A Center Policy Issues Analysis Brief

Screening Mental Health Problems in Schools

Long-standing policy controversies have heated up as a result of increasing proposals for using schools to screen for mental health problems (e.g., depression screening).

This brief highlights the following issues:

- How appropriate is large-scale screening for mental health problems?
- Will the costs of large-scale mental health screening programs outweigh the benefits?
- Are schools an appropriate venue for large-scale screening of mental health problems?

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Issue: *Screening Mental Health Problems in Schools*

New federal initiatives seek to increase the scope of mental health screening. The emphasis is on identification of those with mental health problems and those at risk for such problems. A major focus is on depression and suicidality. The intent is to find and treat as many problems as possible before they become severe and to reduce the numbers diagnosed with a mental illness. For a variety of reasons, schools are a prominently mentioned venue for large-scale screening programs.

Few argue against the *intent* of efforts to find, treat, and prevent. Issues arise related to the appropriateness of large-scale screening for mental health problems, whether the costs of such large-scale screening outweigh the benefits, and about whether schools are an appropriate venue for such programs. Embedded in these issues are arguments about rights to privacy and informed consent, how good first-level mental health screens are, how likely good follow-up assessments will be used to identify errors, how available treatment will be for most who are identified, how negative the consequences will be with respect to stigmatization and self-fulfilling prophecies, and the role of schools related to public health concerns.

Examples of what one hears:

Screening is essential to improving how we respond to mental health problems.

Large-scale screening identifies too many kids as having a mental illness who do not.

Schools make it possible to screen a lot of kids quickly and at less cost than community programs.

Once begun, large-scale screening at schools will end up as a mandated requirement for all students.

It is irresponsible, unethical, and immoral not to find and help students who are experiencing mental health problems.

Mental health screening infringes on the rights of families, over-identifies some subgroups in the student population, and results in self-fulfilling prophecies.

Based on the research evidence to date, there is a great deal more research that must be done before policy makers should invest in the enterprise of large-scale screening for suicidality and clinical depression among children and adolescents.

There is not enough available and accessible treatment for most students currently referred for mental health treatment.

Positions:

- Advocates for large-scale MH screening in schools see major benefits to individuals and society of finding many more students with problems in order to treat them before the problems become severe. In citing benefits for screening children and adolescents, the assumption is that those identified will receive effective treatments. Based on this assumption, key benefits claimed are preventing problems from becoming worse and enhancing student success at school, which generates other benefits for students, their families, and their teachers and for the society in terms of future productivity and which reduces costs because there is less need for intensive treatments and special education.

  In citing benefits for using schools as a venue for public health programs, as compared to other community venues, matters of ready access and reduced costs are stressed, as well as the benefits to schools of having students with problems treated.

- Those who oppose large-scale screening raise a host of concerns (i.e., potential costs). For some, there is a fundamental fear that society will mandate such screening and thereby interfere with what should remain a personal family matter and will violate rights to privacy, consent, and parental control. Others are concerned that screening will increase referrals for nonexistent treatment resources and that the dollars budgeted for screening will reduce the dollars allocated for treatment. Still others point to the evidence that available screening methods used in schools produce too many errors (e.g., false positive identifications, inappropriate over-identification of subgroups such as some ethnic groups and boys with externalizing problems and girls with internalizing problems). Relatedly, they argue there will be insufficient follow-up assessment resources to correct for false positive identifications. And, some argue there are significant costs resulting from self-fulfilling prophecies and stigmatization.

  In arguing against using schools, there is the social philosophical argument that mental health is one of those matters that should remain a domain for family, not school, intervention. More pragmatically, it is argued that scarce school time and resources should not be used for matters not directly related to teaching. Others point to the lack of enough competent school personnel to plan, implement, and evaluate large-scale screening.

Examples of documents covering the issues:

(a) Discussions that Explore Both Sides

>>*Screening Aimed at Preventing Youth Suicide* (2005)
by Ellie Ashford for the National School Board Association's School Board News
http://www.nsba.org/site/print.asp?TRACKID=&VID=55&ACTION=PRINT&CID=682&DID=36189

Provides a quick overview for school boards of some of the controversies and places them in the context of current events.

