DORGAN) was added as a cosponsor of amendment No. 1313 intended to be proposed to S. 1348, a bill to provide for comprehensive immigration reform and for other purposes.

AMENDMENT NO. 1314

At the request of Mr. GRAHAM, the names of the Senator from Colorado (Mr. SALAZAR), the Senator from California (Mrs. FEINSTEIN) and the Senator from Illinois (Mr. DURBIN) were added as cosponsors of amendment No. 1314 intended to be proposed to S. 1348, a bill to provide for comprehensive immigration reform and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mrs. FEINSTEIN (for herself, Ms. SNOWE, Mr. LEAHY, Mr. DURBIN, Mr. LAUTENBERG, Mrs. CLINTON, Mr. BROWN, Mr. KERRY, Mr. DODD, Mrs. MURRAY, Mr. FEINGOLD, and Mrs. BOXER):

S. 1553. A bill to provide additional assistance to combat HIV/AIDS among young people, and for other purposes; to the Committee on Foreign Relations.

Mrs. FEINSTEIN. Mr. President, I rise today with Senator SNOWE to introduce legislation to strengthen our international HIV prevention efforts and empower the people on the ground who are fighting this disease to design the most effective and appropriate HIV prevention program.

The bill is cosponsored by Senator LEAHY, Senator DURBIN, Senator CLINTON, Senator LAUTENBERG, Senator BROWN, Senator KERRY, Senator BOXER, Senator DODD, Senator MURRAY, and Senator FEINGOLD.

This bill simply strikes the provision in the United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003 that mandates that at least 33 percent of HIV prevention funding in the President's Emergency Plan for AIDS Relief, PEPFAR, be set aside ''abstinence-until-marriage'' programs.

Let me be clear from the beginning: this bill does not prohibit the administration from funding ''abstinence-until-marriage'' programs.

In fact, if the bill becomes law, the administration would still be able to spend all of our HIV prevention funding on abstinence-until-marriage programs if it decided do so.

This bill is about giving the administration and HIV/AIDS workers the flexibility to design the most effective HIV prevention program without having to worry about artificial earmarks that are based on politics, not science.

Indeed, in the fight against the HIV/AIDS pandemic, we cannot afford to tie ourselves down with undue restrictions.

Worldwide, 40 million people are infected with HIV. Each day, approximately 12,000 people are newly infected with HIV. In 2006, there were 4.3 million new HIV infections around the world, 2.8 million in sub-Saharan Africa alone. Sub-Saharan Africa is home to almost two-thirds of the estimated 40 million people currently living with HIV.

Across sub-Saharan Africa, the prevalence rate for the adult population is 6 percent. Mr. President, 2.1 million adults and children died of AIDS in 2005.

Despite these devastating numbers, according to UNAIDS, less than one in five people at risk for infection of HIV have access to basic prevention services. Studies have shown that two-thirds of new HIV infections could be averted with effective prevention programs.

Clearly, we still have a long ways to go to rein in this disease.

The 2003 HIV/AIDS legislation recognized that prevention, along with care and treatment, is an essential component of that fight and demands a multipronged approach. It endorsed the ''ABC'' model for prevention of the sexual transmission of HIV: abstain, be faithful, use condoms.

Yet instead of allowing HIV/AIDS workers and doctors the ability to use all of the prevention tools at their disposal to respond to local needs, we required them to spend at least 33 percent on ''abstinence-until marriage'' programs.

The question has to been asked: Why 33 percent? Why not 15 percent? Why not 50 percent? What scientific study concluded that 33 percent of HIV prevention funds for abstinence only programs was appropriate?

There was no study and it begs the question: when you are fighting a pandemic that has already cost so many lives, who should decide how to allocate funding among different types of HIV prevention programs, Congress or the people with the knowledge and expertise on how to fight this disease?

I support abstinence programs as a critical part of our HIV prevention programs. But mandating an earmark has negative consequences for other effective tools.

It means less money for funds to prevent mother-to-child transmission, less money to promote a comprehensive prevention message to high risk groups such as sexually active youth, and fewer funds to protect the blood supply.

Indeed, the evidence clearly shows that the one-third earmark has inhibited the ability of local communities to design a multipronged HIV prevention program that works best for them.

Last year, the Government Accountability Office issued a report that found ''significant challenges'' associated with meeting the abstinence-until-marriage programs. The report concluded that the 33 percent abstinence spending requirement is squeezing out available funding for other key HIV prevention programs such as mother-to-child transmission and maintaining a health blood supply.

Country teams that are not exempted from the one-third earmark have to spend more than 33 percent of prevention funds on abstinence-until-marriage activities, sometimes at the expense of other programs, in order for the administration to meet the overall 33 percent earmark.

The spending requirement limited or reduced funding for programs directed to high-risk groups, such as sexually active youth and the majority of country teams on the ground reported that meeting the spending requirement ''challenges their ability to develop interventions that are responsive to local epidemiology and social norms.''

Last month, a congressionally mandated review by the Institute of Medicine on the first 3 years of the President's Emergency Plan for AIDS Relief also found significant problems with the abstinence earmark. It concluded: there is no evidence to support a 33 percent abstinence only earmark; the 33 percent earmark does not allow country teams on the ground the flexibility they need to respond to local needs.

Our bill seeks to address the problems highlighted in the GAO and the Institute of Medicine reports and provide local communities the necessary flexibility to achieve the goal we all share: stopping the spread of HIV, especially among young people.

Simply put, our bill balances congressional priorities with public health needs. Under our legislation, country teams can take into account country needs including cultural differences, epidemiology, population age groups and the stage of the epidemic in designing the most effective prevention program.

One size does not fit all. A prevention program in one country may look a lot different than a prevention program in another country.

A May 2003 report from the Bill and Melinda Gates Foundation and Henry J. Kaiser Foundation highlights that proven prevention programs include behavior change programs, including delay in the initiation of sexual activity, faithfulness and correct and consistent condom use; testing and treatment for sexually transmitted diseases; promoting voluntary counseling and testing; harm reduction programs for IV drug users; preventing the transmission of HIV from mother to child; increasing blood safety; empowering women and girls; controlling infection in health care settings; and devising programs geared towards people living with HIV.

For example, studies have shown that combining drugs with counseling and instruction on use of such drugs reduces mother-to-child transmission by 50 percent.

