Columbia University TeenScreen® Program

A Collaborative Opportunity with

The Carmel Hill Center
at the Division of Child & Adolescent Psychiatry
Columbia University

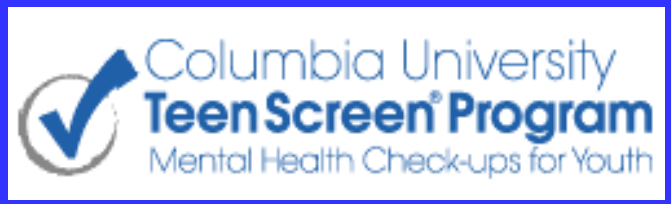


EXHIBIT D MentalHealth Document consists of 33 pages.

☑ Entire document provided.

☐ Due to size limitations, pages _____ provided. A copy of the complete document is available through the Research Library (775/684-6827) or e-mail library@lcb.state.nv.us).

Meeting Date 11/4/03

The Problems of Mental Illness and Suicide in Youth

The Problems of Mental Illness and Suicide in Youth

- **7-12 million youth suffer from mental illness**
  - **2 out of 3 do not receive treatment**
- **Suicide = 3rd cause of death in 15-19 year-olds**
- **3 million youth are at risk for suicide**
  - **yet only 36% receive treatment**
- **Effective screening tools are available**
- **Effective treatments are available**

ADOLESCENT DEPRESSION

- **Affects 750,000 teens at any one time**
- **Directly or indirectly results in 1,700 suicides per year**
- **60–80 percent will go undiagnosed and untreated**

12-MONTH INCIDENCE OF SUICIDAL IDEATION & BEHAVIOR

—U.S. HIGH-SCHOOL STUDENTS—

(2001, N=13,601)

	RATE	TEENS 15–19
Ideation	19.0% (± 1.4)	(3.8 million)
Ideation with plan	14.8% (± 1.1)	(3.0 million)
Attempt	8.8% (± 0.8)	(1.8 million)
Attempt requiring medical attention	2.6% (± 0.4)	(520,000)
SUICIDE (age 15–19)*	.008%	(1,639)

* Anderson et al. 2002; Grunbaum et al. 2002 (YRBS), U.S. Census 2000

LEADING CAUSES OF DEATH IN 15- TO 19-YEAR-OLDS

— UNITED STATES, 2000 —

CAUSE	# OF DEATHS	
Accidents	6755	
Homicide	1914	
Suicide	**1621**	
Cancer	745	
Heart Disease	403	
Congenital Anomalies	225	
Chronic Lower Respiratory Disease	86	**1639**
Stroke	67	
Influenza and Pneumonia	65	
Diabetes	48	

Source: Anderson 2002

STATE RANK 2000

— 15- TO 24-YEAR-OLDS —

STATE	DEATHS	POPULATION	RATE	STATE	DEATHS	POPULATION	RATE
1 Alaska	49	108,096	45.3	27 D.C.	7	60,374	11.6
2 New Mexico	63	2,64,568	23.8	28 North Carolina	117	1,031,862	11.3
3 Arizona	129	689,404	18.7	29 Louisiana	77	699,897	11.0
4 South Dakota	20	116,792	17.1	30 Iowa	46	418,254	11.0
5 Nevada	40	244,742	16.3	31 Alabama	68	620,536	11.0
6 North Dakota	16	99,882	16.0	32 Texas	340	3,114,716	10.9
7 Oregon	74	463,292	16.0	33 Washington	91	836,357	10.9
8 Nebraska	38	254,056	15.0	34 Hawaii	18	166,282	10.8
9 Maine	25	167,180	15.0	35 Maryland	72	672,606	10.7
10 Montana	20	134,685	14.8	36 Pennsylvania	159	1,532,267	10.4
11 Vermont	12	81,058	14.8	37 Rhode Island	13	125,996	10.3
12 Colorado	88	597,225	14.7	38 Minnesota	71	700,320	10.1
13 Idaho	31	211,470	14.7	39 Florida	186	1,869,606	9.9
14 Utah	62	428,402	14.5	40 Michigan	133	1,382,271	9.6
15 Wyoming	11	79,924	13.8	41 Ohio	141	1,569,303	9.0
16 Oklahoma	68	508,277	13.4	42 Illinois	146	1,677,845	8.7
17 Wisconsin	99	768,160	12.9	43 South Carolina	48	560,521	8.6
18 Tennessee	94	749,898	12.5	44 Virginia	82	975,645	8.4
19 Arkansas	46	368,851	12.5	45 Connecticut	32	392,893	8.1
20 Kansas	50	404,295	12.4	46 New York	173	2,337,475	7.4
21 Missouri	96	777,522	12.3	47 New Hampshire	11	155,465	7.1
22 Kentucky	70	575,494	12.2	48 Massachusetts	53	762,804	6.9
23 Georgia	137	1,133,356	12.1	49 Delaware	7	101,824	6.9
24 West Virginia	30	249,685	12.0	50 California	322	4,852,602	6.6
25 Indiana	101	842,454	12.0	51 New Jersey	60	994,675	6.0
26 Mississippi	52	436,047	11.9	TOTAL	3,994	38,367,211	10.4

