Comprehensive Adolescent Mental Health Care: It takes a community

Neerav (Nick) Desai MD
Adolescent Medicine
Vanderbilt University
July 11th, 2016

Disclosure

- I do not have any real or perceived financial conflicts of interest with regards to this discussion
- I will not promote the use of any specific products or proprietary material

Background

- A larger number of patients are receiving screening and initial management of mood disorders in various community settings.
- Mood disorder management is occurring in a variety of locations and by a variety of practioners- Physicians, Nurse Practioners, Physicians Assistants, Social Workers, Phds, and mental health therapists working in schools, community clinics, hospitals, religious organizations, private practices, and juvenile care facilities.
- Patient quality of life, cost effectiveness, portability, integrated care, and access to care are key drivers of mental health care in the coming years.

Objectives

- The learner should appreciate the components of the adolescent psychosocial review and understand the concept of motivational interviewing.
- The learner should understand the multidisciplinary nature of adolescent mental health care.
- The learner should appreciate the importance of communication and collaboration amongst providers and translate this into patient centered care.

Case 1

- Sam is a 16 y/o WM who is in your office for a first time visit with his mother. His mom is concerned about his recent drop in grades and detachment from the family. He seems distracted, and uninterested in school and baseball both of which he excelled at in the past.

Case 2

- Julie is an unaccompanied 17 y/o female who has a history of depression and a previous suicide attempt who comes in with one year history of tension headaches which get worse during times of stress.

Case 3

- Sean is a 17 y/o Latino male in your office with his mother to discuss familial conflict over his sexuality. He is bisexual but has felt hostility and anger from members of his family and some acquaintances. In addition he was recently involved in a physical altercation with two classmates.

Adolescent Development

Adolescent development

Tasks	Early, 10–14 years	Middle, 15–17 years	Late, 18 and older
Physical	Initiation of puberty; preoccupation with appearance; potential to reproduce	Completing puberty	Physical reproductive maturity
Cognitive	Concrete thinking	Increasing ability for abstract reasoning; risk-consequence deficits	Abstract reasoning; understands risk-consequence
Emotional	Egocentric	Developing sense of identity; risk-taking and experimentation	Intimacy as basis for sexual relationships; empathy and connectedness with others
Social	Reliance on family/parents; same-sex peer relationships; and few romantic relationships	Peer influence, sexual exploration; differentiating from family	Exploring new mature role in family, romantic relationships, social networks, and workplace
Sexual	"Crushes"; beginning sexual experimentation	Exploration and experimentation; intense romantic relationships; serial monogamy	Mature intimacy and enjoyment of sexual self; good communication and decision-making skills regarding sex

Courtesy of Robert Garofalo, MD, MPH, and Michelle Forcier, MD, MPH.

SETTING THE STAGE……
(How do we get in there?)

- Environment
- Establish the adolescent visit as different with different "rules"
- Emphasize new responsibilities for the patient
- Discuss this with patient and parents
- Establish and discuss confidentiality issues with patient and parents

CONFIDENTIALITY

- Know State laws
  - Contraception/STD testing/mental health care
    - Adolescents have the legal right to confidential contraceptive/STD/mental health related care and must consent to have that information released to their parents/guardians.
  - Abortion
    - Tennessee requires parental consent
- Establish exception to confidentiality
  - Harm to self or others
  - Abuse
  - At the discretion of the provider

IMPORTANCE OF CONFIDENTIALITY

Increases adolescent's willingness to disclose information and seek health care

Adolescent's perceive they are receiving "better" healthcare when they feel it is confidential.

HOW DO WE GET ALL THIS INFORMATION?

HEEADDSSS 3.0

HEEADDSSS 3.0

- H- Home
- E- Education/Employment
- E- Eating/Exercise
- A- Activities, Friends, Hobbies
- D- Drugs, Tobacco, Alcohol, performance enhancers
- S- Sexual activity, Sexuality, Dating Violence
- S- Suicidality, Depression
- S – Safety

Case 1

- You decide to talk to Sam alone and find out that he has recently been smoking marijuana every couple of days and has been feeling a bit down and unenthusiastic. This started five months ago after a breakup with a girlfriend. He denies other substance use or any SI or HI. He does report lots of anger and irritability.

