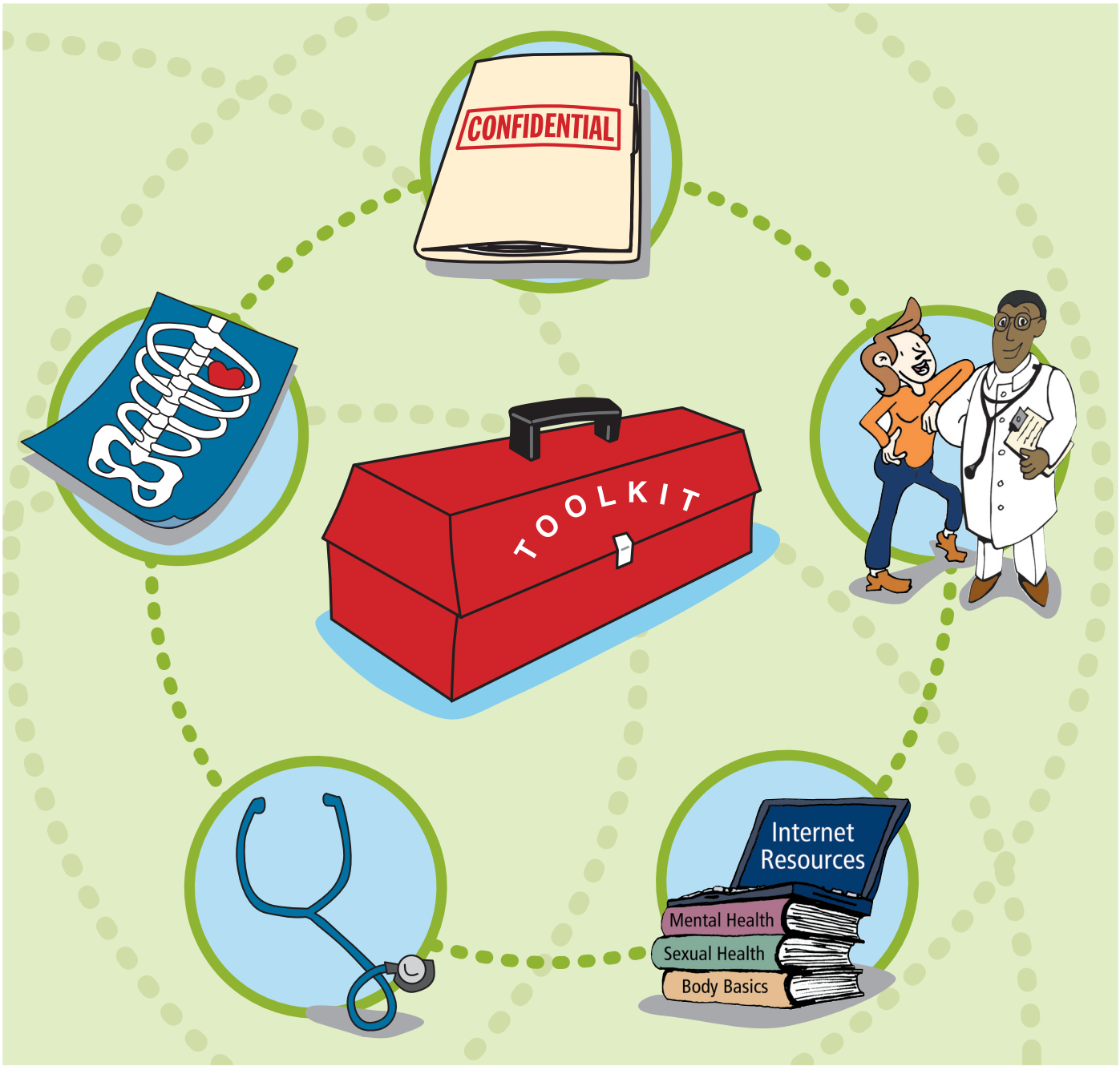
BEHAVIORAL HEALTH

An Adolescent Provider Toolkit



Illustrations by Jordan Zioni, 17

HOW TO OBTAIN A COPY OF THIS TOOLKIT

The Behavioral Health Module of the Adolescent Provider Toolkit can be downloaded for free from the following website:

Adolescent Health Working Group -- www.ahwg.net

Please visit our website for information on purchasing hard copies of the Behavioral Health Module.

Additional AHWG materials available for free download:

- Adolescent Provider Toolkit Modules:
  - Understanding Confidentiality and Minor Consent in California
  - Adolescent Health Care 101
  - Sexual Health
  - Body Basics
- Counseling Tips Bookmark
- "What We Say Here, Stays Here" Minor Consent Posters
- California Minor Consent Laws Pocket Card
- Youth Health Rights and Responsibilities Posters
- H.E.A.L.T.H. Presentation Curriculum
- The Real World: Young Adults and the Health Insurance Crisis
- Health education materials in multiple languages

ADOLESCENT HEALTH WORKING GROUP

The Adolescent Health Working Group (AHWG) was formed in 1996 when adolescent health providers, administrators, and youth advocates in San Francisco became concerned about Medicaid managed care's impact on young people's access to youth-sensitive, comprehensive health care. Today, the mission of the AHWG is to significantly advance the health and well-being of young people by applying the collective wisdom, resources, and energy of individuals and agencies that care for and support young people. The AHWG's activities include community-level research, public policy/advocacy, training, and community outreach and education. Members of the AHWG include representatives of youth agencies, public and private primary care, behavioral health clinics and programs, academic institutions, health plans, schools, social service and advocacy organizations, and youth and parents.

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Adolescent Health Working Group
San Francisco, CA

Dear Colleagues:

We are pleased to present you with the fourth module of the Adolescent Provider Toolkit series, entitled *Behavioral Health: An Adolescent Provider Toolkit*. The production of the Behavioral Health Module was made possible through the generous support of the John & Lisa Pritzker Family Fund, The California Endowment, The California Wellness Foundation, California Mental Health Services Act managed by San Francisco Community Behavioral Health Services, Judi Kletter, California Pacific Medical Center, and Kaiser Permanente Community Service Benefit Program.

This module focuses on adolescent mental health and substance use conditions. The shortage of practice standards for diagnosing and treating adolescent behavioral health problems in primary care made this the most challenging module in the Toolkit series to create. Therefore, the development of this module relied heavily on the wisdom and contributions of a consensus panel of San Francisco Bay Area primary care providers and behavioral health providers. The time and expertise this team of multidisciplinary providers shared with us was incredibly valuable.

After extensive discussion with experts and specialists in our community, specific disorders were selected to be examined more closely in the Behavioral Health Module. Selections were based on relevance to the primary care setting. In order to maintain brevity, we had to prioritize certain disorders, summarize succinctly, and omit several important disorders including: Obsessive Compulsive Disorder (OCD), Schizophrenia, Bipolar Disorder, and learning disabilities. Nevertheless, we have provided a list of internet resources that covers a broad range of behavioral health related matters.

This module takes a closer look at common substance use and mental health issues among adolescents and includes:

- Screening and assessment tools
- 12 mental health and substance use issue briefs
- Evaluation and treatment algorithms for general behavioral health concerns, depression, and Attention Deficit Hyperactivity Disorder (ADHD)
- Brief office interventions and counseling guidelines
- Behavioral health information and worksheets for providers
- Health education materials for teens and their adult caregivers
- Online resources and hotlines

We did not repeat information/tools that are included elsewhere in the Adolescent Provider Toolkit series. General screening and counseling techniques can be found in the *Adolescent Health Care 101 Module*. Information and treatment algorithms on body image and eating disorders can be found in the *Body Basics Module*.

We encourage you to visit our website, www.ahwg.net, for free downloads of the Behavioral Health Module, the accompanying four modules of the Adolescent Provider Toolkit series, and additional tools and resources. We hope the Adolescent Provider Toolkit series will be a useful resource for you as you improve the health of adolescents.

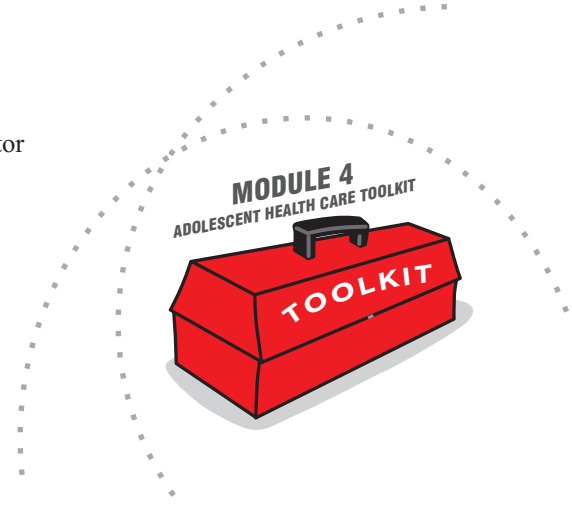
Regards,

Janet Shalwitz, MD
Founder and Senior Advisor
Adolescent Health Working Group

Tina Sang
Project Coordinator

Natalie Combs
Project Coordinator

P.S. We would love your feedback! Please use the attached evaluation survey to communicate your comments and thoughts on the Behavioral Health Module.



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ADOLESCENT PROVIDER TOOLKIT ADVISORY COUNCIL

Eileen Aicardi, MD - General Pediatrician
Michael Baxter, MSW - San Francisco Department of Public Health
Ernest Brown, PhD - Walden House
Sara M Buckelew, MD, MPH - University of California San Francisco, Div. of Adolescent Medicine
Tonya Chaffee, MD, MPH - University of California San Francisco, Department of Pediatrics
Natalie Combs - Adolescent Health Working Group
Joyce Dorado, PhD - University of California San Francisco/San Francisco General Hospital
David Knopf, LCSW, MPH - University of California San Francisco, Div. of Adolescent Medicine
Molly Koren, MSW - University of California San Francisco, Mt. Zion Teen Services
Lisa Mihaly, RN, FNP - Mission Neighborhood Health Center/University of California San Francisco
Erica Monasterio, MN, FNP - University of California San Francisco, Div. of Adolescent Medicine
Kim Norman, MD - University of California San Francisco, Dept. of Psychiatry at Langley Porter
Susan Obata, MD - San Francisco Dept. of Public Health, Community Health Programs for Youth
Tina Sang - Adolescent Health Working Group
Naomi A. Schapiro, RN, MS, CPNP - University of California San Francisco, School of Nursing
Janet Shalwitz, MD - Adolescent Health Working Group
Susan M. Smiga, MD - University of California San Francisco, Children's Center at Langley Porter
Irene Sung, MD - San Francisco Dept. of Public Health, Community Behavioral Health Services
Gloria Thornton, MA, LMFT - Blue Cross of California, State Sponsored Business
Lina Weissman, PhD - Edgewood Center for Children and Families
Kelly K. Wong, MD - General Pediatrician
Alison Yaeger, PsyD - University of California San Francisco, Children's Center at Langley Porter

YOUTH AND PARENTS/ADULT CAREGIVERS Balboa High School Youth Advisory Board, Cole Street Clinic, Coleman Parent Advocates, Dimensions Clinic, Everett Middle School PTSA, Excelsior Boys and Girls Club, New Generation Health Center, and San Francisco Youth Task Force.

FORMER AHWG STAFF AND INTERNS

Dena Bushman (Peace Corps), Kathryn Davis, MD, MPH (University of California San Francisco, Department of Pediatrics), Britt Payne (University of Florida Medical School), Lisa Turman, MD, MPH (Children's Hospital Oakland), Edward Velasco, MSc (Berlin Public Health).

CONTRIBUTORS/REVIEWERS

Rebecca Gudeman, JD, MA (National Center for Youth Law), Celeste Prothro, MPH (University of California San Francisco, Division of General Internal Medicine), Lisa Mihaly, RN, FNP (Mission Neighborhood Health Center/University of California San Francisco), Seth Ammerman, MD, FSAM (Stanford University, Division of Adolescent Medicine), Nancy Lim-Yee, LCSW (Chinatown Child Development Center), Cathy McDonald, MD, MPH (Medical Consultant for Thunder Road Adolescent Treatment Centers), Ariel Karahalios (San Francisco State University).

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Many, many thanks! This work couldn't have been done without you!

MODULE **FOUR:** BEHAVIORAL HEALTH

A. FOR PROVIDERS/CLINICS

1. Practice Readiness

Behavioral Health Module Roadmap I and II D-1
Behavioral Health Facts At-A-Glance D-3
Barriers to Addressing Behavioral Health D-4
Are You Prepared to Address Adolescent Behavioral Health? D-5
Setting the Stage: Rapport, Active Listening and Empathy D-6
Brief Supportive Interviewing Technique D-7
Motivational Counseling D-8

2. Screening, Assessment & Referral

HEADSSS Assessment: Risk and Protective Factors D-9
Behavioral Health Annual Screening Tool D-10
In-Depth Medical/Psychosocial Assessment D-11
Adolescent Behavioral Health Referral Process D-13

3. Issue Briefs

Diagnosis and treatment algorithms are included for depression and ADHD.

Psychosocial Stress D-14
Violence D-15
Bullying D-16
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Cutting/Self-Mutilation D-18
ADHD, Treatment Guidelines, Diagnosis and Treatment Algorithms, Monitoring Sheet . . D-19
Anxiety D-24
Trauma and Acute/Post-Traumatic Stress Disorder D-25
Depression, Primary Care Practice Guidelines, Monitoring Sheet D-27
Suicide D-31
Substance Use, Drug Testing in California, Recreational Drugs Fact Sheet D-33
Tobacco, Treatment Options for Smoking Cessation D-37

4. Resources

Behavioral Health and Community Resources D-39
Adolescent Sleep and Nutrition Needs D-40
Psychosocial Screening Tools D-41
Psychotropic Medications At-A-Glance D-43
Types of Psychotherapy D-45
Advocate for Your Adolescent Patients D-46
California Minor Consent Laws: Mental Health D-47
Uses and Limitations of the Diagnostic and Statistical Manual of Mental Disorders D-49

B. FOR PARENTS/ADULT CAREGIVERS

Please print and distribute these handouts to the parents and adult caregivers of your teen patients.

Know Myself, Know My Teen D-50
The 5 Basics of Parenting Adolescents D-51
Peace Begins at Home D-53
Does My Teen Need Help? D-54
Finding Help for My Teen D-55
Educational Rights of Students with Mental Health Needs D-56

C. FOR YOUTH

Please print and distribute these handouts to your teen patients.

Print youth pamphlets double-sided and fold along the dotted lines.

Myths and Facts about Behavioral Health D-58
Taking Care of Myself-A Plan of Action D-59
Stress Busters D-60
5 Steps to Lower Stress D-61
Stressed Out?! Youth Pamphlet D-62
Keep the Peace D-64
Love Shouldn't Hurt D-65
Coping With Loss D-66
Dealing With Separation and Divorce D-67
The Truth about Tobacco, Alcohol and Other Drugs Youth Pamphlet D-68
Study Smart! Stay Organized! D-70
Offer a Helping Hand D-71
Confidentiality Facts for Teens (12-17 years old) D-72
Making a Behavioral Health Appointment D-73
Youth Behavioral Health Rights and Responsibilities D-74

D. INTERNET RESOURCES

Click On This! D-75

Behavioral Health Module Roadmap (I)

Practice Readiness

- Increase access, adolescent friendliness, and reduce stigma (D-4, 5, 6)
- Improve knowledge and skills. Become very knowledgeable about a few psychotropic medications that you plan to prescribe (D-3, 43, 44, 47, 48)
- Gather resources, referrals, and consultants (Adolescent Provider Toolkit Modules 1-3, 5*; D-39)

PSYCHOSOCIAL SCREENING & ASSESSMENT

Screen annually and during acute visits (MODULE 2, D-9, 10)**

Wellness Promotion and Guidance

- Acknowledge positive behaviors
- Provide health education and guidance to teen & adult caregivers (D-2)
- Reinforce assets, relationships and adult/school connections (B-14 in Module 2**, D-9)
- Emphasize to parents and teen the value and importance of healthy diet, exercise, sleep, social support AND annual primary care visit (D-40, 50, 51, 52)
- Utilize adult caregiver/parent and youth worksheets/handouts and internet resource list (D-50 to 79)

Further Assessment

- Behavioral Health Annual Screening Tool (D-10)
- In-Depth Assessment (D-11, 12)
- Psychosocial Screening Tools (D-41, 42)
- Drug Testing (D-35)
- Issue Briefs (D-14 to 38)

Issue Briefs for Specific Information

- Psychosocial Stress (D-14)
- Violence (D-15)
- Bullying (D-16)
- Conduct Disorder/ODD (D-17)
- Cutting/Self-Mutilation (D-18)
- ADHD (D-19)
- Anxiety (D-24)
- Trauma/ASD/PTSD (D-25)
- Depression (D-27)
- Suicide (D-31)
- Substance Use (D-33)
- Tobacco Use (D-37)

Emergency Response

- Techniques for Talking with Suicidal Youth (D-32)
- Call/refer to 911, crisis line, police, ER or poison control

Urgency Determination

- Referral Algorithm (D-13)
- Stages of Substance Use (D-34)
- Depression Algorithm (D-29)
- Suicide Issue Brief (D-31)

Non-Emergency Response

Consider your own expertise, comfort level, internal, and external resources

PCP-Based Counseling/Treatment

- Supportive Interviewing (D-7)
- Motivational Counseling (D-8)
- Treatment Algorithms & Tools (D-21, 22, 29, 38)
- ADHD & Depression Monitoring Sheets (D-23, 30)

Consultation and/or Treatment Referral

- Referral Worksheet (D-39)
- Advocate for Your Adolescent Patients (D-46)
- Resources (D-43, 44, 45)

Follow-up with adolescent/adult caregivers

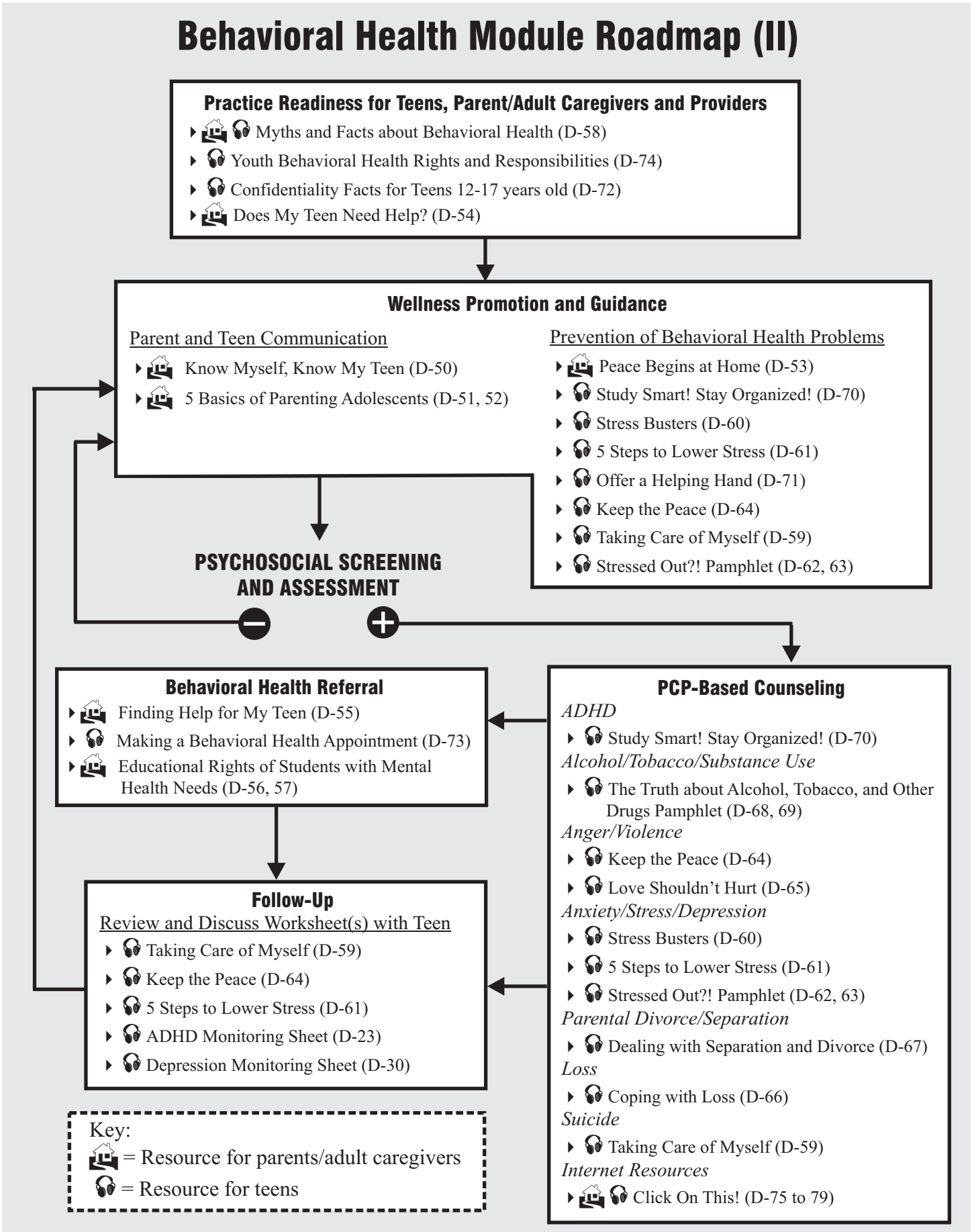
Ensure:

- Safety
- Improved functioning
- Connection/support
- Wellness promotion and guidance
- Next steps and appointments
- Annual psychosocial screening/ assessment

*Free downloads of Adolescent Provider Toolkit Modules 1-3, 5 at www.ahwg.net

**Simmons M, Shalwitz J, Pollock S, Young A. *Adolescent Health Care 101: The Basics.* Adolescent Health Working Group. 2003, http://www.ahwg.net/resources/toolkit.htm

Behavioral Health Module Roadmap (II)



Behavioral Health Facts At-A-Glance

EMERGENCE IN ADOLESCENCE

Adolescence is a vulnerable time for youth and their loved ones. Adolescents are particularly susceptible to developing behavioral health conditions due to rapid development, brain growth, and newly manifesting genetic risk factors.

The following changes occur in adolescence which can also contribute to the expression of mental health conditions:

- Sleep disturbances
- Hormonal changes
- Substance use
- Increased levels of stress
- School/academic pressures

21% of 9-17 year olds have a mental illness and 11% are "significantly limited" because of their illness[1]

Two out of three young people with mental health problems are not getting the help that they need!

DEPRESSION/SUICIDE

- In 2003, 1.5 million youth aged 12-17 with Major Depressive Disorder experienced severe to very severe impairment in at least one of four domains: home, school/work, social life, close relationships during the past year.[2]
- Suicide is the third leading cause of death for 15-24 year olds (approx 5,000 young people) and the sixth leading cause of death for 5-15 year olds.[3]
- The rate of suicide has fluctuated over the past 50 years. While the rate nearly tripled since 1960, the number of teen suicides hit a plateau in the mid-1990s.[3] Now, suicide rates among 15-24 year old males and 10-24 year old females are in decline.[4]

EFFECTS OF UNTREATED BEHAVIORAL HEALTH PROBLEMS

- If untreated, mental disorders can become more severe, more difficult to treat, and lead to the development of co-occurring mental illnesses.[5]
- 65% of students with an "emotional disturbance" drop out of school. This drop out rate is the highest of all other disability categories.[6]

SUBSTANCE USE

- More than half of U.S. high school graduates will have tried an illegal drug by the end of 12th grade.[7]
- Over 66% of young people with a substance use disorder have a co-occurring mental health problem that complicates treatment.[8]
- In 2004, youth ages 16 to 20 years old had the highest fatality and injury rates due to car accidents than other age groups. Of the 16-20 year olds who were killed in traffic accidents that year, 36% died in alcohol related incidents.[9]
- In 2004, 22% of high school students were current smokers. Ninety percent of adults who smoke started by age 21 and half of them had become regular smokers by their eighteenth birthday.[10]

[1] Rosen DS. Management of Mental Illness in Primary Care Practice: Part 1. *Adolescent Health Update.* 2005: 17(3): 1-8.
[2] SAMHSA, National Mental Health Information Center. Major Depression in Children and Adolescents. 2003, http://www.mentalhealth.samhsa.gov/publications/allpubs/CA-0011/default.asp
[3] National Mental Health Association. Adolescent Depression: Helping Depressed Teens. http://www.nmha.org/index.cfm?objectid=C7DF950F-1372-4D20-C8B5BD8DFDD94CF1
[4] Moskos MA et al. Adolescent Suicide Myths in the United States. *Crisis.* 2004; 25(4): 179.
[5] National Institute of Mental Health. NIMH-Funded National Comorbidity Survey Replication Study: Mental Illness Exacts Heavy Toll Beginning in Youth. 2005, http://www.nimh.nih.gov/healthinformation/ncs-r.cfm
[6] US Department of Education. Twenty-fifth Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act, 2003; 1(1).
[7] Monitoring the Future. Trends in Lifetime Prevalence of Use of Various Drugs for Eighth, Tenth, and Twelfth Graders. 2005, http://www.monitoringthefuture.org/data/05data/pr05t1.pdf
[8] US Public Health Service, Reports of the Surgeon General. Mental Health: A Report of the Surgeon General. 1999, http://www.surgeongeneral.gov/library/mentalhealth/home.html
[9] National Highway Traffic Safety Administration. Traffic Safety Facts: A Compilation of Motor Vehicle Crash Data from the Fatality Analysis Reporting System and the General Estimates System. 2004, http://www.nhtsa.dot.gov
[10] American Lung Association, Epidemiology and Statistics Unit Research and Program Services. Trends in Tobacco Use. 2006, http://www.lungusa.org/site/apps/s/content.asp?c=dvLUK9O0E&b=34706&ct=67648

Barriers to Addressing Behavioral Health

Bringing up behavioral health matters in a primary care setting can be very difficult due to the challenges that exist in communities and primary care practices. Patient/family, provider, and institutional barriers may create denial and discomfort that prevent discussions about and treatment for behavioral health problems. Healthcare providers play an essential role in promoting mental wellness, preventing problems, intervening early, and treating/referring adolescents and their loved ones for behavioral health problems. Therefore, it is crucial that barriers are recognized and addressed in every practice setting.

What Barriers Exist?

Patient/Family Barriers

- Lack of awareness of behavioral health problems
- Difficulty accepting mental illness diagnosis
- Somatic complaints as the focus
- Co-existing conditions complicate understanding/ appreciation of new or different symptoms
- Stigma/discrimination
- Shame/guilt
- Hopelessness

Provider Barriers

- Insufficient training/confidence
- Limited access to psychiatric consultation or age-appropriate referrals
- Attitudes about mental illness (etiology, responsibility)
- Lack of confidence about treatment modalities & efficacy

Systemic Barriers

- Time, liability, and reimbursement concerns
- Diffusion of responsibility
- Absent or inadequate insurance coverage
- Mental health "carve-outs"
- Inadequate treatment resources
- Inadequate infrastructure for successful primary care and behavioral health collaboration and integration

Overcoming Barriers - Tips for Providers:

- **Create and maintain an open discussion with staff and coworkers.** Discuss stereotypes about mental and substance use disorders to increase knowledge and comfort.
- **Establish practice measures to ensure confidential handling** of sensitive information and to reassure patients that what they say in the office is shared with their consent/assent.
- **Educate adolescent patients about their right to consent** to mental health and substance use services and your state's confidentiality laws regarding behavioral health.
- **Routinely discuss mental health and substance use issues** with adolescents and families as part of anticipatory guidance during annual visits and also acute care visits.
- **Ask adolescents and their families about their beliefs** concerning mental health and substance use.
- **Emphasize increasing adolescent and family wellness** and functioning rather than specific diagnostic labels or treatment approaches.
- **Collaborate with mental health providers** to reduce stigma and increase awareness and communication about behavioral health issues, and improve the referral process and treatment options for teens.

Stigma Must Be Addressed!

DO

- **Use** respectful language
- **Emphasize** abilities, not limitations
- **Tell** someone if they express a stigmatizing attitude
- **Listen** to and acknowledge the feelings and pain expressed by stigmatized youth and families
- **Routinely** screen for assets and psychosocial risks/problems

DO NOT

- **Assume** that an adolescent and/or family is without risks or problems
- **Use terms** like crazy, nuts, lunatic, manic, wacko, depressive, or slow functioning
- **Use generic labels** such as retarded or mentally ill
- **Portray** successful persons with disabilities or behavioral health conditions as super human

Sources:
1) Jellinek M, Patel BP, Froehle MC, eds. *Bright Futures in Practice: Mental Health Volume 1 Practice Guide.* National Center for Education in Maternal and Child Health. 2002: 10.
2) Rosen DS. Management of Mental Illness in Primary Care Practice: Part 1. *Adolescent Health Update.* 2005; 17(3): 1-8.
3) SAMHSA, National Mental Health Information Center. Anti-Stigma: Do You Know the Facts? 2003, http://www.mentalhealth.samhsa.gov/publications/allpubs/OEL99-0004/default.asp

Are You Prepared to Address Adolescent Behavioral Health?

DOES YOUR OFFICE/CLINIC HAVE…

- ❑ Age-appropriate health education materials that cover substance use and mental health topics?
- ❑ Up-to-date local referrals and resources for teen mental health and substance use emergencies and treatment?
- ❑ A systematic way to follow-up on mental health and substance use referrals?
- ❑ A policy on drug testing?
- ❑ Courteous and friendly staff who are familiar with your practice's minor consent and confidentiality guidelines?
- ❑ A procedure for dealing with emergency and crisis situations?
- ❑ A DSM-IV for reference?

WHEN TAKING INTO ACCOUNT CULTURAL INFLUENCES DO YOU…

- ❑ Use an open-minded, non-judgmental approach?
- ❑ Try to understand an individual's and family's cultural beliefs regarding illness and symptoms?
- ❑ Clarify your role since patients may have different expectations about health care services and providers?
- ❑ Engage the family, when appropriate, but remember **NOT** to use family members as translators?
- ❑ Accept and recognize the role of natural helpers (such as curanderos or shamans)?
- ❑ Maintain sensitivity for the age, race, ethnicity, gender, sexual orientation, family structure, and lifestyle choices of your patients and their loved ones?
- ❑ Have culturally appropriate materials in the language and literacy level of your patients?
- ❑ Provide referrals for mental health and substance use treatment that represent the diverse characteristics and preferences of your patient population?

ARE YOU…

- ❑ Aware of your own attitudes, feelings, and behaviors around mental health and drug, alcohol, and tobacco use and how your own experiences have shaped your opinions toward adolescents who have mental health or substance use conditions?
- ❑ Ready to provide factual information to teens and families about substance use and mental health and address stigma and discrimination?
- ❑ Familiar with current and culturally appropriate resources for substance use and mental health for teens and their families?
- ❑ Familiar with up-to-date information on at least one or two psychotropic medications in each drug class?
- ❑ Prepared to refer a teen for evaluation and treatment of substance use, depression, anxiety, ADHD, or other behavioral health problems?
- ❑ Familiar with the legal and confidentiality issues dealing with teen substance use, including drug testing, parent/guardian involvement, and releasing medical records?
- ❑ Aware of your abilities and comfort level regarding behavioral health screening, assessment, treatment, and referrals?
- ❑ Committed to increasing your knowledge and skills in the practice areas you are unsure of?
- ❑ Willing to get help for any mental health and/or substance use problems you may have?

Sources:
1) Jellinek M, Patel BP, Froehle MC, eds. *Bright Futures in Practice: Mental Health Volume 1 Practice Guide.* National Center for Education in Maternal and Child Health. 2002: 10.
2) Kang M, Chown P. *General Practitioners' Resource Kit.* NSW Centre for the Advancement of Adolescent Health. 2004, http://www.caah.chw.edu.au/resources
3) SAMHSA, National Mental Health Information Center. Cultural Competence in Serving Children and Adolescents With Mental Health Problems. 1996, http://www.mentalhealth.samhsa.gov/publications/allpubs/Ca-0015/default.asp

Setting the Stage: Rapport, Active Listening and Empathy

Make every effort to create a safe, non-judgmental, and supportive environment so that your adolescent patients will be open to discussing their feelings and behaviors.

ESTABLISH RAPPORT

- Design your office to be welcoming to teens.
- Spend time alone with the teen during each visit. Start when the teen is 11 years old. Explain this to parents ahead of time.
- Explain your confidentiality practices to parents and teens at the start of each visit.
- Wash your hands within view of the adolescent.
- Shake hands with the adolescent and begin the visit with informal conversation. Explain what she/he can expect during the visit.
- Help teens recognize and appreciate their assets and strengths.
- Use terminology and expressions that the teen will understand.
- Ask the teen if he/she wants a parent or chaperone present during physical exams.
- Ask for the teen's input into treatment plans.
- Summarize findings, treatment plans, and next steps to the teen and, when appropriate, to parents.
- Allow time for questions and provide information on community resources.
- Provide teen patients with your office or clinic contact information, including the names of people to call for questions or follow-up, office hours, and daytime and after hours phone numbers.

LISTEN ACTIVELY

- Pay attention to teen's concerns. Try to understand the teen's perspective and keep an open mind.
- Use gender-neutral terms when conversing with the teen. Example: "Are you going out with someone?" Rather than, "Do you have a girlfriend?"
- Avoid interrupting.
- Minimize note-taking, particularly during sensitive questioning.
- Notice teen's non-verbal cues such as eye contact, facial expressions, affect, posture, and physical movements.
- Ask open-ended questions in a non-threatening and judgment free manner.
  - × DO NOT ask: "Do you use drugs or alcohol?"
  - ✓ DO ask: "I know drugs and alcohol are common at a lot of schools. What drugs are popular at your school? What do you think about your peers using drugs or alcohol? How do you deal with that? What have you tried?"

EXPRESS EMPATHY

- Sense the emotion the teen is feeling then state it back to him/her. Wait for the teen to respond before continuing. Example: "You seem tense. Do you feel stressed or worried?"
- Validate the teen's feelings by letting her/him know you understand the reason for the emotions. Example: "Breaking up with a boy/girl friend is very hard. I can understand why you feel sad."
- Educate the teen about mental health and substance use. Refer him/her to additional resources and give out emergency and hotline contact information. Education helps to reduce stigma.
- Focus on the teen's strengths such as caring friends, supportive family, or coping abilities.
- Construct a plan of action with the teen. Set realistic short-term goals and then follow up by phone and/or in person.
- Reassure the teen that she/he is not alone.
- Honor the teen's emotions and honesty. Example: "It took a lot of courage to talk about your feelings. Thanks for your honesty. I am impressed with how well you are doing under these circumstances."

Sources:
1) Egener B. Empathy. *Behavioral Medicine in Primary Care.* Eds. Feldman M and Christensen J. Appleton and Lange Publishing. 1997: 8-14.
2) Simmons M, Shalwitz J, Pollock S, Young A. *Adolescent Health Care 101: The Basics.* Adolescent Health Working Group. 2003: B-7-B-8. http://www.ahwg.net/resources/toolkit.htm.

Brief Supportive Interviewing Technique

Behavioral health concerns are among the most common reasons for adolescents to visit their primary care providers. BATHE is one technique for conducting brief assessments, exploring concerns and counseling during routine or episodic office visits.

		EXAMPLE QUESTIONS/COMMENTS	PURPOSE
B	**BACKGROUND**	▸ What's going on in your life? ▸ Tell me about a typical day for you.	Invites adolescents to talk about the significant matters in their lives by using direct, open-ended questions.
A	**AFFECT**	▸ How do you feel about that? ▸ That situation sounds very _____. ▸ Are you feeling _____?	Asks adolescents to recognize their feelings and understand how situations affect their emotions and behaviors.
T	**TROUBLING**	▸ What troubles you the most about this problem/situation/condition? ▸ How has this problem caused difficulties for you at home, school, or anywhere else in your life?	Aims to help adolescents determine why and how significantly a situation troubles them and how it impacts them.
H	**HANDLING**	▸ How are you dealing with that? ▸ That is a great way to handle the situation. ▸ Could you respond to the situation differently? ▸ What might help improve the situation or help you feel better?	Provides an opportunity to learn about and reinforce adolescent's healthy coping strategies and to suggest additional interventions.
E	**EMPATHY**	▸ That must be very difficult for you. ▸ Thank you for being so honest with me.	Shows the adolescent's response to the situation is reasonable. Demonstrates understanding for the adolescent's position, feelings and perceptions.

- **Adapt the questions and comments so they are in your own words and can be understood by your patients.**
- **Always remind adolescents and families that they can come and talk to you with their concerns.**
- **If you are concerned about the teen's safety, condition or ability to function, make sure he/she gets the help that's needed in a timely fashion.**

Source:
1) Lieberman J, Stuart M. The BATHE Method: Incorporating Counseling and Psychotherapy Into the Everyday Management of Patients. *Primary Care Companion Journal of Clinical Psychiatry.* 1999, 1: 35-39. Copyright 1999, Physicians Postgraduate Press. Adapted and reprinted with permission.

