BRIGHT FUTURES

Promoting Child Development and Mental Health - (Part 2)

March 22, 2011

ASK A QUESTION !!

by using feature at top of speaker screen anytime during the presentations

Introduction to Media Site

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

PRESENTERS

Murray L. Katcher, Chief Medical Officer, BCHP
Wisconsin Department of Health Services (DHS)

Patricia K. Kokotailo, MD, MPH,
Associate Dean for Faculty Development and Faculty Affairs, University of Wisconsin School of Medicine and Public Health

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.

PRESENTERS

Paul Grossberg, MD, Clinical Professor Emeritus, Department of Pediatrics, University of Wisconsin School of Medicine and Public Health

Megan Lederer, MD, Pediatric Resident, University of Wisconsin Hospital and Clinics

Claude Gilmore, Youth Policy Director, Wisconsin Department of Health Services

Bright Futures

Murray L. Katcher, MD, PhD
Chief Medical Officer, BCHP
Wisconsin Department of Health Services (DHS)

Bright Futures

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**

Bright Futures

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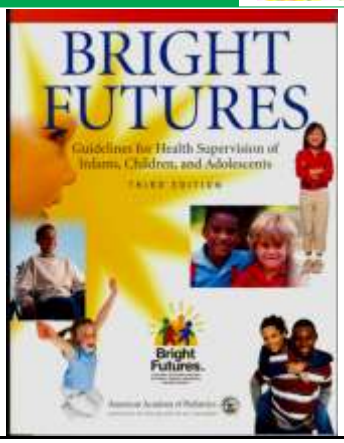
Bright Futures



Bright Futures

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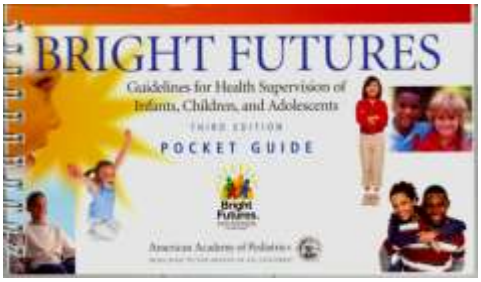
Bright Futures



Bright Futures

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Bright Futures

What Is Bright Futures?

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

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Bright Futures

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Integrating Bright Futures into Public Health at the State and Local Levels

Bright Futures

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

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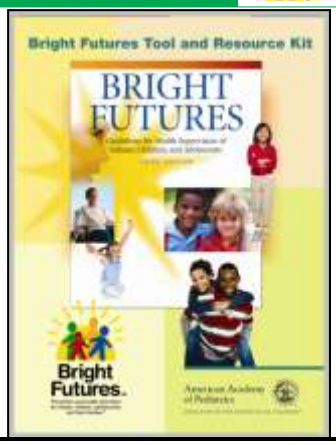
Integrating Bright Futures into Public Health at the State and Local Levels

Bright Futures



Integrating Bright Futures into Public Health at the State and Local Levels

Bright Futures

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

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Integrating Bright Futures into Public Health at the State and Local Levels

Bright Futures

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=9824

Integrating Bright Futures into Public Health at the State and Local Levels

Bright Futures

Wisconsin's Bright Futures Webcasts

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

Applying the 10 Bright Futures Themes to Public Health

- Promoting Family Support
- Promoting Child Development
- Promoting Mental Health
- Promoting Healthy Sexual Development and Sexuality
- Promoting Community Relations and Resources

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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

