Talking to Teens: Screening for Risks and Strengths

Ken Cheyne, MD, FAAP
Adolescent Medicine
Blank Children's Hospital

Conflict of Interest

- ☐ I have nothing to disclose that would create a conflict of interest.
- ☐ I will discuss unapproved/investigative use of commercial product(s)/device(s) in my presentation.

Objectives:

At the conclusion of the presentation participants will be able to:

- ☐ Act as a first resource for adolescents and their families with respect to behavioral and mental health issues.
- ☐ Screen, evaluate, and treat/refer adolescents for mental health and behavior problems.
- ☐ Implement a strength-based approach in interacting with adolescents to promote behavioral change.

How can I be a more effective resource?

Refer

Screen → **Evaluate** → **Treat** → **Refer**

Normal or abnormal?
Anticipatory guidance / Health Counseling
Teen-parent conflict
Tobacco, Alcohol, & Other Drug Use
Somatic Complaints / Chronic Illness
School avoidance / Absenteeism

How can I be a more effective resource?

Refer

Screen → **Evaluate** → **Treat** → **Refer**

Bereavement / Adjustment reactions
Poor school performance
ADHD
Eating disorders
Anxiety disorders
Depression

Recommendations for Screening for Depression

- ☐ 2007: AAP endorsed Guidelines for Adolescent Depression in Primary Care – GLAD-PC (Zuckerbrot et al)
- ☐ 2009: US Preventive Services Task Force endorsed depression screening in pediatric primary care for teens ages 12- 18 y/o

Adolescent Visits

Bright Futures

Priorities for the Visit

The first priority is to address the concerns of the adolescent and his parents. In addition, the Bright Futures Adolescence Expert Panel has given priority to the following additional topics for discussion in the 4 Early Adolescence Visits. The goal of these discussions is to determine the health needs of the youth and family that should be addressed by the health care professional. The following priorities are consistent throughout adolescence. However, the questions used to effectively obtain information and the anticipatory guidance provided to the adolescent and family can vary.

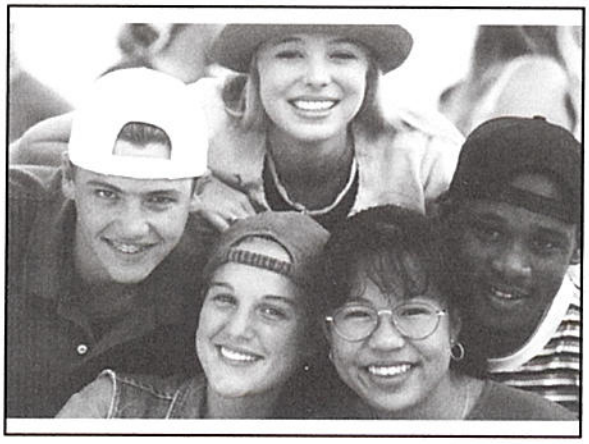
Including all the priority issues in every visit may not be feasible, but the goal should be to address issues important to this age group over the course of the 4 visits. These issues include:

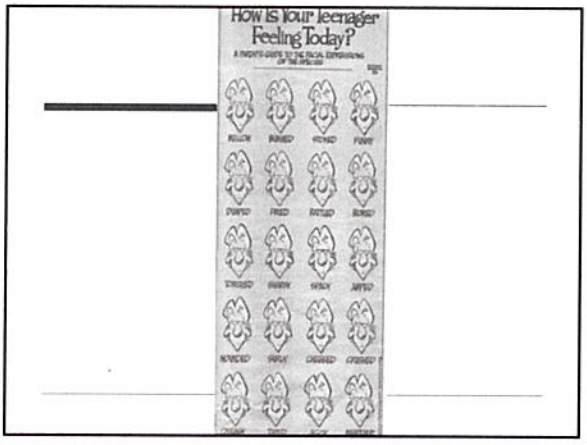
- Physical growth and development (physical and oral health, body image, healthy eating, physical activity)
- Social and academic competence (connectedness with family, peers, and community; interpersonal relationships; school performance)
- Emotional well-being (coping, mood regulation and mental health, sexuality)
- Risk reduction (tobacco, alcohol, or other drugs; pregnancy; STIs)
- Violence and injury prevention (safety belt and helmet use, substance abuse and riding in a vehicle, guns, interpersonal violence [fights], bullying)

