my colleague, Senator GREGG, for his leadership on this important legislation.

I rise today to lend my support to S. 2341, the IDEA Full Funding Act of 2000. One of my top priorities as a United States Senator has been to provide equal access to high quality public education for all children, including those with special needs. My commitment to education for those with special needs began while I was a State legislator and worked with the Oregon Disabilities Council to ensure that children with special needs had equal access to a quality education. I have continued that work here in the Senate, but realize that we have a long ways to go.

This legislation takes a step in the right direction by funding the federal mandates put forth in the Individuals with Disabilities Education Act (IDEA). These federal funds will free up state and local dollars that can then be used in the classroom for new textbooks, pencils and computers that are necessary for students to learn.

In 1954, the Supreme Court established, in Brown v. Board of Education, that all children are guaranteed equal access to education under the 14th Amendment of the Constitution. Despite this decision, it was estimated that one million children with disabilities were being denied access to public education. It was not until 1975, with the passage of the Individuals with Disabilities Education Act, that equal access to education was extended to children with disabilities.

The purpose of the 1975 IDEA legislation was ''[T]o assure that all children with disabilities have available to them, a free appropriate public education which emphasizes special education and related services designed to meet the unique needs, to assure the rights of children with disabilities and their parents or guardians are protected, to assist States and localities to provide for the education of all children with disabilities, and to assess and assure the effectiveness of efforts to educate children with disabilities.''

With the passage of IDEA the federal government promised to assist states with 40 percent of the national average per pupil expenditure for disabled children. Based on the national average per pupil expenditure for the year 2000, 40 percent of that average would represent approximately $2,500 per student. However, since 1975 the federal government has not met this commitment. In fact, the federal government gets an ''F'' in arithmetic in this instance, currently paying only 12.7 percent of the per pupil expenditure.

But, we are slowly working to improve this grade. In 1997, funding for IDEA was only $2.6 billion. In the last 3 years, the Republican-controlled Congress has nearly doubled Federal funding on IDEA to approximately $4.9 billion. Although Congress has allocated more money to IDEA, current funding levels are 3.1 times less than what is needed to fully fund the forty percent commitment.

The purpose of providing this additional funding to the IDEA program is to free up local and state dollars. Currently state and local education agencies have been forced to divert their precious resources to pay for the additional costs, due to federal mandates, of educating children with disabilities.

As a result, Washington has created an inappropriate and unfair conflict between children with disabilities and children without. We owe it to all children to live up to our responsibility and resolve this conflict.

This important legislation would take a step in that direction by authorizing funding for Part B of the Individuals with Disabilities Education Act to reach the Federal government's goal of providing 40 percent of the national average per pupil expenditure to assist states and local education agencies with the excess costs of educating children with disabilities.

By steadily working to increase IDEA funding to $2 billion each year annually until 2010, Congress would increase opportunity and flexibility for local school districts to fund the programs that they feel are best for their students, whether it be school construction, teacher training or smaller classrooms.

I was pleased to see that the House of Representatives passed similar legislation, H.R. 4055, on May 3, 2000 with a 421–3 vote. It is my hope that the Senate can follow the strong lead of the House and work for swift passage of this necessary legislation.

THE CHILDREN'S PUBLIC HEALTH ACT OF 2000 AND THE YOUTH DRUG AND MENTAL HEALTH SERVICES ACT

Mr. HATCH. Mr. President, I am delighted the Senate has now given final approval to an important bill that will go far toward improving our nation's public health infrastructure. I strongly support the Children's Public Health Act of 2000 and the Youth Drug and Mental Health Services Act (H.R. 4365). I hope this measure will soon pass the House as well.

It is obvious that we owe our colleagues on the Health, Education, Labor, and Pensions Committee a debt of gratitude for their perseverance and dedication in developing this landmark legislation which contains a number of provisions of importance to my home state of Utah.