Motivational Counseling

These tools offer different methods for intervention that are both brief and effective. Although motivational counseling techniques are frequently used for alcohol or substance use counseling, they can also be used to engage a youth in mental health care.

1 ASK PERMISSION to engage in the topic of discussion.

2 ASSESS READINESS for change and youth's belief in his/her ability to make change.

0	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

NOT READY FOR CHANGE (0-3)	UNSURE (4-6)	READY FOR CHANGE (7-10)
⇩	⇩	⇩
Educate, Advise and Encourage	Explore Ambivalence	Strengthen Commitment and Facilitate Action

4 KEEP "FRAMES" IN MIND when counseling for behavior change.

F:	Provide **FEEDBACK** on risk/ impairment	Use the adolescent's own description of the problem. ▸ *It sounds like your grades dropped this year and you were in an accident after drinking at a party.* ▸ *It sounds like you cannot concentrate at school or complete homework because of anxiety.*
R:	Emphasize personal **RESPONSIBILITY** for change	▸ *I'd like to help you, but it's also very important that you take responsibility for changing things. Are you able to take steps to help yourself?*
A:	Offer clear **ADVICE** to change	▸ *I believe the best thing for you would be to stop using drugs and alcohol.* ▸ *I believe the best thing for you would be to manage your anxiety.*
M:	Give a **MENU** of options for behavior change and treatment	Tailor these options to teen's readiness for change. ▸ *You could try stopping your drug/alcohol use completely, cutting down, or reducing your harm to yourself and others.* ▸ *You could try stress-reduction techniques, regular exercise and/or therapy.*
E:	Counsel with **EMPATHY**	▸ *I know that these things may be difficult to hear, but I'm worried about you. I care about your health and your future.*
S:	Express your faith in the adolescent's **SELF-EFFICACY**	▸ *Even though this may be difficult to do, I believe in you and I know that you can do this, once you decide the time is right.*

Resource:

Motivational Interviewing - Resources for clinicians, researchers, and trainers: www.motivationalinterview.org

Sources:
1) Jellinek M, Patel BP, Froehle MC, eds. *Bright Futures in Practice: Mental Health Toolkit.* National Center for Education in Maternal and Child Health. 2002: 63.
2) Miller WR, Rollnick S, eds. *Motivational Interviewing: Preparing People to Change Addictive Behavior.* 1991: 191-202.
3) Miller WR, Sanchez VC. Motivating Young Adults for Treatment and Lifestyle Change. *Alcohol Use and Misuse by Young Adults.* 1994: 55-81.
4) Prochaska JO, DiClemente CC, Norcross JC. In Search of How People Change: Applications to Addictive Behaviors. *The American Psychologist.* 1992; 47: 1102-4.

HEADSSS Assessment: Risk and Protective Factors

Risk factors increase the likelihood that an adolescent will engage in risky behaviors. Protective factors, on the other hand, build an adolescent's resiliency and contribute to his/her ability to cope with stress and thrive. Identify the adolescent's risk and protective factors during each visit. Encourage all of your patients to build upon their assets and reach out for help.

Biological Risk Factors:

- ❖ Genetics: family history of mood, anxiety, and/or eating disorders, schizophrenia, substance addiction.
- ❖ In-utero and childhood risks: fetal alcohol exposure, toxin exposure, brain injury, infections, nutritional deficits.

PSYCHOSOCIAL REALMS	PROTECTIVE FACTORS	RISK FACTORS
HOME	• Positive relationship with parent(s) • Parent(s)/family seen as resource • Good communication with parent(s)/family • Caring adults involved in his/her life	• Conflicted/negative relationship with parent(s) • Absent or excessive rules, structure, or supervision • Uncomfortable asking parent(s)/family for help • Poor communication with parent(s)/family • Caring adults cannot be identified
EDUCATION/ EMPLOYMENT	• Positive attitude about school • Involvement in school and school activities • Belief that teachers and school are caring and fair • High academic expectations communicated by parent(s) • Good academic achievement • Future educational attainment goals	• Belief that school is boring, useless, and/or unsafe • Isolated, disengaged, or discriminated in school • Belief that teachers and school mistreat him/her • Low or extremely high academic expectations from parent(s) • Grade(s) repeated, ↓ school performance/attendance • Education not seen as part of her/his future life • 20 hours or more per week of work
ACTIVITIES	• Involvement in supervised group activities such as after-school, community-based, sports, arts and/or faith-based programs • Religious and/or spiritual practice • Involvement in social justice, advocacy, and/or community work • At least one meal per day eaten with family	• Lack of supervision in school or after school • Engaged in risky and/or harmful behaviors • Isolated or disconnected from peers, community, and family • Overscheduled and without down time • Inadequate nutrition or sleep • Excessive preoccupation with diet and/or exercise
DRUGS	• Not associated w/ substance-involved peers • Parent(s)/family members do not use substances • Negative attitude towards substances • Past substance use but now abstinent	• Substance use by peers • Substance use by parent(s)/family members • Early, intense, and/or consistent substance involvement
SEXUALITY	• Intention to abstain from sexual intercourse until late adolescence/young adulthood • Not currently sexually active or using reliable methods to reduce pregnancy and STI/HIV risk • Sexual debut after 15 years of age • Trusted adult to talk to about sexual issues	• Engaged in unprotected sex • Pregnancy or STI in the past • Sexual debut before 14 years of age • Peers are only source of sexual information • History of sexual assault or abuse
SUICIDE/ DEPRESSION/ SELF-IMAGE	• Caring adult to talk to when stressed • Peer support network • Healthy coping skills • Positive self-esteem/ self-image • Acceptance of appearance and weight	• Current depression/isolation/disengagement • Current suicidal ideation • History of suicide attempt and/or major trauma • Family member/friend who committed suicide • Unreasonable expectations from self or others • Extreme dissatisfaction with appearance or weight
SAFETY	• Seat belt and protective gear usage • Good problem solving skills when faced with dangerous situations • Non-violent conflict resolution skills	• No or inconsistent seat belt & protective gear usage • Easy access to weapons or carrying weapons • Victimization through family, intimate partner, gang, or school violence/bullying

Sources:
1) Simmons M, Shalwitz J, Pollock S, Young A. *Adolescent Health Care 101: The Basics.* Adolescent Health Working Group. 2003: B-9. http://www.ahwg.net/resources/toolkit.htm Annotated HEADSSS assessment can be found in *Adolescent Health Care 101.*
2) Erica Monasterio, RN, MN, FNP. University of California San Francisco, Division of Adolescent Medicine. 2006.

Behavioral Health Annual Screening Tool

Every year a teenager should undergo a comprehensive preventive health visit. As part of that visit, mental health and substance use concerns should be assessed and discussed. This screening tool draws upon the adolescent preventative health visit and psychosocial assessment "Annotated HEADSSS" which can be found in the Adolescent Health Care 101Module.[1]

ESSENTIAL QUESTIONS TO ASK EVERY TIME YOU SEE AN ADOLESCENT:

☑ **Have there been any significant changes/losses in your home/family/community? (Use a specific time frame).**

☑ **Do you have someone who you can turn to if you are having a problem, worry, or bad day?**

RELATED SCREENING QUESTIONS FROM ADOLESCENT HEALTH CARE 101:

HOME

- Tell me a little about your home life.

EDUCATION/EMPLOYMENT

- Are you going to school?
- How are you doing in school? Grades/marks? Better, worse or the same?
- Do you have friends at school?

ACTIVITIES

- What do you do for fun?
- Who do you hang out with?
- What do you do after school?
- What physical activities did you do last week? Is this typical?

DRUGS/ALCOHOL/TOBACCO

- What drugs have you tried?
- How much/how often do you use? In what kinds of situations?
- Do the people you hang out with smoke, drink, smoke weed, use other drugs, sell drugs?

SEXUALITY

- Are you attracted to guys, girls or both?
- Has anyone ever touched you in a way that made you uncomfortable or forced you to have sex?
- Have you ever had sex under the influence of drugs/alcohol?

SUICIDE/DEPRESSION/SELF-IMAGE

- How do you feel about the way you look? How do you feel about your weight?
- How often do you feel very sad, tearful, bored, disconnected, out-of-control, nervous, blue? (choose a few to ask)
- What do you do when you feel stressed or overwhelmed?
- Have you ever felt that life isn't worth living?
- Do you think about hurting or killing yourself? Have you ever tried to hurt or kill yourself? When? Why?

SAFETY

- How many physical fights have you been in?
- Is there a gun in your home?
- Do you ever carry a weapon?
- Has anyone in or out of your home ever physically/sexually threatened or hurt you?

ADDITIONAL SCREENING QUESTIONS

HOME

- How do you spend time with your family (meals, celebrations, trips, community/religious activities)?
- What makes you feel welcomed or cared for in your home?
- What makes you feel safe/unsafe in your home, neighborhood, or community?
- Are you worried about losing your housing?
- Have you ever been homeless, in foster care, or been arrested?

EDUCATION/EMPLOYMENT

- Who can you turn to for help at school?
- Do you get bullied or picked on at school or out of school?
- Are you working more than 20 hours per week?
- What are your future plans for school or work?

ACTIVITIES

- How much time do you spend alone?
- How do you feel and what do you do when you are alone?
- Are there some activities you'd like to be involved in?
- What are your eating and sleeping patterns?
- What do you do for exercise? How much and why do you exercise (qualify level of intensity and amount of time)?

DRUGS

- Refer to the CRAFFT (Car, Relax, Alone, Forget, Friends and Family, Trouble) screening tool (D-33)

SEXUALITY

- When was the last time you talked to your parent(s) about sex?
- Does anyone ever scare you or hurt you physically/emotionally/sexually?
- Do you enjoy sex?

SUICIDE/DEPRESSION/SELF-IMAGE

- How often do you think or talk about losing/gaining weight or dieting?
- How are you trying to change your weight?
- Do you ever fast, vomit, take laxatives or diet pills to control your weight? Do you ever binge eat?
- Are you enjoying life as much as you used to?
- Is there anything that you are really worried about? What percentage of the day do you spend worrying about it?
- Do you see or hear things that other people don't?

SAFETY

- Do you spend time with anyone who has trouble controlling anger? If so, how do you handle it?
- What do you do or say when you are angry?
- What do you have to do to keep yourself safe?

[1] Simmons M, Shalwitz J, Pollock S, Young A. *Adolescent Health Care 101: The Basics*. Adolescent Health Working Group. 2003: B-9. http://www.ahwg.net/resources/toolkit.htm

Source:
1) Erica Monasterio, RN, MN, FNP. University of California San Francisco, Division of Adolescent Medicine. 2006.

In-Depth Medical/Psychosocial Assessment

Diagnosing behavioral health disorders can be tricky, especially if the youth's presentation is not straightforward, if multiple psychiatric or medical conditions co-exist and/or if developmental or cultural issues cloud the picture. As such, the best way to properly identify causative, contributing and/or co-existing conditions is to review health and school records and conduct a complete current and past medical, psychiatric, and social history, review of systems, mental status and physical examinations. Lab tests should be performed when indicated by the history and physical findings.

Ideally, an assessment should include input from the adolescent, parents, other significant household members, and a counselor or teacher. Adolescents report their feelings and thoughts more accurately and parents/adult caregivers are more reliable reporters of a teen's behavior, interactions, and medical, psychiatric and developmental histories. Separate interviews should take place with both the teen and adult caregiver(s). Generally, the first interview should be with the adolescent, followed by a meeting with the parents. The group should also meet together, allowing an important opportunity to observe communication and interaction between family members. At the start of the visit, the provider should clarify to the teen and parents how and when information will or will not be shared. When a teen's information must be disclosed to facilitate patient care or safety measures, obtain the young person's consent/ assent in accordance with state and federal laws.

PATIENT ASSESSMENT

1. Chief Concern/Complaint or Reason for Evaluation – in the teen's words.

2. History of the Present Concern:
   - In chronological order – history (hx) of symptoms from current onset; precipitating and aggravating factors; coping strategies; suicidal ideation; impact on daily home, school/work, social activities and relationships; previous diagnoses and treatments; response to treatments.
   - Note duration, severity, frequency, intensity, symptoms and impact on sleeping, appetite, eating, school attendance, hygiene, sexual and drug/alcohol activity.
   - The patient should be asked what he/she thinks is contributing to the situation/condition.

3. Past Medical/Psychiatric History:
   - If teen is seen without parents, obtain signed release of information and order pertinent health records.
   - Ask about major and chronic illnesses, accidents, ER visits, hospitalizations, medications (from all sources) and allergies.
   - Ask about medical and behavioral health providers/clinics/services that parents may not know about such as school/community nurses, clinics, and programs.

4. Family History (FH):
   - If teen is seen without parents, obtain as much information as possible about family/household medical, psychiatric and substance use history and include parents' age, current location, education and employment.
   - Ask about family/household history of suicide, homicide, unexplained deaths, violence/aggression, incarceration, and homelessness.

5. Psychosocial/HEADSSS:
   - Utilize the *Behavioral Health Annual Screening Tool* (D-10) or similar in-depth psychosocial assessment tool to cover significant life domains.
   - Most importantly, ask about recent changes, stressors, losses, deaths, illnesses, moves, traumatic events, fights, threats, arrests, worries and criminal justice/foster care/homeless services involvement.
   - Take a detailed Rx, OTC, complementary/herbal and street drug hx - date of onset and duration, frequency, quantity, time, reason for use, affects of use on relationships, school, mood, thoughts. Ask specifically about alcohol, tobacco, caffeine, energy drinks, cough medicine, stimulants, sleep/study aids, hallucinogens, inhalants, antihistamines, decongestants, sedatives, bronchodilators, antidepressants, anticonvulsants, thyroid replacement, corticosteroids and hormones. Complete the CRAFFT tool if teen or parents/ adult caregivers report any past or present substance use by teen (D-33).

Additional tools & materials to aid in-depth assessments can be found in partnering Adolescent Provider Toolkit modules (www.ahwg.net):

1) Adolescent Health Care 101:
   - Initial/Annual Comprehensive Adolescent Visit
   - Adolescent Past History
   - Adolescent Follow-up/Interval Visit
   - Parent/Guardian Questionnaire
   - Contact Information
   - General Guidelines for the Office Visit
   - Annotated HEADSSS Assessment
   - Take Care of Yourself: Health Tips for Teens

2) Body Basics
   - Annual Screening Tool (disordered eating)
   - Eating Disorder Algorithm for Assessment and Intervention

Sources:
1) Kaye D, Montgomery M, Munson S, eds. *Child and Adolescent Mental Health*. Lippincott Williams & Wilkins. 2002
2) Dulcan M, Martini R, Lake M. *Concise Guide to Child and Adolescent Psychiatry, 3rd Edition*. American Psychiatric Publishing, Inc. 2003
3) Erica Monasterio, RN, MN, FNP. University of California San Francisco, Division of Adolescent Medicine. 2006.

In-Depth Medical/Psychosocial Assessment (continued)

PARENT/ADULT CAREGIVER ASSESSMENT:

1. Chief Concern/Complaint or Reason for Evaluation - from the parent/adult caregiver's perspective.

2. History of the Present Concern:
   - In chronological order - history of symptoms from current onset; precipitating and aggravating factors; impact on daily home, school/work, social activities and relationships; previous diagnoses and treatments; response to treatments.
   - Note the duration, severity, frequency, intensity, and distress of symptoms and changes in sleeping, appetite, eating, school attendance and hygiene.

3. Past Medical/Psychiatric History:
   - In chronological order – prenatal, birth, childhood and neurodevelopmental history; past significant illnesses, accidents, head injuries, traumatic events, diagnoses, sleep disturbances; treatments including response and adherence; ER visits/ hospitalizations; medications (by prescription, OTC, family/local healers); allergic reactions. Note provider names, locations and dates.
   - Ask specifically about thyroid and neurological disorders, diabetes, infectious diseases (mononucleosis, hepatitis, HIV/AIDS, Lyme), chronic fatigue, fibromyalgia, migraines, seizures, tics, concussions, multiple sclerosis, collagen vascular disorders, irritable or inflammatory bowel disease.

4. Family History (FH):
   - Age, race/ethnicity, gender, religion, current location, and deaths of patient's parents, grandparents, siblings, children; medical and psychiatric hx of close biological and household members that may have a genetic or environmental influence on the teen.
   - FH - depression, anxiety, bipolar or eating disorders, schizophrenia, ADHD, substance (drugs, alcohol, tobacco) use/addiction, suicide, homicide, unexplained deaths, violence/aggression, incarceration, and homelessness.

PATIENT REVIEW OF SYSTEMS

Particular attention should be paid to symptoms not already covered in the history or common symptoms of illnesses for which adolescent may be at risk for.

General/Constitutional	General state of growth, health & well-being, average weight, appetite & weight loss/gain, exercise and energy level, sleep pattern, sleepiness, dreams, pain/discomfort, fever, chills, sweating, thirst
HEENT/Neck	Headache, vision, tinnitus, sore throat, neck swelling
Skin/Nodes	Node changes, hives, itching/scratching, tattoos, piercings, cutting, jaundice, bruising, rashes
Resp/CV	Shortness of breath, cough, wheezing, choking, chest pain/pressure, palpitations, racing heart
GI	Nausea, vomiting, indigestion, diarrhea, constipation, abdominal pain/discomfort
Gyn/Uro-genital	LMP, menstrual changes, STI or pregnancy risk, sexual dysfunction, dysuria, polyuria
Musculoskeletal	Swelling, aches, pains, weakness, shaking, numbing, tingling
Neurologic	Loss of consciousness/blackouts, balance, coordination, seizures, tics, parasthesias, memory, concentration, problem solving
Psychiatric	Usual mood state, nervousness, emotional problems/worries, depressed mood – persistent sadness, boredom or blues, crying, anger or rage, level of control, euphoria, hallucinations, racing thoughts

MENTAL STATUS EXAM – Note the following while interviewing teen: personal appearance and general behavior; mood and affect (facial expressions, body language, interaction during the interview); speech and language; motor activity and coordination; tics, mannerisms, repetitive movements; expressed thoughts and perceptions (hallucinations, worries, suicidal ideation); associations (loose, contradicting); teen's understanding of the interview; cognitive status - alertness level, orientation, attention and concentration, age and culturally appropriate knowledge, calculation, writing, abstract reasoning, impulse control and maintaining focus, insight and judgment, intellectual ability.

PHYSICAL EXAM – Obtain height, weight and vital signs. A thorough physical and detailed neurological exam should be carefully performed to assess for physical illnesses that may be causing, contributing or co-existing with symptoms. Clothing should be removed in order to observe hygiene, nutritional status and skin for signs of self-injury, abuse and drug use. Be alert to signs of medication/drug use; physical, sexual and emotional abuse; endocrine, neurologic, respiratory (esp. asthma), and movement disorders; infectious diseases (mononucleosis, hepatitis, HIV, Lyme); chronic fatigue, fibromyalgia; anemia; collagen vascular diseases; irritable and inflammatory bowel disorders.

Adolescent Behavioral Health Referral Process

Increase Awareness of Adolescent Referrals and Resources
- Become familiar with local mental health and substance use providers, services and resources including providers who will treat a minor without parental consent or initial family involvement
- Identify and utilize emergency services, local and national hotlines, websites, and resource hubs

Assess Level of Urgency Including Adolescent Safety

EMERGENCY REFERRAL
- Acutely suicidal or homicidal
- Out-of-control behavior
- Psychosis or mania
- Serious substance abuse
- Physically unsafe from abuse
- Unable to take care of his/her basic needs

NON-EMERGENCY REFERRAL

Ability to function is impaired but does not meet emergency referral criteria

Suicidal, Homicidal, or Out-of-Control Behavior

For hospitalization, emergency room, or psychiatric evaluation:
- Call/refer to 911 for emergency situation or out-of-control behavior. Anticipate police response.
- Call 24-hour crisis team/hotline
- Notify and involve parent, if possible

Abuse
- Assess safety
- Notify appropriate authorities such as Child Protective Services and police
- Refer immediately for services
- File mandated and appropriate reports

Discuss Referral w/ Patient and, If Appropriate, w/ Parent
- Review minor consent and confidentiality laws with teen (D-72). Discuss importance of parental involvement, even if no parental involvement is requested by teen
- Discuss how referral can help improve patient's functioning
- Refer to available mental health services such as school and community-based peer and group counseling
- Emphasize your continued involvement in patient's care
- Assess reaction to referral and address stigma
- Review mental health billing procedure. (Bills might be sent home which can compromise confidentiality).

Maintain Safety

Do **NOT** allow patient to wait alone or leave your office until help arrives

Referral is Accepted

Parent and/or Patient Refuse
- Provide info and support
- Encourage referral using motivational counseling (D-8)

After Immediate Danger
- Strongly encourage adherence to recommended treatment and follow-up
- If no follow-up has been arranged with behavioral health provider, proceed with referral
- Provide patient in ongoing unsafe/risky situation with information on legal options, counseling, crisis intervention services, shelters, and hotlines

Assist in Making Referral Appointment
- Assist patient and/or parent with initial call
- Review minor consent laws and appropriateness of referral (D-47, 48). Note: Parent or patient may often be required to initiate referral for some private and public health plans and programs

Provide Transitional Care
- Develop an emergency plan with the patient and, if appropriate, with family if situation/symptoms worsen while waiting for referral
- Create an interim plan with the patient that may include the following recommendations:
  - ◊ Stop/decrease substance use or use harm reduction techniques (D-68, 69)
  - ◊ Lower stress by using stress reduction exercises (D-60, 61, 62, 63)
  - ◊ Maintain safety in an abusive situation (D-65) and/or suicidal situation (D-32, 59)
  - ◊ Eat a healthy diet and get plenty of exercise, sleep, and social support (D-40). Identify a trusted adult for help and support.
- Utilize school and community resources such as school-based counseling, after-school, mentoring and peer counseling programs
- Schedule follow-up visits and phone calls with patient

Communicate/Coordinate with Behavioral Health Provider
- Review with patient what information and family history you will share with behavioral health provider
- Obtain signed consent to release information from the person consenting for care (patient or parent)
- Discuss confidentiality practices, including billing, with mental health professional and your continued level of involvement in patient's care

Follow-Up
- Provide patient and family with information, support, assistance, and routine adolescent primary care
- Encourage patient to let you know if referral is helpful
- Look for signs of improvement, relapse, and effects of medications including suicidal thoughts and/or increased agitation

Sources:
1) Adolescent Health Working Group, Youth Suicide Crisis– Quick Reference Card. 2003, http://www.ahwg.net/projects/ReferenceCard.pdf
2) Jellinek M, Patel B, Froehle M, eds. *Bright Futures in Practice: Mental Health– Volume I.* National Center for Education in Maternal and Child Health. 2002: 2-20.
3) Levenberg P, Elster A. *Guidelines for Adolescent Preventive Services (GAPS)*. American Medical Association. 1995.
4) Rosen D. Management of Mental Illness in Primary Care Practice: Part I. *Adolescent Health Update*. 2005; 17(3): 1-8.

Psychosocial Stress

Fast Facts

Adolescence is a time when young people are adjusting to rapid physical changes, discovering their sexuality and personal identities, identifying with peer groups, developing independence from their families, gaining abstract reasoning skills, and planning for the future.[1] The usual demands of adolescence are particularly difficult for young people who have to deal with stressors which tax or exceed their available internal and external resources. Stress is a risk factor for adolescent physical health and mental health problems.[2] Adjustment Disorder, as defined by the DSM-IV-TR, is a psychological response to identifiable stressor(s) resulting in clinically significant emotional or behavioral symptoms that emerge within 3 months of stress exposure and subside within 6 months of stress resolution. This stress reaction exceeds the normal range of stress symptoms and causes significant impaired functioning.

RISK FACTORS

- Perception of situations as stressful
- Pre-existing/chronic physical, emotional, or learning disorders
- Exposure to interpersonal violence, disaster, war, dislocation, or other trauma
- Family problems/conflict or parental divorce/separation
- Death or loss of a parent or loved one
- Household members impaired due to mental or physical health problem, substance use, or severe trauma[3]
- Isolation; disconnected from social support
- Target of discrimination or bullying
- Sexual orientation questioning; lesbian, gay, bisexual, transgender, transsexual, or queer identification
- Low academic achievement or high pressure to achieve
- Low socioeconomic status

PROTECTIVE FACTORS

- Positive outlook on life
- Effective coping strategies
- Good physical and emotional health
- Family support,[2] communication, and minimal conflict
- Household members in good physical & emotional health
- Social support from friends and caring adults
- Connection to school personnel and activities
- Religious/spiritual practice or engagement
- Access to resources

Assessment

When possible, obtain history/information from parent as well as patient. Assess physical, emotional, social, academic, occupational, and overall functioning with a psychosocial/HEADSSS assessment (D-10). Determine the stressor's duration, severity, and impact on adolescent. Responses to stress reflect situational characteristics, individual temperament, development, and cultural factors.[2] An adolescent may react to stress by becoming anxious, depressed, fearful, angry, and/or ashamed. Symptoms may include difficulty concentrating, restlessness, irritability, difficulty sleeping, nightmares, fatigue, headaches, stomachaches, self-medication with alcohol or drugs and exacerbation of co-existing physical and psychiatric disorders. Adolescents may also present with physical symptoms that cannot be explained by organic factors, declining school attendance/preformance, escalating risky and/or confrontational behaviors, and decreasing adherence to treatment recommendations among youth with chronic conditions.[1]

Intervention

Adolescents are often relieved when they have an opportunity to talk about their stressors and means of coping.[2]

- Safety: Monitor and maintain the safety of actively suicidal or homicidal adolescents until they are assessed by a mental health provider experienced in crisis intervention. Refer to/call 911, ER or crisis team. See *Referral Algorithm* (D- 13).
- Patient/Parent Education/Reassurance: Discuss the physical/emotional impact of stress and warning signs. Emphasize the importance of healthy diet, exercise, sleep, and socialization. Provide emergency contact/resource information.
- Parenting Skills/Support: Emphasize to parents the importance of regularly talking with their teen about dealing with and reacting to stressful situations (D-50, 51, 52).[2] Supportive parents can decrease the level of stress adolescents feel. Discuss counseling or support groups for parents who are having difficulty dealing with their adolescent or the stressors in their own lives.
- Social Support: Recommend adolescents reach out to family, friends, and supportive adults.[2] Encourage participation in mentor programs, sports leagues, faith-based activities, and/or after-school programs. Discuss available peer counseling services.
- Coping Strategies: Acknowledge the adolescent's current coping strategies and guide him/her towards more effective strategies such as making behavioral and environmental changes. Utilize the *BATHE* approach (D-7) to actively problem solve with the teen. Review and practice stress reduction exercises (D-60 to 63). Have him/her complete and then discuss the *Taking Care of Myself* worksheet (D- 59) and ensure the teen identifies a trusted adult for help and support.
- Medications: Cautious use of sedatives for a limited time, and as part of an overall treatment plan, may provide relief of acute stress symptoms. Side effects such as drowsiness, agitation, confusion and irritability should be monitored closely.
- Referral: Refer teens needing additional evaluation and treatment for substance use and/or prolonged or increasing symptoms to behavioral health specialist and/or specialized community treatment programs. The treatment of choice for stress disorders is cognitive behavioral therapy (CBT) (D-45).
- Follow-up: Follow-up according to acuity and severity of symptoms. Provide routine adolescent primary care and anticipatory guidance. Coordinate care with behavioral health provider.

[1] Geist R, Grdisa V, Otley A. Psychosocial Issues in the Child with Chronic Conditions. *Best Practice & Research Clinical Gastroenterology.* 2003; 17(2): 141-3.
[2] Bonica C, Henderson DJ. Helping Adolescents Cope with Stress During Stressful Times. *Current Opinion in Pediatrics.* 2003; 15: 385-8.
[3] Felitti VJ. The Relation Between Adverse Childhood Experiences and Adult Health: Turning Gold into Lead. *The Permanente Journal.* 2002; 6(1).

Violence

Fast Facts

Homicide is the second leading cause of death among American adolescents and the leading cause of death among African American youth.[1] School-associated violent deaths account for less than 1% of homicides among school-aged children and youth[2] In 2005, 36% of US high school students reported being in a physical fight during the past year.[3] Although most violent incidents involve young men, 1 in 3 violence-related injuries treated in emergency rooms and primary care settings are caused by female adolescents fighting with other young women.[4] Adolescents also experience or witness domestic violence, intimate partner violence, bullying, hate crimes, robberies, abuse, assault, and acts of terrorism. Youth face serious short and long-term physical and emotional consequences as victims, witnesses, and perpetrators of violence. See *Trauma and ASD/PTSD* Issue Brief (D-25, 26) for information on the mental health consequences of violence.

RISK FACTORS[1]

- Mental health and/or substance use problems
- Poor self-esteem or depression
- Substance abuse by parents, other family or household members
- Family stressors
- Insufficient supervision and care
- Lack of support from family and social network
- Corporal punishment and/or physical/emotional abuse from parents or adult caregivers
- Exposure to violence in the home, school, community, or media
- Access to firearms
- Gang involvement/exposure from family, school or neighborhood
- Experience of physical assault or sexual victimization

PROTECTIVE FACTORS[1,5]

- Well developed sense of self
- Optimism about the future
- Sense of internal control
- Strong social skills and ability to empathize
- Flexibility
- Sense of humor
- Nonviolent anger management and conflict resolution skills
- Consistent discipline from parents that is not abusive or violent
- Perceived support from social network/friends
- Engagement in positive activities such as supervised sports, music, and/or community programs
- Lack of access to firearms

Assessment

Before assessments, always inform adolescent about state notification regulations (parents, police, CPS) regarding abuse and harm to self or others. It is important that they understand the implications of their disclosures. Screen adolescents for exposure to violence and the impact violence has on their lives. Use psychosocial assessment/HEADSSS (D-10) to assess for child abuse, witnessing domestic violence, date rape, physical fighting, weapons carrying, gang violence, other safety issues, and for signs/symptoms of substance use and/or mental health disorders. Use FISTS for additional assessment. A disrobed physical exam is critical to assess for physical signs of abuse.

FISTS MNEMONIC[4]

F ighting	How many fights have you been in during the past year? When was your last fight? How did it start? Were you attacked by surprise? Why did you fight? Who was involved? Was a weapon used? Can you walk away from a fight?
I njuries	Have you ever been injured in a fight? Have you ever injured someone else in a fight?
S ex	Has your partner ever hit you? Have you hit (hurt) your partner? Have you had sex against your will? Do you think couples can stay in love when one partner makes the other one afraid?
T hreats	Has someone ever threatened you? What happened? Has anything changed since then to make you feel safer?
S elf-defense	What do you do if someone tries to pick a fight with you? Have you ever carried a weapon to protect yourself? What do you do to stay safe?

Intervention

- Safety: Monitor and maintain the safety of actively suicidal or homicidal adolescents until they are assessed by trained emergency personnel. Seek immediate help if adolescent is in serious danger due to intimate partner, gang, school, or domestic violence. Refer to/contact 911, police or crisis team. See *Referral Algorithm* (D-13).
- Mandatory Child Abuse Reporting: File a child abuse report anytime you discover facts that lead you to know or reasonably suspect a minor is a victim of abuse. In California, a mutual fray between two minors does not need to be reported. Refer to *Understanding Confidentiality and Minor Consent in California* Toolkit Module (www.ahwg.net) for additional information.
- Patient/Parent Engagement and Education: Emphasize the importance of removing or locking up guns and other weapons in the home.[4] See *Peace Begins at Home* (D-53). Discuss with parents/caregivers the need for consistent adult guidance, structure, communication, safety, and non-violent disciplinary methods (D-51, 52). Review opportunities for structured socially positive youth activities, family communication/gatherings and family/parent psychosocial education groups. Provide emergency contact/resource information.
- Counseling/Coping Strategies: Acknowledge, encourage, and support youth's strengths and assets. Identify and strategize non-violent ways to solve problems such as walking away from fights.[4] Use motivational counseling (D-8) for anger management and low/moderate substance use. Review the completed *Keep the Peace* worksheet with teen (D-64) to reinforce using non-violent alternatives in response to anger. Review *Love Shouldn't Hurt* (D-65) with teens experiencing dating/intimate partner violence.
- Referral: Connect youth who report being in 4+ physical fights during the past year or carrying weapons to community resources (school counselors, youth development programs, faith-based organizations, or social workers).[4] Refer youth suspected of having mental health and/or substance use problems to behavioral health provider for further evaluation and/or treatment. Inform teens who are afraid to return home about youth shelters.
- Follow-up: Ensure follow-up for ongoing risk/strength assessment, motivational counseling, and referrals to socially positive youth/community programs. Provide routine adolescent primary care, health promotion and anticipatory guidance. Coordinate with behavioral health provider.

[1] American Academy of Pediatrics. The Role of the Pediatrician in Youth Violence Prevention in Clinical Practice and at the Community Level. *Pediatrics*. 1999;103(1): 173-81.
[2] Anderson M, Kaufman J, et al. School-Associated Violent Deaths in the US, 1994-1999. *Journal of the American Medical Association.* 2001; 286 (21): 2695-702.
[3] Centers for Disease Control and Prevention. Youth Risk Behavioral Surveillance- US 2005. *Morbidity and Mortality Weekly Report, Surveillance Summaries.* 2006; 55(SS-5).
[4] Alpert E, Sege R, Bradshaw Y. Interpersonal Violence and the Education of Physicians. *Academic Medicine*. 1997; 72(suppl): S41-S50. Adapted and reproduced with permission.
[5] Egger S, Waterman J, Corona R. Helping Teens who Live in Violent Communities. *Western Journal of Medicine*. 2000; 172: 197-200.

Bullying

Fast Facts

Bullying is defined as a power imbalance between an individual/group and a target, whereby intentional acts of physical and/or emotional intimidation are inflicted on the target. A bully's power may be derived from physical size, strength, verbal skill, popularity, or gender. Physical acts include hitting, pushing, tripping, kicking, slapping, and destroying someone's belongings. Emotional intimidation includes exclusion, withdrawing friendship, spreading rumors, teasing, threatening, and name calling. Male bullies usually use physical intimidation while female bullies are more likely to use emotional intimidation.[1] Almost 30% of youth in the US are involved in bullying as a bully, target of bullying or both.[2] Both bullies and those bullied have poorer psychosocial functioning than their noninvolved peers. As adults, bullies have higher levels of criminal activity and arrests while bullying targets have higher levels of depression and low self-esteem.[3]

RISKS/CHARACTERISTICS OF YOUTH WHO ARE BULLIED[2]	RISKS/CHARACTERISTICS OF YOUTH BULLIES[2]
▸ Anxious, insecure, cautious, lacking in self-esteem ▸ Unlikely to defend themselves when confronted ▸ Socially unskilled and/or isolated **-OR-** ▸ Adolescents who do not "fit it" such as those with physical, behavioral, race/ethnic, social, or economic differences from the majority including sexual minority youth (lesbian, gay, bisexual, transgender, transsexual, queer, and questioning youth)	▸ Confident with high self-esteem or insecure teen who feels powerful/confident while bullying in a group ▸ Hot-tempered, low frustration threshold, highly impulsive ▸ Physically aggressive, pro-violence attitudes ▸ Dominating, manipulative, enjoys feeling powerful ▸ Affiliates with other aggressive/bullying teens ▸ Males often physically bigger/stronger than their targets ▸ Lack of parent/adult caregiver supervision/involvement/support

Assessment

Use psychosocial/HEADSSS assessment (D-10) to screen for exposure to/impact of aggressive behavior, intimidation, and violence. With a positive screen, use the FISTS (D-15) mnemonic for a more specific assessment of violence. Information from teen, family, and school is important to assess family dynamics, structure, communication; school behavior/performance; tobacco, drug and alcohol use; psychiatric co-morbidities. Teens with frequent somatic complaints and depression/anxiety symptoms should always be assessed for bullying and trauma.

