The CRAFFT Screening Interview

Begin: "I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."

Part A

During the PAST 12 MONTHS, did you:	**No**	**Yes**
1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	☐	☐
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")	☐	☐

For clinic use only: Did the patient answer "yes" to any questions in Part A?

No ☐ **Ask CAR question only, then stop**

Yes ☐ **Ask all 6 CRAFFT questions**

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?	☐	☐

CONFIDENTIALITY NOTICE:

The information recorded on this page may be protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient for this purpose.

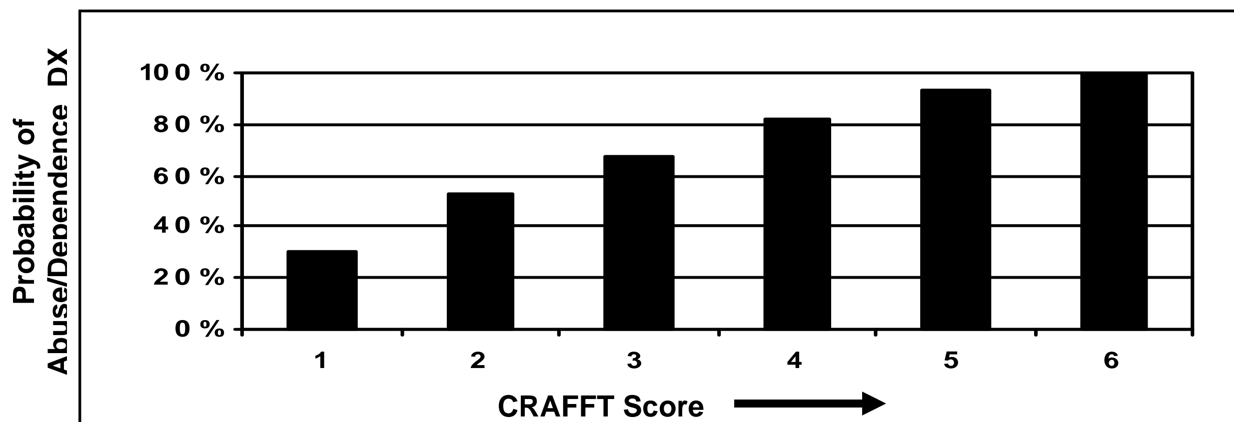
© CHILDREN'S HOSPITAL BOSTON, 2009. ALL RIGHTS RESERVED.

Reproduced with permission from the Center for Adolescent Substance Abuse Research, CeASAR, Children's Hospital Boston. (www.ceasar.org)

SCORING INSTRUCTIONS: FOR CLINIC STAFF USE ONLY

CRAFFT Scoring: Each “yes” response in **Part B** scores 1 point.
A total score of 2 or higher is a positive screen, indicating a need for additional assessment.

Probability of Substance Abuse/Dependence Diagnosis Based on CRAFFT Score[1,2]



DSM-IV Diagnostic Criteria[3] (Abbreviated)

Substance Abuse (1 or more of the following):

- Use causes failure to fulfill obligations at work, school, or home
- Recurrent use in hazardous situations (e.g. driving)
- Recurrent legal problems
- Continued use despite recurrent problems

Substance Dependence (3 or more of the following):

- Tolerance
- Withdrawal
- Substance taken in larger amount or over longer period of time than planned
- Unsuccessful efforts to cut down or quit
- Great deal of time spent to obtain substance or recover from effect
- Important activities given up because of substance
- Continued use despite harmful consequences

© Children’s Hospital Boston, 2009. This form may be reproduced in its exact form for use in clinical settings, courtesy of the Center for Adolescent Substance Abuse Research, Children’s Hospital Boston, 300 Longwood Ave, Boston, MA 02115, U.S.A., (617) 355-5433, www.ceasar.org.

References:

1. Knight JR, Shrier LA, Bravender TD, Farrell M, Vander Bilt J, Shaffer HJ. A new brief screen for adolescent substance abuse. Arch Pediatr Adolesc Med 1999;153(6):591-6.
2. Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. Arch Pediatr Adolesc Med 2002;156(6):607-14.
3. American Psychiatric Association. Diagostic and Statistical Manual of Mental Disorders, fourth edition, text revision. Washington DC, American Psychiatric Association, 2000.

DECISIONAL BALANCE WORKSHEET

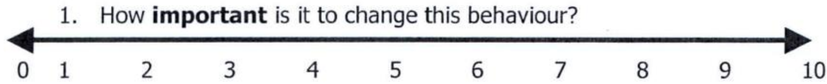
Things I like about my (alcohol, drug) use……..	Things I don't like about my (alcohol, drug) use……
Things I would dislike about changing (cutting down or not using)……………	Things I would like about changing (cutting down or not using)…………..

Reasons to stay the same	Reasons to change

Readiness Ruler

People usually have several things they would like to change in their lives – your substance use may be only one of those things. So ***importance***, ***confidence*** and ***readiness to change*** your substance use can vary depending on other things that are happening. Circle the number (from zero to 10) on each of the lines that best fits with how you are feeling right now.