CDC WISQARS (updated December 2002)

HIGH RISK FOR SUICIDE

- **Boys** at much higher risk than girls
- **Among Boys :**
  - Previous suicide attempt(s) (28%)
  - Age 16 or over
  - Associated mood disorder (60%)
  - Associated substance abuse (42%)
- **Among Girls:**
  - Mood disorder (68%)
  - Previous suicide attempt(s) (50%)

Source: Shaffer et al. 1996

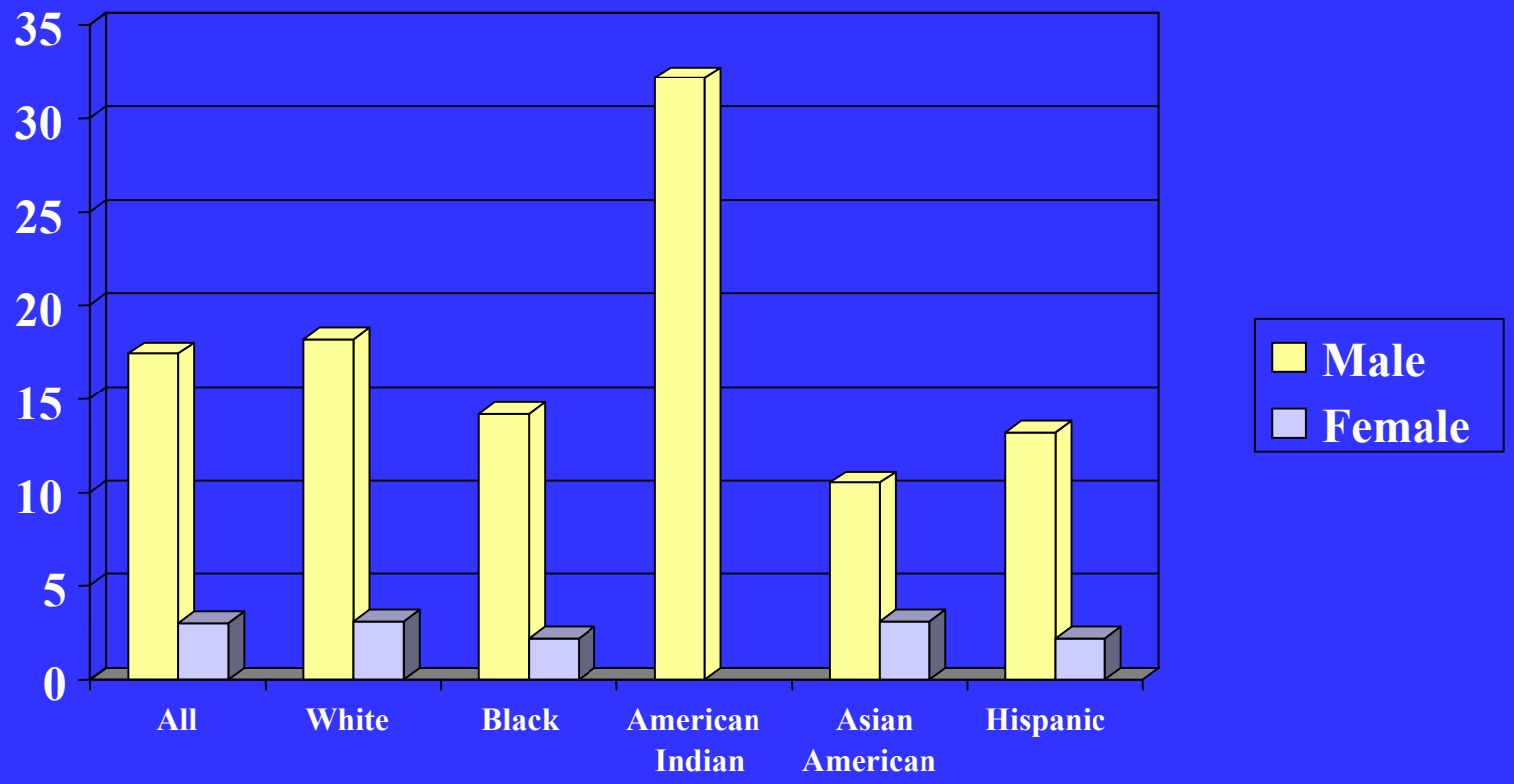
SUICIDE RATES DURING ADOLESCENCE

— UNITED STATES, AGES 10–24, 2000 —

Age

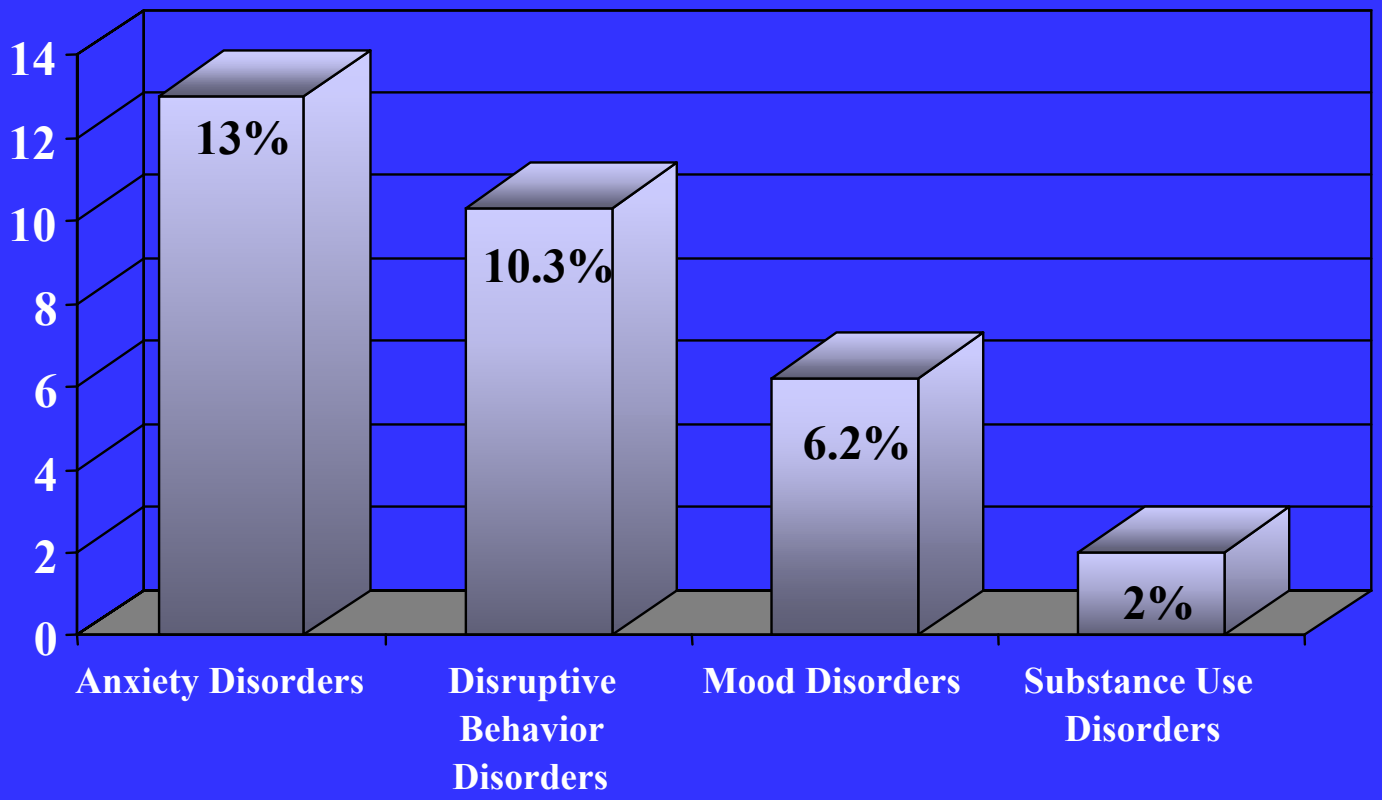
Source: CDC 2002 (WISQARS)

