

S. 2725

At the request of Mrs. CLINTON, the name of the Senator from California (Mrs. BOXER) was added as a cosponsor of S. 2725, a bill to amend the Fair Labor Standards Act of 1938 to provide for an increase in the Federal Minimum wage and to ensure that increases in the Federal minimum wage keep pace with any pay adjustments for Members of Congress.

S. 2810

At the request of Mr. GRASSLEY, the name of the Senator from Utah (Mr. BENNETT) was added as a cosponsor of S. 2810, a bill to amend title XVIII of the Social Security Act to eliminate months in 2006 from the calculation of any late enrollment penalty under the Medicare part D prescription drug program and to provide for additional funding for State health insurance counseling program and area agencies on aging, and for other purposes.

S. 2816

At the request of Mr. HARKIN, the name of the Senator from Minnesota (Mr. COLEMAN) was withdrawn as a cosponsor of S. 2816, a bill to amend the Internal Revenue Code of 1986 to provide an income tax credit for the manufacture of flexible fuel motor vehicles and to extend and increase the income tax credit for alternative fuel refueling property, and for other purposes.

S. 2824

At the request of Mr. DEMINT, the name of the Senator from Louisiana (Mr. VITTER) was added as a cosponsor of S. 2824, a bill to reduce the burdens of the implementation of section 404 of the Sarbanes-Oxley Act of 2002.

S. 2999

At the request of Mr. DEWINE, the name of the Senator from New York (Mrs. CLINTON) was added as a cosponsor of S. 2999, a bill to improve protections for children and to hold States accountable for the safe and timely placement of children across State lines, and for other purposes.

S. 3255

At the request of Mrs. CLINTON, the names of the Senator from California (Mrs. BOXER), the Senator from Massachusetts (Mr. KERRY) and the Senator from Louisiana (Ms. LANDRIEU) were added as cosponsors of S. 3255, a bill to provide student borrowers with basic rights, including the right to timely information about their loans and the right to make fair and reasonable loan payments, and for other purposes.

S. 3275

At the request of Mr. ALLEN, the names of the Senator from Mississippi (Mr. COCHRAN) and the Senator from Oklahoma (Mr. COBURN) were added as cosponsors of S. 3275, a bill to amend title 18, United States code, to provide a national standard in accordance with which nonresidents of a State may carry concealed firearms in the State.

S. 3323

At the request of Mr. MENENDEZ, the name of the Senator from New Jersey

(Mr. LAUTENBERG) was added as a cosponsor of S. 3323, a bill to suspend temporarily the duty on Propylene Glycol Alginates (PGA) be eliminated.

S. 3325

At the request of Mr. BUNNING, the name of the Senator from Alaska (Ms. MURKOWSKI) was added as a cosponsor of S. 3325, a bill to promote coal-to-liquid fuel activities.

S.J. RES. 1

At the request of Mr. ALLARD, the name of the Senator from Idaho (Mr. CRAIG) was added as a cosponsor of S.J. Res. 1, a joint resolution proposing an amendment to the Constitution of the United States relating to marriage.

S. CON. RES. 20

At the request of Mr. COCHRAN, the name of the Senator from Maine (Ms. SNOWE) was added as a cosponsor of S. Con. Res. 20, a concurrent resolution expressing the need for enhanced public awareness of traumatic brain injury and support for the designation of a National Brain Injury Awareness Month.

S. RES. 224

At the request of Mr. DEWINE, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. Res. 224, a resolution to express the sense of the Senate supporting the establishment of September as Campus Fire Safety Month, and for other purposes.

S. RES. 462

At the request of Mr. GRASSLEY, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. Res. 462, a resolution designating June 8, 2006, as the day of a National Vigil for Lost Promise.

#### STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. CRAIG:

S. 3421. A bill to authorize major medical facility projects and major medical facility leases for the Department of Veterans Affairs for fiscal years 2006 and 2007, and for other purposes; to the Committee on Veterans' Affairs.

Mr. CRAIG. Mr. President, I seek recognition today to introduce legislation to authorize major medical facility projects and major medical facility leases for the Department of Veterans Affairs, VA. Most VA hospitals, clinics, nursing homes, and research facilities have ongoing needs for maintenance, repair, and modernization to promote patient and employee safety and provide a higher standard of care for our Nation's veterans. Earlier this month, I held a hearing of the Senate Committee on Veterans' Affairs on these needs, at which VA and a service organization representative delivered testimony about what is required in the next phase of addressing the needs of health care facilities for our Nation's veterans. In addition, several committee members and noncommittee colleagues remarked about the signifi-

cance of these projects to their States. It is my belief that this bill will expand VA's ability to provide health care services to this group of deserving Americans. I will take a few moments now to explain the provisions of this legislation.

First, the bill authorizes three major medical facility projects in immediate need of fiscal year 2006 authorization; the restoration of VA's health care infrastructure in the Biloxi and New Orleans areas following Hurricane Katrina, and the cost of land acquisition for replacement of the current Denver VA Medical Center with a new facility at the former Fitzsimons Army Medical Center. The Denver facility was constructed over a half-century ago and many of the core facilities have been deemed to be past or near the end of their useful life.

Second, this legislation reauthorizes 18 major medical facility construction projects that were authorized under Public Law 108-170, but for which it is unlikely that contract awards will be accomplished by September 30, 2006, as required by that law. Therefore, for each of these projects, the draft bill extends the date by which contracts must be awarded, from September 30, 2006, September 20, 2009. These projects were identified and prioritized under the capital asset realignment for enhanced services process. CARES, as it has become known, is a market-based national assessment of infrastructure needs that VA has developed into a schedule for completion. These projects represent the most pressing CARES-identified needs that VA has undertaken in order to improve access-to-care and provide services in areas of recent, current, and projected growth in veterans population, such as Las Vegas and Orlando. To allow a lapse in VA's authority to move forward on these projects would result in tremendous setbacks, and conceivably, additional taxpayer expense.

Third, the legislation authorizes major medical facility leases that did not receive authorization in the current fiscal for outpatient clinics in Baltimore, MD, Marion, IL, and the Dallas, TX, area. In addition, five major medical facility leases fiscal year 2007 are included for outpatient clinics in Austin, TX, Lowell, MA, Grand Rapids, MI, Las Vegas, NV, and Parma, OH.

This legislation represents the administration's request of the Veterans' Affairs Committee and the Congress, with a significant exception. I have chosen not to authorize the six requested fiscal year 2007 major medical facility construction projects at this time. I want to make it clear to my colleagues that my intent is not to micromanage VA's construction budget or to delay the Department's capital plan. And no one in the Senate is more committed to seeing that we are not diverting important resources away from facilities that are extremely important to our veterans. But as chairman of this committee, my approach

puts Congress on record as expecting progress with the 18 CARES projects on which we are extending authorizations, attaching a reasonable amount of money to those efforts, and then monitoring the progress closely from the Veterans' Committee. As we have seen with the need for significant and expensive Katrina-related construction, VA's capital plan requires consistent monitoring, frequent review and, at times, significant modification. But VA must finish some of what it has started before taking on new major projects.

Over the next several weeks, the Committee on Veterans' Affairs will be taking up this bill and other legislation introduced to improve the range of services and benefits available to our Nation's veterans. I look forward to working with my colleagues throughout the rest of this Congress on these and other important efforts.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 3421

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

**SECTION 1. AUTHORIZATION OF FISCAL YEAR 2006 MAJOR MEDICAL FACILITY PROJECTS.**

The Secretary of Veterans Affairs may carry out the following major medical facility projects in fiscal year 2006, with each project to be carried out in the amount specified for that project:

(1) Restoration, new construction or replacement of the medical center facility for the Department of Veterans Affairs Medical Center, New Orleans, Louisiana, due to damage from Hurricane Katrina in an amount not to exceed \$675,000,000.

(2) Restoration of the Department of Veterans Affairs Medical Center, Biloxi, Mississippi, and consolidation of services performed at the Department of Veterans Affairs Medical Center, Gulfport, Mississippi, in an amount not to exceed \$310,000,000.

(3) Replacement of the Department of Veterans Affairs Medical Center, Denver, Colorado, in an amount not to exceed \$52,000,000.

**SEC. 2. EXTENSION OF AUTHORIZATION FOR MAJOR MEDICAL FACILITY CONSTRUCTION PROJECTS AUTHORIZED UNDER CAPITAL ASSET REALIGNMENT INITIATIVE.**

Notwithstanding subsection (d) of section 221 of the Veterans Health Care, Capital Asset, and Business Improvement Act of 2003 (Public Law 108-170; 117 Stat. 2050), the Secretary of Veterans Affairs may enter into contracts before September 30, 2009, to carry out each major medical facility project, as originally authorized by such section 221, as follows with each project to be carried out in the amount specified for that project:

(1) Construction of an outpatient clinic and regional office at the Department of Veterans Affairs Medical Center, Anchorage, Alaska, in an amount not to exceed \$75,270,000.

(2) Consolidation of clinical and administrative functions of the Department of Veterans Affairs Medical Center in Cleveland, Ohio, and the Department of Veterans Affairs Medical Center in Brecksville, Ohio, in an amount not to exceed \$102,300,000.

(3) Construction of the Extended Care Building at the Department of Veterans Af-

fairs Medical Center in Des Moines, Iowa, in an amount not to exceed \$25,000,000.

(4) Renovation of patient wards at the Department of Veterans Affairs Medical Center in Durham, North Carolina, in an amount not to exceed \$9,100,000.

(5) Correction of patient privacy deficiencies at the Department of Veterans Affairs Medical Center, Gainesville, Florida, in an amount not to exceed \$85,200,000.

(6) 7th and 8th Floor Wards Modernization addition at the Department of Veterans Affairs Medical Center, Indianapolis, Indiana, in an amount not to exceed \$27,400,000.

(7) Construction of a new Medical Center Facility at the Department of Veterans Affairs Medical Center, Las Vegas, Nevada, in an amount not to exceed \$406,000,000.

(8) Construction of an Ambulatory Surgery/Outpatient Diagnostic Support Center in the Gulf South Submarket of Veterans Integrated Service Network (VISN) 8 and completion of Phase I land purchase, Lee County, Florida, in an amount not to exceed \$65,100,000.

(9) Seismic Corrections-Buildings 7 & 126 at the Department of Veterans Affairs Medical Center, Long Beach, California, in an amount not to exceed \$107,845,000.

(10) Seismic Corrections-Buildings 500 & 501 at the Department of Veterans Affairs Medical Center, Los Angeles, California, in an amount not to exceed \$79,900,000.

(11) Construction of a New Medical Center facility in the Orlando, Florida, area in an amount not to exceed \$377,700,000.

(12) Consolidation of Campuses at the University Drive and H. John Heinz III divisions, Pittsburgh, Pennsylvania, in an amount not to exceed \$189,205,000.

(13) Ward Upgrades and Expansion at the Department of Veterans Affairs Medical Center, San Antonio, Texas, in an amount not to exceed \$19,100,000.

(14) Seismic Corrections-Building 1, Phase 1 Design at the Department of Veterans Affairs Medical Center, San Juan, Puerto Rico, in an amount not to exceed \$15,000,000.

(15) Construction of a Spinal Cord Injury Center at the Department of Veterans Affairs Medical Center, Syracuse, New York, in an amount not to exceed \$53,900,000.

(16) Upgrade Essential Electrical Distribution Systems at the Department of Veterans Affairs Medical Center, Tampa, Florida, in an amount not to exceed \$49,000,000.

(17) Expansion of the Spinal Cord Injury Center addition at the Department of Veterans Affairs Medical Center, Tampa, Florida, in an amount not to exceed \$7,100,000.

(18) Blind Rehabilitation and Psychiatric Bed renovation and new construction project at the Department of Veterans Affairs Medical Center, Temple, Texas, in an amount not to exceed \$56,000,000.

**SEC. 3. AUTHORIZATION OF FISCAL YEAR 2006 MAJOR MEDICAL FACILITY LEASES.**

The Secretary of Veterans Affairs may carry out the following major medical facility leases in fiscal year 2006 at the locations specified, and in an amount for each lease not to exceed the amount shown for such location:

(1) For an outpatient clinic, Baltimore, Maryland, \$10,908,000.

(2) For an outpatient clinic, Evansville, Illinois, \$8,989,000.

(3) For an outpatient clinic, Smith County, Texas, \$5,093,000.

**SEC. 4. AUTHORIZATION OF FISCAL YEAR 2007 MAJOR MEDICAL FACILITY LEASES.**

The Secretary of Veterans Affairs may carry out the following major medical facility leases in fiscal year 2007 at the locations specified, and in an amount for each lease not to exceed the amount shown for such location:

(1) For an outpatient and specialty care clinic, Austin, Texas, \$6,163,000.

(2) For an outpatient clinic, Lowell, Massachusetts, \$2,520,000.

(3) For an outpatient clinic, Grand Rapids, Michigan, \$4,409,000.

(4) For up to four outpatient clinics, Las Vegas, Nevada, \$8,518,000.

(5) For an outpatient clinic, Parma, Ohio, \$5,032,000.

**SEC. 5. AUTHORIZATION OF APPROPRIATIONS.**

(a) AUTHORIZATION OF APPROPRIATIONS FOR FISCAL YEAR 2006 MAJOR MEDICAL FACILITY PROJECTS.—There is authorized to be appropriated to the Secretary of Veterans Affairs for fiscal year 2006 for the Construction, Major Projects, account, \$1,606,000,000 for the projects authorized in section 1.

(b) AUTHORIZATION OF APPROPRIATIONS FOR MAJOR MEDICAL FACILITY PROJECTS UNDER CAPITAL ASSET REALIGNMENT INITIATIVE.—

(1) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated for the Secretary of Veterans Affairs for fiscal year 2007 for the Construction, Major Projects, account, \$1,750,120,000 for the projects whose authorization is extended by section 2.

(2) AVAILABILITY.—Amounts appropriated pursuant to the authorization of appropriations in paragraph (1) shall remain available until September 30, 2009.

(c) AUTHORIZATION OF APPROPRIATIONS FOR MAJOR MEDICAL FACILITY LEASES.—

(1) FISCAL YEAR 2006 LEASES.—There is authorized to be appropriated for the Secretary of Veterans Affairs for fiscal year 2006 for the Medical Care account, \$24,990,000 for the leases authorized in section 4.