Such cost effective programs are not related to abstinence and should not be constrained by the 33 percent earmark on funds for prevention.

I understand the importance of teaching abstinence. It is and will remain a key part of our strategy in preventing the spread of HIV.

But let us listen to the words of someone with firsthand experience about the challenges sub-Saharan African countries face in combating HIV/AIDS and the constraints the ''abstinence-until-marriage'' earmark places on those efforts.

In an August 19, 2005, op-ed in the New York Times, Babatunde Osotimehin, chairman of the National Action Committee on AIDS in Nigeria, wrote:

Abstinence is one critical prevention strategy, but it cannot be the only one. Focusing on abstinence assumes young people can choose whether to have sex. For adolescent girls in Nigeria and in many other countries, this is an inaccurate assumption. Many girls fall prey to sexual violence and coercion. . . . When dealing with AIDS, we must address the realities and use a multipronged approach to improving education and health systems, one that can reach all of our people.

He concludes:

National governments must have the freedom to employ the very best strategies at our disposal to help our people.

I could not agree more.

If we want to help the girls of Nigeria and the youth of sub-Saharan Africa, we cannot limit the information they receive about keeping them safe from acquiring HIV.

We do not have time to lose. I urge my colleagues to support this legislation and support a pro-abstinence, multipronged approach to preventing the spread of HIV.

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. 1553

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''HIV Prevention Act of 2007''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) The President's Emergency Plan for AIDS Relief (in this Act referred to as ''PEPFAR'') is an unprecedented effort to combat the global AIDS epidemic, with $9,000,000,000 targeted for initiatives in 15 focus countries.

(2) The PEPFAR prevention goal is to avert 7,000,000 HIV infections in the 15 focus countries—most in sub-Saharan Africa, where heterosexual intercourse is by far the predominant mode of HIV transmission.

(3) According to the Joint United Nations Programme on HIV/AIDS, young people between the ages of 15 and 24 years old are ''the most threatened by AIDS'' and ''are at the centre of HIV vulnerability''. Globally, young people between the ages of 10 and 24 years old account for ½ of all new HIV cases each year. About 7,000 young people in this cohort contract the virus every day.

(4) A recent review funded by the United States Agency for International Development found that sex and HIV education programs that encourage abstinence but also discuss the use of condoms do not increase sexual activity as critics of sex education have long alleged. Sex education can help delay the initiation of intercourse, reduce the frequency of sex and the number of sexual partners, and also increase condom use.

(5) The United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7601 et seq.) requires that at least ⅓ of all prevention funds be reserved for abstinence-until-marriage programs.

(6) A congressionally mandated review by the Institute of Medicine of the first 3 years of PEPFAR unequivocally recommends greater flexibility in the global fight against AIDS. The March 2007 Institute of Medicine report entitled ''PEPFAR Implementation: Progress and Promise'' calls for greater emphasis on prevention than the law currently allows and says that ''removal of the abstinence-until-marriage'' earmark, among other changes, ''could enhance the quality, accountability, and flexibility'' of prevention efforts.

(7) The Institute of Medicine report further found that the abstinence-until-marriage earmark ''has greatly limited the ability of Country Teams to develop and implement comprehensive prevention programs that are well integrated with each other and with counseling and testing, care and treatment programs and that target those populations at greatest risk''.

(8) The Institute of Medicine report also found that the earmark has ''limited PEPFAR's ability to tailor its activities in each country to the local epidemic and to coordinate with . . . the countries' national plans''.

(9) The Institute of Medicine report is in keeping with the conclusions of a report issued in 2006 by the Government Accountability Office. The GAO report, entitled ''Spending Requirement Presents Challenges for Allocating Funding under the President's Emergency Plan for AIDS Relief '', found ''significant challenges'' associated with meeting the earmark for abstinence-until-marriage programs.

(10) The Government Accountability Office found that a majority of country teams report that fulfilling the requirement presents challenges to their ability to respond to local epidemiology and cultural and social norms.

(11) The Government Accountability Office found that, although some country teams may be exempted from the abstinence-until-marriage spending requirement, country teams that are not exempted have to spend more than the 33 percent of prevention funds on abstinence-until-marriage activities—sometimes at the expense of other programs.

(12) The Government Accountability Office found that, as a result of the abstinence-until-marriage spending requirement, some countries have had to reduce planned funding for Prevention of Mother-to-Child Transmission programs, thereby limiting services for pregnant women and their children.

(13) The Government Accountability Office found that the abstinence-until-marriage spending requirement limited or reduced funding for programs directed to high-risk groups, such as services for married discordant couples, sexually active youth, and commercial sex workers.

(14) The Government Accountability Office found that the abstinence-until-marriage spending requirement made it difficult for countries to fund medical and blood safety activities.

(15) The Government Accountability Office found that, because of the abstinence-until-marriage spending requirement, some countries would likely have to reduce funding for condom procurement and condom social marketing.

(16) In addition, the Government Accountability Office found that ⅔ of focus country teams reported that the policy for implementing PEPFAR's ABC model (defined as ''Abstain, Be faithful, use Condoms'') is unclear and open to varying interpretations, causing confusion about which groups may be targeted and whether youth may receive the ABC message.

(17) The Government Accountability Office found that the ABC guidance does not clearly delineate permissible ''C'' activities under the ABC model. Program staff reported that they feel ''constrained'' by restrictions on promoting or marketing condoms to youth. Other country teams reported confusion about whether PEPFAR funds may be used for broad condom social marketing, even to adults in a generalized epidemic.

(18) Young people are our greatest hope for changing the course of the AIDS epidemic. According to the World Health Organization, ''[f]ocusing on young people is likely to be the most effective approach to confronting the epidemic, particularly in high prevalence countries''.

SEC. 3. ENSURING BALANCED FUNDING FOR HIV PREVENTION METHODS.

(a) SENSE OF CONGRESS ON ABSTINENCE-UNTIL-MARRIAGE FUNDING REQUIREMENT.—Section 402(b)(3) of the United States Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (22 U.S.C. 7672(b)(3)) is amended by striking '', of which such amount at least 33 percent should be expended for abstinence-until-marriage programs''.

(b) ELIMINATION OF ABSTINENCE-UNTIL-MARRIAGE FUNDING REQUIREMENT.—Section 403(a) of such Act (22 U.S.C. 7673(a)) is amended by striking the second sentence.

