Representation: National Forum of School Health Educators

Title: Depression Screening Measure for School Nurses

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School Nurses lead on delivering the ‘Healthy Child Programme’ (Department of Health, DH, 2009) for school aged children, hence they have expertise in health promotion, protection and prevention at an individual, community and population level. Since April 2013 the commissioning of key public health services for school aged children has transformed with this responsibility being devolved to Local Authorities. Therefore the provision of school nursing services has altered with the emphasis on productivity, demonstrating the effectiveness of their role and in providing a framework to deliver improved outcomes which meet the current and future health needs of children and young people (DH/Public Health England, PHE 2014).

One of the key current and future public health issues which has significantly developed in children and young people over the last decade is emotional health and wellbeing. Approximately “one in ten 5-16 year olds are known to have a diagnosable mental health condition and 50% of these lifetime cases begin by the age of 14 years” (Green *et al*.,2005, p.xxi). Furthermore approximately “18% of children living with a parent who has a mental health problem are twice as likely to develop emotional disorders themselves” (Green *et al*., 2005, p.xxi). However most worrying is the World Health Organisation’s (WHO 2001) prediction that at its current rate depression will be the second most disabling disease globally by 2020.

Depression is an episodic emotional disorder which has intervening periods of both normal mood and periods of low mood for at least two weeks. This is also accompanied by other cognitive symptoms such as poor concentration, reduced sense of enjoyment of pleasurable activities, suicidal ideation and/or intent. Therefore often depression can be mistaken for dysthymic disorder which has similar features which are characterised as having a "chronically depressed mood for at least twelve months with some cognitive and vegetative symptoms" (Bettge *et al*., 2008: 72) but displaying lesser severity than in depression (Figure 1).

Figure 1: Differences between Depression and Dysthymic Disorder (Bettge et al. 2008)

Depression	Dysthymic Disorder
Period of depressed mood or irritability for at least two weeks in addition to further characteristic symptoms such as:	Milder mood disorder with chronically depressed moor or irritability for at least twelve months.
Cognitive symptoms: Poor Concentration, Loss of Temper, Reduced sense of pleasure/interest, tearfulness, Feelings of worthlessness and guilt,	Cognitive and vegetative symptoms also maybe present but with lesser severity of symptoms than in major depression.
Vegetative symptoms: Changes in appetite/weight, Insomnia/hypersomnia, Changes to motor behaviour such as slowing down/agitation.	

Kramer and Garralda (2000) state that only approximately 2 -10% of children and young people present with psychological symptoms on initial presentation, and are more likely to present with physical symptoms such as headaches, anxiety and behavioural problems. Thus it is no surprise that up to 50% of cases of depression were missed by practitioners (Mitchell & Kakkadasam 2011) and overall professional help seeking rates remain low for children and young people with emotional problems (Collins *et al*.,2005).

To further add to this challenge children and young people's brain's do not fully develop until the age of 25 years (Royal College of Psychiatrists, RCP 2010b) therefore they may display some of the cognitive and vegetative symptoms such as irritability, low mood, loss of temper and poor decision making associated with normal healthy brain development. Albeit, certain regions within the brain have been linked to the occurrence of depression thus indicating vulnerability within this developmental stage (Forbes & Dahl 2005).

Consequently the identification and recognition of early indicators of depression in children and young people is cited as one of the many challenges practitioners face in practice (Roberts 2014). This raises an important question as to whether school nurses have the tools to assist them in identifying and recognising the manifestation of symptoms of depression in children and young people. Particularly when the National Institute for Clinical Excellence guidance on depression in children and young people indicates that "healthcare professionals in primary care should be familiar with screening for mood disorders" (NICE 2005: 20).

Therefore a review of emotional health screening measures was undertaken which included the following: Strengths and Difficulties Questionnaire (SDQ, Goodman 1997), Short Mood and Feelings Questionnaire (SMFQ, Angold et al., 1995) and the Beck Depression Inventory (Beck et al 1996). It was evident that both the SMFQ and Beck Depression Inventory are "specific measures for depressive symptomology which considers how a child or young person has been feeling or acting over the last two weeks" (Angold *et al*., 1995: 237).

Whereas the SDQ is designed to recognise behavioural and emotional disorders in young people such as hyperactivity, peer friendships, emotional symptoms and conduct behaviours (Goodman 1997).

Following consideration of these screening measures the SMFQ was identified as an appropriate tool to be introduced within the school nursing service due to the following: use for ages 8-18 years, 13 items self-report and parent screening measure which is quick, feasible, effective and well accepted by patients and practitioners (Zuckerbrot *et al*., 2007), and it can be administered and easily scored within five minutes or less (Angold *et al*., 1995). The SMFQ addresses both the cognitive and affective components of depression thus providing indicators of depressive status (Burlesson Daviss *et al*., 2006: 928). One systematic review indicated the psychometric testing results as having high reliability and criterion validity with sensitivity levels of 70% identifying children and young people with depression and specificity levels of 85% of children and young people who do not have depression (Angold *et al*., 1995; Burlesson Daviss *et al*., 2006; aap, 2012, Figure 2).