WARNING SIGNS YOUTH IS BEING BULLIED[1]	WARNING SIGNS YOUTH IS A BULLY[1]
▸ Feelings of rejection, tension, anxiety, fear, helplessness, hopelessness, isolation, and/or sadness ▸ Difficulty concentrating ▸ Avoids and/or dreads going to school ▸ Increased social withdrawal or isolation ▸ Depressed mood, tearful, and/or mood swings ▸ Frequent complaints of illness, aches, and pains ▸ Changes in eating and/or sleeping patterns ▸ Body language: hangs head, avoids eye contact ▸ Threats of hurting self or others ▸ Weapons carried for protection	▸ Boastful and arrogant winner, sore loser ▸ Satisfaction derived from other's discomfort and pain ▸ Activities/behaviors hidden from adults ▸ Excitement gained from conflicts ▸ Blame placed on others for his/her problems ▸ History of discipline and school problems ▸ Pattern of aggressive or delinquent behaviors ▸ Tobacco, alcohol, and/or substance use ▸ Gang involvement ▸ Lack of empathy toward others

Intervention

Helping Targets of Bullying[4]

- Education: Clarify to teen/parents that being bullied is not teen's fault and that bullying is very serious. Advise parents to remove/lock up weapons/lethal items. Provide emergency contact/resource information.
- Counseling: Tell teen you care and are concerned. Acknowledge/encourage teen's assets and talents. Help youth identify non-violent responses to bullying (D-64) and urge him/her to seek help from school/neighborhood center staff. Have teen complete and then discuss the *Taking Care of Myself* worksheet (D-59) and ensure that he/she identifies a trusted adult for help and support. Counsel parents to support and advocate for their teen and help them develop strategies to communicate regularly with their teen and watch for signs of withdrawal or depression (D-54).
- Refer: Refer teen to pro-social community/youth groups, peer counseling/support and to behavioral health provider if teen's emotional well-being and/or functioning deteriorates or co-morbidities are identified such as depression or anxiety. Encourage parents to advocate for school/community violence/bullying prevention and for their teen's protection.
- Follow-up: Provide ongoing adolescent primary care, risk/strength assessment, health promotion and motivational counseling and coordination with behavioral health provider.

Helping Youth Bullies[5]

- Education: Inform parents/youth about the impact of bullying on targets and the seriousness of bullying. Advise parents to remove/lock up weapons/lethal items. Provide emergency contact/resource information.
- Counseling: Tell teen you care and are concerned. Acknowledge, encourage and support youth's assets and talents. Help the youth identify and practice anger management (D-64) and stress management strategies (D-60 to 63). Have the youth complete and then discuss the *Taking Care of Myself* worksheet (D-59) and ensure that he/she identifies a trusted adult for help and support. Assist parents in developing strategies to communicate regularly with their teen, set limits and monitor teen's behavior (D-51, 52, 54).
- Refer: Refer teen to pro-social community/youth activities and peer counseling/support. Refer to behavioral health provider if bullying continues, escalates, interferes with functioning, or if co-morbidities are identified such as substance use or CD/ODD. Encourage parents to advocate that the school/community institute a consistent approach to bullying.
- Follow-up: Provide ongoing adolescent primary care, risk/strength assessment, health promotion and motivational counseling and coordination with behavioral health provider.

[1] SAMHSA, National Mental Health Information Center. Take Action Against Bullying. 2003, http://www.mentalhealth.samhsa.gov/publications/allpubs/SVP-0056
[2] National Youth Violence Prevention Resource Center. Bullying Facts and Statistics. 2003, http://www.safeyouth.org/scripts/faq/bullying.asp
[3] Nansel TR, Overpeck M, et al. Bullying Behaviors Among US Youth. *Journal of the American Medical Association.* 2001; 285(16): 2094-100.
[4] National Youth Violence Prevention Resource Center. Treating a Bullying Victim. 2003, http://www.safeyouth.org/scripts/faq/treatbullyasp.asp
[5] National Youth Violence Prevention Resource Center. Helping a Youth Who Bullies Others. 2003, http://www.safeyouth.org/scripts/faq/helpbullies.asp

Conduct Disorder/Oppositional Defiant Disorder (CD/ODD)

Fast Facts:

Disruptive behaviors reflect an interplay of genetic and environmental factors. About 4% of 13-16 year olds are affected by Conduct Disorder (CD)[1], with boys more likely to be diagnosed than girls (6-16% vs. 2-9%).[2] Current CD diagnostic criteria do not reflect female anti-social behavior well[3], which may account for the discrepancy in prevalence based on gender. While CD is characterized by a recurrent pattern of extreme displays of aggression, violations of rules, and anti-social behavior, Oppositional Defiant Disorder (ODD) is less acute than CD and lacks the characteristics of violation of others' rights and "major age-appropriate societal norms."[4] The incidence of CD increases from childhood to adolescence. Almost all boys with CD also have ODD. However, nearly two-thirds of boys with ODD who did not already exhibit CD, did not go on to develop CD.[3] Early interventions at the first sign of anti-social behavior show more promise than CD treatments.[5] Early development of CD in childhood increases the likelihood of progress to Anti-Social Personality Disorder.[6]

CONDUCT DISORDER VS. OPPOSITIONAL DEFIANT DISORDER[1,4] *(Based on DSM-IV-TR Criteria)*

CONDUCT DISORDER

- Cruel to animals/people
- Initiates fights
- Uses weapons
- Commits robbery/burglary
- Forces sex
- Destroys property
- Sets fires
- Lies to con others
- Violates parent/school rules
- Runs away

OPPOSITIONAL DEFIANT DISORDER

- Often loses temper
- Argues with adults
- Behaves in a defiant, spiteful and/or vindictive manner
- Deliberately annoys others
- Blames others
- Overly sensitive and easily annoyed
- Feels angry/resentful

- Exhibits behavior for > 6 months and behavior disrupts family, school, or community

CD/ODD RISK FACTORS

- Family history and/or household exposure to criminal activity
- ADHD, learning disorders, psychotic or mood disorders
- High impulsiveness
- Low intelligence, weak executive brain function
- Low academic performance
- Poor parental supervision
- Physical or sexual abuse, maltreatment, neglect
- Household conflict and hostility
- Poverty
- Violence in the home or community
- Early initiation of substance use, smoking or sexual activity (i.e. 10-13 yrs old)

CD POTENTIAL OUTCOMES AND CO-MORBIDITIES

- 30-50% of youth with CD meet the criteria for Anti-Social Personality Disorder in adulthood[1]
- Co-morbid symptomology[1]
  - ➡ Approximately 50% have ADHD
  - ➡ 30% depression
  - ➡ 30% anxiety disorder
  - ➡ 30-40% learning disabilities
- Substance use disorder
- Increased risk of marital breakups in adulthood
- Early pregnancy
- Poor employment/school record (drop out)

Assessment

Gather information from the adolescent, and if possible, from family/household members, teachers, and/or probation officers. Screen adolescent with psychosocial/HEADSSS (D-10) assessment during all visits. Use FISTS (D-15) to further assess violent behaviors. The Conners', Child Behavior Checklist, and Vanderbilt are widely used to diagnose and measure the severity of symptoms (D-41, 42). Assess for co-morbidities such as endocrine and neurological disorders, substance use, ADHD, mood and other psychiatric disorders. Obtain information about behavior triggers and settings, stressors and parental/household/school responses to behavior. Determine developmental appropriateness of behaviors.

Intervention

- Safety: Monitor and maintain safety of actively suicidal or homicidal adolescents until they are assessed by trained emergency personnel. Refer to/call 911, police or crisis team. See *Referral Algorithm* (D-13). Advise that adult caregivers remove or lock up guns and weapons (D-53).
- Patient/Parent Education: Inform adolescent and parents about CD and ODD. Emphasize to parents/caregivers the importance of supervision, structure, communication, safety, and consistent non-violent disciplinary methods. Discuss establishing daily routines that include structured socially positive youth activities and family interaction and communication (D-51, 52). Encourage healthy diet, exercise, sleep, and social support. Provide emergency contact/resource information.
- Counseling/Coping Strategies: Recognize, encourage and support youth's assets and talents. Provide motivational counseling (D-8) for anger management and low/moderate substance use (D-34). Brainstorm with teen non-violent ways to solve problems such as walking away from fights.[4] Discuss the completed *Keep the Peace* worksheet (D-64) and ensure that teen identifies a trusted adult for help and support. Encourage parents to recognize and reinforce teen's positive attributes, behaviors and talents.
- Referral: Refer parents/adult caregivers to parent training programs to help manage behavior. Refer adolescent to mental health provider for further evaluation/treatment if adolescent has moderate to high levels of aggressive, impulsive, harmful behaviors or other co-morbid psychiatric/substance use conditions. Treatment may include: anger management programs, family therapy to improve communication, cognitive behavioral therapy to increase problem-solving skills and decrease negativity, and social skills training to increase flexibility. Medications for CD/ODD include stimulants, mood stabilizers, clonidine, anti-convulsants, and typical and atypical anti-psychotics.[7]
- Follow-up: Provide ongoing adolescent primary care, risk/strength assessment, motivational and supportive counseling and referrals to socially positive youth/community programs. Coordinate with behavioral health and human service providers.

[1] Buitelaar JK, Montgomery SA, van Zwieten-Boot BJ. Conduct Disorder. *European Neuropsychopharmacology.* 2003; 13: 305-11.
[2] Searight HR, Rottnek F, Abby SL. Conduct Disorder: Diagnosis and Treatment in Primary Care. *American Family Physician.* 2001; 63(8): 1579-88.
[3] Lahey BB, Loeber R, Quay HC, Frick PJ, Grimm J. Oppositional Defiant Disorder and Conduct Disorder. *DSM-IV Sourcebook.* 1997; 3:195-205.
[4] Loeber R, Burke JD, et al. Oppositional Defiant and Conduct Disorder: A Review of the Past 10 Years, Part I. *J of the AACAP.* 2000; 39: 12.
[5] Loeber R, Lahey BB, Thomas C. Diagnostic Conundrum of Oppositional Defiant Disorder and Conduct Disorder. *Journal of Abnormal Psychology.* 1991; 100: 387.
[6] Loeber R. Antisocial Behavior: More Enduring than Changeable? *J of the AACAP.* 1991; 30(3): 393-7.
[7] Burker JD, Loeber R, Birmaher B. Oppositional Defiant and Conduct Disorder: A Review of the Past 10 Years, Part II. *J of the AACAP.* 2002; 41: 11.

Cutting/Self-Mutilation

Definition: Self-Mutilation

Self-mutilation (also referred to as self-cutting, cutting, deliberate self-harm or auto-aggression) is defined as superficial cutting in response to intolerable tension without conscious suicidal intent.[1,2] This term should not be confused with the term self-harm, which broadly defines many different actions including attempted hanging and impulsive self-poisoning. There are three different types of self-mutilation: major self-mutilation, stereotypic self-mutilation, and superficial or moderate self-mutilation.[3] The most common form of self-mutilation in adolescents is moderate self-mutilation. Behaviors may include cutting, burning, head banging, wound picking, hair pulling, severe scratching, deep biting, and bruising. Instruments used to self-mutilate include razor blades, scissors, paper clips, staples, broken glass, erasers, cigarettes, lighters, and matches.

Fast Facts

It is estimated that between 1.5% and 30% of adolescents self-mutilate.[1,4] Although more than 5% of people who self-harm will attempt suicide, self-mutilators typically do not have suicidal intent. While all acts of self-mutilation are equally divided between males and females, most moderate self-mutilators are women and girls.[2,5] The condition is often episodic and may resolve in time although the outcome is more problematic once the behavior is firmly established and associated with mood and borderline personality disorders. Risk factors for suicide increase in young adults, males, and youth who repeatedly self-harm and have a psychiatric disorder and/or substance use problem. Common reasons why adolescents self-mutilate include reduction/relief of mental pain, anguish, anxiety and/or tension; "depersonalizing" events; feelings of relief and analgesia from endorphin release; coping mechanism; gaining control of one's body. Common sites for self-mutilation include arms, wrists, ankles, lower legs, "hidden" areas such as inner thighs, under breasts, feet, and abdomen.

RISK FACTORS

- Underlying depression, anxiety, or substance use
- Low self-esteem
- Interpersonal difficulties (ex. school, romantic relationships)
- Bulimia or other eating disorders
- Dysfunctional, separated or divorced family
- "Contagion" factor: awareness of self-mutilation by others
- Trauma: physical, sexual and emotional abuse/recurrent abuse

PROTECTIVE FACTORS

- Optimistic outlook
- Adapative coping mechanisms
- Social and family support
- Strongly held religious or cultural beliefs
- Cultural norms that disapprove of self-harm

Assessment

Interview adolescent and when possible, obtain history from parent(s). Psychosocial/HEADSSS assessment (D-10) may reveal self-mutilation behaviors and triggers. Pay attention to behavioral clues during all visits. During the physical exam, look for fresh and healing wounds and scars on extremities and "hidden" areas. Scars, wounds, and burn marks may present as lines, letters, symbols, or designs. Always assess self-mutilating teens for anxiety and depression, triggers, suicidal ideation/intention, and beliefs about the lethality of self-mutilation.

BEHAVIORAL CLUES OF ADOLESCENTS AT RISK FOR SELF-MUTILATION

- Mood swings
- Low self-esteem
- Poor impulse control
- Sadness/tearfulness
- Anger/anxiety
- Disappointment in oneself
- Inability to identify positive aspects of their lives
- Wears long sleeves and pants during hot weather
- Resistance to disrobing
- Avoids activities requiring skin exposure (PE, swimming, outdoor activities)

Intervention

- Safety: Monitor and maintain the safety of actively suicidal or homicidal teens until evaluated by a mental health provider experienced in crisis intervention. Advise the removal/safe-keeping of weapons/lethal means to prevent teen from accessing them. Refer to/contact 911, ER or crisis team. See *Referral Algorithm* (D-13).
- Patient/Parent Engagement and Education: Provide nonjudgemental information about self-mutilation and its medical implications and the importance of healthy diet, exercise, sleep and socialization. Provide emergency contact/ resource information.
- Social Support: Recommend adolescents reach out to family, friends, and supportive adults. Encourage participation in mentor programs, sports leagues, faith-based activities, and/or after-school programs. Discuss available peer counseling services.
- Counseling/Coping Strategies: Acknowledge, encourage, and support youth's assets and strengths. Review effective coping strategies such as active problem solving, information gathering, and identification of substitution behavior that doesn't involve self-mutilation. Review/practice stress reduction exercises (D-60 to 63) and complete/discuss the *Taking Care of Myself* worksheet (D-59) with patient. Ensure teen identifies a trusted adult for help and support.
- Referral: Refer to behavioral health provider if psychiatric co-morbidities are identified or further assessment and treatment is needed. Current treatments for youth who self-mutilate include dialectical behavioral therapy (DBT), cognitive behavioral therapy (CBT) (D-45), substance use treatment, assertiveness and communication skills training, and medication (SSRIs). Provide information and referrals to parents for psychoeducation groups.
- Follow-up: Schedule follow-up visits depending upon acuity and severity of symptoms. Monitor medical complications and provide motivational/ supportive counseling. Provide routine adolescent primary care and anticipatory guidance and coordinate with behavioral health provider.

[1] Skegg K. Self-Harm. *Lancet.* 2005; 366: 1471-83.
[2] Clarke L, Whittaker M. Self-Mutilation: Culture, Contexts and Nursing Responses. *Journal of Clinical Nursing*. 1998; 7: 129-37.
[3] Froeschle J, Moyer M. Just Cut It Out: Legal and Ethical Challenges in Counseling Students who Self-Mutilate. *Professional School Counseling*. 2004; 7(4): 231.
[4] Derouin A, Bravender T. Living on the Edge: The Current Phenomenon of Self-Mutilation in Adolescents. *MCN American Journal of Maternal and Child Nursing.* 2004; 29(1):12-8.
[5] Nichols P. Bad Body Fever and Deliberate Self-Injury. *Reclaiming Children and Youth*. 2000; 9 (3):151-56.

Sources:
1) MacAniff Zila L, Kiselica MS. Understanding and Counseling Self-Mutilation in Female Adolescents and Young Adults. *Journal of Counseling & Development.* 2001; 79: 46-52.

Attention Deficit Hyperactivity Disorder (ADHD)

Fast Facts

ADHD is the most common behavioral health problem among children. 3-5% of school-aged children are diagnosed with ADHD and 65% of those children have symptoms that persist into adolescence. The three types of ADHD are: inattentive, hyperactive-impulsive and combined. 65% have the combined type. Girls are more than twice as likely as boys to have the inattentive type. Three times more males than females are diagnosed with ADHD, and it affects all socioeconomic and racial/ethnic groups. Many are diagnosed in their childhood, but some are diagnosed during adolescence, particularly with the inattentive type. Hyperactivity symptoms decline during childhood while impulsivity and inattentiveness often persist into adulthood. There is a strong genetic component, although the extent of impairment and co-morbidities are influenced by family, school, peers and environmental factors, such as abuse, neglect and family discord.

CHARACTERISTICS OF ADOLESCENTS WITH ADHD

- Low self-esteem
- Accident prone
- Newly emerging academic problems
- Problems with time management, problem solving, organization, following directions, completing tasks
- Problems with peer relationships
- Fidgetiness, feeling of jitteriness/restlessness
- Higher risk of substance use if untreated
- Higher incidence of traffic citations/accidents if untreated
- 2-5x greater risk of co-morbid learning/psychiatric disorders than adolescents without ADHD
  - ➡ 48% have depression/dysthymic disorder
  - ➡ 36% anxiety disorder
  - ➡ 36% oppositional defiant disorder
  - ➡ 25% learning disability
- Family history: ADHD and mood, anxiety, learning, substance-related or antisocial personality disorders

Assessment

Assessment may require 2-3 visits and includes: a thorough medical, psychosocial/HEADSSS, family and ADHD symptom history from patient and parent; physical, neurologic, vision, hearing and mental status exams; information/reports from at least 2-3 school teachers/counselors. Lab tests are not specifically indicated for ADHD. Conditions that can mimic or co-exist with ADHD are seizure disorders, vision/hearing problems, endocrine disorders, CNS trauma/infection, Tourette's/tic disorders (50% have ADHD), chronic/painful disease, mild mental retardation, pervasive developmental disorders, sleep disorders, learning disability, severe anemia, substance and caffeine use/withdrawal, medication (anticonvulsants, antihistamines, bronchodilators) side effects, environmental/psychosocial stressors and other psychiatric conditions – adjustment, depression, anxiety, PTSD, bipolar, conduct, oppositional and eating disorders. Parent and teacher/counselor rating scales such as the Conners', Vanderbilt and Child Behavior Checklist (D-41, 42) can be used to collect baseline information and monitor effects of treatment. If available, student study team reviews, IEP and 504 Plan reports should be reviewed.

PARENT/CAREGIVER AND PATIENT HISTORY

- Inattention/hyperactivity/impulsivity symptoms
- Symptoms manifest in multiple settings (school, home, etc.)
- Age of onset
- Duration of symptoms
- Degree of functional impairment

SCHOOL HISTORY

- Inattention/hyperactivity/impulsivity symptoms
- In and out of classroom behavior and interventions
- Learning abilities/challenges and school attendance
- Degree of functional impairment
- Report cards, teacher evaluations, reports

A. SYMPTOMS OF INATTENTION

- Fails to attend to details; makes careless mistakes
- Difficulty sustaining attention
- Does not seem to listen
- Does not follow instructions or finish work/tasks
- Poor organization
- Avoids/dislikes sustained mental effort
- Loses things
- Easily distracted
- Forgetful in daily activities

B. SYMPTOMS OF HYPERACTIVITY/IMPULSIVITY (I)

- Fidgets/squirms
- Trouble sitting still
- Feels restless/jittery
- Difficulty staying quiet
- On the go
- Talks excessively
- Blurts out answers (I)
- Difficulty awaiting turn (I)
- Interrupts/intrudes on others (I)

DSM IV-TR Diagnostic Criteria (1-5 are all required)

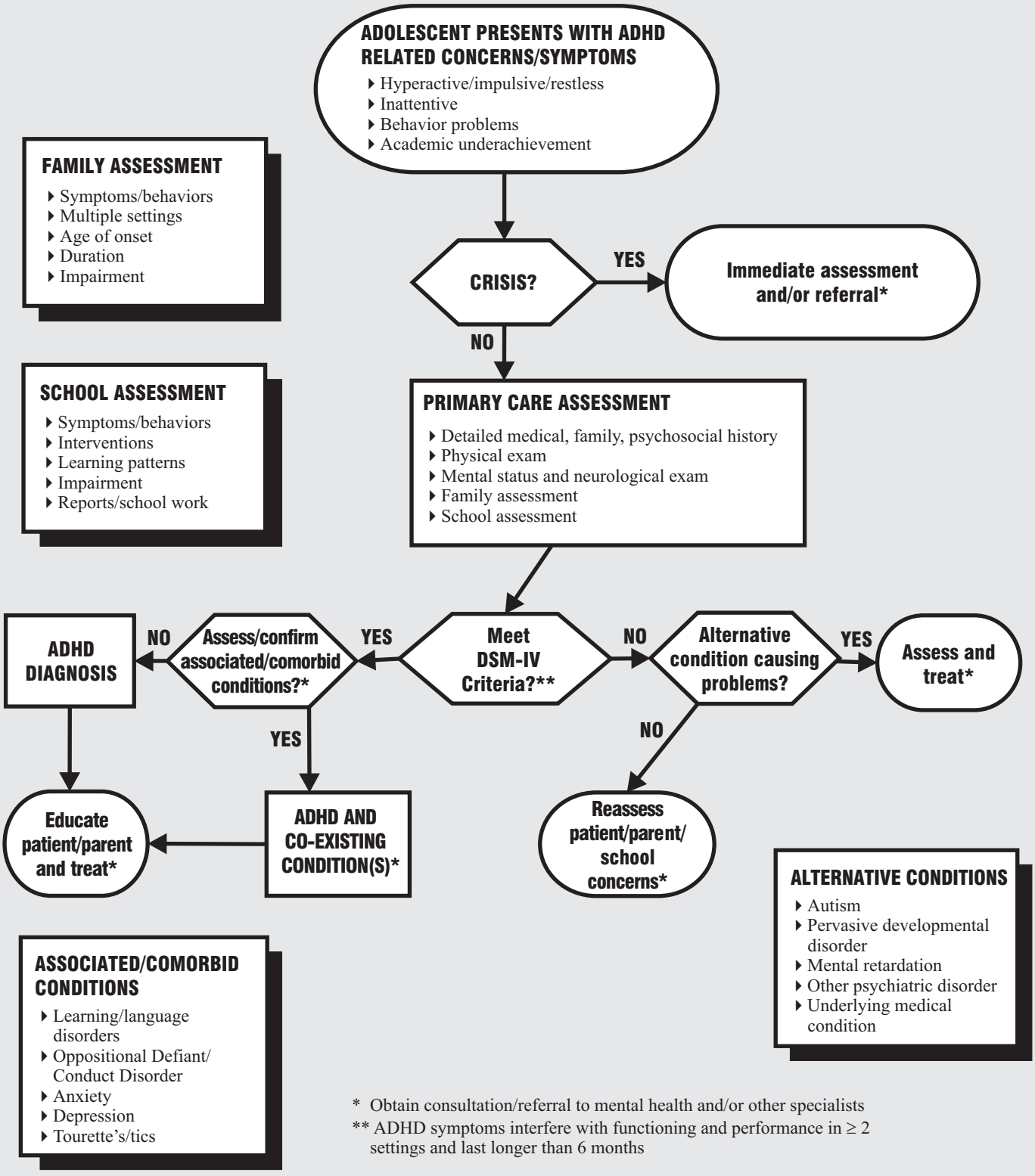
1. > 6 symptoms from group A or B for > 6 months to a maladaptive degree and is inconsistent with developmental level
2. Some symptoms before age 7
3. Some impairment from symptoms in 2 or more settings
4. Clear evidence of significant impairment in social, academic or work functioning
5. Symptoms do not exist solely due to PDD (Pervasive Developmental Disorder i.e. autism or Asperger's), psychotic disorder AND are not better accounted for by another physical or mental disorder

Combined type- If criteria are met from group A and B for at least 6 months.
ADHD Not Otherwise Specified- Prominent symptoms that do not meet full diagnostic criteria. Examples include age of onset after age 7 or symptoms of inattention such as sluggishness, daydreaming and hypoactivity.

Resources:

- Caring for Children with ADHD: A Resource Toolkit for Clinicians. National Initiative for Children's Healthcare Quality (NICHQ). 2002, http://www.nichq.org
- San Diego ADHD. Child and Adolescent Services Research Center. http://www.sandiegoadhd.org

Diagnosis and Evaluation of Attention-Deficit/Hyperactivity Disorder



* Obtain consultation/referral to mental health and/or other specialists

** ADHD symptoms interfere with functioning and performance in ≥ 2 settings and last longer than 6 months

Sources:
1) American Academy of Pediatrics. Clinical Practice Guideline: Diagnosis and Evaluation of the Child with Attention-Deficit/Hyperactivity Disorder. *Pediatrics*. 2000; 105(5):1158-70.
2) Institute for Clinical Systems Improvement. Diagnosis and Management of Attention Deficit Hyperactivity Disorder in Primary Care for School Age Children and Adolescents, 6th Edition. 2005, http://www.icsi.org. Copyright 2005 by ICSI. Adapted with permission.

Treatment Guidelines for ADHD

Once a diagnosis of ADHD without comorbid conditions is made, the treatment should be a coordinated effort among the provider, adolescent, parent/caregiver and school. A combination of psychostimulants and behavioral interventions have been shown to be the most effective approach when functioning is compromised. Obtain consultation from child/adolescent psychologist, psychiatrist or behavioral pediatrician when complications emerge due to co-existing/alternative conditions, treatment response is insufficient or unexpected, or when practice has insufficient time, expertise, training and/or comfort in caring for the adolescent with ADHD and his/her family.

1 Initiate education about ADHD as soon as the diagnosis is made. Patients and parents should understand:

- What ADHD is and that it is a treatable chronic neurological condition that may extend through adulthood;
- The behavioral and medication treatment options;
- That ADHD affects behavior, self-esteem, school/work performance, interactions with family, peers and authority figures;
- The importance of parent/teen's active involvement in establishing, maintaining and modifying treatment goals;
- The value of and resources for psychosocial and peer support for families and teens with ADHD;
- The need for ongoing advocacy and involvement in the school;
- That no one is to blame for ADHD.

2 Develop 3-6 realistic target outcomes with the teen, parent and school to maximize function and guide treatment. Desired treatment targets may include:

- Improved communication/relationships with family members, peers, teachers, counselors, supervisors and other adults;
- Decreased arguments, yelling, crying, or emotional outbursts;
- Improvements in keeping track of assignments and deadlines; homework quantity, quality and timeliness (D-70);
- Following through on home responsibilities, agreements, driving expectations and curfew;
- Increased personal/community safety behaviors such as biking/skateboarding with protective gear and using seatbelts.

3 Provide behavioral interventions in the office or refer adolescents and their families to mental health providers, schools and community organizations for the following:

- Motivational counseling (D-8) to identify or clarify a target outcome, identify barriers and facilitators to achieving success and agreeing on a practical step-by-step approach for behavior change;
- Parent behavior management strategies to establish and maintain consistent daily schedules, expectations, rules, rewards, consequences; reduce distractions; provide positive feedback and reinforcement; model healthy behaviors;
- 8-12 week parent training groups for peer support and to gain knowledge and skills on ADHD, parenting adolescents, adolescent development, family dynamics, and working with schools;
- School, clinic, community and camp-based adolescent psycho-education and support groups focusing on academic, social, behavioral competencies; organizational skills; conflict resolution; building self-esteem and self-efficacy;
- School interventions to improve classroom behavior, academic performance or peer relationships that might include sitting near the teacher or away from distractions, taking un-timed tests, assistance with organization or homework, peer tutor, IEP or 504 Plan (D-56, 57);
- Individual, family or group psychotherapy especially for troubled families or teens with ADHD and co-existing psychiatric disorders.

4 Recommend stimulant medication to improve core ADHD symptoms; 70% will respond to the 1st stimulant:

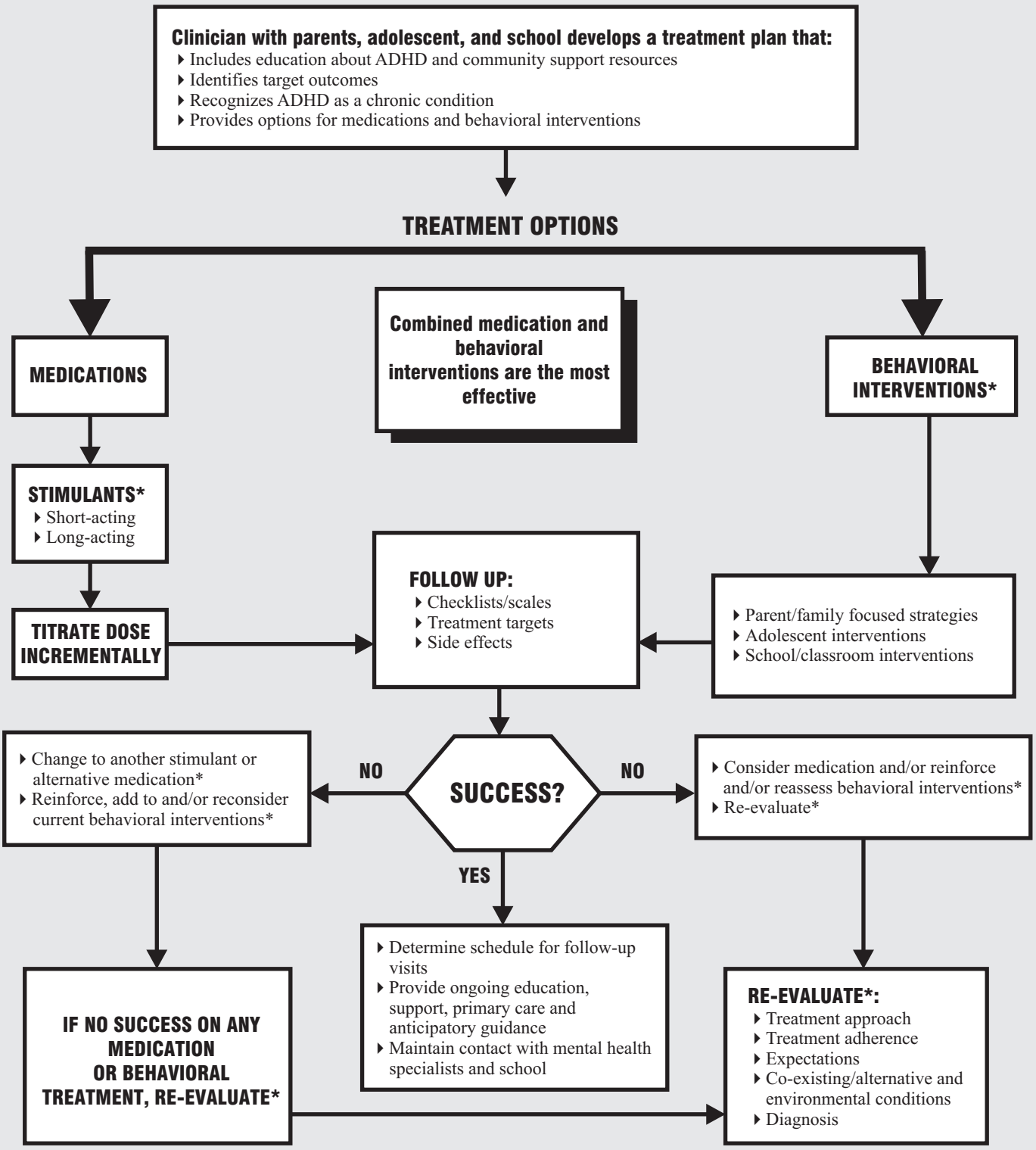
- Start with low doses of a short or long-acting stimulant and titrate upwards as often as weekly over 4-6 weeks until a response based on target outcomes/behaviors is adequate, unacceptable side effects are observed, or the maximum dose has been reached. Base dosing schedules on the severity and timing of target symptoms;
- If the first medication fails, prescribe another stimulant or atomoxetine (Strattera). Most children who fail to respond to 1 medication will respond positively to another stimulant;
- Second tier medications (clonidine, bupropion, tricyclic antidepressants) may be prescribed if 2 or more stimulants have been tried and if clinician is familiar with their use;
- Obtain a psychiatric consultation if these symptoms emerge during treatment: hallucinations or psychotic symptoms, depression or extreme mood swings, significant anxiety, obsessive-compulsive symptoms, increase in ADHD symptoms or tics.

5 Schedule systematic follow-up to monitor target symptoms, academic progress, medication side effects.

- Reassess progress by repeating or using youth, parent and school rating scales, checklists or thorough interim histories;
- Schedule frequent phone or office visits during initial phase of treatment, especially when titrating medication. When treatment goals have been met, schedule visits every 3 months x 2 and then every 6-12 months. Monitor symptoms and medication side effects using *ADHD Monitoring Sheet* (D-23);
- If treatment is successful, provide ongoing education and support to the family, communicate periodically with school personnel, provide routine annual adolescent preventive health care and anticipatory guidance;
- If treatment is not successful, reevaluate treatment approach, adherence, expectations, co-existing and environmental conditions;

Sources:
1) American Academy of Child & Adolescent Psychiatry. Practice Parameters for the Assessment and Treatment of Children, Adolescents, and Adults with Attention-Deficit/Hyperactivity Disorder. *J of the AACAP.* Supplement. 1997; 36: 10.
2) Cincinnati Children's Hospital Medical Center, Health Policy and Clinical Effectiveness Program. Evidence-Based Clinical Practice Guideline for Outpatient Evaluation and Management of ADHD. Guideline 27. 2004, http://www.cincinnatichildrens.org/svc/alpha/h/health-policy/ev-based/adhd.htm.
3) Gotlieb E, Knight J, Ross EC, Shubiner H, Wolraich M, Wibbelsman C, Brown T, Evans S, Wender E, Wilens T. Attention-Deficit/Hyperactivity Disorder Among Adolescents: A Review of the Diagnosis, Treatment, and Clinical Implications. *Pediatrics.* 2005; 115: 1734-46.
4) Schubiner HH, Robin AL. Attention Deficit/Hyperactivity Disorder in Adolescence. *Adolescent Health Update.* 1998; 10(3): 1-8.

Treatment of Attention-Deficit/Hyperactivity Disorder



*Consider consultation/referral to mental health and/or other specialists

Source:

1) Cincinnati Children's Hospital Medical Center, Attention Deficit/Hyperactivity Disorder Guideline Team. Evidence-Based Clinical Practice Guideline for Outpatient Evaluation and Management of Attention Deficit/Hyperactivity Disorder. 2004; Guideline 27: 1-24. http://www.cincinnatichildrens.org/svc/alpha/h/health-policy/ev-based/adhd.htm Adapted with permission.

Name:_____

ADHD Monitoring Sheet

Date:_____

SYMPTOMS

For each symptom, circle the number that describes how much of a problem it was this week.
1= Not a Problem 3= Somewhat a Problem 5= Severe Problem

1 2 3 4 5
Trouble paying attention

1 2 3 4 5
Hard to stay still

1 2 3 4 5
Trouble finishing school work

1 2 3 4 5
Hard not to blurt out things or interrupt

1 2 3 4 5
Trouble finding or keeping track of things

1 2 3 4 5
Trouble finishing chores or tasks at home

1 2 3 4 5
Got into arguments or fights with others

1 2 3 4 5
Got into trouble for not listening

MEDICATIONS

Name of Medication:

_____

_____

Take When?

Morning During School After School

Morning During School After School

How Much?

_____

_____

SIDE EFFECTS

For each side effect, circle the number that describes how much of a problem it was this week.
1= Not a Problem 3= Somewhat a Problem 5= Severe Problem

1 2 3 4 5
Trouble falling asleep

1 2 3 4 5
Too sleepy

1 2 3 4 5
Not feeling hungry

1 2 3 4 5
Trouble with eyes

1 2 3 4 5
Feeling grouchy or irritable

1 2 3 4 5
Stomach aches

1 2 3 4 5
Feeling restless or fidgety

1 2 3 4 5
Feeling thirsty a lot

Source:
1) Children's Medication Algorithm Project, Texas Dept. of State Health Services. *ADHD Monitoring Sheet.* 2004. www.dshs.state.tx.us/mhprograms/CMAPed.shtm. Adapted with permission.

