Healthy Teens Initiative

Seven Steps to Comprehensive Sexual and Reproductive Health Care for Adolescents in New York City

A toolkit and resource guide for health care providers

Prepared by the New York City Department of Health and Mental Hygiene and the New York City Family Planning Providers Group

NYC Health

THE NEW YORK CITY DEPARTMENT of HEALTH and MENTAL HYGIENE

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PRELIMINARY PREVIEW COPY

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THE CITY OF NEW YORK

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Michael R. Bloomberg
Mayor

Thomas R. Frieden, M.D., M.P.H.
Commissioner

nyc.gov/health

August 2006

Dear Health Care Professional:

Addressing the health care needs of adolescents in New York City is a public health priority. Caring adults, including health care providers, can help ensure that adolescents have the information and support they need to make good choices about health, including sexual and reproductive health. Not all adolescents engage in sexual intercourse or risky behaviors, and the adults in their lives can encourage them to continue to postpone sexual activity. For those adolescents who are sexually active, health care providers can play a key role in helping them make responsible decisions.

Because adolescents generally view health care providers as credible sources of information, you are in a good position to correct misinformation and offer scientifically sound education and counseling to reduce risky behaviors, as well as provide screening and services for sexual and reproductive health, mental health, and other health concerns, including alcohol and drug use.

The Healthy Teens Initiative is part of the Department of Health and Mental Hygiene's efforts to reduce teen pregnancy in New York City. The Initiative is designed to provide you with tools, resources, and technical assistance to support sexual and reproductive health services for adolescents. This toolkit also outlines best practices and features worksheets to help you assess your practice and identify areas you may wish to strengthen. The Department of Health and Mental Hygiene will offer free training and technical assistance, directly or through expert consultants, to help you implement the recommendations in this toolkit.

We hope you will join us in this renewed effort to reduce teen pregnancy and improve the health of our young people. Together, we can make a difference in the lives of New York City adolescents, their families, and their communities.

Sincerely,

Thomas R. Frieden, M.D., M.P.H.
Commissioner
New York City Department of Health and Mental Hygiene

Introduction

Adolescence is a period of dramatic physical and psychosocial change. Caring adults, including health care workers, should help adolescents navigate this period and promote respect for self and others. In the case of sexual health, it is crucial for adolescents to have the education, skills and support to make good choices, protect themselves and have healthy loving relationships during adolescence and in adulthood. Not all adolescents engage in sexual intercourse or risky behavior, and the adults in their lives can encourage them to continue to postpone sexual activity. Young adolescents should be strongly encouraged not to have sex. For those adolescents who are sexually active, adults must help them make responsible decisions about sexual behavior – including limiting their numbers of partners, preventing HIV and other sexually transmitted infections, and protecting against pregnancy. Too many young people have too little information to ensure good health.

Sexual and reproductive health is a vital part of adolescents' health and wellbeing. Addressing the health care needs of adolescents in New York City is a public health priority. Nearly half of all New York City's public high school students have had sex.[1] Infants born to adolescent mothers are at increased risk of low birth weight and infant mortality, and teen mothers are at greater risk for poor pregnancy-related health outcomes and limited educational attainment.[2]

In 2004 in NYC, the pregnancy rate was 90 per 1,000 female adolescents aged 15 to 19 years. Significant disparities occur in some groups: Rates ranged from 62.2 in Staten Island to 127.6 in the Bronx; by race/ethnicity, rates ranged from 28.1 among non-Hispanic whites to 127.0 among non-Hispanic blacks.[3]

The good news is that many of the most common adolescent health problems that are related to sexuality – such as pregnancy, STIs and HIV – are preventable. Because adolescents generally view pediatricians, OB/GYNs, and other primary care providers as credible sources of information, health care providers can correct misinformation and offer scientifically sound education, as well as counseling to reduce risk-taking behaviors.

By integrating sexual and reproductive health care – including health screenings, risk-reduction counseling and education, STI/HIV testing and treatment, contraception, and pregnancy testing and options counseling – into their routine practices, health care providers can greatly improve the physical and mental health of adolescents.

Most sexual and reproductive health services focus primarily on females. It is critical to reach out to young men and to make them feel comfortable accessing services. Their sexual and reproductive health needs are often overlooked by providers, parents, policy makers, and/or the adolescents themselves. Standards of sexual and reproductive health care have not been as extensively developed for young men as they have for young women, and services for young men are not always covered by insurance.[4]

NYC Family Planning Providers Group

In 2003, The New York City Department of Health and Mental Hygiene convened a Family Planning Providers Group, representing family planning service provider organizations, research organizations, adolescent health centers and advocacy organizations. Its task was to coordinate citywide efforts to ensure access to quality family planning and reproductive health services.

The group decided its first undertaking would be to improve services for adolescents. The members recognized that excellent care for adolescents depends on adherence to the New York State laws guaranteeing adolescents' rights to autonomous consent and confidentiality. The group promotes family and caregiver involvement wherever possible. In order to integrate sexual and reproductive health services into their practices, providers need scientifically sound, unbiased information both for themselves and their patients, as well as support to provide the best services to adolescents.

Academy for Educational Development

Center for Community Health and Education / Columbia University

The Children's Aid Society

Community Health Care Network

The Door

Inwood House

Medical and Health Research Association of New York City, Inc. (MHRA) /
MIC-Women's Health Services

Mount Sinai Adolescent Health Center

New York City Department of Health and Mental Hygiene
Bureau of Maternal, Infant and Reproductive Health
Bronx District Public Health Office

New York Civil Liberties Union

Physicians for Reproductive Choice and Health

Planned Parenthood of New York City, Inc.

Reproductive Health Access Project

The Healthy Teens Initiative (HTI)

The work of the New York City Department of Health and Mental Hygiene and the New York City Family Planning Providers Group resulted in the creation of the Healthy Teens Initiative. The initiative is part of the New York City Department of Health and Mental Hygiene's (DOHMH) adolescent pregnancy prevention activities. The goal of the initiative is to improve adolescents' access to sexual and reproductive health services.

The initiative has 3 key components:

- **Toolkit: Seven Steps to Comprehensive Sexual and Reproductive Health Care for Adolescents in New York City:** Guidance and tools for interacting with patients and implementing organizational changes.
- **Training and technical assistance:** Provided by the Department of Health and Mental Hygiene's Bureau of Maternal, Infant and Reproductive Health directly or through expert consultants.
- **Instruments for measuring progress:** For individual practices and the Initiative as a whole.

Healthy Teens Initiative Sponsors

Affinity Health Plan

American Academy of Pediatrics, District II New York State

The American College of Obstetricians & Gynecologists, District II/NY

Bronx Community Health Network

HealthFirst/A+ Health Plan

MetroPlus Health Plan

The Society for Adolescent Medicine, New York Regional Chapter

New York City Department of Youth and Community Development

New York City Health and Hospitals Corporation

New York State Coalition for School Based Primary Care

New York State Academy of Family Physicians

New York State Department of Health

How to Use This Toolkit

- Read each Step to find:
    - Best Practices for clinicians, allied health staff and administrators
    - Resources and tools (where appropriate, sample tools are enclosed)
    - Training and technical assistance
    - Table of Measures toward Success, which identifies who is responsible for ensuring that the measure is met
- Complete the Practice Assessment and Outcome Measures Worksheets before participating in training and technical assistance, to prioritize areas of need for training/technical assistance and to obtain baseline measures for your practice.
- Contact the Bureau of Maternal, Infant & Reproductive Health about training and technical assistance needs.
- Complete the Provider Assessment and Outcome Measures Worksheets yearly after initiation of training and technical assistance to assess progress.

How to Become an HTI Partner

This Toolkit and the other components of the Initiative are adaptable to any health care setting where primary care services are delivered to adolescents, including:

- Hospitals
- Community health centers
- Family planning clinics
- Adolescent health centers
- Group practices
- School-based health services
- Private practices
- Individual health care providers

To get the most out of the Initiative, we encourage health care providers to become Partners. Partners are expected to:

- Participate in a minimum of two (2) trainings:
    - Minors' Rights and Confidentiality
    - Public Health Insurance for adolescents
- Participate in other training and receive technical assistance in as many areas as are needed to implement the Seven Steps
- Conduct baseline and annual assessments
- Provide data to the DOHMH for outcome measures

Completing all of the steps may be challenging for some providers, given resources, setting, etc. We encourage you to proceed "one step at a time" until you have achieved them all.

If you'd like to explore partnership, contact the Bureau of Maternal, Infant, and Reproductive Health at 212-341-3855.

Seven Steps to Comprehensive Adolescent Sexual and Reproductive Health Care

In providing health services to adolescents, providers should:

(1) Guarantee confidentiality and adolescents' rights to consent to sexual and reproductive health care.

(2) Make services accessible and facilities welcoming to adolescents.

(3) Deliver care that is sensitive to each adolescent's culture, ethnicity, community values, religion, language, educational level, sex, gender and sexual orientation.

(4) Screen all adolescents for sexual and reproductive health issues, substance use, and mental health concerns, and provide appropriate care or referrals.

(5) Provide risk-reduction counseling and education to every adolescent.

(6) Provide contraceptive methods, including emergency contraception (EC), to adolescents at risk for pregnancy.

(7) Offer information, assistance, and support for all decisions regarding pregnancy.

Guarantee confidentiality and adolescents' rights to consent to sexual and reproductive health care

Nearly half of all adolescents seeking sexual health services say they would rather forego services than have a parent notified that they were obtaining birth control. An additional 11% would forego or delay sexually transmitted infection (STI) testing or treatment if parental notification were required.[5]

Parents/guardians generally have the right to make health care decisions for their children and access information about that care. Providers should encourage parental involvement whenever that is possible and in the adolescent's best interest.

However, under New York law minors (under 18) who understand the risks and benefits of available treatments can consent to and obtain the following sexual and reproductive health care without parental involvement or knowledge:

- Family planning care, including prescription contraception and emergency contraception;
- Abortion;
- Prenatal care and care during labor and delivery;
- Testing and treatment for sexually transmitted infections (STIs);
- HIV testing; and
- Sexual assault treatment, including rape crisis counseling and forensic evidence collection.[6]

Confidentiality is as important as autonomous consent. Adolescents are more forthcoming about risky behaviors if they have time alone with a provider. Because confidentiality is vital to sexual and reproductive health care, New York State law protects the confidentiality of minors regarding such care. When a minor independently consents to sexual and reproductive health care, the health care provider may not disclose information about it to parents or any other third party without the minor's permission, or unless otherwise required or permitted by law.

> ***"My doctor asked me about school and checked my breathing, ears, and mouth. Then she asked me whether or not I drank, smoked, or had sex. My mother was in the room with me the whole time. The experience felt very impersonal and practiced. It was not a comfortable atmosphere."***
>
> *Crystal, Age 16*

Best Practices

For Clinicians and Allied Health Staff:

- Provide private time with the adolescent at every visit, in a space that allows for confidential conversation.
- At the beginning of every appointment, give the patient a written consent form, explain it, and assure the patient that the law allows minors to get sexual and reproductive health care without the permission of a parent or guardian.
- Explain that the provider is required by law to maintain an adolescent patient's confidentiality regarding care and conversations, except under specific circumstances. Explain those circumstances. Inform the patient about who has access to his or her medical records.
- Do not collect medical history or reason for visit in an open area. Provide a space where patients can fill out paperwork in some degree of privacy.
- Verify with the patient that you can leave telephone messages on a given number or send mail to a given address.
- Provide clinic literature that is small enough to fit in a wallet or pocket.
- If parents/guardians are present, inform them that NYS law gives minors a right to confidentiality regarding sexual and reproductive health care. (Also explain that adolescents will be encouraged to talk to their parents/guardians about the care they need and receive).
- Do not discuss patient information in elevators, hallways or waiting rooms.

Limits to Consent and Confidentiality Laws

- When it is the parent/guardian, not the minor, who consents, medical information can generally be disclosed to the parent/guardian. However, even when the parent/guardian consents, a provider cannot reveal medical information if the provider believes disclosure would be detrimental to the minor's care or to the minor's relationship with parents/guardians or with the provider.
- Sometimes the law requires a health care provider to report otherwise confidential patient information to specific government agencies or in legal proceedings. Examples include reporting of child abuse, sexually transmitted infections, and HIV.

For Administrators:

- Train staff on NYS adolescent consent and confidentiality laws and on ways to protect confidentiality.
- Provide written consent forms to all adolescents, clearly explaining their right to keep personal, sexual, and reproductive health information confidential.
- Post New York State adolescent consent laws prominently.
- Distribute pamphlets on adolescents' rights to all adolescents.

Resources and Tools

Minors' Rights to Confidential Reproductive Health in New York card. (Enclosed)
"Teenagers, Health Care and the Law. A Guide to the Law on Minors' Rights in New York State," New York Civil Liberties Union (2002). www.nyclu.org

"Your Rights to Sexual Health Services: A reference card for youth." New York Civil Liberties Union. www.nyclu.org/thi

"Confidential Health Care for Adolescents: Position Paper of the Society for Adolescent Medicine," Society for Adolescent Medicine (2004). (Enclosed) www.adolescenthealth.org.PositionPapers.htm

Training and Technical Assistance (See Training/TA menu for details)

Minors' Rights and Confidentiality
Working with Parents and Caregivers

Measures toward Success

Measure	Who is responsible	
	Clinicians & Allied Health Staff	Administrators
Private space available for confidential conversation		X
% of adolescent visits that include private time with provider	X	X
% staff trained in Minors' Rights & Confidentiality	X	X
% of adolescents who sign consent forms	X	X
Written consent forms clearly explain adolescents' right to keep personal, sexual, and reproductive health information confidential		X
NYS adolescent consent laws posted prominently		X

Resources & Tools

Make services accessible and facilities welcoming to adolescents

Adolescents may face formidable barriers to accessing health care. One-quarter of female adolescents and one-fifth of males report that they have sometimes been unable to get care when they needed it.[7]

Inconvenient hours or location, expense of care and lack of insurance coverage or misinformation about insurance eligibility, and judgmental attitudes of staff all contribute to limiting access for adolescents.[8] Youth in foster care, immigrant youth, and youth of color face additional barriers due to culture, language, and fear of deportation.

Turnover in staff or inattention to a patient's connection with a particular clinician may also contribute to adolescents' discomfort and reluctance to seek sexual and reproductive health care. Adolescents are most likely to discuss sexual problems with their usual provider.[9]

> ***"After the nurse took my information, I waited in the waiting room until the doctor was available. I waited for a while and got bored again. There were little toys and books for younger kids, but nothing really for teens."***
>
> *Paula, Age 16*

Best Practices

For Administrators:

- Offer hours convenient for adolescents, e.g. after school or on weekends.
- Adjust protocols to make it easy for adolescents to make appointments.
- Provide clear directions, including public transportation information, to office or clinic on literature and recorded messages.
- Offer all adolescents the option to see the same provider at every visit.
- Minimize on-site visit waiting time.
- Train staff on Medicaid coverage and other public insurance options for adolescents, e.g., Family Planning Benefit Program (FPBP), Family Planning Extension Program (FPEP), and Prenatal Care Assistance Program (PCAP).
- Maintain contact with local schools and community-based organizations. Distribute literature through them whenever possible.
- Hire front-desk staff and phone receptionists who are friendly to adolescents.
- Make office décor "adolescent friendly" – display posters and provide magazines appropriate to ethnically diverse female and male adolescents.

Resources and Tools

"Questions to Consider When Creating a Youth Friendly Environment," *Adolescent Provider Toolkit,* Adolescent Health Working Group (2003). (Enclosed)

Family Planning Benefit Program, New York State Department of Health (Enclosed)
www.health.state.ny.us and enter Family Planning Benefit Program in the search field.

"Request for Family Planning Benefit Programs Materials," NYS DOH (Enclosed)
www.health.state.ny.us/forms/order_forms/family_planning.pdf

For more information on public health insurance, visit www.nyc.gov and enter "Mayor's Office of Health Insurance Access" in the Search field.

