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NC INTEGRATED CARE FOR KIDS

ECHO Series: Adolescent Behavioral Health

Thursday, September 11th, 2025: 12:00-1:30 PM

This project is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $13,999,227 in 2025 with 0% percentage financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS, HHS or the U.S. Government.

Agenda

- Grounding
- NC InCK Funding and Landscape Update
- Managing Adolescent Depression and Suicidal Behavior in a Post-COVID World (w/ Dr. Nerissa Price)
- A Look Ahead

Grounding for All InCK ICRs & Echos

Respect for All: *There will be topics, situations, or maybe even resources that you as a person have various feelings about. We ask that in these spaces, we all show respect for all, by being supportive, caring, and professional.*

Take 2 and Pause: *Discussion and hearing from you is so powerful, and what we strive for in these spaces. We ask that if you have shared twice, take a pause, to encourage colleagues to take the floor and share as well.*

Questions Encouraged: *If you have a questions please ask, in most cases someone has the same one. Be BOLD and PROUD, ask it! You are always welcome to private chat questions to any member of our team.*

Play, Learn, Grow: *Just like Fisher Price, we want you to enjoy this learning space, learn and grow from/with each topic!*



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Funding and Landscape Update

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Managing Adolescent Depression and Suicidal Behavior in a Post-COVID World

September 11, 2025: 12:00-1:30 PM

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Nerissa M. Price MD is the Behavioral Health Medical Director for AmeriHealth Caritas NC and joined the AmeriHealth Caritas team in January 2024. Dr. Price is a NC native who received her medical degree and completed a Child and Adolescent Psychiatry Fellowship at the University of North Carolina at Chapel Hill School of Medicine. She is Board-Certified in General Psychiatry and is a child, adolescent, and adult psychiatrist.

Dr. Price is responsible for developing the AmeriHealth Caritas NC behavioral health strategy, overseeing implementation, and ensuring effective execution and scaling to improve population health and wellness outcomes. She serves as a behavioral health subject matter expert to other departments and in the community.

Prior to joining AmeriHealth Caritas, Dr. Price has over 20 years of experience from her work with UNC School of Medicine, Value Options, Cardinal Innovations, the NC Department of Public Safety, and WakeMed. At WakeMed, Dr. Price was the medical director for Behavioral Health Community Case Management and the homeless outreach team (H.E.A.R.T), as well as, the medical director of WakeMed Physician Practices Well-Being Initiatives where her mission was to improve provider well-being by promoting the culture of wellness, work-life integration and joy in work. Dr. Price has devoted her career to improving the health of the mentally ill and the marginalized in our society.

Ben

- Ben just started the 9th grade
- Parents divorced last year. He has a younger sister.
- His mother brings him to the office today for follow-up on his asthma, frequent stomachaches which prevent him from going to school and complains that he has an “attitude problem”
- She described that all he wants to do is listen to “dark angry music” and stay in his room. Before he loved playing soccer and recently announced he no longer wants to be on the team.
- Ben admits he can’t sleep as well as he used to and his appetite is non-existent.



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Ben

What might be going on with Ben?



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Biases

- Aren’t they all depressed?
- Isn’t depression a part of being teenager?
- When is moodiness depression?
- Teenage angst?

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Prior to the COVID Pandemic…

- Lack of pediatric mental health resources
  - Lack of inpatient psychiatric hospital beds
  - “Boarding” crisis in EDs and acute hospitals
  - Lack of pediatric mental health specialists
- 2016 National Survey of Youth
  - Prevalence of at least one mental health disorder: 16.5%
  - Did not receive treatment from a mental health professional: 50% (rural 70%)
- Increase in adolescent mental health-related ED visits
  - From 2011 to 2015, mental health-related ED visits increased by 54%
  - Especially notable in Black (53%) and Hispanic (91%) youth
  - Average yearly increase for suicide-related ED visits was 23.1% (5% of all pediatric ED visits)

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Prior to the COVID Pandemic…