Figure 2: Comparison of Screening Measures (Aap 2012)

Tools and Description	Number of items/format	Age Groups	Administration	Psychometric properties
Strengths and Difficulties Questionnaire (SDQ)	25 items	3-17 years	Self/Parent report	Sensitivity: 63% Specificity: 88%
Short mood and feelings Questionnaire (SMFQ)	13 items	8-18 years	Self/Parent report	Sensitivity: 70% Specificity: 88%
Beck Depression Inventory	21 items	14 years +	Self- administered	Sensitivity: 84% Specificity: 81%
Sensitivity = Accuracy in identifying a problem **Specificity**= Accuracy in identifying individuals who do not have a problem.				

However according to the NICE guidelines (2005) Child and Adolescent Mental Health Services (CAMHS) undertake the SMFQ with a child or young person over the age of 11 years upon initial assessment (NICE 2005:1.4.1.1), yet surely practitioners working within universal services should be trained to use this tool instead to guide and support their decision making in practice in order to aid early identification and intervention and prevent inappropriate referrals to an already stretched CAMHS service (Wilson et al.2007).

By asking a child or young person to complete the SMFQ it is the first and most important step towards managing depression, not diagnosing the condition (Sharp and Lipsky 2002), as a screening measure evaluates the presence of a particular problem, as opposed to an assessment tool which determines a diagnosis and treatment recommendations (Rockville 2009). The foundations of utilising this screening measure (SMFQ) are based upon building a therapeutic relationship between a child/young person and the school nurse (Dziopa and Ahern 2009) thus 'making every contact count' (RCN 2012). During the interaction if a school nurse has any concerns regarding a child/young person's emotional health, screening questions (Figure 3) would be asked to identify risk factors relating to depression and to support building a risk profile (NICE 2005, Figure 4).

Figure 3: Points to consider during initial consultation (Roberts 2014)

Who does the child/young person live with?
Has there been any recent life changes – bereavement, separation, moving house/school?
Does the child/young person regularly attend school or college?
Do they have a supportive peer group, close friends, supportive parents?
What are the child/young person's interests/plans for the future or are they hopeless about the future?
Are they being bullied or been previously bullied?
Ascertain dietary/sleep patterns- are they sleeping, overeating, lack of appetite?
Are they self-harming? Thoughts of suicidal ideation

Figure 4: Risk factors of Depression in Children and Young People (NICE 2005: 57)

Key Symptoms:

At least one of the following symptoms are present on most days, most of the time for at least 2 weeks:

- Persistent sadness or low mood,
- Loss of interests and/or pleasure,
- Fatigue or low energy
-

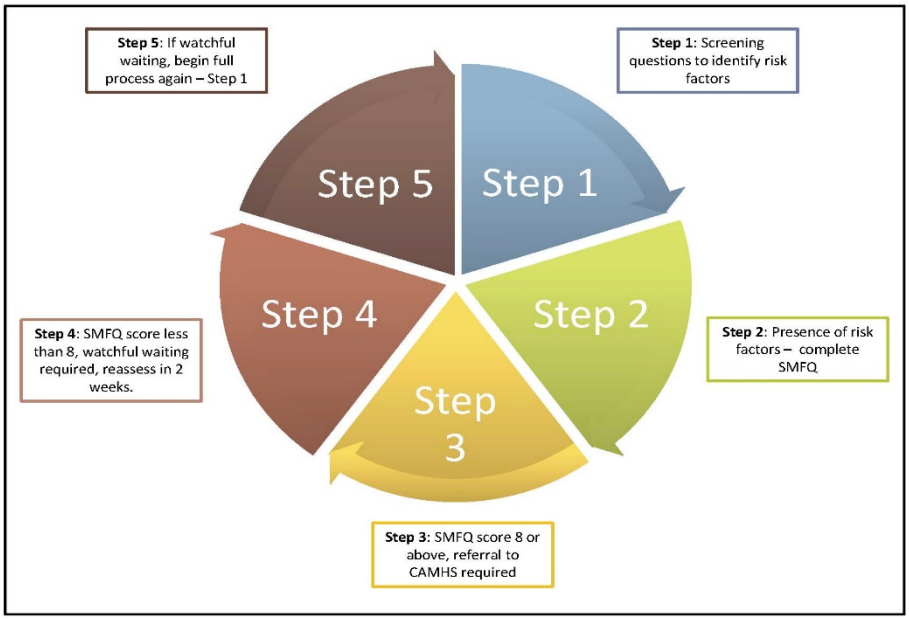
If any of the above key symptoms are present, check the associated symptoms below:

Associated symptoms:

- Poor or increase sleep
- Poor concentration or indecisiveness
- Low self confidence
- Poor or increased appetite
- Suicidal thoughts or acts
- Agitation of slowing of movements
- Guilt or self-blame.

If risk factors are identified relating to depression, the child/young person would be asked to complete the SMFQ self-report measure (Figure 5). Upon completion if the overall score of the SMFQ totals a score of 8 or above this would then require referral to CAMHS for diagnosis, support and treatment (Angold *et al*., 1995).

