2019 Submission - Royal Commission into Victoria's Mental Health System

SUB: 0002.0028.0353

Name
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What are your suggestions to improve the Victorian communitys understanding of mental illness and reduce stigma and discrimination?
"Stigma is inherent in a ""mental"" health disorder or infirmity. Reducing stigma and discrimination shall require an ongoing effort at multiple levels in the system. Some situations where I experienced that stigma and discrimination was less were - 1. Mental health disorder was viewed by clients/families/medical colleagues/community as a medical disorder, not a choice. 2. Media resources that sensitize population well were made available e.g. the Videos like the WHO Black Dog (https://www.youtube.com/watch?v=XiCrniLQGYc) 3. World Mental Health day was celebrated in schools 4. Trained and sensitive workers (non-clinical) from NGOs like Wellways supported clients' employers or teachers. Reassurance from someone who is not a family member of the client and who is available for contact to understand what to do when mental health disorder fluctuates made it more ""tolerable"" for these stakeholders to work with mental health clients."

What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?
"What is working well - 1. Mental health is one of the priorities for the state. 2. Ongoing efforts to educate primary care clinicians in mental health. What can be done better to prevent mental illness: 1. Focus on Adverse Childhood Experiences - screening at school level and primary care, adopting preventive strategies at policy level (https://www.youtube.com/watch?v=8gm-lNpzU4g) 2. Substance abuse, Domestic Violence and Mental Health services - defragmentation is necessary. Someone has to think how these can be addressed together rather than funding them as per political situation arises. 3. Neurodevelopmental disorders - early detection and intervention (Paediatricians, GPs, and Maternal child health services in regional areas struggle with this) 4. Screening for Depression in Young in primary care (see attachment). US Preventive Services Task Force (2016) recommends screening or ALL adolescents aged 12-18yrs be screening in primary care for Depression. 5. Emphasis on mental hygiene and social media hygiene from an early age 6. Supporting new parents with knowledge and skills to raise emotionally secure children who can thus resiliently face adversity. Especially if there is family history of mental health disorders or if there are ante-natal or peri-natal complications. Circle of Security-Parenting program is a one such helpful education tool. "

What is already working well and what can be done better to prevent suicide?
"We do understand the various factors that lead to suicide in those who are depressed or suffering with a severe mental illness and even in those who are not clinically depressed or have a severe mental illness. In younger population, interpersonal sensitivity, mentalizing deficits, emotional dysregulation, lack of alternative mature adaptive ways to cope/find solution are commonly seen in suicide attempts. In older population, disconnection may contribute significantly to the finality of suicide. Promoting early life attachment security, especially in those with risk factors for mental health disorders or family history of suicide can reduce these factors. Accessibility to thoughtful

and well-resourced child and adolescent mental health service providers will be critical who can work alongside primary care services and child protection to promote early life attachment repairs. There certainly are efforts in the current system to identify and manage risk of suicide. Coroners being trained to provide formative feedback rather than punitive can help with ensuring less anxious and more containing and hence more effective and thoughtful responses from mental health and non-mental health medical professionals (for e.g. in Emergency Dept) to suicide risk presentation. Screening for Depression in Young in primary care (see attachment) could also help. It only takes 5-10 minutes for a young person sitting in the GP waiting room to fill the attached questionnaire which is based on evidence based measures. Teenagers find it non-threatening to fill in the attached Self-report Health questionnaire. In schools, every six-12 months random screening using the questionnaire could occur - with specific instructions to seek out the right person in that school or local system if adolescents have self-identified concerns on the questionnaire (no need to show or submit responses to anyone). "

What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

"When struggling with mental health concerns, people and carers need the right guidance and need to be pointed to the appropriate service provider or even self-management resource. GPs are not uniform in their support extended at primary level, especially in the regional areas. One of my suggestions (based on what a colleague informed me about NSW mental health service) is - Statewide 24x7 1300- number for mental health Triage (could be called Emotional Health Line and NOT Triage) when struggling with emotional difficulties or need mental health advice including crisis or needing to refer --> option 1: do you wish to speak with someone anonymously (divert to helpline for instant help/advice on services available); or option 2: would you like to contact local mental health service (divert to local area mental health service) Services linking with each other to provide seamless and well-coordinated mental health treatment and support - this is a major issue in my regional area, especially when it comes to child protection and mental health interface. The DHHS VIC has failed to show appropriate leadership. This is clear from the recent Victorian Auditor General Office report (2019). But even before the report, we've experienced this first hand time and again while working in mental health. Regular meetings have been set up by senior CAMHS clinician to discuss complex mental health needs of clients with the child protection services, but the meetings are not a priority (get cancelled recurrently). This leads to worsening of client's mental health, suicide and self-harm risk, family violence and more crises. The adverse impact on the client's developing personality and future mental illness risk is quite clear and can be prevented with timely coordination between DHHS arms of mental health and child protection. Would be good if there is a specific person in leadership position in DHHS who understands mental health and child protection and coordinates these two systems. Such a position should exist for all individual areas under the DHHS with a coordinator at the central DHHS. Geographical barriers to service access and seamless service provision. i. DHHS areas for child protection and area mental health services should map accurately onto each other. ii. DHHS areas for paediatrics and mental health services should map accurately onto each other. Eating disorder clients from my child and adolescent mental health service need to access Royal Children's Hospital (from lower Hume) or GV Health (from Shepparton and surrounds) for paediatrics. How can we ensure seamless service? iii. DHHS areas should be redrawn according to geographical distance to access a service. Clients from lower Hume are required to travel long distances up north to GV Health whereas Northern Metropolitan Melbourne services are just 30-40min away from them. Clients in crisis are taken by ambulance to the emergency dept at The

Northern ED. Then again they have to be transferred back to GV Health for in-patient admission."

