

## Report on the Use of TeenScreen in CR

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**NOTE: This report has been altered to remove identifying details of the family involved and other legal details not relevant to the discussion of the medical aspects and harm of mental screening.**

**INTRODUCTION:** There are many problems with the administration of the TeenScreen psychiatric screening survey to CR in December of 2004. Each of these will be discussed below and include:

1. There is lack of science behind the diagnostic categories for the various mental illnesses themselves, much less for screening instruments.
2. This particular screening instrument has a very high false positive rate.
3. Suicide screening is not effective in general.
4. Issues of parental consent make screening very problematic.
5. There is emotional and iatrogenic harm of psychiatric screening.

**Lack of scientific and medical consensus for the criteria of the actual disorders** – TeenScreen is based on criteria from the American Psychiatric Association’s Diagnostic and Statistical Manual, 4<sup>th</sup> edition, (DSM – IV). Experts in the psychiatric community admit that there are significant problems with the diagnostic criteria themselves, describing them as “over inclusive,” leading to false positives.<sup>1</sup> If, as evidenced below, there is as much disagreement by expert entities for diagnostic criteria performed during full and detailed evaluations, how could a screening instrument for any mental condition be accurate?

“Diagnostic categories of mental disorders are social constructions (Bandura, 1969). It is essential, therefore, that the mental health field continually question whether diagnostic categories are defined in ways that serve the best interests of the diagnosed. That is, each of the many aspects of the validity of each diagnosis, including ADHD, must be thoughtfully and persistently questioned.”<sup>2</sup>

“Childhood and adolescence being developmental phases, it is difficult to draw clear boundaries between phenomena that are part of normal development and others that are abnormal.”<sup>3</sup>

“All of psychiatry’s diagnoses are merely syndromes [or disorders], clusters of symptoms presumed to be related, not diseases.”<sup>4</sup>

“The diagnosis of mental disorders is often believed to be more difficult than diagnosis of somatic or general medical disorders since there is no definitive lesion, laboratory test or abnormality in brain tissue that can identify the illness.”<sup>5</sup>

“In other words, what it means to be mentally healthy is subject to many different interpretations that are rooted in value judgments that may vary across cultures.”<sup>6</sup>

“DSM-IV (Diagnostic and Statistical Manual, 4<sup>th</sup> Edition) criteria remain a consensus without clear empirical data supporting the number of items required for the diagnosis . . . Furthermore, the behavioral characteristics specified in DSM-IV, despite efforts to standardize them, remain subjective . . .”<sup>7</sup>

**High False Positives** – As evidenced by the quotes below about TeenScreen specifically and about screening in general, these surveys are fraught with difficulties relating to false positives that cause one to seriously question how valid and reliable these instruments are. It has been claimed by a Minnesota

legislator with ties to the National Alliance for the Mentally Ill that TeenScreen is more accurate than pap smears for detecting cervical cancer with no citation of evidence to substantiate that claim. Yet, if a cancer- screening test falsely told patients that they had cancer at such a high rate, as CR was told that she had two different mental disorders, use of that test would rapidly stop and the purveyors of it would likely be sued.

According to information from TeenScreen in a commentary defending it by Dr. Richard Friedman, a lecturer at Columbia, 55,000 students were screened across the country in 2005.<sup>8</sup> Of those, one third, or 18,150, screened positive and one half of those screening positive, or 9075, were referred for treatment. If one applies Shaffer's admitted 84% false positive rate<sup>9</sup> to the 18,150 who screened positive, 15,246 were false positives. That could easily include all of the 9075 students that were referred for treatment. If one then applies new data, cited at the 2006 meeting of the American Academy of Child and Adolescent Psychiatry, that 59% of children and adolescents with depression are treated with anti-depressants,<sup>10</sup> then up to 5,354 students could have falsely and dangerously received antidepressants that are under the FDA's strongest Black Box Warnings for potentially fatal suicidal thoughts and actions just from that one screening program.

