Depression in Youth: A Coordinated Approach to Diagnosis and Treatment

- Depression is challenging to all families
- Multiple moves pose additional challenges for military connected children and families
- MCEC recognizes the challenge
Leaving Your Footprint: Depression in Youth

At the MCEC Work Session:
- Join with other participants in a dialogue around Depression
- Co-create simple messages from expert content

Back at Home:
- Use the content to build understanding
- Engage and support families in using the content to convey their needs

As Families Move On:
- Prepare them to share the content in a new setting
- Prepare them to use the content to convey their needs to new school staff and a new set of providers

Going Forward:
- Stay connected through MCEC website
- Access resources on MCEC website
- Offer resources that you recommend
Seminar Session  
1:00 – 4:15 p.m.

Part 1: Expert Panel – 1:00 – 2:35 p.m.
- Provide information
- Share latest thinking on Depression
- Discuss Depression in the context of military-connected children and families

Break: 2:35 – 2:50 P.M.

Part 2: Customize information for families and providers – 2:50 – 4:15 p.m.
- Accurate information communicated simply
- Infographic co-created with participants
- Plan for sharing to build understanding and capacity
Session Goals

Create a stakeholder-developed infographic that communicates the most important messages from the Expert Panel (Part 1) to be used by parents and professionals *(Infographic first; Dialogue Guide next)*

Enable participants to share messages in their current assignment *and* to take information to future assignments. *(Initiative: Leaving Your Footprint: Depression)*

Encourage participants to connect and interact beyond the session
• Michael E. Faran, M.D.,
  Child & Adolescent Psychiatrist

• Eric Flake, M.D., FAAP, Col, USAF MC,
  Developmental & Behavioral Pediatrician

• Patti Johnson, Ph.D.,
  Pediatric Psychologist

• Kendon Johnson, Ph.D.,
  DoDEA, School Counselor Support
Depression in Adolescents: Pharmacological Treatment

Michael E. Faran, MD, PhD
Child and Family Behavioral Health System
Program Management Office
(CAFBHS PMO)

July 2019

UNCLASSIFIED
The views expressed are those of the author(s) and do not reflect the official policy of the Department of the Army, the Department of Defense or the U.S. Government.
• Trade Names are used in this module because these drugs are typically only known by their Trade Names due to the numerous formulations of methylphenidate and amphetamines

• Use of Trade Names does not, in any way, endorse these medications, nor promote one medication over another within the same medication class

• Therefore every reasonable attempt was made to include all ADHD medications (by Trade Name) in each medication class discussed in this Presentation
Depression in Children and Adolescents
Prevalence of Depression

- Childhood – 0.4-2.5% prevalence
- Increases with age up to 8-12% in adolescents
- Cumulative incidence of major depression during adolescence is 15-20%
- Female: Male Ratio; Children 1:1, Adolescents 2:1
- United States Preventive Service Task Force (USPSTF) recommends screening of adolescents (12-18) for major depressive disorder when systems in place to provide accurate diagnosis, psychotherapy and follow-up: Is a Grade ‘B’ recommendation (February, 2016)
Diagnostic Criteria

• Major Depressive Episode:
  – 5 or more symptoms for ≥ 2 weeks
  – Must have either depressed mood or loss of interest/pleasure as one symptom
  – Symptoms cause significant impairment or distress
  – No mania
Symptoms:

- Depressed mood or irritability
- Diminished interest/pleasure most activities
- Significant weight or appetite change
- Insomnia/Hypersomnia
- Fatigue or loss of energy
- Psychomotor retardation
- Feelings of worthlessness or guilt
- Difficulties with concentration
- Recurrent thoughts of death or suicidal ideation
All children and adolescents who meet criteria for Depression should be assessed for ‘Suicidality’
Severity and Impact of Depression Informs Treatment Planning

- **For Mild Depression:**
  CBT (Psychosocial TX) is the first line treatment

- **For Moderate to Severe Depression:**
  CBT plus inclusion of Medication is most efficacious treatment
• Three treatment approaches:
  ▪ Psychoeducation (also a CBT component)
  ▪ Psychosocial Treatment – i.e. CBT
  ▪ Pharmacotherapy - SSRIs recommended: Fluoxetine, Sertraline, and Escitalopram

