

112TH CONGRESS
1ST SESSION

S. 1800

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

IN THE SENATE OF THE UNITED STATES

NOVEMBER 3, 2011

Mr. PAUL introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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 2011”.

6 **SEC. 2. FINDINGS.**

7 The Congress finds as follows:

8 (1) The United States Preventive Services Task
9 Force (USPSTF) issued findings and recommenda-
10 tions against screening for suicide that corroborate

1 those of the Canadian Preventive Services Task
2 Force, “USPSTF found no evidence that screening
3 for suicide risk reduces suicide attempts or mor-
4 tality. There is limited evidence on the accuracy of
5 screening tools to identify suicide risk in the primary
6 care setting, including tools to identify those at high
7 risk.”.

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

18 (3) A 2005 report by the National Center for
19 Infant and Early Childhood Health Policy admitted,
20 with respect to the psychiatric screening of children
21 from birth to age 5, the following: “We have men-
22 tioned a number of the problems for the new field
23 of IMH [Infant Mental Health] throughout this
24 paper, and many of them complicate examining out-
25 comes.”. Briefly, such problems include:

1 (A) Lack of baseline.

2 (B) Lack of agreement about diagnosis.

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

5 (D) Lack of longitudinal outcome studies.

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

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

15 (4) Authors of the bible of psychiatric diag-
16 nosis, the Diagnostic and Statistical Manual, admit
17 that the diagnostic criteria for mental illness are
18 vague, saying, “DSM–IV criteria remain a con-
19 sensus without clear empirical data supporting the
20 number of items required for the diagnosis. . . .
21 Furthermore, the behavioral characteristics specified
22 in DSM–IV, despite efforts to standardize them, re-
23 main subjective. . . .” (American Psychiatric Asso-
24 ciation Committee on the Diagnostic and Statistical
25 Manual (DSM–IV 1994), pp. 1162–1163).

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

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

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

16 (8) Despite many statements in the popular
17 press and by groups promoting the psychiatric label-
18 ing and medication of children, that ADD/ADHD is
19 due to a chemical imbalance in the brain, the 1998
20 National Institutes of Health Consensus Conference
21 said, ". . . further research is necessary to firmly
22 establish ADHD as a brain disorder. This is not
23 unique to ADHD, but applies as well to most psy-
24 chiatric disorders, including disabling diseases such
25 as schizophrenia. . . . Although an independent di-

1 agnostic test for ADHD does not exist. . . . Finally,
2 after years of clinical research and experience with
3 ADHD, our knowledge about the cause or causes of
4 ADHD remains speculative.”.

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

7 (A) The use of antipsychotic medication in
8 children has increased nearly fivefold between
9 1995 and 2002 with more than 2.5 million chil-
10 dren receiving these medications, the youngest
11 being 18 months old (Vanderbilt University,
12 2006).

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

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

20 (10) A September 2004 Food and Drug Admin-
21 istration hearing found that more than two-thirds of
22 studies of antidepressants given to depressed chil-
23 dren showed that they were no more effective than
24 placebo, or sugar pills, and that only the positive
25 trials were published by the pharmaceutical industry.

1 The lack of effectiveness of antidepressants has been
2 known by the Food and Drug Administration since
3 at least 2000 when, according to the Food and Drug
4 Administration Background Comments on Pediatric
5 Depression, Robert Temple of the Food and Drug
6 Administration Office of Drug Evaluation acknowl-
7 edged the “preponderance of negative studies of
8 antidepressants in pediatric populations”. The Sur-
9 geon General’s report said of stimulant medication
10 like Ritalin, “However, psychostimulants do not ap-
11 pear to achieve long-term changes in outcomes such
12 as peer relationships, social or academic skills, or
13 school achievement.”.

14 (11) The Food and Drug Administration finally
15 acknowledged by issuing its most severe Black Box
16 Warnings in September 2004, that the newer
17 antidepressants are related to suicidal thoughts and
18 actions in children and that this data was hidden for
19 years. A confirmatory review of that data published
20 in 2006 by Columbia University’s department of
21 psychiatry, which is also the originator of the
22 TeenScreen instrument, found that “in children and
23 adolescents (aged 6–18 years), antidepressant drug
24 treatment was significantly associated with suicide
25 attempts . . . and suicide deaths. . . .”. The Food

1 and Drug Administration had over 2,000 reports of
2 completed suicides from 1987 to 1995 for the drug
3 Prozac alone, which by the agency's own calculations
4 represent but a fraction of the suicides. Prozac is
5 the only such drug approved by the Food and Drug
6 Administration for use in children.

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

15 (13) Parents are already being coerced to put
16 their children on psychiatric medications and some
17 children are dying because of it. Universal or man-
18 datory mental health screening and the accom-
19 panying treatments recommended by the New Free-
20 dom Commission on Mental Health will only in-
21 crease that problem. Across the country, Patricia
22 Weathers, the Carroll Family, the Johnston Family,
23 and the Salazar Family were all charged or threat-
24 ened with child abuse charges for refusing or taking
25 their children off of psychiatric medications.

1 (14) The United States Supreme Court in
2 Pierce versus Society of Sisters (268 U.S. 510
3 (1925)) held that parents have a right to direct the
4 education and upbringing of their children.

5 (15) Universal or mandatory mental health
6 screening violates the right of parents to direct and
7 control the upbringing of their children.

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

18 **SEC. 3. PROHIBITION AGAINST FEDERAL FUNDING OF UNI-**
19 **VERSAL OR MANDATORY MENTAL HEALTH**
20 **SCREENING.**

21 (a) UNIVERSAL OR MANDATORY MENTAL HEALTH
22 SCREENING PROGRAM.—No Federal funds may be used
23 to establish or implement any universal or mandatory
24 mental health, psychiatric, or socioemotional screening
25 program.

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

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

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

22 (2) includes—

23 (A) any program of State incentive grants
24 for transformation to implement recommenda-
25 tions in the July 2003 report of the New Free-

1 dom Commission on Mental Health, the State
2 Early Childhood Comprehensive System, grants
3 for TeenScreen, and the Foundations for
4 Learning Grants; and
5 (B) any student mental health screening
6 program that allows mental health screening of
7 individuals under 18 years of age without the
8 express, written, voluntary, informed consent of
9 the parent or legal guardian of the individual
10 involved.

○