Even if one is more conservative, and assumed that all 16% of the true positives (2,904) of those screened for suicide were in the group of 9,075 referred for treatment, that would leave 6,171 (9,075 - 2,904 or 68%) improperly referred for treatment, and if 59% of those received anti-depressants, 3,640 children and adolescents still could have improperly received antidepressants from one screening program.

The case of Aliah Gleason also shows the great harm that a false positive on a suicide screening can do to one's physical and emotional well being as well as one's liberty. According to the published account<sup>11</sup>, Aliah, 13 years old at the time, underwent a psychiatric screening at her school in Texas under unclear parental consent procedures. The parents initially received a letter several weeks after the screening stating that their daughter reported, "not experiencing a significant level of distress." Shortly after that, however, a psychologist phoned her parents saying that Aliah had scored high on some suicide rating and that she needed to be evaluated. Her parents reluctantly agreed to have her seen by a psychiatrist who did not admit her but referred her for follow-up. Six weeks after that, she was forcibly removed from school by Child Protection and committed to the state mental hospital; denied family contact for five months; forcibly medicated with twelve different medications, including multiple atypical antipsychotics that are not approved for use in this age group, many simultaneously and all without parental consent; and physically restrained at least twenty-six times.

As will be discussed below, there is evidence in both the medical and legal literature of the potential harm of the effects of falsely labeling any young person as potentially suicidal or with any mental disorder. Here are some of the citations showing evidence of high false positives related to TeenScreen.

"Although the sensitivity of the CSS [Columbia Suicide Screen] is excellent, in practice a specificity of 0.83 would deliver many who were not at risk for suicide, and that could **reduce the acceptability** of a school-based prevention program. The CSS's positive predictive value of 16% (determined by a weighted prevalence of DISC positive in the sample) **would result in 84 nonsuicidal teens being referred for further evaluation for every 16 youths correctly identified.**"<sup>12</sup> (Emphasis added.)

"[TeenScreen has] reasonable sensitivity identifying students at risk for suicide. A second-stage evaluation would be needed to reduce the burden of low specificity.... As with other suicide risk

instruments, the CSS has the potential of having high (0.88) sensitivity at the expense of specificity [false positives]...”<sup>13</sup>

“San Francisco Unified School District, for example, passed on TeenScreen because it can generate false positives and drain counseling resources, said spokeswoman Gentle Blythe.”<sup>14</sup>

**Lack of Validity or Effectiveness of Suicide Screening Programs** – The US Preventative Services Task Force report is the most definitive document available, because it reviewed all available studies through 2004. There have since been references to the lack of validity of these screening efforts by other experts. “USPSTF found no evidence that screening for suicide risk reduces suicide attempts or mortality. There is limited evidence on the accuracy of screening tools to identify suicide risk in the primary care setting, including tools to identify those at high risk.”<sup>15</sup>

““By and large, brief diagnostic tests -- especially doing broad screening in children -- are not well validated, and one has to be concerned about missing real illness or, conversely, interpreting transient life troubles as a mental illness requiring intervention,” Hyman said.”<sup>16</sup>

**Issues of Consent and Parental Rights** – At the time the incident involving CR took place, all of the evidence indicates that primary method of parental consent was passive or “opt-out,” meaning that parental consent is assumed unless parents actively work to keep their children from participating.

“Parental passive consent and teen active consent was obtained in all cases.”<sup>17</sup> (Emphasis added.)

The one peer reviewed study of TeenScreen in a major journal described the consent procedures as follows: “The project and its procedures were presented to parents, school faculty, and administration at appropriate meetings. The project was described as inquiring into the physical and emotional health of teenagers. Students took home a letter to all parents describing the project and offering an opportunity to not participate. Just prior to screening, teachers read a description of the project, described as a ‘health survey,’ and distributed the assent form to the students in their classrooms. Students who were interested in participating and whose parents had not denied consent signed the assent form and completed the survey.”<sup>18</sup> This is a classic description of “opt-out” or “passive” parental consent.