What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?
"I can talk about regional Victoria. Regional areas are not well-resourced with primary and secondary tier private mental health services. So mental health response is expected from tertiary services for significant number of clients who'd be serviced in primary and secondary tiers in metropolitan Melbourne. So funding for tertiary mental health services should be higher per capita in regional places. But that is not the case. In addition, population is growing even in the regional areas, but funding cuts are being experienced. Can this please be considered? This disparity also leads to dissatisfaction in population towards tertiary mental health service in the regional areas. Consequently dissatisfaction in the staff who cop the flak from the consumers with preformed ideas about ""mental health service"" can be seen. More people leave the job and turn to cities. High turnover of staff and instability again leads to reduced efficiency of already limited tertiary mental health resources for the community in regional Victoria. "

What are the needs of family members and carers and what can be done better to support them?
N/A

What can be done to attract, retain and better support the mental health workforce, including peer support workers?
N/A

What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?
N/A

Thinking about what Victorias mental health system should ideally look like, tell us what areas and reform ideas you would like the Royal Commission to prioritise for change?
I have talked about the sensitive and thoughtful coordination of services at DHHS level earlier.

What can be done now to prepare for changes to Victorias mental health system and support improvements to last?
N/A

Is there anything else you would like to share with the Royal Commission?
N/A

Self- report Health Questionnaire

(age 11yrs and upwards)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name: Mr/Ms _____ DOB: ___/___/_____

Today's Date: ___/___/_____

#1.	During the **past 2 weeks**, how much have you been bothered by any of the following problems?	Not bothered	Bothered a little	Bothered a lot
	Stomach pain	□	□	□
	Back pain	□	□	□
	Pain in your arms, legs, or joints (knees, hips, etc.)	□	□	□
	Menstrual cramps or other problems with menstrual periods (skip if not applicable)	□	□	□
	Pain or problems during sexual intercourse	□	□	□
	Headaches	□	□	□
	Chest pain	□	□	□
	Dizziness	□	□	□
	Fainting spells	□	□	□
	Feeling your heart pound or race	□	□	□
	Shortness of breath	□	□	□
	Constipation, loose bowels, or diarrhea	□	□	□
	Nausea, gas, or indigestion	□	□	□

References:

- PHQ – Patient Health Questionnaire (http://www.phqscreeners.com/select-screener)
- PHQ-A – Patient Health Questionnaire modified for Adolescents
- SDS – Sheehan Disability Scale (http://www.cqaimh.org/pdf/tool_lof_sds.pdf)
- JA Ewing "Detecting Alcoholism: The CAGE Questionnaire" JAMA 252: 1905-1907, 1984.
- Luck, A.J., Morgan, J.F., Reid, F., O'Brien, A., Brunton, J., Price, C., Perry, L., Lacey, J.H. (2002), 'The SCOFF questionnaire and clinical interview for eating disorders in general practice: comparative study', British Medical Journal, 325,7367, 755 - 756.

#2.	During the **past 2 weeks**, how often have you been bothered by each of the following symptoms?	**Not at all**	**Less than half the days** in the past 2 weeks	**More than half the days** in the past 2 weeks	**Nearly every day** in the past two weeks
	Feeling down, depressed, irritable, or hopeless?	□	□	□	□
	Little interest or reduced pleasure in doing things?	□	□	□	□
	Trouble falling asleep, staying asleep, or sleeping too much?	□	□	□	□
	Poor appetite, weight loss, or overeating?	□	□	□	□
	Feeling tired, or having little energy?	□	□	□	□
	Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	□	□	□	□
	Trouble concentrating on things like school work, reading, or watching TV?	□	□	□	□
	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?	□	□	□	□
	Thoughts that you would be better off dead, or of hurting yourself in some way?	□	□	□	□

Additional information:

In the past year have you felt depressed or sad most days, even if you felt okay sometimes?	□ Yes	□ No
Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?	□ Yes	□ No
Has there been a time in the past month when you have had serious thoughts about ending your life?	□ Yes	□ No

#3.	**Questions about anxiety**		
	a. In the **last 2 weeks**, have you had an anxiety attack — suddenly feeling fear or panic?	□ Yes	□ No
	b. Has this ever happened before?	□ Yes	□ No
	c. Do some of these attacks come suddenly out of the blue — that is, in situations where you don't expect to be nervous or uncomfortable?	□ Yes	□ No
	d. Do these attacks bother you a lot or are you worried about having another attack?	□ Yes	□ No

