Vermont Child Health Improvement Program
UNIVERSITY OF VERMONT LARNER COLLEGE OF MEDICINE

Adolescent & Young Adult Health National Resource Center

VERMONT DEPARTMENT OF HEALTH

Adolescent and Young Adult Health

Resource Kit

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Introduction

This resource kit was developed by the Youth Health Improvement Initiative, a collaborative project between Vermont Child Health Improvement Program (VCHIP), the Vermont Department of Health, and with support from the Adolescent and Young Adult Health National Resource Center. We would like to thank all our partners and collaborators who help promote high quality adolescent and youth services throughout Vermont.

The Youth Health Improvement Initiative has worked with Vermont primary care providers to improve health outcomes for adolescents and young adults through coaching providers to improve the consistency and quality of preventive services during well care visits.

Creating interest and value with adolescents, young adults and parents and guardians ensures Vermont youth are accessing timely and appropriate care. This resource kit was designed to help guide health care practitioners to develop their own unique approach to delivering high quality adolescent and young adult services. All aspects of this kit should be used in conjunction with clinical judgment and sensitivity to this dynamic population.

v.1 April 2018

Clinical Resource Web Links

Section 1: Tools for Patients and Families

Handouts for Patients and Families:

Adolescent Health Care

- Be in Charge of Your Health*
  http://idph.iowa.gov/Portals/1/userfiles/110/Be%20In%20Charge%20Original.pdf

Body Image, Health Eating & Exercise

- Daily Activity Diary – BACE (Body Care, Achievement, Connect with others & Enjoyment)*
  https://www.get.gg/docs/BACEdiary.pdf

Contraception

- Reproductive Health Access Project Contraception Handouts
  https://www.reproductiveaccess.org/key-areas/contraception/

Immunizations

- CDC: If You Choose Not to Vaccinate Your Child, Understand the Risks and Responsibilities*
  https://www.cdc.gov/vaccines/hcp/conversations/downloads/not-vacc-risks-color-office.pdf

- CHOP: Recommended Immunization Schedule: What You Should Know: Q & A
  https://media.chop.edu/data/files/pdfs/vaccine-education-center-recomm-immuniz-sched-eng.pdf

Substance Use Resources

- National Institute on Alcohol Abuse and Alcoholism (NIH): Family Checkup, Positive Parenting Prevents Drug Abuse.*
  https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/familycheckup_8_15.pdf

- NIH: Parenting to Prevent Alcohol Abuse*
  https://pubs.niaaa.nih.gov/publications/adolescentflyer/adolFlyer.pdf

- Students Against Destructive Decisions (SADD). Contract for Life*
  https://crafft.org/contract/

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- The Teen Years Explained: A Guide to Health Adolescent Development (specific chapters are included in the toolkit)
  https://www.jhsph.edu/research/centers-and-institutes/center-for-adolescent-health/_docs/TTYE-Guide.pdf

AHWG: Adolescent Health Working Group:

- **Resources for Youth Around Body Image, Healthy Eating & Exercise**
  https://ahwg.org/youth-resources/

  - Building Your Plate*
  - Checklist for a Healthier Lifestyle*
  - Eating, Exercise & Body Image Continuum*
  - Exercise Pyramid*
  - Healthy Eating & Snacking Tips*
  - Healthy Weight*
  - Myths and Facts of Dieting*
  - What is a Single Serving?*
  - What is Body Image?*

- **Resources for Parents and Caregivers**
  https://ahwg.org/parent-caregiver-resources/

  - Does My Teen Need Help? Behavioral Warning Signs*
  - The 5 Basics of Parenting Adolescent*

Websites & Resources for Parents and Teens:

- Center for Young Men's Health at Boston Children's Hospital
  http://youngmenshealthsite.org/

- Center for Young Women's Health at Boston Children's Hospital
  https://youngwomenshealth.org/

- National Institute on Drug Abuse for Children & Teens
  https://www.drugabuse.gov/children-and-teens

- NIH: Make a difference. Talk to Your Child About Alcohol
  https://pubs.niaaa.nih.gov/publications/MakeADiff_HTML/makediff.htm

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- NIH National Institute on Drug Abuse for Teens. Drug Facts
  https://teens.drugabuse.gov/drug-facts

- NIH National Institute on Drug Abuse. Easy to Read Drug Facts
  https://easyread.drugabuse.gov/

- Partnership for Drug Free Kids
  https://drugfree.org/

Section 2: Tools for Clinicians

Adolescent Friendly Services:

- 3 Keys to Youth Friendly Health Services
  http://www.amchp.org/programsandtopics/AdolescentHealth/Documents/3%20Keys%20Infographic.png

- Adolescent Well Visit Brochure Template (click *View* then *Edit Document*)
  http://contentmanager.med.uvm.edu/docs/awv_brochure_template/vchip-documents/awv_brochure_template.docx?sfvrsn=2

- Setting Up An Adolescent Friendly Environment*
  http://contentmanager.med.uvm.edu/docs/michigan_setting_up_adolescent_friendly_enviornment/vchip-documents/michigan_setting_up_adolescent_friendly_enviornment.pdf?sfvrsn=2

- Standards of Youth Centered Care*
  http://contentmanager.med.uvm.edu/docs/standards_of_youth_centered_care_infographic_final/vchip-documents/standards_of_youth_centered_care_infographic_final.jpg?sfvrsn=2

- Tips for Creating a More Youth Friendly Clinic Environment
  http://contentmanager.med.uvm.edu/docs/oregon_doh_teenfriendlyclinic/vchip-documents/oregon_doh_teenfriendlyclinic.pdf?sfvrsn=2

- VCHIP's Adolescent and Youth Friendly Clinic Assessment Tool*

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http://contentmanager.med.uvm.edu/docs/vermont_aya_assessment_tour_toolee97e3e4b8896cc59be4ff0000359472/vchip-documents/vermont_aya_assessment_tour_toolee97e3e4b8896cc59be4ff0000359472.pdf?sfvrsn=2

Adolescent Well Visit

- Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well Care Visits http://contentmanager.med.uvm.edu/docs/paving-the-road-to-good-health/vchip-documents/paving-the-road-to-good-health.pdf?sfvrsn=a6fc679b_2

- Society for Adolescent Health and Medicine Clinical Care Resources: Adolescent and Young Adult Clinical Care Resources by Topic https://www.adolescenthealth.org/Resources/Clinical-Care-Resources.aspx

Building Strengths and Resilience

- Inspiring Health Adolescent Choices: A Rationale for and Guide to Strength Promotion in Primary Care https://www.jahonline.org/article/S1054-139X(07)00240-6/abstract

- Trauma & Resilience: An Adolescent Provider Toolkit by the Adolescent Health Working Group* https://rodriguezgsarah.files.wordpress.com/2013/05/traumaresbooklet-web.pdf

Confidentiality

- **Adolescent & Young Adult Health Care in Vermont** http://contentmanager.med.uvm.edu/docs/vermont_ayah_confidentiality_guide/vchip-documents/vermont_ayah_confidentiality_guide.pdf?sfvrsn=2

- Adolescent Health Working Group-Confidentiality http://www.publichealth.lacounty.gov/dhsp/Providers/toolkit2.pdf

General Adolescent Healthcare

- AAP: Bright Futures Periodicity Schedule* https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

- Adolescent Health Working Group https://ahwg.org/

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- Comparison of the Adolescent Well Care Visit and Pre-Participation Physical Evaluation*
  http://contentmanager.med.uvm.edu/docs/ohaosaa_wellvisit_sportphys_compare/vchip-documents/ohaosaa_wellvisit_sportphys_compare.pdf?sfvrsn=2d5e1216_2

- Health Provider Toolkit for Adolescent and Young Adult Males
  http://ayamalehealth.org/#sthash.Xx8zzFuV.GHf8CfWo.dpbs

- Know Your Health Toolkit*
  http://www.amchp.org/programsandtopics/AdolescentHealth/Documents/Know%20Your%20Health%20Toolkit%20(DRAFT)%20from%20New%20Mexico.pdf

- Michigan Adolescent Health Initiative
  https://www.umhs-adolescenthealth.org/

- Summary of Recommended Guidelines for Clinical Preventive Services for Young Adults ages 18-25
  http://nahic.ucsf.edu/wp-content/uploads/2013/10/Screening-Guidelines-YA-11.20.17.pdf

- Recommended Guidelines for Clinical Preventive Services for Young Adults ages 18-25: Risk Factors and Recommended Screening Tests
  http://nahic.ucsf.edu/wp-content/uploads/2017/11/YA-Summary-Guidelines_Nov-20-2017.pdf

Handouts

- 5 Things Parents Need to Know about the Adolescent Well Visit*
  http://idph.iowa.gov/Portals/1/userfiles/110/Parents%20Guide%20Original.pdf

- 5 Things Teens Need to Know about the Adolescent Well Visit*
  http://idph.iowa.gov/Portals/1/userfiles/110/Teens%20Guide%20Original.pdf

- Be in Charge of Your Health*
  http://idph.iowa.gov/Portals/1/userfiles/110/Be%20In%20Charge%20Original.pdf

- HPV Vaccine for Preteens and Teens
  https://www.cdc.gov/vaccines/parents/diseases/hpv-basics-color.pdf

- HPV Fact Sheets and Brochures
  https://www.cdc.gov/std/hpv/facts-brochures.htm

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- HPV Information for Parents
  https://www.cdc.gov/hpv/parents/index.html

- Human Papillomavirus (HPV) Educational Materials for Your Office Staff and to Give to Parents
  https://www.cdc.gov/hpv/hcp/educational-materials.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhpv%2Fhcp%2Ftools-materials.html

- The Adolescent Health Supervision Visit
  http://contentmanager.med.uvm.edu/docs/adolescent_well_visit_for_parents/vchip-documents/adolescent_well_visit_for_parents.pdf?sfvrsn=2

- Understanding the Roles*
  http://idph.iowa.gov/Portals/1/userfiles/110/The%20Roles%20Original.pdf

- Vermont Child Health Improvement Program's Understanding Confidentiality*
  http://contentmanager.med.uvm.edu/docs/understanding_confidentiality/vchip-documents/understanding_confidentiality.pdf?sfvrsn=2

Immunizations:

- American Academy of Pediatrics: Human Papillomavirus (HPV) CHAMPION TOOLKIT
  https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/immunizations/HPV-Champion-Toolkit/Pages/HPV-Champion-Toolkit.aspx

- Centers for Disease Control and Prevention (CDC): Vaccinations & Immunizations
  https://www.cdc.gov/vaccines/index.html

- CDC: HPV Vaccine Schedule and Dosing
  https://www.cdc.gov/hpv/hcp/schedules-recommendations.html

- CDC: Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger
  https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html

- CDC: Talking to Parents about HPV Vaccine (page 2)
  https://www.cdc.gov/hpv/hcp/for-hcp-tipsheet-hpv.pdf

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- CDC: HPV Posters
    - Protect Your Preteen Patients Today with HPV Vaccine*
      https://www.cdc.gov/hpv/hcp/hpv-important/infographic-hpv-screening-508.pdf
    - HPV Vaccine is Cancer Prevention*
      https://www.cdc.gov/vaccines/partners/downloads/teens/close-the-door-f.pdf
    - Vaccine Against Cancer for Your Kids
      https://www.cdc.gov/vaccines/partners/downloads/teens/vaccine-for-cancer-f.pdf
- Immunization Action Coalition
  https://www.immunize.org/

Interviewing

- AYA Male Health Toolkit. SAMPLE PATIENT QUESTIONS
  https://www.ayamalehealth.org/docs/Sample-Patient-Questions.pdf
- Strength-based Interviewing *(Article)*
  https://www.ncbi.nlm.nih.gov/pubmed/19492689

LGBTQ and Transgender Health

- ACT for Youth – Resources for Working with LGBT Patients: Guides, Kits and Recommendations
  http://actforyouth.net/adolescence/healthcare/lgbt.cfm
- Caring for LGBTQ Youth: The Fenway Guide to LGBT Health – Module 4
  http://www.lgbthealtheducation.org/wp-content/uploads/Module-4-Caring-for-LGBTQ-Youth.pdf
- CDC: LGBT Youth
  https://www.cdc.gov/lgbthealth/youth.htm
- Gender Pronouns*
  http://www.transstudent.org/pronounsgraphic.jpg
- GLSEN safe space kit (Safe Space kits: Be an ALLY to LGBTQ for purchase)
  https://www.glsen.org/activity/glsen-safe-space-kit-be-ally-lgbtq-youth

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- It Gets Better (Connecting LGBTQ youth around the world)
  https://itgetsbetter.org/

- **List of Mental Health Providers Experienced with Trans Youth in Vermont and New York State***
  http://contentmanager.med.uvm.edu/docs/mental_health_providers_experienced_with_trans_youth/vchip-documents/by_location_mental_health_providers_experienced_with_trans_youth.pdf?sfvrsn=6

- Outright Vermont (Local resources, support, and events)
  http://www.outrightvt.org/

- Recommendations for Promoting the Health and Well-Being of Lesbian, Gay, Bisexual, and Transgender Adolescents *(Article)*
  https://www.jahonline.org/article/S1054-139X(13)00057-8/pdf

- Safe Schools Coalition (posters, stickers, calendars for purchase)
  http://www.safeschoolscoalition.org/RG-posters.html

- The Gender Unicorn*
  http://www.transstudent.org/wp-content/uploads/2017/10/genderunicornexample1.jpg

- The Trevor Project (Crisis intervention and suicide prevention help)
  https://www.thetrevorproject.org/

Mental Health

- Cognitive Behavioral Therapy Self-Help and Therapy Resources
  https://www.getselfhelp.co.uk/index.html

Posters & Brochures

- Adolescent Working Group: Resources for Teens, Parents, and Providers
  https://ahwg.org/

- Trans Student Educational Resources
  http://www.transstudent.org/graphics

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Screening

- CDC: STD Treatment Wall Chart
  https://www.cdc.gov/std/tg2015/2015-wall-chart.pdf

- CRAFFT Screening Tool (substance use)
  http://contentmanager.med.uvm.edu/docs/crafft-adolescent-substance-use-screen/vchip-documents/crafft-adolescent-substance-use-screen.pdf?sfvrsn=7efd2bca_2

- PHQ-9 (depression screening)*
  http://contentmanager.med.uvm.edu/docs/phq_-_questions-1ffa3e0e4b8896cc59be4ff0000359472/vchip-documents/phq_-_questions-1ffa3e0e4b8896cc59be4ff0000359472.pdf?sfvrsn=2

Sexual and Reproductive Health

- 2015 STD Treatment Guidelines APP available for iPhone and Android
  - Apple Devices: https://apps.apple.com/us/app/std-tx-guide/id655206856
  - Android: https://play.google.com/store/apps/details?id=gov.cdc.stdtxguide&hl=en

- ACT Youth – Sexual Health: Clinical Tools and Patient Education
  http://actforyouth.net/adolescence/healthcare/clinical_tools.cfm

- Adolescent STI Screening guidelines – May 2014
  http://contentmanager.med.uvm.edu/docs/2014_sti_screening_guidelines_vermont/vchip-documents/2014_sti_screening_guidelines_vermont.pdf?sfvrsn=2

- Birth Control for Men (handout)*
  https://www.reproductiveaccess.org/wp-content/uploads/2014/12/bc-men.pdf

- CDC Contraceptive APP available for iPhone and Android
  - Apple Devices: https://apps.apple.com/us/app/contraception/id595752188
  - Android Devices: https://play.google.com/store/apps/details?id=gov.cdc.ondieh.nccdphp.contraception2

- Centers for Disease Control and Prevention: Morbidity and Mortality Weekly Report: Sexually Transmitted Diseases Treatment Guide, 2015
  https://www.cdc.gov/std/tg2015/tg-2015-print.pdf

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- CDC: STD Summary of CDC Treatment Guidelines 2015 Pocket Guide
  https://www.cdc.gov/std/tg2015/2015-pocket-guide.pdf

- CDC: STD Summary of CDC Treatment Guidelines 2015 Wall Chart*
  https://www.cdc.gov/std/tg2015/2015-wall-chart.pdf

- Combined and Progestin-Only Oral Contraceptives Color Photos
  http://www.contraceptivetechnology.org/wp-content/uploads/2013/10/Pill-Pages.pdf

- North American Society for Pediatric and Adolescent Gynecology Clinical Recommendations
  https://www.naspag.org/page/clinicalrecommend

- Physicians for Reproductive Health: Adolescent Reproductive & Sexual Health Case Videos
  https://prh.org/adolescent-reproductive-sexual-health-case-videos/

- Quick Start Algorithm – Patient requests a new birth control method*
  https://www.reproductiveaccess.org/wp-content/uploads/2014/12/QuickstartAlgorithm.pdf

- Reproductive Health Access Project Contraception Handouts
  https://www.reproductiveaccess.org/contraception/

- Your Birth Control Choices (handout)*
  https://www.reproductiveaccess.org/wp-content/uploads/2014/06/contra_choices.pdf

Sexual Education

- Amaze
  https://amaze.org/

Substance Use

- AAP Clinical Report: Substance Use Screening, Brief Intervention and Referral to Treatment
  https://pediatrics.aappublications.org/content/pediatrics/138/1/e20161211.full.pdf

- NIH: Alcohol Screening and Brief Intervention for Youth: A Practitioners Guide
  https://www.niaaa.nih.gov/sites/default/files/publications/YouthGuide.pdf

- NIH: The AUDIT Questionnaire*
  https://pubs.niaaa.nih.gov/publications/Practitioner/YouthGuide/AUDIT.pdf

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- SAMHSA-HRSA: SBIRT: Screening, Brief Intervention and Referral to Treatment*
  https://www.integration.samhsa.gov/SBIRT_Issue_Brief.pdf

- SBIRT – Implementing Care for Alcohol & Other Drug Use in Medical Settings
  https://integration.samhsa.gov/sbirt/Implementing_Care_for_Alcohol_and_Other_Drug_Use_In_Medical_Settings_-_An_Extension_of_SBIRT.pdf

- The CRAFFT Questionnaire (version 2.1)*
  https://www.integration.samhsa.gov/clinical-practice/sbirt/CRAFFT_Screening_interview.pdf

- **Vermont Department of Health: Division of Alcohol & Drug Abuse Programs**
  https://www.healthvermont.gov/alcohol-drugs

- **Vermont Department of Health – How do I find alcohol and drug addiction treatment in Vermont?**
  https://www.healthvermont.gov/alcohol-drug-abuse/how-get-help/find-treatment

Videos

- Adolescence 101 (video)
  https://www.youtube.com/watch?v=3s8-_X0NY8I

- Intro to Motivational Interviewing (video)
  https://www.youtube.com/watch?v=s3MCJZ7OGRk

- Motivational Interviewing: OARS Skills (video)
  https://www.youtube.com/watch?v=_KNIPGV7Xyg

- Pedicases' Effective Interviewing of Adolescent Boys and Young Men (video)
  http://pedicases.org/interviewing/vig1.html

- Seeking Common Ground: Managing Challenging Adolescent Behaviors (video)
  https://www.youtube.com/watch?v=cPDI-rTgrxE

- The Partnership for Male Youth: AYA Health Provider Toolkit (video library)
  http://www.ayamalehealth.org/video-library.php#sthash.VL1spHth.OeK4wIFH.dpbs&sref=https://delicious.com/sahrc/HealthCare

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Section 3: Online Training Opportunities for Clinicians

- Adolescent Immunization Update and the 16-Year-Old Platform
  https://www.immunize.org/webinars/atkinson2/

- Adolescent Working Group: Provider Resources
  https://ahwg.org/provider-resources/

- American Academy of Pediatrics: Role Play Simulations for Clinical Training
  https://aap.kognito.com/

- Online Training and Webinars for Health Care Professionals
  http://actforyouth.net/adolescence/healthcare/training.cfm

- SAMHSA and SBIRT: General Resources, Youth and Young Adults, and Webinars
  https://www.integration.samhsa.gov/clinical-practice/sbirt

- University of Michigan Adolescent Health Initiative: Spark Trainings
  http://www.umhs-adolescenthealth.org/improving-care/spark-trainings/

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WE'RE HERE FOR YOU

As in, you can ask us anything.

Really.

Don't worry if this takes a minute to sink in.

We're not going anywhere.

Take your time.

And if we don't hit the mark, let us know.

ADOLESCENT **HEALTH** INITIATIVE

Transforming adolescent and young adult health

www.adolescenthealthinitiative.org

Teen Pregnancy Prevention Initiative

Setting Up An Adolescent Friendly Environment

ENVIRONMENT

An adolescent-friendly atmosphere is important to setting the stage for an office visit. Magazines geared toward adolescents, as well as posters and brochures with targeted health messages in patient areas are important in making adolescents feel welcome. A separate waiting area and confidential space to complete paperwork (away from parents and others waiting to be seen) is essential.

CONFIDENTIALITY

Without confidentiality protections, some adolescents forgo care for pregnancy, sexually transmitted infections or substance abuse. Assurances of confidentiality can increase an adolescents' willingness to disclose information, report truthfully and consider a return visit.

PARENT PRESENCE

Adolescents are less likely to share information about risk behaviors when parents are present. Every treatment setting should establish routine procedures that separate parents from their adolescent children during part of each office visit.

RESOURCES

Adolescents may not have the ability to follow through with external resources or referrals provided to them. Transportation and costs are significant barriers to obtaining needed resources.

Adolescent Friendly Office Space Checklist

	Separate waiting space
	Setting up special times for adolescent visits
	Allowing more time for the first visit
	Adolescent friendly décor
	Reading materials/magazines for teens
	Targeted health messages through posters, brochures, hotline numbers and websites
	Examination table should not face the door
	Chairs in exam rooms should be utilized for the adolescent interview *(do not put an adolescent on the exam table while health professional is in a chair or in a chair with professional behind a desk)*
	Adolescents should not be asked to undress until after the interview

Visit Guidelines for Health Professionals

1) Enjoy adolescents *(display a positive attitude, be empathetic and attentive)*
2) Establish rapport *(ask about activities or hobbies they enjoy)*
3) Ensure confidentiality *(discuss confidentiality prior to beginning an assessment or interview)*
4) Discuss billing arrangements *(an insurance payment may result in parents finding out about visits and diagnosis, however a neutral diagnosis can be used in many situations)*
5) Involve the family *(discuss concerns of parents at beginning or end of the visit)*
6) Act as an advocate *(share adolescent's positive attributes, abilities and characteristics with parents/guardians)*
7) Discover hidden agendas *(a review of adolescent risk behaviors during the visit may uncover many other concerns)*
8) Information gathering using developmental approach *(refer to "Adolescent Sexual Developmental" document)*
9) Limit note taking *(take as few notes as possible during the visit)*

Standards of Quality Youth-Centered Care

Adolescents' Participation

Youth are involved in the planning, monitoring and evaluation of health services.

Policies are in place to engage adolescents in service planning, monitoring and evaluation

Adolescents' Health Literacy

Systems are implemented to ensure adolescents are knowledgeable about their health and how to access and obtain health services.

Health facility has a signboard that mentions operating hours

Provide youth with age and developmentally-appropriate health education and available services

Community Support

Parents, guardians, and other community members recognize the value of adolescent health services.

Providers educate parents, teachers, and other community organizations about the value added of adolescent health services

Appropriate Package of Clinical Services

The health facility provides a package of information, counseling, diagnostic, treatment and care services that fulfills the needs of adolescents.

Policies are in place that define the required package of evidence-based clinical preventative services

Providers' Competencies

Providers demonstrate the technical competence required to provide effective health services to adolescents (e.g. confidentiality, respect, and non-discrimination).

Providers and staff have been trained on providing sensitive health services to adolescents

Current support tools (e.g. protocols, guidelines) are in place for providers

Providers' obligations and adolescents' rights are clearly communicated to adolescent patients

Facility Characteristics

The health facility has convenient operating hours and an adolescent-friendly environment that maintains privacy and confidentiality.

Extend operating hours, allow walk-in appointments

Youth-friendly amenities in waiting room (e.g. magazines, internet access, brochures)

Equity and Non-Discrimination

Adolescents are provided quality services regardless of income, age, sex, marital status, education, race/ethnicity, sexual orientation, or other characteristics.

Policies and procedures are in place to ensure equitable care for all young people

Services are offered at more affordable rates

Providers and staff are trained on providing sensitive services to vulnerable groups of adolescents

Data and Quality Improvement

Data and service utilization and quality of care is collected, analyzed, and used to support quality improvement.

Systems are in place to collect relevant data

Staff is trained to collect and analyze data

Adolescent Health & Young Adult Health National Resource Center

WHAT are Youth-Friendly Services?

Young people may avoid accessing the services they need for various reasons including concerns about confidentiality, fear of judgment, and inconvenient hours and location. It is important that youth-serving organizations take seriously the unique needs and concerns of young people and implement changes to make their organization more youth-friendly. The World Health Organization describes youth-friendly services as those that are **equitable**, **accessible**, **acceptable**, **appropriate**, and **effective**. Take a look at the following strategies and resources to learn ways your organization's policies, practices, and environment can become more youth-friendly.

STRATEGIES for providing youth-friendly services

Make your services accessible to youth.

- Offer your services at times when youth are available. This may include after-school, evening, and/or weekend hours. Survey your youth patients or consult with a youth advisory council on their preferences.
- Provide youth access to services on short notice by offering drop-in, same-day, or next-day visits.
- Establish policies and procedures to ensure young people can access services for free or at low cost (e.g., a sliding fee scale), especially for services that teens may want to keep confidential.
- Provide services in a location that young people can easily get to. If your location is not ideal, try offering transportation assistance (e.g., bus tokens, cab fare, shuttle service). You can also install bike racks near your facility.
- Bring your services to young people. This can include partnering with youth-serving organizations (e.g., schools, community centers) to offer your services onsite.
- Provide services and materials in the languages spoken most in your community.

Create an environment that is welcoming to young people.

- Maintain a clean and welcoming environment. Some ways to make your space more youth-friendly[1] include having magazines for teens, cell phone charging stations, and artwork by local teens.
- Provide visual and auditory privacy if you offer services that might be sensitive (e.g., counseling). Room dividers and white noise machines are quick fixes for an environment with limited privacy.
- Develop and post a non-discrimination policy so youth of all identities know they are welcome.
- Review intake forms, handouts, posters,[2] and other materials to ensure they are inclusive (e.g., images reflect the diversity of your community, language is LGBTQ+ inclusive[3]) and easy to understand.[4]
- Train[5] staff to provide friendly, respectful, and non-judgmental services to youth.

Identify young people's needs and connect them to additional resources.

- Schedule longer visits with young people to ensure adequate time to address all of their needs.
- Establish an effective referral system[6] to connect young people to other youth-friendly services in the community.

Provide confidential services (where applicable).

If you offer services that are legally protected for adolescents (e.g., pregnancy testing):

- Develop and post a confidentiality policy[7] that is aligned with state laws.
- Provide clear information to adolescents, parents, and staff about which services young people can access confidentially. Strategies to share information about your confidential services may include:
  - Provide handouts[8] to adolescent clients and their parents describing the protections and limitations of confidentiality and minor consent.
  - Train[9] all staff on the protections, rights, and limitations of confidential services.
  - Train all service providers to discuss these protections, rights, and limitations in all of their interactions with adolescent clients.
  - Develop procedures to preserve the confidentiality of youth (e.g., billing, documentation).
  - If parents or guardians are present, meet with young people one-on-one for a portion of every visit.

Implement a youth-friendly marketing and communications plan.

- Increase awareness of your services and how to access them by marketing your services to young people, parents, and other adults who work with youth. Engaging youth in the development of a marketing plan can help to ensure its relevancy. Marketing strategies may include the following:
  - Utilize outreach workers and teens to promote your services at youth-serving organizations and events.
  - Communicate regularly with referring organizations (e.g., schools, health centers, youth-serving organizations) and/or trusted adults who work with youth (e.g., school counselors and coaches) to ensure they are aware of your services and know how to refer youth to them.
  - Develop print materials to distribute throughout your community, especially to referring organizations.
  - Maintain an up-to-date website and social media presence.

Solicit youth feedback on your services.

- Engage young people in providing feedback on your services. Youth engagement strategies may include:
  - Collect and review adolescent client/patient satisfaction surveys at least annually.
  - Invite a group of adolescent clients to participate in a focus group to learn about their experiences accessing your services and their ideas about how services can be improved.
  - Invite a local youth council to tour your organization and provide feedback.

Additional **RECOMMENDATIONS**

- Spark trainings,[10] pre-packaged mini-trainings for staff meetings, on topics including adolescent brain development, being youth-friendly, cultural responsiveness.
- Tools to assess youth-friendliness: Youth-Friendly Services Assessment Tool;[11] Quality Assessment Guidebook.[12]
- Factsheet on youth-friendly health care: Characteristics of Youth-Friendly Health Care Services.[13]
- Youth-friendly services staff training manual: Youth-Friendly Services: a Manual for Service Providers.[14]
- Youth engagement resources: Creating and Sustaining a Thriving Youth Advisory Council;[15] Youth-Adult Partnerships;[16] Strategies for Youth to Change the World.[17]

[1] https://www.youtube.com/watch?v=vAu5ad827I8
[2] http://www.umhs-adolescenthealth.org/wp-content/uploads/2017/01/tactac_poster-final-nologo_2.pdf
[3] https://www.lgbthealtheducation.org/wp-content/uploads/Collecting-Sexual-Orientation-and-Gender-Identity-Data-in-EHRs-2016.pdf
[4] https://www.cdc.gov/healthliteracy/pdf/simply_put.pdf
[5] http://www.umhs-adolescenthealth.org/improving-care/spark-trainings/
[6] http://www.ncsddc.org/sites/default/files/docs/referral_system_implementation_kit_020615_.pdf
[7] http://www.umhs-adolescenthealth.org/improving-care/confidentiality/
[8] http://www.umhs-adolescenthealth.org/improving-care/confidentiality/
[9] http://www.umhs-adolescenthealth.org/improving-care/spark-trainings/
[10] http://www.umhs-adolescenthealth.org/improving-care/spark-trainings/
[11] http://www.healthyteennetwork.org/resources/youth-friendly-services-assessment
[12] http://apps.who.int/iris/bitstream/10665/44240/1/9789241598859_eng.pdf
[13] http://www.healthyteennetwork.org/wp-content/uploads/2015/04/TipSheet_CharacteristicsYouth-FriendlyClinicalServices.pdf
[14] https://www.engenderhealth.org/files/pubs/gender/yfs/yfs.pdf
[15] http://www.umhs-adolescenthealth.org/wp-content/uploads/2017/02/manual-for-website.pdf
[16] http://www.advocatesforyouth.org/youth-adult-partnerships
[17] https://freechild.org/strategies/

Adolescent and Youth Friendly Service Tour
Clinic Environmental Assessment Tool

Instructions: Walk through the clinic, paying attention to how welcoming the clinic is to adolescents and young adults (AYA). After walking through the clinic site, read each statement and place an "X" in the appropriate "Yes or No" column. Please use the "Comments and Recommendations" column for any additional information that celebrates the clinic or guides improvements.

Name of Clinic: **Date of Visit:**

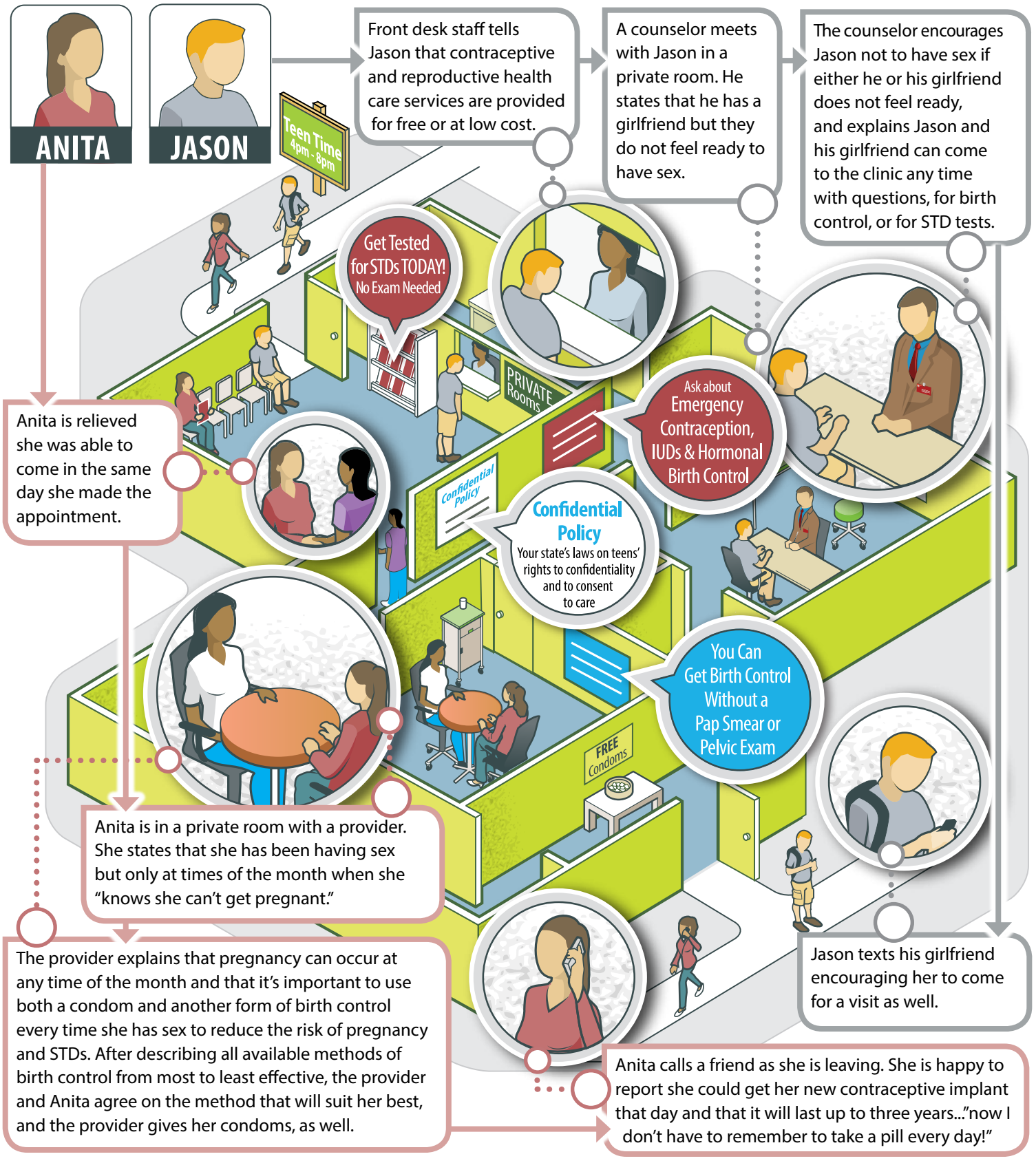
Clinic Characteristic	Yes	No	Comments & Recommendations
Accessibility			
The clinic hours are clearly posted			
The clinic is open hours that are convenient to AYA (after school, nights, weekends)			
Walk in or same day appointments are available			
The clinic is accessible by public transportation			
The clinic is accessible to people with mobility impairments			
The clinic has a working, up to date, website that is easy to find and use			
Environment			
Signage makes clear that AYA are served at this clinic			
Confidentiality policies are clearly posted			
The clinic clearly welcomes diverse groups (such as LGBT youth, racial minorities)			
Waiting environment appeals to AYA (i.e. appealing decoration, displays, music, magazines, etc.)			
Waiting room has Wi-Fi or computers to use			
Waiting room has evidence of community engagement (flyers advertising local activities, concerts, schools events, etc.)			
The clinic has posters, brochures, health educational materials that interest AYA			
Exam room environment appeals to AYA (i.e. appealing decoration, displays, music, activities, etc.)			
Routine Screening			
Clinicians use a standardized assessment tool with AYA that includes a sexual history and screening for alcohol, tobacco, and drug use, and other psychological issues			
Standardized assessment tools are easy to complete (Look at tools)			

Interview Questions ***Please speak with an identified clinic staff member to complete this section***	**Yes**	**No**	**Comments & Recommendations**
Do you communicate with AYA by their preferred method (phone, email, text, portal, etc.)?			
Does your clinic utilize social media (Facebook, Twitter, etc.) to get information to patients?			
Are AYA specific patient satisfaction surveys regularly distributed and are improvements addressed?			
Do you have a way to inform AYA, including parents and guardians, about your clinic's confidentiality policy?			
Is staff trained on policy and protocol on minor's rights and confidentiality that includes patient visits, billing, patient contact, records, and lab results?			
Are free or low cost services available if a patient does not want to use insurance for confidentiality reasons?			
Do you offer adequate appointment length to address needs of youth (enough time to discuss all an AYA's problems and concerns)?			
Are clinicians available to answer follow up questions after the visit? Can I get in touch if I have a question?			
What on-site services are available, such as metal health services, nutrition services, drug and alcohol counseling, or access to variety of birth control services?			
Are linkages in place for referrals to care for alcohol, tobacco, and drug abuse; mental health concerns; and other social service needs not offered on site?			
Are linkages are in place for referrals for clinical care and behavioral and social services specific to LGBTQ youth that are not offered onsite?			
Are linkages are in place for referrals for services related to intimate partner violence?			
Does staff ***assist*** AYA patients in making connections or making appointments to off-site services?			
Overall Assessment	**Yes**	**No**	**Comments & Recommendations**
Would you recommend this clinic to other AYA patients? Why or why not?			

*This tool adapted from the *State of Texas Youth-Friendly Services Tour: Assessment Tool &*
http://www.hse.ie/eng/services/yourhealthservice/SUI/Library/Guides/AFQuATs.pdf

A Teen-Friendly Reproductive Health Visit

Two teen-friendly reproductive health visits: one for a sexually active female, and one for a male not yet having sex.



Learn more at www.cdc.gov/TeenPregnancy/TeenFriendlyHealthVisit.html

National Center for Chronic Disease Prevention and Health Promotion
Division of Reproductive Health

CS246240

Sponsored By:
NM Adolescent & Young Adult Health CoIIN

Empowering Adolescents & Young Adults

Know Your Health Toolkit

Draft as of March 2017

YOUTH-ADULT PYD PARTNERSHIP

Thank You to ALL of Our Partners

NM Youth Partners

Alfred Delgado
Danielle Wheeler
Dayana Diaz
Destiny Onnen
Dominique Marquez
Juan Andres Rodriguez
Malcohm King
Mariah Espeset
Matilda Yatsco
Nik Hoover
Oceana Vasquez
Sarah Faulkner
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Xavier Gomez
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Sponsored By:
NM AYAH CoIIN Team
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The **Know Your Health Toolkit** is a resource for healthcare providers & staff to utilize in promoting & empowering

ADOLESCENT & YOUNG ADULT HEALTH

(Age 10-25)

GOALS: TO INCREASE

✓Youth friendly environment/services

✓Preventative health services

✓Youth health literacy

Overview

Developing the ***Know Your Health Toolkit*** was a youth-adult partnership to compile pertinent information to accomplish the goals set forth. We've done all the work so you don't have to…THAT'S AWESOME, RIGHT…

The toolkit includes 3 sections as a comprehensive approach to promoting & empowering adolescent & young adult health. The great thing about this toolkit is your healthcare clinic can work on implementing all 3 sections, 1 section or just use some resources within it. You all determine your readiness level to promoting & empowering adolescent & young adult health.

Section I: Training & Educational Material for Healthcare Providers & Staff- Get everyone within your health office or clinic to be on the same page when working with young people. Foster respect & youth-adult partnership so young people feel comfortable & want to come back to the clinic.

Section II: Assessments, Surveys & Questionnaires- Assess where your clinic is on youth-friendly services/environment. Use a holistic approach to assessing young people's health & promoting preventative services. Make sure youth have a voice!!

Section III: Know Your Health Campaign Materials- Here are several resource (posters, memes, piktocharts, handouts) to promote youth health literacy, a safe & youth-friendly environment.

UNM | SCHOOL of MEDICINE
Department of Pediatrics

envision new mexico
The Initiative for Child Healthcare Quality

Sessions are open to all professionals.
A certificate in Adolescent Health from the Division of Adolescent Medicine at the University of New Mexico is available for either content area.

How to Get Started

- ✓ Download the AHI Flyer
- ✓ Download the Case Consultation Form
- ✓ Download the Certificate Program Agreement Form
- ✓ Download the AHI FAQs.
- ✓ Download the Moodle Instructions

For more information about the

Certificate Program
Please contact: Kirsten Bennett
kdbennett@salud.unm.edu 505.925.7604

AHI sessions and case consultation
Please contact: Michelle Widener
miwidener@salud.unm.edu 505.925.7840

Go to http://envisionnm.org/index.php/telehealth/videos/#vid02
to view access the AHI archived videoed sessions.

PRIMARY CARE FOCUS:

- Cultural Perspectives in Adolescent Reproductive Health
- Adolescent Friendly Care
- Consent and Confidentiality for Minors in Health Care
- Secondary Amenorrhea and Heavy Menstrual Bleeding in Adolescents
- Sports Preparticipation Exam: Two-Minute Orthopedic Evaluation & Concussion Assessment
- Motivational Interviewing as an Approach to Addressing the Needs of Adolescents
- The Obese Adolescent: Evaluating Comorbid Conditions in Primary Care
- Gender Nonconforming/Transgender Youth: Current Concepts, Management, & Barriers to Care
- Adolescence and Population Health in the 21st Century

BEHAVIORAL HEALTH FOCUS:

- Principles of Trauma-Informed Systems of Care
- Restorative Practices in NM Medical Communities: Promising Pathways
- MORE TO COME…

H.E.A.D.S.S. Model

The H.E.A.D.S.S. Model is an easy way to assess what's happening in different areas of a young person's life. It is a holistic way of understanding different factors that could be contributing to their symptoms and/or behaviors.

- H.E.A.D.S.S.-A Psychosocial Interview for Adolescents
- Getting Into Adolescent Heads: An Essential Update By John M. Goldenring, MD, MPH, JD, David S. Rosen Contemporary Pediatrics
- Adolescent History- H.E.A.D.S.S. Assessment from Centre for Faculty Development

H.E.A.D.S.S Model
H= home environment
E= education, employment & eating
A= activities (interests & peer relations)
D= drug usage (cigarettes, alcohol, marijuana, other drugs; using and driving)
S= sexuality (sexual orientation, activity safety & issues of gender identity)
S= suicide/depression & safety (home, school, neighborhood, weapons at school, guns at home, use of seat belts)

Essential Elements When Interacting With Adolescence & Young Adults:

All providers should incorporate the essential elements when interacting with adolescents, especially around confidentiality which is one of teens' biggest concerns. These elements will promote an environment where youth feel safe and comfortable communicating their needs.

- **Review Chart, Health Questionnaire & Permission Slips**
- **Statement of Confidentiality**
- **Create Rapport**
- **Bridge Statements**
- **Use Patient's Name**
- **Recognized Verbal & Body Language**
- **Use Open-Ended Questions**
- **Active Listening**
- **Use Non-Judgmental Questions/Statements (Know Your Biases)**
- **Remember: No Assumptions**
- **Provide Health Material**
- **Understandable Terminology**
- **Follow-Up (As Needed)**
- **Exercise Warm Handoff (As Needed)**

Youth

Motivational Interviewing (MI)

Source: https://www.pinterest.com/pin/91549804897695753/

Motivational interviewing is a style of patient-centered counseling developed to facilitate change in health-related behaviors. The core principle of the approach is negotiation rather than conflict.

- A Brief Introduction to Motivational Interviewing (YouTube Video) by Bill Matulich, Ph.D., MI Network of Trainers

- Motivational Interviewing Strategies to Facilitate Adolescent Behavior Change by Melanie A. God, DO, FAAP & Patricia K. Kokotailo, MD, MPH, FAAP

Annual Comprehensive Well-Visit

Adolescence is a time when many chronic physical, mental health, and substance use conditions first emerge

$700 billion is spent annually on costs directly and indirectly associated with preventable adolescent health problems

Behavioral patterns established during adolescence influence lifelong health habits

Source: ***Strategies for Increasing Adolescent Well-Care Visits***

An annual comprehensive & confidential well- visit is one vital key to preventive services & improving young people's health. In fact, every visit should be viewed as an opportunity to ask about risky behaviors and provide brief counseling.

It's about building healthy relationships between youth and health care providers,

as well as, taking advantage of teachable moments…

- **Early and Periodic Screening, Diagnostic, & Treatment (EPSDT):** EPSDT benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services
- **Paving the Road to Good Health-Strategies for Increasing Medicaid Adolescent Well-Care Visits:** This guide offers an array of approaches in which states can choose to best fit local needs and resources and increase awareness of the importance of the well-care visit for this age group.
- **Adolescent Well Care Visit Guidance Document:** This document is a resource to help Coordinated Care Organizations (CCOs), health systems, quality improvement professionals, and providers improve their approach to comprehensive adolescent well care. This document will be updated as appropriate to reflect any changes in policy, regulation, and measurement. (Oregon Stats but good general information)

[I am looking for information for 14-17 year olds . . .]

[I am looking for information for someone 13 or under . . .]

[Places to Go For Health Care]

[Other Resources]

Feeling alone or scared? Thinking of hurting yourself? Need help?
Agora Crisis Center: 1-866-435-7166 or chat online: www.AgoraCares.org
New Mexico Crisis Line: 1-855-662-7474
National Crisis Line: 1-800-237-8255

Source: http://pegasuslaw.org/knowurrights/

NM Know Ur Rights Video Links:

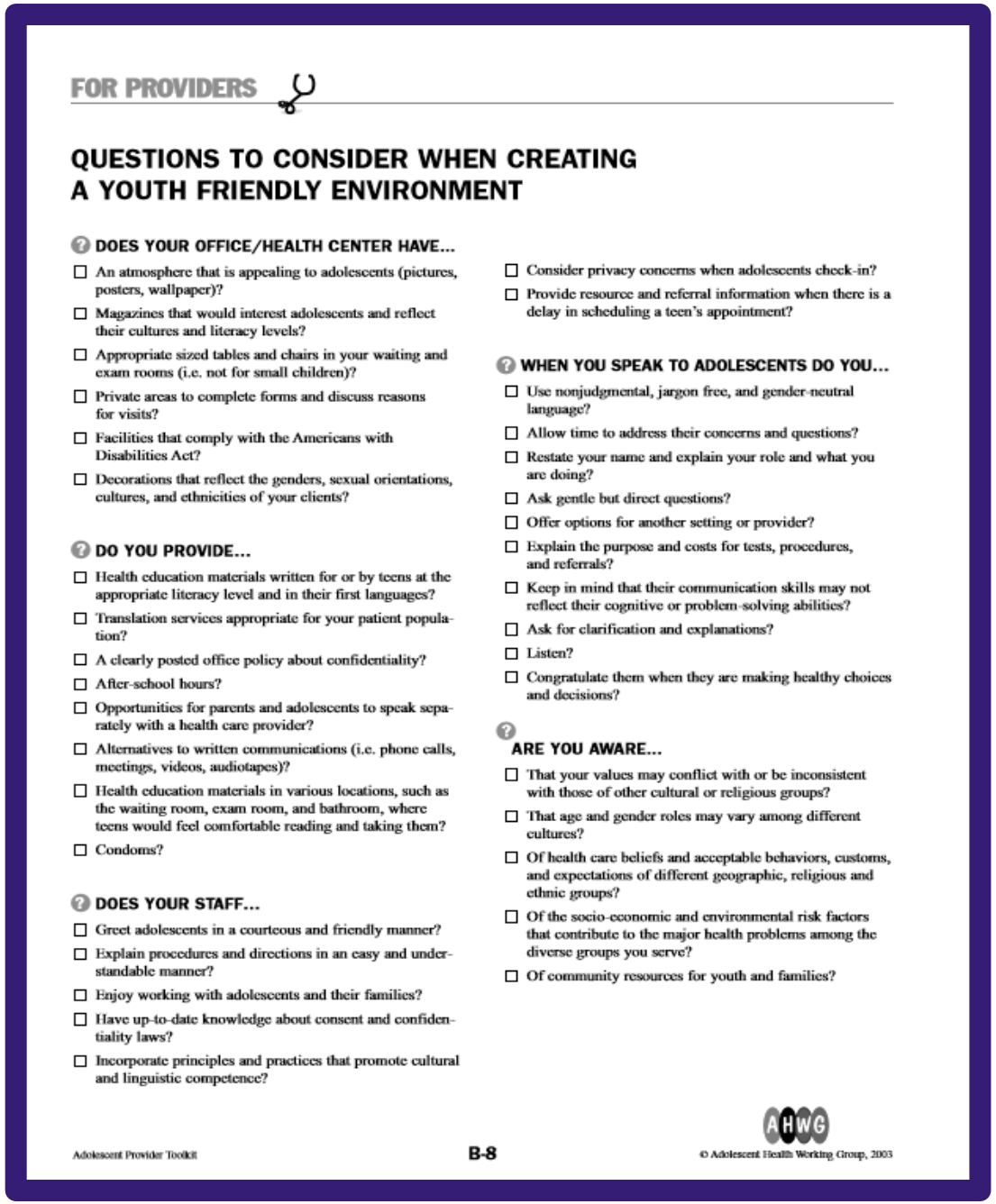
Carrie the Cool Consent Chick – Awkward Doctor

Carrie the Cool Consent Chick- Birth Control

Carrie the Cool Consent Chick- I Fell & Broke Everything

Carrie the Cool Consent Chick- STDs & Confidentiality

This page is to provide youth in New Mexico information about their rights to access health care. We use the term "consent" to talk about consenting (agreeing) to health care services. If you are looking for information on the law about consent to sex, click here.



FOR PROVIDERS

QUESTIONS TO CONSIDER WHEN CREATING A YOUTH FRIENDLY ENVIRONMENT

DOES YOUR OFFICE/HEALTH CENTER HAVE...

- ☐ An atmosphere that is appealing to adolescents (pictures, posters, wallpaper)?
- ☐ Magazines that would interest adolescents and reflect their cultures and literacy levels?
- ☐ Appropriate sized tables and chairs in your waiting and exam rooms (i.e. not for small children)?
- ☐ Private areas to complete forms and discuss reasons for visits?
- ☐ Facilities that comply with the Americans with Disabilities Act?
- ☐ Decorations that reflect the genders, sexual orientations, cultures, and ethnicities of your clients?

DO YOU PROVIDE...

- ☐ Health education materials written for or by teens at the appropriate literacy level and in their first languages?
- ☐ Translation services appropriate for your patient population?
- ☐ A clearly posted office policy about confidentiality?
- ☐ After-school hours?
- ☐ Opportunities for parents and adolescents to speak separately with a health care provider?
- ☐ Alternatives to written communications (i.e. phone calls, meetings, videos, audiotapes)?
- ☐ Health education materials in various locations, such as the waiting room, exam room, and bathroom, where teens would feel comfortable reading and taking them?
- ☐ Condoms?

DOES YOUR STAFF...

- ☐ Greet adolescents in a courteous and friendly manner?
- ☐ Explain procedures and directions in an easy and understandable manner?
- ☐ Enjoy working with adolescents and their families?
- ☐ Have up-to-date knowledge about consent and confidentiality laws?
- ☐ Incorporate principles and practices that promote cultural and linguistic competence?
- ☐ Consider privacy concerns when adolescents check-in?
- ☐ Provide resource and referral information when there is a delay in scheduling a teen's appointment?

WHEN YOU SPEAK TO ADOLESCENTS DO YOU...

- ☐ Use nonjudgmental, jargon free, and gender-neutral language?
- ☐ Allow time to address their concerns and questions?
- ☐ Restate your name and explain your role and what you are doing?
- ☐ Ask gentle but direct questions?
- ☐ Offer options for another setting or provider?
- ☐ Explain the purpose and costs for tests, procedures, and referrals?
- ☐ Keep in mind that their communication skills may not reflect their cognitive or problem-solving abilities?
- ☐ Ask for clarification and explanations?
- ☐ Listen?
- ☐ Congratulate them when they are making healthy choices and decisions?

ARE YOU AWARE...

- ☐ That your values may conflict with or be inconsistent with those of other cultural or religious groups?
- ☐ That age and gender roles may vary among different cultures?
- ☐ Of health care beliefs and acceptable behaviors, customs, and expectations of different geographic, religious and ethnic groups?
- ☐ Of the socio-economic and environmental risk factors that contribute to the major health problems among the diverse groups you serve?
- ☐ Of community resources for youth and families?

Source: http://www.ahwg.net/uploads/3/4/5/5/34557719/adolescent_health_care_101.pdf

Questions to Consider When Creating A Youth Friendly Environment

(For Healthcare Providers & Staff)

- Does your office/health center have…
  - ❑ A private area to complete forms & discuss reasons for the visit?
- Do you provide…
  - ❑ After-school hours?
- Does your staff…
  - ❑ Greet adolescents in a courteous & friendly manner?
- When you speak to adolescents, do you…
  - ❑ Use nonjudgmental, jargon free & gender-neutral language?
- Are you aware…
  - ❑ That your values may conflict with or be inconsistent with those of other cultures/religious groups?

Just Health Questionnaire

(For Young Adults 18-25 years)

What is Just Health?

Universal screen geared toward adolescent populations in primary care settings

Customized, instant individual reporting with clinical guidance and counseling messages/motivational interviewing prompts

Aggregate reporting for population management and to inform professional development planning, and evaluation

What's Inside Just Health?

- Bright Futures Guideline
- HEADSS
  - Home/School
  - Health Behaviors
  - Safety/Injuries
  - Feelings/Well-Being
  - Sexual Health
  - Substance Use
- PHQ-9
- GAD 7
- CRAFFT
- CDC Clinical STD Guidelines
- Motivational Interviewing Prompts
- Development/Future Plans

For More Information

CLICK HERE to View PowerPoint or

Contact Carlos Romero, Apex

c.romero@apexeval.org

Office: 505.828.0082

The Case for Just Health

Challenge of taking accurate, consistent, comprehensive de-stigmatized sexual history and translating data to a positive patient-provider conversation.

Patient-provider-organization-healthcare system levels

Adolescents and the primary care providers that serve them

The whole patient and relationships between sexual behavior and risk and other factors such as substance use and mental health – and a strengths-based approach.
Address continuum of education – prevention – screening - treatment

Source: Adapted from the NM School Health Questionnaire

Youth Satisfaction Survey

Adolescent & Young Adult Health National Resource Center

NM AYAH CoIIN

Building Healthy Relationships Between Youth & Health Providers

YOU COULD WIN $25

YOUTH SATISFACTION SURVEY (AGE 10-25)

How was your visit today? Your experience is important to us! Follow the link to help us improve our services for youth!

IT'S CONFIDENTIAL...

bit.ly/1Xnjs8g

When you're done, fill out your name/# and give it to the receptionist to qualify.

NAME _____

PHONE # _____

Drawings done the last Friday of each month. GOOD LUCK

Youth Voice is Vital!!

This patient satisfaction survey is vital for receiving feedback from young people to ensure quality improvement at your clinic continues to be elevated over time.

Place this poster throughout your clinic and ask young people ages 10-25 to fill out this quick and easy survey at the end of the appointment.

Make a space for the young person to fill out the survey before they leave. Be creative & provide the young person with an incentive. (See example to the left)

Tell youth their input is very important to making sure your environment & services are youth friendly. Thank them for coming in ☺

III. Know Your Health Campaign Materials

OUTLINE OF KYH CAMPAIGN MATERIALS

- Know Your Health Branding Logos
- Highlighted Health Featured Posters for Each Calendar Month
- Year-Round Health Posters
- Health Educational Handouts
  - ➢ For Adolescents & Young Adults
  - ➢ For Parents/Guardians
- Comprehensive Well-Exam Reminder Card & Resources

Branding Logos

Know Your Health Logo Created By:
Malcohm King (Young Adult)

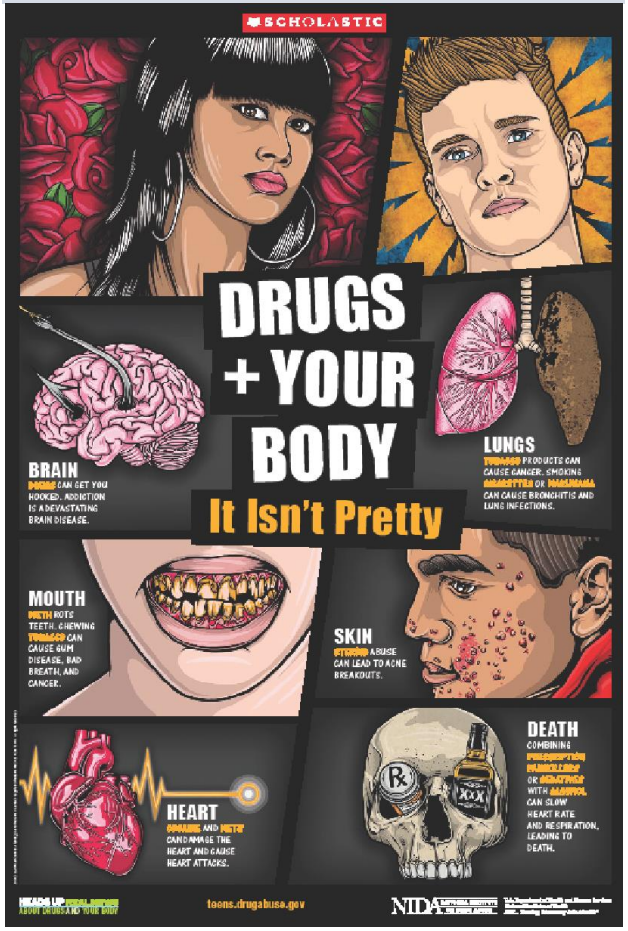
Positive Youth Development (PYD) Youth-Adult Partnership Logo Created By:
Tessa Medina-Lucero, NMDOH Adolescent Health Coordinator

Featured Poster for the month goes here☺

Campaign Poster Format: These will be approximately 24 x 38 posters.

Highlighted Health Featured Posters for Each Calendar Month

January - National Drug & Alcohol Facts



Source: https://www.drugabuse.gov/publications/drugs-your-body-it-isnt-pretty-teaching-guide-poster

February – Dating Violence Prevention

Source: http://www.loveisrespect.org/resources/download-materials/

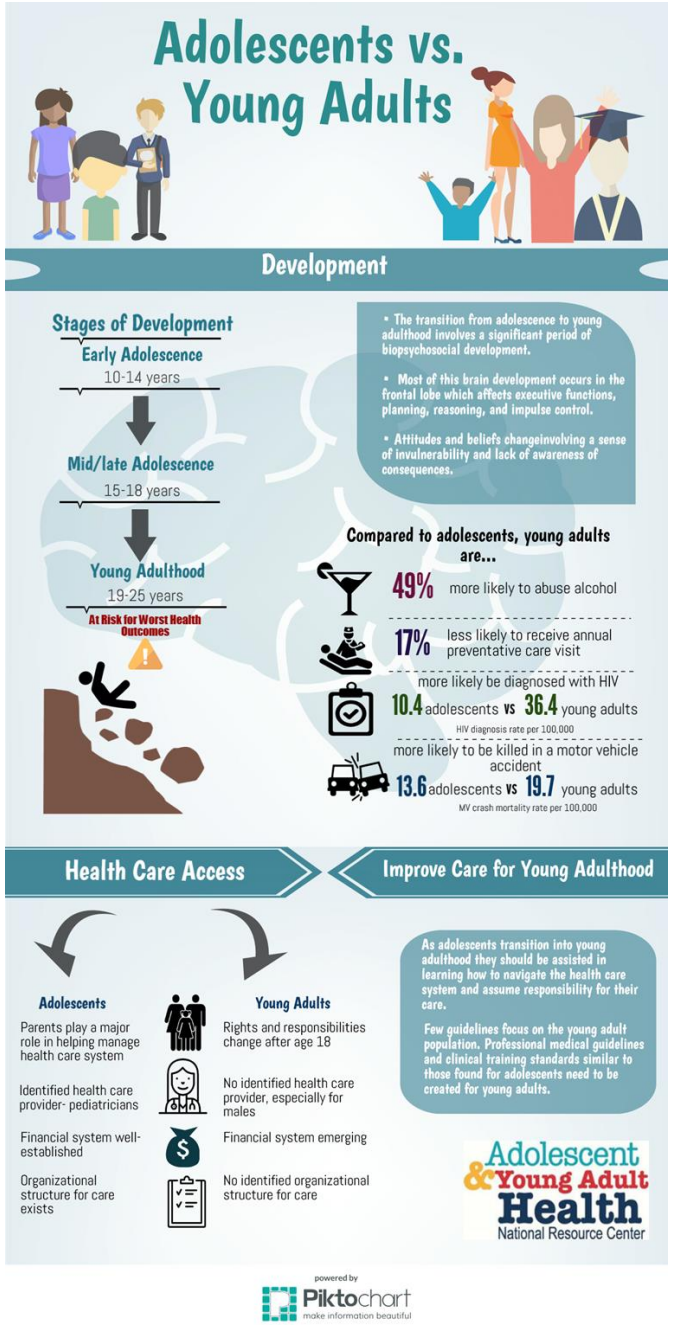
March – National Nutrition Month

Source: http://www.schoolnursesupplyinc.com/assets/images/56152.jpg

Year-Round Health Posters

(These posters should stay up throughout the year)

Source: http://www.ipgbook.com/40-developmental-assets-poster---adolescent-products-9781574822809.php



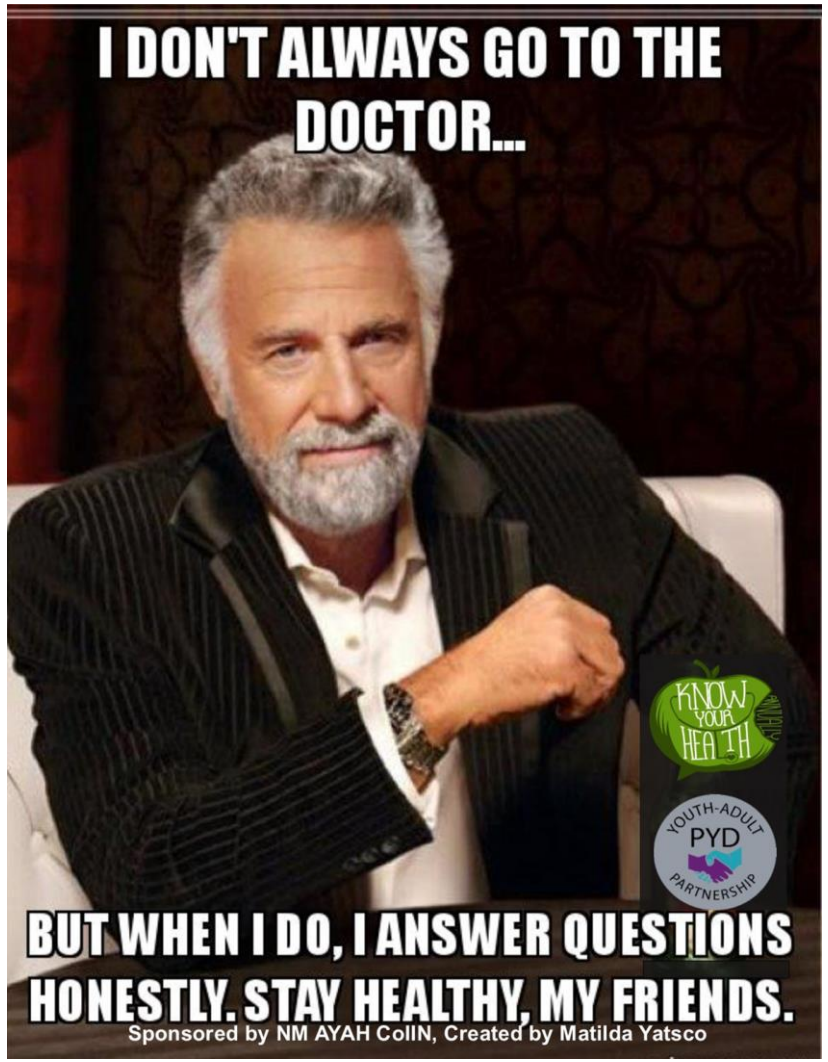
Source: http://nahic.ucsf.edu/toolkit-youth-centered-care/

Check Out What Youth & Adult Say About
2016 Head to Toe Conference
Positive Youth Development-Youth Leadership Track

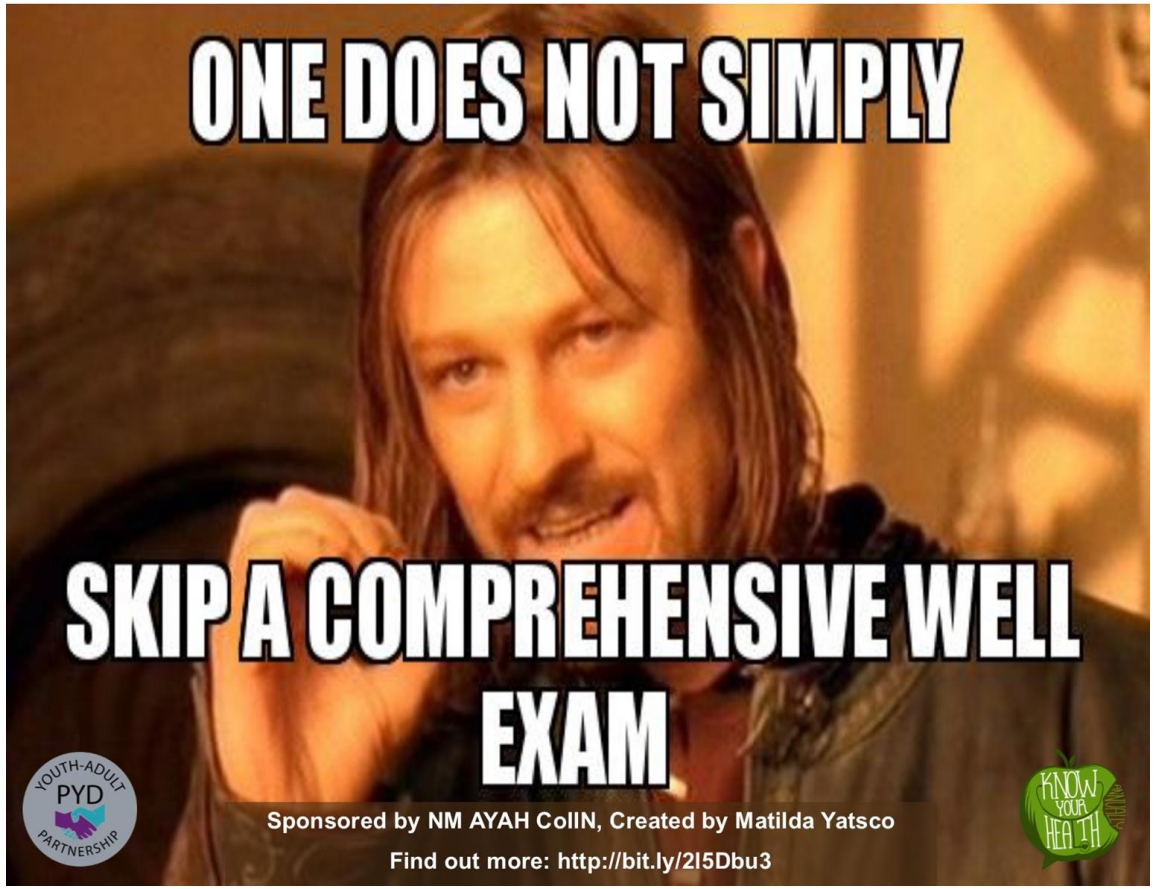
Youth Created & Meme & Infographic Posters

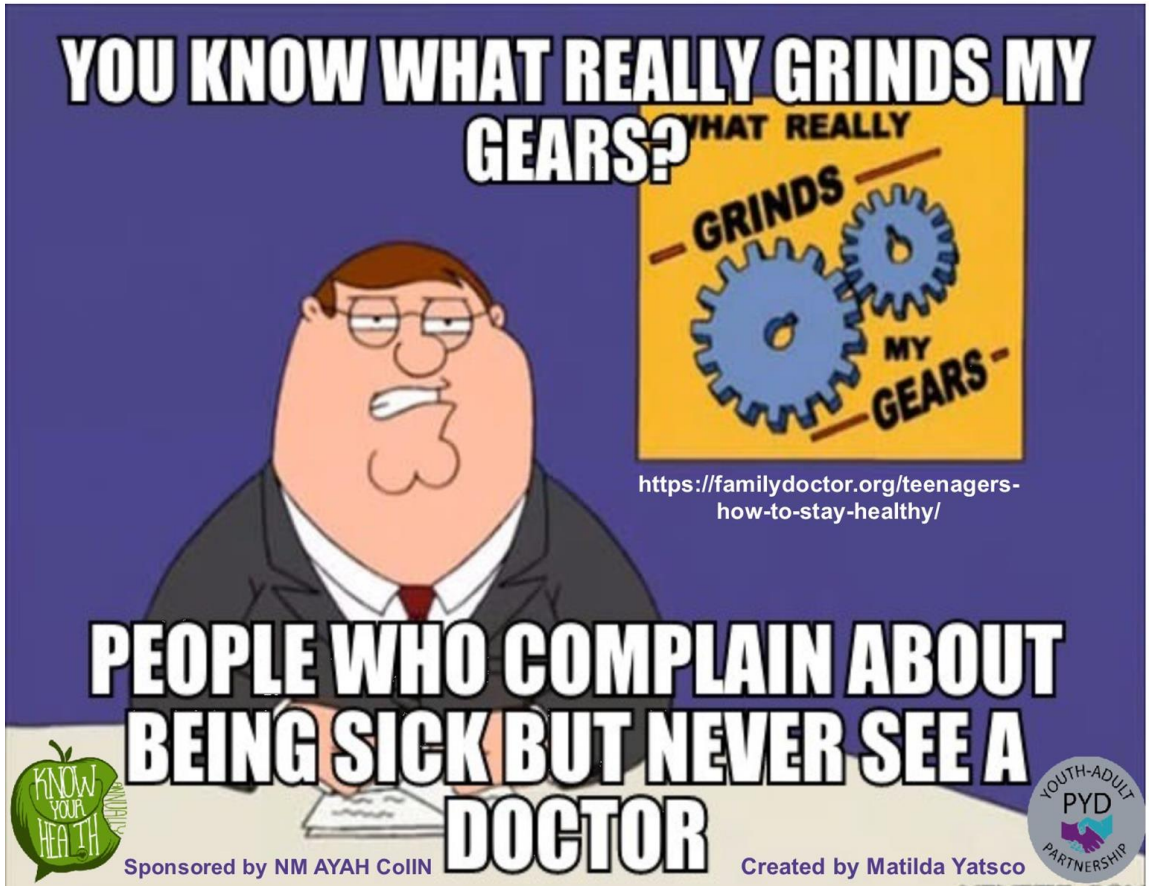
These smaller posters can be put up in your clinic &/or posted on your social media sites…
Campaign Poster Format: These will be approximately 8.5 x 11 posters.

Youth Created & Approved Messages



Youth Created & Approved Messages





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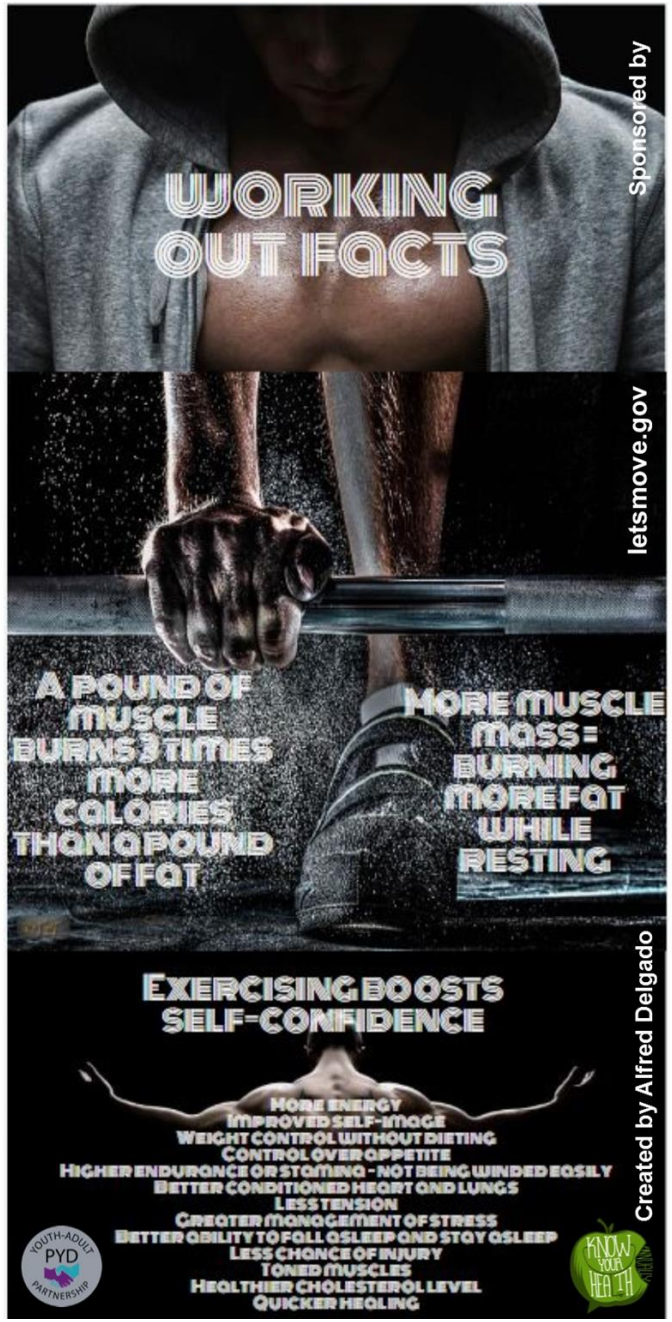
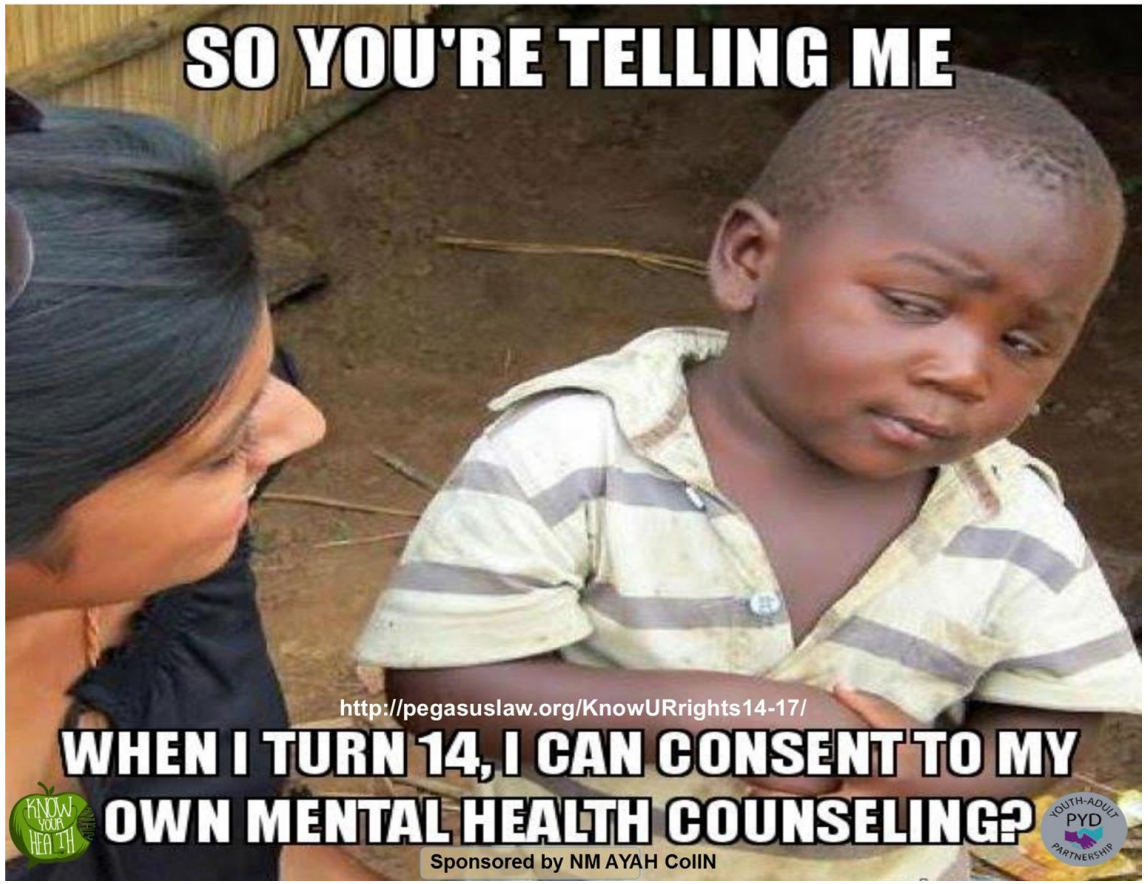


Youth Created & Approved Messages



Health Educational Handouts

(For Adolescents & Young Adults)

Take a picture it will last longer!!!

Your Health Care Rights

Know UR Rights 14-17 Information for youth ages 13 and under OR 14-17 about their rights to consent and confidentiality in health and mental health care.
Website for 14-17: http://pegasuslaw.org/knowurrights14-17/
Website for 13 or under: http://pegasuslaw.org/know-ur-rights-ages-13-and-under/

LGBTQ Health Care Bill of Rights What rights do LGBT people have right now when you go see a healthcare provider? LGBT people suffer from stigma related health issues like smoking or mental health problems.
Website: http://healthcarebillofrights.org/

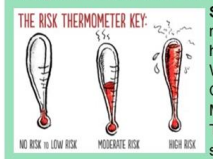
Teen Dating Violence

Love is Respect Offers support, information and advocacy to young people who have questions or concerns about their dating relationships. They also provide information and support to concerned friends.
Website: www.loveisrespect.org

Text" "loveis" to 22522 (Available 24/7/365)
Call 1-866-331-9474 (Available 24/7/365)
Take relationship quizzes such as "is my relationship healthy," "can abusers change," "am I a good partner," or "how would you help." http://www.loveisrespect.org/#quizhome
Instagram: loveisrespectofficial
Instagram: thatsnotcool
Instagram: just1love

Sex Education

In Case You're Curious Have your questions about sex, your body, relationships, birth control, STIs, etc. answered by health educators at Planned Parenthood within 24 hours.
Text: "PPNM" to 57890 (Wait for confirmation text, then send your question)
Instagram: incaseyouaecurious



Scarleteen A teen and young adult friendly service that provides information, education and support within the scope of sex and sexuality, sexual health and relationships.
Website: http://www.scarleteen.com/ (Website homepage)
Chat: http://www.scarleteen.com/our_live_chat_service (Chat services available Monday, Tuesday, Friday 3-6pm MT)
Text: 1-206-866-2279 (available 24/7. Ask questions about sex and sexuality, sexual health and relationships)

Consent Tea This flash animation video explains sexual consent, making it easier for people to know when they are giving or receiving it.
https://www.youtube.com/watch?v=fGoWLWS4-kU

Substance Abuse (Drug and alcohol)

National Institute for Drug Abuse Learn about over 15 types of drugs, including how they are used, how they affect the brain and body, and how many people die as a result of use.
Website: https://teens.drugabuse.gov/drug-facts
Call: 1-800-784-6776 (Talk to people who have successfully recovered addiction)

SAMHSA A helpline for individuals facing substance abuse and mental health issues.
Call: 1-800-662-4357 (Helpline available 24/7 in English)
SAMHSA Behavioral Health Treatment Services Locator For persons seeking treatment facilities for substance abuse/addiction and/or mental health problems.
https://findtreatment.samhsa.gov/

Suicide Prevention and Crisis Intervention

New Mexico Crisis and Access Line Their services include: crisis intervention for suicidal and homicidal thoughts, assistance with non-life-threatening mental health emergencies, trauma response, assistance with finding treatment resources, and assistance for those who have family members or loved ones who are experiencing a mental health crisis.

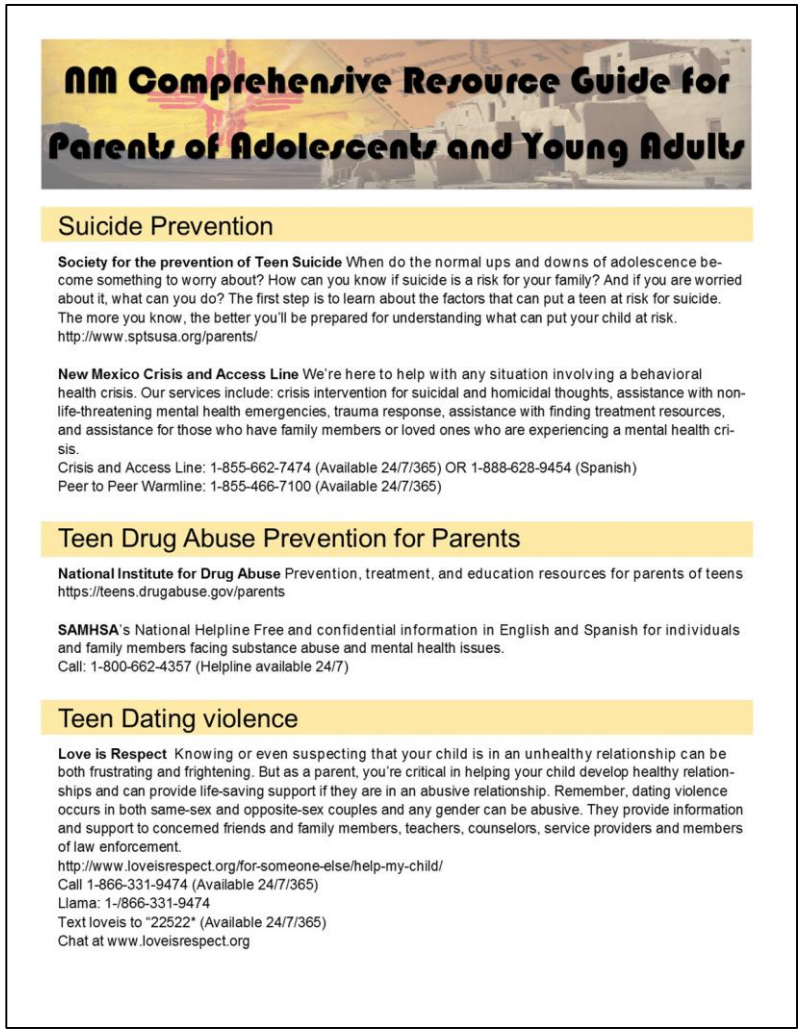
Crisis and Access Line: 1-855-662-7474 (Available 24/7/365) OR 1-888-628-9454 (Spanish)
Peer to Peer Warmline: 1-855-466-7100 (Available 24/7/365)
Native Youth Crisis Hotline Find a therapist or counselor, talk with a trusted elder, or spiritual leader
Call: 1-877-209-1266
Trevor Project The leading national organization providing crisis intervention and suicide prevention services to LGBTQ young people ages 13-24.
Call: 1-866-488-7386 (Available 24/7)
Text "Trevor" to 1-202-304-1200. (Available on Thursdays and Fridays between 1:00pm - 7:00pm MT)
Trans Lifeline is staffed by transgender people for transgender people. Trans Lifeline volunteers are ready to respond to whatever support needs members of our community might have.
Call: 1-877-565-8860 (This is a warmline i.e. people call for a variety of reasons with a variety of needs.)

Healthy Eating

MyPlate is a reminder to find your healthy eating style and build it throughout your lifetime. Everything you eat and drink matters. The right mix can help you be and feel healthier now and in the future.
Website: https://www.choosemyplate.gov/MyPlate-Daily-Checklist-input

Health Educational Handouts

(For Parents & Guardians)



NM Comprehensive Resource Guide for Parents of Adolescents and Young Adults

Suicide Prevention

Society for the prevention of Teen Suicide When do the normal ups and downs of adolescence become something to worry about? How can you know if suicide is a risk for your family? And if you are worried about it, what can you do? The first step is to learn about the factors that can put a teen at risk for suicide. The more you know, the better you'll be prepared for understanding what can put your child at risk.
http://www.sptsusa.org/parents/

New Mexico Crisis and Access Line We're here to help with any situation involving a behavioral health crisis. Our services include: crisis intervention for suicidal and homicidal thoughts, assistance with non-life-threatening mental health emergencies, trauma response, assistance with finding treatment resources, and assistance for those who have family members or loved ones who are experiencing a mental health crisis.
Crisis and Access Line: 1-855-662-7474 (Available 24/7/365) OR 1-888-628-9454 (Spanish)
Peer to Peer Warmline: 1-855-466-7100 (Available 24/7/365)

Teen Drug Abuse Prevention for Parents

National Institute for Drug Abuse Prevention, treatment, and education resources for parents of teens
https://teens.drugabuse.gov/parents

SAMHSA's National Helpline Free and confidential information in English and Spanish for individuals and family members facing substance abuse and mental health issues.
Call: 1-800-662-4357 (Helpline available 24/7)

Teen Dating violence

Love is Respect Knowing or even suspecting that your child is in an unhealthy relationship can be both frustrating and frightening. But as a parent, you're critical in helping your child develop healthy relationships and can provide life-saving support if they are in an abusive relationship. Remember, dating violence occurs in both same-sex and opposite-sex couples and any gender can be abusive. They provide information and support to concerned friends and family members, teachers, counselors, service providers and members of law enforcement.
http://www.loveisrespect.org/for-someone-else/help-my-child/
Call 1-866-331-9474 (Available 24/7/365)
Llama: 1-/866-331-9474
Text loveis to "22522" (Available 24/7/365)
Chat at www.loveisrespect.org

NM Comprehensive Resource Guide for Parents of Adolescents and Young Adults

Health Care Transition

Got Transition Transitioning from childhood to adulthood is exciting and challenging—both as a young person and as a parent of a young person. Preparing for health care transition often receives less attention than preparing for other transitions in school, work, relationships, and independent living. Learn everything you need to about health care transition.
Website: http://www.gottransition.org/youthfamilies/index.cfm

Internet Safety

Net Smartz Online-safety education for kids, parents, educators, and law enforcement
Parents and Guardian's main page: http://www.netsmartz.org/Parents
Cyberbullying: http://www.netsmartz.org/Cyberbullying
Cell Phones: http://www.netsmartz.org/CellPhones
Social Media: http://www.netsmartz.org/SocialMedia

LGBTQ youth

PFLAG Support and resources for parents, families, friends and allies of LGBTQ teens; also information on local chapters.
Information resources: https://www.pflag.org/family
NM PFLAG Chapters: http://www.pflagabq.org/links/nm_chapters.pdf

Straight for Equality Support and resources specifically for parents of transgender youth. a resource and community for people who are not lesbian, gay, bisexual, or transgender (LGBT) to understand why their voices are critical to achieving equality for all, and provide them with the information and tools to effectively raise their voices.
Website: http://www.straightforequality.org/transmaterials

Healthy Eating

MyPlate is a reminder to find your healthy eating style and build it throughout your lifetime. Everything you eat and drink matters. The right mix can help you be healthier now and in the future.
Website: https://www.choosemyplate.gov/MyPlate-Daily-Checklist-input

Comprehensive Well-Exam Reminder Card & Resources

FRONT

BACK

- ➔ Add your clinic name & contact number to the template & print out copies (front & back) on business card stock. Have them available at the front desk.
- ➔ Schedule the young person's next comprehensive well-visit before they leave, give them a reminder card and let them know there are youth-friendly resources on the back of the card, as well as, your clinics contact information in case they have any questions.
- ➔ Ask for a phone number so you can give them a courtesy call or text to remind them of the appointment a couple of days prior to the actual appointment. Follow through with what you say.

Contact Information

For more information or technical assistance, please contact:

Tessa Medina-Lucero MPH, Adolescent Health Coordinator
NM Department of Health, Office of School & Adolescent Health
Tessa.Medina-Lucero@state.nm.us

Health Providers Can Get A Package of Posters for Free!!

(LIMITED AMOUNT AVAILABLE)

Vermont Child Health Improvement Program
UNIVERSITY OF VERMONT COLLEGE OF MEDICINE

Understanding Confidentiality

Your teen is changing, and raising a teen can be tough. Teens need involved parents and adults, however, they also need privacy. Without privacy, teens may avoid getting the care they need for some health services. As a parent, it can be difficult to understand your role in privacy and confidentiality.

Your Changing Teen	The Parent	The Health Provider
• Wants more responsibility and independence • Needs more privacy • Thinks a lot about their own personal concerns • Feels no one understands them • Explores new behaviors and activities – some healthy and some risky	• Supports their teen • Listens without judgment • Guides them • Sets limits • Becomes involved and aware of what is going on in their lives • Expresses love • Acknowledges strengths • Gives them their time	• Asks about strengths • Builds rapport and trust • Acts as their health advisor • Advocates for healthy choices • Helps with any risky behaviors • Provides confidential health services and brief office interventions • Listens to concerns

Parents need to provide consent for most medical care for their teens. However, under Vermont law, teens can get private care without parental consent for some visits. These include:

- Reproductive health services
- Substance abuse treatment
- Mental health treatment

Why can my teen go to the doctor for these issues without me knowing about it?
Each state has laws for children under 18 to get some kinds of health care without parental consent. Parents play an important role in helping teens stay healthy, and most teens want their parents' advice. There are some issues that your teen may feel embarrassed, ashamed, or scared to talk about with you, and if services are not private, they may avoid going to the doctor. Most healthcare providers understand the importance of parents in the lives of teens and will encourage and assist teens in sharing difficult information with parents.

What if my teen is in danger?
In most situations that pose a substantial threat to the child's life or well-being, such as abuse, or if the teen is at risk of harming themselves or others, health providers work with the teen and/or family to ensure that appropriate referrals or resources are made available. Providers also aide the teen in communicating concerns to parents or guardians.

How do I let my teen know that they can talk to me about these issues?
Let them know you are always there to help and listen, even when you might not agree with their decisions or choices. Staying calm and helping your teen learn how to make healthy decisions will allow them the space to be independent and the assurance that you will be there to support them, even with difficult issues.

Health Rights for Teens

1. You have the right to be treated with respect regardless of race, skin color, place where you were born, religion, sex, age, sexual orientation, gender identity, gender expression, ability, immigration status, financial status, health status or parental status.

2. At this health center, you have the right to talk to your provider alone, without your parent or guardian in the room. We may encourage you to share what we talk about with a parent/legal guardian or a trusted adult.

3. You have the right for private information you share with our health center staff to remain confidential and not be shared without your permission (giving consent) except for in the cases listed below:
    - You tell us or we suspect that an adult is hurting you.
    - You tell us that you want to hurt yourself.
    - You tell us you want to hurt someone else.
    - You are under 12 years old and having sex.

4. According to Michigan law, you have the right to the following services without the permission of a parent or legal guardian:
    - Pregnancy testing, prenatal care, and pregnancy services
    - Birth control information and contraceptives
    - Testing and treatment for sexually transmitted infections
    - Substance abuse treatment
    - If you are 14 or older: outpatient counseling (mental health) services, up to 12 visits

5. You have the right to have your options for care explained to you.

6. You have the right to review your health center records.

7. If you have questions about your rights or feel you have been mistreated, please inform the health center staff.

Some insurance plans may mail information about your visit to your house.
Talk to your provider if you are using your family's insurance and want confidential care.

TIPS FOR PROTECTING YOUTH CONFIDENTIALITY

While adolescent confidentiality laws provide us with formal (although often confusing) guidelines for ensuring confidentiality of our teen patients, it is frequently the small stuff that can seriously compromise an adolescent patient's confidence in his/her provider. The following is a list of tips-some obvious, some not –for preserving patient privacy and minimizing embarrassment in a clinical setting.

1. Do not discuss patient information in elevators, hallways, or waiting rooms.
If an adolescent patient overhears this conversation, he or she may assume that you will also discuss his or her case in an open environment.

2. Do not collect an adolescent patient's medical history or reason for visit in an open area.
It will be difficult for a teenager to discuss his or her personal issues honestly if he/she thinks other people can overhear.

3. When an adolescent patient gives you a contact phone number, make sure that you can leave messages.
If you can not, ask for an alternative number at which you can leave messages if necessary.

4. Likewise, do not send mail (such as appointment reminders and bills) home unless you have discussed whether or not the patient feels comfortable receiving mail from you at his or her home.
If he or she does not wish to receive mail at home, try to work out an arrangement whereby mail is picked up at the clinic. TIP: Some clinics have check boxes indicating a teen's preference regarding mail and phone calls. Other clinics clarify what kind of message might be ok to leave at a teen's contact number. (e.g. "Tina"called).

5. When discussing anything sensitive, such as sexual history, weight, or substance use, make sure all doors are closed.
A patient in the waiting room may overhear a discussion and thus be more reluctant to share information when he or she sees the health care provider.

6. Think about how your clinic administers paperwork to patients.
Are you asking clients to fill out forms such that other people might be able to read their answers? Give out a clipboard with the forms; also make sure that there is enough room in which to complete forms with some degree of privacy.

7. Make sure that any clinic literature your clinic or practice distributes is small enough to fit into purse or wallet.
Asking a teenager to leave with bright, large brochures on a sensitive subject, such as gonorrhea, will cause more embarrassment than anything else. These types of materials should be offered to teens in private.

8. At the beginning of the appointment, make it clear that a provider is required to maintain patient confidentiality, except under very specific circumstances. Periodically remind the patient that anything he/she says about sex, drugs, and feelings will not leave the room.

IS YOUR OFFICE CONFIDENTIALITY CONSCIOUS?

Adolescents tend to underutilize existing health care resources. ***The issue of confidentiality has been identified by both providers and youth as a significant access barrier to health care.*** To support the promotion of adolescent care, please take a few moments to assess your office in determining whether it is confidentiality conscious. Creating a safe environment for teenagers to discuss issues concerning their health will facilitate the best possible care and counseling to respond to their needs.

- Do you have an office policy about confidential issues pertaining to youth and their families?
- Is it the usual practice in your clinic to allow adolescents and parents to talk separately with health care providers about their concerns?
- Do you educate your members and staff regarding laws that specifically pertain to adolescents and their right to receive care without parent or guardian's consent? (Please see summary of the "Legal Consent Requirements for Medical Treatment of minors", included in this packet.)
- Does the atmosphere (pictures, wallpapers, etc.) create a safe and comfortable environment for teens to discuss private concerns regarding their health?
- Do you display and /or offer educational materials on confidentiality to adolescent patients and/or patients?
- Are you and your staff careful not to discuss patient information in open environments (elevators, hallways or waiting rooms)?
- When collecting an adolescent patient's medical history or discussing anything sensitive, do you make sure all doors are closed?
- Do you ask if your adolescent patient feels comfortable receiving messages or mail from you, your patients, and his/her parents?
- Do you discuss situations in which you may need to breach confidentiality?

Source: Adolescent Health Working Group, 2003

PERFORMING AN ATRAUMATIC "PARENTECTOMY"

Or, how do I provide adolescent sensitive services when a parent or a caregiver is present?

Attempting to provide confidential services can cause great discomfort for the youth, parents, and providers if it is not handled in a sensitive manner. The following are recommendations that can facilitate a smooth transition from the parent-accompanied visit to the confidential adolescent visit.

ROADMAP

Lay out 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 meet together again 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 youth and parent.*
- ***Acknowledge*** *that the youth is a minor and therefore has specific legal rights related to consent and confidentiality.*
- ***Introduce*** *the concept of fostering adolescent self-responsibity and self-reliance.*
- ***Reinforce*** *that this policy applies to all adolescents in your practice or clinic (in other words, this is not specific to YOUR child).*

Validate the parental role in their child's health and well-being.

Elicit any specific questions or concerns from the parent.

Direct questions and discussion to the youth while attending to and validating parental input.

REMOVE

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

REVISIT

- Once the parent is out of the room, revisit issues of consent and confidentiality with the youth, including situations when confidentiality has to be breached (suicidality, abuse.).
- Revisit areas of parental concern with the youth and obtain the youth's perspective.
- Conduct the psycho-social interview and physical exam (ascertain whether youth desires parent's presence during PE and accommodate youth's preference.)

- Clarify what information from the psycho-social interview and PE the youth is comfortable sharing with the parent.

REUNITE

Invite the parent back to close the visit with both parent and youth.

TIPS……

- A young person is more likely to disclose sensitive information to a health care provider if the youth is provided with confidential services, and has time alone with the provider to discuss his/her issues.
- Remember that even when the chief compliant is acne or earache, there may be underlying issues on the part of the adolescent (such as the need for a pregnancy test or contraception), which will only surface when provided confidential services.

EXTRA NOTES:

Additional ways to explain your policy regarding confidentiality:

- A letter to new adolescent patient and their parents, and all parents and patients on the youth's 11^{th} or 12^{th} birthday explaining your policy. This will help families to come prepared for the adolescent and the provider to spend some time alone.
- Posters in the waiting area explaining adolescent consent and confidentiality and your policy as it relates to the law can also help lay groundwork that provider will spending time alone with the youth.

Source: Adolescent Health Working Group, 2003

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Position paper

Confidentiality Protections for Adolescents and Young Adults in the Health Care Billing and Insurance Claims Process

The Society for Adolescent Health and Medicine and the American Academy of Pediatrics

Keywords: Adolescent; Young adult; Confidentiality; Healthcare; Insurance; Billing

A B S T R A C T

The importance of protecting confidential health care for adolescents and young adults is well documented. State and federal confidentiality protections exist for both minors and young adults, although the laws vary among states, particularly for minors. However, such confidentiality is potentially violated by billing practices and in the processing of health insurance claims. To address this problem, policies and procedures should be established so that health care billing and insurance claims processes do not impede the ability of providers to deliver essential health care services on a confidential basis to adolescents and young adults covered as dependents on a family's health insurance plan.

Positions

The Society for Adolescent Health and Medicine, American Academy of Pediatrics, and American College of Obstetricians and Gynecologists endorse the following positions:

(1) Health care providers should be able to deliver confidential health services to consenting adolescents and young adults covered as dependents under a family's health insurance plan. These sensitive services include care related to sexually transmitted infections (STIs), contraception, pregnancy, substance use/abuse, and mental health, as well as care for other health issues that an adolescent or young adult considers sensitive. Assurance of confidentiality does not obviate the need for parents or guardians to be actively engaged in the care of their adolescent children, especially those who are minors, nor does it obviate the need for health care providers to assist adolescents in engaging their parents for appropriate support.

(2) Policies and procedures should be established to ensure that health care billing and insurance claims processes such as explanation of benefit (EOB) notifications do not impede the confidential provision of health care services to adolescents and young adults. Specifically:

(a) The Department of Health and Human Services should issue guidance to clarify the meaning of the terms "endanger" and "endangerment" in the special confidentiality provisions of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule [1]. These provisions allow individuals to request special privacy protections when necessary to protect the health or safety of an individual. This guidance should make clear that "endangerment" includes the harms that result when access to important sensitive services, such as contraception and STI services, is impeded by fear of loss of confidentiality.

(b) Sending of EOBs or other similar notices should not be required when individuals insured as dependents obtain sensitive services. All avenues for eliminating these requirements should be explored, including: (1) use of provisions of the Patient Protection and Affordable Care Act (ACA) [2] that require coverage of key preventive services, including contraception and many STI services without cost sharing, thereby eliminating residual financial liability on the part of a policyholder for the services [3–5]; (2) modification or interpretation of state-level EOB requirements so they do not apply when individuals insured as dependents obtain sensitive services, especially if the policyholder has no residual financial liability; and (3) negotiation between employers and health insurers to include provisions in insurance

Position Paper of the Society for Adolescent Health and Medicine and the American Academy of Pediatrics.

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contracts and policies that protect confidentiality when individuals insured as dependents receive sensitive services.

(c) Health care professional organizations, clinicians, and policymakers should explore all available legal options for enabling health care providers to deliver confidential services to adolescents and young adults in the context of health care billing and insurance claims.

(d) Health insurance plans and health care providers should collaborate to develop simplified mechanisms that allow individuals insured as dependents to receive confidential care. First, tools should be developed for health care providers to use in discussions with patients about their need for confidential care. Second, a simple procedure should be developed to facilitate health care provider use of the special confidentiality protections included in HIPAA. This would allow health care providers to designate that maintaining an adolescent or young adult's confidentiality for a particular service is needed and may be required by state or federal law. Insurers should honor requests made using this procedure.

(e) Health insurers and government agencies should provide information to adolescent and young adult patients and their health care providers about ways in which billing processes can result in inadvertent disclosure of otherwise confidential information, and ways to potentially avoid this disclosure of confidential information. Health care professionals should remind their adolescent and young adult patients about the risks of inadvertent disclosure and encourage their patients to seek information about ways to avoid unwanted disclosure of confidential information.

(f) Research is needed to determine whether existing or new policies designed to maintain confidentiality in the health care billing and insurance claims process are effective. This research should include evaluation of the interaction between confidentiality policies related to insurance and billing and those related to electronic health records [6]. To the extent that effective solutions are identified, their adoption by policymakers should be encouraged. Policies that are effective should be adopted broadly.

Background Information

EOBs and other mechanisms for communicating billing and insurance claims information to policyholders are intended to protect policyholders and insurers from fraud and abuse and to ensure policyholders have information about services provided under their health insurance policies for which they may have some financial liability. However, these forms of communication can have unanticipated and unintended negative consequences. EOBs are notifications to policyholders that health care services were provided under a health insurance plan, including those services provided to any dependents covered by the plan. Insurers routinely send EOBs to policyholders whenever a claim for services received by a covered dependent, regardless of age, is processed. EOBs generally disclose that services were provided to a dependent, the name and profession of the provider, and the specific laboratory used or other services rendered. Accordingly, EOBs and other similar communications can erode the confidential delivery of essential health care to adolescents and young adults [7,8]. Thus, although the ACA increased access to sensitive services through expanded coverage and less cost sharing, challenges remain as the ACA also expanded health insurance coverage for young adults, the group of individuals most vulnerable to confidentiality breaches by EOBs and other billing and health insurance claims communications.

Importance of confidential health services

The importance of providing confidentiality protections for adolescents and young adults seeking sensitive services—care related to STIs, contraception, pregnancy, substance use/abuse, and mental health, as well as other care for a health issue that an adolescent or young adult may perceive as sensitive, such as electronic health records—cannot be overstated [6,9]. Numerous health care professional organizations have formal policy statements supporting the importance of confidentiality [10]. These organizations include, among many others, the American Academy of Pediatrics [6], the American Academy of Child and Adolescent Psychiatry [10], the Society for Adolescent Health and Medicine [11], the American College of Obstetricians and Gynecologists [12], and the American Medical Association [13].

State and federal laws and policies

State and federal laws and policies also recognize the importance of confidentiality in health care services delivery and provide confidentiality protection. Such laws apply differently to minors and adults. It is important to note that young adults who have reached the age of majority—age 18 years in almost every state—are entitled to the same legal confidentiality protections as older adults.

Although all states have laws that specifically allow minors to provide consent for a range of sensitive services independent of their parents, variation exists among states. For example, all states allow minors to consent to the diagnosis and treatment of STIs, although some states have age restrictions (e.g., only minors over age 14 years may consent) [14]. A significant majority of states explicitly permit minors to consent to contraceptive services; in other states, minors may consent to these services on the basis of their legal status or living situation (e.g., married, emancipated, or living apart from parents) [15]. Moreover, more than half of states allow minors to consent to outpatient mental health services [16]. Finally, almost all states permit minors to consent to substance abuse counseling and treatment [16]. State laws allowing minors to consent to certain services do not guarantee confidentiality. Some states have laws that specifically prohibit providers from disclosing information about certain services to parents. Other states provide physicians with the discretion to inform parents [16]. Even if a health care provider chooses not to share or is not legally allowed to share information with the minor's parents regarding sensitive services received by the minor, breaches of confidentiality may still occur in documentation of billing and health insurance claims.

In addition to state laws, federal laws also provide a layer of confidentiality protections for both adults and minors. Federal HIPAA privacy regulations contain significant protections for individuals, including young adults and adolescents, seeking confidential health care. With regard to adults, HIPAA regulations also require the consent of patients greater than the age of 18

years before confidential health information is disclosed to parents or other family members [17]. However, an exception in HIPAA allows for, but does not require, the disclosure of protected health information without an individual's authorization when such disclosure is necessary for payment. This can result in disclosures to policyholders when an adult child is a dependent on a health plan and receives a service that leaves the parent policyholder liable for payment [17].

When minors consent for their own health care services, HIPAA regulations defer to state or other applicable law regarding whether parents have access to confidential health information about their minor children. If state and other laws are silent, HIPAA gives discretion to the health care provider whether to grant the parents access to the minor's protected health information. It is the responsibility of physicians to know the applicable laws regarding confidentiality and disclosure [14–16,18].

In addition to its general requirements, the HIPAA privacy rule also includes special confidentiality provisions that can be used when necessary to protect the health or safety of an individual. These provisions allow individuals, including young adults and minors who have consented to their own care, to:

- Request that disclosure of their protected health information not be made without their authorization. Individuals may make such requests—withhold the sending of an EOB, for example—when they believe disclosure to a family member or policyholder would endanger them [19]. Covered entities are not required to agree to such requests, but if they do agree, they are required to comply. When payment is made in full by the patient or a third party other than the insurer, a covered entity is required to withhold disclosure [20].
- Request that communications, including sending of an EOB, be made by alternate means or to a different location. Specifically, this enables a beneficiary to request communications be sent by email rather than regular mail, that phone calls to remind about appointments not be made to the beneficiary's home phone, or that mail be sent to an address other than the home address. Health care providers are required to accommodate reasonable requests of this nature. Health plans also are required to accede to such requests for these "confidential" communications but may require that the individual making the request state that disclosure of the information with respect to which the request is made would endanger the individual [19].

Expanded access to sensitive health care services

The ACA expanded access to sensitive services for both minors and young adults. For example, adult children ages 18 to 26 are allowed to remain on their parents' health insurance plans [21]. Also under the ACA, Department of Health and Human Services requires new health plans to cover specific preventive services for women without cost sharing, based on an Institute of Medicine Consensus Report. The Institute of Medicine's report recommended a range of preventive women's health services, including (1) improved screening and counseling for cervical cancer and STIs; (2) full range of Food and Drug Administration–approved contraceptive methods and reproductive counseling; and (3) annual well-women visits [22]. In addition, for both men and women, the ACA required health plans to cover without cost sharing a range of preventive services, including some sensitive services (e.g., STI screening) recommended by the US Preventive Services Task Force [3–5].

Danger to health from confidentiality loss in billing and insurance claims process

The breaches of confidentiality that occur through the billing and insurance claims process have potentially serious consequences because protecting confidentiality for minors and young adults is critical to encouraging those individuals to access health care needed to prevent negative health outcomes [6–8,11–13,18]. Although there are positive benefits of parental involvement in an adolescent's health care, situations exist in which parental notification could place an adolescent at risk of verbal and/or physical abuse or conflict. This could lead to underutilization of essential health services by adolescents. The possibility of parental notification has been shown to contribute to forgone care or delays in seeking health care. In one survey, adolescent females younger than 18 years seeking sexual health services in US family planning clinics were asked whether they would continue to use the clinic for prescription contraception if parental notification were mandated. Although 79% of adolescent patients whose parents were aware of their family planning clinic use would continue to use these services, only 29.5% of adolescent patients whose parents were unaware of their clinic visits reported intent to continue accessing the clinic for contraceptive services [8]. Overall, 18% reported that they would engage in risky sexual behavior, and 5% would forgo STI services [8]. The risk of avoiding health care because of confidentiality concerns also exists for young adults who are covered as dependents on family policies.

Given the serious consequences of unintended pregnancy and untreated STIs, lack of access to confidential care endangers the health and well being of adolescents and young adults. In addition, when individuals who have health insurance coverage are deterred from seeking services and using that coverage to pay for it, they often turn to publicly funded clinics and services, placing a burden on the public health system and potentially fragmenting care. Ultimately, stakeholders must collaborate to implement policies that enable providers to deliver sensitive health services confidentially to individuals insured as dependents in an effort to prevent unnecessary negative health outcomes.

Provisions to address confidentiality in the health care billing and insurance claims process

Current laws and policies have established ways to improve confidentiality in the health care billing and insurance claims process [23]. Some of these pertain to private health insurance plans; others are found in state Medicaid policies. In addition, some insurers, as a matter of practice, send EOBs to the patient who is >18 years rather than to the policyholder.

Several states have adopted provisions to address confidentiality in the private health care billing and insurance claims process. Approaches include identifying situations in which EOBs do not have to be sent (e.g., when no balance is due from the policyholder); sending EOBs for sensitive services directly to the patient at an address specified by that patient and using minor consent laws to specify that the care to which the minor can consent must be confidential including in the health care billing process [18,24].

Exempting sensitive services such as contraception and STI care from EOBs is standard practice in many state Medicaid programs. A review of state Medicaid policies on EOBs conducted

found that state policies vary [25]. Significantly, many states expressly exclude information related to sensitive services, such as family planning and STI services, received by Medicaid recipients, regardless of age, from EOBs.

Protecting confidentiality in health care billing and insurance claims is essential in providing health care for adolescents and young adults. Health care providers must be able to deliver confidential health services to young people covered as dependents under a family's health insurance plan. Policies and procedures should be established so that EOB notifications do not impede the otherwise confidential provision of health care services to adolescents and young adults.

Endorsed by the American College of Obstetricians and Gynecologists and should be construed as American College of Obstetricians and Gynecologists clinical guidance.

This position paper has also been endorsed by the North American Society for Pediatric and Adolescent Gynecology.

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MODULE ONE: CONFIDENTIALITY

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	"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 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).
CONTRACEPTION	A minor may receive birth control without parental consent. (Cal. Family Code § 6925).	
ABORTION	A minor may consent to an abortion without parental consent. (Cal. Family Code § 6925; *American Academy of Pediatrics v. Lungren*, 16 Cal.4th 307 (1997)).	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. (*American Academy of Pediatrics v. Lungren*, 16 Cal.4th 307 (1997); Cal. Health & Safety Code §§ 123110(a), 123115(a)(1); Cal. Civ. Code §§ 56.10, 56.11).
SEXUAL ASSAULT[1] SERVICES [1]For the purposes of minor consent alone, sexual assault includes acts of oral copulation, sodomy, and other crimes of a sexual nature.	"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).	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). 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.
RAPE[2] SERVICES FOR MINORS UNDER 12 YRS[3] [2]Rape requires an act of non-consensual sexual intercourse. [3]See also "Rape Services for Minors 12 and Over" on page 3 of this chart	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).	

MINORS OF ANY AGE MAY CONSENT	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATION OF THE HEALTH CARE PROVIDER IN RELATION TO PARENTS
EMERGENCY MEDICAL SERVICES* *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)).	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).	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. *But see exception at endnote* (EXC.)).
SKELETAL X-RAY TO DIAGNOSE CHILD ABUSE OR NEGLECT* * The provider does not need the minor's or her parent's consent to perform a procedure under this section.	"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).	Neither the physician-patient privilege nor the psychotherapist-patient privilege applies to information reported pursuant to this law in any court proceeding.
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**
OUTPATIENT MENTAL HEALTH SERVICES[4]/SHELTER SERVICES [4]This section does not authorize a minor to receive convulsive therapy, psychosurgery or psychotropic drugs without the consent of a parent or guardian.	"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).	**MENTAL HEALTH TREATMENT:** 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. *See also exception at endnote* (EXC). **SHELTER:** 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.

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
DRUG AND ALCOHOL ABUSE TREATMENT • 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)).	"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)).	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. **FEDERAL:** Federal confidentiality law applies to any individual, program, or facility that meets the following two criteria: 1. 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 2. The individual or program: 1) Is an individual or program that holds itself out as providing alcohol or drug abuse diagnosis, treatment, or referral; OR 2) 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 3) 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). 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.).

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	"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).	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). 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.
RAPE SERVICES FOR MINORS 12 AND OVER	"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).	
AIDS/HIV TESTING AND TREATMENT	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).	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).
DIAGNOSIS AND/OR TREATMENT FOR SEXUALLY TRANSMITTED DISEASES	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).	

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	"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)).	"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)).
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	An emancipated minor may consent to medical, dental and psychiatric care. (Cal. Family Code § 7050(e)). See Cal. Family Code § 7002 for emancipation criteria.	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).

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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.

CALIFORNIA MINOR CONSENT LAWS

SERVICES YOUTH CAN RECEIVE WITHOUT PERMISSION FROM THEIR PARENT/GUARDIAN		CAN PROVIDER TELL YOUTH'S PARENT/GUARDIAN?
Birth Control *Except Sterilization*	Minors of any age	**No** Parental notification allowed only with consent of minor
Pregnancy (Prev, Dx, Tx) *Including inpatient care*	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 *Including inpatient care*	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.

[1]The 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.

[2]Sexual 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.

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

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

[5]If (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					
19	M	M	CJ	CJ	CJ	CJ					
20	M	M	CJ	CJ	CJ	CJ					
21 and older	M	M	M	M	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 (3rd Dist. Ct. App. 1989); 226 Cal. Rptr. 361, 381 (1st Dist. Ct. App. 1986); 73 Cal. Rptr. 2d 331, 333 (1st Dist. Ct. App. 1998).

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

Q: What are the services a minor can consent to?	**A:** See pages 2-8 "CALIFORNIA MINOR CONSENT LAWS: Who can consent for what services and providers' obligations."
Q: If a minor cannot give consent to health care, who (besides a parent) can give it for them?	**A:** ***Adult Caretaker:*** With letter from parent, or with a caretaker consent affidavit; ***Guardian:*** With court order granting guardianship; ***Court:*** Minors 16 and over whose parents are unavailable; ***Juvenile Court:*** Minor who is a dependent of court; ***Foster Parent:*** In some cases. ***Emergency:*** Consent not required in an emergency Note: For complete information, please refer to http://www.teenhealthrights.org/
Q: How far should I go when trying to reach a parent?	**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.
Q: Can consent be given verbally?	**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)
Q: If parents give consent to treatment, does that give them the right to look over medical records?	**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.
Q: When the youth has the right to confidential care, what do I do if I'm uncomfortable NOT telling parents?	**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.

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

Q: Who is a Mandated Reporter?

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.

Q: Why and when am I required to make a report?

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.

"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."

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)

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.

Q: What about the right of patient confidentiality?

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.

Q: When does a mandated reporter have to report sexual activity?

A: See page A-8 "When Sexual Intercourse is Reportable as Child Abuse in California?"

Q: How do I make a report?

A:

1. Reports should be made to any one of the following:
   - 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:** 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:** 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: 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:** 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 <u>all</u> 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

YOUTH

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.

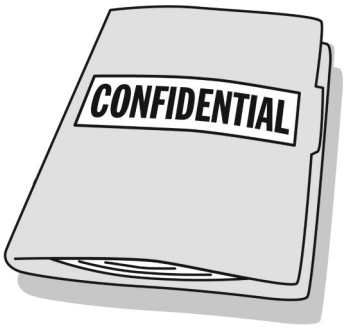
CONFIDENTIALITY TIPS FOR TEENS

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.

What we say here stays here

*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.

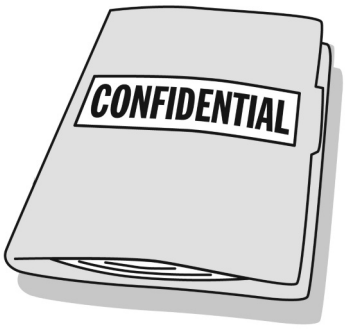
TRUE: There are many laws about what information your parent/guardian will be given. It is important to talk to your doctor about what will stay private. In some situations, you get to decide what is shared.

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/

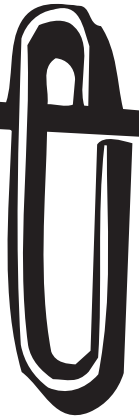
SIECUS– Families are Talking
http://www.familiesaretalking.org

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/

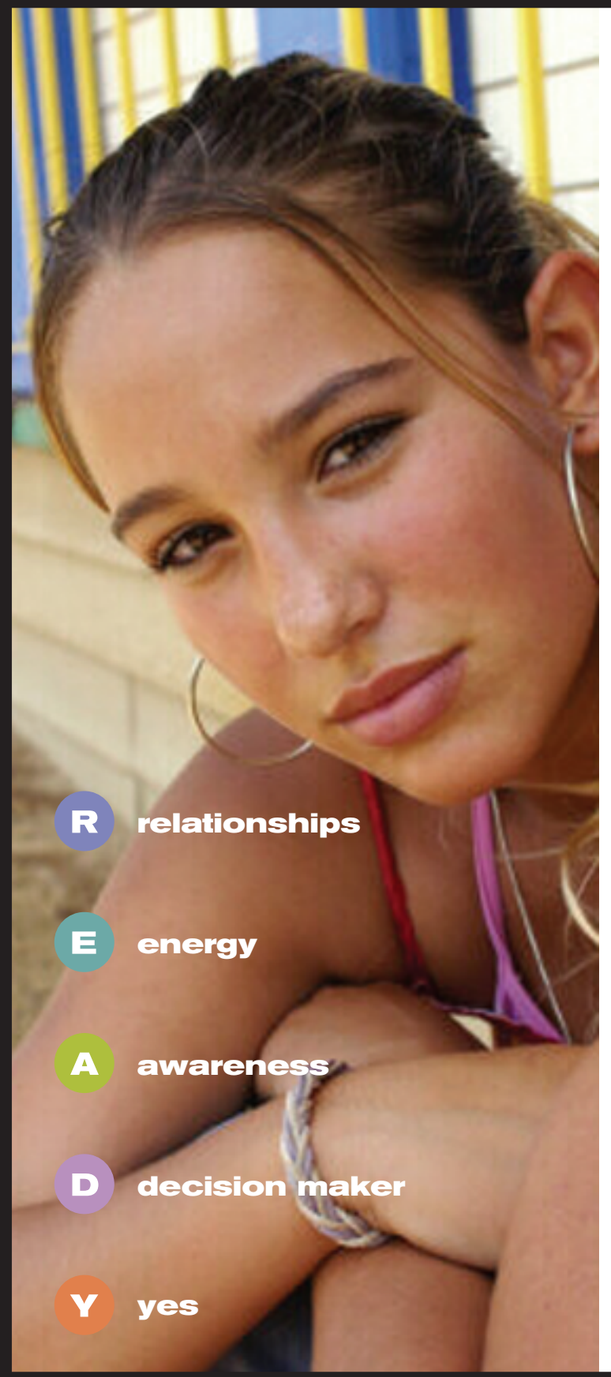
Nickelodeon–Parents Connect
http://www.parentsconnect.com

PARENT



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!



If you would like more information on adolescent parenting issues, please call the Vermont Parents Assistance Line at:

1-800-PARENTS

VERMONT FAMILIES Talk!

Vermont Department of Health
108 Cherry Street
Burlington, VT 05401

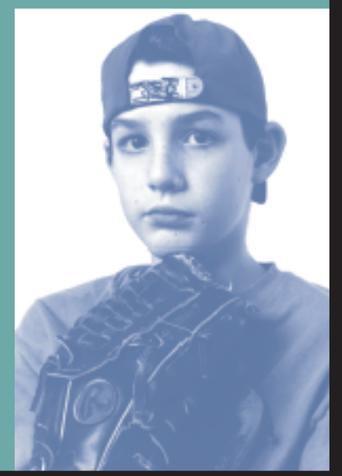
READY

FOR LIFE:

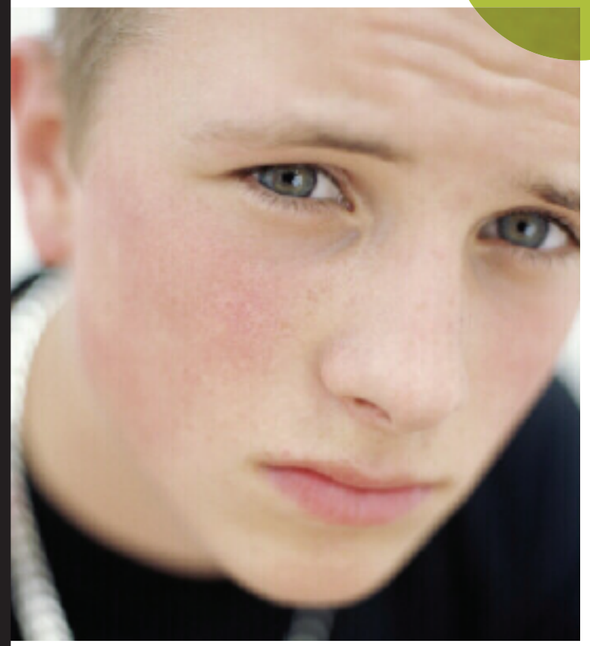
Building Adolescent Strengths

Are you worried about early and risky sexual behavior, drugs, drinking and school failure?

Most parents have instinctively been building their children's strengths since infancy but sometimes the positive messages can become buried in adolescence.



READY



Being the parent of an adolescent is a challenging and rewarding time. You watch your child develop talents and strengths for a successful adult life while at the same time learning to avoid some of the risks of youth.

Always, parents ask, "What can I do to help my child through all the ups and downs of adolescence?" Today's parents worry about drugs, drinking and smoking, early and risky sexual behavior, school failure, and any number of social and relationship problems.

There seems to be a lot of negative news for parents to hear. However there is good news for parents based on our most recent years of research. Researchers have been finding that parents can help prevent problem adolescent behaviors and promote healthy development by helping their teens build on their strengths.

The Vermont Child Health Improvement Program has developed an approach called **READY**, based on that research. The **READY** plan outlines areas of strength that will help adolescents grow successfully through their teen years. It offers parents a way to focus on those areas of strength and help their teens in a positive way.

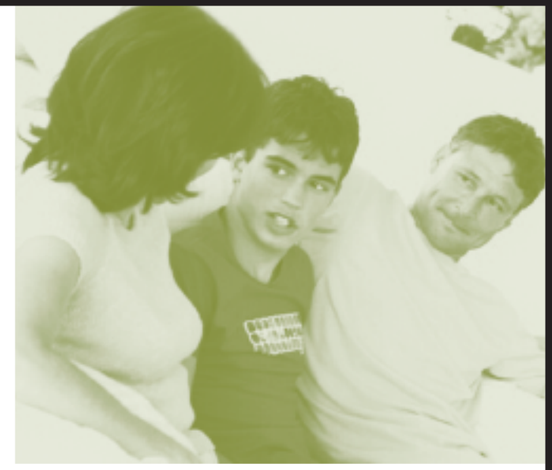
R stands for relationships with friends, other students, coworkers and family. Does your child build strong relationships with the other important people in his or her life? A teenager who feels strong bonds with family members and friends has a major strength. A primary goal of parents is to love and connect with their children. Children are much more likely than parents may think to adopt their parents' values, especially when they feel loved and connected.

E stands for energy. It's the energy to give to the things they enjoy. Many parents of strong, resilient teenagers have spent considerable effort helping their youngsters find activities that they enjoy and that give them a way to happily participate.

A stands for awareness. It's awareness of the world around them, their place in the world and their contribution. A healthy adolescent is growing into that awareness. That awareness is leading to a sense of direction and belonging, of learning how to make his or her own contribution. One way to develop this strength is through volunteer activities. Parents can help their teens learn to be contributors, enjoying a positive relationship with their community.

D stands for decision maker. Adolescents who know how to get things done and can control their behavior will have an important strength in avoiding adolescent risk behaviors. This is a major strength that leads to success in school and in extra-curricular activities. Parents can have an important role in providing opportunities for their youth to become successful decision makers.

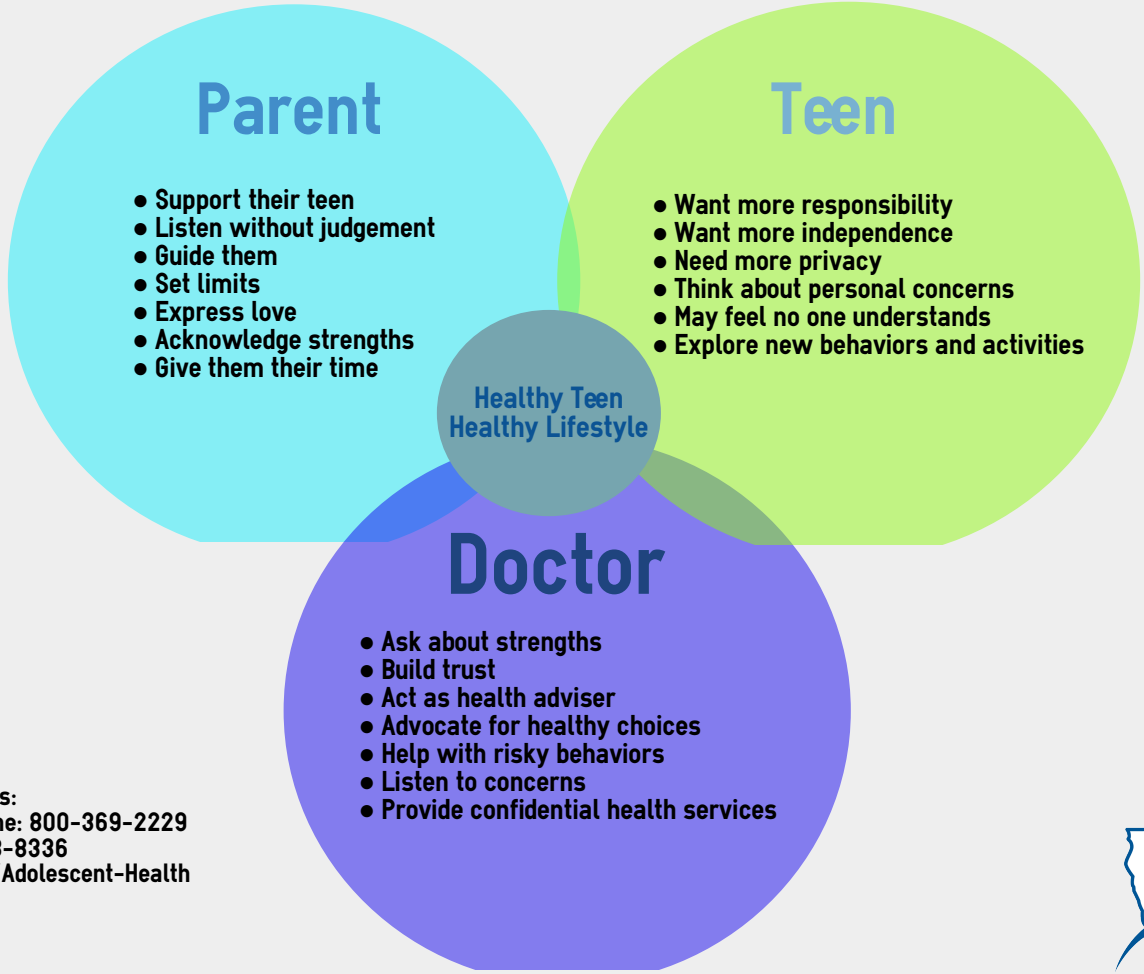
Y stands for "Yes". A strong teenager will say yes to healthy behavior; he or she will eat well, play hard, work hard. Parents can help by modeling that healthy behavior and affirming it when they see it in their own children.



With a renewed effort to approach the challenges of adolescence in a positive, strength-building way, families, pediatricians, teachers, and others working with our youth can give young people the tools they need to be successful.

Understanding the Roles

Teens experience many changes, from physical and emotional changes to social roles and relationship changes. Creating healthy behaviors early on will play an important role into adulthood. Teens need involved parents and doctors. However, they also need privacy.



Additional Resources:
Healthy Families Line: 800-369-2229
TEEN Line: 800-443-8336
www.idph.iow.gov/Adolescent-Health

IDPH
Iowa Department of Public Health

The 5 Basics of Parenting Adolescents

Adapted from "Raising Teens: A Synthesis of Research and a Foundation for Action"

1. LOVE AND CONNECT

Teens need a connection with their parents. Continue to support and accept your teen as she/he gets older and more mature.

Tips for Parents:

- Say good things about your teen when he or she does something well.
- Enjoy the good times you spend with your teen.
- Your teen will challenge your point of view. Discuss your ideas with your teen. It's OK to have a difference in opinion.
- Spend time just listening to what your teen is feeling, thinking, and experiencing.
- Treat each teen as a unique individual.
- Encourage your teen to build his or her interests, strengths, and talents.
- Provide meaningful roles for your teen in the family.
- Spend time together one-on-one and as a family.

Key Message for Parents:
Their world is changing. Make sure your love doesn't.

2. MONITOR AND OBSERVE

Teens need parents to know what is going on in their lives. Be aware of what they are doing in school and after school. Let them know you are aware of their activities. Find out what is going on by talking, not by constantly watching your teen.

Key Message for Parents:
Pay attention to your teen's activities. Your involvement matters.

Tips for Parents:

- Know where your teen is and what he or she is doing. Listen, observe, and talk with other adults who know your teen.
- Keep in touch with the other adults in your teen's life. They will let you know how he or she is doing when you are not there. Ask to know the good and the bad.
- Involve yourself in school events.
- Stay on top of information about your teen's classes, grades, job, and interests.
- Learn and watch for warning signs of physical and mental health problems.
- Ask for advice if you notice any warning signs.
- Be aware of the relationships your teen has in and outside of the home.
- Encourage your teen to challenge him or herself.

3. GUIDE AND LIMIT

Teens need parents to set clear limits. These limits should protect your teen from unsafe situations and give him/her room to grow and mature.

Key Message for Parents:
Remember to be both firm and flexible.

Tips for Parents:

- Keep two kinds of "house rules." The rules around safety cannot be argued. The rules around household tasks and schedules can be discussed.
- Have clear expectations that are high and also reasonable.
- Stand firm on the important issues such as safety and let go of the smaller issues.
- Help teens make better choices by teaching them, rather than punishing them.
- Enforce rules without hurting your teen's body or feelings.
- Give your teen more duties and more choices as they grow into adults.

The 5 Basics of Parenting Adolescents (continued)

MODEL AND CONSULT

Teens need parents to help them make good choices and guide them while they grow into adults. 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 teens to behave.
- Share your opinions with your teen.
- Model the kind of relationships that you would like your teen to have.
- Give teens truthful answers when they ask questions. Keep in mind their level of understanding.
- Take pride in your family customs. Share your family's culture and history with your teen.
- Support your teen's positive school and work habits and interests.
- Help teens plan for their future and talk about their options.
- Give teens the chance to solve their own problems and make decisions.

Key Message for Parents:
Be a good example for your teen.

PROVIDE AND ADVOCATE

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.

Key Message for Parents:
Trust your teen while guiding her or him to better choices.

Tips for Parents:

- Meet with people in your neighborhood, schools, and local groups.
- Locate the best schools and youth programs for your teen.
- Choose the safest neighborhood you can for your teen.
- Make sure your teen gets yearly health check-ups and the mental health care he or she needs.
- Find people and local groups that will help you be a better parent.

RESOURCES

- **Positive Parenting. KidsHealth for Parents:**
  www.kidshealth.org/parent/positive
  Articles in English and Spanish.
- **Parenting. About Our Kids:**
  www.aboutourkids.org/aboutour/articles_parenting.html
  Articles in English and some in Spanish, Chinese & Korean.

Do you have any comments or questions about this handout? Please contact Adolescent Health Working Group by emailing feedback@ahwg.net or calling (415) 554-8429. Thank you.

[1] 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. Adapted with permission.

PARENT

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!

P PARENT

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?

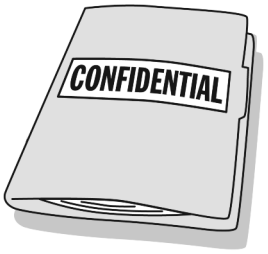
There are some limits to confidentiality. If a doctor or nurse learns that a teen under 18 years is being abused, or is thinking about hurting him/her self or others, the proper authorities must be contacted for help.

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/

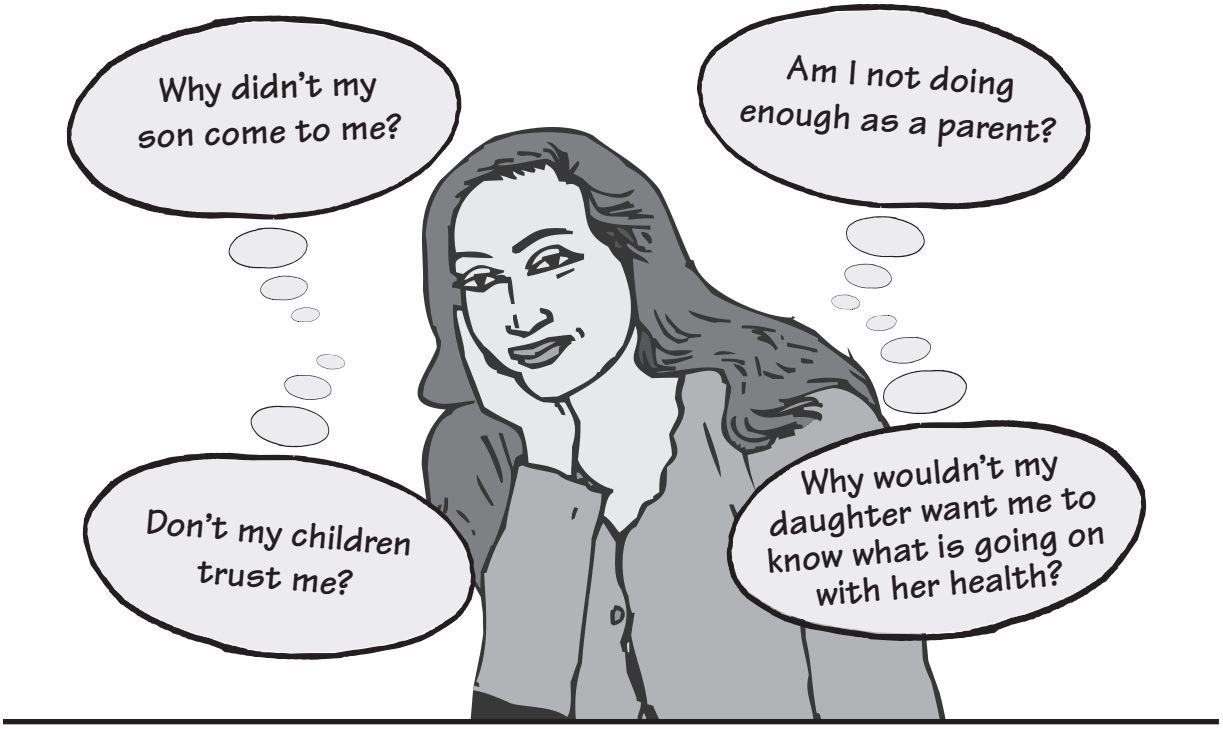
US Department of Health & Human Services–Parents Speak Up
http://www.4parents.gov/

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

PARENT

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 <u>their</u> 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 <u>their</u> 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.

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Strength-Based Interviewing

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[c]*Vermont Child Health Improvement Program, University of Vermont College of Medicine, 1 South Prospect Street, Burlington, VT 05401, USA*

Bright Futures,[1] in its 2007 guidelines, called for an assessment of adolescent development and the use of strength-based approaches in the adolescent health supervision visit. The 7 developmental tasks of adolescence noted in the developmental surveillance at each yearly visit include:

- healthy behaviors;
- caring and supportive relationships;
- physical, cognitive, emotional, social, and moral competencies;
- self-confidence, hopefulness, and well-being;
- resiliency, when confronted with life stressors;
- responsible and independent decision-making; and
- positive engagement in the life of the community.[2]

Using strength-based approaches in the clinical setting requires that clinicians have the following skills and knowledge:

- understanding what constitutes strengths;
- knowing how to ask about and elicit strengths by using a framework;
- improving youth confidence by reflecting strengths back to youth and their parents;
- providing guidance about adding strengths in domains where they may be lacking; and
- using shared decision-making strategies when behavior change is needed.

The rationale for using a strength-based approach and building developmental assets has been reviewed by us previously.[3] Risk assessment is still mandatory,

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especially for the health behaviors that contribute the most to adolescent and adult morbidity and mortality. These risk behaviors include inadequate physical activity and nutrition, sexual behavior that may lead to unintended pregnancy or infection, substance use and abuse, and behaviors that contribute to unintentional injuries and violence (ie, homicide/suicide).[4] Much of our literature review focused on finding a lower number of these risky behaviors in youth who had a greater number of developmental assets.[1,5–8]

A list of approaches that the medical home can use to support healthy adolescent development (eg, physical and psychological safety, supportive relationships, and opportunities for skill building) was provided in our previous article (see Table 3 in ref[3]). This list was adopted from a report on community approaches prepared by Eccles for the National Research Council and Institute of Medicine Committee on Community- Level Programs.[9]

The advocacy for strength-based approaches in the medical home is supported by the field of positive psychology, which builds on Bandura's social cognitive theory.[10] Both emphasize self-efficacy. A list of strengths that enable human thriving[11] can also inform this work. In addition to facilitation of self-management and behavior change, strength-based approaches can also result in more positive engagement with youth and their parents.

The work described here, which has been developed over the past 8 years, was inspired by the work of Brendtro, Van Bockem, and Brokenleg,[12] Benson,[13] and Pittman et al[14] and initiatives of the Vermont Agency of Human Services and Vermont Regional Partnerships, which have focused on community and school-level interventions.

To participate in this strength-based model, health care practitioners needed clinically workable models for integrating these services into their busy practices. Design of the practice-level implementation involved input from adolescents, parents, and professionals from schools, community groups, and youth-serving agencies as well as health care and mental health professionals. Actual implementation relied on the expertise and suggestions of Vermont pediatricians, family physicians, nurse practitioners, physician assistants and nurses, in the settings of practices, clinics, and school-based health centers.

The Search Institute work identifies 40 assets arranged in the following categories: support, empowerment, boundaries and expectations, constructive use of time, commitment to learning, positive values, social competencies, and positive identity.[5] Pittman has focused on 5 C's (competence, connection, contribution, character, and confidence)[14]; Brendtro et al, in the Circle of Courage, identified the importance of generosity, independence, mastery, and belonging.[12] Our practices were given an opportunity to choose 1 of these frameworks, and almost all chose the Circle of Courage model. Many practices have implemented

strength-based approaches and have allowed chart audits to measure their use as part of a quality improvement effort.[15] Many health care professionals, parents, and advocates in various settings outside Vermont have participated in workshops on strength-based approaches and have shared their ideas and experiences.

Several other pediatricians have devoted significant effort to similar issues, and their contributions have provided additional examples and tools for the incorporation of strengths into preventive services. Ginsberg has recommended the use of the SSHADESS (strengths, school, home, activities, drugs, emotions/depression, sexuality, safety) interview format[16] and the 7 C's, adding coping and control to Pittman's 5 C's.[17] Sege served as the project director and co-editor with Spivak, Flanigan, and Licenziato for the American Academy of Pediatrics *Connected Kids: Safe, Strong, Secure Clinical Guide* (2007).[18] *Connected Kids*, which includes parent handouts and a practitioner guide, outlines a strength-based approach to violence prevention.

IDENTIFYING STRENGTHS: A PRACTICAL APPROACH

Most pediatricians are already asking a lot of questions about strengths, although not necessarily in a systematic way. We commonly ask questions related to mastery and belonging, but adolescents need to develop all the strengths to be successful adults. Incorporating strengths in your adolescent interviews is not an "add-on" to the clinical visit but, rather, a rethinking of the way you work with adolescents, a way to efficiently reorganize and prioritize the content of anticipatory guidance.[19] The goals of a strength-based approach are to raise adolescents' awareness of their developing strengths and to motivate them to take responsibility for the role they can play in their own health and well-being. Discussing strengths orients youth toward actively seeking out and acquiring the personal, environmental, and social assets that are the "building blocks" of future success.

If you are already using a HEADSSS (home, education, activities, drugs, sexual activity/sexual identity, suicide/depression, and safety) type of interview strategy,[20] you would just need to add a few more questions (Table 1). Ginsburg has suggested using the SSHADESS format[16] as a way to remember to ask about strengths. He comments that "we risk losing the opportunity to inspire (adolescents) when they quietly become defensive and close themselves off."[16] Respectful, reflective listening, rather than teaching or preaching, allows adolescents to reveal their strengths.

If you choose to use the Brendtro et al Circle of Courage as your framework, you will be asking about strengths in 4 essential areas (Table 2). You would not use all the questions, and you would probably want to ask slightly different questions on the basis of the age of the adolescent and what you already know about his or her strengths and challenges.

Table 1
Using HEEADSSS with a strength-based approach

HEEADSSS Risk Areas	Questions to Help Identify Strengths	Example Responses Indicating the Presence of Strengths	Strengths
Home	Who lives at home with you?	Close family relationships (as opposed to living alone)	Belonging
	What responsibilities do you have at home?	Care-taking responsibilities	Generosity
Education/employment	What's going well at school?	Working with a tutor	Independence
	Are you working?	Working for college money	Mastery
Eating	How do you stay healthy?	Choosing healthy foods	Independence
	What do you think about your diet?	Making healthy meals	Mastery
Peer-related activities	What do you do for fun?	Volunteer/civic activities	Generosity
	Do you have friends you socialize with?	Hanging out with friends	Belonging
Drugs	Do you have friends who use drugs? Do you?	Pledge to abstain	Independence
		Friendships with people who do not use drugs	Belonging
Sexuality	Have you ever had sex?	Consistently responsible behavior	Independence
	Has anyone ever made you do something you didn't want to?	Supportive or understanding relationships	Mastery; belonging
Suicide/depression	What do you do when you feel sad?	Access to a confidant	Belonging
	Do you have someone you talk to about your problems?	Successful coping skills	Mastery; independence
Safety from injury and violence	Do you wear a seatbelt? Do you wear a helmet when riding bikes?	Seatbelt and helmet use	Independence
	Do you feel safe at home?	Feelings of safety or security at home and school	Belonging

Adapted from Goldenring JM, Rosen DS. Getting into adolescents heads: an essential update. *Contemporary Pediatrics*. 2007. Reprinted with permission from Duncan PM, Garcia AC, Frankowski BL, et al. Inspiring healthy adolescent choices: a rationale for and guide to strength promotion in primary care. *J Adolesc Health*. 2007;41(6):531

Some may want to use a different framework with older adolescents. The "READY for Life" framework[21] can work well with older adolescents:

Am I READY for life as an adult[21]?

