

The Dangers of Mental Health Screening

Nathaniel S. Lehrman, M.D.

ABSTRACT

The mental health screening program created by the president's New Freedom Commission on Mental Health (NFC) is presented as a way of ferreting out hidden mental illness, beginning with school children, so that appropriate treatment, primarily medication, can then be given. The program may do more harm than good by inappropriately stigmatizing people as mentally ill, starting people on an unnecessary life-long course of medication, and harming our basic freedoms.

The New Freedom Commission on Mental Health

According to the President's New Freedom Commission on Mental Health (NFC), all American parents will receive notice from their youngsters' schools of the new screening program during the 2005-2006 school year.¹ It will test for mental illness in the 52 million students and 6 million adults working in schools, and expects to find at least 6 million in need of treatment.² The force of government will then urge or compel them to receive that treatment.

But children aren't the only targets. The commission's final report looks forward to having both children and adults screened for mental illnesses during their routine physical examinations.

The sale of psychiatric medications—antipsychotics and antidepressants—rose from \$500 million to \$20 billion between 1987 and 2004, a 40-fold increase.³ A pharmaceutical stock analyst recently predicted that continuing to widen our definitions of illness will result in increased sales of medications. This amounts to corporate-sponsored creation of illness, to enhance revenue.⁴ With the new screening program, the government-sponsored “discovery” of illness will augment the already existing corporate “promotion of undiscovered illness”—which means even more medication sales. And by allowing experts to define peaceful, law-abiding citizens as ill and in need of treatment (which increasingly is becoming involuntary) the program comes to resemble the witch-hunts of 16th-century Europe.

Screening and Its Victims

This is how the program works. In December, 2004, as part of the TeenScreen program created to implement the NFC blueprint, Chelsea Rhoades and her Indiana public high school classmates were given a 10-minute, yes-or-no computer test, which had no room for alternate answers or explanations. A few students were not given the test because their parents had opted them out, an option the Rhoades family had not known about in advance.

Shortly after Chelsea took the test, a local mental health center employee told her that she was suffering from obsessive-

compulsive disorder because she liked to help clean the house, and from 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. Chelsea says all her friends were also told they had something mentally wrong with them. The only youngsters not supposed to be suffering from some mental disorder were those with opt-out slips.

Furious at this intrusion into their privacy and parental rights, the Rhoadeses sounded the alarm. With the help of the Rutherford Institute, they have filed a lawsuit against the school district for failing to inform them about the test or to obtain permission for Chelsea to take it.⁵

Even more frightening was the experience of 13-year-old, black Aliah Gleason,² an average, but rather obstreperous seventh-grade student in an Austin, Texas, suburb. After her class was screened for mental illness, her parents were told that she needed further evaluation because she scored high on a suicide rating. She was referred to a university consulting psychiatrist, and thence to an emergency clinic. Six weeks later, a child protection worker appeared at her school, interviewed her, summoned her father to the school, and ordered him to take the girl at once to Austin State (psychiatric) Hospital. When he refused, she took Aliah into emergency custody and had a police officer drive her to the hospital.

During Aliah's five terrible months in hospital, her parents were forbidden to see or speak to her. While there, she was placed in restraints more than 26 times and given at least 12 different psychiatric medications, many of them simultaneously. After that, she spent four more months in a residential facility, where she received even more psychotropic medications.

Despite her caretakers' uncertainty about her clinical diagnosis (and whether she even had a psychiatric illness), her parents had to go to court to have her released. The professionals they chose for her then tapered her off all medication and successfully addressed problems—both hers and the family's. She is now doing well in school, participating in extracurricular activities, and, according to her psychologist, Dr. John Breeding of Austin, recovering her high spirits.

At a Colorado homeless shelter, 50 percent of the 350 young people given the TeenScreen were found to be suicidal risks, and 71 percent screened positive for psychiatric disorders. Although such youngsters are certainly suffering from residential and social instability, and probably from not eating or sleeping properly, the TeenScreen diagnoses lead to medications instead of appropriate interventions.⁶

The particular purpose of children's mental health screening is supposedly to prevent suicide. But the Columbia University TeenScreen program acknowledged that 84 percent of the teens who tested positive were found to be not really at risk.² And, as Sharav⁷ points out, an evaluation by the authoritative U.S. Preventive Services Task Force (USPSTF) concluded that screening for suicide failed to demonstrate any benefit at reducing

suicide. The report noted that the screening instruments have not been validated. Moreover, there is insufficient evidence that treatment of those identified as high risk reduces either suicide attempts or mortality.⁸

What Is Mental Illness?

