

The Dangers of Mental Health Screening

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A. Introduction

The “mental health screening program” created by the President’s New Freedom Commission on Mental Health is a colossal fraud built upon, and aggravating, earlier frauds. It is presented as a way of ferreting out hidden “mental illness,” first in school children, so they can then get “appropriate treatment” - medications. It is actually a brazen attempt to hide the injuries caused by 50 years of peddling increasingly harmful and increasingly costly psychiatric drugs. Not only will the program increase America’s huge, ever-rising, rate of mental disability by dispensing ever more medications which produce and aggravate these disabilities, but it represents the misuse of medicine to destroy this country’s basic freedoms. It is also the latest Bush administration hand-out to the drug companies, so many of which have changed from legitimate businesses into patent-protected rackets.

During the 2005-2006 school year, all American parents will receive notice of the new screening program from their youngsters’ schools. It will “test” for “mental illness” 52 million students and six million adults working in schools, and expects to find at least 6 million in need of “treatment.” All the force of government will then urge or compel them to receive it. The heart of that treatment will be medication.

But children aren’t the only targets. The Commission’s final report states that “both children and adults will be screened for mental illnesses during their routine physical examinations.”

In 2003, a pharmaceutical analyst happily predicted (1) that “the coming years will bear greater witness to the **corporate-sponsored creation of illness**” - by greatly widening our definitions of illness. In 2005, the mental health screening program bears even greater witness to the **governmentally-sponsored creation of illness** - by greatly increasing the use of brain-injuring, disability-producing medications. And by allowing “experts” to define peaceful, law-abiding citizens as “ill,” and in need of (increasingly forced) “treatment,” the program resurrects the witch-hunts of 16th century Europe.

B. What screening really does

The mental health screening of children is supposed to prevent suicide, and to detect mental illness so it can be treated promptly and effectively. It can do the opposite. In doing so, it violates fundamental American freedoms.

In 2003, thirteen-year-old, African-American Aliah Gleason (2) was in the 7th grade in an Austin, Texas, suburb. She was a B and C student who often “got in trouble for running my mouth.” The school authorities saw her as suffering from an “oppositional disorder” and put her in a special education track. Her parents considered her bright and spirited, but with a tendency to clown and argue.

Early that fall, University of Texas psychologists came to her school to screen 6th and 7th grade girls for mental illness. A few weeks later, a university psychologist phoned that Aliah had scored high on a suicide rating, and needed further evaluation. Reluctantly, the Gleasons agreed to have her see a university consulting psychiatrist.

The doctor referred Aliah to an emergency clinic for further evaluation. Six weeks later, a child protection worker came to the school to interview her, summoned her father to the school and ordered him to take the girl at once to Austin State Hospital, a mental facility. When he refused, the protection worker took Aliah into emergency custody (!) and had a police officer drive her to the hospital. Mental health trumps both parental rights and the Bill of Rights.

Aliah spent five terrible months in hospital, during which her parents were forbidden to see or speak to her. She was placed in restraints more than 26 times and given at least 12 different psychiatric drugs, many of them simultaneously, among them the SSRI antidepressants Zoloft, Celexa, Lexapro and Desyrel; Ativan, an antianxiety

drug; and two of the newer, very expensive “atypical antipsychotics” - Geodon and Abilify. After the hospital, she spent four more months in a residential facility - getting even more drugs.

What, if anything, was wrong with Aliah is still unclear. So is her clinical diagnosis. She reportedly said repeatedly that she was suicidal, and that her father beat her - and then recanted. Her attorney says her statements were due to the high dosages of psychotropic drugs forced upon her.

Fortunately, Aliah survived - unlike some other heavily medicated children. After her parents went to court, and she was finally released into their custody, the professionals they chose to treat her tapered her off all medication and successfully addressed problems within the family. She is now doing well in school, participating in extracurricular activities and, according to her psychologist, Dr. John Breeding of Austin, is once again “starting to get that gleam in her eye.”

The experience of fifteen-year-old Chelsea Rhoades of Indiana was equally significant (3). Last December, as part of the national TeenScreen program, most of her public high school home-room classmates were given a ten minute, yes-or-no computer test, which had no room for alternate answers or explanations. (Those few not given the test had been opted-out in advance by their parents, an option Chelsea’s parents had not known about.) Shortly after Chelsea took it, a local mental health center employee told her that she was suffering from “OCD” (“obsessive compulsive disorder”) because she said she liked to help clean the house, and “social anxiety disorder” because she didn’t party much. The worker then suggested that if her “condition” worsened, her mother should bring her to the center for treatment - treatment which almost always involves medication.

Chelsea was not the only youngster given this recommendation; she says all of her friends were told something was wrong with them. The only children not supposedly suffering from some “disorder” or other were those with the opt-out slips. Furious at this intrusion on their privacy, her parents sounded the alarm throughout their community. And with the help of The Rutherford Institute, they have filed a lawsuit against the school district for failing to inform them in advance about the test and to obtain their permission for Chelsea to take it.

What might occur after large-scale screening can be seen from what has already happened when school children are “diagnosed” with “attention deficit disorder.” After a school psychologist told Patricia Weathers that her first-grade son suffered from it, she was pressured into medicating him. “The medication eventually made him psychotic,” she says, “but when she stopped giving it to him, the school reported her to state child protection officials for child abuse.” Weathers, president and co-founder of AbleChild (AbleChild.org), who has filed a lawsuit against school officials, says “we have 1,000 stories like this.” Meanwhile, her son is now 15 and “doing fine.” (4) Congressman Ron Paul, a physician for over thirty years, has also criticized the way “some parents have been charged with child abuse for refusing to drug their children.” Some have even had their children removed for refusing to give them drugs.

No matter how we define mental illness in children or adults, it cannot be found by simple screening. Nobody can, by merely looking at someone else, or even on the basis of a pen and pencil questionnaire, differentiate the transient emotional disturbances we all have from those which last longer. Screenings won’t prevent suicide because those who are contemplating it usually won’t tell. Indeed, the screening process itself can produce significant anxiety among those within whom “mental illness” is being sought, as it did with Aliah. Such efforts to find people’s troubles by aggravating those troubles are ridiculous on its face. Only when gross insanity exists can “mental illness” be recognized on inspection - and then we need neither experts nor screening.

C. What’s “mental illness”? the problem of psychiatric diagnosis

What’s “mental illness”? Years ago, the term was limited to the insane: disabled people with crazy ideas who are unable to function socially and may be dangerous to themselves or others. Psychological distress, such as nervousness, has also been called “mental illness.” The term has, however, been expanded over the past several decades to include more and more of the “thousand natural ills the flesh is heir to.” Indeed, a new study (5) by Harvard University and the National Institute of Mental Health claims that 46% of Americans will “at some point in their lives develop a mental disorder.”

Many of those “thousand natural ills” are included among the 400-odd “disorders” listed in the latest edition of the “psychiatric bible” - the American Psychiatric Association’s “Diagnostic and Statistical Manual of Mental

Disorders,” the DSM. But these diagnoses are based almost entirely on symptoms - depression, anxiety and so forth - with little or no mention of the problems producing these symptoms. Basing diagnosis entirely on symptoms can be compared to defining fever as a diagnosis: both it and anxiety, for example, are really products of other physiological or psychological processes. There are as many causes of depression as there are people suffering from it.

Troubled people can indeed benefit from good mental health care. But good treatment requires addressing *voluntarily* a patient’s *unique individual problems*. For this, screenings are unnecessary.

Any discussion of psychiatric diagnosis, and the nature of mental illness, should include the subject of homosexuality. The current *Journal of American Physicians and Surgeons* examines some of its less recognized aspects - such as its “laundering” over the past 135 years from sin and/or crime, to mental disorder, to acceptable alternate life style. (6) Let us note here, however, that in view of American psychiatry’s eager acceptance of homosexuality, “homophobia” - a term already widely used in both the specialty and mass media, and which may soon be included in the D.S.M. - has already been used in Illinois, along with being a “defender of the US constitution against the federal government and the UN,” as criteria for labeling people as mentally unstable. (7) And “sick” ideas can be followed by forced drugging and incarceration - as in the European witch-hunts.

D. Problems with psychiatric treatment: the harmfulness of drugs

Thorazine (chlorpromazine) is seen as having “initiated a revolution in psychiatry comparable to the introduction of penicillin in general medicine.” (8) In 1954, it began psychopharmacology’s takeover of psychiatric treatment. But evidence recently assembled by Whitaker shows that in addition to these drugs’ well-known, but frequently downplayed, side-effects, treatment with both the neuroleptics and the antidepressants is **in itself** seriously harmful, with the SSRI (Selective Serotonin Reuptake Inhibitors) antidepressants, such as Prozac, among the most damaging.

In 1996, Steven Hyman, then Director of the National Institute of Mental Health, described (9) how psychiatric drugs “create perturbations in neurotransmitter functions” after which the brain goes through a series of compensatory adaptations. For drugs like Prozac and the other SSRI antidepressants, which block serotonin reuptake, the brain tones down its whole serotonergic system; the density of serotonin receptors in the brain decreases by 50% or more. After a few weeks, the brain is functioning in a manner that is “qualitatively as well as quantitatively different from the normal state.” Similar changes occur with neuroleptics.

This is pathology, produced by drug treatment. Princeton neuroscientist Barry Jacobs (10) makes this point explicit about SSRI antidepressants. He writes that they “alter the level of synaptic transmission beyond the physiological range achieved under (normal - RW) environmental/biological conditions. Thus, any behavioral or physiological change produced under these conditions might more appropriately be considered pathological, rather than reflective of the normal biological role of serotonin.”

The harm these drugs cause is also shown by a different methodology. Serial MRI pictures taken over 18 months of people newly diagnosed with schizophrenia (all of whom were then started on medication) showed significant and increasing brain changes, including shrinking of the cerebral cortex and enlargement of the basic ganglia. (11) And as the enlargement progressed, the patients’ negative symptoms (apathy, etc.) worsened. “Over the long term, the drugs cause changes in the brain associated with worsening of the very symptoms the drugs are supposed to alleviate.”

Also: examination of the literature reveals that use of these drugs increases the likelihood that a person will become chronically ill, and that they cause a significant percentage of patients to become ill in new and more severe ways. (12) And with all classes of psychiatric drugs, patients given them have more relapses, and less ability to function afterward, than patients not exposed to them. Disabled populations treated without drugs fare better than those given them.

Finally, since the drugs were introduced, rates for psychiatric disability (Table 1) in America (13) have risen rapidly and steadily: from 3.38 per thousand in 1954, to 13.75 in 1987, when the “atypical” anti-psychotics and SSRI antidepressants were introduced, to 19.69 in 2003. The number of “patient care episodes” - the amount of care given, as measured by the number of people treated each year for mental illness at psychiatric hospitals, residential facilities for the mentally ill and ambulatory care facilities - rose similarly: from 1,028 per 100,000 population in

1955 to 3,295 in 1987 and to 3,806 in 2000. Since the start of the drug era, which supposedly made it possible for the first time for patients with schizophrenia to “lead relatively normal lives and not be confined to institutions,” the number of mentally disabled people has risen nearly six-fold.

The SSRI’s apparently play a unique role in transforming the distressed into the disabled. “A depressed patient treated with an anti-depressant suffers a manic or psychotic episode (a very common side effect), at which time his or her diagnosis is changed to bipolar disorder. At that point, the person is prescribed an antipsychotic to go along with the antidepressant” - as with Aliah. “Once on a drug cocktail, the person is well along on the road to permanent disability. Since Prozac was introduced in 1987, the number of disabled mentally ill in the US has risen by 2.4 million people” - from 3.3 million to 5.7 million. (14)

E. The atypicals and SSRI’s

Psychiatry’s acceptance of psychopharmaceuticals, beginning with Thorazine in 1954, represents one of the greatest triumphs of false advertising in all of history. But by the early 1980’s, with more than a dozen neuroleptics being sold, the market for them had become relatively unprofitable. The leading drugs, Thorazine and Haldol (haloperidol), were vulnerable to competition from generics because they had lost their patent protection. Generic Thorazine was selling for less than \$10 per month and haloperidol for not much more. In the late 1980’s, sales for all neuroleptics in the United States totaled less than \$500 million - “less than what one ‘breakthrough’ medication would hope to generate in a year.” (15)

“The market was ripe for a novel antipsychotic, and it came in the form of a drug that, fifteen years earlier, had been discarded as too dangerous”: Clozapine (clozaril-Sandoz). This was the first of the new “atypical neuroleptics,” which, in addition to blocking the dopamine receptors blocked by the earlier drugs, also blocked serotonin receptors. It was supposedly better than existing drugs, but since it also produced agranulocytosis, white blood cell depletion, in up to 2% of the patients, the company bundled the drug with weekly blood tests at a price of \$9,000 a year. As the newest and supposedly best drug, psychiatrists prescribed it.

Two new atypicals without agranulocytosis then appeared on the market: Janssen’s Risperdal (risperidone) in 1996 and Lilly’s Zyprexa (olanzapine) two years later. With price ceilings on psychiatric drugs having been broken by Clozapine - in part because Medicaid paid for an increasing fraction of it - Risperdal’s price was set at \$240 per month, and Zyprexa’s at \$10 per day. In 1996, U.S. sales of Risperdal topped \$500 million, “which was greater than revenues for all other neuroleptics combined;” (16) two years later, Zyprexa topped \$1 billion in United States sales alone.

After the appearance of still another atypical, AstraZeneca’s Seroquel (quetiapine), “there was no longer any possible doubt about the superiority of these new drugs.” *The Los Angeles Times* said, for example, “It used to be that schizophrenics were given no hope of improving. But now, thanks to new drugs and commitment, they’re moving back into society like never before.” But despite these glowing reports, **the largest study of these drugs to date (17) found “no clear evidence that atypical antipsychotics are more effective or better tolerated than conventional antipsychotics.”**

In 2003, total sales of antipsychotic drugs in the U.S. reached \$2.3 billion, roughly six times what they had been before the “atypicals.” In 2004, the atypicals were the fourth-highest-grossing class of drugs in the U.S., with sales totaling over \$8.6 billion - \$3.4 of which was paid for by state Medicaid funds. (18)

The new SSRI antidepressants, of which Prozac was the first, followed a similar path. **Media stories lauded them even though their level of efficacy was very minor: roughly 41% of patients got better in the short term versus 31% with placebo, and in comparison with an active placebo, which produces a physiological change with no benefit, outcome differences virtually disappeared. (19) And because of the many youngsters given SSRI’s who then killed themselves or others, the FDA finally placed suicidality warnings on most of these drugs. (20)**

I list a few of the many other social changes produced by the psychotropic revolution:

(1) 29 million prescriptions were written last year in the United States for Ritalin and similar drugs to treat attention deficit disorder and hyperactivity, 23 million of them for children, (21);

- (2) 60 - 70% of child(ren in foster care in Massachusetts now being given psychiatric drugs (22);
- (3) the arrival at some colleges of 40 to 50% of students with psychiatric prescriptions (23);
- (4) the revelation that 41% of prescriptions for some 765,000 people over 65 were for psychotropics (24), and
- (5) the finding of another study that 75% of elderly, long term care, nursing home residents are being given psychotropics. (25)

But the drug companies did well. (**Table 2**) Between 1986 and 2004, the sales of antidepressants and antipsychotics jumped hugely: for antidepressants, from \$240 million to \$11.2 billion - almost 47 times; and for anti-psychotics, from \$263 million to \$8.6 billion, almost 33 times. For the two combined, sales rose from \$500 million to nearly \$20 billion, a forty-fold increase. (26) And for Eli Lilly, whose value on Wall Street in 1987 was about \$2 billion, by 2000, with Prozac its number one drug and Zyprexa also in its formulary, its capitalization had reached \$80 billion - also a forty fold increase. (27) But the companies want to do still better - which brings us to the screening program.

F. The current screening plan

This program represents a new and outrageous level of government promotion of harmful psychopharmaceuticals, i.e. federal drug-pushing.

The screenings will define (or create) many new mental patients, almost all of whom will then be given medication. (28) The Texas Medication Algorithm Project (TMAP), which the President's New Freedom Commission has commended as a model medication treatment plan which "illustrates an evidence based practice that results in better consumer outcomes," calls for the newest and most expensive medications to be used first in the treatment of schizophrenia, bipolar disorder and major depression in adults. This we saw with Aliah. It also calls for specific drugs for specific disorders, as though the latter really exist. (29) Current prices for a month's supply of the 3 top antipsychotics, all "atypicals," are \$342 for Risperdal, \$414 for Seroquel and \$572 for Zyprexa. "Because these drugs are the most expensive on the market, and are so often paid for by the government, the rampant over-prescribing of these medications is bankrupting state Medicaid programs all over the country." (30)

PennMap is Pennsylvania's TMAP-type model for treating the mentally ill in state care. Allan Jones, a former investigator for the state, described it publicly as "part of a large pharmaceutical marketing scheme designed to infiltrate public institutions and influence treatment practices. Pennsylvania is paying tens of millions of dollars for patented drugs that have no proven advantage over cheaper generic drugs." Jones was fired for his efforts. (31)

"As part of the overall scheme, on July 27, 2001, Gov. Tom Ridge appointed Gerald Radke, an Eli Lilly Marketing Director, to head the state Office of Mental Health and Substance Abuse. With Radke at the helm, state Medicaid-funded sales of Lilly's Zyprexa rose from approximately \$26.5 million in 2000 to \$34.2 million in 2001, and to \$39.2 million in 2003." [Under the leadership of Lilly's man in state government, spending on Lilly's expensive leading drug increased 50% over four years.] "In state hospitals, hundreds of patient had their medications switched in the absence of medical need or indication, to comply with administrative decisions." (32)

Zyprexa's dangerous side-effects were, however, carefully hidden. Stefan Kruszewski, M.D., a Harvard-trained psychiatrist engaged to oversee statewide mental health care, pointed out (33) that the new generation of antipsychotics - the "atypicals" - substantially increase the risk of obesity, diabetes type II, hypertension, cardiovascular complications, heart attacks and stroke, and that the drug-makers had this information but "simply ignored the problem." To Dr. Kruszewski, Zyprexa is a drug "whose massive revenues and promotion are based upon faulty disclosures by the manufacturer, Eli Lilly. The drug causes both a severe metabolic syndrome and cardiovascular problems at the same time that it continues to cause neurological side-effects like the older 'typical' antipsychotics." Dr. Kruszewski was also fired for his efforts.

In Feb. 2004, the American Diabetes Association, the American Psychiatric Association, the American Association of Clinical Endocrinologists and the North American Association for the Study of Obesity published a joint statement (34) confirming the association between Zyprexa and diabetes. In June, 2005, Lilly agreed to pay \$690 million to settle lawsuits filed by approximately 8,000 Zyprexa patients who alleged they had not been warned that the drug might increase the risk of diabetes. More than 2,500 other claimants refused to take part in the settlement, presumably believing that the \$62,500 received by each claimant on average was insufficient compensation for their

pain and suffering. But Zyprexa earned Eli Lilly \$4.4 billion in 2004, a considerable fraction of that company's total net sales of \$13 billion that year. (35)

G. Conclusion

The mental health screening program created by President Bush's New Freedom Commission is a colossal fraud, based on other frauds, which elevates still further the drug companies' already soaring profits. It will harm thousands of Americans by giving them stigmatizing diagnoses which can follow them for the rest of their lives, and then drugging them.

The greatest fraud underlying the program is that "mental illness" is best treated by drugs. The sad fact is that, as a group, psychiatric drugs impair brain function, thus producing or aggravating mental illness.

Good psychiatric care is voluntary, and based on trust between patient and doctor. This program, as demonstrated by the case of Aliah Gleason, therefore represents the grossest kind of psychiatric malpractice by the government. Her case also demonstrates how the program undermines basic American freedoms. Dr. Karen Effrem, a leading opponent of screening, warns that under it, parental rights are unclear or non-existent, that parents are already being coerced to put their children on psychiatric medication - with some children dying because of it - and that merging screening with the academic standards required by the No Child Left Behind program, as already mentioned in Illinois, leads to diagnosis for political reasons.

By exposing the colossal fraudulence of the screening program and defeating it, we can perhaps start to undo the 50 years of psychopharmacological fraud which has made psychiatry the whore of the drug companies and the enemy of American democratic freedoms. A hundred years ago, President Theodore Roosevelt curbed the oil and railroad "trusts." Today's America needs another Teddy Roosevelt who will curb the pharmaceutical trust.

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Table 1: Mental disability in America

	1955	1987	ca.2004
Mentally disabled per 1,000 population	3.38	13.75	19.69
Patient care episodes per 100,000 population	1,028	3,295	3,806

Table 2: Psychiatric drug sales, in millions of dollars

	increase		#times
anti-psychotics	\$263	\$ 8,600	33x
antidepressants	\$240	\$11,200	47x
combined	\$500	\$20,000	40x
Eli Lilly capitalization	\$2 billion	\$80 billion	40x

Source: Whitaker R. Anatomy of an epidemic: Psychiatric Drugs and the Astonishing Rise of Mental Illness in America. *Ethical Human Psychology and Psychiatry*, v. 7, no. 1, spring 2005, 23 - 35.