- Relationships with friends, other students, co-workers, and family

Table 2
Identifying Strengths

Belonging (connection)	How do you get along with the different people in your household?
	What do you like to do together as a family? Do you eat meals together?
	Do you feel you have at least 1 friend or a group of friends with whom you are comfortable?
	What do you and your friends like to do together after school? On weekends?
	How do you feel you "fit in" at school? In your neighborhood?
	Do you feel like you matter in your community?
	Do you have at least 1 adult in your life who cares about you and to whom you can go if you need help?
	When you're stressed out, who do you go to?
Mastery (competence)	What do you do to stay healthy?
	What are you good at?
	How are you doing in school?
	What do you like to do after school with your free time?
	Do you feel you are particularly good at doing a certain thing like math, soccer, theater, cooking, hunting, or anything else?
	What are your responsibilities at home? At school?
Independence (confidence)	Do you feel that you have been allowed to become more independent or make more of your own decisions as you have become older?
	Do you feel you have a say in family rules and decisions?
	Are you able to take responsibility for your actions even when things don't work out perfectly or as you planned?
	Have you figured out a way to control your actions when you're angry or upset?
	Everyone has stress in their lives. Have you figured out how to handle stress?
	How confident are you that you can make a needed change in your life?
Generosity (contribution, character)	What makes your parents proud of you?
	What do your friends like about you the most?
	What do you like about yourself?
	What do you do to help others (at home, or by working with a group at school, church, or community)?
	What do you do to show your parents or siblings that you care about them?
	How do you support your friends when they are trying to do the right thing, like quitting smoking or avoiding alcohol and other substances?

- Energy to give to the things you enjoy
- Awareness of the world around you, your place in the world, and your contribution
- Decision-maker (you know how to get things done and control your behavior)
- Yes—you should say yes to healthy behavior: eat well, play hard, work hard

This can be used to help adolescents take stock of what strengths they already have, on what strengths they need to work, and how they can use strengths to

make needed changes. The READY brochure, written for the parents of adolescents, outlines these concepts further.[21]

TEACHING STRENGTHS TO PARENTS

Pediatricians may find it helpful to explain strengths to parents of adolescents. Just as we use anticipatory guidance in early childhood to help parents watch for expected milestones, the strengths are expected and necessary milestones for adolescents. Parents can play a needed role in encouraging strengths in areas that are lagging. In addition, pediatricians should be committed to recognizing and reinforcing parents' strengths by using a similar framework. Pointing out a parent's strengths can be particularly helpful when he or she is going through a difficult time with an adolescent son or daughter.

Parents are often worried about the risks of adolescence and are sometimes so put off by their own child's behavior that they tend to worry about and focus on the negative aspects of adolescence rather than seeing it as a growth experience for them and their child. Adolescence takes many parents by surprise. By teaching them to "watch out" not only for risky behavior, we can help them see their own child's strengths and help them figure out ways to build strengths that may need boosting. All parents want their children to experience joy, success, love, and hope, and adolescents need to develop all the strengths to end up as happy, productive adults.

strengths = assets = protective factors = developmental milestones for adolescents

Using the Circle of Courage framework is 1 way to explain the strength-based approach to parents.

Mastery

"What am I good at?" Parents need to help their adolescent figure this out, especially if he or she is not a great student. Encourage your adolescent to try sports, clubs, a musical instrument, etc. Make him or her an expert on something in the family (research driving directions on-line before a family trip). Model problem-solving behaviors when something does not go well. Help the adolescent to be persistent when he or she does not succeed at something the first time around (or second). Make him or her feel competent in more than 1 area.

Belonging

"Who do I fit in with? Who do I feel connected to?" Parents are often disappointed as friends become more important, but peer relations are vital to adolescents. Keeping your adolescent attached to your family as he or she develops friendly and romantic relationships is tricky. Get to know your adolescent's

friends and make your home a welcome place for them. Encourage appropriate relationships with other adults you trust. Be sure your child knows to whom he or she can go if there is a problem that he or she does not feel can be shared with you (his or her doctor could be one of these people). Help your adolescent figure out how he or she "fits in" with your extended family ("Your little cousins sure look up to you and love to play soccer with you!"), your neighbors ("If I wasn't home and you had a problem, you could get help from Mrs X or Y." "Let's help Mr Z shovel his driveway/mow his lawn."), his or her school ("Who are the teachers/students you get along with the best?"), and his or her community (attend neighborhood events together, or encourage your adolescent to go with his or her friends), including faith-based organizations.

Independence

This is scary for parents of early adolescents, but we all want our children to grow up and be able to function independently (yet remain attached). For many adolescents, this means starting to make healthy independent decisions for themselves, especially decisions to avoid unhealthy risks. Guide your adolescent in healthy decision-making; let him or her work out the solution to a problem and then run it by you for final approval. Independence also means being responsible; as time goes by, this should happen more and more with less and less reminding from you. Some adolescents have a harder time gaining independent control of their behavior and showing self-discipline. Point out to your adolescent that every time he or she makes a healthy decision and controls his or her behavior without reminders from you, he or she is exercising independence. Encourage confidence in your adolescent by putting your trust in him or her when you assign a task to do. Good teachers will try to do the same thing. Let your adolescent take a leadership role in something he or she is good at.

Generosity

This can be the most difficult strength for some adolescents to develop, because most of them go through a stage when they are naturally self-centered as they try to figure out who they are. Point out and name qualities such as caring, sharing, loyalty, and empathy when you see your adolescent displaying them with his or her friends. Encourage the adolescent to practice these qualities when it is more difficult (eg, with a younger brother or an unpopular classmate). The broadest definition of this strength is the sense of giving back to one's community. This can start with parents involving adolescents in volunteering in their neighborhood, school, or faith-based community. Many older adolescents who have not developed this strength feel like they do not "matter" in their family, school, or community. The ability to feel like what you do matters—that the world (or at least your family, school, or community) is a little better because you are there—is very empowering, gives adolescents confidence and hope, and keeps them engaged.

Armed with these strengths, adolescents can be encouraged to take "healthy" risks. As youth advocate Matt Morton has noted, "If you don't give us healthy risks to take, we'll take unhealthy ones."[22] Remember, it is the taking of risks and failing, then having the strength, confidence, and hope to try again, that helps adolescents become resilient adults.

GOING TO THE NEXT LEVEL: USING STRENGTHS

After eliciting strengths in an adolescent, there are several things a clinician can do with the information. First, you can identify or reflect back the adolescent's strengths as a teaching tool about strengths and youth development (much as we encourage parents to identify or put into words a younger child's emotions). Many talented youth do not recognize their own strengths until they are pointed out to them. Second, you can make suggestions to boost strength areas that may be lacking or deficient, because adolescents need strengths in all areas to become healthy, happy, productive adults. Third, you can use strengths as an engagement strategy to lead into a discussion about a needed behavior change. Fourth, you can bring strengths into a structured discussion about behavior change, such as shared decision-making or motivational interviewing.[23]

Some examples of using the Circle of Courage as a teaching tool for adolescents are as follows:

- For a younger adolescent: "Some kids struggle in middle school or high school and get involved in unhealthy, risky behaviors. Others have an easier time becoming a healthy adult. Young people who develop strengths in these 4 areas seem to be 'protected' from a lot of these risks. I can't help but notice that you have developed strengths in these areas [point out strengths that you have elicited]. Are there any areas you think you could work on getting better at?"
- For an adolescent with special health needs (eg, spina bifida): "Have you heard of the Circle of Courage? It represents strengths I look for in adolescents that can help them mature into healthy adults. I can't help but notice how many strengths you have developed over the past 2 years. You struggled, especially with friendships and independence in middle school, but you're doing well in those areas now. And you've really developed your talent for art, and you are thinking of becoming an art teacher. Generosity, making a contribution in your community, is also important. Have you ever done any volunteer work? Would you consider working with children at the homeless shelter? They have program called 'Art From the Heart,' and I think the kids would really enjoy working with you."

Sometimes we notice that a particular strength is lacking in some adolescents. See Table 3 for some examples of how you and parents can boost needed strengths.

Table 3
Promoting strengths that are lacking

Generosity	
	Ask "What are you doing to help out at home?" "How can you contribute to your community?" Suggest a volunteering commitment that takes advantage of something the youth is good at or interested in. Parents can help steer towards a volunteer experience.
Independence	
	Ask "How do you make a decision about something important?" "How do you control your feelings when you are angry?" Suggest writing down pros and cons the next time they are struggling with a decision, or point out ways to alleviate stress with deep breathing, etc. Parents can help by discussing how they make decisions (about saving money for a needed item, for whom to vote in an election).
Mastery	
	Ask "What are you getting good at?" "What are you interested in outside of school?" Suggest joining a club or sport. Parents can help by providing transportation to or from after-school or weekend meetings or events.
Belonging	
	Ask "Who do you go to for help?" "Who are the adults you trust?" Suggest getting involved in a mentoring program. Parents can help by pointing out relatives or neighbors who can be trusted to go to for help and advice.

What if your patient has a particular problem or challenge? Here are some examples:

- Obesity (strengthen mastery): "Become an expert and take control of your exercise and eating."
- Attention-deficit/hyperactivity disorder (strengthen independence): "You and I have discussed how your attention problems have a biological basis, but you can learn to develop inner control and self-discipline. Learn a way to stop and think before you make an impulsive decision, and practice this skill. The goal is not to get off all your meds, but your appropriate decision-making will make you more independent and get your parents and teachers off your back!"
- Special health needs (developmentally delayed) (strengthen belonging): "Who are your friends, and what do you like to do with them? How are you a good friend? Who are the adults you can go to if you have a problem?"
- "Smart but selfish" (strengthen generosity): "Be aware of the world around you, and see how you can contribute to it. Think about how you could volunteer in the community; maybe you can help set up a Web site for the local teen center. Think about ways you can help out at home or in your extended family."

MAKING STRENGTHS WORK IN DIFFICULT SITUATIONS

Adolescents in difficult situations (eg, those living in foster care or who have dropped out of high school) often have trouble seeing their own strengths and can benefit greatly from having their strengths pointed out to them. For adolescents

who have many challenges, you can use strengths as an "engagement strategy" to enhance communication, help establish trust, promote self-efficacy, and increase patient satisfaction.[16] You can use strengths to work on a needed behavior change by using an established model.

There are several models, from relatively straightforward (the "helping skill"[23]) to more complex (motivational interviewing[24]), that pediatricians can use with adolescents. The "helping skill" involves the following steps: identify the issue; explore the options; consider the consequences; make a plan; and follow-up. Motivational interviewing is a structured set of interviewing skills that help patients move along the stages of change from precontemplation to contemplation, to preparation, and to action. Strategies for motivational interviewing involve expressing empathy, developing discrepancy, avoiding argumentation, rolling with resistance, and supporting self-efficacy. Using strengths can enhance these techniques. The following cases provide a few examples.

Case 1

Tiffaney is a 16-year-old girl who is living in her fifth foster home and fourth school district and comes in for a health supervision visit. She has been in her current foster home for ~9 months and is able to keep the rules pretty well. She has her own room and feels safe. She does some chores but mostly is out of the house. She eats breakfast with both foster parents most mornings. She is a vegetarian and walks 2 or 3 miles per day "getting around" because none of her friends have a car.

She attends public school, is in the 10th grade, and is passing all her courses except one with mostly Cs and Ds. She is failing algebra at the moment, but she loves her art class and gets along well with her teacher. She thinks she may be able to graduate on time in 2 years if she really tries, but it is "a little iffy." She is not sure what she wants to do after high school, but she would like to figure out a way to help kids who are like her.

She had a social worker in a different county whom she still calls and sees occasionally. She feels that this woman helped her a lot with encouragement and choices. She is not currently smoking or drinking, although she has in the past. She now hangs out with a "straight-edge" crowd that does not do drugs of any kind. She is artistic and can draw well. She is interested in body art and has 2 piercings. She keeps a journal and feels that she can express her emotions and thoughts pretty well.

She has had a boyfriend for 6 months, and she spends much of her time with him at his friend's apartment. He works and plays music and enjoys spending time with her and their friends. He tries to support her in her decision to finish high school, although he did not. She has been sexually active with him (her third sexual partner in her life) for 5 months. They use a condom "sometimes," but he

does not really like them. When she is in a car she wears her seatbelt. She describes her mood now as happy and positive. Although she has felt very depressed in the past, she never considered hurting herself.

Her examination is normal. She is in the 50th percentile for height and the 30th percentile for weight; her BMI is in the 25th to 50th percentile.

Tiffaney's risk is unprotected sexual intercourse. Her strengths are:

- generosity (wants to help other kids in foster care);
- independence (expresses herself well, gets around town, makes healthy decisions about substance use, manages her health care);
- mastery (keeping on track at school, art, "survival skills"); and
- belonging (foster parents, art teacher, former social worker, friends, boyfriend).

Use the helping skill:

- Identify the issue: "I just met you and I can't help but notice how many strengths you have . . .. But, I am concerned that you are having sex without using a condom. Can we talk about that?"
- Explore the options with Tiffaney: "What could you do? What else could you do?"
- Consider the consequences of each option that Tiffaney comes up with: "What could happen if you did that? How would that work with your life now?"
- Make a Plan: "It sounds like you are thinking about hormonal birth control, probably the patch. Can I give you a prescription for that today, along with some condoms?" (Tiffaney indicates that she would like to talk it over with her boyfriend first.)
- Follow-up: "That's great! Why don't you make an appointment to come in next Tuesday with your boyfriend and we can talk about it together. Because your pregnancy test today is negative, do you think you two could abstain from sexual intercourse until then?"

Case 2

Carlos, a 17-year-old boy, comes in for a physical for his job.

He lives with his dad, who has a history of involvement with the law for driving while intoxicated. His dad used to hit him but does not really bother with him too much now. He loves his mom, but he thinks that she should take more responsibility for his 3 younger brothers.

He dropped out of school this year in his junior year. He was never good in school, but he did well in weightlifting, and he felt that the coach gave him

encouragement. Because his dad does not give him any financial support beyond a place to live, he decided to drop out of school and work. He thinks he will get a GED (general equivalency diploma) someday, but not right now. He works at a gas station 30 hours/week. Because he likes to talk about car engines, and he likes the money, he is pretty reliable at work. His boss thinks that he is basically a good kid and thinks of him as an apprentice. He is pretty good with his hands and works on 4-wheelers. His dad has one that he rides a lot.

His friends think he is reliable. They like having him around, and they describe him as funny. He always spends 1 evening and 1 weekend afternoon with his brothers, because he wants his brothers to have a guy to look up to because he never did. He is teaching them to shoot hoops and lift weights. He goes to church with them some Sundays.

He eats a lot of "fast food" for breakfast and lunch but often has dinner at his boss' house. He binges on the weekend but usually does not drink more than 1 beer per day after work. He has been in trouble with the law for possession of malt beverage and was picked up for "doing doughnuts" with his car in the school parking lot. He does not use any other substances.

He is sexually active once a month with different partners, and he always uses a condom. He is not depressed or suicidal. He is basically content and deals with what his life has to offer. He wears a helmet whenever he rides his 4-wheeler.

He is proud to be self-reliant. He knows a few things in depth (engines, nature [hunting, fishing]) and almost nothing about many life skills (bank accounts, college applications). He says he would never expect help from outsiders or an "agency."

Carlos' risks are alcohol use and sexual activity with multiple partners. For the alcohol use, use the CRAFFT screening tool[25] with him:

- Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
- Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?
- Do you ever use alcohol/drugs while you are by yourself, alone?
- Do you ever forget things you did while using alcohol or drugs?
- Do your family or friends ever tell you that you should cut down on your drinking or drug use?
- Have you ever gotten into trouble while you were using alcohol or drugs?

Carlos has 2 positive responses on the screen (he has driven while using and has gotten in trouble).

Carlos' strengths are:

- generosity (really cares about his younger brothers);
- independence (has a job, earns his own money, makes some healthy decisions);
- mastery (has a job he is getting good at [but did not finish high school], likes outdoor sports [hunting, fishing] and weight lifting); and
- belonging (family [brothers], friends, boss, church).

Try motivational interviewing:

- "Carlos, I haven't seen you in a couple of years, and I'm impressed with your maturity and sense of independence, and there are so many things you are getting good at. Sounds like your job is going well, although it would be great for you to get your GED sometime soon. Your younger brothers really look up to you, and you are very generous with your time that you spend with them. However, I'm really concerned about how your drinking could affect your health and your plans for the future. Could we talk about that some more?" (Carlos might indicate that, sure, he can talk about it, but he does not see any problem with his drinking, because he is not an alcoholic like his dad. He only got in trouble once, and he will not let that happen again. He is in the precontemplative stage.)
- Develop discrepancy: "Carlos, what do you like about your drinking? What else?" Keep asking until there are no more "good things." (Carlos may indicate that he likes how it makes him feel relaxed, he feels more like a part of the gang at work, he feels his sense of humor is better when he's had a few beers, etc.) "Carlos, what are the 'not-so-good' things about your drinking? What else?" (Keep asking until there are no more not-so-good things. Carlos may indicate that he does not like the way he feels the next morning after he has been drinking, he hates the way his dad tells him he is 'just like him' when he drinks, he disappointed his boss by not showing up for work a couple of times when he felt too 'hung over,' he was really ashamed that his mother and little brothers found out when he got in trouble with the police.)
- "So, it sounds like you enjoy drinking, but it may be starting to interfere with some things that are really important to you, like your job and your relationship with your brothers. What do you make of that?" (Carlos may indicate that he never really thought about it that way.)
- "Would you be willing to start cutting down on your drinking? When would be the easiest time of the week to not use? Could I meet with you next week during your lunch break at work to see how it went?"
- "You have many strengths in your life now, especially your generosity and your sense of independence. I know you can use that independence to help you make the healthiest decision for yourself right now."

Case 3

Rochelle, who is 12½ years old, comes in with her mother for her checkup.

She continues to live at home with both parents and her younger brother. Rochelle gets along "fine" with everyone in the house, although her mother comments that they "clash" over things more than they have in the past. When asked what they disagree on, Rochelle shrugs, and her mother expresses concern about Rochelle's weight. She does mention that Rochelle continues to get along with her younger brother, aged 10, and has a lot of patience with him and helps him with his math homework.

Rochelle just started the 6th grade 2 months ago; this is her first year in middle school. She expresses disappointment that most of her friends from last year are not in her classes, and she occasionally eats lunch by herself. She continues to do well in her classes and got all A's in her first-quarter report card. She did not join the soccer team this year, because she wanted to focus on her schoolwork. In addition, her mother had been finding it difficult to drive Rochelle to practice with her new job. Rochelle now has to baby-sit her brother after school. She does not mind, because they watch television together. Her father has a demanding job in sales that requires him to work 10-hour days and travel a lot, but the family manages to eat dinner together 4 nights per week.

Her diet is "okay," with fruits and vegetables, 2% milk, lots of cheese, and mostly chicken and fish. She usually buys soda at school; there is a new vending machine in the cafeteria. She admits to snacking a lot after school with her brother. She denies the use of tobacco, alcohol, marijuana, and other drugs. Her parents do not smoke, and neither do her friends. She is not interested in any "romantic relationships" at this time, although she does have some friends who are boys, mostly ones with whom she played soccer last year. She has never had sex. She always wears a seatbelt in the car and a helmet on her bike. She used to ride her bike more often but now stays home after school.

Rochelle says that things are "fine," but she is disappointed that school is not as fun as it was in the 5th grade. Her mom has been "getting on her" about her weight, but she thinks it is not her fault, because both her parents are overweight. She says she feels "kind of down" a lot of days but not really bad, and she would never consider harming herself.

On physical examination, Rochelle has sexual maturation ratings (SMRs) of 4 (breasts) and 4 (pubic hair). She is 61 in tall (75th percentile) and 135 lb (95th percentile); her BMI is 25.5 (just below the 95th percentile). The rest of examination is unremarkable. She started her period ~6 months ago and has had it ~3 times; she has had no problems with heavy bleeding or cramps.

Rochelle's risks are:

- poor nutrition (more snacking, soda at school);
- inadequate physical activity (not playing soccer this year, more television time); and
- sadness or depressed mood (misses friends from soccer, school not as fun).

Her strengths are:

- generosity (takes care of her brother after school, helps him with his homework);
- independence (knows how to keep herself and brother safe when parents are not home);
- mastery (good at school, all A's); and
- belonging (family, but not as much with friends now).

Use a written change plan[26]:

- "Rochelle, you are showing a lot of strengths in your life now. You've successfully transitioned to middle school and are keeping up your excellent grades. You are demonstrating independence and maturity by watching your brother after school, and you are very generous to be spending the time helping him with his homework. But, it seems that you are not as active and not eating as well as you were last year, and you seem not as happy with things. Can we talk about that today?" (Rochelle indicates that she really wanted to talk about her weight, because she does not like the way she is looking these days. She wants some help deciding what to do.)
- "Rochelle, on a scale of 1 to 10, with 1 being not ready and 10 being very ready, how ready are you to start making a change?" (Rochelle says 10!)
- "Some people find it helpful to write down their ideas about change. Would you like to fill out this change plan with me today while you are here?"

Fill out the change plan together (see Fig 1), and give her a copy to take home.

TOOLS

If you are just getting started with strengths, pick a framework or model that works well for you (Circle of Courage, 5 C's, READY, etc). Think about what questions you want to ask to identify strengths in each major developmental area. The following are some ideas that have helped other clinicians incorporate strengths in their practice:

- Consider a previsit questionnaire that asks about risks and strengths. Although most practitioners cannot extend the time they spend with patients, the use of tools can help optimize this precious time we do have

How important is it to make a change? **How ready am I to make a change now?**	
__1__2__3__4__5__6__7__8__9__10	
Nutrition	**Physical Activity**
Change:	Change:
How will I make this happen?	How will I make this happen?
Who or what can help me? My strengths: My family's strengths:	Who or what can help me? My strengths: My family's strengths:
What can get in the way?	What can get in the way?
How confident am I that I can make this change? __1__2__3__4__5__6__7__8__9__10	

Return visit: _____

Patient Signature Parent Signature_____Clinician Signature

Fig 1. Fit & healthy change plan. Data source: http://healthvermont.gov/family/fit/documents/Promoting-Healthier-Weight_pediatric_toolkit.pdf.

face-to-face with youth and parents. Instead of asking questions about strengths, this information can be collected by questionnaire, on paper or electronically on a computer or handheld device. Olsen et al[27] have piloted the use of a personal digital assistant (PDA) with an expanded GAPS (Guidelines for Adolescent Preventive Services) questionnaire for use by teenagers in the waiting room. The questionnaire does not substitute for the conversation to elicit strengths, but it gets the youth (and parents if they are going to be involved) thinking in this direction. You can use ones that have been developed or construct your own with your

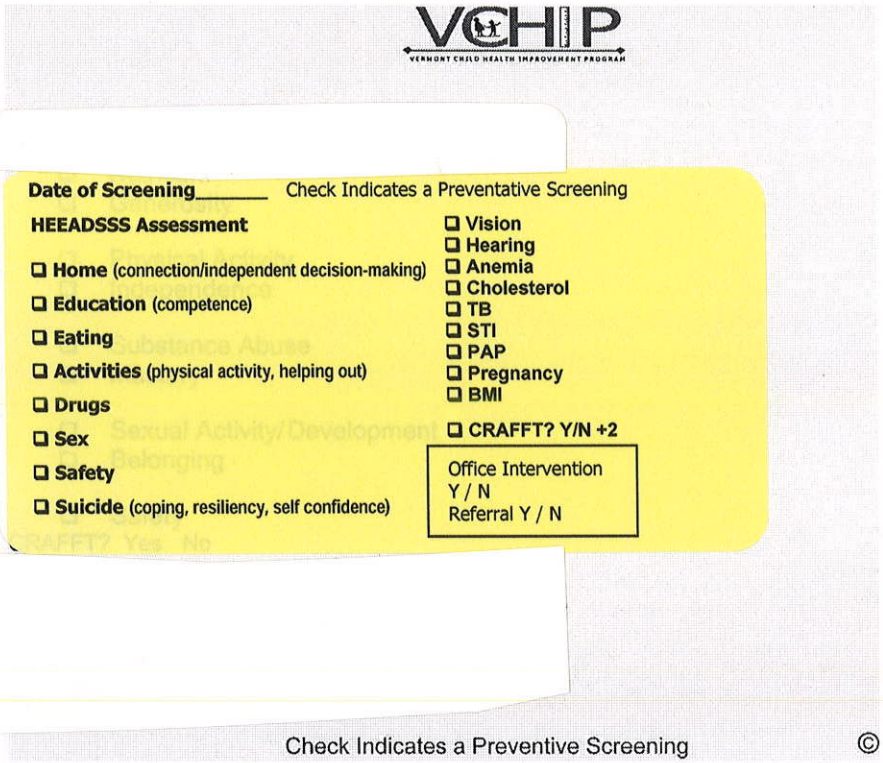

Fig 2. Vermont Child Health Improvement Program (VCHIP) reminder sticker. The sticker is attached to patient charts to remind primary care practitioners to track a set of 6 risk behaviors and 4 wellness-promoting assets during patient screening visits.

favorite questions to elicit strengths. You could also choose questions suggested in Table 2. Consider asking different questions for different age groups. Consider asking parents to describe their adolescent's strengths.

- Use prompts: If you have paper records, you can add a sticker on your encounter form that cues you to ask questions about risks and strengths. The example in Fig 2 was developed by the Vermont Child Health Improvement Program and encourages practitioners to try new interviewing skills before they make changes to their encounter forms.
- You can use a Circle of Courage poster in your examination rooms as your prompt,[28] or the 5 C's or READY brochure. If you are not facile with motivational interviewing, consider using a worksheet such as SMART (Specific, Measurable, Achieveable, Realistic, Time-framed)[29] or a Fit & Healthy change plan worksheet.[26]
- Have educational materials or resources available for parents and/or patients. Some examples could include the READY pamphlet,[21] Gins-

berg's book,[17] *Connected Kids* brochures,[18] parent books, and handouts from the Search Institute.[13]

CONCLUSIONS

In our experience, the implementation of strength-based approaches in the medical home setting requires only a modest restructuring of the visit. A conscious focus on protective factors and strengths does not take the place of the essential risks assessment but, rather, reinforces the commitment of our practitioners and their staff to wellness and health promotion in addition to disease prevention.

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Adolescent Health Update

A Clinical Guide for Pediatricians

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Engaging Adolescents and Building on Their Strengths

by Kenneth R. Ginsburg, MD, MS Ed, FAAP

Adolescent health is tightly linked to behavior. Health professionals are often the only adults a young person sees repeatedly and confidentially throughout adolescence, which positions us to influence adolescent behavior. Our ability to engage adolescents in a health-promoting process is tied to whether we have formed an effective relationship. This means that we must avoid the pitfalls that jeopardize teens' trust, such as lecturing without regard to their readiness to hear the message or failing to consider the context of their lives or the underlying meaning of their behavior. The best of our intentions can backfire when we inadvertently reinforce adolescents' sense of shame or incompetence, ignore the perceived benefits of their behaviors, and speak in abstract terms they may not yet be able to grasp. Above all, we need to demonstrate our trustworthiness and convey our intention to enable them to move forward propelled by their existing strengths.

This article will discuss the process of building an effective relationship with adolescents and their families. It will focus on applying a strengths-based approach and will cover four key points:

1) Building a trusting relationship
2) Recognizing and building on existing strengths
3) Helping teens develop their own solutions to problems
4) Helping teens develop positive coping strategies to deal with life's inevitable challenges

This article is not meant to offer a comprehensive counseling model, but rather to expose clinicians to an alternative philosophi-

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Goals and Objectives

Goal: To give pediatricians new strategies to effectively interact with and counsel adolescents in the course of everyday practice.

Objectives: After reading this article, the pediatrician will be better prepared to:

- Set the stage for building a positive bond with adolescent patients and their families
- Understand a strengths-based approach for interviewing and counseling teens
- Perform a psychosocial assessment using creative counseling techniques that includes evaluation for risky behaviors
- Establish and maintain trusting and appropriate relationships with families

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cal approach to caring for teens that is based on empirical observation and practice, and grounded in positive youth development and resiliency theories.

BUILDING A TRUSTING RELATIONSHIP

An initial step to uncovering strengths is to create a setting where our adolescent patients can comfortably reveal their experiences, perspectives, and complex emotions. Young people will not, and should not, share intimate details of their lives before they conclude that we are trustworthy. They will withhold information unless they think sharing will benefit them and until they are comfortable that they will not be judged as a person solely on the basis of what they disclose. The effective clinician shows concern about risky behavior in a way that simultaneously communicates respect.

When adolescents remain closed, clinicians "learn" from experience that attempts to connect are often futile. The provider may then be less likely to attempt to use future visits for health promotion and risk reduction. And parents who do not understand that confidentiality is part of a health promotion strategy may not comfortably acquiesce to the evolving confidential relationship between their adolescent and the health professional. For these reasons, it is valuable to spend 3 to 5 minutes at the outset of the office visit to "set the stage" for an effective relationship by briefly addressing everyone's concerns. **(See Table 1)**

The goals of this initial step include making ourselves trustworthy to teenagers and clearly defining the importance of the parents' role in the adolescent-professional-parent relationship. It is ideal to set the stage in the beginning of the initial visit with a parent present because teenagers may be more likely to trust the social contract when parents express agreement. Having parents present in the beginning of the visit also assures that their concerns are known before the visit is focused.

While 3 to 5 minutes may seem burdensome in the context of a busy office visit, we need to set the stage only once, either in the beginning of a relationship with an adolescent patient or during the transition from the parent-centered pediatric visit to the adolescent-centered visit. This effort will be well invested if it increases the yield of the interview, the effectiveness of counseling, and the likelihood that adolescents will be willing to consult with us when they need help to avert a crisis or navigate a challenge. It will also facilitate parental buy-in to a relationship where privacy is honored.

TABLE 1

Essential Points for Setting the Stage

- Adolescents need to learn how to navigate the health care system independently. That process begins by giving their own histories and spending private time with the clinician.
- Private issues will be discussed. The clinician will:
  - Strive to be nonjudgmental
  - Share a commitment of honesty
  - Guarantee privacy (with exceptions to privacy clearly stated)
- Parents have an essential role.
  - They are central members of "the team"
  - They agree that physician/patient privacy may help their teen share and reflect on their behaviors.
  - They are the most important people in their adolescents' lives and will be included as much as is possible and appropriate.
  - They agree that information disclosed to them in a medical setting should be met with strategies for safety, not punishment.
- Recognize and reinforce effective parenting. Credit parental efforts to support and enhance their teen's strengths and/or resilience.

Structuring the Assessment

While each clinician will tailor the introductory conversation to match his or her clinical style, the topics to cover and the reasons for covering them are relatively consistent in most contexts. A guide to these topics is presented below, along with the rationale for addressing each. An italicized script embedded within each section demonstrates how the conversation might flow. We have found that this sequence allows adolescents and parents to become more comfortable with a biopsychosocial approach.

Defining Your Practice Style

Adolescent patients may not see the medical setting as a place to seek help for emotional problems or guidance about behavioral choices. It is helpful to clarify this.

As I see it, a doctor's job is to keep kids healthy, safe, and moving toward a positive future. This means that in addition to working to keep your body healthy, I check in with you on how you're handling stress, your emotional health, and whether or not your behaviors are safe.

Talking About the Flow of the Visit

Underscore the importance of the teen's assuming responsibility for his or her own health without losing sight of the changing, but important, role of parents.

In today's visit, I will ask about why you are here, your health history, and your family's health history. I don't expect that you will have all of the answers, so at the end of every set of questions, I will turn to your parents and we'll both learn from them. After you have shared your concerns for the visit, we'll listen to your parents' concerns. Then I'll ask them to leave the room, and you and I will finish with the check-up. This will give us an opportunity to talk privately. Of course, you can ask me questions at any time.

Considering the Context

Insight into the factors likely to have an impact on your patient's health can be ascertained if you ask the following question, and then listen intently to the patient's response.

During this private time we can talk about all sorts of things. Imagine you were a doctor caring for kids your age. If you wanted to help them stay healthy and safe, what kinds of things would you want to know about?

It is ideal to conduct a full psychosocial screen at every routine visit, but this may not be realistic. The teenager's response to the previous question helps the clinician focus on issues likely to be of greatest concern to the patient.

Acknowledging the Teen's Right to Decide What to Disclose

It is important that teens know that they are in control of what they disclose. This part of the conversation enables the interviewer to demonstrate trustworthiness.

Just because I ask a question doesn't mean that you have to answer it. You have 3 choices. First, you can tell me that you'd rather not talk about it right now. I would really respect that answer. Second, you could lie to me. Because I don't read minds, I would never know, but I wouldn't be able to help you either. The third choice is what I'm hoping for: to create a space safe enough for you to get good solid health information and where you feel comfortable telling me what is going on in your life.

Honesty

Teenagers have ample experience with adults who use scare tactics or threats to manipulate their behavior. They need an adult who will listen, allow them to reflect on their behavior and, when necessary, engage them in a risk-reduction process. If they are taking the chance to be honest, they need to know they will get honest information in exchange. Many adolescents fear that clinicians withhold information and give the full story only to parents.

For me to be able to help you, I need to know what is really going on in your life. That means that I am asking you to be honest. In exchange, I promise to be honest with you – you'll know what I know and even what I don't know. This is a place you'll always be able to get truthful information.

Judgment

Adolescents are unlikely to share information if they believe they will be judged.

I take care of many young people in this community -- teens who do all sorts of things. My job is to help all of them become the best they can be. Sometimes teens tell me about behaviors they know are unsafe and that I wish they weren't doing. I may try to guide them toward safer, wiser behaviors, but I don't judge them as human beings and, of course, I don't punish them. I am honored that they choose to tell me the truth, and I respect their honesty.

Confidentiality

Privacy is at the core of the adolescent-clinician relationship. Adolescents must clearly understand their rights within the medical setting so they can comfortably seek services and guidance. Our choice of language is critical. Be careful about using the word "confidential" because many adolescents interpret that as meaning you intend to have confidence in them. Do not use the word "secret" because it has negative connotations. All adolescents understand the word "privacy." When they worry about lapses of privacy, they are concerned about their parents, teachers, the police, even persons in your front office who may know their neighbors.

Adolescents need to understand the explicit limitations of privacy, which may vary by state. The standard script ("Unless I thought you were going to hurt yourself, hurt someone else, or someone were abusing or hurting you") does not sufficiently clarify limitations or protections. From a teenager's perspective, a health professional thinks cigarettes, unprotected sex, maybe even skipping school could "hurt" them. Therefore, it is important to be clear.

Your information will be kept private. That means I will not tell the people at the front desk, your teachers, your friends, not even your parents, unless I get permission from you first. However, there are exceptions. If I thought your life was in danger because you were thinking of killing yourself, or worried that you were seriously thinking about hurting another person, or if you were being abused or neglected by an adult, I would not want to -- nor would I be able to -- keep your information private. I would work closely with you to get you immediate help. Everything else stays private unless you say otherwise.

The Role of Parents

Parents are not likely to trust the clinician if they feel that they have been excluded. In talking with parents and teens, clinicians should acknowledge that parents are the most important figures in their teens' lives and that brief counseling in a pediatrician's office cannot substitute for ongoing parental guidance. It is also important that parents do not undermine future disclosure by punishing their adolescents for behaviors revealed during an office visit.

Ask the teen directly: *If you and I decided that you might really be in trouble, who could help you the most?* Then, listen silently as you learn about his or her essential support system. While few teens will respond spontaneously by identifying their parents as their primary support system, eventually almost all adolescents will do so.

I'm glad you trust your mom/dad. And although I promise you strict privacy, if I think you might be headed for trouble I may suggest that we work together to figure out the best way to get your parent(s) involved. But, I will never do it without your permission unless your life or someone else's life is in danger.

Then ask the parent: *I'd like us to work together as a team. As a parent, you may need to set up guidelines, or even appropriate rules, to keep your child safe. But can we agree that if something comes up in our visits, your son/daughter would not be punished? The best way for me to help your son/daughter is to team up with you, but at the same time, it's important to understand that teenagers are most likely to come to their doctor, or their parents, to get out of trouble if they can do so without fear of getting into trouble.*

At this point, the clinician can begin the initial history, allowing the adolescent to answer each question to the best of his or her ability. Parents should be invited to comment after their teen has completed each section of the history. When the parents feel that their concerns have been heard, they can be asked to step out for a few minutes to give their child the opportunity to be interviewed and examined alone. Once in private, the clinician can perform the psychosocial assessment. One approach, the SSHADESS mnemonic, is presented in **Table 2.** If younger adolescents prefer that their parents stay in the room, follow their lead, but only perform a limited SSHADESS screen. Instead, use the opportunity to teach and to promote good communication between parents and child about adolescent issues and behaviors. It is likely that they will desire privacy for the next visit.

TABLE 2

SSHADESS: A Strengths Assessment Tool for the Psychosocial Screening

Many clinicians use a standard flow of questioning to assure they cover the major areas of concern in adolescents' emotional and behavioral health. (See resource lists, pp 7, 8). One of the best-known screening tools, HEADSS (Cohen, Mackenzie, and Yates, 1991), has been in use in pediatric practices for 15 years. SHADSSS was a modification (Clark and Ginsburg, 1995) that added questions about violence-related risks. The SSHADESS screen (Ginsburg, 2007) underscores resiliency by opening with questions about strengths before proceeding to environmental context and risks.

Strengths

Begin by allowing adolescents to offer a description of their **S**trengths or interests. Many patients have trouble describing themselves, and find it particularly challenging to praise themselves. If this is the case, ask, *"Well, what makes you proud?"* Some adolescents with a low self-image may still remain at a loss. In this case, try the follow-up question *"Well, what would your good friends say about you?"*

From here, lead into questions about **S**chool, **H**ome, **A**ctivities, **D**rugs/substance use, **E**motions/depression, **S**exuality and **S**afety. Always take care to explore assets as well as potential risks and to allow the teenager the opportunity to offer context. Explore ways in which the young person is contributing to his or her community or school, and notice solid connections with family. Pay attention to healthy behaviors that display creativity or keep your patient emotionally, physically, or spiritually well balanced. Listen for environmental context that can offer a history of resilience or unusual insight.

RECOGNIZING AND BUILDING ON EXISTING STRENGTHS

There are practical advantages to focusing on our adolescent patients' strengths. The risk-based approach, which focuses on negative behaviors, may engender shame. Shame is a barrier to engagement; adolescents may be confused or even angry when their behavior is highlighted out of context.

A person contemplating change is more likely to take action if he or she has confidence in the potential for change. That confidence derives from a deep-seated belief in one's capabilities and is undermined by a fear of failure. Adolescents are not inspired to change or take positive action when equipped only with knowledge that others think they have failed.

Our approach also sets the tone for our interaction. A central tenet of the strengths-based approach is that adolescents live up or down to our expectations. When they know that we respect them and enjoy seeing evidence of their thoughtfulness, or their newfound ability to be self-reflective or gain new insights, they engage in conversation more readily. Teens will be more receptive to health messages offered by someone who believes in their capability to succeed.

Defining success as the absence of risk behaviors conveys low expectations. As ongoing stable adults in their lives, we should consistently hold our adolescent patients to high expectations and continually reinforce the idea that they are individuals prepared to contribute to their families and their communities. Proponents of the youth development and resiliency approaches recognize the destructive potential of risk behaviors, but believe that a positive, strength-based approach will reinforce inherent strengths and help adolescents propel themselves forward.

When we identify risk, it can be too easy to slip into a pattern of assuming these risks reflect the adolescent's life. In doing so, we are often responding to the crises parents present to us. "I know Jake is using drugs, I think it explains his nasty attitude." "I see marks on Katie's arms; she's doing it to herself." Other times, the clinical history reveals 15-year-olds who think a baby will bring instant love, 17-year-olds who think a gun keeps them safe, and 14-year-olds engaging in unprotected sex. Certainly we need to address these problems, but if we focus only on mistakes we lose the opportunity to help teenagers realize that they can do better. We risk losing the

A Strengths-based Approach to Address Risk

When we know something about what an adolescent is doing well, or have seen evidence of emotional depth or resilience, we are prepared to address problems and convey a genuine belief that he or she can do better.

Reflect back to the patient some of his or her positive points.

Listen to the patient until you grasp something authentically positive. This can't be about external trappings; it has to be a genuine strength. When doing this, don't be afraid to tell your patient that you are impressed! Show how you know that he or she can do things well.

In talking to you, I am struck by how deeply you care about your little brother. As tough as things have been, you remain a kind young man committed to making sure your brother has it better than you. And you want to be a counselor so that you can help other kids make it through tough times. Some people are defeated by difficulty, but you seem to be able to use tough times to figure out how to grow stronger.

Pause for a moment

This is an opportunity to let what you have just said sink in and then shift your focus.

Share your concerns

Adolescents appreciate it when adults are worried about them so long as they don't attempt to control them.

I am really worried about you. You're really stressed out and are smoking a lot of marijuana. I am concerned that the marijuana will get in the way of everything you've been working for. Your brother needs you to be successful because you are his role model. I'd hate for anything to mess that up.

Ask permission to address the problem

Adolescents are rarely in control of who tries to guide them. While they may be forced to listen, they will be the ones to decide whether or not they are ready to hear the message.

I would like to talk a bit about marijuana use and maybe some other ways to deal with stress. Is that all right?

Address the problem

Once the adolescent has expressed agreement, the clinician can directly address the risk behavior, and ideally suggest healthy alternatives to worrisome behaviors.

opportunity to inspire them when they quietly become defensive and close themselves off.

An adult committed to building resiliency or strength would address these problems differently. First, we listen for context. A teen may be using drugs in an attempt to obscure or ease her pain. A young girl who desires a baby may need to prove she has the capacity to nurture. Patients may explain that self-mutilation (cutting) allows them to control when, where, and how deeply they experience pain; they are seeking a solution to unbearable pain perhaps so intense that a person with less strength may not have survived at all.

Respectful, reflective, and intent listening, rather than teaching or preaching, allows teens to reveal their strengths. Look beyond the behavior and begin to explore the need that behavior fulfills. Behind most worrisome choices are tales of coping with a stressful world and sometimes even matters of survival. Behind many masks of invincibility are worried children with a limited sense of control over their environments.

Even teens engaging in very worrisome behaviors are almost always doing something in their lives worthy of praise. Listen for demonstrations of resiliency, of overcoming the odds, of genuine kindness or compassion. Explore the young person's dreams and discover how he or she hopes to contribute to the world. Don't take "I don't care" at face value. Many kids who "don't care" or are "lazy" care so deeply that the facade feels more comfortable. When an adolescent tells you of a life filled with risk, appreciate her honesty. When she grasps the connection between her drug use and her stress, note her insight.

If we are to engage rather than alienate teens, we must address risk in a way that enables them to recognize problems themselves and then generate their own solutions.

Adolescents whose competencies are recognized are reassured that we do not view them as failures. The clinician can leverage confidence based upon points of competency to help teens contemplate change and overtake the forces of self-doubt and hopelessness that make negative behaviors seem to be the most viable alternatives. (See **A Strengths-Based Approach to Address Risk**, page 5)

Similarly, parents whose competencies are recognized are more inclined to build on their own strengths. When their children are engaging in risky behaviors or rejecting their love, attention, or authority, parents may feel like failures. Those who have lost faith in their own effectiveness are less likely to offer essential supervision and guidance. They may begin to convey low expectations, undermining their adolescent's resolve. For these reasons, we should be equally committed to recognizing and reinforcing parental strengths.

HELPING TEENS DEVELOP THEIR OWN SOLUTIONS

When we recognize adolescents' existing strengths, we reinforce their ability to make healthy decisions. In parallel, we hope to lower barriers to success by encouraging risk avoidance. However, if we are to engage rather than alienate teens, we must address risk in a way that enables them to recognize problems themselves and generate their own solutions. This means moving beyond only offering information or a lecture.

The traditional lecture starts with a definitive statement about a behavior (essentially, *"Stop that!"*), then presents 3 or 4 reasons to stop, and ends with theoretical examples that show how failing to stop will lead to dire consequences. The speaker presumes that linking potential consequences to each choice will convince adolescents to do the right thing, but teenagers who have no opportunity to explain their choices may instead feel cut off, unheard, and disrespected. More importantly, those who are cognitively unprepared to grasp a complex chain of associations may feel incompetent, confused, frustrated, and even angry. Ultimately, because they may not grasp the potential harm of their behavior and resent what they perceive to be adults' overreactions, they may proceed to prove that the behavior is "no big deal" by doing precisely what we counsel against.

The disconnect between the good intentions with which lectures are delivered and the reality in which they are received may be largely explained by the cognitive differences between adults and adolescents. A typical lecture has an abstract pattern that is obscure to younger adolescents who are still concrete thinkers. Instead of grasping the intended message, they may feel alienated.

When we steer adolescents through real and hypothetical experiences by breaking abstract concepts into concrete, under-

standable steps, they are more likely to independently grasp how their behaviors can lead to unintended consequences. Our concerns can be broken down: "*Could you imagine how A could go to B? Have you ever seen it happen? Tell me about that.*" When that association is understood, proceed with "*Do you see how B might lead to C? Do you know anyone that it happened to?*" Or, "*What kinds of things do you think might make a difference in whether B would lead to C?*" With this approach, we guide them down the path, but they themselves arrive at conclusions they need not resent or rebel against because they have figured them out on their own. They experience their own competence and gain the confidence to take the first steps toward positive behavioral change.

HELPING TEENS DEVELOP POSITIVE COPING STRATEGIES

When a behavior of concern is viewed out of its environmental and emotional context, it is often approached in a manner that causes the young person to feel ashamed. An embarrassed adolescent is unlikely to be receptive to guidance. On the contrary, his or her sense of incompetence is highlighted and level of stress is increased. Because stress drives many worrisome behaviors, our interventions may do harm.

We must move beyond telling adolescents what not to do, and instead reinforce the positive steps they can take. Adolescents often engage in unhealthy behaviors as a means to deal with a stressful world. Stress causes discomfort and adolescents reach for coping strategies to lessen those uncomfortable feelings. There are positive and negative ways of coping, but the terms "positive" and "negative" are not meant to describe effectiveness. They convey value judgments.

Negative coping strategies offer short term quick-fixes, but become destructive. They generate and perpetuate a dangerous cycle and sometimes lead to addictions. Many concerning adolescent behaviors sometimes serve as coping strategies (eg, running away, substance use, sexual activity, violence, self-mutilation, gang affiliation, teen pregnancy, or disordered eating).

Rather than presenting a few convincing facts and then telling our patients to "stop that," we can help our patients realize — without shame — that their behaviors may very well be attempts to manage stressful life circumstances.

Many people find it difficult to describe themselves as sad, nervous, or fearful. However, "stress" remains an acceptable term that allows youth to acknowledge their feelings. When we view adolescent behaviors in the context of their efforts to decrease stress, we avoid subtly accusing them of being careless, reckless, or thoughtless. Instead, we are able to guide them to develop a repertoire of positive strategies to serve as lifelong stress-reduction tools.

Because every person has unique needs and interests, the clinician can guide patients to develop individual plans. A stress-reduction plan may include such strategies as breaking large problems into manageable pieces and knowing when to let things go. It may also feature physical, spiritual, meditative, and creative outlets.

It can be difficult, in a busy practice, to find time to develop a stress management plan with every patient. Many will be able to develop their own plan with limited guidance. See http://aap.org/stress for a 10-point interactive theory-based stress reduction tool that adolescents can navigate independently to create plans tailored to their unique needs, experiences, and interests.

We will never be able to prevent worrisome behaviors altogether because some are enjoyable and experimentation is a part of adolescence, but we can decrease young people's reliance on dangerous quick fixes when we guide them toward positive strategies to manage stress.

ONLINE RESOURCES

Karen J. Pittman, Peter L. Benson, Richard F. Catalano, and J. David Hawkins are associated with some of the best-known research in positive youth development; some have been writing on this topic for more than 30 years. Peter Benson's 40 Developmental Assets, *for example, is an excellent guide for anyone hoping to foster healthy, responsible, and caring behavior.*

The Forum for Youth Investment
Karen J. Pittman, executive director.
www.forumfyi.org.

Search Institute
Peter L. Benson, PhD, president
www.search-institute.org/assets

Social Development Research Group
Richard F. Catalano, PhD., director;
J. David Hawkins, founding director.
http://depts.washington.edu/sdrg

CONCLUDING THOUGHTS

Health professionals are ideally positioned to monitor adolescent patients for worrisome behaviors and guide them toward healthier choices. Adolescents are more likely to disclose behaviors of concern if we make an effort to demonstrate that we are trustworthy. When we help teens develop their own solutions to problems, we reinforce their sense of competence and help them gain confidence to move in the right direction. When we see even troublesome behaviors in the context of what they are also doing well, we diminish shame and encourage young people to build on their existing strengths. Finally, when we help young people develop a repertoire of positive coping strategies to manage life's inevitable challenges, we help them find the courage to avoid dangerous quick-fixes.

Physicians, parents, schools, and communities should send a consistent message to our youth: that our goals for them are far higher than the absence of negative behaviors. We must recognize and celebrate the strengths of adolescents so that they know we expect them to successfully lead us into the future.

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The Parent's Role in the Adolescent Health Care Visit

During adolescence, children learn to navigate the world on their own. Adolescents still require supervision but also need to take on more responsibility. These years can be a scary time for parents, who worry that their children may make mistakes along the journey to adulthood.

The health care setting is an important, safe place for your child to learn to function independently. Our goal is to help adolescents become comfortable and competent in seeking health care. With your help, we can assure that by the time they leave your home they will be able to:

- Know when and how to seek health care
- Talk to a clinician (doctor, nurse, or physician's assistant) on their own
- Give their own medical and family health history
- Advocate for their own health needs

To help children learn to deal with clinicians independently, we suggest that parents allow their teens to take the lead when they visit the doctor. You can do this by:

- Allowing your child to express his/her concerns and medical history
- Listening carefully for points he or she might have missed
- And then adding your thoughts after they are done

This will give your child the opportunity to learn from you about how to get points across to clinicians. We do not expect that your child will become an overnight expert in working with us. Adolescents build skills every year so they will be able to function independently by the time they leave home. In late adolescence, most teens are ready to see their physicians on their own, but as parents, you will always have the opportunity to express your concerns.

Now that your child is becoming more independent, health care visits will routinely include a private conversation with the health care provider that will focus on emotional and behavioral health. During this time, we will ask personal questions and guarantee privacy. Adolescents are told we will not keep information private if their life is in immediate danger. *We know parents are the most important people in children's lives and will always encourage your child to share information with you.*

Frequently asked questions

Why do adolescents need privacy?

Many teenagers don't open up to their parents mainly because of how much they love their parents and worry about disappointing them. Private time with a clinician allows them to get guidance from an adult who they know cares about them but whom they worry less about disappointing. If adolescents trust us and talk with us, we can do a much better job of helping you to keep your son or daughter healthy.

What can I do to make it more likely that my child will come to me first with problems?

There is nothing more important to children than knowing that their parents will listen and remain supportive even if they are in trouble. When they need help, adolescents need to know that their parents will respond to problems with guidance, not punishment. Our goal is always to include you. Children are more likely to tell us that they do not need privacy if their parents make it clear that they will help with any problem that comes up in our visit, and that helping will not involve punishment.

We can do our best work keeping your child moving toward a positive future when he or she knows our office is a place to get out of trouble *without* worrying about getting into trouble! We are here as a positive resource for you as you help your child navigate adolescence.

This patient education sheet is distributed in conjunction with the March 2007 issue of *Adolescent Health Update*, published by the American Academy of Pediatrics.

What Is New in the New CDC STD Treatment Guidelines?

by Gale R. Burstein, MD, MPH, FAAP and Kimberly A. Workowski, MD, FACP, FIDSA

On August 4, 2006, the United States Centers for Disease Control and Prevention (CDC) published updated guidelines for treatment of sexually transmitted diseases. This edition of Hot Topics summarizes updated recommendations for (1) the diagnosis and prevention of genital herpes simplex virus (HSV) infection, and (2) genital *Chlamydia trachomatis* and *Neisseria gonorrhoeae* screening and retesting.

Genital HSV Infection

Type-specific HSV serologic assays may be useful when clinicians encounter recurrent genital symptoms or atypical symptoms with negative HSV cultures. They are also useful when there is a clinical diagnosis of genital herpes without laboratory confirmation or a partner with genital herpes. Some specialists believe that HSV serologic testing should be included in a comprehensive sexually transmitted infections (STI) evaluation among persons with multiple sex partners, human immunodeficiency virus (HIV) infection, and among men who have sex with men (MSM).

Current HSV-specific glycoprotein G2 (HSV-2) and glycoprotein G1 (HSV-1) assays should be specifically requested when HSV serology is performed. These include HerpeSelect™-1 or -2 enzyme-linked immunosorbent assay (ELISA) immunoglobulin G (IgG), HerpeSelect™ 1 and 2 Immunoblot IgG (Focus Technology, Inc., Herndon, Virginia), and HSV-2 ELISA (Trinity Biotech USA, Berkeley Heights, New Jersey). Test sensitivities of these vary from 80%-98% and specificities are ≥96%. Beware of older assays that do not accurately distinguish HSV-1 fromHSV-2 antibody.

Prevention.

In addition to consistent condom use and the avoidance of sexual activity during recurrences, treatment with valacyclovir 500 mg daily decreases the transmission rate in discordant heterosexual couples where the source partner has a history of genital HSV-2 infection. Suppressive antiviral therapy probably reduces transmission when used by persons with multiple partners and by those who are HSV-2 seropositive without a history of genital herpes, but these groups were not evaluated.

Chlamydia trachomatis and *Neisseria gonorrhoeae*

In the United States, chlamydial genital infection is the most frequently reported infectious disease and gonorrhea the second most common bacterial STI. Prevalences of both are highest in persons ≤25 years. In females, most *C. trachomatis* and *N. gonorrhoeae* infections are asymptomatic, yet they can lead to pelvic inflammatory disease (PID), ectopic pregnancy, and infertility. Annual *C. trachomatis* screening of all sexually active females aged ≤25 years is recommended. Evidence is insufficient to recommend routine *C. trachomatis* and *N gonorrhoeae* screening in sexually active young men. However, male chlamydia screening may be appropriate in clinics with high chlamydia prevalence. *C. trachomatis* nucleic acid amplification tests (NAATs) are the most sensitive tests for endocervical, urethral, and urine specimens and some are also cleared for vaginal swab specimen testing. All *C. trachomatis* NAATs offer combination *N. gonorrhoeae* testing, but product inserts for each NAAT vendor must be carefully examined to assess current indications for FDA-cleared specimen types.

Chlamydia and gonorrhea reinfection rates are high in females – in some studies up to 13%-16% within 4 months posttreatment. Since repeat infections may confer a higher risk for PID and other complications, providers are encouraged to advise ALL chlamydia- and gonorrhea-infected females to be retested approximately 3 months after treatment (or whenever they next seek medical care). Although there is limited evidence on the benefit of retesting males for chlamydial and gonococcal infection, some specialists suggest retesting approximately 3 months after treatment. If concerns exist that sex partners will not seek evaluation and treatment, the provision of antibiotic therapy (either a prescription or medication) by heterosexual male or female patients to their partners should be considered, but may not be feasible because of logistical or legal barriers.

References

1. Sexually Transmitted Diseases Treatment Guidelines, 2006. Centers for Disease Control and Prevention. *MMWR.* 2006;55(RR11):1-94
2. Corey L, Wald A, Patel R, et al. Once-daily valacyclovir to reduce the risk of transmission of genital herpes. 2004;350:11-20
3. Legal Status of Expedited Partner Therapy (EPT). Available at: www.cdc.gov/std/ept/legal/default.htm. Accessed January 18, 2007

Gale R. Burstein, MD, MPH, FAAP, is medical director of Epidemiology and Surveillance, STD & TB Control at the Erie County Department of Health, and a clinical assistant professor of pediatrics at Women and Children's Hospital, Buffalo, NY.

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Hot Topics in Adolescent Medicine is designed to keep readers of *Adolescent Health Update* apprised of the latest developments in adolescent care. Please forward your comments to Sheryl A. Ryan, MD, FAAP, editor, (sheryl.ryan@yale.edu).

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American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

TRAUMA & RESILIENCE

AN ADOLESCENT PROVIDER TOOLKIT

ADOLESCENT HEALTH WORKING GROUP

AHWG

THE ADOLESCENT HEALTH WORKING GROUP (AHWG)

History: The AHWG was formed in 1996 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.

Vision: All youth have unimpeded access to high quality, culturally competent, youth friendly health services.

Mission: Support and strengthen the network of providers working to improve adolescent health.

Core Functions:

1) Develop tools and trainings that increase providers' capacity to effectively serve youth/young adults.

2) Advocate for policies that increase access to care and utilization of youth/young adult services.

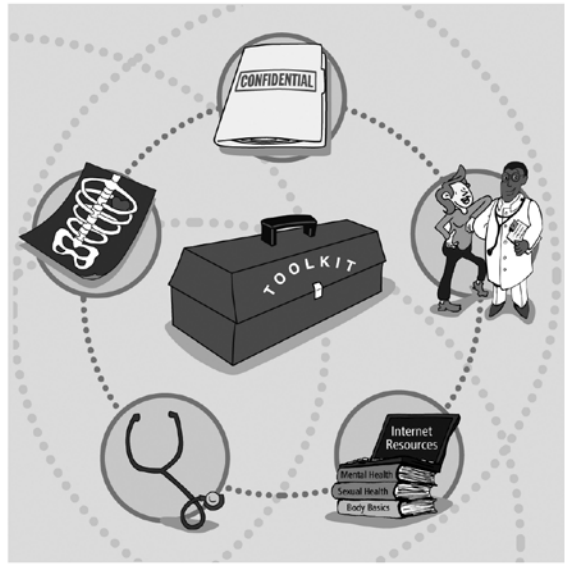
3) Convene stakeholders and coordinate linkages across systems to improve information sharing, networking, and referrals for youth/young adult services.

Fiscal Sponsor: The AHWG is a project of the Tides Center.

Additional Info: www.ahwg.net

AHWG

www.ahwg.net



Illustrations by Jordan Zaini, 17

THE AHWG ADOLESCENT PROVIDER TOOLKIT SERIES

The toolkit consists of five modules:

1. Adolescent Health 101 (2003)
2. Body Basics (2004)
3. Understanding Minor Consent and Confidentiality in CA (2003, 2010)
4. Behavioral Health (2007)
5. Sexual Health (2010)
6. Trauma & Resilience (2013)

Designed for busy providers, each module addresses a complexity of issues through accessible, user-friendly resources including screening and assessment tools, evidence based best practices and promising approaches, and health education handouts for youth/young adults and parents/caregivers. The toolkit series, developed locally, has been distributed and utilized by providers nation wide. Accompanying training has also been developed and delivered locally and regionally to health plans, community clinics, and educators.

For more information on AHWG resources, training, and events, please visit:

www.ahwg.net.

TRAUMA & RESILIENCE

Trauma & Resilience, the sixth module of the AHWG Adolescent Provider Toolkit Series, was created in response to a continued demand among providers for resources focused on the intersections of health and violence.

The Trauma & Resilience toolkit module is designed to:

1) Encourage paradigm shifts from:
   - Trauma to resilience
   - Deficits to assets
   - Oppression to empowerment
   - Individuals to systems

2) Increase communication and collaboration among different service sectors and systems of care including: health, education, juvenile justice, workforce development, human services, housing, and youth/young adult development programs.

The Trauma & Resilience toolkit module is designed for:

- All levels of youth/young adult service providers, from front line staff, to clinicians, to administrators.

Youth Handouts

- Handouts specifically designed for youth/young adults are starred and underlined in the Table of Contents.
- Youth handouts may also be useful with parents/caregivers and community members, as deemed appropriate by providers, and in conjunction with supportive services.
- Youth handouts are intended to enhance communication, education, and support for youth/young adults, parents/caregivers, and community members, NOT replace it.

Capacity Building

The AHWG recognizes that this work is dependent on the involvement of providers, youth/young adults, and parents/caregivers across all sectors and systems. As a result, the AHWG will continue to focus its efforts on capacity building among health providers to meet the unique needs of youth and young adults, in addition to assisting with the development of supports for providers across other sectors and systems. Please contact the AHWG to inquire about possible collaboration opportunities. Current contact info can be accessed at www.ahwg.net

Suggested Citation

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- Instituto Familiar de la Raza
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- Transitional Age Youth San Francisco
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Dedicated to:

Jeff & Lyla St. Andrews

CONTENTS

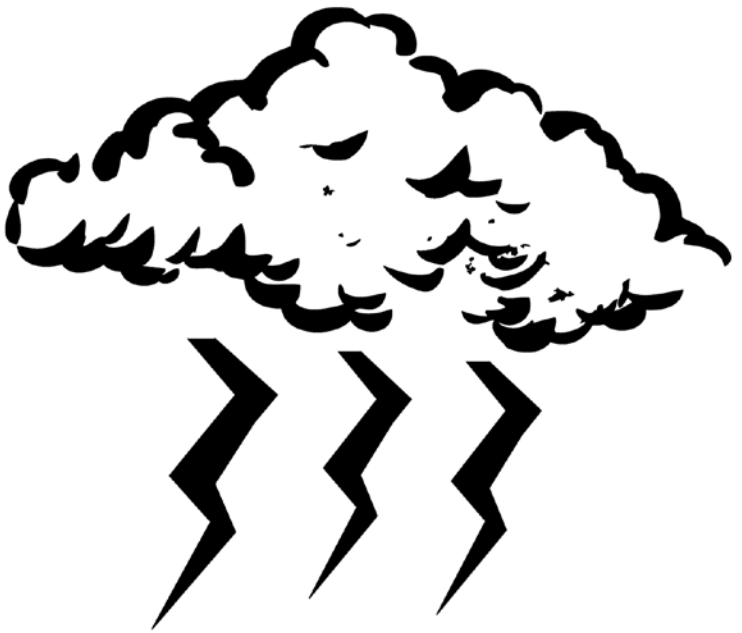
1. TRAUMA

2. RESILIENCE

3. CARE

▲ FOR YOUTH: Youth handouts specifically designed for youth/young adults are starred and underlined. Youth handouts may also be useful with parents/caregivers and community members, as deemed appropriate by providers, and in conjunction with supportive services. Youth handouts are intended to enhance communication, education, and support for youth/young adults, parents/caregivers, and community members, NOT replace it.

TRAUMA



KEY FACTS ON TRAUMA

THE TRAUMA EQUATION: TRAUMA = THE SUM OF EVENTS, EXPERIENCE, AND EFFECTS (1)

EVENTS

+ Events or circumstances may include the actual or extreme threat of physical or psychological harm or the severe withholding of resources for healthy development.
+ Events may occur once or repeatedly over time.

EXPERIENCE

+ An event may be experienced as traumatic by one individual and not another.
+ The experience may be influenced by cultural beliefs and the developmental stage of the individual.

EFFECTS

+ Adverse effects may occur immediately or over time.
+ Effects may include physical, mental, emotional, cognitive, behavioral, social, and spiritual challenges.
+ Individuals may not recognize the connection between effects and events.

TRAUMA IN THE CONTEXT OF COMMUNITY

- Trauma occurs in the context of community including:

  1) Neighborhoods: shared identity, culture, ethnicity, socioeconomic status, or experience, and 2) Organizations: place of work, learning, or worship.
- How a community responds to individual trauma sets the foundation for the impact of the traumatic events, experience, and effects.
- Communities that provide understanding, support, and self-determination may facilitate the healing and recovery process for the individual.
- Communities that avoid, overlook, or misunderstand the impact of trauma may often re-traumatize the individual and interfere with the healing process.

TRAUMA AND THE COLLECTIVE COMMUNITY EXPERIENCE

- Similar to an individual, a community may be subjected to a threatening event, share an experience of the event, and have adverse prolonged effects.
- Resulting trauma is often transmitted from one generation to the next in a pattern referred to as historical, community, or intergenerational trauma.
- Communities can collectively experience trauma similarly to the ways in which individuals respond to trauma.

TRAUMA-INFORMED CARE IS AS MUCH ABOUT SOCIAL JUSTICE AS IT IS ABOUT HEALING

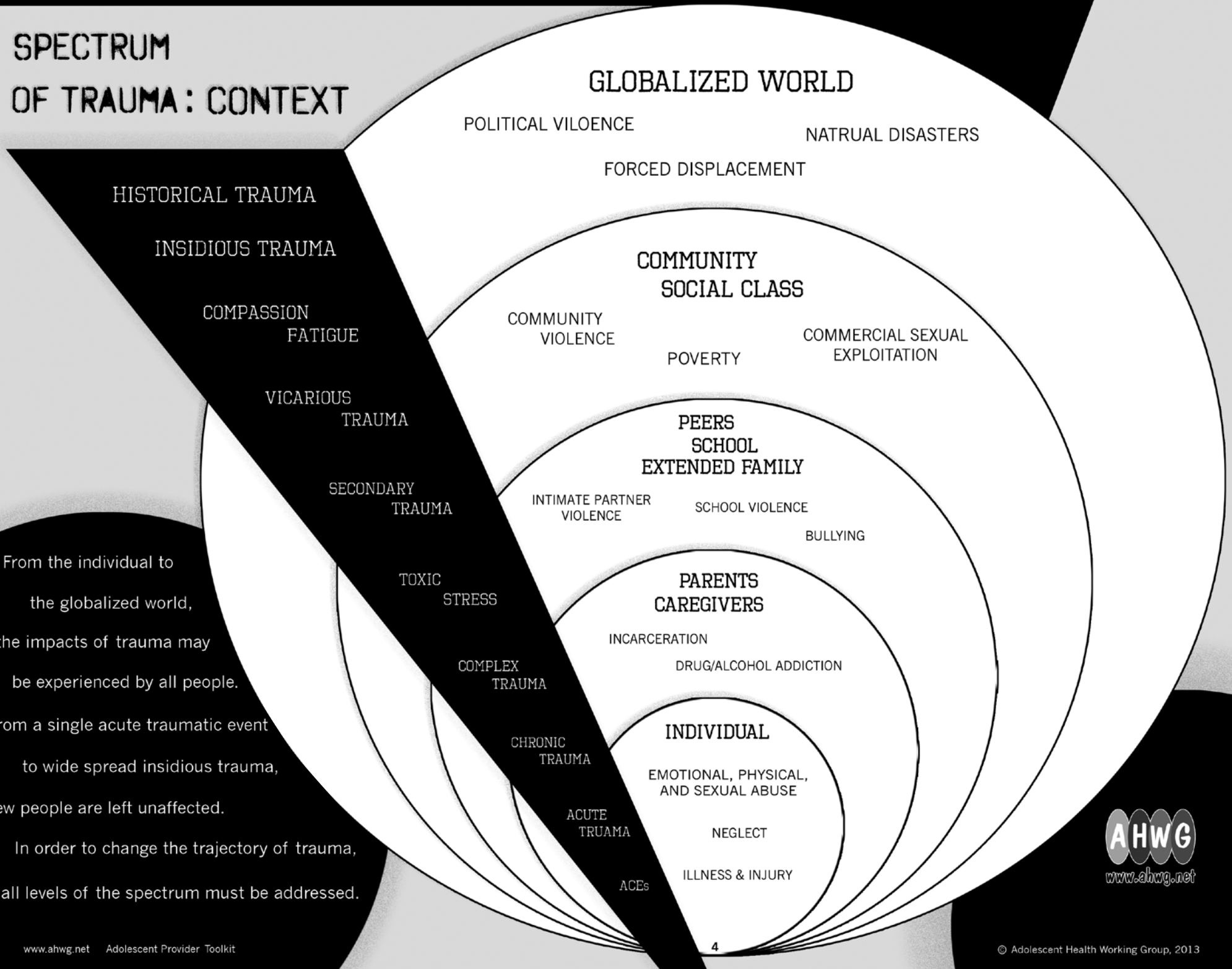
- The earlier in life trauma occurs, the more damaging the consequences may be.
- Prevention and early intervention of traumatic events and resulting consequences are critical.
- People are resilient and can recover from even severe trauma.
- With services, support, and resilience, healing is possible.

Sources: 1. Substance Abuse and Mental Health Services Administration (SAMHSA). 2012. Trauma Definition Working Draft. http://www.samhsa.gov/traumajustice/traumadefinition/index.aspx.
2. National Association of State Mental Health Program Directors (2012, September). Changing Communities, Changing Lives. Report prepared for the Substance Abuse and Mental Health Services Administration's National Center for Trauma-Informed Care. Alexandria, VA: (Joan Gillece, Project Director; Andrea Blanch, Author).

SPECTRUM OF TRAUMA : TERMINOLOGY

TERM	DEFINITION	EXAMPLES
Adverse Childhood Exeriences (ACEs) (2) 	Single or multiple traumatic exposures and/or events experienced during childhood.  	• Child physical abuse, sexual abuse, or emotional abuse • Child physical or emotional neglect • Mentally ill, depressed, or suicidal person in the home • Drug addicted or alcoholic family member • Witnessing domestic violence against the mother • Loss of a parent to death or abandonment in the context of divorce or separation • Incarceration of any family member
Acute Trauma (3)	A single, time-limited traumatic event.	• Physical maltreatment, abuse, assault • Sexual maltreatment, abuse, assault, rape • Emotional abuse, psychological maltreatment • Neglect • Natural disasters, war, terrorism, political violence • Kidnapping, human trafficking, commercial sexual exploitation • Forced displacement (refugees, political asylees) • Intimate partner violence, community violence, school violence • Bullying, harassment • Injuries, accidents • Illness, painful medical procedures • Severely impaired caregiver • Abandonment, betrayal of trust by primary caregiver • Traumatic loss, bereavement • Accumulated burdens of family's severe economic hardship • Homelessness
Chronic Trauma (3)	Multiple traumatic exposures and/or events over extended periods of time.	
Complex Trauma (4) **and Polyvictimization** (5)	Children/adolescent's experiences of multiple traumatic events and the impact of exposure to these events, often occurring within the care giving system.	
Toxic Stress (6)	Adverse experiences that lead to strong, frequent, or prolonged activation of the body's stress response system.	
Secondary Trauma (7) **and Vicarious Trauma** (8)	Exposure to the trauma of others as experienced, realized, or imagined by providers, family members, partners, or friends in close contact with traumatized individual.	
Compassion Fatigue (9)	Cumulative physical, emotional, and psychological effects of exposure to traumatic stories or events when working in a helping capacity.	
Insidious Trauma (10) **and Historical Trauma** (11)	Collective, massive group trauma and compounding forms of multiple oppressions including discrimination based on race, economic status, gender, sexuality, and immigration status, as experienced over extended periods of time, within societies and institutions.	• Colonialism • Genocide • Slavery • Poverty • Internment

SPECTRUM OF TRAUMA: CONTEXT



From the individual to the globalized world, the impacts of trauma may be experienced by all people. From a single acute traumatic event to wide spread insidious trauma, few people are left unaffected. In order to change the trajectory of trauma, all levels of the spectrum must be addressed.

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TRAUMA INEQUITIES

SOCIAL DETERMINANTS OF HEALTH

- Youth living in poverty are most likely to be exposed to trauma experiences, both at home and in the community.
- Roughly three times as many African-American, Hispanic, and American Indian/Alaska Native children live in poverty compared to White and Asian-American children.
- Poverty is a greater problem for minority ethno-cultural groups that have historically been subjected to political and cultural trauma in the US and in their families' countries of origin.
- Asian-American children and their families who are immigrants from impoverished and violence-torn countries are more vulnerable to violence as a result of racism and the scars of historical trauma.
- Other groups at high risk for exposure to violence in childhood include: urban and rural poor, tribal communities, lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth and adults; children and parents with physical disabilities or mental illness and addictions; and homeless individuals and families.(12)

CRADLE TO PRISON PIPELINE

- African American boys born in 2001 have a 1 in 3 chance of being imprisoned in thier lifetimes.(13)
- Latino boys born in 2001 have a 1 in 6 chance of being imprisoned in their lifetimes.(13)
- Arrest rates of trauma-exposed youth are up to 8 times higher than community samples of same-age peers.(14,15)
- Being abused or neglected as a child increases the likelihood of arrest as a juvenile by 59%.(16)
- 70%-92% of incarcerated girls report sexual, physical, or severe emotional abuse in childhood.(17,18)
- 70% of youth in residential placement have some type of past traumatic experience, with 30% having experienced frequent and/or injurious physical and/or sexual abuse.(19)

SUBSTANCE ABUSE

- Trauma increases the risk of developing substance abuse, and substance abuse increases the likelihood that adolescents will experience trauma.
- Up to 59% of youth with Post Traumatic Stress Disorder (PTSD) subsequently develop substance abuse problems.
- In surveys of adolescents receiving treatment for substance abuse, more than 70% had a history of trauma exposure. (20)
- Traumatic stress/PTSD may make it more difficult for adolescents to stop using, as exposure to reminders of traumatic events have been shown to increase drug cravings in people with co-occurring trauma and substance abuse. (20)
- Youth who are already abusing substances may be less able to cope with traumatic events as a result of the functional impairments associated with problematic use.
- Youth with both substance abuse and trauma exposure show more severe and diverse clinical problems than do youth who have been afflicted with only one of these problems.
- When trauma and substance abuse are treated separately, youth are more likely to relapse and revert to previous maladaptive coping strategies.(20)

TRAUMA EVIDENCE

ADVERSE CHILDHOOD EXPERIENCES (ACEs) STUDY (2)

Kaiser Permanente and Centers for Disease Control and Prevention, 1998

The Study:

17,000 mostly white, college-educated, employed adults were screened for 10 prominent childhood traumatic experiences as part of their routine health care at Kaiser. Participants received one point for each type of trauma.

The Results:

- 70% of the 17,000 people experienced at least one type of trauma, resulting in an "ACE score" of one; 87% of those had more than one.
- ACE scores of 4 or more resulted in four times the risk of emphysema or chronic bronchitis; over four times the likelihood of depression; and 12 times the risk of suicide.
- ACE scores were also directly correlated with early initiation of smoking and sexual activity, adolescent pregnancy, and risk for intimate partner violence.
- Eighteen states have since conducted ACE surveys with similar results.

NATIONAL SURVEY OF CHILDREN EXPOSED TO VIOLENCE (NATSCEV) (21)

Department of Justice and Centers for Disease Control and Prevention, 2009

The Study:

Over 4,500 children and youth from birth to age 17 were surveyed in the first attempt to measure the cumulative exposure to violence over a young person's lifetime, including violence in the home, school, and community.

The Results:

- Over 60% of children were exposed to violence in a year.
- Nearly half (46%) experienced a physical assault.
- 30% witnessed an assault in their community.
- 20% witnessed an assault in their family.
- 6% experienced sexual victimization.
- Over 38% were victimized two or more times.
- Over 10% were victimized five or more times.

Trauma Screening and Re-traumatization: Why Answering Questions About Trauma May Be Less Distressing Than Waiting in Line At The Bank (22)

University of New Mexico, 2012

The Study:

Over 500 undergraduate college students were randomly assigned to take a standardized intelligence test or to answer questions about trauma and sex, for two hours.

The Results:

- Participants who completed the trauma/sex survey reported slightly higher negative emotion on average than the intelligence-test participants, but the difference was very small, and the average level of negative emotion in both conditions was very low.
- Participants who completed the trauma/sex survey reported more positive emotion, more personal insight, less boredom, and less mental exhaustion.
- Participants in both conditions reported that the two-hour study was significantly less distressing than all 15 ordinary life events, including getting a paper cut, or waiting in line for 20 minutes at a bank.

COMPASSION FATIGUE:

INCLUDES: 1) PROVIDER BURNOUT, AND 2) SECONDARY TRAUMA/VICARIOUS TRAUMA

BURNOUT

- State of physical, emotional and mental exhaustion caused by long-term involvement in emotional demanding situations. (23)
- Associated with feelings of hopelessness and difficulties in dealing with work or doing one's job effectively. (24)

SECONDARY TRAUMA/VICARIOUS TRAUMA

- Work-related, secondary exposure to extremely or traumatically stressful events.
- Can be the result of the exposure of helpers to experiences of clients, in tandem with empathy experienced for clients. (25)
- Can be sudden and acute.

VICARIOUS TRAUMATIZATION

- A transformation in the helper's inner experience, as a result of empathic engagement with traumatized clients and their traumatic experiences, coupled with a commitment or responsibility to help. (26)

SIGNS AND SYMPTOMS OF VICARIOUS TRAUMATIZATION (27)

General Symptoms

- Numbing
- Social withdrawl
- Nightmares
- Despair and hopelessness
- No time or energy for self
- Disconnection from loved ones
- Increased sensitivity to violence

Internal Transformations

1. A Shifted Frame of Reference: Identity, spirituality, and worldview (e.g. questions goodness of others, loss of hope or optimism).
2. Diminished Self-Capacities: Capacity to tolerate strong emotion, and maintain connection with self and others.
3. Alterations in Sensory and Memory Experiences: Client's memories become incorporated into helper's memory.
4. Disrupted Psychological Needs: Safety, trust, esteem, intimacy, control.
5. Lessened Ego Resources/Internal Resources: Ability to establish and maintain boundaries, ability to strive for personal growth, ability to be introspective, awareness of psychological needs, clear cognitive processing, perspective, empathy, and sense of humor.

Impact on Organizations

- Colleagues experiencing vicarious trauma may treat each other with acts of unkindness, discourtesy, sabotage, infighting, lack of cohesiveness, scape-goating, bullying, and criticism among colleagues within and between affiliated organizations, a phenonmenon referred to as "horizontal violence." (28)

Assessment

- The Professional Quality of Life Scale (ProQOL) is the most commonly used measure of the negative and positive affects of helping others who experience suffering and trauma. The ProQOL has sub-scales for compassion satisfaction, burnout, and compassion fatigue. See: http://www.proqol.org/ProQol_Test

Source: Joyce Dorado, (2013). Self-Care for Educators: Coping with Stress in School. UCSF Healthy Environment and Response to Trauma in Schools (HEARTS), Child and Adolescent Services, Dept. of Psychiatry, University of California, San Francisco.

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE (PROQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout_____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test so you understand the interpretation for you. To find your score on **each section,** total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

3. _____
6. _____
12. _____
16. _____
18. _____
20. _____
22. _____
24. _____
27. _____
30. _____

Total: _____

The sum of my Compassion Satisfaction questions is	So My Score Equals	And my Compassion Satisfaction level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score

You Wrote	Change to
	5
2	4
3	3
4	2
5	1

*1. _____ = _____
*4. _____ = _____
8. _____
10. _____
*15. _____ = _____
*17. _____ = _____
19. _____
21. _____
26. _____
*29. _____ = _____

Total: _____

The sum of my Burnout Questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Secondary Traumatic Stress Scale

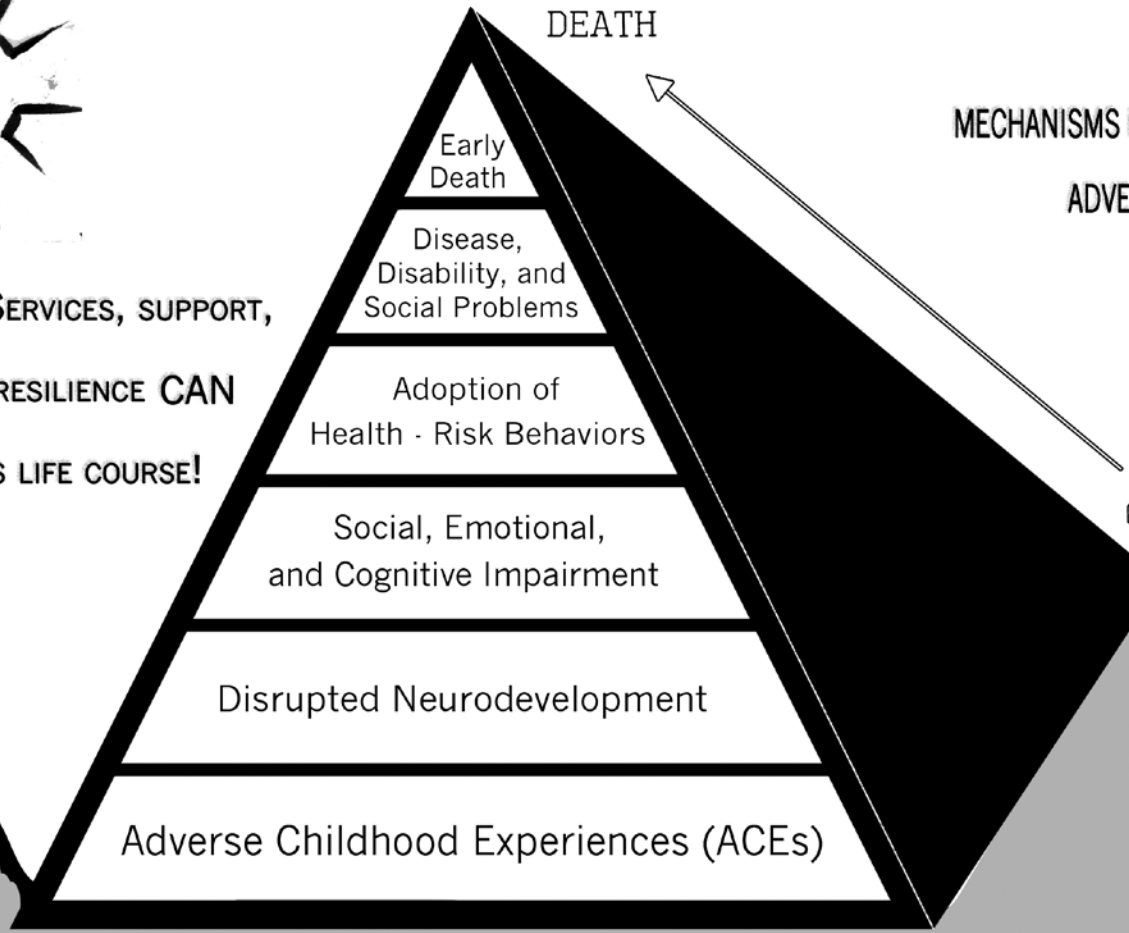
Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

2. _____
5. _____
7. _____
9. _____
11. _____
13. _____
14. _____
23. _____
25. _____
28. _____

Total: _____

The sum of my Secondary Trauma questions is	So My Score Equals	And my Secondary Traumatic Stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

ACEs Pyramid[29]: The Origins of Risk Factors



MECHANISMS BY WHICH

ADVERSE CHILDHOOD EXPERIENCES (ACEs)

INFLUENCE HEALTH AND WELL-BEING

THROUGHOUT THE LIFE-SPAN

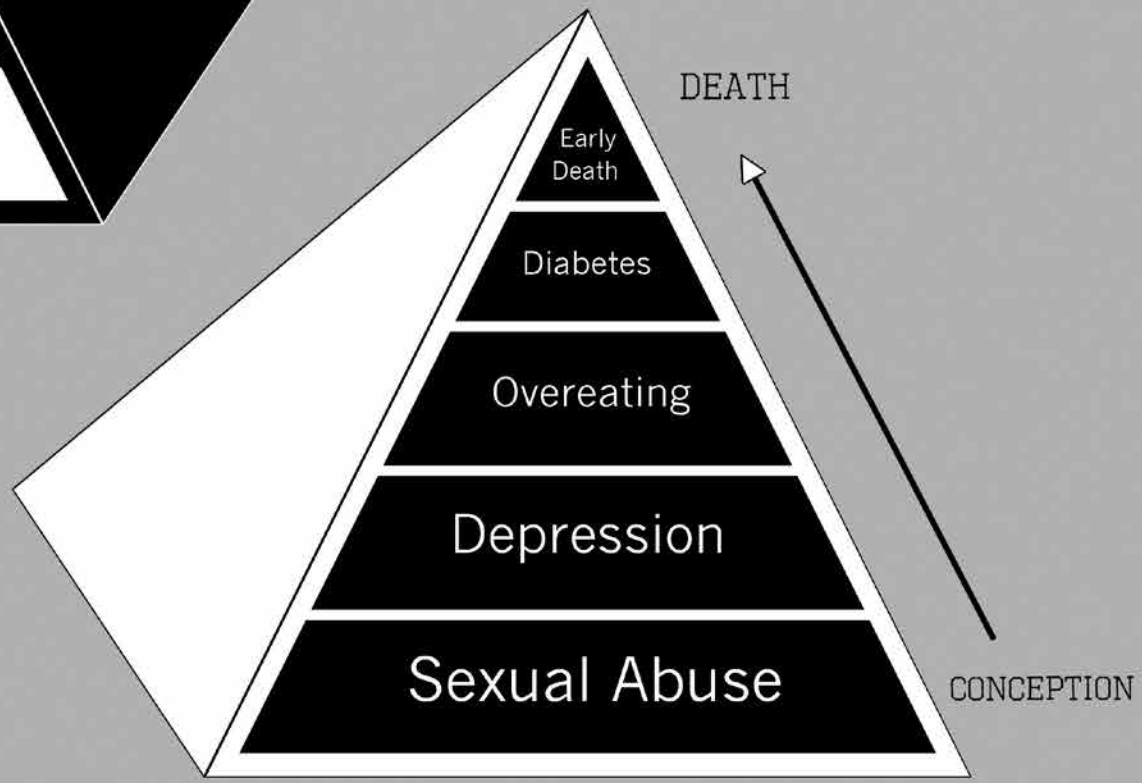
SERVICES, SUPPORT,

AND RESILIENCE CAN

CHANGE THIS LIFE COURSE!

ACEs Pyramids:[29]

REAL LIFE SCENARIOS



SERVICES, SUPPORT, AND RESILIENCE CAN CHANGE THIS LIFE COURSE!

HEALTH RISK BEHAVIORS:

MALADAPTIVE COPING STRATEGIES FOR ADVERSE CHILDHOOD EXPERIENCES (ACEs)

SEEKING TO COPE

- Health risk behaviors underlying adult diseases may actually function as effective coping strategies during adolescence.(30)
- Health risk behaviors may not be viewed by youth as the problem, they might be the youth's solution, a way to feel safe, reduce tension, and feel better, OR the youth may be completely unaware of what drives ACE-related behaviors, compulsions, or reactions.
- Dismissing maladaptive coping strategies as "bad habits" or "self destructive" misses their function.
- Maladaptive coping strategies need to be investigated, linked to previous ACEs, and adapted into positive coping strategies and behaviors.

ADVERSE CHILDHOOD EXPERIENCES (ACES) (2)

Abuse of Child Under Age 18

- Emotional Abuse
- Physical Abuse
- Sexual Abuse

Neglect of Child Under Age 18

- Physical neglect
- Emotional neglect

Household Environment

- Alcohol or drug user in home
- Chronically depressed, emotionally disturbed, or suicidal household member
- Mother treated violently
- Imprisoned household member
- Parents separated or divorced

EFFECTS OF TRAUMA AND RELATED HEALTH RISK BEHAVIORS(2)

Neurobiologic Effects of Trauma

- Disrupted neuro-development
- Difficulty controlling anger, rage
- Hallucinations
- Depression
- Anxiety
- Panic reactions
- Multiple (6+) somatic problems
- Sleep problems
- Impaired memory
- Flashbacks
- Dissociation

Health Risk Behaviors Used to Ease the Pain of Trauma

- Smoking
- Physcial inactivity
- Eating disorders
- Alcoholism
- Drug abuse
- Suicide attempts
- Self injury
- 50+ sexual partners
- Repitition of original trauma
- Perpetrate interpersonal violence

LONG-TERM CONSEQUENCES OF UNADDRESSED TRAUMA (ACES)(2)

Disease and Disability

- Cancer
- Ischemic heart disease
- Chronic lung disease
- Chronic emphysema
- Asthma
- Liver disease
- Severe obesity
- Skeletal fractures
- Poor self rated health
- Sexually transmitted infections
- HIV/AIDS

Serious Social Issues

- Homelessness
- Commercial sex work
- Delinquency, violence, criminal activity
- Inability to sustain employment
- Re-victimization: domestic violence, rape, bullying
- Long-term use of multiple human service systems
- Compromised ability to parent
- Intergenerational trauma

Source: Ann Jennings, PhD. www.theannainstitute.org

ADVERSE CHILDHOOD EXPERIENCES (ACEs) 10 QUESTION SCREENING TOOL

The ACEs 10 Question Screening Tool is an abbreviated version of the ACEs Family Health History Questionnaires and Health Appraisal Questionnaires available at: http://www.cdc.gov/ace/questionnaires.htm

A comprehensive list of validated youth trauma screening and assessment tools are maintained on the NCTSN Measures Review available at: http://www.nctsn.org/resources/online-research/measures-review

FINDING YOUR ACEs SCORE

WHILE YOU WERE GROWING UP, DURING YOUR FIRST 18 YEARS OF	Circle	One	If YES Enter 1
1. Did a parent or other adult in the household **often or very often** swear at you, insult you, put you down, or humiliate you? **OR** act in a way that made you afraid that you might be physically hurt?	Yes	No	
2. Did a parent or other adult in the household **often or very often** push, grab, slap, or throw something at you? **OR** ever hit you so hard that you had marks or were injured?	Yes	No	
3. Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way? **OR** attempt or actually have oral, anal, or vaginal intercourse with you?	Yes	No	
4. Did you **often or very often** feel that: No one in your family loved you or thought you were important or special? **OR** your family didn't look out for each other, feel close to each other, or support each other?	Yes	No	
5. Did you **often or very often** feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **OR** your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	Yes	No	
6. Were your parents ever separated or divorced?	Yes	No	
7. Was your mother or stepmother **often or very often** pushed, grabbed, slapped, or had something thrown at her? **OR** sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? **OR** ever repeatedly hit at least a few minutes or threatened with a gun or knife?	Yes	No	
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	Yes	No	
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?	Yes	No	
10. Did a household member go to prison?	Yes	No	
NOW ADD UP YOUR "YES" ANSWERS. THIS IS YOUR ACEs SCORE.			

Source: http://acestoohigh.com/got-your-ace-score/

ADOLESCENT BRAIN DEVELOPMENT

Brain Function: Manages cognitive, emotional, behavioral, and physical functioning.

Brain System: Made up of interconnecting systems that go from least complex (brainstem: mediates heart rate) to most complex (frontal lobe: the main decision maker of the brain).

Brain Growth: 2 major growth spurts: 1) in the womb, and 2) between childhood and adolescence.

IMPORTANT: Brain development is **NOT** complete until mid to late 20's.

Neurons that Fire Together Wire Together (Hebb's Rule): Brain neurons synapse (i.e. connect with other neurons) or change (chemically and structurally) in response to signals from the environment (experiences) and create memories (cognitive, emotional, behavioral, and physical). The more often neural connections are made, the stronger these connections become.

Synaptic Pruning: During adolescence, the brain begins to break down the least used synapses, or connections and strengthens those most used.

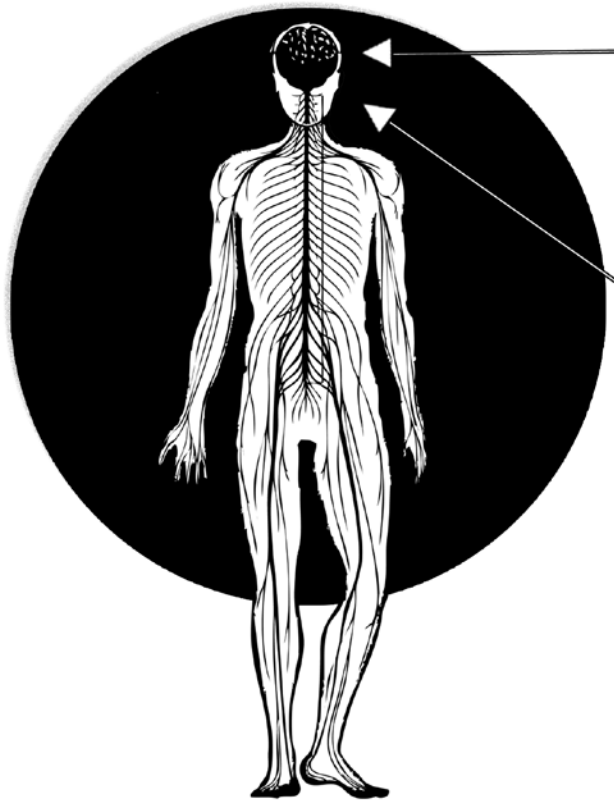
MOST COMPLEX

Frontal Lobe

Abstract Thought
Concrete Thought
Affiliation
Attachment
Sexual Behavior
Emotional Reactivity
Motor Regulation
Arousal
Appetite
Sleep
Blood Pressure
Heart Rate
Body Temperature

Brainstem

LEAST COMPLEX



HIGHER FUNCTIONS

Frontal Lobe

Learning Brain: thinking, planning, decision-making
Impulse and behavior control
Undergoing development in youth ages 10-24

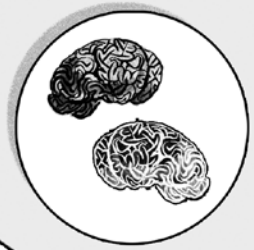
LOWER FUNCTIONS

Brainstem

Survival Brain: flight, flight, or freeze
Emotion-driven processing
Heavily relied on by youth

Source: Dorado, J. 2013. Promoting School Success for Students Who Have Experienced Complex Trauma: Creating Trauma-Sensitive School Environments. Healthy Environments and Response to Trauma in Schools (HEARTS), University of California San Francisco (UCSF).

SURVIVAL BRAIN VS. LEARNING BRAIN



ALARM SYSTEM: We all have normal alarm systems in our brain/body that lets us know when we are under threat and mobilizes us to fight, flight, or flee threat. When youth experience continuous threats/trauma, the brain/body is put into a chronic state of fear, activating the "survival brain" (mid/lower areas of the brain). This can create an overactive alarm system in the developing brain. A youth's brain/body that develops within the context of trauma can be more easily triggered into "survival brain" by "trauma reminders" or "triggers" even when there is no actual threat. (32,33)

TRAUMA TRIGGERS: Can activate the "survival brain," causing youth to react as though a "there and then" experience (previous traumatic event) is happening "here and now" (in current reality).

Common triggers include:

- Unpredictability
- Sudden changes or transitions
- Loss of control
- Sensory overload
- Feeling vulnerable
- Rejection
- Loneliness
- Confrontation
- Intimacy
- And even praise or positive attention

When youth are in a triggered state, they may not be able to access higher functions of the frontal lobe ("learning brain"). At this time, verbal warnings of consequences, or making demands on the higher "learning brain" (i.e. asking them to explain their decision-making process), may escalate the situation.

DE-ESCALATION: Youth in a triggered state need help to calm down from "there and then" triggers and become more present in "here and now" reality, (in which there may be no actual threat). Feelings of safety and control must be re-established in order for youth to think more clearly.

Strategies include:

- Noticing signs of distress
- Connecting with the youth
- And then re-directing behavior through providing reasonable choices/options for alternative activities/circumstances
- After youth is calm, discussion about what happened can take place and if necessary, consequences can be determined

The long-term goal is NOT to turn off the brain/body alarm system, as the alarm is needed to detect ongoing/real threats. The goal is to increase the alarm's accuracy so that it doesn't turn on unnecessarily.

BRAIN PLASTICITY: Patterned, repetitive activities can help the brain to re-wire and organize itself into more healthy functioning. Activities may include: music, movement, drumming, yoga, deep breathing, mindfulness, and positive, nurturing interactions with trustworthy adults and peers. (32)

Source: Dorado, J. 2013. Promoting School Success for Students Who Have Experienced Complex Trauma: Creating Trauma-Sensitive School Environments. Healthy Environments and Response to Trauma in Schools (HEARTS), University of California San Francisco (UCSF).

NEUROBIOLOGICAL RESPONSE SYSTEMS

STRESS RESPONSE: POSITIVE, TOLERABLE, OR TOXIC (33)

POSITIVE STRESS RESPONSE

- Normal and essential part of healthy development.
- Includes brief increases in heart rate and mild elevations in hormone levels.

Examples: Attending a new school; going out with new friends.

TOLERABLE STRESS RESPONSE

- Activates the mind/body alarm system as a result of more severe, longer-lasting difficulties.
- If activation is time-limited and buffered by relationships with caring adults who help youth to adapt, the brain and other organs may recover from possible damaging effects.

Examples: Loss of a loved one; natural disaster; frightening injury.

TOXIC STRESS RESPONSE

- Can occur when youth experiences strong, frequent, and/or prolonged adversity.
- Without adequate adult support, prolonged activation of the stress response system can disrupt the development of brain architecture and other organs
- Risk for stress-related disease and cognitive impairment is increased well into adulthood.

Examples: Physical or emotional abuse; chronic neglect; caregiver substance abuse or mental illness; exposure to violence; accumulated burdens of severe family economic hardship.

SURVIVAL RESPONSE: FIGHT, FLIGHT, OR FREEZE (34-36)

FIGHT

- Youth struggle to regain or hold on to power, especially when feeling coerced.

Youth often mislabeled as: Non-compliant or combative.

FLIGHT

- Youth disengages or runs away and "checks out" emotionally.

Youth often mislabeled as: Uncooperative or resistant.

FREEZE

- Youth gives in to those in positions of power; does not, or is unable to "speak up."

Youth often mislabeled as: Passive or unmotivated.

CHRONIC TRAUMA

AFFECTS THE WHOLE YOUTH

EMOTIONAL

Terror/fear
Sadness
Shock
Loss of pleasure from activities
Despair
Emotional numbering
Hypersensitivity
Helplessness
Depression
Irritability
Guilt
Grief
Phobias
Anger

PHYSICAL

Sleep disturbance
Startle response
Somatic complaints
Insomnia
Impaired immune response
Gastrointestinal problems
Decreased appetite
Hyperarousal
Decreased libido
Headaches
Fatigue

INTERPERSONAL & BEHAVIORAL

Aggression
Regression in behavior
Crying easily
Risk taking
Social withdrawl
Change in eating patterns
Alienation
Avoiding trauma reminders
Tantrums
School impairment
Refusal to go back to school
Increased relationship conflict
Vocational impairment
Isolation

CONGNITIVE

Worry
Nightmares
Confusion
Disbelief
Memory impairment
Impaired decision making ability
Impaired concentration
Decreased self-efficancy
Self blame
Distortion
Decreased self-esteem
Intrusive thoughts/ memories

POST TRAUMATIC STRESS DISORDER (PTSD)

Post Traumatic Stress Disorder (PTSD) is the leading diagnosis available in the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-IV) for post traumatic symptoms among youth and adults. (37)

PTSD is an important diagnosis, however it is limited by the following: (38)

- Originally developed for and is most relevant to adults, not children/youth.
- More often captures symptoms of single/acute traumatic events, not complex/chronic traumatic events.
- Focuses on the individual.

PTSD A: Stressor

The person has been exposed to a traumatic event in which both of the following have been present:

1. The person has experienced, witnessed, or been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others.
2. The person's response involved intense fear, helplessness, or horror. Note: in children, it may be expressed instead by disorganized or agitated behavior.

PTSD B: Intrusive Recollection

The traumatic event is persistently re-experienced in at least one of the following ways:

1. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions.

Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

2. Recurrent distressing dreams of the event. Note: in children, there may be frightening dreams without recognizable content.
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). Note: In children, trauma-specific reenactment may occur.
4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. Physiologic reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

PTSD C: Avoidant/Numbing

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
2. Efforts to avoid activities, places, or people that arouse recollections of the trauma.
3. Inability to recall an important aspect of the trauma.
4. Markedly diminished interest or participation in significant activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect (e.g., unable to have loving feelings).
7. Sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

PTSD D: Hyper-Arousal

Persistent symptoms of increasing arousal (not present before the trauma), indicated by at least two of the following:

1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hyper-vigilance.
5. Exaggerated startle response.

PTSD E: Duration

Duration of the disturbance (symptoms in B, C, and D) is more than one month.

PTSD F: Functional Significance

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify If: Acute: If duration of symptoms is less than three months; Chronic: if duration of symptoms is three months or more; With or Without delay onset: Onset of symptoms at least six months after the stressor.

BEYOND PTSD: DEVELOPMENTAL TRAUMA DISORDER

Developmental Trauma Disorder is a proposed diagnosis for the upcoming fifth edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-V) to capture more developmentally appropriate post traumatic symptoms specific to children/youth. (38)

Developmental Trauma Disorder Includes:

1) Child/youth specific and developmentally appropriate symptoms. 2) Complex/chronic trauma symptoms. 3) Role of impaired caregiving systems.

AFFECTIVE AND PHYSIOLOGICAL DYSREGULATION Impaired arousal regulation	• Inability to modulate, tolerate, or recover from extreme affect states (e.g fear, anger, shame) including prolonged and extreme tantrums, or immobilization. • Disturbances in regulation of bodily functions (e.g. sleeping, eating, and elimination; over-reactivity or under-reactivity to touch and sounds; disorganization during routine transitions). • Decreased awareness or dissociation of sensations, emotions, and bodily states. • Impaired capacity to describe emotions or bodily state.
ATTENTIONAL AND BEHAVIORAL DYSREGULATION Impaired attention, learning, and coping mechanisms	• Preoccupation with threat, or impaired capacity to perceive threat, including misreading of safety and danger cues. • Impaired capacity for self-protection, including extreme risk-taking or thrill-seeking. • Maladaptive attempts at self-soothing (e.g. rocking, other rhythmical movements, compulsive masturbation). • Habitual (intentional, automatic, or reactive) self-harm. • Inability to initiate or sustain goal-directed behavior.
SELF AND RELATIONAL DYSREGULATION Impaired sense of personal identity and involvement in relationships	• Intense preoccupation with safety of caregiver or loved ones, or difficulty tolerating reunion with them after separation. • Persistent negative sense of self (e.g. self-loathing, helplessness, worthlessness, ineffectiveness, or defectiveness). • Extreme and persistent distrust, defiance or lack of reciprocal behavior in close relationships with adults or peers. • Reactive physical or verbal aggression toward peers, caregivers, or other adults. • Inappropriate (excessive or promiscuous) attempts to get intimate contact (including but not limited to sexual or physical intimacy) or excessive reliance on peers or adults for safety and reassurance. • Impaired capacity to regulate empathic arousal (e.g. lack of empathy for, or intolerance of distress in others, or excessive responsiveness to the distress of others).
FUNCTIONAL IMPAIRMENT School, family, peer group, legal, health, and work impairments	• **School:** Under-performance, non-attendance, disciplinary problems, drop-out, failure to complete degree/credentials, conflict with school personnel, learning disabilities or intellectual impairment that cannot be accounted for by neurological or other factors. • **Family:** Conflict, avoidance/passivity, running away, detachment and surrogate replacements, attempts to physically or emotionally hurt family members, non-fulfillment of responsibilities within family. • **Peers:** Isolation, deviant affiliations, persistent physical or emotional conflict, avoidance/passivity, involvement in violence or unsafe acts, age inappropriate affiliations or style of interaction. • **Legal:** Arrests/recidivism, detention, convictions, incarceration, violation of probation/court orders, increasingly severe offenses, crimes against other persons, disregard or contempt for the law or for conventional moral standards. • **Health:** Physical illness or problems that cannot be fully accounted for, involving digestive, neurological, sexual, immune, cardiopulmonary, proprioceptive, sensory systems, severe headaches (including migraine), or chronic pain/fatigue. • **Work:** Youth involved in, seeking, or referred for employment, volunteer, or job training show disinterest in work/vocation, inability to get or keep jobs, persistent conflict with co-workers or supervisors, under-employment in relation to abilities, failure to achieve expectable advancements.

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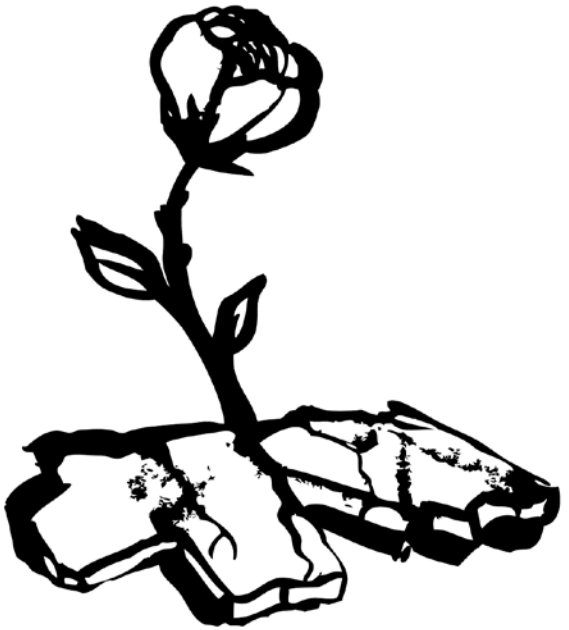
RESILIENCE



SPECTRUM OF RESILIENCE

RESILIENCE

- The positive capacity to cope, adjust to, or recover from stress and negative life events; includes personality traits, social skills, and responses that enable thriving in the face of adversity. (1-5)

- All people are born with resilience; it can be nurtured and recaptured if lost.

- Factors can be internal characteristics such as individual talents, energies, strengths, and constructive interests; or external influences like family support, adult role models outside the family, high expectations within the community, and the availability of creative activities.

POSTTRAUMATIC GROWTH

- 30%-90% of people affected by a serious crisis describe some type of posttraumatic growth. (8)

- Posttraumatic growth includes changes in perception of self, the improvement and deepening of relationships with others, a heightened compassion for others, an increased ability for expressing emotions, and an ability to find meaning in the trauma experienced.

VICARIOUS RESILIENCE/ (6) COMPASSION SATISFACTION (7)

- Compassion satisfaction includes the pleasure from being able to do one's work well, helping others through work, positive feelings about colleagues, and contributing to the work setting or greater good of society.

- Vicarious resilience is the process in which workers in helping professions may experience positive influences, such as hope and increased self-efficacy, through their work with trauma survivors.

RESILIENCE TRUMPS ACEs

ADVERSE CHILDHOOD EXPERIENCE (ACEs)

- ACEs are NOT a life sentence and they are NOT set in stone.
- There ARE ways to lessen the effects of ACEs.

RESILIENCE

- Responsive caregiving provided to youth from trusted adults can moderate the effects of early stress and neglect associated with ACEs.
- Building resilience can counter the effects of ACEs and help lead youth to more effective, productive, and healthy adulthoods.

BUILDING BLOCKS

- Resilience building blocks include simple actions, responses, and attitudes.
- Each block can look small and simple, but together form a solid foundation on which youth and adults can build the capacity to thrive, even when life poses inevitable hardships, challenges, and disappointments.

Adverse Childhood Experiences (ACEs)

- Sexual abuse
- Physical abuse
- Emotional abuse
- Physical neglect
- Emotional neglect
- Loss of a parent/caregiver
- Witnessing family violence
- Incarceration of a family member
- Drug addicted or alcoholic family member
- Mentally ill, depressed, or suicidal family member

Source: Resilience Trumps ACEs (copyright). Children's Resilience Initiative. www.resiliencetrumpsaces.org

RESILIENCE BUILDING BLOCKS

FOR ADULTS

- Model appropriate behavior
- Model problem solving skills
- Set clear expectations and rules
- Establish consequences
- Teach youth self-discipline and responsibility
- Assign chores to give youth responsibility
- Have regular check-ins with youth
- Let youth know they are loved
- Let youth know you are available to help
- Help youth express their feelings
- Help youth develop problem-solving skills
- Help youth appreciate cultural and ethnic heritage
- Give youth choices
- Respect youth's ability to make decisions
- Allow youth's experience of success and failure

FOR YOUTH AND ADULTS

- Hope, trust, and a sense of belonging
- Attachment to a caring adult
- Ability to express feelings and calm oneself
- Learn to sense triggers that create negative behaviors and accept ownership of behaviors
- Learn responsibility, problem solving, and decision making
- Learn to ask for help and accept help
- Learn to show appreciation and empathy
- Learn to self-advocate and develop self-esteem
- Develop friendships and share something important
- Develop a sense of control
- Work as a team and give back to the community
- Master a skill and experience success

POSTTRAUMATIC GROWTH

Posttraumatic growth does NOT mean that pain or fear from trauma go away. Posttraumatic growth means that individuals are able to find meaning in the trauma, learn more about themselves in the process, and find opportunities to apply increased self-knowledge to making healthy life choices.

REQUIREMENTS FOR POSTTRAUMATIC GROWTH:(9)

A safe environment

- Since feelings of extreme danger and vulnerability are inherent to most traumatic experiences, establishing feelings of safety for youth is necessary before beginning to process the experience.

Listening without trying to solve

- Youth may feel angry or scared and express a variety of emotions in order to make sense of an experience.
- Caring adults must resist the urge to "make it all better," which may come from personal needs to make intense feelings more tolerable.

Recognizing and highlighting growth or changed perspective:

- Making note and commenting on a youth's new insights can help reinforce positive growth.

Reframing growth and opportunity

- There is a tendency to say that a traumatic experience caused growth. It may be more helpful to reframe and say that trauma didn't cause the growth but created an opportunity for growth.

Referrals for counseling, if appropriate

- Many youth don't know about, are afraid of, or have heard negative experiences about mental health services, however counseling can be a useful tool for youth in making sense out of life

POSTTRAUMATIC GROWTH INCLUDES:

- Changes in one's perception of self.
- Improvement and deepening of one's relationships with others.
- Heightened compassion for others.
- Increased ability to express emotions.

TIPS FOR POSTTRAUMATIC GROWTH: (10)

- Support appropriate interpersonal skills.
- Promote affect regulation (e.g. practicing coping skills such as self-soothing or distraction).
- Support autonomous decision-making and independent functioning.
- Foster spirituality through exploration of beliefs, attitudes and faith.
- Emphasize ability to make changes in the course of life.
- Nurture a clear and positive identity, encouraging identity exploration, and integrating different parts of self.
- Foster hope, belief in the future, goal-setting, and envisioning future plans.
- Recognize positive behavior, and celebrating healthy behavioral changes.
- Provide opportunities for pro-social involvement by creating time or space for positive interaction and community support.
- Establish pro-social norms by not tolerating destructive behavior, and normalizing positive interactions and healthy coping.

Source: Providing Trauma Informed Care for Homeless Youth: A Supervisor's Guide. Hollywood Homeless Youth Partnership. http://hhyp.org/download-material-2/

40 DEVELOPMENTAL ASSETS® FOR ADOLESCENTS (AGES 12-18)

Search Institute® has identified the following building blocks of healthy development—known as Developmental Assets®—that help young people grow up healthy, caring, and responsible.

EXTERNAL ASSETS

SUPPORT

1. Family support—Family life provides high levels of love and support.
2. Positive family communication—Young person and her or his parent(s) communicate positively, and young person is willing to seek advice and counsel from parents.
3. Other adult relationships—Young person receives support from three or more nonparent adults.
4. Caring neighborhood—Young person experiences caring neighbors.
5. Caring school climate—School provides a caring, encouraging environment.
6. Parent involvement in schooling—Parent(s) are actively involved in helping young person succeed in school.

EMPOWERMENT

7. Community values youth—Young person perceives that adults in the community value youth.
8. Youth as resources—Young people are given useful roles in the community.
9. Service to others—Young person serves in the community one hour or more per week.
10. Safety—Young person feels safe at home, school, and in the neighborhood.

BOUNDARIES AND EXPECTATIONS

11. Family boundaries—Family has clear rules and consequences and monitors the young person's whereabouts.
12. School Boundaries—School provides clear rules and consequences.
13. Neighborhood boundaries—Neighbors take responsibility for monitoring young people's behavior.
14. Adult role models—Parent(s) and other adults model positive, responsible behavior.
15. Positive peer influence—Young person's best friends model responsible behavior.
16. High expectations—Both parent(s) and teachers encourage the young person to do well.

CONSTRUCTIVE USE OF TIME

17. Creative activities—Young person spends three or more hours per week in lessons or practice in music, theater, or other arts.
18. Youth programs—Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in the community.
19. Religious community—Young person spends one or more hours per week in activities in a religious institution.
20. Time at home—Young person is out with friends "with nothing special to do" two or fewer nights per week.

INTERNAL ASSETS

COMMITMENT TO LEARNING

21. Achievement Motivation—Young person is motivated to do well in school.
22. School Engagement—Young person is actively engaged in learning.
23. Homework—Young person reports doing at least one hour of homework every school day.
24. Bonding to school—Young person cares about her or his school.
25. Reading for Pleasure—Young person reads for pleasure three or more hours per week

POSTIVE VALUES

26. Caring—Young person places high value on helping other people.
27. Equality and social justice—Young person places high value on promoting equality and reducing hunger and poverty.
28. Integrity—Young person acts on convictions and stands up for her or his beliefs.
29. Honesty—Young person "tells the truth even when it is not easy."
30. Responsibility—Young person accepts and takes personal responsibility.
31. Restraint—Young person believes it is important not to be sexually active or to use alcohol or other drugs.

SOCIAL COMPETENCIES

32. Planning and decision making—Young person knows how to plan ahead and make choices.
33. Interpersonal Competence—Young person has empathy, sensitivity, and friendship skills.
34. Cultural Competence—Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.
35. Resistance skills—Young person can resist negative peer pressure and dangerous situations.
36. Peaceful conflict resolution—Young person seeks to resolve conflict nonviolently.

POSITIVE IDENTITY

37. Personal power—Young person feels he or she has control over "things that happen to me."
38. Self-esteem—Young person reports having a high self-esteem.
39. Sense of purpose—Young person reports that "my life has a purpose."
40. Positive view of personal future—Young person is optimistic about her or his personal future.

ASSETS EVIDENCE

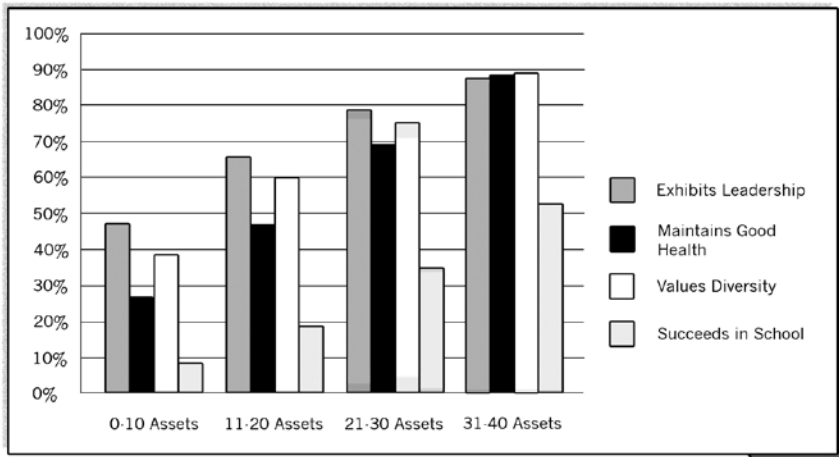
WHAT ARE THEY?

- Assets are common sense positive experiences and qualities that help influence choices young people make and help them become caring, responsible, successful adults.
- Based in youth development, resiliency, and prevention research, with proven effectiveness. (11)

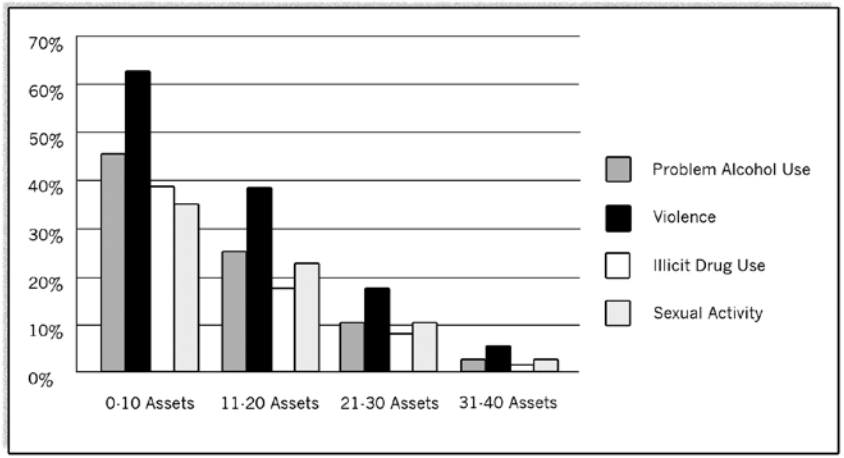
WHO NEEDS THEM?

- Studies of more than 2.2 million young people consistently show that the more assets young people have, the less likely they are to engage in a wide range of high-risk behaviors and the more likely they are to thrive. (11)
- Research has proven that youth with the most assets are least likely to engage in four different patterns of high-risk behavior, including problem alcohol use, violence, illicit drug use, and sexual activity.
- The same kind of impact is evident with many other problem behaviors, including tobacco use, depression and attempted suicide, antisocial behavior, school problems, driving and alcohol, and gambling.

ASSETS PROMOTE POSITIVE ATTITUDES AND BEHAVIORS



ASSETS PROTECT YOUTH FROM HEALTH RISK BEHAVIORS



THE POWER OF ASSETS

- The positive power of assets is evident across all cultural and socioeconomic groups of youth.
- In addition to protecting youth from negative behaviors, having more assets increases the chances that young people will have positive attitudes and behaviors. (11)

Source: Search Institute (copyright). http://www.search-institute.org/developmental-assets

DEVELOPMENTAL ASSETS PROFILE

Self-Report for Ages 11-18

NAME / ID: _____ **TODAY'S DATE:** Mo: _____ Day:_____ Yr:_____

SEX: ☐ Male ☐ Female **AGE:** _____ **GRADE:**_____ **BIRTH DATE:** Mo:_____ Day:_____ Yr:_____

RACE/ETHNICITY (Check all that apply): ☐ American Indian or Alaska Native ☐ Asian

☐ Black or African American ☐ Hispanic or Latino/Latina ☐ Native Hawaiian or Other Pacific Islander

☐ White ☐ Other (*please specify*):

INSTRUCTIONS: Below is a list of positive things that you might have in *yourself, your family, friends, neighborhood, school, and community*. For each item that describes you **now or within the past 3 months**, check if the item is true:

Not At All or Rarely **Somewhat or Sometimes** **Very or Often** **Extremely or Almost Always**

If you do not want to answer an item, leave it blank. But please try to answer all items as best you can.

Not At All or Rarely	Somewhat or Sometimes	Very or Often	Extremely or Almost Always	I . . .
☐	☐	☐	☐	1. Stand up for what I believe in.
☐	☐	☐	☐	2. Feel in control of my life and future.
☐	☐	☐	☐	3. Feel good about myself.
☐	☐	☐	☐	4. Avoid things that are dangerous or unhealthy.
☐	☐	☐	☐	5. Enjoy reading or being read to.
☐	☐	☐	☐	6. Build friendships with other people.
☐	☐	☐	☐	7. Care about school.
☐	☐	☐	☐	8. Do my homework.
☐	☐	☐	☐	9. Stay away from tobacco, alcohol, and other drugs.
☐	☐	☐	☐	10. Enjoy learning.
☐	☐	☐	☐	11. Express my feelings in proper ways.
☐	☐	☐	☐	12. Feel good about my future.
☐	☐	☐	☐	13. Seek advice from my parents.
☐	☐	☐	☐	14. Deal with frustration in positive ways.
☐	☐	☐	☐	15. Overcome challenges in positive ways.
☐	☐	☐	☐	16. Think it is important to help other people.
☐	☐	☐	☐	17. Feel safe and secure at home.
☐	☐	☐	☐	18. Plan ahead and make good choices.
☐	☐	☐	☐	19. Resist bad influences.
☐	☐	☐	☐	20. Resolve conflicts without anyone getting hurt.
☐	☐	☐	☐	21. Feel valued and appreciated by others.
☐	☐	☐	☐	22. Take responsibility for what I do.
☐	☐	☐	☐	23. Tell the truth even when it is not easy.
☐	☐	☐	☐	24. Accept people who are different from me.
☐	☐	☐	☐	25. Feel safe at school.

PLEASE TURN OVER AND COMPLETE THE BACK.

Note: The term "Parent(s)" means 1 or more adults who are responsible for raising you.

Not At All or Rarely	Somewhat or Sometimes	Very or Often	Extremely or Almost Always	
				I AM . . .
☐	☐	☐	☐	26. Actively engaged in learning new things.
☐	☐	☐	☐	27. Developing a sense of purpose in my life.
☐	☐	☐	☐	28. Encouraged to try things that might be good for me.
☐	☐	☐	☐	29. Included in family tasks and decisions.
☐	☐	☐	☐	30. Helping to make my community a better place.
☐	☐	☐	☐	31. Involved in a religious group or activity.
☐	☐	☐	☐	32. Developing good health habits.
☐	☐	☐	☐	33. Encouraged to help others.
☐	☐	☐	☐	34. Involved in a sport, club, or other group.
☐	☐	☐	☐	35. Trying to help solve social problems.
☐	☐	☐	☐	36. Given useful roles and responsibilities.
☐	☐	☐	☐	37. Developing respect for other people.
☐	☐	☐	☐	38. Eager to do well in school and other activities.
☐	☐	☐	☐	39. Sensitive to the needs and feelings of others.
☐	☐	☐	☐	40. Involved in creative things such as music, theater, or art.
☐	☐	☐	☐	41. Serving others in my community.
☐	☐	☐	☐	42. Spending quality time at home with my parent(s).
				I HAVE . . .
☐	☐	☐	☐	43. Friends who set good examples for me.
☐	☐	☐	☐	44. A school that gives students clear rules.
☐	☐	☐	☐	45. Adults who are good role models for me.
☐	☐	☐	☐	46. A safe neighborhood.
☐	☐	☐	☐	47. Parent(s) who try to help me succeed.
☐	☐	☐	☐	48. Good neighbors who care about me.
☐	☐	☐	☐	49. A school that cares about kids and encourages them.
☐	☐	☐	☐	50. Teachers who urge me to develop and achieve.
☐	☐	☐	☐	51. Support from adults other than my parents.
☐	☐	☐	☐	52. A family that provides me with clear rules.
☐	☐	☐	☐	53. Parent(s) who urge me to do well in school.
☐	☐	☐	☐	54. A family that gives me love and support.
☐	☐	☐	☐	55. Neighbors who help watch out for me.
☐	☐	☐	☐	56. Parent(s) who are good at talking with me about things.
☐	☐	☐	☐	57. A school that enforces rules fairly.
☐	☐	☐	☐	58. A family that knows where I am and what I am doing.

THANK YOU FOR COMPLETING THIS FORM.

ATTACHMENT, SELF-REGULATION, AND COMPETENCY (ARC)[12]

ARC: A Conceptual framework and core intervention principles for working with youth who have experienced multiple and/or prolonged traumas. Can be used in: 1) Clinical work with youth, 2) Provider team meetings, and 3) Administrative review of agency policies and procedures.

ATTACHMENT: The capacity to form and maintain a healthy emotional bond with another person as a source of mutual comfort, safety, and caring.

SELF-REGULATION: Developing and maintaining the ability to identify, express, and modulate feelings such as frustration, anger, and fear.

COMPETENCY: Mastering the developmental tasks of adolescence and developing the ability to plan and organize for the future. Areas of competency include: judgment, impulse control, planning, prioritizing tasks, organizing, insight, empathy, and decision-making. Competency also includes specific life skills such as: hygiene, literacy, budgeting and banking, shopping and cooking, transportation, safety planning, time management, and the ability to be assertive.

QUESTIONS FOR CLINICAL WORK WITH YOUTH AND PROVIDER TEAM MEETINGS

ATTACHMENT

- What is known about the quality and consistency of the youth's early child caregiver experiences?
- What quality of relationships does the youth form with peers?
- How does the youth relate to adults, program staff, and authority figures?

SELF-REGULATION

- What does it look like when the youth is experiencing unpleasant feelings (i.e. frequency, intensity, and recovery time)?
- What kinds of situations trigger unpleasant feelings?
- What methods does the youth use to calm down?

COMPETENCY

- Is the youth able to think realistically and with sound judgment about the past, present and future?
- Is the youth able to problem solve, organize/prioritize time, and plan ahead?
- What specific skills does the youth possess and what skills does the youth still need to acquire?

QUESTIONS FOR ADMINSTRATIVE REVIEW OF AGENCY POLICIES AND PROCEDURES

How do agency policies, procedures, and culture support:

- Youth's positive self-regard and ATTACHMENT to the program, peers, providers, family, and community?
- Youth's ability to learn and practice appropriate SELF-REGULATION skills?
- Youth's development of new COMPETENCIES and skills?

NEXT STEPS: After reviewing agency strengths and challenges in each area, providers and administrators can decide how to improve agency support in the three key areas. Often times, small, low or no cost efforts can make significant improvements in creating healing environments for youth.

EXAMPLES:

ATTACHMENT

- Create structured and predictable environments by establishing rituals and routines, and showing unconditional respect and acceptance.

COMPETENCY

- Create opportunities for youth to positively engage with peers, adults, and community members.

SELF-REGULATION

- Create a safe space for youth experiencing intense emotions by training providers to help youth accurately identify and manage feelings.

DEVELOPMENTAL COMPETENCIES

Psychological & Emotional Development

Empathy

Positive self-regard

Sense of autonomy

Self-regulation skills

Positive coping skills

Conflict resolution skills

Optimism coupled with realism

Ability to comfort self and others

Recognition of right and wrong

Physical Development

Healthy Habits

Personal hygiene

Nutrition and exercise

Regular medical and dental care

Risk Management

Seat belts

Condoms

Bike helmets

Social Development

Sense of belonging to society

Connectedness with parents/cargivers, peers, and other adults

Attachment to pro-social institutions such as school and church

Ability to navigate in multiple cultural contexts

Commitment to civic engagement

Intellectual Development

Essential Life Skills:

Literacy

Budgeting and banking

Shopping and cooking

Transportation and Safety planning

Essential Vocational Skills:

Job applications and interviews

Time management

Knowledge of more than one culture

Critical thinking and reasoning

Decision-making and planning

SUPPORT THE WHOLE YOUTH

RESILIENCE PYRAMIDS:

FROM BIRTH TO YOUNG ADULTHOOD

RESILIENCE BUILDING BLOCKS

COMPETENCY
Mastering
developmental
tasks of adolescence
and the ability to plan
and organize for the future

SELF-REGULATION
Developing and maintaining the
ability to identify, express, and modulate
feelings such as frustration, anger, and fear

ATTACHMENT
The capacity to form and maintain a
healthy emotional bond with another person
as a source of mutual comfort, safety, and caring (12)

RESILIENCE IN REAL LIFE

YOUTH CAN
Be insightful,
Prioritize tasks,
Plan effectively,
Make good judgments, and
Organize thoughts and actions

YOUTH DEVELOPS
Empathy,
Impulse control,
Healthy boundaries, and
Conflict management skills

YOUTH PROVIDED WITH
Receptive, attuned cargiving from and adult (12)

PROVIDER SELF-CARE STRATEGIES FOR BURNOUT AND VICARIOUS TRAUMA

PEACE: *It does not mean to be in a place where there is no noise, trouble, or hard work. It means to be in the midst of these things and still be calm in your heart.*

–Author Unknown

BUILDING RESILIENCE: ABC'S OF SELF CARE (13)

A: Awareness of one's limits, resources, and emotions.

B: Balance among personal and professional activities.

C: Connection to one's inner self, to others, and to something "larger" (e.g. spiritual).

BUILDING RESILIENCE: HOW TO'S (14)

- Make connections and build good relationships.
- Avoid seeing crises as insurmountable problems.
- Accept that change is part of living.
- Move towards goals.
- Take decisive actions.
- Look for opportunities for self-discovery.
- Nurture a positive view of yourself.
- Keep things in perspective.
- Maintain a hopeful outlook.

STRESS/BURNOUT: DECREASE OVERUSE OF "DIRECTED ATTENTION"(15)

- "Directed attention" (watching TV) leads to more burnout, whereas "locomotion in nature" (e.g., walk in the park) and "fascination" is restorative and decreases burnout.

VICARIOUS TRAUMA: MINIMIZE UNNECESSARY EXPOSURE TO TRAUMATIC MATERIAL

- Reduce viewing of traumatic media, including violent movies and news about tragic events.

CONNECTION: THE SCIENCE OF POSITIVE PSYCHOLOGY

- Health and Happiness Ratio = 3:1
- 3 positive emotions are needed for each negative emotion (16)

Sources: 1) Joyce Dorado, (2013). Self-Care for Educators: Coping with Stress in School. UCSF Healthy Environment and Response to Trauma in Schools (HEARTS), Child and Adolescent Services, Dept. of Psychiatry, University of California, San Francisco. 2) Greater Good Science Center (2013). University of California Berkeley. http://greatergood.berkeley.edu/topic/happiness/definition#how_to_cultivate

RECOGNIZING AND RESPONDING TO TRAUMA TRIGGERS

Trauma triggers are reminders of past traumatic events. Past traumatic events may include:

- Physical, sexual, or emotional abuse
- Injuries or accidents
- Interpersonal, school, or community violence
- Natural disasters, war, or terrorism

Trauma triggers may include:

- Different types of physical contact
- Different sounds, smells, or places
- Dissagreements, conflicts, or certain topics of conversation
- Unpredictable situations or sudden changes

When triggered, you may react to "there and then" past traumatic events instead of "here and now" reality. Trauma triggers may cause you to:

- Yell or fight
- Get nervous, angry, or frustrated
- Shut down, get quiet, and want to be alone
- Drink, smoke, or eat to feel better

TIPS FOR RECOGNIZING TRAUMA TRIGGERS:

1. Notice your current mood, state of mind, and environment
2. Notice certain situations and places that remind you of past traumatic events
3. Notice when, where, and how you react to reminders of past traumatic events

TIPS FOR RESPONDING TO TRAUMA TRIGGERS:

Get Emotional: Talk to a trusted friend or caring adult about traumatic events, triggers, and reactions

Get Mindful: Stop what you are doing, pay attention to what's happening in your body, and breathe deeply

Get Physcial: Move your body- stretch, walk, run, or dance on a regular basis

Get Creative: Try writing in a journal, drawing, painting, freestyling, or singing

Get Spiritual: Meditate, go out in nature, or go to a religious place of worship

Get Community: Volunteer/participate in community projects such as murals, gardens, or mentoring

EXAMPLE: You smell cologne that reminds you of a time when you were raped. You are immediately triggered. You feel scared and begin to feel anxious.

RESPONSE 1: (You do NOT recognize your triggers). You decide to shake it off, call your friends, and get some drinks or go smoke to suppress your feelings. You hope the trigger never happens again. When you get home, you are left alone to deal with your fears and anxieties.

RESPONSE 2: (You do recognize your triggers). You are aware of your fears and anxieties and understand you have been triggered. You have already decided that when you are triggered you will stop, breathe deeply, and call your cousin to briefly talk about what happened. After expressing your emotions, you feel like it is an issue of the past and are able to continue with your day.

MINDFULNESS SKILLS

MINDFULNESS IS:

- Paying attention, here and now, with kindness and curiosity. (16)
- A mental state, characterized by focused awareness of one's thoughts, actions or motivations.
- A component of many therapeutic treatments for trauma.

BUILDING MINDFULNESS SKILLS CAN HELP YOUTH AND ADULTS:

1. Become more aware of negative judgments and thoughts.
2. Build more positive decision-making skills.
3. Become more focused on the moment.
4. Be less reactive to their environments.
5. Be utilized in group meetings or individual sessions with youth, or among adult providers.

MINDFULNESS "WHAT" SKILLS

Observe

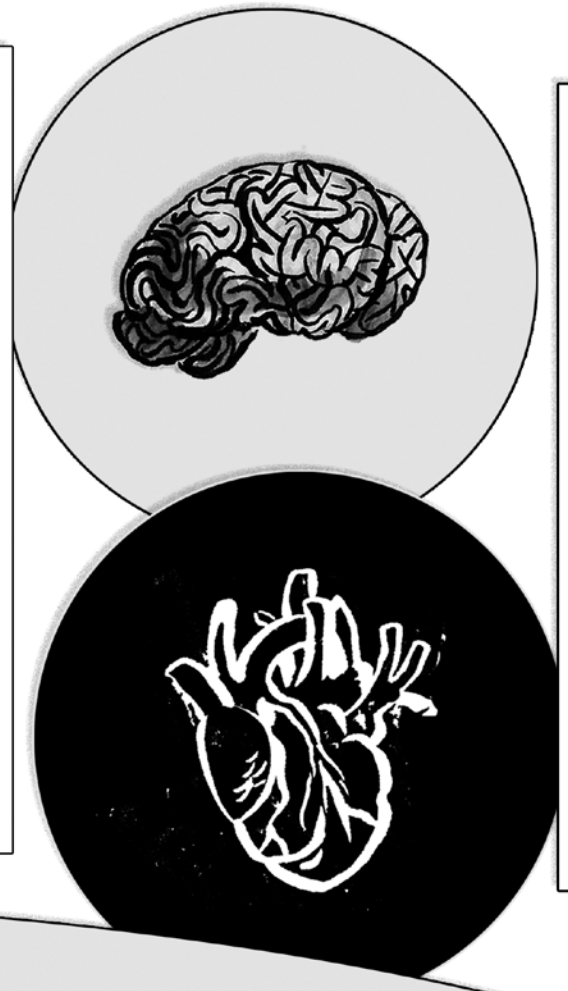
- Just notice: Use your 5 senses- sight, sound, taste, touch, smell
- Watch your thoughts and feelings come and go: Don't push them away or hold onto them

Describe

- Put words on the experience: "my stomach muscles are tightening"
- Name your feelings: "I'm so mad I could scream"
- Label your thoughts as thoughts, not facts: "Thinking you're dumb doesn't mean that you are dumb"
- Name thoughts, feelings, and sensations separately

Participate

- Become one with your experience
- Dive into what you do and get really into it without being self-conscious or fearful
- Practice, practice, practice, like learning how to ride a bike



MINDFULNESS "HOW" SKILLS

Don't judge

- See without evaluating
- Acknowledge without judgment
- Don't judge your judging

Stay focused

- Do ONE thing at a time
- Let go of distractions
- Dive into the current moment, the here and now
- Concentrate your mind

Do what works

- Focus on what's going to help
- Do what you need to do to achieve your goals
- Play by the rules
- Act as skillfully as you can
- Let go of feelings that hurt you and others

Source: SPARCS: Structured Psychotherapy for Adolescents Responding to Chronic Stress- Group Trauma Treatment Curriculum (V16).(16-18)

SLOW DOWN, ORIENT, AND SELF-CHECK (SOS): A TOOL FOR YOUTH/YOUNG ADULTS (19)

What is the situation? What is going on? _____

Practice steps 1, 2, & 3. Circle ratings for step 3.

STEP 1: SLOW DOWN

- Pause, take a time out, calm your body, relax.
- Take a deep breath- feel the air, listen to the sounds around you, notice your heartbeat.
- One thought at a time.

STEP 2: ORIENT YOURSELF

- Bring your mind and body back to the present time and place.
- Look around and notice where you are, who you're with, and what you're doing.
- Feel yourself (feet on the ground, sitting in a chair).

STEP 3: SELF CHECK

PERSONAL DISTRESS

Right Now I Feel...

Completely Calm	1	2	3	4	5	6	7	8	9	10	Most Distressed Ever

PERSONAL CONTROL

Right Now I Feel...

Completely in Control	1	2	3	4	5	6	7	8	9	10	Totally Out of Control

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CARE

SPECTRUM OF TRAUMA-INFORMED CARE: TERMINOLOGY

TRAUMA-SPECIFIC INTERVENTIONS (1)

- Practices developed to address trauma experienced by individuals, families, and communities.
- Shown to work with specific age groups, settings, and types of trauma.
- Most often used by practitioners trained in the specific intervention.

TRAUMA-SPECIFIC SERVICES (2)

- Programs that address trauma with a continuum of interventions from screening to treatment to recovery supports.
- Recognize that recovery occurs within a context of relationships.
- Characterized by belief in persuasion and trust rather than coercion, ideas rather than force, and mutuality rather than control.

TRAUMA-INFORMED CARE/APPROACHES (3)

- A program, organization, or system that realizes the widespread impact of trauma and understands potential paths for healing.
- Recognizes signs and symptoms of trauma in providers, clients, and others involved with the system.
- Responds by fully integrating knowledge about trauma into policies, procedures, practices, and settings.
- **Trauma-informed approaches ask: "What happened to you?" NOT "What's wrong with you?"**

THREE R'S OF TRAUMA-INFORMED APPROACHES TO CARE

WHAT IS A TRAUMA-INFORMED APPROACH? (2,3)

- How a program, agency, organization or community thinks about and responds to those who have experienced or may be at risk for experiencing trauma- includes a change in organizational culture.
- All components of the organization incorporate a deep understanding of the prevalence and impact of trauma, the role that trauma plays, and the complex and varied paths in which people recover and heal.
- Designed to avoid re-traumatizing those who seek assistance, to focus on safety first, commitment to do no harm, and facilitates participation and meaningful involvement of consumers, families, and trauma survivors in the planning of services and programs.
- Requires closely knit collaborative relationships with other public sector service systems.

THREE KEY ELEMENTS

1. *Realizing* the prevalence of trauma.
2. *Recognizing* how trauma affects all individuals involved with programs, organizations, or systems, including the workforce.
3. *Responding* by putting knowledge into practice.

REALIZING

- All people at all levels of an organization or system have a basic realization about trauma and understand how trauma affects individuals, groups, organizations, and communities.
- There is an understanding that trauma plays a role in mental and substance use disorders and should be systematically addressed in treatment and recovery settings.
- There is a realization that trauma is not confined to the behavioral health service sector- trauma is integral to all other systems including child welfare, criminal justice, primary health care, and education, and is often a barrier to effective outcomes across systems of care.

RECOGNIZING

- People in the organization or system are able to recognize the signs of trauma.
- Signs may be gender, age, or setting-specific and may be experienced by those seeking service and those providing services.
- The organization assumes that everyone is at risk of experiencing a traumatic event at some point in life and might benefit from a trauma-informed approach, including trauma screening and assessment.

RESPONDING

- Programs, organizations, or systems respond by applying the principles of a trauma -informed approach to all areas of functioning.
- People in every part of the organization, from the front desk to the executive, have changed their language, behaviors and policies to take into consideration the experiences of trauma among children and adult users of services and among service providers.
- Organizations have a meaningful definition of trauma; have a culture based on beliefs about resilience, recovery and healing; and accept key values and principles that guide the way the organization is designed, operated, and provides services to meet the unique needs of those impacted by trauma.

Source: National Association of State Mental Health Program Directors (2012, September). Changing Communities, Changing Lives. Report prepared for the Substance Abuse and Mental Health Services Administration's National Center for Trauma-Informed Care. Alexandria, VA: (Joan Gillece, Project Director; Andrea Blanch, Author).

KEY PRINCIPLES OF TRAUMA-INFORMED APPROACHES TO CARE

A trauma-informed approach reflects the adoption of underlying values or principles rather than a specific set of procedures. These values or principles are generalizable across all settings, although language and application may be setting or sector-specific.

1. ***SAFETY:*** Throughout the organization, providers and people served feel physically and psychologically safe; including physical settings and interpersonal interactions.

2. ***TRUSTWORTHINESS AND TRANSPARENCY:*** Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among providers, clients, and family members of those served.

3. ***COLLABORATION AND MUTUALITY:*** There is true partnering and leveling of power differences between providers and clients and among organizational staff from direct care to administrators; there is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making.

4. ***EMPOWERMENT:*** Throughout the organization and among clients served, individuals' strengths are recognized and validated and new skills are developed as necessary.

5. ***VOICE AND CHOICE:*** The organization aims to strengthen client and family members' experience of choice, and recognizes that every person's experience is unique and requires an individualized approach.

6. ***PEER SUPPORT AND MUTUAL SELF-HELP:*** Are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.

7. ***RESILIENCE AND STRENGTHS BASED:*** A belief in resilience and the ability of individuals, organizations, and communities to heal and promote recovery from trauma; builds on what clients, providers, and communities have to offer rather than responding to their perceived deficits.

8. ***INCLUSIVENESS AND SHARED PURPOSE:*** The organization recognizes that everyone has a role to play in a trauma-informed approach; one does not have to be a therapist to be therapeutic.

9. ***CULTURAL, HISTORICAL, AND GENDER ISSUES:*** Are addressed; the organization actively moves past cultural stereotypes and biases, offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.

10. ***CHANGE PROCESS:*** Is conscious, intentional and ongoing; the organization strives to become a learning community, constantly responding to new knowledge and developments.

Source: Substance Abuse and Mental Health Services Administration (SAMHSA). 2012. Trauma Definition Working Draft. http://www.samhsa.gov/traumajustice/traumadefinition/index.aspx

GUIDELINES FOR IMPLEMENTATION OF TRAUMA-INFORMED APPROACHES TO CARE

Guidelines can provide a roadmap to help individuals and agencies get started in the process of implementing a trauma-informed approach. In a trauma-informed approach, change permeates all levels of an organization or system, and all aspects of organizational culture are in alignment. While different organizations have varying responsibilities and influence, the following organizational domains are identified as potentially relevant across a variety of settings.

1. ***GOVERNANCE AND LEADERSHIP:*** Leadership and governance bodies support and invest in implementing and sustaining a trauma-informed approach. There is an identified point of responsibility within the organization to lead and oversee this work.

2. ***POLICY:*** There is a written policy establishing a trauma-informed approach as an important part of the organizational mission.

3. ***INVOLVEMENT OF TRAUMA SURVIVORS, CONSUMERS, AND FAMILY MEMBERS:*** These groups have significant involvement, voice, and meaningful choice at all levels and in all areas of organizational functioning, (e.g., program design, implementation, service delivery, quality assurance, access to peer support, workforce development, and evaluation).

4. ***CROSS SECTOR COLLABORATION:*** There is collaboration between adult and children/youth services, prevention and treatment, health and human service sectors, education, legal, child welfare, and criminal justice sectors and systems.

5. ***ORGANIZATIONAL PROTOCOLS:*** Organizational procedures reflect trauma-informed principles, including collaborations with other agencies.

6. ***INTERVENTIONS:*** All interventions, including screening and assessment, are based on the best available empirical evidence, are culturally appropriate, and reflect principles of a trauma-informed approach. A trusted and effective referral system is in place, and trauma-specific interventions are acceptable, effective, and available for individuals, youth, and families seeking services.

7. ***TRAINING AND WORKFORCE DEVELOPMENT:*** Training on trauma and how to respond is available for all staff. A human resource system incorporates trauma-informed principles in hiring, supervision, and staff evaluation. Procedures are in place to support staff with trauma histories.

8. ***CONSULTATION AND SUPERVISION:*** All levels of staff receive regular and ongoing consultation and supervision around issues of trauma, vicarious trauma, and burnout faced in the work place, including interactions between staff and clients, and among staff themselves.

9. ***PHYSICAL ENVIRONMENT:*** Investments are made to ensure the physical environment promotes a sense of safety for clients and staff.