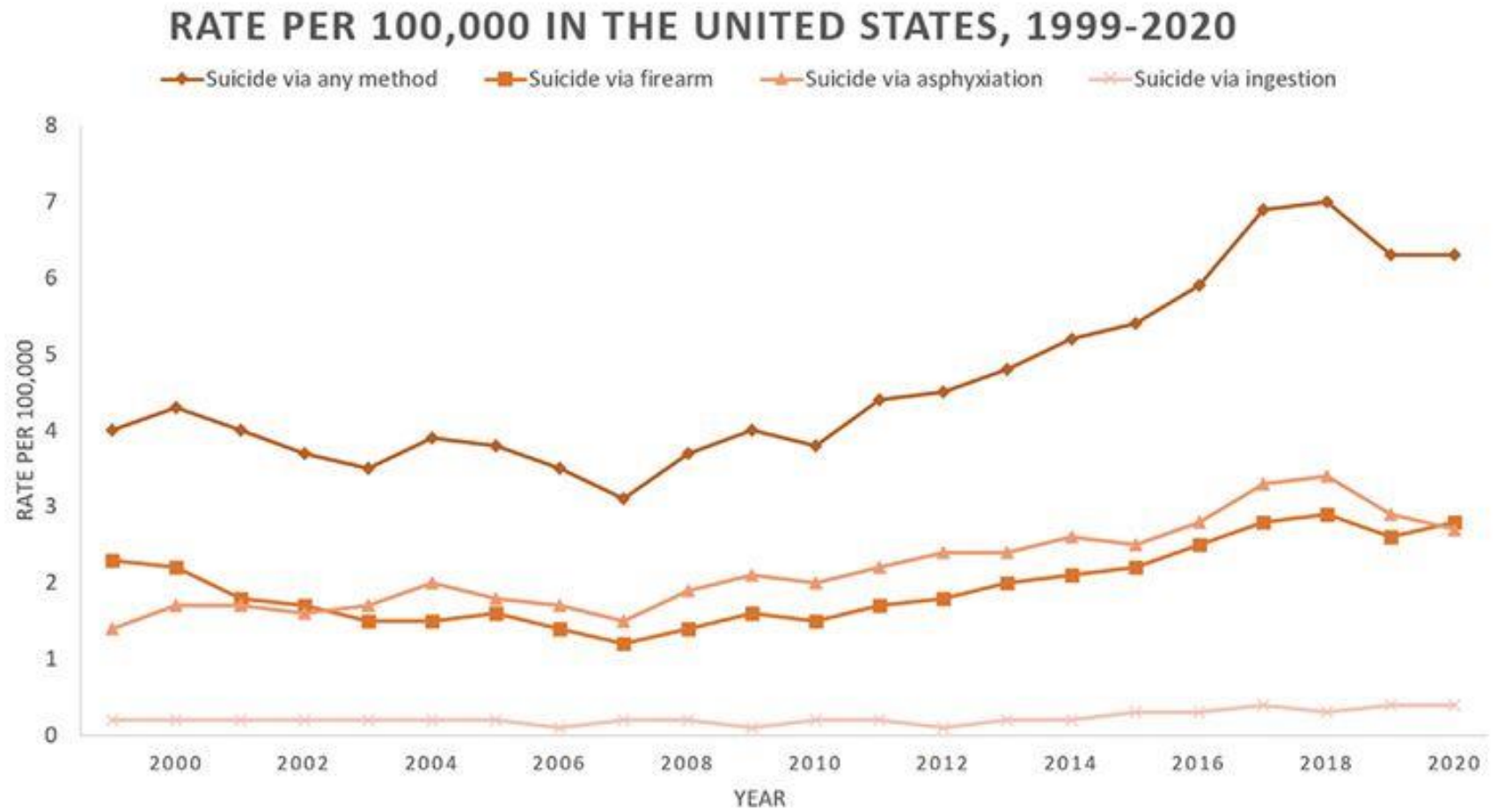


Fig. 1. Cause of death of children aged 12 to 17 years.[8] (*Source*: Data from CDC WONDER Underlying Causes of Death were used. (does not require permission).)

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During COVID Pandemic…

- More than 1 in 10 youth reported symptoms of depression that impacted their functioning
- Scarcity of specialty mental health care exacerbated by pandemic
  - 1 in 5 live in a county without a child psychiatrist
  - Only 35% of psychiatrists accept Medicaid
- Apx. 60% of youth with MDD did not receive treatment from mental health professionals
  - 78% of Asian youth
- 51% increase in emergency room visits for suspected suicide attempts by teenage girls in 2021, when compared with 2019.