By Ms. COLLINS (for herself and Mr. LIEBERMAN):

S. 1554. A bill to comprehensively address challenges relating to energy independence, air pollution, and climate change facing the United States; to the Committee on Finance.

Ms. COLLINS. Mr. President, I rise today to introduce the Energy Independence, Clean Air, and Climate Security Act of 2007. This legislation takes an integrated approach that is much needed and long overdue if we are to address effectively three intertwined issues of crucial importance to our Nation's economy and security and to the health of our people and our planet. I am very pleased to be joined on this legislation by Senator LIEBERMAN, a true leader on energy, climate change, and environmental issues.

The majority leader has announced the Senate may well take up a broad package of energy legislation next week. The bill I am introducing today lays out my own vision of how our Nation can best address its energy problems.

If Mark Twain were with us today, it is not hard to imagine he would rephrase his famous quip about the weather to something along the lines of: Everyone talks about climate change and energy independence, but nobody does anything about it.

Since the actions we take to reduce our dependence on foreign oil, to clean our air, and to reduce our contribution to climate change all affect each other, it is necessary we develop a comprehensive strategy for all three of these challenges.

Indeed, since the oil embargo of 1973, through 17 Congresses and 7 different Presidents, energy efficiency and energy independence have generated a lot

of talk, some pretty good ideas, and a lot of promises but not enough concerted, determined, coordinated action. During these 34 years, our Nation's imports of foreign oil have soared from less than 35 percent to more than 60 percent, leaving us dangerously reliant on unstable regions of the world in order to fuel our Nation and our economy.

In addition to our increased reliance on foreign oil, we are also consuming more and more electricity. As demand puts increasing pressure on supply, electricity prices have soared. In the summer, when air-conditioners struggle to keep up with rising temperatures, we run the risk of blackouts, brownouts, and price spikes.

At the same time, our greenhouse gas emissions have soared, leading to virtually indisputable evidence that human activity is contributing to climate change. In the United States, emissions of the primary greenhouse gas, carbon dioxide, have risen more than 20 percent since 1990. Globally, carbon dioxide concentrations in the atmosphere now far exceed the natural range over the last 650,000 years. We know this from scientific analyses of ice cores and other evidence.

According to the Intergovernmental Panel on Climate Change, the increase in greenhouse gas emissions has already increased global temperatures and has likely contributed to more extreme weather events, such as droughts and floods. These emissions will continue to change the climate, causing warming in most regions and likely causing more floods, droughts, and an increase in the intensity of hurricanes.

Climate change is not the only environmental problem caused by fossil fuel use. The quality of our air also suffers. Although we have made some important strides in improving air quality since the 1970s, we have not done enough. Fossil fuel use is the primary cause of mercury pollution, smog, and acid rain that continue to plague our Nation. Indeed, air pollution causes thousands of asthma attacks and costs many lives annually.

The time has come to address our air quality, climate change, high energy prices, and dangerous reliance on foreign oil. The legislation I am introducing today is, I believe, the first Senate bill that would address all these problems in a single, integrated approach. There have been many bills introduced that address one of these problems. This is an attempt to have a comprehensive approach and to recognize that each of these problems affects the other.

My legislation focuses primarily on two sectors of the economy: electricity and transportation. Together, these two sectors account for 73 percent of carbon dioxide emissions. Electricity generation accounts for more than 40 percent of our carbon dioxide emissions. More than 80 percent of these emissions are attributable to coal-fired powerplants. Coal-fired powerplants are also the single largest source of mercury pollution, smog, and acid rain. Between 1990 and 2004, emissions from these sectors increased by 27 percent.

My legislation requires utilities to reduce carbon dioxide emissions to 1990 levels by the year 2020, while also addressing the emissions that cause smog, acid rain, and mercury pollution. It includes a renewable portfolio standard which would help to diversify our electricity supplies and energy efficiency resource standards that the Alliance to Save Energy estimates would save consumers, over time, billions of dollars on their electricity bills.

The transportation sector, which relies almost entirely on oil, is not only partly responsible for our dangerous reliance on foreign oil but also accounts for 33 percent of carbon dioxide emissions. My legislation would help to reduce emissions from this sector through a combination of provisions such as CAFE standards for automobiles and heavy-duty trucks, tax incentives for consumers to encourage them to purchase hybrid and alternative fueled vehicles, incentives for manufacturers to produce the next generation of energy-efficient vehicles, and a low carbon fuel standard that will help to replace some gasoline with biofuels. Taken together, these provisions will substantially reduce our reliance on foreign oil, while reducing greenhouse gas emissions by hundreds of millions of tons.

I wish to make clear the choice is not between hobbling our Nation's economy and protecting our environment. This legislation is based on the principle that research, development, and implementation of new approaches to energy independence and environmental stewardship will provide a powerful new stimulus for our economy. All too often, we are confronted with proposals to address one issue that only aggravate another problem. The integrated approach I am proposing will help us break through that impasse.

This legislation does not attempt to reinvent the wheel. In fact, it incorporates several good ideas from my colleagues that have been introduced as separate bills, many of which I have cosponsored, such as the Ten-in-Ten and other CAFE bills, the DRIVE Act, and the Clean Power Act. It includes provisions of legislation I have introduced to address abrupt climate change and to eliminate certain tax credits for the oil industry. It contains many of the excellent energy efficiency provisions in the Energy for Our Future Act introduced by Representative CHRIS SHAYS in the House.

My bill is also complementary with the McCain-Lieberman Climate Stewardship and Innovation Act. We need to pass that bill in order to establish a nationwide cap and trade program for addressing climate change. However, the regulations to implement that could take many years. The legislation I am proposing today will help us take some early action to help achieve the targets in the McCain-Lieberman bill.

I believe the first step toward energy independence is to make better, more efficient use of our current energy supplies. The first title of this bill tackles that issue on several fronts.

It would implement the ''Ten-in-Ten'' legislation I have co-sponsored with Senators FEINSTEIN and SNOWE to increase fuel economy standards to 35 miles per gallon by 2016. It would then go a step further and increase CAFE standards to 45 miles per gallon by 2025. This provision would save approximately 2.5 million barrels of oil per day.

It would help consumers buy more fuel-efficient cars by repealing the phase-out of the tax credit for hybrid vehicles, which is scheduled to sunset at the end of 2009. It would also require light trucks that use diesel fuel to meet more stringent EPA emission standards in order to qualify for the lean-burn credit.