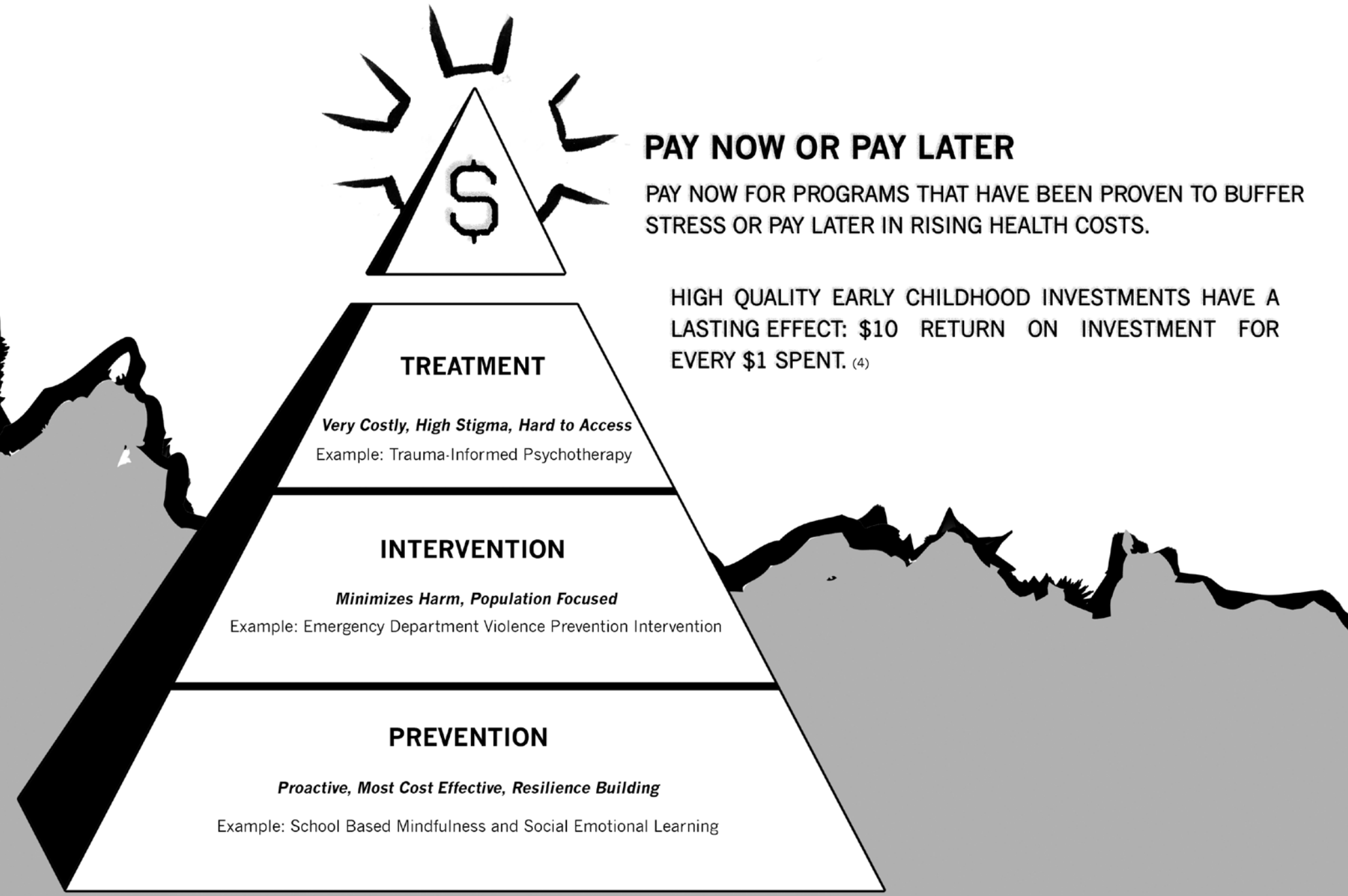
10. ***QUALITY ASSURANCE:*** There is ongoing assessment, tracking, and monitoring of trauma-informed principles.

11. ***FINANCING:*** Financial structures are designed to support a trauma-informed approach including initial staff training, ongoing consultation, supervision, and support for all staff, appropriate facilities, and evidence based trauma-specific services.

12. ***EVALUATION:*** Measures used to evaluate service or program effectiveness reflect an understanding of trauma.

Source: Substance Abuse and Mental Health Services Administration (SAMHSA). 2012. Trauma Definition Working Draft. http://www.samhsa.gov/traumajustice/traumadefinition/index.aspx

TRAUMA-INFORMED PREVENTION, INTERVENTION, AND TREATMENT PYRAMID



PAY NOW OR PAY LATER

PAY NOW FOR PROGRAMS THAT HAVE BEEN PROVEN TO BUFFER STRESS OR PAY LATER IN RISING HEALTH COSTS.

HIGH QUALITY EARLY CHILDHOOD INVESTMENTS HAVE A LASTING EFFECT: $10 RETURN ON INVESTMENT FOR EVERY $1 SPENT. (4)

CULTURALLY SENSITIVE APPROACHES TO TRAUMA

APPROACHES THAT ARE NOT TRAUMA-INFORMED ASK: "WHAT'S WRONG WITH YOU."	TRAUMA-INFORMED APPROACHES ASK: "WHAT HAPPENED TO YOU."
WHAT "HELP" LOOKS LIKE (NOT TRAUMA-INFORMED)	**WHAT "HELP" LOOKS LIKE (TRAUMA-INFORMED)**
• The "helper" decides what "help" looks like.	→ • A sense of trust and safety is mutually defined, created, and sustained in all relationships.
• Focused on "needs" as defined by helper.	→ • Collaboration and shared decision-making exists.
• Relationships are based solely on problem-solving and resource coordination, not creating meaningful connections.	→ • Crisis becomes opportunity for growth and connection.
• Safety is defined only as risk management.	→ • Authentic relationships are emphasized in a context of wellness.
• Common experience is assumed and defined by setting: i.e. in clinical setting experience is based only on "illness" and coping with "illness."	→ • It is recognized that people rarely have the same experience or make the same meaning out of similar events.

COMMON CULTURAL MISTAKES ABOUT TRAUMA	MORE CULTURALLY SENSITIVE APPROACHES TO TRAUMA (5)
• Assuming everyone who has experienced violence needs professional help.	→ • Assuming people are resilient and giving them many opportunities to tell you if they need help.
• Focusing on the most extreme instances of violence as the most damaging.	→ • Allowing individuals to define what aspects of their experiences have been most traumatic and recognizing that this may change over time.
• Assuming that violence is unusual, an aberration, and generally perpetrated by individuals.	→ • Recognizing that violence is perpetrated by groups and institutions, not only individuals, and may be so common that people become desensitized to it.
• Relying only on DSM diagnoses or lists of trauma "symptoms."	→ • Recognizing that political and social oppression may affect priorities and values; allowing individuals to define the meaning of their experiences.
• Applying norms and standards of behavior without considering political and social context.	→ • Recognizing that trauma responses are varied and that different cultures express grief and loss and understand trauma differently; learning how different people and cultures expresses distress.
• Assuming that one person's story represents the "typical" story for a group of people.	→ • Recognizing that one person's story is just one person's story.
• Inadvertently highlighting the stories of people that fit cultural stereotypes.	→ • Providing opportunities for many people to share their stories, noticing what is unique, and making sure many points of view are represented.
• Assuming that if people speak English, you don't have to worry about an interpreter or translated documents.	→ • Recognizing that some topics are very difficult to talk about in anything other than your first language; knowing and acting within the law about provision of language assistance services.
• Assuming that people always (or never) want to tell their stories and that if people want help they will ask for it.	→ • Being aware that self-disclosure and help-seeking vary widely across cultures and may be dependent upon whether an individual feels safe; learning different cultural norms and expectations.

Source: Engaging Women in Trauma-Informed Peer Support: A Guidebook. Blanch, A., Filson, B., and Penny, D., 2012. http://www.nasmhpd.org/publications/engagingWomen.aspx

RESTORATIVE PRACTICES FOR TRAUMA-INFORMED CARE

RESTORATIVE PRACTICES

Foundation: People are happier, more cooperative and productive, and more likely to make positive changes when those in positions of authority do things with them, rather than to them or for them.
Includes: "Restorative justice" (criminal justice), "empowerment" (social work), "trauma-informed consequences," (behavioral health), "positive discipline" (education), and "horizontal management" (organizational leadership).
Examples: In schools, the use of restorative practices has demonstrated reliable reduction of misbehavior, bullying, violence and crime among students and improvements in overall learning climates.(6)In juvenile justice, the use of restorative practices has demonstrated significant reductions in offending rates and improvements in youth attitudes.(6)

PUNISHMENT VS. CONSEQUENCES

Punishment: Used by specific authorities to enforce obedience. Usually used to assert power and control and often leaves youth feeling helpless, powerless, and shamed.
Consequences: Intentionally designed to teach, change, or shape behavior. Logical consequences are clearly connected to behavior, given with empathy and a respectful tone, and are reasonable to the behavior.

CONSISTENCY AND INDIVIDUALIZED RESPONSES

Consistency: Rules and consequences apply to everyone, understanding that predictability and routines can help a youth feel safe.
Individualized Responses: Consequences are consistent with youth's needs and level of functioning, while also holding youth accountable for their actions. Some youth are more highly impacted by past traumatic experiences and may need tailored consequences.

ADOLESCENT DEVELOPMENT AND TRAUMA-INFORMED CONSEQUENCES

- The adolescent brain is acutely sensitive to positive reward and relatively insensitive to negative consequences.(7)
- Disrupting service delivery or learning (i.e. exiting youth from a program/site or restricting participation) may lead to more negative outcomes than positive.
- Some youth will repeatedly test limits and challenge providers with their behaviors until they build trust and feel connected.
- If providers have to ask youth to leave or restrict access due to safety concerns, maintaining contact with the youth can "open the door" to important learning opportunities and engagement.

CHARACTERISTICS OF TRAUMA INFORMED CONSEQUENCES

- Take into account trauma triggers and past traumatic experiences.
- Attempt to retain youth in services/learning, in spite of problematic behavior.
- Consider the function of problematic behavior and help youth develop more effective strategies for getting needs met.
- Shape youth's behavior by assisting them to recognize the impact of their actions on themselves and their community.
- Build youth's capacity to manage strong emotions and increase confidence in what they are able to accomplish.
- Invest great energy, creativity, and resources upfront in order to support long-term success in helping youth succeed.
- Take the long view and understand that behavior change is slow and incremental.

CHALLENGES OF IMPLEMENTING TRAUMA-INFORMED CONSEQUENCES

- May require a paradigm shift in the way providers understand and respond to challenging, negative, and disruptive behavior.
- Providers must balance what is best for individual youth with needs of other youth and the agency as a whole.
- Best implemented in a calm and thoughtful manner, with time for planning and processing between youth and providers, and among providers and administrators.
- Provider safety and wellness must be attended to in order for providers to feel well equipped to be attuned and responsive to youth.
- Providers must receive adequate supervision and ongoing support for learning and implementing trauma-informed consequences.

Sources: 1) Wachtel, T. (2012). Defining Restorative. International Institute for Restorative Practices. www.iirp.edu. 2) Schneir, A., Ballin, D., Carmichael, H., Stefanidis, N., Phillips, L., Hendrickson, C., and de Gyarfas, L. 2009. The Community Trauma Treatment Center for Runaway and Homeless Youth. An Initiative of the Hollywood Homeless Youth Partnership. SAMHSA Grant # SM57247. http://hhyp.org/download-material-2/

TRAUMA-INFORMED CONSEQUENCES IN PRACTICE (PAGE 1 OF 3)

Well-intentioned providers assisting youth with trauma histories and behavioral challenges may unknowingly mirror aspects of traumatic relationships:

Characteristics of Traumatic Relationships

- Betrayal occurs at the hands of a trusted caregiver or supporter.
- Hierarchical boundaries are violated and then re-imposed at the whim of the abuser.
- Secret knowledge, secret information, and secret relationships are encouraged and maintained.
- The voice of the victim is unheard, denied, or invalidated.
- The victim feels powerless to alter or leave the relationship.
- Reality is reconstructed to represent the values and beliefs of the abuser.
- Events are reinterpreted and renamed to protect the guilty.

How Helping Relationships Can Re-traumatize Youth

- Youth feel betrayed by the organization, program, or provider.
- Youth-provider relationships are inconsistent, unclear, or confusing.
- Provider-agency relationships allow for and maintain secrets.
- Youth feel there is no opportunity to be heard, and their perspectives are not taken into account.
- Youth feel powerless to alter or leave the relationship or agency.
- Reality is reconstructed to match the needs and values of the provider or agency, not the youth.

As providers respond to challenging behaviors with trauma-informed consequences, it may be useful to explore the following questions and answers:

1. What is the purpose of enforcing rules? Is it to discipline/teach youth how to manage emotions, or to enforce the rules for the "rule's sake?"
2. Is a youth intentionally pushing my buttons? Why would the youth want this type of attention from me? Does the youth prefer negative attention to no attention at all?
3. How much of my response is because I feel personally hurt, offended, disrespected, helpless and frightened, or need to prove that I am in control?
4. What assumptions am I making about this youth's behavior? Could there be another explanation?
5. What options do I have to respond to this behavior? How does the youth expect me to respond?
6. Which option most closely fits my intent to maintain safety while building the youth's capacity to manage intense emotions and learn more effective behavior? Which option is least disruptive to service/learning delivery?

Why does it seem like some youth are asking to be discharged from services by repeatedly breaking the rules even when they know the consequences?

Many youth bring multiple experiences of rejection and abandonment by family and other caregivers. Due to past experiences, there is an expectation that providers will also reject them and, in turn, abandon them. In order to protect themselves, consciously or not, many youth act out to speed up the rejection that they are convinced is coming anyway.

If we don't exit/punish youth when they break the rules, aren't we enabling them?
No. When a youth that is highly impacted by past trauma is exited, what is the lesson? Although providers may believe youth are learning they can't write on walls or disrespect providers, mostly providers are just confirming a youth's belief that they are unlovable and undeserving of attention and support. It is not suggested that agencies and providers ignore inappropriate behavior. Instead, it is recommended that providers work with youth to identify problematic behavior, put it in the context of trauma, and help youth find different ways to express anger, frustration, or sadness. The goal is for youth to know that providers can see far beyond the problem behavior, and see the youth's capabilities and potential to succeed.

Source: Stefanidis, N., Schneir, A., Ballin, D., Carmichael, H., Gore, P., de Gyarfas, L., Hendrickson, C., Hubbard, E., McGaffey, J., Phillips, L., Rodriguez, M., and Schwartz, J. (2010). Trauma-Informed Consequences for Homeless Youth. The Community Trauma Treatment Center for Runaway and Homeless Youth. SAMHSA Grant #SM57247. ©Hollywood Homeless Youth Partnership. http://hhyp.org/download-material-2/

TRAUMA-INFORMED CONSEQUENCES IN PRACTICE (PAGE 2 OF 3)

INCIDENT # 1: Youth is verbally aggressive towards a provider.

Punishment

Provider Interpretation: Youth is being disrespectful. Youth doesn't appreciate the services/learning offered. A firm example needs to be set condoning this type of verbal abuse.

Reaction: Provider threatens to exit youth if behavior continues.

Trauma-Informed Consequences

Provider Reflection and Interpretation: What is going on in the environment that is setting the youth off? Youth needs to know it's inappropriate to verbally abuse providers and at the same time get help to develop more constructive self-regulation skills.

Response: Youth is asked to cool off in a safe place. Provider processes the experience with the youth when appropriate (i.e. after the youth is no longer visibly agitated). Provider shares with youth their observation regarding the interaction and asks for feedback. Provider and youth explore alternative/pro-social ways of communicating feelings.

INCIDENT # 2: Youth comes to agency/site but doesn't do anything, just sits and dozes.

Punishment

Provider Interpretation: The youth is lazy, is taking advantage of services/learning, and should be doing something productive. Providers help youth, not just let them sit around and do nothing.

Reaction: Providers don't invest time in the youth.

Trauma-Informed Consequences

Provider Reflection and Interpretation: The youth is very tired. Services/learning were made available to the youth. What could be interfering with the youth's ability to participate/focus? Lots of youth are worried about failing so they don't even want to try. How can the youth be engaged?

Response: Provider approaches the youth and asks if anything is needed. Provider tries to engage youth in pro-social activity (i.e. game, group) to try and engage further. Even if the youth is generally unresponsive, the provider gently continues to try and engage periodically and spends as much time with the youth as tolerated by the youth.

INCIDENT # 3: Youth has a crush on a provider and follows them around.

Punishment

Provider Interpretation: This is very awkward. I don't want to hurt the youth's feelings but I don't want to give them the wrong idea. It is probably better if the youth works with someone else.

Reaction: Youth is given a new provider.

Trauma-Informed Consequences

Provider Reflection and Interpretation: This young person is trying to connect with me. I might be one of few people who sincerely tried to help this youth. This is very awkward but with some supervision and support, I think I can help.

Response: Provider gets supervision and support in talking to the youth about the crush and working to reinforce appropriate boundaries and expectations.

Source: Stefanidis, N., Schneir, A., Ballin, D., Carmichael, H., Gore, P., de Gyarfas, L., Hendrickson, C., Hubbard, E., McGaffey, J., Phillips, L., Rodriguez, M., and Schwartz, J. (2010). Trauma-Informed Consequences for Homeless Youth. The Community Trauma Treatment Center for Runaway and Homeless Youth. SAMHSA Grant #SM57247. ©Hollywood Homeless Youth Partnership. http://hhyp.org/download-material-2/

TRAUMA-INFORMED CONSEQUENCES IN PRACTICE (PAGE 3 OF 3)

INCIDENT # 4: Youth acts out and storms out of a group/class.

Punishment

Staff Interpretation: This young person is disrespecting the group and disrespecting me. I can't create a cohesive group when the youth feels free to leave at will. It's not fair to the other youth participants/learners.

Reaction: Youth receives a warning to be exited from the group/class if it happens again.

Trauma-Informed Consequences

Provider Reflection and Interpretation: Did something in the group/class trigger the youth or bring up uncomfortable feelings or memories? What else could I do to help the youth feel safe?

Response: Provider checks in to find out if the youth is ready to rejoin the group/class. If not, the provider talks to the youth after the group/class to find out what happened. The provider lets the youth know where they can go during a group/class, when feeling upset or anxious, to sit quietly or talk with a trusted adult (i.e. safe space- counselor, wellness center, etc). The provider invites the youth to rejoin the group/class when ready.

INCIDENT # 5: Youth enters agency/site clearly drunk or high.

Punishment

Provider Interpretation: The youth knows they are not allowed to come to the agency/site under the influence. This is totally disruptive to other youth and providers. Youth needs to learn that this is just not allowed.

Reaction: Youth is exited and referred to detox/rehab.

Trauma-Informed Consequences

Provider Reflection and Interpretation: This is disruptive to other youth and providers. However, if I send the youth back outside, they will be vulnerable to being victimized or offending. We need to find a safe place for the youth to sober up. Youth needs further assessment regarding substance use.

Response: Youth is asked to move to secure place within agency/site to sober up and be safe. When youth is more coherent, a provider discusses the circumstances of youth's drug/alcohol use. The youth is reminded about the provider's concern for the youth's safety and the agency/site policies about using. The youth is encouraged to speak to a substance abuse counselor.

Source: Stefanidis, N., Schneir, A., Ballin, D., Carmichael, H., Gore, P., de Gyarfas, L., Hendrickson, C., Hubbard, E., McGaffey, J., Phillips, L., Rodriguez, M., and Schwartz, J. (2010). Trauma-Informed Consequences for Homeless Youth. The Community Trauma Treatment Center for Runaway and Homeless Youth. SAMHSA Grant #SM57247. ©Hollywood Homeless Youth Partnership. http://hhyp.org/download-material-2/

TRANSFORMING TRAUMA THROUGH SOCIAL ACTION

SOCIAL ACTION: A TOOL FOR HEALING FROM TRAUMA

- Trauma often leaves survivors feeling voiceless, hopeless, and powerless.
- Taking social action, individually or as part of a group, can be a positive act of healing for trauma survivors, especially those in positions of lesser cultural power, including youth, women, and people of color, and can help to reclaim power in the world.
- Social action includes working to change harmful policies and practices and overcome injustice.
- Social action requires many different skills, which provides opportunities for all group members to utilize their strengths and make significant contributions.
- The process of healing from trauma often includes: 1) An increased sense of awareness and rage about the traumatic events experienced; and 2) Outrage at the sight of others harmed or treated unjustly.
- If anger and rage is left unexamined and unchecked, it can be hurtful to the self and others.
- If anger and rage is recognized and transformed to help the self and others, it can be a powerful force for positive healing and social change.

A GOOD PLACE TO START

In order to break down a social issue and create a strong position on which to enact change, individuals and groups can start by answering the following questions:

- What is it we want to change?
- What outcomes or solutions will satisfy us?
- What are we willing/not willing to trade, compromise, or let go of?
- What information already exists on the issue and what struggles are currently being fought for the issue?
- Is a rule, policy, or law being violated?
- What additional information/resources are needed and how will the group get them?
- Who has the power to change the situation/fix the problem, and how can the group engage them in the struggle?
- What are possible barriers and solutions to reaching an outcome that facilitates healing and social change for those involved?
- When there is conflict, is there a point of shared interest on which there is some agreement?

NEXT STEPS

- Develop a clear and concise understanding of the problem and desired solution to the problem in about five spoken sentences and no more than one written page; this is the position statement.
- When presenting the position statement, focus on facts not feelings for greatest impact on the decision-maker.
- Decide who to approach and how to approach them.
- Try starting with the lowest pressure technique and apply only as much as necessary to succeed.
- The activities below are arranged in order of increasing pressure, from lowest to highest:
    - o Meet with management or policy makers.
    - o Meet with the responsible government officials.
    - o Develop letter-writing, fax, phone, e-mail, and social network campaigns.
    - o Develop and distribute position papers and fact sheets throughout the community.
    - o Join relevant committees and task forces.
    - o Testify at public hearings.
    - o Launch media campaigns.
    - o Organize rallies and demonstrations.
    - o File lawsuits.

ADDITIONAL RECOMMENDED ACTIVITIES

- Create healing circles and opportunities to connect and bond in peer groups and across multiple generations.
- Organize candle light vigils to honor those lost/injured and to mourn as a community.
- Design public murals and artwork that represents community strength and power.

Source: Engaging Women in Trauma-Informed Peer Support: A Guidebook. Blanch, A., Filson, B., and Penny, D. (2012). http://www.nasmhpd.org/publications/engagingWomen.aspx

MANY MEDICINES:

TRUAMA-INFORMED EVIDENCE-BASED BEST PRACTICES AND PROMISING APPROACHES (PAGE 1 OF 6)

For extended and updated listings of programs nationwide, please visit:
National Child Traumatic Stress Network (NCTSN): http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices
Substance Abuse Mental Health Services Administration (SAMHSA): http://www.nrepp.samhsa.gov/

EMERGENCY DEPARTMENT VIOLENCE PREVENTION INTERVENTION

Designed to: Reduce injury recidivism and criminal recidivism by working directly with survivors of violent injury and connecting at teachable moments in the hospital setting.

Components:

- May include intensive case management, crisis response, mental health services for youth/young adults and families, along with access to after school, vocational, life skills, and tattoo removal programs.

Resources:

1. National Network of Hospital Based Violence Intervention Programs
   www.nnhvip.org
2. Youth Alive
   www.youthalive.org/caught-in-the-crossfire
3. Wrap-Around Project
   www.violenceprevention.surgery.ucsf.edu

EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)

Designed to: 1) Overwrite original memory of the trauma with more adaptive beliefs, emotions, and somatic responses, and 2) Reduce trauma-related stress, anxiety, and depression symptoms.

Components:

- 1-3 or more 60-90 minute sessions depending on complexity of trauma.
- Target trauma triggers and related psychological distress are reviewed and processed with a focus on accessing positive images and beliefs.
- Repetitive 30-second dual-attention exercises, typically side-to-side eye movements guided by therapist's finger, are repeated until client reports no distress.

Resources:

EMDR Training Institute: http://www.emdr.com/index.php

PHARMACOTHERAPY

Designed to: Reduce specific post traumatic stress related symptoms including nightmares, difficulty sleeping, and anxiety.

Components:

- Medication treatment to be taken as prescribed by doctor.

Resources:

National Child Traumatic Stress Network
http://www.nctsnet.org/sites/default/files/assets/pdfs/effective_treatments_youth_trauma.pdf

TRAUMA FOCUSED COGNITIVE BEHAVIORAL THERAPY (TF-CBT)

Designed to: Reduce levels of post traumatic stress symptoms including anxiety, depression, and dissociation.

Components:

- 60-90 minute sessions once a week for 12-16 weeks, based on PRACTICE skills.
- P: Psycho-education about childhood trauma and PTSD for youth and parent/caregiver.
- P: Parenting management skills for parent/caregiver.
- R: Relaxation skills individualized to youth and parent/caregiver.
- A: Affective modulation skills adapted to the youth, family and culture.
- C: Cognitive coping: connecting thoughts, feelings, and behaviors related to trauma.
- T: Trauma narrative: assisting youth in sharing verbal, written, or artistic narrative about the trauma and related experiences, and cognitive and affective processing of the trauma experiences.
- I: In vivo exposure and mastery of trauma reminders if appropriate.
- C: Conjoint parent-youth sessions to practice skills and enhance trauma-related discussions.
- E: Enhancing future personal safety and enhancing optimal developmental trajectory through providing safety and social skills training as needed.

Resources:

Web Based Learning Course for TF-CBT
http://tfcbt.musc.edu

MANY MEDICINES:

TRUAMA-INFORMED EVIDENCE-BASED BEST PRACTICES AND PROMISING APPROACHES (PAGE 2 OF 6)

ATTACHMENT, SELF-REGULATION, AND COMPETENCY (ARC)

Designed to: : 1) Reduce posttraumatic stress symptoms, anxiety, and depression, 2) Increase adaptive and social skills among youth, and 3) Reduce distress among parents/caregivers, and 3) Parents/caregivers view their children's behaviors as less dysfunctional.

Components:

- Flexible framework, rather than a protocolized intervention for working with youth and families who have experienced multiple and/or prolonged traumatic stress.
- Identifies three core domains frequently impacted among traumatized youth, and relevant to future resiliency: attachment, self-regulation, and competency.
- Identifies ten building blocks of trauma-informed treatment and services within the core domains.
- Attachment: 1) caregiver affect management, 2) attunement, 3) consistent response, 4) routines and rituals.
- Self regulation: 5) affect identification, 6) affect modulation, 7) affect expression.
- Competency: 8) developmental tasks, 9) executive functioning, 10) self development.

Resources:

Trauma Center at Justice Resource Institute
http://www.traumacenter.org/research/ascot.php

STRUCTURED PSYCHOTHERAPY FOR ADOLESCENTS RESPONDING TO CHRONIC STRESS (SPARCS)

Designed to: Address the needs of chronically traumatized adolescents who may still be living with ongoing stress and experiencing problems in several areas of functioning.

Components:

- 16-session group intervention.
- Areas include: difficulties with affect regulation and impulsivity, self-perception, relationships, somatization, dissociation, numbing and avoidance, struggles with purpose, meaning, and worldviews.
- Group members learn and practice each of the core SPARCS skills including: mindfulness practice, relationship building/communication skills, distress tolerance, problem-solving, and meaning making.
- Treatment also includes psychoeducation regarding stress, trauma, and triggers.

Resources:

Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
http://sparcstraining.com/

INTEGRATIVE TREATMENT OF COMPLEX TRAUMA

Designed to: 1) Decrease depression, anxiety, anger, posttraumatic stress, dissociation, internalizing symptoms, externalizing symptoms, and sexual concerns, 2) Increase affect regulation capacities, enhanced self-esteem, and a greater sense of self-efficacy.

Components:

- 16-36 sessions.
- Interventions are adapted to youth's specific symptoms, culture, and age, and include relationship-building, psychoeducation, affect regulation training, trigger identification, cognitive processing, titrated emotional processing, mindfulness training, collateral treatments with parents and families, group therapy, and system-level advocacy.
- Specific approaches for complex trauma treatment include aspects of the Self Trauma model (Briere, 2002; Briere & Scott, 2006), Trauma Focused Cognitive Behavioral Therapy (Cohen et al., 2004), and traumatic grief therapy (Saltzman et al., 2003).

Resources:

Integrative Treatment of Complex Trauma for Adolescents (ITCT-A): A Guide for the Treatment of Multiply-Traumatized Youth
www.johnbriere.com

TRAUMA AFFECT REGULATION: GUIDE FOR EDUCATION AND THERAPY (TARGET)

Designed to: Prevent and reduce PTSD symptoms, including rage, traumatic grief, survivor guilt, shame, interpersonal rejection, and existential/spiritual alienation.

Components:

- 10 sessions, based on FREEDOM skills.
- F: Self-regulation via Focusing (SOS: Slow down, Orient, Self-Check)
- R: Processing current traumatic stress reactions via Recognizing current triggers
- EE: Emotions, and cognitive Evaluations
- D: Strength-based reintegration by Defining core goals
- O: Identifying currently effective responses (Options)
- M: Affirming core values by Making positive contributions

Resources:

Trauma Affect Regulation: Guide for Education and Therapy
http://www.ptsdfreedom.org/index.html
Advanced Trauma Solutions
http://www.advancedtrauma.com/index.html

MANY MEDICINES:

TRUAMA-INFORMED EVIDENCE-BASED BEST PRACTICES AND PROMISING APPROACHES (PAGE 3 OF 6)

SEEKING SAFETY

Designed to: Reduce substance abuse and post traumatic stress symptoms.

Components:

- Safety: Helping clients attain safety in their relationships, thinking, behavior, and emotions.
- Integrated treatment: Working on both PTSD and substance abuse at the same time.
- A focus on ideals to counteract the loss of ideals in both PTSD and substance abuse.
- Four content areas: cognitive, behavioral, interpersonal, case management.
- Attention to clinician processes: Helping clinicians work on countertransference, self-care, and other issues.

Resources:

Seeking Safety: A Model for Trauma and/or Substance Abuse

www.seekingsafety.org

COGNITIVE BEHAVIORAL INTERVENTION FOR TRAUMA IN SCHOOLS (CBITS)

Designed to: 1) Reduce symptoms of post-traumatic stress, depression, and behavioral problems, 2) Improve functioning, grades, attendance, peer and parent support, and coping skills.

Components:

- Includes 10 group sessions; 1-3 individual sessions; 2 parent psychoeducational sessions; 1 teacher educational session
- Cognitive-behavioral techniques include psychoeducation, relaxation, social problem solving, cognitive restructuring/how to challenge upsetting thoughts, and exposure/processing traumatic memories.

Resources:

Cognitive Behavioral Intervention for Trauma in Schools

http://cbitsprogram.org

SOMATIC EXPERIENCING (SE)

Designed to: 1) Complete the initiated survival responses unable to be completed at initial time of trauma, and discharge the neurological memory stored in the peripheral nervous system, 2) Restore self-regulation, resilience, equilibrium, and a sense of wholeness.

Components:

- Nine Step Method for Transforming Trauma including:
  1. Create an environment of relative safety.
  2. Support initial exploration of touch sensations including pendulation and titration.
  3. Pendulation: rhythm of contraction and extraction.
  4. Titration: survival based arousal.
  5. Provide corrective experiences.
  6. Uncouple fear from immobility; contain sensation of hyper-arousal.
  7. Discharge and regulate hyper-arousal states.
  8. Engage in self-regulation to restore dynamic equilibrium and relaxed alertness.
  9. Reorient in the here and now.

Resources:

Somatic Experiencing Trauma Institute

http://www.traumahealing.com/somatic-experiencing/index.html

NEUROSEQUENTIAL MODEL OF THERAPEUTICS

Designed to: Structure assessment of child/youth, articulate primary problems, identify key strengths, and apply interventions (educational, enrichment, and therapeutic) to help family, educators, therapists and related professionals best meet the needs of the child.

Components:

- The NMT process helps match the nature and timing of specific therapeutic techniques to the developmental stage of the child/youth, and to the brain region and neural networks that are likely mediating the neuropsychiatric problems.

Resources:

Child Trauma Academy

http://childtrauma.org/index.php/articles/cta-neurosequential-model

MANY MEDICINES:

TRUAMA-INFORMED EVIDENCE-BASED BEST PRACTICES AND PROMISING APPROACHES (PAGE 4 OF 6)

MINDFULNESS

Designed to: 1) Strengthen concentration and increase capacity to focus, 2)

Decrease stress & anxiety and increase sense of calm, 3) Improve immune response and general health.

Components:

Mindfulness activities build skills in:

- Emotional intelligence
- Self-awareness
- Impulse control
- Empathy
- Conflict resolution

Trauma Considerations for Working with Youth:

Be aware that increasing one's awareness of bodily sensations, emotions, and thoughts can potentially be overwhelming to a youth who has experienced trauma.

- Start with simple, non-threatening mindfulness exercises (e.g., focusing awareness on an object in the hand, and if teaching meditation, suggesting only to close eyes if comfortable or look down at a spot in front of them).
- Proceed in a slow, step-wise manner, and check in frequently with youth to ensure that youth feels safe and supported.
- Ensure non-judgmental acceptance of wherever youth is with mindfulness practice.

If youth becomes overwhelmed or triggered, stop the exercise, help youth calm down, then re-evaluate with youth how best to proceed.

Resources:

1. Mindful Schools
   http://www.mindfulschools.org/
2. Mind Body Awareness Project
   http://www.mbaproject.org/
3. Applied Mindfulness
   http://www.applied-mindfulness.org/
4. John Briere Mindfulness Materials
   http://www.johnbriere.com/Mindfulness%20materials.htm

HEALTHY DRUMMING

Designed to: 1) Bridge mind, body, and spiritual realms of self, 2) Decrease stress and anxiety, 3) Induce an awakened and reflective state of consciousness.

Components:

- Participants play basic intuitive rhythmical patterns on a drum, vocalizations, breathing exercises, meditation, and verbal and non-verbal communication.
- Medicinal drumming circles are not music classes and are not focused on learning any traditional rhythms or percussive patterns.

Resources:

Healthy Drumming

http://healthydrumming.org/home.html

HEALING HISTORICAL TRAUMA

Designed to: 1) Increase awareness of unconscious sources of grief and anger, 2) Reclaim traditional mourning, grieving rituals, and ceremonies.

Components:

- Confronting the trauma and embracing history.
- Understanding the trauma.
- Releasing the pain.
- Transcending the trauma.

Resources:

Native American Center for Excellence
http://nace.samhsa.gov/HistoricalTrauma.aspx

MANY MEDICINES

TRUAMA-INFORMED EVIDENCE-BASED BEST PRACTICES AND PROMISING APPROACHES (PAGE 5 OF 6)

NATIONAL CHILD TRAUMATIC STRESS NETWORK (NCTSN)

Designed to: Improve access to care, treatment, and services for traumatized children and adolescents exposed to traumatic events.

Components:

- National Center for Child Traumatic Stress : works with the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop and maintain the Network structure, provide technical assistance to grantees within the Network, oversee resource development and dissemination, and coordinate national education and training efforts.
- Treatment and Services Adaptation Centers : Provide national expertise on specific types of traumatic events, population groups, and service systems and support the specialized adaptation of effective treatment and service approaches for communities across the country.
- Community Treatment and Services (CTS) Centers : Implement and evaluate effective treatment and services in community settings and youth-serving service systems and collaborate with other Network centers on clinical issues, service approaches, policy, financing, and training issues.

Resources:

http://www.nctsn.org

2012 ATTORNEY GENERAL'S TASK FORCE ON CHILDREN EXPOSED TO VIOLENCE

Designed to: Address epidemic levels of exposure to violence faced by our nation's children.

Components:

- Based on public hearing testimony, comprehensive research, and extensive input from experts, advocates, and impacted families and communities nationwide, the final report includes findings and comprehensive policy recommendations to serve as a blueprint for preventing and reducing children's exposure to violence across the United States.

Resources:

http://www.justice.gov/defendingchildhood/index.html

CORE CURRICULUM ON CHILDHOOD TRAUMA

Designed to: 1Expand the nationwide mental health workforce including graduate training programs in social work, psychology, medicine, nursing, marriage and family therapy, and related fields to incorporate trauma-focused approaches to care including strength-based treatment plans that aim to both reduce distress and dysfunction, and promote wellness and positive youth development.

Components:

Basic training for practitioners who lack experience in trauma-focused work and a resource for the continuing education of experienced practitioners to broaden and refine areas of expertise, including:

1. Core Concepts: Basic principles and knowledge regarding trauma-focused treatment including psychoeducation and coping skills.
2. Core Components: Basic treatment elements of trauma- focused treatment including balance between advantages of adhering to a manualized treatment protocol with advantages of tailoring interventions to reflect the specific needs, strengths, and living circumstances of each youth and family.
3. Core Skills: Essential clinical proficiencies in trauma-focused treatment including case conceptualization that centers on empathetic understanding of youth's life and individual trauma experience, rather than only on symptom profile or type of trauma exposure.

Resources:

The National Center for Child Traumatic Stress (NCCTS)

http://www.nctsn.org/resources/audiences/parents-caregivers/what-is-cts/12-core-concepts

MANY MEDICINES

TRUAMA-INFORMED EVIDENCE-BASED BEST PRACTICES AND PROMISING APPROACHES (PAGE 6 OF 6)

NATIONAL CENTER FOR TRAUMA-INFORMED CARE

Designed to: Build awareness of trauma-informed care and promote the implementation of trauma-informed practices in programs and services.

Components:

- Training for staff, leaders, and consumers on the implementation of trauma-informed care in a range of service systems, including mental health, substance abuse, criminal justice, victim assistance, peer support, education, primary care, domestic violence, and child welfare.
- Training is offered either in brief sessions to diverse meeting or conference audiences or over several hours or days to specific programs or agencies.
- Technical assistance and consultation to support systems and programs that are committed to implementing trauma-informed approaches to service delivery.
- Technical assistance helps to identify and implement some of the steps that programs, agencies, or institutions can take to begin the transformation to a trauma-informed environment.

Resources:

National Center for Trauma Informed Care

http://www.samhsa.gov/nctic/default.asp

ACES TOO HIGH

Designed to: Be the go-to site for the general public on news and information about ACEs epidemiology, the neurobiological effects of toxic stress, epigenetics, biomedical effects of ACEs, and how schools, cities, states, agencies, and organizations are implementing trauma-informed practices.

Components:

- Research: Links to current research.
- Resources: Links to useful presentations, backgrounders, reports, and ACE concepts in the news.
- ACEs in Action: Links to projects and programs.
- Our Stories: A place where people can tell their personal stories about how child trauma affected their lives and health.

Resources:

http://acestoohigh.com

AMERICAN ACADEMY OF PEDIATRICS (AAP) MEDICAL HOME FOR CHILDREN EXPOSED TO VIOLENCE

Designed to: Provide pediatricians and all medical home teams with the resources they need to modify practice operations to more effectively identify, treat, and refer children and youth who have been exposed to or victimized by violence.

Components:

- Educational Opportunities: Meetings, webinars, and resources from past events.
- Best Practices and Quality Improvement: Support for ongoing improvement of care within the medical home model.
- Vignettes: Demonstrations in clinical settings to consider exposure to violence as a differential diagnosis.

Resources:

http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Medical-Home-for-Children-and-Adolescents-Exposed-to-Violence/

ACES CONNECTION

Designed to: Be the companion social network to ACEsTooHigh.com for individuals who are implementing, or thinking about implementing practices based on ACE and trauma-informed concepts.

Components:

- Members can post information (text posts, photos, videos, events) directly to the site, "friend" and message others who are doing things of interest, and form groups around interests.

Resources:

http://acesconnection.com

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ADOLESCENT HEALTH WORKING GROUP, 2013

AHWG

www.ahwg.net

Adolescent & Young Adult Health
National Resource Center

Evidence-based Clinical Preventive Services for Adolescents and Young Adults

✓ Indicates recommendations* of the U.S. Preventive Services Task Force (USPSTF).

ADOLESCENTS

Substance Use
✓ Tobacco education and brief counseling

Reproductive Health
✓ Same as Reproductive Health for Young Adults [except for HIV and cervical cancer screening]

✓ Screening for HIV [<15 at increased risk]

Mental Health
✓ Screening for depression [everyone aged 12-18 when there are adequate systems in place to ensure accurate diagnosis, effective treatment and follow-up]

Nutrition and Exercise
✓ Obesity/BMI screening and referral†

Immunizations
✓ CDC recommended immunizations

Safety and Violence
✓ Intimate partner violence - screen women of childbearing age, refer those at risk to relevant services

In addition to the USPSTF recommendations, there is promising research in a number of other areas suggesting that preventative screening may result in adolescent behavior change.

For example, studies support the effectiveness of screening and brief counseling in primary care for alcohol and illicit drug use (Harris 2011; Walker 2002), helmet use (Ozer 2011; Stevens 2002), healthy diet (Walker 2002), suicide risk (Wintersteen 2010), chlamydia in boys (Tebb 2005), and physical activity (Walker 2002; Ortega-Sanchez 2004).

Other services recommended for adolescents between 11 and 21 years in Bright Futures Guidelines** include: Screening and counseling for alcohol and illicit drugs; chlamydia and gonorrhea screening in males, birth control use screening, suicide screening, cholesterol level, healthy diet, physical activity counseling, family/partner violence, fighting, helmets, seat belts, alcohol while driving, guns, and bullying.

YOUNG ADULTS

Substance Use
✓ Alcohol screening and counseling

✓ Tobacco screening and cessation help

Reproductive Health
✓ Screening for HIV [everyone aged 15 to 65]

✓ Screening for syphilis [anyone at increased risk]†

✓ Screening for chlamydia and gonorrhea [sexually active women age 24 years and younger]

✓ Intensive behavioral counseling for all who are at increased risk for STIs [sexually transmitted infections]

✓ Cervical cancer screening [≥21]

Mental Health
✓ Screening for depression [when there are adequate systems in place to ensure accurate diagnosis, effective treatment and follow-up]

Nutrition and Exercise
✓ Lipid disorder [≥20 with increased risk for coronary artery disease]†

✓ Obesity/BMI screening and referral†

✓ Hypertension [≥18]

✓ Healthy diet [anyone who is obese/overweight and has additional risk factors]

Immunizations
✓ CDC recommended immunizations

Safety and Violence
✓ Intimate partner violence - screen women of childbearing age, refer those at risk to relevant services

* Recommendation has an A or B grade.

**Bright Futures Guidelines are expected to be updated in 2016

† USPSTF topic update in progress

Resources

U.S. Preventive Services Task Force: http://www.uspreventiveservicestaskforce.org/

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Adolescent & Young Adult Health
National Resource Center

Funded by MCHB, the AYAH-NRC is focused solely on the unique health and development needs of adolescents and young adults.

Inspired by and aligned with Title V transformation strategies, the AYAH-NRC will collaborate with the MCH community to integrate public health and health care delivery systems.

AYAH-NRC partners include:

- University of California/San Francisco **(lead)**
- Association of Maternal and Child Health Programs
- University of Minnesota/State Adolescent Health Resource Center
- University of Vermont/National Improvement Projects Network

For more information about the Center, contact Ms. Jane Park -- Jane.Park@UCSF.edu or visit our website nahic.ucsf.edu/resources/resource_center/

Supported (in full or in part) by Grant # U45MC27709 from the Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (Title V, Social Security Act), Division of Child, Adolescent and Family Health, Adolescent Health Branch

Prepared by UCSF for the Adolescent and Young Adult Health National Resource Center, March 2016

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

Bright Futures
prevention and health promotion for infants, children, adolescents, and their families™

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in a satisfactory fashion. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits. Additional visits also may become necessary if circumstances suggest variations from normal.

These recommendations represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in the *Bright Futures Guidelines* (Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 4th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2017).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

	INFANCY								EARLY CHILDHOOD							MIDDLE CHILDHOOD						ADOLESCENCE										
AGE[1]	**Prenatal**[2]	**Newborn**[3]	**3-5 d**[4]	**By 1 mo**	**2 mo**	**4 mo**	**6 mo**	**9 mo**	**12 mo**	**15 mo**	**18 mo**	**24 mo**	**30 mo**	**3 y**	**4 y**	**5 y**	**6 y**	**7 y**	**8 y**	**9 y**	**10 y**	**11 y**	**12 y**	**13 y**	**14 y**	**15 y**	**16 y**	**17 y**	**18 y**	**19 y**	**20 y**	**21 y**
HISTORY Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																															
Length/Height and Weight		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference		●	●	●	●	●	●	●	●	●	●	●																			
Weight for Length		●	●	●	●	●	●	●	●	●	●																				
Body Mass Index[5]												●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure[6]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																															
Vision[7]		★	★	★	★	★	★	★	★	★	★	★	★	●	●	●	●	★	●	★	●	★	●	★	★	●	★	★	★	★	★
Hearing		●[8]	●[9] →			★	★	★	★	★	★	★	★	★	●	●	●	★	●	★	●	←		●[10]	→	←	●	→	←		●	→
DEVELOPMENTAL/BEHAVIORAL HEALTH																															
Developmental Screening[11]								●			●		●																		
Autism Spectrum Disorder Screening[12]											●	●																			
Developmental Surveillance		●	●	●	●	●	●		●	●		●		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Psychosocial/Behavioral Assessment[13]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Tobacco, Alcohol, or Drug Use Assessment[14]																					★	★	★	★	★	★	★	★	★	★	★
Depression Screening[15]																						●	●	●	●	●	●	●	●	●	●
Maternal Depression Screening[16]				●	●	●	●																								
PHYSICAL EXAMINATION[17]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[18]																															
Newborn Blood		●[19]	●[20] →																												
Newborn Bilirubin[21]		●																													
Critical Congenital Heart Defect[22]		●																													
Immunization[23]		●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Anemia[24]						★			●	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Lead[25]							★	★	● or ★[26]		★	● or ★[26]		★	★	★	★															
Tuberculosis[27]				★			★		★			★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
Dyslipidemia[28]												★			★		★		★	←	● →	★	★	★	★	★	←			●	→	
Sexually Transmitted Infections[29]																						★	★	★	★	★	★	★	★	★	★
HIV[30]																						★	★	★	★	←		● →		★	★	★
Cervical Dysplasia[31]																															●
ORAL HEALTH[32]							●[33]	●[33]	★		★	★	★	★	★	★	★														
Fluoride Varnish[34]							←				●			→																	
Fluoride Supplementation[35]							★	★	★		★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★					
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up-to-date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per "The Prenatal Visit" (http://pediatrics.aappublications.org/content/124/4/1227.full).
3. Newborns should have an evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
4. Newborns should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for feeding and jaundice. Breastfeeding newborns should receive formal breastfeeding evaluation, and their mothers should receive encouragement and instruction, as recommended in "Breastfeeding and the Use of Human Milk" (http://pediatrics.aappublications.org/content/129/3/e827.full). Newborns discharged less than 48 hours after delivery must be examined within 48 hours of discharge, per "Hospital Stay for Healthy Term Newborns" (http://pediatrics.aappublications.org/content/125/2/405.full).
5. Screen, per "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrics.aappublications.org/content/120/Supplement_4/S164.full).
6. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
7. A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3-year-olds. Instrument-based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See "Visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153596) and "Procedures for the Evaluation of the Visual System by Pediatricians" (http://pediatrics.aappublications.org/content/137/1/e20153597).
8. Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs" (http://pediatrics.aappublications.org/content/120/4/898.full).
9. Verify results as soon as possible, and follow up, as appropriate.
10. Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See "The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies" (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext).
11. See "Identifying Infants and Young Children With Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening" (http://pediatrics.aappublications.org/content/118/1/405.full).
12. Screening should occur per "Identification and Evaluation of Children With Autism Spectrum Disorders" (http://pediatrics.aappublications.org/content/120/5/1183.full).
13. This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See "Promoting Optimal Development: Screening for Behavioral and Emotional Problems" (http://pediatrics.aappublications.org/content/135/2/384) and "Poverty and Child Health in the United States" (http://pediatrics.aappublications.org/content/137/4/e20160339).
14. A recommended assessment tool is available at http://www.ceasar-boston.org/CRAFFT/index.php.
15. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf.
16. Screening should occur per "Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice" (http://pediatrics.aappublications.org/content/126/5/1032).
17. At each visit, age-appropriate physical examination is essential, with infant totally unclothed and older children undressed and suitably draped. See "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://pediatrics.aappublications.org/content/127/5/991.full).
18. These may be modified, depending on entry point into schedule and individual need.

(continued)

KEY: ● = to be performed ★ = risk assessment to be performed with appropriate action to follow, if positive ← ● → = range during which a service may be provided

(continued)

19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf) establish the criteria for and coverage of newborn screening procedures and programs.
20. Verify results as soon as possible, and follow up, as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications" (http://pediatrics.aappublications.org/content/124/4/1193).
22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (http://pediatrics.aappublications.org/content/129/1/190.full).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at http://redbook.solutions.aap.org/SS/Immunization_Schedules.aspx. Every visit should be an opportunity to update and complete a child's immunizations.
24. See "Diagnosis and Prevention of Iron Deficiency and Iron-Deficiency Anemia in Infants and Young Children (0–3 Years of Age)" (http://pediatrics.aappublications.org/content/126/5/1040.full).
25. For children at risk of lead exposure, see "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (https://www.nhlbi.nih.gov/health-topics/integrated-guidelines-for-cardiovascular-health-and-risk-reduction-in-children-and-adolescents).
29. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases.*
30. Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
31. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (http://pediatrics.aappublications.org/content/126/3/583.full).
32. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (https://www.aap.org/RiskAssessmentTool) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
33. Perform a risk assessment (https://www.aap.org/RiskAssessmentTool). See "Maintaining and Improving the Oral Health of Young Children" (http://pediatrics.aappublications.org/content/134/6/1224).
34. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspsdnch.htm). Once teeth are present, fluoride varnish may be applied to all children every 3–6 months in the primary care or dental office. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).
35. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://pediatrics.aappublications.org/content/134/3/626).

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care

(Periodicity Schedule)

This schedule reflects changes approved in February 2017 and published in April 2017.
For updates, visit www.aap.org/periodicityschedule.
For further information, see the *Bright Futures Guidelines*, 4th Edition, *Evidence and Rationale chapter* (https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_Evidence_Rationale.pdf).

CHANGES MADE IN FEBRUARY 2017

HEARING

- Timing and follow-up of the screening recommendations for hearing during the infancy visits have been delineated. Adolescent risk assessment has changed to screening once during each time period.
- Footnote 8 has been updated to read as follows: "Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per 'Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs' (http://pediatrics.aappublications.org/content/120/4/898.full)."
- Footnote 9 has been added to read as follows: "Verify results as soon as possible, and follow up, as appropriate."
- Footnote 10 has been added to read as follows: "Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See 'The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies' (http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext)."

PSYCHOSOCIAL/BEHAVIORAL ASSESSMENT

- Footnote 13 has been added to read as follows: "This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See 'Promoting Optimal Development: Screening for Behavioral and Emotional Problems' (http://pediatrics.aappublications.org/content/135/2/384) and 'Poverty and Child Health in the United States' (http://pediatrics.aappublications.org/content/137/4/e20160339)."

TOBACCO, ALCOHOL, OR DRUG USE ASSESSMENT

- The header was updated to be consistent with recommendations.

DEPRESSION SCREENING

- Adolescent depression screening begins routinely at 12 years of age (to be consistent with recommendations of the US Preventive Services Task Force [USPSTF]).

MATERNAL DEPRESSION SCREENING

- Screening for maternal depression at 1-, 2-, 4-, and 6-month visits has been added.
- Footnote 16 was added to read as follows: "Screening should occur per 'Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice' (http://pediatrics.aappublications.org/content/126/5/1032)."

NEWBORN BLOOD

- Timing and follow-up of the newborn blood screening recommendations have been delineated.
- Footnote 19 has been updated to read as follows: "Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf) establish the criteria for and coverage of newborn screening procedures and programs."
- Footnote 20 has been added to read as follows: "Verify results as soon as possible, and follow up, as appropriate."

NEWBORN BILIRUBIN

- Screening for bilirubin concentration at the newborn visit has been added.
- Footnote 21 has been added to read as follows: "Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See 'Hyperbilirubinemia in the Newborn Infant ≥35 Weeks' Gestation: An Update With Clarifications' (http://pediatrics.aappublications.org/content/124/4/1193)."

DYSLIPIDEMIA

- Screening for dyslipidemia has been updated to occur once between 9 and 11 years of age, and once between 17 and 21 years of age (to be consistent with guidelines of the National Heart, Lung, and Blood Institute).

SEXUALLY TRANSMITTED INFECTIONS

- Footnote 29 has been updated to read as follows: "Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*."

HIV

- A subheading has been added for the HIV universal recommendation to avoid confusion with STIs selective screening recommendation.
- Screening for HIV has been updated to occur once between 15 and 18 years of age (to be consistent with recommendations of the USPSTF).
- Footnote 30 has been added to read as follows: "Adolescents should be screened for HIV according to the USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually."

ORAL HEALTH

- Assessing for a dental home has been updated to occur at the 12-month and 18-month through 6-year visits. A subheading has been added for fluoride supplementation, with a recommendation from the 6-month through 12-month and 18-month through 16-year visits.
- Footnote 32 has been updated to read as follows: "Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (https://www.aap.org/RiskAssessmentTool) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See 'Maintaining and Improving the Oral Health of Young Children' (http://pediatrics.aappublications.org/content/134/6/1224)."
- Footnote 33 has been updated to read as follows: "Perform a risk assessment (https://www.aap.org/RiskAssessmentTool). See 'Maintaining and Improving the Oral Health of Young Children' (http://pediatrics.aappublications.org/content/134/6/1224)."
- Footnote 35 has been added to read as follows: "If primary water source is deficient in fluoride, consider oral fluoride supplementation. See 'Fluoride Use in Caries Prevention in the Primary Care Setting' (http://pediatrics.aappublications.org/content/134/3/626)."

Summary of Recommended Guidelines for Clinical Preventive Services for Adolescents up to Age 18

UCSF Division of Adolescent and Young Adult Medicine

NAHIC

Guidelines as of 11/2017, subject to change.

	Preventive Services	All (√)	At Risk (+)	Screening Test/ Procedure and Other Notes
	Nutrition/exercise/obesity			
☐	Hypertension/Blood Pressure	√		√ Bright Futures, USPSTF insufficient evidence
☐	**Obesity/BMI**	√		**Screen ≥6 years; offer/refer to appropriate intervention**
☐	Cholesterol level		+	√ Bright Futures, USPSTF insufficient evidence
☐	Healthy diet		+	√ Bright Futures
☐	Dyslipidemia	√		√ Bright Futures recommends one screening between ages 9-11 & 17-21, *USPSTF insufficient evidence*
	Substance Use			
☐	Alcohol (screening and counseling)†	√		√ Bright Futures, USPSTF insufficient evidence
☐	**Tobacco screening†**	√		**Provide interventions (education, brief counseling)**
☐	Illicit Drugs (screening and counseling)	√		√ Bright Futures* and ACOG**, USPSTF insufficient evidence
	Mental Health/Depression			
☐	**Depression (screening and treatment)**	√		**Screen for MDD ≥ age 12, w/ adequate systems in place**
☐	Suicide Screening	√		√ Bright Futures and ACOG, USPSTF insufficient evidence
	Safety/Violence			
☐	**Family/partner violence**	√		**Screen women of childbearing age**
☐	Fighting	√		√ Bright Futures and ACOG
☐	Helmets	√		√ Bright Futures and ACOG
☐	Seat belts	√		√ Bright Futures and ACOG
☐	Guns	√		√ Bright Futures and ACOG
☐	Bullying	√		√ Bright Futures only
	Reproductive Health			
☐	**HIV†**	√	+	**Bright Futures and USPSTF recommend one screening between ages 15-18, and annually for those at increased risk**
☐	**STI (screening and counseling)**		+	**High-Intensity Counseling Interventions**
☐	**Syphilis**		+	**VDRL**
☐	**Gonorrhea (females)**		+	**NAATs; test if ≤24 and sexually active**
☐	**Chlamydia (female)**		+	**NAATs; test if ≤24 and sexually active**
☐	Chlamydia & Gonorrhea (male)		+	√ Bright Futures only
☐	Birth Control Methods	√	+	√ ACOG, + Bright Futures
☐	Pregnancy		+	+ Bright Futures
	Cancer Screening			
☐	**Cervical Cancer**		+	**USPSTF recommends against screening ≤21**
☐	**Skin Cancer (counseling)†**		+	**Counsel those with fair skin ages 10-24 about reducing UV exposure**
☐	**BRCA-Related Cancer**		+	**Family Hx of breast, ovarian, tubal, or peritoneal cancer**
	Infectious Diseases including CDC Immunization Recommendations			
☐	**Td/Tdap**	√		**Td booster every 10 years**
☐	**Human papillomavirus**	√		**9vHPV vaccine for males and females up to age 26; 3 lifetime doses**
☐	**Varicella** (LIVE VACCINE)	√ ***		**2 lifetime doses at least 4 weeks apart** ***See below
☐	**Measles, mumps, rubella**	√		**1 or 2 lifetime doses**
☐	**Influenza**	√		**1 dose annually**
☐	**Pneumococcal**		+	**PCV13: 1 lifetime dose | PPSV23: 1-2 lifetime doses**
☐	**Hepatitis A**	√		**2 or 3 lifetime doses**
☐	**Hepatitis B**	√		**3 lifetime doses**
☐	**Meningococcal Quadrivalent**	√		**2 lifetime doses**
☐	**Serogroup B Meningococcal**		+	**Men B vaccine (2 or 3-dose series) to those 16-23 years old**
☐	**Hepatitis C Screening**		+	**Anti–HCV antibody testing, polymerase chain reaction testing**

Bold = US Preventive Services Task Force (USPSTF) A or B Recommendation or CDC recommendations for immunizations.

Current evidence is insufficient to assess the balance of benefits and harms of service.

√ = All adolescents + = Adolescents at risk

For more information, please view the appendix, and visit the official website.

* Bright Futures: recommendations are for annual visits, up to age 21.

** American Congress of Obstetricians and Gynecologists (ACOG) recommendations, up to age 26.

*** The varicella vaccine should **NOT** be given to patients with these contraindications.

† USPSTF update in progress.

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Recommended Guidelines for Clinical Preventive Services for Young Adults ages 18-25: Risk Factors and Recommended Screening Tests

UCSF Division of Adolescent and Young Adult Medicine

Guidelines as of 11/2017, subject to change.

The United States Preventive Services Task Force (USPSTF) conducts scientific evidence reviews of a broad range of clinical preventive health care services and develops recommendations for primary care clinicians and health systems. These reviews are conducted periodically and published in the form of Recommendation Statements. This document serves as a broad overview of the relevant recommendations for the 18-25 age group and is not meant to be all encompassing. There may be special considerations for certain subpopulations within the young adult age group, such as pregnant women. For information on screening, please visit the USPSTF website. For information on immunizations, please visit the CDC website.

Area	Recommendation	Risk Factors (defined by USPSTF unless otherwise noted)	USPSTF Recommended Screening Tests
Nutrition, Exercise, Obesity	Hypertension/ High Blood Pressure Website: http://www.uspreventiveservicestaskforce.org/uspstf07/hbp/hbprs.pdf Updated 10/2015	Persons at increased risk include • Those who have high-normal blood pressure (130 to 139/85 to 89 mm Hg) • Those who are overweight or obese • African Americans	Office measurement of blood pressure is most commonly done with a **sphygmomanometer**. The USPSTF recommends confirmation outside of the clinical setting before a diagnosis of hypertension is made and treatment is started. Confirmation may be done by using HBPM or ABPM. Because blood pressure is a continuous value with natural variations throughout the day, repeated measurements over time are generally more accurate in establishing a diagnosis of hypertension. The USPSTF did not find evidence for a single gold standard protocol for HBPM or ABPM.
Nutrition, Exercise, Obesity	Obesity/BMI Website: http://www.uspreventiveservicestaskforce.org/uspstf11/obeseadult/obesers.pdf Updated 09/2012		**BMI is calculated either as weight in pounds divided by height in inches squared multiplied by 703, or as weight in kilograms divided by height in meters squared.** Persons with a BMI between 25 and 29.9 are overweight and those with a BMI of 30 and above are obese. There are 3 classes of obesity: class I (BMI 30-34.9), class II (BMI 35-39.9), and class III (BMI 40 and above).

Area	Recommendation	Risk Factors	USPSTF Recommended Screening Tests
Nutrition, Exercise, Obesity	Healthy diet Website: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/healthy-diet-and-physical-activity-counseling-adults-with-high-risk-of-cvd Updated 08/2014	• Hyperlipidemia • Other known risk factors for cardiovascular and diet-related chronic disease	Intensive behavioral counseling interventions have moderate benefits for CVD risk in overweight or obese adults who are at increased risk for CVD, including decreases in blood pressure, lipid and fasting glucose levels, and body mass index (BMI) and increases in levels of physical activity. The reduction in glucose levels was large enough to decrease the incidence of a diabetes diagnosis. This recommendation applies to adults aged 18 years or older in primary care settings who are overweight or obese and have known CVD risk factors (hypertension, dyslipidemia, impaired fasting glucose, or the metabolic syndrome). In the studies reviewed by the USPSTF, the vast majority of participants had a BMI greater than 25 kg/m2
Substance Use	Alcohol: Screening and Counseling Website: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care Updated 05/2013	Risky use of alcohol is defined by the NIAAA and USDA as: • More than 7 drinks per week or more than 3 drinks per day for women. • More than 14 drinks per week or 4 drinks per day for men.	Numerous screening instruments can detect alcohol misuse in adults with acceptable sensitivity and specificity. The USPSTF prefers the following tools for alcohol misuse screening in the primary care setting: **NIAAA single-question screening**, such as asking, "How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day?" The **Alcohol Use Disorders Identification Test (AUDIT)** is the most studied screening tool for detecting the full spectrum of alcohol-related problems in primary care settings. Also available is the abbreviated AUDIT- Consumption test, or **AUDIT-C.**

Area	Recommendation	Risk Factors	USPSTF Recommended Screening Tests
Substance Use	Tobacco: Screening and Counseling for non-pregnant adults Website: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1 Updated 09/2015	According to the 2012–2013 National Adult Tobacco Survey, smoking prevalence is higher in the following groups: • Men • Adults aged 25 to 44 years • Persons with a race or ethnicity category of "other, non-Hispanic" • Persons with a GED (vs. graduate-level education • Persons with an annual household income of less than $20,000 • Persons who are lesbian, gay, bisexual, or transgender. • Higher rates of smoking have been found in persons with mental health condition	The **"5-A" framework** provides a useful counseling strategy: 1. Ask about tobacco use. 2. Advise to quit through clear personalized messages. 3. Assess willingness to quit. 4. Assist to quit. 5. Arrange follow-up and support. Both intervention types (pharmacotherapy and behavioral interventions) are effective and recommended; combinations of interventions are most effective, and all should be offered. The best and most effective combinations are those that are acceptable to and feasible for an individual patient; clinicians should consider the patient's specific medical history and preferences and offer and provide the combination that works best for the patient.
Substance Use	Tobacco: Screening and Counseling for Pregnant Women Website: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions1 Updated 09/2015		Because many pregnant women who smoke do not report it, using multiple-choice screening questions to assess smoking status in this group may improve disclosure. The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco. The USPSTF found convincing evidence that behavioral interventions substantially improve achievement of tobacco smoking abstinence in pregnant women, increase infant birthweight, and reduce risk for preterm birth.

			The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant women.
Area	**Recommendation**	**Risk Factors**	**USPSTF Recommended Screening Tests**
Mental Health	Depression Website: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-adults-screening1 Updated 01/2016	• The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. • A number of factors are associated with an increased risk of depression ○ Women, young and middle-aged adults, and nonwhite persons have higher rates of depression than their counterparts, as do persons who are undereducated, previously married, or unemployed. ○ Other groups who are at increased risk of developing depression include persons with chronic illnesses (eg, cancer or cardiovascular disease), other mental health disorders (including substance misuse), or a family history of psychiatric disorders. • Among older adults, risk factors for depression include disability and poor health status related to medical illness, complicated grief, chronic sleep disturbance, loneliness, and a history of depression • Risk factors for depression during pregnancy and postpartum include poor self-esteem, child-care stress, prenatal	Commonly used depression screening instruments include the Patient Health Questionnaire (PHQ) in various forms and the Hospital Anxiety and Depression Scales in adults, the Geriatric Depression Scale in older adults, and the Edinburgh Postnatal Depression Scale (EPDS) in postpartum and pregnant women. All positive screening results should lead to additional assessment that considers severity of depression and comorbid psychological problems (eg, anxiety, panic attacks, or substance abuse), alternate diagnoses, and medical conditions. Effective treatment of depression in adults generally includes antidepressants or specific psychotherapy approaches (eg, CBT or brief psychosocial counseling), alone or in combination. Given the potential harms to the fetus and newborn child from certain pharmacologic agents, clinicians are encouraged to consider CBT or other evidence-based counseling interventions when managing depression in pregnant or breastfeeding women.

		anxiety, life stress, decreased social support, single/unpartnered relationship status, history of depression, difficult infant temperament, previous postpartum depression, lower socioeconomic status, and unintended pregnancy.	
Area	**Recommendation**	**Risk Factors**	**USPSTF Recommended Screening Tests**
Reproductive Health	HIV Website: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/human-immunodeficiency-virus-hiv-infection-screening Updated 04/2013	• Men who have sex with men and active injection drug users are at high risk for new HIV infection. • Those who have acquired or request testing for other sexually transmitted infections. Behavioral risk factors for HIV infection include: • Having unprotected vaginal or anal intercourse • Having sexual partners who are HIV-infected, bisexual, or injection drug users • Exchanging sex for drugs or money The USPSTF recognizes that the above categories are not mutually exclusive, the degree of sexual risk is on a continuum, and individuals may not be aware of their sexual partners' risk factors for HIV infection.	The standard test for diagnosing HIV infection is the **repeatedly reactive enzyme immunoassay**, followed by **confirmatory western blot or immunofluorescent assay**. Conventional HIV test results are available within 1 to 2 days from most commercial laboratories. **Rapid HIV antibody testing** is also highly accurate, may use either blood or oral fluid specimens, and can be performed in 5 to 40 minutes, and when offered at the point of care, is useful for screening high-risk patients who do not receive regular medical care (e.g., those seen in emergency departments), as well as women with unknown HIV status who present in active labor. Initial positive results require confirmation with conventional methods. Other U.S. Food and Drug Administration–approved tests for detection and confirmation of HIV infection include combination tests (for p24 antigen and HIV antibodies) and qualitative HIV-1 RNA.

Area	Recommendation	Risk Factors	USPSTF Recommended Screening Tests
Reproductive Health	STI: Behavioral Counseling Website: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/sexually-transmitted-infections-behavioral-counseling1 Updated 09/2014	• All sexually active adolescents are at increased risk for STIs and should be counseled. • Other risk groups that have been included in counseling studies include adults with current STIs or other infections within the past year, adults who have multiple sex partners, and adults who do not consistently use condoms. Clinicians should be aware of populations with a particularly high prevalence of STIs such as: • All African Americans have the highest STI prevalence of any racial/ethnic group, and STI prevalence is higher in American Indians, Alaska Natives, and Latinos than in white persons. Increased STI prevalence rates are also found in: • Men who have sex with men (MSM) • Persons with low incomes living in urban settings • Current or former inmates • Military recruits • Persons who exchange sex for money or drugs • Persons with mental illness or a disability • Current or former intravenous drug users • Persons with a history of sexual abuse • Patients at public STI clinics	Interventions ranging in intensity from 30 minutes to 2 or more hours of contact time are beneficial. Evidence of benefit increases with intervention intensity. High-intensity counseling interventions (defined in the review as contact time of ≥2 hours) were the most effective. Interventions can be delivered by primary care clinicians or through referral to trained behavioral counselors. Most successful approaches provided basic information about STIs and STI transmission; assessed the person's risk for transmission; and provided training in pertinent skills, such as condom use, communication about safe sex, problem solving, and goal setting. Many successful interventions used a targeted approach to the age, sex, and ethnicity of the participants and also aimed to increase motivation or commitment to safe sex practices. Intervention methods included face-to-face counseling, videos, written materials, and telephone support.

Reproductive Health	Syphilis Website: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/syphilis-infection-in-nonpregnant-adults-and-adolescents Updated 06/2016	• Men who have sex with men • Sex work • Exchange of sex for drugs • Incarceration • Men and women with HIV • Men younger than 29	Screening for syphilis infection is a two-step process that involves an initial nontreponemal test (**Venereal Disease Research Laboratory or Rapid Plasma Reagin**), followed by a confirmatory treponemal test **FTA-ABS (fluorescent treponemal antibody absorbed) or TP-PA (T. pallidum particle agglutination**).
Area	**Recommendation**	**Risk Factors**	**USPSTF Recommended Screening Tests**
Reproductive Health	Gonorrhea and Chlamydial Infection Website: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/chlamydia-and-gonorrhea-screening Updated 09/2014	Those with the highest chlamydial and gonococcal infection rates occur in women aged 20 to 24 years, followed by females aged 15 to 19 years. Chlamydial infections are 10 times more prevalent than gonococcal infections in young adult women. Among men, infection rates are highest in those aged 20 to 24 years. Other risk factors for infection include having: • a new sex partner • more than 1 sex intimate • a sex partner with concurrent partners • a sex partner who has an STI • inconsistent condom use among persons who are not in mutually monogamous relationships • previous or coexisting STI exchanging sex for money or drugs	*Chlamydia trachomatis* and *Neisseria gonorrhoeae* infections should be diagnosed by using nucleic acid amplification tests (NAATs) because their sensitivity and specificity are high and they are approved by the U.S. Food and Drug Administration for use on urogenital sites, including male and female urine, as well as clinician-collected endocervical, vaginal, and male urethral specimens. Most NAATs that are approved for use on vaginal swabs are also approved for use on self-collected vaginal specimens in clinical settings. Rectal and pharyngeal swabs can be collected from persons who engage in receptive anal intercourse and oral sex, although these collection sites have not been approved by the U.S. Food and Drug Administration.

Area	Recommendation	Risk Factors	USPSTF Recommended Screening Tests
Reproductive Health	Hepatitis C Website: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/hepatitis-c-screening Updated 06/2013	The most important risk factor for HCV infection is past or current injection drug use. Another established risk factor for HCV infection is receipt of a blood transfusion before 1992. Additional risk factors include: • long-term hemodialysis • being born to an HCV-infected mother • incarceration • intranasal drug use • getting an unregulated tattoo • other percutaneous exposures (such as in health care workers or from having surgery before the implementation of universal precautions).	Anti–HCV antibody testing followed by polymerase chain reaction testing for viremia is accurate for identifying patients with chronic HCV infection. Various noninvasive tests with good diagnostic accuracy are possible alternatives to liver biopsy for diagnosing fibrosis or cirrhosis.
Reproductive Health	Folic Acid Website: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/folic-acid-for-the-prevention-of-neural-tube-defects-preventive-medication Updated 01/2017	Although all women of childbearing age are at risk of having a pregnancy affected by neural tube defects and should take folic acid supplementation, some factors increase their risk. Additional risk factors include: • Personal or family history of neural tube defects • Use of antiseizure medication • Maternal diabetes • Obesity • Mutations in folate-related enzymes	The current statement recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.

Area	Recommendation	Risk Factors	USPSTF Recommended Screening Tests
Cancer Screening	Cervical Cancer Website: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/cervical-cancer-screening Updated 03/2012	• All women who have a cervix, regardless of sexual history • Women with HPV infection • HIV infection • Compromised immune system • In-utero exposure to diethylstilbestrol • Previous treatment of a high-grade precancerous lesion or cervical cancer	Current evidence indicates that there are no clinically important differences between liquid-based cytology and conventional cytology. Women who have had a hysterectomy with removal of the cervix and who do not have a history of a high- grade precancerous lesion or cervical cancer are not at risk for cervical cancer and **should not be screened.** Women who had their cervix removed during surgery for ovarian or endometrial cancer are not at high risk for cervical cancer and **would not benefit from screening.**
Cancer Screening	Testicular Cancer Website: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/testicular-cancer-screening Updated 04/2011		The United States Preventive Services Task Force recommends **against** screening for testicular cancer in adult males.

Area	Recommendation	Risk Factors	USPSTF Recommended Screening Tests
Safety/Violence	Family/Partner Violence Website: https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/intimate-partner-violence-and-abuse-of-elderly-and-vulnerable-adults-screening Updated 01/2013	Women of child-bearing age are most at risk, however all women are at potential risk for abuse Factors that elevate risk include: • young age • substance abuse • marital difficulties • economic hardships	Several screening instruments can be used to screen women for IPV. Those with the highest levels of sensitivity and specificity for identifying IPV are Hurt, Insult, Threaten, Scream (HITS) (English and Spanish versions); Ongoing Abuse Screen/Ongoing Violence Assessment Tool (OAS/OVAT); Slapped, Threatened, and Throw (STaT); Humiliation, Afraid, Rape, Kick (HARK); Modified Childhood Trauma Questionnaire– Short Form (CTQ-SF); and Woman Abuse Screen Tool (WAST). The HITS instrument includes 4 questions, can be used in a primary care setting, and is available in both English and Spanish. It can be self- or clinician- administered. HARK is a self-administered 4-item instrument. STaT is a 3-item self-report instrument that was tested in an emergency department setting.

Area		
Infectious Diseases, including CDC Recommended Immunizations	Below is a list of vaccinations relevant to the young adult age group, which the CDC regularly updates. The most current CDC immunizations page can be viewed here.	
	Td/Tdap	http://www.cdc.gov/vaccines/hcp/vis/vis-statements/tdap.pdf
	Human Papillomavirus	http://www.cdc.gov/vaccines/hcp/vis/vis-statements/hpv-gardasil-9.pdf
	Varicella	http://www.cdc.gov/vaccines/hcp/vis/vis-statements/varicella.pdf
	Measles, mumps, rubella	MMR Website: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/mmr.pdf MMRV Website: http://www.cdc.gov/vaccines/hcp/vis/vis-statements/mmrv.pdf
	Influenza	http://www.cdc.gov/vaccines/hcp/vis/vis-statements/flu.pdf
	Pneumococcal (polysaccharide)	http://www.cdc.gov/vaccines/hcp/vis/vis-statements/ppv.pdf
	Hepatitis A	http://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-a.pdf
	Hepatitis B	http://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-b.pdf
	Hepatitis C	http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/hepatitis-c-screening
	Serogroup B Meningococcal (MenB):	http://www.cdc.gov/vaccines/hcp/vis/vis-statements/mening-serogroup.pdf
	Quadrivalent Meningococcal	http://www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.pdf

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BARRIERS to adolescent risk screening

Completing a confidential screening for high-risk behaviors in adolescents can be a challenge for health care providers. Teens are unlikely to bring up risky behaviors on their own, especially if they think the information might not be kept confidential. Conversations about risky behaviors can be difficult for providers to navigate with adolescents and parents, and providers may not believe adolescent patients will be honest with them. Time with each patient may be limited, and providers may find it hard to imagine fitting in one more assessment.

STRATEGIES for adolescent risk screening

Use a standardized risk screening tool for high-risk behaviors.

- Using a screening tool allows risky behaviors to be reviewed before talking with teens so that the provider can gather resources. It can help start the conversation, and, while still screening for multiple risks, allows the discussion and counseling to be focused on the issues most affecting that teen.
- Administration and interpretation of a health risk assessment tool is reimbursable by some insurance companies.
- With a standardized, validated tool, individual changes can be measured over time and risk trends in a clinic population identified.
- The Rapid Assessment for Adolescent Preventive Services (RAAPS[1]) is one risk screening tool recommended by the Society for Adolescent Health and Medicine.
- Other risk screening tool options include GAPS[2] and Bright Futures[3].
- Best practice is to use an electronic version, as teens prefer to communicate through and respond more honestly when using technology.
- If a clinic cannot use an electronic version due to cost, workflow, or lack of computers or tablets for patients to use, risk assessments can be done on paper instead.

Create a workflow that ensures risk screening is done confidentially at least once a year.

- Build risk screening into the well visit workflow for patients age 12 to 21. (See sample workflows on page 3.)
- Patients should complete the risk screening form privately, while no one is around.
- Risk screenings should **NOT** be completed while sitting with a parent in the waiting room; giving adolescents their own clipboard is not enough to make them comfortable sharing sensitive information.
- Explain confidentiality laws and/or provide a handout when giving instructions for completing the risk screening so the teen can feel comfortable answering the questions honestly.
- Consider scheduling slightly longer visits with adolescents when possible so they have time to get answers to their questions.
- AHI developed an infographic[4] on confidential risk screening than can be posted or shared with colleagues, parents, and patients.

Help parents feel like partners in the process.

- Send letters home to families before well child visits explaining the following:
  - Allowing teens to use their voice & share their views of their health is an important developmental step.
  - Confidential time alone with teens is standard.
  - Teens will complete a health survey on their own to give them a chance to independently express their views on their health.
  - See sample letter on page 4.
- Provide adolescents and parents handouts at check in so that parents know to expect that confidential time will be spent with their child and both parties know about minor healthcare rights.
- Consider using a questionnaire for parents in addition to an adolescent questionnaire.
  - A parent questionnaire can get important information from parents to supplement information provided by the adolescent patient and provide parents with a task to focus on while their adolescent completes the risk assessment tool.
  - The Children's Clinic created this parent questionnaire[5] to accompany their adolescent questionnaire[6].
  - Encourage open communication between teens and parents after completion of the questionnaires.

Make sure all providers and staff members know confidentiality laws and limitations.

- Setting clear expectations minimizes confusion for families, improves communication with adolescents, and decreases teens' uncertainty about what can and cannot be managed confidentially.
- Have front desk staff systematically confirm the preferred method for communicating with each adolescent patient.
- Consider allowing adolescents to choose a password to confirm that providers/staff are talking with the right person when they call to discuss results.
- Be sure adolescents understand that if they use private insurance, and Explanation of Benefits (EOB) will be sent home to their parents, detailing services received even if services were requested confidentially.
- Keep lists of clinics where patients can receive confidential care on a free or sliding scale, like school-based health centers, Planned Parenthood, and local health departments.
- Establish connections with local pharmacies to ensure adolescents' confidentiality will be respected there; ask the pharmacist to call the clinician (not the parents) with questions about teens' prescriptions.

Make staff aware of at-risk populations and how they can respond.

- Some adolescents, including those in foster care, homeless shelters, juvenile detention centers, and substance abuse programs have higher rates of risk-taking than other adolescents.
- Develop protocols for risk intervention and referral, particularly for patients disclosing self-harm, suicidal ideation, or abuse, keeping in mind your state's confidentiality and mandatory reporting laws. Refer to these policies and procedures used by the University of Michigan Health System Regional Alliance for Healthy Schools as examples for suicide[7], psychiatric crises[8], child abuse[9], and domestic abuse[10] situations that may arise.

ADDITIONAL RECOMMENDATIONS

- Use the Parent Handout, Teen Handout, and Poster on confidentiality rights to inform families of the laws and your practices. These resources for sites in the state of Michigan can be found here.[11] Materials for other states may be available upon request.

SAMPLE WORKFLOWS FOR CONFIDENTIAL RISK SCREENING

Workflow 1:

1. Front desk staff gives the parent/guardian a letter explaining confidential time with adolescent patients.
2. MA calls patient and explains to parent/guardian "I'm going to take your child back to get their vital signs and have them complete a brief health survey, and then I'll bring you to the room before the provider comes to see them."
    a. MA can explain that "We give teens a chance to share their own views on their health, and that's why we have them complete the health survey on their own." If there is parent push-back, MA rooms the patient without doing risk screening, and the provider can address the issue.
3. MA rooms the patient, has them complete the risk screening, and brings the results to the provider for review. MA then gets the parent/guardian from the waiting room.
4. Provider meets with the parent/guardian and patient then asks the parent/guardian to step out at the end of the visit for confidential time. Provider then reviews risk screening with the patient.

Limitations of this workflow: Parent is asked to not be present twice and has to go back and forth between the waiting room and patient room.

Workflow 2:

1. Front desk staff gives the parent/guardian a letter explaining confidential time with adolescent patients.
2. Front desk staff or MA brings the patient to an area in waiting room with a privacy screen to complete their risk screening. Staff instructs the patient to return the risk screening directly to the front desk staff when they are finished (if on paper) or submit electronically (if on a computer or tablet).
3. When risk screening is completed, provider receives it for review (either from staff or electronically).
4. MA calls the patient and parent/guardian back, and the provider meets with both together.
5. Provider then asks the parent/guardian to step out for confidential time with the patient, then reviews the risk screening with the patient alone.
6. MA brings the parent/guardian in from the waiting room for the remainder of the visit.

Limitations of this workflow: May be hard to create a truly private space in the waiting room and for the patient to successfully hand a paper form directly back to the front desk.

SAMPLE PARENT LETTER

Dear Parent /Guardian:

Adolescence is a time of transition from childhood to adulthood. We want to help prepare your teen to be an active participant in their medical care. A normal developmental step in this process is allowing your teen to share their views of health in their own voice. We have two standard practices to give them this chance to express their views: your teen will complete a health survey on their own, and we will talk to your teen independently for part of their visit. Since this can be a difficult time of life, we will be taking some time to talk to them in private concerning issues that you or your teen may not necessarily be comfortable discussing with each other.

Some of the topics that we will be talking about will include:

- Healthy eating and sleeping habits
- Friends and relationships
- Emotions and mood
- Sexuality
- Drugs and alcohol

We will address all these subjects in an age- and maturity-appropriate manner.

In order for these discussions to be as open and helpful as possible, we will assure your teenager that our discussions will be confidential. If there is a concern about your teen doing harm to themselves or someone else, we will inform you. On issues of sexually transmitted diseases, birth control, pregnancy, and drug use, we will encourage your teen to share this information with you.

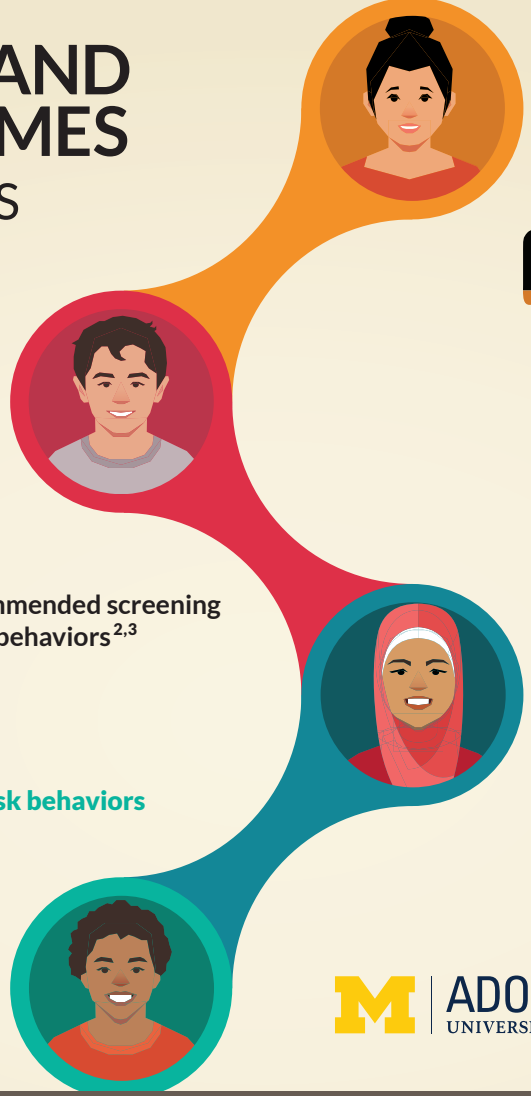
If there are any particular issues that you would like us to address with your teen, please let us know. Also, let us know if you would like to talk to us privately about concerns you have about your teen or strategies to discuss sensitive topics with them. We want to do our very best to be your ally in helping your child grow up to be healthy and happy.

Sincerely,

[provider name or health center name]

[1] http://www.possibilitiesforchange.com/raaps/
[2] https://www.uvpediatrics.com/health-topics/stage/#GAPS
[3] https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/adolescence-tools.aspx
[4] http://www.umhs-adolescenthealth.org/wp-content/uploads/2017/02/riskscreeninginfographic.pdf
[5] http://www.umhs-adolescenthealth.org/wp-content/uploads/2017/06/adolescent-parent-questionnaire-tcc.pdf
[6] http://www.umhs-adolescenthealth.org/wp-content/uploads/2017/06/adolescent-questionnaire-tcc.pdf
[7] http://www.umhs-adolescenthealth.org/wp-content/uploads/2017/02/policy-2-5-suicide-assessment.pdf
[8] http://www.umhs-adolescenthealth.org/wp-content/uploads/2017/02/psych-emergencies-policy-procedure-draft.docx
[9] http://www.umhs-adolescenthealth.org/wp-content/uploads/2017/06/rahs-procedure-for-reporting-child-abuse-2.pdf
[10] http://www.umhs-adolescenthealth.org/wp-content/uploads/2017/06/rahs-procedure-for-reporting-domestic-abuse.pdf
[11] http://www.umhs-adolescenthealth.org/improving-care/health-center-materials/

IDENTIFYING RISKS AND IMPROVING OUTCOMES
FOR ADOLESCENT PATIENTS



High-Risk Behaviors

High-risk behaviors are the **primary causes of morbidity and mortality** in adolescent patients (ages 12 to 21):[1]

- **» Substance abuse**
- **» Unsafe sexual activity**
- **» Interpersonal violence**
- **» Suicide**

of adolescents receive recommended screening and counseling for high-risk behaviors[2,3]

Why Confidentiality Matters

- Adolescents are **more likely to discuss high-risk behaviors** if they believe their care is confidential.[2,4,5]
- Adolescents **answer confidential screenings more honestly**.[6]
- State and national **laws allow minors to receive confidential care** related to sexual health, mental health, and substance abuse.

Barriers to Confidential Care

There is **low knowledge about minor consent laws.**[7,8,9]

Less than half of adolescents receive a yearly well or preventative exam. **Most do not spend any time alone with their provider** during that visit.[10]

Providers have noted a **lack of expertise, insurance issues,** and **concerns about medical records**.[11]

Advantages of Screening Tools

- Screening tools **provide a comprehensive picture** of the patient.
- They **increase efficiency and effectiveness of care**, allowing physicians to tailor their conversations with patients.
- When paired with effective counseling and intervention, **they can make a significant impact on adolescent high-risk behaviors.**[12]

ADOLESCENT HEALTH INITIATIVE
UNIVERSITY OF MICHIGAN HEALTH SYSTEM

Example of a Confidential Work Flow

1. At check-in, front desk staff gives parent/guardian and patient a letter about confidential time with adolescent patients.
2. Medical Assistant (MA) calls patient, explains to parent/guardian, "I'll be bringing your child back to get their vital signs and have them complete a brief health survey. Then I'll bring you to the room."
3. MA places patient in an exam room, has them complete the screening tool, brings the results to the provider to review, and then brings back parent/guardian.
4. Provider meets with parent/guardian and patient, and then asks the parent/guardian to step out for confidential time. Provider then discusses the risk screen confidentially with the patient.

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Vermont Child Health Improvement Program
UNIVERSITY OF VERMONT COLLEGE OF MEDICINE

Is Your Adolescent getting READY for Life?
The Adolescent Health Supervision Visit

As your child becomes an adolescent, the hormonal shifts common during puberty result in emotional and physical changes. This transition can feel overwhelming; your teen's health care provider is one person who can guide you both through this journey. Yearly check-ups, also called health supervision or well care visits, are often overlooked but can provide you with the tools to successfully transition your teen through adolescence.

Is a Well Care Visit a Sports Physical?
Some schools require athletes to provide proof of a physical exam before participating in sports. This exam is simply intended to evaluate one's physical ability to safely participate in sports. Well care visits allow for a more thorough physical exam and health screen. They also provide the opportunity to address other important teen issues.

What happens during an adolescent's Well Care Visit?
The provider will review several areas of development and preventative health topics. The provider can measure BMI and give advice about nutrition and physical activity. Well care visits through middle and high school also provide a chance to review your teen's vaccine history and discuss other recommended vaccines. Screening tests may be recommended (vision and hearing screening, testing for anemia, or screening for hidden infections such as tuberculosis or chlamydia).

What about my adolescent's behavior and emotional health?
Teens are surrounded by confusing messages from the media and peers who may be making unhealthy choices. This visit allows your teen the chance to discuss sensitive topics and address problems early. Some of these topics may include drugs and alcohol, eating disorders, depression, anxiety, puberty, and sexuality. The majority of teen fatal and non-fatal accidents are preventable, and well care visits can provide guidance teens need to make good decisions and decrease their risks of injury.

What can I do to protect my adolescent from risky behavior?
Reinforcing strengths or assets can protect teens from risks and help them get READY for life. Your doctor may ask your teen about their strengths:
R for Relationships: Is your teen learning to form healthy relationships with peers, teachers, and coaches? Does he feel he belongs or fits in at school and in the community? Does he have at least one adult he can go to if he is has a problem to discuss? What about romantic relationships?
E for Energy to get things done. Does your teen have enough energy to get school work done and have fun? If not, why not? Is there a health problem, not enough sleep, or could she be depressed?
A for Awareness of the world and how one fits in. Does your teen have opportunities to contribute in the family, at school, in the community? Is he developing a sense of honesty, kindness, empathy, and generosity?
D for Decision maker. Is your teen learning how to make healthy, independent decisions about her health and behavior choices? Can you help her be a better decision maker?
Y for saying Yes to healthy behaviors – Does your teen eat well, sleep well, work hard and play hard?

What about confidentiality and privacy during my adolescent's Well Care Visit?
Allowing your teen the space to freely discuss any health issues with the doctor ensures that important health issues will not be overlooked due to embarrassment, shame, or fear. This also helps create confidence in your teen's ability to handle their own healthcare as they transition into adulthood.

Physical Health

Tobacco, Drugs & Alcohol

Mental Health

WE ARE HERE FOR YOU

Vaccines & Screens

Stress & Anxiety

Sexual Health

ASK US ANYTHING

CONFIDENTIAL HEALTH CARE

ALL Are Welcome Here

Adolescent Well Care Visits

Don't have a doctor? Talk to your school nurse.

VCHIP
Vermont Child Health Improvement Program
UNIVERSITY OF VERMONT LARNER COLLEGE OF MEDICINE

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Achieving Quality Health Services for Adolescents

COMMITTEE ON ADOLESCENCE

This update of the 2008 statement from the American Academy of Pediatrics redirects the discussion of quality health care from the theoretical to the practical within the medical home. This statement reviews the evolution of the medical home concept and challenges to the provision of quality adolescent health care within the patient-centered medical home. Areas of attention for quality adolescent health care are reviewed, including developmentally appropriate care, confidentiality, location of adolescent care, providers who offer such care, the role of research in advancing care, and the transition to adult care.

INTRODUCTION

The American Academy of Pediatrics (AAP)-endorsed patient-centered medical home (PCMH) model has transformed the delivery of primary care in the United States and offers newly defined measures of quality.[1] Coupled with *Bright Futures*,[2] an evidence- and expert opinion-based guide on how best to provide clinical care for adolescents, a new blueprint for quality health services has emerged. Advanced and open-access models of care delivery have improved efficiency and decreased wait time for patients. Continuity of care with a primary care provider, electronic health record use for population management, and implementation of evidence-based guidelines for preventive care have significantly progressed. Focus on preventive care with attention to specific quality measures, such as those within the Healthcare Effectiveness Data and Information Set (HEDIS),[3] which consists of 81 measures across 5 domains of care, allow for an objective measurement of quality care delivery. A renewed attention to patient satisfaction strengthens the provider-patient relationship. In addition, greater attention to transition of care may allow the opportunity for an easier move from adolescent to adult care. Despite these significant advances, unique challenges to achieving quality health care for adolescents remain in areas such as access to care, provider availability, confidentiality, the

abstract

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electronic health record, and adult transitions for adolescents with chronic health conditions.

EVOLUTION OF THE MEDICAL HOME AS QUALITY HEALTH CARE

The conceptual framework by which a primary care practice intends to improve the quality, efficiency, and patient experience of care has evolved since the middle of the 20th century. The AAP first introduced the term "medical home" in 1967 to describe the need for a central location of archiving a child's medical records. This medical home primarily focused on children with special health care needs.[4] By 1992, the AAP broadened the concept of a medical home to include an identifiable, well-trained primary care physician to promote quality care for all children and adolescents. In the 2002 revision of its 1992 statement, the AAP reiterated and enhanced its explanation of care under this model known as the medical home, retaining the 1992 principles of medical care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective, and then expanded an operational definition to include 37 specific activities that should occur within a medical home.[5] Similar models of adult primary care were concurrently proposed by other medical organizations.

In 2007, the AAP joined the American Academy of Family Physicians, the American College of Physicians, and the American Osteopathic Association to endorse the "Joint Principals of the Patient-Centered Medical Home,"[1] which describes 7 core characteristics:

1. Personal physician for every patient.
2. Physician-directed medical practice.
3. Whole-person orientation.
4. Care is coordinated and/or integrated.
5. Quality and safety are hallmarks of PCMH care.
6. Enhanced access to care.
7. Appropriate payment for providing PCMH care.

The PCMH, a physician-led, team-based model of whole-person primary care intended to improve quality and efficiency of care, has been adopted by many stakeholders in addition to professional associations, including payers and policy makers.[6] The Agency for Healthcare Research and Quality defines the PCMH as a way to improve health care in America by transforming how primary care is organized and delivered.[7] Increased focus on improving the quality of health services in the United States through the PCMH model has led to a directed effort toward improving access to care, with more timely delivery of services, continuity of care with a primary care provider, patient satisfaction with care, and positive measurable outcomes resulting from care.[8–15] The PCMH uses these quality elements as its cornerstone and is a widely accepted means of achieving quality health service reform.[1,5] Voluntary certification of PCMH status assesses practice structural capabilities to meet the requirements of PCMHs. Certification is provided by a number of organizations, including the National Committee on Quality Assurance,[16] The Joint Commission,[17] the United States Military Health System,[18] and other certifying organizations.

THE PCMH SHIFTS FOCUS FROM QUANTITY TO QUALITY

Traditional productivity measures of quantity of care focus on business outcomes, which, in a fee-for-service system, assist in measuring revenue generation and complexity of care delivered. In such a model, the health care system is rewarded when providing a high volume of care, particularly face-to-face care, because those visits generate the most revenue. From the patient's vantage point, this model promotes brief, episodic, discontinuous, acute illness-centric care. The result can be care that is not cost-effective, efficient, or guided by published recommendations, without sufficient regard for quality in the context of the whole patient. Access to care, continuity of care, and satisfaction with care are potentially excluded. This system may perpetuate a health and wellness trajectory in a negative direction.[19]

In contrast, the PCMH revolves around the patient-physician relationship. In this model, patient-based outcomes are at the forefront: access to care, continuity of care, confidentiality of care, preventive care, and measurable health outcomes, such as HEDIS quality measures. The PCMH reorients outcome measures of care away from provider- and system-based metrics of quantity of care and toward patient-centered metrics of quality of care. This model of care, if it includes appropriate payment by private-sector and government payers, encourages continuous, comprehensive, and preventive care that promotes wellness. This system rewards cost-effective care and promotes improvement in patient health to promote high-quality health care at reduced costs. This model transforms a health care system to a system of health.[19]

EFFECTIVENESS OF THE PCMH

The nascent research on the effectiveness of PCMH for child and adult health care is promising.[20] PCMHs with open-access scheduling have been shown, in multiple managed care systems, to increase access and continuity of care; improve outcomes; increase

productivity, with relative value unit gains of as much as 17% per encounter; raise total revenue per visit; increase physician compensation; provide more efficient clinic operations, with decreased use of urgent-care services; and improve patient and provider satisfaction, all while reducing health care costs.[21–26] Not all studies have found short-term cost-savings, however.[27,28] By using claims data, one study found that participation in a multipayer medical home pilot of National Committee for Quality Assurance–certified adult practices was associated with limited improvements in quality and was not associated with reductions in utilization of hospital, emergency department, or ambulatory care services or total costs over 3 years. The authors suggested that there may be a need for continued refinement of PCMH practice models within complex health systems.[29] This study reveals the complexity of evaluating PCMH interventions in large multipayer systems and may support the lack of uniformity of success among PCMH practices or a variable latency period between initiating quality improvements and reaching desired outcomes.[30] Transition toward a fully operational PCMH has inherent challenges, and it may take several years to reach maturity and reduce costs in a managed care system.[31–33]

The future direction and modifications of PCMHs will rely on continued research and rigorous evaluation, particularly for health care outcomes for adolescents within PCMHs, for whom little research exists to date. Consistent with lack of research in this area, the ability of the medical home to address the unique health service needs of adolescents is not well defined, and there remain differing approaches to the care of adolescents, such as length of appointment times; availability of confidential time with the pediatric provider; access to confidential services, including confidentiality within the electronic health record and explanation of benefits; and access to adolescent medicine specialists within the PCMH and neighborhood.

Medical organizations recommend that health services provided to adolescents be adolescent oriented, comprehensive, and coordinated and that they promote healthful behavior, manage chronic health conditions, and focus on prevention.[34–36] *Bright Futures* contains evidence-based and expert-informed practice guidelines for adolescent health care providers.[2] However, health services in the United States often are not designed around the adolescent, nor do they usually take into account the unique issues of adolescence that affect their health. As a result, some adolescents face gaps in care, fragmented services, less-than-ideal medical management, missed opportunities for health promotion and disease prevention, and challenges in transition to adult care for young people with chronic health conditions.[37]

ISSUES SPECIFIC TO ADOLESCENCE

Adolescents engage in high-risk behaviors that cause significant morbidity and mortality. Adolescents and young adults have higher incidences of reckless driving, substance abuse, unprotected sex, and violent behavior, compared with adults. Unintentional injuries are the leading cause of death for children, adolescents, and young adults, and alcohol use plays a role in many injuries. Homicide and suicide are the next leading causes of death for adolescents. Recent US high school data reveal that 4 in 10 high school students text or E-mail while driving. Thirty-five percent of high school students drink alcohol, and 23% have used marijuana. In the past year, nearly 15% of high school students were electronically bullied, nearly 20% were bullied on school property, and 8% attempted suicide. Nearly half (46.8%) of US high school students have had sexual intercourse, 34% are currently sexually active, and 15% had sexual intercourse with 4 or more persons during their life. Among currently sexually active students, 59% used a condom during their last sexual intercourse.[38]

Risky and healthy behaviors that are associated with adult morbidity, such as cardiovascular disease, cancer, and diabetes, also have their origins during the adolescent years. Fifteen percent of high school students smoke cigarettes, and nearly 9% have used smokeless tobacco. Few adolescents consume the recommended amount of daily fruits and vegetables, and in the past week, 5% had not consumed any fruit or 100% fruit juice, and 6.6% had not eaten any vegetables. Forty-one percent had played video or computer games or used a computer for something not related to school work for 3 or more hours per day on an average school day.[38] In the context of these and other health behaviors, the PCMH, centered on the patient-pediatrician relationship, may have a significant impact on adolescent and young adult health.

Within the PCMH model of care as well as other health systems, adolescents receive care within a variety of delivery systems with varying access to comprehensive care, specialty care, and coordination of care and from a variety of providers with varied levels of training in adolescent care. The consequences of these variations are largely unknown for the adolescent population.[10] Issues unique to adolescence that are either incompletely or nonspecifically addressed with the PCMH model include developmentally appropriate care, confidentiality, location where adolescents receive care, providers who offer such care, the role of research in advancing care,

and transition to adult care. These measures need to exist within the PCMH to address adolescent care effectively.

The AAP, American Academy of Family Physicians, and American College of Physicians purport that optimal health care is achieved when each person, at every age, receives developmentally appropriate care.[39] Providing quality health care for adolescents requires that pediatricians maintain relationships with families and with community institutions, such as schools or youth development organizations, while maintaining the relationship with each patient.[34,40] In providing quality care for adolescents, pediatricians help patients develop autonomy, responsibility, and an adult identity, and therefore, care should be developmentally appropriate. Developmentally appropriate care for adolescents may require longer appointment times, which may be a challenge to accommodate within a PCMH that serves a broad age spectrum.[13]

Confidentiality, both in determining whether youth receive what they need and whether there are opportunities for private one-on-one time during health care visits, is a major factor that determines the extent to which adolescents receive appropriate care.[41] Confidentiality and privacy issues can pose significant barriers to successful screening, assessment, compliance, and follow-up for adolescents and, therefore, is inextricably intertwined with quality health care for this population.[42–45] Moreover, lack of confidential billing for patients with commercial health insurance provides an obstacle to recommended screening and treatment, particularly for sexually transmitted infections and contraception care.[46]

Even within certified PCMHs, a range of providers may care for adolescents. A common clinical management approach within PCMH is for teenagers to be assigned advanced clinical practitioners, such as nurse practitioners and physician assistants, as primary care providers, because of relatively low utilization rates and generally well health status of this population overall to maximally leverage open- and advanced-access model systems of clinical care.[21,47] With the advent of excellent guidelines for provision of adolescent health care, such as *Bright Futures*, and use of validated quality measures, such as data from HEDIS, this may be an appropriate delivery model for well teenagers, presuming providers are adequately trained in provision of adolescent health care, but research on this topic is lacking. A primary concern is that elements necessary for highest-quality adolescent preventive health care, including additional time for confidential interview and discussion, may not be available in a medical home model focused on short-term cost benefits, when such care limits enrollment numbers and the number of patients available to be seen per day, further limiting access to preventive care in a population that often fails to receive preventive care.[48]

Supporting the health care transition from adolescence to adulthood in the medical home is another challenge for quality adolescent health care. In 2011, a clinical report authored by the AAP, American Academy of Family Physicians, and American College of Physicians reviewed the importance of supporting and facilitating the transition of adolescents with special health care needs into adulthood.[49] Despite renewed attention and effort, widespread implementation of health transition supports as a basic standard of high-quality care has not been realized and has not yet been incorporated into routine adolescent health care in the PCMH.[39]

Within the medical home model of care, and in comparison with other age groups, little research exists regarding adolescent health care. As a result, the impact of the medical home in delivery of quality adolescent health care is still unclear, because it is largely unstudied. Although more research is clearly needed, concerns also exist regarding the ability for the medical home to maintain clinical research activities to produce the types of outcomes data helpful in optimization of the model for adolescents.[50] Addressing these issues now is critical for the future success of adolescent care within the medical home, which remains early in its implementation in the United States.

PRIMARY CARE ACCESS AND UTILIZATION

Adolescents and young adults are among those least likely to have access to preventive health care, and they historically have the lowest rate of primary care use of any age group in the United States.[48,51] One analysis based on claims data from a 700 000-member health plan in Minnesota revealed that one-third of adolescents with 4 or more years of continuous enrollment had no preventive care visits from age 13 through 17 years, and another 40% had only a single preventive care visit.[52] National surveys with past-year preventive visit measures show significant variation across adolescents (43% to 81%) and young adults (26% to 58%).[53] Those with behavioral health diagnoses are especially lacking in access to care, as fewer than half of all adolescents with psychiatric disorders received care within the past year.[54] In 2012, more than 8% of adolescents lacked insurance, and as of 2014, 18.3% of 18- to 24-year-olds are uninsured in the United States.[55] Health disparities are well described among subgroups of adolescents, including those who are homeless or in the

state child welfare or juvenile justice systems.[56,57] Lesbian, gay, bisexual, and transgender adolescents are at highest risk of lacking access to primary care and behavioral health services.[58] Further access challenges exist for adolescents in more rural areas, as well as those who have difficulty negotiating the health care system or live in poverty and lack insurance coverage.[57] The Patient Protection and Affordable Care Act[59] shows promise in improving preventive care of young adults and adolescents.[60] Among those 10 to 17 years old, Healthy People 2020 data reveal that the proportion of adolescents who have had a well-patient visit in the past 12 months increased by 9.6% from 2008 to 2013.[61] The Affordable Care Act may continue to improve access to preventive health care for many adolescents, but its implementation and access to services provided vary by state.

School-based health centers (SBHCs) provide convenient preventive health services for a small number of adolescents and young adults. They serve as a model for improving the linkage between health and education and community systems to improve preventive and primary care. SBHCs may further provide an entry point and source of primary care, with ongoing connections to a medical home, for children who do not otherwise have access to consistent care.[62] There are more than 130 000 schools in the United States serving students in kindergarten through 12th grade. According to the School-Based Health Alliance 2013–2014 census report, there are 2315 SBHCs that serve US students and communities in 49 of 50 states and the District of Columbia. Eighty percent of SBHCs provide care for students in grade 6 and above. More than half of SBHCs serve populations in addition to students in the school, such as students from other schools, family members of student users, out-of-school youth, school faculty and staff, and other people in the community. Although half of SBHCs are in urban areas, the largest growth of SBHCs has been in rural areas, accounting for nearly 60% of new SBHCs since 2010, and addressing unique challenges to rural youth access to quality primary, behavioral, and oral health care.[63]

Although household surveys indicate that most adolescents receive their primary care in a doctor's office or clinic, approximately 10% of adolescents rely on the hospital or emergency department as their usual source of care.[10] Among adolescents who received care, studies using national compliance rates data from the Medical Expenditures Panel Survey have shown that rates of preventive counseling, health promotion, and screening were low. Only half of adolescents received care that followed recommended guidelines, such as those for annual well-patient visits, confidential and comprehensive health screening, and immunizations.[48,64,65]

Adolescents with chronic medical needs face additional challenges within the medical home model.[39] The ability of primary care providers within a medical home to effectively manage chronic disease, considering time requirements, has been questioned.[66] Models of care encouraged in PCMH that address chronic health care needs include dedicated care coordinators and patient-care teams,[14] as well as population health registries, such as chronic disease, high-risk, high-utilizer, and transition registries. Solutions within the medical home for adults who have complex health needs and require both medical and social services and support from a wide variety of providers and caregivers have been proposed, but the feasibility for smaller practices, including those that care for pediatric and adolescent patients with complex needs, remain unclear.[67]

A further complicating factor is that adolescents and young adults, especially those living in poverty, are more likely to be uninsured than any other age group. Beginning in 2014, the Affordable Care Act required state Medicaid programs to cover adolescents 16 through 18 years of age in families with incomes up to 133% of the federal poverty level. States can also choose to expand their Medicaid programs to 133% of the federal poverty level for late adolescents and young adults starting at 19 years of age. Even under the Affordable Care Act, which provides this extended eligibility for Medicaid and access to private coverage through state exchanges, people living in poverty may remain uninsured, particularly in states that opt to not expand Medicaid.

ELECTRONIC HEALTH RECORDS AND HEALTH INFORMATION TECHNOLOGY

The electronic health record offers remarkable opportunity to improve the quality of care for adolescents within a PCMH and also offers unique challenges. The AAP, among other organizations, recommends standards for health information technology to help protect adolescent privacy.[68–70] Challenges to privacy for adolescents posed by commercial health information technology systems require the creation and implementation of electronic health record systems that do not impede access, continuity, privacy/confidentiality, or quality of care for adolescents. The AAP also offers specific recommendations for health information and the medical home to promote confidentiality, continuity of care, patient-care transitions, and overall quality of care. These include criteria for electronic health records that encompass flexibility and specific technological capabilities and are compatible with state-specific laws as well as billing systems.[69] Requirements regarding explanations of benefits add additional

confidentiality concerns relevant to the medical visit for the privately insured adolescent, and strategies to address or mitigate the potential for inadvertent confidentiality breeches associated with explanations of benefits vary widely by state.[71] Current electronic health record and billing systems afford an opportunity to prompt providers to address adolescent-specific needs of the patient, to document adolescent health care compatible with current recommendations, and to provide data for process improvement in care for adolescents. Electronic health record and billing systems also allow for meaningful use of data, portals for patients to access their own electronic health records, secure messaging systems to expand access for adolescents to their health care team, and the opportunity for improved patient education through patient instruction sheets and other electronic means. Despite many systems in place, these opportunities are, as yet, not fully realized, and their effectiveness has not been well studied.[70–72]

QUALITY MEASURES FOR ADOLESCENT HEALTH CARE

Although multiple data sets and measures currently exist in the United States, there is no robust national information system that can provide timely, comprehensive, and valid and reliable indicators of health and health care quality specifically for adolescents. The health of adolescents is influenced by multiple factors, including biology, behavior, and social and physical environments. It is also influenced by the availability, use, and quality of health care services, especially for those with life-threatening conditions or special health care needs who require frequent interactions with health care providers. Therefore, understanding the health status of adolescents is closely intertwined with understanding the quality of health care they receive. Health and health care measures can be used to assess the effects of many variables and inform improvements to adolescent health quality. In response to a mandate in the Children's Health Insurance Program Reauthorization Act of 2009 (Pub L No. 111-3), the Institute of Medicine and the National Research Council of the National Academies, under contract with the US Department of Health and Human Services, conducted an 18-month study concluding that, although multiple and independent federal, state, and private data sources exist that include measures of health and health care quality of children and adolescents, the existing data sources are fragmented, not timely, and insufficiently robust as a whole; lack standardization in measurements; and reveal an absence of common definitions.[73] The recommendations of that study included setting goals for child and adolescent quality measures, including adolescent measures in annual reports; standardizing measurement disparities in health and health care quality; improving data collection, reporting, and analysis; and improving public and private capacities to use and report data.

HEDIS outcomes within an adolescent medical home–enrolled population allow a practice to monitor the preventive health status for specific disease elements deemed important to the practice. HEDIS provides objective measurement of patient-centered quality care delivery. Limitations of HEDIS measures as markers of quality adolescent care are that they are relatively few in number, disease specific, and dependent on the practice to record and track the data. Similarly, a set of quality health care measures for Medicaid and the Children's Health Insurance Program, known as the child core set, allow for states to voluntarily report their quality metrics and may serve as reasonable early measures for a practice to adopt (http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-child-core-set.pdf).

One area for improvement of quality measures includes using adolescents themselves as sources of measurement data. Adolescents have been found to be more valid and reliable than chart review and other data sources in reporting their experiences with preventive care.[74–76] However, even health systems that measure patient satisfaction with care do not directly query adolescents younger than 18 years. Although standardization of clinical care and the process of care within the medical home may provide much progress toward the goals outlined in this policy statement, it is important that this process be accompanied by similarly standardized and rigorous research methods in measures of quality and quality services for adolescents.[23,77]

RECOMMENDATIONS

The AAP recommends the following:

1. Adolescents should receive comprehensive, appropriately confidential, developmentally appropriate primary care, as recommended by AAP guidelines (*Bright Futures*), within a medical home.
2. Feasible, valid, and reliable quality measures should be developed and implemented that use adolescent self-reported data to help assess the quality of preventive care provided to youth. In addition, existing measures that were developed in association with initiatives designed to improve the care delivered to adolescent patients should be cataloged and improved for use by external quality-measurement organizations.

3. Research on the effectiveness of the PCMH to achieve specific adolescent quality outcome measures is necessary to gauge the impact, and guide the future direction, of the medical home on the health of adolescents.
4. Adolescent access to care, continuity of care, confidentiality of care, preventive care, and desired measurable health outcomes should be rewarded by private-sector and government payers to promote high-quality adolescent health care.
5. Electronic health records and associated billing and notification systems should protect the confidentiality of care for adolescents. Electronic health records should be configured with templates that are compliant with *Bright Futures* and HEDIS measures.
6. PCMHs that care for adolescents should plan for a well-timed and well-executed transition to adult care, especially for adolescents with chronic health conditions.
7. Pediatricians and other adolescent health care providers from multiple disciplines should receive professional education about effective strategies for delivery of high-quality adolescent primary care, in accordance with *Bright Futures* guidelines. Educational opportunities currently exist to improve quality through Maintenance of Certification part IV activities as offered by the American Board of Pediatrics.

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ABBREVIATIONS

AAP: American Academy of Pediatrics
HEDIS: Healthcare Effectiveness Data and Information Set
PCMH: patient-centered medical home
SBHC: school-based health centers

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Achieving Quality Health Services for Adolescents

COMMITTEE ON ADOLESCENCE

Pediatrics 2016;138;
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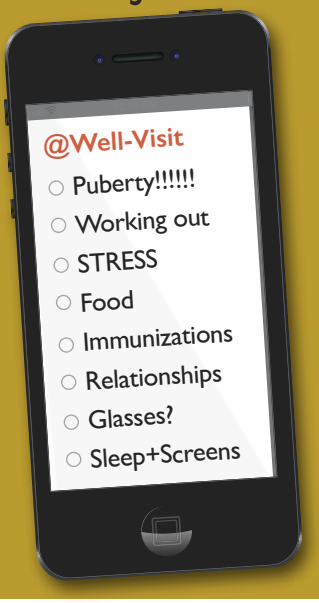
adolescents & young adults

do they still need a WELL-VISIT?

a.k.a.
Annual Visit
Well-child Visit
Yearly Check-Up
Wellness Exam
~~Sports Physical~~ not the same thing

what?

This preventive health care visit focuses on healthy physical and emotional growth. It includes a health assessment, physical exam and offers guidance on teen and young adult health and well-being.



when?

1x every year

Teens & young adults should receive a well visit annually.

where?

Visit your family practice doctor or pediatrician – or ask at any local clinic.

who?

At a well-visit, young people meet with health experts **privately** and **together** with their care-givers.

care team
- Doctor
- Nurse
- Physician's Assistant

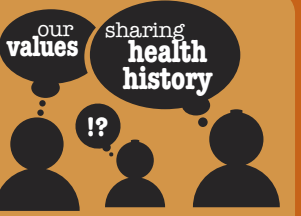
home team
- Teens
- Young Adults
- Families & Care Givers

why?

HEALTHY ADULTING

- Advocating for and managing health
- Navigating the health care system
- Building a relationship with health provider

adolescence is a time of **physical, social** and **emotional** growth with unique **health** challenges and opportunities



good time for a **family health talk**

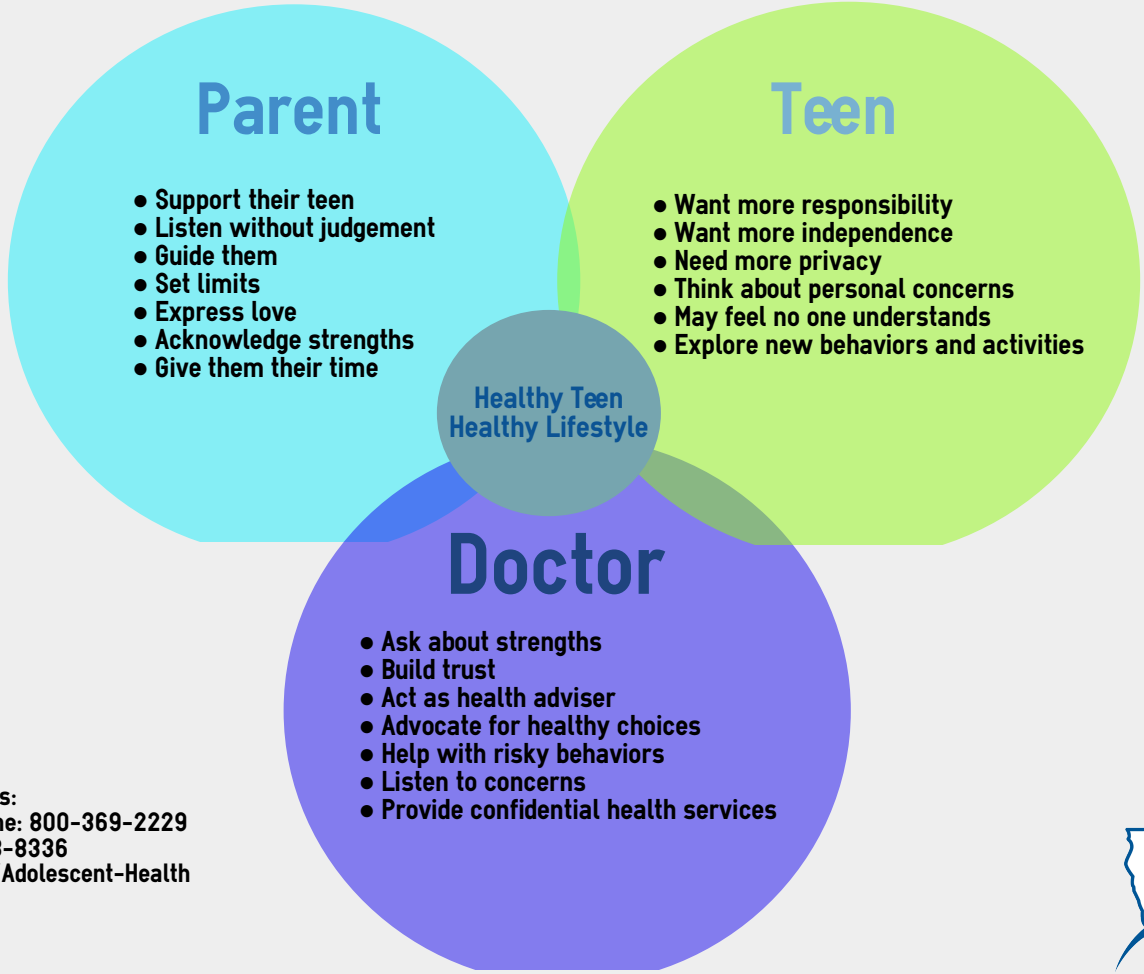
American Academy of Pediatrics liked
Centers for Disease Control Retweeted

TheRealBenFranklin@1706...
An ounce of #prevention is worth a pound of cure.

Supported (in full or in part) by Grant # U45MC27709 from the Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (Title V, Social Security Act), Division of Child, Adolescent and Family Health, Adolescent Health Branch

Understanding the Roles

Teens experience many changes, from physical and emotional changes to social roles and relationship changes. Creating healthy behaviors early on will play an important role into adulthood. Teens need involved parents and doctors. However, they also need privacy.



Additional Resources:
Healthy Families Line: 800-369-2229
TEEN Line: 800-443-8336
www.idph.iow.gov/Adolescent-Health

IDPH
Iowa Department of Public Health

5 Things

PARENTS NEED TO KNOW ABOUT THE *Adolescent Well Visit*

01

When should teens get a well visit?

The American Academy of Pediatrics recommends that adolescents and young adults to get a well visit every year.

02

What happens at the well visit?

A well visit is more than a physical exam. The visit also includes discussion of other health related topics or anything that is troubling either you or your child.

03

How much does it cost?

Most insurance companies will have NO charge for an annual well visit.*

* check with your insurance company

04

Why should I take my teen to a well visit?

Getting a well visit helps identify and guide your teen's behaviors. It also allows the opportunity to ask a professional any questions.

05

A well visit isn't just for teens!

Teens tend to follow in their parent's footsteps. Schedule a well visit for yourself which will help to encourage your teen to get a well visit.

#EveryAgeEvenTeenage

Additional Resources:
Healthy Families: 800-369-2229
www.idph.gov/Adolescent-Health

IDPH

5 things YOU need to know about the Adolescent Well Visit

The well visit is more than a physical

It includes discussion of health topics

The well visit is recommended every year

The doctor will respect your privacy

The doctor can talk about any of your personal concerns

Don't be embarrassed or afraid of being honest

#EveryAgeEvenTeenage

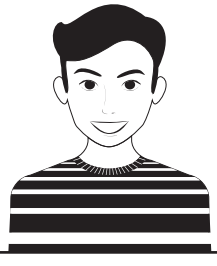
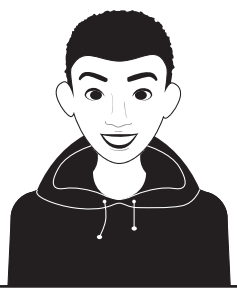
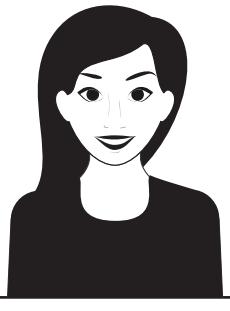
Additional Resources:
TEEN Line: 800-443-8336
www.idph.iowa.gov/Adolescent-Health

IDPH Iowa Department of Public Health

TAKE CHARGE OF YOUR HEALTH CARE

Throughout your teenage years, there are opportunities for you to take charge of your health and your health care. Your parents or guardians may currently help you do things like make appointments, fill prescriptions, and keep track of any medications you might take. As you get older, it's important for you to learn how to do these yourself.

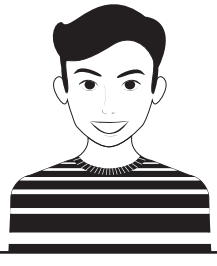
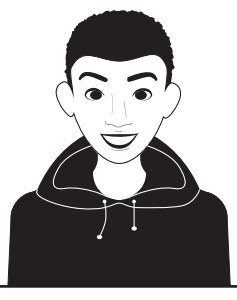
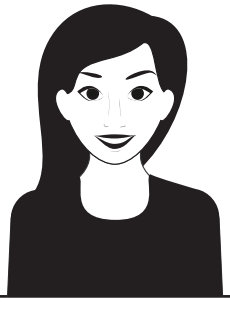
Take a look at the chart below for ideas on how to access health care on your own. The age ranges and tips presented on this chart are just suggestions. Try out those that feel most comfortable to you. Any progress you make helps set you up for a healthy future!

AGE 11–12	AGE 13–14	AGE 15–16	AGE 17–18
☑ Know your health care rights. ☑ Learn your personal and family medical histories, including any medications and allergies. ☑ Know your medications and take them on schedule. ☑ Talk directly with the health care provider at your appointment: Be honest and ask questions.	☑ Ask to spend time alone with your health care provider during your visit. ☑ If available, set up an online portal to view medical information and message your health care provider. ☑ Check in for your appointment yourself.	☑ Make your own appointments. ☑ Call your pharmacy to refill your prescriptions. ☑ Know how to contact all of your health care providers (doctor, dentist, etc.). ☑ Learn about your health insurance and carry your card. ☑ If you don't have insurance, ask about your options.	☑ If you are moving away from home or need to switch to an adult care provider, make a plan for where you will receive health care next. ☑ Transfer your medical records to your new health care provider, if applicable. ☑ Ask your health care provider what your privacy rights will be when you turn 18. ☑ Make sure you will still have health insurance after turning 18. If you won't, talk to your health care provider about options.
			

TAKE CHARGE OF THEIR HEALTH CARE

Your child's teen years are an excellent time to set them up for a healthy future! You have the opportunity to help them learn and care about their health. Just like you support your teens to develop skills, like cleaning up after themselves and driving, you can also help them learn how and why their health is important.

This chart provides some suggestions about how teens can become more involved in their health care. Different teens will be ready to take these steps at different times. Your health center can partner with you and your teen to put these tips into practice.

AGE 11–12	AGE 13–14	AGE 15–16	AGE 17–18
☑ Know your health care rights. ☑ Learn your personal and family medical histories, including any medications and allergies. ☑ Know your medications and take them on schedule. ☑ Talk directly with the health care provider at your appointment: Be honest and ask questions.	☑ Ask to spend time alone with your health care provider during your visit. ☑ If available, set up an online portal to view medical information and message your health care provider. ☑ Check in for your appointment yourself.	☑ Make your own appointments. ☑ Call your pharmacy to refill your prescriptions. ☑ Know how to contact all of your health care providers (doctor, dentist, etc.). ☑ Learn about your health insurance and carry your card. ☑ If you don't have insurance, ask about your options.	☑ If you are moving away from home or need to switch to an adult care provider, make a plan for where you will receive health care next. ☑ Transfer your medical records to your new health care provider, if applicable. ☑ Ask your health care provider what your privacy rights will be when you turn 18. ☑ Make sure you will still have health insurance after turning 18. If you won't, talk to your health care provider about options.
			

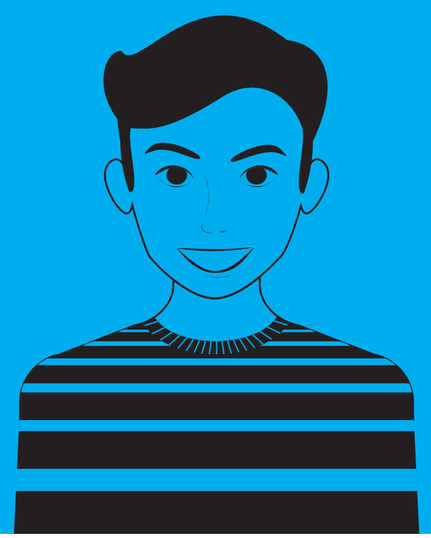
TAKE CHARGE OF YOUR HEALTH CARE

Created by:

ADOLESCENT **HEALTH** INITIATIVE

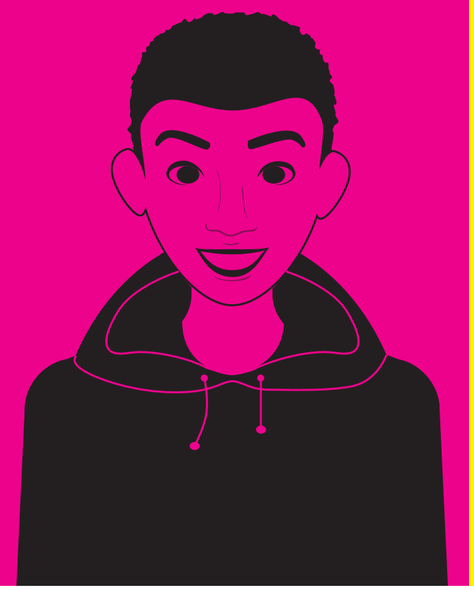
AGE 11–12

- ☑ Know your health care rights.
- ☑ Learn your personal and family medical histories, including any medications and allergies.
- ☑ Know your medications and take them on schedule.
- ☑ Talk directly with the health care provider at your appointment: Be honest and ask questions.



AGE 13–14

- ☑ Ask to spend time alone with your health care provider during your visit.
- ☑ If available, set up an online portal to view medical information and message your health care provider.
- ☑ Check in for your appointment yourself.

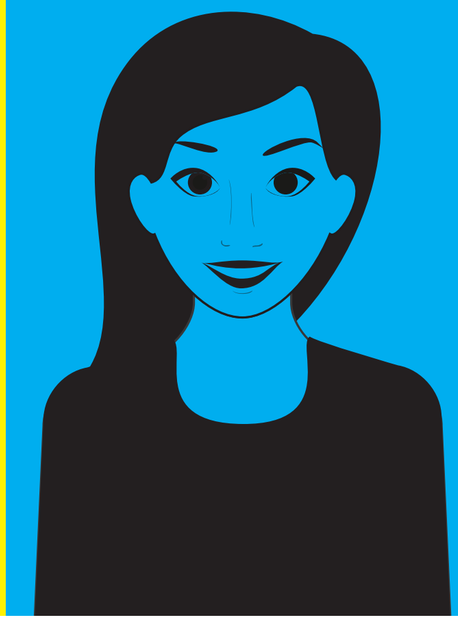


AGE 15–16

- ☑ Make your own appointments.
- ☑ Call your pharmacy to refill your prescriptions.
- ☑ Know how to contact all of your health care providers (doctor, dentist, etc.).
- ☑ Learn about your health insurance and carry your card.
- ☑ If you don't have insurance, ask about your options.

AGE 17–18

- ☑ If you are moving away from home or need to switch to an adult care provider, make a plan for where you will receive health care next.
- ☑ Transfer your medical records to your new health care provider, if applicable.
- ☑ Ask your health care provider what your privacy rights will be when you turn 18.
- ☑ Make sure you will still have health insurance after turning 18. If you won't, talk to your health care provider about options.



BARRIERS to increasing adolescent and young adult (AYA) well-child exams

Increasing adolescent well-child exam rates is a genuine challenge for clinics. Parents and adolescents may not see the value in well-child exams. And adolescents typically won't make these appointments themselves and come in independently for a check-up. There are issues with access, as sometimes it can take months to get in for a well-child exam, which is frustrating for families.

STRATEGIES for adolescent risk screening

Provide education for parents and families.

- Provide information for families detailing what happens in the well exam. Here[1] is an infographic from the Adolescent & Young Adult Health National Resource Center that includes key points about the value of well-visits for parents of AYA.
- Explain why it is important to do appropriate risk screening. Here[2] is an AAFP article discussing why risk screening is important.
- Discuss the importance of counseling on healthy behaviors, catching people up on immunizations, and the need for appropriate screening labs for some patients.

Send reminders to parents, AYAs, and families.

- Have automatic mailings, texts, emails, or calls reminding patients to make appointments for yearly check-ups.

Change your scheduling paradigm.

Adolescents don't often come in for a yearly well exam, but they are usually seen at least once a year for an acute visit. Therefore, have systems in place where that acute visit can be changed to be acute/well visit whenever possible.

- Train the schedulers/call center/front desk staff to schedule a well visit instead of acute visit when possible.
  - When an adolescent or parent calls, if the AYA hasn't been seen for a well visit in the past year and does not have one scheduled, a prompt can come up in your scheduling system that tells your scheduler to schedule the appointment as a well visit instead of an acute visit.
  - This can be tricky with timing, but can happen if they have room for an extended visit during that time slot, or if you have the capability to have a little bit of wiggle room in your schedule to accommodate a well visit in an acute spot.
- Schedule a future well exam at the same time you schedule an acute appointment.

Use your EHR as a tool to increase well-child rates.

- Providers can have a prompt that reminds them that the patient is due for a well exam, and they may be able to transition an acute appointment into a well visit upon seeing that cue.

Do a well-child exam for sports physical visits.

- If you see a patient who is scheduled for a sports physical who hasn't had a well visit, the sports physical should be rolled into a comprehensive well exam whenever possible.
  - It's very rare to die from sudden cardiac disease, but it's very common to get chlamydia or have depression, and so providers should focus in issues that have significant morbidity for AYA patients.
- Sports physical season is an excellent time to capture young people who need well exams, but it also requires an office to be very facile about accommodating a large number of patients for these visits. Some strategies to consider include adding a Saturday clinic or evening clinic just for well visits during sports physical season.
- We don't want patients doing mass screenings in a gym setting or going to an urgent care to get their sports physical. We want them coming to their medical home to get a comprehensive well exam. We need to be able to accommodate those, and quickly, during sports physical season

Partner with school-based health centers (SBHCs).

- Communicate with patients who are due for a well exam about visiting their/a local SBHC for this service.
  - SBHCs are almost always staffed with a Nurse Practitioner who can complete the well exam. SBHCs often also have a Social Worker on site who can offer additional behavioral health support. Find and connect with SBHCs in your area.
  - If you and the SBHC use a shared EHR, you can pull reports of patients who have been seen at both sites. Care coordinators can help patients coordinate care between PCPs and SBHCs and ensure that care is provided across the continuum.
- PCP payment may hinge on meeting quality measures including well-child exams, and it doesn't matter where the patient gets the physical, so creative partnerships may improve your bottom line.
- Read the AAP's Policy Statement[3] on SBHC/PCP collaboration.

ADDITIONAL RECOMMENDATIONS

- The NAHIC has a helpful summary[4] of recommended guidelines for clinical preventive services for young adults (18-26). This can be helpful and easily referred to during clinical practice.

[1] http://nahic.ucsf.edu/wp-content/uploads/2018/01/Full-customizable-package.pdf
[2] http://www.aafp.org/afp/2012/1215/p1109.html
[3] http://pediatrics.aappublications.org/content/129/2/387
[4] http://nahic.ucsf.edu/yaguidelines/

the adolescent and young adult well-visit FAQ

A GUIDE FOR FAMILIES

What is an Adolescent Well Visit?

A well visit is a yearly checkup with a health provider for young people (ages 11-21).

The goal is to keep your child healthy, and allow them to get their important health questions answered.

1x every year

Teens and young adults should receive a well visit annually.

What happens at a Well Visit?

Health providers (e.g., doctor, nurse practitioner, physician's assistant):

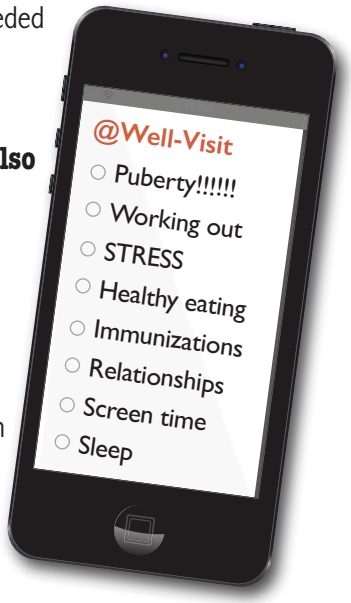
- Conduct a physical exam, height/weight and blood pressure check
- Check for behavioral and mental health concerns
- Give advice and support on staying healthy (e.g., healthy eating physical activity, healthy relationships, stress management)
- Give Immunizations as needed

My adolescent just had a Sports Physical. Do they also need an Adolescent Well Visit?

YES. The Well Visit addresses important issues that are not covered in a Sports Physical.

A Sports Physical is a limited exam that only evaluates health issues that would prevent participation in sports.

Ask your provider if both can be done at the same time.



Why is the Well Visit important – even when my adolescent is feeling well?

Maintains Good Health

It's an important opportunity to discuss healthy development and other important information with adolescents and their parents/caregivers.

Develops Skills

Spending time alone with a health care provider helps young people learn to

- Take charge of their health
- Build trusting relationship with their providers
- Discuss health topics important to them.

Helps Families Communicate

Families help adolescents understand their health history, and learn how to schedule appointments.

HEALTHY ADULTING

- 👉 Advocating for and managing health
- 👉 Navigating the health care system
- 👉 Building a relationship with health provider

Learn More

Supported (in full or in part) by Grant # U45MC27709 from the Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau (Title V, Social Security Act), Division of Child, Adolescent and Family Health, Adolescent Health Branch

UPDATE: JULY 2017

Comparison of the Adolescent Well Care Visit and Pre-participation Physical Evaluation



Oregon Health Authority

PUBLIC HEALTH DIVISION
Adolescent and School Health

TRANSFORMATION CENTER
Health Policy & Analytics Division

OREGON SCHOOL ACTIVITIES ASSOCIATION
OSAA
SINCE 1918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Executive summary

Comparison of the Adolescent Well Care Visit and Pre-participation Physical Evaluation was created through a partnership between the Oregon Health Authority and the Oregon School Activities Association to help organizations understand the differences between the Adolescent Well Care Visit (AWV) and the Pre-participation Physical Evaluation (PPE), also known as a "sports physical." These organizations include Oregon's school districts, schools, athletic departments, school-based health centers, adolescent primary care providers, private insurers and coordinated care organizations. Student athletes benefit from both the AWV and the PPE:

- The AWV has a stronger sense of development and overall health and well-being.
- The PPE has focused screening for medical conditions or injuries (primarily cardiovascular and musculoskeletal, respectively) which may be worsened by athletic activity (a sample PPE form has been included on pages 9-11).

This publication emphasizes that schools and providers should encourage student athletes to complete both evaluations as recommended. There is enough overlap between the two methods that a health care provider could complete both assessments at the same time. The table* provides points of comparison to maximize coordination in parental involvement, the health information sought during a pre-visit questionnaire, and the physical exam. It shares recommendations for providers on modifying an AWV or PPE to include elements of both. This coordination will help limit a student's absence from school and sports, and will ensure exams cover all aspects of a student's health during an Adolescent Well Care visit or sports physical.

	Adolescent Well Care Visit (AWV)	Pre-participation Physical Evaluation (PPE) "Sports Physical"
Timing	n/a	Recommend at least six weeks before the start of the sports season. Can take place as early as May to enable use for summer camps.
Periodicity	Annually	Once every two years (state law)
Provider	MD, DO, PA, NP, ND	MD, DO, PA, NP, ND, DC

* The content for this table was sourced from best practices presented in:
Adolescent Well Care Visit (American Academy of Pediatrics' *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*): https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx and Bright Futures Adolescence Tools: https://brightfutures.aap.org/materials-and-tools/tool-and-resource-kit/Pages/adolescence-tools.aspx

Pre-participation Physical Evaluation (American Academy of Pediatrics' *PPE: Physical Evaluation, Fourth Addition*): https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Council-on-sports-medicine-and-fitness/Pages/PPE.aspx

	Adolescent Well Care Visit (AWV)	Pre-participation Physical Evaluation (PPE) "Sports Physical"
Parental Involvement	Parents are encouraged to be involved in the AWV. The patient can be alone, however, for some adolescent visits. Pre-visit questionaries' are confidential based on applicable Oregon law.	Parental involvement needed to ensure accuracy of medical history. Physical and risk screening completed confidentially.
Goals/Priority	**First Priority:** Address concerns of adolescent and parent **Bright Futures Discussion Priorities:** 1. Physical growth and development 2. Social and academic competence 3. Emotional well-being (coping, MH, sexuality) 4. Risk Reduction (tobacco, alcohol, pregnancy, STI) 5. Violence and injury prevention	**Primary goals:** 1. Screen for conditions that may be life-threatening or disabling 2. Screen for conditions that may predispose to injury or illness **Secondary goals:** 3. Determine general health 4. Serve as an entry point to the health care system 5. Provide an opportunity to initiate discussion on health-related topics
Structure/ Components	1. Pre-visit questionnaire and history (supplemental assessment) 2. Developmental Observation: - Observation of parent-child interaction - Development surveillance - School Performance 3. Physical exam, screenings, and immunizations 4. Anticipatory guidance	1. Medical history questionnaire 2. Physical exam and screenings (includes confidential risk screening questions and some anticipatory guidance) 3. Specialty exam (if needed) 4. Optional: Immunization, education 5. Clearance for activity
Pre-visit Questionnaire/ History Forms	Pre-visit includes discussion prompts based on Bright Futures priorities; screening questions on vision, hearing, TB, alcohol, drugs, cigarettes, sex/STI/pregnancy, and anemia; and growth and development questions. Supplemental questions follow Bright Futures priorities in detail (includes detailed questions on nutrition, emotional well-being, etc).	• General medical history • Heart health (family and patient) • Musculoskeletal • Head injury or concussion • Asthma • Diabetes • Medications • Supplements • Allergies • Heat illness • Missing organ • Vision and eye injuries • Nutrition and eating disorder • Sickle cell • Menstruation (anemia) PPE requires specific details in physical health history (including family history). Physical exam gets at risk behaviors influencing health in part.
Immunizations	Screening required: Consult with https://www.cdc.gov/vaccines/schedules/	Screening optional

	Adolescent Well Care Visit (AWV)	Pre-participation Physical Evaluation (PPE) "Sports Physical"
Highlighted Elements of Full Physical Exam and Screenings	1. **Vitals:** blood pressure, height, weight, BMI	1. **Vitals:** blood pressure, height, weight, BMI, pulse
	2. **Vision/Eyes:** acuity (periodicity varies)	2. **Vision/Eyes:** acuity and pupil size
	3. **Skin:** acne, acanthosis nigricans, atypical nevi, tattoos and piercings, signs of abuse, injury	3. **Skin:** MRSA, herpes simplex, signs associated with eating disorders
	4. **Musculoskeletal:** examine back/spine	4. **Musculoskeletal:** full general screen*/ upper extremity
	5. **Genitalia** - **Females:** Sexual maturity rating, visual observation for STIs, pelvic exam if warranted but by age 21 - **Males:** Testicles for hernia, varicocele, masses; sexual maturity rating; and observe for STIs	5. **Genitalia** - **Females:** NA unless part of health maintenance exam - **Males:** (optional) Scrotum for hernia, varicocele, masses. (Not contraindicatied for athletics).
	6. **Breasts: Females** assessed for sexual maturity rating, clinical breast exam after age 20. **Males:** gynecomastia	6. **Breasts:** NA for PPE
	7. **ENT:** Universal hearing screening (once in early, mid, and late adolescence)	7. **ENT:** Hearing if signs of damage, oral ulcers, herpes, leukoplakia (tobacco), nasal polyps, deviated septum
	8. **Cardiovascular:** dyslipidemia (screen* at least once between age 17-21)	8. **Cardiovascular:** vitals, dynamic auscultation of heart, palpation of heart, physical exam for Marfan Syndrome*.
	9. **Anemia:** if positive on risk screen	9. **Anemia:** check for eating disorders through visual observation of height, weight, ear, nose, mouth, throat, abdomen, and skin; and history of injury, neurological conditions, nutrition, and menstrual cycle.
	10. **Tuberculosis:** if positive on risk screen 11. **STIs:** if sexually active 12. **HIV:** universal at least once between age 15 and 18 13. **Pregnancy:** if sexually active without contraception, late menses, or amenorrhea 14. **Cervical Dysplasia:** universal screen at age 21 15. **Alcohol or drug use:** universal risk assess 16. **Depression:** universal screen 17. **Psychosocial/Behavior:** universal assess 18. **Oral health:** screen for fluoride supplementation up to age 16	10. **Central Nervous System:** Upper extremity, neck range of motion, reflexes. 11. **Pulmonary Exam** (bronchospasm test, tobacco) 12. **Abdominal exam** 13. **Risk Behavior:** Stress, Depression, Feeling Safe, Tobacco, Alcohol, Drugs, Steroids, Supplements, Body Image
Anticipatory Guidance	Tied to Bright Futures priorities, and based on patient needs, developmental observation, and stage of adolescence	Related to reduction in risk of injury or sustained absence. Examples: warnings about PED use, teaching self-admin testicular exam, prevention strategies on MRSA

* http://www.osaa.org/sportsmedicine

The state requires that a PPE take place every two years. This offers a unique opportunity for athletes disconnected from the health system to have a wellness exam. Athletes who see a primary care provider for annual check-ups have an opportunity to fulfill the PPE requirement. The following recommendations will help providers maximize care in the assessments.

Recommendations for Providers:

How to modify an Adolescent Well Visit to include all elements of a Pre-participation Evaluation.

- Use the AWV pre-visit screening questions recommended by Bright Futures on physical activity and hobbies. This will help you to broach the subject of school sports.
- Complete PPEs at least six weeks before the start of the sports season. This will allow time for any referrals and follow-up exams. Ideally, you will conduct PPEs in the late spring or early summer for students who participate in fall sports.
- If you know the adolescent to be an athlete, send the parents the comprehensive PPE medical history form prior to the visit. You can also have them obtain it online*.
  - If you do not have the form prior to the visit, then attempt to get a detailed past medical and family history at the visit. The student can fill out as much of the history form as possible. With consent of the adolescent, you or your medical assistant can call a parent to complete the history portion. Then you may review and sign-off on the PPE form. Studies show cardiovascular screening questions are more accurate if the parents help in providing the history.
- Make clear to the student that confidential information provided on the AWV pre-screening questionnaire will not be in the medical history form shared with the parent and school.
- Conduct focused (see above) examinations of the lung, abdomen, heart, and central nervous and musculoskeletal systems.
  - Provider should keep in mind specific recommendations for the cardiovascular/murmur exam, the two-minute musculoskeletal exam, the Marfan screen, and the concussion protocol. These are included on the second page of the OSAA Sports Physical Form found at http://www.osaa.org/sportsmedicine.

* http://www.osaa.org/sportsmedicine

- Assure that you ask appropriate risk behavior questions. Risk behavior questions in the PPE are likely in an AWV.

How to modify a Pre-participation Physical Evaluation to include all elements of an Adolescent Well Care Visit.

- Assure a separate, confidential space is available. This way an athlete can feel comfortable discussing Bright Future's AWV topic areas.
  - This is especially important in an "assembly-line," "locker room," or "station-based" PPE (see Different Formats below).
- Provide previsit questions from Bright Futures/AWV to the student athlete. These can be topical conversation prompts at the time of the visit, for direct anticipatory guidance and to prompt additional physical screens.
- Provide additional screens as necessary (hearing, STIs, pregnancy, cervical dysplasia, and drug or alcohol use, etc.).
- Provide recommended vaccinations for athlete if available or advise to obtain from their primary care provider.
- Complete more thorough examinations of the genitals and breasts, as recommended for the AWV, if private setting is available.
- Based on screening, be prepared to provide pelvic exams which are recommended as needed by age 21.
- Ensure proper claims reporting for the Adolescent Well Visit.