Training and Technical Assistance (See Training/TA Menu for details)

Public Health Insurance in New York State

Measure	Who is responsible	
	Clinicians & Allied Health Staff	Administrators
% staff trained in Medicaid coverage and other public insurance options for adolescents		X
% of adolescents enrolled in public insurance, e.g., Family Planning Benefit Program		X
% of adolescents who wait less than 1 hour from arrival to time to the time they see a health care provider		X
Staff member available at appointment time or time of visit to inform adolescents about Medicaid coverage and other public insurance options		X
After-school and/or weekend hours offered		X
Office décor is "adolescent friendly"		X

Resources & Tools

QUESTIONS TO CONSIDER WHEN CREATING A YOUTH FRIENDLY ENVIRONMENT

DOES YOUR OFFICE/HEALTH CENTER HAVE...

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

DO YOU PROVIDE...

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

DOES YOUR STAFF...

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

WHEN YOU SPEAK TO ADOLESCENTS DO YOU...

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

ARE YOU AWARE...

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

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

REQUEST FOR FAMILY PLANNING BENEFIT PROGRAM MATERIALS

To order the following publications, please complete the form below and send to:

N.Y.S. Department of Health Box 2000 Albany, NY 12220

All items are available free of charge to New York State residents and organizations. Please allow **2-3** weeks for delivery.

Title	**Publication Number**	**Quantity** (please circle)
Family Planning Benefit Program Client Brochure		
Dual English/Spanish	#1130	200 600 1000 5000
Russian	#1131	25 50 100 200
Chinese	#1132	25 50 100 200
Arabic	#1133	10 25 50 100
Haitian – Creole	#1134	10 25 50 100
Korean	#1135	10 25 50 100
Vietnamese	#1136	10 25 50 100
Family Planning Benefit Program Posters		
English	#1137	5 10 25 50
Spanish	#1138	5 10 25 50

Requester Information: (Please note: bulk orders cannot be delivered to P.O. Boxes.)

Name: _____

Organization: _____

Street Address: _____

City/State/Zip: _____

Phone #: _____Date: _____

*Supplies may be limited. If requesting quantities larger than noted above, please send the order form with a note justifying the need.

Family Planning Benefit Program

The **Family Planning Benefit Program** provides family planning services to all females of child bearing age and males who meet certain income and residency requirements.

Eligibility Requirements Include:

- **Age**: Female or male of childbearing age;
- **Identity**
- **Residency**: Must be a New York State resident;
- **Citizenship/Immigration Status**: Can be a U.S. citizen or fall under one of many immigration categories. Undocumented immigrants and people on short-term visas who are not in the process of applying for permanent status are not eligible;
- **Health Coverage**: Not eligible for Medicaid or Family Health Plus or wish to only apply for the Family Planning Benefit Program;
- **Income**: Please see chart below for monthly income levels.

Family Planning Benefit Program Income Levels This chart is only a guide. Individuals should see an enrollment counselor for eligibility screening.			
Family Size	Yearly Income	Monthly Income	Weekly Income
1	**$20,100**	**$1,675**	**$387**
2	**$26,700**	**$2,225**	**$513**
3	**$33,300**	**$2,775**	**$640**
4	**$39,900**	**$3,325**	**$767**
5	**$46,500**	**$3,875**	**$894**
For each additional person add:	**$6,600**	**$550**	**$127**
* Pregnant Women count as two individuals.			
NOTE: Chart effective January 1, 2006. Subject to annual income updates.			

What Health Services are Covered by the Family Planning Benefit Program?

- Most FDA approved birth control methods, devices, prescription drugs and supplies (e.g., birth control pills, injectables, patches, condoms, diaphragms, IUDs);
- Emergency contraception services and follow-up care;
- Male and female sterilization;
- Preconception counseling, preventive screening and family planning options before pregnancy.

The following additional services are only covered when they are part of a family planning visit **and** when the service provided is directly related to family planning:

planning visit **and** when the service provided is directly related to family planning:

- Pregnancy testing and counseling;
- Gynecological exams including clinical breast exam (mammograms not included);
- Reproductive health information, education and counseling services related to pregnancy, sexually transmitted infection risk and family planning options;
- HIV counseling and testing;
- Screening for sexually transmitted infections, cervical cancer (Pap smears) and urinary tract or female-related infections;
- Screening and related diagnostic lab testing for medical conditions that affect the choice of birth control contraceptive choice such as high blood pressure, diabetes, smoking, blood clots and other conditions;
- Counseling services related to pregnancy, informed consent, and STD/HIV risk counseling.

How to Enroll in the Family Planning Benefit Program
In some instances, *family planning providers*, local health departments, and *Prenatal Care Assistance Program (PCAP) providers* may also assist in the application process.
Find a family planning provider in your neighborhood (in PDF)

Other Helpful Resources
For more information regarding this and other public health insurance programs, please contact an agency listed below:
Human Resources Administration at 1-877-472-8411
New York State Department of Health at 1-800-541-2831or visit its website at New York State Department of Health:
(www.health.state.ny.us/health_care/medicaid/program/longterm/familyplanbenprog.htm)

Deliver care that is sensitive to each client's ethnicity, culture, community values, religion, language, educational level, sex, gender, and sexual orientation

Measures toward Success

When asked about what affects their use of health care services, adolescents emphasize the importance of providers and staff treating them with respect, treating all of the patients equally, and relating well to adolescents.[10]

An important way to meet adolescents' desire for respect and good communication is to tailor services and referrals to each individual and remember that certain circumstances may make it more challenging for adolescents to seek sexual and reproductive health services and for providers to serve them. Of most importance is being non-judgmental and not making assumptions. While every adolescent should be treated as an individual, circumstances to consider include:

- Sexual orientation
- Mental, physical, or developmental disability
- Immigration status
- Race/ethnicity
- Culture
- Religion
- Chronic illnesses
- Gender: Male adolescents in particular
    - Sexual and reproductive health services for young men are not always covered by insurance
    - Some providers are reluctant to address young men's needs because they lack interest or training or believe resources are more effectively spent on women[11]

> ***"The last time I saw my doctor, he asked me a few questions. When we talked about my sexual orientation, he said, 'Oh, are you are still gay?' I felt like he didn't really care about me."***
>
> *Joshua, Age 19*

Best Practices

For Clinicians and Allied Health Staff:

- Tailor education and counseling to the developmental and learning needs and abilities of each adolescent.
- Always use inclusive language – for instance, say "person you have sex with," "romantically involved with," or "partner" instead of assuming the adolescent is heterosexual.
- Maintain comprehensive, up-to-date referral lists for services not offered on-site, for instance for youth with disabilities, GLBTQ or immigrant youth.

For Administrators:

- Provide health education materials at appropriate reading levels and in appropriate language/s.
- Train all staff who interact with adolescents (including frontline staff) on adolescent health and developmental issues, adolescent-friendly services, and cultural competency.
- Hire staff whose genders, races, and ethnicities reflect the populations served.
- At all points of contact, provide language assistance, including bilingual staff and interpreter services, at no cost to patients with limited English proficiency.
- Administer client satisfaction surveys periodically and improve unsatisfactory services that are identified. Use standardized tools such as the Young Adult Health Care Survey (enclosed).

Resources and Tools

"Adolescent Growth and Development," Adolescent Provider Toolkit, Adolescent Health Working Group (2003). (Enclosed)

Young Adult Health Care Survey, Version 2N. (Enclosed)

Training and Technical Assistance (See Training/TA Menu for details)

Adolescent Development
Adolescent-Friendly Services
Cultural Competency
Male Adolescent Reproductive Health Services

Measures of Success

Measure	Who is responsible	
	Clinicians & Allied Health Staff	Administrators
% of staff trained in adolescent development and appropriate interaction with and service for adolescents	X	X
% of staff trained in cultural competency	X	X
% of staff trained in male adolescent reproductive health services	X	X
Language assistance services, including bilingual staff and interpreter services, are provided at no cost to each patient with limited English proficiency		X
Health education materials are provided at appropriate reading levels and in appropriate language/s	X	X
Comprehensive referral lists are developed and regularly updated for services not offered on site		X
Client satisfaction surveys are regularly distributed to adolescents and needed service improvements are addressed		X

Resources & Tools

ADOLESCENT GROWTH AND DEVELOPMENT

CHARACTERISTICS	EARLY ADOLESCENCE	MIDDLE ADOLESCENCE	LATE ADOLESCENCE
AGE RANGE (These stages are variable and fluid.)	• Females: 9-13 years • Males: 11-15 years	• Females: 13-16 years • Males: 15-17 years	• Females: 16-21 years • Males: 17-21 years • The upper end varies and depends on cultural, economic, and educational factors.
GROWTH	• Secondary sexual characteristics appear. • Voice changes and body odor increases. • Growth rapidly accelerating; reaches peak velocity.	• Secondary sexual characteristics well advanced. • Menstruation begins in females. • Growth decelerating; stature reaches 95% of adult height.	• Physically mature; statural and reproductive growth virtually complete.
COGNITION	• Concrete thought dominant. • Existential orientation. • Cannot perceive long-range implications of current decisions and acts.	• Rapidly gaining competence in abstract thought. • Capable of perceiving future implications of current acts and decisions but variably applied. • Reverts to concrete operations under stress.	• Established abstract thought processes. • Future oriented. • Capable of perceiving and acting on long-range options.
PSYCHOLOGICAL SELF AND SELF-PERCEPTION	• Preoccupation with rapid body change. • Former body image disrupted. • Concerned with privacy. • Frequent mood swings. • Very self-focused.	• Reestablishes body image as growth decelerates and stabilizes. • Extremely concerned with appearance and body. • Preoccupation with fantasy and idealism in exploring expanded cognition and future options. • Often risk takers. • Development of a sense of omnipotence and invincibility.	• Emancipation completed. • Intellectual and functional identity established. • May experience “crisis of 21” when facing societal demands for autonomy. • Body image and gender role definition nearly secured.
FAMILY	• Defining independence–dependence boundaries. • Conflicts may occur but relate to minor issues.	• Frequency of conflicts may decrease but their intensity increases. • Struggle for emancipation.	• Transposition of child-parent dependency relationship to the adult-adult model
PEER GROUP	• Seeks peer affiliation to counter instability generated by rapid change. • Compares own normality and acceptance with same sex/age mates. • Same-sex friends and group activities.	• Strong need for identification to affirm self-image. • Looks to peer group to define behavioral code during emancipation process. • Cross-gender friendships more common.	• Group recedes in importance in favor of individual friendships and intimate relationships.

ADOLESCENT GROWTH AND DEVELOPMENT (continued)

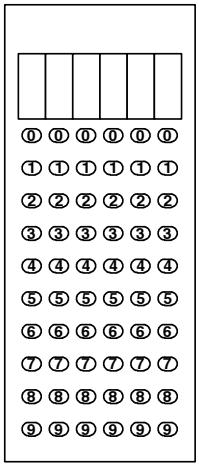
CHARACTER-ISTICS	EARLY ADOLESCENCE	MIDDLE ADOLESCENCE	LATE ADOLESCENCE
SEXUALITY	• Self-exploration and evaluation. • Limited dating. • Sexual fantasies are common and may serve as a source of guilt. • Masturbation begins during this period and may be accompanied by guilt. • Sexual activities are usually non-physical. Early adolescents are often highly content with nonsexual interactions such as telephone calls to peers.	• Multiple plural relationships. • Heightened sexual activity. • Testing ability to attract boy/girl-friends and parameters of masculinity or femininity. • Preoccupation with romantic fantasy. • Experimentation with relationships and sexual behaviors. • More emphasis on physical contact. • Establishing sexual identity; fears/questions about homosexuality. • Dating and making out (petting) are common, and casual relationships with both noncoital and coital contacts are prevalent. • Denial of consequences of sexual behavior is typical.	• Forms stable relationships. • Capable of mutuality and reciprocity in caring for another rather than former narcissistic orientation. • Plans for future in thinking of marriage and/or family. • Intimacy involves commitment rather than exploration and romanticism. • Sexual orientation nearly secured.
TIPS	• Effective communication tools must be very specific. • Use materials with pictures rather than tables and graphs. • Focus on issues that most concern these teens (weight gain, acne, physical changes, peer acceptance). • Early and late maturation can lead to difficulties. • Parents will welcome guidance on discipline, rules and communication.	• Healthcare providers perceived as "friends" rather than authority figures help to develop trust with teens. • Teens must identify with the healthcare message to ensure follow through and success. • Peer counseling, if carefully selected, can be effective with this age group. • Focus on supportive adult connections, health promotion and harm reduction is key during this stage.	• More abstract reasoning allows for more traditional counseling approaches that rely on knowing consequences of behaviors. • Pediatric practices need to assist in transition to adult healthcare providers. • Provide the option to include close friends and/or partners for office visits.

Adapted from Greydanus, D. (2002) "Characteristics of Early, Middle, and Late Adolescence." *Delivering Culturally Effective Health Care to Adolescents*. American Medical Association. Permission from Dr. Greydanus, December, 2002.

Young Adult Health Care Survey

Version 2.N

Confidential Code



Instructions:

1. In this survey, the term doctor or other health provider is used. A doctor or other health provider could be a general doctor, a specialist, a nurse practitioner, a physician assistant, a nurse, or anyone else you see for health care

2. You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow and then a note that tells you what question to answer next, like this:

① Yes

② No ===> GO TO QUESTION 10

So, if you choose to answer "No" to this question, continue the survey with question 10.

3.	MARKING INSTRUCTIONS

- **Use a No. 2 pencil or a blue or black ink pen only.**
- **Do not use pens with ink that soaks through the paper.**
- **Make solid marks that fill the response completely.**
- **Make no stray marks on this form.**

CORRECT: ● **INCORRECT:** ✓ ⊗ ◒ ◯

Thank you for your help with this survey!

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SECTION I -- HEALTH CARE UTILIZATION

1. Where do you USUALLY go for medical care?

① Doctor's Office or Clinic
② School based health center
③ Community clinic/health center
④ Hospital clinic
⑤ Hospital emergency room
⑥ Family planning center (e.g. planned parenthood)
⑦ School nurse
⑧ Urgent care clinic
⑨ No one usual place

2. Have you seen a doctor or other health provider in the LAST 12 MONTHS?

① Yes
② No

3. When was the LAST TIME you went to a doctor or other health provider for REGULAR or ROUTINE care?

① 0-6 months ago
② 7-12 months ago
③ 13-24 months ago
④ More than 2 years ago
⑤ I did not go to a doctor or other health provider for REGULAR or ROUTINE care ===> GO TO QUESTION 6

4. Where did you go the last time you went to a doctor or other health care provider for REGULAR or ROUTINE care?

① Doctor's Office or Clinic
② School based health center
③ Community clinic/health center
④ Hospital clinic
⑤ Hospital emergency room
⑥ Family planning center (e.g. planned parenthood)
⑦ School nurse
⑧ Urgent care clinic

5. At your visit with the doctor or other health care provider for REGULAR or ROUTINE care, did you fill out a checklist or survey about your health?

① Yes
② No

6. In the LAST 12 MONTHS is there any OTHER place you have gone to for medical care?
MARK ALL THAT APPLY

1 No other place
2 Doctor's office or clinic
3 School based health center
4 Community clinic/health center
5 Hospital clinic
6 Hospital emergency room
7 Family planning center (e.g. planned parenthood)
8 School nurse
9 Urgent care clinic

SECTION II -- PRIVACY

7. In the LAST 12 MONTHS, did you get a chance to SPEAK with a doctor or other health care provider privately? (Meaning one on one -- without your parents or other people in the room).

① Yes
② No

8. In the LAST 12 MONTHS, did a doctor or other health provider TELL YOU that what you talked about with them was confidential? (Meaning it would not be shared with anyone else.)

① Yes
② No

9. Do you KNOW of a place (other than the school nurse) where teenagers can go to see a doctor or other health provider without their parents knowing about it?

① Yes
② No

SECTION III -- HEALTH AND SAFETY

10. In the LAST 12 MONTHS, did a doctor or other health provider talk with you about any of the following:

a. Weight?

① Yes
② No

b. Healthy eating / Diet?

① Yes
② No

c. Physical activity or exercise?

① Yes
② No

11. In the LAST 12 MONTHS, did a doctor or other health provider talk with you about any of the following:

a. Your friends?

① Yes
② No

b. Your school performance or grades?