The Children's Health Act of 2000 authorizes services that will ensure the health and well-being of future generations of America's young people, our most precious resources. I can think of no more important aim for legislation than to focus on our nation's future by providing for our children today.

At the same time, through the Youth Drug and Mental Health Services Act, the bill will address serious drug abuse issues that affect our young people, including a reauthorization of the important programs of the Substance Abuse and Mental Health Services Administration, SAMHSA.

The SAMSHA reauthorization legislation will improve this vital agency by providing greater flexibility for states and accountability based on performance, while at the same time placing critical focus on youth and adolescent substance abuse and mental health services. SAMHSA, formerly known as the Alcohol, Drug Abuse, and Mental Health Services Administration, ADAMHA, was created in 1992 by Public Law 102–321, the ADAMHA Reorganization Act. SAMHSA's purpose is to assist states in addressing the importance of reducing the incidence of substance abuse and mental illness by supporting programs for prevention and treatment.

SAMHSA provides funds to states for alcohol and drug abuse prevention and treatment programs and activities, and mental health services through the Substance Abuse Prevention and Treatment, SAPT, and the Community Mental Health Services, CMHS, Block Grants. SAMHSA's block grants are a major portion of this nation's response to substance abuse and mental health service needs.

As a proud supporter of H.R. 4365, I would like to highlight several provisions that are based on legislation I have introduced.

First, this legislation reauthorizes the Traumatic Brain Injury Act, a law I authored in 1996. By incorporating my bill, S. 3081, H.R. 4365 will extend authority for the critical Traumatic Brain Injury, TBI, programs from fiscal year 2001 through 2005.

Each year, approximately two million Americans experience a traumatic brain injury; in Utah, 2000 individuals per year experience brain injuries. TBI is the leading cause of death and disability in young Americans, and the risk of a traumatic brain injury is highest among adolescents and young adults. Motor vehicle accidents, sports injuries, falls and violence are the major causes. These injuries occur without warning and often with devastating consequences. Brain injury can affect a person cognitively, physically and emotionally.

Important provisions added to the Traumatic Brain Injury Act through this bill include extending the Center for Disease Control and Prevention's, CDC, grant authority so it may conduct research on ways to prevent traumatic brain injury. In addition, the legislation directs the CDC to provide information to increase public awareness on this serious health matter. The bill also calls on the National Institutes of Health, NIH, to conduct research on the rehabilitation of the cognitive, behavioral, and psycho-social difficulties associated with traumatic brain injuries.

Finally, the measure requests the Health Resource Services Administration to provide and administer grants

for projects that improve services for persons with a traumatic brain injury.

I am grateful that the members of the HELP Committee were willing to include provisions from my legislation which reauthorizes this program. As a result, many more deserving individuals whose lives and families have been affected by a traumatic brain injury will now receive some type of assistance or help.

Second, the Children's Health Act of 2000 also contains a bill that I authored, S. 3080, to address a troubling yet treatable malady—poor oral health in children.

I have been concerned over reports from Utah and around the country about the poor oral health of our nation's children. A recent General Accounting Office report on dental disease calls tooth decay the most common chronic childhood disease and finds that it is most prevalent among low-income children.

Eighty percent of untreated decayed teeth is found in roughly 25 percent of children, mostly from low-income and other vulnerable groups. Decay left untreated leads to infection, pain, poor eating habits, and speech impediments.

Compounding this problem is that there are few places for these children to receive care. Low provider reimbursement rates from state-operated dental plans make it financially impossible for private practitioners to treat all the children in need. Today, there are a large number of children living in either the inner city or in rural areas who do not have a place to seek treatment. Our goal should be to provide access to dental care to children, regardless of where they live.

Therefore, I am pleased to report that the ''Children's Public Health Act of 2000'' contains provisions to address this serious health concern. The legislation directs the Secretary of Health and Human Services to establish a program funding innovative oral health activities to improve the oral health of children under six years of age. The legislation will make these grants available to innovative programs at community health centers, dental training institutions, Indian Health Service facilities, and other community dental programs.

