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CD Summary

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OREGON TEENS WITH DISABILITIES: ADDRESSING HEALTH AND SAFETY NEEDS

Despite recent public health efforts to promote health equity within marginalized populations,[1] knowledge of disparities experienced by people with disabilities — especially youth — is limited by multiple factors. First, the term "disability" is often associated with older age, as evidenced by the frequent combination of public services for disabled and elderly populations. Second, disability is often treated as an outcome of injury or poor health as opposed to one of many characteristics that shape the way people interact with their environment.[2,3] Third, what little research is available often ignores diversity among people with disabilities — contrasting individuals with disabilities as a homogenous group against individuals without disabilities.

This *CD Summary* presents an analysis of health disparities among Oregon 11th graders by disability type, based on data from the 2015 Oregon Healthy Teens (OHT)* survey. The disability questions on the OHT are based on self-reported functional limitations, not on diagnoses, impairments, or identities. We focus on the most concerning disparities (e.g. abuse, bullying and safety at school, sexual health and unmet health care needs), and include resources for health care providers.

WHO ARE OREGON STUDENTS WITH DISABILITIES?

Overall, 26% of Oregon 11th graders report having a physical, mental, cognitive, or emotional limitation or disability (students can report >1 disability; Table). There is considerable diversity among students with disabilities (SWD). Twenty percent report a cognitive disability, defined as serious difficulty concentrating, remembering, or making decisions. Other reported disabilities include: difficulty with independent living (trouble doing errands alone like shopping or visiting a doctor's office); blindness/low vision; mobility issues (serious difficulty walking or climbing stairs); deaf/hard of hearing; and difficulty with self-care (problems dressing or bathing).

Table. Percent of 11th grade students reporting a disability by type.

Disability Type	Percent
Cognitive disability	20%
Difficulty with independent living	7%
Blind/low vision	5%
Mobility issues	3%
Deaf/Hard of hearing	2%
Difficulty with self-care	1%
Any one or more of the above disability types	26%

Compared to students without a disability, those with a disability were more likely to be female (60% compared to 40%); particularly students who have difficulties with mobility (67% female) and/or independent living (75% female). No significant differences were observed between students with disabilities and those without by geographic region or race/ethnicity.

WHAT ARE THE DISPARITIES?

Living with a disability is a social determinant of health; negative treatment of disabled people and lack of access to conditions that promote health and well-being (e.g., safety, relationships, and healthcare) impacts health and well-being.[1] In Oregon, SWD are more likely than SWoD to report conditions that include experiences of abuse, bullying, a lack of safety at school, and sexual behavior that places them at higher risk for pregnancy and contracting sexually-transmitted diseases (STDs). SWD also report having unmet physical and mental health care needs. These patterns persist across all disability types for each indicator.

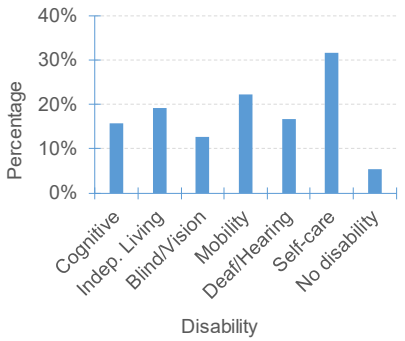
Experiences of abuse. Students across all disability types are more than twice as likely as SWoD to report sexual assault and coercion — including forced sex and being pressured into unwanted sexual activity. SWD are twice as likely to report physical and sexual abuse by an adult. Specifically, students reporting cognitive, mobility and/or independent living difficulties are more than three times as likely to report sexual abuse by an adult (Figure 1, *verso*). Dating violence is also more likely to be reported by SWD, and is highest for students who have difficulty with self-care.

Bullying and safety at school. Students across all disability types are more likely than SWoD to report bullying and a lack of safety at school. Specifically, SWD report being bullied for their friends, physical characteristics, and sexual orientation at three times the rate of SWoD; for students with self-care and independent living difficulties this rate is four times as high. SWD are also twice as likely as SWoD to report cyberbullying.

Relative to safety, SWD are more likely to report missing at least one day of school in the last 30 because of safety concerns. Missing school was especially pronounced among deaf/hard of hearing students and those with self-care, mobility, and independent living difficulties. SWD are also twice as likely to report being in a physical fight and being threatened with a weapon at school at least once in the last 12 months. Students who have difficulty with self-care are the most likely to report

* OHT is a school-based survey with including a sample of 13,608 Oregon 11th graders; percentages are weighted to the population of Oregon 11th graders enrolled in public schools. Data for table and figures from 2015 OHT Survey.