① Yes
② No

c. Your emotions or mood?

① Yes
② No

d. Suicide?

① Yes
② No

12. In the LAST 12 MONTHS, did a doctor or other health provider talk with you about any of the following:

a. Using a helmet when riding a bicycle, roller-blading, or skateboarding?

① Yes
② No

b. Riding in a motor vehicle with a driver who has been drinking or using drugs?

① Yes
② No

c. Violence prevention?

① Yes
② No

d. Guns and other weapons?

① Yes
② No

13. In the LAST 12 MONTHS, did a doctor or other health provider talk with you about any of the following:

a. Chewing tobacco or snuff?

① Yes
② No

b. Drug use (including marijuana, cocaine, crack, heroin, acid, speed, ecstasy, roofies, or others)?

① Yes
② No

c. Use of steroids or shots without a doctor's prescription?

① Yes
② No

d. Use of herbal medicine or nutritional supplements?

① Yes
② No

14. In the LAST 12 MONTHS, did a doctor or other health provider talk with you about any of the following:

a. Sexual orientation (that is, being gay or straight)?

① Yes
② No

b. Sexually transmitted diseases, or STD's (such as gonorrhea or chlamydia)?

① Yes
② No

c. Sexual or physical abuse?

① Yes
② No

d. Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS)?

① Yes
② No

The next questions ask about how you feel.

15. During the LAST 12 MONTHS, did you ever feel so sad or hopeless almost every day for TWO WEEKS or more in a row that you stopped doing some usual activities?

① Yes
② No

16. In the LAST 12 MONTHS, did you and a doctor or other health provider TALK about whether you ever felt sad or hopeless almost evey day?

① Yes
② No

The next questions ask about tobacco and smoking.

17. During the PAST 30 DAYS, on how many DAYS did you smoke cigarettes?

① 0 days (didn't smoke any cigarettes)
② 1 or 2 days
③ 3 to 5 days
④ 6 to 9 days
⑤ 10 to 19 days
⑥ 20 to 29 days
⑦ All 30 days

18. In the LAST 12 MONTHS, did you and a doctor or other health provider TALK about cigarettes or smoking?

① Yes
② No ===> GO TO QUESTION 20

19. How HELPFUL was this discussion in understanding the risks of cigarettes or smoking to your health?

① Not at all helpful
② Somewhat helpful
③ Helpful
④ Very helpful
⑤ Not sure

20. In the LAST 12 MONTHS, have you ever smoked cigarettes daily, that is, at least one cigarette every day for 30 days?

① Yes
② No ===> GO TO QUESTION 23

21. In the LAST 12 MONTHS, did you and a doctor or other health provider TALK about how and why to quit smoking (such as setting a date to quit)?

① Yes

② No ===> GO TO QUESTION 23

③ No, because I did not tell my doctor that I smoked cigarettes ===> GO TO QUESTION 23

22. How HELPFUL were your discussions in QUITTING smoking?

① Not at all helpful
② Somewhat helpful
③ Helpful
④ Very helpful
⑤ Not sure

The next questions ask about drinking alcohol

Examples of drinking alcohol include drinking beer, wine, wine coolers, and liquor such as tequila, rum, gin, vodka, or whiskey. For these questions, drinking alcohol does not include drinking a few sips of wine for religious purposes.

23. During the PAST 30 DAYS, on how many days did you have at least one drink of alcohol?

① 0 days (didn't drink alcohol) ===> GO TO QUESTION 25
② 1 or 2 days
③ 3 to 5 days
④ 6 to 9 days
⑤ 10 to 19 days
⑥ 20 to 29 days
⑦ All 30 days

24. During the PAST 30 DAYS, on how many days did you have 5 OR MORE DRINKS of alcohol in a row, that is within a couple of hours?

① 0 days (didn't drink 5 or more drinks of alcohol in a row)
② 1 or 2 days
③ 3 to 5 days
④ 6 to 9 days
⑤ 10 to 19 days
⑥ 20 to 29 days
⑦ All 30 days

25. In the LAST 12 MONTHS, did you and a doctor or other health provider TALK about alcohol use?

① Yes
② No ===> GO TO QUESTION 27

26. How HELPFUL was this discussion in understanding alcohol use and its risk to your health?

① Not at all helpful
② Somewhat helpful
③ Helpful
④ Very helpful
⑤ Not sure

The next questions ask about sexual behavior and related topics

27. Have you EVER had sexual intercourse?

① Yes
② No ===> GO TO QUESTION 29

28. The LAST TIME you had sexual intercourse, did you or your partner use a condom?

① Yes
② No

29. In the LAST 12 MONTHS, did you and a doctor or other health provider talk about condoms?

① Yes
② No ===> GO TO QUESTION 31

30. How HELPFUL was this discussion in understanding how to use condoms to prevent HIV and other STD's (Sexually Transmitted Diseases)?

① Not at all helpful
② Somewhat helpful
③ Helpful
④ Very helpful
⑤ Not sure

31. In the LAST 12 MONTHS, did you and a doctor or other health provider TALK about birth control?

① Yes
② No ===> GO TO QUESTION 33

32. How HELPFUL was this discussion in understanding how and why to use birth control?

① Not at all helpful
② Somewhat helpful
③ Helpful
④ Very helpful
⑤ Not sure

The next questions ask about safety.

33. How OFTEN do you wear a seat belt when riding or driving in a car?

① Never
② Rarely
③ Sometimes
④ Most of the time
⑤ Always

34. In the LAST 12 MONTHS, did you and a doctor or other health provider TALK about the importance of wearing a seat belt?

① Yes
② No

SECTION IV -- HEALTH INFORMATION

Health information can be given to you in many different ways:

- In written pamphlets
- In your doctor or other health provider's office
- Through posters in the waiting room
- At school
- Through recorded information over the telephone
- On the Internet

35. In the LAST 12 MONTHS, did you see or hear information that provided safety tips for you? (Such as bicycle helmet use, seat belt use, violence prevention)

① Yes
② No

36. In the LAST 12 MONTHS, did you see or hear information about the risks of smoking?

① Yes
② No

37. In the LAST 12 MONTHS, did you see or hear information about the benefits of a healthy diet, physical activity or exercise?

① Yes
② No

38. In the LAST 12 MONTHS, did you see or hear information that provided tips about how to prevent Sexually Transmitted Diseases (STD's)?

① Yes
② No

39. In the LAST 12 MONTHS, did you see or hear information about how to quit smoking?

① Yes
② No

SECTION V -- YOUR HEALTH CARE IN THE LAST 12 MONTHS

The next section asks you to rate your doctor or other health provider and your experience in a health care setting.

40. In the LAST 12 MONTHS, how often were office staff at a doctor's office or clinic as HELPFUL as you thought they should be?

① Never
② Sometimes
③ Usually
④ Always

41. In the LAST 12 MONTHS, how often did doctors or other health providers listen CAREFULLY TO YOU?

① Never
② Sometimes
③ Usually
④ Always

42. In the LAST 12 MONTHS, how often did you have a hard time SPEAKING WITH OR UNDERSTANDING a doctor or other health provider because you spoke different languages?

① Never
② Sometimes
③ Usually
④ Always

43. In the LAST 12 MONTHS, how often did doctors or other health providers EXPLAIN THINGS in a way that you could understand?

① Never
② Sometimes
③ Usually
④ Always

44. In the LAST 12 MONTHS, how often did doctors or other health providers show RESPECT FOR WHAT YOU HAD TO SAY?

① Never
② Sometimes
③ Usually
④ Always

45. In the LAST 12 MONTHS, how often did doctors or other health providers SPEND ENOUGH TIME with you?

① Never
② Sometimes
③ Usually
④ Always

46. In the LAST 12 MONTHS, how much of a problem, if any, was it to GET THE CARE you or a doctor or other health provider believed necessary?

① A big problem
② Somewhat of a problem
③ A small problem
④ Not a problem

47. In the LAST 12 MONTHS, have you ever had a serious HEALTH PROBLEM that went UNTREATED?

① Yes
② No

48. We want to know your rating of all health care in the last 12 months from all doctors or other health providers. Use any number from 1 to 10 where 1 is the worst health care possible and 10 is the best health care possible.
How would you rate all of your health care? MARK ONE.

① Worst health care possible
② .
③ .
④ .
⑤ .
⑥ .
⑦ .
⑧ .
⑨ .
⑩ Best health care possible

SECTION VI -- YOUR HEALTH

49. How is your health in general?

① Excellent
② Very good
③ Good
④ Fair
⑤ Poor

50. For statements a-c, mark the box below the statement to show if you completely agree, mostly agree, agree a little or do not agree with the statement.

a. I am full of energy.

① Completely agree
② Mostly agree
③ Agree a little
④ Do not agree

b. I have lots of good qualities.

① Completely agree
② Mostly agree
③ Agree a little
④ Do not agree

c. I am satisfied with my life and how I live it.

① Completely agree
② Mostly agree
③ Agree a little
④ Do not agree

51. In the LAST 4 WEEKS, how many days did you have pains that really bothered you?

① No days
② 1 to 3 days
③ 4 to 6 days
④ 7 to 14 days
⑤ 15 to 28 days

52. In the LAST 4 WEEKS, on how many days did you exercise or play sports hard enough to make you breathe hard or make you sweat for 20 minutes or more?

① No days
② 1 to 9 days
③ 10 to 13 days
④ 14 to 20 days
⑤ 21 to 28 days

53. In the LAST 4 WEEKS, on how many days did a HEALTH OR EMOTIONAL problem keep you from doing what you usually do at school or with friends or family.

① No days
② 1 to 3 days
③ 4 to 6 days
④ 7 to 14 days
⑤ 15 to 28 days

SECTION VII -- DEMOGRAPHICS

The next questions are about you. They are being asked for grouping purposes only.

54. How old are you?

① 12 or younger
② 13
③ 14
④ 15
⑤ 16
⑥ 17
⑦ 18
⑧ 19
⑨ 20 or older

55. Are you a female or male?

① Female
② Male

56. How do you describe yourself?
MARK ALL THAT APPLY.

① White
② Black or African-American
③ Asian
④ Hispanic or Latino
⑤ American Indian or Alaska Native
⑥ Native Hawaiian or Pacific Islander
⑦ Other

57. Did someone help you complete this survey?

① Yes ===> GO TO QUESTION 58
② No YOU ARE DONE!

58. How did that person help you?
MARK ALL THAT APPLY.

① Read the questions to me

② Wrote down my answers

③ Answered the questions for me

④ Helped me remember when I last went to a doctor or other health provider

⑤ Translated the questions into my language

⑥ Helped in other way. Please print below.

YOU'RE DONE!!

Thank you for completing the survey.

Please return it in the envelope provided.

If you have any questions about this survey, please call (800) 852-3685 Ext. 284

Screen all adolescents for sexual and reproductive health issues, substance use, and mental health concerns; provide appropriate care or referrals

Nearly half of all NYC public high school students have had sex. Many of them are engaging in risky sexual behaviors.[12]

Adolescents account for about one-fourth of all diagnosed sexually transmitted infections in the U.S. each year[13]; in NYC chlamydia and gonorrhea rates are highest among adolescent females.[14] Much of the infection rate – far higher than in older adults – can be attributed to behavior: adolescents are more likely to engage in unprotected intercourse or to have multiple sexual partners. They may also be more physiologically susceptible to certain STIs because of cervical ectopy.[15] The presence of STIs increases the risk of HIV acquisition and transmission.

Sexual risk-taking is often correlated with substance abuse and/or other mental health problems – and NYC adolescents face substantial psychosocial risks. New York's adolescents are not receiving sufficient sexual health screening. For instance, 15% of HIV-positive adolescents are not diagnosed until they have full-blown AIDS.[16] Screening all adolescents for sexual health, substance abuse, and other mental health concerns enable providers to intervene with treatment, counseling, education, and appropriate referrals.

It is important to screen for forced sex and other relationship violence and make appropriate referral for counseling. According to data from the NYC Youth Risk Behavior Survey, 1 in 4 sexually active female high school student has experienced forced sex (See data below).

Among NYC public high school students surveyed in 2005:[17]

- 11% reported having sex before age 13, 18% had sex with 4 or more partners, and 16% used alcohol or drugs the last time they had sex;
- 10% of females and 5% of males had experienced forced sex;
- 30% tried alcohol before age 13, 11% smoked cigarettes, and 7% used marijuana;
- 32% reported profound sadness, and 10% had attemped suicide; and
- 11% of females and 10% of males reported dating violence.

Among students who were sexually active within three months of the survey:[18]

- 19% of females had experienced forced sex;
- 22% of males used alcohol the last time they had sex;
- 32% of males reported having sex before age 13; and
- 61% of males reported having had sex with 4 or more partners.

> ***"My doctor asked me questions about sex and friendship. It was interesting, because they cared about the problem I got into. They also wanted to know if any of my family members deal drugs or any other harmful thing."***
>
> *Justin, Age 16*

Best Practices

For Clinicians and Allied Health Staff:

- Conduct comprehensive health and risk assessments, including sexual history and screening for alcohol, tobacco, and drug use, and mental health concerns. Use standardized tools designed for adolescent patients (See Resources and Tools).
- Conduct or make appropriate referrals for STI and confidential HIV screening with all sexually active adolescents and their partners (a new testing option, the urine-based chlamydia test, is reimbursable under some insurance plans). Inform adolescents about free, low-cost, and/or anonymous testing sites.
- Counsel and treat or refer all adolescents who test positive for an STI or HIV.
- Inform all sexually active female adolescents about Pap tests and the importance of being screened. Follow current guidelines for Pap tests: women should receive Pap tests by age 21 or within 3 years of initiating sexual intercourse.
- Provide appropriate care or referrals to treatment for alcohol, tobacco, and drug use, depression, and other mental health problems.

For Administrators:

- Train all health care providers in conducting comprehensive health assessments for adolescents, including taking a sexual history and screening for psychosocial risks, such as alcohol and substance abuse, depression, and interpersonal violence.
- Provide on-site STI, HIV, and other sexual health screenings or up-to-date referrals to other testing sites.

Resources and Tools

Guidelines for Adolescent Preventive Services (GAPS) Questionnaires for younger adolescents; and middle-older adolescents. (Enclosed)
www.ama-assn.org/ama/pub/category/1980.html

"Annotated HEADSSS (Home, Education/Employment, Activities, Drugs, Sexuality, Safety, Suicide) Assessment," *Adolescent Provider Toolkit,* Adolescent Health Working Group (2003). (Enclosed)

Sexual History Form. NYC DOHMH. (Enclosed) **www.nyc.gov/health/maternity**

"Taking a Sexual History: Tips & Tools." (Enclosed)

"Topics for Substance Abuse and Mental Health Screening." (Enclosed)

"Tobacco, Alcohol, and Other Drugs: The Role of the Pediatrician in Prevention, Identification, and Management of Substance Abuse,"American Academy of Pediatrics, Pediatrics (March, 2005) (Enclosed) **http://aappublications.org/cgi/reprint/pediatrics;101/1/125.pdf**

Training and Technical Assistance (See Training/TA Menu for details)

Health Assessment

Taking a Sexual History

Measures toward Success

Measure	Who is responsible	
	Clinicians & Allied Health Staff	Administrators
% of staff trained in evidence-based health assessment for adolescents, including taking a sexual history and psychosocial assessment	X	X
Providers use standardized health assessment tools	X	X
% of adolescents screened using standardized health assessment tools	X	
Linkages are in place for referrals to STI and HIV care and treatment		X
Linkages are in place for referrals to care for alcohol, tobacco and drug abuse, and other mental health concerns		X

Resources & Tools

Guidelines for Adolescent Preventive Services
Younger Adolescent Questionnaire

Confidential (Your answers will not be given out.)