Different Formats for Performing PPE or Sports Physicals

Not all "sports physicals" are equal. Timing, available personnel, and a community's resources, traditions and standards all determine how middle and high school athletes get clearance to participate in sports. Whenever possible, we recommend that athletes receive a sport physical (especially those combined with an Adolescent Well Visit) in an office-based setting, including a School Based Health Center or a patient's primary care home.

- ***The "office-based" examination:*** This type of exam allows privacy for history taking, examination and discussion of specific concerns. It allows for anticipatory guidance and health maintenance (including immunizations), as well as more (but not always sufficient) time. Ideally, the exam takes place in the athlete's medical home. This is where he or she is an established patient with a well-known medical history. An exam at a medical home can be combined with or qualify for an AWV exam***.***

Other sports physical formats will be less than ideal. In addition, these formats may not be conducive to providing a comprehensive well visit. Therefore, avoid the following formats when trying to complete both exams:

- ***The "station-based" examination:*** This is the most appropriate format when performing a mass sports physical at a school or clinic. Athletes proceed through a series of stations. Stations are for height and weight measurements, blood pressure reading, visual acuity, general exam, cardiovascular exam, orthopedic screening, and review of history and final clearance. Ideally, an additional station will focus on risks and behaviors. This can include mental health, sexual health and substance use issues. These topics can be sensitive in the non-medical environment and require provision of confidential space. Station-based exams require multiple volunteer licensed healthcare providers. You may need athletic trainers and coaches to coordinate logistics, if performed at a school.
- ***The "assembly-line" or "locker room" physical:*** A single provider screens a large number of athletes. This occasionally occurs in a medical office, but more often in the school locker room, cafeteria or gymnasium. Although sometimes necessary, you should avoid the assembly-line physical when possible. There is little time to review thoroughly the athlete's medical history. Additionally, it offers little to no privacy for the physical exam or a private discussion of the athlete's history or questions.

School Sports Pre-Participation Examination – Part 1: Student or Parent Completes

Revised May 2017

HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the provider. The provider should keep this form in the medical record.)

Date of Exam: _____

Name: _____ Date of birth: _____

Sex: _____ Age: _____ Grade: _____ School: _____ Sport(s): _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens ☐ Foods ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you do not know the answers to.

GENERAL QUESTIONS	YES	NO
1. When was the student's last complete physical or "checkup?" Date: Month/ Year _____/_____ (Ideally, every 12 months)		
2. Has a doctor or other health professional ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical conditions? If so, please identify below.		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**YES**	**NO**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ___ High blood pressure ___ A heart murmur ___ High cholesterol ___ A heart infection ___ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected, or get tired more quickly than your friends or classmates during exercise?		
11. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**YES**	**NO**
12. Has any family member or relative died of heart problems or had an unexpected sudden death before age 50 (including drowning, unexplained car accident or sudden infant death syndrome)?		
13. Does anyone in your family have a pacemaker, an implanted defibrillator, or heart problems like hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome or catecholaminergic polymorphic ventricular tachycardia?		

BONE AND JOINT QUESTIONS	YES	NO
14. Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice, game or an event?		
15. Do you have a bone, muscle or joint problem that bothers you?		
MEDICAL QUESTIONS	**YES**	**NO**
16. Do you cough, wheeze or have difficulty breathing during or after exercise?		
17. Have you ever used an inhaler or taken asthma medicine?		
18. Are you missing a kidney, an eye, a testicle (males), your spleen or any other organ?		
19. Do you have any rashes, pressure sores, or other skin problems such as herpes or MRSA skin infection?		
20. Have you ever had a head injury or concussion?		
21. Have you ever had numbness, tingling, or weakness, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or someone in your family have sickle cell trait or disease?		
24. Have you, or do you have any problems with your eyes or vision?		
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of food?		
28. Have you ever had an eating disorder?		
29. Do you have any concerns that you would like to discuss today?		
FEMALES ONLY	**YES**	**NO**
30. Have you ever had a menstrual period?		
31. How old were you when you had your first menstrual period? _____		
32. How many periods have you had in the last 12 months? _____		

Explain "yes" answers here: _____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

ORS 336.479, Section 1 (3) "A school district shall require students who continue to participate in extracurricular sports in grades 7 through 12 to have a physical examination once every two years." Section 1(5) "Any physical examination required by this section shall be conducted by a (a) physician possessing an unrestricted license to practice medicine; (b) licensed naturopathic physician; (c) licensed physician assistant; (d) certified nurse practitioner; or a (e) licensed chiropractic physician who has clinical training and experience in detecting cardiopulmonary diseases and defects."

School Sports Pre-Participation Examination – Part 2: Medical Provider Completes

Revised May 2017

PHYSICAL EXAMINATION FORM

Date of Exam: _____

Name: _____ Date of birth: _____

Sex: _____ Age: _____ Grade: _____ School: _____ Sport(s): _____

EXAMINATION			
Height:	Weight:	BMI:	
BP: / (/)	Pulse:	Vision R 20/ L 20/	Corrected ☐ YES ☐ NO

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/ears/nose/throat		
Lymph nodes		
Heart •Murmurs (auscultation standing, supine, with and without Valsalva)		
Pulses		
Lungs		
Abdomen		
Skin		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for:

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports: _____
  Reason: _____

Recommendations: _____

_____

_____

_____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the provider may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians). This form is an exact duplicate of the current form required by the State Board of Education containing the same history questions and physical examination findings. I have also reviewed the "Suggested Exam Protocol".

Name of provider (print/type): _____ Date: _____

Address: _____ Phone: _____

Signature of provider: _____

ORS 336.479, Section 1 (3) "A school district shall require students who continue to participate in extracurricular sports in grades 7 through 12 to have a physical examination once every two years." Section 1(5) "Any physical examination required by this section shall be conducted by a (a) physician possessing an unrestricted license to practice medicine; (b) licensed naturopathic physician; (c) licensed physician assistant; (d) certified nurse practitioner; or a (e) licensed chiropractic physician who has clinical training and experience in detecting cardiopulmonary diseases and defects."

School Sports Pre-Participation Examination – Suggested Exam Protocol for Medical Provider *Revised May 2017*

MUSCULOSKELETAL

Have patient:	To check for:
1. Stand facing examiner	AC joints, general habitus
2. Look at ceiling, floor, over shoulders, touch ears to shoulders	Cervical spine motion
3. Shrug shoulders (against resistance)	Trapezius strength
4. Abduct shoulders 90 degrees, hold against resistance	Deltoid strength
5. Externally rotate arms fully	Shoulder motion
6. Flex and extend elbows	Elbow motion
7. Arms at sides, elbows 90 degrees flexed, pronate/supinate wrists	Elbow and wrist motion
8. Spread fingers, make fist	Hand and finger motion, deformities
9. Contract quadriceps, relax quadriceps	Symmetry and knee/ankle effusion
10. "Duck walk" 4 steps away from examiner	Hip, knee and ankle motion
11. Stand with back to examiner	Shoulder symmetry, scoliosis
12. Knees straight, touch toes	Scoliosis, hip motion, hamstrings
13. Rise up on heels, then toes	Calf symmetry, leg strength

MURMUR EVALUATION – Auscultation should be performed sitting, supine and squatting in a quiet room using the diaphragm and bell of a stethoscope.

Auscultation finding of:	Rules out:
1. S1 heard easily; not holosystolic, soft, low-pitched	VSD and mitral regurgitation
2. Normal S2	Tetralogy, ASD and pulmonary hypertension
3. No ejection or mid-systolic click	Aortic stenosis and pulmonary stenosis
4. Continuous diastolic murmur absent	Patent ductus arteriosus
5. No early diastolic murmur	Aortic insufficiency
6. Normal femoral pulses (Equivalent to brachial pulses in strength and arrival)	Coarctation

MARFAN'S SCREEN – Screen all men over 6'0" and all women over 5'10" in height with echocardiogram and slit lamp exam when any two of the following are found:

1. Family history of Marfan's syndrome (this finding alone should prompt further investigation)
2. Cardiac murmur or mid-systolic click
3. Kyphoscoliosis
4. Anterior thoracic deformity
5. Arm span greater than height
6. Upper to lower body ratio more than 1 standard deviation below mean
7. Myopia
8. Ectopic lens

CONCUSSION -- When can an athlete return to play after a concussion?

After suffering a concussion, no athlete should return to play or practice on the same day. Previously, athletes were allowed to return to play if their symptoms resolved within 15 minutes of the injury. Studies have shown that the young brain does not recover that quickly, thus the Oregon Legislature has established a rule that no player shall return to play following a concussion on that same day and the athlete must be cleared by an appropriate health care professional before they are allowed to return to play or practice.

Once an athlete is cleared to return to play, they should proceed with activity in a stepwise fashion to allow their brain to readjust to exertion. The athlete may complete a new step each day. The return to play schedule should proceed as below following medical clearance:

Step 1: Light exercise, including walking or riding an exercise bike. No weightlifting.
Step 2: Running in the gym or on the field. No helmet or other equipment.
Step 3: Non-contact training drills in full equipment. Weight training can begin. Step 4: Full contact practice or training.
Step 5: Game play.

If symptoms occur at any step, the athlete should cease activity and be re-evaluated by a health care provider.

581-021-0041 Form and Protocol for Sports Physical Examinations

1. The State Board of Education adopts by reference the form entitled "School Sports Pre-Participation Examination " dated May, 2017 that must be used to document the physical examination and sets out the protocol for conducting the physical examination. The form may be used in either a hard copy or electronic format. Medical providers may use their electronic health records systems to produce the electronic form. Medical providers conducting physicals of students who participate in extracurricular activities in grades 7 through 12 must use the form.
2. The form must contain the following statement above the medical provider's signature line:
   This form is an exact duplicate of the current form required by the State Board of Education containing the same history questions and physical examination findings. I have also reviewed the "Suggested Exam Protocol".
3. Medical providers conducting physicals on or after April 30, 2011 and prior to May 1, 2017 must use the form dated May 2010.
4. Medical providers conducting physicals on or after May 1, 2017 and prior to May 1, 2018 may use either the form dated May 2010 or the form dated May, 2017.
5. Medical providers conducting physicals on or after May 1, 2018 must use the form dated May, 2017.

NOTE: The form can be found on the Oregon School Activities Association (OSAA) website: http://www.osaa.org
Stat. Auth.: ORS 326.051 Stats.
Implemented: ORS 336.479

Oregon Health Authority

PUBLIC HEALTH DIVISION
Adolescent and School Health

TRANSFORMATION CENTER
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OREGON SCHOOL ACTIVITIES ASSOCIATION
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www.oregon.gov/oha/Transformation-Center/Pages/Resources-Metric.aspx

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OHA 8460 (Rev. 07/2017)

AYA Male Health Toolkit

SAMPLE PATIENT QUESTIONS

Health Provider Toolkit for Adolescent and Young Adult Males

Before you start screening it is important to build trust with your adolescent patient. To foster honest responses, and to build that trust, consider:

1) Interview the adolescent patient without their parents in the room. At times it might be difficult to ask parents to leave the exam room, but below is one approach:

   "Your child is getting older and at this developmental stage, I believe that it is important to foster their involvement in the clinical encounter and to respect decision-making. Therefore, I like to put some time aside at each appointment from this point forward to talk to them individually about their health decision and behaviors. Afterwards, I can bring you back into the room and we can wrap up the appointment together."

2) Clearly explain your confidentiality policy right from the start. Accepted practice is that providers will only break confidentiality if and when an adolescent states that they want to harm themselves or others. You can explain this by saying:

   "As your doctor, I am called to respect your confidentiality. This means that the things we talk about will just stay between the two of us. It is important that you feel comfortable disclosing information so that I can provide you with medical advice and recommendation based your specific situation. The only exception to my ability to keep your information confidential is if you tell me you are going to harm yourself or others. As your doctor, I want to keep you and everyone healthy so if you have thoughts or intentions to harm yourself or others, then I would have to tell the appropriate people to prevent that from happening. Do you have any questions about this?"

3) Use the HEADDSSS approach because it goes from least to most invasive questioning fostering increasing trust as the encounter proceeds:

   H: Home (who lives at home, dynamics, concerns, smokers in the home)
   E: Education/Employment (school, grade, grades/evaluations, learning disabilities, bullying/harassment, jobs)
   A: Activities (sports, clubs, what do they do with their free time)
   D: Drugs (alcohol, smoking, marijuana, IV drug use, anabolic steroid , supplement use, medication misuse)
   D: Developmental Concerns (independence, autonomy, judgment, appropriate socializing, risk-taking)
   S: Safety (including access to firearms, gang involvement, intimate partner violence)
   S: Sex (gender identity, sexual orientation, current relationship, comprehensive sexual history, contraception use/understanding)
   S: Suicidality (and Mood/Anxiety Assessment)

Healthy Eating and Physical Activity

Do you have friends who are concerned about their weight? Are you concerned about your body (image) or weight? Have you gained or lost weight recently?
Do you know how to tell if you are too heavy, too light, or just right? How do you feel right now?
Are their foods you try to avoid? Why? Do you avoid fats? Do you know that your body needs to metabolize fats to function normally and to not get any fat can lead to medical problems?

Do you do anything to change your weight? Have you ever dieted? Have you ever restricted your diet, tried to eat less, or skipped meals in order to lose weight? Have you ever made yourself vomit in an effort to lose weight? Do you Calorie count or always look at nutrition labels before eating foods? Why? Does anyone you know?
Do you take pills, laxatives, vitamins or any other supplements or medications to change your body shape or to change your appetite? Does anyone you know?
Do you ever over-indulge or over-eat? How often? Do you think this is a problem for you? Why?
Do you use steroids or sports supplements (such as powdered protein or creatine drinks) to make yourself stronger? Does anyone you know?
Do you participate in sports or exercise regularly? How much? Why do you exercise? Do you exercise solely for the reason of losing weight or burning off calories?
What would you do if you had a problem with your eating or you were concerned that a friend had a problem? Do you known anyone who has a problem with their eating? Have you talked to them about it or tried to get help for them?
Do you ever feel guilty about your eating? How often do you feel this way? Why?
Adapted from Abigail H. Natenshon, http://www.empoweredparents.com
Do you participate in sports?
If you exercise, how much per day?

Sexual and Reproductive Health

Sexual development and maturity

Are you in a romantic relationship? Have you ever been?
Have your friends started dating? Have you been on a date? What kinds of things do you do on dates?
Have any of your relationships ever been sexual relationship? What does it mean to you to be in a "sexual relationship"? Do you have any friends in sexual relationships?
Have you ever had sex? How old were you the first time you had sex?
When was the last time you had sex?
Do you have any specific concerns related to relationship, dating, sex, or sexuality?
Where do you get information about sex? Have you talked about sex in school/health class? With your friends? With your parents or any family members? Do you trust the information you receive? Do you have any questions?

Sexual Orientation

Have your partners been male, female or both?
Do you prefer male partners, females, both or neither?
How would describe your sexuality and sexual orientation? Is there a term that you prefer I use?
Have you ever liked someone of the same-sex? Do you know that straight people can have same-sex attractions, especially in adolescents?
Do you know anyone who is gay, lesbian, bisexual, questioning or queer (LGBQQ)? Do you have any friends or do any of your friends have parents who

	are LGBQQ? What challenges do they face? Are you being bullied or teased because of your real or perceived sexual orientation? Do you known anyone who has been? Has anyone spread rumors about your sexual orientation? Are you afraid for your safety at all? *(If pt has same sex attractions or identifies as LGBQQ):* Do you have anyone you can trust talk to about this? Who makes up your support system? *(If pt has same sex attractions or identifies as LGBQQ):* Have you ever thought about coming out? Would it be safe to do so? What might you be risking? What would the benefits be? Do you think your friends and family would accept your [sexuality, attractions, etc.]? *(If pt has same sex attractions or identifies as LGBQQ):* Do you know that relationship violence, STIs/STDs, and HIV/AIDS can happen in homosexual relationships? Do you have any concerns about these topics? Are you having any thoughts of wanting to hurt or kill yourself?
Gender Identity	Do you have any concerns about your gender? How do you define your gender? Do you have the sense that your body does not match your gender identity? Have you ever been bullied or teased about your real or perceived gender? Do you known anyone who is? Has anyone spread rumors about your gender? Are you afraid for your safety at all? *(If pt identifies as transgender):* Do you have anyone you can trust talk to about this? Who makes up your support system? *(If pt identifies as transgender):* Have you ever thought about coming out? Would it be safe to do so? What might you be risking? What would the benefits be? Do you think your friends and family would accept your gender identity? *(If pt identifies as Female-to-Male transgender):* Do you know that even though you identify as male, you can still become pregnant if you are having sex with men? What is your birth control plan? Is there any chance that you could be pregnant? *(If pt identifies as Female-to-Male transgender):* How do manage issues such as going to the bathroom at school or public places? Changing for gym class? Swimming? Going to the beach? How can I support and advocate for you? Are you having any thoughts of wanting to hurt or kill yourself?
HIV/STI Risk Assessment and Reduction	How many sexual partners have you had? What kind of sex do you have? Have you ever had anal or oral sex? What do you know about STIs/STDs? What do you known about HIV/AIDS? What is your plan to prevent yourself from getting STIs/STDs and HIV/AIDS? Do you think you are at risk for an STI/STD or HIV/AIDS? Why? Have you ever been tested or treated? Do you know where you can get testing? Would you like to get tested for STIs/STDs and HIV/AIDS? Do you ever talk to your partner about their STI/STD and HIV/AIDS status? Has your partner been tested? How do you know? Have you talked about getting

	tested together? If you have female partners, are you aware that birth control (such as "the pill" or IUD, etc.) does not prevent STIs/STDs or HIV/AIDS? Do you know how to use condoms? Do you have condoms? Did you use condoms every single time you have had sex, including anal and oral sex? Do you know where you can get them? Has anything ever gotten in the way of using condoms? Have you ever had sex while you were intoxicated (drunk or high)? Have you ever had sex for money, drugs, gifts or other things? Do you know how to use condoms? Do you have condoms? Did you condoms them every single time you have had sex, including anal and oral sex? Do you know where you can get them? Has anything ever gotten in the way of using condoms?
Reproductive Life Plan & Pregnancy Prevention/ Preconception Care	*(For male patients who report having sex with men)* Have you ever had a sexual relationship with a woman? Have you ever gotten someone pregnant? Are worried that could happen? Why? What are you and your female partners using for birth control? Have you talked to your female partners about what they are using? Do you know what options are available to girls? Do you know what options are available to boys? Are you satisfied with the methods you have chosen? Do you know what "Plan B" is? Do you know that if your female partners want "Plan B" that you, as a guy, can buy it for them? Do you know how to get it? Have you ever thought about having a family? Have you throught about being a father? How does being a father fit with your other goals and aspirations (e.g. going to college, getting a job, etc.)? Do you know anyone your age who is a father? What challenges do they face? Have you ever used a condom?

Trauma

Intimate Partner or Relationship Violence	Do your partners respect you? What does it mean for them to respect you? Do you they ever hurt you in any way? Are your sexual activities enjoyable? Are you ever forced to do things you do not want to? What does "safe sex" mean? Have you ever heard of the term "relationship violence"? Do you know anyone who has been in a violent relationship? Have you ever been? Have you ever heard of the term "rape"? Do you know that violence and rape affect both men and women, and can occur in all relationships including gay and straight ones? Have you ever experienced relationship violence or rape? Have you ever had sex while you were intoxicated (drunk or high)? Do you know that if you have sex with someone who cannot say "no" because they are intoxicated (or for any other reason) that it can be considered rape? Have you ever had sex for money, drugs, gifts or other things?
Violence	Do you feel safe at home, school, in your community/neighborhood, and online? Who do you get along with at home? How is conflict resolved at home? When

people argue in your house, what happens? Do arguments or fights ever become physical?
Do you know anyone who is bullied or who is a bully? How would you respond if you witness someone being bullied? Have you ever been bullied or bullied someone else?
Are you on Facebook, or any social networks? Have you ever seen mean things or rumors online about your friends? Have people spread rumors about you online? Do you ever talk to people you do not know? Do you use online dating sites? How do you keep yourself safe online?
Is there a lot of violence in your school? In your neighborhood? Among your friends? Are there gangs in your school or community? Are you involved in a gang?
Has anyone ever touched you inappropriately? Do people ever say things about you that make you feel bad about yourself? Has anyone ever hit, slapped or punched you? Do you feel like you ever have been physically, sexually, or emotionally abused?
Are there guns in your home? Are they locked? Can you access them? Have you ever felt the need to carry a weapon such as a knife or gun? Do you carry a weapon? Why?
Have you ever been arrested? What for? Have you ever thought about hurting or killing someone else? Have you been in a fight recently? Why?

Unintentional Injury

What do you like to do for fun/after school?
Have you ever had a serious injury or motor vehicle accident? Have any of your friends? What happened? How could it have been prevented?
Do you know what the #1 cause of teenage deaths is? (Accidental injuries, specifically motor vehicle accidents where teens are not wearing their seatbelt)
Do you always wear a seatbelt? Do you always wear a helmet on your….(bike, skateboard, ATV, snowboard, when skiing, etc)? Do wear a mouthguard when you play contact sports?
Do you drive (with or without) a license? Are you planning to learn? How?
Have you ever driven with someone who was drunk or high? How often? *If Yes, then follow with remainder of CRAFFT screen (see Substance abuse section below).*

Substance Use Disorders

Have you EVER tried [insert items below]? How much do you use this substance? How often? When did you start? Why do you use them
cigarettes, chewing tobacco, or other tobacco products
alcohol
IV drugs such as heroin
Inhalants such as crack, household cleaners or glue/paint
Hallucinogenics such as Molly, Ecstasy, PCP, LSD, or shrooms
Do you know anyone who uses tobacco, alcohol or drugs? Does anyone in your family have a problem now or in the past with drugs or alcohol?
Have you ever taken medications out of the medicine cabinet (prescribed to you or someone else) and taken them in order to get a high?

Where do you get information about drugs? Have you talked about sex in school/health class? With your friends? With your parents or any family members? Do you trust the information you receive? Do you have any questions?
CRAFFT Screen for Adolescents:
Opening Questions: In the past 12 months, did you…
…drink and alcohol?
…smoke any marijuana?
…use anything else to get high?
If no to all three, only ask the "C" question. If yes to any, then ask all CRAFFT questions:
C - Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
R - Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
A - Do you ever use alcohol/drugs while you are by yourself, ALONE?
F - Do you ever FORGET things you did while using alcohol or drugs?
F - Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?
T - Have you gotten into TROUBLE while you were using alcohol or drugs?
Two or more positive responses indicates further evaluation for substance use is needed.
Do you know anyone who uses tobacco, alcohol or drugs?
Who talks with you about alcohol or drugs?
Does anyone in your family have a problem now or in the past with drugs or alcohol?
Have you ever tried tobacco, alcohol or any drugs including prescriptions that weren't yours to get high?

Mental Health

ADHD

Do you have difficulty staying focused on a task or activity, such as reading a book or paying attention in class?
Do you have difficulty finishing your work because you get distracted? Do people tell you that you are disorganized or forgetful?
Do you have difficulty sitting still? Do you have difficulty in activities that require you to be quiet?
Do you blurt out answers in class or have trouble waiting until you are called on to participate? Have you heard that you need to work on taking turns? Do people get mad that you frequently interrupt them?
Do you have trouble concentrating? Do you have trouble sitting in one place even if you are watching a video or movie?
Did your teachers in elementary school ever say things like you are disorganized, you are not working up to your potential, you are talking out of turn?

Psychotic Disorders

Do you see or hear things that other people do not see or hear?
Do you ever feel that people are following you or trying to hurt you? Do you have special powers, abilities (e.g. ability to read others' minds), or status?

	When you hear the radio, watch TV, use a computer, or read, do you feel that there are messages intended just for you? Do you ever hear someone speaking to you even if there is no one around? Do you ever see fleeting shapes or shadows? Do you ever hear unusual noises or someone calling your name? Do you worry that others may be following you or want to harm you? Do you have any thoughts that you think are unusual or others would think are unusual?
Bipolar Disorder	Do you ever feel the opposite of depressed—very cheerful, happy, productive? Does it last more than a week and impact your relationships, school work, and ability to function? Do you find that during these periods you do not need much sleep to feel rested? Do your thoughts race? Do you sometimes feel too good or cheerful for a long time? During those times do you have trouble sleeping? Do you ever have extreme mood swings? Like you feel very very happy or very very irritable, and other times when you feel extremely depressed, like it's hard to function?
Depressive Disorders	Have you been feeling down, sad, depressed, irritable or angry? Have you felt this way in the last 2 weeks? Have you lost interest in activities that you used to enjoy? Have you had any recent changes in sleep, weight, sex drive, or your energy level? Do you ever feel worthless or guilty? Have you ever had thoughts of wanting to hurt or kill yourself? Are you feeling down, irritable for the last few weeks? Is it hard to get your mind off of how you are feeling? If so, do you have trouble doing every day things like going to school or work? Do you do things that interest you or give you pleasure? Do you ever feel hopeless?
Anxiety Disorders	Do you worry a lot? Is it hard for you to control? Does this worrying affect your relationships, school work, extracurricular involvements or ability to function? Do you ever have episode of intense fear for no apparent reason when you don't expect it? Do you feel tense or nervous to the point that in gets in the way of you doing things? Have you ever felt panicky or had a panic attack? (describe symptoms: heart pounding, shortness of breath, sweating, nausea, chest tightness, tingling in extremities, feeling of going crazy or fear that you are dying) If so, how often and in what circumstances? (panic disorder) Do you have anxiety in social situations? crowds? just in general? (social anxiety, agoraphobia, general anxiety disorder) If you are feeling anxious, what do you do to help yourself feel better? Does it work? Is there anything you are really afraid of? i.e. Heights? Illness? germs? needles? (phobias)
Obsessive Compulsive	Do you have unwanted urges, thoughts or obsessions? Are you driven to do

and Related Disorders	things in order to avoid or reduce the distress associated with these urges, thoughts, or obsessions? Do you have to do things in very particular ways or it makes you upset? Do you have repetitive thoughts that you can't shake? Do you have any habits that don't make sense but you do them anyway, like checking things, counting, handwashing? Do you have any thoughts that you don't want to think, but they keep occurring?
Disruptive, Impulse-Control and Conduct Disorders	Do you ever become so upset that you make or act upon threats to hurt other people, animals, or property? Do you tend to get in a lot of physical fights? Do you find that you often resort to threats and violence to solve problems? If you do hurt someone, do you feel bad about it afterwards? Are you having any thoughts of wanting to hurt or kill anyone else? Have you ever been arrested? For what? Do you frequently have run-ins with law enforcement? Do you sometimes do things that you wish you had not done on an impulse? Are you frequently getting into conflicts with others or into trouble with authorities? Do you ever feel out of control? How quickly do you get very angry? Do you have trouble controlling your anger? Do you ever get in fights? hurt others? punch walls? Do you ever get so angry that you black out?
Suicidal and Self-Injurious Behaviors	Do you have thoughts of hurting or killing yourself? How would you do it, do you have a plan? Do you have the means available to hurt or kill yourself? When do plan on doing it? Do you cut, burn, punch, or starve yourself? Do you hurt yourself as a means to cope with feeling overwhelmed or emotionally distressed? Do you sometimes feel life is not worth living? Do you have thoughts of harming yourself? Do you have a plan as to how? Do you have access to the means to fulfill your plan? Have you tried to harm yourself in the past? Do you ever feel that you wish you were dead? Do you ever actually want to kill yourself?
Trauma and Stressor Related Disorders	Have you ever been abused, neglected, or in a situation where you were seriously injured or your life was in danger? Do you think about it a lot? Do you experience thoughts, images, or dreams related to this event? Do you avoid reminders of this event?

What is Body Image?

BODY IMAGE IS ...

- How you see yourself when you look in the mirror or when you picture yourself in your mind.
- How you feel about your body and appearance, including your height, weight, and shape.
- How you feel *in* your body, not just *about* your body.

Do You Respect Your Body? (circle True or False)

1.	True	False	I often talk negatively about my body.
2.	True	False	I weigh myself more than once a week.
3.	True	False	I would exercise less if appearance did not matter.
4.	True	False	I often compare my looks or body to others.
5.	True	False	I often feel guilty or anxious after eating a high fat food.
6.	True	False	I cannot accept a compliment about my appearance.
7.	True	False	If I had to, I would do unhealthy things to change my weight (such as fasting, taking laxatives, throwing up, or excessive exercising).
8.	True	False	I feel unhappy or discontent with my life at this time.
9.	True	False	I would panic if I gained a few pounds.
10.	True	False	I am dissatisfied with my current body shape and size.

Count the number of questions you answered FALSE and read below to see if you respect your body.

POSITIVE BODY IMAGE IS ...

- A clear, true idea of your shape—you can see your body as it really is.
- You feel comfortable and confident in your body and appreciate your unique physical qualities.

8-10 You seem satisfied with your body! Be a role model for others.

4-7 You may be too hard on yourself. Look below for ways to improve your body image. Or get more information from an organization near you, such as Body Positive. Visit www.bodypositive.com.

0-3 Are you having a rough time right now? Help is available. Find an adult that you trust to talk to about this, such as a doctor, school nurse, school counselor, or family member.

How Can You Improve Your Body Image?

1. **Focus your attention and energy on what you *can* do:**
   - ***Eat well and exercise!*** This will help you develop into your natural weight, and balance the natural chemicals in your brain to help you feel happy. It's never too late to start exercising and eating well.
   - Limit sedentary activity, such as watching TV and movies and playing video/computer games.
   - Choose realistic role models that allow you to feel good about yourself. Remember that advertisers spend tons of money to make you feel there is something wrong with you, so that you will buy their product to "fix" the problem.

2. **Accept what is not in your control.**
   - Understand that bodies develop in ways that you can't always control. However, having a healthy lifestyle will help your developing and changing body.

Eating, Exercise & Body Image Continuum

This continuum represents the range of eating and exercise behaviors and attitudes towards food and body image. The goal is to function in the *Concerned in a Healthy Way* category, which reflects good physical and emotional health. Throughout life, many people move in this continuum due to many factors such as family, culture, friends, school, sports, health, finances, the media, etc. No matter where you fit, there are resources for you.

☑ Check where you are today
◯ Circle where you want to be in the future

FOOD IS NOT AN ISSUE	*CONCERNED IN A HEALTHY WAY*	FOOD PREOCCUPIED/OBSESSED	DISRUPTIVE EATING PATTERNS	EATING DISORDERED
☐ I am not concerned about what or how much I eat.	☐ I pay attention to what I eat to have a healthy body.	☐ I think about food a lot.	☐ My food and exercise concerns interfere with my school, family, and social life.	☐ I worry about what I will eat and/or when I will exercise enough.
☐ I feel no guilt or shame no matter what or how much I eat.	☐ Food and exercise are important but not the major part of my life.	☐ I think and read a lot about dieting, fitness, and weight control.	☐ I use food to make myself feel better.	☐ I follow a strict eating plan and I always know how many calories, fat grams, and/or carbs I eat.
☐ Exercise is not really important to me.	☐ I enjoy eating, but I balance this with my concern for good health.	☐ I sometimes miss school, work, and having fun because of my diet or exercise schedule.	☐ I have tried fasting, diet pills, laxatives, vomiting, or extra time exercising to lose or maintain my weight.	☐ I feel a lot of guilt, shame, and anxiety when I break my diet.
☐ I choose foods based on cost, taste, and convenience.	☐ I usually eat 2-3 balanced meals daily, plus snacks, to get me through the day.	☐ I divide food into 2 categories: "good" and "bad".	☐ If I cannot exercise to burn off calories, I worry.	☐ I regularly stuff myself and then exercise, vomit, or use laxatives to get rid of the food.
☐ I don't worry about meals; I just eat whatever I can, whenever I can.	☐ I have realistic goals for eating well and being physically active.	☐ I feel guilty when I eat "bad" foods or when I eat too much.	☐ I feel strong when I can cut down on how much I eat.	☐ My friends and family tell me I am too thin, but I feel fat.
☐ I enjoy eating lots of tasty food when I have a chance.	☐ Sometimes I eat more (or less) than I really need, but mostly I listen to my body.	☐ I am afraid of getting fat.	☐ I feel out of control when I eat more than I want to.	☐ I am out of control when I eat.
		☐ I wish I could change how much I want to eat and what I am hungry for.		☐ I am afraid to eat in front of others.

BODY IS NOT AN ISSUE	*BODY ACCEPTANCE*	BODY PREOCCUPIED/OBSESSED	DISTORTED BODY IMAGE	BODY HATE - DISASSOCIATION
☐ I feel fine about my body.	☐ I pay attention to my body and my appearance because it is important to me, but it is not a huge deal.	☐ I weigh myself a lot.	☐ I spend a lot of time exercising and dieting to change my body.	☐ I often feel as if my body belongs to someone else.
☐ I don't worry about changing my body shape or weight.	☐ There are some things about my body that I would like to change, but I'm okay with my positive features.	☐ I spent a lot of time looking at myself in the mirror.	☐ My body shape and size keeps me from dating or finding someone who will treat me right.	☐ I hate my body.
☐ I hardly ever weigh or measure myself.	☐ My self-esteem is based on my abilities, talents, and relationships — not just my looks.	☐ I often compare my body to others.	☐ I would like to change my body shape and size by surgery.	☐ I often keep away from others.
☐ My feelings about my body are not influenced by the media or what others think of me.		☐ I have days when I feel fat.	☐ I wish I could change the way I look in the mirror.	☐ There's not much or nothing that's okay about my body shape and size.
☐ I know that my friends and family will always love me for who I am, not for how I look.		☐ I accept society's ideal body shape and size as okay.		☐ I don't believe others when they tell me I look okay.
		☐ I'd be more attractive if I were thinner and more muscular.		☐ I hate the way I look in the mirror.

Adapted from Smiley/King/Avey, 96

Sheri Barke, MPH, RD. COC Student Health & Wellness Center

Healthy Weight

▶ Why is staying at a healthy weight good for you?

A healthy weight means that you feel healthy in your body and mind, and that you are decreasing your chance of getting diseases such as heart disease, diabetes, and high blood pressure. A healthy weight allows you to be physically active so you can run up and down hills, participate fully in sports and P.E., and help out with family chores. Staying at a healthy weight as a teen will improve the way you feel about yourself and your body and help you manage your weight for life.

▶ How can you get to or stay at a healthy weight?

If you want to lose some weight, try being more active and eating fewer calories each day. Here are some things to try:

✔ Be active almost every day to burn extra calories and get fit.

Play sports, walk to school in a group or with a friend/family member, rollerblade, and ride a bike instead of playing video games and watching TV. Being active doesn't mean you have to exhaust yourself—it's about moving around for 30-60 minutes everyday. Exercise with friends and try different and enjoyable physical activities.

✔ Cut down on calories.

Some simple ways to cut calories include:

1. Drink water instead of soda, juice, or sports drinks. You can cut 100-150 calories every time you do this..
2. Eat a piece of fruit instead of a candy bar or junk food. You will cut about 200 calories or more.
3. Eat smaller portions of food and drink lots of water with meals and snacks.
4. Try some of the ideas in this chart:

❑ **Drink a lot of water throughout your day.** Try to drink at least four 16 oz. bottles of water each day. This will help you digest food.	❑ **Cut down** on foods that are fried, battered and covered in sauces and gravies.
❑ **Drink nonfat/lowfat milk and eat nonfat/lowfat dairy products (cheese, yogurt)** rather than whole milk dairy products.	❑ **Cut back on watching TV, playing video games, and sitting at the computer** to no more than one or two hours per day. Pick a few favorites and skip the rest.
❑ **Increase your intake of fiber-rich foods.*** They are filling and easily digested.	❑ **Avoid eating in front of the TV or computer.** While watching TV, you may keep eating, even when you're not hungry.
❑ **Eat when you are hungry.** Refusing to eat when you are hungry can lead to binging/overeating later. So have a healthy snack if you're hungry, but WATCH PORTION SIZE. Or, share a snack with a friend.	❑ **Don't eat when you're not hungry.** If you feel like munching but you're not really hungry, do something else like go for a walk, call a friend, or read a book. If you really want to snack, eat cut-up vegetables or a piece of fruit.
❑ **Eat slowly.** Stretch your meals to at least 20 minutes. It takes 20 minutes for your brain to recognize that you are full.	❑ **Walk and talk!** When you're talking on the phone, walk around, do squats, sit-ups, or run in place.

YOUTH

*Some examples of fiber-rich foods include:

- **Cereals:** raisin and other bran cereals, shredded wheat, frosted mini-wheats, oatmeal, and puffed wheat.
- **Breads and Grains:** corn tortillas, brown rice, graham crackers, brown bread, dark rye bread, multi-grain, whole grain, brown and rye breads.
- **Vegetables:** carrots, broccoli, peas, lettuce, spinach, sweet potatoes (with skin), string beans, corn, jicama, turnips, lima beans, brussel sprouts, swiss chard, kale, collards, winter squash.
- **Fruits:** apples (with skin), berries, raisins, apricots, oranges, figs, blackberries, prunes, pears (with skin), tangerines.
- **Beans, nuts, and seeds:** almonds, cashews, chestnuts, peanuts, filberts, sesame and sunflower seeds, walnuts, yams, lentils, black, garbanzo (chickpeas), kidney, pinto, split, white (such as great northern and navy) and soy beans.

Adapted from: www.weight-loss-information.featherish.com

Myths and Facts of Dieting

MYTHS	FACTS
1. Fad diets work for permanent weight loss.	**Fact:** Fad diets are not the best ways to lose weight and keep it off. These diets often promise quick weight loss, but this often happens by cutting out important nutrients from your diet. **Better Idea:** To safely lose weight, improve your eating habits and increase your physical activity.
2. Skipping meals is a good way to lose weight.	**Fact:** Your body needs a certain amount of calories and nutrients each day. Skipping meals can cause increased snacking or overeating at the next meal. **Better Idea:** Eat 3 small meals and 2-3 small snacks throughout the day that include a variety of nutritious, low fat, and lower calorie foods. Drink 8 glasses of water every day!
3. I can lose weight while I eat anything I want.	**Fact:** It is *possible* to eat any kind of food you want and lose weight, but you still need to limit the amount of foods AND calories you eat on a daily basis. **Better Idea:** Burn up more calories than you take in by being active and exercising.
4. Eating after 8 p.m. causes weight gain.	**Fact:** It doesn't matter what time of day you eat. It is about how much you eat during the whole day and how much exercise you get that makes you gain or lose weight. **Better Idea:** Try not to snack when doing other activities, like while watching television, playing video games, or using the computer.
5. Certain foods, like grapefruit, celery, or cabbage soup, can burn fat and make you lose weight.	**Fact:** No foods can burn fat. **Better Idea:** The best way to lose weight is to cut back on the number of calories you eat and increase your physical activity.
6. Nuts are fattening and you shouldn't eat them if you want to lose weight.	**Fact:** Nuts are high in calories and fat, but they are also low in saturated fat (the fat that can lead to high cholesterol and increased risk of heart disease). **Better Idea:** Nuts are a good source of protein and fiber, and don't have any cholesterol. In small amounts, nuts can be a part of a healthy weight-loss program.
7. Eating red meat is bad for your health and will make it harder to lose weight.	**Fact:** Red meat contains some saturated fat and cholesterol but also has nutrients like protein, iron, and zinc. **Better Idea:** Eat lean meat (meat without visible fat on it) in small amounts.
8. Fresh fruits and vegetables are more nutritious than frozen or canned.	**Fact:** Most fruits and vegetables are naturally low in fat and calories. Frozen and canned fruits and vegetables can be just as nutritious as fresh. **Better Idea:** Eat lots of fruit and veggies but avoid cream sauces or sugary syrups.
9. Fast foods are always unhealthy and shouldn't be eaten when dieting.	**Fact:** It is possible to make healthy choices at fast food restaurants. **Better Idea:** Choose salads and grilled and baked foods. Use small amount of dressings and condiments.
10. High protein, low carbohydrate diets are a healthy way to lose weight.	**Fact:** In such a diet, most calories come from protein foods (like meats, eggs, cheese) and few from carbohydrates (pasta, bread, fruits, vegetables, rice). These diets can lack important nutrients and the fatty foods in this diet, like bacon and cheese, can cause increased blood cholesterol levels. **Better Idea:** Exercise and eat well-balanced and nutritious meals and snacks.
11. Becoming a vegetarian means you are sure to lose weight and be healthier.	**Fact:** Vegetarian diets can be healthy because they are often lower in saturated fat and cholesterol and higher in fiber. Yet, some vegetarians can eat large amounts of bread and pasta, junk food and snacks. **Better Idea:** Work with your healthcare provider to be sure you are getting all of the necessary nutrients throughout the day and don't forget to exercise.
12. Low fat, reduced fat, and lite all mean the same thing.	**Low Fat:** Three grams of fat or less per serving. **Reduced Fat:** At least 25% less fat per serving than the original food. **Lite:** At least 50% less fat per serving than the original food. **Better Idea:** Check out food labels!
13. Dairy products are high in fat and should be avoided.	**Fact:** Dairy products are your main source of calcium, which is needed to help your bones grow. **Better Idea:** Have 2-3 dairy servings a day. Low or nonfat milk, soy milk, cottage cheese, and yogurt are great dairy options which are low in fat and high in calcium.

Checklist for a Healthier Lifestyle

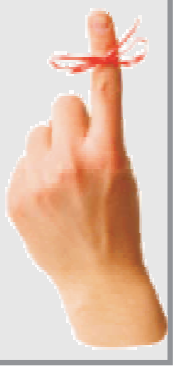
This is a list of suggestions you can use to try to improve your health habits.

Try the following: Choose two or three steps to focus on. Once those steps have become part of your daily life, add another new step.

- ❑ Drink lots (8 glasses a day) of water! Water is the fuel your body needs. Keeping bottles of water around the house and in your backpack makes this easier.
- ❑ Eat breakfast. Skipping breakfast tells your body to store calories as fat instead of burning them up. You definitely do better in school when you eat breakfast. Start your day with whole grain toast, hard-boiled eggs, nonfat or low fat yogurt or cheese, a piece of fruit, or oatmeal.
- ❑ Take your own lunch to school. Make your own lunch the night before. A simple sandwich (with lean deli meat, lettuce, and mustard) with a piece of fruit and/or some veggies and a bottle of water is nutritious and quick to make. Your own lunch can be healthier and better tasting than school lunches.
- ❑ Learn to make your own healthy snacks and meals. Help prepare meals with the person that does most of the cooking in your house This will give you some control over what you eat.
- ❑ Eat dinner with your family at a regular time. Studies show that families who eat together eat healthier. Remember to turn off the TV while at the dinner table. Instead, find out how everyone's day was.
- ❑ Eat more fiber. Eat whole grain bread and bran cereals instead of white bread and sugar cereals. Fiber helps you digest your food and it also makes you feel satisfied.
- ❑ Eat more fruits and vegetables. Have at least 3-5 servings of vegetables and 2-3 servings of fruit each day and eat whole fruit rather than drinking juice.
- ❑ Drink nonfat or 1% milk. Drinking milk builds strong bones (calcium and vitamins). If you are lactose intolerant, you can get just as much calcium by drinking lactose-free milk or soy milk, or taking Lactaid tablets when you eat dairy.
- ❑ Cut down on soda, juice drinks, sports drinks, chips, and candy. These are empty calories with no nutritional value. Did you know that a 20-oz. soda has almost 20 teaspoons of sugar? Too much soda can make your bones thinner and more breakable, and can cause dental cavities.
- ❑ Reduce fast food. If you want fast food, make it a special treat and don't "super size". Once you cut down on fast food, you'll find that you won't really miss it.
- ❑ Pick a new physical activity. It is important that you pick an activity that you enjoy. For example, join a sports team or league, go fast walking in a group every day, or rent and workout with an exercise video/DVD from the public library. Stick with it for 4-6 weeks because this is how long it takes to form a new habit. ***Remember: Exercise is as important as what you eat***.
- ❑ Cut back on TV/video game/computer time. Try to watch or play less than 1-2 hours of TV/computer/video games a day—even during holidays, weekends, and summer vacations. Get rid of your remote controls. *Every little bit helps!*
- ❑ Do fun things with your friends other than eating. Eating is a fun social activity but do other activities with your friends besides eating. Try walking to and from places together.
- ❑ Go food shopping. Once you learn how to make healthy food choices, go to the store and pick out nutritious foods. But remember: It is a bad idea to go food shopping when you are hungry. You'll be tempted to buy junk food.
- ❑ Notice what causes you to over or under eat or eat a lot of junk food. Try different ways of dealing with those situations such as calling a friend, talking to a trusted adult, exercising, listening to music, slow deep breathing, and taking a walk or running in place.
- ❑ Brush and floss your teeth. It's important to take good care of your teeth and gums. Try to brush at least two times a day and floss at least once a day.
- ❑ Make a list of 3-4 important food or activity reminders and put them up where you're most likely to see them, like the refrigerator, bathroom, or near your bed.

THINGS TO REMEMBER

- ▶ The goal is to be more active, have fun, feel good about yourself, and to eat well.
- ▶ Get friends and family to help. It definitely works better when you partner with someone else to make changes in the way you eat or exercise.
- ▶ **You are NOT on a diet!** A "diet" usually means only a short-term change and generally isn't something that is healthy.
- ▶ Limiting foods just doesn't work and causes you to crave "forbidden" food more often. The goal is to maintain healthy eating and exercise habits as a regular part of life. Avoid over and under eating and find a place somewhere in between.
- ▶ **Last BUT NOT least:** Avoid short-term goals because nothing changes overnight. There will be times when it will be rough to stick to the changes you've decided to make. This is okay. Lifestyle change is very difficult for everyone, so try to remain positive and congratulate yourself for the changes you make. ***Hang in there and take one day at a time!***[13]



[13] Adapted from Daniel Delgado, County of Santa Clara

Building Your Plate for a Better Meal

DAIRY & MILK ALTERNATIVES

Nonfat and lowfat
Milk, yogurt and cottage cheese
Soy milk

WHOLE GRAINS

Whole grain bread
Whole wheat pasta
Brown rice
High-fiber cereal
Whole wheat tortillas
Whole wheat soba noodles
Rice wheat buns

PROTEINS

Fish
Tofu
Eggs
Seeds
Lean meat
Poultry
Beans
Nuts

Vegetables and Salads — Lettuce, collard greens, bok choy, watercress, coriander, bamboo shoots, baby corn, kale, mustard greens, Mexican cactus, yams, chilies, squash, jicama, sweet potatoes, carrots, green peppers, broccoli, cauliflower, eggplant, zucchini, green beans, mushroom, spinach, corn, and potatoes (reduce or avoid french fries)

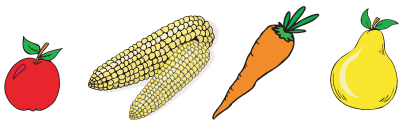
Fruits — Apple, banana, strawberry, orange, kiwi, mango, grape, pineapple, watermelon, peach, pear, guava, cherimoya

FRUITS & VEGETABLES

Essential fats
Use olive or canola oil for cooking and dressing on salad

Adapted from the UCSF Watch Clinic. Garber, A., Drohr, D. (2003)

* Available in Spanish, Chinese and Vietnamese at www.ahwg.net



What Is a Single Serving?

Your body needs different servings (or helpings) of food groups. This chart outlines what a single serving looks like in each group.

FOOD	SINGLE SERVING	LOOKS LIKE	SERVINGS PER DAY
VEGETABLES			
Chopped	1/2 cup	1/2 baseball or size of an ice cream scoop	3-5
Raw Leafy Vegetables (such as lettuce)	1 cup	1 baseball/tennis ball or average adult fist	
Vegetable Juice	1/2 to 3/4 cup		
FRUIT			
Whole/pieces	1 medium fresh piece or 1/2 cup chopped, canned, or frozen	1 tennis ball	2-4
Juice	½ cup	1 scoop ice cream	
Dried	1/4 cup	1 golf ball	
GRAINS			
Pasta, Rice, Bread, Hot Cereal (such as oatmeal)	1/2 cup of cooked cereal, rice or pasta	1/2 baseball	6-11
	1 medium potato	Computer mouse	
	1 slice of bread	Hockey puck	
	2 handfuls of baked chips or pretzels		
Cold Cereal	1 oz., which varies from 1/4 cup to 1¼ cup (check label)	*(Note: Most bagels sold in stores are equal to about 5 slices of bread—equals 4-6 servings!!)*	
MEAT/PROTEIN			
Meat, Chicken or Fish	3 oz. (boneless, cooked weight from 4 oz. raw)	Deck of cards or a checkbook	2-3 (for a total of 6-7 ounces)
Tofu	3 oz.	Deck of cards	
Beans (kidney, white, split, blackeye)	1/2 cup cooked (about 5 tablespoons)*	1/2 baseball or small handful	
Nuts and Seeds	2 tablespoons peanut butter* or 1/3 cup nuts	A golf ball	
Eggs	1 egg*	*(Limit egg yolks to 4 a week)*	
DAIRY *(Choose nonfat or lowfat)*			
Milk	1 cup (8 oz. glass)	1 small yogurt container	2-3
Cheese	1½ ounces	1 oz. looks like four dice put together	
Yogurt	1 cup	2 scoops of ice cream	

* equals 1 ounce meat

Adapted from:
1) Severson, Kim. The Obesity Crisis, Perils of portion distortion: Why Americans don't know when enough is enough. San Francisco Chronicle. 3.7.04.
2) Recommendations per Dietary Guidelines for Americans, 2000. U.S. Department of Agriculture, Center for Nutrition Policy and Promotion, The Food Guide Pyramid, Home and Garden Bulletin Number 252, 1996.

* Available in Spanish, Chinese and Vietnamese at www.ahwg.net

HEALTHY EATING & SNACKING TIPS

✔ Check out the **FOOD LABEL** so you know what you are eating!

How many servings are you eating?

How many calories are you eating?

Get *ENOUGH* vitamins and minerals!
*5% or less is low
*20% or more is high for 1 serving

Nutrition Facts

Serving Size: 1/4 Recipe (188g)
Servings Per Recipe: 4

Amount Per Serving		
Calories 199	**Cal. from Fat** 45	
		% Daily Value*
Total Fat 5g		**8%**
Saturated Fat 1g		**4%**
Cholesterol 0mg		**0%**
Sodium 245mg		**10%**
Total Carbohydrate 31g		**10%**
Dietary Fiber 8g		**35%**
Sugars 0g		
Protein 10g		

Vitamin A	75%	Vitamin C	40%
Calcium	10%	Iron	20%

*Percent Daily Values is based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs.

Get *LESS* saturated fat!
*5% or less is low
*20% or more is high for 1 serving

Use the % daily value (DV) to select foods high in fiber, vitamins and minerals (calcium and iron) and low in fats, cholesterol and sodium.

✔ Before you snack or eat, think about if you're *really* hungry. ***If you're not, hold off!***
✔ Take your time when you eat. Wait 15-20 minutes before eating second helpings. It takes about 15-20 minutes for your stomach to tell your brain that you are full.
✔ Switch to whole grain bread, cereal, pasta, and rice instead of white bread, white rice, and sugar cereal.
✔ Cut back on soda, sports drinks, and juice. Instead try water (eight glasses a day), flavored water, natural tea, lowfat/nonfat milk, and diet soda (if you must have soda!).
✔ Fill up half of your plate with salad or vegetables.
✔ Try fruit for snacks and dessert instead of candy and cookies. If you are going to have sugary foods, sweets, desserts, or candy, eat only a small serving at the end of the meal or share a portion with someone else.

WHAT ABOUT FAST-FOOD RESTAURANTS?

Fast foods can be okay, but watch out for portion sizes, how they're made (baked, grilled, fried, etc.) and toppings.

WHAT ABOUT SNACKS?

There are a lot of healthy snacks, just remember to pay attention to serving sizes!

- A handful of pretzels
- A handful of dried fruit
- Frozen 100% juice bars
- Microwave low fat popcorn
- Rice cakes
- Cup of soup
- Nuts/trail mix
- Half a sandwich
- Cut up vegetables - plain or with low fat dressing
- Low sugar cereal (plain or with low/nonfat milk)
- Fruit (fresh, frozen, or canned in juice/light syrup)
- Low fat or nonfat yogurt or cottage cheese

*Can you believe the difference in the calories?**

Instead of ...	Calories	Go for ...	Calories
Big Mac	590	A regular hamburger	310
Whopper	760		
Quarterpounder	530		
Large fries	520	Small fries (or share a large size with a friend!)	220
Large shakes (32 oz.)	1120	Small shakes (12 oz.)	430
Large sodas (32 oz.)	310	Small sodas (12 oz.)	110
Fried/fillet chicken sandwich or nuggets	510	Grilled chicken sandwich	400
Hamburger with secret sauce, cheese, and mayo	530	Hamburger with lettuce, tomato, ketchup, and mustard	400
One slice of deep dish pizza with pepperoni	275	One slice of thin crust pizza with veggies	142
Small french fries	220	Side salad with light dressing	70

* Calories measure the amount of energy your body gets from food. You need energy to be physically active and for your body to grow and function. The current daily recommended teen calorie levels are: 2500 for males 11-14 years, 3000 for males 15-18, and 2200 for females 11-18.

Exercise Pyramid

Exercise keeps your body and mind healthy and strong. It can also help you feel better, relax, and sleep well. There are many different ways to be active — you don't have to play a sport or go to the gym to be physically active.

Check out the pyramid for ideas!

HAVE FUN!
Aim for 30-60 minutes a day!

Cut Down On Sedentary (Couch Potato) Activities:

Watching/playing TV, videos/DVDs, computer games, surving the net, sitting for more than 30 minutes at a time

2-3 Times a Week (at least):

Strength and Flexibility
Pull-ups/push-ups/sit-ups, yoga, ballet/dance, karate, tae bo, pilates, weight lifting

3-5 Times a Week (at least):

Aerobic
(at least 20 minutes)
Biking, swimming, jump rope, skating, jogging, hiking, aerobics, exercise videos

Recreation Activities
(at least 20 minutes)
Basketball, soccer, skiing, volleyball, capoeira, skating, dancing, tennis

Every Day (as much as possible):

Take the stairs instead of the elevator, ride your bike or walk to school/the store/a friend's house

Throw a frisbee, walk your or your neighbor's dog, play basketball/softball, help clean up and/or garden at home or in your community

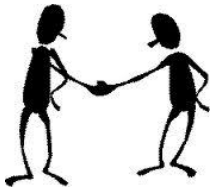
Ways to Increase Your Physical Activity

- ***Add an activity***. Find a new activity that you enjoy.
- ***Replace inactive time with active time***. For example, take a walk instead of watching TV.
- ***Do more of what you are already doing.*** For example, walk for 30 minutes instead of 20.
- ***Work a little harder.*** Turn your walks into power walks or jogs. Walk up and down the stairs instead of riding the elevators and escalators.

Exercising with Asthma

- Talk to your medical provider to figure out what exercises and medications are best for you.
- Always have your inhaler nearby when you are exercising.
- Do not begin exercising when you have asthma symptoms. Always stop if you feel bothered by your asthma.
- Use extra caution when you have a cough, cold, or allergy symptoms.
- Take extra time to warm up and cool down.
- Cover your mouth and nose with a scarf when exercising in cold weather. Breathing cold air can make asthma worse.
- Exercise for short amounts of time and more often. Non-stop activities are more likely to affect asthma.
- Take a warm bath or shower after exercising. This may help post-exercise attacks.

Daily Activity Diary - BACE

Activity	Morning AM 	Afternoon PM 	Evening EVE 
Body care Exercise Healthy eating Treat illness Rest & sleep 			
Achievement Work Chores Study 			
Connect with others Friends Family Community 			
Enjoyment Play Fun Pleasure 			

Obesity: Nutrition and Exercise

Obesity is a societal problem

Weight matters

Many young people today are living large. Obesity rates have doubled since 1980 among children and have tripled for adolescents. In the past 20 years, the proportion of adolescents aged 12 to 19 who are obese increased from 5 percent to 18 percent. Obesity is defined as a body mass index (BMI) that is equal to or greater than the 95th percentile for age and gender on growth charts developed by the Centers for Disease Control and Prevention (CDC).

A predisposition to obesity can be inherited. However, genetic factors do not explain the dramatic increase in obesity over the last 30 years. Human beings, like animals, are hardwired to eat not simply to sustain life, but to eat high-calorie foods in anticipation of an unpredictable food supply. Our surroundings make it possible to eat fatty foods on a regular basis, but difficult to burn off all those calories through activity. High-fat food is cheap and tasty, and teens' primary activities—school and media consumption—are sedentary.

Thus, obesity is a social problem rather than a personal flaw or a failure of willpower. Teens, especially, are impacted by their surroundings, and several studies at the University of Illinois-Chicago and the University of Michigan confirm that our modern environment is designed to make adolescents fat.

There are some environmental factors that contribute to teen obesity.

- Schools sell more high-fat, high-calorie foods and sugary drinks than nutritious, lower-calorie choices.
- Low-income communities offer limited access to healthy food. In some neighborhoods, convenience stores are the only places to buy food.
- Adolescents live sedentary lives. Teens spend the school day mostly sitting, and then go on to spend an average of three more hours parked in front of a TV or computer screen.
- School physical education programs have been slashed. In 1991, 42 percent of high school students participated in daily phys. ed. classes. By 2007, that number was 25 percent or lower.
- Airwaves are saturated with food-product ads. Teenagers see, on average, 17 ads a day for candy and snack foods, or more than 6,000 ads a year.
- Big portions provide far more calories than young people can burn up. Fast-food burgers can top

THE PERILS OF POUNDS

Being overweight or obese is more than a matter of appearance. Excess pounds contribute significantly to health problems and can lead to Type 2 (adult-onset) diabetes, high blood pressure, stroke, heart conditions, cancer, gallstones and gall bladder disease, bone and joint problems, sleep apnea, and breathing difficulties. An adolescent who is obese (with a body mass index above the 95th percentile) has a 60 percent chance of developing one of these conditions.

In addition, studies have found that overweight youth are at greater risk for emotional distress than their non-overweight peers. Overweight teenagers have fewer friends, are more likely to be socially isolated, and suffer higher rates of depression than young people of normal weight. Being overweight also affects self-esteem. According to one study, obese girls aged 13 to 14 are four times more likely to suffer from low self-esteem than non-obese girls. Low self-esteem in adolescents is associated with higher rates of loneliness, sadness, and nervousness.

become the norm; and some popular restaurant chains offer entrees that weigh in at 1,600 calories. The average adolescent needs only 2,300 to 2,500 calories a day.

Because the causes of excess weight are so complex, dietary changes are just one aspect of treating obesity. Adolescent weight problems can be related to poor eating habits, overeating or binging, physical inactivity, family history of obesity, stressful life events or changes (divorce, moves, deaths, and abuse), problems with family and friends, low self-esteem, depression, and other mental health conditions.

Teens are consuming more calories, but getting less nourishment

Adequate nutrition during adolescence is particularly important because of the rapid growth teenagers experience: they gain 50 percent of their adult weight and 50 percent of their bone mass during this decade of life.

Dietary choices and habits established during adolescence greatly influence future health. Yet many studies report that teens consume few fruits and vegetables and are not receiving the calcium, iron, vitamins, or minerals necessary for healthy development. Low-income youth are more susceptible to nutritional deficiencies, and since their diets tend to be made up of high-calorie and high-fat foods, they are also at greater risk for overweight or obesity.

Teasing about weight is toxic

Weight is one of the last sanctioned targets of prejudice left in society. Being overweight or obese subjects a teen to teasing and stigmatization by peers and adults. It can happen at home, at school, on the street—anywhere, even on TV. Ads and programming usually portray the overweight as the target of jokes, perpetual losers, and not as smart or successful as their thinner counterparts.

Teasing by family members, including parents, is surprisingly common, perhaps because family members mistakenly believe they are being helpful when they draw attention to someone's size or harass them about what they are eating. When they label their overweight adolescents with such epithets as "greedy," "lazy," or "little piggies," parents and siblings become an integral part of the problem.

A 2003 study of nearly 5,000 teenagers in the Minneapolis area found that 29 percent of girls and 16 percent of boys were teased by family members and one-third of the girls and

WAYS YOU CAN MAKE A DIFFERENCE

- **REALIZE** that "kid-friendly" meals such as chicken nuggets, fries, and pizza with meat toppings are not the healthiest choices.
- **ADVOCATE** for recreation and com-munity centers and safe parks and trails so that youths can read-ily participate in physical activities and sports programs.
- **DISCOURAGE** late-night eating or the habit of consuming most of the day's calories in the evening.
- **RALLY** for the building of super-markets and for greater access to fresh foods in urban neighborhoods.
- **PUSH** for direct access from bus and subway routes to farmers' markets.
- **SUPPORT** schoolwide efforts to promote physical activity and to limit offerings of junk foods and sugary beverages in the cafeteria and vending machines.
- **JOIN** forces with adolescents on an advocacy project insisting that food companies live up to their promises to stop marketing un-healthy foods to youth.
- **ACKNOWLEDGE** disparate views of the body and food based on gender, such as approval of larger size among boys.
- **EXAMINE** whether entrenched be-liefs within your family, e.g., that it is important to finish everything on your plate, might be contribut-ing to overeating.

one-fourth of the boys had been teased by their peers about their weight.

Weight-based taunting is not harmless. Adolescents in the study saw the teasing as having a greater negative impact on their self-image than did their actual body size.

Teasing should be taken seriously and never tolerated at home, in school, or in the community. Policies have helped to establish norms making ethnic slurs unacceptable. Perhaps similar policies can be formed to send a clear message that bullying people about body shape is not sanctioned in the schools or the community.

What can be done?

Young people can conquer weight problems and get adequate nutrition with a combination of a healthful diet, regular physical activity, counseling, and support from adults and peers. For severely obese teens, medication or bariatric surgery is sometimes prescribed to supplement weight management efforts.

While proper diet and exercise improve physical health, parents and caregivers can also enhance mental health by emphasizing the overweight teen's strengths and positive qualities. After all, the measure of a young person's worth is far more than the numbers on the scale.

Some heavier adolescents will lose excess weight through positive lifestyle changes and through the normal growth spurts of puberty that make their bodies taller and leaner. In other cases, obesity becomes a lifelong struggle.

Eating healthy foods in right-sized portions and exercising are lifelong habits, not temporary fixes. During growth spurts, adolescents do need a lot of calories, and the classic portrait of a teenager as a bottomless pit—someone who can consume volumes of food and burn it all off—seems to hold true. These increased calories should come from healthy foods because teens need more nutrition as well as more calories. Learning to pay attention to cues of fullness from the body, as opposed to eating mindlessly, will help teens avoid a habit of overeating in later years when their metabolism inevitably slows down.

Adults can help control what happens in the home, schools, and neighborhood when it comes to eating and exercise. One of the best ways adults can influence young people is by changing their own eating and exercise habits. Adults can help young people establish healthy habits by

- Not skipping breakfast.
- Eating fruits, vegetables, lean protein, and whole grains.
- Cooking dinner at home using fresh, whole foods.
- Not buying or drinking beverages with added sugars.
- Building exercise and physical activity into one's own daily routines and encouraging one's children to join them.
- Not inappropriately encouraging youth to lose weight.

Weight gain accompanies puberty: teens grow in height, boys develop muscle mass; girls develop breasts and hips; and both boys and girls can put on body fat before a growth spurt. Adults should understand normal physical development (see the Physical Development chapter) to avoid putting undue pressure on an adolescent to be a certain size or weight.

> **"I think there's a lot of pressure out there to look perfect, but what's perfect?"**
>
> *Girl, 16*

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

Scoring the PHQ-9 modified for Teens

Scoring the PHQ-9 modified for teens is easy but involves thinking about several different aspects of depression.

To use the PHQ-9 as a diagnostic aid for Major Depressive Disorder:

- Questions 1 and/or 2 need to be endorsed as a "2" or "3"
- Need five or more positive symptoms (positive is defined by a "2" or "3" in questions 1-8 and by a "1", "2", or "3" in question 9).
- The functional impairment question (How difficult….) needs to be rated at least as "somewhat difficult."

To use the PHQ-9 to screen for all types of depression or other mental illness:

- All positive answers (positive is defined by a "2" or "3" in questions 1-8 and by a "1", "2", or "3" in question 9) should be followed up by interview.
- A total PHQ-9 score $\geq$ 10 (see below for instructions on how to obtain a total score) has a good sensitivity and specificity for MDD.

To use the PHQ-9 to aid in the diagnosis of dysthymia:

- The dysthymia question (In the past year…) should be endorsed as "yes."

To use the PHQ-9 to screen for suicide risk:

- All positive answers to question 9 as well as the two additional suicide items MUST be followed up by a clinical interview.

To use the PHQ-9 to obtain a total score and assess depressive severity:

- Add up the numbers endorsed for questions 1-9 and obtain a total score.
- See Table below:

Total Score	**Depression Severity**
0-4	No or Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Does My Teen Need Help?

Physical Warning Signs:

- Cuts on arms or legs or other physical signs of self-harm
- Rapid or major weight loss or weight gain
- Physical injuries without good explanations
- Many stomach, head, and/or back aches
- Worsening of a chronic condition

Behavioral or Emotional Warning Signs:

- Major change in eating and/or sleeping habits
- Signs of frustration, stress, or anger
- Unusual or increasing fear, anxiety, or worry
- Relationship difficulties with family, friends, classmates, or teachers
- Skipping school, not participating in class, and/or a drop in grades
- Changes or problems with energy level or concentration
- Sudden mood swings
- Feeling down, hopeless, worthless, or guilty
- Aggressive or violent behavior
- Sudden loss of self confidence or sense of security
- Risky behaviors, breaking laws, stealing, hurting people
- Signs of alcohol or drug use
- Losing interest in things that were once enjoyed
- Constant concern about physical appearance or decrease in personal hygiene
- Isolation from others and often spends time alone
- Secretive about activities and whereabouts

If you notice any of the above warning signs, talk with your teen and then call your teen's health care provider. Be ready to discuss how serious the problem is, when the problem started, and any changes in your teen's school or family situation. Don't wait too long before seeking help.

IMPORTANT QUESTIONS TO ASK YOUR TEEN

- ☑ When and why did this problem start?
- ☑ How much is this problem troubling you?
- ☑ Is the problem getting in the way of your school work or relationships with friends or family members?
- ☑ Have you been having any thoughts about dying or hurting yourself?
- ☑ How can I help you?

Don't be afraid to ask your teen what's going on in his/her life. It will not cause any harm. A teenager in trouble needs support from caring parents.

MENTAL HEALTH EMERGENCIES

- Losing touch with reality
- In great danger of harming him/herself
- In great danger of harming others

If your teen is having an emergency, take her/him to the nearest hospital emergency room or call 911.

***DO NOT** leave her/him alone or unattended. Remove all dangerous items (guns, knives, pills) from your teen's reach.*

Do you have any comments or questions about this handout? Please contact Adolescent Health Working Group by emailing feedback@ahwg.net or calling (415) 554-8429. Thank you.

Sources:
1) Goodman RF. Choosing a Mental Health Professional for Your Child. New York University Child Study Center. 2000, http://www.aboutourkids.org
2) Substance Abuse and Mental Health Services Administration, National Mental Health Information Center. Child and Adolescent Mental Health. 2003, http://www.mentalhealth.samhsa.gov/publications/allpubs/CA-0004/default.asp

Mental Health

The process of managing emotions

Emotions can bring discomfort for everyone, but this is especially true for adolescents, who are still learning to identify and manage their emotional responses. Emotional extremes are common during the teen years and may be reflected in mood swings, emotional outbursts, sadness, or behaviors intended to distract from uncomfortable feelings (such as sleeping or listening to loud music).

Teens, like all people, have some periods that are more challenging than others. For some, though, feelings of anxiety, sadness, anger, or stress may linger and become severe enough to interfere with their ability to function. It is estimated that at some point before age 20, one in 10 young people experiences a serious emotional disturbance that disrupts their ability to function at home, in school, or in the community. The good news is that most emotional disturbances are treatable.

Signs of emotional disturbance

What is considered normal and healthy behavior depends to some degree on culture. Serious disorders in one culture may not appear in another culture. The same is true across generations. One contemporary example is intentional self-injury (known as "cutting"), which is incomprehensible to many adults who are familiar with other types of emotional disturbances, such as depression or substance abuse.

A signpost of trouble to watch for is whether a teen's capacity to function in school, at home, and in relationships is being negatively affected by emotions or behaviors. Family and friends are usually the first people to notice.

Emotional disturbance follows no single pattern. Some adolescents suffer a single, prolonged episode in their teen years and enjoy good mental health in adulthood. Others experience emotional disturbances episodically, with bouts of suffering recurring in their later teen years and adulthood. Only a small percentage of adoles-

SIGNS OF DEPRESSION

- Frequent sadness, tearfulness, crying
- Decreased interest in activities or inability to enjoy formerly favorite activities
- Hopelessness
- Persistent boredom, low energy
- Social isolation, poor communication
- Extreme sensitivity to rejection or failure
- Increased irritability, anger, or hostility
- Difficulty with relationships
- Frequent complaints of physical illness such as headaches or stomachaches
- Frequent absences from school or poor performance in school
- Poor concentration
- Feeling overwhelmed easily or often
- A major change in eating and/or sleeping patterns
- Talk of or efforts to run away from home
- Thoughts or expressions of suicide or self-destructive behavior

SOURCE: *American Academy of Child and Adolescent Psychiatry.* (2008). The depressed child. Facts for Families. Retrieved from www.aacap.org/cs/root/facts_for_families/the_depressed_child.

SUICIDE

If a young person says he or she wants to kill him or herself, always take the statement seriously and immediately get help. If you think someone is suicidal, do not leave that person alone.

The suicide rate increases during the teen years and peaks in early adulthood (ages 20-24). There is a second peak in the suicide rate after age 65, and old age is when people are at highest risk. It is nearly impossible to predict who might attempt suicide, but some risk factors have been identified. These include depression or other mental disorders, a family history of suicide, family violence, and exposure to suicidal behavior of others, including media personalities. Opportunity also plays a role. Having a firearm in the home increases the risk.

The American Academy of Child and Adolescent Psychiatry recommends asking a young person whether she is depressed or thinking about suicide. They advise, "Rather than putting thoughts in the child's head, such a question will provide assurance that somebody cares and will give the young person the chance to talk about problems."

SOURCES: *American Academy of Child & Adolescent Psychiatry.* (2008). Teen suicide. Facts for Families. Retrieved June 4, 2009, from www.aacap.org/cs/root/facts_for_families/teen_suicide.

National Institute of Mental Health. (2009). Suicide in the U.S.: Statistics and prevention. Retrieved June 4, 2009, from www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml.

cents who experience an episode of emotional disturbance will go on to have a lifelong disorder that seriously impairs their functioning as an adult.

The most common mental health disorders in adolescence are depression, characterized by prolonged periods of feeling hopeless and sad; anxiety disorders, which include extreme feelings of anxiety and fear; and alcohol and other drug abuse, including use of prescription drugs like Vicodin or Ritalin for non-medical reasons.

The underlying causes of emotional disturbances are varied and cannot always be identified. Many factors go into the mix, including genetic predisposition, environmental conditions such as exposure to lead or living in a chaotic household, and trauma such as abuse or witnessing a homicide.

Prolonged stress makes teens more vulnerable to emotional disturbances. A normal coping reaction to a difficult experience can impair someone's well-being if it goes on for too long. For example, if a teen is teased at school, it is normal—even if not desirable—for him or her to feel humiliated and anxious and to avoid the pain by skipping school, playing video games, or even experimenting with substances. These coping strategies can become harmful if chronic symptoms of anxiety or depression develop, or if behaviors such as overeating, self-injury ("cutting"), alcohol or other drug use—originally started to distract from uncomfortable emotions—become compulsive or habitual.

Getting help

Most mental health disorders are treatable. Treatment often includes—and often works best—when multiple approaches are used. These can include cognitive-behavioral therapy, family therapy, medication, and supportive education for parents and other caring adults in how to provide stability and hope as the family navigates its way through the episode of emotional disturbance.

Parents of teens with Attention Deficit Hyperactivity Disorder (ADHD), however, have often experienced years of the frustration and

exasperation that comes from trying to establish limits and discipline for children who seem consistently unable or unwilling to listen. Because all adolescents naturally strive toward assuming more responsibility and independence, the frustration of parenting a teen with ADHD may well intensify during this period of development.

A cycle of negative interaction, stress, and failure can also occur in the classroom between teachers and teens with ADHD. Teenagers who are disruptive, fidgety and impulsive can be singled out by the teacher, and labeled as disciplinary problems. Academic settings with multiple periods, large classes, teachers who have differing styles, and complex schedules present additional problems for the teenager with ADHD.

Professional help, especially help that is affordable, can be hard to find, as there is a shortage of trained mental health providers with expertise in adolescence. The sidebar in this section provides some resources where caring adults and teens can look for help.

The power of prevention

It is important to get involved early to teach positive coping skills and address environmental situations that may trigger emotional disturbances. The supports that bolster good mental health are the very same ones that promote healthy development in general. Especially valuable are opportunities for young people to practice identifying and naming emotions, to figure out coping skills that help them dissipate the energy of negative emotions, and to have the repeated, encouraging experience of being heard, understood, respected, and accepted.

RESOURCES

American Academy of Child and Adolescent Psychiatry: Facts for Families
Extensive series of briefs on a wide variety of behaviors and issues affecting families. http://www.aacap.org/cs/root/facts_for_families/facts_for_families

The Center for Mental Health in Schools: School Mental Health Project
Clearinghouse for resources on mental health in schools, including systemic, programmatic, and psychosocial/mental health concerns. http://smhp.psych.ucla.edu/

Surgeon General's Report on Mental Health
Includes a chapter on children and mental health. http://www.surgeongeneral.gov/library/mentalhealth/home.html

Technical Assistance Partnership for Child and Family Mental Health: Youth Involvement in Systems of Care. A Guide to Empowerment
Blueprints for local systems of care that are seeking to increase youth involvement. http://www.tapartnership.org/docs/Youth_Involvement.pdf

SOURCE: Whitlock, J., and Schantz, K. (2009). Mental illness and mental health in adolescence. *Research Facts and Findings*. ACT for Youth Center of Excellence. Retrieved June 3, 2009 from http://www.actforyouth.net/documents/MentalHealth_Dec08.pdf

Evidence-Based Child and Adolescent Psychosocial Interventions

This report is intended to guide practitioners, educators, youth, and families in developing appropriate plans using psychosocial interventions. It was created for the period October 2017 – April 2018 using the PracticeWise Evidence-Based Services (PWEBS) Database, available at www.practicewise.com. If this is not the most current version, please check the American Academy of Pediatrics (AAP) mental health Web site (www.aap.org/mentalhealth) for updates.

Please note that this chart represents an independent analysis by PracticeWise and should not be construed as endorsement by the AAP. For an explanation of PracticeWise determination of evidence/level, please see below or visit www.practicewise.com/aap.

Problem Area	Level 1- BEST SUPPORT	Level 2- GOOD SUPPORT	Level 3- MODERATE SUPPORT	Level 4- MINIMAL SUPPORT	Level 5- NO SUPPORT
Anxious or Avoidant Behaviors	Cognitive Behavior Therapy (CBT), CBT and Medication, CBT for Child and Parent, CBT with Parents, Education, Exposure, Modeling	Assertiveness Training, Attention, Attention Training, CBT and Music Therapy, CBT and Parent Management Training (PMT), CBT with Parents Only, Cultural Storytelling, Family Psychoeducation, Hypnosis, Mindfulness, Relaxation, Stress Inoculation	Contingency Management, Group Therapy	Behavioral Activation and Exposure, Biofeedback, Play Therapy, PMT, Psychodynamic Therapy, Rational Emotive Therapy, Social Skills	Assessment/Monitoring, Attachment Therapy, Client Centered Therapy, Eye Movement Desensitization and Reprocessing (EMDR), Peer Pairing, Psychoeducation, Relationship Counseling, Teacher Psychoeducation
Autism Spectrum Disorders	CBT, Intensive Behavioral Treatment, Intensive Communication Training, Joint Attention/Engagement, PMT, Social Skills	Imitation, Peer Pairing, Theory of Mind Training	None	Massage, Peer Pairing and Modeling, Play Therapy	Attention Training, Biofeedback, Cognitive Flexibility Training, Communication Skills, Contingent Responding, Eclectic Therapy, Executive Functioning Training, Fine Motor Training, Modeling, Parent Psychoeducation, Physical/Social/Occupational Therapy, Sensory Integration Training, Structured Listening, Working Memory Training
Delinquency and Disruptive Behavior	Anger Control, Assertiveness Training, CBT, Contingency Management, Multisystemic Therapy, PMT, PMT and Problem Solving, Problem Solving, Social Skills, Therapeutic Foster Care	CBT and PMT, CBT and Teacher Training, Communication Skills, Cooperative Problem Solving, Family Therapy, Functional Family Therapy, PMT and Classroom Management, PMT and Social Skills, Rational Emotive Therapy, Relaxation, Self Control Training, Transactional Analysis	Client Centered Therapy, Moral Reasoning Training, Outreach Counseling, Peer Pairing	CBT and Teacher Psychoeducation, Exposure, Physical Exercise, PMT and Classroom Management and CBT, PMT and Self-Verbalization, Stress Inoculation	Behavioral Family Therapy, Catharsis, CBT with Parents, Education, Family Empowerment and Support, Family Systems Therapy, Group Therapy, Imagery Training, Play Therapy, PMT and Peer Support, Psychodynamic Therapy, Self Verbalization, Skill Development, Wraparound
Depressive or Withdrawn Behaviors	CBT, CBT and Medication, CBT with Parents, Client Centered Therapy, Family Therapy	Attention Training, Cognitive Behavioral Psychoeducation, Expression, Interpersonal Therapy, MI/Engagement and CBT, Physical Exercise, Problem Solving, Relaxation	None	Self Control Training, Self Modeling, Social Skills	CBT and Anger Control, CBT and Behavioral Sleep Intervention, CBT and PMT, Goal Setting, Life Skills, Mindfulness, Play Therapy, PMT, PMT and Emotion Regulation, Psychodynamic Therapy, Psychoeducation
Eating Disorders	CBT, Physical Exercise and Dietary Care and Behavioral Feedback	Family-Focused Therapy, Family Systems Therapy, Family Therapy with Parents Only	None	Physical Exercise and Dietary Care	Behavioral Training and Dietary Care, CBT with Parents, Client Centered Therapy, Dietary Care, Education, Family Therapy, Family Therapy with Parent Consultant, Goal Setting, Psychoeducation, Yoga
Elimination Disorders	Behavior Alert, Behavior Alert and Behavioral Training, Behavioral Training, Behavioral Training and Biofeedback and Dietary Care and Medical Care, Behavioral Training and Dietary Care and Medical Care	Behavioral Training and Dietary Care, Behavioral Training and Hypnosis and Dietary Care, CBT	Behavior Alert and Medication	None	Assessment/Monitoring, Assessment/Monitoring and Medication, Behavioral Training and Medical Care, Biofeedback, Contingency Management, Dietary Care, Dietary Care and Medical Care, Hypnosis, Medical Care, Psychoeducation

Problem Area	Level 1- BEST SUPPORT	Level 2- GOOD SUPPORT	Level 3- MODERATE SUPPORT	Level 4- MINIMAL SUPPORT	Level 5- NO SUPPORT
Mania	None	CBT for Child and Parent, Cognitive Behavioral Psychoeducation	None	None	Cognitive Behavioral Psychoeducation and Dietary Care, Dialectical Behavior Therapy and Medication, Family-Focused Therapy, Psychoeducation
Substance Use	CBT, Community Reinforcement, Contingency Management, Family Therapy, MI/Engagement	Assertive Continuing Care, CBT and Contingency Management, CBT and Medication, CBT with Parents, Family Systems Therapy, Functional Family Therapy, Goal Setting/Monitoring, MI/Engagement and CBT, MI/Engagement and Expression, Multidimensional Family Therapy, Problem Solving, Purdue Brief Family Therapy	Drug Court, Drug Court and Multisystemic Therapy and Contingency Management, Eclectic Therapy	Goal Setting, Psychoeducation	Advice/Encouragement, Assessment/Monitoring, Behavioral Family Therapy, Case Management, CBT and Community Information Campaign, CBT and Functional Family Therapy, Client Centered Therapy, Drug Court and Multisystemic Therapy, Drug Education, Education, Family Court, Feedback, Group Therapy, Mindfulness, MI/Engagement and CBT and Family Therapy, Multisystemic Therapy, Parent Psychoeducation, PMT, Therapeutic Vocational Training
Suicidality	None	Attachment Therapy, CBT with Parents, Counselors Care, Counselors Care and Support Training, Interpersonal Therapy, Multisystemic Therapy, Parent Coping/Stress Management, Psychodynamic Therapy, Social Support	None	None	Accelerated Hospitalization, Case Management, CBT, Communication Skills, Counselors Care and Anger Management
Traumatic Stress	CBT, CBT with Parents, EMDR	Exposure	None	Play Therapy, Psychodrama, Relaxation and Expression	Advice/Encouragement, Client Centered Therapy, CBT and Medication, CBT with Parents Only, Education, Expressive Play, Interpersonal Therapy, Problem Solving, Psychodynamic Therapy, Psychoeducation, Relaxation, Structured Listening

Adapted with permission from PracticeWise.

Note: CBT = Cognitive Behavior Therapy; MI = Motivational Interviewing; PMT = Parent Management Training; Level 5 refers to treatments whose tests were unsupportive or inconclusive. This report updates and replaces the “Blue Menu” originally distributed by the Hawaii Department of Health, Child and Adolescent Mental Health Division, Evidence-Based Services Committee from 2002–2009.

Background

The PracticeWise "Evidence-Based Child and Adolescent Psychosocial Interventions" tool is created twice each year and posted on the AAP Web site at www.aap.org/mentalhealth, using data from the PracticeWise Evidence-Based Services Database, available at www.practicewise.com. The table is based on an ongoing review of randomized clinical psychosocial and combined treatment trials for children and adolescents with mental health needs. The contents of the table represent the treatments that best fit a patient's characteristics, based on the primary problem (rows) and the strength of evidence behind the treatments (columns). Thus, when seeking an intervention with the best empirical support for an adolescent with depression, one might select from among cognitive behavior therapy (CBT) alone, CBT with medication, CBT with parents included, client centered therapy, or family therapy. Each clinical trial must have been published in a peer-reviewed scientific journal, and each study is coded by 2 independent raters whose discrepancies are reviewed and resolved by a third expert judge. Prior to report development, data are subject to extensive quality analyses to identify and eliminate remaining errors, inconsistencies, or formatting problems.

Strength of Evidence Definitions

The strength of evidence classification uses a 5-level system that was originally adapted from the American Psychological Association Division 12 Task Force on the Promotion and Dissemination of Psychological Procedures.[1] These definitions can be seen in the Box below. Higher strength of evidence is an indicator of the reliability of the findings behind the treatment, not an index of the expected size of the effect.

Treatment Definitions

"Evidence-Based Child and Adolescent Psychosocial Interventions" uses a broad level of analysis for defining treatments, such that interventions sharing a majority of components with similar clinical strategies and theoretical underpinnings are considered to belong to a single treatment approach. For example, rather than list each CBT protocol for depression on its own, the tool handles these as a single group that collectively has achieved a particular level of scientific support. This approach focuses more on "generic" as opposed to "brand name" treatment modalities, and it also is designed to reduce the more than 500 distinct treatments that would otherwise be represented on this tool to a more practical level of analysis.

Problem Definition

The presenting problems represented in the table rows are coded using a checklist of 25 different problem areas (e.g., anxious or avoidant behaviors, eating disorders, substance use). The problem area refers to the condition that a treatment explicitly targeted and for which clinical outcomes were measured. These problem areas are inclusive of diagnostic conditions (e.g., all randomized trials targeting separation anxiety disorder are considered collectively within the "Anxious or Avoidant Behaviors" row) but also include the much larger number of research trials that tested treatments but did not use diagnosis as a study entry criterion. For example, many studies use elevated scores on behavior or emotion checklists or problems such as arrests or suicide attempts to define participants. Mental health diagnoses are therefore nested under these broader categories.

History of This Tool

This tool has its origins with the Child and Adolescent Mental Health Division of the Hawaii Department of Health. Under the leadership of then-division chief Christina Donkervoet, work was commissioned starting in 1999 to review child mental health treatment outcome literature and produce reports that could serve the mental health system in selecting appropriate treatments for its youth.[2] Following an initial review of more than 120 randomized clinical trials,[3] the division began to issue the results of these reviews in quarterly matrix reports known as the Blue Menu (named for the blue paper on which it was originally printed and distributed). This document was designed to be user-friendly and transportable, thereby making it amenable to broad and easy dissemination. As of 2010, the AAP supports the posting of the next generation of this tool. "Evidence-Based Child and Adolescent Psychosocial Interventions" now represents over 900 randomized trials of psychosocial treatments for youth. PracticeWise continues to identify, review, and code new research trials and plans to continue providing updates to this tool to the AAP for the foreseeable future.

References

1. American Psychological Association Task Force on Promotion and Dissemination of Psychological Procedures, Division of Clinical Psychology. Training in and dissemination of empirically-validated psychological treatments: report and recommendations. *Clin Psychol.* 1995;48:3–23

2. Chorpita BF, Donkervoet CM. Implementation of the Felix Consent Decree in Hawaii: the implementation of the Felix Consent Decree in Hawaii. In: Steele RG, Roberts MC, eds. *Handbook of Mental Health Services for Children, Adolescents, and Families.* New York, NY: Kluwer Academic/Plenum Publishers; 2005:317–332

3. Chorpita BF, Yim LM, Donkervoet JC, et al. Toward large-scale implementation of empirically supported treatments for children: a review and observations by the Hawaii Empirical Basis to Services Task Force. *Clin Psychol Sci Pract.* 2002;9(2):165–190

See more on the PracticeWise publications page.

Strength of Evidence Definitions

Level 1: Best Support

I. At least 2 randomized trials demonstrating efficacy in one or more of the following ways:
   a. Superior to pill placebo, psychological placebo, or another treatment.
   b. Equivalent to all other groups representing at least one level 1 or level 2 treatment in a study with adequate statistical power (30 participants per group on average) that showed significant pre-study to post-study change in the index group as well as the group(s) being tied. Ties of treatments that have previously qualified only through ties are ineligible.

II. Experiments must be conducted with treatment manuals.

III. Effects must have been demonstrated by at least 2 different investigator teams.

Level 2: Good Support

I. Two experiments showing the treatment is (statistically significantly) superior to a waiting list or no-treatment control group. *Manuals, specification of sample, and independent investigators are not required.*

OR

II. One between-group design experiment with clear specification of group, use of manuals, and demonstrating efficacy by either
   a. Superior to pill placebo, psychological placebo, or another treatment
   b. Equivalent to an established treatment (See qualifying tie definition above.)

Level 3: Moderate Support

One between-group design experiment with clear specification of group and treatment approach and demonstrating efficacy by either
   a. Superior to pill placebo, psychological placebo, or another treatment
   b. Equivalent to an already established treatment in experiments with adequate statistical power (30 participants per group on average)

Level 4: Minimal Support

One experiment showing the treatment is (statistically significantly) superior to a waiting list or no-treatment control group. *Manuals, specification of sample, and independent investigators are not required.*

Level 5: No Support

The treatment has been tested in at least one study but has failed to meet criteria for levels 1 through 4.

CHAPTER 3

EMOTIONAL & SOCIAL DEVELOPMENT

A quest for emotional and social competence

"Adults influence me more than my friends because they have more wisdom and experience in the world."

Girl, 16

Although the stereotype of adolescence emphasizes emotional outbursts and mood swings, in truth, the teen years are a quest for emotional and social competence.

Emotional competence is the ability to perceive, assess, and manage one's own emotions. Social competence is the capacity to be sensitive and effective in relating to other people. Cognitive development in the adolescent brain gives teens increasing capacity to manage their emotions and relate well to others.

Unlike the physical changes of puberty, emotional and social development is not an inevitable biological process during adolescence. Society expects that young people will learn to prevent their emotions from interfering with performance and relate well to other people, but this does not occur from brain development alone—it must be cultivated.

Four areas of emotional and social development

Emotional and social development work in concert: through relating to others, you gain insights into yourself. The skills necessary for managing emotions and successful relationships have been called "emotional intelligence" and include self-awareness,

social awareness, self-management, and the ability to get along with others and make friends.

Self-awareness: What do I feel?

Self-awareness centers on young people learning to recognize and name their emotions. Feelings cannot be labeled accurately unless conscious attention is paid to them, and that involves going deeper than saying one feels "good," "bad," or the all-purpose "OK."

Going deeper means an adolescent might discover he or she feels "anxious" about an upcoming test, or "sad" when rejected by a potential love interest. Identifying the source of a feeling can lead to figuring out constructive ways to resolve a problem.

Without this awareness, undefined feelings can become uncomfortable enough that adolescents may grow withdrawn or depressed or pursue such numbing behaviors as drinking alcohol, using drugs, or overeating.

Social awareness: What do other people feel?

While it is vital that youth recognize their own emotions, they must also develop empathy and take into account the feelings of others. Understanding the thoughts and feelings of others and appreciating the value of human differences are the cornerstones of social awareness.

Cognitive development during adolescence may make social awareness difficult for some young people. Adolescents actually read emotions through a different part of the brain than do adults. Dr. Deborah Yurgelun-Todd, director of Neuropsychology and Cognitive Neuroimaging at McLean Hospital in Belmont, Massachusetts, took magnetic resonance imaging (MRI) scans of the brains of both teenagers and adults as they were shown images of faces that clearly expressed fear. All the adults correctly identified fear. About half of the teens got it wrong, mistaking the expression as that of shock, sadness, or confusion.

Yurgelun-Todd discovered that on the MRI scans of the adults, both the limbic area of the brain (the part of the brain linked to emotions) and the prefrontal cortex (connected to judgment and reasoning) were lit up. When teens saw the same images, the limbic area was bright, but there was almost no activity in the prefrontal cortex. Until the prefrontal cortex fully develops in

BRAIN BOX

Increases in estrogen and testosterone at puberty literally change the brain structure so that it processes social situations differently. Pubertal hormones prompt a proliferation of receptors for oxytocin, a hormone that functions as a neurotransmitter, in the limbic area of the brain, where emotional processing occurs. The effect of increased oxytocin is to increase feelings of self-consciousness, to the point where an adolescent may truly feel that his or her behavior is the focus of everyone else's attention. These feelings of having the world as an audience peak around age 15 and then decline.

SOURCE: Steinberg, L. (2008) A social neuroscience perspective on adolescent risk-taking. *Developmental Review*, 28, 78–106.

early adulthood, teens may misinterpret body language and facial expressions. Adults can help by telling teens how they are feeling. For example, a parent can say, "I'm not mad at you, just tired and crabby."

Self-management: How can I control my emotions?

Self-management is monitoring and regulating one's emotions and establishing and working toward positive goals. Adolescents can experience intense emotions with puberty. Researchers have found that the increase of testosterone in both boys and girls at puberty literally swells the amygdala, an area of the brain associated with social acceptance, responses to reward, and emotions, especially fear.

Nonetheless, adolescents can and do learn to manage their emotions. Self-management in a young person involves using developing reasoning and abstract thinking skills to step back, examine emotions, and consider how those emotions bear on longer-term goals. By actively managing emotions rather than reacting to a flood of feelings, young people can learn to avoid the pitfalls and problems that strong emotions often evoke. Recognizing that they have the power to choose how to react in a situation can greatly improve the way adolescents experience that situation.

Peer relationships: How can I make and keep friends?

Social and emotional development depends on establishing and maintaining healthy, rewarding relationships based on cooperation, effective communication, and the ability to resolve conflict and resist inappropriate peer pressure.

These social skills are fostered by involvement in a peer group, and teens generally prefer to spend increasing amounts of time with fellow adolescents and less time with family. Peers provide a new opportunity for young people to form necessary social skills and an identity outside the family.

Possible causes of heightened emotions in adolescents

- Hormones, which set off physical changes at puberty, also affect moods and general emotional responses in teens.
- Concerns about physical changes—height, weight, facial hair, developing breasts in girls—are a source of sensitivity and heightened emotions.
- Irregular meal patterns, skipping breakfast, and fasting to lose weight can affect mood.
- Inadequate sleep can lead to moodiness, gloominess, irritability, and a tendency to overreact.
- Experiencing the normal ups and downs of social relationships, especially romantic relationships, can make a teen feel anything from elation to abject despair.

The influence of peers is normal and expected. Peers have significant sway on day-to-day values, attitudes, and behaviors in relation to school, as well as tastes in clothing and music. Peers also play a central role in the development of sexual identities and the formation of intimate friendships and romantic relationships.

Friends need not be a threat to parents' ultimate authority. Parents remain central throughout adolescence. Young people depend on their families and adult caregivers for affection, identification, values, and decision-making skills. Teens report, and research confirms, that parents have more influence than peers on whether or not adolescents smoke, use alcohol and other drugs, or initiate sexual intercourse.

Teens also frequently seek out adult role models and advisors such

> **"My mom is my biggest influence because she always knows the answers to my questions and would never tell me anything that would hurt me in the long run."**
>
> *Boy, 15*

Popularity plusses and minuses

Most parents wish their teenagers to be popular. Certainly, most teens want to be popular, too. However, a recent study in the journal *Child Development* suggests that being on the A-list is not always what it's cracked up to be.

The advantages of popularity are that popular adolescents possess a broader array of social skills than their less well-liked peers, better self-concepts, a greater ability to form meaningful relationships with both friends and parents, and greater ability to resolve conflicts within these relationships.

But there is a downside. Popular teens are at higher risk for exposure to—and participation in—whatever risky behaviors are condoned by their peers. Popularity can be associated with higher levels of alcohol and substance abuse and minor deviant behavior, such as vandalism and shoplifting.

Popular kids tend to get along better with their friends and family members and seem to have more emotional maturity than others. This maturity can be compromised by their need for group approval, as popular teens may be even more willing than other teens to adopt behaviors they think will earn them greater acceptance. Sometimes the behaviors are "pro-social"—as when a group pressures popular members to be less aggressive and hostile. Sometimes, when risky behaviors are valued by popular kids, the behaviors are more deviant.

SOURCE: Allen, J.P., Porter, M.R., & McFarland, F.C. (2005). The two faces of adolescents' success with peers: adolescent popularity, social adaptation, and deviant behavior. *Child Development.* 76(3), 747–760.

as teachers, relatives, club leaders, or neighbors. Studies show that connections to teachers, for example, can be just as protective as connections to parents in delaying the initiation of sexual activity and use of drugs, alcohol, and tobacco.

Some teenagers, of course, trade the influence of parents and other adults for the influence of their peers, but this usually happens when family closeness and parental monitoring are missing. Youth need to learn independent-thinking, decision-making, and problem-solving skills from their parents or guardians and other caring adults, so they can apply these skills within their peer network.

The nature of social relationships changes as adolescents get older. Younger teens typically have at least one primary group of friends, and the members are usually similar in many respects, including gender. During the early teen years, both boys and girls are concerned with conforming and being accepted by their peer group.

"A good parent listens to you and does not look down on you."

Girl, 14

Emerging brain science indicates that during early adolescence social acceptance by peers may be processed by the brain similarly to other pleasurable rewards, such as receiving money or eating ice cream. This makes social acceptance highly desirable and helps explain why adolescents change their behavior to match their peers'. Teens often adopt the styles, values, and interests of the group to maintain an identity that distinguishes their group from other students.

Peer groups in middle adolescence (14-16 years) tend to contain both boys and girls, and group members are more tolerant of differences in appearance, beliefs, and feelings. By late adolescence (17-19 years), young people have diversified their peer network beyond a single clique or crowd and develop intimate relationships within these peer groups, such as one-on-one friendships and romances.

Dating is a way to develop social skills, learn about other people, and explore romantic and sexual feelings. The hormonal changes that accompany pu-

> **"My friends have inspired me to help anyone that I see in need."**
>
> *Girl, 12*

berty move adolescents toward dating relationships. Mainstream culture plays a role as well. Media and popular culture are awash in images and messages that promote adolescent sexuality and romance. Dating can lead to sexual activity, but also to opportunities for expanded emotional growth. Dating and friendships open up an adolescent to experiencing extremes of happiness, excitement, disappointment, and despair. Recent research has shown that both boys and girls value intimacy in romantic relationships, dispelling the prevailing stereotype that boys prefer casual sexual relationships.

Emotional and social development in context

Adolescents face an astonishing array of options in modern society—everything from choosing multiple sources of entertainment to deciding among alternative educational or vocational pathways. Teenagers are confronted with more decisions, and more complicated decisions, than their parents and grandparents faced, often in complex environments that trigger conflicting feelings and desires.

Responsible decision-making involves generating, implementing, and evaluating ethical choices in a given situation. The choices ideally will benefit both the decision-maker and the well-being of others.

The still-developing frontal lobes in the brain render adolescents vulnerable to making poor decisions; they can have trouble forming judgments when things are cloudy or uncertain. The Cognitive Development chapter gives strategies for helping young people with their decision-making skills.

Decisions about risk-taking often are made in group situations—settings that activate intense feelings and trigger impulses. In a recent experimental study, teenagers, college students, and adults were asked to play a video driving game. When participants were alone, levels of risky driving were the same for the teens, college students, and adults. However, when they played the game in front of friends, risky driving doubled among the adolescents and increased by 50 percent among the college students, but remained unchanged among the adults. Risky behavior increased for both boys and girls.

In a follow-up study, Laurence Steinberg, PhD, of Temple University used functional MRI to map brain activity during the video driving game. The brain scans showed that teen brains respond differently when peers are present compared to when they are not present. When teens played the driving game alone, brain regions linked to cognitive control and reasoning were activated. When peers were present, additional brain circuitry that processes rewards was also activated,

The building blocks of empathy

Empathy is the ability to identify with another person's concerns and feelings. Empathy is the foundation of tolerance, compassion, and the ability to differentiate right from wrong. Empathy motivates teens and adults alike to care for those who are hurt or troubled.

Ways you can help build empathy in an adolescent:

- Demonstrate tolerance and generosity in your thoughts, words, and actions.
- Actively participate in religious or social organizations that ask you to focus on issues larger than yourself.
- Fine-tune your own empathetic behaviors and act on your concerns to comfort others, so that teenagers can copy your actions.
- Build a young person's emotional vocabulary by using such "feelings" statements as "Your friend seems really (anxious, mad, discouraged)." You can also point out nonverbal feeling cues to a teenager.
- Teach empathy and awareness of others, such as helping youth understand on an emotional level the negative consequences of prejudice.
- Talk with a young person about how his or her own suffering can lead to compassion for other teens who experience suffering.

suggesting that, for teens, potentially rewarding—and potentially risky—behaviors become even more gratifying in the presence of peers. By late adolescence and early adulthood, the cognitive control network matures, so that even among friends in a high-pressure situation, the urge to take risks diminishes.

Because heightened vulnerability to peer influence and risk-taking appears to be a natural and normal part of neurobiological development, telling adolescents not to give in to peer influence may not be effective, especially during early adolescence. Instead, teens may be best protected from harm through limiting exposure to risky situations. Harm-reducing tactics include raising the price of cigarettes, rigorously policing the sale of alcohol to minors, placing restrictions on teen driving, and making reproductive health services more accessible to adolescents.

"A good friend is 100% real with you all the time."

Boy, 16

WAYS TO HELP TEENS MAKE HEALTHY SOCIAL CONNECTIONS

Discuss the meaning of true friendship

People have plenty of acquaintances, but true friends can be rare gifts. Talk with young people about what distinguishes true friends from situational friends. True friends like you for yourself. They try to help and encourage you, and they stand by you when the other kids make fun of you or give you a hard time. A true friend does not judge you by the clothes you wear or how much expensive stuff you have, pressure you to go along with the crowd, make you do dangerous or illegal things, or leave you high and dry when things get rough.

Help teens get involved in things they care about

Young people can make friends at school, but they can also form relationships through mutual interests. Find out what adolescents are interested in—computers, music, dance, poetry slams, sports, science fiction/fantasy—and help start a club, or get teens involved in existing organizations.

Find role models for friendship

Examples of good friendships abound in movies, books, and songs, and also in your community. Friendship could be the theme of a book club or a movie series in a youth program. Expose adolescents to real-life role models and then discuss what good friendships have in common. What attributes or values do these people share?

Promote service to others

Getting youth involved with a service project in your community is a way to strengthen friendships, both with people their own age and across the generations, and to make social connections through the pursuit of common goals. Community service also promotes the values of caring and kindness, and it helps adolescents develop a sense of empathy. Let teens decide what kind of service project they would like to do.

Teach about the relationship between honesty and tact

Friends don't tear each other down—even in the name of honesty. You can help sharpen a young person's decision-making skills by talking about ways of handling certain situations without being hurtful. Possible scenarios include what to say when someone asks, "Do you like my new haircut?" or what to say when a friend or relative mentions, "I've never seen you wear the sweater I gave you."

Talk about boundaries

Being a friend does not mean being a doormat or being joined at the hip 24/7. Friendships need boundaries, just as other relationships do. Stress the importance of boundaries, establishing limits, and respecting privacy and "alone time," which make friendships healthier and stronger in the long run.

Teen Stress

Teens feel the pressure

"I think stress is a problem for teenagers like me…because when you get a certain age, you start worrying about certain things, like, when your puberty comes, your body starts to develop more, and then you get to worry about school, your families, and what most people think about you." Girl, 14

You may have caught yourself thinking, "Teen stress? Wait until they're older—then they'll know stress."

Yet teen stress is an important health issue. The early teen years are marked by rapid changes—physical, cognitive, and emotional. Young people also face changing relationships with peers, new demands at school, family tensions, and safety issues in their communities. The ways in which teens cope with these stressors can have significant short- and long-term consequences on their physical and emotional health. Difficulties in handling stress can lead to mental health problems, such as depression and anxiety disorders.

What is stress? It is the body's reaction to a challenge, which could be anything from outright physical danger to asking someone for a date or trying out for a sports team. Good and bad things create stress. Getting into a fight with a friend is stressful, but so is a passionate kiss and contemplating what might follow.

The human body responds to stressors by activating the nervous system and specific hormones. The hypothalamus signals the adrenal glands to produce more of the hormones adrenaline and cortisol and release them into the bloodstream. The hormones speed up heart rate, breathing rate, blood pressure, and metabolism. Blood vessels open wider to let more blood flow to large muscle groups, pupils dilate to improve vision, and the liver releases stored glucose to increase the body's energy. This physical response to stress kicks in much more quickly in teens than in adults because the part of the brain that can calmly assess danger and call off the stress response, the prefrontal cortex, is not fully developed in adolescence.

The stress response prepares a person to react quickly and perform well under pressure. It can help teens be on their toes and ready to rise to a challenge.

The stress response can cause problems, however, when it overreacts or goes on for too long. Long-term stressful situations, like coping with a parent's divorce or being bullied at school, can produce a lasting, low-level stress that can wear out the body's reserves, weaken the immune system, and make an adolescent feel depleted or beleaguered.

The things that cause adolescents stress are often different from what stresses adults. Adolescents will have different experiences from one another, as well. A good example of this can be seen by observing teens at a dance.

Some are hunched in the corner, eyes downcast and hugging the wall. They can't wait for the night to be over. Others are out there dancing their feet off, talking and laughing and hoping the music never stops. In between, you

THINGS THAT CAN CAUSE YOUTH STRESS

- School pressure and career decisions
- After-school or summer jobs
- Dating and friendships
- Pressure to wear certain types of clothing, jewelry, or hairstyles
- Pressure to experiment with drugs, alcohol, or sex
- Pressure to be a particular size or body shape. With girls, the focus is often weight. With boys, it is usually a certain muscular or athletic physique.
- Dealing with the physical and cognitive changes of puberty
- Family and peer conflicts
- Being bullied or exposed to violence or sexual harassment
- Crammed schedules, juggling school, sports, after-school activities, social life, and family obligations

may find a few kids pretending to be bored, hanging out with their friends, and maybe venturing onto the floor for a dance or two. So, is the dance uniformly stressful?

Several strategies can help teens with their stress. It is best, whenever possible, to help teens address stressful situations immediately. Listen to them, be open, and realize that you can be supportive even if you cannot relate to what they are feeling. Tune in to your own levels of stress, since your overwhelmed feelings can be contagious. For chronic stress, parents or caring adults can help teens understand the cause of the stress and then identify and practice positive ways to manage the situation.

SIGNS AN ADOLESCENT IS OVERLOADED

- Increased complaints of headache, stomachache, muscle pain, tiredness
- Shutting down and withdrawing from people and activities
- Increased anger or irritability; i.e., lashing out at people and situations
- Crying more often and appearing teary-eyed
- Feelings of hopelessness
- Chronic anxiety and nervousness
- Changes in sleeping and eating habits, i.e., insomnia or being "too busy" to eat
- Difficulty concentrating

STRESS MANAGEMENT SKILLS FOR YOUNG PEOPLE—& ADULTS

- Talk about problems with others
- Take deep breaths, accompanied by thinking or saying aloud, "I can handle this"
- Perform progressive muscle relaxation, which involves repeatedly tensing and relaxing large muscles of the body
- Set small goals and break tasks into smaller, manageable chunks
- Exercise and eat regular meals
- Get proper sleep
- Break the habit of relying on caffeine or energy drinks to get through the day
- Focus on what you can control (your reactions, your actions) and let go of what you cannot (other people's opinions and expectations)
- Visualize and practice feared situations
- Work through worst-case scenarios until they seem amusing or absurd
- Lower unrealistic expectations
- Schedule breaks and enjoyable activities
- Accept yourself as you are; identify your unique strengths and build on them
- Give up on the idea of perfection, both in yourself and in others

SOURCE: Dyl, J. Helping teens cope with stress. *Lifespan.* Retrieved from www.lifespan.org/services/childhealth/parenting/teen-stress.htm

Bullying

Teen bullying: A part of growing up?

Most adults can remember being teased or bullied when they were younger. It may be regarded as a regular—albeit nasty—part of growing up, but research has shown that bullying has far-reaching negative effects on adolescents. This all-too-common experience can lead to serious problems for young people at a critical time in their development, including poor mental health and dropping out of school.

Estimates from a 2002 CDC survey reveal that approximately 30 percent of teens in the United States, or over 5.7 million teens, have been involved in bullying as a victim, spectator, or perpetrator. In a 2001 national survey of students in grades six to 10, 13 percent reported bullying others, 11 percent reported being the target of school bullies, and another 6 percent said they bullied others and were bullied themselves. Teen bullying appears to be much more common among younger teens than older teens. As teens grow older, they are less likely to bully others and to be the targets of bullies.

Bullying involves a person or a group repeatedly trying to harm someone they see as weaker or more vulnerable. Appearance and social status are the main reasons for bullying, but young people can be singled out because of their sexual orientation, their race or religion, or because they may be shy and introverted.

Bullying can involve direct attacks—hitting, threatening or intimidating, maliciously teasing and taunting, name-calling, making sexual remarks, sexual assault, and stealing or damaging belongings. Bullying can also involve the subtler, indirect attacks of rumor-mongering or encouraging others to snub someone. New technology, such as text messaging, instant messaging, social networking websites, and the easy filming and online posting of videos, has introduced a new form of intimidation—cyberbullying—which is widespread on the Internet.

WARNING SIGNS

- Damaged or missing clothing and belongings
- Unexplained cuts, bruises, or torn clothes
- Lack of friends
- Frequent claims of having lost pocket money, possessions, packed lunches, or snacks
- Fear of school or of leaving the house
- Avoidance of places, friends, family members, or activities teens once enjoyed
- Unusual routes to and from school or the bus stop
- Poor appetite, headaches, stomachaches
- Mood swings
- Trouble sleeping
- Lack of interest in schoolwork
- Talk about suicide
- Uncharacteristic aggression toward younger siblings or family members

SOURCE: The Youth Connection, January/February 2005, Institute for Youth Development, www.youthdevelopment.org

Debunking the myth of the bully

The typical portrait of a young bully is someone who is insecure and seething with self-loathing. The latest research indicates the opposite is often true, that teen bullies—both boys and girls—tend to be confident, with high self-esteem and elevated social status among their peers.

Despite bullies' social status, their classmates would rather not spend a lot of time with them. Nonetheless, bullies' stature means that other teens tolerate bullying behavior. This can

TAKING THE BARK OUT OF BULLIES

Bullying should not be shrugged off as a normal rite of passage in adolescence. It is abusive behavior that is likely to create emotional and social problems during the teen years and later in life for both the victim and the aggressor. Here is how adults can help:

- **SPEAK UP** after a teen tells you about being bullied at school or elsewhere. Take his or her concerns seriously. Go to the school and talk to the teachers, coaches, and principal. Speak to the parents or adults in charge if a teen is being harassed by a peer or social clique.
- **OBSERVE** your own behavior. Adolescents look to adults for cues as to how to act, so practice being caring and empathetic, and controlling your aggressions. Avoid engaging in physical violence, harsh criticism, vendettas, and vicious emotional outbursts.
- **ADVOCATE** for policies and programs concerning bullying in the schools and the community. Anti-bullying policies have been adopted by state boards of education in North Carolina, Oregon, California, New York, Florida, and Louisiana.

One successful program used throughout the country has been developed by Dan Olweus, a Norwegian psychologist and bullying expert. The program focuses on creating a "caring community" as opposed to eliminating bad behavior. For more information on the Olweus Bullying Prevention Program, go to http://www.clemson.edu/olweus/.

pose challenges for those addressing bullying problems.

Bullies also tend to be physically aggressive, impulsive, and quick to anger, which fits in with the profile of a classic intimidator. Most often, adolescent bullies are mirroring behavior they have seen in their home or observed in adults.

School bullying

School bullying occurs more frequently among boys than among girls. Teenage boys are more likely both to bully others and to be the targets of bullies. While both boys and girls say others bully them by making fun of the way they look or talk, boys are more likely to report being hit, shoved, or punched. Girls are more often the targets of rumors and sexual comments, but fighting does occur.

While teenage boys target both boys and girls, teenage girls most often bully other girls, using sly and more indirect forms of aggression than boys, such as spreading gossip or urging others to reject or exclude another girl.

Harassment hurts

Bullying can make teens feel stressed, anxious, and afraid. Adolescent victims of bullying may not be able to concentrate in school, a problem that can lead to avoiding classes, sports, and social situations. If the bullying continues for long periods of time, feelings of self-worth suffer. Bullied teens can become isolated and withdrawn. In rare cases, adolescents may take drastic measures, such as carrying weapons for protection.

One of the most common psychiatric disorders found in adolescents who are bullied is depression, an illness which, if left untreated, can interfere with their ability to function. According to a 2007 study linking bullying and suicidal behavior, adolescents who were frequently bullied in school were five times as likely to have serious suicidal thoughts and four times as likely to attempt suicide as students who had not been victims.

Even after the bullying has stopped, its effects can linger. Researchers have found that years later, adults who were bullied as teens have higher levels of depression and poorer self-esteem than other adults.

Bullies also fare less well in adulthood. Being a teen bully can be a warning sign of future troubles. Teens, particularly boys, who bully are more likely to engage in other delinquent behaviors in early adulthood, such as vandalism, shoplifting, truancy, and drug use. They are four times more likely than non-bullies to be convicted of crimes by age 24, with 60 percent of bullies having at least one criminal conviction.

CYBER BULLIES

Text messaging, social networking sites, blogs, email, instant messaging—all these are ways teens stay connected to each other and express who they are to the world.

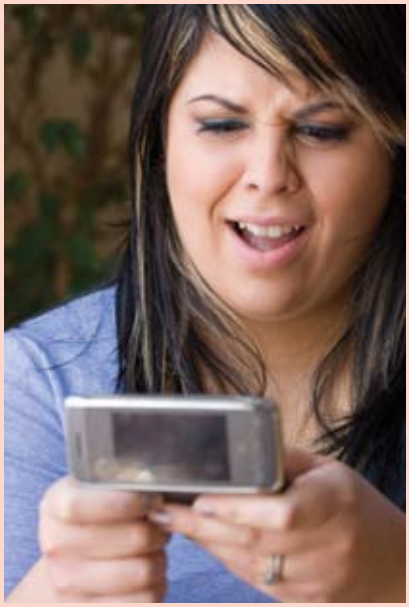
However, this new technology can make young people vulnerable to the age-old problem of bullying. Unmonitored social networking sites and chat rooms can be a forum for messages that are sexually provocative, demeaning, violence-based, or racist.

Cyberbullies send harassing or obscene messages, post private information on a public site, intentionally exclude someone from a chat room, or pretend to be someone else to try to embarrass a person (for example, by pretending to be a boy or girl who is romantically interested in the person).

Cyberbullying can spiral into a "flame war"—an escalation of online attacks sent back and forth, either privately through text and instant messaging or on a public site. On public sites flaming is meant to humiliate the person attacked and drive him or her away from the web site or forum.

Often, the information used for cyberbullying at first appears innocent or inconsequential. A teen could post or text what he or she thinks is run-of-the-mill news about a friend, teacher, or family member, but others could use it for harassment or bullying purposes.

Although there is still very little research on cyberbullying, it appears to occur at about the same rate as traditional bullying. A 2007 study of middle schools in the Southeast found



that boys and girls are equally likely to engage in cyberbullying, but girls are more likely to be victims. Twenty-five percent of girls and 17 percent of boys reported having been victims of cyberbullying in the past couple of months. Over one-third of victims of electronic bullying in this study also reported bullying behaviors. Instant messaging is the most common method for cyberbullying.

Cyberbullying differs from traditional bullying in that it can be harder to escape. It can occur at any time of the day or night, and it can be much more public, since rude and obscene messages can be spread quickly. It also can be anonymous. In the same 2007 study of middle school students, almost half of the victims of cyberbullying did not know who had bullied them.

Cyberbullying is much more common than online sexual solicitation, another serious concern. Most online sex crimes involve adult men soliciting teens between the ages of 12 and 17 into meeting them to have sex. The common media portrayal of teen victims as naïve is largely false. The vast majority of teens who are victims of online sexual predators know they are communicating with adults, communicate online about sex, and expect to have a romantic or sexual experience if and when they meet. About three-quarters of teens who meet the offender meet them more than once. To help teens avoid becoming victims of online sex crimes, it is important to have accurate and candid discussions about how it is wrong for adults to take advantage of normal sexual feelings among teens.

Teens are more vulnerable to sexual solicitations online if they send (not just post) private information to someone unknown, visit chat rooms, access pornography, or make sexual remarks online themselves.

There is no evidence that use of social networking sites such as Facebook or MySpace increases a teen's risk of aggressive sexual solicitation.

SOURCES: Gengler, C. (2009). Teens and the internet. *Teen Talk: A Survival Guide for Parents of Teenagers.* Regents of the University of Minnesota. Available at http://www.extension.umn.edu/distribution/familydevelopment/00145.pdf.
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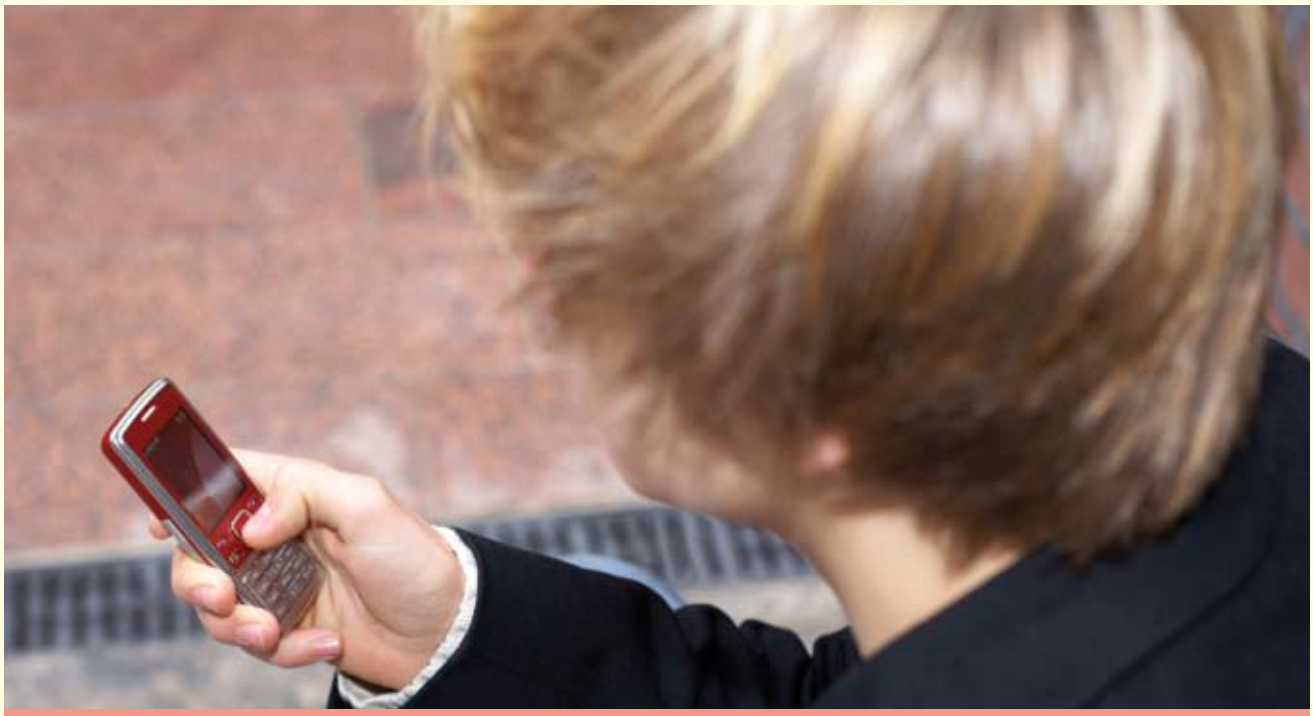

WAYS ADULTS CAN PROTECT TEENS FROM CYBERBULLIES AND PREDATORS

- Stress to teens what is not safe to put on the web or give out to people they don't know: their full name, address, cell phone number, specific places they hang out, financial information, ethnic background, school, or anything else that would help someone locate them. Although it is important to protect young people's privacy, it may be necessary to review a teen's social networking site to make sure they do not reveal too much personal information.

- Emphasize that in cyberspace, there's no such thing as an "erase" button—messages, photos, rants, and musings can and do hang around forever. Information that may seem harmless now to a teen can be used against them at any time—maybe in the future when applying to college or looking for a job. Photos posted on the sites should not reveal too much personal information about teens.

- Shut down a personal website or blog when the adolescent is subjected to bullying or flaming. If necessary, it is possible get a new email address and instant-messaging (IM) identity.

- Make clear to young people what kinds of messages are harmful and inappropriate. Enforce clearly spelled-out consequences if young people engage in those behaviors.

- Encourage teens not to respond to cyberbullying. The decision whether to erase messages is difficult. It is not good for teens to revisit them, but they may need to be saved as evidence if the bullying becomes persistent.

- Keep computers out of teens' bedrooms so that computer activity can be monitored better.

SOURCES: Kowalski, R.M. & Limber, S.P. (2007). Electronic bullying among middle school students. *Journal of Adolescent Health*, 41, S22–S30.
Wolak, J., Finkelhor, D., Mitchell, K.J., & Ybarra, M.L. (2008). Online "predators" and their victims: myths, realities, and implications for prevention and treatment. *American Psychologist*, 63(2): 111–128.

STATEMENT OF ENDORSEMENT

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Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management

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abstract

OBJECTIVES: To update clinical practice guidelines to assist primary care (PC) clinicians in the management of adolescent depression. This part of the updated guidelines is used to address practice preparation, identification, assessment, and initial management of adolescent depression in PC settings.

METHODS: By using a combination of evidence- and consensus-based methodologies, guidelines were developed by an expert steering committee in 2 phases as informed by (1) current scientific evidence (published and unpublished) and (2) draft revision and iteration among the steering committee, which included experts, clinicians, and youth and families with lived experience.

RESULTS: Guidelines were updated for youth aged 10 to 21 years and correspond to initial phases of adolescent depression management in PC, including the identification of at-risk youth, assessment and diagnosis, and initial management. The strength of each recommendation and its evidence base are summarized. The practice preparation, identification, assessment, and initial management section of the guidelines include recommendations for (1) the preparation of the PC practice for improved care of adolescents with depression; (2) annual universal screening of youth 12 and over at health maintenance visits; (3) the identification of depression in youth who are at high risk; (4) systematic assessment procedures by using reliable depression scales, patient and caregiver interviews, and *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* criteria; (5) patient and family psychoeducation; (6) the establishment of relevant links in the community; and (7) the establishment of a safety plan.

CONCLUSIONS: This part of the guidelines is intended to assist PC clinicians in the identification and initial management of adolescents with depression in an era of great clinical need and shortage of mental health specialists, but they cannot replace clinical judgment; these guidelines are not meant to be the sole source of guidance for depression management in adolescents. Additional research that addresses the identification and initial management of youth with depression in PC is needed, including empirical testing of these guidelines.

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BACKGROUND

Major depression in adolescents is recognized as a serious psychiatric illness with extensive acute and chronic morbidity and mortality.[1–4] Research shows that only 50% of adolescents with depression are diagnosed before reaching adulthood.[5] In primary care (PC), as many as 2 in 3 youth with depression are not identified by their PC clinicians and fail to receive any kind of care.[6,7] Even when diagnosed by PC providers, only half of these patients are treated appropriately.[5] Furthermore, rates of completion of specialty mental health referral for youth with a recognized emotional disorder from general medical settings are low.[8]

In view of the shortage of mental health clinicians, the barriers to children's access to mental health professionals, the well-documented need for PC clinicians to learn how to manage this condition, the increasing evidence base that is available to guide clinical practice, the increased selective serotonin reuptake inhibitor–prescribing rates in pediatric PC,[9,10] and new evidence that a multifaceted approach with mental health consultation may improve the management of depression in PC settings,[8,10–16] guidance for the identification and management of depression in adolescents in PC were urgently needed. To address this gap as well as to meet the needs of PC clinicians and families who are on the front lines with few mental health resources available, in 2007, the Center for the Advancement of Children's Mental Health at Columbia University and the Sunnybrook Health Sciences Center at the University of Toronto joined forces with the New York Forum for Child Health, the New York District II Chapter 3 of the American Academy of Pediatrics (AAP), and the Resource for Advancing Children's Health (REACH) Institute along with leading experts across the United States and Canada to address the need for a synthesis of knowledge in this area. The result of this initiative was the development of the Guidelines for Adolescent Depression in Primary Care (GLAD-PC). These guidelines are based on available research and the consensus of experts in depression and PC. The two companion articles[17,18] constituted the first-ever evidence- and expert consensus–derived guidelines to guide PC clinicians' management of adolescent depression. The guidelines were also accompanied by a tool kit (available at no cost for download at http://www.gladpc.org).

In this article, we present the updated recommendations on the identification, assessment, and initial management of depression in PC settings and new recommendations on practice preparations (not previously in the GLAD-PC). In the accompanying report, we present the results of the reviews and recommendations on treatment (psychotherapy, psychopharmacology, and pediatric counseling) and ongoing management.

Major depressive disorder (MDD) is a specific diagnosis described in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5)[19] characterized by discrete episodes of at least 2 weeks' duration (although episodes can last considerably longer) and involving changes in affect, cognition and neurovegetative functions, and interepisode remissions. Other types of depression exist, such as persistent depressive disorder and premenstrual dysphoric disorder. It is important to note that depressive disorders have been separated from bipolar and related disorders in the DSM-5. Although the evidence for the psychopharmacology recommendations in the accompanying article focuses exclusively on MDD, the recommendations around identification, assessment, and initial management can be applied to other forms of depression as well.

Our guidelines also distinguish between mild, moderate, and severe forms of MDD. The DSM-5 depression criteria include 9 specific symptoms that have been shown to cluster together, run in families, and have a genetic basis,[20–24] and a large body of evidence accumulated over time now supports the internal consistency of depressive symptoms and the validity of the major depression construct.[20] According to the DSM-5, the severity of depressive disorders can be based on symptom count, intensity of symptoms, and/or level of impairment. This commonly used method to define depression severity has been used in large population-based studies[25] and may be particularly relevant in PC settings, in which less severe clinical presentations of depression may be more common. Thus, mild depression may be characterized on the basis of lower scores on standardized depression scales with a shorter duration of symptoms or meeting minimal criteria for depression. Following the DSM-5, mild depression might be defined as 5 to 6 symptoms that are mild in severity. Furthermore, the patient might experience only mild impairment in functioning.

In contrast, depression might be deemed severe when a patient experiences all of the depressive symptoms listed in the DSM-5. Depression might also be considered severe if the patient experiences severe impairment in functioning. Moderate depression falls between these 2 categories.

In general, however, even if not all 9 DSM-5–defined symptoms of depression are present, for the purposes of these guidelines, an adolescent with at least 5 criteria of MDD should be considered in the severe category if he or she presents with a specific suicide plan, clear intent, or recent attempt; psychotic symptoms; family history of first-degree relatives with bipolar disorder; or severe impairment in functioning (such as being unable to leave home).

These guidelines were developed for PC clinicians who are in a position to identify and assist youth with depression in their practice settings. Although the age range of 10 to 21 years may encompass preteenagers, adolescents, and young adults in specific instances, this age range was chosen to include those who might be considered developmentally adolescent. Research that supports adult depression guidelines includes adults 18 years and older. Much of the adolescent depression research focuses on children 18 years and younger. However, because adolescent medicine clinicians and school health clinicians often see patients until they are 21 years old, we have included the older adolescents. Furthermore, a PC clinician faced with an adolescent between the ages of 18 and 21 years can choose to use either adult or adolescent depression guidelines on the basis of the developmental status of the adolescent and his or her own comfort and familiarity with each set of guidelines.

METHODS

The original GLAD-PC recommendations were developed on the basis of a synthesis of expert consensus– and evidence-based research review methodologies, as described in Zuckerbrot et al.[17] The 5-step process included conducting focus groups with PC clinicians, patients, and their families, a systematic literature review, a survey of depression experts to address questions that were not answered in the empirical literature,[26] an expert consensus workshop, and an iterative guideline drafting process with opportunity for input from all workshop attendees.

For the research update of the GLAD-PC, systematic literature reviews were conducted in the same 5 key areas of adolescent depression management in PC settings as the original guidelines: identification and assessment, initial management, safety planning, treatment, and ongoing management of youth depression. Consistent with the original review, the updated searches were conducted by using relevant databases (eg, Medline and PsycInfo), and all primary studies published since the original GLAD-PC reviews in 2005 and 2006 were examined. All update procedures were conducted with the input and guidance of the steering group, which is composed of clinical and research experts, organizational liaisons, and youth and families with lived experience. As in the original review, recommendations were graded on the basis of the University of Oxford's Centre for Evidence-Based Medicine grade of evidence (1–5) system, with 1 to 5 corresponding to the strongest to the weakest evidence respectively (see http://www.cebm.net/wp-content/uploads/2014/06/CEBM-Levels-of-Evidence-2.1.pdf). They were also rated on the basis of the strength of expert consensus among the steering group members that the recommended practice is appropriate. Recommendations with strong (>70%) or very strong (>90%) agreement are given here.

In addition, a new review on the topic of practice preparation was conducted given the emerging evidence for this area since the development of the original GLAD-PC guidelines. Electronic searches of relevant databases were conducted for English-language studies in which researchers examined practice preparation for treating youth depression in PC that were published between 1946 and September 2016. Search terms were grouped by categories and included the following: "child* or adolesc* or youth or teen* or juvenile" and "primary care or pediatr* or family prac* or general prac*" and "depress* or dysth* or mood or bipolar" and "collaborative care or integrat* health or medical-behavioral health care or behavioral health or medical home or shared care or facilita* or practice prepar*". Reference lists for relevant articles were also examined for additional studies that were not identified through search engines. A total of 135 abstracts were carefully examined. Studies that were conducted outside of PC facilities or that used solely adult populations were screened out, leaving a total of 8 relevant articles. A full report of all the literature reviews is available on request.

RESULTS

Literature Reviews

Practice Preparation

Once PC practices have buy-in from administrative and clinical staff to improve depression care for youth, 2 important steps are necessary. First, before practices embark on screening for or identifying youth who are at risk for depression, training in such issues as appropriate screening tools, assessment and diagnostic methods, safety planning, and so on is important. Second, it

is necessary to have access to community resources, such as mental health specialists (mental health specialists can include child and adolescent psychiatrists, psychiatric nurse practitioners, and therapists), not just as a potential referral resource but also for as-needed consultation for case patients that the PC clinicians choose to manage. We review the available evidence pertaining to these 2 areas (provider training and specialty consultation) below.

Effective Training Methods

PC practices vary widely in their capacity to implement full-scale collaborative or integrative behavioral health programs to address psychological difficulties in youth. At minimum, providing PC providers with guidance, education, and training in key topic areas such as identification, evaluation of suicide risk, and initial management of adolescent depression can be a feasible and cost-efficient means of improving care delivery when comprehensive organizational restructuring efforts are out of reach. However, simply providing PC providers with relevant information is not enough because passive education strategies are usually inadequate for producing lasting change in provider behavior.[27]

Researchers in large-scale review studies suggest that the adoption of practice guidelines improves when training and implementation strategies are tailored to the PC practice (eg, training that is developed by primary mental health care specialists, such as the training provided by the REACH Institute [http://www.thereachinstitute.org/] and Child and Adolescent Psychology for Primary Care [http://www.cappcny.org/])[28] and/or use comprehensive training methods, such as varying information delivery methods and skill-building exercises, such as role-playing.[27] Evidence regarding which specific theory-driven training strategies are most effective at eliciting behavior change with PC providers, particularly related to mental health, is sparse, but 1 promising framework leverages principles from the theories of reasoned action and planned behavior to inform training methodology (see Perkins et al[29] for explanation and review). This approach posits 3 primary determinants of PC behavior change: attitudes toward the practice innovation, the strength of intention to adopt the new practice(s), and sense of self-efficacy in one's ability to continue the new behavior. Although no randomized trials in which researchers use this or other systematic frameworks for PC provider–training methodologies were identified, researchers in preliminary studies offer support for training approaches that incorporate basic science-guided behavior change theory and methods. There is increasing evidence that quality-improvement strategies and techniques can change PC practitioner behavior both in mental health and in other arenas.[30,31] The REACH Institute (which is committed to renewing and improving techniques for professionals and parents to treat children with behavioral and emotional needs) has developed and widely implemented a 3-day intensive training on evidence-based pediatric mental health assessment, diagnosis, and treatment practices (including for youth depression) that is guided by basic science behavior change principles, demonstrating long-term practice changes (eg, increased use of symptom scales) as well as favorable PC provider attitudes toward, intentions to follow, and self-efficacy to adhere to the clinical guidelines up to 1 year later.[32] In another study of the same training approach, participating PC providers showed higher levels of self-efficacy in diagnosing and managing youth depression and related disorders than those who received only more traditional continuing education programs (eg, lectures).[33]

An unrelated study demonstrated that provider attitudes toward youth mental health in PC impacts rates of identification. PC providers who viewed psychosocial treatment as burdensome were less likely to identify youth mental health problems.[34] A subsequent follow-up to the study revealed that providing PC staff with communication training enhanced their self-efficacy and willingness to discuss depression symptoms with patients and staff, and this was associated with long-term changes in practice behaviors, such as providing an agenda during the PC visit, querying for additional mental health concerns, and making encouraging statements to patients and families when symptoms are disclosed.[35] The small amount of available literature offers support for hands-on, interactive, and basic science theory–driven training strategies for PC clinicians, but more research is needed before a consensus can be reached on how best to optimize training and educational strategies for PC providers.

Access to Specialty Consultation

In addition to obtaining relevant training, PC providers will benefit from having access to ongoing consultation with mental health specialists.[36,37] Consultation after training allows learning to be tailored to the PC provider's actual practice[38] and can increase provider comfort with diagnosing and treating mental health issues.[33,39] More than 25 states have established programs to promote collaboration between PC providers

and child psychiatrists by providing PC providers with education, rapid access to consultation, and referral options. Among the first psychiatric consultation programs was Targeted Child Psychiatry Services (TCPS) in the state of Massachusetts,[40,41] which offered regional providers access to real-time telephone consultation with a child psychiatrist and the option to refer a child to the psychiatry practice for a mental health evaluation, short-term psychosocial therapy, and/or pharmacotherapy. Program use data revealed that TCPS consultation support alone was sufficient to retain and treat in PC 43% of youth who potentially would have been referred to specialty services.[40] TCPS was subsequently expanded statewide and became known as the Massachusetts Child Psychiatry Access Project.[14] Similar programs in other states offer free training, telephone consultation, and referral advice to PC providers.[14,42,43] Participating PC providers consistently report being highly satisfied with the consultation they receive[14,42,43] and increasingly comfortable with treating mental health problems within the PC setting after consultation.[14,42,43] Additionally, consultation programs may improve access to mental health care not only by increasing its availability within PC but also by decreasing potentially unnecessary referrals to specialty care, which in turn makes specialty providers more available to treat complex or severe patients.[41,44]

Identification and Assessment

In 2009, after the publication of the GLAD-PC, the United States Preventive Services Task Force (USPSTF) endorsed universal adolescent depression screening in teenagers ages 12 to 18 years.[45] This recommendation was based on evidence that there are validated depression screening tools that work in an adolescent PC population and the evidence that there are treatments that work for the identified population.[45,46] On the basis of our review to date, no researchers in a randomized control trial (RCT) have compared functional or depressive outcomes in a cohort of adolescents who were screened in PC by the PC providers themselves versus a cohort of adolescents who were not screened. This lack of evidence, which is also mentioned in the Canadian review of the literature in 2005,[47] the 2009 Williams et al[46] review performed for the USPSTF, the updated 2016 Forman-Hoffman et al[48] review for the USPSTF, and a 2013 systematic literature review published in *Pediatrics*,[49] becomes less relevant as more evidence accumulates regarding the specific steps in the process, such as the validity of PC screening, the feasibility of PC screening, the feasibility of implementing treatment in those who are identified as having depression, and the efficacy of treatment of those who received evidence-based treatments in PC. In our updated review in this area, we found 8 new articles that provide some psychometric data regarding the use of depression screens in the pediatric PC population (Supplemental Table 1) and 38 other articles that touch on screening issues that range from whether screening is taking place and whether screening impacts follow-up procedures or treatment to the specifics of screening, such as the use of mobile devices or gated procedures (Supplemental Table 2). Supplemental Tables 1 and 2 present the new evidence as well as the limitations for existing screening tools and protocols. Please see our original 2007 guidelines for the past review of screening tools and protocols.

During the original GLAD-PC development process, secondary to the paucity of data on the validity of screening tools in the adolescent PC population, the original GLAD-PC guideline was used to review instruments that are used in community and psychiatric populations as well.[17] Given that those screens are still in use and that their psychometric data still apply, in this current review, we focus only on new screening data in PC. Eight of the articles present psychometric data, such as sensitivity, specificity, positive predictive value (PPV), negative predictive value (NPV), or area under the curve (Supplemental Table 1). Most relevant were the 2 publications by Richardson et al[56,57] in which they validated the Patient Health Questionnaire-2 (PHQ-2) and the Patient Health Questionnaire-9 (PHQ-9) in a PC sample against a gold standard diagnostic interview (the Diagnostic Interview Schedule for Children-IV [DISC-IV]). The PHQ-9, with a cut-point of 11, had a sensitivity and specificity of 89.5% and 77.5%, respectively, to DISC-IV MDD with a PPV of 15.2% and NPV of 99.4%. A PHQ-2 cut score of 3 had a sensitivity and specificity of 73.7% and 75.2%, respectively, to DISC-IV MDD.

Researchers have looked at brief depression-specific screening questions that stand alone (eg, the PHQ-2),[51,57,65,75,79,82,85] longer depression-specific scales that stand alone (eg, the PHQ-9, the Mood and Feelings Questionnaire, the Columbia Depression Scale, and the PHQ-9: Modified for Teens),[58,62,63,66,67,70,74,78,80–82,86–88] brief depression screening questions that are part of a larger psychosocial tool (eg, the Guidelines for Adolescent Preventive Services [GAPS] questionnaire and the Pediatric Symptom Checklist [PSC]),[53,54,64,68,69] and brief screening questions or longer depression-specific scales that are combined with other screens for

either other psychiatric disorders (eg, Screen for Child Anxiety Related Disorders-5) and/or screens for other high-risk behaviors (eg, substance use and sexual activity) to make a more multidimensional tool or packet in 1 (eg, the behavioral health screen [BHS]).[50,52,55,59–61,76,77,83,84,89] Not all of the screens in these studies have specific psychometric validation data (eg, 2 depression questions on the GAPS). Clinicians may also consider the use of tools that can be used to screen for depression and other risk behaviors or more disorders. Although no researchers have compared the functional or depressive outcomes of a cohort of adolescents who were initially screened only for depression with a cohort of adolescents who were initially screened for an array of high-risk behaviors and emotional issues, some hint at the possibility that too much information may overwhelm the clinician and result in positive depression screening questions being overlooked in the morass of issues needing to be addressed.[52,53,59–61,64,76,80,82–84,89] Therefore, clinicians should base the selection of a depression-specific tool versus a more general tool on their own expertise and clinical supports in their practices. For example, a solo practitioner starting to address depression care in his or her practice may choose to start with screening for depression alone before moving to more general screening for riskier behaviors or disorders.

There is limited evidence to evaluate whether one can use a general parent questionnaire as a gated entry for adolescent self-report depression screening. Researchers in 1 study of general mental health screening used the parent- or youth-completed Pediatric Symptom Checklist-35 alone to screen for internalizing disorders, but this provides no psychometric data,[69] whereas others used the Parent Pediatric Symptom Checklist-17 (PSC-17) along with other, more depression-specific child and parent scales.[54,56,57,82] One of these studies reveals adequate psychometric data for the parent PSC-17 internalizing subscale as compared with the Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS) MDD module, performing as well as the Children's Depression Inventory but only with children aged 8 to 15 years.[54] Richardson et al[56,57,82] suggest some correlation with adolescent depression self-report tools, with the adolescent scores that are higher on the PHQ-9 or PHQ-2 being associated with higher mean on the parent PSC-17 internalizing subscale, with a correlation of 0.21 (P = .02). However, the data presented do reveal that some teenagers who scored above the cutoffs on the self-reports would have parents who score below the cutoff of 5 on the internalizing subscale of the PSC-17. The authors do not present the data regarding how many teenagers would be missed by using the internalizing subscale as a gate and whether those teenagers met DISC-IV MDD criteria. Lastly, researchers in 1 study looked at the correlation of the PSC-17 internalizing subscale between the parent- and youth-completed PSC-17 but only among subjects whose parents were already positive.[53] The data revealed low agreement, with a κ of 0.15 (95% confidence interval of 0.00–0.30). However, those adolescents who did match with their parents were of higher severity than those parents who were positive but did not match with their negative-scoring teenagers. In addition, the parent PSC-17 in general has usually been studied with the younger adolescent cohort and not the older adolescent cohort. Once again, there is no RCT in which researchers compare the outcomes of a cohort of adolescents who were universally screened with an adolescent depression self-report versus a cohort that was only screened with self-reports after a positive parent PSC result. All of these data reveal that there is limited evidence in the older teenage cohort about using parent reports alone, that parent information may be helpful if used in conjunction with child reports when a clinician is available to resolve discrepant data, and that if used alone, parent reports may only account for the adolescents with the most severe conditions, but those data are unclear.

Researchers have also looked at paper screens, Internet-based screens, and electronic screens that are accessed through a mobile or personal digital assistant device. Although there appears to be no evidence of researchers comparing such screening methods to each other, all methods seem to be equally successful (in that adolescents rarely refuse screening) and equally problematic (obstacles to universal screening exist with every method). See Supplemental Tables 1 and 2 for more specific information.

Some researchers report adaptive (brief initial questions and, if gated questions have positive results, then automated additional questions)[61] as well as algorithmic screening, in which a positive PHQ-2 result or the equivalent triggers a person to then administer a PHQ-9 or the equivalent.[65,75,79,85] Although evidence for this type of gated screening is limited, researchers in 1 study compared the psychometric data of the PHQ-2 versus the PHQ-9 in the same population.[57]

One limitation of brief depression screening may be the loss of the suicide questions if one focuses

only on brief questions on the basis of criterion A for MDD. The validation study of the PHQ-2 found that 19% of teenagers who did endorse suicidality did not screen positive on the PHQ-2, suggesting that in a real-world setting, they would have been missed.[57] Several studies in which researchers used brief or long depression-specific screenings that did not include a suicide question did add a suicide question for this reason.[60,70,83,84,89] In this review, we did not review the suicide screening in pediatric PC literature but are aware of the USPSTF decision not to endorse suicide screening secondary to its conclusion for the lack of evidence for PC intervention for suicidal adolescents.[90] However, we do note which depression screening studies also looked for suicide as well as the rates of suicidality that were found (Supplemental Tables 1 and 2).

One other area that was examined in the review is the definition of depression when screening for depression. The definition of depression affects the psychometric properties and evidence for the use of a screen given that trying to find only MDD versus trying to find any depressive symptoms requires different specificities and sensitivities, and using the same screens for both purposes would result in choosing different cutoffs. Again, whereas the USPSTF comments on screening for MDD, the screening literature seems to be more unfocused. Richardson et al[79] used a score of 2 as the initial gate and a score of 10 on the PHQ-9 as a positive score for entry into the next step. Forty percent of the sample did not meet the criteria for MDD but were deemed to be impaired enough with depressive symptoms to enter the study. When Lewandowski et al[74] studied the large-scale use of the PHQ-9 modified in the health maintenance organization (HMO), they looked at whether any depressive disorder was identified, even adjustment disorder, rather than just MDD. The Youth Partners in Care (YPIC) intervention[11,58] also included teenagers without MDD who had clinically significant and current depressive symptoms. Van Voorhees et al,[91] in a series of small studies and now in a large RCT, have been purposely screening to account for depressive symptoms and depressive disorders other than MDD because the Competent Adulthood Transition with Cognitive-behavioral, Humanistic and Interpersonal Training (CATCH-IT) prevention model was developed for teenagers with depressive symptoms and disorders other than MDD.[65] Thus, the evidence for choosing instruments and cutoff scores may depend on what depression end point a PC provider is pursuing and what intervention the clinician wishes to put in place.

Although the USPSTF clearly endorsed screening at age 12 years, the literature in which researchers look at depression screening includes studies that have starting ages ranging from age 8 to 14 years and later ages ranging from 15 to 24 years. Most of the younger-age studies include depression as part of a broader psychosocial screening effort, with the researchers looking specifically at depression screening that focuses on some of the older age ranges (Supplemental Tables 1 and 2). With that said, there is no evidence to compare outcomes in a cohort of adolescents who were screened at age 11 years versus age 12 years versus age 13 years.

