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p < .001); 5) medication initiation (2.2 to 3.6, p < .001); 6) medication management (2.0 to 3.3, p < .001); and 7) mental health service collaboration (2.5 to 3.4, p < .001). Resident confidence significantly improved with 1) using validated screening tools (2.8 to 4.2, p < .001); 2) applying diagnostic criteria (2.9 to 4.1, p < .001); 3) performing safety assessments (3.1 to 4.0, p < .001); 4) non-pharmacologic management (2.8 to 3.9, p < .001); 5) initiating medication (2.0 to 3.8, p < .001); 6) managing medication (2.1 to 3.4, p < .001); and 7) collaborating with mental health services (2.6 to 3.6, p < .001).
Conclusions: These preliminary results suggest that case-based training on adolescent depression during the AM rotation can improve resident knowledge of and confidence with diagnosing and managing depression in adolescents. We are hopeful that this could lead to improved mental health access for youth, but additional study is warranted.
Sources of Support: CCHMC Division of Adolescent and Transition Medicine (Colburn).

25.

REACHING OUT TO YOUTH ABOUT TRAUMA: ADOLESCENT RAPID SCREENING VALIDATION PILOT

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Purpose: Background: Despite high global prevalence rates of adolescent trauma exposure and increasing evidence of lifelong health impacts, screening for trauma in adolescent health care settings is inconsistent. Purpose: To identify an effective rapid screen for post-traumatic stress disorder (PTSD) symptoms in a group of diverse, immigrant and underserved early adolescents by comparing brief PTSD symptom screens validated for use in adult primary care settings to a longer questionnaire validated with children.
Methods: This pilot study examined the accuracy of two brief trauma screening tools, the PTSD Checklist 2 (PCL-2) and the Primary Care PTSD Screen for DSM-5 (PC-PTSD) to identify youth experiencing symptoms of trauma, compared with a longer tool validated for use with adolescents (PTSD Reaction Index for DSM 5). Screening tools were administered to 77 youth (ages 12–15 years) at three school-based health centers (SBHCs) in Northern California with a high proportion of low income and immigrant clients. Only youth who had already been screened for depression, trauma and substance use at their SBHCs and offered behavioral health services, if indicated, were recruited for the study. Average scores, ranges and standard deviations were compared for youth who scored above and below clinical cutoffs on the PTSD Reaction Index. Sensitivity, specificity, positive and negative predictive values (PPV and NPV) and likelihood ratios were calculated. Focus groups were conducted to obtain qualitative feedback on the screening questions. Equal numbers of boys and girls participated in screens: 64% were Latino, 13% African American, 16% Asian/Pacific Islander, and 8% Other.
Results: In this sample, 8% met DSM-5 criteria for PTSD. Analyses revealed that the PC-PSTD demonstrated high sensitivity (100%) and specificity (83%) with adolescent clients when using a cutoff score that was slightly lower than that recommended for adult populations. Similarly, the PCL-2 demonstrated high sensitivity (83%) and specificity (85%) when using a lower cutoff score. Both tools also had high NPV (100% PC-PTSD and 98% PCL-2), but low PPV (33% and 31% respectively). During focus group discussions, youth noted several questions that were difficult to interpret or were not specific to youth who had been traumatized. Participants endorsed the importance of reaching out to youth who had been traumatized, felt questions about frequency of symptoms were harder to answer than yes-no about symptom presence, and disputed that questions related to sleep, inattention, fighting, and being on guard were only specific to youth who had experienced trauma.
Conclusions: Both the PCL-2 and the PC-PTSD screens had good sensitivity and specificity, but youth may be answering these screening questions without understanding them fully. Studies are needed to refine questions to develop a more effective short screen and to compare results with culturally sensitive, recommended or validated depression, anxiety and substance use screens in order to disentangle symptom clusters. Future research also needs to recognize that the synergy of community-trauma and individual trauma may be so prevalent that it overshadows individual adolescent perceptions and ensure that screening tools address this contextual issue.
Sources of Support: Blue Shield of California Foundation.

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THE RELATIONSHIP BETWEEN SCHOOL-LEVEL FACTORS AND ADOLESCENT STUDENT WELL-BEING: CROSS-SECTIONAL FINDINGS FROM THE INCLUSIVE TRIAL

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Purpose: Well-being can be defined as "a multidimensional construct incorporating mental/psychological, physical, and social dimensions". In adolescents, higher well-being has been related to better mental and physical health, and educational attainment. Furthermore, these effects appear to continue into later life. For adolescents, a large part of their social interactions and personal development occur within the school environment. School size, quality, and demographics are likely, therefore, to impact student well-being. This UK study aims to investigate the relationship between school-level characteristics and student well-being.
Methods: INCLUSIVE is a 3-year (2014–2017) cluster randomized controlled trial (RCT) aimed at 11-16-year-olds in 40 secondary schools (N = 5,960 students) in England. Data from the baseline survey were used to assess school-level characteristics in relation to well-being. Well-being was assessed using the (Short Warwick-Edinburgh Mental Wellbeing Scale: SWEMWBS). School-level factors assessed were school type (voluntary, community, academy-converter, academy-sponsor, and foundation), school size, mixed/single-sex schools, the proportion of students with free school meals (FSM; a measure of deprivation), school performance (Ofsted rating), and student's overall academic attainment ("Value Added" (VA) scores). Statistical analysis was performed using an intention-to-treat approach and multilevel models to account for school-level clustering, and adjusting for gender, IDACI scores, and ethnicity.
Results: In multilevel models, at the school level, school type and school quality measures were associated with well-being: community and academy-converter schools reported lower student well-being scores than voluntary schools ((-1.71(C.I.=-2.42, -1.01)) and