Chart# _____

Name _____ Today's Date _____
Last First Middle Initial month day year

Birthdate _____ Grade in School _____ **Boy** or **Girl** (*circle one*) Age _____
month day year

Address _____ City _____ State _____ Zip _____

Phone Number _____ Pager/Beeper Number _____
area code

What languages are spoken where you live? _____

Are you: ☐ White ☐ African-American ☐ Asian/Pacific Islander
☐ Latino/Hispanic ☐ Native American ☐ Other _____

Medical History

1. Why did you come to the clinic/office today? _____

_____

2. Are you allergic to any medicines?
☐ No ☐ Yes, name of medicine(s): _____ ☐ Not Sure

3. Do you have any health problems?
☐ No ☐ Yes, problem (s): _____ ☐ Not Sure

4. Are you taking any medicine now?
☐ No ☐ Yes, name of medicine(s): _____ ☐ Not Sure

5. Have you been to the dentist in the last year? ..... ☐ No ☐ Yes ☐ Not Sure

6. Have you stayed overnight in a hospital in the last year? ..... ☐ No ☐ Yes ☐ Not Sure

7. Have you ever had any of the problems below?

	Yes	No	Not Sure		Yes	No	Not Sure
Allergies or hay fever	☐	☐	☐	Seizures	☐	☐	☐
Asthma	☐	☐	☐	Cancer	☐	☐	☐
Tuberculosis (TB)	☐	☐	☐	Diabetes	☐	☐	☐

For Girls Only

8. Have you started having periods? ☐ No ☐ Yes
   a. *If yes*, are your periods regular (once a month)? ☐ No ☐ Yes
   b. *If yes*, what was the 1st day of your last period? Month _____ Day _____
9. Have you ever been pregnant? ☐ Yes ☐ No

Family Information

10. Who do you live with? (Check all that apply).

☐ Mother	☐ Stepmother	☐ Brother(s)/ages_____
☐ Father	☐ Stepfather	☐ Sister(s)/ages_____
☐ Guardian	☐ Other adult relative	☐ Other/(explain)_____

11. Do you have older brothers or sisters who live away from home? ☐ Yes ☐ No ☐ Not Sure

12. During the past year, have there been any changes in your family such as: (Check all that apply)

☐ Marriage	☐ Loss of job	☐ Births	☐ Other changes_____
☐ Separation	☐ Moved to a new neighborhood	☐ Serious Illness/Injury	_____
☐ Divorce	☐ A new school	☐ Deaths	_____

Specific Health Issues

13. Please check whether you have questions or are worried about any of the following:

☐ Height	☐ Neck or back	☐ Muscle or pain in arms/legs	☐ Anger or temper
☐ Weight	☐ Breasts	☐ Menstruation or periods	☐ Feeling tired
☐ Eyes or vision	☐ Heart	☐ Wetting the bed	☐ Trouble sleeping
☐ Hearing or earaches	☐ Coughing or wheezing	☐ Trouble urinating or peeing	☐ Fitting in/belonging
☐ Colds/runny or stuffy nose	☐ Chest pain or trouble breathing	☐ Drip from penis or vagina	☐ Cancer
☐ Mouth or teeth or breath	☐ Stomach ache	☐ Wet dreams	☐ HIV/AIDS
☐ Headaches	☐ Vomiting or throwing up	☐ Skin (rash/acne)	☐ Dying

☐ Other_____

These questions will help us get to know you better. Choose the answer that best describes what you feel or do. Your answers will be seen only by your health care provider and his/her assistant.

Health Profile

Eating/Weight/Body

14. Do you eat fruits and vegetables every day? ☐ No ☐ Yes
15. Do you drink milk and/or eat milk products every day? ☐ No ☐ Yes
16. Do you spend a lot of time thinking about ways to be skinny? ☐ Yes ☐ No
17. Do you do things to lose weight (skip meals, take pills, starve yourself, vomit, etc)? ☐ Yes ☐ No
18. Do you work, play, or exercise enough to make you sweat or breathe hard at least 3 times a week? ☐ No ☐ Yes
19. Have you pierced your body (not including ears) or gotten a tattoo? ☐ Yes ☐ No

School

20. Is doing well in school important to you? ☐ No ☐ Yes
21. Is doing well in school important to your family and friends? ☐ No ☐ Yes
22. Are your grades this year worse than last year? ☐ Yes ☐ No ☐ Not Sure
23. Are you getting failing grades in any subjects this year? ☐ Yes ☐ No ☐ Not Sure
24. Have you been told that you have a learning problem? ☐ Yes ☐ No
25. Have you been suspended from school this year? ☐ Yes ☐ No

Friends and Family

26. Do you know at least one person who you can talk to about problems? ☐ No ☐ Yes
27. Do you think that your parent(s) or guardian(s) usually listen to you and take your feelings seriously? ☐ No ☐ Yes
28. Have your parents talked with you about things like alcohol, drugs, and sex? ☐ No ☐ Yes ☐ Not Sure
29. Are you worried about problems at home or in your family? ☐ Yes ☐ No ☐ Not Sure
30. Have you ever thought seriously about running away from home? ☐ Yes ☐ No

Weapons/Violence/Safety

31. Is there a gun, rifle, or other firearm where you live? ☐ Yes ☐ No ☐ Not Sure
32. Have you ever carried a gun, knife, club, or other weapon to protect yourself? ☐ Yes ☐ No
33. Have you ever been in a physical fight where you or someone else got hurt? ☐ Yes ☐ No
34. Have you ever been in trouble with the police? ☐ Yes ☐ No
35. Have you ever seen a violent act take place at home, school, or in your neighborhood? ☐ Yes ☐ No
36. Are you worried about violence or your safety? ☐ Yes ☐ No ☐ Not Sure
37. Do you usually wear a helmet and/or protective gear when you rollerblade, skateboard, or ride a bike? ☐ No ☐ Yes
38. Do you always wear a seat belt when you ride in a car , truck, or van? ☐ No ☐ Yes

Tobacco

39. Have you ever tried cigarettes or chewing tobacco? ☐ Yes ☐ No
40. Have any of your close friends ever tried cigarettes or chewing tobacco? ☐ Yes ☐ No
41. Does anyone you live with smoke cigarettes/cigars or chew tobacco? ☐ Yes ☐ No

Alcohol

42. Have you ever tried beer, wine, or other liquor (except for religious purposes)? ☐ Yes ☐ No
43. Have any of your close friends ever tried beer, wine, or other liquor (except for religious purposes)? ☐ Yes ☐ No
44. Have you ever been in a car when the driver has been using drugs or drinking beer, wine or other liquor? ☐ Yes ☐ No
45. Does anyone in your family drink so much that it worries you? ☐ Yes ☐ No ☐ Not Sure

Drugs

46. Have you ever taken things to get high, stay awake, calm down or go to sleep? ☐ Yes ☐ No ☐ Not Sure
47. Have you ever used marijuana (pot, grass, weed, reefer, or blunt)? ☐ Yes ☐ No ☐ Not Sure
48. Have you ever used other drugs such as cocaine, speed, LSD, mushrooms, etc.? ☐ Yes ☐ No ☐ Not Sure
49. Have you ever sniffed or huffed things like paint, 'white-out', glue, gasoline, etc.? ☐ Yes ☐ No ☐ Not Sure

50. Have any of your close friends ever used marijuana, other drugs, or done other things to get high? ☐ Yes ☐ No ☐ Not Sure
51. Does anyone in your family use drugs so much that it worries you? ☐ Yes ☐ No ☐ Not Sure

Development/Relationships

52. Are you dating someone or going steady? ☐ Yes ☐ No ☐ Not Sure
53. Are you thinking about having sex ("going all the way "or "doing it")? ☐ Yes ☐ No ☐ Not Sure
54. Have you ever had sex? ☐ Yes ☐ No ☐ Not Sure
55. Have any of your friends ever had sex? ☐ Yes ☐ No ☐ Not Sure
56. Have you ever felt pressured by anyone to have sex or had sex when you did not want to? ☐ Yes ☐ No ☐ Not Sure
57. Have you ever been told by a doctor or a nurse that you had a sexually transmitted disease like herpes, gonorrhea, or chlamydia? ☐ Yes ☐ No ☐ Not Sure
58. Would you like to receive information on abstinence ("how to say no to sex")? ☐ Yes ☐ No ☐ Not Sure
59. Would you like to know how to avoid getting pregnant, getting HIV/AIDS, or getting sexually transmitted diseases? ☐ Yes ☐ No ☐ Not Sure

Emotions

60. Have you done something fun during the past two weeks? ☐ No ☐ Yes
61. When you get angry, do you do violent things? ☐ Yes ☐ No
62. During the past few weeks, have you felt very sad or down as though you have nothing to look forward to? ☐ Yes ☐ No
63. Have you ever seriously thought about killing yourself, made a plan, or tried to kill yourself? ☐ Yes ☐ No
64. Is there something you often worry about or fear? ☐ Yes ☐ No
65. Have you ever been physically, emotionally, or sexually abused? ☐ Yes ☐ No ☐ Not Sure
66. Would you like to get counseling about something that is bothering you? ☐ Yes ☐ No ☐ Not Sure

Special Circumstances

67. In the past year have you been around someone with tuberculosis (TB)? ☐ Yes ☐ No ☐ Not Sure
68. In the past year, have you stayed overnight in a homeless shelter, jail, or detention center? ☐ Yes ☐ No
69. Have you ever lived in foster care or a group home? ☐ Yes ☐ No

Self

70. What two words best describe you?
1)_____2)_____

71. What would you like to be when you grow up?
_____

72. If you could have three wishes come true, what would they be?

1)_____

2)_____

3)_____

Confidential (Your answers will not be given out.)

Guidelines for Adolescent Preventive Services

Middle-Older Adolescent Questionnaire

Chart # _____

Name _____ Date _____
Last First Middle Initial

Date of Birth _____ Grade in School_____ Year in college_____ Sex: Male Female Age _____

Address_____ City _____ Zip _____

Phone number where you can be reached _____ Pager/beeper number_____

What languages are spoken where you live? _____Race _____

Medical History

1. Why did you come to the clinic/office today? _____
2. Do you have any health problems? ☐ Yes ☐ No Problem(s) _____
3. Did you have any health problems in the past 12 months? ☐ Yes ☐ No Problem(s) _____
4. Are you taking any medicine now? ☐ Yes ☐ No Name of medicine _____

For Girls

5. Date when last period started_____ Are your periods regular (monthly)? ☐ No ☐ Yes
Month Date
6. Have you had a miscarriage, an abortion, or live birth in the past 12 months? ☐ Yes ☐ No

Specific Health Issues

7.Please check whether you have questions or are worried about any of the following:

- ☐ Height/weight
- ☐ Blood pressure
- ☐ Diet/food/appetite
- ☐ Future plans/job
- ☐ Skin (rash, acne)
- ☐ Headaches/migraines
- ☐ Dizziness/fainting
- ☐ Eyes/vision
- ☐ Ears/hearing/ear aches
- ☐ Nose
- ☐ Lots of colds
- ☐ Mouth/teeth/breath
- ☐ Neck/back
- ☐ Chest pain/trouble breathing
- ☐ Coughing/wheezing
- ☐ Breasts
- ☐ Heart
- ☐ Stomach ache
- ☐ Nausea/vomiting
- ☐ Diarrhea/constipation
- ☐ Muscle or joint pain in arms/legs
- ☐ Frequent or painful urination
- ☐ Discharge from penis or vagina
- ☐ Wetting the bed
- ☐ Sexual organs/genitals
- ☐ Menstruation/periods
- ☐ Wet dreams
- ☐ Physical or sexual abuse
- ☐ Masturbation
- ☐ HIV/AIDS
- ☐ Trouble sleeping
- ☐ Feeling tired a lot
- ☐ Cancer
- ☐ Dying
- ☐ Sad or crying a lot
- ☐ Stress
- ☐ Anger/temper
- ☐ Violence/personal safety
- ☐ Other (explain)

_____

_____

Health Profile

These questions will help us get to know you better. Choose the answer that best describes what you feel or do. Your answers will be seen only by your health care provider and his/her assistant.

Eating/Weight

8. Are you satisfied with your eating habits? ☐ No ☐ Yes
9. Do you ever eat in secret? ☐ Yes ☐ No
10. Do you spend a lot of time thinking about ways to be thin? ☐ Yes ☐ No
11. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or starving yourself? ☐ Yes ☐ No
12. Do you exercise or participate in sport activities that make you sweat and breathe hard for 20 minutes or more at a time at least three or more times during the week? ☐ No ☐ Yes

School

13. Are your grades this year worse than last year? ☐ Yes ☐ No ☐ Not in school
14. Have you either been told you have a learning problem or do you think you have a learning problem? ☐ Yes ☐ No
15. Have you been suspended from school this year? ☐ Yes ☐ No ☐ Not in school

Friends & Family

16. Do you have at least one friend who you really like and feel you can talk to? ☐ No ☐ Yes
17. Do you think that your parent(s) or guardian(s) *usually* listen to you and take your feelings seriously? ☐ No ☐ Yes
18. Have you ever thought seriously about running away from home? ☐ Yes ☐ No ☐ Not sure

Turn page

Weapons/Violence/Safety

19. Do you or anyone you live with have a gun, rifle, or other firearm? ☐ Yes ☐ No ☐ Not sure
20. In the past year, have you carried a gun, knife, club, or other weapon for protection? ☐ Yes ☐ No
21. Have you been in a physical fight during the *past 3 months*? ☐ Yes ☐ No
22. Have you ever been in trouble with the law? ☐ Yes ☐ No
23. Are you worried about violence or your safety? ☐ Yes ☐ No ☐ Not sure
24. Do you usually wear a helmet when you rollerblade, skateboard, ride a bicycle, motorcycle, minibike, or ride in an all-terrain vehicle (ATV)? ☐ No ☐ Yes
25. Do you usually wear a seat belt when you ride in or drive a car, truck, or van? ☐ No ☐ Yes

Tobacco

26. Do you ever smoke cigarettes/cigars, use snuff or chew tobacco? ☐ Yes ☐ No
26. Do any of your close friends ever smoke cigarettes/cigars, use snuff or chew tobacco? ☐ Yes ☐ No
28. Does anyone you live with smoke cigarettes/cigars, use snuff or chew tobacco? ☐ Yes ☐ No

Alcohol

29. In the past month, did you get drunk or very high on beer, wine, or other alcohol? ☐ Yes ☐ No
30. In the past month, did any of your close friends get drunk or very high on beer, wine, or other alcohol? ☐ Yes ☐ No
31. Have you ever been criticized or gotten into trouble because of drinking? ☐ Yes ☐ No ☐ Not sure
32. In the past year have you used alcohol and then driven a car/truck/van/motorcycle? ☐ Yes ☐ No ☐ Does not apply
33. In the past year, have you been in a car or other motor vehicle when the driver has been drinking alcohol or using drugs? ☐ Yes ☐ No
34. Does anyone in your family drink or take drugs so much that it worries you? ☐ Yes ☐ No

Drugs

35. Do you ever use marijuana or other drugs, or sniff inhalants? ☐ Yes ☐ No ☐ Not sure
36. Do any of your close friends ever use marijuana or other drugs, or sniff inhalants? ☐ Yes ☐ No ☐ Not sure
37. Do you ever use non-prescription drugs to get to sleep, stay awake, calm down, or get high? (These drugs can be bought at a store without a doctor's prescription.) ☐ Yes ☐ No
38. Have you ever used steroid pills or shots without a doctor telling you to? ☐ Yes ☐ No ☐ Not sure

Development

39. Do you have any concerns or questions about the size or shape of your body, or your physical appearance? ☐ Yes ☐ No ☐ Not sure
40. Do you think you may be gay, lesbian, or bisexual? ☐ Yes ☐ No ☐ Not sure
41. Have you ever had sexual intercourse? (How old were you the first time?_____) ☐ Yes ☐ No ☐ Not sure
42. Are you using a method to prevent pregnancy? (Which:_____) ☐ No ☐ Yes ☐ Not active
43. Do you and your partner(s) *always* use condoms when you have sex? ☐ No ☐ Yes ☐ Not active
44. Have any of your close friends ever had sexual intercourse? ☐ Yes ☐ No ☐ Not sure
45. Have you ever been told by a doctor or nurse that you had a sexually transmitted infection or disease? ☐ Yes ☐ No ☐ Not sure
46. Have you ever been pregnant or gotten someone pregnant? ☐ Yes ☐ No ☐ Not sure
47. Would you like to receive information or supplies to prevent pregnancy or sexually transmitted infections? ☐ Yes ☐ No ☐ Not sure
48. Would you like to know how to avoid getting HIV/AIDS? ☐ Yes ☐ No ☐ Not sure
49. Have you pierced your body (not including ears) or gotten a tattoo? ☐ Yes ☐ No ☐ Thinking about it

Emotions

50. Have you had fun during the past two weeks? ☐ No ☐ Yes
51. During the past few weeks, have you *often* felt sad or down or as though you have nothing to look forward to? ☐ Yes ☐ No
52. Have you ever *seriously* thought about killing yourself, made a plan or actually tried to kill yourself? ☐ Yes ☐ No
53. Have you ever been physically, sexually, or emotionally abused? ☐ Yes ☐ No ☐ Not sure
54. When you get angry, do you do violent things? ☐ Yes ☐ No
55. Would you like to get counseling about something you have on your mind? ☐ Yes ☐ No ☐ Not sure

Special Circumstances

56. In the past year, have you been around someone with tuberculosis (TB)? ☐ Yes ☐ No ☐ Not sure
57. In the past year, have you stayed overnight in a homeless shelter, jail, or detention center? ☐ Yes ☐ No
58. Have you ever lived in foster care or a group home? ☐ Yes ☐ No

Self

59. What four words best describe you?_____
60. If you could change one thing about your life or yourself, what would it be?_____
_____
61. What do you want to talk about today?_____

97-892:1.2M:11/97

ANNOTATED HEADSSS ASSESSMENT

The **Annotated HEADSSS Assessment** is designed to walk the clinician through a psychosocial assessment utilizing the mnemonic HEADSSS as a guide to questioning. For each domain of questioning, the **Annotated HEADSSS Assessment** lists some sample opening and possible follow-up questions, and highlights responses that are considered to be indicators of strengths or protection from risk, as well as those that are indicators of risky behaviors or situations. HEADSSS is a flexible interview tool, and the interviewer should modify questions based on the subject's responses. The following questions are suggested areas of inquiry, not a list of questions which must be answered by every young person with whom you undertake a psychosocial assessment.

