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Depression Intervention Programs in Low-Income High Schools

Gopika Hari
Virginia Commonwealth University

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INTRODUCTION

As mental health is cast into the public health spotlight, an increasing number of clinicians have developed an interest in understanding depression. Depressive disorders on the DSM-5 vary greatly, and are measured on a spectrum of severity using various diagnostic tools. Since many adult psychiatric illnesses have roots in adolescent mental health, the increasing incidence rate of depression in adolescents is concerning. Low-income communities are also at increased risk – the Population Attributable Risk of depression in regards to parental income is now at 26%. Currently however, consolidated guidelines on addressing low-income adolescent depression have yet to be established.

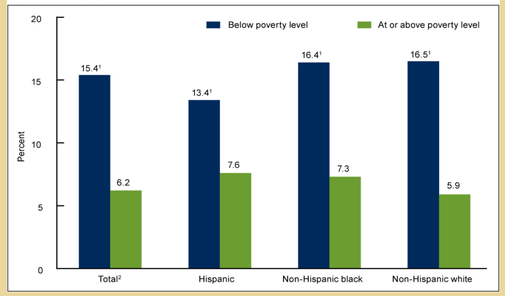
2,000,000
Adolescents had a depressive episode last year

$83 Billion
The economic burden of depression in the US every year

2x
The likelihood of developing mental health complications as a consequence of being socioeconomically disadvantaged

0-27
Scoring range for the PHQ-A diagnostic tool, with 0 being "None" to 27 being "Severe"

Figure 3. Percentage of persons aged 12 and over with depression, by poverty status and race and Hispanic origin: United States, 2009–2012



OBJECTIVES

This study had two main objectives:

1) To understand whether or not current literature suggests a need for low-income-specific adolescent depression intervention programs.
2) To establish guidelines on depression intervention protocols specific to this target population with the goal of ensuring maximum mental health services to those most in need.

METHODS

A compilation of expert opinions on depression screening, education, and treatment, as well as analysis of previously implemented school screening and/or awareness programs, was examined in order to understand key strategies. In addition to past school-based mental health programs, literature from sources such as the US Preventative Services Task Forces and California Department of Public Health was consulted.

RESULTS

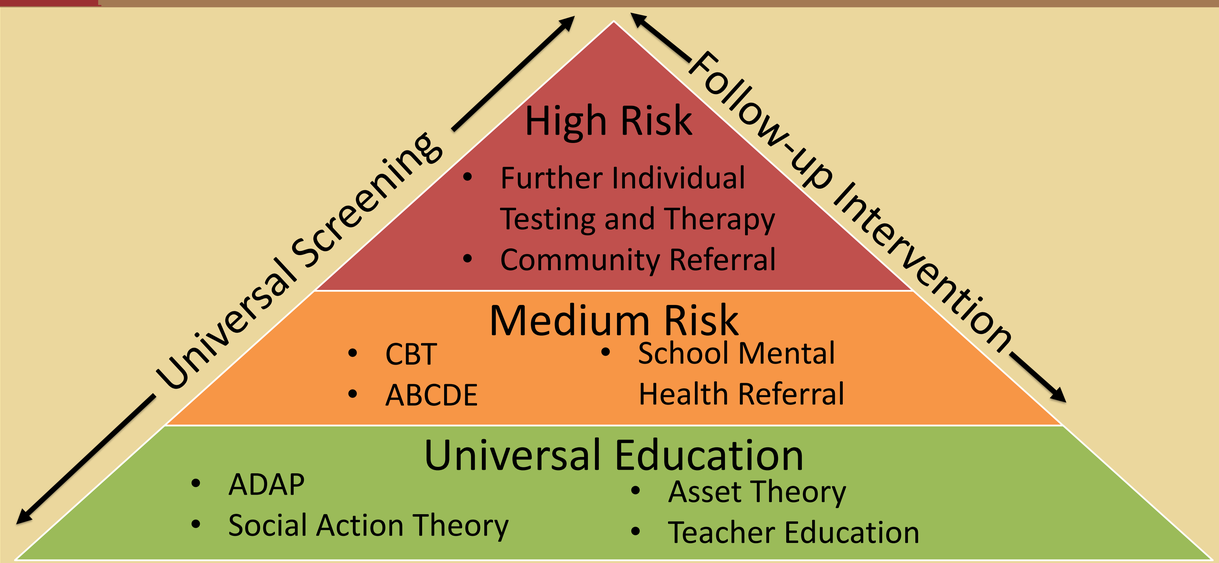
Finding #1 — Empirical and Theoretical Evidence for School-Based Depression Intervention

Inadequate Current Resources: Currently, less than 25% of children with mental health needs receive adequate care. While community mental health centers exist, they are often not well integrated and youth miss out on key clinical opportunities. Likewise, a general practitioner's office is generally ineffective in providing resources – not only do those who are low-income access healthcare less, those who do only get screened 0.2% of the time.

