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Depression in children and adolescents: The role of school professionals

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DEPRESSION IN CHILDREN AND ADOLESCENTS:

THE ROLE OF SCHOOL PROFESSIONALS

An Abstract of a Thesis

Submitted

in Partial Fulfillment

of the Requirements for the Degree

Educational Specialist

Emily Dawn Hoerman

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August 2013

ABSTRACT

Depression in children and adolescents is a significant issue for schools. Research has indicated that most students who see mental health professionals do so within the school setting, indicating a need for effective school-based programs to address mental health issues in the schools. The symptoms of depression and short and long term effects are reviewed. The need for, and necessary components of, a comprehensive mental health system in the school setting is discussed.

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CHAPTER 1

INTRODUCTION

The notion of the 1970s that depression is an ailment of adulthood and that children and adolescents do not experience depression is now long gone. It has been estimated that depression is the form of mental illness affecting the greatest number of adolescents (Cash, 2003) with prevalence rates between ten (Cash, 2003; Huberty, 2006) and twenty (Khalil et al., 2010) percent. Seely, Rohde, Lewinsohn and Clark (2002) indicated that approximately 28% of adolescents would experience a major depressive disorder by age 19. These authors cited annual incidence rates of 1-2% for children 13 and younger and 3-7% for adolescents starting at age 15. While they state that the average onset age of depression is 15.5 years old they indicate prevalence rates begin to increase for females around age 12 and for males around age 14 (Seely et al., 2002). The lifetime prevalence of depression in teens becomes greater as the teens age; the lifetime prevalence of 13-14 year olds, 15-16 year olds, and 17-18 year olds is 8.4%, 12.6%, and 15.4%, respectively (Merikangas et al., 2010). The National Institute of Mental Health (n.d.) has reported statistically significant differences across age and sex in the lifetime prevalence of mood disorders, including depression, for adolescents 13 to 18. Merikangas and colleagues (2010) found the lifetime prevalence of depression among female adolescents to be 15.9% while lifetime prevalence for males was 7.7%.

Depression is more than feeling sad or down. Depression has been described as "a low, sad state in which life seems dark and its challenges overwhelming" (Comer, 2008, p. 187), a "serious health problem that can affect people of all ages (Cash, 2004, p. 1), "a

persistent sad or irritable mood as well as anhedonia, a loss of the ability to experience pleasure in nearly all activities" (Cash, 2003, p. 2), and a disorder that "affects the entire person changing the way he or she feels, thinks, and acts" (Cash, 2003, pp. 2-3). These descriptions indicate that depression is more than simply being sad; it is a mental health issue that needs to be taken seriously. The age-old notion that adolescence is a normal time of moodiness and emotionality does not accurately describe depressed youth and the description does not indicate to others the amount of help these young people will need to deal with their depression. Reynolds (1990) stated that this 'moody stage' perspective of adolescent depression cannot continue in light of the large numbers of depressed and suicidal youth for whom the consequence of depression is to not survive to adulthood.

Mental health programs need to be part of the solution, sending a message to depressed individuals that their depression is treatable, that they can be helped, and that things can improve for them. Because school is the place young people spend a majority of their waking hours, it is prudent that the schools become part of the solution by offering comprehensive mental health programs that include prevention and intervention services targeted at children and youth suffering from depression. This paper will present a way to organize a comprehensive mental health program in the school setting. This comprehensive program should be set up using the Response to Intervention (RTI) or Positive Behavior Intervention and Supports (PBIS) frameworks already in place in many schools.

CHAPTER 2

SYMPTOMS AND OUTCOMES

The signs and symptoms of depression are different from "normal" adolescent moodiness in several ways. A moody teenager may experience levels of sadness and irritability. However, a teenager experiencing depression will experience these feelings for prolonged amounts of time. In addition, the depressed teen's sadness and irritability will significantly impact the young person's ability to function. In order to meet the Diagnostic and Statistical Manual IV-TR criteria for a major depressive episode, a person must present with five of the following symptoms for a period of at least two weeks and one symptom must be depressed mood or loss of interest: depressed mood, markedly diminished interest or pleasure in all or almost all activities, significant (>5% body weight) weight loss or gain or increase or decrease in appetite, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or inappropriate guilt, diminished concentration or decisiveness, and recurrent thoughts of suicide or death (American Psychiatric Association [APA], 2000). To meet diagnostic criteria, these symptoms must cause significant distress or impairment in areas such as social, occupational, or school functioning; must not be due to effects of a substance or medical condition; and must not be better accounted for by the loss of a loved one (APA, 2000).

