COMPREHENSIVE APPROACH TO ADOLESCENTS IN HEALTH SERVICES

From understanding to clinical practice

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Abstract: The approach to adolescents in clinical practice requires knowledge of this age group, their biopsychosocial development and their health context.

This will provide an understanding of the needs of health services and their professionals for a holistic approach.

Key words: Adolescent, biopsychosocial, protective factors, risk factors, friendly services, integrated approach, HEADSSS.

INTRODUCTION

Adolescents are people between the ages of 10 and 19. Since young people are those between the ages of 15 and 24, adolescents between the ages of 15 and 19 are both adolescents and young people (WHO, 1989).

Adolescence is a phase of the life cycle with specific characteristics, specific needs and tasks of its own. It is no longer defined as a "transition between childhood and adulthood" (Krauskopf, 2015). It is marked by an important biopsychosocial development and health professionals must provide adequate and comprehensive care, having the necessary knowledge and skills to care for people in this age group (SMA, 2005).

In summary, the goals of adolescence include growth and puberty (biological), the evolution from concrete to abstract thinking (cognitive), the redefinition of interpersonal relationships (specifically with family and peers), the progressive establishment of identity/individuality (vocational, moral, religious/spiritual, cultural, gender and sexual) and the acquisition of autonomy. It also includes experimentation and risky behaviours (Moleiro, 2017).

Adolescence is theoretically divided into 3 phases: early, middle and late adolescence. This division is based on what is considered to predominantly characterize each phase, in relation to biopsychosocial development (Hofmann, 1997).

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Each adolescent must be seen and approached as a unique person, assessing every aspect of their biopsychosocial development. At the same time, it must always be borne in mind that each adolescent is a subject of rights, as established in the Convention on the Rights of the Child (understood up to the age of 18) (UN, 1989).

The health professional will thus offer the best care to the adolescent in front of him or her, care that will be provided with a comprehensive approach and from a rights-based perspective.

Morbidity and mortality in adolescence

In addition to assessing the adolescent stage, the health professional must take into account that in this age group there is a "shift" in the causes of morbidity and mortality. As age advances, behavioural situations such as HIV infection (and other sexually transmitted infections), pregnancy (associated with voluntary termination or childbirth), malnutrition (and/or nutrient deficiencies) and/or malnutrition (due to overweight/obesity), tobacco, alcohol and other drug use, violence and mental illness also increase. Also with age, violent causes of mortality (violence, accidents and suicide) predominate over natural causes (WHO, 2002a; WHO, 2021).

CHARACTERISTICS OF HEALTH SERVICES AND PROFESSIONALS

In 2001, the World Health Organization (WHO) established a consensus on the characteristics of "Adolescent and Youth Friendly Services" (YFYSS) to respond to the specific needs of this age group (WHO, 2002b). YFYAS should be equitable, accessible, acceptable, appropriate and effective (WHO, 2012). Therefore, the components of a YFYSS should include:

1. Access to health services and the possibility of receiving care, with (*ideally)* a space exclusively for adolescents that is well signposted and has a good atmosphere. Opening hours should be appropriate to the times when adolescents can come to the service, alone or accompanied, and the consultation should last no less than 30 minutes (and a first consultation should be 60 minutes). The existence of these services should be communicated to the community; there should be messages in these services that encourage adolescents/young people and their peers and inform them of the confidentiality of the service.
2. Health professionals and staff with good knowledge and practices and with skills that promote autonomy for free and responsible decision-making.
3. Administrative and management procedures.
4. Availability of a wide range of services.
5. Adolescent and youth and community involvement. Adults should support adolescents and youth in seeking services and should make arrangements with other institutions, with the creation of support groups including groups of other adolescents and youth.

In addition to having the technical skills and the ability to understand the physical, cognitive, emotional and social changes of this phase, the health professional must have interest and availability and know how to work in an interdisciplinary team.

ADOLESCENT CARE

Dynamics of the query(s)

At the first consultation, the adolescent is usually accompanied by a family member or other adult or legal representative. First of all, they should be greeted and asked for the name they wish to be addressed by (and record it for future attendances). Professionals should introduce themselves (SMA, 2005) (Moleiro, 2017).

In that consultation, the "New Rules" should be clearly defined and explained to all present (recalled in subsequent consultations, whenever necessary) (SMA, 2005) (Moleiro, 2017):

- The right to privacy and confidentiality (defining its limits as abuse, risk of harm to self and/or others, crime);

- The (increasing) responsibility for their health (in an empowerment perspective);
- Establishing "alone" times with the health professional (depending on the adolescent's stage of development and/or desire).

Due to ignorance or for other reasons, the adolescent will not always provide certain information, so the entry of a family member or other person accompanying the adolescent will make it possible to find out the reasons for consultation, the main complaints and problems, review the personal and family history, understand the family dynamics and establish an "alliance" with the parents (without ever breaking confidentiality, establishing an empathetic relationship with the adolescent and having moments alone) (Moleiro, 2017).

The dialogue. Physical examination.

Dialogue should preferably take place with the adolescent and the latter dressed. The professional must demonstrate: security and neutrality (being tolerant, avoiding judgment and prejudices); attention, genuine interest and empathy; ability to use simple and clear language (avoiding technicalities and "adolescent" language, although it may include expressions typical of this age group) (AME, 2005) (Moleiro, 2017).

In a first consultation, the physical examination can be delayed, if necessary (although it may reveal the true reason for the consultation). When it is performed, it should be done with respect and ensure its normality or variations of normality (Moleiro, 2017).

The interview.

The objectives of the interview aim to establish an appropriate therapeutic relationship, assess the (bio)psychosocial development of the adolescent, identify the real reason/problem (physical, psychological and/or social) and the respective guidance. At the same time, it aims to promote the adolescent's autonomy, reinforce healthy behaviors, promote other behaviors and prevent future health problems (Moleiro, 2017).

Table 1. Interview techniques, we refer to the aspects to take into account when interviewing adolescents (Canals, 1999) (Moleiro, 2017). Other techniques are motivational interviewing and brief interventions.

***Table 1**. INTERVIEW TECHNIQUES*

WAYS OF ASKING (Canals, 1999)	Comment (Miller, 2017)
With open questions	Closed-ended questions result in yes/no answers. The scores obtained must be brief.
With mirrored responses	Its aim is to encourage dialogue.
Clarify complex or non-complex issues explained adequately	In addition to clarifying, it demonstrates attention and interest on the part of the professional.
Summarizing the most relevant aspects for the throughout the interview	In addition to summarizing, it demonstrates attention and interest on the part of the professional.
Normalization of the most "shameful" before interrogating them	It conveys the concept that all topics are addressable in consultation.

More sensitive issues should be left to the end	Start with more general topics, empathy and subsequently a more favourable environment in which to address the sensitive issues.

These techniques are embedded in established interview models such as the original HEADSS (Cohen, 1991) through to the HEEADSSS 3.0 version (Klein, 2014), among others. These models (Table 2.
HEAADSSSS) were constructed in order to question the easier topics initially and the more sensitive ones later, to establish which protective and risk factors are present and to reveal the true reasons for consultation (Moleiro, 2017).

Note that the adolescent interview templates serve as a guide for health professionals. They may not be followed in a single consultation; items may need to be re-evaluated throughout follow-up. Each practitioner can "recreate" their script within existing templates or create their own script. Above all, the interview should be conducted according to the above assumptions.

***Table 2**. HEAADSSSSSSS*

HEAADSSSSSS	NOTES
H. Habitation (Home)	**Where you live, with whom, relationships (family tree) Employment/education of parents and relatives Family Dynamics Family History . Health (including psychiatric disorders) . . Violence, drug use . Events - key in the family**
E. Education. Employment. (Education. Employment)	**Frequency, location and school year Subjects: preferred and least preferred; qualifications Relations with teachers, teaching assistants and colleagues Future plans Absenteeism. Changes in school and reasons Employment/jobs.**
A. Eating. (Eating)	**Dietary pattern (obesity and eating disorders). Body image/body weight/body shape. dieting Compulsive exercise and/or other compensatory behaviors. APP and sites web.**
A. Activities	**Extracurricular and leisure activities . Hobbies, sports, groups, support networks, religion, etc. . Social Networking/Online Gaming/Screen Time Friendships Fun Modes/Outputs nocturnal Sleep pattern**
D. Drugs	**Usual medication Smoking (including e-cigarettes), alcohol, other drugs (including pharmaceuticals). Problematic use of the Internet/social networking/online gaming. . In friends, in family . In the Circumstances, quantity, frequency, consumption routes Other risky behaviors (driving, relaxing, alone, forgetting, with friends, trouble with the law): . "CRAFFT"= Car+Relaxation+Alone+Forgotten+Friends+Problems**
S. Sexuality	**Relationship. Affections. Not to assume the orientation**

	Knowledge: Sexually Transmitted Infections and Contraception **. Sources of information. Knowledge of health information and support services.** **Sexual activity** **. Masturbation** **. Relationships: Age(s)? partner(s)? with protection?** **. Yes: STIs, Pregnancy, Under the Influence of Drugs** **. "Virtual sex. Sexting. Sharing intimate images by mobile phone, chats or social networks.** **Sexual abuse? Prostitution?**
S. Suicide	**Changes in sleep, appetite, appetite** **Mood changes (irritability, boredom, anxiety, sadness) Sexual orientation and gender identity** **Social isolation, feelings of guilt** **. Suicidal ideation, self-injury** **. Suicide Attempts** **. History of depression/psychotherapeutic counseling.**
S. Security	**Helmet and seatbelt use, driving Bullying,** **cyberbullying** **Domestic violence, dating violence, sports violence, abuse (sexual and otherwise) Gangs, access to guns/knives, trouble with the law** **Previous behaviours under the influence of drugs Strategies for coping with safety risk situations**
(S.) Support	**Qualities from your point of view:** **. Family** **. Friends** **. Own** **. Healthcare Professional**

Adapted from (Klein, 2014) and (Miller, 2017).

REFERENCE

Adolescents with diabetes are suggested to be referred to Adolescent Medicine consultations (SPMA, 2016):

- Suspected alteration of growth and/or pubertal development (except in situations already observed and evaluated by a Paediatrician and/or if a Paediatric Endocrinology Clinic is available).
- Eating and feeding disorders (when possible, in articulation with a child psychiatry and nutrition consultation).
- Experimentation and/or consumption of alcohol, tobacco or other psychoactive substances (excluding situations of dependence, which should preferably be referred to the respective Integrated Response Centers - IRC).
- Need for contraceptive counselling, problem associated with sexuality and/or risky sexual behaviour.
- Nonspecific discomfort and the need for differential diagnosis between organic disease and psychosomatic discomfort.

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- Psychosocial problem1 (emotional, behavioural, family, social and/or in the context of chronic illness/physical malformation), without follow-up and without indication of prior observation in child psychiatry consultation2 .
- Other pathological situation specific to this age group or with a significant impact on their biopsychosocial development.

BIBLIOGRAPHIC REFERENCES

Canals, J. C. (1999). Interview techniques with the adolescent. *Anales Españoles de Pediatría. Suppl124*, pp. 7-10. X Congress of the A.E.P. Spanish Society of Adolescent Medicine.

Cohen, E. M. (1991). HEADSS, a psychosocial risk assessment instrument: implications for designing effective intervention programs for runaway youth. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine.* pp. 539-544. doi:10.1016/0197-0070(91)90084-y

Hofmann, A. D. (1997). Adolescent growth and development. In D. E. Adele Dellenbaugh Hofmann, *Adolescent Medicine (*pp. 10-22). Connecticut: Appleton & Lange.

Klein, M. G. (2014). HEEADSSS 3.0: The psychosocial adolescent interview updated for a new media-fueled century. . *Contemporary Pediatrics*.

Krauskopf, D. (2015). The markers of youth: The complexity of ages. *Last Decade*, pp. 115-128. doi:http://dx.doi.org/10.4067/S0718-22362015000100006

Moleiro, P. (2017). Interview with adolescents. Interview with adolescents. *12ª Escola de Outono de Medicina do Adolescente.* Ponta Delgada: SPP Portuguese Society of Adolescent Medicine. doi:10.13140/RG.2.2.32832.43524/1.

UN. (1989). *Convention on the Rights of the Child.* New York: United Nations. Retrieved from https://gddc.ministeriopublico.pt/sites/default/files/documentos/instrumentos/convencao_sobre_direitos_da_crianca.pdf

1 Excluded from this context are situations of poor school performance caused by specific learning disorders or cognitive deficits and school problems related to the professional area (situations that should be, on a case by case basis, referred to other specific consultations).

2 Whenever available, the following situations should preferably be referred to a child psychiatry consultation: 1) Adolescents with behavioural disturbances in the context of mental illness - e.g. psychosis, depression, cognitive deficits, etc.; 2) Adolescents with suicidal ideation; 3) Adolescents with self-injurious behaviours.

SMA. (2005). *Requirements for Adolescent Care.* Lisbon: Secção de Medicina do Adolescente da Sociedade Portuguesa de Pediatria. Retrieved from http://www.spp.pt/UserFiles/file/Protocolos_SPP/Atendimento_Adolescente.pdf

SPMA. (2016). Criteria for referral to the Adolescent Medicine Consultation. *SPMA-SPP Annual Meeting.* Penafiel: SOCIEDADE PORTUGUESA DE MEDICINA DO ADOLESCENT. Retrieved from https://www.spp.pt/UserFiles/file/eventos%20nacionais_2016/1encontro%20SPMA%20outubro_I.pdf

WHO. (1989). *The health of young people.* Geneva: World Health Organization.

WHO. (2002a). *Adolescent friendly health services. An agenda for change.* Geneva: World Health Organization.

WHO. (2002b). Global consultation on adolescent-friendly health services. A consensus statement. pp. 1-25.

WHO. (2012). *Making adolescent friendly health services. Developing national quality standards for adolescent-friendly health services.* (ISBN: 978 92 92 4 150359 4 ed.). Geneva: World Health Organization.

WHO. (2021). Adolescent and young adult health. *Adolescent and young adult health.* Geneva: World Health Organization. Retrieved from https://www.who.int/news-room/fact-sheets/detail/adolescents-health-risks-and-solutions