

Challenges Faced

- Identifying more patients with diabetes who need mental health assistance
- Limited number of mental health providers who are familiar with diabetes care at CMH and in the community
- More mental health problems = more problems with diabetes care



Mental Health in Students with Type 1 Diabetes

Anna Egan, PhD, ABPP, Licensed Psychologist
Professor of Pediatrics, UMKC-SOM

&

Gail Robertson, PhD, ABPP, Licensed Psychologist
Associate Professor of Pediatrics, UMKC-SOM

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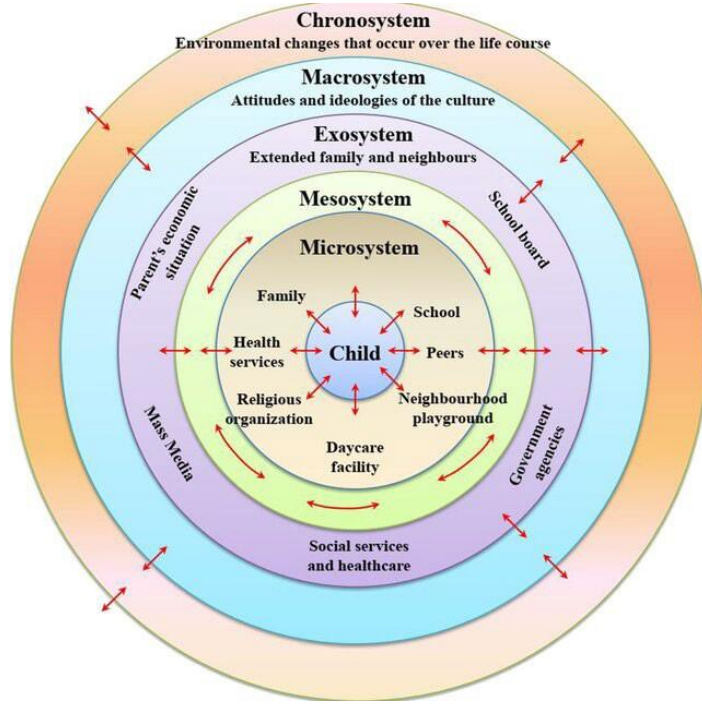
Conflict of Interest

We have no actual or potential conflict of interest in relation to this program/presentation.

Goals & Objectives

- Identify mental health symptoms that youth with diabetes may experience (e.g., irritability, sadness, worry, distraction)
- Detect unhealthy coping behaviors in children with diabetes
- Recognize options for intervening at school
- Describe resources available to children and families

Bronfenbrenner's Ecological System's Model



- Bronfenbrenner's theory demonstrates the interrelated influences on child development.
- Awareness of the systems that children live in can help us understand the differences in the way children may act in different settings.
- Bronfenbrenner proposed that many of these interactions are bi-directional: how children react to people in their microsystem will also affect how these people treat the children in return.

Overview

- Management of and adjustment to diabetes is impacted by the child, their experiences, and their environment.
- To have well-controlled diabetes, one must have:
 - Continuous monitoring (bg, carb ingestion, exercise)
 - Math skills (carb counting, dosing, correction)
 - Problem solving skills (responding to variations in bg)
 - Flexibility (stopping plans and addressing bg or symptoms)
 - Support (from parents, school personnel, friends, medical)
- Problems in these areas or other stressors can impact functioning in multiple domains for kids



Common Psychosocial Issues

- Developmental Grief and Adjustment
- Diabetes Distress or Burnout
- Low Socioeconomic Status
- Food insecurity
- Lack of access to T1D supplies
- Systemic barriers to health care
- Poor Family Communication
 - Parent/Child Conflict
 - Parent/Parent Conflict
 - Divorce or Separation
 - Inequitable division of T1D management responsibilities.
- Substance use or abuse in child or parent
- Cognitive dysfunction in child or parent

Common Mental Health Issues impacting T1D

- Depression & Suicidal Ideation
- Anxiety, including Generalized Anxiety Disorders, Needle Phobia, Obsessive Compulsive Disorder, etc.
- Neurocognitive Functioning and Attention Deficit Hyperactivity Disorder (ADHD)
- Eating Disorders: Anorexia, Bulimia, Diabulimia

