POINTS TO KEEP IN MIND WHEN INTERVIEWING ADOLESCENTS

1. Need to actively engage adolescent in process
   - What are the meanings/expectations associated with risk-taking behaviors or their potential outcomes? (e.g. for Alicia, becoming pregnant is seen as a way to keep her father at a distance from Alicia and mother's lives)
   - What other activities or involvement could meet some of these same needs without putting the adolescent at risk for pregnancy/STD?
   - What in his or her life does the adolescent perceive as problematic?
   - What is the adolescent motivated to change related to his/her risk behavior?
2. Assessment of adolescent's level of risk and protective factors present within the individual, their family, their friends and peers, and their school environment.
3. Skills in Building Trusting Relationship
   - Active listening –
     i. Paying attention to non-verbal cues
     ii. Maintaining objectivity –withholding judgments
     iii. Listen for understanding
   - Responding to Emotions/Expressing empathy
4. Follow-up offered
   - Showing respect for the adolescent and his/her
     - Developmental stage;
     - Cultural and religious beliefs and practice;
     - Gender;
     - Sexual preference;
     - Rights; and
     - Ability to make decisions
5. Other Process Skills, e.g.
   Confidentiality
   Honesty—no hidden agendas
   Open- ended questions
   Mutually understood language

HEADSSS

Guide to Interviewing Adolescents

Subject	Long Form	Short Form
Home	Where do you live? Who do you live with? Do you share a bedroom? With whom? How do you get along with the people you live with? How much time do you spend at home? What do you and your family argue about? Can you go to your parents with problems? Have you ever run away from home?	How are things at home? Who lives at home? How do you get along with mom, dad, siblings?
Education	What grade are you in? What kind of grades to you get? Have they changed? What are your best/worst classes? Why? Do you need extra help in school? Do you work after school or on weekends? Have you ever failed any classes or a grade? Do you ever cut classes?	How are things at school? What classes do you like best? Least? Grades?
Activities	What do you do for fun? What activities are you involved in during and after school? Are you active in sports? Do you exercise? Who do you do fun things with? Do you have a best friend? Who do you hang out with? Who are your friends? Who do you go to with problems? What do you do on weekends? Evenings?	How many good friends do you have? What do you do together? What do your parents think of your friends?
Drugs	Do you drink coffee or tea? Do you smoke cigarettes? Have you ever smoked one? Have you ever tasted alcohol? When? What kind? How often? Do any of your friends drink or use drugs? What drugs have you tried? Have you ever injected drugs or steroids? When? How often do you use them? How did you pay for the drugs?	Do any of your friends smoke? Drink alcohol? Do you? Have you tried other drugs?
Sexual Activity / Sexual Identity	Have you ever had sex with men? Women? Both? Have you ever had sex unwillingly? How many sexual partners have you had? How old were you when you first had sex? Have you ever been pregnant? Have you ever had an infection as a result of sex? Do you use condoms or another form of contraception for prevention against sexually transmitted diseases? Have you ever traded sex for money, drugs, clothes or a place to stay? Have you ever been tested for HIV? Do you think it would be a good idea to be tested?	Are you attracted to boys? Girls? Do you have a boyfriend or girlfriend? How long? Do you get along well? Do you have sex? Does it go OK? Do you know how to say "no"? Do you know how to protect yourself from STDs and pregnancy?
Suicide / Depression	How do you feel today on a scale of zero to ten, with zero as very sad and ten as very happy? Have you ever felt less than five? What made you feel that way? Did you ever think about hurting yourself? Think that life wasn't worth living? Hope that when you went to sleep you wouldn't wake up again?	Do you ever feel really depressed? How long does it last? Have you ever thought of hurting yourself or suicide?
Safety	Are you afraid of violence in your school? In your neighborhood? Do you carry a weapon to school? What kind and how often? Do your friends carry weapons? What kind? Do you have a personal history of fighting? Have you used weapons? Are there guns in your home? Do you have access to them? Have you been a victim of a violent crime? When? Where? Who was involved? What happened? Do you have a history of physical abuse? Have you been the victim of date rape or rape? Have you been arrested? Have you run away from home? Been homeless? Been involved with cults?	Do you ever feel unsafe? When? At school? At home? In your neighborhood? Have you ever been hurt by someone?