1. How **important** is it to change this behaviour?

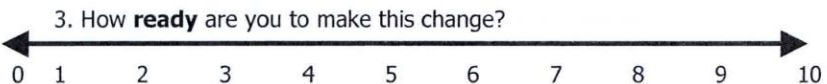


Comments: (What else is more important at this time? What has made this change this important to you so far, as opposed to it being unimportant (zero)? What would it take to make this change even more important to you?)

2. How **confident** are you that you could make this change?

Comments: (Why are you at (current score) and not zero? What would it take for you to get from (current score) to (higher score)?)

3. How **ready** are you to make this change?



Comments: (Why are you at (current score) and not zero? What would it take for you to get from (current score) to (higher score)? What would you need that would support you in making a change, if you chose to do so?)

(Adapted from Miller and Rollnick, 2002)

Adolescent Health Update

A Clinical Guide for Pediatricians

Vol. 20, No. 1
October 2007

Motivational Interviewing Strategies to Facilitate Adolescent Behavior Change

by Melanie A. Gold, DO, FAAP and Patricia K. Kokotailo, MD, MPH, FAAP

Motivational interviewing (MI) is a patient-centered, directive counseling style that builds on intrinsic motivation. When doing MI, the pediatrician creates a partnership with the patient to explore and resolve ambivalence about behavioral change.

MI is often associated with the transtheoretical model first described nearly 25 years ago by Prochaska and DiClemente, who identified what they called stages of change, a continuum of readiness to change behavior. (**Figure 1**)

Melanie A. Gold, DO, FAAP, is an associate professor of pediatrics with certification in adolescent medicine at the University of Pittsburgh School of Medicine. Dr Gold is director of family planning services within the Division of Adolescent Medicine at Children's Hospital of Pittsburgh and a motivational interviewing network trainer.

Patricia K. Kokotailo, MD, MPH, FAAP, is a professor of pediatrics and director of adolescent medicine within the Division of General Pediatrics and Adolescent Medicine at the University of Wisconsin School of Medicine and Public Health. Dr Kokotailo is a member of the AAP Committee on Substance Abuse and the *Adolescent Health Update* editorial board.

Drawing in part on this understanding of the change process, William R. Miller and Stephen Rollnick collaborated to develop the motivational interviewing approach.

In the stages of change model, the pediatrician facilitates change by matching counseling strategy to patient readiness. Readiness is viewed not as a patient trait but as a fluctuating product of interpersonal interaction. MI refers to "looking and seeing together from the patient's perspective" rather than probing to extract information for diagnosis and management. MI has been successfully applied to many types of behavioral goals (eg, diet and exercise, contraception, smoking, and drug use).

MI is particularly effective for those who are not interested in change (precontemplation stage) or are thinking about it but are not yet prepared to make a commitment (contemplation stage). MI can also help pediatricians working with adolescents who are firmly committed to change within 1 month (determination/preparation stage), whose behavior change has already begun (action stage), and those whose behavior change is well established, typically for 6 months or longer (maintenance). If a patient resumes an unhealthy behavior, MI can be used to reframe relapse as a learning opportunity.

Comprehensive MI can be time consuming, which is why it is not typically suited to the busy primary care set-

Goals and Objectives

Goal: To enable pediatricians to use a motivational approach to counseling adolescents about health behavior change

Objectives: After reading this article, the pediatrician will be better prepared to:

- Describe motivational interviewing in the office setting and its role in behavior change
- Discuss motivational interviewing strategies best suited to primary care practice
- Recognize when motivational interviewing might be applicable
- Apply motivational interviewing strategies in a variety of circumstances

Supported through an educational grant from
Merck & Co., Inc.

Section on Adolescent Health
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

ting. However, adaptations of MI that include key strategies described in this paper have shown promise for modifying teens' risky or unhealthy behaviors.

THE SPIRIT OF MI

The essential spirit of MI comprises 3 elements: collaboration, evocation, and autonomy.

- Collaboration is a partnership between pediatrician and adolescent that positions the adolescent as an expert about his/her own experiences, values, beliefs, and goals.
- Evocation is the use of open-ended questions and reflections to help the patient identify his or her intrinsic motivation for change. In MI, it is the adolescent's task to articulate and resolve ambivalence about change and the pediatrician's role to help the adolescent examine his or her internal conflicts about values, goals, beliefs, and behaviors.
- Autonomy is the adolescent's responsibility to change his or her behavior and decide if, how, and when changes will occur. In support of autonomy, MI proposes that direct persuasion is not an effective way to resolve ambivalence.

These elements underscore the pediatrician's respect for the patient's perspective and behavioral choices. While respect for a perspective or a choice does not imply agreement, it communicates a premise: that the patient's beliefs and behaviors arise from a distinct combination of needs, desires, and information (or lack of information) unique to him or her.

