Peter Brown, an editor at the ''Orlando Sentinel'' conducted a study that discovered a profound cultural disconnect between journalists and readers. He found that reporters are far more likely than other Americans to approve of abortion on demand, to express disdainful attitudes towards the suburbs and rural areas, and to identify strongly with people who see themselves as victims of society. They are also less likely to go to church or do volunteer work in their communities.

But what is the answer? We need to tell the media, give us the facts, and let us make up our own mind.

PRESCRIPTION DRUG BENEFIT UNDER MEDICARE IS WHAT SENIORS WANT

(Ms. SCHAKOWSKY asked and was given permission to address the House for 1 minute and to revise and extend her remarks.)

Ms. SCHAKOWSKY. Mr. Speaker, as we speak right now, outside of this Chamber, our senior citizens who have come here begging us for some relief for the high cost of prescription drugs, they are telling us about how they are spending all of their money, rather than being able to buy the nutritious food or put a decent roof over their head, they are struggling to pay for the drugs that they need. We have only a few days left to provide real relief. A prescription drug benefit under Medicare is what they want.

Now we are talking about reimportation of lower-cost drugs from Canada. That is fine. Let us do that. Although, I have to tell my colleagues, it is pretty crazy that we have to rely on the Canadian Government who puts some controls on the cost of drugs, the cost they are willing to pay, and we as Americans have to go and buy those same American-made drugs from the Canadians because we do not do anything to control the cost.

Senior citizens need help. Let us get a prescription drug benefit under Medicare.

PRESCRIPTION DRUG COVERAGE FOR AMERICA'S SENIORS IS IMPORTANT

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

Mr. SAM JOHNSON of Texas. Mr. Speaker, prescription drug coverage for America's seniors is important. Our two parties differ, however.

Republicans believe in choice, not government control. Americans themselves can always make decisions that best meet their individuals needs. On the other hand, Democrats believe government, not individuals, make the best decisions for all people in every circumstance.

The Clinton-Gore administration's prescription drug proposals are total government control. Vice President GORE claims to have a recipe of hopes and promises. But when we get in the kitchen, we discover it is the same old concoction of government ingredients and bureaucratic spices. One can present it any way one wants to, but one knows it still tastes the same, it still smells the same. It is not good.

We need a prescription drug benefit under Medicare that offers seniors real choices without government control. Americans do not want, need, or deserve any more Hillary care.

SHAME ON THE CONGRESS FOR NOT TAKING ACTION ON PRESCRIPTION DRUGS

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

Mr. FARR of California. Mr. Speaker, I rise today to admonish this country, it is a shame that we are here talk, talk, talk, and not doing anything about prescription drugs.

My daughter recounted to me a story last Saturday night when she was in a pharmacy at midnight on Saturday night, to pick up some pain medicine. She told me that the people waiting in line there were limited English speaking, about eight families.

One of the gentlemen was pleading with the pharmacist to sell him at least two of the pills that were prescribed, he could not afford the whole package, because his infant daughter was sick and needed these prescription drugs. But the pharmacist would not sell the drugs to him because he could not buy the entire package, the entire dosage which the doctors recommend.

He said, ''I cannot afford it. Give me two now, and I will come back in a couple of days and buy the rest of them.'' It went on and on, and the pharmacist would not sell it because the process would not allow them to do it, and the person could not afford the drugs. He was in tears, as any parent would be.

Shame on America that we cannot take care of people; we cannot even disburse those drugs that have been prescribed because people cannot pay for them. Shame on the drug companies. Shame on the process. Shame on Congress for not correcting it.

THIS ADMINISTRATION NOT CONNECTED WHEN IT COMES TO EDUCATION

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

Mr. KINGSTON. Mr. Speaker, now we have from the Gore-Clinton administration the formula for turning around education. This was revealed on September 7, 2000, by the Secretary of Education, Richard Riley, and I quote: ''What we need are the three R's in education: relationships, resilience, and readiness.''

Now, is not that odd, because back home in Georgia, none of the parents or teachers have come to me and said, what we really need is resilience in education. Somehow their idea of the three R's is a little bit different. We need local control of education. We need parental involvement. We need the money going to the teacher in the classroom, not the bureaucrats in Washington. We need safe campuses.

No wonder the gentleman from California (Mr. GEORGE MILLER), a Democrat Congressman, said January 10, 2000, and I quote directly: ''I sit on the House Committee on Education and the Workforce, and I have witnessed the failure of this administration and AL GORE to do enough to address our Nation's education needs.''

Well, I agree with the gentleman from California (Mr. GEORGE MILLER), my Democrat colleague. It does not appear that this administration is connected when it comes to education.

UNITED STATES RANKS NEAR BOTTOM IN EDUCATION COMPARED TO INDUSTRIALIZED COUNTRIES AROUND THE WORLD

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

Mr. SCHAFFER. Mr. Speaker, I have an obscenity to share with the Members of the House. For the 8 years that the Clinton-Gore administration has possessed the White House, they have squandered their opportunity to fix education in America.

The Third International Math and Science Study comparison compared 21 industrialized countries around the world in math and science. Let me read the list of countries that outperform the United States: Netherlands, Sweden, Denmark, Switzerland, Iceland, Norway, France, New Zealand, Australia, Canada, Austria, Slovenia, Germany, Hungary, Italy, Russia, Lithuania, the Czech Republic.

After the United States comes two countries: Cyprus and South Africa.

Yes, Mr. Speaker, we rank near the bottom when compared to industrial countries around the world in education.

Republicans have a different message. Stop squandering opportunity in the White House. Get dollars to the classroom. Get money to the teachers, the administrators, the school board members who know the names of our children. Stop wasting billions on a huge bureaucracy here in Washington, D.C. that cannot teach.

CHILDREN'S HEALTH ACT OF 2000

Ms. PRYCE of Ohio. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 594 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 594

Resolved, That upon adoption of this resolution it shall be in order to take from the

Speaker's table the bill (H.R. 4365) to amend the Public Health Service Act with respect to children's health, with Senate amendment thereto, and to consider in the House, without intervention of any point of order, a motion offered by the chairman of the Committee on Commerce or his designee that the House concur in the Senate amendment. The Senate amendment and the motion shall be considered as read. The motion shall be debatable for one hour equally divided and controlled by the chairman and ranking minority member of the Committee on Commerce. The previous question shall be considered as ordered on the motion to final adoption without intervening motion.

The SPEAKER pro tempore (Mr. OSE). The gentlewoman from Ohio (Ms. PRYCE) is recognized for 1 hour.

Ms. PRYCE of Ohio. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentleman from Texas (Mr. FROST); pending which I yield myself such time as I may consume. During consideration of the resolution, all time yielded is for the purpose of debate only.

Mr. Speaker, House Resolution 594 is a rule waiving all points of order against a motion to concur in the Senate amendment to H.R. 4365, the Children's Health Act of the year 2000.

The rule provides 1 hour of debate on the motion to be equally divided and controlled by the chairman and ranking minority member of the Committee on Commerce.

Mr. Speaker, H.R. 4365, the Children's Health Act of 2000, was passed in the House earlier this year on May 9 by a vote of 419 to two. Last week, our colleagues in the other body considered and passed this important legislation with an amendment by unanimous consent.

Adoption of this rule and passage of this legislation today is the last step in our work to sending this bill to the President for his signature and thus making this important package a reality.

I would like to congratulate the gentleman from Florida (Mr. BILIRAKIS) and the gentleman from Ohio (Mr. BROWN) for their renewed efforts and success on this important legislation and also to commend the gentleman from Virginia (Mr. BLILEY), chairman of the Committee on Commerce and the gentleman from Michigan (Mr. DINGELL), ranking member, for their hard work and leadership.

H.R. 4365, along with the decisions made by the other body, is a comprehensive package of several important children's health bills. Together it addresses a wide variety of critical issues, including day care safety, maternal and infant health, pediatric public health promotion, pediatric research, along with efforts to fight youth drug abuse and provide mental health services.

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The legislation includes two important divisions. Division A addresses issues regarding children's health; while Division B focuses on youth drug abuse. Together this package will form the foundation for efforts to address the unique needs of one of our most important constituencies: Our children.

The provisions contained in the second part of this legislation, Division D, include a number of provisions previously introduced and considered in the House of Representatives and will allow us to tackle the plague of drug abuse and addiction which are moving through many of our communities.

The 1999 National Household Survey on drug abuse reported that some 10.9 percent of our youths, between the ages of 12 and 17, use some form of illicit drug. Just as tragic are the report's findings that alcohol use is also on the rise with our Nation's youth, with some 10.4 million drinkers under the legal age of 21.

H.R. 4365 reauthorizes and improves the Substance Abuse and Mental Health Services Administration, SAMSHA, by giving it greater focus on our youth and increased flexibility and accountability for the States. It will provide the needed funds for community-based programs, helping individuals with substance abuse and mental health disorders.

It includes the Drug Addiction Treatment Act, introduced by the gentleman from Virginia (Mr. BLILEY), to permit qualified physicians to treat their addicted patients and speed up the drug approval process of narcotic drugs needed for additional treatment.

Finally, H.R. 4365 includes important provisions to reduce the proliferation of the drug methamphetamine, and tackle the devastating drug currently on the rise with our youth commonly known as Ecstasy.

Mr. Speaker, we all hope that the wealth of our Nation and the amazing technological advances that have been made in medicine will give us the necessary resources to protect our children from harm. We have made tremendous progress, but the sad fact is that there are still so many diseases that affect our children for which there is no cure or even an effective treatment.

Division A of the legislation before us will give child victims and their families hope by devoting more Federal resources to diseases such as autism, asthma, juvenile diabetes and arthritis. I am especially pleased that this new version of H.R. 4365 includes specific provisions on childhood cancer.

By awarding grants, expanding data collection, encouraging uniform reporting standards and urging the national coordination of activities, this bill will go a long way in the battle against this disease that takes the lives of so many of our Nation's children.

This legislation also focuses on a new pediatric research initiative at NIH, and reauthorizes money to train physicians at children's hospitals, in order to help us better understand the way in which diseases attack children and how to give them the most effective and appropriate care.

There are critical differences between medical care for adults and medical care for children that must be reflected in the training of physicians and treatments designed for a child's system, which is still developing. The children's hospitals across the Nation need funding to adequately train their physicians, and I am so very pleased that H.R. 4365 extends the authorization of appropriations for graduate medical education programs in children's hospitals through fiscal year 2005.

This is an issue of fairness, and full authorization is necessary to provide children's hospitals support that is on par with that received by teaching hospitals that care for adults. This legislation recognizes and focuses on these many important differences.

Mr. Speaker, while we may never be able to make a child understand why he or she is sick or is made to suffer, we can invest in the research that will allow our best and brightest scientists to solve the mysteries of childhood disease so that more children can have the carefree youths to which they are entitled. What better way to invest our Nation's resources?

Mr. Speaker, this measure is straightforward and noncontroversial and its adoption will allow us to complete the work and the business of the House and pass this comprehensive package. I urge all my colleagues to support both the rule and this very important child health initiative.

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

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

As the gentlewoman has explained, this rule will take a Senate amendment from the Speaker's desk and agree to it. Under this procedure, there will be no opportunity to change the bill under consideration with a motion to recommit.

Mr. Speaker, 6 years after the Republican majority took control of this House, the Republican leadership has yet to find a way to effectively manage the business of the House. It is 3 days before the end of the fiscal year and 9 days before the Congress is scheduled to end, yet only 2 of the 13 appropriation bills have been sent to the President to be signed; we have yet to consider on this floor the funding bills we need to help people find housing or have safe transportation to get to work or plow their ground to produce food or learn the basic skills to be able to get and hold a job in the modern day workplace.

Last night, the members of the Committee on Rules were held hostage for hours past the last vote so that we might be available to bail out the Republican leadership so that the House might have some business to conduct today. Why should the Committee on Rules be held here until 9:30? For one very simple reason, Mr. Speaker. And that is because the majority party still has not figured out how to run this institution in an efficient manner and

could not find anything to do on the floor today.

However, sometime around 9 p.m. the Republican leadership came up with a solution. So what did they do? The Republican leadership has taken one of the bills that was supposed to be considered yesterday under procedures for noncontroversial bills, suspension of the rules, and moved it to today to be considered under a rule.

I do not mean to take anything away from the value of this bill. The Children's Health Act is vitally important to help find new ways to prevent or cure diseases which affect our children. But it should have been passed last night under suspension of the rules, as it was intended to be done. The health organizations, including the March of Dimes, the Spina Bifida Foundation, the Autism Society of America, the Association of Maternal and Child Health Programs, the Epilepsy Foundation, the Cereberal Palsy Association, and many, many others have worked hard to see the bill to completion and were counting on us to do our work. It is past time to get on with this business.

Mr. Speaker, I strongly support the Children's Health Act of 2000. This bill now spans 400 pages and has two basic purposes. The first addresses a host of specific childhood health problems and prenatal risk factors, including many provisions which passed in the House earlier this year. The bill authorizes research and public health and health education services that respond to fragile X syndrome, epilepsy, asthma, childhood lead poisoning, pediatric cancers, childhood obesity prevention, traumatic brain injury, juvenile diabetes, hearing loss, oral health, autism, arthritis, muscular dystrophy, autoimmune conditions, child care safety and pediatric organ transplants.

It also provides block grants to the States for laboratory infrastructure and patient care services for those affected with or at risk for genetic conditions. The bill contains the first ever authorization of the very successful Healthy Start demonstration project, now in their ninth year of reducing infant mortality and improving pregnancy outcomes in underserved populations.

The second feature of this bill covers a wide range of youth drug and mental health service programs that will strengthen America's communities, including extending and reauthorizing programs administered by the Substance Abuse and Mental Health Services Administration. These programs provide critical safety net services for individuals and families with substance abuse problems and mental illness, and also exclusively target youth. It also supports public and professional education programs related to substance abuse and mental illness. The breadth of services provided here range from an underage drinking provision and a suicide prevention initiative, to services for youth offenders, the homeless, and adults with fetal alcohol syndrome.

This large and complex bill, however, is marked with a number of procedural irregularities. As worthy as the goals may be, no bill of this scope and magnitude should proceed to the floor without going through the committee process, yet this occurred in the majority's apparent rush to move this bill to the floor.

For example, the bill contains a provision that invokes charitable choice. This is a difficult issue for many Members, yet the Committee on the Judiciary was never given the opportunity for public debate on this issue. I know this is of particular concern to my colleague, the gentleman from Virginia (Mr. SCOTT), who is here to voice his concerns this morning.

The second example is marked with some irony. The fine provision promoting safe motherhood includes a public education initiative addressing the dangers of alcohol, tobacco and illicit drug use in pregnancy. Most women do not begin smoking during pregnancy, they begin as adolescents. Yet neither the House nor the Committee on Commerce had the opportunity to even debate the issue of FDA regulation of youth tobacco use during this Congress.

I will vote for this bill, however, I want America's children to know that while H.R. 4365 is a measurable step toward improving the quality of their collective health, we can and should do better. It is obvious that this Congress will fail to address many major health care issues that confront us. I am only grateful we have the opportunity to vote for this bill and do something constructive to improve the health care of our Nation's children.

Mr. Speaker, I yield 3 minutes to the gentleman from Virginia (Mr. SCOTT).

Mr. SCOTT. Mr. Speaker, I thank the gentleman for yielding me this time, and I rise to oppose the rule because, in its present form, good health care for children now includes a bad crime bill and a provision which waters down our fundamental civil rights. A good child health care bill should not come at such a price.

By adopting the rule, we will prohibit amendments to the bill that could fix the methamphetamine drug part of the bill. A similar bill was considered in the Committee on the Judiciary, and amendments could have conformed that 46-page bill to the formal deliberations of the committee. But the rule prohibits amendments, and so the bill now provides new Draconian mandatory minimums for violations of methamphetamines, mandatory minimums that everyone knows do not work. The same mandatory minimums as for crack cocaine.

Now, it is interesting that crack cocaine is prevalent in the black community; methamphetamine is more prevalent in the Hispanic community. They get the Draconian mandatory minimums. However, there is an exception to all of this. Ecstasy, which is prevalent in the middle class white community, does not suffer the same mandatory minimums. The Committee on the Judiciary at least had the common decency to make them all equal. But now we have a rule which prohibits any consideration for equalizing this penalty. We have this exemption and, because of the rule, we have to just do it.

The rule also protects another form of discrimination: Religious discrimination. Section 3305 has a provision that allows some sponsors of federally funded programs to discriminate on employment based on religion. That is they can tell otherwise qualified individuals that they do not hire their kind because of their religion. These are federally funded programs. We cannot address this discrimination because the rule protects that provision and does not allow any amendments.

So if we want good child health care, we have to accept the discrimination; we have to accept the mandatory minimums, with the exception for the middle class white kids. We should not be forced to accept ineffective counterproductive mandatory minimums and religious discrimination as a price for good child health care, and that is why I oppose this rule.

Mr. FROST. Mr. Speaker, I yield 2 minutes to the gentleman from New Jersey (Mr. PASCRELL).

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

Mr. PASCRELL. Mr. Speaker, I thank the gentleman from Texas for yielding me this time.

Mr. Speaker, I am thrilled that the Children's Health Act of 2000 is on the floor today. I would like to thank the Chair of the Subcommittee on Health and the Environment, the gentleman from Florida (Mr. BILIRAKIS), and the ranking member, the gentleman from Ohio (Mr. BROWN), for their leadership and determination to see the bill through.

But I want to take special time to salute the gentleman from Pennsylvania (Mr. GREENWOOD) for his work on behalf of children in America. The gentleman from Pennsylvania has worked tirelessly on behalf of millions of Americans suffering from traumatic brain injury. He has also assisted in my efforts to create the first national traumatic brain injury registry, which is critical.

I first became involved with this issue several years ago when a constituent of mine, Dennis Benigno, approached me to tell me about his son, who was struck by a car, hospitalized for months, leaving him with severe cognitive and physical damage.

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As a result of his son's accident, Mr. Benigno has been on the front lines researching the disease, informing others, reaching out to the medical research and scientific community, and lobbying elected officials like myself.

I am proud of the efforts and the progress my good friend has made on

behalf of traumatic brain injury, and I am pleased that the national registry will be included in the Children's Health Act.

These brain injury registries will also charge hospitals and local and State departments of health with the task of collecting data for up to a year following the injury.

A national registry will help all of us to better understand the injury, what types of treatment people have received, what services they use, and how we can best link people with services.

I also hope that we fight each day, like Dennis does, to raise awareness of this disease and to fight for the injured, like his son.

I urge all my colleagues to, when the bill comes up after we debate the rule, vote for the passage of this bill.

Ms. PRYCE of Ohio. Mr. Speaker, I reserve the balance of my time.

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

Mr. Speaker, as I indicated in my opening remarks, this is a good bill. The gentleman from Virginia (Mr. SCOTT) has some legitimate concerns about a particular matter that he was not able to address. The overall bill is an important piece of legislation.

We have concerns on this side that we seem to be treading water here in not being able to bring anything up on the floor on a regular basis. We do not know from day to day what is going to be considered.

This bill could have been done on suspension yesterday. That does not diminish the bill. This is an important piece of legislation. I support the bill and support the rule.

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

Ms. PRYCE of Ohio. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, in closing, let me just respond. This very well could have been considered under the suspension calendar last night. We would all have been considering this bill at about 11 p.m. if that were the case.

Instead, we chose to come back in the light of day and with everyone well rested and alert and consider this important piece of legislation and allow the American public to hear all the goods things that we are promoting and adopting.

In closing, let me remind my colleagues that the House has already passed this with a strong bipartisan support vote of 419–2. Our work today will allow us to dedicate important resources and focus Members on the very unique needs in the health and well-being of our children.

I urge adoption of this straightforward, noncontroversial rule and passage of the comprehensive legislation.

I applaud my colleagues, the gentleman from Florida (Chairman BILIRAKIS), and my colleague, the gentleman from Ohio (Mr. BROWN), on their hard work.

Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The previous question was ordered.

The resolution was agreed to.

A motion to reconsider was laid on the table.

Mr. BILIRAKIS. Mr. Speaker, pursuant to House Resolution 594, I call up from the Speaker's table the bill (H.R. 4365) to amend the Public Health Service Act with respect to children's health, with the Senate amendment thereto, and ask for its immediate consideration.

The Clerk read the title of the bill.

MOTION OFFERED BY MR. BILIRAKIS

Mr. BILIRAKIS. Mr. Speaker, I offer a motion.

The SPEAKER pro tempore (Mr. OSE). The Clerk will designate the motion.

The text of the motion is as follows:

Mr. BILIRAKIS moves that the House concur in the Senate amendment to H.R. 4365, as follows:

Senate amendment:

Strike out all after the enacting clause and insert:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Children's Health Act of 2000''.

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

DIVISION A—CHILDREN'S HEALTH

TITLE I—AUTISM

SEC. 101. EXPANSION, INTENSIFICATION, AND COORDINATION OF ACTIVITIES OF NATIONAL INSTITUTES OF HEALTH WITH RESPECT TO RESEARCH ON AUTISM.

Part B of title IV of the Public Health Service Act (42 U.S.C. 284 et seq.) is amended by adding at the end the following section:

''EXPANSION, INTENSIFICATION, AND COORDINATION OF ACTIVITIES OF NATIONAL INSTITUTES OF HEALTH WITH RESPECT TO RESEARCH ON AUTISM

''SEC. 409C. (a) IN GENERAL.—

''(1) EXPANSION OF ACTIVITIES.—The Director of NIH (in this section referred to as the 'Director') shall expand, intensify, and coordinate the activities of the National Institutes of Health with respect to research on autism.

''(2) ADMINISTRATION OF PROGRAM; COLLABORATION AMONG AGENCIES.—The Director shall carry out this section acting through the Director of the National Institute of Mental Health and in collaboration with any other agencies that the Director determines appropriate.

''(b) CENTERS OF EXCELLENCE.—

''(1) IN GENERAL.—The Director shall under subsection (a)(1) make awards of grants and contracts to public or nonprofit private entities to pay all or part of the cost of planning, establishing, improving, and providing basic operating support for centers of excellence regarding research on autism.

''(2) RESEARCH.—Each center under paragraph (1) shall conduct basic and clinical research into autism. Such research should include investigations into the cause, diagnosis, early detection, prevention, control, and treatment of autism. The centers, as a group, shall conduct research including the fields of developmental neurobiology, genetics, and psychopharmacology.

''(3) SERVICES FOR PATIENTS.—

''(A) IN GENERAL.—A center under paragraph (1) may expend amounts provided under such paragraph to carry out a program to make individuals aware of opportunities to participate as subjects in research conducted by the centers.

''(B) REFERRALS AND COSTS.—A program under subparagraph (A) may, in accordance with such criteria as the Director may establish, provide to the subjects described in such subparagraph, referrals for health and other services, and such patient care costs as are required for research.

''(C) AVAILABILITY AND ACCESS.—The extent to which a center can demonstrate availability and access to clinical services shall be considered by the Director in decisions about awarding grants to applicants which meet the scientific criteria for funding under this section.

''(4) COORDINATION OF CENTERS; REPORTS.—The Director shall, as appropriate, provide for the coordination of information among centers under paragraph (1) and ensure regular communication between such centers, and may require the periodic preparation of reports on the activities of the centers and the submission of the reports to the Director.

''(5) ORGANIZATION OF CENTERS.—Each center under paragraph (1) shall use the facilities of a single institution, or be formed from a consortium of cooperating institutions, meeting such requirements as may be prescribed by the Director.

''(6) NUMBER OF CENTERS; DURATION OF SUPPORT.—

''(A) IN GENERAL.—The Director shall provide for the establishment of not less than 5 centers under paragraph (1).

''(B) DURATION.—Support for a center established under paragraph (1) may be provided under this section for a period of not to exceed 5 years. Such period may be extended for 1 or more additional periods not exceeding 5 years if the operations of such center have been reviewed by an appropriate technical and scientific peer review group established by the Director and if such group has recommended to the Director that such period should be extended.

''(c) FACILITATION OF RESEARCH.—The Director shall under subsection (a)(1) provide for a program under which samples of tissues and genetic materials that are of use in research on autism are donated, collected, preserved, and made available for such research. The program shall be carried out in accordance with accepted scientific and medical standards for the donation, collection, and preservation of such samples.

''(d) PUBLIC INPUT.—The Director shall under subsection (a)(1) provide for means through which the public can obtain information on the existing and planned programs and activities of the National Institutes of Health with respect to autism and through which the Director can receive comments from the public regarding such programs and activities.

''(e) FUNDING.—There are authorized to be appropriated such sums as may be necessary to carry out this section. Amounts appropriated under this subsection are in addition to any other amounts appropriated for such purpose.''.

SEC. 102. DEVELOPMENTAL DISABILITIES SURVEILLANCE AND RESEARCH PROGRAMS.

(a) NATIONAL AUTISM AND PERVASIVE DEVELOPMENTAL DISABILITIES SURVEILLANCE PROGRAM.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), acting through the Director of the Centers for Disease Control and Prevention, may make awards of grants and cooperative agreements for the collection, analysis, and reporting of data on autism and pervasive developmental disabilities. In making such awards, the Secretary may provide direct technical assistance in lieu of cash.

(2) ELIGIBILITY.—To be eligible to receive an award under paragraph (1) an entity shall be a public or nonprofit private entity (including health departments of States and political subdivisions of States, and including universities and other educational entities).

(b) CENTERS OF EXCELLENCE IN AUTISM AND PERVASIVE DEVELOPMENTAL DISABILITIES EPIDEMIOLOGY.—

(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish not less than 3 regional centers of excellence in autism and pervasive developmental disabilities epidemiology for the purpose of collecting and analyzing information on the number, incidence, correlates, and causes of autism and related developmental disabilities.

(2) RECIPIENTS OF AWARDS FOR ESTABLISHMENT OF CENTERS.—Centers under paragraph (1) shall be established and operated through the awarding of grants or cooperative agreements to public or nonprofit private entities that conduct research, including health departments of States and political subdivisions of States, and including universities and other educational entities.

(3) CERTAIN REQUIREMENTS.—An award for a center under paragraph (1) may be made only if the entity involved submits to the Secretary an application containing such agreements and information as the Secretary may require, including an agreement that the center involved will operate in accordance with the following:

(A) The center will collect, analyze, and report autism and pervasive developmental disabilities data according to guidelines prescribed by the Director, after consultation with relevant State and local public health officials, private sector developmental disability researchers, and advocates for those with developmental disabilities.

(B) The center will assist with the development and coordination of State autism and pervasive developmental disabilities surveillance efforts within a region.

(C) The center will identify eligible cases and controls through its surveillance systems and conduct research into factors which may cause autism and related developmental disabilities.

(D) The center will develop or extend an area of special research expertise (including genetics, environmental exposure to contaminants, immunology, and other relevant research specialty areas).

(c) CLEARINGHOUSE.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall carry out the following:

(1) The Secretary shall establish a clearinghouse within the Centers for Disease Control and Prevention for the collection and storage of data generated from the monitoring programs established by this title. Through the clearinghouse, such Centers shall serve as the coordinating agency for autism and pervasive developmental disabilities surveillance activities. The functions of such a clearinghouse shall include facilitating the coordination of research and policy development relating to the epidemiology of autism and other pervasive developmental disabilities.

(2) The Secretary shall coordinate the Federal response to requests for assistance from State health department officials regarding potential or alleged autism or developmental disability clusters.

(d) DEFINITION.—In this title, the term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the Virgin Islands, and the Trust Territory of the Pacific Islands.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 103. INFORMATION AND EDUCATION.

(a) IN GENERAL.—The Secretary shall establish and implement a program to provide information and education on autism to health professionals and the general public, including information and education on advances in the diagnosis and treatment of autism and training and continuing education through programs for scientists, physicians, and other health professionals who provide care for patients with autism.

(b) STIPENDS.—The Secretary may use amounts made available under this section to provide stipends for health professionals who are enrolled in training programs under this section.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 104. INTER-AGENCY AUTISM COORDINATING COMMITTEE.

(a) ESTABLISHMENT.—The Secretary shall establish a committee to be known as the ''Autism Coordinating Committee'' (in this section referred to as the ''Committee'') to coordinate all efforts within the Department of Health and Human Services concerning autism, including activities carried out through the National Institutes of Health and the Centers for Disease Control and Prevention under this title (and the amendment made by this title).

(b) MEMBERSHIP.—

(1) IN GENERAL.—The Committee shall be composed of the Directors of such national research institutes, of the Centers for Disease Control and Prevention, and of such other agencies and such other officials as the Secretary determines appropriate.

(2) ADDITIONAL MEMBERS.—If determined appropriate by the Secretary, the Secretary may appoint to the Committee—

(A) parents or legal guardians of individuals with autism or other pervasive developmental disorders; and

(B) representatives of other governmental agencies that serve children with autism such as the Department of Education.

(c) ADMINISTRATIVE SUPPORT; TERMS OF SERVICE; OTHER PROVISIONS.—The following shall apply with respect to the Committee:

(1) The Committee shall receive necessary and appropriate administrative support from the Department of Health and Human Services.

(2) Members of the Committee appointed under subsection (b)(2)(A) shall serve for a term of 3 years, and may serve for an unlimited number of terms if reappointed.

(3) The Committee shall meet not less than 2 times each year.

SEC. 105. REPORT TO CONGRESS.

Not later than January 1, 2001, and each January 1 thereafter, the Secretary shall prepare and submit to the appropriate committees of Congress, a report concerning the implementation of this title and the amendments made by this title.

TITLE II—RESEARCH AND DEVELOPMENT REGARDING FRAGILE X

SEC. 201. NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT; RESEARCH ON FRAGILE X.

Subpart 7 of part C of title IV of the Public Health Service Act is amended by adding at the end the following section:

''FRAGILE X

''SEC. 452E. (a) EXPANSION AND COORDINATION OF RESEARCH ACTIVITIES.—The Director of the Institute, after consultation with the advisory council for the Institute, shall expand, intensify, and coordinate the activities of the Institute with respect to research on the disease known as fragile X.

''(b) RESEARCH CENTERS.—

''(1) IN GENERAL.—The Director of the Institute shall make grants or enter into contracts for the development and operation of centers to conduct research for the purposes of improving the diagnosis and treatment of, and finding the cure for, fragile X.

''(2) NUMBER OF CENTERS.—

''(A) IN GENERAL.—In carrying out paragraph (1), the Director of the Institute shall, to the extent that amounts are appropriated, and subject to subparagraph (B), provide for the establishment of at least three fragile X research centers.

''(B) PEER REVIEW REQUIREMENT.—The Director of the Institute shall make a grant to, or enter into a contract with, an entity for purposes of establishing a center under paragraph (1) only if the grant or contract has been recommended after technical and scientific peer review required by regulations under section 492.

''(3) ACTIVITIES.—The Director of the Institute, with the assistance of centers established under paragraph (1), shall conduct and support basic and biomedical research into the detection and treatment of fragile X.

''(4) COORDINATION AMONG CENTERS.—The Director of the Institute shall, as appropriate, provide for the coordination of the activities of the centers assisted under this section, including providing for the exchange of information among the centers.

''(5) CERTAIN ADMINISTRATIVE REQUIREMENTS.—Each center assisted under paragraph (1) shall use the facilities of a single institution, or be formed from a consortium of cooperating institutions, meeting such requirements as may be prescribed by the Director of the Institute.

''(6) DURATION OF SUPPORT.—Support may be provided to a center under paragraph (1) for a period not exceeding 5 years. Such period may be extended for one or more additional periods, each of which may not exceed 5 years, if the operations of such center have been reviewed by an appropriate technical and scientific peer review group established by the Director and if such group has recommended to the Director that such period be extended.

''(7) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subsection, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

TITLE III—JUVENILE ARTHRITIS AND RELATED CONDITIONS

SEC. 301. NATIONAL INSTITUTE OF ARTHRITIS AND MUSCULOSKELETAL AND SKIN DISEASES; RESEARCH ON JUVENILE ARTHRITIS AND RELATED CONDITIONS.

(a) IN GENERAL.—Subpart 4 of part C of title IV of the Public Health Service Act (42 U.S.C. 285d et seq.) is amended by inserting after section 442 the following section:

''JUVENILE ARTHRITIS AND RELATED CONDITIONS

''SEC. 442A. (a) EXPANSION AND COORDINATION OF ACTIVITIES.—The Director of the Institute, in coordination with the Director of the National Institute of Allergy and Infectious Diseases, shall expand and intensify the programs of such Institutes with respect to research and related activities concerning juvenile arthritis and related conditions.

''(b) COORDINATION.—The Directors referred to in subsection (a) shall jointly coordinate the programs referred to in such subsection and consult with the Arthritis and Musculoskeletal Diseases Interagency Coordinating Committee.

''(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

(b) PEDIATRIC RHEUMATOLOGY.—Subpart 1 of part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.) is amended by adding at the end the following:

''SEC. 763. PEDIATRIC RHEUMATOLOGY.

''(a) IN GENERAL.—The Secretary, acting through the appropriate agencies, shall evaluate whether the number of pediatric rheumatologists is sufficient to address the health care needs of children with arthritis and related conditions, and if the Secretary determines that the number is not sufficient, shall develop strategies to help address the shortfall.

''(b) REPORT TO CONGRESS.—Not later than October 1, 2001, the Secretary shall submit to the Congress a report describing the results of the evaluation under subsection (a), and as applicable, the strategies developed under such subsection.

''(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

SEC. 302. INFORMATION CLEARINGHOUSE.

Section 438(b) of the Public Health Service Act (42 U.S.C. 285d–3(b)) is amended by inserting '', including juvenile arthritis and related conditions,'' after ''diseases''.

TITLE IV—REDUCING BURDEN OF DIABETES AMONG CHILDREN AND YOUTH

SEC. 401. PROGRAMS OF CENTERS FOR DISEASE CONTROL AND PREVENTION.

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by inserting after section 317G the following section:

''DIABETES IN CHILDREN AND YOUTH

''SEC. 317H. (a) SURVEILLANCE ON JUVENILE DIABETES.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall develop a sentinel system to collect data on juvenile diabetes, including with respect to incidence and prevalence, and shall establish a national database for such data.

''(b) TYPE 2 DIABETES IN YOUTH.—The Secretary shall implement a national public health effort to address type 2 diabetes in youth, including—

''(1) enhancing surveillance systems and expanding research to better assess the prevalence and incidence of type 2 diabetes in youth and determine the extent to which type 2 diabetes is incorrectly diagnosed as type 1 diabetes among children; and

''(2) developing and improving laboratory methods to assist in diagnosis, treatment, and prevention of diabetes including, but not limited to, developing noninvasive ways to monitor blood glucose to prevent hypoglycemia and improving existing glucometers that measure blood glucose.

''(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

SEC. 402. PROGRAMS OF NATIONAL INSTITUTES OF HEALTH.

Subpart 3 of part C of title IV of the Public Health Service Act (42 U.S.C. 285c et seq.) is amended by inserting after section 434 the following section:

''JUVENILE DIABETES

''SEC. 434A. (a) LONG-TERM EPIDEMIOLOGY STUDIES.—The Director of the Institute shall conduct or support long-term epidemiology studies in which individuals with or at risk for type 1, or juvenile, diabetes are followed for 10 years or more. Such studies shall investigate the causes and characteristics of the disease and its complications.

''(b) CLINICAL TRIAL INFRASTRUCTURE/INNOVATIVE TREATMENTS FOR JUVENILE DIABETES.—The Secretary, acting through the Director of the National Institutes of Health, shall support regional clinical research centers for the prevention, detection, treatment, and cure of juvenile diabetes.

''(c) PREVENTION OF TYPE 1 DIABETES.—The Secretary, acting through the appropriate agencies, shall provide for a national effort to prevent type 1 diabetes. Such effort shall provide for a combination of increased efforts in research and development of prevention strategies, including consideration of vaccine development, coupled with appropriate ability to test the effectiveness of such strategies in large clinical trials of children and young adults.

''(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

TITLE V—ASTHMA SERVICES FOR CHILDREN

Subtitle A—Asthma Services

SEC. 501. GRANTS FOR CHILDREN'S ASTHMA RELIEF.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following part:

''PART P—ADDITIONAL PROGRAMS

''SEC. 399L. CHILDREN'S ASTHMA TREATMENT GRANTS PROGRAM.

''(a) AUTHORITY TO MAKE GRANTS.—

''(1) IN GENERAL.—In addition to any other payments made under this Act or title V of the Social Security Act, the Secretary shall award grants to eligible entities to carry out the following purposes:

''(A) To provide access to quality medical care for children who live in areas that have a high prevalence of asthma and who lack access to medical care.

''(B) To provide on-site education to parents, children, health care providers, and medical teams to recognize the signs and symptoms of asthma, and to train them in the use of medications to treat asthma and prevent its exacerbations.

''(C) To decrease preventable trips to the emergency room by making medication available to individuals who have not previously had access to treatment or education in the management of asthma.

''(D) To provide other services, such as smoking cessation programs, home modification, and other direct and support services that ameliorate conditions that exacerbate or induce asthma.

''(2) CERTAIN PROJECTS.—In making grants under paragraph (1), the Secretary may make

grants designed to develop and expand the following projects:

''(A) Projects to provide comprehensive asthma services to children in accordance with the guidelines of the National Asthma Education and Prevention Program (through the National Heart, Lung and Blood Institute), including access to care and treatment for asthma in a community-based setting.

''(B) Projects to fully equip mobile health care clinics that provide preventive asthma care including diagnosis, physical examinations, pharmacological therapy, skin testing, peak flow meter testing, and other asthma-related health care services.

''(C) Projects to conduct validated asthma management education programs for patients with asthma and their families, including patient education regarding asthma management, family education on asthma management, and the distribution of materials, including displays and videos, to reinforce concepts presented by medical teams.

''(2) AWARD OF GRANTS.—

''(A) APPLICATION.—

''(i) IN GENERAL.—An eligible entity shall submit an application to the Secretary for a grant under this section in such form and manner as the Secretary may require.

''(ii) REQUIRED INFORMATION.—An application submitted under this subparagraph shall include a plan for the use of funds awarded under the grant and such other information as the Secretary may require.

''(B) REQUIREMENT.—In awarding grants under this section, the Secretary shall give preference to eligible entities that demonstrate that the activities to be carried out under this section shall be in localities within areas of known or suspected high prevalence of childhood asthma or high asthma-related mortality or high rate of hospitalization or emergency room visits for asthma (relative to the average asthma prevalence rates and associated mortality rates in the United States). Acceptable data sets to demonstrate a high prevalence of childhood asthma or high asthma-related mortality may include data from Federal, State, or local vital statistics, claims data under title XIX or XXI of the Social Security Act, other public health statistics or surveys, or other data that the Secretary, in consultation with the Director of the Centers for Disease Control and Prevention, deems appropriate.

''(3) DEFINITION OF ELIGIBLE ENTITY.—For purposes of this section, the term 'eligible entity' means a public or nonprofit private entity (including a State or political subdivision of a State), or a consortium of any of such entities.

''(b) COORDINATION WITH OTHER CHILDREN'S PROGRAMS.—An eligible entity shall identify in the plan submitted as part of an application for a grant under this section how the entity will coordinate operations and activities under the grant with—

''(1) other programs operated in the State that serve children with asthma, including any such programs operated under titles V, XIX, or XXI of the Social Security Act; and

''(2) one or more of the following—

''(A) the child welfare and foster care and adoption assistance programs under parts B and E of title IV of such Act;

''(B) the head start program established under the Head Start Act (42 U.S.C. 9831 et seq.);

''(C) the program of assistance under the special supplemental nutrition program for women, infants and children (WIC) under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786);

''(D) local public and private elementary or secondary schools; or

''(E) public housing agencies, as defined in section 3 of the United States Housing Act of 1937 (42 U.S.C. 1437a).

''(c) EVALUATION.—An eligible entity that receives a grant under this section shall submit to the Secretary an evaluation of the operations and activities carried out under the grant that includes—

''(1) a description of the health status outcomes of children assisted under the grant;

''(2) an assessment of the utilization of asthma-related health care services as a result of activities carried out under the grant;

''(3) the collection, analysis, and reporting of asthma data according to guidelines prescribed by the Director of the Centers for Disease Control and Prevention; and

''(4) such other information as the Secretary may require.

''(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

SEC. 502. TECHNICAL AND CONFORMING AMENDMENTS.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended—

(1) in part L, by redesignating section 399D as section 399A;

(2) in part M—

(A) by redesignating sections 399H through 399L as sections 399B through 399F, respectively;

(B) in section 399B (as so redesignated), in subsection (e)—

(i) by striking ''section 399K(b)'' and inserting ''subsection (b) of section 399E''; and

(ii) by striking ''section 399C'' and inserting ''such section'';

(C) in section 399E (as so redesignated), in subsection (c), by striking ''section 399H(a)'' and inserting ''section 399B(a)''; and

(D) in section 399F (as so redesignated)—

(i) in subsection (a), by striking ''section 399I'' and inserting ''section 399C'';

(ii) in subsection (a), by striking ''subsection 399J'' and inserting ''section 399D''; and

(iii) in subsection (b), by striking ''subsection 399K'' and inserting ''section 399E'';

(3) in part N, by redesignating section 399F as section 399G; and

(4) in part O—

(A) by redesignating sections 399G through 399J as sections 399H through 399K, respectively;

(B) in section 399H (as so redesignated), in subsection (b), by striking ''section 399H'' and inserting ''section 399I'';

(C) in section 399J (as so redesignated), in subsection (b), by striking ''section 399G(d)'' and inserting ''section 399H(d)''; and

(D) in section 399K (as so redesignated), by striking ''section 399G(d)(1)'' and inserting ''section 399H(d)(1)''.

Subtitle B—Prevention Activities

SEC. 511. PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT; SYSTEMS FOR REDUCING ASTHMA-RELATED ILLNESSES THROUGH INTEGRATED PEST MANAGEMENT.

Section 1904(a)(1) of the Public Health Service Act (42 U.S.C. 300w–3(a)(1)) is amended—

(1) by redesignating subparagraphs (E) and (F) as subparagraphs (F) and (G), respectively;

(2) by adding a period at the end of subparagraph (G) (as so redesignated);

(3) by inserting after subparagraph (D), the following:

''(E) The establishment, operation, and coordination of effective and cost-efficient systems to reduce the prevalence of illness due to asthma and asthma-related illnesses, especially among children, by reducing the level of exposure to cockroach allergen or other known asthma triggers through the use of integrated pest management, as applied to cockroaches or other known allergens. Amounts expended for such systems may include the costs of building maintenance and the costs of programs to promote community participation in the carrying out at such sites of integrated pest management, as applied to cockroaches or other known allergens. For purposes of this subparagraph, the term 'integrated pest management' means an approach to the management of pests in public facilities that combines biological, cultural, physical, and chemical tools in a way that minimizes economic, health, and environmental risks.'';

(4) in subparagraph (F) (as so redesignated), by striking ''subparagraphs (A) through (D)'' and inserting ''subparagraphs (A) through (E)''; and

(5) in subparagraph (G) (as so redesignated), by striking ''subparagraphs (A) through (E)'' and inserting ''subparagraphs (A) through (F)''.

Subtitle C—Coordination of Federal Activities

SEC. 521. COORDINATION THROUGH NATIONAL INSTITUTES OF HEALTH.

Subpart 2 of part C of title IV of the Public Health Service Act (42 U.S.C. 285b et seq.) is amended by inserting after section 424A the following section:

''COORDINATION OF FEDERAL ASTHMA ACTIVITIES

''SEC. 424B (a) IN GENERAL.—The Director of Institute shall, through the National Asthma Education Prevention Program Coordinating Committee—

''(1) identify all Federal programs that carry out asthma-related activities;

''(2) develop, in consultation with appropriate Federal agencies and professional and voluntary health organizations, a Federal plan for responding to asthma; and

''(3) not later than 12 months after the date of the enactment of the Children's Health Act of 2000, submit recommendations to the appropriate committees of the Congress on ways to strengthen and improve the coordination of asthma-related activities of the Federal Government.

''(b) REPRESENTATION OF THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT.—A representative of the Department of Housing and Urban Development shall be included on the National Asthma Education Prevention Program Coordinating Committee for the purpose of performing the tasks described in subsection (a).

''(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

Subtitle D—Compilation of Data

SEC. 531. COMPILATION OF DATA BY CENTERS FOR DISEASE CONTROL AND PREVENTION.

Part B of title III of the Public Health Service Act, as amended by section 401 of this Act, is amended by inserting after section 317H the following section:

''COMPILATION OF DATA ON ASTHMA

''SEC. 317I. (a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall—

''(1) conduct local asthma surveillance activities to collect data on the prevalence and severity of asthma and the quality of asthma management;

''(2) compile and annually publish data on the prevalence of children suffering from asthma in each State; and

''(3) to the extent practicable, compile and publish data on the childhood mortality rate associated with asthma nationally.

''(b) SURVEILLANCE ACTIVITIES.—The Director of the Centers for Disease Control and Prevention, acting through the representative of the Director on the National Asthma Education Prevention Program Coordinating Committee, shall, in carrying out subsection (a), provide an update on surveillance activities at each Committee meeting.

''(c) COLLABORATIVE EFFORTS.—The activities described in subsection (a)(1) may be conducted in collaboration with eligible entities awarded a grant under section 399L.

''(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

TITLE VI—BIRTH DEFECTS PREVENTION ACTIVITIES

Subtitle A—Folic Acid Promotion

SEC. 601. PROGRAM REGARDING EFFECTS OF FOLIC ACID IN PREVENTION OF BIRTH DEFECTS.

Part B of title III of the Public Health Service Act, as amended by section 531 of this Act, is amended by inserting after section 317I the following section:

''EFFECTS OF FOLIC ACID IN PREVENTION OF BIRTH DEFECTS

''SEC. 317J. (a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall expand and intensify programs (directly or through grants or contracts) for the following purposes:

''(1) To provide education and training for health professionals and the general public for purposes of explaining the effects of folic acid in preventing birth defects and for purposes of encouraging each woman of reproductive capacity (whether or not planning a pregnancy) to consume on a daily basis a dietary supplement that provides an appropriate level of folic acid.

''(2) To conduct research with respect to such education and training, including identifying effective strategies for increasing the rate of consumption of folic acid by women of reproductive capacity.

''(3) To conduct research to increase the understanding of the effects of folic acid in preventing birth defects, including understanding with respect to cleft lip, cleft palate, and heart defects.

''(4) To provide for appropriate epidemiological activities regarding folic acid and birth defects, including epidemiological activities regarding neural tube defects.

''(b) CONSULTATIONS WITH STATES AND PRIVATE ENTITIES.—In carrying out subsection (a), the Secretary shall consult with the States and with other appropriate public or private entities, including national nonprofit private organizations, health professionals, and providers of health insurance and health plans.

''(c) TECHNICAL ASSISTANCE.—The Secretary may (directly or through grants or contracts) provide technical assistance to public and nonprofit private entities in carrying out the activities described in subsection (a).

''(d) EVALUATIONS.—The Secretary shall (directly or through grants or contracts) provide for the evaluation of activities under subsection (a) in order to determine the extent to which such activities have been effective in carrying out the purposes of the program under such subsection, including the effects on various demographic populations. Methods of evaluation under the preceding sentence may include surveys of knowledge and attitudes on the consumption of folic acid and on blood folate levels. Such methods may include complete and timely monitoring of infants who are born with neural tube defects.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

Subtitle B—National Center on Birth Defects and Developmental Disabilities

SEC. 611. NATIONAL CENTER ON BIRTH DEFECTS AND DEVELOPMENTAL DISABILITIES.

Section 317C of the Public Health Service Act (42 U.S.C. 247b–4) is amended—

(1) by striking the heading for the section and inserting the following:

''NATIONAL CENTER ON BIRTH DEFECTS AND DEVELOPMENTAL DISABILITIES'';

(2) by striking ''SEC. 317C. (a)'' and all that follows through the end of subsection (a) and inserting the following:

''SEC. 317C. (a) IN GENERAL.—

''(1) NATIONAL CENTER.—There is established within the Centers for Disease Control and Prevention a center to be known as the National Center on Birth Defects and Developmental Disabilities (referred to in this section as the 'Center'), which shall be headed by a director appointed by the Director of the Centers for Disease Control and Prevention.

''(2) GENERAL DUTIES.—The Secretary shall carry out programs—

(A) to collect, analyze, and make available data on birth defects and developmental disabilities (in a manner that facilitates compliance with subsection (d)(2)), including data on the causes of such defects and disabilities and on the incidence and prevalence of such defects and disabilities;

(B) to operate regional centers for the conduct of applied epidemiological research on the prevention of such defects and disabilities; and

(C) to provide information and education to the public on the prevention of such defects and disabilities.

''(3) FOLIC ACID.—The Secretary shall carry out section 317J through the Center.

''(4) CERTAIN PROGRAMS.—

''(A) TRANSFERS.—All programs and functions described in subparagraph (B) are transferred to the Center, effective upon the expiration of the 180-day period beginning on the date of the enactment of the Children's Health Act of 2000.

''(B) RELEVANT PROGRAMS.—The programs and functions described in this subparagraph are all programs and functions that—

''(i) relate to birth defects; folic acid; cerebral palsy; mental retardation; child development; newborn screening; autism; fragile X syndrome; fetal alcohol syndrome; pediatric genetic disorders; disability prevention; or other relevant diseases, disorders, or conditions as determined the Secretary; and

''(ii) were carried out through the National Center for Environmental Health as of the day before the date of the enactment of the Act referred to in subparagraph (A).

''(C) RELATED TRANSFERS.—Personnel employed in connection with the programs and functions specified in subparagraph (B), and amounts available for carrying out the programs and functions, are transferred to the Center, effective upon the expiration of the 180-day period beginning on the date of the enactment of the Act referred to in subparagraph (A). Such transfer of amounts does not affect the period of availability of the amounts, or the availability of the amounts with respect to the purposes for which the amounts may be expended.''; and

(3) in subsection (b)(1), in the matter preceding subparagraph (A), by striking ''(a)(1)'' and inserting ''(a)(2)(A)''.

TITLE VII—EARLY DETECTION, DIAGNOSIS, AND TREATMENT REGARDING HEARING LOSS IN INFANTS

SEC. 701. PURPOSES.

The purposes of this title are to clarify the authority within the Public Health Service Act to authorize statewide newborn and infant hearing screening, evaluation and intervention programs and systems, technical assistance, a national applied research program, and interagency and private sector collaboration for policy development, in order to assist the States in making progress toward the following goals:

(1) All babies born in hospitals in the United States and its territories should have a hearing screening before leaving the birthing facility. Babies born in other countries and residing in the United States via immigration or adoption should have a hearing screening as early as possible.

(2) All babies who are not born in hospitals in the United States and its territories should have a hearing screening within the first 3 months of life.

(3) Appropriate audiologic and medical evaluations should be conducted by 3 months for all newborns and infants suspected of having hearing loss to allow appropriate referral and provisions for audiologic rehabilitation, medical and early intervention before the age of 6 months.

(4) All newborn and infant hearing screening programs and systems should include a component for audiologic rehabilitation, medical and early intervention options that ensures linkage to any new and existing state-wide systems of intervention and rehabilitative services for newborns and infants with hearing loss.

(5) Public policy in regard to newborn and infant hearing screening and intervention should be based on applied research and the recognition that newborns, infants, toddlers, and children who are deaf or hard-of-hearing have unique language, learning, and communication needs, and should be the result of consultation with pertinent public and private sectors.

SEC. 702. PROGRAMS OF HEALTH RESOURCES AND SERVICES ADMINISTRATION, CENTERS FOR DISEASE CONTROL AND PREVENTION, AND NATIONAL INSTITUTES OF HEALTH.

Part P of title III of the Public Health Service Act, as added by section 501 of this Act, is amended by adding at the end the following section:

''SEC. 399M. EARLY DETECTION, DIAGNOSIS, AND TREATMENT REGARDING HEARING LOSS IN INFANTS.

''(a) STATEWIDE NEWBORN AND INFANT HEARING SCREENING, EVALUATION AND INTERVENTION PROGRAMS AND SYSTEMS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall make awards of grants or cooperative agreements to develop statewide newborn and infant hearing screening, evaluation and intervention programs and systems for the following purposes:

''(1) To develop and monitor the efficacy of state-wide newborn and infant hearing screening, evaluation and intervention programs and systems. Early intervention includes referral to schools and agencies, including community, consumer, and parent-based agencies and organizations and other programs mandated by part C of the Individuals with Disabilities Education Act, which offer programs specifically designed to meet the unique language and communication needs of deaf and hard of hearing newborns, infants, toddlers, and children.

''(2) To collect data on statewide newborn and infant hearing screening, evaluation and intervention programs and systems that can be used for applied research, program evaluation and policy development.

''(b) TECHNICAL ASSISTANCE, DATA MANAGEMENT, AND APPLIED RESEARCH.—

''(1) CENTERS FOR DISEASE CONTROL AND PREVENTION.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall make awards of grants or cooperative agreements to provide technical assistance to State agencies to complement an intramural program and to conduct applied research related to newborn and infant hearing screening, evaluation and intervention programs and systems. The program shall develop standardized procedures for data management and program effectiveness and costs, such as—

''(A) to ensure quality monitoring of newborn and infant hearing loss screening, evaluation, and intervention programs and systems;

''(B) to provide technical assistance on data collection and management;

''(C) to study the costs and effectiveness of newborn and infant hearing screening, evaluation and intervention programs and systems conducted by State-based programs in order to answer issues of importance to state and national policymakers;

''(D) to identify the causes and risk factors for congenital hearing loss;

''(E) to study the effectiveness of newborn and infant hearing screening, audiologic and medical evaluations and intervention programs and systems by assessing the health, intellectual and social developmental, cognitive, and language status of these children at school age; and

''(F) to promote the sharing of data regarding early hearing loss with State-based birth defects

and developmental disabilities monitoring programs for the purpose of identifying previously unknown causes of hearing loss.

''(2) NATIONAL INSTITUTES OF HEALTH.—The Director of the National Institutes of Health, acting through the Director of the National Institute on Deafness and Other Communication Disorders, shall for purposes of this section, continue a program of research and development on the efficacy of new screening techniques and technology, including clinical studies of screening methods, studies on efficacy of intervention, and related research.

''(c) COORDINATION AND COLLABORATION.—

''(1) IN GENERAL.—In carrying out programs under this section, the Administrator of the Health Resources and Services Administration, the Director of the Centers for Disease Control and Prevention, and the Director of the National Institutes of Health shall collaborate and consult with other Federal agencies; State and local agencies, including those responsible for early intervention services pursuant to title XIX of the Social Security Act (Medicaid Early and Periodic Screening, Diagnosis and Treatment Program); title XXI of the Social Security Act (State Children's Health Insurance Program); title V of the Social Security Act (Maternal and Child Health Block Grant Program); and part C of the Individuals with Disabilities Education Act; consumer groups of and that serve individuals who are deaf and hard-of-hearing and their families; appropriate national medical and other health and education specialty organizations; persons who are deaf and hard-of-hearing and their families; other qualified professional personnel who are proficient in deaf or hard-of-hearing children's language and who possess the specialized knowledge, skills, and attributes needed to serve deaf and hard-of-hearing newborns, infants, toddlers, children, and their families; third-party payers and managed care organizations; and related commercial industries.

''(2) POLICY DEVELOPMENT.—The Administrator of the Health Resources and Services Administration, the Director of the Centers for Disease Control and Prevention, and the Director of the National Institutes of Health shall coordinate and collaborate on recommendations for policy development at the Federal and State levels and with the private sector, including consumer, medical and other health and education professional-based organizations, with respect to newborn and infant hearing screening, evaluation and intervention programs and systems.

''(3) STATE EARLY DETECTION, DIAGNOSIS, AND INTERVENTION PROGRAMS AND SYSTEMS; DATA COLLECTION.—The Administrator of the Health Resources and Services Administration and the Director of the Centers for Disease Control and Prevention shall coordinate and collaborate in assisting States to establish newborn and infant hearing screening, evaluation and intervention programs and systems under subsection (a) and to develop a data collection system under subsection (b).

''(d) RULE OF CONSTRUCTION; RELIGIOUS ACCOMMODATION.—Nothing in this section shall be construed to preempt or prohibit any State law, including State laws which do not require the screening for hearing loss of newborn infants or young children of parents who object to the screening on the grounds that such screening conflicts with the parents' religious beliefs.

''(e) DEFINITIONS.—For purposes of this section:

''(1) The term 'audiologic evaluation' refers to procedures to assess the status of the auditory system; to establish the site of the auditory disorder; the type and degree of hearing loss, and the potential effects of hearing loss on communication; and to identify appropriate treatment and referral options. Referral options should include linkage to State coordinating agencies under part C of the Individuals with Disabilities Education Act or other appropriate agencies, medical evaluation, hearing aid/sensory aid assessment, audiologic rehabilitation treatment, national and local consumer, self-help, parent, and education organizations, and other family-centered services.

''(2) The terms 'audiologic rehabilitation' and 'audiologic intervention' refer to procedures, techniques, and technologies to facilitate the receptive and expressive communication abilities of a child with hearing loss.

''(3) The term 'early intervention' refers to providing appropriate services for the child with hearing loss, including nonmedical services, and ensuring that families of the child are provided comprehensive, consumer-oriented information about the full range of family support, training, information services, communication options and are given the opportunity to consider the full range of educational and program placements and options for their child.

''(4) The term 'medical evaluation by a physician' refers to key components including history, examination, and medical decision making focused on symptomatic and related body systems for the purpose of diagnosing the etiology of hearing loss and related physical conditions, and for identifying appropriate treatment and referral options.

