
Thinking Cautiously About Screening for Major Depressive Disorder (MDD) in Adolescents: The U.S. Preventive Services Task Force Recommendations and Implications for Schools

Depression differs from just experiencing commonplace, temporary, emotional states such as feelings of sadness or “the blues.” The reality is that many people are unhappy and emotionally upset for significant periods of time; this is certainly the case for a large proportion of adolescents. But only a small percent of individuals are clinically depressed..

Clinical depression is characterized by pervasive, prolonged feelings of hopelessness that interfere with daily living and learning. The disorder has physical, emotional and cognitive effects. Formal diagnoses include four subtypes: Major Depressive Disorder (MDD), Persistent Depressive Disorder, Premenstrual Dysphoric Disorder, and for children up to age 18, Disruptive Mood Dysregulation.

A recent report from the U.S. Preventive Services Task Force (USPSTF) has been widely cited as supporting large-scale screening of adolescent depression. Our Center offers this resource to highlight key statements from the Task Force and to temper incautious interpretations of their recommendations.

What the Task Force Indicates about MDD

Created in 1984, the U.S. Preventive Services Task Force (USPSTF) is a volunteer national expert panel focused on prevention and evidence-based medicine. Task Force members come from the fields of preventive medicine and primary care, including internal medicine, family medicine, pediatrics, behavioral health, obstetrics and gynecology, and nursing. Given its composition, it is not surprising that the Task Force approached the matter of screening depression from a medical practice perspective and did not comment on school screening.

In its 2016 report, the Task Force recommended screening adolescents ages 12-18 for major depressive disorder (MDD). Note that the Task Force focused only on MDD and stated that screening should only be done “with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.” In addition, the Task Force concluded that “current evidence is insufficient to assess the balance of benefits and harms of screening for MDD in children a g e d 1 1 y e a r s o r y o u n g e r . ”

<http://www.uspreventiveservicestaskforce.org/Home/GetFile/1/4289/chlddeprfinalrs/pdf>

Cause and Risk Factors

Quoting the Task Force: “The causes of MDD are not fully known and likely involve a combination of genetic, biological, and environmental factors. Risk factors for MDD in children and adolescents include female sex; older age; family (especially maternal) history of depression; prior episode of depression; other mental health or behavioral problems; chronic medical illness; overweight and obesity; and, in some studies, Hispanic race/ethnicity. Other psychosocial risk factors include childhood abuse or neglect, exposure to traumatic events (including natural disasters), loss of a loved one or romantic relationship, family conflict, uncertainty about sexual orientation, low socioeconomic status, and poor academic performance.”

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Screening Tests and Intervals

The Task Force states: “Many MDD screening instruments have been developed for use in primary care and have been used in adolescents. Two that have been most often studied are the Patient Health Questionnaire for Adolescents (PHQ-A) and the primary care version of the Beck Depression Inventory (BDI). Data on the accuracy of MDD screening instruments in younger children are limited.” (See the brief description of the instruments appended to this resource from our Center.)

“The USPSTF found no evidence on appropriate or recommended screening intervals, and the optimal interval is unknown. Repeated screening may be most productive in adolescents with risk factors for MDD. Opportunistic screening may be appropriate for adolescents, who may have infrequent health care visits.”

Implementation

In discussing screening in general, the Task Force cautions about positive findings stemming from first level screening. They state: “A positive result on an initial screening test does not necessarily indicate the need for treatment.” And they emphasize that initial screening is to be “followed by a second phase in which skilled clinicians take into account contextual factors surrounding the patient's current situation, through either additional probing or a formal diagnostic interview.”

It is particularly noteworthy that the Task Force stressed the importance of having “adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.” They caution that “inadequate support and follow-up may result in treatment failures or harms.... ‘Adequate systems in place’ refers to having systems and clinical staff to ensure that patients are screened and, if they screen positive, are appropriately diagnosed and treated with evidence-based care or referred to a setting that can provide the necessary care.”

Implications for Schools

First level screening for serious mental health and psychosocial problems by schools has long been debated. The Task Force made no recommendation about school screening for depression. This is not surprising given the group's focus on clinical medicine. What is stated is that the “essential functions can be provided through a wide range of arrangements of clinician types and settings.”

No one is likely to argue against the value of preventing and responding quickly when problems arise. And schools clearly have a role to play in watching for student learning, behavior, and emotional problems and addressing those that are barriers to learning and teaching. Indeed, in recent years, schools have been increasingly vigilant about identifying potential and existing student problems. Resources regularly are deployed to deal with a variety of student problems (e.g., bullying, emotional concerns, suicidal behavior, ADHD, LD, obesity).

Even so, continuous policy conflicts arise over whether schools should play a formal, institutionalized role in screening for mental health problems. Issues arise around:

Is universal first level screening for behavior and emotional problems an appropriate role for schools to play?