Depression and Suicidal Ideation

- Youth with T1D have higher rates of depression than the general population
- Adolescents with T1D experience higher rates of suicidal ideation and suicide attempts than those without T1D

Depression & T1D Management

- Youth with T1D & depressive symptoms have:
 - Less frequent self-monitoring of blood glucose (SMBG)
 - Impaired glycemic control
 - More frequent hospitalizations for acute T1D complications (e.g., severe hypoglycemia, diabetic ketoacidosis)

Depression & T1D Management

- Depression in adolescents with T1D is associated with:
 - Poor long-term outcomes (both medically and in mental health)
 - Increased risk for long-term complications
 - Repeat T1D-related hospitalizations
- Elevated depressive symptoms are related to lower quality of life and increased suicidal ideation in youth with T1D

Suicide Risk (in T1D)

- Research shows current risk of suicidal ideation to be between 8-13% for last 3-12 months and 26% for lifetime.
- Unique concern for T1D—insulin is needed to survive, but it means easy access for lethal intentional overdosing.

Suicide Risk: Screening

Columbia Suicide Severity Rating Scale (CSSRS or Columbia) - 3 questions

- **Have you wished you weren't alive anymore?**
 - Assessing thoughts?
- **Have you had thoughts about killing yourself?**
 - Assessing plans?
- **Have you ever done anything to try to kill yourself?**
 - Assessing Actions?



ASQ Screener

ASQ will provide you with more information about:

- **Passive suicidal ideation** (wishing to be dead/feels as though they are better off dead)
- **Active suicidal ideation** (thoughts of killing oneself)
- **Suicide attempt history** (including method use and time frame of attempt)

NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. In the past few weeks, have you wished you were dead? ☐ Yes ☐ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ☐ Yes ☐ No
3. In the past week, have you been having thoughts about killing yourself? ☐ Yes ☐ No
4. Have you ever tried to kill yourself? ☐ Yes ☐ No
If yes, how? _____
When? _____

If the patient answers **Yes** to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now? ☐ Yes ☐ No
If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).
- If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a **positive screen**. Ask question #5 to assess acuity:
 - ☐ "Yes" to question #5 = **acute positive screen** (imminent risk identified)
 - Patient requires a STAT safety/full mental health evaluation.
 - Patient cannot leave until evaluated for safety.
 - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
 - ☐ "No" to question #5 = **non-acute positive screen** (potential risk identified)
 - Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.
 - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) 1/12/2008



Critical Information for Screening

- Prior to screening:

- Have a plan for what to do based on the results
- Have clinical cut-offs for positive screens accessible to healthcare providers
- Have a Screener Action Plan developed based on each score, including:
 - When and how to continue to monitor mood/behavior at school
 - Who to contact about results (parent/caregiver, counselor, etc.)
 - When to seek emergency treatment

Anxiety in T1D

- Children and adolescents with T1D have a 26-32% lifetime prevalence of anxiety disorders
- 13.4% of youth with Type 1 Diabetes reported anxiety regarding their hemoglobin A1c and 17% reported anxiety with blood glucose monitoring.

Neurocognitive Functioning

- Having T1DM is associated with poorer performance in the following areas:
 - visual-spatial ability, memory, IQ (full scale, performance, & verbal)
 - motor speed
 - writing & reading
 - sustained attention
- Factors associated with increase difficulty:
 - Length of time since diagnosis
 - Diagnosis before age 5
 - Metabolic control
 - Co-morbid psychological diagnoses
 - Number of hypoglycemic episodes

Executive Functioning

- Two domains of executive functioning:
 - Behavioral Regulation—the ability to inhibit, shift, and sustain emotional control
 - Metacognition—the abilities to initiate, plan, organize, & monitor, and working memory
- These skills are necessary for:
 - insulin management
 - bg monitoring
 - monitoring of dietary intake
 - adjustment of activity level

ADHD & Executive Functioning

- Parent report of problems with child executive functioning is associated with elevated HbA1c
- Problems with child executive functioning is associated with poor T1D management
- Better child executive functioning is associated with better adherence and management

