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Depression Education As Primary Prevention: The Erika's Lighthouse School-Based Program For High School Students

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Abstract: *Major depression is a treatable and common mental health disorder for youth. Untreated depression is a major risk factor for youth who become suicidal and die by suicide. Recent focus in the school-based literature on creating universal mental health promotion programs have recognized the need for effective depression awareness education programs to assist youth in identifying symptoms of depression in themselves and their peers, and to encourage those youth to seek trusted adults for help. A quasi-experimental design (QED) was employed in two suburban Chicago high schools (n=652) to evaluate the intervention, Real Teenagers Talking About Adolescent Depression (RTTAAD), a video-based universal classroom discussion intervention created by clinical social workers, parents, and youth. The analysis showed that RTTAAD led to statistically significant changes in adolescent knowledge about depression and their stated willingness to seek help from trusted adults at 6-week follow-up compared to a control classroom condition. This study supports the notion that school social workers and other school mental health professionals need to allocate more time to primary prevention work to help build mental health awareness in their school communities and to help prevent depression and suicidal behavior.*

Keywords: *Depression; youth; school social work; suicide prevention*

Major depression is a prevalent disorder for young people. According to the National Institute for Mental Health (2018), 12.8% of youth (ages 12-17) experienced major depressive disorder in 2016, suicide is the second leading cause of death for individuals between the ages of 10 and 24, and over 6,000 youth died by suicide in 2016. Research continues to show a strong link between youth depression and risk of suicide attempts and completions (Deutz, Geeraerts, van Baar, Deković, & Prinzie, 2016; Goldston et al., 2009; Miller et al., 2017; NIMH, 2015). Still, despite these serious outcomes from depression, many youth do not seek or receive the mental health treatment they need to treat their depression, increasing the chance that their depression might escalate into suicidal ideation (NIMH, 2017). Recent research has focused on using depression education as a prevention activity to increase the knowledge youth have about depression and suicide risk, to build their capacity to identify trusted adults in school and their community to help them and their peers, and to increase the help-seeking behavior of depressed youth (Balaguru, Sharma, & Waheed, 2013; Surgenor, Quinn, & Hughes, 2016). The present study extends that work using a one-session universal intervention (a school-based depression awareness curriculum) to assess whether youth's knowledge and skills can be impacted by such an intervention.

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With depression being one of the primary mental health issues associated with suicide, and many youth reporting that stigma presents a major barrier to seeking help for depression, education in schools is viewed as a key component in preventing youth suicide (Petrova, Wyman, Schmeelk-Cone, Pisani, 2015; Pisani et al., 2012; Ruble, Leon, Gilley-Hensley, Hess, & Swartz, 2013; Surgenor et al., 2016; Swartz et al., 2010). By offering depression education as a primary prevention strategy for youth, and addressing depression through school programs, a larger segment of the youth population can be reached (Bevan et al., 2017). The evidence indicates that these interventions can be beneficial, though the evidence is still limited by a lack of rigorous randomized trials and quasi-experimental designs, though more rigorous trials have been conducted recently (Singer, Erbacher, & Rosen, 2018; Swartz et al., 2017). Current research indicates that the more youth and school communities can learn about depression, the more likely it is for the stigma around mental disorders to be reduced and, in turn, for students to seek out help from trusted adults (Joshi, Hartley, Kessler, & Barstead, 2015; Pisani et al., 2012; Surgenor et al., 2016).

School social workers (SSW) have long been at the front lines of providing support for youth within an ecological framework that addresses prevention as well as direct clinical problems (Kelly, 2008; Thompson, Frey, & Kelly, 2018). SSW have reported a high level of interaction with students who are depressed and suicidal (Singer & Slovak, 2011), and have worked to implement depression education and suicide prevention programs in diverse school contexts (Ciffone, 2007; Schmidt, Iachini, George, Koller, & Weist, 2015; Wright-Berryman, Hudnall, Hopkins, & Bledsoe, 2018). As with most problems SSW report working with, the challenge with providing prevention support for youth with depression is identifying interventions that are feasible to implement within the school context (Kelly, Raines, Stone, & Frey, 2010; Singer et. al, 2018).

