when it passed and had been working on trying to get it renewed in this Congress. He worked in a major way on the Fair Sentencing Act that took away the disparity in crack and cocaine sentences that was wrongful.

Before he came to his position at the Leadership Conference, he was active in the NAACP here in Washington, where he was the bureau director, and he worked on other issues with the ACLU and other groups on civil and human rights.

When Wade Henderson came to the Capitol, he was a voice of conscience. He and Hilary Shelton, together with the NAACP, are two of the most conscientious men I know. They have served this country well. I will miss him in his retirement. I appreciate the remaining time he has. He is a foot soldier. I thank him for his service.

CONGRATULATIONS TO THE LIGO TEAM

(Mr. NEWHOUSE asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. NEWHOUSE. Mr. Speaker, I rise today to recognize the efforts behind an incredible breakthrough in humanity's understanding of the universe: the first detection ever of the existence of gravitational waves.

Gravitational waves are invisible ripples in the fabric of space-time. Albert Einstein theorized their existence 100 years ago as part of his theory of general relativity.

After more than a decade of work by researchers at two identical observatories—one in Livingston, Louisiana, and another in Hanford, Washington, located in my congressional district—Einstein's theory of the existence of gravitational waves has direct evidence as scientific fact.

On February 11, the Laser Interferometer Gravitational-Wave Observatory, or LIGO, Scientific Collaboration officially confirmed that the world's most sensitive instruments at these observatories had detected gravitational waves for the first time. The gravitational wave detected by LIGO's team was the result of the collision of two black holes 1.3 billion years ago.

Congratulations to my constituents and the entire LIGO team on their historic discovery, which will continue to add to the scientific understanding of the universe for generations.

THE FEDERAL GOVERNMENT'S BACKDOOR KEY TO THE IPHONE

(Mr. POE of Texas asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. POE of Texas. Mr. Speaker, Benjamin Franklin said: ''Those who would give up essential liberty, to purchase a little temporary safety, deserve neither liberty nor safety.''

A Federal judge now has ordered that Apple take an unprecedented step developing a backdoor key for an iPhone. The software that the government is demanding does not exist. It would have to be created from scratch.

The government wants the golden key to crack this phone. Such a key could be used to crack all other phones in the future. Giving a master key for the government to access any phone of any citizen at any time without their knowledge violates the right of privacy. Americans' constitutional right of privacy is under attack by the spying eyes of a powerful government.

My legislation, H.R. 2233, End Warrantless Surveillance of Americans Act, specifically prohibits the government from either mandating or requesting that a backdoor key be installed in the private phones of citizens.

Mr. Speaker, privacy must not be sacrificed on the altar of temporary safety and false security.

And that is just the way it is.

IN MEMORY OF OFFICER JASON MOSZER

(Mr. CRAMER asked and was given permission to address the House for 1 minute.)

Mr. CRAMER. Mr. Speaker, I rise to pay tribute to a hero, Fargo police officer Jason Moszer.

While in the Army National Guard, he was deployed as a combat medic to Bosnia and Iraq. Officer Moszer joined the Fargo Police Department in 2009. In 2012, he and a fellow officer were awarded the department's Silver Star Medal for rescuing two children from an apartment fire.

On the night of February 10, Officer Moszer responded to a domestic disturbance, putting himself in danger to help others, something he had done many times. On this night, however, gunshots were fired and a bullet struck Officer Moszer, causing a fatal wound.

He died the next afternoon, but not before one last heroic act. It is reported at least five people, ages 26 to 61, are being helped thanks to his donated organs.

I thank our U.S. Capitol Police officers for their service to us every day. I especially thank Officer Andy Maybo, who traveled to Fargo to represent the Capitol Police and the National Memorial Committee, which he chairs. Andy lent his expertise to the Fargo PD and planners as they prepared for a fellow officer's funeral, an event that had not occurred in Fargo in over 130 years.

God bless all the men and women who wear the badge, and God bless the memory of Officer Jason Moszer.

IN MEMORY OF REPRESENTATIVE BOB BRYANT

(Mr. CARTER of Georgia asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. CARTER of Georgia. Mr. Speaker, I rise today to remember a true civil servant and my friend, Representative Bob Bryant, who died this morning.

Over his lifetime, Representative Bryant's professional career included a variety of services in different areas. He began his career serving 2 years in South Vietnam and 10 years as an Army recruiter before retiring in 1982. He then worked 5 years as general manager for a local radio station, spent time as office manager to a local law firm, and worked 13 years for the city of Savannah, until he retired in 2001. After 40 years of service to his community, he was not done. He was elected to the Georgia House of Representatives in 2004 and was currently serving his 12th year.

I will always remember Representative Bryant, as he and I worked together to pass our first pieces of legislation in the Georgia House over a decade ago. I can truly say that he was beloved by his constituents and colleagues alike. I am deeply saddened by the loss of my friend and colleague.

I wish to extend my condolences to his family. He will be missed.

□ 1730

CARE FOR THE MENTALLY ILL

The SPEAKER pro tempore (Mr. WALKER). Under the Speaker's announced policy of January 6, 2015, the gentleman from Pennsylvania (Mr. MURPHY) is recognized for 60 minutes as the designee of the majority leader.

GENERAL LEAVE

Mr. MURPHY of Pennsylvania. 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 Pennsylvania?

There was no objection.

Mr. MURPHY of Pennsylvania. Mr. Speaker, let me start off with some sobering news. I call it the body count.

Last year, 2015, in the United States, there were 41,000 suicide deaths in this country. There were 45,000 deaths from drug overdoses. Many of those folks suffered from depression. There were an estimated 1,200 homicides by people who are seriously mentally ill. About half of all deadly police encounters occurred with someone who is mentally ill.

There is an unknown number of mentally ill who died 25 years sooner because they tend to die of chronic illnesses. There is about one homeless person per day in Los Angeles who dies. We know about 200,000 homeless people in this country are mentally ill.

It is a sad case in any numbers. But if you add those numbers up, even the most conservative version is that there were some 85,000 deaths last year related to mental illness—and it is probably much higher—and more have died from mental illness-related problems than the total United States combat

deaths of the entire Korean War and Vietnam Wars combined.

That is sobering, but it is worse. It is worse because we could prevent a large number of these mental illness problems. We could save many of those with mental illness from their early demise. We could save their families from suffering. But, unfortunately, the Federal Government is the problem.

Let me lay out this evening in this Special Order some of the particular problems that we have.

In particular, for those who are low income, Medicaid itself is one of the biggest discriminators against people with mental illness getting treatment.

First, consider this. Fifteen percent of Medicaid recipients have serious mental illness. That is far more than the general population. Serious mental illness is things like schizophrenia, bipolar illness, schizoaffective disorder, and severe depression.

Thirty-one percent of those on SSI have serious mental illness. Twenty-six percent of those with Social Security disability have serious mental illness.

In the general population, by the way, there is only about 1 percent with schizophrenia. About 2.6 of the general population have been diagnosed as bipolar.