Depressed teens may experience a number of symptoms including relentless sadness and irritability; loss of interest in activities; social withdrawal; changes in appetite, sleeping patterns and activity levels; feelings of worthlessness; difficulty

concentrating; substance abuse; and in some cases thoughts of suicide or death, suicide attempts, or completed suicide (Cash, 2003, 2004; Reynolds, 1990; Rønning et al., 2011). These teens also experience more coexisting emotional and behavior problems than do nondepressed teens. At the same time that they experience depression, teens also report more anxiety, difficulties with inattention and/or hyperactivity, acts of aggression, substance use, and Post Traumatic Stress Disorder (PTSD) symptoms (Jaycox et al., 2009). Huberty (2006) indicated additional signs of depression in young people including difficulty finishing necessary tasks; difficulty making decisions; negative thoughts about self, world, and future; flat affect; irrational reactions to everyday events; decline in personal hygiene; and excessive crying. These depressed teens not only experience changes within themselves, but changes in their relationships with others.

Depressed teens report lower levels of peer and parent support than do nondepressed teens, indicating that these teens have, or perceive they have, impaired levels of social and familial functioning (Jaycox et al., 2009). When asked about relationships and academics, parents report lower levels of social, family and school functioning for the depressed teens than parents of teens who are not depressed. Verboom, Sijtsema, Verhulst, Penninx, and Ormel (2013) found that higher levels of depression were correlated with lower perceived social well-being and increased social problems. For this study, social well-being included a teen's perceptions of how they were regarded by peers, whereas social problems were based on a parent report of the teen's social behaviors. Depression in teens predicted a decrease in social well-being for teens, but low social well-being did not predict depression. While depressed teens are

experiencing relationship issues caused by their depression, a teen's academic performance may also be impacted.

Depressed students of any age may display depressive and negative thinking about their school performance, meaning that they have pessimistic views of their abilities to produce quality work. This negative thinking can lead to students who are capable of doing their schoolwork presenting with "won't do" tendencies. In response to negative feelings about their abilities, including their schoolwork, depressed teens may refuse to complete work. Verboom et al. (2013) found an inverse correlation between depressive symptoms and academic performance. As depressive symptoms increased, academic performance decreased. Jaycox et al. (2009) found that depressed teens reported significantly lower levels of academic engagement and academic efficacy and significantly lower grade point averages than did teens who were not depressed. In this study, almost twice as many teens who were depressed had grade point averages below C than did teens who were not depressed. These teens also reported approximately twice as many impaired days as teens without depression (Jaycox et al., 2009), indicating that these teens are missing more school or have impaired functioning during school more often than teens without depression. Moreover, teenagers, may display depression through self-destructive tendencies in school such as increased attendance issues, impaired school performance, increased behavior problems, poor attention in class, and decreased participation in activities. Behavioral issues of depressed teens may also include withdrawal from, or fights with, friends (Cash, 2003; Reynolds, 1990).

While these are common effects of depression on school functioning, it is important to remember that each student is a unique individual and that their symptoms and experience of depression will also be unique. Huberty (2006) indicated that while two teens may share the diagnosis of depression, their symptoms would not likely be the same. He indicated the differences in manifestation are due to different life circumstances and the range of problems that cause or contribute to the person's depression.

Long Term Effects

While it is important to look at the immediate impacts of depression on young people, the long-term effects are equally significant. Jaycox et al. (2009) pointed out that the impact of school failure is long-term, as "better-educated individuals have improved long-term social and economic outcomes, including earning higher wages and spending less time unemployed" (p. 602). Fergussen, Boden and Horwood (2007) indicated that depression is relatively common in children, adolescents, and young adults and many of the people experiencing depression early in life will have recurrent episodes into later adolescence and early adulthood. Depression early in life is also associated with other long-term mental health issues, such as anxiety and suicidal behaviors.

Individuals affected by child and adolescent depression are more likely to have other negative outcomes. In their longitudinal study, Fergusson and Woodward (2002) found that adolescents with depression had an increased risk of "nicotine dependence, alcohol abuse or dependence, suicidal behavior, school failure, and a reduced likelihood of entering university or post-secondary education" between ages 16 and 21 (p. 228).

