''(D) include options and recommendations for the various entities responsible for elementary and secondary education to address the challenges and issues identified in the reports.''.

SEC. 208. STUDY OF ACCESSIBILITY TO INFORMATION TECHNOLOGY.

Section 201 of the High-Performance Computing Act of 1991 (15 U.S.C. 5524), as amended by sections 3(a) and 4(a) of this Act, is amended further by inserting after subsection (g) the following new subsection:

''(h) STUDY OF ACCESSIBILITY TO INFORMATION TECHNOLOGY.—

''(1) STUDY.—Not later than 90 days after the date of the enactment of the Federal Research Investment Act, the Director of the National Science Foundation, in consultation with the National Institute on Disability and Rehabilitation Research, shall enter into an arrangement with the National Research Council of the National Academy of Sciences for that Council to conduct a study of accessibility to information technologies by individuals who are elderly, individuals who are elderly with a disability, and individuals with disabilities.

''(2) SUBJECTS.—The study shall address—

''(A) current barriers to access to information technologies by individuals who are elderly, individuals who are elderly with a disability, and individuals with disabilities;

''(B) research and development needed to remove those barriers;

''(C) Federal legislative, policy, or regulatory changes needed to remove those barriers; and

''(D) other matters that the National Research Council determines to be relevant to access to information technologies by individuals who are elderly, individuals who are elderly with a disability, and individuals with disabilities.

''(3) TRANSMITTAL TO CONGRESS.—The Director of the National Science Foundation shall transmit to the Congress within 2 years of the date of the enactment of the Federal Research Investment Act a report setting forth the findings, conclusions, and recommendations of the National Research Council.

''(4) FEDERAL AGENCY COOPERATION.—Federal agencies shall cooperate fully with the National Research Council in its activities in carrying out the study under this subsection.

''(5) AVAILABILITY OF FUNDS.—Funding for the study described in this subsection shall be available, in the amount of $700,000, from amounts described in subsection (c)(1).''.

SEC. 209. COMPTROLLER GENERAL STUDY.

Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall transmit to the Congress a report on the results of a detailed study analyzing the effects of this Act, and the amendments made by this Act, on lower income families, minorities, and women.

CHILDREN'S HEALTH ACT OF 2000

Mr. LOTT. I ask unanimous consent that the health committee be discharged from further consideration of H.R. 4365 and the Senate then proceed to its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report the bill by title.

The assistant legislative clerk read as follows:

A bill (H.R. 4365) to amend the Public Health Service Act with respect to children's health.

There being no objection, the Senate proceeded to consider the bill.

AMENDMENT NO. 4181

Mr. LOTT. Senator FRIST has an amendment at the desk and I ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Mississippi [Mr. LOTT], for Mr. FRIST, proposes an amendment numbered 4181.

Mr. LOTT. Mr. President, I ask unanimous consent reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

Mr. FRIST. Mr. President, I am pleased that the Senate has passed today, H.R. 4365, the Children's Health Act of 2000, a comprehensive of several important children's health bills on which I and the rest of the Senate have spent a great amount of time over the past year and a half. These bills address a wide variety of critical children's health issues, including day care safety, maternal and infant health, pediatric public health promotion, pediatric research, and efforts to fight youth drug abuse and provide mental health services. Collectively, this comprehensive bill will form the backbone of efforts that will improve the health and safety of America's children well into the coming years.

The bill which passed the Senate today includes two divisions, with Division A addressing issues regarding children's health, while Division B addresses youth drug abuse.

Perhaps the most critical section in Division A of this bill are provisions relating to day care health and safety, which were included in S. 2263, the ''Children's Day Care Health and Safety Improvement Act,'' which I introduced with Senator DODD on March 9, 2000. These provisions recognize that while more than 13 million children under the age of six spend some part of their day in day care, including 254,000 children in Tennessee alone, evidence suggests a need to make these settings safer and improve the health of children in child care settings.

The danger in child care settings has recently become evident in Tennessee. Tragically, within the span of 2 years, there have been 4 deaths in child care settings in Memphis, and 1 in 5 child-care programs in the Nashville area were found to have potentially put the health and safety of children at risk during 1999. But this isn't just a Tennessee concern. It affects parents nationwide.

For example, according to a Consumer Product Safety Commission Study, in 1997, 31,000 children ages four and younger were treated in hospital emergency rooms for injuries sustained in child care or school settings. Since 1990, more than 60 children have died in child care settings. This is unacceptable. The thousands of parents leaving their children in the hands of child care providers each day deserve reassurance that their children are safe.

Further evidence of day care health and safety concerns were made clear in a recent study by the American Academy of Pediatrics which showed a disturbing trend among infants and Sudden Infant Death Syndrome (SIDS) in day care. The study examined 1,916 SIDS cases from 1995 to 1997 in 11 states, and found that about 20 percent, 391 deaths, occurred in day care settings. Most troubling was the fact that in over half of the cases where caretakers placed children on their stomach, the children were usually put to sleep on their backs by their parents.

Parents and advocates who are dedicated in helping to eliminate the incidence of SIDS have urged that child care providers be required to have SIDS risk reduction education. I agree, which is why I included provision in the bill to carry out several activities, including the use of health consultants to give health and safety advice to child care providers on important issues like SIDS prevention.

Overall the bill provides $200 million to states, including $4.2 million for my state of Tennessee, to help improve the health and safety of children in child care. The grants could be used for a number of activities, including child care provider training and education; inspections and criminal background checks for day care providers; enhancements to improve a facility's ability to serve children with disabilities; transportation safety procedures; and information for parents on choosing a safe and healthy day care setting. The funding could also be used to help child care facilities meet health and safety standards or employ health consultants to give health and safety advice to child care providers.

As a father, my highest concern is the safety of my three sons, and I understand the fears that so many parents have. Parents shouldn't be afraid to leave their children in the care of a licensed child care facility. This bill helps ensure that our child care centers will be safer.

The major portion of Division A are provisions which were included in the ''Children's Public Health Act of 2000'' which I introduced on July 13, 2000 with Senators JEFFRODS and KENNEDY. Provisions in the ''Children's Public Health Act of 2000'' address a wide range of children's health issues including maternal and infant health, pediatric health promotion, and pediatric research.

Unintentional injuries are the leading cause of death for every age group between 1 and 19 years of age, comprising 26 deaths per 100,000 children aged 1–14 and 62 deaths per 100,000 children aged 15–19. More than 1.5 million American children suffer a brain injury each year. Therefore, the bill reauthorizes and strengthens the Traumatic Brain Injury programs at the Centers for Disease Control and Prevention

(CDC), the National Institutes of Health (NIH) and the Health Resources and Services Administration (HRSA).

Because birth defects are the leading cause of infant mortality and are responsible for about 30 percent of all pediatric hospital admissions, the bill also focuses on maternal and infant health. This legislation establishes a National Center for Birth Defects and Developmental Disabilities at the CDC to collect, analyze, and distribute data on birth defects. In addition, the bill authorizes the Healthy Start program to reduce the rate of infant mortality and improve perinatal outcomes by providing grants to areas with a high incidence of infant mortality and low birth weight.

Furthermore, over 3,000 women experience serious complications due to pregnancy. Two out of three will die from complications in their pregnancy. Therefore, the bill develops a national monitoring and surveillance program to better understand maternal complications and mortality, and to decrease the disparities among populations at risk of death and complications from pregnancy.

The bill also combats some of the most common childhood diseases and conditions. For instance, it provides comprehensive asthma services and coordinates the wide range of asthma prevention programs in the federal government to address the most common chronic childhood disease, asthma, which affects nearly 5 million children.

We also focus on childhood obesity, which has doubled in just the past 15 years, and produced 4.7 million seriously overweight children and adolescents ages 6–19 years. To address this epidemic, the bill supports state and community-based programs to promote good nutrition and increased physical activity among American youth.

In examining the problems affecting children across the nation and in Tennessee, I was very concerned to learn that in Memphis, over 12 percent of children under the age of 6 may have lead poisoning. Such poisoning can cause a variety of debilitating health problems, including seizure, and coma, and even death. Even at lower levels, lead can contribute to learning disabilities, loss of intelligence, hyperactivity, and behavioral problems. This bill includes physician education and training programs on current lead screening policies, tracks the percentage of children in the Health Centers program who are screened for lead poisoning, and conducts outreach and education for families at risk of lead poisoning,

The May 2000 Surgeon General's report noted that oral health is inseparable from overall health, and that while a majority of the population has experienced great improvements in oral health, disparities affecting poor children and those who live in underserved areas represent 80 percent of all dental cavities in 20 percent of children. This bill encourages pediatric oral health by supporting community-based research and training to improve the understanding of etiology, pathogenesis, diagnoses, prevention, and treatment of pediatric oral, dental, and craniofacial diseases.

Finally, the bill strengthens pediatric research efforts by establishing a Pediatric Research Initiative within the NIH to enhance collaborative efforts, provide increased support for pediatric biomedical research, and ensure that opportunities for advancement in scientific investigations and care for children are realized.

I also want to highlight the critical issue of childhood research protections. Included in this bill are provisions to address safety issues in children's research by requiring the Secretary of HHS to review the current federal regulations for the protection of children participating in research, which address such issues as determining acceptable levels of risk and obtaining parental permission, and to report to Congress on how to ensure the highest standards of safety. Also, the provision requires that all HHS-funded and regulated research comply with these additional protections for children. During this year, the Senate Subcommittee on Public Health, which I chair, held two important hearings relating to gene therapy trials and human subject protections. The Subcommittee discovered that there was a lapse of protection for individuals participating as subjects in clinical trial research. Next Congress, I intend to make the further review and updating of human subject protections a major priority of the Subcommittee.

Division B of the bill contains provisions which address the scourge upon children of drug abuse. The 1999 National Household Survey on Drug Abuse, conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), reported that 10.9 percent of youths age 12–17 currently use illicit drugs. It further estimated that nearly 11.3 percent of 12–17 year-old boys and 10.5 percent of 12–17 year-old girls used drugs in the past month. But just as important is the growth in alcohol abuse among our youth, as SAMHSA reports that 10.4 million current drinkers are younger than the legal drinking age of 21 and that more than 6.8 million engaged in binge drinking. Tragically, all of these numbers among youth substance abuse have risen since 1992.

To address the tragedy of drug use by our children, the bill incorporates the ''Youth Drug and Mental Health Services Act,'' which I introduced with Senator KENNEDY last spring and was first passed the Senate on November 3, 1999.

The ''Youth Drug'' bill addresses the problem of youth substance abuse by reauthorizing and improving SAMHSA through a renewed focus on youth and adolescent substance abuse and mental health services, in conjunction with greater flexibility and new accountability for States for the use of federal funds.

Created in 1992 to assist States in reducing the incidence of substance abuse and mental illness through prevention and treatment programs, SAMHSA provides funds to States for alcohol and drug abuse prevention and treatment programs and activities, as well as mental health services, with its block grants accounting for 40 percent and 15 percent respectively of all substance abuse and community mental health services funding in the States. In my own State of Tennessee, SAMHSA provides more than 70 percent of overall funding for the Tennessee Department of Health's Bureau of Alcohol and Drug Abuse Services.

This bill accomplishes six critical goals: (1) promotes State flexibility by easing outdated or unneeded requirements governing the expenditure of Federal block grants; (2) ensures State accountability by moving away from the present system's inefficiencies to a performance based system; (3) provides substance abuse treatment services and early intervention substance abuse services for children and adolescents; (4) helps local communities treat violent youth and minimize outbreaks of youth violence through partnerships among schools, law enforcement and mental health services; (5) ensures Federal funding for substance abuse or mental health emergencies; and (6) supports and expands programs providing mental health and substance abuse treatment services to homeless individuals.

The bill also includes a number of other important provisions, including those to address how to treat individuals with co-occurring mental health and substance abuse disorders the proper and safe use of restraints and seclusions in mental health facilities, and important ''charitable choice'' provision that permits Federal assistance for religious organizations providing substance abuse services. We know that no one approach works for everyone who needs and wants substance abuse treatment and that faith-based programs have strong records of successful rehabilitation. This provision will allow faith-based programs to continue to offer their assistance and expertise.

The ''Youth Drug and Mental Health Services Act'' provides Tennessee and other states needed funds for community based programs helping individuals with substance abuse and mental health disorders, dramatically increasing State flexibility and ensuring that each State is able to address its unique needs. The bill provides a much needed focus on the troubling issue of drug use by our youth and helps local communities deal with the issue of children and violence.

I would also like to highlight the ''Methamphetamine Anti-Proliferation Act of 1999,'' which is sponsored by Senator ASHCROFT and included in this comprehensive bill. This bill address the plague of methamphetamine which has severely impacted Tennessee, other

southern states, the Mid-West, and Rocky Mountain states. Under these provisions, criminal penalties are increased for individuals who manufacture methamphetamine. The provisions also increase funding for law enforcement training and target high intensity methamphetamine trafficking areas.

Finally the bill also tackles another devastating drug which has shown signs of increased use in our youth, the drug known as ''Ecstasy.'' In short, the bill directs the Sentencing Commission to review and amend the Ecstasy guidelines to provide for increased penalties to reflect the seriousness of the offenses of trafficking in and importing Ecstasy and related drugs.

Mr. President, this legislation which has passed the Senate today is a comprehensive, multifaceted attack on the numerous threats to our children's health. I am thankful for all my colleagues for their support and willingness to help the children of this nation. I would especially like to thank Senators JEFFORDS and KENNEDY and Representatives TOM BLILEY, MICHAEL BILIRAKIS, JOHN DINGELL and SHERROD BROWN, and their excellent staffs for all the hard work and dedication which has gone into this bill. I would also like to thank Mr. Bill Baird and Ms. Daphne Edwards, of the Office of Senate Legislative Counsel, for their tireless work and for their great expertise in drafting this comprehensive bill. I would also like to personally thank Mr. Joseph Faha, Director of Legislation and External Affairs of the Substance Abuse and Mental Health Service Administration as well as other member of the Department of Health of Human Services. Finally, I would like to thank my Staff Director, of the Public Health Subcommittees, Anne Phelps and my Health Policy Advisor, Dave Larson. Finally, I would like to thank the may groups advocating on behalf of children and parents and families who have worked so hard to bring this bill to fruition. I look forward to swift action in the House on this measure and it's enactment into law.

Mr. KENNEDY. Mr. President, this legislation will help millions of children in the years ahead. It takes needed action to improve children's health by expanding pediatric research and taking specific steps to deal with a wide range of childhood illnesses, disorders, and injuries. It also reauthorizes the Substance Abuse and Mental Health Services Adminstration, which has an important role in reducing substance abuse and maintaining and improving the mental health of the nation's children and adolescents. Coordinated efforts in these areas can lead to significant benefits for all children.

Senator FRIST and I have worked closely with many of our Democratic and Republican colleagues on this important legislation. We have talked with experts and advocates in the children's health community and in the mental health and substance abuse treatment communities. This legislation will lead to significant progress in addressing many of today's most pressing pediatric public health problems.

The legislation includes a variety of new and reauthorized children's health provisions. It represents a compromise with our colleagues in the House and addresses a wide range of pediatric public health issues raised by experts in the field and championed by numerous members from both sides of the aisle in both chambers.

Division A of the bill focuses on general children's health. It includes programs to improve the health of pregnant women and prenatal outcomes, including prevention of birth defects and low birth weight. It establishes a new Center for Birth Defects and Developmental Disabilities at the Centers for Disease Control and Prevention, in order to focus the nation's activities more effectively in these important areas. It also directs the Secretary of the Department of Health and Human Services to expand public education efforts on folic acid consumption in order to decrease neural tube birth defects.

The bill also deals with traumatic brain injury which is the leading cause of death and disability in young Americans. The Centers for Disease Control and Prevention has estimated that 5.3 million Americans are living with long-term, severe disability as a result of brain injuries, and each year 50,000 people die as a result of such injuries. The Children's Public Health Act revises and extends the authorization for a series of important programs that were enacted in 1996 to deal with these injuries. This reauthorization will assure continued progress toward understanding, treating and preventing them.

In addition, the bill includes the long overdue reauthorization of the CDC's Injury Prevention and Control Programs. There are steps we should take to modernize this authority and increase the authorization levels, but it is welcome progress at last to renew its authorization.

Improving and protecting the safety of child care facilities is also a high priority for Congress. This legislation creates a new program to improve the safety of children in child care settings, and to encourage child care providers to take steps to prevent illness and injuries and protect the health of the children they serve.

It is said that the 21st century will be the century of life sciences. Our national health policy will have the benefit of brilliant new scientific discoveries that have already begun to change how we diagnose, treat and prevent countless conditions. The legislation creates a new grant program that focuses on inherited disorders. Based on legislation introduced last year that has the strong support of a broad-based coalition of both the genetics and public health communities, our bill provides funds for state or local public health departments to expand existing programs or initiate new programs that provide screening, counseling or health services to infants and children who have genetic conditions or are at risk for such conditions. It also establishes an Advisory Committee to assist the Secretary on these issues.

The bill also takes a number of steps to address other prevalent childhood conditions. Asthma is the most common chronic childhood illness, affecting more than seven percent of all American children. The death rate for children with asthma increased by 78 percent between 1980 and 1993, and asthma-related costs total nearly $2 billion annually in direct health care for children. The nation is handicapped by a lack of basic information on where and how asthma strikes, what triggers it, and how effectively the health care system is responding to those who suffer from this chronic disease. Our bill will provide greater asthma services to children, including mobile clinics and patient and family education, and it will help to reduce allergens in housing and public facilities.

Poor nutrition and lack of physical activity are also hurting many American children and contributing to lifelong health problems. The nation spends $39 billion a year—equal to six percent of overall U.S. health care expenditures—on direct health care related to obesity. Twenty percent of American children—one in five—are overweight. Unhealthy eating habits and physical inactivity in childhood can lead to heart disease, cancer and other serious illnesses decades later. Children and adolescents who suffer from eating disorders, such as anorexia nervosa and bulimia, can have wide-ranging physical and mental health impairments. Our legislation establishes new grant programs to reduce childhood obesity and eating disorders, promote better nutritional habits among children, and encourage an appropriate level of physical activity for children and adolescents.

The bill also requires the Secretary to study issues related to effective treatment for metabolic disorders, including PKU, and access to such treatments, in order to prevent worsening of these conditions. It is my hope that this study will be useful for employers, insurers, insurance commissioners and others who provide insurance or set coverage standards.

Another major area where additional efforts are needed is dental care. Last May, the Surgeon General published a landmark report on oral health in America, emphasizing the need to consider oral health as an essential part of total health. There is no question that oral and dental health care should be included in primary care. Tooth decay is the most common childhood infectious disease, and it can lead to devastating consequences, including problems with eating, learning and speech. Twenty-five percent of children in the United States suffer 80 percent of the tooth decay, with significant racial and

age disparities. The number of dentists in the country has been declining since 1990, and is projected to continue to decline through the year 2020.

According to a 1995 report by the Inspector General, only one in five Medicaid-eligible children receive dental services annually, and the shortage of dentists exacerbates the problem of unmet needs. Yet tooth decay is largely preventable. More effective efforts to educate parents and children about the causes of tooth decay—and initiatives to prevent and treat it—can lead to lasting public health improvements. Our legislation includes a variety of approaches to deal with this silent epidemic, including a new grant program to improve the understanding of prevention, diagnosis, and treatment of pediatric oral diseases and conditions, and grants to increase community-wide fluoridation and school-based dental sealant programs. It also directs the Secretary to undertake a coordinated oral health initiative to fund innovative activities to improve the oral health of low-income children.