''(5) The term 'medical intervention' refers to the process by which a physician provides medical diagnosis and direction for medical and/or surgical treatment options of hearing loss and/or related medical disorder associated with hearing loss.

''(6) The term 'newborn and infant hearing screening' refers to objective physiologic procedures to detect possible hearing loss and to identify newborns and infants who, after rescreening, require further audiologic and medical evaluations.

''(f) AUTHORIZATION OF APPROPRIATIONS.—

''(1) STATEWIDE NEWBORN AND INFANT HEARING SCREENING, EVALUATION AND INTERVENTION PROGRAMS AND SYSTEMS.—For the purpose of carrying out subsection (a), there are authorized to be appropriated to the Health Resources and Services Administration such sums as may be necessary for fiscal year 2002.

''(2) TECHNICAL ASSISTANCE, DATA MANAGEMENT, AND APPLIED RESEARCH; CENTERS FOR DISEASE CONTROL AND PREVENTION.—For the purpose of carrying out subsection (b)(1), there are authorized to be appropriated to the Centers for Disease Control and Prevention such sums as may be necessary for fiscal year 2002.

''(3) TECHNICAL ASSISTANCE, DATA MANAGEMENT, AND APPLIED RESEARCH; NATIONAL INSTITUTE ON DEAFNESS AND OTHER COMMUNICATION DISORDERS.—For the purpose of carrying out subsection (b)(2), there are authorized to be appropriated to the National Institute on Deafness and Other Communication Disorders such sums as may be necessary for fiscal year 2002.''.

TITLE VIII—CHILDREN AND EPILEPSY

SEC. 801. NATIONAL PUBLIC HEALTH CAMPAIGN ON EPILEPSY; SEIZURE DISORDER DEMONSTRATION PROJECTS IN MEDICALLY UNDERSERVED AREAS.

Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b) is amended by adding at the end the following section:

''SEC. 330E. EPILEPSY; SEIZURE DISORDER.

''(a) NATIONAL PUBLIC HEALTH CAMPAIGN.—

''(1) IN GENERAL.—The Secretary shall develop and implement public health surveillance, education, research, and intervention strategies to improve the lives of persons with epilepsy, with a particular emphasis on children. Such projects may be carried out by the Secretary directly and through awards of grants or contracts to public or nonprofit private entities. The Secretary may directly or through such awards provide technical assistance with respect to the planning, development, and operation of such projects.

''(2) CERTAIN ACTIVITIES.—Activities under paragraph (1) shall include—

''(A) expanding current surveillance activities through existing monitoring systems and improving registries that maintain data on individuals with epilepsy, including children;

''(B) enhancing research activities on the diagnosis, treatment, and management of epilepsy;

''(C) implementing public and professional information and education programs regarding epilepsy, including initiatives which promote effective management of the disease through children's programs which are targeted to parents, schools, daycare providers, patients;

''(D) undertaking educational efforts with the media, providers of health care, schools and others regarding stigmas and secondary disabilities related to epilepsy and seizures, and its effects on youth;

''(E) utilizing and expanding partnerships with organizations with experience addressing the health and related needs of people with disabilities; and

''(F) other activities the Secretary deems appropriate.

''(3) COORDINATION OF ACTIVITIES.—The Secretary shall ensure that activities under this subsection are coordinated as appropriate with other agencies of the Public Health Service that carry out activities regarding epilepsy and seizure.

''(b) SEIZURE DISORDER; DEMONSTRATION PROJECTS IN MEDICALLY UNDERSERVED AREAS.—

''(1) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may make grants for the purpose of carrying out demonstration projects to improve access to health and other services regarding seizures to encourage early detection and treatment in children and others residing in medically underserved areas.

''(2) APPLICATION FOR GRANT.—A grant may not be awarded under paragraph (1) unless an application therefore is submitted to the Secretary and the Secretary approves such application. Such application shall be submitted in such form and manner and shall contain such information as the Secretary may prescribe.

''(c) DEFINITIONS.—For purposes of this section:

''(1) The term ''epilepsy'' refers to a chronic and serious neurological condition characterized by excessive electrical discharges in the brain causing recurring seizures affecting all life activities. The Secretary may revise the definition of such term to the extent the Secretary determines necessary.

''(2) The term ''medically underserved'' has the meaning applicable under section 799B(6).

''(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

TITLE IX—SAFE MOTHERHOOD; INFANT HEALTH PROMOTION

Subtitle A—Safe Motherhood Prevention Research

SEC. 901. PREVENTION RESEARCH AND OTHER ACTIVITIES.

Part B of title III of the Public Health Service Act, as amended by section 601 of this Act, is amended by inserting after section 317J the following section:

''SAFE MOTHERHOOD

''SEC. 317K. (a) SURVEILLANCE.—

''(1) PURPOSE.—The purpose of this subsection is to develop surveillance systems at the local, State, and national level to better understand the burden of maternal complications and mortality and to decrease the disparities among population at risk of death and complications from pregnancy.

''(2) ACTIVITIES.—For the purpose described in paragraph (1), the Secretary, acting through the Director of the Centers for Disease Control and Prevention, may carry out the following activities:

''(A) The Secretary may establish and implement a national surveillance program to identify

and promote the investigation of deaths and severe complications that occur during pregnancy.

''(B) The Secretary may expand the Pregnancy Risk Assessment Monitoring System to provide surveillance and collect data in each State.

''(C) The Secretary may expand the Maternal and Child Health Epidemiology Program to provide technical support, financial assistance, or the time-limited assignment of senior epidemiologists to maternal and child health programs in each State.

''(b) PREVENTION RESEARCH.—

''(1) PURPOSE.—The purpose of this subsection is to provide the Secretary with the authority to further expand research concerning risk factors, prevention strategies, and the roles of the family, health care providers and the community in safe motherhood.

''(2) RESEARCH.—The Secretary may carry out activities to expand research relating to—

''(A) encouraging preconception counseling, especially for at risk populations such as diabetics;

''(B) the identification of critical components of prenatal delivery and postpartum care;

''(C) the identification of outreach and support services, such as folic acid education, that are available for pregnant women;

''(D) the identification of women who are at high risk for complications;

''(E) preventing preterm delivery;

''(F) preventing urinary tract infections;

''(G) preventing unnecessary caesarean sections;

''(H) an examination of the higher rates of maternal mortality among African American women;

''(I) an examination of the relationship between domestic violence and maternal complications and mortality;

''(J) preventing and reducing adverse health consequences that may result from smoking, alcohol and illegal drug use before, during and after pregnancy;

''(K) preventing infections that cause maternal and infant complications; and

''(L) other areas determined appropriate by the Secretary.

''(c) PREVENTION PROGRAMS.—

''(1) IN GENERAL.—The Secretary may carry out activities to promote safe motherhood, including—

''(A) public education campaigns on healthy pregnancies and the building of partnerships with outside organizations concerned about safe motherhood;

''(B) education programs for physicians, nurses and other health care providers; and

''(C) activities to promote community support services for pregnant women.

''(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

Subtitle B—Pregnant Women and Infants Health Promotion

SEC. 911. PROGRAMS REGARDING PRENATAL AND POSTNATAL HEALTH.

Part B of title III of the Public Health Service Act, as amended by section 901 of this Act, is amended by inserting after section 317K the following section:

''PRENATAL AND POSTNATAL HEALTH

''SEC. 317L. (a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall carry out programs—

''(1) to collect, analyze, and make available data on prenatal smoking, alcohol and illegal drug use, including data on the implications of such activities and on the incidence and prevalence of such activities and their implications;

''(2) to conduct applied epidemiological research on the prevention of prenatal and postnatal smoking, alcohol and illegal drug use;

''(3) to support, conduct, and evaluate the effectiveness of educational and cessation programs; and

''(4) to provide information and education to the public on the prevention and implications of prenatal and postnatal smoking, alcohol and illegal drug use.

''(b) GRANTS.—In carrying out subsection (a), the Secretary may award grants to and enter into contracts with States, local governments, scientific and academic institutions, Federally qualified health centers, and other public and nonprofit entities, and may provide technical and consultative assistance to such entities.

''(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

TITLE X— PEDIATRIC RESEARCH INITIATIVE

SEC. 1001. ESTABLISHMENT OF PEDIATRIC RESEARCH INITIATIVE.

Part B of title IV of the Public Health Service Act, as amended by section 101 of this Act, is amended by adding at the end the following:

''PEDIATRIC RESEARCH INITIATIVE

''SEC. 409D. (a) ESTABLISHMENT.—The Secretary shall establish within the Office of the Director of NIH a Pediatric Research Initiative (referred to in this section as the 'Initiative') to conduct and support research that is directly related to diseases, disorders, and other conditions in children. The Initiative shall be headed by the Director of NIH.

''(b) PURPOSE.—The purpose of the Initiative is to provide funds to enable the Director of NIH—

''(1) to increase support for pediatric biomedical research within the National Institutes of Health to realize the expanding opportunities for advancement in scientific investigations and care for children;

''(2) to enhance collaborative efforts among the Institutes to conduct and support multidisciplinary research in the areas that the Director deems most promising; and

''(3) in coordination with the Food and Drug Administration, to increase the development of adequate pediatric clinical trials and pediatric use information to promote the safer and more effective use of prescription drugs in the pediatric population.

''(c) DUTIES.—In carrying out subsection (b), the Director of NIH shall—

''(1) consult with the Director of the National Institute of Child Health and Human Development and the other national research institutes, in considering their requests for new or expanded pediatric research efforts, and consult with the Administrator of the Health Resources and Services Administration and other advisors as the Director determines to be appropriate;

''(2) have broad discretion in the allocation of any Initiative assistance among the Institutes, among types of grants, and between basic and clinical research so long as the assistance is directly related to the illnesses and conditions of children; and

''(3) be responsible for the oversight of any newly appropriated Initiative funds and annually report to Congress and the public on the extent of the total funds obligated to conduct or support pediatric research across the National Institutes of Health, including the specific support and research awards allocated through the Initiative.

''(d) AUTHORIZATION.—For the purpose of carrying out this section, there are authorized to be appropriated $50,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 through 2005.

''(e) TRANSFER OF FUNDS.—The Director of NIH may transfer amounts appropriated under this section to any of the Institutes for a fiscal year to carry out the purposes of the Initiative under this section.''.

SEC. 1002. INVESTMENT IN TOMORROW'S PEDIATRIC RESEARCHERS.

(a) IN GENERAL.—Subpart 7 of part C of title IV of the Public Health Service Act, as amended by section 921 of this Act, is amended by adding at the end the following:

''INVESTMENT IN TOMORROW'S PEDIATRIC RESEARCHERS

''SEC. 452G. (a) ENHANCED SUPPORT.—In order to ensure the future supply of researchers dedicated to the care and research needs of children, the Director of the Institute, after consultation with the Administrator of the Health Resources and Services Administration, shall support activities to provide for—

''(1) an increase in the number and size of institutional training grants to institutions supporting pediatric training; and

''(2) an increase in the number of career development awards for health professionals who intend to build careers in pediatric basic and clinical research.

''(b) AUTHORIZATION.—For the purpose of carrying out subsection (a), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

(b) PEDIATRIC RESEARCH LOAN REPAYMENT PROGRAM.—Part G of title IV of the Public Health Service Act (42 U.S.C. 288 et seq.) is amended by inserting after section 487E the following section:

''PEDIATRIC RESEARCH LOAN REPAYMENT PROGRAM

''SEC. 487F. (a) IN GENERAL.—The Secretary, in consultation with the Director of NIH, may establish a pediatric research loan repayment program. Through such program—

''(1) the Secretary shall enter into contracts with qualified health professionals under which such professionals will agree to conduct pediatric research, in consideration of the Federal government agreeing to repay, for each year of such service, not more than $35,000 of the principal and interest of the educational loans of such professionals; and

''(2) the Secretary shall, for the purpose of providing reimbursements for tax liability resulting from payments made under paragraph (1) on behalf of an individual, make payments, in addition to payments under such paragraph, to the individual in an amount equal to 39 percent of the total amount of loan repayments made for the taxable year involved.

''(b) APPLICATION OF OTHER PROVISIONS.—The provisions of sections 338B, 338C, and 338E shall, except as inconsistent with paragraph (1), apply to the program established under such paragraph to the same extent and in the same manner as such provisions apply to the National Health Service Corps Loan Repayment Program established under subpart III of part D of title III.

''(c) FUNDING.—

''(1) IN GENERAL.—For the purpose of carrying out this section with respect to a national research institute the Secretary may reserve, from amounts appropriated for such institute for the fiscal year involved, such amounts as the Secretary determines to be appropriate.

''(2) AVAILABILITY OF FUNDS.—Amounts made available to carry out this section shall remain available until the expiration of the second fiscal year beginning after the fiscal year for which such amounts were made available.''.

SEC. 1003. REVIEW OF REGULATIONS.

(a) REVIEW.—By not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall conduct a review of the regulations under subpart D of part 46 of title 45, Code of Federal Regulations, consider any modifications necessary to ensure the adequate and appropriate protection of children participating in research, and report the findings of the Secretary to Congress.

(b) AREAS OF REVIEW.—In conducting the review under subsection (a), the Secretary of Health and Human Services shall consider—

(1) the appropriateness of the regulations for children of differing ages and maturity levels, including legal status;

(2) the definition of ''minimal risk'' for a healthy child or for a child with an illness;

(3) the definitions of ''assent'' and ''permission'' for child clinical research participants and their parents or guardians and of ''adequate provisions'' for soliciting assent or permission in research as such definitions relate to the process of obtaining the agreement of children participating in research and the parents or guardians of such children;

(4) the definitions of ''direct benefit to the individual subjects'' and ''generalizable knowledge about the subject's disorder or condition'';

(5) whether payment (financial or otherwise) may be provided to a child or his or her parent or guardian for the participation of the child in research, and if so, the amount and type given;

(6) the expectations of child research participants and their parent or guardian for the direct benefits of the child's research involvement;

(7) safeguards for research involving children conducted in emergency situations with a waiver of informed assent;

(8) parent and child notification in instances in which the regulations have not been complied with;

(9) compliance with the regulations in effect on the date of enactment of this Act, the monitoring of such compliance, and enforcement actions for violations of such regulations; and

(10) the appropriateness of current practices for recruiting children for participation in research.

(c) CONSULTATION.—In conducting the review under subsection (a), the Secretary of Health and Human Services shall consult broadly with experts in the field, including pediatric pharmacologists, pediatricians, pediatric professional societies, bioethics experts, clinical investigators, institutional review boards, industry experts, appropriate Federal agencies, and children who have participated in research studies and the parents, guardians, or families of such children.

(d) CONSIDERATION OF ADDITIONAL PROVISIONS.—In conducting the review under subsection (a), the Secretary of Health and Human Services shall consider and, not later than 6 months after the date of enactment of this Act, report to Congress concerning—

(1) whether the Secretary should establish data and safety monitoring boards or other mechanisms to review adverse events associated with research involving children; and

(2) whether the institutional review board oversight of clinical trials involving children is adequate to protect children.

SEC. 1004. LONG-TERM CHILD DEVELOPMENT STUDY.

(a) PURPOSE.—It is the purpose of this section to authorize the National Institute of Child Health and Human Development to conduct a national longitudinal study of environmental influences (including physical, chemical, biological, and psychosocial) on children's health and development.

(b) IN GENERAL.—The Director of the National Institute of Child Health and Human Development shall establish a consortium of representatives from appropriate Federal agencies (including the Centers for Disease Control and Prevention, the Environmental Protection Agency) to—

(1) plan, develop, and implement a prospective cohort study, from birth to adulthood, to evaluate the effects of both chronic and intermittent exposures on child health and human development; and

(2) investigate basic mechanisms of developmental disorders and environmental factors, both risk and protective, that influence health and developmental processes.

(c) REQUIREMENT.—The study under subsection (b) shall—

(1) incorporate behavioral, emotional, educational, and contextual consequences to enable a complete assessment of the physical, chemical, biological and psychosocial environmental influences on children's well-being;

(2) gather data on environmental influences and outcomes on diverse populations of children, which may include the consideration of prenatal exposures;

(3) consider health disparities among children which may include the consideration of prenatal exposures.

(d) REPORT.—Beginning not later than 3 years after the date of enactment of this Act, and periodically thereafter for the duration of the study under this section, the Director of the National Institute of Child Health and Human Development shall prepare and submit to the appropriate committees of Congress a report on the implementation and findings made under the planning and feasibility study conducted under this section.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $18,000,000 for fiscal year 2001, and such sums as may be necessary for each the fiscal years 2002 through 2005.

TITLE XI—CHILDHOOD MALIGNANCIES

SEC. 1101. PROGRAMS OF CENTERS FOR DISEASE CONTROL AND PREVENTION AND NATIONAL INSTITUTES OF HEALTH.

Part P of title III of the Public Health Service Act, as amended by section 702 of this Act, is amended by adding at the end the following section:

''SEC. 399N. CHILDHOOD MALIGNANCIES.

''(a) IN GENERAL.—The Secretary, acting as appropriate through the Director of the Centers for Disease Control and Prevention and the Director of the National Institutes of Health, shall study environmental and other risk factors for childhood cancers (including skeletal malignancies, leukemias, malignant tumors of the central nervous system, lymphomas, soft tissue sarcomas, and other malignant neoplasms) and carry out projects to improve outcomes among children with childhood cancers and resultant secondary conditions, including limb loss, anemia, rehabilitation, and palliative care. Such projects shall be carried out by the Secretary directly and through awards of grants or contracts.

''(b) CERTAIN ACTIVITIES.—Activities under subsection (a) include—

''(1) the expansion of current demographic data collection and population surveillance efforts to include childhood cancers nationally;

''(2) the development of a uniform reporting system under which treating physicians, hospitals, clinics, and states report the diagnosis of childhood cancers, including relevant associated epidemiological data; and

''(3) support for the National Limb Loss Information Center to address, in part, the primary and secondary needs of persons who experience childhood cancers in order to prevent or minimize the disabling nature of these cancers.

''(c) COORDINATION OF ACTIVITIES.—The Secretary shall assure that activities under this section are coordinated as appropriate with other agencies of the Public Health Service that carry out activities focused on childhood cancers and limb loss.

''(d) DEFINITION.—For purposes of this section, the term 'childhood cancer' refers to a spectrum of different malignancies that vary by histology, site of disease, origin, race, sex, and age. The Secretary may for purposes of this section revise the definition of such term to the extent determined by the Secretary to be appropriate.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

TITLE XII—ADOPTION AWARENESS

Subtitle A—Infant Adoption Awareness

SEC. 1201. GRANTS REGARDING INFANT ADOPTION AWARENESS.

Subpart I of part D of title III of the Public Health Service Act, as amended by section 801 of this Act, is amended by adding at the end the following section:

''SEC. 330F. CERTAIN SERVICES FOR PREGNANT WOMEN.

''(a) INFANT ADOPTION AWARENESS.—

''(1) IN GENERAL.—The Secretary shall make grants to national, regional, or local adoption organizations for the purpose of developing and implementing programs to train the designated staff of eligible health centers in providing adoption information and referrals to pregnant women on an equal basis with all other courses of action included in nondirective counseling to pregnant women.

''(2) BEST-PRACTICES GUIDELINES.—

''(A) IN GENERAL.—A condition for the receipt of a grant under paragraph (1) is that the adoption organization involved agree that, in providing training under such paragraph, the organization will follow the guidelines developed under subparagraph (B).

''(B) PROCESS FOR DEVELOPMENT OF GUIDELINES.—

''(i) IN GENERAL.—The Secretary shall establish and supervise a process described in clause (ii) in which the participants are—

''(I) an appropriate number and variety of adoption organizations that, as a group, have expertise in all models of adoption practice and that represent all members of the adoption triad (birth mother, infant, and adoptive parent); and

''(II) affected public health entities.

''(ii) DESCRIPTION OF PROCESS.—The process referred to in clause (i) is a process in which the participants described in such clause collaborate to develop best-practices guidelines on the provision of adoption information and referrals to pregnant women on an equal basis with all other courses of action included in nondirective counseling to pregnant women.

''(iii) DATE CERTAIN FOR DEVELOPMENT.—The Secretary shall ensure that the guidelines described in clause (ii) are developed not later than 180 days after the date of the enactment of the Children's Health Act of 2000.

''(C) RELATION TO AUTHORITY FOR GRANTS.—The Secretary may not make any grant under paragraph (1) before the date on which the guidelines under subparagraph (B) are developed.

''(3) USE OF GRANT.—

''(A) IN GENERAL.—With respect to a grant under paragraph (1)—

''(i) an adoption organization may expend the grant to carry out the programs directly or through grants to or contracts with other adoption organizations;

''(ii) the purposes for which the adoption organization expends the grant may include the development of a training curriculum, consistent with the guidelines developed under paragraph (2)(B); and

''(iii) a condition for the receipt of the grant is that the adoption organization agree that, in providing training for the designated staff of eligible health centers, such organization will make reasonable efforts to ensure that the individuals who provide the training are individuals who are knowledgeable in all elements of the adoption process and are experienced in providing adoption information and referrals in the geographic areas in which the eligible health centers are located, and that the designated staff receive the training in such areas.

''(B) RULE OF CONSTRUCTION REGARDING TRAINING OF TRAINERS.—With respect to individuals who under a grant under paragraph (1) provide training for the designated staff of eligible health centers (referred to in this subparagraph as 'trainers'), subparagraph (A)(iii) may not be construed as establishing any limitation

regarding the geographic area in which the trainers receive instruction in being such trainers. A trainer may receive such instruction in a different geographic area than the area in which the trainer trains (or will train) the designated staff of eligible health centers.

''(4) ADOPTION ORGANIZATIONS; ELIGIBLE HEALTH CENTERS; OTHER DEFINITIONS.—For purposes of this section:

''(A) The term 'adoption organization' means a national, regional, or local organization—

''(i) among whose primary purposes are adoption;

''(ii) that is knowledgeable in all elements of the adoption process and on providing adoption information and referrals to pregnant women; and

''(iii) that is a nonprofit private entity.

''(B) The term 'designated staff', with respect to an eligible health center, means staff of the center who provide pregnancy or adoption information and referrals (or will provide such information and referrals after receiving training under a grant under paragraph (1)).

''(C) The term 'eligible health centers' means public and nonprofit private entities that provide health services to pregnant women.

''(5) TRAINING FOR CERTAIN ELIGIBLE HEALTH CENTERS.—A condition for the receipt of a grant under paragraph (1) is that the adoption organization involved agree to make reasonable efforts to ensure that the eligible health centers with respect to which training under the grant is provided include—

''(A) eligible health centers that receive grants under section 1001 (relating to voluntary family planning projects);

''(B) eligible health centers that receive grants under section 330 (relating to community health centers, migrant health centers, and centers regarding homeless individuals and residents of public housing); and

''(C) eligible health centers that receive grants under this Act for the provision of services in schools.

''(6) PARTICIPATION OF CERTAIN ELIGIBLE HEALTH CLINICS.—In the case of eligible health centers that receive grants under section 330 or 1001:

''(A) Within a reasonable period after the Secretary begins making grants under paragraph (1), the Secretary shall provide eligible health centers with complete information about the training available from organizations receiving grants under such paragraph. The Secretary shall make reasonable efforts to encourage eligible health centers to arrange for designated staff to participate in such training. Such efforts shall affirm Federal requirements, if any, that the eligible health center provide nondirective counseling to pregnant women.

''(B) All costs of such centers in obtaining the training shall be reimbursed by the organization that provides the training, using grants under paragraph (1).

''(C) Not later than one year after the date of the enactment of the Children's Health Act of 2000, the Secretary shall submit to the appropriate committees of the Congress a report evaluating the extent to which adoption information and referral, upon request, are provided by eligible health centers. Within a reasonable time after training under this section is initiated, the Secretary shall submit to the appropriate committees of the Congress a report evaluating the extent to which adoption information and referral, upon request, are provided by eligible health centers in order to determine the effectiveness of such training and the extent to which such training complies with subsection (a)(1). In preparing the reports required by this subparagraph, the Secretary shall in no respect interpret the provisions of this section to allow any interference in the provider-patient relationship, any breach of patient confidentiality, or any monitoring or auditing of the counseling process or patient records which breaches patient confidentiality or reveals patient identity. The reports required by this subparagraph shall be conducted by the Secretary acting through the Administrator of the Health Resources and Services Administration and in collaboration with the Director of the Agency for Healthcare Research and Quality.

''(b) APPLICATION FOR GRANT.—The Secretary may make a grant under subsection (a) only if an application for the grant is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

''(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

Subtitle B—Special Needs Adoption Awareness

SEC. 1211. SPECIAL NEEDS ADOPTION PROGRAMS; PUBLIC AWARENESS CAMPAIGN AND OTHER ACTIVITIES.

Subpart I of part D of title III of the Public Health Service Act, as amended by section 1201 of this Act, is amended by adding at the end the following section:

''SEC. 330G. SPECIAL NEEDS ADOPTION PROGRAMS; PUBLIC AWARENESS CAMPAIGN AND OTHER ACTIVITIES.

''(a) SPECIAL NEEDS ADOPTION AWARENESS CAMPAIGN.—

''(1) IN GENERAL.—The Secretary shall, through making grants to nonprofit private entities, provide for the planning, development, and carrying out of a national campaign to provide information to the public regarding the adoption of children with special needs.

''(2) INPUT ON PLANNING AND DEVELOPMENT.—In providing for the planning and development of the national campaign under paragraph (1), the Secretary shall provide for input from a number and variety of adoption organizations throughout the States in order that the full national diversity of interests among adoption organizations is represented in the planning and development of the campaign.

''(3) CERTAIN FEATURES.—With respect to the national campaign under paragraph (1):

''(A) The campaign shall be directed at various populations, taking into account as appropriate differences among geographic regions, and shall be carried out in the language and cultural context that is most appropriate to the population involved.

''(B) The means through which the campaign may be carried out include—

''(i) placing public service announcements on television, radio, and billboards; and

''(ii) providing information through means that the Secretary determines will reach individuals who are most likely to adopt children with special needs.

''(C) The campaign shall provide information on the subsidies and supports that are available to individuals regarding the adoption of children with special needs.

''(D) The Secretary may provide that the placement of public service announcements, and the dissemination of brochures and other materials, is subject to review by the Secretary.

''(4) MATCHING REQUIREMENT.—

''(A) IN GENERAL.—With respect to the costs of the activities to be carried out by an entity pursuant to paragraph (1), a condition for the receipt of a grant under such paragraph is that the entity agree to make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that is not less than 25 percent of such costs.

''(B) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions under subparagraph (A) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

''(b) NATIONAL RESOURCES PROGRAM.—The Secretary shall (directly or through grant or contract) carry out a program that, through toll-free telecommunications, makes available to the public information regarding the adoption of children with special needs. Such information shall include the following:

''(1) A list of national, State, and regional organizations that provide services regarding such adoptions, including exchanges and other information on communicating with the organizations. The list shall represent the full national diversity of adoption organizations.

''(2) Information beneficial to individuals who adopt such children, including lists of support groups for adoptive parents and other postadoptive services.

''(c) OTHER PROGRAMS.—With respect to the adoption of children with special needs, the Secretary shall make grants—

''(1) to provide assistance to support groups for adoptive parents, adopted children, and siblings of adopted children; and

''(2) to carry out studies to identify—

''(A) the barriers to completion of the adoption process; and

''(B) those components that lead to favorable long-term outcomes for families that adopt children with special needs.

''(d) APPLICATION FOR GRANT.—The Secretary may make an award of a grant or contract under this section only if an application for the award is submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.

''(e) FUNDING.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

TITLE XIII—TRAUMATIC BRAIN INJURY

SEC. 1301. PROGRAMS OF CENTERS FOR DISEASE CONTROL AND PREVENTION.

(a) IN GENERAL.—Section 393A of the Public Health Service Act (42 U.S.C. 280b–1b) is amended—

(1) in subsection (b)—

(A) in paragraph (1), by striking ''and'' at the end;

(B) in paragraph (2), by striking the period and inserting ''; and''; and

(C) by adding at the end the following:

''(3) the implementation of a national education and awareness campaign regarding such injury (in conjunction with the program of the Secretary regarding health-status goals for 2010, commonly referred to as Healthy People 2010), including—

''(A) the national dissemination of information on—

''(i) incidence and prevalence; and

''(ii) information relating to traumatic brain injury and the sequelae of secondary conditions arising from traumatic brain injury upon discharge from hospitals and trauma centers; and

''(B) the provision of information in primary care settings, including emergency rooms and trauma centers, concerning the availability of State level services and resources.'';

(2) in subsection (d)—

(A) in the second sentence, by striking ''anoxia due to near drowning.'' and inserting ''anoxia due to trauma.''; and

(B) in the third sentence, by inserting before the period the following: '', after consultation with States and other appropriate public or nonprofit private entities''.

(b) NATIONAL REGISTRY.—Part J of title III of the Public Health Service Act (42 U.S.C. 280b et seq.) is amended by inserting after section 393A the following section:

''NATIONAL PROGRAM FOR TRAUMATIC BRAIN INJURY REGISTRIES

''SEC. 393B. (a) IN GENERAL.—The Secretary, acting through the Director of the Centers for

Disease Control and Prevention, may make grants to States or their designees to operate the State's traumatic brain injury registry, and to academic institutions to conduct applied research that will support the development of such registries, to collect data concerning—

''(1) demographic information about each traumatic brain injury;

''(2) information about the circumstances surrounding the injury event associated with each traumatic brain injury;

''(3) administrative information about the source of the collected information, dates of hospitalization and treatment, and the date of injury; and

''(4) information characterizing the clinical aspects of the traumatic brain injury, including the severity of the injury, outcomes of the injury, the types of treatments received, and the types of services utilized.''.

SEC. 1302. STUDY AND MONITOR INCIDENCE AND PREVALENCE.

Section 4 of Public Law 104–166 (42 U.S.C. 300d–61 note) is amended—

(1) in subsection (a)(1)(A)—

(A) by striking clause (i) and inserting the following:

''(i)(I) determine the incidence and prevalence of traumatic brain injury in all age groups in the general population of the United States, including institutional settings; and

''(II) determine appropriate methodological strategies to obtain data on the incidence and prevalence of mild traumatic brain injury and report to Congress concerning such within 18 months of the date of enactment of the Children's Health Act of 2000; and''; and

(B) in clause (ii), by striking '', if the Secretary determines that such a system is appropriate'';

(2) in subsection (a)(1)(B)(i), by inserting '', including return to work or school and community participation,'' after ''functioning''; and

(3) in subsection (d), to read as follows:

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

SEC. 1303. PROGRAMS OF NATIONAL INSTITUTES OF HEALTH.

(a) INTERAGENCY PROGRAM.—Section 1261(d)(4) of the Public Health Service Act (42 U.S.C. 300d–61(d)(4)) is amended—

(1) in subparagraph (A), by striking ''degree of injury'' and inserting ''degree of brain injury'';

(2) in subparagraph (B), by striking ''acute injury'' and inserting ''acute brain injury''; and

(3) in subparagraph (D), by striking ''injury treatment'' and inserting ''brain injury treatment''.

(b) DEFINITION.—Section 1261(h)(4) of the Public Health Service Act (42 U.S.C. 300d–61(h)(4)) is amended—

(1) in the second sentence, by striking ''anoxia due to near drowning.'' and inserting ''anoxia due to trauma.''; and

(2) in the third sentence, by inserting before the period the following: '', after consultation with States and other appropriate public or nonprofit private entities''.

(c) RESEARCH ON COGNITIVE AND NEUROBEHAVIORAL DISORDERS ARISING FROM TRAUMATIC BRAIN INJURY.—Section 1261(d)(4) of the Public Health Service Act (42 U.S.C. 300d–61(d)(4)) is amended—

(1) in subparagraph (C), by striking ''and'' after the semicolon at the end;

(2) in subparagraph (D), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(E) carrying out subparagraphs (A) through (D) with respect to cognitive disorders and neurobehavioral consequences arising from traumatic brain injury, including the development, modification, and evaluation of therapies and programs of rehabilitation toward reaching or restoring normal capabilities in areas such as reading, comprehension, speech, reasoning, and deduction.''.

(d) AUTHORIZATION OF APPROPRIATIONS.—Section 1261 of the Public Health Service Act (42 U.S.C. 300d–61) is amended by adding at the end the following:

''(i) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

SEC. 1304. PROGRAMS OF HEALTH RESOURCES AND SERVICES ADMINISTRATION.

Section 1252 of the Public Health Service Act (42 U.S.C. 300d–51) is amended—

(1) in the section heading by striking ''***DEMONSTRATION***'';

(2) in subsection (a), by striking ''demonstration'';

(3) in subsection (b)(3)—

(A) in subparagraph (A)(iv), by striking ''representing traumatic brain injury survivors'' and inserting ''representing individuals with traumatic brain injury''; and

(B) in subparagraph (B), by striking ''who are survivors of'' and inserting ''with'';

(4) in subsection (c)—

(A) in paragraph (1), by striking '', in cash,''; and

(B) in paragraph (2), by amending the paragraph to read as follows:

''(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions under paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.'';

(5) by redesignating subsections (e) through (h) as subsections (g) through (j), respectively; and

(6) by inserting after subsection (d) the following subsections:

''(e) CONTINUATION OF PREVIOUSLY AWARDED DEMONSTRATION PROJECTS.—A State that received a grant under this section prior to the date of the enactment of the Children's Health Act of 2000 may compete for new project grants under this section after such date of enactment.

''(f) USE OF STATE GRANTS.—

''(1) COMMUNITY SERVICES AND SUPPORTS.—A State shall (directly or through awards of contracts to nonprofit private entities) use amounts received under a grant under this section for the following:

''(A) To develop, change, or enhance community-based service delivery systems that include timely access to comprehensive appropriate services and supports. Such service and supports—

''(i) shall promote full participation by individuals with brain injury and their families in decision making regarding the services and supports; and

''(ii) shall be designed for children and other individuals with traumatic brain injury.

''(B) To focus on outreach to underserved and inappropriately served individuals, such as individuals in institutional settings, individuals with low socioeconomic resources, individuals in rural communities, and individuals in culturally and linguistically diverse communities.

''(C) To award contracts to nonprofit entities for consumer or family service access training, consumer support, peer mentoring, and parent to parent programs.

''(D) To develop individual and family service coordination or case management systems.

''(E) To support other needs identified by the advisory board under subsection (b) for the State involved.

''(2) BEST PRACTICES.—

''(A) IN GENERAL.—State services and supports provided under a grant under this section shall reflect the best practices in the field of traumatic brain injury, shall be in compliance with title II of the Americans with Disabilities Act of 1990, and shall be supported by quality assurance measures as well as state-of-the-art health care and integrated community supports, regardless of the severity of injury.

''(B) DEMONSTRATION BY STATE AGENCY.—The State agency responsible for administering amounts received under a grant under this section shall demonstrate that it has obtained knowledge and expertise of traumatic brain injury and the unique needs associated with traumatic brain injury.

''(3) STATE CAPACITY BUILDING.—A State may use amounts received under a grant under this section to—

''(A) educate consumers and families;

''(B) train professionals in public and private sector financing (such as third party payers, State agencies, community-based providers, schools, and educators);

''(C) develop or improve case management or service coordination systems;

''(D) develop best practices in areas such as family or consumer support, return to work, housing or supportive living personal assistance services, assistive technology and devices, behavioral health services, substance abuse services, and traumatic brain injury treatment and rehabilitation;

''(E) tailor existing State systems to provide accommodations to the needs of individuals with brain injury (including systems administered by the State departments responsible for health, mental health, labor/employment, education, mental retardation/developmental disorders, transportation, and correctional systems);

''(F) improve data sets coordinated across systems and other needs identified by a State plan supported by its advisory council; and

''(G) develop capacity within targeted communities.'';

(5) in subsection (g) (as so redesignated), by striking ''agencies of the Public Health Service'' and inserting ''Federal agencies'';

(6) in subsection (i) (as redesignated by paragraph (3))—

(A) in the second sentence, by striking ''anoxia due to near drowning.'' and inserting ''anoxia due to trauma.''; and

(B) in the third sentence, by inserting before the period the following: '', after consultation with States and other appropriate public or nonprofit private entities''; and

(7) in subsection (j) (as so redesignated), by amending the subsection to read as follows:

''(j) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

SEC. 1305. STATE GRANTS FOR PROTECTION AND ADVOCACY SERVICES.

Part E of title XII of the Public Health Service Act (42 U.S.C. 300d–51 et seq.) is amended by adding at the end the following:

''SEC. 1253. STATE GRANTS FOR PROTECTION AND ADVOCACY SERVICES.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration (referred to in this section as the 'Administrator'), shall make grants to protection and advocacy systems for the purpose of enabling such systems to provide services to individuals with traumatic brain injury.

''(b) SERVICES PROVIDED.—Services provided under this section may include the provision of—

''(1) information, referrals, and advice;

''(2) individual and family advocacy;

''(3) legal representation; and

''(4) specific assistance in self-advocacy.

''(c) APPLICATION.—To be eligible to receive a grant under this section, a protection and advocacy system shall submit an application to the Administrator at such time, in such form and manner, and accompanied by such information

and assurances as the Administrator may require.

''(d) APPROPRIATIONS LESS THAN $2,700,000.—

''(1) IN GENERAL.—With respect to any fiscal year in which the amount appropriated under subsection (i) to carry out this section is less than $2,700,000, the Administrator shall make grants from such amount to individual protection and advocacy systems within States to enable such systems to plan for, develop outreach strategies for, and carry out services authorized under this section for individuals with traumatic brain injury.

''(2) AMOUNT.—The amount of each grant provided under paragraph (1) shall be determined as set forth in paragraphs (2) and (3) of subsection (e).

''(e) APPROPRIATIONS OF $2,700,000 OR MORE.—

''(1) POPULATION BASIS.—Except as provided in paragraph (2), with respect to each fiscal year in which the amount appropriated under subsection (i) to carry out this section is $2,700,000 or more, the Administrator shall make a grant to a protection and advocacy system within each State.

''(2) AMOUNT.—The amount of a grant provided to a system under paragraph (1) shall be equal to an amount bearing the same ratio to the total amount appropriated for the fiscal year involved under subsection (i) as the population of the State in which the grantee is located bears to the population of all States.

''(3) MINIMUMS.—Subject to the availability of appropriations, the amount of a grant a protection and advocacy system under paragraph (1) for a fiscal year shall—

''(A) in the case of a protection and advocacy system located in American Samoa, Guam, the United States Virgin Islands, or the Commonwealth of the Northern Mariana Islands, and the protection and advocacy system serving the American Indian consortium, not be less than $20,000; and

''(B) in the case of a protection and advocacy system in a State not described in subparagraph (A), not be less than $50,000.

''(4) INFLATION ADJUSTMENT.—For each fiscal year in which the total amount appropriated under subsection (i) to carry out this section is $5,000,000 or more, and such appropriated amount exceeds the total amount appropriated to carry out this section in the preceding fiscal year, the Administrator shall increase each of the minimum grants amount described in subparagraphs (A) and (B) of paragraph (3) by a percentage equal to the percentage increase in the total amount appropriated under subsection (i) to carry out this section between the preceding fiscal year and the fiscal year involved.

''(f) CARRYOVER.—Any amount paid to a protection and advocacy system that serves a State or the American Indian consortium for a fiscal year under this section that remains unobligated at the end of such fiscal year shall remain available to such system for obligation during the next fiscal year for the purposes for which such amount was originally provided.

''(g) DIRECT PAYMENT.—Notwithstanding any other provision of law, the Administrator shall pay directly to any protection and advocacy system that complies with the provisions of this section, the total amount of the grant for such system, unless the system provides otherwise for such payment.

''(h) ANNUAL REPORT.—Each protection and advocacy system that receives a payment under this section shall submit an annual report to the Administrator concerning the services provided to individuals with traumatic brain injury by such system.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $5,000,000 for fiscal year 2001, and such sums as may be necessary for each the fiscal years 2002 through 2005.

''(j) DEFINITIONS.—In this section:

''(1) AMERICAN INDIAN CONSORTIUM.—The term 'American Indian consortium' means a consortium established under part C of the Developmental Disabilities Assistance Bill of Rights Act (42 U.S.C. 6042 et seq.).

''(2) PROTECTION AND ADVOCACY SYSTEM.—The term 'protection and advocacy system' means a protection and advocacy system established under part C of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6042 et seq.).

''(3) STATE.—The term 'State', unless otherwise specified, means the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.''.

SEC. 1306. AUTHORIZATION OF APPROPRIATIONS FOR CERTAIN PROGRAMS.

Section 394A of the Public Health Service Act (42 U.S.C. 280b–3) is amended by striking ''and'' after ''1994'' and by inserting before the period the following: '', and such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

TITLE XIV—CHILD CARE SAFETY AND HEALTH GRANTS

SEC. 1401. DEFINITIONS.

In this title:

(1) CHILD WITH A DISABILITY; INFANT OR TODDLER WITH A DISABILITY.—The terms ''child with a disability'' and ''infant or toddler with a disability'' have the meanings given the terms in sections 602 and 632 of the Individuals with Disabilities Education Act (20 U.S.C. 1401 and 1431).

(2) ELIGIBLE CHILD CARE PROVIDER.—The term ''eligible child care provider'' means a provider of child care services for compensation, including a provider of care for a school-age child during non-school hours, that—

(A) is licensed, regulated, registered, or otherwise legally operating, under State and local law; and

(B) satisfies the State and local requirements, applicable to the child care services the provider provides.

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(4) STATE.—The term ''State'' means any of the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

SEC. 1402. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to carry out this title $200,000,000 for fiscal year 2001, and such sums as may be necessary for each subsequent fiscal year.

SEC. 1403. PROGRAMS.

The Secretary shall make allotments to eligible States under section 1404. The Secretary shall make the allotments to enable the States to establish programs to improve the health and safety of children receiving child care outside the home, by preventing illnesses and injuries associated with that care and promoting the health and well-being of children receiving that care.

SEC. 1404. AMOUNTS RESERVED; ALLOTMENTS.

(a) AMOUNTS RESERVED.—The Secretary shall reserve not more than ½ of 1 percent of the amount appropriated under section 1402 for each fiscal year to make allotments to Guam, American Samoa, the United States Virgin Islands, and the Commonwealth of the Northern Mariana Islands to be allotted in accordance with their respective needs.

(b) STATE ALLOTMENTS.—

(1) GENERAL RULE.—From the amounts appropriated under section 1402 for each fiscal year and remaining after reservations are made under subsection (a), the Secretary shall allot to each State an amount equal to the sum of—

(A) an amount that bears the same ratio to 50 percent of such remainder as the product of the young child factor of the State and the allotment percentage of the State bears to the sum of the corresponding products for all States; and

(B) an amount that bears the same ratio to 50 percent of such remainder as the product of the school lunch factor of the State and the allotment percentage of the State bears to the sum of the corresponding products for all States.

(2) YOUNG CHILD FACTOR.—In this subsection, the term ''young child factor'' means the ratio of the number of children under 5 years of age in a State to the number of such children in all States, as provided by the most recent annual estimates of population in the States by the Census Bureau of the Department of Commerce.

(3) SCHOOL LUNCH FACTOR.—In this subsection, the term ''school lunch factor'' means the ratio of the number of children who are receiving free or reduced price lunches under the school lunch program established under the National School Lunch Act (42 U.S.C. 1751 et seq.) in the State to the number of such children in all States, as determined annually by the Department of Agriculture.

(4) ALLOTMENT PERCENTAGE.—

(A) IN GENERAL.—For purposes of this subsection, the allotment percentage for a State shall be determined by dividing the per capita income of all individuals in the United States, by the per capita income of all individuals in the State.

(B) LIMITATIONS.—If an allotment percentage determined under subparagraph (A) for a State—

(i) is more than 1.2 percent, the allotment percentage of the State shall be considered to be 1.2 percent; and

(ii) is less than 0.8 percent, the allotment percentage of the State shall be considered to be 0.8 percent.

(C) PER CAPITA INCOME.—For purposes of subparagraph (A), per capita income shall be—

(i) determined at 2-year intervals;

(ii) applied for the 2-year period beginning on October 1 of the first fiscal year beginning after the date such determination is made; and

(iii) equal to the average of the annual per capita incomes for the most recent period of 3 consecutive years for which satisfactory data are available from the Department of Commerce on the date such determination is made.

(c) DATA AND INFORMATION.—The Secretary shall obtain from each appropriate Federal agency, the most recent data and information necessary to determine the allotments provided for in subsection (b).

(d) DEFINITION.—In this section, the term ''State'' includes only the several States of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

SEC. 1405. STATE APPLICATIONS.

To be eligible to receive an allotment under section 1404, a State shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require. The application shall contain information assessing the needs of the State with regard to child care health and safety, the goals to be achieved through the program carried out by the State under this title, and the measures to be used to assess the progress made by the State toward achieving the goals.

SEC. 1406. USE OF FUNDS.

(a) IN GENERAL.—A State that receives an allotment under section 1404 shall use the funds made available through the allotment to carry out 2 or more activities consisting of—

(1) providing training and education to eligible child care providers on preventing injuries and illnesses in children, and promoting health-related practices;

(2) strengthening licensing, regulation, or registration standards for eligible child care providers;

(3) assisting eligible child care providers in meeting licensing, regulation, or registration standards, including rehabilitating the facilities of the providers, in order to bring the facilities into compliance with the standards;

(4) enforcing licensing, regulation, or registration standards for eligible child care providers, including holding increased unannounced inspections of the facilities of those providers;

(5) providing health consultants to provide advice to eligible child care providers;

(6) assisting eligible child care providers in enhancing the ability of the providers to serve children with disabilities and infants and toddlers with disabilities;

(7) conducting criminal background checks for eligible child care providers and other individuals who have contact with children in the facilities of the providers;

(8) providing information to parents on what factors to consider in choosing a safe and healthy child care setting; or

(9) assisting in improving the safety of transportation practices for children enrolled in child care programs with eligible child care providers.

(b) SUPPLEMENT, NOT SUPPLANT.—Funds appropriated pursuant to the authority of this title shall be used to supplement and not supplant other Federal, State, and local public funds expended to provide services for eligible individuals.

SEC. 1407. REPORTS.

Each State that receives an allotment under section 1404 shall annually prepare and submit to the Secretary a report that describes—

(1) the activities carried out with funds made available through the allotment; and

(2) the progress made by the State toward achieving the goals described in the application submitted by the State under section 1405.

TITLE XV—HEALTHY START INITIATIVE

SEC. 1501. CONTINUATION OF HEALTHY START PROGRAM.

Subpart I of part D of title III of the Public Health Service Act, as amended by section 1211 of this Act, is amended by adding at the end the following section:

"SEC. 330H. HEALTHY START FOR INFANTS.

''(a) IN GENERAL.—

''(1) CONTINUATION AND EXPANSION OF PROGRAM.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, Maternal and Child Health Bureau, shall under authority of this section continue in effect the Healthy Start Initiative and may, during fiscal year 2001 and subsequent years, carry out such program on a national basis.

''(2) DEFINITION.—For purposes of paragraph (1), the term 'Healthy Start Initiative' is a reference to the program that, as an initiative to reduce the rate of infant mortality and improve perinatal outcomes, makes grants for project areas with high annual rates of infant mortality and that, prior to the effective date of this section, was a demonstration program carried out under section 301.

''(3) ADDITIONAL GRANTS.— Effective upon increased funding beyond fiscal year 1999 for such Initiative, additional grants may be made to States to assist communities with technical assistance, replication of successful projects, and State policy formation to reduce infant and maternal mortality and morbidity.

''(b) REQUIREMENTS FOR MAKING GRANTS.—In making grants under subsection (a), the Secretary shall require that applicants (in addition to meeting all eligibility criteria established by the Secretary) establish, for project areas under such subsection, community-based consortia of individuals and organizations (including agencies responsible for administering block grant programs under title V of the Social Security Act, consumers of project services, public health departments, hospitals, health centers under section 330, and other significant sources of health care services) that are appropriate for participation in projects under subsection (a).

''(c) COORDINATION.—Recipients of grants under subsection (a) shall coordinate their services and activities with the State agency or agencies that administer block grant programs under title V of the Social Security Act in order to promote cooperation, integration, and dissemination of information with Statewide systems and with other community services funded under the Maternal and Child Health Block Grant.

''(d) RULE OF CONSTRUCTION.—Except to the extent inconsistent with this section, this section may not be construed as affecting the authority of the Secretary to make modifications in the program carried out under subsection (a).

''(e) ADDITIONAL SERVICES FOR AT-RISK PREGNANT WOMEN AND INFANTS.—

''(1) IN GENERAL.—The Secretary may make grants to conduct and support research and to provide additional health care services for pregnant women and infants, including grants to increase access to prenatal care, genetic counseling, ultrasound services, and fetal or other surgery.

''(2) ELIGIBLE PROJECT AREA.—The Secretary may make a grant under paragraph (1) only if the geographic area in which services under the grant will be provided is a geographic area in which a project under subsection (a) is being carried out, and if the Secretary determines that the grant will add to or expand the level of health services available in such area to pregnant women and infants.

''(3) EVALUATION BY GENERAL ACCOUNTING OFFICE.—

''(A) IN GENERAL.—During fiscal year 2004, the Comptroller General of the United States shall conduct an evaluation of activities under grants under paragraph (1) in order to determine whether the activities have been effective in serving the needs of pregnant women with respect to services described in such paragraph. The evaluation shall include an analysis of whether such activities have been effective in reducing the disparity in health status between the general population and individuals who are members of racial or ethnic minority groups. Not later than January 10, 2004, the Comptroller General shall submit to the Committee on Commerce in the House of Representatives, and to the Committee on Health, Education, Labor, and Pensions in the Senate, a report describing the findings of the evaluation.

''(B) RELATION TO GRANTS REGARDING ADDITIONAL SERVICES FOR AT-RISK PREGNANT WOMEN AND INFANTS.—Before the date on which the evaluation under subparagraph (A) is submitted in accordance with such subparagraph—

''(i) the Secretary shall ensure that there are not more than five grantees under paragraph (1); and

''(ii) an entity is not eligible to receive grants under such paragraph unless the entity has substantial experience in providing the health services described in such paragraph.

''(f) FUNDING.—

''(1) GENERAL PROGRAM.—

''(A) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section (other than subsection (e)), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.

''(B) ALLOCATIONS.—

''(i) PROGRAM ADMINISTRATION.—Of the amounts appropriated under subparagraph (A) for a fiscal year, the Secretary may reserve up to 5 percent for coordination, dissemination, technical assistance, and data activities that are determined by the Secretary to be appropriate for carrying out the program under this section.

''(ii) EVALUATION.—Of the amounts appropriated under subparagraph (A) for a fiscal year, the Secretary may reserve up to 1 percent for evaluations of projects carried out under subsection (a). Each such evaluation shall include a determination of whether such projects have been effective in reducing the disparity in health status between the general population and individuals who are members of racial or ethnic minority groups.

''(2) ADDITIONAL SERVICES FOR AT-RISK PREGNANT WOMEN AND INFANTS.—

''(A) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out subsection (e), there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.

''(B) ALLOCATION FOR COMMUNITY-BASED MOBILE HEALTH UNITS.—Of the amounts appropriated under subparagraph (A) for a fiscal year, the Secretary shall make available not less than 10 percent for providing services under subsection (e) (including ultrasound services) through visits by mobile units to communities that are eligible for services under subsection (a).''.

TITLE XVI—ORAL HEALTH PROMOTION AND DISEASE PREVENTION

SEC. 1601. IDENTIFICATION OF INTERVENTIONS THAT REDUCE THE BURDEN AND TRANSMISSION OF ORAL, DENTAL, AND CRANIOFACIAL DISEASES IN HIGH RISK POPULATIONS; DEVELOPMENT OF APPROACHES FOR PEDIATRIC ORAL AND CRANIOFACIAL ASSESSMENT.

(a) IN GENERAL.—The Secretary of Health and Human Services, through the Maternal and Child Health Bureau, the Indian Health Service, and in consultation with the National Institutes of Health and the Centers for Disease Control and Prevention, shall—

(1) support community-based research that is designed to improve understanding of the etiology, pathogenesis, diagnosis, prevention, and treatment of pediatric oral, dental, craniofacial diseases and conditions and their sequelae in high risk populations;

(2) support demonstrations of preventive interventions in high risk populations including nutrition, parenting, and feeding techniques; and

(3) develop clinical approaches to assess individual patients for the risk of pediatric dental disease.

(b) COMPLIANCE WITH STATE PRACTICE LAWS.—Treatment and other services shall be provided pursuant to this section by licensed dental health professionals in accordance with State practice and licensing laws.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section for each the fiscal years 2001 through 2005.

SEC. 1602. ORAL HEALTH PROMOTION AND DISEASE PREVENTION.

Part B of title III of the Public Health Service Act, as amended by section 911 of this Act, is amended by inserting after section 317L the following section:

''ORAL HEALTH PROMOTION AND DISEASE PREVENTION

''SEC. 317M. (a) GRANTS TO INCREASE RESOURCES FOR COMMUNITY WATER FLUORIDATION.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may make grants to States and Indian tribes for the purpose of increasing the resources available for community water fluoridation.

''(2) USE OF FUNDS.—A State shall use amounts provided under a grant under paragraph (1)—

''(A) to purchase fluoridation equipment;

''(B) to train fluoridation engineers;

''(C) to develop educational materials on the benefits of fluoridation; or

''(D) to support the infrastructure necessary to monitor and maintain the quality of water fluoridation.

''(b) COMMUNITY WATER FLUORIDATION.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in collaboration with the Director of the Indian Health Service, shall establish a demonstration project that is designed to assist rural water systems in successfully implementing the water fluoridation guidelines of the Centers for Disease Control and Prevention that are entitled ''Engineering

and Administrative Recommendations for Water Fluoridation, 1995'' (referred to in this subsection as the 'EARWF').

''(2) REQUIREMENTS.—

''(A) COLLABORATION.—In collaborating under paragraph (1), the Directors referred to in such paragraph shall ensure that technical assistance and training are provided to tribal programs located in each of the 12 areas of the Indian Health Service. The Director of the Indian Health Service shall provide coordination and administrative support to tribes under this section.

''(B) GENERAL USE OF FUNDS.—Amounts made available under paragraph (1) shall be used to assist small water systems in improving the effectiveness of water fluoridation and to meet the recommendations of the EARWF.

''(C) FLUORIDATION SPECIALISTS.—

''(i) IN GENERAL.—In carrying out this subsection, the Secretary shall provide for the establishment of fluoridation specialist engineering positions in each of the Dental Clinical and Preventive Support Centers through which technical assistance and training will be provided to tribal water operators, tribal utility operators and other Indian Health Service personnel working directly with fluoridation projects.

''(ii) LIAISON.—A fluoridation specialist shall serve as the principal technical liaison between the Indian Health Service and the Centers for Disease Control and Prevention with respect to engineering and fluoridation issues.

''(iii) CDC.—The Director of the Centers for Disease Control and Prevention shall appoint individuals to serve as the fluoridation specialists.

''(D) IMPLEMENTATION.—The project established under this subsection shall be planned, implemented and evaluated over the 5-year period beginning on the date on which funds are appropriated under this section and shall be designed to serve as a model for improving the effectiveness of water fluoridation systems of small rural communities.

''(3) EVALUATION.—In conducting the ongoing evaluation as provided for in paragraph (2)(D), the Secretary shall ensure that such evaluation includes—

''(A) the measurement of changes in water fluoridation compliance levels resulting from assistance provided under this section;

''(B) the identification of the administrative, technical and operational challenges that are unique to the fluoridation of small water systems;

''(C) the development of a practical model that may be easily utilized by other tribal, state, county or local governments in improving the quality of water fluoridation with emphasis on small water systems; and

''(D) the measurement of any increased percentage of Native Americans or Alaskan Natives who receive the benefits of optimally fluoridated water.

''(c) SCHOOL-BASED DENTAL SEALANT PROGRAM.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in collaboration with the Administrator of the Health Resources and Services Administration, may award grants to States and Indian tribes to provide for the development of school-based dental sealant programs to improve the access of children to sealants.

''(2) USE OF FUNDS.—A State shall use amounts received under a grant under paragraph (1) to provide funds to eligible school-based entities or to public elementary or secondary schools to enable such entities or schools to provide children with access to dental care and dental sealant services. Such services shall be provided by licensed dental health professionals in accordance with State practice licensing laws.

''(3) ELIGIBILITY.—To be eligible to receive funds under paragraph (1), an entity shall—

''(A) prepare and submit to the State an application at such time, in such manner and containing such information as the state may require; and

''(B) be a public elementary or secondary school—

''(i) that is located in an urban area in which and more than 50 percent of the student population is participating in federal or state free or reduced meal programs; or

''(ii) that is located in a rural area and, with respect to the school district in which the school is located, the district involved has a median income that is at or below 235 percent of the poverty line, as defined in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)).

''(d) DEFINITIONS.—For purposes of this section, the term 'Indian tribe' means an Indian tribe or tribal organization as defined in section 4(b) and section 4(c) of the Indian Self-Determination and Education Assistance Act.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

SEC. 1603. COORDINATED PROGRAM TO IMPROVE PEDIATRIC ORAL HEALTH.

Part B of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by adding at the end the following:

''COORDINATED PROGRAM TO IMPROVE PEDIATRIC ORAL HEALTH

''SEC. 320A. (a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a program to fund innovative oral health activities that improve the oral health of children under 6 years of age who are eligible for services provided under a Federal health program, to increase the utilization of dental services by such children, and to decrease the incidence of early childhood and baby bottle tooth decay.