If schools do first level screening, what procedures are appropriate and who should do it?

Given the screening will produce false positives, won't this collude with practices that label commonplace adolescent problems as mental illness?

By focusing mainly on screening individuals, are schools avoiding the reality that some students' problems are the product of bad environmental conditions (at school, home, in the neighborhood). As a result, does such screening contribute to “blaming the victim.”

And given the various costs of school-wide screening, what is the evidence that the benefits will outweigh costs? Will school screening do more harm than good?

Concerns also arise about parental consent, privacy and confidentiality protections, staff qualifications, negative consequences of monitoring (especially for false positive identifications), and access and availability of appropriate assistance.

Examples of Often Heard Pro and Con Positions Related to Schools Doing First Level Screening

Pro: School personnel are well-situated to assess kids who are “at risk.”

Con: Schools can’t take on another task and aren’t qualified to monitor such students.

Pro: Such assessment can be done by qualified student support staff.

Con: Screening infringes on the rights of families and students.

Pro: It’s irresponsible not to identify anyone who is “at risk.”

Con: It’s inappropriate to encourage schools to diagnose mental illness.

Pro: Screening is needed so that steps can be made to help quickly.

Con: Screening has too many negative effects.

Here’s is the type of argument made by strong advocates of screening adolescent depression:

Mental illnesses are a leading cause of disability in the United States. Major depressive disorders are strongly associated with other mental disorders and increase suicide attempts and suicide. We have screening for all kinds of rare infectious diseases, but we don't screen for common behavioral disorders that are costly to individuals, families, and society (e.g., in terms of health care utilization, crime cost, high risk of death). A significant proportion of children and adolescents with a mental illness go without treatment. To some degree this is because their illnesses go undiagnosed. Early identification of mental health problems and intervention hold promise for a reduction of learning barriers and more positive educational outcomes. It is imperative that we improve screening and identification, so support for these children can be provided before their academic careers are at risk. School screening enables schools to be a first line of defense in identifying and responding to youth depression. School personnel are well-situated to screen students and, with training, can screen effectively using appropriate safeguards for privacy and confidentiality. They also are situated to make quick referrals. In sum, we believe that the benefits of school screening outweigh the costs.

Here’s an example of what those arguing against such screening say:

There is no satisfactory research on the effectiveness of school screening of problems such as depression, suicide, and substance abuse, and some negative findings have been reported. Given sparse school budgets, it is stressed that funds for screening take away resources from other high priority needs. This problem is exacerbated because of the need to follow-up first level screens to ensure false positives are identified and students who are referred for help actually receive it. The practice often infringes on the rights of families and students. It distracts school staff from the mission of schools. Teachers and other non-clinically trained school staff are ill-equipped to do appropriate screening of mental disorders. Existing assessment practices are primarily effective for those manifesting severe symptoms that already are obvious at school and at home, so the problem is mainly to ensure that schools have effective referral systems. Depression screening will produce too many negative effects for the school and students (e.g., costs will outweigh potential benefits). An overemphasis on screening students colludes with the tendency to downplay the need for addressing external factors (at home, at school, in the neighborhood) that result in students being chronically unhappy. In sum, we believe the costs of school screening outweigh the benefits.

Our Center's Position

It is essential for schools to play a role in supporting students who manifest warning signs. However, we view that role not as one of formal first level screening of depression (or of screening for the many other pathologies that can plague young people). Certainly, schools must be alert to students who are not doing well. And there are many resources available to guide school staff in monitoring for warning signs as part of their regular encounters with students. See the Center resource entitled: *School-Based Client Consultation, Referral, and Management of Care* – <http://smhp.psych.ucla.edu/pdfdocs/consultation/consultation2003.pdf>

However, schools must do more than identify problems. They must have an intervention system in place to address learning, behavior, and emotional problems in ways that enhance equity of opportunity for success at school and beyond. Such a system includes pursuing changes in the school environment that create unhappy students (and staff) as well as providing a comprehensive set of student and learning supports.

We stress that the intervention system needs to encompass (a) personalized instruction, accommodations, and special assistance in regular classrooms, (b) supports that facilitate transitions, (c) practices that increase connections with families, (d) strategies for responding to and, where feasible, preventing school and personal crisis and traumatic events, (e) outreach to increase community involvement, and (f) a focus on facilitating student and family access to effective services and specialized assistance as needed (see Adelman & Taylor, 2015).

For more on what a school can do to address learning, behavior, and emotional problems, see our *National Initiative for Transforming Student and Learning Supports* – <http://smhp.psych.ucla.edu/newinitiative.html>. The initiative highlights a unified, comprehensive, and equitable approach designed to address barriers to learning and teaching and re-engage disconnected students.