Research has long shown that childhood lead poisoning can have devastating effects on children, causing reduced IQ and attention span, stunted growth, behavior problems, and reading and learning disabilities. Yet too many children remain unscreened and untreated, and adequate services often are not available for children with elevated levels of lead in their blood. There is no excuse for not taking greater steps to eliminate childhood lead poisoning. Our bill includes screening for early detection and treatment, professional education and training programs, and outreach and education activities for at-risk children.

Pediatric research discoveries promote and maintain health throughout a child's life span, and also contribute significantly to new insights that aid in the prevention and treatment of illnesses among adults. A growing body of evidence shows that risk factors for conditions such as coronary artery disease and stroke begin in childhood and persist through adulthood. Congress has a strong record of promoting basic and clinical research, and the steps taken in this legislation continue that priority with a special focus on children.

The legislation establishes a pediatric research initiative, authorized at $50 million annually, that will increase support for pediatric biomedical research at the National Institutes of Health, including an increase in collaborative efforts among multidisciplinary fields in areas that are promising for children. The legislation also requires coordination with the Food and Drug Administration to increase the number of pediatric clinical trials, and to provide greater information on safer and more effective use of prescription drugs in children.

Children have unique health care needs. They are not simply small adults. Nothing is more important to the future health of America's children than maintaining a steady supply of pediatricians, pediatric specialists and pediatric-focused scientists.

Our legislation takes several important steps to improve the growth and development of a pediatric-focused medical community. It enhances support through the NIH expressly for training and career development activities of pediatric researchers, including establishing a loan repayment program for health care professionals who focus on pediatric research.

It revises and extends the authorization of a program enacted last year to support graduate medical education at independent children's hospitals. These hospitals train half of all pediatric specialists, and 30 percent of all pediatricians. However, because GME activities have historically been supported by Medicare and because these hospitals serve very few Medicare patients, they have traditionally received very little federal financial support for this important and costly activity. As a result, children's hospitals are struggling to maintain the important training, pediatric research, and primary and specialty care services that they provide. Children's hospitals should be treated like all other teaching hospitals when it comes to support for their GME activities. I have sponsored other legislation to guarantee full funding each year, without being subject to the appropriations process. That proposal has been included in the Balanced Budget Refinement Act of 2000. It is awaiting consideration in the Finance Committee, and I hope it will be enacted this year.

The bill also authorizes a new long-term study to monitor and evaluate health and development of children through adulthood. The kind of information that will be obtained by this study is long-overdue, and I look forward to its results.

The bill also takes two steps to protect children who participate in clinical trials and other research. It requires all HHS-regulated and funded research to comply with current pediatric-specific human subject protection regulations. This provision is supported by the FDA and industry alike, and it is an important step toward assuring full public confidence in life-saving research activities. In addition, it requires the Secretary to review those regulations and report on their adequacy and recommendations, if any, for changes within six months. Our committee intends to look more broadly at the issue of human subject protections next year, and this report will help inform those discussions.

Finally, this legislation also includes a variety of directives to increase activities at public health agencies on specific disorders and diseases affecting children. Children living with autism, Fragile X, diabetes, arthritis, muscular dystrophy, epilepsy, cystic fibrosis, and a number of other conditions have much to be grateful for today. We all have the highest hopes that the provisions in this bill will lead to successful efforts to combat these debilitating and often deadly conditions.

Division B of the bill will enable the Substance Abuse and Mental Health Services Administration to meet the mental health and substance abuse needs of communities through its successful existing programs and through new and innovative initiatives.

The recent National Household Survey on Drug Abuse indicates that we have made important progress in combating substance abuse, especially among the nation's youth. The goal of this legislation is to build on that progress with expanded prevention and treatment services. Several of the bill's provisions come from the Mental Health Early Intervention, Treatment, and Prevention Act, which Senator DOMENICI and I introduced in response to the Surgeon General's groundbreaking Report on Mental Health. These provisions take needed steps to give the mentally ill the services they need.

This legislation is the product of bipartisan cooperation, and I especially commend Senator FRIST for his leadership in bringing everyone together. His efforts have helped ensure that the measure we pass today is an effective response to the mental illness and substance abuse problems we face.

Over the past two decades, we have made great progress in determining the causes of mental illnesses and developing strategies to treat them. We have also begun to understand the biological basis of substance abuse. Despite these scientific advances, mental illness and substance abuse continue to be a national crisis. One in five Americans will experience some form of mental illness this year—and two-thirds of them will not seek treatment. Substance abuse costs the country an estimated $270 billion in annual economic costs, and it leads to unacceptable violence, injury, and HIV infection in our communities.

Too often, patients with mental illness are denied the state-of-the-art treatment that would be available if their illnesses were physical instead of mental. We have failed to provide them with the services they need to meet the overwhelming obstacles they face. We have not made an adequate effort to help them overcome their addictions. The bill we pass today is intended to correct these injustices.

It will provide treatment to those who desperately need it and prevention services to those at risk. Much of the bill focuses on the unique needs of youths, adolescents, and young adults. It provides services for children of substance abusers, training for teachers to recognize the symptoms of mental illness, and a suicide prevention program for children and youth. In addition, it provides a range of community services for children with serious emotional disturbances and for youth offenders. Agencies will receive funding to study

and treat post-traumatic stress disorder in children. The bill also provides funds to coordinate welfare and mental health services for children who would benefit from this approach.

For homeless individuals, the bill provides expanded mental health and substance abuse services, along with transition assistance. For residents of treatment facilities, it offers protections from the inappropriate and often harmful use of seclusion and restraints. The bill will help to divert persons with mental illness from the criminal justice system, which for too long has served as a dumping-ground, and give them the services they need. It will provide special treatment for those who suffer simultaneously from mental illness and addiction. It will also provide funds to designate facilities as emergency mental health centers, especially in underserved areas. In all the services included, there will be a special emphasis on meeting the unique needs of specific cultures and ethnic groups, and on giving states the flexibility they need to address the concerns of their individual communities.

For too long, we have blamed the mentally ill and those addicted to alcohol and other drugs for their behavior, rather than extending a helping hand. Recent scientific advances have opened new windows onto the biochemical basis of mental illness and addictive behavior. This legislation will ensure that these advances are translated into practical services for those who need them. By creating this more effective framework to deliver appropriate services, we will help many more individuals to re-enter society as productive members, and do much more to dispel the stigma of diseases that affect the mind.

This legislation deserves to be a major public health priority for the nation. Congress should send the President this legislation before the end of this session.

I ask unanimous consent that the summary of the legislation be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

THE CHILDREN'S HEALTH ACT OF 2000:
DIVISION A—CHILDREN'S HEALTH

TITLE I—AUTISM

Under this provision, the Director of NIH shall expand, intensify, and coordinate the activities of the NIH with respect to research on autism. The Director of NIH will establish not less than 5 Centers of Excellence on autism research. Each center will conduct basic and clinical research into the cause, diagnosis, early detection, prevention, control and treatment of autism, including research in the fields of developmental neurobiology, genetics and psychopharmacology. The Director shall provide for the coordination of information among centers. The Director shall provide for a program under which samples of tissues and genetic materials that are of use in research on autism are made available for this research.

The provision also establishes 3 CDC regional centers of excellence in autism and pervasive developmental disabilities, to collect and analyze information on the number, incidence, and causes of autism and related developmental disabilities. The Secretary shall also establish a program to provide information on autism to health professionals and the general public, and establish a committee to coordinate all activities within HHS concerning autism.

TITLE II—RESEARCH AND DEVELOPMENT REGARDING FRAGILE X

Instructs the National Institute of Child Health and Human Development to expand, intensify, and coordinate research on Fragile X and authorizes the development of coordinated Fragile X research centers.

TITLE III—JUVENILE ARTHRITIS AND RELATED CONDITIONS

Requires the National Institute of Arthritis and Musculoskeletal and Skin Diseases to expand and intensify research concerning juvenile arthritis. Directs HHS to evaluate whether the supply of pediatric rheumatologists is adequate to meet the health care needs of children with arthritis.

TITLE IV—REDUCING BURDEN OF DIABETES AMONG CHILDREN AND YOUTH

Directs the Secretary, acting through the CDC, to develop a sentinel system to collect incidence and prevalence data on juvenile diabetes. Requires NIH to conduct or support long-term epidemiology studies to investigate the causes and characteristics of juvenile diabetes, and to support regional clinical research centers for the prevention, detection, treatment and cure of juvenile diabetes. Provides for research and development of prevention strategies.

TITLE V—ASTHMA SERVICES FOR CHILDREN

This provision authorizes the Secretary to award grants to provide comprehensive asthma services to children, equip mobile health care clinics, conduct patient and family education on asthma management, and identify children eligible for Medicaid, the State Children's Health Insurance Program, and other children's health programs. This provision amends the Preventive Health and Health Services Block Grant program to provide for the establishment, operation, and coordination of effective and cost-efficient systems to reduce the prevalence of asthma and asthma-related illnesses, especially among children, by reducing the level of exposure to allergens through the use of integrated pest management.

This provision also requires the National Heart Lung and Blood Institute, through the National Asthma Education Prevention Program Coordinating Committee, to identify all federal programs that carry out asthma-related activities, develop a Federal plan for responding to asthma in consultation with appropriate federal agencies, professional and voluntary health organizations, and recommend ways to strengthen and improve the coordination of asthma-related Federal activities. CDC will collect and publish data on the prevalence of children suffering from asthma in each State, as well as mortality data at the national level.

TITLE VI—BIRTH DEFECTS PREVENTION ACTIVITIES

This provision expands CDC's folic acid education program to prevent birth defects. In partnership with the States and local, public, and private entities, CDC shall expand an education and public awareness campaign; conduct research to identify effective strategies for increasing folic acid consumption by women of reproductive capacity; evaluate the effectiveness of these strategies; and conduct research to increase our understanding of the effects of folic acid in preventing birth defects.

This provision elevates the Division of Birth Defects and Developmental Disabilities to a National Center for Birth Defects and Developmental Disabilities within CDC. The purpose of this Center would be to collect, analyze, and distribute data on birth defects and developmental disabilities including information on causes, incidence, and prevalence; conduct applied epidemiological research on the prevention of such defects and disabilities; and provide information to the public on proven prevention activities.

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

Authorizes grants or cooperative agreements to develop statewide newborn and infant hearing screening, evaluation and intervention programs and systems, and provide technical assistance to State agencies. Directs the NIH to continue a program of research and development on the efficacy of new screening techniques and technology. Provides for federal coordination with State and local agencies, consumer groups, national medical, health, and education organizations. Coordinated activities shall include policy recommendations and development of a data collection system.

TITLE VIII—CHILDREN AND EPILEPSY

Authorizes the agencies of HHS to expand current epilepsy surveillance activities; implement public and professional education activities; enhance research initiatives; and strengthen partnerships with government agencies and organizations that have experience addressing the health needs of people with disabilities. Authorizes demonstration projects in medically underserved areas, to improve access to health services regarding seizures, to encourage early detection and treatment in children.

TITLE IX—SAFE MOTHERHOOD AND INFANT HEALTH PROMOTION

The provision authorizes the Secretary of HHS to develop a national surveillance program to better understand the burden of maternal complications and mortality and to decrease the disparities among populations at risk of death and complications from pregnancy. The provision allows the Secretary to expand the Pregnancy Risk Assessment Monitoring System to provide surveillance and data collection in each State. Furthermore, the provision would expand research concerning risk factors, prevention strategies, and the roles of the family, health care providers, and the community in safe motherhood. The provision also authorizes public education campaigns on healthy pregnancy, education programs for health care providers, and activities to promote community support services for pregnant women. Finally, the provision authorizes grant funding for research initiatives and programs to prevent drug, alcohol, and tobacco use among pregnant women.

TITLE X—PEDIATRIC RESEARCH INITIATIVE

This provision establishes a Pediatric Research Initiative within the National Institutes of Health to enhance collaborative efforts, provide increased support for pediatric biomedical research, and ensure that expanding opportunities for advancement in scientific investigations and care for children are realized.

The Secretary of HHS will make available enhanced support for activities relating to the training and career development of pediatric researchers, including general authority for loan repayment of a portion of education loans.

This provision also requires that all HHS-funded and regulated research comply with current pediatric-specific human subject protection regulations. (Currently FDA-regulated research is not required to comply).

National Institute of Child Health and Human Development is authorized to convene and direct a consortium of federal agencies, including CDC and EPA, to develop and implement a prospective cohort study to evaluate the effects of both chronic and intermittent external influences on human development, and to investigate basic mechanisms of developmental disorders and environmental factors, both risk and protective, that influence growth and developmental processes. The study will 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. The study shall gather data on environmental influences and outcomes until at least age 21, shall include diverse populations, and shall consider health disparities.

TITLE XI—CHILDHOOD MALIGNANCIES

Directs the Secretary of HHS, through CDC and NIH, to study risk factors that affect or cause childhood cancers and carry out projects to improve outcomes for children with cancer and resultant secondary conditions. Provides for the expansion of current data collection and support for CDC's National Limb Loss Information Center.

TITLE XII—ADOPTION AWARENESS

This title authorizes the Secretary of HHS to make grants to adoption organizations to train the staff of eligible health centers in providing adoption information and referrals based on guidelines developed by the adoption community. The Secretary, through the Health Resources and Services Administration and the Agency for Healthcare Research and Qaulity, shall evaluate the effectiveness of the training program as well as the extent to which such training complies with federal requirements which may apply to eligible health centers, to provide adoption information and referrals on an equal basis with all other courses of action included in nondirective pregnancy options counseling.

The Secretary shall carry out a national campaign to provide information to the public about adoption of children with special needs. Additionally, the Secretary shall make grants to provide assistance to adoption support groups and carry out studies to identify components that lead to favorable long-term outcomes for families that adopt children with special needs.

TITLE XIII—TRAUMATIC BRAIN INJURY

This provision reauthorizes the Traumatic Brain Injury Act of 1996 to extend the authority for CDC to support research into strategies for the prevention of TBI and to implement public information and education programs for the prevention of traumatic brain injuries. CDC will support additional data collection and development of State TBI registries. NIH research is expanded to include cognitive disorders and neurobehavioral consequences arising from TBI. The bill authorizes HRSA to make grants for new and expanded community support services. Grants may be used to educate consumers and families, train professionals, improve case management, develop best practices in the areas of family support, return to work, and housing for people with traumatic brain injury. HRSA shall also make grants to protection and advocacy systems, to provide services to individuals with traumatic brain injury. This title also reauthorizes CDC's injury prevention and control programs to 2005.

TITLE XIV—CHILD CARE SAFETY AND HEALTH GRANTS

To address the need for increased safety of child care facilities, the Secretary of HHS shall provide grants to States to carry out activities related to the improvement of the health and safety of children in child care settings. Grants may be used for two or more of the following activities: 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 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; provide information to parents on choosing a safe and healthy setting for their children; or improve the safety of transportation of children in child care.

TITLE XV—HEALTHY START INITIATIVE

Healthy Start, which was created as a demonstration project in 1991, is authorized in this bill for the first time. The Healthy Start program is designed to reduce the rate of infant mortality and improve perinatal outcomes by providing grants to areas with a high rate of infant mortality and low birth weight infants. This provision also authorizes a new grant program to conduct and support research and provide additional services to enhance access to health care for pregnant women and infants.

TITLE XVI—ORAL HEALTH

This provision requires HHS to support community-based research to identify interventions that reduce the burden and transmission of oral, dental and craniofacial diseases in high risk populations, and develop clinical approaches for pediatric assessment. HHS is authorized to fund innovative oral health activities to decrease the incidence of baby bottle and early childhood tooth decay, and to increase utilization of pediatric dental services in children under 6.

The Secretary of HHS is authorized to provide grants to States to increase community water fluoridation and to provide school-based dental sealant services to children in low income areas. This provision also authorizes HHS to provide for the development of school-based dental sealant programs to improve the access of children to sealants. Finally, HHS shall make grants to dental training institutions and community-based programs, as well as those operated by the Indian Health Service, to develop oral health promotion programs and to increase utilization of dental services by children eligible for such services under a federal health program.

TITLE XVII—VACCINE-RELATED PROGRAMS

Modifies the Vaccine Injury Compensation Program, to allow compensation for those who suffer an adverse reaction to the rota virus. This provision provides compensation if a vaccine causes an injury that requires hospitalization and surgical intervention. Additionally, the preventive health services childhood immunization program is reauthorized to 2005.

TITLE XVIII—HEPATITIS C

Authorizes HHS to implement a national system to determine the incidence of hepatitis C virus infection, and to assist the States in determining the prevalence of HCV infection. Also authorizes HHS to identify, counsel and offer testing to individuals who are at risk of HCV infection, and to develop public and professional education programs for the detection and control of HCV infection. Provides for improvements in clinical laboratory procedures regarding Hepatitis C.

TITLE XIX—NIH INITIATIVE ON AUTOIMMUNE DISEASES

The Director of NIH shall expand, intensify, and coordinate the activities of NIH with respect to autoimmune diseases.

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

This provision makes technical corrections to the pediatric GME program, which supports training activities in freestanding children's hospitals, and extends its authorization through fiscal year 2005.

TITLE XXI—SPECIAL NEEDS OF CHILDREN REGARDING ORGAN TRANSPLANTATION

Requires HHS to implement organ donation policies that recognize the unique needs of children. HHS shall carry out studies and demonstration projects to improve rates of organ donation and determine the unique needs of children. HHS shall conduct a study to determine the costs of immunosupressive drugs for children who have received transplants and the extent to which public and private health insurance plans cover these costs.

TITLE XXII—MUSCULAR DYSTROPHY RESEARCH

NIH will expand and increase coordination in activities with respect to research on muscular dystrophies.

TITLE XXIII—CHILDREN AND TOURETTE SYNDROME AWARENESS

HHS will implement public and professional education programs on Tourette Syndrome, with a particular emphasis on children.

TITLE XXIV—CHILDHOOD OBESITY PREVENTION

This provision authorizes the CDC to support the development, implementation, and evaluation of state and community-based programs to promote good nutrition and increased physical activity. States would be required to develop comprehensive, interagency school- and community-based approaches to encourage and promote nutrition and physical activity in local communities, with technical support from CDC.

The CDC will coordinate and conduct research to improve our understanding of the relationship between physical activity, diet, health, and other factors that contribute to obesity. Research will also focus on developing and evaluating effective strategies for the prevention and treatment of obesity and eating disorders, as well as study the prevalence and cost of childhood obesity and its effects into adulthood.

The CDC in collaboration with State and local health, nutrition, and physical activity experts, will develop a nationwide public education campaign regarding the health risks associated with poor nutrition and physical inactivity, and will promote effective ways to incorporate good eating habits and regular physical activity into daily living.

The CDC, in collaboration with HRSA, will develop and carry out a program to train health professionals in effective strategies to better identify, assess, and counsel (or refer) patients with obesity, an eating disorder, or who are at risk of becoming obese or developing an eating disorder. They will also develop and carry out a program to train educators and child care professionals in effective strategies to teach children and their families about ways to improve dietary habits and levels of physical activity.