(2) FISCAL YEAR 2007 LEASES.—There is authorized to be appropriated for the Secretary of Veterans Affairs for fiscal year 2007 for the Medical Care account, \$26,642,000 for the leases authorized in section 5.

(d) LIMITATION.—The projects authorized in sections 1 and 2 may only be carried out using—

(1) funds appropriated for fiscal year 2006 or 2007 pursuant to the authorization of appropriations in subsections (a), (b), and (c) of this section;

(2) funds available for Construction, Major Projects, for a fiscal year before fiscal year 2006 that remain available for obligation;

(3) funds available for Construction, Major Projects, for a fiscal year after fiscal year 2006 or 2007 that are available for obligation; and

(4) funds appropriated for Construction, Major Projects, for fiscal year 2006 or 2007 for a category of activity not specific to a project.

By Ms. MURKOWSKI:

S. 3422. A bill to provide for the tax treatment of income received in connection with the litigation concerning the *Exxon Valdez* oil spill; to the Committee on Finance.

Ms. MURKOWSKI. Mr. President, I rise to introduce a bill that will help the commercial fishermen and others whose livelihoods were negatively impacted by the *Exxon Valdez* oil spill.

As all of us know, the *Exxon Valdez* ran aground on March 23, 1989, spilling 11 million gallons of oil into Prince William Sound in Alaska. A class action jury trial was held in Federal court in Anchorage, AK, in 1994. The plaintiffs included 32,000 fishermen among others whose livelihoods were gravely affected by this disaster. The jury awarded \$5 billion in punitive

damages to the plaintiff class. The punitive damage award has been on repeated appeal by the Exxon Corporation since 1994. Many of the original plaintiffs, possibly more than 1,000 people, have already died.

Once the punitive damage award of the *Exxon Valdez* litigation is settled, many fishermen will receive payments to reimburse them for fishing income lost due to the environmental consequences of the *Exxon Valdez* oilspill. It is estimated that the eventual settlement could be \$6.75 billion or more.

My bill gives the affected fishermen, as well as other plaintiffs in this case, a fair shake when it comes to contributions to retirement plans and averaging of income for tax purposes.

With respect to retirement plan contributions, my bill increases the caps on both deductions and income for traditional IRAs to the extent of the income a plaintiff receives from the settlement or judgment. Also, it allows the plaintiffs to make contributions to Roth IRAs and other retirement plans to the extent of the income received from the settlement or judgment.

Fishermen are currently allowed to average their income over a several year period due to the often inconsistent nature of the fishing business. The litigation stemming from the *Exxon Valdez* oilspill poses an even more unique situation since fishermen and other plaintiffs have been waiting to receive lost income—in the form of a settlement or judgment—for 12 years. My bill allows plaintiffs to average their income for the period of time between December 31 of the year they receive the settlement or judgment payment and January 1, 1994—the year of the original jury award in Federal court.

It is imperative that we address this important issue soon. The Exxon Corporation has appealed this case and a decision is expected later this year.

I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 3422

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

**SECTION 1. TAX TREATMENT OF INCOME RECEIVED IN CONNECTION WITH THE EXXON VALDEZ LITIGATION.**

(a) INCOME AVERAGING OF AMOUNTS RECEIVED FROM THE EXXON VALDEZ LITIGATION.—

(1) IN GENERAL.—At the election of a qualified taxpayer who receives qualified settlement income during a taxable year, the tax imposed by chapter 1 of the Internal Revenue Code of 1986 for such taxable year shall be equal to the sum of—

(A) the tax which would be imposed under such chapter if—

(i) no amount of elected qualified settlement income were included in gross income for such year, and

(ii) no deduction were allowed for such year for expenses (otherwise allowable as a deduction to the taxpayer for such year) at-

tributable to such elected qualified settlement income, plus

(B) the increase in tax under such chapter which would result if taxable income for each of the years in the applicable period were increased by an amount equal to the applicable fraction of the elected qualified settlement income reduced by any expenses (otherwise allowable as a deduction to the taxpayer) attributable to such elected qualified settlement income.

Any adjustment under this section for any taxable year shall be taken into account in applying this section for any subsequent taxable year.

(2) COORDINATION WITH FARM INCOME AVERAGING.—If a qualified taxpayer makes an election with respect to any qualified settlement income under paragraph (1) for any taxable year, such taxpayer may not elect to treat such amount as elected farm income under section 1301 of the Internal Revenue Code of 1986.

(3) DEFINITIONS.—For purposes of this subsection—

(A) APPLICABLE PERIOD.—The term “applicable period” means the period beginning on January 1, 1994, and ending on December 31 of the year in which the elected qualified settlement income is received.

(B) APPLICABLE FRACTION.—The term “applicable fraction” means the fraction the numerator of which is one and the denominator of which is the number of years in the applicable period.

(C) ELECTED QUALIFIED SETTLEMENT INCOME.—The term “elected qualified settlement income” means so much of the taxable income for the taxable year which is—

(i) qualified settlement income, and

(ii) specified under the election under paragraph (1).

(b) CONTRIBUTIONS OF AMOUNTS RECEIVED TO RETIREMENT ACCOUNTS.—

(1) IN GENERAL.—Any qualified taxpayer who receives qualified settlement income during the taxable year may, at any time before the end of the taxable year in which such income was received, make one or more contributions to an eligible retirement plan of which such qualified taxpayer is a beneficiary in an aggregate amount not to exceed the amount of qualified settlement income received during such year.

(2) TIME WHEN CONTRIBUTIONS DEEMED MADE.—For purposes of paragraph (1), a qualified taxpayer shall be deemed to have made a contribution to an eligible retirement plan on the last day of the taxable year in which such income is received if the contribution is made on account of such taxable year and is made not later than the time prescribed by law for filing the return for such taxable year (not including extensions thereof).

(3) TREATMENT OF CONTRIBUTIONS TO ELIGIBLE RETIREMENT PLANS.—For purposes of the Internal Revenue Code of 1986, if a contribution is made pursuant to paragraph (1) with respect to qualified settlement income, then—

(A) except as provided in paragraph (4)—

(i) to the extent of such contribution, the qualified settlement income shall not be included in taxable income, and

(ii) for purposes of section 72 of such Code, such contribution shall not be considered to be investment in the contract, and

(B) the qualified taxpayer shall, to the extent of the amount of the contribution, be treated—

(i) as having received the qualified settlement income—

(I) in the case of a contribution to an individual retirement plan (as defined under section 7701(a)(37) such Code), in a distribution described in section 408(d)(3) of such Code, and

(II) in the case of any other eligible retirement plan, in an eligible rollover distribution (as defined under section 402(f)(2) of such Code), and

(ii) as having transferred the amount to the eligible retirement plan in a direct trustee to trustee transfer within 60 days of the distribution.

(4) SPECIAL RULE FOR ROTH IRAS AND ROTH 401(k)s.—For purposes of the Internal Revenue Code of 1986, if a contribution is made pursuant to paragraph (1) with respect to qualified settlement income to a Roth IRA (as defined under section 408A(b) of such Code) or as a designated Roth contribution to an applicable retirement plan (within the meaning of section 402A of such Code), then—

(A) the qualified settlement income shall be includible in taxable income, and

(B) for purposes of section 72 of such Code, such contribution shall be considered to be investment in the contract.

(5) ELIGIBLE RETIREMENT PLAN.—For purpose of this subsection, the term “eligible retirement plan” has the meaning given such term under section 402(c)(8)(B) of the Internal Revenue Code of 1986.

(c) QUALIFIED SETTLEMENT INCOME NOT INCLUDED IN SECA.—For purposes of chapter 2 of the Internal Revenue Code of 1986 and section 211 of the Social Security Act, no portion of qualified settlement income shall be treated as gross income derived from a trade or business carried on by a qualified taxpayer.

(d) QUALIFIED TAXPAYER.—For purposes of this section, the term “qualified taxpayer” means any plaintiff in the civil action *In re Exxon Valdez*, No. 89-095-CV (HRH) (Consolidated) (D. Alaska).

(e) QUALIFIED SETTLEMENT INCOME.—For purposes of this section, the term “qualified settlement income” means income received (whether as lump sums or periodic payments) in connection with the civil action *In re Exxon Valdez*, No. 89-095-CV (HRH) (Consolidated) (D. Alaska).

By Mr. SANTORUM:

S. 3432. A bill to protect children from exploitation by adults over the Internet, and for other purposes; to the Committee on the Judiciary.

Mr. SANTORUM, Mr. President, over the past few years, we have heard the tragic stories of how sexual predators have targeted children in our states. We have seen troubling headlines from Pennsylvania and across the country, and the frequency seems to be increasing rather than decreasing. The National Center for Missing and Exploited Children in partnership with the Federal Bureau of Investigation, Bureau of Immigration and Customs Enforcement, U.S. Secret Service, U.S. Postal Inspection Service, state and local law enforcement, and Internet Crimes Against Children Task Forces operates the CyberTipline. The number of referrals to the ICAC task forces has increased from 2,002 referrals in January-March 2005 to 3,392 referrals in January-March 2006. Additionally, the prosecutions in child pornography and child abuse cases have increased nearly every year since 1995.

Recently Congress has heard disturbing and saddening accounts of how these predators have used the Internet to exploit our children. As a father of six, I am keenly aware of the dangers

to our children and the concerns of parents across Pennsylvania and the Nation. In February, the Department of Justice launched Project Safe Childhood, a initiative to “combat the proliferation of technology-facilitated sexual exploitation crimes against children.”

“Project Safe Childhood” has five main purposes. First, it seeks to integrate Federal, State, and local efforts to investigate and prosecute child exploitation cases including partnerships by each U.S. Attorney with each Internet Crimes Against Children Task Force in their district, other Federal, State, and local law enforcement, and community and faith-based organizations to develop district-specific strategic plans to combat and prosecute child exploitation crimes. Second, the Project allows major case coordination by the Department of Justice or other appropriate Federal agency. Third, it increases Federal involvement in child exploitation cases by providing additional investigative tools and increased penalties available under Federal law. Fourth, the Project provides increased training of Federal, State, and local law enforcement regarding the investigation and prosecution of computer-facilitated crimes against children. Finally, it promotes community awareness and educational programs to raise national awareness about the threat of online sexual predators and to provide information to families on how to report possible violations.

According to recent Congressional testimony from Alice S. Fisher, Assistant U.S. Attorney in charge of the Criminal Division, and from William W. Mercer, Principle Associate Deputy Attorney General noted, this initiative is working.

On May 17, 2006, the Department of Justice released a document that outlines the need for this project, an overview of the program and guides for how law enforcement, parents, teachers, and communities can come together to implement this program effectively. While I am encouraged by the DOJ actions to raise the profile and enforcement through Project Safe Childhood—and appreciate all that many at the Department of Justice and the State and local levels are doing to catch and prosecute these predators—I am concerned that this program does not have the legislative authorization or dedicated funding that it needs to accomplish its goal of protecting our children.

I intend to work to help the Department of Justice fully implement and expand this initiative, therefore, I am introducing the Project Safe Childhood Authorization Act. Specifically, the bill will authorize and expand Project Safe Childhood; add new elements regarding child exploitation crimes that have been requested by the Department of Justice to strengthen the requirements to effectively report child pornography, require warning labels on commercial Websites that contain sex-

ually explicit material, and prohibit the embedding of words or images on a Website in order to deceive individuals into viewing obscenity or material harmful to minors; increase penalties for registered sex offenders, child sex trafficking and sexual abuse, and other child exploitation crimes; create Children’s Safety Online Awareness Campaigns; and authorize grants for online child safety programs.

The bill authorizes \$18 million for fiscal year 2007 for the initial implementation of Project Safe Childhood, and up to \$29 million for the expansion of the program for fiscal year 2007, and such sums as may be necessary for each of the 5 succeeding fiscal years.

I know all of us—particularly those of us with children—want to know how to keep our children safe, and want to know that anyone that endangers or harms our children will be punished. I am glad to be here to take this important step in protecting our children. I hope my colleagues will agree with me and we will pass the Project Safe Childhood Authorization Act this year.

By Mr. DODD:

S. 3449. A bill to amend the Public Health Service Act to improve the quality and availability of mental health services for children and adolescents; to the Committee on Health, Education, Labor, and Pensions,

Mr. DODD. Mr. President, I rise to introduce legislation that seeks to meet the mental health needs of children and adolescents.

I believe that the task of ensuring the emotional well-being and resiliency of our young people is one of paramount importance. We all know that mental health is a critical component contributing to a child’s general health and ability to grow—both intellectually and physically. Yet, the task of ensuring the mental health of children and adolescents is not an easy one. In fact, it is arguably one of the most difficult and largely unspoken tasks facing our Nation today.

According to the Substance Abuse and Mental Health Services Administration, one in ten children and adolescents suffers from mental health disorders serious enough to cause some level of impairment. Out of these young people, only one in five receives the specialty mental health services they require.

These startling statistics prompted former Surgeon General Dr. David Satcher to convene a conference in 1999 that examined the mental health needs of children. The conference—composed of some of the Nation’s leading experts in mental and public health—published a seminal report that concluded that “. . . the burden of suffering experienced by children with mental illness and their families has created a health crisis in this country.” The report further concluded that “. . . there is broad evidence that the Nation lacks a unified infrastructure to help children suffering from mental illness.”

I would like to submit for the RECORD personal testimony offered by three families in Connecticut. I believe their words and experiences speak most directly to the “burden of suffering” described in Surgeon General Satcher’s report—a burden endured by millions of children, adolescents, and then families nationwide. I ask unanimous consent that this testimony be printed in the RECORD.

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

#### TESTIMONY

DEAR SENATOR DODD, I wanted to take a moment to share with you what my experience has been navigating services for my son who has been diagnosed with severe psychosis and bipolar disorder. Due to the lack of psychiatric services when the extended day program my son attended was closed down, my son as well as seven other kids were left without the services they so needed. After a couple of weeks they started to have meltdowns. My son was one of them. The fact that he attended a therapeutic school didn’t at this point make a difference. After two short hospitalizations (one was for two weeks the other four weeks) my son, who is 12 years old, has been sitting at [a mental health services facility] for the past 9 weeks awaiting availability for sub-acute care. In the meantime he is not receiving the level of care that he needs.