The present intervention (Real Teenagers Talking About Adolescent Depression [RTTAAD], 2015) builds on previous evidence-based interventions (e.g., Break Free from Depression [BFFD], Boston Children's Hospital, 2018; Signs of Suicide [SOS], SOS 2018) offered to youth in schools to raise awareness about depression and decrease suicidal behavior, but with some key differences. RTTAAD is shorter, free, and driven by youth's voice in ways that distinguish it from the other established programs. It is designed to be implemented by any high school staff who want to bring the program to their campus with minimal start-up costs or training.

Like the other programs, RTTAAD uses video as its prime teaching tool, but unlike the multiple sessions of the other programs, the video and ensuing discussion are built around one typical 50-minute high school class session. Teen voice is also included in other programs, though RTTAAD explicitly involves the youth themselves in creating the video content (not as actors or using scripted content) in direct collaboration with the mental health experts of Erika's Lighthouse (EL), the Chicagoland-based non-profit organization that created RTTAAD. The youth in the RTTAAD videos are essentially "the voice" of the program, telling their stories and relating what they have learned about their own depression and how they decided to seek help. Finally, in the interest of increasing the social validity of the program, all RTTAAD materials are free and require no additional training for use by a school mental health professional and/or health educator, making the program accessible to most any high school (SOS charges for their training and materials,

and BFFD requires an online train-the-trainers component that might prevent some schools from adopting the program quickly.)

Background on RTTAAD

Real Teenagers Talking About Adolescent Depression: A Video-Based Study Guide was created by the staff and advisory board of EL to be a turn-key universal intervention for high school classroom environments (RTTAAD, 2015). While the clinicians and staff at EL are clinical social workers with decades of experience in clinical work with youth, the organization's advisory board is composed of adults and teens, many of whom are either suicide survivors and/or people who have suffered depression, who have come together to work to reduce the stigma around childhood and adolescent depression.

The purpose of RTTAAD is to increase student knowledge about depression, reduce stigma surrounding depression, and increase the likelihood that students with depression will seek help. The program content, developed by a team of school-based mental health professionals, parents, and youth, draws on the latest evidence to help students understand that depression is common amongst youth, that it is serious and the largest risk factor for youth suicide, and that it is a diagnosable and treatable mental disorder with specific symptoms, and that peers are often the first to know of a teen's depression. The tone of the program is critical to its success and is also derived from evidence-based concepts of safe and effective messaging for suicide prevention - avoiding dark, sensational and fear-based messaging, and instead, providing a message that is positive, honest, fact-based, and inclusive (RTTAAD, 2015; Singer et al., 2018).

RTTAAD has been offered by EL since 2011. To date, it has been implemented in over 60 schools, religious institutions, and health care settings. The program contains two sections, both to be delivered in a classroom setting by a classroom teacher, and preferably, with a school mental health professional co-leading the session.

The first section of the program engages students in a beginning exercise that introduces mental health and depression concepts. Students watch the 10-minute RTTAAD video in their class and then participate in a discussion with the facilitator about teen depression. Though schools can use the materials themselves without contracting directly with EL, it is considered best practice to have proper student support and school mental health infrastructure in place to handle the potential student response to RTTAAD. This includes the potential increase in self-referrals and peer referrals related to depression (RTTAAD, 2015).

The second section of RTTAAD builds on the first with supplemental exercises to be led by the classroom teacher for a typical 50-minute class period. This session focused on stigma reduction, depression and brain science, and suggestions on how to help a peer with depression. (Note: this program evaluation is restricted to only the first section, as EL noted that at least some of the schools were not consistently implementing the second section, and they wished to evaluate the most commonly-used component of RTTAAD). RTTAAD is also equipped with facilitator teaching instructions which includes: a) a primer on depression; b) a mental health resource ("bookmark handout") for students; c) an intervention tool that students can use at the end of the session to confidentially ask for

help; and, d) an appendix with other mental health resources and information (RTTAAD, 2015). Though the program has proven to be popular and has numerous anecdotal examples testifying to its impact and effectiveness, to date no formal evaluation of RTTAAD has been conducted. The EL team asked the first author to help them construct a study to examine the impact of RTTAAD.