TITLE XXV—EARLY DETECTION AND TREATMENT REGARDING CHILDHOOD LEAD POISONING

This provision requires HRSA to report annually to the Congress on the percentage of children in the Health Centers program who are screened for lead poisoning, and requires HRSA to work with the CDC and HCFA to conduct physician education and training programs on current lead screening policies. CDC will issue recommendations and establish requirements for its grantees to ensure

uniform reporting of blood lead levels from laboratories to State and local health departments and to improve data linkages between health departments and federally funded benefit programs.

This provision authorizes new funding through the Maternal and Child Health Block Grant to states with a demonstrated need to conduct outreach and education for families at risk of lead poisoning, provide individual family education designed to reduce exposures to children with elevated blood lead levels, implement community environmental interventions, and ensure continuous quality measurement and improvement plans for communities committed to comprehensive lead poisoning prevention.

TITLE XXVI—SCREENING FOR HERITABLE DISORDERS

Amends the Public Health Service Act 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. This provision also creates an advisory committee to provide advice and recommendations to the Secretary for the development of grant administration policies and priorities, and to enhance the ability of the Secretary to reduce mortality or morbidity from heritable disorders.

TITLE XXVII—PEDIATRIC RESEARCH PROTECTIONS

This provision addresses critical safety issues in children's research by requiring the Secretary of HHS to review the current federal regulations for the protection of children participating in research, which address such issues as determining acceptable levels of risk and obtaining parental permission, and to report to Congress on how to update them to ensure the highest standards of safety.

TITLE XXVIII—MISCELLANEOUS PROVISIONS

This provision would require the NIH Director to report to Congress within 180 days of enactment on activities conducted and supported by the NIH during FY 2000 with respect to rare diseases in children and the activities that are planned to be conducted and supported by the NIH with respect to such diseases during the FY 2001–2005. This provision also requires HHS to study issues related to access to effective treatment for metabolic disorders, including PKU. Results of the study shall be made available to public health agencies, Medicaid, insurance commissioners, and other interested parties.

DIVISION B—YOUTH DRUG AND MENTAL HEALTH SERVICES

This division reauthorizes programs within the Substance Abuse and Mental Health Services Administration (SAMHSA) to improve mental health and substance abuse services for children and adolescents, implement proposals giving States more flexibility in the use of block grant funds with accountability based on performance, and consolidate discretionary grant authorities to give the Secretary more flexibility to respond to the needs of those who need mental health and substance abuse services. It also provides a waiver from the requirements of the Narcotic Addict Treatment Act that would permit qualified physicians to dispense or prescribe schedule III, IV, or V narcotic drugs or combinations of such drugs approved by FDA for the treatment of heroin addiction. It also provides a comprehensive strategy to combat Methamphetamine use.

TITLE XXXI—PROVISIONS RELATING TO SERVICES FOR CHILDREN AND ADOLESCENTS

SECTION 3101—CHILDREN AND VIOLENCE

Authorizes $100 million for the Secretary to make grants to public entities in consultation with the Attorney General and the Secretary of Education to assist local communities in developing ways to assist children in dealing with violence. Four different types of grants are permitted under the authority: grants to provide financial support to enable the communities to implement the programs; to provide technical assistance to local communities; to provide technical assistance in the development of policies; and to assist in the creation of community partnerships among the schools, law enforcement and mental health services. Grantees would have to ensure that they will carry out six activities which include: security of the school; educational reform to deal with violence; review and updating of school policies to deal with violence; alcohol and drug abuse prevention and early intervention; mental health prevention and treatment services; and early childhood development and psychosocial services. However, Federal funding is available for prevention, early intervention, and treatment services.

Authorizes $50 million for the Secretary to develop knowledge with regard to evidence-based practices for treating psychiatric disorders resulting from witnessing or experiencing domestic, school and community violence and terrorism. Establishes centers of excellence to provide technical assistance to communities in dealing with the emotional burden of domestic, school and community violence and terrorism if and when they occur.

SECTION 3102—EMERGENCY RESPONSE

Permits the Secretary to use up to 2.5% of the funds appropriated for discretionary grants for responding to emergencies. The authority would permit an objective review instead of peer review. This would permit an expedited process for making awards. The Secretary is required to define an emergency in the Federal Register subject to public comment.

The section also includes language that provides additional confidentiality protection for the information collected from individuals who participate in national surveys conducted by the Substance Abuse and Mental Health Services Administration.

SECTION 3103—HIGH RISK YOUTH REAUTHORIZATION

Reauthorizes the High Risk Youth Program, which provides funds to public and non-profit private entities to establish programs for the prevention of drug abuse among high risk youth.

SECTION 3104—SUBSTANCE ABUSE TREATMENT SERVICES FOR CHILDREN AND ADOLESCENTS

Authorizes $40 million for the Secretary to make grants, contracts or cooperative agreement to public and non-profit private entities including American Indian tribes and tribal organizations for the purpose of providing substance abuse treatment services for children and adolescents. Priority is given to applicants who can apply evidenced based and cost effective methods, coordinate services with other social service agencies, provide a continuum of care dependent on the needs of the individual, provide treatment that is gender specific and culturally appropriate, involve and work with families of those in treatment, and provide aftercare.

Authorizes $20 million for the Secretary to make grants, contracts or cooperative agreements to public and non-profit private entities including local educational agencies for the purposes of providing early intervention substance abuse services for children and adolescents. Under the provision, priority is given to applicants who demonstrate an ability to screen for and assess the level of involvement of children in substance abuse, make appropriate referrals, provide counseling and ancillary services, and who develop a network with other social agencies. Requires the Secretary to ensure geographical distribution of awards.

Authorizes $4 million to create centers of excellence to assist States and local jurisdictions in providing appropriate care for adolescents who are involved with the juvenile justice system and have a serious emotional disturbance.

Authorizes $10 million for the Secretary to make grants, contracts, or cooperative agreements to carry out school based as well as community based programs to prevent the use of methamphetamine and inhalants.

SECTION 3105—COMPREHENSIVE COMMUNITY SERVICES FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

This program was begun in 1994 to provide seed money to local communities to develop systems of care for children with serious emotional disturbances thus improving the quality of care and increasing the likelihood that these children would remain in local communities rather than being sent to residential facilities. This section reauthorizes this program through fiscal year 2002 and provides an authority for the Secretary to waive certain requirements for territories and American Indian tribes.

This section also would extend some grants under this program to 6 years. The intent of the program is to provide seed funding for comprehensive systems of care. Unfortunately, many successful programs have had a difficult time ensuring their continuation without Federal support. This provision would give them an additional year to secure that support.

SECTION 3106—SERVICES FOR CHILDREN OF SUBSTANCE ABUSERS

Improves coordination by transferring this program from Health Resources and Services Administration (HRSA) to SAMHSA and authorizes the Secretary to make grants to public and non-profit private entities to provide the following services to children of substance abusers: periodic evaluations, primary pediatric care, other health and mental health services, therapeutic interventions, preventive counseling, counseling related to witnessing of chronic violence, referrals for and assistance in establishing eligibility for services under other programs, and other developmental services. Grantees would also provide services to families where one or both of the parents are substance abusers. The program requires that grantees match Federal funds with funds from other sources.

The program is authorized at $50 million through fiscal year 2002 and the authority is updated to include changes that have occurred since fiscal year 1992 when it was first authorized: e.g. developing connection to the Temporary Assistance for Needy Families (TANF) and the Children's Health Insurance Program (CHIP) programs.

SECTION 3107—SERVICES FOR YOUTH OFFENDERS

Authorizes $40 million for the Secretary to make grants, contracts or cooperative agreements to State and local juvenile justice agencies to help such agencies provide aftercare services for youth offenders who have or are at risk of a serious emotional disturbance and who have been discharged from juvenile justice facilities. The funds may be used for planning, coordinating and implementing these services.

SECTION 3108—GRANTS FOR STRENGTHENING FAMILIES THROUGH COMMUNITY PARTNERSHIPS

Provides for grants to develop and implement model substance abuse prevention programs and substance abuse prevention services for individuals in high risk families.

SECTION 3109—UNDERAGE DRINKING

Authorizes $25 million for the Secretary to 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 and community based programs for the prevention of alcoholic beverages consumption by individuals who have not attained the legal drinking age.

SECTION 3110—SERVICES FOR INDIVIDUALS WITH FETAL ALCOHOL SYNDROME

Authorizes $25 million for the Secretary to make grants, cooperative agreement or contracts with public or nonprofit private entities including Indian tribes and tribal organizations to provide services to individuals diagnosed with fetal alcohol syndrome or alcohol related birth defects. The funds can be used for screening and testing; mental health, health or substance abuse services; vocational services; housing assistance; and parenting skills.

Authorizes $5 million for the Secretary to make 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.

SECTION 3111—SUICIDE PREVENTION

The provision authorizes $75 million for the Secretary to make grants, contracts or cooperative agreement to public and nonprofit private entities to establish programs to reduce suicide deaths in the United States among children and adolescents. The provision requires collaboration among various agencies with the Department of Health and Human Services. Findings from the programs are then to be disseminated to public and private entities.

SECTION 3112—GENERAL PROVISIONS

This provision amends the sections that establish the responsibilities of the Centers for Substance Abuse Treatment, Substance Abuse Prevention and the Mental Health Services to include an emphasis on children. In the case of the Center for Mental Health Services it would require the Director to collaborate with the Attorney General and the Secretary of Education on programs that assist local communities in developing programs to address violence among children in schools.

TITLE XXXII—PROVISIONS RELATING TO MENTAL HEALTH

SECTION 3201—PRIORITY MENTAL HEALTH NEEDS OF REGIONAL AND NATIONAL SIGNIFICANCE

In 1996, the appropriation committees started a practice which they have continued through fiscal year 1999 of appropriating funds to SAMHSA's general authority (Section 501) instead of specific programs. This section codifies what the appropriations committees have done by repealing several specific authorities related to mental health services in favor of a broad authority that gives the Secretary more flexibility in responding to individuals in need of mental health services. It would authorize four types of grants: (1) knowledge development and application grants which are used to develop more information on how best to serve those in need; (2) training grants to disseminate the information that the agency garners through its knowledge development; (3) targeted capacity response which enables the agency to respond to service needs in local communities; and (4) systems change grants and grants to support family and consumer networks in States. Repealed in this section are sections 303, 520A and 520B of the Public Health Service Act and section 612 of the Stewart B. McKinney Act.

This section includes a provision that would permit $6,000,000 of the first $100,000,000 appropriated to the program and 10 percent of all funds above $100,000,000 to be given competitively to States to assist them in developing data infrastructures for collecting and reporting on performance measures.

This section also addresses the importance of the interface between mental health services and primary care.

SECTION 3202—GRANTS FOR THE BENEFIT OF HOMELESS INDIVIDUALS

The section reauthorizes the Grants for the Benefit of Homeless Individuals program which provides grants to develop and expand mental health and substance abuse treatment services to homeless individuals. Preference is maintained for organizations that provide integrated primary health care, substance abuse and mental health services to homeless individuals, programs that demonstrate effectiveness in serving homeless individuals, and programs that have experience in providing housing for individuals who are homeless.

SECTION 3203—PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH)

This section reauthorizes the PATH program which provides funds to States under a formula for the provision of mental health services to homeless individuals. Preference is maintained for organizations with demonstrated effectiveness in serving homeless veterans. The section also provides an authority for the Secretary to waive certain requirements for territories.

SECTION 3204—COMMUNITY MENTAL HEALTH SERVICES (CMHS) PERFORMANCE PARTNERSHIP PROGRAM

The Community Mental Health Services Block Grant is a formula program under which funds are distributed to States for the provision of community based mental health services for adults with a serious mental illness and children with a serious emotional disturbance. This program and the Substance Abuse Prevention and Treatment Block Grant provide funds to States to provide services. State accountability under these programs is built on State expenditure of funds.

Provisions in this section and other sections of this bill provide for the first steps in increasing State flexibility in the use of funds while establishing an accountability system based on performance. In this section, the number of elements that States must include in their plan for use of CMHS Block Grant funds are reduced from 12 to 5, thus providing additional flexibility for the States and reduced administrative costs.

This section also expands the responsibilities of the already existing State Planning Councils. Under current law, these councils are required to review and comment on State plans for use of CMHS Block Grant funds. Under this provision they would also be required to review and comment on State reports on the outcomes of their activities.

One provision within current law requires States to maintain their financial support for providing community based mental health services at an average of what they spent over the past two years. This requirement discourages States from adding one time infusions of funds into community mental health services since it would increase the States' maintenance of effort requirement. This provision would indicate that an infusion of funds of a non-recurring nature for a singular purpose may be exempt from the calculation of the maintenance of effort requirement.

Current law allows for the Secretary to set a date for the submission of grant applications. Applications must include a plan on how the State intends to use the funds and a report on how funds were spent the previous year. A provision in this section would establish that State plans for use of funds must be submitted by September 1 of the fiscal year prior to the fiscal year for which the State is seeking funds and the reports by the following December 1.

The section also makes changes to the current waiver authority for territories.

SECTION 3205—DETERMINATION OF ALLOTMENT

There are three elements to determine the allocation of funding for SAMHSA block grants: (1) the population of individuals needing services; (2) the cost of providing services; and (3) the state income level. In August of 1997, SAMHSA changed the data on determining the cost of providing services from the use of manufacturing wages to non-manufacturing wages, which was determined to be the most appropriate method to reflect cost differences among states. This action would have caused a decline of funding in several states. To address this problem, this section makes permanent provisions enacted in Public Law 105–277 on the formula for distribution of funds under the Community Mental Health Services Block Grant (CMHS). The CMHS Block Grant formula includes a ''hold harmless'' provision which guarantees that no State will receive less funding than it did in fiscal year 1998.

SECTION 3206—PROTECTION AND ADVOCACY FOR MENTALLY ILL INDIVIDUALS ACT OF 1986

This section makes technical changes to the formula for distribution of funds under this program to correct a provision that would have inappropriately reduced minimum State allotments. It also provides for the renaming of the Act to conform with changes made in previous laws, makes a technical change to the provision on territories and reauthorizes the program through fiscal year 2002.

The bill would also permit an American Indian Consortia to receive direct funding after the appropriation exceeds $25 million. It would also extend the responsibilities of the Protection and Advocacy program to individuals living in the communities when the appropriation exceeds $30 million.

SECTION 3207—REQUIREMENT RELATING TO THE RIGHTS OF RESIDENTS OF CERTAIN FACILITIES

This measure would require facilities that are both within the purview of the Protection and Advocacy program and which receive appropriated funding from the Federal government to protect and promote the rights of individuals with regard to the appropriate use of seclusions and restraints. Such covered facilities are required to inform the Secretary of each death that occurs while a patient is restrained or in seclusion, or each death that occurs within 24 hours after a patient is restrained or in seclusion, or where it is reasonable to assume that a patient's death is a result of seclusion or restraint. The Secretary is required to issue regulations within one year of enactment on appropriate staff levels, appropriate training for staff on the use of restraints and seclusions.

Requires any such facility that is supported in whole or in part with funds appropriated under the Public Health Service Act to 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 seclusion imposed for purposes of discipline or convenience; sets standards for when restraints or seclusion may be imposed; requires each such facility to notify

the appropriate State licensing or regulatory agency of each death that occurs in the facility and of the use of seclusion or restraint in accordance with regulations promulgated by the Secretary. Failure to comply with these requirements including the failure to appropriately train staff makes such facility ineligible for participation in any program supported in whole or in part by funds appropriated under this Act.

SECTION 3208—REQUIREMENTS RELATING TO THE RIGHTS OF RESIDENTS OF CERTAIN NON-MEDICAL COMMUNITY-BASED FACILITIES FOR CHILDREN AND YOUTH

Ensures that appropriately-trained supervisory personnel are present whenever a physical restraint is required of a resident of a non-medical community-based treatment facility. The use of mechanical or chemical restraints in such facilities is prohibited and physical restraint must be used only in emergency situations. The section also authorizes the Secretary to develop guidelines for licensing rules regarding training use of restraints.

SECTION 3209—GRANTS FOR EMERGENCY MENTAL HEALTH CENTERS

This provision authorizes $25 million for the Secretary to make 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 which will serve as a central receiving point in the community for individuals who may be in need of emergency mental health services.

SECTION 3210—GRANTS FOR JAIL DIVERSION PROGRAMS

Authorizes $10 million for the Secretary to make grants to States, political subdivisions of States, Indian tribes and tribal organizations to develop and implement programs to divert individuals with a mental illness from the criminal justice system to community-based services.

SECTION 3211—GRANTS FOR IMPROVING OUTCOMES FOR CHILDREN AND ADOLESCENTS THROUGH SERVICES INTEGRATION BETWEEN CHILD WELFARE AND MENTAL HEALTH SERVICES

The provision authorizes $10 million for the Secretary to make grants 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.

SECTION 3212—GRANTS FOR THE INTEGRATED TREATMENT OF SERIOUS MENTAL ILLNESS AND CO-OCCURRING SUBSTANCE ABUSE

Authorizes $40 million for the Secretary to make grants, contracts or cooperative agreements with States, political subdivisions of States, Indian tribes and tribal 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.

SECTION 3213—TRAINING GRANTS

The prevision authorizes $25 million for the Secretary to award grants States, political subdivisions of States, Indian tribes and tribal organizations or non-profit private entities to train teachers and other relevant school personnel to recognize symptoms of childhood and adolescent mental disorders and 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 emergency personnel regarding resources that are available in the community for individuals with a mental illness.

TITLE XXXIII—PROVISIONS RELATING TO SUBSTANCE ABUSE

SECTION 3301—PRIORITY SUBSTANCE ABUSE TREATMENT NEEDS OF REGIONAL AND NATIONAL SIGNIFICANCE

As explained in section 3201, this section codifies what the appropriations committees have done by repealing several specific authorities related to substance abuse treatment services that gives the Secretary more flexibility in responding to the needs of people in need of substance abuse treatment. It would authorize three types of grants: (1) knowledge development and application grants, which are used to develop more information on how best to serve those in need; (2) training grants to disseminate the information that the agency garners through its knowledge development; and (3) targeted capacity response, which enables the agency to respond to services needs in local communities. Repealed in this section are sections 508, 509, 510, 511, 512, 571 and 1971 of the Public Health Service Act.

This section also addresses the importance of the interface between substance abuse treatment services and primary care.

SECTION 3302—PRIORITY SUBSTANCE ABUSE PREVENTION NEEDS OF REGIONAL AND NATIONAL SIGNIFICANCE

This section implements in authorization for substance abuse prevention what the appropriations committees did in fiscal year 1996. It authorizes the same type of grants as described in the previous section except that they pertain to substance abuse prevention. Repeals sections 516 and 518 of the Public Health Service Act.

This section also addresses the importance of the interface between substance abuse prevention services and primary care.

SECTION 3303—SUBSTANCE ABUSE PREVENTION AND TREATMENT PERFORMANCE PARTNERSHIP BLOCK GRANT

This program provides funds to States for their use in providing substance abuse prevention and treatment services. While there is considerable flexibility in State use of funds, there are a number of requirements which are directly related to public health issues. This provision would begin the process of giving States greater flexibility in their use of funds and accountability based on performance instead of expenditures.

Greater flexibility is enhanced by the repeal of a requirement that States spend 35 percent of their allotment on drug related activities and 35 percent on alcohol related activities. A provision requiring States to maintain a $100,000 revolving fund to support homes for persons recovering from substance abuse would be made optional thus permitting States to continue such efforts or to use those funds for other services as they deem necessary.

