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Readiness Assessment as a D&I Strategy

Informing Universal Depression Screening Implementation in Schools

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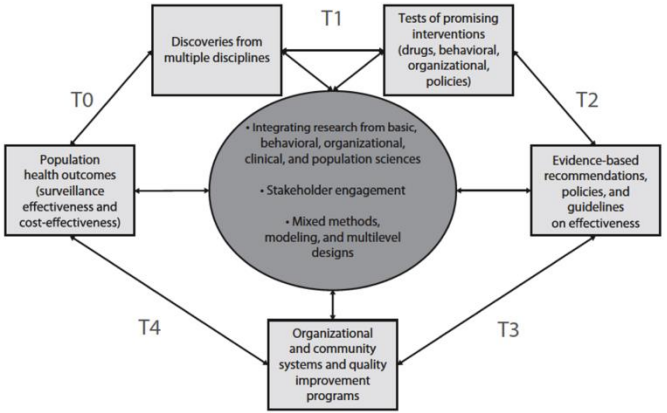
Conceptual Framing

- Policy implementation is complex and dynamic
- Ambiguity is intrinsic to the policy implementation process

- **Pre-implementation readiness assessments** systematically capture stakeholder perceptions, capacity, anticipated barriers, and needed supports before policy implementation.



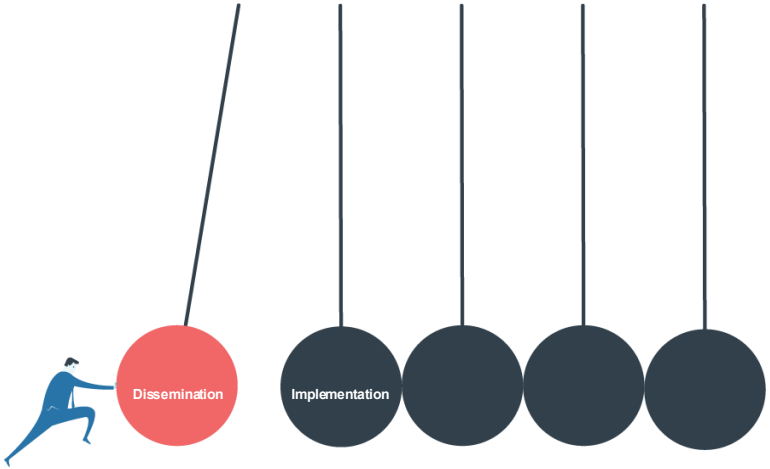
Glasgow, R. E., Vinson, C., Chambers, D., Khoury, M. J., Kaplan, R. M., & Hunter, C. (2012). National Institutes of Health approaches to dissemination and implementation science: current and future directions. American journal of public health, 102(7), 1274-1281.

(Sekhar et al., 2021)

Context: Universal Adolescent Depression Screening in NJ

US Preventive Services Task Force recommends universal depression screening for ages 12-18, yet rates remain low with persistent inequities.

NJ POLICY: P.L. 2021, C. 237: Established Mental Health Screening in Schools Grant Program to support voluntary implementation of universal annual depression screening for grades 7-12.



Can research and evidence support implementation?

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Research Use in Policy Implementation

- Research evidence is valuable to the extent it decreases decisionmakers' ambiguity regarding one or more aspects or domains of policy implementation.
- Research has greater influence in policy implementation when it is shared by credible, reputable, and/or non-partisan actors (intermediaries) with a direct stake at implementation.
- There are two critical windows for research and other inputs to influence policy implementation:
  - Final phase of legislation (amendments).
  - Start of the implementation planning process (bureaucracy).

Project ASPEN

- Funded by a grant from the William T. Grant Foundation.
- A collaboration between a team of D&I researchers at Rutgers and NAMI NJ to produce and provide state policymakers with relevant and timely research evidence regarding barriers and facilitators to implementation of policies to institute universal screening for adolescent depression in NJ schools.
- Specific focus of research activities on documenting, analyzing, and synthesizing evidence regarding the views, concerns, and anticipated needs of implementation stakeholders – the most ambiguous aspect of implementing this policy statewide.