Public transportation is one of the most effective ways we can get more passenger miles per gallon. This legislation would promote the development and use of public transportation by subsidizing fares, encouraging employers to assist their employees with fares, and authorizing funding to build energy-efficient and environmentally friendly modes of transport, such as clean buses and light rail.

It would direct the Department of Transportation to designate 20 Transit-Oriented Development Corridors in urban areas by 2015, and 50 by 2025. These TOD Corridors would be developed with the aid of grants to state and local governments to construct or improve facilities for motorized transit, bicycles, and pedestrians. These provisions would be funded by an authorization of $500 million per year from 2007 through 2016.

We must do more to encourage the development and manufacture of energy-efficient vehicles. This legislation would create a 20-percent investment tax credit for automobile manufacturers, and a fuel economy achievement credit for manufacturers that have a combined fleet fuel economy that exceeds that of their 2005 model year. This credit would begin at 5 percent next year and rise to 50 percent in 2015.

And we must do more to help existing vehicles be as energy efficient as possible. This legislation would direct the DOT to create a National Tire Fuel Efficiency Program that would include tire testing and labeling, energy-efficient tire promotions through incentives and information, and the creation of minimum fuel economy standards for tires. These standards would establish the maximum technically feasible and cost-effective fuel savings without adversely affecting tire safety or average tire life.

Heavy-duty vehicles move our economy. This legislation would keep them on the move while helping to reduce both fuel consumption and emissions.

It would require DOT to develop a testing and assessment program to determine what is feasible to improve the efficiency of heavy vehicles, and then to develop the appropriate fuel-economy standards. It also would provide a tax credit of up to $3,500 for the purchase of idling reduction technology for heavy vehicles.

In order for the Federal Government to lead by example, this legislation would require the Secretary of Energy to issue regulations for federal fleets covered by the Energy Policy Act of 1992 to reduce petroleum consumption by 30 percent from a 1999 baseline by 2016.

Title II of my legislation focuses on increasing our energy independence and reducing our emissions from the transportation sector through the use of alternative fuels.

Renewable fuels offer great potential to help us achieve greater energy independence. This legislation would help us realize that potential by establishing a clean, renewable fuels performance standard. The performance standard would require fuel providers to increase the volume of clean, low-carbon, renewable fuels by up to 35 billion gallons by 2025, unless EPA finds that the increase is technically infeasible or is likely to result in adverse impacts.

This legislation would expand existing tax credits for ethanol to include cellulosic biomass. While there has been a great deal of focus on using corn-based ethanol in order to decrease our reliance upon foreign oil, there are other renewable, plant-based energy sources that are more environmentally friendly and have greater potential to reduce greenhouse gas emissions.

Researchers at the University of Maine have been at the forefront of applying a research technique known as ''Life Cycle Analysis.'' Life Cycle Analysis is a unique interdisciplinary research tool that analyzes the energy requirements and environmental footprint involved with the manufacture, use, and disposal of a material. This technique is ideal for identifying fuels which have the lowest environmental impact and the greatest potential for reducing greenhouse gas emissions, while reducing our dependence on foreign oil.

My legislation would authorize $275 million over five years for research that would use Life Cycle Analysis in order to identify and develop new biotechnologies. These technologies will help move our petroleum-based economy toward a renewable, sustainable forest bio-economy.

Environmental stewardship must go beyond the tailpipes of our vehicles to the smokestacks of our power plants. Title III of my legislation builds upon the Clean Power Act that I introduced in the last Congress with Senators JEFFORDS and LIEBERMAN. I have, however, modified this provision to provide assistance to small businesses struggling with high electricity costs. I have also included increased funding for important conservation programs such as Forest Legacy, in order to help wildlife adapt to the impacts of climate change.

This legislation would cut all four major power plant pollutants over the next six years. Sulfur dioxide and nitrogen oxides, which cause smog, acid rain, and asthma attacks, would be cut by 75 percent. Toxic mercury emissions would be cut by 90 percent from 1999 levels, and carbon dioxide, which forms the heat-trapping blanket that contributes to global warming, would be cut to 1990 levels.

These reductions would do more than provide long-term protection for our environment; they also would produce dramatic and immediate health gains for our people. According to the EPA, quick and decisive cuts in nitrogen and sulfur emissions from power plants would save 18,700 lives every year, avoid 366,000 asthma attacks, and prevent $100 billion in health care costs. In addition, these cuts would combat the acid rain that is spoiling some of our Nation's most treasured parks and wilderness areas.

The Centers for Disease Control has concluded that 4.9 million women of childbearing age have elevated levels of mercury, and that 322,000 newborns are at risk of neurological damage from mercury exposure. This provision preserves our national commitment to reduce toxic threats to pregnant women and to children by requiring meaningful reductions and by prohibiting trading.

The Clean Power Act incorporated into this legislation closes the grandfather loophole that exempts dirty, aging power plants from cleanup. Every power plant will be required to meet the most modern pollution control standards by either the plant's 40th year of operation or by the fifth year of the enactment of this legislation.

The Clean Power Act uses market mechanisms, such as buying and selling pollution allowances known as ''emissions trading.'' As I have already stated, under my bill, this trading will not be allowed for toxic mercury. Nor will it be allowed if it enables a power plant to pollute at a level that damages public health or the environment.

Power plants are the largest source of our Nation's contribution to global warming; as I stated earlier, they account for some 40 percent of our carbon dioxide emissions. This legislation would return carbon dioxide emissions to 1990 levels. By providing electricity producers with regulatory certainty now about future pollution-reduction requirements, this legislation would allow smarter investments and more cost-efficient planning.

As with existing motor vehicles, we must make more efficient use of the energy we now produce to heat our homes and power our lights. This legislation would double funding for the Department of Energy Weatherization Program, reaching $1.4 billion for 2008. It also would provide predictable funding for the valuable Energy Star Program, which helps consumers buy energy efficient appliances, and would extend the renewable electricity tax credit through 2011 and the residential investment tax credit for solar and energy efficient buildings through 2012.

This legislation also includes an Energy Efficiency Performance Standard for utilities. This provision requires utilities to achieve energy efficiency improvements. This provision would help consumers save on their electricity bills. By way of example, in California, where a similar provision was employed, utilities achieved energy savings at a cost of around 2–4 cents per kilowatt hour. According to the Alliance to Save Energy, an Energy Efficiency Performance Standard could save consumers $64 billion in net savings, and avoid the need to build 400 power plants, preventing 320 million metric tons of carbon dioxide emissions.

