

Major Problems with Mental Health Screening for Congress

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1. TeenScreen, which received \$13 million in grants from SAMHSA in October of 2005 for the states of Arizona, Nevada, New Mexico and New York¹, violates Congressional intent in the Garrett Lee Smith (GLS) legislation that says that “preferred programs” will, “obtain informed written consent from a parent or legal guardian of an at-risk child before involving the child in a youth suicide early intervention and prevention program.” TeenScreen’s own research paper and the other sites around the country admit that they use passive consent where parental consent is assumed and parents have to opt their children out:

“Parental passive consent and teen active consent was obtained in all cases.”²

“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.”³

2. TeenScreen teaches its sites through its publications how to get around federal parental consent laws, such as the Protection of Pupil Rights Amendment (PPRA) which requires written parental consent for non-emergency surveys that contains such items as, “Mental or psychological problems of the student or the student’s family;” “Illegal, anti-social, or demeaning behavior;” or “Critical appraisals of other individuals with whom respondents have close family relationships.”

“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).”⁴

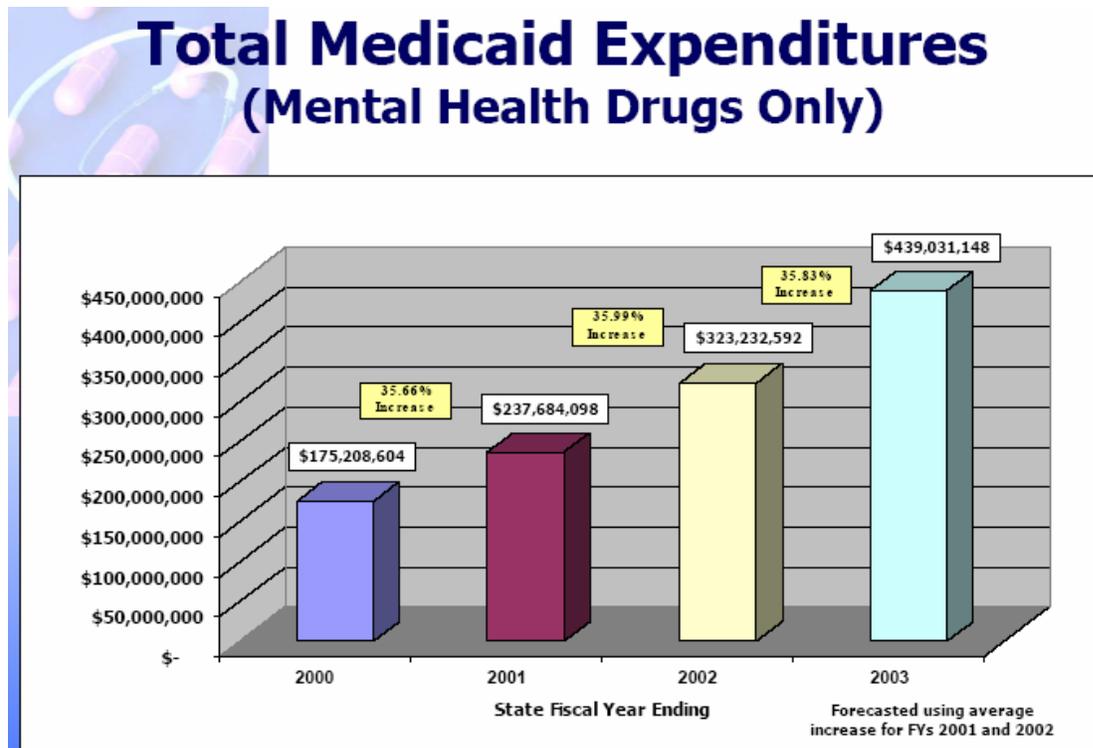
3. Funding TeenScreen through GLS Suicide Prevention Act and other programs administered by the Substance Abuse and Mental Health Services Administration (SAMSHA) Federal Mental Health Action Agenda⁵ is a waste of taxpayer funds because of the high rates of false positives and because major government analyses of suicide screening programs show they do not prevent suicide or decrease mortality.

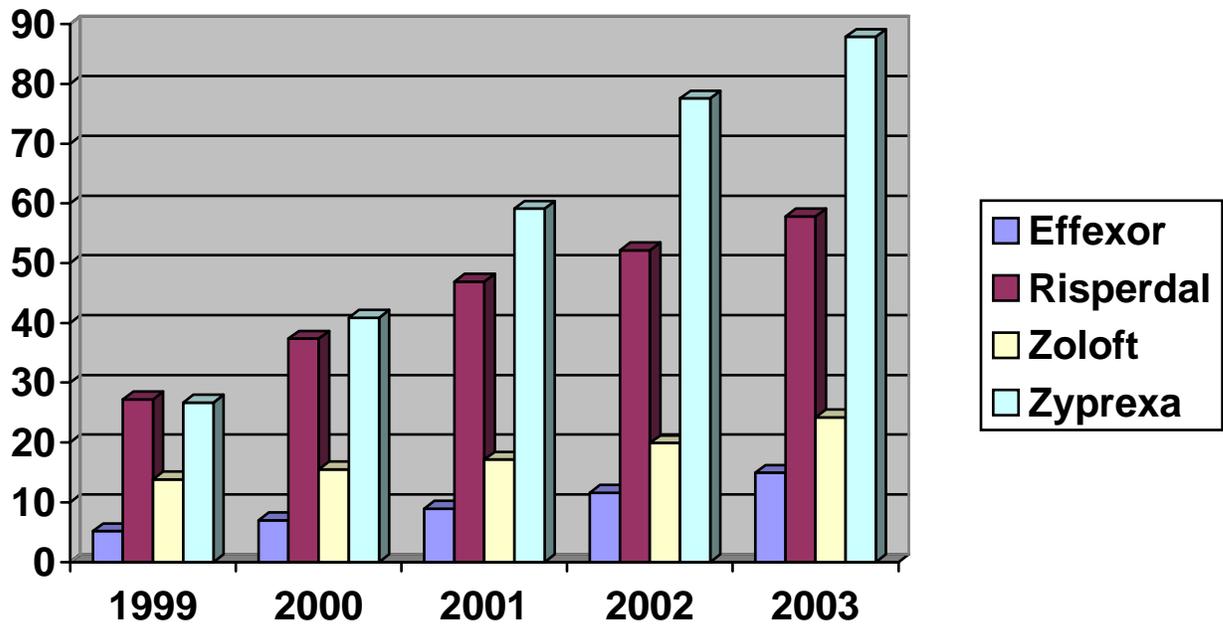
Further analysis by Dr. Shaffer, et al (in 2004) found that when students were retested, the positive predictive value of TeenScreen was only 16%. The authors acknowledge that their screening tool “**would result in 84 non-suicidal teens being referred for evaluation for every 16 suicidal youths correctly identified.**”⁶ (Emphasis added.)

“[TeenScreen has] reasonable specificity 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]...”⁷

“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.”⁸

4. Mental health screening will result in the false labeling of children that will increase unnecessary treatment costs for already overburdened public programs, particularly Medicaid, with thousands of mental patients and children trapped in government programs such as juvenile justice, welfare, and foster care⁹ are forced to take these drugs, when most are not approved for use in children. They are given in unstudied cocktails of up to sixteen drugs, starting as young as age three. These drugs are very dangerous, with all being or about to receive the FDA’s most stringent Black Box Warnings. These medications are also expensive, bankrupting state Medicaid budgets. (See charts below.)





Texas Medicaid Expenditures on 4 Commonly Used Mental Health Drugs

¹ <http://www.newsrx.com/article.php?articleID=274144>

² 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 in Study Design and Procedure section.

³ Rumbach, South Bend Tribune, 1/19/2005

⁴ TeenScreen News (Fall 2003) <http://www.antidepressantsfacts.com/TeenScreen-crimin.pdf>

⁵ http://www.samhsa.gov/Federalactionagenda/NFC_FMHAAspx

⁶ 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.

⁷ *Journal of the American Academy of Child & Adolescent Psychiatry*, 2004, v. 42, 71-79

⁸ US Preventative Services Task Force <http://www.ahrq.gov/clinic/3rduspstf/suicide/suiciderr.htm#clinical>

⁹ Over 60% of foster children in Texas (<http://www.ahrp.org/infomail/04/11/13.php>), nearly two-thirds in Massachusetts (<http://www.ahrp.org/infomail/04/08/11.php>), and 55% of foster children in Florida (<http://www.ahrp.org/infomail/03/09/24.php>) are on as many as 16 different psychiatric drugs, starting as young as age 3.