Let's face it, dental disease in young children is a significant public health problem. And this legislation is the beginning of a coordinated, inter-agency strategy that will assist states and localities reduce this preventable problem.

I am also pleased that we are considering the Youth Drug and Mental Health Services Act. This legislation addresses many important issues such as drug abuse and mental health services and how to treat these serious problems within our society.

One issue that is highlighted in this bill is the prevention of teen suicide. This is an issue that is rapidly becoming a crisis not only in my State of Utah but throughout the entire country.

Young people in the United States are taking their own lives at alarming rates. The trend of teen suicide is seeing suicide at younger ages, with the United States suicide rate for individuals under 15 years of age increasing 121 percent from 1980 to 1992. Suicide is the third leading cause of death for young people aged 15 to 24, and the fourth leading cause of death for children between 10 and 14. In 1997 study, 21 percent of the nation's high school students reported serious thoughts about attempting suicide, with 15.7 percent making a specific plan.

Utah consistently ranks among the top ten states in the nation for suicide, and we continue to see increases in suicide rates among our youth. In Utah, suicide rates for ages 15 to 19 have increased almost 150 percent in the last 20 years. According to the CDC, Utah had the tenth highest suicide rate in the country during 1995–1996 and was 30 percent above the U.S. rate. This is one statistical measure on which I want to see my state at the bottom.

Although numerous symptoms, diagnoses, traits, and characteristics have been investigated, no single fact or set of factors has ever come close to predicting suicide with any accuracy.

I have worked on legislation that will help us determine the predictors of suicide among at risk and other youth. We need to understand what the barriers are that prevent youth from receiving treatment so that we can facilitate the development of model treatment programs and public education and awareness efforts. It also calls for a study designed to develop a profile of youths who are more likely to contemplate suicide and services available to them.

This bill also contains provisions from S. 1428, the Methamphetamine Anti-Proliferation Act of 2000. I introduced this bill because of evidence that methamphetamine remains a threat to the entire country, and particularly to my state of Utah. Elements of this bill are also contained in S. 486 as it was reported by the Judiciary Committee.

Throughout my travels in Utah, I have heard from state and local law enforcement officials, mayors, city councils, parents, and youth about the seriousness of the methamphetamine problem.

Recently, I held two field hearings in Utah during which I heard directly from constituents whose lives had been affected by methamphetamine. I listened to a mother tell a heart-wrenching story of how her beloved daughter had become addicted to methamphetamine and how she feared for her daughter's life. She tearfully described her daughter as being two people, the person ''who has the values of our family, who is kind hearted and loving; and then there's our daughter who's the meth user, and they are completely opposite.''

I also heard testimony from the wife of a methamphetamine addict. I heard how her husband's methamphetamine addiction destroyed their marriage and their financial security. Painfully, she explained how her husband put her and their infant son at risk when he decided to manufacture methamphetamine in their home. She had no choice but to report his activities to the police, a decision that undoubtedly will haunt her for the rest of her life.

Methamphetamine use is an insidious virus sapping the strength and character of our country. We need to attack it. This bill contains the tools to help the people of Utah and the rest of the country fight this wicked drug.

This bill bolsters the Drug Enforcement Agency's, DEA, ability to combat the manufacturing and trafficking of methamphetamine by authorizing the creation of satellite offices and the hiring of additional agents to assist State and local law enforcement officials. More than any other illicit drug, methamphetamine manufacturers and traffickers operate in small towns and rural areas. And, unfortunately, rural law enforcement agencies often are overwhelmed and in dire need of the DEA's expertise in conducting methamphetamine investigations.

To address this problem, the bill authorizes the expansion of the number of DEA resident offices and posts-of-duty, which are smaller DEA offices often set up in small and rural cities that are overwhelmed by methamphetamine manufacturing and trafficking. There are also provisions to assist state and local officials in handling the dangerous toxic waste left behind by methamphetamine labs.