SUICIDE RATES FOR 2000
Ages 15-24, by Race and Gender



Source: National Vital Statistics Report, 2002 (rates per 100,000)

PREVALENCE OF MENTAL DISORDERS
U.S. Children and Adolescents Aged 9-17



Shaffer et al., 1996

PSYCHIATRIC DISORDER IN ADOLESCENT SUICIDE

- 90% of teens who commit suicide suffer from mental illness
- 63% are symptomatic for more than a year before their suicides
- The most common risk factors are:
    1. Mood disorder
    2. Drug/alcohol abuse
    3. Past suicide attempt

ONSET OF ANY PSYCHIATRIC SYMPTOMS BEFORE A SUICIDE

(N=121)

TIME BEFORE DEATH	%
> 12 months	63%
3–12 months	13%
< 3 months	4%

Source: Shaffer et al. 1996

COMPLICATIONS OF UNTREATED DEPRESSION IN ADOLESCENCE

SCHOOL

- Deteriorating schoolwork
- School absenteeism
- Held back or fail to get to college

HOME

- Strained relations with parents and siblings

PEERS

- Withdrawal leading to reduced support system

SELF

- Distress
- Increased chance of smoking, excess alcohol, and drugs
- Potential for suicide

MENTAL HEALTH AND ACADEMIC ACHEIVEMENT IN YOUTH

Depression	→	**Lower levels of school performance, high scholastic anxiety, poor peer and teacher relationships**
Anxiety Disorders	→	**Drug use and dependence, suicidal behavior and reduced likelihood of attending college**
Suicidal Behavior	→	**Lower levels of school performance and school connectedness**
Substance Abuse/Dependence	→	**Lower levels of school performance**

Based on a literature review of the following: Fosterling & Binser (2002), Masi et al. (2001), Marmorstein (2001), Woodward et al. (2001), Slap et al. (2001), Alatorre & de Los Reyes (1999), Chen et al. (1995), Reinherz et al. (1993).

THE COLUMBIA UNIVERSITY TEENSCREEN PROGRAM

COLUMBIA TEENSCREEN PROGRAM

– HISTORY –

1991: Pilot Study
- **Funded by NIMH and CDC**
- **8 screening sites in metro NY**
- **2,000 subjects**

1995: Public Service Screening Projects Begin
- **24 screening projects in metro NY**

1998: Follow-Up Study
- **533 subjects**

1999: National TeenScreen Program Launch

2003: PATH Launch

To Date: 91 sites trained in 29 states, Guam, Panama and Canada

COLUMBIA TEENSCREEN PROGRAM

- HOW WE WORK -

- **Partnership with communities across the nation to implement early-identification programs for suicide and mental illness in youth**
- **Screening programs based on the Columbia TeenScreen Program will be adapted to the specific needs and resources of each community**
- **Education, staff training, and consultation in the development and implementation of a screening program**