Anxiety

Fast Facts

Anxiety is one of the most common behavioral health problems among adolescents. While up to 70% of teens have fears and worries about school, peers, and family, their anxiety symptoms are not excessive or disabling. 10-15% display symptoms consistent with an anxiety disorder and 4-7% have symptoms that cause significant distress or interference.[1] Adolescent females are twice as likely as males to have an anxiety disorder especially phobias, Panic Disorder, and Social Anxiety Disorder. Studies have shown that adolescents with anxiety disorders have increased rates of anxiety, depression, drug dependence, and educational underachievement as young adults. Long-term prognosis depends on severity of symptoms, availability and response to treatment, family history, coping abilities, and protective factors. The three contributors to the expression of anxiety disorders are environment (traumatic event, stressor), genetics (50% have an affected family member) and neuron-hormonal dysfunction (especially OCD and PTSD).[2]

Common Anxiety Disorders[3]

DISORDER	DESCRIPTION
Panic Disorder	Recurrent and unanticipated panic attacks with persistent worry about further or unexpected attacks. Occurs with or without agoraphobia - anxiety about or avoidance of places/ situations where escape is difficult/embarassing or help may be unavailable. Panic attack is a sudden onset of intense worry, fear, or terror often associated with feelings of impending doom. Symptoms: shortness of breath, palpitations, chest pain/discomfort, sweating, trembling, paresthesias, choking sensation, and/or feeling/fear of "going crazy" or losing control. Panic attacks can accompany any anxiety disorder and medical condition.
Specific Phobia	Clinically significant anxiety for 6 months or more that is provoked by exposure to or anticipation of a feared object/ situation, often leading to avoidance behavior.
Social Phobia or Social Anxiety Disorder (SAD)	Clinically significant anxiety in response to certain social or performance situations, often leading to avoidance behavior. SAD may emerge from childhood shyness or social inhibition.
Obsessive Compulsive Disorder (OCD)	Recurrent, unwanted, and intrusive thoughts and actions accompanied by anxiety symptoms. Obsessions are recurrent thoughts, images, and impulses that may be understood as excessive or unreasonable, yet are ignored, suppressed, or neutralized by compulsive thoughts/actions. Compulsions (hand washing, counting, checking) are aimed at preventing or reducing anxiety. The prevalence in children and adolescents is 1-4%.
Acute/Post-Traumatic Stress Disorder (ASD/PTSD)	Reexperiencing an extremely catastrophic event or series of traumatic events with symptoms of increased arousal and avoidance of trauma-associated stimuli. See *ASD/PTSD Issue Brief* (D-25).
Generalized Anxiety Disorder (GAD)	$\geq$ 6 months of chronic, excessive, and exaggerated worry that is difficult to control. Symptoms: difficulty relaxing, fatigue, and chronic aches and pains. The symptoms cause clinically significant distress or impaired social, school or family functioning.

CHARACTERISTICS/RISK FACTORS OF ADOLESCENTS WITH ANXIETY DISORDER

- Avoidance behaviors
- Low self-esteem
- School refusal
- Difficulty concentrating
- Decreased motivation
- Suicide attempts
- Family history of anxiety
- History of trauma and/or life stressors
- Co-morbid conditions:
  - 50% have a second anxiety disorder[1,4]
  - 5-30% have depression or other mood disorder[1,4]
  - 15-24% have ADHD[4]
  - 50% with panic disorder have mitral valve prolapse[4]

Assessment

The standard assessment for anxiety involves self-report and, if appropriate, an interview with parent(s). Conduct a thorough medical and psychosocial/HEADSSS assessment (D-10), review of symptoms, and physical exam to rule out medical disorders, substance use, and psychiatric disorders, such as depression (D-27) and ADHD (D-19), that cause or co-exist with anxiety. Ask about past or current use of prescription, OTC, or recreational drugs that may cause anxiety – antihistamines, bronchodilators, sympathomimetics, steroids, cold preparations, neuroleptics, psychotropics, amphetamines, caffeine, cocaine, alcohol, and/or sedatives. Signs/symptoms of anxiety: decreased attention/concentration, irritability, sleep changes, sweating, headache, tachycardia, palpitations, systolic click murmur, hyperventilation, chest tightness/pressure, choking sensation, labile hypertension, GI symptoms, muscle tension/spasm, backaches, paresthesias, dizziness, syncope, flushing, shaking, unrealistic/excessive worry or nervousness, intrusive thoughts, and fear of doom/dying or going "crazy." Note symptom onset, duration, frequency, character, triggers, relievers, aggravators, and impact. Rule out hyperthyroidism, caffeinism, medication/drug/alcohol use or withdrawal, other psychiatric conditions, migraine, asthma, pneumonia, seizure disorder, hyperparathyroidism, hypoglycemia, pheochromocytoma, brain tumor, cardiac disorders, mitral value prolapse (especially in Panic Disorder), vitamin deficiencies, and irritable bowel disease.

Anxiety (continued)

Intervention

Adolescents with an anxiety disorder and another co-morbid psychiatric disorder, OCD, significant functional impairment, and/or an unclear diagnosis should be referred to a mental health provider.

- Safety: Monitor and maintain the safety of adolescents who are actively suicidal or homicidal until they are assessed by a mental health provider experienced in crisis intervention. Refer to/contact 911, police or crisis team. See *Referral Algorithm* (D-13). Advise removal/safe-keeping of weapons and other lethal means to prevent teen from harming self or others.
- Patient/Parent Engagement and Education: Provide education about anxiety and review treatment options with teen and family. Remember that an adolescent with an anxiety disorder has a high likelihood of having a parent with an anxiety disorder.[1] Emphasize to parents the importance of talking with their teen on a regular basis about reacting to stressful situations and dealing with problems and challenges (D-51, 52). Reinforce the importance of healthy diet, exercise, sleep, socialization and social support. Provide emergency contact/resource information.
- Coping Strategies: Acknowledge, encourage, and support teen's assets and talents. Discuss the adolescent's current coping methods and guide him/her towards more effective strategies such as making behavioral, cognitive, and environmental changes. Utilize the *BATHE* approach (D-7) to actively problem solve with the teen. Review/practice stress reduction exercises (D-60 to 63). Have him/her complete and then discuss the *Taking Care of Myself* worksheet (D- 59). Ensure teen identifies a trusted adult for help and support.
- Medications: Cautious short-term use of sedatives, as part of an overall treatment plan, may provide relief of acute anxiety symptoms. Monitor closely for drowsiness, agitation, confusion and irritability. SSRIs are the medications of choice for treatment of anxiety disorders and are indicated when symptoms are moderate to severe, impairment makes participation in psychotherapy difficult, or psychotherapy results in a partial response. SSRIs are generally well tolerated.
- Referral: Refer adolescent and, if appropriate, refer parent to a behavioral health provider for further evaluation and treatment. Cognitive behavioral therapy (CBT) has been found to be the most effective for managing anxiety and is the treatment of choice for PTSD, OCD, and SAD. Specialized treatment approaches are also used for SAD and specific phobias.
- Follow up: Arrange follow up according to acuity and severity of symptoms. Provide routine adolescent primary care, anticipatory guidance and supportive and motivational counseling. Coordinate with behavioral health provider.

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[2] Kelly MN. Recognizing and Treating Anxiety Disorders in Children. *Pediatric Annals.* 2005; 34(2): 147-50.
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Sources:
1) AACAP. Practice Parameters for the Assessment and Treatment of Children and Adolescents with Anxiety Disorders. *J of the AACAP.* 2007; 46(2): 267-83.
2) Rosen S. Management of Mental Illness in Primary Care Practice: Part 2. *Adolescent Health Update.* 2005; 18 (1): 1-8.

Trauma and Acute/Post-Traumatic Stress Disorders (ASD/PTSD)

Definitions: ASD/PTSD

PTSD is a unique anxiety disorder because its onset depends on exposure to a traumatic event. PTSD criteria include: (1) exposure to an extremely traumatic stressor(s) with a response of fear, helplessness or horror, (2) development of reexperiencing, avoidance/numbing and increased arousal symptoms for at least 1 month, (3) clinically significant distress/impaired functioning results from the trauma. ASD is similar to PTSD except symptom duration is greater than 2 days and less than 1 month. ASD often precedes PTSD.[1]

Fast Facts

Over 5 million US children and adolescents are exposed to extreme traumatic stressors each year. These traumatic events include natural disasters, automobile accidents, life-threatening illnesses, painful medical procedures, physical abuse, sexual assault, witnessing domestic violence, exposure to community violence, death of a parent/caregiver, and refugee experience among others. More than 30% of these youth will develop Post-Traumatic Stress Disorder.[2] In a nationally representative sample of 12-17 year olds, overall prevalence of PTSD was 3.7% in males and 6.3% in females.[3] In the National Comorbidity Survey, the 12 month prevalence in 15-24 year olds was 5% for males and 10.4% for females.[4] Those who do not meet the diagnostic criteria for PTSD may have trauma-related reactions such as difficulty achieving a strong sense of self-efficacy, difficulty regulating emotions, somatic symptoms and sleep disturbances, feeling helpless or hopeless, and emotional numbing.[5]

The natural course of PTSD has not been adequately determined in adolescents. PTSD symptoms are common soon after exposure to trauma, although there may be a delay of months or years before symptoms appear. 50% have complete recovery in 3 months but many others have persisting symptoms for longer than 12 months after trauma. Symptom reactivation may occur in response to trauma reminders, life stressors and new traumatic events. The disorder may be especially severe or long lasting when stressor violates personal integrity (physical assault, rape). The likelihood of developing PTSD varies with severity, duration and proximity of the stressor, media re-exposure (when relevant) and the underlying resiliency of the affected individual and family. Exposure to multiple traumatic events, especially within the caregiving environment, can have long lasting sequelae that extend beyond PTSD including suicidality, disruptive behaviors, substance use and relationship, school and work problems.[6]

Trauma and ASD/PTSD (continued)

RISK FACTORS[2,7]

- **Proximity to trauma and perceived physical threat**
- **Direct physical and emotional harm resulting from trauma**
- **Chaotic, distant, absent, or anxious family/support system**
- High level of anxiety
- Maladaptive coping style
- Low self-esteem
- Pre-existing ADHD, depression, neurodevelopmental disabilities
- Chronic exposure to violence
- Childhood sexual or physical trauma
- Family history of psychiatric disorders, PTSD
- Females are 2 to 3 times more likely to develop PTSD than males

PROTECTIVE FACTORS[2,5]

- Structured, predictable, and nurturing family/support system
- Involvement in academic and extracurricular activities
- Well-developed sense of self
- Appropriate coping skills
- Internal locus of control
- Strong social skills
- Flexibility
- Sense of humor
- Empathy
- Optimism about the future

Assessment

Use direct, empathic, nonjudgmental questioning when screening adolescents for exposure to trauma and violence using a psychosocial/HEADSSS assessment (D-10). Ask teen and when appropriate, adult caregivers, direct questions about the trauma and its effect on their lives.[8] The Traumatic Events Screening Inventory- Child Version can be used to assess for PTSD (D-42). Many teens will exhibit symptoms similar to anxiety disorder, especially panic attacks, and depression in response to trauma. They may feel guilty and/or blame him/herself for the trauma or for surviving and may be ashamed to disclose the traumatic event(s) and/or resulting symptoms. Also, teens may not connect their symptoms to the trauma.

POST-TRAUMA and ASD/PTSD SYMPTOMS[7]

RE-EXPERIENCING	Recurrent and distressing memories, flashbacks, and/or dreams of the trauma; acting or feeling as if the trauma is recurring (reenactment); intense distress when exposed to cues that symbolize or resemble an aspect of the trauma
AVOIDANCE/NUMBING	Persistent avoidance of things, places, people, thoughts, feelings, or conversations associated with the trauma; amnesia of an important part of the trauma; diminished interest or participation in usual activities; feelings of detachment or estrangement from others; efforts to distance oneself from feelings
INCREASED AROUSAL	Sleep difficulties, irritability, angry outbursts, difficulty concentrating, extra vigilance, exaggerated startle response
AFFECT DYSREGULATION	Difficulty modulating intense emotion

Common co-morbidities of post-trauma symptoms include depression, anxiety, substance use, memory and cognition problems, and medical conditions such as irritable bowel disease, chronic fatigue, and reproductive health problems. Other common adolescent reactions to trauma include decline in school performance and increase in risk-taking behaviors (ex. alcohol/substance use, unprotected sex).[5]

Intervention

- Safety: Monitor and maintain the safety of adolescents who are actively suicidal/homicidal until they are assessed by a mental health provider experienced in crisis and trauma intervention. Refer to/contact 911, police or crisis team. *See Referral Algorithm* (D-13). Advise removal/ safe-keeping of weapons/other lethal means to prevent teen from harming self or others.
- Patient/Parent Education and Reassurance: Explain normal reactions to trauma such as nightmares, anxiety, depression, anger, irritability, and guilt. Emphasize that the patient is not at fault for the trauma. Reinforce the importance of healthy diet, exercise, sleep, family communication, socialization and social support. Provide emergency contacts/local resources pertinent to teen's type of trauma.
- Psychosocial Support: Recommend adolescents reach out to family, friends, and supportive adults. Encourage participation in mentor programs, sports leagues, faith-based activities, and/or after-school programs. Discuss available peer counseling services. Make sure parents know how important their support and availability is to their teen. (D-51, 52)
- Counseling/Coping Strategies: Provide 1 or 2 supportive counseling sessions during the first 2 weeks after trauma exposure and evaluate need for specialized intervention. Review effective coping, problem-solving, and stress reduction strategies with teen (D-60 to 63). Ask teen to complete and discuss the *Taking Care of Myself* worksheet (D- 59). Ensure teen identifies a trusted adult for help and support.
- Referral: Refer teen and, if appropriate, adult caregiver to mental health provider/program when post-trauma symptoms impair functioning at home, school or community, whether or not diagnostic criteria is met. Trauma-focused cognitive behavioral therapy (CBT) has been found to be the most effective treatment for PTSD. This therapy includes direct exploration of the traumatic event(s) in a safe setting; stress management techniques (muscle relaxation, thought-stopping, guided imagery); and systematic exploration of teen's feelings of guilt/insecurity.[8]
- Medications: Cautious short-term use of sedatives, as part of an overall treatment plan, may be used in the acute stage to treat target symptoms such as nightmares, difficulty sleeping, anxiety and headaches. Closely monitor side effects such as drowsiness, agitation, confusion and irritability. SSRIs are considered the long-term treatment of choice for moderate to severe PTSD.[9]
- Follow-up: Arrange follow-up according to acuity and severity of symptoms and provide routine adolescent primary care, anticipatory guidance and supportive and motivational counseling. Coordinate care with behavioral health provider.

[1] American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision*, 2000.
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[3] Kilpatrick DG, Ruggiero RA, et al. Violence & Risk of PTSD, Major Depression, Substance Abuse/Dependence, & Co-morbidity: Results from the Nat'l Survey of Adolescents. *J Consult Clin Psych*. 2003; 71:692-700.
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[8] Cohen J. Summary of the Practice Parameters for the Assessment and Treatment of Children and Adolescents with Posttraumatic Stress Disorder. *Journal of the AACAP.* 1998; 37(9): 997-1001.
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[8] Brown EJ. Clinical Characteristics and Efficacious Treatment of Posttraumatic Stress Disorder in Children and Adolescents. *Pediatric Annals.* 2005; 34(2): 138-46.
[9] Ballenger JC, Davidson JT, et al. Consensus Statement on Posttraumatic Stress Disorder From Internat'l Consensus Grp on Depression & Anxiety. *J of Clin Psychiatry*. 2000; 61(Suppl 5): 60-66.

Depression

Definitions

Major Depressive Episode: symptoms that last most days for > 2 weeks and cause a major change in functioning. Symptoms: persistent depressed/irritable/sad mood and/or loss of pleasure/interest in usual/once enjoyed activities **and** four of the following: 1) major weight loss/gain, appetite change, 2) insomnia or hypersomnia, 3) observable psychomotor agitation or retardation, 4) fatigue or loss of energy, 5) feelings of worthlessness or inappropriate guilt, 6) decreased ability to think, make decisions, concentrate, 7) recurrent death/suicidal thoughts or suicide attempt.

Major Depressive Disorder (MDD): >2 major depressive episodes separated by at least 2 months. Symptoms cause clinically significant distress/impairment in home, social, academic/occupational or other areas of functioning.

Dysthymic Disorder (DD): milder, more chronic, less disabling but more persistent depressed mood than MDD for >1 year. Includes >2 symptoms of major depression. Average episodes last 3-4 years. 70% with DD develop MDD.

Bipolar Disorder (BPD)/Manic-Depressive illness: begins with manic, depressive, or mixed symptoms. Risk is higher in children of bipolar parents. 20 - 40% of teens with MDD develop BPD <5 years after depression onset. Early adolescent onset may present with continuous rapid-cycling and mixed symptom state, and may co-occur with conduct disorder (CD) or ADHD. Later adolescent onset may be sudden and present as classic mania. Depression and manic episodes may alternate, with relatively stable periods between episodes, and with less co-occurring CD and ADHD. Manic symptoms: extreme mood changes, intensely euphoric to irritable, grandiose, hyper-energetic, needing little sleep, pressured speech, very distractible, hypersexual, intensely goal-directed, physically agitated, reckless.

Fast Facts

It is estimated that 20% of youth will have at least 1 episode of major depression before they reach age 18. Depression reflects a complex interplay of genetic, neurobiological, psychosocial, and personality factors. It greatly affects and is affected by co-existing physical and psychiatric conditions. Depression prevalence increases with age and puberty. Over the last 60 years, prevalence has increased and the age of onset has decreased. In the general adolescent community, MDD prevalence is estimated at 4 - 8%, and 1.6 - 8% for dysthymia. Many more youth have depression symptoms as revealed by the 2005 CDC Youth Risk Behavior Survey– 36% of Latino/Hispanic, 28% of black and 26% of white US high school students felt sad or hopeless every day for > 2 weeks. The 2005 California Health Interview Survey found that 22% of Asian teens were at risk for depression.[1] The gender ratio for depression in adolescents is 2 females:1 male compared to children with a 1:1 ratio.

Depressive symptoms, episodes and disorders can have far reaching effects on teen functioning and adjustment. Increased depressive symptoms, even without MDD, predisposes to later development of recurrent depression, other mental health disorders, low educational achievement, poor physical health, substance use and social isolation. The typical duration for an untreated MDD episode in teens is 7 to 9 months. Recovery is the rule, but recurrence is common. 20-40% of adolescents will relapse within 2 years, and 70% will do so within 5 years. Predictors of increased risk for MDD recurrence include younger age at onset, increased number of previous episodes, increased severity of index episode, increased psychosocial stressors, other comorbid disorders, psychosis, and unsuccessful treatment. Depression is a leading risk factor for youth suicide. 41% and 21% of depressed youth reported suicidal ideation and suicide attempts.[2]

RISK FACTORS

- Genetics: 20-50% of depressed youth have a family history of depression or mental health disorder; female gender
- Biologic: hormonal changes – puberty, premenstrual, post-partum
- Environment: mental health/substance use disorders in household; increased family conflict; early parent death; past/current abuse; discrimination; poverty
- Negative Life Events: death or loss of parent, loved one, friend, romantic relationship, important person; parental divorce/separation; major stress/trauma
- Individual factors: drug/alcohol/tobacco use; high anxiety or self-criticism; poor self-esteem, school performance, social skills
- Co-morbidities: 40-70% have substance use, anxiety, ADHD, eating, CD/ODD, learning disorders; chronic conditions (i.e. diabetes, asthma, cancer, AIDS)

PROTECTIVE FACTORS

- No history of family mental health or substance use disorders
- Physically/mentally healthy
- Healthy/supportive household members
- Close family relationship
- Optimism
- High self-esteem
- Strong social/communication skills
- Access to resources

Assessment

Interview the adolescent alone and, if appropriate and possible, include the input of adult caregivers and teachers/counselors. Teens are better reporters of their emotions and parents/teachers are better observers of behaviors. Screen adolescent using a psychosocial/HEADSSS assessment. The Center for Epidemiological Studies Depression Scale for Children (CES-DC) is one of many assessment tools (D-41) that aids assessment. If depression is suspected, determine symptom severity and duration; triggers/relievers; impact on home, school, work, social functioning; current/past suicidal ideation, intent and means to self harm. Substance use, aggressive behavior and past suicide attempts increase risk of suicide (D-31). A complete past/current substance use history should include prescribed, OTC and recreational drugs. Look for medications with depression side effects such as corticosteroids, hormonal contraceptives, neuroleptics, beta-blockers, benzodiazepines, Clonidine and Accutane. Perform a ROS, PE and lab tests (per history and PE) to rule out conditions that mimic depression such as thyroid disease, anemia, mononucleosis, HIV, hepatitis, chronic fatigue, inflammatory bowel and collagen vascular disease, and CNS disorders. Assess for psychiatric co-morbidities and bipolar symptoms/family history since teens susceptible to bipolar disorder may become agitated or develop mania while on antidepressants.

Signs/symptoms: withdrawal from friends and usual interests; eating, appetite, sleeping changes; frequent vague aches, pains and fatigue; slow movements; increased irritability, anger, hostility, shouting, crying; feeling worthless or inappropriately guilty; highly sensitive to rejection/failure; trouble concentrating or making decisions; thoughts, fears, plans of death/suicide; increased risky behaviors, acting out; boredom; hopelessness; poor communication and trouble with relationships; alcohol/substance use; decreased school performance/attendance; talk of/attempts to run away from home.

Depression (continued)

Adolescent Depression Symptom Mnemonic

A nhedonia (loss of pleasure/interest in usual or once enjoyed activities) and/or irritable, sad, depressed mood

S leep disturbance

A gitation/psychomotor retardation

D ecisions, concentration, thinking impaired

S uicide attempt, recurrent death/suicidial thoughts

A ppetite/weight change

G uilt or worthlessness

E nergy loss/fatigue

To fulfill the definition for a Major Depressive Episode per DSM-IV-TR criteria, anhedonia or mood changes **and** four other symptoms from SADSAGE must be present most of the day for at least 2 weeks, accompanied by significant impairment in school/work, home, and/or social functioning.

Other signs/symptoms: withdrawal from friends; frequent vague aches/pains; highly sensitive to rejection/failure; increased risky behaviors/acting out; pervasive boredom and blues; hopelessness; poor communication and trouble with relationships; alcohol/substance use; decreased school performance/attendance; talk of/attempts to run away from home.

Intervention

The American Academy of Child and Adolescent Psychiatry recommends all adolescents with depression receive psychotherapy, even if they are taking antidepressants. Combination treatment has been found to be more effective than either medication or psychotherapy alone.

- Emergency: Monitor/maintain safety of actively suicidal/homicidal adolescents pending evaluation by mental health provider experienced in crisis intervention. Refer to/call 911, ER or crisis team. See *Referral Algorithm* (D-13). Urge safe keeping/no access to weapons and other potential suicide methods.
- Engagement/Education: Recruit teens/parents as treatment partners. Provide information about stigma, depression causes, prevalence, signs/symptoms, mind-body connection, treatment options and emergency contacts/referrals. Review the importance of healthy diet, exercise, sleep (D-40), socialization, social support and routine adolescent primary care.
- Social Support: Recommend reaching out to family, friends, and trusted adults. Encourage participation in mentor programs, sports leagues, faith-based activities, and/or after-school programs. Discuss peer counseling services.
- Counseling/Coping Strategies: Acknowledge, reinforce and support teen's strengths, talents and insights. Provide supportive counseling to parents to address their own guilt, blame, concerns and coping needs. Use motivational interviewing techniques (D-8) to assist teen in problem solving, communication, increasing healthy behaviors and decreasing substance use (D-68, 69). Recommend and practice stress reduction exercises (D-60 to 63). Have the teen complete and then discuss the *Taking Care of Myself* worksheet (D-59) and ensure teen identifies a trusted adult is identified for help and support.
- Referral: Refer adolescents with suicidal/homicidal ideation, impaired functioning, treatment unresponsiveness, psychotic (hallucinations, paranoia) or bipolar symptoms, alcohol/drug use and other co-morbid conditions, and/or unclear/complicated diagnoses to a behavioral health provider. Short-term cognitive behavioral therapy (CBT) and interpersonal therapy (D-45) have proven to be effective adolescent depression treatments. Family therapy is also used. Continuing psychotherapy for several months after symptoms subside may help patients and families consolidate the skills learned during the acute phase of depression, cope with depression after-effects, effectively address environmental stressors, and understand how the teen's thoughts/behaviors could contribute to a relapse.
- Medications: *Providers lacking time, comfort and/or expertise should refer patients to a psychiatrist for medication evaluation and monitoring.* If psychotherapy response is insufficient after 6-8 weeks or symptoms are moderate/severe, an anti-depressant should be prescribed. SSRIs are one of the few classes of antidepressants with proven effectiveness in adolescents and are the first line of pharmacologic treatment for moderate/severe depression. Discuss medication benefits, risks (agitation, irritability, mania, suicidality), slow (6-10 week) response time for full benefits, and importance of adherence. **Youth and adult caregivers must be encouraged to call with any medication difficulties.** Start an SSRI at a low dose. If well tolerated for 1 week, it can be increased to the lowest effective therapeutic dose. Due to side effects, many teens discontinue medications during the first few weeks of treatment. Therefore, assess every 1-2 weeks until symptoms/side effects subside and a stable dose is reached. Maximal symptom response should be achieved at 4 to 6 weeks of a consistent dose. The dose can be increased every 4 weeks with no or partial responses. Use a standard tool to monitor symptoms and side effects such as the *Depression Monitoring Sheet* (D-30). Following symptom remission, treatment with medication and/or psychotherapy is recommended for at least 6-9 months due to the high risk of relapse and depression recurrence. When medications are discontinued they should be tapered over 6 weeks or longer.
- Follow-up: Provide ongoing adolescent primary care, anticipatory guidance, supportive and motivational counseling to teen and parents and monitor as indicated by symptom acuity and severity and treatment modalities. Coordinate care with behavioral health provider.

Resources:

- Guide Lines for Adolescent Depression in Primary Care (GLAD-PC), Columbia University, www.kidsmentalhealth.org/GLAD-PC.html
- MacArthur Initiative on Depression and Primary Care, Dartmouth and Duke, www.depression-primarycare.org

[1] California Health Interview Survey. Teen at risk for depression after screening with Center for Epidemiological Studies Depression Scale then compared by race/ethnicity for the entire state of California. 2005, http://www.chis.ucla.edu

[2] Lewinsohn PM, Rohde P, Seeley JR. Major Depressive Disorder in Older Adolescents: Prevalence, Risk Factors, and Clinical Implications. *Clin Psychol Rev.* 1998; 18: 765-94.

Sources:
1) Nat'l Institute of Mental Health. Depression in Children and Adolescents: A Fact Sheet for Physicians. 2000, http://www.nimh.nih.gov/publicat/NIMHdepchildresfact.pdf
2) Richardson LP, Katzenellenbogen R. Childhood & Adolescent Depression: Role of Primary Care Providers in Diagnosis & Treatment. *Curr Prob Ped Adol Health Care*, 2005; 35(1): 6-24.
3) American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision*, 2000.

Primary Care Practice Guidelines for Adolescent Depression

ESTABLISH RAPPORT AT EACH VISIT

- See teen alone
- Be friendly and nonjudgmental
- Appear unhurried and actively listen
- Define confidentiality and its limits
- Seek permission before asking sensitive questions
- Compliment adolescent's strengths, talents and insights
- Address stigma and resistance
- Involve family w/ teen's assent

SCREEN FOR DEPRESSION AT EACH VISIT

- Ask how life is going and about recent changes in home, school/work, relationships (D-10)
- Screen for mental health problems, substance use, risky behaviors, chronic conditions, headaches, abdominal pains and fatigue

FEATURES OF MAJOR DEPRESSION DETECTED?

(Symptoms for most days for ≥ 2 weeks and major change in family, home, school or social functioning)

- **Anhedonia and/or irritable/sad/depressed mood and four symptoms from SADSAGE:**
- **S**leep disturbance
- **A**gitation/psychomotor retardation
- **D**ecisions, concentration, thinking impaired
- **S**uicide attempt, recurrent death/suicidal thoughts
- **A**ppetite/weight change
- **G**uilt or worthlessness
- **E**nergy loss/fatigue

Other signs/symptoms: pervasive blues & boredom, aches and pains, social isolation, high risk/acting out behaviors, school problems, outbursts

ASSESS SUICIDE RISK (D-31)

Observe/ask directly:

- **P**lan
- **L**ethality
- **A**ccess to means
- **I**llness
- **D**epression
- **P**rior suicide attempts
- **A**lone
- **L**oss
- **S**ubstance use

Suicide risk increases with:

- Mental health disorder
- Previous suicide attempt
- Drug/alcohol use
- Stressful life events
- Suicide plan

HIGH RISK SUICIDE (D-31)

- Refer to/contact 911, ER or crisis team
- Do NOT allow teen to leave office without safety plan
- Explain course of action to keep teen safe
- Inform family/adult caregivers and ask them to monitor and support, if appropriate
- Strongly advise family to remove lethal weapons/means from home

POST CRISIS INTERVENTION

- Provide education, support, motivational counseling and follow-up primary care
- Coordinate care with parents, mental health provider and school
- Develop personal plan (D-59)
- Ensure follow-up care & appointment with behavioral health provider

REFERRAL CONSIDERATIONS: ARE ANY OF THE FOLLOWING PRESENT?

- Unclear/complex diagnosis
- Worsening/unresponsive symptoms
- Co-morbidity present: ADHD, substance use, disorders-anxiety, eating, bipolar or psychosis
- Further evaluation is needed for diagnosis, medication and/or therapy
- Proper patient care exceeds provider's expertise, time or resources

Refer ASAP to behavioral health program or psychiatrist with experience and comfort treating teens to ensure appropriate evaluation and treatment.

Determine if teen was seen by behavioral health provider. If yes, coordinate care. If no, ensure behavioral health follow-up and transitional (D-13) and routine primary care.

MODERATE/SEVERE DEPRESSION & NOT CURRENTLY SUICIDAL

- Strongly recommend and encourage referral to behavioral health provider
- Provide education/counseling to teen and family: safety, risk and protective factors, warning signs, natural history and prognosis, treatment, support, stigma
- Coordinate with school, employer, counselors and others to support teen
- Provide transitional care (D-13) while waiting for behavioral health care to start
- Develop personal plan (D-59)
- Consider prescribing anti-depressant
- Provide appropriate follow-up

NO/MILD DEPRESSION & NO/LOW SUICIDE RISK

- Address recent stressors with education, supportive and motivational counseling (D-8) and referrals
- Provide emergency contact/resource information
- Re-screen psychosocial risks/strengths at each visit and acknowledge assets
- Advise healthy diet, sleep (D-40), exercise, and socialization with friends/family
- Develop personal plan (D-59)
- Arrange follow-up based on need and adolescent primary care

SSRIs/ANTI-DEPRESSANTS

- If possible, consult with a psychiatrist before prescribing
- Obtain consent from parents and clearly review medication benefits, risks and side effects before prescribing
- Strongly encourage psychotherapy while on med
- Start an SSRI at a low dose & increase weekly or as tolerated to lowest effective therapeutic dose
- Regularly and frequently monitor response and side effects (D-30), esp. during the first 2 months of treatment
- With no response to med or symptoms of irritability, mania or worsening depression or suicidal ideation, refer to/ contact psychiatrist or crisis team in a timely fashion
- With symptom remission, treat for 6-9 months
- When discontinuing med withdraw slowly & monitor teen closely

Source:

1) Summary Chart of NHMRC Clinical Practice Guidelines on Depression in Young People. Australian Government National Health and Medical Research Council. 1997. The algorithm has been rescinded, is out of date and no longer is endorsed by the Australian Government. Adapted and revised with permission.

Name:_____

Depression Monitoring Sheet

Date:_____

SYMPTOMS

For each symptom, circle the number that describes how much of a problem it was this week.
1= Not a Problem 3= Somewhat a Problem 5= Severe Problem

1 2 3 4 5
Feeling sad all day

1 2 3 4 5
Feeling grouchy or irritable

1 2 3 4 5
Feeling restless or fidgety

1 2 3 4 5
Hard to think or concentrate

1 2 3 4 5
Bigger or smaller appetite

1 2 3 4 5
Having no interest in favorite activities

1 2 3 4 5
Having low energy

1 2 3 4 5
Not sleeping enough or sleeping too much

1 2 3 4 5
Feeling guilty or worthless

1 2 3 4 5
Thinking about death or suicide

Medications

Name of Medication:

_____

_____

Take When?

Morning Noon Evening

Morning Noon Evening

How Much?

_____

_____

Side Effects

For each side effect, circle the number that describes how much of a problem it was this week.
1= Not a Problem 3= Somewhat a Problem 5= Severe Problem

1 2 3 4 5
Trouble falling asleep

1 2 3 4 5
Stomach aches

1 2 3 4 5
Headaches

1 2 3 4 5
Trouble with eyes

1 2 3 4 5
Feeling thirsty a lot

1 2 3 4 5
Feeling restless or fidgety

Other Side Effects:

_____

_____

Source:
1) Children's Medication Algorithm Project, Texas Dept. State Health Services. *Depression Monitoring Sheet.* 2004. www.dshs.state.tx.us/mhprograms/CMAPed.shtm. Adapted with permission.

Suicide

Fast Facts

Suicide is the 3rd leading cause of death for US adolescents 15 to 19 years old.[1] Every year, approximately 1,600 US adolescents commit suicide.[2] The 2005 CDC Youth Risk Behavior Survey found that 17% of high school students seriously considered suicide, 13% developed a suicide plan, 8.4% reported attempting suicide, and 2.3% made a "medically serious" suicide attempt that required medical care.[3] While female adolescents are more likely to attempt suicide, adolescent males are 4-5 times more likely to commit suicide. The highest 2003 US suicide rate (deaths/100,000) in 10-24 year old males was 24.3 in American Indians/Alaskan Natives, followed by whites (12.7), blacks (8.6), Hispanics (8), and Asian/Pacific Islanders (6.2). Suicide rates in 10-24 year old females were: American Indians/Alaskan Natives (6.7), Asian/Pacific Islanders (2.7), whites (2.4), Hispanics (1.6), and blacks (1.5). While suicide rates have decreased for 15-24 year old males since rates peaked in the early 1990s, the rate among 10-14 year old males has increased slightly from 1.2 in 1981 to 1.7 in 2003 and rates for all females ages 10-24 have decreased.[4]

RISK FACTORS

- Psychiatric disorder (depression, bipolar, impulsive/ aggressive behavior, anxiety, eating disorders)
- Previous suicide attempt
- Family history of suicidal behavior, psychiatric disorder, substance abuse
- Drug and alcohol use/abuse
- Stressful life events or loss
- Family disruption, conflict, or stress
- Access to lethal methods, especially guns
- History of physical, sexual, or emotional abuse
- Isolation, rejection, or feelings of shame
- Chronic physical illness or condition
- Lesbian/gay/bi-sexual/transgender/queer/questioning (LGBTQQ) & immigrant youth without family/community support
- Hopelessness or despair
- Preoccupation with death/suicide

PROTECTIVE FACTORS

- Family connection and support
- Strongly held religious or cultural beliefs
- Realistic life goals or future plans
- Academic achievement
- No access to lethal means
- Perception of stress as limited, does not blame self for stress
- Community and school connections, support and engagement
- Perceived support
- Problem solving skills

Assessment Utilize P.L.A.I.D.P.A.L.S.[5] to assess for suicidal risk:

P lan- Does s/he have a suicide plan? Has the plan been rehearsed or practiced in the past or the present? How often? When?
L ethal- Is the plan lethal (as perceived by adolescent or provider)?
A ccess- Does s/he have access to the means to carry out the suicide plan?
I llness- Does s/he have a history or signs/symptoms of acute or chronic physical and/or mental condition(s)?
D epression- Does s/he have signs or symptoms of depression or a history of depression? (see D-27)
P rior attempts- Has s/he and/or family members had prior suicide attempts? If yes, when?
A lone- Is s/he alone, isolated, or without support?
L oss- Has s/he experienced sudden loss, change or other stressful life event?
S ubstance use/abuse- Has s/he been using or increasing use of alcohol/drugs?

ATTEMPTERS AT GREATEST RISK FOR SUICIDE[6]

Suicidal history	Demographics	Mental State
➤ Continuing suicidal ideation	➤ Male	➤ Depressed, manic, hypomanic and/or severely anxious
➤ Has made a prior suicide attempt	➤ Lives alone	➤ Substance abuse with or without a mood disorder

High Risk: Adolescent has aforementioned risk factors or "resolved plan and preparation" for suicide.
Moderate Risk: Adolescent has suicidal ideation, a few risk factors, and no suicide plan or preparation.
Low Risk: Adolescent has suicidal ideation without other risk factors and no suicide plan or preparation.

Intervention

S afety comes first!: If adolescent is at high risk for suicide, monitor and do not leave him/her alone. Call local crisis support or 911. Limit access to lethal means.

A ctive plan for intervention: If not at imminent risk, make an immediate plan for behavioral health treatment and psychosocial support. See *Behavioral Health Referral Process* (D-13). Involve someone close to the youth. Provide information on emergency resources/contacts. Ask youth to complete and then discuss *Taking Care of Myself* worksheet (D-59).

F ind consultation, back-up and support.

E nsure timely follow-up: Increase contact, make a commitment to help the youth through crisis, coordinate with behavioral health provider(s), and provide adolescent primary care and supportive and health promotion counseling.

[1] American Academy of Pediatrics, Committee on Adolescence. Suicide and Suicide Attempts in Adolescents. *Pediatrics*. 2000; 105(4): 871-74.
[2] Gould M, Greenberg T, Velting D, Shaffer D. Youth Suicide Risk and Preventive Interventions: A Review of the Past 10 Years. *Journal of the AACAP*. 2003; 42: 4.
[3] Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance System. 2005, http://www.cdc.gov/healthyyouth/yrbs/index.htm
[4] National Adolescent Health Information Center, Univ. of California San Francisco. Fact Sheet on Suicide: Adolescents and Young Adults. 2006, http://nahic.ucsf.edu/downloads/Suicide.pdf
[5] San Francisco Suicide Prevention. P.L.A.I.D.P.A.L.S. 2006, http://www.sfsuicide.org/html/plaid.html. Copyright San Francisco Suicide Prevention. Not to be reproduced without permission. Support your local suicide prevention organizations. Adapted and reproduced with permission.
[6] AACAP. Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. *Journal of the AACAP*. Supplement. 2001; 40: 7.

