

111TH CONGRESS
1ST SESSION

H. R. 2218

To prohibit the use of Federal funds for any universal or mandatory mental health screening program.

IN THE HOUSE OF REPRESENTATIVES

APRIL 30, 2009

Mr. PAUL (for himself, Mr. BARTLETT, Mr. BURTON of Indiana, Mrs. BLACKBURN, Mr. McCOTTER, and Mr. HENSARLING) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means and Education and Labor, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To prohibit the use of Federal funds for any universal or mandatory mental health screening program.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Parental Consent Act
5 of 2009”.

6 **SEC. 2. FINDINGS.**

7 The Congress finds as follows:

1 (1) The United States Preventive Services Task
2 Force (USPSTF) issued findings and recommenda-
3 tions against screening for suicide that corroborate
4 those of the Canadian Preventive Services Task
5 Force. “USPSTF found no evidence that screening
6 for suicide risk reduces suicide attempts or mor-
7 tality. There is limited evidence on the accuracy of
8 screening tools to identify suicide risk in the primary
9 care setting, including tools to identify those at high
10 risk.”.

11 (2) The 1999 Surgeon General’s report on men-
12 tal health admitted the serious conflicts in the med-
13 ical literature regarding the definitions of mental
14 health and mental illness when it said, “In other
15 words, what it means to be mentally healthy is sub-
16 ject to many different interpretations that are rooted
17 in value judgments that may vary across cultures.
18 The challenge of defining mental health has stalled
19 the development of programs to foster mental health
20 (Secker, 1998). . . .”.

21 (3) A 2005 report by the National Center for
22 Infant and Early Childhood Health Policy admitted,
23 with respect to the psychiatric screening of children
24 from birth to age 5, the following: “We have men-
25 tioned a number of the problems for the new field

1 of IMH [Infant Mental Health] throughout this
2 paper, and many of them complicate examining out-
3 comes.”. Briefly, such problems include:

4 (A) Lack of baseline.

5 (B) Lack of agreement about diagnosis.

6 (C) Criteria for referrals or acceptance
7 into services are not always well defined.

8 (D) Lack of longitudinal outcome studies.

9 (E) Appropriate assessment and treatment
10 requires multiple informants involved with the
11 young child: parents, clinicians, child care staff,
12 preschool staff, medical personnel, and other
13 service providers.

14 (F) Broad parameters for determining
15 socioemotional outcomes are not clearly defined,
16 although much attention is now being given to
17 school readiness.

18 (4) Authors of the bible of psychiatric diag-
19 nosis, the Diagnostic and Statistical Manual, admit
20 that the diagnostic criteria for mental illness are
21 vague, saying, “DSM–IV criteria remain a con-
22 sensus without clear empirical data supporting the
23 number of items required for the diagnosis. . . . Fur-
24 thermore, the behavioral characteristics specified in
25 DSM–IV, despite efforts to standardize them, re-

1 main subjective. . . .” (American Psychiatric Asso-
2 ciation Committee on the Diagnostic and Statistical
3 Manual (DSM–IV 1994), pp. 1162–1163).

4 (5) Because of the subjectivity of psychiatric di-
5 agnosis, it is all too easy for a psychiatrist to label
6 a person’s disagreement with the psychiatrist’s polit-
7 ical beliefs a mental disorder.

8 (6) Efforts are underway to add a diagnosis of
9 “extreme intolerance” to the Diagnostic and Statis-
10 tical Manual. Prisoners in the California State penal
11 system judged to have this extreme intolerance
12 based on race or sexual orientation are considered to
13 be delusional and are being medicated with anti-psy-
14 chotic drugs. (Washington Post 12/10/05)

15 (7) At least one federally funded school violence
16 prevention program has suggested that a child who
17 shares his or her parent’s traditional values may be
18 likely to instigate school violence.

19 (8) Despite many statements in the popular
20 press and by groups promoting the psychiatric label-
21 ing and medication of children, that ADD/ADHD is
22 due to a chemical imbalance in the brain, the 1998
23 National Institutes of Health Consensus Conference
24 said, “. . . further research is necessary to firmly es-
25 tablish ADHD as a brain disorder. This is not

1 unique to ADHD, but applies as well to most psy-
2 chiatric disorders, including disabling diseases such
3 as schizophrenia. . . . Although an independent diag-
4 nostic test for ADHD does not exist. . . . Finally,
5 after years of clinical research and experience with
6 ADHD, our knowledge about the cause or causes of
7 ADHD remains speculative.”.

8 (9) There has been a precipitous increase in the
9 prescription rates of psychiatric drugs in children:

10 (A) The use of antipsychotic medication in
11 children has increased nearly fivefold between
12 1995 and 2002 with more than 2.5 million chil-
13 dren receiving these medications, the youngest
14 being 18 months old. (Vanderbilt University,
15 2006)

16 (B) More than 2.2 million children are re-
17 ceiving more than one psychotropic drug at one
18 time with no scientific evidence of safety or ef-
19 fectiveness. (Medco Health Solutions, 2006)

20 (C) More money was spent on psychiatric
21 drugs for children than on antibiotics or asthma
22 medication in 2003. (Medco Trends, 2004)

23 (10) A September 2004 Food and Drug Admin-
24 istration hearing found that more than two-thirds of
25 studies of antidepressants given to depressed chil-

1 dren showed that they were no more effective than
2 placebo, or sugar pills, and that only the positive
3 trials were published by the pharmaceutical industry.
4 The lack of effectiveness of antidepressants has been
5 known by the Food and Drug Administration since
6 at least 2000 when, according to the Food and Drug
7 Administration Background Comments on Pediatric
8 Depression, Robert Temple of the Food and Drug
9 Administration Office of Drug Evaluation acknowl-
10 edged the “preponderance of negative studies of
11 antidepressants in pediatric populations”. The Sur-
12 geon General’s report said of stimulant medication
13 like Ritalin, “However, psychostimulants do not ap-
14 pear to achieve long-term changes in outcomes such
15 as peer relationships, social or academic skills, or
16 school achievement.”.

17 (11) The Food and Drug Administration finally
18 acknowledged by issuing its most severe Black Box
19 Warnings in September 2004, that the newer
20 antidepressants are related to suicidal thoughts and
21 actions in children and that this data was hidden for
22 years. A confirmatory review of that data published
23 in 2006 by Columbia University’s department of
24 psychiatry, which is also the originator of the
25 TeenScreen instrument, found that “in children and

1 adolescents (aged 6–18 years), antidepressant drug
2 treatment was significantly associated with suicide
3 attempts . . . and suicide deaths. . . . ”. The Food
4 and Drug Administration had over 2,000 reports of
5 completed suicides from 1987 to 1995 for the drug
6 Prozac alone, which by the agency’s own calculations
7 represent but a fraction of the suicides. Prozac is
8 the only such drug approved by the Food and Drug
9 Administration for use in children.

10 (12) Other possible side effects of psychiatric
11 medication used in children include mania, violence,
12 dependence, weight gain, and insomnia from the
13 newer antidepressants; cardiac toxicity including le-
14 thal arrhythmias from the older antidepressants;
15 growth suppression, psychosis, and violence from
16 stimulants; and diabetes from the newer anti-psy-
17 chotic medications.

18 (13) Parents are already being coerced to put
19 their children on psychiatric medications and some
20 children are dying because of it. Universal or man-
21 datory mental health screening and the accom-
22 panying treatments recommended by the New Free-
23 dom Commission on Mental Health will only in-
24 crease that problem. Across the country, Patricia
25 Weathers, the Carroll Family, the Johnston Family,

1 and the Salazar Family were all charged or threat-
2 ened with child abuse charges for refusing or taking
3 their children off of psychiatric medications.

4 (14) The United States Supreme Court in
5 Pierce versus Society of Sisters (268 U.S. 510
6 (1925)) held that parents have a right to direct the
7 education and upbringing of their children.

8 (15) Universal or mandatory mental health
9 screening violates the right of parents to direct and
10 control the upbringing of their children.

11 (16) Federal funds should never be used to sup-
12 port programs that could lead to the increased over-
13 medication of children, the stigmatization of children
14 and adults as mentally disturbed based on their po-
15 litical or other beliefs, or the violation of the liberty
16 and privacy of Americans by subjecting them to
17 invasive “mental health screening” (the results of
18 which are placed in medical records which are avail-
19 able to government officials and special interests
20 without the patient’s consent).

21 **SEC. 3. PROHIBITION AGAINST FEDERAL FUNDING OF UNI-**
22 **VERSAL OR MANDATORY MENTAL HEALTH**
23 **SCREENING.**

24 (a) UNIVERSAL OR MANDATORY MENTAL HEALTH
25 SCREENING PROGRAM.—No Federal funds may be used

1 to establish or implement any universal or mandatory
2 mental health, psychiatric, or socioemotional screening
3 program.

4 (b) REFUSAL TO CONSENT AS BASIS OF A CHARGE
5 OF CHILD ABUSE OR EDUCATION NEGLECT.—No Federal
6 education funds may be paid to any local educational
7 agency or other instrument of government that uses the
8 refusal of a parent or legal guardian to provide express,
9 written, voluntary, informed consent to mental health
10 screening for his or her child as the basis of a charge of
11 child abuse, child neglect, medical neglect, or education
12 neglect until the agency or instrument demonstrates that
13 it is no longer using such refusal as a basis of such a
14 charge.

15 (c) DEFINITION.—For purposes of this Act, the term
16 “universal or mandatory mental health, psychiatric, or
17 socioemotional screening program”—

18 (1) means any mental health screening program
19 in which a set of individuals (other than members of
20 the Armed Forces or individuals serving a sentence
21 resulting from conviction for a criminal offense) is
22 automatically screened without regard to whether
23 there was a prior indication of a need for mental
24 health treatment; and

25 (2) includes—

1 (A) any program of State incentive grants
2 for transformation to implement recommenda-
3 tions in the July 2003 report of the New Free-
4 dom Commission on Mental Health, the State
5 Early Childhood Comprehensive System, grants
6 for TeenScreen, and the Foundations for
7 Learning Grants; and

8 (B) any student mental health screening
9 program that allows mental health screening of
10 individuals under 18 years of age without the
11 express, written, voluntary, informed consent of
12 the parent or legal guardian of the individual
13 involved.

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