HOME

OPENING QUESTIONS

- Tell me a little about your home life.
- Who do you live with?
- Are there other adults who are important to you?
- Tell me about your relationship with your parent(s), brother(s) /sister(s), other family members.

FOLLOW-UP QUESTIONS

- Do you feel safe in your home? In your community or neighborhood? Are you worried about losing your housing?
- Are you at home alone much?
- Has anyone in your home ever physically hurt you?
- Do you feel unwelcome or uncared for in your home?

STRENGTH/ PROTECTIVE RESPONSES

The youth:

- Indicates a positive relationship with parent(s).
- Sees parents/family as a resource.
- Indicates good communication with parent(s).
- Can identify caring adult(s).

RISK INDICATOR RESPONSES

The youth:

- Indicates conflicted /negative relationship with parent(s).
- Is unable to identify any adults who are caring and a resource.
- Indicates poor communication in family.

EDUCATION/EMPLOYMENT

OPENING QUESTIONS

- How do you feel about school?
- Are you going to school?
- What grade are you in?
- How are you doing in school? Grades/marks? Better, worse or the same?
- What do you like the best? The least?
- What are your school and/or work goals?
- How do you get along with other people at school?
- Do you have friends at school?
- Do you work? How much? What kind of job?

FOLLOW-UP QUESTIONS

- Do you go to classes? How often do you cut?
- Do you think school is important? Why, why not?
- Have you ever been suspended or expelled?
- How do you usually spend your day during and after school?
- Do you have a job right now (or some other responsibility, such as caring for your child or siblings) which keeps you busy every day?
- Do you have someone around to talk to?
- Do you plan to finish high school or get your GED?
- What are the reason(s) you are not in school? What made you stop going to school?

(EDUCATION continued)
STRENGTH/ PROTECTIVE RESPONSES

The youth:

- Indicates positive attitude about school.
- Feels part of and involved in school.
- Feels that teachers and school are caring and fair.
- Indicates that parents communicate high academic expectations.
- Shows good academic achievement.
- Has future goals related to educational attainment.

RISK INDICATOR RESPONSES

The youth:

- Has repeated a grade.
- Is cutting classes.
- Indicates school failure.
- Reports a recent decrement in grades.
- Indicates feeling isolated, unsafe or disengaged from school.
- Works more than 20 hrs. per week.

ACTIVITIES

OPENING QUESTIONS

- How do you spend your spare time?
- What do you do for fun?
- Who do you hang out with?
- Where/with whom do you eat your meals?
- How many hours do you spend in front of a screen (TV/video/video games/computer) daily?
- What kinds of physical activities are you involved in daily?
- What do you eat during and after school?

FOLLOW-UP QUESTIONS

- Are you involved with any organized sports activities? Community center? Religious/church groups?
- How often do you volunteer? What do you do?
- How do you get money? Work, allowance?
- Where and when do you do your homework?

STRENGTH/ PROTECTIVE RESPONSES

The youth:

- Is involved in supervised group activities (in after-school, community-based, sports, arts and/or faith-based organizations).
- Reports that religion and prayer are important to him/her.
- Is involved in social justice, political advocacy and/or community work.
- Eats at least one meal/day with family.

RISK INDICATOR RESPONSES

The youth:

- Indicates largely unsupervised after school time or is not in school.
- Works >20 hours/week.
- Is isolated or disconnected from peers.
- Indicates engagement in risky behaviors (e.g.: In response to "What do you do for fun?" youth states "I get high with my friends".)

DRUGS

OPENING QUESTIONS

- Do your friends/family members smoke?
- What drugs have you tried?
- Do you smoke tobacco? Chew tobacco? How much/how often? What kinds of situations?
- Do you drink alcohol (beer, wine, coolers, hard liquor)? How much/how often? What kinds of situations?
- Do you smoke marijuana (weed)? How much/how often? What kinds of situations?
- What about other drugs? Prescription, OTC, illegal?
- How much/how often? What kinds of situations?
- Do the people you hang out with smoke, drink, smoke weed, use other drugs, sell drugs?

FOLLOW-UP QUESTIONS

- How do you feel about your _____ (cigarette, alcohol, marijuana…) use?
- How do your parents/teachers/friends feel about your _____ (cigarette, alcohol, marijuana…) use?
- Have you ever tried to quit or cut down? How has that gone for you?

(DRUGS continued)

- Do you want help with your _____ (cigarette, alcohol, marijuana…) use?
- Have you ever gotten into trouble with (cigarette, alcohol, drug) use? (e.g. caught using, arrested, accident, fight, etc.)

STRENGTH/ PROTECTIVE RESPONSES

The youth:

- Does not associate with substance-involved peers.
- Indicates that parents/family members do not use substances.
- Indicates a negative attitude towards substances of abuse.
- Has used but quit.

RISK INDICATOR RESPONSES

The youth:

- Reports easy access to substances, particularly in the home.
- Has a parent with substance abuse/addiction.
- Indicates early, intense and/or consistent engagement in substance use.

S EXUALITY

OPENING QUESTIONS

- Have you ever had a crush on anyone?
- Have you/are you in a serious relationship?
- Are you attracted to guys, girls or both?
- Have you ever had sex? What do you mean by "having sex" (intercourse/outercourse)?

  If yes: • How old were you the first time you had sex?
  • Do you have sex with guys, girls or both?

  If no: • What are your plans about sex in the future?
- Has anyone ever touched you in a way that made you uncomfortable or forced you to have sex?
- Have you ever had sex unwillingly?
- How do you feel about your sexual life?
- Do you talk with your parents or other adults about sex and sexual issues?

FOLLOW-UP QUESTIONS

- How many people have you had sex with in the last 3 months? In your life?
- Do you (or your partner) use anything to prevent getting pregnant or getting an STD?
- Have you ever been pregnant? What happened with that pregnancy?
- Have you ever been told that you had an STD?
- Have you ever traded sex for money, drugs, a place to stay or other things that you need?

STRENGTH/ PROTECTIVE RESPONSES

The youth:

- Indicates the intention to abstain from sexual intercourse until late adolescence/young adulthood.
- Is not currently sexually active or is using a reliable approach to reduce their pregnancy and STD/HIV risk.
- Indicates a sexual debut when > 15 y.o.
- Indicates that s/he talks with an adult about sexual issues.

RISK INDICATOR RESPONSES

The youth:

- Indicates an early (<14 y.o.) sexual debut.
- Reports a history of sexual molestation, assault or abuse.
- Reports unprotected sex.
- Has been pregnant or has had an STD in the past.
- Indicates that s/he only talks with peers about sexual issues.

SUICIDE/DEPRESSION/SELF-IMAGE

OPENING QUESTIONS

- How is life going in general?
- Are you satisfied with your height and weight?
- What do you do when you feel stressed or overwhelmed?
- Do you ever feel very sad, tearful, bored, disconnected, depressed, blue? (choose a few, not all, for your question)
- Have you ever felt so sad that you feel life isn't worth living? Do you think about hurting or killing yourself? Have you ever tried to hurt or kill yourself?

FOLLOW-UP QUESTIONS

- Is there any adult that you can talk to if you feel depressed/suicidal (mirror youth language e.g.: sad, low, down)?
- Do you think a lot about losing or gaining weight or dieting?
- Have you ever been in counseling or therapy?
- What was that like for you?
- Have you ever been given any medications to affect your mood or behavior?
- Are you thinking about hurting/killing yourself now? Have you thought about it recently?
- Do you know anyone who has tried to kill her/himself or has committed suicide?

STRENGTH/ PROTECTIVE RESPONSES

The youth:

- Indicates a generally positive outlook.
- Has healthy coping mechanisms.
- Has a caring adult that s/he can talk to when stressed/distressed.

RISK INDICATOR RESPONSES

The youth:

- Reports current depression/isolation/boredom/disengagement.
- Reports current suicidal ideation (ASSESS FOR LETHALITY AND TRIAGE AS APPROPRIATE.)
- Has thought about or attempted suicide in the past.
- Has a family member or friend who committed suicide.

SAFETY

OPENING QUESTIONS

- When you drive or ride in a car, do you use a seat belt?
- What do you do if the person you are riding with is drunk or using drugs?
- When you bike, ride a motorcycle, skateboard or roller skate do you use a helmet/protective gear?
- Is there a gun in your home?
- Do you ever carry a weapon to protect yourself?
- Have you been in a serious physical fight?

FOLLOW-UP QUESTIONS

- What do you do when you think the situation you are in is dangerous? Give me an example.
- How do you and your parents resolve conflicts?
- Has anyone ever hurt you or intentionally destroyed something that you value?
- If you felt that you needed a weapon, where/how would you get one?
- What do you/would you do if you are/were in a situation that might lead to a physical fight?

STRENGTH/ PROTECTIVE RESPONSES

The youth:

- Uses seat belts and protective equipment.
- Shows good problem solving skills related to dangerous situations.
- Engages in non-violent conflict resolution.

RISK INDICATOR RESPONSES

The youth:

- Has been victimized through intrafamilial, partner, gang or school violence.
- Carries a weapon or reports easy access to weapons.
- Reports that there is a gun in the home.

AMERICAN ACADEMY OF PEDIATRICS

CLINICAL REPORT
Guidance for the Clinician in Rendering Pediatric Care

John W. Kulig, MD, MPH; and the Committee on Substance Abuse

Tobacco, Alcohol, and Other Drugs: The Role of the Pediatrician in Prevention, Identification, and Management of Substance Abuse

ABSTRACT. Substance abuse remains a major public health concern, and pediatricians are uniquely positioned to assist their patients and families with its prevention, detection, and treatment. The American Academy of Pediatrics has highlighted the importance of such issues in a variety of ways, including its guidelines for preventive services. The harmful consequences of tobacco, alcohol, and other drug use are a concern of medical professionals who care for infants, children, adolescents, and young adults. Thus, pediatricians should include discussion of substance abuse as a part of routine health care, starting with the prenatal visit, and as part of ongoing anticipatory guidance. Knowledge of the nature and extent of the consequences of tobacco, alcohol, and other drug use as well as the physical, psychological, and social consequences is essential for pediatricians. Pediatricians should incorporate substance-abuse prevention into daily practice, acquire the skills necessary to identify young people at risk of substance abuse, and provide or facilitate assessment, intervention, and treatment as necessary. *Pediatrics* 2005;115:816–821; *tobacco, alcohol, drugs, substance abuse.*

ABBREVIATION. AAP, American Academy of Pediatrics.

PERVASIVENESS OF DRUG USE

In a recent public opinion poll of Americans' views of the top 2 or 3 problems facing adolescents today, 67% identified drugs or drug abuse, 13% identified alcohol abuse, and 6% identified smoking. In the same poll, a question assessing Americans' views of the seriousness of 36 health problems revealed that drug abuse (82%) was rated higher than cancer (78%), followed by drunk driving (75%), smoking (68%), and alcohol abuse (65%).[1]

The pattern of substance abuse among adolescents has changed significantly during the past 35 years. Before the late 1960s, it was predominantly adults who were abusing alcohol and other psychoactive drugs, including tobacco. Beginning in the late 1960s and early 1970s, substance abuse became widespread among adolescents and, more recently, among preadolescents. Alcohol and tobacco as well as opiates, cocaine, amphetamines, barbiturates, marijuana, hallucinogens, anabolic steroids, and prescription and nonprescription medications and inhalants (volatile substances) are used and abused by many adolescents and a growing number of preadolescents.[2] Tobacco use in these groups represents a significant health threat and is associated with an increased likelihood of future use of marijuana and other illicit drugs.[3,4] In *Healthy People 2010*,[5] multiple national goals have been established to decrease child and adolescent substance use (Table 1).

Three periodic surveys track national trends in use of alcohol, tobacco, and other drugs by adolescents: (1) the annual Monitoring the Future Study[6] of students in grades 8, 10, and 12; (2) the biannual Youth Risk Behavior Survey[7] of students in grades 9 through 12; and (3) the annual National Household Survey on Drug Abuse (renamed in 2003 to the National Survey on Drug Use and Health),[8] in which computer-assisted interviewing is conducted in the home for residents 12 years and older. In reviewing survey data and published reports, pediatricians should be aware that adolescent substance use may be reported as lifetime, annual, 30-day, 2-week, or daily.

Alcohol and tobacco use often begins in adolescence or earlier. Data analysis from the National Survey on Drug Use and Health[9] demonstrates that adolescents who smoke or drink experience immediate negative health consequences and report poorer health during adolescence than those who do not. Alcohol is involved in more than one third of the deaths attributable to unintentional injury, homicide, and suicide, which together account for 76% of mortality in the 15- to 19-year age group. By the end of high school, 77% of students have tried alcohol, and 46% have done so by eighth grade. More than half (58%) of 12th-grade students and one fifth (20%) of 8th-grade students report having been drunk at least once in their life.[6] Tobacco is associated with the 5 leading causes of death in adult Americans, accounting for 435 000 deaths annually.[10] By the 12th grade, 54% of American youth have tried cigarettes and 24% are current smokers.[6] Alcohol and tobacco are often referred to as licit (or lawful) drugs, but in the United States the legal age for use of alcohol remains 21 years or older, and the legal minimum age for purchase of tobacco remains 18 years.

The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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TABLE 1. *Healthy People 2010*: Child- and Adolescent-Specific Goals for Substance Use[5]

7-2	Increase the proportion of middle, junior high, and senior high schools that provide school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol and other drug use; unintended pregnancy, HIV/AIDS, and sexually transmitted diseases; unhealthy dietary patterns; inadequate physical activity; and environmental health.
16-18	Reduce the occurrence of fetal alcohol syndrome.
26-1	Reduce deaths and injuries caused by alcohol- and drug-related motor vehicle crashes.
26-6	Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol.
26-9	Increase the age and proportion of adolescents who remain alcohol- and drug-free.
26-10	Reduce past-month use of illicit substances.
26-11	Reduce the proportion of persons engaging in binge drinking of alcoholic beverages.
26-14	Reduce steroid use among adolescents.
26-15	Reduce the proportion of adolescents who use inhalants.
26-16	Increase the proportion of adolescents who disapprove of substance abuse.
26-17	Increase the proportion of adolescents who perceive great risk associated with substance abuse.
27-2	Reduce tobacco use by adolescents.
27-3	Reduce the initiation of tobacco use among children and adolescents.
27-4	Increase the average age of first use of tobacco products by adolescents and young adults.
27-7	Increase tobacco-use cessation attempts by adolescent smokers.
27-9	Reduce the proportion of children who are regularly exposed to tobacco smoke at home.
27-14	Reduce the illegal buy rate among minors through enforcement of laws prohibiting the sale of tobacco products to minors.
27-16	Eliminate tobacco advertising and promotions that influence adolescents and young adults.
27-17	Increase adolescents' disapproval of smoking.

