Stone, Chair of the President's Advisory Council of Postpartum Support International, says that these statistics do not include mothers whose babies are stillborn, who miscarry, or who are vulnerable to these devastating disorders which raises those at risk into the millions. The most extreme form, postpartum psychosis, is exhibited in about one percent of all new mothers.

At what should be the happiest time in a woman's life these mood disorders result in feelings of despondency, tearfulness, inadequacy, guilt and fatigue. In the worst case scenario, if left untreated or not treated properly, postpartum depression and postpartum psychosis has resulted in suicide and infanticide. The consequences of untreated maternal depression in the mother range from chronic disability to death of the infant as well as learning and behavioral disabilities that can negatively impact a child's development.

In light of all these sobering facts, sadly, I was finally compelled to author H.R. 20 in December 2007 after watching the news accounts of the missing Melanie Blocker Stokes. This bright, vibrant woman who loved life was a first time mother, a successful business woman and my constituent. Despite her family's valiant interventions, Melanie's psychosis was so severe that she slipped away and ended her life in solitary agony.

As news of her death swept throughout Chicago, I reached out to Melanie's mother, Carol Blocker, who told me her daughter's diagnosis and suicide was the result of postpartum psychosis.

And, sometime later, Dr. Nada Stotland of the American Psychiatric Association, also a constituent of mine, also reached out to me. Dr. Stotland detailed the value of additional research and discussed the under-reporting and misdiagnosis of postpartum depression and psychosis in our country.

There is no denying the fact that the need for resources to combat postpartum depression grows more and more each and every year. Here are the facts: H.R. 20 will finally put significant money and attention into research, screening, treatment and education for mothers suffering from this disease. Research indicates that some form of postpartum depression affects approximately 1 in 1,000 new mothers, or up to 800,000 new cases annually. This data does not include the additional cases of women who may be vulnerable to these illnesses even after they've miscarried or who deliver stillborn infants.

Of the new postpartum cases this year, less than 15 percent of mothers will receive treatment and even fewer will receive adequate treatment; however, with treatment over 90 percent of these mothers could overcome their depression. Every 50 seconds a new mother will begin struggling with the effects of mental illness.

Mr. Speaker, these facts are profound and, in the words of Carol Blocker, ''. . . hundreds of thousands of women, who have suffered from postpartum depression and psychosis are still waiting for Congress to act eight years after legislation was first introduced.'' Mr. Speaker, thank you for this day because, today, Mrs. Blocker and hundreds of thousands of mothers will not have to wait any longer for Congress to act! By passage of H.R. 20, today, we will put mothers first.

When this bill becomes law, my legislation will:

Encourage the Secretary of Health and Human Services to continue: (1) activities on postpartum depression; and (2) research to expand the understanding of the causes of, and treatments for, postpartum conditions.

Express the sense of Congress that the Director of the National Institute of Mental Health may conduct a nationally representative longitudinal study of the relative mental health consequences for women of resolving a pregnancy in various ways.

Amend the Public Health Service Act to authorize the Secretary to make grants for projects for the establishment, operation, and coordination of effective and cost-efficient systems for the delivery of essential services to individuals with a postpartum condition and their families.

Direct the Secretary to ensure that such projects provide education and services with respect to the diagnosis and management of postpartum conditions.

Moreover, this bill is an affordable approach to research and services. This is good policy, good politics and a good public health bill.

Before I close, I'd like to take a moment to remember and honor the hundreds of thousands of women—women who have lost either their ability to ''mother'' or, in far too many cases, their lives to postpartum depression.

Mr. Speaker, this bill, this day and this moment would not be a reality had it not been for a beautiful, young Chicago native, the late Melanie Blocker Stokes, and the valiant effort her husband and her family made to save her lift but to no avail. And, even though Melanie did not survive her battle with postpartum psychosis, Melanie's battle and her ultimate sacrifice will never be forgotten because of our efforts, here, today.

I would like to thank Carol Blocker, my friend, constituent and fellow activist, who with grace and dignity found a way for her daughter's memory to live on.

I would also like to thank all the groups who support this legislation. Groups like, Postpartum Support International, the Family Mental Health Foundation, the American Psychological Association, the American Psychiatric Association and the American College of Obstetricians and Gynecologists.

