Concerns with Indiana's State Social, Emotional, and Behavioral Health Plan

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INTRODUCTION: Indiana's (IN) state children's mental health plan legislation passed in the Spring of 2005 corresponds closely, and in many cases exactly with the legislation passed in 2004 and state mental health plan being implemented in Illinois (IL), the Florida Strategic plan for infant mental health, as well as legislation proposed, but blocked in Texas (TX) in 2005. This state legislation was in turn based on the New Freedom Commission Report on Mental Health (NFC), the preliminary version being published in 2003. The Federal Mental Health Action Agenda (FMHAA), although published in August of 2005 was in process well before then and also contains many of the same elements.

This plan is full of statements and assumptions that are not supported by science by agencies and groups that have a direct financial and policy self-interest in see that these types of programs expand. They are uncritical supporters of screening and treatment without looking at any of the problems with these programs and treatments. The assumptions and ideas in this report are helping to spread universal mental health screening starting in infancy; invasive, non-academic early childhood programs that interfere with parental autonomy; and the use of dangerous, ineffective psychiatric medication.

DANGEROUS ASSUMPTIONS:

It is government's job via the schools and other agencies to monitor, screen, set norms regarding, and intervene in the social emotional and behavioral health for all of Indiana's children, beginning at birth, as long as active parental consent is obtained – The plan says on p. 30, "Assure earlier identification and intervention of mental health disorders in infants and toddlers and young children by providing practitioners with mental health consultation and training to increase their capacity to identify and assist families with infants and young children whose behavior has begun to deviate from the normal range of development."

Government sponsored and controlled universal mental health screening, no matter how sweetly wrapped in the fig leaf of parental consent, should never, ever be implemented. It is never, EVER, the proper role of government to set norms for, assess or intervene in the thoughts and emotions of free citizens, much less innocent, vulnerable, and still developing children. It is our thoughts and emotions that make each of us uniquely and individually human, and we use these thoughts and emotions to understand the world and maintain our inalienable right to liberty.

There have been so many examples of coerced mental health drugging in schools that over 20 states and the US Congress have proposed and or passed legislation prohibiting this practice. Aliah Gleason was forcibly committed and drugged against her will as the result of a school mental health screening. There has now been federal legislation proposed against coercive screening as well.

Children are being screened and labeled based on their beliefs, as evidenced by the Early Warning, Timely Response program funded under No Child Left Behind. This violence prevention program lists several supposed warning signs for potential mental health and violence problems that include "intolerance for differences and prejudicial attitudes." The description of this warning sign says, "All children have likes and dislikes. However, an intense prejudice toward others based on racial, ethnic, religious, language, gender, sexual orientation, ability, and physical appearance when coupled with

other factors may lead to violent assaults against those who are perceived to be different." http://www.ed.gov/about/offices/list/osers/osep/gtss.html

Parental consent or opt-out language referred to for this plan is just a way to assuage concerns long enough to put this dangerous system into place. Once it is implemented with parental consent, that language will either be changed by future commissions or legislators, not enforced, or side stepped in some other way. The non-existent enforcement of the federal Protection of Pupil Rights Amendment on invasive surveys is a classic example of this phenomenon.

This plan is only for "at risk children," however that is defined - The enacting legislation for this plan says, "The department of education, in cooperation with the department of child services, the department of correction, and the division of mental health and addiction, shall: (1) develop and coordinate the children's social, emotional, and behavioral health plan that is to provide recommendations concerning: (A) comprehensive mental health services; (B) early intervention; and (C) treatment services; for individuals from birth through twenty-two (22) years of age…" There is no distinction describing which children will be covered. In addition the plan discusses mental health of children at birth without regard to the admitted lack of science in diagnosis and treatment, especially in that age group without mentioning any risk criteria.

In fact, Indiana's Early Childhood Comprehensive System plan lists 3 objectives "across all outcomes" that include mental health screening from birth and that are clearly meant for all children:

- **All** children in Indiana will have a medical home
- **All** children will be covered by a source of payment, whether public or private, for medical and developmental services that are identified by the medical home
- The medical home will facilitate developmental, behavioral and **mental health screening** with appropriate treatment and referrals to community resources. (Emphasis added).

