

The impact of mental illness on older adults is considerable. Prevalence in this population of mental disorders of all types is substantial. Eight to 20 percent of older adults in the community and up to 37 percent in primary care settings experience symptoms of depression, while as many as one in two new residents of nursing facilities are at risk of depression. Older people have the highest rate of suicide in the country, and the risk of suicide increases with age. Americans age 85 years and up have a suicide rate of 65 per 100,000. Older white males, for example, are six times more likely to commit suicide than the rest of the population. There is a clear correlation of major depression and suicide: 60 to 75 percent of suicides of patients 75 and older have diagnosable depression. Put another way, untreated depression among the elderly substantially increases the risk of death by suicide.

Mental disorders of the aging are not, of course, limited to major depression with risk of suicide. The elderly suffer from a wide range of disorders including declines in cognitive functioning, Alzheimer's disease (affecting 8 to 15 percent of those over 65) and other dementias, anxiety disorders (affecting 11.4 percent of adults over 55), schizophrenia, bipolar disorder, and alcohol and substance use disorders. Some 3 to 9 percent of older adults can be characterized as heavy drinkers (12 to 21 drinks per week). While illicit drug use among this population is relatively low, there is substantial increased risk of improper use of prescription medication and side effects from polypharmacy.

While we tend to think of Medicare as a "senior citizen's health insurance program," there are substantial numbers of disabled individuals who qualify for Medicare by virtue of their long-term disability. Of those, the National Alliance for the Mentally Ill reports that some 400,000 non-elderly disabled Medicare beneficiaries become eligible by virtue of mental disorders. These are typically individuals with the severe and persistent mental illnesses, such as schizophrenia.

Regardless of the age of the patient and the specific mental disorder diagnosed, it is absolutely clear that mental illness in the Medicare population causes substantial hardships, both economically and in terms of the consequences of the illness itself. As Dr. Satcher puts it, "mental illnesses exact a staggering toll on millions of individuals, as well as on their families and communities and our Nation as a whole."

Yet there is abundant good news in our ability to effectively and accurately diagnose and treat mental illnesses. The majority of people with mental illness can return to productive lives if their mental illness is treated. That is the good news: Mental illness treatment works. Unfortunately, today, a majority of those who need treatment for mental illness do not seek it. Much of this is due to stigma, rooted in fear and ignorance, and an outmoded view that mental illnesses are character flaws, or a sign of individual weakness, or the result of indulgent parenting. This is most emphatically not true. Left untreated, mental illnesses are as real and as substantial in their impact as any other illnesses we can now identify and treat.

Mr. Speaker, Medicare's elderly and disabled mentally ill population faces a double burden. Not only must they overcome stigma against their illness, but once they seek treat-

ment the Federal Government via the Medicare program forces them to pay half the cost of their care out of their own pockets. Congress would be outraged and rightly so if we compelled a Medicare cancer patient to pay half the cost of his or her outpatient treatment, or a diabetic 50 cents of every dollar charged by his or her endocrinologist. So why is it reasonable to tell the 75-year-old that she must pay half the cost of treatment for major depression? Why should the chronic schizophrenic incur a 20 percent copayment for visiting his internist, but be forced to pay a 50 percent copayment for visiting a psychiatrist for the treatment of his schizophrenia?

It is most emphatically not reasonable. It is blatant discrimination, plain and simple, and we should not tolerate it any longer. That is why I am introducing the Medicare Mental Illness Non-Discrimination Act. It is time we acknowledged what Dr. Satcher and millions of patients and physicians and other health professionals and researchers have been telling us: Mental illnesses are real, they can be accurately diagnosed, and they can be just as effectively treated as any other illnesses affecting the Medicare population. We can best do that by eliminating the statutory 50 percent copayment discrimination against Medicare beneficiaries who, through no fault of their own, suffer from mental illness.

My legislation is extremely simple. It repeals Section 1833(c) of the Social Security Act, thereby eliminating the discriminatory 50 percent copayment requirement. Once enacted, patients seeking outpatient treatment for mental illness would pay the same 20 percent copayment we require of Medicare patients seeking treatment for any other illnesses. My bill is a straightforward solution to this last bastion of Federal health care discrimination.

Last year, via Executive Order we at last initiated parity coverage of treatment for mental illness for our federal employees and their families. Members of Congress and their staff, who are covered under FEHPB, have parity for treatment of mental illnesses. If parity is good enough for federal employees and for Members of Congress and their staff, can we now do any less for our Medicare beneficiaries? I urge my colleagues to join with me in righting this wrong.

Mr. Speaker, I ask that a letter in support of this legislation from Dr. Daniel B. Borenstein, President of the American Psychiatric Association, be included in the Record.

AMERICAN PSYCHIATRIC ASSOCIATION,  
Washington, DC, January 5, 2001.  
Hon. MARGE ROUKEMA,  
House of Representatives, Rayburn House Office  
Building, Washington DC.

DEAR CONGRESSWOMAN ROUKEMA: The American Psychiatric Association (APA) a medical specialty society representing over 40,000 psychiatric physician nationwide, is deeply concerned about the crisis surrounding children's mental health. We welcome the opportunity to work with the 107th Congress as it presents America with the opportunity to dedicate itself to the well being of our children and families.

According to the "National Action Agenda on Children's Mental Health" released by the Surgeon General earlier this week; the United States is facing a disastrous state of health care for children. In the U.S., 1 in 10 children and adolescents suffer from mental illness severe enough to cause impairment. Yet, in any given year, it is estimated that fewer than 1 in 5 of these children receives

needed treatment. The long-term consequences of untreated childhood disorders are costly, both in human and fiscal terms.

It is a national crisis that millions of Americans continue to struggle with mental illness. Children and families are suffering because of missed opportunities for prevention and early identification, low priorities for research and resources and fragmented services. Overriding all of this is the issue of stigma, which continues to surround mental illness.

The American Psychiatric Association and our members are pleased to offer our medical expertise and experience expertise to you and your staff on the critical issues outlined in the Surgeon General's Report. We place particular emphasis on the Report's call for the need to: develop and disseminate scientifically-proven prevention, diagnostic and treatment services in the field of children's mental health; eliminating the ethnic and socioeconomic disparities in access to mental health care; and increasing access to and coordination of quality mental health care services. If the APA can be of further assistance, have your staff contact our Division of Government Relations at 202/682-6060.

Sincerely,

DANIEL B. BORENSTEIN, M.D.,  
President.

HONORING MARY VIRGINIA  
BURRUS

HON. JAMES A. LEACH

OF IOWA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, February 13, 2001

Mr. LEACH. Mr. Speaker, today I express my gratitude and appreciation for the work of Mary Virginia "Ginny" Burrus.

Ginny joined my staff on January 16, 1985, providing constituent service in my Burlington, Iowa, office. She and her late husband David owned their own business in Burlington and she had long been active in promoting tourism, the arts as well as the economy of southeastern Iowa.

After redistricting, Ginny helped open my Iowa City office in 1992, continuing to provide outstanding service to the residents of Iowa's First Congressional District.

All of my colleagues know how essential to the functioning of government is the ombudsman role in Congressional offices, and particularly caseworkers within them, play. For constituents with problems, be it with veterans benefits, Social Security, Medicare or student loans, the federal bureaucracy can be a bewildering maze, the applicable laws and regulations often seemingly irrational. An experienced, knowledgeable and sympathetic caseworker can be indispensable in getting the answers needed and problems resolved.

In the 16 years she worked with me, Ginny epitomized the consummate professional and her file is fat with letters from Iowans thanking her for the help she provided. In recent years, as immigration casework increased, her knowledge of immigration law, regulations, processes and paperwork has become legendary. Equally well known has been her patience, both with harried staffers at INS and with newcomers to this country, unfamiliar with both its language and its ways.

Ginny has provided me and the citizens of Iowa a model of what public service is all about. She will now have more time to enjoy

her daughters, Alicia, Alexandra and Anita, and her grandson Kerr and granddaughter Hannah, as well as the opportunity to play more bridge.

It is with profound gratitude that I wish Ginny all the best in a well-earned retirement.

#### PERSONAL EXPLANATION

### HON. MARY BONO

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

*Tuesday, February 13, 2001*

Mrs. BONO. Mr. Speaker, I was necessarily absent for all legislative business during the week of February 5, 2001 through February 10, 2001, due to a medical condition. As a result, I missed the following votes: On Tuesday, February 6, 2001—question “On Motion to Suspend the Rules and Pass” (roll No. 9) for issue H.J. Res. 7—Recognizing the 90th birthday of Ronald Reagan—question “On Motion to Suspend the Rules and Agree” (roll No. 10) for issue H. Res. 28—Honoring the contributions of Catholic schools. On Wednesday, February 7, 2001—question “On Motion to Suspend the Rules and Pass” (roll No. 11) for issue H.R. 132—To designate the Goro Hokama Post Office Building in Lanai City, Hawaii.

Had I been present, I would have voted “yea” for question “On Motion to Suspend the Rules and Pass” for issue H.J. Res. 7 (roll No. 9), “yea” for question “On Motion to Suspend the Rules and Agree” for issue H. Res. 28 (roll No. 10), and “yea” for question “On Motion to Suspend the Rules and Pass” for issue H.R. 132 (roll No. 11).

#### PRESCRIBING ALTERNATIVE PAYMENT METHODS UNDER THE TRICARE PROGRAM

### HON. PATSY T. MINK

OF HAWAII

IN THE HOUSE OF REPRESENTATIVES

*Tuesday, February 13, 2001*

Mrs. MINK of Hawaii. Mr. Speaker, I rise to introduce a bill that would allow retired members of the military to pay their TRICARE enrollment fees on a monthly basis.

Currently, TRICARE enrollees must pay their annual enrollment fees all at once or on a quarterly basis. Enrollment fees are \$230/year for individual enrollment, and \$460/year for family enrollment.

My bill establishes alternative payment mechanisms to provide for payment of such fees through: a deduction from military retired or retainer pay; a deduction from monthly Social Security benefits; and an electronic funds transfer from a checking or savings account.

Last year we passed legislation that enables the Department of Defense to provide TRICARE benefits to Medicare-eligible beneficiaries. As we honor our military retirees with access to a wonderful health care program, we should remember that many retirees are living on a fixed income. A one-time enrollment payment can severely limit their resources. My bill is designed to help individuals with a limited income spread out the payment of the yearly enrollment fee over 12 months.

I urge all members to cosponsor this legislation.

#### TRIBUTE TO CLAFLIN UNIVERSITY STUDENTS

### HON. JAMES E. CLYBURN

OF SOUTH CAROLINA

IN THE HOUSE OF REPRESENTATIVES

*Tuesday, February 13, 2001*

Mr. CLYBURN. Mr. Speaker, I rise today to pay tribute to twenty-two exceptional students at Claflin University, who are participating in the “Call Me Mister” program.

“Call Me Mister” was developed to address the looming shortage of teachers, especially black male teachers. The program strives to place black males in front of elementary school classrooms in order to provide positive role models for our children.

Each of the twenty-two participants in “Call Me Mister” at Claflin underwent a rigorous application process and are required to maintain a minimum grade point average. The students will complete 300 hours of community service before they graduate.

Black youths in South Carolina have the highest dropout rate of any group and twenty percent are held back in the first grade. These children are in desperate need of African American men to model their lives after, who can show them that the American dream can come true for all Americans.

“Call Me Mister” promises to provide the State of South Carolina with a new breed of teachers. Less than one percent of the state’s teachers are African American males despite the fact that the state is one-third black. Claflin University and the wonderful participants in the “Call Me Mister” program are working to make South Carolina’s elementary school classrooms more representative of the state itself.

Mr. Speaker, the “Call Me Mister” program is working to improve South Carolina schools along with the mentality of African American men. Please join me in paying tribute to these wonderful students and this long overdue program as they work to better the educational system in my state.

#### CONGRATULATING THE UKRAINIAN PEOPLE ON POPE JOHN PAUL II’S UPCOMING VISIT

### HON. DENNIS J. KUCINICH

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

*Tuesday, February 13, 2001*

Mr. KUCINICH. Mr. Speaker, today I congratulate the Ukrainian people on His Holiness Pope John Paul II’s upcoming visit in June. The Pope recently accepted an invitation from Ukraine’s President to visit the country, undoubtedly answering the prayers of many Catholic Ukrainians.

Mr. Speaker, many of my constituents would also like to see His Holiness Orthodox Patriarch Bartholomew of Constantinople visit Ukraine. Ukraine has a large Orthodox population, and a visit by the Patriarch to the country would be a blessing to them and would promote harmony between Catholic and Orthodox worshippers throughout Ukraine.

#### INTRODUCTION OF LEGISLATION ON MODIFYING THE FTC’S ORIGIN RULES FOR WATCHES

### HON. DONNA M. CHRISTENSEN

OF VIRGIN THE ISLANDS

IN THE HOUSE OF REPRESENTATIVES

*Tuesday, February 13, 2001*

Mrs. CHRISTENSEN. Mr. Speaker, today I am introducing legislation which would modify the Federal Trade Commission’s practices for determining the country of origin of domestic watches, including those watches manufactured in the United States Virgin Islands.

The watch industry is the largest light manufacturing industry in the U.S. Virgin Islands and remains one of the most important direct and indirect sources of private sector employment in the Territory. The insular watch production industry is also highly import-sensitive and faces continued threats from multinational watch producers, who have continued to move their watch production to lower wage countries. The legislation that I am introducing today will help assure that domestic watch producers can compete on a level playing field with foreign producers with respect to the labeling and advertising of the origin of watches sold in the U.S. marketplace.

Currently, the FTC’s test for determining whether a watch is made in the United States differs from the FTC’s origin test for foreign-made watches, the Customs Service origin test for imported watches and longstanding international practice. The legislation that I am introducing today would rationalize these various tests by requiring that the FTC employ a common and well-established standard for determining the origin of all watches. This modification to the FTC’s practice would help ensure that consumers have a uniform basis on which to judge the country of origin of watches. It would also help promote the operations of U.S. watch producers, particularly those in the U.S. Virgin Islands. The production of watch movements by these producers (and their subsequent production of finished watches) involve highly labor intensive operations which add considerable value to the finished watch and to the U.S. and Virgin Islands economies.

The country of origin of a watch is, by longstanding international trade practice, generally considered to be the country in which the watch movement is produced. The movement is the “guts” of a watch. The production of a watch movement involves numerous, labor-intensive operations involving inspection, quality control, reworking and testing of some 35 to 45 individual parts prior to, during and after assembly. These operations require substantial investment in diversified precision equipment and employee training and add considerable value to the finished watch.

In determining the country of origin of imported products, the U.S. Customs Service generally employs the well-established concept of “substantial transformation.” The substantial transformation test—which is supported by almost 100 years of judicial and administrative precedent—recognizes that some functional changes and processes involved in the production of an imported product are so