PERSONAL EXPLANATION

Mr. GILMAN. Mr. Speaker, because of a commitment in my congressional district earlier this week I missed the last few rollcall votes on the Treasury-Postal appropriations bill. Had I been present, I would have voted "yes" on rollcall No. 465, the Ashbrook amendment protecting tax-exempt status of private, religious, or church operated schools.

On rollcall No. 466, the Ashbrook amendment prohibiting the use of funds for abortion under the Federal employees health benefit program. Had I been present I would have voted "no."

On rollcall No. 467, the McDade amendment prohibiting the use of funds to calculate or transmit the number of Representatives in Congress to which each State shall be entitled under the 20th decennial census. Had I been present I would have voted "no."

On rollcall No. 468, the final passage of the bill. Had I been present I would have voted "yes."

DIRECTING THE SECRETARY OF THE SENATE TO MAKE CORRECTIONS IN THE ENROLLMENT OF S. 2680, AUTHORIZING ASSISTANCE TO FOLGER LIBRARY AND CORCORAN GALLERY IN WASHINGTON, D.C.

Mr. UDALL. Mr. Speaker, I ask unanimous consent to take from the Speaker's table the concurrent resolution (H. Con. Res. 410) directing the Secretary of the Senate to make corrections in the enrollment of the Senate bill (S. 2680), an act to improve the administration of the Historic Sites, Buildings, and Antiquities Act of 1935 (49 Stat. 666), and ask for its immediate consideration.

The Clerk read the title of the concurrent resolution.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Arizona?

There was no objection.

The Clerk read the concurrent resolution, as follows:

H. CON. RES. 410

Resolved by the House of Representatives (the Senate concurring), That the Secretary of the Senate, in the enrollment of S 2680—an Act to improve the administration of the Historic Sites, Buildings, and Antiquities Act of 1935 (49 Stat. 666) shall make the following corrections:

In section 17, change "Relations" to "Organizations" in both the first and second sentences.

The concurrent resolution was agreed to.

A motion to reconsider was laid upon the table.

MENTAL HEALTH SYSTEMS ACT

Mrs. CHISHOLM. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 751 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 751

Resolution providing for the consideration of the bill (H.R. 7299) to revise and improve the Federal programs of assistance for the provision of mental health services, and for other purposes

Resolved, That upon adoption of this resolution it shall be in order to move, section 402(a) of the Congressional Budget Act of 1974 (Public Law 93-344) to the contrary notwithstanding, that the House resolve itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 7299) to revise and improve the Federal programs of assistance for the provision of mental health services, and for other purposes, and the first reading of the bill shall be dispensed with. After general debate, which shall be confined to the bill and shall continue not to exceed one hour, to be equally divided and controlled by the chairman and ranking minority member of the Committee on Interstate and Foreign Commerce, the bill shall be read for amendment under the five-minute rule by titles instead of by sections. At the conclusion of the consideration of the bill for amendment, the Committee shall rise and report the bill to the House with such amendments as may have been adopted, and the previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit.

The SPEAKER pro tempore. (Mr. GARCIA). The gentlewoman from New York (Mrs. CHISHOLM) is recognized for 1 hour.

Mrs. CHISHOLM. Mr. Speaker, for the purposes of debate only, I yield the customary 30 minutes to the gentleman from Mississippi (Mr. LOTT) pending which I yield myself such time as I may consume.

Mr. Speaker, House Resolution 751 provides for the consideration of the bill (H.R. 7299), the Mental Health Systems Act, to revise and improve the Federal programs of assistance for the provision of mental health services.

This is an open rule, Mr. Speaker, providing for 1 hour of general debate to be equally divided and controlled by the chairman and ranking minority member of the Committee on Interstate and Foreign Commerce. The rule provides that the bill shall be read for amendment under the 5-minute rule by titles instead of sections and provides for one motion to recommit.

In addition, the rule waives points of order against the legislation for failure to comply with section 402(a) of the Budget Act. Section 402(a) of the Budget Act prohibits consideration of any bill which directly or indirectly authorizes the enactment of new budget authority for a fiscal year unless the bill was reported by May 15, preceding the beginning of such fiscal year. The waiver is technical in nature, since no new budget authority is authorized for the current fiscal year. However, title V of the legislation which establishes an Associate Director of the National Institute of Mental Health for Minority Concerns could be construed as authorizing funds for fiscal year 1980. Thus, the budget waiver was necessary. I understand that the Committee on Interstate and Foreign Commerce will be offering a technical amendment to clarify this section by making the effective date of establishment at the beginning to fiscal year 1981.

Mr. Speaker, the legislation before us represents a commendable effort by the Committee on Interstate and Foreign Commerce to translate the recommendations of the President's Commission on Mental Health into positive and effective action. In particular, the committee should be complimented for its emphasis on the mental health problems of special populations—the chronically mentally ill, adolescent and elderly persons and minority populations. In addition, the legislation seeks to bring the States, which up to now have been silent third partners, more fully into planning and implementation of comprehensive mental health care.

The Nation has much work ahead of it if we are to continue our commitment to comprehensive and adequate mental health care for millions of suffering Americans. I urge my colleagues to adopt House Resolution 751, so that the House may proceed to the consideration of H.R. 7299 and continue that work.

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

Mr. Speaker, this is a 1-hour, open rule with only one waiver. The rule waives section 402(a) of the Congressional Budget Act. This section requires that new budget authority be reported by May 15 preceding the beginning of the fiscal year for which it is effective. Since section 501 of the bill would establish a new position within the National Institutes of Mental Health and would authorize new budget authority effective upon enactment, the bill would be subject to a point of order. Although the Commerce Committee intends to offer an amendment making section 501 effective on October 1, 1980, thereby curing this violation, a technical waiver of section 402(a) of the Budget Act is necessary to allow consideration of the bill.

The bill is to be read by titles rather than by sections.

Mr. Speaker, the community mental health centers program was designed to provide treatment to the mentally ill at the local level. It was an excellent idea. In 1963, Congress first authorized the program and approved seed money to aid the States in the construction of community-based mental health centers. However, since first being authorized, the program has expanded and the Federal involvement has grown ever larger.

H.R. 7299 would further increase the Federal participation in the program. The bill proposes $78 million for community mental health centers in fiscal year 1981. However, beginning in fiscal year 1982, new programs are added which almost double the cost of the program. As far as I am concerned, this

program is destined to follow in the footsteps of so many other ill-fated ventures where the Federal Government aims to get a new program on its feet, but eventually ends up carrying the major part of the financial burden itself. At a time of fiscal austerity and restraint, actually doubling the cost of the program spells defeat for our ambitious plans toward economic stability.

I have been a strong supporter of this program. I endorse its goals. But I am fearful that making changes in the design of it will be self-defeating. The staggering costs which are recommended in this bill are simply not consistent with the goals of fiscal restraint which are now so vital to our Nation. Further, I feel that this huge price tag will cause Members to vote against a program which they would otherwise embrace as an essential part of our health system. It is my hope that, in the future, House committees would refrain from reporting legislation which invites opposition on the grounds of excessive spending.

□ 1300

Mr. Speaker, I have no further requests for time, and I yield back the balance of my time.

Mrs. CHISHOLM. Mr. Speaker, I move the previous question on the resolution.

The previous question was ordered.

The resolution was agreed to.

A motion to reconsider was laid on the table.

Mr. WAXMAN. Mr. Speaker, I move that the House resolve itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 7299) to revise and improve the Federal programs of assistance for the provision of mental health services, and for other purposes.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from California (Mr. WAXMAN).

The motion was agreed to.

IN THE COMMITTEE OF THE WHOLE

Accordingly the House resolved itself into the Committee of the Whole House on the State of the Union for the consideration of the bill, H.R. 7299, with Mr. BEILENSON in the chair.

The Clerk read the title of the bill.

The CHAIRMAN. Pursuant to the rule, the first reading of the bill will be dispensed with.

Under the rule, the gentleman from California (Mr. WAXMAN) will be recognized for 30 minutes, and the gentleman from Kentucky (Mr. CARTER) will be recognized for 30 minutes.

The Chair recognizes the gentleman from California (Mr. WAXMAN).

Mr. WAXMAN. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I am asking the House to consider today H.R. 7299, the Mental Health Systems Act, a bill which would amend the Community Mental Health Centers Act to revise and improve the Federal programs of assistance for the provision of mental health services. I want to thank the members of the Interstate and Foreign Commerce Committee, and especially Chairman STAGGERS and Dr. CARTER for their help in bringing this legislation before us.

The mental health program which we are proposing to extend and amend, was established by Public Law 88–164 in 1963 and has been revised several times since.

At the time of the enactment of the original legislation it was hoped that the Federal Government could establish a network of outpatient clinics to serve as alternatives to the large and expensive State mental hospitals, and that voluntary organizations and local and State governments would begin to assume responsibility for their citizens who were mentally ill.

Part of this goal has been achieved. With Federal aid under the CMHC Act, more than 750 local centers have been established and, in 1979, more than 2.4 million persons received services from them. More than 20 percent of these local centers are now fully independent of Federal support. During this same time the number of institutionalized patients has dropped from over one-half million to 148,000.

But there are problems also. Since they were given little authority over the local programs, States have been understandably reluctant to lend their full support to CMHCs. A large number of areas are still without comprehensive services. And many patients leaving institutions have been lost in the cracks in the system and now live in nursing homes and boarding homes without access to the care they need to return them to a productive life.

The Committee on Interstate and Foreign Commerce considered these issues in several days of oversight and legislative hearings and recommends H.R. 7299 as a measure providing extension of most authorities as well as some distinct improvements. The committee has concluded that the CMHC program has had many successes on which we may now build and recommends that this program continue to establish and operate community programs for mental health care.

But in H.R. 7299 the committee further recommends several major changes and additions:

In an effort to get more State support for the program, the bill provides for an enlarged State role in planning services.

States have made an overall financial contribution to mental heath services, greater than that of the Federal Government. But most of this money has gone to provide patient care in State mental hospitals.

States have been reluctant to commit extensive funds to community mental health centers, since they have had little control over those programs.

However, from testimony received during hearings on deinstitutionalization held by the Subcommittee on Health and the Environment, State representatives described a variety of programs to provide community care for former mental patients. Over $275 million in State funds went to community mental health centers in 1977 giving evidence of State interest in the problems of the mentally ill in the community.

This bill will involve States more fully in the planning and provision of community services, and thus will result, we hope, in increased State funds for these programs.

In an attempt to find and aid those people who have left mental institutions, we have provided a new special grant category for services to the chronically mentally ill. These would include case management and assistance with health problems, employment, and housing. The committee was especially desirous of helping these persons lead normal and useful lives in our very complicated society.

The subcommittee has created a special grant category for services to disturbed children to help them at an early point in their illness, before they become the chronically mentally ill of the 1980's and 1990's.

Members were particularly distressed to learn of the plight of young children who are in and out of psychiatric hospitals, often shuttled from one institution to another. They are rarely served by the existing deinstitutionalization efforts, because of the difficulty in finding care suitable for this age group.

Noting that nursing home patients also have very special needs, we have developed a categorical grant program for the provision of mental health services within ambulatory health care centers.

We know that a large percent of nursing home residents receive no mental health treatment whatever, despite estimates indicating that up to 70 percent of such elderly residents develop severe symptoms of mental illness.

The bill would insure that ambulatory health centers, including nursing homes, enter into affiliations with local mental health providers.

H.R. 7299 also provides a grant program to fund services to those groups that State and local health planning agencies find to be unserved or underserved.

The State, through its local planning process, will determine which groups in each area are in need of special attention.

And finally, in recognition of the qualified successes of the centers program in providing local care, we have extended the funding to begin centers in those areas which do not have them.

We have, moreover, extended the present centers program through 1981 to allow implementation of the new Systems Act proposals.

The committee bill identifies the successes and the gaps in the present CMHC program. The bill does much to fill the gaps and to build a comprehensive system from the disparate authorities and agencies which provide care to the mentally ill.

Mr. Chairman, H.R. 7299 is legislation dealing with one of the most fragile, vulnerable groups in our country. We believe it an important and compassionate piece of legislation.

□ 1310

Mr. CARTER. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, over the years it has been my privilege to have helped develop legislation to improve the delivery of mental health services in this country. And I remain committed to that goal.

The bill we are considering today—H.R. 7299—the "Mental Health Systems Act" continues and strengthens the Federal commitment to improve mental health care—in a manner which builds upon the strengths of our current community mental health centers program—and which targets funds for specific groups and services that have not been adequately addressed in the past.

Most importantly, this bill provides an expanded role for the States in the planning and operation of mental health services delivery. In my view this recognition of the importance of State involvement will greatly improve coordination of services and enhance the overall effectiveness of the program.

Mr. Chairman, in order to appreciate the need for this legislation I believe it is important to review the progress as well as some of the shortcomings of previous legislation.

Mr. Chairman, as I remember this legislation over the years, it was first introduced in 1963, and its purpose was to care for the mentally retarded and others who have mental problems. That original legislation only provided funds for construction of community mental health centers.

In 1965, amendments to the original legislation were written which included funds for staffing of these centers. The purpose of these centers was to replace large mental institutions as the locus of care, so that patients of such institutions could be cared for in areas nearest to where they live. In this way, community-based facilities could provide the needed services to the mentally ill.

In 1965, 1967, and 1968, there were additional amendments. Construction and staffing funds were added for the provision of alcoholism services and narcotic addition. Requirements for the provision of comprehensive mental health services were included, and provision for 51 months of declining Federal matching funds was made.

In 1970 the legislation was further amended by increasing the Federal share of the costs of center construction. Also, the matching formula was changed to 8 years, and centers in poverty areas were entitled to a more favorable rate than centers in nonpoverty areas. Again in 1975 the law was amended. The definition of a community health center was clarified and the number of required services was expanded from 5 to 12. Also, a program of financial distress grants was added to the legislation. Further amendments were made in 1978.

Since the original community mental health centers legislation was enacted in 1963 Federal funds have assisted in the initiation of 763 CMHC's.

As a result, community-based mental health services have been made available to over 110 million people under this program, with an average of 6 patient visits per year.

In addition, this program has contributed to a dramatic shift from inpatient care to outpatient care now, three out of four patients receiving mental health care are treated as outpatients—whereas in 1955 three-quarters were treated as inpatients.

