

## Section 4 Adolescent Preventive Health

### B. HEALTH AND DEVELOPMENTAL HISTORY

#### Medical and Family History

For adolescents, the health history is an important tool for identifying health problems and risks. Both the medical and family history are important in order to obtain information relevant to health supervision, compile demographic information, and help the Primary Care Provider (PCP) develop a general understanding of the history, functioning, questions and concerns of the family. An adolescent history, in addition to history of illness, injuries, and hospitalizations, includes reproductive and gynecological history and assessments for substance use and mental health. The *Medical/Family History Questionnaire* (Refer to Section 7, Appendix I for the *English* and the *Spanish* versions) and the *Pediatric Visit Sheets* (Refer to Section 7, Appendix I) can be utilized to obtain the family and personal health histories. Updating these histories annually **is required** to help identify emerging health problems of significance to the adolescent.

On the initial visit with an adolescent, the practitioner should establish himself/herself as the adolescent's practitioner and focus on encouraging the adolescent to take responsibility for his/her personal health care. This empowers the adolescent to comply with recommendations and take responsibility for his/her personal progress.

Adolescents will often present with chief complaints that are unrepresentative of their true concerns. An adolescent presenting with mild acne or pelvic pain, in fact, may be afraid she is pregnant. An adolescent male with chest pains may be concerned about gynecomastia. Gentle but persistent exploration of the adolescent's concerns is often necessary before the true chief complaint is evident.

#### Psychosocial History and Developmental Surveillance

Healthy adolescent development is a complex and evolving process that requires supportive and caring families, peers, and communities; access to high quality services (health, education, social and other community services), and opportunities to engage in skill building activities to succeed in the developmental tasks of adolescence. Therefore, a comprehensive psychosocial history is required to determine the impact of the environment at home, at school, and in the community on the adolescent's physical health, development, and emotional well-being.

Significant changes in the adolescent's environment should be documented as part of the psychosocial history. The psychosocial history may include, but is not limited to new hobbies or activities, recent achievements in and out of school, separation or divorce of parents, recent death of a family member or friend, job loss of a family member, loss of a house or frequent moving, a recent birth in family, adolescent pregnancy, or exposure to violence in the home, school or community. It also should address certain environmental factors in the adolescent's household, such as smoking in the house, pets living in the house, and the general living conditions in the house.

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Adolescents are well past the age when traditional objective developmental tests of younger ages can be used. Therefore, providers need to assess the adolescent's progress toward independence and adulthood as part of the developmental surveillance. Assessment of grade level, school performance and/or job performance, extracurricular activities, peer relations and future plans are all components of adolescent developmental surveillance.

In addition, demonstrating a positive attitude toward family and community, and exhibiting a sense of self-confidence and resiliency when confronted with live stressors are important indicators of achieving developmental tasks. When problems are identified, the provider should refer the adolescent for specialty services appropriate to the problem. Referral to school counseling services may be helpful in assisting the adolescent when school related problems are identified.

Providers can use the *HEEADSSS (Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide/Depression, and Safety)* tool to assess the adolescent's psychosocial and developmental status (Refer to Section 4, Addendum).<sup>1</sup> Using the *HEEADSSS* framework, providers can discuss many sensitive issues that are potential threats to good health, such as initiation of drug use. The adolescent can complete this assessment questionnaire prior to the medical interview, and the provider can use it to trigger a dialog and elicit further information during face-to-face interview.

### Mental Health Assessment

During the transition to adulthood, young people experience many emotional challenges that have a significant impact on their character and personal development. Annual preventive health visits are important opportunities to identify early evidence of mental health problems that emerge during this time of growth and change. Similarly, behaviors such as eating disorders or drug/alcohol abuse often begin during adolescence.

It is the responsibility of the PCP to conduct a mental health assessment at each adolescent preventive health visit to identify risks associated with behavioral or emotional problems.