''(b) GRANTS.—The Secretary shall award grants to or enter into contracts with public or private nonprofit schools of dentistry or accredited dental training institutions or programs, community dental programs, and programs operated by the Indian Health Service (including federally recognized Indian tribes that receive medical services from the Indian Health Service, urban Indian health programs funded under title V of the Indian Health Care Improvement Act, and tribes that contract with the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act) to enable such schools, institutions, and programs to develop programs of oral health promotion, to increase training of oral health services providers in accordance with State practice laws, or to increase the utilization of dental services by eligible children.

''(c) DISTRIBUTION.—In awarding grants under this section, the Secretary shall, to the extent practicable, ensure an equitable national geographic distribution of the grants, including areas of the United States where the incidence of early childhood caries is highest.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $10,000,000 for each the fiscal years 2001 through 2005.''.

TITLE XVII—VACCINE-RELATED PROGRAMS

Subtitle A—Vaccine Compensation Program

SEC. 1701. CONTENT OF PETITIONS.

(a) IN GENERAL.—Section 2111(c)(1)(D) of the Public Health Service Act (42 U.S.C. 300aa–11(c)(1)(D)) is amended by striking ''and'' at the end and inserting ''or (iii) suffered such illness, disability, injury, or condition from the vaccine which resulted in inpatient hospitalization and surgical intervention, and''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect upon the date of the enactment of this Act, including with respect to petitions under section 2111 of the Public Health Service Act that are pending on such date.

Subtitle B—Childhood Immunizations

SEC. 1711. CHILDHOOD IMMUNIZATIONS.

Section 317(j)(1) of the Public Health Service Act (42 U.S.C. 247b(j)(1)) is amended in the first sentence by striking ''1998'' and all that follows and inserting ''1998 through 2005.''.

TITLE XVIII—HEPATITIS C

SEC. 1801. SURVEILLANCE AND EDUCATION REGARDING HEPATITIS C.

Part B of title III of the Public Health Service Act, as amended by section 1602 of this Act, is amended by inserting after section 317M the following section:

''SURVEILLANCE AND EDUCATION REGARDING HEPATITIS C VIRUS

''SEC. 317N. (a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may (directly and through grants to public and nonprofit private entities) provide for programs to carry out the following:

''(1) To cooperate with the States in implementing a national system to determine the incidence of hepatitis C virus infection (in this section referred to as 'HCV infection') and to assist the States in determining the prevalence of such infection, including the reporting of chronic HCV cases.

''(2) To identify, counsel, and offer testing to individuals who are at risk of HCV infection as a result of receiving blood transfusions prior to July 1992, or as a result of other risk factors.

''(3) To provide appropriate referrals for counseling, testing, and medical treatment of individuals identified under paragraph (2) and to ensure, to the extent practicable, the provision of appropriate follow-up services.

''(4) To develop and disseminate public information and education programs for the detection and control of HCV infection, with priority given to high risk populations as determined by the Secretary.

''(5) To improve the education, training, and skills of health professionals in the detection and control of HCV infection, with priority given to pediatricians and other primary care physicians, and obstetricians and gynecologists.

''(b) LABORATORY PROCEDURES.—The Secretary may (directly and through grants to public and nonprofit private entities) carry out programs to provide for improvements in the quality of clinical-laboratory procedures regarding hepatitis C, including reducing variability in laboratory results on hepatitis C antibody and PCR testing.

''(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

TITLE XIX—NIH INITIATIVE ON AUTOIMMUNE DISEASES

SEC. 1901. AUTOIMMUNE DISEASES; INITIATIVE THROUGH DIRECTOR OF NATIONAL INSTITUTES OF HEALTH.

Part B of title IV of the Public Health Service Act (42 U.S.C. 284 et seq.), as amended by section 1001 of this Act, is amended by adding at the end the following:

''SEC. 409E. AUTOIMMUNE DISEASES.

''(a) EXPANSION, INTENSIFICATION, AND COORDINATION OF ACTIVITIES.—

''(1) IN GENERAL.—The Director of NIH shall expand, intensify, and coordinate research and other activities of the National Institutes of Health with respect to autoimmune diseases.

''(2) ALLOCATIONS BY DIRECTOR OF NIH.—With respect to amounts appropriated to carry out this section for a fiscal year, the Director of NIH shall allocate the amounts among the national research institutes that are carrying out paragraph (1).

''(3) DEFINITION.—The term 'autoimmune disease' includes, for purposes of this section such diseases or disorders with evidence of autoimmune pathogensis as the Secretary determines to be appropriate.

''(b) COORDINATING COMMITTEE.—

''(1) IN GENERAL.—The Secretary shall ensure that the Autoimmune Diseases Coordinating Committee (referred to in this section as the 'Coordinating Committee') coordinates activities across the National Institutes and with other Federal health programs and activities relating to such diseases.

''(2) COMPOSITION.—The Coordinating Committee shall be composed of the directors or their designees of each of the national research institutes involved in research with respect to autoimmune diseases and representatives of all other Federal departments and agencies whose programs involve health functions or responsibilities relevant to such diseases, including the Centers for Disease Control and Prevention and the Food and Drug Administration.

''(3) CHAIR.—

''(A) IN GENERAL.—With respect to autoimmune diseases, the Chair of the Committee shall serve as the principal advisor to the Secretary, the Assistant Secretary for Health, and the Director of NIH, and shall provide advice to the Director of the Centers for Disease Control and Prevention, the Commissioner of Food and Drugs, and other relevant agencies.

''(B) DIRECTOR OF NIH.—The Chair of the Committee shall be directly responsible to the Director of NIH.

''(c) PLAN FOR NIH ACTIVITIES.—

''(1) IN GENERAL.—Not later than 1 year after the date of enactment of this section, the Coordinating Committee shall develop a plan for conducting and supporting research and education on autoimmune diseases through the national research institutes and shall periodically review and revise the plan. The plan shall—

''(A) provide for a broad range of research and education activities relating to biomedical, psychosocial, and rehabilitative issues, including studies of the disproportionate impact of such diseases on women;

''(B) identify priorities among the programs and activities of the National Institutes of Health regarding such diseases; and

''(C) reflect input from a broad range of scientists, patients, and advocacy groups.

''(2) CERTAIN ELEMENTS OF PLAN.—The plan under paragraph (1) shall, with respect to autoimmune diseases, provide for the following as appropriate:

''(A) Research to determine the reasons underlying the incidence and prevalence of the diseases.

''(B) Basic research concerning the etiology and causes of the diseases.

''(C) Epidemiological studies to address the frequency and natural history of the diseases, including any differences among the sexes and among racial and ethnic groups.

''(D) The development of improved screening techniques.

''(E) Clinical research for the development and evaluation of new treatments, including new biological agents.

''(F) Information and education programs for health care professionals and the public.

''(3) IMPLEMENTATION OF PLAN.—The Director of NIH shall ensure that programs and activities of the National Institutes of Health regarding autoimmune diseases are implemented in accordance with the plan under paragraph (1).

''(d) REPORTS TO CONGRESS.—The Coordinating Committee under subsection (b)(1) shall biennially submit to the Committee on Commerce of the House of Representatives, and the Committee on Health, Education, Labor and Pensions of the Senate, a report that describes the research, education, and other activities on autoimmune diseases being conducted or supported through the national research institutes, and that in addition includes the following:

''(1) The plan under subsection (c)(1) (or revisions to the plan, as the case may be).

''(2) Provisions specifying the amounts expended by the National Institutes of Health with respect to each of the autoimmune diseases included in the plan.

''(3) Provisions identifying particular projects or types of projects that should in the future be considered by the national research institutes or other entities in the field of research on autoimmune diseases.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005. The authorization of appropriations established in the preceding sentence is in addition to any other authorization of appropriations that is available for conducting or supporting through the National Institutes of Health research and other activities with respect to autoimmune diseases.''.

TITLE XX—GRADUATE MEDICAL EDUCATION PROGRAMS IN CHILDREN'S HOSPITALS

SEC. 2001. PROVISIONS TO REVISE AND EXTEND PROGRAM.

(a) PAYMENTS.—Section 340E(a) of the Public Health Service Act (42 U.S.C. 256e(a)) is amended—

(1) by striking ''and 2001'' and inserting ''through 2005''; and

(2) by adding at the end the following: ''The Secretary shall promulgate regulations pursuant to the rulemaking requirements of title 5, United States Code, which shall govern payments made under this subpart.''.

(b) UPDATING RATES.—Section 340E(c)(2)(F) of the Public Health Service Act (42 U.S.C. 256e(c)(2)(F)) is amended by striking ''hospital's cost reporting period that begins during fiscal year 2000'' and inserting ''Federal fiscal year for which payments are made''.

(c) RESIDENT COUNT FOR INTERIM PAYMENTS.—Section 340E(e)(1) of the Public Health Service Act (42 U.S.C. 256e(e)(1)) is amended by adding at the end the following: ''Such interim payments to each individual hospital shall be based on the number of residents reported in the hospital's most recently filed medicare cost report prior to the application date for the Federal fiscal year for which the interim payment amounts are established. In the case of a hospital that does not report residents on a medicare cost report, such interim payments shall be based on the number of residents trained during the hospital's most recently completed medicare cost report filing period.''.

(d) WITHHOLDING.—Section 340E(e)(2) of the Public Health Service Act (42 U.S.C. 256e(e)(2)) is amended—

(1) by adding ''and indirect'' after ''direct'';

(2) by adding at the end the following: ''The Secretary shall withhold up to 25 percent from each interim installment for direct and indirect graduate medical education paid under paragraph (1) as necessary to ensure a hospital will not be overpaid on an interim basis.''.

(e) RECONCILIATION.—Section 340E(e)(3) of the Public Health Service Act (42 U.S.C. 256e(e)(3)) is amended to read as follows:

''(3) RECONCILIATION.—Prior to the end of each fiscal year, the Secretary shall determine any changes to the number of residents reported by a hospital in the application of the hospital for the current fiscal year to determine the final amount payable to the hospital for the current fiscal year for both direct expense and indirect expense amounts. Based on such determination, the Secretary shall recoup any overpayments made to pay any balance due to the extent possible. The final amount so determined shall be considered a final intermediary determination for the purposes of section 1878 of the Social Security Act and shall be subject to administrative and judicial review under that section in the same manner as the amount of payment under section 1186(d) of such Act is subject to review under such section.''.

(f) AUTHORIZATION OF APPROPRIATIONS.—Section 340E(f) of the Public Health Service Act (42 U.S.C. 256e(f)) is amended—

(1) in paragraph (1)(A)—

(A) in clause (i), by striking ''and'' at the end;

(B) in clause (ii), by striking the period and inserting ''; and''; and

(C) by adding at the end the following:

''(iii) for each of the fiscal years 2002 through 2005, such sums as may be necessary.''; and

(2) in paragraph (2)—

(A) in subparagraph (A), by striking ''and'' at the end;

(B) in subparagraph (B), by striking the period and inserting ''; and''; and

(C) by adding at the end the following:

''(C) for each of the fiscal years 2002 through 2005, such sums as may be necessary.''.

(g) DEFINITION OF CHILDREN'S HOSPITAL.—Section 340E(g)(2) of the Public Health Service Act (42 U.S.C. 256e(g)(2)) is amended by striking ''described in'' and all that follows and inserting the following: ''with a medicare payment agreement and which is excluded from the medicare inpatient prospective payment system pursuant to section 1886(d)(1)(B)(iii) of the Social Security Act and its accompanying regulations.''.

TITLE XXI—SPECIAL NEEDS OF CHILDREN REGARDING ORGAN TRANSPLANTATION

SEC. 2101. ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK; AMENDMENTS REGARDING NEEDS OF CHILDREN.

(a) IN GENERAL.—Section 372(b)(2) of the Public Health Service Act (42 U.S.C. 274(b)(2)) is amended—

(1) in subparagraph (J), by striking ''and'' at the end;

(2) in each of subparagraphs (K) and (L), by striking the period and inserting a comma; and

(3) by adding at the end the following subparagraphs:

''(M) recognize the differences in health and in organ transplantation issues between children and adults throughout the system and adopt criteria, polices, and procedures that address the unique health care needs of children,

''(N) carry out studies and demonstration projects for the purpose of improving procedures for organ donation procurement and allocation, including but not limited to projects to examine and attempt to increase transplantation among populations with special needs, including children and individuals who are members of racial or ethnic minority groups, and among populations with limited access to transportation, and

''(O) provide that for purposes of this paragraph, the term 'children' refers to individuals who are under the age of 18.''.

(b) STUDY REGARDING IMMUNOSUPPRESSIVE DRUGS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this subsection as the ''Secretary'') shall provide for a study to determine the costs of immunosuppressive drugs that are provided to children pursuant to organ transplants and to determine the extent to which health plans and health insurance cover such costs. The Secretary may carry out the study directly or through a grant to the Institute of Medicine (or other public or nonprofit private entity).

(2) RECOMMENDATIONS REGARDING CERTAIN ISSUES.—The Secretary shall ensure that, in addition to making determinations under paragraph (1), the study under such paragraph makes recommendations regarding the following issues:

(A) The costs of immunosuppressive drugs that are provided to children pursuant to organ transplants and to determine the extent to which health plans, health insurance and government programs cover such costs.

(B) The extent of denial of organs to be released for transplant by coroners and medical examiners.

(C) The special growth and developmental issues that children have pre- and post- organ transplantation.

(D) Other issues that are particular to the special health and transplantation needs of children.

(3) REPORT.—The Secretary shall ensure that, not later than December 31, 2001, the study under paragraph (1) is completed and a report describing the findings of the study is submitted to the Congress.

TITLE XXII—MUSCULAR DYSTROPHY RESEARCH

SEC. 2201. MUSCULAR DYSTROPHY RESEARCH.

Part B of title IV of the Public Health Service Act, as amended by section 1901 of this Act, is amended by adding at the end the following:

''MUSCULAR DYSTROPHY RESEARCH

''SEC. 409F. (a) COORDINATION OF ACTIVITIES.—The Director of NIH shall expand and increase coordination in the activities of the National Institutes of Health with respect to research on muscular dystrophies, including Duchenne muscular dystrophy.

''(b) ADMINISTRATION OF PROGRAM; COLLABORATION AMONG AGENCIES.—The Director of NIH shall carry out this section through the appropriate institutes, including the National Institute of Neurological Disorders and Stroke and in collaboration with any other agencies that the Director determines appropriate.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section for each of the fiscal years 2001 through 2005. Amounts appropriated under this subsection shall be in addition to any other amounts appropriated for such purpose.''.

TITLE XXIII—CHILDREN AND TOURETTE SYNDROME AWARENESS

SEC. 2301. GRANTS REGARDING TOURETTE SYNDROME.

Part A of title XI of the Public Health Service Act is amended by adding at the end the following section:

''TOURETTE SYNDROME

''SEC. 1108. (a) IN GENERAL.—The Secretary shall develop and implement outreach programs to educate the public, health care providers, educators and community based organizations about the etiology, symptoms, diagnosis and treatment of Tourette Syndrome, with a particular emphasis on children with Tourette Syndrome. Such programs may be carried out by the Secretary directly and through awards of grants or contracts to public or nonprofit private entities.

''(b) CERTAIN ACTIVITIES.—Activities under subsection (a) shall include—

''(1) the production and translation of educational materials, including public service announcements;

''(2) the development of training material for health care providers, educators and community based organizations; and

''(3) outreach efforts directed at the misdiagnosis and underdiagnosis of Tourette Syndrome in children and in minority groups.

''(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

TITLE XXIV—CHILDHOOD OBESITY PREVENTION

SEC. 2401. PROGRAMS OPERATED THROUGH THE CENTERS FOR DISEASE CONTROL AND PREVENTION.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 1101 of this Act, is amended by adding at the end the following part:

''PART Q—PROGRAMS TO IMPROVE THE HEALTH OF CHILDREN

''SEC. 399W. GRANTS TO PROMOTE CHILDHOOD NUTRITION AND PHYSICAL ACTIVITY.

''(a) IN GENERAL.—The Secretary, acting though the Director of the Centers for Disease Control and Prevention, shall award competitive grants to States and political subdivisions of States for the development and implementation of State and community-based intervention programs to promote good nutrition and physical activity in children and adolescents.

''(b) ELIGIBILITY.—To be eligible to receive a grant under this section a State or political subdivision of a State shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a plan that describes—

''(1) how the applicant proposes to develop a comprehensive program of school- and community-based approaches to encourage and promote good nutrition and appropriate levels of physical activity with respect to children or adolescents in local communities;

''(2) the manner in which the applicant shall coordinate with appropriate State and local authorities, such as State and local school departments, State departments of health, chronic disease directors, State directors of programs under section 17 of the Child Nutrition Act of 1966, 5-a-day coordinators, governors councils for physical activity and good nutrition, and State and local parks and recreation departments; and

''(3) the manner in which the applicant will evaluate the effectiveness of the program carried out under this section.

''(c) USE OF FUNDS.—A State or political subdivision of a State shall use amount received under a grant under this section to—

''(1) develop, implement, disseminate, and evaluate school- and community-based strategies in States to reduce inactivity and improve dietary choices among children and adolescents;

''(2) expand opportunities for physical activity programs in school- and community-based settings; and

''(3) develop, implement, and evaluate programs that promote good eating habits and physical activity including opportunities for children with cognitive and physical disabilities.

''(d) TECHNICAL ASSISTANCE.—The Secretary may set-aside an amount not to exceed 10 percent of the amount appropriated for a fiscal year under subsection (h) to permit the Director of the Centers for Disease Control and Prevention to—

''(1) provide States and political subdivisions of States with technical support in the development and implementation of programs under this section; and

''(2) disseminate information about effective strategies and interventions in preventing and treating obesity through the promotion of good nutrition and physical activity.

''(e) LIMITATION ON ADMINISTRATIVE COSTS.—Not to exceed 10 percent of the amount of a grant awarded to the State or political subdivision under subsection (a) for a fiscal year may be used by the State or political subdivision for administrative expenses.

''(f) TERM.—A grant awarded under subsection (a) shall be for a term of 3 years.

''(g) DEFINITION.—In this section, the term 'children and adolescents' means individuals who do not exceed 18 years of age.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of the fiscal years 2001 through 2005.

''SEC. 399X. APPLIED RESEARCH PROGRAM.

''(a) IN GENERAL.—The Secretary, acting through the Centers for Disease Control and Prevention and in consultation with the Director of the National Institutes of Health, shall—

''(1) conduct research to better understand the relationship between physical activity, diet, and health and factors that influence health-related behaviors;

''(2) develop and evaluate strategies for the prevention and treatment of obesity to be used in community-based interventions and by health professionals;

''(3) develop and evaluate strategies for the prevention and treatment of eating disorders, such as anorexia and bulimia;

''(4) conduct research to establish the prevalence, consequences, and costs of childhood obesity and its effects in adulthood;

''(5) identify behaviors and risk factors that contribute to obesity;

''(6) evaluate materials and programs to provide nutrition education to parents and teachers of children in child care or pre-school and the food service staff of such child care and pre-school entities; and

''(7) evaluate materials and programs that are designed to educate and encourage physical activity in child care and pre-school facilities.

''(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of the fiscal years 2001 through 2005.

''SEC. 399Y. EDUCATION CAMPAIGN.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, and in collaboration with national, State, and local partners, physical activity organizations, nutrition experts, and health professional organizations, shall develop a national public campaign to promote and educate children and their parents concerning—

''(1) the health risks associated with obesity, inactivity, and poor nutrition;

''(2) ways in which to incorporate physical activity into daily living; and

''(3) the benefits of good nutrition and strategies to improve eating habits.

''(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of the fiscal years 2001 through 2005.

''SEC. 399Z. HEALTH PROFESSIONAL EDUCATION AND TRAINING.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, in collaboration with the Administrator of the Health Resources and Services Administration and the heads of other agencies, and in consultation with appropriate health professional associations, shall develop and carry out a program to educate and train health professionals in effective strategies to—

''(1) better identify and assess patients with obesity or an eating disorder or patients at-risk of becoming obese or developing an eating disorder;

''(2) counsel, refer, or treat patients with obesity or an eating disorder; and

''(3) educate patients and their families about effective strategies to improve dietary habits and establish appropriate levels of physical activity.

''(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

TITLE XXV—EARLY DETECTION AND TREATMENT REGARDING CHILDHOOD LEAD POISONING

SEC. 2501. CENTERS FOR DISEASE CONTROL AND PREVENTION EFFORTS TO COMBAT CHILDHOOD LEAD POISONING.

(a) REQUIREMENTS FOR LEAD POISONING PREVENTION GRANTEES.—Section 317A of the Public Health Service Act (42 U.S.C. 247b–1) is amended—

(1) in subsection (d)—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6) the following:

''(7) Assurances satisfactory to the Secretary that the applicant will ensure complete and consistent reporting of all blood lead test results

from laboratories and health care providers to State and local health departments in accordance with guidelines of the Centers for Disease Control and Prevention for standardized reporting as described in subsection (m).''; and

(2) in subsection (j)(2)—

(A) in subparagraph (F) by striking ''(E)'' and inserting ''(F)'';

(B) by redesignating subparagraph (F) as subparagraph (G); and

(C) by inserting after subparagraph (E) the following:

''(F) The number of grantees that have established systems to ensure mandatory reporting of all blood lead tests from laboratories and health care providers to State and local health departments.''.

(b) GUIDELINES FOR STANDARDIZED REPORTING.—Section 317A of the Public Health Service Act (42 U.S.C. 247b–1) is amended by adding at the end the following:

''(m) GUIDELINES FOR STANDARDIZED REPORTING.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall develop national guidelines for the uniform reporting of all blood lead test results to State and local health departments.''.

(c) DEVELOPMENT AND IMPLEMENTATION OF EFFECTIVE DATA MANAGEMENT BY THE CENTERS FOR DISEASE CONTROL AND PREVENTION.—

(1) IN GENERAL.—The Director of the Centers for Disease Control and Prevention shall—

(A) assist with the improvement of data linkages between State and local health departments and between State health departments and the Centers for Disease Control and Prevention;

(B) assist States with the development of flexible, comprehensive State-based data management systems for the surveillance of children with lead poisoning that have the capacity to contribute to a national data set;

(C) assist with the improvement of the ability of State-based data management systems and federally-funded means-tested public benefit programs (including the special supplemental food program for women, infants and children (WIC) under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786) and the early head start program under section 645A of the Head Start Act (42 U.S.C. 9840a(h)) to respond to ad hoc inquiries and generate progress reports regarding the lead blood level screening of children enrolled in those programs;

(D) assist States with the establishment of a capacity for assessing how many children enrolled in the medicaid, WIC, early head start, and other federally-funded means-tested public benefit programs are being screened for lead poisoning at age-appropriate intervals;

(E) use data obtained as result of activities under this section to formulate or revise existing lead blood screening and case management policies; and

(F) establish performance measures for evaluating State and local implementation of the requirements and improvements described in subparagraphs (A) through (E).

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection such sums as may be necessary for each the fiscal years 2001 through 2005.

(3) EFFECTIVE DATE.—This subsection takes effect on the date of enactment of this Act.

SEC. 2502. GRANTS FOR LEAD POISONING RELATED ACTIVITIES.

(a) IN GENERAL.—Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.), as amended by section 1801 of this Act, is amended by inserting after section 317N the following section:

''GRANTS FOR LEAD POISONING RELATED ACTIVITIES

''SEC. 317O. (a) AUTHORITY TO MAKE GRANTS.—

''(1) IN GENERAL.—The Secretary shall make grants to States to support public health activities in States and localities where data suggests that at least 5 percent of preschool-age children have an elevated blood lead level through—

''(A) effective, ongoing outreach and community education targeted to families most likely to be at risk for lead poisoning;

''(B) individual family education activities that are designed to reduce ongoing exposures to lead for children with elevated blood lead levels, including through home visits and coordination with other programs designed to identify and treat children at risk for lead poisoning; and

''(C) the development, coordination and implementation of community-based approaches for comprehensive lead poisoning prevention from surveillance to lead hazard control.

''(2) STATE MATCH.—A State is not eligible for a grant under this section unless the State agrees to expend (through State or local funds) $1 for every $2 provided under the grant to carry out the activities described in paragraph (1).

''(3) APPLICATION.—To be eligible to receive a grant under this section, a State shall submit an application to the Secretary in such form and manner and containing such information as the Secretary may require.

''(b) COORDINATION WITH OTHER CHILDREN'S PROGRAMS.—A State shall identify in the application for a grant under this section how the State will coordinate operations and activities under the grant with—

''(1) other programs operated in the State that serve children with elevated blood lead levels, including any such programs operated under titles V, XIX, or XXI of the Social Security Act; and

''(2) one or more of the following—

''(A) the child welfare and foster care and adoption assistance programs under parts B and E of title IV of such Act;

''(B) the head start program established under the Head Start Act (42 U.S.C. 9831 et seq.);

''(C) the program of assistance under the special supplemental nutrition program for women, infants and children (WIC) under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786);

''(D) local public and private elementary or secondary schools; or

''(E) public housing agencies, as defined in section 3 of the United States Housing Act of 1937 (42 U.S.C. 1437a).

''(c) PERFORMANCE MEASURES.—The Secretary shall establish needs indicators and performance measures to evaluate the activities carried out under grants awarded under this section. Such indicators shall be commensurate with national measures of maternal and child health programs and shall be developed in consultation with the Director of the Centers for Disease Control and Prevention.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of the fiscal years 2001 through 2005.''.

(b) CONFORMING AMENDMENT.—Section 340D(c)(1) of the Public Health Service Act (42 U.S.C. 256d(c)(1)) is amended by striking ''317E'' and inserting ''317F''.

SEC. 2503. TRAINING AND REPORTS BY THE HEALTH RESOURCES AND SERVICES ADMINISTRATION.

(a) TRAINING.—The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration and in collaboration with the Administrator of the Health Care Financing Administration and the Director of the Centers for Disease Control and Prevention, shall conduct education and training programs for physicians and other health care providers regarding childhood lead poisoning, current screening and treatment recommendations and requirements, and the scientific, medical, and public health basis for those policies.

(b) REPORT.—The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, annually shall report to Congress on the number of children who received services through health centers established under section 330 of the Public Health Service Act (42 U.S.C. 254b) and received a blood lead screening test during the prior fiscal year, noting the percentage that such children represent as compared to all children who received services through such health centers.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each the fiscal years 2001 through 2005.

SEC. 2504. SCREENINGS, REFERRALS, AND EDUCATION REGARDING LEAD POISONING.

Section 317A(l)(1) of the Public Health Service Act (42 U.S.C. 247b–1(l)(1)) is amended by striking ''1994'' and all that follows and inserting ''1994 through 2005.''.

TITLE XXVI—SCREENING FOR HERITABLE DISORDERS

SEC. 2601. PROGRAM TO IMPROVE THE ABILITY OF STATES TO PROVIDE NEWBORN AND CHILD SCREENING FOR HERITABLE DISORDERS.

Part A of title XI of the Public Health Service Act, as amended by section 2301 of this Act, is amended by adding at the end the following:

''SEC. 1109. IMPROVED NEWBORN AND CHILD SCREENING FOR HERITABLE DISORDERS.

''(a) IN GENERAL.—The Secretary shall award grants to eligible entities to enhance, improve or expand the ability of State and local public health agencies to provide screening, counseling or health care services to newborns and children having or at risk for heritable disorders.

''(b) USE OF FUNDS.—Amounts provided under a grant awarded under subsection (a) shall be used to—

''(1) establish, expand, or improve systems or programs to provide screening, counseling, testing or specialty services for newborns and children at risk for heritable disorders;

''(2) establish, expand, or improve programs or services to reduce mortality or morbidity from heritable disorders;

''(3) establish, expand, or improve systems or programs to provide information and counseling on available therapies for newborns and children with heritable disorders;

''(4) improve the access of medically underserved populations to screening, counseling, testing and specialty services for newborns and children having or at risk for heritable disorders; or

''(5) conduct such other activities as may be necessary to enable newborns and children having or at risk for heritable disorders to receive screening, counseling, testing or specialty services, regardless of income, race, color, religion, sex, national origin, age, or disability.

''(c) ELIGIBLE ENTITIES.—To be eligible to receive a grant under subsection (a) an entity shall—

''(1) be a State or political subdivision of a State, or a consortium of 2 or more States or political subdivisions of States; and

''(2) prepare and submit to the Secretary an application that includes—

''(A) a plan to use amounts awarded under the grant to meet specific health status goals and objectives relative to heritable disorders, including attention to needs of medically underserved populations;

''(B) a plan for the collection of outcome data or other methods of evaluating the degree to which amounts awarded under this grant will be used to achieve the goals and objectives identified under subparagraph (A);

''(C) a plan for monitoring and ensuring the quality of services provided under the grant;

''(D) an assurance that amounts awarded under the grant will be used only to implement the approved plan for the State;

''(E) an assurance that the provision of services under the plan is coordinated with services

provided under programs implemented in the State under titles V, XVIII, XIX, XX, or XXI of the Social Security Act (subject to Federal regulations applicable to such programs) so that the coverage of services under such titles is not substantially diminished by the use of granted funds; and

''(F) such other information determined by the Secretary to be necessary.

''(d) LIMITATION.—An eligible entity may not use amounts received under this section to—

''(1) provide cash payments to or on behalf of affected individuals;

''(2) provide inpatient services;

''(3) purchase land or make capital improvements to property; or

''(4) provide for proprietary research or training.

''(e) VOLUNTARY PARTICIPATION.—The participation by any individual in any program or portion thereof established or operated with funds received under this section shall be wholly voluntary and shall not be a prerequisite to eligibility for or receipt of any other service or assistance from, or to participation in, another Federal or State program.

''(f) SUPPLEMENT NOT SUPPLANT.—Funds appropriated under this section shall be used to supplement and not supplant other Federal, State, and local public funds provided for activities of the type described in this section.

''(g) PUBLICATION.

''(1) IN GENERAL.—An application submitted under subsection (c)(2) shall be made public by the State in such a manner as to facilitate comment from any person, including through hearings and other methods used to facilitate comments from the public.

''(2) COMMENTS.—Comments received by the State after the publication described in paragraph (1) shall be addressed in the application submitted under subsection (c)(2).

''(h) TECHNICAL ASSISTANCE.—The Secretary shall provide to entities receiving grants under subsection (a) such technical assistance as may be necessary to ensure the quality of programs conducted under this section.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of the fiscal years 2001 through 2005.

''SEC. 1110. EVALUATING THE EFFECTIVENESS OF NEWBORN AND CHILD SCREENING PROGRAMS.

''(a) IN GENERAL.—The Secretary shall award grants to eligible entities to provide for the conduct of demonstration programs to evaluate the effectiveness of screening, counseling or health care services in reducing the morbidity and mortality caused by heritable disorders in newborns and children.

''(b) DEMONSTRATION PROGRAMS.—A demonstration program conducted under a grant under this section shall be designed to evaluate and assess, within the jurisdiction of the entity receiving such grant—

''(1) the effectiveness of screening, counseling, testing or specialty services for newborns and children at risk for heritable disorders in reducing the morbidity and mortality associated with such disorders;

''(2) the effectiveness of screening, counseling, testing or specialty services in accurately and reliably diagnosing heritable disorders in newborns and children; or

''(3) the availability of screening, counseling, testing or specialty services for newborns and children at risk for heritable disorders.

''(c) ELIGIBLE ENTITIES.—To be eligible to receive a grant under subsection (a) an entity shall be a State or political subdivision of a State, or a consortium of 2 or more States or political subdivisions of States.

''SEC. 1111. ADVISORY COMMITTEE ON HERITABLE DISORDERS IN NEWBORNS AND CHILDREN.

''(a) ESTABLISHMENT.—The Secretary shall establish an advisory committee to be known as the 'Advisory Committee on Heritable Disorders in Newborns and Children' (referred to in this section as the 'Advisory Committee').

''(b) DUTIES.—The Advisory Committee shall—

''(1) provide advice and recommendations to the Secretary concerning grants and projects awarded or funded under section 1109;

''(2) provide technical information to the Secretary for the development of policies and priorities for the administration of grants under section 1109; and

''(3) provide such recommendations, advice or information as may be necessary to enhance, expand or improve the ability of the Secretary to reduce the mortality or morbidity from heritable disorders.

''(c) MEMBERSHIP.—

''(1) IN GENERAL.—The Secretary shall appoint not to exceed 15 members to the Advisory Committee. In appointing such members, the Secretary shall ensure that the total membership of the Advisory Committee is an odd number.

''(2) REQUIRED MEMBERS.—The Secretary shall appoint to the Advisory Committee under paragraph (1)—

''(A) the Administrator of the Health Resources and Services Administration;

''(B) the Director of the Centers for Disease Control and Prevention;

''(C) the Director of the National Institutes of Health;

''(D) the Director of the Agency for Healthcare Research and Quality;

''(E) medical, technical, or scientific professionals with special expertise in heritable disorders, or in providing screening, counseling, testing or specialty services for newborns and children at risk for heritable disorders;

''(F) members of the public having special expertise about or concern with heritable disorders; and

''(G) representatives from such Federal agencies, public health constituencies, and medical professional societies as determined to be necessary by the Secretary, to fulfill the duties of the Advisory Committee, as established under subsection (b).''.

TITLE XXVII—PEDIATRIC RESEARCH PROTECTIONS

SEC. 2701. REQUIREMENT FOR ADDITIONAL PROTECTIONS FOR CHILDREN INVOLVED IN RESEARCH.

Notwithstanding any other provision of law, not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall require that all research involving children that is conducted, supported, or regulated by the Department of Health and Human Services be in compliance with subpart D of part 45 of title 46, Code of Federal Regulations.

TITLE XXVIII—MISCELLANEOUS PROVISIONS

SEC. 2801. REPORT REGARDING RESEARCH ON RARE DISEASES IN CHILDREN.

Not later than 180 days after the date of the enactment of this Act, the Director of the National Institutes of Health shall submit to the Congress a report on—

(1) the activities that, during fiscal year 2000, were conducted and supported by such Institutes with respect to rare diseases in children, including Friedreich's ataxia and Hutchinson-Gilford progeria syndrome; and

(2) the activities that are planned to be conducted and supported by such Institutes with respect to such diseases during the fiscal years 2001 through 2005.

SEC. 2802. STUDY ON METABOLIC DISORDERS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall, in consultation with relevant experts or through the Institute of Medicine, study issues related to treatment of PKU and other metabolic disorders for children, adolescents, and adults, and mechanisms to assure access to effective treatment, including special diets, for children and others with PKU and other metabolic disorders. Such mechanisms shall be evidence-based and reflect the best scientific knowledge regarding effective treatment and prevention of disease progression.

(b) DISSEMINATION OF RESULTS.—Upon completion of the study referred to in subsection (a), the Secretary shall disseminate and otherwise make available the results of the study to interested groups and organizations, including insurance commissioners, employers, private insurers, health care professionals, State and local public health agencies, and State agencies that carry out the medicaid program under title XIX of the Social Security Act or the State children's health insurance program under title XXI of such Act.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of the fiscal years 2001 through 2003.

TITLE XXIX—EFFECTIVE DATE

SEC. 2901. EFFECTIVE DATE.

This division and the amendments made by this division take effect October 1, 2000, or upon the date of the enactment of this Act, whichever occurs later.

DIVISION B—YOUTH DRUG AND MENTAL HEALTH SERVICES

SEC. 3001. SHORT TITLE.

This division may be cited as the ''Youth Drug and Mental Health Services Act''.

TITLE XXXI—PROVISIONS RELATING TO SERVICES FOR CHILDREN AND ADOLESCENTS

SEC. 3101. CHILDREN AND VIOLENCE.

Title V of the Public Health Service Act (42 U.S.C. 290aa et seq.) is amended by adding at the end the following:

''PART G—PROJECTS FOR CHILDREN AND VIOLENCE

''SEC. 581. CHILDREN AND VIOLENCE.

''(a) IN GENERAL.—The Secretary, in consultation with the Secretary of Education and the Attorney General, shall carry out directly or through grants, contracts or cooperative agreements with public entities a program to assist local communities in developing ways to assist children in dealing with violence.

''(b) ACTIVITIES.—Under the program under subsection (a), the Secretary may—

''(1) provide financial support to enable local communities to implement programs to foster the health and development of children;

''(2) provide technical assistance to local communities with respect to the development of programs described in paragraph (1);

''(3) provide assistance to local communities in the development of policies to address violence when and if it occurs;

''(4) assist in the creation of community partnerships among law enforcement, education systems and mental health and substance abuse service systems; and

''(5) establish mechanisms for children and adolescents to report incidents of violence or plans by other children or adolescents to commit violence.

''(c) REQUIREMENTS.—An application for a grant, contract or cooperative agreement under subsection (a) shall demonstrate that—

''(1) the applicant will use amounts received to create a partnership described in subsection (b)(4) to address issues of violence in schools;

''(2) the activities carried out by the applicant will provide a comprehensive method for addressing violence, that will include—

''(A) security;

''(B) educational reform;

''(C) the review and updating of school policies;

''(D) alcohol and drug abuse prevention and early intervention services;

''(E) mental health prevention and treatment services; and

''(F) early childhood development and psychosocial services; and

''(3) the applicant will use amounts received only for the services described in subparagraphs (D), (E), and (F) of paragraph (2).

''(d) GEOGRAPHICAL DISTRIBUTION.—The Secretary shall ensure that grants, contracts or cooperative agreements under subsection (a) will be distributed equitably among the regions of the country and among urban and rural areas.

''(e) DURATION OF AWARDS.—With respect to a grant, contract or cooperative agreement under subsection (a), the period during which payments under such an award will be made to the recipient may not exceed 5 years.

''(f) EVALUATION.—The Secretary shall conduct an evaluation of each project carried out under this section and shall disseminate the results of such evaluations to appropriate public and private entities.

''(g) INFORMATION AND EDUCATION.—The Secretary shall establish comprehensive information and education programs to disseminate the findings of the knowledge development and application under this section to the general public and to health care professionals.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $100,000,000 for fiscal year 2001, and such sums as may be necessary for each of fiscal years 2002 and 2003.

''SEC. 582. GRANTS TO ADDRESS THE PROBLEMS OF PERSONS WHO EXPERIENCE VIOLENCE RELATED STRESS.

''(a) IN GENERAL.—The Secretary shall award grants, contracts or cooperative agreements to public and nonprofit private entities, as well as to Indian tribes and tribal organizations, for the purpose of developing programs focusing on the behavioral and biological aspects of psychological trauma response and for developing knowledge with regard to evidence-based practices for treating psychiatric disorders of children and youth resulting from witnessing or experiencing a traumatic event.

''(b) PRIORITIES.—In awarding grants, contracts or cooperative agreements under subsection (a) related to the development of knowledge on evidence-based practices for treating disorders associated with psychological trauma, the Secretary shall give priority to mental health agencies and programs that have established clinical and basic research experience in the field of trauma-related mental disorders.

''(c) GEOGRAPHICAL DISTRIBUTION.—The Secretary shall ensure that grants, contracts or cooperative agreements under subsection (a) with respect to centers of excellence are distributed equitably among the regions of the country and among urban and rural areas.

''(d) EVALUATION.—The Secretary, as part of the application process, shall require that each applicant for a grant, contract or cooperative agreement under subsection (a) submit a plan for the rigorous evaluation of the activities funded under the grant, contract or agreement, including both process and outcomes evaluation, and the submission of an evaluation at the end of the project period.

''(e) DURATION OF AWARDS.—With respect to a grant, contract or cooperative agreement under subsection (a), the period during which payments under such an award will be made to the recipient may not exceed 5 years. Such grants, contracts or agreements may be renewed.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $50,000,000 for fiscal year 2001, and such sums as may be necessary for each of fiscal years 2002 and 2003.''.

SEC. 3102. EMERGENCY RESPONSE.

Section 501 of the Public Health Service Act (42 U.S.C. 290aa) is amended—

(1) by redesignating subsection (m) as subsection (o);

(2) by inserting after subsection (l) the following:

''(m) EMERGENCY RESPONSE.—

''(1) IN GENERAL.—Notwithstanding section 504 and except as provided in paragraph (2), the Secretary may use not to exceed 2.5 percent of all amounts appropriated under this title for a fiscal year to make noncompetitive grants, contracts or cooperative agreements to public entities to enable such entities to address emergency substance abuse or mental health needs in local communities.

''(2) EXCEPTIONS.—Amounts appropriated under part C shall not be subject to paragraph (1).

''(3) EMERGENCIES.—The Secretary shall establish criteria for determining that a substance abuse or mental health emergency exists and publish such criteria in the Federal Register prior to providing funds under this subsection.

''(n) LIMITATION ON THE USE OF CERTAIN INFORMATION.—No information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under section 505 may be used for any purpose other than the purpose for which it was supplied unless such establishment or person has consented (as determined under regulations of the Secretary) to its use for such other purpose. Such information may not be published or released in other form if the person who supplied the information or who is described in it is identifiable unless such person has consented (as determined under regulations of the Secretary) to its publication or release in other form.''; and

(3) in subsection (o) (as so redesignated), by striking ''1993'' and all that follows through the period and inserting ''2001, and such sums as may be necessary for each of the fiscal years 2002 and 2003.''.

SEC. 3103. HIGH RISK YOUTH REAUTHORIZATION.

Section 517(h) of the Public Health Service Act (42 U.S.C. 290bb–23(h)) is amended by striking ''$70,000,000'' and all that follows through ''1994'' and inserting ''such sums as may be necessary for each of the fiscal years 2001 through 2003''.

SEC. 3104. SUBSTANCE ABUSE TREATMENT SERVICES FOR CHILDREN AND ADOLESCENTS.

(a) SUBSTANCE ABUSE TREATMENT SERVICES.—Subpart 1 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb et seq.) is amended by adding at the end the following:

''SEC. 514. SUBSTANCE ABUSE TREATMENT SERVICES FOR CHILDREN AND ADOLESCENTS.

''(a) IN GENERAL.—The Secretary shall award grants, contracts, or cooperative agreements to public and private nonprofit entities, including Native Alaskan entities and Indian tribes and tribal organizations, for the purpose of providing substance abuse treatment services for children and adolescents.

''(b) PRIORITY.—In awarding grants, contracts, or cooperative agreements under subsection (a), the Secretary shall give priority to applicants who propose to—

''(1) apply evidenced-based and cost effective methods for the treatment of substance abuse among children and adolescents;

''(2) coordinate the provision of treatment services with other social service agencies in the community, including educational, juvenile justice, child welfare, and mental health agencies;

''(3) provide a continuum of integrated treatment services, including case management, for children and adolescents with substance abuse disorders and their families;

''(4) provide treatment that is gender-specific and culturally appropriate;

''(5) involve and work with families of children and adolescents receiving treatment;

''(6) provide aftercare services for children and adolescents and their families after completion of substance abuse treatment; and

''(7) address the relationship between substance abuse and violence.

''(c) DURATION OF GRANTS.—The Secretary shall award grants, contracts, or cooperative agreements under subsection (a) for periods not to exceed 5 fiscal years.

''(d) APPLICATION.—An entity desiring a grant, contract, or cooperative agreement under subsection (a) shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

''(e) EVALUATION.—An entity that receives a grant, contract, or cooperative agreement under subsection (a) shall submit, in the application for such grant, contract, or cooperative agreement, a plan for the evaluation of any project undertaken with funds provided under this section. Such entity shall provide the Secretary with periodic evaluations of the progress of such project and such evaluation at the completion of such project as the Secretary determines to be appropriate.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $40,000,000 for fiscal year 2001, and such sums as may be necessary for fiscal years 2002 and 2003.

''SEC. 514A. EARLY INTERVENTION SERVICES FOR CHILDREN AND ADOLESCENTS.

''(a) IN GENERAL.—The Secretary shall award grants, contracts, or cooperative agreements to public and private nonprofit entities, including local educational agencies (as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)), for the purpose of providing early intervention substance abuse services for children and adolescents.

''(b) PRIORITY.—In awarding grants, contracts, or cooperative agreements under subsection (a), the Secretary shall give priority to applicants who demonstrate an ability to—

''(1) screen for and assess substance use and abuse by children and adolescents;

''(2) make appropriate referrals for children and adolescents who are in need of treatment for substance abuse;

''(3) provide early intervention services, including counseling and ancillary services, that are designed to meet the developmental needs of children and adolescents who are at risk for substance abuse; and

''(4) develop networks with the educational, juvenile justice, social services, and other agencies and organizations in the State or local community involved that will work to identify children and adolescents who are in need of substance abuse treatment services.

''(c) CONDITION.—In awarding grants, contracts, or cooperative agreements under subsection (a), the Secretary shall ensure that such grants, contracts, or cooperative agreements are allocated, subject to the availability of qualified applicants, among the principal geographic regions of the United States, to Indian tribes and tribal organizations, and to urban and rural areas.

''(d) DURATION OF GRANTS.—The Secretary shall award grants, contracts, or cooperative agreements under subsection (a) for periods not to exceed 5 fiscal years.

''(e) APPLICATION.—An entity desiring a grant, contract, or cooperative agreement under subsection (a) shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

''(f) EVALUATION.—An entity that receives a grant, contract, or cooperative agreement under subsection (a) shall submit, in the application for such grant, contract, or cooperative agreement, a plan for the evaluation of any project undertaken with funds provided under this section. Such entity shall provide the Secretary with periodic evaluations of the progress of such project and such evaluation at the completion of such project as the Secretary determines to be appropriate.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry

out this section, $20,000,000 for fiscal year 2001, and such sums as may be necessary for fiscal years 2002 and 2003.''.

(b) YOUTH INTERAGENCY CENTERS.—Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–31 et seq.) is amended by adding the following:

''SEC. 520C. YOUTH INTERAGENCY RESEARCH, TRAINING, AND TECHNICAL ASSISTANCE CENTERS.

''(a) PROGRAM AUTHORIZED.—The Secretary, acting through the Administrator of the Substance Abuse and Mental Health Services Administration, and in consultation with the Administrator of the Office of Juvenile Justice and Delinquency Prevention, the Director of the Bureau of Justice Assistance and the Director of the National Institutes of Health, shall award grants or contracts to public or nonprofit private entities to establish not more than 4 research, training, and technical assistance centers to carry out the activities described in subsection (c).

''(b) APPLICATION.—A public or private nonprofit entity desiring a grant or contract under subsection (a) shall prepare and submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(c) AUTHORIZED ACTIVITIES.—A center established under a grant or contract under subsection (a) shall—

''(1) provide training with respect to state-of-the-art mental health and justice-related services and successful mental health and substance abuse-justice collaborations that focus on children and adolescents, to public policymakers, law enforcement administrators, public defenders, police, probation officers, judges, parole officials, jail administrators and mental health and substance abuse providers and administrators;

''(2) engage in research and evaluations concerning State and local justice and mental health systems, including system redesign initiatives, and disseminate information concerning the results of such evaluations;

''(3) provide direct technical assistance, including assistance provided through toll-free telephone numbers, concerning issues such as how to accommodate individuals who are being processed through the courts under the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), what types of mental health or substance abuse service approaches are effective within the judicial system, and how community-based mental health or substance abuse services can be more effective, including relevant regional, ethnic, and gender-related considerations; and

''(4) provide information, training, and technical assistance to State and local governmental officials to enhance the capacity of such officials to provide appropriate services relating to mental health or substance abuse.

''(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated $4,000,000 for fiscal year 2001, and such sums as may be necessary for fiscal years 2002 and 2003.''.

(c) PREVENTION OF ABUSE AND ADDICTION.—Subpart 2 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–21 et seq.) is amended by adding the following:

''SEC. 519E. PREVENTION OF METHAMPHETAMINE AND INHALANT ABUSE AND ADDICTION.

''(a) GRANTS.—The Director of the Center for Substance Abuse Prevention (referred to in this section as the 'Director') may make grants to and enter into contracts and cooperative agreements with public and nonprofit private entities to enable such entities—

''(1) to carry out school-based programs concerning the dangers of methamphetamine or inhalant abuse and addiction, using methods that are effective and evidence-based, including initiatives that give students the responsibility to create their own anti-drug abuse education programs for their schools; and

''(2) to carry out community-based methamphetamine or inhalant abuse and addiction prevention programs that are effective and evidence-based.

''(b) USE OF FUNDS.—Amounts made available under a grant, contract or cooperative agreement under subsection (a) shall be used for planning, establishing, or administering methamphetamine or inhalant prevention programs in accordance with subsection (c).

''(c) PREVENTION PROGRAMS AND ACTIVITIES.—

''(1) IN GENERAL.—Amounts provided under this section may be used—

''(A) to carry out school-based programs that are focused on those districts with high or increasing rates of methamphetamine or inhalant abuse and addiction and targeted at populations which are most at risk to start methamphetamine or inhalant abuse;

''(B) to carry out community-based prevention programs that are focused on those populations within the community that are most at-risk for methamphetamine or inhalant abuse and addiction;

''(C) to assist local government entities to conduct appropriate methamphetamine or inhalant prevention activities;

''(D) to train and educate State and local law enforcement officials, prevention and education officials, members of community anti-drug coalitions and parents on the signs of methamphetamine or inhalant abuse and addiction and the options for treatment and prevention;

''(E) for planning, administration, and educational activities related to the prevention of methamphetamine or inhalant abuse and addiction;

''(F) for the monitoring and evaluation of methamphetamine or inhalant prevention activities, and reporting and disseminating resulting information to the public; and

''(G) for targeted pilot programs with evaluation components to encourage innovation and experimentation with new methodologies.

''(2) PRIORITY.—The Director shall give priority in making grants under this section to rural and urban areas that are experiencing a high rate or rapid increases in methamphetamine or inhalant abuse and addiction.

''(d) ANALYSES AND EVALUATION.—

''(1) IN GENERAL.—Up to $500,000 of the amount available in each fiscal year to carry out this section shall be made available to the Director, acting in consultation with other Federal agencies, to support and conduct periodic analyses and evaluations of effective prevention programs for methamphetamine or inhalant abuse and addiction and the development of appropriate strategies for disseminating information about and implementing these programs.

''(2) ANNUAL REPORTS.—The Director shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Appropriations of the Senate and the Committee on Commerce and Committee on Appropriations of the House of Representatives, an annual report with the results of the analyses and evaluation under paragraph (1).

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out subsection (a), $10,000,000 for fiscal year 2001, and such sums as may be necessary for each of fiscal years 2002 and 2003.''.

SEC. 3105. COMPREHENSIVE COMMUNITY SERVICES FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE.

(a) MATCHING FUNDS.—Section 561(c)(1)(D) of the Public Health Service Act (42 U.S.C. 290ff(c)(1)(D)) is amended by striking ''fifth'' and inserting ''fifth and sixth''.

(b) FLEXIBILITY FOR INDIAN TRIBES AND TERRITORIES.—Section 562 of the Public Health Service Act (42 U.S.C. 290ff–1) is amended by adding at the end the following:

''(g) WAIVERS.—The Secretary may waive 1 or more of the requirements of subsection (c) for a public entity that is an Indian Tribe or tribal organization, or American Samoa, Guam, the Marshall Islands, the Federated States of Micronesia, the Commonwealth of the Northern Mariana Islands, the Republic of Palau, or the United States Virgin Islands if the Secretary determines, after peer review, that the system of care is family-centered and uses the least restrictive environment that is clinically appropriate.''.

(c) DURATION OF GRANTS.—Section 565(a) of the Public Health Service Act (42 U.S.C. 290ff–4(a)) is amended by striking ''5 fiscal'' and inserting ''6 fiscal''.

(d) AUTHORIZATION OF APPROPRIATIONS.—Section 565(f)(1) of the Public Health Service Act (42 U.S.C. 290ff–4(f)(1)) is amended by striking ''1993'' and all that follows and inserting ''2001, and such sums as may be necessary for each of the fiscal years 2002 and 2003.''.

(e) CURRENT GRANTEES.—

(1) IN GENERAL.—Entities with active grants under section 561 of the Public Health Service Act (42 U.S.C. 290ff) on the date of enactment of this Act shall be eligible to receive a 6th year of funding under the grant in an amount not to exceed the amount that such grantee received in the 5th year of funding under such grant. Such 6th year may be funded without requiring peer and Advisory Council review as required under section 504 of such Act (42 U.S.C. 290aa–3).

(2) LIMITATION.—Paragraph (1) shall apply with respect to a grantee only if the grantee agrees to comply with the provisions of section 561 as amended by subsection (a).

SEC. 3106. SERVICES FOR CHILDREN OF SUBSTANCE ABUSERS.

(a) ADMINISTRATION AND ACTIVITIES.—

(1) ADMINISTRATION.—Section 399D(a) of the Public Health Service Act (42 U.S.C. 280d(a)(1)) is amended—

(A) in paragraph (1), by striking ''Administrator'' and all that follows through ''Administration'' and insert ''Administrator of the Substance Abuse and Mental Health Services Administration''; and

(B) in paragraph (2), by striking ''Administrator of the Substance Abuse and Mental Health Services Administration'' and inserting ''Administrator of the Health Resources and Services Administration''.

(2) ACTIVITIES.—Section 399D(a)(1) of the Public Health Service Act (42 U.S.C. 280d(a)(1)) is amended—

(A) in subparagraph (B), by striking ''and'' at the end;

(B) in subparagraph (C), by striking the period and inserting the following: ''through youth service agencies, family social services, child care providers, Head Start, schools and after-school programs, early childhood development programs, community-based family resource and support centers, the criminal justice system, health, substance abuse and mental health providers through screenings conducted during regular childhood examinations and other examinations, self and family member referrals, substance abuse treatment services, and other providers of services to children and families; and''; and

(C) by adding at the end the following:

''(D) to provide education and training to health, substance abuse and mental health professionals, and other providers of services to children and families through youth service agencies, family social services, child care, Head Start, schools and after-school programs, early childhood development programs, community-based family resource and support centers, the criminal justice system, and other providers of services to children and families.''.

(3) IDENTIFICATION OF CERTAIN CHILDREN.—Section 399D(a)(3)(A) of the Public Health Service Act (42 U.S.C. 280d(a)(3)(A)) is amended—

(A) in clause (i), by striking ''(i) the entity'' and inserting ''(i)(I) the entity'';

(B) in clause (ii)—

(i) by striking ''(ii) the entity'' and inserting ''(II) the entity''; and

(ii) by striking the period and inserting ''; and''; and

(C) by adding at the end the following:

''(ii) the entity will identify children who may be eligible for medical assistance under a State program under title XIX or XXI of the Social Security Act.''.

(b) SERVICES FOR CHILDREN.—Section 399D(b) of the Public Health Service Act (42 U.S.C. 280d(b)) is amended—

(1) in paragraph (1), by inserting ''alcohol and drug,'' after ''psychological,'';

(2) by striking paragraph (5) and inserting the following:

''(5) Developmentally and age-appropriate drug and alcohol early intervention, treatment and prevention services.''; and

(3) by inserting after paragraph (8), the following:

''Services shall be provided under paragraphs (2) through (8) by a public health nurse, social worker, or similar professional, or by a trained worker from the community who is supervised by a professional, or by an entity, where the professional or entity provides assurances that the professional or entity is licensed or certified by the State if required and is complying with applicable licensure or certification requirements.''.

(c) SERVICES FOR AFFECTED FAMILIES.—Section 399D(c) of the Public Health Service Act (42 U.S.C. 280d(c)) is amended—

(1) in paragraph (1)—

(A) in the matter preceding subparagraph (A), by inserting before the colon the following: '', or by an entity, where the professional or entity provides assurances that the professional or entity is licensed or certified by the State if required and is complying with applicable licensure or certification requirements''; and

(B) by adding at the end the following:

''(D) Aggressive outreach to family members with substance abuse problems.

''(E) Inclusion of consumer in the development, implementation, and monitoring of Family Services Plan.'';

(2) in paragraph (2)—

(A) by striking subparagraph (A) and inserting the following:

''(A) Alcohol and drug treatment services, including screening and assessment, diagnosis, detoxification, individual, group and family counseling, relapse prevention, pharmacotherapy treatment, after-care services, and case management.'';

(B) in subparagraph (C), by striking '', including educational and career planning'' and inserting ''and counseling on the human immunodeficiency virus and acquired immune deficiency syndrome'';

(C) in subparagraph (D), by striking ''conflict and''; and

(D) in subparagraph (E), by striking ''Remedial'' and inserting ''Career planning and''; and

(3) in paragraph (3)(D), by inserting ''which include child abuse and neglect prevention techniques'' before the period.

(d) ELIGIBLE ENTITIES.—Section 399D(d) of the Public Health Service Act (42 U.S.C. 280d(d)) is amended—

(1) by striking the matter preceding paragraph (1) and inserting:

''(d) ELIGIBLE ENTITIES.—The Secretary shall distribute the grants through the following types of entities:'';

(2) in paragraph (1), by striking ''drug treatment'' and inserting ''drug early intervention, prevention or treatment; and

(3) in paragraph (2)—

(A) in subparagraph (A), by striking ''; and'' and inserting ''; or''; and

(B) in subparagraph (B), by inserting ''or pediatric health or mental health providers and family mental health providers'' before the period.

(e) SUBMISSION OF INFORMATION.—Section 399D(h) of the Public Health Service Act (42 U.S.C. 280d(h)) is amended—

(1) in paragraph (2)—

(A) by inserting ''including maternal and child health'' before ''mental'';

(B) by striking ''treatment programs''; and

(C) by striking ''and the State agency responsible for administering public maternal and child health services'' and inserting '', the State agency responsible for administering alcohol and drug programs, the State lead agency, and the State Interagency Coordinating Council under part H of the Individuals with Disabilities Education Act; and''; and

(2) by striking paragraph (3) and redesignating paragraph (4) as paragraph (3).