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During COVID Pandemic…

- The Trevor Project's National Survey in 2021on the Mental Health of LGBTQ reported that 45% of youth seriously considered suicide
- Youth suicide rates increased
  - Non-Hispanic American Indian or Alaskan Native youth and non-Hispanic Black youth
- Children in low-income areas were more vulnerable
  - Lack of access to treatment
  - Disproportionately destabilized households and communities; greater caregiver loss
  - Chronic stress, racism

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Major Depressive Disorder (MDD) Epidemiology

- Depression commonly begins in adolescence
- Lifetime prevalence 15-20%
- From 2009 to 2019, the prevalence of past-year major depressive episodes among U.S. adolescents nearly doubled (8.1% to 15.8%)
- Female: male 2:1
- Depression prevalence increases as family income level decreased
- < 50% of adolescents with a major depressive episode receive treatment.

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Why is MDD prevalence increasing?

- Increased social media and electronic communication use
- Higher rates of psychosocial stress, particularly among girls.
- Societal inequities, including structural and systemic racism.
- Early onset of depression is linked to more severe illness in adulthood, screening and early identification critical.
  - The USPSTF recommends screening for major depressive disorder in adolescents ages 12 to 18.

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Clinical Course of Depression

- Prognostic Indicators:
  - Poor prognosis: earlier onset, more recurrent episodes, greater comorbidity, parental psychiatric disorder, social chaos and/or social isolation
- Mean length of depressive episode~9 months
- Recurrence: 40% by 2 years; 70% by 5 years

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Clinical Course: Genetic Factors

- Children with depressed parent 3X as likely to have lifetime episode of MDD
- Prevalence of MDD in first degree relative of children with MDD is 30-50%

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Major Depressive Disorder: Comorbidity

- 40-70% comorbid psychiatric disorders
- 20-50% have two or more diagnoses
  - Dysthymic Disorder and Anxiety Disorders (30-80%)
  - Disruptive Behavioral Disorders (10-80%)
  - Substance Abuse (20-30%)
  - Personality Disorders

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Comparison of Depressive Symptoms in Adults vs. Youth

Adult (DSM criteria)	Youth
Depressed mood most of day	**Irritable or cranky** mood: preoccupation with nihilistic songs
Decreased interest or enjoyment	Loss of interest in sports, video games, and activities with friends
Significant weight loss or gain	Failure to gain weight; anorexia or bulimia; frequent complaints of physical illness
Psychomotor retardation or agitation	Talk of running away from home or efforts to do so
Fatigue or loss of energy	Persistent boredom
Low self esteem, feelings of guilt	Oppositional and/or negative behavior
Decreased ability to concentrate; indecisive	Poor performance in school; frequent absences
Insomnia or hypersomnia	Excessive late night TV; refusal to wake for school in AM
Recurrent suicidal behavior or ideation	Recurrent suicidal ideation or behavior

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Depression in Adolescents

- more sleep or appetite disturbances
- more suicidal ideation and serious attempts; 30X increased risk
- more behavioral problems (defiance, risk-taking)
- increased risk of substance abuse
- greater impairment in function than children

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Adolescent Suicide

- Suicide: the second leading cause of death for people ages 10 to 34
  - Boys more likely to complete
  - Completion method: firearms, suffocation, poisoning
- Depression has a 9% fatality rate for ages 15-45 (Chisolm, 2004)
- 5-10% of those with adolescent depression will complete suicide within 15 years of initial episode of MDD (Weissman, 1999)
- Asking does not increase ideation or likelihood of attempt or completion

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Adolescent Suicide

- 90% of suicide cases, there is an underlying psychiatric disorder
- Depression is the most common
  - 50% of suicides of adolescent boys and 70% of girls
- Antisocial behavior is the 2nd leading accompanying condition followed by substance abuse and anxiety disorder
- 50% never had therapy
- 75% communicated thoughts about their suicide aloud to several people months before dying

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Suicidal Statements Continuum