Overall, more than half (51%) of American youth have tried an illicit (unlawful) drug by the time they complete high school. Data obtained in 2003 from the Monitoring the Future survey document a second year of decline in the use of ecstasy (3,4-methylenedioxymethamphetamine [MDMA]) by adolescents and young adults, with lifetime prevalence of 8.3% by the 12th grade, reversing a sharp increase that began in 1998 and peaked at 11.7% in 2001. Lifetime use of marijuana (46%), amphetamines (14%), tranquilizers (10%), barbiturates (9%), lysergic acid diethylamide (LSD [6%]), and inhalants (11%) showed gradual decreases among high-school seniors. Lifetime use held steady for cocaine (8%), anabolic steroids (4%), heroin (2%), and 3 of the "club drugs": Rohypnol, gammahydroxybutyrate (GHB), and ketamine (each less than 2%). Among 12th-graders, no drug showed increased use in 2003. Divergence in trends for substance use is attributable in part to perceived benefits and perceived risks of each drug. Perception of risks often lags behind perception of benefits; thus, newly introduced drugs experience a "grace period," as was seen with ecstasy. Older drugs may be rediscovered by youth, in a process termed "generational forgetting," as knowledge of adverse consequences fades.[6]

Possible factors implicated in changing patterns of substance use include a decrease in perceived risk, fewer school-based substance-abuse prevention programs, pervasive messages in the electronic and print media as well as advertisements that glamorize tobacco and alcohol, and changing patterns of parenting in the 1990s.[2,11] The perception that casual use of recreational drugs is not a significant concern is held by many adults as well, including a sizable number of pediatricians surveyed by the American Academy of Pediatrics (AAP) in 1995. Although the prevalence of drug use may vary from community to community, there is general agreement that use of tobacco and alcohol at an early age is a predictive factor for use of other drugs, use of a greater variety of drugs, and use of more potent agents.[3,4] Furthermore, the onset of tobacco addiction occurs primarily among children. Most adults who smoke began to do so before 19 years of age, at an average age of 12 years; most were regular smokers by 14 years of age. Thus, it is critical for pediatricians to be knowledgeable about smoking prevention and treatment measures. Youth-oriented prevention and cessation interventions can be successful, as demonstrated by a recent decrease in tobacco use.[12] Cigarette smoking among adolescents continued to decrease significantly in 2003, extending a trend that began in 1997. Daily smoking by eighth-graders decreased by half (10.4% to 4.5%) since the recent peak in 1996.[6]

BARRIERS TO PHYSICIAN INVOLVEMENT

Data from a periodic survey of AAP members[13] in 1995 indicate that fewer than 50% of pediatricians screen adolescent patients for substance abuse. Primary barriers to physician involvement in prevention, screening, and management of substance abuse include: (1) time constraints associated with high patient volume; (2) inadequate reimbursement relative to the time and effort required to address sub-

stance-abuse disorders with patients and their families; (3) physician fear of alienating or labeling patients and their families; (4) inadequate education and training in substance abuse and addiction; (5) lack of dissemination to physicians of research supporting positive treatment outcomes and negative effects of failure to intervene early in substance abuse; and (6) lack of information about how to access referral and treatment resources. A White House conference[14] recently defined 3 levels of core competencies for clinicians to address substance-abuse issues, ranging from screening and referral to assuming responsibility for long-term treatment.

MAXIMIZING THE PEDIATRIC EVALUATION

Given their longstanding relationship with patients and their families, primary care pediatricians may be the only health care professionals in a position to recognize problems with substance abuse as they develop. This relationship may also facilitate referral and provide support through the process of substance-abuse evaluation and treatment and during recovery and aftercare.

Adolescent substance abuse may be the most commonly missed pediatric diagnosis. Primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists need to maintain a high index of suspicion and be aware of both the medical and behavioral presentations of substance use as well as its association with psychiatric comorbidity. Newly published resources provide guidelines for pediatric office assessment of substance abuse.[2,15]

Appropriate interviewing techniques are critical in obtaining a comprehensive substance-abuse history. Confidentiality is central in this issue, and the most useful information will be obtained in an atmosphere of mutual trust and comfort. Adolescents should be interviewed privately during each office visit with assurance of limited confidentiality.[16] This approach is appropriate for many preadolescents as well.

Although substance abuse commonly has behavioral manifestations, pediatricians should recognize medical manifestations as well. Even an apparently straightforward complaint such as headache or sore throat may be associated with underlying substance use. Trauma, chronic cough, chest pain, worsening asthma unresponsive to therapy, or abdominal complaints associated with gastritis, hepatitis, and even pancreatitis may be signs of substance abuse. Open-ended questions are usually the most nonthreatening to the patient, and an empathic, nonjudgmental style of interviewing facilitates the development of an honest doctor-patient relationship. It may be helpful to begin with questions about the patient's attitudes toward use of tobacco, alcohol, and other drugs within his or her environment (home, school, and friends) rather than probing personal beliefs or habits. This questioning may lead logically to inquiry about the patient's experiences with tobacco, alcohol, and other drugs. Many clinicians use structured interviews and questionnaires to elicit a substance-abuse history.[2] The CRAFFT questionnaire was validated recently as 1 of the few brief screening tools specific to identifying adolescent alcohol and substance abuse (Table 2).[17]

TABLE 2. CRAFFT: Questions to Identify Adolescents With Substance Abuse Problems[17]

C	Have you ever ridden in a *c*ar driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
R	Do you ever use alcohol or drugs to *r*elax, feel better about yourself, or fit in?
A	Do you ever use alcohol or drugs while you are by yourself, or *a*lone?
F	Do you ever *f*orget things you did while using alcohol or drugs?
F	Do your family or *f*riends ever tell you that you should cut down on your drinking or drug use?
T	Have you ever gotten into *t*rouble while you were using alcohol or drugs?

Two or more "yes" answers suggest that the adolescent may have a serious problem with substance abuse, and additional assessment is warranted.

Research has identified multiple risk and protective factors that influence adolescent substance use (Table 3).[2,18–21] Obtaining an age-appropriate psychosocial history such as family and peer relationships, academic progress, nonacademic activities, acceptance of authority, degree of self-esteem, and ongoing episodes of intrafamilial or extrafamilial conflict may reveal risk and/or protective factors for current or future substance abuse. These issues should be part of a routine history when a patient 8 years or older is seen for health care.

Family history is especially important, because substance abuse among family members is associated with childhood behavior problems, school problems, and multiple somatic complaints. It is estimated that 1 in 5 children grows up in a home in which there is someone who abuses alcohol or other drugs.[22] Inquiry regarding the extent of tobacco, alcohol, or other drug use by family members and peers should be a part of the routine history of every child who is seen in the pediatrician's office. After questioning, an age-appropriate discussion of the possible consequences of such use should be held with the child and his or her parent or guardian. If this discussion reveals a family history of chemical dependency, the pediatrician should address the issue and make appropriate referrals for care.

Inquiry regarding other risk behaviors is also important in dealing with the issue of substance abuse. Research suggests behaviors such as early sexual activity, membership in gangs, illegal use of firearms, use of drugs while riding in or driving a motor vehicle, and engaging in other illegal activities are clustered: those who engage in 1 risk behavior are more likely to engage in others.[4]

Information should be obtained on the adolescent's use of specific drugs, including tobacco and alcohol; the extent of such use; settings in which the use occurs; and the degree of social, educational, and vocational disruption attributable to drug use. Continually updated Web sites (Table 4) may be useful in obtaining general information about substance abuse, following national trends, and identifying

TABLE 3. Risk and Protective Factors Associated With Adolescent Use of Tobacco, Alcohol, and Other Drugs[2,18–21]

	Risk Factors	Protective Factors
Individual	Early initiation of substance use	Late initiation of substance use
	Attitude favorable to substance use	Perceived risk of substance use
	Low self-esteem or poor coping skills	Positive sense of self, assertiveness, social competence
	Early antisocial or delinquent behavior	
	Psychopathologic problems, particularly depression	
	Attention-deficit/hyperactivity disorder	Pharmacotherapy for attention-deficit/hyperactivity disorder
	Conduct disorder or aggressive behavior	
	Sensation seeking, impulsivity, distractibility	Resilient temperament
	Perinatal complications or brain injury	
	Low intensity of religious beliefs and observance	High intensity of religious beliefs and observance
	Rebelliousness and alienation from the dominant values of society and conventional norms	Positive social orientation, adoption of conventional norms about substance use
Family	Permissive or authoritarian parenting	Authoritative parenting, parental monitoring of activities
	Parental and older sibling use of alcohol, tobacco, or other drugs	Clearly communicated parental expectation of nonuse and clear rules of conduct consistently enforced
	Family history of alcoholism	Parent in recovery
	High levels of family conflict	Positive, supportive relationships with family
	Parental divorce during adolescence	Open communication with parents
	Child abuse and neglect or sexual abuse	Supportive relationships with prosocial adults
Peers	Friends who drink, smoke, or use other drugs	Friends not engaged in substance use
	Perceived peer drug use	Peer disapproval of substance use
School	Poor academic achievement and school failure	Good academic achievement and school success
	Low interest in school and achievement	High academic aspirations
Community	Disorganization in the community or neighborhood	Less acculturation and higher ethnic identification
	Availability of tobacco and alcohol	Increased legal smoking and drinking ages
	Marketing of tobacco and alcohol	Increased excise taxes on tobacco and alcohol
	Availability of licit and illicit drugs	Strict law enforcement
Sociocultural	Media portrayal of substance use	Media literacy
	Advertising licit substances	Comprehensive, theory-based antidrug education programs

TABLE 4. Internet Resources

Government agency Web sites
National Institute on Drug Abuse: www.drugabuse.gov
National Institute on Alcohol Abuse and Alcoholism: www.niaaa.nih.gov
Substance Abuse and Mental Health Services Administration: www.samhsa.gov
National survey Web sites
Monitoring the Future: www.monitoringthefuture.org
Youth Risk Behavior Surveillance: www.cdc.gov/nccdphp/dash/yrbs
National Survey on Drug Use and Health: http://oas.samhsa.gov/nhsda.htm
Street-drug name Web sites
Office of National Drug Control Policy: www.whitehousedrugpolicy.gov/streetterms/default.asp
Addictions & Life Page: www.cox-internet.com/dabster/slang.htm

drugs of abuse by their "street names," which often vary by geographic region. Adolescents may display varying degrees of honesty when discussing their use of tobacco, alcohol, and other drugs. Use may be exaggerated or minimized, and the pediatrician may need to rely on other contextual clues such as mood, appearance, and physical and behavioral symptoms (such as illegal activity or problems at home or school) to fully assess usage patterns.

DRUG TESTING

Laboratory investigation (drug testing) may be used when it is necessary to determine the cause of dysfunctional behavior and other changes in mental status or suspicious physical findings. It is important to differentiate between screening and testing for drugs of abuse. "Screening" is a technique used to evaluate broad populations, such as screening all athletes trying out for a school team. "Testing," on the other hand, implies evaluation on the basis of a clinical suspicion of use. Guidelines published by the AAP[23] as well as issues of consent and confidentiality[16] should be considered when deciding whether to use drug testing in the diagnosis and management of substance abuse. When obtaining urine for testing, it is critical that accidental or purposeful contamination, dilution, or substitution be avoided. Office policies should be developed to preserve the chain of custody in processing urine specimens for testing. Knowledge about the capability of the laboratory to identify specific substances and the sensitivity and specificity of the procedures used is necessary when such testing is ordered.[24]

Initially, a clinical history of substance abuse may obviate the need for testing. In general, testing should be performed only with the patient's consent. Exceptions include situations in which the patient's mental status or judgment is impaired. Testing is often used as a routine component of treatment and maintenance of abstinence.

OFFICE MANAGEMENT

The preadolescent or adolescent who admits repeated use of alcohol, tobacco, or other drugs re-

quires careful evaluation to determine appropriate intervention and treatment. Any substance use by preadolescents carries extraordinary risk because of the likelihood of progression to the use of additional and more dangerous substances and the effect of such use on physical, physiologic, neurologic, and emotional development.

Intervention is required for any patient when substance use is having an effect on academic, social, or vocational functioning. Use of substances in association with other risk behaviors also warrants immediate intervention. Substance abuse in adolescence is often associated with psychiatric comorbidity, such as depression, bipolar disorder, posttraumatic stress disorder, oppositional-defiant disorder, attention-deficit/hyperactivity disorder, schizophrenia, bulimia nervosa, and social phobia.[25] Referral of adolescents with suspected "dual diagnosis" to a mental health professional for additional evaluation and management is indicated.[25] Clinicians may wish to refer to the *Diagnostic and Statistical Manual for Primary Care (DSM-PC) Child and Adolescent Version* for assistance in classification of substance use behaviors.[26]

Adolescents may be more able to accept that they need help if they are shown how their use has progressed from occasional use in safe situations to more regular use in more risky situations. Discussing reasons and motivations to quit using tobacco, alcohol, and other drugs may encourage the adolescent to consider changing such behaviors and to recognize the importance of seeking treatment. Pediatricians with an interest in substance-abuse treatment may also consider implementing brief, office-based interventions incorporating motivational interviewing and cognitive-behavioral therapy for their substance-abusing patients.[27,28] Help may consist of 1 or more of the following approaches: counseling (family or individual); behavioral therapy; inpatient or outpatient drug treatment; psychologic evaluation and/or testing; psychiatric assessment; and drug detoxification. Environmental changes such as living in a different community with a relative may be integrated with any of these options. Pediatricians can be most helpful if they are familiar with the referral resources within their communities, including private and public facilities, those offering inpatient and outpatient treatment, and the capability to treat adolescents from diverse backgrounds. Availability of the pediatrician for follow-up after successful treatment is essential for relapse prevention.[28]

A far more common scenario is the use of drugs, particularly alcohol and marijuana, as an occasional activity without disruption of behavior or academic performance. Because many adolescents and their families do not regard such use as a health issue, the pediatrician will need to offer advice regarding the associated risks although no such advice has been solicited. At other times, the pediatrician may be asked to help resolve a conflict between parent and child over the use of these drugs. Thus, pediatricians need to be knowledgeable, objective, and able to give adolescents and their families accurate information on the health and safety hazards of using tobacco, alcohol, and other drugs. Recently published AAP statements have addressed alcohol,[29] tobacco,[30] and marijuana[31] use as well as indications for management and referral of patients.[32]

Even infrequent casual use poses increased risk of serious problems, including abuse, date rape, and intentional or unintentional injury. Of 1023 consecutive admissions at 1 trauma unit (two thirds from automobile crashes), approximately half of the patients tested positive for alcohol, marijuana, or both. Positive tests for both were found in one third of those affected, and marijuana and alcohol alone each accounted for one third.[33] Death and serious injury often result from risk-taking behavior while impaired.

Pediatricians hold valued, respected positions with their patients and their patients' families and within the community. Armed with the knowledge of normal adolescent development, the pediatrician has the unique ability to provide appropriate anticipatory guidance and counseling in substance-abuse prevention and to place tobacco, alcohol, and other drug use in the context of risk behavior in general, which may lead to the identification of other risk behaviors and provide the opportunity to intervene by encouraging protective behaviors.

ADVICE FOR PEDIATRICIANS

The AAP advises the following actions to promote the pediatrician's role in the prevention and management of tobacco, alcohol, and other drug abuse.

