

**Chapter 1 : Shop Gap for Casual Women's, Men's, Maternity, Baby & Kids Clothes**

*The Adolescent Treatment Gap Many youth with mental disorders, even severe and impairing disorders, have never received treatment for their conditions. Among those who have received care, treatment is often quite limited.*

A random sample of medical records was reviewed. The mean number of risk behaviors and health concerns documented was higher in the initial GAPS 4. Controlling for sex, age, and clinician, discussion of psychosocial topics increased during the study period; however, there was considerable variation among clinicians regarding the topics addressed. The GAPS-related referral rate did not change significantly. The GAPS has several components, including recommendations for the organization and content of services, clinician training materials, parent and youth screening questionnaires, and educational materials. The GAPS model includes questionnaires that streamline screening during the annual examination. Adolescents and their parents independently complete GAPS questionnaires that include an inventory of adolescent health concerns and risk behaviors. We adopted the GAPS model in our clinic to respond to what appeared to be a major unaddressed public health problem. Our medical records contained parent-completed screening questionnaires for children from birth to school age, but none for adolescents. Regular use of the GAPS instruments promised to improve detection of risk behavior involvement, increase counseling, and increase risk-behavior-related referrals. Our evaluation was designed to answer several questions about the effect of implementing GAPS screening. A pilot evaluation of the GAPS model involving 95 adolescents in an urban setting found that clinicians often addressed the risk behaviors the adolescent had checked during screening. In a study conducted at 5 community health centers, the use of the GAPS model, over the course of 15 months, was associated with increased adolescent receipt of health education materials, increased clinician discussion of risk behavior prevention, and increased documentation of screening and counseling. Prior studies also did not address whether GAPS screening leads to increased use of follow-up services for risk behaviors, or if it increases parental education regarding youth risk behaviors. Finally, we wanted to determine whether the prevalence of risk factors, as reflected by GAPS screening, would be comparable to the level suggested by the YRBS. The Bassett Pediatric Clinic is a hospital-based general pediatric clinic located in the center of this network. Clinic protocols and procedures were changed to accommodate the GAPS model using the Implementation and Resource Manual 8 as a guide, and the medical record committee approved GAPS forms for inclusion in medical records. Copies of the GAPS topic sheets and educational materials for parents were produced and made available for distribution. When age-appropriate patients arrived for an annual health maintenance visit, they and their parents received GAPS questionnaires to complete while they were waiting. To underscore the voluntary nature of GAPS questionnaire completion, the nurse informed the adolescent to answer only those questions he or she felt comfortable answering. The adolescent and parent completed the forms in separate rooms parent in the waiting area and adolescent in the examination room, unless the parent and adolescent wanted to remain together for the physical examination. Subsequently, clinicians used a structured encounter form, including the history, physical examination, assessment, and plan, to document the visit. Because the use of structured encounter forms is associated with significantly higher levels of both documented and observed performance in pediatric primary care, the planning section of the clinician form includes a list of GAPS topics to prompt clinician action and documentation. The GAPS topic sheets and parent information packets were available for use by clinicians to reinforce counseling. Limited resources precluded having a designated prevention educator; therefore, clinicians did their own counseling, arranging follow-up and referrals. The GAPS screening forms come in 2 versions, an initial form for first health maintenance encounters between a given patient and clinician and a shortened form for subsequent annual visits. Feedback from clinicians during discussions about using GAPS led us to shorten both versions by omitting items that were rarely endorsed on the locally administered YRBS. Omitted questions included moderate physical activity, helmet and seat belt use, body piercing, ever been pregnant or gotten someone else pregnant, when you get angry do you violent things, and would you like to get counseling about something on your mind. These omissions reduced the initial GAPS questionnaire from 74 to 69 items and the periodic subsequent