(f) REPORTS TO THE SECRETARY.—Section 399D(i)(6) of the Public Health Service Act (42 U.S.C. 280d(i)(6)) is amended—

(1) in subparagraph (B), by adding ''and'' at the end; and

(2) by striking subparagraphs (C), (D), and (E) and inserting the following:

''(C) the number of case workers or other professionals trained to identify and address substance abuse issues.''.

(g) EVALUATIONS.—Section 399D(l) of the Public Health Service Act (42 U.S.C. 280d(l)) is amended—

(1) in paragraph (3), by adding ''and'' at the end;

(2) in paragraph (4), by striking the semicolon and inserting the following: '', including increased participation in work or employment-related activities and decreased participation in welfare programs.''; and

(3) by striking paragraphs (5) and (6).

(h) REPORT TO CONGRESS.—Section 399D(m) of the Public Health Service Act (42 U.S.C. 280d(m)) is amended—

(1) in paragraph (2), by adding ''and'' at the end;

(2) in paragraph (3)—

(A) in subparagraph (A), by adding ''and'' at the end;

(B) in subparagraph (B), by striking the semicolon and inserting a period; and

(C) by striking subparagraphs (C), (D), and (E); and

(3) by striking paragraphs (4) and (5).

(i) DATA COLLECTION.—Section 399D(n) of the Public Health Service Act (42 U.S.C. 280d(n)) is amended by adding at the end the following: ''The periodic report shall include a quantitative estimate of the prevalence of alcohol and drug problems in families involved in the child welfare system, the barriers to treatment and prevention services facing these families, and policy recommendations for removing the identified barriers, including training for child welfare workers.''.

(j) DEFINITION.—Section 399D(o)(2)(B) of the Public Health Service Act (42 U.S.C. 280d(o)(2)(B)) is amended by striking ''dangerous''.

(k) AUTHORIZATION OF APPROPRIATIONS.—Section 399D(p) of the Public Health Service Act (42 U.S.C. 280d(p)) is amended to read as follows:

''(p) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $50,000,000 for fiscal year 2001, and such sums as may be necessary for each of fiscal years 2002 and 2003.''.

(l) GRANTS FOR TRAINING AND CONFORMING AMENDMENTS.—Section 399D of the Public Health Service Act (42 U.S.C. 280d) is amended—

(1) by striking subsection (f);

(2) by striking subsection (k);

(3) by redesignating subsections (d), (e), (g), (h), (i), (j), (l), (m), (n), (o), and (p) as subsections (e) through (o), respectively;

(4) by inserting after subsection (c), the following:

''(d) TRAINING FOR PROVIDERS OF SERVICES TO CHILDREN AND FAMILIES.—The Secretary may make a grant under subsection (a) for the training of health, substance abuse and mental health professionals and other providers of services to children and families through youth service agencies, family social services, child care providers, Head Start, schools and after-school programs, early childhood development programs, community-based family resource centers, the criminal justice system, and other providers of services to children and families. Such training shall be to assist professionals in recognizing the drug and alcohol problems of their clients and to enhance their skills in identifying and understanding the nature of substance abuse, and obtaining substance abuse early intervention, prevention and treatment resources.'';

(5) in subsection (k)(2) (as so redesignated), by striking ''(h)'' and inserting ''(i)''; and

(6) in paragraphs (3)(E) and (5) of subsection (m) (as so redesignated), by striking ''(d)'' and inserting ''(e)''.

(m) TRANSFER AND REDESIGNATION.—Section 399D of the Public Health Service Act (42 U.S.C. 280d), as amended by this section—

(1) is transferred to title V;

(2) is redesignated as section 519; and

(3) is inserted after section 518.

(n) CONFORMING AMENDMENT.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by striking the heading of part L.

SEC. 3107. SERVICES FOR YOUTH OFFENDERS.

Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–31 et seq.), as amended by section 3104(b), is further amended by adding at the end the following:

''SEC. 520D. SERVICES FOR YOUTH OFFENDERS.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Center for Mental Health Services, and in consultation with the Director of the Center for Substance Abuse Treatment, the Administrator of the Office of Juvenile Justice and Delinquency Prevention, and the Director of the Special Education Programs, shall award grants on a competitive basis to State or local juvenile justice agencies to enable such agencies to provide aftercare services for youth offenders who have been discharged from facilities in the juvenile or criminal justice system and have serious emotional disturbances or are at risk of developing such disturbances.

''(b) USE OF FUNDS.—A State or local juvenile justice agency receiving a grant under subsection (a) shall use the amounts provided under the grant—

''(1) to develop a plan describing the manner in which the agency will provide services for each youth offender who has a serious emotional disturbance and has been detained or incarcerated in facilities within the juvenile or criminal justice system;

''(2) to provide a network of core or aftercare services or access to such services for each youth offender, including diagnostic and evaluation services, substance abuse treatment services, outpatient mental health care services, medication management services, intensive home-based therapy, intensive day treatment services, respite care, and therapeutic foster care;

''(3) to establish a program that coordinates with other State and local agencies providing recreational, social, educational, vocational, or operational services for youth, to enable the agency receiving a grant under this section to provide community-based system of care services for each youth offender that addresses the special needs of the youth and helps the youth access all of the aforementioned services; and

''(4) using not more than 20 percent of funds received, to provide planning and transition services as described in paragraph (3) for youth offenders while such youth are incarcerated or detained.

''(c) APPLICATION.—A State or local juvenile justice agency that desires a grant under subsection (a) shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

''(d) REPORT.—Not later than 3 years after the date of enactment of this section and annually

thereafter, the Secretary shall prepare and submit, to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Commerce of the House of Representatives, a report that describes the services provided pursuant to this section.

''(e) DEFINITIONS.—In this section:

''(1) SERIOUS EMOTIONAL DISTURBANCE.—The term 'serious emotional disturbance' with respect to a youth offender means an offender who currently, or at any time within the 1-year period ending on the day on which services are sought under this section, has a diagnosable mental, behavioral, or emotional disorder that functionally impairs the offender's life by substantially limiting the offender's role in family, school, or community activities, and interfering with the offender's ability to achieve or maintain 1 or more developmentally-appropriate social, behavior, cognitive, communicative, or adaptive skills.

''(2) COMMUNITY-BASED SYSTEM OF CARE.—The term 'community-based system of care' means the provision of services for the youth offender by various State or local agencies that in an interagency fashion or operating as a network addresses the recreational, social, educational, vocational, mental health, substance abuse, and operational needs of the youth offender.

''(3) YOUTH OFFENDER.—The term 'youth offender' means an individual who is 21 years of age or younger who has been discharged from a State or local juvenile or criminal justice system, except that if the individual is between the ages of 18 and 21 years, such individual has had contact with the State or local juvenile or criminal justice system prior to attaining 18 years of age and is under the jurisdiction of such a system at the time services are sought.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $40,000,000 for fiscal year 2001, and such sums as may be necessary for each of fiscal years 2002 and 2003.''.

SEC. 3108. GRANTS FOR STRENGTHENING FAMILIES THROUGH COMMUNITY PARTNERSHIPS.

Subpart 2 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–21 et seq) is amended by adding at the end the following:

''SEC. 519A. GRANTS FOR STRENGTHENING FAMILIES.

''(a) PROGRAM AUTHORIZED.—The Secretary, acting through the Director of the Prevention Center, may make grants to public and nonprofit private entities to develop and implement model substance abuse prevention programs to provide early intervention and substance abuse prevention services for individuals of high-risk families and the communities in which such individuals reside.

''(b) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to applicants that—

''(1) have proven experience in preventing substance abuse by individuals of high-risk families and reducing substance abuse in communities of such individuals;

''(2) have demonstrated the capacity to implement community-based partnership initiatives that are sensitive to the diverse backgrounds of individuals of high-risk families and the communities of such individuals;

''(3) have experience in providing technical assistance to support substance abuse prevention programs that are community-based;

''(4) have demonstrated the capacity to implement research-based substance abuse prevention strategies; and

''(5) have implemented programs that involve families, residents, community agencies, and institutions in the implementation and design of such programs.

''(c) DURATION OF GRANTS.—The Secretary shall award grants under subsection (a) for a period not to exceed 5 years.

''(d) USE OF FUNDS.—An applicant that is awarded a grant under subsection (a) shall—

''(1) in the first fiscal year that such funds are received under the grant, use such funds to develop a model substance abuse prevention program; and

''(2) in the fiscal year following the first fiscal year that such funds are received, use such funds to implement the program developed under paragraph (1) to provide early intervention and substance abuse prevention services to—

''(A) strengthen the environment of children of high risk families by targeting interventions at the families of such children and the communities in which such children reside;

''(B) strengthen protective factors, such as—

''(i) positive adult role models;

''(ii) messages that oppose substance abuse;

''(iii) community actions designed to reduce accessibility to and use of illegal substances; and

''(iv) willingness of individuals of families in which substance abuse occurs to seek treatment for substance abuse;

''(C) reduce family and community risks, such as family violence, alcohol or drug abuse, crime, and other behaviors that may effect healthy child development and increase the likelihood of substance abuse; and

''(D) build collaborative and formal partnerships between community agencies, institutions, and businesses to ensure that comprehensive high quality services are provided, such as early childhood education, health care, family support programs, parent education programs, and home visits for infants.

''(e) APPLICATION.—To be eligible to receive a grant under subsection (a), an applicant shall prepare and submit to the Secretary an application that—

''(1) describes a model substance abuse prevention program that such applicant will establish;

''(2) describes the manner in which the services described in subsection (d)(2) will be provided; and

''(3) describe in as much detail as possible the results that the entity expects to achieve in implementing such a program.

''(f) MATCHING FUNDING.—The Secretary may not make a grant to a entity under subsection (a) unless that entity agrees that, with respect to the costs to be incurred by the entity in carrying out the program for which the grant was awarded, the entity will make available non-Federal contributions in an amount that is not less than 40 percent of the amount provided under the grant.

''(g) REPORT TO SECRETARY.—An applicant that is awarded a grant under subsection (a) shall prepare and submit to the Secretary a report in such form and containing such information as the Secretary may require, including an assessment of the efficacy of the model substance abuse prevention program implemented by the applicant and the short, intermediate, and long term results of such program.

''(h) EVALUATIONS.—The Secretary shall conduct evaluations, based in part on the reports submitted under subsection (g), to determine the effectiveness of the programs funded under subsection (a) in reducing substance use in high-risk families and in making communities in which such families reside in stronger. The Secretary shall submit such evaluations to the appropriate committees of Congress.

''(i) HIGH-RISK FAMILIES.—In this section, the term 'high-risk family' means a family in which the individuals of such family are at a significant risk of using or abusing alcohol or any illegal substance.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $3,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 and 2003.''.

SEC. 3109. PROGRAMS TO REDUCE UNDERAGE DRINKING.

Subpart 2 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–21 et seq), as amended by section 3108, is further amended by adding at the end the following:

''SEC. 519B. PROGRAMS TO REDUCE UNDERAGE DRINKING.

''(a) IN GENERAL.—The Secretary shall make awards of grants, cooperative agreements, or contracts to public and nonprofit private entities, including Indian tribes and tribal organizations, to enable such entities to develop plans for and to carry out school-based (including institutions of higher education) and community-based programs for the prevention of alcoholic-beverage consumption by individuals who have not attained the legal drinking age.

''(b) ELIGIBILITY REQUIREMENTS.—To be eligible to receive an award under subsection (a), an entity shall provide any assurances to the Secretary which the Secretary may require, including that the entity will—

''(1) annually report to the Secretary on the effectiveness of the prevention approaches implemented by the entity;

''(2) use science based and age appropriate approaches; and

''(3) involve local public health officials and community prevention program staff in the planning and implementation of the program.

''(c) EVALUATION.—The Secretary shall evaluate each project under subsection (a) and shall disseminate the findings with respect to each such evaluation to appropriate public and private entities.

''(d) GEOGRAPHICAL DISTRIBUTION.—The Secretary shall ensure that awards will be distributed equitably among the regions of the country and among urban and rural areas.

''(e) DURATION OF AWARD.—With respect to an award under subsection (a), the period during which payments under such award are made to the recipient may not exceed 5 years. The preceding sentence may not be construed as establishing a limitation on the number of awards under such subsection that may be made to the recipient.

''(f) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $25,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 and 2003.''.

SEC. 3110. SERVICES FOR INDIVIDUALS WITH FETAL ALCOHOL SYNDROME.

Subpart 2 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–21 et seq), as amended by sections 3108 and 3109, is further amended by adding at the end the following:

''SEC. 519C. SERVICES FOR INDIVIDUALS WITH FETAL ALCOHOL SYNDROME.

''(a) IN GENERAL.—The Secretary shall make awards of grants, cooperative agreements, or contracts to public and nonprofit private entities, including Indian tribes and tribal organizations, to provide services to individuals diagnosed with fetal alcohol syndrome or alcohol-related birth defects.

''(b) USE OF FUNDS.—An award under subsection (a) may, subject to subsection (d), be used to—

''(1) screen and test individuals to determine the type and level of services needed;

''(2) develop a comprehensive plan for providing services to the individual;

''(3) provide mental health counseling;

''(4) provide substance abuse prevention services and treatment, if needed;

''(5) coordinate services with other social programs including social services, justice system, educational services, health services, mental health and substance abuse services, financial assistance programs, vocational services and housing assistance programs;

''(6) provide vocational services;

''(7) provide health counseling;

''(8) provide housing assistance;

''(9) parenting skills training;

''(10) overall case management;

''(11) supportive services for families of individuals with Fetal Alcohol Syndrome; and

''(12) provide other services and programs, to the extent authorized by the Secretary after consideration of recommendations made by the National Task Force on Fetal Alcohol Syndrome.

''(c) REQUIREMENTS.—To be eligible to receive an award under subsection (a), an applicant shall—

''(1) demonstrate that the program will be part of a coordinated, comprehensive system of care for such individuals;

''(2) demonstrate an established communication with other social programs in the community including social services, justice system, financial assistance programs, health services, educational services, mental health and substance abuse services, vocational services and housing assistance services;

''(3) show a history of working with individuals with fetal alcohol syndrome or alcohol-related birth defects;

''(4) provide assurance that the services will be provided in a culturally and linguistically appropriate manner; and

''(5) provide assurance that at the end of the 5-year award period, other mechanisms will be identified to meet the needs of the individuals and families served under such award.

''(d) RELATIONSHIP TO PAYMENTS UNDER OTHER PROGRAMS.—An award may be made under subsection (a) only if the applicant involved agrees that the award will not be expended to pay the expenses of providing any service under this section to an individual to the extent that payment has been made, or can reasonably be expected to be made, with respect to such expenses—

''(1) under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or

''(2) by an entity that provides health services on a prepaid basis.

''(e) DURATION OF AWARDS.—With respect to an award under subsection (a), the period during which payments under such award are made to the recipient may not exceed 5 years.

''(f) EVALUATION.—The Secretary shall evaluate each project carried out under subsection (a) and shall disseminate the findings with respect to each such evaluation to appropriate public and private entities.

''(g) FUNDING.—

''(1) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $25,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 and 2003.

''(2) ALLOCATION.—Of the amounts appropriated under paragraph (1) for a fiscal year, not less than $300,000 shall, for purposes relating to fetal alcohol syndrome and alcohol-related birth defects, be made available for collaborative, coordinated interagency efforts with the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Child Health and Human Development, the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, the Department of Education, and the Department of Justice.

''SEC. 519D. CENTERS OF EXCELLENCE ON SERVICES FOR INDIVIDUALS WITH FETAL ALCOHOL SYNDROME AND ALCOHOL-RELATED BIRTH DEFECTS AND TREATMENT FOR INDIVIDUALS WITH SUCH CONDITIONS AND THEIR FAMILIES.

''(a) IN GENERAL.—The Secretary shall make awards of grants, cooperative agreements, or contracts to public or nonprofit private entities for the purposes of establishing not more than 4 centers of excellence to study techniques for the prevention of fetal alcohol syndrome and alcohol-related birth defects and adaptations of innovative clinical interventions and service delivery improvements for the provision of comprehensive services to individuals with fetal alcohol syndrome or alcohol-related birth defects and their families and for providing training on such conditions.

''(b) USE OF FUNDS.—An award under subsection (a) may be used to—

''(1) study adaptations of innovative clinical interventions and service delivery improvements strategies for children and adults with fetal alcohol syndrome or alcohol-related birth defects and their families;

''(2) identify communities which have an exemplary comprehensive system of care for such individuals so that they can provide technical assistance to other communities attempting to set up such a system of care;

''(3) provide technical assistance to communities who do not have a comprehensive system of care for such individuals and their families;

''(4) train community leaders, mental health and substance abuse professionals, families, law enforcement personnel, judges, health professionals, persons working in financial assistance programs, social service personnel, child welfare professionals, and other service providers on the implications of fetal alcohol syndrome and alcohol-related birth defects, the early identification of and referral for such conditions;

''(5) develop innovative techniques for preventing alcohol use by women in child bearing years;

''(6) perform other functions, to the extent authorized by the Secretary after consideration of recommendations made by the National Task Force on Fetal Alcohol Syndrome.

''(c) REPORT.—

''(1) IN GENERAL.—A recipient of an award under subsection (a) shall at the end of the period of funding report to the Secretary on any innovative techniques that have been discovered for preventing alcohol use among women of child bearing years.

''(2) DISSEMINATION OF FINDINGS.—The Secretary shall upon receiving a report under paragraph (1) disseminate the findings to appropriate public and private entities.

''(d) DURATION OF AWARDS.—With respect to an award under subsection (a), the period during which payments under such award are made to the recipient may not exceed 5 years.

''(e) EVALUATION.—The Secretary shall evaluate each project carried out under subsection (a) and shall disseminate the findings with respect to each such evaluation to appropriate public and private entities.

''(f) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $5,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 and 2003.''.

SEC. 3111. SUICIDE PREVENTION.

Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–31 et seq), as amended by section 3107, is further amended by adding at the end the following:

''SEC. 520E. SUICIDE PREVENTION FOR CHILDREN AND ADOLESCENTS.

''(a) IN GENERAL.—The Secretary shall award grants, contracts, or cooperative agreements to States, political subdivisions of States, Indian tribes, tribal organizations, public organizations, or private nonprofit organizations to establish programs to reduce suicide deaths in the United States among children and adolescents.

''(b) COLLABORATION.—In carrying out subsection (a), the Secretary shall ensure that activities under this section are coordinated among the Substance Abuse and Mental Health Services Administration, the relevant institutes at the National Institutes of Health, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the Administration on Children and Families.

''(c) REQUIREMENTS.—A State, political subdivision of a State, Indian tribe, tribal organization, public organization, or private nonprofit organization desiring a grant, contract, or cooperative agreement under this section shall demonstrate that the suicide prevention program such entity proposes will—

''(1) provide for the timely assessment, treatment, or referral for mental health or substance abuse services of children and adolescents at risk for suicide;

''(2) be based on best evidence-based, suicide prevention practices and strategies that are adapted to the local community;

''(3) integrate its suicide prevention program into the existing health care system in the community including primary health care, mental health services, and substance abuse services;

''(4) be integrated into other systems in the community that address the needs of children and adolescents including the educational system, juvenile justice system, welfare and child protection systems, and community youth support organizations;

''(5) use primary prevention methods to educate and raise awareness in the local community by disseminating evidence-based information about suicide prevention;

''(6) include suicide prevention, mental health, and related information and services for the families and friends of those who completed suicide, as needed;

''(7) provide linguistically appropriate and culturally competent services, as needed;

''(8) provide a plan for the evaluation of outcomes and activities at the local level, according to standards established by the Secretary, and agree to participate in a national evaluation; and

''(9) ensure that staff used in the program are trained in suicide prevention and that professionals involved in the system of care have received training in identifying persons at risk of suicide.

''(d) USE OF FUNDS.—Amounts provided under grants, contracts, or cooperative agreements under subsection (a) shall be used to supplement and not supplant other Federal, State, and local public funds that are expended to provide services for eligible individuals.

''(e) CONDITION.—An applicant for a grant, contract, or cooperative agreement under subsection (a) shall demonstrate to the Secretary that the applicant has the support of the local community and relevant public health officials.

''(f) SPECIAL POPULATIONS.—In awarding grants, contracts, and cooperative agreements under subsection (a), the Secretary shall ensure that such awards are made in a manner that will focus on the needs of communities or groups that experience high or rapidly rising rates of suicide.

''(g) APPLICATION.—A State, political subdivision of a State, Indian tribe, tribal organization, public organization, or private nonprofit organization receiving a grant, contract, or cooperative agreement under subsection (a) shall prepare and submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require. Such application shall include a plan for the rigorous evaluation of activities funded under the grant, contract, or cooperative agreement, including a process and outcome evaluation.

''(h) DISTRIBUTION OF AWARDS.—In awarding grants, contracts, and cooperative agreements under subsection (a), the Secretary shall ensure that such awards are distributed among the geographical regions of the United States and between urban and rural settings.

''(i) EVALUATION.—A State, political subdivision of a State, Indian tribe, tribal organization, public organization, or private nonprofit organization receiving a grant, contract, or cooperative agreement under subsection (a) shall prepare and submit to the Secretary at the end of the program period, an evaluation of all activities funded under this section.

''(j) DISSEMINATION AND EDUCATION.—The Secretary shall ensure that findings derived

from activities carried out under this section are disseminated to State, county and local governmental agencies and public and private nonprofit organizations active in promoting suicide prevention and family support activities.

''(k) DURATION OF PROJECTS.—With respect to a grant, contract, or cooperative agreement awarded under this section, the period during which payments under such award may be made to the recipient may not exceed 5 years.

''(l) STUDY.—Within 1 year after the date of enactment of this section, the Secretary shall, directly or by grant or contract, initiate a study to assemble and analyze data to identify—

''(1) unique profiles of children under 13 who attempt or complete suicide;

''(2) unique profiles of youths between ages 13 and 21 who attempt or complete suicide; and

''(3) a profile of services which might have been available to these groups and the use of these services by children and youths from paragraphs (1) and (2).

''(m) AUTHORIZATION OF APPROPRIATION.—

''(1) IN GENERAL.—For purposes of carrying out this section, there is authorized to be appropriated $75,000,000 for fiscal year 2001 and such sums as may be necessary for each of the fiscal years 2002 through 2003.

''(2) PROGRAM MANAGEMENT.—In carrying out this section, the Secretary shall use 1 percent of the amount appropriated under paragraph (1) for each fiscal year for managing programs under this section.''.

SEC. 3112. GENERAL PROVISIONS.

(a) DUTIES OF THE CENTER FOR SUBSTANCE ABUSE TREATMENT.—Section 507(b) of the Public Health Service Act (42 U.S.C. 290bb(b)) is amended—

(1) by redesignating paragraphs (2) through (12) as paragraphs (4) through (14), respectively;

(2) by inserting after paragraph (1), the following:

''(2) ensure that emphasis is placed on children and adolescents in the development of treatment programs;

''(3) collaborate with the Attorney General to develop programs to provide substance abuse treatment services to individuals who have had contact with the Justice system, especially adolescents;'';

(3) in paragraph (7) (as so redesignated), by striking ''services, and monitor'' and all that follows through ''1925'' and inserting ''services'';

(4) in paragraph (13) (as so redesignated), by striking ''treatment, including'' and all that follows through ''which shall'' and inserting ''treatment, which shall''; and

(5) in paragraph 14 (as so redesignated), by striking ''paragraph (11)'' and inserting ''paragraph (13)''.

(b) OFFICE FOR SUBSTANCE ABUSE PREVENTION.—Section 515(b) of the Public Health Service Act (42 U.S.C. 290bb–21(b)) is amended—

(1) by redesignating paragraphs (9) and (10) as (10) and (11);

(2) by inserting after paragraph (8), the following:

''(9) collaborate with the Attorney General of the Department of Justice to develop programs to prevent drug abuse among high risk youth;''; and

(3) in paragraph (10) (as so redesignated), by striking ''public concerning'' and inserting ''public, especially adolescent audiences, concerning''.

(c) DUTIES OF THE CENTER FOR MENTAL HEALTH SERVICES.—Section 520(b) of the Public Health Service Act (42 U.S.C. 290bb–3(b)) is amended—

(1) by redesignating paragraphs (3) through (14) as paragraphs (4) through (15), respectively;

(2) by inserting after paragraph (2), the following:

''(3) collaborate with the Department of Education and the Department of Justice to develop programs to assist local communities in addressing violence among children and adolescents;'';

(3) in paragraph (8) (as so redesignated), by striking ''programs authorized'' and all that follows through ''Programs'' and inserting ''programs under part C''; and

(4) in paragraph (9) (as so redesignated), by striking ''program and programs'' and all that follows through ''303'' and inserting ''programs''.

TITLE XXXII—PROVISIONS RELATING TO MENTAL HEALTH

SEC. 3201. PRIORITY MENTAL HEALTH NEEDS OF REGIONAL AND NATIONAL SIGNIFICANCE.

(a) IN GENERAL.—Section 520A of the Public Health Service Act (42 U.S.C. 290bb–32) is amended to read as follows:

''SEC. 520A. PRIORITY MENTAL HEALTH NEEDS OF REGIONAL AND NATIONAL SIGNIFICANCE.

''(a) PROJECTS.—The Secretary shall address priority mental health needs of regional and national significance (as determined under subsection (b)) through the provision of or through assistance for—

''(1) knowledge development and application projects for prevention, treatment, and rehabilitation, and the conduct or support of evaluations of such projects;

''(2) training and technical assistance programs;

''(3) targeted capacity response programs; and

''(4) systems change grants including statewide family network grants and client-oriented and consumer run self-help activities.

The Secretary may carry out the activities described in this subsection directly or through grants or cooperative agreements with States, political subdivisions of States, Indian tribes and tribal organizations, other public or private nonprofit entities.

''(b) PRIORITY MENTAL HEALTH NEEDS.—

''(1) DETERMINATION OF NEEDS.—Priority mental health needs of regional and national significance shall be determined by the Secretary in consultation with States and other interested groups. The Secretary shall meet with the States and interested groups on an annual basis to discuss program priorities.

''(2) SPECIAL CONSIDERATION.—In developing program priorities described in paragraph (1), the Secretary shall give special consideration to promoting the integration of mental health services into primary health care systems.

''(c) REQUIREMENTS.—

''(1) IN GENERAL.—Recipients of grants, contracts, and cooperative agreements under this section shall comply with information and application requirements determined appropriate by the Secretary.

''(2) DURATION OF AWARD.—With respect to a grant, contract, or cooperative agreement awarded under this section, the period during which payments under such award are made to the recipient may not exceed 5 years.

''(3) MATCHING FUNDS.—The Secretary may, for projects carried out under subsection (a), require that entities that apply for grants, contracts, or cooperative agreements under this section provide non-Federal matching funds, as determined appropriate by the Secretary, to ensure the institutional commitment of the entity to the projects funded under the grant, contract, or cooperative agreement. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in cash or in kind, fairly evaluated, including plant, equipment, or services.

''(4) MAINTENANCE OF EFFORT.—With respect to activities for which a grant, contract or cooperative agreement is awarded under this section, the Secretary may require that recipients for specific projects under subsection (a) agree to maintain expenditures of non-Federal amounts for such activities at a level that is not less than the level of such expenditures maintained by the entity for the fiscal year preceding the fiscal year for which the entity receives such a grant, contract, or cooperative agreement.

''(d) EVALUATION.—The Secretary shall evaluate each project carried out under subsection (a)(1) and shall disseminate the findings with respect to each such evaluation to appropriate public and private entities.

''(e) INFORMATION AND EDUCATION.—

''(1) IN GENERAL.—The Secretary shall establish information and education programs to disseminate and apply the findings of the knowledge development and application, training, and technical assistance programs, and targeted capacity response programs, under this section to the general public, to health care professionals, and to interested groups. The Secretary shall make every effort to provide linkages between the findings of supported projects and State agencies responsible for carrying out mental health services.

''(2) RURAL AND UNDERSERVED AREAS.—In disseminating information on evidence-based practices in the provision of children's mental health services under this subsection, the Secretary shall ensure that such information is distributed to rural and medically underserved areas.

''(f) AUTHORIZATION OF APPROPRIATION.—

''(1) IN GENERAL.—There are authorized to be appropriated to carry out this section, $300,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 and 2003.

''(2) DATA INFRASTRUCTURE.—If amounts are not appropriated for a fiscal year to carry out section 1971 with respect to mental health, then the Secretary shall make available, from the amounts appropriated for such fiscal year under paragraph (1), an amount equal to the sum of $6,000,000 and 10 percent of all amounts appropriated for such fiscal year under such paragraph in excess of $100,000,000, to carry out such section 1971.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 303 of the Public Health Service Act (42 U.S.C. 242a) is repealed.

(2) Section 520B of the Public Health Service Act (42 U.S.C. 290bb–33) is repealed.

(3) Section 612 of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 290aa–3 note) is repealed.

SEC. 3202. GRANTS FOR THE BENEFIT OF HOMELESS INDIVIDUALS.

Section 506 of the Public Health Service Act (42 U.S.C. 290aa–5) is amended to read as follows:

''SEC. 506. GRANTS FOR THE BENEFIT OF HOMELESS INDIVIDUALS.

''(a) IN GENERAL.—The Secretary shall award grants, contracts and cooperative agreements to community-based public and private nonprofit entities for the purposes of providing mental health and substance abuse services for homeless individuals. In carrying out this section, the Secretary shall consult with the Interagency Council on the Homeless, established under section 201 of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11311).

''(b) PREFERENCES.—In awarding grants, contracts, and cooperative agreements under subsection (a), the Secretary shall give a preference to—

''(1) entities that provide integrated primary health, substance abuse, and mental health services to homeless individuals;

''(2) entities that demonstrate effectiveness in serving runaway, homeless, and street youth;

''(3) entities that have experience in providing substance abuse and mental health services to homeless individuals;

''(4) entities that demonstrate experience in providing housing for individuals in treatment for or in recovery from mental illness or substance abuse; and

''(5) entities that demonstrate effectiveness in serving homeless veterans.

''(c) SERVICES FOR CERTAIN INDIVIDUALS.—In awarding grants, contracts, and cooperative agreements under subsection (a), the Secretary shall not—

''(1) prohibit the provision of services under such subsection to homeless individuals who are suffering from a substance abuse disorder and are not suffering from a mental health disorder; and

''(2) make payments under subsection (a) to any entity that has a policy of—

''(A) excluding individuals from mental health services due to the existence or suspicion of substance abuse; or

''(B) has a policy of excluding individuals from substance abuse services due to the existence or suspicion of mental illness.

''(d) TERM OF THE AWARDS.—No entity may receive a grant, contract, or cooperative agreement under subsection (a) for more than 5 years.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $50,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 and 2003.''.

SEC. 3203. PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS.

(a) WAIVERS FOR TERRITORIES.—Section 522 of the Public Health Service Act (42 U.S.C. 290cc–22) is amended by adding at the end the following:

''(i) WAIVER FOR TERRITORIES.—With respect to the United States Virgin Islands, Guam, American Samoa, Palau, the Marshall Islands, and the Commonwealth of the Northern Mariana Islands, the Secretary may waive the provisions of this part that the Secretary determines to be appropriate.''.

(b) AUTHORIZATION OF APPROPRIATION.—Section 535(a) of the Public Health Service Act (42 U.S.C. 290cc–35(a)) is amended by striking ''1991 through 1994'' and inserting ''2001 through 2003''.

SEC. 3204. COMMUNITY MENTAL HEALTH SERVICES PERFORMANCE PARTNERSHIP BLOCK GRANT.

(a) CRITERIA FOR PLAN.—Section 1912(b) of the Public Health Service Act (42 U.S.C. 300x–2(b)) is amended by striking paragraphs (1) through (12) and inserting the following:

''(1) COMPREHENSIVE COMMUNITY-BASED MENTAL HEALTH SYSTEMS.—The plan provides for an organized community-based system of care for individuals with mental illness and describes available services and resources in a comprehensive system of care, including services for dually diagnosed individuals. The description of the system of care shall include health and mental health services, rehabilitation services, employment services, housing services, educational services, substance abuse services, medical and dental care, and other support services to be provided to individuals with Federal, State and local public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities, including services to be provided by local school systems under the Individuals with Disabilities Education Act. The plan shall include a separate description of case management services and provide for activities leading to reduction of hospitalization.

''(2) MENTAL HEALTH SYSTEM DATA AND EPIDEMIOLOGY.—The plan contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children and presents quantitative targets to be achieved in the implementation of the system described in paragraph (1).

''(3) CHILDREN'S SERVICES.—In the case of children with serious emotional disturbance, the plan—

''(A) subject to subparagraph (B), provides for a system of integrated social services, educational services, juvenile services, and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (such system to include services provided under the Individuals with Disabilities Education Act);

''(B) provides that the grant under section 1911 for the fiscal year involved will not be expended to provide any service under such system other than comprehensive community mental health services; and

''(C) provides for the establishment of a defined geographic area for the provision of the services of such system.

''(4) TARGETED SERVICES TO RURAL AND HOMELESS POPULATIONS.—The plan describes the State's outreach to and services for individuals who are homeless and how community-based services will be provided to individuals residing in rural areas.

''(5) MANAGEMENT SYSTEMS.—The plan describes the financial resources, staffing and training for mental health providers that is necessary to implement the plan, and provides for the training of providers of emergency health services regarding mental health. The plan further describes the manner in which the State intends to expend the grant under section 1911 for the fiscal year involved.

Except as provided for in paragraph (3), the State plan shall contain the information required under this subsection with respect to both adults with serious mental illness and children with serious emotional disturbance.''.

(b) REVIEW OF PLANNING COUNCIL OF STATE'S REPORT.—Section 1915(a) of the Public Health Service Act (42 U.S.C. 300x–4(a)) is amended—

(1) in paragraph (1), by inserting ''and the report of the State under section 1942(a) concerning the preceding fiscal year'' after ''to the grant''; and

(2) in paragraph (2), by inserting before the period ''and any comments concerning the annual report''.

(c) MAINTENANCE OF EFFORT.—Section 1915(b) of the Public Health Service Act (42 U.S.C. 300x–4(b)) is amended—

(1) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively; and

(2) by inserting after paragraph (1), the following:

''(2) EXCLUSION OF CERTAIN FUNDS.—The Secretary may exclude from the aggregate State expenditures under subsection (a), funds appropriated to the principle agency for authorized activities which are of a non-recurring nature and for a specific purpose.''.

(d) APPLICATION FOR GRANTS.—Section 1917(a)(1) of the Public Health Service Act (42 U.S.C. 300x–6(a)(1)) is amended to read as follows:

''(1) the plan is received by the Secretary not later than September 1 of the fiscal year prior to the fiscal year for which a State is seeking funds, and the report from the previous fiscal year as required under section 1941 is received by December 1 of the fiscal year of the grant;''.

(e) WAIVERS FOR TERRITORIES.—Section 1917(b) of the Public Health Service Act (42 U.S.C. 300x–6(b)) is amended by striking ''whose allotment under section 1911 for the fiscal year is the amount specified in section 1918(c)(2)(B)'' and inserting in its place ''except Puerto Rico''.

(f) AUTHORIZATION OF APPROPRIATION.—Section 1920 of the Public Health Service Act (42 U.S.C. 300x–9) is amended—

(1) in subsection (a), by striking ''$450,000,000'' and all that follows through the end and inserting ''$450,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 and 2003.''; and

(2) in subsection (b)(2), by striking ''section 505'' and inserting ''sections 505 and 1971''.

SEC. 3205. DETERMINATION OF ALLOTMENT.

Section 1918(b) of the Public Health Service Act (42 U.S.C. 300x–7(b)) is amended to read as follows:

''(b) MINIMUM ALLOTMENTS FOR STATES.—With respect to fiscal year 2000, and subsequent fiscal years, the amount of the allotment of a State under section 1911 shall not be less than the amount the State received under such section for fiscal year 1998.''.

SEC. 3206. PROTECTION AND ADVOCACY FOR MENTALLY ILL INDIVIDUALS ACT OF 1986.

(a) SHORT TITLE.—The first section of the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (Public Law 99–319) is amended to read as follows:

''SECTION 1. SHORT TITLE.

''This Act may be cited as the 'Protection and Advocacy for Individuals with Mental Illness Act'.''.

(b) DEFINITIONS.—Section 102 of the Protection and Advocacy for Individuals with Mental Illness Act (as amended by subsection (a)) (42 U.S.C. 10802) is amended—

(1) in paragraph (4)—

(A) in the matter preceding subparagraph (A), by inserting '', except as provided in section 104(d),'' after ''means'';

(B) in subparagraph (B)—

(i) by striking ''(i)'' who'' and inserting ''(i)(I) who'';

(ii) by redesignating clauses (ii) and (iii) as subclauses (II) and (III);

(iii) in subclause (III) (as so redesignated), by striking the period and inserting ''; or''; and

(iv) by adding at the end the following:

''(ii) who satisfies the requirements of subparagraph (A) and lives in a community setting, including their own home.''; and

(2) by adding at the end the following:

''(8) The term 'American Indian consortium' means a consortium established under part C of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6042 et seq.).''.

(c) USE OF ALLOTMENTS.—Section 104 of the Protection and Advocacy for Individuals with Mental Illness Act (as amended by subsection (a)) (42 U.S.C. 10804) is amended by adding at the end the following:

''(d) The definition of 'individual with a mental illness' contained in section 102(4)(B)(iii) shall apply, and thus an eligible system may use its allotment under this title to provide representation to such individuals, only if the total allotment under this title for any fiscal year is $30,000,000 or more, and in such case, an eligible system must give priority to representing persons with mental illness as defined in subparagraphs (A) and (B)(i) of section 102(4).''.

(d) MINIMUM AMOUNT.—Paragraph (2) of section 112(a) of the Protection and Advocacy for Individuals with Mental Illness Act (as amended by subsection (a)) (42 U.S.C. 10822(a)(2)) is amended to read as follows:

''(2)(A) The minimum amount of the allotment of an eligible system shall be the product (rounded to the nearest $100) of the appropriate base amount determined under subparagraph (B) and the factor specified in subparagraph (C).

''(B) For purposes of subparagraph (A), the appropriate base amount—

''(i) for American Samoa, Guam, the Marshall Islands, the Federated States of Micronesia, the Commonwealth of the Northern Mariana Islands, the Republic of Palau, and the Virgin Islands, is $139,300; and

''(ii) for any other State, is $260,000.

''(C) The factor specified in this subparagraph is the ratio of the amount appropriated under section 117 for the fiscal year for which the allotment is being made to the amount appropriated under such section for fiscal year 1995.

''(D) If the total amount appropriated for a fiscal year is at least $25,000,000, the Secretary shall make an allotment in accordance with subparagraph (A) to the eligible system serving the American Indian consortium.''.

(e) TECHNICAL AMENDMENTS.—Section 112(a) of the Protection and Advocacy for Individuals with Mental Illness Act (as amended by subsection (a)) (42 U.S.C. 10822(a)) is amended—

(1) in paragraph (1)(B), by striking ''Trust Territory of the Pacific Islands'' and inserting ''Marshall Islands, the Federated States of Micronesia, the Republic of Palau''; and

(2) by striking paragraph (3).

(f) REAUTHORIZATION.—Section 117 of the Protection and Advocacy for Individuals with Mental Illness Act (as amended by subsection (a)) (42 U.S.C. 10827) is amended by striking ''1995'' and inserting ''2003''.

SEC. 3207. REQUIREMENT RELATING TO THE RIGHTS OF RESIDENTS OF CERTAIN FACILITIES.

Title V of the Public Health Service Act (42 U.S.C. 290aa et seq.) is amended by adding at the end the following:

''PART H—REQUIREMENT RELATING TO THE RIGHTS OF RESIDENTS OF CERTAIN FACILITIES

''SEC. 591. REQUIREMENT RELATING TO THE RIGHTS OF RESIDENTS OF CERTAIN FACILITIES.

''(a) IN GENERAL.—A public or private general hospital, nursing facility, intermediate care facility, or other health care facility, that receives support in any form from any program supported in whole or in part with funds appropriated to any Federal department or agency shall protect and promote the rights of each resident of the facility, including the right to be free from physical or mental abuse, corporal punishment, and any restraints or involuntary seclusions imposed for purposes of discipline or convenience.

''(b) REQUIREMENTS.—Restraints and seclusion may only be imposed on a resident of a facility described in subsection (a) if—

''(1) the restraints or seclusion are imposed to ensure the physical safety of the resident, a staff member, or others; and

''(2) the restraints or seclusion are imposed only upon the written order of a physician, or other licensed practitioner permitted by the State and the facility to order such restraint or seclusion, that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

''(c) CURRENT LAW.—This part shall not be construed to affect or impede any Federal or State law or regulations that provide greater protections than this part regarding seclusion and restraint.

''(d) DEFINITIONS.—In this section:

''(1) RESTRAINTS.—The term 'restraints' means—

''(A) any physical restraint that is a mechanical or personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs, or head freely, not including devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or any other methods that involves the physical holding of a resident for the purpose of conducting routine physical examinations or tests or to protect the resident from falling out of bed or to permit the resident to participate in activities without the risk of physical harm to the resident (such term does not include a physical escort); and

''(B) a drug or medication that is used as a restraint to control behavior or restrict the resident's freedom of movement that is not a standard treatment for the resident's medical or psychiatric condition.

''(2) SECLUSION.—The term 'seclusion' means a behavior control technique involving locked isolation. Such term does not include a time out.

''(3) PHYSICAL ESCORT.—The term 'physical escort' means the temporary touching or holding of the hand, wrist, arm, shoulder or back for the purpose of inducing a resident who is acting out to walk to a safe location.

''(4) TIME OUT.—The term 'time out' means a behavior management technique that is part of an approved treatment program and may involve the separation of the resident from the group, in a non-locked setting, for the purpose of calming. Time out is not seclusion.

''SEC. 592. REPORTING REQUIREMENT.

''(a) IN GENERAL.— Each facility to which the Protection and Advocacy for Mentally Ill Individuals Act of 1986 applies shall notify the appropriate agency, as determined by the Secretary, of each death that occurs at each such facility while a patient is restrained or in seclusion, of each death occurring within 24 hours after the patient has been removed from restraints and seclusion, or where it is reasonable to assume that a patient's death is a result of such seclusion or restraint. A notification under this section shall include the name of the resident and shall be provided not later than 7 days after the date of the death of the individual involved.

''(b) FACILITY.—In this section, the term 'facility' has the meaning given the term 'facilities' in section 102(3) of the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10802(3)).''.

''SEC. 593. REGULATIONS AND ENFORCEMENT.

''(a) TRAINING.—Not later than 1 year after the date of enactment of this part, the Secretary, after consultation with appropriate State and local protection and advocacy organizations, physicians, facilities, and other health care professionals and patients, shall promulgate regulations that require facilities to which the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10801 et seq.) applies, to meet the requirements of subsection (b).

''(b) REQUIREMENTS.—The regulations promulgated under subsection (a) shall require that—

''(1) facilities described in subsection (a) ensure that there is an adequate number of qualified professional and supportive staff to evaluate patients, formulate written individualized, comprehensive treatment plans, and to provide active treatment measures;

''(2) appropriate training be provided for the staff of such facilities in the use of restraints and any alternatives to the use of restraints; and

''(3) such facilities provide complete and accurate notification of deaths, as required under section 592(a).

''(c) ENFORCEMENT.—A facility to which this part applies that fails to comply with any requirement of this part, including a failure to provide appropriate training, shall not be eligible for participation in any program supported in whole or in part by funds appropriated to any Federal department or agency.''.

SEC. 3208. REQUIREMENT RELATING TO THE RIGHTS OF RESIDENTS OF CERTAIN NON-MEDICAL, COMMUNITY-BASED FACILITIES FOR CHILDREN AND YOUTH.

Title V of the Public Health Service Act (42 U.S.C. 290aa et seq.), as amended by section 3207, is further amended by adding at the end the following:

''PART I—REQUIREMENT RELATING TO THE RIGHTS OF RESIDENTS OF CERTAIN NON-MEDICAL, COMMUNITY-BASED FACILITIES FOR CHILDREN AND YOUTH

''SEC. 595. REQUIREMENT RELATING TO THE RIGHTS OF RESIDENTS OF CERTAIN NON-MEDICAL, COMMUNITY-BASED FACILITIES FOR CHILDREN AND YOUTH.

''(a) PROTECTION OF RIGHTS.—

''(1) IN GENERAL.—A public or private non-medical, community-based facility for children and youth (as defined in regulations to be promulgated by the Secretary) that receives support in any form from any program supported in whole or in part with funds appropriated under this Act shall protect and promote the rights of each resident of the facility, including the right to be free from physical or mental abuse, corporal punishment, and any restraints or involuntary seclusions imposed for purposes of discipline or convenience.

''(2) NONAPPLICABILITY.—Notwithstanding this part, a facility that provides inpatient psychiatric treatment services for individuals under the age of 21, as authorized and defined in subsections (a)(16) and (h) of section 1905 of the Social Security Act, shall comply with the requirements of part H.

''(3) APPLICABILITY OF MEDICAID PROVISIONS.—A non-medical, community-based facility for children and youth funded under the medicaid program under title XIX of the Social Security Act shall continue to meet all existing requirements for participation in such program that are not affected by this part.

''(b) REQUIREMENTS.—

''(1) IN GENERAL.—Physical restraints and seclusion may only be imposed on a resident of a facility described in subsection (a) if—

''(A) the restraints or seclusion are imposed only in emergency circumstances and only to ensure the immediate physical safety of the resident, a staff member, or others and less restrictive interventions have been determined to be ineffective; and

''(B) the restraints or seclusion are imposed only by an individual trained and certified, by a State-recognized body (as defined in regulation promulgated by the Secretary) and pursuant to a process determined appropriate by the State and approved by the Secretary, in the prevention and use of physical restraint and seclusion, including the needs and behaviors of the population served, relationship building, alternatives to restraint and seclusion, de-escalation methods, avoiding power struggles, thresholds for restraints and seclusion, the physiological and psychological impact of restraint and seclusion, monitoring physical signs of distress and obtaining medical assistance, legal issues, position asphyxia, escape and evasion techniques, time limits, the process for obtaining approval for continued restraints, procedures to address problematic restraints, documentation, processing with children, and follow-up with staff, and investigation of injuries and complaints.

''(2) INTERIM PROCEDURES RELATING TO TRAINING AND CERTIFICATION.—

''(A) IN GENERAL.—Until such time as the State develops a process to assure the proper training and certification of facility personnel in the skills and competencies referred in paragraph (1)(B), the facility involved shall develop and implement an interim procedure that meets the requirements of subparagraph (B).

''(B) REQUIREMENTS.—A procedure developed under subparagraph (A) shall—

''(i) ensure that a supervisory or senior staff person with training in restraint and seclusion who is competent to conduct a face-to-face assessment (as defined in regulations promulgated by the Secretary), will assess the mental and physical well-being of the child or youth being restrained or secluded and assure that the restraint or seclusion is being done in a safe manner;

''(ii) ensure that the assessment required under clause (i) take place as soon as practicable, but in no case later than 1 hour after the initiation of the restraint or seclusion; and

''(iii) ensure that the supervisory or senior staff person continues to monitor the situation for the duration of the restraint and seclusion.

''(3) LIMITATIONS.—

''(A) IN GENERAL.—The use of a drug or medication that is used as a restraint to control behavior or restrict the resident's freedom of movement that is not a standard treatment for the resident's medical or psychiatric condition in nonmedical community-based facilities for children and youth described in subsection (a)(1) is prohibited.

''(B) PROHIBITION.—The use of mechanical restraints in non-medical, community-based facilities for children and youth described in subsection (a)(1) is prohibited.

''(C) LIMITATION.—A non-medical, community-based facility for children and youth described in subsection (a)(1) may only use seclusion when a staff member is continuously face-to-face monitoring the resident and when strong licensing or accreditation and internal controls are in place.

''(c) RULE OF CONSTRUCTION.—

''(1) IN GENERAL.—Nothing in this section shall be construed as prohibiting the use of restraints for medical immobilization, adaptive support, or medical protection.

''(2) CURRENT LAW.—This part shall not be construed to affect or impede any Federal or State law or regulations that provide greater protections than this part regarding seclusion and restraint.

''(d) DEFINITIONS.—In this section:

''(1) MECHANICAL RESTRAINT.—The term 'mechanical restraint' means the use of devices as a means of restricting a resident's freedom of movement.

''(2) PHYSICAL ESCORT.—The term 'physical escort' means the temporary touching or holding of the hand, wrist, arm, shoulder or back for the purpose of inducing a resident who is acting out to walk to a safe location.

''(3) PHYSICAL RESTRAINT.—The term 'physical restraint' means a personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs, or head freely. Such term does not include a physical escort.

''(4) SECLUSION.—The term 'seclusion' means a behavior control technique involving locked isolation. Such term does not include a time out.

''(5) TIME OUT.—The term 'time out' means a behavior management technique that is part of an approved treatment program and may involve the separation of the resident from the group, in a non-locked setting, for the purpose of calming. Time out is not seclusion.

''SEC. 595A. REPORTING REQUIREMENT.

''Each facility to which this part applies shall notify the appropriate State licensing or regulatory agency, as determined by the Secretary—

''(1) of each death that occurs at each such facility. A notification under this section shall include the name of the resident and shall be provided not later than 24 hours after the time of the individuals death; and

''(2) of the use of seclusion or restraints in accordance with regulations promulgated by the Secretary, in consultation with the States.

''SEC. 595B. REGULATIONS AND ENFORCEMENT.

''(a) TRAINING.—Not later than 6 months after the date of enactment of this part, the Secretary, after consultation with appropriate State, local, public and private protection and advocacy organizations, health care professionals, social workers, facilities, and patients, shall promulgate regulations that—

''(1) require States that license non-medical, community-based residential facilities for children and youth to develop licensing rules and monitoring requirements concerning behavior management practice that will ensure compliance with Federal regulations and to meet the requirements of subsection (b);

''(2) require States to develop and implement such licensing rules and monitoring requirements within 1 year after the promulgation of the regulations referred to in the matter preceding paragraph (1); and

''(3) support the development of national guidelines and standards on the quality, quantity, orientation and training, required under this part, as well as the certification or licensure of those staff responsible for the implementation of behavioral intervention concepts and techniques.

''(b) REQUIREMENTS.—The regulations promulgated under subsection (a) shall require—

''(1) that facilities described in subsection (a) ensure that there is an adequate number of qualified professional and supportive staff to evaluate residents, formulate written individualized, comprehensive treatment plans, and to provide active treatment measures;

''(2) the provision of appropriate training and certification of the staff of such facilities in the prevention and use of physical restraint and seclusion, including the needs and behaviors of the population served, relationship building, alternatives to restraint, de-escalation methods, avoiding power struggles, thresholds for restraints, the physiological impact of restraint and seclusion, monitoring physical signs of distress and obtaining medical assistance, legal issues, position asphyxia, escape and evasion techniques, time limits for the use of restraint and seclusion, the process for obtaining approval for continued restraints and seclusion, procedures to address problematic restraints, documentation, processing with children, and follow-up with staff, and investigation of injuries and complaints; and

''(3) that such facilities provide complete and accurate notification of deaths, as required under section 595A(1).

''(c) ENFORCEMENT.—A State to which this part applies that fails to comply with any requirement of this part, including a failure to provide appropriate training and certification, shall not be eligible for participation in any program supported in whole or in part by funds appropriated under this Act.''.

SEC. 3209. EMERGENCY MENTAL HEALTH CENTERS.

Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–31 et seq.), as amended by section 3111, is further amended by adding at the end the following:

''SEC. 520F. GRANTS FOR EMERGENCY MENTAL HEALTH CENTERS.

''(a) PROGRAM AUTHORIZED.—The Secretary shall award grants to States, political subdivisions of States, Indian tribes, and tribal organizations to support the designation of hospitals and health centers as Emergency Mental Health Centers.

''(b) HEALTH CENTER.—In this section, the term 'health center' has the meaning given such term in section 330, and includes community health centers and community mental health centers.

''(c) DISTRIBUTION OF AWARDS.—The Secretary shall ensure that such grants awarded under subsection (a) are equitably distributed among the geographical regions of the United States, between urban and rural populations, and between different settings of care including health centers, mental health centers, hospitals, and other psychiatric units or facilities.

''(d) APPLICATION.—A State, political subdivision of a State, Indian tribe, or tribal organization that desires a grant under subsection (a) shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a plan for the rigorous evaluation of activities carried out with funds received under this section.

''(e) USE OF FUNDS.—

''(1) IN GENERAL.—A State, political subdivision of a State, Indian tribe, or tribal organization receiving a grant under subsection (a) shall use funds from such grant to establish or designate hospitals and health centers as Emergency Mental Health Centers.

''(2) EMERGENCY MENTAL HEALTH CENTERS.—Such Emergency Mental Health Centers described in paragraph (1)—

''(A) shall—

''(i) serve as a central receiving point in the community for individuals who may be in need of emergency mental health services;

''(ii) purchase, if needed, any equipment necessary to evaluate, diagnose and stabilize an individual with a mental illness;

''(iii) provide training, if needed, to the medical personnel staffing the Emergency Mental Health Center to evaluate, diagnose, stabilize, and treat an individual with a mental illness; and

''(iv) provide any treatment that is necessary for an individual with a mental illness or a referral for such individual to another facility where such treatment may be received; and

''(B) may establish and train a mobile crisis intervention team to respond to mental health emergencies within the community.

''(f) EVALUATION.—A State, political subdivision of a State, Indian tribe, or tribal organization that receives a grant under subsection (a) shall prepare and submit an evaluation to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require, including an evaluation of activities carried out with funds received under this section and a process and outcomes evaluation.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $25,000,000 for fiscal year 2001 and such sums as may be necessary for each of the fiscal years 2002 through 2003.''.

SEC. 3210. GRANTS FOR JAIL DIVERSION PROGRAMS.

Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–31 et seq.), as amended by section 3209, is further amended by adding at the end the following:

''SEC. 520G. GRANTS FOR JAIL DIVERSION PROGRAMS.

''(a) PROGRAM AUTHORIZED.—The Secretary shall make up to 125 grants to States, political subdivisions of States, Indian tribes, and tribal organizations, acting directly or through agreements with other public or nonprofit entities, to develop and implement programs to divert individuals with a mental illness from the criminal justice system to community-based services.

''(b) ADMINISTRATION.—

''(1) CONSULTATION.—The Secretary shall consult with the Attorney General and any other appropriate officials in carrying out this section.

''(2) REGULATORY AUTHORITY.—The Secretary shall issue regulations and guidelines necessary to carry out this section, including methodologies and outcome measures for evaluating programs carried out by States, political subdivisions of States, Indian tribes, and tribal organizations receiving grants under subsection (a).

''(c) APPLICATIONS.—

''(1) IN GENERAL.—To receive a grant under subsection (a), the chief executive of a State, chief executive of a subdivision of a State, Indian tribe or tribal organization shall prepare and submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary shall reasonably require.

''(2) CONTENT.—Such application shall—

''(A) contain an assurance that—

''(i) community-based mental health services will be available for the individuals who are diverted from the criminal justice system, and that such services are based on the best known practices, reflect current research findings, include case management, assertive community treatment, medication management and access, integrated mental health and co-occurring substance abuse treatment, and psychiatric rehabilitation, and will be coordinated with social services, including life skills training, housing placement, vocational training, education job placement, and health care;

''(ii) there has been relevant interagency collaboration between the appropriate criminal justice, mental health, and substance abuse systems; and

''(iii) the Federal support provided will be used to supplement, and not supplant, State, local, Indian tribe, or tribal organization sources of funding that would otherwise be available;

''(B) demonstrate that the diversion program will be integrated with an existing system of care for those with mental illness;

''(C) explain the applicant's inability to fund the program adequately without Federal assistance;

''(D) specify plans for obtaining necessary support and continuing the proposed program following the conclusion of Federal support; and

''(E) describe methodology and outcome measures that will be used in evaluating the program.

''(d) USE OF FUNDS.—A State, political subdivision of a State, Indian tribe, or tribal organization that receives a grant under subsection (a) may use funds received under such grant to—

''(1) integrate the diversion program into the existing system of care;

''(2) create or expand community-based mental health and co-occurring mental illness and substance abuse services to accommodate the diversion program;

''(3) train professionals involved in the system of care, and law enforcement officers, attorneys, and judges; and

''(4) provide community outreach and crisis intervention.

''(e) FEDERAL SHARE.—

''(1) IN GENERAL.—The Secretary shall pay to a State, political subdivision of a State, Indian tribe, or tribal organization receiving a grant under subsection (a) the Federal share of the cost of activities described in the application.

''(2) FEDERAL SHARE.—The Federal share of a grant made under this section shall not exceed 75 percent of the total cost of the program carried out by the State, political subdivision of a State, Indian tribe, or tribal organization. Such share shall be used for new expenses of the program carried out by such State, political subdivision of a State, Indian tribe, or tribal organization.

''(3) NON-FEDERAL SHARE.—The non-Federal share of payments made under this section may be made in cash or in kind fairly evaluated, including planned equipment or services. The Secretary may waive the requirement of matching contributions.

''(f) GEOGRAPHIC DISTRIBUTION.—The Secretary shall ensure that such grants awarded under subsection (a) are equitably distributed among the geographical regions of the United States and between urban and rural populations.

''(g) TRAINING AND TECHNICAL ASSISTANCE.—Training and technical assistance may be provided by the Secretary to assist a State, political subdivision of a State, Indian tribe, or tribal organization receiving a grant under subsection (a) in establishing and operating a diversion program.

''(h) EVALUATIONS.—The programs described in subsection (a) shall be evaluated not less than 1 time in every 12-month period using the methodology and outcome measures identified in the grant application.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $10,000,000 for fiscal year 2001, and such sums as may be necessary for fiscal years 2002 through 2003.''.

SEC. 3211. IMPROVING OUTCOMES FOR CHILDREN AND ADOLESCENTS THROUGH SERVICES INTEGRATION BETWEEN CHILD WELFARE AND MENTAL HEALTH SERVICES.

Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–31 et seq.), as amended by section 3210, is further amended by adding at the end the following:

''SEC. 520H. IMPROVING OUTCOMES FOR CHILDREN AND ADOLESCENTS THROUGH SERVICES INTEGRATION BETWEEN CHILD WELFARE AND MENTAL HEALTH SERVICES.

''(a) IN GENERAL.—The Secretary shall award grants, contracts or cooperative agreements to States, political subdivisions of States, Indian tribes, and tribal organizations to provide integrated child welfare and mental health services for children and adolescents under 19 years of age in the child welfare system or at risk for becoming part of the system, and parents or caregivers with a mental illness or a mental illness and a co-occurring substance abuse disorder.

''(b) DURATION.—With respect to a grant, contract or cooperative agreement awarded under this section, the period during which payments under such award are made to the recipient may not exceed 5 years.

''(c) APPLICATION.—

''(1) IN GENERAL.—To be eligible to receive an award under subsection (a), a State, political subdivision of a State, Indian tribe, or tribal organization shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

''(2) CONTENT.—An application submitted under paragraph (1) shall—

''(A) describe the program to be funded under the grant, contract or cooperative agreement;

''(B) explain how such program reflects best practices in the provision of child welfare and mental health services; and

''(C) provide assurances that—

''(i) persons providing services under the grant, contract or cooperative agreement are adequately trained to provide such services; and

''(ii) the services will be provided in accordance with subsection (d).

''(d) USE OF FUNDS.—A State, political subdivision of a State, Indian tribe, or tribal organization that receives a grant, contract, or cooperative agreement under subsection (a) shall use amounts made available through such grant, contract or cooperative agreement to—

''(1) provide family-centered, comprehensive, and coordinated child welfare and mental health services, including prevention, early intervention and treatment services for children and adolescents, and for their parents or caregivers;

''(2) ensure a single point of access for such coordinated services;

''(3) provide integrated mental health and substance abuse treatment for children, adolescents, and parents or caregivers with a mental illness and a co-occurring substance abuse disorder;

''(4) provide training for the child welfare, mental health and substance abuse professionals who will participate in the program carried out under this section;

''(5) provide technical assistance to child welfare and mental health agencies;

''(6) develop cooperative efforts with other service entities in the community, including education, social services, juvenile justice, and primary health care agencies;

''(7) coordinate services with services provided under the medicaid program and the State Children's Health Insurance Program under titles XIX and XXI of the Social Security Act;

''(8) provide linguistically appropriate and culturally competent services; and

''(9) evaluate the effectiveness and cost-efficiency of the integrated services that measure the level of coordination, outcome measures for parents or caregivers with a mental illness or a mental illness and a co-occurring substance abuse disorder, and outcome measures for children.

''(e) DISTRIBUTION OF AWARDS.—The Secretary shall ensure that grants, contracts, and cooperative agreements awarded under subsection (a) are equitably distributed among the geographical regions of the United States and between urban and rural populations.

''(f) EVALUATION.—The Secretary shall evaluate each program carried out by a State, political subdivision of a State, Indian tribe, or tribal organization under subsection (a) and shall disseminate the findings with respect to each such evaluation to appropriate public and private entities.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $10,000,000 for fiscal year 2001, and such sums as may be necessary for each of fiscal years 2002 and 2003.''.

SEC. 3212. GRANTS FOR THE INTEGRATED TREATMENT OF SERIOUS MENTAL ILLNESS AND CO-OCCURRING SUBSTANCE ABUSE.

Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–31 et seq.), as amended by section 3211, is further amended by adding at the end the following:

''SEC. 520I. GRANTS FOR THE INTEGRATED TREATMENT OF SERIOUS MENTAL ILLNESS AND CO-OCCURRING SUBSTANCE ABUSE.

''(a) IN GENERAL.—The Secretary shall award grants, contracts, or cooperative agreements to States, political subdivisions of States, Indian tribes, tribal organizations, and private nonprofit organizations for the development or expansion of programs to provide integrated treatment services for individuals with a serious mental illness and a co-occurring substance abuse disorder.

''(b) PRIORITY.—In awarding grants, contracts, and cooperative agreements under subsection (a), the Secretary shall give priority to applicants that emphasize the provision of services for individuals with a serious mental illness and a co-occurring substance abuse disorder who—

''(1) have a history of interactions with law enforcement or the criminal justice system;

''(2) have recently been released from incarceration;

''(3) have a history of unsuccessful treatment in either an inpatient or outpatient setting;

''(4) have never followed through with outpatient services despite repeated referrals; or

''(5) are homeless.

''(c) USE OF FUNDS.—A State, political subdivision of a State, Indian tribe, tribal organization, or private nonprofit organization that receives a grant, contract, or cooperative agreement under subsection (a) shall use funds received under such grant—

''(1) to provide fully integrated services rather than serial or parallel services;

''(2) to employ staff that are cross-trained in the diagnosis and treatment of both serious mental illness and substance abuse;

''(3) to provide integrated mental health and substance abuse services at the same location;

''(4) to provide services that are linguistically appropriate and culturally competent;

''(5) to provide at least 10 programs for integrated treatment of both mental illness and substance abuse at sites that previously provided only mental health services or only substance abuse services; and

''(6) to provide services in coordination with other existing public and private community programs.

''(d) CONDITION.—The Secretary shall ensure that a State, political subdivision of a State, Indian tribe, tribal organization, or private nonprofit organization that receives a grant, contract, or cooperative agreement under subsection (a) maintains the level of effort necessary to sustain existing mental health and substance abuse programs for other populations served by mental health systems in the community.

''(e) DISTRIBUTION OF AWARDS.—The Secretary shall ensure that grants, contracts, or cooperative agreements awarded under subsection (a) are equitably distributed among the geographical regions of the United States and between urban and rural populations.

''(f) DURATION.—The Secretary shall award grants, contract, or cooperative agreements under this subsection for a period of not more than 5 years.

''(g) APPLICATION.—A State, political subdivision of a State, Indian tribe, tribal organization, or private nonprofit organization that desires a grant, contract, or cooperative agreement under this subsection shall prepare and submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require. Such application shall include a plan for the rigorous evaluation of activities funded with an award under such subsection, including a process and outcomes evaluation.

''(h) EVALUATION.—A State, political subdivision of a State, Indian tribe, tribal organization, or private nonprofit organization that receives a grant, contract, or cooperative agreement under this subsection shall prepare and submit a plan

for the rigorous evaluation of the program funded under such grant, contract, or agreement, including both process and outcomes evaluation, and the submission of an evaluation at the end of the project period.

''(i) AUTHORIZATION OF APPROPRIATION.—There is authorized to be appropriated to carry out this subsection $40,000,000 for fiscal year 2001, and such sums as may be necessary for fiscal years 2002 through 2003.''.

SEC. 3213. TRAINING GRANTS.

Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb–31 et seq.), as amended by section 3212, is further amended by adding at the end the following:

''SEC. 520J. TRAINING GRANTS.

''(a) IN GENERAL.—The Secretary shall award grants in accordance with the provisions of this section.

''(b) MENTAL ILLNESS AWARENESS TRAINING GRANTS.—

''(1) IN GENERAL.—The Secretary shall award grants to States, political subdivisions of States, Indian tribes, tribal organizations, and nonprofit private entities to train teachers and other relevant school personnel to recognize symptoms of childhood and adolescent mental disorders, to refer family members to the appropriate mental health services if necessary, to train emergency services personnel to identify and appropriately respond to persons with a mental illness, and to provide education to such teachers and personnel regarding resources that are available in the community for individuals with a mental illness.

''(2) EMERGENCY SERVICES PERSONNEL.—In this subsection, the term 'emergency services personnel' includes paramedics, firefighters, and emergency medical technicians.

''(3) DISTRIBUTION OF AWARDS.—The Secretary shall ensure that such grants awarded under this subsection are equitably distributed among the geographical regions of the United States and between urban and rural populations.

''(4) APPLICATION.—A State, political subdivision of a State, Indian tribe, tribal organization, or nonprofit private entity that desires a grant under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a plan for the rigorous evaluation of activities that are carried out with funds received under a grant under this subsection.

''(5) USE OF FUNDS.—A State, political subdivision of a State, Indian tribe, tribal organization, or nonprofit private entity receiving a grant under this subsection shall use funds from such grant to—

''(A) train teachers and other relevant school personnel to recognize symptoms of childhood and adolescent mental disorders and appropriately respond;

''(B) train emergency services personnel to identify and appropriately respond to persons with a mental illness; and

''(C) provide education to such teachers and personnel regarding resources that are available in the community for individuals with a mental illness.

''(6) EVALUATION.—A State, political subdivision of a State, Indian tribe, tribal organization, or nonprofit private entity that receives a grant under this subsection shall prepare and submit an evaluation to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require, including an evaluation of activities carried out with funds received under the grant under this subsection and a process and outcome evaluation.

''(7) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection, $25,000,000 for fiscal year 2001 and such sums as may be necessary for each of fiscal years 2002 through 2003.''.

TITLE XXXIII—PROVISIONS RELATING TO SUBSTANCE ABUSE

SEC. 3301. PRIORITY SUBSTANCE ABUSE TREATMENT NEEDS OF REGIONAL AND NATIONAL SIGNIFICANCE.

(a) RESIDENTIAL TREATMENT PROGRAMS FOR PREGNANT AND POSTPARTUM WOMEN.—Section 508(r) of the Public Health Service Act (42 U.S.C. 290bb–1(r)) is amended to read as follows:

''(r) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary to fiscal years 2001 through 2003.''.

(b) PRIORITY SUBSTANCE ABUSE TREATMENT.—Section 509 of the Public Health Service Act (42 U.S.C. 290bb–1) is amended to read as follows:

''SEC. 509. PRIORITY SUBSTANCE ABUSE TREATMENT NEEDS OF REGIONAL AND NATIONAL SIGNIFICANCE.

''(a) PROJECTS.—The Secretary shall address priority substance abuse treatment needs of regional and national significance (as determined under subsection (b)) through the provision of or through assistance for—

''(1) knowledge development and application projects for treatment and rehabilitation and the conduct or support of evaluations of such projects;

''(2) training and technical assistance; and

''(3) targeted capacity response programs.

The Secretary may carry out the activities described in this section directly or through grants or cooperative agreements with States, political subdivisions of States, Indian tribes and tribal organizations, other public or nonprofit private entities.

''(b) PRIORITY SUBSTANCE ABUSE TREATMENT NEEDS.—

''(1) IN GENERAL.—Priority substance abuse treatment needs of regional and national significance shall be determined by the Secretary after consultation with States and other interested groups. The Secretary shall meet with the States and interested groups on an annual basis to discuss program priorities.

''(2) SPECIAL CONSIDERATION.—In developing program priorities under paragraph (1), the Secretary shall give special consideration to promoting the integration of substance abuse treatment services into primary health care systems.

''(c) REQUIREMENTS.—

''(1) IN GENERAL.—Recipients of grants, contracts, or cooperative agreements under this section shall comply with information and application requirements determined appropriate by the Secretary.

''(2) DURATION OF AWARD.—With respect to a grant, contract, or cooperative agreement awarded under this section, the period during which payments under such award are made to the recipient may not exceed 5 years.

''(3) MATCHING FUNDS.—The Secretary may, for projects carried out under subsection (a), require that entities that apply for grants, contracts, or cooperative agreements under that project provide non-Federal matching funds, as determined appropriate by the Secretary, to ensure the institutional commitment of the entity to the projects funded under the grant, contract, or cooperative agreement. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in cash or in kind, fairly evaluated, including plant, equipment, or services.

''(4) MAINTENANCE OF EFFORT.—With respect to activities for which a grant, contract, or cooperative agreement is awarded under this section, the Secretary may require that recipients for specific projects under subsection (a) agree to maintain expenditures of non-Federal amounts for such activities at a level that is not less than the level of such expenditures maintained by the entity for the fiscal year preceding the fiscal year for which the entity receives such a grant, contract, or cooperative agreement.

''(d) EVALUATION.—The Secretary shall evaluate each project carried out under subsection (a)(1) and shall disseminate the findings with respect to each such evaluation to appropriate public and private entities.

''(e) INFORMATION AND EDUCATION.—The Secretary shall establish comprehensive information and education programs to disseminate and apply the findings of the knowledge development and application, training and technical assistance programs, and targeted capacity response programs under this section to the general public, to health professionals and other interested groups. The Secretary shall make every effort to provide linkages between the findings of supported projects and State agencies responsible for carrying out substance abuse prevention and treatment programs.

''(f) AUTHORIZATION OF APPROPRIATION.—There are authorized to be appropriated to carry out this section, $300,000,000 for fiscal year 2001 and such sums as may be necessary for each of the fiscal years 2002 and 2003.''.

(c) CONFORMING AMENDMENTS.—The following sections of the Public Health Service Act are repealed:

(1) Section 510 (42 U.S.C. 290bb–3).
(2) Section 511 (42 U.S.C. 290bb–4).
(3) Section 512 (42 U.S.C. 290bb–5).
(4) Section 571 (42 U.S.C. 290gg).

SEC. 3302. PRIORITY SUBSTANCE ABUSE PREVENTION NEEDS OF REGIONAL AND NATIONAL SIGNIFICANCE.

(a) IN GENERAL.—Section 516 of the Public Health Service Act (42 U.S.C. 290bb–1) is amended to read as follows:

''SEC. 516. PRIORITY SUBSTANCE ABUSE PREVENTION NEEDS OF REGIONAL AND NATIONAL SIGNIFICANCE.

''(a) PROJECTS.—The Secretary shall address priority substance abuse prevention needs of regional and national significance (as determined under subsection (b)) through the provision of or through assistance for—

''(1) knowledge development and application projects for prevention and the conduct or support of evaluations of such projects;

''(2) training and technical assistance; and

''(3) targeted capacity response programs.

The Secretary may carry out the activities described in this section directly or through grants or cooperative agreements with States, political subdivisions of States, Indian tribes and tribal organizations, or other public or nonprofit private entities.

''(b) PRIORITY SUBSTANCE ABUSE PREVENTION NEEDS.—

''(1) IN GENERAL.—Priority substance abuse prevention needs of regional and national significance shall be determined by the Secretary in consultation with the States and other interested groups. The Secretary shall meet with the States and interested groups on an annual basis to discuss program priorities.

''(2) SPECIAL CONSIDERATION.—In developing program priorities under paragraph (1), the Secretary shall give special consideration to—

''(A) applying the most promising strategies and research-based primary prevention approaches; and

''(B) promoting the integration of substance abuse prevention information and activities into primary health care systems.

''(c) REQUIREMENTS.—

''(1) IN GENERAL.—Recipients of grants, contracts, and cooperative agreements under this section shall comply with information and application requirements determined appropriate by the Secretary.

''(2) DURATION OF AWARD.—With respect to a grant, contract, or cooperative agreement awarded under this section, the period during which payments under such award are made to the recipient may not exceed 5 years.

''(3) MATCHING FUNDS.—The Secretary may, for projects carried out under subsection (a), require that entities that apply for grants, contracts, or cooperative agreements under that project provide non-Federal matching funds, as determined appropriate by the Secretary, to ensure the institutional commitment of the entity

to the projects funded under the grant, contract, or cooperative agreement. Such non-Federal matching funds may be provided directly or through donations from public or private entities and may be in cash or in kind, fairly evaluated, including plant, equipment, or services.

''(4) MAINTENANCE OF EFFORT.—With respect to activities for which a grant, contract, or cooperative agreement is awarded under this section, the Secretary may require that recipients for specific projects under subsection (a) agree to maintain expenditures of non-Federal amounts for such activities at a level that is not less than the level of such expenditures maintained by the entity for the fiscal year preceding the fiscal year for which the entity receives such a grant, contract, or cooperative agreement.

''(d) EVALUATION.—The Secretary shall evaluate each project carried out under subsection (a)(1) and shall disseminate the findings with respect to each such evaluation to appropriate public and private entities.

''(e) INFORMATION AND EDUCATION.—The Secretary shall establish comprehensive information and education programs to disseminate the findings of the knowledge development and application, training and technical assistance programs, and targeted capacity response programs under this section to the general public and to health professionals. The Secretary shall make every effort to provide linkages between the findings of supported projects and State agencies responsible for carrying out substance abuse prevention and treatment programs.

''(f) AUTHORIZATION OF APPROPRIATION.—There are authorized to be appropriated to carry out this section, $300,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 and 2003.''.

(b) CONFORMING AMENDMENTS.—Section 518 of the Public Health Service Act (42 U.S.C. 290bb–24) is repealed.

SEC. 3303. SUBSTANCE ABUSE PREVENTION AND TREATMENT PERFORMANCE PARTNERSHIP BLOCK GRANT.

(a) ALLOCATION REGARDING ALCOHOL AND OTHER DRUGS.—Section 1922 of the Public Health Service Act (42 U.S.C. 300x–22) is amended by—

(1) striking subsection (a); and

(2) redesignating subsections (b) and (c) as subsections (a) and (b).

(b) GROUP HOMES FOR RECOVERING SUBSTANCE ABUSERS.—Section 1925(a) of the Public Health Service Act (42 U.S.C. 300x–25(a)) is amended by striking ''For fiscal year 1993'' and all that follows through the colon and inserting the following: ''A State, using funds available under section 1921, may establish and maintain the ongoing operation of a revolving fund in accordance with this section to support group homes for recovering substance abusers as follows:''.

(c) MAINTENANCE OF EFFORT.—Section 1930 of the Public Health Service Act (42 U.S.C. 300x–30) is amended—

(1) by redesignating subsections (b) and (c) as subsections (c) and (d) respectively; and

(2) by inserting after subsection (a), the following:

''(b) EXCLUSION OF CERTAIN FUNDS.—The Secretary may exclude from the aggregate State expenditures under subsection (a), funds appropriated to the principle agency for authorized activities which are of a non-recurring nature and for a specific purpose.''.

(d) APPLICATIONS FOR GRANTS.—Section 1932(a)(1) of the Public Health Service Act (42 U.S.C. 300x–32(a)(1)) is amended to read as follows:

''(1) the application is received by the Secretary not later than October 1 of the fiscal year for which the State is seeking funds;''.

(e) WAIVER FOR TERRITORIES.—Section 1932(c) of the Public Health Service Act (42 U.S.C. 300x–32(c)) is amended by striking ''whose allotment under section 1921 for the fiscal year is the amount specified in section 1933(c)(2)(B)'' and inserting ''except Puerto Rico''.

(f) WAIVER AUTHORITY FOR CERTAIN REQUIREMENTS.—

(1) IN GENERAL.—Section 1932 of the Public Health Service Act (42 U.S.C. 300x–32) is amended by adding at the end the following:

''(e) WAIVER AUTHORITY FOR CERTAIN REQUIREMENTS.—

''(1) IN GENERAL.—Upon the request of a State, the Secretary may waive the requirements of all or part of the sections described in paragraph (2) using objective criteria established by the Secretary by regulation after consultation with the States and other interested parties including consumers and providers.

''(2) SECTIONS.—The sections described in paragraph (1) are sections 1922(c), 1923, 1924 and 1928.

''(3) DATE CERTAIN FOR ACTING UPON REQUEST.—The Secretary shall approve or deny a request for a waiver under paragraph (1) and inform the State of that decision not later than 120 days after the date on which the request and all the information needed to support the request are submitted.

''(4) ANNUAL REPORTING REQUIREMENT.—The Secretary shall annually report to the general public on the States that receive a waiver under this subsection.''.

(2) CONFORMING AMENDMENTS.—Effective upon the publication of the regulations developed in accordance with section 1932(e)(1) of the Public Health Service Act (42 U.S.C. 300x–32(d))—

(A) section 1922(c) of the Public Health Service Act (42 U.S.C. 300x–22(c)) is amended by—

(i) striking paragraph (2); and

(ii) redesignating paragraph (3) as paragraph (2); and

(B) section 1928(d) of the Public Health Service Act (42 U.S.C. 300x–28(d)) is repealed.

(g) AUTHORIZATION OF APPROPRIATION.—Section 1935 of the Public Health Service Act (42 U.S.C. 300x–35) is amended—

(1) in subsection (a), by striking ''$1,500,000,000'' and all that follows through the end and inserting ''$2,000,000,000 for fiscal year 2001, and such sums as may be necessary for each of the fiscal years 2002 and 2003.'';

(2) in subsection (b)(1), by striking ''section 505'' and inserting ''sections 505 and 1971'';

(3) in subsection (b)(2), by striking ''1949(a)'' and inserting ''1948(a)''; and

(4) in subsection (b), by adding at the end the following:

''(3) CORE DATA SET.—A State that receives a new grant, contract, or cooperative agreement from amounts available to the Secretary under paragraph (1), for the purposes of improving the data collection, analysis and reporting capabilities of the State, shall be required, as a condition of receipt of funds, to collect, analyze, and report to the Secretary for each fiscal year subsequent to receiving such funds a core data set to be determined by the Secretary in conjunction with the States.''.

SEC. 3304. DETERMINATION OF ALLOTMENTS.

Section 1933(b) of the Public Health Service Act (42 U.S.C. 300x–33(b)) is amended to read as follows:

''(b) MINIMUM ALLOTMENTS FOR STATES.—

''(1) IN GENERAL.—With respect to fiscal year 2000, and each subsequent fiscal year, the amount of the allotment of a State under section 1921 shall not be less than the amount the State received under such section for the previous fiscal year increased by an amount equal to 30.65 percent of the percentage by which the aggregate amount allotted to all States for such fiscal year exceeds the aggregate amount allotted to all States for the previous fiscal year.

''(2) LIMITATIONS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), a State shall not receive an allotment under section 1921 for a fiscal year in an amount that is less than an amount equal to 0.375 percent of the amount appropriated under section 1935(a) for such fiscal year.

''(B) EXCEPTION.—In applying subparagraph (A), the Secretary shall ensure that no State receives an increase in its allotment under section 1921 for a fiscal year (as compared to the amount allotted to the State in the prior fiscal year) that is in excess of an amount equal to 300 percent of the percentage by which the amount appropriated under section 1935(a) for such fiscal year exceeds the amount appropriated for the prior fiscal year.

''(3) DECREASE IN OR EQUAL APPROPRIATIONS.—If the amount appropriated under section 1935(a) for a fiscal year is equal to or less than the amount appropriated under such section for the prior fiscal year, the amount of the State allotment under section 1921 shall be equal to the amount that the State received under section 1921 in the prior fiscal year decreased by the percentage by which the amount appropriated for such fiscal year is less than the amount appropriated or such section for the prior fiscal year.''.

SEC. 3305. NONDISCRIMINATION AND INSTITUTIONAL SAFEGUARDS FOR RELIGIOUS PROVIDERS.

Subpart III of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x–51 et seq.) is amended by adding at the end the following:

''SEC. 1955. SERVICES PROVIDED BY NONGOVERNMENTAL ORGANIZATIONS.

''(a) PURPOSES.—The purposes of this section are—

''(1) to prohibit discrimination against nongovernmental organizations and certain individuals on the basis of religion in the distribution of government funds to provide substance abuse services under this title and title V, and the receipt of services under such titles; and

''(2) to allow the organizations to accept the funds to provide the services to the individuals without impairing the religious character of the organizations or the religious freedom of the individuals.

''(b) RELIGIOUS ORGANIZATIONS INCLUDED AS NONGOVERNMENTAL PROVIDERS.—

''(1) IN GENERAL.—A State may administer and provide substance abuse services under any program under this title or title V through grants, contracts, or cooperative agreements to provide assistance to beneficiaries under such titles with nongovernmental organizations.

''(2) REQUIREMENT.—A State that elects to utilize nongovernmental organizations as provided for under paragraph (1) shall consider, on the same basis as other nongovernmental organizations, religious organizations to provide services under substance abuse programs under this title or title V, so long as the programs under such titles are implemented in a manner consistent with the Establishment Clause of the first amendment to the Constitution. Neither the Federal Government nor a State or local government receiving funds under such programs shall discriminate against an organization that provides services under, or applies to provide services under, such programs, on the basis that the organization has a religious character.

''(c) RELIGIOUS CHARACTER AND INDEPENDENCE.—

''(1) IN GENERAL.—A religious organization that provides services under any substance abuse program under this title or title V shall retain its independence from Federal, State, and local governments, including such organization's control over the definition, development, practice, and expression of its religious beliefs.

''(2) ADDITIONAL SAFEGUARDS.—Neither the Federal Government nor a State or local government shall require a religious organization—

''(A) to alter its form of internal governance; or

''(B) to remove religious art, icons, scripture, or other symbols;

in order to be eligible to provide services under any substance abuse program under this title or title V.

''(d) EMPLOYMENT PRACTICES.—

''(1) SUBSTANCE ABUSE.—A religious organization that provides services under any substance

abuse program under this title or title V may require that its employees providing services under such program adhere to rules forbidding the use of drugs or alcohol.

''(2) TITLE VII EXEMPTION.—The exemption of a religious organization provided under section 702 or 703(e)(2) of the Civil Rights Act of 1964 (42 U.S.C. 2000e–1, 2000e–2(e)(2)) regarding employment practices shall not be affected by the religious organization's provision of services under, or receipt of funds from, any substance abuse program under this title or title V.

''(e) RIGHTS OF BENEFICIARIES OF ASSISTANCE.—

''(1) IN GENERAL.—If an individual described in paragraph (3) has an objection to the religious character of the organization from which the individual receives, or would receive, services funded under any substance abuse program under this title or title V, the appropriate Federal, State, or local governmental entity shall provide to such individual (if otherwise eligible for such services) within a reasonable period of time after the date of such objection, services that—

''(A) are from an alternative provider that is accessible to the individual; and

''(B) have a value that is not less than the value of the services that the individual would have received from such organization.

''(2) NOTICE.—The appropriate Federal, State, or local governmental entity shall ensure that notice is provided to individuals described in paragraph (3) of the rights of such individuals under this section.

''(3) INDIVIDUAL DESCRIBED.—An individual described in this paragraph is an individual who receives or applies for services under any substance abuse program under this title or title V.

''(f) NONDISCRIMINATION AGAINST BENEFICIARIES.—A religious organization providing services through a grant, contract, or cooperative agreement under any substance abuse program under this title or title V shall not discriminate, in carrying out such program, against an individual described in subsection (e)(3) on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice.

''(g) FISCAL ACCOUNTABILITY.—

''(1) IN GENERAL.—Except as provided in paragraph (2), any religious organization providing services under any substance abuse program under this title or title V shall be subject to the same regulations as other nongovernmental organizations to account in accord with generally accepted accounting principles for the use of such funds provided under such program.

''(2) LIMITED AUDIT.—Such organization shall segregate government funds provided under such substance abuse program into a separate account. Only the government funds shall be subject to audit by the government.

''(h) COMPLIANCE.—Any party that seeks to enforce such party's rights under this section may assert a civil action for injunctive relief exclusively in an appropriate Federal or State court against the entity, agency or official that allegedly commits such violation.

''(i) LIMITATIONS ON USE OF FUNDS FOR CERTAIN PURPOSES.—No funds provided through a grant or contract to a religious organization to provide services under any substance abuse program under this title or title V shall be expended for sectarian worship, instruction, or proselytization.

''(j) EFFECT ON STATE AND LOCAL FUNDS.—If a State or local government contributes State or local funds to carry out any substance abuse program under this title or title V, the State or local government may segregate the State or local funds from the Federal funds provided to carry out the program or may commingle the State or local funds with the Federal funds. If the State or local government commingles the State or local funds, the provisions of this section shall apply to the commingled funds in the same manner, and to the same extent, as the provisions apply to the Federal funds.

''(k) TREATMENT OF INTERMEDIATE CONTRACTORS.—If a nongovernmental organization (referred to in this subsection as an 'intermediate organization'), acting under a contract or other agreement with the Federal Government or a State or local government, is given the authority under the contract or agreement to select nongovernmental organizations to provide services under any substance abuse program under this title or title V, the intermediate organization shall have the same duties under this section as the government but shall retain all other rights of a nongovernmental organization under this section.''.

SEC. 3306. ALCOHOL AND DRUG PREVENTION OR TREATMENT SERVICES FOR INDIANS AND NATIVE ALASKANS.

Part A of title V of the Public Health Service Act (42 U.S.C. 290aa et seq.) is amended by adding at the end the following:

''SEC. 506A. ALCOHOL AND DRUG PREVENTION OR TREATMENT SERVICES FOR INDIANS AND NATIVE ALASKANS.

''(a) IN GENERAL.—The Secretary shall award grants, contracts, or cooperative agreements to public and private nonprofit entities, including Native Alaskan entities and Indian tribes and tribal organizations, for the purpose of providing alcohol and drug prevention or treatment services for Indians and Native Alaskans.

''(b) PRIORITY.—In awarding grants, contracts, or cooperative agreements under subsection (a), the Secretary shall give priority to applicants that—

''(1) propose to provide alcohol and drug prevention or treatment services on reservations;

''(2) propose to employ culturally-appropriate approaches, as determined by the Secretary, in providing such services; and

''(3) have provided prevention or treatment services to Native Alaskan entities and Indian tribes and tribal organizations for at least 1 year prior to applying for a grant under this section.

''(c) DURATION.—The Secretary shall award grants, contracts, or cooperative agreements under subsection (a) for a period not to exceed 5 years.

''(d) APPLICATION.—An entity desiring a grant, contract, or cooperative agreement under subsection (a) shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may reasonably require.

''(e) EVALUATION.—An entity that receives a grant, contract, or cooperative agreement under subsection (a) shall submit, in the application for such grant, a plan for the evaluation of any project undertaken with funds provided under this section. Such entity shall provide the Secretary with periodic evaluations of the progress of such project and such evaluation at the completion of such project as the Secretary determines to be appropriate. The final evaluation submitted by such entity shall include a recommendation as to whether such project shall continue.

''(f) REPORT.—Not later than 3 years after the date of enactment of this section and annually thereafter, the Secretary shall prepare and submit, to the Committee on Health, Education, Labor, and Pensions of the Senate, a report describing the services provided pursuant to this section.

''(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $15,000,000 for fiscal year 2001, and such sums as may be necessary for fiscal years 2002 and 2003.

SEC. 3307. ESTABLISHMENT OF COMMISSION.

(a) IN GENERAL.—There is established a commission to be known as the Commission on Indian and Native Alaskan Health Care that shall examine the health concerns of Indians and Native Alaskans who reside on reservations and tribal lands (hereafter in this section referred to as the 'Commission').

(b) MEMBERSHIP.—

(1) IN GENERAL.—The Commission established under subsection (a) shall consist of—

(A) the Secretary;

(B) 15 members who are experts in the health care field and issues that the Commission is established to examine; and

(C) the Director of the Indian Health Service and the Commissioner of Indian Affairs, who shall be nonvoting members.

(2) APPOINTING AUTHORITY.—Of the 15 members of the Commission described in paragraph (1)(B)—

(A) 2 shall be appointed by the Speaker of the House of Representatives;

(B) 2 shall be appointed by the Minority Leader of the House of Representatives;

(C) 2 shall be appointed by the Majority Leader of the Senate;

(D) 2 shall be appointed by the Minority Leader of the Senate; and

(E) 7 shall be appointed by the Secretary.

(3) LIMITATION.—Not fewer than 10 of the members appointed to the Commission shall be Indians or Native Alaskans.

(4) CHAIRPERSON.—The Secretary shall serve as the Chairperson of the Commission.

(5) EXPERTS.—The Commission may seek the expertise of any expert in the health care field to carry out its duties.

(c) PERIOD OF APPOINTMENT.—Members shall be appointed for the life of the Commission. Any vacancy in the Commission shall not affect its powers, but shall be filed in the same manner as the original appointment.

(d) DUTIES OF THE COMMISSION.—The Commission shall—

(1) study the health concerns of Indians and Native Alaskans; and

(2) prepare the reports described in subsection (i).

(e) POWERS OF THE COMMISSION.—

(1) HEARINGS.—The Commission may hold such hearings, including hearings on reservations, sit and act at such times and places, take such testimony, and receive such information as the Commission considers advisable to carry out the purpose for which the Commission was established.

(2) INFORMATION FROM FEDERAL AGENCIES.—The Commission may secure directly from any Federal department or agency such information as the Commission considers necessary to carry out the purpose for which the Commission was established. Upon request of the Chairperson of the Commission, the head of such department or agency shall furnish such information to the Commission.

(f) COMPENSATION OF MEMBERS.—

(1) IN GENERAL.—Except as provided in subparagraph (B), each member of the Commission may be compensated at a rate not to exceed the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time), during which that member is engaged in the actual performance of the duties of the Commission.

(2) LIMITATION.—Members of the Commission who are officers or employees of the United States shall receive no additional pay on account of their service on the Commission.

(g) TRAVEL EXPENSES OF MEMBERS.—The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under section 5703 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(h) COMMISSION PERSONNEL MATTERS.—

(1) IN GENERAL.—The Secretary, in accordance with rules established by the Commission, may select and appoint a staff director and other personnel necessary to enable the Commission to carry out its duties.

(2) COMPENSATION OF PERSONNEL.—The Secretary, in accordance with rules established by

the Commission, may set the amount of compensation to be paid to the staff director and any other personnel that serve the Commission.

(3) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Commission without reimbursement, and the detail shall be without interruption or loss of civil service status or privilege.

(4) CONSULTANT SERVICES.—The Chairperson of the Commission is authorized to procure the temporary and intermittent services of experts and consultants in accordance with section 3109 of title 5, United States Code, at rates not to exceed the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of such title.

(i) REPORT.—

(1) IN GENERAL.—Not later than 3 years after the date of enactment of the Youth Drug and Mental Health Services Act, the Secretary shall prepare and submit, to the Committee on Health, Education, Labor, and Pensions of the Senate, a report that shall—

(A) detail the health problems faced by Indians and Native Alaskans who reside on reservations;

(B) examine and explain the causes of such problems;

(C) describe the health care services available to Indians and Native Alaskans who reside on reservations and the adequacy of such services;

(D) identify the reasons for the provision of inadequate health care services for Indians and Native Alaskans who reside on reservations, including the availability of resources;

(E) develop measures for tracking the health status of Indians and Native Americans who reside on reservations; and

(F) make recommendations for improvements in the health care services provided for Indians and Native Alaskans who reside on reservations, including recommendations for legislative change.

(2) EXCEPTION.—In addition to the report required under paragraph (1), not later than 2 years after the date of enactment of the Youth Drug and Mental Health Services Act, the Secretary shall prepare and submit, to the Committee on Health, Education, Labor, and Pensions of the Senate, a report that describes any alcohol and drug abuse among Indians and Native Alaskans who reside on reservations.

(j) PERMANENT COMMISSION.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Commission.

(k) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $5,000,000 for fiscal year 2001, and such sums as may be necessary for fiscal years 2002 and 2003.

TITLE XXXIV—PROVISIONS RELATING TO FLEXIBILITY AND ACCOUNTABILITY

SEC. 3401. GENERAL AUTHORITIES AND PEER REVIEW.

(a) GENERAL AUTHORITIES.—Paragraph (1) of section 501(e) of the Public Health Service Act (42 U.S.C. 290aa(e)) is amended to read as follows:

''(1) IN GENERAL.—There may be in the Administration an Associate Administrator for Alcohol Prevention and Treatment Policy to whom the Administrator may delegate the functions of promoting, monitoring, and evaluating service programs for the prevention and treatment of alcoholism and alcohol abuse within the Center for Substance Abuse Prevention, the Center for Substance Abuse Treatment and the Center for Mental Health Services, and coordinating such programs among the Centers, and among the Centers and other public and private entities. The Associate Administrator also may ensure that alcohol prevention, education, and policy strategies are integrated into all programs of the Centers that address substance abuse prevention, education, and policy, and that the Center for Substance Abuse Prevention addresses the Healthy People 2010 goals and the National Dietary Guidelines of the Department of Health and Human Services and the Department of Agriculture related to alcohol consumption.''.

(b) PEER REVIEW.—Section 504 of the Public Health Service (42 U.S.C. 290aa–3) is amended as follows:

''SEC. 504. PEER REVIEW.

''(a) IN GENERAL.—The Secretary, after consultation with the Administrator, shall require appropriate peer review of grants, cooperative agreements, and contracts to be administered through the agency which exceed the simple acquisition threshold as defined in section 4(11) of the Office of Federal Procurement Policy Act.

''(b) MEMBERS.—The members of any peer review group established under subsection (a) shall be individuals who by virtue of their training or experience are eminently qualified to perform the review functions of the group. Not more than ¼ of the members of any such peer review group shall be officers or employees of the United States.

''(c) ADVISORY COUNCIL REVIEW.—If the direct cost of a grant or cooperative agreement (described in subsection (a)) exceeds the simple acquisition threshold as defined by section 4(11) of the Office of Federal Procurement Policy Act, the Secretary may make such a grant or cooperative agreement only if such grant or cooperative agreement is recommended—

''(1) after peer review required under subsection (a); and

''(2) by the appropriate advisory council.

''(d) CONDITIONS.—The Secretary may establish limited exceptions to the limitations contained in this section regarding participation of Federal employees and advisory council approval. The circumstances under which the Secretary may make such an exception shall be made public.''.

SEC. 3402. ADVISORY COUNCILS.

Section 502(e) of the Public Health Service Act (42 U.S.C. 290aa–1(e)) is amended in the first sentence by striking ''3 times'' and inserting ''2 times''.

SEC. 3403. GENERAL PROVISIONS FOR THE PERFORMANCE PARTNERSHIP BLOCK GRANTS.

(a) PLANS FOR PERFORMANCE PARTNERSHIPS.—Section 1949 of the Public Health Service Act (42 U.S.C. 300x–59) is amended as follows:

''SEC. 1949. PLANS FOR PERFORMANCE PARTNERSHIPS.

''(a) DEVELOPMENT.—The Secretary in conjunction with States and other interested groups shall develop separate plans for the programs authorized under subparts I and II for creating more flexibility for States and accountability based on outcome and other performance measures. The plans shall each include—

''(1) a description of the flexibility that would be given to the States under the plan;

''(2) the common set of performance measures that would be used for accountability, including measures that would be used for the program under subpart II for pregnant addicts, HIV transmission, tuberculosis, and those with a co-occurring substance abuse and mental disorders, and for programs under subpart I for children with serious emotional disturbance and adults with serious mental illness and for individuals with co-occurring mental health and substance abuse disorders;

''(3) the definitions for the data elements to be used under the plan;

''(4) the obstacles to implementation of the plan and the manner in which such obstacles would be resolved;

''(5) the resources needed to implement the performance partnerships under the plan; and

''(6) an implementation strategy complete with recommendations for any necessary legislation.

''(b) SUBMISSION.—Not later than 2 years after the date of enactment of this Act, the plans developed under subsection (a) shall be submitted to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Commerce of the House of Representatives.

''(c) INFORMATION.—As the elements of the plans described in subsection (a) are developed, States are encouraged to provide information to the Secretary on a voluntary basis.

''(d) PARTICIPANTS.—The Secretary shall include among those interested groups that participate in the development of the plan consumers of mental health or substance abuse services, providers, representatives of political divisions of States, and representatives of racial and ethnic groups including Native Americans.''.

(b) AVAILABILITY TO STATES OF GRANT PROGRAMS.—Section 1952 of the Public Health Service Act (42 U.S.C. 300x–62) is amended as follows:

''SEC. 1952. AVAILABILITY TO STATES OF GRANT PAYMENTS.

''Any amounts paid to a State for a fiscal year under section 1911 or 1921 shall be available for obligation and expenditure until the end of the fiscal year following the fiscal year for which the amounts were paid.''.

SEC. 3404. DATA INFRASTRUCTURE PROJECTS.

Part C of title XIX of the Public Health Service Act (42 U.S.C. 300y et seq.) is amended—

(1) by striking the headings for part C and subpart I and inserting the following:

''PART C—CERTAIN PROGRAMS REGARDING MENTAL HEALTH AND SUBSTANCE ABUSE

''Subpart I—Data Infrastructure Development'';

(2) by striking section 1971 (42 U.S.C. 300y) and inserting the following:

''SEC. 1971. DATA INFRASTRUCTURE DEVELOPMENT.

''(a) IN GENERAL.—The Secretary may make grants to, and enter into contracts or cooperative agreements with States for the purpose of developing and operating mental health or substance abuse data collection, analysis, and reporting systems with regard to performance measures including capacity, process, and outcomes measures.

''(b) PROJECTS.—The Secretary shall establish criteria to ensure that services will be available under this section to States that have a fundamental basis for the collection, analysis, and reporting of mental health and substance abuse performance measures and States that do not have such basis. The Secretary will establish criteria for determining whether a State has a fundamental basis for the collection, analysis, and reporting of data.

''(c) CONDITION OF RECEIPT OF FUNDS.—As a condition of the receipt of an award under this section a State shall agree to collect, analyze, and report to the Secretary within 2 years of the date of the award on a core set of performance measures to be determined by the Secretary in conjunction with the States.

''(d) MATCHING REQUIREMENT.—

''(1) IN GENERAL.—With respect to the costs of the program to be carried out under subsection (a) by a State, the Secretary may make an award under such subsection only if the applicant agrees to make available (directly or through donations from public or private entities) non-Federal contributions toward such costs in an amount that is not less than 50 percent of such costs.

''(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions under paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

''(e) DURATION OF SUPPORT.—The period during which payments may be made for a project under subsection (a) may be not less than 3 years nor more than 5 years.

''(f) AUTHORIZATION OF APPROPRIATION.—

''(1) IN GENERAL.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2001, 2002 and 2003.

''(2) ALLOCATION.—Of the amounts appropriated under paragraph (1) for a fiscal year, 50 percent shall be expended to support data infrastructure development for mental health and 50 percent shall be expended to support data infrastructure development for substance abuse.''.

SEC. 3405. REPEAL OF OBSOLETE ADDICT REFERRAL PROVISIONS.

(a) REPEAL OF OBSOLETE PUBLIC HEALTH SERVICE ACT AUTHORITIES.—Part E of title III (42 U.S.C. 257 et seq.) is repealed.

(b) REPEAL OF OBSOLETE NARA AUTHORITIES.—Titles III and IV of the Narcotic Addict Rehabilitation Act of 1966 (Public Law 89–793) are repealed.

(c) REPEAL OF OBSOLETE TITLE 28 AUTHORITIES.—

(1) IN GENERAL.—Chapter 175 of title 28, United States Code, is repealed.

(2) TABLE OF CONTENTS.—The table of contents to part VI of title 28, United States Code, is amended by striking the items relating to chapter 175.

SEC. 3406. INDIVIDUALS WITH CO-OCCURRING DISORDERS.

The Public Health Service Act is amended by inserting after section 503 (42 U.S.C. 290aa–2) the following:

''SEC. 503A. REPORT ON INDIVIDUALS WITH CO-OCCURRING MENTAL ILLNESS AND SUBSTANCE ABUSE DISORDERS.

''(a) IN GENERAL.—Not later than 2 years after the date of enactment of this section, the Secretary shall, after consultation with organizations representing States, mental health and substance abuse treatment providers, prevention specialists, individuals receiving treatment services, and family members of such individuals, prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Commerce of the House of Representatives, a report on prevention and treatment services for individuals who have co-occurring mental illness and substance abuse disorders.

''(b) REPORT CONTENT.—The report under subsection (a) shall be based on data collected from existing Federal and State surveys regarding the treatment of co-occurring mental illness and substance abuse disorders and shall include—

''(1) a summary of the manner in which individuals with co-occurring disorders are receiving treatment, including the most up-to-date information available regarding the number of children and adults with co-occurring mental illness and substance abuse disorders and the manner in which funds provided under sections 1911 and 1921 are being utilized, including the number of such children and adults served with such funds;

''(2) a summary of improvements necessary to ensure that individuals with co-occurring mental illness and substance abuse disorders receive the services they need;

''(3) a summary of practices for preventing substance abuse among individuals who have a mental illness and are at risk of having or acquiring a substance abuse disorder; and

''(4) a summary of evidenced-based practices for treating individuals with co-occurring mental illness and substance abuse disorders and recommendations for implementing such practices.

''(c) FUNDS FOR REPORT.—The Secretary may obligate funds to carry out this section with such appropriations as are available.''.

SEC. 3407. SERVICES FOR INDIVIDUALS WITH CO-OCCURRING DISORDERS.

Subpart III of part B of title XIX of the Public Health Service Act (42 U.S.C. 300x–51 et seq.) (as amended by section 3305) is further amended by adding at the end the following:

''SEC. 1956. SERVICES FOR INDIVIDUALS WITH CO-OCCURRING DISORDERS.

''States may use funds available for treatment under sections 1911 and 1921 to treat persons with co-occurring substance abuse and mental disorders as long as funds available under such sections are used for the purposes for which they were authorized by law and can be tracked for accounting purposes.''.

TITLE XXXV—WAIVER AUTHORITY FOR PHYSICIANS WHO DISPENSE OR PRESCRIBE CERTAIN NARCOTIC DRUGS FOR MAINTENANCE TREATMENT OR DETOXIFICATION TREATMENT

SEC. 3501. SHORT TITLE.

This title may be cited as the ''Drug Addiction Treatment Act of 2000''.

SEC. 3502. AMENDMENT TO CONTROLLED SUBSTANCES ACT.

(a) IN GENERAL.—Section 303(g) of the Controlled Substances Act (21 U.S.C. 823(g)) is amended—

(1) in paragraph (2), by striking ''(A) security'' and inserting ''(i) security'', and by striking ''(B) the maintenance'' and inserting ''(ii) the maintenance'';

(2) by redesignating paragraphs (1) through (3) as subparagraphs (A) through (C), respectively;

(3) by inserting ''(1)'' after ''(g)'';

(4) by striking ''Practitioners who dispense'' and inserting ''Except as provided in paragraph (2), practitioners who dispense''; and

(5) by adding at the end the following paragraph:

''(2)(A) Subject to subparagraphs (D) and (J), the requirements of paragraph (1) are waived in the case of the dispensing (including the prescribing), by a practitioner, of narcotic drugs in schedule III, IV, or V or combinations of such drugs if the practitioner meets the conditions specified in subparagraph (B) and the narcotic drugs or combinations of such drugs meet the conditions specified in subparagraph (C).

''(B) For purposes of subparagraph (A), the conditions specified in this subparagraph with respect to a practitioner are that, before the initial dispensing of narcotic drugs in schedule III, IV, or V or combinations of such drugs to patients for maintenance or detoxification treatment, the practitioner submit to the Secretary a notification of the intent of the practitioner to begin dispensing the drugs or combinations for such purpose, and that the notification contain the following certifications by the practitioner:

''(i) The practitioner is a qualifying physician (as defined in subparagraph (G)).

''(ii) With respect to patients to whom the practitioner will provide such drugs or combinations of drugs, the practitioner has the capacity to refer the patients for appropriate counseling and other appropriate ancillary services.

''(iii) In any case in which the practitioner is not in a group practice, the total number of such patients of the practitioner at any one time will not exceed the applicable number. For purposes of this clause, the applicable number is 30, except that the Secretary may by regulation change such total number.

''(iv) In any case in which the practitioner is in a group practice, the total number of such patients of the group practice at any one time will not exceed the applicable number. For purposes of this clause, the applicable number is 30, except that the Secretary may by regulation change such total number, and the Secretary for such purposes may by regulation establish different categories on the basis of the number of practitioners in a group practice and establish for the various categories different numerical limitations on the number of such patients that the group practice may have.

''(C) For purposes of subparagraph (A), the conditions specified in this subparagraph with respect to narcotic drugs in schedule III, IV, or V or combinations of such drugs are as follows:

''(i) The drugs or combinations of drugs have, under the Federal Food, Drug, and Cosmetic Act or section 351 of the Public Health Service Act, been approved for use in maintenance or detoxification treatment.

''(ii) The drugs or combinations of drugs have not been the subject of an adverse determination. For purposes of this clause, an adverse determination is a determination published in the Federal Register and made by the Secretary, after consultation with the Attorney General, that the use of the drugs or combinations of drugs for maintenance or detoxification treatment requires additional standards respecting the qualifications of practitioners to provide such treatment, or requires standards respecting the quantities of the drugs that may be provided for unsupervised use.

''(D)(i) A waiver under subparagraph (A) with respect to a practitioner is not in effect unless (in addition to conditions under subparagraphs (B) and (C)) the following conditions are met:

''(I) The notification under subparagraph (B) is in writing and states the name of the practitioner.

''(II) The notification identifies the registration issued for the practitioner pursuant to subsection (f).

''(III) If the practitioner is a member of a group practice, the notification states the names of the other practitioners in the practice and identifies the registrations issued for the other practitioners pursuant to subsection (f).

''(ii) Upon receiving a notification under subparagraph (B), the Attorney General shall assign the practitioner involved an identification number under this paragraph for inclusion with the registration issued for the practitioner pursuant to subsection (f). The identification number so assigned shall be appropriate to preserve the confidentiality of patients for whom the practitioner has dispensed narcotic drugs under a waiver under subparagraph (A).

''(iii) Not later than 45 days after the date on which the Secretary receives a notification under subparagraph (B), the Secretary shall make a determination of whether the practitioner involved meets all requirements for a waiver under subparagraph (B). If the Secretary fails to make such determination by the end of the such 45-day period, the Attorney General shall assign the physician an identification number described in clause (ii) at the end of such period.

''(E)(i) If a practitioner is not registered under paragraph (1) and, in violation of the conditions specified in subparagraphs (B) through (D), dispenses narcotic drugs in schedule III, IV, or V or combinations of such drugs for maintenance treatment or detoxification treatment, the Attorney General may, for purposes of section 304(a)(4), consider the practitioner to have committed an act that renders the registration of the practitioner pursuant to subsection (f) to be inconsistent with the public interest.

''(ii)(I) Upon the expiration of 45 days from the date on which the Secretary receives a notification under subparagraph (B), a practitioner who in good faith submits a notification under subparagraph (B) and reasonably believes that the conditions specified in subparagraphs (B) through (D) have been met shall, in dispensing narcotic drugs in schedule III, IV, or V or combinations of such drugs for maintenance treatment or detoxification treatment, be considered to have a waiver under subparagraph (A) until notified otherwise by the Secretary, except that such a practitioner may commence to prescribe or dispense such narcotic drugs for such purposes prior to the expiration of such 45-day period if it facilitates the treatment of an individual patient and both the Secretary and the Attorney General are notified by the practitioner of the intent to commence prescribing or dispensing such narcotic drugs.

''(II) For purposes of subclause (I), the publication in the Federal Register of an adverse determination by the Secretary pursuant to subparagraph (C)(ii) shall (with respect to the narcotic drug or combination involved) be considered to be a notification provided by the Secretary to practitioners, effective upon the expiration of the 30-day period beginning on the date on which the adverse determination is so published.

''(F)(i) With respect to the dispensing of narcotic drugs in schedule III, IV, or V or combinations of such drugs to patients for maintenance or detoxification treatment, a practitioner may, in his or her discretion, dispense such drugs or combinations for such treatment under a registration under paragraph (1) or a waiver under subparagraph (A) (subject to meeting the applicable conditions).

''(ii) This paragraph may not be construed as having any legal effect on the conditions for obtaining a registration under paragraph (1), including with respect to the number of patients who may be served under such a registration.

''(G) For purposes of this paragraph:

''(i) The term 'group practice' has the meaning given such term in section 1877(h)(4) of the Social Security Act.

''(ii) The term 'qualifying physician' means a physician who is licensed under State law and who meets one or more of the following conditions:

''(I) The physician holds a subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties.

''(II) The physician holds an addiction certification from the American Society of Addiction Medicine.

''(III) The physician holds a subspecialty board certification in addiction medicine from the American Osteopathic Association.

''(IV) The physician has, with respect to the treatment and management of opiate-dependent patients, completed not less than eight hours of training (through classroom situations, seminars at professional society meetings, electronic communications, or otherwise) that is provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Psychiatric Association, or any other organization that the Secretary determines is appropriate for purposes of this subclause.

''(V) The physician has participated as an investigator in one or more clinical trials leading to the approval of a narcotic drug in schedule III, IV, or V for maintenance or detoxification treatment, as demonstrated by a statement submitted to the Secretary by the sponsor of such approved drug.

''(VI) The physician has such other training or experience as the State medical licensing board (of the State in which the physician will provide maintenance or detoxification treatment) considers to demonstrate the ability of the physician to treat and manage opiate-dependent patients.

''(VII) The physician has such other training or experience as the Secretary considers to demonstrate the ability of the physician to treat and manage opiate-dependent patients. Any criteria of the Secretary under this subclause shall be established by regulation. Any such criteria are effective only for 3 years after the date on which the criteria are promulgated, but may be extended for such additional discrete 3-year periods as the Secretary considers appropriate for purposes of this subclause. Such an extension of criteria may only be effectuated through a statement published in the Federal Register by the Secretary during the 30-day period preceding the end of the 3-year period involved.

''(H)(i) In consultation with the Administrator of the Drug Enforcement Administration, the Administrator of the Substance Abuse and Mental Health Services Administration, the Director of the National Institute on Drug Abuse, and the Commissioner of Food and Drugs, the Secretary shall issue regulations (through notice and comment rulemaking) or issue practice guidelines to address the following:

''(I) Approval of additional credentialing bodies and the responsibilities of additional credentialing bodies.

''(II) Additional exemptions from the requirements of this paragraph and any regulations under this paragraph.

Nothing in such regulations or practice guidelines may authorize any Federal official or employee to exercise supervision or control over the practice of medicine or the manner in which medical services are provided.

''(ii) Not later than 120 days after the date of the enactment of the Drug Addiction Treatment Act of 2000, the Secretary shall issue a treatment improvement protocol containing best practice guidelines for the treatment and maintenance of opiate-dependent patients. The Secretary shall develop the protocol in consultation with the Director of the National Institute on Drug Abuse, the Administrator of the Drug Enforcement Administration, the Commissioner of Food and Drugs, the Administrator of the Substance Abuse and Mental Health Services Administration and other substance abuse disorder professionals. The protocol shall be guided by science.

''(I) During the 3-year period beginning on the date of the enactment of the Drug Addiction Treatment Act of 2000, a State may not preclude a practitioner from dispensing or prescribing drugs in schedule III, IV, or V, or combinations of such drugs, to patients for maintenance or detoxification treatment in accordance with this paragraph unless, before the expiration of that 3-year period, the State enacts a law prohibiting a practitioner from dispensing such drugs or combinations of drug.

''(J)(i) This paragraph takes effect on the date of the enactment of the Drug Addiction Treatment Act of 2000, and remains in effect thereafter except as provided in clause (iii) (relating to a decision by the Secretary or the Attorney General that this paragraph should not remain in effect).

''(ii) For purposes relating to clause (iii), the Secretary and the Attorney General may, during the 3-year period beginning on the date of the enactment of the Drug Addiction Treatment Act of 2000, make determinations in accordance with the following:

''(I) The Secretary may make a determination of whether treatments provided under waivers under subparagraph (A) have been effective forms of maintenance treatment and detoxification treatment in clinical settings; may make a determination of whether such waivers have significantly increased (relative to the beginning of such period) the availability of maintenance treatment and detoxification treatment; and may make a determination of whether such waivers have adverse consequences for the public health.

''(II) The Attorney General may make a determination of the extent to which there have been violations of the numerical limitations established under subparagraph (B) for the number of individuals to whom a practitioner may provide treatment; may make a determination of whether waivers under subparagraph (A) have increased (relative to the beginning of such period) the extent to which narcotic drugs in schedule III, IV, or V or combinations of such drugs are being dispensed or possessed in violation of this Act; and may make a determination of whether such waivers have adverse consequences for the public health.

''(iii) If, before the expiration of the period specified in clause (ii), the Secretary or the Attorney General publishes in the Federal Register a decision, made on the basis of determinations under such clause, that this paragraph should not remain in effect, this paragraph ceases to be in effect 60 days after the date on which the decision is so published. The Secretary shall in making any such decision consult with the Attorney General, and shall in publishing the decision in the Federal Register include any comments received from the Attorney General for inclusion in the publication. The Attorney General shall in making any such decision consult with the Secretary, and shall in publishing the decision in the Federal Register include any comments received from the Secretary for inclusion in the publication.''.

(b) CONFORMING AMENDMENTS.—Section 304 of the Controlled Substances Act (21 U.S.C. 824) is amended—

(1) in subsection (a), in the matter after and below paragraph (5), by striking ''section 303(g)'' each place such term appears and inserting ''section 303(g)(1)''; and

(2) in subsection (d), by striking ''section 303(g)'' and inserting ''section 303(g)(1)''.

(c) ADDITIONAL AUTHORIZATION OF APPROPRIATIONS.—For the purpose of assisting the Secretary of Health and Human Services with the additional duties established for the Secretary pursuant to the amendments made by this section, there are authorized to be appropriated, in addition to other authorizations of appropriations that are available for such purpose, such sums as may be necessary for each of fiscal years 2001 through 2003.

TITLE XXXVI—METHAMPHETAMINE AND OTHER CONTROLLED SUBSTANCES

SEC. 3601. SHORT TITLE.

This title may be cited as the ''Methamphetamine Anti-Proliferation Act of 2000''.

Subtitle A—Methamphetamine Production, Trafficking, and Abuse

PART I—CRIMINAL PENALTIES

SEC. 3611. ENHANCED PUNISHMENT OF AMPHETAMINE LABORATORY OPERATORS.

