

## **TEENSCREEN & UNIVERSAL MENTAL HEALTH SCREENING: ICSPP TASK FORCE TALKING POINTS**

### **What is TeenScreen?**

TeenScreen is a 52 question computerized self-administered questionnaire that takes 10 minutes to complete and was developed by Columbia University Children's Psychiatric Center. It can also be completed with paper and pencil. The test supposedly identifies the warning signs of "mental illness" through the answers on these multiple choice questions.

### **How was the TeenScreen test constructed?**

The questions are a checklist specifically geared to match criteria from the American Psychiatric Association's (APA) DSM IV, a manual of "symptoms" and diagnostic categories **voted** into existence by the APA. It supposedly identifies at least 6 mental disorders: Social Phobia; Panic Disorder; General Anxiety Disorder; Major Depression; Alcohol and Drug Abuse; and Suicidality.

### **What is the underlying purpose of the TeenScreen Questions?**

The questions on the test are "loaded." They are designed to plant the seeds of mental illness criteria and make an adolescent feel that normal, everyday feelings and thoughts are abnormal. For example: "In the past year, has there been any time when you weren't interested or involved with anything?"\* (How many of you were interested for 365 days in a row?) "In the last year, has there been any situation when you had less energy than usual?"\* (Who can honestly answer no to that?)

\*The above questions are not taken from the TeenScreen test but are similar in nature so that copyright laws are not violated.

### **How did TeenScreen develop?**

President Bush established the **New Freedom Commission on Mental Health (NFC)** in April, 2002 to study and make recommendations regarding the mental health delivery system in the U.S. Many of the Commission members were highly connected to the nation's largest drug companies. On July 26, 2004, he announced that the NFC recommended mental health screening of **every** American from "birth to old age" with particular emphasis upon children, adolescents, and school personnel. In other words, "**Universal Mental Health Screenings.**" These screenings would serve to identify people with symptoms and connect them to treatment programs. The NFC went on to recommend the **Texas Medication Algorithm Project (TMAP)** as the model for treatment. He also instructed more than 25 federal agencies to develop an implementation plan based upon those recommendations.

## **What is TMAP?**

TMAP began with a “consensus” from a group of mental health “experts” at the University of Texas in the mid-1990s during the time when President Bush was the Governor of Texas. Most of these “experts had ties with the major pharmaceutical companies and all this was funded by companies such as Janssen, Johnson & Johnson, Pfizer, Astrazeneca, Eli Lilly, Novartis, GlaxoSmithKline, Abbot, Janssen-orthoMcNeil, Forest Labs, Wyeth-Ayerst, and Bristol-Myers-Squibb. This group formed an alliance of University of Texas personnel, pharmaceutical companies, and the mental health and corrections systems of Texas, with support from the American Psychiatric Association. TMAP is a psychiatric treatment plan that **mandates** the use of specific brand name drugs as a legal protocol to treat mental illness based upon symptoms. It is a “decision tree” approach to medication treatment based upon: “If symptoms A, B, and C are evident, then use medication X, and Y.” Put another way, TMAP is a list of symptoms and drugs that doctors are **required** to use in treating persons diagnosed psychiatrically. In the wording of the NFC, the recommended “linkage of screening with treatment and supports” includes using “state-of-the-art treatments” using “specific medications for specific conditions.” They go on to recommend TMAP as a “model” treatment plan that “illustrates an evidence-based practice that results in better consumer outcomes.” In 1997-1998, a panel determined which drugs would be used in the treatment of children, (The same drugs as are used with adults), and which were never approved by the FDA for use with children. All have “Black Box” warnings listed for children.

## **Since its inception, what do we know about TMAP?**

TMAP requires the use of the most expensive brand name psychiatric drugs and since its inception, has almost bankrupted the State of Texas and has eaten up both the Medicaid and Medicare budgets in that State. There is no consideration given to alternative treatment approaches. In Pennsylvania, which adapted the TMAP protocols, the Inspector General’s office found that officials received bribes from the pharmaceutical companies who stood to gain from the plan. TMAP specifies the use of newer extremely expensive psychiatric drugs rather than the older versions which are much less expensive and have the same or better outcomes. This is the same problem in all the states who have adapted the TMAP system.

## **What has been the outcome of the TMAP-like programs so far in this country?**

Pharmaceutical company profits have increased astronomically. A New York Times article by Gardiner Harris reported that 70% of Zyprexa sales (which totaled \$4.28 Billion in 2003) are paid for by government agencies like Medicare and Medicaid. Journalist Robert Whitaker, author of “Mad In America,” states that the whole TMAP-TeenScreen program could be seen as drug companies and Psychiatry “fishing for customers.” In an April, 2004 report, Carole Keeton Strayhorn, the comptroller for the

State of Texas, criticized the foster care agency in the State for giving children drugs, “so doctors and drug companies can make a buck.”

### **Are psychiatric drugs safe for children?**

Tricyclic anti-depressants have been linked to cardiac arrhythmias and sudden death. SSRI anti-depressants have been shown consistently to be linked to suicidal behavior and akathisia. Stimulants have been shown to produce cognitive toxicity, impairments in divergent thinking, depression, problems with flexibility and problem solving, tics, growth suppression and much more. Anti-psychotics have been linked to diabetes, obesity, tardive dyskinesia, and suicide. Even the FDA has concluded that suicidal thinking or behavior may occur with **any** type of anti-depressant, and this is an extremely conservative statement. Most of these drugs have “Black Box” warnings on their labels for use with children.

### **Are psychiatric drugs effective with children?**

When tested in controlled trials, these drugs were found not to work. Neither anti-depressants nor stimulants are effective in children. More than 2/3 of the studies of anti-depressants given to children showed that the medications were no more effective than a placebo (sugar pill.) Most of the positive results came from drug company sponsored trials. Psychostimulants have not produced long term changes in either social skills, academic skills, peer relationships, or school achievement levels.

### **Does early biochemical intervention improve a child’s future mental health?**

There has never been a study supporting this. However, there is a vast body of studies that show the dangerous and deadly side effects of these biochemical interventions in **children** who do have emotional problems.

### **Can we accurately diagnose mental illness in young children?**

Due to very rapid developmental changes, it is difficult if not impossible to diagnose young children accurately. Often, adult signs and symptoms of mental disorders in adults are the characteristics of normal development in children and adolescents.

### **Are children who should be treated for mental illness not being treated?**

Between 1991-1995, there was a 300% increase in psychoactive drugs used in 2 to 4 year old children. Between 1999-2003, antidepressant prescriptions for children in the U.S. have increased over 50%. More is currently being spent on psychoactive drugs for children in America than on antibiotics or asthma medications. Certainly, there are

children with problems and parents who are resistant to seeking help, but drugging them is not a realistic solution and problems are not synonymous with “mental illness.”

### **Are psychiatric diagnoses scientifically validated and non-controversial among experts in the field?**

Mental health diagnoses are vague, subjective, and are subject to multiple interpretations. There is no lesion, lab test, or brain tissue abnormality that can identify any of these disorders, nor are there any consistent functional, structural, chemical, or neurological markers found in these disorders.

### **Does TeenScreen work?**

The Center For The Prevention Of Suicide, Rochester, New York, released a study completed in 2006. They concluded that “Given the lack of an adequate evidence base regarding either the use of or the utility of screening programs for preventing suicides, suicide attempts, or factors associated with suicide risk, efforts to use such programs should be regarded as *investigational in nature*,” (their emphasis).

### **Is the TeenScreen Test reliable?**

The U.S. Preventative Services Taskforce (USPSTF) states: “We found no evidence that screening for suicide risk reduces suicide attempts or mortality.”

### **Is drugging children effective?**

The USPSTF found in a study that: “there is insufficient evidence that treatment of those at high risk reduces suicide attempts or mortality.” In addition, in nearly every school shooting incident in the United States in the past 15 years, the children involved were already taking one or more psychiatric drugs, had the dose increased, or had just stopped them abruptly. The question now becomes: **Are these drugs creating cases of extreme violence and suicide?**

### **Is TeenScreen scientifically validated & effective at preventing suicide? (How effective is it as a diagnostic tool?)**

TeenScreen’s extremely high false positive rates makes the test virtually useless as a diagnostic instrument. One study, completed by the creators of the test themselves, found an **82% false positive** rate, meaning that if 100 adolescents scored in the diagnosable range, 82 of them would be flagged as having some mental illness without having any real problems. A weegie board would only produce a 50% false positive result. Dr. David Shaffer, Chairman of Child & Adolescent Psychiatry at Columbia University, the man who developed TeenScreen, found in one study that of 1,729 New York City high school students who were screened, 475 students tested positive for

depression and suicide. 262 of the 475 students who tested positive agreed to a follow-up. Of those, 203 had no evidence of depression and suicidality at follow-up, (77%). Shafer also found that when students were retested, the positive predictive value of TeenScreen was 16%. That means that 84% of those designated by the test as mentally ill and were not would have been referred for treatment for every 16 suicidal youths correctly identified. This makes TeenScreen invalid for screening anything.

The test has no more scientific validity or ethical legitimacy than the mass screening for “mental defectives” during the eugenics movement 2 centuries ago in the U.S. That screening resulted in the sterilization of 72,000 Americans, among them children as young as 10 years old.

### **What happens to a child falsely labeled?**

A child mislabeled as “mentally ill” is likely to be harmed emotionally, psychologically, and neurologically, especially if he/she is prescribed powerful psychoactive drugs.