This section also creates authority for the Secretary to waive certain requirements for States who meet established criteria. Those criteria would be established in regulation after consultation with the States, providers and consumers.

One provision within current law requires the State to maintain its financial support for substance abuse prevention and treatment services at the average of what it spent over the past two years. While States support this requirement, it discourages States from adding one time infusions of funds into substance abuse services since it would increase the calculation of the State's maintenance of effort requirement. This section includes a provision that would exempt from maintenance of effort requirements any one time infusion of funds which are for a singular purpose.

Current law allows the Secretary to set a date for the submission of grant applications. Applications include a plan on how funds will be used and a report on how funds were spent the previous year. A provision in this section would establish that State applications are due on October 1 of the fiscal year prior to the fiscal year for which they are seeking funds.

This section also simplifies the waiver for territories and reauthorizes the program through fiscal year 2002.

SECTION 3304—DETERMINATION OF ALLOTMENT

There are three elements to determine the allocation of funding for SAMHSA block grants: (1) the population of individuals needing services; (2) the cost of providing services; and (3) the state income level. In August of 1997, SAMHSA changed the data on determining the cost of providing services from the use of manufacturing wages to non-manufacturing wages, which was determined to be the most appropriate method to reflect cost differences among states. This action would have caused a decline of funding in several states. To address this problem, this section makes permanent provisions in Public Law 105-277 on the formula for distribution of funds under the Substance Abuse Prevention and Treatment Block Grant (SAPT).

The SAPT Block Grant formula includes Minimum Growth and Small State Minimum Rules needed to complete the phase-in of the new formula. Also, the provision includes a Proportional Scale Down Rule if appropriations decline in future years.

SECTION 3305—NONDISCRIMINATION AND INSTITUTIONAL SAFEGUARDS FOR RELIGIOUS PROVIDERS

This section would permit religious organizations which provide substance abuse services to receive Federal assistance either through the Substance Abuse Prevention and Treatment Block Grant or discretionary grants through the Substance Abuse and Mental Health Services Administration while maintaining their religious character and their ability to hire individuals of the same faith. Such programs may not discriminate against anyone interested in treatment at the facility. If a person who is referred for services needs or would prefer to be served in a different facility, the program will refer that person to an appropriate treatment program.

The provision further stipulates that Federal funds received under a block or discretionary grant for substance abuse services by a religious organization will be maintained in a separate account and only the Federal funds used by such providers shall be subject to Federal audit requirements.

A religious organization that believes that it has been discriminated against based on the fact that it is a faith based program may bring an action for injunctive relief against the appropriate government agency or entity that has allegedly committed the violation.

Federal funds may not be used for sectarian worship, instruction or proselytization.

If a State or local government chooses to co-mingle their funds with Federal funds, then the State and or local government funds are subject to the provisions of this section.

SECTION 3306—ALCOHOL AND DRUG PREVENTION AND TREATMENT SERVICES FOR INDIANS AND NATIVE ALASKANS

Authorizes $15 million for the Secretary to make grants, contracts or cooperative agreements with public and private non-profit private entities including American Indian

tribes and tribal organizations and Native Alaskans for the purpose of providing alcohol and drug prevention or treatment services for Indians and Native Alaskans. Priority is given to those entities that will provide such services on reservations or tribal lands, employ culturally appropriate approaches, and have provided prevention or treatment services for at least one year prior to applying for a grant. The Secretary is required to submit a report to the Committees of jurisdiction after three years and annually thereafter describing the services that have been provided under this program.

SECTION 3307—ESTABLISHMENT OF COMMISSION

Authorizes $5 million to establish a Commission on Indian and Native Alaskan Health Care that shall carry out a comprehensive examination of the health concerns of Indians and Native Alaskans living on reservations or tribal lands. The Commission will consist of the Secretary as Chair and 15 appointed and voting members, 10 of whom must be American Indians or Native Alaskans. The Director of the Indian Health Service and the Commissioner of Indian Affairs are non-voting members. The commission is to issue a report within three years detailing the health condition of individuals living on tribal lands, what services are currently available and if there are insufficient services detail why this situation exists, and make recommendations to the Congress on how to address these issues.

TITLE XXXIV—PROVISIONS RELATING TO FLEXIBILITY AND ACCOUNTABILITY

SECTION 3401—GENERAL AUTHORITIES AND PEER REVIEW

This section removes the requirement that there be an Associate Administrator for Alcohol Policy, and makes necessary corrections to the peer review requirements to reflect changes since 1992. The section also includes language that provides additional confidentiality protection for the information collected from individuals who participate in national surveys conducted by the Substance Abuse and Mental Health Services Administration.

SECTION 3402—ADVISORY COUNCILS

SAMHSA and each of its Centers are required under statute to have an Advisory Council. Current law requires that they meet three times a year. This section reduces the number of times the councils are required to meet to two.

SECTION 3403—GENERAL PROVISIONS FOR THE PERFORMANCE PARTNERSHIP BLOCK GRANTS

As part of the effort to change the current CMHS and SAPT Block Grants into performance-based systems, the Secretary is required to submit to Congress within two years a plan for what these performance based programs would look like and how they would operate. This plan would include how the States would receive greater flexibility, what performance measures would be used in holding States accountable, definitions for the data elements that would be collected, the funds needed to implement this system and where those funds would come from, and needed legislative changes. This would give the committees of jurisdiction one year to consider the plan and implement any necessary changes in the next reauthorization of SAMHSA in 2003.

SECTION 3404—DATA INFRASTRUCTURE PROJECTS

This section creates an authority for the Secretary to make grants to States to assist them in developing the data infrastructure necessary to implement a performance based system. States are required to match the Federal contribution.

SECTION 3405—REPEAL OF OBSOLETE ADDICT REFERRAL PROVISIONS

This section repeals certain obsolete provisions of the Narcotic Addict Rehabilitation Act of 1966.

SECTION 3406—INDIVIDUALS WITH CO-OCCURRING DISORDERS

The section requires the Secretary to report to the committees of jurisdiction on how services are currently being provided to those with a co-occurring mental health and substance abuse disorder, what improvements are needed to ensure that they receive the services they need, and a summary of best practices on how to provide those services including prevention of substance abuse among individuals who have a mental illness and treatment for those with a co-occurring disorder.

SECTION 3407—SERVICES FOR INDIVIDUALS WITH CO-OCCURRING DISORDERS

The section clarifies that both Substance Abuse Prevention and Treatment and Community Mental Health Service Block Grant funds may be used to provide services to those with a co-occurring mental health and substance abuse disorder as long as the funds are used for the purposes for which they were authorized.

TITLE XXXV—WAIVER AUTHORITY FOR PHYSICIANS WHO DISPENSE OR PRESCRIBE CERTAIN NARCOTIC DRUGS FOR MAINTENANCE TREATMENT OR DETOXIFICATION TREATMENT

SECTION 3501—SHORT TITLE

Drug Addition Treatment Act of 2000

SECTION 3502—WAIVER AUTHORITY FOR PHYSICIANS WHO DISPENSE OR PRESCRIBE CERTAIN NARCOTIC DRUGS FOR MAINTENANCE TREATMENT OR DETOXIFICATION TREATMENT

The waiver from the requirements of the Narcotic Addict Treatment Act would permit qualified physicians to dispense (including prescribe) schedule III, IV, or V narcotic drugs or combinations of such drugs approved by FDA for the treatment of heroin addiction. The physician would be required to refer the patient for appropriate counseling and limit his or her practice to 30 patients.

Physicians are qualified if they are licensed under State law and hold a subspeciality board certification in addiction psychiatry from the American Board of Medical Specialties, certification in a subspeciality from the American Osteopathic Association, certification from the American Society of Addiction Medicine, the physician has participated in a clinical trial on the narcotic drug, is approved by the State licensing board or has such other training or experience as the Secretary considers necessary. Permits the Secretary to issue regulation on criteria for using other credentialing bodies or on the limit of 30 patients. The Secretary is also required under the provision to issue practice guidelines within 120 days. States are given 3 years in which to pass legislation that would prohibit a practitioner from dispensing such drugs or combinations of such drugs if they want.

The Secretary or the Attorney General are authorized to determine whether the program is working and to stop the program with 60 days notice.

TITLE XXXVI—METHAMPHETAMINE ANTI-PROLIFERATION

SECTION 3601—SHORT TITLE

Methamphetamine Anti-Proliferation Act of 1999

SUBTITLE A—METHAMPHETAMINE PRODUCTION

PART I—CRIMINAL PENALTIES

SECTION 3611—ENHANCED PUNISHMENT OF AMPHETAMINE LABORATORY OPERATORS

Section 3602 directs the Sentencing Commission to raise the penalties for amphetamine related offenses to a level comparable to those for methamphetamine.

SECTION 3612—ENHANCE PUNISHMENT OF AMPHETAMINE AND METHAMPHETAMINE OPERATORS

This section amends the Sentencing Guidelines by increasing the base offense level for manufacturing amphetamine or methamphetamine to not less than level 27 if the offense created a substantial risk of harm to human life or to the environment and to not less than level 30 if the offense created a substantial risk of harm to the life of a minor or incompetent.

SECTION 3613—MANDATORY RESTITUTION FOR METH LAB CLEAN-UP

Section 103 makes reimbursement for the costs incurred by the U.S. or State and local governments for the cleanup associated with the manufacture of amphetamine or methamphetamine mandatory. It also provides that the restitution money will go to the Asset Forfeiture Fund instead of the treasury.

SECTION 3614—METHAMPHETAMINE PARAPHERNALIA

This section amends the anti-paraphernalia statute to include paraphernalia used in connection with methamphetamine use.

PART II—ENHANCED LAW ENFORCEMENT

SECTION 3621—ENVIRONMENTAL HAZARDS ASSOCIATED WITH ILLEGAL MANUFACTURE OF AMPHETAMINE AND METHAMPHETAMINE

This section authorizes the DEA to receive money from the Asset Forfeiture Fund to pay for clean-up costs associated with the illegal manufacture of amphetamine or methamphetamine for the purposes of federal forfeiture and disposition. It also allows for reimbursement to State and local entities for clean-up costs when they assist in a federal prosecution on amphetamine or methamphetamine related charges to the extent such costs exceed equitable sharing payments made to such State or local government in such case. The section also expressly states that funds from the Violent Crime Reduction Trust Fund can be used to pay for clean-up costs.

SECTION 3622—REDUCTION IN THRESHOLD FOR NON-SAFE HARBOR PRODUCTIONS

This section reduces the threshold for retail sales of non-safe harbor products containing pseudoephedrine or phenylpropanolamine from 24 grams to 9 grams. It also limits the package size to not more than 3 grams of pseudoephedrine or phenylpropanolamine base.

SECTION 3623—TRAINING FOR DRUG ENFORCEMENT ADMINISTRATION AND STATE AND LOCAL LAW ENFORCEMENT PERSONNEL RELATING TO CLANDESTINE LABORATORIES

Section 3613 authorizes $5.5 million in funding for DEA training programs designed to (1) train State and local law enforcement in techniques used in meth investigations (2) provide a certification program for State and local law enforcement enabling them to meet requirements with respect to the handling of wastes created by meth labs; (3) create a certification program that enables certain State and local law enforcement to recertify other law enforcement in their regions; and (4) staff mobile training teams which provide State and local law enforcement with advanced training in conducting clan lab investigations and with training that enables them to recertify other law enforcement personnel. The training programs are authorized for 3 years after which the States, either alone or in consultation/combination with other States, will be responsible for training their own personnel. The

States will be required to submit a report detailing what measures they are taking to ensure that they have programs in place to take over the responsibility after the three year federal program expires.

SEC. 3624—COMBATING METHAMPHETAMINE IN HIGH INTENSITY DRUG TRAFFICKING AREAS

This section authorizes $15 million a year for fiscal years 2000-2004 to be appropriated to ONDCP to combat trafficking of methamphetamine in designated HIDTA's by hiring new federal, State, and local law enforcement personnel, including agents, investigators, prosecutors, lab technicians and chemists. It provides that the funds shall be apportioned among the HIDTA's based on the following factors: (1) number of Meth labs discovered in the previous year; (2) number of Meth prosecutions in the previous year; (3) number of Meth arrests in the previous year; (4) the amounts of Meth seized in the previous year; and (5) intelligence and predictive data from the DEA and HHS showing patterns and trends in abuse, trafficking and transportation patterns in methamphetamine, amphetamine and listed chemicals. Before apportioning any funds, the Director must certify that the law enforcement entities responsible for clan lab seizures are providing lab seizure data to the national clandestine laboratory database at the El Paso Intelligence Center. It also provides that not more than five percent of the appropriated amount may be used for administrative costs.

SECTION 3625—COMBATING AMPHETAMINE AND METHAMPHETAMINE MANUFACTURING AND TRAFFICKING

This section authorizes $6.5 million to be appropriated for the hiring of new agents to (1) assist State and local law enforcement in small and mid-sized communities in all phases of drug investigations, including assistance with foreign-language interpretation; (2) staff additional regional enforcement and mobile enforcement teams; (3) establish additional resident offices and posts of duty to assist State and local law enforcement in rural areas; and (4) provide the Special Operations Division with additional agents for intelligence and investigative operations.

It also authorizes $3 million to enhance the investigative and related functions of the Chemical Control Program to implement further the provisions of the Comprehensive Methamphetamine Control Act of 1996. The funds shall be used to account accurately for the import and export of List I chemicals and coordinate investigations surrounding the diversion of these chemicals; to develop a computer infrastructure sufficient to process and analyze time sensitive enforcement information from suspicious orders reported to DEA field offices and other law enforcement; and to establish an education, training, and communications process to alert industry of current trends and emerging patterns of illicit manufacturing activities.

PART III—ABUSE PREVENTION AND TREATMENT

SECTION 3631—EXPANSION OF METHAMPHETAMINE RESEARCH

This section allows the Director of the National Institute on Drug Abuse (NIDA) to make grants and enter into cooperative agreements to expand the National Drug Abuse Treatment Clinical Trials Network and current and on-going research and clinical trials with treatment centers relating to methamphetamine abuse and addiction and other biomedical, behavioral and social issues related to methamphetamine abuse and addiction. It authorizes to be appropriated such sums as may be necessary and such sums are to supplement and not supplant any other amounts appropriated for research on methamphetamine abuse and addiction.

SECTION 3632—METHAMPHETAMINE AND AMPHETAMINE ADDICTION TREATMENT

This section authorizes $10 million in grants to States that have a high rate, or have had a rapid increase, in methamphetamine or amphetamine abuse or addiction, for treatment of methamphetamine and amphetamine addiction.

SECTION 3633—STUDY OF METHAMPHETAMINE TREATMENT

This section requires the Secretary of HHS, in consultation with the Institute of Medicine of the National Academy of Sciences, to conduct a study on the development of medications for the treatment of addiction to amphetamine and methamphetamine and to report the findings to the Judiciary Committees of the Senate and House of Representatives.

PART IV—ABUSE PREVENTION AND TREATMENT

SECTION 3641—REPORT ON CONSUMPTION OF METHAMPHETAMINE AND OTHER ILLICIT DRUGS IN RURAL AREAS, METROPOLITAN AREAS, AND CONSOLIDATED METROPOLITAN AREAS

This section requires HHS to include in its annual National Household Survey on Drug Abuse prevalence data on the consumption of methamphetamine and other illicit drugs in rural, metropolitan, and consolidated metropolitan areas.

SECTION 3642—REPORT ON DIVERSION OF ORDINARY, OVER-THE-COUNTER PSEUDOEPHEDRINE AND PHENYLPROPANOLAMINE PRODUCTS

This section requires the Attorney General to conduct a study on the use of ordinary over-the-counter pseudoephedrine and phenylpropanolamine products in the clandestine production of illicit drugs. The report is to be submitted to Congress and shall include the AG's findings and recommendations on the need for additional measures, including thresholds, to prevent diversion of blister pack products.

SUBTITLE B—CONTROLLED SUBSTANCE GENERALLY

SECTION 3651—ENHANCED PUNISHMENT OF TRAFFICKING IN LIST I CHEMICALS

This section directs the Sentencing Commission to increase the penalties for violations involving ephedrine, pseudoephedrine, and phenylpropanolamine so that the penalties correspond to the quantity of controlled substance that could reasonably have been manufactured from these chemicals. The Sentencing Commission is also directed to establish a conversion table to determine the quantity of controlled substances that can be manufactured from these chemicals. The Sentencing Commission also shall review and amend its guidelines concerning list I chemicals other than those above, to provide for increased penalties to reflect the dangerous nature of such offenses and the dangers associated with manufacturing methamphetamine.

SECTION 3652—MAIL ORDER REQUIREMENTS

This section represents changes to the reporting requirements of 21 U.S.C. 830(b)(3) worked out between the DEA and industry. Reporting will no longer be required for valid prescriptions, limited distributions of sample packages, distributions by retail distributors if consistent with authorized activities, distributions to long term care facilities, and any product which has been exempted by the AG. It also allows the AG to revoke an exemption if he finds the drug product being distributed is being used in violation of the Controlled Substances Act.

SECTION 3653—THEFT AND TRANSPORTATION OF ANHYDROUS AMMONIA FOR PURPOSES OF ILLICIT PRODUCTION OF CONTROLLED SUBSTANCES

This section makes it unlawful for a person to steal anhydrous ammonia or 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. Also provides funding to Iowa State University to permit it to continue and expand its current research into the development of inert agents that will eliminate the usefulness of anhydrous ammonia as an ingredient in the production of methamphetamine.

SUBTITLE C—ECSTASY ANTI-PROLIFERATION ACT OF 2000

SECTION 3661—3665

Directs the Sentencing Commission to review and amend the Ecstasy guidelines to provide for increased penalties such that those penalties reflect the seriousness of the offenses of trafficking in and importing Ecstasy and related drugs. Section 3665 authorizes $10 million in grants for prevention efforts concerning Ecstasy and other ''club drugs.''

SUBTITLE D—MISCELLANEOUS

SECTION 3671—ANTI-DRUG MESSAGES ON FEDERAL GOVERNMENT INTERNET WEBSITES

This section requires all federal departments and agencies, in consultation with ONDCP, to place anti-drug messages on their Internet websites and an electronic hyperlink to ONDCP's website. Numerous government agencies have children's websites, including the Social Security Administration.

SECTION 3672—REIMBURSEMENT BY DRUG ENFORCEMENT ADMINISTRATION OF EXPENSES INCURRED TO REMEDIATE METHAMPHETAMINE LABORATORIES

Authorizes $20 million to be appropriated in FY 2001 for the DEA to reimburse States, units of local government, Indian tribal governments, and other public entities 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.

SECTION 3673—SEVERABILITY SECTION

Any provision held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, is to be given the maximum effect permitted by law, or if it is held to be invalid or unenforceable, such provision shall be severed from this Act.

Ms. COLLINS. Mr. President, I commend my colleagues, the chair and ranking member of the Public Health Subcommittee of the Health, Education, Labor, and Pensions Committee, for all of their efforts in bringing the Children's Health Act of 2000 to the Senate floor. This omnibus bill is the result of months of bipartisan collaboration and discussion between Members of both the House and the Senate in an effort to address important children's health issues in this Congress.