"Long Form" adapted from Goldenring JM, Cohen E. Getting into adolescent heads. Contemp Pediatr 1988;5(7):75-90. Copyright 1988 Medical Economics Publishing Inc., Montvale, N.J. Reprinted with permission.

"Short Form" from Reif CJ, Elster AB, Adolescent Preventive Services. In Primary Care: Clinics in Office Practice, Vol 25, No 1, March 1998. WB Saunders, Philadelphia.

Minor Consent

1. 18 and older = Adult...person gives their own consent.

2. If person is younger than 18 = Minor. Every minor needs parental consent for all medical evaluation and treatment...except...

3. Emancipated Minor:
   - Living separate and managing own finances, or
   - Married, or
   - Has born a child

4. Mature Minor:
   - Minor is 15 or older; able to give own consent, and
   - Treatment is necessary and for minor's benefit, and
   - Treatment is not high risk

5. Emergency Care:
   - Delay a treatment to obtain parental consent would be a risk to minor's life or health

6. "Confidential Services" A minor may consent to diagnosis and treatment, including medical and mental health services for the following:
   - Pregnancy Related Care
   - Sexually Transmitted Diseases
   - Contraceptive Care
   - Alcohol and other drug abuse, inpatient and outpatient
   - Inpatient Mental Health Services: a minor 16 and older may request admission
   - Abortion: if unemancipated, a minor needs parental notification and 48 hours waiting period...or, obtain a court waiver

In each case, CONFIDENTIALITY follows CONSENT.

Teen Screen

Do Not Copy from Medical Record

place sticker

Health Ed. Given?			**Want More Info?**
☐	1.	In general, are you happy with the way things are going for you? ☐ Yes ☐ Sometimes ☐ No	☐
☐	2.	Do you get along with your family? ☐ Yes ☐ Sometimes ☐ No	☐
☐	3.	Do you go to school regularly? ☐ Yes ☐ Sometimes ☐ No	☐
☐	4.	Have your grades gotten worse than they used to be? ☐ Yes ☐ Sometimes ☐ No	☐
☐	5.	Do you have at least one adult you can really talk to? ☐ Yes ☐ Sometimes ☐ No	☐
☐	6.	Do you get some exercise at least 3 times a week? ☐ Yes ☐ Sometimes ☐ No	☐
☐	7.	Do you feel you are about the right weight for your height? ☐ Yes ☐ Sometimes ☐ No	☐
☐	8.	Do you ever use laxatives or throw up on purpose after eating? ☐ Yes ☐ Sometimes ☐ No	☐
☐	9.	Do you wear a seat belt in a car/truck? ☐ Yes ☐ Sometimes ☐ No	☐
☐	10.	Do you wear a helmet when you skateboard, bicycle, motorcycle, snowmobile, or use an ATV? ☐ Yes ☐ Sometimes ☐ No	☐
☐	11.	Do you smoke cigarettes or chew tobacco? ☐ Yes ☐ Sometimes ☐ No	☐
☐	12.	Do you drink alcohol? ☐ Yes ☐ Sometimes ☐ No	☐
☐	13.	Have you tried any drugs (pot, crack, cocaine, heroin, acid, speed, etc.?) ☐ Yes ☐ No	☐
☐	14.	Do you – or does anyone you live with – have a gun or carry a gun around? ☐ Yes ☐ Sometimes ☐ No	☐
☐	15.	Are you – or have you been – in a gang? ☐ Yes ☐ No	☐
☐	16.	Are you worried about money, a place to live, or having enough food to eat? ☐ Yes ☐ Sometimes ☐ No	☐
☐	17.	Have you ever had sex (with women, men or both)? ☐ Yes ☐ No	☐
☐	18.	Have you ever been tested for or diagnosed with a sexually transmitted disease (VD)? (herpes, gonorrhea, Chlamydia, genital warts, PID, syphilis) ☐ Yes ☐ No	☐
☐	19.	Are you – or do you ever wonder if you are – gay, lesbian, bisexual, or transgender? ☐ Yes ☐ Sometimes ☐ No	☐

Please re-read the italicized paragraph on the reverse side before answering the following questions.