Depression Screening in Clinic

TABLE 6 Patient Health Questionnaire 2

A score of 3 or greater has good sensitivity and specificity for detecting major depression in adolescents.

OVER THE PAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING?	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Richardson LP, et al.[9]

PHQ-9 screening

Suicidality

- Past suicide attempts are a strong risk factor for future attempts and suicide
- LGBTI youth are five times more likely to have a suicide attempt than heterosexual teens over 12 months
- Cutting and other acts of self harm could be a mood stabilizing behavior or a call for attention – either way providers should take it seriously and investigate further
- AAP Mental Health toolkit SADPERSONS scoring

Obtaining a substance use history

- Must be done in a confidential matter
  - Set it up by explaining to parents why
  - Remind them it is a positive way for them to build confidence in seeking individual care
  - We discourage the use of Urine drug screens in the primary care setting in youth and promote and facilitate an open conversation
- Should target major drugs of abuse in adolescents and young adults
  - Alcohol
  - Marijuana
  - Amphetamines
  - Performance enhancers
  - tobacco (all forms)
  - Synthetic cannabinoids
  - club drugs
  - inhalants

Spirit of Motivational Interview

Motivational Interview	Mirror Image Opposite Approach
Collaboration – counselor creates conducive partnership	**Confrontation**–over riding clients impaired perspective
Evocation–motivation and ability for change resides in client	**Education**–client is presumed to lack key knowledge
Autonomy– clients right and capacity for self direction	**Authority**–counselor tells client what he or she must do

Establishing Empathy

- Open with a compliment – helps patient feel comfortable
- Use open ended questions
- Use reflections – helps patient realize they are being heard
  a. Simple – restate patient's words
  b. Complex – identify emotions behind patient's words
- Normalize – "I see a lot of patients who struggle with this issue"
- Ask permission – I have some ideas is it ok for me to share them with you?

The Stages of Change

- **Precontemplation Stage:** client doesn't recognize that change is needed or is in denial of a problematic behavior
- **Contemplation Stage:** Client is ambivalent about change and has considered the benefits and barriers to change
- **Preparation Stage:** Client is preparing and intending to change behavior imminently
- **Action Stage:** client modifies behavior with commitment
- **Maintenance Phase/Relapse Prevention:** client works to consolidate gains and works to prevent relapse

Facilitator for change

Your goal is to develop a discrepancy between the clients current behavior and the clients desired behavior

1. Have client write down pros and cons of behavior – this works well for people who are in pre-contemplative and contemplative states of change
2. Desire for change- ask probing questions about motivation and desire for change in behavior
3. A typical day – help client realize how typical daily behaviors are discrepant from desired behaviors
4. Have client give three reasons for change

Case 1

After discussing with Sam and his mom they agree to seek counseling and you provide the number and hotlines for Centerstone, Mental Health Cooperative, and Life Care. You also provide him with a handout about marijuana cessation and have him return in 3 weeks.

Marijuana Cessation Information

- http://www.brown.edu/Student_Services/Health_Services/docs/marijuana.pdf
- http://www.marijuana-anonymous.org/12questions.shtml
- http://www.drugabuse.gov/infofacts/marijuana.html

Take home Points from Case 1

- Try to engender trust by ensuring confidentiality to get an accurate history and assessment
- Plan should involve family members for youth in order ensure accountability
- Know the resources in your community for mental health care and substance abuse
- Close follow up to discuss and evaluate progress to motivation for change

Case 2

- Julie mentions she has been under lots of stress with work and school as she is trying to make some money before going to college. She often feels overwhelmed and has passively thought suicide but has no active ideations. She is not on any meds and denies illicit substances but uses ibuprofen occasionally. She averages 6 hours of sleep per night.

Barriers to mental health care

- Denial
- Stigma
- Confidentiality
- Limited Insight, Availability, Access, and Time
- Bias of provider and patient

Overview of therapeutic modalities for anxiety and depression in youth

Mental Health Therapy
https://www.aap.org/en-us/Documents/CRPsychosocialInterventions.pdf

Medication Management
http://web.jhu.edu/pedmentalhealth/Psychopharmacolog%20use.html

Patient and family centered lifestyle modifications
http://pediatrics.aappublications.org/content/125/Supplement_3/S126.full.pdf

Mental Health Therapy
The Role of the Primary Provider

- Empower parents and patients to seek out qualified professionals with goal oriented therapeutic interventions
- Engage the patient in motivational discussion prior to referral to gauge readiness for interventions
- Maintain open communication with family while respecting confidentiality "I will walk along with you and advocate on your behalf in this journey"
- Communicate effectively with mental health providers – synergize

Higher Resilience Factors

- Youth involved in sports or group based activities
- Strong family bonds including siblings
- Strong friend support system
- Substance free
- Above average school performance

Risk factors for complications

- Previous Suicide attempts
- Concurrent polysubstance abuse
- Poor social and family support system
- Lack of compliance with medication management
- Co morbid psychiatric conditions
- Lack of family consensus
- Trouble with police or legal system or school truancy

Case 2

- After some discussion Julie agrees to reinitiate fluoxetine at a low dose and agrees she needs to go back to counseling. She quit behavioral counseling a year ago because her provider left the practice and she was not pleased with the replacement provider. Today she mentions that she is close to one of the counselors at school and that she would like to initiate counseling at school first. You both agree that she will return in 10-15 days for a follow up.

Take home points from Case 2

- Recognize that depression and anxiety can present with physical manifestations
- Understand clients' reluctance for behavioral therapy could stem from many factors
- Be open to various avenues and professionals for behavioral therapy options
- Empower patients about what to expect from professional counselors and be realistic about time frames
- Communicate with mental health providers while preserving confidentiality

Case 3

- Sean mentions that his mood is ok but he does get down when people discriminate against him or try to bully him. He occasionally feels hostility at home from brothers and step father but there has been no physical harm. Mom mentions that the entire family could benefit from therapeutic intervention.

Lesbian, Gay, Bisexual, and Transgendered youth

- 5% of teens identify as lesbian gay or bisexual
- Youth with male and female partners have higher rates of unprotected sex, teen dating violence, and forced sex
- Gender variant youth experience high rates of bullying, isolation and suicidality

Teens and Media

- Adolescents spend 7-11 hours per day with various media
- Most of this media use is unsupervised (cell phone)
- One quarter of adolescent experience electronic bullying
- Cyberbullying, sexting, driving while texting, online solicitation, and media related depression are challenging issues for youth, family and providers

Case 3

- After discussion with Sean and his mom you refer him to the Oasis Center for individual counseling. You ask Sean to specifically ask about conflict management skills and to inquire about healthy management of stress.
- In addition Mom and step dad agree to attend family counseling sessions with Sean at the Oasis Center once a month.

Family based Therapy

- Psychodynamic family therapy guides family with insight and knowledge about the source of conflict.
- Structural Family therapy involves examining and modifying existing family bonds to make the environment more nurturing.
- Cognitive Behavior Family therapy uses conditioning and psychoeducation to individual members.

Take Home from Case 3

- Recognize that LGBTI youth are a particularly vulnerable population
- Communication with therapist is key for corroboration and can be a useful to determine if psychopharmacology is necessary
- Understand the role of the family in adolescent behavioral health

Summary

- I feel confident taking a basic adolescent psychosocial history in a confidential manner
- I recognize the concept of motivational interviewing and how it could be effective in my practice
- I recognize the wide variety of professionals and locations that can provide ongoing mental health care
- I recognize the importance and value of communication between mental health providers

References

1. Klein DA. Goldenring JM. Adelman WP. HEEADSSS 3.0: The Psychosocial interview for adolescents updated for a new century fueled by media. Contemporary Pediatrics. January 2014.
2. Pitts S, Shrier L. Substance Abuse Screening and brief intervention for adolescents in primary care. Pediatric Annals. 2014;43(10):e248-252
3. Unite for Sight http://www.uniteforsight.org/mental-health/module6
4. Adolescent Sexuality. UpToDate. Michele Forcier. Accessed 6/2016
5. Broderick P, Weston C, Gillig P. Family Therapy with a depressed adolescent. Psychiatry 2009 Jan; 6(1): 32-37