POTENTIAL SCREENING SITES

- Schools
- School-Based Health Centers
- Residential Treatment Facilities
- Clinics
- Drop-In Centers
- Summer Camps
- Shelters
- Pediatrician's Offices

COLUMBIA TEENSCREEN PROGRAM

— WHAT WE OFFER —

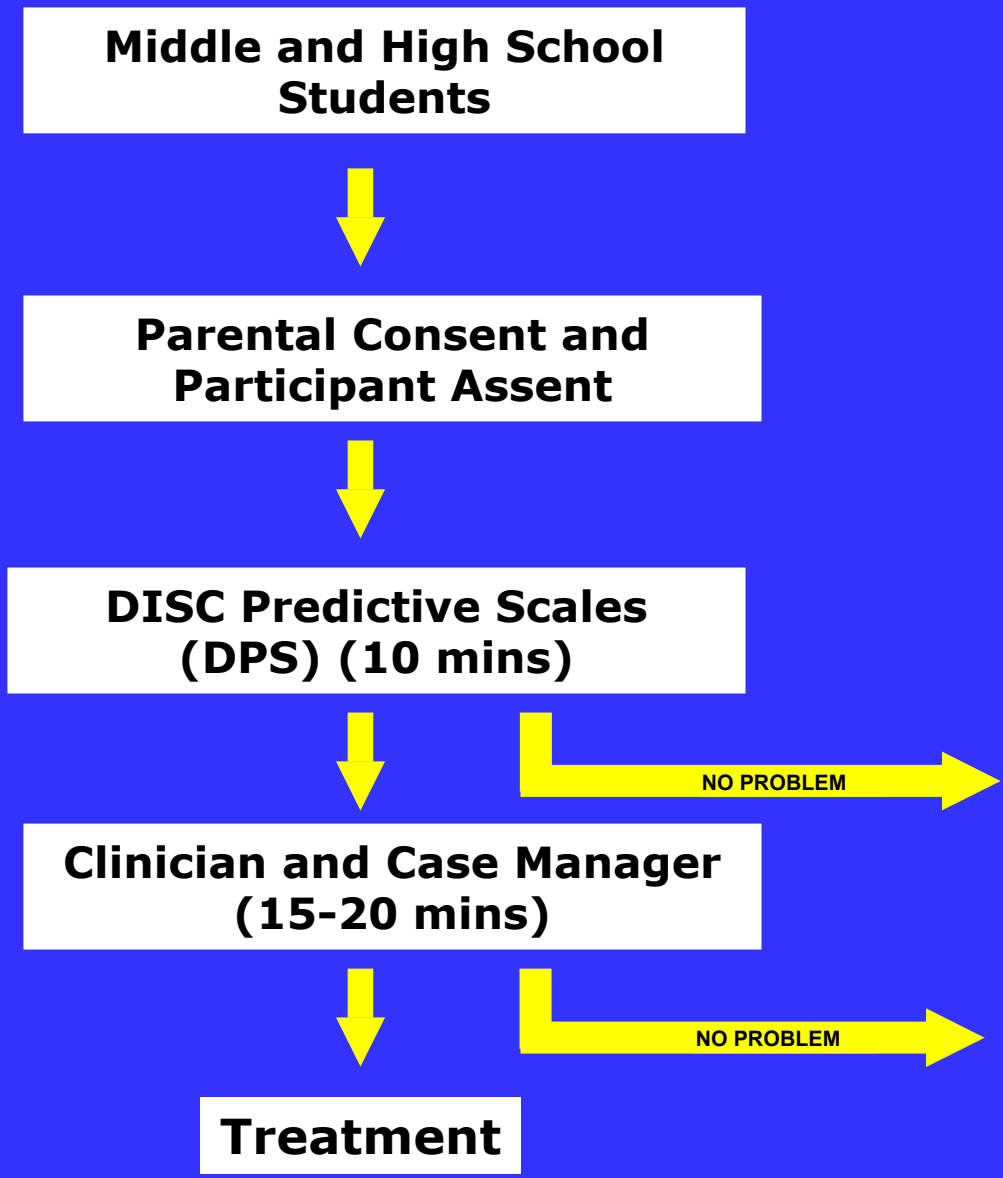
- **Pre-training consultation**
- **Training**
- **Screening instruments**
- **Post-training technical assistance**
- **Screening materials**