What Families Find Helpful

" Families emphasized that having a primary care pediatrician ask about developmental, emotional and behavioral issues during well-child visits was important and would help normalize mental health issues. Also stressed the importance of using mental health screening tools, questionnaires and check lists as part of routine clinical practice."

NAMI – May 2011



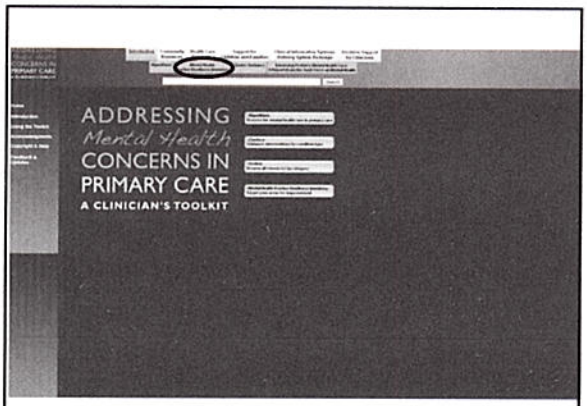


Bright Futures Resources

- ☐ Pre-visit questionnaires
- ☐ Documentation forms
- ☐ Patient / Parent handouts

AAP Mental Health Toolkit

- Community Resources
- Health Care Financing
- Support for Children & Families
- Clinical Information Systems/Delivery System Redesign
- Decision Support for Clinicians



Teen Screen for Primary Care

TeenScreen®
National Center

Depression

- Prevalence:
  - Up to 3% of children
  - 2-8% of adolescents
- M to F ratio:
  - 1:1 during childhood
  - 1:2 during adolescence
- Cumulative incidence by age 18 is approximately 20% in community samples.

Initial steps

- Mental health practice readiness inventory
- Referral sources
- Screening tools
- Diagnosis
- Treatment / referral

Depression Screening Tools

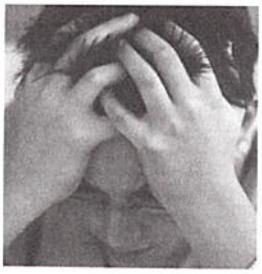
Pros:

- Increased identification
- Universal screening
- Time efficient
- Providers do not have to start the conversation
- Appears to increase adolescent disclosure of symptoms

Cons:

- Does take time
- Burden to system
- Many instruments available – how to choose?
- False positives possible
- Improved outcomes depend on proper F/U of positive screens

Depression Screening Tools



- Patient Health Questionnaire for Adolescents
  - PHQ-A, PHQ-9, PHQ-9 Modified for Teens
- Pediatric Symptom Checklist for Youth (PSC-Y)

Screening Tool for Depression

- Ages 12 to 18
- <5 minutes to complete & < 1 minute to score
- Score ≥ 11 is positive
- If answer to either question 12 or 13 is Yes – positive

Examples of Questionnaires

Depression – Diagnostic Criteria

- At least 2 weeks of depressed or irritable mood &/or loss of interest and pleasure, and at least 4 other symptoms from the following list.

Depression – Diagnostic Criteria

- **S** - sleep (insomnia or hypersomnia)
- **I** - decreased interest/enjoyment
- **G** - guilt/self-esteem (scale 1-10)
  - feelings of hopelessness or worthlessness
- **E** - decreased energy level
- **C** - decreased concentration
  - decreased school grades
- **A** - appetite/weight (decreased or increased)
- **P** - psychomotor retardation/agitation
- **S** - suicide

"Cutting"

- Cutting is a way for adolescents to deal with physical pain when their emotional pain is overwhelming.
- "It is better to feel pain on the outside than on the inside."
- It is very upsetting to adults.

