

# SKYROCKETING MENTAL HEALTH COSTS

## *A Matter of Fraud*

A REPORT,  
CONCLUSIONS  
AND  
RECOMMENDATIONS

*by*



CITIZENS COMMISSION ON HUMAN RIGHTS INTERNATIONAL



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## *A Matter of Fraud*

Report, Conclusions & Recommendations  
by the Citizens Commission on Human Rights®

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# INTRODUCTION

## Funding a Scientific Sham

*“Everyone is neurotic. I have no trouble giving out diagnoses. In my office I only see abnormal people. Out of my office, I see only normal people. It’s up to me. It’s just a joke. This is what I mean by this fraud, this arrogant fraud....To make some kind of pretension that this is a scientific statement is...damaging to the culture...”<sup>1</sup>*

– Ron Leifer, New York psychiatrist

**A** group of seasoned business experts in the United States were invited to evaluate a selection of graphs and information representing the history of an anonymous professional healthcare organization. For more than 30 years, the government had funded the organization—and many of its services were largely covered by insurance—to resolve social problems that it claimed were its area of expertise.

One graph showed the amount of government funding. The other graphs depicted the improvement or decline of the nominated problems. While the funding graph showed a large and constant increase, the performance graphs showed significant decline.

- “These results are horrible and show most likely poor management, poor products and absolutely no success whatsoever,” a money and funds manager stated.
- “Obviously there is something wrong...why does the government keep investing in this?” wrote an investment advisor.

The anonymous organization was psychiatry and the continuously worsening problems were drug abuse, suicide, illiteracy, crime, and mental illness.

Some critics might say, “Analyzing the field of mental health care in this way reduces human suffering to mere numbers on a spreadsheet. You cannot put a price on helping those who suffer mental illness.” But unless results are measured, there is no accurate way to determine if results are improving or worsening. And the results are not improving. Despite receiving colossal increases in government funding and



mandated mental health insurance coverage for its treatments, psychiatry has only made things drastically worse.

- The main factor in this is the widespread acceptance of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. This defines mathematical, reading, spelling and writing problems as "mental disorders." The child who is unable to read properly, who fidgets in class and doesn't focus, is no longer taught phonics, but is labeled with "Attention Deficit Hyperactivity Disorder" (ADHD). He is also prescribed a cocaine-like stimulant that studies show does not improve academic performance.

- Because *DSM*—with its ever-expanding list of mental illnesses and no cure—is a fundamental component of insurance reimbursement, mental health treatment costs up to 300% more than general medical treatment. Countless numbers of patients are unnecessarily and, thereby, fraudulently treated.

- Professors Herb Kutchins from the California State University, Sacramento, and Stuart A. Kirk from the University of New York, say *DSM* is an unreliable "diagnostic tool." "In practical terms, this means that many people who do not have any mental disorder (although they may have other difficulties) will be inappropriately labeled as mentally ill and those who have a mental disorder will not have it recognized. It means that reimbursement systems tied to diagnostic categories will be misused...."<sup>2</sup>

- In 1995, psychologist Jeffrey A. Schaler, said: "The notion of scientific validity, though not an act, is related to fraud. Validity refers to the extent to which something represents or measures what it purports to represent or measure. When diagnostic measures do not represent what they purport to represent, we say that the measures lack validity. If a business transaction or trade rested on such a lack of validity, we might say that the lack of validity was instrumental in a commitment of fraud. The *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* published by the American Psychiatric Association...is notorious for low scientific validity."

- Paul Genova, M.D., writing in *Psychiatric Times*, suggests the "*DSM* diagnostic system has outlived its usefulness by about two decades. It should be abandoned, not revised."<sup>3</sup>

More relevant to health insurers is the problem of financial fraud.

**In spite of receiving huge increases in government funding and mandated insurance coverage for treatment of apparent mental illness, psychiatry has managed to make things drastically worse.**



- A 1992 study of Medicaid and Medicare insurance fraud in the United States showed psychiatry to have the worst track record of all medical disciplines.<sup>4</sup>

- Recently, the U.S. Congressional Budget Office (CBO) estimated that mental health parity would cost American taxpayers \$23 billion over the next ten years. We estimate that at least \$7 billion of this will be defrauded, in addition to the estimated \$20 to \$30 billion that the mental health system is already embezzling per year.

Because of the individual harm and waste of mental health funds committed in the name of *DSM*-styled mental health care today, mental health practitioners should be held fully accountable. We believe that health insurers should demand refunds for mental health treatments that do not achieve a promised result or which result in proven harm to the individual.

We present the information in this report to encourage health insurers to discover more truth about our mental health care systems. We firmly believe that, better informed, health insurers could effect not only great economic savings for themselves and the community, but also indirectly influence real mental health improvement, and even the preservation of life.

Sincerely,

**Jan Eastgate**  
President, CCHR International

**Bruce Wiseman**  
President, CCHR United States

**Lloyd McPhee**  
Health Insurance Broker

**Dr. Megan Shields**  
Family Practitioner



## CHAPTER ONE

# THE DANGERS OF PSYCHIATRIC LABELING

## A Parody of Medicine and Science

*“As practicing clinicians, we have seen the DSM categories treated like elastic waistbands that stretch to any psychological size.”<sup>5</sup>*

— Psychiatrists Sally Satel and Keith Humphreys

**I**n 2002, Dr. Donald Young, president of the Health Insurance Association of America (HIAA), stated, “The so-called mental health parity legislation...is a misguided effort to provide additional treatment resources for a wide variety of ill-defined and difficult-to-diagnose mental disorders. But, in doing so, it will drive up the cost of health insurance for everyone, and it will cause hundreds of thousands of Americans to lose their health coverage altogether.”

Insurance companies warn that opening the door to all the disorders in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* will drive health costs up steeply.<sup>6</sup> In 2001, Ken Sperling, a health-care consultant for Hewitt & Associates, a Lincolnshire-based employee benefits consulting firm, said that at least, “with an appendectomy, there’s no question when you’re better and when you return to work. But, with anxiety, who knows?”

### “SCIENTIFIC VALIDITY” OF PSYCHIATRY

As psychiatrists desire to be seen as the social sciences equivalent of physical scientists—physicists, chemists, etc.—it is important to review the scientific validity of psychiatry.

