

A HIGH SCHOOL COUNSELOR'S LEADERSHIP IN PROVIDING SCHOOL-WIDE SCREENINGS FOR DEPRESSION AND ENHANCING SUICIDE AWARENESS

The prevalence of mental health issues and suicidal thoughts and actions among school-aged children and adolescents is a serious issue. This article examines the scope of the problem nationwide and provides a brief overview of the literature regarding the effectiveness of school-wide screening programs for depression and suicide risk. The authors describe a suicide prevention program that has been implemented by the first author (a high school counselor in Minnesota) that combines classroom guidance, screening, and referrals for outside mental health services. This article includes recommendations for school counselors interested in implementing a school-wide screening and prevention program.

In a high school of 1,000 students, an average of 63 (or 6.3%) will report having made a suicide attempt in the past 12 months (Centers for Disease Control and Prevention [CDC], 2010). Considering that approximately 100-200 attempts take place for every suicide completion (CDC, 2009), a high school of this size would experience the trauma of a student death by suicide at least every 2 to 3 years. Clearly, suicide prevention and the school's response to the mental health needs of its students is a highly relevant issue for school counselors. According to the American School Counselor Association (ASCA, 2009), school counselors play many roles in supporting students with mental health needs, including providing short-term counseling or crisis intervention, delivering classroom guidance around mental health issues, advocating for mental health services for students, and educating adults in the school and community about these issues. This article focuses on these critical roles and also brings to light the need to screen for students who may be in need of outside mental health services.

The prevalence of mental health issues and suicidal thoughts and actions among school-aged children and adolescents is a serious issue. According to the World Health Organization (WHO, 2004), approximately 20% of youth under the age of 18 years have mental health concerns. Among high school students in the United States, 26.1% of those surveyed reported feeling "sad or hopeless" almost every day for two or more weeks in a row (CDC, 2010). Furthermore, according to the CDC (2010), suicide is the fourth leading cause of death among youth ages 10-24 in the United States, account-

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ing for 12% of all deaths in this age group. In 2009, 13.8% of high school students reported seriously considering suicide in the previous 12 months, while 10.9% of students made a suicide plan, and 6.3% of students attempted suicide (CDC, 2010).

In recognition of alarming statistics such as those above, President George W. Bush tasked the President's New Freedom Commission on Mental Health with the mission of examining the mental health service deliv-

(advance and implement...a national strategy for suicide prevention); 4.1 (promote the mental health of young children); 4.2 (improve and expand school mental health programs); and 4.3 (screen for co-occurring mental and substance use disorders and link with integrated treatment strategies).

The New Freedom Commission is not alone in calling for increased screening for suicide risk and mental health issues. The National Alliance on Mental Illness (NAMI) has is-

that mental health disorders account for as much as 46% of the failure to complete secondary school (Stoep, Weiss, Kuo, Cheney, & Cohen, 2003) is not surprising.

With this perspective, school counselors' steps to improve the mental health of their students is imperative. Indeed, efforts on the part of school counselors to organize, lead, and implement mental health screening and suicide prevention programming in the schools are consistent with many of the School Counselor Competencies put forth by the American School Counselor Association (ASCA, 2007), including:

- I-A-9. (Knowledge of) the continuum of mental health services, including prevention and intervention strategies to enhance student success.
- II-C-1. School counseling is an organized program for every student and not a series of services provided only to students in need.
- III-C-2. School counselors coordinate and facilitate counseling and other services to ensure all students receive the care they need, even though school counselors may not personally provide the care themselves.

In general, efforts to screen students for mental health issues have been proven effective, so long as they are carried out appropriately and accompanied by treatment for those found to be in need of mental health services (Cujipers, van Straten, Smits, & Smit, 2006; Levitt, Saka, Romanelli, & Hoagwood, 2007; Stoep et al., 2005; Weist, Rubin, Moore, Adelsheim, & Wrobel, 2007). Cujipers and colleagues (2006) conducted a meta-analysis using eight studies in which students (ages 7-19) were screened for depression using various self-report measures (or a diagnostic interview in the case of one study) and in which cognitive-behavioral therapy was subsequently provided for participants who demonstrated "high levels of depressive symptomology" (p. 305). The authors found an overall effect size of 0.55 for these interventions,