ADOLESCENT HEALTH POLICY TRENDS

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

ADOLESCENT HEALTH POLICY TRENDS

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

ADOLESCENT HEALTH POLICY TRENDS

- 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

ADOLESCENT HEALTH POLICY TRENDS

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

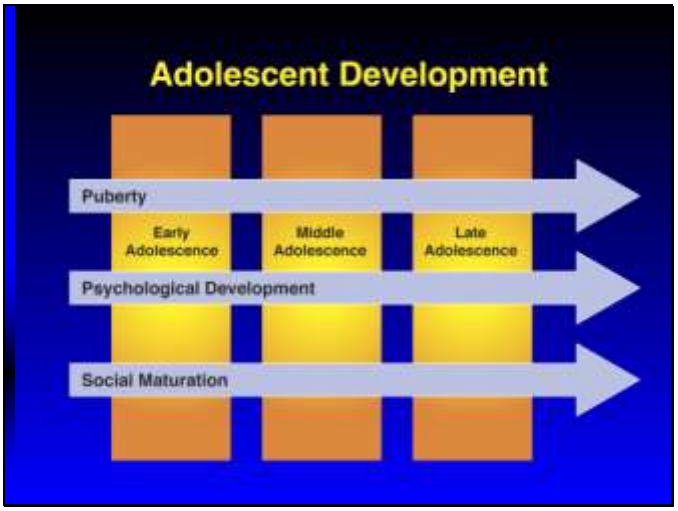
ADOLESCENT HEALTH POLICY TRENDS

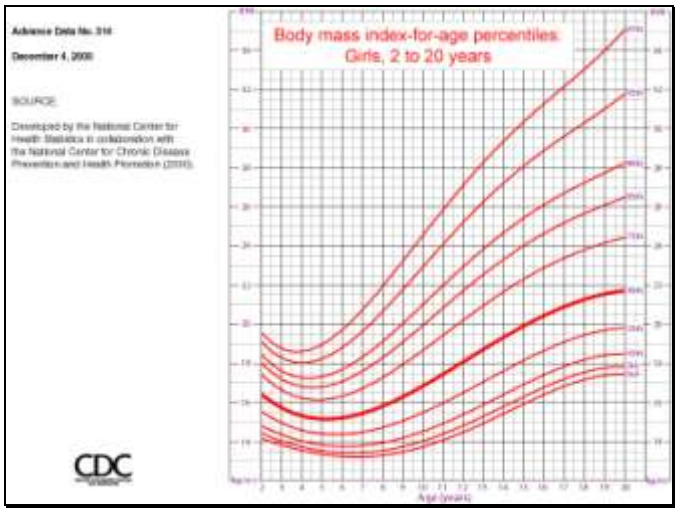
- Federal Interagency Working Group on Youth Programs Current Emphasis
  - Bullying Prevention
  - Positive Youth Development
  - Afterschool Programs
  - Transition Age Youth

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

	Girls	Boys
Onset	9 y/o	11 y/o
PHV Age	11.5 y/o	13.5 y/o
PHV	9 cm/yr	10.3 cm/yr
Avg. growth	25 cm	28 cm