- *DSM* disorders are not discovered by scientific process but voted into existence by a panel of psychiatric peers. Unlike medical diagnosis, psychiatrists categorize symptoms only, not disease. Regarding this, psychiatrist Matthew Dumont wrote: “No argument I might make about the bankruptcy of *DSM-III* and its offspring could be as powerful as



[psychiatrists] own experience in case conferences. Who can calculate the wasted hours of foolish, futile discussion about how to compartmentalize patients who never seem to fit the numbered cubicles in which we are forced...to place them?"<sup>7</sup>

- Professors Herb Kutchins & Stuart A. Kirk state, "There are indeed many illusions about *DSM* and very strong needs among its developers to believe that their dreams of scientific excellence and utility have come true, that is, that its diagnostic criteria have bolstered the validity, reliability and accuracy of diagnoses used by mental health clinicians." The "bitter medicine" is that *DSM* has "unsuccessfully attempted to medicalize too many human troubles."<sup>8</sup>

- Dr. Thomas Dorman, internist and fellow of the Royal College of Physicians of Canada, writes, "In short, the whole business of creating psychiatric categories of 'disease,' formalizing them with consensus, and subsequently ascribing diagnostic codes to them, which in turn leads to their use for insurance billing, is nothing but an extended racket furnishing psychiatry a pseudo-scientific aura. The perpetrators are, of course, feeding at the public trough."<sup>9</sup>

- There is also junk science. According to Peter Huber, author of *Galileo's Revenge: Junk Science in the Courtroom*, "Junk science is the mirror image of real science, with much of the same form but none of the same substance....It is a hodgepodge of biased data, spurious inference, and logical legerdemain [trickery], patched together by researchers whose enthusiasm for discovery and diagnosis far outstrips their skill. It is a catalog of every conceivable kind of error: data dredging, wishful thinking, truculent dogmatism, and, now and again, outright fraud."

- Often tagged "junk science," the *DSM-IV* was voted one of the ten worst psychiatric papers of the millennium in an international poll of mental health experts conducted in England in 2001.

- Dr. Joseph Glenmullen, clinical instructor in psychiatry at Harvard Medical School, stated, "...[T]he current *DSM* is a compendium of checklist diagnoses: cursory, superficial menus of symptoms in which a minimum number (for example, four of eight or three of twelve) is needed to make a particular diagnosis....Any attempt to help patients understand themselves and to effect real change is lost in the rush to diagnose and medicate them."<sup>10</sup>

## **PSYCHIATRISTS ADMIT THEY CANNOT DEFINE WHAT THEY ARE TREATING**

- On schizophrenia, the *DSM-II* says, "Even if it had tried, the [American Psychiatric Association] Committee could not establish agreement about what this disorder is; it could only agree on what to call it."





- *DSM-III* stated, “There is no satisfactory definition that specifies precise boundaries for the concept ‘mental disorder’....For most of the *DSM-III* disorders...the etiology [cause] is unknown. A variety of theories have been advanced...not always convincing—to explain how these disorders come about.”

- *DSM-IV* says the term “mental disorder” continues to appear in the volume “because we have not found an appropriate substitute.”

- An APA Task Force admitted “...[T]here are those who want some or all mental disorders designated as diseases in order to protect reimbursement and research funding.”<sup>11</sup>

- Psychiatric diagnoses are based on politics, not medicine. In 1973, APA committee members voted—5,584 to 3,810—to cease calling homosexuality a mental disorder after gay activists picketed the APA conferences. Attorney Lawrence Stevens comments: “If mental illness were really an illness in the same sense that physical illnesses are illnesses, the idea of deleting homosexuality or anything else from the categories of illness by having a vote would be as absurd as a group of physicians voting to delete cancer or measles from the concept of disease.”<sup>12</sup>

- Dr. Loren Mosher, psychiatrist and former National Institute of Mental Health schizophrenia researcher, says, “*DSM-IV* is the fabrication upon which psychiatry seeks acceptance by medicine in general. Insiders know it is more a political than scientific document...*DSM-IV* has become a bible and a money making best seller—its major failings notwithstanding....The issue is what do the categories tell us? Do they in fact accurately represent the person with the problem? They don’t and can’t....If you tell a lie long enough, it becomes the truth.”<sup>13</sup>

## MENTAL ILLNESS IS NOT A “TREATABLE BRAIN DISEASE”

**“No single gene has been found to be responsible for any specific mental disorder.”<sup>14</sup> —U.S. Surgeon General’s Report on Mental Health, 1999**

Review any studies that purport there is a biological or genetic cause for mental disorders and you will find the words: “suggests,” “suspect,” “believe,” “may,” “could,” “think,” “probably,” “perhaps,” “argue” and every other conceivable verbal safety valve possible.

In psychiatry, no tests or brain scan exists to prove that a “mental disorder” is a physical disease. Disingenuous comparisons between physical and mental illness and medicine are simply part of psychiatry’s public relations and marketing campaign.

- Steven Hyman, former director of the National Institute of Mental Health says brain scans (for mental disorders) are “pretty but inconsequential pictures of the brain.”<sup>15</sup>





• Psychiatrist Joseph Glenmullen wrote in *Prozac Backlash*, “We do not yet have proof either of the cause or the physiology for any psychiatric diagnosis. In every instance where such an imbalance was thought to have been found, it was later proven false....No claim of a gene for a psychiatric condition has stood the test of time, in spite of popular misinformation.”<sup>16</sup>

**In psychiatry, no test or brain scan exists to prove that a “mental disorder” is a physical disease. Disingenuous comparisons between physical and mental illness and medicine are simply part of psychiatry’s orchestrated public relations and marketing campaign.**

• “There’s no biological imbalance. When people come to me and say, ‘I have a biochemical imbalance,’ I say, ‘Show me your lab tests.’ There are no lab tests. So what’s the biochemical imbalance?” said Dr. Ron Leifer.<sup>17</sup>

• And psychiatrist David Kaiser says, “...[M]odern psychiatry has yet to convincingly prove the genetic/biologic cause of any single mental illness....Patients [have] been diagnosed with 'chemical imbalances' despite the fact that no test exists to support such a claim, and...there is no real conception of what a correct chemical balance would look like.”<sup>18</sup>

Biological “no-fault brain diseases” should be discounted as unproven, fallacious and harmful. Dr. Mosher says these are a “no fault insurance against personal responsibility.” Were such a theory valid, treatment would become the responsibility of neurologists.

**DSM “DISORDERS” AND “PARITY”**

“We are troubled by the use of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*....No other area of medical specialty has similar blanket coverage.” Mandated mental health coverage, would cover such “celebrated conditions as Circadian Rhythm Sleep Disorder/Jet Lag (*DSM-IV* 307.45), Partner Relational Problem (V61.1), Malingering (V65.2) and Oppositional Defiant Disorder (313.81).” — E. Neil Trautwein, Director of Employment Policy for the National Association of Manufacturers

Speaking about federal mandated mental health parity legislation, Karen Ignagni, president of the American Association of Health Plans, stated: “The Senate bill will require coverage of a range of conditions, including caffeine addiction, jet lag, religious problems, occupation problems.”