The last guideline review included the YPIC study, which did reveal that an identification program in PC, when combined with high-quality depression treatment, actually yields better outcomes than treatment-as-usual conditions (when no high-quality depression treatment is available).[11] Two follow-up publications from the same intervention[58,87] are included in this review and once again show that identified youth who receive evidence-based treatment do have better outcomes. More recently, Richardson and colleagues, in their collaborative care for adolescent depression RCT, compared controls who screened positive and whose positive results were given to both parents and PC clinicians with subjects who were screened and placed in a collaborative care intervention.[79] Those in the collaborative care intervention had a greater chance of response and remission at 12 months and a greater likelihood of receiving evidence-based treatments. The researchers only tracked outcomes in those who were screened; although it is possible that those who were screened did better than those adolescents with depression who were not screened, the study does reveal that screening alone is not likely to improve outcomes by much given how much better those in the group that had screening combined with an intervention in place did and how much more likely they were to receive care than those who were only screened.

Although much of the literature on identification crosses both the area of screening and assessment in that the PC provider can use the screening tool to aid in the assessment, we found some studies that focused less on the screening tools and more on the assessment of depression in pediatric PC. These studies included those in which researchers used standardized patients to help with depression and suicide assessment as well as a protocol to teach PC clinicians how to do a therapeutic interview during the assessment process.[62,63,71–73]

In summary, no perfect depression screening and/or assessment tool exists, and no perfect screening algorithm or systematic protocol exists, but a number of adolescent depression assessment instruments do possess adequate psychometric properties to recommend their use in depression detection and assessment, and there is a limited amount of evidence to support some differing methods of implementation (Supplemental Table 3). Thus, it is reasonable to expect that depression detection in PC can be improved by the use of adolescent self-report checklists with or without parent self-reports. Reliance on adolescent self-report depression checklists alone will lead to substantial numbers of false-positive and false-negative cases. Screening and detection are only the first step to making a diagnosis. Instead, optimal diagnostic procedures should combine the use of depression-specific screening tools as diagnostic aids, buttressed by follow-up clinical interviews in which one obtains information from other informants (eg, parents) as legally permissible and uses either other tools or interviews to assess for other psychiatric diagnoses as well, reconciling discrepant information to arrive at an accurate diagnosis and impairment assessment before treatment. Although screening parents may not be required, gathering information from third-party collaterals to make a diagnosis is important. Teenagers should be encouraged to allow their parents to access their information, and the importance of including parents in the diagnostic discussion should be emphasized. For more information about rating scales and cutoff scores, please refer to the GLAD-PC tool kit.

Initial Management of Adolescent Depression

On behalf of the initial GLAD-PC team, Stein et al[92] reviewed the literature on psychosocial interventions for anticipatory guidance. No RCTs or evidence-based reviews were found. Citing earlier literature reviews in the area of injury prevention[93] and anticipatory guidance,[94] Stein et al[92] found some limited evidence that anticipatory guidance strategies, such as education and counseling, in the PC setting can be effective.

Another area reviewed by Stein et al[92] involved psychosocial interventions for improved adherence. In an evidence review on asthma adherence, Lemanek et al[95] suggested that some educational and behavioral strategies are probably efficacious in creating change. In addition, a study in which researchers used cognitive behavioral strategies revealed that diabetic adherence can also be improved.[95]

For this update, our team searched the Cochrane Database of Systematic Reviews for all types of interventions that were implemented in the adherence arena. These reviews[96–98] revealed that only complex, multifaceted approaches that include convenient care, patient education, reminders, reinforcement, counseling, and additional supervision by a member of the care team were effective in improving adherence in different chronic medical conditions, including asthma, hypertension, diabetes, and adult depression. In the pediatric literature, research regarding adherence commonly involved interventions that targeted both patients and their families.[99] Several key components have been identified that may improve compliance and/or adherence, including patient self-management and/or monitoring, patient and/or family education and/or support, and the setting and supervision of management goals.[100,101] The identification and periodic review of short- and long-term goals provides an individualized plan that both the provider and the patient and family can follow over time.[100,101] Specifically in the area of youth depression, however, current research evidence reveals that only more complex interventions are likely to have the greatest impact on both adherence and treatment outcomes. This kind of coordinated care, which is often described as collaborative care or integrated behavioral health, is discussed further in the accompanying report on depression treatment and ongoing management.[102]

Safety Planning

Safety planning with adolescent patients who have depression and are suicidal or potentially suicidal usually consists of instructing the family to remove lethal means, instructing the family to monitor for risk factors for suicide (including sexual orientation and intellectual disability), engaging the potentially suicidal adolescent in treatment, providing adolescents with mutually agreeable and available emergency contacts, and establishing clear follow-up. In our updated review of the literature, we found no trials in which researchers have studied the impact of or how to conduct any of these aspects of safety planning with adolescents with depression. Once again, no studies were found in which researchers examined the benefits or risks of a safety contract. Researchers in several articles reviewed what little literature is available regarding the use of suicide safety contracts, and all concluded that these should not be used in clinical practice because there is no empirical evidence that they actually prevent suicide.[103–107] Multiple authors also asserted that contracts have numerous flaws, which could actually be harmful to the clinician-patient alliance. Some alternatives to a contract have been proposed (for example, the commitment to treatment statement discussed by Rudd et al[107]), but none have been tested in a clinical trial. Some studies have suggested that

limiting access to firearms or other lethal means can decrease suicide by those methods, but the evidence is still unclear as to whether, on a broader population level, restricting access to certain lethal methods results in an overall decrease of suicide rates.[108–116] In addition, Brent et al[117] found that the families of adolescents with depression are frequently noncompliant with recommendations to remove firearms from the house. Yet, a small prospective follow-up of patients who were seen in an emergency department (ED) for mental health concerns found that the majority of their families removed or secured lethal means (firearms, alcohol, prescription medications, and over the counter medications) after injury-prevention education in the ED.[117] Some limited evidence suggests that quick and consistent follow-up and/or treatment with a team approach will be most helpful in increasing compliance and engagement among patients who are suicidal.[118–120]

GUIDELINES

The strength of the evidence on which each recommendation is based has been rated 1 (strongest) through 5 (weakest) according to the Centre for Evidence-Based Medicine levels of evidence and paired with the strength of the recommendation (strong or very strong).

Practice Preparation

Recommendation 1:*PC clinicians are encouraged to seek training in depression assessment, identification, diagnosis, and treatment if they are not previously trained (grade of evidence: 5; strength of recommendation: very strong).*

Consistent with the original GLAD-PC guidelines, PC clinicians who manage adolescent depression are advised to pursue additional education in identification, assessment, diagnosis, treatment and follow-up, consent and confidentiality, safety risk assessment and management, liability, and billing practices. Appropriate training on the assessment, diagnosis, and treatment of adolescent depression enhances PC providers' attitudes and self-efficacy to treat youth depression within their practices, thereby making it more likely that psychological disorders will be identified in the patient population.[34] The REACH Institute and Child and Adolescent Psychology for Primary Care are examples of organizations that provide training opportunities to PC clinicians. In addition to high-quality content, studies of PC provider training reveal that effective information delivery methods are important to the successful uptake of new practice behaviors. Such training methods include a succinct presentation of high-priority information, interactive content delivery methods, hands-on learning activities (eg, role-plays), and cultivating peer leaders to champion new practices. Additionally, access to ongoing consultation after training allows learning to be tailored to the PC provider's actual practice[38] and can increase comfort with diagnosing and treating mental health issues.[33,39] Clinicians also need to practice self-care by using supports for themselves as they take on more responsibilities of caring for youth with depression because engaging with this population can prove to be emotionally challenging.

Recommendation 2: PC clinicians should establish relevant referral and collaborations with mental health resources in the community, which may include patients and families who have dealt with adolescent depression and are willing to serve as a resource for other affected adolescents and their family members. Consultations should be pursued whenever available in initial cases until the PC clinician acquires confidence and skills and when challenging cases arise. In addition, whenever available, these resources may also include state-wide or regional child and adolescent psychiatry consultation programs (grade of evidence: 5; strength of recommendation: very strong).

The lack of linkages among relevant services within a system of care is a large gap in the management of chronic disorders in young people.[121] Furthermore, family-based interventions have been shown to help youth with mental illness.[122] Therefore, establishing mental health referral and collaboration resources in the local community for adolescents with depression and their families is essential to ensuring timely and effective access to needed services.[11,123] Such linkages may include mental health sites to which patients can be referred for specialty care services, such as comprehensive evaluations, psychosocial treatment, pharmacotherapy, and crises intervention services (in the event of suicidality). In highly underserved areas, these linkages may also include paraprofessionals who are tasked with providing the bulk of supportive counseling services to local residents. To reduce barriers to care, PC providers may arrange to have standing agreements with these practices regarding referral, the exchange of clinical information, points of contact, and so on. Schools play a critical role, especially if therapeutic support is available. Clinicians should connect to any available resources in the school system. PC providers should also work with the patient and/or family to establish an individual education plan to provide supports for the teenager in the school setting. Other linkages may include online or in-person support groups, advocacy groups (eg, the American

Foundation for Suicide Prevention), and family partner organizations (ie, patients and/or caregivers who have experience dealing with adolescent depression and serve as a resource for affected adolescents and families whenever these services are available).

To provide support to PC providers, >25 states have established programs to promote collaboration between PC providers and child psychiatrists by providing PC providers with education, rapid access to consultation, and referral options. PC sites may wish to search registries such as the National Network of Child Psychiatry Access Programs (www.nncpap.org) to identify any regional or state-wide programs that are available in their areas.

Identification and Surveillance

Recommendation 1: Adolescent patients ages 12 years and older should be screened annually for depression (MDD or depressive disorders) with a formal self-report screening tool either on paper or electronically (universal screening) (grade of evidence: 2; strength of recommendation: very strong).

Given the high prevalence of adolescent depression (lifetime prevalence is estimated to be ~ 20% by age 20 years), the evidence that adolescent depression can be persistent, the fact that adolescence is a time of significant brain maturation, and longitudinal studies that reveal that adolescents with depression have significant problems as adults, it is important to try to identify and treat adolescents with depression early in the course of the disorder. Although most PC clinicians believe it is their responsibility to identify depression in their adolescent patients, evidence suggests that only a fraction of these youth are identified when presenting in PC settings even after the USPSTF mandate on screening.[45] Extant evidence does suggest that screening with a systematic tool will identify more adolescents with depressive disorders than not screening at all. Providers should choose a tool with at least minimal validation data. Given that more evidence is needed to guide the choice of a depression screening tool, at this point, providers should choose a depression-only tool or a combined tool, a short tool as a gate or a longer initial tool, and an adaptive screening or a paper screen on the basis of what they believe will work better for their practices, patients, and health organizations. Furthermore, the current literature does reveal that screening and scoring before the provider is in the room with the patient can be most helpful to the workflow. Although both the USPSTF and the AAP support the universal use of an adolescent self-report screen, using a parent-completed PSC as an initial gate may be acceptable given the limited evidence. However, 1 limitation to gated depression screening, using either a short self-report or a longer parent psychosocial report as the initial gate, is the loss of the suicide questions that are part of longer adolescent self-reports. Given the high rate of suicidal ideation and attempts among adolescents and the fact that not all adolescents who are suicidal will have MDD, it seems likely that screening for suicidality may be helpful as well, so providers should consider including suicide questions. Choosing a cutoff score for the selected tool will need to depend on the practice's expected prevalence rates as well as the practice's available and accepted pathways for intervention. Although there is no evidence to suggest how often a teenager should be screened, screening once per year seems reasonable until more evidence is amassed, whether this takes place at health maintenance visits or at the next available sick visit. Finally, this recommendation should not discourage PC providers who regularly speak with their teenagers about their moods from continuing to do so and should not dissuade clinicians from learning how to better identify teens with depression through interview, but we merely endorse universal adolescent depression self-report instruments as an initial screening tool.

Recommendation 2: Patients with depression risk factors (eg, a history of previous depressive episodes, a family history, other psychiatric disorders, substance use, trauma, psychosocial adversity, frequent somatic complaints, previous high-scoring screens without a depression diagnosis, etc) should be identified (grade of evidence: 2; strength of recommendation: very strong) and systematically monitored over time for the development of a depressive disorder by using a formal depression instrument or tool (targeted screening) (grade of evidence: 2; strength of recommendation: very strong).

As part of overall health care, PC clinicians should routinely monitor the psychosocial functioning of all youth because problems in psychosocial functioning may be an early indication of a variety of problems, including depression. Risk factors that clinicians may use to identify those who are at high risk for depression include a previous history or family history of (1) depression, (2) bipolar disorder, (3) suicide-related behaviors, (4) substance use, and (5) other psychiatric illness; (6) significant psychosocial stressors, such as family crises, physical and sexual abuse, neglect, and other trauma history; (7) frequent somatic complaints; as well as (8) foster care and adoption.[124–126] Research evidence shows that patients who present with such risk factors are likely to experience future depressive episodes.[22,127–133] There are recent

data as well that reveal that those who score high on depression screening instruments, even when they are not initially diagnosed with depression, may be at risk for a depression diagnosis within 6 months.[66] Although these at-risk teenagers may be screened annually as part of the practice's universal depression screening, they may also require a more frequent, systematic, targeted screening during other health care visits (ie, well-child visits and urgent care visits). Following the chronic care model, teens with depression, past depression, frequent somatization, or other risk factors may need to be included in a registry and managed more closely over time.

Assessment and/or Diagnosis

Recommendation 1: PC clinicians should evaluate for depression in those who screen positive on the formal screening tool (whether it is used as part of universal or targeted screening), in those who present with any emotional problem as the chief complaint, and in those in whom depression is highly suspected despite a negative screen result. Clinicians should assess for depressive symptoms on the basis of the diagnostic criteria established in the* DSM-5 *or the* International Classification of Diseases, 10th Revision *(grade of evidence: 3; strength of recommendation: very strong) and should use standardized depression tools to aid in the assessment (if they are not already used as part of the screening process) (grade of evidence: 1; strength of recommendation: very strong).

Scoring high on a screening tool alone does not make for a diagnosis of MDD, especially given that in a low-risk PC population, the PPV of a positive screen result may be low. However, as discussed earlier, a positive screen result can also indicate a different depressive disorder or subthreshold depression. On the other hand, in youth who are suspected of having depression on the basis of other initiating triggers, such as risk factors, somatic complaints, or other emotional chief complaints, assessing for depression (regardless of whether there is a positive screen result) may be in order. PC clinicians should probe for the presence of any of several depressive disorders, including MDD, persistent depressive disorder (dysthymia), and other specified or unspecified depressive disorders by using systematic, rigorous assessment methods. Although standardized instruments should be used to help with diagnosis, they should not replace direct interview by a clinician.[134–136] Because adolescents with depression may not be able to clearly identify depressed mood as their presenting complaint, providers need to be aware of common presenting symptoms that may signal MDD. These may include irritability, fatigue, insomnia or sleeping more, weight loss or weight gain, decline in academic functioning, family conflict, and other symptoms of depressive disorders.[137]

Recommendation 2: Assessment for depression should include direct interviews with the patients and families and/or caregivers (grade of evidence: 2; strength of recommendation: very strong) and should include the assessment of functional impairment in different domains (grade of evidence: 1; strength of recommendation: very strong) and other existing psychiatric conditions (grade of evidence: 1; strength of recommendation: very strong). Clinicians should remember to interview an adolescent alone.

Evidence of the core symptoms of depression and functional impairment should be obtained from the youth as well as from families and/or caregivers separately.[138–140] The involvement of the family is critical in all phases of management and should be included in the assessment for depressive disorders. If family involvement is determined to be detrimental, then involving another responsible adult would be appropriate. Family relationships may also affect the presentation of depression in adolescents. However, despite the importance of family involvement and the imperative to try to include family, adolescents value their sense of privacy, confidentiality, and individuality. It is important to remember that adolescents should be interviewed alone about their depressive symptoms, suicidality, and psychosocial risk factors and circumstances. The cultural backgrounds of the patients and their families should also be considered during the assessments because they can impact the presentation of core symptoms.[141] Collateral information from other sources (eg, teachers) may also be obtained to aid in the assessment. Given the high rates of comorbidities, clinicians should assess for the existence of comorbid conditions that may affect the diagnosis and treatment of the depressive disorder.[2,22,142,143] These comorbidities may include 1 or more of the following conditions: substance use, anxiety disorder, attention-deficit/hyperactivity disorder, bipolar disorder, physical abuse, and trauma. Instruments that assess for a range of common comorbid mental health conditions should be considered as well during this assessment phase if they were not used in the initial screening protocol. Clinicians should also assess for impairment in key areas of functioning, including school, home, and peer settings.[144] Subjective distress should be evaluated as well. Regardless of the diagnostic impression or any further treatment plans, a safety assessment, including

for suicidality, should be completed by the clinician (see recommendation 3 in Initial Management of Depression).

Initial Management of Depression

Recommendation 1: Clinicians should educate and counsel families and patients about depression and options for the management of the disorder (grade of evidence: 5; strength of recommendation: very strong). Clinicians should also discuss the limits of confidentiality with the adolescent and family (grade of evidence: 5; strength of recommendation: very strong).

Management should be based on a plan that is developed with the understanding that depression is often a recurring condition. As seen in studies of depression interventions, families and patients need to be educated about the causes and symptoms of depression, impairments associated with it, and the expected outcomes of treatment.[145–148] Information should be provided at a developmentally appropriate level and in a way that the patient and family can understand the nature of the condition and the management plan. Communication that is developmentally appropriate should facilitate the ability of parents and patients to work with the clinicians to develop an effective and achievable treatment plan. To establish a strong therapeutic alliance, the clinicians should also take into account cultural factors that may affect the diagnosis and management of this disorder.[141] Clinicians should also be aware of the negative reactions of family members to a possible diagnosis of depression in a teen (ie, sadness, anger, and denial). Sample materials are available in the GLAD-PC and include resources for patients and parents. Because the symptoms of depression can also affect many areas of an adolescent's life, other ongoing partnerships may need to be established with personnel in schools and other settings (eg, extracurricular activities). Confidentiality should also be discussed with the adolescent and his or her family. Adolescents and families should be aware of the limits of confidentiality, including the need to involve parents or legal authorities when the risk of harm to the adolescent or others may be imminent. Clinicians should be aware of state laws regarding confidentiality (for additional information, see www.advocatesforyouth.org).

Recommendation 2: After appropriate training, PC clinicians should develop a treatment plan with patients and families (grade of evidence: 5; strength of recommendation: very strong) and set specific treatment goals in key areas of functioning, including home, peer, and school settings (grade of evidence: 5; strength of recommendation: very strong).

From studies of chronic disorders in youth, it is suggested that better adherence to treatment is associated with the identification and tracking of specific treatment goals and outcomes. Written action plans in asthma management have some evidence for improved outcomes.[149] Similarly, studies of adolescents with depression reveal greater adherence and outcomes when they were assessed to be ready for change and received their treatment of choice.[11,86] If a patient presents with moderate-to-severe depression or has persistent depressive symptoms, treatment goals and outcomes should be identified and agreed on via close collaboration with the patient and family at the time of treatment initiation. Treatment goals may include the establishment of a regular exercise routine, adequate nutrition, and regular meetings to resolve issues at home. In the adult depression literature, monitoring appears to be most effective when it is implemented through designated case managers who monitor patients' clinical status and treatment plan adherence.[12] The benefits of such programs may be enhanced through the use of electronic medical records (EMRs) and the development of patient registries. Technologies such as apps are being used more commonly in clinical practice, and there is emerging evidence for their effectiveness.[150]

Recommendation 3: All management should include the establishment of a safety plan, which includes restricting lethal means, engaging a concerned third party, and developing an emergency communication mechanism should the patient deteriorate, become actively suicidal or dangerous to others, or experience an acute crisis associated with psychosocial stressors, especially during the period of initial treatment, when safety concerns are the highest (grade of evidence: 3; strength of recommendation: very strong). The establishment and development of a safety plan within the home environment is another important management step.

Suicidality, including ideation, behaviors, and attempts, is common among adolescents with depression. In studies of completed suicide, more than 50% of the victims had a diagnosis of depression.[151] Therefore, clinicians who manage this disorder should develop an emergency communication mechanism for handling increased suicidality or acute crises. After assessing a patient for suicidality, the clinician should obtain information from a third party, assess that adequate adult supervision and support are available, have an adult agree to help remove lethal means (eg, medications and firearms) from the premises, warn the patient of the disinhibiting effects of drugs and alcohol, put contingency planning

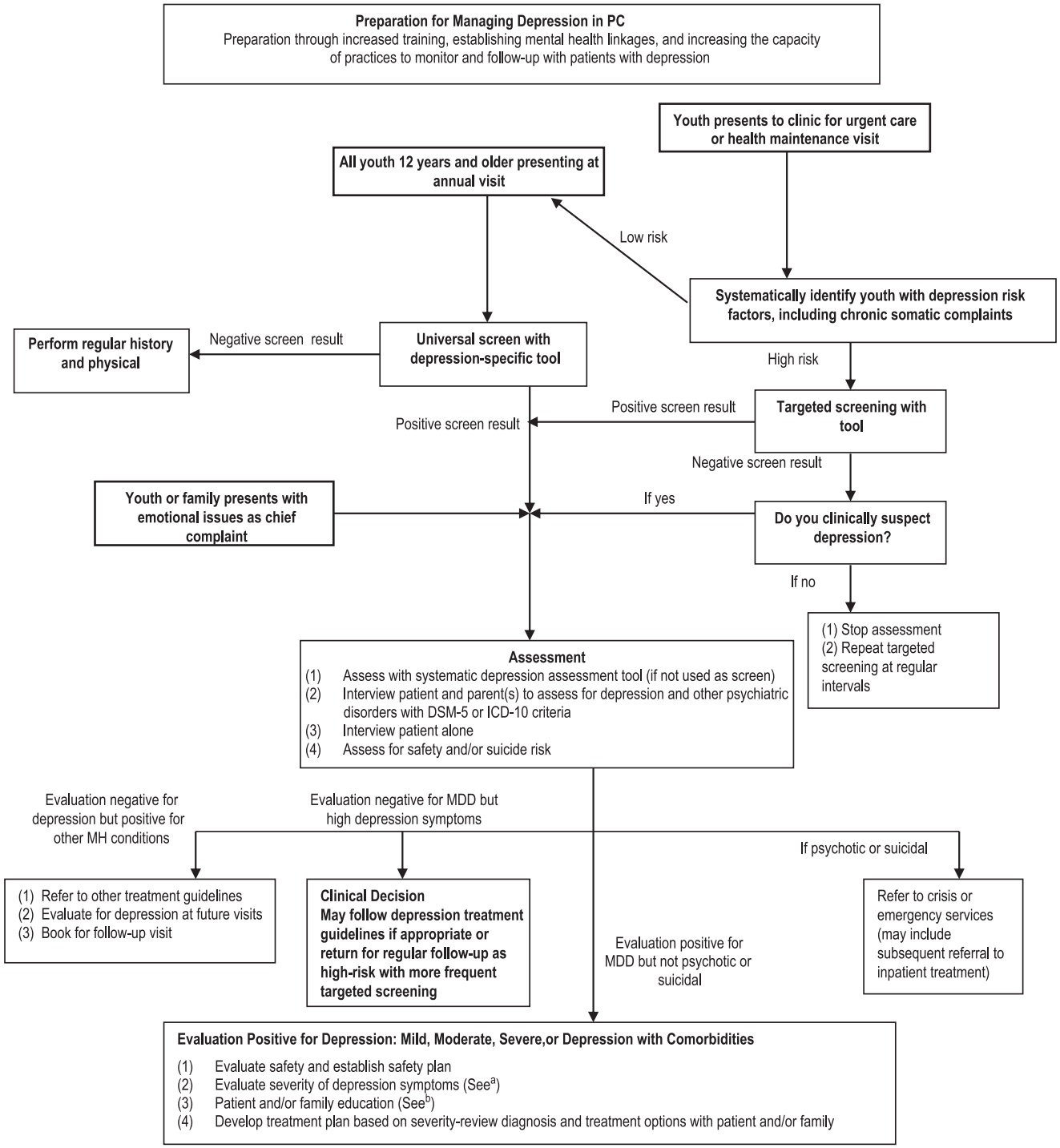

FIGURE 1

Clinical assessment flowchart. ICD-10, *International Classification of Diseases, 10th Revision*; MH, mental health. [a] See part I of the guidelines for definitions of mild, moderate, and severe depression. Please consult the tool kit for methods that are available to aid clinicians in distinguishing among mild, moderate, and severe depression. [b] Psychoeducation, supportive counseling, facilitation of parental and patient self-management, referring for peer support, and regular monitoring of depressive symptoms and suicidality.

in place, and establish follow-up within a reasonable period of time.[109,120,152,153] This plan should be developed with adolescents (and with their families and/or caregivers if possible) and should include a list of persons and/or services for the adolescent to contact in case of acute crisis or increased suicidality. The establishment of this plan is especially important during the period of diagnosis and initial

treatment, when safety concerns are the highest. It is critical for PC clinicians to make linkages with their closest crisis support and hospital services so that they are supported in crisis situations when caring for youth with depression. Clinicians may also work with schools to develop an emergency plan for all students who may experience acute suicidal crises. This global approach may prevent, in some instances, having to label a specific child as suicidal when providers are merely trying to ensure that safety measures are in place in case the child decompensates. Components of a safety plan may also include a list of persons who are aware of the adolescents' issues and will be able to assist if contacted during an acute crisis (Fig 1).

DISCUSSION

Although not definitive and subject to modification on the basis of the ongoing accumulation of additional evidence, this part of the updated guidelines is intended to help address the lack of recommendations regarding practice preparation, screening, diagnosis, and initial management of depression in adolescents aged 10 to 21 years in PC settings in the United States and Canada. As such, these guidelines are intended to assist PC clinicians in family medicine, pediatrics, nursing, and internal medicine, who may be the first (and sometimes only) clinicians to identify, manage, and possibly treat adolescent depression. These guidelines may also be helpful to allied health professionals who care for adolescents.

Although not all the steps involved in identifying, diagnosing, and initially managing the care for adolescent depression in PC have been (or even can be) subject to rigorous RCTs, there is sound reason to believe that existing tools and management protocols for adolescent depression can be applied in the PC setting. Although more research is needed, we suggest that these components of the identification and initial management of adolescent depression in PC can be done. The recommendations were developed and updated on the basis of areas that had at least strong agreement among experts.

Should These Guidelines Be Universally Deployed?

One might question whether PC clinicians should identify and diagnose the problem of adolescent depression if the lack of psychiatric services prevents them from referring these youth.[154] This caution notwithstanding, the increasingly prevailing recommendation is that at a minimum, PC clinicians should be provided the necessary guidance to support the initial management of adolescent depression.[155,156] Nonetheless, because practitioners and their clinical practice settings vary widely in their degree of readiness in identifying and managing adolescent depression, it is likely that a good deal of time and flexibility will be required before these guidelines are adopted systematically or as a universal requirement. It is conceivable that integrated health care systems with EMRs, tracking systems, and access to specialty mental health backup and consultation will be most ready and able to fully implement the guidelines. The second part of the guidelines, the companion article, addresses the treatment of depression. Practices that do identify adolescent depression and have nowhere to refer patients to may benefit from the guidance offered in the next set of recommendations.

Preparatory Steps

Because the management of adolescent depression may constitute a new or major challenge for some PC practices, a number of important considerations should be kept in mind when preparing to implement the guidelines given the findings from studies in the adult literature; input from our focus groups of clinicians, families, and patients; and the experience of members of the GLAD-PC Steering Committee. Specifically, PC clinicians who manage adolescent depression should pursue the following: (1) additional training regarding issues such as advances in screening, diagnosis, treatment, follow-up, liability, consent, confidentiality, and billing; (2) practice and systems changes, such as office staff training and buy-in, EMRs, and automated tracking systems, whenever available; and (3) establishing linkages with mental health services.

Linkages with community mental health resources are necessary to both meet the learning needs of the PC clinicians and to facilitate consultation for and/or referral of difficult cases. Practice and systems changes are useful in increasing clinicians' capacity to facilitate monitoring and follow-up of patients with depression. For example, staff training may help prioritize calls from adolescent patients who may not state the nature of their call. Specific tools and/or templates have been developed that offer examples of how to efficiently identify, monitor, track, and refer teenagers with depression. These materials are available in the GLAD-PC tool kit. The tool kit addresses how each of the recommendations might be accomplished without each practice necessarily having to "reinvent the wheel."

CONCLUSIONS

Review of the evidence suggests that PC clinicians who have appropriate training and are attempting to deliver comprehensive health care should be able to identify

and initiate the management of adolescent depression. This will likely require real changes in existing systems of care. As health care models such as the medical home indicate, comprehensive health care should include assessment and coordination of care for both physical and behavioral health issues. This first part of the guidelines for adolescent depression in PC may enable providers to pull together the current best evidence and deliver the best available, high-quality care even in instances when they are not in a position to treat such youth. Mounting evidence suggests that pediatric providers can and should identify and coordinate depression care in their adolescent populations.

APPENDIX: PART I TOOLKIT ITEMS

- Screening/assessment instruments (i.e., Columbia Depression Scale)
- Information sheet on the developmental considerations in the diagnosis of depression
- Assessment Algorithm/Flow Sheet (Fig 1)
- Fact sheet/family education materials
- Educational materials on suicide prevention/safety planning

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ABBREVIATIONS

AAP: American Academy of Pediatrics
BHS: Behavioral Health Screen
CATCH-IT: Competent Adulthood Transition with Cognitive-behavioral, Humanistic and Interpersonal Training
DISC-IV: Diagnostic Interview Schedule for Children-IV
DSM-5: *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*
ED: emergency department
EMR: electronic medical record
GAPS: Guidelines for Adolescent Preventive Services
GLAD-PC: Guidelines for Adolescent Depression in Primary Care
HMO: health maintenance organization
K-SADS: Kiddie Schedule for Affective Disorders and Schizophrenia
MDD: major depressive disorder
NPV: negative predictive value
PC: primary care
PHQ-2: Patient Health Questionnaire-2
PHQ-9: Patient Health Questionnaire-9
PPV: positive predictive value
PSC: Pediatric Symptom Checklist
PSC-17: Pediatric Symptom Checklist-17
RCT: randomized controlled trial
REACH: Resource for Advancing Children's Health
TCPS: Targeted Child Psychiatry Services
USPSTF: United States Preventive Services Task Force
YPIC: Youth Partners in Care

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Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management

Rachel A. Zuckerbrot, Amy Cheung, Peter S. Jensen, Ruth E.K. Stein, Danielle Laraque and GLAD-PC STEERING GROUP

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STATEMENT OF ENDORSEMENT

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Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part II. Treatment and Ongoing Management

Amy H. Cheung, MD,[a] Rachel A. Zuckerbrot, MD,[b] Peter S. Jensen, MD,[c] Danielle Laraque, MD,[d] Ruth E.K. Stein, MD,[e] GLAD-PC STEERING GROUP

abstract

OBJECTIVES: To update clinical practice guidelines to assist primary care (PC) in the screening and assessment of depression. In this second part of the updated guidelines, we address treatment and ongoing management of adolescent depression in the PC setting.

METHODS: By using a combination of evidence- and consensus-based methodologies, the guidelines were updated in 2 phases as informed by (1) current scientific evidence (published and unpublished) and (2) revision and iteration among the steering committee, including youth and families with lived experience.

RESULTS: These updated guidelines are targeted for youth aged 10 to 21 years and offer recommendations for the management of adolescent depression in PC, including (1) active monitoring of mildly depressed youth, (2) treatment with evidence-based medication and psychotherapeutic approaches in cases of moderate and/or severe depression, (3) close monitoring of side effects, (4) consultation and comanagement of care with mental health specialists, (5) ongoing tracking of outcomes, and (6) specific steps to be taken in instances of partial or no improvement after an initial treatment has begun. The strength of each recommendation and the grade of its evidence base are summarized.

CONCLUSIONS: The Guidelines for Adolescent Depression in Primary Care cannot replace clinical judgment, and they should not be the sole source of guidance for adolescent depression management. Nonetheless, the guidelines may assist PC clinicians in the management of depressed adolescents in an era of great clinical need and a shortage of mental health specialists. Additional research concerning the management of depressed youth in PC is needed, including the usability, feasibility, and sustainability of guidelines, and determination of the extent to which the guidelines actually improve outcomes of depressed youth.

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BACKGROUND

Studies have revealed that up to 9% of teenagers meet criteria for depression at any one time, with as many as 1 in 5 teenagers having a history of depression at some point during adolescence.[1–7] In primary care (PC) settings, point prevalence rates are likely higher, with rates up to 28%.[8–12] Taken together, in epidemiologic and PC-specific studies it is suggested that despite relatively high rates, major depressive disorder (MDD) in youth is underidentified and undertreated in PC settings.[13,14]

Because adolescents face barriers to receive specialty mental health services, only a small percentage of depressed adolescents are treated by mental health professionals.[15] As a result, PC settings have become the de facto mental health clinics for this population, although most PC clinicians feel inadequately trained, supported, or reimbursed for the management of depression.[14–21] Although MDD management guidelines have been developed for specialty care settings (eg, the American Academy of Child and Adolescent Psychiatry[22]) or related problems such as suicidal ideation or attempts,[23] it is clear that significant practice and clinician differences exist between the primary and specialty care settings that do not allow a simple transfer of guidelines from one setting to another.

Recognizing this gap in clinical guidance for PC providers, in 2007, a group of researchers and clinical experts from the United States and Canada established Guidelines for Adolescent Depression in Primary Care (GLAD-PC), a North American collaborative, to develop guidelines for the management of adolescent depression in the PC setting. The development process of GLAD-PC is described in detail in Part I of the original GLAD-PC articles.[24,25] In this article, we describe the updated recommendations regarding treatment, ongoing management, and follow-up, along with the supporting empirical evidence for these recommendations. In our companion article, we provide a detailed description of the update process as well as the corresponding updated recommendations for GLAD-PC regarding practice preparation, depression identification, assessment, and diagnosis, and initial management before formal treatment.

METHODS

A full description of the methodology used for the update of GLAD-PC is included in our companion article. In brief, the expert collaborative used a mix of qualitative (expert consensus) and quantitative (literature reviews) methods to inform the update of GLAD-PC. In view of space limitations, only the methods and results of the updated literature reviews regarding available evidence for treatment and ongoing management are presented in this article.

The following 3 literature reviews were conducted for the updated GLAD-PC recommendations: (1) nonspecific psychosocial interventions in pediatric PC, including studies pertaining to integrated behavioral health and collaborative care models; (2) antidepressant treatment; and (3) psychotherapy interventions.

For the first review, we searched the literature (PubMed, PsycInfo, and the Cochrane Database) for articles published from 2005 to the present in which researchers examined evidence for psychosocial interventions delivered in the PC setting to update the previous review conducted by Stein et al.[26] The "related articles" function was used to search for articles similar to Asarnow et al[14] and Richardson et al.[27] In addition, reference lists of all relevant articles were also examined for other relevant studies.

In the second updated review, we examined the efficacy and safety of antidepressant medications in the pediatric population (under the age of 18 years). This review was used to update the findings from the US Food and Drug Administration (FDA) safety report[28] and the previously published GLAD-PC review on antidepressants in youth depression.[29] Studies in which researchers examined the management of depression with the use of antidepressants as both monotherapy and combination therapy were included.

In the third review, we searched the literature for depression trials in which researchers examined the efficacy of psychotherapy for the management of depression in children and adolescents. The search included all forms of psychotherapy, including both individual and group-based therapies. We not only identified both individual studies but also high-quality systematic reviews, given the extensive empirical literature in this area. In both the second and third reviews, the literature searches were conducted by using Medline and PsycInfo to find studies published between 2005 to the present. To ensure additional articles were not missed, reference lists of included articles were hand-searched for other relevant studies. A full description of the 3 reviews is available on request.

RESULTS

Organizational Adoption of Integrative Care

Within the past decade, there has been a shift in medicine and in mental health away from the "traditional" model of autonomous individual providers and toward delivering empirically supported interventions in a team-based manner. This followed a growing recognition that complex chronic conditions, such as depression,

are more successfully managed with proactive, multidisciplinary patient-centered care teams. Ongoing changes in the health care landscape helped to solidify support for this revolution. Systems are enacting top-down changes designed to make the entire delivery system (organizations, clinics, and providers) more effective, efficient, safe, and satisfying to both patients and providers.

Proposed integrated care models include "chronic care management," "integrated behavioral health care," "collaborative care," and "medical home." Here, the term "integrative care" will be used to collectively refer to models such as these. These complex care models share multiple features, such as an emphasis on systematically identifying and tracking target populations, multidisciplinary patient care, structured protocols for symptom management, regular follow-ups, decreasing fragmentation across the care team, and enhancing the patient's ability to self-manage their condition.[30] The following list represents many of the components described in 1 or more of these health care models:

1. a treatment team that includes the patient, the family, and access to mental health expertise;
2. education (including decision tools) for PC providers, patients, and family;
3. tools and/or procedures to systematically identify, assess, and diagnose patients who are at risk or are currently experiencing depressive symptoms;
4. a care plan for target patients (which may involve the family when possible and includes resources at other agencies or in the community);
5. improved communication and coordination of care across providers and/or between patient, family, and provider;
6. case management and/or patient and family support;
7. routine tracking of patient progress, with appropriate follow-up action as needed;
8. routine evaluation of staff performance metrics to inform ongoing quality improvement efforts; and
9. increased patient and family motivation and capacity to self-manage symptoms, including education, feedback, etc.

A variety of integrative care models have been proposed or discussed in the literature,[31,32] but few studies have actually been conducted to examine whether they ultimately improve care for children and adolescents with mental health disorders, broadly speaking, or depression, specifically. In the present review, only 3 randomized clinical trials were identified. In the first, Asarnow et al[14] found that adolescents treated for depression at PC clinics engaging in a quality improvement initiative received higher rates of mental health care and psychosocial therapy, endorsed fewer depressive symptoms, reported a greater quality of life, and expressed greater satisfaction with their care than comparison adolescents in a usual care condition. In a second study, researchers examined the additive benefits of providing brief (4-session) cognitive behavioral therapy (CBT) for depression in conjunction with antidepressant medication compared with medication alone in a collaborative care practice with embedded care managers and found a weak but positive benefit for adjunctive CBT.[33] Finally, Richardson et al[27] randomly assigned adolescents to either an integrative care condition, in which patients chose from a treatment menu of antidepressant medication alone, brief CBT alone, or a combination of the 2, versus usual care. Results revealed that integrative care was associated with significant decreases in depression scores and improved response and remission rates at 12 months compared with treatment as usual.[27] The results of a cost-effectiveness analysis of this trial revealed that the integrative care condition was more effective at reducing depression symptoms for adolescents, resulting in incremental cost savings given the quality of life years gained from improved functioning.[34]

Although research studies offer support for the impact of integrative or collaborative health care delivery models as a whole,[35] multiple changes to the practice setting are being evaluated simultaneously. The components of integrative health care models have largely been identified through practice-based research[36] or "best ideas" about how to solve identified problems, without a clear theoretical or empirical basis for these components individually or in combination. Thus, it is unknown what "active ingredients" account for the greatest proportion of variance in patient improvement because no dismantling studies have been conducted in which the relative impact of the individual components was examined. Given that integrated health care approaches are resource-intensive to implement and maintain, it may not be feasible for many PC practices to fully adopt such a model. Some states and communities have attempted to implement "wraparound services" under the "systems of care model"; however, unfortunately, these services are usually restricted to severely impaired children with chronic mental health problems. Nonetheless, such services are available if PC providers are interested.[37,38] Unfortunately, there is relatively little information to help guide prioritization and decision-making for PC clinics that wish to improve patient care within the constraints

of highly limited human and/or financial resources.

Antidepressant Treatment

The updated treatment review for antidepressant safety and efficacy included randomized controlled trials (RCTs) of antidepressants in youth with depression. In this GLAD-PC review, we identified 27 peer-reviewed articles in this area, including trials with fluoxetine, sertraline, citalopram, paroxetine, duloxetine, and venlafaxine. In addition, in several studies, the switch from a selective serotonin reuptake inhibitor (SSRI) to venlafaxine, a serotonin norepinephrine reuptake inhibitor, was explored.[39–41] Older antidepressants (ie, monoamine oxidase inhibitors, tricyclic antidepressants) were not included in our updated review because of several reasons. First, the 2004 FDA review that was used for the development of the guidelines only involved newer classes of antidepressants. Second, older antidepressants are not used because of the lack of efficacy demonstrated in clinical trials data for other classes of older antidepressants.[42]

Overall, both individual clinical trial evidence and evidence from systematic reviews still support the use of antidepressants in adolescents with MDD. Bridge et al[43] conducted a meta-analysis of the clinical trials data and calculated the numbers needed to treat and numbers needed to harm. They concluded that 6 times more teenagers would benefit from treatment with antidepressants than would be harmed.[43] In reviewing the individual studies, the percentage of subjects who responded to antidepressants ranged from 47% to 69% and from 33% to 57% for those on placebo (see Table 1). The majority of these studies revealed a significant difference between those on medication versus those on placebo. Similarly, on the basis of the updated review, fluoxetine still has the most evidence to support its use in the adolescent population.[44]

TABLE 1 Response Rates in RCTs of Antidepressants Based on Clinical Global Impression

Medication	Drug, %	Placebo, %	*P*
Fluoxetine[45,a]	56	33	.02
Fluoxetine[46]	52	37	.03
Fluoxetine[47]	61	35	.001
Paroxetine[48,b]	66	48	.02
Paroxetine[49]	69	57	NS
Paroxetine[49]	65	46	.005
Citalopram[50]	47	45	NS
Citalopram[51]	51	53	NS
Sertraline[52]	63	53	.05
Escitalopram[53]	63	52	.14
Escitalopram[54]	64	53	.03

NS, not significant.
[a] Fluoxetine alone compared with placebo.
[b] Paroxetine compared with placebo.

The largest study, the Treatment of Adolescent Depression Study, involved subjects who were randomly assigned to receive placebo, CBT alone, fluoxetine alone, or a combination treatment of CBT with fluoxetine.[45] Subjects assigned to receive combination treatment or fluoxetine alone showed significantly greater improvement in their depressive symptoms compared with those on placebo or those treated with CBT alone (also see subsection "CBT"). There is also a more rapid initial response when medication is initiated first or in combination with therapy.[55] The superiority of combination therapy is also demonstrated in adolescents with anxiety.[56,57] However, a few trials have revealed little extra benefit to combination therapy, but these findings might be confounded by the control therapy intervention (ie, routine specialist care).[58–60]

Combination therapy has also been evaluated in adolescents with treatment-resistant depression. In the Treatment of SSRI-resistant Depression in Adolescents study, researchers examined treatment options for adolescents aged 12 to 18 whose depression had not improved after 1 adequate trial of an SSRI.[39–41,49,61–63] Subjects were randomly assigned to 4 possible interventions: (1) switch to a different SSRI (citalopram, fluoxetine, paroxetine), (2) switch to a second SSRI in combination with CBT, (3) switch to venlafaxine, or (4) switch to venlafaxine in combination with CBT. Patients who received CBT and changed their medication to a second SSRI or venlafaxine had a higher response rate (54.8%; 95% confidence interval [CI]: 47%–62%) than changing the medication alone (40.5%; 95% CI: 33%–48%; $P = .009$). Additionally, there was no difference in response rate between venlafaxine and a second SSRI (48.2%; 95% CI: 41%–56%; and 47%; 95% CI: 40%–55%; $P = .83$) as well as no significant differences among Children's Depression Rating Scale–Revised improvements between treatment options.

Finally, with available evidence from RCTs, it is suggested that adverse effects do emerge in depressed youth who are treated with antidepressants.[45] Adverse effects (ie, nausea, headaches, behavioral activation, etc) were found to occur in most adolescents treated with antidepressants, with duloxetine, venlafaxine, and paroxetine as the most intolerable.[45] Therefore, routine monitoring of the development of adverse events is critical for depressed youth treated with antidepressants.

The most significant adverse effect of antidepressants is the emergence of

new onset or worsening suicidality, which was demonstrated in the FDA review in 2004.[29] The estimated risk of suicidality is 4% in those on medication versus 2% in those on placebo. However, further analyses of clinical trials data revealed that there is overall improvement in suicidality in subjects treated with antidepressants, with only a few subjects reporting worsening or new onset suicidality.[49] In the FDA review, it was also suggested that paroxetine and venlafaxine have a significantly higher risk for suicidality compared with other serotonergic antidepressants.

The doubling of risk of suicidality was also confirmed in population level studies.[63] However, studies have also revealed that almost all adolescents who die by suicide do not test positive for antidepressants in postmortem toxicology tests despite being prescribed these drugs.[64] Furthermore, Olfson et al[65] found an inverse relationship between rates of SSRI prescriptions and rates of suicide in adolescent populations.

Psychotherapy

In the third review conducted, we examined the efficacy of psychotherapy, such as CBT, interpersonal psychotherapy for adolescents (IPT-A), as well as nonspecific interventions such as counseling and support. Through our search, we were able to identify both individual studies as well as several high-quality meta-analyses and/or reviews that were recently conducted to examine the efficacy of psychotherapy in adolescent depression.

CBT

Numerous meta-analyses and reviews have been conducted on CBT in the treatment of adolescent depression and showed improved outcomes for subjects treated with CBT.[66–68] There are also several ongoing studies in which researchers are evaluating CBT in youth up to age 21.[69]

The effectiveness of CBT for adolescents with moderate to moderately severe depression was also evaluated in Treatment of Adolescent Depression Study, in which researchers randomly assigned 439 12- to 17-year-olds who were depressed to treatment with CBT, fluoxetine, CBT plus fluoxetine, or placebo.[45,70] According to Clinical Global Impressions severity scores, the posttreatment response rate to 15 sessions of CBT over 12 weeks (43.2%; 95% CI: 34%–52%) was not significantly different ($P = .40$) from placebo (34.8%; 95% CI: 26%–44%). The authors attributed this relatively low response rate, in part, to the fact that the study population suffered from more severe and chronic depression than participants in previous studies and to a high rate of psychiatric comorbidity in their study participants. Along with the fairly robust placebo-response rate, it is also possible that the nonspecific therapeutic aspects of the medication management could have successfully competed with the specific effects of the CBT intervention. As a consequence, one cannot and should not conclude that CBT is ineffective.

In another study with adolescents with depression, Fleming et al[71] evaluated the effectiveness of a computerized cognitive behavioral therapy (CCBT) intervention called SPARX in treating adolescents aged 13 to 16 years excluded from mainstream education ($n = 20$). After randomly assigning them to CCBT or the waitlist control, it was found that there were significantly greater reductions in Children's Depression Rating Scale and Reynolds Adolescent Depression Scale scores from baseline to week 5 for the intervention group compared with those who waited. In addition, the SPARX group was significantly more likely to be in remission or have a significant reduction in symptoms.

In several other studies, researchers have evaluated CCBT interventions and have also found similar results, with 1 study conducted in the PC setting.[72,73]

IPT-A

In terms of IPT-A, only a handful of studies have been conducted. First, Tang et al[74] randomly assigned 347 adolescents who were depressed to receive IPT-A in schools or treatment as usual. IPT-A was found to have significantly higher effects on reducing severity of depression, suicidal ideation, and hopelessness compared with treatment as usual. In Gunlicks-Stoessel et al's[75] study, 63 adolescents who were depressed were randomly assigned to IPT-A or treatment as usual. Adolescents who were depressed who reported higher baseline levels of interpersonal difficulties showed a greater and more rapid reduction in depressive symptoms if treated with IPT-A compared with treatment as usual. In the most recent study,[76] 57 adolescents with depressive symptoms were randomly assigned to receive either 8 weeks of interpersonal therapy–adolescent skills training or supportive school counseling. Adolescents who were treated with interpersonal therapy–adolescent skills training showed significantly greater rates of change compared with adolescents who received school counseling on the Center for Epidemiologic Studies Depression Scale ($t[215] = -2.56$, $P = .01$), Children's Depression Rating Scale-Revised ($t[169] = -3.09$, $P < .01$), and the Children's Global Assessment Scale ($t[168] = 3.24$, $P < .01$).

GUIDELINES

Each of the recommendations below was graded on the basis of the level of supporting research evidence from the literature and the extent to which experts agreed that it is highly appropriate in PC. The level

of supporting evidence for each recommendation is based on the Oxford Centre for Evidence-Based Medicine grades of evidence[1–5] system, with 1 to 5 corresponding to strongest to weakest evidence (see http://www.cebm.net/wp-content/uploads/2014/06/CEBM-Levels-of-Evidence-2.1.pdf/).

Recommendation strength based on expert consensus was rated in 4 categories: very strong (>90% agreement), strong (>70% agreement), fair (>50% agreement), and weak (<50% agreement). The recommendations in the guidelines were developed only in areas of management that had at least a "strong agreement" among experts (see Fig 1 for the treatment algorithm).

Treatment

Recommendation 1: PC clinicians should work with administration to organize their clinical settings to reflect best practices in integrated and/or collaborative care models (eg, facilitating contact with psychiatrists, case managers, embedded therapists). (grade of evidence: 4; strength of recommendation: very strong).

There is a growing recognition that complex chronic conditions, such as depression, are most successfully managed with proactive, multidisciplinary, patient-centered care teams.[77,78] Proposed integrated care models include chronic care management, integrated behavioral health care, collaborative care, and medical home. These complex care models have been shown to be more effective in improving outcomes and share multiple features, such as an emphasis on systematically identifying and tracking target populations, decreasing fragmentation across the care team, and enhancing the patient's ability to self-manage their condition.

Recommendation 2: After initial diagnosis, in cases of mild depression, clinicians should consider a period of active support and monitoring before starting evidence-based treatment (grade of evidence: 3; strength of recommendation: very strong).

After a preliminary diagnostic assessment, in cases of mild depression, clinicians should consider a period of active support and monitoring before recommending treatment (from 6 to 8 weeks of weekly or biweekly visits for active monitoring). Evidence from RCTs with antidepressants and CBT show that a sizable percentage of patients respond to nondirective supportive therapy and regular symptom monitoring.[42,43,45,48,50,70,79] However, if symptoms persist, treatment with antidepressants or psychotherapy should be offered, whether provided by PC or mental health. Active support and monitoring is also essential in cases in which depressed patients and/or their families and/or caregivers refuse other treatments. Active support and counseling for adolescents by pediatric PC clinicians have been evaluated for several different disorders, including substance abuse and sleep disorders.[22]

Furthermore, expert opinion based on extensive clinical experience and qualitative research with families, patients, and clinicians indicates that these strategies are a crucial component of management by PC clinicians. For further guidance on how to provide active support, please refer to the GLAD-PC toolkit (http://www.gladpc.org).

For moderate or severe cases, the clinician should recommend treatment; crisis intervention; patient and family support services, such as in-home or skill-building services (as indicated); and mental health consultation immediately, without a period of active monitoring.

Recommendation 3: If a PC clinician identifies an adolescent with moderate or severe depression or complicating factors and/or conditions such as coexisting substance abuse or psychosis, consultation with a mental health specialist should be considered (grade of evidence: 5; strength of recommendation: strong). Appropriate roles and responsibilities for ongoing comanagement by the PC clinician and mental health clinician(s) should be communicated and agreed on (grade of evidence: 5; strength of recommendation: strong). The patient and family should be active team members and approve the roles of the PC and mental health clinicians (grade of evidence: 5; strength of recommendation: strong).

In adolescents with severe depression or comorbidities, such as substance abuse, clinicians should consider consultation with mental health professionals and refer to such professionals when deemed necessary. In cases of moderate depression with or without comorbid anxiety, clinicians should consider consultation by mental health and/or treatment in the PC setting. Although the access barriers to mental health services need to be addressed by policy makers to make mental health consultations more feasible, available, and affordable in underserviced areas, clinical judgment should prevail in the meantime; thus, the need for consultation should be based on the clinician's judgment. PC providers should also take into consideration the treatment preferences of patients and/or families, the severity and urgency of the case presentation, and the PC provider's level of training and experience.

Active support and treatment should also be started in cases in which there is a lengthy waiting list for mental health services. Once a

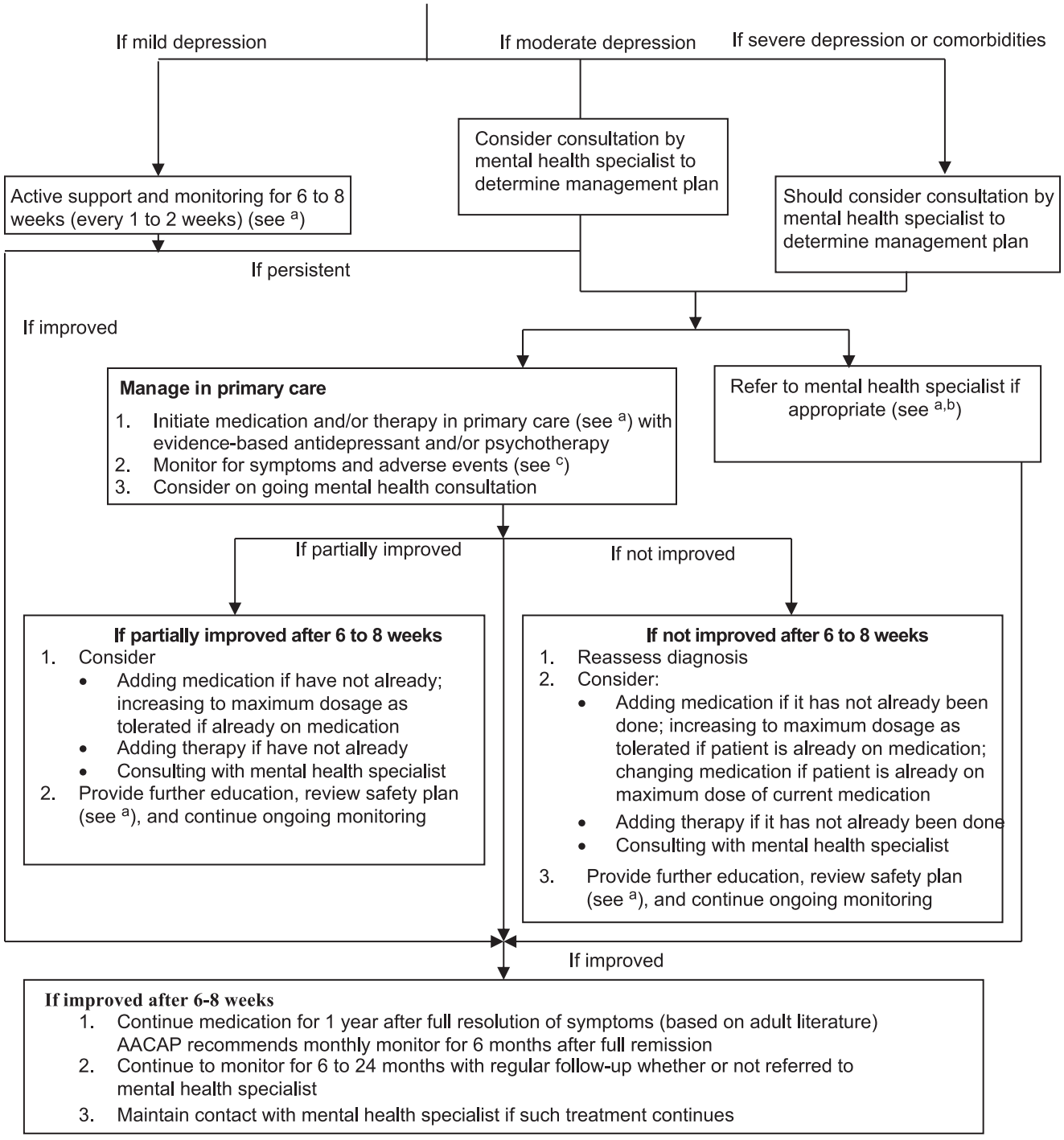

FIGURE 1

Clinical management flowchart. [a]Psychoeducation, supportive counseling, facilitate parental and patient self-management, refer for peer support, and regular monitoring of depressive symptoms and suicidality. [b]Negotiate roles and/or responsibilities between PC and mental health and designate case coordination responsibilities. Continue to monitor in PC after referral and maintain contact with mental health. [c]Clinicians should monitor for changes in symptoms and emergence of adverse events, such as increased suicidal ideation, agitation, or induction of mania. For monitoring guidelines, please refer to the guidelines and/or toolkit. AACAP, American Academy of Child and Adolescent Psychiatry.

referral is made, comanagement of treatment should take place with the PC clinician remaining involved in follow-up. In particular, roles and responsibilities should be agreed on between the PC clinician and mental health clinician(s), including the designation of case coordination responsibilities.[48,50,77,78,80,81] It is critical for PC clinicians to make linkages with their closest crisis support and hospital services so that

they are supported in crisis situations when caring for depressed youth.

Recommendation 4: PC clinicians should recommend scientifically tested and proven treatments (ie, psychotherapies, such as CBT or IPT-A, and/or antidepressant treatment, such as SSRIs) whenever possible and appropriate to achieve the goals of the treatment plan[82] (grade of evidence: 1; strength of recommendation: very strong).

After providing education and support to the patient and family, the range of effective treatment options, including medications, psychotherapies, and family support should be considered. The patient and family should be assisted to arrive at a treatment plan that is both acceptable and implementable, taking into account their preferences and the availability of treatment services. The treatment plan should be customized according to the severity of disease, risk of suicide, and the existence of comorbid conditions. The GLAD-PC toolkit (www.gladpc.org) provides more detailed guidance around the factors that may influence treatment choices (ie, a patient with psychomotor retardation may not be able to actively engage in psychotherapy). A "common factors" approach is focused on evidence-based practices, which are common across therapies. Common factors include better communication skills, to be supportive, to take advantage of therapeutic alliance, and to engage in shared decision-making.[83] Common sense approaches such as the prescription of physical exercise, sleep hygiene, and adequate nutrition should also be used in the management of these patients.

As an aside, the majority of CBT and IPT-A studies in which researchers included patients with MDD also included patients with depression not otherwise specified, subthreshold depressive symptoms, or dysthymic disorder. In contrast, medication RCTs for depression in adolescents generally only included subjects with MDD. Thus, although the general treatment of depression is addressed in these guidelines, medication-specific guidelines apply only to fully expressed MDD.

TABLE 2 Components of CBT and IPT-A

Therapy	Key Components
CBT	Thoughts influence behaviors and feelings and vice versa. Treatment targets patient's thoughts and behaviors to improve his or her mood. Essential elements of CBT include increasing pleasurable activities (behavioral activation), reducing negative thoughts (cognitive restructuring), and improving assertiveness and problem-solving skills to reduce feelings of hopelessness. CBT for adolescents may include sessions with parents and/or caregivers to review progress and to increase compliance with CBT-related tasks.
IPT-A	Interpersonal problems may cause or exacerbate depression, and that depression, in turn, may exacerbate interpersonal problems. Treatment targets patient's interpersonal problems to improve both interpersonal functioning and his or her mood. Essential elements of interpersonal therapy include identifying an interpersonal problem area, improving interpersonal problem-solving skills, and modifying communication patterns. Parents and/or caregivers are involved in sessions during specific phases of the therapy.

Psychotherapies

Both CBT and IPT-A have been adapted to address depression in adolescents and have been shown to be effective in treating adolescents with MDD in tertiary care as well as community settings.[57,84] CBT has been used in the PC setting with preliminary positive results.[33,35] Also suggested in emerging evidence is the superior efficacy of combination therapy (medication and CBT) versus CBT alone.[43] For a brief description of the 2 therapies, see Table 2.

Antidepressant Treatment

Previous research has shown that up to 25% of pediatric PC clinicians and 42% of family physicians in the United States had recently prescribed SSRIs for more than 1 adolescent under the age of 18.[15] When indicated by clinical presentation (ie, clear diagnosis of MDD with no comorbid conditions) and patient and/or family preference, an SSRI should be used. The selection of the specific SSRI should be based on the optimum combination of safety and efficacy data. Deliberate self-harm and/or suicide risk is more likely to occur if the SSRI is started at higher doses (rather than normal starting doses).[85] The patient and family should be informed about the possible adverse effects (clinicians may use checklist), including possible switch to mania or the development of behavioral activation or suicide-related events. Once the antidepressant is started, and if tolerated, the clinician should support an adequate trial up to the maximum dose and duration.

In Table 3, recommended antidepressants and dosages for use in adolescents with depression are listed. These recommendations are based on the updated literature review and reviewed by the GLAD-PC Steering Committee. Generally, the effective dosages for antidepressants in adolescents are lower than would be found in adult guidelines. Note that only fluoxetine has been approved by the FDA for use in children and adolescents with depression, and only escitalopram has been approved for use in adolescents aged 12 years and older. Clinicians should know the potential drug interactions with SSRIs. Further information on the use of antidepressants is described in the GLAD-PC toolkit (www.gladpc.org). In addition, all SSRIs should be slowly tapered when discontinued because of risk of withdrawal effects. Details regarding the initial selection of a specific SSRI and possible reasons for initial drug choice can be found in the GLAD-PC toolkit.

TABLE 3 SSRI Titration Schedule

Medication	Starting Dose (qd/od), mg	Increments, mg	Effective Dose, mg	Maximum Dosage, mg	Contraindicated
Citalopram	10	10	20	60	MAOIs
Fluoxetine	10	10–20	20	60	MAOIs
Fluvoxamine	50	50	150	300	MAOIs
Paroxetine[a]	10	10	20	60	MAOIs
Sertraline	25	12.5–25	50	200	MAOIs
Escitalopram	10	5	10	20	MAOIs

MAOI, monoamine oxidase inhibitor; qd/od, every day once daily.
[a] Not recommended to be started in PC.

Contact (either in person or by telephone with either the clinician or member of the clinical staff) should take place after the initiation of treatment to review the patient's and family's understanding of and adherence to the treatment plan. Issues such as the current status of the patient and the patient and/or family's access to educational materials regarding depression should be discussed during follow-up conversations. For relevant educational resources for patients and/or families, please refer to the GLAD-PC toolkit (www.gladpc.org).

Recommendation 5: PC clinicians should monitor for the emergence of adverse events during antidepressant treatment (SSRIs) (grade of evidence: 3; strength of recommendation: very strong).[82]

Re-analysis of safety data from clinical trials of antidepressants led to a black-box warning from the FDA regarding the use of these medications in children and adolescents in 2004 and a recommendation for close monitoring. The exact wording of the FDA recommendation is:

All pediatric patients being treated with antidepressants for any indication should be observed closely for clinical worsening, suicidality, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases.

It should be noted, however, that there is no empirical evidence to support the requirement of face-to-face meetings per se. In fact, evidence from large population-based surveys reveals high reliability of telephone interviews with adolescent subjects for the diagnosis of depression.[86,87] Although obtaining a diagnosis is not the same as the elicitation of adverse events while in treatment, with this evidence, it is suggested that telephone contact may be just as effective in monitoring for adverse events. More importantly, a regular and frequent monitoring schedule should be developed, taking care to obtain input from the adolescents and families to ensure compliance with the monitoring strategy.[88,89] This may include monitoring of depressive symptoms, risky behaviors, and also functioning in the school setting, especially if an individualized education program is in place. Working closely with the family will ensure appropriate monitoring and help-seeking by caregivers.

Ongoing Management

The strength of evidence on which each recommendation is based has been rated 1 (strongest) through 5 (weakest), according to the Oxford Centre for Evidence-Based Medicine levels of evidence, and paired with the strength of recommendation (Very strong [>90% agreement]), Strong [>70% agreement], Fair [>50% agreement], Weak [<50% agreement]).

Recommendation 1: Systematic and regular tracking of goals and outcomes from treatment should be performed, including assessment of depressive symptoms and functioning in several key domains. These include home, school, and peer settings (grade of evidence: 4; strength of recommendation: very strong).

Goals should include both improvement in functioning and resolution of depressive symptoms. Tracking of goals and outcomes from treatment should include function in several important domains (ie, home, school, peers). Evidence from large RCTs reveals that depressive symptoms and functional impairments may not improve at the same rate with treatment.[28,70] Therefore, symptoms and functioning should be tracked regularly during the course of treatment with information gathered from both the patients and their families when possible.

According to expert consensus, it is ideal that patients are assessed in person within 1 week of the initiation of treatment. At every assessment, clinicians should inquire about each of the following: (1) ongoing depressive symptoms, (2) risk of suicide, (3) possible adverse effects from treatment (including the use of specific adverse-effect scales), (4) adherence to treatment, and (5) new or ongoing environmental stressors. In several studies, researchers have examined medication maintenance after response.[90–93] Emslie et al[93] randomly assigned pediatric patients who had responded to fluoxetine by 19 weeks to placebo or to medication continuation for an additional 32 weeks. Of the 20 subjects randomly assigned to the 32-week medication relapse-prevention arm, 10 were exposed to fluoxetine for 51 weeks. Significantly fewer relapses occurred in the group randomly assigned to medication maintenance, which suggests that longer medication continuation periods, possibly 1 year, may be necessary for relapse prevention. In addition, Emslie et al[93] found the greatest risk of relapse to be in the first 8 to 12 weeks

after discontinuing medication, which suggests that after stopping an antidepressant, close follow-up should be encouraged for at least 2 to 3 months. Other studies have revealed similar benefits of prolonged treatment after acute response.[90–93]

With the limited evidence in children and adolescents and the emerging evidence in the adult literature in which it is suggested that antidepressant medication should be continued for 1 year after remission, both GLAD-PC and the American Academy of Child and Adolescent Psychiatry concluded that medication be maintained for 6 to 12 months after the full resolution of depressive symptoms.[22,90–93]

However, regardless of the length of treatment, all patients should be monitored on a monthly basis for 6 to 12 months after the full resolution of symptoms.[22,93,94] If the depressive episode is a recurrence, clinicians are encouraged to monitor patients for up to 2 years given the high rates of recurrence as demonstrated in the adult literature in which maintenance treatment in those with recurrent depression continues for up to 2 years after the full resolution of symptoms. Clinicians should obtain consultation from mental health professionals if a teenager develops psychosis, suicidal or homicidal ideation, and new or worsening of comorbid conditions.

Recommendation 2: Diagnosis and initial treatment should be reassessed if no improvement is noted after 6 to 8 weeks of treatment (grade of evidence: 4; strength of recommendation: very strong). Mental health consultation should be considered (grade of evidence: 4; strength of recommendation: very strong).

If improvement is not seen within 6 to 8 weeks of treatment, mental health consultation should be considered. Evidence of improvement may include reduction in the number of depressive symptoms, improved functioning in social or school settings, or improvement spontaneously reported by the adolescent and/or parent or caregiver. The clinician should also reassess the initial diagnosis, choice and adequacy of initial treatment, adherence to treatment plan, presence of comorbid conditions (eg, substance abuse) or bipolar symptoms that may influence treatment effectiveness, and new external stressors. If a patient has no response to a maximum therapeutic dose of an antidepressant medication, the clinician should consider changing the medication. Alternatively, if the patient has failed to improve on antidepressant medication or therapy alone, the addition of or switch to the other modality should be considered.

Recommendation 3: For patients achieving only partial improvement after PC diagnostic and therapeutic approaches have been exhausted (including exploration of poor adherence, comorbid disorders, and ongoing conflicts or abuse), a mental health consultation should be considered (grade of evidence: 4; strength of recommendation: very strong).

If a patient only partially improves with treatment, mental health consultation should be considered. The clinician should also review the diagnosis and explore possible causes of partial response, such as poor adherence to treatment, comorbid disorders, or ongoing conflicts and/or abuse. These causes may need to be managed first before changes to the treatment plan are made.

If a patient has been treated with a SSRI (maximum tolerated dosage) and has shown only partial improvement, the addition of an evidence-based psychotherapy should be considered, if not previously initiated. Other considerations may include the addition of another medication, an increase of the dosage above FDA-approved ranges, or a switch to another medication as suggested in the Treatment of SSRI-resistant Depression in Adolescents study,[39] preferably done in consultation with a mental health professional. Likewise, if a patient's condition fails to improve after a trial of either CBT or IPT-A and has not yet begun medication, the clinician should consider a trial of SSRI antidepressant treatment. Strong consideration should also be given to a referral to mental health services.

Recommendation 4: PC clinicians should actively support depressed adolescents referred to mental health services to ensure adequate management (grade of evidence: 5; strength of recommendation: very strong). PC clinicians may also consider sharing care with mental health agencies and/or professionals where possible (grade of evidence: 1; strength of recommendation: very strong). Appropriate roles and responsibilities regarding the provision and comanagement of care should be communicated and agreed on by the PC clinician and the mental health clinician(s) (grade of evidence: 4; strength of recommendation: very strong).

PC clinicians should continue follow-up with adolescents with depression who have been referred to mental health services for assessment and/or management.[95] Where possible, PC clinicians may consider sharing management of depressed adolescents with mental health agencies and/or professionals. There is emerging evidence from the literature about the greater effectiveness of "shared-care" models for the management of depression in the PC setting.[27,31,95–97] There is also increasing evidence to support that quality improvement strategies and techniques can change PC

practitioner behavior both in mental health and in other arenas.[98,99]

DISCUSSION

The recommendations regarding treatment and ongoing management highlight the need for PC providers to become familiar with the use of empirically tested treatments for adolescent depression, including both antidepressants and psychotherapy. In particular, antidepressant treatments can be useful in certain clinical situations in the PC setting. In many of these clinical scenarios, PC providers should schedule systematic and routine follow-up, including mental health support when appropriate. The need for systematic follow-up, whether by PC provider or by mental health provider, is especially important in light of the FDA black-box warnings regarding the emergence of adverse events with antidepressant treatment.

Psychotherapy is also recommended as first-line treatment of adolescents who are depressed in the PC setting. Although the provision of psychotherapy may be less feasible and practical within the constraints (ie, time, availability of trained staff) of PC settings, there is some evidence to support that quality improvement projects involving psychotherapy can improve the care of adolescents who are depressed.[35]

GLAD-PC was developed and now updated on the basis of the needs of PC clinicians who are faced with the challenge of caring for depressed adolescents as well as many barriers, including the shortage of mental health resources in most community settings. Although it is clear that more evidence and research in this area are needed, these updated guidelines represent a necessary step toward improving the care of depressed adolescents in the PC setting. Similar guidelines have also been produced for other health care contexts, such as in the United Kingdom (https://www.nice.org.uk/guidance/cg28). The updated GLAD-PC guidelines and the toolkit (www.gladpc.org) reflect the coming together of available evidence and the consensus of experts representing a broad spectrum of specialties and advocacy organizations within the North American health care context. However, no improvements in care will be achieved if changes do not occur in the health care systems that would allow for increased training in mental health for PC clinicians and in collaborative models for both primary and specialty care clinicians. Therefore, it is critical that training programs for PC providers increase their focus on mental health issues and that trainees in both PC and specialty care areas be helped to hone their skills in working in collaborative care models[89] (see http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/implementing_mental_health_priorities_in_practice.aspx). For providers who are currently practicing, continuing education should strengthen skills in collaborative work, and specifically, for PC providers, increase skills and knowledge in the management of depression.

LIMITATIONS

Although the guidelines covered a range of issues regarding the management of adolescent depression in the PC setting, there were other controversial areas that were not addressed in these recommendations. These included such issues as the use of augmenting agents and treatment of subthreshold symptoms. New emerging evidence may impact on the inclusion of such areas in future iterations of the guidelines and the toolkit (available for download at www.gladpc.org). Many of these recommendations are made in the face of an absence of evidence or at lower levels of evidence.

FUTURE DIRECTIONS

Ample evidence exists to support the notion that guidelines alone are insufficient in closing the gaps between recommended versus actual practices.[100,101] Thus, it will be necessary to identify effective methods for disseminating information and provide assistance to PC clinicians in changing practice. Researchers should build on this work by piloting and evaluating methods, tools, and strategies to facilitate the adoption of these guidelines for the management of adolescent depression in PC settings. Researchers should also explore optimal methods for helping clinicians and their clinical settings address the range of obstacles that may interfere with the adoption of necessary practices to yield sustainable management of adolescent depression in PC settings.

Many jurisdictions have recognized the need to increase collaborative care to address the care of adolescents with mental illness. In Canada and the United States, models of care involving mental health and PC are being implemented (National Network of Child Psychiatry Access Programs: www.nncpap.org; Massachusetts Child Psychiatry Access Program: https://www.mcpap.com/; Partnership Access Line; Training and Education for the Advancement of Children's Health).[102–106] However, the empirical support for these models is modest internationally; therefore, additional research is urgently needed.

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ABBREVIATIONS

CBT: cognitive behavioral therapy
CCBT: computerized cognitive behavioral therapy
CI: confidence interval
FDA: Food and Drug Administration
GLAD-PC: Guidelines for Adolescent Depression in Primary Care
IPT-A: interpersonal psychotherapy for adolescents
MDD: major depressive disorder
PC: primary care
RCT: randomized controlled trial
SSRI: selective serotonin reuptake inhibitor

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Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part II. Treatment and Ongoing Management

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Suicide and Suicide Attempts in Adolescents

Benjamin Shain, MD, PhD, COMMITTEE ON ADOLESCENCE

abstract

Suicide is the second leading cause of death for adolescents 15 to 19 years old. This report updates the previous statement of the American Academy of Pediatrics and is intended to assist pediatricians, in collaboration with other child and adolescent health care professionals, in the identification and management of the adolescent at risk for suicide. Suicide risk can only be reduced, not eliminated, and risk factors provide no more than guidance. Nonetheless, care for suicidal adolescents may be improved with the pediatrician's knowledge, skill, and comfort with the topic, as well as ready access to appropriate community resources and mental health professionals.

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INTRODUCTION

The number of adolescent deaths that result from suicide in the United States had been increasing dramatically during recent decades until 1990, when it began to decrease modestly. From 1950 to 1990, the suicide rate for adolescents 15 to 19 years old increased by 300%,[1] but from 1990 to 2013, the rate in this age group decreased by 28%.[2] In 2013, there were 1748 suicides among people 15 to 19 years old.[2] The true number of deaths from suicide actually may be higher, because some of these deaths may have been recorded as "accidental."[3] Adolescent boys 15 to 19 years old had a completed suicide rate that was 3 times greater than that of their female counterparts,[2] whereas the rate of suicide attempts was twice as high among girls than among boys, correlating to girls tending to choose less lethal methods.[4] The ratio of attempted suicides to completed suicides among adolescents is estimated to be 50:1 to 100:1.[5]

Suicide affects young people from all races and socioeconomic groups, although some groups have higher rates than others. American Indian/Alaska Native males have the highest suicide rate, and black females have the lowest rate of suicide. Sexual minority youth (ie, lesbian, gay, bisexual, transgender, or questioning) have more than twice the rate of suicidal ideation.[6] The 2013 Youth Risk Behavior Survey of students in

grades 9 through 12 in the United States indicated that during the 12 months before the survey, 39.1% of girls and 20.8% of boys felt sad or hopeless almost every day for at least 2 weeks in a row, 16.9% of girls and 10.3% of boys had planned a suicide attempt, 10.6% of girls and 5.4% of boys had attempted suicide, and 3.6% of girls and 1.8% of boys had made a suicide attempt that required medical attention.[7]

The leading methods of suicide for the 15- to 19-year age group in 2013 were suffocation (43%), discharge of firearms (42%), poisoning (6%), and falling (3%).[2] Particular attention should be given to access to firearms, because reducing firearm access may prevent suicides. Firearms in the home, regardless of whether they are kept unloaded or stored locked, are associated with a higher risk of completed adolescent suicide.[8,9] However, in another study examining firearm security, each of the practices of securing the firearm (keeping it locked and unloaded) and securing the ammunition (keeping it locked and stored away from the firearm) were associated with reduced risk of youth shootings that resulted in unintentional or self-inflicted injury or death.[10]

Youth seem to be at much greater risk from media exposure than adults and may imitate suicidal behavior seen on television.[11] Media coverage of an adolescent's suicide may lead to cluster suicides, with the magnitude of additional deaths proportional to the amount, duration, and prominence of the media coverage.[11] A prospective study found increased suicidality with exposure to the suicide of a schoolmate.[12] Newspaper reports about suicide were associated with an increase in adolescent suicide clustering, with greater clustering associated with article front-page placement, mention of suicide or the method of suicide in the article title, and detailed description in the article text about the individual or the suicide act.[13] More research is needed to determine the psychological mechanisms behind suicide clustering.[14,15] The National Institute of Mental Health suggests best practices for media and online reporting of deaths by suicide.[16]

ADOLESCENTS AT INCREASED RISK

Although no specific tests are capable of identifying a suicidal person, specific risk factors exist.[11,17] The health care professional should use care in interpreting risk factors, however, because risk factors are common, whereas suicide is infrequent. Of importance, the lack of most risk factors does not make an adolescent safe from suicide. Fixed risk factors include: family history of suicide or suicide attempts; history of adoption[18,19]; male gender; parental mental health problems; lesbian, gay, bisexual, or questioning sexual orientation; transgender identification; a history of physical or sexual abuse; and a previous suicide attempt. Personal mental health problems that predispose to suicide include sleep disturbances,[20] depression, bipolar disorder, substance intoxication and substance use disorders, psychosis, posttraumatic stress disorder, panic attacks, a history of aggression, impulsivity, severe anger, and pathologic Internet use (see *Internet Use* section). In particular, interview studies showed a marked higher rate of suicidal behavior with the presence of psychotic symptoms.[21] A prospective study found a 70-fold increase of acute suicidal behavior in adolescents with psychopathology that included psychosis.[22] By definition, nonsuicidal self-injury (NSSI) does not include intent to die, and risk of death is deliberately low. Nonetheless, NSSI is a risk factor for suicide attempts[23,24] and suicidal ideation.[25] More than 90% of adolescent suicide victims met criteria for a psychiatric disorder before their death. Immediate risk factors include agitation, intoxication, and a recent stressful life event. More information is available from the American Academy of Child and Adolescent Psychiatry[26] and Gould et al.[11]

Social and environmental risk factors include bullying, impaired parent–child relationship, living outside of the home (homeless or in a corrections facility or group home), difficulties in school, neither working nor attending school, social isolation, and presence of stressful life events, such as legal or romantic difficulties or an argument with a parent. An unsupported social environment for lesbian, gay, bisexual, and transgender adolescents, for example, increases risk of suicide attempts.[27] Protective factors include religious involvement and connection between the adolescent and parents, school, and peers.[26]

Bullying

Bullying has been defined as having 3 elements: aggressive or deliberately harmful behavior (1) between peers that is (2) repeated and over time and (3) involves an imbalance of power, for example, related to physical strength or popularity, making it difficult for the victim to defend himself or herself.[28] Behavior falls into 4 categories: direct-physical (eg, assault, theft), direct-verbal (eg, threats, insults, name-calling), indirect-relational (eg, social exclusion, spreading rumors), and cyberbullying.[29] The 2013 Youth Risk Behavior Survey of students in grades 9 through 12 in the United States indicated that during the 12 months before the survey, 23.7% of girls and 15.6% of boys were bullied on school property, 21.0% of girls and 8.5% of boys were electronically bullied, and 8.7% of girls and 5.4% of boys did not go to school 1 day in the past 30 because they felt unsafe at or to or from school.[7] Studies have focused on 3 groups: those who were

victims, those who were bullies, and those who were both victims and bullies (bully/victims).[30]

Reviewing 31 studies, Klomek et al[29] found a clear relationship between both bullying victimization and perpetration and suicidal ideation and behavior in children and adolescents. Females were at risk regardless of frequency, whereas males were at higher risk only with frequent bullying. A review by Arseneault et al[31] cited evidence that bullying victimization is associated with severe baseline psychopathology, as well as individual characteristics and family factors, and that the psychopathology is made significantly worse by the victimization. Being the victim of school bullying or cyberbullying is associated with substantial distress, resulting in lower school performance and school attachment.[32] Suicidal ideation and behavior were greater in those bullied with controlling for age, gender, race/ethnicity, and depressive symptomology.[33] Suicidal ideation and behavior were increased in victims and bullies and were highest in bully/victims.[34] Similar increases in suicide attempts were found comparing face-to-face bullying with cyberbullying, both for victims and bullies.[35]

Bullying predicts future mental health problems. Bullying behavior at 8 years of age was associated with later suicide attempts and completed suicides,[36] although among boys, frequent perpetration and victimization was not associated with attempts and completions after controlling for conduct and depressive symptoms. Among girls, frequent victimization was associated with later suicide attempts and completions even after controlling for conduct and depressive symptoms. High school students with the highest psychiatric impairment 4 years later were those who had been identified as at-risk for suicide *and* experiencing frequent bullying behavior. Copeland et al[30] found that children and adolescents involved in bullying behavior had the worst outcomes when they were both bullies and victims, leading to depression, anxiety, and suicidality (suicidality only among males) as adults. Assessment for adolescents with psychopathology, other signs of emotional distress, or unusual chronic complaints should include screening for participation in bullying as victims or bullies.

Internet Use

Pathologic Internet use correlates with suicidal ideation and NSSI.[37] Self-reported daily use of video games and Internet exceeding 5 hours was strongly associated with higher levels of depression and suicidality (ideation and attempts) in adolescents.[38] A more specific problem is that adolescents with suicidal ideation may be at particular risk for searching the Internet for information about suicide-related topics.[39] Suicide-related searches were found to be associated with completed suicides among young adults.[40] Prosuicide Web sites and online suicide pacts facilitate suicidal behavior, with adolescents and young adults at particular risk.[37]

A number of factors diminish the exposure of prosuicide Web sites. Web site results from the search term, "suicide," are predominantly of institutional origin, with content largely related to research and prevention. Although there are a substantial number of sites from private senders (these sites are often antimedical, antitreatment, and pro-suicide,[41] including sites that advocate suicide or describe methods in detail[42]), suicide research and prevention sites tend to come up in searches more commonly. Clicking on links within each site keeps the reader in the site, strengthening the site's position. Methods sites and overtly prosuicide sites are more isolated, decentralized, and unfocused; these are less prevalent among the first 100 search results, perhaps related to a recent and deliberate strategy by the internet search engines (eg, search engine optimization).[41]

Learning of another's suicide online may be another risk factor for youth.[43] Exposure to such information is through online news sites (44%), social networking sites (25%), online discussion forums (15%), and video Web sites (15%). Social networking sites have particular importance, because these may afford information on suicidal behavior of social contacts that would not otherwise be available. Fortunately, exposure to information from social networking sites does not appear related to changes in suicidal ideation, with increased exposure mitigated by greater social support. Participation in online forums, however, was associated with increases in suicidal ideation, possibly related to anonymous discussions about mental health problems. For example, suicide attempts by susceptible individuals appear to have been encouraged by such conversations.[44,45]

INTERVIEWING THE ADOLESCENT

Primary care pediatricians should be comfortable screening patients for suicide, mood disorders, and substance abuse and dependence. Ask about emotional difficulties and use of drugs and alcohol, identify lack of developmental progress, and estimate level of distress, impairment of functioning, and level of danger to self and others. Depression screening instruments shown to be valid in adolescents include the Patient Health Questionnaire (PHQ)-9 and PHQ-2.[46] If needed, a referral should be made for appropriate mental health evaluation and treatment. In areas where the resources necessary to make a timely mental health

referral are lacking, pediatricians are encouraged to obtain extra training and become competent in providing a more in-depth assessment.

Suicidal ideation may be assessed by directly asking or screening via self-report. Self-administered scales can be useful for screening, because adolescents may disclose information about suicidality on self-report that they deny in person. Scales, however, tend to be oversensitive and underspecific and lack predictive value. Adolescents who endorse suicidality on a scale should be assessed clinically. Screening tools useable in a primary care setting have not been shown to have more than limited ability to detect suicide risk in adolescents,[47] consistent with the findings of an earlier review.[48] Instruments studied in adolescent groups with high prevalence of suicidal ideation and behavior showed sensitivity of 52% to 87% and specificity of 60% to 85%; the results are only generalizable to high-risk populations.[49,50] Suicide screening, at least in the school setting, does not appear to cause thoughts of suicide or other psychiatric symptoms in students.[51,52]

One approach to initiate a confidential inquiry into suicidal thoughts or concerns is to ask a general question, such as, "Have you ever thought about killing yourself or wished you were dead?" The question is best placed in the middle or toward the end of a list of questions about depressive symptoms. Regardless of the answer, the next question should be, "Have you ever done anything on purpose to hurt or kill yourself?" If the response to either question is positive, the pediatrician should obtain more detail (eg, nature of past and present thoughts and behaviors, time frame, intent, who knows and how they found out). Inquiry should include suicide plans ("If you were to kill yourself, how would you do it?"), whether there are firearms in the home, and the response of the family. No data indicate that inquiry about suicide precipitates the behavior, even in high-risk students.[51]

The adolescent should be interviewed separately from the parent, because the patient may be more likely to withhold important information in the parent's presence. Information should also be sought from parents and others as appropriate. Although confidentiality is important in adolescent health care, for adolescents at risk to themselves or others, safety takes precedence over confidentiality; the adolescent should have this explained by the pediatrician so that he or she understands that at the onset. Pediatricians need to inform appropriate people, such as parent(s) and other providers, when they believe an adolescent is at risk for suicide and to share with the adolescent that there is a need to break confidentiality because of the risk of harm to the adolescent. As much as is possible, the sequence of events that preceded the threat should be determined, current problems and conflicts should be identified, and the degree of suicidal intent should be assessed. In addition, pediatricians should assess individual coping resources, accessible support systems, and attitudes of the adolescent and family toward intervention and follow-up.[53] Questions should also be asked to elicit known risk factors. Note that it is acceptable and, in some cases, more appropriate for the patient to be referred to a mental health specialist to access the degree of suicide intent and relevant factors such as coping mechanisms and support systems.

Care in interviewing needs to be taken, because abrupt, intrusive questions could result in a reduction of rapport and a lower likelihood of the adolescent sharing mental health concerns. This is especially true during a brief encounter for an unrelated concern. Initial questions should be open-ended and relatively nonthreatening. Examples include "Aside from [already stated non–mental health concern], how have you been doing?" "I know that a lot of people your age have a lot going on. What kinds of things have been on your mind or stressing you lately?" "How have things been going with [school, friends, parents, sports]?" When possible, more detailed questions should then follow, particularly during routine care visits or when a mental health concern is stated or suspected.

Suicidal thoughts or comments should never be dismissed as unimportant. Statements such as, "You've come really close to killing yourself," may, if true, acknowledge the deep despair of the youth and communicate to the adolescent that the interviewer understands how serious he or she has felt about dying. Such disclosures should be met with reassurance that the patient's pleas for assistance have been heard and that help will be sought.

Serious mood disorders, such as major depressive disorder or bipolar disorder, may present in adolescents in several ways.[54] Some adolescents may come to the office with complaints similar to those of depressed adults, having symptoms, such as sad or down feelings most of the time, crying spells, guilty or worthless feelings, markedly diminished interest or pleasure in most activities, significant weight loss or weight gain or increase or decrease in appetite, insomnia or hypersomnia, fatigue or loss of energy, diminished ability to think or concentrate, and thoughts of death or suicide. The pediatrician should also look for adolescent behaviors that are characteristic of symptoms (Table 1).[54] Some adolescents may present with irritability rather than depressed mood as the main manifestation. Other adolescents present for an acute care visit

with somatic symptoms, such as abdominal pain, chest pain, headache, lethargy, weight loss, dizziness and syncope, or other nonspecific symptoms[55] Others present with behavioral problems, such as truancy, deterioration in academic performance, running away from home, defiance of authorities, self-destructive behavior, vandalism, substance use disorder, sexual acting out, and delinquency.[56] Typically, symptoms of depression, mania, or a mixed state (depression and mania coexisting or rapidly alternating) can be elicited with careful questioning but may not be immediately obvious. The American Academy of Pediatrics (AAP) provides more information about adolescent bipolar disorder and the role of the pediatrician in screening, diagnosis, and management.[57]

At well-adolescent visits, adolescents who show any evidence of psychosocial or adaptive difficulties should be assessed regularly for mental health concerns and also asked about suicidal ideation, physical and sexual abuse, bullying, substance use, and sexual orientation. Depression screening is now recommended for all adolescents between the ages of 11 and 21 years of age in the third edition of *Bright Futures*.[58] The AAP developed a resource, "Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit," which is available for a fee.[59] The AAP also developed a Web site that provides resources and materials free of charge.[60] Identification and screening at acute care visits, when possible, is desirable, because mental health problems may manifest more strongly at these times.

TABLE 1 Depressive Symptoms and Examples in Adolescents[54]

Signs and Symptoms of Major Depressive Disorder	Signs of Depression Frequently Seen in Youth
Depressed mood most of the day	Irritable or cranky mood; preoccupation with song lyrics that suggest life is meaningless
Decreased interest/enjoyment in once-favorite activities	Loss of interest in sports, video games, and activities with friends
Significant wt loss/gain	Failure to gain wt as normally expected; anorexia or bulimia; frequent complaints of physical illness (eg, headache, stomach ache)
Insomnia or hypersomnia	Excessive late-night TV; refusal to wake for school in the morning
Psychomotor agitation/retardation	Talk of running away from home or efforts to do so
Fatigue or loss of energy	Persistent boredom
Low self-esteem; feelings of guilt	Oppositional and/or negative behavior
Decreased ability to concentrate; indecisive	Poor performance in school; frequent absences
Recurrent thoughts of death or suicidal ideation or behavior	Recurrent suicidal ideation or behavior (threats of suicide, writing about death; giving away favorite toys or belongings)

MANAGEMENT OF THE SUICIDAL ADOLESCENT

Management depends on the degree of acute risk. Unfortunately, no one can accurately predict suicide, so even experts can only determine who is at higher risk. Intent is a key issue in the determination of risk. Examples of adolescents at high risk include: those with a plan or recent suicide attempt with a high probability of lethality; stated current intent to kill themselves; recent suicidal ideation or behavior accompanied by current agitation or severe hopelessness; and impulsivity and profoundly dysphoric mood associated with bipolar disorder, major depression, psychosis, or a substance use disorder. An absence of factors that indicate high risk, especially in the presence of a desire to receive help and a supportive family, suggests a lower risk but not necessarily a low risk. Low risk is difficult to determine. For example, an adolescent who has taken 8 ibuprofen tablets may have thought that it was a lethal dose and may do something more lethal the next time. Alternatively, the adolescent may have known that 8 ibuprofen tablets is not lethal and took the pills as a rehearsal for a lethal attempt. In the presence of a recent suicide attempt, the lack of current suicidal ideation may also be misleading if none of the factors that led to the attempt have changed or the reasons for the attempt are not understood. The benefit of the doubt is generally on safety in the management of the suicidal adolescent.

The term "suicide gesture" should not be used, because it implies a low risk of suicide that may not be warranted. "Suicide attempt" is a more appropriate term for any deliberately self-harmful behavior or action that could reasonably be expected to produce self-harm and is accompanied by some degree of intent or desire for death as well as thinking by the patient at the time of the behavior that the behavior had even a small possibility of resulting in death. In a less-than-forthcoming patient, intent may be inferred by the lethality of the behavior, such as ingesting a large number of pills, or by an affirmative answer to a question such as, "At the time of your action, would you have thought it okay if you had died?"

Adolescents who initially may seem at low risk, joke about suicide, or seek treatment of repeated somatic complaints may be asking for help the only way they can. Their concerns should be assessed thoroughly. Adolescents who are judged to be at low risk of suicide should still receive close follow-up, referral for a timely mental health evaluation, or both if they should have any significant degree of dysfunction or distress from emotional or behavioral symptoms.

For adolescents who seem to be at moderate or high risk of suicide or have attempted suicide, arrangements for immediate mental health professional evaluation should be made during the office visit. Options for immediate evaluation include hospitalization, transfer to an emergency department, or a same-day appointment with a mental health professional.

Intervention should be tailored to the adolescent's needs. Adolescents with a responsive and supportive family, little likelihood of acting on suicidal impulses (eg, thought of dying with no intent or plan for suicide), and someone who can take action if there is mood or behavior deterioration may require only outpatient treatment.[17] In contrast, adolescents who have made previous attempts, exhibit a high degree of intent to commit suicide, show evidence of serious depression or other psychiatric illness, engage in substance use or have an active substance use disorder, have low impulse control, or have families who are unwilling to commit to counseling are at high risk and may require psychiatric hospitalization.

Although no controlled studies have been conducted to prove that admitting adolescents at high risk to a psychiatric unit saves lives,[17] likely the safest course of action is hospitalization, thereby placing the adolescent in a safe and protected environment. An inpatient stay will allow time for a complete medical and psychiatric evaluation with initiation of therapy in a controlled setting as well as arrangement of appropriate mental health follow-up care.

Pediatricians can enhance continuity of care and adherence to treatment recommendations by maintaining contact with suicidal adolescents even after referrals are made. Collaborative care is encouraged, because it has been shown to result in greater reduction of depressive symptoms in a primary care setting.[61] Recommendations should include that all firearms are removed from the home, because adolescents may still find access to locked guns stored in their home, and that medications, both prescription and over-the-counter, are locked up. Vigorous treatment of the underlying psychiatric disorder is important in decreasing short-term and long-term risk of suicide. Although asking the adolescent to agree to a contract against suicide has not been proven effective in preventing suicidal behavior,[17] the technique may still be helpful in assessing risk in that refusal to agree either not to harm oneself or to tell a specified person about intent to harm oneself is ominous. In addition, safety planning may help guide a patient and his or her family in what steps to take in moments of distress to ensure patient safety.

Working with a suicidal adolescent can be very difficult for those who are providing treatment. Suicide risk can only be reduced, not eliminated, and risk factors provide no more than guidance. Much of the information regarding risk factors is subjective and must be elicited from the adolescent, who may have his or her own agenda. Just as importantly, pediatricians need to be aware of their personal reactions to prevent interference in evaluation and treatment and overreaction or underreaction.

ANTIDEPRESSANT MEDICATIONS AND SUICIDE

The Food and Drug Administration (FDA) directive of October 2004 and heavy media coverage changed perceptions of antidepressant medications, and not favorably. The FDA directed pharmaceutical companies to label all antidepressant medications distributed in the United States with a "black-box warning" to alert health care providers to an increased risk of suicidality (suicidal thinking and behavior) in children and adolescents being treated with these agents. The FDA did not prohibit the use of these medications in youth but called on clinicians to balance increased risk of suicidality with clinical need and to monitor closely "for clinical worsening, suicidality, or unusual changes in behavior."[62] The warning particularly stressed the need for close monitoring during the first few months of treatment and after dose changes.

The warning by the FDA was prompted by a finding that in 24 clinical trials that involved more than 4400 child and adolescent patients and 9 different antidepressant medications, spontaneously reported suicidal ideation or behavior was present in 4% of subjects who were receiving medication and in just half that (2%) of subjects who were receiving a placebo. No completed suicides occurred during any of the studies. In the same studies, however, only a slight reduction of suicidality was found when subjects were asked directly at each visit about suicidal ideation and behavior, which was considered a contradictory finding. The method of asking directly does not rely on spontaneous reports and is considered to be more reliable than the spontaneous events report method used by the FDA to support the black-box warning.[63] In addition, a reanalysis of the data including 7 additional studies and using a more conservative model showed only a trivial 0.7% increase in the risk of suicidal ideation or behavior in those receiving antidepressant medications.[64]

Subsequent studies have addressed the validity of the black-box warning and suggest that, for appropriate youth, the risk of not prescribing antidepressant medication is significantly higher than the risk of prescribing. Gibbons et al[65] conducted a reanalysis of all sponsor-conducted

randomized controlled trials of fluoxetine and venlafaxine, which included 12 adult, 4 geriatric, and 4 youth studies of fluoxetine and 21 adult trials of venlafaxine. Adult and geriatric patients treated with both medications showed decreased suicidal thoughts and behaviors, an effect mediated by the decreases of depressive symptoms with treatment. No significant treatment effect on suicidal thoughts and behaviors was found with youth treated with fluoxetine, although depressive symptoms in fluoxetine-treated patients decreased more quickly than symptoms in patients receiving placebo. There was no overall greater rate of suicidal thoughts and behaviors in the treatment groups versus the placebo groups. The finding of increased suicidal ideation and behavior in the treatment groups that formed the basis of the FDA black-box warning on antidepressant use in children and adolescents was not found in this reanalysis of the fluoxetine studies. More importantly, these reanalyses demonstrated the efficacy of fluoxetine in the treatment of depression in youth. Patients in all age and drug groups had significantly greater improvement relative to patients in placebo groups, with youth having the largest differential rate of remission over 6 weeks—46.6% of patients receiving fluoxetine versus 16.5% of those receiving placebo.[66]

Suicidal ideation and behavior are common, and suicides are vastly less common, which makes it difficult to relate a change in one to a change in the other.[63] Examining all available observational studies, Dudley et al[67] found that recent exposure to selective serotonin reuptake inhibitor medications was rare (1.6%) for young people who died by suicide, supporting the conclusion that most of the suicide victims did not have the potential benefit of antidepressants at the time of their deaths. The study suggests that whether antidepressants increase suicidal thoughts or behaviors in adolescents, few actual suicides are related to current use of the medications.

Several studies showed a negative correlation between antidepressant prescribing and completed adolescent suicide. The 28% decrease in completed suicides in the 10- to 19-year-old age group from 1990 to 2000 may have been at least partly a result of the increase in youth antidepressant prescribing over the same time period. Analyzing US data by examining prescribing and suicide in each of 588 2-digit zip code zones showed a significant ($P < .001$) 0.23-per-100 000 annual decrease in adolescent suicide with every 1% increase in antidepressant prescribing.[68] A second study analyzed county-level data during the period from1996 to1998 and found that higher selective serotonin reuptake inhibitor prescription rates significantly correlated with lower suicide rates among children and adolescents 5 to 14 years of age.[69] Using a decision analysis model, Cougnard et al[70] calculated that antidepressant treatment of children and adolescents would prevent 31.9% of suicides of depressed subjects, similar to findings in the adult (32.2%) and geriatric (32.3%) age groups.

The FDA advisory panel was aware that the black-box warning could have the unintended effect of limiting access to necessary and effective treatment[63] and reported that prescriptions of antidepressants for children and adolescents decreased by 19% in the third quarter of 2004 and 16% in the fourth quarter compared with the year before.[71] Claims data for Tennessee Medicaid showed a 33% reduction of new users of antidepressants 21 months after the black-box warning.[72] US national managed care data showed reduced diagnosing of pediatric depression and a 58% reduction of antidepressant prescribing compared with what was predicted by the preadvisory trend.[73] Decreased antidepressant prescribing was also seen with chart review.[74] Most of the reductions in diagnosing and prescribing were related to substantial reductions by primary care providers, with these reductions persisting through 2007.[75] Studies differed as to whether there was[76] or was not[73,74] a compensatory increase of psychotherapy treatment during the same time period.

Concern was expressed that the reduction of antidepressant prescribing may be related to the increase in US youth suicides from 2003 to 2004 after a decade of steady declines.[77] Gibbons et al[78] found that antidepressant prescribing for youth decreased by 22% in both the United States and the Netherlands the year after the black-box warnings in both countries and a reduction in prescribing was observed across all ages. From 2003 to 2004, the youth suicide rate in the United States increased by 14%; from 2003 to 2005, the youth suicide rate in the Netherlands increased by 49%. Across age groups, data showed a significant inverse correlation between prescribing and change in suicide rate. The authors suggested that the warnings could have had the unintended effect of increasing the rate of youth suicide.[78] Examining health insurance claims data for 1.1 million adolescents, 1.4 million young adults, and 5 million adults, the rate of psychotropic medication poisonings, a validate proxy for suicide attempts, was found to have increased significantly in adolescents (21.7%) and young adults (33.7%), but not in adults (5.2%), in the second year after the FDA black-box warning, corresponding with decreases in antidepressant prescribing (adolescents, –31.0%; young adults, –24.3%; adults, –14.5%).[79]

Regardless of whether the use of antidepressant medications changes the risk of suicide, depression is an

important suicide risk factor, and careful monitoring of adolescents' mental health and behavioral status is critically important, particularly when initiating or changing treatment. Furthermore, despite the aforementioned new information, the FDA has not removed or changed the black-box warning; the warning should be discussed with parents or guardians and appropriately documented. The American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry recommended a monitoring approach[63] that enlists the parents or guardians in the responsibility for monitoring and individualizing the frequency and nature of monitoring to the needs of the patient and the family. This approach potentially increases the effectiveness of monitoring and provides greater flexibility, thus reducing a barrier to prescribing. Warning signs for family members to contact the prescribing physician are listed in Table 2.[63]

TABLE 2 Treatment With Antidepressant Medication: Warning Signs for Family Members To Contact the Physician

New or more frequent thoughts of wanting to die
Self-destructive behavior
Signs of increased anxiety/panic, agitation, aggressiveness, impulsivity, insomnia, or irritability
New or more involuntary restlessness (akathesia), such as pacing or fidgeting
Extreme degree of elation or energy
Fast, driven speech
New onset of unrealistic plans or goals

SUMMARY

1. Adolescent suicide is an important public health problem.
2. Knowledge of risk factors, particularly mood disorders, psychosis, and bullying victimization and perpetration, may assist in the identification of adolescents who are at higher risk.
3. It is important to know and use appropriate techniques for interviewing potentially suicidal adolescents.
4. Mood disorders predisposing adolescents to suicide have a variety of presentations.
5. Management options depend on the degree of suicide risk.
6. Treatment with antidepressant medication is important when indicated.

ADVICE FOR PEDIATRICIANS

1. Ask questions about mood disorders, use of drugs and alcohol, suicidal thoughts, bullying, sexual orientation, and other risk factors associated with suicide in routine history taking throughout adolescence. Know the risk factors (eg, signs and symptoms of depression) associated with adolescent suicide and screen routinely for depression. Consider using a depression screening instrument, such as the PHQ-9 or PHQ-2, at health maintenance visits from 11 to 21 years of age and as needed at acute care visits.[46]
2. Educate yourself and your patients about the benefits and risks of antidepressant medications. Patients with depression should be carefully monitored, with appropriately frequent appointments and education of the family regarding warning signs for when to call you, especially after the initiation of antidepressant medication treatment and with dose changes. Recent studies suggest that, for appropriate youth, the benefits of antidepressant medications outweigh the risks.
3. Recognize the medical and psychiatric needs of the suicidal adolescent and work closely with families and health care professionals involved in the management and follow-up of youth who are at risk or have attempted suicide. Develop working relationships with emergency departments and colleagues in child and adolescent psychiatry, clinical psychology, and other mental health professions to optimally evaluate and manage the care of adolescents who are at risk for suicide. Because mental and physical health services are often provided through different systems of care, extra effort is necessary to ensure good communication, continuity, and follow-up through the medical home.
4. Because resources for adolescents and physicians vary by community, become familiar with local, state, and national resources that are concerned with treatment of psychopathology and suicide prevention in youth, including local hospitals with psychiatric units, mental health agencies, family and children's services, crisis hotlines, and crisis intervention centers. Compile the names and contact information of local mental health resources and providers and make that information available to patients/families when needed.
5. Because there is great variation among general pediatricians in training and comfort with assessing and treating patients with mental health problems, as well as in access to appropriate mental health resources, consider additional training and ongoing education in diagnosing and managing adolescent mood disorders, especially if practicing in an underserved area.

Pediatricians with fewer resources still have an important role in screening, comanaging with mental health professionals, and referring patients when necessary (as recommended in *Bright Futures, Fourth Edition*).

6. During routine evaluations and where consistent with state law, ask whether firearms are kept in the home and discuss with parents the increased risk of adolescent suicide with the presence of firearms. Specifically for adolescents at risk for suicide, advise parents to remove guns and ammunition from the house and secure supplies of prescription and over-the-counter medications.

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ABBREVIATIONS

AAP: American Academy of Pediatrics
FDA: Food and Drug Administration
NSSI: nonsuicidal self-injury
PHQ: Patient Health Questionnaire

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Suicide and Suicide Attempts in Adolescents

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Effects of Tobacco, Alcohol and Drugs on the Developing Adolescent Brain

Risk-taking may be based in biology, but that does not diminish the possible unhealthy consequences of alcohol and other drugs and tobacco on the developing teen brain.

Recent brain research with magnetic resonance imaging suggests that alcohol impacts adolescents differently than it does adults. Young people are more vulnerable to the negative effects of alcohol on the hippocampus—the part of the brain that regulates working memory and learning. Consequently, heavy use of alcohol and other drugs during the teen years can result in lower scores on tests of memory and attention in one's early to mid-20s.

People who begin drinking before age 15 are four times more likely to become alcohol-dependent than those who wait until they are 21. Teens also tend to be less sensitive than adults to alcohol's sedative qualities. Sedation in response to alcohol is one of the ways the body protects itself, since it is impossible to keep drinking once asleep or passed out. Teenagers are able to stay awake longer with higher blood alcohol levels than older drinkers can. This biological difference allows teens to drink more, thereby exposing themselves to greater cognitive impairment and perhaps brain damage from alcohol poisoning.

There are also striking differences in the way nicotine affects adolescent and adult smokers. Nicotine results in cell damage and loss throughout the brain at any age, but in teenagers the damage is worse in the hippocampus, the mind's memory bank. Compared to adults, teen smokers experience more episodes of depression and cardiac irregularities, and are more apt to become quickly and persistently nicotine-dependent.

Drugs such as cocaine and amphetamines target dopamine receptor neurons in the brain, and damage to these neurons may affect adolescent brain development for life in the areas of impulse control and ability to experience reward.

Other effects of substance abuse in adolescents include delays in developing executive functions (judgment, planning and completing tasks, meeting goals) and overblown and immature emotional responses to situations.

The CRAFFT Interview (version 2.1)

To be orally administered by the clinician

Begin: "*I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential.*"

Part A

During the PAST 12 MONTHS, on how many days did you:

1.	Drink more than a few sips of beer, wine, or any drink containing **alcohol**? Put "0" if none.	☐ # of days
2.	Use any **marijuana** (weed, oil, or hash by smoking, vaping, or in food) or "**synthetic marijuana**" (like "K2," "Spice")? Put "0" if none.	☐ # of days
3.	Use **anything else to get high** (like other illegal drugs, prescription or over-the-counter medications, and things that you sniff, huff, or vape)? Put "0" if none.	☐ # of days

Did the patient answer "0" for all questions in Part A?

Yes ☐ → **Ask CAR question only, then stop**

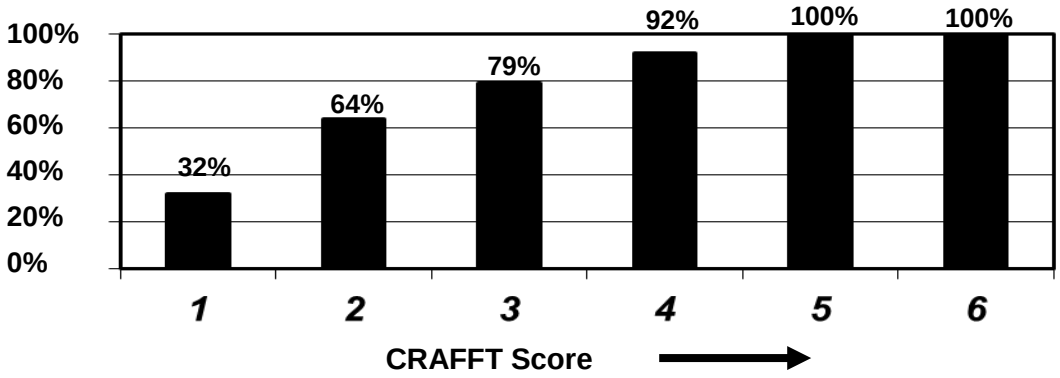
No ☐ → **Ask all six CRAFFT* questions below**

Part B		**No**	**Yes**
C	Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
R	Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
A	Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
F	Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
F	Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
T	Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

***Two or more YES answers suggest a serious problem and need for further assessment. See back for further instructions →**

1. Show your patient his/her score on this graph and discuss level of risk for a substance use disorder.

Percent with a DSM-5 Substance Use Disorder by CRAFFT score*



*Data source: Mitchell SG, Kelly SM, Gryczynski J, Myers CP, O'Grady KE, Kirk AS, & Schwartz RP. (2014). The CRAFFT cut-points and DSM-5 criteria for alcohol and other drugs: a reevaluation and reexamination. Substance Abuse, 35(4), 376–80.

2. Use these talking points for brief counseling.

1. **REVIEW** screening results
   For each "yes" response: *"Can you tell me more about that?"*

2. **RECOMMEND** not to use
   "As your doctor (nurse/health care provider), my recommendation is not to use any alcohol, marijuana or other drug because they can: 1) Harm your developing brain; 2) Interfere with learning and memory, and 3) Put you in embarrassing or dangerous situations."

3. **RIDING/DRIVING** risk counseling
   "Motor vehicle crashes are the leading cause of death for young people. I give all my patients the Contract for Life. Please take it home and discuss it with your parents/guardians to create a plan for safe rides home."

4. **RESPONSE** elicit self-motivational statements
   Non-users: *"If someone asked you why you don't drink or use drugs, what would you say?"* Users: *"What would be some of the benefits of not using?"*

5. **REINFORCE** self-efficacy
   "I believe you have what it takes to keep alcohol and drugs from getting in the way of achieving your goals."

3. Give patient Contract for Life. Available at www.crafft.org/contract

(617) 355-5433 www.ceasar.org

For more information and versions in other languages, see www.ceasar.org.

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization and the Generalitat Valenciana Conselleria De Benestar Social. To reflect standard drink sizes in the United States, the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care is available online at www.who.org.

National Institute on Alcohol Abuse and Alcoholism

Parenting to Prevent Childhood Alcohol Use

Drinking alcohol undoubtedly is a part of American culture, as are conversations between parents and children about its risks and potential benefits. However, information about alcohol can seem contradictory. Alcohol affects people differently at different stages of life—small amounts may have health benefits for certain adults, but for children and adolescents, alcohol can interfere with normal brain development. Alcohol's differing effects and parents' changing role in their children's lives as they mature and seek greater independence can make talking about alcohol a challenge. Parents may have trouble setting concrete family policies for alcohol use. And they may find it difficult to communicate with children and adolescents about alcohol-related issues.

Research shows, however, that teens and young adults do believe their parents should have a say in whether they drink alcohol. Parenting styles are important—teens raised with a combination of encouragement, warmth, and appropriate discipline are more likely to respect their parents' boundaries. Understanding parental influence on children through conscious and unconscious efforts, as well as when and how to talk with children about alcohol, can help parents have more influence than they might think on a child's alcohol use. Parents can play an important role in helping their children develop healthy attitudes toward drinking while minimizing its risk.

Alcohol Use by Young People

Adolescent alcohol use remains a pervasive problem. The percentage of teenagers who drink alcohol is slowly declining; however, numbers are still quite high. About 22.8 percent of adolescents report drinking by 8th grade, and about 46.3 percent report being drunk at least once by 12th grade.[1]

Parenting Style

Accumulating evidence suggests that alcohol use—and in particular binge drinking—may have negative effects on adolescent development and increase the risk for alcohol dependence later in life.[2,3] This

underscores the need for parents to help delay or prevent the onset of drinking as long as possible. Parenting styles may influence whether their children follow their advice regarding alcohol use. Every parent is unique, but the ways in which each parent interacts with his or her children can be broadly categorized into four styles:

- Authoritarian parents typically exert high control and discipline with low warmth and responsiveness. For example, they respond to bad grades with punishment but let good grades go unnoticed.
- Permissive parents typically exert low control and discipline with high warmth and responsiveness. For example, they deem any grades at all acceptable and fail to correct behavior that may lead to bad grades.
- Neglectful parents exert low control and discipline as well as low warmth and responsiveness. For example, they show no interest at all in a child's school performance.
- Authoritative parents exert high control and discipline along with high warmth and responsiveness. For example, they offer praise for good grades and use thoughtful discipline and guidance to help improve low grades.[4]

Regardless of the developmental outcome examined—body image, academic success, or substance abuse—children raised by authoritative parents tend to fare better than their peers.[5] This is certainly true when it comes to the issue of underage drinking,[6] in part because children raised by such parents learn approaches to problem solving and emotional expression that help protect against the psychological dysfunction that often precedes alcohol misuse.[7] The combination of discipline and support by authoritative parents promotes healthy decisionmaking about alcohol and other potential threats to healthy development.[8]

Modeling

Some parents wonder whether allowing their children to drink in the home will help them develop an appropriate relationship with alcohol. According to most studies this does not appear to be the case. In a study of 6th, 7th, and 8th graders, researchers observed that students whose parents allowed them to drink at home and/or provided them with alcohol experienced the steepest escalation in drinking.[9] Other studies suggest that adolescents who are allowed to drink at home drink more heavily outside of the home.[10] In contrast, adolescents are less likely to drink heavily if they live in homes where parents have specific rules against drinking at a young age and also drink responsibly themselves.[11] However, not all studies suggest that parental provision of alcohol to teens leads to trouble. For instance, one study

showed that drinking with a parent in the proper context (such as a sip of alcohol at an important family function) can be a protective factor against excessive drinking.[12] In other contexts, parental provision of alcohol serves as a direct risk factor for excessive drinking, as is the case when parents provide alcohol for parties attended or hosted by their adolescents. Collectively, the literature suggests that permissive attitudes toward adolescent drinking, particularly when combined with poor communication and unhealthy modeling, can lead teens into unhealthy relationships with alcohol.

Genetics

Regardless of what parents may teach their children about alcohol, some genetic factors are present from birth and cannot be changed. Genes appear to influence the development of drinking behaviors in several ways. Some people, particularly those of Asian ancestry, have a natural and unpleasant response to alcohol that helps prevent them from drinking too much. Other people have a naturally high tolerance to alcohol, meaning that to feel alcohol's effects, they must drink more than others. Some personality traits are genetic, and those, like impulsivity, can put a person at risk for problem drinking. Psychiatric problems may be caused by genetic traits, and such problems can increase risk for alcohol abuse and dependence. Finally, having a parent with a drinking problem increases a child's risk for developing an alcohol problem of his or her own.[13]

Do Teens Listen?

Adolescents do listen to their parents when it comes to issues such as drinking and smoking, particularly if the messages are conveyed consistently and with authority.[5] Research suggests that only 19 percent of teens feel that parents should have a say in the music they listen to, and 26 percent believe their parents should influence what clothing they wear. However, the majority—around 80 percent—feel that parents should have a say in whether they drink alcohol. Those who do not think that parents have authority over these issues are four times more likely than other teens to drink alcohol and three times more likely to have plans to drink if they have not already started.[5]

Whether teens defer to parents on the issue of drinking is statistically linked to how parents parent. Specifically, authoritative parents—those who provide a healthy and consistent balance of discipline and support—are the most likely to have teenagers who respect the boundaries they have established around drinking and other behaviors; whereas adolescents exposed to permissive, authoritarian, or neglectful parenting are less influenced by what their parents say about drinking.[5]

Research suggests that, regardless of parenting styles, adolescents who are aware that their parents would be upset with them if they drank are less likely to do so, highlighting the importance of communication between parents and teens as a protective measure against underage alcohol use.[12]

What Can Parents Do?

Parents influence whether and when adolescents begin drinking as well as how their children drink. Family policies about adolescent drinking in the home and the way parents themselves drink are important. For instance, if you choose to drink, always model responsible alcohol consumption. But what else can parents do to help minimize the likelihood that their adolescent will choose to drink and that such drinking, if it does occur, will become problematic? Studies[14] have shown that it is important to:

- Talk early and often, in developmentally appropriate ways, with children and teens about your concerns—and theirs—regarding alcohol. Adolescents who know their parents' opinions about youth drinking are more likely to fall in line with their expectations.
- Establish policies early on, and be consistent in setting expectations and enforcing rules. Adolescents do feel that parents should have a say in decisions about drinking, and they maintain this deference to parental authority as long as they perceive the message to be legitimate. Consistency is central to legitimacy.
- Work with other parents to monitor where kids are gathering and what they are doing. Being involved in the lives of adolescents is key to keeping them safe.
- Work in and with the community to promote dialogue about underage drinking and the creation and implementation of action steps to address it.
- Be aware of your State's laws about providing alcohol to your own children.
- Never provide alcohol to someone else's child.

Children and adolescents often feel competing urges to comply with and resist parental influences. During childhood, the balance usually tilts toward compliance, but during adolescence, the balance often shifts toward resistance as teens prepare for the autonomy of adulthood. With open, respectful communication and explanations of boundaries and expectations, parents can continue to influence their children's decisions well into adolescence and beyond. This is especially important in young people's decisions regarding whether and how to drink—decisions that can have lifelong consequences.

For more information, please visit: www.niaaa.nih.gov.

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February 2017

FAMILY CHECKUP

POSITIVE PARENTING PREVENTS DRUG ABUSE

National Institute
on Drug Abuse

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Introduction

Could your kids be at risk for substance abuse?

Families strive to find the best ways to raise their children to live happy, healthy, and productive lives. Parents are often concerned about whether their children will start or are already using drugs such as tobacco, alcohol, marijuana, and others, including the abuse of prescription drugs. Research supported by the National Institute on Drug Abuse (NIDA) has shown the important role that parents play in preventing their children from starting to use drugs.

This publication presents evidence-based information developed by the Child and Family Center at the University of Oregon. It highlights parenting skills that are important in preventing the initiation and progression of drug use among youth. This publication also provides access to video clips that can help you practice positive parenting skills.

Families strive to find the best ways to raise their children to live happy, healthy, and productive lives.

Communication

Good communication between parents and children is the foundation of strong family relationships. Developing good communication skills helps parents catch problems early, support positive behavior, and stay aware of what is happening in their children's lives.

Before you begin:

- Be sure it's a good time to talk and you can focus one hundred percent on communicating with your child.
- Have a plan.
- Gather your thoughts before you approach your child.
- Be calm and patient.
- Limit distractions.

Key communication skills include:

Questioning—The kind of information you receive depends a lot on how you ask the question.

- Show interest/concern. Don't blame/accuse. For example, instead of, "How do you get yourself into these situations?" say, "That sounds like a difficult situation. Were you confused?"
- Encourage problem-solving/thinking. For example: Instead of, "What did you think was going to happen when you don't think?" say, "So, what do you think would have been a better way to handle that?"

EXTRA TIPS

- Be present and tuned in.
- Show understanding.
- Listen with respect.
- Be interested.
- Avoid negative emotions.
- Give encouragement.

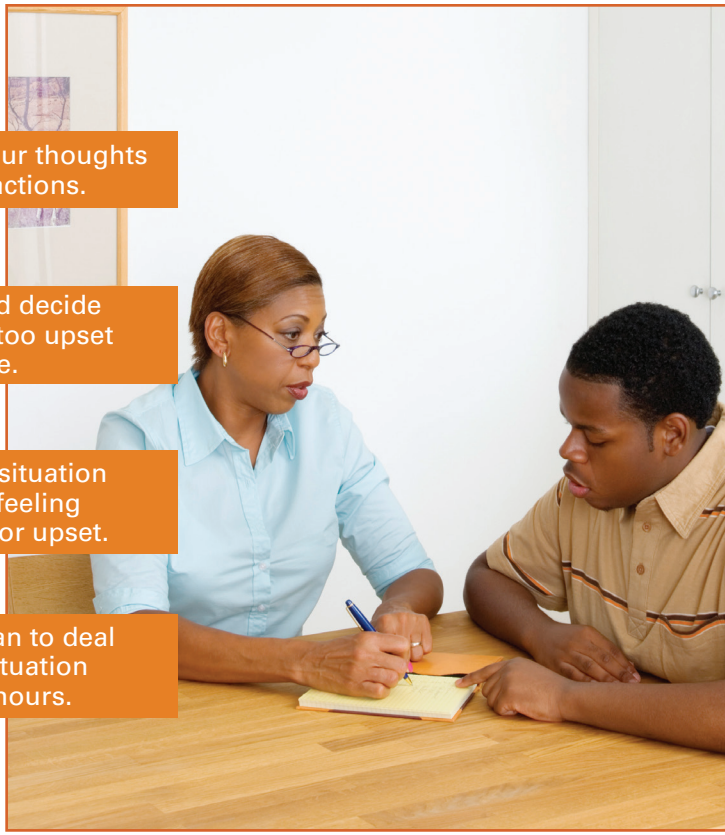
Listening and observing—Youth feel more comfortable bringing issues and situations to their parents when they know they will be listened to and not be accused.

C Control your thoughts and your actions.

A Assess and decide if you are too upset to continue.

L Leave the situation if you are feeling too angry or upset.

M Make a plan to deal with the situation within 24 hours.



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Reducing Emotion

Sometimes talking with children brings up strong feelings that interfere with clear thinking. Following the CALM steps can help a parent keep the conversation moving in the right direction.

Videos

For videos that show examples of good communication, visit www.drugabuse.gov/family-checkup/question-1-communication.

Encouragement

Encouragement is key to building confidence and a strong sense of self and helps parents to promote cooperation and reduce conflict. Many successful people remember the encouragement of a parent, teacher, or other adult. Consistent encouragement helps youth feel good about themselves and gives them confidence to:

- try new activities
- tackle difficult tasks
- develop new friendships
- explore their creativity

Encouragement promotes a strong sense of self because it sends three main messages to your child:

You can do it! Youth believe they can do things if parents:

- help them break a problem down into smaller parts
- remind them of their strengths and past successes
- encourage them by sharing how they have dealt with challenges

You have good ideas! Youth believe they have good ideas if parents:

- ask them to share their opinions and feelings
- listen to what they have to say
- ask them for input concerning family plans and events
- ask them for ideas to solve family problems

You are important! Youth know they are important if parents:

- remember what they have told them
- make time for them each day
- attend school and extracurricular activities

- let them know that they are thinking about them when they can't be with them
- display things they have made and recognitions they receive from school or the community

Practices That are Discouraging

- Being sarcastic or negative about a child's ability to be successful
- Comparing a child to brothers and sisters
- Taking over when a child's progress is slow
- Reminding a child of past failures

Videos

For videos that show examples of encouragement, visit www.drugabuse.gov/family-checkup/question-2-encouragement.

Examples of Encouraging Words

- "I know that wasn't easy."
- "You did such an awesome job!"
- "Keep on trying."
- "You are very good at that."
- "You are learning a lot."
- "I like the way you did that."
- "I can tell you've been practicing."
- "It's great to see you working so hard!"
- "I'm so proud of you."

Negotiation

Negotiating solutions offers parents a way to work together to solve problems, make changes, promote and improve cooperation, and teach youth how to:

- focus on solutions rather than problems
- think through possible outcomes of behavior
- develop communication skills

Set Up for Success

When: Select an unemotional or regularly scheduled time (not in the middle of a problem).

Where: Choose a neutral place with few distractions.

How:

- Choose problems that are small and specific!
- State the problem neutrally.
- Recognize the other person's positive behavior.
- Accept part of the responsibility for the problem.
- Restate what you hear, show understanding, and stop if you get too upset.

The Steps to Problem-Solving

Brainstorm — Open your mind to all ideas:

- Try to come up with three ideas each.
- Any idea is good — even ones that seem silly.
- Take turns coming up with ideas.

Evaluate your list of ideas:

- Go through and list the pluses and minuses of each idea.

Choose a solution:

- Combine ideas if needed.
- All of you should agree on the chosen solution.

Follow Up

- Check in with each other after you have tried your solution a couple of times to see how it is working.
- If it isn't working, go back to your list of ideas.
- If necessary, start over with some more brainstorming.

Videos

For videos that show examples of negotiating solutions, visit www.drugabuse.gov/family-checkup/question-3-negotiation.

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Problem-Solving Traps

- Don't try to solve hot issues.
- Don't blame the other person or put the other person down.
- Don't defend yourself—try to let it go.
- Don't make assumptions about another person's intentions.
- Don't bring up the past—avoid using words such as "always" and "never."
- Don't lecture—a simple statement will get your point across better.

Setting Limits

Setting limits helps parents teach self-control and responsibility, show caring, and provide safe boundaries. It also provides youth with guidelines and teaches them the importance of following rules. This is a two-step process:

Step 1: Setting Rules

- Make clear simple, specific rules.
- Make sure your child understands your rules.
- Have a list of consequences.
- Be ready to follow through.

Step 2: Following Up

Research shows that parents are most effective in setting limits when they follow up right away. Youth are more likely to follow rules if they know parents are checking up on them and will enforce the consequences consistently.

- Give a consequence when rules are broken.
- Offer encouragement when rules are followed.

Extra Tips

- State the limit and the consequence clearly.
- Catch the problem early.
- Avoid arguments and threats.
- Remember to use a firm and calm tone of voice.
- Follow through each time a limit is stretched or a rule is broken.
- Offer encouragement each time a rule is followed.

Setting limits helps parents teach self-control and responsibility.

Testing limits is a natural part of growing up, but it presents a special challenge for parents. Often our first reactions may come from fear for our child's safety, or anger at being disobeyed. The SANE guidelines can help parents establish appropriate consequences when youth break rules.

S Small consequences are better

A Avoid consequences that punish you

N Nonabusive responses

E Effective consequences (are under your control and non-rewarding to your child)

Alon Brik/Shutterstock

Youth may get angry, act out, or become isolated when parents enforce consequences. Your child is testing you and your limits. Don't react. Be consistent with your rules.

Videos

For videos that show examples of setting limits, visit www.drugabuse.gov/family-checkup/question-4-setting-limits.

Supervision

Supervision is the centerpiece of effective parenting during childhood. When youth begin to spend more and more time away from home, monitoring their behavior and whereabouts is challenging. Supervision helps parents recognize developing problems, promote safety, and stay involved.

The 4 Cs of supervision can help you with this difficult task:

Clear Rules — Have a few non-negotiable rules about your child's behavior and state them clearly! For example:

- "Give me a phone number for any place you will be."
- "I need 24-hour notice for spending the night or going to a party, dance, or other special event." (This gives you time to check out the event.)
- "No friends at the house when I am not at home."

Communication — Regular communication with other parents and teachers:

- keeps you involved in your child's activities
- creates resources to deal with problems and builds a strong safety network for your child
- informs you of dangerous places or people

Checking Up —This lets your child know that you care about his or her safety and that your rules are important. This is hard for some of us because we want to trust our children and they may resist our efforts.

- When your child gives you the phone number of a friend, call it and talk to the parent.
- Meet all the parents of your child's friends to make sure new situations are safe and supervised.
- Find out about the parties and special events your child wants to attend to make sure that responsible adults will be supervising.

Consistency — Supervision is most effective when parents set clear limits and follow through with consequences for misbehavior. Also, be consistent with giving praise and incentives when a rule is followed.

How do you supervise when you are not at home?

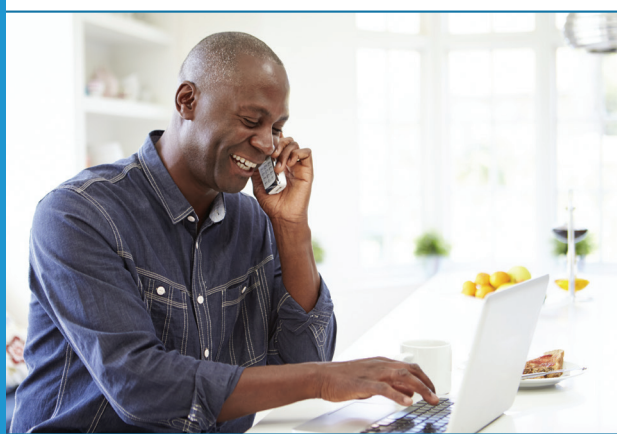
- Know your child's schedule.
- Call your child at varying times.
- Have your child check in with you or other caregivers when he or she reaches home.
- Have your child check in when he or she reaches his or her destination.
- Surprise your child with a random visit or call.
- Remain in communication with adults who interact with your child.

Videos

For videos that show examples of supervision, visit www.drugabuse.gov/family-checkup/question-5-supervision.

Extra Tips

- Stay involved.
- Spend time listening to your child.
- Know who your child's friends are and watch your child interact with them and others.
- Talk to the parent(s) of your child's friends.



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Knowing Your Child's Friends

Childhood is a period of major growth and change. Youth tend to be uncertain about themselves and how they "fit in," and at times they can feel overwhelmed by a need to please and impress their friends. These feelings can leave children open to peer pressure. Knowing your child's friends and peers helps parents improve communication, reduce conflict, and teach responsibility.

You can help your child and increase your influence by:

knowing your child's friends in the neighborhood and at school:

- Communicate with friends and their parents whenever possible.
- Go to school—observe school behavior and who your child spends time with.
- Observe behaviors, speech, and attitude and acknowledge and encourage positive behavior.

staying involved in your child's activities:

- Help your child understand his or her feelings.
- Discuss your child's new ideas.
- Be responsible for sex and drug information.
- Share your values and beliefs; it gives your child a base to work from.

EXTRA TIPS

- Keep lines of communication open.
- Be patient and observe; don't react—it may pass.

talking to your child when a concern comes up, such as:

- spending time with friends you don't know
- changes in speech and attitude
- changes in schoolwork
- lying and sneaking around

Peer Influence

Youth do not always make wise choices in picking friends. Help them see what qualities they should value in friends — such as honesty, school involvement, and respect.

To decrease negative peer influence, spend time together and try these ideas:

- Play board/outdoor games.
- Read with your child or tell family stories.
- Encourage your child's interests (such as drawing, scientific curiosity, music, and cooking).
- Include your child in social/cultural events in the community.
- Include your child's friends in family activities.

Help children see what qualities they should value in friends—such as honesty, school involvement, and respect.

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CONTRACT FOR LIFE

A Foundation for Trust and Caring

This Contract is designed to facilitate communication between young people and their parents about potentially destructive decisions related to alcohol, drugs, peer pressure, and behavior. The issues facing young people today are often too difficult for them to address alone. SADD believes that effective parent-child communication is critically important in helping young adults to make healthy decisions.

YOUNG PERSON

I recognize that there are many potentially destructive decisions I face every day and commit to you that I will do everything in my power to avoid making decisions that will jeopardize my health, my safety and overall well-being, or your trust in me. I understand the dangers associated with the use of alcohol and drugs and the destructive behaviors often associated with impairment.

By signing below, I pledge my best effort to remain free from alcohol and drugs; I agree that I will never drive under the influence; I agree that I will never ride with an impaired driver; and I agree that I will always wear a seat belt.

Finally, I agree to call you if I am ever in a situation that threatens my safety and to communicate with you regularly about issues of importance to both of us.

YOUNG PERSON

PARENT (or Caring Adult)

I am committed to you and to your health and safety. By signing below, I pledge to do everything in my power to understand and communicate with you about the many difficult and potentially destructive decisions you face.

Further, I agree to provide for you safe, sober transportation home if you are ever in a situation that threatens your safety and to defer discussions about that situation until a time when we can both have a discussion in a calm and caring manner.

I also pledge to you that I will not drive under the influence of alcohol or drugs, I will always seek safe, sober transportation home, and I will always wear a seat belt.

PARENT/CARING ADULT

Students Against Destructive Decisions

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SBIRT: Screening, Brief Intervention, and Referral to Treatment

Opportunities for Implementation and Points for Consideration

SBIRT: Basics

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidenced-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and drugs[1, 2]. Typically, this practice is conducted in medical settings, including community health centers, and has proved successful in hospitals, specialty medical practices such as HIV/STD clinics, emergency departments, and workplace wellness programs such as Employee Assistance Programs. SBIRT can be easily used in primary care settings and enables healthcare professionals to systematically screen and assist people who may not be seeking help for a substance use problem, but whose drinking or drug use may cause or complicate their ability to successfully handle health, work, or family issues. SBIRT aims to prevent the unhealthy consequences of alcohol and drug use among those whose use may not have reached the diagnostic level of a substance use disorder, and to help those with the disease of addiction enter and stay with treatment.

Charged with developing a strategy to substantially improve healthcare quality over 10 years, the Institute of Medicine's Committee on the Quality of Health Care in America in 2001 called for community-based screening for health risk behaviors — including substance use — with appropriate assessment and referral activities[3] in its report, *Crossing the Quality Chasm: A New Health System or the 21st Century*. In that landmark report, the Institute of Medicine specifically cited the SBIRT model as a promising practice.

SBIRT: Benefits

Substance misuse and abuse often result in poor health outcomes and substantial healthcare costs related to illness, hospitalizations, motor vehicle injuries, and premature deaths. An Office of National Drug Control Policy study estimated that in 2011 substance use accrued a societal cost of $193 billion[4]. Research has demonstrated SBIRT's numerous benefits. Specifically, SBIRT successfully reduces:

- Healthcare costs[5];
- Severity of drug and alcohol use; and
- Risk of trauma (distressing events that may have long lasting, harmful effect on a person's physical and emotional health and wellbeing) and the percentage of at-risk patients who go without specialized substance use treatment[6].

A 2010 study examined SBIRT's cost - benefit from an employer's perspective. The study considered the costs of absenteeism and impaired presenteeism due to problem drinking. The results indicated that when absenteeism and impaired presenteeism costs, the net value of SBIRT adoption was $771 per employee[7].

SBIRT reduces healthcare costs

- Multiple studies have shown that investing in SBIRT can result in healthcare cost savings that range from $3.81 to $5.60 for each $1.00 spent[8].

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE
SAMHSA A Life in the Community for Everyone
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- People who received screening and brief intervention in an emergency department, hospital or primary care office experienced 20% fewer emergency department visits, 33% fewer nonfatal injuries, 37% fewer hospitalizations, 46% fewer arrests and 50% fewer motor vehicle crashes[9].

SBIRT decreases severity of drug and alcohol use

- In 2002, researchers analyzed more than 360 controlled trials on alcohol use treatments and found that screening and brief intervention was *the single most effective treatment method* of the more than 40 treatment approaches studied, particularly among groups of people not actively seeking treatment. Additional studies and reports have produced similar results showing that substance use screening and intervention help people recognize and change unhealthy patterns of use[10].
- Studies have found that patients identified through screening as having unhealthy patterns of drug or alcohol use are more likely to respond to brief intervention than those who drink heavily[11]. The latter group is more likely to meet diagnostic criteria for a substance use disorders that needs more intensive treatment.

SBIRT reduces risk of physical trauma and the percentage of patients who go without specialized substance use treatment

- Studies on brief intervention in trauma centers and emergency departments have documented positive effects such as reductions in alcohol consumption,[12] successful referral to and participation in alcohol treatment programs,[13] and reduction in repeat injuries and injury hospitalizations[14, 15].

Given SBIRT's demonstrated cost and health savings, federal agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA), Veterans Administration, Department of Defense and the White House Office of National Drug Control Policy, as well as managed care providers and major medical associations, have recommended SBIRT's routine use. Not only does SAMHSA recommend SBIRT, but the agency also continues to support SBIRT's expanded use by funding grants across the country to further implement the practice in healthcare settings.

SBIRT: Core Components

Screening

Screening is a quick, simple method of identifying patients who use substances at at-risk or hazardous levels and who may already have substance use-related disorders. The screening instrument provides specific information and feedback to the patient related to his or her substance use. The typical screening process involves the use of a brief 1-3 question screen such as the National Institute on Alcohol Abuse and Alcoholism's single question screen or National Institute on Drug Abuse's quick screen. If a person screens positive on one of these instruments, s/he is then given a longer alcohol or drug use evaluation, using a standardized risk assessment tool such as AUDIT or ASSIST. The screening and risk assessment instruments are easily administered and provide patient-reported information about substance use that any healthcare professional can easily score.

Brief Intervention

Brief Intervention is a time-limited, patient-centered strategy that focuses on changing a patient's behavior by increasing insight and awareness regarding substance use. Depending on severity of use and risk for adverse consequences, a 5-10 minute discussion or a longer 20-30 minute discussion provides the patient with

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personalized feedback showing concern over drug and/or alcohol use. The topics discussed can include how substances can interact with medications, cause or exacerbate health problems, and/or interfere with personal responsibilities[16].

Brief intervention is designed to motivate patients to change their behavior and prevent the progression of substance use. During the intervention, patients are:

- Given information about their substance use based on their risk assessment scores.
- Advised in clear, respectful terms to decrease or abstain from substance use.
- Encouraged to set goals to decrease substance use and to identify specific steps to reach those goals.
- Taught behavior change skills that will reduce substance use and limit negative consequences.
- Provided with a referral for further care, if needed.

Brief interventions are typically provided to patients with less severe alcohol or substance use problems who do not need a referral to additional treatment and services. In addition to behavioral health professionals, medical personnel (e.g., doctors, nurses, physician assistants, nurse practitioners) can conduct these interventions and need only minimal training. In the case of patients with addictions, more intensive interventions may be needed. Much of the discussion in intensive intervention is similar to that of the brief intervention; however, the intensive sessions tend to be longer (20-30 minute) and can include multiple sessions, a referral to an addiction specialty program, and the addition of a specific pharmacological therapy. While medical personnel who have received additional training may conduct intensive interventions, behavioral health professionals often conduct these longer counseling sessions.

Referral to Treatment

In some cases, a more advanced treatment option is necessary and the patient is referred to a higher level of care. This care is often provided at specialized addiction treatment programs. The referral to treatment process consists of helping patients access specialized treatment, selecting treatment facilities, and facilitating the navigation of any barriers such as cost of treatment or lack of transportation that would hinder them from receiving treatment in a specialty setting. In order for this process to occur smoothly, primary care providers must initially establish and cultivate relationships with specialty providers, and then share pertinent patient information with the referral provider. Handling the referral process properly and ensuring that the patient receives the necessary care coordination and follow-up support services is critical to the treatment process and to facilitating and maintaining recovery.

SBIRT: Opportunities and Points for Consideration

The passage of the Patient Protection and Affordable Care Act in 2010 availed several opportunities for service delivery and payment reform in healthcare, including recognition of the importance of screening and intervention in primary care to reduce disease, disability and premature mortality.

As of October 14, 2011, Medicare covers screening and behavioral counseling related to alcohol misuse in the primary care setting, which the U.S. Preventive Services Task Force recommended with a grade of B. In its

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Decision Memo for Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse, the Centers for Medicare and Medicaid Services (CMS) conclude that these services are "reasonable and necessary for the prevention or early detection of illness or disability"[17]. Medicare entitles beneficiaries to yearly alcohol screenings by a primary care provider and up to four behavioral counseling interventions[18].

Additionally, in December 2011, the U.S. Department of Health and Human Services (HHS) issued its first round of guidance on how states and health plans are to implement the Essential Health Benefits (EHBs) provisions of the Affordable Care Act. The Essential Health Benefits are a set of healthcare service categories that must be covered by all insurance policies participating in state health insurance exchanges and all state Medicaid plans beginning in 2014. As required by the Affordable Care Act, the EHB package must include mental health and substance use disorder services at parity with other medical/surgical care, prevention services, and rehabilitative services. However, rather than designing one standard benefit package for all health plans in the nation to follow, HHS proposed to allow states to define their own essential health benefits. States would have 10 options for selecting a "benchmark" plan in which its covered benefits would be the basis of that state's EHB package. While the package must include mental health and substance use disorder services, each state will determine the extent of coverage. The development of the EHB package is a prime opportunity to promote the inclusion of SBIRT across multiple healthcare settings. However, inclusion of these services may be dependent upon action at the state level. Stakeholders should pay close attention to further guidance released by HHS, as well as opportunities within their own state to influence the process.

Even with reimbursement codes available, it is important to note that some states may still have difficulty covering screening and brief intervention services when they are provided by non-physician professionals. According to a SAMHSA learning collaborative run by the National Network to Eliminate Disparities, Federally Qualified Health Centers (FQHCs) in Tennessee and Colorado received reimbursement from insurance carriers only when SBIRT services were conducted by primary care physicians and not when provided by psychologists or social workers. As it turned out, this caveat was included in the criteria for payment in these states. Once identified, both states were able to change their payment methodologies to correct this problem. In Colorado, health educators are now able to receive payment for delivering screening and brief intervention.

Utilizing SBIRT Reimbursement Codes

SBIRT is an effective method to identify, intervene and help treat individuals with substance use problems. Its use across healthcare settings, including emergency rooms, community clinics and trauma centers, is paramount. Hence, SBIRT coding and billing policies are a crucial component to widespread use of this practice. However, coding and reimbursement are dependent upon the payer type; reimbursement is available through commercial insurance Current Procedural Terminology (CPT) codes, Medicare G codes, and Medicaid Healthcare Common Procedure Coding System (HCPCS) codes[19].

While Medicare currently pays for screening and brief intervention as a preventive service in the primary care setting, some states are working to "activate" Medicaid codes for SBIRT reimbursement. According to the most recent information from SAMHSA, 16 states have approved SBIRT codes in their respective Medicaid plans; of these, five states have activated codes that allow providers to bill and receive payment for the services, four have activated SBIRT codes to allow for reimbursement of non-physician professionals, including Alaska, Tennessee, Colorado, and Virginia, and two states — Indiana and Oklahoma — have activated SBIRT codes to allow for reimbursement of physicians only.

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SAMHSA has funded a number of state SBIRT initiatives and has found that SBIRT programs can be implemented successfully in primary care settings[20]. However, sustainability can pose a problem once a grant-funded project ends. Addressing SBIRT reimbursement barriers not only expands the use of SBIRT, but also assists in the sustainability of providing these services in the primary care setting.

More information on SBIRT billing codes may be found through the Institute for Research, Education &Training Institute in Addictions, CMS and the SAMHSA-HRSA Center for Integrated Health Solutions.

Addressing Workflow Issues

In addition to reimbursement issues, SBIRT proponents encounter other barriers to broad implementation and sustainability of this evidence-based practice. In Maryland, efforts to integrate SBIRT into community health centers demonstrate the importance of resolving workflow hurdles and providers' time constraints in the primary care setting. Through an Open Society Institute-funded pilot project in 2010, four community health centers in Baltimore engaged in a workflow redesign process that resulted in successful institutionalization of SBIRT practices in their centers. Through this process, key lessons learned were that administrative and physician champions are essential to early adoption and that recognizing the role of technology was critical. As a result, the Baltimore SBIRT pilot supported sites in incorporating SBIRT screening into their electronic health records. This produced a dramatic improvement in delivery of brief interventions and facilitated ease in documentation and data collection.

One common barrier to implementing SBIRT in primary care settings is the additional time the practice will add to already short visits. As indicated above, the Baltimore SBIRT project overcome this hurdle by employing multi-disciplinary change team to identify not only the best screening and risk assessment tools for that practice setting, but also which existing clinical and administrative staff would conduct specific SBIRT functions. This led to the creation of several different SBIRT delivery models across seven community health centers in 14 separate locations across the state of Maryland. In some models, medical assistants complete the screening and risk assessment tools with patients; then, the primary care provider reviews the information and conducts the brief intervention. In other health centers, the primary care provider conducts only part of the brief intervention for each patient and refers to internal behavioral health professionals for completion. The success of the Maryland health center project led Baltimore Substance Abuse Systems, Inc., the lead funder of substance abuse treatment for the city, to fund SBIRT projects in six high schools and one emergency department. These efforts are currently underway. The keys to Maryland's successful implementation have included collaboration with health staff to tailor SBIRT to existing infrastructure and resources, ongoing training, data collection for quality monitoring and process revision based on results.

