

Mental Health Screening in Schools

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ABSTRACT

BACKGROUND: This article discusses the importance of screening students in schools for emotional/behavioral problems.

METHODS: Elements relevant to planning and implementing effective mental health screening in schools are considered. Screening in schools is linked to a broader national agenda to improve the mental health of children and adolescents. Strategies for systematic planning for mental health screening in schools are presented.

RESULTS: Mental health screening in schools is a very important, yet sensitive, agenda that is in its very early stages. Careful planning and implementation of mental health screening in schools offers a number of benefits including enhancing outreach and help to youth in need, and mobilizing school and community efforts to promote student mental health while reducing barriers to their learning.

CONCLUSIONS: When implemented with appropriate family, school, and community involvement, mental health screening in schools has the potential to be a cornerstone of a transformed mental health system. Screening, as part of a coordinated and comprehensive school mental health program, complements the mission of schools, identifies youth in need, links them to effective services, and contributes to positive educational outcomes valued by families, schools, and communities.

Keywords: mental health; health screening; counseling; school psychology.

Citation: Weist MD, Rubin M, Moore E, Adelsheim S, Wrobel G. Mental health screening in schools. *J Sch Health*. 2007; 77: 53-58.

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Supported by cooperative agreement U45 MC 00174-10-0 from the Office of Adolescent Health, Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, with cofunding by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; also supported by grant 1R01MH71015-01A1 from the National Institute of Mental Health. At the time of writing this article, S.A. was a psychiatric consultant of the Columbia TeenScreen Program. We express our appreciation to Ernest Coletta for ideas that contributed to this article.

BACKGROUND

A significant gap between the mental health needs of children and adolescents and the available services has been well documented. For example, between 12% and 27% of youth might have acting-out behavioral problems, depression, and anxiety; yet, as few as one sixth to one third of these youth receive any mental health treatment.¹⁻³ In this context, school mental health (SMH) programs have grown progressively.⁴ This growth reflects increasing recognition of the need to address the mental health needs of children and youth and the many advantages of SMH programs. These include reducing barriers to student learning, unmatched access to youth, and ability to engage youth in an array of strategies that can simultaneously address their educational, emotional, behavioral, and developmental needs.⁵ In fact, for youth who do receive mental health services, most receive them in schools.⁶⁻⁸ In addition, SMH programs can reduce stigma,⁹ enhance the generalization and maintenance of interventions,¹⁰ increase opportunities for preventive services,^{11,12} and promote efficiency and productivity of staff and programs.¹³ Program evaluation data and early research suggest that *when done well*, SMH services are associated with satisfaction by a number of different stakeholder groups including students¹⁴ and contribute to achieving outcomes valued by families and schools.^{9,15-18}

Strong federal support for SMH programs and services is found in the US Surgeon General's reports on mental health⁷ and child and adolescent mental health;¹⁹ large federal initiatives such as the Safe Schools/Healthy Students Program and the Child and Adolescent Service System Program. *Achieving the Promise: Transforming Mental Health Care in America*, the report issued by the President's New Freedom Commission on Mental Health in 2003,²⁰ emphasized the large gap between needs and effective services and the lack of a national priority on child and adolescent mental health. The 6 goals and 19 recommendations of the report strongly support SMH, including recommendation 4.2 to "improve and expand school mental health programs" and a related recommendation 4.3 to "screen for co-occurring mental and substance use disorders and link with integrated treatment strategies" (Table 1).

Achieving the Promise calls for an approach that connects policy, training, practice, and research on mental health services and that improves behavioral, emotional, and academic functioning of youth. This approach is reflected in a pyramid of programs and services. The foundation aims to improve school environments and broadly promotes health as well as academic success. The second tier encompasses targeted prevention programs and early identification

Table 1. Goals and Selected Recommendations of the President's New Freedom Commission (www.mentalhealthcommission.gov)

Goal 1: Americans understand that mental health is essential to overall health
Recommendation 1.1: Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention
Goal 2: Mental health care is consumer and family driven
Goal 3: Disparities in mental health services are eliminated
Goal 4: Early mental health screening, assessment, and referral to services are common practice
Recommendation 4.1: Improve the mental health of young children
Recommendation 4.2: Improve and expand school mental health programs
Recommendation 4.3: Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies
Recommendation 4.3: Screen for mental disorders in primary health care, across the lifespan, and connect to treatment and supports
Goal 5: Excellent mental health care is delivered and research is accelerated
Goal 6: Technology is used to access mental health care and information

practices that help recognize and refer students with unmet mental health needs. Providing access to effective treatment services for serious and/or chronic disorders occupies the top of the pyramid. This model is congruent with a public health approach to disease prevention and detection. It incorporates a continuum of educational messages that promote health and prevention and incorporates early identification practices that ensure cost-effective treatment for disabling health conditions. This pyramid model for health and mental health promotion has been embraced by the World Health Organization²¹ and other groups but unfortunately does not reflect the way programs and services are delivered to children and youth in the United States.^{7,20}