They also state that individuals who experience depression as children or adolescents, typically experience higher rates of repeated unemployment and early parenthood than do persons who are not depressed during childhood or adolescence. When depression in teens goes untreated, young people may experience school failure, conduct disorder and delinquency, anorexia and bulimia, school phobia, substance abuse, or even suicide (Cash, 2004).

<u>Suicide</u>

The most shocking and devastating outcome of depression in young people is suicide. Suicide is currently the third leading cause of death among young people. If we use Khalil et al.'s (2010) estimate that 20% of adolescents suffer from depression, in a school of 1,000 students as many as 200 may be experiencing depressive symptoms or mood swings enough to warrant a diagnosis of depression. Of those 200 depressed students, approximately 24 will attempt suicide in one year. The Centers for Disease Control and Prevention (CDC; 2013) reported that 12.5% of the deaths of young people between the ages of 1 to 24 were caused by suicide. In their fatal injury reports for 2000-2010, the CDC (2010) reported 48,910 deaths by suicide in children and adolescents age 0 to 24. Depressed females are more likely to attempt suicide than depressed males, but males are far more likely to succeed in committing suicide. The CDC (2013) reported that 19.3% of females and 12.5% of males seriously considered attempting suicide. Moreover, 9.8% of females and 5.8% of males surveyed had attempted suicide one or more times. Eighty-three percent of the young people who succeeded in ending their lives were males and only 17% were female.

Many students who consider suicide will give warning signs and indications of these plans, so educators should be aware of these signs and the appropriate steps to follow if they suspect a student is at risk. Behavioral warning signs of suicide are included in Table 1.

Table 1

Warning Signs for Suicide

Suicide notes
Threats of / references to suicide
Previous suicide attempts
Obsession with death
Increased risk-taking behavior
Efforts to hurt oneself
Inability to think rationally
Changes in physical habits
Changes in appearance
Sudden changes in personality, friends, or behaviors
Making final arrangements, taking care of personal matters
Giving away personal items or prized possessions
Suicide plan and access to identified method
Statements such as "I won't be around"
Visiting friends and family not seen in awhile
Talking about how they would like to be remembered

(Cash, 2003; Huberty, 2006)

Huberty (2006) indicated that a depressed person most often turns to thoughts of suicide when they begin to feel that their situation is doomed and that nothing can be done to help improve their circumstances. It is imperative that systems be put in place to treat young people experiencing depressive episodes and fend off future problems related to depression. The personal and societal costs are too great to ignore.

CHAPTER 3

COMPREHENSIVE MENTAL HEALTH SERVICES IN THE SCHOOLS

Research indicates that mental health services are most likely to be provided to young people within the school setting. Leaf et al. (1996) reported that young people's contacts with mental health professionals came most frequently in the school setting. Burns et al. (1995) reported that between 70 and 80 percent of children who received treatment for a mental health issue did so within the education setting. While the schools are the primary source of mental health treatment for young people, research has indicated that many students with mental health diagnoses and/or impairments are going untreated. Burns et al. reported that 23% of students with no diagnosis but mental health impairment received mental health services. Young people with both a diagnosis and impairment were more likely to receive mental health services, but the prevalence only increases to 36-40% (Burns et al., 2005; Leaf et al., 1996). These data suggest that more than half of the students with mental health needs are left untreated.

Schools need to provide effective programs to better address child and adolescent depression. Reynolds (1990) indicated that psychologists in school settings are interested in providing mental health interventions. In their study of 83,000 public schools, Foster et al. (2005) found that 96% of schools had one or more staff member whose responsibilities included providing mental health services to students. Commonly these staff members included school counselors, school nurses, school psychologists, school social workers, or some combination of these staff members. Despite the numbers of available staff members, less than half of students are receiving mental health services in

the schools. The discrepancy may indicate that providing mental health services is not the priority in these people's job responsibilities or the lack of a good referral system that enables students to take advantage of services provided by these staff members. Whatever the reason for the discrepancy between the number of staff members available to provide mental health services and the number of students receiving these services, schools need to address the issue.