Services are so limited at this point in time that because of time of delivery children who may have benefitted from less intensive intervention are being put in a position where by the time they receive care they are in need of higher level care that to me doesn’t seem very cost effective when you look at long term care. I often think about what would be different if my child was diabetic. Would he only receive services when available, and would they be appropriate to his medical needs?

I can’t explain in one letter what my son’s illness has done to our family and how difficult it is for all of us. Mental Health is a cruel monster who enters your life in sometimes undetected ways and when it finally attacks the blow can be fatal. The media has succeeded in painting a picture of individuals like my son as real dangers to society if not in proper treatment but what they have failed to shed light on is the lack of such services. My son deserves a better quality of services as well as a better quality of life.

DEAR SENATOR DODD, The following is to share some of what my family is struggling with due to my son’s mental illness. My son has been diagnosed with severe depression and mood disorder; he has mutilated himself various times and is a cutter. [My son] has been hospitalized three times due to this ongoing behavior; he is in need of sub-acute treatment but has only received stabilization services and out-patient services because the level of treatment that he needs is not available for boys 14 years or older. In the meantime we have extended day programs, voluntary services as well as systems of care in place yet the services he needs are not available. For a mother with three additional children with special needs I have serious concerns for my son’s safety. Who will be accountable if at some point my son succeeds in taking his own life when I have sought services and I am told over and over again that they are not available?

I really would like Congress to take a look at the great deal of families fighting our own personal battles with these unseen enemies.

We need weapons if we are to win these battles. We need more psychiatric services made available to all of our children regardless of age or gender.

SENATOR DODD, My son was always “different,” “difficult,” and “didn’t socialize well with the other children,” according to the daycare centers, camps, after school programs and even in the early part of kindergarten. His kindergarten school teacher was concerned enough to refer us to the school social worker when he held a plastic knife up to a fellow classmate’s throat and said he was going to slit it. She suggested parenting classes and perhaps family therapy. Since it was only my son and I as I was divorced and his father was not in the picture, of course I eagerly complied. I brought him to his pediatrician as well, who suggested behavior modification and consistency. No one was more consistent than I was a parent. I learned this early on with my son.

I sat through hours of parenting tapes, learning nothing new, while my son played with Legos and puppets. This service was on a sliding fee scale offered by our town and even so all I could afford to go was every other week. When my son was seven years old I woke up in the wee hours of the morning to find him standing in the middle of the kitchen surrounded by knives holding onto one in each hand. Although I was shocked and more scared than I had ever been in my entire life I instinctively knew I had to stay calm, that this was something beyond his control. I asked him what he was doing up, maintaining eye contact, and he said that there was a devil on one side telling him to hurt himself and an angel on the other telling him not to. I gathered up the knives as he was talking and spoke gently to my son who was so clearly in such pain. He gave me the knives without even realizing he was doing it, and I scooped him up and we waited for his psychiatrist’s office to open. He had been seeing a psychiatrist for 6 months or so, and was on stimulants for ADHD (the first diagnosis of choice as usual for children).

The doctor immediately added depression with psychotic features as another diagnosis and suggested hospitalization. The first of many hospitalizations my son would experience and the doctor also added an antipsychotic and antidepressant medication to the regiment. My son was in the hospital for 10 days and was no better, so additional diagnoses were added, oppositional defiant disorder, impulse control disorder and anxiety disorder as well as more medications. He started individual therapy regularly, seeing the psychiatrist and along with the medications the co-pays were more than I could afford, I applied for HUSKY. I was accepted, thankfully I thought at the time.

My son was rapidly becoming worse, so I went to the Department of Children and Families for help through Voluntary Services. This is insulting to caring parents trying to find help for their children as the request has to be made via the Hotline and is an embarrassment. However, it is the only way to gain access to certain services in the State that are not offered through private insurance companies. By now, my son is almost ten years old and has been hospitalized many times, in several partial hospitalizations, intensive outpatient hospitalization programs and extended day treatment programs. He has also been removed from the public school systems special education program and out-placed into a therapeutic day program for school out of district.

I made a call to the head of a psychiatric unit at a hospital who I had come to know through my work to ask for a referral for my son as I thought perhaps this was something more than what the doctors were saying. He

referred me to Mass. General’s Pediatric Psychopharmacology Unit. I called, my son was seen within 3 weeks and a diagnosis of Early Onset Bipolar Disorder as well as Major Multiple Anxiety Disorder was given. My son had already had an appointment with a new psychiatrist within the next couple of weeks and medications were changed to reflect the new diagnosis—unfortunately, too little too late.

My son, ended up in the hospital for 3 months and then in a sub-acute unit 4½ months, despite all of the in-home services we had on board, partially because the waiting time between services were detrimental and the length of the services were not long enough. When the service finally started to work, it was time to pull out. My son never engaged in any service because he knew if he got attached to anyone they were going to be gone in a short time anyway and his attitude was why bother? I can’t say I blamed him. For a child who needed consistency in his life there wasn’t a lot of it with the providers. He went to a residential setting for 18 months following the sub-acute unit and finally came back home. On his last day at the residential treatment center he was assaulted by a staff member who was found guilty and fired. At the same time, HUSKY notified me, that my premium would increase to 221.00 per month as I was over the income limit by 200.00 for a family of 2. I called and tried to plead my case, as they were unaware of my living expenses, such as rent, past medical bills I was trying to catch up on, etc. but they go by gross income and don’t take into account any other issues. I placed my son on my work insurance once again. Try as I might, I ended up filing for bankruptcy two years later, the ultimate embarrassment as far as I was concerned.

When my son came home, the discharge plan was to send him to a summer program called the Wilderness School for the summer. Unbeknownst to us this program was for juvenile delinquents who were in trouble with the law for the majority of their lives and in and out of the system. My son was petrified, and refused to stay, even saying he would hurt himself if they made him stay. I picked him up 1½ days after dropping him off and scrambled to find childcare for the summer once again.

Whether a family uses their own insurance or State insurance and services, it is a catch 22. With private insurance, services are extremely limited; both time limited and the type of service that is available is limited. With HUSKY, finding providers is extremely difficult. There are no specialists that will take HUSKY patients, dentists, orthodontists, neuropsychologists, psychiatrists, therapists and the list goes on. As a parent trying to do the best for her child it was very frustrating getting the door shut in my face no matter where I turned for help. All I wanted was to get my son the medical attention he so desperately needed, and I had to fight for everything. In an already traumatic time in my little family’s life, this was an unnecessary added burden.

My son is now a junior, still in special education, but in a public high school. He’s doing remarkably and I can say that it isn’t due to the services that he received but to his own strength and courage to fight his way back and make it on his own. His is truly an incredible young man and I am so proud of him. I have a bumper sticker that reads, “I am a proud parent of an honor roll student” which I never thought I would have. He earned that on his own.

Thank you for this opportunity to share my story.

Mr. DODD. I thank these families for sharing their personal experiences with

me, and for following me to share their experiences publicly. More importantly, I commend their tenacity in facing the challenges they face each and every day in caring for their children. Their stories, along with the stories I have heard from other families in Connecticut and elsewhere in the country, have fueled my belief that child and adolescent mental health needs to be a top priority.

Recognizing the fragmentation of the Nation’s mental health delivery system, Surgeon General Satcher’s report concluded that one fundamental way to meet the mental—health needs of children and adolescents is to “. . . move towards a community-based mental health delivery system that balances health promotion, disease prevention, early detection, and universal access to care.” The report further stated eight goals to ensure the resiliency of children and adolescents. These goals were: first, to promote public awareness of children’s mental health issues and reduce stigma associated with mental illness; second, to continue to develop, disseminate, and implement scientifically-proven prevention and treatment services in the field of children’s mental health; third, to improve the assessment of and recognition of mental health needs in children; fourth, to eliminate racial, ethnic and socioeconomic disparities in access to mental health care services; fifth, to improve the infrastructure for children’s mental health services, including support for scientifically-proven interventions across professions; sixth, to increase access to and coordination of quality mental health care services; seventh, to train frontline providers to recognize and manage mental health issues, and educate mental healthcare providers about scientifically-proven prevention and treatment services, and; finally, to monitor the access to and coordination of quality mental health care services.

In 2002, President Bush established the President’s New Freedom Commission on Mental Health to study three obstacles identified by the President that prevent Americans with mental illness from getting the care they require. These obstacles were identified as the stigma that surrounds mental health care, a lack of mental health parity, and the fragmented mental health delivery system. In 2003, the President’s New Freedom Commission issued a report that made a series of recommendations on how the Nation’s mental health system could be transformed for the better. Like Surgeon General Satcher’s report, this publication also set forth a series of goals. They were: first, to ensure Americans understand that mental health is essential to overall health; second, to ensure that mental health care is consumer- and family-driven; third, to eliminate disparities in mental health care services; fourth, to ensure that

early mental health screening, assessment, and referral services are common practices; fifth, to ensure that excellent mental health care is delivered and research is accelerated, and; finally, to ensure that technology is used to access mental health care and information.

I describe these two reports because the legislation I am introducing today seeks to address the recommendations they espouse. My legislation, the Child and Adolescent Mental Health Resiliency Act of 2006, authorizes \$210 million in an effort to meet five principal objectives.

The first objective is to increase access to, and improve the quality of, mental health care services delivered to children and adolescents. My legislation seeks to meet this objective in several ways.

First, it authorizes a new grant of \$50 million for States to develop and implement a comprehensive mental health plan exclusively for children and adolescents that provides community-based mental health early intervention and prevention services and relevant support services, such as primary health care, education, transportation and housing. The plan would have to meet a set of core operational and evaluative requirements and would have to be developed through extensive outside consultation with children and adolescents, their families, advocates and health professionals.

Second, my legislation authorizes two matching grants of \$22.5 million each for community health centers—many of which primarily serve low-income populations and primary health care facilities, such as a pediatrician's office, to provide community-based mental health services in coordination with community mental health centers and/or trained mental health professionals.

Third, my legislation authorizes a new grant of \$22.5 million for States, localities and private nonprofit organizations—e.g., school districts—to provide community-based mental health services in schools appropriate mental health training activities to relevant school and health professionals.

Fourth, my legislation authorizes a new grant of \$20 million for States, localities and private nonprofit organizations to provide community-based mental health services specifically for at-risk mothers and their children.

Fifth, my legislation authorizes a new grant of \$10 million for States, localities and private nonprofit organizations to provide community-based mental health services for children and adolescents in juvenile justice systems.

Sixth, my legislation authorizes \$10 million for the Secretary of Health and Human Services to establish, run and evaluate a demonstration project that improves the ability of local case managers to work across the mental health, public health, substance abuse, child welfare, education, juvenile justice and social services systems in a State.

Finally, my legislation requires States to meet their statutory obligations to fund fully mental health screening services under the Early and Periodic Screening, Diagnostic and Treatment Services Program. It also requires current successful initiatives, such as the Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbance Program, the Community Mental Health Services Performance Partnership Block Grant, the Community Mental Health Services Block Grant, and the Jail Diversion Program, to expand their scope with respect to certain reporting, evaluative, and service activities.

The second objective my legislation seeks to meet is ensuring greater public awareness and greater family participation in mental health services decision-making. Towards this end, my legislation does the following:

First, it authorizes a new grant of \$10 million for States, localities and private nonprofit organizations to develop policies that enable families of children and adolescents with mental health disorders to have increased control and choice over mental health services provided and received through a publicly-funded mental health system.

Second, it authorizes a new grant of \$10 million for private nonprofit organizations to provide information on child and adolescent mental health disorders, services, support services and respite care to families of children and adolescents with or who are at risk for mental health disorders.

Third, it authorizes a new grant of \$10 million for private nonprofit organizations to develop community coalitions and public education activities that promote child and adolescent resiliency.

In addition, my legislation authorizes \$10 million to establish two new technical assistance centers. These centers are designed to collect and disseminate information on mental health disorders, mental health disorder risk factors, mental health services, mental health service access, relevant support services, reducing seclusion and restraints, and family participation in mental health service decision-making—exclusively for children and adolescents with or at risk of mental health disorders.

The third objective that this legislation seeks to meet is for the Federal Government to develop a policy specifically designed to meet the unique mental health needs of children and adolescents. The legislation authorizes \$10 million for the establishment of an interagency coordinating committee consisting of all Federal officials whose departments or agencies oversee mental health activities for children and adolescents. Modeled after language in the Garrett Lee Smith Memorial Act, my legislation requires the coordinating committee to consult with outside parties, develop a Federal policy

exclusively pertaining to child and adolescent mental health, and report annually to Congress on specific challenges and solutions associated with comprehensively addressing the mental health needs of children and adolescents.

The fourth and final objective that this legislation seeks to meet is increasing the amount of research into child and adolescent mental health. Only through intensive research can we develop evidence-based best practices that allow us to develop services that fully meet the mental health needs of our children. Towards that end, my legislation authorizes a new grant of \$12.5 million for States, localities, institutions of higher education and private nonprofit organizations to identify and research current service, training and information awareness gaps in mental health delivery systems for children and adolescents. My legislation also authorizes \$12.5 million to enhance comprehensive Federal research and evaluation of promising best practices, existing disparities, psychotropic medications, trauma, recovery and rehabilitation, and co-occurring disorders as they relate to child and adolescent mental health.

My colleague on the Health, Education, Labor, and Pensions Committee, Chairman ENZI, has indicated a desire to bring up the Substance Abuse and Mental Health Services Administration reauthorization measure soon. It is my hope that this legislation can contribute to that reauthorization effort.

I would like to conclude by saying that this legislation, while comprehensive, is a first step—not a complete solution—towards fully meeting the challenge of ensuring the resiliency of our children and adolescents. We need to continue working together—young people, families, doctors, counselors, nurses, teachers, advocates, and policymakers—since we all have a stake, either professional or personal—in this issue. Only by working together can we develop effective and compassionate ways through which every young person in this nation is given a solid foundation upon which to reach his or her dreams in life.

I ask unanimous consent that the text of this legislation be printed in the CONGRESSIONAL RECORD.

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

S. 3449

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

**SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

(a) **SHORT TITLE.**—This Act may be cited as the “Child and Adolescent Mental Health Resiliency Act of 2006”.

(b) **TABLE OF CONTENTS.**—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

Sec. 2. Findings.

