

110TH CONGRESS
1ST SESSION

H. R. 4897

To amend the Social Security Act and the Public Health Service Act to improve elderly suicide early intervention and prevention strategies, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

DECEMBER 19, 2007

Ms. HOOLEY (for herself, Mr. TIM MURPHY of Pennsylvania, Ms. DELAURO, Mrs. JONES of Ohio, Mr. KENNEDY, Mr. KLEIN of Florida, Mrs. MCCARTHY of New York, Ms. MATSUI, Mr. RAMSTAD, and Mr. WYNN) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Social Security Act and the Public Health Service Act to improve elderly suicide early intervention and prevention strategies, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Stop Senior Suicide
5 Act”.

1 **SEC. 2. FINDINGS.**

2 Congress makes the following findings:

3 (1) The rate of suicide among older adults is
4 higher than that for any other age group, and the
5 suicide rate for individuals 85 years of age and older
6 is the highest of all. In 2004, 6,860 older Americans
7 (age 60 and older) died by suicide (Centers for Dis-
8 ease Control and Prevention, 2007).

9 (2) In 2004, the elderly (age 65 and older)
10 made up only 12.4 percent of the population but ac-
11 counted for 16 percent of all suicides.

12 (3) According to the Centers for Disease Con-
13 trol and Prevention, from 1980 to 1992, the suicide
14 rate rose 9 percent for Americans 65 years of age
15 and above, and rose 35 percent for men and women
16 ages 80 to 84.

17 (4) Older adults have a considerably higher rate
18 of completed suicide than other groups. While for all
19 age groups combined there is one suicide for every
20 20 attempts, there is one suicide for every 4 at-
21 tempts among those 65 years of age and older.

22 (5) Of the nearly 35,000,000 Americans age 65
23 and older, it is estimated that 2,000,000 have a de-
24 pressive illness and another 5,000,000 suffer from
25 depressive symptoms and syndromes that fall short
26 of meeting full diagnostic criteria for a disorder

1 (Mental Health: A Report of the Surgeon General,
2 1999).

3 (6) Seniors covered by Medicare are required to
4 pay a 50 percent co-pay for outpatient mental health
5 services while they are only required to pay a 20
6 percent co-pay for physical health services.

7 (7) It is estimated that 20 percent of older
8 adults who complete suicide visited a physician with-
9 in the prior 24 hours, 41 percent within the past
10 week, and 75 percent within the past month (Sur-
11 geon General's Call to Action to Prevent Suicide,
12 1999).

13 (8) A substantial proportion of older patients
14 receive no treatment or inadequate treatment for
15 their depression in primary care settings (National
16 Institutes of Health Consensus Development Panel
17 on Depression in Late Life, 1992; Lebowitz et al.,
18 1997).

19 (9) Suicide in older adults is most associated
20 with late-onset depression. Among patients 75 years
21 of age and older, 60 to 75 percent of suicides have
22 diagnosable depression (Mental Health: A Report of
23 the Surgeon General, 1999).

24 (10) Research suggests that many seniors re-
25 ceive mental health assistance from their primary

1 care providers or other helping professionals versus
2 specialty mental health professionals (Mental
3 Health: A Report of the Surgeon General, 1999).

4 (11) Objective 4.6 of the National Strategy for
5 Suicide Prevention calls for increasing the propor-
6 tion of State Aging Networks that have evidence-
7 based suicide prevention programs designed to iden-
8 tify and refer for treatment elderly people at risk for
9 suicidal behavior.

10 (12) Objective 1.1 of the President's New Free-
11 dom Commission on Mental Health calls for advanc-
12 ing and implementing a national campaign to reduce
13 the stigma of seeking care and a national strategy
14 for suicide prevention. The report addresses tar-
15 geting to distinct and often hard-to-reach popu-
16 lations, such as ethnic and racial minorities, older
17 men, and adolescents (NFC Report, 2003).