Purpose of the Evaluation

The main objectives of the proposed evaluation were to examine the effects of RTTAAD on first-year high school students on knowledge of depression, help-seeking, and trust of adults related to help-seeking. Specifically, the evaluation sought to test the following hypotheses:

- 1) Students in RTTAAD classrooms will show increased knowledge about depression, stigma, and signs of suicide compared to a control group of similar first-year high school students.
- 2) Students receiving the RTTAAD intervention will show higher scores on knowledge of help-seeking behaviors for depression and suicidal ideation compared to control group first-year students.
- 3) Students receiving RTTAAD will show an increase in their reported trust of adults to help them or their peers with depression and suicidal behavior compared to students in the control group condition.

Method

Two Chicago suburban high schools agreed to be part of the RTTAAD intervention study. Both schools (referred hereafter as HS 1 and HS 2) agreed to have the program delivered to first-year students via their required health classes in accordance with the team's research design goals. In collaboration with the first author's institution, the team received approval for the research project from the Institutional Review Board (IRB), and the project followed typical research procedures for a school-based intervention study.

In both schools, a pre-post-test wait-list control quasi-experimental design was used. The pre-test was delivered to both the RTTAAD groups (in their health class) and the control students (in their P.E. class) at the same time, and each condition received the post-test at 6 weeks after the RTTAAD intervention. The RTTAAD intervention was conducted by the second and third author of this paper (both of them creators of the intervention). This approach further ensured that the program was implemented with full fidelity. All students in the two schools' control conditions received RTTAAD in the Winter 2015 semester when the students in the P.E. class control condition had their health class. Each student in the study (total n=652) completed a questionnaire that incorporated a depression knowledge scale created by the EL team and two additional standardized scales, detailed below.

Measures. Two standardized measures were employed for this evaluation: the Help-Seeking Acceptability at School Scale (HSA), a 4-item scale that tests youth's willingness to seek help from an adult at school for mental health distress (Wyman et al., 2008) and the Adult Help for Suicidal Youth Scale (AHSY), a 3-item scale that tests adolescent's

beliefs that there are trusted adults who can help them and their peers with mental health distress (Schmeelk-Cone, Pisani, Petrova, & Wyman, 2012). Both scales were found in a 2012 study by Schmeelk-Cone and colleagues to have acceptable internal consistency (0.84 for HSA, 0.67 for the AHSY). According to these authors, the scales “provide researchers and program evaluators with psychometrically sound scales for measuring, within a school population, student norms and attitudes about help-seeking for suicide concerns” (Schmeelk-Cone et al., 2012, p. 169).

Table 1. *Codebook example for open-ended knowledge questions*

List 5 symptoms a teen might have to be diagnosed with depression – **0-5 points** (Note: each coder independently entered 1 point for any of the items on this list, and then compared their codes after completing them to get to acceptable inter-rater reliability.)

1. Sad/always sad/constantly sad/sadness, depressed, feeling down
2. Change in sleep, irregular sleeping patterns
3. Sleeping too much, sleeping more, over-sleeping
4. Sleeping too little, sleeping less, insomnia, not sleeping/not sleeping well
5. Restlessness, agitation, feeling “sped up”
6. Persistent crying, tearfulness
7. Physical symptoms, aches and pains, headaches, stomachaches
8. Trouble focusing, trouble concentrating, trouble paying attention, trouble making decisions
9. Withdrawal from people/isolation, anti-social behavior, spending lots of time alone
10. Loss of interest or pleasure in favorite activities
11. Change in weight, weight gain, weight loss
12. Change in appetite
13. Loss of appetite, eating less, eating too little, not eating, not eating enough
14. Increase in appetite, eating more, eating too much, over-eating
15. Pessimism
16. Fatigue, tired all the time/exhausted, no energy/loss of energy
17. Feelings of worthlessness
18. Feelings of guilt
19. Feelings of hopelessness
20. Thoughts of death, suicidal thoughts, any other signs of suicidal behavior
21. Self-harm/self-injury, cutting
22. Lack of hygiene, lack of self-care for appearance
23. Low self-esteem
24. Using/abusing drugs and/or alcohol
25. Emotional numbness/apathy
26. Feeling lonely/alone/loneliness
27. Missing a lot of school, skipping school
28. Drop in grades, failing classes, low motivation
29. Reckless behavior (including examples of reckless behavior)
30. Anger, irritability

Additionally, the EL team created a knowledge instrument containing true/false items on depression, as well as six open-ended questions to evaluate the extent that students understood depression symptoms, strategies students could use to improve their mental health, the impact of stigma on help-seeking for depression and suicidal ideation, and

warning signs indicating a teen might be considering suicide. The final study instrument is available from the first author. Two college-aged student research assistants coded the responses to the six open-ended questions, scoring them based on the quality of the answers. Two EL team members coded a sub-sample of responses to attain sufficient inter-rater reliability (IRR) of .8 or above. All remaining responses were coded and all responses (both IRR and the two separate coders' work) were built into the analysis. (See Table 1 for sample codes).