(a) AMENDMENT TO FEDERAL SENTENCING GUIDELINES.—Pursuant to its authority under section 994(p) of title 28, United States Code, the United States Sentencing Commission shall amend the Federal sentencing guidelines in accordance with this section with respect to any offense relating to the manufacture, importation, exportation, or trafficking in amphetamine (including an attempt or conspiracy to do any of the foregoing) in violation of—

(1) the Controlled Substances Act (21 U.S.C. 801 et seq.);

(2) the Controlled Substances Import and Export Act (21 U.S.C. 951 et seq.); or

(3) the Maritime Drug Law Enforcement Act (46 U.S.C. App. 1901 et seq.).

(b) GENERAL REQUIREMENT.—In carrying out this section, the United States Sentencing Commission shall, with respect to each offense described in subsection (a) relating to amphetamine—

(1) review and amend its guidelines to provide for increased penalties such that those penalties are comparable to the base offense level for methamphetamine; and

(2) take any other action the Commission considers necessary to carry out this subsection.

(c) ADDITIONAL REQUIREMENTS.—In carrying out this section, the United States Sentencing Commission shall ensure that the sentencing guidelines for offenders convicted of offenses described in subsection (a) reflect the heinous nature of such offenses, the need for aggressive law enforcement action to fight such offenses, and the extreme dangers associated with unlawful activity involving amphetamines, including—

(1) the rapidly growing incidence of amphetamine abuse and the threat to public safety that such abuse poses;

(2) the high risk of amphetamine addiction;

(3) the increased risk of violence associated with amphetamine trafficking and abuse; and

(4) the recent increase in the illegal importation of amphetamine and precursor chemicals.

(d) EMERGENCY AUTHORITY TO SENTENCING COMMISSION.—The United States Sentencing Commission shall promulgate amendments pursuant to this section as soon as practicable after

the date of enactment of this Act in accordance with the procedure set forth in section 21(a) of the Sentencing Act of 1987 (Public Law 100–182), as though the authority under that Act had not expired.

SEC. 3612. ENHANCED PUNISHMENT OF AMPHETAMINE OR METHAMPHETAMINE LABORATORY OPERATORS.

(a) FEDERAL SENTENCING GUIDELINES.—

(1) IN GENERAL.—Pursuant to its authority under section 994(p) of title 28, United States Code, the United States Sentencing Commission shall amend the Federal sentencing guidelines in accordance with paragraph (2) with respect to any offense relating to the manufacture, attempt to manufacture, or conspiracy to manufacture amphetamine or methamphetamine in violation of—

(A) the Controlled Substances Act (21 U.S.C. 801 et seq.);

(B) the Controlled Substances Import and Export Act (21 U.S.C. 951 et seq.); or

(C) the Maritime Drug Law Enforcement Act (46 U.S.C. App. 1901 et seq.).

(2) REQUIREMENTS.—In carrying out this paragraph, the United States Sentencing Commission shall—

(A) if the offense created a substantial risk of harm to human life (other than a life described in subparagraph (B)) or the environment, increase the base offense level for the offense—

(i) by not less than 3 offense levels above the applicable level in effect on the date of enactment of this Act; or

(ii) if the resulting base offense level after an increase under clause (i) would be less than level 27, to not less than level 27; or

(B) if the offense created a substantial risk of harm to the life of a minor or incompetent, increase the base offense level for the offense—

(i) by not less than 6 offense levels above the applicable level in effect on the date of enactment of this Act; or

(ii) if the resulting base offense level after an increase under clause (i) would be less than level 30, to not less than level 30.

(3) EMERGENCY AUTHORITY TO SENTENCING COMMISSION.—The United States Sentencing Commission shall promulgate amendments pursuant to this subsection as soon as practicable after the date of enactment of this Act in accordance with the procedure set forth in section 21(a) of the Sentencing Act of 1987 (Public Law 100–182), as though the authority under that Act had not expired.

(b) EFFECTIVE DATE.—The amendments made pursuant to this section shall apply with respect to any offense occurring on or after the date that is 60 days after the date of enactment of this Act.

SEC. 3613. MANDATORY RESTITUTION FOR VIOLATIONS OF CONTROLLED SUBSTANCES ACT AND CONTROLLED SUBSTANCES IMPORT AND EXPORT ACT RELATING TO AMPHETAMINE AND METHAMPHETAMINE.

(a) MANDATORY RESTITUTION.—Section 413(q) of the Controlled Substances Act (21 U.S.C. 853(q)) is amended—

(1) in the matter preceding paragraph (1), by striking ''may'' and inserting ''shall'';

(2) by inserting ''amphetamine or'' before ''methamphetamine'' each place it appears;

(3) in paragraph (2)—

(A) by inserting '', the State or local government concerned, or both the United States and the State or local government concerned'' after ''United States'' the first place it appears; and

(B) by inserting ''or the State or local government concerned, as the case may be,'' after ''United States'' the second place it appears; and

(4) in paragraph (3), by striking ''section 3663 of title 18, United States Code'' and inserting ''section 3663A of title 18, United States Code''.

(b) DEPOSIT OF AMOUNTS IN DEPARTMENT OF JUSTICE ASSETS FORFEITURE FUND.—Section 524(c)(4) of title 28, United States Code, is amended—

(1) by striking ''and'' at the end of subparagraph (B);

(2) by striking the period at the end of subparagraph (C) and inserting ''; and''; and

(3) by adding at the end the following:

''(D) all amounts collected—

''(i) by the United States pursuant to a reimbursement order under paragraph (2) of section 413(q) of the Controlled Substances Act (21 U.S.C. 853(q)); and

''(ii) pursuant to a restitution order under paragraph (1) or (3) of section 413(q) of the Controlled Substances Act for injuries to the United States.''.

(c) CLARIFICATION OF CERTAIN ORDERS OF RESTITUTION.—Section 3663(c)(2)(B) of title 18, United States Code, is amended by inserting ''which may be'' after ''the fine''.

(d) EXPANSION OF APPLICABILITY OF MANDATORY RESTITUTION.—Section 3663A(c)(1)(A)(ii) of title 18, United States Code, is amended by inserting ''or under section 416(a) of the Controlled Substances Act (21 U.S.C. 856(a)),'' after ''under this title,''.

(e) TREATMENT OF ILLICIT SUBSTANCE MANUFACTURING OPERATIONS AS CRIMES AGAINST PROPERTY.—Section 416 of the Controlled Substances Act (21 U.S.C. 856) is amended by adding at the end the following new subsection:

''(c) A violation of subsection (a) shall be considered an offense against property for purposes of section 3663A(c)(1)(A)(ii) of title 18, United States Code.''.

SEC. 3614. METHAMPHETAMINE PARAPHERNALIA.

Section 422(d) of the Controlled Substances Act (21 U.S.C. 863(d)) is amended in the matter preceding paragraph (1) by inserting ''methamphetamine,'' after ''PCP,''.

PART II—ENHANCED LAW ENFORCEMENT

SEC. 3621. ENVIRONMENTAL HAZARDS ASSOCIATED WITH ILLEGAL MANUFACTURE OF AMPHETAMINE AND METHAMPHETAMINE.

(a) USE OF AMOUNTS OR DEPARTMENT OF JUSTICE ASSETS FORFEITURE FUND.—Section 524(c)(1)(E) of title 28, United States Code, is amended—

(1) by inserting ''(i) for'' before ''disbursements'';

(2) by inserting ''and'' after the semicolon; and

(3) by adding at the end the following:

''(ii) for payment for—

''(I) costs incurred by or on behalf of the Department of Justice in connection with the removal, for purposes of Federal forfeiture and disposition, of any hazardous substance or pollutant or contaminant associated with the illegal manufacture of amphetamine or methamphetamine; and

''(II) costs incurred by or on behalf of a State or local government in connection with such removal in any case in which such State or local government has assisted in a Federal prosecution relating to amphetamine or methamphetamine, to the extent such costs exceed equitable sharing payments made to such State or local government in such case;''.

(b) GRANTS UNDER DRUG CONTROL AND SYSTEM IMPROVEMENT GRANT PROGRAM.—Section 501(b)(3) of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3751(b)(3)) is amended by inserting before the semicolon the following: ''and to remove any hazardous substance or pollutant or contaminant associated with the illegal manufacture of amphetamine or methamphetamine''.

(c) AMOUNTS SUPPLEMENT AND NOT SUPPLANT.—

(1) ASSETS FORFEITURE FUND.—Any amounts made available from the Department of Justice Assets Forfeiture Fund in a fiscal year by reason of the amendment made by subsection (a) shall supplement, and not supplant, any other amounts made available to the Department of Justice in such fiscal year from other sources for payment of costs described in section 524(c)(1)(E)(ii) of title 28, United States Code, as so amended.

(2) GRANT PROGRAM.—Any amounts made available in a fiscal year under the grant program under section 501(b)(3) of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3751(b)(3)) for the removal of hazardous substances or pollutants or contaminants associated with the illegal manufacture of amphetamine or methamphetamine by reason of the amendment made by subsection (b) shall supplement, and not supplant, any other amounts made available in such fiscal year from other sources for such removal.

SEC. 3622. REDUCTION IN RETAIL SALES TRANSACTION THRESHOLD FOR NON-SAFE HARBOR PRODUCTS CONTAINING PSEUDOEPHEDRINE OR PHENYLPROPANOLAMINE.

(a) REDUCTION IN TRANSACTION THRESHOLD.—Section 102(39)(A)(iv)(II) of the Controlled Substances Act (21 U.S.C. 802(39)(A)(iv)(II)) is amended—

(1) by striking ''24 grams'' both places it appears and inserting ''9 grams''; and

(2) by inserting before the semicolon at the end the following: ''and sold in package sizes of not more than 3 grams of pseudoephedrine base or 3 grams of phenylpropanolamine base''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect 1 year after the date of enactment of this Act.

SEC. 3623. TRAINING FOR DRUG ENFORCEMENT ADMINISTRATION AND STATE AND LOCAL LAW ENFORCEMENT PERSONNEL RELATING TO CLANDESTINE LABORATORIES.

(a) IN GENERAL.—

(1) REQUIREMENT.—The Administrator of the Drug Enforcement Administration shall carry out the programs described in subsection (b) with respect to the law enforcement personnel of States and localities determined by the Administrator to have significant levels of methamphetamine-related or amphetamine-related crime or projected by the Administrator to have the potential for such levels of crime in the future.

(2) DURATION.—The duration of any program under that subsection may not exceed 3 years.

(b) COVERED PROGRAMS.—The programs described in this subsection are as follows:

(1) ADVANCED MOBILE CLANDESTINE LABORATORY TRAINING TEAMS.—A program of advanced mobile clandestine laboratory training teams, which shall provide information and training to State and local law enforcement personnel in techniques utilized in conducting undercover investigations and conspiracy cases, and other information designed to assist in the investigation of the illegal manufacturing and trafficking of amphetamine and methamphetamine.

(2) BASIC CLANDESTINE LABORATORY CERTIFICATION TRAINING.—A program of basic clandestine laboratory certification training, which shall provide information and training—

(A) to Drug Enforcement Administration personnel and State and local law enforcement personnel for purposes of enabling such personnel to meet any certification requirements under law with respect to the handling of wastes created by illegal amphetamine and methamphetamine laboratories; and

(B) to State and local law enforcement personnel for purposes of enabling such personnel to provide the information and training covered by subparagraph (A) to other State and local law enforcement personnel.

(3) CLANDESTINE LABORATORY RECERTIFICATION AND AWARENESS TRAINING.—A program of clandestine laboratory recertification and awareness training, which shall provide information and training to State and local law enforcement personnel for purposes of enabling such personnel to provide recertification and awareness training relating to clandestine laboratories to additional State and local law enforcement personnel.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for

each of fiscal years 2000, 2001, and 2002 amounts as follows:

(1) $1,500,000 to carry out the program described in subsection (b)(1).

(2) $3,000,000 to carry out the program described in subsection (b)(2).

(3) $1,000,000 to carry out the program described in subsection (b)(3).

SEC. 3624. COMBATING METHAMPHETAMINE AND AMPHETAMINE IN HIGH INTENSITY DRUG TRAFFICKING AREAS.

(a) IN GENERAL.—

(1) IN GENERAL.—The Director of National Drug Control Policy shall use amounts available under this section to combat the trafficking of methamphetamine and amphetamine in areas designated by the Director as high intensity drug trafficking areas.

(2) ACTIVITIES.—In meeting the requirement in paragraph (1), the Director shall transfer funds to appropriate Federal, State, and local governmental agencies for employing additional Federal law enforcement personnel, or facilitating the employment of additional State and local law enforcement personnel, including agents, investigators, prosecutors, laboratory technicians, chemists, investigative assistants, and drug-prevention specialists.

(b) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section—

(1) $15,000,000 for fiscal year 2000; and

(2) such sums as may be necessary for each of fiscal years 2001 through 2004.

(c) APPORTIONMENT OF FUNDS.—

(1) FACTORS IN APPORTIONMENT.—The Director shall apportion amounts appropriated for a fiscal year pursuant to the authorization of appropriations in subsection (b) for activities under subsection (a) among and within areas designated by the Director as high intensity drug trafficking areas based on the following factors:

(A) The number of methamphetamine manufacturing facilities and amphetamine manufacturing facilities discovered by Federal, State, or local law enforcement officials in the previous fiscal year.

(B) The number of methamphetamine prosecutions and amphetamine prosecutions in Federal, State, or local courts in the previous fiscal year.

(C) The number of methamphetamine arrests and amphetamine arrests by Federal, State, or local law enforcement officials in the previous fiscal year.

(D) The amounts of methamphetamine, amphetamine, or listed chemicals (as that term is defined in section 102(33) of the Controlled Substances Act (21 U.S.C. 802(33)) seized by Federal, State, or local law enforcement officials in the previous fiscal year.

(E) Intelligence and predictive data from the Drug Enforcement Administration and the Department of Health and Human Services showing patterns and trends in abuse, trafficking, and transportation in methamphetamine, amphetamine, and listed chemicals (as that term is so defined).

(2) CERTIFICATION.—Before the Director apportions any funds under this subsection to a high intensity drug trafficking area, the Director shall certify that the law enforcement entities responsible for clandestine methamphetamine and amphetamine laboratory seizures in that area are providing laboratory seizure data to the national clandestine laboratory database at the El Paso Intelligence Center.

(d) LIMITATION ON ADMINISTRATIVE COSTS.—Not more than 5 percent of the amount appropriated in a fiscal year pursuant to the authorization of appropriations for that fiscal year in subsection (b) may be available in that fiscal year for administrative costs associated with activities under subsection (a).

SEC. 3625. COMBATING AMPHETAMINE AND METHAMPHETAMINE MANUFACTURING AND TRAFFICKING.

(a) ACTIVITIES.—In order to combat the illegal manufacturing and trafficking in amphetamine and methamphetamine, the Administrator of the Drug Enforcement Administration may—

(1) assist State and local law enforcement in small and mid-sized communities in all phases of investigations related to such manufacturing and trafficking, including assistance with foreign-language interpretation;

(2) staff additional regional enforcement and mobile enforcement teams related to such manufacturing and trafficking;

(3) establish additional resident offices and posts of duty to assist State and local law enforcement in rural areas in combating such manufacturing and trafficking;

(4) provide the Special Operations Division of the Administration with additional agents and staff to collect, evaluate, interpret, and disseminate critical intelligence targeting the command and control operations of major amphetamine and methamphetamine manufacturing and trafficking organizations;

(5) enhance the investigative and related functions of the Chemical Control Program of the Administration to implement more fully the provisions of the Comprehensive Methamphetamine Control Act of 1996 (Public Law 104–237);

(6) design an effective means of requiring an accurate accounting of the import and export of list I chemicals, and coordinate investigations relating to the diversion of such chemicals;

(7) develop a computer infrastructure sufficient to receive, process, analyze, and redistribute time-sensitive enforcement information from suspicious order reporting to field offices of the Administration and other law enforcement and regulatory agencies, including the continuing development of the Suspicious Order Reporting and Tracking System (SORTS) and the Chemical Transaction Database (CTRANS) of the Administration;

(8) establish an education, training, and communication process in order to alert the industry to current trends and emerging patterns in the illegal manufacturing of amphetamine and methamphetamine; and

(9) carry out such other activities as the Administrator considers appropriate.

(b) ADDITIONAL POSITIONS AND PERSONNEL.—

(1) IN GENERAL.—In carrying out activities under subsection (a), the Administrator may establish in the Administration not more than 50 full-time positions, including not more than 31 special-agent positions, and may appoint personnel to such positions.

(2) PARTICULAR POSITIONS.—In carrying out activities under paragraphs (5) through (8) of subsection (a), the Administrator may establish in the Administration not more than 15 full-time positions, including not more than 10 diversion investigator positions, and may appoint personnel to such positions. Any positions established under this paragraph are in addition to any positions established under paragraph (1).

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for the Drug Enforcement Administration for each fiscal year after fiscal year 1999, $9,500,000 for purposes of carrying out the activities authorized by subsection (a) and employing personnel in positions established under subsection (b), of which $3,000,000 shall be available for activities under paragraphs (5) through (8) of subsection (a) and for employing personnel in positions established under subsection (b)(2).

PART III—ABUSE PREVENTION AND TREATMENT

SEC. 3631. EXPANSION OF METHAMPHETAMINE RESEARCH.

Section 464N of the Public Health Service Act (42 U.S.C. 285o–2) is amended by adding at the end the following:

''(c) METHAMPHETAMINE RESEARCH.—

''(1) GRANTS OR COOPERATIVE AGREEMENTS.—The Director of the Institute may make grants or enter into cooperative agreements to expand the current and on-going interdisciplinary research and clinical trials with treatment centers of the National Drug Abuse Treatment Clinical Trials Network relating to methamphetamine abuse and addiction and other biomedical, behavioral, and social issues related to methamphetamine abuse and addiction.

''(2) USE OF FUNDS.—Amounts made available under a grant or cooperative agreement under paragraph (1) for methamphetamine abuse and addiction may be used for research and clinical trials relating to—

''(A) the effects of methamphetamine abuse on the human body, including the brain;

''(B) the addictive nature of methamphetamine and how such effects differ with respect to different individuals;

''(C) the connection between methamphetamine abuse and mental health;

''(D) the identification and evaluation of the most effective methods of prevention of methamphetamine abuse and addiction;

''(E) the identification and development of the most effective methods of treatment of methamphetamine addiction, including pharmacological treatments;

''(F) risk factors for methamphetamine abuse;

''(G) effects of methamphetamine abuse and addiction on pregnant women and their fetuses; and

''(H) cultural, social, behavioral, neurological and psychological reasons that individuals abuse methamphetamine, or refrain from abusing methamphetamine.

''(3) RESEARCH RESULTS.—The Director shall promptly disseminate research results under this subsection to Federal, State and local entities involved in combating methamphetamine abuse and addiction.

''(4) AUTHORIZATION OF APPROPRIATIONS.—

''(A) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out paragraph (1), such sums as may be necessary for each fiscal year.

''(B) SUPPLEMENT NOT SUPPLANT.—Amounts appropriated pursuant to the authorization of appropriations in subparagraph (A) for a fiscal year shall supplement and not supplant any other amounts appropriated in such fiscal year for research on methamphetamine abuse and addiction.''.

SEC. 3632. METHAMPHETAMINE AND AMPHETAMINE TREATMENT INITIATIVE BY CENTER FOR SUBSTANCE ABUSE TREATMENT.

Subpart 1 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb et seq.) is amended by adding at the end the following new section:

''METHAMPHETAMINE AND AMPHETAMINE TREATMENT INITIATIVE

''SEC. 514. (a) GRANTS.—

''(1) AUTHORITY TO MAKE GRANTS.—The Director of the Center for Substance Abuse Treatment may make grants to States and Indian tribes recognized by the United States that have a high rate, or have had a rapid increase, in methamphetamine or amphetamine abuse or addiction in order to permit such States and Indian tribes to expand activities in connection with the treatment of methamphetamine or amphetamine abuser or addiction in the specific geographical areas of such States or Indian tribes, as the case may be, where there is such a rate or has been such an increase.

''(2) RECIPIENTS.—Any grants under paragraph (1) shall be directed to the substance abuse directors of the States, and of the appropriate tribal government authorities of the Indian tribes, selected by the Director to receive such grants.

''(3) NATURE OF ACTIVITIES.—Any activities under a grant under paragraph (1) shall be based on reliable scientific evidence of their efficacy in the treatment of methamphetamine or amphetamine abuse or addiction.

''(b) GEOGRAPHIC DISTRIBUTION.—The Director shall ensure that grants under subsection (a) are distributed equitably among the various regions of the country and among rural, urban,

and suburban areas that are affected by methamphetamine or amphetamine abuse or addiction.

''(c) ADDITIONAL ACTIVITIES.—The Director shall—

''(1) evaluate the activities supported by grants under subsection (a);

''(2) disseminate widely such significant information derived from the evaluation as the Director considers appropriate to assist States, Indian tribes, and private providers of treatment services for methamphetamine or amphetamine abuser or addiction in the treatment of methamphetamine or amphetamine abuse or addiction; and

''(3) provide States, Indian tribes, and such providers with technical assistance in connection with the provision of such treatment.

''(d) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—There are authorized to be appropriated to carry out this section $10,000,000 for fiscal year 2000 and such sums as may be necessary for each of fiscal years 2001 and 2002.

''(2) USE OF CERTAIN FUNDS.—Of the funds appropriated to carry out this section in any fiscal year, the lesser of 5 percent of such funds or $1,000,000 shall be available to the Director for purposes of carrying out subsection (c).''.

SEC. 3633. STUDY OF METHAMPHETAMINE TREATMENT.

(a) STUDY.—

(1) REQUIREMENT.—The Secretary of Health and Human Services shall, in consultation with the Institute of Medicine of the National Academy of Sciences, conduct a study on the development of medications for the treatment of addiction to amphetamine and methamphetamine.

(2) REPORT.—Not later than 9 months after the date of enactment of this Act, the Secretary shall submit to the Committees on the Judiciary of the Senate and House of Representatives a report on the results of the study conducted under paragraph (1).

(b) AUTHORIZATION OF APPROPRIATIONS.—There are hereby authorized to be appropriated for the Department of Health and Human Services for fiscal year 2000 such sums as may be necessary to meet the requirements of subsection (a).

PART IV—REPORTS

SEC. 3641. REPORTS ON CONSUMPTION OF METHAMPHETAMINE AND OTHER ILLICIT DRUGS IN RURAL AREAS, METROPOLITAN AREAS, AND CONSOLIDATED METROPOLITAN AREAS.

The Secretary of Health and Human Services shall include in each National Household Survey on Drug Abuse appropriate prevalence data and information on the consumption of methamphetamine and other illicit drugs in rural areas, metropolitan areas, and consolidated metropolitan areas.

SEC. 3642. REPORT ON DIVERSION OF ORDINARY, OVER-THE-COUNTER PSEUDOEPHEDRINE AND PHENYLPROPANOLAMINE PRODUCTS.

(a) STUDY.—The Attorney General shall conduct a study of the use of ordinary, over-the-counter pseudoephedrine and phenylpropanolamine products in the clandestine production of illicit drugs. Sources of data for the study shall include the following:

(1) Information from Federal, State, and local clandestine laboratory seizures and related investigations identifying the source, type, or brand of drug products being utilized and how they were obtained for the illicit production of methamphetamine and amphetamine.

(2) Information submitted voluntarily from the pharmaceutical and retail industries involved in the manufacture, distribution, and sale of drug products containing ephedrine, pseudoephedrine, and phenylpropanolamine, including information on changes in the pattern, volume, or both, of sales of ordinary, over-the-counter pseudoephedrine and phenylpropanolamine products.

(b) REPORT.—

(1) REQUIREMENT.—Not later than 1 year after the date of enactment of this Act, the Attorney General shall submit to Congress a report on the study conducted under subsection (a).

(2) ELEMENTS.—The report shall include—

(A) the findings of the Attorney General as a result of the study; and

(B) such recommendations on the need to establish additional measures to prevent diversion of ordinary, over-the-counter pseudoephedrine and phenylpropanolamine (such as a threshold on ordinary, over-the-counter pseudoephedrine and phenylpropanolamine products) as the Attorney General considers appropriate.

(3) MATTERS CONSIDERED.—In preparing the report, the Attorney General shall consider the comments and recommendations including the comments on the Attorney General's proposed findings and recommendations, of State and local law enforcement and regulatory officials and of representatives of the industry described in subsection (a)(2).

(c) REGULATION OF RETAIL SALES.—

(1) IN GENERAL.—Notwithstanding section 401(d) of the Comprehensive Methamphetamine Control Act of 1996 (21 U.S.C. 802 note) and subject to paragraph (2), the Attorney General shall establish by regulation a single-transaction limit of not less than 24 grams of ordinary, over-the-counter pseudoephedrine or phenylpropanolamine (as the case may be) for retail distributors, if the Attorney General finds, in the report under subsection (b), that—

(A) there is a significant number of instances (as set forth in paragraph (3)(A) of such section 401(d) for purposes of such section) where ordinary, over-the-counter pseudoephedrine products, phenylpropanolamine products, or both such products that were purchased from retail distributors were widely used in the clandestine production of illicit drugs; and

(B) the best practical method of preventing such use is the establishment of single-transaction limits for retail distributors of either or both of such products.

(2) DUE PROCESS.—The Attorney General shall establish the single-transaction limit under paragraph (1) only after notice, comment, and an informal hearing.

Subtitle B—Controlled Substances Generally

SEC. 3651. ENHANCED PUNISHMENT FOR TRAFFICKING IN LIST I CHEMICALS.

(a) AMENDMENTS TO FEDERAL SENTENCING GUIDELINES.—Pursuant to its authority under section 994(p) of title 28, United States Code, the United States Sentencing Commission shall amend the Federal sentencing guidelines in accordance with this section with respect to any violation of paragraph (1) or (2) of section 401(d) of the Controlled Substances Act (21 U.S.C. 841(d)) involving a list I chemical and any violation of paragraph (1) or (3) of section 1010(d) of the Controlled Substance Import and Export Act (21 U.S.C. 960(d)) involving a list I chemical.

(b) EPHEDRINE, PHENYLPROPANOLAMINE, AND PSEUDOEPHEDRINE.—

(1) IN GENERAL.—In carrying this section, the United States Sentencing Commission shall, with respect to each offense described in subsection (a) involving ephedrine, phenylpropanolamine, or pseudoephedrine (including their salts, optical isomers, and salts of optical isomers), review and amend its guidelines to provide for increased penalties such that those penalties corresponded to the quantity of controlled substance that could reasonably have been manufactured using the quantity of ephedrine, phenylpropanolamine, or pseudoephedrine possessed or distributed.

(2) CONVERSION RATIOS.—For the purposes of the amendments made by this subsection, the quantity of controlled substance that could reasonably have been manufactured shall be determined by using a table of manufacturing conversion ratios for ephedrine, phenylpropanolamine, and pseudoephedrine, which table shall be established by the Sentencing Commission based on scientific, law enforcement, and other data the Sentencing Commission considers appropriate.

(c) OTHER LIST I CHEMICALS.—In carrying this section, the United States Sentencing Commission shall, with respect to each offense described in subsection (a) involving any list I chemical other than ephedrine, phenylpropanolamine, or pseudoephedrine, review and amend its guidelines to provide for increased penalties such that those penalties reflect the dangerous nature of such offenses, the need for aggressive law enforcement action to fight such offenses, and the extreme dangers associated with unlawful activity involving methamphetamine and amphetamine, including—

(1) the rapidly growing incidence of controlled substance manufacturing;

(2) the extreme danger inherent in manufacturing controlled substances;

(3) the threat to public safety posed by manufacturing controlled substances; and

(4) the recent increase in the importation, possession, and distribution of list I chemicals for the purpose of manufacturing controlled substances.

(d) EMERGENCY AUTHORITY TO SENTENCING COMMISSION.—The United States Sentencing Commission shall promulgate amendments pursuant to this section as soon as practicable after the date of enactment of this Act in accordance with the procedure set forth in section 21(a) of the Sentencing Act of 1987 (Public Law 100–182), as though the authority under that Act had not expired.

SEC. 3652. MAIL ORDER REQUIREMENTS.

Section 310(b)(3) of the Controlled Substances Act (21 U.S.C. 830(b)(3)) is amended—

(1) by redesignating subparagraphs (A) and (B) as subparagraphs (B) and (C), respectively;

(2) by inserting before subparagraph (B), as so redesignated, the following new subparagraph (A):

''(A) As used in this paragraph:

''(i) The term 'drug product' means an active ingredient in dosage form that has been approved or otherwise may be lawfully marketed under the Food, Drug, and Cosmetic Act for distribution in the United States.

''(ii) The term 'valid prescription' means a prescription which is issued for a legitimate medical purpose by an individual practitioner licensed by law to administer and prescribe the drugs concerned and acting in the usual course of the practitioner's professional practice.'';

(3) in subparagraph (B), as so redesignated, by inserting ''or who engages in an export transaction'' after ''nonregulated person''; and

(4) adding at the end the following:

''(D) Except as provided in subparagraph (E), the following distributions to a nonregulated person, and the following export transactions, shall not be subject to the reporting requirement in subparagraph (B):

''(i) Distributions of sample packages of drug products when such packages contain not more than 2 solid dosage units or the equivalent of 2 dosage units in liquid form, not to exceed 10 milliliters of liquid per package, and not more than one package is distributed to an individual or residential address in any 30-day period.

''(ii) Distributions of drug products by retail distributors that may not include face-to-face transactions to the extent that such distributions are consistent with the activities authorized for a retail distributor as specified in section 102(46).

''(iii) Distributions of drug products to a resident of a long term care facility (as that term is defined in regulations prescribed by the Attorney General) or distributions of drug products to a long term care facility for dispensing to or for use by a resident of that facility.

''(iv) Distributions of drug products pursuant to a valid prescription.

''(v) Exports which have been reported to the Attorney General pursuant to section 1004 or

1018 or which are subject to a waiver granted under section 1018(e)(2).

''(vi) Any quantity, method, or type of distribution or any quantity, method, or type of distribution of a specific listed chemical (including specific formulations or drug products) or of a group of listed chemicals (including specific formulations or drug products) which the Attorney General has excluded by regulation from such reporting requirement on the basis that such reporting is not necessary for the enforcement of this title or title III.

''(E) The Attorney General may revoke any or all of the exemptions listed in subparagraph (D) for an individual regulated person if he finds that drug products distributed by the regulated person are being used in violation of this title or title III. The regulated person shall be notified of the revocation, which will be effective upon receipt by the person of such notice, as provided in section 1018(c)(1), and shall have the right to an expedited hearing as provided in section 1018(c)(2).''.

SEC. 3653. THEFT AND TRANSPORTATION OF ANHYDROUS AMMONIA FOR PURPOSES OF ILLICIT PRODUCTION OF CONTROLLED SUBSTANCES.

(a) IN GENERAL.—Part D of the Controlled Substances Act (21 U.S.C. 841 et seq.) is amended by adding at the end the following:

''ANHYDROUS AMMONIA

''SEC. 423. (a) It is unlawful for any person—

''(1) to steal anhydrous ammonia, or

''(2) to transport stolen anhydrous ammonia across State lines,

knowing, intending, or having reasonable cause to believe that such anhydrous ammonia will be used to manufacture a controlled substance in violation of this part.

''(b) Any person who violates subsection (a) shall be imprisoned or fined, or both, in accordance with section 403(d) as if such violation were a violation of a provision of section 403.''.

(b) CLERICAL AMENDMENT.—The table of contents for that Act is amended by inserting after the item relating to section 421 the following new items:

''Sec. 422. Drug paraphernalia.
''Sec. 423. Anhydrous ammonia.''.

(c) ASSISTANCE FOR CERTAIN RESEARCH.—

(1) AGREEMENT.—The Administrator of the Drug Enforcement Administration shall seek to enter into an agreement with Iowa State University in order to permit the University to continue and expand its current research into the development of inert agents that, when added to anhydrous ammonia, eliminate the usefulness of anhydrous ammonia as an ingredient in the production of methamphetamine.

(2) REIMBURSABLE PROVISION OF FUNDS.—The agreement under paragraph (1) may provide for the provision to Iowa State University, on a reimbursable basis, of $500,000 for purposes the activities specified in that paragraph.

(3) AUTHORIZATION OF APPROPRIATIONS.—There is hereby authorized to be appropriated for the Drug Enforcement Administration for fiscal year 2000, $500,000 for purposes of carrying out the agreement under this subsection.

Subtitle C—Ecstasy Anti-Proliferation Act of 2000

SEC. 3661. SHORT TITLE.

This subtitle may be cited as the ''Ecstasy Anti-Proliferation Act of 2000''.

SEC. 3662. FINDINGS.

Congress makes the following findings:

(1) The illegal importation of 3,4-methylenedioxy methamphetamine, commonly referred to as ''MDMA'' or ''Ecstasy'' (referred to in this subtitle as ''Ecstasy''), has increased in recent years, as evidenced by the fact that Ecstasy seizures by the United States Customs Service have increased from less than 500,000 tablets during fiscal year 1997 to more than 9,000,000 tablets during the first 9 months of fiscal year 2000.

(2) Use of Ecstasy can cause long-lasting, and perhaps permanent, damage to the serotonin system of the brain, which is fundamental to the integration of information and emotion, and this damage can cause long-term problems with learning and memory.

(3) Due to the popularity and marketability of Ecstasy, there are numerous Internet websites with information on the effects of Ecstasy, the production of Ecstasy, and the locations of Ecstasy use (often referred to as ''raves''). The availability of this information targets the primary users of Ecstasy, who are most often college students, young professionals, and other young people from middle- to high-income families.

(4) Greater emphasis needs to be placed on—

(A) penalties associated with the manufacture, distribution, and use of Ecstasy;

(B) the education of young people on the negative health effects of Ecstasy, since the reputation of Ecstasy as a ''safe'' drug is the most dangerous component of Ecstasy;

(C) the education of State and local law enforcement agencies regarding the growing problem of Ecstasy trafficking across the United States;

(D) reducing the number of deaths caused by Ecstasy use and the combined use of Ecstasy with other ''club'' drugs and alcohol; and

(E) adequate funding for research by the National Institute on Drug Abuse to—

(i) identify those most vulnerable to using Ecstasy and develop science-based prevention approaches tailored to the specific needs of individuals at high risk;

(ii) understand how Ecstasy produces its toxic effects and how to reverse neurotoxic damage;

(iii) develop treatments, including new medications and behavioral treatment approaches;

(iv) better understand the effects that Ecstasy has on the developing children and adolescents; and

(v) translate research findings into useful tools and ensure their effective dissemination.

SEC. 3663. ENHANCED PUNISHMENT OF ECSTASY TRAFFICKERS.

(a) AMENDMENT TO FEDERAL SENTENCING GUIDELINES.—Pursuant to its authority under section 994(p) of title 28, United States Code, the United States Sentencing Commission (referred to in this section as the ''Commission'') shall amend the Federal sentencing guidelines regarding any offense relating to the manufacture, importation, or exportation of, or trafficking in—

(1) 3,4-methylenedioxy methamphetamine;

(2) 3,4-methylenedioxy amphetamine;

(3) 3,4-methylenedioxy-N-ethylamphetamine;

(4) paramethoxymethamphetamine (PMA); or

(5) any other controlled substance, as determined by the Commission in consultation with the Attorney General, that is marketed as Ecstasy and that has either a chemical structure substantially similar to that of 3,4-methylenedioxy methamphetamine or an effect on the central nervous system substantially similar to or greater than that of 3,4-methylenedioxy methamphetamine;

including an attempt or conspiracy to commit an offense described in paragraph (1), (2), (3), (4), or (5) in violation of the Controlled Substances Act (21 U.S.C. 801 et seq.), the Controlled Substances Import and Export Act (21 U.S.C. 951 et seq.), or the Maritime Drug Law Enforcement Act (46 U.S.C. 1901 et seq.).

(b) GENERAL REQUIREMENTS.—In carrying out this section, the Commission shall, with respect to each offense described in subsection (a)—

(1) review and amend the Federal sentencing guidelines to provide for increased penalties such that those penalties reflect the seriousness of these offenses and the need to deter them; and

(2) take any other action the Commission considers to be necessary to carry out this section.

(c) ADDITIONAL REQUIREMENTS.—In carrying out this section, the Commission shall ensure that the Federal sentencing guidelines for offenders convicted of offenses described in subsection (a) reflect—

(1) the need for aggressive law enforcement action with respect to offenses involving the controlled substances described in subsection (a); and

(2) the dangers associated with unlawful activity involving such substances, including—

(A) the rapidly growing incidence of abuse of the controlled substances described in subsection (a) and the threat to public safety that such abuse poses;

(B) the recent increase in the illegal importation of the controlled substances described in subsection (a);

(C) the young age at which children are beginning to use the controlled substances described in subsection (a);

(D) the fact that the controlled substances described in subsection (a) are frequently marketed to youth;

(E) the large number of doses per gram of the controlled substances described in subsection (a); and

(F) any other factor that the Commission determines to be appropriate.

(d) SENSE OF CONGRESS.—It is the sense of Congress that—

(1) the base offense levels for Ecstasy are too low, particularly for high-level traffickers, and should be increased, such that they are comparable to penalties for other drugs of abuse; and

(2) based on the fact that importation of Ecstasy has surged in the past few years, the traffickers are targeting the Nation's youth, and the use of Ecstasy among youth in the United States is increasing even as other drug use among this population appears to be leveling off, the base offense levels for importing and trafficking the controlled substances described in subsection (a) should be increased.

(e) REPORT.—Not later than 60 days after the amendments pursuant to this section have been promulgated, the Commission shall—

(1) prepare a report describing the factors and information considered by the Commission in promulgating amendments pursuant to this section; and

(2) submit the report to—

(A) the Committee on the Judiciary, the Committee on Health, Education, Labor, and Pensions, and the Committee on Appropriations of the Senate; and

(B) the Committee on the Judiciary, the Committee on Commerce, and the Committee on Appropriations of the House of Representatives.

SEC. 3664. EMERGENCY AUTHORITY TO UNITED STATES SENTENCING COMMISSION.

The United States Sentencing Commission shall promulgate amendments under this subtitle as soon as practicable after the date of enactment of this Act in accordance with the procedure set forth in section 21(a) of the Sentencing Act of 1987 (Public Law 100–182), as though the authority under that Act had not expired.

SEC. 3665. EXPANSION OF ECSTASY AND CLUB DRUGS ABUSE PREVENTION EFFORTS.

(a) PUBLIC HEALTH SERVICE ACT.—Part A of title V of the Public Health Service Act (42 U.S.C. 290aa et seq.), as amended by section 3306, is further amended by adding at the end the following:

''SEC. 506B. GRANTS FOR ECSTASY AND OTHER CLUB DRUGS ABUSE PREVENTION.

''(a) AUTHORITY.—The Administrator may make grants to, and enter into contracts and cooperative agreements with, public and nonprofit private entities to enable such entities—

''(1) to carry out school-based programs concerning the dangers of the abuse of and addiction to 3,4-methylenedioxy methamphetamine, related drugs, and other drugs commonly referred to as 'club drugs' using methods that are effective and science-based, including initiatives

that give students the responsibility to create their own anti-drug abuse education programs for their schools; and

''(2) to carry out community-based abuse and addiction prevention programs relating to 3,4-methylenedioxy methamphetamine, related drugs, and other club drugs that are effective and science-based.

''(b) USE OF FUNDS.—Amounts made available under a grant, contract or cooperative agreement under subsection (a) shall be used for planning, establishing, or administering prevention programs relating to 3,4-methylenedioxy methamphetamine, related drugs, and other club drugs.

''(c) USE OF FUNDS.—

''(1) DISCRETIONARY FUNCTIONS.—Amounts provided to an entity under this section may be used—

''(A) to carry out school-based programs that are focused on those districts with high or increasing rates of abuse and addiction to 3,4-methylenedioxy methamphetamine, related drugs, and other club drugs and targeted at populations that are most at risk to start abusing these drugs;

''(B) to carry out community-based prevention programs that are focused on those populations within the community that are most at-risk for abuse of and addiction to 3,4-methylenedioxy methamphetamine, related drugs, and other club drugs;

''(C) to assist local government entities to conduct appropriate prevention activities relating to 3,4-methylenedioxy methamphetamine, related drugs, and other club drugs;

''(D) to train and educate State and local law enforcement officials, prevention and education officials, health professionals, members of community anti-drug coalitions and parents on the signs of abuse of and addiction to 3,4-methylenedioxy methamphetamine, related drugs, and other club drugs and the options for treatment and prevention;

''(E) for planning, administration, and educational activities related to the prevention of abuse of and addiction to 3,4-methylenedioxy methamphetamine, related drugs, and other club drugs;

''(F) for the monitoring and evaluation of prevention activities relating to 3,4-methylenedioxy methamphetamine, related drugs, and other club drugs and reporting and disseminating resulting information to the public; and

''(G) for targeted pilot programs with evaluation components to encourage innovation and experimentation with new methodologies.

''(2) PRIORITY.—The Administrator shall give priority in awarding grants under this section to rural and urban areas that are experiencing a high rate or rapid increases in abuse and addiction to 3,4-methylenedioxy methamphetamine, related drugs, and other club drugs.

''(d) ALLOCATION AND REPORT.—

''(1) PREVENTION PROGRAM ALLOCATION.—Not less than $500,000 of the amount appropriated in each fiscal year to carry out this section shall be made available to the Administrator, acting in consultation with other Federal agencies, to support and conduct periodic analyses and evaluations of effective prevention programs for abuse of and addiction to 3,4-methylenedioxy methamphetamine, related drugs, and other club drugs and the development of appropriate strategies for disseminating information about and implementing such programs.

''(2) REPORT.—The Administrator shall annually prepare and submit to the Committee on Health, Education, Labor, and Pensions, the Committee on the Judiciary, and the Committee on Appropriations of the Senate, and the Committee on Commerce, the Committee on the Judiciary, and the Committee on Appropriations of the House of Representatives, a report containing the results of the analyses and evaluations conducted under paragraph (1).

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section—

''(1) $10,000,000 for fiscal year 2001; and

''(2) such sums as may be necessary for each succeeding fiscal year.''.

Subtitle D—Miscellaneous

SEC. 3671. ANTIDRUG MESSAGES ON FEDERAL GOVERNMENT INTERNET WEBSITES.

Not later than 90 days after the date of enactment of this Act, the head of each department, agency, and establishment of the Federal Government shall, in consultation with the Director of the Office of National Drug Control Policy, place antidrug messages on appropriate Internet websites controlled by such department, agency, or establishment which messages shall, where appropriate, contain an electronic hyperlink to the Internet website, if any, of the Office.

SEC. 3672. REIMBURSEMENT BY DRUG ENFORCEMENT ADMINISTRATION OF EXPENSES INCURRED TO REMEDIATE METHAMPHETAMINE LABORATORIES.

(a) REIMBURSEMENT AUTHORIZED.—The Attorney General, acting through the Administrator of the Drug Enforcement Administration, may reimburse States, units of local government, Indian tribal governments, other public entities, and multi-jurisdictional or regional consortia thereof for expenses incurred to clean up and safely dispose of substances associated with clandestine methamphetamine laboratories which may present a danger to public health or the environment.

(b) ADDITIONAL DEA PERSONNEL.—From amounts appropriated or otherwise made available to carry out this section, the Attorney General may hire not more than 5 additional Drug Enforcement Administration personnel to administer this section.

(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to the Attorney General to carry out this section $20,000,000 for fiscal year 2001.

SEC. 3673. SEVERABILITY.

Any provision of this title held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed as to give the maximum effect permitted by law, unless such provision is held to be utterly invalid or unenforceable, in which event such provision shall be severed from this title and shall not affect the applicability of the remainder of this title, or of such provision, to other persons not similarly situated or to other, dissimilar circumstances.

The SPEAKER pro tempore. Pursuant to House Resolution 594, the gentleman from Florida (Mr. BILIRAKIS) and the gentlewoman from Colorado (Ms. DEGETTE) each will control 30 minutes.

The Chair recognizes gentleman from Florida (Mr. BILIRAKIS).

GENERAL LEAVE

Mr. BILIRAKIS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and to include extraneous material on H.R. 4365.

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

There was no objection.

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

Mr. Speaker, I am very pleased to bring H.R. 4365, the Children's Health Act of 2000, to the floor of the House today. This measure is a result of strong bipartisan, and I underline strong bipartisan, bicameral cooperation and extensive negotiations.

The bill before us today includes the original children's health bill passed by the House in May, as well as provisions to reauthorize the Substance Abuse and Mental Health Services Administration. The Senate passed the revised bill last Friday. Since then, more than a dozen children's health advocacy groups have issued statements publicly applauding the bill and praising this effort.

In developing this legislation, my Committee on Commerce colleagues and I examined many of the difficult barriers we face in working to improve children's health and well-being. Witnesses testified about a variety of serious childhood afflictions, including autism, Fragile X, childhood asthma, and juvenile diabetes.

The bill before us authorizes and reauthorizes children's disease research and prevention activities conducted under the Public Health Service Act. Among its key provisions, the bill establishes a new Pediatric Research Initiative within the National Institutes of Health to enhance opportunities for research and improve coordination of efforts to prevent or cure diseases affecting children.

The bill also addresses a number of specific concerns, including autism, Fragile X, birth defects, early hearing loss, epilepsy, asthma, juvenile arthritis, childhood malignancies, juvenile diabetes, safe motherhood and infant health promotion, adoption awareness, traumatic brain injury, Healthy Start, oral health, vaccine injury compensation, Hepatitis C, autoimmune diseases, graduate medical education in children's hospitals, muscular dystrophy, and rare pediatric diseases.

Equally important, Mr. Speaker, it does not include specific funding earmarks or other controversial provisions.

This legislation incorporates a number of separate legislative proposals, and I would like to acknowledge the efforts of those Members who worked to develop provisions that were included in the bill.

I also want to acknowledge all of the patient advocates, there were many, as there were many Members and also cosponsors of the original children's health bill, who lent us strong support for this initiative. Their dedication helped keep this legislation alive.

We can never estimate the human toll of childhood diseases. However, they also have an enormous financial impact through billions of dollars in increased health care costs. Every dollar spent by the Federal Government on disease research and prevention is an extremely wise investment.

Any parent can tell us that nothing is more heart-wrenching than watching their own child suffer with an illness. As a father and grandfather myself, I know how terrible that can be. Today, however, we have a rare opportunity to do something that will give hope to families devastated by childhood disease.

This bill, Mr. Speaker, also takes great steps to reauthorize and refine

the mission of the Substance Abuse and Mental Health Services Administration. It gives States more flexibility in the use of their block grant funds and follows the trend in other Federal programs to require more accountability based on performance.

The bill authorizes funding for many important services for youths and adolescents. These include youth drug treatment, early intervention for juvenile substance abuse, prevention of methamphetamine and inhalant use, follow-up services for youth offenders released from juvenile justice facilities, comprehensive community services for children with serious emotional disturbances, services for individuals with fetal alcohol syndrome, and prevention of underage drinking and suicide prevention.

The bill also addresses the needs of adults by authorizing grants for emergency mental health centers, programs to divert individuals with mental illness from the criminal justice system, and programs to expand mental health and substance abuse treatment services for the homeless.

In addition, this bill facilitates some physicians' ability to prescribe certain narcotics, such at buprenorpine, that are used in treating narcotics addiction. It also provides a comprehensive strategy to combat methamphetamine use. These provisions were approved by my subcommittee as H.R. 2634, the Drug Addiction Treatment Act of 2000, and this language was carefully worked out with the Committee on the Judiciary.

In closing, Mr. Speaker, I urge all of my colleagues to support this important legislation in addition to reauthorizing the Federal Substance Abuse and Mental Health Services programs. The bill before us will provide vital resources targeted at ending the scourge of childhood diseases.

Mr. Speaker, I want to thank the gentleman from Ohio (Mr. BROWN), a member of the subcommittee, for his tireless efforts. Together, we did put kids ahead of politicians, and I am truly grateful for his commitment to improve the health of our Nation's children.

I also want to recognize the staff who worked to advance this legislation, and first and foremost, to thank my health policy advisor, Anne Esposito, for her hard work and dedication through long hours and extensive negotiations.

I am also grateful to her partner in that effort, Ellie Dehoney from the staff of the gentleman from Ohio (Mr. BROWN). Together they demonstrated the patience and determination necessary to keep this process on track and moving forward.

Additionally, I would like to thank Mr. Jeremy Allen, who was with me for a short time as, I guess, a presidential fellow. He worked to pass the bill through the House and helped with the Senate negotiations; Michael Reilly, who was also with us in that capacity at one time; and, of course, my chief of staff, Todd Tuten, because it was his consent based on our success with the women's health initiative that led to doing this; and, additionally, Dr. Carolyn Sporn, who is a third-year resident at George Washington University in the Emergency room who chose to spend a month in my office to gain the knowledge that I think all medical doctors should have regarding this process.

Together we are doing something good for kids. I urge every Member to support passage of H.R. 4365.

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

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

Mr. Speaker, I am pleased that the House is moving forward today to pass legislation seeking to improve the health care of our Nation's children.

While much of the health focus in the 106th Congress has been in the area of Medicare programs and other areas of health care policy, Congress has largely neglected the area of children's health and development until my colleagues, the gentleman from Florida (Mr. BILIRAKIS) and the gentleman from Ohio (Mr. BROWN), spearheaded this important initiative.

I would like to thank the chairman and the ranking member for their work in this area and really forcing this issue before the end of the 106th Congress.

I, too, want to add my thanks to the staff, particularly John Ford, Judith Bankendorf, and Eleanor Dehoney of the Committee on Commerce and Bruce Lesley from my staff for their outstanding work on this legislation, as it has been improved through every step of the process due to their hard work and diligence.

As the chairman knows, nothing could be more important to our Nation's future than our children. Numerous indicators of the well-being of our children paint a mixed picture. Both in terms of success and shortcomings, they give us a mixed view of what our Nation's future holds.

Reports of both gains and continued unmet needs are also apparent with regard to a variety of other pediatric health care needs including infant mortality, immunization rates, pediatric asthma care, youth violence, and the critically important fact that over 11 million children in this country still remain uninsured.

It is on this latter point, the issue of uninsured children and adolescents, that I hope this Congress will choose to address through legislative action in the near future. We cannot fully address the health care needs of children without addressing the fact that 11 million children still continue to have limited, sporadic, if any, access to health care.

H.R. 4365 takes very important strides to expand pediatric research efforts and increase coordination in Federal resources for a variety of childhood diseases or health problems. While some have questioned such a focus on the needs of children, the Federal Government commitment related to child and adolescent health and development is completely inadequate and desperately needs greater focus and attention to the unique health care problems facing children.

According to a report issued by the President's National Science and Technology Council entitled ''Investing in Our Future: A National Research Initiative for America's Children for the 21st Century,'' the combined research spending for children and adolescents through the Federal Government represents ''less than three percent of the total Federal research enterprise''.

Thus, the Federal Government commits less than 3 percent of its research focus to improve the lives of children despite the fact that they represent over 30 percent of our Nation's population and our future.

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As such, pediatric research and prevention efforts must be at the forefront. As the President's National Science and Technology Council concluded:

''Our Nation has a clear stake in ensuring that all of America's children grow up to be healthy, educated, productive and contributing adults. Scientific research is and will continue to be a catalyst for achieving that goal.''

I would like to highlight those provisions in this bill that come from legislation that I introduced in this Congress, including:

H.R. 4008, the Pediatric Organ Transplantation Improvement Act of 2000. This legislation, introduced with the gentleman from Pennsylvania (Mr. PETERSON), will require that our Nation's organ transplant system recognizes children's unique health care needs and increases research into improving pediatric organ transplantation. For some of our Nation's most vulnerable citizens, children awaiting lifesaving organ transplants, this language should improve their care and even save lives.

H.R. 4594, the Pediatric Diabetes Research and Prevention Act. This initiative, introduced with the gentleman from Washington (Mr. NETHERCUTT), the gentleman from Pennsylvania (Mr. WELDON) and the gentleman from New York (Mr. LAFALCE) as well as in the Senate by Senator COLLINS improves our Nation's research and prevention efforts into pediatric diabetes. The language increases the necessary tools to expand clinical trials on children with diabetes to move some of the remarkable research that we are seeing on diabetes from the laboratory bench to the patient's bedside.

H.R. 5198, the Children's Research Protection Act. This legislation, introduced with the gentleman from Ohio (Mr. LATOURETTE) and Senators DODD and DEWINE, promotes the improvement of pediatric research and protections for children involved in medical

research. The provision requires that all HHS-funded and regulated research comply with pediatric-specific human subject protections and has many other important provisions.

Finally, H.R. 1313, the Patient Freedom from Restraint Act of 1999. This initiative, which was introduced as companion legislation to bills by Senators LIEBERMAN and DODD, would take important steps to protect both children and adults with mental illness or mental retardation from being inappropriately placed in endangering restraints or seclusion, which has caused personal harm and even death.

There are many other fine provisions of this bill. Several I would like to talk about is the reauthorization of the Substance Abuse and Mental Health Services Administration, or SAMHSA, Act which improves mental health and substance abuse services for children and adolescents. There are several provisions that have become known as the Columbine provisions because they deal with children and adolescents who are at great risk. One, grants to public entities, seeks to develop ways to assist children in dealing with violence. Another allows the Secretary to use up to 2.5 percent of the funds appropriated for discretionary grants for responding to emergencies. Yet another reauthorizes the high-risk youth program which provides funds to public and nonprofit private entities to establish programs for the prevention of drug abuse among high-risk youths. There are many other fine provisions of SAMHSA which are in this bill and which we will hear about from my colleagues.

In addition, the bill has numerous other important children's health provisions, including fragile X research, pediatric asthma, birth defects, hearing loss and newborn screening, childhood cancer, traumatic brain injury, child care safety, graduate medical education for our Nation's children's hospitals and lead poisoning.

I am proud of this legislation. I know we are all proud of this legislation. Again I would like to thank the chairman and the ranking member for their courageous leadership on this broad bill.

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

Mr. BILIRAKIS. Mr. Speaker, I yield 3 minutes to the gentleman from Tennessee (Mr. BRYANT), a member of the Subcommittee on Health and Environment and a very conscientious and active Member.

Mr. BRYANT. Mr. Speaker, I thank the gentleman for yielding me this time. I thank him for bringing this bill to the floor and for his leadership on all health care issues.

Mr. Speaker, I do rise in support of the Children's Health Act and would like to alert my colleagues to two issues which specifically are addressed in this bill and which are of concern to me and interest to me: Duchenne muscular dystrophy and day care safety. Duchenne muscular dystrophy is the most common and most catastrophic form of genetic childhood disease, occurring in one of every 3,500 live births and generally killing its victims in their late teens or early twenties.

My first experience with a family suffering from this devastating disease was in 1998 when my constituents Roy and Carol Henderson from Memphis first contacted my office. Their son had been diagnosed with Duchenne muscular dystrophy. I remember the pain and frustration that that strong family expressed to me as they began to search for answers to the difficult questions of why their child was afflicted with this awful, debilitating disease. Why were there so few treatment options for their son? And, most importantly, why had the government failed to prioritize more Federal resources toward finding a cure to this terrible disease?

Despite the 1987 discovery of the dystrophin gene, the survivability of this childhood disease has not been extended in any significant way. For decades, the only treatment known to somewhat alter the course of this disease was the use of steroids whose serious side effects are well known.

For these reasons it is imperative that the National Institutes of Health, NIH, begin to focus some of its Federal resources toward muscular dystrophy research. Today we will be voting on comprehensive children's health legislation which directs NIH to provide a more coordinated emphasis on muscular dystrophy research and assigns the National Institute of Neurological Disorders and Stroke with the responsibility of leading NIH's efforts in this promising field.

The bill also includes legislation authored by Senator BILL FRIST and introduced in the House by myself and the gentlewoman from New York (Mrs. MCCARTHY). This section will provide the States with over $200 million to improve the safety of its day care centers throughout the United States. The bill would allow States the flexibility to use the funding for a number of purposes, including training child care providers, rehabilitating child care facilities, improving the safety of transporting children and conducting criminal background checks for child care providers. With the all too frequent reports of abuse and neglect in child care facilities, there was a need to give States additional resources to provide quality child care. Under the bill's formula, my State, Tennessee, would receive $4.2 million to give child care providers the tools needed to offer safe, affordable, quality child care to the children of Tennessee.

In conclusion, too many of our children needlessly suffer and even die from abuse, birth defects and diseases which can be prevented given the proper investment of our time and resources. With the passage of this bill, Congress will renew its commitment to America's children. I am pleased that the sponsors of this legislation recognized the seriousness of these issues by including them in this legislation. I encourage my colleagues to support its passage.

Ms. DEGETTE. Mr. Speaker, I am pleased to yield 2 minutes to the gentlewoman from Texas (Ms. JACKSON-LEE).

Ms. JACKSON-LEE of Texas. Mr. Speaker, I thank the gentlewoman from Colorado for her leadership along with the gentleman from Ohio (Mr. BROWN), who is the ranking member, and as well the chairman, the gentleman from Florida (Mr. BILIRAKIS) for their leadership.

This is an important issue. I know there are many legislative initiatives that are found in this legislation dealing with children's health. I applaud the reauthorization of SAMHSA dealing specifically with the important issues of substance abuse and also the provisions that assist children in dealing with violence as well as the $2.5 million in grants to assist local communities in reauthorizing high-risk programs dealing with children susceptible to drug use. That is clearly still a viable concern in our communities. My 15-year-old son acknowledges that we have a problem, and I imagine that he may be representative of many of our children around the Nation.