### **What is the impact of the questionnaire itself on the child?**

We have no idea. However, in one study completed by Arlene Seal, Ph.D., titled “Questions, Questions: Do surveys influence children?” which was published in Education Advocate, July/August, 2000, Vol. 4, she finds that the questionnaire does influence the child because the questions direct focus on the survey’s topics, making the respondent think seriously about them. The survey can also stimulate curiosity about those topics and arouse possibilities of which the respondent was previously unaware, (suicide.) She goes on to report that the extent and detail of the information pursued by the question is related to the degree of influence that can impact the respondent’s thinking and affective behaviors. Therefore, **it is possible that such surveys are actually socializing children into the problems that they are intending to prevent.**

### **Is informed parental consent a component of the TeenScreen program?**

The President’s Freedom Commission on Mental Health concocted a way around telling parents what they wanted to do with your child, probably because they knew that parents would object. So they created the concept of “**passive parental consent.**” In other words, if the parent is uninformed and does not send in an “opt-out” letter to the school, the school can assume that the parent “passively” gave consent for the screening. The 1998 Protection of Pupil Rights Amendment (PPRA) as amended by the 2003 No Child Left Behind Act, states: “No student shall be required as part of any applicable program, to submit to a survey, analysis, or evaluation that reveals information concerning....mental or psychological problems of the student or the student’s family....without the **prior** consent of the student (if the student is an adult or emancipated minor,) or in the case of a non-emancipated minor, without the **prior** written

consent of the parent.” Parents, therefore, have the right to refuse this test if any federal funds are involved, and they are.

The program tried to slip by with the passive consent scheme at first. However, after a lawsuit, they modified this stance and started to request active parental consent. However, this can change again at any time which is why ICSPP is distributing “Parent opt-out forms.”

### **Is the decision to treat a child with psychiatric drugs always between parents and their physician?**

Parents throughout the country have been coerced into giving their child psychiatric drugs under the threat of child abuse charges. These come from schools, the State child protection agencies, principals, child study teams and other sources. If not coerced, most parents are more subtly pressured to do this.

### **How extensive is TeenScreen? How many States are involved?**

According to the Suicide Prevention Resource Center (SPRC), 41 states have plans in place and 35 of them will be using TeenScreen type surveys thus far. New York, Florida, Nebraska, New Mexico, Oregon, and Vermont are specifying TeenScreen by name. Within the year, all 50 states should have plans in place.

### **What other screening programs are in use?**

Screening for Mental Health, Inc., has put out The Signs of Suicide Prevention Kit, (SOS), which first provides students with a video that details the warning signs of suicide. Students are then given a 7 question survey with yes or no answers regarding suicidality. If a school official feels a student is at substantial risk for suicide, they can arrange for an emergency hospitalization **without parental consent**.

The Massachusetts Department of Education distributed anonymous voluntary mental health screening called “The Youth Risk Behavioral Survey” to select schools. The reports of the 2001 and 2003 testing indicates a reduced amount of suicidal, aggressive, and dangerous behaviors, whatever that result means. Other similar tests are also being published.

### **What is the underlying motivation for TeenScreen?**

The New Freedom Commission, TMAP, and TeenScreen appears to be a blatant political/pharmaceutical company alliance that promotes medication, and more precisely, the newer, more expensive antidepressants and antipsychotics which are at best, of questionable benefit and come with deadly side effects. These programs appear designed to simply recruit customers for pharmaceutical companies by channeling children to “treatment,” especially where TMAP is used. (Ohio’s version is OMAP).

By creating the NFC, the pharmaceutical industry has taken over control of U.S. public health policy, representing one of the biggest hijackings of public tax dollars in history. Individuals are unable to pay for these high priced psychiatric drugs; Insurance companies are unwilling to pay for high priced psychoactive drugs. Through the NFC recommendations of mental health screenings of all Americans, followed by a TMAP type treatment program, the pharmaceutical industry has arranged that the state and federal governments will pay for their psychiatric drugs in an ever expanding market. Hence, the purpose of all this is **“market expansion.”**

### **Who will profit from these programs?**

Primarily, large pharmaceutical companies will receive the major profits. However, assorted mental health providers will also be able to feed at the trough.

### **Who will suffer from these programs?**

As these TeenScreen programs and early childhood screening and seniors screening become commonplace, **parent’s rights to control what happens to their children will suffer** and more children will suffer the negative and sometimes permanent side effects of the potent drugs they are forced to take.

### **Do political “contributions” have anything to do with these programs?**

The pharmaceutical industry has spent more than \$800 Million in federal lobbying and campaign contributions at both state and federal levels. In the past seven years, more than with any other industry, the money has swayed public policy and has rendered the FDA totally ineffective as a regulatory agency.