#4.	**Think about your last bad anxiety attack. (Skip this question if you've never had an anxiety attack).**		
	Did your heart race, pound, or skip?	□ Yes	□ No
	Did you sweat?	□ Yes	□ No
	Did you tremble or shake?	□ Yes	□ No
	Did your mouth go dry?	□ Yes	□ No
	Were you short of breath?	□ Yes	□ No
	Did you have chest pain or pressure?	□ Yes	□ No
	Did you feel as if you were choking?	□ Yes	□ No
	Did you feel a lump in your throat?	□ Yes	□ No
	Did you have hot flashes or chills?	□ Yes	□ No
	Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	□ Yes	□ No
	Did you feel dizzy, unsteady, or faint?	□ Yes	□ No
	Did you have tingling or numbness in parts of your body?	□ Yes	□ No
	Were you afraid you were dying?	□ Yes	□ No
	Fear of losing control, going crazy or passing out?	□ Yes	□ No
	Feelings that objects are "unreal"?	□ Yes	□ No
	Feeling that one's self is distant of "not really here"?	□ Yes	□ No

#5.	Over the **last 2 weeks**, how often have you been bothered by each of the following symptoms?	**Not at all**	**Less than half the days** in the past 2 weeks	**More than half the days** in the past 2 weeks	**Nearly every day** in the past two weeks
	Feeling nervous, anxious, on edge or keyed up	□	□	□	□
	Being so restless that it is hard to sit still	□	□	□	□
	Trouble relaxing	□	□	□	□
	Not being able to stop or control worrying	□	□	□	□
	Worrying too much about different things	□	□	□	□
	Worrying about *misfortunes* – about different things going wrong	□	□	□	□
	Feeling afraid as if something awful might happen	□	□	□	□
	Becoming easily annoyed or irritable	□	□	□	□
	Muscle tension, aches or soreness	□	□	□	□

#6.	**Questions about eating**		
	Are you satisfied with your eating patterns?	□ Yes	□ No
	Do you ever eat in secret?	□ Yes	□ No
(C)	Do you often feel that you can't control what or how much you eat?	□ Yes **(Go to next question)**	□ No **(Skip and go to #7)**
	Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food?	□ Yes **(Go to next question)**	□ No **(Skip and go to #7)**
	Has this been as often, on average, as twice a week for the last 3 months?	□ Yes	□ No

#7.	**In the last 3 months have you often done any of the following in order to avoid gaining weight?**		
(S)	Made yourself sick or vomit?	□ Yes	□ No
	Took laxatives?	□ Yes	□ No
	Fasted — not eaten anything at all for at least 24 hours?	□ Yes	□ No

	Exercised for more than an hour specifically to avoid gaining weight?	□ Yes	□ No
	Made other efforts to avoid gaining weight?	□ Yes	□ No
	Did you do any of the above more than once every week?	□ Yes	□ No
(O)	Did you lose more than 6kg in the last three months?	□ Yes	□ No
(F)	Do you believe yourself to be **Fat** when others say you are too thin?	□ Yes	□ No
(F)	Would you say **Food** dominates your life?	□ Yes	□ No

#8.	**Alcohol and substance use**	**Never**	**More than 3 months ago**	**In the last 3 months**
	a. Did you drink alcohol in any form?	□	□	□
	b. Did you use any recreational drugs (experiment or get "high", smoke, snort, or use pills)?	□	□	□
	c. Did you inject any drugs?	□	□	□

#9.	**Has any of the following happened to you in the last 3 months?**		
	You had a strong desire or urge to drink alcohol or use drugs.	□ Yes	□ No
(A)	A friend or relative expressed concern or annoyance about your use of alcohol or drugs	□ Yes	□ No
(C)	You tried to cut down or stop drinking alcohol or using drugs.	□ Yes	□ No
(E)	You needed to drink alcohol or use drugs first thing in the morning to steady your nerves or get rid of hangover.	□ Yes	□ No
	You drank alcohol or used drugs even though a doctor suggested that you stop because of a problem with your health.	□ Yes	□ No
	You were high or hung over while you were working, going to school, or taking care of children or other responsibilities.	□ Yes	□ No
	You missed or were late for work, school, or other activities because you were drinking, using drugs or hung over.	□ Yes	□ No
	You had a problem getting along with other people while you were drinking or using drugs.	□ Yes	□ No
	You drove a car after drinking or using drugs.	□ Yes	□ No
(G)	You felt guilty about your drinking alcohol or using drugs	□ Yes	□ No

#10. If you checked off any problems on this questionnaire please rate the extent to which your school/work life, home life/family responsibilities and social life/leisure activities were impaired by the problems over the last 2 weeks?

➔ *Please rate on a scale of 0-10 below for all three areas of life*

WORK* / SCHOOL

The problems have disrupted my learning, performance or attendance at work or school:

	Not at all	Mildly (I'm struggling a bit but it's not noticeable to others)			Moderately (Only those who know me well are aware that I'm struggling)			Markedly (Even those who don't know me well can see that I'm struggling)			Extremely
➔	0	1	2	3	4	5	6	7	8	9	10

□ I have not worked / studied at all during the past two weeks for reasons unrelated to the problems marked previously

* Work – includes paid, unpaid, volunteer work or training

SOCIAL LIFE / LEISURE ACTIVITIES

The problems have impacted on my social life / peer relationships / leisure activities:

	Not at all	Mildly (I'm struggling a bit but it's not noticeable to others)			Moderately (Only those who know me well are aware that I'm struggling)			Markedly (Even those who don't know me well can see that I'm struggling)			Extremely
➔	0	1	2	3	4	5	6	7	8	9	10