What is the mental illness for which we are now screening? Years ago, the term “mental illness” referred only to the insane: people with bizarre ideas who were unable to function socially. Such disabled individuals were social annoyances who might also be dangerous to themselves, others, or both. Other maladaptive psychological patterns such as nervousness or sadness have also been called mental illness, but these produce distress rather than disability. Over the past several decades, however, the term has been expanded to include increasingly more of the thousand natural ills to which the flesh is heir. A recent report from Harvard and the National Institute of Mental Health, for example, says that 46 percent of Americans will at some point in their lives develop a “mental disorder.”⁹

Many of those thousand natural ills are included among the 400-odd disorders listed in the latest edition of the American Psychiatric Association’s (APA) *Diagnostic and Statistical Manual of Mental Disorders*, the DSM. Calling it the psychiatric bible, Herb Kutchins, professor of social welfare at California State University, Sacramento, and Stuart A. Kirk, professor of social welfare at the University of California at Los Angeles (UCLA), point out that since there are no biological tests, markers, or known causes for most mental illnesses, psychiatric diagnosis is based almost entirely on symptomatology—depression, anxiety, disorganization, obsessive thinking, compulsive behavior, and other subjective symptoms.¹⁰

Depression, for example, has as many causes as there are people suffering from it: job difficulties, failure to attain expectations, and problems in relationships are but a few. Basing psychiatric diagnosis entirely on symptoms can be compared to making fever a definitive diagnosis; symptoms are not disorders in themselves, but products of other psychological and/or physiological phenomena. The cure of depression—a term rarely used today although a common occurrence yesterday—requires that an individual’s particular problems be addressed. Psychiatry’s dependence on symptom-based diagnostics is a major reason for the specialty’s mounting pessimism.

One reason for higher estimates of the prevalence of mental disorders is that the APA keeps adding new disorders and more behaviors to the manual, as Kutchins and Kirk point out.¹¹ The increase in the number of these disorders, along with the greatly increased use of new medications to treat them, parallels the increase in individuals disabled by these disorders. Rates for psychiatric disability in America have risen 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 2003.³ 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 “medication era,” the number of mentally disabled people has risen nearly six-fold.³

How the History of ADHD Predicts the Effects of Screening

Kutchins and Kirk point out that children are considered to exhibit signs of attention deficit hyperactivity disorder (ADHD) when they are deceitful, break rules, can’t sit still or wait in lines, have trouble with math, don’t pay attention to details, don’t listen, don’t like to do homework, lose their school assignments or pencils, or speak out of turn. This common childhood behavior is defined as a disorder by the psychiatry department of the New York University (NYU) School of Medicine.¹² ADHD is now diagnosed in 6 to 9 percent of school-age children and 4 percent of adults. Its “symptoms”—acting impulsively; easy distractibility; interrupting others; constant fidgeting or moving; and difficulty in paying attention, waiting one’s turn, planning ahead, following instructions, or meeting deadlines—can be found in any of us. With diagnosis and treatment, the department contends, ADHD symptoms can be substantially decreased.

The process through which ADHD became accepted is important, but little recognized. In 1980, the list of symptoms then called ADD (attention deficit disorder) was first accepted into the DSM. Seven years later, hyperactivity was added, thus making ADHD. Within a year, 500,000 youngsters were assigned this diagnosis.

A few years later, ADHD was classified as a disability, and a cash incentive program was initiated for low-income families with children diagnosed with ADHD. A family could get \$450 a month for each child so labeled, and the cost of treatment and medication for low-income children would be covered by Medicaid. Then in 1991, schools began receiving educational grants of \$400 annually for each ADHD child. The same year, the U.S. Department of Education classified the disorder as a handicap, which required special services to be provided to each disabled child.

By 1996, close to \$15 billion was spent annually on the diagnosis, treatment, and study of this supposed neuropsychiatric disorder. Recently, public health officials in the United States, Canada, and the United Kingdom have issued warnings about previously known but undisclosed risks associated with the stimulant medications used to treat ADHD.¹³

What has happened with ADHD presages what can be expected from government-sponsored mental health screening. One example is the case of the first-grade son of Patricia Weathers. After a school psychologist diagnosed the “disorder,” she was pressured into medicating him.

“The medication eventually made him psychotic,” she said. But when she stopped giving it to him, the school reported her to state child protection officials for “child abuse.” Weathers co-founded AbleChild (www.AbleChild.org) and filed a lawsuit against school officials.

“We have 1,000 stories like this,” she states. Meanwhile, her son is now 15 and “doing fine.”¹⁴

Rep. Ron Paul, M.D., (R-TX) a congressman who has been a physician for more than 30 years, has criticized government agencies for charging parents with child abuse if they refuse to drug their children.¹⁵ Some parents have even had their children taken from them for refusing to give them medications.

Mrs. Weathers’s experience is far from unique. According to Dr. Andrew Mosholder of the FDA’s Office of Drug Safety,¹⁶ about 2.5 million children in this country between ages 4 and 17 currently take ADHD drugs, 9.3 percent of 12-year-old boys, and 3.7 percent of 11-year-old girls. And although these medications have been used for years, the harm they can cause to the heart and circulatory

system, and the psychiatric difficulties they can produce, are only now being publicly discussed.^{1 6}

No matter how we define mental illness in children or adults, it cannot be diagnosed by simple screening. Nobody can, by merely looking at someone else, or even on the basis of a questionnaire, differentiate the transient emotional disturbances we all have from those that last longer.

The ephemeral nature of suicidal ideation and depressive feelings among teens is specifically mentioned by the Columbia TeenScreen report. 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 in whom mental illness is being "diagnosed." Such efforts to find their troubles by frightening people, and thus aggravating those troubles, are misdirected. Only when gross insanity exists can mental illness be recognized on inspection, and then we need neither experts nor screening.

Troubled people can indeed benefit from good mental health care. But good treatment requires that a physician actually examine a patient and address that individual's unique problems, with the patient's knowledge and consent. This requires time, and busy practitioners are often under severe time constraints. Thus they are pressured to quickly prescribe medications to relieve symptoms that are often transient even if untreated.

In my opinion, relying on medication as the definitive treatment of psychiatric complaints, rather than addressing their real causes in patients' lives, is responsible for the gross overuse of psychiatric medications, especially among children, but also among seniors:

- Twenty-nine million prescriptions were written last year in the United States for Ritalin and similar medications to treat ADHD, 23 million of them for children.^{1 6}
- From 60 to 70 percent of children in foster care in Massachusetts are now being given psychiatric medications.^{1 7}
- About 40 to 50 percent of students arrive at some colleges with psychiatric prescriptions.^{1 7}
- Approximately 41 percent of prescriptions for one group of 765,000 people over 65 were for psychotropics.⁶
- As many as 75 percent of elderly, long-term-care nursing home residents in another study were being given psychotropics.⁶

The screening program will aggravate this already unfortunate situation.

Conclusions

Good intentions notwithstanding, the mental health screening program created by the president's NFC probably will harm thousands of Americans by giving them stigmatizing diagnoses that can follow them for the rest of their lives. The program's government-sponsored promotion of long-term medications will compound the harm, as the experience with ADHD has shown.

As Sharav points out,⁷ screening for mental illness serves no medical or societal purpose. Screening will, however, do much to increase the benefits to the drug manufacturers and to the mental health provider industry. Good psychiatric care is voluntary, and based on trust between patient and physician. The involuntary government-sponsored mental health screening program, as demonstrated by the cases of Aliah Gleason and Chelsea Rhoades, represents psychiatric malpractice.

Their cases also demonstrate how the program undermines basic American freedoms, as parents are coerced to medicate their children, sometimes with severe adverse effects.

We need to start to undo psychiatry's 50 years of overdependence on psychopharmacology, rather than expanding it through mental health screening.