If the interest and the resources are in the school, there should be no question about the appropriateness of school-based treatment. The prevalence rates of school age youth suffering from depression suggests a significant number of students in need of psychological attention and services. It is therefore imperative that we provide opportunities for training for the people that work with these children; not only the school counselors and psychologists, but the classroom and special education teachers as well. Teachers have contact with more children for longer amounts of time and as a result can see trends and changes in students' behaviors. While recognizing depression in the schools is of utmost importance, evaluating and treating depressed youth is the necessary second step.

School counselors and school psychologists can be utilized to help children and adolescents experiencing depression when it is clear that an outside professional will not be contacted. School psychologists are trained to provide mental health services in the schools. More specifically, they are trained to recognize and plan for mental health issues in students, especially mental illness demonstrated through problem behavior, through

prevention, intervention, and outcomes evaluation (National Association of School Psychologists [NASP], 2012). School counselors and school psychologists can and should be called upon to help students in these situations. Along with the school resources, in order to be most effective, interventions within the schools should be paired with connections and resources outside of the school.

School mental health professionals such as school psychologists, school counselors, and school social workers, should be utilized in screening for mental health issues in students, designing interventions and plans, prevention programs, in providing direct interventions and counseling to students, and in creating a comprehensive mental health program that includes collaboration with community mental health providers. Not only is awareness of mental illness of growing importance for school professionals, an awareness of mental healthiness in our classrooms will be essential as well.

In order to provide comprehensive mental health services in the schools, schools should implement a tiered system for mental health services similar to an RTI or PBIS system. This system would educate all students about mental illness and build resiliency and protective factors at the universal level, provide supplemental support through prevention programs to those students determined to be at risk at the supplemental or tier 2 level, and provide more intensive support to students with more individualized needs at the intensive or tier 3 level (Hunter, 2003). Data would be collected for each student to determine students' levels of need and placement within the tiered system. Additional data would be collected for students within intervention groups to ensure that students are making progress and interventions are effective.

<u>Universal/Tier 1</u>

<u>Addressing Stigma</u>

In a tiered system of services, all students receive Tier 1 or the universal program. There are several components of universal programming that schools can implement to support student's mental health. First, schools should address the stigma related to mental illness and depression in an effort to increase openness about the illness with both students and educators. This can help students who are depressed to not feel so disconnected. Wright, Jorm, and Mackinnon (2011) indicated that the use of accurate psychiatric labeling of depression could counter stigmatizing attitudes. Using the accurate label was the strongest predictor of people viewing the depressed person as sick rather than weak. Educators can work to eliminate stigma by talking about prevalence, signs, and symptoms of depression. Esters, Cooker, and Ittenbach (1998) found that an educational program for adolescents 13-17 years old was effective in fostering more positive attitudes toward seeking help for mental illness and creating more positive opinions regarding mental illness. This program focused on the roles of mental health professionals and the etiology, symptoms, diagnosis, prognosis, and treatment of mental illness. These effects were seen immediately after the educational program and in a follow up 12 weeks later.

The Adolescent Depression Awareness Program (ADAP) is a program by a team at the Johns Hopkins Hospital aimed at providing education about depression to high school students, teachers, and parents in order to decrease the number of teens suffering

from depression without treatment (The Johns Hopkins University, n. d.). ADAP strives to help students, parents, and teachers to recognize depression and help those suffering from this illness to seek evaluation and treatment. ADAP accomplishes this goal through a student curriculum, educational videos, a training program for health and school-based professionals, and presentations for parents and communities. The goal is for this program to be used across the nation by school professionals in the classroom (The Johns Hopkins University, n. d.). Swartz et al. (2010) assessed the effectiveness of the ADAP curriculum in improving high school student's knowledge of depression. They did pre and post assessments with 3,538 students over 4 years measuring their knowledge of depression after exposure to the ADAP curriculum. The researchers found a significant increase in the number of students who scored 80% or higher from the pretest (701) to the posttest (2,180), suggesting that the program was effective in increasing knowledge regarding depression (Swartz et al., 2010).

Schools should also train their staff members, students, and parents to intervene effectively when someone around them is suffering from depression. This should involve schools developing and teaching procedures for reaching out to those who may be depressed and referring them for mental health services. This training should extend to teachers, bus drivers, coaches, support staff, parents, and students, as they are all in positions to intervene early and appropriately for depressed teens (Cash, 2003). In addition to educating staff members on depression, schools should implement programs to support positive mental health.