I'd also like to acknowledge the tremendous work of groups like the Children's Defense Fund, the Melanie Blocker Stokes Foundation, Suicide Prevention Action Network, Planned Parenthood Federation of America, Depression and Bipolar Support Alliance, Mental Health America, NARAL, National Alliance for Mental Illness, Community Behavioral Healthcare, the March of Dimes, The National Association of Social Workers, National Organization for Women and North American Society for Psychosocial Obstetrics and Gynecology.

I thank these groups and various activists for their relentless efforts to address this issue including calling their congressional representatives and mailing or faxing letters in support of H.R. 20. Our work will not be done until this bill is signed by the President. And, the good news is, this time we have a friend and fellow Chicagoan in the White House.

And, finally, let me once again thank the hundreds of thousands of unsung women, and their families, who have battled postpartum depression in silence or isolation, in some form, for far too long. To those women and their families I say, you will never suffer in silence again. And, with that, I proudly urge my colleagues to vote "yes" on H.R. 20.

Mr. SCALISE. I yield back the balance of my time.

Mr. PALLONE. Mr. Speaker, I ask that the bill be passed, and I yield back the balance of my time.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. PALLONE) that the House suspend the rules and pass the bill, H.R. 20, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. BROUN of Georgia. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

WAKEFIELD ACT

Mr. PALLONE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 479) to amend the Public Health Service Act to provide a means for continued improvement in emergency medical services for children, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 479

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Wakefield Act''.

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—Congress makes the following findings:

(1) There are 31,000,000 child and adolescent visits to the Nation's emergency departments every year.

(2) Over 90 percent of children requiring emergency care are seen in general hospitals, not in free-standing children's hospitals, with one-quarter to one-third of the patients being children in the typical general hospital emergency department.

(3) Severe asthma and respiratory distress are the most common emergencies for pediatric patients, representing nearly one-third of all hospitalizations among children under the age of 15 years, while seizures, shock, and airway obstruction are other common pediatric emergencies, followed by cardiac arrest and severe trauma.

(4) Up to 20 percent of children needing emergency care have underlying medical conditions such as asthma, diabetes, sickle-cell disease, low birth weight, and bronchopulmonary dysplasia.

(5) Significant gaps remain in emergency medical care delivered to children. Only about 6 percent of hospitals have available all the pediatric supplies deemed essential by the American Academy of Pediatrics and the American College of Emergency Physicians for managing pediatric emergencies, while about half of hospitals have at least 85 percent of those supplies.

(6) Providers must be educated and trained to manage children's unique physical and psychological needs in emergency situations, and emergency systems must be equipped with the resources needed to care for this especially vulnerable population.

(7) Systems of care must be continually maintained, updated, and improved to ensure that

research is translated into practice, best practices are adopted, training is current, and standards and protocols are appropriate.

(8) The Emergency Medical Services for Children (EMSC) Program under section 1910 of the Public Health Service Act (42 U.S.C. 300w–9) is the only Federal program that focuses specifically on improving the pediatric components of emergency medical care.

(9) The EMSC Program promotes the nationwide exchange of pediatric emergency medical care knowledge and collaboration by those with an interest in such care and is depended upon by Federal agencies and national organizations to ensure that this exchange of knowledge and collaboration takes place.

(10) The EMSC Program also supports a multi-institutional network for research in pediatric emergency medicine, thus allowing providers to rely on evidence rather than anecdotal experience when treating ill or injured children.

(11) The Institute of Medicine stated in its 2006 report, ''Emergency Care for Children: Growing Pains'', that the EMSC Program ''boasts many accomplishments . . . and the work of the program continues to be relevant and vital''.

(12) The EMSC Program is celebrating its 25th anniversary, marking a quarter-century of driving key improvements in emergency medical services to children, and should continue its mission to reduce child and youth morbidity and mortality by supporting improvements in the quality of all emergency medical and emergency surgical care children receive.

(b) PURPOSE.—It is the purpose of this Act to reduce child and youth morbidity and mortality by supporting improvements in the quality of all emergency medical care children receive.