### **What are the real costs of Teen Screen?**

In a study by TeenScreen’s developers, it was concluded that the screening cost is \$37.00 per child and \$250.00 per child who is referred, which would be approximately 1/3 of all children tested. Additional costs were not calculated. However, if only 10 million children are tested, the testing cost alone would amount to \$370 million dollars and referral costs would be over \$1.2 billion dollars. This does not even take into account follow-up and medication costs which could produce ongoing costs of over \$90 billion dollars per year. That is only 10 million children. TeenScreen and the NFC want to screen “all” children.

### **Who Pays for TeenScreen?**

Some of the cost will come from federal grants, but the bulk of the costs will be picked up by local taxes. One out of every five dollars now spent on mental health services goes directly for psychoactive drugs. TMAP programs throughout the country

are already bankrupting state Medicaid programs, particularly in Massachusetts, Florida, Texas, and Illinois. According to the May 8, 2005 issue of *Lab Business Week*, the U.S. Substance Abuse & Mental Health Services Administration found that Medicaid is now the largest single payer for mental health services, exceeding private insurance, Medicare, or other state and local spending.

Last year, TeenScreen executive director Laurie Flynn went before Congress looking for money and asked lawmakers to divert funds from alcohol and drug abuse programs to TeenScreen. Think about it! Take funds from drug abuse programs to implement a pill pushing scheme.

### **What are some of the political ties in TeenScreen?**

Michael Hogan, Ohio Mental Health Director and Stephen Mayberg, California Mental Health Director, are both members of the board of the NFC and the Janssen advisory board. Hogan is also on the TeenScreen advisory board. This is merely a small sample of the nationwide web of interlocking drug company/political connections. Another major connection involves the National Alliance For The Mentally Ill (NAMI), a front group for the pharmaceutical industry. In determining which drugs should be on the approved list, no less than 39 NAMI representatives were on the voting panel. NAMI representative Laurie Flynn is also the Executive Director of TeenScreen. On March 2, 2004, she testified before a congressional hearing that a child is screened for social phobia, panic disorder, generalized anxiety disorder, major depression, alcohol and substance abuse, and suicidality in the 10 minute TeenScreen questionnaire. Perhaps the next step is to figure out a way to cut out the doctor (middle man) and set up a “drive through” for kids to pick up their pills at the local pharmacy.

### **What has been the role of the American Psychiatric Association in promoting TeenScreen?**

The APA states unabashedly in the organizations *Advocacy News*, that they worked to successfully suppress the story of mental health screening from being reported by the mainstream media.

### **Why should we not put the pharmaceutical industry in charge of our mental health in America?**

Putting the pharmaceutical industry in charge of the mental health of our children is like putting the fast food industry in charge of our diet.

### **Is there a childhood suicide epidemic in the United States?**

According to statistics from the U.S. Center For Disease Control, between 1992 and 2001, the suicide rate for children, ages 10 to 19 **fell** from 6.2 deaths per 100,000 to 4.6 deaths per 100,000.



### **Have psychiatric drugs in any way been implemented in suicides and death?**

Both the anti-depressants and stimulants have been shown to cause akathisia, which often results in suicidal ideation and sometimes in suicidal actions.

Robert Whitaker, journalist and author of the best selling book “Mad In America,” recently published evidence that the death rate of patients on the newer, more expensive TMAP drugs, the “atypical” antipsychotics such as Risperdal, Zyprexa, Seroquel, etc., is 2 times that of patients taking the older, much cheaper, typical antipsychotics such as Haldol and Thorazine.\*\* Even though this has been verified in multiple studies, these drugs have not been taken off the market and continue to be the drugs of choice in the TMAP program and it’s clones.

In another study, David Healy, M.D., the British psychiatrist whose research was responsible for the British banning antidepressants for children and the United States placing Black Box warnings on them, found that the suicide rate for “treated” schizophrenics has increased 20 fold since the introduction of psychotropic drugs. He also found major increases in diabetes.\*\*\*

\*\* Whitaker, R. “Anatomy of an epidemic: Psychiatric drugs and the astonishing rise of mental illness in America.” Ethical Human Psychology and Psychiatry, Vol. 7, 1, Spring, 2005.

\*\*\*Healy, D. et al., “Lifetime suicide rates in treated Schizophrenia: 1875-1924 and 1994-1999 – cohorts.’ British Journal of Psychiatry, 2006, 118: 223-228.

### **What is the position of The International Center For The Study Of Psychiatry & Psychology, (ICSPP), in terms of TeenScreen?**

ICSPP opposes psychiatric screening of any kind, as well as the use of unproven psychiatric medications whose benefit/risk ratio is negative. ICSPP also opposes any intrusion into the privacy of the family without full prior disclosure and active, informed parental consent.