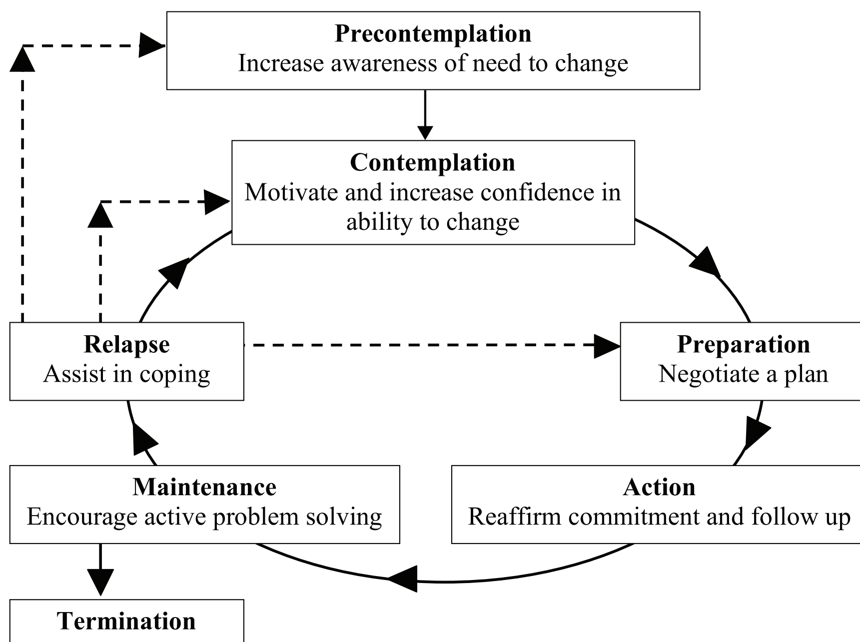
PRINCIPLES OF MI

Pediatricians wishing to incorporate MI in their practices should become skilled in communication strategies that have been shown to promote rapport and resolve ambivalence that is an expected component of behavior change. The 4 principles of MI are to: (1) express empathy, (2) develop discrepancy, (3) roll with resistance, and (4) support self-efficacy in each patient encounter.

- Facilitate behavior change by expressing empathy and accepting patient beliefs and behaviors. This is more effective than applying pressure through persuasion. Direct persuasion ("finger-wagging") usually elicits resistance, especially among adolescents and particularly among those with an oppositional or defiant temperament. MI creates a nonjudgmental environment that allows the adolescent to talk openly about behaviors and beliefs. Practice reflective listening to communicate understanding. When your patient describes a behavior with a negative health impact, temporarily compartmentalize and hold off on voicing your concerns. Encourage an alliance by resisting the urge to give advice until it is requested or at least ask for the adolescent's permission before offering an alternative point of view.
- Develop discrepancy by recognizing inconsistencies between current status and important goals or between current behavior and important values. Adolescents who are aware of these inconsistencies will usually attempt to make changes when they become aware of the consequences of current behavior. Ask the patient's permission to offer objective information about any discrepancies.
- Roll with resistance by recognizing that it is normal to feel ambivalent about behavior change. (**Tables 1 and 2**) Resistance usually occurs when the patient feels pushed to do something he or she is not yet ready to do. Signs of resistance include arguing, interrupting, denying there is a problem, ignoring the provider, missing appointments, presenting too late for an appointment, or failing to complete requested tasks. Overt compliance with covert defiance is another form of resistance, signaled when the visit goes "too smoothly" and the adolescent seems to be agreeing too easily. In MI, arguing and persuasion in the face of ambivalence are deemed counterproductive. These approaches, along with labeling the adolescent with his or her behavior ("a smoker")

FIGURE 1

Stages of Change Model



Based upon the transtheroretical model developed by James O. Prochaska, PhD, and Carlo C. DiClemente, PhD, which describes stages of change in terms of a continuum of readiness to change behavior.

can be expected to elicit a defensive response and increase resistance. If you see signs of resistance, shift to a new strategy.
- Change is most likely to occur when a problem is recognized and the patient believes in his or her ability to do something about it. Communicating optimism about the motivated patient's ability to succeed at a desired change is a powerful facilitator. When you believe your patient is ready to change, support self efficacy by expressing your optimism. Point out, with permission, that change is not an all-or-nothing venture. Describe the patient's past successes and failures as learning opportunities. Help the adolescent identify a range of effective alternatives for achieving his or her goals.

WHAT DOES MI LOOK LIKE?

MI employs open-ended questions and reflective listening to engage the patient in a conversation about a behavior change intended to maintain health and/or decrease risk. MI increases the adolescent's receptivity and decreases resistance. This begins with rapport, and to that end, the pediatrician takes care to verify his or her interpretation of patient statements by paraphrasing and summarizing what is said. Finally, the pediatrician never offers information or advice without first requesting and receiving permission to do so, and always seeks feedback on any suggestions.

Strategies to Establish Rapport

Reflective listening, open-ended questions, affirmations, and summaries are key MI strategies used to build rapport early in a visit.

