BRIGHT FUTURES

Promoting Child Development and Mental Health - (Part 2)

March 22, 2011

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**Before We Get Started**

http://www.dhs.wisconsin.gov/health/mch/BrightFutures/index.htm

Remember to complete the evaluation when we are finished. Link can be found on the above website, along with the slides from today’s presentation.

If more than one person is at your site, please send one email informing us of how many.

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**Introduction to Media Site**

Ann Stueck, Infant and Child Nurse Consultant
Bureau of Community Health Promotion (BCHP)
Family Health Section (FHS)

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**PRESENTERS**

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Wisconsin Department of Health Services (DHS)

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**ASK A QUESTION !!**
by using feature at top of speaker screen anytime during the presentations
What Is Bright Futures?

Bright Futures is a national health care promotion and disease prevention initiative that uses a developmentally-based approach to address children's health needs in the context of family and community.

Bright Futures Guidelines—3rd Edition

Features of special interest to Public Health professionals:
- Revised Periodicity Schedule
- Integrated adaptations throughout for children and youth with special health care needs
- Visit section defines newer, more family- and community-driven, enhanced content for the well care of infants, children, and adolescents in primary care practice
- The 10 Themes have special application to Public Health
How do the 3rd edition Guidelines differ from previous editions?

- **Structure**
  - **Part I—Themes**
    - Includes 10 chapters highlighting key health promotion themes
    - Emphasizes “significant challenges”—e.g., mental health and healthy weight
  - **Part II—Visits**
    - Provides detailed health supervision guidance and anticipatory guidance for 31 age-specific visits
    - Lists 5 priorities for each visit
    - Includes sample questions and discussion topics for parent and child

- **Health Supervision Priorities**
  - Designed to focus visit on most important issues for age of child
  - Anticipatory guidance presented in several ways
  - Include health risks, developmental issues, positive reinforcement

**Wisconsin’s Bright Futures Webcasts**

http://dhs.wisconsin.gov/dph_bfch/MCH/BrightFutures.htm

Applying the 10 Bright Futures Themes to Public Health

- Promoting Oral Health
- Promoting Safety and Injury (and Violence) Prevention
- Promoting Healthy Weight
- Promoting Healthy Nutrition
- Promoting Physical Activity

**Wisconsin’s Bright Futures Webcasts**

http://dhs.wisconsin.gov/dph_bfch/MCH/BrightFutures.htm

**Child Development and Infant Mental Health**

Reference: Institute of Medicine Study (2000)

Jack Shonkoff and Deborah A. Phillips, eds

*From Neurons to Neighborhoods: The Science of Early Childhood Development*

http://books.nap.edu/catalog.php?record_id=9624

**ADOLESCENT HEALTH POLICY TRENDS**

Claude Gilmore
Youth Policy Director
Department of Health Services
ADOLESCENT HEALTH POLICY TRENDS

America’s Promise Alliance’s Five Promises
• Caring Adult
• Safe Place
• Healthy Start
• Effective Education & Marketable Skill
• Opportunities to Help Others

Wisconsin Health Disparities
• 2008 Teen birth rates for African Americans, Hispanics, Native Americans and Asians was 5, 5, 4, & 2 times higher than Whites
• 2009 STD rate for African Americans in comparison to Whites reflects a 14-fold difference
• 2009 HIV rate for African Americans and Latinos men was 5 times higher and 3 times higher than for White men

Two Competing Approaches:
• Individual and Environmental Risk Factors including Social and Economic Determinants
  ▪ Racism, Poverty, Housing, Employment, Health Conditions/Access, Crime, Education
• Individual Resiliency and Protective Factors including parent, peer and school connectedness
  ▪ Racism, Poverty, Housing, Employment, Health Conditions/Access, Crime, Education

Key Healthy People 2020 Objectives
• Increase the proportion of adolescents who are connected to a parent or other positive adult caregiver
• Increase the proportion of adolescents and young adults who transition to self-sufficiency from foster care
• Increase the proportion of students who graduate with a regular diploma four years after starting 9th grade
• Increase the proportion of students who are served under the Individuals with Disabilities education Act who graduate from high school with a diploma