Increasing Resiliency

Schools should implement programs focused on increasing resiliency and improving mental health. Whelley, Cash, and Bryson (2002) indicated that "although historically mental health has been viewed through the lens of mental illness, we have come to recognize that good mental health is not simply the absence of illness but also the possession of skills necessary to cope with life's challenges" (p. 1). In a universal mental health program, it is important to support students' current skills related to positive mental health. These skills are the protective factors that will help students to prevent future mental health issues, so it is important to teach them to all students. It is important that school personnel understand the role of mental healthiness in students because of its importance in their social, emotional, and academic success (Whelley et al., 2002). There are several important ways schools can support building protective factors in students.

In her longitudinal study on development, Werner (1993) found that young people, who were at-risk because of perinatal stress, low socioeconomic status, or troubled family environment, could successfully overcome these risk factors to lead healthy lives. Werner and her colleagues identified the protective factors that allowed these people to be successful when others with similar life circumstances were not. These protective factors included extracurricular interests and activities that provided them an opportunity for connection with others and a source of pride; the establishment of close bonds with caregivers within or outside of the family; and trusted, supportive adults

including teachers and mentors. The young people with these protective factors in their lives developed a positive self-concept, an internal locus of control, and the values and skills to efficiently use their abilities. This research indicates that the focus on building protective factors and fostering resiliency in students should include promoting competence, self-efficacy, and self-esteem. This can be accomplished through supporting students so they experience academic success, fostering participation and interest in hobbies and extra-curricular activities, giving them socially desirable jobs or tasks in which they can help others or provide community service, and providing them with supportive relationships and connections. Werner indicated that a key component in the lives of these resilient individuals was their confidence that they could overcome challenges. Schools should actively support the development of these protective factors in students.

Fostering resiliency in students has been found to be an effective prevention strategy for negative life outcomes for at-risk youth, including depression and mental illness. Ginsburg (2011) defined resiliency as the capacity to overcome difficult circumstances or to recover from setbacks. He indicates that adults can help foster resilience in children and teens by helping them to feel competent and confident, helping them to establish connections, instilling them with character and values, helping them to contribute to their communities, equipping them with strategies for coping, and helping them maintain a sense of control. Doll, Zucker, and Brehm (2004) established a system to help prepare school professionals across grade levels to create resilient classrooms. The authors indicated six characteristics that help students connect to their classrooms:

academic efficacy, behavioral self-control, academic self-determination, effective

teacher-student relationships, effective peer relationships, and effective home-school

relationships. These characteristics fall under two different but equally important strands

for promoting resilient students and successful classrooms. One strand works to

emphasize the self-agency of individual students within the classroom and the other

strand emphasizes the classroom community focusing on the relationships between

students (Doll et al., 2004). Self-agency of students refers to the autonomy, self-

regulation, and self-efficacy of students and their ability to be independent learners and

have confidence in themselves. The second strand focuses on building the community

within the classroom by helping students to learn to work together, care for one another,

and build connected relationships with other students in the classroom community. This

program includes methods to support students emotionally, academically, and socially,

and focuses on developing the components of a resilient classroom. Resilient classrooms

support building relationships, establishing routines, and fostering academic efficacy and

behavioral self-control. Positive home-school relationships are also critical within this

program. This system includes methods for building a resilient classroom that focus on

involving students in planning and classroom changes and evaluation tools that can be

used to document change within the classroom.

Schools have the capacity to begin building protective factors as early as

elementary school that help children long-term in the areas of positive behavior, social

skills, academic achievement, and emotional well-being (Whelley et al., 2002). Schools

should work on creating a supportive environment in which all children feel that their

needs are met. Children should feel that they belong in their school, and there should be a conscious effort to build a sense of connectedness within the building. Schools should provide students with routines that make them feel comfortable, but should also work on easing the anxiety that comes with adapting to change. This can be done by simply giving students warnings about changes, discussing what may happen, and teaching them coping strategies they can use when things change abruptly (Whelley et al., 2002). Educators need to recognize the successes of children as well as their efforts. This recognition can be accomplished by praising not only the child who got the best score, but also the one who showed improvement. Children need to know that they are capable of making a difference, that they are important, and that what they do is and will be important. Werner (1993) indicated that these students should be engaged in extra curricular activities or hobbies, community service activities, or socially desirable jobs to help others.