18 (13) One of the top 10 resolutions at the 2005
19 White House Conference on Aging called for improv-
20 ing the recognition, assessment, and treatment of
21 mental illness and depression among older Ameri-
22 cans.

1 **SEC. 3. ESTABLISHMENT OF A FEDERAL INTERAGENCY**
2 **GERIATRIC MENTAL HEALTH PLANNING**
3 **COUNCIL.**

4 (a) IN GENERAL.—The Secretary of Health and
5 Human Services shall establish an Interagency Geriatric
6 Mental Health Planning Council (referred to in this sec-
7 tion as the “Council”) to coordinate and collaborate on
8 the planning for the delivery of mental health services, to
9 include suicide prevention, to older adults.

10 (b) MEMBERS.—The members of the Council shall in-
11 clude representatives of—

12 (1) the Substance Abuse and Mental Health
13 Services Administration;

14 (2) the Indian Health Service;

15 (3) the Health Resources and Services Adminis-
16 tration;

17 (4) the Centers for Medicare & Medicaid Serv-
18 ices;

19 (5) the National Institute of Mental Health;

20 (6) the National Institute on Aging;

21 (7) the Centers for Disease Control and Preven-
22 tion;

23 (8) the Department of Veterans Affairs; and

24 (9) older adults, family members of older adults
25 with mental illness, and geriatric mental health ex-
26 perts or advocates for elderly mental health con-

1 cerns, to be appointed by the Secretary of Health
2 and Human Services in consultation with a national
3 advocacy organization focused on suicide prevention,
4 including senior suicide prevention.

5 (c) CO-CHAIRS.—The Assistant Secretary for Health
6 and the Assistant Secretary for Aging of the Department
7 of Health and Human Services shall serve as the co-chairs
8 of the Council.

9 (d) ACTIVITIES.—The Council shall—

10 (1) carry out an interagency planning process
11 to foster the integration of mental health, suicide
12 prevention, health, and aging services, which is crit-
13 ical for effective service delivery for older adults;

14 (2) make recommendations to the heads of rel-
15 evant Federal agencies to improve the delivery of
16 mental health and suicide prevention services for
17 older adults; and

18 (3) submit an annual report to the President
19 and Congress concerning the activities of the Coun-
20 cil.

21 **SEC. 4. ELIMINATION OF DISCRIMINATORY COPAYMENT**
22 **RATES FOR MEDICARE OUTPATIENT PSY-**
23 **CHIATRIC SERVICES.**

24 Section 1833(c) of the Social Security Act (42 U.S.C.
25 1395l(c)) is amended to read as follows:

1 “(c)(1) Notwithstanding any other provision of this
2 part, with respect to expenses incurred in a calendar year
3 in connection with the treatment of mental, psycho-
4 neurotic, and personality disorders of an individual who
5 is not an inpatient of a hospital at the time such expenses
6 are incurred, there shall be considered as incurred ex-
7 penses for purposes of subsections (a) and (b)—

8 “(A) for expenses incurred in any year before
9 2009, only 62½ percent of such expenses;

10 “(B) for expenses incurred in 2009, only 68¾
11 percent of such expenses;

12 “(C) for expenses incurred in 2010, only 75
13 percent of such expenses;

14 “(D) for expenses incurred in 2011, only 81¼
15 percent of such expenses;

16 “(E) for expenses incurred in 2012, only 87½
17 percent of such expenses;

18 “(F) for expenses incurred in 2013, only 93¾
19 percent of such expenses; and

20 “(G) for expenses incurred in 2014 or any sub-
21 sequent year, 100 percent of such expenses.

22 “(2) For purposes of subparagraphs (A) through (G)
23 of paragraph (1), the term ‘treatment’ does not include
24 brief office visits (as defined by the Secretary) for the sole
25 purpose of monitoring or changing drug prescriptions used

1 in the treatment of such disorders or partial hospitaliza-
2 tion services that are not directly provided by a physi-
3 cian.”.

