

Noth Iowa Teen Screen Initiative A Summary Report

Introduction

Suicide represents the second leading cause of death among Iowa's youth and third nationally. Iowa's suicide prevention strategy includes the implementation of Columbia Teen Screen as a method of screening and promoting access to services when needed. A series of attachment have been included to allow for a more detailed summary of this program.

North Iowa was fortunate to initiate the Columbia Teen Screen through a partnership of organizations, the consultation on site locally by the University of Columbia and supported by the mission and funding of North Central Iowa United Way.

We would like to briefly summarize the key actions that occurred in this project.

Summary of Key Events and Findings

A spring conference was conducted on Columbia Teen Screen which was attended by over 100 participants mainly from various school districts in our area.

Nine school districts expressed interest in moving forward in the 2006/07 school year.

The Mental Health Center of North Iowa agreed to serve as a project coordinator as part of an across agency partnership endeavor that included Prairie Ridge, Department of Human Services, United Way, and other community service providers. The project coordinator function was established to work with the University of Columbia and the specific school sites.

With United Way's assistance we were able to alter the traditional pattern of training for this program. Heather Scanlon from Columbia conducted the training locally involving all the sites rather than one person traveling to New York and in turn training others.

The following page breaks down further the type of resources that were drawn upon at each site. In addition to the planning, training and coordination time, the project required the following functions to be carried out: orientation and administering of the screen to the students (approximately 45 minutes per application); scorers (usually 5 or more people); debriefers (varied by site); clinical screeners (varied by site), and case management (varied by site) We estimate that in all the resources contributed to this over all project exceeded 20,000 dollars. The United way grant made this possible.

The next page takes a closer look at the activity by the specific site as we had projected it. Actual numbers varied slightly. Schools anticipated that they would exceed national

norms in securing affirmative consents for student participation. That was true in Forest City with 80% and Nora Springs with nearly 70%. Manly exceeded a 50% return. Because of two major snow storms one following shortly after the other, Mason City did not get to the 50% national norm.

Each site served as a mentor for others and allowed for a continuous quality improvement process incorporating what we learned as we went along. This was especially helpful as we prepared for Mason City as the largest and most complicated site. Interestingly, though Mason City had a smaller over all percentage of the students participating, this site had the most screens that had endorsed the presence of suicidal ideation. In fact of the positive screens over half fit this category.

Though each site was unique in its implementation, a general pattern emerged. Usually a screening episode included a 30 minute block of time to orient students and administer the screen. A scoring team took 15 minutes to review and assign follow up actions. Debriefing of negatives screens took about 5-10 minutes per student. Clinical screening involved 25-30 minutes as a norm with a number going closer to an hour. When ever possible we tried to incorporate a staffing prior to a second administration. The pattern normally took around 90 minutes per administration excluding the staffing. Most of the time we had to defer the staffing till all the administrations were completed for the day. In most sites we conducted two administrations a day covering one or two days. Mason City was the exception. The administration was comparable but extended over four days.

All student screens were scored and reviewed. They fell into one of several categories: negative, positive, or positive for suicidal ideation and/or history. We later added a fourth category for marginally scored screens that did not quite reach the threshold of scoring as a positive screen.

All students with a negative screen were visited by a debriefer who had the option of later recommending a clinical screen based on their visit with the student. We had multiple experiences at each site where this turned out to be the case as additional information was learned.

Approximately 30% of all students taking the screening were thought to test positive and meet with a mental health clinician for a clinical screening. Our numbers over all hovered closer to 20%.

Within the group scoring positive, The Columbia Teen Screen further distinguished those who endorsed past history of suicide or recent suicidal ideation. The program required we have an emergency plan for immediate access to mental health services each day we conducted a screening. We did have 5 immediate referrals for same day emergency clinical evaluations that occurred during the course of administering the screening process. We had one attempted suicide in the week we were conducting the screening at one site - which was picked up in the course of screening another student.

All students scoring positive were staffed by a team of clinicians, debriefers, case managers, site coordinator and project coordinator. The staffings were generally an hour.

18% of the students administered a screening were thought to benefit from further referral for mental health evaluation. Our screening also included in house referral for additional school resources. Over all this number was lower than this.

School/Grade	Total Students	Student Screens	Debrief	Clinical	Case follow
Forest City(9)	102	84	71	17	14
Nora Springs(9,10)	80	35	29	6	5
Manly (10)	40	26	19	5	5
Manly (9)	40	22	16	6	6
Mason City (10)	324	132	94	38	16

Iowa Falls (8,9) Information was not available to us for this report.

Outcome and Directions

A meeting was held to review outcomes and consider future directions. Each site contributed to this process. This was considered to be a highly successful project and each site learned considerably in the first year. The mentoring process was though especially helpful. Starting earlier in the school year was thought also to be a helpful way of increasing overall student participation. We concurred that we were able at each site to reach students and secure timely referral. Concerns that we would overwhelm service resources or would not be able to respond to emergencies was not realized – but do remain very real issues. The group concluded that this process worked and mainly because of the strong partnership. The communities counseling and treatment resources were pretty much exhausted. For example, on average a new referral might will anticipate a four to six week wait to complete a referral to any one of a number of community resources.

At least three more schools have expressed their intent to complete a Columbia Teen Screen project application. We may well have nine schools participating in the 2007/08 school year. A planning session was held at the end of May to assist with this process

The Mental Health Center of North Iowa has agreed to continue to serve as the project coordinator through the partnership model with Prairie Ridge, Department of Human

Services, United Way, and the other organizations. The involvement of the Area Education Agency beyond that of planning has again been sought in the implementation of these projects. Though very supportive of this initiative it remains unlikely again this year that AEA staff will be able to help. Concern was raised on the ability to expand this initiative without these much needed resources. Interested school districts are now putting plans together for next year and we should soon know the magnitude of the request. We may have to limit further expansion. However, one option is to develop a special project position for a clinician to work on a limited part time contract to help fill in from the time that screening has been completed till the time a youth and their family is connected with a community resource. Such a person might also assist at each site in conducting clinical screenings. The Mental Health Center would be willing to explore funding options for such a position should this need present itself.