In addition, my legislation includes a renewable portfolio standard which would require utilities to generate 20 percent of their electricity from environmentally sound renewable energy sources by the year 2020. For example, biomass electricity generated under this provision must be done using sustainable forest practices.

This legislation will help Americans save on utility bills, and make our tax code fairer, too. Title V would eliminate two major tax credits that benefit large oil and gas companies: tax credits for intangible drilling costs and for excess percentage over cost depletions. This would save the taxpayers billions of dollars over the next five years.

This legislation also would help us better understand and assess climate change. During the last three years, I have had the opportunity to meet in the field with some of the world's foremost climate scientists. I have traveled to Ny-Alesund, Norway, the northernmost community in the world, where I saw the dramatic loss of sea-ice cover and the retreating Arctic glaciers. I have seen the same alarming changes in Alaska. Just a year ago, I went to the other end of the world and met with researchers—including a team from the University of Maine's outstanding Climate Change Institute—in Antarctica. These regions are the canary in the coal mine, and the changes taking place provide a warning we cannot ignore.

Nor can we forestall taking action by arguing over the precise extent of climate change and the human contribution to it. The answer to scientific uncertainty is additional research. Title VI of my legislation would authorize $60 million for abrupt climate change research. Studies suggest that the climate can change dramatically within a very short period of time. An abrupt climate change triggered by the ongoing buildup of greenhouse gases could cause catastrophic droughts and floods.

Understanding and predicting climate change are enormous scientific challenges. A great deal more scientific research is necessary in order to better understand the potential risk of abrupt climate change, and this legislation would provide the resources that are so urgently required.

There are few issues of greater concern to my constituents in my home state of Maine than our nation's ongoing and escalating reliance on foreign oil, and the damage our vehicle and power plant emissions are doing to the environment. They bear the brunt of wildly fluctuating and steadily increasing energy prices. They know the harm this dependence causes to our national security, and they know the harm our current energy usage causes to the air they breathe. And although a bone-chilling, winter nor'easter may bring a new round of jokes about the possible benefits of global warming, they know that human-caused climate change is no laughing matter. They know we must be better stewards of our planet.

I believe that all Americans—whether they live in the sunny south or a winter wonderland—share these concerns. They have heard enough talk; they want us to act. Americans deserve to breathe clean air, pay reasonable gasoline and electricity prices, live in a world with a stable climate future, and have the peace of mind that comes with secure energy supplies. The Energy Independence, Clean Air, and Climate Security Act offers a comprehensive, integrated approach to these issues.

In conclusion, let me describe the six titles very briefly.

The first title of my bill would increase energy independence and reduce greenhouse gas emissions by improving the efficiency of our transportation sector. The second title would accomplish similar goals by replacing some gasoline with alternative fuels. The third title would reduce emissions of mercury, carbon dioxide, sulfur dioxide, and nitrogen oxides from powerplants. The fourth title would help to reduce heat and electricity bills and diversify our electricity supply through a combination of energy efficiency and renewable energy provisions. The fifth title would help save taxpayers money through the elimination of certain tax breaks for the oil industry. Finally, the sixth title would authorize $60 million for abrupt climate change research to help us better understand this phenomenon.

I am particularly excited about renewable fuels. I think there is a lot we could do to expand the tax break for ethanol to include cellulosic biomass. There is very exciting research being done at the University of Maine which has been in the forefront of applying a research technique known as ''Life Cycle Analysis,'' which is a tool that analyzes the energy requirements and environmental footprint involved in the manufacture, use, and disposal of a material. It is ideal for identifying fuels which have the lowest environmental impact and the greatest potential for reducing greenhouse gas emissions while reducing our dependence on foreign oil. This technology will help us move our petroleum-based economy toward a renewable, sustainable, forest bioeconomy.

This is a complex bill. I appreciate the indulgence of my colleagues.

By Mr. DODD (for himself, Mr. ENSIGN, Mr. AKAKA, Ms. COLLLNS, Mr. MENENDEZ, Mr. COCHRAN, Mr. WHITEHOUSE, and Mr. CASEY):

S. 1557. A bill to amend part B of title IV of the Elementary and Secondary Education Act of 1965 to improve 21st Century Community Learning Centers; to the Committee on Health, Education, Labor, and Pensions.

Mr. DODD. Mr. President, I rise today, joined by my colleague Senator ENSIGN, to introduce the Improving 21st Century Community Learning Centers Act of 2007, which will provide children with safe, healthy, and academically focused afterschool programs. This bill is endorsed by the Afterschool Alliance, an organization representing more than 20,000 public, private, and nonprofit afterschool providers who are dedicated to expanding access to high quality afterschool programs, as well as many other national and local organizations.

More than 14 million children enrolled in kindergarten through 12th grade spend time unsupervised in the hours after school. Between the hours of 3 p.m. and 6 p.m., while parents are at work, kids are most likely to experiment with risky behaviors. To the contrary, students who regularly attend afterschool programs have better grades and behavior in school, better peer relations and emotional adjustment, and lower incidences of drug use, violence, and pregnancy. America's families rely on afterschool programs to give their children the opportunity to be engaged in high quality learning activities that will enhance their children's success in school and in life.

The Improving 21st Century Community Learning Centers Act of 2007 is designed to do three things: enhance program quality and sustainability, address the obesity epidemic by including physical fitness and wellness programs in the list of possible programming activities, and encourage service learning. First, our bill provides States with tools designed to sustain high quality afterschool programs by allowing program grantees to renew their grants based on their program performance. The legislation also gives States the option to expand their technical assistance functions to further improve the quality of afterschool programs.

Second, this bill will increase opportunities for children and young people to be more physically active. As obesity reaches epidemic proportions in our society, allowing for such opportunities is critical in ensuring our children's overall health. Obesity is among the easiest medical conditions to recognize, but among the most difficult to treat. The annual cost to society for obesity is estimated at nearly $100 billion. Physical activity and wellness programs are critical to our overall health and well-being.

Third, this bill encourages children to be involved in service learning and youth development activities. Service learning integrates student designed service projects with academic studies. This type of program has been shown to strengthen student engagement, enhance student achievement, lower drop out and suspension rates, develop workforce and leadership skills and provide opportunities for team work. The Improving 21st Century Community Learning Centers Act will help build the character and work ethic of our children and youth.