Suicide Prevention

The Signs of Suicide (SOS) prevention program is a nationally recognized program and the only school-based suicide prevention program listed on the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (Screening for Mental Health, 2010). This program incorporates peer intervention as a suicide prevention strategy as research has shown that young people are more likely to confide in their peers than adults when dealing with a suicidal crisis (Screening for Mental Health, 2010). SOS teaches teens to recognize signs of depression, self-injury, and suicidal ideation and gives them action steps to empower

them to intervene when they recognize these signs and symptoms in a friend (Screening

for Mental Health, 2010). Aseltine and DeMartino (2004) found that students

participating in the SOS program had significantly fewer suicide attempts. Students also

had significantly increased knowledge about depression, and more adaptive attitudes

toward depression and suicide, than did students in a control group. Students in the

treatment group were approximately 40% less likely to report a suicide attempt in the last

3 months than students in the control group. Programs like these are essential in the

prevention of the most tragic consequence of depression in children and teens.

<u>Screening</u>

In a tiered system, screening is a data collection process used to identify students

who need more support than the universal programming. Screening for depression is an

important component in the implementation of a comprehensive mental health system in

the schools. The students whose needs are not being met through the universal instruction

and programming will be identified through screening efforts. These students can then be

referred to supplemental or intensive levels as appropriate. The Committee on the

Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and

Young Adults (2009) indicated that the use of universal screening to identify students

who are at risk for problems such as school failure or psychological or behavioral

problems is gaining recognition as an essential professional practice. The US Preventive

Services Task Force (2009) recommended screening adolescents (12-18 years) for

depression when systems are in place to ensure accurate diagnosis, intervention for those

identified, and follow-up. It is important that universal screening procedures be valid, technically adequate, and brief in order to gain acceptance in the schools. It is also important to communicate with parents regarding screening and to respect the wishes of parents who do not want their children to participate.

Universal screeners are used to identify children and adolescents that have, or are at risk for developing, mental health issues in order to help these students to receive appropriate intervention. The Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults (2009) suggests, "the ultimate justification for school-based screening [will be] that it can contribute to preventing the development of psychological and behavioral problems, which interfere with school performance" (p. 230). Screening for depression involves the use of sets of questions about depression and symptoms of depression to identify students with current depression whom have not previously been identified for treatment (Thombs, Roseman & Kloda, 2012).

The screening measures proposed for use in schools should be research-based and determined to be effective. TeenScreen is a screener developed by Columbia University, which uses the Diagnostic Predictive Scales to screen students ages 11 to 18 to identify youth with possible mental health disorders. This system assesses symptoms of depression, as well as suicidal ideation and attempts, anxiety, alcohol and drug use, and general health problems (TeenScreen, 2003). Shaffer et al. (2004) indicated validity scores for two algorithms when studying the Columbia screener. The algorithm that

included students' responses regarding suicide attempt or ideation, depression, and anxiety had a sensitivity of 75%. The algorithm that focused only suicide attempts and ideation had a sensitivity of 88%. While each algorithm has a score that suggests that the screener is valid, the algorithm that focused on suicide attempts and ideation was better able to identify students who were depressed or were at-risk for depression. Shaffer et al. also reported the test-retest reliabilities for the screener were in the good to excellent range.

Williams, O'Connor, Eder, and Whitlock (2009) looked at the accuracy of screeners completed in school-based health clinics or in the school setting (not through school health clinics) and found that 7 of the 8 studies reported sensitivity in the screeners above 70%. They reported that the Patient Health Questionnaire for Adolescents (PHQ-A) had a sensitivity of 73% and the Beck Depression Inventory-Primary Care Version (BDI-PC) had a sensitivity of 91%. This indicates that both screeners were fairly sensitive to depression and accurate when identifying students with depression. However, it was noted that studies for screeners that involved younger children tended to have less sensitivity than did studies whose screeners targeted adolescents. The sensitivity in a study with children ages 5 to 10 was only 53% (Williams et al., 2009). Currently, this data suggests that there is only enough evidence to support screening with adolescents 11 years and older. As a result, elementary school systems will need to rely on educators for the identification of students with symptoms of depression as well as an effective referral system.