Stakeholders & Methodology

Key-informant interviews and a survey of school professionals to assess schools' implementation readiness:

1. Perceived prevalence of adolescent depression
2. Current screening practices
3. Acceptability, feasibility, anticipated barriers
4. Policy/system supports needed for adoption

Taking place in concert with content analysis of legislative hearings, reports, and news stories as well as state and national parent surveys.

Quantitative

Statewide Survey

N = 70 school-based mental health professionals (75% school psychologists, 15% school social workers, 10% counselors/CST members)

Qualitative

Key Informant Interviews

N = 15 school stakeholders (mix of administrators, educators, and school-based mental health professionals)

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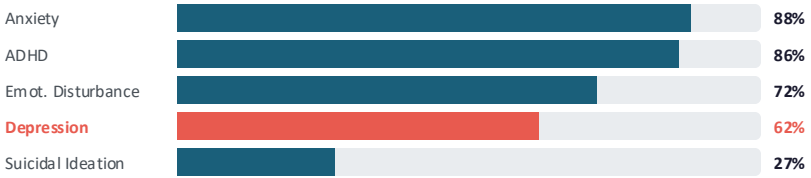
Prevalence vs. Current Practice

62% report depression as common/very common in their schools:



<5%

report routine depression screening for grades 7-12

QUALITATIVE CONTEXT

All 15 informants described MH concerns as increasing; 12/15 specifically identified depression as growing. Noted underreporting among Black and low-income students due to stigma and help-seeking barriers.

QUALITATIVE CONTEXT

Current efforts are typically informal/reactive. Students are referred only after concerns raised by staff, parents, or peers. Existing resources target suicidality, not. Among those with practices, <50% had formal training.

Clear gap between perceived need and formalized practice.
Infrastructure, not awareness, is the barrier.

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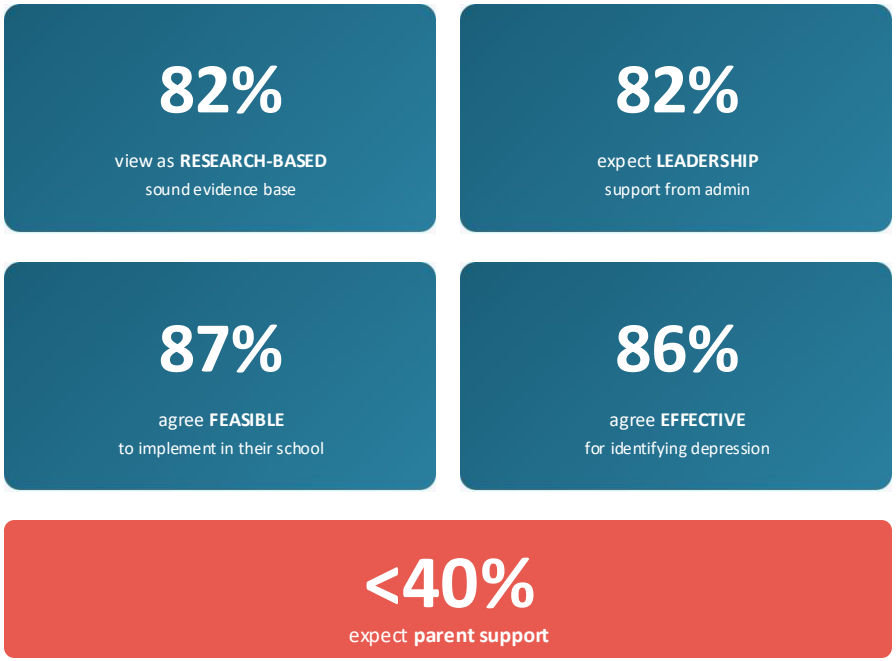
Perceptions of Universal Screening

Broad endorsement across Forman et al. (2012) constructs (acceptability, feasibility, and perceived evidence base).

Practitioners anticipate parent resistance as a major barrier. This highlights the need for proactive parent engagement as an implementation strategy.



