



Uncovering an Epidemic — Screening for Mental Illness in Teens

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Courtney, a 15-year-old from Portland, Oregon, always knew she was different from the other kids. “I had a sense that something was going on, but I was afraid to say anything because I didn’t

know anyone else had a similar problem,” she said. Like thousands of U.S. teens, Courtney participated in a mental health screening program that was offered in her school. “Teenagers have a hard time asking for help,” she explained. “Without the screening, I’m not sure how I would have gotten the help I needed.”

Before screening, Courtney was part of a silent epidemic of mental illness among teenagers. We know from the National Comorbidity Survey that half of all serious adult psychiatric illnesses — including major depression, anxiety disorders, and substance abuse — start by 14 years of age, and three fourths of them are present by 25 years of age (see

table).¹ Yet the majority of mental illness in young people goes unrecognized and untreated, leaving them vulnerable to emotional, social, and academic impairments during a critical phase of their lives. Even those who receive treatment tend to do so only after a long delay: 6 to 8 years for patients with mood disorders and 9 to 23 years for those with anxiety disorders.

But it is not psychiatric morbidity that makes headlines; rather, it is the most extreme consequence of psychiatric illness: suicide. In the United States, suicide is the third-leading cause of death among persons 15 to 19 years of age. In 2005 alone, according to the Centers for Disease Control and Pre-

vention, 16.9% of U.S. high school students seriously considered suicide, and 8.4% had attempted suicide at least once during the preceding year.

These grim statistics argue strongly for early detection and intervention and provide a rationale for mental health screening among teenagers. The premise is that the primary risk factors for suicide — mood disorder, a previous suicide attempt, and alcohol or substance abuse — can be identified and treated.

Courtney participated in Teen-Screen, a large, school-based mental health screening program that was developed under the direction of David Shaffer at Columbia University. The screening is conducted in two stages: teens fill out a short questionnaire and are then interviewed by a master’s level social worker or clinical psychologist, who verifies that a positive result is really clinically signifi-

cant. If it is, the clinician recommends a more comprehensive psychiatric evaluation to the teen and his or her parents. The screening is voluntary and requires the active consent of the parents and assent of the teen. Screening results are confidential and are not shared with school officials or teachers. And since all teenagers who undergo screening also receive a follow-up interview, they cannot be identified by their peers as having screened positive, a system that preserves privacy.

In 2005, the program screened 55,000 young people in 42 states. “About one third of kids screened positive on the questionnaire, and one half of those — about 17% — were referred for further evaluation after the clinical interview,” said Laurie Flynn, executive director of Columbia University Teen-Screen.

There is substantial federal support and funding for such voluntary mental health screening programs. In 2003, the President’s New Freedom Commission on Mental Health specifically recommended increased screening for suicidality and mental illness. The commission promoted only programs that were voluntary and conducted with explicit parental consent. In 2004, the Garrett Lee Smith Memorial Act — named for Oregon Senator Gordon Smith’s son, who committed suicide when he was 21 years old — earmarked \$82 million for youth suicide prevention and early intervention programs.

Not everyone approves of screening teens for psychiatric illness, however. One vocal opponent, Representative Ron Paul (R-TX), who is also a physician, tried unsuccessfully to pass legislation in 2005 banning the use of federal funds for such screen-

ing. “I believe the real goal is to make screening mandatory,” Paul said. “The motivation might be sincere, but a lot of these folks in government are arrogant and don’t believe that parents know what’s best for their own kids.”

Voluntary screening programs don’t interfere with parental rights, but they might well threat-



en the common — and tragically false — belief that parents are always in a position to know when their child is in trouble and needs help. The fact is that children and teens are notoriously secretive about their own psychopathology: parents are unaware of 90% of suicide attempts made by teenagers, and the vast majority of teens who attempt suicide give no warning to parents, siblings, or friends.² As Courtney put it, “You can be the greatest parent in the world and your kid could still have a serious problem you don’t know about.”

One 23-year-old woman I interviewed had been screened when she was 15. “I remember being really depressed and suicidal after my cousin sexually molested me,” she said. “I couldn’t tell my parents about it, and I took an overdose of pills that no one knew about.” She says that her meeting

with the screening staff helped her to feel comfortable telling her parents what had happened to her and how she felt. “They were shocked and had no idea what I had been going through,” she said.

Given the unfortunate stigma that is still attached to mental illness, many observers see screening as an invasion of privacy. Yet suicide has public health implications, for it is, in a sense, contagious: there is ample evidence of suicide clusters among teens, and the relative risk of suicide after exposure to another person’s suicide has been estimated to be two to four times as high among teens between the ages of 15 and 19 years as in other age groups.³

Some critics worry that asking teens about their mood or suicidal feelings will cause distress or induce suicidal feelings or behavior. In fact, there is evidence to the contrary. In one study, teens were randomly assigned to undergo mental health screening with or without questions that probed suicidal feelings and behavior.⁴ The participants who were asked these questions were neither more distressed nor more suicidal than those who were not. In fact, among high-risk students with a known history of depression or suicide attempts, those who had been asked about suicidal thoughts and feelings actually felt less depressed and suicidal after the survey than those who had not been asked such questions.

Some question the effectiveness of mental health screening, arguing that there is little evidence that this intervention prevents young people from committing suicide. Proof that any intervention reduces suicide rates is a high bar to pass, however, since the rarity of suicide would necessitate that a very large population be

Median Age at the Onset of Mental Disorders.*	
Type of Disorder	Median Age at Onset yr (interquartile range)
Any disorder	14 (7–24)
Anxiety disorder	11 (6–21)
Mood disorder	30 (18–43)
Impulse-control disorder	11 (7–15)
Substance-use disorder	20 (18–27)

* Data are from Kessler et al.¹

studied over a long period in order to demonstrate efficacy. Still, preliminary evidence suggests that screening has some positive effects. In one follow-up survey of parents of children who were identified through TeenScreen as having clinically significant psychiatric symptoms, including suicidal tendencies, 72% reported that their child was doing very well or had significantly improved and was seeing a mental health professional.

Finally, there is concern about the high sensitivity but relatively low specificity of the screening instruments, a combination that

leads to many false positive results. The potential consequences of falsely identifying a teen as needing a more thorough psychiatric evaluation seem far less dire, however, than those of failing to identify a suicidal teenager. Stigma is real, but unlike suicide, it doesn't kill.

It is accepted medical practice for teenagers to get frequent physical checkups, even though the odds of finding a serious physical disease in this population are very small. In contrast, the chance that a teen has a treatable psychiatric illness (such as anxiety, mood, or addictive disorder) is nearly 21%.⁵ How can we not routinely screen young people for mental illness when it is such an important cause of suffering and death?

I believe that voluntary mental health screening of teens should be universal. But we need to go beyond school-based screening if we are optimally to reach young people who are at risk for psychiatric illness and suicide. Pediatric clinicians are in an ideal position to detect mental illness in young people, and they should

be better trained to probe for and recognize the signs and symptoms of major psychiatric disorders.

Courtney put it bluntly: "I'm not sure where I would be today if I didn't get screened. I'm not even sure if I would be here at all."

An interview with Cynthia Montgomery, whose son took his life at the age of 14, can be heard at www.nejm.org.

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Familial Pathways to Suicidal Behavior — Understanding and Preventing Suicide among Adolescents

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A 16-year-old boy whose brother recently committed suicide is seen in the emergency room after slashing his wrists. He reports having felt severely depressed and hopeless since his brother died and has markedly increased his alcohol intake. His depression actually began 4 years ago, after the death of his father, and has continued unabated. The patient has a history of being disciplined

for fighting in school, usually after being teased or provoked by his peers. Immediately before his suicide attempt, he had a fight with his girlfriend, his mood plummeted, and he decided that he might as well be dead. His mother reports that the boy's father died of "accidental carbon monoxide poisoning." The father had had problems with depression, alcohol dependence, and

aggression and most likely also committed suicide.

This patient has many of the known risk factors for suicide in a young person: a mood disorder, alcohol abuse, recent loss of a loved one, and a family history of suicidal behavior.¹ Although suicide is the third leading cause of death among young people, the vast majority of people who face personal losses, have mood