>>*Screening for Depression: Recommendations and Rationale* (2002)
by U.S. Preventive Services Task Force for Agency for Healthcare Research and Quality
http://www.ahrq.gov/clinic/3rduspstf/depressrr.htm

and

>>*Screening for Suicide Risk: Recommendation and Rationale* (2004)
by U.S. Preventive Services Task Force for Agency for Healthcare Research and Quality
http://www.ahrq.gov/clinic/3rduspstf/suicide/suiciderr.htm

These two reviews summarize the Task Force's recommendations on screening for depression and suicide risk and the supporting scientific evidence. With respect to depression screening of children and adolescents, they recognize the evidence on the accuracy and reliability of screening tests is insufficient to recommend for or against routine screening of children or adolescents .... The benefit of routinely screening children and adolescents for depression are not known .... The predictive value of positive screening tests is lower in children and adolescents than in adults...."

With respect to screening for suicide risk, the USPSTF found "no evidence that such screening reduces suicide attempts or mortality ... limited evidence on the accuracy of screening tools to identify suicide risk in the primary care setting, including tools to identify those at high risk ... insufficient evidence that treatment of those at high risk reduces suicide attempts or mortality ... no studies that directly address the harms of screening and treatment for suicide risk. As a result, the USPSTF could not determine the balance of benefits and harms of screening for suicide risk in the primary care setting."

Further, they note: “The potential harms of screening include false-positive screening results, the inconvenience of further diagnostic work-up, the adverse effects and costs of treatment for patients who are incorrectly identified as being depressed, and potential adverse effects of labeling. None of the research reviewed provided useful empirical data regarding these potential adverse effects.”

>>*Youth Suicide Risk and Prevention Interventions: A Review of the Past 10 years* (2003)
Journal of the American Academy of Child & Adolescent Psychiatry, 42(4): 386-405.

With specific reference to the likelihood that school-based MH screening will balance Type I and Type II errors in favor of false positives, this review states: "The few studies that have examined the efficacy of school-based screening (Reynolds, 1991; Shaffer and Craft, 1999; Thompson and Eggert, 1999) found that the sensitivity of the screens ranged from 83% to 100%, while the specificities ranged from 51 % to 76%. Thus, while there are few false negatives, there were many false-positives .....

>>*Screening and Assessing Adolescents for Substance Use Disorders*
Treatment Improvement Protocol (TIP) Series 31
from SAMHSA’s Center for Substance Abuse Treatment
http://www.health.org/govpubs/bkd306/

Outlines many of the concerns related to screening substance abuse. Most of what is discussed relates to issues raised with respect to depression and suicide prevention screening (e.g., when to screen, when to assess, how to involve the family, legal issues of screening, including confidentiality, duty to warn, and how to communicate with other agencies, etc.).

>>*Assessment of Suicidal Behaviors and Risk Among Children and Adolescents* (2000)
by David B. Goldston, Ph.D., Wake Forest University School of Medicine
Technical report submitted to NIMH under Contract No. 263-MD-909995.
http://www.nimh.nih.gov/suicideresearch/measures.pdf

This major review helps to understand the state of the art related to instruments used for large-scale screening. See the summary and recommendations (pp. 198-201). Among his conclusions: " ... as part of the validation procedures for measures of suicidal behavior, it is common to demonstrate that the suicidal behavior instrument correlates in a predicted way with other related constructs such as depression and hopelessness (convergent validity). However, there has been insufficient attention paid to discriminate validity, or the degree to which suicidal behavior does not correlate with constructs with which it should not. There also has been insufficient attention paid to issues of incremental validity, or the degree to which a test provides information not available elsewhere. "...studying the clinical characteristics of juvenile suicidal attempts has not been a particularly fruitful exercise to date. Empirical data about the clinical characteristics of suicidal attempts have not been shown to be related to course or response in therapy, have not been used to demonstrate that certain types of therapy are any more or less effective with specific suicidal behaviors, and have not been found to be related to future behavior. Beyond simply using instruments that assess clinical characteristics of suicidal attempts for descriptive purposes, there is a need to better understand the significance of those clinical characteristics." ...."Unfortunately, there are a limited number of prospective studies which have identified risk factors with predictive utility that might be candidates for potential intervention (it makes sense to intervene with variables that portend later risk, rather than current or past risk). There are even fewer studies in which assessment measures have been administered on multiple occasions and which might yield data on the effects of repeated test administrations. And it almost goes without saying that there is a paucity of controlled intervention studies with suicidal youths - studies which might yield clues about the usefulness of different measures related to suicidality."