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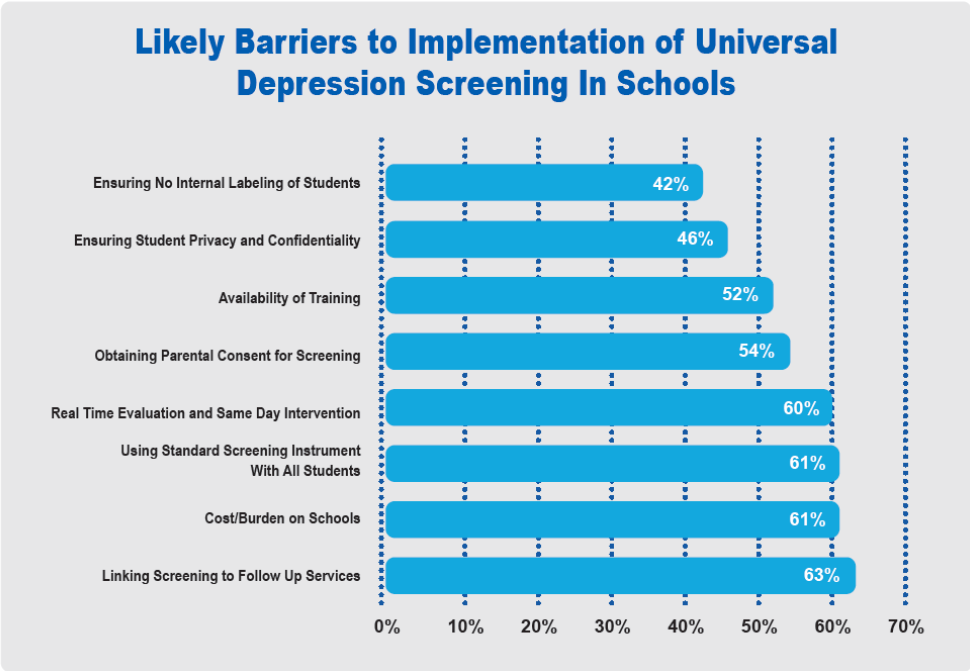
Anticipated Implementation Barriers

Top barriers again relate to capacity and infrastructure.

COM Model for Behavior Change

QUALITATIVE CONTEXT

Without clear guidance and dedicated funding, schools will struggle to implement consistently and effectively, particularly under-resourced districts.



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Supports Needed

Explicit Procedural Guidance

Clear protocols for screening logistics, timing, administration procedures, and handling results

Role & Liability Clarity

Defined responsibilities and legal frameworks for schools following positive screens

Dedicated Funding

Resources for staffing, administration, follow-up services, and ongoing program support

Staff Training

Professional development on instrument administration, scoring, and response protocols

Workforce Expansion

Additional mental health personnel to handle increased demand from universal screening

Parent Engagement Strategy

Proactive communication and consent processes addressing anticipated concerns

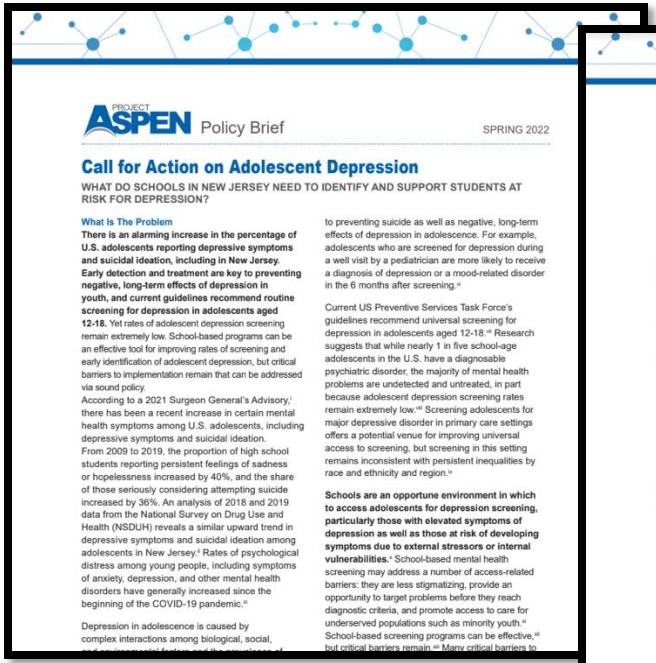
From Findings to Recommendations

- High acceptance, low infrastructure/capacity
  - Pair mandates with protocols and dedicated resources
- Anticipated parent hesitance (<40% support)
  - Develop proactive communications to address concerns
- Follow-up capacity as the top barrier
  - Fund workforce expansion and training prior to implementation