As the co-chair of the Senate Diabetes Caucus, I am particularly pleased that the Pediatric Diabetes Research and Prevention Act, which I introduced earlier this year with Senators BREAUX, ABRAHAM, CRAIG, and BUNNING, has been included in this bill. Our legislation—which was also cosponsored by Senators GRASSLEY,

BINGAMAN, CHAFEE, ROTH, HOLLINGS, and SCHUMER—will help us to reduce the tremendous toll that diabetes takes on our nation's children and young people, and I want to thank my colleagues for including it in the omnibus bill.

As noted in the recent cover story in Newsweek, diabetes is a devastating, lifelong condition that affects people of every age, race, and nationality. Sixteen million Americans suffer from diabetes and about 800,000 new cases are diagnosed each year. It is one of our nation's most costly diseases in both human and economic terms. Diabetes is the leading cause of kidney failure, blindness in adults, and amputations not related to injury. It is a major risk factor for heart disease and stroke and shortens life expectancy up to 15 years. Moreover, diabetes costs our nation more than $105 billion a year in health-related expenditures. More than one out of every ten health care dollars and about one out of four Medicare dollars are spent on people with diabetes.

Unfortunately, there currently is no method to prevent or cure diabetes and available treatments have only limited success in controlling its devastating consequences. The burden of diabetes is particularly heavy for children and young adults with type I, also known as juvenile diabetes. Juvenile diabetes is the second most common chronic disease affecting children. Moreover, it is one that they never outgrow.

As the founder of the Senate Diabetes Caucus, I have met many children with diabetes who face a daily struggle to keep their blood glucose levels under control: kids like nine-year-old Nathan Reynolds, an active young boy from North Yarmouth, who was Maine's delegate to the Juvenile Diabetes Foundation's Children's Congress last year. Nathan was diagnosed with diabetes in December of 1997, which forced him to change both his life and his family's life. He has learned how to take his blood—something his four-year-old brother reminds him to do before every meal—check his blood sugar level, and give himself an insulin shot on his own, sometimes with the help of his parents or his school nurse. Nathan told me that his greatest wish was that, just once, he could take a ''day off'' from his diabetes.

The sad fact is that children like Nathan with diabetes can never take a day off from their disease. There is no holiday from dealing with their diabetes. They face a lifetime of multiple daily finger pricks to check their blood sugar levels and daily insulin shots. Moreover, insulin is not a cure for diabetes, and it does not prevent the onset of serious complications. As a consequence, children like Nathan also face the possibility of lifelong disabling complications, such as kidney failure and blindness.

Reducing the health and human burden of diabetes and its enormous economic impact depends upon identifying the factors responsible for the disease and developing new methods for prevention, better treatment, and ultimately a cure. The provisions of the Pediatric Diabetes Research and Prevention Act that have been included in the Children's Health Act of 2000 will do just that.

One of the most important actions we can take is to establish a type I diabetes monitoring system. Currently there is no way to track the incidence of type I diabetes across the country. As a consequence, the estimates for the number of people with type I diabetes from the American Diabetes Association, the Juvenile Diabetes Foundation, the Centers for Disease Control and Prevention, and the National Institutes of Health vary enormously from 123,000 to over 1.5 million, a 13-fold variation. One of the best ways to define the prevalence and incidence of a disease, as well as to characterize and study populations, is to establish a national database specific to that disease, which our legislation would do.

Obesity and inadequate physical activity—both major problems in the United States today—are important risk factors for type 2, or non-insulin dependent diabetes. Unfortunately, obesity is a significant and growing problem among children in the United States, which has led to a disturbing increase in the incidence of type 2 diabetes among young people. This is particularly alarming since type 2 diabetes has long been considered an ''adult'' disease. Nearly all of the documented cases of type 2 diabetes in young people have occurred in obese children, who are also at increased risk for the complications associated with the disease. Moreover, these complications will likely develop at an earlier age than if these children had developed type 2 diabetes as adults. Our legislation therefore calls for the implemention of a national public health effort to address the increasing incidence of type 2 diabetes in children and young people.

In addition, the legislation calls for long-term studies of persons with type 1 diabetes at the National Institutes of Health where these individuals will be followed for 10 years or more. This long-term analysis of type 1 diabetes will provide an invaluable basis for the investigation and identification of the causes and characteristics of diabetes and its complications and it will also help to identify a potential study population for clinical trials. The legislation also directs the Secretary of Health and Human Services to support regional clinical research centers for the prevention, detection, treatment and cure of type 1 diabetes. And finally, the legislation directs the Secretary of HHS to provide for a national program to prevent type 1 diabetes, including efforts to develop a vaccine.

Mr. President, these provisions will help us to better understand and ultimately conquer diabetes, which has had such a devastating impact on millions of American children and their families. It is therefore most appropriate that they be included in the Children's Health Act of 2000, and I urge all of my colleagues to join me in supporting it.

Mr. REED. Mr. President, I rise to add my voice to the chorus of support for this legislation, which will have a strong positive impact on the youth of this nation.

The first element of this initiative that I would like to highlight are the provisions regarding children's public health. This effort will greatly enhance health promotion and disease prevention directed towards youth, improve access to certain health care services for needy children and bolster resources for pediatric-specific medical research. Children are our most precious resource, and we should do all we can to enable our children to reach their full potential both physically and intellectually. The Children's Public Health Act takes an important step toward achieving this goal by creating an environment where children are able to grow and develop unhindered by the burden of disease.

Medical science has made incredible strides in reducing and preventing devastating childhood diseases that were prevalent only a generation ago. Yet, despite these advances in our ability to stem the spread of deadly infectious diseases, there has been an increase in the incidence of chronic and debilitating disorders that afflict children. Specifically, over the past decade, we have seen a rise in the number of children suffering from asthma, autism, and other diseases attributed to poor diet and lack of physical activity, such as diabetes, high cholesterol and hypertension in young children. This legislation sets forth a balanced, creative approach to these troubling pediatric conditions by augmenting pediatric clinical research, while also expanding and intensifying screening, education, outreach, monitoring and training efforts led by State and local public health agencies and other health care providers.

There are two specific initiatives that I am especially proud of in this legislation. The first seeks to address an entirely preventable problem that continues to plague far too many children in this nation—lead poisoning. While tremendous strides have been made over the last 20 years in reducing lead exposure among our citizens, it is estimated that nearly one million preschoolers nationwide still have excessive levels of lead in their blood—making lead poisoning the leading childhood environmental disease.

Lead is most harmful to children under age six because lead is easily absorbed into their growing bodies, and interferes with the developing brain and nervous system. The effect of lead poisoning on a child ranges from mild to severe. Most often in the U.S., children are poisoned through chronic, low-level exposure to lead-based paint, which can cause reduced IQ and attention span, hyperactivity, impaired

growth, reading and learning disabilities. Children with high blood lead levels can suffer from brain damage, behavior and learning problems, slowed growth, and hearing loss, among other maladies.

Timely childhood lead screening and appropriate follow-up care for children most at-risk of lead exposure is critical to mitigating the long-term health and developmental effects of lead. Regrettably, our current system is not adequately protecting children, particularly low-income children, from this hazard. It is estimated that two-thirds of at-risk children have never been screened and, consequently, remain untreated.

This legislation takes some of the critical steps necessary to begin to address this problem. Specifically, the bill strengthens the lead program at the Centers for Disease Control and Prevention by providing new resources to conduct extensive outreach and education in coordination with other state programs that serve families with children at-risk of lead poisoning, such as WIC and Head Start. The bill also authorizes the implementation of community-based interventions to mitigate lead hazards and establishes guidelines for the reporting and tracking of blood lead screening tests so that we may have more accurate data on the number of lead-exposed children nationwide. The legislation also designates resources for health care provider education and training on current lead screening practices.

The second element of this bill that I believe will have a major impact on improving the overall health of children relates to the problem of childhood obesity. Over the past fifteen years, the number of overweight children in this country has doubled. It is estimated that an alarming five million youth 6–19 years of age are overweight, while another six million children are overweight to the point that their health is endangered.

Contributing to this alarming trend has been the rise in fast food consumption, coupled with an increasingly sedentary lifestyle where time engaged in physical activity has been replaced by hours playing computer games and watching television. The New York Times recently noted that the average child between the ages of 6 and 11 watches 25 hours of television a week—and this does not include time spent playing video games or on a computer.

Another reason for the lack of physical activity in children is the reduction in daily participation in physical education classes. Fewer and fewer States require school districts to offer physical education, despite the fact that children who engage in regular physical activity often perform better in school. We are raising a generation of inactive children that will likely become inactive, chronically ill adults. By not ensuring kids take time to participate in regular physical activity, we, as a society, are doing them a great disservice in the long run.

Already, we are seeing younger and younger Americans with the signs of heart disease and diabetes, among other obesity-linked illnesses. The Centers for Disease Control and Prevention reports that 60 percent of overweight 5–10 year old children already have at least one risk factor for heart disease, such as hypertension, while the number of children diagnosed with Type II diabetes has skyrocketed. If we continue on this trajectory, obesity-related illnesses will soon rival smoking as a leading cause of preventable death, costing hundreds of thousands of American lives and billions of dollars in health care costs and lost productivity. Clearly, action needs to be taken.

This legislation acknowledges this trend and attempts to reverse it through a multi-faceted approach. First, the bill authorizes a new competitive grant program through the Centers for Disease Control and Prevention to assist states and localities to develop and implement comprehensive school- and community-based approaches to promoting good nutrition and physical activity among children. The bill also calls for greater applied research to improve our understanding of the multiple factors that contribute to obesity and eating disorders and emphasizes the need for a nationwide public education campaign to educate families about the importance of good eating habits and regular physical activity. Lastly, the bill provides for health professional education and training to aid in the identification and treatment of overweight children, children suffering from an eating disorder or children at risk of these conditions.

The other major component of this bill is based on S. 976, the Youth Drug and Mental Health Services Act, which originated in the Senate Health, Education, Labor, and Pensions Committee, and passed the full Senate last year. This legislation reauthorizes programs administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), and also provides many enhancements that will specifically benefit children and adolescents suffering from substance abuse or mental health problems, children who have witnessed violence, and children from families needing substance abuse or mental health treatment and other support services.

I am pleased that this legislation includes a provision that I worked on to address the severe shortage of transitional services for youth who are leaving the juvenile justice system. Specifically, the bill addresses this shortage by authorizing grants to local juvenile justice agencies to provide comprehensive community-based services such as mental health and substance abuse treatment, job training, vocational services, and mentoring programs to juvenile offenders.

Studies have found that the juvenile population has a special need for these types of services, mental health and substance abuse treatment, in particular. It is estimated that the rate of mental disorder is two to three times higher among the juvenile offender population than among youth in the general population. According to a 1994 Department of Justice study, 73 percent of the juveniles surveyed reported mental health problems, and 57 percent reported past treatment. Also, it is estimated that 60 percent of youth in the juvenile justice system have substance abuse disorders, compared to 22 percent in the general population.

Unfortunately, there currently exists little, if any, support for youth who are leaving the juvenile justice system. Many services, such as mental health and substance abuse treatment, provided while the youngster was detained or incarcerated, are discontinued upon their release. Given this breakdown in the continuity of services, it is hardly surprising that of the 4 million youngsters arrested each year, 30 percent are likely to recidivate within the year of arrest.

In the handful of places where transitional services have been provided, the results have been outstanding. For instance, in Rhode Island we have a successful program called ''Project Reach.'' Yale University, in its evaluation of Project Reach, found that children receiving transitional services improved dramatically: 80 percent had significant increases in their grades in school; school attendance increased from 50 to 75 percent; and there was a 60 percent reduction in youth encounters with police after enrolling in the program. In addition, there was a 50 percent decrease in out-of-home placement for these children. In other words, children who once had problems so severe that they had to be removed from their homes are now able to remain with their families in their communities.

Adequate transitional and aftercare services to prevent recidivism are essential to reducing the societal costs associated with juvenile delinquency, promoting teen health, and fostering safe communities. These provisions recognize the serious gap in services for youth offenders and takes important steps to address this serious deficiency. I am grateful for the inclusion of this critical language in the bill.

As I have noted, there are many positive aspects to this legislation. However, I have deep reservations about a particular provision that was retained in the SAMHSA bill that allows all religious institutions, including pervasively religious organizations, such as churches and other houses of worship, to use taxpayer dollars to advance their religious mission. I oppose this ''charitable choice'' language and offered an amendment to modify it when the original legislation was considered in Committee last year.

Although charitable choice has already become law as a part of welfare reform and the Community Services Block Grant, CSBG, section of the Human Services Reauthorization Act,

the inclusion of charitable choice in this legislation is particularly disturbing since, unlike its application to the intermittent services provided under Welfare Reform and CSBG, SAMHSA funds are used to provide substance abuse treatment which is ongoing, involves direct counseling of beneficiaries and is often clinical in nature. In the context of these programs it would be difficult if not impossible to segregate religious indoctrination from the social service.

Faith-based organizations do have an important and necessary role to play in combating many of our nation's social ills, including youth violence, homelessness, and substance abuse. In fact, I have seen first-hand the impact that faith-based organizations such as Catholic Charities have on delivering certain services to people in need in my own state. By enabling faith-based organizations to join in the battle against substance abuse, we add another powerful tool in our ongoing efforts to help people move from dependence to independence.

While there are many benefits that come with allowing religious organizations to provide social services with federal funds, I am concerned that without proper safeguards, well-intentioned proposals to help religious organizations aid needy populations, might actually harm the First Amendment's principle of separation of church and state. The charitable choice provision creates a disturbing new avenue for employment discrimination and proselytization in programs funded by SAMHSA. Under current law, many religiously-affiliated nonprofit organizations already provide government-funded social services without employment discrimination and proselytization. However, the legislation extends Title VII's religious exemption to cover the hiring practices of organizations participating in SAMHSA programs.

As I already mentioned, during markup, I offered an amendment that would have addressed this issue by including important safeguards and protections for beneficiaries and employees of SAMHSA funded programs. Specifically, the amendment would have removed the provision that allows religious organizations to require employees hired for SAMHSA funded programs to subscribe to the organization's religious tenets and teachings. Since the bill prohibits religious organizations from proselytizing in conjunction with the dissemination of social services under SAMHSA programs, it seems contradictory to permit religious organizations to require their employees to subscribe to the organization's tenets and teachings when it has no bearing on the provision of services. Second, the amendment would have eliminated the extension of Title VII's religious exemption to cover the hiring practices of organizations participating in SAMHSA funded programs.

Ultimately, my proposal would not have reduced the ability of religious groups to hire co-religionists or more actively participate in SAMHSA funded programs. It merely would have eliminated the explicit ability to discriminate in taxpayer-funded employment and left to the courts the decision of whether employees who work on, or are paid through, government grants or contracts are exempt from the prohibition on religious employment discrimination.

For the last 30 years, federal civil rights laws have expanded employment opportunities and sought to counter discrimination in the workplace. I recognize that we need the assistance of religious organizations in the battle against substance abuse. However, partnerships with faith-based organizations should augment—not replace—government programs. These partnerships should respect First Amendment protections and not allow taxpayer dollars to be used to proselytize or to support discrimination. I believe we need a far more robust and informed debate before we allow any expansion of current exemptions to Title VII.

Nevertheless, this combined legislation has many meaningful provisions that will go a long way towards improving the health and well-being of our children. This legislation not only strengthens pediatric medical research, it also includes important enhancements in maternal and prenatal health as well as several other health promotion and disease prevention initiatives that will greatly enhance the quality of life for children. Similarly, the bill contains elements that will greatly improve mental health and substance abuse services for children and adolescents.

I am pleased to have worked on this legislation and look forward to its expeditious passage this year.

Mr. DOMENICI. Mr. President, I rise today to briefly speak about the passage of the children's health bill and the Substance Abuse and Mental Health Services Administration reauthorization bill.

I would like to begin by congratulating Senators FRIST and KENNEDY for their work on this important piece of legislation and to tell them how pleased I am the package contains a number of provisions from the Mental Health Early Intervention, Treatment, and Prevention Act of 2000, S. 2639.

Today we do not even question whether mental illness is treatable. But, today we recoil in shock and disbelief at the consequences of individuals not being diagnosed or following their treatment plans. The results are tragedies we would have prevented.

Just look at the tragic incidents at the Baptist Church in Dallas/Fort Worth, the Jewish Day Care Center in Los Angeles, and the United States Capitol to see the common link: a severe mental illness. Or the fact that there are 30,000 suicides every year, including 2,000 children and adolescents.

It was not too long ago that our Nation decided we did not want to keep people with a mental illness institutionalized. Simply put, it was inhumane to simply lock these individuals up without even using science to consider other alternatives.

Make no mistake, our Nation still has these same individuals with mental illness, we just do not have a very good way to deal with these individuals. Many of these individuals formerly locked up are now our neighbors taking the proper medication to manage their illness.

However, our Nation simply does not have an understanding of what happens when individuals stop taking their medications because sadly many of these highly publicized incidents of mass violence all too often involve an individual with a mental illness.

When these incidents occur, my wife and I watch with horror on television and we often turn to each other and say that person was a schizophrenic or that individual was a manic depressive.

Some of you may have seen the recent 4 part series of articles in the New York Times reviewing the cases of 100 rampage killers. Most notably the review found that 48 killers had some kind of formal diagnosis for a mental illness, often schizophrenia.

Twenty-five of the killers had received a diagnosis of mental illness before committing their crimes. Fourteen of 24 individuals prescribed psychiatric drugs had stopped taking their medication prior to committing their crimes.

With this in mind I am especially pleased that with the passage of this package we are taking a very positive step forward to address the problem I have mentioned. The provisions adopted from the Mental Health Early Intervention, Treatment, and Prevention Act of 2000 will serve to give more people the ability to identify when someone might be suffering from mental illness and pose a threat to themselves or others.

I think it's important that we begin to find ways to get these people help before we find them involved in a violent tragedy and I would like to briefly touch upon several of those provisions I believe will take us a long way towards that goal:

A grant program will provide training to teachers and emergency services personnel to identify and respond to individuals with mental illness, and to raise awareness about available mental health resources. Another grant program creates Emergency Mental Health Centers that will serve as a specific site in communities for individuals in need of emergency mental health services, and will also provide mobile crisis intervention teams.

The Jail Diversion Demonstration will create 125 programs to divert individuals with mental illness from the criminal justice system to community-based services. And finally, the Mental Illness Treatment Grant will provide integrated treatment for individuals with a serious mental illness and a co-

occurring substance abuse disorder with an emphasis placed on individuals with a history of involvement with law enforcement or a history of unsuccessful treatment.

In closing, I really believe we have a historic opportunity to become preventers of serious, serious acts of violence before they happen and I look forward to working with my colleagues in the future to continue addressing this important issue.

Mr. WELLSTONE. Mr. President, I rise today in support of the passage of the Children's Health Act of 2000, an extraordinary bipartisan bill that includes so many outstanding provisions to improve the health and mental health of the children of our country. The bill includes the reauthorization of the Substance Abuse and Mental Health Services Administration, a long-overdue reauthorization and revitalization of an agency that provides most of the public funding of mental health and addiction services to our communities. SAMHSA has many dedicated staff who have worked so hard to develop and manage remarkable programs over the last several years. I am proud to have played a role in the development of this comprehensive bill, and to join my colleagues in encouraging its quick passage into law.

The Children's Health Act of 2000 takes a major step forward in supporting research, services, treatment, and professional training to begin to address some of the most significant health problems affecting children of all ages. This legislation clearly states that children's health, including their mental health and addiction treatment needs, must be a priority for our country. It is not enough to deal with our children's health needs only after they have become crises. Many of the programs outlined in this bill recognize this problem by focusing on prevention and education programs, and by supporting programs to train researchers and health care providers who specialize in children's health.