So look at how much higher those numbers are among the poor. That makes sense. Because mentally ill people are three times more likely to have low income as a result of their mental illness. Low-income individuals are three times more likely to have mental illness, many as a result of being poor.

Poverty and homelessness are both associated with serious mental illness. Both are associated with inadequate primary care and preventative care. But here are some ways that Medicaid makes it harder for people with mental illness to get care.

First of all, there is a rule called the same-day doctor rule. If you take someone to the doctor and the internist or family physician is very concerned that person has a mental illness, they are told they have to come back another day before they can see the psychiatrist.

That is a serious problem. Because when you have the warm handoff in the doctor's office, you have 95 percent that will return versus less than half if they have to come back another day. And treatment is the key to getting better.

There is a 16-bed rule from the Institute of Mental Diseases which says that, if the hospital has more than 16 beds and you are between ages 22 and 64, we are not paying for it.

The problem with that is that serious mental illness tends to emerge in 50 percent of the cases by age 14 and in 75 percent of the cases by age 24.

So at the very time when problems are emerging, the very time when someone may have their first serious crisis that may require some inpatient care, they are told there will be no room.

Only 45 percent of Medicaid recipients with schizophrenia actually get evidence-based care. Only 35 percent of those with a bipolar diagnosis who are on Medicaid get evidence-based care.

Listen to this statistic. Ninety-two percent of low-income children and foster children are prescribed drugs off label—those are drugs that are not approved by FDA—according to an HHS Inspector General's report, and many of those prescriptions, according to the report, are done without clinical justification.

The homeless with schizophrenia have a rate of hospitalization for complications of hypertension almost twice as high as others. Fifty percent of individuals with schizophrenia are noncompliant with treatment regimens during their illness and don't adhere to medications. They need assistance in doing so.

Also, half of those with serious mental illness have at least two chronic physical health conditions, such as chronic pulmonary disease, infectious disease, cardiovascular disease, gastrointestinal problems, and these people are generally in poorer health.

So what happens is that those with serious mental illness and a number of other clinical aspects have compromised physical symptoms and we don't have a place to treat them.

We used to have 550,000 psychiatric hospital beds in the 1950s. Now we have less than 40,000. During that same time, the population of the United States climbed from 150 million to over 300 million today.

So where do people who have an acute mental health crisis go? Sadly, whether it is acute or chronic, about 200,000 of our homeless are mentally ill. Twenty-eight percent of them get some of their food out of a garbage can.

We also have a large portion of those with mental illness filling our prisons. When we closed down those psychiatric hospitals, some got better. But, basically, we traded the hospital bed for the prison cot, a blanket over a subway grate, an emergency room or a gurney or a slab in some morgue.

The incarceration rate among the seriously mentally ill is 16 percent of the population. Some 60 percent of the incarcerated may have some level of mental illness.

And then what happens in the area of violence? Well, in general, people with mental illness are no more violent than the rest of the population. But when untreated serious mental illness occurs, they are 16 times more likely to be perpetrators of violence.

As I said before, there are over 1,000 homicides a year, and we have no idea how many are victims of crime. Estimates are it is 6 to 10 times greater.

What happens if a person with mental illness is not treated? The longer a person waits for treatment for a psychotic episode, the longer it takes a person's illness to come into remission. That means it costs more.

For bipolar illness, the sooner a person starts lithium, the greater their improvement. It means it would cost less if we treated them. Delusions, hallucinations, and other severe symptoms increase the longer treatment is withheld.

As far as the costs go, the cost of schizophrenia alone far exceeds that of coronary artery disease. The mortality rates of schizophrenia are far more than breast cancer.

The costs of serious mental illness in this country are about $55 billion in direct costs and $70 billion in indirect costs, but there is also the added cost of emergency room care, added cost of primary care, and the cost of treating their other medical problems.

The deinstitutionalization move in this country is associated with much higher suicide rates, such that, while our country has made great strides in reducing mortality rates over the last couple of decades in heart disease, auto accidents, HIV/AIDS, stroke, and cancer, we have seen huge increases in suicide rates and drug overdose deaths.

As a Nation, we should be ashamed of that. As a Congress, we should be ashamed if we do nothing about this. That requires a great deal of change on our part. That means we are going to have to do something to help people with mental illness get treatment.

Half are simply not compliant and don't adhere to their medication. They get worse. Their medical problems get worse. The Medicaid bills get higher. Half of those with serious mental illness, as I said, have two or more chronic physical health conditions, and it gets worse for them.

There are several things we must do to treat this. Tonight we are going to hear from a number of Members of Congress. First, my friend JIM MCDERMOTT of the State of Washington will speak. We will talk about a number of the issues before us and what we must do in Congress.

I yield to the gentleman from Washington (Mr. MCDERMOTT).

(Mr. MCDERMOTT asked and was given permission to revise and extend his remarks.)

Mr. MCDERMOTT. I want to first begin by acknowledging Congressman MURPHY. He has taken on an extremely difficult issue. It takes courage to bring that kind of issue to the floor of the House.

More than half a million Americans with serious mental illness continue to fall through the cracks of a broken and outdated system.

As Congress begins the consideration of how to address this national crisis, it is important that we take some stock of history.

Prior to the 1960s, commitment was based on a medical model where two physicians made a determination that a patient needed treatment. I did that when I came out of the military in 1970 in Seattle.

When the first attempt at comprehensive mental health reform began in the 1960s in California, it signaled a shift from the medical model to the legal model.

Ronald Reagan had been elected Governor and was interested in reducing the population in the mental hospitals in California. The result was the Lanterman-Petris-Short Act in the California State Assembly.

This act set a new standard, making it increasingly difficult to obtain commitment to a hospital. That standard was that a patient must be suicidal, homicidal, or gravely disabled. Gravely disabled means that they can't take care of their basic needs.

I moved to California in 1968 shortly after that bill was passed to serve as the chief psychiatrist at the Long Beach Naval Station, where I saw servicemen and -women and their families. For the 2 years I was in California, I had almost no success in getting civil commitment for people that I felt were suicidal.

I was overruled by State employees charged with the duty of evaluating the need for civil commitment. The real pressure was so great on them and the court system that it was nearly impossible to get anyone into treatment in a secure facility. The hospitals in the State were quickly emptied, and literally thousands of mentally disabled people went out on the streets.

At the same time, in Congress, the mental health center movement was taking hold. The Community Mental Health Act was signed into law in 1963. The bill promised adequate funding would go to mental health centers to effectively treat most of these patients on an outpatient basis.

But things didn't go as planned. The political reality resulted in insufficient money going to the mental health system. This had a devastating effect and led to more patients wandering the streets in need of treatment.

When I finished my time in the military and went back to Washington State, I went to the legislature and saw a similar movement was occurring in my State. Remembering what had happened in California, I argued against changing that commitment standard, but the majority ruled and a similar law was passed.