Supplemental/Tier 2

Students determined to be at-risk through the screening process or identified as at-risk through the referral process, will be provided increasingly intensive supports through the supplemental level of intervention, or Tier 2. Typically these services are provided within a small group setting with students with similar needs. Data will be collected at this level to ensure that students are making progress. Mental health providers in the schools will be essential for implementing prevention strategies and programs. Through the implementation of depression and suicide prevention strategies, professionals can work to ensure students have the skills they need to deal with obstacles. The programs and strategies discussed here are meant to be utilized within the school setting and to be implemented by school professionals. School psychologists, social workers, and counselors can help to establish these initiatives for depression prevention.

Several factors have been found to influence the effectiveness of prevention programs. Stice, Shaw, Bojon, Marti, and Rohde (2009) found that prevention programs that targeted high-risk youth produced larger effects than did programs that were universal in nature. This indicates that prevention efforts may be more successful when used to target students who are found to be at-risk than to attempt universal prevention programs for all students without risk factors. Stice et al. also indicated that shorter prevention programs were more successful than longer prevention programs. The authors indicated that programs that are extremely long do not appeal to young people and lead to drop out and weakened intervention effects (Stice et al., 2009). Depression prevention

efforts should therefore include programs that are briefer in nature (Stice et al., 2009). Schools need to keep programs short and interesting in order to hold the attention of young people.

Stice et al. (2009) also found that prevention programs including a homework component were more successful than those without homework assignments. This application of the skills learned within depression prevention groups to real world situations is more effective in decreasing current and future depression (Stice et al., 2009). The application of skills learned within group sessions helps students to generalize these skills to situations outside of the group and to think about real-world applications of their newly acquired skills.

The Penn Resiliency Program (PRP) is an example of a Tier 2 intervention. PRP is a group intervention for late elementary and middle school students that focuses on teaching cognitive-behavioral and social problem solving skills (Gillham & Reivich, 2007). This program is based on cognitive-behavioral theories of depression and centers around the Adversity-Consequences-Beliefs model or "the notion that our beliefs about events mediate their impact on our emotions and behavior" (Gillham & Reivich, 2007, para. 1). Students learn a variety of skills and strategies, including detecting and evaluating inaccurate thoughts, challenging negative beliefs, problem solving and coping skills, techniques for assertiveness, negotiation, decision making, social problem solving, and relaxation. The program is typically taught by group leaders, including school professionals whom have received training and supervision, and is delivered in twelve

90-minute lessons or eighteen to twenty-four 60-minute lessons (Gillham & Reivich,

2007). Brunwasser, Gillham, and Kim (2009) "found that youths who participate in PRP

report reliably lower levels of depressive symptoms through 12 months of follow-up

compared with youths who receive no intervention" (p. 1049). This prevention program

is effective in teaching students skills and reducing symptoms of depression.

<center>Intensive/Tier 3</center>

Students identified as having significant symptoms of depression or as not making

progress toward symptom reduction or risk reduction in the supplemental level, are

referred to an intensive level or Tier 3. At this level students receive intensive

interventions that target individual students' areas of skill deficits. Depression is treatable

when appropriate and timely interventions are implemented. This level of intervention is

important in a comprehensive school-based program to ensure students receive effective

treatment. Because children spend most of their time in schools and this setting is

equipped with school-based mental health professionals who know the students, parents,

and staff members, schools are an ideal place to provide these intensive mental health

services (NASP, 2012). School psychologists are trained to collaborate with parents, their

mental health colleagues in the schools, and community agencies to work toward creating

a continuum of intensive services to meet the individual child's needs (NASP, 2012).

A number of types of psychotherapy are considered evidence-based treatments for

children and adolescents with depression. Psychotherapy is defined as "any intervention

that is designed to reduce stress or maladaptive behavior or enhance adaptive

functioning" (Weisz & Kazdin, 2010, p. 3). The list of evidence-based psychotherapies includes the ACTION treatment program for girls (Stark, Streusand, Krumholz, & Patel, 2010), group and individual cognitive behavioral treatment for adolescent depression (Clarke & DeBar, 2010; Weersing & Brent, 2010), and interpersonal psychotherapy (Jacobson & Mufson, 2010). The US Preventive Services Task Force (2009) recommended cognitive-behavioral or interpersonal psychotherapy for students identified as experiencing depression or symptoms of depression. When students are identified as in need of intensive level services, they should be provided with either small group or individual interventions within the school environment. The intensity of the intervention should be determined by the individual student's level of need. These interventions should include the evidence-based practice of psychotherapy.