FAMILY LIFE / HOME RESPONSIBILITIES

The problems have impacted on my family relationships or personal/home responsibilities:

	Not at all	Mildly (I'm struggling a bit but it's not noticeable to others)			Moderately (Only those who know me well are aware that I'm struggling)			Markedly (Even those who don't know me well can see that I'm struggling)			Extremely
➔	0	1	2	3	4	5	6	7	8	9	10

CLINICAL GUIDELINE

Annals of Internal Medicine

Screening for Depression in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement

Albert L. Siu, MD, MSPH, on behalf of the U.S. Preventive Services Task Force*

Description: Update of the 2009 U.S. Preventive Services Task Force (USPSTF) recommendation on screening for major depressive disorder (MDD) in children and adolescents.

Methods: The USPSTF reviewed the evidence on the benefits and harms of screening; the accuracy of primary care–feasible screening tests; and the benefits and harms of treatment with psychotherapy, medications, and collaborative care models in patients aged 7 to 18 years.

Population: This recommendation applies to children and adolescents aged 18 years or younger who do not have a diagnosis of MDD.

Recommendation: The USPSTF recommends screening for MDD in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. (B recommendation)

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for MDD in children aged 11 years or younger. (I statement)

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For author affiliation, see end of text.
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* For a list of USPSTF members, see the **Appendix** (available at www.annals.org).

The U.S. Preventive Services Task Force (USPSTF) makes recommendations about the effectiveness of specific preventive care services for patients without related signs or symptoms.

It bases its recommendations on the evidence of both the benefits and harms of the service and an assessment of the balance. The USPSTF does not consider the costs of providing a service in this assessment.

The USPSTF recognizes that clinical decisions involve more considerations than evidence alone. Clinicians should understand the evidence but individualize decision making to the specific patient or situation. Similarly, the USPSTF notes that policy and coverage decisions involve considerations in addition to the evidence of clinical benefits and harms.

Summary of Recommendations and Evidence

The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. (B recommendation)

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for MDD in children aged 11 years or younger. (I statement)

See the **Figure** for a summary of the recommendations and suggestions for clinical practice.

Appendix Table 1 describes the USPSTF grades, and **Appendix Table 2** describes the USPSTF classification of levels of certainty about net benefit (both tables are available at www.annals.org).

See also:

Related article 342
Editorial comment 372
Summary for Patients 1

Web-Only
CME quiz
Consumer Fact Sheet

Rationale

Importance

Depression is a leading cause of disability in the United States. Children and adolescents with MDD typically have functional impairments in their performance at school or work, as well as in their interactions with their families and peers. Depression can also negatively affect the developmental trajectories of affected youth. Major depressive disorder in children and adolescents is strongly associated with recurrent depression in adulthood; other mental disorders; and increased risk for suicidal ideation, suicide attempts, and suicide completion.

In nationally representative U.S. surveys, about 8% of adolescents reported having major depression in the past year. Little is known about the prevalence of MDD in children. Among children and adolescents aged 8 to 15 years, 2% of boys and 4% of girls reported having MDD in the past year.

Figure. Screening for depression in children and adolescents: clinical summary.

Annals of Internal Medicine

U.S. Preventive Services TASK FORCE
www.USPreventiveServicesTaskForce.org

Population	Adolescents aged 12 to 18 y	Children aged ≤11 y
Recommendation	Screen for major depressive disorder (MDD). Adequate systems should be in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. Grade: B	No recommendation. Grade: I (insufficient evidence)
Risk Assessment	Risk factors for MDD 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.	
Screening Tests	Two instruments that have been most often studied are the Patient Health Questionnaire for Adolescents and the primary care version of the Beck Depression Inventory.	
Screening Interval	The optimal interval for screening for MDD is not known. Opportunistic screening may be appropriate for adolescents, who may have infrequent health care visits.	
Treatment and Interventions	Treatment options for MDD include pharmacotherapy, psychotherapy, collaborative care, psychosocial support interventions, and complementary and alternative medicine approaches.	
Balance of Benefits and Harms	Screening for MDD in adolescents aged 12 to 18 y has a moderate net benefit.	The evidence on screening for MDD in children aged ≤11 y is insufficient, and the balance of benefits and harms cannot be determined.
Other Relevant USPSTF Recommendations	The USPSTF has made recommendations on screening for suicide risk in adolescents, adults, and older adults. Other USPSTF recommendations on mental health topics pertaining to children and adolescents, including illicit drug and alcohol use, can be found on the USPSTF Web site (www.uspreventiveservicestaskforce.org).	

For a summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement, and supporting documents, please go to www.uspreventiveservicestaskforce.org.

Detection

The USPSTF found adequate evidence that screening instruments for depression can accurately identify MDD in adolescents aged 12 to 18 years in primary care settings. The USPSTF found no studies of screening instruments for depression in children aged 11 years or younger in primary care (or comparable) settings and concluded that the evidence is inadequate.

Benefits of Early Detection and Intervention and Treatment

The USPSTF found no studies that directly evaluated whether screening for MDD in adolescents in primary care (or comparable) settings leads to improved health and other outcomes. However, the USPSTF found adequate evidence that treatment of MDD detected through screening in adolescents is associated with moderate benefit (for example, improved depression severity, depression symptoms, or global functioning scores).

