Collaborative Care: Adolescent Depression Management and Bullying Mitigation - Tackling Tough Topics in Your Office

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Dr. Neavel earned her medical degree from Baylor College of Medicine, Houston, Texas, and completed residency and a fellowship at the University of Cincinnati, Ohio. She is board certified in family medicine and has a Certificate of Added Qualifications (CAQ) in Adolescent Medicine, as well as fellowship training in both adolescent medicine and developmental disorders. Dr. Neavel supervises and teaches a variety of health care professionals within her own team, as well as trainees rotating through the clinic. She founded—and continues to direct—the Center for Adolescent Health and the GOALS Program at People's Community Clinic, a nonprofit federally qualified health center (FQHC). The Center for Adolescent Health provides primary, behavioral, and reproductive care at a main clinic site, with additional sites embedded in youth-serving community agencies. The GOALS Program is a developmental, behavioral, and primary care program for individuals ages 4 to 19.

Dr. Neavel works with diverse community organizations. She is on the Texas Health Steps Advisory Council, as well as serving as a Travis County Medical Society delegate to the Texas Medical Association and a medical advisor for the Texas Youth-Friendly Initiative. The recipient of numerous awards, she frequently is named Austin's top adolescent medicine physician in Austin Monthly magazine. Dr. Neavel has given national, state, and local presentations on integrated behavioral health, adolescent wellness care, reproductive health, and minor consent and confidentiality. She currently collaborates with University of Texas faculty on research on integrated behavioral health.
Geordi Cortez-Neavel

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Cortez-Neavel earned his bachelor’s degree in global health from Washington University in St. Louis, Missouri. He is currently pursuing a master’s degree in clinical research management from University of North Texas Health Science Center and applying to medical schools for the 2019-2020 cycle. Previously, he has participated in projects focused on access to quality care; youth assessment and treatment; emergency medicine; and primary care. He has received training as an emergency medical technician-basic (EMT-B), a National Academy of Sports Medicine (NASM) trainer, and—most recently—a youth peer wellness specialist. As a volunteer at People’s Community Clinic, he serves as an ambassador and a member of the Youth Advisory Council.

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Jaquez received her doctorate degree in Clinical Psychology, with an emphasis on pediatric/child clinical psychology, from Oklahoma State University, Stillwater. She completed her predoctoral psychology internship at University of Alabama at Birmingham/Children’s of Alabama, followed by a postdoctoral fellowship at University of Texas at Austin, where she worked both at Dell Children’s Medical Center and Texas Child Study Center. Following postdoctoral fellowship, she moved to Akron, Ohio, where she received training in pediatric behavioral sleep medicine, established the Sleep Psychology Clinic at Akron Children’s Hospital, and worked on the inpatient consultation/liaison team. Upon returning to Austin, Jaquez became the director of the Medical Coping Specialty Clinic at Texas Child Study Center and saw patients within the Texas Center for the Prevention and Treatment of Childhood Obesity (TCPTCO). She sees patients in the Dermatology, Allergy, and Comprehensive Care Clinics at Dell Children’s Medical Group. In these clinics, she specializes in cognitive behavioral therapy with youth who present with comorbid psychological and medical concerns, as well as sleep disorders. In addition to medical residents and fellows, she trains psychology graduate students, interns, and postdoctoral fellows. Her current research focuses on weight bias among pediatric providers and trainees and use of behavioral interventions during dermatology procedures.
Learning Objectives

1. Utilize appropriate diagnostic criteria to screen adolescent patients for depression, bullying, mood disorders, and suicide risk.

2. Counsel caregivers and adolescent patients regarding bullying prevention and intervention.

3. Devise collaborative treatment plans, including appropriate psychotherapy and pharmacotherapy, 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

Step 1

Step 2

Step 3
AES POLL QUESTION #1

What % of your practice is between the ages of 10-24?
1) 0-10%
2) 10-30%
3) 30-50%
4) >50%

Youth Account of Experiences
During the 12 months before the survey, 31.5% of students nationwide had felt so sad or hopeless almost every day for 2 or more weeks in a row that they stopped doing some usual activities.

**Suicide rates among America's young people continue to soar, study shows**

By Jacqueline Howard, CNN
Updated 12:09 PM ET, Tue June 18, 2019

"our new information shows that suicide [among] adolescents has reached its highest recorded level, and it shows that there's especially an increase in recent years in adolescent males," he said. "The data shows that it is a very real threat."

First author Oren Miron, research associate Harvard Medical school
Suicide Rates Among Adolescents and Young Adults in the United States, 2000-2017

Oren Miron, MA1; Kun-Hsing Yu, MD, PhD2; Rachel Wilf-Miron, MD, MPH2; et al
Isaac S. Kohane, MD, PhD1

Author Affiliations Article Information

AES POLL QUESTION #2

Which organization(s) recommend depression screening starting at age 12? (Select all that apply)

1) United States Preventive Services Task Force
2) American Academy of Family Practice
3) American Academy of Pediatrics
4) Bright Futures
5) Institute Of Medicine
A Look at Each Agency’s Guidelines

1) **USPSTF**: screening for major depressive disorder (MDD) in adolescents (12 to 18 years).
   - should be implemented with adequate systems in place (ensures accurate diagnosis, effective treatment, and appropriate follow-up). Grade B

2) **AAFP**: supports the USPSTF recommendation

3) **AAP**: supports that adolescent patients ages 12 years and older be screened annually for depression (MDD or depressive disorders) with a formal self-report screening tool either on paper or electronically (universal screening) (grade of evidence: 2; strength of recommendation: very strong)

4) **Bright Futures**: screen teens for depression, if indicated. (Share results of screening with teen and parents).

5) In light of the benefits associated with early intervention and the existence of effective treatment options, the IOM recommended that physicians in primary care settings screen adolescents for MDD

VALIDATED TOOLS

- **PSC, PSC-17, PSCY** Pediatric Symptom Checklist
- **CRAFFT** Car, Relax, Alone, Friends, Forget, Trouble
- **PHQ 2, 9, & A**
- **SCARED** Screen for Child Anxiety Related Disorders
- **CES-DC** Center for Epidemiological Studies Depression Scale for Children
- **CDI** Beck Child Depression Inventory for Primary Care (not free)
- **CBCL** Child Behavior Checklist (not free), TRF, YSR Achenbach System of Empirically Based Assessment (ASEBA)
- **RAAPS** Rapid Assessment for Adolescent Preventive Services
EXCEEMEAEADSSSSS NG INTERVIEW

• Home
• Education
• Eating
• Activities
• Drugs

• Sexuality
• Suicide/Depression
• Safety
• Strengths

PRACTICE RECOMMENDATIONS

– Universal screen for depression WCC 12 & up
– Screen as indicated by clinical situation
– Use validated tools
– Office champion
LISTENING/WATCHING FOR FLAGS

- Somatization
- Declining medical adherence
- Behavior change
- Affect in office
- LGBTQ youth at risk for all 3
- Depressed AND being bullied: higher risk for suicide
- History of trauma or ACES

Clinical Assessment Flowchart

Rachel A. Zuckerbrot et al.
Pediatrics 2018;141:e20174081
©2018 by American Academy of Pediatrics
Asses if Bullying Victim

• “Any unwanted aggressive behavior by another youth or group of youths who are not sibling or current dating partners that involves an observed or perceived power imbalance and is repeated multiple times or is highly likely to be repeated.” CDC, 2014
• Can be physical, verbal or relational
• Direct – blatant attacks on a targeted young person
• Indirect – communication with others about targeted individual
• Makes it more difficult for others to recognize what is happening
Prevalence Rates (US)

- 20% of 12-28 yo students
- 19% in grades 9-12 at school
- 49% in grades 4-12 in last month
- 30% youth admit bullying others
- Mostly in school, school grounds, school bus
- Only 20 to 30% bullied students notify adults

Screening: Best Practice

- Start when enter elementary school
- Screen high risk groups
  - Special needs (including chronic illness)
  - Under- or overweight
  - Identify as LGBTQ+
- Watch for indicators and ask about behaviors
  - Mood changes, psychosomatic sxns, behavioral concern, substance use
  - SIB, SI or attempt, decline academic functioning, school truancy
- Screen if engaging in bullying behavior
- Screen if bystander to bullying
CYBERBULLYING

- May not admit
- Don't want access restricted
- Less common, but correlated trad’l bullying
- School environment impt, but can take place away from school
- Cyberbullies can be anonymous
- Can happen 24 hrs/day
- No amt parent monitoring can catch all
- Higher rates suicidality

INTERVENING BULLYING

- **Information:**
  - For families [https://www.stopbullying.gov/](https://www.stopbullying.gov/)
  - [https://www.helpguide.org/articles/abuse/bullying-and-cyberbullying.htm](https://www.helpguide.org/articles/abuse/bullying-and-cyberbullying.htm) & others
  - Most effective interventions school-based

- **Reps for Parents:**
  - support the teen with empathy, take it seriously, **don’t confront other parents**, advocate at school

- **In the office:**
  - Express support – kids right to feel safe
  - **Engage in problem solving** – create a plan for school, create family media plan
    - [https://www.healthychildren.org/English/media/Pages/default.aspx](https://www.healthychildren.org/English/media/Pages/default.aspx)

- **Advocate** with the teen’s school and inquire about resources
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 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, recurrent suicidal ideation without specific plan, or suicide attempt or a specific plan for committing suicide.
ASSESSING RISK

RISKS:
• Interpersonal loss & stressors
• Psychiatric disorders
• Prior attempts
• Substance use / risky behaviors
• LGBTQ with little support
• Access to means
• Isolation
• Chronic disease or disability

PROTECTIVE:
• Access to interventions
• Social support/connectedness
• Life skills
• Restricted access to means
• Self-esteem & sense of purpose
• Cultural/religious/personal beliefs against suicide

FURTHER SAFETY ASSESSMENT

SEX
• Previous attempt
• ETOH or drug abuse
• Rational thinking loss
• Social supports lacking
• Organized plan
• Negligent parenting or family stress or suicidal modeling
• School Problems

AGE
Depression or affective disorder
*Self harm not always equal suicidality
*Clarify passive vs active thoughts
*Who knows? Trusted adult relationship?
*Try stay neutral. Keep pt focused on questions and history. Bring structure.
*Your presence invaluable
DEPRESSION INTERVENTION

• **Educate:**
  – AACAP Facts for Families [https://www.aacap.org](https://www.aacap.org) & others
  – Stress mind-body connection
• **For Caregivers:**
  – Importance of treating; clear directions
  – No blame; offer support
• **With Adolescent**
  – Validate, normalize
  – Behavioral activation
  – Consider medication and/or referral
  – Close follow-up

BRIEF INTERVENTION: BEHAVIORAL ACTIVATION

• 5 minutes
• Make or provide list
• Teen tracks completion and rates mood
• Present as a “prescription”
REFERRALS: Behavioral Health

- **Doctoral Level**: Psychologists (PhD, PsyD, EdD), Psychiatrists - *Telehealth available? Develop relationships with consulting psychiatrist & others*
- **Master’s Level**: Social Workers (LMSW, LCSW), Licensed Counselors (LPC), Licensed Marriage and Family Therapists (LMFT)
- **Bachelor’s Level**: Licensed Chemical Dependency Counselors (LCDC)
- **Mental Health Nurse**
- **Assess patient & family readiness & potential barriers**
- **Ensure insurance will work**
- **Ensure evidence-based treatment**

OTHER RESOURCES

- National Alliance Mentally Ill (NAMI)
- MHMR
- Child Guidance Center
- Schools, especially if on-site therapy
- Insurance Plan
- Specialized Hospital Systems
- Local Non-profits
- Regional Academic Center
AES POLL QUESTION #3

Which medication is FDA approved for treating depression in a 14 yo?
1) Paroxetine
2) Fluoxetine
3) Bupropion
4) Amitriptyline

SSRIs

Figure 1. FDA-Approved Pediatric Age Ranges and Indications for Antidepressant Medications

*Fluoxetine is FDA approved for the treatment of MDD in pediatric patients up to 18 years old.
SSRI TITRATION SCHEDULE

<table>
<thead>
<tr>
<th>Medication</th>
<th>Starting Dose (qd/od), mg</th>
<th>Increments, mg</th>
<th>Effective Dose, mg</th>
<th>Maximum Dosage, mg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citalopram</td>
<td>10</td>
<td>10</td>
<td>20</td>
<td>60</td>
</tr>
<tr>
<td>Fluoxetine</td>
<td>10</td>
<td>10–20</td>
<td>20</td>
<td>60</td>
</tr>
<tr>
<td>Fluvoxamine</td>
<td>50</td>
<td>50</td>
<td>150</td>
<td>300</td>
</tr>
<tr>
<td>Sertraline</td>
<td>25</td>
<td>12.5–25</td>
<td>50</td>
<td>200</td>
</tr>
<tr>
<td>Escitalopram</td>
<td>10</td>
<td>5</td>
<td>10</td>
<td>20</td>
</tr>
</tbody>
</table>

STARTING MEDICATION

- **Be positive and optimistic**
- Take with breakfast
- Start low
- See or connect q week 1<sup>st</sup> 4 weeks
- Clinical effects continue improve 3-6 weeks
- Primary care may underdose
- If no response > 4 weeks, consider switch
  - May be 30-40%
SAFETY PLAN

Coping strategies and resources
Do together
Gives control, framework
or search:
Developing effective safety plan for suicidal youth
- Star Center

Have handouts, websites, textlines, hotline numbers available
FOR LGBTQ+ YOUTH & FAMILIES
https://pflag.org/hotlines

ACTIVELY SUICIDAL/NEEDS ADMISSION

Make immediate referral to mental health provider or emergency services if severe depression, psychotic, or suicidal ideation/risk is evident.

- Already have practice plan
- If have IBH, page them
- Call 911, mental health deputies, local mental health hotline, police or EMS as needed
- Hospital emergency department
- Local mental health authority if have intake site
- Psychiatric hospital

Let family know what to expect, including your role
CARE COORDINATION

• Post hospitalization if occurred
• Communication between behavioral health, primary care, family, & school
• Clarify duration therapy &/or medication
• Ongoing screening

PRACTICE RECOMMENDATIONS

• *Follow best practices workflow*
  • Use validated tools & structured interviews
  • Have plan for + screens
  • Harm in not treating
  • Utilize compassion, optimism, and close f/u

• *Practice self-care; acknowledge when cases are difficulty; talk about with your team*
SOCIAL MEDIA POLL QUESTION
What social media sites/apps are youth using most frequently?
1. Twitter
2. Instagram
3. Snapchat
4. Pinterest
5. YouTube
6. Facebook

WHAT ADOLESCENTS WANTED TO INCLUDE IN THIS TALK

• Using ‘Meme Culture’ as an outlet for stress and depression.
• Engaging adolescents in healthy “Self-Talk”
• “Teenagers are masters at disguising their depression… Across both physiological and mental illness: kids have really long compensatory phases before they suddenly crash”
MEMES

Engaging Youth Through Social Media

- How can we use social media
- Texting
- Outreach
Mental Health Screening

- [https://www.cdc.gov/features/yrbs/index.html](https://www.cdc.gov/features/yrbs/index.html) 2017 YRBS
- For Pediatric Symptom Checklist
  - [http://www.massgeneral.org/psychiatry/services/psc_home.aspx](http://www.massgeneral.org/psychiatry/services/psc_home.aspx)
- For CRAFFT [http://www.ceasar-boston.org/clinicians/crafft.php](http://www.ceasar-boston.org/clinicians/crafft.php)

Mental Health Screening - 2

Key Resources Assessment & Management
Adolescent Depression in Primary Care


- http://www.glad-pc.org/ Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit

Depression Treatment


- 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

- https://www.aacap.org American Academy of Child & Adolescent Psychiatry- has information for families and treatment recommendations for physicians

- https://jamanetwork.com/journals/jama/fullarticle/199274 TADS
DEPRESSION RESOURCES TEENS & FAMILIES

https://www.helpguide.org/articles/depression/teenagers-guide-to-depression.htm
https://www.aacap.org/
https://kidshealth.org/en/teens/depression.html
Has Spanish and oral

Bullying Resources

• https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Pages/Connected-Kids.aspx Connected Kid includes a Clinical Guide and 21 handouts for parent and teen topics such as bullying, discipline, interpersonal skills, parents, suicide and television violence.
• https://www.stopbullying.gov/
• https://www.helpguide.org/articles/abuse/bullying-and-cyberbullying.htm
Suicide Prevention

• [http://www.sprc.org/](http://www.sprc.org/) Suicide Prevention Resource Center. Has hotline # and Suicide Assessment Five-step Evaluation and Triage for Mental Health Professionals


• [www.sprc.org/library/SafetyPlanTemplate.pdf](http://www.sprc.org/library/SafetyPlanTemplate.pdf) and Search Developing effective safety plan for suicidal youth-Star Center

• [https://pflag.org/hotlines](https://pflag.org/hotlines) comprehensive for LGBTQ+ youth and families