Validated screening tools, such as *PHQ-9 Modified for Teens (PHQ-Modified)* and the *Pediatric Symptom Checklist (PSC-Y)* should be used for adolescents 11 – 18 years of age. They were developed by Columbia University and are brief questionnaires that the adolescents can complete in the waiting or exam rooms (Refer to Section 4, Addendum).

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<sup>1</sup> Klein, D., Goldenring, D., & Adelman, W. (2014) HEEADSSS 3.0: The psychosocial interview for adolescents updated for a new century fueled by media. *Contemporary Pediatrics*. Retrieved on 10/29/2014, from [http://contemporarypediatrics.modernmedicine.com/sites/default/files/images/ContemporaryPediatrics/cn\\_tped0114\\_Feature%201%20Hi-Res.pdf](http://contemporarypediatrics.modernmedicine.com/sites/default/files/images/ContemporaryPediatrics/cn_tped0114_Feature%201%20Hi-Res.pdf)

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PCPs can use these screening tools to help evaluate whether an adolescent is suffering from depression, anxiety, or other conditions. When identified early, adolescents with mental illness have the best chance to lead healthy lives and reach their full potential.

Providers can also use the age-specific *Mental Health Questionnaires*, developed by the Maryland Healthy Kids Program, in collaboration with the DHMH Mental Hygiene Administration, to assist with this assessment (Refer to Section 7, Appendix II for the *English* and *Spanish* versions).

Note the results of the mental health assessment in the adolescent's medical record. In some cases, when a mental health problem is identified, the PCP can counsel the patient and note it in the record. However, when specialty mental health services are needed, refer the patient directly to the **Maryland Public Mental Health System** by contacting **1-800-888-1965 (consumers and providers)**. Access additional mental health information and resources online at: <http://www.beaconhealthoptions.com>. Document the referral in the medical record.

***Maryland Behavioral Health Integration in Pediatric Primary Care (B-HIPP)*** is a free service for PCPs caring for patients with mental health needs from infancy through the transition to young adulthood. It provides support to PCP through four main components: telephone consultation, continuing education, resource and referral networking and social work co-location. For more information, refer to B-HIPP website at [www.mdbhipp.org](http://www.mdbhipp.org) at or call **855-632-4477**.

***Bright Futures in Practice***, in a series of publications from the Maternal and Child Health Bureau and the National Center for Education in Maternal & Child Health, provides additional information regarding mental health assessment for children and adolescents. Information regarding mental health assessment can be found on the *Bright Futures* website at <http://brightfutures.aap.org>.

### *Depression/Suicide*

A review by the National Adolescent Health Information Center found that the most common mental health disorder among adolescents is depression.<sup>2</sup> Adolescents with unidentified mental health disorders have poorer physical health and engage in more risky behaviors. Both the Institute of Medicine (IOM)<sup>3</sup> and United States Preventive

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<sup>2</sup>National Adolescent Health Information Center.(2008). *The Mental Health of Adolescents: A National Profile, 2008*. Retrieved on 10/29/14, from <http://nahic.ucsf.edu/downloads/MentalHealthBrief.pdf>

<sup>3</sup>Institute of Medicine (2009). *Preventing Mental, Emotional and Behavioral Disorders Among Young People: Progress and Possibilities*. Retrieved on 10/29/2014, from [http://www.nap.edu/catalog.php?record\\_id=12480](http://www.nap.edu/catalog.php?record_id=12480)

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Services Task Force (USPSTF)<sup>4</sup> recommend that physicians in primary care settings screen adolescents for major depressive disorders with its associated potential for suicide. Using a validated screening tools, such as *PHQ-9 Modified for Teens (PHQ-Modified)* and the *Pediatric Symptom Checklist (PSC-Y)* will help early identification and treatment of adolescent depression (Refer to Section 4, Addendum).<sup>5</sup> PCPs should also educate families about signs of depression in children and adolescents (Refer to Section 3, *Depression in Children*). For more information, review to the endorsed by *AAP Guidelines for Adolescent Depression in Primary Care (GLAD-PC) I*<sup>6</sup> and *GLAD-PC II*<sup>7</sup> and the *AAP Policy on Suicide and Suicide Attempts*.<sup>8</sup>