Finally, it is of paramount importance that we adequately fund our afterschool programs. Currently, afterschool programs have served, at most, only 1.4 million children. It is critical that we provide more opportunities for youth to be engaged in high quality afterschool programming.

The Improving 21st Century Community Learning Centers Act provides a critical first step toward ensuring the health, safety, and education of our Nation's children. I hope that my colleagues will join me in supporting this important legislation.

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. 1557

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''21st Century Community Learning Centers Act of 2007''.

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) More than 28,000,000 children in the United States have parents who work outside the home and 14,300,000 children in the United States are unsupervised after the school day ends.

(2) 6,500,000 children are in after school programs but an additional 15,300,000 would participate if such a program were available.

(3) After school programs inspire learning. In academic year 2003–2004, 45 percent of all 21st Century Community Learning Centers program participants had improved their reading grades, and 41 percent improved their mathematics grades.

(4) In academic year 2003-2004 teachers reported that a majority of students who participated in 21st Century Community Learning Centers programs demonstrated improved student behavior, particularly in the areas of academic performance, homework completion, and class participation.

(5) A growing body of research also suggests that children who participate in after school programs attend school more regularly, are more likely to stay in school, and are better prepared for college and careers.

(6) Benefits of after school programs extend beyond the classroom. Communities

with after school programs have reported reduced vandalism and juvenile crime.

(7) After school programs help working families. One study estimates that decreased worker productivity due to stress and absenteeism caused by issues related to after school care arrangements costs employers $496 to $1,984 per employee, per year, depending on the annual salary of the employee. The total cost to the business industry is estimated to be between $50,000,000,000 and $300,000,000,000 annually in lost job productivity.

(8) While students in the United States are falling behind in science, technology, engineering, and mathematics (STEM), more than 90 percent of after school programs funded by 21st Century Community Learning Centers offer STEM activities, providing more time for children and youth to gain skills and build interest in the STEM fields. Evaluations of after school programs offering STEM activities to students have found increases in the reading, writing, and science skills proficiency of these students. Children who participate in such programs show more interest in science careers, and are more likely to have engaged in science activities just for fun.

(9) Data from 73 after school studies indicate that after school programs employing evidence-based approaches to improving students' personal and social skills were consistently successful in producing multiple benefits for students, including improvements in students' personal, social, and academic skills, as well as students' self-esteem.

(10) Teens who do not participate in after school programs are nearly 3 times more likely to skip classes than teens who do participate. The teens who do not participate are also 3 times more likely to use marijuana or other drugs, and are more likely to drink alcohol, smoke cigarettes, and engage in sexual activity. In general, self care and boredom can increase the likelihood that a young person will experiment with drugs and alcohol by as much as 50 percent.

(11) A 2006 study predicts that by the year 2010 more than 46 percent of school-age children in the Americas will be overweight and 1 in 7 such children will be obese. A study of after school program participants in 3 elementary schools found that after school participants were significantly less likely to be obese at the 3-year follow-up physical exam and were more likely to have increased acceptance among their peers. After school programs provide children and youth with opportunities to engage in sports and other fitness activities.

(12) After school programs have been identified as effective venues for improving nutrition, nutrition education, and physical activity at a time when just 20 percent of youth in grades 9 through 12 consume the recommended daily servings of fruits and vegetables.

(13) After school programs also provide children and youth with opportunities for service learning, a teaching and learning approach that integrates student-designed service projects that address community needs with academic studies. With structured time to reflect on their service experience, these projects can strengthen student engagement, enhance students' academic achievement, lower school drop out and suspension rates, and help develop important workforce skills that employers are looking for, including leadership skills, critical thinking, teamwork, and oral and written communication.

SEC. 3. REFERENCES.

Except as otherwise expressly provided, wherever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6301).

SEC. 4. 21ST CENTURY COMMUNITY LEARNING CENTERS.

(a) PURPOSE.—Section 4201 (20 U.S.C. 7171) is amended—

(1) in subsection (a)(2)—

(A) by inserting ''service learning and nutrition education,'' after ''youth development activities,''; and

(B) by striking ''recreation programs'' and inserting ''physical fitness and wellness programs''; and

(2) in subsection (b)—

(A) by striking paragraph (2); and

(B) by redesignating paragraphs (3) and (4) as paragraphs (2) and (3), respectively.

(b) ALLOTMENTS TO STATES.—Section 4202 (20 U.S.C. 7172) is amended—

(1) in subsection (a)—

(A) by striking paragraph (1); and

(B) by redesignating paragraphs (2) and (3) as paragraphs (1) and (2), respectively; and

(2) in subsection (c)(3)—

(A) in the matter preceding subparagraph (A), by striking ''3 percent'' and inserting ''5 percent''; and

(B) by adding at the end the following:

''(E) Supporting State-level efforts and infrastructure to ensure the quality and availability of after school programs.''.

(c) AWARD DURATION.—Section 4204(g) (20 U.S.C. 7174(g)) is amended by striking the period and inserting '', and are renewable for a period of not less than 3 years and not more than 5 years based on grant performance.''.

(d) AUTHORIZATION OF APPROPRIATIONS.—Section 4206 (20 U.S.C. 7176) is amended to read as follows:

''SEC. 4206. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated to carry out this part such sums as may be necessary for fiscal year 2008 and each of the 5 succeeding fiscal years.''.

Mr. ENSIGN. Mr. President, I rise today to introduce the Improving 21st Century Community Learning Centers Act of 2007 with my colleague, Senator CHRIS DODD.

The Improving 21st Century Community Learning Centers Act of 2007 will go a long way toward providing our Nation's children with safe, healthy, and academically focused aftershool programs. Mr. President, 21st century community learning centers provide students in rural and inner-city public schools with access to homework centers, tutors, mentors, and drug and alcohol prevention counseling, as well as cultural and recreational activities.

Today, 14.3 million children go home alone when the school day ends, including over 40,000 kindergartners and almost 4 million middle school students. With less than half of the children in afterschool programs, the parents of another 15.3 million children say their children would participate in afterschool—if a program were available. The 21st Century Community Learning Centers Program is a critical resource to children, families, and communities in their struggle to meet the need for high-quality afterschool programs.