To counter the dangers that manufacturing drugs like methamphetamine inflict on human life and on the environment, the bill imposes stiffer penalties on manufacturers of all illegal drugs when their actions create a substantial risk of harm to human life or to the environment. The inherent dangers of killing innocent bystanders and, at the same time, contaminating the environment during the methamphetamine manufacturing process warrant a punitive penalty that will deter some from engaging in the activity.

Finally, the bill increases penalties for manufacturing and trafficking the drug amphetamine, a lesser-known, but no-less dangerous drug than methamphetamine. Other than for a slight difference in potency, amphetamine is manufactured, sold, and used in the same manner as methamphetamine. Moreover, amphetamine labs pose the same dangers as methamphetamine labs. Not surprisingly, every law enforcement officer with whom I have spoken agreed that the penalties for amphetamine should be the same as those for methamphetamine. For these reasons, the bill equalizes the punishment for manufacturing and trafficking the two drugs.

While we know that vigorous law enforcement measures are necessary to combat the methamphetamine scourge, we also recognize that we must act to prevent our youth from ever starting

down the path of drug abuse. We also must find ways to treat those who have become trapped in addiction. For these reasons, the bill contains several significant prevention and treatment provisions.

The comprehensive nature of this bill attacks the methamphetamine problem on several fronts. It bolsters our law enforcement efforts to crack down on traffickers, provides treatment and prevention funding for our schools and communities, and authorizes much needed resources for cleaning-up the toxic pollutants left behind by methamphetamine lab operators.

I have been working for over a year with colleagues on both sides of the aisle and in both Houses of Congress to pass this important legislation. It is important to highlight that, as part of this process, there have been changes to the bill made in response to legitimate complaints raised by my colleagues and constituents. For example, provisions relating to search warrants and the Internet have been deleted because of these concerns.

Overall, this bill represents a bipartisan effort that will result in real progress in our continuing battle against the scourge of methamphetamine.

Yet another important anti-drug abuse provision in this bill we are adopting today is the Drug Addiction Treatment Act, or the DATA bill. With the bipartisan cosponsorship of Senators LEVIN, BIDEN and MOYNIHAN, I introduced S. 324 last year, and I am pleased that this bill has been inserted in H.R. 4365.

In 1999, as part of the comprehensive methamphetamine bill, S. 486, the DATA bill was reported by the Judiciary Committee and adopted by the full Senate. The DATA bill also was included in the anti-drug provisions that were adopted as part of the bankruptcy reform legislation, S. 625, that passed the Senate last year. I hope the third Senate passage is indeed the charm.

The goal of the DATA provisions is simple but it is important: The DATA bill attempts to make drug treatment more available and more effective to those who need it.

This legislation focuses on increasing the availability and effectiveness of drug treatment. The purpose of the Drug Addiction Treatment Act is to allow qualified physicians, as determined by the Department of Health and Human Services, to prescribe schedule III, IV and V anti-addiction medications in physicians' offices without an additional Drug Enforcement Administration, DEA, registration if certain conditions are met.

These conditions include certification by participating physicians that they are licensed under state law and have the training and experience to treat opium addicts and they will not treat more than 30 in an office setting unless the Secretary of Health and Human Services adjusts this number.

The DATA provisions allow the Secretary, as appropriate, to add to these conditions and allow the Attorney General to terminate a physician's DEA registration if these conditions are violated. This program will continue after three years only if the Secretary and Attorney General determine that this new type of decentralized treatment should not continue.

This bill would also allow the Secretary and Attorney General to discontinue the program earlier than three years if, upon consideration of the specified factors, they determine that early termination is advisable.

Nothing in the waiver policy called for in my bill is intended to change the rules pertaining to methadone clinics or other facilities or practitioners that conduct drug treatment services under the dual registration system imposed by current law. And nothing in this bill is intended to diminish the existing authority of DEA to enforce rigorously the provisions of the Controlled Substances Act. Doctors and health care providers should be free to practice the art of medicine but they may never violate the terms of the Controlled Substances Act.