**TITLE I—STATE AND COMMUNITY ACTIVITIES CONCERNING THE MENTAL HEALTH OF CHILDREN AND ADOLESCENTS**

- Sec. 101. Grants concerning comprehensive state mental health plans.
- Sec. 102. Grants concerning early intervention and prevention.
- Sec. 103. Activities concerning mental health services in schools.
- Sec. 104. Activities concerning mental health services under the early and periodic screening, diagnostic, and treatment services program.
- Sec. 105. Activities concerning mental health services for at-risk mothers and their children.
- Sec. 106. Activities concerning interagency case management.
- Sec. 107. Grants concerning consumer and family participation.
- Sec. 108. Grants concerning information on child and adolescent mental health services.
- Sec. 109. Activities concerning public education of child and adolescent mental health disorders and services.
- Sec. 110. Technical assistance center concerning training and seclusion and restraints.
- Sec. 111. Technical assistance centers concerning consumer and family participation.
- Sec. 112. Comprehensive community mental health services for children and adolescents with serious emotional disturbances.
- Sec. 113. Community mental health services performance partnership block grant.
- Sec. 114. Community mental health services block grant program.
- Sec. 115. Grants for jail diversion programs.

**TITLE II—FEDERAL INTERAGENCY COLLABORATION AND RELATED ACTIVITIES**

- Sec. 201. Interagency coordinating committee concerning the mental health of children and adolescents.

**TITLE III—RESEARCH ACTIVITIES CONCERNING THE MENTAL HEALTH OF CHILDREN AND ADOLESCENTS**

- Sec. 301. Activities concerning evidence-based or promising best practices.
- Sec. 302. Federal research concerning adolescent mental health.

**SEC. 2. FINDINGS.**

Congress makes the following findings:

(1) According to the Surgeon General's Conference on Children's Mental Health: A National Action Agenda, mental health is a critical component of children's learning and general health.

(2) According to the Surgeon General's Conference on Children's Mental Health: A National Action Agenda, one in 10 children and adolescents suffer from mental illness severe enough to cause some level of impairment.

(3) According to the Surgeon General's Conference on Children's Mental Health: A National Action Agenda, only one in five children and adolescents who suffer from severe mental illness receive the specialty mental health services they require.

(4) According to the World Health Organization, childhood neuropsychiatric disorders will rise by over 50 percent by 2020, internationally, to become one of the five most common causes of morbidity, mortality, and disability among children.

(5) According to the Surgeon General's Conference on Children's Mental Health: A

National Action Agenda, the burden of suffering experienced by children with mental illness and their families has created a health crisis in this country.

(6) According to the Surgeon General's Conference on Children's Mental Health: A National Action Agenda, there is broad evidence that the nation lacks a unified infrastructure to help children suffering from mental illness;

(7) According to the President's New Freedom Commission on Mental Health, President George Bush identified three obstacles preventing Americans with mental illness from getting the care they require: stigma that surrounds mental illness; unfair treatment limitations and financial requirements placed on mental health benefits in private health insurance, and; the fragmented mental health service delivery system.

(8) According to the Surgeon General's Conference on Children's Mental Health: A National Action Agenda, one way to ensure that the country's health system meets the mental health needs of children is to move towards a community-based mental health delivery system that balances health promotion, disease prevention, early detection, and universal access to care.

(9) According to the President's New Freedom Commission on Mental Health, transforming the country's mental health delivery system rests on two principles: services and treatments must be consumer and family-centered, and; care must focus on increasing a person's ability to successfully cope with life's challenges, on facilitating recovery, and building resiliency.

(10) According to the Surgeon General's Conference on Children's Mental Health: A National Action Agenda, the mental health and resiliency of children can be ensured by methods that: promote public awareness of children's mental health issues and reduce stigma associated with mental illness; continue to develop, disseminate, and implement scientifically-proven prevention and treatment services in the field of children's mental health; improve the assessment of and recognition of mental health needs in children; eliminate racial, ethnic and socioeconomic disparities in access to mental healthcare services; improve the infrastructure for children's mental health services, including support for scientifically-proven interventions across professions; increase access to and coordination of quality mental healthcare services; train frontline providers to recognize and manage mental health issues, and educate mental healthcare providers about scientifically-proven prevention and treatment services, and; monitor the access to and coordination of quality mental healthcare services.

(11) According to the President's New Freedom Commission on Mental Health, the country's mental health delivery system can be successfully transformed by methods that: ensure Americans understand that mental health is essential to overall health; ensure mental health care is consumer and family-driven; eliminate disparities in mental healthcare services; ensure early mental health screening, assessment, and referral services are common practices; ensure that excellent mental health care is delivered and research is accelerated, and; technology is used to access mental health care and information.

**TITLE I—STATE AND COMMUNITY ACTIVITIES CONCERNING THE MENTAL HEALTH OF CHILDREN AND ADOLESCENTS**

**SEC. 101. GRANTS CONCERNING COMPREHENSIVE STATE MENTAL HEALTH PLANS.**

Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290bb-31 et

seq.) is amended by inserting after section 520A, the following:

**“SEC. 520B. COMPREHENSIVE STATE MENTAL HEALTH PLANS.**

“(a) GRANTS.—The Secretary, acting through the Center for Mental Health Services, shall award a 1-year, non-renewable grant to, or enter into a 1-year cooperative agreement with, a State for the development and implementation by the State of a comprehensive State mental health plan that exclusively meets the mental health needs of children and adolescents, including providing for early intervention, prevention, and recovery oriented services and supports for children and adolescents, such as mental and primary health care, education, transportation, and housing.

“(b) APPLICATION.—To be eligible to receive a grant or cooperative agreement under this section a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including—

“(1) a certification by the governor of the State that the governor will be responsible for overseeing the development and implementation of the comprehensive State mental health plan; and

“(2) the signature of the governor of the State.

“(c) REQUIREMENTS.—The Comprehensive State Plan shall include the following:

“(1) An evaluation of all the components of the current mental health system in the State, including the estimated number of children and adolescents requiring and receiving mental health services, as well as support services such as primary health care, education, and housing.

“(2) A description of the long-term objectives of the State for policies concerning children and adolescents with mental disorders. Such objectives shall include—

“(A) the provision of early intervention and prevention services to children and adolescents with, or who are at risk for, mental health disorders that are integrated with school systems, educational institutions, juvenile justice systems, substance abuse programs, mental health programs, primary care programs, foster care systems, and other child and adolescent support organizations;

“(B) a demonstrated collaboration among agencies that provide early intervention and prevention services or a certification that entities will engage in such future collaboration;

“(C) implementing or providing for the evaluation of children and adolescents mental health services that are adapted to the local community;

“(D) implementing collaborative activities concerning child and adolescent mental health early intervention and prevention services;

“(E) the provision of timely appropriate community-based mental health care and treatment of children and adolescents in child and adolescent-serving settings and agencies;

“(F) the provision of adequate support and information resources to families of children and adolescents with, or who are at risk for, mental health disorders;

“(G) the provision of adequate support and information resources to advocacy organizations that serve children and adolescents with, or who are at risk for, mental health disorders, and their families;

“(H) identifying and offering access to services and care to children and adolescents and their families with diverse linguistic and cultural backgrounds;

“(I) identifying and offering equal access to services in all geographic regions of the State;

“(J) identifying and offering appropriate access to services in geographical regions of the State with above-average occurrences of child and adolescent mental health disorders;

“(K) identifying and offering appropriate access to services in geographical regions of the State with above-average rates of children and adolescents with co-occurring mental health and substance abuse disorders;

“(L) offering continuous and up-to-date information to, and carrying out awareness campaigns that target children and adolescents, parents, legal guardians, family members, primary care professionals, mental health professionals, child care professionals, health care providers, and the general public and that highlight the risk factors associated with mental health disorders and the life-saving help and care available from early intervention and prevention services;

“(M) ensuring that information and awareness campaigns on mental health disorder risk factors, and early intervention and prevention services, use effective and culturally-appropriate communication mechanisms that are targeted to and reach adolescents, families, schools, educational institutions, juvenile justice systems, substance abuse programs, mental health programs, primary care programs, foster care systems, and other child and adolescent support organizations;

“(N) implementing a system to ensure that primary care professionals, mental health professionals, and school and child care professionals are properly trained in evidence-based best practices in child and adolescent mental health early intervention and prevention, treatment and rehabilitation services and that those professionals involved with providing early intervention and prevention services are properly trained in effectively identifying children and adolescents with or who are at risk for mental health disorders;

“(O) the provision of continuous training activities for primary care professionals, mental health professionals, and school and child care professionals on evidence-based or promising best practices;

“(P) the provision of continuous training activities for primary care professionals, mental health professionals, and school and child care professionals on family and consumer involvement and participation;

“(Q) conducting annual self-evaluations of all outcomes and activities, including consulting with interested families and advocacy organizations for children and adolescents.

“(3) A cost-assessment relating to the development and implementation of the State plan and a description of how the State will measure performance and outcomes across relevant agencies and service systems.

“(4) A timeline for achieving the objectives described in paragraph (2).

“(5) An outline for achieving the sustainability of the objectives described in paragraph (2).

“(d) APPLICATION OF OTHER REQUIREMENTS.—The authorities and duties of State mental health planning councils provided for under sections 1914 and 1915 with respect to State mental health block grant planning shall apply to the development and the implementation of the comprehensive State mental health plan.

“(e) PARTICIPATION AND IMPLEMENTATION.—

“(1) PARTICIPATION.—In developing and implementing the comprehensive State mental health plan under a grant or cooperative agreement under this section, the State shall ensure the participation of the State agency

heads responsible for child and adolescent mental health, substance abuse, child welfare, Medicaid, public health, developmental disabilities, social services, juvenile justice, housing, and education.

“(2) CONSULTATION.—In developing and implementing the comprehensive State mental health plan under a grant or cooperative agreement under this section, the State shall consult with—

“(A) the Federal interagency coordinating committee established under section 401 of the Child and Adolescent Mental Health Re-siliency Act of 2006;

“(B) State and local agencies, including agencies responsible for child and adolescent mental health care, early intervention and prevention services under titles IV, V, and XIX of the Social Security Act, and the State’s Children’s Health Insurance Program under title XXI of the Social Security Act;

“(C) State mental health planning councils (described in section 1914);

“(D) local, State, and national advocacy organizations that serve children and adolescents with or who are at risk for mental health disorders and their families;

“(E) relevant national medical and other health professional and education specialty organizations;

“(F) children and adolescents with mental health disorders and children and adolescents who are currently receiving early intervention or prevention services;

“(G) families and friends of children and adolescents with mental health disorders and children and adolescents who are currently receiving early intervention or prevention services;

“(H) families and friends of children and adolescents who have attempted or completed suicide;

“(I) qualified professionals who possess the specialized knowledge, skills, experience, training, or relevant attributes needed to serve children and adolescents with or who are at risk for mental health disorders and their families; and

“(J) third-party payers, managed care organizations, and related employer and commercial industries.

“(3) SIGNATURE.—The Governor of the State shall sign the comprehensive State mental health plan application and be responsible for overseeing the development and implementation of the plan.

“(f) SATISFACTION OF OTHER FEDERAL REQUIREMENTS.—A State may utilize the comprehensive State mental health plan that meets the requirements of this section to satisfy the planning requirements of other Federal mental health programs administered by the Secretary, including as the Community Mental Health Services Block Grant and the Children’s Mental Health Services Program, so long as the requirements of such programs are satisfied through the plan.

“(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section \$50,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2011.”

#### SEC. 102. GRANTS CONCERNING EARLY INTERVENTION AND PREVENTION.

Title V of the Public Health Services Act (42 U.S.C. 290aa et seq.) is amended by adding at the end the following:

#### “PART K—MISCELLANEOUS MENTAL HEALTH PROVISIONS

#### “SEC. 597. GRANTS FOR MENTAL HEALTH ASSESSMENT SERVICES.

“(a) IN GENERAL.—The Secretary shall award 5-year matching grants to, or enter into cooperative agreements with, community health centers that receive assistance under section 330 to enable such centers to

provide child and adolescent mental health early intervention and prevention services to eligible children and adolescents, and to provide referral services to, or early intervention and prevention services in coordination with, community mental health centers and other appropriately trained providers of care.

“(b) APPLICATION.—To be eligible to receive a grant or cooperative agreement under subsection (a) an entity shall—

“(1) be a community health center that receives assistance under section 330;

“(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

“(3) provide assurances that the entity will have appropriately qualified behavioral health professional staff to ensure prompt treatment or triage for referral to a specialty agency or provider; and

“(4) provide assurances that the entity will encourage formal coordination with community mental health centers and other appropriate providers to ensure continuity of care.

“(c) IDENTIFICATION.—In providing services with amounts received under a grant or cooperative agreement under this section, an entity shall ensure that appropriate screening tools are used to identify at-risk children and adolescents who are eligible to receive care from a community health centers.

“(d) MATCHING REQUIREMENT.—With respect to the costs of the activities to be carried out by an entity under a grant or cooperative agreement under this section, an entity shall provide assurances that the entity will make available (directly or through donations from public or private entities) non-Federal contributions towards such costs in an amount that is not less than \$1 for each \$1 of Federal funds provided under the grant or cooperative agreement.

#### “SEC. 597A. GRANTS FOR PRIMARY CARE AND MENTAL HEALTH EARLY INTERVENTION AND PREVENTION SERVICES.

“(a) IN GENERAL.—The Secretary shall award 5-year matching grants to, or enter into cooperative agreements with, States, political subdivisions of States, consortium of political subdivisions, tribal organizations, public organizations, or private nonprofit organizations to enable such entities to provide assistance to mental health programs for early intervention and prevention services to children and adolescents with, or who are at-risk of, mental health disorders and that are in primary care settings.

“(b) APPLICATION.—To be eligible to receive a grant or cooperative agreement under subsection (a) an entity shall—

“(1) be a State, a political subdivision of a State, a consortia of political subdivisions, a tribal organization, a public organization, or private nonprofit organization; and

“(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

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

“(1) provide appropriate child and adolescent mental health early intervention and prevention assessment services;

“(2) provide appropriate child and adolescent mental health treatment services;

“(3) provide monitoring and referral for specialty treatment of medical or surgical conditions for children and adolescents; and

“(4) facilitate networking between primary care professionals, mental health professionals, and child care professionals for—

“(A) case management development;

“(B) professional mentoring; and

“(C) enhancing the provision of mental health services in schools.