Treatment of Depression

- Educate family and adolescent regarding the condition
- Ask about / remove firearms
- Provide hope: "You don't' have to feel like this"
- Healthy activities:
  - Good sleep / Days & nights not mixed up
  - Healthier diet
  - Exercise (get out of the house)

Treatment of Depression

- Healthy activities:
  - Dedicated time with important adults
  - Just say yes to activities
- Avoid self-medication
- Take steps to reduce stress (consider limiting media)
- Monitor progress – phone, F/U appointments
- Build on the adolescent's strengths

What Families Find Helpful

- Five most helpful things a provider can say:
  - There is hope
  - You are not alone
  - It's not your fault
  - I understand
  - You or your child/ adolescent has many strengths

NAMI – May 2011

Treatment of Depression

- Counseling
  - Supportive
  - CBT
  - IPT
- Medication
- Referral

Treatment of Depression

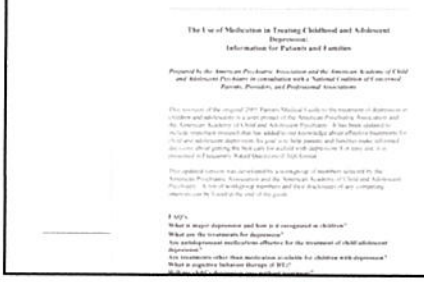
- Medication:
  - First line treatment is with SSRIs
  - FDA approved for pediatric depression:
    - Fluoxetine (Prozac) > 7 years old
    - Escitalopram (Lexapro) > 12 years old

SSRI Dosing

Medication	Starting Dose	Increments	Effective Dose	Maximum Dose
Citalopram (Celexa)	10 mg	10 mg	20 mg	60 mg
Fluoxetine (Prozac)	10mg	10-20 mg	20 mg	60 mg
Sertraline (Zoloft)	25-50 mg	12.5-50 mg	50 mg	60 mg
Escitalopram (Lexapro)	5mg	5 mg	10 mg	20 mg

Cheung, Zuckerbrot, Jensen, Ghalib, Laraque & Stein, 2007

Information for parents
(www.parentsmedguide.org/parentsmedguide.pdf)



Treatment of Adolescents with Depression Study (TADS)

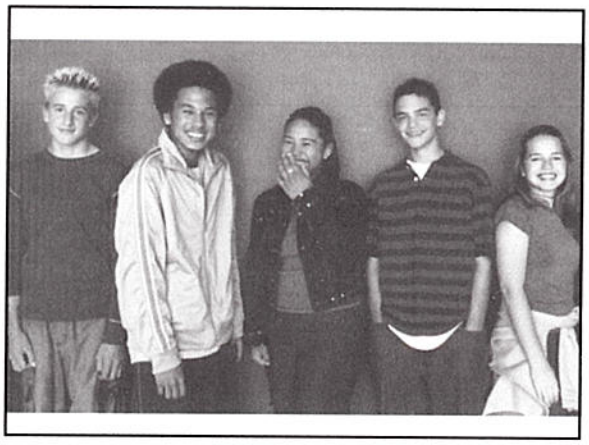
- ☐ Adolescents with moderate to severe depression:
  - COMB is fastest, most effective, and safest (relative to FLX) alone
  - FLX alone is effective, but not as effective as COMB
  - CBT alone is less effective than FLX and not significantly more effective than placebo acutely

March, Silva, Petrycki, Curry et al., 2004

What Families Find Helpful:
Ideal Action Steps

- ☐ Listen
- ☐ Ask questions
- ☐ Screen
- ☐ Evaluate
- ☐ Refer
- ☐ Follow-up
- ☐ Provide treatment
- ☐ Encourage

NAMI – May 2011



Circle of Courage:
Looking for Strengths

Belonging (connection)

- ☐ How do you get along with the different people in your household?
- ☐ Do you feel you have at least one friend or a group of friends with whom you are comfortable?
- ☐ How do you feel you "fit in" at school? In your neighborhood?