INCORRECT CONCEPTS – Here are just a few prominent examples:

High prevalence rates of childhood mental illness – The plan says, "Prevalence studies indicate that almost 21% of children, ages 9 to 17, meet the criteria for a mental health diagnosis. Adding a criterion for mental health symptoms with a significant functional impairment, the rate is 11%. These children experience significant impairments at home, at school, and with peers. When extreme functional impairment is the criterion, the estimates are 5% of all children." However, the documents that contain these prevalence studies, as well as many prominent experts in mental health admit that that the definition of mental health, the diagnostic criteria and the screening instruments have problems with lack of consensus, reliability, and scientific validity. Here are a few examples:

- "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." - World Health Organization (2001) World Health Report Mental Health: New Understanding, New Hope, p.50 of pdf, http://www.who.int/entity/whr/2001/en/whr01_en.pdf
- "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." (Surgeon General Report on Mental Health. 1999. p. 1-5 http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c1.pdf)
- "The science is challenging because of the ongoing process of development. The normally developing child hardly stays the same long enough to make stable measurements. Adult criteria for illness can be difficult to apply to children and adolescents, when the signs and symptoms of mental disorders are often also the characteristics of normal development." - (1999) Surgeon General's Report on Mental Health, p. 7 of pdf, http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c3.pdf

- "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." (Surgeon General, p. 2-18, http://www.surgeongeneral.gov/library/mentalhealth/pdfs/c2.pdf)
- Dr. Benedetto Vitiello, chief of child and adolescent psychiatry at NIMH, admitted "the diagnostic uncertainty surrounding most manifestations of psychopathology in early childhood." Vitiello, B. (2001) Psychopharmacology for young children: clinical needs and research opportunities. Pediatrics. 108: 983-990.
- "Diagnostic classifications for infancy are still being developed and validated…" National Center for Infant and Early Childhood Health Policy (2005) Addressing Social Emotional Development and Infant Mental Health in Early Childhood Systems, http://www.healthychild.ucla.edu/Publications/Documents/IMHFinal.pdf
- "No consistent structural, functional, or chemical neurological marker is found in children with the ADHD diagnosis as currently formulated." Jensen, P. and Cooper, J. (Editors) (2000) Attention Deficit Hyperactivity Disorder State of the Science - Best Practices, Civic Research Institute, Kingston, NJ, p. 3-7

If the state of the science for mental health problems in children is so uncertain, as described above, how can one believe the prevalence studies and that there is such a crisis that requires the implementation of all of the various elements of this plan?

Screening instruments are accurate at pinpointing true mental health problems – The screening instruments are based on the diagnostic criteria that are shown above to be subjective and unscientific with very high rates of false positives..

- "The questionnaires most commonly used to diagnose ADHD are highly subjective and impressionistic." (Attention Deficit Hyperactivity Disorder State of the Science - Best Practices, Peter S. Jensen and James R. Cooper, Eds, Civic Research Institute, Kingston, N.J. 2000, p. 3-2)
- "It would result in 84 non-suicidal teens being referred for evaluation for every 16 suicidal youths correctly identified." (Dr. David Shaffer, JAACAP, 2004)
- The technical data for the one of the most commonly used screening instruments (Ages and Stages: SE) lists an overall positive predictive value of only 27%. This means that for every 27 children correctly identified by admittedly vague standards, 73 are falsely identified as having emotional problems. http://www.brookespublishing.com/store/books/squires-asqse/ASQ-SE_TechnicalReport.pdf, p.17

Mental health treatments are safe, effective, and well-researched in children – The plan admits, "The gap between science and practice includes limitations in the evidence base...(p. 23)" Here are just a few examples of much recent research and expert opinion showing the uncertainty, dangers, and ineffectiveness of both pharmacological and psychosocial treatments in children:

- Dr. Benedetto Vitiello, chief of child and adolescent psychiatry at NIMH, stated, "Little research has been conducted to study the effectiveness of psychosocial interventions in young children, and the long-term risk-benefit ratio of psychosocial and pharmacologic treatments is basically unknown." Vitiello, B. (2001) Psychopharmacology for young children: clinical needs and research opportunities. Pediatrics. 108: 983-990
- "Despite the evidence that they are effective in the short-term, there is little evidence documenting long-term effects of any intervention [medication, psychosocial therapies, or combined treatment] for ADHD, and the risk–benefit analysis is different for long-term use of at least one modality—medication. There is no evidence that stimulants produce effects that maintain over years, generalize after medication is stopped, and/or alter long-term outcomes of treated individuals. There is growing concern that growth suppression may be an iatrogenic effect of stimulants that will reliably accompany long-term use." (American Psychological Association (2006) Report of the Working Group on Psychoactive Medications for Children and Adolescents. Psychopharmacological, psychosocial, and combined interventions for childhood disorders: Evidence base, contextual factors, and future directions http//www.apa.org/pi/cyf/childmeds.pdf, p. 52)
- "At the same time, reports of deaths and dangerous side effects linked to the drugs are mounting. A USA TODAY study of FDA data collected from 2000 to 2004 shows at least 45 deaths of children in which an atypical anti-psychotic was listed in the FDA database as the 'primary suspect.' There also were 1,328 reports of bad side effects, some of them life-threatening. Drug companies are required to file any reports they have to the FDA, but consumers and doctors report such events on a voluntary basis. Studies suggest the FDA's Adverse Events Reporting System database captures only 1% to 10% of drug-induced side effects and deaths, 'maybe even less than 1%,' says clinical pharmacologist Alastair J.J. Wood, an associate dean at Vanderbilt Medical School in Nashville. So the real number of cases is almost certainly

much higher. 'We're conducting a very large experiment on our children,' March says." http://www.usatoday.com/news/health/2006-05-01-atypical-drugs_x.htm