• Treatment for Adolescent Depression Study (TADS)\(^1\)
  ▪ 440 Moderately depressed teens
  ▪ Response: CBT 43.2 %, Fluoxetine 60%, Combo 71%

• Adding CBT to medication treatment decreases risk of relapse\(^2,3\)
Depression: Remission, not simply a response or improvement
Demonstrated uses of Antidepressants

- Major Depressive Disorder
- Persistent Depressive Disorder
- Panic Disorder
- Generalized Anxiety Disorder
- Obsessive Compulsive Disorder
- Social Anxiety Disorder
- Posttraumatic Stress Disorder
- Premenstrual Dysphoric Disorder
- Trichotillomania
- Anorexia Nervosa
- Bulimia Nervosa
- Pathological Gambling
Medications: Evidence for Efficacy

• **A: Proven**
  – two or more well-designed, randomized clinical trials

• **B: Supported**
  – only one well-designed, randomized clinical trial

• **C: Suggested**
  – only by observational surveys, uncontrolled studies, or case reports

GRADE (Grading of Recommendations Assessment, Development and Evaluation) Working Group 2007 (modified by the EBM Guidelines Editorial Team)
http://www.essentialevidenceplus.com/product/ebm_loe.cfm?show=grade
Classes of Antidepressants

- Selective Serotonin Reuptake Inhibitors (SSRIs)
- Serotonin partial agonist/reuptake inhibitors (SPARIs) (vilazodone)
- Serotonin modulator (vortioxetine)
- Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)
- Selective Norepinephrine Reuptake Inhibitors (NRIs)
- Norepinephrine Dopamine Reuptake Inhibitors (NDRIs) (buproprion)
- Alpha-2 Antagonists (mirtazapine)
- Serotonin antagonist/reuptake inhibitors (SARIs) (trazodone and nefazodone)
- Monoamine Oxidase Inhibitors (MAOIs)
- Tricyclic Antidepressants
**Parameters of Safety**

- **FDA Approval in Youth**
  - Requires evidence of short-term safety
- **Sufficient Exposure (10+ Years on Market)**
  - Minimizes risk of rare adverse events
- **Minimal Overdose Harm**
  - Reduces risk of accidental/intentional harm
- **No Substantive FDA Boxed Warning**
  - Reduces likelihood of serious adverse event
- **No/Minimal Known Long-Term Risk**

*Dr. Mark Riddle, Johns Hopkins Medical School*
• FDA published “Black Box” Warning for antidepressants in 2004

• FDA 2006 study showed that 4% of patients on SSRI had suicidal ideations/behaviors vs. 2% not on SSRIs = 2% increase

• Other studies have shown risk is not as high

• UpToDate summary states: Taken together, the data suggest that compared with placebo, antidepressant medications in some children and adolescents may result in a small increase in the risk of suicidality

• Risk is higher early on in treatment

• Risk appears to be lower when SSRI started at lower dose

• After the Black Box warning there were increases in suicide in children and adolescents correlated with decreases in prescriptions of SSRIs in primary care
# Level 1 Medications

## Anxiety & Major Depressive Disorders

<table>
<thead>
<tr>
<th>Drug (Mode of Action)</th>
<th>Indication (s)</th>
<th>FDA Approval/Approved Age</th>
<th>Level of Evidence</th>
<th>Generic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluoxetine (SSRI)</td>
<td>ANX MDD OCD</td>
<td>No Yes; ≥ 8 Yes; ≥ 7</td>
<td>B A</td>
<td>Yes</td>
</tr>
<tr>
<td>Sertraline (SSRI)</td>
<td>ANX MDD OCD</td>
<td>No No Yes; ≥ 6</td>
<td>B B A</td>
<td>Yes</td>
</tr>
<tr>
<td>Escitalopram (SSRI)</td>
<td>ANX MDD OCD</td>
<td>No Yes; ≥ 12</td>
<td>B A Insuff data</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Dr. Mark A. Riddle, MD*

*Johns Hopkins University*
• Blocks pre-synaptic reuptake pump, thereby allowing more serotonin to be in the synaptic space for a longer period of time