SEC. 3. REAUTHORIZATION OF EMERGENCY MEDICAL SERVICES FOR CHILDREN PROGRAM.

Section 1910 of the Public Health Service Act (42 U.S.C. 300w–9) is amended—

(1) in subsection (a), by striking ''3-year period (with an optional 4th year'' and inserting ''4-year period (with an optional 5th year'';

(2) in subsection (d)—

(A) by striking ''and such sums'' and inserting ''such sums''; and

(B) by inserting before the period the following: '', $25,000,000 for fiscal year 2010, $26,250,000 for fiscal year 2011, $27,562,500 for fiscal year 2012, $28,940,625 for fiscal year 2013, and $30,387,656 for fiscal year 2014'';

(3) by redesignating subsections (b) through (d) as subsections (c) through (e), respectively; and

(4) by inserting after subsection (a) the following:

''(b)(1) The purpose of the program established under this section is to reduce child and youth morbidity and mortality by supporting improvements in the quality of all emergency medical care children receive, through the promotion of projects focused on the expansion and improvement of such services, including those in rural areas and those for children with special health care needs. In carrying out this purpose, the Secretary shall support emergency medical services for children by supporting projects that—

''(A) develop and present scientific evidence;

''(B) promote existing and innovative technologies appropriate for the care of children; or

''(C) provide information on health outcomes and effectiveness and cost-effectiveness.

''(2) The program established under this section shall—

''(A) strive to enhance the pediatric capability of emergency medical service systems originally designed primarily for adults; and

''(B) in order to avoid duplication and ensure that Federal resources are used efficiently and effectively, be coordinated with all research, evaluations, and awards related to emergency medical services for children undertaken and supported by the Federal Government.''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New Jersey (Mr. PALLONE) and the gentleman from Louisiana (Mr. SCALISE) each will control 20 minutes.

The Chair recognizes the gentleman from New Jersey.

GENERAL LEAVE

Mr. PALLONE. Mr. Speaker, again, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks on the bill.

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

There was no objection.

Mr. PALLONE. I yield myself such time as I may consume.

Mr. Speaker, I rise in support of H.R. 479, the Wakefield Act. Every year, more children between the ages of 1 and 19 die due to injury than all other forms of illness. Though we have made huge advances in our system to provide rapid interventions and transport for adults, there has been only limited focus on the specialized needs of children.

Recognizing this gap in knowledge, Congress created the Emergency Medical Services for Children grant program in 1984, which is designed to ensure state-of-the-art emergency medical care for ill or injured children and adolescents.

The bill before us today reauthorizes this vital public health care program that covers the entire spectrum of emergency medical care. It also allows grants awarded under the EMSC program to be 4 years, with an optional fifth year, which is an increase of 1 year over current law.

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I would like to thank my colleague from Utah, Representative MATHESON, for his hard work on this issue. We passed this bill out of the House of Representatives last Congress, and I urge us to pass it again this year.

Mr. Speaker, I reserve the balance of my time.

Mr. SCALISE. Mr. Speaker, I rise in support of H.R. 479, the Wakefield Act.

This legislation was introduced by Representative JIM MATHESON, and was passed by the House last Congress. The bill reforms the Public Health Service Act to improve emergency medicine services for children.

The Wakefield Act would authorize grants to States and medical schools to purchase equipment for children requiring trauma or critical care. About 31 million children and adolescents visit emergency rooms every year, and more than 90 percent of them are seen in general hospitals, not in children's hospitals that are best equipped to treat them.

The bill also requires the Secretary of Health and Human Services to support projects that are based on scientific evidence, promote innovative technology, and provide information on health outcomes, including cost effectiveness. I urge my colleagues to support H.R. 479.

Mr. MATHESON. Mr. Speaker, I am pleased to rise today in support of my legislation. H.R. 479, the Wakefield Act, which seeks to reauthorize the Emergency Medical Services for Children (EMSC) program.

Unfortunately, today the hospital emergency department has become the fundamental source of our health care delivery system for both primary and emergency care. Due to this trend, it's easy to forget that emergency medicine is actually a relatively new specialty. Emergency rooms were first established in the 1970s as medical personnel returning from the Vietnam War sought to put to use the battlefield medicine they had learned. Skills initially developed to save wounded soldiers were translated to saving victims of car crashes and trauma.