- Active suicidal statements
  - “I want to die,” “I’m going to kill myself”
  - Have a plan-means and opportunity
  - Highest concern
  - Should always be referred for psychiatric evaluation-may need IVC
- Passive suicidal statements
  - “I wish I wasn’t here,” “It’d be better if I wasn’t alive,” “I’d be easier if I wasn’t here”
  - Don’t have a plan
  - Can become active; needs close monitoring

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Suicide Triggers

- Most common:
  - Relationship problems- breakup or rejection
  - Being suspended from school or getting into trouble with the law
  - Serious school failure
  - Humiliation
  - Pregnancy

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Suicide Risk Factors

Koplewicz, 2002

- Impulsivity
- Lack of strong family ties
- Social factors-social isolation, recent suicide of someone close or in same community, absence of strong taboo about suicide
- Easy access and familiarity with gun
- Agitated mental state
- Substance use
- Psychiatric Disorder

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Suicide Contagion

- Exposure to suicide or suicidal behaviors can increase suicide and suicide behaviors
  - Suicide and the media
  - Managing suicide at school
    - Debriefing discouraged
- Vulnerable populations mostly at risk
- When discussing suicide to groups:
  - Be concise
  - Just the facts
  - Give hotline number

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Protective Factors

- Strong family and social support
- Religious taboo
- Difficulty of access to means
- Slowed down rather than agitated mental state

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Risk Mitigation Strategies

- Call collateral (therapist, teacher, coach, family/guardian, etc.)
- Remove weapons or access to medications
- Referral to a higher level of care
- Safety planning: what if symptoms worsen?
- Removal of stressful stimuli
- More frequent office and/or phone follow-up
- Team meeting/discuss with medical director

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You suspect Ben has Depression, so what next?



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Depression Screening

- PHQ-2
- PHQ-9 Modified for Adolescents (PHQ-A)
- SAFE-T: Suicide Assessment Five-Step Evaluation and Triage (SAMSHA)

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You've decided to start treatment, What next?



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Evidence-Based & Best Practice

- **TADS (Treatment for Adolescent Depression Study);** Archives of Gen. Psych. 10/07
  - 12 weeks, 439 adolescents, RCT
  - Improvement Rates:
    - 61% Fluoxetine alone (10mg-40mg)
    - 71% Fluoxetine + CBT
    - 43% CBT alone
    - 35% Placebo alone

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Evidence-Based & Best Practice

TADS

- Improvement Rates at 36 weeks :
  - 81% Fluoxetine alone (10mg-40mg)
  - 86% Fluoxetine + CBT
  - 81% CBT alone

- Suicidal thinking or behavior (early stages of treatment):
  - 15% Fluoxetine alone
  - 8% Fluoxetine + CBT
  - 6% CBT alone

- Suicidal thinking decreased in all active treatment groups.
- There were no suicides in the TADS study

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Discussion with Parent/Child

- Discuss diagnosis, treatment options including meds, review benefits and risks of treating vs. not treating, and side effects
- Discuss the need for close monitoring both for the depression and if medication is initiated; especially SI
- Parents and caregivers play an important role in modeling effective strategies for coping with stress, as well as promoting healthy habits related to nutrition and sleep
- Parent makes decision
- May be helpful to talk with teen and parent separately and then together
- Some parents may struggle with denial, anger, and guilt

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Pharmacologic Treatment of Depression in Youth

- Some studies medications demonstrate an overall 65-75% response rate in children and adolescents
- Special considerations:
  - Confounding presentations
  - Side effects and safety
  - Patient/family history of medication response
  - Patient/family preferences

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Selective Serotonin Reuptake Inhibitors

- Utilized for:
  - Depression*
  - Generalized anxiety disorder
  - Post traumatic stress disorder
  - Panic disorder
  - Social phobia
  - PMDD
  - Bulimia
  - Obsessive Compulsive disorder**

*FDA approval for children with Depression – only Prozac, Lexapro

**FDA approval for children with OCD- Luvox, Prozac, Clomipramine and Zoloft

FDA approval for Generalized Anxiety Disorder- Duloxetine (Cymbalta)-SNRI

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Selective Serotonin Reuptake Inhibitors

Choice of SSRI	Typical Dose for Depression
Fluoxetine (Prozac)	10-20 mg daily; max. 60mg
Citalopram (Celexa)	10-20 mg daily; max. 40mg
Escitalopram (Lexapro)	5-10 mg daily; max. 20mg
Sertraline (Zoloft)	12.5-100mg daily; max. 200mg
Fluvoxamine (Luvox)	25-200mg nightly; max. 300mg