• Metabolized in the liver

• Induction of different enzymes
• Interview and screening

• Appropriate physical exam

• Labs to rule out other common disorders that give signs and symptoms of depression/anxiety and labs that are recommended before prescribing an SSRI
  – BHCG (when applicable)
  – CBC
  – Chem 7 or equivalent, include glucose
  – LFTs
  – TSH
  – Vit D (higher latitudes or suspected deficiency)
  – Vit B12/folate (if suspect)
Common Adverse Effects of SSRIs

- Headaches
- Insomnia
- Sedation
- Nausea
- Diarrhea
- Sexual dysfunction

- Not common but important Hypomania/Mania – more common in school-age children than in adolescents
• If no response after 2-3 weeks, incrementally increase SSRI at intervals of at least a week

• Usual dose increments are:
  • Fluoxetine 10-20 mg
  • Sertraline 25-50 mg
  • Escitalopram 5-10 mg
What To Do If SSRI Does Not Work?

- Answer these Questions
  - Is dose maximized?
  - Is duration sufficient?
  - Is poor adherence the problem?
  - Is there a co-morbid disorder and is this the correct diagnosis?

- Has patient had adequate trial of CBT?
  - For depression adding CBT has been shown to increase proportion that respond (*TORDIA study)

Resistant Depression = Consultation or Referral

Strategies the CAFBHS Child Psychiatrist may utilize include:

- Add Buspirone – partial 5HT$_{1A}$
- Add Antidepressant with different receptor activity – Several alternative medications
- Add Stimulant if comorbid for ADHD
- Add Atypical Antipsychotic, such as aripiprazole or quetiapine
- Add Lithium
- Add Thyroid hormone
- Transcranial magnetic stimulation
- ECT (rare in adolescents in US)
• Length of SSRI treatment for Depression is 6-12 months

• Even if responds well to medication, may need adjunctive therapy as Depression and Anxiety may disrupt developmental tasks

• During maintenance, patient should be re-assessed monthly

• Discontinuation of therapy should be at low stress time such as summer
When the treatment plan for Depression includes medication, SSRIs are the medication of choice.

SSRIs can be effectively provided by the Primary Care Manager.

A ‘Start Low, Go Slow’ dosing approach is best for optimal results.

Maintenance is necessary to prevent relapse.


Questions
Demoralization and Depression in Children with Special Needs

Eric M. Flake MD
Developmental Pediatrics
Madigan Army Medical Center
DISCLOSURE STATEMENTS

The views expressed in this presentation are those of the author(s) and do not reflect the official policy of the Department of the Air Force, the Department of Defense or the U.S. Government.

I have no commercial or financial interest to disclose.
Demoralization and Depression in Children with special needs

Positive
Brief increases in heart rate, mild elevations in stress hormone levels.

Tolerable
Serious, temporary stress responses, buffered by supportive relationships.

Toxic
Prolonged activation of stress response systems in the absence of protective relationships.
Depression and Special Needs Children

• Nearly 75% of depressed adolescents do not receive treatment.
  • Greater risk for special needs youth.

• Any Chronic illness is a risk factor for major depression and can negatively influence the illness
  • 40+% of all CSHCN experienced internalizing mental health symptoms, but this rate varied significantly by the age of the child
  • Children with activity limitations have 3x the amount depressive symptoms compared to other CSHCN
  • Least associated with depression were asthma (22%), diabetes (29%), and allergies (29%).

• Some illnesses also demonstrate the same symptoms that overlap with depression

• Teasing apart the root of the symptoms can be challenging but important when treating children with special needs.

• Early childhood developmental problems = 7 fold increase of mental disorders
• Familial – 2-4x increased risk if parent with depression
• Anxiety precursor – 65%

• Environmental adversity
• Adverse child events or past trauma
• Other medical or developmental problems
Anxiety often proceeds depression

- Children often hide their anxiety and discouragement behind defiant and rebellious attitudes

- Lack of motivation is the problem of demoralization, whether overt or disguised

- Children, when they are not angry or discouraged, want to do well

- Undiagnosed attention and learning disorders are the most common source of discouragement and lack of motivation
  - Doing schoolwork is like running with a sprained ankle

- Demoralization develops over time
  - This become habitual and much time is needed to reverse
Autism and ADHD high rates of co-morbid depression in children with special needs

- Children with Autism
  - Affect vs Mood
  - Not easy to determine if depressed
  - 70% diagnosed with internalizing disorder

- Children with ADHD
  - Demoralized (>90%)
  - ODD/CD (35%)
  - Mood disorder (25%)
  - Learning Disability (20%)
  - Tourette Syndrome (7%)

- % of children rated by their parents as “sometimes” to “very often” contemplating or attempting suicide was 28 times greater for those with autism than those with typical development.