- Furthermore, whereas the benefits of some behavioral treatments have been well documented through numerous single-subject design studies and group crossover designs, there is a relative dearth of well-controlled randomized clinical trials supporting their effectiveness.
- "It is trade-offs like these that have led regulatory bodies in Europe, Britain, Canada, Australia, and the United States to issue stern warnings or outright contraindications for the use of Report of the Working Group on Psychotropic Medications antidepressants in children. When risk of harm is considered in a cost–benefit analysis together with medical cost offset (Hunsley, 2003), relapse, and side effects, psychological interventions can be very cost-effective, particularly in a group format (Antonuccio, Thomas, & Danton, 1997). Finally, although these drugs have modest adverse effects in the short-term, future research must demonstrate their long-term effects on the central nervous system of children and adolescents." (Ibid.)
- "For many of these interventions, the short-term efficacy for decreasing symptoms is fairly well demonstrated. In contrast, evidence supporting the acute impact of treatment on daily life functioning and the long-term impact on both symptoms and other outcomes is less well documented. In particular, safety concerns remain for a number of psychopharmacological interventions." (Ibid)
- "The major finding of this meta-analysis is that the evidence base for pharmacotherapy of childhood schizophrenia is poor, reflecting a paucity of medication trials most of which are of low quality. The data on adverse effects is likewise deficient and lacks standardized reporting. The conclusion for clinicians is that FGAs [first generation antipsychotics] seem to be an appropriate and relatively safe choice, but long-term outcomes and risk of tardive dyskinesia are not addressed in this article." (Armenteros JL, Davies M (2006) Antipsychotics in Early-Onset Schizophrenia: Systematic Review and Meta-analysis Eur Child Adolesc Psychiatry. 2006;15:141-148)
- No evidence of long-term safety or effectiveness of psychostimulants in the treatment of ADHD in a review of 2,287 studies of these drugs (Oregon Health Sciences University, May 2006, Drug Class Review on Pharmacologic Treatments for ADHD, p. 12-16, http://www.ohsu.edu/drugeffectiveness/reports/documents/ADHD%20Final%20Report%20Update%201.pdf)

Children should be given mental health services even without having a diagnosis – The plan says on p. 9, "It is recommended that service systems develop ways to offer services to children and families that are having difficulties but do not reach the level of a mental health diagnosis…" Given the lack of scientific validity and consensus regarding the diagnostic criteria, screening instruments, and safety and effectiveness of treatments that include both pharmacological and psychosocial, this is at best ineffective, and at worst harmful for children and their families.

Social and emotional academic standards can be accurately, fairly, objectively applied even to young children before kindergarten. – This is obviously not true, given all of the quotes from experts groups cited above and individuals showing the subjective and unscientific nature of mental health criteria and the emphasis placed on cultural and linguistic relevancy of these programs and standards. Also, it is highly questionable that these types of vague, non-academic standards should be added to already over-extended curricula when there are so many problems with effectively teaching academic basics in public schools as evidenced by both national and international test scores.

Early childhood programs improve social and emotional development – The plans says on p. 30, "Cost-benefit analyses confirm that providing young children with social, emotional and behavioral skills through quality early educational experiences produces an economic return to society." In fact, there are two recent prominent studies that say the opposite and much older research and expert opinion dating back to the 1950s that shows that separating young children from their parents actually does academic, emotional and developmental harm. Here are several examples:

- "Children who experience long hours of child care over the first four years of life are more at risk for showing behavior problems, particularly aggression. Not only were these children more likely to engage in assertive, defiant, and even disobedient activities, but they were also more likely to bully, fight with, or act mean to other children." - The NICHD Early Child Care Research Network as quoted on the Society for Research on Child Development website at http://www.srcd.org/pp1.html