The USPSTF found no studies that directly evaluated whether screening for MDD in children aged 11 years or younger in primary care (or comparable) settings leads to improved health and other outcomes and found inadequate evidence on the benefits of treatment in children with screen-detected MDD.

Harms of Early Detection and Intervention and Treatment

The USPSTF found no direct evidence on the harms of screening for MDD in adolescents. Medications for the treatment of depression, such as selective serotonin reuptake inhibitors (SSRIs), have known harms. However, the magnitude of the harms of pharmacotherapy is small if patients are closely monitored, as recommended by the U.S. Food and Drug Administration (FDA). The USPSTF found adequate evidence on the harms of psychotherapy and psychosocial support in adolescents and estimates that the magnitude of these harms is small to none.

The USPSTF found inadequate evidence on the harms of screening for or treatment of MDD in children aged 11 years or younger.

USPSTF Assessment

The USPSTF concludes with moderate certainty that screening for MDD in adolescents aged 12 to 18 years has a moderate net benefit.

The USPSTF concludes that the evidence on screening for MDD in children aged 11 years or younger is insufficient. Evidence is lacking, and the balance of benefits and harms cannot be determined.

CLINICAL CONSIDERATIONS

Patient Population Under Consideration

This recommendation applies to children and adolescents aged 18 years or younger who do not have a diagnosis of MDD. This recommendation focuses on screening for MDD and does not address screening for other depressive disorders, such as minor depression or dysthymia.

Assessment of Risk

The USPSTF recommends screening for MDD in all adolescents but notes that several risk factors might help identify patients who are at higher risk. 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.

Screening Tests

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.

Screening Intervals

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.

Treatment or Interventions

Treatment options for MDD in children and adolescents include pharmacotherapy, psychotherapy, collaborative care, psychosocial support interventions, and complementary and alternative medicine approaches. Fluoxetine is approved by the FDA for treatment of MDD in children aged 8 years or older, and escitalopram is approved for treatment of MDD in adolescents aged 12 to 17 years. The FDA has issued a boxed warning for antidepressants, recommending that patients of all ages who start antidepressant therapy be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior (1). Collaborative care is a multicomponent, health care system–level intervention that uses care managers to link primary care providers, patients, and mental health specialists.

Suggestions for Practice Regarding the I Statement

In deciding whether to screen for MDD in children aged 11 years or younger, primary care providers should consider the following issues.

Potential Preventable Burden

Little is known about the prevalence of MDD in children aged 11 years or younger. The mean age of onset of MDD is about 14 to 15 years. Early onset is associated with worse outcomes. The average duration of a depressive episode in childhood varies widely, from 2 to 17 months.

Potential Harms

The USPSTF found inadequate evidence on the harms of screening for MDD in children. The USPSTF concluded that screening itself is unlikely to be associated with significant harms, aside from opportunity costs, labeling and potential stigma associated with a positive result, and referral for further evaluation and treatment.

The USPSTF concluded, on the basis of a previous review, that the use of SSRIs in children is associated with harms, specifically risk for suicidality. Evidence on the harms of psychotherapy alone or in combination with SSRIs in children is limited. Newer studies provide little additional evidence on treatment harms in children and adolescents but do not suggest more risks. Only 4 studies examined the harms of treatment with SSRIs in children and adolescents. These studies found no increased risk for suicidality associated with antidepressant use, but risk for rare events could not be precisely determined because the studies had limited statistical power. No trials of psychotherapy or combined interventions in children examined harms.

Current Practice

The USPSTF found no evidence on the current frequency of or methods used in primary care for screening for MDD in children.

Additional Approaches to Prevention

The Community Preventive Services Task Force recommends collaborative care for the management of depressive disorders, based on strong evidence of effectiveness in improving depression symptoms, adherence and response to treatment, and remission and recovery from depression. For this and related recommendations from the Community Preventive Services

Task Force, go to www.thecommunityguide.org/mentalhealth/index.html.

Useful Resources

In a separate recommendation statement, the USPSTF concluded that the current evidence is insufficient to assess the balance of benefits and harms of screening for suicide risk in primary care settings, including among adolescents (I statement). Other USPSTF recommendations on mental health topics pertaining to children and adolescents, including illicit drug and alcohol use, can be found on the USPSTF Web site (www.uspreventiveservicestaskforce.org).

OTHER CONSIDERATIONS

Implementation

Many screening tools are available to identify depression in children and adolescents, and some have been used in primary care. The number of items in each tool, the administrative time required to complete them, and the appropriate ages for screening vary. A positive result on an initial screening test does not necessarily indicate the need for treatment. Screening is usually done in 2 phases: The initial screening is 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. In instances where treatment is recommended, it can be initiated by the screening provider or through referral to another set of treatment providers. A negative result on a screening test, however, does not always preclude referral when clinical judgment or parental concerns suggest it is warranted.

The USPSTF recommends that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. Depression can be managed in the primary care or specialist setting or collaboratively in both settings. Treatment options for depression include pharmacologic, behavioral, multimodal, and collaborative care models, some of which require coordination. Finally, inadequate support and follow-up may result in treatment failures or harms, as indicated by the FDA boxed warning. "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. These essential functions can be provided through a wide range of arrangements of clinician types and settings.