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ery system in the U.S. and making recommendations to improve the lives of adults and children who are living with issues related to mental and emotional health. After a year spent studying research and testimony, the President's New Freedom Commission (2003) recommended a national strategy for suicide prevention, with expanded mental health programming in the schools and early screening for co-occurring mental health and substance abuse disorders as critical components in the effort to transform the mental health system in the country. In short, the New Freedom Commission called for a system in which suicide prevention efforts are intentional and strategic, and in which mental health screenings are regularly administered in a variety of settings, including "readily accessible, low-stigma settings, such as primary health care facilities and schools" (President's New Freedom Commission on Mental Health, 2003, p. 17). A majority of those who receive mental health services in this country access them during childhood and adolescence through school settings (U.S. Department of Health & Human Services, 1999); therefore, that many of the commission's recommendations can be carried out in schools is not surprising. These recommendations include 1.1

sued a statement supporting the need for early screening and has provided guidelines for implementing screening in a variety of settings where youth are served (NAMI, 2004). The Substance Abuse and Mental Health Services Administration (U.S. Department of Health & Human Services, 2005) and U.S. Department of Justice (2004) have issued similar statements.

The link between social-emotional health and academic success has been clearly established (Guzman et al., 2011; Zins, Bloodworth, Weissberg, & Walberg, 2004). Using a sample of more than 11,000 students in Chile, Guzman et al. (2011) examined the relationship between mental health in first grade (as measured by two separate inventories) and scores on a national standardized academic assessment in fourth grade. Results indicated that students who scored "at risk" on one measure of mental health in first grade scored an average of 14-18 points lower (1/3 *SD*) on the fourth grade achievement test than did their peers who were not at risk. Students found to be at risk on both measures of mental health fared even worse, scoring an average of 33 points lower than students categorized as at risk on only one measure. Considering this powerful link between mental health and academic achievement, the finding

which can be considered moderate to high (Cohen, 1988). Stated another way, the authors found that in a typical school classroom of 31 students, about 1 student could be helped by a screening and intervention program. Considering the high price of allowing depressive disorders to go untreated, most schools would consider the pay-off from a screening and intervention program to be well worth the time, effort, and upfront costs.

SCHOOL-WIDE DEPRESSION SCREENING AND SUICIDE AWARENESS AT MAHTOMEDI HIGH SCHOOL¹

Mahtomedi High School (MHS) serves students from several suburbs of St. Paul, Minnesota. The student population is approximately 1,200 in grades 9-12, and is composed of students who are predominantly White (93.4%), high-achieving (average ACT composite of 25.2 in 2012), and financially stable (7.2% receive free or reduced price lunch). In 2001, the school psychologist and I (first author) began noticing an increase in the number of students who were chronically absent or who frequently visited the nurse's office with ailments we believed were psychosomatic symptoms of depression (e.g., headaches, stomachaches, nausea, fatigue). At the same time, we had also noticed an increase in the number of students being hospitalized for depression and suicide attempts, and we oftentimes knew nothing about their condition until we received a phone call from the hospital or the student's parent with a request for homework. Although we were not

tracking specific numbers with regard to these issues, our perceptions were confirmed by the results of the Minnesota Student Survey (MSS; Minnesota Center for Health Statistics, 2010), which is given every 3 years to ninth- and 12th-graders across the state. According to the 2001 results for MHS, 14% of ninth-graders and 11% of 12th-graders reported feeling discouraged or hopeless (extremely or quite a bit) sometime in the last month; 14% of ninth-graders and 13% of 12th-graders reported having suicidal thoughts over the past year;

deemed to be controversial. Next, we created a short classroom guidance lesson to educate our students about the signs and symptoms of depression and suicide, including suggestions about what they could do if they were concerned about themselves or someone they knew. We then reached out to a community-based agency called SAVE (Suicide Awareness Voices of Education) to arrange for classroom speakers who could talk about their personal struggles with depression and deliver a message of hope, including treatment options for students. Finally,

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and 4% of ninth-graders and 3% of 12th-graders reported having made a suicide attempt. It was clear to us that we needed to act on behalf of our students with mental health issues, and at this time we began planning our depression screening and suicide awareness program in an effort to attack the issue proactively, rather than responding to the many negative outcomes these problems were causing our students with regard to their academic performance.

We began planning our program by researching depression screening instruments appropriate for use with adolescents. We ultimately decided on the Reynolds Adolescent Depression Scale-Second Edition (RADS-2; Reynolds, 2004) due to its length (only 30 questions); high reliability and validity with adolescents (Reynolds, 2004); eighth-grade reading level; and absence of questions which we

we applied for and were awarded a grant through a local foundation and our county public health office to implement the program in the ninth and 10th grades by targeting the students in our school's required Health class. These students were specifically chosen because of the MSS results referenced above, which indicated that the ninth grade was an especially difficult time for students with regard to mental health.

