

HISTORY, OBSERVATION, AND SURVEILLANCE

Each Bright Futures visit begins with 3 interrelated components—history, observation, and surveillance. History sets the stage for the visit. It allows health care professionals to assess strengths, accomplish surveillance, and enhance understanding of the child and family. Observation allows the professional to assess interactions between parent and child. Surveillance permits the professional to track the acquisition of developmental milestones and strengths over time.

The chapters in this section of the book focus on topics that often emerge during this portion of the visit. Several, such as **Intimate Partner Violence** and **Parental Health Literacy**, deal with sensitive topics for which health care professionals might find additional guidance useful. Others, such as **Maternal Depression, Disruptive Behavior Disorders, Child and Adolescent Depression**, and **Tobacco Dependence**, explore issues that must be spotted early so as to enhance the likelihood of successful intervention. **Developmental Strengths** focuses on the strengths and skills that lay the foundation for a healthy adulthood.

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CHILD AND ADOLESCENT DEPRESSION

What Is Childhood and Adolescent Depression?

Common Signs and Symptoms in Infants and Preschoolers

- Apathy
- Withdrawal from caregivers
- Delay or regression in developmental milestones
- Failure to thrive without organic cause
- Excessive crying
- Dysregulation
- Irritability

Common Signs and Symptoms in School-Aged Children¹

- Low self-esteem
- Excessive guilt
- Somatic complaints, such as headaches and stomachaches
- Anxiety, such as school phobia or excessive separation anxiety
- Irritability
- Sadness
- Isolation
- Anger
- Bullying
- Fighting

- Fluctuating moods
- Sleep disturbance
- Academic decline

Common Signs and Symptoms in Adolescents

Signs and symptoms of depression in adolescents are similar to those in adults and, according to the *Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR)*,² include

- Depressed or irritable mood
- Loss of interest or pleasure in activities
- Feelings of worthlessness or excessive guilt
- Low energy/fatigue; psychomotor retardation
- Insomnia or hypersomnia; appetite and weight changes
- Poor concentration
- Thoughts of death or suicide

Causes of adolescent depression are complex. Although genetic factors are important, the onset of a depressive episode may be precipitated by difficult or stressful life experiences, such as family, school, or peer relationship problems. Sexual or physical abuse also is a risk factor.³

Why Is It Important to Include Childhood and Adolescent Depression in History, Observation, and Surveillance?

Major depression in children and adolescents is a relatively common disorder. Major depressive disorder is estimated to occur in 1% of preschoolers and 2% of

school-aged children. Evidence also indicates that the prevalence is increasing, with onset at earlier ages.³ Studies also show that 4% to 6% of adolescents may experience depression at any one time, with lifetime prevalence rates by late adolescence of 20% to 25%.³

Depression in prepubertal children occurs equally in males and females.³ Adolescents are different, with depressive disorders after puberty occurring in twice as many females as males.³

Depression is related to serious morbidity and mortality.⁴ Depressed children and adolescents frequently have comorbid mental disorders, such as

- Anxiety disorders
- Attention-deficit/hyperactivity disorder
- Disruptive disorders, including conduct disorder and oppositional defiant disorder (see the “Disruptive Behavior Disorders” chapter for more information on these disorders)
- Eating disorders²

Depressed adolescents are at higher risk of alcohol and substance abuse. Generally depression precedes the onset of alcohol and substance abuse by 4 to 5 years, so identification of depression may provide an opportunity for prevention.¹ Depressed adolescents also experience significant impairment in school functioning and in interpersonal relationships.

Adolescents who are depressed also are at increased risk of suicide ideation, suicide attempts, and completed suicides. Studies show that 85% of depressed teenagers report suicidal ideation and 32% attempt suicide. Approximately 60% of adolescents who commit suicide have a depressive disorder.³ Depression in prepubertal children has a lower rate of suicide (0.8 per 100,000).³

Suicide is the third leading cause of death in youth aged 15 to 19. More than 1,600 youth (aged 15 to 19) committed suicide in 2000.⁵ Suicide is the fourth leading cause of death in youth aged 10 to 14. In this age group, 5 times as many males as females completed a suicide attempt.

Depression among adolescents is likely to continue and may lead to other mental disorders. Studies indicate that 20% to 40% of adolescents with a major depressive episode go on to develop bipolar disorder within 5 years.¹

Moreover, depression in adolescents is likely to continue into adulthood. Approximately 70% will have another episode of depression in 5 years. Teenagers with depression are 4 times as likely as others to have depression as adults.³

Depression is underdiagnosed. Studies show that only 50% of adolescents with depression are diagnosed.⁶

Should You Screen for Depression?

In 2007 the American Academy of Pediatrics endorsed the Guidelines for Adolescent Depression in Primary Care, which recommend primary clinicians assess for depression in adolescents at high risk and those presenting with emotional problems.

The US Preventive Services Task Force (USPSTF), in 2009, recommended screening “adolescents (12–18 years of age) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.” There was insufficient evidence for the USPSTF to recommend screening children (aged 7–11).

In 2010 the American Academy of Pediatrics released a supplement to *Pediatrics, Enhancing Pediatric Mental Health Care: Report from the American Academy of Pediatrics Task Force on Mental Health and Addressing Mental Health Concerns in Primary Care: A Clinician’s Toolkit*, which provides pediatric health care practitioners guidance on how to select appropriate assessment, screening, and surveillance instruments (available at: http://pediatrics.aappublications.org/content/vol125/supplement_3).

A number of depression screening tools for children and adolescents have been evaluated. Some of the more widely used assessments and tools are highlighted below.

Beck Depression Inventory (BDI), Beck Depression Inventory for Primary Care (BDI-PC), Center for Epidemiological Studies–Depression Scale (CES-D), and Center for Epidemiological Studies–Depression Scale for Children (CES-DC)⁷

The Agency for Healthcare Research and Quality⁸ conducted a systematic evidence review of these depression screening tools in children and adolescents.

The review indicated that

- These tools perform reasonably well in community adolescent populations.
- They have sensitivities that range from 75% to 100% and specificities from 49% to 90%.
- The positive predictive values of these tests are low due to the lower specificity and the low prevalence of depression in these populations (most of the patients identified are not depressed⁸).
- The CES-D, while not validated for children younger than 12 years, has been used in several studies involving children as young as 10 years.

Similar evidence regarding operating characteristics of depression screening tools is available in a recent review by Sharp and Lipsky.⁹

The Patient Health Questionnaire for Adolescents (PHQ-A) and the Patient Health Questionnaire (PHQ-9) Quick Depression Assessment

These screening tools

- Have sensitivities of 73% and specificities of 94% to 98% for the diagnosis of major depressive disorder in adolescents
- Have not been validated in preadolescent children
- Have positive predictive values of 40% to 60% depending on the prevalence of depression in the adolescent population being screened (this is due to the higher specificity of these screening tests, at the expense of a somewhat lower sensitivity)

An advantage of the PHQ-A is that it also assesses dysthymic disorder and other common mental health problems of adolescents. The advantage of the PHQ-9 is that it is very short (9 questions).^{10,11}

Children's Depression Inventory (CDI),¹² Child Depression Scale (CDS), Children's Self-Report Rating Scale (CSRS), Depression Self-Rating Scale (DSRS), and Reynolds Adolescent Depression Scale (RADS)

These screening tools for depression in children and adolescents have been tested only in referred

populations, and their use in primary care populations as general screening tools is untested.⁸

Pediatric Symptom Checklist and the Child Behavior Checklist (CBCL)

These general behavioral symptom checklists are good for highlighting psychosocial issues but are not appropriate for identifying the specific diagnosis of depression.¹³

How Should You Perform a Depression Screening?

Although screening for depression in preadolescent children is not specifically recommended in Bright Futures, a behavioral and psychosocial assessment is recommended at every visit. Some specific signs and symptoms of depression in children may be different from those in adolescents, but some overlap exists and you may wish to ask many of the same questions noted here for adolescents.

Perform a Preliminary Assessment Using HEADSS

At every health supervision visit with an adolescent, take a thorough psychosocial history based on the HEADSS method of interviewing. This method has recently been expanded to HEEADSSS (or HE²ADS³).

This assessment includes questions related to the following HE²ADS³ psychosocial domains.^{14–16} Sample question topics are listed. For a complete list, see Goldenring and Rosen.¹⁴

Home: Who lives with the teen? What are relationships like at home? Recent moves or running away?

Education/Employment: School/grade performance—any recent changes? Suspension, termination, dropping out?

Eating: Likes and dislikes about one's body? Any recent changes in your weight or appetite? Worries about weight?

Activities: With peers and family? Church, clubs, sports activities? History of arrests, acting out, crime?

Drugs: Use of tobacco, alcohol, or drugs by peers, by teen, by family members?

Sexuality: Orientation? Degree and types of sexual experience and acts? Number of partners? Sexually transmitted infections, contraception, pregnancy/abortion?

Suicide/Depression:

- Feeling sad
- Sleep disorders (insomnia or hypersomnia)
- Feelings of boredom, helplessness, or hopelessness
- Emotional outbursts and impulsive behavior
- Withdrawal/isolation from peers and family
- Psychosomatic symptoms
- Decreased affect on interview
- Preoccupation with death (music, art, media)
- Suicidal ideation
- History of past suicide attempt, depression, or psychological counseling
- History of depression, bipolar disorder, or suicide in family or peers

Safety: History of accidents, physical or sexual abuse, or bullying? Violence in home, school, or neighborhood? Access to firearms?

To help you with your HEADSS/HE²ADS³ assessment, you also may want to use the Guidelines for Adolescent Preventive Services (GAPS) self-report questionnaires. These instruments, developed by the American Medical Association, are available for younger and middle-older adolescents in both English and Spanish.^{17,18} Have adolescents fill out the GAPS form before you talk with them.

Take Additional Steps if Needed

Consider an adolescent at high risk of depression if the HEADSS/HE²ADS³ interview reveals any of the following:

- Any positive answers in the suicide/depression domain
- Poor or absent relationships with peers or family members
- History of acting out or antisocial behavior

- Recent deterioration in school performance
- Changes in appetite/weight
- Alcohol or substance abuse
- Recurrent serious accidents
- History of sexual or physical abuse
- Comorbid disorders, such as ADHD, anxiety disorders, conduct disorder, or oppositional defiant disorder

If you determine that an adolescent is at high risk on the basis of HEADSS/HE²ADS³ interviews, GAPS questionnaires, or comorbid mental disorders, consider using a standardized screening tool to assess adolescent symptoms of depression.

What Should You Do With an Abnormal Result?

Interview all adolescents who have a positive screen for depression.

Assess them for depressive symptoms and functional impairment based on the *DSM-IV-TR* criteria for major depressive disorder, dysthymia, and depression not otherwise specified.

Assess for comorbid conditions, both medical and psychiatric.

Perform a safety assessment for suicide risk.

- Does the adolescent now have suicidal thoughts or plans?
- Have prior attempts occurred?
- Does the plan or previous attempt have significant lethality or efforts to avoid detection?
- Has the adolescent been exposed to suicide attempt/completion by peers or family members?
- Does the adolescent have alcohol or substance abuse problems?
- Does the adolescent have a conduct disorder or patterns of aggressive/impulsive behavior?
- Does the family show significant family psychopathology, violence, substance abuse, or disruption?

- Does the adolescent have the means available (especially firearms and toxic medications)?

Meet with the adolescent's family members or caregivers.

Discuss a referral to a mental health professional. Make an immediate referral to a mental health provider or emergency services if severe depression, psychotic, or suicidal ideation/risk is evident.¹⁹

Educate adolescents and their family about depression and treatment options.

- Stress that depression is treatable.
- Briefly discuss treatment options, such as watchful waiting for mild depression, psychotherapy (cognitive behavioral therapy or interpersonal therapy), and medication (selective serotonin reuptake inhibitors).
- Encourage families to remove firearms and toxic substances from the house, especially if any suicidal ideation is present.

Provide information about print or online resources that may be helpful to adolescents and their families.

Schedule a follow-up visit in 1 to 2 weeks.

What Results Should You Document?

Document HEADSS/HE²ADS³ assessment, scores of depression screening tools, referrals discussed or made, and follow-up plans.

ICD-9-CM Codes	
296.2x–296.3x	Major depressive disorder
300.4	Dysthymic disorder
309.0	Adjustment disorder with depressed mood
311	Depressive disorder, not otherwise specified

The American Academy of Pediatrics publishes a complete line of coding publications, including an annual edition of *Coding for Pediatrics*. For more information on these excellent resources, visit the American Academy of Pediatrics Online Bookstore at www.aap.org/bookstore/.

Resources

Scales and Tools

A number of good standardized screening tools exist for adolescent depression.

Beck Depression Inventory-II (BDI-II)

- 21-question, self-report questionnaire
- Updated version of Beck Depression Inventory; based on *DSM-IV-TR* criteria
- Appropriate for middle-older adolescents
- Available in Spanish
Must be purchased from <http://www.musc.edu/dfm/RCMAR/Beck.html>

Center for Epidemiological Studies Depression Scale (CES-D)

- 20-question, self-report questionnaire developed for adults
- Appropriate for middle-older adolescents
- Available in Spanish
Available free from http://www.hepfi.org/nnac/pdf/sample_cesd.pdf

Center for Epidemiological Studies Depression Scale for Children (CES-DC)

- 20-question, self-report questionnaire similar to the CES-D
- Appropriate for younger adolescents
- Available free from http://www.brightfutures.org/mentalhealth/pdf/professionals/bridges/ces_dc.pdf

Patient Health Questionnaire Adolescent Version (PHQ-A)

- 83-question, self-report questionnaire that screens for major depressive disorder, dysthymia, minor depressive disorder, anxiety disorders, drug abuse or dependence, nicotine dependence, and eating disorders
- First 16 questions focus on depression and mood and could be used without rest of questionnaire
- Moderately complex scoring schema

Patient Health Questionnaire Quick Depression Screen (PHQ-9)

- 9-question, self-report questionnaire that screens for major depressive disorder and other depressive disorder
- Does not screen for dysthymia
- Easy to score
- Available in Spanish
Available for review at <http://www.mapi-trust.org/questionnaires/66>

Other depression screening tools

- Children's Depression Inventory (CDI)
- Reynolds Adolescent Depression Scale (RADS)

Interview Tools

Guidelines for Adolescent Preventive Services (GAPS): <http://www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/adolescent-health/guidelines-adolescent-preventive-services.shtml>

Books

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Empfield M, Bakalar N. *Understanding Teenage Depression: A Guide to Diagnosis, Treatment, and Management*. New York, NY: Henry Holt and Company; 2001

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Morris TL, March JS, eds. *Anxiety Disorders in Children and Adolescents*. 2nd ed. New York, NY: The Guilford Press; 2004

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Article

US Preventive Services Task Force. Screening and treatment for major depressive disorder in children and adolescents: US Preventive Services Task Force Recommendation Statement. *Pediatrics*. 2009;123(4): 1223–1228

Web Sites

American Academy of Child & Adolescent Psychiatry

The Anxious Child: http://www.aacap.org/galleries/FactsForFamilies/47_the_anxious_child.pdf

American Academy of Pediatrics: Depression and Suicide: <http://www.aap.org/healthtopics/depression.cfm>

Bright Futures in Practice: Mental Health

Common Signs of Depression in Children and Adolescents: http://www.brightfutures.org/mentalhealth/pdf/families/bridges/dep_signs.pdf

Symptoms of Depression in Children and Adolescents: http://www.brightfutures.org/mentalhealth/pdf/families/ad/dep_symptoms.pdf

TeensHealth: http://www.kidshealth.org/teen/your_mind/feeling_sad/depression.html

Maternal and Child Health Bureau: http://www.mchlibrary.info/KnowledgePaths/kp_Mental_Conditions.html

Mayo Clinic: <http://www.mayoclinic.com/invite.cfm?id=AN00685>

National Alliance on Mental Illness: www.nami.org

National Institute of Mental Health: www.nimh.nih.gov

Mental Health America: <http://www.mentalhealthamerica.net>

NYU Child Study Center: <http://www.aboutourkids.org>

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DEVELOPMENTAL STRENGTHS

While developmental surveillance is relatively clear for young children (assessment of motor, social, and language skills), the details of promoting healthy development for school-aged children and adolescents is less well defined. In the third edition of the Bright Futures Guidelines, the visit priorities address healthy development and the Association of Maternal and Child Health Programs framework was adopted as a guide. This Strengths Assessment and Promotion framework provides a platform to accentuate what is going right for a child, and has a positive focus to health promotion and disease prevention. In addition, the concept of using a strength-based approach with children, youth, and families was recommended in all editions of Bright Futures. This chapter gives some ideas about implementing that recommendation in the primary care setting.

Why Is It Important to Include Developmental Strengths in History, Observation, and Surveillance?

Across all socioeconomic and racial/ethnic groups, the presence of assets or strengths is positively linked with increased healthy behaviors and fewer risk behaviors.^{1,2} Incorporating strengths assessment and promotion in the primary care office setting can facilitate discussion of positive changes, and offer parents a strategy for effective communication with their child.³

Incorporating strengths assessment and promotion adds an important dimension to risk prevention. Prevention efforts oriented solely toward stopping or preventing a particular unhealthy behavior are not universally effective.^{4,5} Furthermore, simply because children refrain from risky behavior does not mean they are healthy or accomplishing essential developmental tasks. A child who is “problem-free” isn’t necessarily fully prepared for adulthood.⁶

Along with messages about what to avoid, children and parents should receive acknowledgement of healthy steps already taken.

Strengths assessment and promotion has a diverse research base. Practitioner recommendations supporting positive development have been informed by the research on prevention, resiliency, identity development, social development, and self-determination.

Researchers and practitioners in psychology, sociology, and social work have identified personal, environmental, and social assets that enable healthy and successful transition from childhood, through adolescence, and into adulthood.⁷

The Search Institute identified 40 assets in 8 categories of strengths and, since 1997, has published extensive data on their role in supporting successful development.⁸

A 1997 analysis by Resnick et al⁹ of the National Longitudinal Study on Adolescent Health found that parent-family connectedness and perceived school connectedness protect against every health risk behavior measured except history of pregnancy.

Since 1981, the University of Washington Social Development Research Group has engaged in a longitudinal study testing strategies for reducing childhood risk factors for school failure, drug abuse, and delinquency. Their data support the long-term, protective influence of 2 key protective factors: (1) bonding to prosocial family, school, and peers and (2) clear standards or norms for behavior.¹⁰

This approach has support from agencies and organizations. In 2002, for example, the US Department of Health and Human Services endorsed strengths promotion in the document *Toward a Blueprint for Youth: Making Positive Youth Development a National Priority*.¹¹ States and communities are implementing programs to encourage positive youth development.

In 2005 the Association of Maternal and Child Health Programs adopted positive youth development as one of the guiding principles for the development of policies and programs to maximize the health of adolescents.¹²

The National Research Council and Institute of Medicine Committee on Community-level Programs for Youth conducted a 2-year study of the literature and research on strengths promotion.¹³ It endorsed a summary list of “key youth assets” and developed a “provisional list of features of daily settings that are important for adolescent development.”¹³

How Can You Assess Progress on Developmental Tasks and Promote Strengths in School-Aged Children and Adolescents?

Assessing Progress

- For each visit for school-aged and adolescent youth there are 5 priorities for anticipatory guidance at each visit. (box in next column).

Assess Strengths

- Practitioners have found it easier to provide comprehensive risk and developmental strengths screening if they use a framework or prompt.
- Ask questions about and record what is going well for the patient. For example,

11- to 14-Year Visit Priorities for the Visit

The first priority is to address the concerns of the adolescent and his parents. In addition, the Bright Futures Adolescence Expert Panel has given priority to the following additional topics for discussion in the 4 Early Adolescence Visits. The goal of these discussions is to determine the health needs of the youth and family that should be addressed by the health care professional. The following priorities are consistent throughout adolescence. However, the questions used to effectively obtain information and the anticipatory guidance provided to the adolescent and family can vary.

Including all the priority issues in every visit may not be feasible, but the goal should be to address issues important to this age group over the course of the 4 visits. These issues include:

- Physical growth and development (physical and oral health, body image, healthy eating, physical activity)
- Social and academic competence (connectedness with family, peers, and community; interpersonal relationships; school performance)
- Emotional well-being (coping, mood regulation and mental health, sexuality)
- Risk reduction (tobacco, alcohol, or other drugs; pregnancy; STIs)
- Violence and injury prevention (safety belt and helmet use, substance abuse and riding in a vehicle, guns, interpersonal violence [fights], bullying)

Source: Hagan Jf, Shaw Js, Duncan Pm, eds. 2008. Bright Futures. Guidelines for Infants, Children, and Adolescents, Third Edition. Elk Grove Village, IL: American Academy of Pediatrics

- ▶ What’s been going well for you?
- ▶ What have you been doing to stay healthy?
- ▶ What do you like about yourself?
- ▶ What are you good at?
- ▶ What do you do to help others?
- ▶ Who are the important adults in your life?

H	H ome belonging (connection) decision-making
E	E ducation mastery (competence)
E	E ating
A	A ctivities physical activity, helping others
D	D rugs
S	S exual Activity
S	S uicide (mental health) coping, resilience, self-confidence
S	S afety

Source: Reif, CJ, Elster, AB, Adolescent Preventive Services. *Primary Care: Clinics in Office Practice*. Vol 25, NO1. March 1998. WB Saunders, Philadelphia, PA Goldenring JM, Cohen E. Getting into adolescent heads. *Contemp Pediatr*. 1988;5(7):75–90.

- ▶ If I were an employer, what are all the things that would make me want to hire you?

The commonly used HEADSSS (**H**ome environment, **E**ducation and employment, **E**ating, peer-related **A**ctivities, **D**rugs, **S**exuality, **S**uicide/depression, and **S**afety from injury and violence) assessment also can elicit information about things that are “going well,” such as a supportive home environment or success in school. Adopting the HEADSSS assessment by adding the specific concepts of independent decision-making to the Home component; helping others to the Activities component; and coping, resilience, and self-confidence to the Suicide or mental health component makes it a match for the Bright Futures visit priorities and developmental surveillance recommendations.

While the HEADSSS mnemonic is mostly used with adolescent encounters, this approach can be modified to be consistent with Bright Futures and used with school-aged children.

Healthy behavior choices that present as negative replies to certain risk screening questions may also indicate strengths. For example, not smoking or refraining from unsafe sexual activity can be signs of independence, peer support, and/or good decision-making skills.

Seek out what strengths are present, rather than only looking for what might be missing.

Several strength assessment frameworks have been developed to provide shorthand descriptions of what a

strong, well-rounded youth or adolescent “looks” like. The frameworks synthesize research on the supports, personal qualities, and experiences necessary for healthy development, and tend to echo one another. Examples follow.

- The **Circle of Courage** model for resiliency emphasizes generosity, independence, mastery, and belonging (GIMB).¹⁴ The “GIMB” acronym was adopted for use by pediatricians, family physicians, and nurse practitioners who participated in the Vermont Youth Health Improvement Initiative.
- The Search Institute’s **40 Developmental Assets** fit into 8 categories: support, empowerment, expectation/boundaries, educational competence, values, social competencies, and positive identity.⁹
- **The 5 Cs** (contribution, confidence, competence, connection, and character) were developed by the Forum for Youth Investment.¹⁵
- Social development theorists Ryan and Deci¹⁶ identify **competence, autonomy, and relatedness** as essential for positive social development and personal well-being.

In 2005 the Association of Maternal and Child Health Programs identified the developmental tasks of adolescence, which were subsequently adopted by the Bright Futures Guidelines.¹²

Surveillance of Development

The developmental tasks of middle adolescence can be addressed through information obtained in the medical examination, by observation, by asking specific questions, and through general discussion. The following areas can be assessed to better understand the developmental health of the adolescent. A goal of this assessment is to determine the adolescent is developing in an appropriate fashion and, if not, to provide information for assistance or intervention. In the assessment, determine whether the adolescent is making progress on these developmental tasks.

- Demonstrates physical, cognitive, emotional, social, and moral competencies
- Engages in behaviors that promote wellness and contribute to a healthy lifestyle

- Forms a caring, supportive relationship with family, other adults, and peers
- Engages in a positive way in the life of the community
- Displays a sense of self-confidence, hopefulness, and well-being
- Demonstrates resiliency when confronted with life stressors
- Demonstrates increasingly responsible and independent decision-making¹¹

The National Research Council/Institute of Medicine's list of "Features of Positive Developmental Settings," a chapter in the manual *Community Programs to Promote Youth Development* (see Resources section of this chapter), can guide efforts to develop a strength-based office setting. Practical implications of the list for the pediatric office include using age-appropriate decorations, offering age-appropriate reading materials, and posting community volunteer opportunities.

Promote Strengths

- Model, and encourage your office colleagues to model, a positive, affirming approach toward children and adolescents.
- Briefly talk with patients and families about their particular strengths or about strengths in general.
- Adopt a shared decision-making strategy to encourage positive change when needed.

What Should You Do With an Abnormal Result?

All patients have strengths as well as areas requiring further attention for development.

Congratulate the patient and parent on the strengths that are present.

Offer anticipatory guidance that promotes additional strengths/assets. Even if you do not use an assessment framework, you can provide general guidance and encouragement.

Be aware that families and individuals may differ in their opinions of what constitutes a display of positive development. For example, assertiveness usually is

regarded as a sign of competence in many families, but it may be interpreted as a problem behavior in other cultures. Be respectful and ready to accommodate different perspectives.

Use shared decision-making (eg, motivational interviewing) to identify steps the child or parent can take to make positive change. See the "Motivational Interviewing" chapter for more information.

What Results Should You Document?

Record findings in the patient's chart and note at each visit whether the patient is making progress on the developmental tasks.

Customize your office encounter forms, previsit interview forms, and other materials to document all screenings and responses, and to begin discussions with patients. An example of a **practitioner reminder sticker** illustrated below was used in a preventive services quality improvement project as a prompt and documentation tool.

Practitioner Reminder Sticker for Patient Charts

Date of Screening		
Check Indicates a Preventive Screening		
<input type="checkbox"/>	Nutrition/Physical Activity	
<input type="checkbox"/>	Substance Abuse	
<input type="checkbox"/>	Sexual Activity	
<input type="checkbox"/>	Violence/Injury Prevention	
<input type="checkbox"/>	Oral Health	
Emotional Wellbeing/MH		
<input type="checkbox"/>	Coping/Resiliency	
<input type="checkbox"/>	Competence (School)	
<input type="checkbox"/>	Connectedness (Family, Peers, Community)	
<input type="checkbox"/>	Decision-making	
<input type="checkbox"/>	Self-confidence/Hopefulness	
<input type="checkbox"/>	Puberty/Sexuality	
CRAFFT?	<input type="checkbox"/> Yes <input type="checkbox"/> No	2+ or – Referral
Office Intervention		

Source: Adapted from VCHIP

Resources

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Administration for Children and Families: <http://www.acf.hhs.gov/>

National Clearinghouse on Families and Youth: <http://ncfy.acf.hhs.gov/>

The Search Institute: www.search-institute.org

The Seattle Social Development Research Group: www.sdrp.org

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DISRUPTIVE BEHAVIOR DISORDERS

Bright Futures consistently emphasizes family-centered care, including the mental health of the entire family unit. As such, it is important to incorporate screening and surveillance for issues related to behavior and mental health into routine pediatric care. Primary care practitioners are often the first and only contact for families that are struggling with behavior or mental health problems, and there are insufficient numbers of child psychiatrists, child psychologists, and social workers. Further, social stigma and financial constraints (for families and practitioners) often prevent families seeking help from mental health professionals. Parents may think problems will get better by themselves or that they should be strong enough to handle them on their own, and thus may be unlikely to bring up the topic on their own.

What Are Disruptive Behavior Disorders?

A spectrum of diseases and disease severities exist within disruptive behavior disorders. Children with disruptive disorders can be inattentive, hyperactive, aggressive, and/or defiant. They may repeatedly defy societal rules of their own cultural group or disrupt the classroom or other environments.

Attention-Deficit/Hyperactivity Disorder (ADHD)

Attention-deficit/hyperactivity disorder is the most commonly diagnosed neurobehavioral disorder of childhood. Symptoms include hyperactivity, impulsivity, and inattention. Subtypes include combined type, primarily inattentive, and primarily hyperactive. Children with primarily inattentive type may miss early detection and may therefore incur greater dysfunction.

Boys are 4 times more likely to have ADHD than girls. Etiology is most likely multifactorial; neurotransmitter deficits, genetics, and perinatal complications have been implicated. Although environmental factors may contribute to the severity of problems, they are not considered etiologic by themselves.

Oppositional Defiant Disorder (ODD)

Oppositional defiant disorder is characterized by antisocial behavior (behaviors also common in ADHD) and persistent or consistent pattern of defiance, disobedience, and hostility toward various authority figures, including parents, teachers, and other adults.

Oppositional defiant disorder is more common in boys until after puberty, when rates become equal. The etiology is unknown but is likely due to a combination of biological, genetic, and psychosocial factors. Oppositional defiant disorder is sometimes a precursor of conduct disorder.

Conduct Disorder (CD)

Conduct disorder is characterized by antisocial behavior and may follow ODD. Behaviors include aggression with fighting, bullying, intimidating, assaulting, sexually coercing, and/or cruelty to people and/or animals. Other behaviors include vandalism, theft, truancy, early alcohol and substance abuse, and precocious sexual activity.

The etiology is unknown but is probably due to a combination of biological, genetic, and psychosocial factors. Children with chronic illness have a 2 to 5 times increased incidence of CD, especially if they have developmental or neurologic disabilities. Dysfunctional parenting, especially harsh, inconsistent, rejecting, and abusive forms, predispose to the development of CD.

Why Is It Important to Include Disruptive Disorders in History, Observation, and Surveillance?

Disruptive behavior disorders in children are common. Studies indicate that 4% to 12% of school-aged children have ADHD. The prevalence of ODD and CD is 1% to 6% of school-aged children. Symptoms can also be an indication of other problems, such as child abuse, neglect, or parental discord.

Disruptive disorders often accompany other behavioral conditions and risk behaviors. Learning disabilities, mood and anxiety disorders, and alcohol and other substance use disorders are common in children with a disruptive disorder.

The rate at which these and other mental health problems are detected is improving but is still less than ideal. Despite the prevalence of 10% to 20% in community samples and the repeated contact physicians have with young children, the treated prevalence estimates are increasing but still lower than ideal.

Early intervention has powerful benefits. Early intervention is less costly and more successful than later interventions. Early intervention also may prevent persistent dysfunctional behavior patterns from becoming established. Children with ADHD and CD who are not treated are more likely to experience drug abuse, antisocial behavior, teen pregnancy, and injuries.

Mental health screening has been recommended by national organizations. Healthy People 2010, the Surgeon General's Report on Children's Mental Health, and the President's New Freedom Commission on Mental Health all recommend pediatric mental health screening in primary care.

The US Preventive Services Task Force has not specifically evaluated the evidence regarding screening for disruptive behavior disorders.

How Should You Conduct Surveillance and Screening for Disruptive Disorders?

Surveillance is a flexible, continuous process of monitoring a child's developmental and behavioral status during health supervision visits. It also may include history-taking and the use of structured parent questionnaires.

Screening is assessing for conditions in asymptomatic patients and is part of behavioral surveillance. It includes the use of structured parent questionnaires.

Diagnosis of behavioral disorders typically occurs after surveillance and/or screening reveals concerns in one or more functional areas.

Talk With Parents

At each yearly health supervision visit of school-aged children and adolescents, conduct mental health surveillance by asking parents questions, such as

- How is your child doing in school?
- Are there any problems with learning that you or the teacher has seen?
- Is your child happy in school?
- Are you concerned with any behavioral problems in school, at home, or when your child is playing with friends?
- Is your child having problems completing class work or homework?
- Does your child mind you or follow rules as expected?
- Do you have resources to assist you (eg, family members, child care, adequate financial support)?
- How are things going at home (eg, marital problems, substance abuse, domestic violence)?

Consider a Broad-band Screening Instrument

At the 5-, 6-, and 7-year health supervision visits, consider using a broad-band screening instrument, such as the Pediatric Symptom Checklist, to assess behavior.

- If broad-band screening points toward specific problems, such as attention, hyperactivity, or oppositional behavior problems, consider using one

of the “narrow-band tools” listed in the Resources section to facilitate assessment. For more information about screening tools, see the Resources section of the “Developmental and Behavioral Considerations” chapter.

- If symptoms are identified in multiple areas with the broad-band instrument, refer for full developmental and learning assessment.

What Should You Do With an Abnormal Result?

Assure parents they are not alone and that support is available if they need it. Stress that behavior disorders are treatable and that early intervention is preferable to improve long-term outlook.

Offer to initiate a referral to a mental health professional, support group, or other therapeutic agency. Initiate an immediate referral to a mental health practitioner or facility if a child shows severe impairment, such as danger to self or others.

If a specific diagnosis is made in the primary care setting, begin educating parents about the chronic nature of the condition. Provide a list of print and online resources. Help parents meet other parents and learn about other community resources, such as support groups.

Schedule frequent office visits to follow up with the family and child. If treatment will occur in the primary care office, consult the American Academy of Pediatrics ADHD clinical practice guidelines and those of the AAP Task Force on Mental Health available at: http://pediatrics.aappublications.org/content/vol125/Supplement_3.

Two Toolkits are available with forms and billing information:

- Addressing Mental Health Concerns in Primary Care: A Clinician’s Toolkit (aap.org/bookstore)
- Caring for Children with ADHD: A Resource Toolkit for Clinicians (<http://www.nichq.org/adhd.html>)

What Results Should You Document?

Document parent and teacher questionnaires, to whom referral was made, follow-up plans, and current treatment(s).

ICD-9-CM Codes

312.xx	Disturbance of conduct (CD)
313.81	Oppositional defiant disorder (ODD)
314.xx	Attention-deficit/hyperactivity disorder (ADHD)
V71.02	Childhood or adolescent antisocial behavior
V40.3	Other behavioral problems

The American Academy of Pediatrics publishes a complete line of coding publications, including an annual edition of *Coding for Pediatrics*. For more information on these excellent resources, visit the American Academy of Pediatrics Online Bookstore at www.aap.org/bookstore/.

Resources

Policy and Guidelines

Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: The President’s New Freedom Commission on Mental Health; 2003. <http://www.mentalhealthcommission.gov/>

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Broad-band Screening Scales and Tools

Broad-band tools assess a relatively full range of behavioral and emotional symptoms and disorders.

Pediatric Symptom Checklist

http://www2.massgeneral.org/allpsych/psc/psc_home.htm

Developed to facilitate recognition and referral of child psychosocial problems by primary care pediatricians

- 35-item parent report and 35-item youth self-report (available free online)
- Spanish versions of both and a Japanese parent report available
- A brief 17-item parent-report in English available (not available online)
- Overall sum represents parental impression of their child's psychosocial functioning
- Discrete subscales for attentional, oppositional, and internalizing symptoms
- Strong internal consistency, test-retest reliability, and validity with psychiatric assessments of child functioning

Behavior Assessment System for Children, 2nd Edition—BASC-2

<http://www.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=PAa30000>

Available for purchase

- 100- to 150-item (number of items vary depending on child's age) parent report of competencies and problem behaviors
- Spanish version available
- Teacher and youth self-reports available
- Discrete subscales for attentional, oppositional, and internalizing symptoms
- Strong internal consistency, test-retest reliability, and validity with psychiatric assessments of child functioning
- Recently updated

Child Behavior Checklist—CBCL

<http://www.aseba.org/> Available for purchase

- 118-item parent report of competencies and problem behaviors
- Spanish version available
- Teacher and youth self-reports also available
- Discrete subscales for attentional, oppositional, and internalizing symptoms
- Recently updated with new normative data

Conners Rating Scales-Revised—CRS-R

<http://psychcorp.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=PAG116>

Available for purchase

- First developed in 1970 to assess a wide variety of children's common behavior problems, such as sleep disturbance, eating problems, and peer relationships
- CRS-R includes items specific to *DSM-IV*-defined ADHD and its associated features and updates age and gender normative values
- Parent and teacher forms available in full (80-item, 59-item) and abbreviated (27-item, 28-item) versions
- Adolescent self-report (Conners-Wells' Adolescent Self-Report Scale) in full and abbreviated versions also available

Narrow-band Screening Scales and Tools

Narrow-band tools assess specific diagnostic categories.

NICHQ-Vanderbilt ADHD Rating Scales

Parents' scale

http://www.pedialliance.com/forms/ADHD_Parent_Assessment41.pdf

Teacher's scale

<http://www.brightfutures.org/mentalhealth/pdf/professionals/bridges/adhd.pdf>

- Both scales available free online
- Assess for symptom presence and severity in school, home, and social settings based on *DSM-IV* diagnostic criteria

- 55-item parent form and 43-item teacher form
- 10 minutes to complete

Eyberg Child Behavior Inventory
<http://www4.parinc.com/Products/Product.aspx?ProductID=ECBI> [

Available for purchase

- 35 items for ages 2–16
- Assesses the number and frequency of difficult behaviors
- Good reliability and validity
- 5 minutes to complete and 5 minutes to score

Conduct Disorder Scale
<http://www.proedinc.com/customer/productView.aspx?ID=2277>

Available for purchase

- 40 items for ages 5–22 years
- Assesses aggressive and nonaggressive conduct, deceitfulness, theft, and rule violations
- 5 to 10 minutes to administer

Web Sites

Family Sites

Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD): www.chadd.org

CHADD provides education, advocacy and support for individuals with ADHD.

Clinician Sites

Centers for Disease Control and Prevention (CDC)
www.cdc.gov/ncbddd/adhd/

The CDC offers information on ADD/ADHD as well as resources.

Developmental and Behavioral Pediatrics (DBPeds) Online
<http://www.dbpeds.org>

DBPeds is aimed at professionals interested in child development and behavior, specifically in the medical setting.

Mental Health America (MAH)

www.nmha.org/infoctr/factsheets/74.cfm

MHA offers support and informational services on mental health issues.

National Institute of Mental Health (NIMH)

www.nimh.nih.gov

The NIMH is dedicated to research focused on the understanding, treatment, and prevention of mental disorders and the promotion of mental health

DANIELLE THOMAS-TAYLOR, MD

INTIMATE PARTNER VIOLENCE

Intimate partner violence (IPV) is a common pediatric problem of epidemic proportion, with more than 10 million children witnessing family violence annually. More than half of female victims of IPV live in households with children younger than 12. Bright Futures encourages counseling of IPV in selected visits (prenatal, newborn, 1 month, 9 month, 4 year, middle and late adolescence).

What Is Intimate Partner Violence?

Intimate partner violence is considered present when an intimate partner commits physical, sexual, emotional, economic, or psychological assault on the other partner through the use of a pattern of controlling behaviors, including force, coercion, threats, or intimidation. It is known by a variety of names: domestic violence, family violence, wife beating, and battering.

Why Is It Important to Include IPV in History, Observation, and Surveillance?

Violence by an intimate partner is very common.

It occurs in all socioeconomic groups, ages, races, ethnicities, and among those with and without disabilities. Intimate partner violence occurs in as many as 1 in 4 US households, with an estimated 5.3 million victimizations occurring annually in US women aged 18 and older. Teen dating violence also is common, with 20% to 25% of female high school students reporting physical and/or sexual abuse by a dating partner (see box below).

Dating Abuse Fast Facts

In March 2006 Liz Claiborne Inc. commissioned Teenage Research Unlimited (TRU) to conduct a survey to delve deeper into the issue of teen dating abuse, gauging the degree to which teens have been involved in abusive/controlling relationships and to understand youth perceptions regarding what is and is not acceptable behavior in a relationship.

The findings were astounding. The results show that alarming numbers of teens experience and accept abusive behavior in dating relationships. Many teens also feel physically and sexually threatened.

- 1 in 5 teens who have been in a serious relationship report being hit, slapped, or pushed by a partner.
- 1 in 3 girls who have been in a serious relationship say they've been concerned about being physically hurt by their partner.

- 1 in 4 teens who have been in a serious relationship say that a boyfriend or girlfriend has tried to prevent them from spending time with friends or family, the same number have been pressured to only spend time with their partner.
- 1 in 3 girls between the ages of 16 and 18 say sex is expected for people their age in a relationship; half of teen girls who have experienced sexual pressure report they are afraid the relationship would end if they did not give in.
- Nearly 1 in 4 girls who have been in a relationship (23%) reported going further sexually than they wanted to as a result of pressure.

Source: <http://www.loveisrespect.org/is-this-abuse/dating-abuse-fast-facts/>.

Intimate partner violence is a leading determinant of health for US women. Most IPV (85%) is perpetrated against women. It has been adversely associated with 8 of 10 Healthy People 2010 indicators for women.

Annually, IPV is the leading cause of injury for women between the ages of 15 and 44. It results in 2 million injuries and nearly 1,300 deaths per year. Three women are murdered by their husbands or boyfriends each day.

Intimate partner violence has a high price tag. The cost of domestic abuse against adult women is estimated to exceed \$5.8 billion annually, nearly \$4.1 billion of which is for direct medical and mental health care services.

Intimate partner violence has significant adverse effects on children. Children observe harassment, threats, violence, and murders; overhear these behaviors; and see or suffer the physical and emotional consequences. Children can be the direct victims of domestic violence, being injured either intentionally or accidentally.

The US Advisory Board on Child Abuse suggests that domestic violence may be the single major precursor to child abuse and neglect fatalities. Child abuse coexists in 30% to 60% of homes with IPV.

Children who are exposed to IPV can have short- and/or long-term effects that are affected by the severity and chronicity of the abuse, as well as the age, sex, and developmental stage of the child. Signs and symptoms of children exposed to IPV include

- Post-traumatic stress disorder
- Behavior problems
- Anxiety
- Depression
- Poor school performance and learning difficulty

Children who are exposed to violence and show symptoms of traumatic stress have higher rates of health problems including asthma, allergies, gastrointestinal illness, and headaches.

Initially in 1998 and reaffirmed in 2010, the American Academy of Pediatrics (AAP) stated that the abuse of women is a pediatric issue, and that pediatricians should implement routine surveillance and screening.

When Should You Conduct IPV Surveillance and Screening?

Make it routine. Ask all families about IPV. Bright Futures recommends discussing IPV at the prenatal, newborn, 1-month, 9-month, and 4-year visits and discussing interpersonal and dating violence at the middle and late adolescence health supervision visit.

Consider screening mothers at child health supervision visits when signs or symptoms raise concerns (eg, bruising on the child or mother), or if the mother says she has a new intimate partner.

Consider screening adolescents if they say they have a new intimate partner, when signs or symptoms raise concerns, or during any prenatal visits.

How Should You Conduct IPV Surveillance and Screening?

Understand your state's domestic and child abuse laws. An updated database of these laws is available through the Child Welfare Information Gateway (http://www.childwelfare.gov/systemwide/laws_policies/state/). In some states, health care workers are mandated to report domestic abuse and/or children's exposure to IPV.

Listen supportively, but be direct in your questioning if possible. Ask in an effective and efficient manner that becomes routine for all patients.

Try to assess with children out of the room. If this isn't practical, then ask general questions. Sample questions from Bright Futures include

- Do you always feel safe in your home?
- Has your partner or ex-partner ever hit, kicked, or shoved you, or physically hurt you or the baby?
- Are you scared that you and/or other caretakers may hurt the baby?
- Do you have any questions about your safety at home?
- What will you do if you feel afraid? Do you have a plan?
- Would you like information on where to go or who to contact if you ever need help?

If the mother gives cues she is uncomfortable, use alternative methods of screening and discussion.

No specific tools have been scientifically validated for screening in the pediatric practice. However, several screening tools have been shown to be effective when implemented in primary care pediatric offices.

Screening Questions for IPV

Use the 4-question “Child Safety Questionnaire.”¹

- Have you ever been in a relationship with someone who has hit you, kicked you, slapped you, punched you, or threatened to hurt you?
- Are you currently in a relationship with someone who has hit you, kicked you, slapped you, punched you, sexually abused you, or threatened to hurt you?
- When you were pregnant did anyone ever physically hurt you?
- Are you in a relationship with someone who yells at you, calls you names, or puts you down?

What Should You Do if You Identify IPV?

The pediatricians’ job is not to fix the problem but to

- Provide a safe environment for disclosure and discussion of the issue.
- Support the victim.
- Begin to help the victim understand her situation and to educate and address the impact of IPV on her children.

The key is to assess for safety and report IPV if it is mandated. If you identify IPV,

- Provide referrals to social workers; local IPV support groups; or shelters, mental health or counseling, or legal services.
- Document the problem so that other practitioners will be aware of any disclosure, but develop a protocol for confidentiality because the perpetrator may have access to a child’s records.
- If you need to report to child protective services, inform the mother, assess for possible increase in violence, and arrange a safe place for the woman and her children to go.

Understanding the dynamics of IPV is key to successful support and intervention. Women may not disclose violence, but through surveillance and screening you can help them be aware that this is an important issue they can discuss with you when ready. Many women do not leave violent relationships for a variety of reasons, but you can still help them keep their children and themselves safer.

What Results Should You Document?

Documentation requirements and laws may vary by state and locality. The documentation described below is suggested based on methods used in Rochester, NY, as of 2008.

If perpetrator has no access to patient’s chart

- Use the patient’s (or injured’s) own words regarding injury and abuse.
- For injured patients, legibly document all injuries. Use a body map and take photographs of injuries, if possible.

If perpetrator does or may have access to child’s chart, or uncertain

- Use charting phrases that you have dedicated exclusively to IPV, such as
 - ▶ “Family concerns discussed” for screening done
 - ▶ “Resources offered” for positive screens

ICD-9-CM Codes

E960–E969	Homicide and injury purposely inflicted by other persons
E967	Child battering and other maltreatment
E967.0	by parent
308	Acute reaction to stress
308.4	Mixed disorders as reaction to stress
308.9	Unspecified acute reaction to stress

The American Academy of Pediatrics publishes a complete line of coding publications, including an annual edition of *Coding for Pediatrics*. For more information on these excellent resources, visit the American Academy of Pediatrics Online Bookstore at www.aap.org/bookstore/.

Sample Screening Card

(available for reproduction and distribution to office staff)

Intimate Partner Violence: Have You Screened Today?

What is intimate partner violence?

Abuse in relationships, including pushing, shoving, slapping, punching, choking, kicking, holding, tying down, assault with a weapon, and economic/emotional isolation.

How big is this problem?

- Police in the United States spend one-third of their time responding to domestic violence calls.
- It is estimated that 2 million women are assaulted by their partners each year in the United States. This is the major source of injury to women 14 to 45 years old, causing more injuries than accidents, muggings, and rapes combined.

Why do we need to ask?

- Intimate partner violence against mothers is a pediatric issue.
- The American Academy of Pediatrics recommends pediatricians attempt to recognize evidence of family violence and intervene to maximize safety.
- Between 50% and 70% of men who abuse female partners also physically abuse children.
- Children that witness intimate partner violence show such symptoms as stuttering, bedwetting, insomnia, separation anxiety, difficulty concentrating, headaches, abdominal pain, and aggressive behavior.

Why don't we ask?

- Fear of offending
- Lack of time
- Discomfort with the subject
- Biases about who is affected (ie, socioeconomic status, race, age, education, marital status [none of which matter])
- Inability to give a solution

How can we ask?

With anticipatory guidance

If "Yes"

- Validate.
- Listen nonjudgmentally.
- Encourage communication.
- Reassure them your office is a safe place to talk and find information.
- Refer them to the appropriate resources.

If "No"

- They are now aware your office is a safe place to talk and to receive information.
 - They know that you are concerned and willing to talk about this subject.
1. Be direct in your questioning.
 2.
 - "I ask all my patients this question because I want you to know this is a safe place where help is available. Your health and well-being are important to me and may affect your children's safety and well-being."
 - "Because violence is so common, I have started to routinely ask all of my patients about violence in the home."
 3.
 - "Are you in a relationship where you are being hurt physically or emotionally?"
 - "Have you ever been emotionally or physically abused by your partner? By this I mean have you ever been hit, kicked, slapped, punched, or isolated from your family or someone important to you by your partner?"

Stalking

While Bright Futures does not provide specific guidance on discussing or counseling on stalking, the general prevalence and ties to IPV deserve a mention for practitioners to build awareness. Stalking is a common problem in the United States. It affects 1 in 12 women and 1 in 45 men at some time during their lives. In a national study of college students, 13% of college women report having been stalked.

Most of those who are stalked know their stalker because they had a personal or romantic relationship before the stalking behavior began. The stalkers may be classmates, coworkers, friends, or former girlfriends or boyfriends.

Although many people do not report being stalked, this behavior is unpredictable and serious, and can become violent over time. In fact, 3 out of 4 women killed by an intimate partner were stalked by their killer in the year before their murder.

Stalking

The legal definition of stalking varies by jurisdiction, but it is generally considered an action or conduct by a person that makes a reasonable person feel afraid or in danger. Stalking is considered a crime in all 50 states. Stalking behaviors include

- Showing up at places uninvited
- Watching from afar
- Following
- Repeatedly calling, e-mailing, and text messaging
- Sending letters or gifts
- Contacting family or friends

For individuals being stalked, provide the following recommendations:

- Trust your instincts.
- Do not attempt to communicate with your stalker.
- Tell someone.
- Keep records of calls, e-mails, or other communications as evidence.

- Contact local service hotlines and police.
- Obtain a protection order.

Screening Questions for Stalking

Has anyone phoned, paged, written, e-mailed, followed, or watched you or attempted contact with you in other ways that made you afraid or concerned for your safety?

Resources

Policy and Evidence-based Guidelines

American Academy of Pediatrics Committee on Child Abuse and Neglect. The role of the pediatrician in recognizing and intervening on behalf of abused women. *Pediatrics*. 1998;101:1091–1092

Intimate Partner Violence and Healthy People 2010 Fact Sheet. Family Violence Prevention Fund. http://endabuse.org/userfiles/file/HealthCare/healthy_people_2010.pdf

US Advisory Board on Child Abuse and Neglect. *A Nation's Shame: Fatal Child Abuse and Neglect in the United States*. Washington, DC: US Department of Health and Human Services. 1995. <http://ican-ncfr.org/documents/Nations-Shame.pdf>

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Screening Tools

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Web Sites for Physicians' Offices

LEAP (Look to End Abuse Permanently), <http://leapsf.org/html/index.shtml> An organization of healthcare providers and volunteers dedicated to ending intimate partner violence and family violence by establishing screening, treatment, and prevention programs in the health care setting.

Identifying and Responding to Domestic Violence: Consensus Recommendations for Child and Adolescent Health:

(1) http://endabuse.org/section/programs/children_families/_description

(2) <http://www.endabuse.org/userfiles/file/HealthCare/pediatric.pdf>

Developed by the Family Violence Prevention Fund's National Health Resource Center on Domestic Violence, these recommendations are the first of their kind to

address how to assess children and youth for domestic violence, and specifically offer recommendations on assessing adults for victimization with children present.

Violence against Women Online Resources:

<http://www.vaw.umn.edu/categories/I,II>

This site provides materials on domestic violence, sexual assault, and stalking for criminal justice professionals, sexual assault and domestic violence victim advocates, and other multidisciplinary professionals and community partners who respond to these crimes.

Web Sites for National Organizations

Family Violence Prevention Fund (FVPF):

<http://endabuse.org/>

FVPF develops strategies, programs, and resources to stop family violence. Its Web site offers a news desk and prevention toolkits and information on FVPF programs and services in public education, child welfare, immigration, public health, and criminal justice.

Institute on Violence Abuse and Trauma:

www.ivatcenters.org

The institute provides information, networking, training, education, and program evaluation for other agencies, practitioners, and organizations. Provides information on many areas of family violence and sexual assault, maintains a clearinghouse, and publishes a quarterly bulletin.

National Center on Domestic and Sexual Violence

http://www.ncdsv.org/ncd_about.html

This organization helps a myriad of professionals who work with victims and perpetrators; law enforcement; criminal justice professionals such as prosecutors, judges and probation officers; health care professionals including emergency response teams, nurses and doctors; domestic violence and sexual assault advocates and service providers; and counselors and social workers. In addition to these professionals, NCDSV also works with local, state and federal agencies; state and national organizations; educators, researchers, faith community leaders, media community leaders, elected officials, policymakers and others.

National Coalition Against Domestic Violence (NCADV):

<http://www.ncadv.org/aboutus.php>

The mission of NCADV is to work for major societal changes necessary to eliminate both personal and

societal violence against all women and children. This site provides general IPV resources, statistics, action alerts, and materials for victims, including safety plans and protecting your identity.

National Violence Against Women Prevention Research Center (NVAWPRC):

<http://www.musc.edu/vawprevention/>

Sponsored by the Centers for Disease Control and Prevention, this Web site is designed to be useful to scientists, practitioners, IPV advocates, grassroots organizations, and any other professional or layperson interested in current topics related to violence against women and its prevention.

Office on Violence Against Women

<http://www.ovw.usdoj.gov/>

Office on Violence Against Women (OVW) at the U.S. Department of Justice administers financial and technical assistance to communities across the country that are developing programs, policies, and practices aimed at ending domestic violence, dating violence, sexual assault, and stalking.

Web Sites for Adolescents

PromoteTruth.org

Promote Truth provides support and information about sexual violence issues for teens and their communities. Their Web site offers information and online services, including anonymous use of message boards for targeted audiences: teens, parents, teachers, and other professionals.

LoveisRespect.org/

This Web site provides resources for teens, parents, friends and family, peer advocates, government officials, law enforcement officials, and the general public. All communication is confidential and anonymous.

National Teen Dating Abuse Helpline

Launched in February 2007 with help from founding sponsor Liz Claiborne Inc. It is a national 24-hour resource that can be accessed by phone or the Internet and specifically designed for teens and young adults. The helpline and loveisrespect.org offer real-time one-on-one support from trained Peer Advocates. Managed by the National Domestic Violence Hotline, [loveisrespect](http://loveisrespect.org), National Teen Dating Abuse Helpline operates from a call center in Austin, TX. Peer advocates are trained to offer support, information, and advocacy to those involved in

dating abuse relationships as well as concerned parents, teachers, clergy, law enforcement, and service providers.

866/331-9474 | 866/331-8453 TTY

SeeitandStopit.org

Public awareness Web site, maintained by the Teen Action Campaign, offers facts, statistics, and testimony on teen dating violence and provides information on how teens can get help for themselves or a friend and a toolkit for starting a school organization.

Web Sites for Victims

Call to Protect:

<http://www.wirelessfoundation.org/CalltoProtect/index.cfm>

This program distributes wireless phones to help combat domestic violence. The program is a national initiative of the wireless industry and NCADV.

Domestic Violence: National Directory of Professional Services:

<http://www.soros.org/initiatives/justice>

This online directory is an interactive resource that offers contact information for agencies providing services to victims, batterers, or their families. The interactive feature allows users to seek assistance directly from the desktop while browsing the material online.

National Domestic Violence Hotline:

<http://www.ndvh.org/>

800/799-SAFE (800/799-7233)

TTY: 800/787-3224

Staff provides callers with crisis intervention, information about domestic violence, and referrals to local programs 24 hours a day, 7 days a week. Telephone assistance is available in many languages, including Spanish.

Office for Victims of Crime (OVC):

<http://www.ojp.usdoj.gov/ovc/help/dv.htm#l>

Established by the 1984 Victims of Crime Act to oversee diverse programs that benefit victims of crime. The OVC provides substantial funding to state victim assistance and compensation programs.

Social Security Administration—Domestic Violence:

http://www.ssa.gov/pressoffice/domestic_fact.html

The division instructs victims of domestic violence on how to apply for a new Social Security number.

Witness Justice:

<http://www.witnessjustice.org/>

Witness Justice provides trauma victims and their families with resources that promote physical, psychological, and spiritual healing. The site features access to experts, message boards, and other print and electronic victim resources.

Helpline and Web Sites on Stalking

800-FYI-CALL for assistance related to stalking.

Stalking Resource Center:

www.ncvc.org/src

A continually growing resource for practitioners and victims, the Stalking Resource Center Web site provides diverse resources, including fact sheets on federal statutes, an annotated stalking bibliography, summaries of state stalking laws, a guide to online resources, statistical overviews, practitioner profiles, and more.

Violence Against Women

This specialty page will provide you with information on all types of violence against women, including specific resources and information on how to get help.

<http://www.womenshealth.gov/violence/>

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MATERNAL DEPRESSION

In the Bright Futures Guidelines, maternal depression is a priority for anticipatory guidance at the 1-month and 2-month visits, and Bright Futures encourages assessing for maternal depression at the 1-, 2-, and 6-month visits. Given that maternal depression can appear at any time, a sensitive and open approach to identifying and discussing maternal depression in health supervision care is warranted.

What Is Maternal Depression?

Maternal depression describes chronic or acutely depressed women with dependent children. A spectrum of diseases and disease severities exist within maternal depression, including postpartum blues, perinatal depression, postpartum depression, and postpartum psychosis.

Postpartum blues occurs in approximately 70% of women, lasts about 10 days, and typically does not interfere with a woman's ability to function.

Postpartum depression is more persistent and debilitating than postpartum blues. It occurs in approximately 15% of women, may develop insidiously over the first 3 postpartum months or more acutely, and lasts an average of 7 months if left untreated.

Postpartum depression is considered the most common complication of childbearing. Of 4 million births annually, it affects 500,000 women. It often interferes with the mother's ability to care for herself or her child.

The signs and symptoms of postpartum depression are clinically indistinguishable from major depression that occurs in women at other times. They include

- Feeling of sadness or low mood, feeling "down," feeling worthless
- Loss of interest and/or pleasure in usual activities

- Excessive or inappropriate guilt
- General fatigue and loss of energy
- Thoughts of death
- Anxiety, including worries or obsessions about the infant's health and well-being. The mother may have ambivalent or negative feelings toward the infant. She may also have intrusive and unpleasant fears or thoughts about harming the infant.

Postpartum psychosis occurs in 1 to 2 of every 1,000 births and presents within the first 2 weeks of delivery. It is characterized by the acute onset of major disturbances in thinking and behavior, hallucinations, and delusions. It is a psychiatric emergency requiring immediate action because of the risk of suicide and infanticide.

Why Is It Important to Include Maternal Depression in History, Observation, and Surveillance?

Maternal depression is a common and serious problem. Depression is the leading cause of disease burden worldwide among women ages 15 to 44. Epidemiologic and clinical studies suggest that 8% to 12% of mothers may experience postpartum depression, and elevated depressive symptoms may be present in 24% of mothers.

Maternal depression occurs in 10% to 15% of women in the general population. Rates of depressive *symptoms* are reported in 12% to 42%.

It likely has multiple causes. Although the causes of maternal depression are still unclear, it may involve a complex interaction of biochemical, interpersonal, and social factors.

Many women are at risk of developing maternal depression. Women at highest risk are those with a personal or family history of depression, a previous episode of postpartum depression, low income, low level of education, poor maternal health status, or other stressful life events.

It has serious effects on children. Numerous studies over the past 2 decades confirm that maternal depression has negative consequences for children across all ages in crucial areas, such as bonding and emotional development, behavior, mental health, and early brain development. This places a child's healthy development, especially social-emotional development, in potential peril. Thus it is imperative that the mother receive treatment to encourage the child's most optimal development.

Numerous groups have recognized it as a serious health concern and some urge action in primary care settings. Healthy People 2010 identifies depression as one of the 10 most important health concerns in the United States. The President's New Freedom Commission on Mental Health Report confirms that "mental illnesses rank first among illnesses that cause disability in the United States, Canada, and Western Europe" and pose "a serious public health challenge that is under-recognized as a public health burden."¹

Depression has been highlighted by the Agency for Healthcare Research and Quality (AHRQ) and the US Preventive Services Task Force (USPSTF) as needing improved delivery of care. After an extensive review of the research evidence, AHRQ concluded that "good evidence" exists to recommend screening for depression in primary care settings.

How Should You Screen?

Use Informal Methods

- Ask questions, but not simply, "How are you doing?" Be specific in your questions.
 - ▶ The USPSTF recommends 2 questions for brief maternal depression screening:
 - During the past two weeks, have you ever felt down, depressed, or hopeless?*
 - During the past two weeks, have you felt little interest or pleasure in doing things?*
 - ▶ Ask about suicidal ideation.
 - ▶ Ask about resources for support and assistance (eg, family members, child care, financial assistance).
 - ▶ Ask about history of depression.
 - ▶ Ask about other stressors that may have a negative impact (eg, marital problems, substance abuse, domestic abuse).
- Note interactions between the mother and her child.
- Listen. Mothers will talk about their concerns if they feel you are listening without judgment.
- Assure mothers that they are not alone and that there is support if they need it.
- Help mothers meet other mothers and learn about other community resources (eg, support groups).
- Encourage mothers to get the help they might need to be the best mother they can be.

Use Screening Tools

Consider using a standardized screening tool to assess a mother's symptoms. Several formal screening tools exist.

Edinburgh Postpartum Depression Scale (EPDS)

- 10-item questionnaire
- Effective and easy to use
- High scores predict mothers with depression

- In 2 large community-based studies of women up to 12 weeks postpartum, the EPDS had a sensitivity of 93% to 100% and a specificity of 83% to 90% for major depression using a cut-off score of 10 when compared to structured diagnostic interviews.

Other Helpful Depression Screening Tools

- Patient Health Questionnaire (PHQ-2 and PHQ-9)
- Center for Epidemiological Studies Depression Scale (CES-D)
- Beck Depression Inventory (BDI)
- Parenting Stress Index (PSI)

What Should You Do With an Abnormal Result?

Ask whether the mother has a primary care practitioner of her own and gain permission to initiate a conversation with that professional.

Offer to initiate a referral to a mental health professional, support group, or other therapeutic agency. Initiate an immediate referral if the mother shows severe impairment, psychosis, or suicidal ideation. If the depression is significant or prolonged, it may not be sufficient to only refer the mother for therapy. The mother-infant dyad may also need intervention for attachment concerns, in these cases referral to an Early Intervention Program may be appropriate.

Ask to speak with other family members who might be supportive to the mother and provide a list of print and online resources that might be helpful to the mother at risk.

Stress that depression is treatable. Schedule frequent office visits to follow up with the mother and her child(ren).

ICD-9-CM Codes

296.2x	Major depressive episode
300.4	Dysthymic disorder
309.0	Adjustment disorder with mixed anxiety and depressed mood
296.2x or 296.3x	Postpartum depression
296.x4	Mood disorder with psychotic features

The American Academy of Pediatrics publishes a complete line of coding publications, including an annual edition of *Coding for Pediatrics*. For more information on these excellent resources, visit the American Academy of Pediatrics Online Bookstore at www.aap.org/bookstore/.

What Results Should You Document?

Record the EPDS score, the health care professional to whom any referral was made, follow-up plans (for both the mother and the child), and current treatment(s).

Resources

Evidence-based Guidelines

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Evins GC, Theofrastous JP, Galvin SL. Postpartum depression: a comparison of screening and routine clinical evaluation. *Am J Obstet Gynecol*. 2000;182:1080–1082

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Depression Screening Tools

Beck Depression Inventory (BDI)

Center for Epidemiological Studies Depression Scale (CES-D): http://www.hepfi.org/nnac/pdf/sample_cesd.pdf
A link to a PDF sample of the CES-D.

GHI: Providers: Recognizing Postpartum Depression: <http://www.ghi.com/default.aspx?Page=308>
A link to information about postpartum depression and the Edinburgh Postpartum Depression Scale

Patient Health Questionnaire-2 (PHQ-2): http://www.commonwealthfund.org/usr_doc/PHQ2.pdf

Patient Health Questionnaire-9 (PHQ): <http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/>

Web Sites

4Women.gov—The National Women’s Health Information Center: <http://www.4woman.gov/faq/postpartum.htm>

The Center for Postpartum Health: <http://www.postpartumhealth.com/>
Addresses the physical, mental, and emotional needs of pregnant and postpartum women and their families, facilitating the transition from pregnancy to parenthood.

Depression After Delivery: <http://www.depressionafterdelivery.com/Home.asp>
Depression After Delivery is a national nonprofit organization that provides support for women with antepartum and postpartum disorders.

Knowledge Path: Postpartum Depression: http://www.mchlibrary.info/KnowledgePaths/kp_postpartum.html
This knowledge path about postpartum depression has been compiled by the Maternal and Child Health Library at Georgetown University. It offers a selection of current, high-quality resources about the prevalence and incidence of postpartum depression, identification and treatment, impact on the health and well-being of a new mother and her infant, and implications for service delivery.

MedEdPPD.org: <http://www.mededppd.org>
A Web site developed with the support of the National Institute of Mental Health to provide education about postpartum depression.

The Online PPD Support Group: <http://www.ppdsupportpage.com/>
Offers information, support, and assistance to those dealing with postpartum mood disorders and their families, friends, physicians, and counselors.

Postpartum Depression Community: <http://pub30.ezboard.com/bpostpartumdepression>
This Web site is a place for women who are experiencing mood disorders after giving birth or adopting a baby, as well as their families and friends.

Postpartum Education for Parents: <http://www.sbpep.org>
805/564-3888
This organization is run by parent volunteers and offers services and advice for new parents.

Postpartum Support International: <http://www.postpartum.net/>
800/773-6667
This organization offers support and information to those dealing with postpartum depression.

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PARENTAL HEALTH LITERACY

An estimated 90 million Americans have low literacy or trouble understanding and using health information. These individuals may also struggle with the numeracy and problem-solving skills needed to manage their or their family's health. Low health literacy has been linked to poorer patient outcomes and increased emergency department visits and hospitalization. In pediatrics, these problems may be expressed by trouble reading a thermometer, difficulty determining dosing for an over-the-counter medication, or deciding when to seek emergency care. Literacy screening tools exist, but largely for research purposes. The imperative for clinicians is to make health information and services easier to understand and use for all patients and their families and to use techniques, such as "teach back" and "show back," to confirm understanding.

Why Is It Important to Include Parental Health Literacy in History, Observation, Surveillance, and Delivery of Health Information?

Health literacy is defined as the degree to which individuals have the capacity to obtain process and understand basic health information and services needed to make the appropriate health decisions. Parents today have increasing responsibility for their and their family's health and health care. They must be able to adequately understand and act on health information and have the skills to navigate the health care system. This can be challenging for many people, as health care is increasingly complex, with more drugs and treatment options available. What is often missing is clear communication between patients and providers and confirmation of patients' comprehension of key health information.

Most of our families are likely to have some problem understanding and using health information, accessing health services, navigating through the health system,

interacting with health care practitioners, understanding directions on prescription bottles, following a practitioner's instructions, and knowing to seek care in a timely manner. Low health literacy can result in adverse health outcomes.

Low literacy can be difficult to identify. A common barrier in identifying parental problems with literacy is that adults with poor reading skills often feel ashamed and try to hide the problems. As a result, it is often hard for health care professionals to know which of their patient families struggle with low literacy. Our practice should, therefore, like universal precautions in other aspects of medicine, make health information and services easier to understand and use for all of our patients and families.

Although most research in the field of health literacy has focused on adults, pediatric studies are emerging. Health literacy of parents affects common issues, such as their ability to read a thermometer, calculate the proper dose for over-the-counter medication, or mix formula. Health literacy also affects chronic disease management for children.

Should You Assess (Surveillance) and/or Screen Parents for Health Literacy?

Screening for literacy is not standard clinical practice. Many issues need to be addressed before formal screening can be recommended, including an explanation to patients and families regarding the rationale for screening, assurances of confidentiality, and methods for intervention based on screening results. Some research is being done exploring the addition of literacy screening as the “newest vital sign,” but thus far lacks proof for clinical benefit.

Providers may be interested in informal methods to assess parental literacy, but screening does not obviate the need to address how we educate patients and their families.

Informal Literacy Screening

Several informal methods have been used clinically to identify parents with limited literacy skills.

Before the visits, office staff can

- Ask a parent if she or he would like help in completing intake forms.
- Observe the parent filling out the forms.
 - ▶ Does the parent bring someone with them to fill out forms?
 - ▶ Does the parent leave the clinic before completing forms?
 - ▶ Does the parent get angry with having to fill out a form, or ask for help?
- Review the intake forms after they are completed.
 - ▶ How thoroughly is it completed?
 - ▶ Does the parent provide only name, address, and social security number?
 - ▶ Are many words misspelled?

During the visit, check parents’ understanding of the purpose of any medication for their child and its administration. If the parents do not know why they are giving a medication or are confused about how to dose the medication, this probably reflects inadequate health literacy.

Asking parents how far they went in school, talking about difficulties they may have in reading Reach Out and Read books, and gauging their desire to read better also may give you a sense of the parents’ literacy skills; however, this approach will not accurately measure literacy. Educational attainment, though highly correlated with literacy level, cannot adequately predict a person’s reading level or their functional health literacy.

Formal Literacy Screening

Formal literacy screening remains outside standard clinical practice, even though it is vitally important that research continue to inform us about the extent to which parental health literacy affects the well-being of children. Presented here is a listing to familiarize clinicians with the various screening tools. To date there are no instruments that measure the construct of health literacy. Tests that are widely used in health care research assess literacy in a health context. (More detailed descriptions discussed below.)

Rapid Estimate of Adult Literacy in Medicine (REALM)

is a health word recognition test that assesses literacy based on the ability to correctly pronounce the 66 words listed. Scores can be translated into grade ranges. The REALM, which is the most widely used in health research, can be administered and scored in under 3 minutes. It is only available in English. Low test scores have been related to poorer health knowledge and behavior, and worse health outcomes

Test of Functional Health Literacy in Adults (TOFHLA)

is a comprehension test. The full version takes 22 minutes to administer and includes a numeracy section. A shorter version takes approximately 7 minutes. Both versions are available in English and Spanish. Scores indicate an adult has inadequate, marginal, or adequate literacy. Lower scores have been related to poorer health outcomes.

Newest Vital Sign (NVS)

is a “Nutrition Facts” label taken from a pint of ice cream. Patients are asked 6 questions about how they would interpret the label. The screening takes about 7 minutes and is available in English and Spanish. Scores indicate inadequate, marginal, or adequate literacy.

Single Item Literacy Screener (SILS) is a subjective assessment that asks patients a single question: “How often do you need to have someone help you read instructions, pamphlets, or other written material from your doctor or pharmacy?” Patients are asked to respond in terms of a 5-point Likert scale. Such screens may prove helpful in clinical practice and can be administered over the phone.

Research is lacking that might guide how best to use literacy screening in clinical practice. Be sensitive to the shame associated with low literacy, and use care in how this information is recorded on a patient’s chart. Special care is needed in training environments, where care practitioners at all levels of training and experience may have access to a patient’s charts.

It is not known how documentation of parental literacy in a child’s medical record may be used in determining child custody, as adequacy of parental caregiving is often a point of contention in custody battles.

What Should You Do to Address Low Literacy?

Screening is not the solution, and the role of literacy screening has yet to be determined.

Health care professionals need to slow down when giving information and instructions and use a “teach-back” technique to confirm parent understanding. Avoid jargon, use plain language, and limit information to 3 to 4 key points. Communication is improved when the focus is on what parents need to know and do to best care for their child and understand why it is in their child’s best interest. Using pictures and writing brief take-home information also may be helpful.

All patients benefit when health information is made easier to understand. The average US adult reads on a seventh- to eighth-grade level, while health materials are often written on a high school level, and key messages are often buried. Most patient education materials are unnecessarily complicated and based on a medical model, rather than being patient-centered. Ideally, these materials should be written to a fifth- to eighth-grade level and be formatted for reading ease.

When asking parents to teach back or “show me,” providers assume responsibility for clear communication. Ask, “Can you show me how you’re going to give

this medication to your son when you get home? I want to make sure I did a good job explaining this to you.” The teach-back method not only can uncover misunderstanding, but also can reveal the nature of the misunderstanding and thereby allow for corrective, tailored communication.

Before literacy screening becomes part of routine care, it needs to be determined if screening and identifying patients with poor literacy and poor health literacy has an effect on practitioner-patient relationships or improves patient outcomes. Similarly, interventions to mitigate the impact of low literacy need to be tested.

For now, pediatric health care providers need to recognize the widespread nature of health literacy issues and focus on improving health communication for all patients.

Resources

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Other Screening

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TOBACCO DEPENDENCE

The Hooked on Nicotine Checklist (HONC) is a rapid screening tool for identifying tobacco users who could benefit from assistance with cessation. It identifies when a person has become hooked on tobacco, and can be used with anyone using tobacco. The HONC can be used to help patients realize they are hooked. This may motivate them to quit before it becomes more difficult to do so.

Why Is It Important to Include Tobacco Dependence in History, Observation, and Surveillance?

Adolescents are uniquely susceptible to nicotine.

They develop symptoms of dependence very quickly, and they have difficulty quitting smoking. Symptoms of dependence can appear within days of the onset of use, when youths are smoking as little as one cigarette per week. Many youths are hooked before they even think of themselves as smokers.

The age at which youths begin to use tobacco is crucial. Dependence is more severe when use begins during childhood or early adolescence.

Traditional measures of nicotine dependence were developed for adult smokers. They are not sensitive enough to detect the first symptoms of dependence in youths.

Consensus screening recommendations exist. The Public Health Service clinical guideline, *Treating Tobacco Use and Dependence: 2008 Update*, which is endorsed by the American Academy of Pediatrics, provides consensus recommendations to screen pediatric and adolescent patients for tobacco use.

A tobacco screening tool has been developed specifically for use with adolescents. Nicotine dependence can be identified as soon as a smoker has developed any symptom that presents a barrier to

quitting. When quitting requires an effort, the smoker has lost some degree of autonomy over his or her tobacco use. The loss of autonomy is the central feature of dependence.

The HONC is the first measure developed specifically to identify nicotine dependence in youths by measuring their loss of autonomy over tobacco use.

The HONC has strong psychometric properties as evaluated in multiple studies of youths and adults. In a 30-month prospective study of the natural history of tobacco use in a cohort of 679 seventh-grade students, youths who answered yes to one or more items on the HONC were 44 times more likely to be smoking at the end of the study than were smokers who had no positive responses.¹

The effectiveness of the HONC, or any other tobacco dependence screening tools, in clinical practice has not yet been formally evaluated, although anecdotal reports support its usefulness for screening in clinical settings.

How Should You Screen for Tobacco Dependence?

Administer the HONC either through an interview during an office visit or as part of a self-administered health history form. For users of smokeless tobacco, substitute the word “chew” for “smoke” as appropriate.

The Hooked on Nicotine Checklist		
	Yes	No
1. Have you ever tried to quit smoking, but couldn't?		
2. Do you smoke now because it is really hard to quit?		
3. Have you ever felt like you were addicted to tobacco?		
4. Do you ever have strong cravings to smoke?		
5. Have you ever felt like you really needed a cigarette?		
6. Is it hard to keep from smoking in places where you are not supposed to, like school?		
7. When you tried to stop smoking... (or, when you haven't used tobacco for a while...)		
a. Did you find it hard to concentrate because you couldn't smoke?		
b. Did you feel more irritable because you couldn't smoke?		
c. Did you feel a strong need or urge to smoke?		
d. Did you feel nervous, restless, or anxious because you couldn't smoke?		

How Should You Score and Interpret the HONC?

Scoring the HONC

Score the HONC by counting the number of “yes” responses. The number of symptoms a patient endorses, or says yes to, serves as a measure of the extent to which autonomy has been lost. The average HONC score for adolescents who do not smoke every day is 4, while that for adult daily smokers is 7. It is important to note that a score that is below average for the patient’s age group is NOT an indication that the patient is not dependent.

Patients who score a zero on the HONC by answering “no” to all 10 questions enjoy full autonomy over their use of tobacco. Because each of the 10 symptoms measured by the HONC has face validity as an indicator of diminished autonomy, patients can be informed that they are hooked if they endorse any symptom.

Interpreting HONC Results

An autonomous smoker can quit without effort or discomfort, just as it takes no effort to stop eating spinach for a day. Autonomy is diminished when there is an obstacle to overcome or a price to be paid for quitting. Each question on the HONC addresses some aspect of diminished autonomy over tobacco.

- Have you ever tried to quit smoking but couldn't?*

A failed cessation attempt is an obvious indication of diminished autonomy. If quitting was effortless, the patient would no longer be smoking.
- Do you smoke now because it is really hard to quit?*

This item is included to capture those who do not want to smoke but have not made an “official” effort to quit, often out of a fear of failure. Because they are doing something they don't want to do, they have diminished autonomy.
- Have you ever felt like you were addicted to tobacco?*

A person with full autonomy over his or her tobacco use would not feel addicted.
- Do you ever have strong cravings to smoke?*

Strong cravings, a symptom of addiction, make quitting difficult and unpleasant.
- Have you ever felt like you really needed a cigarette?*

Smokers feel they really need a cigarette because of cravings, withdrawal symptoms, or psychological dependence. Whatever the reason, quitting is more difficult and autonomy is diminished.
- Is it hard to keep from smoking in places where you are not supposed to, like school?*

An autonomous smoker would have no difficulty refraining from smoking, especially where it is forbidden.

7. *When you tried to stop smoking... OR When you haven't used tobacco for a while...*
- Did you find it hard to concentrate because you couldn't smoke?*
 - Did you feel more irritable because you couldn't smoke?*
 - Did you feel a strong need or urge to smoke?*
 - Did you feel nervous, restless, or anxious because you couldn't smoke?*

All of these questions get at withdrawal symptoms, which make quitting unpleasant and more difficult. A person experiencing these symptoms has diminished autonomy.

What Results Should You Document?

Record the patient's total HONC score. Note any symptoms endorsed, as these should be addressed during cessation counseling.

CPT and ICD-9-CM Codes	
305.1	Tobacco use disorder/tobacco dependence
99406	Smoking and tobacco use cessation counseling visit; intermediate, >3 minutes up to 10 minutes.
99407	Intensive, >10 minutes

The American Academy of Pediatrics publishes a complete line of coding publications, including an annual edition of *Coding for Pediatrics*. For more information on these excellent resources, visit the American Academy of Pediatrics Online Bookstore at www.aap.org/bookstore/.

These behavior change intervention codes are reported when the service is provided by a physician or other qualified health care professional. The service involves specific validated interventions, including assessing readiness for change and barriers to change, advising change in behavior, providing specific suggested actions and motivational counseling, and arranging for services and follow-up care. The medical record documentation must support the total time spent in performing the service, which may be reported in addition to other separate and distinct services on the same day.

Resources

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Screening Instruments

The HONC is available at <http://whyquit.com/whyquit/LinksYouth.html>. It is available in several languages.

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