A Sample of Resources Used in Developing this Document

- Adelman, H.S., & Taylor, L. (2015). *Transforming student and learning supports: Developing a unified, comprehensive, and equitable system*. Los Angeles: Center for Mental Health in Schools. <http://smhp.psych.ucla.edu/pdfdocs/book/book.pdf>
- Barston, S., Melinda, S., & Segal, J. (2015). *Helping a depressed person*. HELPGUIDE.org. <http://www.helpguide.org/articles/depression/helping-a-depressed-person.htm>
- Bienefeld, D. B. (2016). *Screening Tests for Depression*. Medscape. <http://emedicine.medscape.com/article/1859039-overview#a1>
- Center for Mental Health in Schools (2015). *Affect and mood problems related to school age children*. Los Angeles: Author at UCLA. <http://smhp.psych.ucla.edu/pdfdocs/affect/affect.pdf>
- Fergusson, D.M., & Woodward, L.J. (2002). Mental health, educational, and social role outcomes of adolescents with depression. *Archives of General Psychiatry*, 59, 225-231. doi:10.1001/archpsyc.59.3.225.
- Katon, W. (2010). Evaluation of the Patient Health Questionnaire (PHQ-9) for detecting major depression among adolescents. *Pediatrics*, 126, 1117-1123. <http://doi.org/10.1542/peds.2010-0852>
- Melinda, S., & Segal, J. (2015). *Teenager's guide to depression*. HELPGUIDE.org. <http://www.helpguide.org/articles/depression/teenagers-guide-to-depression.htm>
- National Association of School Psychologists (nd). *Save a friend: Tips for teens to prevent suicide*. Bethesda, MD: Author. http://www.nasponline.org/resources/crisis_safety/savefriend_general.aspx

National Institute of Mental Health (nd). *What is depression?* Online at <http://www.nimh.nih.gov/health/topics/depression/index.shtml>

Pfeiffer, P.N., Heisler, M., Piette, J.D., Rogers, M.A.M., & Valenstein, M. (2011). Efficacy of peer support interventions for depression: A meta-analysis. *General Hospital Psychiatry, 33*, 29-36.

Substance Abuse and Mental Health Services Administration. (2014). *Suicide prevention*. Online at <http://www.samhsa.gov/suicide-prevention>

Walker, J. (2005). Adolescent Stress and Depression. University of Minnesota Extension. <http://www.extension.umn.edu/youth/research/youth-issues/adolescent-stress-and-depression>

Weist, M. D., Rubin, M., Moore, E., Adelsheim, S. and Wrobel, G. (2007), Mental Health Screening in Schools. *Journal of School Health, 77*, 53-58. doi: 10.1111/j.1746-1561.2007.00167

For more, see the Centers online clearinghouse Quick Finds on:

>*Childhood and Adolescent Depression* – <http://smhp.psych.ucla.edu/qf/depression.htm>

>*Assessment and Screening* – http://smhp.psych.ucla.edu/qf/p1405_01.htm

Appendix

Depression Screening Instruments Cited by the Task Force

For youngsters who are at least 12 years old, the Task Force recommends two instruments:

(1) *Patient Health Questionnaire (PHQ-A)* –

<http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf>

The PHQ-A is a 9+ item adolescent version of the depression portion of the self-administered PRIME-MD interview, which uses DSM-IV criteria to assess for mental disorders in primary care. Each question asks the child to rate on a 4 point scale the frequency of his or her symptoms during the past 2 weeks (i.e., 0=not at all, 1=several days, 2=more than half the days, 3=nearly every day). It is scored to provide a dichotomous diagnosis of probable major depression and to grade symptom severity via a continuous score. The items are:

1. Feeling down, depressed, irritable, or hopeless?
2. Little interest or pleasure in doing things?
3. Trouble falling asleep, staying asleep, or sleeping too much?
4. Poor appetite, weight loss, or overeating?
5. Feeling tired, or having little energy?
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?
7. Trouble concentrating on things like school work, reading, or watching TV?
8. Moving or speaking so slowly that other people could have noticed?
Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?
9. Thoughts that you would be better off dead, or of hurting yourself in some way? (followed by probes)

(2) *Beck Depression Inventory (BDI)* –

<http://mhinnovation.net/sites/default/files/downloads/innovation/research/BDI%20with%20interpretation.pdf>

The Beck Depression Inventory (BDI) is a 21-item multiple-choice self-report symptom severity index. The current version is designed for individuals aged 13 and over and is composed of items relating to symptoms of depression such as hopelessness and irritability, cognitions such as guilt or feelings of being punished, as well as physical symptoms such as fatigue, weight loss, and lack of interest in sex.

See the Task Force report for their conclusions about the reliability, validity, and sensitivity of these instruments.

The Task Force report also offers a summary of treatments for depression among adolescents.