The two high schools were chosen because they matched well on several school characteristics (see Table 2).

Table 2. *Selected RTTAAD Study High School Characteristics*

School Variables	High School 1	High School 2
SES (Low-income households)	13%	8%
Student mobility	<3%	<3%
Graduation rate	98%	95%
Students with IEPs	10%	9%
Racial demographics		
White	61%	Not available
Asian-American	20.7%	

(Illinois Report Card, 2018)

The results from the two schools were combined for this analysis. A pre-post/test wait-list control group design was employed to test the study hypotheses.

Results

Demographics

Of the 652 first-year students in the study, 286 (43.8%) were male and 329 (50.5%) were female; 37 (5.7%) either chose to not identify their gender or left the section blank. No other demographic data was collected on the specific first-year students in this sample (i.e., SES, race/ethnicity).

Findings from RTTAAD Questionnaire Data

Based on an independent sample t-test analysis of the pre-and post-tests for the RTTAAD and Comparison classrooms, the following preliminary results can be drawn from the data.

Student knowledge of depression. For the knowledge scale, participants in the RTTAAD condition showed greater increases in their knowledge score ($M=0.67$, $SE=0.08$) than did those in the control condition ($M=0.39$, $SE=0.12$). This difference was statistically significant $t(650)=2.0209$, $p<.05$. At 6 weeks post-test students who participated in RTTAAD had retained a statistically significant amount of new information about depression and how to deal with depression affecting either a peer or themselves.

For each of the 6 open-ended questions on the questionnaire, RTTAAD participants reported highly significant change from pre-to post-test ($M=1.65$, $SE=.09$) compared to the control condition students ($M=1.13$, $SE=.08$). This difference was statistically significant $t(634)=4.3278$, $p<.0001$. This means that a statistically significant portion of students in the RTTAAD condition could:

- a. Identify up to five symptoms of depression
- b. Accurately recount how long someone needs to be depressed to be diagnosed with depression
- c. Identify up to three healthy ways that youth can take care of their mental health
- d. Explain how stigma might prevent people from seeking help for their depression
- e. List two warning signs for someone considering suicide
- f. Identify strategies to help a peer who is suicidal involving seeking out a trusted adult

Students' willingness to seek help from trusted adults at school with depression and other mental health problems. Participants in the RTTAAD condition showed greater change in their average score on the HSA (Help-Seeking Acceptability Scale; $M=0.19$, $SE=0.03$) than did those in the control condition ($M=0.09$, $SE=0.04$). This difference was statistically significant $t(650)=2.0344$, $p<.05$. At 6 weeks post-test RTTAAD, participants reported that they were more likely to see adults in the school as people they could seek help from if they were upset.

Students' belief that adults could help one of their peers who is suicidal. Students who participated in RTTAAD showed greater change in their average score on the AHSY (Adult Help for Suicidal Youth Scale; $M=0.26$, $SE=0.03$) than those in the control condition ($M=0.10$, $SE=0.04$). This difference was statistically significant $t(650)=3.2250$, $p<.0001$. Students who participated in RTTAAD were much more likely to view adults as helpful resources for an adolescent peer who was suicidal. Overall, at 6-week follow-up across all three measures (the knowledge scale, the HSA, and the AHSY), RTTAAD appeared to have an impact on key areas of depression awareness/suicide prevention for first-year students in the RTTAAD condition compared to the control group classrooms.

Discussion and Implications for Additional Research and Practice

This pilot evaluation confirms that RTTAAD can improve knowledge and attitudes on depression and help-seeking among youth, and these outcomes are consistent with the features of other interventions in the depression awareness/suicide prevention literature (Klimes-Dougan, Klingbeil, & Meller, 2013; Petrova et al., 2015; Swartz et al., 2017; Whitlock, Wyman, & Moore, 2014). These initial findings show that RTTAAD is a promising intervention that merits further investigation, particularly for high school-age youth. Based on the data described here, RTTAAD demonstrates potential as an efficient and basic intervention that builds awareness of what depression in teenagers looks like, how teens can recognize symptoms in themselves and/or their peers, and how they can identify and eventually turn to trusted adults at school to help themselves or a peer.