“Parents at Penn and other schools could withhold their children from the screening by returning a form mailed to their houses. Parents who did not sign the form and return it were considered to have given permission for TeenScreen... ‘We would probably see the level of participation drop way off (if active consent were required),’ he said.”<sup>19</sup> (Emphasis added). In fact, since this incident and the new requirement by TeenScreen for active parental consent, Penn High School has ceased conducting this screening, because the level of participation did indeed precipitously decline.

“Type of parent consent: # Active consent                                    # Passive consent”<sup>20</sup> (Emphasis added).

“Site Application: 5. Please tell us if you plan to use active consent, waiver of consent, or no consent at all. Also tell us if you plan to use an incentive to secure the return of the consent forms, what the incentive is, and if you plan to purchase the incentive or have it donated.”<sup>21</sup> (Emphasis added)

“The interest would be to screen as many as possible, beginning in the 9<sup>th</sup> grade. The passive acceptance style was mostly discussed to increase the numbers from 50% for Consent to near 95% for Passive. [sic]”<sup>22</sup>

In addition, the TeenScreen newsletter explained to affiliates how to avoid complying with the federal Protection of Pupil Rights Amendment as amended in the No Child Left Behind Act of 2001. This law requires opt-in parental consent for non-emergency surveys and examinations funded by the US Department of Education that deal with psychological or family issues among other things.

“If the screening will be given to all students, as opposed to some, it becomes part of the curriculum and no longer requires active parental consent (i.e., if all ninth graders will be screened as a matter of policy, it is considered part of the curriculum).”<sup>23</sup>

Finally, there is the issue of how much understanding parents have of the implications of these screening tests or surveys. TeenScreen is first deceptively described in a letter sent home to parents in Florida (the Rhoades did not receive a letter) as “a health evaluation.” Even if active consent had been obtained from Mr. and Mrs. R, attorneys Scherrer and Roston noted in the Federal Bar Journal back in 1971, “It is unlikely that the average parent knows to what he is consenting when he signs a piece of paper saying that the school psychologist can examine his child,” in this case by computer.<sup>24</sup>

**Harm of Screening** – For CR to go to school as a happy, normal teenager and to return home after undergoing the TeenScreen screening labeled with two psychiatric diagnoses and a computerized survey indicting that she is impaired, all without parental knowledge or consent, will undoubtedly have emotional consequences that are likely to be hard to quantify.

There are known psychosocially deleterious effects of screening for general medical conditions. For instance, a 1997 editorial published in the British Medical Journal stated, “People receiving false positive results have been shown in three different screening programmes (for congenital hypothyroidism, breast cancer, and Down's syndrome) to suffer high levels of anxiety which do not resolve immediately when subsequent testing shows no signs of disease.”<sup>25</sup> A research review on screening for Type II diabetes states, “Additionally, screening may lead to misdiagnosis, inappropriate investigation and treatment, avoidable adverse effects, and unnecessary psychosocial and economic costs.”<sup>26</sup> There is also traumatic emotional impact from receiving medical diagnoses, such as breast cancer.<sup>27</sup> Congenital hypothyroidism, breast cancer, diabetes, and Down's syndrome are quantifiable and verifiable.

In contrast, psychiatric conditions are admitted to be subjective changeable, and impossible to verify by any standard laboratory test as cited above by many psychiatric expert individuals and groups. They are much more prone to false positives than screening tests for general medical conditions, as evidenced by the 84% false positive rate admitted by Dr. Shaffer, TeenScreen's author in his previously cited journal article. In addition, many psychiatric diagnoses are portrayed as incurable biological brain disorders potentially requiring medication for life; there is much more stigma associated with a psychiatric diagnosis compared to a general medical diagnosis; and there is understandable concern about that socially and emotionally charged an issue appearing and staying in one's records for life.

So if there is as much emotional impact of a falsely positive test for a general medical test as cited in these brief examples or the traumatic emotional impact of receiving a verified medical diagnosis like cancer, it doesn't take much imagination to see that there would be even more significant and negative emotional

impact from receiving a false positive psychiatric diagnosis, especially from an authority figure in the field as happened to CR.

Given that the research shows that a strong sense of parent and family connectedness is a key factor in the development of physically and emotionally healthy adolescents<sup>28</sup>, there is basis for the opinion that such a dramatic violation of that family connectedness by strangers that gave an emotionally charged survey and more importantly, two psychiatric diagnoses without the benefit of parental presence or support is an extremely emotionally disturbing event.

For Mr. and Mrs. R, the strong sense of violation of their parental autonomy and authority and the innocence of their child is also quite likely.

A study<sup>29</sup> was done by psychiatrists from Columbia, whose colleague, Dr. David Shaffer, developed TeenScreen, indicating that there was no increased risk of suicide from TeenScreen. However, this study is suspect both because of the vested interest of the authors in the success of TeenScreen and school based psychiatric screening in general, and because there has been criticism<sup>30</sup> of this study's statistical methods. In addition, that Columbia study did not directly examine the emotional impact on still developing adolescents of receiving any psychiatric diagnosis at all, much less two false positive ones from an authority figure in the psychiatric field all without the benefit of parental presence or support.

In addition, increased screening will result in the increased psychiatric drugging of children and adolescents. There is evidence of overuse of psychotropic medication in children and adolescents, with no evidence of effectiveness, and significant evidence of harmful, if not fatal side effects, including suicide, violence, psychosis, hallucinations, diabetes, and movement disorders. The study done to confirm the increased rate of suicidal thoughts and actions found at the FDA in children was done at Columbia by researchers that included Dr. Shaffer, TeenScreen's author. That study concluded, "...in children and adolescents (aged 6-18 years), antidepressant drug treatment was significantly associated with suicide attempts (OR, 1.52; 95% CI, 1.12-2.07 [263 cases and 1241 controls]) and suicide deaths (OR, 15.62; 95% CI, 1.65-infinity [8 cases and 39 controls])."<sup>31</sup> This is a significant danger of screening.

The citations below give some idea of what is present in the literature on this subject. The US Preventative Services Task Force Report was unable to find a great deal of evidence "directly addressing the harms and costs of either screening or treatment" with controlled clinical trials. The information cited below is either since the publication of that report or in other literature not examined by the USPSTF.

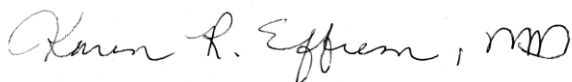
"Although the argument that treating mental disorders would reduce suicides is intuitively appealing, the U.S. Preventive Services Task Force, a federal panel of independent experts, concluded in 2004 that there was insufficient evidence either for or against general physicians screening the public for suicide risk. Ned Calonge, chairman of the task force, established to assess the evidence for various disease-prevention strategies, said the panel would reach the same conclusion today. 'Whether or not we like to admit it, there are no interventions that have no harms,' said Calonge, who is also chief medical officer for the Colorado Department of Public Health and Environment. There is weak evidence that screening can distinguish people who will commit suicide from those who will not, he said. And screening inevitably leads to treating some people who do not need it. Such interventions have consequences beyond side effects from drugs or other treatments', he said."<sup>32</sup>

“It doesn't mean ignorance is good,” he added. “But if your instrument is poor, or you don't know how to intervene to prevent a condition like suicide, there is actually a risk of harm. Besides cost and intrusiveness, there is a risk of harm in terms of stigmatization, but also interventions that backfire.”<sup>33</sup>

“Several recent lines of survey research demonstrate that the simple act of asking a question can lead to changes in a respondent's subsequent behavior. In the current research we asked college students their likelihood to either (i) exercise or (ii) use illegal drugs in the coming 2 months. After 2 months we asked the same college students to report their exercising and illegal drug use behaviors. The findings provide further evidence that these “question-behavior” effects occur for socially normative personal health behaviors, a domain that should have high levels of respondent vigilance and defensive processing. **Of more concern, we demonstrate that when a question is asked about a socially non-normative health behavior (i.e., illegal drug use), instead of decreases in the behavior we see increased rates of the non-normative behavior.**” (Emphasis added)<sup>34</sup> The same could easily apply to suicidal thoughts or attempts. This study was performed after the Columbia study on the potential suicidal effects of screening cited above.