As a result, we closed one of the three mental hospitals in the State of Washington—Northern State Hospital—with the assurance that the money we saved from closing that hospital would go to the mental health centers. We saved $11 million. $3 million went to the mental health centers, and $7 million or $8 million went elsewhere.

As a result, the streets of the State of Washington began to see all kinds of homeless people laying on the street and so forth. As a result, some of the most vulnerable patients were left without a support structure.

Many became homeless or were imprisoned. In the end, we simply replaced hospital beds with prison beds, as Congressman MURPHY has already pointed out. Right now there are 10 times more mentally ill patients in jails and prison than in State hospitals.

Turn the clock forward to 1979. I was a jail psychiatrist in King County, which, in effect, was the second largest mental hospital in the State. I had over 200 patients who belonged in treatment, not in jail.

This had a tremendous cost on our society. All across this country—and Washington is no different than anywhere else you go in this country—it has a human cost as well as a financial cost.

The average cost per year for a prisoner without mental illness in a jail is $22,000 a year. For a mentally ill patient who is a prisoner, the cost is more than double that, at $50,000 a year. It costs 20 times more to imprison a mentally ill patient than to provide that same patient with treatment.

These statistics are deplorable, and the process continues to remain in place across this country. There are some places that have done things on their own and made efforts to improve how they care for behavioral health patients.

In Dixon, Illinois, recently two young people died. It is a town of 20,000 people. The sheriff said: I am going to do what they are doing in Gloucester, Massachusetts, in the ANGEL program.

He made the statement to the community: Anybody who is addicted to heroin or opioids, come in. We won't arrest you. We won't prosecute. We will treat you. Twenty seven people showed up in that jail.

He said, amazingly, another thing happened. The jail was empty because crime went down dramatically. Most of those people were out committing crimes to buy drugs.

□ 1745

Now, this program encouraged those suffering from addiction to go to the police, where they would be directed to drug rehabilitation and not prosecuted. Since then, many individuals have had effective treatment.

We need to treat addiction as a disease state and not as a criminal offense or some moral failure. And the same is true with mental illness. A comprehensive mental health reform bill would go a long way to that effort.

Now, out on the floor here, again and again, we pause for a moment of silence. Some awful thing has happened someplace in this country, in my city, in 25 cities across this country, and we stand here for 1 minute and commemorate the tragedy with a moment of silence. After that pause, we do nothing.

Virtually all mentally ill patients are more likely to be victims of violent crimes rather than perpetrators, and we must recognize there are tragic situations that can be prevented with treatment and early intervention.

I understand—I have been involved in this my whole professional life—that the most contentious issue is whether or not the society has a right to detain a citizen and treat them in the most medically effective way.

Many fear a return to the indeterminate confinement of people like in the 1960s. I saw that in Chicago when I was in medical school. None of us want to see that happen—not me, most of all. But certainly no one on this floor wants that to happen in this society.

The balance between personal liberty and the needs of a society is a challenging one to strike; but difficult as it may be, we have to rise to that challenge. That is why I commend Congressman MURPHY for bringing it out here and beginning the debate that ought to go on in this society.

If a mentally ill person is a danger to themselves or others, there needs to be an ability to commit that person long enough for the treatment to take effect. We need to listen to those who know the patient best. In many cases, it is not their doctor.

We often hear stories from families who have tried desperately to get treatment for their loved ones, or from police officers who have tried desperately to get treatment for people. We, as doctors, can't possible make the best assessment without hearing from family, friends, and those who live with patients and play an integral role in their lives.

Giving patients and families the help they need will dramatically improve and even save lives. That is why we need to work together, on a bipartisan basis, on a bill that Mr. MURPHY has brought out.

Is it a perfect bill? No, but it is a bill from which we can work and reach an agreement to try and help the needs of our society. We have had enough moments of silence on this floor. It is time to act.

Mr. MURPHY of Pennsylvania. I thank Dr. MCDERMOTT. He has been, really, a champion of mental health issues in his career and on this bill as well.

I want to point out, the bill he is referring to is our Helping Families in Mental Health Crisis Act, H.R. 2646. It is bipartisan. It has 183 cosponsors today—50 Democrats, the rest Republicans—because we all recognize that when you are dealing with someone with mental illness, in the 40 years that I have practiced as a psychologist, I have never once asked any of my patients what party they are.

We know that mental illness affects people regardless of gender or race or age, certainly not by party.

We also know, however, that getting care is tougher. Studies have said that if you are Black, your chances of getting treatment for your mental illness are even tougher. In fact, in Los Angeles County, 9.6 percent of the population is Black, and yet they constitute 31 percent of the L.A. County jail prisoners, and they have a lower likelihood of getting psychiatric medication.

Although most crimes committed by people with mental illness tend to be nonviolent, after they have repetitive incarcerations, they tend to serve four times longer sentences when they are

mentally ill than someone who is not. So that is what we mean when we say we have filled our prisons and we have increased our costs with this.

I yield to my friend, the gentleman from Arkansas (Mr. HILL), to also talk about the things we need to do and our problems with mental illness.

Mr. HILL. Mr. Speaker, I thank Congressman MURPHY for this time and for bringing this issue to the floor of the House. I thank my friend, Mr. MCDERMOTT, from Washington, for his views.

Congressman MURPHY's bill opens a bipartisan conversation on how best to address the challenges that have been facing mental health services and our citizens in this country for decades.

President John Kennedy implemented a groundbreaking, community-based treatment model for individuals with mental health illnesses. However, in the decades following his service, the Federal Government has missed opportunity after opportunity to effectively address the needs of Americans with mental illness. Over the years, we have seen our prisons, our hospitals, and our homeless shelters bear the brunt of providing services for our Nation's mentally ill.

One-third of the homeless are mentally ill, some 200,000. Sixteen percent of incarcerated Americans, some 300,000, have mental illness. And mental disorders are some of the most costly health conditions we face in our country.

As noted, many of our incidents of mass violence have mental illness as a factor. Now most States still rely on the standard of imminent danger for commitment of mentally ill individuals. This is, in part, a result of past Supreme Court decisions, most importantly, in 1975, O'Connor v. Donaldson, which has been used consciously many times to oppose involuntary commitment and argue that committing individuals who are not imminently dangerous to themselves or others is unconstitutional.

Congressman MURPHY's bill, the Helping Families in Mental Health Crisis Act, holds our Federal agencies accountable and requires that our States follow evidence-based practices that have proven to reduce hospitalization, homelessness, and violence.

This bill also provides alternatives to institutionalization for Americans with severe mental illness; and for those that need to be institutionalized, it requires States to include need-for-treatment commitment standards in their civil commitment laws in order to remain eligible for certain Federal block grant programs. This will help clarify commitment standards for our States and will ensure that we no longer wait until it is too late to potentially commit dangerous individuals and those who need help.

It is important that we seize this opportunity for future generations of Americans, and I commend my colleague for his leadership on this important issue.