Belonging (connection)

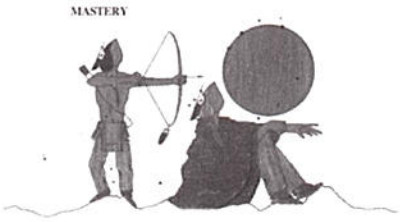
- ☐ Do you feel like you matter in your community?
- ☐ Do you have at least one adult in your life who cares about you and to whom you can go if you need help?
- ☐ When you're stressed out, who do you go to?

Belonging

Mastery (competence)

- ☐ Do you feel you are particularly good at doing a certain thing like math, soccer, theater, cooking, hunting, or anything else?
- ☐ How are you doing in school?
- ☐ What do you do to stay healthy?

Mastery



Independence (confidence)

- ☐ Do you feel that you have been allowed to become more independent or make more of your own decisions as you have become older?
- ☐ Have you figured out a way to control your actions when you're angry or upset?
- ☐ Everyone has stress in their lives. Have you figured out how to handle stress?

Independence (confidence)

- ☐ Have you figured out a way to control your actions when you're angry or upset?
- ☐ Everyone has stress in their lives. Have you figured out how to handle stress?
- ☐ How confident are you that you can make a needed change in your life?

Independence

Generosity
(contribution, character)

- ☐ What do your friends like about you the most?
- ☐ What do you do to help others (at home, or by working with a group at school, church, or community)?
- ☐ How do you support your friends when they are trying to do the right thing, like quitting smoking or avoiding alcohol and other substances?

Generosity

Strength statements on a questionnaire

Check off all of the items that you feel are true for you.

- o I engage in behavior that supports a healthy lifestyle, such as eating healthy foods, being active, and keeping myself safe.
- o I feel I have at least one responsible adult in my life who cares about me and who I can go to if I need help.
- o I feel like I have at least one friend or a group of friends with who I am comfortable.
- o I help others on my own or by working with a group in school, a faith-based organization, or the community.
- o I am able to bounce back from life's disappointments.
- o I have a sense of helpfulness and self-confidence.
- o I have become more independent and made more of my own decision as I have become older.
- o I feel that I am particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe:

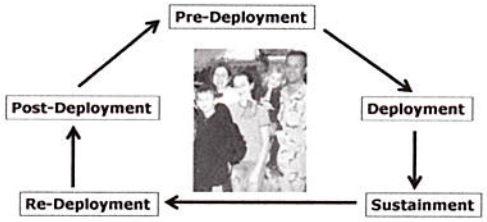
Improving Payment

If counseling or care coordination take up >50% of the face-to-face time spent with a patient, the provider may use time as the key or Controlling factor for a particular E/M service.

New Patient	Established Patient
99201 (10 minutes)	99211 (5 minutes)
99202 (20 minutes)	99212 (10 minutes)
99201 (30 minutes)	99213 (15 minutes)
99204 (45 minutes)	99214 (25 minutes)
99205 (60 minutes)	99215 (40 minutes)

Deployment: Effect on Adolescents

Stages of Deployment



What can health care providers do?

- Ask 3 questions:
  - Do you or your family have any connections with the military?
  - Is anyone deployed, about to be deployed, or recently returned from being deployed?
  - How are things going?

What can health care providers do?