COLUMBIA TEENSCREEN PROGRAM

- WHAT WE REQUIRE -

- **Completion of Site Application**
- **Letter of Agreement**
- **Minimum of 200 youth screened per yr**
- **Biannual reporting of screening results**
- **Commitment to screening routinization**

UNIVERSAL SCREENING MODEL



DPS CHARACTERISTICS (DISC Predictive Scales)

- **Self-completion mental health *screen***
- **9-17 year-olds**
- **Covers: social phobia, generalized anxiety disorder, panic disorder, OCD, major depression, alcohol abuse, marijuana abuse and other substance abuse**
- **Layperson administration & scoring**
- **5-10 minute duration**
- **Computerized and paper and pencil versions**
- **English and Spanish versions**
- **Automatic report with symptoms and impairment**
- **33% positive rate**

— TAKING THE DPS —

Bill Foley 1999

CLINICAL INTERVIEW

- Review results of the screen
- Triage decision
- Diagnostic impression
- Clinical summary

ROLE OF CASE MANAGER

- Informs parents of screening results and makes appointments
- Awareness of available resources
- Provides screening results to treatment provider
- Assists families until connection is made
- Promotes attendance at first appointment

SUMMARY

Screening in Mid-adolescence Identifies

- Students at risk for suicide
- Students who are now in distress from depression and other psychiatric disorders
- Students who are not already in treatment or known by school personnel
- A high proportion of teens who will have a persistent depression and who will make a suicide attempt in their early twenties

POSITIVE ACTION FOR TEEN HEALTH

-PATH-

Positive Action for Teen Health PATH

- Mental health check-ups for all youth before high school graduation
- Promote a public health priority
- Move research into practice
- Forge partnerships with advocates, state departments of mental health, education associations and service agencies
- National Advisory Council launch on 1/28/03
- Media Launch on 2/20/03

NATIONAL ORGANIZATIONS THAT HAVE ENDORSED MENTAL HEALTH CHECK-UPS FOR YOUTH

- American Academy of Child & Adolescent Psychiatry
- American Federation of Teachers
- American Mental Health Counselors Association
- American Psychiatric Association
- Anxiety Disorders Association of America
- Girls' and Boys' Town
- Child and Adolescent Bipolar Foundation
- Depression and Bipolar Support Alliance
- Federation of Families for Children's Mental Health
- International Society of Psychiatric-Mental Health Nurses
- National Association of County Behavioral Health Directors
- National Association of School Psychologists
- National Alliance for the Mentally Ill
- National Education Association
- School Social Work Association of America
- Tourette Syndrome Association
- United States Conference of Catholic Bishops

RESULTS FROM OUR SURVEY OF 900 PARENTS

1. 90% of parents believe that schools must play an important role in identifying students at risk for depression or suicide

2. The majority of parents (74%) would support a screening program in their school

3. Parents incorrectly believe that they would be able to tell if their teen was depressed. In reality only 1/3 of teens with mental health problems are known to parents or any adult

4. 80% of parents believe that not nearly enough is being done to treat mental illness in teenagers

"One boy identified through the TeenScreen Program was actively suicidal at the time of his screening. Not only did he screen positive for marijuana abuse on the DISC and show signs of depression in the clinical interview, but he also reported access to a firearm and to ammunition. The student, who had not been previously identified by school personnel, was rushed to an urgent care appointment at a local mental health clinic. As soon as they were notified, the parents removed the weapon from the house. Now that he is in treatment, the family reports great improvement."

Substance abuse, depression and access to a firearm are a highly lethal combination – without the screening, this would probably have been another young life ended too soon.

COLUMBIA TEENSCREEN PROGRAM

— HOW TO LEARN MORE —

Contact the TeenScreen office at teenscreen@childpsych.columbia.edu

(866) TeenScreen

www.teenscreen.org