Mr. MURPHY of Pennsylvania. I thank the gentleman so much for his kindness and his support for this legislation.

As has been said, whenever one of these tragic killings occur or when some tragedy occurs, we have our moment of silence, and then we do nothing.

We have a chance to do something. America demands it. I know that the overwhelming majority of Americans expect us to do something more than talk about it, particularly when so many family members are struggling.

As we closed many of these institutions, what we ended up with is families themselves being the ones that are being told, here's your son, your daughter, your brother, your sister, your mother or father; go take care of them. By the way, we are not going to give you much information on them. We are not going to provide you much support, unless that person, indeed, is a danger to themselves or others.

I have heard from many family members that they have called the police when they have had troubles at home, struggling.

By the way, with mental illness, when someone's out of control, we call the police. With other illnesses, you call paramedics because we recognize that that is a disease that needs help, like when someone is having a heart attack or something else. But with mental illness, out of our fear, out of our stigma, or other things, we call the police, and the police are oftentimes not fully trained to do this. Then we tell the parents, well, good luck, and take care of them. We are not going to give you much information.

That whole grand experiment of closing down the hospitals, which those asylums needed to be closed down, but the stopping institutional care and stopping all treatment, that whole process has actually shown more failures than successes, especially when we have not provided community-based treatment.

We provide treatment for so many other diseases, but when it comes to mental illness, we fall far short. And we somehow have this idea, this misguided and self-centered and projected belief of our own, that people are at all times fully capable of deciding their own fate and direction, regardless of their deficits and diseases, and that the right to self-decay and self-destruction overrides the right to be healthy.

But remember what I said earlier about people with severe mental illness and having so many other chronic illnesses and somehow going into the slow-motion death spiral, we walk right by and pretend that that is okay. It is not, and it shouldn't be. Somehow, in so doing, we comfortably abdicate our responsibility to action and live under this perverse redefinition that the most compassionate compassion is to do nothing at all.

It further bolsters those most evil of prejudices we have that the person with disabilities deserves no more than what they are. We will leave it up to them. Under that approach, there are no dreams; there are no aspirations; there is no goal to be better that can even exist. Indeed, to help a person heal is some head-on collision with this bigoted belief we have that the severely mentally ill have no right to be better than they are, and we have no obligation to help them.

This is the corrupt evil of this hands-off approach and, in some cases, the antitreatment model and the things that we have lulled ourselves into, this somnolence where we become comfortable with crossing the street or stepping over a homeless person, when we fear those, when we hear the title, the term, ''mental illness.'' It is this perversion of thought embedded in the glorification that to live a life of deterioration and paranoia and filth and squalor and emotional torment trumps a healed brain and the true chance to choose a better life.

What a sad state of affairs our Nation has to become easy with that, and what a sad statement it is about this Congress for taking so long to take action on this. I don't know how we look ourselves in the mirror and continue to delay this.

A number of my colleagues also feel very strongly about this issue of mental health. I yield now to the gentleman from Louisiana (Mr. ABRAHAM) to take a few minutes to talk about his perspectives of what we need to do with mental health.

Mr. ABRAHAM. Mr. Speaker, I want to first say thank you for Dr. Murphy's persistence and determination for bringing this legislation to this point. It has been an act of love on his part, and I greatly appreciate it.

Dr. Murphy, also, great thanks for your continued work with our men and women in uniform in the mental health field as you continue to do today. It is much appreciated.

As a family doctor in rural Louisiana, I have witnessed firsthand the hardships mental illness can put on families, individuals, and friends. I am sure every American has a story of how someone that they know and love has been affected by mental illness. It is not a partisan issue, as has been said here just recently.

Thankfully, the study and treatment of mental health has improved dramatically in the last 50 years, leading to better outcomes and better lives. But, as our knowledge of mental health improves, we must routinely ensure that our government is keeping up.

It has been over 15 years since Congress last passed comprehensive mental health reform. During that time, the size and authority of our Federal mental health bureaucracy has grown to the point where the amount of coordination required to function effectively is too immense.

How much has it grown?

A recent report from the independent Government Accountability Office

found that there are now a total of 112 Federal programs intended to address mental illness—112. As you can imagine, the report also found that there is serious fragmentation and lack of coordination among these programs.

As history continues to prove time and time again, when the size of bureaucracy increases, the effectiveness decreases; but when mental health bureaucracy fails, it fails individuals, it fails families, and it fails communities.

Unfortunately, the President's solution this year is to throw more money at the problem and increase the bureaucracy. His 2017 budget proposes to add $500 million in mandatory spending to the same Federal programs that have been proven to be inefficient, uncoordinated, and inadequate. This is a shortsighted response to a long-term challenge. We must do more than throw money at a problem and hope for a solution.

Congressman MURPHY's Helping Families in Mental Health Crisis Act has taken inventory of these Federal programs. It refocuses the programs that work and removes the ones that don't, greatly increasing program coordination across the Federal Government. This is only one of the many reasons why I have cosponsored this comprehensive bill, and I welcome rigorous debate on this floor on the rest of the bill's merits.

□ 1800

Finally, I thank again Dr. Murphy for his dedication and leadership on this mental health issue. The time, effort, and attention to detail that he has put into this comprehensive reform bill is what the American public should expect from elected officials. I strongly encourage and support his efforts.

Mr. MURPHY of Pennsylvania. Thank you, Doctor. I appreciate your comments and your support for this bill and, of course, your practice in the field and understanding our needs.

A couple of points you made there I want to elaborate on. You said that there are 112 Federal programs identified scattered across 8 departments that deal with mental health. There are 26 programs for the homeless.

But many of these programs have not met since 2009, and according to the General Accounting Office report, it is uncoordinated. A patchwork quilt would be a compliment because a patchwork quilt is at least stitched together and our mental health approach is not.

Part of this bill is to create an office for the Assistant Secretary of Mental Health and Substance Abuse Disorders. That doctor would then be charged with meeting regularly with these programs and agencies to get them to work together.

Where there is unnecessary redundancy, get them to merge. Where there is exemplary programs, let's expand it. But, above all, get treatment back to the States and back to the communities where they can do the most good with evidence-based programs that work.

I will elaborate more on these in a minute, but first I want to call upon my friend, CHRIS GIBSON, from New York for a few minutes.

Mr. GIBSON. Mr. Speaker, I want to thank my friend and colleague, Dr. Murphy, for organizing this Special Order, but also for his strong leadership in an area that is so important to all Americans. I also want to thank him for his service to our Nation.

Indeed, I rise to give a voice for so many of my constituents who are calling on this House to strengthen Federal mental health policies.

I think this is important not only in terms of these policy changes that we are talking about this evening, but, quite candidly, also about the mindset. I think we need to think about this issue area differently.

Misconceptions out there, I hear this often from my constituents, how we need to change the way that we think. Too often we think of mental health as a permanent state, that individuals are either well or not well, when, in fact, what we have learned is that, over the course of our life, mental health is really a spectra. Sometimes we are flourishing, and sometimes we are challenged.