☐	20.	Have you ever had thoughts about killing yourself? ☐ Yes ☐ No		☐
☐	21.	Do you feel afraid in any of your relationships? ☐ Yes ☐ No		☐
☐	22.	Have you ever been physically or sexually abused or mistreated by anyone (kicked, hit, pushed, forced or tricked into having sex, touched on your private parts)? ☐ Yes ☐ No		☐

Provider:

☐ Yes	☐ No	Confidentiality addressed?
☐ Yes	☐ No	Parent present when screen filled out?
☐ Yes	☐ No	Parent present during exam?

Provider Signature:_____

Screening Adolescents for Alcohol and Drugs

During the past year (or since I last saw you) have you:
1. Drank any alcohol (more than a few sips)?
2. Smoked any marijuana or hashish?
3. Used any other drug to get high?
(By other drug I mean street drugs like Ecstasy or cocaine; inhalants like glue or paint thinner; over-the-counter drugs like DXM; or prescription drugs like OxyContin or Klonopin that you did not take the way a doctor prescribed.)

All *NO*	All *YES*
↓	↓
Ask CAR questions only	***CRAFFT Screen (below)**

C Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?

R Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?

A Do you ever use alcohol or drugs while you are by yourself, ALONE?

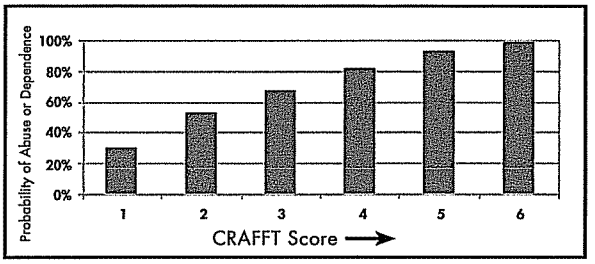
F Do you ever FORGET things you did while using alcohol or drugs?

F Do you family or FRIENDS ever tell you that you should cut down on your drinking or drug use?

T Have you ever gotten into TROUBLE while you were using alcohol or drugs?

*Two or more yes answers on the CRAFFT suggest a serious problem and a need for further assessment.
Referral Information for Comprehensive Assessment: Adolescent Substance Abuse Program at Children's Hospital Boston (617) 355-ASAP (2727)

Probability of a Substance Abuse/Dependence Diagnosis Based on CRAFFT Score



DSM-IV Diagnostic Criteria (Abbreviated from DSM-IV)

Substance Abuse (1 or more of the following):

- Use causes failure to fulfill obligations at work, school, home
- Recurrent use in hazardous situation (e.g, driving)
- Recurrent legal problems
- Continued use despite recurrent problems

Substance Dependence (3 or more of the following):

- Tolerance
- Withdrawal
- Substance taken in larger amount or over longer period of time than planned
- Unsuccessful efforts to cut down or quit
- Great deal of time spent to obtain substance or recover from effect
- Important activities given up because of substance
- Continued use despite harmful consequences

Children's Hospital Boston

The Center for Adoloscent Substance Abuse Research (CeASAR)
617-355-5433
ceasar-boston.org

PHQ-9 for ADOLESCENTS
Modified Patient Health Questionnaire

Name: _____ Date: _____

Over the **last 2 weeks**, how often have you been bothered by any of the following problems? (Please **CIRCLE** to indicate your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, irritable, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite, weight loss, or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as school work, reading or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Note: Clinic Staff - Please file electronically in the EpicCare PHQ9A Document Flow sheet.

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc.