

**Title of Presentation:** The Columbia University TeenScreen Program: Evidenced-Based Prevention and Intervention through Mental Health Screening

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The goal of the Columbia University TeenScreen Program is to help schools, organizations, and communities establish voluntary early identification and prevention programs, through which parents are offered the opportunity for their teens to receive a voluntary mental health check-up. Our primary objective is to help young people and their parents identify mental health problems, such as depression, early – problems that can lead to poor academic achievement, drug use, violence, and suicide.

The TeenScreen Program was developed by Columbia University's Division of Child and Adolescent Psychiatry. The program and the screening instruments have been rigorously researched and evaluated in a variety of settings with diverse youth populations since 1991. The findings of this research reveal that the TeenScreen Program is effective in identifying youth at risk for depression, suicide, and other mental disorders, and has led to the success in moving the program from a research-based project into a public health initiative, now active in over 350 sites in 43 states and two foreign countries. The President's New Freedom Commission on Mental Health recognized the TeenScreen Program as a model program in its July 2003 final report. In addition, the national Suicide Prevention Resource Center (SPRC) listed the TeenScreen Program as a "Promising Program" on its list of Evidence-Based Practices in Suicide Prevention Programs.

The flexibility of the TeenScreen Program and the services that we offer to our sites, allows the program to be a cost effective, evidenced-based practice that can easily be implemented in health and mental health clinics, schools, doctor's offices, shelters, foster care facilities, residential treatment facilities, juvenile justice facilities, etc. Our staff works with communities to develop responsible screening programs that accommodate their specific needs and resources. We provide consultation, screening materials and instruments, and training at no cost to qualifying communities.

The country is currently in a public health crisis when it comes to untreated mental illness and suicide in youth. Between 7-12 million youth suffer from mental illness, and 2 out of 3 youth with mental illness do not receive treatment. According to the CDC, suicide is the third leading cause of death for 15-19 year olds. The Columbia University TeenScreen Program was designed to address the problems of unidentified mental illness and suicide risk in youth. It was developed in 1991 in response to research revealing that 90% of youth who die by suicide suffer from a diagnosable mental illness at the time of their deaths, and that 63% experience symptoms for at least a year prior to their deaths (Shaffer et al., 1996).

Mental health screening is an effective strategy for early identification and intervention because it accurately identifies youth who are suffering from mental illness or at risk of suicide, most of whom would not be identified otherwise. Research on the TeenScreen Program has shown that teens that are at risk for suicide at the time of the screening will be identified through the screening process (Shaffer et al., 2004). One-half of suicidal teens identified by TeenScreen were not known to school personnel or mental health professionals as having problems (Scott, 2004), and one-third of suicidal teens who were also experiencing mental health issues were not known to school personnel or mental health professionals as having problems (Scott, 2004). Research has also shown that teens that are experiencing depression, anxiety, and drug and alcohol abuse at the time of the screening will be identified through the screening process (Shaffer et al., 2004).

The first half of the workshop will be presented by Laurie Flynn, the Director of the TeenScreen Program, to 1) explore the problems of untreated mental illness and suicide in youth, 2) present growing support for mental health screening and the TeenScreen Program, 3) describe the history of TeenScreen, the elements of a screening program, the stages of screening and the instruments offered through the program, and 4) provide participants with an opportunity to discuss strategies to bring the TeenScreen Program to their community.

The second half of the workshop will be presented by Adam Kaplan, the Research Coordinator of the TeenScreen Program, to review the research supporting mental health screening and the TeenScreen Program, and to address the aims of the current research study underway in Erie, Pennsylvania; evaluating the effectiveness and outcomes of implementing a voluntary mental health and suicide risk screening program within a public high school district, using one of the screening tools offered by the TeenScreen Program, the Columbia Health Screen (CHS).

### **References:**

Shaffer, D., Gould, M., Fisher, P., Trautman, P., Moreau, D., Kleinman, M., and Flory, M. (1996). Psychiatric diagnosis in child and adolescent suicide. *Archives of General Psychiatry*; 53: 339-348.

Scott, M., Shaffer, D., Wilcox, H. (2004). The Columbia Suicide Screen: Does Screening Identify New Teens at Risk? American Association of Child and Adolescent Psychiatry. Poster Presentation, Washington, DC.

Shaffer, D., Scott, M., Wilcox, H., Maslow, C., Lucas, C., Garfinkel, R., & Greenwald, S. (2004). The Columbia SuicideScreen: Validity and reliability of a screen for youth suicide and depression. *The Journal of the American Academy of Child and Adolescent Psychiatry*, 43, 71-79.