Many of the health areas included in this comprehensive bill were identified by the Department of Health and Human Services as among the top 10 leading health indicators for children in its major public health initiative ''Healthy People 2010,'' launched in January 2000. Several were of particular importance to me as I worked on this bill, especially programs supporting treatment of mental illness and addiction; increased access to health care, especially for our mentally ill youth in correctional facilities; and overall improvements in fitness and oral health for all our children, including low-income children and children living in rural areas.

Dr. David Satcher, the United States Surgeon General, has released several groundbreaking reports in recent years which highlight the scope and the specific health needs of our children. These reports included ''Mental Health: A Report of the Surgeon General''; ''The Surgeon General's Call to Action to Prevent Suicide''; and the first ever ''Oral Health In America: A Report of the Surgeon General,'' which each begins to address these severe health crises in these areas for so many of our children. The problems identified by Dr. Satcher touch on both the national problems across our country, and also highlight the significant health care disparities for different groups. I am pleased to have contributed to many new legislative and funding efforts to support improvements in these areas of health care.

In the Surgeon General's 2000 report on oral health, the strong link between oral health and overall health was highlighted, and this bill helps to address the problems identified in the report. Dr. Satcher emphasized the devastating consequences of untreated oral disease and how it can affect children's health and well-being, leading to serious pain and suffering, time lost from school, loss of permanent teeth, damage to self-esteem, and co-existing medical conditions. So much of what we need to do is already known. We need to identify the unmet need and improve access to care for those who need it most. This bill includes funding for school-based and other innovative oral health care programs to improve the overall health of our children. The oral health programs included in this bill are an important step forward.

Healthy People 2010 goals also identified obesity as a major problem for children, particularly because of the decline in physical activity among our children. One-fourth of our children aged 6–17 are overweight, and the percentage of children who are seriously overweight has doubled in the last thirty years. This is not a minor issue for the health of our children: obesity as a chronic illness is related to other serious chronic conditions in children, including type II diabetes, hypertension, and asthma. Research has also shown that 60% of overweight children 5–10 years old already have at least one risk factor for heart disease. Adult obesity is associated with many of the leading causes of death and disability, including heart disease, diabetes, arthritis, and cancer. The public health efforts in this bill that focus on this serious national problem, including improvements in physical education funding, public health education, and nutrition education, are ones I enthusiastically support. In the future we must do even more to again make physical education a high priority for our country and establish a national foundation to promote physical activity for all ages.

I am particularly proud of the section of this bill that supports local suicide prevention programs focusing on our young people. Youth suicide must be recognized for the national crisis that it is. In my own state of Minnesota, suicide is the second leading cause of death among our youth, as it is in half of the states in our country. Overall, in the United States, it is the third leading cause of death among our children, taking more lives than homicide. We know from the outstanding research supported by the National Institute of Mental Health that 90% of all completed suicides are linked to untreated or inadequately treated mental illness or addiction. More than 500,000 Americans attempt to take their own lives every year. In this bill, $75 million will be authorized to support local prevention programs focusing on our children who are at risk of taking their own lives. More than 50 groups supported our efforts to improve funding for suicide prevention programs this year, including local programs, like the Minnesota group, Suicide Awareness/Voices of Education (SA/VE), as well as national groups, such as Suicide Prevention and Advocation Network (SPAN), the National Hope Line Network, and the National Mental Health Association.

We can no longer afford to turn our eyes away from the horrible reality that many of our citizens, even our children, may want to die. We continue to treat mental illness and severe drug addiction as somehow less important than other illnesses. We blame the sick for their disease, and the result can be death and tragedy. Today, we begin to acknowledge that this kind of discrimination is against many of our own children.

I am also pleased to have worked to include an additional $4 million to support resource centers for those who work with our mentally ill youth in correctional facilities. Our children need help in many areas: education, child care, juvenile justice, and health care. Many are experiencing severe drug addiction, mental illness, and lack of access to health care coverage. The Director of the Office of National Drug Control Policy (ONDCP) has recognized that the number one priority for the nation's National Drug Control Strategy is to educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco. And yet 80 percent of adolescents needing treatment are unable to access services because of the severe lack of coverage for addiction treatment or the unavailability of treatment programs or trained health care providers in their community. Many of these children end up in the juvenile justice system as a result.

The reauthorization of SAMHSA within this bill, with its state block grant funding for mental health and addiction treatment, is a good beginning. But so much more must be done to stop treating our children as second class citizens, and to stop treating mental illness and addiction as second class illnesses. We must continue to fight for fairness and parity in health care coverage for our children, indeed for all of our citizens, who suffer from mental illness and addiction. It is their future, and ours, as a country, that is at stake.

Mr. ASHCROFT. Mr. President, I am pleased to support the Children's

Health Act of 2000 that will pass the Senate today. This legislation is the result of months of dedicated work by a number of Senators and House members. I believe the final language represents a comprehensive approach to promote physical and mental health for children, and protect them from dangerous, illegal drugs. I am a cosponsor of the Senate version of this bill, a previous Senate version of the Children's Health Act (S. 2868), as well as the author of two key provisions contained in the package we are considering today.

I rise today to speak in favor of this legislation and to thank the bill's sponsor, Senator FRIST, for working with me to include two provisions that I believe are essential tools for advancing health and safety of America's children. The bill that will pass today, H.R. 4365, contains three main sections: (1) the text of S. 486, the Methamphetamine Anti-Proliferation Act, a bill I introduced last year that previously passed the Senate and has been approved by the House Judiciary Committee for consideration by the House of Representatives; (2) the Youth Drug and Mental Health Services Act, which reauthorizes programs within the jurisdiction of the Substance Abuse and Mental Health Services Administration (SAMHSA) to improve mental health and substance abuse services for children and adolescents and allows the Charitable Choice concept, which I first authored in the 104th Congress, to be applied to the programs covered by this Act and (3) the Children's Health Act, which amends the Public Health Services Act to revise, extend, and establish programs with respect to children's health research, health promotion and disease prevention activities conducted through Federal public health agencies.

Mr. President, let me touch briefly on each of these three main sections.

First, this bill includes the text of S. 486, the Methamphetamine Anti-Proliferation Act, a bill I introduced in February 25, 1999 in response to the growing problem of methamphetamine production and use in my home state of Missouri, throughout the Midwest and in many other states as well. Unfortunately, the problem of methamphetamine has only gotten worse in the past year and a half. This anti-meth measure I authored will help fight meth in Missouri and the U.S. with $55 million in new resources for enforcement, cleanup, school- and community-based prevention efforts, and rehabilitation services.

The Methamphetamine Anti-Proliferation Act will bolster the fight against meth through stiffer penalties for drug criminals; more money for law enforcement, education, and prevention; and a wider ban on meth paraphernalia. The bill directs the U.S. Sentencing Commission to raise its guidelines for sentencing meth offenders. It requires mandatory reimbursement for the costs incurred by federal, state and local governments for the cleanup associated with meth labs. It authorizes $5.5 million in funding for DEA programs to train State and local law enforcement in techniques used in meth investigations and staff mobile training teams which provide State and local law enforcement with advanced training in conducting lab investigations. It also provides $15 million in funding to combat the trafficking of meth in counties designated High Intensity Drug Trafficking Areas.

This legislation also provides for further research into the use of meth; authorizes $15 million in funds for community- and school-based anti-meth education programs; and includes an additional $10 million in resources for treatment of meth addiction. It directs HHS to include its annual National Household Survey on Drug Abuse prevalence data on the consumption of methamphetamine and other illicit drugs in rural, metropolitan, and consolidated metropolitan areas and requires the Secretary of HHS, in consultation with the Institute of Medicine, to conduct a study on the development of medications for the treatment of addiction to methamphetamine.

The nation's lead anti-drug agency, the Drug Enforcement Administration (DEA), has thrown its support behind the Methamphetamine Anti-Proliferation Act. In endorsing this bill, DEA Administrator Donnie Marshall said this bill is ''landmark methamphetamine legislation.'' Marshall stated: ''I believe this bill (the Methamphetamine Anti-Proliferation Act) will prove instrumental in the Drug Enforcement Administration's efforts to bring to a halt the continued spread of methamphetamine across our country.''

Mr. President, I am sad that Missouri is notorious as a national center of meth production and distribution. Methamphetamine, for those who are lucky enough not to have a meth problem in their areas, is a highly addictive synthetic drug that is typically made in illegal clandestine ''labs.'' Missouri and California lead the nation in seizures of such labs. In Missouri, the federal Drug Enforcement Administration and state and local law enforcement officers seized only two such labs in 1992, 14 in 1994, and a record 679 in 1998. This number jumped to 920 in 1999, setting a new record.

The second section of this bill is the Youth Drug and Mental Health Services Act, which reauthorizes the Substance Abuse and Mental Health Services Administration (SAMHSA). This section addresses the issue of drug abuse in our nation's youth which has dramatically increased this decade. It creates new programs to provide additional funding for youth-targeted treatment and early intervention services. Under this bill, states will receive more flexibility in the use of block grant funds and the Secretary of Health and Human Services will have more flexibility to respond to the needs of young people who need mental health and substance abuse services.

I am especially pleased that included in the Youth Drug and Mental Health Services Act is an expansion of the Charitable Choice provision, which will allow federally-funded substance abuse services to be open to faith-based providers. Under Charitable Choice, which was first enacted into law in 1996 as part of the welfare reform law, churches and other faith-based providers are able to compete on an equal footing with other non-governmental organizations in providing services to disadvantaged Americans.

Since its enactment, Charitable Choice has been expanded from job training and related services for welfare clients to include the Community Services Block Grant program, which is used for a variety of anti-poverty activities, such as improving job and educational opportunities and providing financial management and emergency assistance. This latest expansion will apply Charitable Choice to federal drug treatment programs that will total $1.6 billion for Fiscal Year 2000. My home state of Missouri is slated to receive $24.46 million in substance abuse block grant funding for the coming fiscal year.

Charitable Choice calls our nation to its highest and best in our effort to help those in need. It meets the tests of compassion and common sense that count for so much in Missouri. When people of faith extend compassionate help to those in need, the results can be stunningly successful. Where too many traditional substance abuse treatment programs have failed to help those in need, faith-based programs have succeeded. For example, Teen Challenge has show that 86% of its graduates remain drug-free. San Antonio's Victory Fellowship boasts of a success rate of over 80%. This is the test of common sense: America needs to create a vibrant partnership that succeeds where other approaches have failed.

Mr. President, the bipartisan support for Charitable Choice is overwhelming in Congress. In additional, both Presidential candidates—Governor Bush and Vice President GORE—strongly support the program. It is my hope that this broad national consensus will continue to grow and that soon will be able to enact a comprehensive expansion of Charitable Choice to all federally-funded social services programs.

Third, the Children's Public Health Act has four overriding themes represented in its four titles: Injury Prevention, Maternal and Infant Health, Pediatric Health Promotion, and Pediatric Research. This legislation focuses federal research efforts in these areas and provides a comprehensive approach to children's health. For example, the bill includes authorization for research to prevent traumatic brain injuries, provides federal grants for comprehensive asthma services to children, and establishes a National Center for Birth

Defects and Development Disabilities within the CDC. The bill also includes childhood obesity prevention programs, childhood lead prevention programs, and a groundbreaking pediatric research initiative within NIH to ensure the realization of expanding opportunities for advancement in scientific investigations and care for children. This legislation also includes support for pediatric graduate medical education in children's hospitals, an issue that has been a high priority of mine for years.

I am hopeful, that with passage of this landmark legislation, we can improve the lives of America's children. By funding research for many childhood diseases and disabilities, expanding programs to assist youth with addiction and mental health problems through faith-based providers, and drastically increasing the war against meth, this bill is an important step in the right direction. I thank all those who worked on this legislation, and urge the President to sign this bill to help secure a safer and healthier future for the next generation.

Mr. LOTT. Mr. President, I ask consent that the amendment that is offered in the nature of a substitute be agreed to, the bill be read the third time and passed, as amended, the motion to reconsider be laid on the table, and that any statements related to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 4181) was agreed to.

The bill (H.R. 4365), as amended, was read the third time and passed.

Mr. BOND. Mr. President, I rise to speak on an issue of great importance to America's families—the health of our nation's children—and to talk about crucial legislation which the Senate has passed today called the Children's Health Act of 2000.

Whenever we talk about children's health, we should not ignore the fact that there is a lot of good news. The fact is that most children are persistently healthy. A majority of children can actually go through a year with no more serious health problems than scrapes and bruises, a stuffy nose, or an easily-treatable earache. I'm not sure how many of us can say that—I know I can't. And on a variety of indicators that measure children's health, the good news is only getting better. In the last decade, we have seen improvements in immunization rates, infant mortality, child mortality, and reduced teen birth rates.

There are of course exceptions to these healthy kids. Thousands of children are born every year with a birth defect. Too many children suffer moderate to serious accidents of all types. And an unfortunate minority face other serious or long-term health problems. Worse, children who are sick are often very sick. These exceptions to the rule are all the more tragic because our expectation is that our children will be healthy.

That is why the Children's Health Act, which the Senate has passed today, is so important. As sound as our children's overall health is, it can be better. As well as our nation is doing to protect our children's health, we can do more.

Mr. President, the Children's Health Act covers many specific health problems that afflict children—autism, arthritis, asthma, brain injuries, lead poisoning, and so on. Each of the legislative provisions that addresses these problems deserves attention, and I hope that the merits of each of these sections can be presented. Right now, I would like to focus on the sections of the Children's Health Act that I have strongly supported. Most of these provisions were included in legislation—called Healthy Kids 2000—which I introduced last year.

As both a Governor and a Senator, one of my main priorities in health care has been to try to find new ways to prevent birth defects. Because we expect our children and our babies to be healthy, birth defects can be truly devastating to a family. Yet they happen far too frequently—150,000 children are born every year with some type of birth defect.

Today alone, about 6 or 7 families in this country will have a child with one very serious type of birth defect, called a neural tube defect. Spina bifida is the most well known of these defects of the brain and spine. The complications that result from this type of birth defect range from serious, long-term health problems to death, but the real tragedy is that many of these birth defects could have been prevented.

One simple step—women of childbearing age taking 400 micrograms of folic acid every day—can help women and families significantly reduce the chance of this type of birth defect by up to 70 percent. Yet most women just don't know about folic acid. Simply making them aware of the importance of folic acid is such an easy and inexpensive way to prevent birth defects, it is simply silly not to do everything we can to make sure every woman in this country knows about the benefits of folic acid.

One provision of the Children's Health Act was taken from the Folic Acid Promotion Act, which I have introduced with Senator ABRAHAM. This section authorizes expanded effort by the Centers for Disease Control to get more women of childbearing age to use folic acid. The CDC has begun activity in this area, but the continued depth of the problem demonstrates that much more can be done.

Another easy thing we can do to bring greater focus and attention to the problem of birth defects is to simply reorganize how and where the work on birth defects is done within the Centers for Disease Control. Right now, the CDC's work on birth defects is done within one of its main branches, the National Center for Environmental Health, whose responsibilities expand significantly beyond birth defects.

I believe the seriousness of this problem—over 400 infants are born every day with some type of birth defect—and the significant amount of CDC funding spent on birth defects justify a Center within the Centers for Disease Control focused exclusively on this issue. The Children's Health Act calls for a fourth Center within the CDC—the National Center for Birth Defects and Developmental Disabilities—which will allow for consolidation, greater visibility and expansion of CDC's efforts to prevent birth defects. This builds on the comprehensive prevention program outlined in the Birth Defects Prevention Act, which I sponsored and Congress passed in 1998.

One area of children's health that has been getting worse over the last decade is the percentage of babies born with a low birth weight. Low birth-weight babies have a much higher chance of developmental and other problems as they grow up. One reason for this declining trend is the persistent levels of cigarette, alcohol, and drug use during pregnancy. Somewhere between 19 and 27 percent of pregnant women in the U.S. smoke during pregnancy, despite the fact that these smokers are at a significantly higher risk for stillbirth, premature births, low birth-weight, and birth defects.

The Children's Health Act contains another provision from my Healthy Kids 2000 legislation which establishes a grant program run by CDC to establish community-based programs designed to reduce and prevent prenatal smoking, alcohol, and drug use. We can work with women to help them understand the consequences of using these types of substances on their babies and to help them change their behavior so they can have healthier infants.

The health of a mother during her pregnancy obviously has a tremendous health impact on her child. Yet we as a nation still have a surprisingly large amount of serious complications that occur during pregnancy even before labor. 1,000 women actually die every year during pregnancy, and this figure has been increasing in the 1990s. A full 20 percent of women have serious health problems even before they go into labor.

But despite these problems, our public health system does not have a comprehensive system in place to monitor, research, and try to prevent these maternal deaths and complications. Only 15 states have a program of their own that does this. Well, if we can't look at a problem and study it, we certainly can't hope to understand the problem, much less to solve it. I believe the CDC needs to do further work with states to understand exactly why so many women are having pregnancy-related problems and to figure out what we can do about it. The Children's Health Act authorizes CDC to expand their efforts so we can prevent these problems and help women have healthy pregnancies so they can have healthy kids.

Finally, I have been a strong supporter of Senator DEWINE's Pediatric

Research Initiative within the National Institutes of Health. I am pleased to be a cosponsor of his bill, and I included the Pediatric Research Initiative in my Healthy Kids 2000 legislation. I am happy to report that the Pediatric Research Initiative has been included in the Children's Health Act.

I believe we need to encourage the NIH to focus more on children's health care research. In recent years, NIH has seen significant increases in the funding needed to support the critical research they do. This crucial work helps us better understand how various diseases work, what we can do to prevent them, and how to cure those who are afflicted. I am concerned, however, that pediatric research at NIH has not shared fully in this research expansion.

The Pediatric Research Initiative provides the NIH with additional funds that are specifically dedicated to pediatric research. This funding can be used by the NIH Director for research that shows the most promise to address successfully childhood health concerns. The Pediatric Research Initiative would not earmark funds to any specific institute or to any specific disease. This commonsense legislation simply provides extra funding to the Office of the Director with maximum flexibility to invest that money in any area of pediatric research in any of the NIH Institutes. I believe this is a reasonable, and not a very restrictive, response to concerns that the NIH shortchanges pediatric research.

Mr. President, I would like to commend and thank Senators FRIST, KENNEDY, and all of the other distinguished Senators who have worked to put this crucial bill together. I have been pleased to work with them to ensure that this bill addresses some of the most pressing health care concerns our nation's children face. I hope and expect that the House of Representatives will follow-up quickly on Senate action so we can send this bill to the President.

Last year, I introduced the Healthy Kids 2000 Act based on a simple idea—we want children to be healthy, and we want pregnant women to be healthy. Passage today of the Children's Health Act promises to bring us closer to this simple but critically important goal.

Mr. LEVIN. Mr. President, according to the experts, the number of heroin users is on the rise while the average age of first heroin use is dropping. Heroin addiction is a public health crisis of significant proportion. This legislation, the Hatch-Levin Drug Addiction Act, S. 324, will allow us to effectively utilize a new medical discovery of a substance called Buprenorphine, which has proven to be an extraordinarily effective means for combating heroin addiction by blocking the craving for heroin.