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Selective Serotonin Reuptake Inhibitors:

- Drug-drug interactions; CYP450 system
- Liquid preparations (e.g. Prozac, Paxil, Zoloft, Lexapro, Celexa)
- Serotonin Syndrome-confusion, restlessness, hyper reflexive, blood pressure changes
- Discontinuation syndrome - “flu-like” symptoms
- Safer in overdose

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SSRI: SIDE EFFECTS

- Most are mild and transient
  - GI-most common-nausea
  - Sleep-insomnia or sedation
  - Sexual dysfunction
  - Nervousness
  - Headache
  - Behavioral Activation- 40%- behavioral disinhibition may be dose dependent—sometimes mistaken for mania/hypomania
  - Rate of inducing mania is greater than for adults (1-2%), but less than for adult BPAD, depressed patients (11-12%)
  - Suicidal ideation

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2004 FDA Black Box Warning

- May increase suicidal thoughts and behaviors
- Not an increase in suicide completion*
- Caveats:
  - Clear link between severe depression and suicidality
  - Difficult to prove that antidepressants cause suicide (rare event)

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Telepsychiatry and adolescents

- Research with adults shows that telepsychiatry is just as effective as treatment provided in-person
- Research with children and teens is evolving
  - Children, families, and referring doctors are very satisfied with the care received through telepsychiatry
  - Likely will help with access, transportation barriers, enhanced comfort, reduced stigma, etc.

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When to Consider a Behavioral Health Referral

- Suicidal ideation
- Homicidal ideation
- Psychosis
- Mania
- Remission not achieved after multiple agents
- Increasing risky behaviors
- Severe physical and behavioral health complexities
- Multiple psychiatric comorbidities
- PCP or parent discomfort with PCP managing alone

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While awaiting a referral:

- Discuss goals and begin steps to reduce stress
- Encourage healthy activities (e.g. exercise, time outdoors, limits on media, balanced and consistent diet, sleep, one-on-one time with parents, reinforcement of strengths, open communication, pro-social peers)
- Educate family
  - De-mystify the condition
  - Support them in monitoring for worsening of symptoms or emergencies
  - Challenges with navigating mental health system
- Initiate care (even if planning referral)
- Monitor progress (e.g. telephone, electronic communication, or return visit)
- Provide assistance with referral

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Take Home Points: Depression in Youth

- Depression is common but very treatable
- Take all suicidal risk serious and evaluate
- Psychotherapy is helpful
- Empirical data supporting medication
- Involve multiple systems (family, school, pediatrician, ancillary staff, community, coaches, behavioral health specialists etc.)
- Consider referral for complex presentations

Resources

- 988
- Call or Text 988
  - 988 Suicide and Crisis Lifeline
  - Free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week in the United States
- NC PAL
- The NC-PAL access line is available Monday through Friday, 8 a.m. to 5 p.m. to support health care providers with questions about the behavioral health needs of pediatric and perinatal patients.
  - (919) 681-2909
- Tailored Plans (Medicaid and uninsured)