Over the last 10 years utilization rates for outpatient care have increased fourfold while between 1977 and 1979 there has been a 36-percent decrease in the number of psychiatric hospital beds in the United States.

Mr. Chairman, it has been my privilege to see some of these community mental health centers in action. The most striking and the most appealing part of the program I have noticed has been the assistance given to the mentally retarded. It was my pleasure to visit the School of Hope near Berea, Ky., and to see youngsters who were little mongols trained so that they could care for themselves. Up until this time it was thought that training of these poor little individuals, God's little children, could never be accomplished, but actually there I saw them caring for themselves. Some of them were even reading and writing.

That portion of the law has been particularly effective. I would hope that other portions could be considered likewise. I think it has by and large been helpful. However, despite the successes of the community mental health centers legislation, the program is not without its shortcomings.

Various evaluations of the CMHC program, including reports by GAO and the President's Commission on Mental Health, have documented certain problems including:

First. The need to provide more flexibility in the legislation to encourage the startup of new CMHC's where they do not exist now. Over 700 catchment areas do not have funded CMHC's.

Second. The need to devote additional resources to serve the chronically mentally ill—a population of approximately one and a half million adults.

Third. The need to provide access to services for groups within the population who have not been adequately served by the existing program—such as the elderly and residents of rural areas—and children with severe mental disabilities.

Fourth. The need to improve administration of CMHC's and coordination of services within States—particularly the need to form closer working relationships between the mental health and general health sectors.

Mr. Chairman, these are difficult and complex problems, which our subcommittee debated extensively and considered thoroughly. With the benefit of expert testimony—and after many lengthy markups—a series of substantive amendments were adopted which improved the bill significantly.

As a result of these revisions, I believe the mental health systems act is now a reasonable and balanced proposal which will enhance our original commitment to community-based mental health care as we move into the 1980's. Briefly, after 1-year simple extension of the existing law's CMHC program—the Mental Health Systems Act becomes effective in 1982, with authorizations of $152 million, $177.5 million, and $200 million for fiscal years 1982–84.

Let me now highlight the principal provisions of the proposed legislation.

The Systems Act would help fill the identified gaps in our current mental health delivery system by targeting funds for "priority populations"—whose mental health needs have been identified by the local health planning process. Such priority groups would be eligible for grant funds to start up mental health projects, but the services must be available to all members of the community. In this way, our bill preserves the original congressional intent of encouraging provision of services for all members of a community who need them.

The Systems Act would also give special attention to services for the chronically mentally ill and for projects to serve severely mentally disturbed children and adolescents.

To address concerns about coordination and accountability, the Systems Act gives States new responsibility and control over the future development of mental health projects within their boundaries.

For example, beginning in 1982 any application for a grant under the Systems Act for "preparation," "operation," or for "priority populations" must receive the approval of the State mental health authority before the Secretary may approve it. Beginning in 1984 grant applications for nonrevenue-producing activities must also receive State approval to be funded.

Furthermore, the Secretary is required to give priority in funding applications for the chronically mentally ill and severely disturbed children to those which have State approval.

I particularly approve of this approach because there has been too much loose administration in our mental health and mental retardation programs throughout the country, and I feel that if we go through the States, the program will be more carefully administered and supervised.

This does give the State a better hold upon this program because of the requirement for approval by the State mental health authority.

In addition, the bill authorizes the Secretary to make grants to assist ambulatory health care centers to participate in the provision of mental health services to the patients. In order to receive funds under this provision each application must include a written agreement of affiliation between a provider of ambulatory health care services and a mental health care provider.

As a physician who has frequently observed and regretted the schism that exists between the mental health and general health sectors, I feel this provision is especially important. Not only will it foster coordination and communication among providers, it will enhance continuity and quality of patient care in many settings where such goals have been neglected.

In addition, the bill also includes a pilot program which would permit State administration of grants under the act in lieu of administration by the Secretary of HHS. It was the committee's view that the experience from such a pilot project would be instrumental in the further development of an even more active State role in the provision of mental health services.

In my view, the expansion of State involvement in this area should lead to more coordination in both the planning and delivery of services. It is only reasonable that as the level of Federal support diminishes over the course of the several years that we look to the States to assume both managerial and fiscal responsibilities.

Finally, Mr. Chairman, I would like to mention that the bill includes a requirement for any project receiving funds under this act to have in effect what is known as a "whistle blower" protection system.

Under this provision, any employee who reports a violation of State or Federal law or regulation may not be discriminated against with regard to his employment. This requirement, which I offered as an amendment, was based on an unfortunate experience in my own State where several employees were treated unfairly by a center director because of their truthful allegations. I regret that such a requirement is needed, but I believe it is. We must do all we can to promote efficient administration of these centers and to project employees from any unjust reprisals.

Mr. Chairman, I strongly support this legislation. I believe we have improved it a great deal in requiring the involvement of the States. Not only that, there is provision for assistance to our Public Health Service officers to see that they receive the same pay as their counterparts in the Army and Navy. This has been the custom over a period of years, but for some reason they were left out in the past legislation. I strongly support this portion of the bill which would give them wage comparability. They do great work, and certainly our corps will not survive and flourish unless we pay them adequately.

In closing, Mr. Chairman, I would like to remind my distinguished colleagues about the magnitude of the problem we are discussing. It has been estimated that between 10 and 15 percent of the population needs some form of mental health services.

Because of both the complexity and extent of mental illness—I believe a comprehensive and coordinated response is needed by government at all levels and by the private sector working together. With regard to mental health services I believe this bill provides an appropriate framework for a Federal-State partnership to respond to the challenges that remain.

However, provision of mental health services is only one part of a comprehensive approach. To respond completely to our citizens' mental health needs we must marshal our resources on all fronts—both public and private.

For example, we must continue to support research so that advances in treatment and prevention may be discovered and transferred promptly to providers and patients.

We must also strengthen our training programs so that mental health personnel are well-trained and so that innovative techniques are made available to patients in their communities.

Only with a comprehensive approach to our Nation's mental health problems will we succeed in significantly improving the lives of the millions of Americans involved. I urge your support for H.R. 7299 as an integral part of the total response which is needed.

Mr. WAXMAN. Mr. Chairman, I yield 5 minutes to a very valued member of the subcommittee, the gentleman from New Jersey (Mr. MAGUIRE).

Mr. MAGUIRE. Mr. Chairman, this, I believe, is one of the important pieces of legislation that the Congress is dealing with in this session.

I want to express my appreciation for the excellent work that has been done by the subcommittee chairman, the gentleman from California (Mr. WAXMAN), the ranking minority member, the gentleman from Kentucky (Mr. CARTER), and all the members of the committee.

We spent a great number of hours, weeks, and months working on this legislation. It, of course, follows the outstanding work that was done by the Presidential Commission chaired by Rosalynn Carter, and I think it is a guarantee to all of our citizens that we are going to continue the very important work which was begun a number of years ago to provide community mental health services to our citizens and to provide those services in a way which they can be most accessible to those who need them.

This bill does improve the existing law in a number of very important respects, in terms of serving those who have not been well served in the past, those with particular needs. As the gentleman from Kentucky (Mr. CARTER) has pointed out, it expands the roles that the States will play, which I think is good and important.

I would add one hope, however, and that is that when we go to conference with the Senate, we can work out some mutually agreeable language that will enable us to deal with the situation which, albeit remote, could occur in which a State might act arbitrarily or capriciously to deny or delay or rearrange funding. I am hopeful that all Members on both sides of the aisle can join with the Senate conferees in attempting to work out some suitable language to protect the public interest in that regard.

This is an excellent bill, Mr. Chairman. It is the result of a lot of hard work by those experts who were appointed by the President to study and reevaluate the issue at this particular turning point in our experience with the provision of community mental health services.

This bill is the result of an awful lot of hard work by all the members of our subcommittee, and I congratulate again our chairman and ranking minority member. And let me salute especially our ranking minority member, who will be retiring from the Congress this year. This is yet another demonstration of the effectiveness and the caring which the gentleman from Kentucky (Mr. CARTER) has brought to this body.

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

Mr. CARTER. Mr. Chairman, I certainly am deeply indebted to the chairman of the subcommittee, the gentleman from California (Mr. WAXMAN), to my friend, the gentleman from New Jersey (Mr. MAGUIRE), and also to the chairman of the full committee (Mr. STAGGERS), for their leadership and help over the years. It has been a pleasure to work with them.

At this time, Mr. Chairman, I yield 5 minutes to the distinguished gentleman from Arkansas (Mr. HAMMERSCHMIDT).

Mr. HAMMERSCHMIDT. Mr. Chairman, I rise in support of H.R. 7299, the Mental Health Systems Act. While I hope my colleagues have no doubts about my willingness to vote for this legislation, I would like to say a few words about the need for greater emphasis on mental health services for the elderly.

I believe there is a gaping discrepancy between the mental health problems of older persons and the adequacy of our current mental health system to address those problems. I regret that there is no special section in the mental health systems bill for delivering services to the elderly and that it has been brought up on such short notice, precluding any opportunity to redress this situation.

The statistics on the mental health problems of the elderly are staggering. Research reveals that 20 to 25 percent of older persons have significant mental health problems and that 16 percent of the suicides in the country are committed by persons 65 and older. Although 70 to 80 percent of all nursing home patients have severe symptoms of mental illness, most are receiving no mental health treatment. Twenty to thirty percent of people who are labelled as "senile" have conditions which are preventable or reversible if they are detected early and receive treatment.

Although the need for effective action seems compelling, experts agree that 80 percent of the elderly requiring mental health services do not have their needs met through existing resources. Furthermore, the over 65 comprise 11 percent of the population, but at best only 4 percent of patients seen at public outpatient mental health clinics are 65 or older, and only 2 percent in private clinics are in this age group.

Indeed, we often hear the types of persons served by CMHC's referred to under the acronym of "YAVIS"—young, attractive, verbal, intelligent, successful. I would certainly not deny that these persons are in need of and entitled to CMHC services, but if they are the majority of persons that our publicly sponsored clinics are content with treating, I believe they are shirking their responsibili-

ties. The Congress should insure that special steps are taken to reach out to mentally ill older persons and to make needed services available to them. It saddens me to think that because of the ineffectiveness and indifference of our mental health system, elderly persons are lying confused and unhappy in their nursing home beds or sitting depressed and alone in their homes when they could be receiving help. Mr. Chairman, I know we can do better.

Mr. Chairman, on behalf of the chairman of the Select Committee on Aging, Mr. PEPPER, I would like to commend you, Chairman WAXMAN and the ranking minority member, Dr. CARTER, for the work that both of you and the committee have put into this important piece of legislation. As members of the Select Committee on Aging, we are concerned that there is very little in the bill that will alleviate the tremendous mental health problems experienced by the elderly. I would like to address some thoughts to you Chairman WAXMAN hoping to receive some reassurances that might alleviate our concern.

We now have had 15 years of experience with the community mental health centers. When they were started it was with the intent that they serve all persons in need. But, it became clear that this was not happening. The elderly were underrepresented in the caseload of CMHC's across the Nation. In 1975 when the bill was amended, it was written into the law that CMHC's shall provide a program of specialized services for the mental health of the elderly, including a full range of diagnostic, treatment, liaison and follow-up services. This congressional mandate has still gone unheeded. The latest data show that less than 4 percent of the elderly are receiving services from CMHC's. This is staggering when it has been estimated by the President's Commission on Mental Health that 20–25 percent of the elderly have significant mental health problems. And, although the elderly make up only 11 percent of the population they account for 16 percent of the suicides.

In the mental health systems bill passed by the Senate last week, there is a special section of grants for priority populations, children and youth, chronic patients, and the elderly. The bill as passed by your committee contains sections for all these groups except the elderly. I believe it is the intention of the House bill that they will be served under this priority populations section. However, the Civil Rights Commission has made it clear that whenever the elderly are grouped with other populations, as in the priority populations sections. they are totally underserved. I would like to yield to the very able member of the subcommittee to respond to a question. Is there a way under the priority populations section that we can insure the elderly will not be sidestepped once more?

□ 1320

I yield to the distinguished chairman for a response.

Mr. WAXMAN. I thank the gentleman for yielding and for raising this subject.

As you know, I, too, am a member of the Aging Committee and have a very large number of older persons in my district, I am aware of the extent of the mental health problems experienced by the elderly and the failure of our current system to address them. It has always been my understanding that the intent of the section entitled "priority populations" is to serve those groups with the greatest need. It is clear that there is almost no population that is documented to have a greater need for mental health services than older Americans.

Under the terms of the bill, local communities can define which groups have priority in receiving mental health services. I believe that in areas of high concentration of older citizens, planners will include the elderly in their definition of priority populations.

Let me add that nursing homes, under this bill, will be able to use the services of a local community mental health center.

I do believe that with these provisions, we can begin to remedy the years of neglect of the mental health problems of the elderly.

Mr. HAMMERSCHMIDT. I very much appreciate the gentleman's response. I know that Chairman PEPPER will be grateful and relieved with that sort of an answer, and I know that elderly people all across this Nation will be grateful, as we are, and I thank the gentleman very much.

Mr. Chairman, while I have the floor, I also want to add my deepest gratitude for the great work that the ranking minority member, the gentleman from Kentucky (Mr. CARTER), has given to this Congress and to this committee, and I wish to convey my respect and thanks to him for his faithful service to this Congress.

Mr. WAXMAN. Mr. Chairman, I yield such time as he may consume to a member of our subcommittee who is very active on this and so many other items of legislation, who has authored in this bill one of the most important and creative and far-reaching sections that we have, the gentleman from Pennsylvania (Mr. WALGREN).

Mr. WALGREN. Mr. Chairman, at the outset, I think every health bill that comes before the Congress should be prefaced by congratulations and an expression of appreciation and respect for the ranking minority member for the Health Subcommittee, the gentleman from Kentucky (Mr. CARTER), who is in his last year here. His footprint is certainly on this bill, as it is on so many others. Mental health is a particularly important area that the Congress has only begun to recognize during the years that Dr. CARTER has influenced health legislation. The mental health of our citizens is a difficult problem for everyone to grapple with and, certainly, the funding that has come to the local levels for this problem has been of infinite good. There are many, many people in this country who should be very grateful to Dr. CARTER for the role that he has played in this area.