Research Needs and Gaps

The systematic evidence review identified several critical research gaps, including the need for studies of screening for and treatment of MDD in children younger than 11 years. Large, good-quality randomized, controlled trials (RCTs) are also needed to better understand the overarching effects of screening for MDD on intermediate and long-term health outcomes. It would be helpful to quantify the proportion of persons with screen-detected MDD who are treated or referred as well as their willingness and ability to be assessed and treated.

The systematic review excluded studies with participants who had comorbid disorders. Children and adolescents with MDD more often have comorbid conditions than those without MDD, particularly in primary care settings. This underscores the importance of additional research in child and adolescent populations that are similar to those found in primary care settings to study the effects of comorbid conditions on screening accuracy, type of MDD treatment selected, and benefits and harms.

For treatment of MDD, research needs include well-designed studies of psychotherapy and combined treatments, as well as studies of the benefits and harms of other treatments (such as non-SSRI medications and complementary or alternative approaches). For rare events, meta-analyses are needed that include only children and adolescents with MDD and focus on current FDA-approved medications. Studies with long-term follow-up are also needed.

DISCUSSION

Burden of Disease

Although it is normal for children and adolescents to experience occasional feelings of sadness and other symptoms of depression, those with MDD have 1 or more major depressive episodes that last at least 2 weeks and cause significant functional impairment across social, occupational, or educational domains. In some children and adolescents with MDD, these symptoms may present as periods of disruptive mood and irritability rather than as a sad mood and may last for weeks, months, or even years. Major depressive disorder is associated with significant morbidity and mortality. Morbidity in children and adolescents may be demonstrated through decreased school performance, poor social functioning, early pregnancy, increased physical illness, and substance abuse. Depressed adolescents have more psychiatric and medical hospitalizations than those who are not depressed. Children with depressive disorders have increased health care costs (including general medical and mental health care) compared with those without mental health diagnoses or those with other mental health diagnoses (except conduct disorder). Major depressive disorder also increases the risk for suicide. Ten percent of children aged 5 to 12.9 years and 19% of adolescents aged 13 to 17.9 years with MDD attempt suicide (2).

The mean age of onset of MDD in childhood and adolescence is about 14 to 15 years, and onset is earlier in girls than boys. In 2 nationally representative U.S. surveys, about 8% of adolescents reported having MDD in the past year. Little is known about the prevalence of the disorder in children. The 2005 National Health and Nutrition Examination Survey found that among children and adolescents aged 8 to 15 years, 2% of boys and 4% of girls reported having MDD in the

past year. However, the prevalence of depression in primary care settings is often higher in studies with community samples of children and adolescents. Only 36% to 44% of children and adolescents with depression receive treatment, suggesting that the majority of depressed youth are undiagnosed and untreated (3).

Scope of Review

The USPSTF commissioned a systematic evidence review to update its 2009 recommendation on screening for child and adolescent MDD among primary care populations (3, 4). To focus on the population most likely to benefit from screening and intervention, the scope of the review was narrowed to focus on screening for and treatment of MDD. In addition, studies of paroxetine were excluded because of the 2003 FDA recommendation that it not be used to treat MDD in children and adolescents because of reports of possible suicidal ideation and suicide attempts in children and adolescents receiving paroxetine for depression. As a result, many studies included in the 2009 review were not included in the updated review. The USPSTF examined the evidence on the benefits and harms of screening; the accuracy of primary care–feasible screening tests; and the benefits and harms of treatment with psychotherapy, medications, and collaborative care models in patients aged 7 to 18 years. Treatment studies were limited to those that were implemented in or received referrals from primary care settings to ensure that the patient population was similar to those who would be identified through screening.

Accuracy of Screening Tests

The USPSTF found 5 good- or fair-quality studies of the accuracy of MDD screening instruments in children and adolescents. One study recruited adolescents from a primary care setting and compared the PHQ-A with a full diagnostic interview by a mental health professional. Four studies recruited adolescents from school settings and compared the screening test with a diagnostic interview or a different screening test. One study evaluated the BDI, 1 evaluated the Center for Epidemiologic Studies Depression Scale (CES-D), 1 evaluated the BDI and the CES-D, and 1 evaluated the Clinical Interview Schedule–Revised. No studies included children younger than 11 years.

The PHQ-A study had the highest positive predictive value. The authors did not report a diagnostic cutoff score but reported sensitivity of 73% and specificity of 94% for a positive test result (5). Results were not stratified by age, sex, or ethnicity. The 2 BDI studies reported sensitivity ranging from 84% to 90% and specificity ranging from 81% to 86% when a cutoff score of 11 was applied (6, 7). One study (7) reported a higher area under the curve for males than for females, but neither of the BDI studies reported results by age or ethnicity.

The CES-D studies used different diagnostic cutoff scores (7, 8). One study enrolled a slightly younger population than the other (age range of 11 to 15 years vs. average age >16 years). Sensitivity ranged from 18% to 84% and specificity ranged from 38% to 83%, depending on the cutoff score used. Results by sex were inconsistent, and neither study stratified results by age or ethnicity. One study evaluated the Clinical Interview Schedule–Revised (9). The mean age was 15.7 years, and sensitivity and specificity were 18% and 97%, respectively. The study did not report other outcomes or stratify results by age, race, or ethnicity.