This readiness assessment *is* proactive D&I research

enabling resource planning and stakeholder engagement before barriers emerge, rather than reactive troubleshooting post-implementation

Policy Implementation-Relevant Research



PROJECT ASPEN Policy Brief SPRING 2022

Call for Action on Adolescent Depression

WHAT DO SCHOOLS IN NEW JERSEY NEED TO IDENTIFY AND SUPPORT STUDENTS AT RISK FOR DEPRESSION?

What Is The Problem

There is an alarming increase in the percentage of U.S. adolescents reporting depressive symptoms and suicidal ideation, including in New Jersey. Early detection and treatment are key to preventing negative, long-term effects of depression in youth, and current guidelines recommend routine screening for depression in adolescents aged 12-18. Yet rates of adolescent depression screening remain extremely low. School-based programs can be an effective tool for improving rates of screening and early identification of adolescent depression, but critical barriers to implementation remain that can be addressed via sound policy.

According to a 2021 Surgeon General's Advisory,[1] there has been a recent increase in certain mental health symptoms among U.S. adolescents, including depressive symptoms and suicidal ideation. From 2009 to 2019, the proportion of high school students reporting persistent feelings of sadness or hopelessness increased by 40%, and the share of those seriously considering attempting suicide increased by 36%. An analysis of 2018 and 2019 data from the National Survey on Drug Use and Health (NSDUH) reveals a similar upward trend in depressive symptoms and suicidal ideation among adolescents in New Jersey.[2] Rates of psychological distress among young people, including symptoms of anxiety, depression, and other mental health disorders have generally increased since the beginning of the COVID-19 pandemic.[3]

Depression in adolescence is caused by complex interactions among biological, social,

to preventing suicide as well as negative, long-term effects of depression in adolescence. For example, adolescents who are screened for depression during a well visit by a pediatrician are more likely to receive a diagnosis of depression or a mood-related disorder in the 6 months after screening.[4]

Current US Preventive Services Task Force's guidelines recommend universal screening for depression in adolescents aged 12-18.[4] Research suggests that while nearly 1 in five school-age adolescents in the U.S. have a diagnosable psychiatric disorder, the majority of mental health problems are undetected and untreated, in part because adolescent depression screening rates remain extremely low.[4][5] Screening adolescents for major depressive disorder in primary care settings offers a potential venue for improving universal access to screening, but screening in this setting remains inconsistent with persistent inequalities by race and ethnicity and region.[6]

Schools are an opportune environment in which to access adolescents for depression screening, particularly those with elevated symptoms of depression as well as those at risk of developing symptoms due to external stressors or internal vulnerabilities.[4] School-based mental health screening may address a number of access-related barriers: they are less stigmatizing, provide an opportunity to target problems before they reach diagnostic criteria, and promote access to care for underserved populations such as minority youth.[4] School-based screening programs can be effective,[4] but critical barriers remain.[4] Many critical barriers to

PROJECT ASPEN Policy Brief SPRING 2022

Adolescent Depression Screening

EXPLORING BARRIERS AND FACILITATORS OF IMPLEMENTATION IN SCHOOL SETTINGS

Prevention and early detection of adolescent depression is a national health priority. Current guidelines recommend routine screening for depression in children and adolescents and subsequently linking those in need to additional evaluation and care. Early detection through school-based screening has considerable potential to identify at-risk adolescents for referral to effective therapeutic services but significant barriers stand in the way of widespread implementation and sustainment. Thus, successful implementation of adolescent depression screening in a school-based setting should prioritize: (1) establishing positive attitudes toward mental health and depression; (2) securing sufficient financial and human resources; and (3) tailoring screening systems to account for individual school context.

Rates of depression spike dramatically during adolescence. Despite broad scientific consensus that early detection and treatment are key to preventing negative, long-term effects of adolescent depression, current screening rates among this population remain extremely low. A broad review of key barriers and facilitators to school-based depression screening was conducted with the goal of informing policy and practice. This paper details key findings and recommendations from the review.