Having been awarded the grant, we were ready to proceed. We decided to use a passive parent permission process whereby parents were informed that we would be administering the RADS-2 in the required Health class to all ninth- and 10th-grade students, but that parents could call or return an enclosed "withdrawal of permission" form if they had questions or did not want their student to participate. After having the language in this form ap-

1. This section of the paper focuses on the depression screening and suicide prevention program at Mahtomedi High School as implemented by the first author. Experiences and recommendations are shared from a first person point of view.

proved by our school district's attorney, we gave it to the Health teacher to send home to parents. Instead of relying on the addresses in our student information system (which are occasionally out of date due to families not reporting a change of address), the Health teacher asked each student to address his or her own envelope in order to ensure that parents received the information. Very few parents pulled their student from the screening or presentation, and those who did generally reported that the student was already being treated for depression, which obviously precluded the need for a screening.

Today, our screenings and classroom presentations look much like they did in 2001. A school counselor or school psychologist is always present in the classroom. We begin by administering the RADS-2, which typically takes about 10 minutes. Next, we deliver

consistently find around 10% of the students screened to be at risk for depression. The parents of these students are contacted and offered a copy of the screening results and contact information for an area mental health agency. This first contact typically comes from a school counselor, as we find that many parents and students have an established relationship with the counselor and perceive this information to be less intimidating coming from a person they know and trust. Parents typically appreciate the help and the connection with school support staff, as well as the insight they gain into their students' personality and academic achievement. In more than 10 years of providing this service, only one parent has been resistant to acting on the information we provided following the screening, and this person was convinced to follow through on seeking outside services after meeting face to face with two of

setting (or a combination of all three), and some also start on medication. Although school personnel are not typically involved in treatment, we do follow the ASCA Ethical Standards for School Counselors (ASCA, 2010) as it relates to seeking out a signed release of information in order to coordinate services and enable us to support and check in with the student at school (A.5.c).

According to the results of the MSS (Minnesota Center for Health Statistics, 2010), from 2001 to 2010, MHS experienced a decrease in the percentage of students reporting depression in ninth grade (14% down to 12%) and 12th grade (11% to 5%), and in the percentage of students making a suicide attempt in 9th grade (4% to 1%) and 12th grade (3% to 2%). Furthermore, the feedback from school counselors, support staff, students, and parents has contributed to our belief that the screening and awareness program has been a success. First and foremost, our school counselors have reported an increase in the number of students who seek help or refer friends for issues related to mental health. The comments from students on evaluations following the presentation have been overwhelmingly positive, and have included students openly telling us in front of their peers that we may have saved their life. Mirroring the results of the MSS, we have seen a noticeable decrease in suicide attempts and hospitalizations, and our school has not experienced a completed suicide since this program was implemented in 2001. Unfortunately, this has not been the case at neighboring school districts, a few of which have implemented similar screening programs after experiencing multiple suicides among their student bodies.

To revisit the opening paragraph of this article, when one considers the nationwide prevalence of suicide attempts (6.3%; CDC, 2010) and completions (roughly 1 for every 100-200 attempts; CDC, 2009) among adolescents, a school of about 1,000 students would expect to deal with the tragic death of a student due to

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a presentation that covers the warning signs and symptoms of depression and suicide, and that stresses the importance of students seeking help and referring friends about whom they are worried. Frequently, these lessons include the chance to role play such situations. Following the lesson, we ask students to rate the session on a survey, and the counselors and counseling interns quickly go to work scoring the RADS-2 instruments.

Impact of Depression Screening Program

Since the program was implemented in 2001, approximately 4,650 MHS students have been screened for depression and received the lesson on mental health and suicide awareness. We

our school counselors.

We are fortunate that families in our community have access to a wide array of mental health providers, many of whom charge on a sliding scale. In addition, our town has a free medical clinic that can be utilized for mental health services should all other options fail. Due to the availability of affordable services, we find that most of the families we refer as a result of the screening are able to arrange for the help their students need. Some students are formally diagnosed by a medical doctor or outside mental health provider, and treatment options are worked out among the parent, student, and medical provider. Many of the referred students enter therapy in an individual, group, or family

suicide at least every 2 to 3 years. While we cannot attribute the absence of a suicide at MHS directly to our prevention and screening program, we are confident that, at the very least, we are making a difference in the lives of students with mental health issues.