Office of Adolescent Health
• DHHS Program, Research & Training Coordination
  ▪ Promotion of Evidenced-Based & Promising Practices
  ▪ Address Youth at High-Risk
  ▪ Help Improve School Performance & Drop-Out Rates

Federal Interagency Working Group on Youth Programs
• Support YouthInfo.gov
• Disseminate Promising & Effective Strategies
• Promote Enhanced Collaboration

Current Emphasis
• Bullying Prevention
• Positive Youth Development
• Afterschool Programs
• Transition Age Youth
Adolescent Physical and Psychosocial Development

Patricia K. Kokotailo M.D., MPH

Professor of Pediatrics
Director of Adolescent Medicine
University of Wisconsin School of Medicine and Public Health

Puberty
• Significant variations in onset, timing, tempo, and magnitude of pubertal changes are normal
• Despite expected variability, the progression through puberty is predictable

Height Growth
• Average growth spurt lasts 24-36 months
• Pubertal growth accounts for 20-25% of final adult height
• Growth spurt related to bone age, not chronological age
• PHV (peak height velocity) occurs 2 years later for boys than girls
### Linear Growth: Girls vs. Boys

<table>
<thead>
<tr>
<th></th>
<th>Girls</th>
<th>Boys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onset</td>
<td>9 y/o</td>
<td>11 y/o</td>
</tr>
<tr>
<td>PHV Age</td>
<td>11.5 y/o</td>
<td>13.5 y/o</td>
</tr>
<tr>
<td>PHV</td>
<td>9 cm/yr</td>
<td>10.3 cm/yr</td>
</tr>
<tr>
<td>Avg. growth</td>
<td>25 cm</td>
<td>28 cm</td>
</tr>
</tbody>
</table>

### Gynecomastia

- Results from a relative estrogen/androgen imbalance at breast tissue level
- Peak prevalence: 64% at 14 years
- Mean age of onset: 13 yrs., 2 mo.
- 50% with onset at Genital Stage 2
- Bilateral in 77-95%
- If persists > 2 years, unlikely to spontaneously resolve

### Weight Growth

- Peak weight velocity (PWV) is variable - coincides with PHV in males; PWV about 6 mos. after PHV in females
- Pubertal weight gain accounts for about 50% of ideal body weight
- Lean body mass % increases for males and decreases for females

### Physiological Changes

- Acne
- Increased skin and scalp oil
- Perspiration/body odor
- Male voice deepening

### Body Composition Growth

- 33-66% of adult bone mass accrues in adolescence
- Erythrocyte mass increases in males and is more level in females
- Blood pressure rises related to age, weight and height

### Female Pubic Hair Development

- [Diagram of Pubic Hair Development](image link)
Pubertal Guidelines - Female

• Puberty completed in about 4 years (1.5 - 8 year range)
• Thelarche usually first event (15% start with adrenarche)
• Asymmetric breast development common
• Pubarche usually occurs about 6 months after thelarche

Pubertal Guidelines - Female

• Physiologic leukorrhea (normal estrogen effect) precedes menarche by about 3-6 months
• Menarche occurs about 2 years past thelarche, usually at late SMR 3 or SMR 4
• Post menarche, expected height gain averages 7 cm
• Regular ovulatory menstrual cycles don’t develop until 1-3 years past menarche
Pubertal Guidelines - Male

- Puberty completed in about 3 years (2-5 year range)
- Testicular enlargement is the first event in 98% (~11.5 years)
- Ejaculation usually occurs during SMR 3, with fertility usually at SMR 4 (sperm can be present at SMR 3)
- Height and strength spurts are later events

Conclusion

- Variability is normal in puberty but predictable progression
- Reassurance re. normalcy of changes is key
- Time of change, but relative good physical health

Psychosocial Development

Early Adolescence (10-13 years)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onset of puberty, concern with body</td>
<td>Concern re. normalcy, occasional masturbation</td>
</tr>
<tr>
<td>Separates from family, peer importance</td>
<td>Can take on some external responsibilities alone</td>
</tr>
<tr>
<td>Concrete thinking</td>
<td>Need of explicit instructions</td>
</tr>
<tr>
<td>Present-oriented, egocentric</td>
<td>Experimentation, risk-taking</td>
</tr>
</tbody>
</table>