That genesis in battlefield medicine, however, failed to account for the very different physical, developmental, and physiological traits of children. By the early 1980s, doctors were seeing marked disparities in survival rates among adults and children with similar injuries.

Created in 1984, the EMSC program sought to address those disparities in children's emergency care. The program has driven fundamental changes in America's emergency medical system and brought vital resources and attention to a neglected population. Since it was established, child injury death rates have dropped 40 percent. With the aid of research and attention from the EMSC program and others, pediatric emergency medicine was developed, and was ultimately established as a separate medical subspecialty in 1992.

This year we are proud to celebrate the 25th anniversary of the EMSC program. The EMSC program provides seed money to every state and territory to carry out activities designed to improve children's emergency care. States may use those funds to ensure that hospitals and ambulances are stocked with appropriate equipment and supplies; to provide pediatric training to paramedics; to improve systems, such as transfer agreements among facilities; and much more. The program also supports the National EMSC Resource Center, an information clearinghouse that provides materials and technical support to states and institutions. The Pediatric Emergency Care Applied Research Network links pediatric emergency providers across the nation to perform research on injury and illness among children. The National EMSC Data Analysis Resource Center—based in my district at the University of Utah—assists states to collect, analyze, and utilize EMSC data.

The EMSC program's authorization expired in September 2005. In summer 2006, the Institutes of Medicine released a report entitled, ''Emergency Care for Children: Growing Pains,'' which documented both the value of the EMSC program and the gaps that remain in providing quality emergency care for all children. The report found that, although children represent 27 percent of all emergency department visits, only about 6 percent of emergency departments have all of the supplies deemed essential for managing pediatric emergencies, and only half of hospitals have at least 85 percent of those supplies. The report described the EMSC program as ''well positioned to assume [a] leadership role'' in addressing deficiencies in emergency care for

children and recommended funding the program at $37.5 million per year.

H.R. 479, the Wakefield Act, has bipartisan, bicameral support. The bill is also endorsed by over 50 organizations, including the American Academy of Pediatrics, the American College of Emergency Physicians, the American Medical Association, the Emergency Nurses Association, and many more. I would like to thank Energy and Commerce Committee Chairman WAXMAN and his staff for working with me and my staff to move this legislation forward.

Last year, the House passed this bill on a vote of 390–1. I urge every Member to support this important legislation once again—together, we can work to ensure that our nation's children have the best possible medical care during emergencies.

Mr. KING of New York. Mr. Speaker, today I rise in strong support of H.R. 479, the Wakefield Act, which will reauthorize the Emergency Medical Services for Children program for an additional four years.

Since its establishment in 1985, the Emergency Medical Services for Children program, also known as EMSC, has provided grants to all fifty states, the District of Columbia, and five U.S. territories to ensure that every child in America has access to quality, appropriate care in a health emergency. The EMSC program has improved the availability of child-appropriate equipment in ambulances and emergency departments, supported hundreds of programs to prevent injuries, and provided thousands of hours of training to EMTs, paramedics, and other emergency medical care providers.

In my home state, New York's EMSC program is working to provide ongoing assessment and improvement of medical care for critically ill or injured children. The state EMSC Advisory Committee continually meets to discuss plans for designating health care resources to optimally serve the needs of critically ill or injured pediatric patients. This Committee is currently designing a road map of resources, standards, and roles for hospitals within the state and for the statewide EMS system as a whole. The plan will improve the state's ability to bring children to the hospitals that are best equipped to treat them as well as establish a general set of interfacility guidelines.

Kids are not just small adults. Methods to treat children in emergencies vary greatly from methods used with adults in the same situations. The EMSC program is an integral part of preparing our nation's healthcare providers and giving them the tools they need to treat children in an emergency. This is especially significant at a time in our history that disaster preparedness, both due to natural disasters as well as potential terrorist attacks, is so important.

I would like to thank Representative MATHESON for his leadership on this issue, as well as Representatives CASTOR and REICHERT for their continued support. I urge my colleagues on both sides of the aisle to support this imperative bill.