Suicide ideation and attempts in children with autism Research in Autism Spectrum Disorders Volume 7, Issue 1, January 2013, Pages 109-119
Elements of family-centered and trauma-informed pediatric care

**FAMILY-CENTERED CARE**
- Focus on dignity & respect for patient / family
- Maximize family involvement in care
- Respect patient / family wishes for interdependence & privacy

**TRAUMA-INFORMED CARE**
- Integrated in every patient interaction
- Share information with patient and family
- Encourage family presence
- Recognize family strengths & needs
- Cultural competence

- Minimize potential for trauma during medical care
- Address distress
- Promote emotional support
- Encourage return to daily activities when possible

https://healthcaretoolbox.org
We are all in this together – Coalition Building

• Medical, Educational and Community
  • Researchers
  • Practitioners
  • Educators
  • Policy makers

• Objective 1: Reduce the stigma of depression
• Objective 2: Recognize how depression evolves and transacts across biological, psychological and social systems
• Objective 3: Respond with effective system interventions and treatments
Resiliency Factors for Military Families

The key is CONNECTIONS!

• Extended family, friends
• Strong parent-child connection
• Sense of purpose directed to the mission
• All of these connections help families COPE!
Take Away: Depression in Children with Special Health Care Needs

- Identifiable risk factors exist and can assist with preventing childhood depression

- Anxiety is often the precursor to depression

- High rates of co-morbid depression is prevalent in children with special needs

- Caring for the entire family and environment is a critical component in treating depression requiring collaborative care.

- Researchers, practitioners and policy makers need to continue to reduce the stigma of depression and move beyond how depression presents to recognize a deeper understanding of how depression evolves and responds across biological, psychological and social systems.
Thank you for Supporting Military Families!
Depression in Adolescents
Psychosocial Treatments

Patti L. Johnson, Ph.D.
Child and Family Behavioral Health System
Program Management Office
(CAFBHS PMO)

July 2019

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Depression in Children and Adolescents
• Childhood – 0.4-2.5% prevalence

• Increases with age up to 8-12% in adolescents

• Adolescents with a major depressive episode in the past year increased 52% (from 8.7% to 13.2%) from 2005-2017

• Cumulative incidence of major depression during adolescence is 15-20%

• Female:Male Ratio; Children 1:1, Adolescents 2:1

• United States Preventive Service Task Force (USPSTF) recommends screening of adolescents (12-18) for major depressive disorder
• **Major Depressive Episode:**
  
  – 5 or more symptoms for $\geq 2$ weeks
  – Must have either depressed mood or loss of interest/pleasure as one symptom
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• Symptoms:
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  - Diminished interest/pleasure most activities
  - Significant weight or appetite change
  - Insomnia/Hypersomnia
  - Fatigue or loss of energy
  - Psychomotor retardation
  - Feelings of worthlessness or guilt
  - Difficulties with concentration
  - Recurrent thoughts of death or suicidal ideation
• Physiological Changes/Puberty
• Changes in Peer and Romantic Relationships
  – Fear of Rejection
  – Homosexual and Transgender Youth at High Risk
• Bullying
• Lack of Coping Skills
• Performance Demands – Academic Pressures, Life Plans
• Technological Advances
  – Overall Screen Time
  – Social Media
  – Video Games
• Pressure to Use Drugs/Alcohol
Depression in the Classroom and at School

- Irritability – Moody, resistive, doesn’t want to do work
- Sad mood – Apathetic, bored, sad, cries
- Poor self-esteem - Negative self-statements
- Sense of hopelessness or helplessness, despair
- Poor concentration, fatigue, loss of energy, lack of motivation
  - Difficulty learning and performing
  - Drop in grades
- Drops out of activities – Clubs, Sports, Volunteering
- Withdraws from friends and/or classroom participation
- Doesn’t enjoy activities, friends – just going through the motions
- Unexplained physical complaints, frequent absences
• Severity and Impact of Depression Informs Treatment Planning
  