Middle Adolescence (14-16 years)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Puberty usually complete</td>
<td>Exploring sexuality</td>
</tr>
<tr>
<td>Peers set standards, although family values persist</td>
<td>Peers affect compliance</td>
</tr>
<tr>
<td>Conflicts re. independence</td>
<td>Increased independence, ambivalence in discussion and negotiation</td>
</tr>
<tr>
<td>Abstract thinking begins, future time perspective</td>
<td>Begins to consider range of possibilities but poor information integration</td>
</tr>
<tr>
<td></td>
<td>Feelings of immortality lead to risk-taking</td>
</tr>
</tbody>
</table>

Late Adolescence (17-21 years)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical maturation complete</td>
<td>More comfortable with relationships, peers less important</td>
</tr>
<tr>
<td>Bodily image and gender role definition secure</td>
<td></td>
</tr>
<tr>
<td>Less narcissism</td>
<td>More open to specific questioning</td>
</tr>
<tr>
<td>Idealistic</td>
<td>Idealism may conflict with family</td>
</tr>
<tr>
<td>Nearly emancipated</td>
<td>Understands consequences of actions</td>
</tr>
<tr>
<td>Cognitive development more complete</td>
<td>Understands health care options</td>
</tr>
<tr>
<td></td>
<td>Interest in life goals</td>
</tr>
</tbody>
</table>

Psychosocial Development

Tasks of Adolescence

- Independence from parents
- Adopting peer codes and lifestyles
- Accepting body image
- Establishing sexual, vocational, and moral identities

Psychosocial Development
Strategies for Working with Psychosocial Issues

Anticipatory guidance
Screening and early identification
  – Quick screens
  – Interviewing vs. written information
Parental support
Counseling
Prevention strategies – base on immediate consequences of behavior

Conclusions

• Work with strengths and resiliency aspects
• Developmentally appropriate strategies
• Draw on community resources
• Advocacy

HEADS Interview

Home
Education/employment, Eating
Activities
Drugs
Sexuality, Suicide, Safety

Principles of Health Counseling

• Tailor to developmental stage
• Prioritize issues
• Parental involvement
• Identifying barriers and resources for change

Bullying
Bright Futures Webcast
3/22/2011

Why now?
Definition

A specific form of aggression, which is intentional, repeated, and involves a disparity of power between the victim and the perpetrators.

Forms of Bullying

- Direct
  - Physical
  - Verbal
  - More often boys

- Indirect
  - More often girls
  - Relational/social

Who cares?

- There is one incidence of bullying every 7 minutes in the US
- Adult intervention takes place in 4% of incidents.
- Peer intervention takes place in 11% of incidents.

Cyber Bullying

A form of aggression that occurs through personal computers (email, social networking) or cell phones (texting).

Who’s bullying and who is being bullied?

- Kids with positive parent relationships bully less and are bullied less.
- Friendship protects adolescents from being selected as targets.
- More friends makes adolescents more likely to bully.

Prevention

- Ask! "Are you being bullied or are you ever a bully?"
- Get parents involved if possible and if positive.
- Help adolescents connect.
- Take action in schools and other places where adolescents spend time.

Craig and Pepler, 1997

Wang, 2009
**Resources**

- Stopbullyingnow.com
- Parenting strategies*
- Ideas for creating bully-free schools

*PDF’s available after this talk

**Resources**

- Cyberbullyhelp.com
  - Cyber Bullying Quick Reference Guide for Parents*
  - ABC’s of Cyber Bullying for Students*

**Bibliography**

3. Electronic Media and Youth Violence: A CDC Issue Brief for Educators and Caregivers 2006
4. www.stopbullyingnow.com
5. www.cyberbullyhelp.com

**Motivational Interviewing Strategies in Public Health: Connecting Adolescent Brain Development to Risk Reduction**

Paul Grossberg, M.D.
Clinical Professor Emeritus
Department of Pediatrics
School of Medicine and Public Health
grossberg@pediatrics.wisc.edu

**Objectives**

- Describe the basic principles, “spirit,” and methods of motivational interviewing in working with adolescents and young adults.
- Discuss the neurobiological effects of alcohol on the developing adolescent brain and on risk-taking behaviors.
- Describe specific strategies you will use in your everyday public health and clinical work to motivate adolescents with risky behaviors (drinking, smoking, drug use, overeating, etc.) who are in denial, pre-contemplative, or resistant about change.