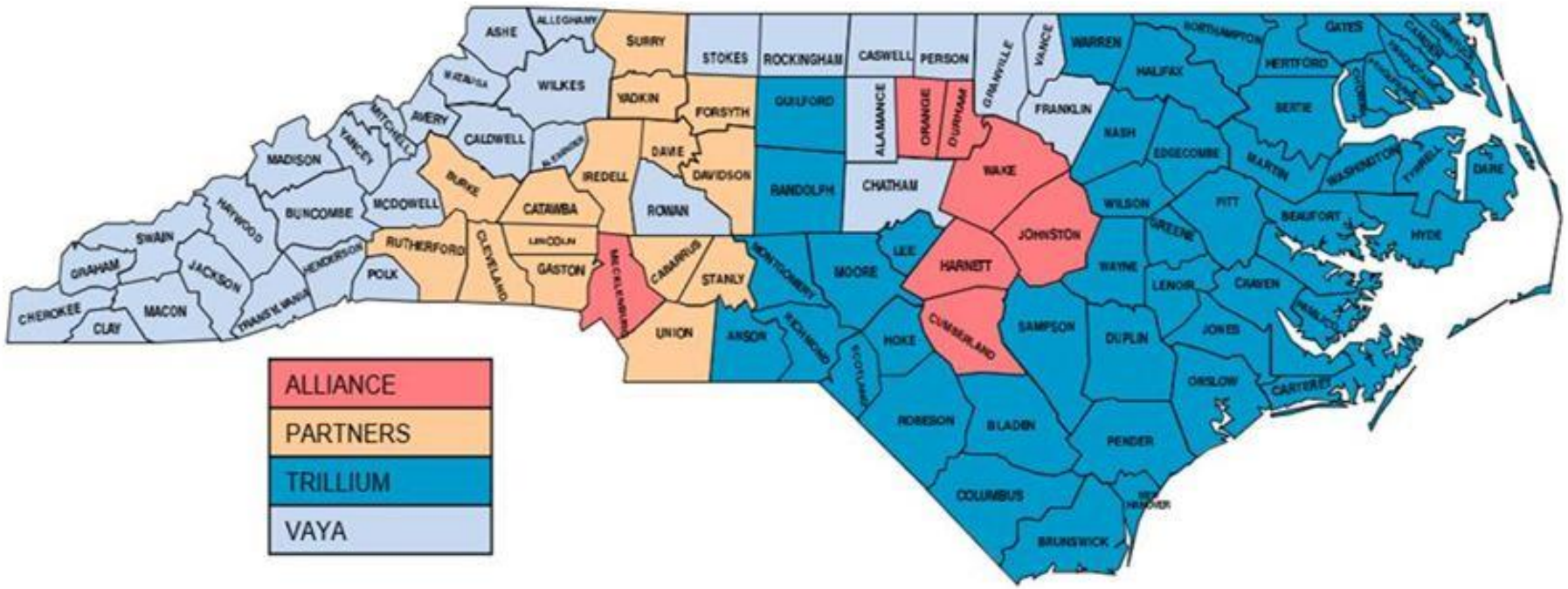
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Tailored Plans

- North Carolina Medicaid Managed Care health plan launched July 1, 2024
- It is for members with serious mental illness, severe substance use disorders, intellectual/developmental disabilities (I/DD) or traumatic brain injuries (TBI)
- Services offered for:
  - physical health
  - pharmacy (prescriptions)
  - care management
  - behavioral health services

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TAILORED PLAN COVERAGE MAP (AS OF FEB. 1, 2024)



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Additional resources & references

- http://www.aacap.org/AACAP/Resources_for_Primary_Care/Home.aspx
- http://www.aacap.org/AACAP/Clinical_Practice_Center/Clinical_Care/Home.aspx
- https://www.nami.org/kids-teens-and-young-adults/
- https://www.nimh.nih.gov/
- Close J, Arshad SH, Soffer SL, Lewis J, Benton TD. Adolescent Health in the Post-Pandemic Era: Evolving Stressors, Interventions, and Prevention Strategies amid Rising Depression and Suicidality. Pediatric Clin North Am. 2024 Aug;71(4):583-600. doi: 10.1016/j.pcl.2024.04.002. Epub 2024 May 19. PMID: 39003003.

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A Look Ahead

Don't forget about the NC InCK training page, resource library, and Family Navigator Resource Library (private) for archived ICRs and shared resources.

Reminder: Request a certificate of attendance for today's ICR at this link

Community Events

Orange County Schools - Family Academy | Gravelly Hill Middle School, 4801 W Ten Rd, Efland, NC
September 18, 2025 | 5:30–7:30 PM

Free Afterschool Program | Granville/Vance
Free for all school-age residents from 4:00pm-5:00pm at the Vance County Housing Authority(Mon/Wed) and Oxford Housing Authority (Tues/Thurs)

Free Car Seat Check | 1801 S. Church St., Burlington (Front of Harbor Freight)
September 27, 2025 | 9:00 AM–12:00 PM

Esperanza 2025 | 100 Block of West Elm St., Graham, NC
September 28, 2025 | 12:00–8:00 PM

FGV Smart Starters |FGV Smart Start Office, 125 Charles Rollins Rd, Henderson, NC
Pre-K & Kindergarten Readiness Sessions (Ages 2–5)
Ongoing Sessions: 9/24, 10/29, 11/19, 12/17



Keep Pressing
PHILIPPIANS 3:14
AIMHIGH

FREE for all school age residents in grades K-12

PARK & PLAY

AFTER SCHOOL PROGRAM

When school is out children need a safe place to be with their friends, with homework assistance, structured activities, and supportive adults. Park & Play afterschool aims to draw children and teenagers into constructive activities that are on-site, safe, fun, and filled with opportunities for learning. The meals and snacks give them the nutrition they need to learn, play, and grow!