“(d) MATCHING REQUIREMENTS.—With respect to the costs of the activities to be carried out by an entity under a grant or cooperative agreement under this section, an entity shall provide assurances that the entity will make available (directly or through donations from public or private entities) non-Federal contributions towards such costs in an amount that is not less than \$1 for each \$1 of Federal funds provided under the grant or cooperative agreement.

**“SEC. 597B. GRANTS FOR MENTAL HEALTH AND PRIMARY CARE EARLY INTERVENTION AND PREVENTION SERVICES.**

“(a) IN GENERAL.—The Secretary shall award 5-year matching grants to, or enter into cooperative agreements with, States, political subdivisions of States, consortium of political subdivisions, tribal organizations, public organizations, or private nonprofit organizations to enable such entities to provide assistance to primary care programs for children and adolescents with, or who are at-risk of, mental health disorders who are in mental health settings.

“(b) APPLICATION.—To be eligible to receive a grant or cooperative agreement under subsection (a) an entity shall—

“(1) be a State, a political subdivision of a State, a consortia of political subdivisions, a tribal organization, or a private nonprofit organization; and

“(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

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

“(1) provide appropriate primary health care services, including screening, routine treatment, monitoring, and referral for specialty treatment of medical or surgical conditions;

“(2) provide appropriate monitoring of medical conditions of children and adolescents receiving mental health services from the applicant and refer them, as needed, for specialty treatment of medical or surgical conditions; and

“(3) facilitate networking between primary care professionals, mental health professionals and child care professionals for—

“(A) case management development; and

“(B) professional mentoring.

“(d) MATCHING FUNDS.—With respect to the costs of the activities to be carried out by an entity under a grant or cooperative agreement under this section, an entity shall provide assurances that the entity will make available (directly or through donations from public or private entities) non-Federal contributions towards such costs in an amount that is not less than \$1 for each \$1 of Federal funds provided under the grant or cooperative agreement.

**“SEC. 597C. AUTHORIZATION OF APPROPRIATIONS.**

“There is authorized to be appropriated to carry out this part \$22,500,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2011.”

**SEC. 103. ACTIVITIES CONCERNING MENTAL HEALTH SERVICES IN SCHOOLS.**

(a) EFFORTS OF SECRETARY TO IMPROVE THE MENTAL HEALTH OF STUDENTS.—The Secretary of Education, in collaboration with the Secretary of Health and Human Services, shall—

(1) encourage elementary and secondary schools and educational institutions to address mental health issues facing children and adolescents by—

(A) identifying children and adolescents with, or who are at-risk for, mental health disorders;

(B) providing or linking children and adolescents to appropriate mental health services and supports; and

(C) assisting families, including providing families with resources on mental health services for children and adolescents and a link to relevant local and national advocacy and support organizations;

(2) collaborate on expanding and fostering a mental health promotion and early intervention strategy with respect to children and adolescents that focuses on emotional well being and resiliency and fosters academic achievement;

(3) encourage elementary and secondary schools and educational institutions to use positive behavioral support procedures and functional behavioral assessments on a school-wide basis as an alternative to suspending or expelling children and adolescents with or who are at risk for mental health needs; and

(4) provide technical assistance to elementary and secondary schools and educational institutions to implement the provisions of paragraphs (1) through (3).

(b) GRANTS.—

(1) IN GENERAL.—The Secretary of Education, in collaboration with the Secretary of Health and Human Services, shall award grants to, or enter into cooperative agreements with, States, political subdivisions of States, consortium of political subdivisions, tribal organizations, public organizations, private nonprofit organizations, elementary and secondary schools, and other educational institutions to provide directly or provide access to mental health services and case management of services in elementary and secondary schools and other educational settings.

(2) APPLICATION.—To be eligible to receive a grant or cooperative agreement under paragraph (1) an entity shall—

(A) be a State, a political subdivision of a State, a consortia of political subdivisions, a tribal organization, a public organization, a private nonprofit organization, an elementary or secondary school, or an educational institution; and

(B) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including an assurance that the entity will—

(i) provide directly or provide access to early intervention and prevention services in settings with an above average rate of children and adolescents with mental health disorders;

(ii) provide directly or provide access to early intervention and prevention services in settings with an above average rate of children and adolescents with co-occurring mental health and substance abuse disorders; and

(iii) demonstrate a broad collaboration of parents, primary care professionals, school and mental health professionals, child care professionals including those in educational settings, legal guardians, and all relevant local agencies and organizations in the application for, and administration of, the grant or cooperative agreement.

(3) USE OF FUNDS.—An entity shall use amounts received under a grant or cooperative agreement under this subsection to provide—

(A) mental health identification services;

(B) early intervention and prevention services to children and adolescents with or who are at-risk of mental health disorders; and

(C) mental health-related training to primary care professionals, school and mental health professionals, and child care professionals, including those in educational settings.

(c) COUNSELING AND BEHAVIORAL SUPPORT GUIDELINES.—The Secretary of Education, in collaboration with the Secretary of Health and Human Services, shall develop and issue guidelines to elementary and secondary

schools and educational institutions that encourage such schools and institutions to provide counseling and positive behavioral supports, including referrals for needed early intervention and prevention services, treatment, and rehabilitation to children and adolescents who are disruptive or who use drugs and show signs or symptoms of mental health disorders. Such schools and institutions shall be encouraged to provide such services to children and adolescents in lieu of suspension, expulsion, or transfer to a juvenile justice system without any support referral services or system of care.

(d) STUDY.—

(1) IN GENERAL.—The Government Accountability Office shall conduct a study to assess the scientific validity of the Federal definition of a child or adolescent with an “emotional disturbance” as provided for in the regulations of the Department of Education under the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.), and whether, as written, such definition now excludes children and adolescents inappropriately through a determination that those children and adolescents are “socially maladjusted”.

(2) REPORT.—Not later than 1 year after the date of enactment of this Act, the Government Accountability Office shall submit to the appropriated committees of Congress a report concerning the results of the study conducted under paragraph (1).

(e) RULE OF CONSTRUCTION.—Nothing in this section shall be construed—

(1) to supercede the provisions of section 444 of the General Education Provisions Act (20 U.S.C. 1232g), including the requirement of prior parental consent for the disclosure of any education records; and

(2) to modify or affect the parental notification requirements for programs authorized under the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6301 et seq.).

(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section \$22,500,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2011.

**SEC. 104. ACTIVITIES CONCERNING MENTAL HEALTH SERVICES UNDER THE EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES PROGRAM.**

(a) NOTIFICATION.—The Secretary of Health and Human Services, acting through the Director of the Centers for Medicare and Medicaid Services, shall notify State Medicaid agencies of—

(1) obligations under section 1905(r) of the Social Security Act with respect to the identification of children and adolescents with mental health disorders and of the availability of validated mechanisms that aid pediatricians and other primary care professionals to incorporate such activities; and

(2) information on financing mechanisms that such agencies may use to reimburse primary care professionals, mental health professionals, and child care professionals who provide mental health services as authorized under such definition of early and period screening, diagnostic, and treatment services.

(b) REQUIREMENTS.—State Medicaid agencies who receive funds for early and period screening, diagnostic, and treatment services funding shall provide an annual report to the Secretary of Health and Human Services that—

(1) analyzes the rates of eligible children and adolescents who receive mental health identification services of the type described in subsection (a)(1) under the Medicaid program in the State;

(2) analyzes the ways in which such agency has used financing mechanisms to reimburse primary care professionals, mental health

professionals, and child care professionals who provide such mental health services;

(3) identifies State program rules and funding policies that may impede such agency from meeting fully the Federal requirements with respect to such services under the medicaid program; and

(4) makes recommendations on how to overcome the impediments identified under paragraph (3).

**SEC. 105. ACTIVITIES CONCERNING MENTAL HEALTH SERVICES FOR AT-RISK MOTHERS AND THEIR CHILDREN.**

Title V of the Social Security Act (42 U.S.C. 701 et seq.) is amended by adding at the end the following:

**“SEC. 511. ENHANCING MENTAL HEALTH SERVICES FOR AT-RISK MOTHERS AND THEIR CHILDREN.**

“(a) GRANTS.—The Secretary shall award grants to, or enter into cooperative agreements with, States, political subdivisions of States, consortium of political subdivisions, tribal organizations, public organizations, and private nonprofit organizations to provide appropriate mental health promotion and mental health services to at-risk mothers, grandmothers who are legal guardians, and their children.

“(b) APPLICATION.—To be eligible to receive a grant or cooperative agreement under subsection (a) an entity shall—

“(1) be a State, a political subdivision of a State, a consortia of political subdivisions, a tribal organization, a public organization, or a private nonprofit organization; and

“(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(c) USE OF FUNDS.—Amounts received under a grant or cooperative agreement under this section shall be used to—

“(1) provide mental health early intervention, prevention, and case management services;

“(2) provide mental health treatment services; and

“(3) provide monitoring and referral for specialty treatment of medical or surgical conditions.

“(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, \$20,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2011.”.

**SEC. 106. ACTIVITIES CONCERNING INTER-AGENCY CASE MANAGEMENT.**

Part L of title V of the Public Health Service Act, as added by section 102, is amended by adding at the end the following:

**“SEC. 597C. INTERAGENCY CASE MANAGEMENT.**

“(a) IN GENERAL.—The Secretary shall establish a program to foster the ability of local case managers to work across the mental health, substance abuse, child welfare, education, and juvenile justice systems in a State. As part of such program, the Secretary shall develop a model system that—

“(1) establishes a training curriculum for primary care professionals, mental health professionals, school and child care professionals, and social workers who work as case managers;

“(2) establishes uniform standards for working in multiple service systems; and

“(3) establishes a cross-system case manager certification process.

“(b) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section \$10,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2011.”.

**SEC. 107. GRANTS CONCERNING CONSUMER AND FAMILY PARTICIPATION.**

Part K of title V of the Public Health Service Act, as added by section 102 and amended

by section 106, is further amended by adding at the end the following:

**“SEC. 597D. CONSUMER AND FAMILY CONTROL IN CHILD AND ADOLESCENT MENTAL HEALTH SERVICE DECISIONS.**

“(a) GRANTS.—The Secretary shall award grants to, or enter into cooperative agreements with, States, political subdivisions of States, consortium of political subdivisions, and tribal organizations for the development of policies and mechanisms that enable consumers and families to have increased control and choice over child and adolescent mental health services received through a publicly-funded mental health system.

“(b) APPLICATION.—To be eligible to receive a grant or cooperative agreement under subsection (a) an entity shall—

“(1) be a State, a political subdivision of a State, a consortia of political subdivisions, or a tribal organization; and

“(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(c) USE OF FUNDS.—An entity shall use amounts received under a grant or cooperative agreement under this section to carry out the activities described in subsection (a). Such activities may include—

“(1) the facilitation of mental health service planning meetings by consumer and family advocates, particularly peer advocates;

“(2) the development of consumer and family cooperatives; and

“(3) the facilitation of national networking between State political subdivisions and tribal organizations engaged in promoting increased consumer and family participation in decisions regarding mental health services for children and adolescents.

“(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, \$10,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2011.”.

**SEC. 108. GRANTS CONCERNING INFORMATION ON CHILD AND ADOLESCENT MENTAL HEALTH SERVICES.**

Part K of title V of the Public Health Service Act, as added by section 102 and amended by section 107, is further amended by adding at the end the following:

**“SEC. 597E. INCREASED INFORMATION ON CHILD AND ADOLESCENT MENTAL HEALTH SERVICES.**

“(a) GRANTS.—The Secretary shall award grants to, or enter into cooperative agreements with, private nonprofit organizations to enable such organizations to provide information on child and adolescent mental health and services, consumer or parent-to-parent support services, respite care, and other relevant support services to—

“(1) parents and legal guardians of children or adolescents with or who are at risk for mental health disorders; and

“(2) families of adolescents with or who are at risk for mental health disorders.

“(b) APPLICATION.—To be eligible to receive a grant or cooperative agreement under subsection (a) an entity shall—

“(1) be a private, nonprofit organization; and

“(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, \$10,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2011.”.

**SEC. 109. ACTIVITIES CONCERNING PUBLIC EDUCATION OF CHILD AND ADOLESCENT MENTAL HEALTH DISORDERS AND SERVICES.**

Part K of title V of the Public Health Service Act, as added by section 102 and amended

by section 108, is further amended by adding at the end the following:

**“SEC. 597F. ACTIVITIES CONCERNING PUBLIC EDUCATION OF CHILD AND ADOLESCENT MENTAL HEALTH DISORDERS AND SERVICES.**

“(a) EDUCATIONAL CAMPAIGN.—The Secretary shall develop, coordinate, and implement an educational campaign to increase public understanding of mental health promotion, child and adolescent emotional well-being and resiliency, and risk factors associated with mental health disorders in children and adolescents.

“(b) GRANTS.—

“(1) IN GENERAL.—The Secretary shall award grants to, or enter into cooperative agreements with, public and private nonprofit organizations with qualified experience in public education to build community coalitions and increase public awareness of mental health promotion, child and adolescent emotional well-being and resiliency, and risk factors associated with mental health disorders in children and adolescents.

“(2) APPLICATION.—To be eligible to receive a grant or cooperative agreement under paragraph (1), an entity shall—

“(A) be a public or private nonprofit organization; and

“(B) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(3) USE OF FUNDS.—Amounts received under a grant or contract under this subsection shall be used to—

“(A) develop community coalitions to support the purposes of paragraph (1); and

“(B) develop and implement public education activities that compliment the activities described in subsection (a) and support the purposes of paragraph (1).

“(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, \$10,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2011.”.