Visit SAMHSA-HRSA Center for Integrated Health Solutions for resources that address workflow issues.

Maintaining Confidentiality

As SBIRT's use advances, patient privacy must be carefully considered as data collected through the screening process by healthcare organizations other than addiction specialty programs are not covered by 42 CFR. Providers must ensure that all applicable safeguards are in place to protect patient data.

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SBIRT: Adapting to the Health Home Model

Under the Affordable Care Act, states have the option to establish a "health home" to better meet the healthcare needs of individuals with chronic conditions. As stipulated by the federal government, these health homes must provide comprehensive, evidence-based care and provide mental health and substance use prevention and treatment services. CMS has released guidance on the development of health homes, (available on SAMHSA's health homes webpage). Hence, as states move forward with implementing health home initiatives, an opportunity exists to significantly expand the use of SBIRT services to provide more comprehensive care to the individuals that are served through these models. The state of New York in its Health Home State Plan Amendment (SPA) and in proposals to transform their Medicaid system have proposed a significant expansion of the use of SBIRT. It is the state's hope that this expansion will lead to early interventions before more severe and costly consequences occur from alcohol and drug misuse. The state of Missouri has also taken a similar approach in the development of its Health Home SPA by identifying the use of SBIRT as a critical component of addressing the health needs of Missouri's low-income populations and those living with chronic medical and behavioral health conditions. Stakeholders must educate state Medicaid directors on the benefits of incorporating SBIRT services into health home models and allowing psychologists and licensed social workers to bill for these services. As mentioned, Alaska, Tennessee, Colorado, and Virginia have successfully worked with state Medicaid programs to activate SBIRT billing codes to allow reimbursement for non-physician professionals.

Stakeholders interested in receiving technical assistance and consultation around the Health Home SPA can contact the Substance Abuse and Mental Health Services Administration.

SBIRT: Implications

The cost of healthcare in the U.S. has been steadily growing and providers, policy makers and consumers are eager to identify high quality, cost-effective strategies to coordinate the care of individuals and manage chronic illnesses[21]. SBIRT is an evidence-based practice that has been clinically shown to identify, reduce and prevent substance misuse and the disease of addiction and ultimately reduce healthcare costs. While implementation barriers still exist, recent developments under the Affordable Care Act have created valuable opportunities for the expansion of SBIRT utilization across various healthcare settings. As states begin to explore opportunities through the Health Homes SPA, stakeholders must recognize SBIRT's value and the need to implement the practice to comprehensively address consumers' health needs. Through the use of evidence-based practices such as SBIRT, individuals will receive quality care that will lead to improved population health outcomes.

SBIRT: Additional Resources

SAMHSA-HRSA Center for Integrated Health Solutions

Substance Abuse and Mental Health Services Administration

Centers for Medicaid and Medicare Services

National Institute on Alcohol Abuse and Alcoholism

The Big Initiative

Foundations of SBIRT

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CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

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Substance Use Screening, Brief Intervention, and Referral to Treatment

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abstract

The enormous public health impact of adolescent substance use and its preventable morbidity and mortality highlight the need for the health care sector, including pediatricians and the medical home, to increase its capacity regarding adolescent substance use screening, brief intervention, and referral to treatment (SBIRT). The American Academy of Pediatrics first published a policy statement on SBIRT and adolescents in 2011 to introduce SBIRT concepts and terminology and to offer clinical guidance about available substance use screening tools and intervention procedures. This clinical report provides a simplified adolescent SBIRT clinical approach that, in combination with the accompanying updated policy statement, guides pediatricians in implementing substance use prevention, detection, assessment, and intervention practices across the varied clinical settings in which adolescents receive health care.

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INTRODUCTION

Adolescent substance use is an issue of critical importance to the American public. In 2011, a nationally representative household survey found that adults rated drug abuse as the number one health concern for adolescents.[1] These concerns are reflected in the *Healthy People 2020* objectives, which call for reducing teen substance use.[2] Alcohol, tobacco, and marijuana are the substances most often used by children and adolescents in the United States. Twenty-eight percent of students have tried alcohol by eighth grade, and 68.2% have tried alcohol by 12th grade. Twelve percent of eighth-graders and more than half of 12th-graders have been drunk at least once in their life.[3] Rates of marijuana use have increased substantially in recent years; in 2012, 45% of ninth- through 12th-graders reported ever using marijuana, and 24% reported marijuana use in the past 30 days.[4] Eight percent of teenagers reported using marijuana nearly every day, an increase of approximately 60% from 2008.[4] Decreases in tobacco use by high school students have plateaued since 2007; 41% of ninth- through 12th-graders reported having tried cigarettes and nearly one-quarter (22.4%)

reported current (past-30-day) use of tobacco in any form.[5] "Misuse" of prescription medication, especially stimulants and pain medications, continues among a substantial minority of adolescents (eg, 15% of 12th-graders[3]). Approximately half (50.4%) of 12th-graders have used any illicit drug (half of these, or 24.7%, reported the use of any illicit drug other than marijuana).[3]

Although it is common for adolescents and young adults to try psychoactive substances, it is important that this experimentation not be condoned, facilitated, or trivialized by adults. Even the first use of a psychoactive substance may result in tragic consequences, such as injury, victimization, or even fatality. Adolescence extends from approximately 12 years of age into the early 20s and is a time of intensive neurodevelopmental molding and maturation that confers greater neurodevelopmental vulnerability at a time during which risk-taking behaviors are generally more prevalent. Adolescents are particularly susceptible to risk-related injuries, including those associated with alcohol, tobacco, and other drug use.[6,7] Most alcohol and drug use consequences during adolescence are attributable not to addiction but to the fact that all substance use confers some amount of risk.[8] Substance use correlates with sexual risk-taking[9] and can complicate pregnancy outcomes. Other health complexities, such as having a chronic disease or disability, including intellectual disability, may increase an adolescent's vulnerability to both substance use and its consequences.[10,11] The neurodevelopmental changes during adolescence confer particular vulnerability to addictions.[12] The age at first substance use is inversely correlated with the lifetime incidence of developing a substance use disorder.[7,12] Adolescence is thus a most critical time period for pediatricians, the medical home, and any other entity providing health advice to deliver clear and consistent messaging about abstaining from substance use.[13]

Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents[14] highlights the unique role of the pediatrician in addressing problem behaviors throughout the pediatric age range. Most adolescents (83%) have contact with a physician annually.[15] Adolescents consider physicians an authoritative source of knowledge about alcohol and drugs and are receptive to discussing substance use.[16] These findings underscore the tremendous opportunity for addressing substance use in primary care settings, the medical home, and other settings in which children and adolescents receive medical care and health advice.

The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends universal substance use screening, brief intervention, and/or referral to treatment (SBIRT) as part of routine health care.[17] Capitalizing on opportunities to screen whenever and wherever adolescents receive medical care can increase the identification of risk behaviors and substance use. Because the adolescent age group is at the highest risk of experiencing substance use–related health consequences,[18] it is also the most likely to derive the most benefit from universal SBIRT. This clinical report, together with an update of the 2011 American Academy of Pediatrics (AAP) policy statement on SBIRT,[19] presents a simplified, practical clinical approach to support widespread implementation of research-informed SBIRT practices. Similar to any other patient interactions, SBIRT must be conducted with sensitivity to various patient population abilities, vulnerabilities, and needs, such as when adolescents have chronic medical conditions or intellectual disabilities,[10,11] and with considerations to modify SBIRT techniques as needed to ensure relevance, comprehensibility, and reliability.

CONFIDENTIALITY

Confidentiality practices in the medical home are important facilitators to SBIRT practices and the care of an adolescent disclosing substance use. Protection of their confidential health care information is an essential determinant of whether adolescents will access care, answer questions honestly, and engage in and maintain a therapeutic alliance with health care professionals.[20,21] Adolescents may disclose substance use or other high-risk behaviors as a way to reveal that they want help or feel unsafe, possibly even in their own home, so a prime consideration for the pediatrician is whether maintaining confidentiality or disclosing confidential health information is in the patient's best interest.

Health care professional organizations guiding best practices in adolescent and young adult medical care, including the American Medical Association, the AAP, the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, and the Society for Adolescent Health and Medicine, have established position statements and recommendations guiding confidentiality and informed consent in this age group.[22,23] The AAP statement recommends that all children and adolescents receive comprehensive, confidential primary care, including indicated screenings, counseling, and physical and laboratory evaluations.[19] The Society for Adolescent Health and Medicine's position paper notes that participation of parents in the health care of their adolescents should usually be encouraged but

not mandated.[22] The Center for Adolescent Health and the Law (CAHL.org) provides detailed information about each state's regulations that specify adolescent and parent rights, including adolescent confidentiality.

Confidentiality practices are best introduced to the patient and the parent(s) or legal guardian simultaneously before the first time the teen or "tween" (preadolescent) patient is interviewed without a parent present or when an adolescent is new to a pediatrician's practice. The "limit" to maintaining confidentiality relies on the pediatrician's clinical judgment of the need to prevent imminent harm to the patient or someone else and to protect the patient's health and safety. Adolescents often express relief that their parents will be informed of serious problems, although they may have preferences about how the information is presented. By first informing the adolescent that confidentiality can no longer be upheld and then strategizing about the disclosure, the pediatrician, with the adolescent's permission, or the patient, together with the pediatrician, can transmit the necessary information to parents while simultaneously protecting the physician-patient bond. Whether or not the adolescent's substance use poses an acute safety risk, adolescents are likely to benefit from the support and involvement of their parents in accessing recommended services and accepting the care plan. Adolescents are unlikely to follow through with referrals without the support of an adult, and even more so if they are being referred for the evaluation or treatment of something they do not believe they have, such as a severe substance use disorder (SUD), or addiction. In many cases and certainly by the time an adolescent has developed an SUD, parents are already aware or at least highly suspect that their adolescent is engaged in substance use, although they may underestimate the extent of use or the seriousness of the situation.[24] In addition, confidentiality, intervention, and treatment are potentially influenced by a parent's substance use or active substance use disorder. Advising the substance-using parent to speak with their own physician or to seek other assistance is likely to be helpful as the pediatrician begins to work with the substance-using adolescent.

Adolescents may be less resistant to breaking confidentiality if the pediatrician and the adolescent first discuss why the disclosure is necessary, what details will be disclosed, who will disclose the details, and how disclosure will help. Teenagers may be most concerned about protecting tangential details (ie, which friends were involved, how and where they obtained substances, etc), which might be possible to keep confidential when disclosure would not substantially change the safety plan. Adolescents may be willing to include their parent(s) in a discussion of recommendations, particularly if the concerns and recommendations can be presented in a way that emphasizes positive attributes, such as the adolescent's honesty, willingness to change behavior, and/or acceptance of further evaluation or treatment. Adolescents who agree to accept a referral without notifying their parents may be able to access services available in the school or the community. Specific laws governing the need for parental consent for SUD treatment vary by state, so legal clarification is advised. Physicians should be aware that health insurance transactions can potentially jeopardize patient confidentiality and rapport with the patient and parent: for example, when a parent's insurance policy sends the policy holder (parent) an explanation of benefits with explicit diagnostic codes about the adolescent's care.

SCREENING

Screening is a procedure applied to populations to identify individuals or groups at risk of or with a disease, condition, or symptoms. Screening is conducted so that the results can form the basis for a corresponding care plan. The best screening tools are those containing the lowest number of succinct validated questions that can elicit accurate and reliable responses. Comprehensive biopsychosocial screening, including substance use screening, is a recommended component of routine adolescent health care. The HEEADSSS mnemonic, which stands for home environment, education and employment, eating, peer-related activities, drugs, sexuality, suicide/depression, and safety from injury and violence,[25,26] is a frequently used framework to conduct a complete psychosocial interview with adolescents, as is the SSHADESS mnemonic, a strength- and resiliency-based tool. Whether the patient responds to a written or electronic survey or provider or medical assistant questioning, the "D" in these tools triggers screening about the patient's substance use but possibly also about use by their friends or household members.

The SBIRT screening goal is to define experience with substance use along a spectrum ranging from abstinence to addiction so that this information can be used to guide the next steps of the related clinical approach, or intervention (see Table 1). Screening results broadly inform clinical care: for example, alcohol and drug use may be the source of a presenting symptom or may interfere with prescribed medications and test results. The management of inattentiveness would be different if the physician learned that the patient used marijuana (a possible cause) or a stimulant drug (a prescribing risk). Awareness about the range of possible screening results allows the pediatrician to be prepared to

TABLE 1 Substance Use Spectrum and Goals for BI

Stage	Description	BI Goals
Abstinence	The time before an individual has ever used drugs or alcohol more than a few sips.	Prevent or delay initiation of substance use through positive reinforcement and patient/parent education.
Substance use without a disorder	Limited use, generally in social situations, without related problems. Typically, use occurs at predictable times, such as on weekends.	Advise to stop. Provide counseling regarding the medical harms of substance use. Promote patient strengths.
Mild–moderate SUD	Use in high-risk situations, such as when driving or with strangers. Use associated with a problem, such as a fight, arrest, or school suspension. Use for emotional regulation, such as to relieve stress or depression. Defined as meeting 2 to 5 of the 11 criteria for an SUD in the DSM-5.	Brief assessment to explore patient-perceived problems associated with use. Give clear, brief advice to quit. Provide counseling regarding the medical harms of substance use. Negotiate a behavior change to quit or cut down. Close patient follow-up. Consider referral to SUD treatment. Consider breaking confidentiality.
Severe SUD	Loss of control or compulsive drug use associated with neurologic changes in the reward system of the brain. Defined as meeting ≥6 of the 11 criteria for an SUD in the DSM-5.	As above. Involve parents in treatment planning whenever possible. Refer to the appropriate level of care. Follow up to ensure compliance with treatment and to offer continued support.

DSM-5, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.*

address the range of potential patient responses.

Pediatricians' self-reported rates of routine substance use screening vary from less than 50%[27,28] to 86%,[29] although few physicians reported using a validated screening tool,[30] and most relied on clinical impressions. The most frequently cited barriers to screening were lack of time,[31] insufficient training,[32] and lack of familiarity with standardized tools.[33] Experienced pediatricians have failed to detect mild, moderate, and sometimes even severe SUDs when relying on clinical impressions alone.[34] A recent study found that when a screening tool was not used, only one-third of youth who were engaged in "excessive alcohol use" were identified.[35]

An array of validated tools is available to conduct alcohol and other substance use screening and to guide assessment for use-related problems (Table 2). The effective incorporation of screening into the pediatric practice depends on pediatricians being knowledgeable about screening options and selecting and implementing the tools most suitable for routine use in their particular care settings and patient population(s), including vulnerable patients in their care. Alcohol-only screening may be most useful with younger children, when time is very limited or when alcohol use is a particular concern. The AAP-endorsed National Institute on Alcoholism and Alcohol Abuse's "Youth Guide"[36] provides clinicians with an age-based schema to ask patients about the frequency of their drinking and their friends' drinking in the past year and to correlate the respective responses with the current and future risk of having an alcohol use disorder. The BSTAD (Brief Screener for Tobacco, Alcohol and other Drugs)[37] uses highly sensitive and specific cutoffs to identify various SUDs among adolescents 12 to 17 years of age: ≥6 days of past-year use for tobacco and >1 day of past-year use for alcohol or marijuana.[37] The Screening to Brief Intervention (S2BI) tool[38] uses a stem question and forced-response options (none, once or twice, monthly, and weekly or more) in a sequence to reveal the frequency of past-year use of tobacco, alcohol, marijuana, and 5 other classes of substances most commonly used by adolescents (Table 3). The S2BI tool is highly sensitive and specific in discriminating among clinically relevant use-risk categories and therefore is remarkably efficient in its ability to detect severe SUDs aligned with criteria from the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*[39] (Table 4). Although the S2BI is not a formal diagnostic instrument, the patient's response to the question about the frequency of use in the past year correlates closely with the present likelihood of having an SUD, as follows: used "once or twice" correlates with no SUD, uses "monthly" correlates with mild or moderate SUD, and uses "weekly or more" correlates with a severe SUD (Fig 1). The CRAFFT (Car, Relax, Alone, Friends/Family, Forget, Trouble)[40] tool originally was validated to screen for substance use risk by scoring each patient's "yes" or "no" responses to 6 questions, but using the tool as an assessment to explore "yes" responses and to reveal the extent of the patient's substance use–related problems may be more effective for gathering details for use in SBIRT intervention.

Incorporating screening into the patient care visit logically assumes that the spectrum of possible screening outcomes will be addressed by using effective approaches and available resources most suitable for the particular patient population and locale. Options for pediatricians to respond to adolescent substance use screening results and to facilitate care are described by a range of "brief intervention and referral to treatment" practices.

BRIEF INTERVENTION

Brief intervention (BI) is a conversation that focuses on

encouraging healthy choices so that the risk behaviors are prevented, reduced, or stopped. In the context of SBIRT, regardless of which substance use screening tools are used, the BI strategy is identical, because it is a direct response to the reported substance use severity. BI encompasses a spectrum of potential pediatrician responses, including positive reinforcement for adolescents reporting no substance use; brief, medically based advice for those reporting use but showing no evidence of an SUD; brief motivational interventions when a mild or moderate SUD is revealed; and referral to treatment of those with a severe SUD. Using motivation-enhancing principles is compatible with all BI dialogue regarding any level of substance use and risk.

Among adolescents presenting to an ED for a substance use–related problem, BI has been shown to reduce subsequent alcohol use,[43] marijuana use,[44] and associated problems[45] and to be cost-effective compared with brief education.[46] Several BI models have been evaluated in primary care: structured intervention "5A's,"[47] "CHAT,"[48] intervention with follow-up "Healthy Choices,"[49] "MOMENT,"[50] and therapist-delivered versus computer-delivered BI.[51] All of these models have been modestly successful in showing reductions in substance use and related consequences and/or risky behaviors, although 1 trial found similar substance use reductions in both experimental and control groups.[50] Physician-implemented BI is acceptable to both teenagers[16] and clinicians.[52] Although a recent US Preventive Services Task Force[53] review found insufficient scientific basis to recommend any particular BI for addressing adolescent substance use, this clinical report reviews the current literature base to summarize expert opinion about practical BI strategies.

TABLE 2 Substance Use Screening and Assessment Tools Used With Adolescents

	Description
Brief screens	
S2BI (Screening to Brief Intervention)[38]	Single frequency-of-use question per substance Identifies the likelihood of a DSM-5 SUD Includes tobacco, alcohol, marijuana, and other/illicit drug use Discriminates among no use, no SUD, moderate SUD, and severe SUD Electronic medical record compatible Self- or interviewer-administered
BSTAD (Brief Screener for Tobacco, Alcohol, and Other Drugs)[37]	Identifies problematic tobacco, alcohol, and marijuana use Built on the NIAAA screening tool with added tobacco and "drug" questions Electronic medical record compatible Self- or interviewer-administered
NIAAA Youth Alcohol Screen (Youth Guide)[36]	Two-question alcohol screen Screens for friends' use and for personal use in children and adolescents aged ≥9 y Free resource: http://pubs.niaaa.nih.gov/publications/Practitioner/YouthGuide/YouthGuide.pdf
Brief assessment guides	
CRAFFT (Car, Relax, Alone, Friends/Family, Forget, Trouble)[40]	Quickly assesses for problems associated with substance use Not a diagnostic tool
GAIN (Global Appraisal of Individual Needs)[41]	Assesses for both SUDs and mental health disorders
AUDIT (Alcohol Use Disorders Identification Test)[42]	Assesses for risky drinking Not a diagnostic tool

Adapted with permission from American Academy of Pediatrics; Levy S, Bagley S. Substance use: initial approach in primary care. In: Adam HM, Foy JM, eds. Signs and Symptoms in Pediatrics. Elk Grove Village, IL: American Academy of Pediatrics; 2015:887–900. DSM-5, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*; NIAAA, National Institute on Alcohol Abuse and Alcoholism.

No Substance Use: Positive Reinforcement

It has been recommended that adolescents reporting no substance use (whether tobacco, alcohol, or other drugs) receive positive reinforcement for making this smart decision and related healthy choices.[54] Even a few positive words from a physician may delay the initiation of alcohol use by adolescents.[55] Any delay in substance use onset coincides with additional brain maturation, so abstaining may be protective against the known acute and long-term consequences of early-onset substance use. Choosing to abstain from substance use can be framed as an active decision, and the adolescent is given credit for making a healthful decision and acting on it. Although screening has never been shown to increase rates of substance use, the National Institute on Alcoholism and Alcohol Abuse recommends including a "normative correction" statement whenever screening children or younger adolescents, such as, "I am glad to hear that you, just like most others your age, have never tried alcohol." Normative correction statements may help avoid the potential for patient misinterpretation that being screened in this case for alcohol use implies that alcohol use by the patient and at his or her age is expected and the age norm.

Substance Use Without an SUD: BI

When substance use is infrequent with a low likelihood of having an SUD, such as an S2BI screening response of using "once or twice" in the past year, the appropriate BI is to advise the patient to abstain in support of health and safety. A BI comprising clear, pointed advice to stop substance use combined with succinct mention of the negative health effects of use can lead to decreased use or

abstinence in adolescent patients who use substances infrequently.[56] Brief medical advice could include statements such as, "For the sake of your health, I advise you to quit smoking marijuana. Marijuana use interferes with concentration and memory and is linked to getting lower grades at school." This BI could also recognize and leverage personal strengths and positive attributes, such as, "You are doing so well in school. I hope you will consider how your marijuana use could change all that, and whether or not that is what you really want."

Mild to Moderate SUD: Brief Motivational Intervention

Brief intervention for adolescents with mild to moderate SUD is a likely short structured conversation based on the principles of motivational interviewing,[57] through which the pediatrician respects patient autonomy while enhancing the patient's self-efficacy to institute behavior change, rather than persuading, coercing, or demanding the behavior change.[58] The core activity of BMI is to help the patient compare the benefits of continued substance use with the potential benefits of behavior change (ie, decreasing or stopping use) and ultimately take action that supports personal health and safety. The intervention is based on the premise that although adolescents who have experienced substance use–related problems can identify the potential benefits of reducing or stopping use, behavior change will not occur until the perceived benefits of giving up use outweigh the perceived "cost" and harms from continued use. For example, an adolescent may realize that marijuana use is causing tension in the relationship with his or her parents but continue to use marijuana because of perceived greater benefit from marijuana use to relieve stress or as a pleasurable activity shared with friends.

TABLE 3 S2BI Screen for Substance Use Risk Level

The following questions will ask about your use, if any, of alcohol, tobacco, and other drugs. Please answer every question by clicking on the box next to your choice.
In the past year, how many times have you used . . .
Tobacco?
-Never
-Once or twice
-Monthly
-Weekly or more
Alcohol?
-Never
-Once or twice
-Monthly
-Weekly or more
Marijuana?
-Never
-Once or twice
-Monthly
-Weekly or more
STOP if answers to all previous questions are "never." Otherwise, continue with the following questions.
In the past year, how many times have you used. . .
Prescription drugs that were not prescribed for you (such as pain medication or Adderall)?
-Never
-Once or twice
-Monthly
-Weekly or more
Illegal drugs (such as cocaine or Ecstasy)?
-Never
-Once or twice
-Monthly
-Weekly or more
Inhalants (such as nitrous oxide)?
-Never
-Once or twice
-Monthly
-Weekly or more
Herbs or synthetic drugs (such as salvia, "K2," or bath salts)?
-Never
-Once or twice
-Monthly
-Weekly or more

Starting an intervention with assessment questions to identify substance use frequency and associated problem severity can guide the pediatrician in deciding the next steps for patient care, namely continued conversation around behavior change managed in the medical home or referring to more specialized substance use evaluation, intervention, and/or treatment. This model optimizes the CRAFFT[40] tool as an assessment guide. For example, an adolescent patient responding "yes" to the CRAFFT question, "Have you gotten into trouble while you were using alcohol or drugs?" The pediatrician can distill these details into a fulcrum to pivot the conversation into discussing the adolescent's plans for avoiding such problems in the future. The pediatrician can assist the patient in making a specific intervention plan to record in the medical record and facilitate follow-up (Box 1).

Box 1

The pediatrician screens a 14-year-old boy who reports monthly alcohol use. The pediatrician asks follow-up questions about patterns of use and associated problems. The patient mentions binge drinking and not always knowing how he gets home from

TABLE 4 DSM-5[39] and ICD-10 Criteria for SUD

DSM-5		ICD-10	
Criteria	Severity	Criteria	Severity
1. Use in larger amounts or for longer periods of time than intended 2. Unsuccessful efforts to cut down or quit	Severity is designated according to the number of symptoms endorsed: 0–1, no diagnosis; 2–3, mild SUD; 4–5, moderate SUD; ≥6, severe SUD	1. A strong desire or sense of compulsion to take the substance 2. Impaired capacity to control substance-taking behavior in terms of onset, termination, or level of use, as evidenced by the substance being often taken in larger amounts over a longer period than intended or any unsuccessful effort or persistent desire to cut down or control substance use	Three or more of these manifestations should have occurred together for at least 1 month or if persisting for periods of <1 month, then they have occurred together repeatedly within a 12-month period
3. Excessive time spent taking the drug		3. A psychological withdrawal state when substance use is reduced or ceased, as evidenced by the characteristic withdrawal syndrome for the substance, or use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms	
4. Failure to fulfill major obligations 5. Continued use despite problems 6. Important activities given up		4. Evidence or tolerance to the effects of the substance, such that there is a need for markedly increased amounts of the substance to achieve intoxication or desired effect, or that there is a markedly diminished effect with continued use of the same amount of the substance	
7. Recurrent use in physically hazardous situations 8. Continued use despite problems		5. Preoccupation with substance use, as manifested by important alternative pleasures or interests being given up or reduced because of substance use, or a great deal of time being spent in activities necessary to obtain the substance, take the substance, or recover from its effects	
9. Tolerance 10. Withdrawal 11. Craving		6. Persisting with substance use despite clear evidence or harmful consequences, as evidenced by continued use when the person was actually aware of, or could be expected to have been aware of, the nature and extent of harm	

DSM-5, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*; ICD-10, International Statistical Classification of Diseases and Related Health Problems, 10th ed.

parties. He admits preferring not to think about it because it frightens him. The pediatrician correlates the report of 'monthly' use to a likelihood that the patient has a mild or moderate SUD, indicating the next step is intervention to reduce use. The patient is given brief advice and challenged to make a behavior change: *"As your doctor, I recommend that you stop drinking alcohol. You described having 'blackouts' from your drinking. This means that you drank enough to poison your brain cells at least temporarily, which is why at times you can't remember how you have gotten home from parties. As you pointed out, a teenager can get into trouble with 'blackouts,' and it sounds like you have had some frightening experiences. How do you think you can protect yourself better in the future?"* The patient says that he is not going to quit drinking, but can agree to limiting himself to 2 drinks per occasion, a sharp decrease from his usual 6 to 8 drinks, because he does not want to black out again. The pediatrician gives advice about alcohol and motor vehicle-associated risks and suggests developing a safety plan. Planning is documented in the medical record and a follow-up appointment is scheduled in 3 months.

Medical home follow-up can be conducted after a few weeks of attempted behavior change to assess whether risk behaviors have diminished, remained the same, or escalated. Adolescents who are found to have met the agreed-on substance use behavior change goals can benefit from discussing the pros and cons of their decreased use and identifying any motivating factors that can be reinforced to sustain the behavior change and lead to abstinence. Adolescents who are unable to meet the behavior change goals may benefit from more extensive substance use–targeted individual counseling provided by an allied mental health professional, such

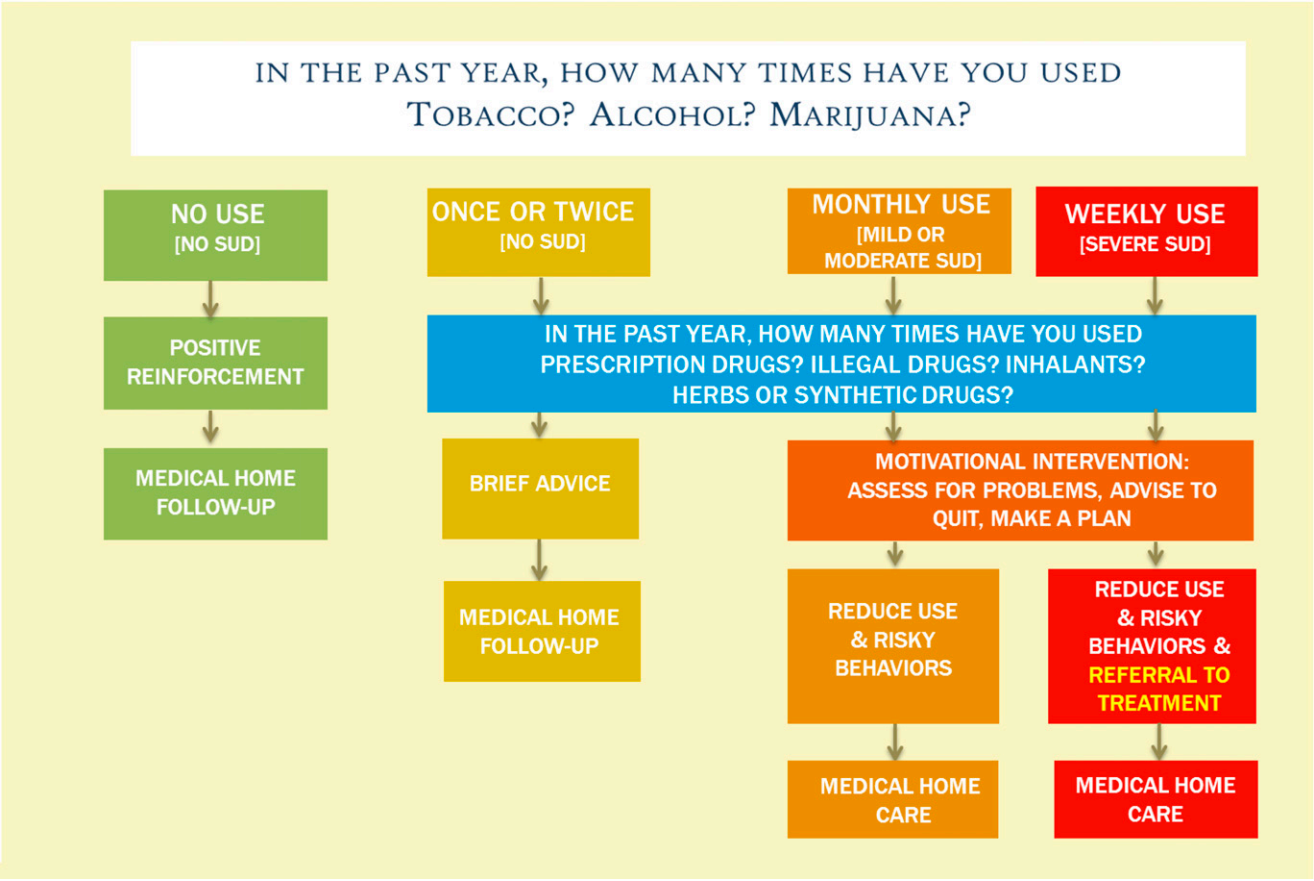

FIGURE 1

The S2BI-based approach to clinical SBIRT. S Levy, L Shrier. 2014. Boston, MA: Boston Children's Hospital. Copyright 2014, Boston Children's Hospital. Reprinted under Creative Commons Attribution-Noncommercial 4.0 International License.

as a social worker or psychologist. Referral for specific substance use evaluation and/or to psychiatric services or other available treatment options is a next step when patients have psychiatric symptomatology or cannot decrease use. When available, referral to mental health professionals within the same medical home practice setting may optimize patient compliance.

Severe SUD: Brief Intervention Focused on Referral to Treatment

Severe SUD, or addiction, is a neurologically based disorder resulting from the disruption of neurons in the reward center of the brain as the result of repeated exposure to a psychoactive substance.[59–61] The earlier an individual initiates psychoactive substance use, the more likely that individual is to develop addiction, a nearly linear and highly significant relationship.[62–64] The S2BI tool delineates use-risk categories so that a patient reporting weekly or more frequent substance use has a high probability of a severe SUD. When addiction is likely, the next SBIRT steps are to engage the patient in a comprehensive evaluation by a substance use specialist, ensure assessment for co-occurring mental health disorders, and engage in available treatment options as soon as possible to initiate the significant behavior change that is necessary for the patient's future health and safety.

Because resistance and denial (ie, lack of insight)[65] are intrinsic SUD symptoms, the patient and/or family may be unwilling to pursue an evaluation or therapy when it is recommended. Despite this challenge, it is important for the pediatrician to remain engaged with the patient and family and supportive during discussions and decision-making about the care options as well as throughout the entire course of care and aftercare. Motivational interviewing strategies can be helpful for encouraging an adolescent and/or the family to accept a referral (Box 2).

Box 2

In response to S2BI screening in the medical home, a 16-year-old girl reports weekly marijuana use. The pediatrician then asks questions to determine quantity, frequency, and context of use and to explore for problems. The patient says she relies on marijuana to help calm her down

TABLE 5 "911 Plan" for Adolescents at Acute Risk of Harm

Break confidentiality and notify parents of risk.
Make a verbal contract with patient not to use substances while awaiting treatment entry.
Ask parents to monitor adolescent closely while awaiting treatment entry.
If parents know adolescent is talking about self-harm, seek an emergency evaluation. Call 911, if adolescent refuses.
If parents note that the adolescent has altered mental status, seek emergency evaluation.
If the adolescent is unwilling to accept parent's rules or becomes violent or threatening, advise parents to call local police station and request emergency assistance.

when she is stressed and that she does not see the harm in it. She also states that her mother knows about her use and thinks marijuana use is bad for her, so their relationship has gotten tense over this disagreement. She was recently suspended from school when caught with marijuana. The pediatrician summarizes the situation and provides brief advice: *"It seems that you depend on marijuana to help you manage stress, and at the same time you realize marijuana use is causing tension at home and has gotten you into trouble at school. It is clear to me that you are thinking about this, and I am glad you are willing to speak with me about it. As your physician and for the sake of your health, your school work, and your relationship with your mom, I recommend that you quit your marijuana use. I would like you to speak with a colleague of mine who can help you continue thinking through the "good things" and "not so good things" about marijuana use and help you figure out what you want to do. What do you think?"* The patient agrees tentatively. The pediatrician gives her positive feedback about her willingness to discuss her marijuana use now and meet with the recommended colleague soon. The pediatrician asks the patient's permission to invite her mother into the room to discuss the plan together and mentions this would also show her that the patient is taking the concerns about her marijuana use seriously. She agrees and the patient's mother joins them for a summary of the conversation. The counseling appointment is scheduled, and the plan is detailed in the medical record. The patient and mother are scheduled for follow-up in 1 month.

Acute Risk of Harm

Substance use screening may reveal that an adolescent patient is at risk of imminent harm and immediate attention is warranted, including screening for suicidal or homicidal ideation. Certain substance use patterns indicate acute risk, such as injection drug use, drug withdrawal symptoms, and active substance use with a past history of a drug-related emergency department visit or medically supervised withdrawal. Very high-risk behaviors include using different sedatives together, such as mixing alcohol, benzodiazepines, barbiturates, and/or opioids; frequent or excessive binge drinking, which is especially concerning for alcohol poisoning; and operating a motor vehicle coincident with alcohol or other drug use. The more recent the activity, the more immediate is the need to address the risk through mental health and/or medical intervention and to detect or confirm an SUD and other underlying or co-occurring health issues.

When an acute risk of harm is revealed, the next steps for the pediatrician are to use brief intervention techniques to facilitate a commitment from the adolescent to curtail or avoid further substance use and high-risk behaviors. Imminent risk of harm calls for the patient and pediatrician to discuss confidentiality and disclosure, because the parent(s) nearly always should be involved in the safety plan and next steps of medical care, including how the parent(s) can support and monitor the adolescent and respond to acute concerns about safety as specialty evaluation and care services are engaged (Table 5, Box 3).

Box 3

A 17-year-old boy reports weekly use of alcohol and marijuana and monthly use of prescription medications and cocaine. The pediatrician asks follow-up questions to gauge the patient's level of acute health and safety risk. He uses marijuana to relax. He often smokes alone and sometimes drinks alone. He has frequent blackouts and explains "that's the point." He likes mixing pills with alcohol because he blacks out faster. He has thought that he may have an alcohol problem, but he does not plan to stop. He denies thoughts of hurting himself or others. The pediatrician responds: "*I am glad you spoke honestly with me today. From what you told me, I am worried about your drug use. Mixing drugs can really get you into trouble, even if you only take a couple of pills. Because I am so concerned, I want you to know that some of this information must be shared with your parents and an appointment will be made for you to speak more about your drug use with one of my colleagues. In the meantime, can you promise me that you will not use any pills or drugs at all before your next appointment? What do you think would be the best way to share the information with your parents?*"

REFERRAL TO TREATMENT

Referral to treatment describes the facilitative process through which patients identified as needing more

TABLE 6 ASAM Levels of Care for Treatment of SUDs

	Description
OUTPATIENT	
Individual counseling	Adolescents with SUDs should receive specific treatment of their substance use; general supportive counseling may be a useful adjuvant but should not be a substitute.[69] Several therapeutic modalities (motivational interviewing, cognitive behavioral therapy, contingency management, etc) have all shown promise in treating adolescents with SUDs.[70]
Group therapy	Group therapy is a mainstay of SUD treatment of adolescents with SUDs. It is a particularly attractive option because it is cost-effective and takes advantage of the developmental preference for congregating with peers. However, group therapy has not been extensively evaluated as a therapeutic modality for this age group, and existing research has produced mixed results.[69–71]
Family therapy	Family-directed therapies are the best-validated approach for treating adolescent SUDs. A number of modalities have all been shown to be effective. Family counseling typically targets domains that figure prominently in the etiology of SUDs in adolescents: family conflict, communication, parental monitoring, discipline, child abuse/neglect, and parental SUDs.[69]
Intensive outpatient program (IOP)	IOPs serve as an intermediate level of care for patients who have needs that are too complex for outpatient treatment but do not require inpatient services. These programs allow individuals to continue with their daily routine and practice newly acquired recovery skills both at home and at work. IOPs generally comprise a combination of supportive group therapy, educational groups, family therapy, individual therapy, relapse prevention and life skills, 12-step recovery, case management, and after-care planning. The programs range from 2 to 9 hours per day, 2 to 5 times per week, and last 1 to 3 months. These programs are appealing because they provide a plethora of services in a relatively short period of time.[72]
Partial hospital program	Partial hospitalization is a short-term, comprehensive outpatient program in affiliation with a hospital that is designed to provide support and treatment of patients with SUDs. The services offered at these programs are more concentrated and intensive than regular outpatient treatment because they are structured throughout the entire day and offer medical monitoring in addition to individual and group therapy. Participants typically attend sessions for 7 or 8 hours per day, at least 5 days per week, for 1–3 weeks. As with IOPs, patients return home in the evenings and have a chance to practice newly acquired recovery skills.[73]
OUTPATIENT	
Detoxification	Detoxification refers to the medical management of symptoms of withdrawal. Medically supervised detoxification is indicated for any adolescent who is at risk for withdrawing from alcohol or benzodiazepines and may also be helpful for adolescents withdrawing from opioids, cocaine, or other substances. Detoxification may be an important first step but is not considered definitive treatment. Patients who are discharged from a detoxification program should then begin either an outpatient or residential SUD treatment program.[70,71]
Acute residential treatment (ART)	ART is a short-term (days–weeks) residential placement designed to stabilize patients in crisis, often before entering a longer-term residential treatment program.[70] ART programs typically target adolescents with co-occurring mental health disorders.
Residential treatment	Residential treatment programs are highly structured live-in environments that provide therapy for those with severe SUD, mental illness, or behavioral problems that require 24-hour care. The goal of residential treatment is to promote the achievement and subsequent maintenance of long-term abstinence as well as equip each patient with both the social and coping skills necessary for a successful transition back into society. Residential treatment programs are classified by the length of the program; short-term refers to programs of ≤30 days' duration, long-term refers to programs of >30 days' duration. Residential treatment programs generally comprise individual and group therapy sessions plus medical, psychological, clinical, nutritional, and educational components. Residential facilities aim to simulate real living environments with added structure and routine to prepare individuals with the framework necessary for their lives to continue drug and alcohol free on completion of the program.[74]
Therapeutic boarding school	Therapeutic boarding schools are educational institutions that provide constant supervision for their students by professional staff. These schools offer a highly structured environment with set times for all activities, smaller, more specialized classes, and social and emotional support. In addition to the regular services offered at traditional boarding schools, therapeutic schools also provide individual and group therapy for adolescents with mental health or SUDs.[75]

extensive evaluation and treatment are able to access the appropriate services. Historically, medical encounters have been notably poor in identifying adolescents who have severe SUDs and connecting them with treatment. SAMHSA has estimated that fewer than 10% of adolescents in need of specialty substance use treatment receive it, and the majority of referrals are from the justice system.[66,67] The referral to treatment, or "RT," of SBIRT is composed of 2 distinct yet connected clinical activities: working with the adolescent and family so they accept that timely referral and treatment are necessary for the patient's health and facilitating the referral process to engage the patient and family with the appropriate professional(s) or program(s).

Deciding where to refer an adolescent in need of treatment is often complicated by limited treatment availability, insurance coverage complexities, and preferences of the adolescent and family. In most cases, pediatricians will refer adolescents with SUDs to a mental health or addiction specialist to conduct a comprehensive biopsychosocial assessment and to determine the appropriate level of care from the treatment spectrum, ranging from outpatient substance use counseling to long-term residential treatment

programs. In 2001, the American Society of Addiction Medicine (ASAM) revised its comprehensive national guidelines for placement, continued stay, and discharge of patients with alcohol and other drug problems. The separate guidelines devised for adults and adolescents detail 5 broad levels of care that range from early intervention to medically managed intensive inpatient treatment and correspond to addiction severity, related problems, and potential for behavior change and recovery[68] (Table 6). Adolescents should be treated in the least-restrictive environment (ie, level of care) that supports their clinical needs. Adolescents who voluntarily accept therapeutic placement will usually engage more readily in their care, which is a key factor influencing SUD treatment success.

The Center for Substance Abuse Treatment has published evidence-based treatment and assessment protocols and manuals (available at: www.ncbi.nlm.nih.gov/books/NBK82999). To help identify treatment options throughout the country, SAMHSA maintains a comprehensive and easy-to-use Substance Abuse Treatment Facility Locator on its Web site (www.samhsa.gov/treatment/index.aspx), which also lists both a Buprenorphine Physician & Treatment Program Locator and an Opioid Treatment Program Directory. Opioid and alcohol use disorders are the primary indications for medication-assisted treatment in adult populations; medication-assisted treatment with buprenorphine or naltrexone also is an option for opioid-dependent adolescents.[76,77]

Successful addiction treatment usually involves a long recovery process during which the patient experiences more than 1 level of care. In 2013, the ASAM reconceived the notion of "patient placement" by incorporating the entire admission, treatment, and continuing care into a single longitudinal process and encouraging the integration of addiction services with general health care, mental health, and a variety of other subjects and settings. Because clinicians and payers need to exchange information frequently and repeatedly during the treatment payment approval process, the current edition of the ASAM *National Treatment Guidelines*[68] includes a section about working effectively with managed care, particularly in the context of health care reform.

Most patients in addiction treatment consider themselves "recovering" rather than "recovered" to recognize their lifelong potential for relapse. Whether treatment begins in outpatient or inpatient care, it should continue at the level appropriate to support the patient's recovery process, which often is achieved through sequential or overlapping therapeutic levels and usually includes participation in a formal structured program, self-help groups (eg, Alcoholics Anonymous, Alateen, Narcotics Anonymous), ongoing after-care programs, and self-help recovery work.

The medical home plays a key role for all patients in recovery through many roles that include providing continuity of general medical care and rapport with the patient and family, coordinating the patient's various care specialties and services involved, and providing SUD follow-up care to detect relapse and providing support through referral and collaborative care. Relapse is not uncommon in SUDs, but anticipating it and viewing it as a learning opportunity can motivate the patient and family to re-engage in care. By collaborating with addiction medicine specialists and other mental health professionals as well as working with the family, third-party payers, and schools, among others, the pediatrician plays an essential role in the ongoing care of children and adolescents with SUDs.

OPTIMAL STANDARDS FOR AN SUD TREATMENT PROGRAM

The following were adapted from SAMHSA and Center for Substance Abuse Treatment standards into optimal goals for inpatient or outpatient SUD treatment programs serving the pediatric population.[78] The program will:

1. View drug and alcohol use disorders as a primary disease rather than a symptom.
2. Include a comprehensive patient evaluation and a developmentally appropriate management and treatment referral plan for associated medical, emotional, and behavioral problems identified.
3. Maintain rapport with the patient's pediatrician to facilitate seamless after-care and primary care follow-up.
4. Adhere to an abstinence philosophy and consider the patient's continued use of tobacco, alcohol, or other drugs as indicating more treatment is needed rather than the program should discharge or refuse to treat.
5. Maintain a low patient-to-staff ratio.
6. Use treatment professionals who are knowledgeable in both addiction treatment and child and adolescent behavior and development.
7. Maintain separate treatment groups for individuals at varying developmental levels (adolescents, young adults, and older adults).
8. Involve the entire family in the treatment and relate to

the patients and their families with compassion and concern. Programs located as close to home as possible are preferable to facilitate family involvement, even though separation of the adolescent from the family may be indicated initially.

9. Offer patients an opportunity to continue academic and vocational education and assistance with restructuring family, school, and social life. Consider formal academic and cognitive skills assessment, because unidentified weaknesses may contribute to emotional factors contributing to the substance use.
10. Keep the family apprised of costs and financial arrangements for inpatient and outpatient care and facilitate communication with managed-care organizations.
11. Ensure that follow-up and continuing care are integral parts of the program.

Billing and payment for screening and office-based BI varies by payer. A fact sheet about coding for behavior change intervention for substance use is available on the AAP Web site (www.aap.org/en-us/professional-resources/practice-support/Coding-at-the-AAP/Pages/Private/Substance-Abuse-Coding-Fact-Sheet.aspx). Further clarification is available through the AAP coding hotline (AAPCodinghotline@aap.org).

SUMMARY

Pediatricians play a key role in preventing and curtailing adolescent substance use and associated harm, whether through direct patient care practices, multidisciplinary collaboration, or support of parenting and community efforts. Research-informed SBIRT practices can be applied across the variety of practice settings and clinicians providing health care to adolescents. SBIRT is recognized to include the use of validated screening tools, assessing for substance use risk and problems, sharing expert health promotion and disease prevention advice, and conducting interventions that encourage substance use reduction and/or referral to treatment. (See the accompanying policy statement for further detail and recommendations.)

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SELECTED RESOURCES FOR PEDIATRICIANS

American Academy of Child and Adolescent Psychiatry. Practice parameter for the assessment and treatment of child and adolescent substance use disorders. Available at: www.aacap.org/App_Themes/AACAP/docs/practice_parameters/substance_abuse_practice_parameter.pdf

American Academy of Pediatrics. Implementing mental health priorities in practice substance use [video]. Available at: www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/substance-use.aspx

American Academy of Pediatrics Julius B. Richmond Center of Excellence. Available at: www2.aap.org/richmondcenter

Massachusetts Department of Public Health. Adolescent SBIRT toolkit for providers. Available at: http://massclearinghouse.ehs.state.ma.us/BSASSBIRTPROG/SA1099.html

National Institute on Alcohol Abuse and Alcoholism. Alcohol screening and brief intervention for youth: a practitioner's guide. Available at: www.niaaa.nih.gov/YouthGuide

Partnership for Drug-Free Kids. The Medicine Abuse Project. Available at: http://medicineabuseproject.org/resources/health-care-providers

SELECTED RESOURCES FOR FAMILIES

American Academy of Child and Adolescent Psychiatry. Family resources. Available at: www.aacap.org/AACAP/Families_and_Youth/Family_Resources/Home.aspx

American Academy of Pediatrics. Patient/parent brochures. Available at: http://bit.ly/1LIC93Z

HealthyChildren.org. Official consumer Web site of the AAP. Available at: www.healthychildren.org/English/ages-stages/teen/substance-abuse

National Institute on Alcohol Abuse and Alcoholism. Make a difference: talk to your child about alcohol. Available at: http://pubs.niaaa.nih.gov/publications/MakeADiff_HTML/makediff.htm

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National Institute on Drug Abuse. NIDA for teens. Available at: http://teens.drugabuse.gov

Substance Use and Mental Health Services Administration. "Talk. They hear you": application. Available at: www.samhsa.gov/underage-drinking/mobile-application

ABBREVIATIONS

AAP: American Academy of Pediatrics
ASAM: American Society of Addiction Medicine
BI: brief intervention
S2BI: Screening to Brief Intervention
SAMHSA: Substance Abuse and Mental Health Services Administration
SBIRT: screening, brief intervention, and referral to treatment
SUD: substance use disorder

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Substance Use Screening, Brief Intervention, and Referral to Treatment

Sharon J.L. Levy, Janet F. Williams and COMMITTEE ON SUBSTANCE USE AND PREVENTION

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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 your 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:

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Adolescent Sexual Development

STAGE	FACTS	TIPS
EARLY ADOLESCENCE Females: 9-13 years Males: 11-15 years	▸ 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]	▸ 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).
MIDDLE ADOLESCENCE Females: 13-16 years Males: 15-17 years	▸ 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.	▸ 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.
LATE ADOLESCENCE Females: 16-21 years Males: 17-21 years	▸ 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.	▸ More abstract reasoning allows for more traditional counseling approaches. ▸ Acknowledge and support healthy relationships or the choice to not be in a relationship.

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

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.

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

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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/*

[1]Resnick, MD et al. Protecting Adolescents from Harm: Findings from the National Longitudinal Study on Adolescent Health. *JAMA*. 1997; 278:823-32.
[2]Whitaker, 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.
[3]Hacker, KA et al. Listening to Youth: Teen Perspectives on Pregnancy Prevention. *J of Adol Health.* 2000; 26:279-88.
[4]Miller, KS et al. Patterns of Condom Use Among Adolescents: The Impact of Mother-Adolescent Communication. *Amer J of Public Health.* 1998; 88: 1542-44.
[5]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.

FACT SHEET

Adolescent Sexual and Reproductive Health in the United States

GUTTMACHER INSTITUTE

Sexual activity

- Sexual activity is a part of human development for many young people in the United States. As they develop, adolescents and young adults need access to comprehensive and non-stigmatizing information about sexual and reproductive health, support networks to have the pregnancies they want, and high-quality, affordable and confidential contraceptive services and abortion services to avoid the pregnancies they do not want.

- On average, young people in the United States have sex for the first time at about age 17, but do not marry until their mid-20s. During the interim period of nearly a decade or longer, they may be at heightened risk for unintended pregnancy and sexually transmitted infections (STIs).

- In 2011–2013, among unmarried 15–19-year-olds, 44% of females and 49% of males had had sexual intercourse. These levels have remained steady since 2002.

- The proportion of young people having sexual intercourse before age 15 has declined in recent years. In 2011–2013, about 13% of never-married females aged 15–19 and 18% of never-married males in that age-group had had sex before age 15, compared with 19% and 21%, respectively, in 1995.

- In 2006–2010, the most common reason that sexually inexperienced adolescents aged 15–19 gave for not having had sex was that it was "against religion or morals" (41% of females and 31% of males). The second and third most common reasons were not having found the right person and wanting to avoid pregnancy.

- Among sexually experienced adolescents aged 15–19, 73% of females and 58% of males reported in 2006–2010 that their first sexual experience was with a steady partner, cohabitor, fiancé or spouse. Sixteen percent of females and 28% of males reported having first had sex with someone they had just met or who was just a friend.

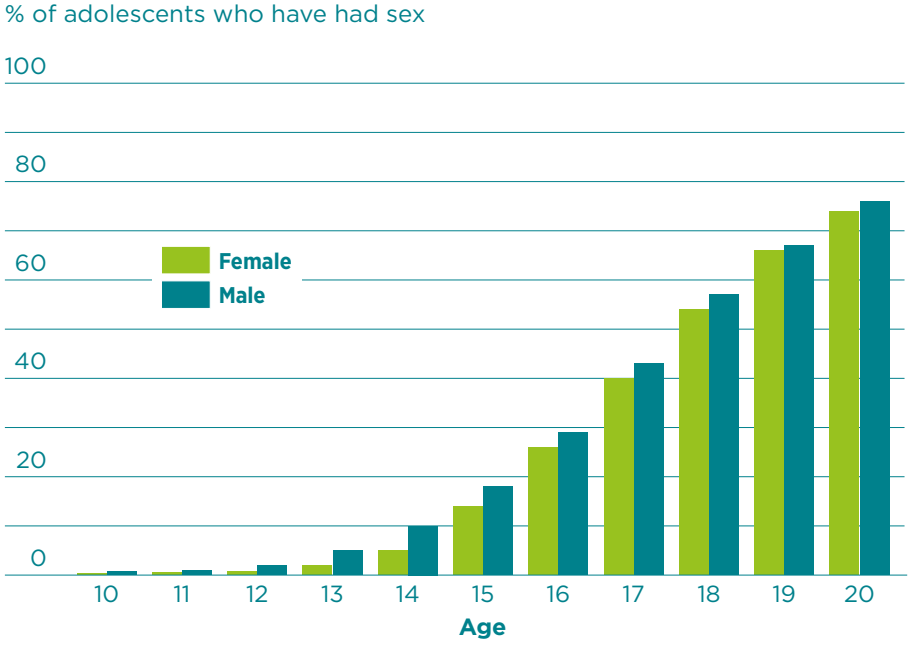
- Adolescent sexual intercourse is increasingly likely to be described as wanted. First sex was described as wanted by 34% of women aged 18–24 in 2002 who had had sex before age 20 and by 41% in 2006–2010. Among men in the same age-group, the share reporting first sex before age 20 as wanted increased from 43% to 62%.

- Three percent of males and 8% of females aged 18–19 in 2006–2008 reported their sexual orientation as lesbian, gay or bisexual. During the same period, 12% of females and 4% of males aged 18–19 reported same-sex sexual behaviors.

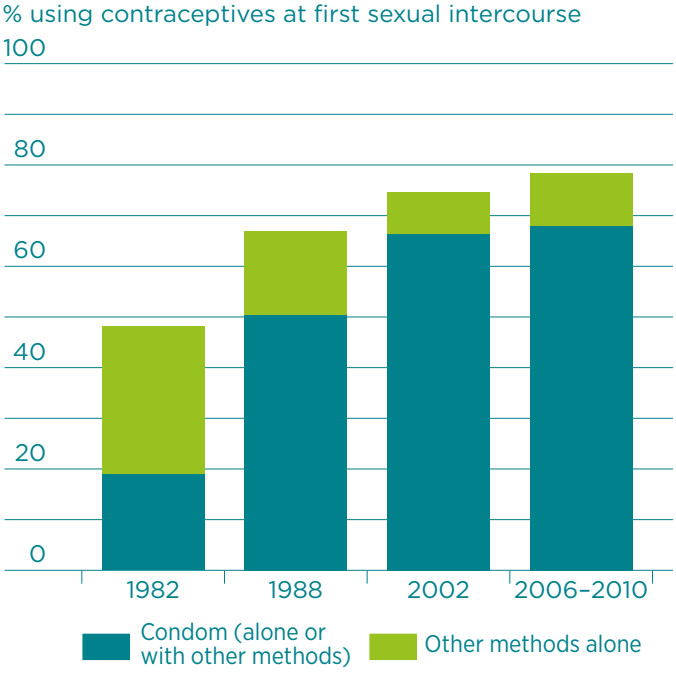
- Adolescent sexual activity may include behaviors other than vaginal intercourse. In 2007–2010, about half of adolescents aged 15–19 reported ever having oral sex with an opposite-sex partner and about one in 10 reported ever having anal sex with an opposite-sex partner.

SEXUAL INTERCOURSE AMONG YOUNG PEOPLE IN THE U.S.

The proportion of young people who have had sexual intercourse increases rapidly with age.



Contraceptive use at first sexual intercourse among 15–19-year-olds has risen steadily.



Contraceptive use

- The proportion of U.S. females aged 15–19 who used contraceptives the first time they had sex has increased, from 48% in 1982 to 79% in 2011–2013.
- Adolescents who report having had sex at age 14 or younger are less likely than those who initiated sex later to have used a contraceptive method at first sex.
- The condom is the contraceptive method most commonly used at first intercourse. In 2006–2010, 68% of females and 80% of males aged 15–19 reported having used a condom the first time they had sex.
- In 2006–2010, 86% of females and 93% of males aged 15–19 reported having used contraceptives the last time they had sex. These proportions represent a marked increase since 1995, when 71% of females and 82% of males in that age-group reported use of a contraceptive method at last sex. However, the proportions were generally unchanged between 2002 and 2006–2010.
- In 2012, 4% of female contraceptive users aged 15–19 used a long-acting reversible contraceptive method (IUD or implant) in the last month.
- Dual method use (i.e., use of a condom in combination with a short- or long-term reversible contraceptive method) can offer protection against both pregnancy and STIs. In 2006–2010, one in five sexually active females aged 15–19 and one-third of sexually active males in this age-group said that they used both a condom and a hormonal method the last time they had sex.
- In 2006–2010, 14% of sexually experienced females aged 15–19 had ever used emergency contraception.
- Adolescents in the United States and Europe have similar levels of sexual activity. However, European adolescents are more likely than U.S. adolescents to use contraceptives and to use the most effective methods; they also have substantially lower pregnancy rates.

Access to and use of contraceptive services

- Current federal law requires health insurance plans to cover the full range of female contraceptive methods, including counseling and related services, without out-of-pocket costs. However, some minors may not use insurance to access contraceptive services because they are not aware that these services are covered or because of confidentiality concerns.
- No state explicitly requires parental consent or notification for minors to obtain contraceptive services. However, two states (Texas and Utah) require parental consent for contraceptive services paid for with state funds.
- Twenty-one states and the District of Columbia explicitly allow minors to obtain contraceptive services without a parent's involvement. Another 25 states have affirmed that right for certain classes of minors, while four states do not have a statute or policy on the subject. The U.S. Supreme Court has ruled that minors' privacy rights include the right to obtain contraceptive services.
- Even when parental consent is not required for contraceptive services, concerns about confidentiality may limit adolescents' access to or use of contraceptive or other reproductive health services. In 2013–2015, 18% of 15–17-year-olds and 7% of 18–19-year-olds reported that they would not seek sexual or reproductive health care because of concerns that their parents might find out.
- In 2006–2010, 66% of sexually active females aged 15–19 reported having received contraceptive services in the last year; about one-third had received this care from publicly funded clinics and the rest from private health care providers.
- In 2014, an estimated 4.7 million women younger than 20 were in need of publicly funded contraceptive care because they were sexually active and neither pregnant nor trying to become pregnant.
- Nearly one million 15–19-year-old women in need of publicly funded contraceptive services received them from publicly supported family planning centers in 2014. These services helped adolescents to avert 232,000 unintended pregnancies, 118,000 unplanned births and 76,000 abortions.
- While school-based health centers are an important source of sexual and reproductive health services for students across the United States, only 37% of these centers dispensed

contraceptives in 2010–2011. Many are prohibited from doing so by state or local policies.

HIV and other STIs and related services

- Adolescents and young adults aged 15–24 accounted for nearly half (9.7 million) of the 19.7 million new cases of STIs in the United States in 2008. This disproportionate share likely reflects larger age-based disparities in access to preventive services and care.

- Human papillomavirus (HPV) infections account for more than two-thirds of STIs diagnosed among 15–24-year-olds each year. HPV is extremely common, often asymptomatic and generally harmless. However, certain types, if left undetected and untreated, can lead to cervical cancer.

- Three HPV vaccines—Gardasil, Gardasil 9 and Cervarix—are currently available, and all of them prevent the types of infections most likely to lead to cervical cancer. The Centers for Disease Control and Prevention now recommends HPV vaccinations for male and female adolescents, starting at age 11. Numerous research studies have confirmed that increases in HPV vaccinations have resulted in significant declines in HPV infections and related negative health outcomes.

- In 2015, 63% of females and 50% of males aged 13–17 had received one or more doses of the vaccine against HPV, and 42% of females and 28% of males had completed the recommended regimen of three doses.

- Chlamydia is the next most common STI diagnosed among 15–24-year-olds, accounting for nearly 20% of diagnoses each year. Genital herpes, gonorrhea and trichomoniasis together account for about 11% of diagnoses. HIV, syphilis and hepatitis B are estimated to account for less than 1% of diagnoses.

- Paralleling broader health disparities, rates of diagnosed STIs among 15–19-year-olds differ widely by race: Among non-Hispanic black adolescents, rates of diagnosed chlamydia are more than five times those among non-Hispanic white adolescents, and rates of gonorrhea are more than fourteen times those among non-Hispanic white adolescents.

- Young people aged 13–24 accounted for about 22% of all new HIV diagnoses in the United States in 2015. Most of these diagnoses occurred among gay or bisexual men (81%), with young black/African American and Hispanic/Latino gay and bisexual men disproportionately affected.

- All 50 states and the District of Columbia explicitly allow minors to consent to STI services without parental involvement, although 11 states require that a minor be of a certain age (generally 12 or 14) to do so. Thirty-two states explicitly allow minors to consent to HIV testing and treatment.

- In 2006–2010, 43% of sexually active females aged 15–19 reported having received counseling or testing for STIs or HIV in the last year.

Pregnancy

- In 2013, the adolescent pregnancy rate reached a record low of 43 pregnancies per 1,000 women aged 15–19, indicating that less than 5% of females in this age-group became pregnant. This rate represented a decline to just over one-third of the peak rate of 118 per 1,000, which occurred in 1990.

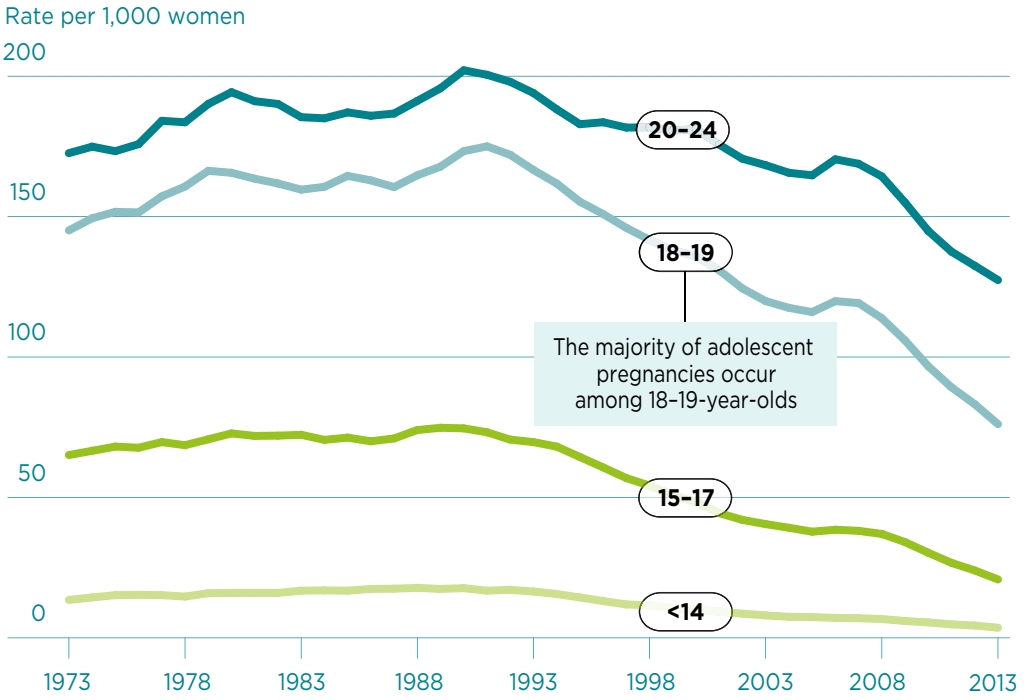
- In 2013, about 448,000 U.S. women aged 15–19 became pregnant. Seventy-two percent of adolescent pregnancies occurred among the oldest age-group (18–19-year-olds).

- Pregnancies are much less common among females younger than 15. In 2013, four pregnancies occurred per 1,000 females aged 14 or younger. In other words, about 0.4% of adolescents younger than 15 became pregnant that year.

- In 2013, non-Hispanic black and Hispanic adolescents had pregnancy rates of 75 and 61 per 1,000 women aged 15–19, respectively;

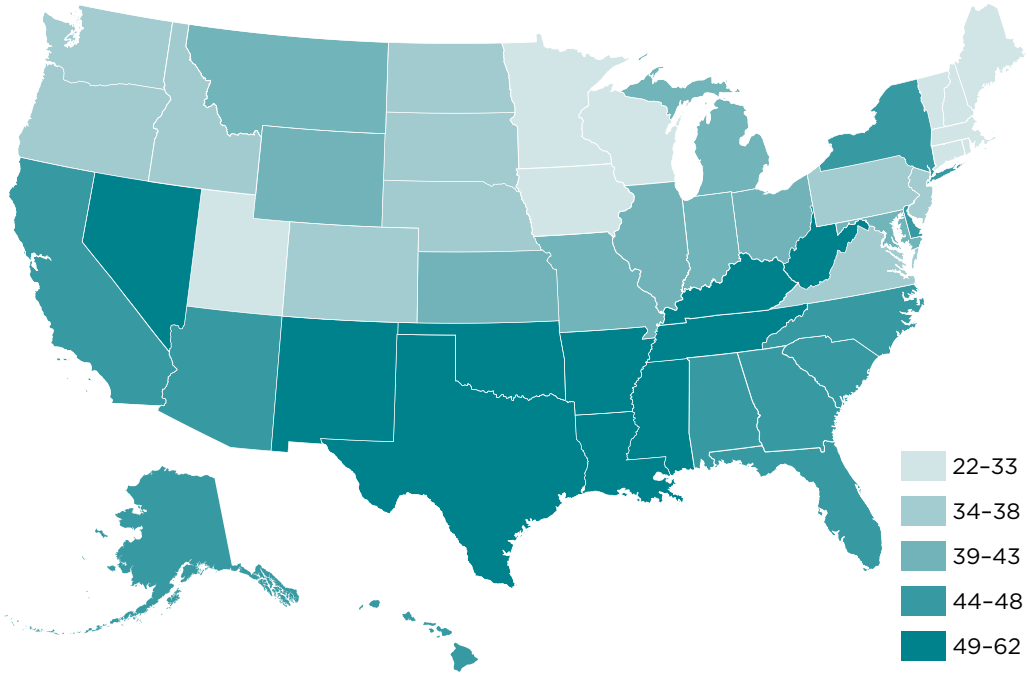
PREGNANCIES AMONG U.S. ADOLESCENTS AND YOUNG ADULTS

Rates of pregnancy among U.S. adolescents and young women reached historic lows in 2013.



Pregnancy rates among U.S. adolescents varied widely by state.

No. of pregnancies per 1,000 women aged 15–19



non-Hispanic white adolescents had a pregnancy rate of 30 per 1,000.

- There are substantial differences in adolescent pregnancy rates at the state level. In 2013, New Mexico had the highest adolescent pregnancy rate (62 per 1,000 women aged 15–19), followed by Arkansas, Mississippi, Oklahoma, Texas and Louisiana. The lowest rate was in New Hampshire (22 per 1,000), followed by Massachusetts, Minnesota, Utah, Vermont and Wisconsin.

- Despite recent declines, the U.S. adolescent pregnancy rate continues to be one of the highest among developed countries. At 43 per 1,000 women aged 15–19 in 2013, it is significantly higher than recent rates found in other developed countries, including France (25 per 1,000) and Sweden (29 per 1,000).

- Nationally, seventy-five percent of pregnancies among 15–19-year-olds were unintended (meaning either mistimed or unwanted) in 2008–2011, and adolescents account for about 15% of all unintended pregnancies annually. Services are needed to support pregnant or parenting young people, regardless of the planned or unintended nature of the pregnancy.

- Sixty-one percent of pregnancies among 15–19-year-olds in 2013 ended in births, while 24% ended in abortions and the rest in miscarriages.

- Unintended pregnancy rates among women younger than 20 were available for 31 states in 2013. The highest unintended pregnancy rates among these states were found in Arkansas (41 per 1,000 women younger than 20), Oklahoma and Tennessee. The states with the lowest unintended pregnancy rates were New Hampshire (16 per 1,000 women younger than 20), Minnesota, Massachusetts, Utah and Vermont.

- The proportion of pregnancies that were unintended among women younger than 20 also varied by state, ranging from 56% in New Mexico to 79% in Maryland and New Jersey.

Abortion

- Although federal funds are not permitted to cover abortion services in most cases, some states and private insurance plans do allow insurance coverage of abortions. However, some minors with coverage may not use insurance to access abortion services because they are not aware that these services are covered or because of confidentiality concerns.

- Women aged 15–19 had just under 110,000 abortions in 2013. About 11% of all abortions that year were obtained by adolescents.

- In 2013, there were 11 abortions for every 1,000 women aged 15–19. This is the lowest rate observed since abortion was legalized nationwide in 1973, and just one-fourth of the peak rate in 1988 (44).

- Between 1985 and 2007, the proportion of pregnancies among 15–19-year-old women (excluding miscarriages) that ended in abortion declined by one-third, from 46% to 31%. This proportion has remained relatively stable since 2007.

- The reasons women younger than 20 most frequently give for having an abortion are concerns about how having a baby would change their lives, inability to afford a baby now and not feeling mature enough to raise a child.

- As of July 2017, laws in 37 states required that a minor seeking an abortion involve one or both parents in the decision.

Childbearing

- In 2013, women aged 19 or younger had 276,000 births, representing 7% of all U.S. births.

- In 2013, there were 26 births per 1,000 women aged 15–19; this rate marked a more than 50% decline from the peak rate of 62 births per 1,000, reached in 1991. Evidence suggests that this decline is primarily attributable to increases in adolescents' contraceptive use; declines in sexual activity played a smaller role.

- Most births to adolescent mothers are first births. In 2013, 17% of births to women aged 15–19 were second or higher-order births.

- Nearly all births among women aged 15–19 occur outside of marriage—89% in 2013, up from 79% in 2000. Yet, over the last several decades, adolescents' share of nonmarital births among all age-groups has declined, from 52% in 1975 to 15% in 2013.

- Between 1991 and 2014, childbearing among young men declined 54%, from 25 births per 1,000 males aged 15–19 to 11 births per 1,000. Among men in this age-group in 2014, 27% reported that the pregnancy was intended.

- The rates of childbearing among young men vary considerably by race. In 2014, the rate among black males aged 15–19 (19 per 1,000) was almost twice that among their white counterparts (10 per 1,000).

SOURCE

These data are the most current available. References are available in the HTML version: https://www.guttmacher.org/fact-sheet/adolescents-sexual-and-reproductive-health-in-united-states

Good reproductive health policy starts with credible research

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CHAPTER 5

SEXUALITY

Understanding sexual development

"If someone wants to accept the consequences of sex, then it is their choice."

Girl, 15

Developing sexually is an expected and natural part of growing into adulthood. Most people have considered or experienced some form of sexual activity by the time they get out of their teens.

Research on adolescent sexuality concentrates on two areas—understanding healthy sexual development and investigating the risks associated with too-early or unsafe sexual activity.

Healthy sexual development involves more than sexual behavior. It is the combination of physical sexual maturation known as puberty, age-appropriate sexual behaviors, and the formation of a positive sexual identity and a sense of sexual well-being. During adolescence, teens strive to become comfortable with their changing bodies and to make healthy and safe decisions about what sexual activities, if any, they wish to engage in.

Expressions of sexual behavior differ among youth, and whether they engage in sexual activity depends on personal readiness, family standards, exposure to sexual abuse, peer pressure, religious values, internalized moral guidelines, and opportunity.

Motivations may include biological and hormonal urges, curiosity, and a desire for social acceptance. There is an added pressure today, especially

with girls, to appear sexy in all contexts throughout their lives—school, leisure time, the workplace, with friends, in the community, and even while participating in sports or exercise.

Decisions to engage in, or limit, sexual activity in ways that are consistent with personal principles and protective of health reflect an adolescent's maturity and self-acceptance.

Healthy sexuality for everyone

Research shows that providing accurate, objective information to adolescents supports healthy sexual development.

All young people need to learn to be comfortable with their sexuality. This task may be especially challenging for teens who are gay, lesbian, bisexual, or transgender. These young people often feel worlds apart from their heterosexual peers, family, or members of their community, and they need support from adults more than ever. Parents and other caregivers may have difficulty providing straightforward information and advice to youth whose sexual orientations or practices diverge from those of the majority of the surrounding society.

Adults may find it helpful to keep in mind that sexual and other stages of development may be different for sexual-minority teens.

Regardless of how young people come to be gay, lesbian or bisexual, it is essential that these youth be loved and cared for during this time of exploring their sexual identity. Perhaps because of the stigma they face, sexual-minority youth are at higher risk than their heterosexual peers for substance abuse, early onset of intercourse, unintended pregnancy, HIV and other STIs, verbal and physical violence, and suicide.

Parents and caregivers of adolescents with disabilities, too, may not know how to respond to their child's sexual maturation and the changes that come with puberty. Young people who live with physical, mental, or emotional disabilities will experience sexual development and must struggle with the same changes and choices of puberty that impact all human beings. This fact might be uncomfortable to some people, who may find it easier to view people with disabilities as "eternal children." In fact, youth with disabilities may need more guidance from adults, not less, because they may frequently feel isolated and quite different from their same-age peers.

Adolescents with disabilities may have some unique needs related to sex education. For example, children with developmental disabilities may learn at a slower rate than do their non-disabled peers; yet their physical maturation usually occurs at the same rate. As a result of the combination of normal physical maturation and slowed emotional and cognitive development, they may need sexual health information that helps build skills for appropriate language and behavior in public.

BRAIN BOX

Common folklore has often assumed that the "raging hormones" of adolescence are responsible for risky behaviors, including unsafe sex. The research, however, shows only small, direct effects of pubertal hormones (androgens and estrogens) on adolescent behavior. Rather, adolescent risk-taking appears to be due to a complex mix of genes, hormones, brain changes, and the environment. Hormones interact with changes occurring in the adolescent brain and in the adolescent's social world to affect adolescent behavior. In fact, psychological and social experiences have been shown to impact brain development and hormone levels, as well as the other way around.

SOURCE: Spear, L.P. (2008). The Psychobiology of Adolescence. In K.K. Kline (Ed.), *Authoritative Communities: The Scientific Case for Nurturing the Whole Child* (263–279). The Search Institute Series on Developmentally Attentive Community and Society (Vol. 5). New York: Springer.

"I believe it is better to have sex while you are young."

Boy, 15

Sexual development through the teen years

The experience of adolescence is a dynamic mixture of physical and cognitive change coupled with social

More media, earlier first sexual activity

In a 2004 longitudinal study funded by the National Institutes of Health, early adolescents who had heavier sexual media diets of movies, music, television, and magazines were twice as likely as those with lighter sexual media diets to have initiated sexual intercourse by the time they were 16.

SOURCE: *The Media as Powerful Teen Sex Educators*, Jane D. Brown, University of North Carolina, March 2007

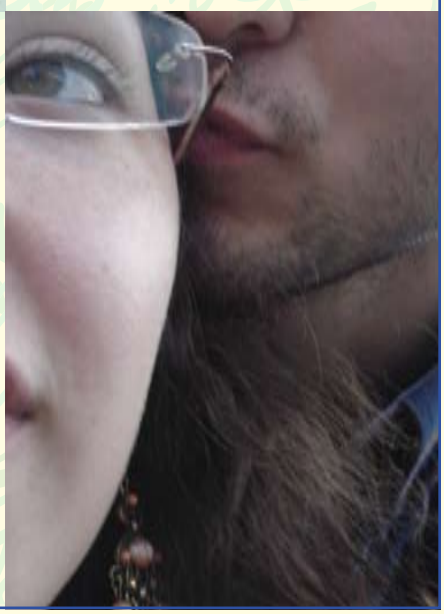
Will having sex make me **popular?**

How do I deal with **pressure** to have sex?

WHAT TEENS MIGHT ASK

How do I know I am ready for **sex?**

How will I know I'm in **love?**



Sexual identity versus gender identity

A person's **SEXUAL IDENTITY** is derived from emotional and sexual attraction to other people based on the other's gender. People may define their sexual identity as heterosexual, homosexual, gay, lesbian, or bisexual. **GENDER IDENTITY** describes a person's internal, deeply felt sense of being male, female, other, or in between. Everyone has a gender identity.

Sexual identity develops across a person's life span—different people might realize at different points in their lives that they are heterosexual, gay, lesbian, or bisexual. Adolescence is a period in which young people may still be uncertain of their sexual identity. Sexual behavior is not necessarily synonymous with sexual identity. Many adolescents—as well as many adults—may identify themselves as homosexual or bisexual without having had any sexual experience. Other people may have had sexual experiences with a person of the same sex but do not consider themselves to be gay, lesbian, or bisexual. This is particularly relevant during adolescence, a developmental stage marked by experimentation.

expectations, all of which impact sexual development. Hormone levels stimulate physical interest in sexual matters, and peer relationships shift toward more adult-style interactions. This section outlines the stages of sexual development.

Pre-adolescence (ages 6-10)

Sexual development begins well before adolescence. Hormonal changes—an elevation of androgens, estradiol, thyrotropin, and cortisol in the adrenal glands—start to emerge between the ages of 6 and 8.

The visible signs of puberty begin to show up between the ages of 9 and 12 for most children. Girls may grow breast buds and pubic and underarm hair as early as 8 or 9. In boys the growth of the penis and testicles usually begins between ages 10 and 11 but can start to occur at the age of 9.

Before age 10, children usually are not sexually active or preoccupied with sexual thoughts, but they are curious and may start to collect information and myths about sex from friends, schoolmates, and family members. Part of their interaction with peers may involve jokes and sex talk.

At this age, children become more self-conscious about their emerging sexual feelings and their bodies, and they are often reluctant to undress in front of others, even a parent of the same gender. Boys and girls tend to play with friends of the same gender and may explore sexuality with them, perhaps through touching. This does not necessarily relate to a child's sexual identity and is more about inquisitiveness than sexual preference.

Early adolescence (ages 11-13)

The passage into adolescence typically begins with the onset of menarche (menstruation) in girls and semenarche (ejaculation) in boys, both of which occur, on average, around age 12 or 13. For girls, menstruation starts approximately two years after breast buds—the first visible sign of puberty—develop, although it can happen anytime between ages 9 and 16.

Hormonal changes generated by the adrenals and testes in boys and the adrenals and ovaries in girls affect brain development. The impact of hormones on brain chemistry results in a larger amygdala in boys (the part of the brain governing emotions and instincts) and a larger hippocampal area in girls (the section of the brain dealing with memory and spatial navigation). The adrenals can also pump some testosterone into girls and estrogen into boys, with 80 percent of boys experiencing temporary breast development during early adolescence.

As physical maturation continues, early adolescents may become alternately fascinated with and chagrined by their changing bodies, and often compare themselves to the development they notice in their peers. Sexual fantasy and masturbation episodes increase between the ages of 10 and 13. As far as social interactions go, many tend to be nonsexual—text messaging, phone calls, email—but by the age of 12 or 13, some young people may pair off and begin dating and experimenting with kissing, touching, and other physical contact, such as oral sex.

The vast majority of young adolescents are not prepared emotionally or physically for oral sex and sexual intercourse. If adolescents this young do have sex, they are highly vulnerable for sexual and emotional abuse, STIs, HIV, and early pregnancy.

Median age at first marriage, 2005

SOURCE: U.S. Census Bureau (2006). *Table: Estimated median age at first marriage, by sex, 1890 to the present, from Current Population Survey, March and Annual Social and Economic Supplements, 2005 and earlier.* http://www.census.gov/population/socdemo/hh-fam/ms2.pdf

High school students who have had sexual intercourse

	1991	1995	2001	2007
Males	57%	54%	48%	50%
Females	51%	52%	43%	46%

SOURCE: Centers for Disease Control and Prevention (2008). *Youth risk behavior surveillance--United States 2007.* Surveillance Summaries, May 9, 2008. Morbidity & Mortality Weekly Report, http:apps.nccd.cdc.gov/yrbss

% ever had sexual intercourse by grade level, 2007

	9th grade	10th grade	11th grade	12th grade
Males	38.1%	45.6%	57.3%	62.8%
Females	27.4%	41.9%	53.6%	66.2%

SOURCE: Centers for Disease Control and Prevention (2007). *Youth risk behavior surveillance—United States, 2007.* Retrieved October 1, 2009 from http://apps.nccd.gov/yrbss

Middle adolescence (ages 14-16)

Testosterone in boys surges between the ages of 14 and 16, increasing muscle mass and setting off a growth spurt. Testosterone levels in boys are usually eight times greater than in girls, and this hormone is the strongest predictor of sexual drive, frequency of sexual thoughts, and behavior.

Middle adolescents exhibit an increased interest in romantic and sexual relationships. The sexual behavior during this time tends to be exploring, with strong erotic interest. Sexual activity at this age varies widely and includes the choice not to have sex.

At this age, both genders experience a high level of sexual energy, although boys may have a stronger sex drive due to higher testosterone levels. Sex drive, commonly known as libido, refers to sexual desire or an interest in engaging in sex with a partner.

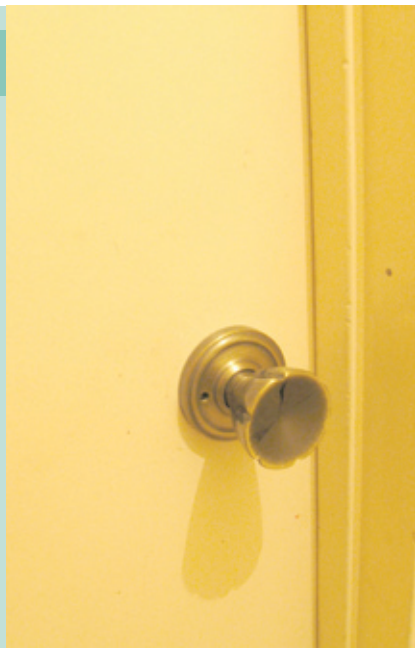
On an abstract level, adolescents ages 14 to 16 understand the consequences of unprotected sex and teen parenthood, if properly taught, but cognitively they may lack the skills to integrate this knowledge into everyday situations or consistently to act responsibly in the heat of the moment.

Before the age of 17, many adolescents have willingly experienced sexual intercourse. Teens who have early sexual intercourse report strong peer pressure as a reason behind their decision. Some adolescents are just curious about sex and want to experience it.

No matter what the motivation, many teens say they regret having had sex as early as they did, even if the activity was consensual. Research published in the journal *Pediatrics* noted that up to one-half of the sexually experienced teenagers in the 2007 study said they felt "used," guilty, or regretful after having sex. The findings indicated that girls were twice as likely as boys to respond that they "felt bad about themselves" after having sex, and three times more likely to say they felt "used."

Masturbation

Masturbation is sexual self-stimulation, usually achieved by touching, stroking, or massaging the male or female genitals until this triggers an orgasm. Masturbation is very ordinary—even young children have been known to engage in this behavior. As the bodies of children mature, powerful sexual feelings begin to develop, and masturbation helps release sexual tension. For adolescents, masturbation is a common way to explore their erotic potential, and this behavior can continue throughout adult life.



Sexual fantasies

Sexual fantasies are usually associated with masturbation, but the two can occur independently. Sexual daydreams and fantasies are common—most people have them, not just teenagers and not just boys.

Fantasies often differ between the sexes. Sexual aggression and dominance are recurring themes in young male fantasies and usually contain very specific and graphic sexual behaviors but little emotional involvement. For adolescent females, sexual fantasies often involve relating to others, and they are more likely to involve sexual activities with which the girl is already familiar. A teenage girl's fantasies also are typically about someone they know—a boyfriend, TV or music stars, friends, casual acquaintances.

The important thing to tell teenagers about sexual fantasies is that thoughts, in and of themselves, are not sick, weird, or wrong. They are just that: thoughts. Making a teenager feel guilty or ashamed or suggesting that their dreams reveal psychological problems can lead to their feeling at odds with their sexuality. It can also make them more vulnerable to becoming obsessed about a particular sexual fantasy.

Late adolescence (ages 17-19)

By the time an adolescent is 17, sexual maturation is typically complete, although late bloomers are not uncommon. Sexual behavior during this time may be more expressive, since cognitive development in older adolescents has progressed to the point where they have somewhat greater impulse control and are capable of intimate and sharing relationships.

Intimate relationships usually involve more than sexual interest. Emotionally, falling in love is powerful and all-consuming, and it involves a greater portion of the adolescent brain.

Brain scientists at University College London scanned the brains of young lovers while they were thinking about their boyfriends and girlfriends and discovered that four separate areas of the brain became very active. This affirms the notion that falling in love is an all-encompassing emotion that engages nearly every part of the mind and body.

"I hear my friends talking about their sex lives, but I don't really care because I am not having sex, so getting information about sex doesn't matter to me."

Girl, 14

Romantic versus sexual relationships

Libido is distinct from romantic interest, which may or may not be sexual in nature. Romantic interest usually emphasizes emotions—love, intimacy, compassion, appreciation—rather than the pursuit of physical pleasure driven by libido.

We may see romance as a feminine tendency, but recent studies indicate that teenage boys are as romantic as girls—a finding that runs counter to the stereotype of adolescent males as "players." Peggy Giordano, a sociology professor at Bowling Green University, conducted interviews with a random sample of 1,316 boys and girls drawn from the seventh, ninth, and 11th grades and found that boys were at least as emotionally invested in their romantic relationships as their partners were.

Both boys and girls in the study agreed, however, that girls in heterosexual romantic relationships hold the power in the decision of when to have sexual intercourse.

What works at what age

EARLY TEEN YEARS (AGES 11-14)

Young teens tend to be concrete and short-term in their thinking, and often do not consider long-term consequences when making decisions. This is a good time to talk about delaying sexual activity but a bad time to hammer home long-term benefits or consequences.

MIDDLE TEEN YEARS (15-17)

Risk peaks during these years, and teens of this age question limits and authority. Scare tactics do not work at this age; rather, emphasize the influence of peers. Talking about how to handle peer pressure and changing social circles (about being associated with certain cliques or groups, and about how hanging around with older and younger teens affects sexual behavior and risk-taking) works best at this age.

LATE TEEN YEARS (17 AND OLDER)

Older adolescents are entering new social situations such as work and college, so talking about sexual behavior in the context of wider relationships can be helpful. For example, one might talk about how sexual behavior helps form a personal identity or define young people, both in how they may see themselves and how they are viewed within an intimate relationship, in their community, or in various peer groups.

Ways teens protect their sexual health

Delaying sexual intercourse is associated with many positive outcomes: less regret about the timing of one's first sexual experience, fewer sexual partners, and a decreased likelihood of being involved in coercive sexual relationships.

Waiting to have sex until one is in a respectful, loving relationship protects a young person's emotional well-being, too. Today's teenagers are postponing their first sexual activity, as compared to young people from prior decades. The proportion of teenagers who reported having sexual intercourse rose steadily through the 1970s and '80s, fueling a sharp rise in teen pregnancy. The trend reversed around 1991 as a result of AIDS, changing sexual mores, and other factors. In 2007 nearly half (48 percent) of high school students ages 15 to 19 reported to the CDC they had had sexual intercourse. This was a minor increase since 2005, but the good news is that teens are initiating sex at older ages today than their counterparts in the 1990s. They also are reporting having fewer sexual partners than high school students in 1991 had.

Sex with multiple partners is not widespread among teenagers. Only 15 percent of adolescents have had sexual intercourse with four or more people during their lives. Teenagers with multiple sex partners are more likely to contract an STI, compared with teenagers who have only one sex partner.

Among those who are sexually active, the majority use contraception. The preferred method of contraception is condoms, although condom use in teens showed a slight drop between 2005 and 2007, from 63 percent to 61 percent who reported having used a condom the last time they had sex.

The younger a teen is at first sex, the less likely is the use of a condom or another form of contraception. Condoms protect teens from sexually transmitted infections and pregnancies when they are used correctly and consistently. Other hormonal forms of contraception for girls like the oral contraceptive pills, the patch, the

Talking to teens about sex

For parents and teens both, talking about sex can be uncomfortable. Teens do not want to see their parents in a sexual light, and parents often do not want to see their children that way, either. That said, teens still report that their parents are the greatest influences on their sexual behavior, and research backs them up. Guidelines for successful teen-parent conversation about sex include the following:

- Engage children in open, honest discussions regarding appropriate dating behavior, emotional and sexual intimacy, sexual identity, and emotional commitment.
- Discuss responsibilities regarding commitment and intimacy in romantic relationships.
- Discuss responsibilities regarding avoiding pregnancy, STIs, and HIV.
- Teach teens not to exploit other people socially, emotionally, or sexually. This is impossible to teach if it is not also modeled. Similarly, teach teens how to recognize abusive and exploitive relationships.
- Set appropriate limits regarding dating, such as the age at which dating will be allowed, curfews, and the age of person your child may date.
- Since teens may be embarrassed to talk with their parents about sex and relationships, try to provide access to other trusted adults (church members, counselors, relatives, etc.)
- Be open to questions and values expressed by the teen.

SOURCE: Beeler, N., Patrick, B., Pedon, S. Normal child sexual development and promoting healthy sexual development. *The Institute for Human Services for the Pennsylvania Child Welfare Training Program 203: Sexuality of Children: Healthy Sexual Behaviors and Behaviors Which Cause Concern.* Handout 3-1. Available at: http://www.pacwcbt.pitt.edu/Curriculum/203%20Sexuality%20of%20Children%20Healthy%20Sexual%20Behaviors%20and/Handouts/HO%203-1.pdf

"It's all right for a person to have sex when they are ready mentally, physically, and emotionally. It is not all right for someone younger than me to have sex."

Girl, 15

injection (Depo-Provera) or the vaginal ring provide higher levels of protection from unintended pregnancies but no protection from sexually transmitted infections (an excellent chart comparing contraceptive methods can be found at www.seasonique.com). When teens become sexually active, ideally, the male partner would use a condom and the female would use a hormonal method of contraception to get double protection. Fewer than one quarter of teens, however, currently do this.

When unprotected sex has already happened, emergency contraception can be used by girls to prevent pregnancy, especially if it is obtained within 72 hours of having sex. Known as Plan B, this concentrated dose of the hormone found in birth control pills is available over the counter in pharmacies for young women ages 17 or older. It is available for younger girls by prescription.

Risky consequences

Early and unsafe sexual activity can result in unintended teenage pregnancy and sexually transmitted infections (STIs).

Research shows that giving birth before age 18 limits the future for both the girl and her baby. Girls who become mothers early are less likely to complete high school and more likely to face poverty as an adult than other teens. Teenage girls who are pregnant often do not get sufficient prenatal care, and are more prone to high blood pressure and preeclampsia, a dangerous medical condition, than pregnant women in their 20s and 30s. Teens also are at greater risk for postpartum depression and having low–birth-weight babies (under five pounds). Low–birth- weight babies can have many medical problems, such as breathing difficulties, as well as developmental or growth delays. In addition, children of teen mothers can experience other health problems and higher rates of abuse or neglect; they are also likely to live in poverty and to receive inadequate health care

compared to children born to mothers aged 18 and over.

For more than a decade, rates of teen pregnancy and birth in the U.S. were down from an all-time peak of 61.8 births per thousand in 1991. This decline has leveled off, and the teen birth rate rose slightly between 2005 and 2007. This translates to about 20,000 more births to teenagers in 2006 compared to the year before. Births have risen slightly among women between the ages of 20 and 24 as well.

Sexually transmitted infections are also a major concern. Sex without condoms puts young people at risk for STIs, including HIV infection. Adolescent cases account for half of all STIs. The latest Centers for Disease Control and Prevention (CDC) statistics tell us that more than 3 million teenage girls in America have an STI. In a national study in 2003, teens aged 14 to 19 were tested for four infections: Human Papillomavirus (HPV), chlamydia, trichomoniasis, and herpes simplex virus. While one-quarter of the girls overall had at least one of these infections, nearly half of the African-American girls were infected.

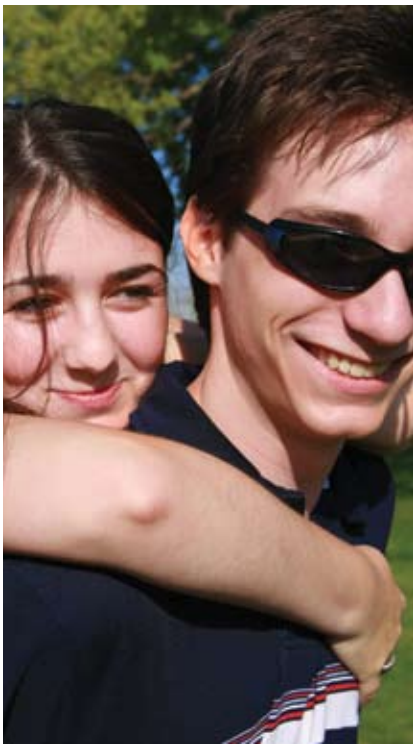
The most common STI found in teen girls ages 14 to 19 is HPV, which can cause genital warts in women and men and is usually not a serious condition. Some HPV viruses can lead to cervical cancer later in life. Fortunately, a vaccine targeting HPV recently became available, and national health organizations recommend the vaccine for 11- and 12-year-old girls, and catch-up shots for females ages 13 to 26. Vaccines for boys are being readied but they are not yet recommended.

"I get my information about sex from my friends and magazines." *Girl, 16*

Chlamydia, another very common infection, can cause pelvic inflammatory disease and infertility. This infection is caused by bacteria and can be easily treated if it is detected. However, many youth with the infection do not have any symptoms and are unaware that they have it. In pregnancy, chlamydia and HIV can infect the growing baby. If these infections are transmitted to babies, they can cause low birth weight, eye

Keeping a cool head on a hot topic

- **Get your zen on**
  When young people bring up sex, try to be calm and reasonable, no matter what the situation. Anger, surprise, and embarrassment are not proper responses, even if your teen is trying to provoke you.
- **Tone is everything**
  Teens may have fears that their sexual thoughts and urges are unnatural or make them freaks. Reassure teens that sexual thoughts and expressions are normal, and it is OK to have these feelings without acting on them.
- **Papa, don't preach**
  Phrases like "But you're only 16!" are not helpful. Teens are looking for someone to listen and to give accurate information about sex, not deliver sermons or make them feel guilty or ashamed.



infection, pneumonia, blood infection, brain damage, lack of coordination in body movements, blindness, deafness, acute hepatitis, meningitis, liver disease, cirrhosis, or stillbirth.

What adults can do

Young people care about what their parents and other important adults in their lives think. When teens—both boys and girls—believe their parents want them to delay having sex, they are more likely to defer first intercourse. When there is a warm relationship, adolescents are even more apt to behave the way their parents wish them to, which often means postponing sexual activity.

Parents and caring adults can foster closeness with their teens and increase the odds of their avoiding risky sexual behavior by establishing an environment in which young people can feel comfortable and respected talking or asking about sexual matters. Clear rules about dating, curfews, and whether adolescents may be alone together in the teen's bedroom are also important but should be negotiated so that they are perceived as fair by the teen.

Parents and those who work with adolescents need to educate themselves about the various factors affecting sexual development. Physical changes make teens appear ready for sexual activities they might not be prepared for emotionally and cognitively. Poor communication about sex, limited or inaccurate information, media influences, and negative attitudes also can impact a young person's sexual health and identity.

An essential way an adult can influence sexual behavior is by being a source of accurate information. Teens need straight talk about how to refuse to have sex if they do not want to have it. They also need to be shown the right way to use condoms. Adult involvement in this regard is more important than ever: 47 percent of teens say their parents are the most important influence in their decisions about sex, and younger teens view parents as even more important. If teenagers cannot get information from their parents or caring adults, they typically will rely on friends and the media, especially the Internet, to answer questions about sexual health.

Sometimes adults wonder how much information is too much. Researchers have found no evidence that either talking about contraception or making contraception available to teens hastens the onset of first sex.

Sex education and social influences

According to the 2002 National Survey of Family Growth (NSFG), only 2 percent of adolescents say they are getting essential information about contraception, sexual safety, and other matters. Research actually suggests that young people who are knowledgeable about sexuality and reproductive health are less likely to engage in early sexual activity or unprotected sex.

Schools do not necessarily provide complete or accurate information to educate adolescents about sexual health and sexuality. Abstinence-only sex education curricula and programs have been widespread in American schools. A recent evaluation of several abstinence-only sex education curricula, which teach young people to postpone sexual intercourse until marriage and include no information about contraception, has shown them to be ineffective. The researchers from Mathematica, Inc. who conducted the evaluation found that the children who took part in sexual-abstinence education classes engaged in sexual intercourse for the first time at the same age as children who did not receive these classes.

The participating students also did not gain more awareness of the dangers of unprotected sex than did their nonparticipating counterparts.

Adults can expand on what is taught in the classroom by welcoming discussions about sexual behavior and risks, relationships, emotions, and sexual urges. This kind of respectful, in-depth communication can positively affect a young person's sexual development.

Sexuality is a vital part of growing up

During adolescence, teens learn how to deal with sexual feelings, experience sexual fantasies, and perhaps enjoy romantic relationships. They may choose to delay sexual activity, or not have sex at all, which falls within the spectrum of normal adolescent behavior.

These choices are all part of sexuality. Healthy sexual development is not simply a matter of sex but involves a young person's ability to manage intimate and reproductive behavior responsibly and without guilt, fear, or shame.

American teenagers grow up in a culture in which sex informs everything from the type of clothes they wear and the music they listen to, to the images and messages they continually absorb through the media.

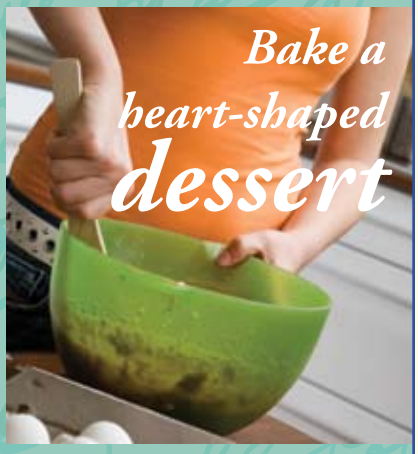
Helping adolescents separate truth from hype and recognize all aspects of sexual development encourages them to make informed and healthy decisions about sexual matters.

10 ways TEENS can express LOVE without SEX

Read to
each other

Contribute or volunteer for a cause he or she cares about

Offer to do a chore



Program their I-Pod or make a CD with songs that are special to both

Go through the car wash together

Rent a romantic movie

CDC Vitalsigns™
April 2015

Preventing Teen Pregnancy

A key role for health care providers

Teen childbearing can carry health, economic, and social costs for mothers and their children. Teen births in the US have declined, but still more than 273,000 infants were born to teens ages 15 to 19 in 2013. The good news is that more teens are waiting to have sex, and for sexually active teens, nearly 90% used birth control the last time they had sex. However, teens most often use condoms and birth control pills, which are less effective at preventing pregnancy when not used consistently and correctly. Intrauterine devices (IUDs) and implants, known as Long-Acting Reversible Contraception (LARC), are the most effective types of birth control for teens. LARC is safe to use, does not require taking a pill each day or doing something each time before having sex, and can prevent pregnancy for 3 to 10 years, depending on the method. Less than 1% of LARC users would become pregnant during the first year of use.

43%

About 43% of teens ages 15 to 19 have ever had sex.

4 in 5

More than 4 in 5 (86%) used birth control the last time they had sex.

5%

Less than 5% of teens on birth control used the most effective types.

Doctors, nurses, and other health care providers can:

- ◇ Encourage teens not to have sex.
- ◇ Recognize LARC as a safe and effective choice of birth control for teens.
- ◇ Offer a broad range of birth control options to teens, including LARC, and discuss the pros and cons of each.
- ◇ Seek training in LARC insertion and removal, have supplies of LARC available, and explore funding options to cover costs.
- ◇ Remind teens that LARC by itself does not protect against sexually transmitted diseases and that condoms should also be used every time they have sex.

→ See page 4

Want to learn more? Visit

www.cdc.gov/vitalsigns

National Center for Chronic Disease Prevention and Health Promotion
Division of Reproductive Health

Problem

Few teens (ages 15 to 19) on birth control use the most effective types.

Use of Long-Acting Reversible Contraception (LARC) is low.

◇ Less than 5% of teens on birth control use LARC.

◇ Most teens use birth control pills and condoms, methods which are less effective at preventing pregnancy when not used properly.

◇ There are several barriers for teens who might consider LARC:

- Many teens know very little about LARC.
- Some teens mistakenly think they cannot use LARC because of their age.

◇ Clinics also report barriers:

- High upfront costs for supplies.
- Providers may lack awareness about the safety and effectiveness of LARC for teens.
- Providers may lack training on insertion and removal.

Providers can take steps to increase awareness and availability of LARC.

◇ Title X is a federal grant program supporting confidential family planning and related preventive services with priority for low-income clients and teens.*

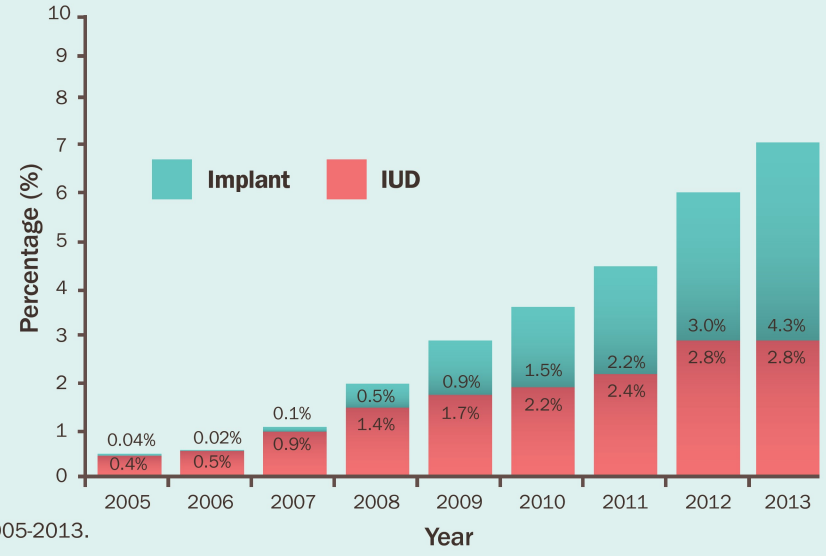
- Title X-funded centers have used the latest clinical guidelines on LARC, trained providers on LARC insertion and removal, and secured low- or no-cost options for birth control.
- Teen use of LARC has increased from less than 1% in 2005 to 7% in 2013.

◇ Other state and local programs have made similar efforts.

- More teens and young women chose LARC, resulting in fewer unplanned pregnancies.

*For more information on Title X, visit: www.hhs.gov/opa/title-x-family-planning/

LARC use among teens ages 15-19 seeking birth control at Title X-funded centers



SOURCE: Title X Family Planning Annual Reports, United States, 2005-2013.

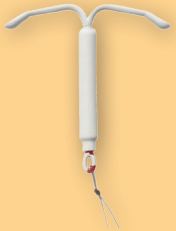
HOW WELL DOES BIRTH CONTROL WORK?

What is your chance of getting pregnant?

Really, really well

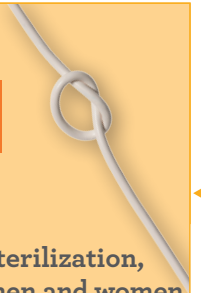
The Implant (Nexplanon)

IUD (Skyla)



IUD (Mirena)

IUD (ParaGard)

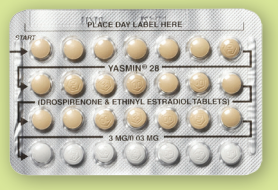


Sterilization, for men and women

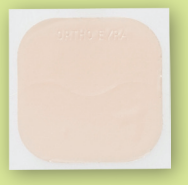
Works, hassle-free, for up to... 3 years | 3 years | 5 years | 12 years | Forever

Less than 1 in 100 women

O.K.



The Pill



The Patch

The Ring

The Shot (Depo-Provera)

For it to work best, use it... Every. Single. Day. | Every week | Every month | Every 3 months

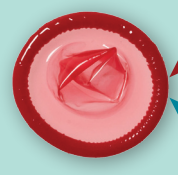
6-9 in 100 women, depending on method

Not as well

Pulling Out

Fertility Awareness

Diaphragm



Condoms, for men or women

For each of these methods to work, you or your partner have to use it every single time you have sex.

12-24 in 100 women, depending on method

FYI, without birth control, over 90 in 100 young women get pregnant in a year.

BEDSIDER
Bedsider.org

Bixby Center for Global Reproductive Health

WHAT'S THE RISK?

Risks of Using Birth Control

IMPLANT

RISKS

Infection/ Complication at Insertion or Removal
0.1 women/1,000
0.1

Accidental Pregnancy
0.5
0.5 women/1,000

IUD

RISKS

Expulsion
50 women/1,000 during the first year of use
50

Pelvic Inflammatory Disease
5 women/1,000 within the first 90 days after insertion
5

Perforation
0.5 women/1,000
0.5

Accidental Pregnancy
8
8 women/1,000

DEPO

RISKS

Reversible Bone Loss
with quick recovery when stopped, and no increased risk of broken bones

Accidental Pregnancy
60
60 women/1,000

THE PILL

RISKS

Blood Clots
1 women/1,000
1

Stroke
0.2 women/1,000
0.2

Heart Attack
0.1 women/1,000
0.1

Accidental Pregnancy
90
90 women/1,000

If you're like most people, you probably took a shower this morning, drove to work or school, or took an aspirin.

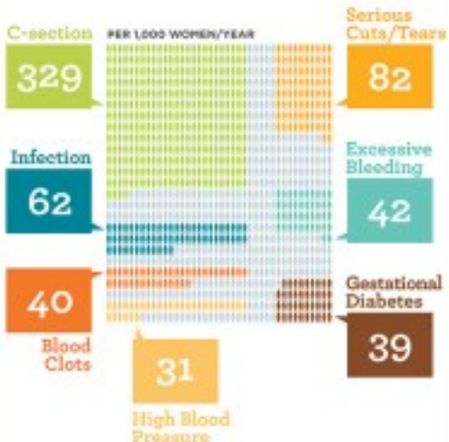
Like many other things in life, using birth control sometimes involves risk.

But, compared to other risks we face on a daily basis, the chance of experiencing a serious health complication from using a contraceptive is low.

Risks of NOT Using Birth Control

Without birth control, 90 in 100 young women will get pregnant each year.

And during pregnancy and birth, half will have a medical problem:



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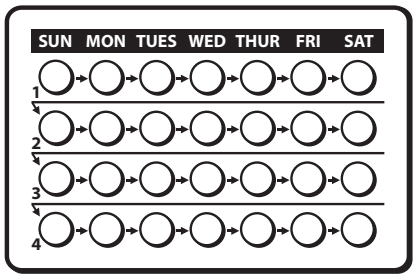
Recommended Actions After Late or Missed Combined Oral Contraceptives

If one hormonal pill is late: (<24 hours since a pill should have been taken)

If one hormonal pill has been missed: (24 to <48 hours since a pill should have been taken)

- Take the late or missed pill as soon as possible.
- Continue taking the remaining pills at the usual time (even if it means taking two pills on the same day).
- No additional contraceptive protection is needed.
- Emergency contraception is not usually needed but can be considered if hormonal pills were missed earlier in the cycle or in the last week of the previous cycle.



If two or more consecutive hormonal pills have been missed: (≥48 hours since a pill should have been taken)

- Take the most recent missed pill as soon as possible (any other missed pills should be discarded).
- Continue taking the remaining pills at the usual time (even if it means taking two pills on the same day).
- Use back-up contraception (e.g., condoms) or avoid sexual intercourse until hormonal pills have been taken for 7 consecutive days.
- If pills were missed in the last week of hormonal pills (e.g., days 15-21 for 28-day pill packs):
  - Omit the hormone-free interval by finishing the hormonal pills in the current pack and starting a new pack the next day.
  - If unable to start a new pack immediately, use back-up contraception (e.g., condoms) or avoid sexual intercourse until hormonal pills from a new pack have been taken for 7 consecutive days.
- Emergency contraception should be considered if hormonal pills were missed during the first week and unprotected sexual intercourse occurred in the previous 5 days.
- Emergency contraception may also be considered at other times as appropriate.

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

Source: For the full recommendations, see the US Selected Practice Recommendations for Contraceptive Use, 2013 (http://www.cdc.gov/mmwr/pdf/rr/rr6205.pdf).

Recommended Actions After Delayed Application or Detachment With Combined Hormonal Patch

Delayed application or detachment* for <48 hours since a patch should have been applied or reattached

- Apply a new patch as soon as possible. (If detachment occurred <24 hours since the patch was applied, try to reapply the patch or replace with a new patch.)
- Keep the same patch change day.
- No additional contraceptive protection is needed.
- Emergency contraception is not usually needed but can be considered if delayed application or detachment occurred earlier in the cycle or in the last week of the previous cycle.

**If detachment takes place but the woman is unsure when detachment occurred, consider the patch to have been detached for ≥48 hours since a patch should have been applied or reattached.*

Delayed application or detachment* for ≥48 hours since a patch should have been applied or reattached

- Apply a new patch as soon as possible.
- Keep the same patch change day.
- Use back-up contraception (e.g., condoms) or avoid sexual intercourse until a patch has been worn for 7 consecutive days.
- If the delayed application or detachment occurred in the third patch week:
  - Omit the hormone-free week by finishing the third week of patch use (keeping the same patch change day) and starting a new patch immediately.
  - If unable to start a new patch immediately, use back-up contraception (e.g., condoms) or avoid sexual intercourse until a new patch has been worn for 7 consecutive days.
- Emergency contraception should be considered if the delayed application or detachment occurred within the first week of patch use and unprotected sexual intercourse occurred in the previous 5 days.
- Emergency contraception may also be considered at other times as appropriate.

Recommended Actions After Delayed Insertion or Reinsertion With Combined Vaginal Ring

Delayed insertion of a new ring or delayed reinsertion* of a current ring for <48 hours since a ring should have been inserted

- Insert ring as soon as possible.
- Keep the ring in until the scheduled ring removal day.
- No additional contraceptive protection is needed.
- Emergency contraception is not usually needed but can be considered if delayed insertion or reinsertion occurred earlier in the cycle or in the last week of the previous cycle.

**If removal takes place but the woman is unsure of how long the ring has been removed, consider the ring to have been removed for ≥48 hours since a ring should have been inserted or reinserted.*

Delayed insertion of a new ring or delayed reinsertion* for ≥48 hours since a ring should have been inserted

- Insert ring as soon as possible.
- Keep the ring in until the scheduled ring removal day.
- Use back-up contraception (e.g., condoms) or avoid sexual intercourse until a ring has been worn for 7 consecutive days.
- If the ring removal occurred in the third week of ring use:
  - Omit the hormone-free week by finishing the third week of ring use and starting a new ring immediately.
  - If unable to start a new ring immediately, use back-up contraception (e.g., condoms) or avoid sexual intercourse until a new ring has been worn for 7 consecutive days.
- Emergency contraception should be considered if the delayed insertion or reinsertion occurred within the first week of ring use and unprotected sexual intercourse occurred in the previous 5 days.
- Emergency contraception may also be considered at other times as appropriate.

Source: For the full recommendations, see the US Selected Practice Recommendations for Contraceptive Use, 2013 (http://www.cdc.gov/mmwr/pdf/rr/rr6205.pdf).

How to Be Reasonably Certain That a Woman is Not Pregnant

A health-care provider can be reasonably certain that a woman is not pregnant if she has no symptoms or signs of pregnancy and meets any one of the following criteria:

- is ≤7 days after the start of normal menses
- has not had sexual intercourse since the start of last normal menses
- has been correctly and consistently using a reliable method of contraception
- is ≤7 days after spontaneous or induced abortion
- is within 4 weeks postpartum
- is fully or nearly fully breastfeeding (exclusively breastfeeding or the vast majority [≥85%] of feeds are breastfeeds), amenorrheic, and <6 months postpartum

In situations in which the health-care provider is uncertain whether the woman might be pregnant, the benefits of starting the implant, depot medroxyprogesterone acetate (DMPA), combined hormonal contraceptives and progestin-only pills likely exceed any risk; therefore, starting the method should be considered at any time, with a follow-up pregnancy test in 2-4 weeks. For IUD insertion, in situations in which the health-care provider is not reasonably certain that the woman is not pregnant, the woman should be provided with another contraceptive method to use until the health-care provider can be reasonably certain that she is not pregnant and can insert the IUD.

When to Start Using Specific Contraceptive Methods

Contraceptive method	**When to start** (if the provider is reasonably certain that the woman is not pregnant)	**Additional contraception** (i.e., back up) needed	**Examinations or tests needed before initiation**[1]
Copper-containing IUD	Anytime	Not needed	Bimanual examination and cervical inspection[2]
Levonorgestrel-releasing IUD	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	Bimanual examination and cervical inspection[2]
Implant	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	None
Injectable	Anytime	If >7 days after menses started, use back-up method or abstain for 7 days.	None
Combined hormonal contraceptive	Anytime	If >5 days after menses started, use back-up method or abstain for 7 days.	Blood pressure measurement
Progestin-only pill	Anytime	If >5 days after menses started, use back-up method or abstain for 2 days.	None

Abbreviations: BMI = body mass index; IUD = intrauterine device; STD = sexually transmitted disease

[1]Weight (BMI) measurement is not needed to determine medical eligibility for any methods of contraception because all methods can be used or generally can be used among obese women. However, measuring weight and calculating BMI at baseline might be helpful for monitoring any changes and counseling women who might be concerned about weight change perceived to be associated with their contraceptive method.

[2]Most women do not require additional STD screening at the time of IUD insertion if they have already been screened according to CDC's STD Treatment Guidelines (available at http://www.cdc.gov/std/treatment). If a woman has not been screened according to guidelines, screening can be performed at the time of IUD insertion and insertion should not be delayed. Women with purulent cervicitis, current chlamydial infection, or gonorrhea should not undergo IUD insertion. Women who have a very high individual likelihood of STD exposure (e.g., those with a currently infected partner) generally should not undergo IUD insertion. For these women, IUD insertion should be delayed until appropriate testing and treatment occurs.

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

Source: For the full recommendations, see the US Selected Practice Recommendations for Contraceptive Use, 2013 (http://www.cdc.gov/mmwr/pdf/rr/rr6205.pdf).

Routine Follow-Up After Contraceptive Initiation*

Action	Contraceptive Method				
	LNG-IUD or Cu-IUD	Implant	Injectable	CHC	POP
General Follow-Up					
Advise a woman to return at any time to discuss side effects or other problems or if they want to change the method. Advise women using IUDs, implants, or injectables when the IUD or implant needs to be removed or when reinjection is needed. No routine follow-up visit is required.	X	X	X	X	X
Other Routine Visits					
Assess the woman's satisfaction with her current method and whether she has any concerns about method use.	X	X	X	X	X
Assess any changes in health status, including medications, that would change the method's appropriateness for safe and effective continued use based on the U.S. MEC (i.e., category 3 and 4 conditions and characteristics).	X	X	X	X	X
Consider performing an examination to check for the presence of IUD strings.	X	–	–	–	–
Consider assessing weight changes and counseling women who are concerned about weight change perceived to be associated with their contraceptive method.	X	X	X	X	X
Measure blood pressure.	–	–	–	X	–

Abbreviations: CHC = combined hormonal contraceptive; Cu-IUD = copper-containing intrauterine device; IUD = intrauterine device; LNG-IUD = levonorgestrel-releasing intrauterine device; POP = progestin-only pills; U.S. MEC = *U.S. Medical Eligibility Criteria for Contraceptive Use,* 2010.

*These recommendations address when routine follow-up is recommended for safe and effective continued use of contraception for healthy women. The recommendations refer to general situations and might vary for different users and different situations. Specific populations that might benefit from more frequent follow-up visits include adolescents, those with certain medical conditions or characteristics, and those with multiple medical conditions.
Source: For the full recommendations, see the US Selected Practice Recommendations for Contraceptive Use, 2013 (http://www.cdc.gov/mmwr/pdf/rr/rr6205.pdf).

ABSTINENCE

Choosing not to have partnered sex (until you're married, until you're ready...whatever) is the only method of protection that's 100% effective.

WHAT IT IS

While people might have different definitions of what abstinence is, most people define it as not having sexual intercourse, including oral, vaginal or anal intercourse, for a particular period of time. Some people decide to remain abstinent until they're a certain age or are in a certain kind of committed relationship, like being in love, being with a person for a certain amount of time or married.

HOW IT WORKS

Once you've decided how you define abstinence, make it clear to your romantic partner that you're not interested in getting physical in these specific ways. You also can think about what to do if your partner has a different definition of abstinence than you; that is the point when you can either come to a compromise or decide that your boundaries are not a good fit for the other person. This is part of establishing and being in a healthy relationship.

EFFECTIVENESS

Abstinence is very effective protection against pregnancy. When both partners are completely committed and practice abstinence (no genital contact) 100% of the time, there is no risk of pregnancy.

Abstinence is also very effective protection against STIs. When both partners are completely committed and practice abstinence (no genital contact, including oral vaginal, or anal sex) 100% of the time, there is very little risk of transmitting an STI. Some STIs can infect the mouth, and others can be transmitted through skin-to-skin contact, so it's important to not do any of these behaviors to prevent transmission.

*Note: Studies show that when teens that choose abstinence but don't practice it (meaning they wind up having sex), they often don't use protection. We don't want that to happen to you. So if you decide to be abstinent, also make a promise to yourself to be informed about how to keep yourself healthy if you decide to have sex. Specifically, know how to use a condom, where to find a health center and how to get emergency contraception (EC) if you need it.

Quick Facts

1: *Less than half of high school age kids have had sex- if you're not having sex, you're not alone.*

2: *There are lots of great reasons to wait to have sex- what's yours?*

3: *You can say no to sex- even if you've said yes before.*

4: *Abstinence is the only 100% way to make sure you don't get pregnant/get someone pregnant.*

5: *If you're not ready to have sex and your bf/gf still pressures you, are they really a good partner to you?*

PERKS

- Really effective when used perfectly
- Easy to remember
- Always available & free!
- No visit to a medical provider required
- Non-hormonal

DRAWBACKS

- You have to be perfect every single time.
- It can be tough or feel impossible to say no.
- If you have a partner, you need their cooperation.
- If you change your mind and decide to become sexually active, it is important to plan ahead and use some kind of protection

Content adapted from: Answer, Rutgers University (https://sexetc.org/info-center/post/what-is-abstinence/); Power to Decide (http://stayteen.org/sex-ed/article/abstinence) and (https://www.bedsider.org/methods/not_right_now); Georgia Dept. of Public Health (https://www.gachd.org/ABSTINENCE.pdf)

Planned Parenthood® of Northern New England

Know how to use a condom the right way, every time.

How do you put a condom on correctly?

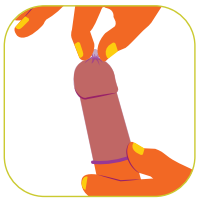
The condom should be put on before any genital contact. Sperm may come out of the penis before the male ejaculates, so put the condom on before any skin-to-skin contact begins. You should also know that some STDs can be transmitted without intercourse, through genital (skin-to-skin) contact. To reduce the risk of pregnancy and STDs (including HIV), males need to wear a condom the entire time from the beginning to the end of genital contact, each and every time.

1 When you are opening the package, gently tear it on the side. Do not use your teeth or scissors because you might rip the condom that's inside. Pull the condom out of the package slowly so that it doesn't tear.

2 Put the rolled up condom over the head of the penis when it is hard.

3 Pinch the tip of the condom enough to leave a half-inch space for semen to collect.

4 Holding the tip of the condom, unroll it all the way down to the base of the penis.



When the condom is on, it should feel snug enough so that it won't fall off during sex, but not too tight.

- If you accidentally put on a condom inside-out, throw it away and get a new one. You can tell a condom is inside-out if it won't roll down the length of the penis easily.
- If the condom ever tears or rips when you are putting it on or when it's being used, throw it away and use a new one.

How do you take off a condom correctly?

The most common mistake is not using condoms from the beginning of sexual contact to the very end, after ejaculation. Immediately after ejaculation, hold the bottom of the condom so it stays on and semen cannot spill out. Then, carefully withdraw the penis while it is still hard. Once the penis is out, you can remove the condom, wrap it in tissue, and throw it in the trash. Do not flush it down the toilet because it might clog.

What if the condom breaks?

If you feel the condom break at any point before or during sex:

Stop immediately! **Withdraw.** **Carefully remove the broken condom and put on a new one.**

If the condom breaks, pregnancy can be prevented with emergency contraception. Emergency contraception (the "Morning-After Pill") works best when it's started as soon as possible after sex, but can be started up to 5 days after sex.

Remember: Emergency contraception helps prevent pregnancy, but it does NOT protect against STDs.

Know your CONDOM DOs & DON'Ts

DO

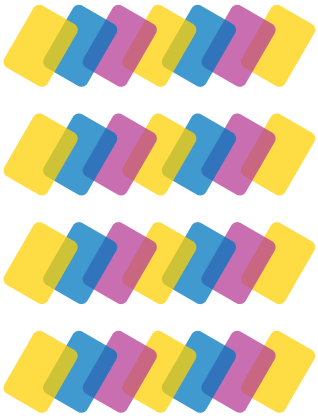
- Read all the information on the package. Know what you are using.
- Check the expiration date on the package. If it is expired, get a new package of condoms and throw away the old ones.
- Use only condoms that are made of latex or polyurethane (plastic). Latex condoms and polyurethane condoms are the best types of condoms to use to help prevent pregnancy, STDs, and HIV.
- Use a pre-lubricated condom to help prevent it from tearing. If you only have a non-lubricated condom, put a little bit of water-based lubricant ("lube") inside and outside the condom.
- Condoms come in different sizes, colors, textures, and thicknesses. Talk with your partner and choose condoms both of you like.

DON'T

- Do not use two condoms at once.
- Do not use condoms made of animal skin, sometimes called "natural" condoms. Animal skin condoms can help prevent pregnancy but don't work as well as latex or polyurethane condoms to prevent STDs, including HIV.
- Do not keep condoms in a place that can get very hot, like in a car. If you keep a condom in your wallet or purse, be sure you replace it with a new one regularly.
- Do not use any kind of oil-based lubricants (like petroleum jellies, lotions, mineral oil, or vegetable oils). These can negatively affect the latex, making it more likely to rip or tear.
- Do not reuse condoms.
- Do not use condoms that are torn or outdated.

www.cdc.gov/teenpregnancy/Teens.html

National Center for Chronic Disease Prevention and Health Promotion
Division of Reproductive Health



Dental Dams

HOT TIPS

Better sex!

Dental dams are latex or polyurethane sheets used between the mouth and vagina or anus during oral sex.

Used correctly *every* time, dental dams can:

- Protect you from most STDs, including HIV.
- Help you feel relaxed and safe.

Planned Parenthood® of Northern New England

www.ppnne.org | 1-866-476-1321

How to Use a Dental Dam

1. **Carefully open dental dam and remove from package.** Add water or silicone-based lube on the receiver's side, if desired.

2. **Place dental dam flat to cover vaginal opening or anus and have one person hold it in place.** Do not stretch it or pull it tight.

3. **Put it on before starting oral sex and keep it on until finished.** Use a new dental dam every time.

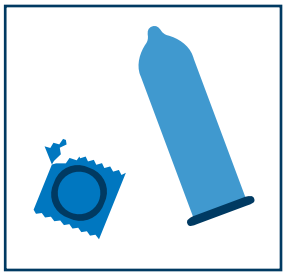
4. **Be sure to *ONLY* use one side.** Do not turn the dam over and continue to use it.

5. **Throw away used dental dam in trash.** Do not flush dental dams down the toilet.

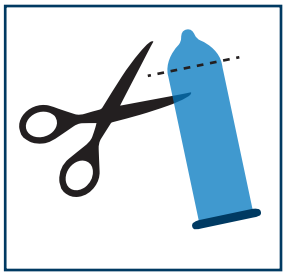
Although oral sex is considered less risky than vaginal or anal sex, there is still a risk of transmitting STDs. To be as safe as possible, use an oral barrier for every act of oral sex to keep fluids from passing from one person to the other.

How to Make a Dental Dam from a Condom

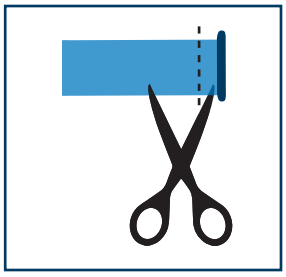
1. **Carefully open package, remove condom, and unroll.**



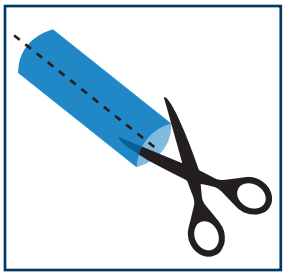
2. **Cut off tip of condom.**



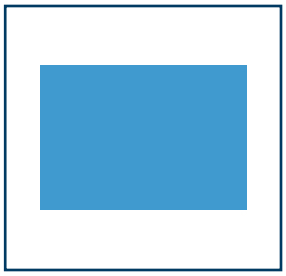
3. **Cut off bottom of condom.**



4. **Cut down one side of condom.**



5. **Lay flat to cover vaginal opening or anus.**



Use lubes!

- **Most dental dams are unlubricated.** They come in different flavors or can be unflavored.
- **Some condoms come with lube.** Read the package to find out.
- **Only use water- or silicone-based lubes** with oral barriers.
- **Lube can help increase the sensation for the receiver.**
- **Never use Vaseline®, hand lotion or oil-based lube.** Oil can break condoms and dental dams.

Try different kinds of lubes to find one you like.

Make it easy

- **Talking about dental dams** can help you feel more comfortable.

- **Think ahead about what you want to say** and how you'll start the conversation.
- **Practice what you'll say** *before* you get in a sexy situation.

Using dental dams is like learning to wear a seat belt all the time– it takes practice to make it a habit.

If you are sexually active and are not ready to become a parent, it is important to use birth control to protect yourself from pregnancy.

It is also important to reduce your risk of getting sexually transmitted diseases (STDs), including HIV.

Condoms are the only birth control that reduces your risk of both pregnancy and STDs, including HIV. But, in order to work, condoms must be used correctly and must be used every time you have sex. It's important to know, however, that they cannot completely protect you and your partner from some STDs, like herpes, syphilis, or human papillomavirus (HPV), the virus that causes genital warts and cervical cancer. Also, condoms can break, slip, or leak, especially if they are not put on and taken off properly.

The only sure way to prevent pregnancy and STDs is NOT to have sex.

If you do have sex, use DUAL PROTECTION.

Even if you or your partner is using another type of birth control, agree to use a condom every time you have sex, to reduce the risk to both of you for HIV and most other STDs.

Condom

+

Birth Control Pill

Patch

Ring

Implant

Injection

IUD

Remember!

- **Use a condom and birth control.**
- **Condoms must be used correctly and used every time you have sex.**
- **Sometimes you or your partner might not know if one of you has an STD.**

OOPS! EMERGENCY CONTRACEPTION: BIRTH CONTROL THAT WORKS AFTER SEX

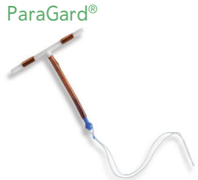
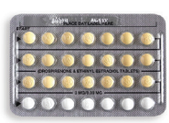
Types of Emergency Contraception	How well does it work?	How soon do I have to use it?	How do I use it?	Where can I get it?
 ParaGard IUD	Almost 100% effective 	Within 5 days	It's placed in the uterus by a health care provider Keeps working as super effective birth control.	From a health care provider Say it's for EC so you are scheduled quickly.
 ella	 Less effective if over 195 pounds. Try a ParaGard IUD.	ASAP Works better the sooner you take it, up to 5 days.	Take the pill as soon as you get it Remember to use it every time you have unprotected sex.	From a health care provider Get an extra pack for future emergencies.
 Plan B One-Step or a generic	 Less effective if over 165 pounds. Try ella or ParaGard.	ASAP Works better the sooner you take it, up to 3 days.	Take the pill(s) as soon as you get it Remember to use it every time you have unprotected sex.	At a pharmacy, no prescription needed Get an extra pack for future emergencies.

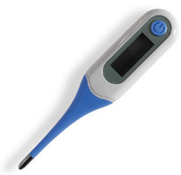
BEDSIDER Bedsider.org

Bixby Center for Global Reproductive Health

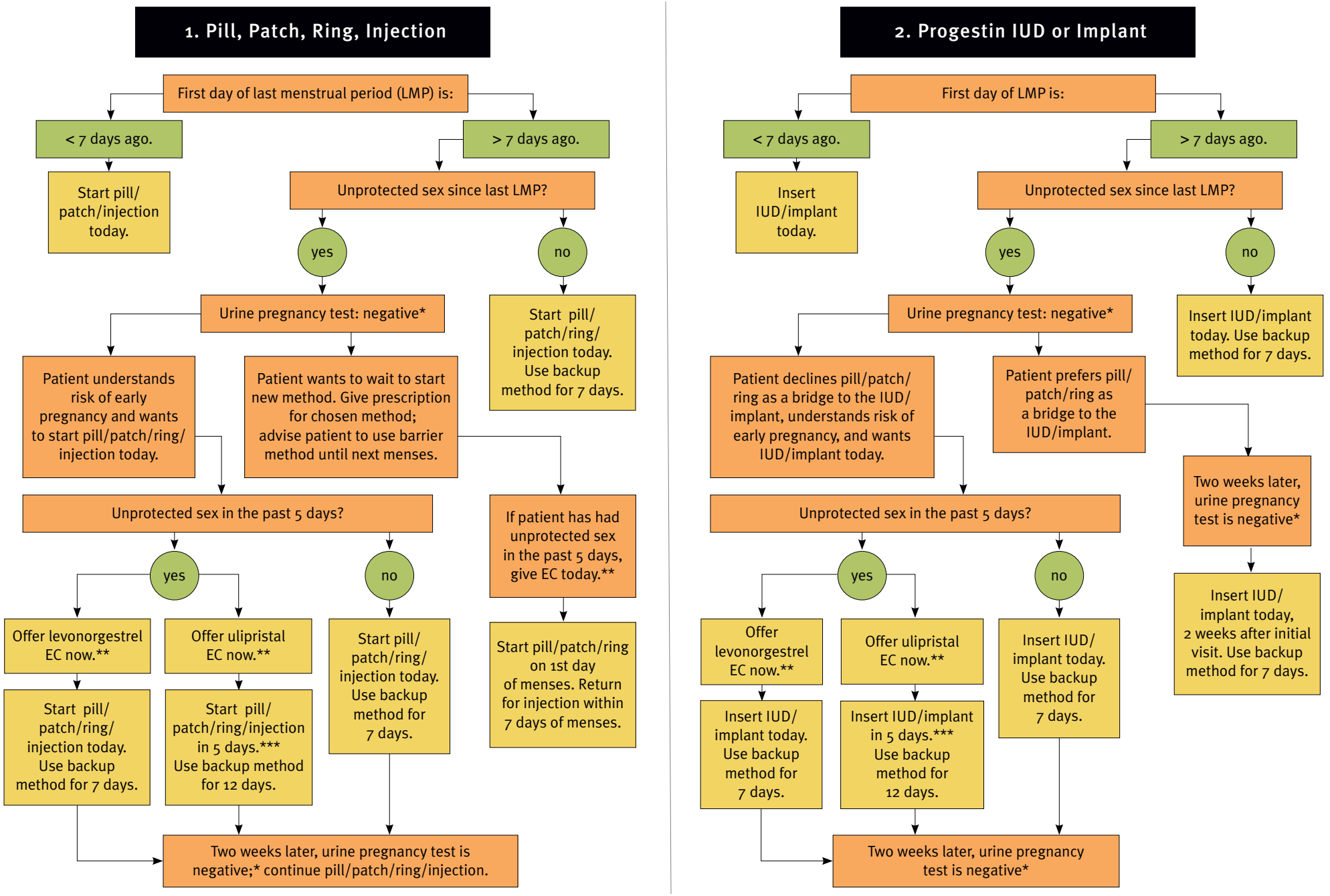
Affordable Emergency Contraception (EC) is always available at Planned Parenthood of Northern New England (PPNNE). Many patients qualify for free or reduced cost EC. Over the counter and prescription options are available. Call 1-866-476-1321 to get an estimate on how much EC might cost you at your nearest PPNNE Health Center.

Your Birth Control Choices

Method	How well does it work?	How to Use	Pros	Cons
The Implant Nexplanon® 	> 99%	A health care provider places it under the skin of the upper arm It must be removed by a health care provider	Long lasting (up to 5 years) No pill to take daily Often decreases cramps Can be used while breastfeeding You can become pregnant right after it is removed	Can cause irregular bleeding After 1 year, you may have no period at all Does not protect against human immunodeficiency virus (HIV) or other sexually transmitted infections (STIs)
Progestin IUD Liletta®, Mirena®, Skyla® and others 	> 99%	Must be placed in uterus by a health care provider Usually removed by a health care provider	May be left in place 3 to 7 years, depending on which IUD you choose No pill to take daily May improve period cramps and bleeding Can be used while breastfeeding You can become pregnant right after it is removed	May cause lighter periods, spotting, or no period at all Rarely, uterus is injured during placement Does not protect against HIV or other STIs
Copper IUD ParaGard® 	> 99%	Must be placed in uterus by a health care provider Usually removed by a health care provider	May be left in place for up to 12 years No pill to take daily Can be used while breastfeeding You can become pregnant right after it is removed	May cause more cramps and heavier periods May cause spotting between periods Rarely, uterus is injured during placement Does not protect against HIV or other STIs
The Shot Depo-Provera® 	94-99%	Get a shot every 3 months	Each shot works for 12 weeks Private Usually decreases periods Helps prevent cancer of the uterus No pill to take daily Can be used while breastfeeding	May cause spotting, no period, weight gain, depression, hair or skin changes, change in sex drive May cause delay in getting pregnant after you stop the shots Side effects may last up to 6 months after you stop the shots Does not protect against HIV or other STIs
The Pill 	91-99%	Must take the pill daily	Can make periods more regular and less painful Can improve PMS symptoms Can improve acne Helps prevent cancer of the ovaries You can become pregnant right after stopping the pills	May cause nausea, weight gain, headaches, change in sex drive – some of these can be relieved by changing to a new brand May cause spotting the first 1-2 months Does not protect against HIV or other STIs
Progestin-Only Pills 	91-99%	Must take the pill daily	Can be used while breastfeeding You can become pregnant right after stopping the pills	Often causes spotting, which may last for many months May cause depression, hair or skin changes, change in sex drive Does not protect against HIV or other STIs
The Patch Ortho Evra® 	91-99%	Apply a new patch once a week for three weeks No patch in week 4	Can make periods more regular and less painful No pill to take daily You can become pregnant right after stopping patch	Can irritate skin under the patch May cause spotting the first 1-2 months Does not protect against HIV or other STIs
The Ring Nuvaring® 	91-99%	Insert a small ring into the vagina Change ring each month	One size fits all Private Does not require spermicide Can make periods more regular and less painful No pill to take daily You can become pregnant right after stopping the ring	Can increase vaginal discharge May cause spotting the first 1-2 months of use Does not protect against HIV or other STIs

Method	How well does it work?	How to Use	Pros	Cons
Male/External Condom 	82-98%	Use a new condom each time you have sex Use a polyurethane condom if allergic to latex	Can buy at many stores Can put on as part of sex play/foreplay Can help prevent early ejaculation Can be used for oral, vaginal, and anal sex Protects against HIV and other STIs Can be used while breastfeeding	Can decrease sensation Can cause loss of erection Can break or slip off
Female/Internal Condom 	79-95%	Use a new condom each time you have sex Use extra lubrication as needed	Can buy at many stores Can put in as part of sex play/foreplay Can be used for anal and vaginal sex May increase pleasure when used for vaginal sex Good for people with latex allergy Protects against HIV and other STIs Can be used while breastfeeding	Can decrease sensation May be noisy May be hard to insert May slip out of place during sex
Withdrawal Pull-out	78-96%	Pull penis out of vagina before ejaculation (that is, before coming)	Costs nothing Can be used while breastfeeding	Less pleasure for some Does not work if penis is not pulled out in time Does not protect against HIV or other STIs Must interrupt sex
Diaphragm Caya® and Milex® 	88-94%	Must be used each time you have sex Must be used with spermicide	Can last several years Costs very little to use May protect against some infections, but **not HIV** Can be used while breastfeeding	Using spermicide may raise the risk of getting HIV Should not be used with vaginal bleeding or infection Raises risk of bladder infection
Fertility Awareness Natural Family Planning 	76-95%	Predict fertile days by: taking temperature daily, checking vaginal mucus for changes, and/or keeping a record of your periods It works best if you use more than one of these Avoid sex or use condoms/spermicide during fertile days	Costs little Can be used while breastfeeding Can help with avoiding or trying to become pregnant	Must use another method during fertile days Does not work well if your periods are irregular Many things to remember with this method Does not protect against HIV or other STIs
Spermicide Cream, gel, sponge, foam, inserts, film 	72-82%	Insert spermicide each time you have sex	Can buy at many stores Can be put in as part of sex play/foreplay Comes in many forms: cream, gel, sponge, foam, inserts, film Can be used while breastfeeding	May raise the risk of getting HIV May irritate vagina, penis Cream, gel, and foam can be messy
Emergency Contraception Pills Progestin EC (Plan B® One-Step and others) and ulipristal acetate (ella®) 	58-94% Ulipristal acetate EC works better than progestin EC if you are overweight Ulipristal acetate EC works better than progestin EC in the 2-5 days after sex	Works best the **sooner** you take it after unprotected sex You can take EC up to 5 days after unprotected sex If pack contains 2 pills, take both together	Can be used while breastfeeding Available at pharmacies, health centers, or health care providers: call ahead to see if they have it People of any age can get progestin EC without a perscription	May cause stomach upset or nausea Your next period may come early or late May cause spotting Does not protect against HIV or other STIs Ulipristal acetate EC requires a prescription May cost a lot

Quick Start Algorithm — Patient requests a new birth control method:

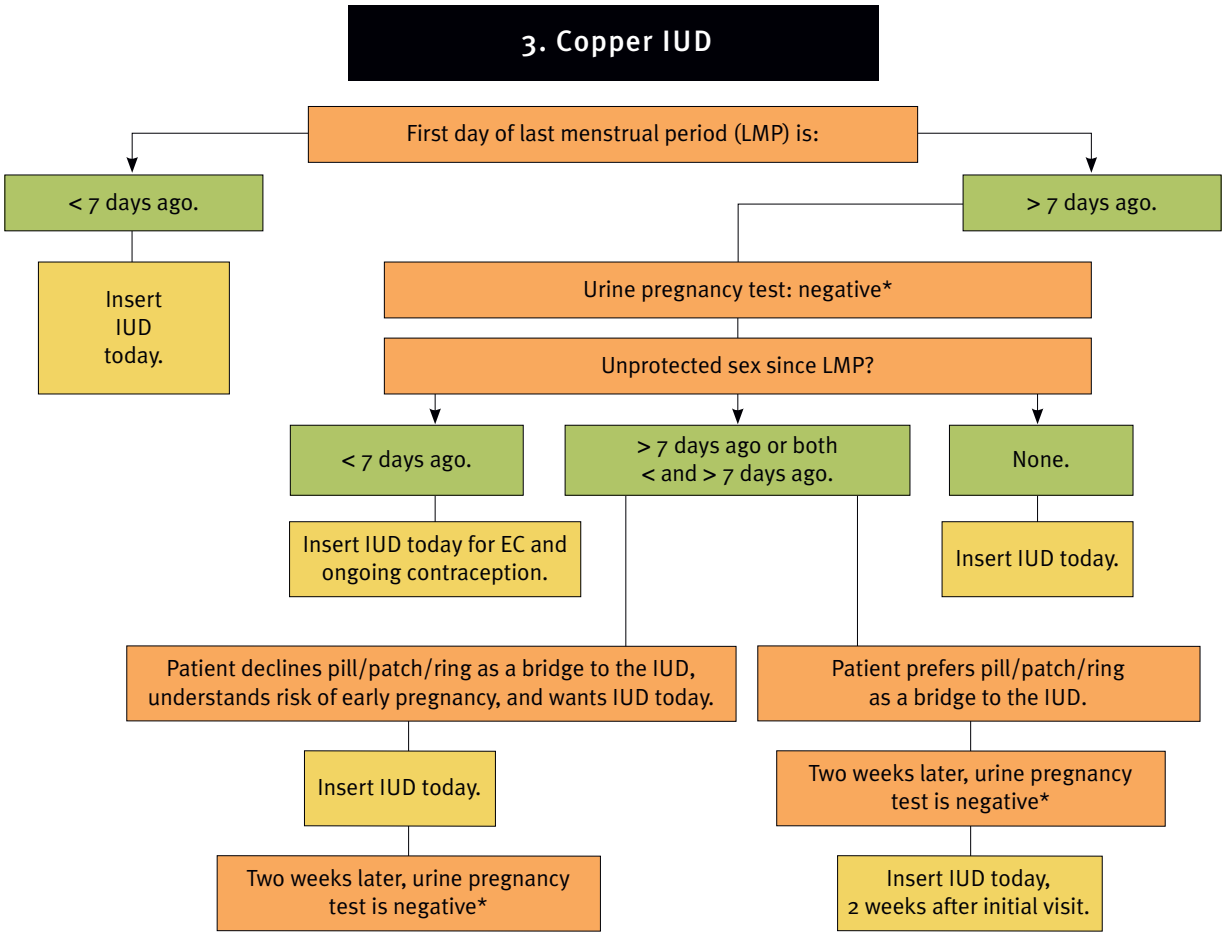


* If pregnancy test is positive, provide options counseling.

** For patients with body mass index over 25, levonorgestrel EC works no better than placebo. For those who had unprotected sex 3-5 days ago, ulipristal EC has higher efficacy than levonorgestrel EC.

*** Because ulipristal EC may interact with hormonal contraceptives, the new method should be started no sooner than 5 days after ulipristal EC. Consider starting injection/IUD/implant sooner if benefit outweighs risk.

Quick Start Algorithm — Patient requests a new birth control method:

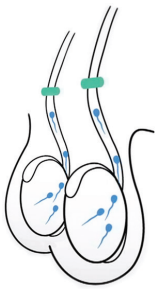


* If pregnancy test is positive, provide options counseling.