But this anti-addiction medication can help us win the war against heroin and heroin addiction only if we change our laws so that the medication can be dispensed in physician's offices instead of a centralized clinic. That is what this legislation accomplishes.

It is estimated that there are approximately one million heroin addicts in the U.S. According to the U.S. Department of Health and Human Services, many of these heroin addicts want to kick their habit, but do not wish to receive treatment in methadone clinics ''. . . because of the stigma of being in methadone treatment or their concerns about the medical effects of methadone.''

The Drug Addiction Treatment Act has now passed the House of Representatives in slightly different form than we passed in the Senate on November 19. Its adoption again by the Senate as Title XXXV, Section 3501 and Section 3502 of the substitute amendment to H.R. 4365, the Children Health Act of 2000, paves the way for physician office-based dispensing of a medication which has been the subject of extensive successful research and clinical trials in the U.S. and France. This medication, Buprenorphine, was developed under a Cooperative Research and Development Agreement between the National Institute on Drug Abuse and a private pharmaceutical manufacturer, and is expected to receive FDA approval in the weeks ahead. Buprenorphine has already been in use, in physician offices, for a number of years in France, where significant success has been achieved in getting individuals off of heroin, reducing crime and heroin-related deaths. For example, since the introduction of Buprenorphine in France, there has been an 80 percent decline in deaths by heroin overdose—from 505 in 1994 to 92 in 1998; user crime and arrests are down by 57 percent—from 17,356 in 1995 to 7,649 in 1998; and trafficking arrests have declined by 40 percent—from 3,329 in 1995 to 1,979 in 1997.

Over a year ago, I introduced the Drug Addiction Treatment Act, S. 324, along with Senator HATCH, Senator MOYNIHAN and Senator BIDEN, in order to put in place the necessary mechanisms to accommodate this revolutionary new treatment that can block the craving for heroin and dramatically restore the quality of the lives of individuals and families who have struggled to get out from under heroin addiction.

There are a number of reasons why our legislation is necessary. Under current law, the Narcotic Addict Treatment Act of 1974, the process by which individual physicians must be approved in order to prescribe narcotics in drug treatment is a cumbersome and complex regulatory process. Federal regulations and State regulations, which could, under existing law, be written to allow Buprenorphine to be utilized in physician offices will take an extensive period of time to be written and take many years to be implemented. Indeed, there is no assurance that such regulations will ever be written by both federal and state governments. In the meantime, a very effective medication is unavailable to those who are addicted to Heroin.

The Hatch-Levin legislation would allow for the utilization of Buprenorphine by qualified physicians in a physician's office. It will also assure that Buprenorphine will be made available in every state unless a state expressly opts out of the program through legislation.

The current federal regulatory process needed to be utilized before treatment of addiction in an office-based setting is allowed include: (1) Writing the regulations, which could take up to a year or more; (2) Issuance of the proposed rule which would be published in the Federal Register, including the announcement of a period of time for public comment on the proposed rule; (3) A review of the public comments, which could take a year or more; (4) The issuance of the final rule, (5) Then each State is required to affirmatively approve and implement the physician office approach which typically takes 2–4 years, in those states that do act.

Based on the experience with the introduction of LAAM for the treatment of heroin addiction—a medication similar to methadone which is effective for up to three days, as opposed to the daily dosage required by methadone—most states may never approve the physician office approach and for those that do the process could go on for as many as 4–5 years. That was the case with California and New York. According to findings reported by the U.S. Department of Health and Human Services on July 14, 1999: ''Current federal and state regulations prevent ease of entry into methadone or LAMM maintenance treatment. . . .''

So, while it is possible under current law for regulations to be written by HHS allowing for the use of Buprenorphine in the treatment of heroin addiction and to allow for it to be prescribed in physician offices,

(1) there is no certainty that they will be written;

(2) if such regulations are written, it would take years for them to take effect; and

(3) each state must explicitly opt into the program by writing regulations or adopting a law.

In each state not opting in, the treatment in a physician office would not be available as described

The result of the above cumbersome and complex process has been a treatment system consisting primarily of large methadone clinics, preventing physicians from treating patients in convenient office-based settings, thereby making treatment unavailable as a practical matter to many in need of it. Also, experts say that many heroin addicts who want treatment are often deterred because, in addition to the stigma that is associated with large centralized methadone clinics, they must travel long distances daily to receive such treatment and cannot maintain a job while doing so. Even though Buprenorphine does not possess the addictive qualities of methadone, because of the constraints in current law, it

would nonetheless have to be dispensed in this same manner—in centralized clinics—rather than in the private office of a qualified physician.

The Drug Addiction Treatment Act, S. 324 (H.R. 2634), will make it possible for medications like Buprenorphine, which have little or no likelihood of diversion or abuse, to be made available in the offices of physicians who have the training and certification and license to treat persons addicted to opiates. It is anticipated that the initial group of eligible physicians to dispense Buprenorphine will come from the 10,000 practitioners with addiction treatment certification from the American Society of Addiction Medicine, or board certification in addiction psychiatry or medical toxicology from the American Board of Medical Specialties or certification in addiction medicine from the American Osteopathic Association. The protections in the legislation against abuse are as follows: Physicians may not treat more than 30 patients in an office setting; appropriate counseling and other ancillary services are a requirement under this legislation; the Attorney General may terminate a physician's DEA registration if these conditions are violated; and the program may be discontinued altogether if the Secretary of HHS and Attorney General determine that this new type of decentralized treatment has not proven to be an effective form of treatment. Finally, states may opt out of the provision.

Recent findings of the Monitoring the Future Program, headed by Dr. Lloyd Johnson of the University of Michigan, indicates that heroin use among American teens doubled between 1991 and 1998, and represents a clear danger for a significant number of American young people. Dr. Johnson attributes this sharp increase to non-injectable use—smoking and snorting, and notes that the very high purity and low cost of heroin on the street has made these new developments possible; and that, unfortunately, a number of those users will switch over to injection.

The Drug Enforcement Administration reports that the price of heroin has steadily declined since 1980, though it is more potent. In 1980, heroin cost $3.90 per milligram and was 3.6 percent pure heroin. Today, heroin costs about $1 per milligram, yet it is 10 times more pure. This purer, cheaper heroin is available everywhere—in our inner cities, in our suburbs and in our small towns. For instance, according to the National Center on Addiction and Substance Abuse, over 32 percent of persons living in small towns, age of 12 and over, have easy access to heroin.

The need for this change in our law to make available more broadly an effective heroin blocker was expressed by experts at a May 9, 1997 Drug Forum on Anti-addiction Research, which I convened along with Senator MOYNIHAN and Senator BOB KERREY. Forum participants, including distinguished experts such as Dr. Herbert Kleber and Dr. Donald Landry of Columbia University, Dr. Charles Schuster of Wayne State University and Dr. James H.Wood of the University of Michigan told us that this dramatic new anti-addiction medication is coming in the nick of time. The untreated population of opiate addicts, and other injection drug users, is the primary means for the spread of HIV, hepatitis B and C, and tuberculosis into the general population, not to mention the families of such addicted persons. Failure to block the craving for illicit drugs along with failure to provide traditional treatment will most certainly contribute to the crime related to addiction and continue the spiral of huge health care costs—costs that will largely be borne not by the addicts, not by insurance companies—but by the American taxpayer.

The President of the Michigan Public Health Association, Dr. Stephanie Meyers Schim, has spoken out eloquently about the ''great problems'' of substance abuse. In her letter to me in support of our bill she says: ''Substance abuse affects health care costs, mortality, workers' compensation claims, reduced productivity, crime, suicide, domestic violence, child abuse, and increased costs associated with extra law enforcement, motor vehicle crashes, crime, and lost productivity.'' Dr. Schim goes on to say, ''Buprenorphine will allow drug addicted individuals to maximize everyday life activities, and participate more fully in work day and family activities while seeking the needed treatment and counseling to become drug free''.

Dr. James H. Wood, Professor of Pharmacology at the University of Michigan Medical School recently wrote: ''One of the most important aspects of your bill is the use of Buprenorphine by well-trained physicians to treat narcotic addiction from their offices, which has the potential to attract and treat effectively sizable populations of currently untreated addicts. A major byproduct of this increased treatment, of course, will be reduction in the demand for illicit narcotics in the U.S.''

Dr. Thomas Kosten, President of the American Academy of Addiction Psychiatry echoed these sentiments in recent testimony on The Drug Addiction Treatment Act before the House Commerce Committee on Health and Environment, and I quote: ''. . . I would like to support the availability of Buprenorphine for office based practice. Addiction is a brain disease and office-based practice is primarily needed for effective treatment of Buprenorphine.''

The American Society of Addiction Medicine (ASAM), and the College on Problems of Drug Dependence which is the nation's longest standing organization of scientists addressing drug dependence and drug abuse, have stated that the availability of Buprenorphine in physicians' offices adds a needed expansion of current treatment for heroin addiction. ASAM also cautioned that Buprenorphine will lose much of its utility if it is tied to the very heavily regulated structure for current treatments of heroin addiction.

There are other compelling reasons why we must expedite the delivery of anti-addiction medications. Of the juveniles who land behind bars in state institutions, more than 60 percent of them reported using drugs once a week or more, and over 40 percent reported being under the influence of drugs while committing crimes, according to a report from the Bureau of Justice Statistics. Drug-related incarcerations are up and we are building more jails and prisons to accommodate them—more than 1000 have been built over the past 20 years. According to the July 14, 1999 Office of National Drug Control Policy Update, ''Drug-related arrests are up from 1.1 million arrests in 1988 to 1.6 million arrests in 1997—steady increases every year since 1991''.

In crafting the provisions of this legislation, we consulted with the U.S. Department of Health and Human Services, including the Federal Drug Administration, and the Drug Enforcement Administration. Of critical importance is the fact that Buprenorphine is not addictive like methadone so the likelihood of diversion is small. Nothing in our bill is intended to change the rules pertaining to methadone clinics or other facilities or practitioners that conduct drug treatment services with addictive substances. I received a very supportive letter from HHS Secretary Donna Shalala in which she reports on the safety and utility of Buprenorphine, as follows:

> I am especially encouraged by the results of published clinical studies of Buprenorphine. Buprenorphine is a partial mu opiate receptor agonist, in Schedule V of the Controlled Substances Act, with unique properties which differentiate it from full agonists such as methadone or LAAM. The pharmacology of the combination tablet consisting of Buprenorphine and naloxone results in. . . .low value and low desirability for diversion on the street.
>
> Published clinical studies suggest that it has very limited euphorigenic affects, and has the ability to percipitate withdrawal in individuals who are highly dependent upon other opioids. Thus, Buprenorphine and Buprenorphine/naloxone products are expected to have low diversion potential. Buprenorphine and Buprenorphine/naloxone products are expected to reach new groups of opiate addicts—for example, those who do not have access to methadone programs, those who are reluctant to enter methadone treatment programs, and those who are unsuited to them {this would include for example, those in their first year of opiates addiction or those addicted to lower doses of opiates}.
>
> Buprenorphine and Buprenorphine/naloxone products should increase the amount of treatment capacity available and expand the range of treatment options that can be used by physicians. Buprenorphine and Buprenorphine/Naloxone would not replace methadone. Methadone and LAAM clinics would remain an important part of the treatment continuum.

In closing, I would like to include excerpts from the statement which was presented by Dr. Charles O'Brien before the Senate Caucus on International Narcotics Control, May 9, 2000. Dr. O'Brien is Professor and Vice Chair of Psychiatry at the University of Pennsylvania, Director of the Behavioral Health, Philadelphia VA Medical Center, Center for Studies of Addiction, Upenn/VAMC, and Research Director, Philadelphia VA. Mental Illness Research, Education and Clinical Center. Dr. O'Brien's remarks are as follows:

While our first goal in the treatment of heroin addiction is complete abstinence, we know that this is not realistic for a great majority of patients. Even those who do well initially in a drug free residential program have a high frequency of relapse when they return to the neighborhood where drugs are available.

Another new medication that is being successfully used in France and is currently being reviewed by the FDA for use in the U.S. is buprenorphine. Its chemical category is somewhat different from methadone in that it is a partial agonist at opiate receptors. This medication has been found to be as effective as methadone and in some cases even better. It seems to be particularly effective for adolescents with a heroin problem. Buprenorphine is very unlikely to produce overdose and in France, the death rate due to opiate overdose has dropped by about 75 percent. Not only does it not produce overdose itself, but it may even provide a measure of protection against overdose by heroin.

The safety and efficacy of buprenorphine is such that it should be made available to all physicians to treat patients with opiate problems in their offices. This would be a major benefit to patients who are unable and unwilling to come to specialized methadone programs. It would be available not just to heroin addicts, but to anyone with an opiate problem, including many citizens who would not ordinarily be associated with the term addiction. The availability of buprenorphine would enable physicians to control the opiate abuse problems of many Americans who are now being inadequately treated or not treated at all.

One important development is the combination of buprenorphine with naloxone, a full antagonist. If the combination is taken by mouth, this new medication is effective in reducing drug craving and stabilizing the person to lead a normal life. If someone tries to abuse it by injecting it, the naloxone component would then be effective in blocking the effects and preventing a ''high'' or euphoria. Thus, the diversion potential of this new medication should be minimized.

Several treatment programs have already studied buprenorphine in the treatment of adolescent heroin abusers. It has been found to detoxify, that is treat withdrawal symptoms, while the body cleanses itself of heroin, more effectively than other medications. Thus a greater proportion of young people are able to get off of heroin and receive counseling and other forms of rehabilitation. Buprenorphine is also very effective as a longer term medication that a young person can take daily, return to school or job training and after six months or more maintain a stable drug free state. Once this medication is approved by the FDA and is allowed to be used in physicians' offices, it could dramatically improve the treatment of heroin addiction in the U.S.

In summary Mr. Chairman, we are in the midst of the highest availability of relatively pure heroin in our recorded history. Fortunately we have effective treatments including new medications that are coming on line. One of them, buprenorphine, is well advanced in the FDA approval process and is being considered for use in a new approach to opiate addiction. This new approach [embodied in S. 324] in keeping with the scientific data, would allow physicians to treat heroin addiction in their offices just as we treat any other medical problem.

The success of this vital legislation would not have been possible without the leadership and support of Senator HATCH, Chairman of the Judiciary Committee. Nor would it have been possible without the strong support of Senator MOYNIHAN, Ranking Member of the Finance Committee, and Senator BIDEN, Ranking Member of the Judiciary Subcommittee on Youth Violence, both of whom possess a clear grasp of the issues surrounding illicit drug addiction and have long sought to address them.

Mr. MOYNIHAN. Mr. President, I rise to commend the Senate for again unanimously passing the Drug Addiction Treatment Act of 2000. Today it passed as an amended version of S. 324, of which I am an original cosponsor, in Title XXXV, sections 3501 and 3502, of the Senate substitute to the Children's Health Act of 2000, H.R. 4365. The Senate's action today marks a milestone in the treatment of opiate dependence. The Drug Addiction Treatment Act increases access to new medications, such as buprenorphine, to treat opiate addiction. I thank my colleagues Senator LEVIN (whose long-term vision inspired this legislation), Senator HATCH, and Senator BIDEN for their leadership and dedication in developing this Act, and I look forward to seeing the Drug Addiction Treatment Act of 2000 become law.

Determining how to deal with the problem of addiction is not a new topic. Just over a decade ago when we passed the Anti-Drug Abuse Act of 1988, I was assigned by our then-Leader, Senator ROBERT BYRD, with Senator Sam Nunn, to co-chair a working group to develop a proposal for drug control legislation. We worked together with a similar Republican task force. We agreed, at least for a while, to divide funding under our bill between demand reduction activities (60 percent) and supply reduction activities (40 percent). And we created the Director of National Drug Control Policy (section 1002); next, ''There shall be in the Office of National Drug Control Policy a Deputy Director for Demand Reduction and a Deputy Director for Supply Reduction.''

We put demand first. To think that you can ever end the problem by interdicting the supply of drugs, well, it's an illusion. There's no possibility.

I have been intimately involved with trying to eradicate the supply of drugs into this country. It fell upon me, as a member of the Nixon Cabinet, to negotiate shutting down the heroin traffic that went from central Turkey to Marseilles to New York —''the French Connection''—but we knew the minute that happened, another route would spring up. That was a given. The success was short-lived. What we needed was demand reduction, a focus on the user. And we still do.

Demand reduction requires science and it requires doctors. I see the science continues to develop, and The Drug Addiction Treatment Act of 2000 will allow doctors and patients to make use of it.

Congress and the public continue to fixate on supply interdiction and harsher sentences (without treatment) as the ''solution'' to our drug problems, and adamantly refuse to acknowledge what various experts now know and are telling us: that addiction is a chronic, relapsing disease; that is, the brain undergoes molecular, cellular, and physiological changes which may not be reversible.

What we are talking about is not simply a law enforcement problem, to cut the supply; it is a public health problem, and we need to treat it as such. We need to stop filling our jails under the misguided notion that such actions will stop the problem of drug addiction. The Drug Addiction Treatment Act of 2000 is a step in the right direction.

Mr. BIDEN. Mr. President, today the United States Senate has passed the Children's Health Act of 2000, an Act which will have a far-ranging impact on the health of America's youth. This legislation not only addresses juvenile arthritis, diabetes, asthma and other childhood diseases, but it also takes important steps to address what I would argue is a public health epidemic for both children and adults—substance abuse and addiction.

The Children's Health Act reauthorizes the Substance Abuse and Mental Health Services Administration (SAMHSA), the federal agency devoted to substance abuse prevention and treatment services as well as a wide range of mental health programs. The bill also includes three important drug bills which I have cosponsored: the Methamphetamine Anti-Proliferation Act, the Ecstasy Anti-Proliferation Act and the Drug Addiction Treatment Act. The result is a comprehensive piece of legislation which includes the law enforcement, treatment and prevention services necessary to address substance abuse in the United States today.

Mr. President, in 1996 I joined with my distinguished friend and colleague, Senator HATCH, to introduce the ''Hatch-Biden Methamphetamine Control Act'' to address the growing threat of methamphetamine use in our country before it was too late.

Our failure to foresee and prevent the crack cocaine epidemic is one of the most significant public policy mistakes in recent history. We were determined not to repeat that mistake with methamphetamine.

That 1996 Act provided crucial tools that we needed to stay ahead of the methamphetamine epidemic—increased penalties for possessing and trafficking in methamphetamine and the precursor

chemicals and equipment used to manufacture the drug; tighter reporting requirements and restrictions on the legitimate sales of products containing precursor chemicals to prevent their diversion; increased reporting requirements for firms that sell those products by mail; and enhanced prison sentences for meth manufacturers who endanger the life of any individual or endanger the environment while making this drug. We also created a national working group of law enforcement and public health officials to monitor any growth in the methamphetamine epidemic.

I have no doubt that our 1996 legislation slowed this epidemic significantly. But we are up against a powerful and highly addictive drug.

The Methamphetamine Anti-Proliferation Act—which I have cosponsored—builds on the 1996 Act. First and foremost, it closes the ''amphetamine loophole'' in current law by making the penalties for manufacturing, distributing, importing and exporting amphetamine the same as those for meth. After all, the two drugs differ by only one chemical and are sold interchangeably on the street. If users can't tell the difference between the two substances, there is no reason why the penalties should be different.