**Brazelton’s Touchpoints Approach™**

The guiding principles of the Touchpoints model

- Value and understand the relationship between you and the parent
- Use the behavior of the child as your language
- Value parents’ attachment history
- Focus on the parent-child relationship
- Look for opportunities to offer support
- Recognize the beliefs and biases that you bring to the interaction
- Be willing to discuss matters that go beyond your traditional role
**Brazelton’s Touchpoints Approach™**
Applicable from Infancy to Adolescence

- **Touchpoints™**: Predictable, new acquisition of skill or ability
- Neurobiological processes:
  - Synaptogenesis, myelination, pruning, others
  - Critical to understanding developmental changes
  - Brain must adapt structurally and functionally to complex environmental interactions
- “Adolescent touchpoints” in developmental continuum
  - Adolescence through ages 21-25

**Brief Intervention**
- Time-limited counseling strategies
- Clinician-directed, patient-centered
- Based on Motivational Interviewing (MI)
- Focus on changing behaviors
  - Alcohol
  - “Other” Clinical Interventions
- Harm reduction paradigm
- SBIRT: Screening, Brief Intervention, and Referral to Treatment

**Rankings of 25 USPSTF-Recommended Clinical Preventive Services**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Service</th>
<th>Lower =</th>
<th>5= Highest</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Daily aspirin use</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>Childhood Immunizations</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>Smoking Cessation</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>Alcohol Screening &amp; Brief Intervention</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>Colorectal Cancer Screening &gt;50 yo</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>Hypertension screening &amp; Rx &gt;18 yo</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7</td>
<td>Influenza Immunization &gt;50 yo</td>
<td>4</td>
<td>4</td>
</tr>
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**Teenage Case 1: Jamie**

- You are called to see “Jamie”, a 17 year old high school junior. Referrals have come from the school, social worker, and teachers who say Jamie is often “out of it.”
- At this visit (e.g., school, local clinic, or home) you are told that her mom found a bag of marijuana in her room and “wants her tested.” Jamie was confronted by her parents and admitted, “sometimes I smoke weed, just like you guys sometimes drink!” She is incensed that her parents searched her room, but agrees to talk with you just to “get my parents off my back.” Her grades have been falling in the past year, and she’s had normal routine sports physicals.
Underage Drinking
Wisconsin Public High School Students

Wisconsin Department of Public Instruction
Wisconsin Youth Risk Behavior Surveys

60%
40%

Binge Alcohol Use Past 30 days

Drinking and Driving
Wisconsin Public High School Students

Wisconsin Department of Public Instruction
Wisconsin Youth Risk Behavior Surveys

30%
17%

“Partying” Perceptions at UW-Madison

American College Health Association
National College Health Assessment (ACHA-NCHA)
UW-Madison Institutional Data Report, Spring 2006
N= 787, representative sample of all UW-Madison students

“Look children, this is all I’m going to say about drugs...Stay away from them...There’s a time and a place for everything...and it’s called college.”

Chef
Parker & Stone, South Park

Slide courtesy of Jason Kilmer, PhD

Marijuana Use by Wisconsin 11th Graders
Wisconsin Youth Risk Behavior Survey 2007

“Once a week” 4x per month
“About 30 times in my life”

20% of men between 18 - 35 consume
70% of all the beer sold in the US
Alcohol Toxicity: MORE Effect on:
• Cognitive function
• Memory
• Drug-seeking
• Auditory
• Language
• Judgment
• Impulse Control
• Problem-solving
• Higher reasoning

Alcohol Toxicity: LESS Effect on:
• Sedation function
• Motor Coordination
• Visual
• Emotions
• Risk-taking
• Thrill-seeking
• Sexual, social

Teen + EtOH = More Awake, More Mobile, Less Cognition

"Those who are most likely to drink heavily are those who may be already most "handicapped" neurologically to begin with."
-- Peter Monti, PhD

Alcohol’s neurotoxic effects: ongoing research on short and long term (?)
Clinical Prevention in Practice

- "If your time is limited, you are better off asking patients why they would want to make a change and how they might do it rather than telling them that they should.
- It is the patient rather than you who should be voicing the arguments for behavior change."