The application of empirically supported cognitive behavior therapy (CBT) techniques is appropriate for school-based treatment of depression and is, in most cases, within the capabilities of school psychologists. CBT techniques, such as attribution change, behavioral activation, cognitive restructuring, emotion regulation, and problem-solving therapy, have been found to be beneficial in the treatment of depression (O'Donohue & Fisher, 2008). Williams et al., (2009) found that nine of the ten psychotherapy intervention trials they researched were more effective in reducing depression symptoms in children than a variety of control conditions.

Since we know that schools are the place that a majority of students in need of mental health services will receive such services, it is essential schools have professionals

who can deliver these services. However, it is also important for these individuals to know their professional limits and when to refer students to outside agencies for more intensive services. These professionals must also have the knowledge and skills to effectively collaborate with community agencies and service providers.

Interventions for students with depression are most likely to be effective when put in place with collaboration with the student's family and perhaps community agencies (Cash, 2004). Family members should be aware of intervention planning and, whenever possible, included in the planning for mental health interventions. Some students will need counseling and psychiatric medications that are beyond the training of a school counselor or school psychologist. Cash (2004) indicates that a "comprehensive treatment plan often involves educating the child or adolescent and the family about the illness, counseling or psychotherapy, ongoing evaluation and monitoring, and, in some cases, psychiatric medication" (p. 2). It is important that school counselors and school psychologists have accurate information and the knowledge and skills necessary to refer students with depression to other mental health professionals.

Referrals to Community Resources

Essential to a comprehensive mental health program in the school will be a referral process to connect students to resources outside of the schools. There needs to be a comprehensive continuum of services available for students. Schools should provide the prevention, screening, and intervention components of the continuum within the school and work with community agencies and mental health professionals to provide intensive

services to students whose needs are not best met within the school setting. This collaboration with mental health service providers within the community and with the students' families becomes crucial for the students with more intensive needs (NASP, 2012).

School-based mental health systems that are truly comprehensive will incorporate community resources that partner with school staff to provide care based on the student's needs (Richardson, Morrisette, & Zucker, 2012). This continuum should be organized so that the level of service needed is chosen based upon student needs. This system would work so that when more intensive supports are needed, team members from the community can be pulled in and students with less intensive needs can be met through wellness, education, and prevention programs provided within the school, by school professionals such as school psychologists, counselors, and social workers (Richardson et al., 2012). As previously stated, school mental health professionals should also be included in intervention services when their training and student level of need indicates that this would be appropriate.

CHAPTER 4

CONCLUSION

Schools need to implement a comprehensive mental health system that operates similar to the RTI system for academic intervention. Within this type of tiered system the goal is that 80-90% of students' needs can be met with effective universal instruction. An additional 10-15% of student needs will require supplemental or tier 2 services. Only 1-5% of students should need intensive or tier 3 supports (Hunter, 2003). A system that is supporting too many students at the supplemental or intensive levels will not be sustainable so it is important to put enough time and resources into universal instruction to ensure a healthy system (Hunter, 2003).

Data collection is important within a tiered system. Data supports the decisions regarding placement and movement between levels. When making data-based decisions, schools are able to effectively provide students with appropriate interventions. Screening data is used to identify students whose needs are not met at the universal level for supplemental or intensive services. Once students are determined to need services in addition to the universal instruction, progress monitoring data should be collected. Progress may be monitored using pre and post tests of knowledge, skill evaluation, or ratings of behavior and/or symptoms. Progress monitoring data should be collected and reviewed on a frequent basis to ensure that students are making progress and needs are being met. If a student is not making progress, the team needs to determine the reason for the lack of progress. At the supplemental level this could mean that the intervention isn't

intense enough for the student's needs. At the intensive level perhaps the intervention isn't focusing on the student's individual skill deficits and more assessment needs to be done to identify the skills that the student needs.

Prevalence rates of depression and mental health issues in childhood and adolescence are higher than ever. Research has identified consistent and tragic links between youth depression and later negative life consequences. There is no better place to identify young people with depression and provide intervention than in the schools. It is important to build effective response strategies to mental health problems within the schools. It is equally important to help children develop positive mental health supports and strategies. A comprehensive mental health program is necessary within the school system that includes a continuum of services with universal supports to all students, supplemental supports for students at-risk for depression, and intensive supports for students suffering from an episode of depression or depression.

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