A newspaper story regarding the abstract of the study cited immediately above said, “‘We ask people questions, and that does change behavior,’ study co-author Gavan Fitzsimons, a marketing professor at Duke University's Fuqua School of Business in Durham, N.C., said Thursday. The provocative effect, he added, can be ‘much greater than most of us would like to believe.’” That same story also said, “Since the study appeared in the June issue of the academic journal Social Influence, **Fitzsimons' research team has fielded calls from health practitioners concerned that asking patients about depression and possible thoughts of suicide might make matters worse.**” (Emphasis added.)<sup>35</sup> That this is a possibility is evidenced by the discussion of the subject leading to the act in Japan's Internet suicide clubs.<sup>36</sup>

The concern of emotional harm by psychiatric surveys or evaluations has been present for decades in the legal literature as well. Attorneys Scherrer and Roston also noted in the Federal Bar Journal back in 1971, “...Any personality test constitutes an invasion of privacy to some degree, as the person tested rarely understands the implications of all the questions...or the significance of the responses. **The tests may not only reveal the thoughts and feelings which the student desires to withhold from others but those he is trying to keep from his own consciousness.** The courts have recognized a common law action for invasion of privacy”<sup>37</sup> (Emphasis added)



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<sup>1</sup> Spitzer, R. and Wakefield, J. (December, 1999) *DSM-IV diagnostic criterion for clinical significance: does it help solve the false positives problem?* American Journal of Psychiatry 156(12): 1856-64