Motivational Interviewing
Basic Principles

1. Express Empathy
2. Develop Discrepancy
3. Roll with Resistance
4. Support Self-Efficacy

Motivational Interviewing
Methods: O A R S

Open Questions
not "yes/no"

Affirm
patient's positives/values/character

Reflective Listening
statements understand content and meaning

Summarize
main points, then shift
Summarize periodically, demonstrating you’re listening

Teenage Case 1: Jamie

- You are called to see “Jamie”, a 17 year old high school junior. Referrals have come from the school, social worker, and teachers who say Jamie is often “out of it.”
- At this visit (e.g., school, local clinic, or home) you are told that her mom found a bag of marijuana in her room and “wants her tested.” Jamie was confronted by her parents and admitted, “sometimes I smoke weed, just like you guys sometimes drink!” She is incensed that her parents searched her room, but agrees to talk with you just to “get my parents off my back.” Her grades have been falling in the past year, and she’s had normal routine sports physicals.

Clinician (RN,NP,SW,MD): “You know, Jamie, marijuana can really mess up your brain, not to mention it’s illegal and really got you into trouble at school and at home. It’s important for you to stop so you can get back on track. Have you ever tried to cut down?...”

Role Play example
What “OARS” do you notice?
Motivational Interviewing

Methods: O A R S

- Open Questions: not "yes/no"
- Affirm: patient’s positives/values/character
- Reflective Listening: statements understand content and meaning
- Summarize: main points, then shift

Summarize periodically, demonstrating you’re listening

Listen for "Change Talk": Themes

- **D**: Desire
  - “I wish I could lose some weight”
  - “I like the idea of getting more exercise”

- **A**: Ability
  - “I might be able to cut down a bit”
  - “I could probably try to drink less”

- **R**: Reasons
  - “Cutting down would be good for my health”
  - “I’d sure have more money if I cut down”

- **N**: Need
  - “I must get some sleep”
  - “I really need to get more exercise”

Examples from and/or adapted from: Rollnick, Miller, & Butler (2008)

Sexual Risk Reduction

- Patient-Centered Approach:
  - “Asking” v. “Telling”
    - What do you think about condoms?
    - Describe your experiences using them…
    - How does your partner feel about this?

"30-Seconds" Brief Intervention in Clinical Visits

- Tobacco listed as part of "vital signs": 15-30 seconds
  - It says here you smoke cigarettes? ["yeah"]
  - What do you think about that? ["I should quit"]
  - Why? ["this cough’s a drag…” “my girlfriend hates it” etc.:]
  - Good for you. What would like to do? [varied responses]
  - What worked/didn’t work in the past? We’ll help you…

- Tobacco not listed in vitals: 15-30 seconds
  - Do you smoke…anything? [cigarettes... weed...?]
  - Every day...week...month...? [observe non-verbals]
  - What do you think about that?

- Smoking link to alcohol question: another 15-30 seconds
  - Do you smoke more when you’re drinking? ["yeah"]
  - What does your girlfriend think about that? ["She’s said to drink less"]
  - Why? ["Well too much of that’s not good either"]

  I agree. What did you do? ["I stopped going out on Thursdays"]

Rolling with Resistance

- "It sucks to be here... the last thing you wanted to do today was talk to a (nurse, doctor, social worker, health educator...) about drugs.”
- “You wish your parents would just leave you alone.”
- “They must care about you, but you wish they’d just let you make your own decisions.”
Developing Discrepancy (between goals and behavior)

- "You enjoy getting high with your friends, but it has affected your grades and gotten you into trouble at school and at home. What do you think about that?..."
- "You talked about trying to get into a good college. How do you think the weed might affect those plans...?"
- "How would you feel if your younger brother found out you were smoking weed?...Why?...How would that affect him?...What would you say to him?"

Motivational Interviewing
Rolling with Resistance examples
Problem Drinking

Patient: I don’t think I have a problem or need to cut down
Clinician: You enjoy drinking and don’t think reducing it would work for you right now.

