Teen Empowered for Exercise and Nutrition (TEEN)

In addition, she teaches and trains future mental health professionals, having served for 12 years as a clinical supervisor and eight years as a director of psychology training. She specializes in depression, anxiety, disruptive behavior, and obesity, and she uses a cognitive behavioral practice for children's mental health and specializes in training mental health professionals in best practices. As a practicing psychologist in Austin, Texas, Gray specializes in depression, anxiety, disruptive behavior, and obesity, and she uses a cognitive behavioral practice for children's mental health and specializes in training mental health professionals in best practices.

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Adolescent Depression and Bullying Management: Interventions That Make A Difference

Celia Neavel, MD, FSAHM

Jane Gray, PhD

DISCLOSURE

It is the policy of the AAFP that all individuals in a position to control content disclose any relationships with commercial interests upon nomination/invitation of participation. Disclosure documents are reviewed for potential conflicts of interest (COI), and if identified, conflicts are resolved prior to confirmation of participation. Only those participants who had no conflict of interest or who agreed to an identified resolution process prior to their participation were involved in this CME activity.

The content of my material/presentation in this CME activity will not include discussion of unapproved or investigational uses of products or devices.

Learning Objectives

1. Utilize appropriate diagnostic criteria to evaluate and screen adolescent patients for depression, bullying, mood disorders, and suicide risk.
2. Counsel parents and adolescent patients regarding bullying prevention and intervention.
3. Devise collaborative treatment plans, including appropriate psychotherapy and pharmacotherapy (or a combination), that take into account the risks and benefits of various interventions.
4. Coordinate care for adolescent patients who require referral to sub-specialists or admission to hospitals for suicide prevention.
Audience Engagement System

AES POLL QUESTION
What % of your practice is between the ages of 10-25?
1) 0-10%
2) 10-30%
3) 30-50%
4) >50%

FRANCISCO
• 12 yo presents for WCC & recurrent HA
• Pt & family known to you
• How can you set up screening for MH?
• What screening tools are available?

IDEAL SCREENING TOOL
• Free, easy to obtain
• Multiple languages & culturally sensitive
• Low patient burden
• Low staff/provider burden
  – Compatible with EHR! Easy to score.
• Reliable
• Sensitive
• Specific
• Validated
• Can measure change over time

PEDIATRIC SYMPTOM CHECKLIST
• Variations
  – 35 for ages 4-18 for parent/guardian to complete
  – PSC-Y for 11-18 y.o., complete and Teen Screen version added 2 suicide questions
  – PSC-17 shorter version for guardians
• Facilitates recognition cognitive, emotional, & behavioral so interventions initiated as early as possible
• Internalizing, externalizing, and attention domains
• If screen (+), assess what significant symptoms are and whether or not cause impairment
• Decide if they need PCP follow-up, or referral
• 94% sensitive, 88% specific
• For PSC-Y a total score of above 30 is positive
CRAFFT

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:
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.”)

CRAFFT PART B
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?

PHQ 9
- Can be used to assess severity & suggest intensity of intervention
- Can be used to monitor response to treatment
- Used in adults and adolescents
- Scores 0-3 on each question
- A score of >11 is positive
  - 89.5% sensitive, 78.8% specific

OTHER RATING SCALES
- PHQ2
- Screen for Child Anxiety Related Disorders (SCARED)
- Center for Epidemiological Studies Depression Scale for Children (CES-DC)
- Child Depression Inventory (not free)
- Strengths and Difficulties Questionnaire
- Edinburgh Postnatal Depression
- Child Behavior Checklist (not free)
- Rapid Assessment for Adolescent Preventive Services (RAAPS)

AES POLL QUESTION
What does USPSTF say about depression screening in 12-18 yo?
1) Recommends the service. There is high certainty that the net benefit is substantial.
2) Recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.
3) Recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.
4) Recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.
5) Current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.
FROM TMA

Access to care remains a critical issue for children and adolescents with mental health disorders, especially underserved children. A physician-led medical home, therefore, can play an important role in recognizing, consulting, and treating children with mental health disorders by:

- Surveying all children for substance abuse, and mental and developmental abnormalities at each preventive care visit. Surveillance tools should be age-appropriate and scientifically validated.