4 **SEC. 5. ELDERLY SUICIDE EARLY INTERVENTION AND PRE-**
5 **VENTION STRATEGIES.**

6 Title V of the Public Health Service Act is amended
7 by inserting after section 520E-2 (42 U.S.C. 290bb-36b)
8 the following:

9 **“SEC. 520E-3. ELDERLY SUICIDE EARLY INTERVENTION**
10 **AND PREVENTION STRATEGIES.**

11 “(a) IN GENERAL.—The Secretary shall award
12 grants or cooperative agreements to eligible entities to de-
13 velop strategies for addressing suicide among the elderly.

14 “(b) ELIGIBLE ENTITIES.—To be eligible for a grant
15 or cooperative agreement under subsection (a) an entity
16 shall—

17 “(1) be a—

18 “(A) State or local government agency, a
19 territory, or a federally recognized Indian tribe,
20 tribal organization (as defined in the Indian
21 Self-Determination and Education Assistance
22 Act), or an urban Indian organization (as de-
23 fined in the Indian Health Care Improvement
24 Act); or

1 “(B) a public or private nonprofit organi-
2 zation; and

3 “(2) submit to the Secretary an application at
4 such time, in such manner, and containing such in-
5 formation as the Secretary may require.

6 “(c) USE OF FUNDS.—An entity shall use amounts
7 received under a grant or cooperative agreement under
8 this section to—

9 “(1) develop and implement elderly suicide early
10 intervention and prevention strategies in 1 or more
11 settings that serve seniors, including senior centers,
12 nutrition sites, primary care settings, veterans’ fa-
13 cilities, nursing facilities, assisted living facilities,
14 and aging information and referral sites, such as
15 those operated by area agencies on aging or Aging
16 and Disability Resource Centers (as those terms are
17 defined in section 102 of the Older Americans Act
18 of 1965);

19 “(2) collect and analyze data on elderly suicide
20 early intervention and prevention services for pur-
21 poses of monitoring, research and policy develop-
22 ment; and

23 “(3) assess the outcomes and effectiveness of
24 such services.

1 “(d) REQUIREMENTS.—An applicant for a grant or
2 cooperative agreement under this section shall dem-
3 onstrate how such applicant will—

4 “(1) collaborate with other State and local pub-
5 lic and private nonprofit organizations;

6 “(2) offer immediate support, information, and
7 referral to seniors or their families who are at risk
8 for suicide, and appropriate postsuicide intervention
9 services care, and information to families and
10 friends of seniors who recently completed suicide and
11 other interested individuals; and

12 “(3) conduct annual self-evaluations concerning
13 the goals, outcomes, and effectiveness of the activi-
14 ties carried out under the grant or agreement, in
15 consultation with interested families and national
16 advocacy organizations focused on suicide preven-
17 tion, including senior suicide prevention.

18 “(e) PREFERENCE.—In awarding a grant or coopera-
19 tive agreement under this section, the Secretary shall give
20 preference to applicants with demonstrated expertise and
21 capability in providing—

22 “(1) early intervention and assessment services,
23 including voluntary screening programs, education,
24 and outreach to elderly who are at risk for mental
25 or emotional disorders that may lead to a suicide at-

1 tempt and that are integrated with aging services
2 support organizations;

3 “(2) early intervention and prevention practices
4 and strategies adapted to the community it will
5 serve, with equal preference given to applicants that
6 are already serving the same community, and appli-
7 cants that will serve a new community under a grant
8 or agreement under this section, if the applicant has
9 already demonstrated expertise and capability in
10 providing early intervention and prevention practices
11 and strategies adapted to the community or commu-
12 nities it currently serves;

13 “(3) access to services and care for seniors with
14 diverse linguistic and cultural backgrounds; and

15 “(4) services in States or geographic regions
16 with rates of elder suicide that exceed the national
17 average as determined by the Centers for Disease
18 Control and Prevention.

19 “(f) REQUIREMENT FOR DIRECT SERVICES.—Not
20 less than 85 percent of amounts received under a grant
21 or cooperative agreement under this section shall be used
22 to provide direct services.