Effectiveness of Treatment

The USPSTF found 8 fair- or good-quality RCTs that reported health outcomes in children or adolescents with screen-detected MDD who were treated with SSRIs (4 RCTs), psychotherapy (2 RCTs), SSRIs combined with psychotherapy (1 RCT), or collaborative care (1 RCT). Most trials were restricted to adolescents aged 12 to 14 years or older; only 2 of the SSRI trials included children aged 7 or 8 years. Outcomes included treatment response, which was defined differently across studies; symptom severity; and global functioning. Depression outcomes were reported after 8 to 12 weeks of SSRI treatment or psychotherapy, whereas the collaborative care study reported outcomes at 52 weeks.

SSRIs

One good-quality study (n = 221) compared fluoxetine with placebo in adolescents aged 12 to 17 years (10–12). Two fair-quality studies (n = 268 and 316) compared escitalopram with placebo in children and adolescents (13) and adolescents only (14). One fair-quality study (n = 178) compared citalopram with placebo in children and adolescents (15). The absolute difference in response favored SSRIs in all 4 studies (range, 2.4% to 25%) and was significant in 2 of the 4 trials. When other outcomes, such as symptom severity or global functioning, were reported, they also favored the SSRI group. One trial examined the efficacy of escitalopram by age group (children vs. adolescents) and found that it was superior to placebo in improving depression symptoms, depression symptom severity, and global functioning in adolescents but not children (13). No trials examined efficacy across sex or race/ethnicity subgroups.

Psychotherapy

Two studies evaluated the benefits of cognitive behavioral therapy (CBT) compared with placebo (waitlist control or clinical monitoring) in adolescents with MDD and reported nonsignificant improvements in response (43.2% vs. 34.8%) and recovery (odds ratio [OR], 2.15 [95% CI, 0.87 to 5.33]) (10, 11, 16). Results for remission (16% vs. 17%) did not differ significantly between groups.

SSRIs Combined With Psychotherapy

One CBT study also compared CBT plus fluoxetine with placebo (10). The CBT plus fluoxetine group showed a 71% response rate versus a 35% response rate in the placebo group, which received a placebo drug and weekly clinical monitoring (P = 0.001).

Collaborative Care

One recent RCT (n = 101) evaluated a 12-month collaborative care intervention in adolescents aged 13 to 17 years who screened positive for depression (60% with MDD) in 9 primary care clinics within 1 health system (17). The intervention was based on the IMPACT (Improving Mood–Promoting Access to Collaborative Treatment) model and was adapted for adolescents. Patients randomly assigned to the collaborative care group had an initial in-person session that included their parents, choice of treatment type, and regular follow-up with depression care managers (28% received psychotherapy alone, 4% received pharmacotherapy alone, and 54% received both). Patients randomly assigned to the usual care control group received screening results and could access mental health services through the usual health care system. Compared with the control group, patients in the collaborative care group had greater reductions in depressive symptoms at 6 and 12 months (8.5- and 9.4-point reductions on the Children's Depression Rating Scale–Revised, respectively; $P < 0.0001$ for interaction), better response rates (≥50% score reduction from baseline) at 12 months (OR, 3.3 [CI, 1.4 to 8.2]) and 6 months (not significant), and higher likelihood of remission at 6 months (OR, 5.2 [CI, 1.6 to 17.3]) and 12 months (OR, 3.9 [CI, 1.5 to 10.6]).

Potential Harms of Screening and Treatment

The USPSTF found no direct evidence on the harms of screening for MDD in adolescents or children.

SSRIs

Five SSRI trials reported on harms and found no significant differences between intervention groups, although none of these studies were powered to detect these differences. Four trials (2 for escitalopram, 1 for citalopram, and 1 for fluoxetine) reported on suicidality (this included worsening suicidal ideation or a suicide attempt; no completed suicides were reported). No studies found significant differences but, again, none were sufficiently powered for this outcome. No studies examined subgroup differences in harms. The USPSTF found no evidence on the long-term (>12 weeks) effects of SSRIs.

Psychotherapy

One CBT trial reported on harms and found no apparent differences in harms-related, suicide-related, or psychiatric adverse events between the CBT and placebo groups (10).

SSRIs Combined With Psychotherapy

The same trial also reported on the harms of CBT plus fluoxetine versus placebo and found no apparent differences (10).

Collaborative Care

The single trial of collaborative care found no differences in the number of psychiatric hospitalizations between the intervention and control groups (6% vs. 4%). More patients in the control group had an emergency department visit with a primary psychiatric diagnosis (10% vs. 2%). However, this study was not powered to detect differences (17).

Estimate of Magnitude of Net Benefit

The USPSTF found adequate evidence that screening tests can accurately identify MDD in adolescents. It also found adequate evidence that treatment of adolescents with screen-detected MDD is associated with beneficial reductions in symptoms. Although the data are limited, the USPSTF concludes that the evidence on the frequency of medication-related adverse events in adolescents is adequate to estimate that the magnitude of harms of pharmacotherapy is small if patients are closely monitored. The USPSTF concludes that the evidence on the harms of psychotherapy and collaborative care in adolescents is adequate to estimate that the magnitude of harms is small to none. Therefore, the USPSTF concludes with moderate certainty that screening for MDD in adolescents aged 12 to 18 years is associated with moderate net benefit.