(b) For and Against One Side or the Other

>>*President's New Freedom Commission on Mental Health: Recommendations for Screening and Treating Children and Subsequent FY2005 Appropriations* (2004)
by C. S. Redhead, Domestic Social Policy Division and F. Larkins, Information Research Division, Congressional Research Service
http://www.psych.org/downloads/CRSMemoOnScreening.pdf

The New Freedom Commission makes clear its position on screening minors. With special emphasis on early detection as one of the goals of the newly "transformed mental health system," they offer short discussions on segments of the recommendations' language that emphasize the centrality of parental notification and confidentiality for appropriate treatment delivery.

>>*Should we screen for depression? Caveats and potential pitfalls* (2000)
by J.C. Coyne, et al.
Applied & Preventive Psychology, 9, 101-121.

While recognizing the value of screening in many instances, this analysis reviews why screening cannot serve as an efficient basis for preventing depression.

>>*Action Alert: Mental-health screening of children* (2004)
by the Liberty Committee
http://www.thelibertycommittee.org/update09.07.04.htm

This political action group adamantly argues against mandatory mental health screening of children stating that it is another violation of parental rights (and a means for pharmaceutical companies to make a profit at the cost of children).

>>*State Trends: Legislation Prohibits Mental Health Screening for Children* (2005)
http://www.nmha.org/shcr/issuebrief/childrenScreening.cfm

and

>>*Threats to Early Intervention and Prevention for Youth in Schools*
by the National Mental Health Association
http://www.nmha.org/shcr/issuebrief/childrenScreeningTalkingPoints.cfm

These documents from the National Mental Health Association (NMHA) raise concerns about legislation designed to prohibit MH screening of children and argue that screening is as essential to early intervention and prevention.

>>*Challenges to Providing Mental Health Services for Hispanic Non-English Speakers* (2005) – A Policy Brief
by the Hispanic Federation
http://www.hispanicfederation.org/res/Pub%20download/Punto%20de%20Vista%20Mental%20Health.pdf

This brief highlights the urgent need to provide culturally competent mental health services to the Latino/Hispanic population. While not focused specifically on screening and schools, it underscores additional issues relevant to policy related to the mental health screening of students (e.g., concerns about communication related to informed consent, cultural appropriateness of screening instruments and their interpretation, lack of services for such populations when they are identified).

>>*Cross assessment of a school-based mental health screening and treatment program in New York City*. (2004) by P. Chatterji, et al.,
Mental Health Services Research, 6, 155-166.

Report estimates the cost of a school-based mental health screening and treatment program located in a middle school in a low-income, largely Hispanic neighborhood in New York City,

aimed to screen all students in Grades 6-8 for anxiety, depression, and substance use disorders. The cost of the screening program ranged from $149 to $234 per student and the cost of the treatment program ranged from $90 to $115 per session. The total cost ranged from $106,125 to $172,018 for the screening program and from $420,077 to $468,320 for the treatment program.

Summary of Key Issues

Arguments for Screening

- Finding many more problems in order to treat them before they become severe
- Preventing problems from becoming worse
- Reducing costs because of less need for intensive treatments and special education
- Enhancing student success at school and related benefits for students, families, teachers, society
- While not perfect, current screening procedures are good enough

Pro Arguments for Schools as Venue

- Schools provide ready access and reduce costs
- Schools are a direct beneficiary because screening and effective treatment enhances student success at school

Arguments Against Screening

- Fear that society will mandate such screening and thereby interfere with what should remain a personal family matter
- Potential violations of rights to privacy, consent, and parental control
- There are insufficient treatment resources to handle increased referrals
- Available screening methods for use in schools produce too many errors (e.g., false positive identifications, inappropriate over-identification of subgroups of students)
- There is a lack of sufficient follow-up assessment resources to correct errors
- Large-scale screening is too costly
- The dollars budgeted for screening will reduce the dollars allocated for treatment.
- Problems will be worsened through self-fulfilling prophecies and stigmatization

Con Arguments Against Schools as Venue

- MH is one of those matters that should remain a domain for family, not school, intervention.
- Scarce school time/resources will be used for matters not directly related to teaching
- There are not enough competent school personnel to plan, implement, and evaluate large-scale screening

For a sampling of resources related to the topics covered in this brief, see the Center's Online Clearinghouse Quick Finds – http://smhp.psych.ucla.edu/