  ▪ For **Mild** Depression:
    CBT (Psychosocial TX) is the first line treatment
  
  ▪ For **Moderate to Severe** Depression:
    CBT plus inclusion of medication is most efficacious treatment
Three treatment approaches:

- Psychoeducation (also a CBT component)
- Psychosocial Treatment – i.e. CBT
- Pharmacotherapy - SSRIs recommended:
  Fluoxetine, Sertraline, and Escitalopram (discussed in later module)

Treatment for Adolescent Depression Study (TADS)\(^1\)

- 440 Moderately depressed teens
- Response: CBT 43.2 %, Fluoxetine 60%, Combo 71%

Adding CBT to medication treatment decreases risk of relapse\(^2,3\)
Components of Cognitive Behavioral Therapy

Cognitive Behavioral Therapy for Depression

- Psychoeducation/CBT Rationale
- Behavioral Activation
- Mood Monitoring
- Relaxation Techniques, Mindfulness
- Communication and Social Engagement
- Problem Solving Skills
- Cognitive Restructuring
The CBT Model

BEHAVIOR

EMOTION

COGNITION
• Teach patient and family about cycle of depression
  ✓ Emotional, cognitive, and behavioral responses to negative life events is normal – feel sad, perceive the world negatively, and withdraw from social activities
  ✓ Withdrawal leads to more negative life events and fewer opportunities for corrective, positive life experiences
  ✓ Cognitive appraisals about world become distorted
  ✓ This creates a spiral or cycle of depression

• Which provides rationale for treatment approach
  ✓ Behavioral Activation – fun, meaningful, social
  ✓ Cognitive Restructuring – more realistic appraisal
  ✓ Somatic Management – breathing and relaxation
  ✓ Problem Solving – alternatives to withdrawal
Treatment Rationale:
Skill Deficits in Youth Depression

- Poor problem-solving
- Poor activity selection
- Tension and poorly-developed self-soothing
- Unengaging social style
- Underdeveloped peer-valued skills
Treatment Rationale: Habits of Thought in Youth Depression

• Negative (depressogenic?) cognitions

• Rumination over adverse events

• Perceived helplessness
  – Low level perseverance in coping
Basic CBT Approach to Depression

• Skill Building
  – Behavioral Activation
  – Mood Monitoring
  – Social Skills Training, Communication and Social Engagement
  – Problem Solving Training, Perseverance
  – Relaxation Techniques, Mindfulness

• Cognitive Work
  – Recognize and change habits of thought
At Home and School

• Encourage students to increase their activities
  – Activities that are fun, enjoyable, and/or socially interactive
  – Activities that bring satisfaction or sense of mastery – meeting a small goal, completing a task
  – Activities that bring a sense of meaning or value – volunteering, helping a friend

• Encourage effort and recognize small incremental progress

• Be patient and non-judgmental, listen and be available

• Develop a collaborative relationship with the student

• Use positive reinforcement to encourage student

• Make accommodations in assignments if necessary
All children and adolescents who meet criteria for Depression should be considered at-risk and assessed for ‘Suicidality’
• Military-connected teens self-report higher level of depressive symptoms and suicidal ideation than their peers

• Research indicates concerning suicide trends over last decade
  • Youth Risk Behavior Survey – HS students who reported seriously considering suicide in past year increased from 14.5% to 17.2% between 2007 and 2017
  • From 2007-2016 rates of suicide increased at a higher rate for kids aged 10-14 than it did for kids aged 15-19, although still a very low rate for youth 10-14 in comparison to youth 15-19
  • From 2007-2016 rates of suicide increased at a significantly higher rate for girls than boys in both age groups
  • The gap between the suicide rate of teen males and teen females is narrowing, decreasing from 4-5 times more likely for males historically to now 2-3 times more likely
  • Suicide is the second leading cause of death for ages 12-18
• Be aware of warning signs
  • Suicidal threats
  • Obsession with death – verbal, writing, art
  • Dramatic change in personality or appearance
  • Irrational thoughts or behavior
  • Giving away belongings
  • Overwhelming sense of guilt, shame, rejection
  • Severe drop in school performance
• Remember girls risk to succeed at suicide is higher now
• Take threats, signs seriously
• Trust your instincts
• Ask directly
• Help student get professional help
• Continue support throughout process
• Rate of depressive disorders in adolescents is high and has increased over the past decade