[Reflective Listening: trying to be guiding]

Patient: I’m having too much fun with all my friends.
Clinician: OK, so how would you know if you are having a problem with...

College Health Intervention Projects (CHIPs)

- A 5-year study (2004-2009), 5 campuses in U.S./Canada, NIAAA-funded
  - University of Wisconsin-Madison
  - University of Wisconsin-Stevens Point
  - University of Wisconsin-Oshkosh
  - University of Washington
  - University of British Columbia

- Randomized Control Trial, n=986 high-risk drinkers
- Brief intervention: 2 clinician visits (15-20 min.) in 4 weeks.
- Outcomes (1 year post-study) in intervention group:
  - Significant reduction in drinks in past 28 days
  - Significant reduction in problems/harms from alcohol
  - Blackouts: strong correlations with harms, ER visits
  - Heavy drinking days independently correlated with any injuries

**Brief Alcohol Interventions in Clinical Practice**

Top 5 Clinician Tools 1

1. Summary of Patient’s Drinking Level
2. Drinking Likes and Dislikes
3. Discussing Life Goals
4. Risk Reduction Agreement
5. Drink Tracking Cards

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**Office-Based Intervention Strategies: “FRAMES”**

Feedback

“I’m concerned about your alcohol use because you told me that your stomach aches were getting more frequent.”

Have you ever thought that you might not be arguing as much with your parents if you weren’t drinking?”

Responsibility

“You’re almost an adult, so you’ll be taking responsibility for your own life. Neither your parents nor I can make you change. It’s your decision. We would like to help you, but it’s really your call…”

Advice

“Because I’m so concerned I recommend that you stop drinking completely (or cut it down) for a while, at least until we can meet to talk about this again…”

Menu of alternatives

“Here are some ideas that have worked for other teens in your situation… what do you think would work for you? What are some good things and some not-so-good things about your drinking? How can you do to avoid those not-so-good experiences you’ve had with drinking? What would you like to do?”

Empathy

“This must be hard for you… You’d probably rather not be here talking about this…”

“… I understand what you’ve been going through, and I know what I’m suggesting is not easy…”

Self-efficacy

“You have a lot of positive things going for you in your life, and I know you can do this…”

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**Brief Intervention “Pearls”**

Alcohol- quantity, frequency, heavy
Blackouts / Brain
Concerned / Confidentiality
Enjoy
Not enjoy
Do: patient-clinician plan
Support / self-efficacy

If you don’t occasionally have a patient (or parent) get upset with you, you are probably not doing a thorough enough job of talking about alcohol or other risky behaviors…

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**Office-Based Intervention for Adolescent Substance Abuse**

1. SBIRT Planning
2. Screen, Brief Intervention
3. Develop an Action Plan
   - Abstinence Challenge
   - CUT (Controlled Use Trial)
   - Contingency Plan
4. Referral to Treatment
   - Community treatment agencies
   - Specialists
   - Know local resources
   - Websites (see references list)

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**Clinical Prevention in Adolescents**

Every adolescent clinical conversation is an opportunity to elicit a prevention “motivational moment”, however brief, but always teen-centered, relevant to the presenting concern, and designed to stimulate individual, specific efforts at behavioral risk reduction.

Ideally, the teenager will verbalize the need and the plan to start changing behavior.
Clinical Prevention

An ounce of prevention…
is a ton of work!

Paul S. Frame, M.D.

References

- US Preventive Services Task Force (USPSTF)
- Advisory Committee on Immunization Practices (ACIP)
- National Commission on Prevention Priorities. http://www.prevent.org/content/view/43/71
- Crews F. Alcohol-induced neurodegeneration secondary to radiation doses and proinflammatory protein that are therapeutic. Alcohol Alcohol 2009, Mar-Apr: 115-127.
- www.thecoolspot.gov (12-14 year olds)
- www.collegedrinkingprevention.gov/HSParentStudents (15-17 year olds)
- www.collegedrinkingprevention.gov/CollegeStudents (18-20 year olds)

~ SAVE THE DATE ~

- May 18, 2011 - Bright Futures: Promoting Healthy Sexual Development and Sexuality

COMPLETE EVALUATIONS:

http://www.dhs.wisconsin.gov/health/mch/BrightFutures/index.htm

Time for Questions