I would hope, however, that as we look at the question of children's health as we will be hearing from many members of the Democratic Caucus discussing specifically this question of children's health and this poor state of children's health in the Nation that we will continue to do this in a more deliberative fashion, that we will be able to give more time to addressing the needs of children, particularly the concerns I have and the legislation I filed, H.R. 3455, the Give a Kid a Chance omnibus mental health bill that is a comprehensive assessment of providing resources to parents, immediate resources so that children who are in need of access to mental health care are not channeled to the juvenile justice system. That is what happens now.

Along with the 11 million children that are uninsured, can you imagine the children that do not have access to mental health services? And even though I know that there are provisions in this bill, there is still much to be accomplished.

Might I also take note of the charitable choice provisions that raises much concern. I wish we would explore this question. We are for these issues, but we want to have them in a nondiscriminatory fashion. I would have hoped the Committee on the Judiciary would have been allowed to address this question in a fair manner. Certainly I think we are moving forward on children's health, but we still have a long way to go on the needs of children's mental health.

Mr. BILIRAKIS. Mr. Speaker, I am pleased to yield 3 minutes to the gentlewoman from Connecticut (Mrs. JOHNSON), my 98th Congress colleague.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I thank my friend and the honored chairman of this subcommittee the gentleman from Florida (Mr. BILIRAKIS) for bringing forward a really extremely important bill that will provide many good services for children throughout America.

There are two specific provisions intended to protect children in therapeutic group homes, patients in psychiatric hospitals, old folks in nursing homes and youths in juvenile detention centers from hurting themselves and others. The intent behind these provisions is to ensure that vulnerable populations who live behind closed doors are safe and treated with respect and dignity. This bill establishes standards for the clinical use of restraints to physically stabilize a patient and protocols for time-out situations that require the patient to be separated from others. This is the first time that Congress has attempted to legislate clinical practices in health care facilities as well as nonmedical community-based facilities. For this reason it is very important that this legislation be clear and unambiguous about the kinds of practices that will be prohibited and the kinds that will be encouraged.

Unfortunately, the legislation is not exactly clear. A distinction is made in the legislation between health care facilities and nonmedical community-based facilities, but there is no definition of either. Where does a residential treatment center fit in? What rules will apply?

A standard practice in treatment facilities is the use of therapeutic holding to calm a patient who is out of control through proximity and physical touch. Therapeutic holds are used to protect children. They are used to express affection. They are used to calm children. I worked as an aide on the children's ward of a major psychiatric hospital and I know the power of therapeutic holds. I chaired the community child guidance clinic in my hometown for many years and as a State senator visited residential facilities for children with serious psychiatric problems throughout Connecticut. We must not deny these critical facilities the ability to provide loving help for our kids.

My reading of section 591(d)(1) in part H where restraint is defined as excluding ''any method that involves the physical holding of a resident'' would allow the practice of therapeutic holding to be used when appropriate to allow residents to resume their activities as soon as possible. It is my expectation that the HHS regulations will reflect this reading and that the Committee on Commerce agrees that therapeutic holds are indeed excluded from any definition of restraint.

While the legislation calls for training and staff development in the use of restraint and seclusion methods, two things are unclear: Who will provide this training and who will pay for it? I would hope, and it would be very helpful, if HHS would promulgate all regulations, both those for health care facilities and those for nonmedical community-based facilities, at the same time to avoid confusion and to ensure seamless delivery of services to the most vulnerable populations in our country.

In summary, I thank the chairman for his leadership on this legislation.

Ms. DEGETTE. Mr. Speaker, I am pleased to yield 2 minutes to the distinguished gentleman from Texas (Mr. EDWARDS).

Mr. EDWARDS. Mr. Speaker, I stand to speak not against the underlying bill but specifically in regard to the so-called charitable choice language in the bill. Let me make five points about that language:

First what it says is Federal tax dollars can go directly to churches, synagogues and houses of worship. I believe that is clearly unconstitutional and for good reason. Federal subsidies of our churches and houses of worship is something we have not done for 200 years in our country.

The second point. It mentions this language under the guise of not wanting to have discrimination against religious organizations. That might be cute marketing but it is faulty logic and it is unconstitutional logic. What that says in effect is that the Bill of Rights and the first amendment thereof discriminates against religion. The reason Mr. Madison, Mr. Jefferson and our Founding Fathers set up a distance between government and religion and church and state was to protect religion, not to discriminate against it. Their argument is that I guess the Bill of Rights is discriminating against religion.

The third point is it talks about stopping discrimination. Charitable choice language in this bill actually subsidizes religious discrimination.

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Very clearly it says you can take my Federal tax dollars, your Federal tax dollars, and put out a government paid for sign that says ''No Catholics, no Jews, no Protestants need apply here for this federally subsidized job.'' That is wrong. It is wrong to have Federal taxpayers paying for religious job discrimination.

The fourth point is that charitable choice language in the name of helping religion is actually going to bring government auditing on our churches. According to the language of the bill itself, the churches and houses of worship are going to have to face the same auditing requirements as non-religious entities. I am not sure our religious entities are helped in America by having Uncle Sam come in and audit.

This language is unnecessary, it is harmful, it is unconstitutional, and it should not be in this bill.

Mr. BILIRAKIS. Mr. Speaker, I am pleased to yield 1 minute to the gentleman from Washington (Mr. NETHERCUTT), who has been quite a leader in diabetes in this House.

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

Mr. NETHERCUTT. Mr. Speaker, I thank the gentleman from Florida and the gentlewoman from Colorado, both great friends of mine, with respect to their commitment to curing the disease of diabetes that affects so many people around this world, especially in the United States of America.

This bill is a great bill with respect to its attention to diabetes. It creates a national registry to track the incidence of juvenile diabetes; it establishes long-term epidemiology studies, in which persons with type 1 diabetes will be followed for 10 years; it addresses type 2 diabetes in youth; it creates a critical trial infrastructure for juvenile diabetes; it provides a look at animal studies, which will provide hope and promise that a true vaccine can be developed to prevent type 1 diabetes in humans; and it also contains a loan repayment program to encourage research.

Overall, this bill is a very good effort as it relates to diabetes, and I am very much supportive of it. I hope that all the 270 members of the House Diabetes Caucus will get on board and support it as well.

Ms. DEGETTE. Mr. Speaker, I am pleased to yield 4 minutes to the gentlewoman from California (Mrs. CAPPS).

Mrs. CAPPS. Mr. Speaker, I thank my colleague for yielding me time.

Mr. Speaker, I rise in very strong support of this legislation. H.R. 4365 reflects consensus around issues that are of deep importance to all of us, keeping our children healthy and free of substance abuse and mental illness.

This bill addresses major challenges in childhood disease and reauthorizes the Substance Abuse and Mental Health Services Administration. As a school nurse, a mother, and now a grandmother, children's health is an issue that has been of great concern to me throughout my entire life.

This bill would dedicate more Federal spending and intensify efforts on childhood diseases, including fragile X, autism, early hearing loss, juvenile diabetes and other child-specific conditions and diseases. This legislation does much to help young victims of childhood disease.

Mr. Speaker, parents and families with children who suffer from these childhood diseases have put their heart and soul into passing this legislation, and we must thank them for their tireless efforts. They have come forward with personal, often very painful stories, illustrating the need for this bill. I commend them, and I urge support for this important legislation.

This bill also includes reauthorization of SAMSHA, based on a version of legislation that I introduced earlier this year. This reauthorization will address substance abuse as it relates to children, in addition to adults, with regard to under-age drinking, children

and violence, and fetal alcohol syndrome, to name a few.

To the extent that we can protect our children from alcohol and substance abuse, we reduce their chances of addiction or abuse as adults. Drug addiction is often an intergenerational family problem, with future use by children of addicts a very common occurrence. Sadly, this is a pattern I saw regularly as a school nurse.

This legislation also includes a bill I authored, the Youth Drinking Elimination Act. This legislation, which has the support of the American Academy of Pediatrics, will provide competitive grants to private organizations and governmental agencies through SAMSHA to develop and implement programs and services to reduce underage drinking.

I have seen the success of SAMSHA prevention programs in my own district, particularly with Santa Barbara's Fighting Back and also with Life Steps in San Luis Obispo. They provide highly successful public awareness initiatives, mentoring, criminal justice partnerships and health care intervention programs.

Mr. Speaker, SAMSHA reauthorization is the best way we can comprehensively address the problems of substance abuse and mental health confronting our communities. These problems are just too great for us to treat in a piecemeal fashion.

I urge my colleagues to support this much-needed legislation.

Mr. BILIRAKIS. Mr. Speaker, I yield 1 minute to the gentlewoman from Illinois (Mrs. BIGGERT).

Mrs. BIGGERT. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, I want to bring to the attention of my colleagues a provision in this legislation that I have authored that will help us address the growing problem of so-called ''club drugs,'' such as Ecstasy.

Five months ago, three young adults in the Chicago area, including two in my Congressional District, died after ingesting what they thought was the club drug Ecstasy, but was in fact a much more powerful cousin called PMA.

These club drugs are flooding our country, and it is not hard to see why. Ecstasy costs just pennies to make, but it is sold here in the United States for as much as $40 per tablet, and the penalties for trafficking are a joke. While the youth of this country believe that Ecstasy is harmless, the problems they face range from paranoia to brain damage, and even to death.

Under this bill, the penalties for Ecstasy trafficking will be increased and we will authorize $10 million to teach our children that these club drugs are dangerous. I believe that this will get the attention of traffickers and the users of Ecstasy, and I urge passage of this bill.

Ms. DEGETTE. Mr. Speaker, I am pleased to yield 2 minutes to the gentlewoman from California (Ms. MILLENDER-MCDONALD).

Ms. MILLENDER-MCDONALD. Mr. Speaker, I thank all of those who have been in the leadership role in bringing this important legislation to the floor.

I support this legislation and any legislation that will help and protect America's children. I do want to bring attention though to one provision that is very dear to my heart and truly affects the inner-city communities in my district. That provision authorizes funding for important life-enhancing and life-saving asthma initiatives.

As author of the Asthma Awareness Education and Treatment Act and founder of the Congressional Asthma Task Force with the gentleman from Texas (Mr. BARTON) and Senators DURBIN and DEWINE, I have been a vocal and unyielding advocate for America's right to breathe.

Countless children and families in my district, which includes Watts, Compton and other low-income inner cities, are literally struggling to breathe, primarily because they lack information and access to effective long-term asthma management medical care.

While the rate of asthma prevalence has grown throughout the country, including rural and suburban areas, it has devastated our inner cities minorities and low-income families. The asthma death rate is twice as high among African Americans, and a staggering four times higher for African-American children. African Americans are also five times more likely to seek emergency room care for asthma, which does not provide long-term management for this disease.

Asthma is also more prevalent among all age groups in lower-income families. In families with an income average of less than $10,000, 80 out of 1,000 individuals have asthma, while in families with an average income of $20,000 to $34,000, 54 out of 1,000 individuals have asthma. That means close to 400,000 more people with extremely limited earnings have asthma.

Mr. Speaker, we can do better. This bill provides that type of funding, and I welcome and appreciate this legislation.

Mr. Speaker, today we will pass historic legislation which will help and protect America's children. The Children's Health Act is the result of bipartisan dedication to ensuring that we address critical problems facing our youth today. From drug abuse to youth violence to prenatal care, this legislation is comprised of critical programs that will impact the lives of children most in need.

While I embrace all the initiatives included in the Children's Health Act, today I would like to address one provision in particular, which is dear to my heart and will truly affect the inner-city communities in my district. That provision authorizes funding for important, life-enhancing and life-saving asthma initiatives.

As author of the Asthma Awareness, Education and Treatment Act and founder of the Congressional Asthma Task Force with Congressman BARTON and Senators DURBIN and DEWINE, I have been a vocal and unyielding advocate for America's right to breathe. Countless children and families in my district which includes Watts, Compton and other low-income inner-city communities are literally struggling to breathe primarily because they lack information and access to effective, long-term asthma management medical care. While the rate of asthma prevalence has grown throughout the country, including rural and suburban areas, it has devastated our inner-cities, minorities and low income families. The asthma death rate is twice as high among African Americans and a staggering four times higher for African American children. African Americans are also five times more likely to seek emergency room care for asthma, which does not provide long-term management of this disease. Asthma is also more prevalent among all age groups in lower income families. In families with an annual income of less than $10,000, 80 out of 1,000 individuals have asthma while in families with an annual income of $20,000 to $34,999, 54 out of 1,000 individuals have asthma—that means close to 400,000 more people with extremely limited earnings have asthma.

Whatever your income, we are all paying the price for the 160% increase in asthma among preschool children over the past decade. The total cost of asthma to Americans was close to $12 billion in 1998. Parents miss work, children miss school, and too many cases are treated in emergency rooms that could have been treated, or in some situations prevented, by education, medication and ongoing management by a physician.

Today with the passage of the Children's Health Act, we are taking meaningful steps to curb this staggering growth in asthma cases, its high cost to society, and its disproportionate effect on minorities and low income families. This bill provides comprehensive asthma services to children, mobile health care clinics, patient and family education on managing asthma, and identification of children eligible for Medicaid, and other children's health programs.

In representing some of the poorest areas of the country in South Central Los Angeles, I have seen the dire need for community assistance, and that is why I applaud the efforts of Senator DURBIN to ensure this legislative language was included in the Senate-passed bill. Furthermore, I urge my colleagues to not only vote for the Children's Health Act but to ensure that you inform your constituents of the asthma services this bill creates. As Members of Congress, it is our job to educate our constituents on the policies we enact and empower them to use the programs we create to improve their lives.

Mr. BILIRAKIS. Mr. Speaker, I am pleased to yield 2 minutes to the gentleman from South Carolina (Mr. DEMINT).

Mr. DEMINT. Mr. Speaker, I rise today to highlight one of the specific provisions of this child health package, the Infant Adoption Awareness Act.

It is truly my privilege to stand here and thank my colleagues in the House and Senate and on many different sides of the family planning issue for their ability to come together and pass adoption provisions which allow us to celebrate life by celebrating adoption.

I would like to thank the leaders in sponsoring and negotiating this legislation, the gentleman from Virginia

(Chairman BLILEY); the ranking member, the gentleman from Michigan (Mr. DINGELL); Senator FRIST; Senator KENNEDY.

In particular, I would like to thank and honor the distinguished chairman of the Committee on Commerce, the gentleman from Virginia (Mr. BLILEY), for his tireless efforts on behalf of adoption. As an adoptive father and co-chairman of the Congressional Coalition on Adoption, as well as the chairman of the House Committee on Commerce, he has championed the adoption issue to help build happy, loving homes across America.

I would also like to thank Marc Wheat of the Committee on Commerce staff for his excellent work and dedication and persistence on this project.

Mr. Speaker, I am pleased that the infant adoption awareness provisions in this bill are a step in the right direction to bring complete and accurate adoption information to women facing unplanned pregnancies. These women in difficult circumstances deserve to hear about the options from a well-trained counselor who can provide accurate, up-to-date information on adoption.

This act provides professional development for pregnancy counselors in adoption counseling. The training will enable pregnancy counselors to feel confident in their knowledge of the adoption process, relevant State and local laws, and the legal, medical and financial resources which can be provided to women with unplanned pregnancies.

Mr. Speaker, I know that it is not easy to get a diverse group of organizations representing a wide variety of interests to agree on anything. I am therefore particularly delighted to be on the floor today praising the infant adoption awareness component of this bill, which reflects the input of a broad range of organizations. I want to thank everyone for their support.

Ms. DEGETTE. Mr. Speaker, I am very pleased to yield 2 minutes to the gentlewoman from the District of Columbia (Ms. NORTON).

Ms. NORTON. Mr. Speaker, I thank the gentlewoman for yielding me time, and I especially thank her and the manager on the other side for the hard work that succeeded in bringing this bill that we have waited so long to get to the floor.

Mr. Speaker, I must say we had no right to subject such an important bill to the constitutional attack it is going to get in the courts almost immediately. We have marred this bill by incorporating two provisions that involve deliberate discrimination. At least one of them puts the bill at constitutional peril. That is the constitutional choice provision.

I am a former Chair of the Equal Employment Opportunity Commission. Title VII gives the broadest deference to religious institutions. They can discriminate in employment involving religion, and even in secular activities that they carry out, and even if conduct as they see it is against their religion.

But once you give a religious organization the right to administer Federal funds, our law and our Constitution require equal treatment. Title VI and title VII both make that clear, and certainly the Constitution does.

We are funding churches, synagogues, other religious entities, as if they were Federal agencies. That in itself raises the most serious constitutional questions, because these are pervasively religious institutions, and that is exactly what the Supreme Court says you cannot fund.

Then we go one unconstitutional step further. We allow these religious institutions to discriminate as to whom they hire to administer Federal funds. That is where the line surely must be drawn.

We go further in discriminating in this bill. We carry into this bill discredited, discriminatory, mandatory sentencing minimums, and we carry it to new legislation, turning a deaf ear to the Federal courts and to all our experience. Worse, we effectively exempt white defendants from mandatory minimums, while assuring black and Hispanic defendants will get them. That is deliberate discrimination. That is the very definition of racism.

Mr. BILIRAKIS. Mr. Speaker, I am pleased to yield 3 minutes to the gentleman from Pennsylvania (Mr. GREENWOOD), who, as has already been said, has spent an awful lot of time particularly on the autism portion of this legislation, and so many other children's issues.

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

Mr. GREENWOOD. Mr. Speaker, I thank the gentleman for yielding me time and for his hard work. He has really been the leader on this.

Mr. Speaker, this is one of the happiest days for me in the House in 8 years here, because of the importance of this bill for America's children. It does so much that none of us can do it justification in a few minutes so I just want to just focus on the autism part.

Autism is not a rare disease. It is the third most common developmental disorder to affect children, following mental retardation and cerebral palsy. Autism currently affects over 400,000 individuals in the United States. One of every 500 children born today will be faced with autism.

The third most common developmental disorder, autism is more prevalent than Down syndrome, childhood cancer or cystic fibrosis. It is a lifelong, severe neurological disorder that usually manifests itself in children during their first two years of life and causes severe impairment in language, cognition and communication.

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Mr. Speaker, I have a friend. His name is John. He lives in California. He has a little boy named Dov. He told me about how this young son of his was coming along, developmentally meeting all of the milestones. And as a father, I can relate to that. I think the greatest joy of childhood is watching your children move along the developmental milestones.

John said that at a certain stage his son just sort of drifted off, and it was like watching him on an ice flow drifting away, because he could no longer communicate. He could not say ''Mommy,'' could not say ''Daddy,'' and he has been impossible to really reach ever since then.

John and his friends, other parents of autistic children, formed an organization. Theirs is called Curing Autism Now, CAN. In my district, we have mothers and fathers who created Caring and Sharing. They are committed to doing something about these children. They are committed to trying to find a cure, to find a way to identify this disorder early.

Mr. Speaker, what this bill will do for these parents who have struggled, because for many, many years doctors actually did not understand what autism was, did not recognize the symptoms and blamed the parents. Blamed usually the mothers and said that they were cold and dispassionate and that is why their children were regressing. What a cruel thing to do to a parent struggling with this awful malady. Doctors still are lacking in their ability to recognize childhood autism early.

What this bill will do is create five research centers geographically dispersed around the country, so that parents who know that there is something wrong with their child can go to get diagnosis, to get their child in an early clinical program to find out what the state of the art is in treatment, and what the state of the art is in curing this disease.

I am delighted and proud today that the House of Representatives is going to answer the prayers of these parents.

Ms. DEGETTE. Mr. Speaker, I yield 2 minutes and 15 seconds to the gentleman from Virginia (Mr. SCOTT).

Mr. SCOTT. Mr. Speaker, although I support the children's health part of the Children's Health Act, I rise to oppose the bill for several reasons.

First, I must object to the process by which we merge an anti-drug bill and attacks on religious liberty into legislation dealing with children's health. Mr. Speaker, the anti-drug part of the bill provides for more mandatory minimum sentences, making penalties for amphetamine abuses comparable to those for abusing methamphetamine and crack cocaine, which is 5 years for 5 grams of possession.

It is interesting to note that the majority has taken out the mandatory minimums for penalties for Ecstasy, a methamphetamine-based drug which is prevalent in the middle-class white community. This is curious, because crack cocaine, prevalent in the African-American community, Draconian

mandatory minimums. Methamphetamine, prevalent in the Hispanic community, mandatory minimums. And for Ecstasy and powder cocaine, prevalent in the white community, no mandatory minimums.

Now, I oppose mandatory minimums for the same reason the Judicial Conference of the United States recently wrote to Chairman HYDE. They said that mandatory minimums are a bad idea because they treat dissimilar offenders in a similar manner, offenders who can be quite different with respect to the seriousness of their conduct or a danger to society. Mandatories require the sentencing court to impose the same sentence on offenders, when sound policy and common sense call for reasonable differences in punishment. But this bill requires no exception except for those drugs used in the middle-class white community.

Additionally, I oppose the bill because it attacks our civil rights laws. It contains the charitable choice, as has already been mentioned on the floor. Let me mention that if this bill passes, some sponsors of federally sponsored programs, not church-run programs, federally funded programs will be able to say for the first time in 30 years that ''we do not hire your kind because of your religion.''

Mr. Speaker, if this bill passes, it contains counterproductive mandatory minimums applied in a racially discriminatory manner and allows religious bigotry to be practiced with Federal funds. There seems to be a suggestion that if the dollar amount is high enough and the programs are good enough, that civil rights can be bought and sold.

Mr. Speaker, I will not vote for this bill, even though it includes a good Children's Health Care Act.

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

Ms. DEGETTE. Mr. Speaker, I yield 1 minute to the gentlewoman from California (Mrs. NAPOLITANO).

Mrs. NAPOLITANO. Mr. Speaker, I thank the gentlewoman from Colorado (Ms. DEGETTE) for yielding me this time.

Mr. Speaker, this bill includes provisions for substance abuse and mental health reauthorization, which allows us to think about our Latino adolescents, ages 9 to 14, leading the Nation in attempted suicide, depression, self-reported gun handling, asthma, diabetes, besides an increase in HIV/AIDS cases and teen pregnancy.

I am sorry to have to recognize the need to pay special attention to this segment of the population who are facing great challenges, and I am thankful for the funding. It will help our communities, schools, community-based organizations work together with families to combat this phenomenon in the United States.

Mr. Speaker, the violence, the drugs, the cultural assimilation, peer pressure, dysfunctional families, environment, media are all some of the causes we must help our adolescents deal with. Our youngsters are our future; and we must neither neglect, ignore, nor turn our backs on them. They do not vote, but let us give them a voice for the future.

Mr. BILIRAKIS. Mr. Speaker, I yield 7 minutes to the gentleman from Arkansas (Mr. HUTCHINSON), a member of the Committee on the Judiciary.

Mr. HUTCHINSON. Mr. Speaker, I thank the gentleman from Florida (Mr. BILIRAKIS) for yielding me this time.

Mr. Speaker, I am pleased to speak in support of this bill, especially in support of the bill's provision dealing with the growing nationwide threat of methamphetamine. The legislation is substantially similar to the Methamphetamine Antiproliferation Act that we considered on the House side in Committee on the Judiciary. It was introduced by the gentleman from Utah (Mr. CANNON).

The bill was brought up in committee after the Subcommittee on Crime traveled across the country and held hearings on the growing problem of methamphetamine. The subcommittee in these hearings heard from law enforcement officials, treatment and prevention organizations, State crime laboratories and concerned community leaders.

Some of the most compelling testimony came from the meth addicts themselves. One recovering addict said that meth is so consuming, that everything from family to employment, from self-dignity to self-restraint is sacrificed for meth.

Mr. Speaker, this threat is real and immediate. My own State of Arkansas was recently declared to have the highest number of meth lab seizures per capita in the Nation. A similar story is repeated across the country. The number of labs cleaned up by the DEA has almost doubled each year since 1995. Last year, more than 5,500 labs were seized by the DEA and other enforcement officials.

This resulted in millions of dollars spent on cleaning up pollutants and toxins left behind by the operators of these labs, which can run as much as $10,000 per lab. But let me emphasize that the legislation, the provisions in the bill concerning meth are balanced in its approach.

First of all, the bill provides additional resources to fight the production and use of methamphetamine. It provides training for State and local agencies in handling the toxic waste created by meth labs, and it provides for stiff penalties for the manufacturing and trafficking of meth.

But in addition, besides the enforcement side, it authorizes significant funding for drug prevention and treatment efforts. $10 million is allocated for State grants for addiction treatment, and $15 million for education programs. So it is a balanced approach to dealing with the problem of meth.

If we look at some of the specifics of the legislation, it makes the penalties for manufacturing and trafficking amphetamine, a lesser-known but no less dangerous drug than meth, the same as methamphetamine. But it increases the penalties when there is a substantial risk of harm to human life or the environment, which is many times the case with meth labs.

It also criminalizes the interstate transportation of anhydrous ammonia, which is used by farmers in the production of fertilizer, but is also used in the production of methamphetamine. And so to help the farmers, though, the legislation authorizes funds to research alternative substances for farming and other uses that cannot be used in making meth.

It requires meth lab operators to reimburse society for the environmental and physical damage they cause through their activity. And it authorizes $5.5 million for DEA training of State and local law enforcement in meth lab detection and investigation techniques.

Mr. Speaker, I could go on about some of the specific provisions of the bill, but it helps us deal with the problem. There are some of the objections raised by the methamphetamine legislation that were deleted from this bill. For example, provisions allowing for delayed notice of a search warrant have been deleted. Penalties for the advertisement of illegal drugs and drug paraphernalia have been deleted. So some of those questionable parts are not in this legislation.

I commend the gentlewoman from Illinois (Mrs. BIGGERT), who has done an excellent job of dealing with the problem of Ecstasy and the club drugs. Those provisions she has described are also in the legislation.

Let me just make some personal comments about the drug problem. When I grew up in northwest Arkansas on the farm, I became aware of the drug problems on the nightly news, thinking it did not affect us in the rural areas. But the National Center for Addiction and Substance Abuse announced recently that the drug use among young teens in rural America is now higher than in the Nation's large urban centers. In fact, eighth graders living in rural America are 100 percent more likely to use amphetamines, 34 percent of rural eighth graders are more likely to smoke marijuana than kids in urban areas.

Mr. Speaker, this should be a wakeup call to parents and community leaders in our country. As a former Federal prosecutor, as a legislator, but most importantly as a father of teenagers, my heart aches over the lives that are ruined by the gripping terror of meth that overpowers so many, from the curious teenager to the innocent victim of its violence.

Recent surveys show that in 1999, 54 percent of high school seniors had used an illicit substance. The number has risen for the past 6 of 7 years. These statistics show that drug-induced deaths now exceed the national murder

rate. These statistics are a call to action. But the cost does not stop with physical violence. The social consequences are equally devastating. Just last August, police raided a heavily armed meth lab in Conway, Arkansas, after discovering that a baby living in the drug trailer had been left alone and had eaten the drugs left strewn around the trailer. Clearly, additional resources are needed to thwart the damage threatening the next generation. That is what is provided in this legislation.

Mr. Speaker, I would like to respond to the objection raised by the gentleman from Virginia (Mr. SCOTT). He has indicated that this creates new mandatory minimums. I understand that he now agrees that new mandatory minimums are not provided in this legislation. There are no new mandatory minimums.

Secondly, there was a question raised about the discriminatory impact of sentences between amphetamine, crack cocaine, and some of the club drugs. First of all, we tried and I think we had a preferable House bill, but this is the Senate bill and I think we probably can improve upon that. I am willing to work with the gentleman from Virginia to make sure that we have equal treatment.

We are giving direction to the Sentencing Commission, and I hope they come up with recommendations that are fair and nondiscriminatory. But we will be happy to look at that in the next Congress as well.

So I am pleased to support this legislation. I ask my colleagues to support it as well. It is fair, and it is what addresses the problems that faces our young people today.

Ms. DEGETTE. Mr. Speaker, I yield 3 minutes to the gentleman from Texas (Mr. BENTSEN).

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

Mr. BENTSEN. Mr. Speaker, I rise today in strong support of the Children's Health Act, legislation that would reauthorize children's health research and prevention programs, graduate medical education programs for children's hospitals, substance abuse and drug abuse prevention and treatment programs, and safety of child care programs.

As an original cosponsor of many of the initiatives that are included in this comprehensive bill, I am pleased that Congress will be acting to protect children's health.

One of the most important provisions is the reauthorization for 5 years of the Graduate Medical Education Program for independent children's hospitals. As one who represents the largest independent children's hospital in the United States, I strongly support the role that pediatric hospitals play in advancing pediatric medicine in the training of physicians dedicated to children's health care needs.

1145

Under the current law, Medicare, which is the main funder of graduate medical education in the United States, does not provide funding for pediatric residencies for freestanding children's hospitals such as Texas Children's Hospital in my district because these hospitals, of course, treat a very small number of Medicare patients who are under the disability program.

Last year, Congress enacted a law that provided a one-time capped entitlement for pediatric Medicare education programs. This legislation would rightly extend this valuable program for 5 years.

Mr. Speaker, I am also working with my colleagues to ensure that the pediatric graduate medical education program receives sufficient funding through the annual appropriations process. Earlier this year, the House of Representatives approved for the fiscal year 2001 Labor, Health and Human Services and Education appropriations bills $80 billion for pediatric graduate medical education, an increase of $40 million, over this year's program. I am committed to maintaining this funding level as the budget is finalized.

Another important issue in this bill is the pediatric research initiative that would require the National Institutes of Health to conduct pediatric biomedical research at the NIH. In particular, this initiative will ensure that more research is done on how diseases affected children as compared to adults. In most cases, clinical trials are conducted on adults without any consideration of how these drugs would affect children.

This initiative would also encourage the development of pediatric clinical trials to ensure that safe and effective drug treatments are available. When children face life-threatening diseases, it is very difficult to determine how much and what type of treatments should be given to them because there is insufficient information about how these treatments would affect them.

With more data in clinical trials, there will be more options for children who are fighting for their lives. The bill also directs the National Institutes of Health to conduct more research on diseases which directly affect children such as hearing loss, autism, asthma and juvenile diabetes.

I think this is a step in the right direction. I commend the gentleman from Florida (Mr. BILIRAKIS) and the ranking members of the Subcommittee on Health and Environment, and I encourage my colleagues to adopt this bill.

Mr. BILIRAKIS. Mr. Speaker, I yield 3 minutes to the gentleman from Kansas (Mr. MORAN).

Mr. MORAN of Kansas. Mr. Speaker, I thank the gentleman from Florida (Mr. BILIRAKIS) for yielding me the time.

Mr. Speaker, I rise to support the comments made by the gentleman from Arkansas (Mr. HUTCHINSON) who has been a tremendous leader on the issue of combatting methamphetamine production, sale and distribution in our country and from my perspective especially in rural America.

I am here today to speak on behalf of this legislation and, particularly, the meth section, that in large part mirrors H.R. 2987, a bill which I am a sponsor.

Kansas was one of those locations, certainly Kansas, a rural State, was one of those locations in which the Committee on the Judiciary came to on location to hear about the problems we face in our part of the country. And the stories that were told, the testimony that was taken was very compelling.

I brought with me today comments made by the sheriff of one of the counties in Kansas who testified before the subcommittee on the Judiciary on the impact of methamphetamines on his rural county, and I think it can be said across the State of Kansas and rural places around the country.

Sheriff Sherrer's testimony before the subcommittee in part is this, ''the adverse effect of meth on rural America is destroying our way of life. We are now combatting narcotics problems on fertile farm ground; problems that previously existed only in large cities with large police forces having large narcotics and violent crime units. The idea that we are living in Mayberry is a myth.

''We are living in a war zone. My office is totally unprepared to combat the rapidly expanding problem of the manufacture of meth in rural Kansas. The money and manpower necessary to combat the problem is destroying my annual budget and exhausting my personnel.

''There were 25 labs seized in Pawnee County in 1999.'' And I might add, as an aside, indicate that Pawnee County's population is 7,470. We have had more than 500 meth busts in 1999 in our State alone, and we are going to, unfortunately, exceed that record this year.

Sheriff Sherrer's testimony continues, ''my personnel are physically exhausted and perhaps even worse is that they are mentally exhausted, 80- and 90-hour workweeks are not uncommon in our attempt to combat the meth problem and still attend to our normal duties. I don't have the budget or the manpower necessary to fight the current meth problem. I have exhausted all manpower and financial efforts to address this problem to no avail. As a law enforcement agency, we are exhausted.

''On behalf of all western Kansas law enforcement administrators, concerning the problem of methamphetamine, we are understaffed, underfunded, outgunned and out of our league.''

I thought originally when I got involved in this issue that it was somewhat beyond the scope of the duties that I normally face as a rural Member of Congress, but this is a problem that

is real in rural America. I am glad this Congress is addressing this issue in this legislation.

Ms. DEGETTE. Mr. Speaker, I yield 2½ minutes to the gentlewoman from New York (Mrs. MCCARTHY).

Mrs. MCCARTHY of New York. Mr. Speaker, I rise and express my strong support for the Children'S Health Act. This important legislation includes the Children's Day Care Health and Safety Improvement Act, a bill that I introduced with the gentleman from Tennessee (Mr. BRYANT).

Mr. Speaker, I just want to take this opportunity to also thank the gentleman from Michigan (Mr. DINGELL), the gentleman from Virginia (Chairman BLILEY) and the gentleman from Tennessee (Mr. BRYANT) and certainly my colleague, the gentlewoman from Colorado (Ms. DEGETTE), for the leadership and hard work on this issue.

Mr. Speaker, we are experiencing a national child care crisis. In 1997, 31,000 children ages 4 and younger were treated in hospital emergency rooms for injuries sustained in child care facilities.

In 1999, in my home district of Nassau County, there were 55 cases of suspected child abuse incidents in child care facilities. Our bill gives $200 million in State grants to improve programs, to improve the health and safety of our children in child care.

These grants can be used for a number of reasons, train and educate child care providers to prevent injuries and illnesses and to promote health-related practices; strengthen and enforce child care provider licensing, regulation and registration; rehabilitate, which is probably one of the most important parts of this bill, child care facilities to meet health and safety standards; provide health consultants to give health and safety advice to child care providers; enhance child care providers' ability to serve children with disabilities; conduct criminal background checks on child care providers, what I think is really important, especially to give our parents the peace of mind of where they are going to send their child is offering the best services possible, and I think to provide information to parents on choosing a safe and healthy setting for their children or to or improve the safety of transportation of children in child care.

Mr. Speaker, being a new grandmother, I have to say watching my daughter-in-law looking for day care is an experience that is happening around this Nation, so the more that we can do to provide certainly our children, the future leaders of this country, with a safe environment and the best environment, we, in Congress, are doing a great job. I appreciate the work of this committee for letting this to go forward and hoping we can do more in the future.

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

Mr. Speaker, let me just close by saying we can sense the breadth of this bill by listening to the debate on the floor today, everything from child care to imaging, to medical research, vital, vital issues for our children. Again, I am proud to be a part of this debate and of this bill. I want to thank the gentleman from Florida (Mr. BILIRAKIS), the chairman, and also the gentleman from Ohio (Mr. BROWN), the ranking member.

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

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

Mr. Speaker, I endorse the remarks of the gentlewoman from Colorado (Ms. DEGETTE) and thank her for her role, the role that she has played, not only in this legislation, but all matters involving particularly children. I want to emphasize that this legislation came about as the result of an awful lot of hard work on a bipartisan basis. The minority was involved in every case, and I ask that everyone support.

Mr. UPTON. Mr. Speaker, I rise today in strong support of H.R. 4365, the Children's Health Act of 2000. This comprehensive measure will make a significant difference in the lives of millions of children and families by boosting biomedical and clinical research on a range of conditions and diseases that afflict children with particular severity and by improving access to treatment. As a member of the Commerce Committee's Subcommittee on Health and the Environment, I was fortunate to have the opportunity to work closely with our chairman, MIKE BILIRAKIS, who has shown great leadership on this legislation.

I am especially pleased and grateful that the final version of this bill includes provisions strengthening the National Institutes of Health's focus on Duchenne muscular dystrophy research. This will be the first time that Duchenne muscular dystrophy is mentioned in the Public Health Service Act.

I have seen the human face of this disease and the toll that it takes on children and families. Some time ago, I had the opportunity to visit with Don and Joyce Carpenter of Kalamazoo, MI, and their young and courageous son, Ben. Ben suffers from Duchenne muscular dystrophy. From them I learned that Duchenne muscular dystrophy is the most common and the most catastrophic form of genetic childhood disease. Sadly, it generally kills its victims in their late teens or early 20's.

For decades, the only drug treatment known to somewhat alter the course of the disease in the use of steroids—whose serious side effects are well-known. We've simply got to do better. We have to find a way to prevent this devastating disorder in the first place—perhaps through the promise of gene therapy. And until we learn how to prevent it, we've got to learn how to treat it more effectively.

I urge every Member of Congress to join me in voting for this bill and giving hope to Don and Joyce and Ben Carpenter and the many like them across this Nation and world. We can work miracles when we really try.

Mr. GILMAN. Mr. Speaker, I rise today in support of H.R. 4365, the Children's Health Act of 2000. This legislation renews America's commitment to children and ensuring that their physical and mental health are cared for.

This comprehensive bill contains a number of provisions that will revise and establish programs with respect to children's health research and prevention activities performed by Federal public health agencies. Of these provisions there are five which I would like to highlight. H.R. 4365 will:

(1) Improve autism research by directing the Director of the National Institutes of Health (NIH) to expand and diversify the NIH's activities with respect to autism, as well as requiring the Director to award grants and contracts to public or nonprofit entities for research on autism and creating the National Autism Developmental Disabilities Surveillance Program, which uses a number of mechanisms to improve the collection, analysis, and reporting of case data on autism and other pervasive developmental disabilities.

(2) Direct the HHS Secretary to develop a system to collect data on juvenile diabetes through the CDC, and establish a national data base for this data and conduct and support long-term studies through the NIH that follow individuals with juvenile, or type 1, diabetes for 10 years or more and establish through the CDC a national health effort to address type 2 diabetes in youth.

(3) Require the Secretary of Health and Human Services to distribute to States sufficient funding to enable them to establish programs to improve the health and safety of children receiving child care outside the home by preventing illnesses and injuries.

(4) Provide funding to the Drug Enforcement Administration (DEA) and Office of National Drug Control Policy (ONDCP) to assistance to State and local law enforcement officials in methamphetamine investigations and establishing additional DEA offices. This legislation provides law enforcement officials with tools and training to combat the methamphetamine and club drug epidemics in America today, and authorize comprehensive prevention and treatment programs to combat abuse and addiction as well.

(5) Modify the vaccine injury compensation program which currently only provides compensation to someone injured from routinely administered vaccines where the injury lasts more than 6 months. Certain vaccines, like rotavirus, often require immediate surgery, which would not be eligible for compensation. The modified program makes compensation available if the injury requires a hospital stay or surgery.

The programs I have mentioned, as well as the other important provisions of this bill, will make significant changes in the lives of children throughout this country. I applaud our colleague from Florida, Mr. BILIRAKIS, for his leadership on this issue and I urge my colleagues to support H.R. 4365, the Children's Health Act of 2000.

Mr. SHAYS. Mr. Speaker, I rise in strong support of H.R. 4365, the Children's Health Act of 2000. In particular, I am pleased the legislation includes S. 976 which reauthorizes the Substance Abuse and Mental Health Services Administration (SAMHSA).

S. 976 includes comprehensive standards for the use of restraint and seclusion in all facilities receiving Federal funding. The regulations, authored primarily by my colleague from Connecticut, Senator CHRISTOPHER DODD, will go a long way toward ensuring those receiving treatment in federally funded facilities are not subject to potentially life threatening inappropriate restraint and seclusion.

I became deeply concerned about the inappropriate use of restraint and seclusion following a series of articles published by the

Hartford Courant in October 1998, entitled ''Deadly Restraint.'' The series reported patient deaths related to the use of restraint or seclusion in 142 cases over 10 years, and chronicled the deaths of 23 patients who had died within 11 months—all apparent victims of overuse of seclusion or restraint.

Among the deaths the Courant investigated was Andrew McClain's. Andrew was an 11 year old foster child from Bridgeport, CT—in my district—who was a patient at Elmcrest Hospital, a State psychiatric institution, in Portland, CT.

On March 22, 1998, Andrew was told to move to a different table than the one where he was seated during breakfast. When he disobeyed, an aide at the hospital forcibly restrained Andrew and placed him in a face-down restraint hold.

Andrew's arms were drawn across his chest. The full weight of an adult on his back pinned this 11-year-old child to the ground, making it impossible for him to breathe, and eventually causing his death.

Andrew's horrifying death and others like it in the Courant series raised serious questions surrounding the use of restraints in mental health facilities nationwide, and more importantly, it raised public awareness of a very serious issue.

It also caused significant concern among members of the Connecticut delegation, who asked the General Accounting Office to study the use of restraint and seclusion among our most vulnerable populations—those with mental illness or mental retardation—who depend on care from others for their well-being.

The study, published last September, revealed a number of disturbing facts including at least 24 deaths associated with restraint or seclusion in 1998 alone. The GAO study also found the lack of a comprehensive reporting system to track injuries to both patients and staff resulting from restraint and seclusion, and an inconsistency among Federal and State regulations regarding restraint and seclusion for the mentally ill and disabled.

The GAO recommended an improved reporting system and led to conclusions that having regulatory protections and reporting requirements in place would reduce the use of restraint and seclusion and improve safety for patients and staff. The report also highlighted the urgent need to regulate the use of restraint and seclusion in federally funded facilities.

As a result of the GAO findings, both Senators DODD and LIEBERMAN introduced comprehensive legislation to regulate the use of restraint and seclusion in mental health facilities.

With the support of other members of the Connecticut delegation, on November 1, I introduced H.R. 3010, the Restraint Safety Act—the House companion to legislation introduced by Senator LIEBERMAN.

Provisions from Senator DODD's bill were included in the Senate-passed SAMHSA reauthorization bill which we are considering today.

Mr. Speaker, only strong Federal guidelines will ensure those in all facilities which receive federal funding will be free from unnecessary restraint and seclusion and I urge my colleagues on both sides of the aisle to support these life-saving provisions by voting for the underlying bill.

Mr. MCCOLLUM. Mr. Speaker, I submit the following letters re H.R. 4365 to be printed in the RECORD.

DEPARTMENT OF JUSTICE,
DRUG ENFORCEMENT ADMINISTRATION,
Washington, DC, September 26, 2000.

Hon. BILL MCCOLLUM,
Chairman, Subcommittee on Crime, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The enclosed letter dated March 15, 2000, from Mr. Robert Raben, Assistant Attorney General, Office of Legislative Affairs, to Chairman Henry J. Hyde, House Judiciary Committee, contains the views of the Drug Enforcement Administration on provisions previously contained in 486, now included in HR 4365, ''An Act to Amend the Public Health Act of 2000'' as placed on the Senate calendar on September 25, 2000.

We continue to support the objectives behind relaxing the restrictions governing practitioners who dispense replacement pharmacotherapies to make drug addiction treatment available in greater numbers. The March 15 letter did state concerns, however, regarding what is now Title XXXV which amends Section 303(g) of the Controlled Substances Act. Specifically, we are concerned about the (g)(2)(B)(II) subparagraph which this amendment adds. As we stated, these concerns would be resolved if the following language were added to the report accompanying the bill to clarify congressional intent regarding this section:

''Nothing in this section is intended to affect either the long standing authority of the Attorney General to enforce the standard that a controlled substance is legally dispensed by a practitioner only when it is dispensed for a legitimate medical purpose by the practitioner acting in the usual course of his/her professional practice or the authority of the Secretary of Health and Human Services under 42 U.S.C. 257a, after consultation with the Attorney General, to determine appropriate methods of professional practice in the medical treatment of narcotic addiction. See, U.S. v. Moore, 423 U.S. 122 (1975). The standard applies to the dispensing of all controlled substances, including the dispensing in the course of maintenance or detoxification of an individual.''

Thank you for the opportunity to reaffirm our views on the bill. Please do not hesitate to call if we may be of additional assistance.

Sincerely,

DONNIE R. MARSHALL,
Administrator.

DEPARTMENT OF JUSTICE,
OFFICE OF LEGISLATIVE AFFAIRS,
Washington, DC, March 15, 2000.

Hon. HENRY J. HYDE,
Chairman, Committee on the Judiciary, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: This letter presents the views of the Department of Justice on S. 486, the ''Methamphetamine Anti-Proliferation Act of 1999,'' as passed by the Senate on November 19, 1999. The Department supports many of the provisions in S. 486, because they provide important and necessary tools for deterring the spread of methamphetamine manufacturing and abuse in our Nation.

We are pleased that several suggested changes to the bill were made to accommodate the Department's concerns. We, however, continue to be troubled by section 211 (''Waiver Authority for Physicians Who Dispense or Prescribe Certain Narcotic Drugs for Maintenance Treatment or Detoxification Treatment''). While we support the objectives behind relaxing the restrictions governing practitioners who dispense replacement pharmacotherapies to make drug addition treatment available to greater numbers, we believe that federal law enforcement must maintain the ability to prosecute unauthorized dispensing of controlled substances.

Our major concern is with section 211(a)(5), adding section 303(g)(2)(B)(ii)(II) of the Controlled Substances Act [page 55, line 7–11, engrossed Senate bill]. That provision states that ''[n]othing in the regulations or practice guidelines under this clause may authorize any Federal official or employee to exercise supervision or control over the practice of medicine or the manner in which the medicinal services are provided.'' As written, section 211 could be interpreted in a way that would narrow the DEA's current authority under the Controlled Substances Act (CSA) to prosecute physicians who dispense controlled substances, but do so without a legitimate medical purpose in the usual course of their professional practice. It is well-settled law that a physician's license is not an automatic and absolute shield to prosecution under the CSA, since the CSA was designed by Congress in part ''to confine authorized medical practice within accepted limits,'' *See United States* v. *Moore*, 423 U.S. 122, 143 (1975). In *Moore*, for example, a defendant/doctor was authorized to dispense methadone for detoxification purposes only. A jury found that he exceeded the bounds of his professional practice by prescribing large quantities of methadone for patients without giving them adequate physical examinations or specific instructions for its use and charged fees according to the quantity of methadone prescribed rather than fees for medical services rendered. The Supreme Court concluded that the doctor was using his medical license as an excuse to facilitate the sale of controlled substances to addicts and, therefore, was in violation of the CSA.

Our concerns would be resolved if the following language were added to the report accompanying the bill to clarify congressional intent regarding this section:

''Nothing in this section is intended to affect neither the long standing authority of the Attorney General to enforce the standard that a controlled substance is legally dispensed by a practitioner only when it is dispensed for a legitimate medical purpose by the practitioner acting in the usual course of his/her professional practice nor the authority of the Secretary of Health and Human Services under 42 U.S.C. §257a, after consultation with the Attorney General, to determine appropriate methods of professional practice in the medical treatment of narcotic addiction. *See, U.S.* v. *Moore*, 423 U.S. 122 (1975). The standard applies to the dispensing of all controlled substances, including the dispensing in the course of maintenance or detoxification of an individual.''

On an unrelated matter, we recommend that section 123(a) of the bill (''Expansion of Methamphetamine Abuse Prevention Reports'') (enacting new section 515(e) of the Public Health Service Act (42 U.S.C. §290bb(e)(1))) be amended by adding after ''the Administrator'' ''of the Substance Abuse and Mental Health Services Administration in the Department of Health and Human Services, in consultation with the Secretary of Education and the Attorney General.'' Although we do not object to this provision as it is currently drafted, we believe that the language we are suggesting would help to ensure coordination among related and ongoing federal initiatives.

Finally, section 114(c) of the bill would require the Director of the Office of National Drug Control Policy (ONDCP) to ''apportion'' funds appropriated for combating methamphetamine in High Intensity Drug Trafficking Areas (HIDTA's). Technically, this is an inaccurate use of the word ''apportion.'' Only the Office of Management and Budget is authorized to ''apportion'' funds. We recommend that the word ''allocate'' be substituted for ''apportion.''

Thank you for the opportunity to present our views. Please do not hesitate to call

upon us if we may be of additional assistance. The Office of Management and Budget has advised that there is no objection from the standpoint of the Administration's program to the presentation of this report.

Sincerely,

ROBERT RABEN,
Assistant Attorney General.

Identical letter to be sent to the ranking minority member, Committee on the Judiciary.

Mr. WICKER. Mr. Speaker, I would like to thank those who have spent so many hours working on developing a comprehensive children's health bill to present to this House today. While this bill makes great strides on many childhood diseases and health issues, I will focus my remarks on the devastating affects that Duchenne Muscular Dystrophy has on the children with the disease and their families.

Duchenne Muscular Dystrophy is the most common genetic illness, crossing all cultures. Although Duchenne MD is an inherited disease and is present from the initial stages of fetal development, there is generally no indication at birth that the child has abnormal muscle function. In the first year of life, it is rare for parents to detect any delay in development. Typically a child is diagnosed between the age of 2–5 years. As a child grows and his muscle cells deteriorate, and he becomes noticeably weak. The child usually loses his ability to walk around 10 years of age. As time progresses, the chest muscles deteriorate, causing respiratory problems. Death often occurs in the late teens unless mechanical breathing is instituted.

This is painful not only for the child but also for the mothers and fathers who care for and love their child. To date there are efforts in finding a cure for this disease and the Children's Health Bill will allow these efforts to come to fruition. In addition, this bill will begin to provide the resources needed to expand research efforts in finding treatment and a cure for this disease.

As a member of the Labor-Health and Human Services, and Education Appropriations Subcommittee, I have supported doubling the NIH's budget over a five year period. I am pleased that this legislation's Muscular Dystrophy title tracks with report language from both the House and Senate Labor/HHS Appropriations bills, calling for increased research and coordination among the institutes of NIH. One of the problems that has confronted this disease community is that MD does not have a natural ''home'' among the institutes. I am confident that the National Institute for Neurological Disorders and Stroke, under the exemplary leadership of Dr. Gerald Fischbach, will increase the pace of research and provide a crucial coordination role.

An essential and logical portion of this heightened research would be the creation of a muscle biology study section, which could easily be accomplished in the context on an ongoing review of the study sections and their scientific peer review processes of NIH. I am troubled that out of the current 105 NIH study sections, there is no study section for muscle, the largest organ of the body.

Mr. Speaker, not only are there no cures for this, the world's number-one genetic killer of children, but there are no real therapies for Duchenne and Becker Muscular Dystrophy. Astonishingly, the pace of research, in real dollars, actually declined after the dystrophin gene was discovered in 1986. Passage of the Children's Health Act is a clear indication from Congress that this is unacceptable. I urge all Members of this House to join me in supporting this legislation.

Mr. DEMINT. Mr. Speaker, as the original sponsor of H.R. 2511, the Adoption Awareness Act, along with the gentleman from Virginia, Chairman BLILEY, a champion of adoption issues, I am pleased to endorse the Infant Adoption Awareness Act included in the child health bill, H.R. 4365.

Adoption is a wonderful option because it brings a positive, life-giving end to what could be difficult circumstances. The mother can place her child in a loving family, the child receives a warm and welcoming home, and an adoptive couple gets to wear one of the greatest titles in America—parent. Additionally, pro-life individuals, groups, and communities should encourage adoption as one of the life-giving choices of women with unplanned pregnancies. With the love and care provided at crisis pregnancy centers and in homes, community and faith-based organizations across the country, more women will hear about the resources available to help them through this difficult time and to encourage them to bring this newly-formed life into the world.

While this language is not as broad as the original legislation, it does reflect significant efforts to advance the purpose of the Adoption Awareness Act. This language was drafted with input from a wide variety of organizations, including those in the adoption and public health communities.

Women facing unplanned pregnancies deserve to hear about their options from a well-trained counselor who can provide accurate, up-to-date information on adoption. This Act provides professional development for pregnancy counselors in adoption counseling. The training will enable pregnancy counselors to feel confident in their knowledge of the adoption process, relevant State and local laws, and the legal, medical, and financial resources which can be provided to women with unplanned pregnancies.

I am pleased to support the Infant Adoption Awareness Act as a step in the right direction to bring complete and accurate adoption information to women facing unplanned pregnancies. I hope that this step significantly advances our Nation in the direction of eliminating a perceived anti-adoption bias in pregnancy counseling in providing lasting answers to difficult circumstances.

I truly believe that in our great Nation, while there may be unwanted pregnancies, there are no unwanted children.

Mr. BLILEY. Mr. Speaker, I rise in support of H.R. 4365, the Childrens' Health Act of 2000, as amended by the other body. This important legislation is the result of long, hard negotiations on the part of members of my staff and their counterparts on the staff of Mr. BILIRAKIS, Mr. BRYANT, Mr. GREENWOOD, Mr. UPTON, Mr. BROWN, Mr. DINGELL, and members of the other body that made this possible.

As members of the House will recall, after we passed H.R. 4365 the first time, the other body moved forward on legislation that would have left many health problems facing children unaddressed. I am pleased to report that were able to restore the House provisions that were omitted in the other body's legislation, and have added authorizations that strengthen the bill.

Though too numerous to mention each provision individually, I want to comment on three provisions that I believe are particularly important. As a proud adoptive father of two, I am pleased that this bill advances adoption policy in this country. The bill ensures that family planning counselors have access to training on presenting complete and accurate adoption information to women facing unplanned pregnancies. In the interest of time, I will extend my remarks for a more full discussion of this aspect of the legislation.

Moreover, this bill contains several initiatives that will foster the adoption of special needs children. The bill also authorizes the Healthy Start program for the first time. For at-risk pregnant women served by this program, it authorizes mobile health clinics equipped with ultra-sound screening technology and also expands access to prenatal and other surgical services to the unborn child, mother, and infant during the first year after birth.

I am also pleased that this bill directs NIH to expand and increase coordination in activities with respect to research on muscular dystrophies. It also makes important strides in the fight against autism, which affects 1 in every 500 children born today. More prevalent than Down syndrome, childhood cancer or cystic fibrosis, autism hits children during the first two years of life and causes severe impairment in language, cognition and communication. Since so many of America's children suffer from so many disorders, it is right that work to ensure that researchers are looking for the cures they need.

Although this bill addresses many tragic disorders among children, among the most tragic is that of drug abuse—and this bill extends a powerful helping hand to help parents to secure their children's future. This bill further extends the war on drugs to those who push methamphetamine, ''ecstasy,'' and heroin onto our young people. Under these provisions, criminal penalties are increased for individuals who manufacture and traffic in methamphetamine and ''ecstasy.'' The provisions also increase funding for law enforcement training and targets high intensity methamphetamine trafficking areas.

Perhaps most importantly, we are attacking heroin abuse by reducing the demand for this deadly drug. Let me relate some of the testimony Mr. Odis Rivers of Detroit, Michigan shared with the Commerce Subcommittee on Health and Environment last year. He has been addicted to heroin for 30 years, and is undergoing treatment with a drug that this bill will help more physicians prescribe to their patients. He told the Subcommittee that he was back with his wife and family and was enjoying their support. He had won their respect, and could again assume his rightful place in their family. As the Detroit Free Press stated on October 3rd of last year, ''this seems like the kind of legislation that should be passed, especially in light of new University of Michigan research showing that heroin use among teens doubled from 1991 to 1998.'' These provisions will make new heroin-blocking medications available to physicians treating patients struggling to be free from heroin addiction.

Not only do we use innovative strategies to address the problems of meth, ecstasy, and heroin, we also ensure that there is a Federal agency that is focused on reducing the incidence of substance abuse and mental illness throughout society. H.R. 4365 reauthorizes the

Substance Abuse and Mental Health Services Administration, which was created in 1992 to assist States develop effective prevention and treatment programs to protect America's children from the scourges of mental illness and drug abuse. The important ''charitable choice'' provision in this legislation permits Federal assistance for religious organizations providing substance abuse services, which is similar to language that has been enacted into law several times with broad support in the House.

It is important that the Members of this House vote for passage of this critically important bill to secure a better future for America's children by helping to reduce the incidence of disease and illness. We know we can lessen the incidence of these diseases through heightened research activities, and through the use of successful interventions that still remain out of reach by many in our society.

Again, I thank my colleagues and many other Members who have contributed to making this bill possible, and I would like to recognize the hard work of the House staff who brought this bill together: Marc Wheat, Jason Lee, Brent Del Monte, Patrick Morrisey, Anne Esposito, Carolyn Sporn, John Ford, Judith Benkendorf, Ellie Dehoney, and Katie Porter.

Last year, Congressman JIM DEMINT of South Carolina and I introduced H.R. 2511, the Adoption Awareness Act. After negotiations with all interested parties, including adoption advocates, foster care advocates, and representatives from the pro-life community as well as the abortion industry, the language of H.R. 2511 changed but the central purpose remained the same: the Infant Adoption Awareness Act ensures that counselors in health clinics and other settings provide women who have unplanned pregnancies complete and accurate information on adoption.

The Infant Adoption Awareness Act passed the House as part of H.R. 4365 by a vote of 419–2 and passed the Senate by unanimous consent. As Chairman of the Commerce Committee, I have been responsible for the negotiations leading to the final form of the Infant Adoption Awareness Act for these many months, and I want to take this opportunity to explain the bill at length to my colleagues in case there is any confusion with the text of the original Adoption Awareness Act, H.R. 2511.