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

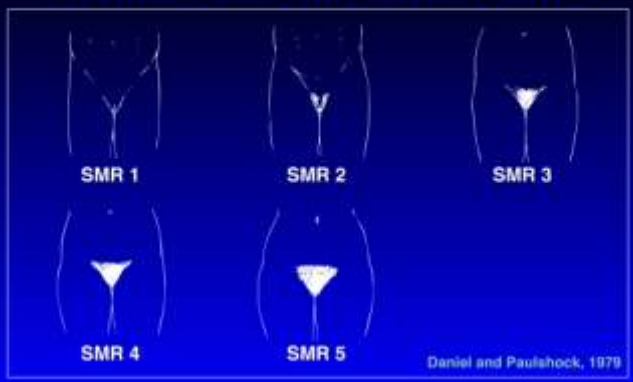
Physiological Changes

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

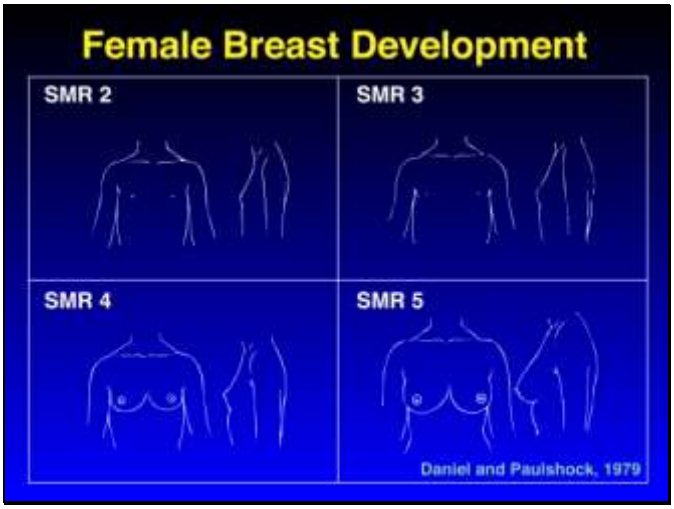
Body Composition Growth

- 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



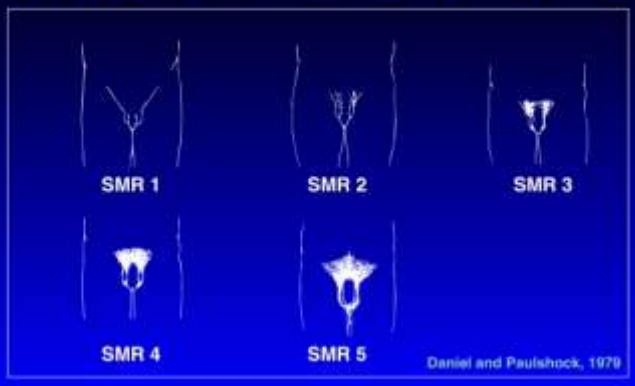
Female Breast Development



Sexual Development: Boys

Rosen DS. Pediatrics in Review Vol.25 No.6 June 2004

Male Genital and Pubic Hair Development



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

Sexual Development: Girls

Rosen DS. Pediatrics in Review Vol.25 No.6 June 2004

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

Psychosocial Development
Early Adolescence (10-13 years)

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

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
Middle Adolescence (14-16 years)

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

Psychosocial Development
Tasks of Adolescence

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

Psychosocial Development
Late Adolescence (17-21 years)

Characteristics	Impact
Physical maturation complete, body image and gender role definition secure	More comfortable with relationships, peers less important
Less narcissism	More open to specific questioning
Idealistic	Idealism may conflict with family
Nearly emancipated	Understands consequences of actions
Cognitive development more complete	Understands health care options
Functional role being defined	Interest in life goals

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

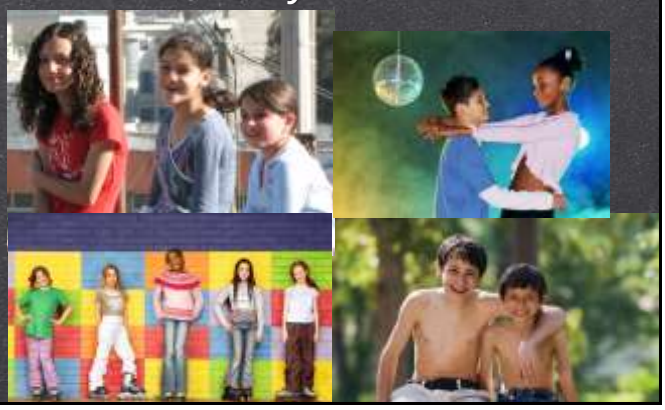
Bullying

Bright Futures Webcast
3/22/2011

Principles of Health Counseling

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

Why now?



Definition

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

Cyber Bullying

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

Forms of Bullying

- Direct
  - Physical
  - Verbal
  - More often boys
- Indirect
  - More often girls
  - Relational/social

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.

Wang,2009

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.

Craig and Pepler, 1997

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.

Resources

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

*PDF's available after this talk

Wisconsin Division of Public Health
Department of Health Services

Bright Futures Webcast
March 22, 2011

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

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

Resources

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

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.

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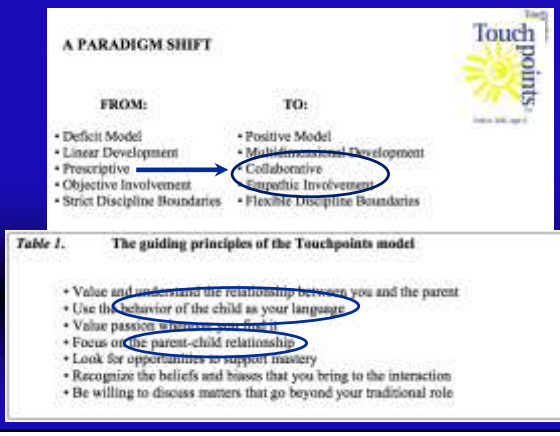
Bibliography

- Wang J, Iannotti RJ, Nansel TR. School bullying among adolescents in the United States: Physical, verbal, relational and cyber. J Adolesc Health 2009;45:368-375.
- Craig WM, Pepler D, Atlas R. Observations of bullying in the playground and in the classroom. School Pyschology International 2000; 21: 22-36.
- Electronic Media and Youth Violence: A CDC Issue Brief for Educators and Caregivers.2006
- www.stopbullyingnow.com
- www.cyberbullyhelp.com

Brazelton's Touchpoints Approach™



Brazelton's Touchpoints Approach™
Applicable from Infancy to Adolescence

- Touchpoints™: Predictable, new acquisition of skill or ability
- Neurobiological processes:
  - synaptogenesis, myelinization, 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

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Motivational Interviewing is simple... ...but not easy[1]

- Complex set of skills, used flexibly and responsively
- Similar to learning to play a complex sport or musical instrument
- Conscious and disciplined use of specific communication principles and strategies
- Not a trick or technique easily mastered in one session or a workshop or two
- Proficiency requires practice with feedback and coaching over time

[1] Miller WR, Rollnick S. Ten Things Motivational Interviewing is Not. *Behavioural and Cognitive Psychotherapy*, 2009, 37, 129-140.

Brief Intervention

- Time-limited counseling strategies
- Clinician-directed, patient-centered
- Based on Motivational Interviewing (MI)
- Focus on changing behaviors
  - Alcohol → "Other" Clinical Interventions
  - Tobacco, STI, obesity, hypertension, adherence with medication, and other medical advice.
- Harm reduction paradigm
- SBIRT: *S*creening, *B*rief *I*ntervention, and *R*eferral to *T*reatment

Alcohol / Substance Use Related Harms in Adolescents

- Injuries, illnesses, trauma, death
- Activity: Loss of Interest
  - school, play, home, work
- Change in Sleeping, Eating
- Personality, Moods, Fighting
- Fatigue
- Depression, Concentration
- Trouble with school, law
- Memory blackouts

Rankings of 25 USPSTF Recommended Clinical Preventive Services

1	Daily aspirin use	5	5
2	Childhood Immunization	5	5
3	Smoking Cessation	5	5
4	**Alcohol Screening & Brief Intervention**	**4**	**5**
5	Colorectal Cancer Screening >50 yo	4	4
6	Hypertension screening & Rx >18 yo	5	3
7	Influenza Immunization >50 yo	4	4

Rating: B Recommendation. High Benefit, Cost-Effective

5= Highest
1= Lowest

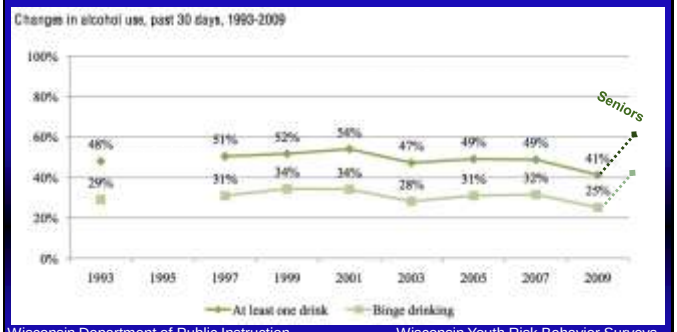
Lower: Screening for Cervical and Breast Cancer, Chlamydia, Nutrition Vision Children, Osteoporosis

- U.S. Preventive Services Task Force 2006
- NIAAA
- American Academy of Pediatrics
- Institute of Medicine
- WHO
- American Society of Addiction Medicine
- American College of Surgeons
- Canadian Task Force on Preventive Care

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

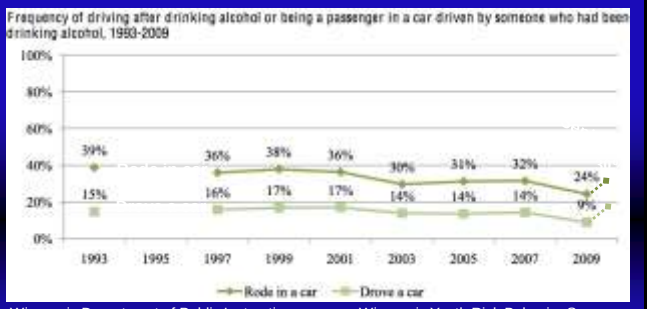
"Look children, this is all I'm going to say about drugs…Stay away from them…There's a time and a place for everything…and it's called college."

Chef

Parker & Stone, South Park

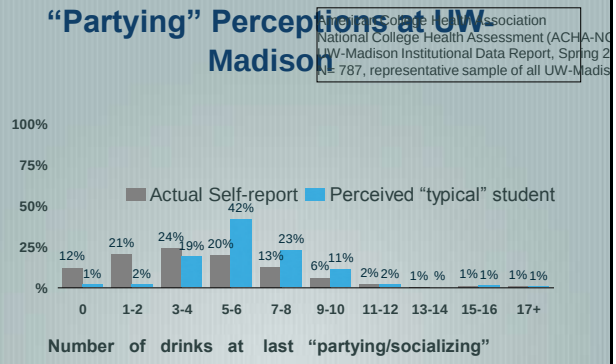
Slide courtesy of Jason Kilmer, PhD

Drinking and Driving
Wisconsin Public High School Students

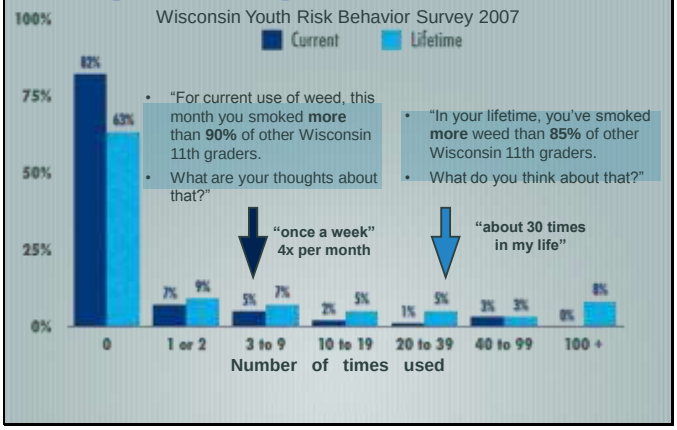


Wisconsin Department of Public Instruction — Wisconsin Youth Risk Behavior Surveys

"Partying" Perceptions at UW-Madison



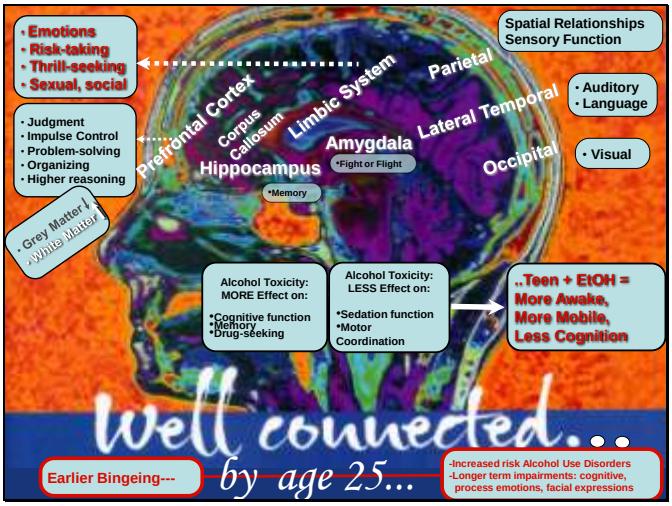
Marijuana Use by Wisconsin 11th Graders

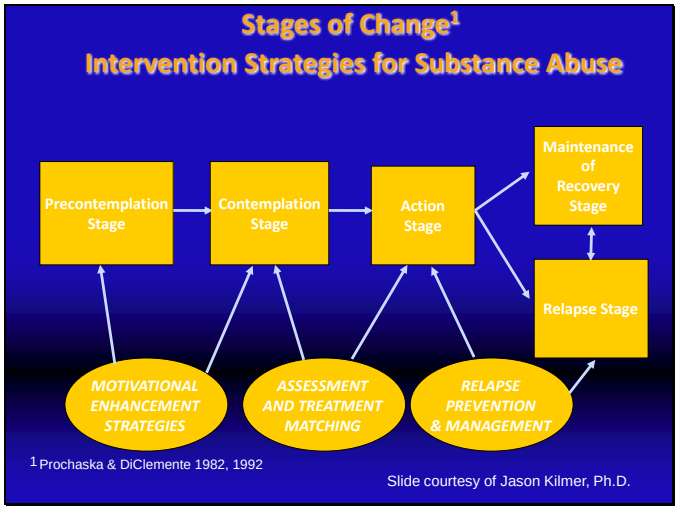


- "For current use of weed, this month you smoked **more** than **90%** of other Wisconsin 11th graders.
- What are your thoughts about that?"

- "In your lifetime, you've smoked **more** weed than **85%** of other Wisconsin 11th graders.
- What do you think about that?"

- 20% of men between 18 - 35 consume
- 70% of all the beer sold in the US

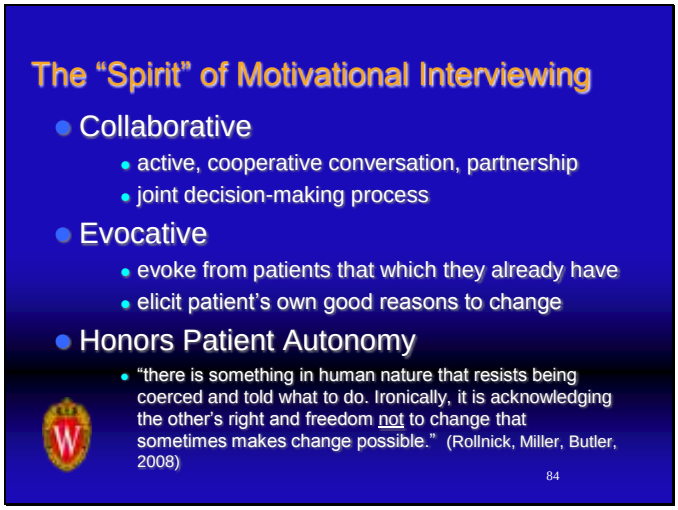

• Emotions
• Risk-taking
• Thrill-seeking
• Sexual, social
Spatial Relationships
Sensory Function
• Judgment
• Impulse Control
• Problem-solving
• Organizing
• Higher reasoning
Prefrontal Cortex
Corpus Callosum
Limbic System
Parietal
Lateral Temporal
Occipital
• Auditory
• Language
• Visual
Amygdala
•Fight or Flight
Hippocampus
•Memory
• Grey Matter
• White Matter
Alcohol Toxicity: MORE Effect on:
•Cognitive function
•Memory
•Drug-seeking
Alcohol Toxicity: LESS Effect on:
•Sedation function
•Motor Coordination
..Teen + EtOH = More Awake, More Mobile, Less Cognition
Well connected...
Earlier Bingeing---
by age 25...
-Increased risk Alcohol Use Disorders
-Longer term impairments: cognitive, process emotions, facial expressions


Stages of Change[1]
Intervention Strategies for Substance Abuse
Precontemplation Stage
Contemplation Stage
Action Stage
Maintenance of Recovery Stage
Relapse Stage
MOTIVATIONAL ENHANCEMENT STRATEGIES
ASSESSMENT AND TREATMENT MATCHING
RELAPSE PREVENTION & MANAGEMENT
[1] Prochaska & DiClemente 1982, 1992
Slide courtesy of Jason Kilmer, Ph.D.


The New York Times
Wednesday, October 27, 2010
Caffeine and Alcohol Drink Is Potent Mix for Young


Clinicians' Usual Advice about Health Behavior Change
It's not very effective
We do it anyway (we've been trained to)
It lowers our anxiety
If we go into "giving advice mode", or sound like we're lecturing, we can re-connect with the patient by saying something like:
"So, what do you make of that?"...


Adolescent Neurodevelopment:
Brains, Behavior, Booze, & Brakes
Prefrontal Cortex- the "brakes"- still "under construction"
Alcohol's neurotoxic effects:
ongoing research on short and long term (?)
"Those who are most likely to drink heavily are those who may be already most "handicapped" neurologically to begin with."
-- Peter Monti, PhD


The "Spirit" of Motivational Interviewing
Collaborative
active, cooperative conversation, partnership
joint decision-making process
Evocative
evoke from patients that which they already have
elicit patient's own good reasons to change
Honors Patient Autonomy
"there is something in human nature that resists being coerced and told what to do. Ironically, it is acknowledging the other's right and freedom not to change that sometimes makes change possible." (Rollnick, Miller, Butler, 2008)
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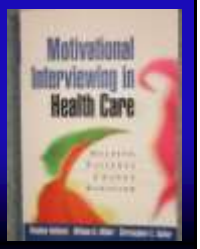
Clinical Prevention in Practice

- "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."
  - Rollnick S, Miller WR, Butler CC. Motivational Interviewing in Health Care: Helping Patients Change Behavior. Guilford Press 2008.



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.

Motivational Interviewing
Basic Principles
(Miller and Rollnick, 1991, 2002, 2008)

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

Teenage Case 1: Jamie

- 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?..."

Motivational Interviewing
Methods: O A R S

Ask permission first
MI is more like "pulling" rather than "pushing"

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

- Role Play example
- What "OARS" do you notice?

Motivational Interviewing Methods: O A R S

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Summarize periodically, demonstrating you're listening

MI Clinician Conversation "Starters"
Alcohol and other behavioral risks

- "Is it ok if we talk a little more about how alcohol affects you and your body? *("ok")*...I talk with all my teenage patients about how alcohol affects the judgment parts of your brain and often leads to drinking more than expected, or sometimes driving, or getting in a car, or having sex with someone who was drinking...
- I'm concerned about your health, but I can't tell you what to do; only you can decide what you'll do. Rather, now that all this has happened, I'd like to find out what you think about drinking, and maybe we can see if together we can come up with some ways to avoid these kinds of situations in the future.
- You're the one who will decide what happens with your drinking. If you choose, you can make some changes, but that's really up to you. How does that sound? Can we try this out?"

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?

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"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."

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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?"

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Rolling with Resistance
[Responding to "Sustain Talk"]

- *"There's nothing to do in high school if you don't drink!"*
  - Potential responses to elicit resistance:
    - I hear what you're saying, but I really think your drinking is interfering with your schoolwork and needs to change.
    - You know that there are lots of things to do without alcohol-- in high school or in town, right?
    - I know where you're coming from, but it's better that you don't just go along with what other people are doing.

Motivational Interviewing
Rolling with Resistance examples
Problem Drinking

- *Patient:* I don't think I have a problem or ne to cut down
- *Clinician:* You enjoy drinking and don't think that reducing it would work fo 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

Rolling with Resistance
[Responding to "Sustain Talk"]

- *"There's nothing to do in high school if you don't drink!"*
  - Potential responses to minimize resistance:
    - Your options seem extremely limited.
    - It's hard to imagine changing your drinking ***and*** having a good social life.
    - Life in high school might get pretty boring if you decided to change your drinking...and that's not a choice you're ready to make now.
    - You're probably not the only student who has felt this way.

Motivational Interviewing
Rolling with Resistance examples
Problem Drinking

- Patient: "I don't really have a problem or need to cut down"
- Clinician: "Actually, Tom, I'm concerned about your broken wrist, the hole in the wall, and the fact that your girlfriend won't talk to you now... It seems to me the alcohol has contributed quite a bit to this situation. What do you think?"
- *[summary; agenda setting; asking]*

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

Fleming MF, Balousek SL, Grossberg PM, Mundt, MP, Brown DD, Wiegel JR, Zakletskaia LI, Saewyc EM. Brief Physician Advice for Heavy Drinking College Students: A Randomized Controlled Trial in College Health Clinics. *J Stud Alcohol Drugs*. 2009 Jan; 71(1):23-31.

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

[1] Grossberg P, Halperin A, MacKenzie S, Gisslow M, Brown D, Fleming M. Inside the Physician's Black Bag: Critical Ingredients of Brief Alcohol Interventions. *Substance Abuse* 2010 Oct; 31(4):240-250.

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 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…"

Levy S, Vaughan B, Knight R. Office-based intervention for adolescent substance abuse. *Pediatr Clin N Am* 2002 49:329-343.

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…

Office-Based Intervention for Adolescent Substance Abuse

- SBIRT Planning
- Screen, Brief Interve
- Develop an Action Pl
  - Abstinence Challenge
  - CUT (Controlled Use Trial)
  - Contingency Plan
- Referral to Treatmen
  - Community treatment agencies
  - Specialists
  - Know local resources
  - Websites (see references list)

Abstinence challenge developed by the Adolescent Substance Abuse Program, Children's Hospital Boston.

CRAFFT

Part A
During the PAST 12 MONTHS, did you:

	No	Yes
1. Drink any alcohol (more than a few sips)?	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high? "Anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff".	☐	☐

If you answered NO to A1, A2, A3 (and answered anything in B1 before this) STOP.

If you answered YES to ANY of A1 to A3 answer B1 to B6 below.

Part B

	No	Yes
1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?	☐	☐
4. Do you ever FORGET things you did while using alcohol or drugs?	☐	☐
5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?	☐	☐

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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.

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- www.thecoolspot.gov (12-14 year-olds)
- www.collegedrinkingprevention.gov/HSParentStudents (15-17 year-olds)
- www.collegedrinkingprevention.gov/CollegeStudents (18-20 year olds)

Integrating Bright Futures into Public Health at the State and Local Levels

Bright Futures

~ SAVE THE DATE ~

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

Integrating Bright Futures into Public Health at the State and Local Levels

Bright Futures

COMPLETE EVALUATIONS:

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

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Time for Questions