23 “(g) COORDINATION AND COLLABORATION.—

24 “(1) IN GENERAL.—In carrying out this section
25 (including awarding grants and cooperative agree-

1 ments under subsection (a)), the Secretary shall col-
2 laborate with the Interagency Geriatric Mental
3 Health Planning Council.

4 “(2) CONSULTATION.—

5 “(A) IN GENERAL.—Except as provided in
6 subparagraph (B), in developing and imple-
7 menting Federal policy to carry out this section,
8 the Secretary shall consult with—

9 “(i) State and local agencies, includ-
10 ing agencies comprising the aging network;

11 “(ii) national advocacy organizations
12 focused on suicide prevention, including
13 senior suicide prevention;

14 “(iii) relevant national medical and
15 other health specialty organizations;

16 “(iv) seniors who are at risk for sui-
17 cide, who have survived suicide attempts,
18 or who are currently receiving care from
19 early intervention and prevention services;

20 “(v) families and friends of seniors
21 who are at risk for suicide, who have sur-
22 vived attempts, who are currently receiving
23 care from early intervention and prevention
24 services, or who have completed suicide;

1 “(vi) qualified professionals who pos-
2 sess the specialized knowledge, skills, expe-
3 rience, and relevant attributes needed to
4 serve seniors at risk for suicide and their
5 families; and

6 “(vii) other entities as determined by
7 the Secretary.

8 “(B) LIMITATION.—The Secretary shall
9 not consult with the entities described in sub-
10 paragraph (A) for the purpose of awarding
11 grants and cooperative agreements under sub-
12 section (a).

13 “(h) EVALUATIONS AND REPORTS.—

14 “(1) EVALUATIONS BY GRANTEES.—

15 “(A) EVALUATION DESIGN.—Not later
16 than 1 year after receiving a grant or coopera-
17 tive agreement under this section, an eligible
18 entity shall submit to the Secretary a plan on
19 the design of an evaluation strategy to assess
20 the effectiveness of results of the activities car-
21 ried out under the grant or agreement.

22 “(B) EVALUATION OF EFFECTIVENESS.—
23 Not later than 2 years after receiving a grant
24 or cooperative agreement under this section, an
25 eligible entity shall submit to the Secretary an

1 effectiveness evaluation on the implementation
2 and results of the activities carried out by the
3 eligible entity under the grant or agreement.

4 “(2) REPORT.—Not later than 3 years after the
5 date that the initial grants or cooperative agree-
6 ments are awarded to eligible entities under this sec-
7 tion, the Secretary shall submit to the appropriate
8 committees of Congress a report describing the
9 projects funded under this section and include an
10 evaluation plan for future activities. The report
11 shall—

12 “(A) be a coordinated response by all rep-
13 resentatives on the Interagency Geriatric Men-
14 tal Health Advisory Council; and

15 “(B) include input from consumers and
16 family members of consumers on progress being
17 made and actions that need to be taken.

18 “(i) DEFINITION.—In this section:

19 “(1) AGING NETWORK.—The term ‘aging net-
20 work’ has the meaning given such term in section
21 102(5) of the Older Americans Act of 1965.

22 “(2) EARLY INTERVENTION.—The term ‘early
23 intervention’ means a strategy or approach that is
24 intended to prevent an outcome or to alter the
25 course of an existing condition.

1 “(3) PREVENTION.—The term ‘prevention’
2 means a strategy or approach that reduces the likeli-
3 hood of risk or onset, or delays the onset, of adverse
4 health problems that have been known to lead to sui-
5 cide.

6 “(4) SENIOR.—The term ‘senior’ means—

7 “(A) an individual who is 60 years of age
8 or older and being served by aging network pro-
9 grams; or

10 “(B) an individual who is 65 years of age
11 or older and covered under Medicare.