• Depression significantly impacts functioning to include school performance and social adjustment

• Cognitive Behavioral Therapy is a well-researched efficacious psychosocial treatment

• Schools have a role to support kids with depressive disorders

• Suicidal ideation and rate of suicide are increasing in youth, especially girls, and schools can play a role in identification of youth in need


Questions
Depression in Youth

SCHOOL PERSPECTIVE
KENDON JOHNSON, PH.D.,
SCHOOL COUNSELING SUPPORT
Depression in Youth

Three Domains:

• Prevention: School-wide prevention programs and opportunities for student engagement. Building relationships with caring adults.

• Response: Responding to individuals, when in possible crises (responding to specific mental health concerns an individual student is experiencing)

• On-going Support: On-going mental health support (for those students who need that on-going support)
Depression in Youth

The harder I try, the worse I get.
What can depression look like in adolescents:

• Feelings Hopelessness and/or Worthlessness (sadness)
• Withdrawn (family, peers, and activities)
• Changes in Sleeping Patterns
• Changes in Eating Patterns
• Low Performance/Failing
• Attendance
Prevention: School-wide Prevention Programs and Student Engagement

Students: Actively engaging students in their education, future, well-being, and social/emotional development (How engaged are our students? Do they have a trusted adult they have connected with in the school that they can go to?)

- Extra/Co-Curricular Activities (getting them to look toward their future with a positive outlook)
- Bullying Prevention Programs
- Character Building and Resiliency Programs
- Engaging Students With Peers and Adults
- Community

School Personnel: Counselors, Psychologists, Nurses, Support Personnel, and other Teachers/Adults engage with students in a variety of preventative ways: health screenings, guidance lessons/social emotional learning, and presence/engagement in the school/community environment/PBIS Programs.

- Extra/Co-Curricular Teachers/Coaches
- Faculty and Staff Relationships with Students and Engagement with Students

Parents/Families: School and family partnerships. Engaged on-going partnerships with our parents. Open door policies for parents/families as well as for students.
Response: Responding to the student in possible crises

- Students: Students need to understand and feel that school personnel are available, especially for concerns in regard to physical health and mental health (Is there a relationship with and open door to that counselor/psychologist/nurse).

- Students need to understand the importance of reporting for their safety and well-being as well as their peers’ safety and well-being (Don’t Walk Alone).

- Students need to feel they can express their feelings and have a trusted adult to turn to.

- Feel safe and heard when reporting bullying and/or harassment.
Depression in Youth

Response: Responding to the student in possible crises

- School Personnel: Counselors, Psychologists, Nurses and other support personnel are actively engaged with the students. Cultivated relationships with open doors. Screening when needed (suicide, threat of violence, health). Consulting/working with one’s school team (short-term individual/group counseling, SST, and Students with Disabilities). Consulting/working with one’s community partners (Appropriate Referrals and Parent Partnerships).
- All Faculty and Staff must be able recognize signs of possible depression and suicide ideation (ideation can be in the form of: stated, writing, class assignment, art, self-injury)
- Must report when they notice changes in a student.
- Listen to students and take seriously reports bullying and harassment.
- Recognize students who may be struggling with LGBTQ concerns (report to counselor or psychologist).
Response: Responding to the student in possible crises

- School personnel: screen for risk and make appropriate referrals (always parents/families are notified and worked with on the best pathway forward).

- Parents/Families: Parents/Families engage with the school when there is an immediate need (Open Communication). Families will take recommendations to heart and follow through.

- Reintegration/Safety Planning: It is vital to hold reintegration meetings and develop safety plans when students experience suicide ideation and are referred out of the school.
On-GOING Support: Helping the student after possible crisis is averted

School Personnel: Counselors, Psychologists, Nurses, Support Personnel, and Teachers/Adults are actively engaged with their students.