The American Medical Association's *Guidelines for Adolescent Preventive Services (GAPS)* also recommends annual screening of adolescents about behaviors or emotions that indicate recurrent or severe depression or risk of suicide. A copy of the GAPS recommendations and an algorithm for suicide and depression can be obtained from the *American Medical Association (AMA)* website at <http://www.ama-assn.org/ama>.

### *Eating Disorders*

Concerns about weight related issues including over-eating, bingeing, and purging, and excessive dietary restriction may increase during adolescence. Eating disorders such as anorexia nervosa and bulimia nervosa are chronic illnesses that can lead to long-term medical consequences. Because eating disorders are prevalent in middle childhood and adolescence, it is important for the PCP to screen for them. For additional information on eating disorders, and how to assess them, refer to the *Bright Futures* website at <http://brightfutures.aap.org/> and the 2010 *AAP Guidelines on Identification and*

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<sup>4</sup>USPSTF (2009) *Final Recommendation Statement: Depression in Children and Adolescents (2009)*. USPSTF Retrieved on 10/15/14, from <http://www.uspreventiveservicestaskforce.org/Page/Topic/recommendation-summary/depression-in-children-and-adolescents-screening>

<sup>5</sup> National Institute for Health Care Management (NIHCM). (2010). *Improving Early Identification & Treatment of Adolescent Depression: Considerations & Strategies for Health Plans*. Retrieved on 10/29/14, from [http://www.nihcm.org/pdf/Adol\\_MH\\_Issue\\_Brief\\_FINAL.pdf](http://www.nihcm.org/pdf/Adol_MH_Issue_Brief_FINAL.pdf)

<sup>6</sup> American Academy of Pediatrics. (2007). Guidelines for Adolescent Depression in Primary Care (GLAD-PC):I. Identification, Assessment, and Initial Management. *Pediatrics*.120(5), 1299-1312. Retrieved on 10/29/2014, from <http://pediatrics.aappublications.org/content/120/5/e1299.abstract>.

<sup>7</sup> AAP. (2007). Guidelines for Adolescent Depression in Primary Care (GLAD-PC): II. Treatment and Ongoing Management. *Pediatrics*. 120(5), 1313-1326. Retrieved on 10/29/2014, from <http://pediatrics.aappublications.org/content/120/5/e1313.full>

<sup>8</sup> AAP. (2007). Suicide and Suicide Attempts in Adolescents. *Pediatrics*. 120 (3), 669-676. Retrieved on 10/29/2014, from <http://pediatrics.aappublications.org/content/120/3/669.full>

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*Management of Eating Disorders in Children and Adolescents.*<sup>9</sup> Once identified, it is important that treatment be initiated. Treatment of adolescents with eating disorders optimally takes place with the support of an interdisciplinary team, including a primary care health professional, a dietitian, a dentist and mental health professional. Contact the adolescent's Managed Care Organization (MCO) for assistance with referrals.

### *Attention Deficit Hyperactive Disorder (ADHD)*

ADHD is a disorder characterized by behavior and attention difficulties exhibited in multiple settings. It begins in childhood and is identified by specific attention, hyperactivity and impulsiveness criteria found in the *American Psychiatric Association's Diagnostic and Statistical Manual (DSMIVR)*.<sup>10</sup> ADHD is relatively common affecting up to 11% of children/adolescents.<sup>11</sup> However, some adolescents may not be diagnosed and treated early in childhood and are at risk for school failure, substance abuse, and depression. In its most recent guidelines, AAP expanded the age range for diagnosis and treatment of ADHD to include preschool-aged children and adolescents. Currently, the AAP guideline addresses the diagnosis and treatment of ADHD in children 4 through 18 years of age.<sup>12</sup>

The overall approach to diagnosing an adolescent with ADHD involves the following:

- A comprehensive interview with the adolescent's parent or guardian,
- A mental status examination of the adolescent,
- A medical evaluation for general health and neurological status,
- A cognitive assessment of ability and achievement,
- Use of ADHD-focused parent and teacher rating scales,
- School reports and other adjunctive evaluations separate from the school reports such as speech, language assessment, etc.