12 “(j) AUTHORIZATION OF APPROPRIATIONS.—

13 “(1) IN GENERAL.—For the purpose of car-
14 rying out this section there is authorized to be ap-
15 propriated \$4,000,000 for fiscal year 2008,
16 \$6,000,000 for fiscal year 2009 and \$8,000,000 for
17 fiscal year 2010.

18 “(2) PREFERENCE.—If less than \$3,500,000 is
19 appropriated for any fiscal year to carry out this
20 section, in awarding grants and cooperative agree-
21 ments under this section during such fiscal year, the
22 Secretary shall give preference to applicants in
23 States that have rates of elderly suicide that signifi-
24 cantly exceed the national average as determined by
25 the Centers for Disease Control and Prevention.”.

1 **SEC. 6. INTERAGENCY TECHNICAL ASSISTANCE CENTER.**

2 (a) INTERAGENCY RESEARCH, TRAINING, AND TECH-
3 NICAL ASSISTANCE CENTERS.—Section 520C(d) of the
4 Public Health Service Act (42 U.S.C. 290bb–34(d)) is
5 amended—

6 (1) in paragraph (1), by striking “youth suicide
7 early intervention and prevention strategies” and in-
8 serting “suicide early intervention and prevention
9 strategies for all ages, particularly for groups that
10 are at a high risk for suicide”;

11 (2) in paragraph (2), by striking “youth suicide
12 early intervention and prevention strategies” and in-
13 serting “suicide early intervention and prevention
14 strategies for all ages, particularly for groups that
15 are at a high risk for suicide”;

16 (3) in paragraph (3)—

17 (A) by striking “youth”; and

18 (B) by inserting before the semicolon the
19 following: “for all ages, particularly for groups
20 that are at a high risk for suicide”;

21 (4) in paragraph (4), by striking “youth sui-
22 cide” and inserting “suicide for all ages, particularly
23 among groups that are at a high risk for suicide”;

24 (5) in paragraph (5), by striking “youth suicide
25 early intervention techniques and technology” and
26 inserting “suicide early intervention techniques and

1 technology for all ages, particularly for groups that
2 are at a high risk for suicide”;

3 (6) in paragraph (7)—

4 (A) by striking “youth”; and

5 (B) by inserting “for all ages, particularly
6 for groups that are at a high risk for suicide,”
7 after “strategies”; and

8 (7) in paragraph (8)—

9 (A) by striking “youth suicide” each place
10 that such appears and inserting “suicide”; and

11 (B) by striking “in youth” and inserting
12 “among all ages, particularly among groups
13 that are at a high risk for suicide”.

14 (b) CONFORMING AMENDMENT.—Section 520C of
15 the Public Health Service Act (42 U.S.C. 290bb–34) is
16 amended in the heading by striking “**YOUTH**”.

17 (c) AUTHORIZATION OF APPROPRIATIONS.—

18 (1) IN GENERAL.—In addition to any other
19 funds made available, there are authorized to be ap-
20 propriated for each of fiscal years 2008 through
21 2010, such sums as may be necessary to carry out
22 the amendments made by subsection (a).

23 (2) SUPPLEMENT NOT SUPPLANT.—Any funds
24 appropriated under paragraph (1) shall be used to
25 supplement and not supplant other Federal, State,

1 and local public funds expended to carry out other
2 activities under section 520C(d) of the Public Health
3 Service Act (42 U.S.C. 290bb–34(d)) (as amended
4 by subsection (a)).

5 (3) RESULT OF INCREASE IN FUNDING.—If, as
6 a result of the enactment of this Act, a recipient of
7 a grant under subsection (a)(2) of section 520C of
8 the Public Health Service Act (42 U.S.C. 290bb–34)
9 receives an increase in funding to carry out activities
10 under subsection (d) of such section related to sui-
11 cide prevention and intervention among groups that
12 are at a high risk for suicide, then, notwithstanding
13 any other provision of such section, such recipient
14 shall provide technical assistance to all grantees re-
15 ceiving funding under such section or section 520E–
16 3 of such Act (as added by section 5).

○