- Military One Source
  - 1-800-342-9647
  - http://www.militaryonesource.com/
- AAP website
  - www.aap.org/sections/unifserv/deployment/index.htm
- Military Child and Adolescent Center of Excellence
  - Director: Maj Keith Lemmon, MD FAAP

Educational Prescription for Your Clinical Setting

- Which of the following are you willing to incorporate into your clinical practice?
  - Screen adolescents for mental health issues using the tools provided in the Bright Futures or Mental Health Toolkits.
  - Use a strengths based approach in working with adolescents in addition to screening for risk taking behaviors
  - Screen adolescents and their families for possible effects of military deployment
  - Provide initial treatment and/or appropriate referral for adolescents with depression.

BLANK CHILDREN'S HOSPITAL
IOWA HEALTH - DES MOINES

CONFIDENTIAL HEALTH PROFILE FOR YOUNG ADOLESCENTS

Name:_____ Date:_____

Age:_____ Sex: M F Name of school & grade:_____

Do you have any concerns, questions, or problems that you would like to discuss today?		
What changes or challenges have there been at home since last year?		
Do you participate in any physical activities, such as walking, skateboarding, dancing, swimming, or playing basketball, for a total of 1 hour each day?	NO	YES
Do you watch TV, play video games, or spend time on the computer for more than 2 hours per day (not including computer time for homework)?	YES	NO
Do you have any concerns or questions about the size or shape of your body, or physical appearance?	YES	NO
In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or starving yourself?	YES	NO
Have you been to the dentist in the last year?	NO	YES
Are you going to school?	NO	YES
Are you in any special classes in school (for example, advanced placement classes, honor classes, resource room, special education classes)?	YES	NO
Are you having any problems in school? *Circle all that apply:* grades worse than last year failing class homework suspended from school during past year fighting missing school	YES	NO
Do you always wear a seat belt when riding in a car, truck, or van?	NO	YES
Do you ever carry a gun (even to protect yourself) or have access to a gun at home or in places where you spend time?	YES	NO
Do you wear a helmet when you in-line skate, skateboard, bicycle, ski, or snowboard?	NO	YES
Is there someone at home, school, or anywhere else who has made you feel afraid, threatened you, or hurt you?	YES	NO
Do you have a person you can call for a ride if you're feeling unsafe with someone?	NO	YES
Have you ever been in trouble with the law?	YES	NO
Do you worry a lot or feel overly stressed out?	YES	NO
When you are angry, do you do violent things?	YES	NO
Do you have trouble sleeping?	YES	NO

(Continued on the back of this page)

During the past few weeks have you felt sad or down, felt irritable, or felt as though you had nothing to look forward to?	YES	NO
Have you ever felt that life was not worth living?	YES	NO
Do you talk with your parents about relationships and sex?	NO	YES
Have you ever had sex (including intercourse or oral sex)?	YES	NO
Do you talk with your parent about alcohol and drugs?	NO	YES
Have you ever drank beer, wine, or other alcoholic beverages?	YES	NO
Have you ever used marijuana?	YES	NO
Have you ever used any drugs other than marijuana?	YES	NO
Do you ever use non-prescription drugs to get to sleep, stay awake, calm down, or get high? *(These drugs can be bought at a store without a prescription.)*	YES	NO
FOR FEMALES ONLY		
Have you gotten your period?	YES	NO
If yes, are you having any problems with or do you have any questions about your period?	YES	NO

Check off all of the items that you feel are true for you.

- o I engage in behavior that supports a healthy lifestyle, such as eating healthy foods, being active, and keeping myself safe.
- o I feel I have at least one responsible adult in my life who cares about me and who I can go to if I need help.
- o I feel like I have at least one friend or a group of friends with who I am comfortable.
- o I help others on my own or by working with a group in school, a faith-based organization, or the community.
- o I am able to bounce back from life's disappointments.
- o I have a sense of helpfulness and self-confidence.
- o I have become more independent and made more of my own decision as I have become older.
- o I feel that I am particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe:

Please list below all the people that live with you.

(Continued on the next page)

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptoms put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thought that you would be better off dead, or of hurting yourself in some way?				