annual visit questionnaire from 61 to 48 items. The GAPS screening began in stages after clinicians and staff had been trained. A year later, in April, all clinicians began using GAPS forms for both older and younger aged years adolescents. Chart audit Clinic registration databases were used to identify patients aged 11 to 19 years seen by a clinician in the Pediatric Clinic from April 1, , to March 31, This database contains an indication of the type of visit eg, acute, annual, neonatal, or return. A list of medical record numbers was then generated for those who had had an annual visit during the study period. Given that older adolescents are likely to have a larger proportion of endorsements, sampling was weighted toward older adolescents 2: Thus, of the annual visits during the 3-year period, a random sample of annual visits was generated. Duplicate medical record numbers were replaced with unique ones; therefore, the sample contained unique adolescent annual visits. Data from each medical record were entered in a confidential manner preserving anonymity. The chart audit took place within the Pediatric Clinic and was performed by one of us S. Four outcomes were sought during the chart audit. First, is there a GAPS screening form present and complete? Second, if so, what risk behaviors were checked off by the adolescent? If not, what risk factors were mentioned in the structured medical note? Third, was there any indication on either the GAPS questionnaire or the clinician checklist that risk factors disclosed were discussed, and, if so, what happened? Options included documentation of discussion during the visit, follow-up visit for the risk behavior, referral, or no action recorded. And fourth, for those medical records with endorsement of 1 or more GAPS risk behaviors, visits up to 1 month after the GAPS index visit were reviewed to see if there was documentation of the problem being resolved, addressed, or referred. The correspondence section of the medical record was also reviewed to see if the patient was seen elsewhere eg, specialist or community-based services. All referrals, as well as GAPS-related referrals, were recorded. Logistic regression was used to evaluate the predictors of risk behavior discussion. Because screening for most of the problems on the GAPS forms occurred only when the forms were used, the documentation of those problems and the use of GAPS were highly correlated. Therefore, whether GAPS screening was done or not was dropped as a variable and replaced with the time period, ie, the year of study. Dummy variables were created for each clinician and for visit type. Age was entered as 2 groups and years. Developed by the Centers for Disease Control and Prevention, the YRBS was designed to be used as a periodic survey to monitor changes in adolescent behavioral risk factors. The high school version of the YRBS that was used locally has 90 questions that cover body weight, obesity, personal safety, violence-related behavior, sad feelings and attempted suicide, tobacco use, alcohol, marijuana use, other drugs, sexual behavior, food you ate or drank during the past 7 days, physical activity, and acquired immunodeficiency syndrome education. The local YRBS was completed anonymously in a paper and pencil survey by county middle and high school students in the fall of Results Use of the gaps questionnaire We reviewed the medical records of younger adolescents aged years and older adolescents aged years from April to March Nine records were not included because they were missing during the medical record audit. The percentage of parental GAPS forms completed was lower than that for adolescents, reflecting the fact that parents do not always accompany adolescents to annual visits. One third of parents who completed the GAPS form requested parenting or developmental information about adolescence. Among younger adolescents, a similar risk behavior prevalence was observed: Girls reported higher mean SD total numbers of risk behaviors 3. Girls had a higher mean number of GAPS-related diagnostic assessments 0. The GAPS questionnaire yielded lower levels of risk behavior reporting compared with those obtained in the YRBS at this school and the aggregated results for the county overall. Table 1 displays results for those questions that are the most similar in wording in the 2 questionnaires. The level of certain risk behaviors reported through the GAPS forms in our clinical sample is often half that reported in the YRBS at the local school and in the county as a whole. The mean number of risk behaviors and health concerns was higher with the initial GAPS form 4. Documentation of discussion of most of the GAPS topics increased during the study period. The topics for which GAPS helped the most in terms of increasing documentation were exercise, body image, sexuality, peer relations, and parent conflicts Table 2. Multivariate equations used to predict the likelihood that documentation of a discussion of a GAPS risk behavior topic occurred also demonstrated increased likelihood of discussion during the study period. For example, even controlling for sex, age, and clinician, discussion of psychosocial topics increased

during the study period as reflected by the increased odds ratio for the variable "study year. These statistically significant odds ratios suggest that documentation of the discussion of these topics increased significantly during the study period. One notable exception was substance abuse, for which the corresponding odds ratio, 1. For example, some clinicians always documented discussion of diet, and some never did in all visits sampled. Only 1 clinician was significantly more likely to discuss exercise odds ratio, 4. As might be expected, older patient age was significantly associated with discussion of tobacco use, acquired immunodeficiency syndrome or sexually transmitted diseases, reproductive health, and driving. Effect on referrals and assessments Although reporting increased significantly for both risk behaviors and health concerns, there was little detectable effect on action, as it was defined in this study Table 3 ; Figure 1. The GAPS-related diagnostic assessments and referrals related to risk factors at the time of the index visit or 1 month later did not change significantly during the study period. Specifically, GAPS-related referrals occurred for There was also no change in the number of adolescents referred for any reason during the study period. This direct relationship suggests that health concerns raised by the adolescent at the annual visit did not distract the clinician from addressing risk behaviors. Comment This study examines the effectiveness of integrating the GAPS questionnaire into routine medical care. Introduction of the GAPS questionnaire was a success in terms of increasing documented discussion of risk behaviors. Specific changes in referral rates or follow-up visits were not detected by this study. Within-practice didactic training in the GAPS model and use of the questionnaire may be insufficient to produce change in referral rates or follow-up visits for adolescents endorsing risk behavior. However, rural areas are limited in services available to adolescents. Thus, the outcomes of screening could be limited if there is no service available to address newly disclosed problems. This is particularly true in rural settings, which historically are underserved areas in terms of medical, mental, dental, and preventive care. The lower referral rates in our study may be a function of differences in adolescent risk profiles, service availability, and clinical training between these 2 studies. Low rates of screening for sexual intercourse, substance abuse, eating disorders, exercise, and peer involvement in risk behavior have been documented in other studies. Increases in discussions regarding parent conflicts and school performance may be particularly important, given the protective effects of parent-family connectedness and perceived school connectedness documented by the National Longitudinal Study on Adolescent Health. We expected the GAPS questionnaire results to approximate the level of risk behaviors reported in the YRBS by adolescents in our community who are also served by our clinic, but it did not. The observed differences might also arise from the health-care-seeking population that supplied the GAPS data vs the more universal sample that supplied the YRBS data. Other studies that have tried to compare clinically based data ie, the Health Plan Employer Data and Information Set and survey-based data ie, the Behavioral Risk Factor Surveillance System also found that clinical data produced rates that were lower than those from survey data. The clinician variation in discussing risk behaviors documented in this study illustrates a common clinical problem. The source of variation among our clinicians is a matter of conjecture because we have not specifically studied this issue. Most likely, it is a reflection of clinician training and comfort level. Clinical preventive services offered to adults have been shown to vary among clinicians, services offered, and clinics, thus illustrating a haphazard and idiosyncratic approach to prevention. It is unclear if this is due to respondent fatigue.

## Chapter 2 : Bridging the Gap: Engaging Adolescents for Nutrition, Health and Sustainable Development

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## Chapter 3 : Adolescent Services |

*The "generation gap" between parent and adolescent is real to the degree that each grows up in a different historical time and culture-imprinted by the tastes and values and icons and events.*

**Chapter 4 : Adolescent and Young Adult Health**

*Adolescent Preventive Care-Screening Questionnaires. The New York State Department of Health / Division of Managed Care and Program Evaluation (DMCPE) has introduced measures of preventive care for adolescents.*

**Chapter 5 : Boys'™ Clothing " Shop New Arrivals | Gap**

*Robbins MS, Bachrach K, Szapocznik J. Bridging the research-practice gap in adolescent substance abuse treatment: The case of brief strategic family therapy.*