Disordered Eating Behavior

Up to 38% of youth with T1D experience disordered eating behaviors

Disordered eating behaviors in youth with T1D are associated with:

- Higher BMI and insulin resistance
- More symptoms of depression
- More episodes of DKA
- Poorer quality of life

20% of youth with T1D are estimated to have used insulin manipulation for weight loss (diabulimia)

- Rates are approximately 2 times higher in females than males
- Can be easily missed by parents and diabetes providers
- Excessive focus on weight can increase likelihood

Identifying Problems

- Possible reasons for problems at school:
 - Difficulty adjusting to diabetes diagnosis (even if diagnosed for years)
 - Lack of understanding about diabetes management
 - Real/perceived
 - interference with peer/social functioning
 - lack of support from school personnel
 - interference with school functioning
 - Pre-existing or recently developed concerns with behavior, fear/anxiety, mood difficulties
 - Issues child brings from home/community that is not known to the school

Common Presentations

- Aggressive: Physically or verbally lashing out when asked to perform a diabetes task
- Argumentative: “I don’t need to go to your office, I can check my BG in the bathroom”
- Avoidance:
 - Of the nurse or diabetes management: “I forgot to check my BG before lunch”
 - Of class: always in the nurse’s office; “I’m not feeling well again, I need to check my BG”
- Dismissive: “I don’t care what my BG is”
- Lying: “My BG is 128”, but a review of the meter shows it is 428
- Refusing: “You can’t make me check”
- Upset/Frustrated: “I hate diabetes”
- Parent involvement (over or under involvement): Parent needs to be notified of every thing or a parent can’t be reached for anything)



Healthy Adjustment

- Low incidence of dramatic/extreme changes in mood or behavior
- Use of coping strategies (writing, reading, talking, exercise, etc.)
- Open communication (acknowledges frustrations, sadness, and/or worries)
- Seeking support and/or asking for help

Coping

- Coping strategies are methods (thoughts or actions) a person uses to deal with stressful situations and reduce overall distress.
- All people use coping strategies; some strategies are just more “helpful” than others
- When does coping become unhealthy or unhelpful
 - It is interfering with functioning in a prominent area
 - It is causing distress
 - It can be contributing to immediate or long-term health concerns

Treatment/Intervention

- What can you do to help?
 - Match expectations to the individual child's abilities (expectations may be lower than same age peers or younger peers)
 - Identify problems early, for both internal and external reasons
 - Set reasonable goals and build upon them once children are successful
 - Develop a collaborative relationship--If something isn't working, ask for input from the child (or parents)
- If you see concerns, talk to someone about it: the child, parent, or teacher/counselor



Treatment/Intervention

- Other Interventions:

- Incorporate psychological diagnoses or behavior plan into 504 plan (have accommodations prepared)
- Psycho-educational assessment or formal IEP may be needed, particularly when educational goals are impacted or comorbidities present
- Therapy (Individual/Family) and/or Medication
- Hospitalization

Managing Behaviors

- Set reasonable goals and build upon them once children are successful
 - Make goals specific, measurable, achievable, results-focused, and time- bound (SMART)
 - Example, if the goal was initially: “Check your bg at school” change it to: “Check your bg in the nurse’s office at school, every day, 20 minutes before lunch”
 - Put the goal in writing, monitor it with a chart, acknowledge small progress and have rewards for making progress that hold value to the child/teen
- Develop a collaborative relationship--If something isn’t working, ask for input from the child (or others)
 - Most kids will tell you what they need
 - The argumentative kids will tell you all the reasons the things you suggest won’t work, but often (not always) are more cooperative when they are asked to help problem solve or when a discrepancy in their behavior is noted

Managing Behaviors

- What is generally NOT helpful:
 - lecturing (they won't listen, it damages the working relationship, parents and/or doctors may have already tried that approach unsuccessfully)
 - Pointing out long-term consequences of behavior (children/adolescents think in the here and now; neither fear nor shame change longterm behavior for most people)
 - Ignoring it (the problem often won't go away and often will worsen)

Resources

- Support groups (JDRF)
- Websites (ADA, Children with Diabetes)
- Therapy options (parent can contact insurance; local community health agency)
- Suicide prevention numbers (988; Trevor Project: 866-488-7386)

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