10. In the ***past year*** have you felt depressed or sad most days, even if you felt okay sometimes?	□Yes □No
11. If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people? □Not difficult at all □Somewhat difficult □Very difficult □Extremely difficult	

12. Has there been a time in the past month when you have had serious thoughts about ending your life?	□Yes □No
13. Have you ***ever***, in your ***whole life***, tried to kill yourself or made a suicide attempt?	□Yes □ No

Signature of health care provider **Date**

(This form was adapted from Bright Futures & includes the PHQ-9 Modified for Teens)

BLANK CHILDREN'S HOSPITAL
IOWA HEALTH - DES MOINES

CONFIDENTIAL HEALTH PROFILE FOR ADOLESCENTS / YOUNG ADULTS

Name:_____ Date:_____

Age:_____ Sex: M F Name of school & grade:_____

Do you have any concerns, questions, or problems that you would like to discuss today?		
What changes or challenges have there been at home since last year?		
Do you participate in any physical activities, such as walking, skateboarding, dancing, swimming, or playing basketball, for a total of 1 hour each day?	NO	YES
Do you watch TV, play video games, or spend time on the computer for more than 2 hours per day (not including computer time for homework)?	YES	NO
Do you have any concerns or questions about the size or shape of your body, or physical appearance?	YES	NO
In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or starving yourself?	YES	NO
Have you been to the dentist in the last year?	NO	YES
Are you going to school?	NO	YES
Are you in any special classes in school (for example, advanced placement classes, honor classes, resource room, special education classes)?	YES	NO
Are you having any problems in school? *Circle all that apply:* grades worse than last year failing class homework suspended from school during past year fighting missing school	YES	NO
Do you always wear a seat belt when riding in a car, truck, or van?	NO	YES
Do you ever carry a gun (even to protect yourself) or have access to a gun at home or in places where you spend time?	YES	NO
Do you wear a helmet when you in-line skate, skateboard, bicycle, ski, snowboard, or ride a motorcycle, ATV, minibike, or snowmobile?	NO	YES
Have you ever had someone at home, school, or anywhere else who has made you feel afraid, threatened you, or hurt you?	YES	NO
Do you have a person you can call for a ride if you're feeling unsafe or have been drinking or are high?	NO	YES
Do you use a cell phone or headphones while driving?	YES	NO
Have you ever been in trouble with the law?	YES	NO
Have you ever felt upset by an experience using the Internet?	YES	NO

(Continued on the back of this page)

Have you ever been forced or pressured to do something sexual that you haven't wanted to do?	YES	NO
Do you worry a lot or feel overly stressed out?	YES	NO
Are all of your relationships with girlfriends/boyfriends, friends, and family free of violence and abuse?	NO	YES
When you are angry, do you do violent things?	YES	NO
Do you have trouble sleeping?	YES	NO
During the past few weeks have you felt sad or down, felt irritable, or felt as though you had nothing to look forward to?	YES	NO
Have you ever felt that life was not worth living?	YES	NO
Are you, or do you ever wonder if you are gay, lesbian, bisexual, or transgender?	YES	NO
Have you ever drank beer, wine, or other alcoholic beverages?	YES	NO
Have you ever used marijuana?	YES	NO
Have you ever used any drugs other than marijuana?	YES	NO
Do you ever use non-prescription drugs to get to sleep, stay awake, calm down, or get high? *(These drugs can be bought at a store without a prescription.)*	YES	NO
If you answered no to all of the questions in this section so far, you can skip the rest of the questions in this section: Have you ever ridden in a car driven by someone (including yourself who was high or had been using alcohol or drugs?	YES	NO
Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	YES	NO
Do you ever use alcohol or drugs while you are by yourself (alone)?	YES	NO
Do you ever forget things you did while using alcohol or drugs?	YES	NO
Do your family or friends ever tell you that you should cut down on your drinking or drug use?	YES	NO
Have you ever gotten into trouble while you were using alcohol or drugs?	YES	NO
FOR FEMALES ONLY		
Do you have excessive menstrual bleeding or does your period last more than 5 days?	YES	NO
Have you ever had sex (including intercourse or oral sex)? *If no, skip the rest of this section.*	YES	NO
Have you been sexually active without using birth control?	YES	NO
Have you been sexually active & had a late or missed period within the last 2 months?	YES	NO
Have you ever been pregnant?	YES	NO
Have you ever been treated for a sexually transmitted infection?	YES	NO
Are you having unprotected sex with multiple partners?	YES	NO
Have your partners been both male and female?	YES	NO
Do you trade sex for money or drugs or have sex partners who do?	YES	NO
FOR MALES ONLY		
Have you ever had sex (including intercourse or oral sex)? *If no, skip the rest of this section.*	YES	NO
Are you using a method to prevent pregnancy?	YES	NO
Have you ever gotten someone pregnant?	YES	NO
Have your ever been treated for a sexually transmitted infection?	YES	NO
Are you having unprotected sex with multiple partners?	YES	NO
Have your partners been both male and female?	YES	NO
Do you trade sex for money or drugs or have sex partners who do?	YES	NO