Sources:
1) Stoelb M, Chiriboga J. A Process Model for Assessing Adolescent Risk for Suicide. *Journal of Adolescence.* 1998; 21: 359-70.
2) Adolescent Health Working Group. Safety First: Preventing Youth Suicide in San Francisco. 2003, http://www.ahwg.net/projects/headsup.htm

Techniques for Talking with a Suicidal Youth

- **Ask yourself "what does the youth need in order to stay safe right now?"** Consider what you need to do to help. A youth may feel s/he is going to be in pain forever. What can you do to help him/her get through tonight? Tomorrow? This week?
- **Never leave a youth who is in imminent danger alone.** Call local crisis support or 911. Do not let the youth leave the office or clinic. Ensure that access to lethal means is limited. Contact parents, if appropriate and support person(s) identified by the youth.
- **Remind the youth that crisis is temporary,** impulsive solutions can be permanent– pain can rise and fall, that it will not always feel this bad, and that it hasn't always been this way.
- **Discuss the ambivalence.** Talk with the youth about the part of him/her that wants to live- the part that is talking to you about the pain. Talking to someone is a sign that some part of him/her wants to stay alive.
- **Ask about the youth's reasons for staying alive.** Ask about friends, family, siblings, pets, something they love. Be careful not to use guilt (ex. "Think how bad you'll make your parents feel if you killed yourself.")
- **Find out how the youth has dealt with pain in the past.** People have extraordinary resources that they forget when in acute pain. Remind the teen that s/he has been able to cope during tough times before.
- **Reinforce the importance of support and connection.** What are her/his support systems?
  If the youth has no family or close friends, ask about trusted adults such as teachers, coaches, counselors, doctors, therapists, clergy, and neighbors. It is easy for youth to believe that no one cares and that they are completely alone. Help her/him brainstorm support resources.
- **Find out what the youth does to soothe him/herself.** Sometimes just making a plan to get through the next few hours is enough to shift the balance. Seeing friends or family, going for a walk, taking a shower, and eating a snack can sometimes help.
- **Encourage the youth to see a therapist.** Emphasize that seeing a therapist does not mean s/he is crazy, rather that you believe it would help if s/he had someone who listens, supports, and teaches him/her ways to get through difficult times.
- **If the youth is <u>not</u> in imminent danger, make a follow-up plan.** A plan can help the youth focus on steps that can get him/her through crisis situations. A plan includes contacts for emergencies and help, coping activities, and future counseling/support/therapy appointments. Help youth create a follow-up plan that includes what s/he plans to do during the next few hours.
- **Talking with a suicidal youth can be very stressful.** Consult with colleagues, coworkers, clergy, or other trusted individuals for help and support. You are not alone.
- **Reminder:** If you interact with a suicidal youth, you are obligated to ensure appropriate follow-up. It is important to know the crisis and treatment resources for youth in your community and to stay in contact with the youth until his or her situation has stabilized and/or appropriate intervention has taken place.

Source:
1) San Francisco Suicide Prevention. Techniques for Talking with a Suicidal Youth. 2006, http://www.sfsuicide.org. Copyright San Francisco Suicide Prevention. Not to be reproduced without permission. Support your local suicide prevention organizations. Adapted and reproduced with permission.

Substance Use

Fast Facts

On average, the first marijuana use among youth occurs in middle school while alcohol use may start before age 12.[1] 57% of 10th grade youth used alcohol and 27% used marijuana in the past year. More than half of U.S. high school graduates will have tried an illegal drug.[2] According to the 2006 Monitoring the Future Survey, the percentage of US adolescents using illicit drugs or alcohol continued a 10-year decline, though the decline is small. However, use of prescription-type drugs remains high; 4.3% to 9.7% of high school seniors illegally used Oxycontin and Vicodin in the last year.[3] Substance use in teenagers is associated with motor vehicle accidents, homicides, suicides, fights, unsafe sexual activities, blood-borne infections (hepatitis B, C, and HIV) and psychiatric conditions such as mood disorders, conduct disorder, ADHD, eating disorders, and psychosis.[4]

RISK FACTORS[5]

- Perceived peer drug use
- Family history of substance use or alcoholism
- Poor academic achievement and school failure
- High levels of family or social conflict
- Parental divorce during adolescence
- Childhood physical abuse, neglect or sexual abuse
- ADHD, Conduct Disorder, mood or anxiety disorders

PROTECTIVE FACTORS[5]

- Early substance use prevention education
- Family members abstaining from substance use
- Association with peer groups who abstain from and disapprove of substance use
- Involvement in healthy recreational and extra-curricular activities
- Religious, spiritual affiliation/involvement
- Pharmacotherapy for ADHD

Assessment

During routine and acute visits, use a psychosocial/HEADSSS assessment (D-10) to screen every adolescent for quantity and frequency of tobacco, alcohol, and drug exposure and use. Ask about the onset, duration, impact of use on school, relationships, and risk taking behaviors. Assess for psychiatric co-morbidites. Perform PE and lab tests to assess for acute or chronic use (hepatitis, pancreatitis, cardiovascular problems, skin lesions, malnutrition). The CRAFFT tool should be completed if the teen reports past or present substance use. It can be filled out by the teen or questions can be asked during the interview. The CRAFFT has been validated in adolescents.[4]

		YES	NO
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?	_____	_____

Scoring: $\geq$2 yes answers suggest a significant problem and indicate the need for further evaluation and intervention.

Substance Use (continued)

Intervention

Assess Level of Substance Use[6,7,8]

RISK LEVEL	CHARACTERISTICS OF RISK LEVEL	TARGETED HEALTH GUIDANCE/REFERRAL
LOW RISK	Infrequent use of alcohol; no effect on psychosocial development or daily activities; not using other drugs; not involved in risky situations (ex. driving, swimming while using)	♦ Acknowledge, encourage, and support assets and strengths ♦ Provide accurate information (D-68, 69), anticipatory guidance, supportive counseling and health promotion to youth and parents ♦ Personalize the message ♦ Emphasize risk reduction and develop a "rescue plan" (ex. call parents for a ride- no questions asked, carry taxi fare) ♦ Advise healthy diet, exercise, sleep, and primary care visits
MODERATE RISK	Regular use of alcohol and occasional binge drinking; experiments with marijuana and other drugs more than once, while alone, or in the context of behavioral/emotional difficulties; use begins to interfere with psychosocial development; any alcohol/drug use before age 15	♦ All of the above ♦ Use motivational counseling (D-8) to decrease use/harm ♦ Inform/encourage use of community resources ♦ Schedule regular follow-up visits every 1 to 3 months ♦ Provide follow-up care as indicated by level of functioning, severity of use and/or co-existing conditions
HIGH RISK	Regular use of alcohol and/or binge drinking; use despite negative effects on psychosocial development; uses other drugs regularly and/or IV drugs; uses increasing amounts of substance to get high; withdrawal symptoms; uses before or during school; drives drunk or other risky behaviors; patient has a psychiatric co-morbidity	♦ **REFER IMMEDIATELY TO SUBSTANCE USE OR MENTAL HEALTH PROVIDER/PROGRAM FOR EVALUATION AND MANAGEMENT/INTERVENTION** ♦ Maintain contact until intervention has taken place ♦ Provide ongoing support, routine adolescent primary care, and coordination with behavioral health provider ♦ Schedule regular follow-up visits every 1 to 3 months

Treatment Options for Substance Use[9]

Outpatient: For teens motivated to change behaviors and not physiologically addicted to substances.

Partial or Day: For teens needing more intensive structure and support, who are motivated to participate in treatment, and not physiologically addicted.

Residential: For teens needing intensive structure and support and are unlikely to stop use if they remain in their home environment.

Inpatient: For teens at significant risk for withdrawal symptoms, with serious psychiatric disorders or symptoms, or who have failed other treatment programs.

Note: Programs that integrate family therapy approaches have the most supporting evidence for success.[10]

What if there is no place to refer?[11]

- If you are unaware of the resources in your area, contact your county or regional mental health/substance use office or ER for help.
- Find out if there are any adolescent substance use counselors or mental health experts in your area.
- Utilize and collaborate with community resources which may not be substance use-focused but are experienced working with youth:
  - ☑ Youth development, leadership, and after-school activities
  - ☑ Sports teams, clubs, mentoring and faith-based programs
  - ☑ School nurses, counselors, and school-based health centers

What if the adolescent is resistant to referral?

- Restate minor confidentiality laws and protections (D-72).
- Provide education and motivational counseling in a non-judgmental manner to reduce harm and improve functioning at home, school, community, and in relationships.
- Encourage patient and family members to use self-help groups (Alcoholics or Narcotics Anonymous, Alateen, or other peer support groups).
- Rule out co-morbid psychiatric disorders with further assessment, consultation and referral.
- Be ready to assist with the referral process if the adolescent and/or family agrees to seek additional help, functioning decreases, or if use escalates and harm increases (D-54, 55).

[1] AACAP. Teens: Alcohol and Other Drugs Facts for Families. 2004, http://www.aacap.org/page.ww?name=Teens%3A+Alcohol +And+Other+Drugs&section=Facts+for+Families

[2] Monitoring the Future. Trends in Lifetime Prevalence of Use of Various Drugs for Eighth, Tenth, and Twelfth Graders. 2005, http://www.monitoringthefuture.org/data/05data/pr05t1.pdf

[3] Johnston LD, O'Malley PM, et al. Teen Drug Use Continues Down in 2006, Particularly Among Older Teens; but Use of Prescription-type Drugs Remains High. Univ. of Michigan News and Information Services. 2006, http://www.monitoringthefuture.org

[4] Shrier LA, Harris SK, Kurland M, Knight JR. Substance Use Problems and Associated Psychiatric Symptoms Among Adolescents in Primary Care. *Pediatrics*. 2003; 111(6): 699-705.

[5] AAP, Comm. on Substance Abuse. Tobacco, Alcohol, and Other Drugs: The Role of the Pediatrician in Prevention and Management of Substance Abuse. *Pediatrics*. 2005; 115(3): 816-21.

[6] American Medical Association. *Guidelines for Adolescent Preventive Services (GAPS) Clinical Evaluation and Management Handbook*. 1995: 124.

[7] American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) Fourth Edition*. 2000.

[8] Kaye D. Office Recognition and Management of Adolescent Substance Abuse. *Current Opinion in Pediatrics*. 2004; 16: 532-41.

[9] Jellinek M, Patel BP, Froehle MC, eds. Stages of Substance Use and Suggested Interventions. *Bright Futures in Practice: Mental Health Volume 1 Practice Guide.* Nat'l Center for Education in Maternal and Child Health. 2002; 331-38.

[10] AACAP. Practice Parameters for the Assessment and Treatment of Children and Adolescents with Substance Use Disorders. *J of the AACAP.* 2005; 44: 6.

[11] American Medical Association, Department of Substance Abuse. *The Busy Physicians' Five Minute Guide to the Management of Alcohol and Other Drug Problems*. 1988.

Drug Testing in California

The Law:

California law states that a minor does not have the right to refuse medical care or treatment for a drug or alcohol related problem if the minor's parent consents for that treatment.[1] Therefore, if a parent consents to drug testing for their child, the adolescent cannot refuse the testing and the provider may order the test. The provider, however, has discretion on whether or not to order the test. This means, even if a parent requests a drug test, a provider doesn't have to comply if testing is considered inappropriate. Minors also have the right to request and give consent for drug testing.

PROS AND CONS OF DRUG TESTING IN A PRIMARY CARE SETTING

PROS

- ☑ Identification of drug use/abuse may result in intervention and treatment that, in some cases, could be life saving
- ☑ Serves as a diagnostic tool when behavior, changes in mental status, or acute/chronic medical symptoms may be associated with drug use, but the history or clinical findings are unclear
- ☑ Verification of abstinence

CONS

- ☑ A positive test does not mean drug abuse or dependence
- ☑ A negative test does not mean lack of substance use since some drugs clear the body quickly
- ☑ Tests can be inaccurate and may result in false positives
- ☑ The patient-provider relationship can be compromised if the patient doesn't agree or consent to the test
- ☑ Involuntary drug testing has not been proven to be a deterrent for drug use

TIPS FOR PROVIDERS

1. If a parent/guardian requests a drug test for their teen, discuss the pros and cons of the possible test results, and the appropriate uses of drug testing in settings such as comprehensive community programs specializing in adolescent substance use treatment.
2. Strategize other interventions besides drug testing such as: counseling, psycho-education groups and referral to community resources.
3. Always ask for the minor's assent before considering a drug test at the parent's request.

RECOMMENDATIONS[2]

1. Do not perform a test on an older, competent teen without the teen's consent, unless his/her capacity to make informed decisions is lacking.
2. Only consider involuntary testing if the following conditions are met:
   - Serious harm would be prevented if a specific drug was identified
   - The adolescent lacks the capacity to make informed judgments
   - You are legally required to test the adolescent (i.e. a court-ordered drug test, or as part of a comprehensive treatment program)
3. If you have concerns about an adolescent's health and/or functioning due to drug use, refer to a substance use or mental health specialist for further evaluation.
4. Be aware of the reliability, validity, and limitations of the testing system used because the consequences of inaccurate results can have significant implications.

[1] California Family Code §6929(f)

[2] American Academy of Pediatrics, Committee on Substance Abuse. Testing for Drugs of Abuse in Children and Adolescents. *Pediatrics.* 1996; 98(2): 305-7.

Sources:
1) National Institute on Drug Abuse. Primary Care and Drug Abuse: A Research-Setting Round Table Seminar. 2003, http://www.drugabuse.gov/whatsnew/meetings/primarycare.html
2) Kulig JW. American Academy of Pediatrics, Committee on Substance Abuse. Tobacco, Alcohol, and Other Drugs: The Role of the Pediatrician in Prevention, Identification, and Management of Substance Abuse. *Pediatrics*. 2005; 115(3): 816-21.

Recreational Drugs Fact Sheet

DRUG CLASS	DRUG	COMMON OR BRAND NAME	DEPENDENCE POTENTIAL PHYSICAL	DEPENDENCE POTENTIAL PSYCHOLOGICAL	ESTIMATED DETECTION TIME IN URINE	DESIRED OR IMMEDIATE EFFECTS	UNDESIRED AND LONG-TERM EFFECTS	OVERDOSE EFFECTS
TOBACCO	Nicotine	Tobacco, cigarettes, cigars, bidis, squares, stoges	High	High	2-4 days	Relaxation, concentration, stimulation	Chronic withdrawal, chronic bronchitis, asthma, emphysema, lung cancer, exercise intolerance, cardiovascular disease	Anxiety, high blood pressure, tachycardia, nausea
		Smokeless, snuff, dip, chew	High	High				
		Patches, gum, inhaler	Moderate	Moderate				
ALCOHOL	Ethanol	Beer, 40s	High	High	24 hours[1]	Euphoria, reduced inhibitions, impaired judgment, lack of coordination, slurred speech, impaired memory	Liver, brain, heart, and nerve damage; esophageal hemorrhage, pancreatitis, victimization (rape), fetal alcohol syndrome/effects, withdrawal seizures, delirium tremens, accidents	Depressed breathing, abnormal heart beat, amnesia, coma, death
		Wine, wine coolers	High	High				
		Whiskey, liquor, jello shots	High	High				
		Liqueurs	High	High				
CANNABIS	Marijuana	Weed, dope, pot, Mary Jane, trees, grapes, purple, dojah, herb, blunts, joints, bud, special brownies, bammer, green, keef, shake, dank, doobie, fade	Low	Moderate	Casual use: 2-7 days Long-term use: Up to 30 days[2]	Euphoria, hilarity, altered perceptions, reduced inhibitions, hunger, increased pulse, impaired judgment, red eyes, paranoia, impaired memory, lack of coordination	Accidents, possible respiratory problems: lung damage and asthma, memory impairment, motivation loss, increased heart rate, impaired reaction time	Hallucinations, panic, agitation, delirium
	Hashish, hash oil	Hash	Low	Moderate				
PSYCHO-STIMULANTS	Cocaine	Coke, crack, rock, yay, chiz, 8 ball, ice, powder, snow, blow, nose candy	High	High	12-72 hours	Alertness, increased concentration, excitation, euphoria, appetite loss, headache, jitteriness, increased blood pressure, insomnia, grandiosity, increased activity level and sexual desire	Tolerance, dehydration, weight loss, itchy and dry eyes/mouth, blurred vision, CNS damage, anxiety, depression, nausea, abdominal pain, impotence, psychosis, agitated delirium, "crash" withdrawal	Agitation, seizures, paranoia, heart attack, stroke, hallucinations, arrhythmias, respiratory failure, fever, death
	Amphetamine	Dexedrine, Adderall, uppers, speed, pep pills	High	High	2-4 days[1]			
	Methylphenydate	Ritalin, pep pills	High	High				
	Methamphetamine	Meth, crystal, tina, speed, chalk, crank, glass	High	High				
	MDMA, MDA, MDEA	Ecstasy, thizz, E, X	Possible	Possible	2-3 days[1]			
OPIOIDS	Opium	Chinese molasses, dreams, gong, O	High	High	2-3 days[1]	Euphoric rush, warm flushing of the skin, pain relief, constricted pupils, slowed breathing, sleepiness, heavy feeling in extremities, decreased level of cognitive functioning, nausea, vomiting, and itching	Tolerance, poor appetite, weight loss, pneumonia, constipation, IV use infections: AIDS, Hep B/C, liver disease, collapsed veins, abcesses, and inflammation Addiction - withdrawal: drug craving, nausea, vomiting, abdominal pain, confusion, muscle and bone pain, and restlessness	Respiratory depression, respiratory arrest, possible coma or death if combined with alcohol or sedatives
	Morphine	Morphine sulfate, M.S., MSO4	High	High	3-4 days[1]			
	Codeine	Tylenol #3	High	High	2-5 days[1]			
	Heroin	H, hey ron, smack, junk, black tar, horse, dope	High	High	3-4 days[1]			
	Meperidine	Demerol	High	High	2-4 days			
	Hydromorphone	Dilaudid	High	High				
	Oxycodone	Percocet, Percodan, Oxycontin	High	High	8-24 hours			
	Hydrocodone	Vicodin	High	High				
	Fentanyl	China white, sublimaze	High	High	2-5 days[1]			
SEDATIVES/ DEPRESSANTS/ TRANQUILIZERS	Barbiturates	Phenobarb, Seconal, Nembutal, Amytal, barbs	High	High	short-acting: 3 days[1] intermediate: 2.5 wks[2]	Relaxation, drowsiness, dizziness, lack of coordination, slurring words, poor concentration, lowered inhibitions, slowed pulse/breathing	Tolerance, fatigue, memory impairment, delirium, victimization (rape) Addiction - withdrawal	Respiratory depression, seizures, possible coma or death if combined with alcohol or opioids
	Benzodiazepines	Valium, Ativan, Xanax, downers	High	High	up to 30 days			
	Flunitrazepam	Rohypnol, roofies	High	High	up to 72 hours			
	Methaqualone	Quaalude, ludes, sopor	High	High	4-6 days[2]			
	Gamma-hydroxybutyrate	GHB, G, liquid E	Unknown	Unknown	up to 24 hours			
	Chloral Hydrate	Knockout drops, mickey	Moderate	Moderate	2-7 days			
HALLUCINOGENS/ DISSOCIATIVE ANESTHETICS	LSD	Acid, blotter, doses	None	Possible	2 days[1]	Sense of insight, integration or detachment, altered perceptions, visual hallucinations, delusions, jitteriness, fast or slow pulse, chills, intense fear, anxiety, paranoia, panic, euphoria, dizziness, insomnia	Flashbacks, unpredictable behavior, delirium, violence, tolerance, depressed mood, impaired memory, persistent psychosis, mood swings, disorientation, impaired judgment, nausea, hot flashes, rigid motor tone	PCP lethal in overdose especially combined with alcohol or sedatives, muscle contractions, fatal heart rhythms, convulsions, coma, hyperthermia, death
	Psilocybin	Shrooms, magic mushrooms	None	Possible	2-4 days[1]			
	Mescaline	Peyote, buttons, mescalito, mesc	None	Possible	2-3 days			
	Phencyclidine	PCP, angel dust, dust	Moderate	Unknown	2-7 days			
	Ketamine	Special K, K, vitamin K, cat tranquilizer	Unknown	Unknown	7-14 days			
	DMT	Businessman special, dimitri	None	None	2-5 days			
	Dextromethorphan	DXM, syrup, robo, skittles, vitamin D, dex, triple C, CCC	Low	Unknown				
INHALANTS	Butyl, cyclohexyl, amyl nitrates	Poppers, rush, aerosols	Low	Unknown	No standard test available	Euphoria, reduced inhibitions, impaired judgment, lack of coordination, slowed reflexes, dizziness, headache	Muscle weakness, disorientation, nerve and brain damage, kidney failure, arrhythmias	Suffocation, coma, heart failure, death
	Nitrous oxide, gases	Laughing gas, whippets, whipped cream	Low	Unknown				
	Petroleum distillates	Glues, solvents, acetone, gasoline	Low	Unknown				
	Chloro-alkenes alkanes	Cleaning agents, adhesives	Low	Unknown				

[1] Heroin Addiction: Help for Addicts. Drug Testing and Detection Periods. 2003, http://helpingaddicts.net/drug_testing.htm

[2] Rosenfeld W, Wingert W. Scientific Issues in Drug Testing and Use of the Laboratory. *Substance Abuse: A guide for health professionals.* American Academy of Pediatrics. 1988.

Sources:

1) Grass W. Summary of Drug Effects. Dartmouth Medical School, Project Cork. 2001, http://www.projectcork.org/clinical_tools/pdf/Summary_Chart.pdf. Adapted and updated with permission.
2) National Institute on Drug Abuse. Research Report Series. 2001-2006, http://www.drugabuse.gov/ResearchReports/default.html
3) Victor Damien, Youth Coach of the San Francisco Youth Task Force and Vicky Valentine, Health Educator for Health Initiatives for Youth.

Tobacco

Fast Facts

Each day, 6,000 US youth under 18 years smoke their first cigarette. Almost 2,000 of them will become regular smokers (757,000 annually).[1] Tobacco is smoked as cigarettes, cigars, bidis (thin, hand-rolled cigarettes imported from Southeast Asia), clove cigarettes, and kreteks (cigarettes imported from Indonesia that contain cloves and other additives).[2] Loose-leaf tobacco can be smoked in pipes and hookahs (an Asian smoking pipe with a long tube that passes through an urn of water). The two most common types of smokeless tobacco in the US are chewing tobacco and snuff (finely ground tobacco placed between the gum and lip).[3] There is no longer a gender gap in teen cigarette smoking. 22% of both female and male high school students are current cigarette smokers. Smoking has increased significantly among Hispanic and African American youth: 15% African American, 18% Hispanic, and 25% white high school students are current cigarette smokers.[4] One-third of Asian American high school seniors are smokers.[5]

RISK FACTORS[4,6]

- Use or approval of tobacco by peers, siblings, or parents
- Accessibility, availability, and affordability of tobacco products
- Perception of tobacco use as normative
- Lack of parental support or involvement
- Lack of self-efficacy to refuse offers of tobacco
- Low self-esteem
- Belief in the functional benefits of tobacco use
- Exposure to tobacco advertising
- Ignorance of tobacco's adverse health consequences
- Self-medication for depression and/or anxiety
- Low levels of academic achievement
- Low socioeconomic status

PROTECTIVE FACTORS[6]

- Disapproval of tobacco by peers, siblings, or parents
- Close communication with parents/adult caregivers
- Positive parental support
- High self-esteem
- Assertiveness skills
- Social competence
- School success
- Regular participation in after-school programs, sports leagues, or faith-based activities
- Strong sense of right and wrong

Assessment

Assess for tobacco use starting in preadolescence.[7] Tobacco use and exposure should be discussed at every visit. The psychosocial/HEADSSS assessment (D-10) includes questions on tobacco. Speak with adolescent confidentially and in a nonjudgmental manner about his/her attitude toward and exposure to tobacco, experience with tobacco, and tobacco's impact on his/her daily functioning.[8]

Health Consequences of Tobacco Use

- Association with increased likelihood of using marijuana and other drugs.
- Smoking: upper respiratory infection, cough, asthma, sinusitis, cardiovascular disease, multiple cancers, impaired fertility, impotence, premature death, and time lost from work and school.
- Chewing tobacco: precancerous leukoplakia (lesions in the mouth) and increased risk of oral cancer.[6]
- Withdrawal symptoms such as difficulty concentrating, increased irritability, nervousness, and cravings for tobacco.
- Fetal tobacco exposure: increased risk of spontaneous abortion, low birth weight, SIDS, and long-term cognitive and behavioral problems.

Intervention

THE 5 A'S OF SMOKING CESSATION COUNSELING[9]

ASK all patients/parents if they have used tobacco. Acknowledge and support youth's strengths and assets.	Example: "Have you ever used tobacco?"
ADVISE patient/parents about the negative consequences of tobacco use and exposure. Advise patient on how to refuse tobacco. Encourage parents to model positive behaviors, to quit tobacco, and/or maintain a tobacco-free house.	"I advise all of my patients to quit smoking. You mentioned wanting to join a soccer team. Quitting will have benefits like more endurance when you play sports."
ASSESS willingness to quit.	"Have you ever tried to stop smoking? Have you thought about quitting?"
ASSIST patient in formulating a personal quit strategy. Use motivational counseling techniques (D-8) and always commend adolescents for their efforts to quit. Remember that ¾ of teen smokers have considered quitting.[7]	"What do you think will be the hardest thing about quitting?" "What are some ways you can overcome these hurdles?"
ARRANGE for follow-up and provide adolescent primary care, anticipatory guidance and promotion of healthy nutrition, exercise, sleep, and social support.	"Nicotine addiction is a serious medical problem. I would like to check in with you soon to see if you have been able to quit and offer you more help if you want it."

- Model behaviors: Set up a tobacco-free office with no tobacco ads.[6]
- Pharmacotherapy: Nicotine replacement therapy may benefit those who smoke 10+ cigarettes/day, smoke a cigarette within 1 hour of awakening, and who experienced withdrawal symptoms/cravings when they tried to quit. Bupropion and Varenicline may help daily smokers quit (D-38).[6]

[1] SAMHSA, Results from the 2002 National Survey on Drug Use and Health. 2003, http://www.oas.samhsa.gov/nhsda/2k2nsduh/Results/2k2Results.htm
[2] CDC, Tobacco Information and Prevention Source. Fact Sheet: Bidis and Kreteks. 2005, http://www.cdc.gov/tobacco/factsheets/bidisandkreteks.htm
[3] CDC, Tobacco Information and Prevention Source. Fact Sheet: Smokeless Tobacco. 2005, http://www.cdc.gov/tobacco/factsheets/smokelesstobacco.htm
[4] CDC, Tobacco Information and Prevention Source. Fact Sheet: Youth and Tobacco Use Current Estimates. 2005, http://www.cdc.gov/tobacco/research_data/youth/Youth_Factsheet.htm
[5] American Legacy Foundation and Centers for Disease Control. National Youth Tobacco Survey. 2000, http://www.americanlegacy.org/168.htm
[6] American Academy of Pediatrics, Committee on Substance Abuse. Tobacco's Toll: Implications for the Pediatrician. *Pediatrics*. 2001; 107(4): 794-98.
[7] Pletcher J, Schwarz D. Current Concepts in Adolescent Smoking. *Current Opinion in Pediatrics*. 2000; 12(5): 444-49.
[8] Kulig J. American Academy of Pediatrics, Committee on Substance Abuse. Tobacco, Alcohol, and Other Drugs. *Pediatrics*. 2005; 115(3): 816-21.
[9] Sargent J, DiFranza J. Tobacco Control for Clinicians Who Treat Adolescents. *CA: A Cancer Journal for Clinicians*. 2003; 53: 102-23. Adapted and reproduced with permission.

Treatment Options for Smoking Cessation

- **Pharmacotherapies** should be used only when the teen shows both **tobacco dependence** AND **intention to quit**.
- **Social support** should be established in addition to, or instead of, pharmacotherapy. Suggest: quit smoking with a friend/family member or join a support group such as Nic-Anon.

WHAT PHARMACOTHERAPIES ARE AVAILABLE?

PRODUCT	AVAILABILITY	DAILY DOSE *(Treatment Duration)*	COMMON SIDE EFFECTS	ADVANTAGES	DISADVANTAGES
TRANSDERMAL PATCH *(Nicoderm CQ and Nicotrol)* »Place on hairless part of body between neck and waist - rotate	OTC	Nicoderm CQ 1 patch for 24 hours *21 mg/ 4 weeks, then* *14 mg/2 weeks, then* *7 mg/ 2 weeks*	▸ Skin irritation (treat with Hydrocortisone cream) ▸ Insomnia (Remove patch at night)	▸ Provides steady level of nicotine ▸ Easy to use ▸ Unobtrusive ▸ Available OTC	▸ User cannot adjust dose if craving occurs
	OTC	Nicotrol 1 patch for 16 hours *15 mg/ 8 weeks* *(use lower dose if smoking ≤ 10 cigs/day)*			
GUM *(Nicorette/Nic Mint)* »Chew until tongue is tingly, park, repeat x 30 min., water only for 15 min. before and during chewing	OTC	1-24 cig./d.: 2 mg. gum (up to 24 pieces/d.) 25+ cig./d.: 4mg. gum (up to 24 pieces/d.) *(Up to 12 weeks)*	▸ Mouth irritation ▸ Sore jaw ▸ Dyspepsia ▸ Hiccups	▸ User controls dose ▸ Provides oral substitute ▸ Available OTC	▸ Proper chewing technique is needed to avoid side effects and achieve efficacy ▸ Can damage dental work ▸ Use difficult for those with orthodontic braces
NICOTINE LOZENGE	OTC	9-20 daily *(Up to 12 weeks)*	▸ Hiccups ▸ Heartburn	▸ Patient controls dosage ▸ Easy to use ▸ Discreet	▸ Limited information on long-term use
VAPOR INHALER *(Nictrol IN)*	Prescription	6-16 cartridges/day *(3-6 months)*	▸ Mouth and throat irritation ▸ Cough	▸ User controls dose ▸ Provides hand-to-mouth substitute for cigarettes	▸ Frequent puffing needed ▸ Device visible when used
NASAL SPRAY *(Nicotrol NS)*	Prescription	8-40 doses/day *(3-6 months)*	▸ Nasal irritation ▸ Sneezing ▸ Cough ▸ Teary eyes	▸ User controls dose ▸ Most rapid nicotine delivery ▸ Highest nicotine levels	▸ Most irritating NRT product to use ▸ Device visible when used
BUPROPION SR *(Zyban, Wellbutrin SR)* »Can be used with NRT* »Start one week before quit date	Prescription	150 mg am x 3 days, then 150 mg bid *(7-12 weeks; up to 6 months to maintain abstinence)*	▸ Insomnia (take dose at 8am & 4pm) ▸ Dry mouth	▸ Easy to use (pill) ▸ No nicotine exposure	▸ Seizure risk for patients with seizure disorder or bulimia
VARENICLINE *(Chantix)* »Can be used with NRT* »Start one week before quit date	Prescription	0.5 mg once a day, 1-3 days 0.5 mg twice a day, 4-7 days 1 mg twice a day thereafter *(Up to 6 months)*	▸ Nausea ▸ Vomiting ▸ Sleep disturbance ▸ Constipation ▸ Flatulence	▸ Easy to use (pill) ▸ No nicotine exposure	▸ Use not well studied for the adolescent population

*Nicotine Replacement Therapy

Note: Nortriptyline and Clonidine are second line pharmacotherapies for tobacco cessation, but are not commonly used for adolescents.

Important Things To Remember When Prescribing Smoking Cessation Pharmacotherapies To Teens…

- Be aware of the psychosocial and behavioral aspects of youth smoking and confirm teen's desire to quit before initiating pharmacotherapy.
- Bupropion SR or Nicotine Replacement Therapy are recommended because there has been no evidence to show they are harmful to teens.
- If the teen has a history of depression, Bupropion may be helpful for both depression and tobacco cessation.
- If the teen is concerned about weight gain, Bupropion and nicotine gum have been shown to delay, but not prevent weight gain.
- Follow-up by phone or in person is essential. Schedule a visit for at least 2 and 4 weeks after quit date.
- Much more research is needed to determine the efficacy of these pharmacotherapies in children and adolescents.

Sources:
1) Massachusetts General Hospital. Quit Smoking Service. Drugs Used to Treat Tobacco Use. 2006, http://www.mgh.harvard.edu/qss/providers.pdf. Chart adapted with permission.
2) US Department of Health and Human Services. Treating Tobacco Use and Dependence: Quick Reference Guide for Clinicians. 2000, www.massgeneral.org/tts/smoking_providers.htm
3) US Department of Health and Human Services. Clinical Guideline: Treating Tobacco Use and Dependence. 2000, http://www.surgeongeneral.gov/tobacco/treating_tobacco_use.pdf

Behavioral Health and Community Resources

Prepared By: _____

Date: _____

CONTACTS:	☎ PHONE NUMBERS:
Private Insurance Companies/ Health Plans:	
Community Mental Health access/ intake lines and clinics:	
Providers/ Agencies with low-cost, sliding scale therapy:	
Child crisis and suicide prevention hotlines/ resources:	
School contacts (teachers, nurses, counselors, coaches), special education coordinators, health centers:	
Substance use treatment programs and support groups:	
Violence and abuse resources (CPS, shelters, police, legal assistance, counseling programs, support groups):	
Professional associations' referral services:	

Source:

1) Knopf D. Accessing Mental Health Services for Adolescents in San Francisco. University of California San Francisco, Division of Adolescent Medicine. 2004. Adapted with permission.