For me, this is certainly a personal issue. My closest adviser is my beautiful wife, Mary Jo, who is a licensed clinical social worker. I get the benefit of her counsel on a regular basis.

I also look to Dr. Murphy as somebody who has spent over 40 years in this field. I also want to thank GRACE NAPOLITANO, who is also a leader of the Mental Health Caucus. I have worked together with her as we push forward these very important initiatives.

I want to say that I do think we have made some progress. In a moment here, I will talk about some of the details of that. I think that we are making some progress particularly with neuroses, anxiety, and to some degree, depression.

But, candidly, we are not making progress at all with regard to policy when it comes to very severe mental health issues. In part, Dr. MCDERMOTT addressed this earlier.

We know that, in the 1960s and the 1970s, there were a series of exposes, very severe issues that were going on in our psychiatric hospitals. Consequent to that we went through a process of deinstitutionalization.

But we have learned that, when we did this and put nothing in behind it—and I certainly can understand a lot of abuses that were going on and understood the need to take action to roll back and to really make sure that we don't have those abuses.

But what we have learned is that it was a mistake not to put policy in behind that. We see this all the time. It has been mentioned already this evening, the issues with homelessness, the issues with mass violence.

Inasmuch as we know most with very severe mental illness are not violent, we also know that, when we have these very tragic events, that, at times, these are correlated with severe mental illness without Federal support, without any support. So that is part of the calling for this evening.

The American people want to know: Is our Congress listening? We are listening. That is part of the reason why Doc has organized this tonight to express this to the American people, that we know this is a very important priority.

I want to provide some overview of some of the actions we have taken. First of all, last year I was at the White House when the President of the United States signed into law the Clay Hunt suicide awareness and prevention bill.

Corporal Clay Hunt was a great American hero. He served our country very honorably and courageously in Iraq and Afghanistan and lost his life to mental health disease. His family has taken up the standard and are working really hard to move us forward on that.

This bill that the President signed into law last year—a very bipartisan bill—is going to help strengthen mental health support for our servicemen and -women and our veterans.

Likewise, the James Zadroga 9/11 healthcare bill for our first responders also includes a provision in there that strengthens mental health. So we are supporting our veterans, and we are supporting our first responders. These are important bills that have been enacted into law.

We have also passed in this House an important bill called the Female Veteran Suicide Prevention Act, and we are calling on the Senate to pick this up so that we can also send that to the President.

While we have made progress in some of these areas, we have much more to do in so many other areas. I want to talk about the Mental Health in Schools Act.

I think this is a very important and certainly a challenging period in the lives of Americans in the teenage years and so many emotions all going through. We need to provide support.

What we have found in some pilot programs in New York is, when we have social workers in schools, this absolutely stems incidences of drug abuse and crime because we are dealing with this in the area where we really need that support: mental health.

We have a bill that will address this that will scale that, and I hope that we can get more support here in the House.

In addition to our teenagers, I also have a bill that helps with our senior citizens. It is a very simple bill. It basically just adjusts Medicare so that, for seniors looking for counseling, they will get that support.

Finally, of course, the bill that we are all rallying around tonight, H.R. 2646, the Helping Families in Mental Health Crisis Act—I think we have

heard about some of the important dimensions of this bill.

I just want to highlight the fact that I think that this bill is going to help us with the very severely mentally ill, particularly those suffering from psychosis.

We have heard tonight how we have a shortage of inpatient care. We have got to address this because, if we don't address it, we end up seeing it in the penal system. That is absolutely the wrong approach to this, and it is costing the taxpayers as well.

So, in addition to that, we see more coordination among agencies and suicide awareness and prevention programs strengthened.

So, Mr. Speaker, I will close with this. This is a very important issue, and the American people are counting on us to take action. I think we have got a series of bills that we can rally around—bipartisan bills—that will truly make a positive difference.

So let me end where I began and just thank Dr. MURPHY for his great leadership and call upon my colleagues to support his bill and these other bills as we move forward.

Mr. MURPHY of Pennsylvania. I thank my friend from New York in his ongoing support for these issues dealing with mental illness.

Now I would like to call upon my friend from the State of Oregon, EARL BLUMENAUER, who has been a great champion on these issues as well. Many times we have conversed about this. I appreciate my friend's guidance and support on this issue.

I know your heart is in this and you are dedicated to it.

Mr. Speaker, I yield to Mr. BLUMENAUER.

Mr. BLUMENAUER. I appreciate your courtesy in permitting me to join you this evening, and I appreciate the conversation that we have had.

Dr. MCDERMOTT's experience in the 1960s and 1970s really touched me. I started in my political career when I was much smarter than I am now and was part of the deinstitutionalization movement in my State of Oregon, where it was quite clear that we could provide better quality services that were less intrusive and more cost-effective through a program of deinstitutionalization. It made perfect sense on paper.

What happened—and, luckily, karma intervened. I was a local official when it hit full force. The commitments that had been made to help with medication, to help with housing, to help with counseling, and to be able to provide the support services weren't ironclad guarantees.

It was easy for subsequent legislators to erode them, and people were out on their own. This was a process that took place across the country, and we have seen the impact, as Dr. MCDERMOTT mentioned.

I really appreciate you sinking your teeth in here to bring this forward. There are some elements that are clearly controversial. I have found over the course of 2 years that we have been talking about this a willingness to engage in conversation and to be open to refinement because we are all seeking the same objectives.

One of the things that has just become clearer and clearer to me is that there needs to be stronger provisions to deal with assisted outpatient treatment programs. We used to call it involuntary commitment.

It strikes me that we would not have a cancer patient just sort of cast loose on their own to sort of fend for themselves.

But we have some of the most vulnerable members of society, in many cases, who are not capable of fully comprehending the situation they are in.

In fact, in some cases, part of the illness they suffer from is that they don't think that they are sick, that we make it much more difficult than it should be, in some cases, impossible, for people who care about them most to be able to participate in treatment.

I appreciate your willingness to work with us to strike the balance.

I see this as part of a much larger movement. In my community, we are finally opening a facility this fall to get people with mental problems out of emergency rooms, where they actually can't be treated. They can just be warehoused at, actually, great expense and risk to the employees in the emergency room.

I am convinced that, if we are able to work together to tease out the expenses—Dr. MCDERMOTT talked about how incarcerating people and treating them behind bars, where so many people with mental illness end up, is 20 times more expensive than treatment.

Being able to hit that sweet spot, to be able to balance treatment, to be able to have intervention with appropriate safeguards, to empower the families, and to be able to help people on a path to treatment like we would do with any other illness is very, very important.

I would hope that we would be able to continue this conversation. I hope that there will be other Special Orders where we have a chance to involve people who want to explore and maybe refine some of these elements, to be able to answer questions about the necessary protections and have the give-and-take that sometimes is hard to do when we are in sort of a formalized setting.