HEADDSSSSS INTERVIEW

- **Home** - parents separated, FTOHIC, Mo depression
- **Education** - 7th grade, Bs & Cs, doesn’t like school
- **Eating** - feels fat, decreased appetite but gaining weight
- **Activities** - video games & on phone 4-6 hrs/day, stopped basketball
- **Drugs** - CRAFFT negative
- **Sexuality** - denies being touched inappropriately, not sure who attracted to, kids call “gay,” no pubertal education
- **Suicide/Depression** - screening tool scored, admits worries, can be sad, no active SI
- **Strengths** - can’t think of anything, then says video games

BULLYING STATISTICS

- Middle school aged children more at risk
- Children who bully or are bullied are more at risk (3X) for suicide ideation and attempts
- LBGTO youth:
  - 10% threatened or injured with a weapon on school property
  - 34% bullied on school property
  - 28% bullied electronically
  - 23% of those who dated during the 12 mos before surveyed experienced sexual violence
  - 18% experienced physical dating violence
  - 18% were raped
  (CDC, data from 2015 Youth Risk Behavior Survey)

BULLYING: INTERVENTION

- Social support/connectedness is the most important
- Parents providing support
- Peer support
- School program elements:
  - Whole school approach
  - Supervision of students
  - Rules and behavior management in the classroom including consequences for bullying
  - Specifically mentioning protected groups (e.g. LGBTQ)

PRACTICE RECOMMENDATIONS

- Screen for depression at well visits or as history or situation indicates
- Use validated tools or as part of interview process
- Address bullying

IN ADOLESCENTS, MAY NOTICE:

- Feeling sad, withdrawal/isolation from peers and family
- Irritability, trouble concentrating
- Sleep and eating changes, fatigue, declining grades
- Feelings of boredom, helplessness, or hopelessness
- Emotional outbursts, impulsive behavior, acting out, substance abuse, running away
- Psychosomatic symptoms - HA, CP, abdominal pain
- Decreased affect on interview
- Preoccupation with death (music, art, media)
SUICIDE AS CAUSE OF DEATH

• CDC data:
  – Suicide second leading cause of death in 12-17 year olds in 2010
  – 17% of high school students seriously considered suicide attempt in past 12 mos (2X as many girls as boys)
  – 13.3% had a plan
  – 8% made an attempt
  – 6% had an ideation
  – These rates are consistently higher in Hispanic youth
  – American Indians/Alaska Native adolescents and young adults have a suicide rate 1.5 times higher than the national average

• Interpersonal stressors are most frequently cited as a trigger for suicidal ideation or attempt
  – Conflict with family
  – Breakup
  – Conflict with friends
  – Bullying

RISK FACTORS

• Interpersonal loss
• Psychiatric disorder
• Prior attempts
• Substance use / high risk behaviors
• Struggling with sexual orientation or gender + little support
• Bullying
• Access to means
• Barriers to getting help

PROTECTIVE FACTORS

• Social support
• Access to clinical intervention
• Restricted access to means
• Coping/problem solving skills

SAFETY ASSESSMENT

• Does the adolescent now have suicidal thoughts or plans?
• Have prior attempts occurred?
• Does the plan or previous attempt have significant lethality or efforts to avoid detection?
• Has the adolescent been exposed to suicide attempt/completion by peers or family members?
• Does the adolescent have alcohol or substance abuse problems?
• Does the adolescent have a conduct disorder or patterns of aggressive/impulsive behavior?
• Does the family show significant family psychopathology, violence, substance abuse, or disruption?
• Does the adolescent have the means available (e.g., firearms and toxic medications)?

Adapted with permission from the 3Put Online Resource: a Peer-Selected Tool, 2010 (bilingual, National Youth Suicide Prevention Resource Center, National Suicide Prevention Lifeline, Organized plan, legitimate parent or family stress or suicidal ideation, and School problems).

MAKING A PLAN

• Meet with the adolescent’s family members or caregivers as possible.
• Discuss a referral to a mental health professional. Make an immediate referral to a mental health provider or emergency services if severe depression, psychotic, or suicidal ideation/risk is evident.
• Educate adolescents and their family about depression and treatment options.
  – Stress that depression is treatable.
    – Discuss treatment options: watchful waiting and supportive care for mild depression, psychotherapy (cognitive behavioral therapy or interpersonal therapy), and medication (SSRIs).
• Encourage families to remove firearms and toxic substances from the house, especially if any suicidal ideation is present.
• Provide information about print or online resources that may be helpful to adolescents and their families.
  – Involve school as possible.
• Schedule follow-up visit in 1-2 weeks.

HELPFUL PROVIDER BEHAVIORS

• Address the problem in an open, curious, empathic manner.
• Communicate that you care about the teen and want him/her to live and want him/her build a life worth living.
• If the child is going home:
  – Work with the family on providing a safe environment at home.
  – Ensure they have emergency numbers in case of a future crisis.
• Set the child and family up with appropriate services and support.
  – Build hope:
    – Elicit and discuss things the child is looking forward to in the future.
    – Elicit positive coping strategies.

BEHAVIORAL ACTIVATION

• Depressed youth
  – Experience more life stress
  – Lack coping and emotion regulation skills for dealing with these stressors and their own emotional reactions
  – Do not engage in pleasurable activities
    • Withdrawal, anhedonia
    • Poor achievement in school/conflict with family often present barriers to fun

Adapted with permission from the 3Put Online Resource: a Peer-Selected Tool, 2010 (bilingual, National Youth Suicide Prevention Resource Center, National Suicide Prevention Lifeline, Organized plan, legitimate parent or family stress or suicidal ideation, and School problems).
Can be done in 5 min in the office
• Make or provide a list of fun activities
• Teen tracks completion of activities and rates mood following participation in activities or at the end of the day
• Present as a “prescription” – Addressing parent concerns

Pleasant Activities List

1. Soaking in the bathtub
2. Thinking about how it will be when school ends
3. Going out with friends
4. Relaxing
5. Going to a movie
6. Going running
7. Listening to a podcast
8. Reading magazines or books
9. Going fishing
10. Planning the future
11. Dancing
12. Doing or cleaning things around the house
13. Taking a class
14. Going hunting or fishing
15. Going to a museum
16. Getting nails done, massage, etc.

17. Cooking good food
18. Taking care of your pets
19. Going rollerblading
20. Going to a beach
21. Traveling
22. Dancing
23. Playing sports
24. Going to a party
25. Talking with friends
26. Going for a bike ride
27. Emailing or texting friends
28. Writing in a diary journal
29. Looking at photos
30. Playing video games
31. Walking around where you live
32. Surfing the internet
33. Surprising someone with a favor
34. Noticing things in nature
35. Shooting pool
36. Bowling
37. Working on machines (cars, bikes, etc.)
38. Building something (furniture, etc.)
39. Solving a puzzle, crossword
40. Doing volunteer work
41. Driving
42. Reading
43. Redecorating
44. Going to religious service
45. Putting on make-up
46. Playing a game

WHAT ADOLESCENTS WANTED TO INCLUDE IN THIS TALK

• Social Media behavior
• Meme culture & as outlet
• “Teenagers are masters at disguising their depression”
  “Both physiological and mental illness: kids have really long compensatory phases before they suddenly crash”
DOCUMENTING VISIT

- Well Adolescent Exam
- Headache
- Depression
- Victim of bullying
- Family stress
- BMI 85-95%

- Consider Counseling Code
  - Preventative medicine counseling (postive risk factor reduction) (available in Training module)
  - Screening
    - HBV/HIV/STD/sexual status exam; screen for drug & drug testing; per hour
    - Review pertinent new population literature per hour
    - Review pertinent new patient literature per hour
    - 15 min face-to-face with patient; initial
    - Consider administration panel (preventative health risk assessment instrument or scoring & risk vs. benefit assessment per population assessment instrument & the development of a treatment plan)

MAJOR DEPRESSIVE DISORDER
F32 (recurrent F33)

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (Note: In children and adolescents, can be irritable mood.)

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).

3. Significant weight loss when not dieting or wt gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)

4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

OTHER BH DX and CODES

- Bipolar Disorder F31
- Adjustment Disorder F43.2
- PTSD F43.1
- Dysthymia/Persisting Mood Disorder F34
- Disruptive Mood Dysregulation Disorder F34.81
- Anxiety Disorder F41
- Unspec Mood Disorder F39
- Suicidal Ideation R45.851

- Suicide Attempt T14.91
- Personal History Self-Harm Z91.5
- Encounter Victim Abuse Z69
- Other Spec Counseling Z71.89
- Stress/Life Management /Social Role Conflict Z73.

FRANCISCO-2

- Returns in 1-2 weeks
- HA improved with more water, less screen time, occas NSAID, nightly Mg and melatonin
- Mother talked with school
- Pt more withdrawn, rubbed pencil eraser in arm, crying at school
- Seeing in-school therapist tomorrow

AES POLL QUESTION

Which medication is FDA approved for treating depression in Francisco (12 yo)?

1) Paroxetine
2) Fluoxetine
3) Bupropion
4) Amitriptyline

SSRIs

- Fluoxetine (FDA approved depression 8 & up & OCD)
- Sertraline (FDA approved OCD 6 & older)
- Fluvoxamine (FDA approved OCD 8 & up)
- Escitalopram oxalate (FDA approved depression 12 & up)
- Citalopram
FDA “BLACK BOX” WARNING
• No completed suicides occurred … However, about 4 percent of those taking SSRI medications experienced suicidal thinking or behavior

STARTING MEDICATION
• Take in AM with breakfast – If makes sleepy, take q HS
• Start low-dose & see back in one week
• Recommended see q week for 1st 4 weeks
• Clinical effects may be delayed 3-6 weeks after treatment
• If no response after 4 weeks, consider switch – May be 30-40%

OTHER POSSIBLE SIDE EFFECTS
• Sexual dysfunction
• Drowsiness
• Weight gain
• Insomnia
• Anxiety
• Dizziness
• Headache
• Dry mouth
• Blurred vision
• Nausea
• Rash or itching
• Tremor
• Constipation
• Stomach upset
• Activation or jitteriness

NIMH-funded Treatment for Adolescents with Depression Study (TADS)² has indicated that a combination of medication and psychotherapy is the most effective treatment for adolescents with depression.

INTEGRATED CARE: FAMILY TREE OF TERMS

CONSIDERATIONS FOR INTEGRATING CARE
• What are the cultural barriers between systems?
• What are the financial challenges/issues?
• Training differences – Psychologists – Social Workers – Licensed Counselors – Substance Abuse Counselors – Marriage and Family Counselors
• Physical space requirements if full integration
• Issues around information sharing - logistics of sharing charts, confidentiality issues, etc.
Behavioral Health Providers

- **Doctoral Level:**
  - Psychologists (PhD, PsyD)
  - Psychiatrists (MD)

- **Master’s Level:**
  - Social Workers (LMSW, LCSW)
  - Licensed Marriage and Family Therapists (LMFT)

- **Bachelor’s Level:**
  - Licensed Chemical Dependency Counselors (LCDC)

**Scope of practice:**
- Consultation with other providers
- Training of providers
- Medicated consultation with patients
- Education and training
- Ongoing interventions
- Coordination with specialists

**EXAMPLES OTHER RESOURCES**

- Local branch National Alliance Mentally Ill
- MHMR
- Child Guidance Center
- Schools, esp if on-site therapy
- Behavioral Health of insurance plan
- Specialized Hospital Systems
- Other local non-profits
- Academic Center

**TANISHA**

- 16 yo
- 24 weeks pregnant
- Followed by your NP who is concerned about depression
- What hx would you like? How will you screen? Can you see her without guardian? What are treatment options if is depressed?

**TANISHA-2**

- Safety Contracts
- When violate confidentiality
- Options to get into emergent care

**CARE COORDINATION**

- Post hospitalization
- Duration of medication use
- Postpartum risk

**PRACTICE RECOMMENDATIONS**

- Use validated tools and structured interviews, both to screen and as f/u for behavioral health issues
- Have a coordinated, team-based systems approach in place
- Harm in not treating, including judicious use of SSRIs and behavioral health consultants
- Utilize empathy, optimism, and close f/u
QUESTIONS

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RESOURCES
• Dev Behav Pediatrics www.dbpeds.org
• For Pediatric Symptom Checklist
  – http://www.massgeneral.org/psychiatry/servicespsc_home
  – http://www.brightfutures.org/mentalhealth/pdf/professionals
  – ped_symptom_chklst.pdf
• For PHQ9 http://www.depression-primarycare.org/images/pdf/phq_9_eng.pdf
• For CRAFFT http://www.ceasar-boston.org/clinicians/crafft.php

RESOURCES
• RAAPS.org Screening Tool
• Chart comparing mental health screening tools
  http://www.aau.org/en-us/advocacy-and-policy/aap-health-
  initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf
• HEEADSSS
  http://contemporarypediatrics.modernmedicine.com/contemporary-
  pediatrics/news/clinical/pediatrics/getting-adolescent-heads-
  essential-update
• Antidepressant med information for caregivers
  https://www.nimh.nih.gov/health/topics/child-and-adolescent-mental-
  healthy/antidepressant-medications-for-children-and-adolescents-
  information-for-parents-and-caregivers.shtml

RESOURCES
• Antidepressant use in pediatric patients https://www.cms.gov/Medicare-
  Medicaid-Coordination/Fraud-Prevention/EnrollInfoAndVerify-
  Payers/EnrollInfoAndVerify-Payers-Medicare-Coordination-EnrollInfo-
  and-Verify.pdf
• Pediatric Psychopharmacology for Treatment of ADHD, Depression, and
  Anxiety
  http://pediatrics.aappublications.org/content/pediatrics/136/2/351.full.pdf
• Effectivechildtherapy.org What evidence supports what mental health
  therapy