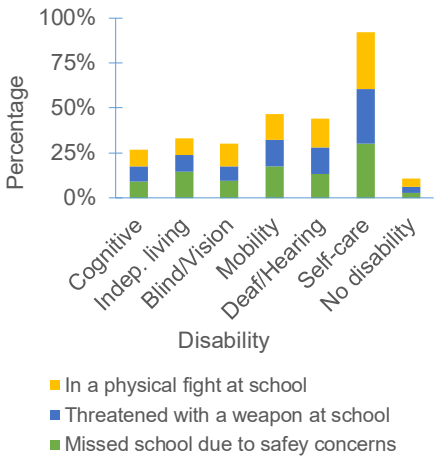
Figure 1. Percent of students who report that an adult has ever had sexual contact with them by disability type.



safety concerns relative to students with any other type of disability (Figure 2).

Risk for pregnancy and STDs. Students across all disability types are more likely than SWoD to be sexually active, to report younger age at first sexual intercourse, and to have more sex partners; they are less likely to use condoms. Sexually active students who have cognitive, self-care, and independent living difficulties are significantly more likely than sexually active SWoD to report having three or more sex partners in their lifetime, and students who have difficulty with self-care report the most sex partners (i.e., six or more) compared to all other disability groups. Despite being more sexually active and having multiple partners, students with cognitive, self-care, and independent living difficulties are less likely than SWoD to have used condoms during their last sexual encounter, placing them at higher risk for pregnancy and contracting STDs.

Figure 2. Percent of students who report safety concerns at school, by disability type.



Unmet health care needs. SWD are four times more likely than SWoD to report having unmet mental health care needs in the last 12 months, and twice as likely to report having unmet physical health care needs. Unmet health care needs were highest in students with cognitive, mobility, and independent living difficulties.

Resilience and support at school. Students with disabilities report some indicators of resilience. Specifically, the majority of SWD rated their overall physical and emotional health as good, very good, or excellent; and >70% responded positively to the question: "I can do most things if I try." This indicates feelings of self-efficacy among SWD, which enhances personal accomplishment and well-being and can smooth the developmental transition from childhood to adulthood.[4] The majority of students across all disability types were also likely to indicate they had one teacher or other adult at school who really cares about them. This was particularly true for deaf/hard of hearing students; 71% reported having a supportive adult at school.

HOW CAN CLINICIANS HELP?

Clinicians play an important role in supporting students with disabilities and helping to reduce these disparities.

- Frame disparities in the context of society and being different. The experience of being bullied is not because students with disabilities are doing something wrong, but because being different increases the risk of being bullied.[5]
- Focus on health promotion rather than disease avoidance or "fixing" the disability. Provide a supportive environment to promote health and well-being.
- Share local resources that promote affirmative disability identity such as the Disability Arts and Culture Project in Portland (https://dacphome.org/).
- Ensure health services for patients with disabilities are inclusive and not based on preconceptions. For example, data from OHT refute the common misbelief that people with disabilities are asexual, and suggest an important need for reproductive health care among SWD.
- Emphasize individual strengths and foster self-efficacy. Resilience develops naturally, but is enhanced by positive supports; reinforce the idea that one can be disabled and healthy.
- Recognize diversity within the disabled population, and that needs may vary considerably based on disability type and other characteristics (e.g., gender, sexual orientation, and race/ethnicity).

FOR MORE INFORMATION

- A recent publication from the Oregon Health Authority provides recommendations on preconception health care for young adults with disabilities (http://1.usa.gov/PCHRec4YAwDis).
- Oregon Family to Family Health Information Center helps families navigate the world of special health care needs for children and youth living with disabilities (http://oregonfamilytofamily.org/).
- OHSU's University Center for Excellence in Developmental Disabilities works with other organizations to improve the lives of people living with disabilities, and hosts a summer camp designed to promote healthy lifestyle choices among adolescents with disabilities (www.ohsu.edu/xd/research/centers-institutes/institute-on-development-and-disability/ucedd/).
- The Centers for Disease Control and Prevention offers many tools and resources for providers such as strategies for disability inclusion (www.cdc.gov/ncbddd/disabilityandhealth/hcp.html).

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