I have appreciated your willingness to tackle tough issues, to be open to suggestions, to be willing to engage others, but, most importantly, that this Congress not go home without having legislation to meet our responsibilities to refine and focus our mental health programs to get more out of the resources that we have, to provide new tools for families, and I think build on a foundation.

I think the bill that you have introduced is a great start. I am encouraged that you have sparked a very robust conversation and that there are other bills that are moving forward. But I hope we can build on this to be able to get across the finish line.

I look forward to continuing our conversation, whether it is here tonight, in another evening, or with our colleagues, to make sure that we are doing what we should do to correct a situation that is a national tragedy, that is unnecessary, that is wasteful and inhumane.

Mr. MURPHY of Pennsylvania. I thank the gentleman for his comments.

I will add to that in the sense that about 10 people per hour die related to mental illness, and it is probably much more than we know of.

I thank you for your good counsel, too. I may have been doing this 40 years, but I have a lot to learn in the field of mental health.

I have learned a great deal from colleagues and from people like Paul Gionfriddo of Mental Health America or the leaders of the American Psychological Association, the American Psychiatric Association, and from Fuller Torrey. There is a whole host of names in this country who continue to write about and talk about this and show us research on this.

Osteopaths, physical therapists—you name the field—and social workers are out there talking about the problems that we have with this. You are right. It is the most compassionate thing to make some changes on this.

I know one of my colleagues who is also in the Energy and Commerce Committee with me, SUSAN BROOKS, would like to comment on this as well and talk about our needs now, what we need to do in mental health.

Mrs. BROOKS of Indiana. I want to thank the gentleman from Pennsylvania, Dr. MURPHY, for introducing this important legislation and arranging for this Special Order today.

As I am sure it has already been stated, one in five Americans struggle with mental illness. One in five. This is a critical situation in the country, as we have just heard, a national tragedy.

That is why we must address it with a comprehensive, community-based, mental health care proposal like the one we are talking about here today, and we must do it in a bipartisan way.

So I am very pleased that we have colleagues from the other side of the aisle here as well this evening talking about it.

We have all seen the tragic headlines about people who lose their battle with mental illness and their families who are often powerless to help them or prevent them from harming themselves or others.

According to researchers, about half of the people with schizophrenia and 40 percent of people with bipolar disorder don't believe they are mentally ill. These individuals have the right to refuse therapy and medication, and under current law, their families are only able to intervene when their condition becomes suicidal or extremely dangerous.

So in practical reality, my young adult children in their 20s, if they struggle with serious mental illness, I could be completely shut out from their diagnosis and treatment, unable to help them before their condition became completely debilitating.

□ 1815

As a mother, as a parent, this is heartbreaking. It is further evidence that something has to change. We have all talked to too many families, whether it is at ceremonies remembering their lives when they have taken their lives or when they have overdosed. That is too late. This bill is important for all parents in America, the loved ones, the family members who desperately want to help but are unable to do so.

But it is also important to every American regardless of whether or not they have a personal connection to mental illness. It is critically important when we look at our criminal justice system.

Sixty years ago—and I think we talked about this a little bit earlier—there was one psychiatric bed for every 300 Americans. Fast-forward 50 years later, that number has shrunk to one psychiatric bed for every 3,000 Americans. Today, it is even less. The people, as you have mentioned, who work in our emergency rooms and in our criminal justice system are paying the price. Those people who work there are paying the price.

The National Alliance on Mental Illness estimates that between 25 and 40 percent of people with mental illness will be jailed or incarcerated at some time in their lives. I am a former criminal defense attorney and a prosecutor. I can tell you not with respect to treatment, but dealing with them, either if they had been arrested or if we needed to prosecute them, I have seen the statistics—and these are real people.

Our courts, jails, and prisons are full of people with mental illness. Most of them are not getting the treatment they need. In our State prisons and local jails, more than half of the women and three-quarters of the men have at least one mental health diagnosis. In Federal prisons, about half of all inmates, regardless of gender, struggle with some form of mental illness.

We must reform the way we care for and treat people with mental illness. We can't rely on the prisons and jails to serve as the de facto mental health institutions that they have become, and we must make families the partner to ensure that patients with serious and debilitating illness can maintain a comprehensive regimen of care.

I applaud the work of my colleague, Dr. MURPHY, the only psychologist serving in Congress, for his leadership and for crafting the Helping Families in Mental Health Crisis Act, H.R. 2646. I am not going to go through all of the proposals because you have so many people. I am so pleased that you have people. I am sure that you have talked about all that is in the bill.

But I must say, I urge my colleagues to join us in supporting this proposal. It does focus on the programs that will help families and patients. It will improve that connectivity between primary care doctors, mental health professionals, and the patients and families. It will help with the existing shortage of in-patient psychiatric beds. It will bring accountability to programs like SAMHSA, to make sure that their resources are being used in the most effective and consistent way for patients.

I just want to applaud Dr. MURPHY and all of those who care deeply about mental illness, because I don't want to go to more of these ceremonies of family members who are remembering their family members who have died from suicide or who have died from an overdose. Thank you for your work.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I thank my friend, Mrs. BROOKS.

I might say that we have all heard those stories from families. I am sure there are families watching tonight, Mr. Speaker, who will consider contacting a Member of Congress and share that story as well. Nothing is more painful than to hear the story of a parent like you described, a nightmare of a parent to be told that their child has a problem and there is nothing the government will let them do about it. How difficult that must be.

While waiting for my other colleague, DOUG LAMALFA, of California, to come forward, I want to mention a couple of things on the bill that have been referenced.

As I said before, the bill has an assistant secretary for substance abuse and mental health disorders that would organize the programs. It would drive evidence-based care for programs such as response after an initial schizophrenic episode, assisted outpatient treatment, and assertive community treatment, or programs like the National Child Traumatic Stress Network, which is an exceptional program. It is a government-funded program that does exceptionally good, high-quality work.

We know that we have to build a mental health workforce to take care of our extreme doctor shortage. There simply aren't enough psychiatrists, psychologists, or clinical social workers. When we have 9,000 child and adolescent psychiatrists, we need 30,000. We have too few clinical psychologists and others who want to work with those with serious mental illness.

As I said earlier, we have to fix the shortage of mental health beds, places that treat people who are in crisis, instead of putting them in jail, sending them back on the street, or strapping them to a gurney in an emergency room, giving them a five-point tie-down and some chemical sedative. We have to eliminate that same-day doctor barrier which says you can't see two doctors in the same day. We have to empower parents to be part of the treatment plan, because right now they are still harnessed and kept away from them.

I yield to the gentleman from California (Mr. LAMALFA) for some of his comments.

Mr. LAMALFA. Mr. Speaker, I thank Dr. MURPHY. I really appreciate him holding this Special Order, his dedication, and his persistence in moving this issue along. It is very important because mental health is an issue that is getting more and more rampant in our communities.