Adolescent Sleep and Nutrition Needs

SLEEP

In general, adolescents need 8.5 to 9.25 hours per night. Inadequate sleep can lead to:

- Daytime sleepiness
- Increased risk of unintentional injuries and death from car accidents
- Poor concentration, low grades and school performance
- Feelings such as sadness, anger, irritability, and difficulty controlling emotions
- Increased likelihood of stimulant use including caffeine and nicotine
- Exacerbation of behaviors and symptoms related to ADHD and other chronic conditions

Recommend:

- Keep consistent sleeping schedules, even on weekends and holidays
- Adjust work/ extra-curricular activities to allow for enough sleep
- Establish a quiet period before bedtime with no loud music, television, computer, or phone use
- Wake up to bright light in the mornings
- Stay away from nicotine and caffeinated drinks after lunch. Alcoholic drinks can also disturb sleep
- Avoid heavy reading, studying, or computer games an hour before bed
- Avoid pulling all-nighters to study or party

NUTRITION

It is especially important for adolescents to consume foods rich in calcium (1,300 mg daily) and iron while they are undergoing growth spurts. Foods rich in calcium include:

- Dairy products
- Green, leafy vegetables
- Calcium-fortified juices and soy, almond, and rice milks
- Salmon and sardines
- Peas, beans, peanuts, and almonds

Recommend:

- Eat three meals a day and healthy snacks
- Do not skip breakfast in the morning
- Hold off on eating a meal or snack until hungry
- Pay attention to serving sizes while eating healthy snacks such as pretzels, dried fruit, low fat popcorn, vegetables, fruit, 100% juice, low sugar cereal, nonfat yogurt
- Cut back on soda, sports drinks, and sugary fruit juices. Instead drink water, tea, low/nonfat milk, and fresh juices
- Switch to whole grain bread, cereal, pasta, and rice instead of white bread, white rice, and sugary cereals
- Wait 15-20 minutes before eating second helpings

For more information on adolescent nutritional needs and health education handouts for youth, see the Body Basics Toolkit Module available at www.ahwg.net

Sources:
1) International Food Information Council Foundation. Child and Adolescent Nutrition. 2005, http://www.ific.org/nutrition/kids/index.cfm
2) Shalwitz J, Bushman D, Davis K, Williams S. *Body Basics*. Adolescent Health Working Group. 2005: E-22. http://www.ahwg.net/resources/toolkit.htm
3) National Sleep Foundation. Adolescent Sleep Needs and Patterns. 2000, http://www.sleepfoundation.org/_content/hottopics/sleep_and_teens_report1.pdf

Psychosocial Screening Tools

GENERAL ASSESSMENT

NAME	SCREENS FOR:	REPORTER	AGE GROUP	# OF ITEMS	TIME*	LANGUAGE/ READING LVL	COST	AVAILABLE FROM	RELATED TOOLS
Child Behavior Checklist (CBCL)- Youth Self Report	Behavioral/emotional problems within the last 6 months- anxious/depressed mood, attention problems, somatic symptoms and rule-breaking behavior. Includes open-ended questions.	Youth	11-18	113	~15 mins	English, Spanish 5th grade	$25 for 50 forms	Achenbach System of Empirically Based Assessment[1]	CBCL/6-18 Parent Report and Teacher Report
General Health Questionnaire (GHQ)	Non-psychotic psychiatric disorders- patient's ability to function, somatic symptoms, anxiety and insomnia, social dysfunction, and severe depression.	Youth	Older Adoles-cents	12, 28, 30, 60	2 mins 3-4 mins 3-4 mins 6-8 mins	English, Spanish, Chinese, & others 5th grade	£25 for 25 forms	nferNelson[2]	Child Health Questionnaire Ages 10+
Patient Health Questionnaire Adolescents (PHQ-A)	Anxiety, depression, eating, and substance use disorders (both licit and illicit substance use).	Youth	13-18	83	~10 mins	English 7th grade	Free	Online, Northeast Florida Area Health Education Center[3]	Prime-MD PHQ-9 for adults
Pediatric Symptom Checklist (PSC)- Youth Report	Cognitive, emotional, and behavioral problems- somatic symptoms, attention problems, rule-breaking behavior, and depressed mood.	Youth	11+	35	4-5 mins	English, Spanish 5th grade	Free	Bright Futures in Practice, PSC Partners[4]	PSC– Parent Report for parents of youth ages 6-16

[1] Achenbach System of Empirically Based Assessment. Child Behavior Checklist for Ages 6-18. 2006, http://www.aseba.org/products/ysr.html
[2] nferNelson Assessments. Health & Psychology. 2006, http://www.nfer-nelson.co.uk/health_and_psychology/default.asp
[3] Northeast Florida Area Health Education Center. Program Resources. http://www.nefahec.org/Other/program%20resources.asp
[4] Pediatric Symptom Checklist (PSC) Partners. Massachusetts General Hospital, Child Psychiatry. Order PSC. http://psc.partners.org/psc_order.htm
Chinese and Japanese translations of the PSC- Parent Report are available at http://psc.partners.org/psc_order.htm

DEPRESSION

NAME	SCREENS FOR:	REPORTER	AGE GROUP	# OF ITEMS	TIME*	LANGUAGE/ READING LVL	COST	AVAILABLE FROM	RELATED TOOLS
Beck Depression Inventory II (BDI-II)	Presence and severity of depressive symptoms in the general population and psychiatrically diagnosed patients.	Youth	14+	21	5-10 mins	English, Spanish 6th grade	$42 for 25 forms	Harcourt Assessment[1]	Beck Youth Inventories for ages 7-18
Center for Epidemiological Studies Depression Scale for Children (CES-DC)	Presence and severity of depressive symptoms within the past week- irritability, changes in eating habits, depressed mood, attention problems, negative thoughts about self, low energy level, and altered sleep patterns.	Youth	12-18	20	5-10 mins	English, Spanish 6th grade	Free	Online, Bright Futures in Practice[2]	CES-D for adults
Children's Depression Inventory (CDI)	Severity of depressive symptoms once depression is diagnosed- depressed mood, interpersonal problems, lack of pleasure, negative self esteem, and ineffective psychomotor functions.	Youth	7-17	27	10-15 mins	English, Spanish 1st grade	$47 for 25 forms	Multi-Health Systems[3]	
Columbia Depression Scale	Likelihood of depression- depressed mood, irritability, changes in sleep and appetite, suicidal thoughts, and previous suicide attempts.	Youth	11-18	22	~8 mins	English, Spanish 5th grade	Free	Columbia University Teen Screen Program[4]	Columbia Health Screen for ages 11-18

[1] Harcourt Assessment. 2006, http://harcourtassessment.com
[2] Bright Futures in Practice: Mental Health– Volume II Toolkit. National Center for Education in Maternal and Child Health. Tools for Health Professionals. 2002, http://www.brightfutures.org/mentalhealth/pdf/tools.html
[3] Multi-Health Systems. 2004, http://www.mhs.com
[4] Columbia University Teen Screen Program. Screening Instruments. 2005, http://www.teenscreen.org

Psychosocial Screening Tools (continued)

ADHD

NAME	SCREENS FOR:	REPORTER	AGE GROUP	# OF ITEMS	TIME*	LANGUAGE/ READING LVL	COST	AVAILABLE FROM
Conners' Rating Scales–Revised (CRS-R)	Opposition, cognitive problems, inattention, hyperactivity, anxiety/shyness, perfectionism, social problems, psychosomatic symptoms, restlessness/impulsivity, ADHD index, and DSM-IV criteria checklist.	Youth, Parent, and Teacher	Parent & Teacher Report 3-17 Youth Self Report 12-17	Short ver. Long ver.	5-10 mins 15-20 mins	English 6th to 9th grade varies w/ version	$37 for 25 forms	Pearson Assessment[1]
Vanderbilt Assessment Scales	Inattention, hyperactivity/impulsivity, combined inattention and hyperactivity subtype, oppositional defiant and conduct disorders, anxiety or depressive symptoms.	Parent, Teacher	6+	Parent 55 Teacher 43	~10 mins	English, Spanish 3rd grade	Free	Online, AAP, NICHQ[2]

[1]Pearson Assessment. Products and Services. 2006, http://www.pearsonassessments.com/products/index.asp
[2]National Initiative for Children's Healthcare Quality (NICHQ). Topics: Chronic Conditions. 2003, http://www.nichq.org/nichq/topics

SUBSTANCE USE

NAME	SCREENS FOR:	REPORTER	AGE GROUP	# OF ITEMS	TIME*	LANGUAGE/ READING LVL	COST	AVAILABLE FROM
CRAFFT	Severity of substance use including driving under the influence, using substances to relax, using substances while alone, forgetfulness, and getting into trouble due to substance use.	Youth	13-20	6	3-4 mins	English, Spanish 3rd grade	Free	Online, Project CORK[1]
POSIT	Problems and potential treatment or service needs in 10 areas including substance use, mental and physical health, and social relations.	Youth	11-18	139	20-30 mins	English, Spanish 5th grade	Free	SAMHSA[2]

[1]Project CORK. Clinical Tools. 2004, http://www.projectcork.org/clinical_tools/index.html
[2]SAMHSA Nat. Clearinghouse for Alcohol and Drug Info. Adolescent Assessment Referral System Manual, CDHHS pub#ADM91-1735, (800) 729-6686

ANXIETY

NAME	SCREENS FOR:	REPORTER	AGE GROUP	# OF ITEMS	TIME*	LANGUAGE/ READING LVL	COST	AVAILABLE FROM	RELATED TOOLS
Beck Anxiety Inventory (BAI)- Youth	Anxious symptoms including worries about school, the future, fears, and physiological symptoms associated with anxiety	Youth	7-18	20	5-10 mins	English, Spanish 1st grade	$42 for 25 forms	Harcourt Assessment[1]	BAI for 17+
Screen for Child Anxiety Related Disorders (SCARED) - Child	Anxiety and related issues- feeling nervous, frightened, worried, having nightmares, and somatic symptoms.	Youth	8-17	41	10-15 mins	English 2nd grade	Free	Advanced Center for Intervention and Services Research[2]	SCARED-Parent Version
Traumatic Events Screening Inventory- Child	Exposure to traumatic events. Measures level of stress and adaptation.	Youth	4+	Short Long	10 mins 30 mins	English, Interview format	Free	National Center for PTSD[3]	TESI-Parent Version
UCLA PTSD Index-Adolescent	Exposure to traumatic events and for all DSM-IV PTSD symptoms in adolescents who report traumatic experiences.	Youth	13+	22	20-30 mins	English 6th grade	$25	Nat'l Center for Child Traumatic Stress/UCLA[4]	PTSD Index Child ver., Parent ver.

[1]Harcourt Assessment. 2006, http://harcourtassessment.com
[2]Advanced Center for Intervention and Services Research for Early Onset Mood and Anxiety Disorders. Anxiety. 2003, http://www.wpic.pitt.edu/research/city/Family/Anxiety/Anxiety.htm
[3]National Center for PTSD, U.S. Dept. of Veterans Affairs. Assessment Instruments. 2006, http://www.ncptsd.va.gov/publications/assessment/index.html
[4]National Center for Child Traumatic Stress/UCLA. 1998. Contact Robert Pynoos MD, MPH at rpynoos@mednet.ucla.edu for more information.

***Estimated amount of time for patient to complete the tool. Does not include time used for scoring/grading.**

RESOURCES

- Hogg Foundation for Mental Health, University of Texas at Austin. Integrated Health Care: Screening Tools. 2005, http://www.hogg.utexas.edu/Pages/IHCScreen.html
- School Psychiatry Program and Madi Resource Center, Massachusetts General Hospital. Table of Screening Tools and Rating Scales. 2006, http://www.mgh.harvard.edu/madiresourcecenter/schoolpsychiatry/screeningtools_table.asp

Psychotropic Medications At-A-Glance

DISCLAIMER: This fact sheet is **NOT** a prescribing guide. Refer to a current drug reference because medication information and dosage recommendations are constantly updated. California minor consent laws state that psychotropic medications can only be prescribed for minors with parent/guardian's consent. When possible, consult a psychiatrist before initiating and adjusting psychotropic medication, especially if patient is taking mood stabilizers, anti-psychotics, or undergoing multiple-drug treatment. Patients should be slowly tapered off of medications.

DRUG CLASS	BRAND NAME	GENERIC NAME	SIDE EFFECTS AND PRECAUTIONS	COMMON DRUG INTERACTIONS
Selective Serotonin Reuptake Inhibitors (SSRIs)	Prozac[1,2]/Weekly	Fluoxetine	Anorexia, dry mouth, ↑↓ weight, headaches, GI upset, nausea, vomiting, diarrhea, constipation, insomnia, fatigue, sedation, weakness, anxiety, tremor, amotivation, sweating, sexual dysfunction. **Caution**: withdrawal syndrome occurs w/ abrupt discontinuation of SSRIs (except for Fluoxetine due to its long half-life) → dizziness, headache, nausea, vomiting, diarrhea, insomnia, tics, irritability, lethargy, anorexia, dysphoria; seratonin syndrome **(SS)** → potentially fatal hyperthermia, rigidity, myoclonus, autonomic instability & mental status changes; suicidal ideation (**S**); mania (**M**);↓ seizure (**Sz**) threshold.	Monoamine oxidase inhibitors (MAOIs) or linezolid, tricyclic anti-depressants such as clomipramine, insulin or oral medications for diabetes, grapefruit juice (sertraline), dextromethorphan (fluoxetine), St. John's wort, kava kava, samE, thioridazine, tryptophan, pimozide, mesoridazine.
	Paxil/CR	Paroxetine		
	Zoloft[2]	Sertraline		
	Luvox[2]	Fluvoxamine		
	Celexa	Citalopram		
	Lexapro	Escitalopram		
Tricyclic Anti-depressants	Anafranil[2]	Clomipramine	Dry mouth/eyes, constipation, nausea, GI upset, ↑↓ appetite, weight ↑, sweating, weakness, nervousness, dizziness, headaches, tremor, sleepiness, visual changes, ↑ HR, sexual dysfunction. Caution w/ cardiac conduction disorders. **SS, S, M, Sz**	MAOIs or linezolid, oral contraceptives, SSRIs, grapefruit juice, St. John's wort, kava kava, samE.
Other Anti-depressants	Wellbutrin/SR/XL	Bupropion	Anorexia, nausea, agitation, headache, insomnia, tremor, dizziness, dry mouth, constipation, sore throat, sweating. Contraindicated in eating disorders. **SS, S, M, Sz**	Zyban, MAOIs, linezolid, beta blockers, diet pills, insulin/oral medications for diabetes, nicotine patch, other anti-depressants, St. John's wort, kava kava, samE.
	Effexor/XR	Venlafaxine	Nausea, ↑↓ appetite, headache, somnolence, insomnia, dizziness, dry mouth, ↑ BP, nervousness, constipation, sweating, sexual dysfunction. **SS, S, M, Sz**	MAOIs or linezolid, lithium, selegiline, triptans, St. John's wort, kava kava, samE, tryptophan, buspirone, meperidine, tricyclic anti-depressants, SSRIs.
Central Nervous System Stimulants	Ritalin[3]/LA/SR	Methylphenidate	Anorexia, ↓ weight , irritability, abdominal pain, headaches, slight ↑ BP/HR, palpitations, insomnia, irritability, hyperactivity, dysphoria, dry eyes & mouth, nausea, GI upset, sweating, nervous habits, blurred vision. Rebound symptoms at the end of the day. May activate/worsen tics/Tourette's, **Sz**. High potential for abuse.	MAOIs, tricyclic antidepressants, SSRIs, clonidine, primidone, phenobarbital, phenytoin, warfarin, phenylbutazone, ethosuximide (dextroamphetamine), St. John's wort. Antacids increase absorption. Acidic foods and juices (Vitamin C decreases absorption).
	Concerta[3]	Methylphenidate		
	Metadate[3]/CD/ER	Methylphenidate		
	Dexedrine[3]/SR	Dextroamphetamine		
	Focalin[3]/XR	Dexmethylphenidate		
	Adderall[3]/XR	Amphetamine and Dextroamphetamine		
Non-Stimulants	Strattera[3]	Atomoxetine	Anorexia, nausea, dizziness, headache, sleepiness, insomnia, upper GI pain, constipation, dry mouth, cough, moodiness, pupil dilation, mild ↑ BP/HR, palpitations, dysmennorhea, sexual dysfunction. Rare severe liver toxicity. **S**	MAOIs, other antidepressants such as Wellbutrin, Anafranil, Prozac, Sarafem, Paxil, Zoloft.
Neuroleptics/ Atypical anti-psychotics	Risperdal[4]	Risperidone	Restlessness, sedation, dizziness, insomnia, headache, GI upset, dry mouth, constipation, weight ↑, visual problems, tremor, weakness, photosensitivity, QT prolongation, postural ↓ BP, ↑ HR, Parkinson-like movements, acute dystonic reaction, hyperglycemia, ↑ diabetes, galactorrhea, gynecomastia, menstrual irregularities, sexual dysfunction, **Sz**, Neuroleptic Malignant Syndrome **(NMS)** → fever, respiratory distress, seizures, ↑ HR, ↑↓ BP, diaphoresis, pallor, tiredness.	SSRIs, anti-seizure drugs, grapefruit juice (pimozide), alcohol, antifungal agents, macrolide antibiotics, St. John's wort, kava kava, dextromethorphan, valproic acid (risperidone).
	Zyprexa	Olanzapine		
	Seroquel	Quetiapine		
Neuroleptics/ Typical anti-psychotics	Haldol	Haloperidol		
	Orap	Pimozide		
	Thorazine	Chlorpromazine		
Anti-convulsants/ Mood stabilizers	Tegretol, Trileptal	Carbamazepine	Dizziness, drowsiness, cognitive slowing, unsteadiness, nausea, GI distress, ↓ appetite, blurred vision, headache, weight ↑, transient hair loss, tics, hepatitis, photosensitivity, menstrual irregularities, CV complications, Stevens-Johnson, bone marrow suppression, pancreatitis (very rare but may be fatal), liver failure mostly in children (Depakote), **Sz**, **M**, teratogenicity (Depakote).	Oral contraceptives, protease inhibitors, seizure drugs, calcium channel blockers, alcohol, St. John's Wort, evening primrose, some antibiotics, risperidone, antihistamines.
	Depakote	Valproic acid		

[1] FDA approved for treating Major Depressive Disorder in pediatric patients, [2] FDA approved for treating Obsessive-Compulsive Disorder in pediatric patients, [3] FDA approved for treating Attention Deficit-Hyperactivity Disorder in children over 6 years old and adolescents, [4] FDA approved for the treatment of irritability associated with autistic disorder in pediatric patients.

Continued on next page

Psychotropic Medications At-A-Glance (continued)

POTENTIAL FOR ABUSE OF PSYCHOTROPIC MEDICATIONS

- Some adolescents and young adults abuse psychotropic medications such as stimulants and benzodiazepines (eg, clonazepam, alprazalam). Pills can be taken orally or by crushing the pills then snorting the powder. Young people may also be pressured by peers to share, barter, or sell their medications.
- Stimulants are abused because they suppress appetite, increase attentiveness and focus, and cause feelings of euphoria. Some adolescents abuse stimulants to lose weight or to help them study all night.
- Benzodiazepines are central nervous system depressants which are abused because they cause sleepiness and feelings of relaxation.
- Prescribe stimulants and benzodiazepines with caution to patients with a history of alcohol or substance abuse. Careful monitoring of refills and early recognition of addiction are necessary.

PSYCHOTROPIC MEDICATIONS AND RECREATIONAL DRUG USE

- Alcohol: In general, adolescents taking psychotropic medication should avoid alcohol. Recent research has shown that fluoxetine may be lower risk than other SSRIs for adolescents who are using alcohol.
- Ecstasy and similar club drugs: SSRIs and Ecstasy should **NEVER** be taken together. The combination can cause Serotonin Syndrome: coma, headache, agitation, sweating, shivering, hypertension, tachycardia, muscle twitching, and death.

FDA Black Box Warning and Implications

- In 2004, the FDA placed a black box warning label on all antidepressants used to treat depression, anxiety, Obsessive-Compuslsive Disorder, and other mental health problems. The FDA issued the warning after studies revealed possible increased risk of suicidality in children and adolescents taking antidepressants.

  All pediatric patients being treated with antidepressants should be observed closely for clinical worsening, suicidality, restlessness, and unusual changes in behavior, especially during the initial few months of drug therapy or at times of dose changes. Family members should closely observe the patient and communicate conditions with healthcare provider. At least weekly face-to-face visits with patients and/or their caregivers should be scheduled during the first 4 weeks of treatment, follow-up visits should be scheduled every other week for the next 4 weeks, then again at 12 weeks, and as clinically indicated beyond 12 weeks. Contact by telephone may be appropriate between face-to-face visits. Patient participation in psychotherapy can also decrease suicidality. Note: Untreated depression carries a greater risk for suicide than any potential risk caused by antidepressants.

- Strattera, an ADHD medication, carries a black box warning due to its association with increased risk of suicidal thinking by children and adolescents.
- Dexedrine, a stimulant used to treat ADHD, carries a black box warning due to cardiac problems linked with the drug.
- See FDA website: www.fda.gov/cder/drug/antidepressants/default.htm, www.fda.gov/Medwatch/safety/2006/safety06.htm#Dexedrine

Resources for Medication Information:

- American Psychiatric Assoc. & American Academy of Child and Adolescent Psychiatry- www.parentsmedguide.org/physiciansmedguide.htm
- National Institute of Mental Health - www.nimh.nih.gov/publicat/medicate.cfm
- National Library of Medicine and National Institutes of Health - www.nlm.nih.gov/medlineplus/druginformation.html
- United States Food and Drug Administration - www.fda.gov/cder/consumerinfo/druginteractions.htm

Sources:
1) American Psychiatric Association and American Academy of Child & Adolescent Psychiatry. Physicians Med Guide. 2004, http://www.parentsmedguide.org/physiciansmedguide.htm
2) National Library of Medicine, Medline Plus. 2006, http://www.nlm.nih.gov/medlineplus/druginformation.html
3) Rosen D. Management of Mental Illness in Primary Care Practice: Part 2. *Adolescent Health Update.* 2005; 18(1): 1-8.
4) Schubiner H, Robin A, Neinstein L. School Problems and ADHD. *Adolescent Health Care: A Practical Guide*. 2002: 1454-76.
5) Taketomo C, Hodding J, Kraus D. *Pediatric Dosage Handbook, 13th Edition*. Lexi-Comp Inc, 2006.
6) US Food and Drug Administration. Drug Information Pathfinder. 2006, http://www.fda.gov/cder/Offices/DDI/pathfinder.htm

Types of Psychotherapy

FORMATS:

◊ **Individual Therapy**- Client participates in one-on-one therapy with a therapist.

◊ **Couples Therapy**- Client and client's romantic partner participate together in therapy that focuses on the couple's communications and interactions.

◊ **Family Therapy**- Client and client's family participate together in therapy that focuses on helping the family function better by exploring patterns of communication and providing support and education.

◊ **Group Therapy**- Client and other people who have similar mental health and/or substance use problem(s) participate together in therapy that uses the power of group dynamics and peer interactions to increase understanding and improve social skills.

TYPES AND MODALITIES*:

◊ **Behavioral Therapies**- Shown to be helpful in disruptive behavioral disorders such as ADHD and ODD. Classroom interventions and parent trainings target specific disruptive behaviors while encouraging more desired behaviors. Parents and teachers learn to provide effective communication, problem solve, set limits, and use rewards and punishments. Most psychologists are well trained in this form of therapy.

◊ **Cognitive Behavioral Therapy (CBT)**- A structured, interactive, and problem-oriented form of psychotherapy shown to be helpful in treating mood and anxiety disorders. CBT focuses on identifying and changing the beliefs and attitudes that lead to negative feelings and unwanted behaviors. CBT strategies include challenging maladaptive beliefs and negative expectations, improving problem solving, enhancing social skills, using stress reduction techniques, and increasing participation in social and other activities such as exercise. Psychologists and some psychiatrists are well trained in this form of therapy.

◊ **Dialectical Behavioral Therapy (DBT)**- A treatment that addresses the problematic actions clients use to deal with extremely intense emotions. Group and individual sessions focus on increasing understanding of what leads to problematic behaviors. Understanding and regulating feelings, increasing interpersonal skills, and developing more adaptive coping strategies are DBT's goals. DBT has been used to treat clients with eating disorders, substance use problems, borderline personality disorder, self mutilating behaviors, and chronic suicidal thoughts. Parents of adolescents are often required to learn DBT skills so they can better support and encourage their teens.

◊ **Interpersonal Therapy (IPT)**- A treatment that focuses on relationship issues such as interpersonal conflict, role transitions, or grief that may contribute to the development or continuation of mental health problems or symptoms. IPT was developed to treat depression and has been shown to be useful in treating bulimia and post-traumatic stress disorder.

◊ **Multisystemic Therapy (MST)**- A family-oriented, home and community-based program for adolescents who engage in criminal activity, truancy, and/or substance use. MST promotes responsible behavior by targeting specific problem behaviors and acknowledging client's strengths. MST recognizes that youth are affected by family, peer, school, and community factors, and it is often necessary to intervene in more than one of these systems. MST is likely to include individual, family, and couples therapy along with community based services.

◊ **Psychodynamic Therapy**- Based on the theory that current symptoms are related to past events and unconscious feelings and thoughts. By revealing these unconscious influences, therapy allows for self-awareness, change, and recovery. Psychodynamic therapy's effectiveness has not been well studied.

*The therapies listed are used to treat/manage other mental health and substance use problems in addition to those specifically mentioned.

Sources:
1) Alexander Youth Network. Multisystemic Therapy Program. 2003, http://www.alexanderyouthnetwork.org/programs/mst.html
2) American Academy of Child and Adolescent Psychiatry. Psychotherapies for Children and Adolescents Fact Sheet. 2003, http://www.aacap.org/publications/factsfam/86.htm
3) Center for Dialectical and Cognitive Behavioral Therapies. Dialectical Behavior Therapy for Adolescents. 2003, http://www.cdcbt.com/problemsadolescents.html
4) Rosen D. Management of Mental Illness in Primary Care Practice: Part 2. *Adolescent Health Update*. 2005; 18(1):1-8.
5) Substance Abuse and Mental Health Services Administration. SAMHSA Model Programs: Multisystemic Therapy. 2005, http://modelprograms.samhsa.gov/template_cf.cfm?page=model&pkProgramID=21

Advocate for Your Adolescent Patients

ASSISTING WITH THE BEHAVIORAL HEALTH REFERRAL PROCESS[1]

- Increase youth/family's awareness of local behavioral health services, support groups, and community organizations (D-55). Provide referral options that are appropriate for the adolescent's level of urgency, developmental age, and condition.
- Be prepared for a behavioral health emergency. ERs connected to large hospitals, large integrated HMOs, and community mental health programs are more likely to take crisis cases quickly than individual or private practices. Push hard for same-day evaluations for emergency or complex cases.
- Keep up-to-date information on the behavioral health carve-outs of your patients' health plans.
- Be wary of behavioral health providers who do not provide other aspects of treatment beyond medications.
- Communicate to behavioral health providers your desired level of involvement in your patient's care and how often you would like updates on patient's condition.

ADVOCATING IN SCHOOLS

- Before sharing patient information, find out how the information you provide will be used. Note: Confidentiality protections for students in schools are different than protections for patients in the healthcare system.
- Enlist patient's teachers and counselors to help monitor adolescent's condition.
- When appropriate, provide written verification of assessments and diagnoses.
- Attend parent-school problem solving, evaluation, and treatment planning meetings.
- Raise adolescent patient's and parents' awareness of Individuals with Disabilities Education Act (IDEA), Section 504, and Americans with Disabilities Act. (D-56, 57)

PARTICIPATING IN OTHER ADVOCACY OPPORTUNITIES[2]

- Appeal denials of reimbursement for counseling and behavioral health services performed in primary care. Participate in managed care/provider committees and provider forums and let your concerns be known.
- Participate in advocacy efforts for improved benefits and reimbursements. Raise public awareness of mental health stigma, the need for early identification of problems, and the importance of behavioral health services expansion.
- Coordinate with or integrate behavioral health professionals into primary care pediatric practice.

TIPS

☑ Document any behavioral health problems and/or abuse. Use the teen's words to describe how she/he feels and what is happening in his/her life. If you observe physical signs of abuse, ensure photos are taken immediately.[3]

☑ Ask the adolescent what he/she would like you to advocate for on his/her behalf. Discuss your advocacy plans in advance with the adolescent and his/her family, if appropriate.

☑ Adhere to confidentiality laws when sharing patient information with parents/adult caregivers, schools, probation and child welfare staff, behavioral health providers, and other individuals and organizations (D-47, 48).

☑ Advocate for the issues you are passionate and concerned about!

[1] Phillips S, Clawson L, Osinski A. Pediatricians' Pet Peeves about Mental Health Referrals. *Adolescent Medicine State of the Art Reviews: Adolescent Psychiatric and Behavioral Disorders*. 1998; 9(2): 243-58.
[2] Jellinek M, Patel B, Froehle M, eds. *Bright Futures in Practice: Mental Health-Volume I Practice Guide.* 2002; 3-10.
[3] Look to End Abuse Permanently. Provider Forms. 2006, http://www.leapsf.org/provider.html

California Minor Consent Laws: Mental Health

Which Minors May Consent for What Services and Providers' Confidentiality Obligations

<table>
<tr><th>SERVICE/TREATMENT</th><th>LAW</th><th>CONFIDENTIALITY AND/OR INFORMING OBLIGATIONS OF THE HEALTH CARE PROVIDER</th></tr>
<tr><td>ASSESSMENT*
*Assessment means the evaluation necessary for an attending professional to assess whether a minor meets criteria (1) and (2) of the minor consent statute, Family Code § 6924, cited at right.

OUTPATIENT COUNSELING

OUTPATIENT TREATMENT*
* The statute does not define "treatment." However, treatment in this context does NOT include convulsive therapy, psychosurgery or psychotropic drugs.</td><td>"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. AND (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. Fam. Code § 6924.</td><td>Confidentiality Obligations
If the minor consents to care, the provider can only share the minor's medical information with the signed consent of the minor. Cal. Health & Safety Code §§ 123110(a), 123115(a); Cal. Civ. Code § 56.10, 56.11; 45 C.F.R 164.502(g)(3); 45 C.F.R. 164.508(a).

EXCEPTIONS TO CONFIDENTIALITY:
Discretion to Inform Parents without Minor's Consent?
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. 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. Cal. Fam. Code § 6924; 45 C.F.R. 164.502(g)(3)(ii).
Discretion to Inform Other Providers without Minor's Authorization?**
In most cases, the health care provider may share medical information for treatment or referral purposes with other qualified professionals treating the client, without need of an authorization. However, the provider cannot share psychotherapy notes without written client authorization. Psychotherapy notes are notes of a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's medical records. 45 C.F.R. 164.502(a)(ii); 45 C.F.R. 164.506; 45 C.F.R. 164.508(a)(2); Cal. Welf. & Inst. Code § 5328(a); Cal. Civil Code § 56.10. But see Cal. Civil Code § 56.104.</td></tr>
<tr><td>PSYCHOTROPIC MEDICATIONS*
*"Psychotropic medication" means those medications prescribed to affect the central nervous system to treat psychiatric disorders or illnesses.</td><td>Only with parent or guardian consent, except a guardian cannot consent to experimental medications for a minor.
Cal. Probate Code § 2356.</td><td rowspan="3">Confidentiality Obligations
If the parent/guardian consents to care, the parent/guardian has a right to access the minor's medical information and the provider can only share the minor's information with others with the signed consent of the parent/guardian. Cal. Health & Safety Code §§ 123105(e), 123110(a); Cal. Civil Code §§ 56.10, 56.11.

EXCEPTIONS TO CONFIDENTIALITY:
Discretion to Refuse Access to Parents?
The parent/guardian of a minor shall not be entitled to inspect or obtain copies of the minor's patient records where the health care provider determines that access to the patient records requested by the parent/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. The decision of the health care provider as to whether or not a minor's records are available for inspection under this section shall not attach any liability to the provider, unless the decision is found to be in bad faith. Cal. Health & Safety Code § 123115(a)(2). See also 45 C.F.R. 164.502(g)(5).
Discretion to Inform Other Providers?**
In most cases, the health care provider may share medical information for treatment or referral purposes with other qualified professionals treating the client, without need of an authorization. However, the provider cannot share psychotherapy notes without written parent authorization. Psychotherapy notes are notes of a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's medical records. 45 C.F.R. 164.502(a)(ii); 45 C.F.R. 164.506; 45 C.F.R. 164.508(a)(2); Cal. Welf. & Inst. Code § 5328(a); Cal. Civil Code § 56.10. But see Cal. Civil Code § 56.104.</td></tr>
<tr><td>INPATIENT TREATMENT</td><td>Only with parent or guardian consent, except a guardian cannot place a minor in a mental health facility against the minor's will. Involuntary placement can only be obtained through a 5150 or 5350 proceeding. This does not preclude a guardian from placing a ward in a state hospital under a WIC 6000 application.
Cal. Probate Code § 2356.</td></tr>
<tr><td>PSYCHOSURGERY/ CONVULSIVE THERAPY</td><td>Only with parent consent. A guardian cannot consent to convulsive therapy. Cal. Probate Code § 2356. However, convulsive treatment shall not be performed on a minor under 12 years of age.
Persons 12-15 may be administered convulsive treatment only if it is an emergency situation and is deemed a lifesaving treatment and other criteria are met. If the minor is able to give informed consent, the surgery cannot be performed if the minor refuses. Minors 16 and 17 must give voluntary informed consent for convulsive treatment. Cal. Welf. & Inst. Code §§ 5326.8, 5326.85.</td></tr>
</table>

California Minor Consent Laws: Mental Health (continued)

Which Minors May Consent for What Services and Providers' Confidentiality Obligations

SERVICE/TREATMENT	LAW	CONFIDENTIALITY AND/OR INFORMING OBLIGATIONS OF THE HEALTH CARE PROVIDER
DRUG COUNSELING by federally assisted drug treatment program* 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. Fam. Code § 6929(f). *An individual, program or facility is federally assisted if: 1. The individual, program, or facility is 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.	"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. Fam. Code §6929(b).	*Confidentiality Obligations* If the minor consents to care, the provider can only share the minor's medical information with the signed consent of the minor. Cal. Health & Safety Code §§ 123110(a), 123115(a); Cal. Civ. Code §§ 56.10, 56.11; 45 C.F.R 164.502(g)(3)(i)(A); 45 C.F.R. 164.508(a). **EXCEPTIONS TO CONFIDENTIALITY:** *Discretion to Inform Parents without Minor's Consent?* Providers may not disclose information to parents without a minor's written authorization However, an exception allows a program to share with parents if the 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. *Discretion to Inform Other Providers without Minor's Consent?* The health care provider only may share medical information with providers employed by the same program or with an entity having direct administrative control, and only in connection with duties arising out of the provision of diagnosis, treatment or referral. Providers also may release information to other medical professionals to meet a bona fide emergency. 42 U.S.C. 290dd-2; 42 C.F.R. 2.12.
DRUG COUNSELING* By individuals, programs or facilities that are not "federally assisted" 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. Fam. 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. Fam. Code § 6929(b).	*Confidentiality Obligations* If the minor consents to care, the provider can only share the minor's medical information with the signed consent of the minor. Cal. Health & Safety Code §§ 123110(a), 123115(a); Cal. Civil Code §§ 56.10, 56.11; 45 C.F.R 164.502(g)(3)(i)(A); 45 C.F.R. 164.508(a). **EXCEPTIONS TO CONFIDENTIALITY:** *Discretion to Inform Parents without Minor's Consent?* 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. While this exception allows providers to inform parents of treatment and involve them in treatment, it does not give providers a right to disclose medical records without the minor's consent. Cal. Fam. Code § 6929(c); 45 C.F.R. 164.502(g)(3)(ii). *Discretion to Inform Other Providers without Minor's Consent?* Records maintained in connection with drug abuse treatment or prevention efforts conducted, regulated, or directly or indirectly assisted by the state Department of Alcohol and Drug programs cannot be shared with providers not employed by the same treatment or prevention program except to meet an emergency. Cal. Health & Safety Code § 11977. For programs that are not state assisted, the health care provider may share medical information for treatment or referral services with other providers. However, the provider cannot share psychotherapy notes without written client authorization. Psychotherapy notes mean notes of a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint or family counseling session and that are separated from the rest of the individual's medical records. 45 C.F.R. 164.502(a)(ii); 45 C.F.R. 164.506; 45 C.F.R. 164.508(a)(2); Cal. Civil Code § 56.10.

** This rule applies to Lanterman Petris Short services which includes most publicly funded mental health services. In other situations, Cal. Civil Code § 56 et al may apply.

Uses & Limitations of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

The DSM, published by the American Psychiatric Association, is utilized by multidisciplinary mental health professionals for clinical, research, administrative, and educational purposes. The DSM contains a listing of psychiatric disorders and corresponding diagnostic codes. Each disorder is accompanied by a set of diagnostic criteria and information including associated features, prevalence, familial patterns, age-, culture-, and gender- specific features, and differential diagnosis. No information about treatment or presumed etiology is included.

The current version, the DSM-IV-TR, was published in July 2000. This was considered a minor text revision (TR) in that changes primarily included recent empirical data for each disorder. In all, there have been 4 major revisions. The 1st DSM edition was published in 1952 followed by the DSM-II in 1968, DSM-III in 1980, DSM-III-R in 1987, and DSM-IV in 1994. The DSM-V is expected in 2011.

The DSM-IV provides health professionals a method of diagnosing disorders and terminology to aid clinical decision making and communication among clinicians.

ORGANIZATION OF DSM-IV

The mental disorders and medical problems described in the DSM-IV-TR are organized into groups according to patterns of symptoms that tend to cluster together. A person can have two or more disorders from the same axis group or disorders from different axis groups. The DSM-IV-TR lists 365 disorders in 17 sections.

- Axis I: all major mental disorders, except personality disorders and mental retardation
- Axis II: personality disorders and mental retardation, pervasive throughout lifetime
- Axis III: medical conditions relevant to treatment of a mental disorder
- Axis IV: psychosocial and environmental factors related to mental disorder
- Axis V: overall level of functioning based on the Global Assessment of Functioning scale (0-100)

HIERARCHICAL DIAGNOSTIC SYSTEM

The diagnostic criteria describe and define the disorder. Descriptions of mental disorders include their intensity, duration, associated behaviors, and symptoms. This places some diagnoses over others. For example, substance use could be causing mental disorders.

LIMITATIONS OF DSM

- No clear distinction between child, adolescent, and adult mental disorders.
- Based on current information and needs constant revision.
- Does not include all conditions.
- Only deals with mental disorders occurring in individuals, not in families or society.
- There is no clear distinction between normal and abnormal psychology.
- DSM diagnosis is based on manifestations of mental disorder and does not always explain etiology.

USES OF DSM IN PRIMARY CARE SETTING

- DSM codes might be used for reimbursement purposes. However, many managed care insurance plans with mental health carve-outs exclude reimbursement for mental health diagnoses by primary care providers.
- DSM terminology can help health care providers communicate with behavioral health providers.
- DSM can help health care providers better understand a patient's diagnosed mental health or substance use disorder.
- DSM can debunk myths about specific mental disorders.

The DSM-IV-PC (DSM-IV Primary Care Version) was developed to help primary care providers diagnose psychiatric and mental disorders. The DSM-IV-TR and DSM-IV-PC can be purchased from American Psychiatric Publishing, Inc www.appi.org. The Classification of Child and Adolescent Mental Diagnoses in Primary Care is compatible with the DSM-IV and can be purchased from the American Academy of Pediatrics at www.aap.org/bookstorepubs.html.