What struck Congressman DEMINT and me was that the studies and statistics available in this field show a lack of activity which may well reflect an anti-adoption bias in pregnancy counseling. According to a University of Illinois study by Professor Edmund Mech, Orientations of Pregnancy Counselors Toward Adoption, 40 percent of self-identified ''pregnancy counselors'' in settings such as health, family planning, and social service agencies do not even raise the issue of adoption with their pregnant clients. Of the 60 percent who raise the issue of adoption in some form, 40 percent provide inaccurate or incomplete information. Furthermore, while pregnancy counselors themselves may not have a negative bias towards adoption, they presuppose that their client is not interested and therefore do not present adoption as a true option for women facing unplanned pregnancies (Source: Mech, Pregnant Adolescents: Communicating the Adoption Option). The Infant Adoption Awareness Act would set up a training program by which clinic workers and others could receive professional in-service training in educational adoption counseling. If properly trained, these counselors would be equipped to provide valuable information on adoption to their clients.

While many societal factors have changed in the last twenty years, including the acceptance of non-marital teen parenting, the availability of welfare, and increased availability of abortion services, there has been a dramatic drop in the number of adoptions among live births to unwed mothers. Prior to 1973, an adoption placement occurred for almost one of every ten premarital births. By the 1990s, the number had dropped to an adoption placement for one of less than every hundred premarital births. A long-term study of the Adolescent Family Life (AFL) pregnancy programs which included an adoption counseling component showed that—given necessary adjustments for client and community characteristics—more women chose to place their child for adoption when enrolled in an AFL Care project which provided adoption counseling as a part of pregnancy resolution decision-making (Source: McLaughlin and Johnson, Battelle Human Affairs Research Centers, The Relationship of Client and Project Characteristics to the Relinquishment Rates of the AFL Care Demonstration Projects). Thus, this Act intends to ensure that the public health and other professionals coming in contact with a high percentage of women facing unplanned pregnancies—often unwed adolescents—are properly prepared to have a complete and accurate discussion of adoption.

The Act allows for a six month period in which representatives of the adoption community come together to adopt or develop best-practices guidelines for counseling on adoption to women facing unplanned pregnancies. Specifically, the Secretary should include representatives of diverse viewpoints in the adoption community, including organizations representing agencies arranging infant adoptions, adoption attorneys, adoptive parents, social services, and appropriate groups representing the adoption triad (birth parents, infant, and adoptive parents). Organizations with significant expertise and history in this arena include the National Council For Adoption, Loving and Caring, Bethany Christian Services, the American Academy of Adoption Attorneys, and the American Bar Association Family Law Section's Adoption Committee. These organizations should be represented on the panel. While recognizing the sensitivity of making an adoption decision, the organizations represented should be those which promote adoption in a realistic, positive manner as beneficial to the birth parents, child, and adoptive parents. The best-practices guidelines should focus on the essential components of adoption information and counseling to be presented during a pregnancy counseling session. Furthermore, the guidelines should include important variables to be presented, such as state laws on adoption, and available medical, legal, and financial resources. Previous curricula developed for these purposes should be the starting point and, as an interim set of guidelines, be determinative.

The role of the public health clinics on the panel developing the best practices guidelines (and organizations representing their interests, such as the Family Planning Councils of America) is to ensure the guidelines are relevant to the health clinic setting. The experts in adoption counseling, including those who have a history of developing and delivering training or tools to teach adoption counseling, should shape the best-practices guidelines to provide an excellent model for presenting adoption to women facing unplanned pregnancies. Since different attitudes towards adoption exist throughout the country which can be attributed to racial, ethnic, religious, social, and geographic differences, the best-practices guidelines should act as a blueprint or model while still allowing localities the flexibility to address their local situation. Therefore, the best-practices guidelines would be a model which could be tailored to address the individual needs of the pregnant woman.

After the best-practices guidelines are developed, the Secretary shall make grants to adoption organizations to carry out training, which will often be training trainers, to teach pregnancy counselors how to present complete and accurate information on adoption. The guidelines are meant to be the basis for the adoption, improvement, or development of a training curriculum by grantees. Furthermore, the grantees can carry out the training programs directly or through grants or contracts with other adoption organizations. For instance, a national office could subgrant or contract with local affiliates throughout the nation or a region thereof. The Secretary should use discretion in ensuring that all regions of the nation will have adequate access to the training without having duplicate services in an area with a small number of eligible health clinics. There are no geographic limitations on where the trainers should be trained. The intent is to provide for training of trainers, often on a statewide or regional basis, so truly expert trainers can teach others.

The trainers should be highly qualified individuals with an expertise in adoption counseling. ''Adoption counseling'' in the adoption community implies an in-depth discussion of adoption which includes knowledge of various types of adoption and familiarity with the viewpoint and challenges of birth mothers, putative fathers, adoptive parents, and the best interest of the child. Trainers should have experience in providing adoption information and referrals in the geographic area of the eligible health centers. With a knowledge of state laws and access to local support networks, a trainer will be able to provide a more extensive review of local information and resources to the pregnancy counselors. The most essential component of the training, however, is to teach pregnancy counselors how to accurately and completely present adoption as an option to their clients and to ensure counselors are able to answer the frequently asked questions clients have regarding adoption.

The Infant Adoption Awareness Act refers to pregnancy counselors providing adoption information and referrals as a part of pregnancy counseling. It is important to note that handing a client a piece of paper or booklet explaining the adoption process and providing phone numbers of agencies or attorneys for adoption referrals does not constitute adoption information and referrals. Adoption information means a counselor is able to fully explore the option of adoption with a client. This includes answering relevant questions such as the types of adoptions, financial and medical resources for birth mothers, and state laws regarding relinquishment procedures and putative father involvement. Referral upon request includes following the procedures of the health clinic to make an appointment for the client and follow-

up as necessary. Referral may be made to an in-house adoption provider, such as a staff member of a licensed adoption agency. Since adoption is explored in the context of pregnancy counseling sessions in which counselors and clients have a limited amount of time, it is essential that the counselors provide complete and accurate summary information to their clients at that time.

The intent of this Act is to ensure that pregnancy counselors are well-trained, knowledgeable and comfortable presenting adoption to their clients. While adoption may not be the right choice for every women facing an unplanned pregnancy, each woman should be presented adoption information to make a well-informed decision. Many women have not thought of the possibility of adoption, do not know how to explore the details of adoption, or have misconceptions of the adoption process which hinder their consideration of the alternative of adoption. Since pregnancy counselors act as an important resource for these women, they must be equipped to fully address the option of adoption with their clients.

The adoption organizations eligible to receive grants for training (or subgrants or contracts) are those national, regional, or local private, non-profit institutions among whose primary purposes is adoption, and are knowledgeable in all elements of the adoption process and on providing adoption information and referrals to pregnant women. These adoption organizations must work in collaboration with existing Health Resources Services Administration (HRSA) funded ''training centers.'' Of particular importance is the organization's experience in explaining the process involved to the birth mother placing the child for adoption. It is essential that adoption is among the primary of the entity, as it should be organizations with true experts in adoption counseling who are training pregnancy counselors.

Health centers which are eligible to have staff receive training are public and nonprofit private entities that provide health-related services to pregnant women. The designated staff of the health centers means the counselors who will interact and provide counseling to women with unplanned pregnancies. The designated staff members are those who provide pregnancy or adoption information and referrals (or will provide such information and referrals after receiving training). Furthermore, while the Act sets out those health centers which should receive priority is being trained, nothing should be construed to prohibit those who provide counseling in other settings, such as on military bases and corrections facilities, to be eligible to participate in the adoption counseling training sessions.

The grant is conditioned on the agreement of the adoption organization to make reasonable efforts to ensure that the eligible health centers which may receive training under this grant include, but are not limited to, those that receive federal family planning funding, community health centers, migrant health centers, centers for homeless individuals and residents of public housing and school-based clinics.

The Secretary has the duty to provide eligible health centers (which receive funding under Section 330 and 1001) with complete information about the training available from the adoption organizations receiving the training grants. Furthermore, the Secretary has the duty to encourage eligible health centers to have their designated staff participate in the training. The Secretary must make reasonable efforts to encourage staff to undergo training within a reasonable period after the Secretary begins making grants for such training. The grantees will cover the costs of training the designated staff and reimbursing the health center for costs associated with receiving the training. Adoption counseling training is a type of professional development for pregnancy counselors and should be reimbursed on a similar basis as other professional development activities which staff receive in the local area.

Within one year, the Secretary shall submit to the appropriate Committees of Congress a report prepared by an independent evaluator, paid for by funds set aside under this Act evaluating the extent to which adoption information, and referral upon request, is provided by eligible health centers. The bill directs the reports to be conducted by the Secretary acting through the Administrator of the Health Resources and Services Administration and in collaboration with the Director of the Agency for Healthcare Research and Quality. The study should be scientifically-based and sufficiently broad so as to gain an understanding of the current practices of providing adoption information in Federally funded health clinics throughout the country. This should include the attention given to adoption relative to other options discussed in pregnancy counseling. Further, the study should indicate how often and in what form (written, verbal) adoption information is offered, the completeness and accuracy of the adoption information provided, and non-identifying information about the options ultimately chosen by clients.

Within a reasonable period of time, the Secretary shall submit to the appropriate Committees of Congress a report evaluating the extent to which adoption information, and referral upon request, is provided by eligible health centers to determine the effectiveness of the training. The bill directs the reports to be conducted by the Secretary acting through the Administrator of the Health Resources and Services Administration and in collaboration with the Director of the Agency for Health Care Research and Quality. Moreover, it is important that the study is scientifically-based, that is, more than a checklist asserting that adoption counseling, information, or referral has been provided, and focus on those health centers in which designated staff have been provided training through this Act. In conducting these studies, the Secretary shall ensure that the research does not allow any interference in the provider-patient relationship, any breach of patient confidentiality, or any monitoring or auditing of the counseling process which breaches patient confidentiality or reveals patient identity.

Funding for research in adoption counseling practices has been sporadic at best. Despite the acknowledged need to ensure pregnancy counselors can present adoption in a positive, accurate manner, funding for such studies has not materialized in proportion to the need. The Adolescent Family Life Program in the Office of Population Affairs provided for limited studies in the 1980s and follow-up studies on the effectiveness of the AFL Demonstration Programs into the early 1990s. The Office of Adolescent Pregnancy Programs in the 1990s proposed an objective of increasing to 90 percent the number of pregnancy counselors who are able to counsel on adoption in a complete, accurate manner. With a change of Administration, this goal never materialized as one of the priorities of the Public Health Service. Furthermore, plans for follow-up study by the Department of Health and Human Services to determine if the orientations of pregnancy counselors toward adoption had changed were dropped in 1995. Thus, research in this area is of critical importance.

Additionally, while the intention was to include ''charitable choice'' language allowing faith-based organizations to compete for grants on the same basis as any other nongovernmental provider without impairing the religious character of such institution, this language is not in the final bill due to opposition from the minority. I hope faith-based institutions will be able to compete for these grants in the future. To clarify, under charitable choice, the Federal Government cannot discriminate against an organization that applies to receive such a grant on the bias that the organization has a religious character and programs must be implemented consistent with the Establishment and Free Exercise Clauses of the United States Constitution. While following the agreed upon charitable choice model, future charitable choice language must be crafted to conform it to the purpose and structure of this Act.

As an adoptive father, Co-Chairman of the Congressional Coalition on Adoption, and Chairman of the House Commerce Committee, I am proud to have worked to make complete and accurate information on adoption a reality for women across the country. I look forward to the implementation of this important legislation as one my legacies to this great country.

Finally, Mr. Speaker, I submit this statement on my behalf and the behalf of Congressman BILL MCCOLLUM, Chairman, Subcommittee on Crime.

JOINT STATEMENT OF THE HONORABLE TOM BLILEY AND THE HONORABLE BILL MCCOLLUM

We write to clarify our intent with respect to Title XXXV of H.R. 4653, the Child Health Act of 2000. We support the objectives of this provision, to amend current law governing practitioners in order to make certain addiction treatment available in appropriate circumstances.

However, subsection within Title XXXV stating that ''Nothing in such regulations or practice guidelines may authorize any Federal official or employee to exercise supervision or control over the practice of medicine or the manner in which medical services are provided'' requires further clarification. Nothing in this subsection is intended to affect either the long standing authority of the Attorney General to enforce the standard governing the dispensing of controlled substances, nor the authority of the Secretary of Health and Human Services, after consultation with the Attorney General, to determine the appropriate methods professional practice in the medical treatment of narcotic addiction. This authority applies to the dispensing of all controlled substances, including that which is authorized by this provision.

Mr. BROWN of Ohio. Mr. Speaker, in this town, it's difficult to take action in any direction without creating controversy.

Consensus is a rarity.

This legislation bucks the trend. It reflects consensus around a common-sense principle.

If we can protect children from needless surgery, preventable disability, premature death—we should do it.

That's what this bill is all about.

We are placing our hope and trust in the National Institutes of Health, the Centers for Disease Control, HRSA, and other federal agencies that have responsibility for improving our nation's health.

We are asking them to intensify their efforts in areas of children's health including juvenile arthritis, muscular dystrophy, asthma, and Fragile X syndrome.

This bill provides screening and health care services for infants and children at risk for heritable disorders, and it implements organ donation policies that recognize the unique needs of children.

We have done a lot in this bill to help young victims of childhood illness and disease. But we in Congress should not take the credit.

Parents and other advocates for children throughout the United States should.

I especially want to acknowledge the parents. I've met with many parents this year, and I am proud that this bill translates their straightforward and eminently justifiable goals into action.

These parents want to see children's health research given the priority it deserves.

We invest generously in our children's basic needs, their education, their happiness . . . we should invest at least as generously in the kind of research that can protect and restore their health.

Many of the parents I spoke with were bringing their stories to Congress not for themselves, not for their own children, but for children and families they will never meet.

These parents are working to prevent others from experiencing the trauma and pain a childhood illness can inflict on a child and their loved ones.

I want to thank the parents for their hard work, dedication and unwavering conviction that we can do much, much more to ease the way for our children.

This same conviction underlies the portion of the Children's Health Act that reauthorizes the Substance Abuse and Mental Health Services Administration (SAMHSA).

In this year's reauthorization of SAMHSA, we do more to address substance abuse and mental health issues as they relate to children—under age drinking, children and violence, and fetal alcohol syndrome, to name a few.

To the extent we can protect our children from alcohol and substance abuse, we reduce their chances of addiction or abuse as adults.

We owe them that.

This is a great success, but once again, it's the public's accomplishment.

Substance abuse prevention is a public priority and has garnered overwhelming support on both sides of the aisle.

We have been asked to make this, as well as children's health, a priority for this Congress.

I am pleased to be among those helping to fulfill those wishes.

Mr. DINGELL. Mr. Speaker, I support H.R. 4365, the Children's Health Act of 2000. This bill, which now contains provisions from the Senate's bill, authorizes a variety of programs for expanding and intensifying children's health research. It also includes prenatal care initiatives (including the first formal authorization of the Healthy Start Program) that were included in the bill we passed in May of this year.

The bill also covers a wide range of youth drug and mental health services programs that will strengthen America's communities. I am very pleased that this Congress is reauthorizing programs administered by the Substance Abuse and Mental Health Services Administration (SAMHSA). These programs provide critical safety-net services for individuals and families with substance abuse problems and mental illness.

I wish to commend a number of my colleagues for their fine contributions: Representative DIANA DEGETTE, for championing provisions on pediatric organ transplants, juvenile diabetes, limits on the use of seclusion and restraints on hospitalized children, and a study concerning the use of children as participants in clinical research; Representative STRICKLAND for his child mental health provisions and for bringing state-of-the-art services to residents of rural communities; and, Representative CAPPS for her efforts in this Chamber not only to make the SAMHSA reauthorization a reality, but for her fine provision on underage drinking. The ranking member of the Health and Environment Subcommittee, Representative BROWN, has done a splendid job with this bill and he deserves our gratitude. Virtually every bill affecting public health bears the mark of my good friend and colleague, Representative WAXMAN, and this one is no exception. Many other of our colleagues made significant contributions to this bill, as well.

Giving credit where it is due, this bill has been improved by our Senate colleagues. Childhood obesity, now a focus of the bill, is one of the Surgeon General's priorities for Healthy People 2010. I am also delighted to see the program for newborn screening for heritable metabolic disorders, an issue of great concern to my colleague, Representative PALLONE. This provision would establish an advisory counsel to guide the Secretary in making timely and informed responses to rapid advances in genetic technologies. State and local public health departments will benefit from their provision as resources would be made available to improve programmatic uniformity, from laboratory infrastructure, to counseling, and healthcare services.

Other new provisions for America's children will develop strategies for improving childcare facilities, increase funds for the early detection and treatment of childhood lead poisoning, and fund a longitudinal study of influences that shape child development. The new National Center for Birth Defects and Developmental Disabilities at the Centers for Disease Control and Prevention will track and identify causes of birth defects and developmental disabilities with the goal of creating effective interventions to prevent the conditions, or their secondary health impacts. But without the full support of our colleagues on the Appropriations Committee in fiscal year 2001 to build and operate the Center, and in successive years to sustain and expand it, the Center will only be a shell.

Despite its many worthy provisions, this bill has been marked by a number of procedural irregularities. No bill of this scope and magnitude should proceed to the House floor without going through the committee process. No children's health bill worth its name should neglect such programs as: (1) supplementing S–CHIP and Medicaid to provide seamless access to state-of-the-art prenatal services to all pregnant women; (2) assuring equal access to pediatric specialists, medically necessary drugs and clinical trials for children with rare and/or serious health problems; (3) establishing guidelines for the administration of psychotropic medications to children under five, which is a major concern to my good friend Representative Towns; and, (4) addressing FDA regulation of youth tobacco use. Ironically, the provision promoting safe motherhood includes a public education initiative addressing the dangers of alcohol, tobacco, and illicit drug use in pregnancy. Most women do not begin smoking during pregnancy; they begin as adolescents. Yet, our Committee was unable to even debate this issue this year.

The provision on narcotic addiction treatment unfortunately fails to provide coverage for the majority of heroin addicts who cannot afford new drugs, such as buprenorphine, which were developed with taxpayer resources. Implementation of this provision, which exempts certain physicians from future guidelines for treatment with a not yet approved and labeled drug, will bear watching.

Finally, it is unfortunate that at a time when our Nation has more than 120,000 children in the foster care and the child welfare system who need homes, the only provision in this bill addressing adoption is based on a very limited, heavily criticized, sixteen year old study of how women with unintended pregnancies are counseled about their options. It speaks volumes that not a single organization involved with special needs adoptions has written to express support for this bill. This provision is based on a pejorative assumption about our publicly funded primary health care system and it burdens the already extended community health centers and Title X family planning clinics. Our tax dollars would be better spent addressing the needs of the more than 120,000 children of this Nation who so desperately need loving, caring homes.

I will vote for this bill. However, I want America's children to know that while H.R. 4365 is a significant step toward improving the quality of your collective health, we can do better. It now seems clear that the horizon of the 106th Congress will be rather limited with respect to health issues. I have great hope and great confidence that in the 107th Congress we will do better.

Mr. GREENWOOD. Mr. Speaker, as a member of the Subcommittee on Health and Environment of the House Committee on Commerce, the committee of jurisdiction, I wish to clarify my intent in voting or H.R. 4365. Section 3207 imposes new requirements on residents of certain facilities with respect to the use of techniques of ''restraint'' and ''seclusion.'' While such practices should be avoided whenever possible, I trust that the regulatory agencies implementing this law will do so in a reasonable, practical manner. New Section 591(d)(1) of the Public Health Service Act defines ''restraint'' to exclude ''any . . . method that involves the physical holding of a resident . . . to permit the resident to participate in activities without the risk of physical harm to the resident . . .'' I construe this phrase to allow facilities covered under this section providing services to children and youth with serious emotional disturbances to continue using a practice known as a ''therapeutic hold'' when appropriate to allow a resident to resume activities as soon as possible.

Mr. CANNON. Mr. Speaker, I rise today in support of the underlying legislation which includes within it an important bill that I sponsored in the House, the Methamphetamine

Anti-Proliferation Act of 2000. Methamphetamine is a powerful and dangerous drug. It differs from other popular illegal narcotics because it can be made from readily available, domestically produced, legal but dangerous chemicals and substances. It puts both human life and the environment at risk and it is reaching epidemic proportions.

Meth has become the fastest growing illegal narcotic in America. Within the last five years, meth use has increased in some communities by as much as 300 percent. In some areas meth accounts for as much as 90 percent of all drug cases. An increasing amount of meth is imported, but there are also hundreds of small ''Mom and Pop'' clandestine labs manufacturing meth in my State of Utah and throughout the country. Cheaply produced, but with a street value as high as $1,500 an ounce, it is no wonder that meth has become the drug of choice for gangs and criminals.

This legislation that I sponsored, and which we consider today, will address the proliferation of methamphetamine and club drug manufacturing, trafficking, use, and addiction in America. It provides Federal, State, and local law enforcement officials with tools and training to combat the methamphetamine and club drug epidemic in America today. It furthermore authorizes comprehensive prevention and treatment programs to combat abuse and addiction as well.

H.R. 2987 provides funding to the Drug Enforcement Administration [DEA] and Office of National Drug Control Policy [ONDCP]. These additional resources will be used to assist State and local law enforcement officials in methamphetamine investigations and establish additional DEA offices in rural areas. It provides training for toxic methamphetamine waste clean up, and authorizes federal reimbursement to states and localities for meth lab cleanup expenses.

H.R. 2987 also increases penalties for amphetamine production, trafficking in meth precursor chemicals, and drug manufacturing that creates a risk to human life or to the environment. The bill also contains provisions to address the problems associated with ''Ecstasy,'' gamma-hydroxbutyric acid (GHB) to so-called ''date rape drug,'' other enumerated ''club'' drugs, as well as similar controlled substances. And finally, the bill contains a number of provisions authorizing effective and science-based methamphetamine and club drug prevention and addiction treatment programs and federal resources for those programs.

Mr. Speaker, by passing this bill today we will be upholding our responsibility to provide additional federal resources that will help local law enforcement take back our cities and towns from the rising tide of methamphetamine and club drugs. I thank all the Members who worked on this bill for their efforts, and urge my colleagues to support this legislation.

Mr. OSE. Mr. Speaker, when the Children's' Health Act was passed by the Senate, the Anti-Methamphetamine Proliferation Act was added as an amendment. I wish to speak about the importance of this provision in the fight against methamphetamines.

Those of us who live on the east coast have not experienced the devastation that methamphetamines can wreak on a community. Unfortunately, in California, where 80 percent of the Nation's Meth supply is produced, we know all too well the dangers of this drug. Methamphetamines are a powerful drug that leaves a path of destruction in its wake. Meth is highly addictive, giving the user a sense of power and paranoia. As a result, a staggering proportion of violent crime in many communities is tied to Meth use. Would you believe that in Sacramento, 27 percent of male arrestees tested positive for Meth? In other western cities, the numbers are equally alarming: San Diego—26 percent; Salt Lake City—25 percent; San Jose—24 percent; Spokane—20 percent; Portland—19 percent; Las Vegas—16 percent; Phoenix—16 percent.

The Meth crisis is full of youth tragedies as well. Since Meth is largely produced on kitchen stoves, children are extremely vulnerable to exposure to lethal chemicals. In addition, I have personally heard horrific stories of child abuse at the hands of Meth users.

In March of this year I hosted a congressional field hearing in Woodland, CA to discuss the Meth crisis. During the hearing I heard from State and local law enforcement officials who fight the Meth crisis. From them I learned the unique challenges that this drug presents. The Anti-Methamphetamines Proliferation Act, for the first time ever, takes a comprehensive approach to fighting Meth and addresses those very problems that I heard from my local sheriffs and police chiefs.

The Anti-Meth Proliferation Act would: increase penalties for possession of precursor chemicals used to make Meth; add $15 million to the High Intensity Drug Trafficking Areas (HIDTAs) specifically targeted towards fighting Meth; increase funds to help state and local officials clean up Meth labs, which are filled with dangerous chemicals that threaten both human lives and the environment; adds funds for research and treatment of Meth.

I congratulate the gentleman from Utah, Mr. CANNON and the gentleman from Florida, Mr. MCCOLLUM for their hard work on this important bill. With this legislation, we are finally giving our law enforcement officials the resources they need to fight Meth production and distribution.

Let's pass this bill and get serious about fighting the scourge of methamphetamines.

Mr. WAXMAN. Mr. Speaker, I rise to express my strong support for H.R. 4365, the Children's Health Act. I am very pleased this bill represents a bipartisan, consensus combination of the children's health legislation and a long overdue reauthorization of the Substance Abuse and Mental Health Administration [SAMHSA].

This legislation contains many important provisions which will advance the treatment, cure and prevention of many childhood diseases and disorders. Among other benefits, they promise to make significant advances in the treatment and prevention of childhood asthma and of autoimmune diseases, like multiple sclerosis, juvenile diabetes and lupus, as well as in education and outreach regarding Tourette Syndrome. And children participating in clinical research will be afforded stronger protections under Federal law.

Title V of this bill consists of H.R. 2840, the Children's Asthma Relief Act of 1999, introduced by Congressman FRED UPTON and myself. Title XIX is based on H.R. 2573, the NIH Office of Autoimmune Diseases Act of 1999, which was authored by Congresswoman CONNIE MORELLA and myself. Title XXIII consists of an amendment, ''Children and Tourette Syndrome Awareness,'' authored by myself. Title XXVII includes enhanced protections for children participating in clinical research, based on H.R. 4605, the Human Research Subjects Protection Act introduced by Congresswoman DIANA DEGETTE, Congressman JOHN MICA and myself.

Equally important, this legislation authorizes programs and grants administered by SAMHSA which are essential to the health of many Americans. The reauthorization of this agency's statutory authority is long overdue and comes at an important juncture in our efforts to improve our health care services

NIH INITIATIVE ON AUTOIMMUNE DISEASES

I am pleased that H.R. 4365 establishes a new initiative at NIH to ''expand, intensify and corrdinate'' research and education on autoimmune diseases.

Last year, Congresswoman MORELLA and I introduced the NIH Office of Autoimmune Diseases Act of 1999. This legislation created an office in the NIH Office of the Director to ensure that federal funding of autoimmune disease research is used optimally and that clinical treatments are developed as rapidly as possible.

There are more than 80 autoimmune diseases—including multiple sclerosis, lupus, and rheumatoid arthritis—in which the body's immune system mistakenly attacks healthy tissues. These diseases affect more than 13.5 million Americans and are major causes of disability. Most striking of all, three-quarters of those afflicted with an autoimmune disease are women.

Research on autoimmune diseases is spread through many institutes of the National Institutes of Health [NIH], just as treatments involve many clinical specialties. Increasingly, however, scientists are identifying the common risk factors and symptoms of autoimmune diseases. This is why greater coordination and additional resources are needed in our Nation's autoimmune research effort.

Title XIX of H.R. 4365 adopts our office, transferring its activities and mission to an Autoimmune Diseases Coordinating Committee. Composed of NIH institute directors and permanently staffed with scientists and health professionals, the coordinating committee would be advised by a public advisory council.

Most significantly, the coordinating committee, in close consultation with the advisory council, will develop a plan for research and education on autoimmune diseases. The plan will establish NIH priorities and the Director of NIH will ensure the plan is fully and appropriately funded. The strategic plan would create crucial new funding opportunities for autoimmune research, based on the professional and scientific judgements of researchers, patients and clinicians. Finally, the committee would report to Congress on implementation of the plan, including the actual amounts dedicated by NIH to autoimmune disease research. The committee will also prospectively identify areas and projects of great promise which Congress should support. I cannot overstate the importance of these activities. In conjunction with the strategic plan, these reports will provide an objective, scientifically sound roadmap to Congress and NIH to follow in the pursuit of new treatments and cures for autoimmune diseases.

ASTHMA SERVICES FOR CHILDREN

Title V will benefit the more than five million American children who have asthma, one of the most significant and prevalent chronic diseases in America. Surgeon General David

Satcher recently concluded that the United States is ''moving in the wrong direction, especially among minority children in the urban communities.''

That is why the Children's Asthma Relief Act provides new funding for pediatric asthma prevention and treatment programs, allowing states and local communities to target and improve the health of low-income children suffering from asthma. The act would also increase the enrollment of these children into Medicaid and state Children's Health Insurance Programs [CHIP], such as California's Healthy Families.

I am particularly pleased that Title V includes mobile ''breathmobiles'' among the community-based programs eligible for funding. These school-based mobile clinics were developed by the Southern California chapter of the Asthma and Allergy Foundation of America, in conjunction with Los Angeles County, Los Angeles Unified School District and the University of Southern California.

Finally, this title reflects the leadership and work of Senators DICK DURBIN and MIKE DEWINE. It also has the strong support of leading child health and asthma organizations, including the American Lung Association, the American Academy of Pediatrics, Association of Maternal and Child Health Programs, the National Association of Children's Hospitals, the American Academy of Chest Physicians and the Children's Health Fund.

CHILDREN AND TOURETTE SYNDROME AWARENESS

Because I had intended to offer title III of this legislation as an amendment to the House legislation, I am very pleased it has been included. This title provides grants to develop and implement outreach programs, with a particular emphasis on children. These programs will target health providers, community groups and educators with enhanced information about the etiology, diagnosis and treatment of Tourette Syndrome [TS], a serious, often misunderstood and frequently misdiagnosed inherited neurological disorder.

I am particularly pleased that this provision reflects the contributions and expertise of the Tourette Syndrome Association, a national organization dedicated to providing information about TS, its treatment and support services and current research to individuals with TS and their families.

RESEARCH SUBJECT PROTECTIONS FOR CHILDREN

I am also very pleased that provisions from Congresswoman DEGETTE's Human Research Subjects Protection Act have been included in title XXVII of this legislation. This bipartisan legislation represents the first comprehensive reforms of research protections in a quarter century. This provision benefitting children is a downpayment on the additional reforms which are urgently needed in informed consent and our national system of Institutional Review Boards [IRBs]. These protections are indispensable to medical research, and recent abuses and failures have understandably shaken public confidence.

In the past, Congress has acted to protect research volunteers in the face of crisis or scandals like Tuskeegee, Willowbrook, and the government's cold war radiation experiments. But today, there is a clear consensus that we must strengthen and expand current protections. In doing so, we will restore the confidence of courageous people who are willing to put their health and welfare on the line to help find new cures and treatments. Without their trust, research simply cannot continue.

ADOPTION POLICY

Finally, the adoption awareness provisions in title XII were the subject to great controversy and debate. The original language raised many serious objections concerning adoption policy as well as abortion policy. These objections were made by Members, including myself, and important public health organizations including the American College of Obstetricians and Gynecologists, the National Association of Community Health Centers, and the National Abortion and Reproductive Rights Action League.

I recognize the sincerity of Chairman TOM BLILEY's concern on the issue of adoption and the significant efforts he has made to achieve a compromise and to remove the more troubling provisions from this Title.

SAMHSA REAUTHORIZATION

With respect to the reauthorization of SAMHSA, substance and alcohol abuse remain complex, troubling issues which elude simply or quick solutions. In light of surveys which indicate a recent increase in teenage drug use, it was particularly troubling to recently learn that nearly half of all parents are simply resigned to having their teenage children be exposed to illegal drugs. Unmet treatment needs continue to drive the annual $160 billion in societal costs from substance and alcohol abuse. Instead of receiving appropriate care, millions of Americans actively seeking treatment are being forced onto waiting lists. This is an unacceptable situation, especially as we have begun to receive conclusive data on the cost-effective health outcomes and dramatic savings produced by effective treatment.

For these reasons, I want to commend Congresswoman LOIS CAPPS on her authorship of the provisions on youth alcohol and fetal alcohol syndrome, Congressman TED STRICKLAND for his hard work on the mental health provisions, and Congresswoman DEGETTE on her provision strengthening protections against the use of seclusion and restraints. I am also particularly pleased that the grant programs targeting homeless individuals, the Grants for the Benefit of Homeless Individuals [GBHI] and the Projects for Assistance in Transition from Homelessness [PATH] have been reauthorized.

CHARITABLE CHOICE

There is one provision which I regret has been included in the SAMHSA reauthorization. It relates to ''charitable choice,'' and wholly exempts faith-based organizations from the application of Federal employment and discrimination laws in the provision of services funded by SAMHSA. I am also concerned that ''pervasively sectarian'' organizations may receive such funding, weakening the clear constitutional separation of church and state. Finally, I question whether this provision weakens the standards for certifying facilities and personnel providing substance abuse or mental health services, and for measuring and assessing the delivery of such services by a faith-based organization.

In conclusion, I urge my colleagues to support H.R. 4365 and commend the House staff for their hard work and dedication on this important public health legislation, particularly Judith Benkendorf, Eleanor Dehoney, Anne Esposito, John Ford and Marc Wheat.

Mr. TOWNS. Mr. Speaker, I'm very pleased that the House approved H.R. 4365, the Children's Health Act of 2000, reflecting a compromise agreement that was reached on a bipartisan basis with the Senate last week. This legislation will establish various children's health research and prevention programs conducted through federal public health agencies. The legislation will amend the Public Health Service Act to authorize additional federal resources targeted at many children's diseases, such as traumatic brain injury, autism, Fragile X, juvenile arthritis, childhood skeletal malignancies, diabetes, birth defects, hepatitis C, and epilepsy.

Today, however, I want to specifically make mention of title 22 of the legislation, which mandates increased research by the National Institutes of Health into Muscular Dystrophy. Passage of this title represents the first time that Muscular Dystrophy, and specifically Duchesne Muscular Dystrophy, has been acknowledged in a federal statute. This is long overdue.

As a member of the Health Subcommittee of the Commerce Committee, I am greatly heartened by the efforts of the gentleman from Ohio, ranking member SHERROD BROWN, to include this title in the legislation. Duchesne Muscular Dystrophy is the world's most prevalent lethal childhood genetic disease, cutting equally across all races and all citizens. To look at the record of research on this disease is to realize that despite our country's enormous resources, sometimes many children are left behind. Today, despite all the advances in medical science, victims of this disease—which afflicts one of every 3,500 boys—have no cures and no effective treatments available to them.

Children afflicted with Duchesne Muscular Dystrophy have no ability to produce the protein dystrophin, the protein that binds the muscle cells together. First, they lose their ability to climb and walk, then the disease spreads to their arms, and ultimately pulmonary or cardiac failure results by the late teens or early twenties. It is an exceptionally cruel disease that slowly robs boys of their independence and ultimately immobilizes them, leading invariably to an untimely and early loss of life.

Sadly, the federal response to this disease has been exceptionally poor. This year, in a NIH budget of more than $18 billion, research into Duchesne and Becker Muscular Dystrophies totals $9.2 million. Because it is a difficult disease that affects only tens of thousands of children—not millions—there is no current commitment from private drug manufacturers to conduct research on this disease. If you want to understand why there is nothing available to treat these children, you need look no further than the weak federal response to this disease. The gene that is flawed in this disease is readily identifiable, and has been so for 14 years. But astonishingly, the pace of research on DMD actually slowed down after the gene was discovered.

It is not that the scientists of NIH do not care about the victims of this disease. Rather, there are significant structural problems that have inhibited leadership at the Institutes in creating the platform for expanded research. Specifically, research into DMD is spread among the institutes of NIH. The National Institute of Child Health and Development does nothing on DMD, even though DMD victims exclusively are children. Of even more concern is the reality that of the more than 100 separate study sections at NIH through which scientists seek grants for research, none are devoted to muscle, the largest organ of the

body. The scientists who work in this area are frequently frustrated by the wide array of study sections through which they must apply for grants, and the lack of affinity that the peer review processes afford them.

Mr. Speaker, passage of this legislation will improve coordination of research into the various forms of Muscular Dystrophy. This is imperative. But beyond that, NIH should take additional steps to ensure that DMD gets a fair share of federal resources based on the severity and prevalence of the disease. An Office of Dystrophinopathies, or a branch devoted to study of Muscular Dystrophy, is certainly called for. A study section is essential. I believe that the Commerce Committee should conduct ongoing oversight of NIH's compliance with the Children's Health Act, specifically in this important area.

While I am neither a scientist nor a doctor, I think it is highly probable that sooner or later gene therapy is going to be able to cure diseases of this nature, particularly those that involve flaws on a single, identifiable gene. Yet the words ''sooner'' and ''later'' have profound consequences in the lives of tens of thousands of American children and their families that are suffering with this disease. With the passage of H.R. 4365, we move a step closer to giving those families hope.

Thank you, and I thank the bipartisan leadership of the Commerce Committee for their hard work in producing this important piece of legislation.

Mrs. EMERSON. Mr. Speaker, I'd like to take this opportunity to show my commitment and support to the children's health bill before us today. This comprehensive children's health legislation was cultivated out of several individual bills, including the Healthy Kids 2000 Act that I introduced last year with my colleague Senator KIT BOND. It was a tremendous pleasure working with Representatives BILIRAKIS and BROWN in developing the first version of this comprehensive children's health legislation, and I applaud their dedication and commitment to seeing the important issue of children's health addressed this year.

Specifically within this bill, there are three key components that I am especially proud of the conferees for including. The first provision is with respect to safe motherhood. Most Americans are surprised to learn that total maternal mortality has not declined in the United States since 1982. Between 1982 and 1996, the national maternal mortality ratio has remained approximately 7.5 maternal deaths per 100,000 live births. Additionally, the CDC estimates that of the 10,000 women who give birth in the United States every day: 2–3 women die from pregnancy-related conditions; 2,100 women experience major pregnancy related complications before labor; 2,500 women have Caesarean section delivery; 2,600 women experience severe labor-related complications.

These rates of mortality and morbidity are simply unacceptable. Fortunately, with passage of the children's health bill today, the CDC will now have the ability and resources to increase surveillance research on maternal health issues, and also implement additional prevention and maternal health promotion programs nationwide.

A second provision I was pleased to sponsor and support earlier this year with my colleague Representative LUCILLE ROYBALL-ALLARD was the folic acid education initiative. This bill contains the authorization of a comprehensive national health education campaign promoting folic acid to prevent serious birth defects. In 1991, research proved that the B vitamin folic acid could prevent serious birth defects of the brain and spine, known as neural tube defects [NTDs]. Spina bifida and anencephaly are two common NTDs. The Centers for Disease Control and Prevention [CDC] has stated that if all American women of childbearing age consumed 400 micrograms of the B vitamin folic acid each day up to 70 percent of all cases of neural tube defects could be prevented.

However, this scientific breakthrough has not been translated into a reduction in neural tube defects because millions of women are not aware of the role of folic acid in preventing NTDs. While public awareness is improving, a majority of women are uninformed about the benefits of folic acid and they are not consuming the recommended daily amount. According to a June 2000 March of Dimes national survey conducted by the Gallup Organizations, only 34 percent of women of childbearing age reported taking a multivitamin with folic acid on a daily basis. The survey also found that 9 out of 10 women do not know that folic acid must be consumed before pregnancy to be effective, and that only 1 in 7 know that folic acid prevents birth defects.

This provision outlines the components of a comprehensive national campaign that would enable CDC to assist states and others to develop and implement programs to reduce the incidence of neural tube birth defects which effect an estimated 2,500 babies each year.

Lastly, I want to take a moment to express my support for title XXII of the bill, which directs the National Institutes of Health to develop a more coordinated research strategy with regards to muscular dystrophy, giving particular attention to Duchenne Muscular Dystrophy. This form of the disease is the most common and most devastating of the muscular dystrophies. One in 3,500 male children born worldwide will be born with Duchenne and will lose the ability to walk by age 10; however, most children are diagnosed between the ages of two and three. Muscle deterioration will continue in the back and chest making it more and more difficult to breathe. The deterioration process will continue until it takes the life of a child some where in their late teens or early twenties. This is a process that no family should ever have to undergo, and I am happy to see that the National Institute for Neurological Disorders and Stroke has been challenged with the task of ensuring a stronger federal focus at NIH towards finding a cure and alternative treatments for Duchenne Muscular Dystrophy. I applaud and thank my colleagues for pushing NIH to take a more responsible role in finding a cure for this devastating disease, and for their commitment to ensuring passage of this important legislation impacting the lives of millions of children throughout the country.

Mr. BENTSEN. Mr. Speaker, I rise today in strong support of the Children's Health Act (H.R. 4365), legislation that would reauthorize children's health research and prevention programs, graduate medical education programs for children's hospital, substance abuse and drug abuse prevention and treatment programs, and safety of children care programs.

As an original cosponsor of many of initiatives that were included in this comprehensive bill, I am pleased that Congress will be acting to protect children's health. One of the most important provisions is the reauthorization for 5 years of the graduate medical education program for independent children's hospitals. I strongly support the role that pediatric hospitals play in advancing pediatric medicine and the training of physicians dedicated to children's health care needs. Under current law, Medicare does not provide funding for pediatric residencies for freestanding children's hospitals such as Texas Children's Hospital in my district because these hospitals do not treat a large number of Medicare patients. Last year, we enacted a law that provided a one-time capped entitlement for pediatric graduate medical education programs. This legislation would extend this valuable program for five years.

I am also working to ensure that the pediatric graduate medical education program receives sufficient funding through the annual appropriations process. Earlier this year, the House of Representatives approved the Fiscal Year 2001 Labor, Health and Human Services and Education appropriations bill (H.R. 4577) that includes $80 million for the pediatric graduate medical education program, an increase of $40 above this year's program. I am committed to maintaining this funding level as the budget is finalized.

Another important issue is the bill is the Pediatric Research Initiative that would require the National Institutes of Health (NIH) to conduct pediatric biomedical research at the NIH. In particular, this initiative will ensure that more research is done on how diseases affect children as compared to adults. In most cases, clinical trials are conducted on adults without any consideration of how these drugs will affect children.

This initiative would also encourage the development of pediatric clinical trials to ensure that safe and effective drug treatments are available for children. When children face life-threatening diseases, it is very difficult to determine how much and what types of treatments should be given to them, because there is insufficient information about how these treatments affect children. With more data and clinical trials, there will more options for children who are fighting for their lives.

This bill would also direct the National Institutes of Health to conduct more research on diseases which directly affect children such as hearing loss, autism, asthma, and juvenile diabetes. For autism, this legislation requires the NIH to establish five Centers for Excellence on autism research as well as three regional centers at the Centers for Disease Control. For asthma, this legislation would establish a grant program to provide comprehensive asthma services to children, equipping mobile health care clinics and conducting patient and family education on managing asthma. For juvenile diabetes, this bill establishes a national database at the Centers for Disease Control. With more information about juvenile diabetes, it will be easier to delineate potential environmental triggers related to type 1 diabetes. This bill would also provide funding for research related to a vaccine to prevent juvenile diabetes.

Another important initiative in this legislation is the creation of a nationwide toll-free phone number for parents to call to get information about poison control centers. Regrettably, the number of accidental poisonings is a real threat to our children. This initiative will ensure

that parents have one location to call to determine what is the best treatment for an accidental poisoning. This legislation also includes funding for a national public information campaign to educate the public about poison prevention and how to access poison control centers in their area. With appropriate information, parents can learn how to reduce the number of poisonings each year.

I am also supportive of provisions in this legislation that would provide new funding to prevent birth defects. In particular, this legislation would authorize the Centers for Disease Controls to conduct a public health program about the effects of folic acid in preventing birth defects in pregnant women. This bill would also establish a National Center on Birth Defects and Development Disabilities to collect and analyze available data on birth defects. With more information, I believe we will discover new ways to prevent birth defects.

This bill would also provide several new programs to address the mental health of our children. This measure authorizes $75 million for a program to provide grants to public and nonprofit organizations to prevent suicide among children and adolescents. This bill also authorizes $300 million next year for grants to prevent substance abuse among children. The legislation also creates a High-Risk Youth Program to help public and nonprofit organizations to combat drug abuse for high-risk youths.

Another importation provision in this bill would create a grant program to improve the health and safety of children in child care facilities. This bill authorizes $200 million next year to ensure that child care facilities are safe for our children. These grants can also be used to improve the training for child care providers as well as rehabilitating existing centers to meet current health and safety requirements. Today, with more children enrolled in child care centers, it is critically important that these facilities are well-equipped so that our children will learn and prosper.

I strongly urge my colleagues to support this effort and vote for H.R. 4365.

Mrs. MINK of Hawaii. Mr. Speaker, I rise today in very strong support of this legislation. I also wish to thank the Senate Committee on Health, Education, Labor and Pensions for including language in H.R. 4365 that will help those who have suffered traumatic brain injury receive cognitive therapy. Traumatic brain injury or TBI is one the leading causes of death and disability among young persons in the United States. The Centers for Disease Control and Prevention recently announced that there are currently 5.3 million Americans living with a serious long-term disability as a result of brain injury.

This important measure will, for the first time, clarify that cognitive therapy is necessary for individuals who have suffered traumatic brain injury. In many cases, rehabilitation focuses exclusively on physical treatment without regard for cognitive treatment, such as reading, speaking, comprehension, reasoning and deductive capabilities.

This provision is based on H.R. 477, which I introduced on February 2, 1999, to clarify that cognitive therapy is a necessary component of treatment for TBI.

There is no widely accepted nor standardized long-term procedure for TBI treatment. The availability of cognitive therapy varies by state, which causes inequitable and varying treatment for TBI victims. But this measure seeks to change that. It clarifies that the National Institutes of Health should conduct research on cognitive therapy needed for TBI patients and that cognitive therapy for TBI should be funded by the Health Resources and Services Administration under its TBI grant program.

Persons with traumatic brain injuries are greatly in need of help to rehabilitate and recover their mental, as well as their physical, capabilities. By passing H.R. 4365, we can help those persons do just that.

I urge all Members to vote for this important legislation.

Mr. WELDON of Florida. Mr. Speaker, I rise in strong support of this bill. I am particularly pleased with the provisions authorizing the Healthy Start Project and pursuing an aggressive effort to address the epidemic of autism in America today. I was pleased to play a role in moving both of these initiatives forward. The Healthy Start project will reduce the rate of infant mortality and improve prenatal care by providing grants to areas with high rates of infant mortality and low birth weight infants. Healthy Start authorizes new grants to provide research and services like mobile health clinics which will provide poor women and their developing child access to ultrasound screenings. This will undoubtedly enhance access to prenatal care, ultrasound services, and prenatal surgery.

I have become increasingly concerned about the rapid increase in the incidence of autism among our children. I have spent a considerable amount of time over the past year on this very issue. I believe this bill will be a great help in addressing this issue. This bill ensures that the Director of National Institutes of Health [NIH] expands of NIH's autism research initiatives. The centers of excellence in autism research that are established under this program will lead to significant advances in basic and clinical research into the cause, diagnosis, early detection, prevention, control, and treatment of autism.

Ms. PELOSI. Mr. Speaker, I serve on the Subcommittee on Labor, Health and Human Services, and Education of the Committee on Appropriations. Our subcommittee's jurisdiction concerns the welfare of America's children in many ways: their health, their education and well-being, and the economic security of their families, which is certainly related to their well-being.

What we see in that subcommittee, from the scientists who come in and tell us what the possibilities are now in science and what they know about the development of children, is how essential it is for children to have quality health care even before they are born. The research has shown time and time again that investments in their good health are very good investments for our country indeed.

The opportunities are great. The knowledge that we have gained through our investments in biomedical research increases the opportunities to help our children not only reach their own personal fulfillment and strengthen the families from which they come, but also enrich our country in terms of our family values and our economic strength. So we all have a responsibility to all children. Every parent, of course, has a responsibility to his or her child, but on the Subcommittee we must think of every child in America as our child, all the children as our children, because indeed they are our responsibility. So in Congress, we have a responsibility to do all that we can to prevent and treat childhood disease. The Children's Health Act comprehensively addresses this responsibility by increasing our commitment to children's health research, health promotion, and disease prevention activities.

Although I strongly support the Children's Health Act, I would like to join my colleagues who have expressed their concerns about the Charitable Choice provisions included in the bill. These provisions would weaken important anti-discrimination civil rights protections; violate the constitutional separation of church and state; and entangle religious institutions in the purview of government. These provisions explicitly enable faith-based organizations to proselytize to those receiving public services and discriminate in employment decisions with public funds.

I am disappointed that the Republican leadership did not allow an amendment to strengthen prohibitions against proselytizing and prevent discrimination against beneficiaries. These needed protections are very important to ensure that the religious rights and the civil rights of Americans can be exercised, and where they overlap, there is an appropriate balance. They also would serve to protect the separation of church and state. Despite these concerns, I do support the underlying language in this bill, and I urge my colleagues to vote yes on the Children's Health Act.

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

The SPEAKER pro tempore (Mr. OSE). Pursuant to House Resolution 594, the previous question is ordered.

The question is on the motion offered by the gentleman from Florida (Mr. BILIRAKIS).

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. BILIRAKIS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the 15-minute vote on this motion will be followed by a 5-minute vote on the motion to suspend the rules and pass H.R. 5272, as amended, on which the yeas and nays were ordered yesterday.

The vote was taken by electronic device, and there were—yeas 394, nays 25, not voting 14, as follows:

[Roll No. 496]

YEAS—394

Abercrombie	Becerra	Boucher
Ackerman	Bentsen	Boyd
Aderholt	Bereuter	Brady (PA)
Allen	Berkley	Brady (TX)
Andrews	Berman	Brown (FL)
Archer	Berry	Bryant
Armey	Biggert	Burr
Baca	Bilbray	Burton
Bachus	Bilirakis	Buyer
Baird	Bishop	Callahan
Baker	Blagojevich	Calvert
Baldacci	Bliley	Camp
Baldwin	Blumenauer	Canady
Ballenger	Blunt	Cannon
Barcia	Boehlert	Capps
Barr	Boehner	Capuano
Barrett (NE)	Bonilla	Cardin
Barrett (WI)	Bonior	Carson
Bartlett	Bono	Castle
Barton	Borski	Chabot
Bass	Boswell	Chambliss

Chenoweth-Hage
Clement
Coble
Coburn
Collins
Combest
Condit
Cook
Cooksey
Costello
Cox
Coyne
Cramer
Crane
Crowley
Cubin
Cunningham
Danner
Davis (FL)
Davis (VA)
Deal
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart
Dickey
Dicks
Dingell
Dixon
Doggett
Dooley
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Ehrlich
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Filner
Fletcher
Foley
Forbes
Ford
Fossella
Fowler
Frank (MA)
Franks (NJ)
Frelinghuysen
Frost
Gallegly
Ganske
Gekas
Gephardt
Gibbons
Gilchrest
Gillmor
Gilman
Gonzalez
Goode
Goodlatte
Goodling
Gordon
Goss
Graham
Granger
Green (TX)
Green (WI)
Greenwood
Gutierrez
Gutknecht
Hall (OH)
Hall (TX)
Hansen
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hill (IN)
Hill (MT)
Hilleary
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Hooley
Horn
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hutchinson
Hyde
Inslee
Isakson
Istook
Jackson-Lee (TX)
Jefferson
Jenkins
John
Johnson (CT)
Johnson, Sam
Jones (NC)
Kanjorski
Kaptur
Kasich
Kelly
Kennedy
Kildee
Kind (WI)
King (NY)
Kingston
Kleczka
Knollenberg
Kolbe
Kucinich
Kuykendall
LaFalce
LaHood
Lampson
Lantos
Largent
Larson
Latham
LaTourette
Leach
Levin
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Luther
Maloney (CT)
Maloney (NY)
Manzullo
Markey
Martinez
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McCrery
McDermott
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Menendez
Metcalf
Mica
Millender-McDonald
Miller (FL)
Miller, Gary
Minge
Mink
Moakley
Mollohan
Moore
Moran (KS)
Moran (VA)
Morella
Murtha
Myrick
Nadler
Napolitano
Neal
Nethercutt
Ney
Northup
Norwood
Nussle
Oberstar
Obey
Olver
Ortiz
Ose
Owens
Oxley
Packard
Pallone
Pascrell
Pastor
Pease
Pelosi
Peterson (MN)
Peterson (PA)
Petri
Phelps
Pickering
Pickett
Pitts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Reyes
Reynolds
Riley
Rivers
Rodriguez
Roemer
Rogan
Rogers
Rohrabacher
Ros-Lehtinen
Rothman
Roukema
Roybal-Allard
Royce
Ryan (WI)
Ryun (KS)
Sabo
Salmon
Sanchez
Sanders
Sawyer
Scarborough
Schaffer
Schakowsky
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shows
Shuster
Simpson
Sisisky
Skeen
Skelton
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Souder
Spence
Spratt
Stabenow
Stark
Stearns
Stenholm
Strickland
Stump
Stupak
Sununu
Sweeney
Talent
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Thune
Thurman
Tiahrt
Tierney
Toomey
Traficant
Turner
Udall (CO)
Udall (NM)
Upton
Velazquez
Visclosky
Vitter
Walden
Walsh
Wamp
Watkins
Watts (OK)
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wexler
Weygand
Whitfield
Wicker
Wilson
Wise
Wolf
Woolsey
Wu
Young (AK)
Young (FL)

NAYS—25

Clay
Clayton
Clyburn
Conyers
Cummings
Davis (IL)
Fattah
Gejdenson
Hastings (FL)
Hilliard
Jackson (IL)
Johnson, E. B.
Kilpatrick
Lee
Lewis (GA)
McKinney
Meeks (NY)
Miller, George
Payne
Sanford
Scott
Slaughter
Towns
Waters
Watt (NC)

NOT VOTING—14

Brown (OH)
Campbell
Ewing
Jones (OH)
Klink
Lazio
McCollum
McIntosh
Paul
Rush
Sandlin
Saxton
Vento
Wynn

1216

Messrs. CONYERS, CLAY, TOWNS, Ms. EDDIE BERNICE JOHNSON of Texas, Messrs. GEJDENSON, HASTINGS of Florida, LEWIS of Georgia, MEEKS of New York, GEORGE MILLER of California, and Ms. KILPATRICK changed their vote from ''yea'' to ''nay.''

So the motion was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PEACE THROUGH NEGOTIATIONS ACT OF 2000

The SPEAKER pro tempore (Mr. WALDEN of Oregon). The unfinished business is the question of suspending the rules and passing the bill, H.R. 5272.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New York (Mr. GILMAN) that the House suspend the rules and pass the bill, H.R. 5272, as amended, on which the yeas and nays are ordered.

This is a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 385, nays 27, answered ''present'' 4, not voting 17, as follows:

[Roll No. 497]

YEAS—385

Abercrombie
Ackerman
Aderholt
Allen
Andrews
Archer
Armey
Baca
Bachus
Baird
Baker
Baldacci
Baldwin
Ballenger
Barcia
Barr
Barrett (NE)
Barrett (WI)
Bartlett
Barton
Bass
Becerra
Bentsen
Bereuter
Berkley
Berman
Berry
Biggert
Bilbray
Bilirakis
Bishop
Blagojevich
Bliley
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bono
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brady (TX)
Brown (FL)
Brown (OH)
Bryant
Burr
Burton
Buyer
Callahan
Calvert
Camp
Canady
Cannon
Capps
Cardin
Castle
Chabot
Chambliss
Chenoweth-Hage
Clement
Clyburn
Coble
Coburn
Collins
Combest
Condit
Cook
Cooksey
Costello
Cox
Coyne
Cramer
Crane
Crowley
Cubin
Cummings
Cunningham
Davis (FL)
Davis (IL)
Davis (VA)
Deal
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart
Dickey
Dicks
Dixon
Doggett
Dooley
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Ehrlich
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Filner
Fletcher
Foley
Forbes
Ford
Fossella
Fowler
Frank (MA)
Franks (NJ)
Frelinghuysen
Frost
Gallegly
Ganske
Gejdenson
Gekas
Gephardt
Gibbons
Gilchrest
Gillmor
Gilman
Gonzalez
Goode
Goodlatte
Gordon
Goss
Graham
Granger
Green (TX)
Green (WI)
Greenwood
Gutierrez
Gutknecht
Hall (OH)
Hall (TX)
Hansen
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hill (IN)
Hill (MT)
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Hooley
Horn
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hutchinson
Hyde
Inslee
Isakson
Istook
Jackson-Lee (TX)
Jefferson
Jenkins
John
Johnson (CT)
Johnson, Sam
Jones (NC)
Kanjorski
Kaptur
Kasich
Kelly
Kennedy
Kildee
Kilpatrick
Kind (WI)
King (NY)
Kingston
Kleczka
Knollenberg
Kolbe
Kuykendall
LaFalce
LaHood
Lampson
Lantos
Largent
Larson
Latham
LaTourette
Leach
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Luther
Maloney (CT)
Maloney (NY)
Manzullo
Markey
Martinez
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McCrery
McGovern
McHugh
McInnis
McIntyre
McKeon
McNulty
Meehan
Meeks (NY)
Menendez
Metcalf
Mica
Millender-McDonald
Miller (FL)
Miller, Gary
Minge
Mink
Moakley
Mollohan
Moore
Moran (KS)
Morella
Myrick
Nadler
Napolitano
Neal
Nethercutt
Ney
Northup
Norwood
Nussle
Oberstar
Olver
Ortiz
Ose
Owens
Oxley
Packard
Pallone
Pascrell
Pastor
Pease
Pelosi
Peterson (MN)
Peterson (PA)
Petri
Phelps
Pickering
Pitts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Quinn
Radanovich
Ramstad
Rangel
Regula
Reyes
Reynolds
Riley
Rodriguez
Roemer
Rogan
Rogers
Ros-Lehtinen
Rothman
Roukema
Roybal-Allard
Royce
Rush
Ryan (WI)
Ryun (KS)
Salmon
Sanchez
Sanders
Sanford
Sawyer
Saxton
Scarborough
Schaffer
Schakowsky
Scott
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shows
Shuster
Simpson
Sisisky
Skeen
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Snyder
Souder
Spence
Spratt
Stabenow
Stearns
Stenholm
Strickland
Stump
Stupak
Sweeney
Talent
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thompson (CA)
Thompson (MS)
Thornberry
Thune
Thurman
Tiahrt
Tierney
Toomey
Towns
Turner