



Adolescent Health

Toolkit for Providers



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INTRODUCTION

LETTER FROM JENNIE PINKWATER, ICAAP EXECUTIVE DIRECTOR

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The Illinois Chapter of the American Academy of Pediatrics (ICAAP) makes it a priority to address the needs of children and families through advocacy and education. When it comes to addressing health issues and behavior change, focusing specifically on adolescent health needs is a must. The transition from childhood to adulthood is one of the most dynamic and best times for engagement in human development. The rate to which physical, emotional, and intellectual changes are occurring during the adolescent stage provides an opportunity to positively impact health outcomes. It is essential to adolescents' health that their independence is built upon a strong foundation to invest in their future as healthy adults.

As part of a four-year project, ICAAP was awarded funding from the Illinois Department of Public Health, Adolescent Health Program, to address the state's adolescent health needs through educational resources and tools. Through this grant, we developed this educational guide for providers, parents, and teens to utilize. We are proud to serve those in Illinois working towards optimal health outcomes for children and youth!

Best Wishes,

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ABOUT

The Illinois Chapter of the American Academy of Pediatrics was awarded funding from the Illinois Department of Public Health, Office of Women's Health and Family Services from 2018 to 2022 to support adolescent health services in Illinois. The purpose of the Illinois Adolescent Health Program is to empower adolescents to adopt healthy behaviors and improve the overall health of adolescents by increasing the rate and quality of adolescent well-care visits.

The American Academy of Pediatrics and Bright Futures recommend annual well-care visits during adolescence. Annual well-care visits during adolescence promote healthy behaviors, prevent risky ones, and detect conditions that can interfere with physical, social, and emotional development.

ICAAP developed this two-part toolkit for pediatric providers, adolescents, and parents/caregivers to improve the effectiveness of adolescent well visits. This toolkit includes tools and resources on adolescent health issues, health equity, the pandemic impact, and implementation strategies to empower youth to take control of their health care.

Funding provided in whole or in part by the Illinois Department of Public Health.

PROJECT WORK GROUP INVOLVEMENT

ICAAP wishes to thank members of the Adolescent Health project planning group for their knowledge and expertise on this project, including:

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HOW TO USE THIS TOOLKIT

This toolkit focuses on the needs of adolescents, best practices, screening tools, education, and resources to address common needs and concerns of adolescents and their families.

The aim is to increase the rates and quality of adolescent well visits for youth ages 11 to 21 years.

There are two sections in this toolkit:

+ PROVIDERS

This toolkit is intended to be a resource for you and your clinical team with updated information regarding best practices in adolescent health, common topics that may be important to your patients, and additional resources and support.

+ TEENS

Use the teen section of this toolkit to prepare for appointments with your primary care provider, understand your rights in a healthcare setting, and be prepared to take charge of your own medical care.

Disclaimer:

Views expressed (and resources listed) are not necessarily those of ICAAP, the planning committee, or staff. They are included for providers, adolescents, and families to review and implement as appropriate for their individual needs.

SURVEY RESULTS

In 2019, ICAAP conducted an adolescent health survey among members. There were 102 respondents for a 5.3% response rate. Response rates varied question.

Survey results showed: **99%** (n=79/80) of survey respondents reported they serve an adolescent population, ages 12–16. Only **18%** (n=13/72) of respondents stated that more than half of their adolescent patients had received an annual health supervision visit in the previous year.

KEY FINDINGS

Adolescent mental health support was a common concern among providers:

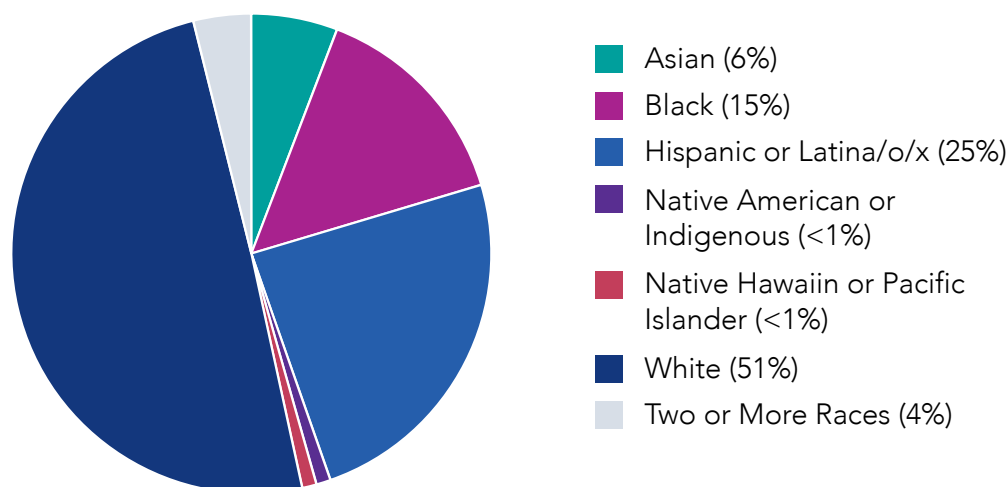
- ▶ **94%** (n=68/72) responded that mental health issues were most impacting adolescents in their area
- ▶ **96%** (n=69/72) responded that mental health issues were most common in their patients
- ▶ **86%** (n=61/71) noted that mental health services were lacking in their area
- ▶ **68%** (n=48/70) indicated a lack of clinical resources for adolescent behavioral health
- ▶ **97%** (n=69/71) responded that emotional well-being of their adolescent patients was impacted due to the COVID-19 pandemic
- ▶ **53%** (n=37/69) indicated that the best form of communication with teens about their well visits is through text or patient portal (technology)
- ▶ **66%** (n=45/68) responded that parent resiliency is lacking in their patient population

In addition, **41%** (n=28/69) of providers reported promoting adolescent health education by marketing in their practices, **38%** (26/69) promote via social media, and **38%** (26/69) promote through school partnerships.

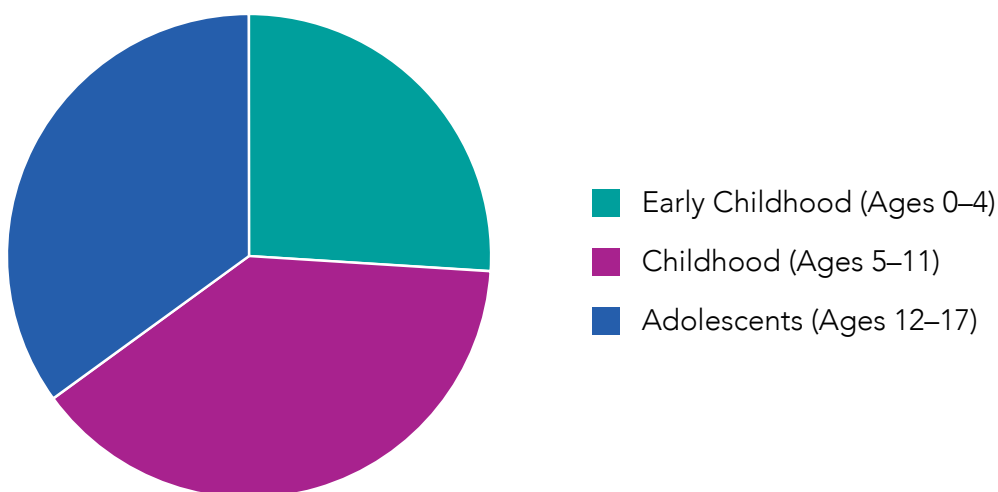
THE ADOLESCENT POPULATION IN ILLINOIS

Based on 2020 Census Data¹, data provided from the Annie E. Casey Foundation², and the 2021 High School Youth Risk Behavior Surveillance System.³

Race/Ethnicity of Children in Illinois



Adolescents Make Up About a Third of Children in Illinois



REFERENCES

¹ [United States Census Bureau, Illinois: 2020 Census.](#)

² [Kids COUNT Data Center, Illinois.](#)

³ [Centers for Disease Control and Prevention \(CDC\), High School YRBS, Illinois 2021.](#)

DATA AT A GLANCE

CHILDREN UNDER THE AGE OF 18 MAKE UP 22% OF THE TOTAL ILLINOIS POPULATION

Economic Need Indicators

- ▶ In the 2019–2020 academic year, **12%** of Illinois high schoolers did not graduate on time
- ▶ **6%** of adolescents age 16 to 19 in Illinois are not working or attending school
- ▶ The **median family income** among households with children in Illinois is \$83,907
- ▶ **7%** of parents in Illinois are unemployed

Mental Health

- ▶ **21%** of children under 17 in Illinois have one or more emotional, behavioral or developmental conditions
- ▶ **42.1%** of Illinois high schoolers report that they felt sad or hopeless almost every day for 2 or more weeks in a row so that they stopped doing usual activities
- ▶ **20.3%** of Illinois high schoolers seriously considered suicide, 17% made a plan about how they'd attempt suicide, and 8.4% made a suicide attempt
- ▶ **30%** of high schoolers in Illinois reported that their mental health was most of the time or always not good

Social Media/Technology

- ▶ **39.2%** of high schoolers in Illinois report texting or emailing while driving a car or other vehicle
- ▶ **17.6%** of high school students in Illinois were electronically bullied
- ▶ **73.3%** of high school students spent 3 or more hours a day on screen time

Tobacco Use

- ▶ **38%** of teens report ever using electronic vapor products, such as e-cigarettes, vape pens, hookah pens, JUUL, etc.) and 16.7% report currently using these products
- ▶ **2.5%** of high schoolers report cigarette use
- ▶ Among high school students who use tobacco products, including electronic vapor products, nearly half (**48.8%**) report never trying to quit

Alcohol & Other Drug Use

Of high schoolers in Illinois:

- ▶ **13%** had their first drink of alcohol before age 13
- ▶ **22.8%** report currently drinking alcohol
- ▶ **11.6%** report current binge drinking
- ▶ **5%** tried marijuana (also called pot or weed) before age 13
- ▶ **15.1%** report current marijuana use
- ▶ **9.5%** report ever using prescription pain medicine without a doctor's prescription or differently than it was prescribed to them
- ▶ **6.7%** report ever using inhalants, such as sniffing glue, breathing the contents of aerosol spray cans, or inhaling paints or sprays to get high
- ▶ **20.7%** report being offered, sold, or given an illegal drug on school property

Sexual Behaviors

- ▶ Of high schoolers in Illinois: **27.5%** report that they have ever had sexual intercourse and **18.3%** report that they were currently sexually active
- ▶ Among students who were sexually active, **75.3%** did not use birth control pills to prevent pregnancy before last sexual intercourse with an opposite sex partner (not including emergency contraception) and **13.9%** did not use any method to prevent pregnancy

- ▶ Over **94%** were never tested for HIV or a sexually transmitted disease other than HIV

Violence

Of high schoolers in Illinois:

- ▶ **16.6%** report having been in a physical fight one or more times in the last year
- ▶ **3.8%** report carrying a weapon on school property at least once in the last 30 days
- ▶ **22.7%** report ever having seen someone get physically attacked, beaten, stabbed, or shot in their neighborhood
- ▶ **12.2%** report that they did not go to school because they felt unsafe at school or on their way to/from school in the last 30 days
- ▶ **11.6%** report having experienced sexual violence in the last year and **8.8%** report being physically forced to have sexual intercourse
- ▶ Of students who had dated someone in the last year, **7.8%** report sexual violence from someone they were dating and **7.4%** reported physical violence from someone they were dating

DEFINE THE POPULATION

The AAP defines the stages of adolescence as follows:⁴

EARLY ADOLESCENCE

(Ages 10 to 13)

During this stage, children often start to grow more quickly. They also begin to notice other body changes, including hair growth under the arms and near the genitals, breast development in females and enlargement of the testicles in males. These changes usually start a year or two earlier in girls than boys, and it can be normal for some changes to start as early as age 8 for females and age 9 for males. Many girls may start their period at around age 12, on average 2–3 years after the onset of breast development.

These body changes can inspire curiosity and anxiety in some adolescents especially if they do not know what to expect or what is normal. Some children may also question their gender identity at this time, and the onset of puberty can be a difficult time for children questioning their gender.

Early adolescents have concrete, black-and-white thinking. Things are either right or wrong, great or terrible, without much room in between. It is normal at this stage for young people to center their thinking on themselves (called “egocentrism”).

As part of this, preteens and early teens are often self-conscious about their

appearance and feel as though they are always being judged by their peers.

Pre-teens feel an increased need for privacy. They may start to explore ways of being independent from their family. In this process, they may push boundaries and may react strongly if parents or guardians reinforce limits.

MIDDLE ADOLESCENCE

(Ages 14 to 17)

Physical changes from puberty continue during middle adolescence. Most males will have started their growth spurt, and puberty-related changes continue. They may have some voice cracking, for example, as their voices lower. Some develop acne. Physical changes may be nearly complete for females, and most girls now have regular periods.

At this age, many teens become interested in romantic and sexual relationships. They may question and explore their sexual identity which may be stressful if they do not have support from peers, family, or community. Another normal way of exploring sex and sexuality for teens of all genders is self-stimulation, also called masturbation.

REFERENCES

4 Reproduced with permission from the American Academy of Pediatrics, Brittany Allen, MD, FAAP; Helen Waterman, DO, [American Academy of Pediatrics \(AAP\), HealthyChildren.org: Stages of Adolescence](https://www.healthychildren.org/About-Adolescence/Pages/HealthyChildren.org-Stages-of-Adolescence.aspx), [HealthyChildren.org](https://www.healthychildren.org/About-Adolescence/Pages/HealthyChildren.org-Stages-of-Adolescence.aspx), Published March 28, 2019, Accessed June 2021, Copyright © 2019 by the AAP.

Many middle adolescents have more arguments with their parents as they struggle for more independence. They may spend less time with family and more time with friends. They are very concerned about their appearance, and peer pressure may peak at this age.

The brain continues to change and mature in this stage, but there are still many differences in how a normal middle adolescent thinks compared to an adult. Much of this is because the frontal lobes are the last areas of the brain to mature and development is not complete until a person is well into their 20s! The frontal lobes play a big role in coordinating complex decision making, impulse control, and being able to consider multiple options and consequences.

Middle adolescents are more able to think abstractly and consider “the big picture,” but they still may lack the ability to apply it in the moment. For example, in certain situations, kids in middle adolescence may find themselves thinking things like:

- ▶ *“I’m doing well enough in math and I really want to see this movie... one night of skipping studying won’t matter.”*
- ▶ *“Do I really have to wear a condom during sex if my girlfriend takes the pill?”*
- ▶ *“Marijuana is legal now, so it can’t be that bad.”*

While they may be able to walk through the logic of avoiding risks outside of these situations, strong emotions often continue to drive their decisions when impulses come into play.

LATE ADOLESCENTS

(18 to 21... and beyond!)

Late adolescents generally have completed physical development and grown to their full adult height. They usually have more impulse control by now and may be better able to gauge risks and rewards accurately. In comparison to middle adolescents, youth in late adolescence might find themselves thinking:

- ▶ “While I do love Paul Rudd movies, I need to study for my final.”
- ▶ “I should wear a condom...even though my girlfriend is on birth control, that’s not 100% in preventing pregnancy.”
- ▶ “Even though marijuana is legal, I’m worried about how it might affect my mood and work/school performance.”

Teens entering early adulthood have a stronger sense of their own individuality now and can identify their own values. They may become more focused on the future and base decisions on their hopes and ideals.

Friendships and romantic relationships become more stable. They become more emotionally and physically separated from their family. However, many reestablish an “adult” relationship with their parents, considering them more an equal from whom to ask advice and discuss mature topics with, rather than an authority figure.



CALL TO ACTION: THE UNIQUE NEEDS OF ADOLESCENTS

Adolescence is a critical period of physical and cognitive development and change, during which time key areas of the brain are still developing and maturing. These changes in brain structure, function, and connectivity make adolescence the opportune time to explore one's developing identity, form relationships with peers and adults, and navigate social and societal situations that will challenge the decisions they make. Routine, comprehensive clinical health supervision visits are important in addressing the needs of this unique and vulnerable population to help them navigate through their transition to adulthood. Adolescents comprise about 25% of the US population, which makes investing in them the key to a more promising future.

CLIMATE OF ADOLESCENT HEALTH CARE

Despite solid evidence demonstrating the benefits of clinical preventive services, most adolescents and young adults in the US do not receive the recommended services needed to support their optimal health. Fewer than half of adolescents (ages 13–18) and even fewer young adults (ages 19–26) have had regular preventive visits. However, when these preventive visits do occur, many young people report that they lack one-on-one confidential discussions with their pediatrician or other clinician. Professional

guidelines regarding adolescent preventive care recommend that youth have access to confidential services, an essential component of comprehensive care for this age group.

BRIGHT FUTURES GUIDELINES

The American Academy of Pediatrics (AAP) Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th Edition, recommend that youth start having confidential, one-on-one time with their pediatrician during early adolescence.

Bright Futures Guidelines, 4th Edition, convened⁵ multidisciplinary expert panels for the age stages of infancy, early childhood, middle childhood, and adolescence. Each panel was co-chaired by a pediatrician content expert and a panel member who represented family members or another health profession. The 39 members of the expert panels were individuals who represented a wide range of disciplines and areas of expertise, including mental health experts, nutritionists, oral health practitioners, family medicine professionals, nurse practitioners, family and school representatives, and members of AAP national committees with relevant expertise.

One component of the Bright Futures Guidelines, 4th Edition, is the Periodicity

REFERENCES

⁵ American Academy of Pediatrics (AAP), [Investing in Adolescent and Young Adult Health: Pediatricians, Parents, and Youth Working Together to Improve Lifelong Health](#).

Schedule, a tool describing which preventive services and screenings should be delivered at each of 32 well visits from prenatal to 21 years of age. In 2018, it was mandated by law that health insurances offering group or individual health insurance coverage are required to cover the services and screenings listed.

Bright Futures Guidelines, 4th Edition, recommends that adolescent and young adult health supervision visits include discussions related to:

- ▶ Physical growth and development
- ▶ Social and academic competence
- ▶ Emotional well-being
- ▶ Risk reduction
- ▶ Violence and injury prevention

In order to ensure that the needs and health of the adolescent or young adult patient are met, pediatricians should:

Protect the patient's confidentiality

- ▶ Incorporate recommended screening results into anticipatory guidance conversations
- ▶ Support adolescent patients in taking responsibility for their own health care
- ▶ Provide a supportive, open, and nurturing environment to foster autonomy

Bright Futures Guidelines, 4th Edition, recommends that pediatricians take a strength-based approach to partnering with adolescents and parents. Pediatricians

can work with parents and adolescents to identify their strengths and use shared decision-making and motivational interviewing techniques to develop a plan for positive behavior change.

ROLE OF A PHYSICIAN

BUILD AN ADOLESCENT-SUPPORTIVE PRACTICE ENVIRONMENT

In order to best support adolescent and young adult patients, pediatric offices should work to adopt a culture that reflects the unique needs of this population and reduces barriers that may interfere with adolescents and young adults accessing essential health care services. A practice that adopts this culture is called an adolescent-supportive practice.

Some strategies for fostering an adolescent-supportive practice environment include:

- ▶ Develop a written office policy about adolescent confidentiality (Note: to help ensure parents, adolescents, and young adults are aware of the policy, consider posting it in a visible location in the office, and/or sending it directly to patients and families via email or mail)
- ▶ Ensure that confidential, one-on-one time is a standard part of all adolescent and young adult clinical visits
- ▶ Train all clinical and office staff in adolescent confidentiality practices

- ▶ Train all clinical and office staff in ways to welcome and speak with adolescent patients
- ▶ Offer extended clinical hours in the evenings and on weekends to allow adolescents and young adults to access care after school or work hours
- ▶ Display brochures/resources about common adolescent health concerns in the office
- ▶ Create a waiting room for teens that has age-appropriate decorations, magazines, and media
- ▶ Ensure the office environment is LGBTQ+ inclusive (Note: some strategies for supporting inclusivity include using clinical forms and questionnaires that allow patients to write-in their own gender and allowing for differentiation between the sex assigned to a patient at birth and their affirmed gender)
- ▶ Normalize confidential, one-on-one discussions with adolescents and young adults as a part of routine clinical care
- ▶ Discuss office privacy and confidentiality practices during every visit, with both the patient and their parent in the room
- ▶ Include parents in the non-confidential aspects of adolescent and young adult care
- ▶ Focus on the adolescent or young adult as the primary patient (Note: some easy ways to do this are to address questions directly to the teen, and to make eye contact during screening and counseling discussions. Patients 18 years and older must authorize parental involvement.)
- ▶ Ask parents to step out of the room for confidential discussions
- ▶ Use one-on-one time to discuss important health issues, including potentially sensitive topics
- ▶ Screen for the health topics recommended by Bright Futures Guidelines, 4th Edition and provide brief counseling and referrals to local resources when appropriate
- ▶ Choose language that is LGBTQ+ inclusive, like using the patient's preferred name and pronouns
- ▶ Understand Illinois laws around confidentiality and age of consent

PROVIDE ADOLESCENT-SUPPORTIVE CARE

In addition to building a supportive environment, it is important that pediatricians and other clinicians also provide adolescent-supportive care during clinical visits. Providing supportive care during adolescent and young adult visits helps to build a trusting relationship and foster open discussion about health, wellness, and potentially sensitive topics. Some strategies for providing adolescent-supportive care include:

ILLINOIS POLICIES ON THE ABILITY FOR MINORS TO CONSENT FOR MEDICAL SERVICES⁶

General Medical Care:

If 14 years of age and older and emancipated, understands benefits and risks, identified by a listed representative, or married, pregnant or a parent

Immunizations:

Yes, if 12 years old or older for HPV or Hep B

Dental Care:

Emergency dental care

Sexual Assault Evaluation:

Yes

STI Testing and Treatment:

Yes, if 12 years of age or older*

HIV Testing and Treatment:

Yes, if 12 years of age or older*

Contraceptive Care:

Yes, if married, a parent, pregnant or ever pregnant, or referred

Prenatal Care:

Yes

Substance Abuse Treatment:

Yes, if 12 years of age or older

Mental Health Care:

Yes, if 12 years of age or older, 16 or older for inpatient*

*parent/guardian may be informed

REFERENCES

⁶ [State-by-State Variability in Adolescent Privacy Laws, Pediatrics, Volume 149, Issue 6, June 2022.](#)

Additional AAP resources, including demonstrations, can be found at [Adolescent Health Care Campaign Toolkit](#)⁷ and are updated frequently.

Adolescence is a very important developmental stage filled with health opportunities yet accompanied with health-related risks. Established health behaviors pave the way towards adult health, productivity, and longevity. Adolescents who thrive have access to caring adults that foster healthy development and are offered meaningful opportunities that build competencies and abilities. This is an opportunity for providers and healthcare professionals to prevent health-related issues and illness and guide them towards successful assets in their communities.

Throughout this toolkit, evidence-based practices were researched to identify, reduce, and prevent dependence on risky behavior in adolescents. Therefore, tools such as Screening, Brief Intervention, and Referral to Treatment (SBIRT) will be referenced when addressing the health issues adolescents may face. We have summarized integrating screening to streamline the process, considering ways to assess the health topic, evaluating the need at hand and ensuring compliance through follow up.

The main health topics identified from this needs assessment survey and addressed in this toolkit are:

- ▶ Mental and Behavioral Health
- ▶ Tobacco and Substance Use
- ▶ Violence and Injury Prevention
- ▶ Sexual Health and Gender Identity
- ▶ Nutritional Health
- ▶ Adolescents with Special Care Needs

REFERENCES

7 American Academy of Pediatrics (AAP), [Adolescent Healthcare Toolkit](#).



Mental & Behavioral Health

MENTAL & BEHAVIORAL HEALTH

Adolescence is a unique and formative time. Multiple physical, emotional, and social changes, including exposure to poverty, abuse, or violence, can make adolescents vulnerable to mental health problems.⁸

This can have a great impact during their rapid development and brain growth. Promoting psychological well-being and protecting adolescents from adverse experiences and risk factors that may impact their potential to thrive are critical for their well-being during adolescence and for their physical and mental health in adulthood.

MENTAL HEALTH AGE OF CONSENT⁹

In Illinois, minors age 12 or older can consent to up to eight 90-minute sessions of outpatient counseling or psychotherapy without consent of a parent or guardian.

There is no limit on the number of sessions for those 17 years of age or older. A minor 16 years of age or older may consent to admission to a mental health facility for inpatient services if they execute the application for voluntary admission.

Unlike outpatient services, providers must immediately inform the minor patient's parent or guardian, even if the minor does not consent to the disclosure.

ILLINOIS TEENS & MENTAL HEALTH¹¹

- ▶ **21%** of children under 17 in Illinois have one or more emotional, behavioral or developmental conditions¹⁰
- ▶ **42.1%** of Illinois high schoolers report that they felt sad or hopeless almost every day for 2 or more weeks in a row so that they stopped doing usual activities¹¹
- ▶ **20.3%** of Illinois high schoolers seriously considered suicide¹¹
- ▶ **17%** made a plan about how they'd attempt suicide¹¹
- ▶ **8.4%** made a suicide attempt¹¹
- ▶ **30%** of high schoolers in Illinois reported that their mental health was most of the time or always not good¹¹

REFERENCES

8 World Health Organization (WHO), [Mental Health of Adolescents](#).

9 Illinois Health and Hospital Association, [Consent by Minors to Medical Treatment](#).

10 Kids COUNT Data Center, [Illinois](#).

11 Centers for Disease Control and Prevention (CDC), [High School YRBS, Illinois 2021](#).



CONSIDERATIONS PRIOR TO VISIT

- ▶ Make every effort to create a safe, non-judgmental, and supportive environment so that your adolescent patients will be open to discussing their feelings and behaviors. Consider including indicators that you are a safe space for LGBTQ+ patients. In a [National Survey](#)¹², 60% of LGBTQ+ adolescents who wanted mental health care said they were unable to access it¹¹
- ▶ Consider reviewing [Illinois Doc Assist](#)¹³ for answering primary care behavior health questions related to children, adolescent and perinatal mental health
- ▶ Identify billing codes to seek reimbursement for mental health services provided by PCPs
- ▶ Are you maintaining an updated mental health referral list? Consider telepsychiatry in more remote areas

REFERENCES

12 The Trevor Project, [2022 National Survey on LGBTQ Youth Mental Health](#).

13 [Illinois Doc Assist](#).

INTEGRATING SCREENING INTO PRACTICE

At selected visits, Bright Futures recommends universal screening for developmental concerns, behavioral/social/emotional concerns, maternal depression, adolescent depression and suicide risk, substance use, or oral health concerns. A number of screening tools have been developed and are commonly used. The [Bright Futures Toolkit](#)¹⁴ provides a list of links to tools for use at specific Bright Futures visits as well as screening and assessment tools for use at the discretion of the health care professional.

The American Academy of Pediatrics does not approve nor endorse any specific tool for screening purposes. This list is not exhaustive, and other screening tools may be available. For best results, it is recommended that users review available instruction manuals before administering, scoring, and analyzing results of the scoring tools. Availability of a tool in multiple languages does not correlate to validation of the tool in such languages.

BEHAVIORAL/ SOCIAL/EMOTIONAL SCREENING TOOLS FOR ADOLESCENTS

Pediatric Symptom Checklist (PSC) age range: 4 to 16 years

A brief screening questionnaire used by pediatricians and other health professionals to recognize psychosocial problems and improve treatment in children. Translations available.

Strengths & Difficulties Questionnaires (SDQ) age range: 2 to 17 years

The SDQ is a brief psychological assessment tool for 2 to 17-year-olds. It exists in several versions to meet the needs of researchers, clinicians, and educators. Translations available.

REFERENCES

14 American Academy of Pediatrics (AAP), [Bright Futures Toolkit: Links to Commonly Used Screening Instruments and Tools](#).

DEPRESSION AND SUICIDE RISK SCREENING TOOLS FOR ADOLESCENTS

PHQ-9 Modified for Teens (PHQ-A) **age range: 11 to 17 years**

A version of the PHQ-9 Modified for Teens is available in the Guidelines for Adolescent Depression in Primary Care Toolkit (in multiple languages).

Another sample of the PHQ-9 Modified for Teens is available through the Community Care of North Carolina.

Ask Suicide-Screening Questions (ASQ) **age range: 8 and older**

The Ask Suicide-Screening Questions (ASQ) tool is a set of four brief suicide screening questions that takes 20 seconds to administer.

Columbia-Suicide Severity Rating Scale (C-SSRS)

The Columbia Protocol, also known as the Columbia-Suicide Severity Rating Scale (C-SSRS), supports suicide risk assessment through a series of simple, plain-language questions that anyone can ask. The answers help users identify whether someone is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support that the person needs.

Patient Safety Screener (PSS-3)

The Patient Safety Screener is designed to screen for non-negligible risk and provide initial stratification for those with non-negligible risk into mild, moderate, or high risk. It can be used as a single, nine-item instrument. In addition, the first three items (the PSS-3) and the final six items (the ED-SAFE Secondary Screener, or ESS) can be used separately.

ASSESS

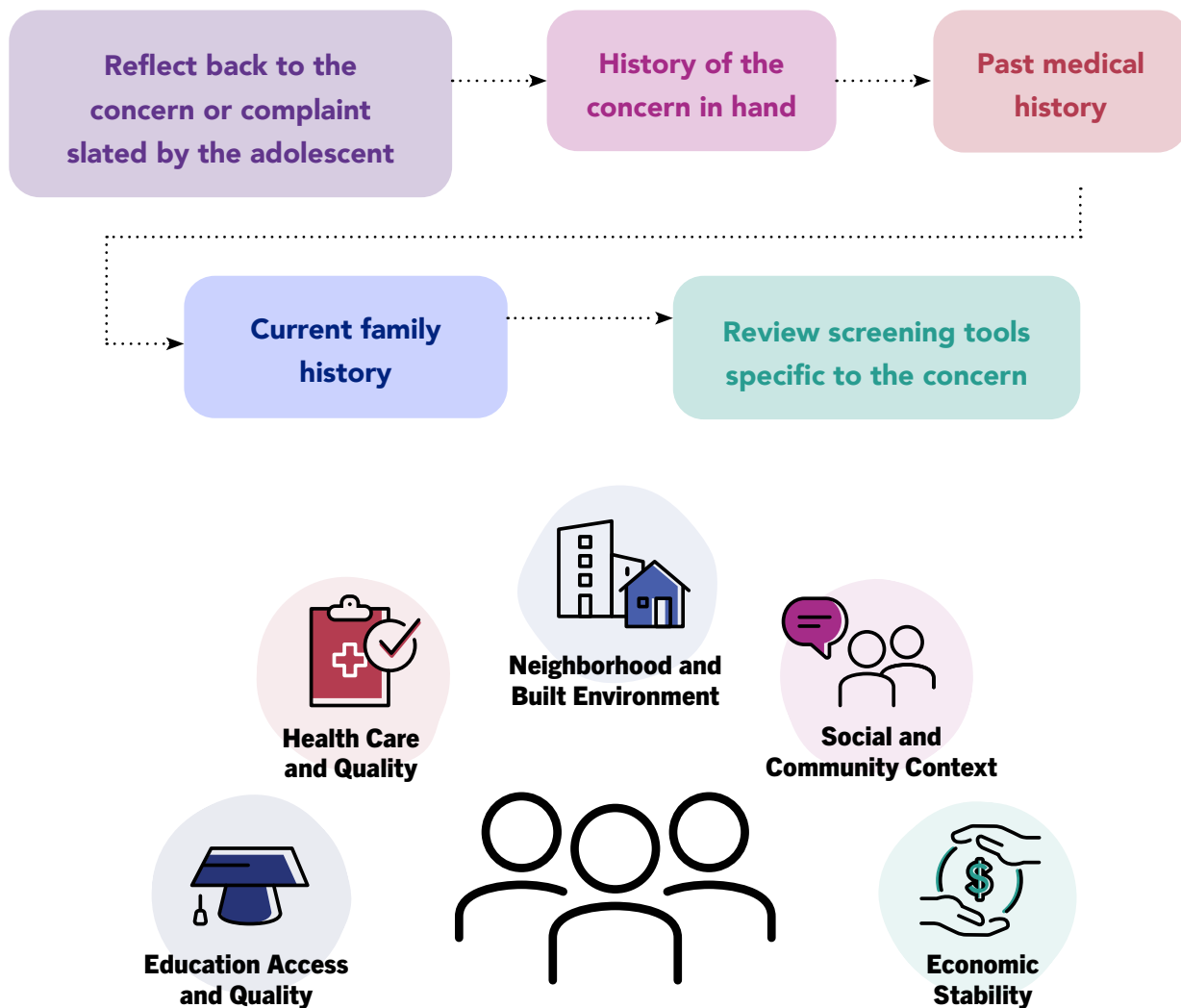
**Remember to reduce stigma—
use neutral terminologies such as:**

Coping skills
Counseling
Stress

Rather than saying:

Problems
Illness

When referring to mental health specialists, state they are behavioral health providers, and ensure confidentiality between you and the patient. Below is a workflow of discussion with an adolescent patient about mental health:



When navigating the workflow discussion with a patient, consider what impact the social determinants of health may have when it comes to problem solving.

REFERENCES

15 Image adapted from: <https://www.cdc.gov/publichealthgateway/sdoh/index.html>.

EVALUATE

- ▶ Provide screening tool to patient and refer as needed
- ▶ Review the risk factors (may re-evaluate what was reviewed from social determinants of health)

FOLLOW UP

- ▶ Set expectations
- ▶ Prioritize the protective factors to build resiliency and build upon their assets
- ▶ Review key takeaways from this appointment
- ▶ Know the variety of resources for Illinois and nationally. Some helpful resources are listed at right



IDPH: Violence Prevention and Support Resources

This document provides a list of violence prevention and support resources available to communities.

Illinois Call4Calm Text Line (24/7)

A free emotional support text line. Text TALK to 552020 or HABLAR for service in Spanish.

Illinois CARES Line (24/7)

Parents can call the Crisis and Referral Entry Services line 1-800-345-9049 to talk to a mental health professional if they feel their child is a risk to themselves or others, having a mental health crisis, or the parent would like a referral to services for children, youth, and families.

Suicide Prevention Hotline

Free and confidential support for individuals experiencing a mental health crisis or their loved ones, available 24-hours a day 7-days a week, 1-800-273-8255 (TALK).

Crisis Text Line

Free and confidential support for individuals in crisis available 24 hours a day 7 days a week. Text HELLO to 741741 or visit www.crisistextline.org.

National Helpline | SAMHSA— Substance Abuse and Mental Health Services Administration

Free and confidential treatment referral and information service available 24 hours a day 7 days a week, 1-800-622-4357 (HELP).

A close-up photograph of a person wearing a dark hoodie, exhaling a large plume of white smoke from a pipe. The person's eyes are closed, and the smoke is thick and billowing. The image is overlaid with a semi-transparent purple and blue gradient.

Tobacco & Substance Use

SURVEY DATA: ILLINOIS 2021 YRBS YOUTH TOBACCO USE¹⁶

- ▶ **2.5%** of Illinois teens currently smoke cigarettes
- ▶ **16.7%** of Illinois teens currently use electronic vapor products
- ▶ **2.6%** of Illinois teens currently smoke cigars
- ▶ **48.8%** of Illinois teens did not attempt to quit using tobacco products

YOUTH TOBACCO USE DATA¹⁷

2022 National Youth Tobacco Survey (NYTS) on youth tobacco use in the Morbidity and Mortality Weekly Report: Tobacco Product Use among Middle & High School Students, US 2022.

Current Use: Over 3 million middle & high school students currently use a tobacco product.

Most Commonly Used Types of Devices

- ▶ E-cigarettes (9.4%)
- ▶ Cigars (1.9%)
- ▶ Cigarettes (1.6%)

Flavored E-Cigarette Use:

Current users overwhelmingly (85%) use flavored e-cigarettes with fruit/candy flavors being most popular.

Frequency of Use: Over a quarter (27.6%) use an electronic cigarette product everyday.

IMPACT OF YOUTH TOBACCO USE¹⁸

Mortality Rate: If smoking continues at current rates, 5.6 million—or 1 out of every 13—of today's children will ultimately die prematurely from a smoking-related illness.

Mental Health: There is a strong relationship between youth smoking and depression, anxiety, and stress.

Usage: Youth who use e-cigarettes are more likely to use cigarettes or other tobacco products. Among adults who smoke cigarettes daily, nearly 90% first started using cigarettes before age 18. Tobacco use disorder almost always develops childhood or adolescence.

Brain Development: Youth are uniquely vulnerable to nicotine/e-cigarette addiction because their brains are still developing. E-cigarettes can harm parts of the brain that control attention, learning, mood, and impulse control.

RESOURCES

16 Centers for Disease Control and Prevention, [High School YRBS Illinois 2021 Results](#).

17 [U.S Food & Drug Administration Results from the Annual National Youth Tobacco Survey](#).

18 Centers for Disease Control and Prevention, [Youth and Tobacco Use](#).

E-CIGARETTE SECONDHAND AEROSOL EXPOSURE¹⁸

The toxins found in e-cigarette devices are similar to toxins found in combustible tobacco.

Exposure to the harmful compounds found in vapes can happen through inhalation, ingestion, and dermal contact with aerosols exhaled into the environment.

Nonsmokers who are exposed to cigarettes and e-cigarettes have similar cotinine levels, indicating that they take in similar levels of nicotine.

RECOMMENDED ACTIONS FOR PEDIATRICIANS: Prevent and Treat Tobacco and Nicotine Use Among Youth Patients¹⁹

Screen all adolescents for tobacco and nicotine use as part of health supervision visits

- ▶ The '5As' model provides a guide for screening and counseling adolescents for e-cigarette use during clinical practice
- ▶ The '5As' can be used to structure clinical conversations about tobacco and e-cigarette use (see resources below)

Include tobacco and nicotine use prevention as part of anticipatory guidance for children and adolescents

- ▶ The US Preventive Services Task Force (USPSTF) recommends that pediatricians provide education or brief counseling to prevent initiation of tobacco use among youth patients
- ▶ Prevention interventions, including face-to-face counseling, telephone counseling, and computer-based and print-based interventions, consistently find small but clinically meaningful reductions in smoking initiation

Offer treatment to patients who use tobacco products

- ▶ Pediatricians should refer adolescents who want to quit using tobacco to behavioral interventions, as it can strengthen skills around coping with emotional, social, and environmental triggers; managing cravings; and coping with withdrawal symptoms

RESOURCES

18 American Academy of Pediatrics, [A Public Health Crisis: Electronic Cigarettes, Vape, and JUUL](#).

19 American Academy of Pediatrics, [Protecting Children and Adolescents From Tobacco and Nicotine](#).

SURVEY DATA: ILLINOIS 2021 YRBS YOUTH ALCOHOL & SUBSTANCE USE²⁰

- ▶ **22.8%** of Illinois teens currently drink alcohol
- ▶ **11.6%** of Illinois teens currently binge drink
- ▶ **15.1%** of Illinois teens currently use marijuana
- ▶ **9.5%** of Illinois teens have used prescription medication not prescribed to them
- ▶ **2.4%** of Illinois teens have used cocaine to quit using tobacco products



RESOURCES

20 Centers for Disease Control and Prevention, [High School YRBS Illinois 2021 Results](#).

SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT)

An evidence-based approach to identifying patients who may be using alcohol or drugs, then taking steps of the related clinical approach or intervention.

Stage	Description	Brief Intervention Goals
Abstinence	Patient has never used drugs or taken more than a few sips of alcohol.	Prevent or delay initiation of substance use through positive reinforcement and patient/parent education.
Substance use without a disorder	Limited use, usually in social situations; typically at predictable times such as on weekends; no associated problems (i.e., fighting, arrest or school suspension).	Advise to stop. Provide counseling regarding the medical harms of substance use. Promote patient strengths.
Mild–moderate SUD	Use in high-risk situations such as driving or with strangers; associated with problems (as above); or use to relieve stress or depression.	Brief assessment to explore patient-perceived problems associated with use. Give clear, brief advice to quit. Provide counseling regarding the medical harms of substance use. Negotiate a behavior change to quit/cut down. Close patient follow-up. Consider referral to SUD treatment.
Severe SUD	Characterized by loss of control or compulsive use, which is associated with neurologic changes in the brain’s reward system.	As above, involve parents in treatment planning whenever possible. Refer to the appropriate level of care. Follow up to ensure compliance with treatment and to offer continued support.

Referral to Treatment is warranted when patients identified as needing more extensive evaluation and treatment are able to access the appropriate services. Treatment Referral is composed of two distinct clinical activities:

- ▶ Working with the adolescent and family so they accept that timely referral and treatment are necessary for the patient’s health
- ▶ Facilitating the referral process to engage the patient and family with the appropriate professional(s) or program(s)

CONFIDENTIALITY²¹

► **Prepare for confidential care:**

Establish procedures for providing confidential care. Before screening, both patients and parents should be well informed about the confidentiality policy followed in that practice setting, including the safety related limits that justify whether to continue or break confidentiality.

► **Become familiar with your state laws on a minor's ability to consent to substance use treatment:**

A minor 12 years of age or older may consent to healthcare services or counseling related to the prevention, diagnosis, or treatment of drug use. Unless the minor consents, providers delivering healthcare services or counseling cannot seek the family's involvement in the minor's treatment. A provider shall not inform the parents or guardians of the minor's condition or treatment without the minor's consent unless, in the provider's judgment, it is necessary to protect the safety of the minor, a family member, or another individual.

Additional Resources for Pediatricians:

Fact Sheets:

- [E-Cigarettes and Vaping: What Clinicians Need to Know](#)
- [Electronic Nicotine Delivery Systems \(ENDS\)](#)

Screening and Assessment Tools Validated for Use with Adolescents²²

S2BI (Screening to Brief Intervention)

- Frequency of use screen for tobacco, alcohol, marijuana and other illicit drug use
- Discriminates between no use, no substance use disorder (SUD), moderate SUD and severe SUD, based on DSM-5 diagnoses
- Electronic medical record compatible
- Self-or-interviewer-administered

BSTAD (Brief Screener for Tobacco, Alcohol, and other Drugs)

- Identifies problematic tobacco, alcohol and marijuana use
- Electronic medical record compatible
- Self-or-interviewer-administered

RESOURCES

²¹ Illinois Health and Hospital Association, [Consent by Minors to Medical Treatment](#).

²² American Academy of Pediatrics Substance Use Screening, [Brief Intervention, and Referral to Treatment](#).

CRAFFT (Car, Relax, Alone, Friends/ Family, Forget, Trouble)

- ▶ Quickly identifies problems associated with substance use (not a diagnostic tool)

GAIN (Global Appraisal of Individual Needs)

- ▶ Assesses for both substance use disorders and mental health disorders

AUDIT (Alcohol Use Disorders Identification Test)

- ▶ Assesses risky drinking

Tobacco & Substance Use Screening Resources

5A Model—Teen Tobacco Cessation

AAP Tobacco Control fact sheet that provides an easy reference guide to help clinicians utilize the '5As' screening and counseling technique with teens

Validated Screening Tools to Address Youth Tobacco Use & Dependency

Provides information for pediatricians on validated screening tools for both tobacco use and tobacco dependency

Counseling & Motivational Interviewing for Teens

AAP Screening, Brief Intervention, Referral to Treatment (SBIRT) Implementation Guide

Handouts

Tips for Teens about Tobacco Use

is a great tool when explaining the severity of tobacco usage in teens

Knowing the Protective Factors when Addressing Youth Substance Use

can be beneficial when educating teens and their parents



Violence & Injury Prevention

VIOLENCE & INJURY PREVENTION

According to the CDC, youth violence is defined as the intentional use of physical force or power to threaten or harm others by young people ages 10 to 24. This may include fighting, bullying, threats with weapons, and gang (intent-related) violence. A young person can be involved with youth violence as a victim, offender, or witness.²³

Youth violence may result in an adverse childhood experience (ACE)²¹ and can have long-term impacts on health and well-being. Additionally, many risk factors for youth violence are linked to toxic stress from experiencing ACEs. Toxic stress (extended or prolonged stress), can negatively change the brain development of children and youth.²⁴

2019 U.S. KEY FACTS²⁵

- ▶ Every day about 360 teens are treated in emergency departments for assault injuries
- ▶ Homicide is the 3rd leading cause of death among teens
- ▶ Female teens are more likely than males to experience three or more types of violence
- ▶ The same risk is true for LGBTQIA+ teens compared to their heterosexual peers
- ▶ Violence can impact school attendance and access to community support services



Image credit: <https://www.cdc.gov/violenceprevention/youthviolence/fastfact.html>

REFERENCES

23 Centers for Disease Control and Prevention, [Fast Facts: Preventing Adverse Childhood Experiences](#).

24 Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, [Prevalence of Multiple Forms of Violence and Increased Health Risk Behaviors and Conditions Among Youths](#).

25 Children's Hospital of Philadelphia, [Types of Violence Involving Youth](#); Centers for Disease Control and Prevention, [Teen Violence Impact](#); Centers for Disease Control and Prevention, [Interpersonal Violence Victimization Among High School Students—YRBS 2019](#); American Academy of Pediatrics, [Intimate Partner Violence](#); Primary Care: Clinics in Office Practice, [Sexual Assault in Adolescents](#).



‘GETTING THEM IN’

- ▶ What is your office environment like? Is there a confidential space for a patient to wait or a prolonged wait in a common area?
- ▶ Do other staff members know what to do if someone shares or hints that they are in danger or harm?
- ▶ What is your engagement strategy like when it comes to these topics? Do you have literature visible?

CONSIDERATIONS PRIOR TO VISIT

Educate office staff:

Ensure that staff members understand the importance of universal screening for youth. Identify a lead “champion” to establish, monitor, and evaluate office screening procedures.

Decide how screening will be conducted:

If a clinical assistant will screen instead of the physician, or if a print or computerized tool is used, work out record-keeping to facilitate follow up in the exam room. Commit to screening at every possible visit.

Augment interpersonal communication and patient care skills:

Become familiar with trauma informed interviewing techniques.

Prepare for confidential care:

Establish procedures for providing confidential care.

Prepare for referrals: Generate a list of, and build a rapport with, violence and injury prevention centers. Keep copies of the list in exam rooms.

INTEGRATE SCREENING INTO PRACTICE ASSESS²⁶

Providers are encouraged to directly ask questions about fighting, injuries, sexual and intimate partner violence, threats, self-defense, and suicide as part of a standard violence-related history in order to assess whether an adolescent's involvement in violence is low, moderate or high and to assess the risk for further involvement in violence. Based on the level of risk, providers can then discuss strategies for avoiding or resolving interpersonal conflicts with friends and peers as well as what constitutes a safe dating relationship.

The level of risk can be determined by low, moderate and high. Those that are low have not engaged in physical violence but may be contemplating it. Those that are at moderate risk for violence are those that have engaged in violence and have other factors to contribute. Lastly, those that are at high risk are those that are consistently engaging in violence with other risk factors such as use of weapon.

FIGHTS

- ▶ How many fights have you been in during the past year?
- ▶ When was your last fight?

REFERENCES

26 American Academy of Pediatrics and Center For The Study of Social Policy, [Promoting Children's Health and Resiliency](#)

INJURIES

- ▶ Have you ever been injured in a fight?
- ▶ Have you ever injured someone else in a fight?

SEXUAL & INTIMATE PARTNER VIOLENCE

- ▶ Has your partner ever hit you?
- ▶ Have you ever hit (hurt) your partner?
- ▶ Have you been forced to have sex against your will?

THREATS

- ▶ Has someone carrying a weapon ever threatened you?
- ▶ What happened?
- ▶ Has anything changed since then to make you feel safer?

SELF-DEFENSE

- ▶ What do you do if someone tries to pick a fight with you?
- ▶ Have you ever carried a weapon in self-defense?

SUICIDE

- ▶ Do you ever have thoughts about hurting yourself?
- ▶ Do you have a plan? Do you have access to what you would need to carry out your plan?