Sources:
1) Fong T, Wolf M. Mental Health and Mental Illness 101: A Basic Introductory Course. California Women's Mental Health Policy Council. 2005: 11-17.
2) Kalat J. *Introduction to Psychology, 4th Edition*. 1996: 600-4.

Know Myself, Know My Teen

Sometimes your opinions and personal experiences can stand in the way of listening 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 and tough issues with your teen.

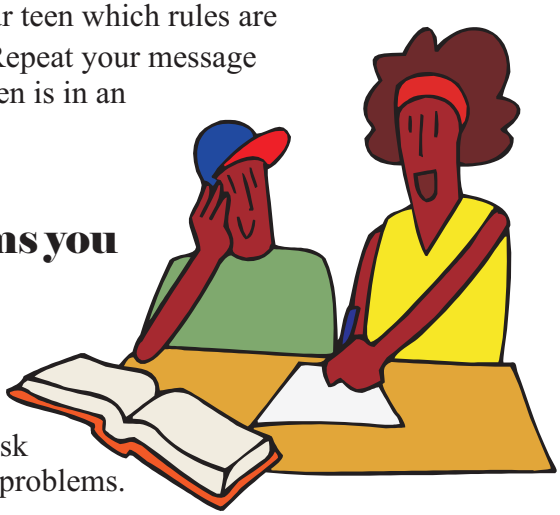
❶ **How do you feel?** Think through your opinions on subjects you will talk about with your teen. What are the memories and personal experiences that may shape your opinions and reactions? Keep in mind that your experiences may be different from your teen's experiences.

❷ **What was I doing when I was 16?** Have you thought about what you want to share with your teenager? Keep in mind where your teen is in his or her development. Hold off on sharing sensitive information with your teen until he/she is in the middle teen years or mature enough to handle the information.

❸ **Are you listening to your teen?** Spend as much time listening as you do talking. The key to good communication is hearing and understanding what your teen is saying and not making quick judgements.

❹ **Do you judge too quickly?** Always ask your teen what she or he is doing rather than assuming the worst. Pay attention to the way your teen makes decisions. Trust that he or she can make good decisions with accurate information. Remember to give information in a way that is easy to understand.

❺ **What are your rules about safety?** Tell your teen which rules are flexible and which rules must be followed for his or her safety. Repeat your message about the importance of safety. Seek help immediately if your teen is in an unsafe situation or is at risk of hurting him/herself or others.



❻ **Are you willing to get help for any problems you may have?**
It is important to be a role model for your teen. For example, if you are worried about your teen's substance use, it sends the wrong message if you or other household members are using drugs or alcohol. Seeing family members or other adults get or ask for help will encourage your teen to seek help for her or his own problems.

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, and 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.

Source:
1) Huberman B, Alford S. Are You an Askable Parent? Advocates for Youth. 2005, http://www.advocatesforyouth.org/publications/frtp/askable.pdf

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.

Peace Begins at Home

Parents play a major role in lowering violence by raising their teens in safe and loving homes. With all the violence on TV, in our neighborhoods, and in schools, it is important that parents teach their teens non-violent ways to solve problems. Is your home a loving, supportive, and safe place for your teen?

- ❑ **Are you able to keep your teen from seeing violence in your home or community?** - Do not allow family members to act violently in your home. Sometimes you can't stop your teen from seeing violence in the streets, at school or at home. Make sure your teen has someone to talk to about his or her feelings.

- ❑ **What is your teen watching on TV, internet, in movies, and video games?** - Check out what your teen is watching and who they chat with on the internet. Help your teen choose shows, movies, games, and web sites that do not encourage violence or risky behaviors. Place TVs and computers in the living room rather than your teen's bedroom.

- ❑ **Be aware of your own behavior**- Be a good example for your teen. Youth often follow their parents' lead. Teach your teen values such as respect and honesty. When you are angry, do you yell or use physical force? Show your teen how to deal with conflicts in a peaceful way.

- ❑ **Keep guns out of reach** - If you have a gun in your home, make sure that it is not loaded. Lock up the gun in one place and keep the extra bullets in another part of your home.

- ❑ **Talk about bullies** - Bullying doesn't end in elementary school. Talk with your teen about how bullies can cause harm by using physical force or hurtful words. Teens may not realize they are being bullied or that they themselves are bullies.

- ❑ **Talk about gangs** - Find out whether your teen is exposed to gangs. Keep in mind that teens in gangs tend to spend less time with adults, and have fewer positive adult role models.[1] It's important for your teen to have supportive and caring relationships with adults.

- ❑ **Pay attention to your teen's actions toward others** - Always teach your teen to solve his or her problems without violence. Talk about the negative consequences of using violence. Encourage your teen to ask you for advice on how to solve conflicts without arguments or fights.

- ❑ **Teach your teen ways to avoid danger** - Encourage your teen to get involved in school activities or after-school programs supervised by responsible adults. Make sure your teen chooses the safest routes when going to and from places or when taking public transportation.

- ❑ **Get the schools involved** - Ask school staff to teach students how to solve problems without yelling, threatening, or fighting. Suggest having peer conflict management groups, community mediation centers, or anger management programs in the school. Do not accept violence, harassment, or bullying from or towards your teen.

- ❑ **How do you show your teen love and support?** - Every teen needs love, trust and honesty in their home to feel safe and supported. Praise your teen when he/she does something well. As much as possible, let your teen know that you love him or her.

RESOURCES

- **Media Awareness Network:** www.media-awareness.ca/english/index.cfm. Website available in English and French.
- **National Youth Violence Prevention Resource Center:** http://safeyouth.org/scripts/parents/index.asp. Articles available in English and Spanish.

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) Children Now and the Kaiser Family Foundation. Talking with Kids about Tough Issues. http://www.talkingwithkids.org/booklet.html
2) American Academy of Pediatrics and American Psychological Association. Raising Children to Resist Violence. 1995, http://helping.apa.org/articles/article.php?id=15
3) Pratt H, Greydanus D. Adolescent Violence: Concepts for a New Millenium. *Adolescent Medicine.* 2000; 11: 103-25.

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

Finding Help for My Teen

WHERE TO START

Your Teen: Talk with your teen and ask him/her:

1) When did this problem start and what may have caused it?
2) Is the problem getting in the way of school, work, or relationships with friends/family?
3) What can I do to help? Then make a plan together about the next steps to take.

Health Care Provider (Doctor, Nurse Practitioner, Physician's Assistant):

Set up an appointment with your teen's health care provider. Be ready to discuss your family's medical and mental health history and recent changes in your teen's life. Make sure your teen spends time alone with the provider. The provider will determine if physical problems have caused your teen's symptoms. The provider can give you advice and recommend qualified mental health providers.

Private Health Insurance Plan:

Call the mental or behavioral health intake number (usually a 1-800 number) or the member services number of your teen's health insurance plan. These numbers are often located on the back of the health insurance card. The health insurance plan can tell you about the mental health and substance use services it covers and can help you set up an appointment.

Community Behavioral Health Services:

Each county in California and many other states have a county or regional mental or behavioral health access telephone line that you can call to make appointments and learn about the mental health and substance use services in your area. Community Behavioral Health usually provides services to people who have limited income, receive Medicaid benefits, and/or do not have health insurance.

School Guidance Counselor:

Your teen's school guidance counselor can offer information on local resources and counseling services offered at school and in the community. Contact the school counselor especially if your teen's behavior or emotions are getting in the way of school.

Clergy:

Clergy can sometimes offer counseling and information on peer programs, support groups, and mental health and drug or alcohol related services. These services may be provided at your place of worship or by local faith-based organizations.

Crisis Services:

If your teen has severe symptoms, there is no time to wait for an appointment. Call 911 or go to a hospital emergency room. Always get help right away if your teen is in danger of hurting him/herself, hurting others, or is unable to function.

CHOOSE A MENTAL HEALTH PROVIDER & TREATMENT PLAN

Ask your teen's mental health provider these questions:

- What do you enjoy about working with and caring for teens? How many teens do you see each week?
- What information will be kept private between you and my teen? What information will be shared with me?
- How involved will I and my family be in my teen's treatment/counseling?
- What types of treatment are available? What are the risks and benefits of each treatment option?
- How can I tell if my teen is improving?
- What are your fees? Do you accept my teen's health insurance plan? Are your fees based upon the patient's ability to pay?

Ask your teen if he/she is comfortable with the mental health provider.

STAND UP FOR YOUR TEEN!

- Encourage your teen to ask for help.
- Learn about your teen's mental health or drug/alcohol problem and the available treatments/resources.
- Tell those who treat your teen about his/her strengths, skills, and talents. Ask mental health providers to include your teen's strengths in his/her treatment plan.
- Keep all of the documents from your teen's health care providers, teachers, and therapists. Write down any changes in your teen's mood and behavior on a calendar.
- Make sure therapists and agencies do what they promise for your teen.
- Ask for a second opinion from another mental health provider when you or your teen feels it would be helpful.

Ask your teen how you can help him/her.

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) Allegheny County Department of Human Services. Taking Charge of Your Child's Mental Health: A Parent's Guide. 2003, www.county.allegheny.pa.us/dhs/BH/TkngChgrChdMntlHlth.pdf
2) Goodman RF. Choosing a Mental Health Professional for Your Child. New York University Child Study Center, 2000, www.aboutourkids.org

Educational Rights of Students with Mental Health Needs

If your teen has mental health problems that get in the way of friendships, homework or anything having to do with school, there are federal laws that protect him/her. These laws were made to give students equal opportunity to access school facilities. These laws also give educational support services to students with mental health needs.

WHICH LAWS SUPPORT SCHOOL ACCOMMODATIONS?

Individuals with Disabilities Education Act (IDEA)

IDEA guarantees all children with disabilities ages 3-21 the right to a free and appropriate public education (the law was last updated in 1997). IDEA defines disabilities as autism, hearing & visual impairment, mental retardation, orthopedic impairments, serious emotional disturbance, specific learning disabilities, and other health impairment. Under IDEA, a student is eligible for an Individualized Education Plan (IEP). The IEP is a set of long-term goals and short-term objectives developed with the parents' and youth's input.

Section 504

Section 504 of the Rehabilitation Act of 1973 protects people with disabilities against discrimination in any program that receives federal funding. Any person with a physical or mental impairment that seriously limits one or more major life activities and has a record of such impairment or is regarded as having such an impairment is eligible for classroom accommodations. These accommodations may include adjusting homework assignments, providing a structured learning environment, simplifying instructions for assignments, adjusting a test taking setting, providing counseling or other therapy, and more.

Steps to access the services under these laws:

1. Meet with your teen's teachers and/or counselor and tell them about your concerns. Then, ask for an evaluation of your teen at his/her school. This evaluation should be free.
2. Always ask for evaluations and services in writing. Include the date on your letters and keep a copy for your records.
3. Always keep careful records of EVERYTHING. This includes communications from teachers and counselors and any notes, reports, and letters between home and school.
4. You can arrange for an evaluation from an independent professional instead of going through the school district, although this may cost money.

TIPS

- ★ Be active and speak up for your teen. Make sure to get answers to your questions.
- ★ Request and read a copy of your school's Section 504 plan.
- ★ Contact the U.S. Department of Education Office of Civil Rights Regional Office for help if the school does not respond to your concerns: 1-800-421-3481
- ★ If your school says your teen is not eligible for help or services under IDEA or Section 504, you have the right to appeal this decision.
- ★ Trust yourself, you know your teen best.

Continued on next page

Edu. Rights of Students w/ Mental Health Needs (continued)

What happens after the evaluation?

If your teen is eligible for services under IDEA, an Individualized Education Plan (IEP) is developed. If he or she is eligible for services under Section 504, a 504 Plan is developed. Parents cannot decide whether or not their child is eligible for the IEP or 504 Plan. If the evaluation team decides that your teen is not eligible, you have the right to appeal the decision. The school is required to give you information on how to make an appeal.

Is an IEP or a 504 Plan better for my teen?

An IEP is recommended for students who have a disability which causes major problems in school performance, as defined by IDEA.

Benefits of an IEP include:

- Short-term and long-term goals are developed for the student.
- IDEA law provides federal funding for IEP services (there is no federal funding through Section 504).
- IDEA law mandates a more in-depth evaluation process and more comprehensive services than Section 504.
- Private school students may be able to receive services if they are found eligible by an IEP.
- Students with IEPs are automatically eligible for civil rights protections under Section 504.

A 504 Plan is recommended for students with disabilities who do not meet the diagnostic criteria for an IEP, such as students with Attention Deficit Hyperactivity Disorder or learning disorders.

Benefits of a 504 Plan include:

- A 504 Plan is easier to get than an IEP and works well for students who do not need a lot of extra help.
- A 504 Plan works well for students who only need extra help in the classroom (i.e. adjusted homework assignments, tests that are not timed, tape recorders to record lectures).
- Students can continue to receive education-related services through Section 504 in college and graduate school if their school receives federal funding.

HELPING YOUR TEEN BECOME HIS/HER OWN ADVOCATE

- Teach your teen how to describe his/her disability and needs to others.
- Make sure your teen knows his/her rights.
- Involve your teen in making decisions around school accommodations. Encourage him/her to participate fully in school accommodation decisions while in high school. Teens need to advocate for themselves once they turn 18 years old.
- Help your teen understand which learning and behavioral strategies work best for him/her.
- Encourage your teen to meet with teachers when he/she needs extra help.

RESOURCES

- **Bazelon Center for Health Law:** www.bazelon.org
- **California State Department of Education:** www.cde.ca.gov/index.asp
- **Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD):** www.chadd.org
- **NICHQ ADHD Toolkit:** www.nichq.org/NICHQ/Topics/ChronicConditions/ADHD/Tools
- **Parent Advocacy Coalition for Educational Rights Center:** www.pacer.org
- **US Dept. of Education Office of Civil Rights Regional Directory:** http://wdcrobcolp01.ed.gov/CFAPPS/OCR/contactus.cfm

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) American Academy of Child & Adolescent Psychiatry. Services in School for Children with Special Needs: What Parents Need to Know. 2002, http://www.aacap.org/publications/factsfam/83.htm
2) CHADD. Educational Rights for Children with AD/HD: CHADD Fact Sheet #4. 2001, http://www.chadd.org

Myths and Facts about Behavioral Health

MYTHS	FACTS
1. Teens don't have mental health or substance use problems.	**Fact:** An estimated 2.7 million U.S. children and teens have emotional or behavioral problems that get in the way of learning, making friends, and family relationships.[1]
2. Once a person has a mental health problem, he/she will be ill forever.	**Fact:** There are different types of mental health conditions and many of them can be effectively treated. Most people feel better after getting help such as therapy and/or medications.
3. Mental disorders and drug addictions are caused by a person's lack of will power.	**Fact:** There are many causes of mental health and substance use problems. These causes include things that a person cannot control such as genetics, family history, brain chemistry, and life experiences.
4. Talking about suicide will cause someone to commit suicide.	**Fact:** Studies show that talking to a suicidal person about suicide does not lead to suicide attempts.[2] In fact, suicidal people often feel relieved when someone gives them a chance to discuss their feelings and suicidal thoughts.
5. Teens use mental health problems as an excuse when they are really just lazy.	**Fact:** People do not ask to have mental health problems. A teen with a mental health problem may seem tired or not interested, but often times she/he feels overwhelmed, hopeless, or has a lot of emotional pain.[3]
6. A person can stop using drugs or alcohol anytime he/she wants.	**Fact:** Addiction, withdrawal (feeling sick when not taking a drug or drinking alcohol), and being near friends or family who use alcohol/drugs can make it very hard for a person to quit.[4]
7. Drugs and alcohol help relieve stress and help people deal with problems.	**Fact:** Drugs and alcohol may make people forget or not care about their problems for a while, but the problems will still be there after the drugs or alcohol wear off.[4] Using drugs or alcohol will not solve the problems.
8. People with mental health problems are dangerous and could flip out at any time.	**Fact:** Most people with mental health problems are not dangerous, violent, or out of control. Unfortunately, this myth often stops people from seeking the help they need because they worry others will think they are "crazy."
9. People who have depression always look like they are sad.	**Fact:** Sadness is only one of the feelings associated with depression. Other signs of depression include being moody, feeling irritable, and losing interest in things that used to be enjoyed.
10. Only abnormal, crazy people go to psychiatrists, psychologists, or therapists.	**Fact:** Many people of all ages, races, ethnicities, and backgrounds meet with psychiatrists, psychologists, and therapists to help them deal with stressful life situations or to get additional support.
11. Psychiatrists, psychologists, and therapists only give common sense advice that people already know.	**Fact:** Psychiatrists, psychologists, and therapists have been specially trained to spot patterns in human thinking, behavior, and emotions. These mental health providers use their education and experience to help people better understand and cope with their life situations.
12. Therapy, substance use treatment, and other types of mental health care are too expensive.	**Fact:** Free and low-cost mental health and alcohol/drug treatment are available. Every county or region has behavioral health services for people who do not have health insurance and for people with limited income. Peer counseling services and support groups are often free.

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] National Institutes of Health, National Institute of Child Health & Human Development. Parents Report Estimated 2.7 Million Children with Emotional and Behavioral Problems. 2005, http://www.nichd.nih.gov/new/releases/americas_children05_bg_parents.cfm
[2] Adolescent Health Working Group. Suicide Myths and Facts. 2003, http://www.ahwg.net/projects/headsup.htm
[3] Zeigler Dendy C. *Teaching Teens with ADD and ADHD*. Woodbine House. 2000; 310-11.
[4] Adolescent Health Working Group. Myths and Facts about Substance Use. 2002.

Taking Care of Myself- A Plan of Action

Name: _____ Date: _____

What **motivates** me to take care of myself?

Who and what are the **people, things, goals, and activities** that are important to me?

-
-
-
-
-
-

What **activities/situations** get me into **trouble**?

1)

2)

3)

How can I **avoid or deal** with these activities /situations?

1)

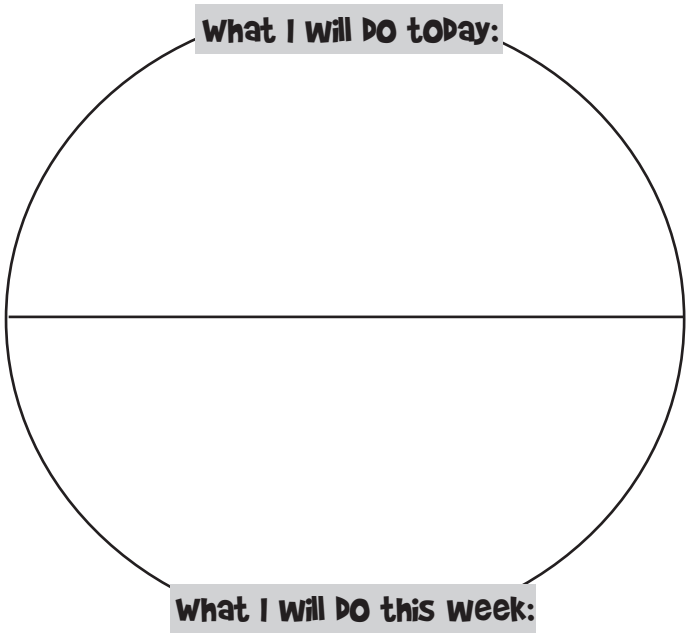
2)

3)

Who will I contact for **help**?
Examples: Parent, relative, friend's parent, clergy member, teacher, coach, therapist.

NAME	CONTACT INFO (Phone#, Address)
1.	
2.	
3.	
4.	
5.	

What **can I do** to **help myself** when I'm feeling down, stressed, or worried?
Examples: Exercise, deep breathing, listening to music, drawing, writing.



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Source:
1) Adolescent Health Working Group. Taking Care of Myself- A Plan of Action. 2003, http://www.ahwg.net/projects/headsup.htm.

Stress Busters

Use one or more of these activities the next time you want to relax or when you feel stressed out. Each activity only takes 10 to 30 minutes.

Exercise 

Exercise for 30 minutes 3 to 5 times a week. You can walk, run, swim, dance, bike, play sports, or any other activity that gets your body moving. Exercise is a great way to release extra energy and keep fit.

Eat Healthy 

Eat healthy foods such as whole grain breads, fruits, vegetables and drink lots of water. Be aware of how much you eat when stressed out. Try not to eat too little or too much. Eat breakfast every day. If you can, pack a healthy lunch and snack such as a sandwich made with wheat bread and a piece of fruit. Avoid junk food, soda, juices with added sugar, caffeine, nicotine, alcohol, and drugs.

Breathe Deeply 

1. Find a quiet and comfortable place to sit or lay down.
2. Close your eyes or look at a spot on the wall.
3. Clear your mind of thoughts or focus on a word like “breathe” or “relax.”
4. Breathe in slowly through your nose until your chest is fully expanded. Breathe out slowly through your mouth until the air in your chest is pushed out. Try not to think about anything else except your breathing.
5. Repeat this deep breathing 10 to 20 times until you feel relaxed. (Don’t be surprised if you fall asleep).

Imagine Relaxation 

1. Find a quiet place and get comfortable.
2. Close your eyes and imagine a place where you feel safe and relaxed. Think about how you feel and what you hear, see, and smell in this place. Or imagine the stress slowly flowing out of your body.
3. Stay with these feelings, thoughts, and sensations. Breathe quietly until you are ready to get up.

Express Yourself 

Write in a journal. Or create art, play music, write stories or poetry, cook, laugh, or volunteer. Talk to someone you trust about how you feel.

Relax your muscles 

1. Find a quiet place where you can lay down and get comfortable.
2. Close your eyes. Relax your entire body. Imagine that your muscles are limp.
3. Flex the muscles in your feet while you keep the rest of your body relaxed. Hold for five seconds and do not release. Then continue to flex other muscle groups one at a time: calves, thighs, stomach, chest, arms, hands, and face until your entire body is tense. Remember to keep parts of your body relaxed until it is time to flex them.
4. Hold your entire body tense for five seconds then release all the tension.
5. Relax, breath slowly and deeply, and imagine your body melting.
6. Get up slowly when you’re ready.

Get in Touch with Your Senses 

Listen to music you enjoy. Take a shower or bath. Go outside for a walk or run. Focus on what you see, hear, and feel.

Resources:

- Emotional Health. Go Ask Alice!: www.goaskalice.columbia.edu/Cat4.html
- Mind Your Mind: www.mindyourmind.ca

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.

5 Steps to Lower Stress

1. Write down any thoughts you have when you are stressed or upset.

2. Read what you wrote. Are your thoughts critical of yourself or others? Circle judgmental or one-sided words such as bad, good, never, and always. These words only show one side of the story.

3. Write down explanations for the stressful situation. There are often multiple reasons why something happens.

4. There are some things that are out of your control. Figure out what you can change and how to take action. Let go of the things you can't control such as what happened in the past and how many classes or credits you need in order to graduate.

What you can change	
Examples: ♦ Telling my mom how I feel without shouting. ♦ Asking my teacher for help. ♦ Forgiving my friend for making a mistake.	♦
♦	♦
♦	♦
♦	♦
♦	♦

5. Your anger or worry can affect how you feel, how you act, and your health. That is why it is important to pay attention to your feelings and lower your stress.

Resources:

- Dealing with Depression workbook: www.mcf.gov.bc.ca/mental_health/pdf/dwd_writable.pdf
- Facts for Teens. National Youth Violence Prevention Center: http://safeyouth.org/scripts/teens.asp

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.

Facts:

- Stress can be caused by past experiences or difficult circumstances currently in your life.
- Everyone responds to stress differently.
- You have the power and ability to lower your feelings of stress.

Stress Can Lead To:

Head aches
Stomach aches
Weight gain or loss
Problems sleeping
Feeling tired
Being grumpy or easily upset
Worrying
Feeling nervous
Feeling sad
Feeling overwhelmed
Problems concentrating
Skin rashes and acne
Drug and alcohol use

Stress affects both your body and mind. You can lower your stress by thinking positively and doing relaxing activities.

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Websites & Hotline

Go Ask Alice!
http://www.goaskalice.columbia.edu
Answers to questions about stress, drugs, sex, and lots more.

It's My Life
http://pbskids.org/itsmylife
Information, interactive games, and online videos for teens.

Mind Your Mind
http://www.mindyourmind.ca
Resources and information to help teens manage stress. Includes online journals and games.

Personal Stress Management Guide
http://www.aap.org/stress/teen1-a.cfm
Create your own stress management plan online.

National Runaway Switchboard
1-800-RUNAWAY
24-hour free and confidential phone line for youth. Information on getting food, shelter, legal aid, medical care, and counseling services.

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Hey Teens!

Stressed Out?!

By: Adolescent Health Working Group

AHWG

www. ahwg. net

50 Ways to Chill Out, Relax, and Stay Cool

Go for a walk
Write in a journal
Dance
Listen to music
Eat a healthy snack
Hang out with friends
Draw
Create art
Cook or bake
Play sports
Sing
Express myself
Play with my pet
Take a nap
Swim
Read a book
Watch TV or a movie
Ride a bike
Take a hot bath/shower
Laugh
Rest
Jog or run
Go on a car ride
Plant a tree or flower
Relax with my family
Believe in myself
Look up at the stars
Lift weights
Play cards or games
Have a water fight
Chill out at a park
Email my friends
Go on a picnic or BBQ
Hug a friend
Fix my bike or car
Dress up for a night out
Call a friend
Solve a problem
Figure out a puzzle
Walk along the beach
Surf the net
Wash a car
Look on the bright side
Cry
Stretch
Write a song or poem
Take some deep breaths
Daydream
Look at photographs
Remember good times

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Stress Busters

Exercise: Walk, run, swim, dance, ride a bike, play sports, or any other physical activity at least three times a week.

Eat healthy: Eat whole grain bread, fruits, and vegetables for long-lasting energy. Notice how much you eat when you are stressed. Drink lots of water.

Imagine Relaxation: Close your eyes and imagine a time and place where you feel safe and relaxed. Think about how you feel and what you hear, see, and smell in this place. As your mind relaxes, your body will too.

Relax Your Muscles:
1) Find a quiet place where you can lay down and get comfortable.
2) Close your eyes. Relax your entire body. Imagine your muscles are limp.
3) Tighten the muscles in your feet while keeping the rest of your body relaxed. Hold for 5 seconds and do not release. Then tighten more muscle groups one at a time: calves, thighs, stomach, chest, arms, hands, and face until your entire body is tense. Keep parts of your body relaxed until it is time to flex them.
4) Hold your entire body tense for 5 seconds then release all of the tension.
5) Relax, breath slowly and deeply, and imagine your body melting.
6) When you're ready, open your eyes and get up slowly.

Deep Breathing:
1) Find a quiet, comfortable place to sit.
2) Close your eyes. Focus on a word like "breathe" or "relax."
3) Breathe in slowly through your nose until your chest is full. Breathe out slowly through your mouth. Focus on the feeling of air coming in and going out.
4) Slowly repeat this deep breathing 10 to 20 times until you feel relaxed.

Talking with a Counselor

- People talk to counselors when they run into problems and need some extra help.
- Counselors are trained to listen non-judgmentally to concerns, offer helpful suggestions, and connect people to community resources.
- Counselors can be found at schools, health centers, clinics, youth organizations, places of worship, or by calling counseling phone hotlines.

Fold Here

Hey Teens!

See the other side for helpful websites and hotlines.

Keep The Peace

Disrespectful acts, teasing, rumors, and bitter words can lead to anger, hurt feelings, and fights. The good news is that problems can be solved without violence. These tips can help you stay calm during a conflict.

Lower the Tension Step-By-Step

1) Don't carry a gun or weapon and don't hang out with people who carry weapons.

2) Leave a tense situation to calm down.

3) Decrease your stress by exercising or doing relaxing activities.

4) Speak truthfully about how you feel without blaming, yelling, or fighting.

5) If you and your friend are having a conflict, listen carefully to your friend's point of view. Then explain why you are upset. Find a fair solution together.

6) Talk to an adult you trust such as a parent, family member, teacher, counselor, coach, or clergy member.

Working Through Problems and Making Decisions

Step 1. Decide what problem or situation you would like to work on.
Example: My little sister gets on my nerves and is always bothering me.

Step 2. Think about all of the possible ways you can solve the problem or improve the situation. Write all of the ideas you came up with on a piece of paper even if the ideas seem wrong, silly, or too difficult.
Example: Ignore my sister.
Ask my mom to keep her away from me.
Calm down and tell my sister I will hang out with her later.
Go play basketball with my friends.

Step 3. Write down the positive and negative points for each action.

Example: Ignore my sister. → (+) *I won't have to deal with her.*
→ (-) *Ignoring her will hurt her feelings.*

Step 4. Choose the best way to solve the problem or improve the situation without hurting other people or using violence.
Example: Calm down when my sister annoys me and tell her I will hang out with her later.

Step 5. Know what you will need to carry out the action. Be prepared for the obstacles you will face.
Example: I will need to control my temper. I will need to keep my promise to my sister.
It will be hard to find time to hang out with my sister. Instead of watching TV by myself in my room, I will do something fun with her after school.

Step 6. Carry out the action you chose and be proud for solving problems in peaceful ways.

Resources:

- Dealing with Depression workbook: www.mcf.gov.bc.ca/mental_health/pdf/dwd_writable.pdf
- Facts for Teens. National Youth Violence Prevention Center: http://safeyouth.org/scripts/teens.asp

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Love Shouldn't Hurt

Dating and being in a romantic relationship can be fun and exciting. Unfortunately, too many teens are hurt by the people they date. Dating or relationship violence is a pattern of violence someone uses against their boyfriend, girlfriend, or date and it includes emotional, verbal, physical, and sexual abuse.

Quiz: Are you in an Abusive Relationship?

1. Are you afraid of your partner or afraid of what your partner will do if you end your relationship?
2. Does your partner call you names, make you feel stupid, or tell you that you can't do anything right?
3. Is your partner extremely jealous?
4. Does your partner try to limit where you go or who you talk to?
5. Do you feel cut off from your friends or family because of your partner?
6. Do you feel threatened by your partner if you say no to touching or sex?
7. Has your partner ever blamed you for his/her violent actions?
8. Has your partner ever shoved, hit, kicked, held you down, or physically hurt you on purpose?
9. Is your partner really nice sometimes and really mean other times as if she/he has 2 different personalities?
10. Does your partner make frequent promises to change and never hurt you again?

If you answered "YES" to any of the above questions, your partner is being abusive towards you. It is very important for you to be safe and reach out for help.

Safety Tips:

- Do not meet or hang out with the abusive person by yourself. Go to a public place or a location where your family or friends are nearby.
- Avoid being alone at school, at work, or on the way to and from places.
- Always tell someone you trust where you are going and when you will be back.
- Make sure you can get home or get to a safe place on your own. Bring your own car, money for the bus or taxi, or go to a public place and call friends/family for a ride.
- Memorize the addresses and phone numbers of people you trust. Go to these people for help if your date or partner becomes violent or abusive. Call 911 if you are in an emergency situation.

You Deserve Healthy Relationships!

Where to Go for Help:

- Educate yourself about dating/relationship violence. Search for information on the internet or at your local public library.
- Talk with your parent, family member, teacher, counselor, doctor/nurse, clergy member, or other trusted adult. The less isolated you are, the less opportunity the abusive person has to hurt you.
- Seek help from professionals. Go to places such as school health centers or counseling offices, clinics, youth or faith-based organizations, community centers and/or call a hotline.

Resources:

- National Teen Dating Abuse Helpline: 1-866-331-9474
- Rape Abuse Incest National Network: 1-800-656-HOPE
- Love is Not Abuse: www.loveisnotabuse.com

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.

Source:
Washington State Office of the Attorney General. Teen Dating Violence Brochure. 2004, http://www.atg.wa.gov/violence. Adapted and reproduced with permission.

COPING With LOSS

Everyone deals with death and loss in different ways. There is no right or wrong way to feel or respond to these important issues. Your feelings are unique. Have faith that painful emotions and thoughts will not last forever and your feelings will change with time.

YOU MIGHT EXPERIENCE ONE OR MORE OF THESE AFTER A LOSS:

Fear	Sadness	Feeling alone
Anger	Worry	Thinking about your own death
Guilt	Sense of injustice	Taking more risks
Relief	Numbness	Overwhelmed
Stomach or headaches	Denial	Eating or sleeping changes/feeling tired
Resentment	Difficulty concentrating	Confusion

Be patient with yourself while you are coping with loss. There might be days when you think a lot about the loss and other days when you don't think about it as much or at all. Try the following suggestions to take care of yourself during this time:

- ❑ Set realistic goals. Start by doing things to take care of yourself such as eating healthy food and getting enough sleep.
- ❑ Keep in touch with your friends. When you are ready, share your feelings with them.
- ❑ When you are ready, talk to an adult you trust. This adult can be a family member, teacher, coach, counselor, family friend, clergy member, or health care provider.
- ❑ Ask if you have questions about what happened. Tell people you want honest answers.
- ❑ Decrease your stress. Do something active like exercise or express yourself through writing or art.
- ❑ If you are involved in a funeral, tell your family how you would like to participate.
- ❑ If you want, take time to think back on your memories.
- ❑ If you like, keep special objects that remind you of the person or place that you miss.
- ❑ Get involved in a volunteer activity. Helping others can give you confidence and direct your energy toward a good cause.

Resources:

- Death and Grief. TeensHealth: www.kidshealth.org/teen/your_mind/feeling_sad/someone_died.html
- Grief and Loss. Go Ask Alice!: www.goaskalice.columbia.edu/Cat4.html

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. Children and Grief: What They Know, How They Feel, and How to Help. New York University Child Study Center. 2001, http://www.aboutourkids.org/aboutour/articles/grief.html
2) UCLA School Mental Health Project. Schools Helping Students Deal with Loss: Guidance Notes. 2005, http://smhp.psych.ucla.edu/pdfdocs/loss.pdf

Dealing with Separation and Divorce

Parental separation or divorce usually causes many changes. Such big changes can be difficult to handle. You may feel many emotions including anger, sadness, confusion, guilt, and relief. At this time, it's important to believe in your ability to cope. There are also people who can and want to help you. Here are some points to keep in mind.

▶ It is NOT Your Fault

Parents split up because they do not want to be together or can no longer get along with each other. You are not responsible for how your parents handle their relationship.

▶ Express Your Feelings

Talk to a friend, an adult you trust, or your parents about how you feel. It is normal to have lots of strong emotions during this time. There is no right or wrong way to feel. It is better to share your feelings rather than keep everything inside.

▶ Keep the Peace

Ask your parents to treat each other with respect when they are in front of you and tell them you will not take sides in their disagreements. You have the right to love both parents and to have both parents involved in your life.

▶ Be Organized

If you take turns living with each parent, make a list of things you need to bring with you when you move. Get two combs and toothbrushes so you have them at both places or make sure you take them with you. Decorate your space or room and make it comfortable. Tell your parents when you would like to change the visiting schedule.

▶ Stay Connected

It's normal to miss a parent that you don't see very often. Try to set up a regular time to contact your parent by email, phone, or by writing a letter. Have special things that remind you of your parent. If your parent does not keep in touch with you, remember it is not your fault.

▶ Take Care of Yourself

You can lower your stress in many ways like talking with a friend, exercising, eating healthy meals, getting enough rest, and writing in a journal. Lowering your stress level will help you deal with difficult situations. Ask for help if you are having a hard time dealing with the changes.

▶ Look for the Positives

You might be surprised by the good things that happen after your parents separate or divorce. Your parents may be happier. You may become more mature after coping with this difficult experience. The strength within yourself will help you deal with changes throughout your life.

Resources:

- Families Change- A Teen Guide to Parental Separation and Divorce: www.familieschange.ca
- Dealing with Divorce. TeensHealth: http://kidshealth.org/teen/your_mind/families/divorce.html

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.

Websites & Hotline

Alateen and Alcoholics Anonymous
www.al-anon.alateen.org/alaabout.html
Support groups and information for teens who are affected by alcohol.

Dance Safe
www.dancesafe.org
Information about drugs and pill testing sites.

Good Drugs Guide
www.thegooddrugsguide.com
Honest and accurate information about recreational drugs.

Harm Reduction Coalition
www.harmreduction.org
Drug use safety tips and a list of teen friendly websites.

Substance Abuse Treatment Locator
http://findtreatment.samhsa.gov
Treatment options organized by zip code.

Tobacco Information and Prevention Source (TIPS)
www.cdc.gov/tobacco
Tobacco fact sheets and ways to quit.

Poison Control Centers
If you are having a poison emergency, call 1-800-222-1222

If person has collapsed or is not breathing, call 911.

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HEY TEENS!

The Truth about Tobacco, Alcohol, & Other Drugs

By: Adolescent Health Working Group

AHWG

www. ahwg. net

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The Whole Truth and Nothing But the Truth

Fact : Even legal drugs like alcohol and tobacco are addictive and can hurt your body and your mind.

Fact : Marijuana causes people to react slower than usual which makes driving very dangerous. Marijuana for recreational use is illegal and being caught with the drug can lead to serious consequences.