We really have some challenges in northern California with it and the lack of available treatment. I just had a doctor visit my office yesterday from Siskiyou County who, had she had this ability, had that county had these resources available in the way that your bill prescribes, tragedy would have been prevented with an attempted suicide and a suicide that actually happened in that same family. It is really inexcusable after a point that we are not able to channel the resources and have the effectiveness of the program that you are seeking.

Previously, in Nevada County, California, we witnessed a devastating shooting at a nearby health clinic that took the lives of three individuals back in 2001. The shooter, who suffered from mental illness, had repeatedly refused treatment, despite his family's best efforts to get him help. This is where the system, again, is broken.

Outdated laws leave individuals suffering with severe mental illness to fend for themselves, only to have intervention step in when it is too late. Does it really take an attempted suicide, does it really take a drug overdose, to get attention, instead, when people that have this and know about these triggers would be able to get them the help they need with the right implementation? We need to break down those barriers and provide that pathway.

The Assisted Outreach Treatment program, for example, helps patients and families experiencing severe mental health issues to get the treatment they need before a crisis occurs. Patients are able to live at home and meet their therapist on a regular basis while having access to lifesaving medications. Success rates are testimony to the effectiveness of the program in terms of compassion and effectiveness. Again, in one of my counties, Nevada County, where this program is in effect, hospitalization was reduced 46 percent, incarceration reduced 65 percent, homelessness reduced 61 percent, and emergency contacts and emergency needs reduced 44 percent.

Of the patients who entered the program overall, 90 percent said it made them more likely to keep their appointments and take their medication, and 81 percent said it helped them get well and stay well. This is what it is all

about: to give them hope and to put them in the mainstream of society where they can function well and be successful. Forty-nine percent fewer abused alcohol, 48 percent fewer abused drugs.

Yet, instead of investing in programs such as this, we continue to spend billions on duplicative behavioral wellness programs that allow far too many Americans to fall through the cracks.

We have got to do more to care for our neighbors in this country. I rise today in support, and I am proud to be a cosponsor of the gentleman's legislation. We cannot stand by anymore and allow the status quo because, as we know too well, the cost of inaction is too high for those who suffer from it and for the families and the communities. This is going to be very effective in helping to channel that and having a success we can all be proud of.

Thank you for the time and for your persistence.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I thank the gentleman for his support.

While waiting for my friend JOHN KATKO of New York to come forward, I want to reflect on how long it has taken us to do this.

What we used to do up through the 1800s is just throw people in jail. Then along came an activist by the name of Dorothea Dix, who saw the abysmal conditions in our prisons for the mentally ill, saw them chained to walls in squalor and filth, beaten and abused. She spoke up to have institutions built that would be better respites for them. Indeed, that took place for awhile, but then they became overcrowded, and that was part of what we shut down.

As my other colleague talked about, Mr. BLUMENAUER mentioned that then we thought, well, we have other outpatient care for them. That promise never came through.

This legislation would, as I mentioned before, allow us to have more providers in psychology, psychiatry, social work. It would also merge the mental health and substance abuse dollars to allow States to use both. We have got to be treating mental health and substance abuse dollars, not to cut either one, but to make sure that a person with substance abuse disorder and mental illness can be treated.

It would bring accountability of spending Federal funds for grants. Our bill would establish a national mental health policy lab within SAMHSA, Substance Abuse and Mental Health Services Administration, and set scientific objective outcome measures.

It would also have an interagency serious mental illness coordinating committee, which could coordinate the Federal spending in mental health and make suggestions to the Assistant Secretary's office and to Congress and bring together government offices with experts in the field to develop reforms in the mental health system.

We want to have alternatives to institutionalization and jail diversion. Assisted outpatient treatment is one version; assertive community treatment is another one. We are making sure that we provide the wraparound services for the mentally ill person instead of dumping them into jails and leaving them there only to get worse. And we want to advance early intervention and prevention programs, where this bill establishes most of its funding there to make sure we have those programs.

I yield to the gentleman from New York (Mr. KATKO), someone whom I have also gotten to know pretty well over this bill, with his own passion for this issue as well.

Mr. KATKO. Mr. Speaker, I thank Dr. MURPHY.

I rise today to talk about one of the most serious challenges facing our country, and that is the mental health issue. It is a problem that affects the rich and the poor, old and young, employed and unemployed. It can strike anyone.

For far too long, the issue of mental health has stayed in the shadows in our country. If we want to directly face the challenges that the American people face in their everyday lives, we cannot allow the silence to continue. That is why I so enthusiastically support your bill, Doctor.

A short time ago, I met with some of my constituents in upstate New York that were part of a drug treatment, education training, and rehabilitation program. One of the individuals told me of his personal battle with mental health.

About 10 years ago, his sister died of cancer, and his marriage broke down soon thereafter. He couldn't sleep because of the trauma and stress, which led to anxiety and depression, and he didn't know what to do. As he was doing yard work one day, someone he knew walked past and said he could provide something to help him sleep. It was heroin. He tried it. Pretty soon he was hooked, and his life was ravaged for years and years. In fact, it took 7 years of him being pushed to the brink by drugs for him to seek help—7 years, 7 lost years.

Six years later, he has found paid work, probably for the first time since his addiction. He told me that if we lived in a culture where the trauma of grief and the need to get help for mental health problems were more clearly recognized, things could have been much different for him. Just think how much better it would have been for him and think how much better it would have been for others in the country.

The reality is that, for many people today, mental health is a huge issue. With the awareness of the mental health issue increasing, I fervently hope that the acceptance and understanding of the individual suffering from it will as well.

We cannot prevent all mental health issues. There are no cures for all conditions. But we can help the culture change in our country. This bill goes a long way towards doing that, and I commend you for that, Doctor.

We can insist that everyone counts and that everyone matters and that no one dealing with any form of illness should ever feel ashamed. That is how you bring real change to America.

Before I close, I want to note that the second leading cause of death among individuals 24 years or younger in this country, as the doctor well knows, is suicide. The 10th leading cause of death in this country for all adults is suicide. It is an epidemic. It is not treated as such in this country, and it is high time that we do so.

For every suicide in this country, there are 12 suicide attempts. Think of the costs to our society. Think of the costs and the burdens on families, the burdens on the health industry who have to deal with this. We must do a better job, and we have to do a better job.

That is why I am proud in my district that soon after I was elected last year, we formed a mental health task force. We are enthusiastic about a lot of things and a lot of changes it is going to bring about, but there is nothing we are more enthused about than this bill.

Doctor, I commend you for this. I hope that we get this passed in the House, and I hope we get this bill moving once and for all.

Again, I commend you, Congressman MURPHY, for your steadfastness on this issue.

Mr. MURPHY of Pennsylvania. Mr. Speaker, how much time do I have remaining?

The SPEAKER pro tempore. The gentleman from Pennsylvania has 2 minutes remaining.

Mr. MURPHY of Pennsylvania. I yield to the gentleman from Indiana (Mr. BUCSHON).