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- <sup>2</sup> Jensen, P. & Cooper, J (2002) *Attention Deficit Hyperactivity Disorder: State of the Science - Best Practices* Civic Research Institute, Kingston, N.J., p. 1-8, 9
- <sup>3</sup> World Health Organization (2001) World Health Report
- <sup>4</sup> Glenmullen, Joseph (2000) *Prozac Backlash: Overcoming the Dangers of Prozac, Zoloft, Paxil, and Other Antidepressants with Safe, Effective Alternatives* Touchstone/Simon and Schuster, New York, NY p. 195.
- <sup>5</sup> US Surgeon General (1999) Report on Mental Health, p. 2-18,  
<http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c2.pdf>
- <sup>6</sup> Ibid., p. 1-5
- <sup>7</sup> American Psychiatric Association Committee on the Diagnostic and Statistical Manual (DSM IV- 1994), pp.1162-1163
- <sup>8</sup> Friedman, R. (12/28/06) *Uncovering an Epidemic — Screening for Mental Illness in Teens* New England Journal of Medicine Volume 355:2717-2719
- <sup>9</sup> See citation in endnote 12 below.
- <sup>10</sup> Robinson, LM et. al. (2006) Poster session at the 2006 meeting of the American Academy of Child And Adolescent Psychiatry as reported in Brunk., D (12/06) *Diagnoses of Depression Doubled in a Decade* Pediatric News
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[http://www.motherjones.com/news/feature/2005/05/medicating\\_aliah.html](http://www.motherjones.com/news/feature/2005/05/medicating_aliah.html)
- <sup>12</sup> David Shaffer et al. (2004). The Columbia Suicide Screen: Validity and Reliability of a Screen for Youth Suicide and Prevention. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(1), 71-79; p. 77.
- <sup>13</sup> *Journal of the American Academy of Child & Adolescent Psychiatry*, 2004, v. 42, 71-79
- <sup>14</sup> Lelchuk, I. & Allday, E. (1/21/007) *Parents reflect, schools mobilize to curb suicide* San Francisco Chronicle at  
<http://www.sfgate.com/cgi-bin/article.cgi?file=/c/a/2007/01/22/MNGDANML2R1.DTL&type=printable> last accessed 3/30/07
- <sup>15</sup> US Preventative Services Task Force <http://www.ahrq.gov/clinic/3rduspstf/suicide/suiciderr.htm#clinical>
- <sup>16</sup> Hyman, S. – Former Director of the National Institutes of Mental Health and current provost at Harvard Medical School – as quoted in Vedatam, S. (6/16/06) *Suicide-Risk Tests for Teens Debated* Washington Post available at  
<http://www.washingtonpost.com/wp-dyn/content/article/2006/06/15/AR2006061501984.html>, last accessed 3/30/07
- <sup>17</sup> David Shaffer, et al (date ?) High-school screening for suicidality: Implications for young adults, American Foundation for Suicide Prevention, [http://www.afsp.org/education/shaff\\_pc.htm](http://www.afsp.org/education/shaff_pc.htm) in Study Design and Procedure section. Last accessed 10/26/05
- <sup>18</sup> Shaffer, D. et al. (2004). The Columbia Suicide Screen: Validity and Reliability of a Screen for Youth Suicide and Prevention. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(1), 71-79
- <sup>19</sup> Rumbach, (1/19/2005) South Bend Tribune
- <sup>20</sup> TeenScreen Handbook obtained by EdWatch Nevada, p. 45
- <sup>21</sup> Ibid., p. 70
- <sup>22</sup> Email from Terry R. Smith to Jim McDonough dated 3/15/04 received in materials to review from the Rutherford Institute.
- <sup>23</sup> TeenScreen News (Fall 2003 ) <http://www.antidepressantsfacts.com/TeenScreen-crimin.pdf>
- <sup>24</sup> Scherrer and Roston, *Federal Bar Journal*, Spring, 1971, as quoted in Eakman, B. (1998) *Cloning of the American Mind: Eradicating Morality through Education*, Lafayette, LA, Huntington House p. 80
- <sup>25</sup> Stewart - Brown, S. and Farmer, A. (2/22/1997) *Screening could seriously damage your health: Decisions to screen must take account of the social and psychological costs* *British Medical Journal* 314:533
- <sup>26</sup> The CDC Diabetes Cost-Effectiveness Study Group (11/25/1998) *The Cost-effectiveness of Screening for Type 2 Diabetes* *JAMA*. 280:1757-1763
- <sup>27</sup> Classen, et. al (2001) *Supportive-Expressive Group Therapy and Distress in Patients With Metastatic Breast Cancer* *Archives of General Psychiatry* 58:494-501
- <sup>28</sup> Resnick, M. et al. (1997) *Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health* *JAMA*, 278(10): 823-32 and Resnick., M. (2005) *Healthy youth development: getting our priorities right* *Medical Journal of Australia* 183 (8): 398-400
- <sup>29</sup> Gould, M. et al (April 2005) *Evaluating Iatrogenic Risk of Youth Suicide Screening Programs: A Randomized Controlled Trial* *JAMA*. 293: 1635-1643.
- <sup>30</sup> Schlenger, W. et al (2005) *Iatrogenic Risk of Screening for Youth Suicide* *JAMA* 294:2578-2579
- <sup>31</sup> Olfson, M and Shaffer D (2006) *Antidepressant Drug Therapy and Suicide in Severely Depressed Children and Adults* *Archives of General Psychiatry* 63: 865-72
- <sup>32</sup> Calogne, N. – Chairman of US Preventative Services Task Force – as quoted in Vedatam, 6/16/06
- <sup>33</sup> Hyman, S. as quoted in Ibid.
- <sup>34</sup> Williams, P. et al (June 2006) *Simply asking questions about health behaviors increases both healthy and unhealthy behaviors* *Social Influence* Volume 1, Issue 2, pages 117 - 127

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<sup>35</sup> Latifi, S. (7/21/06) *Study: Surveys Influence Behavior* Hartford Courant at <http://www.courant.com/hc-questioning0721.artjul21.0.2532851.story> Full story received via email last accessed 3/30/07

<sup>36</sup> Harding, A. (December 7, 2004) Japan's Internet "Suicide Clubs" BBC Asia

<sup>37</sup> Scherrer and Roston, *Federal Bar Journal*, Spring, 1971, as quoted in Eakman, B. (1998) *Cloning of the American Mind: Eradicating Morality through Education*, Lafayette, LA, Huntington House p. 80