In drafting the waiver provisions of the bill, the Drug Enforcement Agency, the Food and Drug Administration, and the National Institute on Drug Abuse were all consulted. Secretary Shalala has provided her leadership in this area. As well, this initiative is consistent with the announcement of the Director of the Office of National Drug Control Policy, General Barry McCaffrey, of the Administration's intent to work to decentralize methadone treatment.

In 1995, the Institute of Medicine of the National Academy of Sciences issued a report, ''Development of Medications for Opiate and Cocaine Addictions: Issues for the Government and Private Sector.'' The study called for ''(d)eveloping flexible, alternative means of controlling the dispensing of anti-addiction narcotic medications that would avoid the 'methadone model' of individually approved treatment centers.''

The Drug Addiction Treatment Act—DATA—is exactly the kind of policy initiative that experts have called for in America's multifaceted response to the drug abuse epidemic. I recognize that the DATA legislation is just one mechanism to attack this problem, and I plan to work with my colleagues in the Congress to devise additional strategies to reduce both the supply and demand for drugs.

These provisions promote a policy that dramatically improves these lives because it helps those who abuse drugs change their lives and become productive members of society. We have work to do on heroin addiction. For example, a 1997 report by the Utah State Division of Substance Abuse, ''Substance Abuse and Need for Treatment Among Juvenile Arrestees in Utah'' cites literature reporting heroin-using offenders committed 15 times more robberies, 20 times more burglaries, and 10 times more thefts than offenders who do not use drugs. We must stop heroin abuse in Salt Lake City and in all of our nation's cities and communities.

In my own state of Utah, I am sorry to report, according to a 1997 survey by the State Division of Substance Abuse, about one in ten Utahns used illicit drug in a given survey month. That number is simply too high; although I cannot imagine that my colleagues would not be similarly alarmed if they looked at data from their own states. We must prevent and persuade our citizens from using drugs and we must help provide effective treatments and systems of treatments for those who succumb to drug abuse.

I hope that the success of this system will create incentives for the private sector to continue to develop new medications for the treatment of drug addiction, and I hope that qualified doctors will use the new system and that general practice physicians will take the time and effort to qualify to use this new law to help their addicted patients. I am proud to have worked with the Administration and my colleagues on a bipartisan basis in adopting the DATA provisions and creating this new approach that undoubtedly will improve the ability for many to obtain successful drug abuse treatment.

In closing, I also want to commend the many staff persons who have worked so hard on this bill. These include Dave Larson, Anne Phelps, Jackie Parker, Marcia Lee, Kathleen McGowan, Leah Belaire, David Russell, Pattie DeLoatche and Bruce Artim in the Senate and Marc Wheat and John Ford in the House.

I strongly support this legislation and urge my colleagues in the House to pass it as quickly as possible. It is a bill that will raise awareness on children's health issues and, at the same time, assist those who have specific needs with regard to alcohol abuse, drug abuse and mental health issues. It is a good consensus product and is worthy of our support.

THE VERY BAD DEBT BOXSCORE

Mr. HELMS. Mr. President, at the close of business yesterday, Monday, September 25, 2000, the Federal debt stood at $5,646,252,666,475.97, five trillion, six hundred forty-six billion, two hundred fifty-two million, six hundred sixty-six thousand, four hundred seventy-five dollars and ninety-seven cents.

Five years ago, September 25, 1995, the Federal debt stood at $4,949,969,000,000, four trillion, nine hundred forty-nine billion, nine hundred sixty-nine million.

Ten years ago, September 25, 1990, the Federal debt stood at $3,213,942,000,000, three trillion, two hundred thirteen billion, nine hundred forty-two million.

Fifteen years ago, September 25, 1985, the Federal debt stood at