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Editorial

Psychosocial Assessments After COVID-19

It is nearly 50 years since Dr Henry Berman first described his approach to routine psychosocial history taking with adolescents using the HEADS framework, an approach that is deeply appreciative of the nexus between biological development, social, and environmental interactions [1]. Berman's original framework slowly expanded into HEADSS and more recently HEEADDSSS [2,3], and other acronyms have flowered around similar approaches albeit with nuanced differences, such as the focus on strengths within SSHADESS [4]. Regardless of acronym, and despite questions of efficacy [5], psychosocial history taking has stood the test of time to become a cornerstone of adolescent medicine practice. Indeed, in the U.S., the perceived value of preventive screening lies at the heart of policies that support annual health checks for adolescents. In other parts of the world, psychosocial history taking has become central to routine consultations with adolescents. Regardless of context, barriers to psychosocial assessment are frequently reported, particularly because of lack of consultation time, lack of clinician training, lack of knowledge of tools, and lack of decision support [5].

The indirect effects of the current pandemic have heightened the rationale for identifying psychosocial risks as "lockdowns," and the resulting family economic and emotional stress compound multiple other challenges for young people, whose lives have been placed on hold. School closures have been accompanied by variable engagement with online learning, jobs have been lost, friendships and supportive relationships have been ripped apart, and most sports and creative pursuits have screeched to a halt. Cross-sectional population studies of depression and anxiety are consistently showing that those who are younger and poorer are most affected [6,7], bringing attention to the influence of socioeconomic determinants during sensitive periods of biological development such as adolescence [8].

Notwithstanding obvious benefits for access to care, the rapid shift to teleconsultations in response to COVID-19 raises new challenges for psychosocial assessment, and not just when video consultations are marred by low bandwidth. Clinicians are concerned about their ability to read and respond to nonverbal cues, especially in patients with communication challenges, as these can be blunted online [9]. In my own practice, uncertainty around privacy has compromised my preparedness to undertake the depth of psychosocial assessment in adolescents' homes that I would normally undertake when confidentiality is guaranteed. These issues raise interest in the role of digital technologies in providing alternative approaches to clinician-driven psychosocial assessment. But which tool to use?

In this context, a systematic review by Glasner et al. of previsit psychosocial screening tools is timely [10]. Also known as preconsultation or preencounter screening tools, this review set out to explore the development of multidomain previsit screening tools of relevance to primary care with the idea of identifying the "gold standard" tool. The authors focused on the last 20 years and defined multidomain tools as those encompassing at least three domains (e.g., mental health, sexual health, substance use). In addition to multiple peer-review databases, their search strategy also involved the gray literature, and they reached out to academic experts and relevant organizations for suggestions. In the end, they screened more than 10,000 records and identified 15 different tools. None were developed in low- and middle-income countries. Given the centrality of psychosocial assessment to routine clinical care, the authors were right to be disappointed about the lack of evaluation of these tools as a group in terms of validity, acceptability, and reliability—let alone the wider question of predictive utility, which was beyond the scope of their review. They did not identify a gold standard.

Pleasingly, almost half the tools are available in an electronic format, as this promotes efficiency of use, validity of assessment, and ease of scoring. One example is YouthCHAT (Youth version, Case-finding and Help Assessment Tool), an electronic previsit tool that uses branching, incorporates a number of validated measures, and provides a summary report to clinicians [11]. It also includes questions about whether the young person would like help with particular issues, a valuable entry point for clinicians. More thorough than most clinician-led psychosocial assessments, YouthCHAT takes half the time to complete [12]. Developed in New Zealand, the clinical utility of YouthCHAT is currently being trialed, but it has been shown to be acceptable to patients and staff.

Yet, just as the COVID-19 pandemic has exposed multiple structural weaknesses within our public health systems, beyond identifying a gold standard measure, the next challenge for previsit screening is overcoming the structural barriers within clinical systems that currently limit their use. As Glasner et al. described [10], linkage into electronic medical record systems

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provides a critical opportunity to integrate previsit psychosocial assessments into clinical care. Patient portals can provide access to previsit questionnaires, but investment is needed in the "back-end" systems that can automate reminders to patients to complete online assessments, summarize or score the assessment, and provide timely feedback to clinicians [5]. Locally crafted decision support tools, which include advice to clinicians and patients about community referral pathways, also need integrating within the electronic medical record, which have been shown to increase screening rates [5]. Given the sensitivity of psychosocial assessment in adolescents, attention to confidentiality is needed at every stage, including parent access to patient portals, health insurance, and billing [13].

The rate of digital disruption that the pandemic has wrought is remarkable. A recent business report suggested that companies have acted 20–25 times faster than expected in normal times and have achieved a level of digital disruption that might otherwise be achieved in 4–10 years [14]. Health is no exception. Rapid uptake of teleconsultations in high-income countries exemplifies the digitization of front-end, consumer-facing elements of traditional operating models, which notwithstanding multiple challenges of rapid uptake, has been largely welcomed by consumers and clinicians alike. The benefits of teleconsultations mean they will no doubt become a larger part of the future adolescent medicine landscape than in prepandemic times. However, to truly build back better consultations after COVID-19, investment is also required in the "back-end" computer systems to support previsit psychosocial assessment, whether as an adjunct to face-to-face visits or through teleconsultations.

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