**SEC. 110. TECHNICAL ASSISTANCE CENTER CONCERNING TRAINING AND SECLUSION AND RESTRAINTS.**

Part K of title V of the Public Health Service Act, as added by section 102 and amended by section 109, is further amended by adding at the end the following:

**“SEC. 597G. TECHNICAL ASSISTANCE CENTER CONCERNING SECLUSION AND RESTRAINTS.**

“(a) SECLUSION AND RESTRAINTS.—Acting through the technical assistance center established under subsection (b), the Secretary shall—

“(1) develop and disseminate educational materials that encourage ending the use of seclusion and restraints in all facilities or programs in which a child or adolescent resides or receives care or services;

“(2) gather, analyze, and disseminate information on best or promising best practices that can minimize conflicts between parents, legal guardians, primary care professionals, mental health professionals, school and child care professionals to create a safe environment for children and adolescents with mental health disorders; and

“(3) provide training for primary professionals, mental health professionals, and school and child care professionals on effective techniques or practices that serve as alternatives to coercive control interventions, including techniques to reduce challenging, aggressive, and resistant behaviors, that require seclusion and restraints.

“(b) CONSULTATION.—In carrying out this section, the Secretary shall consult with—

“(1) local and national advocacy organizations that serve children and adolescents who may require the use of seclusion and restraints, and their families;

“(2) relevant national medical and other health and education specialty organizations; and

“(3) qualified professionals who possess the specialized knowledge, skills, experience, and relevant attributes needed to serve children and adolescents who may require the use of seclusion and restraints, and their families.

“(C) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, \$5,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2011.”

**SEC. 111. TECHNICAL ASSISTANCE CENTERS CONCERNING CONSUMER AND FAMILY PARTICIPATION.**

Part K of title V of the Public Health Service Act, as added by section 102 and amended by section 110, is further amended by adding at the end the following:

**“SEC. 597H. TECHNICAL ASSISTANCE CENTERS CONCERNING CONSUMER AND FAMILY PARTICIPATION.**

“(a) GRANTS.—The Secretary shall award 5-year grants to, or enter into cooperative agreements with, private nonprofit organizations for the development and implementation of three technical assistance centers to support full consumer and family participation in decision-making about mental health services for children and adolescents.

“(b) APPLICATION.—To be eligible to receive a grant or cooperative agreement under subsection (a) an entity shall—

“(1) be a private, nonprofit organization that demonstrates the ability to establish and maintain a technical assistance center described in this section; and

“(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(c) USE OF FUNDS.—An entity shall use amounts received under a grant or cooperative agreement under this section to establish a technical assistance center of the type referred to in subsection (a). Through such center, the entity shall—

“(1) collect and disseminate information on mental health disorders and risk factors for mental health disorders in children and adolescents;

“(2) collect and disseminate information on available resources for specific mental health disorders, including co-occurring mental health and substance abuse disorders;

“(3) disseminate information to help consumers and families engage in illness self management activities and access services and resources on mental health disorder self-management;

“(4) support the activities of self-help organizations;

“(5) support the training of peer specialists, family specialists, primary care professionals, mental health professionals, and child care professionals;

“(6) provide assistance to consumer and family-delivered service programs and resources in meeting their operational and programmatic needs; and

“(7) provide assistance to consumers and families that participate in mental health system advisory bodies, including state mental health planning councils.

“(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, \$5,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2011.”

**SEC. 112. COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCES.**

Section 561 of the Public Health Service Act (42 U.S.C. 290ff) is amended—

(1) in subsection (b)(1)(A), by inserting before the semicolon the following: “and pro-

vides assurances that the State will use grant funds in accordance with the comprehensive State mental health plan submitted under section 520B”; and

(2) in subsection (b), by adding at the end the following:

“(4) REVIEW OF POSSIBLE IMPEDIMENTS.—A State may use amounts received under a grant under this section to conduct an interagency review of State mental health program rules and funding policies that may impede the development of the comprehensive State mental health plan submitted under section 520B.”

**SEC. 113. COMMUNITY MENTAL HEALTH SERVICES PERFORMANCE PARTNERSHIP BLOCK GRANT.**

Section 1912(b) of the Public Health Service Act (42 U.S.C. 300x-2(b)) is amended by adding at the end the following:

“(6) PERFORMANCE MEASURES.—The plan requires that performance measures be reported for adults and children separately.

“(7) OTHER MENTAL HEALTH SERVICES.—In addition to reporting on mental health services funded under a community mental health services performance partnership block grant, States are encouraged to report on all mental health services provided by the State mental health agency.”

**SEC. 114. COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT PROGRAM.**

(a) IN GENERAL.—Section 1912(b) of the Public Health Service Act (42 U.S.C. 300x-2(b)) is amended by adding at the end the following:

“(8) CO-OCCURRING TREATMENT SERVICES.—The plan provides for a system of support for the provision of co-occurring treatment services, including early intervention and prevention, and integrated mental health and substance abuse and services, for adolescents with co-occurring mental health and substance abuse disorders. Services shall be provided through the system under this paragraph in accordance with the Substance Abuse Prevention Treatment Block Grant program under subpart II.”

(b) GUIDELINES FOR INTEGRATED TREATMENT SERVICES.—Section 1915 of the Public Health Service Act (42 U.S.C. 300x-4) is amended by adding at the end the following:

“(c) GUIDELINES FOR INTEGRATED TREATMENT SERVICES.—The Secretary shall issue written policy guidelines for use by States that describe how amounts received under a grant under this subpart may be used to fund integrated treatment services for children and adolescents with mental health disorders and with co-occurring mental health and substance abuse disorders.

“(d) MODEL SERVICE SYSTEMS FORUM.—The Secretary, in consultation with the Attorney General, shall periodically convene forums to develop model service systems and promote awareness of the needs of children and adolescents with co-occurring mental health disorders and to facilitate the development of policies to meet those needs.”

(c) SUBSTANCE ABUSE GRANTS.—Section 1928 of the Public Health Service Act (42 U.S.C. 300x-28) is amended by adding at the end the following:

“(e) CO-OCCURRING TREATMENT SERVICES.—A State may use amounts received under a grant under this subpart to provide a system of support for the provision of co-occurring treatment services, including early intervention and prevention, and integrated mental health and substance abuse services, for children and adolescents with co-occurring mental health and substance abuse disorders. Services shall be provided through the system under this paragraph in accordance with the Community Mental Health Services Block Grant program under subpart I.

“(f) GUIDELINES FOR INTEGRATED TREATMENT SERVICES.—The Secretary shall issue

written policy guidelines, for use by States, that describe how amounts received under a grant under this section may be used to fund integrated treatment for children and adolescents with co-occurring substance abuse and mental health disorders.”

**SEC. 115. GRANTS FOR JAIL DIVERSION PROGRAMS.**

Section 520G of the Public Health Service Act (42 U.S.C. 290bb-38)—

(1) in subsection (a), by striking “up to 125”;

(2) in subsection (d)—

(A) in paragraph (3), by striking “and” at the end;

(B) in paragraph (4), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

“(5) provide appropriate community-based mental health and co-occurring mental illness and substance abuse services to children and adolescents determined to be at risk of contact with the law; and

“(6) provide for the inclusion of emergency mental health centers as part of jail diversion programs.”; and

(3) in subsection (h), by adding at the end the following: “As part of such evaluations, the grantee shall evaluate the effectiveness of activities carried out under the grant and submit reports on such evaluations to the Secretary.”

**SEC. 116. ACTIVITIES CONCERNING MENTAL HEALTH SERVICES FOR JUVENILE JUSTICE POPULATIONS.**

(a) GRANTS.—The Secretary shall award grants to, or enter into cooperative agreements with, States, tribal organizations, political subdivisions of States, consortia of political subdivisions, public organizations, and private nonprofit organizations to provide mental health promotions and mental health services to children and adolescents in juvenile justice systems.

(b) APPLICATION.—To be eligible to receive a grant or cooperative agreement under subsection (a), an entity shall—

(1) be a State, a tribal organization, a political subdivision of a State, a consortia of political subdivisions, a public organization, or a private nonprofit organization; and

(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) USE OF FUNDS.—Amounts received under a grant or cooperative agreement under this section shall be used to—

(1) provide mental health early intervention, prevention, and case management services;

(2) provide mental health treatment services; and

(3) provide monitoring and referral for specialty treatment of medical or surgical conditions.

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, \$10,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2011.

**TITLE II—FEDERAL INTERAGENCY COLLABORATION AND RELATED ACTIVITIES**

**SEC. 201. INTERAGENCY COORDINATING COMMITTEE CONCERNING THE MENTAL HEALTH OF CHILDREN AND ADOLESCENTS.**

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”), in collaboration with the Federal officials described in subsection (b), shall establish an interagency coordinating committee (referred to in this section as the “Committee”) to carry out the activities described in this section relating to the mental health of children and adolescents.

(b) FEDERAL OFFICIALS.—The Federal officials described in this subsection are the following:

- (1) The Secretary of Education.
- (2) The Attorney General.
- (3) The Surgeon General.
- (4) The Secretary of the Department of Defense.
- (5) The Secretary of the Interior.
- (6) The Commissioner of Social Security.
- (7) Such other Federal officials as the Secretary determines to be appropriate.

(c) **CHAIRPERSON.**—The Secretary shall serve as the chairperson of the Committee.

(d) **DUTIES.**—The Committee shall be responsible for policy development across the Federal Government with respect to child and adolescent mental health.

(e) **COLLABORATION AND CONSULTATION.**—In carrying out the activities described in this Act, and the amendments made by this Act, the Secretary shall collaborate with the Committee (and the Committee shall collaborate with relevant Federal agencies and mental health working groups responsible for child and adolescent mental health).

(f) **CONSULTATION.**—In carrying out the activities described in this Act, and the amendments made by this Act, the Secretary and the Committee shall consult with—

(1) State and local agencies, including agencies responsible for child and adolescent mental health care, early intervention and prevention services under titles V and XIX of the Social Security Act, and the State Children's Health Insurance Program under title XXI of the Social Security Act;

(2) State mental health planning councils (as described in section 1914);

(3) local and national organizations that serve children and adolescents with or who are at risk for mental health disorders and their families;

(4) relevant national medical and other health professional and education specialty organizations;

(5) children and adolescents with mental health disorders and children and adolescents who are currently receiving early intervention or prevention services;

(6) families and friends of children and adolescents with mental health disorders and children and adolescents who are currently receiving early intervention or prevention services;

(7) families and friends of children and adolescents who have attempted or completed suicide;

(8) qualified professionals who possess the specialized knowledge, skills, experience, training, or relevant attributes needed to serve children and adolescents with or who are at risk for mental health disorders and their families; and

(9) third-party payers, managed care organizations, and related employer and commercial industries.

(g) **POLICY DEVELOPMENT.**—In carrying out the activities described in this Act, and the amendments made by this Act, the Secretary shall—

(1) coordinate and collaborate on policy development at the Federal level with the Committee, relevant Department of Health and Human Services, Department of Education, and Department of Justice agencies, and child and adolescent mental health working groups; and

(2) consult on policy development at the Federal level with the private sector, including consumer, medical, mental health advocacy groups, and other health and education professional-based organizations, with respect to child and adolescent mental health early intervention and prevention services.

(h) **REPORTS.**—

(1) **INITIAL REPORT.**—Not later than 2 years after the date of enactment of this Act, the Committee shall submit to the appropriate committees of Congress a report that includes—

(A) the results of an evaluation to be conducted by the Committee to analyze the effectiveness and efficacy of current activities concerning the mental health of children and adolescents;

(B) the results of an evaluation to be conducted by the Committee to analyze the effectiveness and efficacy of the activities carried out under grants, cooperative agreements, collaborations, and consultations under this Act, the amendments made by this Act, and carried out by existing Federal agencies

(C) the results of an evaluation to be conducted by the Committee to analyze identified problems and challenges, including—

(i) fragmented mental health service delivery systems for children and adolescents;

(ii) disparities between Federal agencies in mental health service eligibility requirements for children and adolescents;

(iii) disparities in regulatory policies of Federal agencies concerning child and adolescent mental health;

(iv) inflexibility of Federal finance systems to support evidence-based child and adolescent mental health;

(v) insufficient training of primary care professionals, mental health professionals, and child care professionals;

(vi) disparities and fragmentation of collection and dissemination of information concerning child and adolescent mental health services;

(vii) inability of State Medicaid agencies to meet Federal requirements concerning child and adolescent mental health under the early and period screening, diagnostics and treatment services requirements under the Medicaid program under title XIX of the Social Security Act; and

(viii) fractured Federal interagency collaboration and consultation concerning child and adolescent mental health;

(D) the recommendations of the Secretary on models and methods with which to overcome the problems and challenges described in subparagraph (B) for the purposes of improving Federal interagency coordination and the development of Federal mental health policy.

(2) **ANNUAL REPORT.**—Not later than 1 year after the date on which the initial report is submitted under paragraph (1), an annually thereafter, the Committee shall submit to the appropriate committees of Congress a report concerning the results of updated evaluations and recommendations described in paragraph (1).

(i) **PERSONNEL MATTERS.**—

(1) **STAFF AND COMPENSATION.**—Except as provided in paragraph (2), the Secretary may employ, and fix the compensation of an executive director and other personnel of the Committee without regard to the provisions of chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates.

(2) **MAXIMUM RATE OF PAY.**—The maximum rate of pay for the executive director and other personnel employed under paragraph (1) shall not exceed the rate payable for level IV of the Executive Schedule under section 5316 of title 5, United States Code.

(j) **AUTHORIZATION OF APPROPRIATIONS.**—There is authorized to be appropriated to carry out this section, \$10,000,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2011.

### **TITLE III—RESEARCH ACTIVITIES CONCERNING THE MENTAL HEALTH OF CHILDREN AND ADOLESCENTS**

#### **SEC. 301. ACTIVITIES CONCERNING EVIDENCE-BASED OR PROMISING BEST PRACTICES.**

Part K of title V of the Public Health Service Act, as added by section 102 and amended

by section 111, is further amended by adding at the end the following:

#### **“SEC. 597L. ACTIVITIES CONCERNING EVIDENCE-BASED OR PROMISING BEST PRACTICES.**

“(a) **GRANTS.**—

“(1) **IN GENERAL.**—The Secretary shall award grants to, and enter into cooperative agreements with, States, political subdivisions of States, consortia of political subdivisions, tribal organizations, institutions of higher education, or private nonprofit organizations for the development of child and adolescent mental health services and support systems that address widespread and critical gaps in a needed continuum of mental health service-delivery with a specific focus on encouraging the implementation of evidence-based or promising best practices.