The bill also addresses the growing problem of meth labs by establishing penalties for manufacturing the drug with an enhanced penalty for those who would put a child's life at risk in the process. We provide $20 million for the Drug Enforcement Administration (DEA) to reimburse states for cleaning up toxic meth labs and $5.5 million for the DEA to certify state and local officials to handle the hazardous byproducts at the lab sites. We also provide $15 million for additional law enforcement personnel—including agents, investigators, prosecutors, lab technicians, chemists, investigative assistants and drug prevention specialists—in High Intensity Drug Trafficking Areas where meth is a problem.

Also included in the bill is $6.5 million for new agents to assist State and local law enforcement in small and mid-sized communities in all phases of drug investigations and assist state and local law enforcement in rural areas. The bill also provides $3 million to monitor List I chemicals, including those used in manufacturing methamphetamine, and prevent their diversion to illicit use.

Further, the legislation provides $10 million in prevention funds and $10 million for treating methamphetamine addiction, as well as much needed money for researching new treatment modalities, including clinical trials. It asks the Institute of Medicine to issue a report on the status of the development of pharmacotherapies for treatment of amphetamine and methamphetamine addiction, such as the good work that the scientists at the National Institute on Drug Abuse have done to isolate amino acids and develop medications to deal with meth overdose and addiction.

The Children's Health Act also includes the ''Ecstasy Anti-Proliferation Act,'' a bill which Senators GRAHAM, GRASSLEY and THOMAS and I introduced in May to address the new drug on the scene—Ecstasy, a synthetic stimulant and hallucinogen. The legislation takes the steps—both in terms of law enforcement and prevention—to address this problem in a serious way before it gets any worse.

Ecstasy belongs to a group of drugs referred to as ''club drugs'' because they are associated with all-night dance parties known as ''raves.'' There is a widespread misconception that it is not a dangerous drug—that it is ''no big deal.'' I believe that Ecstasy is a very big deal. The drug depletes the brain of serotonin, the chemical responsible for mood, thought, and memory.

If that isn't a big deal, I don't know what is.

A few months ago we got a significant warning sign that Ecstasy use is becoming a real problem. The University of Michigan's Monitoring the Future survey, a national survey measuring drug use among students, reported that while overall levels of drug use had not increased, past month use of Ecstasy among high school seniors increased more than 66 percent.

The survey showed that nearly six percent of high school seniors have used Ecstasy in the past year. This may sound like a small number, but put in perspective it is deeply alarming—it is five times the number of seniors who used heroin and it is just slightly less than the percentage of seniors who used cocaine.

And with the supply of Ecstasy increasing as rapidly as it is, the number of kids using this drug is only likely to increase. So far this year, the Customs Service has already seized 9 million Ecstasy pills—three times the total amount seized in all of 1999 and twelve times the amount seized in all of 1998.

Though New York is the East Coast hub for this drug, it is spreading quickly throughout the country. In my home state of Delaware, law enforcement officials have seized Ecstasy pills in Rehoboth Beach and are noticing the emergence of an Ecstasy problem in Newark among students at the University of Delaware.

The legislation directs the United States Sentencing Commission to increase the recommended penalties for manufacturing, importing, exporting or trafficking Ecstasy.

The legislation also authorizes a $10 million prevention campaign in schools and communities to make sure that everyone—kids, adults, parents, teachers, cops, coaches, clergy, etc.—know just how dangerous this drug really is. We need to dispel the myth that Ecstasy is not a dangerous drug because, as I stated earlier, this is a substance that can cause brain damage and can even result in death. We need to spread the message so that kids know the risk involved with taking Ecstasy, what it can do to their bodies, their brains, their futures. Adults also need to be taught about this drug—what it looks like, what someone high on Ecstasy looks like, and what to do if they discover that someone they know is using it.

Mr. President, I have come to the floor of the United States Senate on numerous occasions to state what I view as the most effective way to prevent a drug epidemic. My philosophy is simple: the best time to crack down on a drug with uncompromising enforcement pressure is before the abuse of the drug has become rampant. The advantages of doing so are clear—there are fewer pushers trafficking in the drug and, most important, fewer lives and fewer families will have suffered from the abuse of the drug.

It is clear that Ecstasy use is on the rise and I am pleased that the Senate has acted today to address the escalating problem of this drug before it gets any worse.

In addition to stopping the proliferation of new drugs, we also need to invest in treating those who are already addicted. More than ten years ago, in December 1989, I released a Senate Judiciary Committee Report entitled ''Pharmacotherapy: A Strategy for the 1990s.'' In this report I argued that there was scientific promise for medicines that might lessen an addict's craving for cocaine and heroin, as well as to reduce their enjoyment of those drugs.

This report asked the question: ''If drug abuse is an epidemic, are we doing enough to find a medical 'cure'?''

At the time, despite the efforts of myself and other members of Congress, the answer to that question was as clear as it was distressing: the nation was doing far too little to find medicines that treat the disease of drug addiction.

To address this shortfall, I authored, along with Senator KENNEDY, the Pharmacotherapy Development Act—which passed into law in 1992. The cornerstone of this Act was its call for a ten year, $1 billion effort to research and develop anti-addiction medications.

I cannot think of a more worthwhile investment. There is no other disease that effects so many, directly and indirectly. We have 14 million drug users in this country, four million of whom are hard-core addicts. We all have a family member, neighbor, colleague or friend who has become addicted. We are all impacted by the undeniable correlation between drugs and crime—an overwhelming 80 percent of the men and women behind bars today have a history of drug and alcohol abuse or addiction or were arrested for a drug-related crime. It only makes sense to unleash the full powers of medical science to find a ''cure'' for this social and human ill.

Ten years ago, the question was: ''Are we doing enough to find a 'cure'?''

Unfortunately that question is still with us. But today we also have another question: ''Are we doing enough to get the 'cures' we have to those who need them?'' We have an enormous ''treatment gap'' in this country. Only two million of the estimated 4.4 to 5.3 million people who need drug treatment are receiving it.

That is why I have worked with Senators HATCH, LEVIN and MOYNIHAN and Representative BILEY to craft the ''Drug Addiction Treatment Act,'' a bill which creates a new system for delivering anti-addiction medications to patients who need them. Under the bill qualified doctors can be granted a waiver to prescribe certain Schedule III, IV and V medications from their offices. This is a significant step toward bridging the treatment gap.

Right now we have some highly effective pharmacotherapies to treat heroin addiction and we are still working on developing similar medications for cocaine addiction. Access to currently available medications such as methadone and LAAM (Levo-Alpha Acetylmethadol) has been strangled by layers of bureaucracy and regulation. As a result, only 22 percent of opiate addicts are now receiving pharmacotherapy treatment. General McCaffrey and Secretary Shalala are leading the charge to fix that problem and I applaud their efforts.

Under the legislation passed today, patients will be able to get new medications such a buprenorphine and a buprenorphine-naloxone combination product—which are now under review by the Food and Drug Administration—much like they can get other medications: a doctor prescribes them and the patient can get the medication from the local pharmacy. This new system helps to move drug treatment into the mainstream of medicine.

The difficulties of distributing treatment medications to addicts not only hurts those who are not getting the treatment they need, but it also stifles private research. I have often bemoaned the fact that private industry has not aggressively developed pharmacotherapies. As we increase access to these drugs, we increase incentives for private investment in this valuable research.

I am proud that the Senate has acted today to pass ''The Drug Addiction Treatment Act'' because it helps get new, promising anti-addiction medications get to those who need them. By allowing certain doctors to dispense Schedule III, IV and V drugs from their offices, the bill expands treatment flexibility and access and encourages others to develop similar medications.

Mr. President, in passing the Children's Health Act today, the Senate has taken an important step to addressing the problem of substance abuse and all of the social ills that go along with it. I congratulate all of my colleagues who have worked on this legislation which will make an important contribution to public health and public safety in this country.

Mr. DEWINE. Mr. President, I rise today as a co-author of the ''Children's Health Act of 2000.'' This bill is essential in enabling us to build a health care system that is responsive to the unique needs of children. The ''Children's Health Act of 2000'' is a big step in the right direction, and I commend my colleagues, Senators FRIST, JEFFORDS, and KENNEDY for their efforts to construct a bill that can really make a positive difference in the health and the lives of children.

Mr. President, I am especially pleased that the ''Children's Health Act'' contains several important initiatives that my colleagues and I had introduced already as separate bills. One such initiative—the Pediatric Research Initiative—would help ensure that more of the increased research funding at the National Institutes of Health (NIH) is invested specifically in children's health research.

While children represent close to 30 percent of the population of this country, NIH devotes only about 12 percent of its budget to children, and, in recent years, that proportion has been declining even further. We must reverse this disturbing trend. It simply makes no sense to conduct health research for adults and hope that those findings also will apply to children. A ''one size fits all'' research approach just doesn't work. The fact is that children have medical conditions and health care needs that differ significantly from adults. Children's health deserves more attention from the research community. That's why the Pediatric Research Initiative is such an important part of the ''Children's Health Act.'' It would provide the federal support for pediatric research that is so vital to ensuring that children receive the appropriate and best health care possible.

The Pediatric Research Initiative would authorize at least $50 million for each of the next five years for the Office of the Director of the National Institute of Health (NIH) to conduct, coordinate, support, develop, and recognize pediatric research. In doing so, we will be able to ensure researchers target and study child-specific diseases. With more than 20 Institutes and Centers and Offices within NIH that conduct, support, or develop pediatric research in some way, this investment would promote greater coordination and focus in children's health research, and hopefully encourage new initiatives and areas of research.

The ''Children's Health Act'' also would authorize the Secretary of HHS to establish a pediatric research loan repayment program for qualified health professionals who conduct pediatric research. Trained researchers are essential if we are to make significant advances in the study of pediatric health care, especially in light of the new and improved Food and Drug Administration (FDA) policies that encourage the testing of medications for use by children.

Additionally, the ''Children's Health Act'' includes the ''Children's Asthma Relief Act,'' which Senator DURBIN and I introduced last year. The sad reality for children is that asthma is becoming a far too common and chronic childhood illness. From 1979 to 1992, the hospitalization rates among children due to asthma increased 74 percent. Today, estimates show that more than seven percent of children now suffer from asthma. Nationwide, the most substantial prevalence rate increase for asthma occurred among children aged four and younger. Those four and younger also were hospitalized at the highest rate among all individuals with asthma.

According to 1998 data from the Centers for Disease Control (CDC), my home state of Ohio ranks about 17th in the estimated prevalence rates for asthma. Based on a 1994 CDC National Health Interview Survey, an estimated 197,226 children under 18 years of age in Ohio suffer from asthma. We need to address this problem adequately. The ''Children's Health Act'' would help do that by ensuring that children with asthma receive the care they need to lead healthy lives. The bill would authorize funding for fiscal years 2001 through 2005 for the Secretary of Health and Human Services (HHS) to establish state and local community grants to be used for asthma detection, treatment, and education services; require coordination with current children's health programs to identify children who are asthmatic and may otherwise remain undetected and untreated; require NIH to direct more resources to its National Asthma Education Prevention Program to develop a federal plan for responding to asthma; and require the Center for Disease Control to conduct local asthma surveillance activities to collect data on the prevalence and severity of asthma. This surveillance data will help us better detect asthmatic conditions, so that we can treat more children and ensure that we are targeting our resources in an effective and efficient way to reverse the disturbing trend in the hospitalization and death rates of asthmatic children.

Since research shows that children living in urban areas suffer from asthma at such alarming rates and that allergens, such as cockroach waste, contribute to the onset of asthma, this bill also adds urban cockroach management to the current preventive health services block grant, which currently can be used for rodent control.

The ''Children's Health Act'' also includes a bill I introduced separately with Senator DODD. This section would require that the Secretary of HHS ensure that all research that is conducted, supported, or regulated by HHS complies with regulations governing the protection of children involved in research. Children who participate in clinical trials are medical pioneers. It is just common sense that we update and apply the strongest federal guidelines to ensure the safety of these young people as they participate in clinical trials that will ensure that

medicines will be safe and appropriate for use in all children.

Finally, Mr. President, the ''Children's Health Act'' includes language that I strongly support to re-authorize funding for children's hospitals' Graduate Medical Education (GME) programs for four additional years. Last year, as part of the ''Health Care Research and Quality Act,'' which was signed into law, we authorized funding for two years for children's hospitals' GME programs. The teaching mission of these hospitals is essential. Children's hospitals comprise less than one percent of all hospitals, yet they train five percent of all physicians, nearly 30 percent of all pediatricians, and almost 50 percent of all pediatric specialists. By providing our nation with highly qualified pediatricians, children's hospitals can offer children the best possible care and offer parents peace of mind. They serve as the health care safety net for low-income children in their respective communities and are often the sole regional providers of many critical pediatric services. These institutions also serve as centers of excellence for very sick children across the nation. Federal funding for GME in children's hospitals is a sound investment in children's health and provides stability for the future of the pediatric workforce.

Mr. President, as the father of eight children and the grandfather of five, I firmly believe that we must move forward to protect the interests—and especially the health—of all children. The ''Children's Health Act of 2000'' makes crucial investments in our country's future—investments that will yield great returns. If we focus on improving health care for all children today, we will have a generation of healthy adults tomorrow.

TO AMEND THE ALASKA NATIVE CLAIMS SETTLEMENT ACT

Mr. LOTT. I ask unanimous consent that the Chair lay before the Senate a message from the House to accompany S. 430.

There being no objection, the Presiding Officer (Mr. DOMENICI) laid before the Senate the following message from the House of Representatives:

Resolved, That the bill from the Senate (S. 430) entitled ''An Act to amend the Alaska Native Claims Settlement Act to provide for a land exchange between the Secretary of Agriculture and the Kake Tribal Corporation, and for other purposes,'' do pass the following amendment:

Strike out all after the enacting clause and insert:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Kake Tribal Corporation Land Transfer Act''.

SEC. 2. DECLARATION OF PURPOSE.

The purpose of this Act is to authorize the reallocation of lands and selection rights between the State of Alaska, Kake Tribal Corporation, and the City of Kake, Alaska, in order to provide for the protection and management of the municipal watershed.

Mr. LOTT. I ask unanimous consent that the Senate agree to the amendment of the House.

The PRESIDING OFFICER. Without objection, it is so ordered.

KENAI MOUNTAINS-TURNAGAIN ARM NATIONAL HERITAGE AREA ACT OF 2000

Mr. LOTT. Mr. President, I ask unanimous consent the Senate now proceed to the consideration of Calendar No. 667, S. 2511.

The PRESIDING OFFICER. The clerk will report the bill by title.

The assistant legislative clerk read as follows:

A bill (S. 2511) to establish the Kenai Mountains-Turnagain Arm National Heritage Area in the State of Alaska, and for other purposes.

There being no objection, the Senate proceeded to consider the bill, which had been reported from the Committee on Energy and Natural Resources, with amendments, as follows:

(Omit the parts in black brackets and insert the parts printed in italic.)

S. 2511

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Kenai Mountains-Turnagain Arm National Heritage [Corridor] Area Act of 2000''.

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress finds that—

(1) the Kenai Mountains-Turnagain Arm transportation corridor is a major gateway to Alaska and includes a range of transportation routes used first by indigenous people who were followed by pioneers who settled the Nation's last frontier;

(2) the natural history and scenic splendor of the region are equally outstanding; vistas of nature's power include evidence of earthquake subsidence, recent avalanches, retreating glaciers, and tidal action along Turnagain Arm, which has the world's second greatest tidal range;

(3) the cultural landscape formed by indigenous people and then by settlement, transportation, and modern resource development in this rugged and often treacherous natural setting stands as powerful testimony to the human fortitude, perseverance, and resourcefulness that is America's proudest heritage from the people who settled the frontier;

(4) there is a national interest in recognizing, preserving, promoting, and interpreting these resources;

(5) the Kenai Mountains-Turnagain Arm region is geographically and culturally cohesive because it is defined by a corridor of historical routes-trail, water, railroad, and roadways through a distinct landscape of mountains, lakes, and fjords;

(6) national significance of separate elements of the region include, but are not limited to, the Iditarod National Historic Trail, the Seward Highway National Scenic Byway, and the Alaska Railroad National Scenic Railroad;

(7) national heritage area designation provides for the interpretation of these routes, as well as the national historic districts and numerous historic routes in the region as part of the whole picture of human history in the wider transportation corridor including early Native trade routes, connections by waterway, mining trail, and other routes;

(8) national heritage area designation also provides communities within the region with the motivation and means for ''grassroots'' regional coordination and partnerships with each other and with borough, State, and Federal agencies; and

(9) [resolution and letters of support have been received from] *national heritage area designation is supported by* the Kenai Peninsula Historical Association, the Seward Historical Commission, the Seward City Council, the Hope and Sunrise Historical Society, the Hope Chamber of Commerce, the Alaska Association for Historic Preservation, the Cooper Landing Community Club, the Alaska Wilderness Recreation and Tourism Association, Anchorage Historic Properties, the Anchorage Convention and Visitors Bureau, the Cook Inlet Historical Society, the Moose Pass Sportsman's Club, the Alaska Historical Commission, the Gridwood Board of Supervisors, the Kenai River Special Management Area Advisory Board, the Bird/Indian Community Council, the Kenai Peninsula Borough Trails Commission, the Alaska Division of Parks and Recreation, the Kenai Peninsula Borough, the Kenai Peninsula Tourism Marketing Council, and the Anchorage Municipal Assembly.

(b) PURPOSES.—The purposes of this Act are—

(1) to recognize, preserve, and interpret the historic and modern resource development and cultural landscapes of the Kenai Mountains-Turnagain Arm historic transportation corridor, and to promote and facilitate the public enjoyment of these resources; and

(2) to foster, through financial and technical assistance, the development of cooperative planning and partnerships among the communities and borough, State, and Federal Government entities.

SEC. 3. DEFINITIONS.

In this Act:

(1) HERITAGE AREA.—The term ''Heritage Area'' means the Kenai Mountains-Turnagain Arm National Heritage Area [establish] *established* by section 4(a) of this Act.

(2) MANAGEMENT ENTITY.—The term ''management entity'' means [the 11 member Board of Directors of the Kenai Mountains-Turnagain Arm National Heritage Area Commission.] *the management entity established by section 5.*

(3) MANAGEMENT PLAN.—The term ''management plan'' means the management plan for the Heritage Area.

(4) SECRETARY.—The term ''Secretary'' means the Secretary of the Interior.

SEC. 4. KENAI MOUNTAINS-TURNAGAIN ARM NATIONAL HERITAGE AREA.

(a) ESTABLISHMENT.—There is established the Kenai Mountains-Turnagain Arm National Heritage Area.

(b) BOUNDARIES.—The Heritage Area shall comprise the lands in the Kenai Mountains and upper Turnagain Arm region generally depicted on the map entitled ''Kenai Peninsula/Turnagain Arm National Heritage Corridor'', numbered ''Map #KMTA–1'', and dated ''August 1999''. The map shall be on file and available for public inspection in the offices of the Alaska Regional Office of the National Park Service and in the offices of the Alaska State Heritage Preservation Officer.

SEC. 5. MANAGEMENT ENTITY.

(a) The management entity shall consist of 7 representatives, appointed by [the Secretary from a list of recommendations submitted by] the Governor of Alaska, from the communities of Seward, Lawing, Moose Pass, Cooper Landing, Hope, Gridwood, Bird-Indian and 4 at large representatives, from such organizations as Native Associations, the Iditarod Trail Committee, historical societies, visitor associations, and private or business entities. Upon appointment, the Commission shall establish itself as a non-