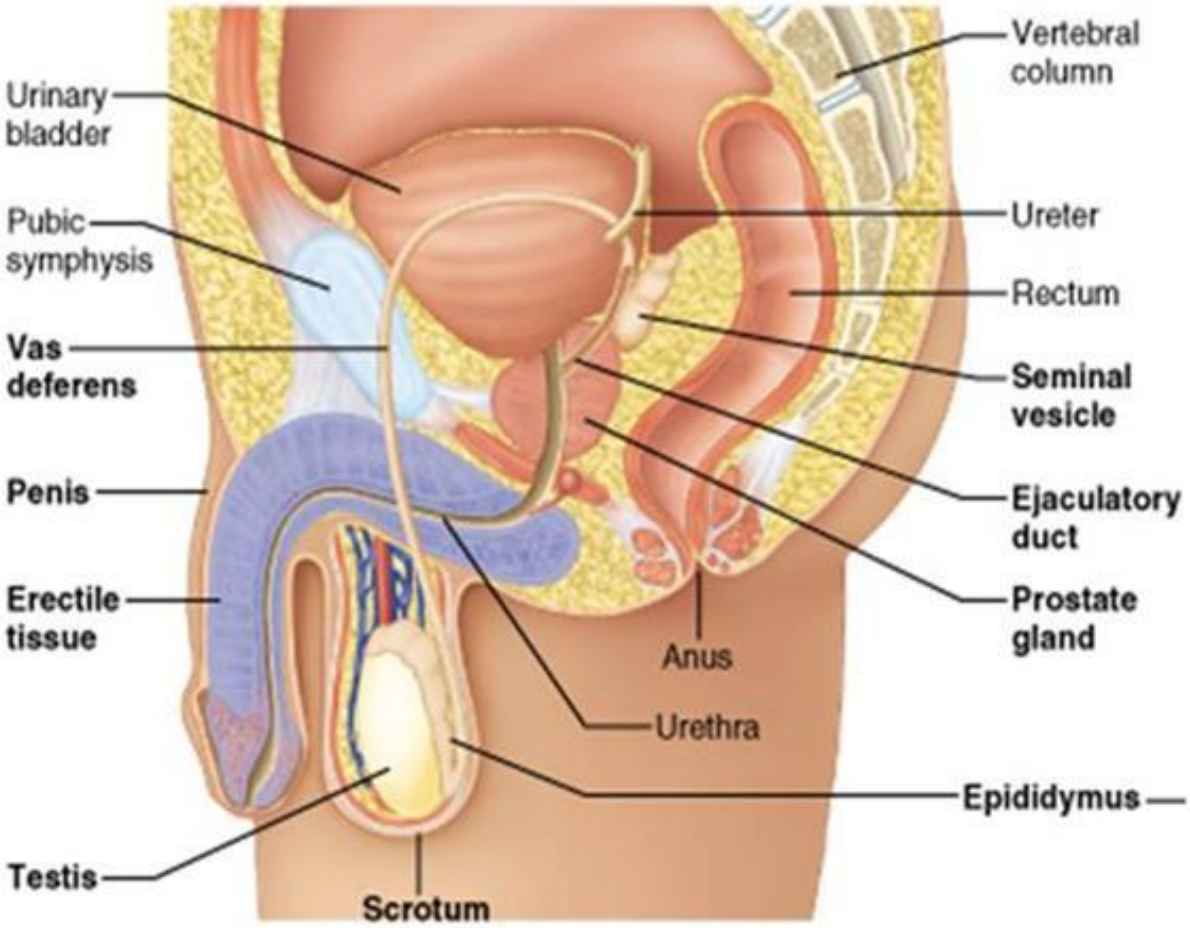
Citation: Curtis KM, Jatlaoui TC, Tepper NK, et al. U.S. Selected Practice Recommendations for Contraceptive Use, 2016. MMWR Recomm Rep 2016;65(No. RR-4):1–66. DOI: http://dx.doi.org/10.15585/mmwr.rr6504a1.

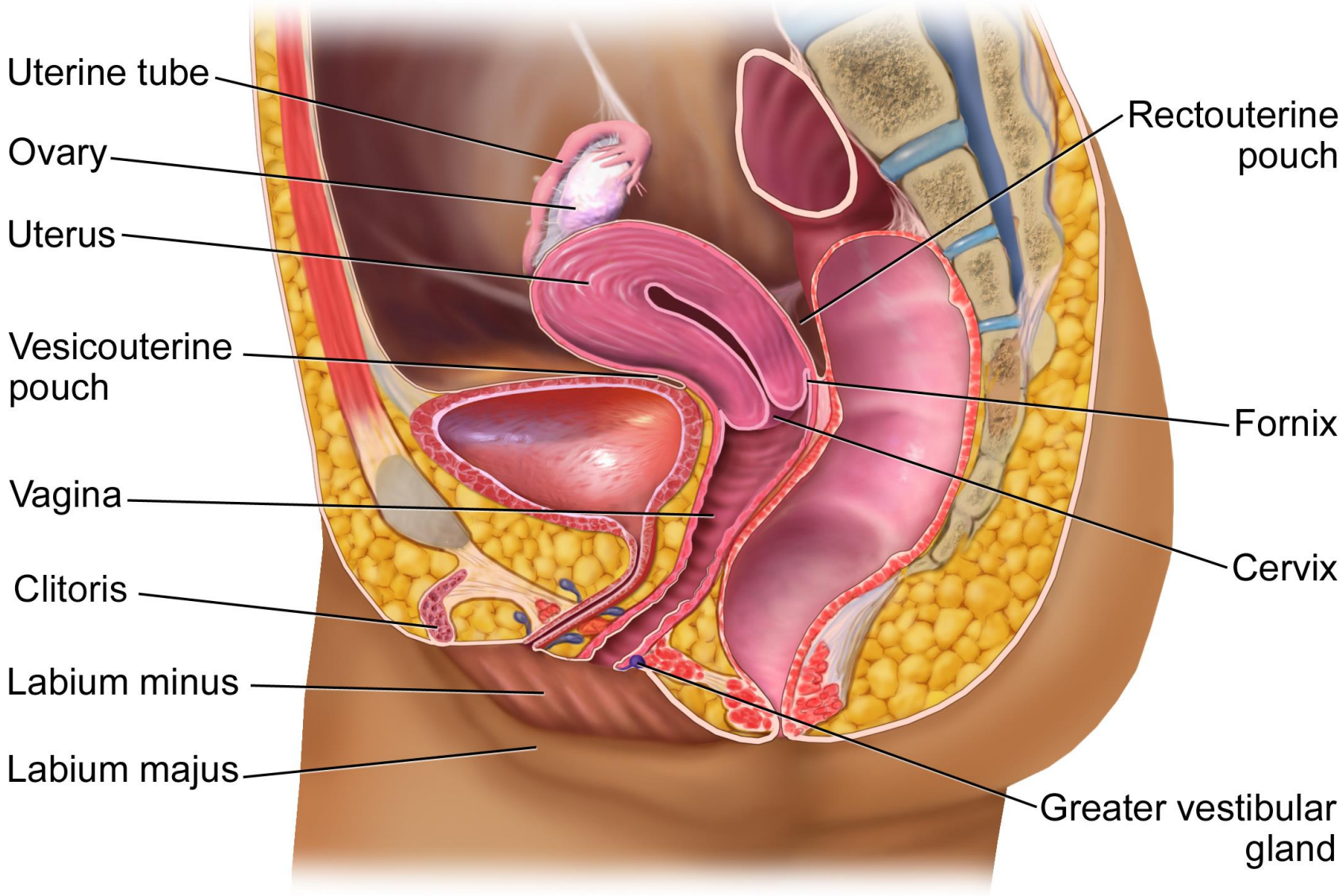
reproductive health access project

Birth Control for Men

Method	How well does it work? *	How to Use	Pros	Cons
Vasectomy 	> 99%	A clinician performs this procedure. It lasts for the rest of your life. Vasectomy works by blocking the tubes that carry sperm from the testes. This prevents sperm from entering the semen (come). After vasectomy, when the semen has no sperm, you don't need to do anything else to prevent pregnancy.	It reduces the worry of pregnancy and provides permanent and highly effective birth control. It can be done in the provider's office in 10-15 minutes. It's covered by most insurance. No general anesthesia No change in sexual function, erections, or feeling Does not affect male hormones	Does not protect against HIV and other sexually transmitted infections (STIs) Sperm may be present for up to 12 weeks after the procedure. Use a backup method until a semen test shows no sperm. Risks include infection and bleeding. Post-procedure pain may occur and you may need a day or two to recover. If you change your mind about wanting to have children, it's hard to reverse vasectomy.
Male Condom 	85-98%	Use a new condom each time you have sex. Use a non-latex condom if allergic to latex.	Can buy at many stores Can put on as part of sex play/ foreplay Can help prevent early ejaculation Can be used for oral, vaginal, and anal sex Protects against HIV and many other STIs	Can decrease sensation Can cause loss of erection Can break or slip off
Withdrawal ("pull out method")	73-96%	Pull penis out of vagina before ejaculation (that is, before coming).	Costs nothing	Less pleasure for some Does not work if the penis is not pulled out in time Does not protect against HIV or STIs Must interrupt sex
Female Condom 	79-95%	Use a new condom each time you have sex. Use extra lubrication as needed.	Can buy at many stores Can put in as part of sex play/ foreplay Can be used for anal and vaginal sex May increase pleasure when used for vaginal sex Good for people with latex allergy Protects against HIV and other STIs	Can decrease sensation May be noisy May be hard to insert May slip out of place during sex
Spermicide Cream, gel, sponge, foam, inserts, film 	71-85%	Insert spermicide each time you have sex.	Can buy at many stores Can insert as part of sex play/ foreplay Comes in many forms: cream, gel, sponge, foam, inserts, film	May raise the risk of getting HIV May irritate vagina, penis Cream, gel, and foam can be messy

The Male Reproductive System





The Female Reproductive System

Depo-Provera Perpetual Calendar

4-TIMES-A-YEAR DOSING FLEXIBILITY

[based on 3-month (13-week) dosing intervals, with the flexibility of dosing between weeks 11 and 13]

GIVEN	DUE
Jan 1	Mar 19 - Apr 2
Jan 2	Mar 20 - Apr 3
Jan 3	Mar 21 - Apr 4
Jan 4	Mar 22 - Apr 5
Jan 5	Mar 23 - Apr 6
Jan 6	Mar 24 - Apr 7
Jan 7	Mar 25 - Apr 8
Jan 8	Mar 26 - Apr 9
Jan 9	Mar 27 - Apr 10
Jan 10	Mar 28 - Apr 11
Jan 11	Mar 29 - Apr 12
Jan 12	Mar 30 - Apr 13
Jan 13	Mar 31 - Apr 14
Jan 14	Apr 1 - Apr 15
Jan 15	Apr 2 - Apr 16
Jan 16	Apr 3 - Apr 17
Jan 17	Apr 4 - Apr 18
Jan 18	Apr 5 - Apr 19
Jan 19	Apr 6 - Apr 20
Jan 20	Apr 7 - Apr 21
Jan 21	Apr 8 - Apr 22
Jan 22	Apr 9 - Apr 23
Jan 23	Apr 10 - Apr 24
Jan 24	Apr 11 - Apr 25
Jan 25	Apr 12 - Apr 26
Jan 26	Apr 13 - Apr 27
Jan 27	Apr 14 - Apr 28
Jan 28	Apr 15 - Apr 29
Jan 29	Apr 16 - Apr 30
Jan 30	Apr 17 - May 1
Jan 31	Apr 18 - May 2
Feb 1	Apr 19 - May 3
Feb 2	Apr 20 - May 4
Feb 3	Apr 21 - May 5
Feb 4	Apr 22 - May 6
Feb 5	Apr 23 - May 7
Feb 6	Apr 24 - May 8
Feb 7	Apr 25 - May 9
Feb 8	Apr 26 - May 10
Feb 9	Apr 27 - May 11
Feb 10	Apr 28 - May 12
Feb 11	Apr 29 - May 13
Feb 12	Apr 30 - May 14
Feb 13	May 1 - May 15
Feb 14	May 2 - May 16
Feb 15	May 3 - May 17

GIVEN	DUE
Feb 16	May 4 - May 18
Feb 17	May 5 - May 19
Feb 18	May 6 - May 20
Feb 19	May 7 - May 21
Feb 20	May 8 - May 22
Feb 21	May 9 - May 23
Feb 22	May 10 - May 24
Feb 23	May 11 - May 25
Feb 24	May 12 - May 26
Feb 25	May 13 - May 27
Feb 26	May 14 - May 28
Feb 27	May 15 - May 29
Feb 28	May 16 - May 30
Mar 1	May 17 - May 31
Mar 2	May 18 - Jun 1
Mar 3	May 19 - Jun 2
Mar 4	May 20 - Jun 3
Mar 5	May 21 - Jun 4
Mar 6	May 22 - Jun 5
Mar 7	May 23 - Jun 6
Mar 8	May 24 - Jun 7
Mar 9	May 25 - Jun 8
Mar 10	May 26 - Jun 9
Mar 11	May 27 - Jun 10
Mar 12	May 28 - Jun 11
Mar 13	May 29 - Jun 12
Mar 14	May 30 - Jun 13
Mar 15	May 31 - Jun 14
Mar 16	Jun 1 - Jun 15
Mar 17	Jun 2 - Jun 16
Mar 18	Jun 3 - Jun 17
Mar 19	Jun 4 - Jun 18
Mar 20	Jun 5 - Jun 19
Mar 21	Jun 6 - Jun 20
Mar 22	Jun 7 - Jun 21
Mar 23	Jun 8 - Jun 22
Mar 24	Jun 9 - Jun 23
Mar 25	Jun 10 - Jun 24
Mar 26	Jun 11 - Jun 25
Mar 27	Jun 12 - Jun 26
Mar 28	Jun 13 - Jun 27
Mar 29	Jun 14 - Jun 28
Mar 30	Jun 15 - Jun 29
Mar 31	Jun 16 - Jun 30
Apr 1	Jun 17 - Jul 1
Apr 2	Jun 18 - Jul 2

GIVEN	DUE
Apr 3	Jun 19 - Jul 3
Apr 4	Jun 20 - Jul 4
Apr 5	Jun 21 - Jul 5
Apr 6	Jun 22 - Jul 6
Apr 7	Jun 23 - Jul 7
Apr 8	Jun 24 - Jul 8
Apr 9	Jun 25 - Jul 9
Apr 10	Jun 26 - Jul 10
Apr 11	Jun 27 - Jul 11
Apr 12	Jun 28 - Jul 12
Apr 13	Jun 29 - Jul 13
Apr 14	Jun 30 - Jul 14
Apr 15	Jul 1 - Jul 15
Apr 16	Jul 2 - Jul 16
Apr 17	Jul 3 - Jul 17
Apr 18	Jul 4 - Jul 18
Apr 19	Jul 5 - Jul 19
Apr 20	Jul 6 - Jul 20
Apr 21	Jul 7 - Jul 21
Apr 22	Jul 8 - Jul 22
Apr 23	Jul 9 - Jul 23
Apr 24	Jul 10 - Jul 24
Apr 25	Jul 11 - Jul 25
Apr 26	Jul 12 - Jul 26
Apr 27	Jul 13 - Jul 27
Apr 28	Jul 14 - Jul 28
Apr 29	Jul 15 - Jul 29
Apr 30	Jul 16 - Jul 30
May 1	Jul 17 - Jul 31
May 2	Jul 18 - Aug 1
May 3	Jul 19 - Aug 2
May 4	Jul 20 - Aug 3
May 5	Jul 21 - Aug 4
May 6	Jul 22 - Aug 5
May 7	Jul 23 - Aug 6
May 8	Jul 24 - Aug 7
May 9	Jul 25 - Aug 8
May 10	Jul 26 - Aug 9
May 11	Jul 27 - Aug 10
May 12	Jul 28 - Aug 11
May 13	Jul 29 - Aug 12
May 14	Jul 30 - Aug 13
May 15	Jul 31 - Aug 14
May 16	Aug 1 - Aug 15
May 17	Aug 2 - Aug 16
May 18	Aug 3 - Aug 17

GIVEN	DUE
May 19	Aug 4 - Aug 18
May 20	Aug 5 - Aug 19
May 21	Aug 6 - Aug 20
May 22	Aug 7 - Aug 21
May 23	Aug 8 - Aug 22
May 24	Aug 9 - Aug 23
May 25	Aug 10 - Aug 24
May 26	Aug 11 - Aug 25
May 27	Aug 12 - Aug 26
May 28	Aug 13 - Aug 27
May 29	Aug 14 - Aug 28
May 30	Aug 15 - Aug 29
May 31	Aug 16 - Aug 30
Jun 1	Aug 17 - Aug 31
Jun 2	Aug 18 - Sept 1
Jun 3	Aug 19 - Sept 2
Jun 4	Aug 20 - Sept 3
Jun 5	Aug 21 - Sept 4
Jun 6	Aug 22 - Sept 5
Jun 7	Aug 23 - Sept 6
Jun 8	Aug 24 - Sept 7
Jun 9	Aug 25 - Sept 8
Jun 10	Aug 26 - Sept 9
Jun 11	Aug 27 - Sept 10
Jun 12	Aug 28 - Sept 11
Jun 13	Aug 29 - Sept 12
Jun 14	Aug 30 - Sept 13
Jun 15	Aug 31 - Sept 14
Jun 16	Sept 1 - Sept 15
Jun 17	Sept 2 - Sept 16
Jun 18	Sept 3 - Sept 17
Jun 19	Sept 4 - Sept 18
Jun 20	Sept 5 - Sept 19
Jun 21	Sept 6 - Sept 20
Jun 22	Sept 7 - Sept 21
Jun 23	Sept 8 - Sept 22
Jun 24	Sept 9 - Sept 23
Jun 25	Sept 10 - Sept 24
Jun 26	Sept 11 - Sept 25
Jun 27	Sept 12 - Sept 26
Jun 28	Sept 13 - Sept 27
Jun 29	Sept 14 - Sept 28
Jun 30	Sept 15 - Sept 29
Jul 1	Sept 16 - Sept 30
Jul 2	Sept 17 - Oct 1
Jul 3	Sept 18 - Oct 2

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4 Times a Year

Depo-Provera Perpetual Calendar

4-TIMES-A-YEAR DOSING FLEXIBILITY

[based on 3-month (13-week) dosing intervals, with the flexibility of dosing between weeks 11 and 13]

GIVEN	DUE
Jul 4	Sept 19 - Oct 3
Jul 5	Sept 20 - Oct 4
Jul 6	Sept 21 - Oct 5
Jul 7	Sept 22 - Oct 6
Jul 8	Sept 23 - Oct 7
Jul 9	Sept 24 - Oct 8
Jul 10	Sept 25 - Oct 9
Jul 11	Sept 26 - Oct 10
Jul 12	Sept 27 - Oct 11
Jul 13	Sept 28 - Oct 12
Jul 14	Sept 29 - Oct 13
Jul 15	Sept 30 - Oct 14
Jul 16	Oct 1 - Oct 15
Jul 17	Oct 2 - Oct 16
Jul 18	Oct 3 - Oct 17
Jul 19	Oct 4 - Oct 18
Jul 20	Oct 5 - Oct 19
Jul 21	Oct 6 - Oct 20
Jul 22	Oct 7 - Oct 21
Jul 23	Oct 8 - Oct 22
Jul 24	Oct 9 - Oct 23
Jul 25	Oct 10 - Oct 24
Jul 26	Oct 11 - Oct 25
Jul 27	Oct 12 - Oct 26
Jul 28	Oct 13 - Oct 27
Jul 29	Oct 14 - Oct 28
Jul 30	Oct 15 - Oct 29
Jul 31	Oct 16 - Oct 30
Aug 1	Oct 17 - Oct 31
Aug 2	Oct 18 - Nov 1
Aug 3	Oct 19 - Nov 2
Aug 4	Oct 20 - Nov 3
Aug 5	Oct 21 - Nov 4
Aug 6	Oct 22 - Nov 5
Aug 7	Oct 23 - Nov 6
Aug 8	Oct 24 - Nov 7
Aug 9	Oct 25 - Nov 8
Aug 10	Oct 26 - Nov 9
Aug 11	Oct 27 - Nov 10
Aug 12	Oct 28 - Nov 11
Aug 13	Oct 29 - Nov 12
Aug 14	Oct 30 - Nov 13
Aug 15	Oct 31 - Nov 14
Aug 16	Nov 1 - Nov 15
Aug 17	Nov 2 - Nov 16
Aug 18	Nov 3 - Nov 17

GIVEN	DUE
Aug 19	Nov 4 - Nov 18
Aug 20	Nov 5 - Nov 19
Aug 21	Nov 6 - Nov 20
Aug 22	Nov 7 - Nov 21
Aug 23	Nov 8 - Nov 22
Aug 24	Nov 9 - Nov 23
Aug 25	Nov 10 - Nov 24
Aug 26	Nov 11 - Nov 25
Aug 27	Nov 12 - Nov 26
Aug 28	Nov 13 - Nov 27
Aug 29	Nov 14 - Nov 28
Aug 30	Nov 15 - Nov 29
Aug 31	Nov 16 - Nov 30
Sept 1	Nov 17 - Dec 1
Sept 2	Nov 18 - Dec 2
Sept 3	Nov 19 - Dec 3
Sept 4	Nov 20 - Dec 4
Sept 5	Nov 21 - Dec 5
Sept 6	Nov 22 - Dec 6
Sept 7	Nov 23 - Dec 7
Sept 8	Nov 24 - Dec 8
Sept 9	Nov 25 - Dec 9
Sept 10	Nov 26 - Dec 10
Sept 11	Nov 27 - Dec 11
Sept 12	Nov 28 - Dec 12
Sept 13	Nov 29 - Dec 13
Sept 14	Nov 30 - Dec 14
Sept 15	Dec 1 - Dec 15
Sept 16	Dec 2 - Dec 16
Sept 17	Dec 3 - Dec 17
Sept 18	Dec 4 - Dec 18
Sept 19	Dec 5 - Dec 19
Sept 20	Dec 6 - Dec 20
Sept 21	Dec 7 - Dec 21
Sept 22	Dec 8 - Dec 22
Sept 23	Dec 9 - Dec 23
Sept 24	Dec 10 - Dec 24
Sept 25	Dec 11 - Dec 25
Sept 26	Dec 12 - Dec 26
Sept 27	Dec 13 - Dec 27
Sept 28	Dec 14 - Dec 28
Sept 29	Dec 15 - Dec 29
Sept 30	Dec 16 - Dec 30
Oct 1	Dec 17 - Dec 31
Oct 2	Dec 18 - Jan 1
Oct 3	Dec 19 - Jan 2

GIVEN	DUE
Oct 4	Dec 20 - Jan 3
Oct 5	Dec 21 - Jan 4
Oct 6	Dec 22 - Jan 5
Oct 7	Dec 23 - Jan 6
Oct 8	Dec 24 - Jan 7
Oct 9	Dec 25 - Jan 8
Oct 10	Dec 26 - Jan 9
Oct 11	Dec 27 - Jan 10
Oct 12	Dec 28 - Jan 11
Oct 13	Dec 29 - Jan 12
Oct 14	Dec 30 - Jan 13
Oct 15	Dec 31 - Jan 14
Oct 16	Jan 1 - Jan 15
Oct 17	Jan 2 - Jan 16
Oct 18	Jan 3 - Jan 17
Oct 19	Jan 4 - Jan 18
Oct 20	Jan 5 - Jan 19
Oct 21	Jan 6 - Jan 20
Oct 22	Jan 7 - Jan 21
Oct 23	Jan 8 - Jan 22
Oct 24	Jan 9 - Jan 23
Oct 25	Jan 10 - Jan 24
Oct 26	Jan 11 - Jan 25
Oct 27	Jan 12 - Jan 26
Oct 28	Jan 13 - Jan 27
Oct 29	Jan 14 - Jan 28
Oct 30	Jan 15 - Jan 29
Oct 31	Jan 16 - Jan 30
Nov 1	Jan 17 - Jan 31
Nov 2	Jan 18 - Feb 1
Nov 3	Jan 19 - Feb 2
Nov 4	Jan 20 - Feb 3
Nov 5	Jan 21 - Feb 4
Nov 6	Jan 22 - Feb 5
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Nov 8	Jan 24 - Feb 7
Nov 9	Jan 25 - Feb 8
Nov 10	Jan 26 - Feb 9
Nov 11	Jan 27 - Feb 10
Nov 12	Jan 28 - Feb 11
Nov 13	Jan 29 - Feb 12
Nov 14	Jan 30 - Feb 13
Nov 15	Jan 31 - Feb 14
Nov 16	Feb 1 - Feb 15
Nov 17	Feb 2 - Feb 16
Nov 18	Feb 3 - Feb 17

GIVEN	DUE
Nov 19	Feb 4 - Feb 18
Nov 20	Feb 5 - Feb 19
Nov 21	Feb 6 - Feb 20
Nov 22	Feb 7 - Feb 21
Nov 23	Feb 8 - Feb 22
Nov 24	Feb 9 - Feb 23
Nov 25	Feb 10 - Feb 24
Nov 26	Feb 11 - Feb 25
Nov 27	Feb 12 - Feb 26
Nov 28	Feb 13 - Feb 27
Nov 29	Feb 14 - Feb 28
Nov 30	Feb 15 - Mar 1
Dec 1	Feb 16 - Mar 2
Dec 2	Feb 17 - Mar 3
Dec 3	Feb 18 - Mar 4
Dec 4	Feb 19 - Mar 5
Dec 5	Feb 20 - Mar 6
Dec 6	Feb 21 - Mar 7
Dec 7	Feb 22 - Mar 8
Dec 8	Feb 23 - Mar 9
Dec 9	Feb 24 - Mar 10
Dec 10	Feb 25 - Mar 11
Dec 11	Feb 26 - Mar 12
Dec 12	Feb 27 - Mar 13
Dec 13	Feb 28 - Mar 14
Dec 14	Mar 1 - Mar 15
Dec 15	Mar 2 - Mar 16
Dec 16	Mar 3 - Mar 17
Dec 17	Mar 4 - Mar 18
Dec 18	Mar 5 - Mar 19
Dec 19	Mar 6 - Mar 20
Dec 20	Mar 7 - Mar 21
Dec 21	Mar 8 - Mar 22
Dec 22	Mar 9 - Mar 23
Dec 23	Mar 10 - Mar 24
Dec 24	Mar 11 - Mar 25
Dec 25	Mar 12 - Mar 26
Dec 26	Mar 13 - Mar 27
Dec 27	Mar 14 - Mar 28
Dec 28	Mar 15 - Mar 29
Dec 29	Mar 16 - Mar 30
Dec 30	Mar 17 - Mar 31
Dec 31	Mar 18 - Apr 1

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Original article

Beyond the Effects of Comprehensive Sexuality Education: The Significant Prospective Effects of Youth Assets on Contraceptive Behaviors

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Keywords: Youth assets; Comprehensive sexuality education; Youth development; Teen pregnancy prevention; Youth reproductive health

A B S T R A C T

Purpose: The purpose of the study was to prospectively determine if youth assets were significantly associated with contraception use after accounting for the effects of youths' exposure to comprehensive sexuality education programming.
Methods: Prospective associations between youth asset scores, comprehensive sexuality education topics received, type of contraceptive used, and consistent contraceptive use were analyzed using multinomial and binomial logistic regression in a sample of 757 sexually active youth.
Results: Higher youth asset scores were associated with condom use (adjusted odds ratio [AOR] = 1.51, 95% CI = 1.01–2.28), hormonal birth control use (AOR = 2.71, 95% CI = 1.69–4.35), dual method use (AOR = 2.35, 95% CI = 1.44–3.82), and consistent contraceptive use (AOR = 1.97, 95% CI = 1.38–2.82). After controlling for youths' experience with comprehensive sexuality education, higher youth asset scores remained a significant predictor of hormonal birth control use (AOR = 2.09, 95% CI = 1.28–3.42), dual method use (AOR = 2.58, 95% CI = 1.61–4.15), and consistent contraceptive use (AOR = 1.95, 95% CI = 1.36–2.80).
Conclusions: Youth serving organizations that are interested in preventing teen pregnancy should consider widespread implementation of evidence-based youth development programs that focus on building and strengthening specific youth assets.

IMPLICATIONS AND CONTRIBUTION

Public health practitioners should consider widespread implementation of youth programs that develop and strengthen specific youth assets with the goal of increasing contraceptive use and reducing teen pregnancy.

Teen pregnancy has declined in the U.S. over the past 3 decades. Teen pregnancy rates peaked in 1990, with 117.6 pregnancies per 1,000 teens (aged 15–19 years) [1]. The 2011 rate, which is 52.4 pregnancies per 1,000 teens, illustrates the continued downturn of teen pregnancy [1]. However, despite the decline, the rates are still very high for U.S. black (93 pregnancies per 1,000 teens) and Hispanic teens

Conflicts of Interest: The authors have no conflicts of interest to disclose.
Disclaimer: The contents of this publication are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.

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1054-139X/
http://dx.doi.org/10.1016/j.jadohealth.2017.06.021

(74 pregnancies per 1,000 teens), and the overall U.S. rate is the highest among 21 countries with complete data [1,2]. Researchers largely attribute the decline in the teen pregnancy rate to improvements in teens' contraception behavior rather than to delays in initiation of sexual intercourse [3,4].

Contraceptive behaviors among teens aged 15–19 years have evolved over the years. Declines in the teen pregnancy rate have been linked to moderate increases in the use of hormonal birth control, long-acting reversible contraceptives, and dual method use (the simultaneous use of a condom plus another modern method of contraception) [3,5]. These improvements are notable as hormonal birth control and dual method use have been found to be more effective in reducing pregnancies than condom use alone [6]. The identification of factors that predict contraceptive behavior has been more difficult.

Changes in contraceptive behavior have been attributed to fluctuations in the national economy, changing childbearing norms, availability of online sexuality and reproductive health information, and clinical recommendations from medical groups that make hormonal contraception more accessible to teens [3,4,7,8]. In addition, comprehensive sexuality education and youth development programs that focused on strengthening "youth assets" have been shown to have an impact on youths' contraceptive behavior [9–12].

Comprehensive sexuality education programs can positively influence teen contraceptive behaviors [9–11]. Reviews of teen pregnancy prevention programs from the Office of Adolescent Health and Manlove et al. [10] identified evidenced-based teen pregnancy prevention programs that impacted recent condom or contraceptive use and contraceptive consistency [11].

Despite the evidence supporting the effectiveness of comprehensive sexuality education programs in changing contraceptive behaviors, program implementation varies widely and remains controversial [13,14]. Currently, fewer than half (n = 24) of states require sexuality education programming and just 18 states require that information on contraception be provided in schools [14]. Recent national data reflect the downward trend in the implementation of sexuality education programming as fewer teens are receiving formal sexuality education in a school, church, or a community center setting than in the past [15]. Between 2006–2010 and 2011–2013, significantly fewer ($p < .05$) adolescent females reported receiving formal education regarding birth control (70% vs. 60%), saying no to sex (89% vs. 82%), sexually transmitted diseases (94% vs. 90%), and HIV/AIDS (89% vs. 86%) [15]. Similarly, significantly fewer ($p < .05$) males report receiving formal education regarding methods of birth control than in the past (61% vs. 55%) [15].

As the implementation of sexuality education programming declines and remains contentious, the continued identification of additional approaches that have an impact on youth contraceptive behaviors is critical if the field is to continuing experiencing declines in the teen pregnancy rate. Youth development programs that focus on strengthening youth assets may be one such approach.

More holistic than traditional comprehensive sexuality education programs, effective youth development programs aim to prepare youth for adult life by providing opportunities and experiences that promote prosocial bonding and build cognitive, social, behavioral, and emotional competencies [16–18]. Youth development programs attempt to reduce risky sexual behaviors by strengthening "youth assets." Youth assets are community, family, and individual factors that help youth avoid risk behaviors and increase the likelihood that they will successfully transition into adulthood [19]. Youth asset interventions can reduce youth participation in risky sexual behavior, and they lack the sexuality and reproductive health content typically found in comprehensive sexuality education programming and which some communities find controversial [17]. Research has shown that assets have a positive impact on youth sexual behaviors including delaying sexual initiation, pregnancy, and increasing birth control use [20–24]. For example, results from a longitudinal study indicate that some youth assets, such as aspirations for the future, self-confidence, peer, and nonparent adult role models and the ability to make responsible choices, increased the odds of birth control use (ranging from a 22% to 42% increase in odds) [20].

Youth development programs that focus on improving youth assets can impact youth sexual and contraceptive behaviors; and pregnancy and birth outcomes [10–12,16,17]. Recent reviews from the Office of Adolescent Health, Manlove et al., and Gavin et al. identified 17 youth development programs that impacted at least one reproductive health outcome. Although at least some of these programs address reproductive health topics, there is evidence to suggest youth development programs that do not include controversial sexuality education topics can still affect youth contraceptive behaviors [17]. For example, Raising Healthy Children is a multiyear social development program aimed at promoting bonding to school and peers by providing opportunities to strengthen youths' social competencies [25]. By age 21 years, African-American participants in the study (n = 349, 51% male, mean age = 10.8 years at baseline, 47% African-American) reported more frequent condom use than their single non–African-American peers in the comparison group [25]. Notably, these outcomes were achieved using a youth asset focus rather than sexuality education. Additional research is needed to determine the impact that youth assets can have on contraceptive behaviors in the absence of reproductive health content.

Despite the availability of youth development programs and the many organizations serving youth, relatively few are implementing evidenced-based youth development programs [26]. Additionally, few studies have examined the impact of the core constructs of youth development programs including youth assets such as peer, school, and community connectedness; parental monitoring; and aspirations for the future, on reproductive outcomes [26].

In summary, comprehensive sexuality education and youth development programs have been successful in improving teen contraceptive behaviors. Comprehensive sexuality education programs remain controversial in conservative communities and their implementation is in decline. Regrettably, despite their apparent effectiveness, evidence-based youth development programs that focus on assets have yet to be widely implemented in the teen pregnancy prevention field [13,26,27]. Youth development programs may be an acceptable alternative for communities that are not ready to implement comprehensive sexuality education and could lead to even further declines in teen pregnancy rates in those communities that do.

Data collected in the present study present a unique opportunity to prospectively evaluate the effect of youth assets on contraceptive use behavior of youth after statistically controlling for the effects of the youths' exposure to comprehensive sexuality education programming. The purpose of this is to determine if youth who possess multiple youth assets were significantly more likely to report a reliable contraception method or

consistent contraception use after accounting for the effects of the youths' exposure to comprehensive sexuality education. The results will provide important information to policy makers as well as to practitioners regarding the potential effectiveness of youth asset programming as a noncontroversial approach to preventing teen pregnancy with significant effects beyond those of comprehensive sexuality education.

Methods

Design

A Midwestern city was stratified by income and race/ethnicity using 2000 census data. Twenty census tracts with diverse race/ethnicity and socioeconomic populations were randomly selected. Participants were recruited for the study via door-to-door canvassing in each census tract. Data were collected annually from 2003 to 2008 for a total of five waves of data collected from 1,111 parent and youth dyads. Youth and parents were interviewed in-person, in their homes. The interviews were conducted using a computer-assisted data entry system. Asset data were collected from the youth via interviewer administered methods, whereas all sexual behavior–related data were collected from the youth via self-administered data collection methods. Youth listened to the recorded items on the laptop using headphones and entered responses into the laptop. This method minimized missing data, insured respondent confidentiality, and lessened the impact of potential low-level reading skills [28].

Inclusion criteria for the youth were being between 12 and 17 years old at baseline, living with a parent or guardian, English or Spanish proficiency, and mental competence to answer interview questions. A parent or guardian completed a consent and HIPPA form and youth completed an assent form. The study was approved by the Institutional Review Board at the University of Oklahoma Health Sciences Center. The response rate was 61% [29]. Wave 4 study data were used to predict youth contraceptive behaviors at wave 5. The analysis is limited to youth (n = 757) who were sexually active at wave 5.

Measures

Demographics. Basic demographic data were collected from the adolescents including age (continuous variable), race/ethnicity, and gender. Parent demographic variables included family structure (1, 2, or inconsistent-parent household), income, education, and employment status (yes/no).

Independent measures

Youth Assets. Seventeen youth assets were assessed using multi-item scales. The asset constructs were conceived and developed based on literature reviews, our previous research, and on psychometric testing [19,30]. The assets included responsible choices, educational aspirations for the future, general aspirations for the future, general self-confidence, religiosity, cultural respect, good health practices, family communication, relationship with mother, relationship with father, parental monitoring, nonparental adult role models, community involvement, positive peer role models, use of time (groups/sports), use of time (religion), and school connectedness.

Assets were reported as present (1) or absent (0) based on mean youth responses to the items included in the asset construct. Items that comprised each asset construct were generally scored from 1 to 4 (4 = the most positive response), and a youth was said to have the asset if the mean score was 3 or higher. A mean score of 3 or higher indicated the positive behavior was reported as "usually or almost always," "very important or extremely important," or "agree or strongly agree." The reliability of the asset constructs was adequate (Cronbach's alphas $>.70$ for 11 assets, $>.60$ and $\leq.70$ for 4 assets, and $>.55$ and $\leq.60$ for 2 assets) [19]. A dichotomous variable was created that assigned youth with fewer than the median number (11) of assets a low asset score with youth who possessed the median number of assets or greater a high asset score.

The 17 assets were tested for multicollinearity. Pearson correlation coefficients among the asset constructs ranged from .02 to .49. Only 4% were between .40 and .49; most (69%) were between .10 and .29 [19]. The results indicated there was no collinearity among the assets suggesting that each asset was distinct.

Comprehensive sexuality education. Comprehensive sexuality education was determined by assessing six sexuality education topics. The topics align with those used in previous studies to assess receipt of sexuality education and with topics addressed in the National Sexuality Education Standards [15,31,32]. Youth completed self-administered items that determined if they had ever been taught about the following sexuality education topics: (1) the female menstrual cycle; (2) how to say "no" to sex; (3) methods of birth control; (4) abstinence as a way to prevent sexually transmitted diseases; (5) sexuality as a natural and healthy part of life; and (6) signs and symptoms of sexually transmitted diseases. Response categories were "yes" or "no." Youth also completed items that determined where they received instruction about each sexuality education topic. Consistent with the literature, youth were considered to have received formal sexuality education if they received instruction in their "school"; "church, temple, or mosque"; "home"; or "youth organization" [15,31]. Sexuality education topics received in other informal settings were not considered. A dichotomous comprehensive sex education variable was created comparing youths who received all six sexuality education topics versus youth who received some or none of the sexuality education topics.

Dependent measures

Contraceptive behaviors. Youth self-administered the following items to assess contraceptive behaviors. "The last time you had sexual intercourse, did you or the other person use birth control?" Youth responding "no" were considered "no method users." "The last time you had sexual intercourse, what methods of birth control did you or your partner use?" [33] Method options included: "shot," "birth control pill," "patch," "ring," "condom," "withdrawal," "rhythm," and "other." For each method, response categories were "yes" or "no." Each youth was placed into one category based on their response: condom use only, hormonal birth control use only, dual method use, or less effective method. Youth responding "yes" to "condom," but "no" to other methods were considered condom users only. Youth responding "yes" to "birth control pill," "patch," "ring," or "shot," but "no" to other methods were considered hormonal birth

control users only. Dual method users were those who responded "yes" to condoms and "yes" to at least one of the hormonal birth control methods (birth control pill, shot, patch, or ring). Less effective methods were considered "rhythm" and "withdrawal." Sexual intercourse was defined in the survey as vaginal intercourse.

Consistent contraceptive use. This outcome was assessed by a self-administered item adapted from the literature "In the last 6 months, how often did you use birth control?" Response categories were never (0%), a few times (1%–40%), half the time (41%–60%), most times (61%–99%), or always (100%) used a method [34]. Consistent contraception users were those who indicated they "always" used a method.

Statistical analysis

The analyses for type of contraception method use were limited to youth (n = 757) who reported ever having had sexual intercourse at wave 5. The analysis for consistent contraceptive use was limited to a subset of the 757 youth (n = 635) who reported having had sex in the past 6 months (youth who responded "Have not had sex in the last 6 months" to the item assessing use of any methods in the last 6 months were excluded). All statistical analyses were performed using SAS 9.3 [35]. An alpha of .05 was used to determine statistical significance.

Multinomial logistic regression was performed to determine the relationship between receipt of comprehensive sexuality education and high youth asset scores and type of contraceptive used at last sexual intercourse. Logistic regression was used to determine the relationship between comprehensive sexuality education and high youth asset scores and contraceptive consistency. Next, to determine if youth who possess multiple youth assets were significantly more likely to report condom, hormonal birth control, or dual method use after accounting for the effects of the youths' exposure to comprehensive sexuality education, regression analyses were performed with both independent measures entered into the model, simultaneously. Each regression model was adjusted for potential confounding demographic variables including youth age, gender, race, parent education, family structure, and income that were significant in the bivariate relationship between the demographic variable and the outcome. To reduce type I error, potential interactions between the total asset or comprehensive sexuality education scores and demographic variables were assessed with an alpha of .01. There was no evidence of interaction in the regression models, and therefore, main effects are presented.

Results

Descriptive data

Demographic data for youth and parents (n = 757) at wave 4 are shown in Table 1. The youths' mean age was 17.5 years (SD = 1.6, range = 14–21 years). Youth were racially and ethnically diverse (37% white, 28% Hispanic, 26% African-American, and 8% other). Most youth lived in two-parent homes, had parents who were employed, and had a parental annual income of less than $35,000. The mean number of assets possessed by the youth participants was 11.1 (range = 1–17 assets), and the mean number of sexuality education topics received was 4.2. Most youth had received formal instruction about the female menstrual cycle (85%), how to say no to sex (83%), abstinence (77%), and birth control (75%). Fewer youth received formal instruction about sexually transmitted diseases (66%) and sexuality being a natural part of life (51%).

Table 1
Parent and youth demographic, asset total, comprehensive sexuality education, and descriptive data at wave 4

Measure	All (%)
Mean age (SD)	17.5 (1.6)
Gender	
Female	52.8
Race	
Non-Hispanic Caucasian or white	37.1
Non-Hispanic, African-American or black	26.4
Hispanic	28.3
Non-Hispanic, other	8.2
Family structure	
Two parent	54.6
One parent	23.8
Inconsistent	21.7
Parental education	
<High school education	16.3
High school education, general educational development, or some college	58.8
>High school education	25.0
Parental employment status	
Employed	74.7
Parental income	
<$35,000	51.3
$35,000–$62,000	27.9
>$62,000	20.7
Mean number of youth assets (SD), (range = 1–17)	11.1 (3.0)
Mean number of sex education topics (SD), (range = 0–6)	4.2 (1.8)
Female menstrual cycle	84.7
How to say no	83.0
Birth control	75.2
Abstinence	76.6
Sexuality as a natural part of life	52.2
Signs and symptoms of sexually transmitted diseases	66.4
Received all topics	29.8

Sample size was n = 757.

Among all sexually active youth, 41% did not use any method of protection at their last sexual intercourse (Table 2). At last sexual intercourse, most youth reported using condoms only (23%) or hormonal birth control only (18%). Fewer youth reported dual method use (16%) or using less effective methods (3%). Among youth who had sex in the last 6 months, 42% reported consistent contraceptive use. As anticipated from the literature, there were significant differences in type of contraceptive used by youth gender, race/ethnicity, and parent education and also in regard to consistent contraceptive use by youth race/ethnicity, income, parent education and income, and family structure (Table 2) [36]. These characteristics were statistically controlled for in the regression analyses.

Sexuality education and youth assets

As shown in Table 3, the regression models included comprehensive sexuality education and youth assets assessed at wave 4 predicting the type of contraceptive method used and contraceptive consistency assessed at wave 5 with the referent groups being no method used and inconsistent contraceptive use, respectively. After controlling for demographic factors, exposure

Table 2
Percentage of youth by each contraceptive behavior at last sex at wave 5 according to selected characteristics

Characteristic	Type of contraceptive used last time you had sex					Consistent contraception use	
	No method (%)	Less effective method (%)	Condom use only (%)	Hormonal birth control only (%)	Dual method use (%)	Yes, consistent contraception use (%)	No, inconsistent contraception use (%)
All	40.9	2.5	22.9	17.9	15.9	41.7	58.3
Demographic							
Age	17.4	18.2	17.3	17.8	17.5	17.6	17.4
Gender							
Female	42.9***	2.9***	21.0***	21.6***	11.7***	43.0	57.0
Male	38.6***	2.1***	25.0***	13.6***	20.8***	40.0	60.0
Race**							
Non-Hispanic Caucasian	39.4**	3.7**	16.8**	22.3**	17.9**	48.4**	51.7**
Non-Hispanic African-American	50.3**	.5**	20.9**	12.3**	16.0**	31.4**	68.6**
Hispanic	37.4**	2.5**	31.3**	16.2**	12.6**	41.4**	58.6**
Non-Hispanic other	29.3**	3.5**	29.3**	20.7**	17.2**	42.2**	57.8**
Income							
<$35,000	43.7	2.9	24.9	15.2	13.3	34.8**	65.2**
$35,000–$62,000	38.0	1.4	24.5	19.7	16.4	43.2**	56.8**
>$62,000	38.2	2.6	17.8	21.0	20.4	51.1**	48.9**
Parent education							
<HS education	40.0*	3.8*	25.7*	17.1*	13.3*	39.6**	60.4**
HS, GED, or some college	46.1*	1.7*	21.2*	16.5*	14.5*	36.3**	63.7**
Bachelor degree or>	30.4*	3.8*	23.9*	21.7*	20.1*	47.2**	52.8**
Family structure							
Two parent	37.4	1.8	24.0	21.1	15.7	46.4**	53.6**
One parent	42.1	2.3	23.4	14.6	17.5	38.2**	61.8**
Inconsistent	48.1	4.4	19.6	13.3	14.6	33.3**	66.7**
Parent employment							
Employed	39.3	2.1	23.1	18.9	16.6	42.9	57.1
Unemployed	45.3	2.9	21.2	16.5	14.1	36.8	63.2

Numbers are percentages except where noted.
Sample size was n = 757 for type of contraception use and n = 635 for consistent contraception use.
*$p < .05$, **$p < .01$, ***$p < .001$.

to comprehensive sexuality education significantly predicted increased condom use (adjusted odds ratio [AOR] = 2.12, 95% CI = 1.37–3.29) and it approached significance in regard to predicting an increase in dual method use (AOR = 1.65, 95% CI = 1.00–2.73). After controlling for demographic factors and assets, comprehensive sexuality education remained a significant predictor condom use (AOR = 2.05, 95% CI = 1.32–3.18), but not dual method use (AOR = 1.54, 95% CI = .93–2.55).

After adjusting for demographic factors, a high asset score significantly predicted condom use (AOR = 1.51, 95% CI = 1.01–2.28), hormonal birth control use (AOR = 2.71, 95% CI = 1.69–4.35), and dual method use (AOR = 2.35, 95% CI = 1.44–3.82). After controlling for demographic factors and receiving comprehensive sexuality education, a high asset score remained a significant predictor of hormonal birth control use (AOR = 2.09, 95% CI = 1.28–3.42) and dual method use (AOR = 2.58, 95% CI = 1.61–4.15).

In addition, a high asset score significantly predicted consistent contraceptive use (AOR = 1.97, 95% CI = 1.38–2.82). A high asset score remained a significant predictor of consistent contraceptive use (AOR = 1.95, 95% CI = 1.36–2.80) after controlling for demographic factors and receiving comprehensive sexuality education.

Table 3
Adjusted odds ratio (AOR) from multinomial and binomial logistic regression models for asset total and comprehensive sexuality education on youth contraceptive behavior outcomes

	AOR for comprehensive sexuality education (95% CI)	AOR for comprehensive sexuality education adjusted for youth assets (95% CI)c	AOR for high asset score (95% CI)	AOR for high asset score adjusted for comprehensive sexuality education (95% CI)[d]
Type of contraceptive used[a]				
No method	Reference	Reference	Reference	Reference
Less effective method	1.18 (.36–3.86)	1.19 (.36–3.90)	.86 (.31–2.39)	.68 (.23–1.99)
Condom use only	**2.12 (1.37–3.29)**	**2.05 (1.32–3.18)**	**1.51 (1.01–2.28)**	1.37 (.90–2.08)
Hormonal birth control use only	1.07 (.65–1.77)	1.00 (.60–1.66)	**2.71 (1.69–4.35)**	**2.09 (1.28–3.42)**
Dual method use[b]	1.65 (1.00–2.73)	1.54 (.93–2.55)	**2.35 (1.44–3.82)**	**2.58 (1.61–4.15)**
Consistent contraception use[c]				
Inconsistent contraceptive use	Reference	Reference	Reference	Reference
Consistent contraception use	.80 (.55–1.17)	.76 (.52–1.11)	**1.97 (1.38–2.82)**	1.95 (1.36–2.80)

The sample size was n = 757 for type of contraception use and n = 635 for consistent contraception use. Bold text = $p < .05$.
[a] Multinomial logistic regression adjusted for youth race and gender and parent education.
[b] Defined as participants responding "yes" to condoms and "yes" to at least one of the hormonal birth control methods (birth control pill, shot, patch, or ring).
[c] Binomial logistic regression adjusted for youth race, family structure, parent employment, income, and education.
[d] Multinomial and bionomial logistic regression models including assets and comprehensive sexuality education and adjusted for demographic characteristics.

Discussion

This study investigated the prospective associations of youth assets and comprehensive sexuality education and type of contraceptive method used and contraceptive consistency among youth who were sexually active. This study extends previous research of comprehensive sexuality education and youth assets, by considering the impact youth assets have on contraceptive behaviors after considering youths' experience with comprehensive sexuality education. After considering exposure to comprehensive sexuality education, a high asset score remained a significant predictor of hormonal birth control use (AOR = 2.09) and dual method use (AOR = 2.58) (relative to using no method) and consistent contraceptive use (AOR = 1.95).

These findings suggest that the odds of using the most effective methods of birth control and doing so consistently are significant even after considering youths' exposure to comprehensive sexuality education. The findings are particularly salient as improvements in the use of hormonal birth control and dual method are driving the declines in the teen pregnancy rate according to some researchers [3]. These results indicate that positive youth development programs that can help youth build assets can be an important part of improving the most effective contraceptive behaviors and helping youth use contraception more consistently even in the absence of reproductive health content.

The present study also extends the research of Oman et al. [20] by examining the association between multiple youth assets and other types of contraceptive methods used and contraceptive consistency. Sexually active youth with a high asset score had increased odds of condom use (AOR = 1.51), hormonal birth control use (AOR = 2.71), and dual method use (AOR = 2.35) (relative to using no method) compared to their peers who possessed fewer assets. A high asset score also increased the odds of consistent contraception use (AOR = 1.97).

Youth exposed to comprehensive sexuality education were twice as likely (AOR = 2.12) to use condoms (relative to using no method) as youth who did not receive comprehensive sexuality education. These findings agree with previous research that suggests comprehensive sexuality education programs and asset building programs can have a positive effect on youth contraceptive behaviors [9–12,17,22–24]. However, surprisingly, this study also found that comprehensive sexuality education was not associated with the use of more effective types of contraceptives including hormonal methods or consistent contraceptive use. This suggests a need for comprehensive sexuality education programs to not only provide instruction about condoms, but also to address the low-maintenance methods such as birth control implants, intrauterine devices, or injectables (Depo-Provera) that are more effective than condom use alone.

Limitations of this study include that it did not consider the quality of sexuality education received or which sexuality education topics best predict the use of the most effective forms of birth control or contraceptive consistency. Similarly, the setting and the person responsible for delivering the sexuality education were not considered in the study. Additionally, the findings of this study may be limited by the validity of self-reported contraceptive behaviors. Youth may report socially desirable behaviors that indicate responsible sexual activity, resulting in an over-reporting of contraceptive use. To reduce social desirability bias, teen respondents used a computer to self-report all sexual behaviors, without the interviewer present. Also, birth control implant and intrauterine device were not included as possible "other" forms of birth control, and therefore, dual method contraceptive use and hormonal birth control use may have been underestimated. Another limitation was that a few of the asset measures had low reliability which may have affected interpretation of the results. Finally, the 61% response rate may have introduced bias; for example, families with youth who possessed fewer assets or who engaged in more sexual risk behaviors may have been less likely to participate.

This research has important implications for additional research as well as practice. Continued research is necessary, using experimental research designs, to investigate the effectiveness of interventions intended to strengthen and increase youth assets. If the results of such studies are positive, youth development programs that do not include reproductive health topics may provide conservative communities with a socially acceptable strategy to improve teen contraceptive behaviors in their community. Additionally, public health practitioners may consider implementing traditional comprehensive sexuality education programs within a positive youth development framework by including mentorship activities, opportunities to belong and make a difference, provision of supportive relationships, and integration of family, school, and community efforts [37,38].

In conclusion, this study found that youth assets are positively associated with the use of effective forms of birth control (hormonal birth control and dual method use) and consistent contraceptive use, even after considering youths' experience with comprehensive sexuality education. Public health practitioners should consider widespread implementation of youth development programs that help build youth assets and ultimately promote contraceptive.

Human participant protection

This study underwent and received full review and approval from the Institutional Review Board of the University of Oklahoma Health Sciences Center.

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What does CONFIDENTIAL mean?

1) It means Private

2) You can trust that it will not be shared with others*

*Unless you talk about abuse, neglect, harming yourself or others, or other acts that must be reported to DCF by law

So what?

This means that if you go to the health office for condoms, answers to questions, or to find out about medical services, the conversation **remains private***!

Did you know?

In Vermont anyone 12 or older has the right to receive sexual & reproductive health services without parental permission. (18 V.S.A. § 4226)

While parental permission is not needed for these services, parents may find out if you use your health insurance.

We encourage all young people to have an adult that they trust to talk to about sexual health and relationships.

You have the right to birth control, STD testing and care, pregnancy tests, and more.

For more information, speak to _____ or visit us between:

_____a.m. and _____p.m.

This poster is intended to be customized by school nurses, health offices, and others who work with youth to identify when and to whom they can ask questions or have conversations about sexual health services.

VERMONT
AGENCY OF EDUCATION

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Healthy Relationship Quiz

EVERYONE DESERVES TO BE IN A SAFE AND HEALTHY RELATIONSHIP. DO YOU KNOW IF YOUR RELATIONSHIP IS HEALTHY? ANSWER YES OR NO TO THE FOLLOWING QUESTIONS TO FIND OUT. MAKE SURE TO CHECK THE BOXES TO RECORD YOUR RESPONSES. AT THE END, YOU'LL FIND OUT HOW TO SCORE YOUR ANSWERS.

THE PERSON I'M WITH	YES	NO
1. Is very supportive of things that I do.	○	○
2. Encourages me to try new things.	○	○
3. Likes to listen when I have something on my mind.	○	○
4. Understands that I have my own life too.	○	○
5. Is not liked very well by my friends.	○	○
6. Says I'm too involved in different activities.	○	○
7. Texts me or calls me all the time.	○	○
8. Thinks I spend too much time trying to look nice.	○	○
9. Gets extremely jealous or possessive.	○	○
10. Accuses me of flirting or cheating.	○	○
11. Constantly checks up on me or makes me check in.	○	○
12. Controls what I wear or how I look.	○	○
13. Tries to control what I do and who I see.	○	○
14. Tries to keep me from seeing or talking to my family and friends.	○	○
15. Has big mood swings, getting angry and yelling at me one minute but being sweet and apologetic the next.	○	○
16. Makes me feel nervous or like I'm "walking on eggshells."	○	○
17. Puts me down, calls me names or criticizes me.	○	○
18. Makes me feel like I can't do anything right or blames me for problems.	○	○
19. Makes me feel like no one else would want me.	○	○
20. Threatens to hurt me, my friends or family.	○	○
21. Threatens to hurt themselves because of me.	○	○
22. Threatens to destroy my things (Phone, clothes, laptop, car, etc.).	○	○
23. Grabs, pushes, shoves, chokes, punches, slaps, holds me down, throws things or hurts me in some way.	○	○
24. Breaks or throws things to intimidate me.	○	○
25. Yells, screams or humiliates me in front of other people.	○	○
26. Pressures or forces me into having sex or going farther than I want to.	○	○

love is respect org

Healthy Relationship

SCORING

GIVE YOURSELF ONE POINT FOR EVERY NO YOU ANSWERED TO NUMBERS 1-4, ONE POINT FOR EVERY YES RESPONSE TO NUMBERS 5-8 AND FIVE POINTS FOR EVERY YES TO NUMBERS 9 AND ABOVE.

NOW THAT YOU'RE FINISHED AND HAVE YOUR SCORE, THE NEXT STEP IS TO FIND OUT WHAT IT MEANS. SIMPLY TAKE YOUR TOTAL SCORE AND SEE WHICH OF THE CATEGORIES BELOW APPLY TO YOU.

0pts

You got a score of zero? Don't worry -- it's a good thing! It sounds like your relationship is on a pretty healthy track. Maintaining healthy relationships takes some work -- keep it up! Remember that while you may have a healthy relationship, it's possible that a friend of yours does not. If you know someone who is in an abusive relationship, find out how you can help them by visiting loveisrespect.org.

1-2pts

If you scored one or two points, you might be noticing a couple of things in your relationship that are unhealthy, but it doesn't necessarily mean they are warning signs. It's still a good idea to keep an eye out and make sure there isn't an unhealthy pattern developing.
The best thing to do is to talk to your partner and let them know what you like and don't like. Encourage them to do the same. Remember, communication is always important when building a healthy relationship. It's also good to be informed so you can recognize the different types of abuse.

3-4pts

If you scored five or points, you are definitely seeing warning signs and may be in an abusive relationship. Remember the most important thing is your safety — consider making a safety plan.
You don't have to deal with this alone. We can help. Chat with a trained peer advocate to learn about your different options at loveisrespect.org.

5pts

If you scored five or points, you are definitely seeing warning signs and may be in an abusive relationship. Remember the most important thing is your safety -- consider making a safety plan.
You don't have to deal with this alone. We can help. Chat with a trained peer advocate to learn about your different options at loveisrespect.org.

This project described was supported by Grant Number 90EV0426 from the Administration on Children, Youth and Families, Family and Youth Services Bureau, U.S. Department of Health and Human Services. The opinions, findings, conclusions and recommendations expressed in this publication are those of the author(s) and do not necessarily reflect the views of the Administration on Children, Youth and Families, Family and Youth Services Bureau, U.S. Department of Health and Human Services.

THE LOWDOWN ON HOW TO PREVENT SEXUALLY TRANSMITTED DISEASES

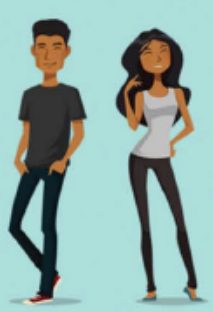
Every year, there are an estimated

20 MILLION

new STD infections in the United States

Anyone who is sexually active can get an STD.

Some groups are disproportionately affected by STDs



Adolescents and Young Adults

Gay, Bisexual, & other Men who have Sex with Men

Some Racial and Ethnic Minorities

The Good News

STDs **ARE** preventable. There are steps you can take to keep yourself and your partner(s) healthy.

Here's How You Can Avoid Giving or Getting an STD:

Practice Abstinence

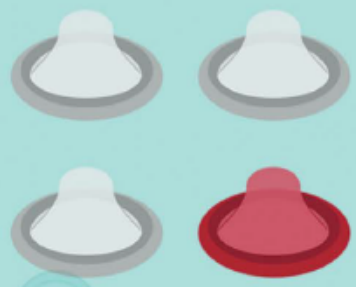
The surest way to avoid STDs is to not have sex.

This means not having vaginal, oral, or anal sex.

Use Condoms

Using a condom correctly every time you have sex can help you avoid STDs.

Condoms lessen the risk of infection for all STDs. You still can get certain STDs, like herpes or HPV, from contact with your partner's skin even when using a condom.

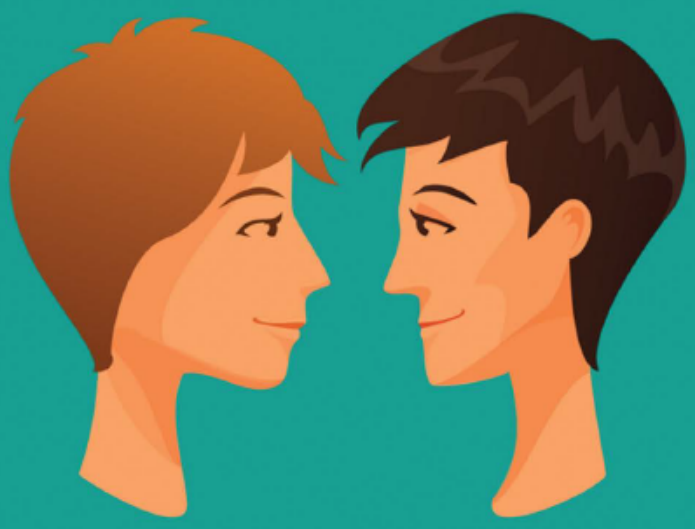


Most people claimed they used a condom the first time they ever had sex, but when asked about the last 4 weeks, less than one quarter said they used a condom every time.

View Infographic Online at: www.

Have Fewer Partners

Agree to only have sex with one person who agrees to only have sex with you.



Make sure you both get tested to know for sure that neither of you has an STD. This is one of the most reliable ways to avoid STDs.

Talk With Your Partner

Talk with your sex partner(s) about STDs and staying safe before having sex.

It might be uncomfortable to start the conversation, but protecting your health is your responsibility.

Get Vaccinated

The most common STD can be prevented by a vaccine.

The HPV vaccine is safe, effective, and can help you avoid HPV-related health problems like genital warts and some cancers.

Who should get the HPV vaccine?

Routine vaccination for boys & girls ages 11 to 12

Catch-up vaccination for:

Young women from age 13 to age 26 and young men from age 13 to age 21

Gay, Bisexual, & other Men who have sex with Men up to age 26

Men with compromised immune systems up to age 26

cdc.gov/std/prevention/lowdown/

Get Tested

Many STDs don't have symptoms, but they can still cause health problems.

Talk with your health care provider

Search for CDC recommended tests

Find a location to get tested for STDs

The only way to know for sure if you have an STD is to get tested.

If You Test Positive...

Getting an STD is not the end!

Many STDs are curable and all are treatable.

If either you or your partner is infected with an STD that can be cured, both of you need to start treatment immediately to avoid getting re-infected.

Screening Recommendations and Considerations Referenced in the 2015 STD Treatment Guidelines and Original Sources

	Women	Pregnant Women	Men	Men Who Have Sex With Men (MSM)	Persons with HIV
CHLAMYDIA	Sexually active women under 25 years of age *USPSTF*[1] Sexually active women aged25 years and older if at increased risk[2] *USPSTF*[1] Retest approximately 3 months after treatment *CDC*[3]	All pregnant women under 25 years of age *USPSTF*[1] Pregnant women, aged 25 years and older if at increased risk[2] *USPSTF*[1] Retest during the 3rd trimester for women under 25 years of age or at risk[4] *CDC*[3] Pregnant women with chlamydial infection should have a test-of-cure 3-4 weeks after treatment and be retested within 3 months *USPSTF*[1]	*Consider screening young men in high prevalence clinical settings[5] or in populations with high burden of infection (e.g. *CDC*[6]	At least annually for sexually active MSM at sites of contact (urethra, rectum) regardless of condom use *CDC*[6] Every 3 to 6 months if at increased risk[7] *CDC*[7]	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter *CDC*[8] More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology *CDC*[8]
GONORRHEA	Sexually active women under 25 years of age *USPSTF*[1] Sexually active women age 25 years and older if at increased risk[9] *USPSTF*[1] Retest 3 months after treatment *CDC*[10]	All pregnant women under 25 years of age and older women if at increased risk[11] *USPSTF*[1] Retest 3 months after treatment *CDC*[10]		At least annually for sexually active MSM at sites of contact (urethra, rectum, pharynx) regardless of condom use *CDC*[10] Every 3 to 6 months if at increased risk[7] *CDC*[7]	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter *CDC*[10] More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology *CDC*[10]
SYPHILIS		All pregnant women at the first prenatal visit *USPSTF*[11] Retest early in the third trimester and at delivery if		At least annually for sexually active MSM *CDC*[13] Every 3 to 6 months if at increased risk[7]	For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter *CDC, HRSA, IDSA, NIH*[14,15,16]

	Women	Pregnant Women	Men	Men Who Have Sex With Men (MSM)	Persons with HIV
		at high risk *AAP/ACOG*[12]		*CDC*[7]	More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology *CDC*[13]
TRICHOMONAS	*Consider for women receiving care in high-prevalence settings (e.g., STD clinics and correctional facilities) and for women at high risk for infection (e.g., women with multiple sex partners, exchanging sex for payment, illicit drug use, and a history of STD) *CDC*[17]				Recommended for sexually active women at entry to care and at least annually thereafter *CDC*[14]
HERPES	*Type-specific HSV serologic testing should be considered for women presenting for an STD evaluation (especially for women with multiple sex partners) CDC[17]	*Evidence does not support routine HSV-2 serologic screening among asymptomatic pregnant women. However, type-specific serologic tests might be useful for identifying pregnant women at risk for HSV infection and guiding counseling regarding the risk for acquiring genital herpes during pregnancy *CDC*[17]	*Type-specific HSV serologic testing should be considered for men presenting for an STD evaluation (especially for men with multiple sex partners) *CDC*[17]	*Type-specific serologic tests can be considered if infection status is unknown in MSM with previously undiagnosed genital tract infection *CDC*[17]	*Type-specific HSV serologic testing should be considered for persons presenting for an STD evaluation (especially for those persons with multiple sex partners), persons with HIV infection, and MSM at increased risk for HIV acquisition CDC[17]
HIV	All women aged 13-64 years (opt-out)** *CDC*[18] All women who seek evaluation and treatment for STDs *CDC*[19]	All pregnant women should be screened at first prenatal visit (opt-out) *USPSTF*[20] Retest in the third trimester if at high risk *CDC*[21]	All men aged 13-64 years (opt-out)** *CDC*[18] All men who seek evaluation and treatment for STDs *CDC*[19]	At least annually for sexually active MSM if HIV status is unknown or negative and the patient himself or his sex partner(s) have had more than one sex partner since most recent HIV test *CDC*[22]	

	Women	Pregnant Women	Men	Men Who Have Sex With Men (MSM)	Persons with HIV
CERVICAL CANCER	Women 21-29 years of age every 3 years with cytology Women 30-65 years of age every 3 years with cytology, or every 5 years with a combination of cytology and HPV testing *USPSTF[23],ACOG[24],ACS[25]*	Pregnant women should be screened at same intervals as nonpregnant women *USPSTF[23],ACOG[24],ACS[25]*			Women should be screened within 1 year of sexual activity or initial HIV diagnosis using conventional or liquid-based cytology; testing should be repeated 6 months later *CDC, NIH, IDSA[26]*
HEPATITIS B SCREENING	Women at increased risk *CDC[27]*	Test for HBsAg at first prenatal visit of each pregnancy regardless of prior testing; retest at delivery if at high risk *CDC,[27] USPSTF [28]*	Men at increased risk *CDC[27]*	All MSM should be tested for HBsAg *CDC[27]*	Test for HBsAg and anti-HBc and/or anti-HBs. *CDC[27]*
HEPATITIS C SCREENING	Women born between 1945-1965 *CDC,[29] USPSTF[30]* Other women if risk factors are present[30] *USPSTF[30]*	Pregnant women born between 1945-1965 *CDC,[29] USPSTF[30]* Other pregnant women if risk factors are present[30] *USPSTF[30]*	Men born between 1945-1965 *CDC,[29] USPSTF[30]* Other men if risk factors are present[30] *USPSTF[30]*	MSM born between 1945-1965 *CDC[29]* Other MSM if risk factors are present[30] *USPSTF[30]* Annual HCV testing in MSM with HIV infection *CDC[31]*	Serologic testing at initial evaluation *CDC, NIH, IDSA[32,33]* Annual HCV testing in MSM with HIV infection *CDC[31]*

** Please note that portions of this table marked with an asterisk are considerations and should not be interpreted as formal recommendations.*

*** USPSTF recommends screening in adults and adolescents ages 15-65*

[1] LeFevre ML. Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement. Annals of internal medicine. Sep 23 2014.

[2] Those who have a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection. Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement. Annals of internal medicine. Sep 23 2014.

[3] Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

[4] e.g., those with a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

[5] Adolescent clinics, correctional facilities, and STD clinics. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

[6] Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

[7] More frequent STD screening (i.e., for syphilis, gonorrhea, and chlamydia) at 3–6-month intervals is indicated for MSM, including those with HIV infection if risk behaviors persist or if they or their sexual partners have multiple partners. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

[8] Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

[9] Those who have a new sex partner, more than one sex partner, a sex partner with concurrent partners, or a sex partner who has an STI. Additional risk factors for gonorrhea include inconsistent condom use among persons who are not in mutually monogamous relationships; previous or coexisting sexually transmitted infections; and exchanging sex for money or drugs. Clinicians should consider the communities they serve and may opt to consult local public health authorities for guidance on identifying groups that are at increased risk. Screening for Chlamydia and Gonorrhea: U.S. Preventive Services Task Force Recommendation Statement. Annals of internal medicine. Sep 23 2014.

[10] Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

[11] US Preventive Services Task Force. Screening for syphilis infection in pregnancy: reaffirmation recommendation statement. Annals of internal medicine. 5/19/2009 2009;150(10):705-709.

[12] American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and March of Dimes Birth Defects Foundation. Guidelines for Perinatal Care. 6th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2007

[13] Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

[14] CDC, Health Resources and Services Administration, National Institutes of Health, HIV Medicine Association of the Infectious Diseases Society of America, HIV Prevention in Clincal Care Working Group. Recommendations for incorporating human immunodeficiency virus (HIV) prevention into the medical care of persons living with HIV. Clin Infect Dis. Jan 1 2004;38(1):104-121.

[15] Aberg JA, Gallant JE, Ghanem KG et al. Primary Care Guidelines for the Management of Persons Infected With HIV: 2013 Update by the HIV Medicine Association of the Infectious Diseases Society of America. CID. Jan 1 2014;58: e1-e34.

[16] Centers for Disease Control and Prevention, Health Resources and Services Administration, National Institutes of Health, American Academy of HIV Medicine, Association of Nurses in AIDS Care, International Association of Providers of AIDS Care, the National Minority AIDS Council, and Urban Coalition for HIV/AIDS Prevention Services. *Recommendations for HIV Prevention with Adults and Adolescents with HIV in the United States, 2014*. 2014. http://stacks.cdc.gov/view/cdc/26062. December 11, 2014.

[17] Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

[18] CDC. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *MMWR.* 9/22/2006 2006;55(No. RR-14):1-17.

[19] Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

[20] Moyer VA, US Preventive Services Task Force. Screening for HIV: US Preventive Services Task Force Recommendation Statement. *Annals of internal medicine.* 2013;159:51–60.

[21] Women who use illicit drugs, have STDs during pregnancy, have multiple sex partners during pregnancy, live in areas with high HIV prevalence, or have partners with HIV infection. Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

[22] Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

[23] Moyer VA. Screening for cervical cancer: US Preventive Services Task Force recommendation statement. *Annals of internal medicine.* Jun 19 2012;156(12):880-891, W312.

[24] American College of Obstetricians and Gynecologists (ACOG). Screening for cervical cancer. ACOG Practice Bulletin Number 131. Obstet Gynecol. Nov 2012;120(5):1222-1238.

[25] Saslow D, Solomon D, Lawson HW, et al. American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer. CA Cancer J Clin. May-Jun 2012;62(3):147-172.

[26] Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents. Guidelines for prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America.Available at: http://aidsinfo.nih.gov/contentfiles/lvguidelines/adult_oi.pdf

[27] Those at increased risk include persons born in regions of high endemicity (>=2% prevalence), IDU, MSM, persons on Immunosuppresive therapy, Hemodialysis patients, HIV positive individuals, and others. For detailed recommendations refer to: Centers for Disease Control and Prevention. Recommendations for Identification and Public Health Management of Person swith Chronic Hepatitis B Virus Infection,2008. MMWR September 19th, 2008; 57(RR-8);1-21. Available at: http://www.cdc.gov/mmwr/pdf/rr/rr5708.pdf

[28] U.S. Preventive Services Task Force. Screening for Hepatitis B Virus Infection in Pregnancy: U.S. Preventive Services Task Force Reaffirmation Recommendation Statement. *Ann Intern Med* 2009;150:869-73

[29] Smith BD, Morgan RL, Beckett GA, et al. Recommendations for the identification of chronic hepatitis C virus infection among persons born during 1945-1965. MMWR. Aug 17 2012;61(No. RR-4):1-32.

[30] Past or current injection drug use, receipt of blood transfusion before 1992, long term hemodialysis, born to mother with Hep. C, intranasal drug use, receipt of an unregulated tattoo, and other percutaneous exposures. Moyer VA. Screening for hepatitis C virus infection in adults: US Preventive Services Task Force recommendation statement. Annals of internal medicine. Sep 3 2013;159(5):349-357.

[31] Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2015.

[32] Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents. Guidelines for prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America.Available at: http://aidsinfo.nih.gov/contentfiles/lvguidelines/adult_oi.pdf

[33] Aberg JA, Gallant JE, Ghanem KG et al. Primary Care Guidelines for the Management of Persons Infected With HIV: 2013 Update by the HIV Medicine Association of the Infectious Diseases Society of America. CID. Jan 1 2014;58: e1-e34.

Planned Parenthood® of Northern New England

STI Testing and Treatment

Bacterial Infections

Infection	About the Infection	Type of Test	When after exposure to test	Treatment
Chlamydia	• Caused by bacteria • Usually no symptoms • If symptoms do occur, may include ▪ genital discharge ▪ pain during urination ▪ pelvic or testicular pain	Urine test or swab of the genital area (from cervix or penis)	2 weeks or more after exposure	Cured with antibiotics
Gonorrhea	• Caused by bacteria • Usually no symptoms • If symptoms do occur, may include ▪ genital discharge ▪ pain during urination ▪ pelvic or testicular pain	Urine test or swab of the genital area (from cervix or penis)	2 weeks or more after exposure	Cured with antibiotics
Syphilis	• Caused by bacteria • May not have symptoms • May have painless sores on genitals or mouth, rash	Blood test Swab of sore	4-12 weeks after exposure	Cured with antibiotics
Pubic Lice (Crabs)	• Caused by parasite • Symptoms include intense itching of genital area • Nits (eggs) may be visible on pubic hair	Visual exam Skin/hair sample viewed under microscope	When symptoms occur	Cured with over the counter medication and thorough cleaning
Scabies	• Caused by parasite • Symptoms include intense itching of genital area, mall bumps or rash on genital area, buttocks, breasts, thighs	Visual exam Skin sample viewed under microscope	When symptoms occur	Cured with over the counter or prescription medication
Trichomonas	• Caused by parasite • May not have symptoms • May have genital discharge and itching, pain during urination	Swab of genital area or discharge	2 weeks or more after exposure	Cured with antimicrobials

Viral Infections

Infection	About the Infection	Type of Test	When after exposure to test	Treatment
Hepatitis B and C	• Caused by a virus • Symptoms may include tiredness, abdominal pain, yellowing of eyes or skin • May not have symptoms • Vaccine available for Hepatitis B	Blood test	3+ months after exposure	There is no cure for Hepatitis B or C; treatment is available to help manage the condition.
Genital Herpes	• Caused by a virus • Can cause painful sores on the genitals or other areas of skin • May not have symptoms	Swab of sore during an outbreak	When symptoms occur	There is no cure for Herpes; treatment is available to help manage the condition if needed.
HIV	• Caused by a virus • Early infection rarely has symptoms • If symptoms do occur, may include ▪ flu-like feelings ▪ rash ▪ joint pain • PrEP is a once a day medication that prevents HIV infection	Blood test or swab from inside of mouth	3+ months after exposure	There is no cure for HIV; treatment is available to help manage the condition.
Human Papilloma Virus (HPV)	• Caused by a virus • Usually no symptoms • There are many kinds of HPV- some are associated with cancers of the cervix, vagina, vulva, penis, anus, or mouth. • Vaccine available	Pap test (sample from cervix) *There is no test available for people who do not have a cervix.*	Routine testing is recommended. Infection can take weeks, months, or years to test positive.	There is no cure. Medications can alleviate some symptoms; further treatment may be needed. Immunity develops over time in many individuals.
Genital Warts (HPV)	• Caused by a virus • Painless, sometimes itchy genital bumps • Vaccine available	No test for types of HPV that cause warts. Bumps can be checked by a health care provider.	When symptoms occur	There is no cure. Medications can alleviate some symptoms; warts can be surgically removed. Immunity develops over time in many individuals.

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*

[1]Youth Risk Behavior Survey, National Youth Behavior Survey: 2007.
[2]Kaiser 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 breech 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 breech 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. Expediated 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/uspschlm.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 ACTS[4] (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	REASONS AGAINST 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]	▸ Routine or universal HIV testing (by itself without counseling) was cost-effective even in low prevalent settings (prevalence >0.1%).[7,8]
▸ Identifies personal risk of HIV infections.	▸ Normalizes HIV and makes it a part of regular STI screenings.
▸ Reduces anxiety by preparing client for a positive diagnosis.	▸ Time constraints for primary care physicians
▸ Decreases cost of repeat testing and stress for clients with no or low risk for HIV.	▸ Counseling for HIV can be integrated into risk-reduction counseling for all clients when discussing other STIs and drug use.
▸ Opens discussion for additional testing and counseling	▸ Client has already been counseled before and does not need more information.
▸ Assesses social support.	

[1]Morris M, Handcock 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.
[2]Marks G, Crepaz 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.
[3]MMWR Morb Mortal Wkly Rep 2006; 55:1-17.
[4]Developed by the Adolescent AIDS Program at Montefiore Medical Center.
[5]Goodman 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.
[6]Samet 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.
[7]Sanders 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.
[8]Paltiel 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

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- ***http://www.adolesecentaids.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.

[1]American 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.
[2]Ibid

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]

[1]2002 American Cancer Society Recommendations can be accessed from the CDC's website at http://www.cdc.gov/std/hpv/ScreeningTables.pdf.
[2]ACOG Practice Bulletin: Clinical Management Guidelines for Obstetrician-Gynecologists. Cervical Cytology Screening. Dec 2009; 109.
[3]Center 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
[5]Evans, D. Pap Smears for Anal Cancer? Poz Magazine. June 2008.

Human Papillomavirus (HPV) Related Cancers *cont.*

SCREENING FOR CERVICAL CANCER[6]:

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.

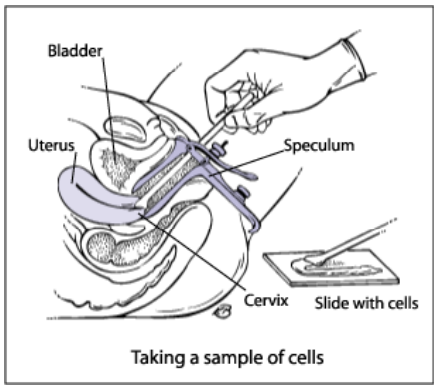

Image taken from "FamilyDoctor.org: Pap Smear": http://familydoctor.org/138.xml

Follow-Up[8]

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.

[6]ACOG Practice Bulletin: Clinical Management Guidelines for Obstetrician-Gynecologists. Cervical Cytology Screening. Dec 2009; 109.
[7]Center 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.
[8]ASCCP Recommendations for the Management of Women with Abnormal Cervical Cancer Screening Tests which can be accessed at http://www.asccp.org/consensus.shtml.

Sexually Transmitted Diseases

Summary of 2015 CDC Treatment Guidelines

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of STD Prevention

Sexually Transmitted Diseases: Summary of 2015 CDC Treatment Guidelines

These summary guidelines reflect the 2015 CDC Guidelines for the Treatment of Sexually Transmitted Diseases. They are intended as a source of clinical guidance. An important component of STD treatment is partner management. Providers can arrange for the evaluation and treatment of sex partners either directly or with assistance from state and local health departments. Complete guidelines can be ordered online at www.cdc.gov/std/treatment or by calling 1 (800) CDC-INFO (1-800-232-4636).

DISEASE	RECOMMENDED Rx		DOSE/ROUTE	ALTERNATIVES
Bacterial Vaginosis	metronidazole oral[1] metronidazole gel 0.75%[1] clindamycin cream 2%[1,2] ★ Treatment is recommended for all symptomatic pregnant women.	OR OR	500 mg orally 2x/day for 7 days One 5 g applicator intravaginally 1x/day for 5 days One 5 g applicator intravaginally at bedtime for 7 days	tinidazole 2 g orally 1x/day for 2 days OR tinidazole 1 g orally 1x/day for 5 days OR clindamycin 300 mg orally 2x/day for 7 days OR clindamycin ovules 100 mg intravaginally at bedtime for 3 days
Cervicitis	azithromycin doxycycline[3]	OR	1 g orally in a single dose 100 mg orally 2x/day for 7 days	Consider concurrent treatment for gonococcal infection if at risk of gonorrhea or lives in a community where the prevalence of gonorrhea is high. Presumptive treatment with antimicrobials for *C. trachomatis* and *N. gonorrhoeae* should be provided for women at increased risk (e.g., those aged <25 years and those with a new sex partner, a sex partner with concurrent partners, or a sex partner who has a sexually transmitted infection), especially if follow-up cannot be ensured or if NAAT testing is not possible.
Chlamydial Infections Adults and adolescents	azithromycin doxycycline[3]	OR	1 g orally in a single dose 100 mg orally 2x/day for 7 days	erythromycin base[4] 500 mg orally 4x/day for 7 days OR erythromycin ethylsuccinate[5] 800 mg orally 4x/day for 7 days OR levofloxacin[6] 500 mg 1x/day orally for 7 days OR ofloxacin[6] 300 mg orally 2x/day for 7 days
Pregnancy[3]	azithromycin[7]		1 g orally in a single dose	★ amoxicillin 500 mg orally 3x/day for 7 days OR erythromycin base[4,8] 500 mg orally 4x/day for 7 days OR erythromycin base 250 mg orally 4x/day for 14 days OR erythromycin ethylsuccinate 800 mg orally 4x/day for 7 days OR erythromycin ethylsuccinate 400 mg orally 4x/day for 14 days
Infants and Children (<45 kg): urogenital, rectal	erythromycin base[9] ethylsuccinate	OR	50 mg/kg/day orally (4 divided doses) daily for 14 days	★ Data are limited on the effectiveness and optimal dose of azithromycin for chlamydial infection in infants and children < 45 kg
Neonates: opthalmia neonatorum, pneumonia	erythromycin base[9] ethylsuccinate	OR	50 mg/kg/day orally (4 divided doses) daily for 14 days	★ azithromycin 20 mg/kg/day orally, 1 dose daily for 3 days
Epididymitis[10,11]				
For acute epididymitis most likely caused by sexually transmitted CT and GC	ceftriaxone doxycycline	PLUS	250 mg IM in a single dose 100 mg orally 2x/day for 10 days	
★ For acute epididymitis most likely caused by sexually-transmitted chlamydia and gonorrhea and enteric organisms (men who practice insertive anal sex)	ceftriaxone levofloxacin ofloxacin	PLUS OR	250 mg IM in a single dose 500 mg orally 1x/day for 10 days 300 mg orally 2x/day for 10 days	
For acute epididymitis most likely caused by enteric organisms	levofloxacin ofloxacin	OR	500 mg orally 1x/day for 10 days 300 mg orally 2x/day for 10 days	
Genital Herpes Simplex				
First clinical episode of genital herpes	acyclovir acyclovir valacyclovir[12] famciclovir[12]	OR OR OR	400 mg orally 3x/day for 7-10 days[13] 200 mg orally 5x/day for 7-10 days[13] 1 g orally 2x/day for 7-10 days[13] 250 mg orally 3x/day for 7-10 days[13]	
Episodic therapy for recurrent genital herpes	acyclovir acyclovir acyclovir valacyclovir[12] valacyclovir[12] famciclovir[12] famciclovir[12] famciclovir[12]	OR OR OR OR OR OR OR	400 mg orally 3x/day for 5 days 800 mg orally 2x/day for 5 days 800 mg orally 3x/day for 2 days 500 mg orally 2x/day for 3 days 1 g orally 1x/day for 5 days 125 mg orally 2x/day for 5 days 1000 mg orally 2x/day for 1 day[13] 500 mg orally once, followed by 250 mg 2x/day for 2 days	
Suppressive therapy[14] for recurrent genital herpes	acyclovir valacyclovir[12] valacyclovir[12] famciclovir[12]	OR OR OR	400 mg orally 2x/day 500 mg orally 1x/day 1 g orally once a day 250 mg orally 2x/day	
Recommended regimens for episodic infection in persons with HIV infection	acyclovir valacyclovir[12] famciclovir[12]	OR OR	400 mg orally 3x/day for 5-10 days 1 g orally 2x/day for 5-10 days 500 mg orally 2x/day for 5-10 days	
Recommended regimens for daily suppressive therapy in persons with HIV infection	acyclovir valacyclovir[12] famciclovir[12]	OR OR	400-800 mg orally 2-3x/day 500 mg orally 2x/day 500 mg orally 2x/day	
Genital Warts[15] (Human Papillomavirus) External genital and perianal warts	**Patient Applied** ★ imiquimod 3.75% or 5%[12] cream podofilox 0.5%[15] solution or gel sinecatechins 15% ointment[2,12]	OR OR	See complete CDC guidelines.	
	Provider Administered Cryotherapy trichloroacetic acid or bichloroacetic acid 80%-90% surgical removal	OR OR	Apply small amount, dry, apply weekly if necessary	★ podophyllin resin 10%–25% in compound tincture of benzoin may be considered for provider-administered treatment if strict adherence to the recommendations for application. OR intralesional interferon OR photodynamic therapy OR topical cidofovir OR
Gonococcal Infections[16] Adults, adolescents, and children >45 kg: uncomplicated gonococcal infections of the cervix, urethra, and rectum	ceftriaxone azithromycin[7]	PLUS	250 mg IM in a single dose 1 g orally in a single dose	★ If ceftriaxone is not available: cefixime[17] 400 mg orally in a single dose PLUS azithromycin[7] 1 g orally in a single dose ★ If cephalosporin allergy: gemifloxacin 320 mg orally in a single dose PLUS azithromycin 2 g orally in a single dose OR gentamicin 240 mg IM single dose PLUS azithromycin 2 g orally in a single dose
Pharyngeal[18]	ceftriaxone azithromycin[7]	PLUS	250 mg IM in a single dose 1 g orally in a single dose	
Pregnancy	See complete CDC guidelines.			
Adults and adolescents: conjunctivitis	ceftriaxone azithromycin[7]	PLUS	1 g IM in a single dose 1 g orally in a single dose	
Children (≤45 kg): urogenital, rectal, pharyngeal	ceftriaxone[19]		25-50 mg/kg IV or IM, not to exceed 125 mg IM in a single dose	
Lymphogranuloma venereum	doxycycline[3]		100 mg orally 2x/day for 21 days	erythromycin base 500 mg orally 4x/day for 21 days
Nongonococcal Urethritis *(NGU)*	azithromycin[7] doxycycline[3]	OR	1 g orally in a single dose 100 mg orally 2x/day for 7 days	erythromycin base[4] 500 mg orally 4x/day for 7 days OR erythromycin ethylsuccinate[5] 800 mg orally 4x/day for 7 days OR levofloxacin 500 mg 1x/day for 7 days OR ofloxacin 300 mg 2x/day for 7 days
★ Persistent and recurrent NGU[3,20,21]	Men initially treated with doxycycline : azithromycin		1 g orally in a single dose	
	Men who fail a regimen of azithromycin: moxifloxacin		400 mg orally 1x/day for 7 days	
	Heterosexual men who live in areas where *T. vaginalis* is highly prevalent: metronidazole[22] tinidazole	OR	2 g orally in a single dose 2 g orally in a single dose	
Pediculosis Pubis	permethrin 1% cream rinse pyrethrins with piperonyl butoxide	OR	Apply to affected area, wash off after 10 minutes Apply to affected area, wash off after 10 minutes	malathion 0.5% lotion, applied 8-12 hrs then washed off OR ivermectin 250 µg/kg, orally repeated in 2 weeks
Pelvic Inflammatory Disease[10]	**Parenteral Regimens** Cefotetan Doxycycline	PLUS OR	2 g IV every 12 hours 100 mg orally or IV every 12 hours	**Parenteral Regimen** Ampicillin/Sulbactam 3 g IV every 6 hours PLUS Doxycycline 100 mg orally or IV every 12 hours
	Cefoxitin Doxycycline	PLUS	2 g IV every 6 hours 100 mg orally or IV every 12 hours	
	Recommended Intramuscular/Oral Regimens Ceftriaxone Doxycycline Metronidazole OR Cefoxitin Probenecid, Doxycycline Metronidazole	PLUS WITH or WITHOUT PLUS PLUS WITH or WITHOUT	250 mg IM in a single dose 100 mg orally twice a day for 14 days 500 mg orally twice a day for 14 days 2 g IM in a single dose 1 g orally administered concurrently in a single dose 100 mg orally twice a day for 14 days 500 mg orally twice a day for 14 days	The complete list of recommended regimens can be found in CDC's 2015 STD Treatment Guidelines.
Scabies	permethrin 5% cream ivermectin	OR	Apply to all areas of body from neck down, wash off after 8-14 hours 200 µg/kg orally, repeated in 2 weeks	lindane 1%[23,24] 1 oz. of lotion or 30 g of cream, applied thinly to all areas of the body from the neck down, wash off after 8 hours
Syphilis Primary, secondary, or early latent <1 year	benzathine penicillin G		2.4 million units IM in a single dose	doxycycline[3,25] 100 mg 2x/day for 14 days OR tetracycline[3,25] 500 mg orally 4x/day for 14 days
Latent >1 year, latent of unknown duration	benzathine penicillin G		2.4 million units IM in 3 doses each at 1 week intervals (7.2 million units total)	doxycycline[3,25] 100 mg 2x/day for 28 days OR tetracycline[3,25] 500 mg orally 4x/day for 28 days
Pregnancy	See complete CDC guidelines.			
Neurosyphilis	aqueous crystalline penicillin G		18–24 million units per day, administered as 3–4 million units IV every 4 hours or continuous infusion, for 10–14 days	procaine penicillin G 2.4 MU IM 1x daily PLUS probenecid 500 mg orally 4x/day, both for 10-14 days.
★ Congenital syphilis	See complete CDC guidelines.			See CDC STD Treatment guidelines for discussion of alternative therapy in patients with penicillin allergy.
Children: Primary, secondary, or early latent <1 year	benzathine penicillin G		50,000 units/kg IM in a single dose (maximum 2.4 million units)	
Children: Latent >1 year, latent of unknown duration	benzathine penicillin G		50,000 units/kg IM for 3 doses at 1 week intervals (maximum total 7.2 million units)	
Trichomoniasis	metronidazole[22] tinidazole[26]	OR	2 g orally in a single dose 2 g orally in a single dose	metronidazole[22] 500 mg 2x/day for 7 days
Persistent or recurrent trichomoniasis	metronidazole		500mg orally 2x/day for 7 days	
	If this regimen fails: metronidazole tinidazole	OR	2g orally for 7 days 2g orally for 7 days	
	If this regimen fails, susceptibility testing is recommended.			

1. The recommended regimens are equally efficacious.
2. These creams are oil-based and may weaken latex condoms and diaphragms. Refer to product labeling for further information.
3. Should not be administered during pregnancy, lactation, or to children <8 years of age.
4. If patient cannot tolerate high-dose erythromycin base schedules, change to 250 mg 4x/day for 14 days.
5. If patient cannot tolerate high-dose erythromycin ethylsuccinate schedules, change to 400 mg orally 4 times a day for 14 days.
6. Contraindicated for pregnant or lactating women.
7. Clinical experience and published studies suggest that azithromycin is safe and effective.
8. Erythromycin estolate is contraindicated during pregnancy.
9. Effectiveness of erythromycin treatment is approximately 80%; a second course of therapy may be required.
10. Patients who do not respond to therapy (within 72 hours) should be re-evaluated.
11. For patients with suspected sexually transmitted epididymitis, close follow-up is essential.
12. No definitive information available on prenatal exposure.
13. Treatment may be extended if healing is incomplete after 10 days of therapy.
14. Consider discontinuation of treatment after one year to assess frequency of recurrence.
15. Vaginal, cervical, urethral meatal, and anal warts may require referral to an appropriate specialist.
16. CDC recommends that treatment for uncomplicated gonococcal infections of the cervix, urethra, and/or rectum should include dual therapy, i.e., both a cephalosporin (e.g., ceftriaxone) plus azithromycin.
17. CDC recommends that cefixime in combination with azithromycin or doxycycline be used as an alternative when ceftriaxone is not available.
18. Only ceftriaxone is recommended for the treatment of pharyngeal infection. Providers should inquire about oral sexual exposure
19. Use with caution in hyperbilirubinemic infants, especially those born prematurely.
20. MSM are unlikely to benefit from the addition of nitroimidazoles.
21. Moxifloxacin 400mg orally 1x/day for 7 days is effective against *Mycoplasma genitalium.*
22. Pregnant patients can be treated with 2 g single dose.
23. Contraindicated for pregnant or lactating women, or children <2 years of age.
24. Do not use after a bath; should not be used by persons who have extensive dermatitis.
25. Pregnant patients allergic to penicillin should be treated with penicillin after desensitization.
26. Randomized controlled trials comparing single 2 g doses of metronidazole and tinidazole suggest that tinidazole is equivalent to, or superior to, metronidazole in achieving parasitologic cure and resolution of symptoms.

★ Indicates update from the 2010 CDC Guidelines for the Treatment of Sexually Transmitted Diseases.

Reviewed by the CDC 6/2015

BARRIERS to chlamydia screening for adolescent and young adults (AYA)

Chlamydia screening is not always offered to asymptomatic youth, and may not be offered at all outside of sexual health visits. Additionally, it can be difficult for youth to access sexual health services and STI screening confidentially at a standard primary care clinic due to insurance issues and the Explanation of Benefits (EOB).

STRATEGIES to increase chlamydia screening rates

Instate universal chlamydia screening.

Many settings have instated mass chlamydia screening for all females age 15-24. This may mean some women are over-screened, but it also allows the opportunity to screen those who really need screening but whose visit type did not trigger the provider to consider chlamydia screening. This strategy can catch cases of chlamydia that would otherwise go undetected. And, while some systems start routine screening at age 16, it may be more appropriate to start routine screening at age 15 or even 14 if you're in an area that has high rates of chlamydia or a younger age for sexual debut.

- Create workflows to ensure that any female patient ages 15-24 are screened. Below is a sample workflow:
  - If the patient has not been screened in the past year, she is given a letter at check-in about chlamydia screening, describing that it is a routine part of care recommended for all young women. The patient's parent is given a similar letter if the patient is under 18.
  - As they are called back for their appointment, the Medical Assistant collects a urine sample or has them self-swab, and then pends the order for chlamydia screening. At this time the MA also gets the adolescent's direct contact number.
  - During the visit, the provider will talk to the patient and decide if the screening test should be sent.
  - It is very important to get a direct contact number for the adolescent, because if there is a positive result in someone under 18, you want to contact them directly and treat them without them having to inform their family if they do not want to.
  - By making chlamydia testing routine, families will hopefully not be surprised or concerned if STI screening is sent home in an EOB.

Build-in reminder systems to your EHR.

- Many electronic health records have built-in reminder systems for quality measures.
  - For example, EPIC can give you best practice advisories for chlamydia screening, and this can cue the provider to offer screening to patients, and to remind medical assistants to collect a urine sample.
  - You want to use your EHR to its highest capabilities to help you remember when things need to be done.
- Residency sites should consider adding a flag to the EHR to cue preceptors to ensure that residents addressed best practice advisories (BPAs) or quality care reminders. Such a prompt may read, "Were BPAs addressed during this encounter?"

Partner with safety net providers, including school-based health centers (SBHCs).

- Safety net providers, including Federally Qualified Health Centers (FQHCs), local health departments, Planned Parenthood clinics, and SBHCs often offer free and confidential STI testing for AYA patients. Connect with your local safety net providers and encourage patients to utilize their services for confidential screening and treatment.
    - Here[1] is a FQHC finder from HRSA. Here[2] is the health center locator for Planned Parenthood. Find and connect with SBHCs in your area. Maintain a list of local resources that you can give to adolescent patients.
    - If you and the SBHC use a shared EHR, you can pull reports of patients who have been seen at both sites. Care coordinators can help patients coordinate care between PCPs and SBHCs and ensure that care is provided across the continuum.
- PCP payment may hinge on meeting quality measures including chlamydia screening, and it doesn't matter where the patient gets the screening, so creative partnerships may improve your bottom line.
- Read the AAP's Policy Statement[3] on SBHC/PCP collaboration.

Should you also screen adolescent males?

The USPSTF recommends that sexually active females under age 25 get screened, and that males should only be screened if they are high risk.

- Every office has to find their own way on how they approach screening young men.
    - Even without automated screening for all males, the familiarity, comfort, and confidence in the benefits of chlamydia screening from an automated female screening pathway may lead to screening many more males, as well.
- There is a chance you may face barriers with insurance companies paying for universal screening for males.
    - Insurance companies are mandated by the Affordable Care Act to cover all USPSTF Grade A and B evidence screenings without cost sharing on the patient's end. Screening AYA females for gonorrhea and chlamydia gets Grade B evidence, but for males screening gets an "I" grade, for insufficient evidence for or against screening. So, there is no mandate for insurers to cover screening.

ADDITIONAL RECOMMENDATIONS

- University of Michigan universal chlamydia screening documents (subsequent pages): 1) Sample workflows; 2) Script for MAs; 3) Sample parent letter; 4) Sample patient letter; 5) Sample handout for patients
- Asymptomatic sexually active adolescents should be screened for certain STIs. Review USPSTF recommendations[4] and CDC recommendations[5] on preventive services and STI screening.
- The NAHIC Summary[6] of Recommended Guidelines for Clinical Preventives Services for Young Adults provides a snapshot of STI recommendations, as well as other preventive recommendations.

1) POSSIBLE WORK FLOWS FOR RISK SCREENING AND CHLAMYDIA SCREENING

Confidential risk screening

1. Front desk staff gives parent letter about confidential time with adolescent patients.
2. MA calls patient, explains to parent "I'll be bringing your child back to get their vital signs and have them complete a brief health survey, and then I'll bring you to the room before the provider comes to see them."
    a. MA can explain that "We are giving teens a chance to share their views on their health, and that's why we have them complete the health survey on their own." If there is parent push-back, the MA rooms the patient without doing risk screening, and the provider can address the issue.
3. The MA rooms the patient, has them complete the risk screening, and brings the results to the provider to review. The MA then gets the parent.
4. The provider meets with the parent and patient, and then asks the parent to step out at the end of the visit for confidential time. The provider then reviews the risk screen with the patient.

Workflow for Chlamydia Screening

1. Front desk staff gives patient and parent letters about chlamydia screening.
2. MA collects urine sample or has patient self-swab as they room the patient.
3. MA collects direct contact information for the patient for results.
4. MA "pends" the order for chlamydia screening in the EHR. The provider discusses the test with the patient, signs the order if the test is indicated.

Merged option for chlamydia screening and risk screening

1. Front desk staff gives patient and parent letters about chlamydia screening, letter about confidential time with adolescents.
2. MA calls patient, explains to parent "I'll be bringing your child back to get their vital signs and have them complete a brief health survey, and then I'll bring you to the room before the provider comes to see them."
3. MA collects urine sample or has patient self-swab as they room the patient.
4. MA collects direct contact information for the patient for results.
5. The MA rooms the patient, has them complete the risk screening, and brings the results to the provider to review. The MA then gets the parent.
6. MA "pends" the order for chlamydia screening in the EHR.
7. The provider meets with the parent and patient, and then asks the parent to step out at the end of the visit for confidential time. The provider then reviews the risk screen with the patient. The provider discusses chlamydia screening with the patient, signs the order if the test is indicated.

2) CHLAMYDIA SCREENING: MA CONVERSATION WITH PATIENT

- We are constantly working to improve the quality of care that we provide to our patients
- One of the measures that we are including is routine Chlamydia screening
- Chlamydia screening is recommended by the United States Preventive Services Task Force for women between the ages of 16 to 24
- The screening is recommended because Chlamydia is the most common sexually transmitted disease and often does not have symptoms, so you may not know you have it
- The problem with Chlamydia is that if it goes untreated it can lead to life-long complications, including infertility.
- It is easily treated with antibiotics
- The test is simple – we just need a urine sample

Information for MA

Proper handling of urine sample for Chlamydia and/or urine culture

- Chlamydia screening alone:
  - For best results make sure that last void was more than 2 hours ago
    - (If not, ask if willing to do a vaginal self-swab instead)
  - First catch
  - Refrigerate immediately!
- Chlamydia screening and urine culture:
  - Clean catch
  - Refrigerate immediately

3) SAMPLE PARENT LETTER

(Insert your health center's logo, if appropriate)

Health Center Contact Information

Dear Parent /Guardian:

Congratulations! Your child has reached the teenage years. Adolescence is a time of transition from childhood to adulthood. We want to help your teen prepare to be an active participant in his/her medical care. We will start talking to your teen independently for part of his/her visit. Since this can be a difficult time of life, we will be taking some time to talk to him/her in private concerning issues that you or he/she may not necessarily be comfortable discussing with each other. Some of the topics that we will be talking about will include:

- healthy eating and sleeping habits
- friends and relationships
- emotions and mood
- sexuality
- drugs and alcohol

We will deal with all these subjects in an age and maturity-appropriate manner.

In order for these discussions to be as open and helpful as possible, we will assure your teenager that our discussions will be confidential. If there is a concern about your teen doing harm to him/herself or someone else, we will inform you. On issues of sexually transmitted diseases, birth control, pregnancy, and drug use we will encourage your teen to share this information with you. Also, in order to provide care that aligns with the United States Preventive Service Task Force, we will begin routine screening of all adolescents 16 years and older for an infection called Chlamydia. Chlamydia infections often do not show symptoms and can lead to life-long complications, including infertility.

If there are any particular issues that you would like to have addressed, please let us know.

Thank you.

4) SAMPLE PATIENT LETTER

(Insert your health center's logo, if appropriate)

Health Center Contact Information

Dear Patient,

We are writing to inform you of a new process that is taking place in our office. We are constantly working to improve the quality of care that we provide. One of the measures that we are including is routine screening for Chlamydia. Chlamydia screening is recommended by the United States Preventive Services Task Force for any women between the ages of 16 and 24. Chlamydia is the most common sexually transmitted disease and often does not have any symptoms. If it goes untreated it can lead to serious pelvic infections including abscesses and Pelvic Inflammatory Disease. It is one of the leading causes of infertility.

Today in clinic we will ask you to leave a urine sample for Chlamydia testing. If your screen is positive, we will contact you via your cell phone to let you know. We will prescribe an antibiotic for you to take. It is recommended that you notify any sexual partners so that they may also be treated. All positive results will be reported to the Health Department. They will contact you via your cell phone if treatment is not ordered.

Thank you!

RECOMMENDED RESOURCES:

1. https://www.cdc.gov/std/chlamydia/stdfact-chlamydia.htm
2. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/chlamydia-and-gonorrhea-screening
3. http://www.itsyoursexlife.com/
4. Partner notification: http://www.inspot.org/

5) SAMPLE CHLAMYDIA HANDOUT

Chlamydia Screening

WHAT IS CHLAMYDIA?

Chlamydia is a common sexually transmitted disease (STD). It can infect both men and women and can cause serious, permanent damage. Women may even lose the ability to become pregnant and have children. Chlamydia is very common, especially among young people. It is estimated that one in 15 sexually active females aged 14-19 years has chlamydia.

HOW COULD I GET CHLAMYDIA?

You might get chlamydia by having sex with someone who has the infection. You would not know a person has chlamydia, because they might not even know. "Having sex" means anal, vaginal, or oral sex. Chlamydia can be transmitted even if a man does not ejaculate. People who have had chlamydia and been treated for it can be infected again if they have sex with an infected person.

WHAT ARE THE SYMPTOMS OF CHLAMYDIA?

Chlamydia is known as a 'silent' infection because most infected people do not have any signs or symptoms. Even when it causes no symptoms, chlamydia can lead to infertility (not being able to get pregnant). For this reason, it's important for sexually active people to be tested regularly. This is called chlamydia screening. Some women with chlamydia have an abnormal vaginal discharge or a burning sensation when urinating.

WHAT HAPPENS IF CHLAMYDIA IS NOT TREATED?

If not treated early, chlamydia may cause serious health problems, including infertility. If the infection spreads to the uterus and fallopian tubes it can cause pelvic inflammatory disease (PID). PID is a serious disease that may lead to several problems:

- Severe pain that can be long-lasting
- Permanent damage to a woman's reproductive organs that would make impossible for her to have children. This damage may also cause ectopic pregnancy - a pregnancy that occurs outside the uterus. This condition can be life threatening.

Untreated chlamydia may also increase a person's chance of getting HIV or infecting others with HIV.

WHO SHOULD BE TESTED FOR CHLAMYDIA?

If you are age 25 or younger and sexually active, we recommend yearly chlamydia testing. Talk to your healthcare provider about your risk factors so they can determine if you need more frequent testing. If you are scheduled for a vaginal exam today, the doctor can take a cotton swab of your vagina to test for chlamydia. Otherwise, you will need to provide a urine sample that will be tested in the lab.

CAN CHLAMYDIA BE CURED?

Chlamydia can be **easily treated and cured** with antibiotics. If you have chlamydia, do not have sex for seven days after taking single dose antibiotics, or until you complete an entire seven-day course of antibiotics. This will prevent the spread of chlamydia to sexual partners.
Repeat infection with chlamydia is common. Persons whose sex partners have not been treated are at high risk for re-infection. Having chlamydia more than once increases your risk of serious health complications, including pelvic inflammatory disease and ectopic pregnancy. If you have chlamydia, you may need to be re-tested about three months after treatment to be sure the infection has been cured. Please discuss with your provider if you will need to be re-tested.

WHAT ABOUT PARTNERS?

If you are diagnosed with chlamydia, you need to tell all anal, vaginal, or oral sex partners from the past 2 months so that they can see a doctor and be treated. This will reduce the risk that the sex partners will develop serious complications from chlamydia and will also reduce the person's risk of becoming re-infected. A person with chlamydia and all of his or her sex partners must avoid having sex until they have completed their treatment for chlamydia (i.e., seven days after a single dose of antibiotics or until completion of a seven-day course of antibiotics) and until they no longer have symptoms. For tips on talking to partners about sex and STD testing, visit http://www.gytnow.org/talking-to-your-partner/%20

HOW CAN CHLAMYDIA BE PREVENTED?

Using latex male condoms, consistently and correctly, can reduce the risk of getting or giving chlamydia. The surest way to avoid chlamydia is to avoid vaginal, anal, and oral sex or to be in a long-term mutually monogamous relationship with a partner who has been tested and is known to not be infected.

Author: Adapted from the CDC Fact Sheet by Kathy R. Bishop, MHSA
Reviewers: Roger Smith, MD; Grant Greenberg, MD;

[1] http://findahealthcenter.hrsa.gov/
[2] https://www.plannedparenthood.org/health-center
[3] http://pediatrics.aappublications.org/content/129/2/387
[4] https://www.uspreventiveservicestaskforce.org/BrowseRec/Index#AZ
[5] https://www.cdc.gov/std/tg2015/screening-recommendations.htm
[6] http://nahic.ucsf.edu/yaguidelines/s

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An Overview of Minors' Consent Law

Background

The legal ability of minors to consent to a range of sensitive health care services—including sexual and reproductive health care, mental health services and alcohol and drug abuse treatment—has expanded dramatically over the past 30 years. This trend reflects the recognition that, while parental involvement in minors' health care decisions is desirable, many minors will not avail themselves of important services if they are forced to involve their parents. With regard to sexual and reproductive health care, many states explicitly permit all or some minors to obtain contraceptive, prenatal and STI services without parental involvement. Moreover, nearly every state permits minor parents to make important decisions on their own regarding their children. In sharp contrast, the majority of states require parental involvement in a minor's abortion.

In most cases, state consent laws apply to all minors age 12 and older. In some cases, however, states allow only certain groups of minors—such as those who are married, pregnant or already parents—to consent. Several states have no relevant policy or case law; in these states, physicians commonly provide medical care without parental consent to minors they deem mature, particularly if the state allows minors to consent to related services. The following chart contains seven categories of state law that affect a minor's right to consent. Further information on these issues can be obtained by clicking on the column headings.

Highlights

- *Contraceptive Services*: 26 states and the District of Columbia allow all minors (12 and older) to consent to contraceptive services. 20 states allow only certain categories of minors to consent to contraceptive services. 4 states have no relevant policy or case law.
- *STI Services*: All states and the District of Columbia allow all minors to consent to STI services. 18 of these states allow, but do not require, a physician to inform a minor's parents that he or she is seeking or receiving STI services when the doctor deems it in the minor's best interests.
- *Prenatal Care*: 32 states and the District of Columbia explicitly allow all minors to consent to prenatal care. Another state allows a minor to consent to prenatal care during the 1st trimester; requires parental consent for most care during the 2nd and 3rd trimesters. 13 of these states allow, but do not require, a physician to inform parents that their minor daughter is seeking or receiving prenatal care when the doctor deems it in the minor's best interests. 4 additional states allow a minor who can be considered "mature" to consent. 13 states have no relevant policy or case law.
- *Adoption*: 28 states and the District of Columbia allow all minor parents to choose to place their child for adoption. In addition, 5 states require the involvement of a parent and 5 states require the involvement of legal counsel. The remaining 12 states have no relevant policy or case law.
- *Medical Care for a Child*: 30 states and the District of Columbia allow all minor parents to consent to medical care for their child. The remaining 20 states have no relevant explicit policy or case law.
- A*bortion*: 2 states and the District of Columbia explicitly allow all minors to consent to abortion services. 21 states require that at least one parent consent to a minor's abortion, while 11 states require prior notification of at least one parent. 5 states require both notification of and consent from a parent prior to a minor's abortion. 6 additional states have parental involvement laws that are temporarily or permanently enjoined. 5 states have no relevant policy or case law.

Minors May Consent TO:

STATE	CONTRACEPTIVE SERVICES	STI SERVICES	PRENATAL CARE	ADOPTION	MEDICAL CARE FOR MINOR'S CHILD	ABORTION SERVICES
Alabama	All†	All*	All	All	All	Parental Consent
Alaska	All	All	All		All	▼ (Parental Notice)
Arizona	All	All		All		Parental Consent
Arkansas	All	All*	All		All	Parental Consent
California	All	All	All	All		▼ (Parental Consent)
Colorado	All	All	All	All	All	Parental Notice
Connecticut	Some	All		Legal counsel	All	All
Delaware	All*	All*	All*	All	All	Parental Notice‡
Dist. of Columbia	All	All	All	All	All	All
Florida	Some	All	All		All	Parental Notice
Georgia	All	All*	All	All	All	Parental Notice
Hawaii	All*,†	All*,†	All*,†	All		
Idaho	All	All†	All	All	All	Parental Consent
Illinois	Some	All*	All	All	All	Parental Notice
Indiana	Some	All		All		Parental Consent
Iowa	All	All				Parental Notice
Kansas	Some	All*	Some	All	All	Parental Consent
Kentucky	All*	All*	All*	Legal counsel	All	Parental Consent
Louisiana	Some	All*		Parental consent	All	Parental Consent
Maine	Some	All*				All
Maryland	All*	All*	All*	All	All	Parental Notice
Massachusetts	All	All	All		All	Parental Consent
Michigan	Some	All*	All*	Parental consent	All	Parental Consent
Minnesota	All*	All*	All*	Parental consent	All	Parental Notice
Mississippi	Some	All	All	All	All	Parental Consent
Missouri	Some	All*	All*	Legal counsel	All	Parental Consent
Montana	All*	All*	All*	Legal counsel	All	▼ (Parental Consent)
Nebraska	Some	All				Parental Consent
Nevada	Some	All	Some	All	All	▼ (Parental Notice)
New Hampshire	Some	All†	Some	All$^{\Omega}$		Parental Notice
New Jersey	Some	All*	All*	All	All	▼ (Parental Notice)
New Mexico	All	All	All	All		▼ (Parental Consent)
New York	All	All	All	All	All	
North Carolina	All	All	All			Parental Consent
North Dakota		All†	ξ*	All		Parental Consent
Ohio		All		All		Parental Consent
Oklahoma	Some	All*	All*	All†	All	Parental Consent and Notice
Oregon	All*	All	All*,‡			
Pennsylvania	All†	All	All	Parental notice	All	Parental Consent
Rhode Island		All		Parental consent	All	Parental Consent
South Carolina	All◊	All◊	All◊	All	All	Parental Consent‡
South Dakota	Some	All				Parental Notice
Tennessee	All	All	All	All	All	Parental Consent
Texas	Some	All*	All*			Parental Consent and Notice
Utah	Some	All	All	All	All	Parental Consent and Notice
Vermont	Some	All		All		
Virginia	All	All	All	All	All	Parental Consent and Notice
Washington	All	All†	All	Legal counsel		
West Virginia	Some	All	Some	All		Parental Notice
Wisconsin		All				Parental Consent
Wyoming	All	All		All		Parental Consent and Notice
TOTAL	**26+DC**	**50+DC**	**32+DC**	**28+DC**	**30+DC**	**2+DC**

Notes: "All" applies to those 17 and younger or to minors of at least a specified age such as 12 or 14. "Some" applies to specified categories of minors (those who have a health issue, or are married, pregnant, mature, etc.) The totals include only those states that allow all minors to consent.

▼ Enforcement permanently or temporarily enjoined by a court order; policy not in effect.

* Physicians may, but are not required to, inform the minor's parents.

† Applies to minors 14 and older.

‡ Delaware's abortion law applies to women younger than 16. Oregon's prenatal care law applies to women at least 15 years old. South Carolina's abortion law applies to those younger than 17.

Ω A court may require parental consent.

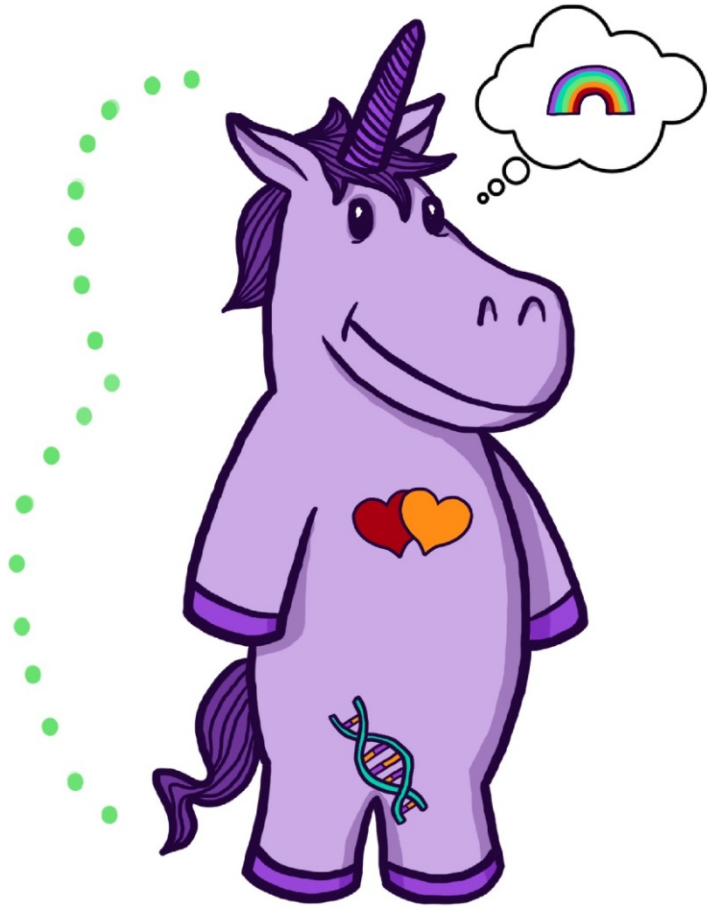
ξ Minor may consent to prenatal care in the 1st trimester and the first visit after the 1st trimester. Parental consent required for all other visits.

◊ Applies to mature minors 15 and younger and to all minors 16 and older.

Source URL: https://www.guttmacher.org/state-policy/explore/overview-minors-consent-law

The Gender Unicorn

Graphic by:
TSER
Trans Student Educational Resources



Gender Identity

- Female/Woman/Girl
- Male/Man/Boy
- Other Gender(s)

Gender Expression

- Feminine
- Masculine
- Other

Sex Assigned at Birth

Female | Male | Other/Intersex

Physically Attracted to

- Women
- Men
- Other Gender(s)

Emotionally Attracted to

- Women
- Men
- Other Gender(s)

To learn more, go to:
www.transstudent.org/gender

Design by Landyn Pan and Anna Moore

Gender Pronouns

Please note that these are not the only pronouns. There are an infinite number of pronouns as new ones emerge in our language. Always ask someone for their pronouns.

Subjective	Objective	Possessive	Reflexive	Example
She	Her	Hers	Herself	She is speaking. I listened to her. The backpack is hers.
He	Him	His	Himself	He is speaking. I listened to him. The backpack is his.
They	Them	Theirs	Themself	They are speaking. I listened to them. The backpack is theirs.
Ze	Hir/Zir	Hirs/Zirs	Hirself/ Zirself	Ze is speaking. I listened to hir. The backpack is zirs.

Design by Landyn Pan

transstudent.tumblr.com
facebook.com/transstudent
twitter.com/transstudent

For more information,
go to transstudent.org/graphics

TSER
Trans Student Educational Resources

When greeting others, be mindful of language.

Consider

"Thanks, **friends**. Have a great night."

"Good morning, **folks**!"

"Hi, **everyone**!"

"And for **you**?"

"Can I get you **all** something?"

Why?

Shifting to gender-inclusive language respects and acknowledges the gender identities of all people and removes assumption.

Based on Toni Latour's "Hello there" cards.

Learn more at qmunity.ca

Terms & Definitions

Gender Identity: One's internal sense of being male, female, neither of these, both, or other gender(s).

Sexual Identity: A persons enduring physical, romantic, emotional, and/or other form of attraction to others. Gender identity and sexual orientation are not the same.

LGBTQIAP: A collection of queer identities short for lesbian, gay, bisexual, trans, queer or questioning, intersex, asexual, and pansexual (sometimes abbreviated to LGBT or LGBTQ+).

Trans(gender): An umbrella term for people whose gender identity differs from the sex they were assigned at birth.

Cis(gender): A term or people whose gender identity is the same as the sex they were assigned at birth.

Queer: General term for gender and sexual minorities who are not cisgender and/or heterosexual. There is some overlap between queer and trans identities, but not all queer folks are trans and not all trans folks are queer. This term has a complicated history.

Non-Binary: Preferred umbrella term for all genders other than female/male or woman/man, used as an adjective. Many nonbinary people identify as trans; not all trans people identify as nonbinary.

Cissexism/Heteronormativity: These terms refer to the assumption that being cisgender/heterosexual is the default; normal and expected. Attitudes, assumptions, policies, and systems can be cissexist and heteronormative.

For more definitions visit www.outrightvt.org/terms-definitions

OUTRIGHT VERMONT

Best Practices for LGBTQ+ Inclusive Sex Ed

Use language that is gender neutral

- Folks/Friends/Y'all/Everyone vs. *Boys and Girls/Ladies and Gentlemen*
- Use "they" pronouns by default, and/or include pronouns as part of introductions for all

Body-first language

- When two people are having vaginal sex vs. *when a guy and a girl have sex*
- People with uteruses often experience X during puberty vs. *girls* often experience X during puberty
- External condom and internal condom vs. *male* condom and *female* condom

Include equal queer & trans representation

- No matter what you're teaching, include LGBTQ+ folks in images, scenarios, etc.

Consent is primary

- Be clear that sexual activity is not either consensual or nonconsensual, there is sexual activity and there is *sexual violence*
- Embedding consent as the correct, normal, and expected approach to sexual contact is key
- Sexual violence may be prevalent but it is NOT normal, and should not be normalized

Non-gendered groups/pairs

- When grouping students together, don't make gender the way they divide or pair up, even if an activity specifies gender
- Ask students to "suspend their disbelief" for situations where they might have to role play or analyze a situation as a different gender/orientation/identity

Build in confidentiality

- In your ground rules, from day one
- Be sure students know how confidentiality works in your class and with their parents

Include LGBTQ+ people in every aspect, explicitly

- If you aren't explicitly including LGBTQ+ people, you're *excluding* them

Advance your understanding! (Don't rely on youth)

- There are lots of places to educate yourself– Outright Vermont, Planned Parenthood, Scarleteen.com, and other reputable online sources
- Take correction, expertise and input from students when and if they offer it
- Students may offer their lived experiences– remember that a story is powerful and also no one person's experience is necessarily universal

Resources

Presentation Slides: http://bit.ly/lgbtqsexedu

Consent Line Up photos: http://bit.ly/1SZyy00

SASS Text Line: 724-888-SASS (7277) Answers about sex and sexuality for LGBTQA+ youth

Andrea Nicoletta, she/her
Planned Parenthood of Northern New England
andrea.nicoletta@ppnne.org | www.ppnne.org

Amanda Rohdenburg, she/her
Outright Vermont
amanda@outrightvt.org | www.outrightvt.org

Mental Health Providers Experienced with Trans Youth

If you are unsure of who to contact or have questions about mental health referrals for trans youth, please contact Dr. Marlene Maron:

Marlene Maron, PhD
802-847-3634
Leave a message for Dr. Maron, specify that you have a question about finding a provider for a trans-identified youth.

Providers by County

Addison County

Ximena Mejia, Ph. D, LMHC
152 Maple St., second floor
Middlebury, VT 05753
802-777-8636
Provides receipts for people to file with their own insurance.
Ages: 13+
Sliding Scale: yes

Charles Rossi, MA
36 Main St.
Middlebury, VT 05753
Phone: 802-388-1422
Insurance: Accepts BCBS, CBA, Medicaid, Cigna
Sliding Scale: yes

Michael Castelli, MA
79 Court Street
Middlebury, Vermont 05753
802-324-1381
Ages: 12+
Insurances: Medicaid, BCBS
Note: Does both psychotherapy and music therapy

Bennington County

Lisa Carton, LICSW
469 Main Street
Bennington, VT 05201
802-379-5456
http://www.lisajcarton.com/
Ages: 4+/works with families
Insurance: accepts Medicaid, BCBS, and other major insurances.
Sliding Scale: yes

Lisa Pezzulich, Psy.D.
Mindful Solutions, PLLC
160 Benmont Ave, Suite 20
Bennington, VT 05201
(802) 442-3520 X211
Ages: 16+
Insurance: Medicaid, Medicare, BCBS, Cigna, MVP, United Health Care

Beth Newman, LMFT, ATR-BC
Bennington, VT 05201
802-688-4557
Ages: teenagers
Insurance: BCBS, MVP, Medicaid, Optum, United
Sliding Scale: yes

Caledonia County

Claire Diamond, MA
Wellspring Mental Health and Wellness
39 Church St
Hardwick, Vermont 05843
Phone: 802-272-0770
Ages: Middle school, High School and Adult
Insurance: Medicaid and BCBS
Note: Also works at Haven Union High School

Chittenden County

Christopher Janeway, MS, NCC
255 S Champlain St, Suite 14
Burlington, VT 05401
Phone: 802-557-1061
Website: http://www.christopherjaneway.com/
Ages: all
Insurance: BCBS, Medicaid, sliding scale

Kara Deleonardis Kraus, LICSW
1233 Shelburne Rd, Lakewood Commons
East O'Lake Building, Suite 120
South Burlington, VT
Phone: 802-999-7042
Ages: all
Insurance: most, including Medicaid, and sliding scale

Rebecca Sherlock, MSW, DCSW
8 Whiteface Street
South Burlington, VT
Phone: 802-865-7878 and 802-229-2946
Website: http://www.rebeccasherlock.com
Ages: 14+
Insurance: most, including Medicaid

Tom Barritt, LICSW
Associates at the Gables
183 Talcott Rd.
Williston, VT 05495
802-876-1100, ext. 313
Ages: Families with kids of any age, couples, and individual therapy for late adolescents-adults.
Insurance: most

Brian Cina, LICSW
200 Main Street
Burlington, VT 05401
Phone: 802-233-9131

Dan Duval, MA, LCMHC
Otter Creek Associates
15 Pinecrest Drive
Essex Junction, VT
Phone: 802-288-1087

Michael Gilman, LICSW, ACSW
Optima Vermont
2 Church Street, Suite 4G
Burlington, VT
Phone: 802-658-4888
Website: http://www.optimavt.org
Ages: 15+
Insurance: most, including Medicaid

Emiry Potter, MA, LCMHC, LADC, NCC
2 Church Street, Suite 4A
Burlington, VT 05401
Phone: 802-858-4998
Ages: 13+
Insurance: Medicaid, BCBS, MVP, United, Optum, sliding scale

Erika Meierdiercks, MS
47 Maple St, Ste 205
Burlington, VT 05401
Phone: 802-5788674
Ages: all
Insurance: BCBS, Medicaid, sliding scale

Gale Golden, LICSW
Burlington, VT
Phone: 802-864-0757
Ages: Adults only
Insurance: none, however provides detailed invoice that may be used to obtain insurance reimbursement
Note: Provides counseling and support to parents and adult family members of transgender youth.

Lauren Berrizbeitia, LCMHC
16 Orchard Terrace
Burlington, VT
Phone: 802-862-6931 (#2)
Ages: all

Ali Dumeer, LICSW
The Adams Center for Mind and Body
1233 Shelburne Rd.
Pierson House D2
South Burlington, VT
Phone: 802-859-1577, extension 316
Ages: all
Note: All intakes must go through Sue Adams

Marlene Maron*, PhD
111 Colchester Ave., Patrick 405,
Burlington, VT.
Phone: 802-847-3634 and 802-847-4880
Ages: All
Insurance: Most

Alison Prine
Optima
2 Church Street
Suite 4G
Burlington, VT 05401
Phone: (802) 651-9898
Insurance: accepts most

Kate Houston Littlefield, LCMHC
3000 Williston Rd. Suite #2
South Burlington, VT 05403
802-951-0450 x1032
www.nfivt-familycenter.org
Ages: Under 6-18
Insurance: accepts
Sliding Scale: Yes
Note: Does only family therapy work.

Nancy E. Feldman, LCMHC
2 Church St. Suite 4A, Burlington VT 05401
802-864-4949
www.nancyfeldmanvt.com
Ages: 16+, case by case basis for under 16 – family needs to be supportive

Logan Hegg, PsyD
UVM Medical Center
1 S Prospect St
Burlington, VT 05401
Phone: 802-8474829
Ages: all
Insurance: most, including Medicaid
Note: Please state that your call is that regarding a transgender youth, to ensure that appointment scheduled promptly

Kate Dearth, MSW, AAP
The Adams Center for Mind and Body
1233 Shelburne Rd.
Pierson House D2
South Burlington, VT
Phone: 802-859-1577, x351
Ages: all
Note: All intakes must go through Sue Adams

Suzanne "Suzi" Tanner, LICSW, ASAC
Community Health Center of Burlington
Pearl Street Youth Center
179 Pearl Street
Burlington, VT 05401
Phone: 802-652-1080
Insurance: most, including Medicaid, sliding scale
Note: services only available to those who receive primary care through the Community Health Center.

Jennifer Kerns, MA
8269 Pearl St., Suite 3
Burlington, VT 05401
781-392-9969
Ages: 13+
Insurance: Accepts Medicaid, Medicare, BCBS
Sliding Scale**:** yes

Sue Shaffer, LMHC, PAT
The Adams Center for Mind and Body
1233 Shelburne Rd.
Pierson House D2
South Burlington, VT
Phone: 802-859-1577, x318
Ages: all
Note: All intakes must go through Sue Adams

Kristine Mary Karge, LCSW
Waters Edge Psychotherapy and Wellness Center
47 Maple Street, Suite 303
Burlington, Vermont 05401
(802) 664-4304
Ages: 14+
Insurance: Aetna, BlueCross and BlueShield, Cigna, MVP, Medicaid, Medicare
Note: Identifies as Hispanic/Latina and speaks Spanish

Jess Horner, MA LICSW
Networks, Inc.
149 Cherry Street
Burlington, Vermont 05401
(802) 863-2495 x710
Ages: 10+ years old
Insurance: Medicaid, Medicare, United, BCBS, Cigna
Sliding Scale: Yes

Franklin County

Michelle Spaulding, MA
75 Fairfield St.
St. Albans, VT 05478
Phone: 802-598-8284
Ages: Works with teens and families
Insurances: All

Patrick Dunn, LMHC
156 North Main St
St. Albans, VT 05478
Phone: 802-933-4732 X 7
Ages: 10+
Insurances: Medicaid, BCBS, Cigna, United, MVP
Note: Available evenings and weekends

Lamoille County

Kate Donnelly, LICSW
34 Pleasant Street
Morrisville, VT 05661
Phone: 802-730-9086
http://katedonnally.com/
Ages: Teens, Youth & Families
Insurances: BCBS, Cigna, MVP, Medicaid, Medicare, Value Options
Sliding Scale: yes

Orange County

Allison Andrews, LICSW
74 Main St.
Wells River, VT
Phone: 802-274-5120
Ages: Works with children (5+), teens, adults
Insurance: Please contact

Susan Jacobs, MA, LCMHA, LADC
25 South Pleasant St.
Randolph, VT 05060
802-249-2973
Ages: Teens, young adults, and families
Insurance: Cigna, Medicaid, BCBS, United, MVP,
Sliding Scale: yes
Note: Can do home visits in area

Rutland County

Lindsey Johnston, MS
167 North Main St,
Wallingford, VT 05773
802-446-3577
mapleleafclinic@vermontel.net
www.mapleleafclinic.com
Ages: works with middle school through adulthood.
Insurance: Medicaid, out of network provider exceptions.
Sliding Scale: Please call if application

Washington County

Adam Grunt PhD
105 North Main St. Suite 10
Barre, VT 05641
802-441-4072
http://www.cvmhp.org/agrundt.html
Insurance: accepts Medicaid and other insurances
Note: Moving to Burlington in mid-July

Darlene Furey, LICSW, MSS, MLSP
Oak Tree Counseling Associates llc
147 State Street
Montpelier, Vermont 05602
Phone: (802) 279-4020
Insurance: BCBS, Medicaid, Cigna
Sliding Scale: Yes

Molly Bernardi-Smith, MA
138 Main St., Suite 5
Montpelier VT 05602
802-778-0483
Ages: 16+
Insurance: BCBS, Medicaid, Medicare
Sliding Scale: yes

Cory Gould, LPMA
149 State Street
Redfield House
Montpelier, Vermont 05602
(802) 992-1501
Ages: 14+
Insurance: Cigna, BCBS, Medicaid, MVP, Aetna

Julia Chafets
132 Main Street
Suite 2
Montpelier, Vermont 05602
Phone: 802-279-8850
Ages: 6+ years old
Insurance: BCBS and Medicaid

PJ Desrochers, LMFT
174 Elm St
Montpelier, VT 05602
Phone: 802-851-5955
Insurance: Most
Sliding Scale: please call

James Nelson, MA, LCMHC, LADC
250 Main Street
Montpelier, VT
(802) 318-5456
16 Orchard Terrace
Burlington, VT
(802)-862-6931 ext 3
Note: accepts patients 14 and up
Insurance: most, including Medicaid

Brooke White, PhD
Full Circle Health and Wellness
73 Main Street
Montpelier, VT
Suite 19
(802) 505-1748
Note: accepts patients 6 and up

Suzanne Mancinelli, MA
The Vermont Center for Integrative Herbalism
252 Main Street, Suite 2
Montpelier, VT 05602
Phone: 802-552-8560
Ages: preteen-adult
Insurance: Medicaid & BCBS-VT
Note: Please state that your call is regarding a transgender youth to ensure prompt response.

Windham County

Michael Gigante, Ph. D
31 Frog Hill
Brattleboro, VT 05301
802-254-8032
Ages: 15+
Please contact about health insurance info.
Sliding Scale: yes

Laura Hoskins, MA, LCMHC, NCC
70 Orchard St
Brattleboro, VT 05301
802-451-9557
www.laurahoskins.net
Ages: 8+ years old
Insurances: Accepts Medicaid and wide range or private insurances
Sliding Scale: Yes

Curtis Graf, Ph. D
139 Main St.
Brattleboro, VT 05301
802-254-2400
www.curtisgrafphd.com
Ages: Works with youth, teens, young adults
Insurance: Medicaid, BCBS, and others
Sliding Scale: yes

Eli Burke, Med, LICSW
Brattleboro, VT 05301
Phone: 802-257-4880
Ages: Teens, young adults
Insurance: BCBS, Medicare, Medicaid

Windsor County

Allison Andrews, LICSW
The Writer's Center
58 N Main St
White River Junction, VT
Phone: 802-274-5120
Ages: Works with children (5+), teens, adults
Insurance: Please contact

Deb Harrison, LICSW
2091 Main St
Cavendish, VT 05142
Phone: 802-226-7900
Ages: All
Insurances: Medicaid, BCBS, Cigna, MVP
Note: Also works at Black River High School

Annette Kennedy, Psy D
16 Beaver Meadow Rd
P.O. 801
Norwich, VT 05055
Phone: 802-785-2639
Ages: Works with teens (13+) and adults
Insurance: Please contact and sliding scale

Provides in New York State

Moriah Warnne
Mental Health Counseling Services
6956 State Highway 56
Potsdam, NY
Phone: (315) 268-0264
Insurance: accepts most

Kelly Hornby, LCSW-R
Clinton County Mental Health and Addiction Services
130 Arizona Avenue
Plattsburgh, NY 12901
Phone: 518-565-4060
Ages: all
Insurances: all
Note: Intake Coordinator is Anne Chauvin

Allsun Ozyesil
Plattsburgh, NY 12901
Phone: 518-566-7832
Ages: all
Insurances: Fedelis, BCBS, call for others
Sliding Scale: Yes

Bethany Waite
Clinton County Mental Health and Addiction Services
130 Arizona Avenue
Plattsburgh, NY 12901
Phone: 518-565-4060
Ages: all
Insurances: all
Note: Intake Coordinator is Anne Chauvin

Erica Leonard
Clinton County Mental Health and Addiction Services
130 Arizona Avenue
Plattsburgh, NY 12901
Phone: 518-565-4060
Ages: all
Insurances: all
Note: Intake Coordinator is Anne Chauvin

Psychiatry Consultation

Please contact Dr. Marlene Maron* (above) if you need help reaching any of these providers.

Jeremiah Dickerson, MD
Child and Family-Based Psychiatry
UVM Medical Center
Burlington, VT
Phone: 802-847-4563
Ages: up to age 18
Note: Specifically state that this is a consultation regarding a transgender patient and ask to leave a message for Dr. Dickerson.

Evan Eyler, MD
Psychiatry
UVM Medical Center
Burlington, VT
Phone: (802) 847-4727
Note: Experienced in working with individuals with gender dysphoria. Prefers to serve as a consulting clinician for individuals already connected with another therapist or psychiatrist and provide expertise and assistance with diagnosis and treatment of gender dysphoria.

Harris Strokoff, MD
Adult and Child Psychiatry
Community Health Center Burlington
617 Riverside Ave
Burlington, VT 05401
Phone: 802-864-6309
Note: Services only able to those who receive primary care through Community Health Center.

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CARING FOR LGBTQ YOUTH IN INCLUSIVE AND AFFIRMATIVE ENVIRONMENTS

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Keywords

Adolescents; sexuality; ambulatory care; primary health care; reproductive health services

Lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) youth – a group including non-heterosexual, gender non-conforming, and gender dysphoric children, adolescents, and young adults on multiple developmental trajectories toward LGBT adulthood -- are more likely than their peers to experience stigma in the health care environment.[1,2] Providing care that is affirming and inclusive – that is, care that draws on knowledge and skills enabling a health care provider to work effectively with LGBTQ youth – is critical to improve health outcomes and quality.[2–4] The broader clinical environment, clinic flow and other organization functions, and administrative systems aso need to be considered in order to ensure that clinical services are welcoming. Increasingly, examining these components and the messages they send to LGBTQ youth is not simply good care, but should be the baseline standard health care organizations apply.[5] This is particularly important since prevalence estimates reveal that LGBTQ youth are inevitably a part of every general medical practice, whether providers realize it or not.[6]

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Conflict of Interest Statement

The authors have nothing to disclose.

This article begins by reviewing special considerations for the care of LGBTQ youth, then turns to systems-level principles underlying inclusive and affirming care. It then examines specific strategies that individual providers can use to provide more patient-centered care, and concludes with a discussion of how clinics and health systems can tailor clinical services to the needs of LGBTQ youth.

Special considerations in LGBTQ youth care

Ensuring high-quality care for LGBTQ youth requires providers to understand principles of caring for LGBTQ individuals as well as those of caring for young people more generally. Although most LGBTQ youth are physically and mentally healthy, certain LGBTQ youth are at elevated risk of human immunodeficiency virus (HIV) infection, sexually transmitted infection (STI), pregnancy, obesity, substance use disorders, mood and anxiety disorders, eating disorders and other body image-related concerns, peer bullying (please see Valerie Earnshaw, Laura Bogart, V. Paul Poteat, et al: LGBT Youth and Bullying, in this issue), and family rejection (please see Sabra Katz-Wise, Margaret Rosario and Michael Tsappis: LGBT Youth and Family Acceptance, in this issue).[1,7] LGBTQ youth may avoid seeking health care due to fear of discrimination, and even once in care, may fear disclosure of their sexual orientation or gender identity and therefore withhold truthful responses from their health care providers.[1] Transgender youth face the added burden of locating providers with sufficient knowledge, competence, and experience to affirm their gender identity.[8,9] LGBTQ youth are also disproportionately more likely to be homeless,[10] and in many cases, this may be due to parental rejection or other trauma.[11]

Critical to understanding care of LGBTQ individuals and underlying many of these health disparities is stigma (please see Mark Hatzenbeuhler: Clinical Implications of Stigma, Minority Stress, and Resilience as Predictors of Health and Mental Health Outcomes, in this issue).[12,13] Stigma is defined as the labeling of a specific group, and associated stereotyping, separation, status loss, and discrimination.[13,14] Both interpersonal (*i.e.,* stigma between patients and other people, which in the health care setting may include providers and other clinic staff) and structural stigma (*i.e.,* stigma resulting from systems and organizations, which in the health care setting may include the clinical environment, clinic flow, and other functions) have been barriers to inclusive and affirmative care for this population.[12,13,15,16]

As an example of how stigma affects the health of youth, rejection of an LGBTQ individual by his or her parents (please see Sabra Katz-Wise, Margaret Rosario and Michael Tsappis: LGBT Youth and Family Acceptance, in this issue) may lead to separation and isolation, loss of resources (such as housing, food, clothing, and money), disadvantaged financial and social status, and ongoing discrimination. The links to social determinants of health (such as homelessness and poverty) and to adverse health outcomes (such as mood and anxiety problems, and substance use and related harms) are obvious. Stigma adversely affects LGBTQ youth, and is perpetuated in some health care settings. This is perhaps not surprising given the current lack of attention to educating medical students, trainees and clinicians about issues related to LGBTQ health.[17,18]

Ensuring inclusive and affirmative health care environments for LGBTQ youth also requires in-depth understanding of general issues pertinent to caring for *all* children, adolescents and young adults.[19] Youth have unique physiological, neurocognitive, and psychosocial needs; accordingly, their care should be developmentally appropriate to these. Appropriate handling of youths' confidentiality is important; when sensitive information is disclosed by LGBTQ youth, it is a matter of paramount importance, discussed later in this article.[22] For youth in the process of transition from pediatric to adult clinical services, care can become fragmented.[20,21]

Youth often use language pertaining to sexual orientation and gender identity that may be unfamiliar to health care providers. Currently, there is expansive thinking about both sexual orientation and gender identity, particularly among youth. Many in the LGBTQ community even reject the terms lesbian, gay, bisexual, and transgender as not capturing all sexual orientations or gender identities.[23] For example, many youth describe themselves as queer, an umbrella term inclusive of all non-heterosexual sexual orientations and non-cis-gender identities. Some youth describe themselves as pansexual, asexual, or aromantic regarding sexual orientation. Gender identity is often thought of as outside the traditional male-female binary and on a spectrum; many youth self-describe as gender non-conforming (defined in this volume as nonconformity in gender role expression, but sometimes used by youth differently to refer to gender identity variance) and use terms such as "gender-queer" or "gender-non binary". These issues, and how providers and their organizations can address them to generate LGBTQ youth-affirming clinical services, are outlined in subsequent sections.

Systems-level principles underlying LGBTQ youth-friendly services

The World Health Organization and other leading professional organizations have highlighted principles that should underlie all youth-friendly care,[19,24–26] and in addition, there are a number of technical reports and clinical practice guidelines to help clinicians apply these principles specifically to the care of LGBTQ youth.[1,5,27,28] Recognizing the unique biological, developmental, and psychosocial needs of children, adolescents, and young adults, and especially those who are LGBTQ, health services for youth should be optimized with regard to *availability*, *accessibility*, *acceptability*, and *equity*.[19]

Availability refers to the presence of health care providers with knowledge, competence and experience working with young people with current or developing LGBTQ identities, feelings, or behavior. Accessibility is the relative ease with which LGBTQ youth can obtain care from an available provider. Acceptability is the extent to which clinical services are culturally competent and developmentally appropriate for LGBTQ youth, and as a critical component of this, the degree to which parents are involved when appropriate (especially in the care of younger children) and confidentiality is assured and protected with youth while maintaining collaborative relationships that include appropriate boundaries with parents, other guardians, community members like school personnel, and colleagues. Equity refers to the extent to which clinical care and services are friendly to all LGBTQ youth, regardless of sexual orientation, gender expression, gender identity, race, ethnicity, language, ability to

pay, housing status, and insurance status, among other factors. Each of these principles is reviewed below and is summarized in Table 1.