Implications for School Counselors

The following are a few practical recommendations for those interested in beginning a similar program. First and foremost, individual school counselors should proceed with caution in implementing a depression screening program. Even the authors of studies that lend support to screening programs frequently point out possible negative consequences associated with screening, such as the risk of false positives or false negatives, the possible stigmatization of those found to be in need of services, the overall cost-effectiveness of such programs, the availability of reliable and valid instruments for use among children and adolescents, and the risk that a school may not have the resources to deal effectively with every student found to be at-risk (Cuijpers et al., 2006; Levitt, Saka, Romanelli, & Hoagwood, 2007; Stoep et al., 2005; Weist et al., 2007). As such, it is critical that school counselors interested in implementing a program like the one at MHS take time to carefully consider the availability of time, resources, and response personnel in their particular school communities, as well as the suggestions of those who have studied the issue and made recommendations for implementing such programs (see Joe & Bryant, 2007; Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007; Stoep et al., 2005; Weist et al., 2007). We also recommend that counselors carry liability insurance (such as that offered through membership in ASCA) in case they end up in a difficult situation.

Another recommendation is to explore a variety of programs and screening tools, paying particular attention to the types of parent permission (i.e., active vs. passive) allowed under the rules of the program or instrument. As described above, the

program at MHS uses the RADS-2 (Reynolds, 2004) screening instrument and a self-developed classroom guidance lesson, but many formalized programs exist for screening students for suicide risk and mental health disorders. Signs of Suicide (Aseltine & DeMartino, 2004) and TeenScreen (Columbia University, 2003) have shown positive results at detecting suicide risk in high school students (Aseltine & DeMartino, 2004; Brown & Goldstein Grumet, 2009; Scott et al., 2008; Shaffer et al., 2004). Another program that is well re-

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searched and includes staff training is the Lifelines program (Underwood & Kalafat, 2009) marketed by Hazelden. Stoep et al. (2005) also described a system called the Developmental Pathways Screening Program (DPSP), which was used to offer sixth-graders the opportunity to be screened for emotional distress. Finally, although SAVE has recently stopped coordinating the volunteer speaker program in schools, they do still sell a classroom curriculum which includes materials similar to those provided through the organization in the past.

School counselors are encouraged to collect, track, and report data related to any screening or prevention program they implement. Data such as attendance, referrals to school support staff for mental health concerns, suicide attempts, hospitalizations for mental health issues, and student feedback given on post-intervention evaluations can all be useful in demonstrating the effectiveness of a school's program.

School counselors also should explore a variety of options for funding such a program, including grants offered by state and local education agencies or businesses, partnerships with community mental health agencies, and reallocation of funds through

the local school board. At MHS, we are fortunate to have received ongoing financial support from a variety of sources following the initial year in which we were funded by the grant mentioned above. The largest source of funding for our project comes from our local Mahtomedi Area Education Foundation (MAEF). This organization works to raise money for our screening program every year, and they also coordinate the distribution of "Oliver's Fund," which was started by the parents of a 2002 graduate of our high school named Oliver Zlonis, who

tragically took his life while attending college in Oregon. Oliver was being treated for depression while in high school, but the extent of the follow-up support he received in college is unknown. His parents graciously started the fund in his memory, and its proceeds are now specifically distributed each October for the purpose of providing the depression and suicide education/prevention program, as well as related projects throughout the school district (see <http://maefgives.org/>).

CONCLUSION

Since the project began at MHS in 2001, we have never skipped a year of screening or presentations in the Health classes, and we still find this to be some of the most meaningful work we do all year. We feel lucky to have supportive administrators who understand these issues and support our staff in continuing this work. Our community cares about their young people and allows them to receive education on this difficult topic. As a result of the screening, education, and student reports of problematic behavior that come out of these lessons, referrals to our school counseling

office have increased, and we feel that we have positively impacted school safety and climate. We also maintain that this work is connected to bullying prevention and response because students who are bullied are at a higher risk for suicide.

Our hope for the future is that all secondary schools would answer the call of the President's New Freedom Commission on Mental Health (2003) and provide screenings for depression in a manner similar to the way elementary school students are screened for problems with vision, hearing, reading, writing, and speech. As trained mental health professionals, school counselors are uniquely positioned to impact the well-being of students who are struggling with mental health issues. Although ASCA does not recommend that counselors provide long-term therapy for students (ASCA, 2009), the organization does state that counselors can impact student mental health through crisis interventions, referrals, advocacy, outreach, classroom guidance, and screening. Depression is treatable and suicide is preventable, but early recognition and intervention are vital. We also hope that counselor educators and practicing school counselors across the nation will continue devoting time, energy, and resources to the study and prevention of issues related to adolescent mental health. This is one of the many ways we can make a difference in the lives of our students. ■

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