Nathaniel S. Lehrman, M.D., is Clinical Director (retired), Kingsboro Psychiatric Center, Brooklyn, NY. Contact: 10 Nob Hill Gate, Roslyn, NY 11576. Email: nsimd@verizon.net

REFERENCES

- ¹ Lenzer J. Bush plans to screen whole U.S. population for mental illness: sweeping initiative links diagnoses to treatment with specific drugs. *WorldNetDaily*, Jun 21, 2004. Available at: www.worldnetdaily.com/news/article.asp?ARTICLE_ID=39078. Accessed Jan 2, 2006. Originally published in: *BMJ* 2004;328:1458.
- ² Waters R. Medicating Aliah. *Mother Jones*, May 2005. Available at: www.motherjones.com/news/feature/2005/05/medicating_aliah.html. Accessed Jan 2, 2006.
- ³ Whitaker R. Anatomy of an epidemic: psychiatric drugs and the astonishing rise of mental illness in America. *Ethical Human Psychology and Psychiatry* 2005;7:23-35. Available at: [http://psychrights.org/Articles/EHPPPpsychDrugEpidemic\(Whitaker\).pdf](http://psychrights.org/Articles/EHPPPpsychDrugEpidemic(Whitaker).pdf). Accessed Feb 21, 2006.
- ⁴ Moynihan R, Cassels A. *Selling Sickness: How the World's Biggest Pharmaceutical Companies Are Turning Us All into Patients*. New York, N.Y.: Nation Books; 2005. Statement quoted in review, *N.Y. Times Book Review*, Sep 4, 2005, p 12.
- ⁵ Whitehead JW. *TeenScreen: One Family's Story*. Charlottesville, Va.: Rutherford Institute; Aug 22, 2005. Available at: www.rutherford.org/articles_db/commentary.asp?record_id=355. Accessed Jan 2, 2006.
- ⁶ Pringle E. August 24 DC protest—activists against TeenScreen will attend. *OpEdNews.com*, Aug 19, 2005. Available at: www.opednews.com/articles/opedne_evelyn_p_050819_august_24_dc_protest.htm. Accessed Jun 21, 2006.
- ⁷ Sharav VH. Screening for mental illness: the merger of eugenics and the drug industry. *Ethical Human Psychology and Psychiatry* 2005;7:111-124.
- ⁸ U.S. Preventive Services Task Force. *Screening for Suicide Risk: Recommendation and Rationale*. Rockville, Md.: Agency for Healthcare Research and Quality; May 2004. Available at: www.ahrq.gov/clinic/3rduspstf/suicide/suiciderr.htm. Accessed Jun 21, 2006.
- ⁹ Fox News. Are half of all Americans mentally ill? *Foxnews.com*, Aug 16, 2005. Available at: www.foxnews.com/story/0,2933,165646,00.html. Accessed Jun 21, 2006.
- ¹⁰ Kirk SA, Kutchins H. Is bad writing a mental disorder? *New York Times*, Jun 20, 1994, p A-17.
- ¹¹ Kutchins H, Kirk SA. *Making Us Crazy: DSM: The Psychiatric Bible and the Creation of Mental Disorders*. New York, N.Y.: Free Press; 1997.
- ¹² NYU Attention Deficit Hyperactivity Disorder (ADHD) Program. *Attention Deficit Hyperactivity Disorder*. New York, N.Y.: NYU School of Medicine, Department of Psychiatry. Available at: www.med.nyu.edu/psych/psychiatrist/adhd.html. Accessed Feb 16, 2006.
- ¹³ Pringle E. ADHD drugs—cash cow for Pharma. *Lawyers and Settlements: Justice for Everyone*. Available at: www.lawyersandsettlements.com/articles/adhd_cash.html. Accessed Feb 16, 2006.
- ¹⁴ MacPherson K. Fierce opposition arises to mental health screening in schools. *Pittsburgh Post-Gazette*, Sep 18, 2005.
- ¹⁵ Snyder K. Mental-health screening of children. Liberty Committee, September 2004. Available at: www.thetruthseeker.co.uk/print.asp?ID=2235. Accessed Jan 2, 2006.
- ¹⁶ Harris G. Report on risk of Ritalin prompts a federal study. *NY Times*, Jul 1, 2005, p A-14.
- ¹⁷ Messman T, Whitaker R. Psychiatric drugs: an assault on the human condition: *Street Spirit* interview with Robert Whitaker. Available at: www.thestreetspirit.org/August2005/interview.htm. Accessed Jun 21, 2006.