The USPSTF found inadequate evidence that screening tests can accurately identify MDD in children and inadequate evidence on the effectiveness of treatment of children with screen-detected MDD. As a result, the USPSTF concludes that the evidence is insufficient to make a recommendation on screening for MDD in children aged 7 to 11 years.

Response to Public Comment

A draft version of this recommendation statement was posted for public comment on the USPSTF Web site from 8 September to 5 October 2015. Many comments focused on the phrase "adequate systems." Some commenters requested a more detailed definition of what constitutes an adequate system for screening, others recommended removing the conditional term "when," and others recommended that the requirement for adequate systems be stronger. To clarify the recommendation, the USPSTF separated it into 2 statements: one to support screening, and a second to explain how screening should be implemented. The USPSTF also revised the section on implementation to clarify that a range of staff types, organizational arrangements, and settings can support the goals of depression screening.

UPDATE OF PREVIOUS USPSTF RECOMMENDATION

In 2009, the USPSTF recommended screening for MDD in adolescents (aged 12 to 18 years) when systems are in place to ensure accurate diagnosis, psychotherapy (CBT or interpersonal), and follow-up and concluded that the evidence was insufficient to make a recommendation for children (aged 7 to 11 years). The current recommendation reaffirms these positions but

removes the mention of specific therapies in recognition of decreased concern over the harms of pharmacotherapy in adolescents when they are adequately monitored.

RECOMMENDATIONS OF OTHERS

The American Academy of Pediatrics' Bright Futures program recommends annual screening in child and adolescent patients for emotional and behavioral problems (18). Medicaid's child health component, the Early and Periodic Screening, Diagnosis, and Treatment program, recommends screening to detect physical and mental conditions at periodic, age-appropriate intervals and, if risk is identified, follow-up with diagnostic and treatment coverage (19). The Canadian Task Force on Preventive Health Care states that there is insufficient evidence to recommend for or against screening for depression in children or adolescents in primary care settings (20).

From the U.S. Preventive Services Task Force, Rockville, Maryland.

Note: This recommendation statement is being published simultaneously in *Pediatrics*.

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Requests for Single Reprints: Reprints are available from the USPSTF Web site (www.uspreventiveservicestaskforce.org).

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Appendix: U.S. Preventive Services Task Force

Members of the USPSTF at the time this recommendation was finalized† are Albert L. Siu, MD, MSPH, *Chair* (Mount Sinai School of Medicine, New York, and James J. Peters Veterans Affairs Medical Center, Bronx, New York); Kirsten Bibbins-Domingo, PhD, MD, MAS, *Co-Vice Chair* (University of California, San Francisco, San Francisco, California); David C. Grossman, MD, MPH, *Co-Vice Chair* (Group Health Research Institute, Seattle, Washington); Linda Ciofu Baumann, PhD, RN, APRN (University of Wisconsin, Madison, Wisconsin); Karina W. Davidson, PhD, MASc (Columbia University, New York, New York); Mark Ebell, MD, MS (University of Georgia, Athens, Georgia); Francisco A.R. García, MD, MPH (Pima County Department of Health, Tucson, Arizona); Matthew Gillman, MD, SM (Harvard Medical School and Harvard Pilgrim Health Care Institute, Boston, Massachusetts); Jessica Herzstein, MD, MPH (independent consultant, Washington, DC); Alex R. Kemper, MD, MPH, MS (Duke University, Durham, North Carolina); Alex H. Krist, MD, MPH (Fairfax Family Practice, Fairfax, and Virginia Commonwealth University, Richmond, Virginia); Ann E. Kurth, PhD, RN, MSN, MPH (New York University, New York, New York); Douglas K. Owens, MD, MS (Veterans Affairs Palo Alto Health Care System, Palo Alto, and Stanford University, Stanford, California); William R. Phillips, MD, MPH (University of Washington, Seattle, Washington); Maureen G. Phipps, MD, MPH (Brown University, Providence, Rhode Island); and Michael P. Pignone, MD, MPH (University of North Carolina, Chapel Hill, North Carolina).

† For a list of current USPSTF members, go to www.uspreventiveservicestaskforce.org/Page/Name/our-members.

Appendix Table 1. What the USPSTF Grades Mean and Suggestions for Practice

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer/provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer/provide this service.
C	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.	Offer/provide this service for selected patients depending on individual circumstances.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the Clinical Considerations section of the USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

Appendix Table 2. USPSTF Levels of Certainty Regarding Net Benefit

Level of Certainty*	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as: the number, size, or quality of individual studies; inconsistency of findings across individual studies; limited generalizability of findings to routine primary care practice; and lack of coherence in the chain of evidence. As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: the limited number or size of studies; important flaws in study design or methods; inconsistency of findings across individual studies; gaps in the chain of evidence; findings that are not generalizable to routine primary care practice; and a lack of information on important health outcomes. More information may allow an estimation of effects on health outcomes.

* The USPSTF defines *certainty* as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general primary care population. The USPSTF assigns a certainty level on the basis of the nature of the overall evidence available to assess the net benefit of a preventive service.