

## “Voluntarily, Knowingly, and Intelligently”: Protecting Informed Consent in School-Based Mental Health Referrals

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### Abstract

*Coherent with mental health literacy curricula, mental health assessment and referral is embedded in Canadian educational contexts. Mental health literacy excludes the substantial scholarly critique of mental health produced by psychiatry, the disciplinary base of the field of mental health. In-school student referrals to mental health professionals may similarly omit important critical information. Key critical areas of concern include scientific evidence, psychiatric drugs, psychiatric diagnosis, misinformation, and potential for harm. Professional ethics codes call for full disclosure of risk and open access to any relevant information needed for informed decision-making. Some mental health interventions commonly take place on an implied consent basis within first-time consult appointments. Consequently, parents and students require access to critical mental health knowledge before or during referral processes. Beyond aligning mental health referral with the ethical principle of informed consent, professional ethics require institutional divestment from any mental health premises and practices that cause harm and lack scientific, intellectual, and ethical integrity.*

*Keywords: mental health literacy, critical psychiatry, referral, mental health promotion, informed consent*

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Anchored in mental health literacy discourse, informal mental health assessment and referral has become a whole-school endeavor for secondary schools in Canada (Kutcher, Wei, & Morgan, 2015). Mental health literacy programs, such as *The Guide*, call upon every member of the school community to recognize or *read* problematic feelings and behaviours as symptoms of individual mental disorder, a term synonymous with mental illness, mental health condition, psychiatric illness, and neuropsychiatric disorder (Kutcher & Wei, 2017). According to mental health literacy, even young people can learn to spot mental disorders in themselves and others and schools can teach them early-detection strategies. Psychiatrist Stan Kutcher and colleagues advise, “It is fundamental that schools not only promote positive mental health, but also enable students to differentiate normal mental distress from mental health problems/disorders” (Kutcher, Yifeng, Costa, Gusmao, Skokauskas, & Sourander, 2016, p. 568). Embedding informal mental health assessment and referral within the everyday life of the school ensures that mental health assessment can be offered by anyone at any time whether requested or not. Hundreds of published articles affirm mental health literacy training, early detection, and referral (Jorm, 2000; Kutcher et al, 2016). Unless school communities are aware of the critical mental health literature, they may not know there is cause for concern.

In this article, I draw on critical mental health scholarship and professional codes of ethics to invite critical inquiry into school-based mental health referrals. I will use a definition of referral that includes both case-by-case individual student referral, as well as the school-wide mental health referral achieved by mental health literacy curricula. In advancing a critical approach, my major claims are as follows: psychiatry, unlike other fields of medicine, lacks scientific evidence of pathology despite at least seventy years of research; second, psychiatry’s diagnostic manuals design psychiatric diagnosis to endure throughout the lifespan and although mental disorder diagnosis can open doors, it can also be used against students many years after diagnosis is initially documented; and third, psychiatric drugs, each with their characteristic potential for dependence, adverse, and harmful effects, exert no disease-specific action but rather act on the central nervous system to superimpose a state of intoxication that may or may not be noticeable or helpful (Moncrieff, 2013). I draw attention to critical mental health research because I am concerned that educators may be facilitating student referral to mental health professionals on the basis of misleading and incomplete information.

Critical mental health scholarship extending back to the 1950s documents misinformation, missing information, and potential for serious harm implicit within mainstream mental health and its disciplinary base of psychiatry (Bracken et al, 2012; Burstow, 2015; Cooper, 1967/2001; Foucault, 1954/2011; Goffman, 1961, 1963; Johnstone & Boyle, 2018; LeFrancois, Menzies, & Reaume, 2013). The critical literature also articulates a vast range of alternative ways of understanding and addressing the phenomena commonly classified as mental health issues (Anderson, 1997; Clark, 2016; DeFehr, 2016, 2017; Foucault, 1954/2011; Linklater, 2014). Mental health promotion materials exclude critical scholarship thereby contributing to an illusion of disciplinary consensus. The Critical Mental Health Nursing Network (2015) asserts it is neither accurate nor ethical to present the field of mental health as a unified cohesive field.

