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Geri Amori, PhD, ARM, DFASHRM, CPHRM: Before we begin, because this podcast is discussing pediatric mental health, including suicide, it might be disturbing to some listeners.

Hello, everyone, and welcome to *Healthcare Perspectives 360*, a podcast dedicated to exploring contemporary healthcare issues from multiple perspectives. I'm Geri Amori, and today I am joined by Dr. Cara Pratt, a psychologist who works with all age groups and specializes in clinical anxiety disorders; Dr. Neil Bruce, a psychiatrist who specializes in child and adolescent affective disorders; and Mary Kisting, a clinical nurse specialist who works primarily with the inpatient pediatric population at a Level 1 trauma teaching hospital. Welcome. Today, we're talking about outpatient care, prevention, and the return from COVID.

So let me give you a little setup before we begin our questioning. When we talk about prevention and mental health issues in young adults, we are encompassing a lot of ground. We're talking about the population from 0 to 17. According to the American Association of Family Practice and the American Association of Pediatrics, a trauma-informed approach to all medical and mental health screening should be the standard for all family and pediatric medical providers. So, what does that mean? In trauma-informed care, the focus is on creating a safe, trusting environment that recognizes the impact of trauma of all sorts on the physical and psychological health of the individual, whether or not they identify having experienced a traumatic event. It's an approach that assumes life experience and provides a safe care environment for everyone.

The Substance Abuse and Mental Health Administration reports that exposure to depression and suicide increases the risk among vulnerable populations but that resilience, problem solving, awareness, and access to care, as well as cultural beliefs and positive peer relationships, positive adult relationships, safe environment, and interpersonal connectedness all serve as protective factors. But the most important factor is a safe, stable, nurturing relationship, which can be fortified by the healthcare system when it focuses on providing trauma-informed approaches to care.

So, Mary, when you treat a child or adolescent, you are not only treating the identified patient, right, the child, but you're also treating the entire family de facto. How does that make treating a young adult more difficult than an older adult?

Mary Kisting, MS, RN, CCNS, CCRN-K: Well, first off, an adult has the potential for independent choices in their environment, and children do not, so they are returning to their environment that they came in from. So that is a really unique piece that I think has to be considered for children because if we don't work with their environment, their family, their parents, the schools, I think we've missed an opportunity to help those children. And I think that's also true in adults if we don't work with their environment, but it seems like it's exponentially greater in children.

Amori: I'm hearing you say that's because the child has a lack of control. They can't control the environment.

Kisting: Right. They have very limited choices. And sometimes, I think that their way of controlling things is to act out. If you can't control, you will do something to maneuver your environment. And so, I think that that's a real distinct difference. And also, not that we don't see that in adults, but I think that there's limitations that children have make it unique.

Amori: And as you were talking, I was thinking, we see that in adults too, don't we? But you're right, the unique limitations make a difference. Neil, what about you? You must learn things about the family, and then what do you do with that? I mean, what about the duty to warn if you learn a minor is suicidal or homicidal? Does that apply to youth too?

Neil Bruce, MD: Yes, it definitely does apply to youth. You're touching on is confidentiality. With kids, they're definitely entitled to confidentiality. The way I discuss it with my patients is, I say, just so you know—this is in a conversation with the kid in the room, the parent is in the waiting room—but just one on one, saying, everything we talk about here is between you and me. The only time I would break that confidentiality, meaning I tell your parent about what we talk about, is if there's a concern for your safety or the concern for others. So if a kid is actively suicidal or actively homicidal, that would be a reason to break that confidentiality, to get them some emergency treatment, to make sure that they're safe and that others are safe.

Amori: So, Cara, how do you deal with the issues of conflict between building patient trust and perhaps the need to inform?

Cara Pratt, PsyD, HSPP: So my policy…and this is what I supervise students as well, and so I kind of teach them the same strategy. During the intake session, I meet with the parents and the child together, usually, or the guardians and the child together for at least a portion of the session. And during that time, I go through all of the confidentiality. And I use examples, specific examples based on the age of the kid about what types of things I would have to share with their parents and not. And I do that with a parent in the room, so the parent also knows what I won't tell them and what I will tell them. And I think since that helps the kid to know I'm being serious because I'm telling your parent the exact same thing I'm telling you. And so we start off treatment…that's one of our first interactions, is me being really transparent about where those lines are and making sure the child and the guardians are aware of that and that we're on the same page.