What We Know About Adolescent Depression Screening In Schools

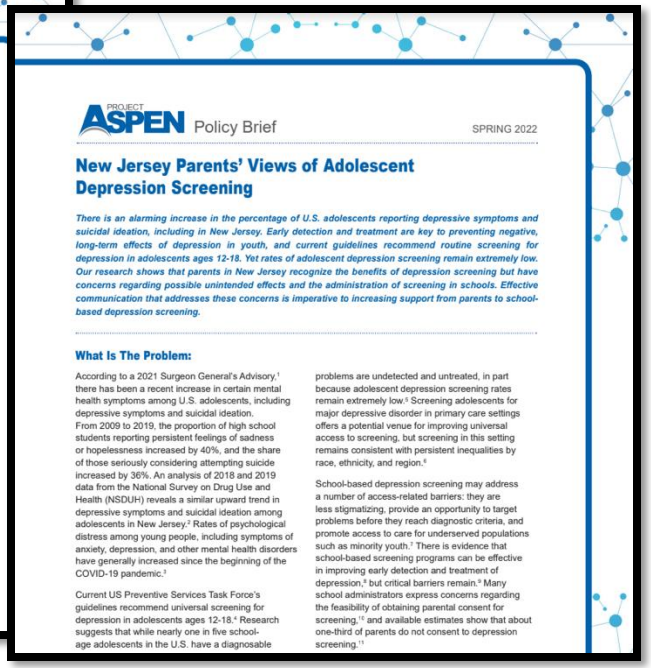
Adolescent Depression

Nationally, 15.7% of youth (ages 12-17) reported suffering at least one major depressive episode in the past year. Rates of depression spike dramatically during adolescence and is associated with a number of adverse outcomes, including suicide, educational and professional underachievement, and later psychopathology.

Adolescent Depression Screening in Schools

A broad scientific consensus has formed that early detection and treatment are key to preventing negative, long-term effects of adolescent depression. Major stakeholder groups, including mental health experts, medical associations, and mental health systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

The school setting is seen by many as an opportune environment in which to target all adolescents for screening, particularly students (a) with elevated symptoms of depression who may not have sought help yet or been identified as being symptomatic, (b) at risk of developing symptoms due to external stressors or internal vulnerabilities, (c) with sub-threshold symptoms of depression, and (d) who are asymptomatic but who may develop symptoms in the future. Accordingly, a growing number of states are in the process of adopting policies to institute school-wide screening. Despite broad support for



PROJECT ASPEN Policy Brief SPRING 2022

New Jersey Parents' Views of Adolescent Depression Screening

There is an alarming increase in the percentage of U.S. adolescents reporting depressive symptoms and suicidal ideation, including in New Jersey. Early detection and treatment are key to preventing negative, long-term effects of depression in youth, and current guidelines recommend routine screening for depression in adolescents ages 12-18. Yet rates of adolescent depression screening remain extremely low. Our research shows that parents in New Jersey recognize the benefits of depression screening but have concerns regarding possible unintended effects and the administration of screening in schools. Effective communication that addresses these concerns is imperative to increasing support from parents to school-based depression screening.

What Is The Problem:

According to a 2021 Surgeon General's Advisory,[1] there has been a recent increase in certain mental health symptoms among U.S. adolescents, including depressive symptoms and suicidal ideation. From 2009 to 2019, the proportion of high school students reporting persistent feelings of sadness or hopelessness increased by 40%, and the share of those seriously considering attempting suicide increased by 36%. An analysis of 2018 and 2019 data from the National Survey on Drug Use and Health (NSDUH) reveals a similar upward trend in depressive symptoms and suicidal ideation among adolescents in New Jersey.[2] Rates of psychological distress among young people, including symptoms of anxiety, depression, and other mental health disorders have generally increased since the beginning of the COVID-19 pandemic.[3]

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School-based depression screening may address a number of access-related barriers: they are less stigmatizing, provide an opportunity to target problems before they reach diagnostic criteria, and promote access to care for underserved populations such as minority youth.[7] There is evidence that school-based screening programs can be effective in improving early detection and treatment of depression,[8] but critical barriers remain.[9] Many school administrators express concerns regarding the feasibility of obtaining parental consent for screening,[10] and available estimates show that about one-third of parents do not consent to depression screening.[11]

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Effect on Policy Implementation

SPECIAL ARTICLE

Screening and Treatment for Major Depressive Disorder in Children and Adolescents: US Preventive Services Task Force Recommendation Statement

US Preventive Services Task Force

The author has indicated he has no financial relationships relevant to this article to disclose.