- Brief school counseling (individual/group),
- Safety/Reintegration Plans: warning signs, coping strategies, who to turn to, safe spaces, and cell phone use. Parents/families must be a part of the reintegration meeting and safety planning.
- Check in/Check out: intervention support. Partner with school resources (SPED, 504, ELL, Coaches, Sponsors, Teachers) Partner with community resources (parent consent).

Parents/Families: Parents/Families engage with the school to work with the ongoing support efforts between the school and other resources.
On‐Going School Support: Personnel and Services

- Physical Health Concerns (Nurse)
- Mental Health/Social Emotional Concerns (Counselor/Psychologist)
- Brief Counseling: Individual/Group (School Counselor and School Psychologists)
- Social/Emotional and Developmental Groups (School Counselor and School Psychologist, Student Support Team ‘SST’/PBISProgram)
- Students with Disabilities (SPED and 504)
- Academic Concerns (Teachers and Other School Specialists, and School Support Personnel, SST)
- All Adults: All adults MUST cultivate relationships with students to ensure positive growth and development.
- Working with Community Based Supports (Local Hospital/Clinics that are available, Local Psychologists/Counselors, Therapist that are available, and MFLC and SBMH, if available)
On-Going Family Support: Partnership with our families

- Working closely with school personnel: Counselor, psychologist, nurse, administration, teachers, and others

- Consent of release of information: School personnel can work with outside providers to support the individual student’s needs. This may include counselors, psychologists, and doctors.

- Maintain the relationship: Provide any needed additional information to the school.

Depression in Youth
Take Aways:

Prevention: School-wide prevention programs and opportunities for student engagement. School engagement supports building relationships with caring adults. Every student needs to have a connection with at least one adult in the building.

Response: Responding to individual, when a student is in possible crises (Responding to specific mental health concerns an individual student is experiencing). All adults in the building need to be able recognize the signs of depression/suicide (recognize changes in students). Students must also understand the importance of reporting self/peers who are in crises.

On-going Support: Meeting the individual student’s needs for on-going mental health support. Support within the school should be coordinated with community support and family support. Safety planning for suicidal is vital for keeping students safe.
Depression in Youth

Happy Well-Adjusted Teens
Depression and Anxiety in Children and Adolescents

References:


Part 2: Defining Messages (2:50 – 4:15 )

2:50 – 3:25 (35 minutes)
- Join a table that works on communicating messages from the Panel
- Review notes to identify key messages. Write your simple messages on Post Its.
- Pose important messages to your group
- As a group, decide which messages are most important
- Paste them on the large top flip chart
- Choose a spokesperson to briefly share your discussion and decisions

3:25 – 3:40 (15 minutes)
- Each table shares three key messages w/ full group

3:40 – 4:05 (25 minutes)
- Refine key messages within each Infographic sub-topic (flip charts) w/ full group

4:05 – 4:15 (10 minutes)
- Dialogue Guide and Leaving Your Footprint Series – Next Steps
This Session: Follow-through for Impact

Leaving Your Footprint: Depression

WITH YOUR INPUT we will develop military family-friendly Infographics, Dialogue Guide & Resources to be available on the MCEC website for easy retrieval:

- Help professionals to share and empower military families
- Help military families hold conversation with:
  - Healthcare and Mental Health Professionals
  - Other military families at current and new installations/communities
  - Installation personnel who can act on the information
- Over time, build a committed group of individuals who have access to information and will share it freely in their setting.
This Session: Follow-through for Impact

Leaving Your Footprint: Depression

- Participate in reviewing the draft infographic ~ TBD, mid-Octoberish
- Develop accurate, military family friendly infographic
- Create a link to the infographic and other resources on MCEC website
- Help professionals (e.g., healthcare providers, school personnel, etc.) to share and empower military families
  - Help military families to hold conversation using the infographic with the dialogue guide
    - with professionals
    - With other families living on the installation/base or in the civilian community
    - with installation/base personnel who can act on the information
- Help military families to hold conversation at the next location
  - with providers
  - with other families living on the installation/base or in the civilian community
  - with installation/base personnel who can act on the information
- Over time, build a committed group of individuals who have access to information and will share it freely in their setting.