BUILDING RESILIENCE IN YOUTH

Pediatricians have a unique opportunity to impact the lives of their patients and families—even before the child is born—to help increase protective factors and build resiliency.

Educating parents on the vital role they play in helping raise their children to be resilient is incredibly important. Pediatricians are seen as a trusted source of information by parents. Promoting Children’s Health and Resiliency: A Strengthening Families Approach developed by the AAP and the Center

for the Study of Social Policy is a great resource for providing tools on resiliency.²⁷

EVALUATE

Guidance on interventions and strategies to ensure safety and prevent injuries target 3 domains:

- ▶ the development and age of the child;
- ▶ the environment in which the safety concern or injury takes place, and;
- ▶ the circumstances surrounding the event

The health supervision visit provides a venue to assess the parents’ and the child’s current safety strategies, encourage and praise their

positive behaviors, provide guidance about potential risks, and recommend community interventions that promote safety.

REFER

Safety: Monitor and maintain the safety of adolescents until they are assessed by trained personnel. Seek immediate help if adolescent is in serious danger due to intimate partner, gang, school, or domestic violence. Refer to/ contact 911, police or crisis team.

Mandatory Child Abuse Reporting:

File a child abuse report anytime you discover facts that lead you to know or reasonably suspect a minor is a victim of abuse.

Patient/Parent Engagement and Education:

Emphasize the importance of removing or locking up guns and other weapons in the home. Discuss with parents/ caregivers the need for consistent adult guidance, structure, communication, safety, and non-violent disciplinary methods.

Review Resources on:

- ▶ Opportunities for structured socially positive youth activities
- ▶ Family communication/gatherings
- ▶ Family/parent psychosocial education groups
- ▶ Provide emergency contact/ resource information

REFERENCES

²⁷ American Academy of Pediatrics, [Bright Futures](#)

FOLLOW UP

- ▶ Connect youth who report being in 4+ physical fights during the past year or carrying weapons to community resources (school counselors, youth development programs, faith-based organizations, or social workers)
- ▶ Refer youth suspected of having mental health and/or substance use problems to a behavioral health provider for further evaluation and/or treatment
- ▶ Inform teens who are afraid to return home about youth shelters
- ▶ Ensure follow-up for ongoing risk strength assessment, motivational counseling, and referrals to socially positive youth/community programs
- ▶ Provide routine adolescent primary care, health promotion and anticipatory guidance
- ▶ Coordinate with behavioral health provider

HANDOUT

The Center of Disease Control provides a [youth violence prevention infographic](#) on reviewing quick strategies when educating adolescents.





Sexual Health & Gender Identity

SEXUAL HEALTH

2021 ILLINOIS YRBS SEXUAL HEALTH DATA²⁸

- ▶ **18.3%** of teens were currently sexually active within three months of the survey
- ▶ **13.9%** of teens did not use any method to prevent pregnancy during their last sexual intercourse encounter with an opposite-sex partner
- ▶ **94.6%** of teens were not tested for STDs

Pediatricians and other health care providers are an important source of health care information for adolescents and young adults and play a significant role in addressing their reproductive and sexual health care needs. This includes promoting healthy relationships and preventing unintended pregnancies and sexually transmitted infections.



REFERENCES

28 Centers for Disease Control and Prevention, [High School YRBS Illinois 2021 Results](#).

29 American Academy of Pediatrics, [Best Practices for Adolescent Sexual and Reproductive Health Care in Clinical Settings](#).

BEST PRACTICES

for Adolescent Sexual and Reproductive Health Care in Clinical Settings²⁹

Confidentiality and Consent:

Preserving confidentiality for adolescent patients supports youth in taking ownership over their own health, facilitates open communication about sensitive topics (eg, sexual health, mental health, and substance use), and supports the transition to adulthood.

Education:

- ▶ Ensure all clinicians and staff understand state laws surrounding informed consent and confidentiality related to contraceptive services; STI testing and treatment; and HIV testing and treatment

Office policies & procedures:

- ▶ Develop an office policy that explicitly outlines the right of adolescent patients to confidential care and share the policy with patients and families
- ▶ Post in a visible location in your office
- ▶ Require education for clinical and office staff about the importance of protecting adolescent confidentiality in all aspects of care delivery, including medical records, appointments, test results, after-visit summaries, explanation of benefits forms, and follow-up care



Communication with adolescents & families:

- Talk directly with adolescent patients and their families about the protections of confidentiality at every visit and allocate time for a one-on-one conversation between the patient and clinician during every visit

Involving families:

- While parent(s) or guardian(s) are present in the room, the provider may find it useful to ask about their concerns and review the past medical history and family history

History taking:

- After reviewing the nonconfidential information with the parent/guardian present, the parent should be asked

to step out so the provider can review sensitive history questions alone with the adolescent or young adult that they may not feel comfortable asking or answering in front of another adult

CREATING AN ADOLESCENT FRIENDLY OFFICE ENVIRONMENT

Incorporating sexual and reproductive health services into the clinic visit:

- Provide the full range of sexual and reproductive health services in one location (eg, screening, counseling, STI prevention and treatment, contraception, pregnancy-related care, abortion), and advertising the breadth of services provided

- ▶ Offer same-day sexual and reproductive procedures or helping adolescents make referral appointments for specialized services, and providing clear directions and instructions, assurances of continuing confidentiality, and information about fees, if any
- ▶ To the extent possible, ensure continuity of care by making every effort to have adolescents see the same provider at every appointment

Incorporate puberty, sexuality, and sexual health assessment into psychosocial history taking. Example screening questions include:

Puberty: *“Do you have any concerns about how your body is developing?”*

Sexuality: *“Many people your age begin to have attractions physically or romantically. Have you thought about that? What are the genders of the people that you are attracted to?”*

Sexual health assessment: *“What types of sexual experiences have you had?”*

AAP RECOMMENDATIONS ON CONTRACEPTION AND ADOLESCENTS FOR PEDIATRICIANS^{30, 31}

Discuss abstaining from sexual intercourse as the most effective way to prevent genital STIs, as well as HIV infection, and unintended pregnancy.

Support and encourage the consistent and correct use of barrier methods, as well as other reliable contraception, as part of anticipatory guidance during visits with adolescents who are sexually active or contemplating sexual activity.

Support the provision of free or low-cost barrier methods within communities, including providing barrier methods within clinics.

Promote communication between parents and adolescents about healthy sexual development, sexuality, prevention of STIs and pregnancies, and proper use of barrier.

Resources

[Barrier Protection Use by Adolescents During Sexual Activity.](#)

[Long Acting Reversible Contraception Specific Issues for Adolescents.](#)

REFERENCES

30 American Academy of Pediatrics Healthy Children, [Updated Recommendations on Contraception and Adolescents.](#)

31 American Academy of Pediatrics, [Pediatricians Have Key Role in Providing Sexual, Reproductive Health Care Services.](#)

INTEGRATE SCREENING INTO PRACTICE^{32, 33}

The Centers for Disease Control and Prevention suggest screening adolescents using the 7-P's:

- ▶ **Partners:** How many have you had sexual encounters with?
- ▶ **Practices:** How do you practice safe sex?
- ▶ **Protection from sexually transmitted infections (STIs):** How do you know you have been protected by an STI?
- ▶ **Past history of STIs:** Do you have knowledge of having a history of STIs?
- ▶ **Prevention of pregnancy:** How do you prevent pregnancy?
- ▶ **Permission (consent):** Do you talk about consent with your partner before engaging in sexual encounters?

Another great resource for screening can be found by using this postcard⁶ for easy accessibility.

REFERENCES

32 https://brightfutures.aap.org/Bright%20Futures%20Documents/MSRTable_AdolVisits_BF4.pdf.

33 U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. [A Guide to Taking a Sexual History](#). (Accessed June, 2021).



ASSESS & EVALUATE³⁴

Consider pregnancy test when last menstrual period (LMP) is more than 4 weeks earlier

- ▶ Options counseling in the event of positive test

STI screen for all sexually active youth younger than 25 years

- ▶ At least annually, more often when risk factors for STIs are present

Recommend condom use to all sexually active youth

- ▶ Preferably latex, without spermicide
- ▶ Polyurethane or polyisoprene condoms in cases of latex-allergy
- ▶ Consider having a supply to offer at no cost in your clinical space

Discuss contraceptive options

Review indications for emergency contraception (consider having some types freely accessible in your clinical space).

Ensure relevant vaccines are up-to-date (HPV, hepatitis A and B, varicella, MMR).

Be aware of sexual consent laws

- ▶ Consult with your local child protective agencies, as necessary.

Assess relationship safety

- ▶ Consent, teen dating violence, sexting

Arrange follow-up

- ▶ When STI screen test is positive, advise teens that they may be contacted by their local Public Health Department.
- ▶ In event of a positive screen, treat patient and partners

REFERENCES

³⁴ <https://www.cps.ca/en/documents/position/comprehensive-sexual-health-assessments-for-adolescents#ref6>

GENDER IDENTITY & YOUTH LGBTQ+ CONSIDERATIONS IN PEDIATRIC CARE

Gender Identity is defined as a person's deep internal sense of being female, male, a combination of both, somewhere in between, or neither, resulting from a multifaceted interaction of biological traits, environmental factors, self-understanding, and cultural expectations.³⁵

Despite growing public awareness, adolescents & young adults who identify as LGBTQ+ continue to face disparities such as societal discrimination, declining mental health, and lack of access to quality healthcare.³⁵

Trevor Project 2022 National Survey on LGBTQ Youth Mental Health:³⁵

- ▶ 34,000 LGBTQ youth respondents between ages 13 to 24 across the United States, with **45%** of respondents being LGBTQ youth of color and **48%** being transgender or nonbinary
- ▶ **45%** of LGBTQ youth seriously considered attempting suicide in the past year
- ▶ **14%** of LGBTQ youth attempted suicide in the past year
- ▶ **73%** of LGBTQ youth reported experiencing symptoms of anxiety

- ▶ **58%** of LGBTQ youth reported experiencing symptoms of depression
- ▶ **60%** of LGBTQ youth who wanted mental health care in the past year were not able to get it

GENDER AFFIRMING CARE³⁶

Pediatric primary care providers are in a unique position to routinely inquire about gender development in children and adolescents as part of recommended well-child visits and to be a reliable source of validation, support, and reassurance.