ABSTRACT

DESCRIPTION. This is an update of the 2002 US Preventive Services Task Force recommendation on screening for child and adolescent major depressive disorder.

METHODS. The US Preventive Services Task Force weighed the benefits and harms of screening and treatment for major depressive disorder in children and adolescents, incorporating new evidence addressing gaps in the 2002 recommendation statement. Evidence examined included the benefits and harms of screening, the accuracy of primary care–feasible screening tests, and the benefits and risks of treating depression by using psychotherapy and/or medications in patients aged 7 to 18 years.

RECOMMENDATIONS. Screen adolescents (12–18 years of age) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up (B recommendation). Evidence is insufficient to warrant a recommendation to screen children (7–11 years of age) for major depressive disorder (I statement). *Pediatrics* 2009;123:1223–1228

THE US PREVENTIVE Services Task Force (USPSTF) makes recommendations about preventive care services for patients without recognized signs or symptoms of the target condition. It bases its recommendations on a systematic review of the evidence of the benefits and harms and an assessment of the net benefit of the service.

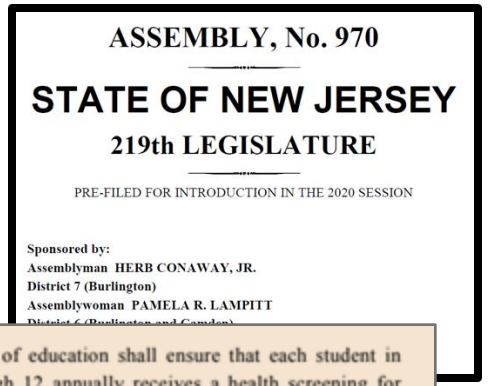
The USPSTF recognizes that clinical or policy decisions involve more considerations than this body of evidence alone. Clinicians and policy-makers should understand the evidence but individualize decision-making to the specific patient or situation.

SUMMARY OF RECOMMENDATION AND EVIDENCE

The USPSTF recommends screening of adolescents (12–18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up (B recommendation) (see "Clinical Considerations" below for additional information).

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening of children (7–11 years of age) for MDD (I statement).

See Fig 1 for a summary of the recommendation and suggestions for clinical practice. Table 1 describes the USPSTF grades, and Table 2 describes the USPSTF classification of levels of certainty about net benefits.