1. Pediatricians are encouraged to:
   - Be knowledgeable about the prevalence, patterns, cultural differences, and health consequences of substance abuse in their community; incorporate substance-abuse prevention into anticipatory guidance at routine and episodic office visits; be aware of the manifesting signs and symptoms of substance abuse, the association with other risk behaviors, and the possibility of dual diagnoses with other mental health disorders; be able to screen for and evaluate the nature and extent of substance use among patients and their families; be aware of confidentiality issues related to substance abuse, including obtaining patient consent before drug testing; be aware of community services for evaluation, referral, and treatment of substance-abuse disorders; and be available to provide aftercare for adolescent patients completing substance-abuse treatment programs and to assist in their reintegration into the community.
   - Serve as a community resource for smoking prevention and cessation and as a community resource for evidence-based substance-abuse prevention initiatives.
   - Advocate for community-based prevention and treatment services.
2. Patients and their families should be advised that even casual use of alcohol, tobacco, and other

drugs by children and adolescents, regardless of amount or frequency, is illegal and has potential adverse health consequences.

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Provide risk-reduction counseling and education to every adolescent

Myths and misinformation about sex and reproduction are common among adolescents. A poll of U.S. adolescents found that 32% did not believe condoms effectively prevent HIV, and 22% did not believe birth control pills effectively prevent pregnancy.[19] Information and services that help young people delay initiation of sexual intercourse and reduce their risk of pregnancy and sexually transmitted infections are an important priority for health care providers.

Risk-reduction education and counseling should be integrated into all visits and be tailored to the individual adolescent's risk factors. All information must be scientifically sound and provided in a non-judgmental manner. Counseling should take place whether or not an adolescent is receiving STI/HIV screening or pregnancy testing.

Ideally, counseling and education about pregnancy prevention should begin before an adolescent becomes sexually active. Only 55% of women who became sexually active before the age of 16 used contraception at first intercourse. Adolescents who do not use contraception the first time are twice as likely to become adolescent mothers as those who do use contraception.[20]

Many factors influence sexual risk-taking, including interpersonal violence and substance abuse. Depending on the adolescent's situation, behavior change may be incremental and require repeated efforts, along with referrals to more comprehensive services.

> ***"My doctor does not even ask me if I am sexually active. While I'm not right now, I would like my doctor to talk to me about sex so that when the opportunity presents itself I'll be prepared and well informed."***
>
> *Eric, Age 13*

Best Practices

For Clinicians and Allied Health Staff:

- Provide scientifically sound, non-judgmental, and developmentally appropriate education and counseling on sexual development and reproductive health.
- Do not assume all adolescents have had sex or are sexually active.
- Acknowledge and praise adolescent's healthy behaviors.
- Encourage delay in initiation of sexual intercourse.
- Reinforce that not engaging in sexual intercourse is the best way to prevent pregnancy and STIs.
- Discuss HIV, STI, and pregnancy prevention at every visit with both female and male adolescents.
- Counsel and educate on negotiating safer sex.
- Offer condoms to all adolescents.

- Counsel adolescents about dual contraceptive method use–condoms primarily for STI prevention, along with a hormonal method, such as the Pill, for pregnancy prevention. Using both methods can reduce the risk of both STIs and pregnancy.[21]
- Advise sexual health screening at least once a year, and if there is a new partner, symptoms, and/or suspicion of pregnancy or exposure to an STI or HIV.
- Counsel on the risks of alcohol and substance abuse and their relationship with other risk behaviors, such as unprotected sexual intercourse.
- Develop individualized risk-reduction plans for all sexually active adolescents and/or those at risk of STI/HIV. The plans should address issues such as substance abuse, sexual coercion, and interpersonal violence.
- If client is using drugs or involved in a violent relationship, recommend treatment and adolescent appropriate referrals.
- If a drug-using adolescent is not ready to seek treatment, counsel him/her on harm reduction.

For Administrators:

- Train staff in sex education and risk-reduction counseling.
- Provide on-site HIV testing or referrals.
- Maintain up-to-date linkages for referral services for STI and HIV treatment.

Resources and Tools

"Talking to Teens about Safer Sex," Adolescent Health Working Group (2003). (Enclosed)

Counseling for Behavior Change. Adolescent Provider Toolkit. Adolescent Health Working Group. 2003. (Enclosed)

'I Can't Get Pregnant'—True or False? Fact sheet. (Enclosed)
www.nyc.gov/html/doh/html/csi/csi-contrakit.shtml

Risk-Reduction Counseling Tips (Enclosed)

Training and Technical Assistance (See Training/TA Menu for details)

Sex Education and Counseling

Risk-reduction Counseling

Measures toward Success

Measure	Who is responsible	
	Clinicians & Allied Health Staff	Administrators
% of staff trained in developmentally-appropriate sex education	X	X
% of staff trained in risk-reduction counseling	X	X
% of sexually active adolescents who receive a risk-reduction plan	X	

Resources & Tools

TALKING TO TEENS ABOUT SAFER SEX

- **Use the "HEADSSS Assessment"** (B-9, Module Two) and the sexual history interview to initiate a discussion with teens about how they perceive their health risks and what behaviors they think need to change.
- **Refer to the "Stages of Change" tips** (B-12, Module Two) for guidelines on how to help adolescents change their behavior.
- **Teach abstinence as a healthy and safe choice** while acknowledging that teens may become or are currently sexually active.
- **Encourage open communication,** when appropriate, with adult caregiver(s) and partner(s) about sexuality and contraception.
- **Use harm reduction,** a practice of mitigating the harmful effects of risky behavior, as much as possible. For example, because teens may engage in intercourse, teach them to use a condom correctly and consistently. Teens may have oral sex, so encourage them to abstain from this activity when they have a cold sore. Teens may use drugs and alcohol; encourage them to always make sure that a designated driver has been identified when they are partying.
- **Stress how well condoms and latex barriers DO work.** Talking about how often they fail will not keep teens from having sex, but it may keep them from using protection*.
- **Teach both male and female teens how to use a condom correctly.** Proper use dramatically increases its effectiveness from 20% of sexually active young women becoming pregnant to only 3% becoming pregnant. Encourage teen boys to practice putting on and taking off condoms by themselves, before they have intercourse.
- **Emphasize the importance of condoms** to prevent STDs, even when the patient is using another form of birth control. Adolescents primarily use condoms and later switch to hormonal contraceptives, often discontinuing condom use.
- **Stress condom/dental dam use for oral sex.** Teens may see oral sex as a safe alternative to intercourse, and should be aware of the danger of STD transmission through this practice.
- **Stress condom use for anal sex** and discuss the range of sexually transmitted infections associated with anal/penile sex and anal/oral sex.

* Advocates for Youth and SIECUS, Towards a Sexually Healthy America, 2001

WHEN COUNSELING ABOUT CONTRACEPTION OPTIONS:

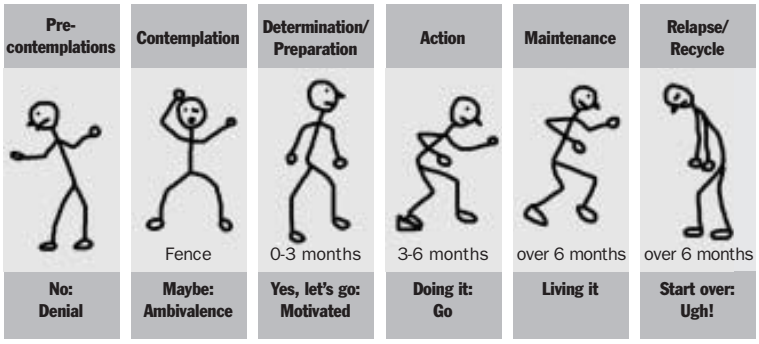
- **First ascertain what methods the youth knows** about and is interested in.
- **Briefly describe all the options.** It is important to value teens' rights to choose the method that they feel most comfortable with and to guide them in this decision based on their needs and behaviors.
- **Describe the chosen method** in greater detail to ensure that the teen knows how to use it effectively.
- **Have the teen repeat back** and demonstrate the correct use of the method.
- **Follow-up on the teen's choice** in a future visit to ensure that the method is working right for him/her.

Use the following chart to help assess which contraceptive might be right for each patient. Section C-23 includes a chart to distribute to teens about different types of contraceptives.

METHOD	PROS	CONS
Oral Contraceptives	• Few conditions requiring precautions. • Safe use after menarche. • Safe use after onset of menstruation. • May improve acne.	• Forgetfulness increases failure (common among teens) • Break through bleeding worries and upsets a number of teens. • No protection against STDs. • Might cause nausea and weight gain.
Combined Injectables (CICs) **Injectables (Lunelle)** (currently unavailable)	• Only requires monthly maintenance. • Non-visible • Few side effects (similar to pills) • Very effective	• Re-injection must be timely. • No protection against STDs.

METHOD	PROS	CONS
Progestin Only (PICs) Injectables (Depo-Prevera)	• Non-visible • Only requires maintenance every 12 weeks.	• Side effects such as thinning hair, depression, weight gain and irregular periods may be especially bothersome to teens. • Some studies show that use in teens within 2 years of menarche may pose additional risk of osteoporosis. • Re-injection must be timely. • No protection against STDs.
IUDs	• Non-visible • No maintenance needed.	• Not recommended for teens who have multiple partners, or who have never had a baby.
Condoms 	• Immediate protection. • Easily accessible.	• Requires planning. • Both partners must be cooperative. • Protects against pregnancy, STDs and HIV/AIDS.
Spermicides	• Easily accessible.	• Much more effective when used with a condom or diaphragm. • Requires planning. • Not the best protection against STDs.
Vaginal Ring (Nuvaring)	• Non-visible. • Does not require taking a pill daily.	• Requires remembering to insert new ring once a month for 3 out of 4 weeks. • Teen must be comfortable touching herself to insert/remove ring. • No protection against STDs.
Birth Control Patch (Ortho Evra)	• Does not require taking a pill daily.	• Requires remembering to put on a new patch once a week for 3 out of 4 weeks. • Visible – particularly on people of color. • Side effects include tenderness of breasts and nausea. • No protection against STDs.
Implant (Implanon)	• Good for 3 years. • Barely visible. • Highly effective. • Capsule can be removed any time.	• No protection against STDs. • Must be inserted/removed by a health care professional. • Side effects may include weight gain, hair loss, headaches, irregular bleeding patterns and arm discomfort.
Diaphragm	• Some protection against STDs.	• Requires fitting and continued use. • Best used when intercourse can be predicted. • Not usually popular among teens.
Withdrawal	• Requires no supplies.	• Very unreliable. • Requires motivation and self-control from both partners. • Pre-ejaculation fluids can lead to pregnancy. • Poor protection against STDs - does provide some protection since little or no fluid is deposited in vagina.
Abstinence	• Requires no supplies. • Only definite way to prevent pregnancy and STDs.	• Requires motivation and self-control from both partners.
Emergency Contraception (Not intended to be a regular form of birth control.)	• Effective and safe for teenagers. (Many teens have unplanned and unprotected intercourse.)	• Side effects such as nausea and vomiting. • Should be taken ASAP, but effective up to 120 hours after intercourse. • Menstrual period is disrupted (may come earlier or later than usual).

COUNSELING FOR BEHAVIOR CHANGE



Adapted from UCSF AIDS Health Project, 1998, Building quality HIV prevention counseling skills: The Basic I training. http://www.engenderhealth.org/res/onc/hiv/preventing/miw/hiv6miw2.html

JAMES 0. PROCHASKA, PH.D.'S TRANSTHEORETICAL MODEL OF THE STAGES OF CHANGE

STAGE OF CHANGE	MEANING	CONSIDERATIONS FOR ADOLESCENTS
PRE-CONTEMPLATION	Is not considering changing or intending to take action.	Adolescents are often focused on the present. Until they see the direct effects of their behavior on their lives, they are likely to remain in this stage. Too much pushing may cause a teen to rebel.
CONTEMPLATION	Intends to take action in the near future, although may be ambivalent.	This stage arrives when individuals sees how their actions affect their lives. This may happen for teens when they see a peer or loved one in their situation or when they are exposed to convincing and consistent messages about something relevant to them. For example, different media presentations about STDs in teens might influence contemplation.
PREPARATION	Intends to take action very soon and has taken some steps in this direction.	This is a planning stage. Again, do not plan for adolescents. Rather, provide options and guide their decisions using open-ended questions that will help them form their own opinions.
ACTION	Changes behavior.	The individual puts planning into action. Because adolescents, especially younger teens, operate in the present, action must be considered on a day-to-day basis. Constant encouragement may be needed to support actions, even small ones. With the teen, create a written plan of action and encourage that he or she record daily activities and thoughts in a journal or diary.
MAINTENANCE	Maintaining new behavior over time.	Maintaining an action is extremely difficult for adults and youth alike. Adolescents will often want immediate gratification and may discontinue behavior if they do not see results. Congratulate and praise them for what they do, rather than admonish them for failure.
RECYCLING	Reworking preparation and action after setbacks.	Relapse often makes adolescents feel very demoralized. It is important to explain that even though there's been a setback, helpful lessons have been learned about themselves and about the process of changing behavior.

FOR PROVIDERS

HOW READY ARE YOU TO MAKE CHANGE?

To determine where an adolescent falls on the spectrum, use a tool like the one below:

1. Once a behavior is identified as one that might be changed, ask the teen where he or she sees him or herself on this scale.
2. Ask a straight question, "Why a 5?"
3. Ask a backward question, "Why a 5 and not a 3?" This elicits why he or she wants to change.
4. Ask a forward question, "Why a 5 and not a 7?" This elicits the barriers to change perceived by the teen.

ALWAYS TAILOR BEHAVIOR CHANGE TO THE INDIVIDUAL AND HIS OR HER STAGE OF DEVELOPMENT

NOT READY (0-3) PRECONTEMPLATION	UNSURE (4-6) CONTEMPLATION	READY (7-10) PREPARATION
Advise and Encourage	**Explore Ambivalence**	**Strengthen Commitment and Facilitate Action**
• Would you like to have more information? • How can I help? • Encourage and emphasize confidence.	• What are the things you like about your behavior? • What are the things you don't like? • What are the advantages of your behavior? • What are the disadvantages? • Where does that leave you? • Summarize.	• Why is this important to you now? • What are your ideas for making this work? • What might get in the way? • How might you deal with those barriers? • How confident are you? • How will you know you've reached your goal? • How might you reward yourself along the way? • Make sure the plan is specific, measurable, and achievable.

! Move one stage at a time!

! Make sure there is enough time to achieve goals!

Sources:
1. Steve's Primer of Practical Persuasion and Influence, Copyright © SBB, 1996-00
http://www.as.wvu.edu/~sbb/comm221/chapters/stages.htm
2. University of South Florida Community and Family Health
TRANSTHEORETICAL MODEL/STAGES OF CHANGE
http://hsc.usf.edu/~kmbrown/Stages_of_Change_Overview.htm
3. Kaiser Permanente Regional Health Education

Provide contraceptive methods, including emergency contraception (EC), to adolescents at risk for pregnancy

In 2005, 1 in 4 NYC public high school students who were sexually active did not use a condom during the last sexual encounter.[22] Use of hormonal methods is particularly low. In 2005, only 8% of NYC's sexually active adolescents reported using the birth control pill. This compares with 18% of sexually active adolescents nationwide.[23]

Delayed initiation of sexual intercourse and the increase in consistent use of contraceptives are reducing adolescent pregnancy and promise to continue to do so.[24] Therefore, adolescents should be encouraged to delay initiation of sexual intercourse, and every effort should be made to increase access to and use of contraceptives among those who are sexually active.

Research shows that access to contraception does not increase adolescents' sexual activity.[25] For example, making condoms available in NYC high schools resulted in increased use of condoms, but not in increased sex.[26]

> ***"During one of my regular visits with my doctor, my doctor refused to give me a prescription for birth control and I was not given any options or referrals. I was frustrated and felt unimportant."***
>
> *Jennifer, Age 14*

Emergency Contraception

Emergency Contraception pills (Plan B) can be taken to prevent pregnancy after unprotected sex. They are most effective when taken within 72 hours (3 days) after unprotected sex and moderately effective when taken within 120 hours (5 days).[27]

EC is under-utilized:
In 2002, only 8% of young women ages 15–19 in the U.S. reported ever having used EC.[28]

Advance prescription of EC:
Research indicates that adolescents who were provided with advance EC are nearly twice as likely to use it and to use it sooner, when it is more effective at preventing pregnancy.[29]

Providing EC to adolescents in advance is not associated with increased unprotected intercourse or decreased contraceptive use.[30]

A physical exam and pregnancy test are not necessary prior to using EC, so providers can prescribe it over the telephone, expediting its use.