Literacy & Homework Support



Safe & Fun Outdoor Play



Snack & Chat Hot Meal & Drink



LOCATIONS:
VANCE COUNTY HOUSING AUTHORITY- MON/WED 4:00PM-5:30PM
OXFORD HOUSING AUTHORITY- TUES/THURS 4:00PM-5:30PM

TRIANGLE NORTH HEALTHCARE FOUNDATION

For more information contact: aimhighkeeppressing@gmail.com





FGV Smart Starters...
Pre K and K Readiness Sessions for children ages 2-5

SEPT. 24

OCT. 29

NOV. 19

DEC. 17

ALL SESSIONS ARE FREE

LOCATION:
FGV SMART START OFFICE
125 CHARLES ROLLINS ROAD
HENDERSON NC

Sessions are from 10 a.m. until 11 a.m. and from 2 pm. until 3 p.m. (select one time slot for each day)

Each session will include developmentally appropriate activties for Pre K and Kindergarten Readiness.

Child must be accompanied by an adult.

Sessions will be facilitated by Ms. Amy Oakes, Dr. Linda Frederickson, and guest presenters.

Preregister by emailing aoakes@fgvsmartstart.org or call Dr. Linda Frederickson at 919-827-6843


SAFE KIDS
ALAMANCE COUNTY
FREE CAR SEAT CHECK
A Burlington Police Department and Alamance County Safe Kids Event
Certified Child Seat Technicians on site to assist with installing seats
SEPTEMBER 27TH · 9 AM – 12 PM
1801 S. CHURCH ST, BURLINGTON
LARGE PARKING LOT
IN FRONT OF HARBOR FREIGHT


FOUNDED AND PRESENTED BY ALAMANCE ARTS AND ALAMANCE CITIZENS FOR A DRUG FREE COMMUNITY
ESPERANZA
09.28.25
12PM-8PM
FREE ENTRANCE
2025
SINCE 2021
Design by
A COMMUNITY EVENT WITH A LATIN FLAVOR
LIVE MUSIC AND CULTURAL PERFORMANCES
FOOD / CRAFTS / COMMUNITY RESOURCES
KIDS ZONES AND FUN FOR ALL
100 Block of West Elm Street Graham, NC
Proud Supporters
Burlington Sock Puppets
ALAMANCE ARTS
BURLINGTON LATINO
ALAMANCE COMMUNITY COLLEGE
CrossRoads
Graham
North Carolina Arts Council
Alamance Citizens for a Drug Free Community
Dream Center
¡Huspa!


ORANGE COUNTY SCHOOLS
FAMILY ACADEMY
Strategic Plan Priority Four— Empowering Culture
Understanding the Importance of Attendance, and ADHD Strategies to Support Students & Families (with El Futuro)
LEARN SKILLS
IDENTIFY STRATEGIES
GATHER SUPPORT
Thursday, September 18
5:30 to 7:30 p.m.
Gravelly Hill Middle School
4801 W Ten Road Efland, NC
Orange County Schools
NORTH CAROLINA


ORANGE COUNTY SCHOOLS
ACADEMIA FAMILIAR
Plan Estratégico, Prioridad Cuatro — Potenciar la Cultura
Comprender la importancia de la asistencia y estrategias sobre el TDAH para apoyar a estudiantes y familias (con El Futuro)
ADQUIERA HABILIDADES
ENCUENTRE ESTRATEGIAS
BUSQUE APOYO
jueves, 18 de septiembre
de 5:30 a 7:30 p.m.
en Gravelly Hill Middle School
4801 W Ten Road Efland, NC
Orange County Schools
NORTH CAROLINA