Figure 5: School nursing indications for utilising the SMFQ in practice:



By introducing the use of SMFQ (Angold *et al*., 1995) into school nursing practice it will support practitioners in their challenging role to recognise, identify and detect depression in children and young people, which will therefore improve children and young people's mental health and wellbeing, enhance practitioners confidence in working within this aspect of their role and subsequently improve the quality and accessibility of services (DH/PHE 2014).

Please note the above work is based upon my own views/opinions, not my employer.

This work will be presented at the School Nursing International Conference in July 2015 – poster presentation.

References:

American Academy of Pediatrics (Aap 2012) Mental health screening and assessment tools for Primary Care.
Available at: http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf. Accessed on 29 March 2015.

Angold, A. Costello, E. Messer, S. & Pickles, A. (1995) Development of a short questionnaire for use in epidemiological studies of depression in children and adolescents: *International Journal of Methods in Psychiatric Research*. Vol 5: pp.237-249.

Beck, AT. Steer, RA. & Brown, GK (1996) Cited in Dihigo, S (2014) Use of screening tools for depression in adolescents: An evidence-based systematic review. *Women's Healthcare*. May 2014, pp.23-30.

Bettge, S. Wille, N. Barkmann, C. Schulte-Markwort & Ravens-Sieberer, (2008) Depressive symptoms of children and adolescents in a German representative sample: results of the BELLA study. *Child Adolescent Psychiatry* 17:71-81.
Burlesson Daviss, W. Birmaher, B. Melhem, N (2006) Criterion validity of the mood and feelings questionnaire for depressive episodes in clinic and non-clinic subjects. *Journal of child psychology and psychiatry.* 47:9, pp. 927-934.

Collins, K A. Westra, H A. Dozois, D. Burns, D (2005) Cited in: Yap, M. Doreen-Pilkington, P. Ryan, S & Jorm, A (2013) Parental factors associated with depression and anxiety in young people: A systematic review and meta-analysis. *Journal of Affective Disorders* 156 (2014) 8-23.

Department of Health/Department for Children, Schools and Families (2009) Healthy Child Programme. From 5-19 years old. London, DH/DCSF.

Department of Health/Public Health England (2014) Health Visiting and School Nurse Programme: Supporting Implementation of the New Service Offer: Promoting Emotional Wellbeing and Positive Mental Health of Children and Young People. DH/PHE.

Dziopa, F. & Ahern, K. (2009) What makes a quality therapeutic relationship in psychiatric/mental health nursing. A review of the research literature. *Journal of Advanced Nursing Practice.* 10, 1 :7-7.

Forbes, E. & Dahl, R. (2005) Neural systems of positive affect. Relevance to understanding Child and Adolescent Depression. Developmental Psychology. 17 (3) pp.827-850.

Green, H. McGinnity, A. Meltzer, H. Ford, T. Goodman, R. (2005) Mental health of children and young people in Great Britain. London; Palgrave Macmillan.

Goodman, R. (1997) The Strengths and Difficulties Questionnaire. A Research Note. *Journal of Child Psychology and Psychiatry,* 38; 581-586.
Kramer, T. & Garralda, M. (2000) Advances in Psychiatric Treatment. 6:287-94.

Mitchell, AJ. & Kakkadasam, V. (2011) Cited in: Haddad, M. & Tylee, A. (2013) The development and first use of the QUEST measures to evaluate school nurses knowledge and skills for depression recognition and management. *Journal of School Health*, Vol 83, No.1.

National Institute of Clinical Excellence (NICE, 2005) Depression in children and young people: Identification and management in primary, community and secondary care – Clinical Guideline 28. National Collaborating Centre for Mental Health.

Roberts, J. (2014) Depression and low mood in young people: towards best practice. *British Journal of Family Medicine,* Jan/Feb 2014.

Rockville, MD. (2009) Substance Abuse and Mental Health Services Administration. United States.

Royal College of Nursing (RCN 2012) Upstream: Nursing contribution to public health. Prevent, Promote and Protect. London, RCN.

Royal College of Psychiatrists (RCP, 2010b) No Health without public mental health. The case for Action. London, RCP.

Sharp, L. & Lipsky, M. (2002) Screening for depression across the lifespan: A review of measure for use in Primary Care Setting. *American Family Physician*, Sep 15:66 (6), pp. 1001-1009.

Wilson, P. Furnivall, J. Barbour, R. Connelly, G. Bryce, G. Phin, L. Stallard, A. (2007) The world of health visitors and school nurses with children with psychological and behavioural problems. *Journal of Advanced Nursing* 61 (4), pp.445-455.

World Health Organisation (2001) Mental Health: New Understanding, New Hope. WHO.

Zuckerbrot, RA. Maxon, L. Pagar, D. (2007) Cited in Dihigo, S. (2014) Use of screening tools for depression in adolescents: An evidence-based systematic review. *Women's Healthcare*. May 2014, pp.23-30.