In a gender-affirmative care model (GACM), pediatric providers offer developmentally appropriate care that is oriented toward understanding and appreciating the youth's gender experience. A strong, nonjudgmental partnership with youth and their families can facilitate exploration of complicated emotions and gender-diverse expressions

REFERENCES

³⁵ The Trevor Project, [2022 National Survey on LGBTQ Youth Mental Health](#).

³⁶ *Pediatrics*, Volume 142, Issue 4: [From the American Academy of Pediatrics | Policy Statement: Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents](#).

while allowing questions and concerns to be raised in a supportive environment.

In a GACM, the following messages are conveyed:

- ▶ transgender identities and diverse gender expressions do not constitute a mental disorder
- ▶ variations in gender identity and expression are normal aspects of human diversity, and binary definitions of gender do not always reflect emerging gender identities
- ▶ gender identity evolves as an interplay of biology, development, socialization, and culture
- ▶ if a mental health issue exists, it most often stems from stigma and negative experiences rather than being intrinsic to the child

The GACM is best facilitated through the integration of medical, mental health, and social services, including specific resources and supports for parents and families. Providers work together to destigmatize gender variance, promote the child's self-worth, facilitate access to care, educate families, and advocate for safer community spaces where children are free to develop and explore their gender.

RECOMMENDATIONS³⁷

The AAP works toward all children and adolescents, regardless of gender identity or expression, receiving care to promote optimal physical, mental, and social well-being.

- ▶ Providing youth with access to comprehensive gender-affirming and developmentally appropriate health care
- ▶ Providing family-based therapy and support be available to meet the needs of parents, caregivers and siblings of youth who identify as transgender
- ▶ Making sure that electronic health records, billing systems, patient-centered notification systems and clinical research are designed to respect the asserted gender identity of each patient while maintaining confidentiality
- ▶ Supporting insurance plans that offer coverage specific to the needs of youth who identify as transgender, including coverage for medical, psychological and, when appropriate, surgical interventions
- ▶ Advocacy by pediatricians within their communities, for policies and laws that seek to promote acceptance of all children without fear of harassment, exclusion or bullying because of gender expression

REFERENCES

³⁷ American Academy of Pediatrics, [AAP Policy Statement Urges Support of Transgender and Gender-Diverse Children and Adolescents](#).

CREATING AN INCLUSIVE PEDIATRIC OFFICE ENVIRONMENT³⁸

The following represent some of the many ways pediatricians can improve the care of their LGBTQ+ patients/families, with the acknowledgement that not all pediatricians may be able to implement all of these recommendations.

- ▶ Train all staff about why inclusivity and acceptance of diversity is a positive way for pediatric professionals to model equity
- ▶ Post LGBTQ+ signs, flags, or stickers in waiting rooms, exam rooms, and bathrooms
- ▶ Provide patient education materials that show LGBTQ+ persons and discuss LGBTQ+ issues
- ▶ Hire staff that reflect community diversity, if possible
- ▶ Review office forms, labels, patient portals, and EHR for inclusivity as well as confidentiality
- ▶ Actively engage in consent with patients. Ask permission for sensitive questions and before examining patients. This approach models consent and shows patients how to assert body autonomy
- ▶ Focus on resiliency and opportunities for support, as well as risk and harm reduction

REFERENCES

38 American Academy of Pediatrics. [A Pediatrician's Guide to an LGBTQ+ Friendly Practice](#)

INTRODUCTIONS

Best Practices

Examples

Include your name, pronouns, and role when introducing yourself.

Hi, I'm Dr __ and my pronouns are she, her, and. hers. How are you today? What name do you go by and what pronouns should we use?

All providers sometimes make mistakes with names and pronouns. Be prepared to correct yourself, or colleagues, when they occur. If you make mistakes, apologize, move on, and do better!

If I make a mistake with name or pronouns, or other information, please correct me so I can do better. Feeling that you are respected and comfortable when talking with me is very important.

SOCIAL HISTORY: SETTING THE TONE

Best Practices

Examples

Discuss the importance of the physician asking about sensitive subjects in order to provide important information and care recommendations.

With your permission, I'd like to ask you some questions that I ask of all the youth that I care for.

Discuss privacy and confidentiality issues using your institutional policies regarding medical records as well as local, state, and national laws as a reference.

In our state, information about __ and __ are considered protected confidential information. We will keep your gender and sexual information private, but understand, your parent/guardian can request to access your health information as a minor. Please let me know what information should not share with your parent/guardian.

Routine surveillance and screening can assess for risk and resiliency factors in the patient's family, school, or community (eg, HEADDSSS for adolescents).

Do you need support or have any questions as you navigate your gender identity, sexual orientation, or relationships?

All youth deserve to have opportunities to be safe, healthy, happy, and have a bright future ahead. Are there any ways I can help you achieve these goals for yourself, with family, and in school and the community?

TAKE ADVANTAGE OF DEVELOPMENTAL STAGES & OPPORTUNITIES

Best Practices

Examples

For prepubertal children, use language and concepts that are attuned to their developmental abilities and experience.

*Do you feel more like a boy girl or neither?
How do you feel about being ____?*

*What do you love and what
makes you happy?*

What name should I call you?

*When people talk about me I like them to
use (providers pronouns) to describe me.*

*What words are pronounced would you
like me to use when referring to you?*

For prepubertal children or early adolescents, assess comfort with bodily and societal changes associated with puberty. Open the door for questions.

*Everyone goes through puberty. How
do you feel about upcoming puberty?*

*What questions, concerns, or information do
you need to navigate puberty successfully?*

For older adolescents and young adults continue to check in with them about gender and sexual development.

Identities grow and evolve over time.

*Do you want to talk more about
gender or sexuality today?*

*Know that it is common for people
to explore these aspects of growing
into adulthood over time.*

Assess family support/safety as well as mental health.

*How much do your caregivers
know about your identity?*

*How does their behavior towards
you or your friends reflect that?*

How safe do you feel at home?

AVOID ASSUMPTIONS

Best Practices

Examples

This includes:

- ▶ Gender identity and pronouns
- ▶ Sexual orientation and partner(s)
- ▶ Sexual behaviors

I ask all my patients about gender identity and sexual orientation as well as specific sexual behaviors. This information can be confidential (depending on state laws), or I can help you discuss these with your caregiver(s).

How would you describe your gender identity?

Many people your age begin to have attractions physically or romantically. Have you thought about that? Who are you attracted to?

In what ways have you explored your own and others' sexuality? Many teens masturbate as a safe form of sexual expression. Other teens make decisions to explore their bodies and sexuality with other persons. Tell me a little about how you have explored sex and intimacy.

Research shows that adolescents not only want, but also expect, their providers to ask questions about sensitive topics. Consider this an opportunity to model open communication with caregivers as well.

How would you describe your gender identity?

Many people your age begin to have attractions physically or romantically. Have you thought about that? Who are you attracted to?

Use open-ended questions and gender-neutral language when talking with patients.

In what ways have you explored your own and others' sexuality? Many teens masturbate as a safe form of sexual expression. Other teens make decisions to explore their bodies and sexuality with other persons. Tell me a little about how you have explored sex and intimacy.

LISTEN TO PATIENTS' LANGUAGE AND CONTEXT

Best Practices	Examples
Terminology is constantly changing. Youth have a language all their own!	<i>How would you describe or how would you like me to refer to your gender identity, body parts, sexuality?</i>
Ask patients what words they use to describe: their gender, their body parts, the type of sexual behaviors they engage in.	<i>If I am hearing correctly, lets use the term front and back holes for those parts?</i>
Reassure them that honest and open discussions will allow you to provide the best recommendations for their care.	<i>Let me know if use terminology that is difficult for you. We can together figure out terms that are more comfortable.</i>

GENDER NEUTRAL LANGUAGE INCLUDES EVERYONE!

Best Practices	Examples
Start this conversation early, when discussing infant gender. Continue along developmentally appropriate pathways for all youth.	<i>Your infant will be assigned a male or female sex at birth. As your child grows, we will learn more about their developing gender identity.</i>
Challenge caregivers to offer children all types of play opportunities. Challenge caregivers to allow children to dress and physically express themselves in ways that are comfortable for them.	<i>Yes, your child is correct: there are no girl or boy toys, just toys! Kids of all genders can love pink! It's okay for your child to dress how they feel most comfortable.</i>
Model use of inclusive language and encourage children and adolescents to be and live their authentic selves in all discussions, including those around health maintenance and sexual health.	<i>Young persons who are sexually active may need protection from pregnancy. Let's talk about your sexuality and what you might need for birth control and STI prevention. As a person who has a uterus, you need to understand that being on testosterone does not protect against pregnancy.</i>

INTERACTING WITH PATIENTS' FAMILIES

Best Practices

Examples

Families and guardians come in all shapes and sizes.

There are all kinds of families, how would you describe yours?

Ask about each person's role in relationship to the child. Be sure to respect each individual's role in the family regardless of biological connection to the patient. For example, don't assume that a birthing parent is a mother.

What name does/will your child use for you?

Please tell me the people who are genetically related to and their medical conditions.

Ask questions about both who is in the households and who are their main supports.

Where do you live?

Who do you live with?

Who else is important to you?