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<sup>9</sup> AAP. (2010). Identification and Management of Eating Disorders in Children and Adolescents. *Pediatrics*, 26(6). 1240-1253. Retrieved on 10/29/2014, from <http://pediatrics.aappublications.org/content/126/6/1240.full>

<sup>10</sup> Diagnostic and Statistical Manual of Mental Disorders.(2013). 5th edition. Arlington, VA., *American Psychiatric Association*

<sup>11</sup> Centers for Disease Control and Prevention (CDC). Key Findings: Trends in the Parent-Report of Health Care Provider-Diagnosis and Medication Treatment for ADHD: United States, 2003—2011 Retrieved on 10/30/2014 from <http://www.cdc.gov/ncbddd/adhd/features/key-findings-adhd72013.html/>

<sup>12</sup> AAP. (2011). ADHD: Clinical Practice Guidelines for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. *Pediatrics*. 128(5), 1007-1022. Retrieved on 10/31/20014, from <http://pediatrics.aappublications.org/content/128/5/1007.full.pdf>

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A clinician with skills and knowledge in the area of mental health, developmental or behavioral pediatrics must perform the ADHD evaluation. A provider who specializes in developmental or behavioral pediatrics can become a specialty mental health provider through Maryland Medical Assistance by registering with the *Community Mental Health Unit* at the *DHMH Office of Health Care Quality* (MHA). To print the *Community Mental Health Program Application*, follow the link: [http://dhmh.maryland.gov/ohcq/MH/docs/MH\\_Forms/mh\\_app.pdf](http://dhmh.maryland.gov/ohcq/MH/docs/MH_Forms/mh_app.pdf). For more information, call the **Community Mental Health Unit** at **877-402-8220/410-402-8060** or visit their webpage at: <http://dhmh.maryland.gov/ohcq/MH/default.aspx>.

An adolescent diagnosed with ADHD without any accompanying emotional disorders can receive care from a primary care provider for management of medications. Medication is one component in the treatment of ADHD and does not appear to increase the likelihood of future cigarette smoking or substance abuse. Additionally, adjunctive services may improve an adolescent's outcome. Teaching and reinforcing organizational skills and social skills are interventions that can significantly improve outcomes. Ongoing contact and follow-up with the parents of an adolescent with ADHD who is on medication is a critical component of the medication management.

ADHD is classified as a mental health disorder, possibly requiring multiple therapeutic approaches. A number of psychiatric conditions frequently occur with ADHD, i.e. mood disorder, conduct disorder, oppositional defiant disorder and bipolar disorder, possibly requiring multiple therapeutic approaches (Refer to Section V, *Public Mental Health System*). If the adolescent's behavior changes significantly, reevaluation is necessary through a mental health referral by calling **Maryland Public Mental Health System** at **1-800-888-1965** (consumers and providers). Access additional mental health information and resources online at: <https://www.beaconhealthoptions.com/>

### *Violence*

PCPs are often the first health professionals to become aware of violence in the adolescent's family, school, and/or community. A violence risk assessment is recommended annually using questions concerning violence, access to guns, and potential violence in personal relationships (sexual assault, partner violence). Advise parents and guardians to avoid the use of physical punishment as a means of resolving conflicts with children and adolescents.

