman and support group.

- **Repeat full blood picture (FBP) at 36 weeks gestation as required.**
  
  Adolescents are at higher risk for anaemia.\(^2\) If medication treatment for anaemia is initiated a follow-up FBP may indicate compliance with management or need for additional dosage.

- **The social worker will assess the adolescent at the:**
  - Booking visit
  - Follow up visits on an individual needs basis
  
  The social worker liaises with the Adolescent Co-ordinator at each clinic and advises who they will review at the clinic that day.

- **The social worker will assess the adolescent’s psychosocial situation, financial situation, support network, and the educational/work circumstances.**
  
  Assistance with financial services, housing services, educational and community support groups is provided by the social work services.

- **A plan of management is formulated and ongoing assessment is made during the pregnancy.**
## PROCEDURE

### 5 Diet and Nutrition

- Provide pamphlets on diet and nutrition.  
  Pamphlets written specifically for adolescents are available at the clinic.
- Refer for Dietician Consultation as required.  
  Adolescents may have poor knowledge of dietary nutrition and quality. Their skeletal maturity has not been reached yet and they are at risk of calcium deficiency. Iron requirements normally increase during adolescence, and pregnancy places them at an even higher risk for anaemia. Lack of folate may impair fetal development.\(^{11}\)
- Monitor weight each visit.  
  Adolescents who fail to gain weight appropriately in pregnancy are at increased risk of preterm birth and delivering a low birth weight infant.\(^ {12}\)

### 6 Parent education

Parent education is provided on an individual basis.

A hospital tour is arranged during the antenatal visit.

### 7 Discharge Planning

#### 7.1 Contraception

- Discuss contraception during the antenatal period and aim for a postnatal management plan prior to labour and birth.
  Contraceptive implants and injectable contraceptives are the most successful methods at preventing repeat teenager pregnancy because they are long acting. Other forms may be used inconsistently or are easily discontinued.\(^6\)
- If an adolescent mother consents to contraception it is recommended to be prescribed prior to discharge.
  The adolescent is less likely to attend GP follow-up.
- Contraception may be provided prior to discharge, however will be provided at the adolescent clinic postnatal appointment.
### 7.2 Sexual Health Education

Discuss risk factors and strategies to reduce risk of STIs.

**ADDITIONAL INFORMATION**

Condom use should be encouraged to prevent STIs. Given the higher contraceptive failure rate of condoms, dual use of condoms with another form of contraception (e.g. hormonal implant) should be encouraged.

### 7.3 Home Visits

Inform the adolescent woman:

- A midwife will visit the home at approximately 36 weeks gestation
- The hospital stay is based on individual needs. This may be from 24 hours to 5 days.
- A midwife will provide follow-up home visits for up to 6 months postnatally.

**ADDITIONAL INFORMATION**

Assessing the home prior to delivery allows the midwife to evaluate the home environment, preparation for an infant, and to implement support plans as required. Postnatal visits can result in a reduction of adverse neonatal outcomes and the visits leads to teenagers having increased knowledge and use of contraception.13 Frequency of visits are based on individual needs and the home situation.

### 7.4 Postnatal Check-up at KEMH

Arrange a clinic follow-up appointment at the KEMH Adolescent clinic 4 weeks postpartum. This does not replace the GP postnatal appointment for mother and infant.

Ensure a pregnancy test is performed prior to commencing contraception at the postnatal follow-up visit.

**ADDITIONAL INFORMATION**

Postnatal follow-up allows ongoing contraception counselling and commencement of contraception as appropriate. It provides the adolescent an opportunity to access staff that provides information and assistance with any physical or psychosocial issues. Some teenage mothers plan a rapid repeat pregnancy, and this may be planned as early as 6 weeks postpartum.9
REFERENCES (STANDARDS)

Family Planning Queensland, Teenage Indicators, 2012.


Do not keep printed versions of guidelines as currency of information cannot be guaranteed. Access the current version from the WNHS website