Availability

Availability of LGBTQ youth-friendly services in many locales is limited by access to a workforce of health care providers with experience working with youth and LGBTQ populations.[27,29,30] This workforce includes a wide range of disciplines, including physicians, nurses, psychologists, social workers, dieticians, clinical assistants, community workers, clerical staff, and other professionals involved in health care delivery. The existing LGBTQ youth-friendly workforce is currently concentrated in urban areas and may be non-existent in some rural and other locales.[31,32]

Even where clinical services for LGBTQ youth are available, quality of care may vary if patients and their caretakers do not receive the full set of recommended physical and mental health screening services, anticipatory guidance, and treatment.[27,28,33–36, 73] For example, *Chlamydia trachomatis* screening for the general adolescent population has shown wide provider variability in adherence to recommended screening practices.[37,38] Although well-established clinical practice guidelines exist for providers caring for LGBTQ youth,[27, 73, 28] such guidelines are relatively new and there is likely to be wide variability in receipt of recommended screening and interventions across health care settings. Furthermore, as new knowledge emerges (as is often the case in the rapidly evolving field of LGBTQ youth health care), providers are likely to require ongoing training to remain up to date. Therefore, ensuring the availability of the full range of appropriate clinical services should not be viewed as a static, binary outcome that is either present or absent, but rather as a continuous process subject to ongoing measurement and quality improvement.[39]

Accessibility

Even where appropriate health services exist and where practices adhere to guidelines, providers should consider the accessibility of their services – not only with regard to the physical location, but also with regard to ease of entry into such services. LGBTQ adolescent and young adult-friendly services should be located near where LGBTQ youth live, study, or work, and should be accessible by public transportation or with free or low-cost parking.[19] In particular, LGBTQ youth may congregate in certain parts of cities or towns that are more LGBT-friendly, and locating clinical services nearby may be a logical choice.[2,40] Since LGBTQ youth are disproportionately likely to be homeless,[10] considering where and how homeless youth access health services is also critical and should take into consideration locations that homeless youth are likely to be present. In some cities, services are provided by a mobile van that travels to particular locations to maximize accessibility.[41]

Where conveniently located, health care providers should ensure optimal accessibility in how adolescents obtain services. A critical component of the patient-centered medical home[42] is ‘enhanced access’,[43,44] which entails offering expanded hours during evenings and weekends,[45] same-day urgent care appointments,[46,47] drop-in visits,[48] and allowances for patients who arrive late for appointments.[49,50] Increasingly, youth and their caretakers

are likely to expect internet-based scheduling and communication with health care providers through email or even telemedicine, where allowable.[51–54]

Acceptability

Especially salient in the care of LGBTQ youth is ensuring that even when services are available and accessible, clinical services have acceptability. Often, improving acceptability requires assessing the clinical environment and understanding ways that it can become more welcoming for and supportive of LGBTQ youth and families. For example, health brochures and other written materials available in the clinic should not assume heterosexuality, and certain topics – particularly safe sex, reproductive health, intimate partner relationship safety, family acceptance, and bullying – should be tailored to address the unique needs of LGBTQ youth.[2]

Traditional bathrooms can be very problematic for transgender youth.[55] For clinics with single-occupancy bathrooms, clinics should avoid labeling them as “male” or “female”, or have an explicit, readily visible policy allowing youth to choose the bathroom that matches their identified gender rather than their biologic sex. For clinics with shared bathrooms, clinics should allow youth to choose the bathroom that matches their identified gender with a highly visible policy statement, and consider installing stalls with walls that reach to the floor for greater privacy.

More than simply identifying and eliminating potential barriers to care for LGBTQ youth, clinical leadership should be proactive about creating an affirming and inclusive environment for LGBTQ youth. This starts with the most fundamental aspect of a clinic: its mission statement.[2,5] Whether a clinic serves a large population of LGBTQ youth or the broader general adolescent population, it should explicitly state that it is welcoming, inclusive and affirming of all youth with regard to sexual orientation, gender expression, and gender identity. To reinforce the mission statement and make clear that the clinical environment is welcoming to LGBTQ youth, signs and stickers might be placed in several well-trafficked locations (*e.g.,* rainbows or other widely understood symbols in clinic check-in areas and examination rooms). Providers might wear lapel pins or lanyards that reaffirm these messages to show that they as an individual clinician also seek to provide care sensitive to the needs of LGBTQ youth. These approaches establish an environment that reduces interpersonal and structural stigma and promotes a safe clinical space for LGBTQ youth.

Providing appropriately confidential clinical services for LGBTQ youth is central to achieving acceptability, since fear of a breach of privacy is a common reason that adolescents avoid seeking care.[22,56] Approaches individual providers should take to protect confidentiality are discussed below.

Equity

Finally, medical care has not been universally equitable for LGBTQ youth. [57,58] To achieve true equity, it must be provided to all groups of lesbian, gay, bisexual, transgender, queer, and questioning youth. For example, providers may have competence in working with gay, lesbian or bisexual youth, but may not feel comfortable or have comparable experience in

caring for transgender and gender nonconforming youth.[59,60] Providers also need to ensure that services are inclusive of and sensitive to the needs of diverse racial/ethnic groups of LGBTQ youth, including those of color and who are non-native English speaking patients.[61] Finally, providers should ensure that services are provided to all LGBTQ youth regardless of ability to pay. Many youth, particularly those without legal immigrant status in the United States, without health insurance, or without stable housing are likely to have unmet health needs.[62–64] LGBTQ youth who have been rejected by their families are especially at risk of being uninsured and homeless. Through public entitlements, grants or other funding opportunities, providers should attempt to provide free or low-cost services to LGBTQ youth who are unable to pay for clinical services.

Strategies for individual providers

Large-scale system changes can be daunting to a health care organization seeking to improve its care for LGBTQ youth. However, some solutions can be adopted more rapidly by providers and clinic staff and may be as simple as changing one's language and approach. Specific strategies to make a clinic more inclusive and affirming for LGBTQ youth that are more immediately available to providers and their organizations are summarized in Box 1.

Box 1

Specific strategies for providers to create a welcoming environment for LGBTQ youth

Language	*Use words that help establish a trusting relationship; avoid words that build barriers to care. Language and word choice is critical not only in your clinical encounter, but also in all communication with nurses, clinical assistants, front desk staff, and all other staff.*
	• Avoid assuming a patient's partner is opposite-sex. Ask, "Are you in a relationship?" rather than, "Do you have a boyfriend?"
	• Use the same terms youth use to describe themselves. If a patient refers to himself as "gay", use this instead of the term "homosexual" in your clinical encounter.
	• Ask what pronouns a patient prefers, then use them. Transgender males, for example, may prefer that you use the terms, "he", "him", and "his". Others youth may use gender-neutral terms such as "they" or "zie".
Expectations	*Be aware that LGBTQ youth may have had prior adverse health care interactions and may not immediately feel comfortable disclosing sensitive information with you.*
	• Up front, let your patient know that you are an LGBT-friendly provider. Many clinics will post materials on the walls stating that they are LGBT-friendly; often, providers will wear a rainbow pin or other affirming symbol to let youth know they welcome LGBTQ youth at their practice.
	• At the beginning of every social history, state, "With your permission, I'd like to ask you some questions that I ask of all the youth I care for."
	• Always discuss confidentiality and assure it with all youth. If a patient comes with a parent, always ensure one-on-one confidential time with youth. Explain confidentiality to parents, also, so they understand that you will not disclose certain aspects of care.

Questions	*Understand that LGBTQ youth may have diverse and fluid identities with regard to sexual attraction, self-identified sexual orientation, gender identity, and gender expression.* • Ask open-ended questions about preferred pronouns, gender identity, self-identified sexual orientation, and sexual attraction, and only when one-on-one with youth. • Understand that the labels youth use do not necessarily dictate a youth's sexual partners and associated sexual behaviors. Understanding who a patient's partners are even despite the labels youth use can help guide clinical care.
Barriers	*Understand that navigating health care systems can be frustrating, and LGBTQ youth experience the same barriers to care as other youth, and more.* • Some barriers to care, such as insurance problems, are common among all youth, but may be especially common for LGBTQ youth who in some cases may be estranged from their families; be prepared to offer assistance with insurance problems and where necessary, free-of-charge services
Charting	*Be aware that health care records and insurance plans often use the name a patient was assigned at birth, which can be problematic for transgender youth who have changed their name. The gender listed often reflects a patient's assigned gender at birth.* • Consider a special chart labeling system or identify a feature in your electronic medical record that identifies patients by their chosen name. • Determine whether your medical record system can include fields not only for "male" or "female", but also for "transgender male" or "transgender female" as appropriate. • Review the forms your clinic mails to patients or administers in the waiting room. Often, these contain binary male/female fields, but should include other options as well.
Handling Mistakes	*Know that even experienced practitioners sometimes make mistakes with names and pronouns. Be prepared to correct them when they occur.* • Confront head-on your own mistakes or those of your colleagues' when they occur. To a transgender female called her assigned male birth name by a clinic staff member, say, "I apologize that we used the wrong name for you. We strive to be respectful of all our patients and we did not mean to disrespect you." • Hold all staff accountable for creating a welcoming environment, starting at the front desk and proceeding to every clinic staff worker. Work to improve the quality of your organization's care by making an LGBTQ youth-friendly environment a priority and discuss it openly and frequently with staff.

Adapted from: National LGBTQ Health Education Center. *Providing Welcoming Services and Care for LGBTQ People*. The Fenway Institute, Boston, MA: 2015, with permission.

Confidentiality

Establishing and safeguarding confidentiality with youth as a crucial element of a safe, viable treatment relationship, concomitantly with maintaining collaborative relationships that include developmentally appropriate privacy from adult parents or guardians, school personnel, colleagues, and other important adults in the youth's life, is critical in the care of *all* youth, but especially so for LGBTQ youth. At the beginning of every encounter,

providers should verify that confidentiality has been appropriately explained, assured, and fully protected in a manner consistent with applicable pediatric guidelines and ethics. Doing so is standard of care,[37,38] and is especially important for youth who have not yet disclosed any non-heterosexual attractions, behavior or identity or gender-variant identity to family or friends.[37,38] Improper disclosure of such details could damage the patient-provider relationship and lead to physical or emotional harm if caretakers or others have a negative reaction. Thus, information on sexual orientation and gender identity should be especially carefully protected.[22,24,33,36] Although in certain clinical situations (such as suicidal ideation, homicidal ideation, or suspicion of abuse or neglect) local law may require disclosure to the parent or guardian of a minor patient, it may at the same time allow or require providers to protect a youth's confidentiality of sexual and reproductive health concerns throughout treatment.[22] Therefore, any mandatory disclosures should be handled in a way that discloses only the minimum information necessary to ensure immediate safety and preserves remaining confidentiality. In addition to protecting youth and preserving the clinical relationship with them, it may also improve the accuracy of youths' responses to questions about risk behaviors and other sensitive topics, because they may feel more confortable disclosing personal information.[65] Clinicians should also maintain confidentiality in medical records (both handwritten and electronic) by specific indications in clinical notes regarding any portions that are not to be shared with parents or guardians.[22]

For youth who are accompanied by a parent or guardian at their visit, the provider should ensure he or she spends time alone one-on-one with the patient.[22,36] The provider can then update the parent on non-confidential aspects of care that the patient agrees to share. In some cases, providers may be instrumental in engaging families in difficult conversations regarding sexual orientation or gender identity if the patient wishes.

Despite efforts to assure confidentiality, some patients may not feel comfortable answering direct questions regarding sexuality, gender nonconformity and/or gender identity or related peer or family difficulties from the clinician honestly, and using collateral or alternatve information sources (including electronic or other forms of screening before the visit or in the waiting room) may help LGBTQ youth provide more honest responses to these and other sensitive topics.[66,67] Unfortunately, for youth who are on parents' insurance plans, explanations of benefit (EOBs) can sometimes reveal confidential care (*e.g.,* sexually transmitted infection [STI] screening and/or treatment). There are currently efforts in some states to limit insurance companies' communication of such confidential information to primary policyholders.[68] Thus,it is important for clinicians to consider that inadvertent disclosure of sensitive clinical details can occur when they order lab tests or prescribe medications for STIs, and should plan accordingly. In some cases, offering care free-of-charge may be the only way to avoid accidental disclosure through EOBs; in some locales, use of special grant funds allows providers to offer free and confidential testing and treatment that avoid the need to bill patients' insurance. Clincians should bear similar issues in mind when making a plan for delivering test results after an encounter or when writing or approving prescriptions, as well as when they are dispensed.

Strategies for clinics and health systems

The principles and strategies outlined above are important general approaches to improving the friendliness of clinical care for LGBTQ youth. However, delivering affirmative care may require moving past a one-size-fits-all approach and exploring the specific needs of the LGBTQ youth population of a clinic or health system. For example, the needs of a clinic serving primarily gay and lesbian youth is likely to be very different from one serving primarily transgender youth. Clinics serving young LGBTQ adults are likely to face different clinical scenarios from those who treat primarily younger adolescents. The needs of rural LGBTQ youth may be quite different from those of urban LGBTQ youth. Children who are or may be growing up, LGBTQ can and do live everywhere. Although core clinical practice guidelines exist and should be adhered to, clinics should explore the needs of their own population in order to develop and improve the services they offer LGBTQ youth. Here, we discuss approaches to assessing the needs of the population that a clinic serves.

Readiness assessment

As highlighted above, providers can make a number of small, easily accomplished changes to substantially improve the inclusiveness of their clinical services for LGBTQ youth. However, some clinics or health systems may seek to create broader changes and should first consider a readiness assessment that combines an analysis of population health data with qualitative study methods.[2,14] For example, in evaluating their own population health data, a clinic might examine its rates of positive STI screens to understand which youth are most likely to test positive, and consider how best to deliver health services to those youth. However, examination of population health data alone is likely to lead to excessive focus on adverse health outcomes to the exclusion of positive health behaviors that clinicians might promote.[69] Additionally, population health data alone are unlikely to fully describe patient satisfaction and experience of care, including highlighting ways in which LGBTQ youth may experience stigma in the health care environment.[2,13]

Therefore, clinics should supplement their study of population health data with qualitative methods in their needs assessment.[70] Methodologic approaches might include focus groups of LGBTQ youth, or if younger adolescents are to be interviewed or there are confidentiality concerns, one-on-one interviews.[71] Parents should also be engaged, either in their own separate focus groups or in interviews. Key informant interviews with community stakeholders (*e.g.,* community workers and other service providers, educators, and faith leaders) should also be conducted to understand how LGBTQ youth interface with the world beyond the clinic's walls.

Questions for youth, families, and stakeholders should focus on all aspects of the care experience and examine the systems-level principles outlined earlier (availability, accessibility, acceptability, and equity)[19,24] as well as individual provider-level characteristics. Details considered might include clinic location, hours, services (including low-cost or free and confidential preventive screening, treatment and referral), costs, mission statement, facilities, signage (including evidence of LGBTQ friendliness), educational materials, confidentiality, and perceived inclusiveness for youth of color.[19,25] Providers should also consider the extent to which they might bolster outside services to aid youth in

the broader community (*e.g.,* help with housing and other social services, legal support, help with employment searches, and collaborations with schools, faith-based organizations and other community organizations). The advantage to this approach is that clinics leveraging community programs do not need to necessarily duplicate such services within their own walls.

Such a needs assessment is likely to uncover unanticipated ways that a clinic might better serve its LGBTQ youth population. Not only should the needs assessment serve to help providers understand new services they might develop or preexisting services they might improve, but it also should help clinical leadership understand new measures for quality improvement.[72] For example, one process measure might be asking all patients about sexual orientation and gender identity or about a preferred name and pronouns for the youth, and recording this in a prominent place in the patient care flow (for youth comfortable with this information being freely available) or in a confidential part of the electronic medical record (for youth who wish to maintain the privacy of this information). Youth might also help providers develop LGBTQ youth-specific patient satisfaction measures for the clinic.[26] Each clinic should let the needs and requests of their own clinic population drive the development of quality measures, and ensure that such measures are frequently assessed to drive ongoing improvement.

Trainings

Many clinics choose to offer training on competent care for LGBTQ youth to their clinic staff. Trainings can be offered as an in-person workshop, or where such workshops are not readily available, online webinars offer excellent convenience (*e.g.,* http://www.lgbthealtheducation.org/training/on-demand-webinars/). Training is available in both cultural and clinical competence. Some aspects of cultural competence training are appropriate for *all* clinic staff (including front desk and other administrative staff), such as proper use of pronouns and preferred names, to ensure competence at every moment of the care experience.[55] Clinical competence trainings, such as those reviewing clinical practice guidelines for the care of LGBTQ youth,[27,28,73,74] are more appropriate for clinicians. Such trainings may be critical given the lack of formal medical education on LGBTQ health care otherwise available to many providers, particularly those who trained some time ago.[17] Providers and clinics might consider reaching out to local organizations who serve youth in the community or to other nearby health care providers with expertise in serving LGBTQ youth to help arrange trainings.

Conclusion

Reevaluating and redesigning systems of care and individual provider practices to improve clinical services for LGBTQ youth should be a priority for health care organizations.[5] Some changes, such as changing the language clinic staff use when working with LGBTQ youth, can be put into practice immediately with minimal overhaul of clinical services. Others require a more in-depth readiness assessment and reorganization of preexisting practices. However, the up-front investment is likely to pay off for both patients and providers. Based on population estimates, *all* general medical providers are likely already caring for LGBTQ

youth but may not realize it because youth are struggling with their own identity or may not be ready to disclose.[6] It is not the task of the provider to identify LGBTQ youth, but rather to ask appropriate questions and signal support for when youth are ready to disclose, and then offer further support and resources. LGBTQ youth are especially susceptible to stigma and discrimination in the traditional health care setting and yet have important physical and mental health care needs. Realizing the goal of creating a welcoming, inclusive, and affirming health care environment can improve health care outcomes for this historically marginalized group and create a rewarding practice for providers.

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Key Points

- Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth may experience interpersonal and structural stigma within the health care environment.
- Inclusive and affirmative care for LGBTQ youth requires a careful understanding not only of the unique aspects of LGBTQ health care, but also of skills unique to caring for youth more generally.
- Although most LGBTQ youth are physically and mentally healthy, certain LGBTQ youth are at elevated risk of human immunodeficiency virus (HIV) infection, sexually transmitted infection (STI), pregnancy, obesity, substance use disorders, mood and anxiety disorders, eating disorders and other body image-related concerns, peer bullying, and family rejection.
- Health care systems should be mindful of the availability, accessibility, acceptability, and equity of their services with regard to LGBTQ youth.
- Large-scale system changes to improve care for LGBTQ youth can be daunting to a health care organization, but some solutions can be adopted rapidly by individual providers and clinic staff and may be as simple as changing one’s language and approach.

Table 1

Systems-level principles underlying LGBTQ youth-friendly services

Principle	Definition	Examples
Availability	The presence of health care providers with knowledge, competence and experience working with young people and with people with current or possibly developing LGBTQ identities, feelings, and/or behavior	• Providers from various disciplines (*e.g.,* physicians and non-physician health care professionals) provide care sensitive to the needs of LGBTQ youth • Quality of care is high, with LGBTQ youth (and when appropriate, their caregivers) universally receiving recommended screening and anticipatory guidance
Accessibility	The relative ease with which LGBTQ youth can obtain care from an available provider	• Clinical services are located near where LGBTQ youth live, study, work or otherwise spend time • Clinical services are easily obtained, with expanded hours during evenings and weekends, same-day urgent bookings, drop-in visits, allowances for late appointments • Technology (*e.g.,* online patient portals, email, telemedicine) is increasingly used to improve access for youth
Acceptability	The extent to which clinical services are culturally competent and developmentally appropriate for LGBTQ youth, and to which confidentiality is assured and protected	• The clinic has a policy affirming its inclusive services for LGBTQ, and the clinical environment has signs, stickers, and other statements showing it is LGBT- friendly • Health brochures and other reading materials are tailored to the needs of LGBTQ youth • Confidentiality is assured and protected in every patient encounter and health care providers spend time one-on-one with patients to elicit sensitive information
Equity	The degree to which clinical care is friendly to *all* LGBTQ youth, regardless of race, ethnicity, language, ability to pay, housing status, and insurance status, among other factors	• High quality care is provided to all youth, regardless of whether they are lesbian, gay, bisexual or transgender • Culturally competent care is provided to LGBTQ youth of color and services are available for non-native English speaking patients • Services are provided free-of-charge for uninsured LGBTQ youth

Adapted from Tylee A, Haller DM, Graham T, Churchill R, Sanci LA. Youth-friendly primary-care services: how are we doing and what more needs to be done? *Lancet*. 2007;369(9572):1565–1573 and Department of Maternal Newborn Child and Adolescent Health. *Making Health Services Adolescent Friendly - Developing National Quality Standards for Adolescent Friendly Health Services*. Geneva, Switzerland; 2012, with permission.

Vaccines for Preteens: What Parents Should Know

Last updated JANUARY 2017

Why does my child need vaccines now?

Vaccines aren't just for babies. Some of the vaccines that babies get can wear off as kids get older. And as kids grow up they may come in contact with different diseases than when they were babies. There are vaccines that can help protect your preteen or teen from these other illnesses.

What vaccines does my child need?

Tdap Vaccine

This vaccine helps protect against three serious diseases: tetanus, diphtheria, and pertussis (whooping cough). Preteens should get Tdap at age 11 or 12. If your teen didn't get a Tdap shot as a preteen, ask their doctor or nurse about getting the shot now.

Meningococcal Vaccine

Meningococcal conjugate vaccine protects against some of the bacteria that can cause meningitis (swelling of the lining around the brain and spinal cord) and septicemia (an infection in the blood). Preteens need the first meningococcal shot when they are 11 or 12 years old. They need a second meningococcal shot at age 16.

HPV Vaccine

Human papillomavirus (HPV) vaccines help protect both girls and boys from HPV infection and cancer caused by HPV. All 11- and 12-year-olds should receive two shots of HPV vaccine 6-12 months apart. Preteens and teens who haven't started or finished the HPV vaccine series should ask the doctor or nurse about getting them now.

Flu Vaccine

The annual flu vaccine is the best way to reduce the chances of getting seasonal flu and spreading it to others. Even healthy preteens and teens can get very sick from the flu and spread it to others. While all preteens and teens should get a flu vaccine, it's especially important for those with chronic health conditions such as asthma, diabetes, and heart disease to get vaccinated. The best time to get the flu vaccine is as soon as it's available in your community, ideally by October. While it's best to be vaccinated before flu begins causing illness in your community, flu vaccination can be beneficial as long as flu viruses are circulating, even in January or later.

When should my child be vaccinated?

A good time to get these vaccines is during a yearly health checkup. Your preteen or teen can also get these vaccines at a physical exam required for sports, school, or camp. It's a good idea to ask the doctor or nurse every year if there are any vaccines that your child may need.

What else should I know about these vaccines?

These vaccines have all been studied very carefully and are safe. They can cause mild side effects, like soreness or redness in the part of the arm where the shot was given. Some preteens and teens might faint after getting a shot. Sitting or lying down when getting a shot and then for about 15 minutes after the shot, can help prevent fainting. Serious side effects are rare. It is very important to tell the doctor or nurse if your child has any serious allergies, including allergies to yeast, latex, or chicken eggs, before they receive any shots.

How can I get help paying for these vaccines?

The Vaccines for Children (VFC) program provides vaccines for children ages 18 years and younger, who are uninsured, Medicaid-eligible, American Indian or Alaska Native. You can find out more about the VFC program by going online to www.cdc.gov and typing VFC in the search box.

Where can I learn more?

Talk to your child's doctor or nurse about what vaccines they may need. You can also find more information about these vaccines on CDC's Vaccines for Preteens and Teens website at www.cdc.gov/vaccines/teens.

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If You Choose Not to Vaccinate Your Child, **Understand the Risks and Responsibilities.**

Reviewed March 2012

If you choose to delay some vaccines or reject some vaccines entirely, there can be risks. Please follow these steps to protect your child, your family, and others.

With the decision to delay or reject vaccines comes an important responsibility that could save your child's life, or the life of someone else.

Any time that your child is ill and you:

- call 911;
- ride in an ambulance;
- visit a hospital emergency room; or
- visit your child's doctor or any clinic

you must tell the medical staff that your child has not received all the vaccines recommended for his or her age.

Keep a vaccination record easily accessible so that you can report exactly which vaccines your child has received, even when you are under stress.

Telling health care professionals your child's vaccination status is essential for two reasons:

- When your child is being evaluated, the doctor will need to consider the possibility that your child has a vaccine-preventable disease. Many of these diseases are now uncommon, but they still occur.
- The people who help your child can take precautions, such as isolating your child, so that the disease does not spread to others. One group at high risk for contracting disease is infants who are too young to be fully vaccinated. For example, the measles vaccine is not usually recommended for babies younger than 12 months. Very young babies who get measles are likely to be seriously ill, often requiring hospitalization. Other people at high risk for contracting disease are those with weaker immune systems, such as some people with cancer and transplant recipients.

Before an outbreak of a vaccine-preventable disease occurs in your community:

- Talk to your child's doctor or nurse to be sure your child's medical record is up to date regarding vaccination status. Ask for a copy of the updated record.
- Inform your child's school, childcare facility, and other caregivers about your child's vaccination status. -
- Be aware that your child can catch diseases from people who don't have any symptoms. For example, Hib meningitis can be spread from people who have the bacteria in their body but are not ill. You can't tell who is contagious.

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA
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When there is vaccine-preventable disease in your community:

- It may not be too late to get protection by getting vaccinated. Ask your child's doctor.
- If there are cases (or, in some circumstances, a single case) of a vaccine-preventable disease in your community, you may be asked to take your child out of school, childcare, or organized activities (for example, playgroups or sports).
- Your school, childcare facility, or other institution will tell you when it is safe for an unvaccinated child to return. Be prepared to keep your child home for several days up to several weeks.
- Learn about the disease and how it is spread. It may not be possible to avoid exposure. For example, measles is so contagious that hours after an infected person has left the room, an unvaccinated person can get measles just by entering that room. -
- Each disease is different, and the time between when your child might have been exposed to a disease and when he or she may get sick will vary. Talk with your child's doctor or the health department to get their guidelines for determining when your child is no longer at risk of coming down with the disease.

Be aware.

- Any vaccine-preventable disease can strike at any time in the U.S. because all of these diseases still circulate either in the U.S. or elsewhere in the world.
- Sometimes vaccine-preventable diseases cause outbreaks, that is, clusters of cases in a given area.
- Some of the vaccine-preventable diseases that still circulate in the U.S. include whooping cough, chickenpox, Hib (a cause of meningitis), and influenza. These diseases, as well as the other vaccine-preventable diseases, can range from mild to severe and life-threatening. In most cases, there is no way to know beforehand if a child will get a mild or serious case.
- For some diseases, one case is enough to cause concern in a community. An example is measles, which is one of the most contagious diseases known. This disease spreads quickly among people who are not immune.

If you know your child is exposed to a vaccine-preventable disease for which he or she has not been vaccinated:

- Learn the early signs and symptoms of the disease.
- Seek immediate medical help if your child or any family members develop early signs or symptoms of the disease. -

  IMPORTANT: Notify the doctor's office, urgent care facility, ambulance personnel, or emergency room staff that your child has not been fully vaccinated before medical staff have contact with your child or your family members. They need to know that your child may have a vaccine-preventable disease so that they can treat your child correctly as quickly as possible. Medical staff also can take simple precautions to prevent diseases from spreading to others if they know ahead of time that their patient may have a contagious disease.

- Follow recommendations to isolate your child from others, including family members, and especially infants and people with weakened immune systems. Most vaccine-preventable diseases can be very dangerous to infants who are too young to be fully vaccinated, or children who are not vaccinated due to certain medical conditions.
- Be aware that for some vaccine-preventable diseases, there are medicines to treat infected people and medicines to keep people they come in contact with from getting the disease.
- Ask your health care professional about other ways to protect your family members and anyone else who may come into contact with your child.
- Your family may be contacted by the state or local health department who track infectious disease outbreaks in the community. -

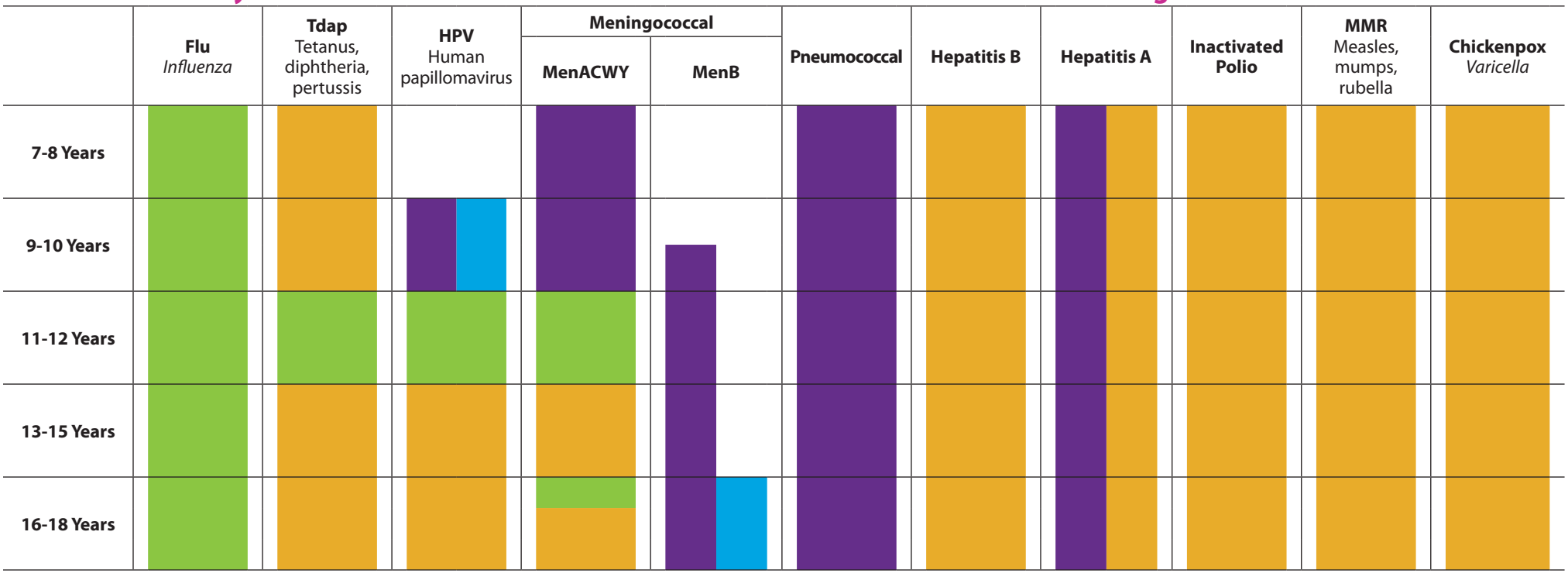
If you travel with your child:

- Review the CDC travelers' information website *(http://www.cdc.gov/travel)* before traveling to learn about possible disease risks and vaccines that will protect your family. Diseases that vaccines prevent remain common throughout the world, including Europe. -
- Don't spread disease to others. If an unimmunized person develops a vaccine-preventable disease while traveling, to prevent transmission to others, he or she should not travel by a plane, train, or bus until a doctor determines the person is no longer contagious.

INFORMATION FOR PARENTS

2018 Recommended Immunizations for Children 7-18 Years Old

Talk to your child's doctor or nurse about the vaccines recommended for their age.



More information:	Preteens and teens should get a flu vaccine every year.	Preteens and teens should get one shot of Tdap at age 11 or 12 years.	All 11-12 year olds should get a 2-shot series of HPV vaccine at least 6 months apart. A 3-shot series is needed for those with weakened immune systems and those age 15 or older.	All 11-12 year olds should get a single shot of a meningococcal conjugate (MenACWY) vaccine. A booster shot is recommended at age 16.	Teens, 16-18 years old, **may** be vaccinated with a serogroup B meningococcal (MenB) vaccine.

These shaded boxes indicate when the vaccine is recommended for all children unless your doctor tells you that your child cannot safely receive the vaccine.

These shaded boxes indicate the vaccine should be given if a child is catching-up on missed vaccines.

These shaded boxes indicate the vaccine is recommended for children with certain health or lifestyle conditions that put them at an increased risk for serious diseases. See vaccine-specific recommendations at www.cdc.gov/vaccines/pubs/ACIP-list.htm.

This shaded box indicates children not at increased risk may get the vaccine if they wish after speaking to a provider.

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Vaccine-Preventable Diseases and the Vaccines that Prevent Them

Diphtheria (Can be prevented by Tdap vaccination)

Diphtheria is a very contagious bacterial disease that affects the respiratory system, including the lungs. Diphtheria bacteria can be spread from person to person by direct contact with droplets from an infected person's cough or sneeze. When people are infected, the bacteria can produce a toxin (poison) in the body that can cause a thick coating in the back of the nose or throat that makes it hard to breathe or swallow. Effects from this toxin can also lead to swelling of the heart muscle and, in some cases, heart failure. In serious cases, the illness can cause coma, paralysis, or even death.

Hepatitis A (Can be prevented by HepA vaccination)

Hepatitis A is an infection in the liver caused by hepatitis A virus. The virus is spread primarily person-to-person through the fecal-oral route. In other words, the virus is taken in by mouth from contact with objects, food, or drinks contaminated by the feces (stool) of an infected person. Symptoms can include fever, tiredness, poor appetite, vomiting, stomach pain, and sometimes jaundice (when skin and eyes turn yellow). An infected person may have no symptoms, may have mild illness for a week or two, may have severe illness for several months, or may rarely develop liver failure and die from the infection. In the U.S., about 100 people a year die from hepatitis A.

Hepatitis B (Can be prevented by HepB vaccination)

Hepatitis B causes a flu-like illness with loss of appetite, nausea, vomiting, rashes, joint pain, and jaundice. Symptoms of acute hepatitis B include fever, fatigue, loss of appetite, nausea, vomiting, pain in joints and stomach, dark urine, grey-colored stools, and jaundice (when skin and eyes turn yellow).

Human Papillomavirus (Can be prevented by HPV vaccination)

Human papillomavirus is a common virus. HPV is most common in people in their teens and early 20s. About 14 million people, including teens, become infected with HPV each year. HPV infection can cause cervical, vaginal, and vulvar cancers in women and penile cancer in men. HPV can also cause anal cancer, oropharyngeal cancer (back of the throat), and genital warts in both men and women.

Influenza (Can be prevented by annual flu vaccination)

Influenza is a highly contagious viral infection of the nose, throat, and lungs. The virus spreads easily through droplets when an infected person coughs or sneezes and can cause mild to severe illness. Typical symptoms include a sudden high fever, chills, a dry cough, headache, runny nose, sore throat, and muscle and joint pain. Extreme fatigue can last from several days to weeks. Influenza may lead to hospitalization or even death, even among previously healthy children.

Measles (Can be prevented by MMR vaccination)

Measles is one of the most contagious viral diseases. Measles virus is spread by direct contact with the airborne respiratory droplets of an infected person. Measles is so contagious that just being in the same room after a person who has measles has already left can result in infection. Symptoms usually include a rash, fever, cough, and red, watery eyes. Fever can persist, rash can last for up to a week, and coughing can last about 10 days. Measles can also cause pneumonia, seizures, brain damage, or death.

Meningococcal Disease (Can be prevented by meningococcal vaccination)

Meningococcal disease has two common outcomes: meningitis (infection of the lining of the brain and spinal cord) and bloodstream infections. The bacteria that cause meningococcal disease spread through the exchange of nose and throat droplets, such as when coughing, sneezing, or kissing. Symptoms include sudden onset of fever, headache, and stiff neck. With bloodstream infection, symptoms also include a dark purple rash. About one of every ten people who gets the disease dies from it. Survivors of meningococcal disease may lose their arms or legs, become deaf, have problems with their nervous systems, become developmentally disabled, or suffer seizures or strokes.

Mumps (Can be prevented by MMR vaccination)

Mumps is an infectious disease caused by the mumps virus, which is spread in the air by a cough or sneeze from an infected person. A child can also get infected with mumps by coming in contact with a contaminated object, like a toy. The mumps virus causes swollen salivary glands under the ears or jaw, fever, muscle aches, tiredness, abdominal pain, and loss of appetite. Severe complications for children who get mumps are uncommon, but can include meningitis (infection of the covering of the brain and spinal cord), encephalitis (inflammation of the brain), permanent hearing loss, or swelling of the testes, which rarely results in decreased fertility.

Pertussis (Whooping Cough) (Can be prevented by Tdap vaccination)

Pertussis spreads very easily through coughing and sneezing. It can cause a bad cough that makes someone gasp for air after coughing fits. This cough can last for many weeks, which can make preteens and teens miss school and other activities. Pertussis can be deadly for babies who are too young to receive the vaccine. Often babies get whooping cough from their older brothers or sisters, like preteens or teens, or other people in the family. Babies with pertussis can get pneumonia, have seizures, become brain damaged, or even die. About half of children under 1 year of age who get pertussis must be hospitalized.

Pneumococcal Disease (Can be prevented by pneumococcal vaccination)

Pneumonia is an infection of the lungs that can be caused by the bacteria called pneumococcus. These bacteria can cause other types of infections too, such as ear infections, sinus infections, meningitis (infection of the lining of the brain and spinal cord), and bloodstream infections. Sinus and ear infections are usually mild and are much more common than the more serious forms of pneumococcal disease. However, in some cases pneumococcal disease can be fatal or result in long-term problems, like brain damage and hearing loss. The bacteria that cause pneumococcal disease spread when people cough or sneeze. Many people have the bacteria in their nose or throat at one time or another without being ill—this is known as being a carrier.

Polio (Can be prevented by IPV vaccination)

Polio is caused by a virus that lives in an infected person's throat and intestines. It spreads through contact with the stool of an infected person and through droplets from a sneeze or cough. Symptoms typically include sore throat, fever, tiredness, nausea, headache, or stomach pain. In about 1% of cases, polio can cause paralysis. Among those who are paralyzed, About 2 to 10 children out of 100 die because the virus affects the muscles that help them breathe.

Rubella (German Measles) (Can be prevented by MMR vaccination)

Rubella is caused by a virus that is spread through coughing and sneezing. In children rubella usually causes a mild illness with fever, swollen glands, and a rash that lasts about 3 days. Rubella rarely causes serious illness or complications in children, but can be very serious to a baby in the womb. If a pregnant woman is infected, the result to the baby can be devastating, including miscarriage, serious heart defects, mental retardation and loss of hearing and eye sight.

Tetanus (Lockjaw) (Can be prevented by Tdap vaccination)

Tetanus mainly affects the neck and belly. When people are infected, the bacteria produce a toxin (poison) that causes muscles to become tight, which is very painful. This can lead to "locking" of the jaw so a person cannot open his or her mouth, swallow, or breathe. The bacteria that cause tetanus are found in soil, dust, and manure. The bacteria enter the body through a puncture, cut, or sore on the skin. Complete recovery from tetanus can take months. One to two out of 10 people who get tetanus die from the disease.

Varicella (Chickenpox) (Can be prevented by varicella vaccination)

Chickenpox is caused by the varicella zoster virus. Chickenpox is very contagious and spreads very easily from infected people. The virus can spread from either a cough, sneeze. It can also spread from the blisters on the skin, either by touching them or by breathing in these viral particles. Typical symptoms of chickenpox include an itchy rash with blisters, tiredness, headache and fever. Chickenpox is usually mild, but it can lead to severe skin infections, pneumonia, encephalitis (brain swelling), or even death.

If you have any questions about your child's vaccines, talk to your healthcare provider.

Last updated on January 17, 2018 • *CS289048-A*

Information for Health Care Professionals about Adolescent Vaccines

The Centers for Disease Control and Prevention (CDC) recommends four vaccines for adolescents to prevent:

- Tetanus, Diphtheria, Pertussis — ***Note: Recommendations for catch-up dose and minimum interval***
- Meningococcal disease — ***Note: A booster shot for teens***
- Human papillomavirus — ***Note: Added indications for Gardasil; recommendation for boys***
- Influenza — ***Note: Universal recommendation for everyone 6 months and older***

These recommendations are supported by the American Academy of Pediatrics, the American Academy of Family Physicians, and the Society for Adolescent Health and Medicine.

What can YOU do to ensure your patients get fully vaccinated?

- *Strongly* recommend adolescent vaccines to parents of your 11 through 18 year old patients. **Parents trust *your* opinion more than anyone else's when it comes to immunizations.** Studies consistently show that provider recommendation is the *strongest* predictor of vaccination.
- Use every opportunity to vaccinate your adolescent patients. **Ask about vaccination status when they come in for sick visits and sports physicals.**
- Patient reminder and recall systems such as automated **postcards, phone calls and text messages are effective tools for increasing office visits.**
- **Educate parents about the diseases that can be prevented by adolescent vaccines.** Parents may know very little about pertussis, meningococcal disease, or HPV.
- **Implement standing orders policies** so that patients can receive vaccines without a physician examination or individual physician order.

Direct parents who want more information on vaccines and vaccine-preventable diseases to visit the CDC website at http://www.cdc.gov/vaccines/teens or to call 800-CDC-INFO.

Note about syncope: *For **all** vaccines given during adolescence, syncope has been reported in both boys and girls. To avoid serious injury related to a syncopal episode, adolescents should always be sitting or lying down to receive vaccines, remain so for 15 minutes, AND be observed during this time.*

Overview of Adolescent Vaccination Recommendations

- All 11 or 12 year olds should receive a single dose of Tdap vaccine if they have completed the recommended childhood DTP/DTaP vaccination series and have not received Tdap
- All 11 or 12 year olds should receive a single dose of meningococcal vaccine, with a booster dose at age 16 years
- All girls 11 or 12 years old should get 3 doses of either HPV vaccine to protect against cervical cancer; All boys 11 or 12 years old should get 3 doses of quadrivalent HPV vaccine to protect against genital warts and anal cancer
- All adolescents should receive a single dose of influenza vaccine every year

Age ▸ / ▾ Vaccine	7–10 YEARS	11-12 YEARS	13-18 YEARS
Tdap	Childhood Catch-up	Recommended	Catch-Up
HPV		Recommended	Catch-Up
MCV4	High-Risk	Recommended	Recommended
Flu	Recommended		

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Tdap (tetanus toxoid - reduced diphtheria toxoid - acellular pertussis) Vaccine

Because immunity from childhood DTaP vaccines wanes by adolescence, a booster dose is recommended. **Of the nearly 17,000 cases of pertussis reported in the United States in 2009, 4265 occurred among 10- through 19-year-olds.** Increasing immunization rates among adolescents is an important strategy for reducing disease among both adolescents and infants too young to be fully immunized. According to the 2010 National Immunization Survey-Teen (NIS-Teen), about 69% of 13- through 17-year-olds received Tdap.

Recommendations:

- **All 11- through 18-year-olds should receive a single dose of Tdap vaccine (preferably at age 11 or 12 years) if they have completed the recommended childhood DTP/DTaP vaccination series and have not received Tdap.**
- Children aged 7 through 10 years and adolescents aged 11 through 18 years who did not complete the childhood DTaP series or with unknown vaccine history should be given one dose of Tdap as part of the catch-up regimen. Td should be used for any other doses needed.
- Tdap should be administered regardless of interval since the last tetanus or diphtheria toxoid-containing vaccine. While longer intervals between Td and Tdap vaccination could decrease the occurrence of local reactions, the benefits of protection against pertussis outweigh the potential risk for adverse events.
- Tdap vaccine can be administered at the same time as other adolescent vaccines.

Vaccines licensed in the United States:

- Boostrix® (GlaxoSmithKline) is indicated for active booster immunization for the prevention of tetanus, diphtheria and pertussis as a single dose in persons 10 through 64 years of age.
- Adacel® (sanofi pasteur) is indicated for active booster immunization for the prevention of tetanus, diphtheria and pertussis as a single dose in persons 11 through 64 years of age.

Possible side effects:

Pain, redness, swelling at the injection site; mild fever; headache; fatigue; nausea, vomiting, diarrhea, or stomach ache.

Contraindications and precautions:

- Tdap is contraindicated for persons with a history of serious allergic reaction (e.g., anaphylaxis) to any component of the vaccine.
- Tdap is contraindicated for adolescents with a history of encephalopathy (e.g., coma or prolonged seizures) not attributable to an identifiable cause within 7 days of administration of a vaccine with pertussis components. This contraindication is for the pertussis components and these adolescents should receive Td instead of Tdap.

Meningococcal Conjugate Vaccine (MCV4)

Although rates of meningococcal disease are the lowest they have ever been in the United States, about 1000 cases are reported each year in this country. Each case is alarming and potentially deadly. **The incidence of meningococcal disease increases in adolescence and early adulthood.** About 10-15% of adolescents who contract the disease will die, and about 20% will suffer from a long-term disability. According to the 2010 National Immunization Survey-Teen (NIS-Teen), about 63% of 13- through 17-year-olds received MCV4.

Recommendations:

- **All 11- or 12-year-olds should receive a single dose of meningococcal vaccine, with a booster dose at age 16 years.**
- For adolescents who receive the first dose at age 13 through 15 years, a one-time booster dose should be administered, preferably at age 16 through 18 years. Persons who receive their f0irst dose of meningococcal conjugate vaccine at or after age 16 years do not need a booster dose.
- Adolescents with persistent complement component deficiencies (e.g., C5-C9, properidin, factor H, or factor D) and asplenia should receive a 2-dose primary series administered 2 months apart and then receive a booster dose every 5 years.
- Adolescents aged 11–18 years with HIV infection should be routinely vaccinated with a 2-dose primary series.
- Vaccination is also recommended for unvaccinated college freshmen who live in dormitories, and also for unvaccinated military recruits. Older adolescents, including college students, who wish to decrease their risk for meningococcal disease, may elect to receive meningococcal vaccine.
- Meningococcal vaccine can be administered at the same time as other adolescent vaccines.

Vaccines licensed in the United States:

- Menactra® (sanofi pasteur) is indicated for active immunization of persons 9 months through 55 years of age for the prevention of invasive meningococcal disease caused by *N. meningitidis* serogroups A, C, Y and W-135.
- Menveo® (Novartis) is indicated for active immunization of persons 2 through 55 years of age to prevent invasive meningococcal disease caused by *N. meningitidis* serogroups A, C, Y, and W-135.

Possible side effects:

The most commonly reported side effects are redness or pain at the injection site. A small percentage of recipients reported fever.

Contraindications and precautions:

- Meningococcal vaccine is contraindicated among persons known to have a severe allergic reaction to any component of the vaccine, including diphtheria toxoid, or to dry natural rubber latex.

Human Papillomavirus (HPV) Vaccine

Cervical cancer, caused by HPV, is one of the most common cancers in women—every year in the United States, about 12,000 women are diagnosed with cervical cancer, and about 4,000 women die from this disease. HPV types 16 and 18 are the most common high-risk types associated with cervical cancer, while HPV 6 and 11 are the most common low-risk types associated with genital and respiratory tract warts (recurrent respiratory papillomatosis or RRP). High-risk HPV types have also been associated with other, less common cancers and precancers in women, such as vulvar, vaginal, anal, opharyngeal carcinomas and dysplasia. HPV-associated cancers in males include certain anal, penile, and oropharyngeal carcinomas and dysplasia.

According to the 2010 NIS-Teen, about 49% of 13- through 17-year-old girls have started an HPV vaccine series. However, only about 32% received all 3 doses. **Completing the 3-dose HPV vaccine series is very important to ensure protection against cervical cancer and other HPV-related disease.**

Vaccines licensed in the United States:

- Cervarix® is indicated for the prevention of cervical cancer and precancers caused by HPV types 16 and 18.
- Gardasil® is indicated for the prevention of cervical, vulvar, vaginal and anal cancers and precancers, as well as genital warts, caused by HPV types 6, 11, 16 and 18.

Recommendations:

- **All 11 or 12 year olds should receive 3 doses of HPV vaccine to protect against HPV-related disease.**
- **All girls 11 or 12 years old should get 3 doses of HPV vaccine to protect against cervical cancer.** Girls and young women ages 13 through 26 should get all 3 doses of an HPV vaccine if they have not yet received all doses. Both brands of vaccine are highly effective for preventing cervical cancer and precancer caused by HPV types 16 and 18. Gardasil also protects against anal cancer and genital warts.
- **All boys 11 or 12 years old should get 3 doses of quadrivalent HPV vaccine (Gardasil) to protect against genital warts and anal cancer.** Boys and young men 13 through 21 years, who did not get any or all of the three recommended doses when they were younger, should also get the HPV vaccine series. MSM and immunocompromised males should receive the vaccine through age 26 years, if they did not start or complete the vaccine series when they were younger.
- HPV vaccines are administered in a 3-dose schedule. The second dose should be administered 1 to 2 months after the first dose, and the third dose should be administered 6 months after the first dose. There is no maximum interval between doses. If the HPV vaccine schedule is interrupted, the vaccine series does not need to be restarted.
- Whenever feasible, the same brand of HPV vaccine should be used for the entire vaccination series. However, if the vaccine provider does not know which brand of vaccine was previously administered or have it available, either brand of HPV vaccine can be used to complete the series.
- Individuals will get the greatest benefit from the vaccine if it is administered before they have initiated *any* type of sexual activity with another person.
- Studies demonstrate that the risk for HPV infection is high immediately following sexual debut. It is also important to note that 1 in 5 women who have only had one lifetime sex partner have been infected with a high-risk HPV type.
- Vaccination is recommended for patients with HPV-related disease and/or apparent HPV infection because the vaccine can offer protection against infection with HPV vaccine types not already acquired. However, vaccination will not have a therapeutic effect on existing HPV infection or HPV-related disease.
- HPV vaccine can be administered at the same time as other adolescent vaccines.

Possible side effects:

Pain, headache, redness or swelling at the injection site are the most commonly reported side effects.

Contraindications and precautions:

- HPV vaccines are not recommended for use in pregnancy. If a patient is found to be pregnant after initiating the vaccination series, the remainder of the 3-dose series should be delayed until completion of pregnancy. However, if a vaccine dose has been administered during pregnancy, no intervention is needed. Clinicians should report exposure to Gardasil during pregnancy to Merck at 800-986-8999, and exposure to Cervarix during pregnancy to GlaxoSmithKline at 888-452-9622.
- HPV vaccines are contraindicated for persons with a history of immediate hypersensitivity to any vaccine component. Gardasil is contraindicated for persons with a history of immediate hypersensitivity to yeast. Prefilled syringes of Cervarix have latex in the rubber stopper and should not be used in persons with anaphylactic latex allergy. Cervarix single-dose vials contain no latex.

Influenza Vaccine

CDC recommends universal annual flu vaccination for everyone aged 6 months and older. Flu can be serious, and even fatal, for healthy adolescents, but pre-teens and teens with certain medical conditions are more likely to suffer from serious flu complications. Conditions that place people at high risk include chronic lung disease (such as asthma); heart disease; endocrine disorders (such as diabetes); blood disorders; neurological and neurodevelopmental conditions; kidney, liver, and metabolic disorders; and weakened immune systems due to disease or medication. Flu seasons are unpredictable and can be severe. Each year in the United States, more than 200,000 people are hospitalized from flu-related complications.

Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications since flu viruses are constantly changing. Protective immunity generally develops in 2 weeks after being vaccinated.

Vaccines Licensed in the United States:

- Trivalent Inactivated Influenza Vaccine (TIV) is given as an injection. It can be used for people 6 months of age or older, including healthy people, those with chronic medical conditions, and pregnant women. Brands licensed in the United States include Fluarix®, Fluvirin®, Fluzone®, FluLaval®, and Afluria®.
- Live, Intranasal Influenza Vaccine (LAIV) is given as a nasal spray. It can be used for healthy people 2 through 49 years of age who are not pregnant. FluMist® is the only brand licensed in the United States.

Recommendations:

- **Adolescents should receive a single dose of influenza vaccine *every year*.**
- Influenza vaccine can be administered at the same time as other adolescent vaccines.

Possible side effects:

TIV (injection): Soreness, redness, or swelling at the injection site; hoarseness; sore, red or itchy eyes, cough; fever, aches. If these problems occur, they begin soon after the shot and usually last 1 to 2 days. TIV contains noninfectious killed viruses and cannot cause influenza.

LAIV (nasal spray): Runny nose, nasal congestion, or cough; fever; headache and muscle aches; wheezing; abdominal pain or occasional vomiting or diarrhea. LAIV contains weakened influenza viruses that cannot replicate outside the nasal passages and cannot cause influenza.

Contraindications and precautions:

- Influenza vaccines should not be administered to people who have anaphylactic hypersensitivity to eggs, unless the recipient has been desensitized.
- Moderate or severe acute illness with or without fever is a precaution for vaccination. People who are moderately or severely ill should not be vaccinated until they recover.
- GBS within 6 weeks following a previous dose of influenza vaccine is a precaution for use of influenza vaccines.
- LAIV (nasal spray) should not be administered to pregnant adolescents, adolescents with chronic medical conditions (including asthma, metabolic disease, or hemoglobinopathy) as well as adolescents receiving aspirin or other salicylates.

Catch-Up Vaccines for Adolescents

Pre-teens and teens should receive doses of these vaccines as indicated to complete each series:

- Hepatitis B vaccine (HepB): Complete the 3-dose series if not previously completed. Note: A 2-dose series (separated by at least 4 months) of Recombivax HB® is licensed for children aged 11 through 15 years.
- Varicella vaccine: Complete the 2-dose series if not previously completed, with at least 3 months between doses for persons aged 12 months through 12 years. (If the second dose was administered at least 28 days after the first dose, it can be accepted as valid.) For persons aged 13 years and older, the minimum interval between doses is 28 days.
- Inactivated poliovirus vaccine (IPV): The childhood series is 4 doses. However, only 3 doses are needed for pre-teens and teens who received their third dose after 4 years of age, as well as pre-teens and teens in your care who have not received any doses. In all cases, a minimum interval of 6 months is needed between the last two doses.
- Measles-mumps-rubella vaccine (MMR): Complete the 2-dose series if not previously completed, with at least 28 days between doses.

A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Refer to the CDC Catch-Up Immunization Schedule for more information.

Vaccine Information Statements

Vaccine Information Statements (VIS) are an excellent source of information for patients about the risks, benefits, and side effects of vaccines. **Federal law requires that VIS be given out *before* vaccines are administered.** To download any VIS, visit http://www.cdc.gov/vaccines/pubs/vis/default.htm

Vaccine Adverse Events Reporting System

Doctors and other health care professionals are encouraged to report any adverse events following administration of vaccines to the Vaccine Adverse Event Reporting System (VAERS), which is jointly administered by CDC and the U.S. Food and Drug Administration. Visit http://vaers.hhs.gov for more information or to file a report.

Vaccines for Children

The Vaccines for Children (VFC) program provides vaccines at no cost to professionals who serve eligible children. Children younger than 19 years of age are eligible for VFC vaccines if they are Medicaid-eligible, American Indian or Alaska Native or have no health insurance. Children who have health insurance that does not cover vaccination can receive VFC vaccines through Federally Qualified Health Centers or Rural Health Centers. VFC vaccines cannot be denied to an eligible child if a family can't afford the administration fee. For more information about participating in VFC, visit
http://www.cdc.gov/vaccines/programs/vfc/

Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, UNITED STATES, 2018

- Consult relevant ACIP statements for detailed recommendations (www.cdc.gov/vaccines/hcp/acip-recs/index.html).
- When a vaccine is not administered at the recommended age, administer at a subsequent visit.
- Use combination vaccines instead of separate injections when appropriate.
- Report clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS) online (www.vaers.hhs.gov) or by telephone (800-822-7967).
- Report suspected cases of reportable vaccine-preventable diseases to your state or local health department.
- For information about precautions and contraindications, see www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

Approved by the

Advisory Committee on Immunization Practices
(www.cdc.gov/vaccines/acip)

American Academy of Pediatrics
(www.aap.org)

American Academy of Family Physicians
(www.aafp.org)

American College of Obstetricians and Gynecologists
(www.acog.org)

This schedule includes recommendations in effect as of January 1, 2018.

The table below shows vaccine acronyms, and brand names for vaccines routinely recommended for children and adolescents. The use of trade names in this immunization schedule is for identification purposes only and does not imply endorsement by the ACIP or CDC.

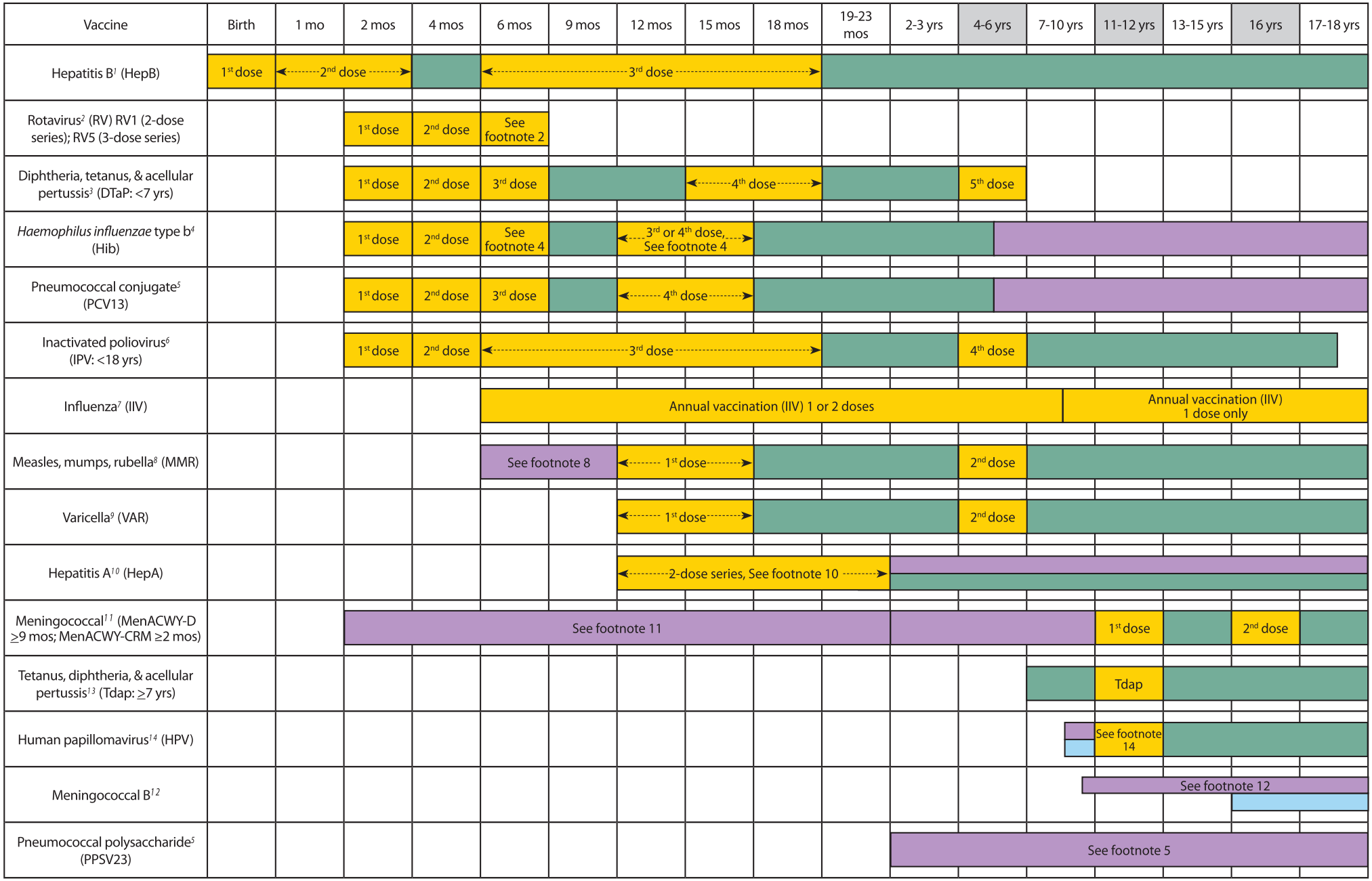
Vaccine type	Abbreviation	Brand(s)
Diphtheria, tetanus, and acellular pertussis vaccine	DTaP	Daptacel Infanrix
Diphtheria, tetanus vaccine	DT	No Trade Name
Haemophilus influenzae type B vaccine	Hib (PRP-T) Hib (PRP-OMP)	ActHIB Hiberix PedvaxHIB
Hepatitis A vaccine	HepA	Havrix Vaqta
Hepatitis B vaccine	HepB	Engerix-B Recombivax HB
Human papillomavirus vaccine	HPV	Gardasil 9
Influenza vaccine (inactivated)	IIV	Multiple
Measles, mumps, and rubella vaccine	MMR	M-M-R II
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-D MenACWY-CRM	Menactra Menveo
Meningococcal serogroup B vaccine	MenB-4C MenB-FHbp	Bexsero Trumenba
Pneumococcal 13-valent conjugate vaccine	PCV13	Prevnar 13
Pneumococcal 23-valent polysaccharide vaccine	PPSV23	Pneumovax
Poliovirus vaccine (inactivated)	IPV	IPOL
Rotavirus vaccines	RV1 RV5	Rotarix RotaTeq
Tetanus, diphtheria, and acellular pertussis vaccine	Tdap	Adacel Boostrix
Tetanus and diphtheria vaccine	Td	Tenivac No Trade Name
Varicella vaccine	VAR	Varivax
Combination Vaccines		
DTaP, hepatitis B and inactivated poliovirus vaccine	DTaP-HepB-IPV	Pediarix
DTaP, inactivated poliovirus and *Haemophilus influenzae* type B vaccine	DTaP-IPV/Hib	Pentacel
DTaP and inactivated poliovirus vaccine	DTaP-IPV	Kinrix Quadracel
Measles, mumps, rubella, and varicella vaccines	MMRV	ProQuad

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Figure 1. Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, 2018.

(FOR THOSE WHO FALL BEHIND OR START LATE, SEE THE CATCH-UP SCHEDULE [FIGURE 2]).

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are shaded in gray.



Range of recommended ages for all children

Range of recommended ages for catch-up immunization

Range of recommended ages for certain high-risk groups

Range of recommended ages for non-high-risk groups that may receive vaccine, subject to individual clinical decision making

No recommendation

NOTE: The above recommendations must be read along with the footnotes of this schedule.

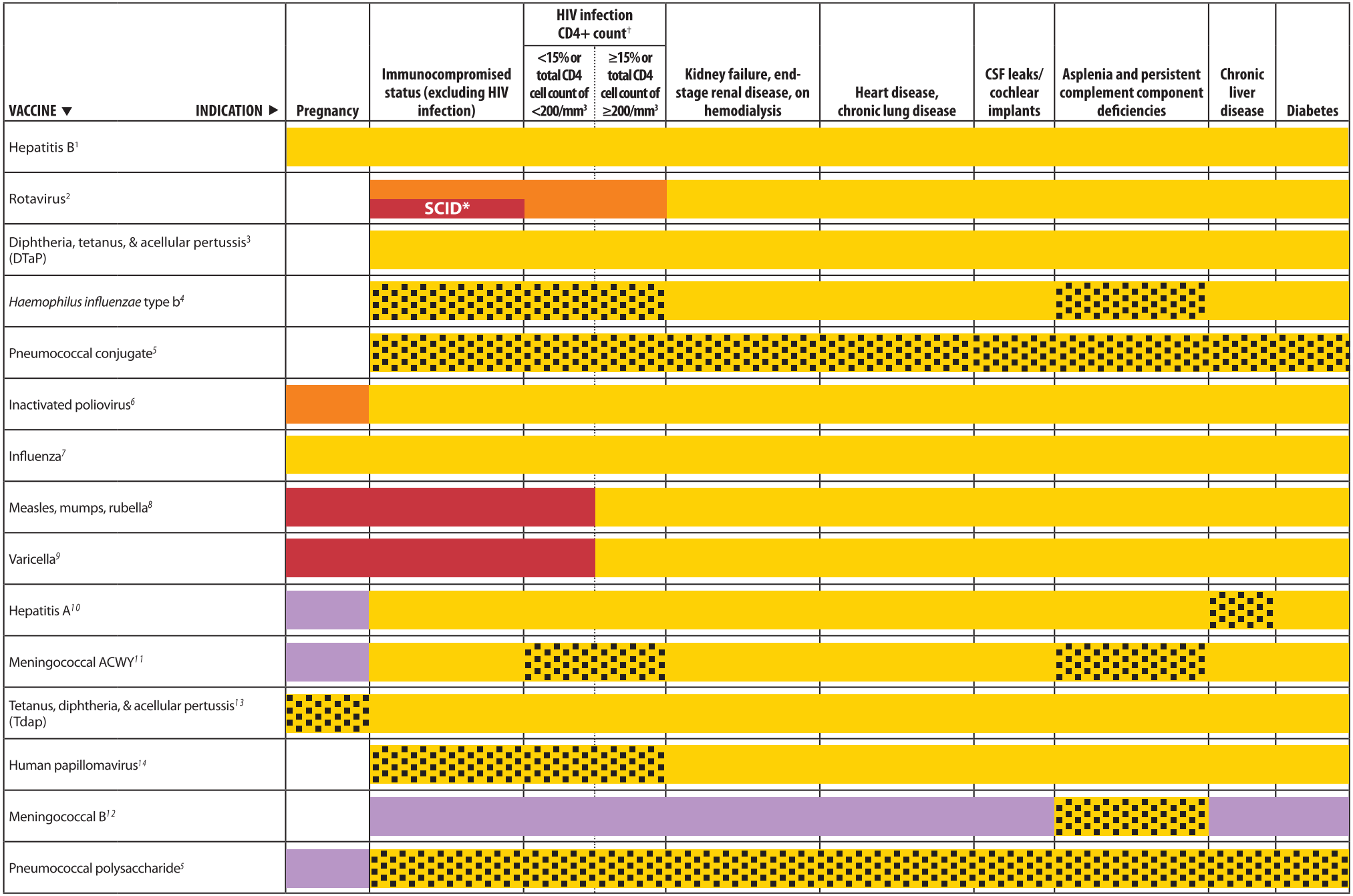
FIGURE 2. Catch-up immunization schedule for persons aged 4 months–18 years who start late or who are more than 1 month behind—United States, 2018.

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. Always use this table in conjunction with Figure 1 and the footnotes that follow.

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Children age 4 months through 6 years					
Hepatitis B[1]	Birth	4 weeks	8 weeks ***and*** at least 16 weeks after first dose. Minimum age for the final dose is 24 weeks.		
Rotavirus[2]	6 weeks Maximum age for first dose is 14 weeks, 6 days	4 weeks	4 weeks[2] Maximum age for final dose is 8 months, 0 days.		
Diphtheria, tetanus, and acellular pertussis[3]	6 weeks	4 weeks	4 weeks	6 months	6 months[3]
Haemophilus influenzae type b[4]	6 weeks	4 weeks if first dose was administered before the 1st birthday. 8 weeks (as final dose) if first dose was administered at age 12 through 14 months. No further doses needed if first dose was administered at age 15 months or older.	4 weeks[4] if current age is younger than 12 months **and** first dose was administered at younger than age 7 months, **and** at least 1 previous dose was PRP-T (ActHib, Pentacel, Hiberix) or unknown. 8 weeks ***and*** age 12 through 59 months (as final dose)[4] • if current age is younger than 12 months **and** first dose was administered at age 7 through 11 months; OR • if current age is 12 through 59 months **and** first dose was administered before the 1st birthday, **and** second dose administered at younger than 15 months; OR • if both doses were PRP-OMP (PedvaxHIB; Comvax) **and** were administered before the 1st birthday. No further doses needed if previous dose was administered at age 15 months or older.	8 weeks (as final dose) This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal conjugate[5]	6 weeks	4 weeks if first dose administered before the 1st birthday. 8 weeks (as final dose for healthy children) if first dose was administered at the 1st birthday or after. No further doses needed for healthy children if first dose was administered at age 24 months or older.	4 weeks if current age is younger than 12 months and previous dose given at <7 months old. 8 weeks (as final dose for healthy children) if previous dose given between 7-11 months (wait until at least 12 months old); OR if current age is 12 months or older and at least 1 dose was given before age 12 months. No further doses needed for healthy children if previous dose administered at age 24 months or older.	8 weeks (as final dose) This dose only necessary for children aged 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age.	
Inactivated poliovirus[6]	6 weeks	4 weeks[6]	4 weeks[6] if current age is < 4 years 6 months (as final dose) if current age is 4 years or older	6 months[6] (minimum age 4 years for final dose).	
Measles, mumps, rubella[8]	12 months	4 weeks			
Varicella[9]	12 months	3 months			
Hepatitis A[10]	12 months	6 months			
Meningococcal[11] (MenACWY-D ≥9 mos; MenACWY-CRM ≥2 mos)	6 weeks	8 weeks[11]	See footnote 11	See footnote 11	
Children and adolescents age 7 through 18 years					
Meningococcal[11] (MenACWY-D ≥9 mos; MenACWY-CRM ≥2 mos)	Not Applicable (N/A)	8 weeks[11]			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis[13]	7 years[13]	4 weeks	4 weeks if first dose of DTaP/DT was administered before the 1st birthday. 6 months (as final dose) if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday.	6 months if first dose of DTaP/DT was administered before the 1st birthday.	
Human papillomavirus[14]	9 years	Routine dosing intervals are recommended.[14]			
Hepatitis A[10]	N/A	6 months			
Hepatitis B[1]	N/A	4 weeks	8 weeks **and** at least 16 weeks after first dose.		
Inactivated poliovirus[6]	N/A	4 weeks	6 months[6] A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years or if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella[8]	N/A	4 weeks			
Varicella[9]	N/A	3 months if younger than age 13 years. 4 weeks if age 13 years or older.			

NOTE: The above recommendations must be read along with the footnotes of this schedule.

Figure 3. Vaccines that might be indicated for children and adolescents aged 18 years or younger based on medical indications



*Severe Combined Immunodeficiency

†For additional information regarding HIV laboratory parameters and use of live vaccines; see the General Best Practice Guidelines for Immunization "Altered Immunocompetence" at: www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html; and Table 4-1 (footnote D) at: www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

NOTE: The above recommendations must be read along with the footnotes of this schedule.

Footnotes — Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, UNITED STATES, 2018

For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html.
For vaccine recommendations for persons 19 years of age and older, see the Adult Immunization Schedule.

Additional information

- For information on contraindications and precautions for the use of a vaccine, consult the *General Best Practice Guidelines for Immunization* and relevant ACIP statements, at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as "through."
- Vaccine doses administered ≤4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum interval or minimum age should not be counted as valid and should be repeated as age-appropriate. The repeat dose should be spaced after the invalid dose by the recommended minimum interval. For further details, see Table 3-1, *Recommended and minimum ages and intervals between vaccine doses,* in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.
- Information on travel vaccine requirements and recommendations is available at wwwnc.cdc.gov/travel/.
- For vaccination of persons with immunodeficiencies, see Table 8-1, *Vaccination of persons with primary and secondary immunodeficiencies,* in *General Best Practice Guidelines for Immunization,* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html; and Immunization in Special Clinical Circumstances. (In: Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. *Red Book: 2015 report of the Committee on Infectious Diseases. 30th ed.* Elk Grove Village, IL: American Academy of Pediatrics, 2015:68-107).
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All routine child and adolescent vaccines are covered by VICP except for pneumococcal polysaccharide vaccine (PPSV23). For more information; see www.hrsa.gov/vaccinecompensation/index.html.

1. Hepatitis B (HepB) vaccine. (minimum age: birth)

Birth Dose (Monovalent HepB vaccine only):

- **Mother is HBsAg-Negative:** 1 dose within 24 hours of birth for medically stable infants ≥2,000 grams. Infants <2,000 grams administer 1 dose at chronological age 1 month or hospital discharge.
- **Mother is HBsAg-Positive:**
  - Give **HepB vaccine** and **0.5 mL of HBIG** (at separate anatomic sites) within 12 hours of birth, regardless of birth weight.
  - Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose.
- **Mother's HBsAg status is unknown:**
  - Give **HepB vaccine** within 12 hours of birth, regardless of birth weight.
  - For infants <2,000 grams, give **0.5 mL of HBIG** in addition to HepB vaccine within 12 hours of birth.
  - Determine mother's HBsAg status as soon as possible. If mother is HBsAg-positive, give **0.5 mL of HBIG** to infants ≥2,000 grams as soon as possible, but no later than 7 days of age.

Routine Series:

- A complete series is 3 doses at 0, 1–2, and 6–18 months. (Monovalent HepB vaccine should be used for doses given before age 6 weeks.)
- Infants who did not receive a birth dose should begin the series as soon as feasible (see Figure 2).
- Administration of **4 doses** is permitted when a combination vaccine containing HepB is used after the birth dose.
- **Minimum age** for the final (3rd or 4th) dose: 24 weeks.
- **Minimum Intervals:** Dose 1 to Dose 2: 4 weeks / Dose 2 to Dose 3: 8 weeks / Dose 1 to Dose 3: 16 weeks. (When 4 doses are given, substitute "Dose 4" for "Dose 3" in these calculations.)

Catch-up vaccination:

- Unvaccinated persons should complete a 3-dose series at 0, 1–2, and 6 months.
- Adolescents 11–15 years of age may use an alternative 2-dose schedule, with at least 4 months between doses (adult formulation **Recombivax HB** only).
- For other catch-up guidance, see Figure 2.

2. Rotavirus vaccines. (minimum age: 6 weeks)

Routine vaccination:

Rotarix: 2-dose series at 2 and 4 months.

RotaTeq: 3-dose series at 2, 4, and 6 months.

If any dose in the series is either RotaTeq or unknown, default to 3-dose series.

Catch-up vaccination:

- Do not start the series on or after age 15 weeks, 0 days.
- The maximum age for the final dose is 8 months, 0 days.
- For other catch-up guidance, see Figure 2.

3. Diphtheria, tetanus, and acellular pertussis (DTaP) vaccine. (minimum age: 6 weeks [4 years for Kinrix or Quadracel])

Routine vaccination:

- 5-dose series at 2, 4, 6, and 15–18 months, and 4–6 years.
  - **Prospectively:** A 4th dose may be given as early as age 12 months if at least 6 months have elapsed since the 3rd dose.
  - **Retrospectively:** A 4th dose that was inadvertently given as early as 12 months may be counted if at least 4 months have elapsed since the 3rd dose.

Catch-up vaccination:

- The 5th dose is not necessary if the 4th dose was administered at 4 years or older.
- For other catch-up guidance, see Figure 2.

For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html.

4. *Haemophilus influenzae* type b (Hib) vaccine. (minimum age: 6 weeks)

Routine vaccination:

- **ActHIB, Hiberix, or Pentacel:** 4-dose series at 2, 4, 6, and 12–15 months.
- **PedvaxHIB:** 3-dose series at 2, 4, and 12–15 months.

Catch-up vaccination:

- **1st dose at 7–11 months:** Give 2nd dose at least 4 weeks later and 3rd (final) dose at 12–15 months or 8 weeks after 2nd dose (whichever is later).
- **1st dose at 12–14 months:** Give 2nd (final) dose at least 8 weeks after 1st dose.
- **1st dose before 12 months and 2nd dose before 15 months:** Give 3rd (final) dose 8 weeks after 2nd dose.
- **2 doses of PedvaxHIB before 12 months:** Give 3rd (final) dose at 12–59 months and at least 8 weeks after 2nd dose.
- **Unvaccinated at 15–59 months:** 1 dose.
- For other catch-up guidance, see Figure 2.

Special Situations:

- **Chemotherapy or radiation treatment**
  12–59 months
  - Unvaccinated or only 1 dose before 12 months: Give 2 doses, 8 weeks apart
  - 2 or more doses before 12 months: Give 1 dose, at least 8 weeks after previous dose.

  Doses given within 14 days of starting therapy or during therapy should be repeated at least 3 months after therapy completion.
- **Hematopoietic stem cell transplant (HSCT)**
- 3-dose series with doses 4 weeks apart starting 6 to 12 months after successful transplant (regardless of Hib vaccination history).
- **Anatomic or functional asplenia (including sickle cell disease)**
  12–59 months
  - Unvaccinated or only 1 dose before 12 months: Give 2 doses, 8 weeks apart.
  - 2 or more doses before 12 months: Give 1 dose, at least 8 weeks after previous dose.

  Unimmunized persons 5 years or older*
  - Give 1 dose
- **Elective splenectomy**
  Unimmunized* persons 15 months or older
  - Give 1 dose (preferably at least 14 days before procedure).
- **HIV infection**
  12–59 months
  - Unvaccinated or only 1 dose before 12 months: Give 2 doses 8 weeks apart.
  - 2 or more doses before 12 months: Give 1 dose, at least 8 weeks after previous dose.

  Unimmunized persons 5–18 years*
  - Give 1 dose
- **Immunoglobulin deficiency, early component complement deficiency**
  12–59 months
  - Unvaccinated or only 1 dose before 12 months: Give 2 doses, 8 weeks apart.
  - 2 or more doses before 12 months: Give 1 dose, at least 8 weeks after previous dose.

**Unimmunized* = Less than routine series (through 14 months) OR no doses (14 months or older)*

5. Pneumococcal vaccines. (minimum age: 6 weeks [PCV13], 2 years [PPSV23])

Routine vaccination with PCV13:

- 4-dose series at 2, 4, 6, and 12–15 months.

Catch-up vaccination with PCV13:

- 1 dose for healthy children aged 24–59 months with any incomplete* PCV13 schedule
- For other catch-up guidance, see Figure 2.

Special situations: High-risk conditions:
Administer PCV13 doses before PPSV23 if possible.

Chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma treated with high-dose, oral, corticosteroids); diabetes mellitus:

Age 2–5 years:

- Any incomplete* schedules with:
  - 3 PCV13 doses: 1 dose of PCV13 (at least 8 weeks after any prior PCV13 dose).
  - <3 PCV13 doses: 2 doses of PCV13, 8 weeks after the most recent dose and given 8 weeks apart.
- No history of PPSV23: 1 dose of PPSV23 (at least 8 weeks after any prior PCV13 dose).

Age 6-18 years:

- No history of PPSV23: 1 dose of PPSV23 (at least 8 weeks after any prior PCV13 dose).

Cerebrospinal fluid leak; cochlear implant:

Age 2–5 years:

- Any incomplete* schedules with:
  - 3 PCV13 doses: 1 dose of PCV13 (at least 8 weeks after any prior PCV13 dose).
  - <3 PCV13 doses: 2 doses of PCV13, 8 weeks after the most recent dose and given 8 weeks apart.
- No history of PPSV23: 1 dose of PPSV23 (at least 8 weeks after any prior PCV13 dose).

Age 6–18 years:

- No history of either PCV13 or PPSV23: 1 dose of PCV13, 1 dose of PPSV23 at least 8 weeks later.
- Any PCV13 but no PPSV23: 1 dose of PPSV23 at least 8 weeks after the most recent dose of PCV13
- PPSV23 but no PCV13: 1 dose of PCV13 at least 8 weeks after the most recent dose of PPSV23.

Sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiency; HIV infection; chronic renal failure; nephrotic syndrome; malignant neoplasms, leukemias, lymphomas, Hodgkin disease, and other diseases associated with treatment with immunosuppressive drugs or radiation therapy; solid organ transplantation; multiple myeloma:

Age 2–5 years:

- Any incomplete* schedules with:
  - 3 PCV13 doses: 1 dose of PCV13 (at least 8 weeks after any prior PCV13 dose).
  - <3 PCV13 doses: 2 doses of PCV13, 8 weeks after the most recent dose and given 8 weeks apart.
- No history of PPSV23: 1 dose of PPSV23 (at least 8 weeks after any prior PCV13 dose) and a 2nd dose of PPSV23 5 years later.

Age 6–18 years:

- No history of either PCV13 or PPSV23: 1 dose of PCV13, 2 doses of PPSV23 (1st dose of PPSV23 administered 8 weeks after PCV13 and 2nd dose of PPSV23 administered at least 5 years after the 1st dose of PPSV23).
- Any PCV13 but no PPSV23: 2 doses of PPSV23 (1st dose of PPSV23 to be given 8 weeks after the most recent dose of PCV13 and 2nd dose of PPSV23 administered at least 5 years after the 1st dose of PPSV23).

For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html.

- PPSV23 but no PCV13: 1 dose of PCV13 at least 8 weeks after the most recent PPSV23 dose and a 2nd dose of PPSV23 to be given 5 years after the 1st dose of PPSV23 and at least 8 weeks after a dose of PCV13.

Chronic liver disease, alcoholism:

Age 6–18 years:

- No history of PPSV23: 1 dose of PPSV23 (at least 8 weeks after any prior PCV13 dose).

*Incomplete schedules are any schedules where PCV13 doses have not been completed according to ACIP recommended catch-up schedules. The total number and timing of doses for complete PCV13 series are dictated by the age at first vaccination. See Tables 8 and 9 in the ACIP pneumococcal vaccine recommendations (www.cdc.gov/mmwr/pdf/rr/rr5911.pdf) for complete schedule details.

6. Inactivated poliovirus vaccine (IPV). (minimum age: 6 weeks)

Routine vaccination:

- 4-dose series at ages 2, 4, 6–18 months, and 4–6 years. Administer the final dose on or after the 4th birthday and at least 6 months after the previous dose.

Catch-up vaccination:

- In the first 6 months of life, use minimum ages and intervals only for travel to a polio-endemic region or during an outbreak.
- If 4 or more doses were given before the 4th birthday, give 1 more dose at age 4–6 years and at least 6 months after the previous dose.
- A 4th dose is not necessary if the 3rd dose was given on or after the 4th birthday and at least 6 months after the previous dose.
- IPV is not routinely recommended for U.S. residents 18 years and older.

Series Containing Oral Polio Vaccine (OPV), *either mixed OPV-IPV or OPV-only series*:

- Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. See www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?s_cid=mm6601a6_w.
- Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements. For guidance to assess doses documented as "OPV" see www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s_cid=mm6606a7_w.
- For other catch-up guidance, see Figure 2.

7. Influenza vaccines. (minimum age: 6 months)

Routine vaccination:

- Administer an age-appropriate formulation and dose of influenza vaccine annually.
  - o **Children 6 months–8 years** who did not receive at least 2 doses of influenza vaccine before July 1, 2017 should receive 2 doses separated by at least 4 weeks.
  - o **Persons 9 years and older** 1 dose
- Live attenuated influenza vaccine (LAIV) not recommended for the 2017–18 season.
- For additional guidance, see the 2017–18 ACIP influenza vaccine recommendations (*MMWR* August 25, 2017;66(2):1-20: www.cdc.gov/mmwr/volumes/66/rr/pdfs/rr6602.pdf).

(For the 2018–19 season, see the 2018–19 ACIP influenza vaccine recommendations.)

8. Measles, mumps, and rubella (MMR) vaccine. (minimum age: 12 months for routine vaccination)

Routine vaccination:

- 2-dose series at 12–15 months and 4–6 years.
- The 2nd dose may be given as early as 4 weeks after the 1st dose.

Catch-up vaccination:

- Unvaccinated children and adolescents: 2 doses at least 4 weeks apart.

International travel:

- **Infants 6–11 months:** 1 dose before departure. Revaccinate with 2 doses at 12–15 months (12 months for children in high-risk areas) and 2nd dose as early as 4 weeks later.
- **Unvaccinated children 12 months and older:** 2 doses at least 4 weeks apart before departure.

Mumps outbreak:

- Persons ≥12 months who previously received ≤2 doses of mumps-containing vaccine and are identified by public health authorities to be at increased risk during a mumps outbreak should receive a dose of mumps-virus containing vaccine.

9. Varicella (VAR) vaccine. (minimum age: 12 months)

Routine vaccination:

- 2-dose series: 12–15 months and 4–6 years.
- The 2nd dose may be given as early as 3 months after the 1st dose (a dose given after a 4-week interval may be counted).

Catch-up vaccination:

- Ensure persons 7–18 years without evidence of immunity (see *MMWR* 2007;56[No. RR-4], at www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have 2 doses of varicella vaccine:
  - o **Ages 7–12:** routine interval 3 months (minimum interval: 4 weeks).
  - o **Ages 13 and older:** minimum interval 4 weeks.

10. Hepatitis A (HepA) vaccine. (minimum age: 12 months)

Routine vaccination:

- 2 doses, separated by 6-18 months, between the 1st and 2nd birthdays. (A series begun before the 2nd birthday should be completed even if the child turns 2 before the second dose is given.)

Catch-up vaccination:

- Anyone 2 years of age or older may receive HepA vaccine if desired. Minimum interval between doses is 6 months.

Special populations:

Previously unvaccinated persons who should be vaccinated:

- Persons traveling to or working in countries with high or intermediate endemicity
- Men who have sex with men
- Users of injection and non-injection drugs
- Persons who work with hepatitis A virus in a research laboratory or with non-human primates
- Persons with clotting-factor disorders
- Persons with chronic liver disease
- Persons who anticipate close, personal contact (e.g., household or regular babysitting) with an international adoptee during the first 60 days after arrival in the United States from a country with high or intermediate endemicity (administer the 1st dose as soon as the adoption is planned—ideally at least 2 weeks before the adoptee's arrival).

11. Serogroup A, C, W, Y meningococcal vaccines. (Minimum age: 2 months [Menveo], 9 months [Menactra].

Routine:

- 2-dose series: 11-12 years and 16 years.

Catch-Up:

- Age 13-15 years: 1 dose now and booster at age 16-18 years. Minimum interval 8 weeks.
- Age 16-18 years: 1 dose.

For further guidance on the use of the vaccines mentioned below, see: www.cdc.gov/vaccines/hcp/acip-recs/index.html.

Special populations and situations:
Anatomic or functional asplenia, sickle cell disease, HIV infection, persistent complement component deficiency (including eculizumab use):

- **Menveo**
  - 1st dose at 8 weeks: 4-dose series at 2, 4, 6, and 12 months.
  - 1st dose at 7–23 months: 2 doses (2nd dose at least 12 weeks after the 1st dose and after the 1st birthday).
  - 1st dose at 24 months or older: 2 doses at least 8 weeks apart.
- **Menactra**
  - Persistent complement component deficiency:
    - 9–23 months: 2 doses at least 12 weeks apart
    - 24 months or older: 2 doses at least 8 weeks apart
  - Anatomic or functional asplenia, sickle cell disease, or HIV infection:
    - 24 months or older: 2 doses at least 8 weeks apart.
    - **Menactra** must be administered at least 4 weeks after completion of PCV13 series.

Children who travel to or live in countries where meningococcal disease is hyperendemic or epidemic, including countries in the African meningitis belt or during the Hajj, or exposure to an outbreak attributable to a vaccine serogroup:

- Children <24 months of age:
  - **Menveo (2-23 months):**
    - 1st dose at 8 weeks: 4-dose series at 2, 4, 6, and 12 months.
    - 1st dose at 7-23 months: 2 doses (2nd dose at least 12 weeks after the 1st dose and after the 1st birthday).
  - **Menactra (9-23 months):**
    - 2 doses (2nd dose at least 12 weeks after the 1st dose. 2nd dose may be administered as early as 8 weeks after the 1st dose in travelers).
- Children 2 years or older: 1 dose of **Menveo** or **Menactra**.

Note: Menactra should be given either before or at the same time as DTaP. For MenACWY booster dose recommendations for groups listed under "Special populations and situations" above, and additional meningococcal vaccination information, see meningococcal *MMWR* publications at: www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html.

12. Serogroup B meningococcal vaccines (minimum age: 10 years [Bexsero, Trumenba].

Clinical discretion: Adolescents not at increased risk for meningococcal B infection who want MenB vaccine.

MenB vaccines may be given at clinical discretion to adolescents 16–23 years (preferred age 16–18 years) who are not at increased risk.

- **Bexsero**: 2 doses at least 1 month apart.
- **Trumenba**: 2 doses at least 6 months apart. If the 2nd dose is given earlier than 6 months, give a 3rd dose at least 4 months after the 2nd.

Special populations and situations:
Anatomic or functional asplenia, sickle cell disease, persistent complement component deficiency (including eculizumab use), serogroup B meningococcal disease outbreak

- **Bexsero**: 2-dose series at least 1 month apart.
- **Trumenba**: 3-dose series at 0, 1-2, and 6 months.

Note: **Bexsero** and **Trumenba** are not interchangeable.
For additional meningococcal vaccination information, see meningococcal *MMWR* publications at: www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mening.html.

13. Tetanus, diphtheria, and acellular pertussis (Tdap) vaccine. (minimum age: 11 years for routine vaccinations, 7 years for catch-up vaccination)

Routine vaccination:

- **Adolescents 11–12 years of age:** 1 dose.
- **Pregnant adolescents:** 1 dose during each pregnancy (preferably during the early part of gestational weeks 27–36).
- Tdap may be administered regardless of the interval since the last tetanus- and diphtheria-toxoid-containing vaccine.

Catch-up vaccination:

- **Adolescents 13–18 who have not received Tdap**: 1 dose, followed by a Td booster every 10 years.
- **Persons aged 7–18 years not fully immunized with DTaP**: 1 dose of Tdap as part of the catch-up series (preferably the first dose). If additional doses are needed, use Td.
- **Children 7–10 years** who receive Tdap inadvertently or as part of the catch-up series may receive the routine Tdap dose at 11–12 years.
- **DTaP inadvertently given after the 7th birthday**:
  - **Child 7–10**: DTaP may count as part of catch-up series. Routine Tdap dose at 11-12 may be given.
  - **Adolescent 11–18**: Count dose of DTaP as the adolescent Tdap booster.
- For other catch-up guidance, see Figure 2.

14. Human papillomavirus (HPV) vaccine (minimum age: 9 years)

Routine and catch-up vaccination:

- Routine vaccination for all adolescents at 11–12 years (can start at age 9) and through age 18 if not previously adequately vaccinated. Number of doses dependent on age at initial vaccination:
  - **Age 9–14 years at initiation:** 2-dose series at 0 and 6–12 months. Minimum interval: 5 months (repeat a dose given too soon at least 12 weeks after the invalid dose and at least 5 months after the 1st dose).
  - **Age 15 years or older at initiation:** 3-dose series at 0, 1–2 months, and 6 months. Minimum intervals: 4 weeks between 1st and 2nd dose; 12 weeks between 2nd and 3rd dose; 5 months between 1st and 3rd dose (repeat dose(s) given too soon at or after the minimum interval since the most recent dose).
- Persons who have completed a valid series with any HPV vaccine do not need any additional doses.

Special situations:

- **History of sexual abuse or assault**: Begin series at age 9 years.
- **Immunocompromised* (including HIV)** aged 9–26 years: 3-dose series at 0, 1–2 months, and 6 months.
- **Pregnancy:** Vaccination not recommended, but there is no evidence the vaccine is harmful. No intervention is needed for women who inadvertently received a dose of HPV vaccine while pregnant. Delay remaining doses until after pregnancy. Pregnancy testing not needed before vaccination.

*See MMWR, December 16, 2016;65(49):1405–1408, at www.cdc.gov/mmwr/volumes/65/wr/pdfs/mm6549a5.pdf.

Talking to Parents about HPV Vaccine

Recommend HPV vaccination in the **same way** and on the **same day** as all adolescent vaccines. You can say, *"Now that your son is 11, he is due for vaccinations today to help protect him from meningitis, HPV cancers, and pertussis."* Remind parents of the follow-up shots their child will need and ask them to make appointments before they leave.

Why does my child need HPV vaccine?

HPV vaccine is important because it prevents infections that can cause cancer. That's why we need to start the shot series today.

Is my child really at risk for HPV?

HPV is a very common infection in women and men that can cause cancer. Starting the vaccine series today will help protect your child from the cancers and diseases caused by HPV.

Why do they need HPV vaccine at such a young age?

Like all vaccines, we want to give HPV vaccine earlier rather than later. If you wait, your child may need three shots instead of two.

I'm worried about the safety of HPV vaccine. Do you think it's safe?

Yes, HPV vaccination is very safe. Like any medication, vaccines can cause side effects, including pain, swelling, or redness where the shot was given. That's normal for HPV vaccine too and should go away in a day or two.

Sometimes kids faint after they get shots and they could be injured if they fall from fainting. We'll protect your child by having them stay seated after the shot.

Would you get HPV vaccine for your kids?

Yes, I gave HPV vaccine to my child (or grandchild, etc.) when he was 11, because it's important for preventing cancer.

Why do boys need HPV vaccine?

HPV vaccination can help prevent future infection that can lead to cancers of the penis, anus, and back of the throat in men.

What diseases are caused by HPV?

Some HPV infections can cause cancer—like cancer of the cervix or in the back of the throat—but we can protect your child from these cancers in the future by getting the first HPV shot today.

How do you know the vaccine works?

Studies continue to prove HPV vaccination works extremely well, decreasing the number of infections and HPV precancers in young people since it has been available.

I'm worried my child will think that getting this vaccine makes it OK to have sex.

Studies tell us that getting HPV vaccine doesn't make kids more likely to start having sex. I recommend we give your child her first HPV shot today.

Can HPV vaccine cause infertility in my child?

There is no known link between HPV vaccination and the inability to have children in the future. However, women who develop an HPV precancer or cancer could require treatment that would limit their ability to have children.

What vaccines are actually required?

I strongly recommend each of these vaccines and so do experts at the CDC and major medical organizations. School entry requirements are developed for public health and safety, but don't always reflect the most current medical recommendations for your child's health.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

HPV VACCINE IS CANCER PREVENTION

December, 2016 | CS269453B

Q&A

Volume 5, Winter 2016

Human Papillomavirus: What you should know

The Children's Hospital of Philadelphia®
VACCINE EDUCATION CENTER

Human papillomavirus (HPV) is a virus that can lead to genital warts and various forms of cancer, including those of the cervix and other reproductive organs as well as cancers of the head and neck. HPV is the most common sexually transmitted infection in the United States and around the world; in fact, each year, about 300,000 women die from cervical cancer caused by HPV.

Q. What is human papillomavirus?

A. Human papillomavirus (HPV) is a family of viruses that commonly infect the genital area and lining of the cervix. Some types of HPV infect the genital areas of men and women, causing warts. Genital warts can be unsightly and emotionally debilitating. Other types of HPV cause cervical cancer, as well as other cancers of the reproductive organs. On occasion, HPV infections can lead to cancers of the head and neck.

Q. How common is HPV?

A. HPV is the most common sexually transmitted infection in the United States and around the world. More than half of sexually active people will be infected with HPV at some time in their lives. Twenty million Americans are currently infected with HPV, and another 6 million become infected every year. Half of those newly infected with HPV are between 15 and 24 years of age.

Q. Is HPV dangerous?

A. Yes. Most of the time, HPV goes away on its own and doesn't cause any health problems. But sometimes HPV can linger and lead to cancer. Every year in the United States, approximately 39,000 men and women develop cancers caused by HPV. Cervical cancer is one of the most common cancers in women, killing about 300,000 every year worldwide.

Q. How do you get HPV? How can you avoid it?

A. HPV in the genital area is passed from one person to another through genital contact, most often, but not always, during sex. The best way to avoid HPV infection is to abstain from any sexual activity. You can also lower your chance of getting HPV by having sex with only one person who isn't infected with HPV. But most people who have HPV don't know they have it, so it can be hard to avoid. Although condoms are recommended as a way of decreasing sexually transmitted infections, they don't offer complete protection against HPV.

Q. Can't women avoid cervical cancer by getting routine Pap tests?

A. Not always. Once, cervical cancer was the most common cause of U.S. cancer deaths. The Pap test changed that. HPV infection causes changes in the cervix that can result in cancer. The Pap test is performed by scraping cells from the cervix and examining them to see whether they show changes consistent with the early development of cancer (called precancerous changes). If these changes are detected, the doctor can perform surgery on the affected areas before cancer develops. Typically, the length of time from infection with HPV to development of cervical cancer is decades. So, although most HPV infections occur in teenagers and young adults, cervical cancer is more common in women during their 40s and 50s.

The Pap test is one of the most effective cancer screening tests and has dramatically reduced the incidence of cervical cancer in the United States. But the test isn't entirely predictive of cancer, and not all women get tested as often as they should. Further, the Pap test will not detect cancer caused by HPV in areas other than the cervix.

Q. Is there a vaccine to prevent HPV?

A. Yes. Gardasil® 9, protects against nine types of HPV. Studies in thousands of girls and young women found the vaccine to be safe and effective in preventing persistent infections caused by HPV. Studies in boys and young men found that the HPV vaccine was safe and prevented anal and genital warts. The vaccine is given as a series of two or three shots depending on the age of the recipient. Those who are younger than 15 years old should get two doses separated by 6 to 12 months. Those 15 years and older or any recipient with a compromised immune system should get three doses. The second shot should be given one or two months after the first, and the third shot, six months after the first.

more ▸

For the latest information on all vaccines, visit our website at

vaccine.chop.edu

Human Papillomavirus: What you should know

Q. Who should get the HPV vaccine?

A. The HPV vaccine is recommended for all boys and girls between 11 and 12 years of age. The vaccine can be given to those as young as 9 years of age. It is also recommended for all teenagers and adults between 13 and 26 years of age if they did not get the vaccine when they were younger. Some people wonder why boys are recommended to get the HPV vaccine. First, because boys can get genital warts as well as cancer caused by HPV, they benefit from receiving the HPV vaccine; in fact, about one-third of the cancers caused by HPV occur in males. Second, by immunizing boys, they will be less likely to transmit the virus to their sexual partners. Although studies in boys lagged behind those in girls, the vaccine has now been shown to be safe and effective in boys as well.

Q. Why is the vaccine recommended for adolescents when it protects against a sexually transmitted disease?

A. Although most 11- and 12-year-olds are not sexually active, it is important to get the vaccine at that age for a few reasons. First, studies have shown that the vaccine is more protective when it is received at an earlier age. Second, in order to have the best protection, all doses should be completed before sexual activity begins and the series takes at least six months to complete. Third, logistically, teens get busier as they get older, so it is often easier to get the doses completed at the younger age. Finally, because studies indicate that the protection is long-lasting, delaying the vaccine provides no benefit and only increases the risk of cancer.

Q. How is the HPV vaccine made?

A. The HPV vaccine is made using a protein from the surface of nine types of HPV virus that most commonly cause either cancers or genital warts.

Q. Is the HPV vaccine safe?

A. Yes. Because the HPV vaccine is made using only a single protein from each type of the virus, it can't cause HPV and, therefore, can't cause cervical cancer or other cancers. The most common side effect of the vaccine is redness and tenderness at the injection site. The vaccine may also cause a slight fever. Because people of the age group recommended to get the HPV vaccine might faint, it is recommended they remain at the doctor's office for about 15 minutes after receiving this or other vaccines. Although adverse events such as blood clots, neurological damage and death have been reported following receipt of the HPV vaccine, scientific studies have found these events were not caused by the vaccine.

Q. Do young women who get the HPV vaccine still need to get Pap tests?

A. Yes. Because the HPV vaccine does not protect against all HPV types that cause cervical cancer, women should continue to be screened with routine Pap tests.

Q. Do women who have received the HPV vaccine still need to worry about sexually transmitted infections?

A. Yes. The HPV vaccine does not prevent other sexually transmitted infections such as syphilis, gonorrhea, chlamydia and herpes. Also, the vaccine doesn't protect against all HPV types.

Q. Do people immunized with older versions of the HPV vaccine (HPV2 or HPV4) need to get the HPV9 vaccine?

A. At this time, additional doses of the vaccine are not routinely recommended by the CDC. However, those who decide to get HPV9 following completion of HPV2 or HPV4 will be protected against five additional serotypes that cause several thousand cases of cancer and several hundred deaths every year. In this situation, HPV9 should be given as two doses separated by 6 to 12 months.

For additional information about HPV disease and vaccination, visit www.prevent-HPV.org.

This information is provided by the Vaccine Education Center at Children's Hospital of Philadelphia. The Center is an educational resource for parents and healthcare professionals and is composed of scientists, physicians, mothers and fathers who are devoted to the study and prevention of infectious diseases. The Vaccine Education Center is funded by endowed chairs from Children's Hospital of Philadelphia. The Center does not receive support from pharmaceutical companies.

The Children's Hospital *of* Philadelphia® | VACCINE EDUCATION CENTER

vaccine.chop.edu

Children's Hospital of Philadelphia, the nation's first pediatric hospital, is a world leader in patient care, pioneering research, education and advocacy.

What Parents Should Know About HPV Vaccine Safety and Effectiveness

Last updated JUNE 2014

HPV vaccines prevent cancer

About 14 million people, including teens, become infected with human papillomavirus (HPV) each year. When HPV infections persist, people are at risk for cancer. Every year, approximately 17,600 women and 9,300 men are affected by cancers caused by HPV. HPV vaccination could prevent many of these cancers.

HPV vaccines are safe

All vaccines used in the United States are required to go through extensive safety testing before they are licensed by FDA. Once in use, they are continuously monitored for safety and effectiveness.

Numerous research studies have been conducted to make sure HPV vaccines were safe both before and after the vaccines were licensed. No serious safety concerns have been confirmed in the large safety studies that have been done since HPV vaccine became available in 2006. CDC and FDA have reviewed the safety information available to them for both HPV vaccines and have determined that they are both safe.

The HPV vaccine is made from one protein from the HPV virus that is not infectious (cannot cause HPV infection) and non-oncogenic (does not cause cancer).

HPV vaccines work

The HPV vaccine works extremely well. In the four years after the vaccine was recommended in 2006, the amount of HPV infections in teen girls decreased by 56%. Research has also shown that fewer teens are getting genital warts since HPV vaccines have been in use. In other countries such as Australia, research shows that HPV vaccine has already decreased the amount of pre-cancer of the cervix in women, and genital warts have decreased dramatically in both young women and men.

HPV vaccines provide long-lasting protection

Data from clinical trials and ongoing research tell us that the protection provided by HPV vaccine is long-lasting. Currently, it is known that HPV vaccine works in the body for at least 10 years without becoming less effective. Data suggest that the protection provided by the vaccine will continue beyond 10 years.

HPV vaccine is recommended and safe for boys

HPV vaccination can help prevent boys from getting infected with the HPV-types that can cause cancers of the mouth/throat, penis and anus as well as genital warts.

Like any vaccine or medicine, HPV vaccines might cause side effects

HPV vaccines occasionally cause adverse reactions. The most commonly reported symptoms among females and males are similar, including injection-site reactions (such as pain, redness, or swelling in the area of the upper arm where the vaccine is given), dizziness, fainting, nausea, and headache.

Brief fainting spells and related symptoms can happen after many medical procedures, including vaccination. Fainting after getting a shot is more common among adolescents. Sitting or lying down for about 15 minutes after a vaccination can help prevent fainting and injuries that can be caused by falls.

When fainting was found to happen after vaccination, FDA changed prescribing information to include information about preventing falls and possible injuries from fainting after vaccination. CDC consistently reminds doctors and nurses to share this information with all their patients. Tell the doctor or nurse if your child feels dizzy, faint, or light-headed.

HPV vaccines don't negatively affect fertility

There is no evidence to suggest that HPV vaccine causes fertility problems. However, not getting HPV vaccine leaves people vulnerable to HPV cancers. If persistent high-risk HPV infection in a woman leads to cervical cancer, the treatment of cervical cancer (hysterectomy, chemotherapy, or radiation, for example) could leave a woman unable to have children. Treatment for cervical pre-cancer could put a woman at risk for problems with her cervix, which could cause preterm delivery or other problems.

How can I get help paying for these vaccines?

The Vaccines for Children (VFC) program provides vaccines for children ages 18 years and younger, who are uninsured, Medicaid-eligible, American Indian or Alaska Native. You can find out more about the VFC program by going online to www.cdc.gov and typing VFC in the search box.

DISTRIBUTED BY:

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CS HCVG15-PTT:105 04/22/2016

HPV Vaccine for Preteens and Teens

Last updated JULY 2015

Why does my child need HPV vaccine?

This vaccine is for protection from most of the cancers caused by human papillomavirus (HPV) infection. HPV is a very common virus that spreads between people when they have sexual contact with another person. About 14 million people, including teens, become infected with HPV each year. HPV infection can cause cervical, vaginal, and vulvar cancers in women and penile cancer in men. HPV can also cause anal cancer, throat cancer, and genital warts in both men and women.

When should my child be vaccinated?

The HPV vaccine is recommended for preteen boys and girls at age 11 or 12 so they are protected before ever being exposed to the virus. HPV vaccine also produces a higher immune response in preteens than in older adolescents. If your teen hasn't gotten the vaccine yet, talk to their doctor about getting it for them as soon as possible.

HPV vaccination is a series of shots given over several months. The best way to remember to get your child all of the shots they need is to make an appointment for the remaining shots before you leave the doctor's office or clinic.

What else should I know about HPV vaccine?

Girls need HPV vaccination to prevent HPV infections that can cause cancers of the anus, cervix, vagina, vulva, and the mouth/throat area. Boys need HPV vaccination to prevent HPV infections that can cause cancers of the anus, penis, and the mouth/throat area. HPV vaccination can also prevent genital warts.

HPV vaccines have been studied very carefully. These studies showed no serious safety concerns. Common, mild adverse events (side effects) reported during these studies include pain in the arm where the shot was given, fever, dizziness and nausea.

Some preteens and teens might faint after getting the HPV vaccine or any shot. Preteens and teens should sit or lie down when they get a shot and stay like that for about 15 minutes after the shot. This can help prevent fainting and any injury that could happen while fainting.

Serious side effects from the HPV vaccine are rare. It is important to tell the doctor or nurse if your child has any severe allergies, including an allergy to latex or yeast. HPV vaccine is not recommended for anyone who is pregnant.

HPV vaccination is recommended by the Centers for Disease Control and Prevention (CDC), the American Academy of Family Physicians, the American Academy of Pediatrics, and the Society for Adolescent Health and Medicine.

How can I get help paying for these vaccines?

The Vaccines for Children (VFC) program provides vaccines for children ages 18 years and younger, who are not insured, Medicaid-eligible, American Indian or Alaska Native. You can find out more about the VFC program by going online to www.cdc.gov and typing VFC in the search box.

Where can I learn more?

For more information about HPV vaccines and the other vaccines for preteens and teens, talk to your child's doctor or nurse. More information is also available on CDC's Vaccines for Preteens and Teens website at www.cdc.gov/vaccines/teens.

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Centers for Disease Control and Prevention

CS 249472_B

HPV

also known as *Human Papillomavirus*

As parents, you do everything you can to protect your children's health for now and for the future. Today, there is a strong weapon to prevent several types of cancer in our kids: the HPV vaccine.

HPV and Cancer

HPV is short for Human Papillomavirus, a common virus. In the United States each year, there are about 17,500 women and 9,300 men affected by HPV-related cancers. Many of these cancers **could be prevented with vaccination.** In both women and men, HPV can cause anal cancer and mouth/throat (oropharyngeal) cancer. It can also cause cancers of the cervix, vulva and vagina in women; and cancer of the penis in men.

For women, screening is available to detect most cases of cervical cancer with a Pap smear. Unfortunately, there is no routine screening for other HPV-related cancers for women or men, and these cancers can cause pain, suffering, or even death. **That is why a vaccine that prevents most of these types of cancers is so important.**

More about HPV

HPV is a virus passed from one person to another during skin-to-skin sexual contact, including vaginal, oral, and anal sex. HPV is most common in people in their late teens and early 20s. Almost all sexually active people will get HPV at some time in their lives, though most will never even know it.

Most of the time, the body naturally fights off HPV, before HPV causes any health problems. But in some cases, the body does not fight off HPV, and HPV can cause health problems, like cancer and genital warts. Genital warts are not a life-threatening disease, but they can cause emotional stress, and their treatment can be very uncomfortable. About 1 in 100 sexually active adults in the United States have genital warts at any given time.

HPV vaccination is recommended for preteen girls and boys at age 11 or 12 years

All preteens need HPV vaccination so they can be protected from HPV infections that cause cancer. Teens and young adults who didn't start or finish the HPV vaccine series also need HPV vaccination. Young women can get HPV vaccine until they are 27 years old and young men can get HPV vaccine until they are 22 years old. Young men who have sex with other men or who have weakened immune systems can also get HPV vaccine until they are 27.

HPV vaccination is a series of shots given over several months. The best way to remember to get your child all of the shots they need is to make an appointment for the remaining shots before you leave the doctor's office or clinic.

Is the HPV vaccine safe?

Yes. HPV vaccination has been studied very carefully and continues to be monitored by CDC and the Food and Drug Administration (FDA). No serious safety concerns have been linked to HPV vaccination. **These studies continue to show that HPV vaccines are safe.**

The most common side effects reported after HPV vaccination are mild. They include pain and redness in the area of the arm where the shot was given, fever, dizziness, and nausea. Some preteens and teens may faint after getting a shot or any other medical procedure. Sitting or lying down for about 15 minutes after getting shots can help prevent injuries that could happen if your child were to fall while fainting.

Why does my child need this now?

HPV vaccines offer the best protection to girls and boys who complete the series and have time to develop an immune response **before** they begin sexual activity with another person. This is not to say that your preteen is ready to have sex. In fact, it's just the opposite—it's important to get your child protected before you or your child have to think about this issue. The immune response to this vaccine is better in preteens, and this could mean better protection for your child.

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CS HCVG15-PTT-111 12/16/2016

Serious side effects from HPV vaccination are rare. Children with severe allergies to yeast or latex shouldn't get certain HPV vaccines. Be sure to tell the doctor or nurse if your child has any severe allergies.

Help paying for vaccines

The Vaccines for Children (VFC) program provides vaccines for children ages 18 years and younger who are uninsured, Medicaid-eligible, or American Indian/Alaska Native. Learn more about the VFC program at **www.cdc.gov/Features/VFCprogram/**

Whether you have insurance, or your child is VFC-eligible, some doctors' offices may also charge a fee to give the vaccines.

Jacquelyn's story: "I was healthy—and got cervical cancer."

When I was in my late 20's and early 30's, in the years before my daughter was born, I had some abnormal Pap smears and had to have further testing. I was told I had the kind of HPV that can cause cancer and mild dysplasia.

For three more years, I had normal tests. But when I got my first Pap test after my son was born, they told me I needed a biopsy. The results came back as cancer, and my doctor sent me to an oncologist. Fortunately, the cancer was at an early stage. My lymph nodes were clear, and I didn't need radiation. But I did need to have a total hysterectomy.

My husband and I have been together for 15 years, and we were planning to have more children. We are so grateful for our two wonderful children, but we were hoping for more—which is not going to happen now.

The bottom line is they caught the cancer early, but the complications continue to impact my life and my family. For the next few years, I have to get pelvic exams and Pap smears every few months, the doctors measure tumor markers, and I have to have regular x-rays and ultrasounds, just in case. I have so many medical appointments that are taking time away from my family, my friends, and my job.

Worse, every time the phone rings, and I know it's my oncologist calling, I hold my breath until I get the results. I'm hopeful I can live a full and healthy life, but cancer is always in the back of my mind.

In a short period of time, I went from being healthy and planning more children to all of a sudden having a radical hysterectomy and trying to make sure I don't have cancer again. It's kind of overwhelming. And I am one of the lucky ones!

Ultimately I need to make sure I'm healthy and there for my children. I want to be around to see their children grow up.

I will do everything to keep my son and daughter from going through this. I will get them both the HPV vaccine as soon as they turn 11. I tell everyone—my friends, my family—to get their children the HPV vaccine series to protect them from this kind of cancer.

What about boys?

HPV vaccine is for boys too! This vaccine can help prevent boys from getting infected with the types of HPV that can cause cancers of the mouth/throat, penis and anus. The vaccine can also help prevent genital warts. HPV vaccination of males is also likely to benefit females by reducing the spread of HPV viruses.

Learn more about HPV and HPV vaccine at **www.cdc.gov/hpv**

For more information about the vaccines recommended for preteens and teens:
800-CDC-INFO *(800-232-4636)*
www.cdc.gov/vaccines/teens

Screening won't protect your patients from most HPV cancers.

protect your preteen patients today with HPV vaccine.

Cervical Cancer
Just the tip of the iceberg.

Cervical cancer is the only type of HPV cancer for which there is a recommended screening test.

Even with screening, in the United States 12,000 women are diagnosed with cervical cancer each year.

Source: CDC. Cancers associated with human papillomavirus, United States—2010–2014. USCS data brief, no. 1. Atlanta, GA: Centers for Disease Control and Prevention. 2017. (https://www.cdc.gov/cancer/hpv/pdf/USCS-DataBrief-No1-December2017-508.pdf)

Cervical Precancers

While cervical precancers are routinely screened for, these precancers may require invasive testing and treatment.

Sources: Joura EA. et al. Cancer Epidemiol Biomarkers Prev. 2014 Oct;23(10):1997-2008. Guan P. et al. Int J Cancer. 2012 Nov 15;131(10):2349-59.

Cases Every Year

- **~216,000** High Grade Cervical Lesions
- **~468,700** Low Grade Cervical Precancers

Other HPV Cancers

Cases Every Year

- **800** Penile Cancer
- **3,200** Vulvar & Vaginal Cancer
- **5,700** Anal / Rectal Cancer
- **12,200** Oropharyngeal Cancer

Recommended cancer screening tests are not available yet for these cancers. These cancers may not be detected until they cause health problems.

OVER 90%
of HPV cancers are preventable through HPV vaccination.

Source: CDC. Cancers associated with human papillomavirus, United States—2010–2014. USCS data brief, no. 1. Atlanta, GA: Centers for Disease Control and Prevention. 2017. (https://www.cdc.gov/cancer/hpv/pdf/USCS-DataBrief-No1-December2017-508.pdf)

Don't rely on screening to catch it later. Protect them now with HPV vaccination.

https://www.cdc.gov/hpv/hcp/more-than-screening/index.html

CDC

HPV VACCINE IS CANCER PREVENTION

You're not opening the door to sex.

You're closing the door to cancer.

HPV vaccine is cancer prevention.

Talk to your child's doctor about vaccinating your 11–12 year old against HPV.

www.cdc.gov/vaccines/teens

U.S. Department of Health and Human Services
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YOU ARE THE KEY TO HPV CANCER PREVENTION

Distributed by:

CS249586-E

YOU WOULD DO ANYTHING TO PROTECT YOUR CHILD FROM CANCER. BUT HAVE YOU DONE EVERYTHING?

HPV vaccine is cancer prevention for boys and girls. Just two shots at ages 11–12 provide safe and lasting protection against the infections that cause HPV cancer. Ask your child's doctor or nurse for HPV vaccine.

U.S. Department of Health and Human Services
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HPV VACCINE IS CANCER PREVENTION

www.cdc.gov/HPV

JAN 2017

U.S. Department of Health and Human Services
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YOU ARE THE KEY TO HPV CANCER PREVENTION

Distributed by:

CS249946-C

Q&A

Volume 5, Spring 2015

Pertussis: What you should know

The Children's Hospital of Philadelphia®

VACCINE EDUCATION CENTER

Outbreaks of pertussis (whooping cough) have sickened thousands and led to the deaths of several infants less than 3 months of age over the last few years in the United States. Although outbreaks of pertussis typically occur every three to five years in the United States, the recent outbreaks have brought attention to two important points — immunity to pertussis is not life-long, and pockets of unimmunized people in a community make controlling outbreaks extremely difficult.

Q. What is pertussis?

A. Pertussis, or whooping cough, is caused by a bacterial infection. The disease occurs in three stages. The first stage appears similar to the common cold, with runny nose, sneezing, low-grade fever and coughing. After a week or two, illness progresses to the second stage where coughs worsen, often ending with a big intake of air or a "whoop." The fits of coughing can be so violent that blood vessels can rupture and ribs can break. Infants, whose windpipes are narrower than those of older children, often turn blue during coughing spells because of lack of oxygen. This stage can last up to two months. During the final stage, which also often lasts for weeks or months, coughing spells will gradually decrease in frequency and intensity. Pertussis used to be called the "100-day cough" because of how long the cough lasted.

Q. Is there a vaccine to prevent pertussis?

A. Yes. The history of pertussis vaccines in the United States is long and complicated.

In the 1920s, vaccines to protect against diphtheria, pertussis and tetanus became available. In the 1940s, these three vaccines were combined into a single shot (called DTP).

The pertussis component of the DTP vaccine was made by killing whole pertussis bacteria with the chemical formaldehyde. The pertussis part of DTP was called "whole-cell" pertussis because whole bacteria were used to make it. The vaccine was given to young children and dramatically reduced the incidence of hospitalizations and deaths caused by pertussis. However, the vaccine also rarely caused side effects that could be severe, such as seizures, high fever and persistent crying.

In the 1990s, a safer pertussis vaccine became available. This vaccine was made by purifying several pertussis proteins and inactivating them with formaldehyde. Because this new pertussis vaccine was purer and didn't contain whole bacteria, it was called the acellular pertussis vaccine (or aP). This new pertussis vaccine was combined with the diphtheria and tetanus vaccines in a combination called DTaP. The new DTaP vaccine caused fewer and less frequent side effects, so it replaced DTP and was recommended for all young children. Unfortunately, the DTaP vaccine couldn't be used in teenagers and adults because side effects from the vaccine (such as fever, headache, fatigue, and pain and swelling at the site of injection) were common in anyone 7 years of age or older.

Fortunately, researchers found that by reducing the quantities of diphtheria and pertussis proteins contained in the DTaP vaccine, teenagers and adults didn't experience the high rate of side effects. This newer version for teens and adults, called "Tdap," reflects the fact that it contains lower quantities of diphtheria (hence the lowercase "d") and pertussis proteins (hence the lowercase "p") as compared with the childhood version, known as DTaP.

Q. Who should get DTaP?

A. DTaP is the version of diphtheria, tetanus and pertussis vaccines used for infants and young children. The first three doses, typically given at 2 months, 4 months and 6 months of age, will protect most infants from these diseases. Unfortunately, infants who have not received all three doses are among the most vulnerable to pertussis infections. An additional dose at 15 to 18 months and another at 4 to 6 years are given as boosters.

Q. Who should get Tdap?

A. Tdap is recommended for all adolescents beginning at 11 or 12 years of age.

Adults, including those 65 years and older, should receive a single dose of Tdap to replace their next tetanus booster. Because healthcare workers are at increased risk of contracting pertussis, they should get the vaccine as soon as possible. Likewise, people who will be in contact with infants younger than 12 months of age should get the vaccine at least two weeks before coming into contact with the baby. Pregnant women should get the vaccine between 27 and 36 weeks gestation during *each* pregnancy. Any woman who does not get the vaccine during pregnancy should get it before going home.

By giving Tdap vaccine to pregnant women during the late second trimester or third trimester, antibodies generated by the mother can be transferred to the baby before birth most efficiently. Because babies less than 2 months of age are most likely to die from pertussis — an age before they would have received the first few doses of vaccine — this strategy of immunizing pregnant women is most likely to protect babies from dying from pertussis.

more ▶

Pertussis: What you should know

Q. Are the DTaP and Tdap vaccines safe?

A. Yes. About one of every three babies and young children will have pain, redness or swelling at the injection site, mostly after the doses around 1 and 5 years of age, and a small number will develop a fever following the DTaP vaccine. For those who get the Tdap vaccine, about half will experience pain or swelling at the site of injection, and a small number will develop headaches and fatigue.

Although about one of every 10,000 children who get the DTaP vaccine will experience a frightening reaction such as uncontrollable crying, high fever or seizure, none will be permanently harmed. However, a child who has a severe reaction to the vaccine should not get additional doses.

Q. Do DTaP and Tdap prevent pertussis?

A. Yes. In medical studies, both DTaP and Tdap have been shown to protect about 80 to 85 of every 100 people who receive them. However, data from recent outbreaks have indicated that immunity wanes, so children become increasingly susceptible between the kindergarten and adolescent doses. These data have emerged following the change from the whole cell to the acellular pertussis vaccine in the mid-1990s. We now know that the price paid for increased safety was decreased protection. However, until a better pertussis vaccine is developed, the current vaccine affords the best opportunity for protecting ourselves and our families from pertussis, so continued use is important. To address waning immunity, the CDC may recommend additional booster doses in the future.

Q. Can people get the Tdap vaccine if they recently had the Td vaccine?

A. Yes. A vaccine to prevent tetanus and diphtheria, called Td, is also available for teenagers and adults. Many people have already gotten this vaccine. Because Td doesn't protect against pertussis, Tdap is still recommended regardless of when Td was given.

Q. Can Tdap be given at the same time as other vaccines?

A. Yes.

Q. Why is pertussis more serious in babies?

A. Because an infant's windpipe is much smaller than that of older children and adults, babies are much more likely to die from pertussis. Babies typically catch the disease from teenagers and adults living in the same home.

Approximately 15 to 20 babies in the United States die every year from pertussis. Almost all are younger than 4 months of age — too early to have been fully protected by the DTaP vaccine.

Because young babies get sick from pertussis and because they are not fully protected until they have had several doses of the DTaP vaccine, healthcare providers recommend that older children and adults who will be around newborns be protected; this is known as cocooning.

Teens and adults who will be around young infants should get a dose of the Tdap vaccine in anticipation of the baby's arrival.

Mothers should request the Tdap vaccine between 27 and 36 weeks gestation during *each pregnancy* or before leaving the hospital if they did not receive Tdap during pregnancy.

This information is provided by the Vaccine Education Center at The Children's Hospital of Philadelphia. The Center is an educational resource for parents and healthcare professionals and is composed of scientists, physicians, mothers and fathers who are devoted to the study and prevention of infectious diseases. The Vaccine Education Center is funded by endowed chairs from The Children's Hospital of Philadelphia. The Center does not receive support from pharmaceutical companies.

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Tdap Vaccine for Preteens and Teens

Last updated JUNE 2014

Why does my child need Tdap vaccine?

Babies and little kids get shots called DTaP to protect them from diphtheria, tetanus, and pertussis (whooping cough). But as kids get older, the protection from the DTaP shots starts to wear off. This can put your preteen or teen at risk for serious illness. The tetanus-diphtheria-acellular pertussis (Tdap) vaccine is a booster shot that helps protect your preteen or teen from the same diseases that DTaP shots protect little kids from.

- **Tetanus** is caused by a toxin (poison) made by bacteria found in soil. The bacteria enter the body through cuts, scratches, or puncture wounds in the skin. Tetanus can cause spasms which are painful muscle cramps in the jaw muscle (lockjaw) and throughout the body. The spasms can cause breathing problems and paralysis. A preteen or teen with tetanus could spend weeks in the hospital in intensive care. As many as 1 out of 5 people who get tetanus dies.
- **Diphtheria** is not as common as tetanus but can be very dangerous. It spreads from person to person through coughing or sneezing. It causes a thick coating on the back of the nose or throat that can make it hard to breathe or swallow. It can also cause paralysis and heart failure. About 1 out of 10 people who get diphtheria will die from it.
- **Pertussis (whooping cough)** spreads very easily through coughing and sneezing. It can cause a bad cough that makes someone gasp for air after coughing fits. This cough can last for many weeks, which can make preteens and teens miss school and other activities. Whooping cough can be deadly for babies who are too young to have protection from their own vaccines. Often babies get whooping cough from their older brothers or sisters, like preteens or teens, or other people in the family.

When should my child be vaccinated?

All preteens should get one Tdap shot when they are 11 or 12 years old. If your teen is 13 years old up through 18 years old and hasn't gotten the shot yet, talk to their doctor about getting it for them right away.

What else should I know about the vaccine?

The Tdap shot has been studied very carefully and is safe. It is recommended by the Centers for Disease Control and Prevention (CDC), the American Academy of Family Physicians, the American Academy of Pediatrics, and the Society for Adolescent Health and Medicine.

The Tdap shot can cause mild side effects, like redness and soreness in the arm where the shot was given, headache, fever, or tiredness. Some preteens and teens might faint after getting the Tdap vaccine or any other shot. To help avoid fainting, preteens and teens should sit or lie down when they get a shot and then for about 15 minutes after getting the shot. Serious side effects from reactions to the Tdap shot are rare.

How can I get help paying for these vaccines?

The Vaccines for Children (VFC) program provides vaccines for children ages 18 years and younger, who are not insured, Medicaid-eligible, American Indian or Alaska Native. You can find out more about the VFC program by going online to www.cdc.gov and typing VFC in the search box.

Where can I learn more?

Your child's doctor or nurse can give you more information about the Tdap vaccine and the other vaccines your child may need. There is also information on CDC's Vaccines for Preteens and Teens website at www.cdc.gov/vaccines/teens.

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Q&A

Volume 7, Winter 2016

Meningococcus: What you should know

The Children's Hospital of Philadelphia®
VACCINE EDUCATION CENTER

Meningococcus can be devastating — claiming a child's life in hours. Although infants less than 1 year of age are at the highest risk of getting this disease, adolescents and teens are most likely to die from it. One meningococcal vaccine that protects against four of the five types of meningococcus is recommended for all adolescents and teens and for some infants. A newer vaccine, specific for type B meningococcus, is recommended for some high-risk groups as well as for adolescents between 16 and 18 years of age.

Q. What is meningococcus?

A. Meningococcus is a bacterium. Meningococcal bacteria live on the lining of the nose and throat and are spread from one person to another by close personal contact. Occasionally, the bacterium enters the bloodstream and causes severe disease.

Five different types of meningococcal bacteria, classified on the basis of a complex sugar that coats the bacteria (called polysaccharide), cause virtually all meningococcal disease in the world. These five different types of meningococcal bacteria are called types A, B, C, Y and W-135.

Q. Is meningococcus dangerous?

A. Yes. Every year in the United States approximately 500 people are infected with meningococcus and as many as 50 die from the disease. Also, about one of every five survivors live the rest of their lives with permanent disabilities, such as seizures, loss of limbs, kidney disease, deafness and mental retardation. The highest incidence of meningococcal disease occurs in infants less than 1 year of age. In children between 2 and 10 years of age, the incidence of meningococcal infections is low, but starting in adolescence the incidence of disease rises. Although adolescents are less likely to be infected than infants, they are more likely to die when infected. Meningococcal bacteria are particularly dangerous because they rapidly make large quantities of a poison called endotoxin. Endotoxin damages blood vessels and causes low blood pressure and shock. For this reason, meningococcal bacteria can kill people soon after they enter the bloodstream. Children can be perfectly healthy one minute and dead four to six hours later; the disease can be so rapid and overwhelming that even appropriate, early medical care may not be sufficient. Because outbreaks occur in colleges, schools, childcare centers, army barracks and other areas where people have close contact, meningococcal infections often cause panic in the community.

Q. What are the symptoms of meningococcal infection?

A. Meningococcus infects the bloodstream (causing sepsis) as well as the lining of the brain and spinal cord (causing meningitis). Symptoms of sepsis include fever, chills, rash, low blood pressure and dark purple spots on the arms and legs. Symptoms of meningitis include fever, headache, confusion and stiff neck.

Q. Is there a vaccine to prevent meningococcus?

A. Yes. Two different vaccines are now available. The vaccine recommended for all adolescents between 11 and 12 years of age protects against four of the five different types of meningococcus (A, C, Y and W-135), but not meningococcus type B. The second vaccine protects against meningococcus type B, which accounts for two-thirds of all meningococcal disease in infants and one-third of cases in adolescents. This vaccine is currently recommended for high-risk groups, including those with complement deficiencies, no spleen or a spleen that does not function, lab personnel regularly exposed to the bacteria, and individuals or groups at risk during an outbreak, such as on a college campus. The vaccine has also been recommended for all adolescents between 16 and 18 years of age.

Q. How are the meningococcal vaccines made?

A. The meningococcal vaccine currently recommended for all 11- to 12-year-olds is made using the complex sugar (called polysaccharide) that resides on the surface of the bacteria. Polysaccharides are stripped from the surface of four of the five different types of meningococcal bacteria that cause disease (types A, C, Y and W-135) and each is linked (conjugated) to a harmless protein. The four conjugated polysaccharides are combined into a single shot and protect against four different types of meningococcal bacteria. High-risk infants can also get this version (Menactra®) or one of two similarly manufactured versions (Menveo®). Menveo, like Menactra, contains types A, C, Y and W-135.

The meningococcal serogroup B vaccines, Trumenba® and Bexsero®, contain two or four proteins, respectively, that reside on the surface of the bacteria.

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Meningococcus: What you should know

Q. Are the meningococcal vaccines safe?

A. Yes. The meningococcal vaccines can cause pain or redness at the site of injection as well as low-grade fever, but because they are not made from whole bacteria, they cannot possibly cause bloodstream infections or meningitis.

Q. Do the meningococcal vaccines work?

A. Yes. The routinely recommended meningococcal vaccine protects recipients from most of the meningococcal disease caused by types in the vaccine, but not from type B. The type B vaccine will likely protect recipients against type B but not other types of meningococcus.

Q. Who should get the meningococcal vaccine?

A. The meningococcal vaccine currently recommended for all 11- to 12-year-olds — the one containing types A, C, W, and Y — is given in two doses. The first dose is recommended to be given between 11 to 12 years of age, and a booster dose is recommended at 16 years of age. If the first dose is given between 13 and 15 years of age, a booster dose should be given between 16 and 18 years of age. Any 16 to 18-year-olds who have not previously received this vaccine should also get a single dose, as should first-year college students through age 21 years who are living in residence halls and have not had the vaccine between the ages of 16 and 18 years. High-risk infants between 2 and 23 months of age are recommended to receive two to four doses of meningococcal vaccine depending upon which product is used. Infants considered to be at high risk include those with complement deficiencies, those with no spleen or with a spleen that is not functional, those who live in an institution or in a community currently experiencing an outbreak and those who will be traveling to the Hajj or to a destination in Africa that is located in the meningitis belt.

Q. Who should get the new type B meningococcal vaccine?

A. People aged 10 years or older and who are considered to be at higher risk of infection should get two or three doses of the vaccine depending upon which one is used. High risk groups include those with complement deficiencies; no spleen or a spleen that does not function; lab personnel regularly exposed to the bacteria; and individuals or groups at risk during an outbreak, such as on a college campus. In addition, the type B meningococcal vaccine is recommended as two doses separated by six months for all 16- to 18-year-olds.

Q. Should college freshmen get the meningococcal vaccine?

A. Yes. All college freshmen, especially students living in dormitories, should receive the meningococcal vaccine containing types A, C, W, and Y if they have not had it between 16 and 18 years of age. College freshmen living in dormitories are five times more likely to get meningococcal disease than people of the same age who do not attend college.

Type B outbreaks of meningococcus have occurred in recent years on college campuses. Therefore, it would be of value for all incoming freshmen to receive the type B vaccine before college entry.

Q. If someone in my child's school gets meningococcal infection, what should I do?

A. Children in close contact with someone with meningococcal infection should receive an antibiotic to prevent the disease. Close contact with someone with meningococcal disease is defined as 1) living in the same house, 2) sharing the same preschool or daycare classroom during the week before illness, 3) kissing or sharing utensils or toothbrushes or 4) sitting next to the person on an eight-hour or longer flight. Antibiotics used to prevent meningococcal infection include rifampin, ceftriaxone, azithromycin and ciprofloxacin.

Q. Does the meningococcal vaccine prevent all cases of meningitis?

A. Neither of the meningococcal vaccines will prevent all cases of meningococcal meningitis since no vaccine is 100 percent effective. In addition, other bacteria, such as pneumococcus and *Haemophilus influenzae* type b (Hib), cause meningitis. Fortunately, vaccines to prevent pneumococcus and Hib are routinely given to all children before 2 years of age. Some viruses also cause meningitis, but meningitis caused by most viruses is usually not as severe as meningitis caused by bacteria.

This information is provided by the Vaccine Education Center at Children's Hospital of Philadelphia. The Center is an educational resource for parents and healthcare professionals and is composed of scientists, physicians, mothers and fathers who are devoted to the study and prevention of infectious diseases. The Vaccine Education Center is funded by endowed chairs from Children's Hospital of Philadelphia. The Center does not receive support from pharmaceutical companies.

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Meningococcal Vaccines for Preteens and Teens

Last updated NOVEMBER 2015

Why does my child need to be vaccinated?

Meningococcal vaccines help protect against the bacteria that cause meningococcal disease. These infections don't happen very often, but can be very dangerous when they do. Meningococcal disease refers to any illness that is caused by *Neisseria meningitidis* bacteria. The two most severe and common illnesses caused by these bacteria include infections of the fluid and lining around the brain and spinal cord (meningitis) and bloodstream infections (bacteremia or septicemia). Even if they get treatment, about 10 to 15 out of 100 people with meningococcal disease will die from it.

Meningococcal disease can spread from person to person. The bacteria that cause this infection can spread when people have close or lengthy contact with someone's saliva, like through kissing or coughing, especially if they are living in the same place. Teens and young adults are at increased risk for meningococcal disease.

Meningococcal disease can become very serious, very quickly. The meningococcal vaccine is the best way to protect teens from getting meningococcal disease.

When should my child be vaccinated?

All 11 to 12 year olds should be vaccinated with a single dose of a quadrivalent meningococcal conjugate vaccine. Older teens need a second shot when they are 16 years old so they stay protected when their risk is the highest.

Teens who got meningococcal vaccine for the first time when were 13, 14, or 15 years old should still get the booster shot when they are 16 years old. If your older teen didn't get the meningococcal shot at all, you should talk to their doctor about getting it as soon as possible.

Teens and young adults (16 through 23 year olds) may also be vaccinated with a serogroup B meningococcal vaccine (2 or 3 doses depending on brand), preferably at 16 through 18 years old. Talk with your teen's doctor or nurse about meningococcal vaccination to help protect your child's health.

What else should I know about the vaccination?

Like many vaccines, meningococcal shots may cause mild side effects, like redness and soreness where the shot was given (usually in the arm). Note that both meningococcal vaccines can be given during the same visit, but in different arms. Some preteens and teens might faint after getting a meningococcal vaccine or any shot. To help avoid fainting, preteens and teens should sit or lie down when they get a shot and then for about 15 minutes after getting the shot.

How can I get help paying for these vaccines?

The Vaccines for Children (VFC) program provides vaccines for children ages 18 years and younger, who are uninsured, Medicaid-eligible, American Indian or Alaska Native. You can find out more about the VFC program by going online to www.cdc.gov and typing VFC in the search box.

Where can I learn more?

Talk to your child's doctor or nurse to learn more about meningococcal vaccines and the other vaccines that your child may need. You can also find out more about these vaccines on CDC's Vaccines for Preteens and Teens website at www.cdc.gov/vaccines/teens.

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Q&A

Volume 12, Fall 2016

Influenza: What you should know

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VACCINE EDUCATION CENTER

Seasonal epidemics of influenza (flu) occur every year in the United States, beginning in the fall. Typically, the epidemics cause thousands to tens of thousands of deaths and about 200,000 hospitalizations each year. Since the 1940s, a vaccine has been available to prevent influenza; unfortunately, the vaccine is not used as much as it should be. To prevent the hospitalizations and deaths caused every year by influenza virus, the Centers for Disease Control and Prevention (CDC) has recommended that all U.S. citizens more than 6 months of age receive the influenza vaccine. ***This recommendation has the potential to save thousands of lives.***

Q. What is influenza (flu)?

A. Influenza (flu) is a virus that infects the nose, throat, windpipe and lungs. The virus is highly contagious and is spread from one person to another by coughing, sneezing or talking. Influenza infections typically occur between October and April each year.

Q. What are the symptoms of influenza?

A. Typical symptoms of influenza include fever, chills, muscle aches, congestion, cough, runny nose and difficulty breathing. Other viruses can cause symptoms similar to influenza. But, influenza virus is a more common cause of severe, fatal pneumonia.

Most, but not all, people who die from influenza are older than 65. Sadly, each year about 50 to 150 children die as a result of influenza. Children younger than 4 often require hospitalization because of high fever, wheezing, croup or pneumonia.

Because influenza is a virus, it can't be successfully treated with antibiotics. While some antiviral medications are available by prescription, not all strains of influenza are susceptible to them, and they work best when used early in the infection.

Q. Who should get the influenza vaccine?

A. The influenza vaccine is recommended for everyone 6 months of age and older.

Children under 9 years of age require two doses of influenza vaccine separated by four weeks if they have never received an influenza vaccine or have an uncertain vaccination history.

Q. How is the vaccine made?

A. In recent years, more types of influenza vaccines have become available:

- **Trivalent inactivated influenza vaccine** – This is the traditional influenza vaccine shot that has been used in the past; it is made by taking three different influenza viruses, growing them (individually) in eggs, purifying them and completely inactivating them with the chemical formaldehyde. A few brands of this vaccine are available with specific ages for use; however, this version is typically given to the broadest group of individuals, including infants.
- **Quadrivalent inactivated influenza vaccine** – This version is made in the same way as the trivalent version; however, it contains four types of influenza viruses. This vaccine is given as a shot and can be used for people 6 months and older.
- **Cell culture-based influenza vaccine** – This version currently contains three different influenza viruses and is made in a manner similar to the other inactivated vaccines; however, instead of growing the viruses in eggs (avian cells), they are grown in mammalian cells. This vaccine represents an advance in technology because it contains less egg protein than the version grown in eggs. It is given as a shot.
- **Recombinant influenza vaccine** – This version of influenza vaccine contains only one surface protein of the virus known as hemagglutinin. The protein is produced by inserting the gene for hemagglutinin into an insect virus that then produces large quantities of the hemagglutinin protein. The protein is purified and used as the vaccine. First available in the fall of 2013, this version represents an advance in technology because it is the first egg protein-free influenza vaccine. This version is given as a shot and can be used in people between 18 and 49 years of age. It currently contains three types of influenza virus.

A"live, weakened" influenza vaccine given as a nasal spray was previously available. However, in recent years, people who got this version were not adequately protected against influenza. Therefore, beginning in the fall of 2016, experts at the Centers for Disease Control and Prevention no longer recommend this vaccine.

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Influenza: What you should know

Q. Does the influenza vaccine work?

A. The influenza vaccine typically prevents about 70 of every 100 people who receive it from developing moderate-to-severe influenza infection. Even though the vaccine might not completely prevent influenza infection, it will still lessen the length and severity of the illness.

Q. When should I get the influenza vaccine?

A. Immunizations should be administered throughout the season because the peak incidence of influenza can occur as late as February or March.

Q. If I got the influenza vaccine last year, do I need this year's influenza vaccine?

A. Yes, getting the current vaccine is still of benefit for a few reasons. First, some people are not protected after getting the vaccine, so another dose will increase their chance of being protected. Second, antibody levels wane, particularly in the elderly, so another dose will boost antibody levels before the start of influenza season. Finally, sometimes influenza viruses change significantly from one year to the next, so immunization or natural infection the previous year is not protective.

Q. Are the influenza vaccines safe?

A. Yes. Influenza vaccine shots can cause pain, redness or tenderness at the site of injection as well as muscle aches and low-grade fever, but because the vaccine viruses are completely inactivated or the vaccine contains only individual proteins, they cannot possibly cause influenza.

Although most versions of the influenza vaccine are made in eggs and some people are severely allergic to eggs, the quantity of egg proteins is typically insufficient to cause a severe allergic response. But just to be sure, it is suggested that people with egg allergies remain at the provider's office for 15 minutes after vaccination.

Q. Does the influenza vaccine contain thimerosal?

A. Some multi-dose preparations of the inactivated influenza vaccine given as a shot still contain a small quantity of the mercury-based preservative known as thimerosal. However, the quantity contained in vaccines does not cause harm. Influenza infections can cause severe illness and death, so the benefits of receiving the vaccine clearly outweigh the theoretical risks.

Q. What is the difference between epidemic, or seasonal, influenza and pandemic influenza?

A. Every year in the United States and throughout the world, influenza viruses cause epidemics. Because many people have some immunity, yearly epidemics don't infect everyone.

A pandemic is a worldwide epidemic caused when new strains of influenza virus form. This happens when genetic material from both human and animal strains of influenza mix. Because virtually no one is immune to these new viruses, they have the potential to sweep across the world unchecked. Typically, many more people become ill and die during pandemics than during yearly epidemics.

In 2009 a pandemic centered on the novel H1N1 strain. Luckily, this new strain was not as fatal as some previous pandemic strains. Still, 60 million people in the United States became ill, 270,000 were hospitalized and about 12,000 died. Of those who died, between 1,100 and 1,200 were children, about 10 times the number who die during a normal influenza season.

Q. Can pregnant women get the influenza vaccine?

A. Yes, in fact, this is one of two vaccines that pregnant women are urged to get during pregnancy; the other is Tdap. Because pregnant women are more likely to experience complications and hospitalization as a result of infection with influenza, it is important for them to be immunized. In addition, studies have shown that babies of women who were immunized with influenza vaccine during pregnancy are less likely to be infected with influenza during the first six months of life, before they are old enough to be vaccinated.

Q. Can I avoid getting the vaccine and the virus by washing my hands and staying away from others who are ill?

A. While careful hand-washing, covering coughs and sneezes, and staying home when ill can help prevent the spread of disease, we cannot be certain that others will do the same. Further, not everyone infected with influenza realizes they are transmitting it since infected people begin to spread the virus a day or two before they have symptoms.

So, while these measures can reduce your chance of getting influenza, and in fact helped to stem transmission during the pandemic of 2009, they can only do so much to prevent influenza infections. The reality is that the only way to ensure protection from a specific disease is to have immunity acquired through immunization or previous exposure to the disease.

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Flu Vaccine for Preteens and Teens

Last updated JUNE 2014

Why does my child need the flu vaccine?

The flu is an illness that infects the nose, throat, and lungs caused by influenza viruses. Flu spreads when infected people cough or sneeze. Flu can cause mild to severe illness, and in some cases it can cause death. While most preteens and teens who get sick with the flu recover within a couple of weeks, some will get complications like sinus infections, or pneumonia (a serious lung infection). Preteens and teens who have chronic health problems like diabetes (type 1 and 2) or asthma, are at a greater risk for complications from the flu, but even healthy adolescents can get very sick from the flu. The flu usually causes a cough, runny or stuffy nose, body aches, fatigue (tiredness) and sometimes fever. Flu spreads easily when sick people cough, sneeze, or talk.

When should my child be vaccinated?

Preteens and teens should get the flu vaccine every year, ideally by October. However, as long as flu viruses are circulating, vaccination should continue throughout the flu season, even in January or later. Flu vaccine is available at your child's doctor's office or clinic, and sometimes other places like the local health department, pharmacies, urgent care clinics, grocery stores, and schools. You can find a flu vaccination clinic near you with the vaccine finder at http://vaccine.healthmap.org.

What else should I know about the flu vaccine?

Flu vaccines can be given to preteens and teens in two ways:

- **Most flu shots** are made from killed flu viruses. This vaccine is a shot that is given in the arm.
- **The nasal spray flu vaccine** is made with live, but weakened, flu virus. This vaccine is sprayed up the nose. Preteens and teens with chronic health conditions, like asthma, diabetes, or heart disease should **NOT** get the nasal spray vaccine and instead get the flu shot.

Talk to your child's doctor or nurse about which flu vaccine is best for your preteen or teen.

Both types of flu vaccine have been studied carefully and are safe. They cannot cause the flu. The annual flu vaccine is recommended for preteens and teens by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices, the American Academy of Family Physicians, the American Academy of Pediatrics, and the Society for Adolescent Health and Medicine.

Both flu vaccines can sometimes cause mild, flu-like symptoms. The most common side effects from a flu shot are a sore arm and a low fever or achiness. The nasal spray flu vaccine might cause congestion, runny nose, sore throat, or cough. These mild effects usually go away a day or two after vaccination. Serious side effects from either type of flu vaccine are rare. It is very important to tell the doctor or nurse if your preteen or teen has a severe allergy to chicken eggs.

How can I get help paying for these vaccines?

The Vaccines for Children (VFC) program provides vaccines for children ages 18 years and younger, who are uninsured, Medicaid-eligible, American Indian or Alaska Native. You can find out more about the VFC program by visiting www.cdc.gov/vaccines/programs/vfc/index.html or typing VFC in the search box of the CDC homepage (www.cdc.gov).

Where can I learn more?

Talk to your child's doctor or nurse to learn more about the flu vaccine and any other vaccines your preteen or teen needs. There is more information about these vaccines on CDC's Vaccines for Preteens and Teens website at www.cdc.gov/vaccines/teens.

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