Don't assume the person accompanying the patient is a parent or guardian—ask about their role.

Who is here with you today?

For older children: what names and pronouns does this person use?

Avoid assumptions about family roles and values.

Tell me more about how your family accepts and supports you.

Does your family know about your identity, sexual orientations, relationships? Would you like support in talking to your family or anyone else about this?

Many LGBTQ+ persons elect to create 'families of choice,' separate from those they are related to or live with. These non biologically related families are a vital part of many LGBTQ+ persons experience.

Who do you consider as part of your family?

Do you need help talking to your family about identity sexual orientation or relationships?

RESOURCES FOR PEDIATRICIANS

Recommendations and clinical guidelines for providing care to LGBTQ+ patients and families.

American Academy of Pediatrics

- ▶ [Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents](#)
- ▶ [Equitable Access to Sexual & Reproductive Health Care for All Youth](#)
- ▶ [A Pediatrician's Guide to an LGBTQ+ Friendly Practice](#)

Lurie Children's Hospital of Chicago:

- ▶ [How to Support Transgender & Gender-Questioning Youth](#)
- ▶ [Mental Health Support for Transgender & Gender Questioning Youth](#)

Additional Resources:

- ▶ [Trevor Project 2022, National Survey on LGBTQ Youth Mental Health](#)



Nutritional Health

NUTRITIONAL HEALTH

Healthy eating during adolescence is important as body changes during this time affect an individual's nutritional and dietary needs. Adolescents are becoming more independent and making many food decisions on their own. Many adolescents experience a growth spurt and an increase in appetite and need healthy foods to meet their growth needs. Adolescents tend to eat more meals away from home than younger children. They are also heavily influenced by their peers. Meal convenience is important to many adolescents and they may be eating too much of the wrong types of food, like soft drinks, fast-food, or processed foods.³⁹ Nutritional habits are important, with high intake of processed, energy-dense foods, high Body Mass Index (BMI), and iron deficiency among the top 20 risk factors of disability-adjusted life years worldwide.⁴⁰

2019 U.S. KEY FACTS⁴¹

Physical Activity

25.4% of adolescents were physically active at least 60 minutes per day on all 7 days in the past week

Overweight and Obesity

- ▶ **14.4%** of adolescents were overweight
- ▶ **11.5%** of adolescents had obesity
- ▶ Illinois is ranked 24 among the 50 states as having **14.9%** of obese youth 10 to 17 years old⁴²

INTEGRATE SCREENING INTO PRACTICE

Most studies and guidelines on eating behavior are from high-income countries (HICs). The 2010 U.S. dietary guidelines for adolescents (ages 9–18 years), for example, suggest that girls require 1,400–2,400 calories per day and boys require 1,600–3,200 because of their typically larger frames and muscle mass. However, any teenager involved in athletic physical activity can require up to 5,000 calories per day.⁴⁰

REFERENCES

39 John Hopkins Medicine, [Healthy Eating During Adolescence](#).

40 National Library of Medicine.

41 Centers for Disease Control and Prevention, [Nutrition, Physical Activity and Obesity Data, Trends and Maps](#).

42 State of Childhood Obesity, [Deeper Dive: New Obesity Rate Data for Youth Ages 10 to 17](#).

ELEMENTS OF A NUTRITION SCREENING AND ASSESSMENT FOR ADOLESCENTS⁴³

ASSESS & EVALUATE

When evaluating an adolescents nutritional needs; the 2015–2020 Dietary Guidelines provides five overarching Guidelines that encourage healthy eating patterns, recognize that individuals will need to make shifts in their food and beverage choices to achieve a healthy pattern, and acknowledge that all segments of our society have a role to play in supporting healthy choices.

Below are recommended resources when evaluating nutritional needs for adolescent population.

Adolescents dietary patterns often resemble those of their household and their peer group, highlighting the importance of their environment in the establishment of a healthy dietary pattern. Shared meals through shopping, cooking, and consumption provides parents, guardians, and caregivers with an opportunity to model healthy eating behaviors and dietary practices. By making nutrient-dense foods and beverages part of the normal household routine, children can observe and learn healthy behaviors that can extend throughout later life stages.



HANDOUT

View the Building Blocks of a Healthy Life Style or [Ways to Provide Empowerment to Teens](#) when discussing nutrition.

The AAP Bright Futures also provides a detailed [Pocket Guide](#) on nutrition by age, goals and tools.⁴⁴

REFERENCES

43 American Academy of Pediatrics, [Bright Futures](#).

44 U.S Department of Agriculture, [Dietary Guidelines for Americans, 2020–2025. 9th Edition](#).



ADOLESCENTS WITH SPECIAL CARE NEEDS

The US Department of Health and Human Services Maternal and Child Health Bureau defines children and youth with special health care needs (CYSHCN) as children “... who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions, and who require health and related services of a type or amount beyond that required by children generally.”⁴⁵

Children and youth with special health care needs share many health supervision needs in common with typically developing children. They also have unique needs related to their specific health condition. Birth defects, inherited syndromes, developmental disabilities, and disorders acquired later in life, such as asthma, are relatively common.

KEY FACTS⁴⁶

- ▶ An estimated **13.5 million** children in this country, or approximately 20% of US children under age 18 years of age, have a special health care need
- ▶ CYSHCN and their families often need services from multiple systems: health care, public health, education, mental health, and social services
- ▶ **One in four households** (24.8%) in the U.S. had one or more CSHCN
- ▶ CSHCN are a diverse group exhibiting a range of needs and severity. In 2017–2018:
 - **one in four** CSHCN (26.6%) had functional limitations
 - In addition, **one in five** (19.9%) were consistently and/or significantly impacted by their health condition(s)
 - **nearly half** (46.0%) were sometimes/moderately impacted by their health condition(s)

REFERENCES

⁴⁵ Health Resources and Services Administration, [Children and Youth with Special Health Needs](#).

⁴⁶ American Academy of Pediatrics, [Bright Futures](#).

CONSIDERATIONS PRIOR TO VISIT⁴⁷

Create a Shared Plan of Care to meet the needs of your CYSHCN patients utilizing resources from Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents.

Principles for Successful Use of a Shared Plan of Care:

- ▶ Children, youth, and families are actively engaged in their care
- ▶ Communication with and among their medical home team is clear, frequent, and timely
- ▶ Providers or team members base their patient and family assessments on a full understanding of child, youth, and family needs, strengths, history, and preferences
- ▶ Youth, families, health care professionals, and their community partners have strong relationships characterized by mutual trust and respect
- ▶ Family-centered care teams can access the information they need to make shared, informed decisions
- ▶ Family-centered care teams use a selected plan of care characterized by shared goals and negotiated actions; all partners understand the care planning process, their individual responsibilities, and related accountabilities
- ▶ The team monitors progress against goals, provides feedback, and adjusts the plan of care on an ongoing basis to ensure that it is effectively implemented
- ▶ Team members anticipate, prepare, and plan for all transitions (e.g., early intervention to school, hospital to home, pediatric to adult care)
- ▶ The plan of care is systematized as a common, shared document; it is used consistently by every health care professional within an organization and by acknowledged health care professionals across organizations
- ▶ Care is subsequently well coordinated across all involved organizations and systems

REFERENCES

⁴⁷ American Academy of Pediatrics, [Bright Futures](#).

SCREEN

The CSHCN Screener^{®48} uses consequences-based criteria to screen for children with chronic or special health care needs.

To qualify as having chronic or special health care needs, the following criteria must be met:

- ▶ The child currently experiences a specific consequence
- ▶ The consequence is due to a medical or other health condition
- ▶ The duration or expected duration of the condition is 12 months or longer

[Access the screening questionnaire](#)

ASSESS, EVALUATE, FOLLOW UP

As children with special health care needs enter adolescence and experience puberty and rapid physical and emotional development, new levels of functionality in the face of their special need can bring important and remarkable gains in independence and autonomy. The pediatric health care professional must understand the importance of this transition and provide parent support or alternative community supports for the family.⁴⁹

REFERENCES

48 [Children with Special Health Care Needs \(CSHCN\) Screener Technical Summary](#), Copyright ©2001 by FACCT—The Foundation for Accountability.

49 Bright Futures, [Implementation Tip Sheet](#), Promoting Health for CYSHCN.



HANDOUT

Along with their particular medical and developmental issues, children and youth with special health care needs have many of the same health supervision needs as typically developing children. The Bright Futures visit provides an opportunity for health care professionals to provide regular preventive and primary care, along with care for the unique needs related to a child's condition. Use this [Implementation Tip Sheet](#) as a resource for supporting families with adolescents with special care needs.

A healthcare provider with dark skin and curly hair, wearing a white lab coat over a pink shirt, is standing and talking to a young woman with long brown hair, wearing a blue button-down shirt. They are in a bright, modern clinical setting with large windows in the background. The text is overlaid on a white circular graphic.

BRIGHT FUTURES HEALTH SUPERVISION VISIT

Overall, integrating the social determinants of health into health supervision visits, health care practices can take a broad view of the circumstances in a family's life and offer strategies that enhance its health and wellness.

The Bright Futures health supervision visits provide opportunities to identify and address the social determinants of health through screening and anticipatory guidance for family members.

By using the tools and steps identified for health supervision visits, health care professionals can comprehensively support patients and their families.

To review this recommended tool, visit this [tip sheet](#) during adolescent health well visits.

CONCLUSION

As it is our mission to promote and advocate for optimal child, youth and family well-being; we hope that this toolkit has provided easy access to resources in order to increase the quality and frequency of adolescent health well visits. Specially focusing on adolescents, this is a time where guidance and support of their parents, families, schools, healthcare providers and communities are important.

We recognize that adolescents need healthy, positive relationships with a trusted adult in order to begin making their own health decisions. We are proud to serve those in Illinois towards optimal health outcomes for children and youth!

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