Although historically, school-based mental health services were provided primarily to students qualified for special education services, more recently, schools have expanded mental health and social services for all students as part of their coordinated school health program.^{22,23} Today, there are a number of different models for offering these services in schools, with an array of service components ranging from alcohol and other drug use treatment, case management, individual and group counseling, and referrals to community mental health systems and providers. Despite this, there remain numerous barriers including:

- insufficient funding
- inadequate training and supervision of staff
- difficulty coordinating a full continuum of prevention and intervention services
 - maintenance of quality and empirical support of services
 - limited evaluation of outcomes of services to improve programs and contribute to policy improvement.²⁴

Providing treatment services within school buildings is often challenging for additional reasons, including:

- environmental characteristics (poor office spaces, crowded classrooms)
- frequent changes in personnel (high teacher and administrator turnover)
- distinctive knowledge bases and cultures (education and mental health)
- difficulties in fully engaging families
- academic demands stemming from the No Child Left Behind educational reforms.

These issues are increasingly documented in the published literature, especially in relation to research-based interventions.^{25,26}

MENTAL HEALTH SCREENING IN SCHOOLS

Youth with internalizing disorders such as depression, anxiety, or suicide ideation are not as easily identified as those with acting-out or externalizing disorders. Individuals with internalizing conditions comprise a significant population; the 2003 Youth Risk Behavior Survey, a nationally representative sample of more than 15,000 high school students throughout the United States, found that in the 12-month period preceding the survey, 16.9% had seriously considered attempting suicide, 16.5% had made a plan for attempting suicide, 8.5% had attempted suicide 1 or more times, and 2.9% had made an attempt requiring medical attention.²⁷ In addition, studies have shown that students contemplating suicide or even those who had previous attempts were not known or detected by school personnel.²⁸ Furthermore, 90% of teens who commit suicide have a mental health issue at the time of their death but are usually not receiving treatment.²⁸

For these reasons, formal screening programs that detect depression and suicide ideation are recommended. The New Freedom Commission on Mental Health recommended screening in multiple settings as a critical component of a public health approach to prevention and early intervention for mental health issues in youth.²⁰ The Commission went so far as to name the Columbia University TeenScreen program as a model program for identifying at-risk youth and linking them to critical intervention services. TeenScreen is currently implemented in 460 sites in 42 states and involves systematic and supported assessment of youth mental health needs in schools along with technical assistance and guidance on addressing identified needs.²⁹ Other effective programs such as *Dominic*³⁰ and the *Signs of Suicide* program³¹ are also widely available. These recommendations have led to increasing discussion among

mental health providers of the need to advance mental health screening in schools. A few states, such as Ohio, Illinois, and New Mexico, have moved to expand screening in multiple settings as part of their efforts to transform their child's mental health system.

However, screening in schools is not without controversy. Some perceive screening as government intrusion, and others describe it as a violation of the family's right to privacy. These concerns appear to be based on the erroneous belief that screening programs in schools require all students to be screened against their wishes or against those of the parents.³² In fact, "mandatory universal screening" for behavioral health issues does not exist anywhere and has never been recommended by any federal agency or community screening program. All existing mental health screening programs are voluntary and require active informed consent of the family and the assent of the student. It is likely that another factor contributing to the misunderstanding surrounding screening is stigma. The President's Commission acknowledged the pervasive nature of stigma and the need to actively address it.

While there are no currently agreed-upon national standards for mental health screening in schools, a number of federal agencies, professional organizations, and advocacy groups have issued helpful resources. Both the Substance Abuse and Mental Health Services Administration³³ and the National Alliance for the Mentally Ill³⁴ recently released documents confirming the importance of screening as part of a public health approach to early identification and intervention for behavioral health problems and offering guidelines for the appropriate use of screening. Well-established screening programs such as TeenScreen generally have experientially based recommendations for implementation and strongly recommend active parental consent for any screening in schools. Another helpful resource on screening and assessing mental health and substance use disorders was issued by the Office of Juvenile Justice and Delinquency Prevention of the US Department of Justice, which includes a set of criteria for selecting screening methods.³⁵ The American Medical Association's Guidelines for Adolescent Preventive Services includes recommendations for screening behavioral and emotional conditions, such as substance abuse, eating disorders, depression, suicide risk, and school or learning problems.³⁶ All these guidelines and criteria for mental health screening can provide a foundation for developing standards for the school setting.