Mr. BUCSHON. Mr. Speaker, I am here to support Dr. MURPHY's tremendous work in the area of mental illness. It shows that one person really can make a difference. Dr. MURPHY is leading the charge for our country to change the way that we deal with our mental health programs.

I have got direct experience with this. I have a high school friend who suffered from schizophrenia and eventually lost her family as it is related to that. I have had two high school friends who suffered from severe depression and ended up suicidal and subsequently did take their own lives.

This is critical legislation. With people like Dr. MURPHY working hard to get this done, we really can make a difference on behalf of people with severe mental illness in our country.

I commend you, Dr. MURPHY, for the strong work. Continue to push. I am hopeful we can get this through the House of Representatives this year.

Mr. MURPHY of Pennsylvania. Mr. Speaker, let me close with these statements.

With 60 million Americans out there with some form of mental illness this

year and 10 million or so with severe mental illness, they all have families. I hope those families wake up and speak up. I hope they contact their Member of Congress.

I know that mental illness can be treated, but it cannot be treated if we ignore it and it gets worse. I don't want more tragedies here. I hate to wish any of these tragedies on my colleagues in Congress, but I know it will happen. We will be here again for moments of silence. We will have more Members that face this suffering in their own families and in their communities, and we should not allow that.

I hope that soon we can call forth H.R. 2646, the Helping Families in Mental Health Crisis Act, because to delay it is to cause more harm, to deny it is to cause more death. Let's finally do something to help turn this problem around with mental health in America.

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

□ 1830

WOMEN'S RIGHTS ARE HUMAN RIGHTS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 2015, the gentlewoman from New Jersey (Mrs. WATSON COLEMAN) is recognized for 60 minutes as the designee of the minority leader.

GENERAL LEAVE

Mrs. WATSON COLEMAN. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and to include extraneous material on the subject of my Special Order.

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

There was no objection.

Mrs. WATSON COLEMAN. Mr. Speaker, next Tuesday the Supreme Court will take up Whole Woman's Health v. Hellerstedt, which is a case that challenges Texas' outright offensive effort to strip women of their right to choose.

Last night the Fifth Circuit Court of Appeals allowed a similar law to move forward in Louisiana, all but guaranteeing the closure of three of four abortion clinics in that State unless the Supreme Court intervenes there as well.

The men who have passed these laws—to be very clear, the Texas State Legislature is 80 percent male, and Louisiana has just made it up from dead last this year at 85 percent—claimed that it would increase the medical accountability and safety of facilities that provide abortion.

That is the new message, the new veil, that covers these laws with the air of legitimacy: We want to make your abortion safer. So every doctor needs to have admitting privileges at a local hospital and every clinic needs to function like an emergency center.

It sounds logical until you hear what the folks behind these laws have to say after the laws have passed.

In Texas, then-Governor Rick Perry said: ''The ideal world is one without abortion. Until then, we will continue to pass laws to ensure that they are as rare as possible.''

One of the authors of the bill said that she was especially proud that ''Texas always takes the lead in trying to turn back what started with Roe v. Wade.''

The first problem here is the same one we have dealt with over and over and over and over again, because Roe v. Wade isn't something you turn back. It wasn't an executive order. It wasn't even a law passed by Congress.

It was a legal challenge 40 years ago that required the Supreme Court to consider whether or not women had the right to make decisions about their bodies. They decided and set a precedent that every woman in this Nation had the constitutional right to an abortion.

What is more, the Court made it clear that States cannot use laws to create an undue burden for women who are seeking to exercise that right. The Court affirmed that decision once more in 1992.

Women in Texas now have firsthand experience of what happens when States ignore the Supreme Court. From what I can see, there is no way that the Texas law can be considered anything other than an undue burden, which brings us to the second problem: There is absolutely no logical, medical reason to suddenly require these clinics to meet the standards of a hospital.

These laws are opposed by a host of leading medical groups, including the American Medical Association and the American College of Obstetricians and Gynecologists, professionals who know better than anyone what kinds of skills and resources should be necessary for an abortion, which is one of the safest medical procedures out there.

I find it incredibly hard to believe that whole organizations of physicians would oppose any of these laws if they really did make clinics safer, Mr. Speaker, but I digress.

In Texas, the full implementation of the bill that is being challenged next week would force more than 75 percent of abortion clinics in that State to close.

In fact, with the limited implementation they have had to date, the number of clinics has been cut in half. If it is allowed to go into effect, only 10 clinics will remain to serve the 5.4 million Texas women of reproductive age.

What is even worse is that, while these laws are being masqueraded as efforts to make abortions safer, they are forcing more women down the dangerous path of attempting to end their pregnancies on their own.

A study by the Texas Policy Evaluation Project found that women who report barriers to abortion are more likely to self-induce an abortion, putting their lives at risk in the process. This sounds like 1955, not 2016.

Mr. Speaker, these laws are an absolute farce, and it is time to stop the sham. Women deserve to make the choices that work for them. If that means having an abortion, they should be able to do it safely, without traveling hundreds of miles or without waiting weeks to be seen.

My colleagues and I are here on the floor tonight because we stand with the women in Texas, with the women in Louisiana, and with the women across this country, women who want to make their own decisions about when, where, and how to make decisions that will change their lives, women whose voices are seldom represented in the legislative bodies, which are filled with men who are ready to take away their rights.

It is now my pleasure to yield to the illustrious Member from the State of Texas, someone who has been a constant fighter for everyone's rights, including women's rights, Congresswoman JACKSON LEE.

Ms. JACKSON LEE. I thank the distinguished gentlewoman from New Jersey, and I thank her for her leadership. As well, I thank my colleagues who are here on the floor of the House who have joined us.

Mr. Speaker, let me associate myself with the comments by the gentlewoman from New Jersey as they relate to Louisiana.

Let me be clear. As I stand here as a constituent of the State of Texas, as a Representative of the State of Texas, and as a woman who lives in Texas, that Texas State Law HB2 has led to the closure of more than 20 abortion facilities in the State, taking the total number of providers down from 40 to 19, its true purpose being to take away women's rights to make their own healthcare decisions.

It could not be more blatant, again, to take away every woman's right to choose. No one stands on this floor tonight to promote and coddle abortion, but we do stand on the floor to protect a woman's right to choose her health and to protect her sacred right of making such decisions with her God, her family, and her physician.

How do HB2 and other bills have the right to interfere with that?

Let me also cite for you that a U.N. working group concluded that women in the United States inexplicably lag behind international human rights.

Pointing to data and research on public and political representation, economic and social rights, and health and safety protections, experts in the U.N. working group boldly acknowledged that there is a myth that women in the United States already enjoy all of the expected standards of rights and protections afforded under America.

Isn't that shameful? Under America, we are still denied our rights.

The reality is women in the United States are experiencing continued discrimination and daunting disparities that prevent the true ability for them to fully participate as equal members of society.

We stand here this evening to acknowledge one striking issue that will