Reflective listening calls for a warm, nonjudgmental restatement, clarification, enhancement, or expansion of what your patient has said. Younger adolescents may respond better to reflections of emotion than to reflections of meaning. (**Table 1**)

Open-ended questions encourage patients to talk about thoughts and feelings; they are phrased to prompt the patient to elaborate. With younger adolescents, it may help to begin with a few choices (*Would you like to talk about X, Y, or Z today?*) but always end with an open-ended question (*…or maybe there is something else you would rather discuss? What do you think?*).

Affirmations express appreciation. (*I really appreciate your being so honest with me,* or *That's an excellent idea!*) Affirmations should be genuine and used sparingly; overuse sounds inauthentic.

Summaries bring together thoughts or feelings that your patient has shared. If appropriate, talk about how you think they fit together. There are 3 types of summaries: (a) collecting summaries are used during the process of exploration and are meant to gather together the patient's statements; (b) linking summaries are used to tie together what has been stated with something previously expressed in order to develop discrepancy; and (c) transitional summaries are used to prepare for a shift in focus (as when ending an encounter) by pulling together essential points to decide on the next step.

MI STRATEGIES FOR BRIEF OFFICE ENCOUNTERS

Certain MI strategies to enhance rapport or build motivation for change adapt well to office practice. It would be unusual to use more than 1 or 2 of these strategies in a single office visit.

Ask Permission

Before offering information or advice, find out whether it will be welcome. (*Would you like to know more about* _______________? or *Would it be okay if I told you what I thought about this?*) This step is critical. If your patient declines, move to another topic.

Elicit-Provide-Elicit (Ask-Tell-Ask)

Before launching into a lecture, first elicit what the adolescent already knows about the topic and/or options for behavior change. Many patients will already have the needed information or may have excellent ideas about what to do. In that case, shift focus to the process of framing a realistic plan to implement their ideas. Again, be sure to ask permission prior to giving information or advice, and after doing so, elicit the adolescent's reaction to what you have said (*What do you make of this information/these options? How does this help you or change things?*)

Decisional Balance

Ask your patient to talk about the advantages and disadvantages of the change he/she is considering. Ask about the "good" and "not so good" things about change rather than the "good" and the "bad." For patients who are not interested in change (precontemplation stage), ask about the pros and cons of maintaining the status quo. For patients in precontemplation stage, summarize the 2 sides, presenting the patient's argument for change second, then ask an open-ended question prompting talk about the change or a commitment to change. The dialogue below might be useful for a patient who is not interested in quitting smoking:

I would like to better understand what you see as the "good things" about smoking cigarettes. What do you enjoy or like about it? What else? (Ask until no further "good things" arise, then continue.) *What is the other side of that? What are the "not-so-good things" about smoking cigarettes? What else?* (Again, ask until no further "not-so-good things" arise. Then reflect both sides by summarizing.) *So the good things about smoking are… and the not-so-good things are….* Finally, ask your patient to assess: *What do you make of this? How does this fit with how you see your smoking and how does it fit in with your future goals?*

Discrepancy is uncomfortable. People do not like feeling internally discrepant and will work to resolve inconsistencies by changing their behavior to fit their goals, values, perceived identity, or beliefs.

Importance and Confidence Rulers

It is sometimes helpful to assess early-on whether to focus on reasons

to change or confidence in ability to change. Importance and confidence rulers are useful tools in this regard. Ask the patient, *On a scale from 0 to 10 where 10 is the most important and 0 is the least important, what number would you give for how important it is to you to* (behavior change)*? Why did you choose a* (current number) *instead of a* (lower number)*? What would need to happen to make it a* (higher number)? Then ask, *On a scale from 0 to 10 where 10 is the most confident and 0 is the least, what number would you give for how confident you are that you could* (behavior change) *if you wanted to? Why is it a* (current number) *instead of a* (lower number)? *What would need to happen to make it a* (higher number)*?*

Some adolescents have difficulty assigning values to numbers without a visual aid. In these instances, it may be helpful to draw two separate visual scales, one each for importance and confidence. (**Figure 2**)

Agenda Setting

When more than one behavior could benefit from change, ask your patient to set the agenda to focus discussion on what interests him or her most. Be honest if you have a different primary concern. It is appropriate to say, *I hear you are most interested in losing weight right now and at the same time I am very concerned about your drinking and driving. Can we talk about that, too? What might be the first step to look at both of those goals?* The goal of agenda setting is to understand the adolescent's priorities and let him or her select the focus.

FRAMES

Miller and Sanchez (1994) identified essential components of effective brief intervention, summarized by the acronym "FRAMES," which overlap substantially with the key elements of MI. In a busy office practice, the pediatrician can conduct a short, FRAMES-based conversation after completing the history and physical examination. The example below describes a pediatrician's encounter with a 15-year–old patient

TABLE 1

Strategies to Increase Receptivity

Strategy	Description	Examples
Simple reflection	Repeat what the patient has just said, staying close to his/her words	Teen: You say that I have to do all this, but I don't think I need it to feel better. *Pediatrician: You're not sure that this is really necessary.*
Reflection of meaning	Reflect implied or underlying cognitive content in what was just said.	Teen: I'm no alcoholic! *Pediatrician: That label really doesn't fit you.*
Reflection of feeling	Reflect implied or underlying affective content in what was just said.	Teen: I'm no alcoholic! *Pediatrician: It makes you angry when you think someone sees you that way.*
Double-sided reflection	Used when both sides of ambivalence have been expressed: reflects the two perspectives, usually starting with the side favoring the status quo and ending with the side favoring change.	Teen: Sometimes I get mad at myself for spending so much time getting high, but I don't do it during school, so I know I'm no addict. *Pediatrician: You don't believe that you're addicted to marijuana and at the same time it bothers you when you spend most of your time getting high.*
Amplified reflection	Used when only the negative side of ambivalence is expressed: exaggerate or intensify what was said to lead the adolescent to correct the distortion. (This requires a light touch so as not to sound sarcastic. It is effective only when teen has some ambivalence.)	Teen: I'm not sure I really need to go through all this treatment. *Pediatrician: Your life is really fine right now, just the way it is.*

who smokes and who presents with wheezing. The patient has asthma and his pulmonary function tests have been worsening.

Feedback (Review current status): *On your exam right now I hear a lot of wheezing, which goes along with your feeling short of breath and coughing. Your tests today show that your lungs are not working as well as they usually do. I also notice you have a pack of cigarettes in your pocket.*

Responsibility (Emphasize personal choice): *It's up to you to decide when or if you are ready to change your smoking*

Advice (Recommend change): *Is it okay if I share with you what I think is important for you to do right now for your health?* (Wait for affirmation; proceed if received) *The best thing you could do right now is stop smoking at least while you are wheezing. What do you think of that suggestion?*

Menu (Present alternative strategies or options): *I realize that stopping cold turkey might be very hard. You might have some ideas about ways to help you stop or cut down, and I could also suggest some options if you were interested.* (Start with the patient's ideas; if none emerge, offer suggestions.)

Empathy: *I imagine even thinking about making this change may be hard.*

TABLE 2

Strategies to Decrease Resistance

Strategy	Description	Examples
Shifting focus	Temporarily shift attention away from contentious area to common ground	Teen: You say that I have to use something for birth control, but I don't think I can get pregnant. *Pediatrician: You're confident that you don't need birth control to keep from getting pregnant. Tell me about that.*
Emphasizing personal choice and control	Assure that any decision about whether or not to change is the adolescent's choice; only he/she can take action toward change	Teen: You say that I have to use something for birth control, but I don't think I can get pregnant. *Pediatrician: Whether or not you start birth control is completely up to you. I definitely would not want you to feel pressured to take anything against your will.*
Reframing	Restates what was said from a new perspective and invites adolescent to consider this viewpoint.	Teen: Every time I talk to my parents they bug me about my smoking. Why won't they get off my back and leave me alone? *Pediatrician: Your parents worry about you, but it feels more like nagging than a way of expressing the concern they have for you.*
Agreement with a twist	Combines a reflection and a reframe; requires a light touch and sensitivity so it doesn't sound like sarcasm or criticism.	Teen: Every time I talk to my parents they bug me about my smoking; why won't they get off my back and leave me alone? *Pediatrician: You really do wish they would leave you alone, even if it meant that they had to stop caring about what happens to you.*
Coming Alongside (eg, siding with the negative)	A last resort: agreeing with expressions of negativity. Extreme exaggeration intended to bring the adolescent back to a more open posture.	Teen: I'm really not sure I want to go through all this stuff you want me to do. *Pediatrician: This treatment is just more than you can handle. Maybe this isn't the right time for a change.*

Self-Efficacy (Reinforce hope and optimism): *Let's look at your past successes to see how you might apply what you learned from those experiences to this situation. I'm confident that together we can come up with a way that will work for you when you decide you want to do something about your smoking.*

The Behavior Change Plan

A behavior change plan is especially appropriate when the patient is in preparation stage (close to readiness for immediate change). Some patients can develop a behavior change plan on their own; others will need guidance. A typical behavior change plan includes the following components:

- *The changes I want to make are:*
- *The most important reasons to make these changes are:*
- *The specific steps I plan to make in changing are:*
- *Some people who can support me are:*
- *They can help me by:*
- *I will know my plan is working when:*
- *Things that could interfere with my plan (barriers) and possible solutions include:*

MI CASES

The following cases illustrate practical use of MI in encounters with patients at different stages of readiness.

Precontemplation

Philip is an 18-year-old high school senior who comes to your office for a regular health supervision visit. His dad stopped you in the hall prior to the visit to say that he wants you to "make Philip stop smoking." The psychosocial history reveals that Philip smokes about a pack of cigarettes a day and has no interest in cutting back or quitting. In fact, he volunteers, "I love to smoke." Philip is planning to work as a car mechanic after graduation from high school. He plays no sports. His physical examination is completely normal. How do you start using MI?

Philip is in the precontemplation stage; attempts to persuade him to set a quit date will likely be futile. In this circumstance, the goal is not to push him to change his behavior but rather to help him think about making a change. Possible barriers to change include ignorance (or misinformation) about relevant risks or consequences, lack of confidence in ability to change, and contentment with his current situation. Given what you know, start by asking Philip first about the good and not so good parts of his smoking, and also how smoking fits into his life and his goals. Then summarize and play back what you heard, starting with the pros and ending with the cons. Follow with an open-ended question: *So where do you want to go from here with your smoking?* Elicit his perception of the risks of smoking and facilitate a balanced discussion of the pros and cons of his behavior in light of his goals for the future. Don't push too hard, but facilitate his moving toward the contemplation stage by developing any discrepancy between his current behavior and what he wants out of life. If he really does not want to think about quitting or cutting down now, thank him for being honest with you and tell him that you would like to talk some more at your next visit. Then ask when he would like to come back.

Contemplation

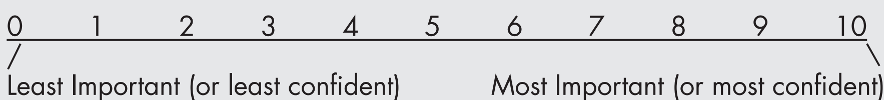
Janie is a 16-year-old junior in high school who comes in for follow-up of a new prescription for contraception. She is sexually active with one male partner and had started an oral contraceptive 4 months before. Janie states that she stopped taking the pill a month ago because she was having a lot of vaginal spotting. When you ask how taking the pill at the same time each day worked for her, she sighs, "I just couldn't seem to remember to take it, no matter what I tried. Maybe I'll just stick with condoms for now. Maybe I will be able to remember to take the pill more regularly when I get back to school in the fall." You thank Janie for being honest about her difficulties in taking the pill. What do you do next?

Janie is in the contemplation stage. She realizes that her plan for taking the pill didn't work very well and she isn't sure what to do. She is not committed to restarting the pill or starting another contraceptive method right now. Your task is to reinforce her commitment to change by helping her move to prepara-

FIGURE 2

Importance and Confidence Rulers

While many adolescent patients will respond readily to a question such as, *How important is it to you to quit smoking right now?* or *How confident are you that you could quit smoking if you wanted to right now?*, this approach may be too abstract for younger adolescents. If this is the case, importance and confidence rulers, as illustrated below, can be quickly drawn on a piece of paper to use as visual aids. Ask the adolescent to point to a number on the scale that indicates how important (or how confident) he or she feels about making a specific behavior change.



The focus of the conversation will depend on the rating levels for importance and confidence. If one number is distinctly lower than the other, focus on the lower number first. If importance is low (≤5), or if both importance and confidence levels are about the same, focus on importance. If both are very low (≤3), explore feelings about talking about the behavior. If both are high (8-10) explore what is preventing the adolescent from changing the behavior.

tion stage. Elicit from her the benefits of taking the pill consistently and on time and reinforce her confidence in her ability to do so (self-efficacy). Talk about what kinds of reminders worked and what kinds did not. Give an affirmation (*It sounds like you have really thought about this issue and have already done some smart things like using your cell phone alarm.*) Ask what she knows about contraceptive methods that do not require daily dosing. If her knowledge of contraception is inaccurate or incomplete, ask her permission to provide information about other methods. Ask Janie where she stands in terms of changing to another contraceptive method or developing other ways to remember the pill. Underscore that she will be the one to decide whether or not she is ready to make a decision today, would prefer to read more or think about it, or wants to discuss it with her partner. If she makes a commitment to start a new method or resume pills, ask her to identify any barriers to her plan and help her to refine it. Remember to honor Janie's decision to change or not, and be sure to ask her to set up follow up by phone and/or in person.

CONCLUSION

MI is a useful tool for counseling adolescents in the office. By recognizing that patients may be anywhere on the spectrum of readiness for change, pediatricians can meet patients "where they are" and work collaboratively to enhance their health. The collaboration can be rewarding and fun. It is amazing how resourceful adolescents can be when their opinions are elicited and lecturing is eliminated from the office encounter. MI enables the pediatrician to support the adolescent's autonomy, facilitate development of important life skills, and promote healthy choices.

ACKNOWLEDGMENT

The editors acknowledge the technical review by Linda J. Ewing, PhD, RN, associate director of the Western Psychiatric Institute and Clinic Behavioral Medicine Program and assistant professor of psychiatry, psychology, and pediatrics at University of Pittsburgh School of Medicine.

REFERENCES AND RESOURCES

Bien TH, Miller WR, Tonigan JS. Brief interventions for alcohol problems: a review. *Addiction*. 1993;88:315-336

Conard LE, Gold MA. What you need to know about providing emergency contraception. *Contemp. Pediatr.* 2006;23:49-70

Erickson SJ, Gerstle M, Feldstein SW. Brief interventions and motivational interviewing with children, adolescents, and their parents in pediatric health care settings: a review. *Arch Pediatr Adolesc Med*. 2005;159:1173-1180

Miller WR, Sanchez VC. Motivating young adults for treatment and lifestyle change. In Howard GS, Nathan PE, eds; *Alcohol Use and Misuse by Young Adults*. Notre Dame, IN: University of Notre Dame Press, 1994

Ott MA, Labbett RL, Gold MA. Counseling adolescents about abstinence in the office setting. *J Pediatr Adolesc Gynecol.*, 2007;20:39-44

Prochaska JO, DiClemente CC. Stages and processes of self-change of smoking: toward an integrative model of change. *J Consult Clin Psychol.* 1983;51:390-395

Rollnick S, Miller WR. What is Motivational Interviewing? *Behavioural and Cognitive Psychotherapy*. 1995;23:325-334

Books

Dunn C, Rollnick S. *Lifestyle Change*. Philadelphia, PA: Mosby / Elsevier Ltd; 2003

Gold MA, Horwitz M, Greene A, Taleb A, Hatcher R. *Teen to Teen – Plain Talk from Teens About Sex, Self-Esteem and Everything in Between*. Dawsonville, GA: Bridging the Gap Communications; 2005

Miller WR, Rollnick S. *Motivational Interviewing: Preparing People for Change*. 2nd ed. New York, NY: Guilford Press; 2002

Rollnick S, Mason P, Butler C. *Health Behavior Change: A Guide for Practitioners*. London, UK: Churchill Livingstone; 1999

On the Internet

www.motivationalinterview.org
Motivational Interviewing: Resources for Clinicians, Researchers, and Trainers. This Web site lists workshops and motivational interviewing network trainers across the U.S. and worldwide, and other resources.

www.ama-assn.org/ama/pub/category/10217.html
Gold MA. Clinical case 1: gynecological care for adolescents. *Virtual Mentor*. 2003;5(5)

DVDs/CDs/Videotapes

Links to order these tools are posted at www.motivationalinterview.org/training/videos.htm

Miller WR, Rollnick, S. *Motivational Interviewing: Professional Training Series*. Moyers TB, director. Albuquerque, NM: University of New Mexico; 1998

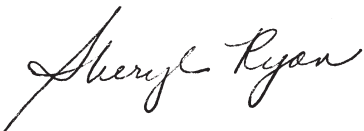
Lewis J, Carlson J. *Motivational Interviewing with Dr William R. Miller*. DesMoines, Iowa: Allyn & Bacon; 2000

A Note from the Editor

The annual editorial column that marks a new volume, this one launching our 20th year of publication, gives me the opportunity to introduce and welcome 2 new editorial board members who joined us this summer: Amy Middleman, MD, MPH, FAAP, of the Baylor College of Medicine Texas Children's Hospital in Houston, and Marsha Sturdevant, MD, FAAP, of the University of Alabama at Birmingham. Drs Middleman and Sturdevant are replacing Drs Walter Rosenfeld and Carol Ford. We thank Drs Rosenfeld and Ford for their hard work, energy, and clinical insight and wish them the best in their future endeavors.

I also want to extend a heartfelt thank you to Merck & Co., Inc., which has provided financial support for *Adolescent Health Update (AHU)* since February 2006. We rely on outside funding sources for much of our budget, beyond what the American Academy of Pediatrics generously provides to us through their administrative support, and we appreciate Merck's decision to fund this publication.

Finally, this editorial gives me the opportunity to underscore the mission of *AHU* and the messages that we try to infuse in each issue. In framing content, we are sensitive to the time constraints that complicate scheduling in the general pediatrician's busy office practice. These challenges are often most apparent with the many clinical issues, both medical and psychosocial, that relate to the care of adolescents and their families. In selecting topics for this year and the next, we have tried to offer useful tools for counseling strategies when time is short, along with information about effective approaches to the medical concerns of modern adolescence (eg, new immunization strategies, lipid disorders, and, in our next issue, care of teens with autism spectrum disorders). By providing the tools to tackle these issues efficiently and effectively, we hope to enhance your ease and enjoyment in providing care to the adolescent patient.



Sheryl A. Ryan, MD, FAAP
Editor

Adolescent Health Update

The American Academy of Pediatrics, through its Section on Adolescent Health, offers *Adolescent Health Update* to all AAP Fellows.

Comments and questions are welcome and should be directed to: *Adolescent Health Update*, American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL 60007, or send an e-mail to adolhealth@aap.org.

© Copyright 2007, American Academy of Pediatrics. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written permission from the publisher. Printed in the United States of America. Pediatricians are encouraged to photocopy patient education materials that appear on the extra pages that wrap around the outside of this newsletter. Request for permission to reproduce any material that appears in the body of this newsletter should be directed to the AAP Department of Marketing and Publications. Current and back issues can be viewed online at www.aap.org. Please go to the Members Only Channel and click on the *Adolescent Health Update* icon/link. The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

Editor

Sheryl A. Ryan, MD, FAAP
New Haven, CT

Editorial Board

Robert M. Cavanaugh, MD, FAAP
Manlius, NY

Patricia K. Kokotailo, MD, FAAP
Madison, WI

Amy Middleman, MD, MPH, FAAP
Houston, TX

David M. Siegel, MD, MPH, FAAP
Rochester, NY

Marsha Sturdevant, MD, FAAP
Birmingham, AL

Supported through an educational grant from

Advisory Board

Kari A. Hegeman, MD, FAAP
Minneapolis, MN

Marc Lashley, MD, FAAP
Valley Stream, NY

Margaret R. Morris, MD, FAAP
Chapel Hill, NC

Paul Neary, MD, FAAP
Fort Atkinson, WI

Scott T. Vergano, MD, FAAP
Chatham, NJ

Franklin H. Wood, MD, FAAP
Tacoma, WA

Managing Editor

Mariann M. Stephens

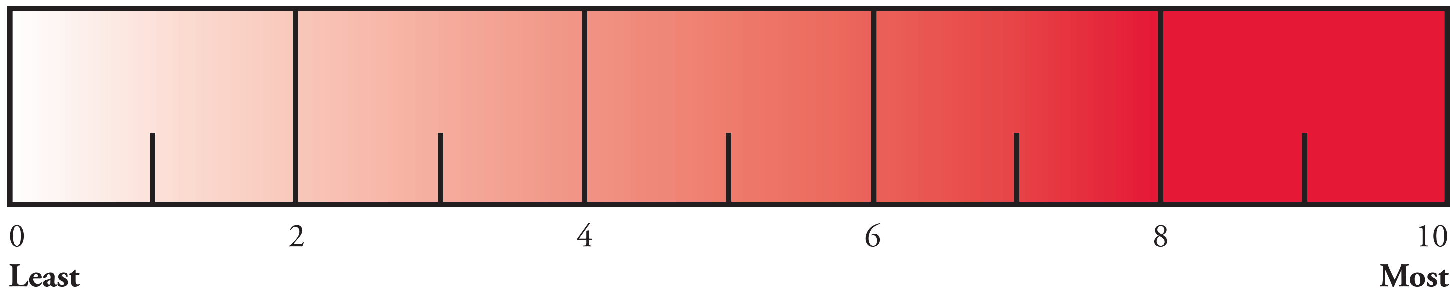
AAP Staff Liaison

Karen Smith
Division of Developmental Pediatrics and Preventive Services

Are You Ready to Make a Change?

The first step toward success is to focus on a goal. Use this readiness ruler to think about getting ready to make a change.

READINESS RULER



Think about a specific change you are considering. Then ask yourself "On this ruler from 0 to 10, where 0 is the least ready to make this change and 10 is the most ready, how ready am I to make this change **right now**?" Once you decide on the number, ask yourself "Why did I pick that number and not a lower number?" Think of all the reasons. Then ask yourself "What would need to happen to help myself feel more ready to make this change?" Think of all the things that would need to happen and what you could do to feel more ready.

Pros and Cons of Change and Pros and Cons of Keeping Things the Same

When trying to decide if you should change, it is helpful to list **all** the good and not-so-good things about making that change. Then make a second list of **all** the good and not-so-good things about keeping things the same.

Write down a possible change you could make and then write out all the good things and not-so-good things about making this change.

Make a SMART Plan

Once you have decided what you want to change and know how ready you are, use this sheet to make a SMART plan. A SMART plan should be:

Specific
Measurable (something you can tell is changing)
Achievable (something you can do well)
Realistic
Time-framed (has a specific time when you plan to do each step)

Your plan does not have to be a commitment to **do** something. It might be a plan to:

1) Think about what you talked about with your healthcare provider
2) Talk with other people about your ideas
3) Get more information to help you make some decisions

Think about what you might consider doing, or might plan to do, between now and your next visit. It is up to you to decide what to put in your plan.

The best plans have small steps towards change. Only you can decide whether or not you want to change anything about your health. Consider what specific steps you want to take and why. Think about barriers — things that might work against your success — and make a plan to deal with each barrier. Come up with a list of people who can help with your plan and write down exactly what each person can do to help you. **Now you can make your own SMART Plan.**

Turn this page to find a worksheet that will help you plan your next steps.

SMART Plan Worksheet

My SMART Plan will be to:

____

____

____

____

____

____

Small steps I can take toward my goal:

____

____

____

____

Reasons this is important to me:

____

____

____

____

Things that might get in the way of my plan: →	Solutions to these barriers:
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

People who can help →	What each person will do:
____________	______________________________
____________	______________________________
____________	______________________________
____________	______________________________
____________	______________________________

This patient education sheet is distributed in conjunction with the October 2007 issue of Adolescent Health Update, published by the American Academy of Pediatrics. The information in this publication should not be used as a substitute for the medical care and advice of your pediatrician.

Pediatricians are encouraged to photocopy this patient resource page and worksheet for distribution to patients.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™