Check off all of the items that you feel are true for you.

- o I engage in behavior that supports a healthy lifestyle, such as eating healthy foods, being active, and keeping myself safe.
- o I feel I have at least one responsible adult in my life who cares about me and who I can go to if I need help.
- o I feel like I have at least one friend or a group of friends with who I am comfortable.
- o I help others on my own or by working with a group in school, a faith-based organization, or the community.
- o I am able to bounce back from life's disappointments.
- o I have a sense of helpfulness and self-confidence.
- o I have become more independent and made more of my own decision as I have become older.
- o I feel that I am particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe:

Please list below all the people that live with you.

(Continued on the back of this page)

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptoms put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thought that you would be better off dead, or of hurting yourself in some way?				

10. In the ***past year*** have you felt depressed or sad most days, even if you felt okay sometimes?	□Yes □No
11. If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people? □Not difficult at all □Somewhat difficult □Very difficult □Extremely difficult	

12. Has there been a time in the past month when you have had serious thoughts about ending your life?	□Yes □No
13. Have you ***ever***, in your ***whole life***, tried to kill yourself or made a suicide attempt?	□Yes □ No

Signature of health care provider **Date**

(This form was adapted from Bright Futures & includes the PHQ-9Modified for Teens)

Talking to Teens: Screening for Risks and Strengths
Useful References

American Academy of Child & Adolescent Psychiatry. *A Guide to Building Collaborative Mental Health Care Partnerships in Pediatric Primary Care.* June 2010. (http://www.aacap.org/galleries/PracticeInformation/Collaboration_Guide_FINAL_approved_6-10.pdf)

American Academy of Pediatrics. *Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit.* 2010. Elk Grove Village, IL. (http://www.aap.org/commpeds/dochs/mentalhealth/)

American Academy of Pediatrics. *Bright Futures Toolkit*. 2007. Elk Grove Village, IL. (http://brightfutures.aap.org/tool_and_resource_kit.html)

Jensen PS, Cheung A, Zuckerbrot R, Ghalib K, Levitt A. *GLAD-PC Toolkit, Version 2*. 2010. (http://c2199892.cdn.cloudfiles.rackspacecloud.com/glad-pctoolkit-v1-r4.pdf)

National Alliance on Mental Illness. *The Family Experience with Primary Care Physicians and Staff.* May 2011. (http://www.nami.org/template.cfm?template=/contentmanagement/contentdisplay.cfm&contentid=120671)

Shalwitz J, Sang T, Combs N, Davis K, Bushman D, Payne B. *Behavioral Health: An Adolescent Provider Toolkit.* 2007. San Francisco, CA: Adolescent Health Working Group, San Francisco. (http://www.ahwg.net/assets/library/98_behavioralhealthmodule.pdf)

TeenScreen National Center for Mental Health Checkups. (http://www.teenscreen.org/)