The 21st Century Community Learning Centers Program is a worthwhile and necessary investment—evaluations show that these investments are having a great impact on children's academic achievement and behavior. In 2003–2004, 45 percent of all program participants had improved their reading grades and 41 percent improved their math grades. Teachers reported that a majority of the students participating in the programs improved their academic performance, improved their school attendance, completed more homework on time and to the teacher's satisfaction, and improved their class participation. Beyond the academic gains, these programs are making kids and communities safer by reducing vandalism and juvenile crime. It is important that we provide our children with access to high-quality, safe, and enriching environments in the hours after the school day.

When my colleagues and I passed the No Child Left Behind Act in 2002 it included a bipartisan commitment to quality afterschool programs and investment in the 21st Century Community Learning Centers Program. The learning centers are currently funded at $981 million and serve about 1 million children, yet this is just a fraction—7 percent—of the children who are eligible for the program and need access to high-quality afterschool programs. Improving 21st Century Community Learning Centers Act of 2007 will address this need and provide our children with the sustainable afterschool opportunities that they deserve.

Recent evaluations of 21st Century Community Learning Center Programs show that participating students are improving both their academic performance and social behavior in and out of the classroom. Yet maintaining quality programs takes constant effort and resources. This legislation increases the investments in quality that are critical to ensuring that programs not only contribute to children's academic and social development but also give young people the opportunities that will ensure their college and workplace readiness in the future.

As the father of three and as a former latch-key kid myself, I understand the benefits of providing children with a place to go and activities to help them excel. I am committed to ensuring that our schools have the assistance they need to ensure that our children leave the public education system as well-rounded individuals. Children attending public schools should not only be proficient in reading, writing, and arithmetic but also be skillful in music, art, and athletics. It is my sincere hope that my colleagues in the Senate will recognize this important need and cosponsor the Improving 21st Century Community Learning Centers Act of 2007.

By Mr. DODD (for himself, Mr. DOMENICI, and Mr. KENNEDY):

S. 1560. 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 today to introduce bipartisan legislation with my colleagues, Senators DOMENICI and KENNEDY, 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 SAMHSA, 1 in 10 children and adolescents suffer from mental health disorders serious enough to cause some level of impairment. Out of these young people, only one in five receive 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.''

The ''burden of suffering'' described in Surgeon General Satcher's report is a burden endured by millions of children, adolescents, and their families in Connecticut and across our Nation. Throughout my Senate career, I have heard from families who have shared with me their personal stories in struggling to care for their children. Their stories 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 the stigma often 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 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 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 health care 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 too often 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 that 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 with my colleagues today seeks to address the recommendations they espouse. The Child and Adolescent Mental Health Resiliency Act of 2007 authorizes $205 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. Our 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, our 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, our legislation authorizes a new grant of $22.5 million for states, localities and private nonprofit organizations, for example, school districts, to provide community-based mental health services in schools and appropriate mental health training activities to relevant school and health professionals.

Fourth, our 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, our 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, our 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, our 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 our legislation seeks to meet is ensuring greater public awareness and greater family participation in mental health services decisionmaking. Toward this end, our 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, our 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 the inappropriate use of 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, our 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. It also gives the committee flexibility to develop and implement joint demonstration projects that bolster appropriate mental health care services to 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. Toward that end, our 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. Our legislation also authorizes $12.5 million to enhance comprehensive Federal research and evaluation of promising best practices, existing disparities, psycho-tropic medications, trauma, recovery and rehabilitation, and co-occurring disorders as they relate to child and adolescent mental health.

I have begun working with my colleagues on the Committee on Health, Education, Labor, and Pensions to reauthorize the Substance Abuse and Mental Health Services Administration. 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, on 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 sincerely hope that my colleagues will join us in this important effort.

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. 1560

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 2007''.

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

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, 1 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 1 in 5 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 more than 50 percent by 2020, internationally, to become 1 of the 5 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 3 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, 1 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 2 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 evidence-based and promising 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 evidence-based and promising 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 evidence-based and promising 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 ensure that 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, child welfare 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 children and adolescents, families, schools, educational institutions, juvenile justice systems, substance abuse programs, mental health programs, primary care programs, foster care systems, child welfare 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 Resiliency Act of 2007;

''(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) national, State, and local 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 2008, and such sums as may be necessary for each of fiscal years 2009 through 2012.''.

SEC. 102. GRANTS CONCERNING EARLY INTERVENTION AND PREVENTION.

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

''PART 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 speciality 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 sections 597, 597A, and 597B, $45,000,000 for fiscal year 2008 and such sums as may be necessary for each of fiscal years 2009 through 2012.''.

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 processionals 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 2008, and such sums as may be necessary for each of fiscal years 2009 through 2012.

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 2008, and such sums as may be necessary for each of fiscal years 2009 through 2012.''.

SEC. 106. ACTIVITIES CONCERNING INTERAGENCY 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. 597D. 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 2008, and such sums as may be necessary for each of fiscal years 2009 through 2012.''.

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. 597E. 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 2008, and such sums as may be necessary for each of fiscal years 2009 through 2012.''.

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. 597F. 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 2008, and such sums as may be necessary for each of fiscal years 2009 through 2012.''.

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. 597G. 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 2008, and such sums as may be necessary for each of fiscal years 2009 through 2012.''.

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. 597H. 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 2008, and such sums as may be necessary for each of fiscal years 2009 through 2012.''.

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. 597I. 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 2008, and such sums as may be necessary for each of fiscal years 2009 through 2012.''.

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 provides 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 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 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, including the transitioning to adulthood.''.

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 2008, and such sums as may be necessary for each of fiscal years 2009 through 2012.

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 (referred to in this section 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).

(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) FLEXIBLE JOINT-FUNDING PROGRAMS.—

(1) IN GENERAL.—In carrying out the activities described in subsection (h), Federal officials participating in the Committee may, notwithstanding any other law, enter into interagency agreements for the purposes of establishing flexible joint-funding programs, and each official may allocate discretionary funds appropriated to that agency to such flexible joint-funding programs.

(2) PROGRAM PURPOSES.—Flexible joint funding programs as described in paragraph (1) may include demonstration projects that address and eliminate the—

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

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

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

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

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

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

(G) 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.

(j) 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.

(k) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $10,000,000 for fiscal year 2008, and such sums as may be necessary for each of fiscal years 2009 through 2012.

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. 597J. 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 2008, and such sums as may be necessary for each of fiscal years 2009 through 2012.''.