ASSEMBLY, No. 970

STATE OF NEW JERSEY

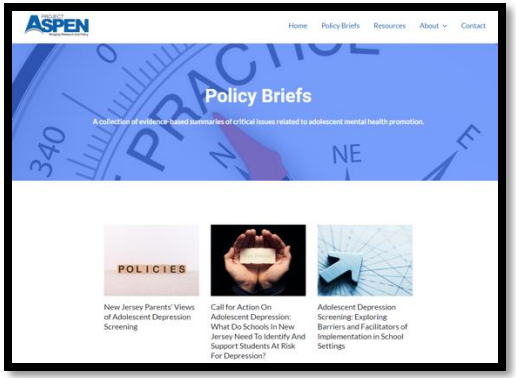
219th LEGISLATURE

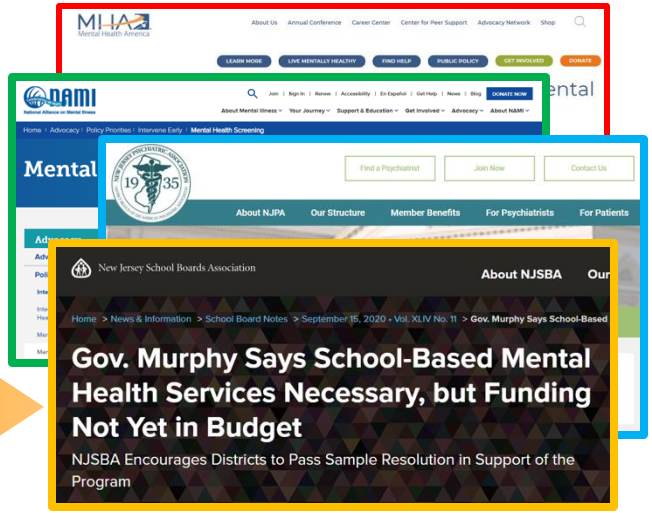
PRE-FILED FOR INTRODUCTION IN THE 2020 SESSION

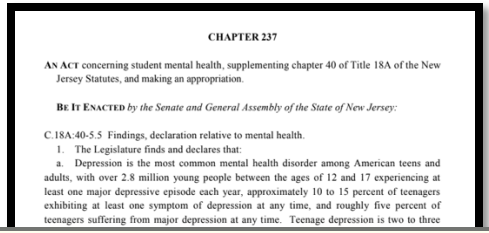
Sponsored by:
Assemblyman HERB CONAWAY, JR.
District 7 (Burlington)
Assemblywoman PAMELA R. LAMPITT

2. a. A board of education shall ensure that each student in grades seven through 12 annually receives a health screening for depression. The screening shall be administered by a qualified professional and shall consist of the Patient Health Questionnaire-2 or an equivalent depression screening tool, as determined by the Commissioners of Education and Health. The Commissioner of Health shall select the screening tool to be utilized by each school district. The screenings shall be conducted in a manner that ensures the privacy of the student during the screening process and the confidentiality of the results consistent with State and federal laws applicable to the confidentiality of student records. The Department of Education and the Department of Health shall jointly establish

Effect on Policy Implementation







CHAPTER 237

AN ACT concerning student mental health, supplementing chapter 40 of Title 18A of the New Jersey Statutes, and making an appropriation.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

C.18A:40-5.5 Findings, declaration relative to mental health.

1. The Legislature finds and declares that:

a. Depression is the most common mental health disorder among American teens and adults, with over 2.8 million young people between the ages of 12 and 17 experiencing at least one major depressive episode each year, approximately 10 to 15 percent of teenagers exhibiting at least one symptom of depression at any time, and roughly five percent of teenagers suffering from major depression at any time. Teenage depression is two to three

C.18A:40-5.6 Mental Health Screening in Schools Grant Program; purposes of program.

2. a. There is established in the Department of Education the Mental Health Screening in Schools Grant Program. The purpose of the grant program shall be to provide funding and resources to allow school districts to implement depression screening programs to identify students in the grades seven through 12 who are at risk of depression.

b. (1) A school district that receives an award under the grant program shall make available to each student in the grades seven through 12 an annual health screening for depression. The school district shall meet the following conditions when implementing its depression screening program:

(a) the school district shall use a research-based screening tool in its depression screening program conducted by a licensed mental health professional or through a partnership with an organization or healthcare provider specializing in pediatric and adolescent mental health to conduct the screenings. Nothing in this subsection shall prohibit a school district from using a self-administered screening tool as part of the depression screening program;

(b) the screenings shall be conducted in a manner that permits real time evaluation of the screening results and same day intervention by a licensed mental health professional as indicated by the screening;

(c) the school district shall ensure that the screenings will be conducted in a manner that accommodates bilingual education students, students with disabilities, and students with low reading proficiency when conducting the screenings;

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Implications for D&I Research

- There is a growing demand from both policymakers and intermediaries for policy implementation-relevant research to reduce ambiguity regarding potential barriers to policy implementation and potential outcomes of implementation.
- Research that assesses key stakeholders' views and concerns regarding implementation and/or implementation readiness appears to be particularly valuable in this regard and therefore can be leveraged to promote greater equity and inclusion in the implementation of health policies.
- This type of research can also enhance evaluations of the effects and outcomes of health policies.

THANK YOU!

- Cynthia L. Blitz, David J. Amiel, & Itzhak Yanovitzky
- Rutgers University | New Brunswick