“(2) **APPLICATION.**—To be eligible to receive a grant or cooperative agreement under paragraph (1) an entity shall—

“(A) be a State, a political subdivision of a State, a consortia of political subdivisions, a tribal organization, an institution of higher education, or a private nonprofit organization; and

“(B) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(3) **USE OF FUNDS.**—Amounts received under a grant or cooperative agreement under this subsection shall be used to provide for the development and dissemination of mental health supports and services described in paragraph (1), including—

“(A) early intervention and prevention services, treatment and rehabilitation particularly for children and adolescents with co-occurring mental health and substance abuse disorders;

“(B) referral services;

“(C) integrated treatment services, including family therapy, particularly for children and adolescents with co-occurring mental health and substance abuse disorders;

“(D) colocating primary care and mental health services in rural and urban areas;

“(E) mentoring and other support services;

“(F) transition services;

“(G) respite care for parents, legal guardians, and families; and

“(H) home-based care.

“(b) **TECHNICAL ASSISTANCE CENTER.**—The Secretary shall establish a technical assistance center to assist entities that receive a grant or cooperative agreement under subsection (a) in—

“(1) identifying widespread and critical gaps in a needed continuum of child and adolescent mental health service-delivery;

“(2) identifying and evaluating existing evidence-based or promising best practices with respect to child and adolescent mental health services and supports;

“(3) improving the child and adolescent mental health service-delivery system by implementing evidence-based or promising best practices;

“(4) training primary care professionals, mental health professionals, and child care professionals on evidence-based or promising best practices;

“(5) informing children and adolescents, parents, legal guardians, families, advocacy organizations, and other interested consumer organizations on such evidence-based or promising best practices; and

“(6) identifying financing structures to support the implementation of evidence-based or promising best practices and providing assistance on how to build appropriate financing structures to support those services.

“(c) **AUTHORIZATION OF APPROPRIATIONS.**—There is authorized to be appropriated to carry out this section, \$12,500,000 for fiscal

year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2011.”

**SEC. 302. FEDERAL RESEARCH CONCERNING ADOLESCENT MENTAL HEALTH.**

Part K of title V of the Public Health Service Act, as added by section 201 and amended by section 301, is further amended by adding at the end the following:

**“SEC. 597J. FEDERAL RESEARCH CONCERNING ADOLESCENT MENTAL HEALTH.**

“(a) **BEST PRACTICES.**—The Secretary shall provide for the conduct of research leading to the identification and evaluation of evidence-based or promising best practices, including—

“(1) early intervention and prevention mental health services and systems, particularly for children and adolescents with co-occurring mental health and substance abuse disorders;

“(2) mental health referral services;

“(3) integrated mental health treatment services, particularly for children and adolescents with co-occurring mental health and substance abuse disorders;

“(4) mentoring and other support services;

“(5) transition services; and

“(6) respite care for parents, legal guardians, and families of children and adolescents.

“(b) **IDENTIFICATION OF EXISTING DISPARITIES.**—The Secretary shall provide for the conduct of research leading to the identification of factors contributing to the existing disparities in children and adolescents mental health care in areas including—

“(1) evidence-based early intervention and prevention, diagnosis, referral, treatment, and monitoring services;

“(2) psychiatric and psychological epidemiology in racial and ethnic minority populations;

“(3) therapeutic interventions in racial and ethnic minority populations;

“(4) psychopharmacology;

“(5) mental health promotion and child and adolescent emotional well-being and resiliency;

“(6) lack of adequate service delivery systems in urban and rural regions; and

“(7) lack of adequate reimbursement rates for evidence-based early intervention and prevention, diagnosis, referral, treatment, and monitoring services.

“(c) **PSYCHOTROPIC MEDICATIONS.**—The Secretary shall provide for the conduct of research leading to the identification of the long-term effects of psychotropic medications and SSRIs and other psychotropic medications for children and adolescents.

“(d) **TRAUMA.**—The Secretary shall provide for the conduct of research leading to the identification of the long-term effects of trauma on the mental health of children and adolescents, including the effects of—

“(1) violent crime, particularly sexual abuse;

“(2) physical or medical trauma;

“(3) post-traumatic stress disorders; and

“(4) terrorism and natural disasters.

“(e) **ACUTE CARE.**—The Secretary shall provide for the conduct of research leading to the identification of factors contributing to problems in acute care. Such research shall address—

“(1) synthesizing the acute care knowledge data base;

“(2) assessing existing capacities and shortages in acute care;

“(3) reviewing existing model programs that exist to ensure appropriate and effective acute care;

“(4) developing new models when appropriate; and

“(5) proposing workable solutions to enhance the delivery of acute care and crisis intervention services.

“(f) **RECOVERY AND REHABILITATION.**—The Secretary shall provide for the conduct of research leading to the identification of methods and models to enhance the recovery and rehabilitation of children and adolescents with mental health disorders.

“(g) **CO-OCCURRING DISORDERS.**—The Secretary shall provide for the conduct of research leading to the identification of methods and models to enhance services and supports for children and adolescents with co-occurring mental health and substance abuse and disorders.

“(h) **RESEARCH COLLABORATION.**—The Secretary shall provide for the conduct of research that reviews existing scientific literature on the relationship between mental and physical health, particularly identifying new methods and models to enhance the balance between mental and physical health in children and adolescents.

“(i) **COLLABORATION.**—In carrying out the activities under this section, the Secretary shall collaborate with the Federal interagency coordinating committee established under section 401 of the Child and Youth Equitable Health Act of 2005, and relevant Federal agencies and mental health working groups responsible for child and adolescent mental health.

“(j) **AUTHORIZATION OF APPROPRIATIONS.**—There is authorized to be appropriated to carry out this section, \$12,500,000 for fiscal year 2007, and such sums as may be necessary for each of fiscal years 2008 through 2011.”

By Mr. BROWNBACK (for himself and Mr. TALENT):

S. 3454. A bill to amend the Internal Revenue Code of 1986 to improve the exchange of healthcare information through the use of technology, to encourage the creation, use and maintenance of lifetime electronic health records that may contain health plan and debit card functionality in independent health record banks, to use such records to build a nationwide health information technology infrastructure, and to promote participation in health information exchange by consumers through tax incentives and for other purposes; to the Committee on Finance.

Mr. BROWNBACK. Mr. President, I rise today to introduce legislation that would address one of the most critical issues facing Americans today, that of rising health care costs. America's collective health care bill represents an increasing percentage of the GDP and, at the same time, mortality rates remain stubbornly high. It is apparent that the time has come for innovative health care solutions that will save money and save lives.

Today, I am introducing the Independent Health Record Bank Act of 2006, a market-driven approach that will save both money and lives by creating a self-sustaining National Health Information Network for doctors and patients. Rather than continuing to get by with a patchwork system of paper records that contributes to medical errors and high cost, this legislation creates a nationwide system of secure electronic health records. Under the Independent Health Record Bank Act, ownership of the record is truly independent and consumer-focused, as this type of bank provides the objective

service of sustaining individual electronic health records, much like the way financial institutions maintain assets. This consumer-driven approach will offer Americans portable and electronic health records over their lifetime at little to no cost, with specific, established measures for privacy and security.

We saw in the aftermath of Hurricane Katrina, when medical records and lab results were literally washed away, that the current system of paper records can prove to be cumbersome at best, and fatal at worst. Americans should have the ability to access their health records as easily as they access their bank accounts—through the use of a national IT network administered by cooperative, not-for-profit institutions. I urge my colleagues to support this effort through cosponsorship of this important legislation.

By Mr. SANTORUM:

S. 3455. A bill to establish a program to transfer surplus computers of Federal agencies to schools, nonprofit community-based educational organizations, and families of members of the Armed Forces who are deployed, and for other purposes; to the Committee on Homeland Security and Governmental Affairs.

Mr. SANTORUM. Mr. President, I rise today to introduce a bill which is intended to ensure that more surplus government computers are put to good use in our schools and by families of deployed service members.

Each year, it is becoming more and more evident that, especially for our youth, computer knowledge is essential for success. While many Americans have computers at home, there are still many Americans who do not have that easy access to computer technology. In addition, not all of our schools have or can afford up-to-date computer technology to aid their students in their learning. This bill is intended to bridge this gap.

It has been estimated that each week, the Federal Government disposes of 10,000 computers. Thanks in part to Executive Order 12999, which was issued in 1996, some of these computers are placed in schools that would otherwise not have access to this technology. The Executive order directs that federal agencies shall safeguard and identify potentially educationally useful federal equipment that is no longer needed or declared surplus. This equipment shall then be transferred directly or through the Government Services Administration Computers for Learning program to public and private schools and nonprofit organizations, including community-based educational organizations. Schools and nonprofits in enterprise communities or empowerment zones are prioritized in receiving these computers.

I have been pleased to be able to work through the related program in the Senate to place excess computers in several Pennsylvania schools where

they are being put to good use. Unfortunately, I have heard from those working in Pennsylvania to obtain such computers that not enough of them are getting through to schools. They are experiencing increased difficulty in maintaining the number and quality of computers they were previously able to get from the government for refurbishment and donation. In some cases, hard drives are being needlessly destroyed before they are turned over.

One of the problems that has prevented schools from getting and using these computers is that many times they are not able to be immediately put into use by the school. Schools may not have the technical ability or storage space to take computers directly from the government if they need maintenance before they can be placed into service. It has been estimated that if schools get the computers directly from the government, only 10 percent can be put into use. However, if they are first refurbished, 40 percent can be used.

The hope is that this legislation would result in federal agencies making more surplus computers available for schools by codifying the previous Executive order. The bill would also allow computers to go directly to nonprofits for refurbishing before going to the school, making it easier for more schools to participate in the program. Currently, a school has to take title to the computer and then can transfer it to a nonprofit refurbisher to be fixed up, an additional step for them. This bill would allow nonprofit organizations like Computers for Schools that can refurbish computers at low-cost to participate in the process, getting computers ready to use and sending them out to schools where they last three more years, enabling more children to learn and profit by them. To prevent the needless destruction of hard drives, the bill also references federal standards on how to completely and securely erase hard drives without destroying them.

Lastly, this bill includes language that would make it possible to distribute these computers to the families of deployed service men and women who do not have a computer in their homes so that they can stay in better touch with their family members while they are fighting for our country.

I believe this legislation is an important step to help ensure that surplus federal computers are put to good use by allowing more of our youth to have access to computers in school. I am hopeful that this legislation will be enacted into law.

By Mr. MENENDEZ:

S. 3456. A bill to ensure the implementation of the recommendations of the National Commission on Terrorist Attacks Upon the United States; to the Committee on Foreign Relations.

Mr. MENENDEZ. Mr. President, first, I congratulate my colleagues in the

House, Representatives SHAYS and MALONEY, for their hard work on this legislation and for introducing H.R. 5017, the companion legislation to the bill I am introducing today.

Almost 5 years ago, our country was attacked by terrorists on September 11, 2001. This attack on our cities, on our symbols, on our democracy, and on our way of life killed nearly 3,000 Americans and over 700 people from my home State of New Jersey. But this attack could not kill our determination to preserve our freedom, our values, and our democratic system.

Almost 2 years ago, the 9/11 Commission published their riveting account of what happened on that terrible day and made 41 unanimous and bipartisan recommendations to make our country safer from future terrorist attacks.

Six months ago, the 9/11 Public Discourse Project published a disturbing report card giving more F's than A's on the implementation of those 41 recommendations.

Today, I am introducing legislation to finally and fully implement the 41 bipartisan and unanimous recommendations of the 9/11 Commission. The former Chairman of the 9/11 Commission, Thomas Kean, and the former Vice Chairman, Lee Hamilton, endorsed this same legislation in the House, H.R. 5017 Shays-Maloney. In a letter, Mr. Kean and Mr. Hamilton said that the legislation "represents a comprehensive approach to carry out each of the recommendations of the Commission . . . [and] focuses on urgent unfinished business before the Nation . . ."

It is the responsibility of the Congress to carry out this urgent unfinished business. We certainly need this comprehensive legislation at a time when the disastrous Dubai Ports World deal made it clear that our ports are not safe and those who live and work near them are not secure; the Department of Homeland Security is increasing homeland security funding for small cities while cutting it to New York and Washington, DC; first responders still don't have the ability to communicate with each other during a disaster; nuclear weapons in the hands of a terrorist remain one of the greatest threats to our Nation, yet the 9/11 Public Discourse Project gave the administration a D on progress towards fixing this problem; and hundreds of Afghans have been killed in the recent violent resurgence of the Taliban.

Since immediately after September 11, many of us in Congress have been working to learn the hard lessons from those attacks so we can prepare for and prevent future terrorist acts. Shortly after the attacks, I introduced comprehensive homeland security legislation and served on the first ad-hoc Homeland Security Committee in the House.

I was a strong supporter of the creation of the 9/11 Commission and introduced a proposal on the House floor to fully implement the 9/11 Commission

recommendation in 2004 during the initial debate on the recommendations. I then served as a House negotiator on and helped secure passage of the final landmark intelligence reform bill that was the first step in implementing the 9/11 Commission recommendations. Introducing this legislation today is the next important step in protecting our country against terrorism. I certainly agree with the former heads of the 9/11 Commission that passing this bill should be a top priority for this Congress.

I think all of us were shocked last week when the Department of Homeland Security actually slashed overall homeland security grant funding for New York, Washington, DC, and New Jersey, while increasing funding for much smaller areas with fewer terrorist targets.

DHS slashed these funds in spite of the 9/11 Commission recommendation which said that "Homeland Security assistance should be based strictly—strictly—on an assessment of risks and vulnerabilities."

And that is exactly what I fought for when I introduced the Menendez substitute to the intelligence reform bill in 2004. That is exactly what I fought for in the conference report on that legislation and what I sought to accomplish in the House when I introduced the Risk-Based Homeland Security Funding Act with Senators Corzine and LAUTENBERG. And that is exactly what the legislation I am introducing today would do.

As many of you know, New Jersey faces unique terrorism threats that require a greater portion of homeland security aid due to its proximity to New York City and to its vast number of potential targets of terror, such as the largest container seaport on the east coast, one of the busiest airports in the country, an area known as the "chemical coastway," our four nuclear power plants, and the six tunnels and bridges that connect New Jersey to New York City.