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. 597K. 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 pyschotropic 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) COST OF UNTREATED MENTAL HEALTH DISORDERS.—The Secretary shall provide for the conduct of research assessing long-term financial costs of mental health disorders left untreated in children and adolescents.

''(i) 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.

''(j) COLLABORATION.—In carrying out the activities under this section, the Secretary shall collaborate with the Federal interagency coordinating committee established under section 201 of the Child and Adolescent Mental Health Resiliency Act of 2007, and relevant Federal agencies and mental health working groups responsible for child and adolescent mental health.

''(k) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $12,500,000 for fiscal year 2008, and such sums as may be necessary for each of fiscal years 2009 through 2012.''.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 221—SUPPORTING NATIONAL PERIPHERAL ARTERIAL DISEASE AWARENESS MONTH AND EFFORTS TO EDUCATE PEOPLE ABOUT PERIPHERAL ARTERIAL DISEASE

Mr. CRAPO (for himself and Mr. DORGAN) submitted the following resolution; which was referred to the Committee on Health, Education, Labor, and Pensions:

S. RES. 221

Whereas peripheral arterial disease is a vascular disease that occurs when narrowed arteries reduce blood flow to the limbs;

Whereas peripheral arterial disease is a significant vascular disease that can be as serious as a heart attack or stroke;

Whereas peripheral arterial disease affects approximately 8,000,000 to 12,000,000 Americans;

Whereas 1 in 5 patients with peripheral arterial disease will experience cardiovascular death, heart attack, stroke, or hospitalization within 1 year;

Whereas the survival rate for individuals with peripheral arterial disease is worse than the outcome for many common cancers;

Whereas peripheral arterial disease is a leading cause of lower limb amputation in the United States;

Whereas many patients with peripheral arterial disease have walking impairment that leads to a diminished quality of life and functional capacity;

Whereas a majority of patients with peripheral arterial disease are asymptomatic and less than half of individuals with peripheral arterial disease are aware of their diagnoses;

Whereas African-American ethnicity is a strong and independent risk factor for peripheral arterial disease, and yet this fact is not well known to those at risk;

Whereas effective treatments are available for people with peripheral arterial disease to reduce heart attacks, strokes, and amputations and to improve quality of life;

Whereas many patients with peripheral arterial disease are still untreated with proven therapies;

Whereas there is a need for comprehensive educational efforts designed to increase awareness of peripheral arterial disease among medical professionals and the greater public in order to promote early detection and proper treatment of this disease to improve quality of life, prevent heart attacks and strokes, and save lives and limbs; and

Whereas September 2007 is an appropriate month to observe National Peripheral Arterial Disease Awareness Month: Now, therefore, be it

Resolved, That the Senate—

(1) supports National Peripheral Arterial Disease Awareness Month and efforts to educate people about peripheral arterial disease;

(2) acknowledges the critical importance of peripheral arterial disease awareness to improve national cardiovascular health;

(3) supports raising awareness of the consequences of undiagnosed and untreated peripheral arterial disease and the need to seek appropriate care as a serious public health issue; and

(4) calls upon the people of the United States to observe the month with appropriate programs and activities.

SENATE RESOLUTION 222—SUPPORTING THE GOALS AND IDEALS OF PANCREATIC CANCER AWARENESS MONTH

Mrs. CLINTON (for herself and Mr. SMITH) submitted the following resolution; which was referred to the Committee on Health, Education, Labor, and Pensions:

S. RES. 222

Whereas over 37,170 people will be diagnosed with pancreatic cancer this year in the United States;

Whereas pancreatic cancer is the 4th most common cause of cancer death in the United States;

Whereas 75 percent of pancreatic cancer patients die within the first year of their diagnosis and only 5 percent survive more than 5 years, making pancreatic cancer the deadliest of any cancer;

Whereas there has been no significant improvement in survival rates in the last 25 years and pancreatic cancer research is still in the earliest scientific stages;

Whereas there are no early detection methods and minimal treatment options for pancreatic cancer;

Whereas when symptoms of pancreatic cancer generally present themselves, it is too late for an optimistic prognosis, and the average survival rate of those diagnosed with metastasis of the disease is only 3 to 6 months;

Whereas the incidence rate of pancreatic cancer is 40 to 50 percent higher in African Americans than in other ethnic groups; and

Whereas it would be appropriate to observe November as Pancreatic Cancer Awareness Month to educate communities across the Nation about pancreatic cancer and the need for research funding, early detection methods, effective treatments, and treatment programs: Now, therefore, be it

Resolved, That the Senate supports the goals and ideals of Pancreatic Cancer Awareness Month.

Mrs. CLINTON. Mr. President, I rise today to introduce a resolution which supports the goals and ideals of Pancreatic Cancer Awareness Month. This resolution is an important step toward bringing the public awareness, funding for research, and congressional attention that is essential for addressing one of the most lethal cancers we face as a Nation.

I doubt that there is one person who hasn't lost a friend or family member to cancer, or knows someone who has. The American Cancer Society tells us that pancreatic cancer is the fourth leading cause of cancer death in the United States. The reality is that pancreatic cancer will take over 33,000 American lives this year, more than 2,330 in New York. And yet, there are no early detection methods and our best treatment is a surgical procedure that is more than 70 years old.

I believe that we can do better. This resolution encourages communities across the country to use the month of November to bring attention to what we have left to tackle. We need research dollars to create early detection methods, to find effective treatments, and to raise awareness about this deadly disease.

I am proud to introduce the Pancreatic Cancer Awareness Month resolution today, and I hope my colleagues will join me in supporting this critical health issue.

Mr. SMITH. Mr. President, I rise today in support of a resolution that recognizes November as National Pancreatic Cancer Awareness Month. I am pleased to be joining my colleague, Senator CLINTON, in introducing this resolution, which represents a way to educate communities across the Nation about pancreatic cancer and the need for increased research funding, early detection methods, and effective treatments and programs.

Like many Americans, I have seen the ramifications of cancer first hand. I support this resolution in honor and loving memory of the millions of Americans who have been diagnosed with pancreatic cancer and their families, and for my mother, Jessica Udall Smith, whom I lost to pancreatic cancer.

Pancreatic cancer is hard to detect in its early stages as it doesn't cause symptoms right away. Also, because the pancreas is hidden behind other organs, health care providers cannot see or feel the tumors during routine