And then if safety issues arise, I, again, review those rules with the kid and plan with them how they want to get parents involved—whether they want me to do that, they want to do it with me or separately, and we kind of plan things out that way.

Amori: Interesting. Saying that in front of my folks with me in the room would certainly build my trust in you more. I would say, okay, she means this, right? So, Neil, I know that sometimes you have to have people that are in foster care or court-ordered to see

you. How do you build the trust of a young adult who's been court-ordered to see you? They don't really want to see you. Or they're in forced foster care. What do you do?

Bruce: I work in juvenile detention. So, I work with kids who are involved in the court system a lot, and I also work with kids who are in foster care or have guardians other than their parents. I think the biggest thing is recognizing they're still humans. They're still people. Just because they're kids and might not be able to consent to medication or treatment, you're still listening to them, taking into account their experience. You have their best interest in mind. This isn't just the court saying this is what the kid needs. I'm still the medical professional making that decision based on my kids' interests. And I think also part of it is meeting them where they're at, like acknowledging that they're not in the most pleasant situation but that you're still there for them. So recognizing what kind of state they're in, what kind of situation they're in, letting them know that you're there for that, not for other people.

Amori: So that seems to be a common thread. Cara, I want to bounce back to you. You work with a lot of anxious youth. I think anxiety disorders is your thing, right? So, how is that different from working with an anxious adult?

Pratt: In a lot of ways, it's really similar. Bouncing back to what Mary said, kids have a lot less control over their environment. So, assessing that, where they have control and where they don't, and working through that. And then when I'm teaching them skills, when we're practicing things, if they're comfortable with it—a lot of my clients are completely comfortable having their parents involved—then we'll bring the parents or the family in and kind of like help them learn how to support the child in trying these new things.

One thing I think is really fun about working with kids, especially with anxiety, is they are much more willing to jump in and try hard interventions with me, where adults sometimes have more defenses built up, and it will take us longer to, like, work up to something. And kids will usually be like, sure, let's do it. And that's something really exciting. And their little brains are so plastic still, they can learn those skills. And there's research showing that, especially with certain interventions, they can maintain that progress up into adulthood. So hopefully, we can teach them those skills early, and they can keep them.

Amori: I can tell you like working with youth, Cara.

Pratt: I really do.

Amori: Mary, do you feel that youth are more hopeful or more skeptical of working on their mental health? Cara seems positive. What do you think?

Kisting: Geri, I've seen both sides of that spectrum. Some of the kids are just hungry for any kind of support, resources, understanding, a listening ear, compassion. They are so willing to accept that because they feel such a need. Conversely, there are adolescents

who, true to their developmental stage, feel invincible. And they don't need anybody's help, they know what they need, they know what their problem is, and they feel that they can address it. And they also desperately don't want to be different. That stage, everybody wants to be part of the group. They want to belong. And so, I think there is some reticence on some children's part because they don't want to be labeled or seen as needing something that everybody else, the popular kids, don't need. So, I think that there's both sides of that spectrum, for sure.

Amori: So, Cara, going back to you, do you think a trauma-informed approach is different from a traditional psychotherapeutic approach? And if so, how?

Pratt: It's different in some ways, but I think there's also a lot in common, especially depending on your conceptualization or kind of the model you use to approach therapy. To really boil it down, trauma-informed care is kind of fundamentally about asking what somebody has been through and what's happened to them, instead of just asking what's wrong. So, it takes broader timeline into account when you're planning care. So, this often includes assessment of those adverse childhood experiences, like we've talked about, and history of the family, and the history of the child individually, as well. And then we use all of that information together to build treatment plan and to kind of move forward and figure out what they want to work on. So sometimes, that's very similar to what you would be doing even if it wasn't trauma informed, and in other cases, it can look very different.