I simply want to underscore the importance of progress made with this bill in the area of funding for rape crisis centers. As we know, the crime of rape is one that is often forgotten about and is not one easy to think about. We often do not think that it is a very frequent act in our society. It has been estimated that all women stand a 1 in 15 chance of encountering the violence of rape in their lifetime. And the most frequent victims of rape are often not those in the prime of life, but the elderly and children.

Rape is a unique crime because the counseling and the support of the psychological state of the victim is absolutely essential to effective law enforcement. Reported rapes have doubled in the first years of this decade, largely because there has been increasing support for the psychological stability and state of mind of the victims without which there is often no prosecution. This bill will go a long way in providing very minimal but widespread funding so that law enforcement can be more effectively developed in this area.

I would like to ask the chairman of the subcommittee if he would respond to a question on one aspect of the bill concerning the circumstances that mentally ill children who are institutionalized and then discharged under the modern health treatments and the difficulty in getting the services in their community after they have been discharged from institutionalization.

Can I ask, Mr. Chairman, what provisions in this bill would specifically address the need for communities to have the help required to provide for the mental health needs of these children?

Mr. WAXMAN. If the gentleman will yield, the President's Commission on Mental Health estimated that over 9 million children in the United States suffer from various emotional problems and that fewer than 10 percent of these children are receiving adequate care and services. H R. 7299 specifically responds to the concern of the Commission that children and youth are an especially underserved group and that failure to insure mental health services may have costly consequences when they become adults. Mental health services for children are cost effective, not only because they prevent long-term mental illness, but they have also been shown to provide cost savings for other medical care services as well.

Throughout the legislation, there are provisions that can be used to improve a seriously fragmented delivery system that too often means that children and adolescents lack access to any mental health services or are inappropriately served. Section 104 specifically targets funds for severely mentally disturbed children and adolescents. Under section 103, States can now provide grants for case management and other community

support services to assist the small population of chronically mentally ill children and adolescents. These are children who, for the most part—although they are often in and out of psychiatric hospitals or shuttled from one place to another—have not been included in States' deinstitutionalization efforts.

Additionally, H.R. 7299 provides opportunities for increasing preventive mental health services for children and adolescents, for strengthening children's programs in community mental health centers, and for improving the State's capacity to plan, develop, and monitor services for this population.

In 1969, a congressionally appointed Joint Commission on Children uncovered a number of critical problems related to the emotional stability of our society's young. The Joint Commission's report, "Crisis in Child Mental Health," brought forth vital and devastating evidence of the neglected needs of disturbed children. Ten years later, the President's Commission on Mental Health again identified many of the same issues. H.R. 7299 represents a beginning step toward eliminating some of these longstanding problems that deny emotionally disturbed children and their families the kinds of services they so desperately need.

□ 1330

I thank the chairman and yield back the balance of my time.

Mr. CARTER. Mr. Chairman, I yield 5 minutes to the distinguished gentleman from Utah (Mr. MARRIOTT).

Mr. MARRIOTT. Mr. Chairman, I rise in support of H.R. 7299.

As a member of the Committee on Interior and Insular Affairs, which has primary jurisdiction over Indian affairs, I would like to commend the Committee on Interstate and Foreign Commerce for including in this bill a provision which recognizes the mental health needs and unique circumstances of more than 1 million American Indians and Alaska Natives.

Section 108 of the bill authorizes the Secretary of Health and Human Services, upon the request of an Indian tribe or organization, to make grants for up to 100 percent of the cost of establishing a tribal mental health system.

By including this provision, the committee has demonstrated its awareness of the deficiencies in available Indian mental health care resources, and the inadequacy of existing funding sources for Indian mental health programs. By requiring tribal initiative and providing for tribal control of their own mental health systems, the committee has also recognized the fact that the most effective help that can be provided to Indians in the field of mental health is from Indians themselves.

I think it is appropriate that Indians be eligible for funding under this legislation that is designed to help meet the mental health needs of all Americans. Certainly the needs in Indian country are extensive and well documented.

Numerous reports and articles in social, psychological, and medical literature as well as official Government documents describe an unusually high incidence of mental and emotional disorders among native American populations. Centuries of conquest, exploitation, continuous changes and encroaching societal pressures have left Indian and Alaska Native communities only partially capable of coping with mental, social, and emotional problems. Alcohol abuse, suicide, family disorganization, homicides, assaults, child abuse, battered wives, violence in all forms, depression, apathy, and dependency are problems which are far too common.

The death rate among Indians from suicides is more than twice that of the general population; from accidents, 3½ times; from cirrhosis of the liver, 4.7 times; from homicides, 2.8 times.

The Indian Health Service, which is the primary provider of health care to more than 700,000 Indians on and near reservations in some 24 States, reported that in fiscal year 1979, 7 percent of all admissions to its own and contract hospitals were for mental health diagnoses, including alcoholism (7,443 out of 106,329 admissions). More than 72,000 outpatient visits for mental health problems were reported at IHS clinics and contract facilities, and another 70,000 contacts with mental health and social services personnel. In addition, more than 11,000 contacts related to mental health problems were made by community health representatives. These numbers increased in fiscal year 1980 and are expected to increase in fiscal 1981.

The history of Federal efforts to assist Indians in dealing with mental health problems is fairly recent. According to the 1977 final report of the American Indian Policy Review Commission, the first reports of manifestations of emotional disturbance among Indians were in 1928 by Brookings Institution investigators who found "excessive use of alcohol, high accident rates, child abandonment, and poor social and school adjustments." A 1955 report by the Public Health Service revealed that there were no facilities for psychiatric care of Indians beyond institutionalization in asylums, and that the few medical social workers serving Indians "were not sufficient in number to meet minimum requirements." Moreover, these social workers were limited to dealing with tuberculosis patients, mothers and children with problems of physical health, and the aged, handicapped, or abandoned.

That same PHS report, citing shortage of time as the reason for not collecting and developing quantitative data, devoted only 2 of its 327 pages to discussion of Indian mental health problems. It did note, however, that "there appears to be especially intense frustration," among Indians.

It was not until 1965 that a pilot mental health project was started at Pine Ridge, S. Dak., with funding from the National Institute of Mental Health. Later a headquarters was established at Albuquerque to provide clinical research training and consultative and administrative resources to mental health sections in reservation service areas. These efforts, while commendable, barely scratched the surface of the mental health problem in Indian country.

The Indian Policy Review Commission, with respect to mental health, found that "severe understaffing keeps every service area from providing more than a fraction of the needed services," and that a lack of a comprehensive needs assessment was causing what few services there were to be delivered on a random basis with limited resources and funds.

The Commission found the Indian Health Service without the necessary tools to cope with the unique cultural patterns of Indian tribes. These patterns, which vary from tribe to tribe, require special education and orientation for mental health professionals.

The Commission also found the availability of direct psychiatric therapy for Indians in acute crisis or with chronic emotional problems to be severely limited, social workers and psychiatric nurses to be equally scarce, and few area programs with enough people with the right skills to train interested Indians to take on some of the community work.

They also found a large portion of the workload in reservation mental health clinics being carried by paraprofessional health workers. These people, without extensive training, try to provide their communities with counseling, aid in handling personal crises, transportation, administrative and liaison support, and assistance with almost any other problems.

With the enactment of the Indian Health Care Improvement Act of 1976, Congress attempted to address across the board the severe shortages of manpower, inadequate facilities and funding which have dogged the efforts of the Indian health service to meet extensive backlogs of basic Indian health care needs. Recent increased funding for mental health programs, coupled with tribal efforts to establish and operate mental health programs via contracts authorized by the Indian Self-Determination Act, has brought some progress and highlighted the need for further efforts.

The Indian Health Service has used the means of contracting services to Indians under the Indian Self-Determination Act in a manner that demonstrates strong support of tribally oriented and operated mental health programs. At present, over 100 tribal employees are involved in mental health programs and over 20 programs are operated on a day-to-day basis under tribal management. Three tribes are included as major beneficiaries in NIMH community mental center grants.

One recent special project, funded by BIA and NIMH, illustrates the extent of the problems in mental health facing Indians. A model mental health program for boarding schools, the Bureau of Indian Affairs conducted at a high school in Carson City, Nev., to obtain a more precise scope and nature of human needs. Comprehensive evaluations of over 80 percent of the 450 Indian students found that 55 percent could be certified as emotionally disturbed, learning disabled, mentally retarded or multiple handicapped and in need of special services.

In fiscal year 1980 the Indian Health Service Office of Mental Health Programs received $6,874,000 and had a total of 285 authorized positions. While these funds and positions represent significant increases over previous efforts, it is still far below the identified need.

To obtain a comprehensive assessment of Indian health needs, the Indian Health Care Improvement Act mandated a study by the Department of Health and Human Services and the Indian Health Service in conjunction with the tribes. That study, sent to Congress in April 1980 reported a need for an additional 334 staff (to include tribal and non-Federal sources as well as the IHS), and $8,286,000 annually. These additional resources would be to provide for the full development and implementation of all of the specific mental health initiatives authorized by the Indian Health Care Improvement Act, expand mental health services within the BIA boarding schools, and implement recommendations concerning traditional Indian health practitioners.

In view of the gap between perceived needs and available means to meet them, the Indian Health Service and tribes have been actively seeking other sources of funding for efforts to address the unmet needs in Indian mental health. The section 108 program of H R. 7299 is thus a timely and highly appropriate additional source of funds to help them meet those needs. It is a modest program but a very intelligent one, and I again commend the members of the Interstate and Foreign Commerce Committee for including it in this legislation. Accordingly, I urge its speedy passage by this House.

I would like to just ask the chairman of the committee one question, if I may.

I am not sure if this comes under his jurisdiction, but I have been very concerned about autistic children. Does the gentleman in this bill or in his committee plan to provide any additional funding or anything for the autistic child?

Mr. WAXMAN. Mr. Chairman, will the gentleman yield?

Mr. MARRIOTT. I yield to the gentleman from California.

Mr. WAXMAN. I thank the gentleman for yielding.

Severely disturbed children would be covered under this legislation and autistic children would fall under that category.

Mr. MARRIOTT. So would that be all autistic children, or would they have to meet certain qualifications?

Mr. WAXMAN. It is my understanding that all autistic children would be covered by this legislation and be entitled to the services that would be available under the Community Mental Health Services Act.

Mr. MARRIOTT. Is that also the opinion of the ranking minority member?

Mr. CARTER. If the gentleman will yield, any autistic child with mental health problems is covered by this bill. Also, for many years, the care of autistic children has been part of a related program, the developmental disabilities legislation. Also dyslexia, which is a reading disability in which a child reads or tends to read from right to left and from down to up and which causes children to have difficulty learning at school is covered under that program. It is estimated that some 10 percent of our prison population is composed of dyslexics.

The amendment of the gentleman from Florida, who formerly was chairman of the subcommittee, provided for care of autistic children. My amendment included coverage for dyslexia children.

Mr. MARRIOTT. It has just been my understanding, as I have had people come back and lobby me regarding autistic children, that there seems to be a void in what is available for them, and therefore they are seeking various types of assistance. Does the gentleman from California believe that we have adequately taken care of autistic children, or should additional funding somehow be available to meet those particular problems?

Mr. WAXMAN. If the gentleman will yield, I do not believe and would not want to represent to my colleagues or to the American public that this legislation adequately addresses the mental health needs of the American people or any particular category of them, and autistic children are clearly a category of people who need special attention.

What we have attempted to do is to start in community mental health centers, to integrate them with the State programs for mental health services for all. But I must tell this body that we are really woefully lacking in committing the resources, despite the framework of this legislation, which gets the program underway so that it will actually reach everyone who needs the assistance and who desires that assistance. There is more yet to be done for autistic children in particular under this program, and I am sure there is more to be done in terms of research for that particular problem to prevent it or cure it or contain it.

Mr. MARRIOTT. I thank the chairman for including the Indians in this bill and certainly hope we will move forward with some more positive legislation to help the autistic children.

Mr. CARTER. If the gentleman would yield further, as I stated both of these conditions are covered under the Developmental Disabilities Act, but any children with mental disabilities should be cared for under the Mental Health Systems Act, and I believe they will be.

Mr. MARRIOTT. I thank the gentleman.

Mr. WAXMAN. Mr. Chairman, I yield such time as she may consume to a very distinguished member of our subcommittee, who has made a very great contribution to this legislation before us, the gentlewoman from Maryland (Ms. MIKULSKI).

Ms. MIKULSKI. Mr. Chairman, I am pleased to support the Mental Health Systems Act (H.R. 7299) because it extends the programs authorized under the Community Mental Health Centers Act, increases access to service for populations who should be, but are not, being served, and increases local and State control over the programs.

This bill recognizes our need to help several underserved populations. In specific, it helps:

End the dumping of the mentally ill from hospitals into the community;

Serve severely disturbed children and adolescents;

Serve local "priority" groups—the young, old, minorities who have been excluded from the service system; and

Serve rape victims.

The services to the "priority" groups is an important part of this bill. It acknowledges that certain groups within every community have not been given a fair shake—equal access to mental health services. It also recognizes that the people in their community, through their HSA, are best equipped to identify who needs to be served under this program and how they should be served.

Providing services to the rape victim and her loved ones represents a major step forward. We have spent enough time researching the rape victim; it is time to make sure she gets served when she needs it. This bill does not create a new entitlement program: What it does is provide additional support to rape crisis centers so they can become self-sufficient. It is very difficult to have your few volunteers simultaneously provide the rape victim and her family with support and be raising funds to pay for the telephone she called on. With these funds, the rape crisis centers will be on sure footing in the future.

For the first time, this bill gives the States a major role in determining how the mental health services are to be delivered. The goal of the Community Mental Health Centers Act has been for the Federal Government to help initiate mental health services in areas where no services exist, and then enable the States, localities, and private agencies to take over the programs. But we have excluded the States from any decision-making role concerning which programs get funded, and how to administer these programs. This bill changes that. Now, localities and States will have a voice in determining grantees.

The bill should also help us control the cost to the Federal Government of administering these community mental health programs. We are going to give some States the opportunity to show us how they can simultaneously administer both their programs and the programs funded under this bill. Also, it allows for funding innovative programs to improve the service delivery system.

I strongly urge my colleagues to support this bill because it represents a dual step toward meeting the health needs of all Americans, especially those who are not now being served, and increasing local control over programs they will eventually operate.

Mr. WAXMAN. Mr. Chairman, I yield 5 minutes to the gentleman from Connecticut (Mr. RATCHFORD).

Mr. RATCHFORD. Mr. Chairman, I rise today to voice my strong support for passage of H.R. 7299, the Mental Health Systems Act.

This landmark legislation, in the field of mental health, is not only vitally important, but also long overdue. Since the creation of the medicaid and medicare programs in the 1960's, the Congress has increasingly recognized the serious health needs of many segments of the American population, and has taken major steps toward the goal of adequate health care, for all Americans. And yet, that concept of health care has always been narrowly defined, including the diverse physical illnesses, but always neglecting the equally pressing mental illnesses. We cannot afford to ignore these tragic psychological disorders any longer.

The Mental Health Systems Act before us today establishes a solid foundation for a national policy in the field of mental health. Expanding upon the existing community mental health services programs, the bill authorizes grants to community mental health centers, as well as grants for services to the chronically mentally ill, and to severely mentally disturbed children, and adolescents. More importantly, the legislation attempts to build a partnership among all levels of government, and between public and private providers, of mental health services, in an effort to increase the availability of badly needed community mental health services, throughout the Nation.

Mental illness is now taking a shocking toll on our Nation, on the productivity of our people, and on the stability of our society. We cannot deny the greater strains felt by all of us, in an increasingly complex and pressured society. Today, we are clearly paying the price, through greater violence in our cities, and in our homes, or through inappropriate, and unnecessary, institutionalization which often serves as our only way of coping with mental health needs. We must do better, and we can do better, through the programs authorized under the bill before us today.

I would urge my colleagues in the House to recognize that we cannot escape the problem of mental illness—if we do not adopt a preventive approach, as proposed in this legislation, we will simply pay a much greater price later on, in much more painful and troubling ways. The programs contained in this bill are targeted, they are thoughtful, and they are prudent. I strongly urge my colleagues to lend their support to the Mental Health Systems Act, so that we can begin this important effort.

□ 1340

Mr. CARTER. Mr. Chairman, I yield 2 minutes to the distinguished gentlewoman from New Jersey (Mrs. FENWICK).

Mrs. FENWICK. Mr. Chairman, I thank my colleague.

I rise only to urge upon the committee something that has come to my attention. As someone who has been extremely interested in the education and rehabilitation of the mentally handicapped I believe that a program which is going on in my State should be more widely disseminated. It is a fact that many handicapped people have skills and abilities that are not always recognized as valuable and they are not taught to regard as valuable.

The time has come when in our schools, where we are teaching these children, they should be tested for these skills which will enable them to become independent citizens. I have proof that this can be one. We have in our State a man called Arthur Rittmaster, who some years ago found work for a severely mentally retarded person in the University Library of Princeton, where he is still working. His skill is design recognition. Mr. Rittmaster is gifted in the whole area. He goes to the businesses and finds out which jobs are monotonous. People do not stay long, because they are not highly paid. He finds what skills those occupations need and identifies those skills among the handicapped.

This is what our education should do, so that the handicapped person does not feel that there is a dead end at the end of schooling, that there is a life in which they can be respected and useful members of society. This ought to be an integral part of education, the training of mentally handicapped and perceptually handicapped to recognize themselves as valuable citizens—needed, not useless, not hopeless, not headed for some institution, but for useful citizenship.

The only thing that Princeton University does in regard to this handicapped person is to pay his rent and, of course, the withholding tax is done by the employer. He is an independent, taxpaying citizen.

Without this kind of training in youth, he might never have known that he was able to do all this.

We really must take this program more seriously. It must be a part of the educational process, that the handicapped should be tested for skills, that those skills should be identified and matched with those in industry which are needed.

The handicapped should be encouraged to find employment and life work in those areas.

I thank my colleagues for the time.

Mr. CARTER. Mr. Chairman, it is always a pleasure to hear the distinguished gentlewoman from New Jersey. She is, indeed, a great addition to this body. She has a great intellect, and with that, an intense feeling for humanity. I want to congratulate her on that.

Mr. Chairman, actually, this legislation was begun in 1963 under the late and martyred President John F. Kennedy, one of the most beloved Presidents we have ever had. Over the years it has grown to where it is helpful not only to the mentally ill and mentally retarded, but to disturbed youth and the chronically ill, and to our aged people who have mental difficulties.

Now, instead of 3 out of 4 of our mentally ill people going to insane asylums, snake pits and places of this nature, 3 out of 4 now are being treated, and have been for some time as outpatients through community-based centers. To me, the success of the program speaks strongly for the need to continue and expand this program.

Mr. Chairman, I have no further requests for time. I yield back the balance of my time.

Mr. WAXMAN. Mr. Chairman, I yield 5 minutes to the distinguished gentleman from Illinois (Mr. SIMON).

Mr. SIMON. Mr. Chairman, I thank the gentleman for yielding.

Let me join with many others in paying tribute to our colleague, the gentleman from Kentucky, Mr. TIM LEE CARTER, for all the contributions the gentleman has made.

Mr. Chairman, I rise to request some clarification of the section of H.R. 7299 pertaining to grants for services from severely mentally disturbed children and adolescents, with regard to a situation which has been of concern to me.

When we passed Public Law 94–142, the Education for All Handicapped Children Act of 1975, all handicapped children were assured the opportunity for a free, appropriate public education. What is appropriate is agreed upon by a team of evaluators, school administrators, and parents with placement usually being made within the local school district.

However, when a child is so severely emotionally disturbed that he or she needs constant attention from mental health professionals in order to benefit from special education, it is usually necessary to place him or her in a residential setting which may be out of State. The cost of such a placement may run as high as $50,000 per year.

Because of these extremely high costs, the State of Illinois governor's purchased care review board, for example, has put a ceiling on the amount they will pay to fund these placements. I had a meeting in my office about the problems relating to that this morning. Generally, they will agree to cover education costs, but see auxiliary mental health services as the responsibility of the medical community. Therefore, many residential schools will no longer accept Illinois residents.

As a result, many severely emotionally disturbed children across the country have been unable to secure the appropriate education placements which are guaranteed to them under the law. One child recently committed suicide while awaiting placement and another was seriously injured by other children in a State mental hospital.

Public Law 94–142 was developed to encourage coordination between service agencies to provide "related services" to handicapped children.

□ 1350

That coordination is clearly needed in the situation I have just described.

Am I correct, Mr. Chairman, in assuming that the State mental health agencies could apply for funds under H.R. 7299 to provide the mental health services for disabled children in residential placement?

Mr. WAXMAN. Mr. Chairman, will the gentleman yield?

Mr. SIMON. I yield to the gentleman.

Mr. WAXMAN. Mr. Chairman, I want to thank the gentleman for bringing this problem to our attention and allowing us to clarify the provisions of this bill. As the gentleman notes, it was clearly the intent of Public Law 94-142 to give the State education agency the authority to see that special education and related services were provided to all handicapped children, through the coordinated efforts of all the necessary social service agencies.

Let me assure the gentleman from Illinois that the provisions of H.R. 7299 are complementary to the provisions of Public Law 94-142 and would enable State mental health agencies to apply for grants to provide mental health services for disabled children in residential placements if those children are severely mentally or emotionally disturbed.

In regard to the gentleman's second question, education agencies would qualify as public agencies eligible to receive funds under this act, but State mental health agencies and community mental health centers would receive priority in their applications.

Mr. SIMON. I thank the gentleman from California. I appreciate his leadership on this. I think this can be of great help in a great number of States.

I yield back the balance of my time.

Mr. WAXMAN. Mr. Chairman, I yield 3 minutes to the gentleman from Texas (Mr. GONZALEZ).

Mr. GONZALEZ. Mr. Chairman, for many Congresses I have introduced legislation which would provide adequate mental health care and psychiatric care to all Americans. I am doing so again today.

In 1975, according to Pollack (1977), there were 6.9 million recorded patient care episodes of which 27 percent were inpatient, 70 percent were outpatient, and 3 percent were day treatment episodes.

During the past 20 years, the bulk of outpatient mental health care has increased from 23 percent in 1955 to 70 percent in 1975. This fourfold increase has placed a major burden on individuals and families because of those who receive mental health care, the majority have had to pay for it out of their own pockets. Many clients who receive mental health care services do so with the understanding that they will pay for the services rendered on a sliding scale schedule. For people on fixed incomes or those with meager means of support, the poor, the elderly, and the minorities, this added burden is intolerable.

In 1975, an estimated 15 percent of the population of the United States was in need of some type of mental health service. Unfortunately, this figure does not differentiate between the number of persons with mental disorders who do not receive treatment in the health and mental health systems, and those who may be in correctional institutions. Furthermore, it does not include those who are served by family service agencies, religious counselors and other social welfare agencies outside the defined health arena.

Of the 15 percent of the population in need of mental health services in 1975, 3.4 percent were under the care of the general hospital and nursing home sector; 54.1 percent were under the care of the primary care medical sector; and 15 percent were under the care of the specialty mental health sector; 6 percent were under care both in the primary care medical sector and the specialty mental health sector. Another 21 percent of these persons were either receiving some assistance or services from the other human services sectors, or worst of all, many were not receiving any service at all.

To date, there has been no definite epidemiological survey based on a national probability sample, however the National Institute of Mental Health (NIMH) has developed ranges of estimated prevalence rates for specific age and diagnostic groupings. They estimate an annual prevalence of mental disorders of roughly 15 percent. For children under 18, the rate is 8 to 10 percent with suicide as the leading cause of death in this category; for adults between the ages of 18 to 65, the prevalence rate is between 10 to 15 percent, and the aged—over 65—10 percent. Large increases are expected in numbers of persons in high risk age groups for the use of mental health facilities and correctional institutions and in homes for the aged and dependent and other institutions that constitute the institutional population.

According to the data provided by NIMH of all those who actually received mental health care during 1976, 3.1 percent were mentally retarded; 5.4 percent had organic brain syndromes; 22.5 percent suffered from schizophrenia; 15 percent from depressive disorders; 8.8 percent from alcoholism; 2.9 percent from drug disorders; 1.5 percent from other psychoses; and 32 4 percent from a category listed as others. Included in the other category were such mental illnesses as neuroses, and various forms of personality disorders. Eight percent were undiagnosed.

During the latter part of the 18th century, the idea that the mentally ill should receive humane treatment in hospitals emerged. In the United States, it was not until the end of the 19th century that the policy of treating the mentally ill in State hospitals became dominant policy. We are now beginning to approach the end of the 20th century and the American people have a right to comprehensive mental health insurance coverage that would actually reduce the overall cost of health care.

Our constituencies want to lead lives which are productive, meaningful, and fulfilling. However, if they or their loved ones are afflicted with some form of mental illness or emotional problem, they are less apt to be able to lead full and productive lives because emotional conditions interfere with such things as one's ability to get and keep a job, or to raise a family whose children are not plagued by neglect or abuse.

Mr. Chairman, this is why I am persistent and continue to reintroduce legislation aimed at providing comprehensive mental health coverage to all Americans. Hopefully, this could be a part of a national health insurance program, but, if not, I advocate a separate program for mental health.

Even though the Federal Government has supported community mental health centers which utilize a sliding fee scale, for many this is not enough. For example, Valde and Fiester (1976) found that Spanish surnamed families that lived within a specific community mental health center made from $3,000 to $5,000 annually. More than 50 percent of these families had an income of less than $5,000. Although the incomes have risen in the past 4 years, the actual buying power is less because of inflation.

In that same study, over 63.3 percent of the clients had to take prescribed medication. Taken together, the sliding fee, the cost of transportation, the prescribed medication, and their meager incomes of $5,000 or less, it is not hard to see why mental health care remains inaccessible for the poor and many middle-income families.

Although a fee of $5 may seem minimal, for the have-nots, it can be devastating, especially when consideration is given to the fact that the majority of mental illnesses are chronic and debilitating. The poor also tend to be multiple users of human services. We all know that it is the poor and middle income who experience the most difficulty with payments for mental health services. Since the vast majority of the population in this country are from the middle and lower income categories and the cost of mental health care remains prohibitive to them, there exists a need to appropriate money for a national mental health insurance.

If a family has a member who is schizophrenic, they can usually anticipate the course to be of a chronic nature. There will be repeated episodes of severe disability and a liftime of varying degrees of impairment and emotional stress for the patient, the family, and significant others in his life. Therefore, the total burden of this illness to society is considerable and financially taxing. According to the 1975 census, the mean family income was $10,401 for black Americans, $11,096 for Americans of Hispanic origin; and $16,115 for non-Hispanic white Americans. These figures coupled with our high annual inflation rate makes the burden of mental illness on the family extremely taxing and probably constitutes one of the primary public health issues of our times.

A national insurance plan which includes complete mental health coverage has the potential of actually reducing the overall cost of national health insurance because it would provide coverage for those illnesses and symptoms which are of a debilitating nature if not treated promptly. Symptoms such as chronic back pain, migraine headaches, and acute gastric pain often necessitate intensive medical workups and in some cases eventual surgical intervention. The

medical community recognizes the fact that more than 60 percent of the people hospitalized in general hospitals for physical illnesses have diseases and complaints based on emotional problems.

Increasingly, the medical community is beginning to develop a deeper appreciation for the part the psyche plays in maintaining the physical well-being of an individual. According to Dorken (1976), the single category of human disability in the United States was attributable to mental disorders.

The proposed program would be funded through a mental health tax with the funding mechanism similar to those under some of pending national health insurance bills. This program that I am introducing could be supplemental to any national health insurance plan or could be instituted as a separate program.

The major services provided for under the bill include: psychiatric hospital care, psychotherapy, prescribed drugs, community health center services, and home therapy. Innovative services provided for by this bill include: Halfway house care, day mental hospital care, and night mental hospital care.

The focal point of care would be community based and emphasis would be placed on treating the individual while in contact with his family. Experience has demonstrated that this type of care reduces the rate of institutionalization and allows the person to lead a richer and more productive life in the community.

Halfway house care as a treatment modality is a relatively new phenomenon in the mental health arena. Historically, there were a few halfway houses for persons who had been in penal institutions, however, the use of the halfway house approach for persons with a mental illness was relatively rare. The results of people participating in halfway house treatment is promising and worthy of increased attention.

In San Antonio, the district which I represent, the halfway house program operates on a funding mechanism which is a combination of private fees, private contributions, and moneys from the Texas Rehabilitation Commission, the United Way, and the Texas Commission for the Blind.