These preliminary results are encouraging for several reasons. First of all, this is the first trial of RTTAAD since its inception, and the results indicate that the anecdotal and intuitive appeal of this program is bolstered by empirical support. Secondly, this trial tested the intervention in a real-world setting of two suburban Chicago high schools. These two high schools are similar to other schools that have been working with EL and the RTTAAD intervention for years. The fact that these changes were seen in two settings that closely match the school conditions that EL is used to working in further validates the efforts of the team to deliver this program as it has been already doing.

Each of the key indicators (increased knowledge, increased willingness to seek help from school adults, increased belief in the ability of adults to provide real help to a suicidal peer) are considered essential to programs that are trying to increase depression awareness and impact help-seeking attitudes around teen suicide. RTTAAD impacted all of these indicators, and did so even after a 6-week follow-up period. It is also important to note that all of this is being accomplished by a remarkably brief and efficient intervention model, one that requires relatively little training to implement and very little time to conduct relative to other evidence-based depression awareness/suicide prevention curriculum. From this initial pilot study, there is preliminary evidence to support the notion that RTTAAD “works,” and does so largely in the ways that its creators intended it to work.

The findings from this initial pilot study offer several important implications for school social workers (SSW) and other related school mental health professionals. Due to high caseloads and other workplace demands, most SSW report struggling to find the time to deliver evidence-informed Tier 1 and Tier 2 interventions within the commonly-understood multi-tiered systems of supports (MTSS) framework (Kelly et al., 2016). This intervention offers an opportunity for SSW to address depression awareness and suicide prevention at the Tier 1 universal level, and to work within their school community to build the capacity of other key stakeholders (teachers, administrators, peers, and parents) to make school communities more responsive to youth who struggle with depression and suicidal thoughts (Erbacher, Singer, & Poland, 2014). That this could be done in a free and time-limited way makes RTTAAD a promising option for SSW looking to become more involved as change agents in mental health promotion and prevention work within their schools (Avant & Lindsey, 2015).

Limitations

While this study shows some positive initial outcomes, there are important limitations to bear in mind when interpreting these results. The sampling plan and wait-list control design, while more rigorous than a simple pre/post-test design, was not a randomized trial, as both the RTTAAD and comparison group youth represented a convenience sample of schools who were willing to participate. The data was all youth self-reports about possible changes to their knowledge and attitudes. The study design did not allow the researchers to assess behavioral outcomes such as whether RTTAAD increased youth referrals for mental health treatment in the school setting, or a resulting decrease in suicidal behaviors among the youth of the two high schools. Future research is needed to discern the behavioral changes stemming from RTTAAD. This is an area that the research team is considering as the next steps of developing the programs offered by EL.

Furthermore, though the two high schools used for this study shared many demographic and SES similarities, the specific youth themselves were not precisely matched on all demographic variables for the evaluation. This significantly limited this study's ability to test RTTAAD's impact on specific racial/ethnic minorities, as well as possible differential impacts of the intervention for LGBT youth. Further research is needed to assess how well RTTAAD and other depression awareness interventions are culturally relevant to the wide diversity of youth in the U.S. Further, because RTTAAD was facilitated by Erika's Lighthouse staff and not the school's own teachers, future studies would benefit from assessing the program's impact when taught by health teachers or other faculty.

Conclusion

The preliminary results discussed here represent encouraging findings that invite additional investigation into the potential scope and reach of RTTAAD to impact depression awareness/suicide prevention outcomes for early adolescent youth in middle and high school. This work stems from a collaboration of a dedicated group of practitioners and researchers, and follows a collective process built on the wisdom of several years of building RTTAAD. Future work would do well to further investigate the ways by which RTTAAD can be feasibly and effectively translated to more diverse adolescent populations (e.g., rural youth, inner-city youth), as well as ways that the materials might be refined by future study to be more widely disseminated through face-to-face educational classroom instruction in the program as well as sharing the RTTAAD program via social media apps and other online tools frequented by youth.

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