Amori: Okay, that's interesting as we talk about trauma-informed care. Mary, would you rather work with a teen who's more discerning or a younger patient? Like, which makes each more and less challenging, and are the issues similar or different?

Kisting: The pediatric populations in those age groups are really unique, and each one is amazing. They bring to the table qualities that are just eye-opening, as an adult, to me. And so, I think, in general, though, providing mental health care in an acute care setting can be challenging, but the age groups vary slightly, I believe, because the older the children are, the more they are embedded into social media. It's true all ages, now, but I think the more savvy children get, the more they're into different sites. And that social media can provide a lot of support, but it can also heighten feelings of stress and inadequacy. And so the impact, depending on the quantity and frequency, really can change in terms of how different age groups might be involved with that. I think there are some unique differences between the age groups, but a lot of it crosses all the developmental stages.

Amori: So, Neil, I'm hearing a lot about younger patients being very suicidal, and we've had some different conversations about this. Do you see this as a trend or a reaction to either social media, COVID? Social media is big. You know, my grandchild, like, lives on social media. What are your thoughts?

Bruce: Yeah, I think suicidal behavior, suicidality, suicidal thoughts, those can be experienced by children as young as preschool, which has been recognized since the 80s.

So, I wouldn't say this is a new thing, but I do think the trend or seeing these kind of thoughts and behaviors more prevalently, that is, I think, in part, related to the social isolation we saw during COVID. And then I think also what you're touching on, the prevalence of mental illness stories on social media. I think that has had a big impact, too. So, the way these social media apps…they're really designed to hold your attention. Sometimes you just go down a rabbit hole, whether it's certain things like crocheting or knitting, but also mental health can be a huge rabbit hole on social media. And in some ways, the kids on these can start to identify with mental health problems. It just creates a tunnel vision that's really hard to get out of.

I remember during the pandemic, there were things like the grippy socks challenge, referring to the kind of socks you get in a hospital, encouraging other people to try to get admitted to a hospital just so you could grow your collection of grippy socks. But I do think beyond that, social media has a big impact on mental health, especially in youth.

Amori: So, we've reached the point in our discussion where I'd like to ask our panelists to tell us, what is the one thing that you think, from today's discussion, is the most important for our audience to keep in mind and remember when we talk about this? I'd like to start with Cara, please.

Pratt: I would just recommend considering outpatient care for anybody who has concerns about their kids and their mental health. Even if it's just for a session to get an evaluation by a professional about level of needs and safety, or even to talk through a plan, or to identify signs if a kid needs higher level of care, to talk through those options. There's a lot available, and you don't have to wait until something is an emergency. And again, it's really common for kids to have these feelings, so having a plan as a family or as a guardian for your kid can be really helpful, and there are options for that before it gets to a crisis.

Amori: Thank you, Cara. Mary, what are your last takeaways for today?

Kisting: One of my thoughts, from listening to all the other panelists, as that relates to the fact that there's many children with treatable mental health issues, and they don't ever receive treatment from medical health professionals. And so, I think one of the things that is a key consideration, or should be a key consideration, is school-based services, as well as telehealth, which I think Neil has mentioned also. And we really need to target the most vulnerable groups. There's a lot of statistics that show which groups are at a higher risk for suicide and who gets most bullied, and I think these services really need to target those populations.

Amori: Thank you. And Neil, would you please tell us what you'd like the one takeaway to be for today?

Bruce: Yeah, I think recognizing that mental health problems can happen in anyone, any age group, any race, any gender, any socioeconomic status. These aren't things that you can run a blood test on. You don't get an x-ray and see that you have major depressive

disorder. So, they can definitely be more subtle. But I think as a parent, knowing that there are clinicians out there ready to help. Just because you have the suspicion and you take them to a therapist, that doesn't mean they're going to be stigmatized. And I think just knowing that there are professionals out there who can adequately assess and treat, I think that can provide a lot of reassurance in knowing you're not just doing this on your own.

Amori: Thank you. This has been a great conversation, and I'd like to offer a special thanks to our panelists for sharing your thoughts and your perspectives. And I want to also thank our audience, our listening audience for joining us here today. We hope to see you next time for our next podcast when we examine another healthcare issue from a *Perspective 360*.

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