Approximately 80 to 85 percent of the residents of the halfway house in San Antonio are full paying or on a sliding fee scale. The major emphasis of the halfway house treatment program is to rehabilitate and help those who otherwise might be doomed to a dismal life of institutionalization. One of the goals of treatment in a halfway house program is to assist mental patients become productive members of society.

Part of the difficulty with today's inadequate mental health care services is that many mental patients have not had the opportunity to participate in halfway house treatment because none has been available. Where facilities do exist, they are frequently overcrowded and unable to accommodate and accept any more patients. Some mental patients never reach the point in the course of their treatment where they recover enough to become eligible for halfway house treatment.

Mr. Chairman, one of the most important purposes of this bill is the prevention of mental illness. This goal will be accomplished by giving to all Americans a right to obtain adequate preventive mental health care which is affordable.

With so many Americans affected by some form of mental disorder, it is time for us to recognize mental and emotional illnesses as valid forms of illnesses. Our country is facing a crisis in the care and treatment of the mentally ill. We have a long way to go in catching up and one way to do this would be to start considering mental health insurance as an integral part of our national health insurance packages. If health in its broadest meaning is a right to which all Americans are entitled to, then a mental health insurance bill should be passed by this Congress.

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Mr. WAXMAN. Mr. Chairman, I have no further requests for time.

Before I yield back the balance of my time, Mr. Chairman, I also want to join in paying tribute to the ranking minority member of the subcommittee, Dr. TIM LEE CARTER, for his contributions in this legislation. His contributions in this legislation, while important, are only one part of the overall contributions he has made to health care in this country and to the fabric of legislation that will long stand as a monument to him in contributing to the betterment of the people of this country.

Mr. MARRIOTT. Mr. Chairman, will the gentleman yield?

Mr. WAXMAN. I yield to the gentleman from Utah.

Mr. MARRIOTT. I appreciate the gentleman yielding. I, too, may not have another chance to express my appreciation to Dr. CARTER. He and I have been longtime friends since I have been here, at least the last 4 years. I think he has made a tremendous contribution to this body, and I appreciate all he has done for both the Congress, this great country, and this legislation.

Mr. WAXMAN. I appreciate the gentleman's comments and want to inform him he will have additional chances to comment on Dr. CARTER's leadership because we have a number of other bills yet coming from our subcommittee on which Dr. CARTER's clear imprint is present.

Mr. CARTER. Mr. Chairman, will the gentleman yield?

Mr. WAXMAN. I yield to my good friend, the ranking minority member of the subcommittee, Dr. CARTER.

Mr. CARTER. I feel very humble. It has been a labor of love to have been a part of the legislation involving health over the past several years. It has been a pleasure to serve with you and with the Members of this House and to preserve the pure water system of the distinguished gentleman from San Antonio. I thank my good friend for yielding and for his kind remarks.

● Mr. STAGGERS. Mr. Chairman, I am pleased to support this bill which does a great deal toward helping some of the most vulnerable people in our society.

The changes provided in this legislation originally came to the Subcommittee on Health and Environment from the President's Commission on Mental Health. That group, under the personal leadership of the First Lady, developed a series of recommendations for providing better mental health care to children, to the elderly, and to the chronically mental ill of the country. After much work by the subcommittee and by the full Commerce Committee, the bill now provides for continued support of the local community programs, for new programs to provide specialized help, and an increased role for State governments in planning these services.

I am especially pleased that the bill contains a grant program devised by the subcommittee to aid children who are severely disturbed. We all know of the special tragedy of a young life which is disrupted by mental illness and emotional problems. What few of us recognize is the inadequacy of the mental health system in treating those children. They are moved from hospital to hospital, from home to institution, with little specialized help. Families are without support to care for their young loved ones.

Under H.R. 7299, the Federal Government will provide grants to develop programs and treatment for these children and their families. I am proud to support this provision to return these children to normal lives as they grow up.

I want to commend the subcommittee chairman, Mr. WAXMAN, and the able ranking minority member, Dr. CARTER, for their work on this bill. It is a good piece of legislation, and I urge all the Members to support it.●

● Mr. FRENZEL. Mr. Chairman, since my days in the Minnesota State Legislature, I have been a continuing supporter of the idea that patients suffering from mental disorders could be more effectively treated in their own community, as opposed to institutional settings. Since I came to Congress, I have had the opportunity to enthusiastically support several revisions of the original Community Mental Centers Act, which were aimed at expanding and improving deinstitutionalization programs.

Although the original legislation, enacted in 1963, was intended to be a demonstration program, to offer formula grants to States to induce them to re-

place the traditional inadequate institutions with smaller, community-based facilities, the scope of the program was broadened considerably in subsequent revisions of the act with Federal support to date, totaling some $2.287 billion over the past 13 years.

The Community Mental Health Centers Act is a good program. Since its inception, Federal dollars have assisted in the creation of 763 community mental health centers which have made mental health services available to over 110 million people. Such services have been provided to rape victims, alcoholics, drug addicts, and include treating children and the elderly. The committee report states that "Over 712 of the centers are fully operational and, in 1979, provided direct services to over 2.4 million persons."

It is my understanding that some 167 centers are now operating independently (without Federal support) and 325 centers no longer require basic operations support. More importantly, this Federal initiative has generated substantial State and local support, which together has resulted in a dramatic shift from inpatient to outpatient mental health care and a decrease of 36 percent in the number of psychiatric hospital beds in the United States today. Clearly, the program has been enormously successful and I have been privileged to support it.

It is for this reason that I am so deeply disturbed by the cost of H.R. 7279. In spite of Congress failure to balance the fiscal year 1981 budget, and considering that even the most worthwhile programs are slated for severe budget cuts, I would have been pleased to support the $13 million increase for the Community Mental Health Centers Act which is included in the first part of H.R. 7299.

However, H.R. 7299, goes far beyond a simple revision and extension of the Community Mental Health Centers Act. The second part of the bill totally overhauls the CMHC Act by creating a variety of new grant authorizations, many of which I strongly support, beginning in fiscal year 1982–84. But this section authorizes some $530 million over 3 years, bringing the increase to over 300 percent. That is more than our budget can stand.

I do not question the value of these programs. My primary concern rests with asking the taxpayers to triple the authorization at a time when taxpayers are already paying some $80 billion in fiscal year 1981 for interest on Congress past sins for overspending—those past sins will accumulate to a grand total of close to $1 trillion in debt.

It is not fair to dangle this $530 million authorization in a carrot like fashion, when in fact we are probably going to wind up asking our Appropriation Committee members to go slow when it comes to giving out the actual dollars. My constituents tell me that they would all benefit from improved mental health if Congress were ever to bring inflation under control.

With great reluctance I shall vote for the Community Mental Health Centers Act. My vote is because it is a worthwhile program. My regret is because it does not need such an expensive authorization to carry on its successful work. I urge my colleagues to take a close look at our current economic picture as they vote on this measure.●

● Mr. HARRIS. Mr. Chairman, I rise in support of H.R. 7299, the Mental Health Systems Act. I am expecially pleased that title VI has been included—the rape services support system. I know that my friend and colleague DOUG WALGREN worked hard in developing this title and every rape program and support group in the Eighth Congressional District of Virginia is appreciative.

The rape crisis centers I have worked with in my district have continually contacted me about the need for legislation which would support direct victim services. Freeing staff from the time-consuming activities of fundraising would allow staff to concentrate on finding long-term funding resources and would allow them to beef up victim services.

The legislation we are considering here today authorizes the Secretary of HHS to award grants and contracts to public and nonprofit rape crisis centers to assist in meeting the costs of providing direct services to rape victims. Types of direct services include accompaniment of the victim to medical, social, and legal services; counseling and referral services to the victim and the victim's immediate family; basic operating expenses; for example, telephone hotlines, office space, and utilities; consultation with allied professionals and public education materials and programs.

Self-sufficiency of existing RCC's will be developed through the establishment of long-term public and private funding sources.

The fragile financial conditions of many of the RCC's throughout the Eighth District and around the country result in periodic closings and hand-to-mouth existence. We must pass H.R. 7299 today to alleviate these problems and assure that these needed support services will be available. It could easily be a member of one of our families who would need assistance from a rape crisis center.●

● Mr. ROYBAL. Mr. Chairman, I rise in support of H.R. 7299. I would, however, like to say that I am sorry that the House version of the Mental Health Systems Act does not contain a special section of grants for the elderly as does the Senate bill, S. 1177, that was passed by that body last month.

The major aging organizations, the National Council of Senior Citizens, the National Retired Teachers Association/American Association of Retired Persons, and the National Council on Aging, are all on record as supporting the aging section in the Senate bill. The U.S. Commission on Civil Rights and the Mental Health Association also support the Senate amendment.

I believe that we need special grants for the elderly so that groups with interest, and knowledge can provide the unique support services and treatment required by this population. The Senate bill requires that public or nonprofit entities must provide outreach services and a differential diagnosis to distinguish between and establish the need for mental health services and other medical care prior to treatment, and at least one other service. The other services include identifying needs and providing services not being provided by existing programs, providing personnel for mental health and support services, coordinating services of other agencies, and providing services and training in nursing homes.

It is my hope that we can incorporate these fine ideas in the final version of the bill.●

The CHAIRMAN. Pursuant to the rule, the Clerk will now read the bill by titles.

The Clerk read as follows:

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

SHORT TITLE AND TABLE OF CONTENTS

SECTION. 1. This Act may be cited as the "Mental Health Systems Act".

TABLE OF CONTENTS

PREPARATION GRANTS

SEC. 101. (a) For the purpose of assisting public or non-profit private entities to prepare for providing mental health services in a mental health service area, the Secretary may make grants to such entities for projects to—

(1) assess the needs of mental health service areas for mental health services;

(2) design mental health services programs for such areas based on such assessment;

(3) obtain financial and professional assistance and support for such programs; and

(4) initiate and encourage continuing community involvement in the development and operation of such programs.

(b) The amount of any grant under subsection (a) may not exceed $75,000.

(c)(1) Only one grant may be found under subsection (a) with respect to a mental health service area.

(2) No grant may be made under subsection (a) with respect to any mental health service area if a grant has previously been made under section 202 of the Community Mental Health Centers Act with respect to (A) the same area, or (B) any other area any substantial part of which (as determined by the Secretary) is included in that mental health service area.

(3) No application for a grant under subsection (a) for a project may be approved unless the State mental health authority for the State in which the project is to be located has recommended that the Secretary approve the application.

(d) For the purpose of making grants under subsection (a) there are authorized to be appropriated $1,000,000 for the fiscal year ending September 30, 1982, $1,000,000 for the fiscal year ending September 30, 1983, and $1,000,000 for the fiscal year ending September 30, 1984.

GRANTS FOR COMMUNITY MENTAL HEALTH CENTERS

SEC. 102. (a)(1) Subject to section 406, the Secretary may make grants to public and nonprofit private community mental health centers to assist them in meeting their costs of operation (other than costs related to construction).

(2) No application for a grant under paragraph (1) for a community mental health center which has not received a grant for its operation under the Community Mental Health Centers Act may be approved unless—

(A)(i) the community mental health center for which the application is submitted is operated by a State, or

(ii) in the case of any other center, the application has been recommended for approval by the State mental health authority for the State in which the center is located; and

(B) in the case of an application for a grant to be determined under subsection (c)(1)(B), the application is accompanied by assurances, provided by the State mental health authority for the State in which the center is located and satisfactory to the Secretary, that the grant applied for and the State, local, and other funds and the fees, premiums, and third-party reimbursements which the applicant may reasonably be expected to collect in the year for which the grant would be made are sufficient to meet the projected costs of operation for that year.

(3) Grants under paragraph (1) may only be made for a grantee's costs of operation during the first eight years after its establishment. In the case of a community mental health center or other entity which received a grant under section 220 of the Community Mental Health Centers Act (as in effect before the date of enactment of the Community Mental Health Centers Amendments of 1975) or section 203(a) of such Act, such center or other entity shall, for purposes of grants under paragraph (1), be considered as having been in operation for a number of years equal to the sum of the number of grants in the first series of grants it received under such section and the number of grants it has received under paragraph (1).

(b)(1) Each grant under subsection (a) to a community mental health center shall be made for the costs of its operation for the one-year period beginning on the first day of the month in which such grant is made, except that if at the end of such period a center has not obligated all the funds received by it under a grant, the center may use the unobligated funds under the grant in the succeeding year for the same purposes for which such grant was made but only if the center is eligible to receive a grant under subsection (a) for such succeeding year.

(2) No community mental health center may receive more than eight grants under subsection (a).

(c)(1) The amount of a grant for any year made under subsection (a) shall be the lesser of the amounts computed under subparagraph (A) or (B) as follows:

(A) An amount equal to the amount by which the grantee's projected costs of operation for that year exceed the total of State, local, and other funds and of the fees, premiums, and third-party reimbursements which the grantee may reasonably be expected to collect in that year.

(B)(i) Except as provided in clause (ii), an amount equal to the following percentages of the grantee's projected costs of operation: 80 per centum of such costs for the first year of its operation, 65 per centum of such costs for the second year of its operation, 50 per centum of such costs for the third year of its operation, 35 per centum of such costs for the fourth year of its operation, 30 per centum of such costs for the fifth and sixth years of its operation, and 25 per centum of such costs for the seventh and eighth years of its operation.

(ii) In the case of a grantee providing services for persons in an area designated by the Secretary as an urban or rural poverty area, an amount equal to the following percentages of the grantee's projected costs of operation: 90 per centum of such costs for the first two years of its operation, 80 per centum of such costs for the third year of its operation, 70 per centum of such costs for the fourth year of its operation, 60 per centum of such costs for the fifth year of its operation, 50 per centum of such costs for the sixth year of its operation, 40 per centum of such costs for the seventh year of its operation, and 30 per centum of such costs for the eighth year of its operation.

(2)(A) The amount of a grant prescribed by paragraph (1) for a community mental health center for any year shall be reduced by the amount of unobligated funds from the preceding year which the center is authorized, under subsection (b)(1), to use in that year.