Other Issues

In trying to decide whether to implement a screening program, there are other factors that districts will need to consider. For example, strategic planning

should attempt to gauge the needs of individual schools in relation to the school/community's abilities to respond to those needs.³⁷ This will require a self-assessment process. In addition, prior to advancing the agenda related to mental health screening in schools, the community should consider:

1. Availability of trained staff and other resources to conduct screening.
2. Availability of mental health providers with training in evaluating and treating those children and youth identified by screening.
3. Need for technical assistance in system development for ensuring parental consent and student assent for participation in screening.
4. Selection of age-appropriate screening measures.
5. Logistics including when to do the screening, finding the right confidential space for screening, and provision of alternative activities for youth who do not have parental permission for screening.
6. Resolution of liability concerns.

First Steps

Once a district has addressed the issues outlined above and decided to move toward implementing a formal screening program, five additional elements will need to be considered: inclusive planning, collaborative relationships, logistics, training and supervision, and integration.

Inclusive Planning. Planning should involve all significant stakeholders including families, education professionals, primary care providers, mental health professionals, and other representatives from the community. Once configured, the planning body might begin with a policy review to ensure that sufficient safeguards are in place to protect privacy and confidentiality. Districts can also benefit from ongoing technical expertise from community agencies that respond to related mental health issues such as substance abuse, child welfare, law enforcement, or other specialty systems.

Collaborative Relationships. To promote collaboration, the sharing of resources, and to address liability concerns, memoranda of agreement should be established between schools and collaborating community agencies to ensure adequate clarification of responsibility. Ideally, local initiatives and agreements between child serving systems should be approved of and supported by state systems, such as state departments of education, mental health, juvenile justice, and child welfare.

Logistics. The time to conduct screening must be determined. Some have recommended transitional years such as sixth and seventh and ninth and 10th grades as critical times when clinical symptoms often linked to increased suicide risk sometimes

develop.^{29,37} However, screening efforts at these ages should ideally be part of broader efforts within communities to promote wellness, mental health, and learning success for youth from preschool through young adulthood. Locally collected data such as emergency room data can assist in identifying age groups at particular risk. In the absence of locally available data, state and national data such as the Youth Risk Behavior Survey (<http://www.cdc.gov/HealthyYouth/yrbs>) can be helpful. However, if the planning group determines that there are inadequate resources to provide adequate follow up to the screen, the screening process should be delayed until adequate resources are marshaled and confidence of adequate follow up is increased.³⁸

Training, Supervision, and Support. Staff that participate in screening will require adequate training and supervision. Personnel will be needed who can coordinate the work; select age-appropriate and culturally sensitive measurement tools; manage associated technology for administering, scoring, and interpreting the data; and establish and sustain relationships with school and community providers.

Regardless of whether a school implements a systematic screening program, all schools should enhance their capacity to identify youth who present signs of emotional/behavioral disturbance. These disturbances represent barriers to learning and are indicative of the development of serious mental health concerns. Schools should connect these youth to appropriate resources and services. Professional development will be required to raise awareness and increase knowledge of child and adolescent mental health needs, the factors that promote healthy youth development and those that contribute to mental health problems, specific signs of distress, and strategies to assist distressed youth in obtaining help.^{39,40} All staff should have a clear understanding of referral procedures and know how to determine when a youth is in crisis and needs an immediate intervention.

Integration. Mental health screening should be one aspect of a full continuum of effective mental health programs and services in schools. Such programs can only exist when there is a full partnership between families, schools, and child serving systems, particularly the mental health system. There must be strong emphases on quality assessment and improvement, empirically supported practice, and evaluating outcomes of services.²⁴ Findings from outcome evaluations should be used to continuously improve services and should connect to advocacy and policy agendas.

CONCLUSION

The President's New Freedom Commission on Mental Health²⁰ provides specific recommendations

to improve and expand school mental health programs and to screen for co-occurring mental and substance use disorders and link with integrated treatment strategies. The New Freedom Initiative and its 19 specific recommendations represent a call to action for communities and states to move beyond fragmented and ineffective approaches to illness care for a small percentage of those in need toward a true public mental health promotion system that ensures quality and effectiveness along a full continuum of services. Consideration of the issues outlined in this article should help schools and communities determine whether they are ready to include screening in schools as part of their SMH program.

When implemented with appropriate family, school, and community involvement, mental health screening in schools has the potential to be a cornerstone of a transformed mental health system that identifies youth in need, links them to effective services, and contributes to positive health and educational outcomes valued by families, schools, and communities.

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