- "Attendance in preschool centers, even for short periods of time each week, hinders the rate at which young children develop social skills and display the motivation to engage classroom tasks, as reported by their kindergarten teachers...Our findings are consistent with the negative effect of non-parental care on the single dimension of social development first detected by the NICHD research team [in 2002]."- Fuller, B. et al (11/05) How Much is Too Much? The Influence of Preschool Centers on Children's Development Nationwide Presentation at the Association for Policy Analysis and Management
- "Since the 1960's a vast body of research has stressed the importance to the developing child of the physical presence and emotional accessibility of both parents. …the loss of a parent through death, divorce, illness, or a time demanding job contributes to many forms of emotional disorder, especially the anger, the low self esteem, and the depression that accompany adolescent suicide." – Armand Nicholi, MD, The Harvard Guide to Psychiatry, 3rd edition, Belknap/Harvard Press, Cambridge, Massachusetts, 1999, p. 623
- "There is no evidence that such early instruction has lasting benefits, and considerable evidence that it can do lasting harm…If we do not wake up to the potential danger of these harmful practices, we may do serious damage to a large segment of the next generation…" (David Elkind, Miseducation: Preschoolers at Risk (New York: Knopf, 1997): 4, as quoted in Darcy Olsen, President of the Goldwater Institute, Assessing Proposals for Preschool and Kindergarten: Essential Information for Parents, Taxpayers and Policymakers, 2/8/05 at http://www.goldwaterinstitute.org/pdf/materials/542.pdf
- "There is a large body of evidence indicating that there is little if anything to be gained by exposing middleclass children to early education... Those who argue in favor of universal preschool education ignore evidence that indicates early schooling is inappropriate for many four-year olds and that it may even be harmful to their development." (Edward Ziglar, co-founder of Head Start and director of the Bush Center in Child Development and Social Policy at Yale University, Formal Schooling for Four-Year-Olds? No" in Early Schooling: the National Debate, ed. Sharon L. Kagan and Edward F. Zigler (New Haven, Conn.:Yale University Press, 1987, as quoted in Olsen, 2005)

Mental health treatment of children is cost effective – Given the lack of evidence of effectiveness and safety, as well as severe, if not fatal, side effects of psychotropic medications; and the lack of evidence regarding psychosocial treatments; and given the rapidly escalating costs of medications (Data from Texas shows doubling, tripling and quadrupling of Medicaid expenditures over 3-4 years and Florida data shows 35% per year increases psychotropic drug expenditures. Graphs available at http://www.edwatch.org/pdfs/Major-MH-screen-prbs.pdf.), this concept seems to lack good support.

RECOMMENDATIONS:

1. **Rather than expanding the size and scope of government in an area that is not at all within its proper scope, this commission should be finding ways to support family autonomy and decrease the tax burden by eliminating wasteful, unscientific and invasive programs so that parents are able to spend more time with their children. Government should also be doing its best to promote two parent stable families that is the greatest and best promoter of children's social and emotional development, by not penalizing paternal involvement in welfare payments and other similar measures.**

2. **Do not implement universal mental health screening due to lack of scientific validity, violation of privacy and family autonomy, and the stunning lack of evidence regarding safe and effective treatments.**

3. **Any targeted mental health screening, as well as treatment or services must be based on clearly defined risk criteria and on clear scientific evidence of safety and effectiveness of screening instrument and treatments. No treatment or services should be provided without a clinically and scientifically valid diagnosis.**

4. **Do not involve the birth to five-age cohort in screening and treatment due to their inability to adequately communicate, admitted lack of validated diagnostic criteria, and lack of long-term data on the safety and effectiveness of screening and of medications on the developing bodies and nervous systems of young children. This view is supported by Dr. Benedetto Vitiello of the NIMH who said, "Besides medications, psychosocial interventions are also used to treat young children with behavioral or emotional disturbances. Little research has been conducted to study the effectiveness of psychosocial interventions in young children, and the long-term risk-benefit ratio of psychosocial and pharmacologic treatments is basically unknown. However, safety considerations seem to suggest that, when possible, nonpharmacologic interventions should be considered before young children are given medications of unproven efficacy and safety.**

5. **Given the very poor evidence of safety and effectiveness of all three classes of psychotropic medications, ideally they should not be used at all in children. However, if they must be used, the following American Psychological Association recommendation should be used that says, "For most of the disorders reviewed herein, there are psychosocial treatments that are solidly grounded in empirical support as stand-alone treatments. Moreover, the preponderance of available evidence indicates that psychosocial treatments are safer than psychoactive medications. Thus, it is our recommendation that in most cases, psychosocial interventions be considered first."**

6. **Social and emotional standards should not be implemented due to their subjective nature and when much more work needs to be done on teaching the academic basics.**

7. **Early childhood programs should not be used to improve social and emotional development of children because there is significant evidence that they will actually harm the emotional and academic development of children.**