(B) If in a fiscal year the sum of—

(i) the total of State, local, and other funds, and of the fees, premiums, and third-party reimbursements collected in that year, and

(ii) the amount of the grant received under this section by a center or entity,

exceeds its costs of operation for that year because the amount collected was greater than expected, and if the center is eligible to receive a grant under subsection (a) in the succeeding year, an adjustment in the amount of that grant shall be made in such a manner that the center may retain such an amount (not to exceed 5 per centum of the amount by which such sum exceeded such costs) as the center can demonstrate to the satisfaction of the Secretary will be used to enable the center (I) to expand and improve its services, (II) to increase the number of persons (eligible to receive services from such a center) it is able to serve, (III) to modernize its facilities, (IV) to improve the administration of its service programs, and (V) to establish a financial reserve for the purpose of offsetting the decrease in the percentage of Federal participation in program operations in future years.

(d)(1) For payments under initial grants under subsection (a) there are authorized to be appropriated $24,000,000 for the fiscal year ending September 30, 1982, $27,000,000 for the fiscal year ending September 30, 1983, and $30,000,000 for the fiscal year ending September 30, 1984.

(2) There are authorized to be appropriated for the fiscal year ending September 30, 1982, and for each of the next nine fiscal years such sums as may be necessary for payments under continuation grants under subsection (a) to community mental health centers.

GRANTS FOR SERVICES FOR THE CHRONICALLY MENTALLY ILL

SEC. 103. (a) The Secretary may make grants to State mental health authorities, community mental health centers, and other public and nonprofit private entities for the provision of services, including case management, designed to assist the chronically mentally ill in gaining access to essential mental health services, medical and dental care, rehabilitation services, and employment, housing, and other support services to enable the chronically mentally ill to function to the maximum extent of their capabilities.

(b) An application for a grant under subsection (a) shall contain a plan for the provision of the mental health and support services to be provided with the grant and describing the priorities to be applied by the applicant in determining which services to offer. Such a plan shall be in accordance with the State health plan in effect under section 1524 of the Public Health Service Act in the State of the applicant.

(c) In considering applications for grants under subsection (a) the Secretary shall give special consideration to appliactions for projects designed to supplement and strengthen existing community support services. The Secretary shall give priority to approved applications for such grants in the following order:

(1) Applications of State mental health authorities to provide mental health and support services in a State (A) through community mental health centers, and (B) in areas where centers do not exist, directly or through public or nonprofit private entities.

(2) Applications of community mental health centers.

(3) Applications of other public and nonprofit private entities for the provision of services in areas where community mental health centers do not exist.

(d) For the purpose of making grants under subsection (a) there are authorized to be appropriated $32,600,000 for the fiscal year ending September 30, 1982, $38,000,000 for the fiscal year ending September 30, 1983, and $43,000,000 for the fiscal year ending September 30, 1984.

GRANTS FOR SERVICES FOR SEVERELY MENTALLY DISTURBED CHILDREN AND ADOLESCENTS

SEC. 104. (a) The Secretary may make grants to State mental health authorities, community mental health centers, and other

public and nonprofit private entities for the provision of mental health and support services for severely mentally disturbed children and adolescents and for members of their families.

(b) An application for a grant under subsection (a) shall contain a plan for the provision of the mental health and support services to be provided with the grant and describing the priorities to be applied by the applicant in determining which services to offer. Such a plan shall be in accordance with the State health plan in effect under section 1524 of the Public Health Service Act in the State of the applicant.

(c) In making grants under subsection (a), the Secretary shall give priority to approved applications for such grants in the following order:

(1) Applications of State mental health authorities to provide mental health and support services in a State (A) through community mental health centers, and (B) in areas where centers do not exist, directly or through public or nonprofit private entities.

(2) Applications of community mental health centers.

(3) Applications of other public and nonprofit private entities for the provision of services in areas where community mental health centers do not exist.

(d) For the purpose of making grants under subsection (a) there are authorized to be appropriated $7,000,000 for the fiscal year ending September 30, 1982, $8,000,000 for the fiscal year ending September 30, 1983, and $9,000,000 for the fiscal year ending September 30, 1984.

GRANTS FOR MENTAL HEALTH SERVICES FOR PRIORITY POPULATIONS

SEC. 105. (a) Subject to section 406, the Secretary may make grants to any public or nonprofit private entity for any project for mental health services which—

(1) are designed to serve principally one or more priority population groups in a mental health service area,

(2) are available to all residents of the area, and

(3) are provided in a mental health service area not served by a community mental health center.

(b) An application for a grant under subsection (a) may be approved only if—

(1) the State mental health authority for the State in which the project to be assisted by the grant is located has recommended that the Secretary approve the application;

(2) the application contains satisfactory assurances that the project for which the application is made will lead to increased or more appropriate mental health services for a priority population group or to the development of mental health services for such a group;

(3) the application contains satisfactory assurances that members of the priority population group or groups to be served by the project have had a reasonable opportunity to comment on the proposed project during its preparation and satisfactory assurances that members of the group or groups will be afforded reasonable opportunity to comment on performance under the project; and

(4) the applicant (A) will during the first three years that it receives a grant under subsection (a) provide outpatient mental health services and any two of the following mental health services determined to be of the greatest need for the priority population to be served by the applicant: inpatient services, screening, followup, consultation and education, and emergency, and (B) has a plan satisfactory to the Secretary for the provision of all the mental health services described in clause (A) upon the expiration of the first three years that it receives a grant under subsection (a).

(c) In any fiscal year not more than two grants may be made under subsection (a) for one mental health service area and the total number of grants that may be made to such an area under subsection (a) may not exceed ten. Not more than five grants may be made under subsection (a) to the same entity for mental health services for the same priority population group or groups. The amount of any grant under subsection (a) shall be determined by the Secretary, except that the fourth and fifth such grants may not exceed 60 per centum and 30 per centum, respectively, of the costs of the project for which the grants are made.

(d) For the purpose of making grants under subsection (a) there are authorized to be appropriated $16,000,000 for the fiscal year ending September 30, 1982, $18,000,000 for the fiscal year ending September 30, 1983, and $200,000,000 for the fiscal year ending September 30, 1984.

(e) For purposes of this section, the term "priority population group" means an identifiable population group in a mental health service area which is unserved or underserved by mental health programs in such area as determined under a health systems plan or a State health plan in effect under section 1513 or 1524 of the Public Health Service Act.

GRANTS FOR NON-REVENUE-PRODUCING ACTIVITIES

SEC. 106. (a)(1) The Secretary may make grants to public and nonprofit private community mental health centers to assist in meeting the costs (as defined by the Secretary by regulation) of—

(A) providing the consultation and education services described in clause (iv) of section 409(b)(1)(A),

(B) providing the followup services described in clause (iii) of such section, and

(C) administering the mental health service programs of the entities.

(2) To be eligible for a grant under paragraph (1) a community mental health center must be a public or nonprofit private center which—

(A) has received a grant under section 203 (a) of the Community Mental Health Centers Act, under section 220 of such Act as in effect before July 29, 1975, or under section 102 of this Act; and

(B) because of the limitations on the perod for which a center may receive such a grant or on the number of such grants the center may receive, is no longer eligible to receive such a grant.

(3) No application for a grant under paragraph (1) for a fiscal year beginning after September 30, 1983, for a community mental health center may be approved unless—

(A) the community mental health center for which the application is submitted is operated by a State, or

(B) in the case of any other center, the application has been recommended for approval by the State mental health authority for the State in which the center is located.

(b) An application for a grant under subsection (a) shall contain assurances satisfactory to the Secretary that the applicant will, during the period which it receives a grant under subsection (a), provide, at a minimum, the comprehensive mental health services described in clauses (i) through (iv) of section 409(b)(1)(A).

(c)(1) No community mental health center may receive more than five grants under subsection (a).

(2) Each grant under subsection (a) shall be made for the one-year period beginning on the first day of the first month beginning after the date the grant is made.

(3) The amount of a grant under subsection (a) shall be determined by the Secretary, except that no grant may exceed the product of $1.00 and the population of the mental health service area of the community mental health center receiving the grant. The population of a mental health service area shall be determined on the basis of the latest available from the Department of Commerce.

(d) For the purpose of making grants under subsection (a) there are authorized to be appropriated $35,000,000 for the fiscal year ending September 30, 1982, $40,000,000 for the fiscal year ending September 30, 1983, and $45,000,000 for the fiscal year ending September 30, 1984.

GRANTS FOR MENTAL HEALTH SERVICES IN AMBULATORY HEALTH CARE CENTERS

SEC. 107. (a)(1) For the purpose of assisting ambulatory health care centers to participate appropriately in the provision of mental health services to their patients, the Secretary may make a grant to—

(A) any public or nonprofit private entity which provides mental health services that include at least twenty-four-hour emergency services, outpatient services, and consultation and education services (as described in section 409(b)(1)(A)(iv)) and has in effect an agreement of affiliation, described in paragraph (2), with an entity which is an ambulatory health care center; or

(B) any public or nonprofit private ambulatory health care center which has in effect an agreement of affiliation, described in paragraph (2), with an entity described in subparagraph (A).

(2) An agreement of affiliation referred to in paragraph (1) is an agreement between a mental health services entity described in paragraph (1)(A) and an ambulatory health care center which agreement—

(A) describes the geographical area the residents of which will be served by the mental health services to be provided under the agreement;

(B) provides for the employment of at least one mental health professional to serve as a liaison between the parties to the agreement and includes a description of the qualifications to be required of that person and of any other professional mental health personnel to be employed under the agreement;

(C) provides satisfactory assurances that the mental health services entity will make mental health services available to patients of the center referred to it by the liaison or other mental health professionals; and

(D) includes transportation arrangements and other arrangements for effecting referral from the center to the mental health services entity of patients needing the services of such entity.

(b) Any grant under subsection (a) may be made for a project for any one or more of the following:

(1) The costs of liaison or other mental health professionals providing services in the ambulatory health care center in accordance with an agreement of affiliation.

(2) Mental health services provided by other personnel of the center which the mental health services entity determines can be appropriately provided by such personnel.

(3) Consultation and inservice training on mental health provided to personnel of the ambulatory health care center by the mental health services entity.

(4) Establishing liaison between the center and other providers of mental health services or support services.

(c) For the purpose of making grants under subsection (a) there are authorized to be appropriated $15,000,000 for the fiscal year ending September 30, 1982, $17,500,000 for the fiscal year ending September 30, 1983, and $20,000,000 for the fiscal year ending September 30, 1984.

GRANTS FOR MEMBERS OF INDIAN TRIBES OR ORGANIZATIONS

SEC. 108. (a) Upon request of any Indian tribe or any urban Indian organization the Indian Health Service may apply to the Secretary for a grant under this title to be made

to the Indian Health Service or any entity of the Service for the provision of mental health services to members of such tribe or organization. Such a grant shall be made on the same terms and conditions as apply to non-Federal entities.

(b) Any grant under subsection (a) may be made for a project serving members of an Indian tribe or an urban Indian organization even though the area in which those members reside is included in two or more mental health service areas of a State.

(c) For purposes of this section, the terms "Indian tribe" and "urban Indian organization" have the same meaning as is prescribed for them in section 4 of the Indian Health Improvement Act (25 U.S.C. 1603(4)).

GRANTS FOR INNOVATIVE PROJECTS

SEC. 109. (a) The Secretary may make grants to public and nonprofit private entities for—

(1) projects for the training and retraining of employees adversely affected by changes in the delivery of mental health services and assistance in securing employment;

(2) projects for the innovative use of personnel in the management and delivery of mental health services; and

(3) any other innovative project of national significance respecting mental health services and mental health services personnel.

(b) The Secretary may set dates by which applications for grants under subsection (a) must be submitted.

(c) In any fiscal year, 5 per centum of the total amount appropriated for such fiscal year under sections 101 through 107 shall be available to the Secretary for grants under subsection (a). Of the funds obligated by the Secretary for such grants, not less than 50 per centum shall be obligated for approvable projects described in subsection (a)(1).

TITLE II—STATE PROGRAMS

GRANTS TO IMPROVE THE ADMINISTRATION OF STATE MENTAL HEALTH PROGRAMS

SEC. 201. (a) For the purpose of assisting States to improve the administration of State mental health programs, the Secretary may make grants to State mental health authorities for any project for any one or more of the following:

(1) Improving the capacity of the State mental health authority to collect and analyze statistics and other data and to otherwise meet the monitoring or reporting requirements under this Act.

(2) Improving the planning and other administrative functions of the State mental health authority.

(3) Improving the ability of the State mental health authority (A) to set performance standards for mental health service projects and programs, (B) to enforce those standards, and (C) to evaluate performance under such projects and programs through data analysis, studies, and other means.

(4) Any other activity designed to improve the provision of mental health services in the State or the administration of State or local mental health programs.

(b) For payments under grants under subsection (a) there are authorized to be appropriated $3,000,000 for the fiscal year ending September 30, 1982, $4,000,000 for the fiscal year ending September 30, 1983, and $5,000,000 for the fiscal year ending September 30, 1984.

PILOT PROJECTS FOR STATE ADMINISTRATION OF GRANTS

SEC. 202. (a) For the purpose of demonstrating the improvement in administration and in the provision of mental health services that can be made by State mental health authorities participating in the administration of the grant programs under this Act, the Secretary may enter into agreements with State mental health authorities under which the authorities will, on behalf of the Secretary—

(1) disburse Federal funds under grants under this Act;

(2) review performance under projects and programs funded by grants under this Act and report to the Secretary the extent to which such performance complies with applicable requirements; and

(3) perform such other functions of the Secretary under the grant programs as the State mental health authority and the Secretary may agree upon.

As determined in the agreements entered into under this subsection, the Secretary shall make grants to State mental health authorities to meet their costs in carrying out the agreements.

(b) For the purpose of payments under grants under subsection (a) there are authorized to be appropriated $3,000,000 for the fiscal year ending September 30, 1982, $4,000,000 for the fiscal year ending September 30, 1983, and $5,000,000 for the fiscal year ending September 30, 1984.

TITLE III—PREVENTION

DEMONSTRATION PROJECTS

SEC. 301. (a) The Secretary may make grants to public and nonprofit private entities to demonstrate the effectiveness of intervention techniques and mental health promotion activities in the—

(1) maintenance and improvement of the mental health of individuals and groups of individuals particularly susceptible to mental illness,

(2) prevention of the onset of mental illness in such individuals and groups, and

(3) prevention of the deterioration of the mental health of such individuals and groups.