Fact : Drinking alcohol or using drugs increases a teen's risk of committing or being a victim of crime, fighting, getting hurt in car accidents, and having unprotected or unwanted sex.

How Tobacco Affects Your Body

BRAIN: Nicotine, the drug that makes tobacco addictive, goes to your brain. It can make you feel anxious, nervous, moody, and depressed after you use it. Tobacco also causes dizziness and headaches.

MOUTH: Tobacco stains your teeth and gives you bad breath. Your favorite foods won't taste as good because tobacco hurts your taste buds. Tobacco use can cause bleeding gums and cancers of the mouth and throat.

HEART: Smoking increases your heart rate and blood pressure. That means your heart has to work harder than usual when you do activities like exercise and play sports.

LUNGS: Smokers have trouble breathing because smoking damages the lungs. Smoking can lead to more frequent and serious asthma attacks. Smoking also causes coughing, lung disease, and cancer.

SKIN & MUSCLES: Smoking causes dry, yellow skin and wrinkles. The tobacco smell sticks to your skin and clothes. Tobacco causes less blood and oxygen to flow to your muscles which causes them to hurt when you exercise or play sports.

Source: GirlsHealth.Gov. Straight Talk about Tobacco. 2006. Adapted and reproduced with permission.

Stop Before You Start

Some reasons why teens start trying tobacco, alcohol, and other drugs include:

- To fit in
- To escape their problems
- To have something to do
- To look cool or older
- To rebel
- To experiment

There are less harmful ways to fit in, feel better, and be curious.

You can:

Learn about the drug and its side effects.

Find friends you feel comfortable with. Try joining a club, sports team, or after school program.

Go for a walk, write in a journal, or talk to a friend when you feel angry, worried, sad, or bored.

Experiment with something that challenges you to improve your talents and abilities. Don't forget to stay safe.

Remember that…
Drugs may help you feel better for a little while, but they don't solve problems. Drugs are addictive and you may become dependent on them.

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Quiz: Do Tobacco, Alcohol, or Drugs Impact Your Life?

1. Do you use tobacco, drugs, or alcohol to forget your problems? __ YES __ NO
2. Do you feel like you can only have fun with tobacco, drugs, or alcohol? __ YES __ NO
3. Do you often feel depressed, angry, or anxious when you aren't using tobacco, drugs, or alcohol? __ YES __ NO
4. Do you need more and more tobacco, drug, or alcohol to get the same feeling or high? __ YES __ NO
5. Do you ever drink alcohol, use tobacco, or use drugs when you are alone? __ YES __ NO
6. Are you isolating yourself or keeping secrets from your friends or family? __ YES __ NO
7. Have your school grades dropped or have you been absent from school due to drug or alcohol? __ YES __ NO
8. Do you ever have blackouts or trouble remembering what happened when you were drunk or high? __ YES __ NO
9. Are you selling or stealing things to buy tobacco, alcohol, or drugs? __ YES __ NO
10. Do you have problems such as stomach cramps, headaches, or shaking when you don't use tobacco, alcohol, or drugs for a while? __ YES __ NO

If you answered YES to ANY of these questions, you may have a serious problem with tobacco, drugs, or alcohol.

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Not Ready to Quit?

It is very hard to admit having a tobacco, alcohol, or drug problem. It's OK if you are not ready, willing, or able to quit at this time. But, it is not OK to harm others or cause unnecessary harm to yourself.

Use these safety tips:

- ◊ Cut down on the amount you use.
- ◊ Avoid mixing drugs and use only small amounts of a new drug.
- ◊ Eat nutritious foods, drink plenty of juice and water, get enough sleep, and get a check-up every year.
- ◊ Plan how much you will use BEFORE you are high or buzzed, and ask a friend to help you stick to your plan.
- ◊ Decrease the amount you use if you haven't used in a few days, are feeling sick, or have lost weight.
- ◊ Find a sober driver to give you or your friends a ride. Do not drive when you are drunk or high.
- ◊ Let the drug/alcohol take affect before taking more.
- ◊ Check out the drug to see if it looks, tastes, and smells OK. Do a little first to see how strong it is.
- ◊ Set a limit on how much money you will spend on drugs/alcohol.
- ◊ Use drugs/alcohol only with trusted friends who will help you if you feel sick, nervous, or pass out.
- ◊ Gather information on the drugs you use and how they affect your body.
- ◊ Use new or clean needles EVERY time you inject.

Fold Here

Move Toward Quitting

1) Think about Quitting

- Learn more about what you are using.
- Practice drug/alcohol use safety tips.
- Know the things you like and dislike about using drugs/alcohol/tobacco.
- Think about the effects drugs/alcohol/tobacco have on school, work, friends, family, and relationships.
- Ask yourself if you depend on the drugs you use.

2) Plan to Quit

- Take the first step towards quitting by cutting down on your use and/or getting help from someone you trust.
- Find out which people, situations, and places trigger your use.
- Identify friends, family members, or caring adults who will support you.
- Find a friend who will quit with you.

3) Commit to Quit

- Be prepared to avoid the triggers that lead you to use. Avoid people and places with drugs/alcohol/tobacco.
- Set a quit date & get rid of your supply.
- Let others know you are quitting.
- Plan alternative activities such as exercise, work, or volunteering.
- Make a plan to quit that has realistic short-term goals.
- Go to an Alcoholics Anonymous, Narcotics Anonymous, or other peer support groups/programs.
- Be ready for times when you don't meet your goals. Believe in yourself, try again, and ask for help.
- Reward yourself for your successes!

Study SMART! Stay Organized!

Organizing your Backpack

- **Water bottle**
- **Books and workbooks**
- **Pencils, pens,** and **erasers** in a pocket with a zipper or in a pencil case.
- **Folders** and **binders** to store your **homework** and **lined paper**.
- A **calendar** or **student planner** to keep track of homework and project due dates.

Before you leave class, check to see if you:

- ❑ Wrote down the important ideas from class.
- ❑ Understand how to do your homework. If you are not sure, ask your teacher for help.
- ❑ Wrote down when the homework is due in your calendar or student planner.

Choose your Study Place:

- ❑ Find a quiet place with **NO** TV, phone, or video/computer games.
- ❑ Go to the library if your house is too noisy or too distracting.
- ❑ Place your books, pencils, and other supplies near you before you start studying.

Tackle Homework and Projects:

- ❑ First, work on projects and homework assignments that are due tomorrow.
- ❑ Second, work on projects that are due next week or next month.
- ❑ Take a 15 minute break for every hour you study.
- ❑ Try studying with a classmate or friend.

Get Ready for Tests:

- ❑ Think of possible test questions. Find the answers to these questions. Quiz yourself or have a friend or parent quiz you.
- ❑ Start studying for a test at least a week ahead of time.
- ❑ Get enough sleep and eat breakfast before taking a test.

Ask Questions! Be Proud for trying your Best!

Resources:

- School. It's My Life: http://pbskids.org/itsmylife/school/index.html
- School and Jobs. TeensHealth: www.kidshealth.org/teen/school_jobs

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.

Offer a Helping Hand

We all run into problems that seem too hard to handle. These problems can cause us to feel sad, angry, scared, hopeless, and worthless. If you have friends with any of these emotions, support them and let them know there are caring people who can help.

1

Listen: Listen to how your friend feels without interrupting or judging him/her.

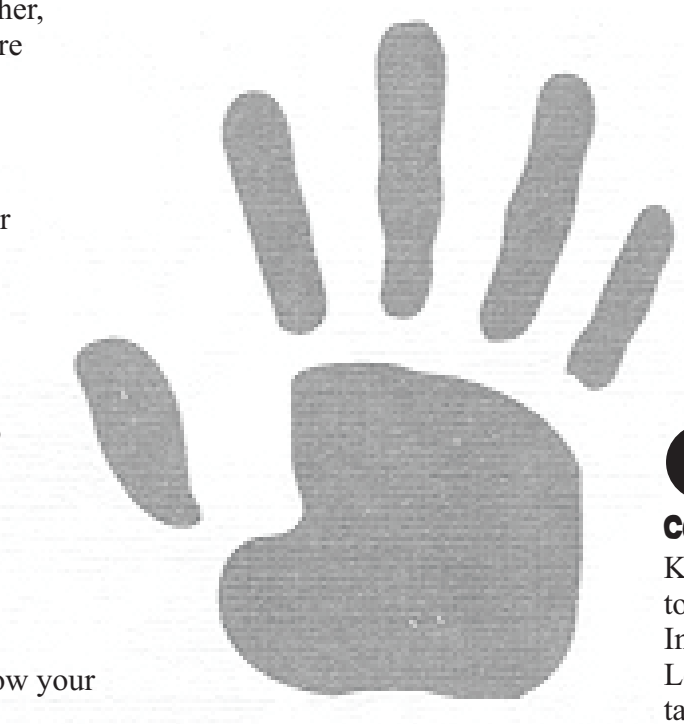
2

Reach out for help:
Encourage your friend to talk with a trusted adult like a school counselor, family member, family friend, teacher, clergy member, or health care provider. Adults may have experience dealing with the problem.

- Make a list of people your friend can go to for help.
- Offer to go for help with your friend.
- If there are no adults who can help, encourage your friend to call a talkline/ hotline.

3

Find solutions: Help your friend come up with a list of things or ways to improve the situation. Encourage him/her to start taking action.



4

Maintain safety: If your friend does not get help from an adult quickly enough, talk about it with an adult you trust. Contact an adult right away if your friend is being harmed or talks about death, suicide, or hurting other people. It is very important that your friend is safe and that other trusted people are assisting him/her. It is better for a group of people to help your friend.

5

Continue to Give Support:
Keep in touch with your friend to see how he/she is doing. Include your friend in activities. Let your friend know it's OK to talk to you about her/his feelings or concerns.

REMEMBER:

★ You **CAN** support your friends, cheer them on, and encourage them to seek help from others.

★ You **CAN NOT** solve all of your friend's problems. Each person must take responsibility for themselves and their own actions.

Resources:

- Helping Others and Getting Help. National Youth Violence Prevention Resource Center: www.safeyouth.org/scripts/teens/helping.asp
- Dealing with Problems. TeensHealth: www.kidshealth.org/teen/your_mind

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.

Confidentiality Facts for Teens (12-17 years old)

➤ Confidentiality means keeping your information as private & safe as possible.

It means that when you talk with your therapist, psychiatrist, psychologist, or social worker, he/she will not tell your parents or guardians what you say unless you give your permission. However, California laws let behavioral health providers make decisions about what information they will share. You should not assume your provider will keep your information private from your parents or guardians.

➤ How can I have confidentiality with my behavioral health provider?

If you don't want your parents or guardians involved in your mental health or substance use treatment, you must explain that to your provider. In some situations, you may be required to have your parents involved.

➤ What if I need care for a mental health or drug/alcohol related crisis?

Teens in crisis can get help without their parents knowing about it. But providers and insurance plans have different definitions of what is a crisis. Check with your provider or health plan for more information. If you need medications or admission to a hospital, your parent/guardian must be contacted.

Tips for Teens!

- ★ Ask questions about consent and confidentiality. Find out who your provider will share your information and records with. Don't stop asking until you understand the confidentiality rules.
- ★ If you feel that you need confidential services, make sure you tell your provider.
- ★ Read and understand written documents before signing them.
- ★ Know your rights in the behavioral health care system and speak up for your rights.

For your safety, some things cannot stay confidential...

Your provider will need to contact someone or your parents/ guardians to help if you say…

- ➤ You were or are being physically or sexually abused.
- ➤ You are at serious risk of hurting yourself or another person.
- ➤ You are unable to function due to a mental health condition.

Even if you don't have to ask your parents for permission to see a behavioral health provider, it's a good idea to talk with them or a trusted adult about the help you need.

Resource:

- California Minor Consent Laws pocket card for youth and health care providers. 2007, Adolescent Health Working Group: www.ahwg.net/resources/resources.htm

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) Adolescent Health Working Group. The Truth about Confidentiality. *H.E.A.L.T.H. Curriculum*. 2005, http://www.ahwg.net/projects/health.htm
2) National Center for Youth Law. Which Minors Can Consent for What Services and Providers™ Confidentiality Obligations, revised. Nov 2006, http://www.youthlaw.org

Making a Behavioral Health Appointment

1. Find your health insurance card

Look on the front or back of your health insurance card for the phone number of mental health, drug treatment and/or behavioral health services. If you cannot find any phone number like this, call the health plan's customer/member services number.

If you do not have health insurance, contact your local community behavioral health services for information. Your doctor, nurse, teacher, or school counselor can help you find this number.

2. Call the Health Plan's mental or Behavioral health services phone

In California, teens 12 years and older can call with a parent, health care provider, counselor, or by themselves. Be ready to explain the situation and your need for services. Tell the person who answers the phone that you'd like to see a behavioral health provider who has experience and enjoys working with teens. Most likely you will be given a list of behavioral health providers to call.

3. Questions to ask yourself before calling a Behavioral health provider

- What am I looking for in a behavioral health provider?
- Do I want a provider that's a certain gender, race/ethnicity, age, or has specific training/treatment approaches?
- Can I get to the provider's office? Is the office open after school or on weekends?
- Do I want my parents/guardians to be involved?

4. Call Behavioral health providers

Psychiatrists are trained medical doctors who can prescribe medications and provide therapy. Psychologists, social workers, and marriage family therapists are trained to provide therapy. When you call, briefly explain why you want help and give the name of your health insurance. Slowly spell your name, repeat your phone number twice, and give the best time to call you back. Keep track of the time and day that you called and who returned your calls.

5. Not having any luck?

Sometimes it is hard to find a behavioral health providers that fits your needs because of their location, office hours, busy schedules, or lack of experience working with teens. If this happens or no one returns your calls, go back to Step 2. Explain that you need special assistance and ask to speak with a supervisor.

6. Once you reach a Behavioral health provider, ask:

- How many teens do you see a week?
- Do you enjoy working with teens?
- Which conditions/problems have you treated in the past?
- What is your license and how many years have you been in practice?
- What is your treatment approach?
- How much will your treatment cost?
- Will you tell my parents or any one else what we talk about during appointments?

If you don't feel comfortable with a behavioral health provider after several sessions, tell the provider your concerns and consider switching to somebody else. Sometimes it takes a while to feel comfortable with a new person and a new situation.

Speak up for your needs! Be persistent! Congratulate yourself for getting help!

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.

Source:
1) Knopf D, Hostetler R. Mental Health Referral Form. University of California San Francisco, Division of Adolescent Medicine. Adapted with permission.

Youth Behavioral Health Rights & Responsibilities

As a youth in the behavioral health care system, I have the right to:

- ★ Be treated with respect.
- ★ Receive quality care and services from providers and staff who are comfortable and experienced working with young people.
- ★ Be presented with honest and complete information and guidance including being informed of all available treatment options.
- ★ Request to see a provider that I feel comfortable with, and to ask for a second opinion when it's necessary.
- ★ Communicate with the provider and staff in a language and manner that I understand.
- ★ Have confidentiality and its limitations explained to me.
- ★ Include family members, friends, and partners in my care at my request.
- ★ Be addressed by my name and to know the names and roles of the providers and staff who help care for me.
- ★ Be informed about my health benefits, health plan procedures, and billing process.
- ★ Review my records.

And, I have the responsibility to:

- ★ Give honest and complete information and let my provider know if my health or situation changes.
- ★ Ask questions about my health or health care including the names, purposes, and side effects of medications that are prescribed to me.
- ★ Follow the plan that I decide on with my provider, and let her/him know if I choose to change my mind about my treatment.
- ★ Be on time for my appointments and call if I will be late or must cancel an appointment.
- ★ Treat staff, other clients or patients, and office policies with respect.

When you have questions- ASK!

When you have concerns- SPEAK UP!

When you like what happens- SMILE AND SAY THANKS!

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.

Source:
1) Adolescent Health Working Group. Youth Health Rights and Responsibilities. 2003, http://www.ahwg.net/resources/resources.htm.

INTERNET RESOURCES: Click On This!

GENERAL BEHAVIORAL HEALTH

- ***American Academy of Child and Adolescent Psychiatry***
  www.aacap.org
  Practice parameters and guidelines for many mental health disorders. Fact sheets for parents in English, Spanish, Arabic, and 4 other languages.
- ***American Academy of Pediatrics,*** www.aap.org
  Resources, publications, and policy statements on child and adolescent health issues.
- ***Bright Futures in Practice: Mental Health, Nat'l Center for Education in Maternal and Child Health & Georgetown University***
  www.brightfutures.org/mentalhealth/pdf/tools.html
  Description of mental health symptoms, early interventions, screening tools, and patient handouts.
- ***Child and Adolescent Mental Health***
  Kaye D, Montgomery M, Munson S (editors)
  Lippincott Williams & Wilkins, 2002
  Guide to pediatric mental health that explains the systems involved in child/adolescent mental health and addresses common mental health conditions.
- ***Go Ask Alice, Columbia University Health Services***
  www.goaskalice.columbia.edu
  Extensive information on sexual health, physical and mental well being, drugs, and relationships.
- ***It's My Life, PBS Kids Go!,*** http://pbskids.org/itsmylife
  Information, videos, and games about family, friends, emotions, and more. Available in Spanish.
- ***Medline Plus, US Nat'l Library of Medicine & NIH,***
  http://medlineplus.gov
  Resources and up-to-date information on health topics and medications. Available in Spanish.
- ***Mental Health: A Report of the Surgeon General***
  www.surgeongeneral.gov/library/mentalhealth/cre
  Addresses mental health problems as a public health concern. Includes a section on mental health stigma.
- ***Mind Your Mind, Family Service Thames Valley***
  www.mindyourmind.ca
  Health information website with games, quizzes, online journals, personal stories, and website links.
- ***National Institute of Mental Health,*** www.nimh.nih.gov
  Up-to-date news and information on treatment options and medications. Some free publications in Spanish.
- ***NSW Centre for the Advancement of Adolescent Health, New South Wales Department of Health***
  www.caah.chw.edu.au/resources/#03
  Publications and toolkits on nutrition, sexuality, substance use, parenting, and youth suicide.
- ***President's New Freedom Commission on Mental Health***
  www.mentalhealthcommission.gov
  Recommendations to improve US mental health system.

General Behavioral Health - cont'd

- ***Reachout.com.au, Inspire Fndtn,*** www.reachout.com.au
  Covers mental health topics, substance use, loss and grief, sexuality and more. Online journal and chat forums.
- ***School Mental Health Project, Univ. of California LA,***
  http://smhp.psych.ucla.edu
  Cutting-edge research, policy recommendations, and extensive library on improving student mental health.
- ***TeensHealth, Nemours Fndtn,*** www.kidshealth.org/teen
  Extensive information on safety, drugs, sexual, physical, and mental well-being. Information available in Spanish.
- ***US Substance Abuse & Mental Health Services Admin.***
  www.samhsa.gov
  Substance use and mental health statistics. Free fact sheets on adolescent drug use. Some free publications available in Spanish.

ATTENTION DEFICIT/HYPERACTIVITY

- ***Caring for Children with ADHD: A Resource Toolkit for Clinicians, National Initiative for Children's Healthcare Quality (NICHQ),*** www.nichq.org
  Diagnosis and treatment information and patient materials. Spanish-language toolkit is available from the American Academy of Pediatrics: www.aap.org
- ***Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD),*** www.chadd.org
  ADHD resources for parents, educators, and health providers. Links to local chapters. Website available in Spanish. CHADD's National Resource Center on ADHD can be accessed at: www.help4adhd.org
- ***Children's Medication Algorithm Project, Texas Department of State Health Services***
  www.dshs.state.tx.us/mhprograms/CMAPed.shtm
  ADHD and Depressive Disorder educational materials available in English and Spanish.
- ***Health Care Guideline for Patients and Families: ADHD, Institute for Clinical Systems Improvement,*** www.icsi.org
  Comprehensive care guideline. Flow charts on evaluation and management as well as information on co-morbid conditions in non-medical language.
- ***National Center for Gender Issues and ADHD***
  www.ncgiadd.org
  Current research findings and resources for women and young women with ADHD.
- ***San Diego ADHD, Child and Adolescent Services Research Center,*** www.sandiegoadhd.org
  Answers to frequently asked questions, real-life stories, and handouts for families, clinicians, and teachers.

= Resource for providers = Resource for parents = Resource for teens

INTERNET RESOURCES: Click On This!

ANXIETY/DEPRESSION/BIPOLAR

- ***Advanced Center for Intervention and Services Research, University of Pittsburgh,*** www.moodykids.org
  Anxiety and depression information and online screening tools for primary care providers.
- ***Children's Medication Algorithm Project, Texas Department of State Health Services***
  www.dshs.state.tx.us/mhprograms/CMAPed.shtm
  ADHD and Depressive materials available in Spanish.
- ***Depression and Bipolar Disorder Information Australia, The Black Dog Institute,*** www.blackdoginstitute.org.au
  Patient handouts, assessment tools, and management strategies for the primary care setting.
- ***Guide Lines for Adolescent Depression in Primary Care (GLAD-PC), Columbia University***
  www.kidsmentalhealth.org/GLAD-PC.html
  Comprehensive toolkit for primary care providers.
- ***MacArthur Initiative on Depression & Primary Care, Dartmouth & Duke Univ.,*** www.depression-primarycare.org
  Toolkit and clinician resources on depression diagnosis, treatment and management.
- ***National Child Traumatic Stress Network, Center for Mental Health Services,*** www.nctsnet.org
  Information & training materials on traumatic stress, natural disasters and terrorism. Available in Spanish.
- ***Obsessive Compulsive Foundation,*** http://ocfoundation.org
  Information, treatment options, support groups, and online magazine written by teens with OCD.
- ***National Center for Post Traumatic Stress Disorder, US Department of Veterans Affairs,*** www.ncptsd.va.gov
  Fact sheets, links to further reading, and assessment tools related to trauma and PTSD.
- ***Parents and Physicians Med Guide, American Psychiatry Association & AACAP*** www.parentsmedguide.org
  Comprehensive information on depression treatment, and monitoring, suicide risk factors, and FDA Black Box Warning. Websites available in Spanish.
- ***Teen Depression Self Help Tool, British Columbia Ministry of Children and Family Development***
  www.mcf.gov.bc.ca/mental_health/pdf/dwd_printable.pdf
  A guide for teens (13 to 17 years). Interactive worksheets teach effective coping and problem solving skills.

CONDUCT/OPPOSITIONAL DEFIANT DISORDERS

- ***Commission on Youth, Virginia General Assembly***
  http://coy.state.va.us/Modalities/defiant.htm
  Information on the relationship between CD and ODD, common co-morbidities, parenting tips, and resources.
- ***Headroom: Mental Health for Young People, Government of South Australia,*** www.headroom.net.au/index.html
  Diagnostic criteria and treatment information for conduct problems. Information on other mental health problems and adolescent-friendly practice guidelines.

EATING DISORDERS

- ***Body Basics Adolescent Provider Toolkit: Resources and References, Adolescent Health Working Group***
  www.ahwg.net/resources/toolkit.htm
  California and national resources on eating disorders, healthy lifestyles, and overweight issues.

LEARNING DISABILITIES

- ***Heath Resource Center, George Washington University***
  www.heath.gwu.edu/index.htm
  National clearinghouse of post-secondary educational opportunities for persons with physical, developmental, or learning disabilities.
- ***National Association for the Education of African American Children with Learning Disabilities***
  www.charityadvantage.com/aacld/HomePage.asp
  Information on IDEA, Section 504, learning disabilities research, legal resources, and parents network.
- ***National Dissemination Center for Children with Disabilities, US Dept. of Education,*** www.nichcy.org
  Information on Special Education, IEPs, educational rights, and transition into adulthood for parents of children with physical, developmental, or learning disabilities. Website available in Spanish.
- ***Schwab Learning, Charles and Helen Schwab Foundation***
  http://schwablearning.org
  Comprehensive resource on learning disabilities. Website available in Spanish.

PARENTAL SEPARATION/DIVORCE

- ***A Teen Guide to Parental Separation and Divorce, British Columbia Ministry of Attorney General***
  www.familieschange.ca/teen/index.htm
  A teen-friendly site that covers changes, feelings, and coping strategies after a parental divorce.

SCHIZOPHRENIA

- ***Open the Doors, World Psychiatric Association***
  http://openthedoors.com/english/index.html
  An international schizophrenia awareness and anti-stigma program. Website available in English, Spanish and 6 other languages.
- ***Schizophrenia: A Handbook for Families, Health Canada***
  www.phac-aspc.gc.ca/mh-sm/pubs/schizophrenia-schizophrenie/index.html
  Schizophrenia symptoms, diagnosis, treatment, and stigma concerns. Website available in French.

= Resource for providers = Resource for parents = Resource for teens

INTERNET RESOURCES: Click On This!

SELF-INJURY

- ***Self-Injury: A Struggle,*** http://self-injury.net
  A website created and maintained by a young woman who self injures. Tips for parents and help for youth who want to stop self injurying.
- ***Young People and Self Harm, National Children's Bureau*** www.selfharm.org.uk/default.aspa
  Self-harm information, reaching out for help, and resources. Personal stories and poetry written by teens.

STIGMA

- ***Mental Health: A Report of the Surgeon General*** www.surgeongeneral.gov/library/mentalhealth/cre
  Addresses mental health problems as a public health concern. Includes a section on mental health stigma.
- ***National Mental Health Awareness Campaign, 1999 White House Conference on Mental Health*** www.nostigma.org
  Mental health myths, related stigma, and links to websites dedicated to mental health issues.
- ***Resource Center to Address Discrimination and Stigma, SAMHSA,*** http://adscenter.org
  Definitions of mental health related discrimination, anti-stigma campaigns, current research, and links to other anti-stigma organizations.
- ***See Me: Let's Stop the Stigma of Mental Ill Health, Scottish Executive Healthier Scotland*** http://justlikeme.org.uk
  Teen-friendly anti-stigma website with comics and information on how to challenge stigma and help people who have mental health problems.

SUBSTANCE USE/ALCOHOL/TOBACCO

- ***Al-Anon/Alateen,*** www.al-anon.alateen.org
  Provides meetings for teens affected by someone's drinking. Website is available in Spanish and French.
- ***DanceSafe,*** http://dancesafe.org
  Promotes health and safety within the rave and nightclub community. Information on harm reduction and pill testing.
- ***Erowid,*** www.erowid.org
  User-friendly, non-judgemental information about psychoactive plants, chemicals, and pharmaceuticals.
- ***Harm Reduction Coalition,*** www.harmreduction.org
  Information for substance users on Hepatitis, HIV/AIDS, safe injection, and overdose prevention. Includes a list of needle exchange and health programs for youth.
- ***National Institute on Drug Abuse (NIDA)*** www.nida.nih.gov
  Charts of commonly abused substances, diagnosis criteria, and drug use research. Information available in Spanish.

Substance Use/Alcohol/Tobacco - cont'd

- ***Parents: The Anti-Drug, National Youth Anti-Drug Media Campaign,*** www.theantidrug.com
  Drug information, advice, and substance use warning signs. Links to Spanish, Chinese, Filipino, Korean, and Vietnamese anti-drug websites.
- ***Partnership for a Drug-Free America,*** www.drugfree.org
  Parent and teen sections on substance use prevention, warning signs, and treatment options. Information available in Spanish.
- ***SAMHSA National Clearinghouse for Drug and Alcohol Information,*** https://ncadistore.samhsa.gov
  Free English and Spanish drug and alcohol posters and publications. Low-cost videos available. Substance Abuse Treatment Facility Locator: http://findtreatment.samhsa.gov
- ***The Cool Spot, National Institute on Alcohol Abuse and Alcoholism,*** www.thecoolspot.gov
  Teen-friendly website with information on alcohol and how to resist peer pressure.
- ***The Good Drugs Guide,*** www.thegooddrugsguide.com
  Truthful, entertaining, and accurate information on recreational drugs.
- ***Tobacco Information and Prevention Source (TIPS), Centers for Disease Control,*** www.cdc.gov/tobacco
  Tobacco fact sheets, education materials, and information on quitting tobacco. Main CDC website available in Spanish.

SUICIDE

- ***Onyourmind.net, Youth and Family Enrichment Services*** www.onyourmind.net
  Information and support for teens by volunteer high school students in the California Bay Area. Hotline information, teen chat room, and referrals.
- ***Suicide Awareness Voices of Education,*** www.save.org
  Information on depression's relationship to suicide, suicide prevention, coping with loss, and supporting survivors of suicide.
- ***Youth at Risk of Suicide, Centre for Suicide Prevention*** www.suicideinfo.ca/youthatrisk
  Suicide prevention information: best practices, warning signs, and how to talk about suicide.

= Resource for providers = Resource for parents = Resource for teens

INTERNET RESOURCES: Click On This!

VIOLENCE/BULLYING/TRAUMA

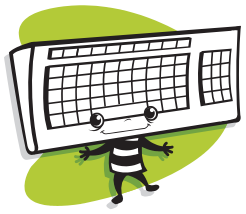
- ***Break the Cycle: Empowering Youth to End Domestic Violence,*** www.breakthecycle.org
  🎧 Domestic violence and dating violence facts. Information on the cycle of violence, helping a friend, and warning signs of abuse.
- ***Bursting the Bubble, DV & Incest Resource Centre Victoria,*** www.burstingthebubble.com
  🎧 Quizzes, checklists, and step-by-step advice for youth to help them identify and respond to family violence.
- ***Family Violence Prevention Fund***
  www.endabuse.org/programs/teens
  🩺 🏠 🎧 Facts for teens and immigrant women on intimate partner violence, resource lists, and safety planning.
- ***Lambda GLBT Community Services,*** http://lambda.org
  🎧 Dedicated to reducing hate crime and discrimination against gay, lesbian, bisexual, and transgender people. Information on what to do after a hate crime incident and safety planning. Website available in Spanish.
- ***Look to End Abuse Permanently (LEAP),*** www.leapsf.org
  🩺 Information and resources to aid health care's response to intimate partner violence. Patient education materials in English, Spanish, Tagalog, Chinese, Arabic, and more.
- ***Love is Not Abuse, Liz Claiborne Inc.***
  www.loveisnotabuse.com
  🏠 🎧 Informational handbooks, wallet cards, links to online resources, and quizzes on teen dating violence and domestic violence in the workplace.
- ***Media Awareness Network,*** www.media-awareness.ca
  🩺 🏠 🎧 Explores violence in the media and advertising. Media awareness activities teachers and parents can do with youth. Website available in French.
- ***National Center for Injury Prevention and Control, Centers for Disease Control,*** www.cdc.gov/ncipc
  🩺 🏠 Statistics, risk factors, prevention strategies, and consequences of child maltreatment, intimate partner violence, suicide, youth violence, and sexual violence.
- ***National Youth Violence Prevention Resource Center, Centers for Disease Control,*** www.safeyouth.org
  🩺 🏠 🎧 Fact sheets on forms of violence, statistics, and links to resources. Information available in Spanish.
- ***Stop Bullying Now, US Department of Health & Human Services,*** http://stopbullyingnow.hrsa.gov
  🎧 🏠 Anti-bullying cartoons, interactive games, and advice on how to deal with bullies. Spanish language content for adults and educators.
- ***Teen Coalition Against Sexual Assault (CASA), North Carolina Coalition Against Sexual Assault***
  www.nccasa.org/teen/index.htm
  🎧 Definitions of rape, date rape, sexual harassment, sexual violence, and other issues. Information on policy advocacy and other ways people can prevent sexual violence.

Violence/Bullying/Trauma - cont'd

- ***That's Not Love, Youth Advisory Council of Asian Pacific Islander Legal Outreach,*** www.thatsnotlove.org
  🎧 Website created by Asian and Pacific Islander youth that provides online peer counseling, referrals, and resources for API youth related to relationship violence.

CULTURALLY SPECIFIC RESOURCES

- ***National Asian Women's Health Organization (NAWHO)***
  www.nawho.org
  🩺 Information on intimate partner violence and mental health issues that affect Asian and Asian American women.
- ***National Association for the Education of African American Children with Learning Disabilities***
  www.charityadvantage.com/aacld/HomePage.asp
  🩺 🏠 Information on IDEA, Section 504, learning disabilities research, legal resources, and parents network.
- ***National Center for Cultural Competence, Georgetown University***
  www11.georgetown.edu/research/gucchd/nccc
  🩺 🏠 Discusses cultural and linguistic competency. Information for consumers, faculty, health care providers, and organizations. Information available in Spanish.
- ***Office of Minority Health, US Department of Health & Human Services,*** www.omhrc.gov
  🩺 🏠 Cultural competency resources, information on minority populations, and overviews of health topics. Information available in Spanish.
- ***That's Not Love, Youth Advisory Council of Asian Pacific Islander Legal Outreach,*** www.thatsnotlove.org
  🎧 Website created by Asian and Pacific Islander youth that provides online peer counseling, referrals, and resources for API youth related to relationship violence.
- ***Your Fountain of Resources, SAMHSA***
  www.hablemos.samhsa.gov/new/default.aspx
  🩺 🏠 Bi-lingual English and Spanish website with information on parenting, violence, alcohol and drugs, mental health issues, and bi-cultural/ acculturation issues. Free bilingual materials available.



🩺 = Resource for providers 🏠 = Resource for parents 🎧 = Resource for teens

LESBIAN, GAY, BISEXUAL, TRANSGENDER QUEER & QUESTIONING (LGBTQQ)

- ***Gay, Lesbian, and Straight Education Network (GLSEN)***
  www.glsen.org
  News, resources, and actions students, parents, and educators can take to ensure safe schools for all students regardless of sexual orientation or gender identity/ expression. Information on local chapters and creating safe middle and high schools.

- ***Outlet, Community Health Awareness Council***
  www.projectoutlet.org
  Supports and empowers LGBTQQ youth. Resource links include organizations dedicated to people of various ethnicities, genders, and sexual identities.

- ***OutProud, National Coalition for Gay, Lesbian, Bisexual & Transgender Youth,*** www.outproud.org
  News, resources, and the Oasis Magazine written by and for queer youth. QueerAmerica national database of community centers, support organizations, PFLAG chapters, queer youth groups, and more.

- ***Parents, Families, and Friends of Lesbians and Gays (PFLAG),*** www.pflag.org
  National organization that supports LGBTQQ persons and their families. Information on local chapters, advocacy campaigns, and how to find support while coming out.

- ***Transgender Health, Public Health Seattle and King County,*** www.metrokc.gov/health/glbt/transgender.htm
  Overview of the health and mental health issues often faced by people who are transgender or transsexual.

- ***Youth Resource, Advocates for Youth***
  www.youthresource.com
  Website made by and for LGBTQQ youth that takes a holistic approach to health and explores issues such as advocacy and peer education.

TALKLINES AND HOTLINES

- ***American Association of Poison Control Centers***
  1-800-222-1222
  24/7, English and Spanish
  Connects callers to their local poison control center. Trained experts provide confidential help for poison emergencies and substance overdoses. Information about poisons and poison prevention.

- ***Gay, Lesbian, Bisexual, Transgender (GLBT) National Youth Talkline, GLBT National Help Center***
  1-800-246-PRIDE
  Mon to Fri 5-9PM (Pacific Time), English
  Youth counselors answer calls and emails from youth 25 years old and younger. Confidential peer counseling on coming-out issues, relationship concerns, school problems, HIV/AIDS anxiety, and safer-sex. Information on local LGBT-friendly organizations.

Talklines and Hotlines - cont'd

- ***National Child Abuse Hotline, Childhelp***
  1-800-4-A-CHILD
  24/7, English, Spanish and 140 other languages
  Free and confidential help for children and teens who are abused or neglected. Parenting tips and information on child abuse and neglect for parents.

- ***National Drug & Alcohol Treatment Hotline, SAMHSA***
  1-800-662-HELP
  24/7, English and Spanish
  Substance use information, treatment options, support and referrals to local treatment centers.

- ***National Hopeline Network, Suicide Prevention Hotline***
  1-800-SUICIDE
  24/7, English and other languages available
  Connects callers to their nearest crisis center to speak with a counselor.

- ***National Runaway Switchboard***
  1-800-RUNAWAY
  24/7, English
  Free and confidential counseling for youth in trouble. Counselors help callers develop a plan of action and provide information on how to stay safe.

- ***National Teen Dating Abuse Helpline, National Domestic Violence Hotline and Liz Claiborne Inc.***
  1-866-331-9474
  24/7, English
  Free and confidential helpline and online chat room for teens (13 to 18 years old) who experience dating violence or abuse.

- ***National Youth Violence Prevention Resource Center, Centers for Disease Control***
  1-866-SAFEYOUTH
  Mon to Fri 8AM-6PM (Eastern Time), English
  Information on youth violence and referrals to violence prevention and intervention organizations.

- ***RAINN: Rape, Abuse, and Incest National Network***
  1-800-656-HOPE
  24/7, English and other languages
  Connects callers to their nearest rape crisis center to speak with a counselor.

= Resource for providers = Resource for parents = Resource for teens

NOTES: