

"On behalf of the more than 1,000 organizations and 1.8 million businesses of the Tax Relief Coalition, we urge you as a member of Congress to support the full elimination of the double taxation of dividends, the increase in the small business expensing allowance, and the acceleration of all the scheduled income tax rate reductions when the Committee on Ways and Means considers the economic growth reconciliation legislation. As companies and organizations representing businesses that employ tens of millions of Americans, we believe these provisions are necessary if we are to jumpstart the economy and put people back to work.

"The full elimination of the double taxation of dividends within the framework of a \$550 billion tax relief package is achievable and will have a singularly positive effect on the economy in both the short term and the long term. It will spur consumer spending by putting more money in the hands of shareholders who will pay less in taxes, receive higher dividend payouts and accumulate increased wealth as a result of the upward pressure on stock prices. The resulting increased demand and lower cost of capital will sustain economic growth and create jobs as companies invest in the new equipment, build new plants and develop new products. Many economists also believe eliminating this double tax will boost the stock market from 10 to 20 percent.

"Since small businesses create two-thirds of the new jobs in the United States, the importance of the small business provisions of the President's proposal should not be underestimated. Approximately 85 percent of small business owners file tax returns as individuals and represent nearly 80 percent of the taxpayers at the top income bracket. Accelerating all of the scheduled income tax rate reductions to this year, 2003, will provide approximately \$10 billion in tax savings to small businesses that file as individuals. Allowing small business owners to expense critical investments will facilitate economic expansion, so we urge you to support raising the small business expensing limit from \$25,000 to \$75,000 and indexing it for inflation. These changes will create savings for small businesses that will put money directly into the economy and create new jobs.

"Any proposal that does not include the critical small business provisions and result in the full elimination of the unfair double taxation on dividends will significantly compromise the economic benefits of the President's package and jeopardize the hundreds of thousands of new jobs that would otherwise be created.

"In our view, representing tens of millions of working Americans and businesses, if you do not include the dividend tax reduction and the critical small business provisions, the jobs and growth package will simply not have the same effect.

"This has been respectfully submitted by the Tax Relief Coalition."

Mr. Speaker, I am just very honored to have been here tonight with the gentleman from North Carolina to present on behalf of nearly 1,000 business associations, businesses and other think tanks that are proposing that we reduce taxes and the tax burden on the American people. I just cannot wait until tomorrow, and I hope the American people follow the debate. I am confident that just as we had the debates following the tax increases of 1993, which when those tax increases were put in place that we heard were so good tonight, the immediate effect was that a Republican Congress was elected for the first time in over 40 years.

And so people do understand these issues. I know in the State of South Carolina that we understand those issues because, in fact, not only was there a new Republican majority in the House here in Washington, but for the first time since 1877 there was a Republican majority and the first Republican Speaker of the House of Representatives in the entire South, David Wilkins, was elected. The American people do understand these issues. We have gotten excellent leadership in our State and here in Washington. The Republicans then achieved a majority in the State Senate in 2001 for the first time since 1877 because people do understand the philosophical differences between the two parties. They understand that we as Republicans are working for limited government, expanded freedom. On the other side, they have tax-and-spend policies. They are well meaning, but they are wrong.

□ 2100

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. HENSARLING). The Chair would generally remind Members to address their remarks to the Chair and not to those outside the Chamber.

GENERAL LEAVE

Mrs. NAPOLITANO. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on the subject of my special order.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

MENTAL HEALTH CAUCUS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 7, 2003, the gentleman from California (Mrs. NAPOLITANO) is recognized for 60 minutes as the designee of the minority leader.

Mrs. NAPOLITANO. Mr. Speaker, as the Democratic Chair of the bipartisan Congressional Mental Health Caucus, which we recently began, I am pleased

to anchor at this time along with my Republican cochair, the gentleman from Pennsylvania (Mr. MURPHY), who spoke a few minutes. He was granted some time by my good friend to make his remarks, and I hope that he will be able to return.

Mr. Speaker, this week is National Suicide Awareness Week, and we want to highlight that fact. Approximately 30,000 people, 30,000 people, commit suicide in the United States every year, making suicide the 11th leading cause of death nationwide. Suicide is particularly a problem among young people, communities of color, and seniors. The States with the five highest suicide rates are Nevada, Wyoming, Montana, New Mexico, and Arizona.

Everyone should be screened by the health care providers in our schools for mental health and/or risk of suicide. Because of the associated stigma of the crazies, we cannot count on people to seek out help on their own. Another key point is our need for more mental health professionals to break down financial and language barriers to mental health.

Mr. Speaker, I will right now take the time to introduce the gentleman from Texas (Mr. RODRIGUEZ) to address this same issue.

Mr. RODRIGUEZ. Mr. Speaker, I would like to thank the gentlewoman from California (Mrs. NAPOLITANO) for taking this opportunity to talk about suicide and the mentally ill. I think one of the difficulties that we encounter is the fact that when it comes to the mentally ill, it is usually one of the last that we talk about, and in fact it is usually an afterthought in terms of providing resources that are drastically needed for not only for the mentally ill but for the issue in terms of preventing suicides.

Mental disorders are common in the United States, and we sometimes do not realize how common they are. There is an estimated 22 percent of Americans age 18 and older and one out of five adults who suffer from diagnosed mental disorders throughout a year. Tragically, mental disorder is often linked with suicide. Of the 29,350 people who died by suicide in the year 2000, more than 90 percent of the people who killed themselves have diagnosable mental disorders, commonly depressive disorders as well as substantive abuse disorders and other dual diagnoses.

At this time I would also like to focus my remarks on critical segments of our population, and that is our veterans. Today while we continue to deploy troops in Iraq, it is important to remember that the wounds of combat that would disable and harm our troops are not merely just physical. Many combat wounds will affect the minds, the brain, and the spirit of our Armed Forces and their loved ones. So often we forget that long after the visible battle wounds are healed, many veterans continue to suffer not only physically but also mentally. For our heroes of today as well as yesterday's

stress-related conditions like post-traumatic stress disorders, PTSD, and depression can be among the most chronic and disabling of the illnesses. For example, more than 30 percent of veterans, Vietnam veterans, have experienced PTSD at some point after the war experience. I have heard alarming statistics just the other day in some testimony on the House Committee on Veterans' Affairs, a witness testified that a great number of Vietnam veterans that did not die during Vietnam, of which we lost over 59,000 lives, committed suicide after they came back than soldiers lost in the battle in that conflict.

Given these alarming statistics, it is shameful that we have not appropriated sufficient funds to provide our heroes with the care that they need. From 1996 to 2000, programs for PTSD, or the homeless substantive abuse programs, and serious mental illness grew approximately 5.5 percent overall in the number of patients that they served, but the resources shrank approximately 13.5 percent for the budgets for the mentally ill that are veterans.

In addition to the painful experience of dealing with their mental disorders and especially PTSD and others, many of these veterans find themselves on the street. Homelessness is prevalent in this segment of veterans. A large number of displaced and at-risk veterans live with lingering effects of posttraumatic stress disorders and substance abuse, compounded by the lack of family and social support networks. Although accurate numbers are challenging to identify since no one really keeps the national records on homeless veterans, but the VA estimates that on any given night we will find 300,000 veterans that are homeless, and more than half a million experience homelessness throughout the course of any given year. This is important to note: Of the homeless that are out there, 40 percent report mental health problems.

In order to properly serve these veterans we must be committed to a comprehensive approach to the treatment and we must appropriate sufficient resources in dollars. Veterans need a coordinated effort that provides secure housing and nutritional meals; essential physical health care, substance abuse aftercare, and the mental health counseling; and personal development. And one of the things about substance abuse is a lot of the times the mentally ill, as they try to cope with their depression, as they try to meet and cope with the problems that they are encountering, they self-medicate, and that is why a lot of them go into substance abuse.

As a Member of the House Committee on Veterans' Affairs, I am proud of the work that we put forth and passed in Public Law 107-95, which is the Homeless Veterans Comprehensive Assistance Act, a year and a half ago, to properly address this shameful issue.

This truly comprehensive legislation sought to end homelessness among vet-

erans within a decade, but we have got to continue to move forward. However, just this week we held an oversight hearing where we invited Deputy Secretary McKay to provide us a status report on the implementation of the Homeless Veterans Comprehensive Assistance Act.

The news is not that good. If we continue at this pace, we will not reach our goal in 10 years. Rather, it will take 25 years. This is not acceptable. Especially now after we have seen also the veterans from the Gulf war and now we have the veterans from Iraq, and we encounter to have veterans who are fighting the war on terrorism, we have to make sure that as they leave the Armed Forces that we are there for them, and I am disappointed that the VA has not moved on the critical programs such as the creation of special needs grants for women, veterans especially, and the chronically mentally ill, the ones who real seriously ill and need that service, as well as the fragile elderly and the terminal ill. We must move on the creation of specialized treatment programs for these veterans that are in need. These critical programs have not yet been designed, and it is difficult and it is hard, but we need to continue to move.

In closing, let me just say that I want to thank my colleagues once again for raising this issue and mentioning the importance of zeroing in on the issue of suicide and the issue of the mentally ill. As a social worker personally with clinical experience and training, I am proud to echo the concerns of my colleagues and to urge this body to devote adequate resources and to implement programs which speak to the needs that are before us and of those that are forgotten, yet critical segment of our society, and that is the mentally ill and those who commit suicide.

And I want to add one additional thing. As we talk about suicide, I know the gentlewoman from California (Mrs. NAPOLITANO) has done significant work for the Latino young ladies, Latinas, who are prone to commit suicide, in the need to reach out to our young. We have forgotten Columbine. We have forgotten the fact that we still have young people throughout this country that need assistance, and when it comes to our young, we have not done what we should do, and that is to make sure we have the programs to reach out to them. Most of the time throughout this country, the only resources they have is after they get into the criminal justice system. And that is too late. We need to make sure we have programs that reach out to our young.

I want to congratulate the gentlewoman from California (Mrs. NAPOLITANO) for her legislation and her efforts in providing that assistance in the area of Latina suicide and health care.

One of the other areas that I would like to mention that sometimes goes unnoticed, and that is the issue of depression. As people suffer from depres-

sion, women and young, men, young people and the elderly, it is an issue that we do not see as a mental health issue, but it is an issue that hits us without us realizing it. Just like the work burnout. By the time one realizes it, they have gotten into trouble, and a lot of times people lose their jobs because they get burned out and do not have the energy. But people suffer from depression, and it is important for us to work on those areas.

And I just want to mention one other item because I think it is important. As we look at the issue of terrorism and as we look at the problems and the things that we have been confronted with, what has occurred here not only at the Pentagon but what has occurred in New York, those in individuals in New York, those individuals at the Pentagon, as well as others, we need to make sure we reach out to them because they have experienced what a lot of us have not, and in so doing, they are also going to be suffering from nightmares. They are also going to be suffering from coping with a situation that they themselves went through, and so they are going to be having what we might consider post-traumatic stress disorders of which they need to be able to deal with. So as a society and as a community in these United States, we need to put the resources in those areas. And once again I want to thank the gentlewoman from California (Mrs. NAPOLITANO) for having taken the time for us to be here tonight and I want to congratulate her in bringing up this issue that is usually left in the back burner.

Mr. Speaker, when we talk about health care a lot of times as an afterthought we talk about mental health, and that is unfortunate. We really need to put that on the front burner. We need to make sure we bring it forth and provide the resources. I thank the gentlewoman for having me here tonight.

Mrs. NAPOLITANO. I thank the gentleman from Texas (Mr. RODRIGUEZ). Mr. Speaker, I think he has made some very valid points, and I want to elaborate a little more on that, in that more than one third of our veterans need psychiatric care, most, as the gentleman has stressed, for the PTSD, posttraumatic stress disorder, and unfortunately the Veterans Administration's spending for mental health care has decreased since 1996 by a whopping 23 percent, almost a quarter. Veterans in need of mental health services often have to wait weeks, even months in some parts of country, for appointments, never mind having assistance by a psychologist, psychiatrist. One reason is because only 40 percent of the Veterans Administration clinics, Mr. Speaker, have mental health professionals.

□ 2115

Many veterans are forced to travel over an hour for care. Veterans who need weekly or biweekly follow-up appointments for therapy or medication

regulation can only be seen every 6 weeks. The Veterans Administration desperately needs more psychiatric staff. Sadly, less than 9 percent of the Veterans Administration funds are available for residency training or designated for psychiatric residency in the year 2002.

Our heroes, our active duty soldiers, just recently on television there was a young soldier who when asked what he was thinking when he came home, he said, I wake up with dreams where I was in the tank seeing the Iraqis use women and children as shields. Somebody needs to help those young men and women who have witnessed the atrocities and do not have the ability to download or be able to have professional assistance to deal with this traumatic scene that they are going to live with for the rest of their lives.

Not only are they in immediate danger in combat service, they need our help to be able to function properly in our society. Many of them experience extreme flashbacks and nightmares of war situations, but they may not openly talk about them. I can tell you, Mr. Speaker, from experience, from my brother-in-law who was in World War II, he refused to talk about his experiences because they were so painful.

Soldiers must be screened for these mental health problems and given assistance before they progress to suicidal proportions. Families of soldiers who have served in war also need mental health services to cope with their loved ones' fears, their anxiety, and their issues.

Very sadly, unfortunately, lack of appropriate mental health services for soldiers has led not only to suicide, but to homicide. Last year, the four soldiers at Fort Bragg allegedly killed their wives or partners. Family members noticed the soldiers were experiencing rage and other mental wounds of service and needed mental health treatment. None was provided; none was available.

We talk about our homeless, our street people. As my colleague just mentioned, there are over 300,000 people without shelter on any given night. Approximately 25 percent of these homeless have serious mental illness, such as schizophrenia, bipolar disorder and PTSD. Unfortunately, many minorities, particularly African Americans, are overrepresented among the mentally ill homeless population.

Only a handful of the homeless shelters currently provide comprehensive mental health services; and yet without these services, we will never break the cycle of homelessness and help people get back on their feet and function in our society. We do not even have accurate figures on the number of homeless people who commit suicide; but given their likelihood of mental health illness, their desperate situation, this number is expected to be high.

Now I go on to our youngsters, Mr. Speaker. Suicide is the third leading cause of death among young people

ages 10 to 24, followed by unintentional injuries and homicide. Our U.S. Surgeon General estimates that one in five children, one in five children, will experience a serious mental health problem during their school years. Can you imagine, one in five? That means three of my grandchildren, because I have fourteen. A sad statistic.

A variety of causes lead youth to serious mental health problems and suicide, including academic problems, peer pressure, fear of school violence, severe change in family situation, rape during college years, and the double stigma of the mental stress and the rape.

Children are considered by many psychologists to be the most resilient age group with regard to mental illness, meaning that, if given appropriate treatment, children are likely to fully recover, if they are given treatment. Children also need a good deal of preventative mental health care to ensure that they do not reach the critical suicide stage. They need help in adapting to dramatic life changes, such as moving from one city to another, switching schools, parental divorce or a loss of a family member, a loved one.

Latino adolescents are the most likely of any racial or ethnic group to attempt suicide in the United States. The Native American and Alaskan Native youth are the most likely of any racial or ethnic group to commit suicide.

I first learned of this problem in a 1990 report by a representative group of health care providers of Hispanic origin that brought to us here in Washington a report presented to the Congressional Hispanic Caucus. It stated that a shocking one in three Latino adolescents ages 9 to 11 had seriously considered suicide, and that 15 percent of those adolescents actually attempted suicide. That is horrible. That is unacceptable.

So we responded by spearheading and securing funding from Health and Human Services, SAMHSA, substance abuse, for a pilot program in my district to provide school-based mental health services through a nonprofit mental health care provider. This program has served over 300 students in three middle schools and one high school, many of whom have no health insurance and could not have received these services elsewhere. They were either unable to provide services to them or their provider would not cover them.

Children exposed to violence and poverty are at a heightened risk for mental illness and for suicide, as are students who have experienced, as I said, parental death or divorce. Children in schools need to be screened for mental illness and suicide risk factors so they can be given appropriate care. Schools should have trained personnel who can spot the first signs and prevent at-risk children from attempting suicide.

Seventy percent of school children and adolescents nationwide who need mental health services are not getting them. Untreated mental illness has led

to violence in schools; and as we have seen in the newspaper, there continues to be almost on a daily basis an instance where something has happened in a school, there is violence, there is a suicide attempt or suicide has been committed.

In 1996 a Health and Human Service study found that almost 20 percent of students feared being violently attacked by their peers at school. Students have attacked their teachers and their administrators at a time that is crucial for children in middle schools and high schools that have tremendous pressures.

Then we look at the shortage of mental health services. Many schools do not have mental health professionals. In fact, I do not know of many that can even afford nurses, let alone mental health care providers. Nearly all people who commit suicide have a diagnosable mental illness or substance abuse problem, something that has been found in about 70 percent of the students that have been treated for mental health illness, or they have more than one.

Most people who need mental health services do not have access to them because of the stigma associated with mental health care, because of financial barriers, because of language barriers, or simply a lack of available services. This is a particular problem in minority communities, where individuals are less likely to have health insurance and more likely to have a language barrier to receive care. Only 32 percent of Hispanic female youth at risk for suicide during the year of 2000 received mental health treatment. That is only 32 percent.

The shortage of mental health professionals is a vital, vital necessity, especially amongst minorities. We are facing a severe shortage of mental health professionals, particularly in the areas in high populations of minorities, who can render services bilingually, in the native language, or a language that they can understand.

Research in other areas of health care indicates that minority health care workers are more likely to practice in areas with high minority populations; but unfortunately, we have shockingly few minority health care professionals. Only 1 percent of licensed psychologists are Hispanic, 1 percent. Moreover, there are only 29 mental health professionals for every 100,000 Hispanics in the United States. There are only 70 Asian American/Pacific Islander mental health providers for every 100,000 Asian American/Pacific Islanders in the United States. Further, half of the Asian American/Pacific Islanders who need mental health services report that they do not access them because of language barriers. Interesting.

But do not think that mental illness and suicide only plague minority communities or young people. Let us look at our elderly. Our Nation's seniors are at an enormously high risk of suicide. In fact, the highest suicide rate in the

United States of any age group occurs among people ages 65 years and older. There is an average of one suicide among elderly every 90 minutes.

Seniors are at a high risk for depression. Fifteen out of every 100 people in the U.S. over 65 are depressed. Unfortunately, it goes unnoticed, because families and health care providers are focused only on their health, more often than not. But depression among seniors, when left untreated, can worsen conditions, lead to disability and, ultimately, result in suicide.

Now, Substance Abuse Mental Health Services estimates that 20 percent of the elderly over 65 years old who commit suicide visited a physician within 24 hours of their act; 41 percent visited within a week of their suicide; and 75 percent have been seen by a physician within 1 month of their suicide. Clearly, our physicians are not screening their elderly patients for depression or suicide risk, nor are they providing adequate treatment for mental illness. This has to change. It must change. It cannot continue.

Depression and suicide are not a normal part of aging; and they must not, they cannot be ignored. The most common causes of senior depression and suicide include terminal illness, physical pain, loss of a spouse, and/or social isolation.

Then we go into Medicare. Unfortunately, current Medicare rules make it very difficult for seniors to access mental health services. Currently, Medicare requires beneficiaries to pay 50 percent copay for mental health services, compared to 20 percent copay for other health services. We must make mental health equal to health care delivery.

Further, Medicare imposes a lifetime limit of in-patient care in psychiatric hospitals of 190 days, a lifetime limit, 190 days. Later this year, hopefully Congress will debate this Medicare modernization; and when we do, we must make it clear that we must address these insufficient mental health provisions, and we must ensure that Medicare provides access to mental health services that our seniors desperately need.

Medicare is not the only Federal program falling short on mental health services. While men are more likely to commit suicide, women attempt suicide twice as often as men, often using less lethal means such as pills or slicing their wrists. Suicide is more common among single, divorced, or widowed women than among married women.

The two most common mental illnesses among women who attempt suicide are postpartum depression and bipolar disorder. Suicide rates for women peak between the ages of 45 and 54, often due, guess what, to hormonal changes during menopause that affect their mental health. Unfortunately, gynecologists and obstetricians do not screen enough patients for postpartum depression or mental health illnesses related to menopause.

Then we look at our college students. They are at a heightened risk for mental illness and suicide because they are away from home for the first time, away from traditional support systems, and face intensive peer pressure and academic pressure, and, as has happened in many of our colleges, unfortunately and sadly, rape on our campuses.

□ 2130

This brings shame, shock, and denial and causes them to take the ultimate step of suicide. It is the second leading cause of death among college students. The rate among these students has tripled since 1970.

Well, Mr. Speaker, we are coming to the end of the hour and I want to make sure that we stress that we need to make mental health a higher national priority, to expand access to health care, mental health care for all Americans. I thank the gentleman from Pennsylvania (Mr. MURPHY). He has consented to be a cochair in our bipartisan Mental Health Caucus which now numbers over 17 Members from both sides. We invite more Members to join and work with us and bring this up into the light and be able to talk about it, discuss it, and do something about it.

Mr. Speaker, this is a large and daunting issue. The mentally ill need all the support and supporters they can get. We must eradicate the stigma and work openly and honestly to help those many that need our help.

I want to thank all of the Members who are working with us to improve mental health issues in our Nation. I want to thank my distinguished colleague and cochair, once again, the gentleman from Pennsylvania (Mr. MURPHY), and I would then say to my colleagues that I am very pleased that even at this late hour, I have an opportunity to bring before my colleagues one of the things that has bothered a lot of us for a long time.

Ms. BORDALLO. Mr. Speaker, I am pleased to join my colleagues this evening on this most important issue and I thank my colleague, Mrs. NAPOLITANO, for bringing attention to National Suicide Awareness Week. This is a very personal issue for me as I have experienced first hand the impact of suicide on family and friends.

Tonight I want to bring special attention to the issue of suicide in youth and young adults.

In the year 2000, persons under age 25 accounted for 15 percent of all suicides. In 1999, more teenagers and young adults died from suicide than from cancer, heart disease, AIDS, birth defects, stroke, and chronic lung disease combined.

Nationally, suicide is the 9th leading cause of death. Among 10–24 year-olds, suicide ranks 3rd and in Guam, where the suicide rate is six times higher than the national average, it ranks 2nd as the leading cause of death in youth and young adults.

Mr. Speaker, we cannot stand by and allow this tragedy to continue. We must focus our efforts on what causes the youth in our communities to choose to end their lives.

The report of the Surgeon General's Conference on Children's Mental Health: Devel-

oping a National Action Agenda indicates that children with mental health needs are usually identified by the schools only after their emotional or behavioral problems cannot be managed by their regular classroom teacher.

We must educate and train parents, teachers and others who work with our children to recognize the warning signs of suicidal young adults.

We must provide funding for the programs and services that will treat our children and provide guidance and support to their family and friends, including expanding Medicaid eligibility to allow lower income and poor families to access programs and services.

We must also recognize the racial, cultural and ethnic influence on behaviors and its effect on properly identifying at-risk youth and address its impact on intervention and access to the programs and services.

Most importantly, we must help our children understand that suicide is never the answer to their problems.

Ms. WATSON. Mr. Speaker, there are approximately 30,000 suicide deaths every year in the U.S. Suicide is the 11th leading cause of death nationwide, and is the 3rd leading cause of death among people ages 10–24, following unintentional injuries and homicide.

Statistics of completed suicide only tell part of the story. National Institute of Mental Health (NIMH) estimates that research indicates that there are an estimated 8–25 attempted suicides to one completion; the ratio is higher in women and youth. Adolescent males are 4 times more likely to actually commit suicide than females. Adolescent females are twice as likely as adolescent males to attempt suicide.

Since peaking in the early 1990's, overall adolescent suicide rates have dropped. However, most of this is attributed to a drop in male adolescent suicide. Rates for females have remained constant. Fifty-three percent of young people who commit suicide abuse substances.

Most people who commit suicide have a diagnosable mental illness, but are not receiving treatment.

Children who are exposed to violence, experience a loss in the family, experience parental divorce, or have academic problems are at a heightened risk for mental health problems and suicide.

The U.S. Surgeon General estimates that 1 in 5 children will experience a serious mental health problem during their school years. Seventy percent of these children will not receive mental health services, putting them at an even higher risk of suicide.

Native American/Alaskan Native youth are more than twice as likely to commit suicide as any other adolescent racial group to commit suicide, with approximately 20 deaths per 100,000 Native Americans/Alaskan Natives ages 15–19.

Hispanic adolescents are most likely to exhibit non-lethal suicide behavior. A 1999 report found that a shocking 1 in 3 Latina adolescents seriously considered suicide. Fifteen percent of Hispanic high school-age females actually attempt suicide each year.

People who are homeless, incarcerated, in the foster care system, or exposed to serious violence are all at a higher risk for mental illness and suicide. African-Americans and Hispanics are overrepresented in these groups.

Minorities are less likely to access mental health care, due to lack of insurance and other

financial barriers and cultural stigma. For instance, only one third of African-Americans in need of mental health services actually receive them.

Among Hispanic Americans with a mental disorder, fewer than 1 in 11 contact mental health specialists, while fewer than 1 in 5 contact general health care providers. Among Hispanic immigrants with mental disorders, fewer than 1 in 20 use services from mental health specialists, while fewer than 1 in 10 use services from general health care providers.

Of Asian-Americans who report needing mental health services, half of them do not receive them because they cannot find a provider who speaks their language.

There is a serious lack of mental healthcare providers, and an even greater lack of minority providers, who are more likely to practice in communities with high minority populations.

We must invest more in our mental healthcare system in order to prevent suicide. We need more psychiatrists and psychologists. We need to screen all of our children for mental health problems and suicide risk factors. And when our children exhibit symptoms of mental illness—such as withdrawal from family and friends, academic trouble, sadness or behavioral problems—we must make sure they get the appropriate treatment immediately.

Mrs. NAPOLITANO. Mr. Speaker, I yield back the balance of my time.

RECESS

The SPEAKER pro tempore (Mr. HENSARLING). Pursuant to clause 12(a) of rule I, the Chair declares the House in recess subject to the call of the Chair.

Accordingly (at 9 o'clock and 32 minutes p.m.), the House stood in recess subject to the call of the Chair.

□ 2201

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. DREIER) at 10 o'clock and 1 minute p.m.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 2, JOBS AND GROWTH RECONCILIATION TAX ACT OF 2003

Mr. REYNOLDS, from the Committee on Rules, submitted a privileged report (Rept. No. 108-95) on the resolution (H. Res. 227) providing for consideration of the bill (H.R. 2) to amend the Internal Revenue Code of 1986 to provide additional tax incentives to encourage economic growth, which was referred to the House Calendar and ordered to be printed.

OMISSION FROM THE CONGRESSIONAL RECORD OF THURSDAY MAY 1, 2003, AT PAGE H3632

SENATE ENROLLED BILL SIGNED

The SPEAKER announced his signature to an enrolled bill of the Senate of the following title:

S. 162—An Act to provide for the use and distribution of certain funds awarded to the Gila River Prima-Maricopa Indian community, and for other purposes.

CORRECTION TO THE CONGRESSIONAL RECORD OF TUESDAY, MAY 6, 2003, AT PAGE H3658

APPOINTMENT AS MEMBERS TO UNITED STATES-CHINA ECONOMIC AND SECURITY REVIEW COMMISSION

The SPEAKER pro tempore. Pursuant to section 1238(b)(3) of the Floyd D. Spence National Defense Authorization Act for fiscal year 2001 (22 U.S.C. 7002), amended by Division P of the Consolidated Appropriations Resolution, 2003 (P.L. 108-7), and the order of the House of January 8, 2003, the Chair announces the Speaker's reappointment of the following members on the part of the House to the United States-China Economic and Security Review Commission:

Ms. June Teufel Dreyer, Coral Gables, Florida, for a term to expire December 31, 2003;

Mr. Larry Wortzel, Alexandria, Virginia, for a term to expire December 31, 2004;

Mr. Stephen D. Bryen, Silver Spring, Maryland, for a term to expire December 31, 2005.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. DINGELL (at the request of Ms. PELOSI) for today on account of medical reasons.

Ms. JACKSON-LEE of Texas (at the request of Ms. PELOSI) for May 7 after 3:00 p.m. on account of official business in the district.

Mr. FEENEY (at the request of Mr. DELAY) for today and the balance of the week on account of official business.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Members (at the request of Mr. DEFAZIO) to revise and extend their remarks and include extraneous material:)

Mr. DEFAZIO, for 5 minutes, today.

Mr. FILNER, for 5 minutes, today.

Ms. NORTON, for 5 minutes, today.

Mr. ALLEN, for 5 minutes, today.

Ms. KAPTUR, for 5 minutes, today.

Ms. CARSON of Indiana, for 5 minutes, today.

Mr. CASE, for 5 minutes, today.

Ms. JACKSON-LEE of Texas, for 5 minutes, today.

Mr. RYAN of Ohio, for 5 minutes, today.

Ms. Linda T. Sanchez of California, for 5 minutes, today.

Mr. PALLONE, for 5 minutes, today.

(The following Members (at the request of Mr. HENSARLING) to revise and extend their remarks and include extraneous material:)

Ms. PRYCE of Ohio, for 5 minutes, today.

Ms. HARRIS, for 5 minutes, today.

Mrs. BLACKBURN, for 5 minutes, today.

Mr. THOMAS, for 5 minutes, today.

ENROLLED BILL SIGNED

Mr. Trandahl, Clerk of the House, reported and found a truly enrolled bill of the House of the following title, which was thereupon signed by the Speaker:

H.R. 289. An act to expand the boundaries of the Ottawa National Wildlife Refuge Complex and the Detroit River International Wildlife Refuge.

ADJOURNMENT

Mr. REYNOLDS. Mr. Speaker, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 10 o'clock and 2 minutes p.m.), under its previous order, the House adjourned until tomorrow, Friday, May 9, 2003, at 9 a.m.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

2089. A letter from the Director, Regulatory Review Group, Department of Agriculture, transmitting the Department's final rule — Tobacco Payment Program (RIN: 0560-AG96) received May 2, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Agriculture.

2090. A letter from the Directors, FinCEN, Department of the Treasury, transmitting the Department's final rule — Customer Identification Programs for Banks, Savings Associations, Credit Unions and Certain Non-Federally Regulated Banks (RIN: 1506-AA31) received May 1, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

2091. A letter from the Assistant General Counsel for Regulations, Office of Housing, Department of Housing and Urban Development, transmitting the Department's final rule — Tenant Participation in State-Financed, HUD-Assisted Housing Developments [Docket No. FR-4611-F-02] (RIN: 2502-AH55) received May 2, 2003; to the Committee on Financial Services.

2092. A letter from the Deputy Secretary, Division of Investment Management, Securities and Exchange Commission, transmitting the Commission's final rule — Customer Identification Programs for Mutual Funds [Release No. IC-26031; File No. S7-26-02] (RIN: 1506-AA33) received May 1, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.

2093. A letter from the Directors, FinCEN, Securities and Exchange Commission, transmitting the Commission's final rule — Customer Identification Programs for Broker-Dealers [Release No. 34-47752, File No. S7-25-02] (RIN: 1506-AA32) received May 1, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Financial Services.