EC is safe and effective for young adolescents.
Research indicates that adolescents ages 13-16 years can use EC properly and return to their normal menstrual cycles at the same rate as adult women taking EC.[31]

Best Practices

For Clinicians and Allied Health Staff:

- Reinforce that not engaging in sexual intercourse is the best way to prevent pregnancy and STIs.
- Provide all adolescents, both female and male, with developmentally appropriate counseling on all contraceptive methods.
- Offer condoms to all adolescents.
- Offer prescriptions for hormonal contraceptives to all sexually active female adolescents. Pelvic exams are not required before provision of hormonal contraceptives, including EC.[32]
- For patients who use oral contraceptives and Depo Provera, use the "Quick Start" method: have her take the first dose in the office at anytime during the menstrual cycle (about a quarter of young women fail to start the Pill on time after the clinic visit.[33])
- Offer the IUD as an option to adolescents who meet the prescribing criteria.[34]
- Inform all adolescents about how to get inexpensive or free contraceptives.
- Counsel all sexually active adolescents about the benefits of dual contraceptive methods.
- Counsel all adolescents about EC and give sexually active female adolescents advance prescriptions and/or pill packs during routine healthcare visits.
- Ask all adolescents whether they have had unprotected sex within 120 hours (5 days) of their visit. If they have:
    - Offer female patients EC. (While not as effective as other forms of hormonal contraception, repeat use of EC is not harmful.)
    - Provide male patients who have female partners with information on where their female partner can get EC immediately.

For Administrators:

- Train all staff on where to refer adolescents for free EC (NYC Department of Health and Mental Hygiene's clinics offer free EC pill packs).
- Facilitate enrollment into the Family Planning Benefit Program.

Resources and Tools

"Talking to Teens about Safer Sex," Adolescent Working Health Group (2003). (Enclosed)

"Provision of Emergency Contraception to Adolescents," Position Paper of the Society for Adolescent Medicine, *Journal of Adolescent Health 35* (2004): 66-70. (Enclosed)
www.adolescenthealth.org.PositionPapers.htm

DOHMH Public Health Detailing Kits (these include downloadable Clinical Tools and Patient Education Materials):

- Contraception Action Kit: **www.nyc.gov/html/doh/html/csi/csi-contrakit.shtml**

- **Contraception Pocket Guide (Enclosed)**
- **Emergency Contraception: A Practitioner's Guide (Enclosed)**
- **Birth Control-What's Right for You fact sheet (Enclosed)**
- **Prevent Unintended Pregnancy Chart Stickers (Enclosed)**
- **Contraception Services Referral Form**
- **"Pregnancy Prevention in Adolescents" American Family Physician**
- **"Emergency Contraception," The New England Journal of Medicine**

- Emergency Contraception Pharmacy Kit:
  www.nyc.gov/html/doh/html/csi/csi-ecpharmkit.shtml

Free EC at DOHMH STD clinics: Call 311

For Referrals:
- Call 311
- 1-888-NOT-2-LATE (888-668-2528)

EC information:
- **www.not2late.com**
- **www.go2planb.com**

Free male or female condoms from DOHMH for individuals and organizations: **www.nyc.gov/health** or call 311

Training and Technical Assistance (See Training/TA Menu for details)

Contraceptive Counseling

Contraceptive Update

Emergency Contraception

Measures toward Success

Measure	Who is responsible	
	Clinicians & Allied Health Staff	Administrators
% of staff trained in counseling on all contraceptive methods	X	X
Number of condoms distributed	X	
Number of prescriptions for hormonal contraceptives (pills and shots)	X	
Number of EC prescriptions or pill packs distributed on demand	X	
Number of advance EC prescriptions or pill packs distributed	X	
Staff has up-to-date referral list of free or low-cost EC		X

Resources & Tools

TALKING TO TEENS ABOUT SAFER SEX

- **Use the "HEADSSS Assessment"** (B-9, Module Two) and the sexual history interview to initiate a discussion with teens about how they perceive their health risks and what behaviors they think need to change.
- **Refer to the "Stages of Change" tips** (B-12, Module Two) for guidelines on how to help adolescents change their behavior.
- **Teach abstinence as a healthy and safe choice** while acknowledging that teens may become or are currently sexually active.
- **Encourage open communication,** when appropriate, with adult caregiver(s) and partner(s) about sexuality and contraception.
- **Use harm reduction,** a practice of mitigating the harmful effects of risky behavior, as much as possible. For example, because teens may engage in intercourse, teach them to use a condom correctly and consistently. Teens may have oral sex, so encourage them to abstain from this activity when they have a cold sore. Teens may use drugs and alcohol; encourage them to always make sure that a designated driver has been identified when they are partying.
- **Stress how well condoms and latex barriers DO work.** Talking about how often they fail will not keep teens from having sex, but it may keep them from using protection*.
- **Teach both male and female teens how to use a condom correctly.** Proper use dramatically increases its effectiveness from 20% of sexually active young women becoming pregnant to only 3% becoming pregnant. Encourage teen boys to practice putting on and taking off condoms by themselves, before they have intercourse.
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- **Have the teen repeat back** and demonstrate the correct use of the method.
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Diaphragm	• Some protection against STDs.	• Requires fitting and continued use. • Best used when intercourse can be predicted. • Not usually popular among teens.
Withdrawal	• Requires no supplies.	• Very unreliable. • Requires motivation and self-control from both partners. • Pre-ejaculation fluids can lead to pregnancy. • Poor protection against STDs - does provide some protection since little or no fluid is deposited in vagina.
Abstinence	• Requires no supplies. • Only definite way to prevent pregnancy and STDs.	• Requires motivation and self-control from both partners.
Emergency Contraception (Not intended to be a regular form of birth control.)	• Effective and safe for teenagers. (Many teens have unplanned and unprotected intercourse.)	• Side effects such as nausea and vomiting. • Should be taken ASAP, but effective up to 120 hours after intercourse. • Menstrual period is disrupted (may come earlier or later than usual).

Offer information, assistance, and support for all decisions regarding pregnancy

A primary goal of sexual and reproductive health services is to help adolescent patients make responsible decisions that are right for them. This is done by offering scientifically informed counseling about all pregnancy options – parenthood, abortion, and adoption – and by assisting patients to exercise their choices and their rights (including the right to abortion). Information must be uninflected by the practitioner's personal beliefs, and assistance must be unimpeded by any deliberately erected barriers to care.

In 2004, New York City women age 19 or younger gave birth to 8,000 babies (7% of the city's total) and underwent more than 14,000 induced abortions (16% of the total).[35]

Adolescent mothers and their infants are at increased risk for poor health outcomes. And adolescent mothers are less likely to finish high school or remain in stable relationships with the babies' fathers than women who delay childbearing until their twenties.[36]

Regardless of an adolescent's decision about her pregnancy, practitioners need to have solid referrals and linkages in place to connect patients immediately with prenatal care, abortion services, adoption agencies or other social services.

> ***"Teen pregnancy prevention should start with education from an adult who is non-judgmental and objective. Further help should be given if a teen makes the conscious decision to keep their baby, abort, or put the baby up for adoption."***
>
> *Sarah, Age 15*

Best Practices

For Clinicians:

- Provide pregnancy tests for all adolescents who may be pregnant.
- Present pregnancy results in a private setting.
- If the test is negative, provide contraceptive counseling.
- If the test is positive:
    - Conduct a medical history; screen for associated pregnancy risks.
    - Discuss all pregnancy options – motherhood, abortion, and adoption.
    - Ask open-ended questions to assess how the young woman feels about the pregnancy. Avoid making assumptions (for instance, contrary to common belief, 20% of adolescent pregnancies are planned).
    - Explore knowledge and beliefs about pregnancy, parenting, abortion, and adoption.
    - Present options in a non-judgmental manner. Help the young woman determine the personal risks and benefits of each option.

- Discuss family/friends/partner influences. Assess the potential for violence against or coercion of the young woman as it influences her decision.
- Encourage the adolescent to involve a parent or other trusted adult in the decision.
- If the young woman is not ready to make a decision, help establish a timeline for decision-making. Emphasize that the decision is time-sensitive.

- Provide STI and HIV testing and counseling
- Assess patient's insurance status and refer to appropriate available public insurance.
- Provide timely referrals for social workers, prenatal care, adoption agencies, abortion providers, and/or parenting classes.

For Administrators:

- Provide pregnancy tests on-site.
- Train clinicians and staff in Pregnancy Options Counseling.

Resources and Tools

Sexual and Reproductive Health Services in NYC (2005). (Enclosed)
www.nyc.gov/health/maternity

Training and Technical Assistance (See Training/TA Menu for details)

Pregnancy Options Counseling

Measure	Who is responsible	
	Clinicians & Allied Health Staff	Administrators
% of staff trained in Pregnancy Options Counseling	X	X
Staff has up-to-date referrals to social workers, adoption agencies, abortion providers, prenatal care, and/or parenting classes		X

Resources & Tools

Training/Technical Assistance Menu

Training/Technical Assistance (TA) will be adapted to meet the specific needs of your practice. Topics can be added based on need.

Staff to Receive Training /TA

- Clinicians: physicians, nurse-practitioners, nurses, physician assistants
- Allied Health: social workers, case workers, health educators, psychologists, etc.
- Administrative Staff: registrars, receptionists, billing, data entry, facilities

Type of Training/TA Available

Workshop
Grand Rounds
Consultation: on-site or phone call
Materials: Clinical tools and patient education

Step	Training/TA Topic	Target Staff
1. Guarantee confidentiality and adolescents' rights to consent to sexual and reproductive health care.	*Minors' Right and Confidentiality	All
	Working with parents/care givers	Clinical & Allied Health
2. Make services accessible and facilities welcoming to adolescents	*NYS Public Health Insurance Adolescent - Friendly Services	Administrative & Allied Health
3. Deliver care that is sensitive to each adolescent's culture, ethnicity, community values, religion, language, educational level, gender and sexual orientation.	Adolescent-Friendly Services Cultural Competency	All
	Adolescent Development Male Adolescent Health Services	Clinical & Allied Health
4. Screen all adolescents for sexual and reproductive health issues, substance use, and mental health concerns; and provide appropriate care or referrals	Health Assessment Taking a Sexual History	Clinical & Allied Health
5. Provide risk-reduction counseling and education to every adolescent	Sex Education and Counseling Risk-Reduction Counseling	Clinical & Allied Health
6. Provide contraceptive methods, including emergency contraception (EC), to sexually active adolescents	Contraceptive Counseling Contraception Update Emergency Contraception	Clinical & Allied Health
7. Offer information, assistance, and support for all decisions regarding pregnancy.	Pregnancy Options Counseling	Clinical & Allied Health

*Training required to be a Healthy Teens Initiative Partner

Partners of the initiative can call (212) 341-3855 to make arrangements for training/TA.

Seven Steps to Comprehensive Sexual and Reproductive Health Care for Adolescents in New York City

Complete this worksheet before participating in training/technical assistance and annually

Practice Assessment Worksheet

Name of Organization: _____

Date: _____

STEP 1 : Guarantee confidentiality and consent

Measure	Accomplishment	Notes
Private space available for confidential conversation		
% of adolescent visits that include private time with provider		
% staff trained in Minors' Rights & Confidentiality		
% of adolescents who sign written consent forms		
Written consent forms clearly explain adolescents' right to keep personal, sexual, and reproductive health information confidential		
NYS adolescent consent laws posted prominently in office		

STEP 2 : Make services accessible and facilities welcoming

Measure	Accomplishment	Notes
% staff trained in Medicaid coverage and other public insurance options for adolescents		
% of adolescents enrolled in public health insurance such as the Family Planning Benefit Program		
% adolescents who wait less than 1 hour from arrival to the time they see a health care provider		
Staff member available at appointment time or visit to inform adolescents about Medicaid coverage and other public insurance options		
After-school and/or weekend hours offered		
Office décor is "adolescent-friendly"		

▸ STEP 3 : Deliver sensitive care

Measure	Accomplishment	Notes
% of staff trained in adolescent development and how to interact appropriately with and serve adolescents		
% of staff trained in cultural competency		
% of staff trained in male reproductive health services		
Language assistance services, including bilingual staff and interpreter services, are provided at no cost to each patient with limited English proficiency		
Health education materials are provided at appropriate reading levels and in appropriate language/s		
Comprehensive referral lists developed and kept up-to-date for services not offered on site		
Client satisfaction surveys are regularly distributed to adolescents and service improvements addressed		

▸ STEP 4 : Screen and refer for sexual health, substance abuse, mental health

Measure	Accomplishment	Notes
% of staff trained in evidence-based health assessment for adolescents, including taking a sexual history and psychosocial assessment		
Providers use standardized health assessment tools		
% of adolescents screened using standardized health assessment tools		
Linkages are in place for referrals to STI and HIV care and treatment		
Linkages are in place for referrals to care for alcohol, substance abuse, and other mental health concerns		

▸ STEP 5 : Provide risk-reduction counseling and education

Measure	Accomplishment	Notes
% of staff trained in developmentally-appropriate sex education		
% of staff trained in risk-reduction counseling		
% of sexually active adolescents who receive a risk-reduction plan		

▸ STEP 6 : Provide contraceptive methods, including emergency contraception

Measure	Accomplishment	Notes
% of staff trained in counseling on all contraceptive methods		
Number of condoms distributed		
Number of prescriptions for hormonal contraceptives (pills and shots)		
Number of EC prescriptions or pill packs distributed on demand		
Number of EC prescriptions or pill packs distributed in advance		
Staff has up-to-date referral list of free or low-cost EC		

▸ STEP 7 : Inform, assist, and support all decisions regarding pregnancy

Measure	Accomplishment	Notes
% of staff trained in Pregnancy Options Counseling		
Staff has up-to-date referrals to social workers, adoption agencies, abortion providers, and/or to prenatal care		

Complete this worksheet before participating in training/technical assistance and annually

OUTCOME MEASURES

Organization Name:_____

Date:_____

Outcome	Target	Actual	Comments
Number of adolescents seen at site: • number of adolescent visits for contraceptive services • number of adolescents by gender, age, and race/ethnicity			
Number of adolescents provided or referred for hormonal contraception or IUD (new)			
Number of adolescents provided or referred for hormonal contraception or IUD contraception (follow-up)			
Number of adolescents provided EC prescription or pills in advance			
Number of adolescents provided EC prescription or pills for immediate use			

A Note about Advocacy

Health care providers can serve as influential advocates for the health of adolescents. Advocacy can include writing letters, testifying before committees, or encouraging patients or other community members to get active. It can include speaking out for or against laws, policies, or regulations at all levels of government or within healthcare delivery, insurance, or professional organizations. Here are some ways to improve the health of adolescents:

Advocate for

- sufficient funding of Medicaid coverage for family planning services, such as the Family Planning Benefit Program
- maintain adolescents' rights to autonomous consent and confidential reproductive and sexual health care
- FDA approval of over-the-counter status for EC; Medicaid coverage of EC if over-the-counter status is achieved
- legalized abortion without restrictions
- mental heath and substance abuse service
- parent-child communications programs
- school-based health care services

The following organizations can provide additional information and may offer ways to advocate on behalf of your adolescent patients:

Advocates for Youth
www.advocatesforyouth.org

American Academy of Pediatrics
www.aap.org

Guttmacher Institute
www.guttmacher.org

Healthy Teen Network
www.noappp.org/Services/Resources/resources.htm

Henry J. Kaiser Family Foundation
www.kaiserfamilyfoundation.org

The National Campaign to Prevent Teen Pregnancy
www.teenpregnancy.org

New York Civil Liberties Union
www.nyclu.org

Planned Parenthood of New York City
www.ppnyc.org

Physicians for Reproductive Choice and Health
www.prch.org

Sexuality Information and Education Council of the United States (SIECUS)
www.siecus.org

Society for Adolescent Medicine
www.adolescenthealth.org

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