(b) An application for a grant under subsection (a) shall—

(1) define the intervention techniques and mental health promotion activities to be funded by the grant;

(2) define the individuals or groups of individuals to be served by such techniques and activities; and

(3) provide for the evaluation of the effectiveness of such techniques and activities and describe the methodology to be used in making such evaluation.

(c) For the purpose of making grants under subsection (a) there are authorized to be appropriated $6,000,000 for the fiscal year ending September 30, 1982, $8,000,000 for the fiscal year ending September 30, 1983, and $10,000,000 for the fiscal year ending September 30, 1984.

TITLE IV—GENERAL PROVISIONS

PART A—STATE PLANS

STATE MENTAL HEALTH SERVICES PLANS

SEC. 401. (a) In order for the State mental health authority of or any entity in a State to be eligible to receive a grant under this Act for any fiscal year, such State must have in effect a State mental health services plan which—

(1) has been prepared by an agency of the State designated by the Governor (hereinafter in this Act referred to as the "State agency") and submitted to the Secretary through the Governor,

(2) is consistent with the provisions, relating to mental health services, of the State health plan prepared in accordance with section 1524(c)(2) of the Public Health Service Act, and

(3) has been approved by the Secretary as meeting the requirements of section 402.

(b) The Secretary may not finally disapprove a State mental health services plan (or any modification thereof) except after reasonable notice and opportunity for a hearing to the State.

(c) Whenever the Secretary, after reasonable notice and opportunity for a hearing to the State agency of a State, finds that the State plan approved under this Act has been so changed that it no longer complies with section 502, or that in the administration of the plan there is a failure to comply substantially with any provision of such section, the Secretary—

(1) may, until the Secretary is satisfied that there will no longer be any such failure, discontinue payments under grants under this Act to the State mental health authority and any other entity in the State receiving such grants or to each program or project (or part of a program or project) affected by such failure, and

(2) shall notify the State agency of the action taken under paragraph (1).

CONTENTS OF PLANS

SEC. 402. To be approved under section 401 a State mental health services plan must be submitted in such form and manner as the Secretary prescribes. The plan shall consist of an administrative part and a services part as follows:

(1) The administrative part shall—

(A) provide for establishment or designation of a single agency of the State (in this Act referred to as the "State agency") to assume responsibility for administration of the plan and the other aspects of the State's mental health services program;

(B) provide for the designation of a State advisory council to consult with the State agency in administering the plan, which council shall include (i) representatives of nongovernment organizations or groups, and of State agencies, concerned with the planning, operation, or use of facilities for the provision of mental health services, and (ii) representatives of consumers and providers of such services who are familiar with the need for such services;

(C) provide that the State agency will make such reports in such form and containing such information as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and vertification of such reports;

(D) provide that any statistics or other data included in the State mental health services plan or on which the State plan is based will conform to such criteria, standards, and other requirements relating to their form, method of collection, content, or other aspects as the Secretary may prescribe;

(E) provide that the State agency will from time to time, but not less often than annually, review the State plan and submit to the Secretary appropriate modifications thereof which it considers necessary; and

(F) include provisions, meeting such requirements as the Office of Personnel Management may prescribe, relating to the establishment and maintenance of personnel standards on a merit basis.

(2) The services part shall—

(A) identify the mental health service areas within the State;

(B) set forth (i) the need of each mental health service area in the State for mental health services, (ii) the public or private facilities, mental health personnel, and services which are available, and the additional facilities, personnel, and services required, to meet that need, (iii) the methods used to determine that need and to determine if the facilities, personnel, and services meet that need, (iv) the way in which and the order in which that need will be met through use of existing Federal, State, or local resources and otherwise, and (v) similar information for the State not included under clause (i), (ii), (iii), or (iv) which is of significance for more than a single mental health service area;

(C) describe the steps that are proposed to be taken at the State level and the local

level in an effort to coordinate the provision of mental health and support services;

(D) describe the legal rights of persons in the State who are mentally ill or otherwise mentally handicapped and what is being done in the State to protect those rights;

(E) provide for emphasizing outpatient mental health services wherever appropriate and include fair and equitable arrangements (as determined by the Secretary after consultation with the Secretary of Labor) to protect the interests of employees affected adversely by actions taken to emphasize such outpatient treatment, including arrangements designed to preserve employee rights and benefits and to provide training and retraining of such employees, where necessary, for work in mental health or other fields and including arrangements under which maximum effort will be made to place such employees in employment; and

(F) contain or be accompanied by such additional information or assurances and meet such other requirements as the Secretary prescribes in order to achieve the purposes of this Act.

PART B—APPLICATIONS AND RELATED PROVISIONS

APPLICATIONS

SEC. 403. (a) No grant may be made under this Act unless an application therefor is submitted to and approved by the Secretary. The application shall be in such form, submitted in such manner, and contain such information, as the Secretary may require.

(b) An application for a grant for any project must, in addition to the application requirements prescribed in the section under which the grant is to be made, contain or be accompanied by—

(1) a budget covering the year for which the grant is sought (and such additional period as the Secretary may require) showing the sources of funding for the project and allocating the funds available for the project among the various types of services to be provided or assisted or the various types of activities to be conducted or assisted and among the various population groups to which the project is directed;

(2) a statement of the objectives of the project;

(3) in the case of any project, under which health services are to be provided, assurances satisfactory to the Secretary that—

(A) the applicant (i) has prepared a schedule of fees or payments for the provision of its services designed to cover its reasonable costs of operation and a corresponding schedule of discounts to be applied to the payment of such fees or payments which discounts are adjusted on the basis of the patient's ability to pay; (ii) has made and will continue to make every reasonable effort (I) to secure from patients payment for services in accordance with such approved schedules, and (II) to collect reimbursement for health services to persons described in subparagraph (B) on the basis of the full amount of fees and payments for such services without application of any discount, and (iii) has submitted to the Secretary such reports as he may require to determine compliance with this subparagraph; and

(B) the applicant has made or will make and will continue to make every reasonable effort to collect appropriate reimbursement for its costs in providing services to persons who are entitled to insurance benefits under title XVIII of the Social Security Act, to medical assistance under a State plan approved under title XIX of such Act, or to assistance for medical expenses under any other public assistance program or private health insurance program;

(C) the applicant will adopt and enforce a policy (i) under which fees for the provision of mental health services through the center will be paid to the center, and (ii) which prohibits health professionals who provide such services to patients through the center from providing such services to such patients except through the center; and

(D) has (i) established a requirement that the mental health care of every patient must be under the supervision of a member of the professional staff, and (ii) provided for having a member of the professional staff available to furnish necessary mental health care in case of an emergency;

(4) in the case of a project which will serve a population which includes a substantial proportion of individuals of limited English-speaking ability, assurances satisfactory to the Secretary that the applicant has (A) developed a plan and made arrangements responsive to the needs of such population for providing services to the extent practicable in the language and cultural context most appropriate to such individuals, and (B) identified an individual on its staff who is fluent in both that language and English and whose responsibilities shall include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitiveness and bridging linguistic and cultural differences;

(5) information on the organization and operation of the applicant;

(6) satisfactory assurances that the applicant will submit such reports, at such times and containing such information, as the Secretary may request and maintain such records as the Secretary may find necessary for purposes of this Act, and afford the Secretary and the Comptroller General of the United States such access to such records and other documents as may be necessary for an effective audit of the project or activity;

(7) satisfactory assurances that funds made available under this Act will be used to supplement and, to the extent practical, increase the level of non-Federal funds that would, in the absence of those Federal funds, be made available for the purpose, and will in no event supplant such non-Federal funds;

(8) satisfactory assurance that the project is consistent with the State mental health services plan; and

(9) such other information and material and such other assurances as the Secretary may prescribe.

TECHNICAL ASSISTANCE

SEC. 404. Such portion as the Secretary may determine, but not more than 2 per centum, of the total amount appropriated under this Act for any fiscal year is available for technical assistance, including short-term training, by the Secretary to any State mental health authority or other entity which is or has been a recipient of a grant under this Act, to assist it in developing, or in better administering, the mental health services program or programs for which it is responsible.

PART C—GRANT LIMITS

LIMITS ON GRANTS

SEC. 406. In any mental health service area the total number of grants under—

(1) section 220 of the Community Mental Health Centers Act (as in effect before the date of the enactment of the Community Mental Health Centers Amendments of 1975),

(2) section 203 of such Act,

(3) section 102 of this Act, and

(4) section 105 of this Act,

may not exceed ten.

PART D—PERFORMANCE

PERFORMANCE STANDARDS

SEC. 407. (a) The Secretary shall prescribe standard measures of performance designed to test the quality and extent of performance by grantees under this Act and the extent to which such performance has helped to achieve the national or other objectives for which the grants were made.

(b) In determining whether or not to approve an application for a grant under this Act, the Secretary shall consider the performance by the applicant under any prior grant under this Act as measured under subsection (a).

EVALUATION AND MONITORING

SEC. 408. (a) With the approval of the Secretary, any recipient of a grant under this Act may use a portion of that grant for evaluation of the project or activity involved and of the recipient's program of which the project or activity is a part.

(b) Not more than 1 per centum of the total amount appropriated under this Act for any fiscal year shall be used by the Secretary, directly or through contracts with State mental health authorities, to monitor activities of grantees under this Act to determine if the requirements of this Act applicable to the receipt of such grants are being met.

PART E—DEFINITIONS

DEFINITION OF COMMUNITY MENTAL HEALTH CENTER

SEC. 409. (a) For purposes of this Act, the term "community mental health center" means a legal entity (1) through which comprehensive mental health services are provided—

(A) principally to individuals residing in a mental health service area,

(B) within the limits of its capacity, to any individual residing or employed in such area regardless of his ability to pay for such services, his current or past health condition, or any other factor, and

(C) in the manner prescribed by subsection (b),

and (2) which is organized in the manner prescribed by subsections (c) and (d).

(b)(1) The comprehensive mental health services which shall be provided through a community mental health center are as follows:

(A) Beginning on the date the community mental health center is established for purposes of this Act the services provided through the center shall include—

(i) inpatient services, emergency services, and outpatient services;

(ii) assistance to courts and other public agencies in screening residents of the center's mental health service area who are being considered for referral to a State mental health facility for inpatient treatment to determine if they should be so referred and provision, where appropriate, of treatment for such persons through the center as an alternative to inpatient treatment at such a facility;

(iii) provision to followup care for residents of its mental health service area who have been discharged from inpatient treatment at a mental health facility;

(iv) consultation and education services which—

(I) are for a wide range of individuals and entities involved with mental health services, including health professionals, schools, courts, State and local law enforcement and correctional agencies, members of the clergy, public welfare agencies, health services delivery agencies, and other appropriate entities; and

(II) include a wide range of activities (other than the provision of direct clinical services) designed to develop effective mental health programs in the center's mental health service area, promote the coordination of the provision of mental health services among various entities serving the center's mental health service area, increase the awareness of the residents of the center's mental health service area of the nature of mental health problems and the types of

mental health services available, and promote the prevention and control of rape and the proper treatment of the victims of rape; and

(v) the services described in subparagraph (B) or, in lieu of such services, providing a plan approved by the Secretary under which the center will, during the three-year period beginning on such establishment date, assume in increments the provision of the services described in subparagraph (B) and will upon the expiration of such three-year period provide all the services described in subparagraph (B).

(B) After the expiration of such three-year period, a community mental health center shall provide, in addition to the services required by subparagraph (A), services which include—

(i) day care and other partial hospitalization services;

(ii) a program of specialized services for the mental health of children, including a full range of diagnostic, treatment, liaison, and followup service (as prescribed by the Secretary);

(iii) a program of specialized services for the mental health of the elderly, including a full range of diagnostic, treatment, liaison, and followup services (as prescribed by the Secretary);

(iv) a program of transitional half-way house services for mentally ill individuals who are residents of its mental health service area and who have been discharged from inpatient treatment in a mental health facility or would without such services require inpatient treatment in such a facility; and

(v) provision of each of the following service programs (other than a service program for which there is not sufficient need (as determined by the Secretary) in the center's mental health service area, or the need for which in the center's mental health service area the Secretary determines is currently being met):

(I) A program for the prevention and treatment of alcoholism and alcohol abuse and for the rehabilitation of alcohol abusers and alcoholics.

(II) A program for the prevention and treatment of drug addiction and abuse and for the rehabilitation of drug addicts, drug abusers, and other persons with drug dependency problems.

(2) The provision of comprehensive mental health services through a center shall be coordinated with the provision of services by other health and social service agencies (including State mental health facilities) in or serving residents of the center's mental health service area to insure that persons receiving services through the center have access to all such health and social services as they may require. The center's services (A) may be provided at the center or satellite centers through the staff of the center or through aprpopriate arrangements with health professionals and others in the center's mental health service area, or, with the approval of the Secretary, in the case of inpatient services, emergency services, and transitional half-way house services, through appropriate arrangements with health professionals and others serving the residents of the mental health service area, (B) shall be available and accessible to the residents of the area promptly, as appropriate, and in a manner which preserves human dignity and assures continuity and high quality care and which overcomes geographic, cultural, linguistic, and economic barriers to the receipt of services, and (C) when medically necessary, shall be available and accessible twenty-four hours a day and seven days a week.

(3) Consistent with the requirements of State law, the medical services provided by a center to individual patients shall be under the direction and supervision of a physician. Whenever possible, the physician providing such direction and supervision shall be a psychiatrist.

(c)(1) Except as provided in paragraph (2), the governing board of a community mental health center shall (A) be composed, where practicable, of individuals who reside in the center's mental health service area and who, as a group, represent the residents of that area taking into consideration their employment, age, sex, and place of residence, and other demographic characteristics of the area, and (B) meet at least once a month, establish general policies for the center (including a schedule of hours during which services will be provided), approve the center's annual budget, and approve the selection of a director for the center. At least one-half of the members of such body shall be individuals who are not providers of health care.

(2) In the case of a community mental health center which is operated by a governmental agency or a hospital, such center may, in lieu of meeting the requirements of paragraph (1), appoint a committee which advises it with respect to the operations of the center and which is composed of individuals who reside in the center's mental health service area, who are representative of the residents of the area as to employment, age sex, place of residence, and other demographic characteristics, and at least one-half of whom are not providers of health care. A center to which this paragraph applies shall submit to such a committee for its review any application for a grant under section 102.