### Bullying and Cyber-bullying

Bullying including cyber-bullying is of increasing concern in the pediatric population. Health care providers should:

- Ask children and adolescents about their experiences, if any, regarding bullying and cyber bullying,
- Provide information in their offices for families to educate them on this topic,

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- Encourage children and adolescents to "report" if they are victims so that appropriate referrals can be initiated,
- Encourage parents to work with schools to promote awareness, prevention, and appropriate intervention.

For more information on youth violence including bullying and dating violence, review *2009 AAP Policy on the Role of Pediatrician in Youth Violence Prevention*.<sup>13</sup> A specific assessment tool measuring bullying victimization is the *Victimization Scale* (refer to Section 7, Appendix II for the *English* and *Spanish* versions of the tool). For other assessment tools, see *Measuring Bullying Victimization, Perpetration, and Bystander Experiences: A Compendium of Assessment Tools*, published by the Centers for Disease Control and Prevention (CDC) in 2011.<sup>14</sup>

### Physical and Sexual Abuse

In addition to the signs of physical abuse, noted in *Section 3 of the Manual*, be alert for signs of possible sexual abuse in both males and females and, when indicated, screen for sexually transmitted diseases by using the *Preventive Screen Questionnaire* (Refer to Section 7, Appendix II).. Possible signs of sexual abuse may include the following:

#### Direct Evidence

- Injury
- Infections including sexually transmitted infections
- Pregnancy

#### Indirect Evidence

- Behavior disorders
- Running away
- Substance use
- Physical complaints
- Depression/suicidal behavior

In Maryland, *Subtitle 7 of the Maryland Family Law Code Annotated* requires professionals, including health practitioners, police officers, educators, and social

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<sup>13</sup> See AAP. (2009). Role of Pediatrician in Youth Violence Prevention. *Pediatrics*. 124(1), 393-402. Retrieved on 06/03/2015, from <http://pediatrics.aappublications.org/content/124/1/393.full>

<sup>14</sup> See CDC (2011). *Measuring Bullying Victimization, Perpetration, and Bystander Experiences: A Compendium of Assessment Tools*. Retrieved on 06/03/2015, from <http://www.cdc.gov/violenceprevention/pdf/bullycompendium-a.pdf>

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workers, to report suspected child abuse or face possible professional sanctions.<sup>15</sup> The law mandates that primary care providers should report any suspected abuse or neglect to the local *Department of Social Services* (Refer to Section 8) or the police. Providers are to identify the potential conditions for abuse and make appropriate referrals for assistance (Refer to Section 3, *Child Abuse Assessment*).

A minor may disclose violent or sexually exploitive behavior such as dating violence, sexual assault, or sexual activity with a partner who is significantly older and is neither a family or household member, nor an individual with any past or present responsibility for the care or supervision of the minor. When this occurs, the client should be advised that the provider and/or staff are there to help any adolescent who requests assistance. The adolescent may need support in seeking the involvement of a parent or family member and/or in accessing community resources, including law enforcement or emergency medical facilities and shelters.

### *Substance Use Disorder Assessment*

Because of the increased number of young adolescents and young adults using drugs and alcohol in our society, primary care providers are in a unique position to identify substance abuse during routine office visits and offer appropriate treatment.<sup>16, 17</sup> The Maryland Healthy Kids Program requires that any provider seeing Medicaid children perform yearly assessment for substance abuse beginning at 12 years of age and recommends assessment at earlier ages when the provider suspects problems.