“When members of Congress think about mental health, they think about schizophrenia,” she continued. “I don’t think they are aware of the generalities and terms used in the Senate legislation which could increase cost for conditions that are not supported by the scientific research.”<sup>19</sup>



**CONSIDER THE *DSM* DISORDERS THAT INSURANCE COMPANIES WOULD BE EXPECTED TO COVER:**

- **Speech Articulation Disorder, Spelling Disorder, Phonological Disorder**
- **Expressive Language Disorder, Disorder of Written Expression**
- **Mathematics Disorder**
- **Nicotine Use or Withdrawal**
- **Caffeine Intoxication or Withdrawal**
- **Conduct Disorder, Oppositional Defiant Disorder**
- **Sibling Rivalry Disorder**
- **Phase of Life Problem**
- **Pathological Fire-Setting, Pathological Stealing**
- **Pedophilia, Sexual Desire Disorders**
- **Sexual Abuse of a Child Problem, Physical Abuse of an Adult “Problem”**
- **Unspecified Mental Disorder (when you can’t find a billing code to fit the “non-psychotic” behavior presented to you)**



## CHAPTER TWO

# MISDIAGNOSING CHILDREN: ECONOMIC AND HUMAN COSTS

### Facts About Child Labeling and Drugging

***“ADHD is a fraud intended to justify starting these children on a life of drug addiction....It is malpractice to remain ignorant of the nature of the 'hyperactive child disorder' and ignorant to advise drug treatment which is unscientific and wholly harmful.”***

— Dr. Edward C. Hamlyn, Founding Member,  
Royal College of General Practitioners, U.K.

**B**ecause of the acceptance of *DSM*, more than six million American children are prescribed mind-altering psychiatric drugs for the learning and behavioral “disorder,” Attention Deficit Hyperactivity Disorder (ADHD). Two million more children take antidepressant and antipsychotic drugs.

- In 1987, the APA voted by committee to include ADHD in the *DSM*. Within a year, 500,000 children were determined to suffer ADHD, with a 900% increase over the next 15 years and a 665% increase in the production of stimulants to “treat” it.
- The soaring numbers of “mentally disordered” children parallel the increases in the number of mental disorders voted into the *DSM*. In 1952, *DSM* had three “disorders” for infants or children. By 1980, there was a nearly thousand-fold increase in the number of child disorders, including mathematics, arithmetic, spelling and language disorders and oppositional defiant disorder (when a child argues with his parent or teacher).
- *DSM-III* in 1980 added 32 infancy, childhood and adolescent “disorders” and the 1987 revision added another 29. Joe Sharkey, author of *Bedlam: Greed, Profiteering, and Fraud in a Mental Health System Gone Crazy* said this “ushered in a population of children with behavior problems that had never before been considered serious enough to require medical intervention, let alone hospitalization.”



- Today, children barely out of diapers are already diagnosed with mental illness, leading to a substantial increase in prescribed psychiatric drug consumption by very young children in the last 15 years.
- By 1989, more than one-third of child and adolescent patient stays in hospitals were based on *DSM* diagnoses such as “conduct disorder,” “adolescent adjustment disorder” and “oppositional defiant disorder.”
- According to Dr. Thomas Szasz, Professor of Psychiatry Emeritus, “...hundreds of thousands of children are incarcerated in psychiatric hospitals, most of them, even according to psychiatric authorities, unnecessarily.”<sup>20</sup> A 1991 study of 20,000 hospitalized children in America, conducted by Ira M. Schwartz, a social worker at the University of Michigan, confirmed that up to 75% of admissions were unnecessary.<sup>21</sup>
- Sharkey pinpointed the common denominator: “Pure economics explains the psychiatric hospitals’ inordinate interest in children. The profit margin for a psychiatric bed occupied by an adult is 20%. For a child, it’s 30%, since children demand less service and attention.”

Despite saturation advertising claiming the opposite, the practice of diagnosing educational and behavioral problems as “ADHD” or “learning disorders,” and prescribing cocaine-like drugs to treat them, is not conclusive science. The following information presents an alternative perspective for initial consideration by insurance professionals.

- Pediatric neurologist Dr. Fred A. Baughman, Jr. says, “The fundamental flaw...is that ADHD has never been proven to be disease, or anything physical or biological.”
- In 1998, a National Institutes of Health Conference of the world’s leading ADHD experts found no evidence to confirm ADHD as a brain dysfunction. Its report stated, “...[O]ur knowledge about the cause or causes of ADHD remains largely speculative.”
- The University of California at San Francisco’s Lawrence Diller, M.D., author of *Running on Ritalin*, sums it up this way: “...[T]he search for a biological marker is doomed from the outset because of the contradictions and ambiguities of the diagnostic construct of ADHD as defined by the *DSM*....I liken the efforts to discover a marker...to the search for the Holy Grail.”<sup>22</sup>

## **BILLING INSURANCE COMPANIES FOR DRUGGING NORMAL CHILDREN**

***“The psychiatrist does not do any testing. The psychiatrist listens to the history and then prescribes a drug.”*** — Dr. Mary Ann Block, author of *No More ADHD*

Many medical experts say that psychiatrists are drugging entirely normal children, which insurance companies are expected to cover. Consequently, misdiagnosis within the psychiatric industry is rife. The following are a few examples:



- “Charlie” was a ten-year-old who suffered violent mood swings, yelled obscenities, kicked his sister, couldn’t control his temper at school, cursed his teachers and had low grades. He was suspected of having “attention deficit disorder” or “conduct disorder” but was eventually labeled as “hyperactive.” His mother was told, “You have two choices: give him Ritalin, or let him suffer.” Charlie was put on Ritalin, but a second medical opinion—based on physical examination and thorough testing—determined he had high blood sugar and low insulin. Psychiatrist and neurologist Sydney Walker III, stated, “Either condition, if uncontrolled, can lead to mood swings, erratic behavior, and violent outbursts—the very symptoms ‘hyperactive’ Charlie had exhibited.” After proper medical treatment, his “hyperactive behaviors cleared, his aggression and tantrums stopped, and his grades went up.”

- Austin from Florida was hailed as “the poster child” for ADHD. He had been kicked out of 11 preschools in three years for doing everything from shouting obscenities and hitting other children to poking a teacher in the eye with a pencil. He was prescribed stimulants. But after a blockage was removed from his colon, he suddenly stopped terrorizing his teachers and classmates. Austin, who is now nine, was able to sit quietly and was a joy to be around. He gave up the medication. His mother said she never would have thought to connect Austin’s behavior with the chronic constipation he had suffered since infancy. “The bad behaviors disappear as soon as the impaction is removed,” said Dr. Paul Hyman, chief of pediatric gastroenterology at the University of Kansas Medical Center in Kansas City.<sup>23</sup>



## CHAPTER THREE

# PSYCHIATRIC DRUGS CREATE FINANCIAL CRISIS

### Facts About Psychiatric Drugs and Harm

***“It's important to remember...that a number of DSM-oriented psychiatrists have, to a large degree, abandoned the science of differential diagnosis, and thus consider most psychiatric illnesses ‘incurable.’ This leaves them with only two weapons: psychotherapy and drugs. It's not surprising that they're among the first to leap on each new drug bandwagon; like long-ago doctors who recommended bleeding for every ailment, they have little else to offer...”***

**— Dr. Sydney Walker III, psychiatrist,  
neurologist, author of *A Dose of Sanity***

**A**ccording to the Employee Benefit Research Institute, mental health treatment costs 200% to 300% more than medical treatment.<sup>24</sup> In the 1950s, Aetna and Blue Cross/Blue Shield began offering generous coverage for mental health services. While their total healthcare expenditures tripled between 1966 and 1975, mental health care expenditures increased by more than six times.<sup>25</sup>

- In Maryland, a 1992 Blue Cross/Blue Shield Association documented outpatient mental health care visits increased 71% once insurance mandates were expanded—from 448,000 in 1983 to 800,000 in 1986.<sup>26</sup>

- Dr. Mark Schiller, psychiatrist and Senior Fellow in Medical Studies at the California-based Pacific Research Institute for Public Policy, states that “historically, psychiatric and substance abuse facilities quickly appear to take advantage of new insurance reimbursement sources. These facilities go on to promote their services extensively, leading to further increases in expenditures and ultimately higher insurance premiums.”<sup>27</sup>

- Mandated chemical dependency treatment coverage alone has already increased costs by 9% in those states that have adopted this type of mandate.<sup>28</sup>

- According to a recent study by the Health Enhance Research Organization, a consortium of employers, “depressed” employees incurred 70% more medical costs than employees without such problems.<sup>29</sup>

- Coverage for psychiatric hospital stays alone increase premiums by 12%.<sup>30</sup>





## SOARING DRUG COSTS

A large percentage of mental health care costs covers psychiatric drugs that can damage the brain and physically harm patients, ensuring almost a lifetime of treatment—and insurance coverage. Spending on drugs generally is rising at three times or more the rate of inflation.<sup>31</sup>

- Antipsychotics sales have reached \$5.5 billion per year. Antidepressant sales are \$12.5 billion. The United States accounts for 70% of the world consumption of antidepressants, 60% of antipsychotics and 90% of methylphenidate (Ritalin).

- On October 5, 2001, *The Wall Street Journal* reported, “Mental health is already a big expense for employers. Brand-name antidepressants have been among the most commonly prescribed medicines that companies pay for....”<sup>32</sup>

- Texas now spends more money on psychiatric drugs for low-income residents than on any other type of prescription drug. Those costs have more than doubled since 1996, when mental health comprised the largest category of expenditures among the top 200 medical drugs.<sup>33</sup>

- Psychiatrists and pharmaceutical-funded psychiatric support groups demand insurance coverage for “newer medications” (atypicals), falsely claiming these offer real hope and treatment for “serious mental illness.” While heralded as new wonder drugs with fewer side effects than their predecessors, the latest neuroleptics have serious effects: blindness, fatal blood clots, heart arrhythmia, heat stroke, swollen and leaking breasts, impotence and sexual dysfunction, blood disorders, painful skin rashes, seizures, birth defects and extreme inner-anxiety.

- The Food and Drug Administration found the clinical trials for three atypicals were biased, with fabricated stories of superiority enabling the drugs to be sold at 30 times the price of the older discredited drugs.

- Atypicals can cause a potentially fatal depletion of white blood cells in up to 2% of patients. More than 140 patients in clinical trials involving four of these drugs died; 36 patients in the clinical trials committed suicide; and 84 experienced such serious life-threatening effects that they required hospitalization.

- In April 2003, *The Wall Street Journal* reported that between 1994 and 2002, 288 patients taking atypicals developed diabetes; 75 of them were seriously ill and 23 died.

- In an eight-year study, the World Health Organization found patients determined to be schizophrenic in three economically disadvantaged countries—India, Nigeria and Colombia—were dramatically better than patients in America and four other developed countries. More than 60% of the patients in the poorer countries were symptom-free and functioning well, compared to 18% in the United States. The difference? In the poor countries, only 16% of the patients were maintained on neuroleptic drugs. In prosperous countries, the figure was more than 60%.





- The Selective Serotonin Reuptake Inhibitor (SSRI) antidepressants were once promoted as safe and virtually side effect-free. In 2002, studies showed that up to 65% of the millions who have taken these were not sufficiently helped. Some experienced sexual dysfunction, emotional numbing, insomnia, weight gain and memory lapses.

- On June 10, 2003, the U.K. government banned the use of Paxil on children under 18, citing suicidal tendencies caused by the drug. Similar warnings were then issued by the appropriate agencies in Canada and the United States.

Medical drugs are essential for treating and curing disease but the same cannot be said of psychiatric treatments.



## CHAPTER FOUR

# FRAUD IN THE MENTAL HEALTH SYSTEM

## Fraudulent Billings

*“What we’ve discovered is that the extent of the fraud is limited only by the imagination. We’ve discovered a huge variety of fraudulent schemes.”<sup>34</sup>*

— Mark Schlein, director of Medicaid, Florida

**P**sychoiatry commits more fraud than any other healthcare sector. This was established by a study of Medicaid and Medicare insurance fraud in the United States, especially in New York, between 1977 and 1995.<sup>35</sup> Yet the U.S. psychiatric industry relentlessly lobbies for a greater share of the country’s healthcare budget and more insurance coverage. Because of their profit-driven practices, psychiatrists have frequently come under federal and state investigations.

- The largest healthcare fraud suit in America’s history involved mental health—the smallest sector of healthcare. After the Federal Bureau of Investigation and other federal agencies raided the offices and facilities of National Medical Enterprises in August 1993, the company paid out \$1.1 billion in criminal penalties and fines and to settle civil suits.

- In 2001, the Audit Review Service, a California company that specializes in the detection, documentation and recovery of fraudulent payments made to mental health providers, investigated a random sampling of bills from approximately 380 mental health providers. The company was able to document fraud in over 21% of the billings from the 68% of the providers who cooperated in the investigation, accounting for losses of \$861,994.00. With 32% of the psychiatric service providers refusing to cooperate, Audit Review Service estimated an overall 30% fraud rate in mental health treatment billings.

- In 1990, a congressional committee report estimated that Community Mental Health Centers (CMHCs) had diverted between \$40 million and \$100 million to



improper uses. In 1998, Medicare barred 80 CMHCs in nine states from serving the elderly and disabled after investigators found patients had been charged \$600 to \$700 per day while watching television and playing bingo, instead of receiving any care.<sup>36</sup>

- The U.S. Office of the Inspector General reported in 2001 that one-third of out patient mental healthcare services provided to Medicare beneficiaries were “medically unnecessary, billed incorrectly, rendered by unqualified providers, and undocumented or poorly documented,” costing Medicare \$185 million in one year.<sup>37</sup>

- According to a veteran California healthcare fraud investigator, one of the simplest ways to detect fraud is to review the drug prescription records of psychiatrists.

While the financial waste is grim, the cost in human lives and misery is much more appalling. The stakes are considerably higher than dollars.

### **\$35,000 FRAUDULENT “FAMILY THERAPY” ENDS IN DIVORCE**

The following is a small sample of the fraudulent psychiatric abuse the Citizens Commission on Human Rights has helped expose:

Joe and Carol Swistok from Ohio needed marriage counseling. They had three children, Maggie, five, John, seven and Joey, eight. To a Florida psychiatric facility they were referred to, the family and a Spanish exchange student staying with them, were a goldmine. On arrival at Horizon hospital, the family members were separated and locked in high security. Joey didn’t understand and protested and was diagnosed with “atypical depression.” A psychologist tested him at zero on the “Depression Rating Scale,” but said he was “probably in denial.” Medical records said John ate too much and, therefore, also had “atypical depression.” Maggie, who was stubborn, was diagnosed with “adjustment problem with a depressive episode.” The exchange student was admitted because psychiatrists needed to know more about the “troubled family” to make a “complete diagnosis.” Two of the children were prescribed

antidepressants. Treatment for the adults was mainly group and music therapy. The family’s health insurance was billed \$35,000. Subsequently, Carol and Joey filed for divorce.<sup>38</sup>

Fourteen-year-old Jeramy Harrel was with his grandmother when a patrol car pulled up beside them, and two hulking uniformed men, who appeared to be police officers, announced they were taking Jeramy to Colonial Hills Psychiatric Hospital. They said that psychiatrist Mark Bowlan and a child welfare agent—who had never spoken with Jeramy or his parents—had ordered the boy’s detention, claiming he was a “substance abuser” and that his grandparents had physically abused him. The psychiatrist said Jeramy was “truant from school, failing grades, violent [and] aggressive,” and was “likely to cause serious harm to self.” It took the efforts of Texas State Senator Frank Tejeda to obtain Jeramy’s release from the hospital after he had discovered the boy’s admission was based on the unsubstantiated and untrue comments made by Jeramy’s 12-year-old brother. The family’s health insurance was billed \$11,000 for this fraudulent “admission” and “treatment.”<sup>39</sup>



## **PSYCHIATRIC FRAUD THAT INSURANCE COMPANIES ARE PAYING FOR:**

**B**lue Cross/Blue Shield United in Wisconsin said that there are as many types of health insurance fraud—which includes mental health—as “the criminal mind can invent.”<sup>40</sup>

The following is a random sample of the extent of imaginative fraud committed by psychiatrists:

- **Billing insurers for therapy to people who were dead.**
- **“False claims”—billing for services never rendered or delivered.**
- **Charging \$150 per day for the use of a television and watching movies as a form of therapy, and billing for playing “bingo.”**
- **Billing for children aged between three and five for treatment of marijuana use.**
- **Charging for baptisms in the psychiatric hospital swimming pool, calling them “recreational therapy.”**
- **Billing for psychotherapy and other treatments on days when the psychiatrist was out of town or on vacation.**
- **Billing insurance companies for having sex with patients.**
- **Charging \$80,000 for a weight-loss program, billed as treatment for anorexia, which the patient didn’t have.**
- **Paying “bounty hunters” \$3,000 per patient routed to psychiatric facilities, with one facility billing taxpayers \$11 million for the treatment of 800 railway workers. Amtrak was billed a further \$1 million.**



## CHAPTER FIVE

# WORKABLE MENTAL HEALTH ALTERNATIVES

### Facts About Alternative Measures that Work

*DSM has “led to the unnecessary drugging of millions of Americans who could be diagnosed, treated, and cured without the use of toxic and potentially lethal medications.”*

— Dr. Sydney Walker, III, author of *A Dose of Sanity*

**I**t is not that the mentally troubled do not deserve the best possible care. They do. However, with little or no accountability in the mental health system, abuse is rampant and insurance companies are unwittingly paying for it. In 2002, *The New York Times* exposed how 960 people died in Group Homes for the mentally ill between 1995 and 2001. Each year 150 individuals, many of them children, die due to violent restraint procedures in psychiatric facilities. Up to 25% of psychiatrists and psychologists sexually abuse their patients.

In addition to clamping down on fraud by the psychiatric industry, there are other ways that health insurers can minimize their costs, while at the same time reducing treatment harm and even influencing real cures.

- Charles B. Inlander, president of The People’s Medical Society wrote: “People with real or alleged psychiatric or behavioral disorders are being misdiagnosed—and harmed—to an astonishing degree....Many of them do not have psychiatric problems but exhibit physical symptoms that may mimic mental conditions, and so they are misdiagnosed, put on drugs, put in institutions, and sent into a limbo from which they may never return....”

- Studies show the frequency with which physical illnesses are misdiagnosed as “mental illness.” In one, 42% of individuals with “psychoses” were found to be suffering from a medical illness, and in another study, 48% had an undiagnosed and untreated physical condition.<sup>41</sup>



- In Frederick Goggan’s book, *Medical Mimics of Psychiatric Disorders*, the case of a 27-year-old executive is discussed. She was hospitalized after attempting to kill herself by overdosing on the antidepressants prescribed by her psychiatrist. The attempted suicide followed a year of psychotherapy that had failed to relieve her fatigue, cognitive problems and despondency. Doctors conducted a thorough physical exam and found what the psychiatrist hadn’t looked for. The woman had hypothyroidism that manifests with “listlessness, sadness and hopelessness.” She was given thyroid supplements, has since been “psychiatric” symptoms-free and has “thrived both personally and professionally.”

- Dr. Walker described the case of John, a successful and happy family man, who began experiencing fatigue and sadness. Two psychiatrists saddled him with a variety of *DSM* labels and treated him with 26 different drugs without ever conducting a single neurological examination. When a qualified medical doctor finally conducted a thorough diagnostic evaluation, he discovered that John had a brain tumor. Once removed, his “emotional” problems and tiredness rapidly vanished.

## IN SUMMARY

**No insurance system should rely on the psychiatric invention called the *DSM*. We ask you to consider the idea of undertaking searching and competent, non-psychiatric physical examinations to discount any underlying, physical condition as the cause of a person’s mental condition, before any health insurance coverage for mental health problems will be provided. This simple expedient would save countless people from being falsely labeled and treated as mentally ill through the use of the *DSM*. This is not only sound financial judgment, it is sound mental health as well.**



# RECOMMENDATIONS

***“Congress should not make the mistake of tying parity to the entire DSM. Many of the diagnoses it contains are not really mental illnesses at all. They are signifiers of unhappiness, dissatisfaction, or troubling character traits.”<sup>42</sup>***

— Psychiatrists Sally Satel and Keith Humphreys

- 1** Establish rights for patients and insurance companies to receive refunds for mental health treatment which did not achieve the promised result or improvement, or which resulted in proven harm to the individual.
- 2** Recover funds where psychiatrists have billed insurance agencies for fraudulent and abusive practices such as sexually abusing a patient, or labeling a child “ADHD” without examination to rule out physical or educational causes, and drugging him.
- 3** Mental health insurance coverage should not be based on the *Diagnostic and Statistical Manual of Mental Disorders*.
- 4** The provision of an “opt-out” clause where individuals could decline mental health coverage offered by their employer/insurance carrier in the same way that they can decline dental and vision coverage and, thereby, pay less premiums. Psychiatric intervention should be user-driven, not provider-driven.
- 5** Only those mental disorders that can be proven through physical tests (blood test, CAT scan, X ray, etc.) to be a disease (physical abnormality) should receive “parity” insurance coverage. Psychiatrists and psychologists should irrefutably and scientifically prove the physical existence of mental disorders that require psychiatric treatment covered by insurance in the same way that physical diseases are.
- 6** Health insurance coverage for mental health problems should only be provided on the proviso that full, searching physical examinations are first undertaken to determine that no underlying untreated physical condition is causing the person’s mental health condition. Such examinations would be covered under existing health coverage.
- 7** Regular financial audits be conducted of psychiatric facilities that receive insurance payments to ensure accountability.





# THE CITIZENS COMMISSION ON HUMAN RIGHTS INTERNATIONAL

**T**he Citizens Commission on Human Rights (CCHR®) was co-founded in 1969 by the Church of Scientology and Professor Emeritus of Psychiatry, Thomas Szasz, to investigate and expose psychiatric violations of human rights and to clean up the field of mental healing. Today, it has more than 130 chapters in 34 countries. Its board of advisors includes doctors, lawyers, educators, artists, businessmen, and civil and human rights representatives.

CCHR has inspired and contributed to many hundreds of reforms by testifying before legislative hearings and conducting public hearings into psychiatric abuse, as well as by working with media, law enforcement and public officials the world over.

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# ENDORSEMENTS OF CCHR

## **DETECTIVE MIKE MORRISON**

Newport Beach Police Department, California

*“I wanted to make sure to commend your organization and the individuals involved in assisting me in the criminal prosecution of a psychiatrist...[CCHR’s] efforts were of a superior quality and greatly assisted me. You have some very special people working for you.”*

## **DENNIS D. BAUER**

Senior Deputy District Attorney  
Orange County, California

*“I was incredulous to find out that a private organization was following up on leads where we had drawn blanks or were unable to cover....I found all of [CCHR’s] personnel very positive, eager, intelligent and exceptionally well informed on issues that are obscure to the majority of the population....I commend you and your staff for the tireless energy and unselfish commitment to solving one of society’s neglected and secret problems—‘experimental psychiatry.’”*

## **RAYMOND N. HAYNES**

California State Assemblyman

*“The [CCHR] is renowned for its long standing work aimed at preventing the inappropriate labeling and psychotropic drugging of children....The contributions that the Citizens Commission on Human Rights International has made to the local, national and international areas on behalf of mental health issues are invaluable and reflect an organization devoted to the highest ideals of mental health services.”*

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*“Whereas, [CCHR] works to preserve the rights of individuals as defined by the Universal Declaration of Human Rights and to protect individuals from ‘cruel, inhuman or degrading treatment’...the House of Representatives of Pennsylvania congratulates [CCHR International]...its noble humanitarian endeavors will long be remembered and deeply appreciated.”*



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**Fact Sheets: Summarized  
Facts for Quick Reference**

# FACT SHEET

## ***DSM—DRIVING UP HEALTHCARE COSTS***

***“Everyone is neurotic. I have no trouble giving out diagnoses. In my office I only see abnormal people. Out of my office, I see only normal people. It’s up to me. It’s just a joke. This is what I mean by this fraud, this arrogant fraud....To make some kind of pretension that this is a scientific statement is...damaging to the culture....”***

**Ron Leifer, New York psychiatrist**

1. Despite receiving colossal increases in government funding and mandated mental health insurance coverage for its treatments, the practice of psychiatry has no scientific foundation, resulting in mental health treatments costing 200% to 300% more than general medical treatment. The underlying problem is the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*, an economic, not medical tool.

2. Professors Herb Kutchins from the California State University, Sacramento, and Stuart A. Kirk from the University of New York, say *DSM* is an unreliable “diagnostic tool.” “In practical terms, this means that many people who do not have any mental disorder (although they may have other difficulties) will be inappropriately labeled as mentally ill and those who have a mental disorder will not have it recognized. It means that reimbursement systems tied to diagnostic categories will be misused....”

3. Dr. Joseph Glenmullen, Clinical Instructor in Psychiatry at Harvard Medical School, states, “...[T]he current *DSM* is a compendium of checklist diagnoses: cursory, superficial menus of symptoms....Any attempt to help patients understand themselves and to effect real change is lost in the rush to diagnose and medicate them.”

4. Dr. Thomas Dorman, internist and fellow of the Royal College of Physicians, Canada, stated, “In short, the whole business of creating psychiatric categories of ‘disease,’ formalizing them with consensus, and subsequently ascribing diagnostic codes to them, which in turn leads to their use for insurance billing, is nothing but an extended racket furnishing psychiatry a pseudo-scientific aura. The perpetrators are, of course, feeding at the public trough.”

5. Psychiatrist David Kaiser states, “...[M]odern psychiatry has yet to convincingly prove the genetic/biologic cause of any single mental illness....Patients [have] been diagnosed with ‘chemical imbalances’ despite the fact that no test exists to support such a claim, and...there is no real conception of what a correct chemical balance would look like.”

6. An APA Task Force admitted, “...[T]here are those who want some or all mental disorders designated as diseases in order to protect reimbursement and research funding.”

Although a mammoth task, it is nevertheless vital that the *DSM* diagnostic system is universally rejected before any chance of meaningful mental health reform and advancement can occur.

# FACT SHEET

## MISDIAGNOSING CHILDREN

***“With no abnormality in the ‘ADHD child,’ the pseudo-medical label is nothing but stigmatizing, and the unwarranted drug treatment that invariably follows, a physical assault. The ‘medication’ typically prescribed for ADHD and ‘learning disorders’ is a hazardous and addictive amphetamine-like drug.”***

**Dr. Fred Baughman, Jr.  
Pediatric Neurologist, California, 2002**

1. Because of the widespread acceptance of the Diagnostic and Statistical Manual of Mental Disorders (DSM), more than six million American children are prescribed cocaine-like stimulants for “Attention Deficit Hyperactivity Disorder” (ADHD), a diagnosis that has never been scientifically proven to exist. Two million more children take antidepressant and antipsychotic drugs for other “disorders.”
2. In 1987, the APA voted to include ADHD in the *DSM*. Within a year, 500,000 children were determined to suffer ADHD, with a 900% increase over the next 15 years and a 665% increase in the production of stimulants to “treat” it.
3. The soaring numbers of “mentally disordered” children parallel the increases in the number of mental disorders voted into the *DSM*. In 1952, *DSM* had three “disorders” for infants or children.
4. By 1980, there was a nearly thousand-fold increase in the number of child “disorders,” including mathematics, arithmetic, spelling and language disorders, and oppositional defiant disorder (a child arguing with a parent or teacher). *DSM-III* added 32 infancy, childhood, and adolescence “disorders” and the 1987 revision added another 29. Joe Sharkey, author of *Bedlam: Greed, Profiteering, and Fraud in a Mental Health System Gone Crazy*, said, “[T]his ushered in a population of children with behavior problems that had never before been considered serious enough to require medical intervention, let alone hospitalization.”
5. By 1989, more than one-third of child and adolescent patient stays in hospitals were based on *DSM* diagnoses such as “conduct disorder,” “adolescent adjustment disorder,” and “oppositional defiant disorder.” A 1991 study of 20,000 hospitalized children found that up to 75% of the admissions were unnecessary.
6. While medicine’s scientific procedures are verifiable, psychiatry lacks any scientific approach to mental health. In 1998, a National Institutes of Health Conference of the world’s leading ADHD experts, found, “[O]ur knowledge about the cause or causes of ADHD remains largely speculative.”

In his book, *A Dose of Sanity*, neurologist and psychiatrist Sydney Walker III, said the *DSM* has “led to the unnecessary drugging of millions of Americans who could be diagnosed, treated, and cured without the use of toxic and potentially lethal medications.” Millions of children may simply need proper medical treatment or educational solutions.



# FACT SHEET

## SOARING PSYCHIATRIC DRUG COSTS

1. A large percentage of mental health care costs covers psychiatric drugs that can damage the brain and physically harm patients, ensuring almost a lifetime of treatment—and insurance coverage. The cost of drugs generally is rising at three times the inflation rate.
2. Texas now spends more money on psychiatric drugs for low-income residents than on any other type of prescription drug. Those costs have more than doubled since 1996, when mental health medications were the third largest category of expenditures.
3. Psychiatrists and pharmaceutically-funded support groups demand insurance coverage for “newer medications” (atypicals), falsely claiming to offer real hope and treatment for “serious mental illness.” While heralded as wonder drugs with fewer side effects than their predecessors, the latest neuroleptics have serious side effects: blindness, fatal blood clots, heart arrhythmia, birth defects, and extreme inner-anxiety.
4. The Food and Drug Administration found clinical trials for three atypicals were biased with fabricated stories of superiority enabling the drugs to be sold at *30 times* the price of the older discredited drugs.
5. In April 2003, *The Wall Street Journal* reported that between 1994 and 2002, 288 patients taking atypicals developed diabetes; 75 of them were seriously ill and 23 died. Atypicals can cause a potentially fatal depletion of white blood cells in up to 2% of patients; 36 patients in the clinical trials of four atypicals committed suicide; and 84 experienced such serious life-threatening effects that they required hospitalization.
6. In a study over eight years, the World Health Organization found patients determined to be schizophrenic in three economically disadvantaged countries—India, Nigeria, and Colombia—were dramatically better than patients in America and four other developed countries; 64% of the patients in the poorer countries were without symptoms and functioning well, compared to 18% in the United States. The difference? In the poor countries, only 16% of the patients were maintained on neuroleptic drugs. In prosperous countries, the figure was more than 60%.
7. The Selective Serotonin Reuptake Inhibitor (SSRI) antidepressants were promoted as safe and virtually side effect-free. In 2002, studies showed that up to 65% of the millions who had taken these were not sufficiently helped. Some experienced sexual dysfunction, emotional numbing, insomnia, weight gain, and memory lapses. On June 10, 2003, the UK government banned the use of Paxil on under-18s, citing suicidal tendencies caused by the drug. Similar warnings were then issued by the appropriate agencies in Canada and the United States.

Medical drugs are essential for treating and curing disease, but the same cannot be said of psychiatric drugs.



# FACT SHEET

## FRAUD IN THE MENTAL HEALTH SYSTEM

1. A 1992 study of Medicaid and Medicare insurance fraud in the United States, especially in New York, between 1977 and 1995, showed psychiatry commits more fraud than any other health care sector. Yet the U.S. psychiatric industry relentlessly lobbies for a greater share of the country's health care budget and insurance coverage.
2. The largest health care fraud suit in America's history involved the smallest sector of health care—mental health. After the Federal Bureau of Investigation and other federal agencies raided the offices and facilities of National Medical Enterprises in August 1993, the company paid out \$1.1 billion in criminal penalties and fines and to settle civil suits.
3. Recently, the U.S. Congressional Budget Office estimated that mental health parity would cost American taxpayers \$23 billion over the next 10 years. An estimated \$7 billion of this will be defrauded.
4. In 2001, Audit Review Service, a California company which specializes in the detection, documentation and recovery of fraudulent payments made to mental health providers, investigated a random sampling of bills from approximately 380 mental health providers. With a 68% provider-cooperation rate with the investigation, the company was able to document fraud in over 21% of the billings, accounting for \$861,994.00. With 32% of the psychiatric service providers refusing to cooperate, the company estimated an overall 30% fraud rate in mental health treatment billings.
5. The U.S. Office of the Inspector General reported in 2001 that one-third of out-patient mental health care services provided to Medicare beneficiaries were “medically unnecessary, billed incorrectly, rendered by unqualified providers, and undocumented or poorly documented,” costing Medicare \$185 million in 1998 alone.
6. Psychiatrists have billed for: therapy that was given to people who were dead, services never rendered or delivered, treatments on days when the psychiatrist was out of town or on vacation, having sex with patients, and weight loss programs that were “treatment” for anorexia, which the patient didn't have.
7. According to a veteran California health care fraud investigator, one of the simplest ways to detect fraud is to review the drug prescription records of psychiatrists.

The untold individual harm and waste of mental health funds because of the *Diagnostic and Statistical Manual of Mental Disorders* requires psychiatrists and psychologists be held fully accountable. For health insurers, this means demanding refunds for mental health treatments that did not achieve a promised result or which resulted in proven harm to the individual.

**Supporting Articles  
and Media**

# DIAGNOSIS BY DESIGN

BY THOMAS SZASZ

*Dr. Thomas Szasz, Professor of Psychiatry Emeritus at the State University of New York Health Science Center and author of more than 25 books, has been internationally acclaimed as “one of the most important writers in present-day psychiatry.” He writes:*

Using a poll surveying the nation’s health, Parade magazine concluded that depression is “the third most common ‘disease.’” Yet when the respondents were asked, “What is your greatest personal health concern for the future?” they did not even mention depression. They were concerned about cancer and heart disease.

Even though people have accepted the categorization of depression as a disease, they are not afraid of getting depression because they intuitively recognize that it is a personal problem, not a disease. They are afraid of getting cancer and heart disease because they know these are diseases—true medical problems—not just names.

Allen J. Frances, Professor of Psychiatry at Duke University Medical Center and Chair of the DSM-IV Task Force, writes: “DSM-IV is a manual of mental disorders, but it is by no means clear just what is a mental disorder....There could arguably not be a worse term than mental disorder to describe the conditions classified in DSM-IV.” Why, then, does the APA continue to use this term?

The primary function and goal of the DSMs is to lend credibility to the claim that certain behaviors, or more correctly, misbehaviors, are mental disorders and that such disorders are, therefore, medical diseases. Thus, pathological gambling enjoys the same status as myocardial infarction (blood clot in heart artery). In effect, the APA maintains that betting is something the patient cannot control; and that, generally, all psychiatric “symptoms” or “disorders” are outside the patient's control. I reject that claim as patently false.

The ostensible validity of the DSM is reinforced by psychiatry’s claim that mental illnesses are brain diseases—a claim supposedly based on recent discoveries in neuroscience, made possible by imaging techniques for diagnosis and pharmacological agents for treatment. This is not true. There are no objective diagnostic tests to confirm or disconfirm the diagnosis of depression; the diagnosis can and must be made solely on the basis of the patient’s appearance and behavior and the reports of others about his behavior.

There is no blood or other biological test to ascertain the presence or absence of a mental illness, as there is for most bodily diseases. If such a test were developed (for what, theretofore, had been considered a psychiatric illness), then the condition would cease to be a mental illness and would be classified, instead, as a symptom of a bodily disease.

If schizophrenia, for example, turns out to have a biochemical cause and cure, schizophrenia would no longer be one of the diseases for which a person would be involuntarily committed. In fact, it would then be treated by neurologists, and psychiatrists then have no more to do with it than they do with Glioblastoma [malignant tumor], Parkinsonism, and other diseases of the brain.

# MALPRACTICE AND VIOLATION OF INFORMED CONSENT

BY DR. FRED A. BAUGHMAN, JR.

*Dr. Baughman is a board certified neurologist and child neurologist and a Fellow of the American Academy of Neurology. He has discovered and described real diseases, yet has found no abnormality—no sign of disease—in children said to have ADD/ADHD and “learning disabilities.”*

Neurologists, not psychiatrists, are medically and legally responsible for the diagnosis and treatment of actual abnormalities/diseases of the brain. Throughout the eighties and nineties, I witnessed the exploding ADHD epidemic. Just as it was my duty to every patient to diagnose actual disease when it was present, it was equally my duty to make clear to them that they had no disease when that was the case—that is, when no abnormality could be found. Moreover, it was my duty to know the scientific literature concerning every real neurological disease, and every purported neurological disease as well.

By contrast, in 40 years, “biological psychiatry” has yet to validate a single psychiatric condition/diagnosis as an abnormality/disease, or as anything “neurological,” “biological,” “chemically-imbalanced” or “genetic.”

With no abnormality in the “ADHD child,” the pseudo-medical label is nothing but stigmatizing, and the unwarranted drug treatment that invariably follows, a physical assault. The “medication” typically prescribed for ADHD and “learning disorders” is a hazardous and addictive amphetamine-like drug.

The following children are no longer hyperactive or inattentive—they are dead. Between 1994 and 2001, I was consulted, medically or legally, formally or informally, in the following death cases: Stephanie, 11, prescribed a stimulant and died of cardiac arrhythmia; Matthew, 13, prescribed a stimulant and died of cardiomyopathy [disease of heart muscle]; Macauley, 7, prescribed a stimulant and three other psychiatric drugs, suffered a cardiac arrest; Travis, 13, prescribed a stimulant and suffered cardiomyopathy; Randy, 9, given a stimulant and several other drugs and died from cardiac arrest; Cameron, 12, prescribed a stimulant and died from hyper-eosinophilic syndrome [abnormal increase in white blood cells].

This is a high price to pay for the “treatment” of a “disease” that does not exist.

In calling ADHD an abnormality/disease, without scientific facts, the psychiatrist knowingly lies, and violates the informed consent rights of both patient and parents. This is de facto medical malpractice.

I urge all physicians to remember, “No demonstrable physical or chemical abnormality: no disease!”