Mr. SCALISE. Mr. Speaker, I have no speakers. I yield back the balance of my time.

Mr. PALLONE. Mr. Speaker, I yield back the balance of my time, and ask for passage of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. PALLONE) that the House suspend the rules and pass the bill, H.R. 479, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. BROUN of Georgia. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

DEXTROMETHORPHAN DISTRIBUTION ACT OF 2009

Mr. PALLONE. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1259) to amend the Federal Food, Drug, and Cosmetic Act with respect to the distribution of the drug dextromethorphan, and for other purposes.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 1259

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Dextromethorphan Distribution Act of 2009''.

SEC. 2. RESTRICTIONS ON DISTRIBUTION OF BULK DEXTROMETHORPHAN.

The Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321 et seq.) is amended—

(1) in section 501, by inserting at the end the following:

''(j) If it is unfinished dextromethorphan and is possessed, received, or distributed in violation of section 506D.''; and

(2) by inserting after section 506C the following:

''SEC. 506D. RESTRICTIONS ON DISTRIBUTION OF BULK DEXTROMETHORPHAN.

''(a) RESTRICTIONS.—No person shall—

''(1) possess or receive unfinished dextromethorphan, unless the person is registered under section 510 or otherwise registered, licensed, or approved pursuant to Federal or State law to engage in the practice of pharmacy, pharmaceutical production, or manufacture or distribution of drug ingredients; or

''(2) distribute unfinished dextromethorphan to any person other than a person registered under section 510 or otherwise registered, licensed, or approved pursuant to Federal or State law to engage in the practice of pharmacy, pharmaceutical production, or manufacture or distribution of drug ingredients.

''(b) EXCEPTION FOR COMMON CARRIERS.—This section does not apply to a common carrier that possesses, receives, or distributes unfinished dextromethorphan for purposes of distributing such unfinished dextromethorphan between persons described in subsection (a) as registered, licensed, or approved.

''(c) DEFINITIONS.—In this section:

''(1) The term 'common carrier' means any person that holds itself out to the general public as a provider for hire of the transportation by water, land, or air of merchandise, whether or not the person actually operates the vessel, vehicle, or aircraft by which the transportation is provided, between a port or place and a port or place in the United States.

''(2) The term 'unfinished dextromethorphan' means dextromethorphan that is not contained in a drug that is in finished dosage form.''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from New Jersey (Mr. PALLONE) and the gentleman from Louisiana (Mr. SCALISE) each will control 20 minutes.

The Chair recognizes the gentleman from New Jersey.

GENERAL LEAVE

Mr. PALLONE. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks.

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

There was no objection.

Mr. PALLONE. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise in support of H.R. 1259, the Dextromethorphan Distribution Act. This bill addresses the problem of abuse of this drug, particularly by teenagers and young adults.

DXM, as it is called, is an ingredient commonly found in over-the-counter cough medications. When taken as directed, there are hardly any side effects. However, this ingredient is often abused, particularly by teenagers and young adults, and can result in devastating health effects.

The bill amends the Food, Drug and Cosmetic Act to restrict the distribution, possession, and receipt of unfinished DXM to entities registered with the Secretary of Health and Human Services.

I want to thank my colleague Representative UPTON for his work on this important bill, and I urge us to pass this bill.

I reserve the balance of my time.

Mr. SCALISE. Mr. Speaker, I rise in favor of H.R. 1259, and I would like to thank Mr. UPTON of Michigan and Mr. LARSEN of Washington for their work on this important legislation.

Dextromethorphan, or DXM as it is sometimes called, is an ingredient found in cough medicine. This ingredient relieves the coughing associated with a cold or the flu. Cough medicines containing this drug are common and can be obtained without a prescription.

While this drug can be safe and effective if used as directed, it can also be dangerous if taken improperly. The abuse of this drug can cause death as well as other serious adverse effects such as brain damage, seizure, loss of consciousness, and irregular heartbeat.

This legislation would allow the Secretary of Health and Human Services to prohibit the distribution of DXM that is in bulk form to any person not registered with the FDA. It is hoped that these restrictions on the distribution of DXM will lower the potential for its abuse while at the same time protecting access to these needed medications.