Schools as a Medium: Providing adequate care requires a program well-integrated with the lifestyle socioeconomically disadvantaged adolescents specifically. 80% of mental health care has been found to come from schools. Schools provide the perfect environment in which to connect mental health wellbeing to students' academic achievement and sociobehavioral functioning.

Public Health Considerations: In order to provide long term public health results for this population, resources need to be provided to those most in need while also integrating the larger population with awareness programs. Depression intervention must be seen on a spectrum from prevention to treatment – simply screening for the disease is not enough. Several studies have pointed to the importance of a multitier approach involving screening, education, and follow-up treatment.

Figure #1 — Multi-Tier School-Based Depression Intervention Model



Finding #2 — Establishing Universal Screening Protocol and Mental Health Education

Screening: A PHQ-A test, modified to include questions about suicidal ideation, is ideal due to its cost-efficiency, efficacy, and direct link to DSM-5 guidelines. In order to strengthen the mental health environment within schools, the tests are best carried out by school psychologists & trained staff.

Screenings should be carried out with careful planning of protocol, including ensuring student privacy and providing transparent information about post-screen results. Initial screening should be followed shortly by results in order to then conduct clinical interviews and rapid interventions for those deemed as "Medium Risk" and "High Risk."

Universal Education: Screening without additional awareness programs has been noted as ineffective in lowering depression rates. Providing depression education allows for students to understand how to confront mental illnesses, access resources, and change the school environment as a whole. A feasible curriculum would consist of:

Adolescent Depression Awareness Program: 3-hr curriculum with pre- and post-tests focused on diagnosis, suicidal ideation, and help-seeking.

Social Action Theory: Teaches low-income students about mental health empowerment and building social capital.

Asset Theory: Curriculum focused on improving adolescents' mental health functioning, educational and financial goal-setting, and behavioral change.

Teacher Awareness: Studies have noted the importance of educating teachers on promoting positive behavior in the classroom and recognizing early warning signs of mental health disorders.

Finding #3 — Medium/High-Risk Intervention and Follow-Up

Following screening, clinical interviews would be held for those who self-identify as help-seeking and for those with high scores on the diagnostic tests. Follow-up intervention should then follow a triage model, in which the extent of treatment and resources is based on severity of depression.

Resources such as group psychotherapy is then available for medium- and high- risk students. This includes Cognitive-Behavioral Therapy (CBT), which focuses on directing one's feelings, thoughts, and behaviors toward positive change and ABCDE, which focuses on combating negative schemata. Along with referrals to school mental health services, both therapies have been shown to decrease depression rates.

For the highest-risk group, further individualized screening and therapy (Person-Centered Planning, one-on-one mentoring, crisis planning) is suggested. Additionally, referrals to community health centers (as opposed to school resources) should be available. This allows students most at risk to receive adequate care suited to individual needs.

Research has noted that use of SSRIs (Selective Serotonin Reuptake Inhibitors) is associated with increased suicidal ideation in adolescents. Thus, school interventions should focus solely on psychotherapy, allowing larger community mental health centers to determine need for antidepressants for individual students.

CONCLUSIONS

Low-Income adolescents are in fact in need of depression screening and follow-up services; schools provide an optimal environment to implement such programs.

A multi-tier intervention should begin with a modified PHQ-A screening from school psychologists.

Universal depression education and self-help curriculum should be available for all students and teachers.

Students screened positively for depression or suicidality should receive high-risk protocols, ranging from group Cognitive-Behavioral Therapy to facilitated mental health center referrals based on individual severity.

FURTHER STUDIES

Before programs are fully implemented, further research should be conducted on understanding:

- Mental health funding of low-income schools
- Differences in receptiveness of low-income rural and urban mental health centers
- Strategies for increased engagement with parents or caretakers
- Financially-feasible community-wide elimination of stigma

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