This article begins with a review of key critical mental health concerns, outlining critique regarding scientific evidence, psychiatric drugs, and psychiatric diagnosis. To address the

question of how to begin integrating critical scholarship with school-based discussions of student mental health in a constructive, compassionate, and ethical manner, I present *informed consent* directives from professional codes of ethics for Canadian counsellors and psychologists. The article concludes with an open-ended series of questions for consideration. My central argument is that mental health referral practices—whether intended for individual students or whole school communities—breach the ethical principle of informed consent if they omit relevant critique articulated within critical mental health scholarship. Students and parents are entitled to full disclosure (Canadian Counselling and Psychotherapy Association, 2015).

I engage with both conventional and critical mental health scholarship as a former counsellor for twenty years, first, in government-named youth corrections, and then within publicly funded community healthcare settings and university student counselling services. I now teach and research critical mental health as a professor in a university faculty of education. With an ongoing commitment to work for anticolonial social and environmental justice, I approach the topic of critical mental health from a geopolitical location, as a settler living and working in Treaty 1 territory and the homeland of the Métis Nation.

### **Absence of Biomarker Evidence of Illness**

Prior to their attendance at a first mental health consultation appointment, students, parents, and guardians require basic knowledge of key critical concerns regarding mental health premises and practices. The topic of scientific evidence provides an essential foundation for critical mental health awareness. Educators may not be aware that psychiatry has not produced any scientifically valid biological evidence of illness for any of its 300-plus mental illness diagnoses (Frances, 2013; Johnstone & Boyle, 2018; Kinderman, 2014; Rose, 2015). This criticism contrasts with mental health promotion curricula which routinely advises that mental illness is like any other illness. Although the body, with its genes, biochemistry, and brain, is inevitably involved in all human experience, hypotheses about the pathological nature of mental disorder have never been substantiated by science. There is no scientific evidence of illness, pathology, or disease, for any mental disorder listed in psychiatry's latest diagnostic manual. "[W]hen DSM-5 was published in 2013, there was not a single clinically validated biomarker for any psychiatric disorder" (Rose, 2015, p. 1).

Psychiatry's crisis of legitimacy has been openly acknowledged by both critical and conventional psychiatrists. Thomas Insel's (2013) infamous remarks can still be read at the National Institute of Mental Health (NIMH) website: "While DSM has been described as a "Bible" for the field, it is, at best, a dictionary, creating a set of labels and defining each... the weakness is its lack of validity" (para. 2). Insel wrote these words as director of the NIMH, the largest funder of mental health research in the world (National Institute of Mental Health, 2019). Allen Frances (2013) Chair of the DSM-IV Task Force similarly acknowledged: "The brain has provided us with no low-hanging fruit—thousands of studies on hundreds of putative biological markers have so far come up empty" (p. 11).

Related to the issue of evidence, educators should be aware that psychiatry has not developed a single objective laboratory test for any of its diagnoses; no scan, X-ray, or test of fluids or tissues has ever been available or required for any psychiatric diagnosis (Guest, Guest,

& Martins-de Souza, 2016; Kinderman, 2014). Psychiatry has no laboratory test for chemical imbalance, just as it has never produced or utilized any test for measuring chemical *balance* (Lynch, 2015). Although chemical imbalance is commonly presumed to be a leading cause of supposed mental disorders, extensive critical scholarship credits the marketing departments of pharmaceutical companies with the popularization of this unproven assumption (Healy, 2012; Whitaker & Cosgrove, p. 2015).

David Kupfer, chair of the most current DSM edition (DSM-5) (APA, 2013), criticized psychiatry's lack of objective, scientifically validated biological evidence when research for DSM-5 was beginning:

...the goal of validating these [DSM] syndromes and discovering common etiologies has remained elusive. Despite many proposed candidates, not one laboratory marker has been found to be specific in identifying any of the DSM-defined syndromes. (Kupfer, First & Regier, 2002, p. xviii)

Calling for a paradigm change within psychiatry, Kupfer and colleagues (Kupfer, First & Regier, 2002) argued it was "falsely optimistic" to regard mental disorders as "discrete biomedical entities" (p. 8). Approximately one decade later, however, with DSM-5's publication date fast approaching, Kupfer and Regier (2011) publically disclosed, "DSM-5 does not represent a radical departure from the past..." (para. 7). In an American Psychiatric Association press release, DSM-5 chair David Kupfer (2013) elaborated:

In the future, we hope to be able to identify disorders using biological and genetic markers that provide precise diagnoses that can be delivered with complete reliability and validity. Yet this promise, anticipated since the 1970s, remains disappointingly distant. We've been telling patients for several decades that we are waiting for biomarkers. We're still waiting. (Kupfer, 2013, para. 1)

Kupfer's (2013) announcement warrants critical discussion. Other medical specialties such as neurology are grounded in scientific evidence, while psychiatry is soon to enter its eighth decade of "waiting." Psychiatry's first diagnostic manual was published in 1952. Kupfer's language of waiting deflects attention from the billions of dollars and thousands of person-hours spent in pursuit of basic genetic, neurologic, or biochemical evidence of pathology (Rose, 2015). The term waiting presents the profession of psychiatry as appropriately dormant when instead it has been significantly expanding its diagnostic manuals, treating and profiting from the treatment of pathology it has not yet discovered. Kupfer's claim that psychiatry has been "telling the public for several decades" is also problematic. Psychiatric experts, such as mental health promotion proponents, have done the opposite, speaking extensively of mental disorder as biological illness (Hyman, 1999). The popular classroom resource *Canadian Mental Health and Highschool Curriculum Guide* (2017) declares that "mental illnesses are diseases" (Kutcher & Wei, 2017, p. 8). Describing "the Guide" (p. 4) as an "evidence-based" (p. 4) mental literacy resource, its authors Kutcher and Wei attribute problematic emotions and behaviours to brain deficiency: "It is a medical condition" (Kutcher & Wei, 2017, p. 20), "a health condition arising from changes in usual brain functioning" (Kutcher & Wei, 2017, p. 8), "a specific part of the brain that needs to be working in a specific manner is working in the wrong way" (Kutcher & Wei, 2017, p. 17). These claims about brain pathology have not been substantiated by scientific evidence and are made without any reference to academic scholarship. No brain scan has ever been required or available for mental disorder diagnosis (APA, 2013). The well-known Canadian *Mental Health*

*First Aid* program for practitioners who work with youth similarly coaches its trainees to advise distressed young people that “they have a real medical condition” (Mental Health Commission of Canada, 2010, p. 4), even though this scientific claim lacks biological evidence, as DSM-5 chair David Kupfer has acknowledged. Part of a larger longstanding pattern of medicalization (Conrad, 1992, 2007), practitioners in the helping professions routinely discuss human distress and difference as though difficult or problematic feelings and behaviours are manifestations of mental illness (Strong, 2017). When learning communities gain familiarity with basic outcomes of critical mental health research, they are better able to interrogate widespread assumptions and constructively engage with a broader range of explanations and strategies.

### **Psychiatric Drugs: Effective Treatments?**

Just as ethical referral to mental health professions requires critical awareness of psychiatry’s crisis of evidence, ethical in-school referral requires critical awareness about psychiatric drugs. The critical scholarship of practicing and academic psychiatrist Joanna Moncrieff (2008, 2009, 2013, 2018, 2019) is relevant to students, parents, and teachers considering the possibility of chemical intervention. Co-chair of the UK-based Critical Psychiatry network, Moncrieff (2009) contends that members of the public make decisions about beginning psychiatric drug use “on the basis of totally inadequate information” (p. 124). Western medicine categorizes psychiatric drugs within the class of psychoactive substances along with other recreational drugs, such as caffeine, nicotine, alcohol, amphetamines, heroin, LSD, cocaine, and cannabis (Moncrieff, 2009). Moncrieff (2013) discourages moralizing about whether the prescribed substances are good or bad and instead argues for fully informed evaluation of the full range of potential harms and benefits of psychiatric drug use.

It is crucial that school communities understand a central outcome of Moncrieff’s (2008, 2013, 2018, 2019) research: there is no scientific evidence that psychiatric drugs exert any disease-specific action, no scientific evidence that psychiatric drugs cleverly target illness, stopping, reversing, preventing, or changing illness in any way. Correspondingly, psychiatric drugs do not correct physiological anomalies or provide chemicals that so-called normal bodies produce. Rather than changing a disease process, psychiatric drugs act on the central nervous system to superimpose a state of intoxication, part of humanity’s ancient history of using substances to relieve suffering, induce euphoria, or enhance life (Moncrieff, 2013). The altered state of consciousness produced by psychiatric drugs may or may not be noticeable, pleasant, or preferable. Moncrieff (2009) argues it is incorrect to equate psychiatric drug-induced effects with normalcy:

Drugs do not simply reproduce ordinary emotional states. They produce characteristic altered states, which vary according to the pharmacological properties of the drug concerned. Drugs are not a sophisticated way of restoring or enhancing normal functioning. They are just drugs. They can make you fast or slow, euphoric or dysphoric. They can produce some curious and usually unpleasant experiences and sensations. But they do not make a troubled person happy or a disturbed person normal. (p. 126)

Psychiatric drug classes vary but all produce their characteristic range of effects regardless of whether people meet psychiatric diagnostic criteria or not (Moncrieff, 2013).



If psychiatric drugs do not modify a process of illness, might they at least relieve students' "symptoms" of the phenomena presumed to be mental illness? Critical mental health scholarship indicates that although psychiatric drugs can alter feelings, behaviours, perceptions, and thinking, these substances also produce toxicity (Breggin, 1991). Pharmaceutical companies use the term "side" effects to acknowledge unwanted outcomes of psychiatric prescriptions, but critical scholars see the word "side" as a marketing strategy that arbitrarily partitions some effects, always the negative effects, from other effects (Moncrieff, 2009, 2013). The term "side effect" wrongly implies the drugs exert a *central* disease-specific action. Further, the word "side" serves to minimize the seriousness and potential centrality of common unpleasant and harmful psychiatric drug effects. Psychiatric drugs can produce a full range of harms, such as facial tics, metabolic disorders, brain damage, suppressed growth and increased risk of death (Breggin, 2014; Moncrieff, 2009, 2013). Major tranquilizers, also referred to as antipsychotics, atypicals, neuroleptics, and more recently renamed and remarketed as mood stabilizers (Healy, 2006) can produce debilitating movement disorders accompanied by intellectual impairment (APA, 2013; Moncrieff, 2013). Psychiatric drugs produce a blunt global effect throughout the body, changing not only cognitive or emotional experience but also physical processes such as increasing blood pressure and heart rate (Moncrieff, 2009).

Desperate for improvement, students' teachers and caregivers may presume the prescribed drug use can simply be discontinued if it is not helpful. Mental health promotion campaigns do not publicize that discontinuation of psychiatric drugs, even when taken as prescribed, can be severely difficult (Read, Gee, Diggle & Butler, 2019). Psychoactive substances, including psychiatric drugs, commonly produce dependence, as evidenced by the phenomena of tolerance and withdrawal syndromes (Moncrieff, 2009; Moncrieff, Cohen & Porter, 2013). Careful withdrawal from psychiatric drug use can be swift and uncomplicated or it can be excruciating and debilitating, requiring a period of months or years (Cartwright, Gibson, Read, Cowan & Dehar, 2016; Moncrieff, 2009; Read, Gee, Diggle & Butler, 2019). Students who have not been cautioned about withdrawal syndromes commonly conclude that their "mental disorder" is returning when what they are experiencing is a drug withdrawal syndrome (Moncrieff, 2006). Many people first notice the effects of their psychiatric drug (say in the case of antidepressants) when they attempt to stop taking it (Moncrieff, Cohen & Porter, 2013). The body produces adaptations to regular psychoactive substance use and thus, drug-induced effects presumed to be therapeutic are often temporary and not sustainable over time (Moncrieff, 2009).

Parents, guardians, and students contemplating the prospect of consulting a mental health diagnostic professional may also benefit from knowledge about the saturation of for-profit industry within mental health services. Cosgrove and Wheeler's (2013) research indicates 69% of DSM-5 task force and 58% of DSM-5 panel members maintain financial conflicts of interest with pharmaceutical industry. Phenomena of *ghost writing*, *publication bias*, and *disease mongering*, are additional well-documented examples of psychiatry's scientific compromise in exchange for corporate gain (Cosgrove & Wheeler, 2013; Healy, 2012; Whitaker & Cosgrove, 2015). While individual authors may indicate they have no conflicts of interest, the field of psychiatry itself deeply intertwines with pharmaceutical industry (Burstow, 2015; Healy, 2012; Whitaker & Cosgrove, 2015). DSM-IV Chair Allen Frances (2013) reports that psychiatric drugs are "the star revenue producers" (p. xv) for pharmaceutical corporations. Unique as a medical

specialty, psychiatry's absence of biological markers of pathology makes it more prone to industry influence (Cosgrove & Wheeler, 2013), "a marketer's dream" (Healy, 2012, p. 39).

## **Mental Illness Diagnosis**

### *How it Happens*

Students and parents require critical knowledge regarding mental disorder diagnosis. Prior to a first consult with a professional in the helping professions, people need to know that psychiatric diagnosis commonly takes place invisibly in the thinking and questioning of the professional in the first minutes of the first appointment (Frances, 2013). Expecting a medical procedure, patients reporting distress or unusual problematic behavior to their service provider may not know that a mental disorder diagnostic process has already begun and may be well underway. Some diagnoses, such as personality disorder diagnoses, can be profoundly stigmatizing, but even commonplace diagnoses mark students as defective, different from others, less than their ideal selves (Gergen, 1994).

### *Implied Consent*

The conventional in-office process of psychiatric diagnosis is based on implied consent and requires no explicit permission or agreement from the student or student's guardian or parent. After a first appointment with a diagnosing professional has begun, there is no way for a student to secure a particular diagnostic outcome. Simply attending an appointment or consult as a patient or client of a diagnosing professional is the only indication of consent required for mental disorder diagnosis in Canada. Because consent to diagnosis is implied in medical settings, it is important that students and parents access critical knowledge about diagnosis prior to their first appointment. The ethical principle of informed consent must therefore be explicitly and conscientiously integrated with all mental health referral processes.

### *Who Diagnoses Mental Disorders?*

Prior to the first appointment, persons planning to attend should understand whether the professional they anticipate meeting has been granted mental disorder diagnostic privileges. The Canadian colonial state grants psychiatrists, family physicians, pediatricians, psychologists, and nurse practitioners ultimate naming rights—the authority to diagnose their patients with mental disorder labels. Canadian social workers, family therapists, psychiatric nurses, and guidance counsellors are not authorized to diagnose clients, but these non-diagnosing professionals commonly assume informal yet powerful diagnostic roles as they affirm and disseminate psychiatric assumptions, adopt psychiatric diagnostic vocabulary, and facilitate referral to diagnosing professionals (DeFehr, 2017). Teachers also commonly contribute powerfully to diagnostic processes as they draw on psychiatric truth claims to understand and address student distress and difference. At times, educators may be called upon to shape diagnostic process and outcome with their own documented observations of students.

### *Can the Diagnosis be Dropped?*

School-based referrals to diagnosing professionals should inform students that even though diagnosis can happen quickly, it endures throughout the lifespan in ways that contrast with diagnosis of pathology in the rest of medicine. As I discuss shortly, the longevity of psychiatric diagnosis can have detrimental legal, social, personal, and financial effects for

students long after diagnosis is initially documented. An uncomfortable or disappointing mental disorder diagnosis cannot be given back like shoes returned to the mall. Psychiatry provides no mechanism such as a laboratory test to objectively verify recovery (APA, 2013; DeFehr, 2017; Kirk, Cohen & Gomory, 2015). Psychiatry offers no diagnosis, label, or criteria for normal, healed, cured, or recovered (Rose & Abi-Rached, 2013). Mental health awareness campaigns advertise recovery without revealing that the only post-diagnosis options provided by DSM-5 are *remission* (full or partial) or *relapse* (APA, 2013). While some diagnoses indicate specific age ranges, there is no separate youth or pre-school nosology for mental disorder diagnosis (APA, 2013). There is always potential for students to pick up additional diagnoses but like a hallway without an exit, the DSM-5 provides no means for subtraction. Arguing for the abolishment of psychiatric diagnosis along with his colleagues from the British Psychological Society (Johnstone & Boyle, 2018), psychologist Peter Kinderman (2014) discusses the way psychiatric diagnosis is uniquely designed to endure over time: “the label sticks to them [the student], not to the disembodied ‘symptoms’” (p. 54).

Students objecting to their diagnoses may seek a second professional opinion, but the second opinion cannot reverse the first opinion, even if both opinions clearly differ or contradict. The second consult produces additional diagnostic opportunity (DeFehr, 2017). Some medical diagnosticians might document their objection to a previous mental disorder diagnosis, and they may document their opinion that the person in question no longer meets diagnostic criteria, but any changes noted must be made in a way that preserves the original documentation of diagnosis (Canadian Medical Protective Association, 2019). Diagnosing medical professionals may choose to cease documenting references to the mental disorder diagnosis and they may even remove diagnoses from patient problem lists, but they may not delete or destroy the original documented diagnosis. Parents and students need to understand that if they are assigned a mental disorder diagnosis by a diagnosing medical professional, “you will never be able to remove such a diagnosis from your health records” (Kirk, Cohen & Gomory, 2015, p. 77). I will soon discuss how the courts, insurance corporations, and professional licensing authorities help to produce the durability of mental disorder diagnosis with their “have you ever been” lines of inquiry specific to psychiatric diagnosis.

### *Comorbidity?*

Students and parents may benefit from knowing that diagnoses are often assigned in multiples. DSM-5 frequently deploys the concept of *comorbidity* to account for the considerable overlap between diagnostic classifications (Frances, 2013). For example, anxiety disorders are said to resemble unipolar depressive disorders, thus DSM-5 advises that “individuals whose presentation meets criteria for generalized anxiety disorder are likely to have met, or currently meet, criteria for other anxiety and unipolar depressive disorders” (APA, 2013, p. 226). Some have wryly observed that DSM-5’s frequent comorbidity statements resemble YouTube “recommended for you” suggestions. What psychiatry names comorbidity can alternatively be understood as poor diagnostic reliability. Assignment of psychiatric diagnoses in clusters further entrenches a deficit-oriented psychiatric identity.

### *Costs of Diagnosis*

People often describe their experiences of diagnosis as helpful however it is crucial that educators know that diagnosis can be particularly costly and detrimental at various life junctures.



Diagnosis, given the public's general understanding of mental disorder diagnosis, may initially bring relief, validation, and clarity; many families take hope and comfort from the realization that their struggle is known, has a name and can be explained and presumably treated or healed. Often the process of diagnosis reduces the isolation as students and their families realize they are not alone in their struggle. Some school divisions make psychiatric diagnosis a requirement for special funding or accommodation. Psychiatric diagnosis of children and youth can diminish parents' feelings of guilt or embarrassment. Psychiatric diagnosis can also create impairments and barriers decades after diagnoses are initially documented.

Many educators and students may not realize that their psychiatric diagnoses must be declared at different junctures in life. Some professional licensing, such as physician licensing (Morris, 2017) requires on-going disclosure of personal mental health history. A psychiatric diagnosis can be used against students later in life to influence adoption proceedings and child custody deliberations (Deutch & Clyman, 2016). Court orders can require diagnosticians to release diagnostic information. Mental disorder diagnosis is a factor determining eligibility and cost of life, house, and disability insurance, and can be used to determine whether people are able to drive a vehicle (Frances, 2013; Manitoba Public Insurance, 2018) or manage their own legal and medical decisions (Caplan & Cosgrove, 2004). Even when access to medical history is not required, diagnosed persons may feel compelled to disclose their mental disorder diagnoses to family members or potential life partners. Consequently, the privacy characterizing the inaugural diagnostic moment usually diminishes to include numerous unanticipated others throughout the lifespan.

### *Diagnosis and Identity*

After mental disorder diagnosis, it can be difficult for diagnosed students to distinguish their own human feelings and behaviours from their so-called psychiatric symptoms. As Gergen (1994) noted,

In effect, once people understand their actions in terms of mental deficits, they are sensitized to the problematic potential of all their activities and how they are infected or diminished. The weight of the "problem" now expands manifold; it is an inescapable as their own shadow. (p. 150-151)

Many adults lament that they have never had opportunity to know a diagnosis-free, drug-free identity; they have been psychiatric subjects for as long as they can recall (Delano, 2010).

### *Demystifying Diagnosis: A Case Example*

In my experience, direct engagement with the DSM-5 text rapidly clarifies and demystifies psychiatric diagnosis for teachers. I recommend that teachers read the DSM-5, not to diagnose themselves or others, but to see for themselves how the diagnoses psychiatrize a wide range of human feelings and behaviours, many of which are common and wholly understandable. In the courses I teach, I find that teachers and pre-service teachers quickly grasp the simplicity of the diagnostic criteria and the circularity of its logic.

The diagnosis of General Anxiety Disorder, perhaps the most common diagnosis in schools, illustrates the word-bound, subjective nature of psychiatric diagnosis. The first purported symptom of Generalized Anxiety Disorder, according to DSM-5, is anxiety: "excessive anxiety and worry (apprehensive expectation), occurring more days than not for at

least 6 months, about a number of events or activities (such as work or school performance)” (APA, 2013, p. 222). The second DSM-5 criteria for General Anxiety Disorder asserts that “the individual finds it difficult to control the worry” (p. 222). The third criteria form the bulk of the diagnostic criteria for General Anxiety Disorder: “The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months)” (p. 222).

DSM-5 (APA, 2013) uses the following words to comprise the core of the General Anxiety Disorder diagnostic criteria:

1. “Restlessness or feeling keyed up or on edge.”
  2. “Being easily fatigued.”
  3. “Difficulty concentrating or mind going blank.”
  4. “Irritability.”
  5. “Muscle tension.”
  6. “Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).”
- (APA, 2013, p. 222)

The criteria states that “Only one item is required in children” (p. 222) thus almost ensuring that any child persistently overwhelmed by problems at home or school can readily acquire the General Anxiety Disorder diagnosis. Within a conventional mental health rationality, students anxious about life conditions directly resulting from past and present-day colonization and genocide can have their understandable feelings of distress and resistance inappropriately read as individual mental pathology instead of understood as an understandable human response to environmental, social, and economic injustice (Blackstock, 2012; Clark, 2016; Linklater, 2014; Million, 2013).

DSM-5 further specifies that “anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning” (APA, 2013, p. 222). The phrase *clinically significant distress* is vague and not quantified. It is important to notice the assumption that the fully-human response of anxiousness is presumed to be the root cause of the “impairment in social, occupational, or other important areas” (p. 222) rather than the hardship, injustice, or problematic cognitive habits to which the anxiousness may be a response.

DSM-5 openly acknowledges that young persons acquire the General Anxiety Disorder diagnosis through very common and legitimate worries: “Children and adolescents tend to worry more about school and sporting performance, whereas older adults report greater concern about the well-being of family or their own physical health” (2013, p. 223). DSM-5 notes further that children and adolescents worry also about environmental catastrophe and atrocity caused by war (p. 224). Indeed, these worries seem widespread and important, even necessary to human survival.

Like other diagnoses in DSM-5, the *unspecified* and *other specified* anxiety diagnoses allow diagnostic labelling to take place even in situations where even the minimal diagnostic criteria are not met. The dragnet function of unspecified and other specified diagnoses can be seen in the Unspecified Anxiety Disorder diagnosis which can be assigned

in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific anxiety disorder and includes presentations in which there

is insufficient information to make a more specific diagnosis (e.g., in emergency room settings. (APA, 2013, p. 233)

Like all other psychiatric diagnoses, including schizophrenia (APA, 2013, p. 87), ADHD (APA, 2013, p. 59) and bipolar disorders (APA, 2013, pp. 123-154), DSM-5 General Anxiety Disorder diagnosis requires no medical procedure and offers no criteria for recovery. Critical awareness of mental disorder diagnosis is essential for ethical referral processes in school.

### **Aligning Referral with Professional Ethics**

If teachers contribute to mental health assessment and referral processes in schools, it would seem they should know and uphold the informed consent ethics standards outlined by mental health professional codes of ethics. Professional codes of ethics discuss informed consent as the centerpiece of ethical practice (Robinson, Lehr & Severi, 2015). According to the Canadian Counselling and Psychotherapy Association informed consent must be granted “voluntarily, knowingly, and intelligently” (Robinson, Lehr & Severi, 2015, p. 54). Voluntarily means the consent must be given “freely without pressure, coercion, or without powerful incentives to do so” (Canadian Counselling and Psychotherapy Association, 2015, p. 15). To offer consent knowingly means professionals must fully disclose relevant information including information about “implications of diagnosis,” “limits of confidentiality,” and “potential risks and benefits” (p. 16). To give consent intelligently means that clients can understand descriptions of the expected and potential “treatments and procedures” (p. 15) well enough to make informed decisions. The Standards of Practice guidelines further specify that clients should be permitted to withdraw their consent, and further, “counsellors should not equate silence with consent” (Canadian Counselling and Psychotherapy Association, 2015, p. 16). In contrast with implied consent practices, professional ethics standards for counsellors encourage documentation of consent although “effecting a proper consent necessitates completion of a *consent process*, which is considerably more involved and detailed than simply getting a signature on a form” (Robinson, Lehr & Severi, 2015, p. 27).

Teachers and school counsellors may understandably feel reluctant to speak about potential for harm within helping systems, yet professional ethics demand straightforward, clear and full disclosure of risks (Canadian Psychological Association, 2017; Robinson, Lehr & Severi, 2015). Psychologists must provide as much information as persons would reasonably want to know before making decisions or consenting to intervention (Canadian Psychological Association, 2017). Ethics codes call for integrity, truthfulness, accuracy, open communication and honesty throughout every professional-client encounter (Canadian Psychological Association, 2017). As a profession, psychologists are to promote “freedom of enquiry, innovation, and debate (including scientific and academic freedom)” (Canadian Psychological Association, 2017, p. 30). Psychologists are to help encourage “critical analysis” and “participate in the discipline’s process of critical self-evaluation” (p. 32). Psychologist codes of ethics require psychologists to ensure that psychological knowledge is used for “just and beneficial” purposes (p. 31). Further,

if structures or policies seriously ignore or oppose the principles of respect for the dignity of persons and peoples, responsible caring, integrity in relationships, or responsibility to society, psychologists involved have a responsibility to speak out .... [a]nd advocate for

appropriate change to occur as quickly as possible. (Canadian Psychological Association, 2017, p. 31)

Psychologists “have a higher duty of care to members of society than the general duty of care that all members of society have to each other” (Canadian Psychological Association, 2017, p. 3).

Regarding discussion of risk of harm, psychologists must do more than merely offer full disclosure of potential hazards. They must “terminate an activity when it is clear that the activity carries more than minimal risk of harm and is found to be more harmful than beneficial, or when the activity is no longer needed” (Canadian Psychological Association, 2017, p. 15).

Psychologists must refuse to participate in practices or assumptions that are known to cause harm. Furthermore, psychologists must “be open to the concerns of others about perceptions of harm that they as a psychologist might be causing” (Canadian Psychological Association, 2017, p. 23-24) and again, the code of ethics reminds psychologists they are required to not only “stop activities that are causing harm”, they must “not punish or seek punishment for those who raise such concerns in good faith” (p. 23-24).

Beyond full disclosure of potential for harm, it is crucial that discussions of student well-being not only refrain from disseminating unsubstantiated claims, but it is also important that educators counter the profoundly flawed assumption that difficult, strange, or extreme emotions and behaviours are manifestations of physiological pathology. To the extent that schools publicize the erroneous claim that mental illness is like any other illness, schools must correspondingly assume responsibility for systematically correcting this misinformation and addressing its associated harms.

## Conclusion

The following open-ended series of questions might be useful as educators consider the extent to which their school facilitates awareness of critical scholarship in the field of mental health. Are students aware that there are many ways to understand and address their difficulties, and that the psychiatric paradigm is just one option? Are students and their caregivers aware that phenomena referred to as mental illness fundamentally differs from physical illness? Are they aware that there are correspondingly no objective laboratory tests or medical procedures required for mental illness diagnoses? Regarding psychiatric drugs such as antianxiety or antidepressants, are students, parents, and guardians aware that psychiatric drugs, in the same class of substances as recreational drugs, do not cleverly target diseases but instead produce an altered drug-induced state that may or may not be useful (Moncrieff, 2013)? Are they aware of potential unpleasant and devastating drug effects, drug tolerance, dependence, and withdrawal syndromes? Concerning diagnosis, are they aware of which helping professionals assign psychiatric diagnoses? Are they aware of how and when diagnosis typically takes place? Are students, parents, and guardians aware that diagnosis of young persons can create significant barriers for them at various junctures in their lives? These are only a few examples of questions that help build student and parent awareness of critical mental health knowledge.

Referral to mental health services, whether accomplished through school-wide mental health literacy curricula or through case-by-case discussion, is itself a mental health intervention. An ethical goal, as I see it, is not to persuade students to adopt conventional or critical

perspectives nor to dispense medical advice, but rather to compassionately and respectfully open school access to the critical scholarship that is routinely omitted from mental health promotion programs. Educators can help ensure that school-based referrals to helping professionals align with the ethical principle of informed consent. Student or parental consent to intervention, if and when it is granted, can then be offered authentically, “voluntarily, knowingly, and intelligently” (Robinson, Lehr & Severi, 2015, p. 54).

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