And if that were not enough, the Federal Bureau of Investigation has placed more than a dozen New Jersey sites on the National Critical Infrastructure List and has called the area in my former congressional district between Port Elizabeth and Newark International Airport the "most dangerous two miles in the United States when it comes to terrorism." An article in The New York Times pointed out that this 2-mile area provides "a convenient way to cripple the economy by disrupting major portions of the country's rail lines, oil storage tanks and refineries, pipelines, air traffic, communications networks and highway system."

The bottom line is that States and municipalities, like New Jersey, which are under the greatest risk should receive homeland security dollars based solely on that risk. The funding awarded to Newark and Jersey City clearly proves that New Jersey is well served when Federal homeland security dollars are awarded based on risk. Yet I

cannot understand why the Department of Homeland Security would not use a risk-based formula when awarding all of their grants. So long as Homeland Security grants are awarded based on factors other than risk, those States most at risk will continue to lack the necessary resources to protect the people they serve.

I know that many Americans would also be shocked to learn that almost 5 years after 9/11 and almost 1 year after Hurricane Katrina, many first responders still cannot communicate with each other during a disaster.

In fact, when I speak to firefighters in my home State of New Jersey, they consistently tell me that this remains a serious impediment to their work. In our port in New Jersey, the largest container port in the east coast, firefighters, Coast Guard, police, and other law enforcement officials often still cannot communicate with each other. When Hurricane Katrina hit, emergency personnel were on at least five different channels and were hampered in communicating with one another. As the Washington Post reported on September 2, 2005, "Police officers and National Guard members, along with law officers imported from around the State, rarely knew more than what they could see with their own eyes."

It is astonishing that our firefighters, police, and paramedics still do not have the ability to communicate in an emergency. How is it possible that almost 5 years after September 11, our local first responders still do not have interoperable communications systems that can talk with each other as they carry out their lifesaving work?

That is why my legislation would provide adequate radio spectrum for first responders and a status report on creating a unified incident command system during disasters.

In its final report card, the 9/11 Public Discourse Project gave the administration a D for its efforts to secure WMDs. The former Commissioners then recommended that the U.S. Government make this issue the top national security priority to counter what it called "the greatest threat to America's security."

I certainly believe that a nuclear weapon in the hands of a terrorist is one of the greatest threats to our national security. Osama Bin Laden himself has said that it is al-Qaida's "religious duty" to acquire weapons of mass destruction.

According to CNN, in January 2002, documents found in a house in Kabul, Afghanistan, reportedly used by al-Qaida operatives included a 25-page document filled with information about nuclear weapons. That document included a design for a nuclear weapon that would require hard-to-obtain materials like plutonium to create a nuclear explosion.

One document appeared to be plans to create a nuclear device. Although experts contended that the design in this document labeled "superbombs" is

unworkable, the author, noted CNN, was clearly knowledgeable of various ways to set off a nuclear bomb.

In combination with the discovery of AQ Khan's clandestine nuclear super-market, the potential of al-Qaida building a nuclear weapon is not a fairytale. In fact, according to CNN, al-Qaida may have had some help in its efforts to develop a nuclear device from two Pakistani nuclear scientists.

This bill works to ensure that the fairytale does not become a cataclysmic reality.

The bill specifically implements the 9/11 Commission's recommendation to expand programs to stop shipments of weapons of mass destruction. With this legislation, the United States would also be able to extend our assistance to help countries control, protect, and dismantle their nuclear programs to countries outside of the former Soviet Union. It would also create an Office of Nonproliferation Programs in the Executive Office of the President to prevent terrorist access to WMDs. Finally, the bill includes a provision to enhance the Global Threat Reduction Initiative and would require the President to establish a Department of Energy task force on nuclear materials removal.

I believe we all want to make sure that a nuclearized al-Qaida never becomes a reality. And we should spare absolutely no effort in pursuing this goal.

Many of us have been horrified as we have watched the resurgence of the Taliban and strong anti-American sentiment in Afghanistan. Over just the past few weeks, over 250 people have been killed in the upsurge in violence, and we see techniques borrowed from Iraq, like the use of improvised explosive devices, in Afghanistan. According to the New York Times, Pentagon officials say that 32 suicide bombs were exploded in 2006, which is already 6 more than exploded in all of 2005. Roadside bombs are up 30 percent over last year, and the Taliban are fighting in groups triple the size of last year. And after a deadly traffic accident involving the U.S. military, an anti-American riot exploded in Kabul last week.

The 9/11 Commission made it clear in their recommendations that Afghanistan must be a priority stating that the "United States and the international community should make a long-term commitment to a secure and stable Afghanistan to improve life and make sure it is not a terrorist sanctuary." Unfortunately, we are clearly a long way from achieving that goal.

The administration never finished the job in Afghanistan, the birthplace of the Taliban, the home to al-Qaida, the land of Osama bin Laden, and the place where the attacks of 9/11 were planned.

That is why this legislation is an important step to help us move in the right direction in Afghanistan. My bill urges a new commitment to a long-term economic plan to ensure Afghanistan's stability as well as a report on

progress towards achieving the goals in the Afghanistan Freedom Support Act.

This bipartisan, bicameral legislation is the next step to finally implementing all of the 41 recommendations of the 9/11 Commission. Their report was a call to action. Their report card was a reminder of what still needed to be done. Their work cannot be left unfinished.

We must all heed advice of the 9/11 Commission and learn from the hard lessons of 9/11. We cannot wait any longer to take action, and I urge my colleagues to join me in supporting this legislation.

By Mrs. BOXER:

S.J. Res. 39. A joint resolution to spur a political solution in Iraq and encourage the people of Iraq to provide for their own security through the redeployment of the United States military forces; to the Committee on Foreign Relations.

Mrs. BOXER. Mr. President, I rise today to introduce a resolution to spur a political solution in Iraq and encourage the people of Iraq to provide for their own security through the redeployment of U.S. military forces.

I introduce this resolution with the hope and prayer that we will redeploy U.S. troops from Iraq and end this ill-fated war that has resulted in more than 20,000 U.S. troops killed or wounded.

This resolution speaks for itself. I ask unanimous consent that it be printed in the RECORD.

There being no objection, the text of the joint resolution was ordered to be printed in the RECORD, as follows:

S.J. RES. 39

Whereas the United States military forces have served bravely in Iraq and deserve the heartfelt support of the United States;

Whereas more than 2,450 members of the United States military forces have been killed and more than 18,000 wounded in support of military operations in Iraq;

Whereas more than 200 coalition personnel have been killed in support of military operations in Iraq;

Whereas it is estimated that at least 40,000 people of Iraq have been killed during the military intervention in Iraq;

Whereas much of the intelligence used by the Bush Administration to justify the use of force in Iraq was either exaggerated or simply wrong;

Whereas President George W. Bush stated that the mission in Iraq was to rid that country of weapons of mass destruction;

Whereas weapons of mass destruction have not been found in Iraq;

Whereas President George W. Bush then stated that the mission in Iraq was to end the regime of Saddam Hussein and free the people of Iraq;

Whereas Saddam Hussein is in custody and standing trial for crimes against humanity;

Whereas President George W. Bush then stated that the mission in Iraq was to establish a free, self governing, and democratic Iraq;

Whereas the people of Iraq elected their first permanent democratically elected government on December 15, 2005, and the cabinet of Prime Minister Nouri al-Maliki has been approved by the Parliament of Iraq, concluding the transition of Iraq to full political sovereignty;

Whereas President George W. Bush then stated that the mission in Iraq was to train the security forces of Iraq so that they can do the fighting in Iraq;

Whereas the Pentagon reports that more than 240,000 military and police personnel of Iraq are now trained and equipped;

Whereas on May 1, 2003, President George W. Bush stood under a banner proclaiming "Mission Accomplished" and declared that Iraq was an ally of al Qaeda;

Whereas the report of the 9/11 Commission found no collaborative operational relationship between Iraq and al Qaeda;

Whereas the commander of the Multi-national Forces Iraq, General George Casey, testified before the Senate Committee on Armed Services on September 29, 2005, that "[i]ncreased coalition presence feeds the notion of occupation . . . contributes to the dependency of Iraqi security forces on the coalition . . . [and] extends the amount of time that it will take for Iraqi security forces to become self reliant"; and

Whereas, according to a January 2006 poll, 64 percent of Iraqis believe that crime and violent attacks will decrease when the United States redeploys from Iraq, 67 percent of Iraqis believe that their day-to-day security will increase if the United States redeploys from Iraq, and 73 percent of Iraqis believe that there will be greater cooperation among the political factions of Iraq when the United States redeploys from Iraq: Now, therefore, be it

*Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That—*

(1) United States military forces in Iraq are to be redeployed from Iraq by December 31, 2006, or earlier if practicable;

(2) nothing in this resolution prohibits the use of United States military forces from training Iraqi security forces in the region outside of Iraq; and

(3) nothing in this resolution prohibits the use of United States military forces based outside of Iraq to—

(A) conduct targeted and specialized counter-terrorism missions in Iraq; and

(B) protect military and civilian personnel of the United States in Iraq.

#### SUBMITTED RESOLUTIONS

#### SENATE RESOLUTION 500—EX-PRESSING THE SENSE OF CONGRESS THAT THE RUSSIAN FEDERATION SHOULD FULLY PROTECT THE FREEDOMS OF ALL RELIGIOUS COMMUNITIES WITHOUT DISTINCTION, WHETHER REGISTERED OR UNREGISTERED, AS STIPULATED BY THE RUSSIAN CONSTITUTION AND INTERNATIONAL STANDARDS

Mr. BROWNBACK (for himself, Mr. BIDEN, Mr. SMITH, and Mr. NELSON of Florida) submitted the following resolution; which was referred to the Committee on Foreign Relations:

Mr. BROWNBACK. Mr. President, I rise today to introduce a resolution whereby the Senate calls upon the Government of the Russian Federation to fully protect the right of individuals to worship and to practice their faith as they see fit. This resolution reiterates provisions on religious freedom that are contained within the Russian Constitution of 1993 and international agreements to which the Russian Federation is a party.

I am especially appreciative for the co-sponsorship of this important resolution by my colleagues and friends, the senior Senator from Delaware, Mr. BIDEN, the junior Senator from Oregon, Mr. SMITH, and the senior Senator from Florida, Mr. NELSON.

It is true that religious practice in Russia today is much freer than during the Soviet era. However, many minority religious communities throughout the Russian Federation continue to suffer harassment and discrimination on the part of some local officials who, either through personal prejudice or misplaced paranoia, see a threat to their society by religious faiths with whom they are unfamiliar.

Until fairly recently, the U.S. Helsinki Commission, which I chair, was receiving troubling reports of several instances of violence against religious minorities in Russia. Arson attacks against churches in Russia have occurred in several towns and cities with little or no police response. I would note that reports of such attacks have decreased in number of late.

I would like to quote from the International Religious Freedom Report for 2005, which is published by the State Department Office on International Religions Freedom annually:

Some Federal agencies and many local authorities continue to restrict the rights of various religious minorities. Moreover, contradictions between Federal and local laws and varying interpretations of the law provide regional officials with opportunities to restrict the activities of religious minorities. Many observers attribute discriminatory practices at the local level to the greater susceptibility of local governments than the Federal Government to discriminatory attitudes in lobbying by local majority religious groups. The government only occasionally intervenes to prevent or reverse discrimination at the local level.

Mr. President, on April 14, 2005, the Helsinki Commission held hearings on the treatment of religious minorities in Russia. Mr. Larry Uzzell, a journalist and researcher specializing in religious liberty issues, noted that Russian bureaucrats had increased the pressure on minority religious confessions, especially by denying them places to worship.

In March 2004, a city court banned the religious activity of Jehovah's Witnesses in Moscow. Since that time, officials in St. Petersburg have been threatening to "liquidate" the Jehovah's Witnesses Administration Center in that city. If the administrative center were to cease to exist, the effect on local congregations could be devastating. Just this month, police in Ivanovo, Russia, reportedly broke up an evangelical event where Bibles were being distributed and detained three members. Catholic parishes in the cities of Sochi and Rostov-on-Don have also had difficulty with local officials in obtaining official permission to use their new church buildings.

Concerning anti-Semitism, on January 11 of this year a "skinhead" attacked worshipers with a knife and

wounded eight persons in the Moscow Headquarters and Synagogue of Agudas Chasidei Chabad of the Former Soviet Union. Thankfully, the Moscow City Court sentenced the attacker to 13 years in prison for attempted murder. However, a copycat attack that followed in Rostov-on-Don was not handled as well, with the perpetrator only being charged with "hooliganism" and given 5 days administrative detention. I urge Russian authorities to be more consistent with their response to these heinous crimes.

Another difficult situation is that of Muslim believers in Russia today, with officials often harassing communities practicing outside of government approved mosques. For instance, there are repeated and credible reports that police are arresting Russian Muslim citizens on charges of terrorism on the basis of fabricated evidence. Certainly Russia has a right to defend itself from terrorism, but I would urge authorities not to sow the seeds of further bitterness and violence through wholesale arrests and unjust trials.

Mr. President, I certainly don't want to suggest that all Russian officials are hostile to religious faith and practice. There are countries with worse far records, and there are many areas of the Russian Federation where the principles of religious freedom are genuinely observed and still others where progress is being made. Moreover, many officials at the federal level have made sincere efforts to see that their government observes its own laws as well as international standards.

This resolution reminds the leadership of the Russian Federation of the critical importance of enforcing Russian constitution and Russia's international commitments on religious freedom. Considering Russia's presidency of the G-8, a grouping of the world's major industrialized democracies, it is time to live up to the standards of religious liberty that characterize the nations of the G-8 and the community of democracies as a whole.

I urge my colleagues to support this resolution.

S. RES. 500

Whereas the Russian Federation is a participating State of the Organization for Security and Cooperation in Europe (OSCE) and has freely committed to fully respect the rights of individuals, whether alone or in community with others, to profess and practice religion or belief;

Whereas the 1989 Vienna Concluding Document calls on OSCE participating States to "take effective measures to prevent and eliminate discrimination against individuals or communities on the grounds of religion or belief" and to "grant upon their request to communities of believers, practicing or prepared to practice their faith within the constitutional framework of their States, recognition of the status provided for them in the respective countries";

Whereas Article 28 of the Constitution of the Russian Federation declares that "every-one shall be guaranteed the right to freedom of conscience, to freedom of religious worship, including the right to profess, individually or jointly with others, any religion"