Use of a standardized tool for screening for substance abuse is strongly recommended.<sup>18</sup> The *CRAFFT* (*C*ar, *R*elax, *A*lone, *F*orget, *F*riends, *T*rouble) is a brief, self-administered, validated, adolescent substance abuse screening tool (Refer to Section 7, Appendix II for both *English* and *Spanish* language versions of the tool). For availability of CRAFFT in other languages, refer to the *Center for Adolescent Substance Abuse Research* website at

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<sup>15</sup> 2010 Maryland Code Family Law Title 5 - Children Subtitle 7 - Child Abuse and Neglect Section 5-704

<sup>16</sup> AAP Policy on Tobacco, Alcohol, and Other Drugs: The Role of the Pediatrician in Prevention, Identification, and Management of Use. (2005) *Pediatrics*.115(3). 816–821. Reaffirmed March 2013. Retrieved on 08/18/2014, from <http://pediatrics.aappublications.org/content/115/3/816.full>

<sup>17</sup> AAP Policy on Alcohol Use by Youth and Adolescents: A Pediatric Concern. (2010). *Pediatrics*. 125(5), 1078-1087. Retrieved on 10/31/2014, from <http://pediatrics.aappublications.org/content/125/5/1078.full>

<sup>18</sup> AAP Policy Statement: Substance Use Screening, Brief Intervention, and Referral to Treatment for Pediatricians. (2011). *Pediatrics*. 128 (5). 1330 -1340. Retrieved on 08/18/2014, from <http://pediatrics.aappublications.org/content/128/5/e1330.full?sid=f5722c8f-0064-40c2-927f-da32a3a674ef>

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<http://www.ceasar-boston.org/>. Both physicians and general clinicians may administer the tool. The *CRAFFT* can assist primary care providers to determine which adolescent patients are appropriate for brief office interventions and those that need prompt referral to substance abuse specialists.

One positive answer indicates further assessment of quantity and frequency of substance use is needed. If an incident happened only once, three years ago, then it may not be cause for great concern. However, if the substance abuse occurred several times during the past year, then the situation warrants additional follow-up.

Two or more “yes” answers on the *CRAFFT* indicate that the adolescent is at risk for substance abuse, requiring further assessment, counseling, and/or referral that should be documented in the adolescent’s record.

Access additional substance abuse health information and resources online at: <https://www.beaconhealthoptions.com/>.

### Common Indicators of Adolescent Drug and Alcohol Abuse \*

- Changes in school attendance and grades,
- Unusual flare-ups or outbreaks of temper,
- Poor physical appearance (often becomes slovenly),
- Furtive behavior regarding drugs (especially when in possession),
- Wearing of sunglasses at inappropriate times to hide dilated or constricted pupils,
- Long-sleeved shirts worn consistently to hide needle marks (if injecting drugs),
- Association with known drug abusers,
- Borrowing money from students to purchase drugs,
- Stealing small items from school or home,
- Hiding in odd places; i.e., closets, storage area, to take drugs,
- Attempting to appear inconspicuous in manner and appearance to mask usage,
- Withdrawal from responsibility,
- Change in overall attitude – depression, low self-esteem, poor social skills, and school problems.

*\* Note that some of these changes may occur in normal adolescents or result from other problems.*

A “diagnostic” referral for addiction treatment will either rule out a problem or identify the problem at an early stage before the adolescent reaches the disease stage of alcohol or

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substance abuse. Treatment is much more likely to succeed when the problem is identified at an early stage.

### *Tobacco*

Tobacco use continues to be a health care concern among children and adolescents. Therefore, providers who see adolescents should screen adolescents for tobacco use, offer smoking cessation advice and interventions to both adolescents and parents, and teach the importance of decreasing exposure to second hand smoke.<sup>19, 20</sup>

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<sup>19</sup> Tobacco, Alcohol, and Other Drugs: The Role of the Pediatrician in Prevention, Identification, and Management of Use. (2005) *Pediatrics*.115(3). 816–821. Reaffirmed March 2013. Retrieved on 08/18/2014, from <http://pediatrics.aappublications.org/content/115/3/816.full>

<sup>20</sup> AAP Policy on Tobacco Use: A Pediatric Disease. (2009). Reaffirmed 05/2013. *Pediatrics*. 124(5), 1474-1487. Retrieved on 10/31/2014, from <http://pediatrics.aappublications.org/content/124/5/1474.full>