(3) For purposes of paragraphs (1) and (2), the term "provider of health care" has the same meaning as is prescribed for that term by section 1531(3) of the Public Health Service Act.

(d) A center shall, in accordance with regulations prescribed by the Secretary, have (1) an ongoing quality assurance program (including utilization and peer review systems) respecting the center's services, (2) an tegrated medical records system (including a drug use profile) which, in accordance with Federal and State laws respecting confidentiality, is designed to provide access to all past and current information regarding the health status of each patient and to maintain safeguards to preserve confidentiality and to protect the rights of the patient, (3) a professional advisory board, which is composed of members of the center's professional staff, to advise the governing board in establishing policies governing medical and other services provided by such staff on behalf of the center, and (4) an identifiable administrative unit which shall be responsible for providing the consultation and education services described in subsection (b)(1)(A)(iv). The Secretary may waive the requirements of clause (4) with respect to any center if he determines that because of the size of such center or because of other relevant factors the establishment of the administrative unit described in such clause is not warranted.

OTHER DEFINITIONS

SEC. 410. For purposes of this title:

(1) The term "ambulatory health care center" may include an outpatient facility operated in connection with a hospital, a community health center, a migrant health center, a clinic of the Indian Health Service, a skilled nursing home, an intermediate care facility, and an outpatient health care facility of a medical group practice, a public health department, or a health maintenance organization.

(2) The term "State mental health authority" means the agency of a State to which has been delegated the responsibility for the mental health programs of the State.

(3) A mental health service area shall, except to the extent permitted under regulations of the Secretary, have boundaries which conform to or are within the boundaries of a health service area established under title XV of the Public Health Service Act and, to the extent practicable, conform to boundaries of one or more school districts or political or other subdivisions in the State. Each State shall be covered by one or more mental health service areas.

PART F—MISCELLANEOUS

INDIRECT PROVISION OF SERVICES

SEC. 411. Except as provided in section 409(b)(2), any mental health service for the provision of which an entity is responsible for purposes of a grant under this Act may be provided by it directly at its primary or satellite facilities or through arrangements with other entities or health professionals and others in, or serving residents of, the same mental health service area.

COOPERATIVE AGREEMENTS

SEC. 412. In lieu of providing funds under a grant under this Act, the Secretary may provide such funds under a cooperative agreement, and all requirements which would apply with respect to such a grant shall apply to the cooperative agreement.

CONTRACT AUTHORITY

SEC. 413. The authority of the Secretary to enter into contracts under this Act shall be effective for any fiscal year only to such extent or in such amounts as are provided in advance by appropriation Acts.

TITLE V—MINORITY CONCERNS

ASSOCIATE DIRECTOR OF NATIONAL INSTITUTE OF MENTAL HEALTH

SEC. 501. (a) There shall be in the National Institute of Mental Health an Associate Director for Minority Concerns.

(b) The Secretary of Health and Human Services, acting through the Associate Director for Minority Concerns, shall—

(1) support programs for the delivery of mental health services to minority populations;

(2) support programs of basic and applied social and behavioral research on the mental health problems of minority populations;

(3) develop a plan to increase tht representation of minority populations in the delivery of mental health services and in mental health research;

(4) support programs to develop in individuals providing mental health services and conducting mental health research an understanding of the needs of minority populations;

(5) study the effect of discrimination on institutions and individuals; and

(6) support and develop research, demonstration, and training programs aimed at eliminating institutional discrimination.

Support of programs under this subsection shall be made by grants to and contracts with public and nonprofit private entities.

TITLE VI—RAPE SERVICES SUPPORT PROGRAM

GRANTS FOR SERVICES FOR RAPE VICTIMS

SEC. 601. (a) The Secretary may make grants to and enter into contracts with public and nonprofit private entities to assist in meeting the cost of—

(1) providing counseling and followup counseling for rape victims and the immediate family of rape victims;

(2) providing assistance in securing mental health, social, medical, and legal services for rape victims;

(3) demonstration projects to develop and implement methods of preventing rape and assisting rape victims.

(b)(1) An application for a grant or contract under subsection (a) shall contain such assurances as the Secretary may require that the applicant will comply with the requirements of subsection (e).

(2) The amount of any grant or contract under this section shall be determined by the Secretary, except that the amount may

not exceed 90 per centum of the cost of the project (as determined by the Secretary) with respect to which the grant or contract is made or entered into

(c)(1) In carrying out this section, the Secretary shall coordinate with other activities related to rape carried out by the Secretary and the heads of other Federal departments and agencies

(2) The Secretary shall establish a grant review panel to make recommendations to the Secretary with respect to the approval of applications for grants and contracts under subsection (a). The Secretary shall appoint individuals to the panel who are or have been engaged in the provisions of services to rape victims.

(d)(1) There are authorized to be appropriated to make payments under grants and contracts under subsection (a) $6,000,000 for the fiscal year ending September 30, 1981, $9,000,000 for the fiscal year ending September 30, 1982, $12,000,000 for the fiscal year ending September 30, 1983, and $12,000,000 for the fiscal year ending September 30, 1984.

(2) The Secretary may in a fiscal year obligate not more than 10 per centum of the funds appropriated for that fiscal year under paragraph (1) to provide, upon request, technical assistance in the development and submission of applications for a grant or contract under subsection (a). Such assistance shall be provided only to those entities which the Secretary determines do not possess the resources or expertise necessary to develop and submit such an application.

(e) No officer or employee of the Federal Government or of any recipient of a grant or contract under subsection (a) may use or disclose any information obtained by the recipient in carrying out an activity assisted by such grant or contract unless such use or disclosure is to carry out a purpose for which the information was obtained. Such information shall be immune from legal process and may not, without the consent of the person furnishing the information, be admitted as evidence or otherwise used in any civil or criminal action or other judicial or administrative proceeding.

TITLE VII—EXTENSION OF COMMUNITY MENTAL HEALTH CENTERS ACT

ONE-YEAR EXTENSION OF COMMUNITY MENTAL HEALTH CENTERS ACT

SEC. 701. (a) Subsection (d) of section 202 of the Community Mental Health Centers Act (42 U.S.C. 2689a(d)) (relating to grants for planning) is amended by striking out "for the fiscal year ending September 30, 1980" and inserting in lieu thereof "each of the fiscal year ending September 30, 1980, and the next fiscal year."

(b) Subsection (d) of section 203 of such Act (relating to grants for initial operation) is amended—

(1) in paragraph (1), by (A) striking out "and" after "1979,", and (B) inserting before the period a comma and the following: "and $37,000,000 for the fiscal year ending September 30, 1981"; and

(2) effective October 1, 1981, by striking out "(1)" and paragraph (2).

(c) Subsection (c) of section 204 of such Act (42 U.S.C. 2689(c)) (relating to grants for consultation and education services) is amended (1) by striking out "and" after "1979,", and (2) by inserting before the period a comma and the following: "and $15,000,000 for the fiscal year ending September 30, 1981".

(d)(1) Section 213 of such Act (42 U.S.C. 2689h) (relating to financial distress grants) is amended (1) by striking out "and" after "1978,", and (B) by inserting after "1979," the following: "and $15,000,000 for the fiscal year ending September 30, 1981,".

(2) Section 212(c) of such Act (42 U.S.C. 2689g(c)) of such Act is amended by striking out "five" and inserting in lieu thereof "six".

(e) Subsection (d) of section 231 of such Act (42 U.S.C. 2689q) (relating to rape prevention and control) is amended (1) by striking out "and" after "1979,", and (2) by inserting before the period a comma and the following: "and $40,000,000 for the fiscal year ending September 30, 1981".

TITLE VIII—MISCELLANEOUS

OBLIGATED SERVICE FOR MENTAL HEALTH TRAINEESHIPS

SEC. 801. (a) Section 303 of the Public Health Service Act is amended by adding at the end thereof the following new subsection:

"(d)(1) Any individual who has received a clinical traineeship, in psychology, psychiatry, nursing, or social work, under subsection (a)(1) that was not of a limited duration or experimental nature (as determined by the Secretary) is obligated to serve, in service determined by the Secretary to be appropriate in the light of the individual's training and experience, at the rate of one year for each year (or academic year, whichever the Secretary determines to be appropriate) of the traineeship.

"(2) The service required under paragraph (1) shall be performed—

"(A) for a State mental institution providing in-patient care or any entity receiving a grant under the Mental Health Systems Act,

"(B) in a health manpower shortage area (as determined under subpart II of part D of this title), or

"(C) in any other area or for any other entity designated by the Secretary,

and shall begin within such period after the termination of the traineeship as the Secretary may determine. In developing criteria for determining for which institutions or entities or in which areas, referred to in the preceding sentence, individuals must perform service under paragraph (1), the Secretary shall give preference to institutions, entities, or areas which in his judgment have the greatest need for personnel to perform that service. The Secretary may permit service for or in other institutions, entities, or areas if the Secretary determines that the request for such service is supported by good cause.

"(3) Any individual who fails to perform the service required under this subsection within the period prescribed by the Secretary is obligated to repay to the United States an amount equal to three times the cost of the traineeship (including stipends and allowances) plus interest at the maximum legal rate at the time of payment of the traineeship, multiplied, in any case in which the service so required has been performed in part, by the percentage which the length of the service so performed is of the length of the service so required to be performed.

"(4)(A) In the case of any individual any part of whose obligation to perform service under this subsection exists at the same time as any part of his obligation to perform service under section 752 or 753 (because of receipt of a scholarship under subpart IV of part C of title VII) or his obligation to perform service under section 472 (because of receipt of a National Research Service Award), or both, the same service may not be used to any extent to meet more than one of those obligations.

"(B) In any case to which subparagraph (A) is applicable and in which one of the obligations is to perform service under section 752 or 753, the obligation to perform service under that section must be met (by performance of the required service or payment of damages) before the obligation to perform service under this subsection or under section 472.

"(C) In any case to which subparagraph (A) is applicable, if any part of the obligation to perform service under section 472 exists at the same time as any part of the obligation to perform service under this subsection, the manner and time of meeting each obligation shall be prescribed by the Secretary.".

(b) The amendment made by subsection (a) applies in the case of any academic year (of any traineeship awrded under section 303(a)(1) of the Public Health Service Act) beginning after the date of the enactment of this Act if the award for such academic year is made after such date.

CONFORMING AMENDMENTS

SEC. 802. (a) Section 507 of the Public Health Service Act (relating to grants to Federal institutions) is amended by inserting ", and appropriations under the Mental Health Systems Act," before "shall also be available".

(b) Section 513 of such Act (relating to evaluation of programs by the Secretary) is amended by inserting "the Mental Health Systems Act," after "Community Mental Health Centers Act,".

(c) Sections 1513(e)(1)(A)(i) and 1524(c)(6) of such Act (relating to review of proposed use of Federal funds) are each amended by inserting "the Mental Health Systems Act," after "Community Mental Health Centers Act,".

SPECIAL PAY FOR PUBLIC HEALTH SERVICE PHYSICIANS AND DENTISTS

SEC. 803. Section 208(a) of the Public Health Service Act (42 U.S.C. 210(a)) is amended (1) by inserting "(1)" after "(a)", and (2) by adding at the end the following:

"(2) Commissioned medical and dental officers in the Regular and Reserve Corps shall while on active duty be paid special pay in the same amounts as, and under the same terms and conditions which apply to, the special pay now or hereafter paid to commissioned medical and dental officers of the Armed Forces under chapter 5 of title 37, United States Code.".

MENTAL HEALTH PERSONNEL

SEC. 804. Section 303 of the Public Health Service Act (42 U.S.C. 242a) (as amended by section 801) is amended by adding at the end the following:

"(e) Because of the rising demands for mental health services and the wide disparity in the distribution of psychiatrists, clinical psychologists, social workers, and psychiatric nurses, there is a shortage in the medical specialty of psychiatry and there are also shortages among the other health personnel who provide mental health services.".

Mr. WAXMAN (during the reading). Mr. Chairman, I ask unanimous consent that the bill be considered as read, printed in the RECORD, and open to amendment at any point.

The CHAIRMAN. Is there objection to the request of the gentleman from California?

There was no objection.

COMMITTEE AMENDMENTS

The CHAIRMAN. The Clerk will report the first committee amendment.

The Clerk read as follows:

Committee amendment: Page 6, line 11, strike "or other entity."

Mr. WAXMAN. Mr. Chairman, I ask unanimous consent that the committee amendments be considered as read, printed in the RECORD, and considered en bloc.

The CHAIRMAN. Is there objection to the request of the gentleman from California?

There was no objection.

The remaining committee amendments are as follows:

Committee amendments: Page 9, line 18, strike out "payments under" and insert in lieu thereof "the purposes of making" and, beginning on page 10 in line 11, strike out "payments under".

Page 10, insert after the period in line 14 the following:

No grant may be made under this subsection to a public entity (other than a State mental health authority) or a nonprofit private entity for the provisions of services in a mental health service area served by a community mental health center.

Page 12, insert after the period in line 4 the following:

No grant may be made under this subsection to a public entity (other than a State mental health authority) or a nonprofit private entity for the provision of services in a mental health service area served by a community mental health center.

Page 15, insert on line 1 the following:

The Secretary may not approve an application of an entity which has received a grant for three years under subsection (a) unless the applicant is providing all the mental health services described in paragraph (4)(A).

Page 18, line 14, strike out "a grant" and insert in lieu thereof "grants".

Page 21, line 20, insert "providing" after "and".

Page 23, line 11, strike out "payments under" and insert in lieu thereof "the purpose of making".

Page 24, line 14, strike out "payments under" and insert in lieu thereof "making".

Page 26, line 20, strike out "except after" and insert in lieu thereof "unless the State agency has been provided" and in line 21 strike out "to the State".

Page 26, line 25, strike out "502" and insert in lieu thereof "402".

Page 27, strike out lines 19 through 21 and insert in lieu thereof the following:

(A) provide that the State agency will assume

Page 28, line 4, strike out "nongovernment" and insert in lieu thereof "nongovernmental".

Page 32, line 1, insert ", to be assisted by a grant under title I," after "project".

Page 34, insert after line 9 the following:

(5) satisfactory assurances that the applicant has in effect a system, satisfactory to the Secretary, to assure that an employee of the applicant who reports to any officer or employee of the Department of Health and Human Services or appropriate State authority any failure on the part of the applicant to comply with an applicable requirement of this Act or regulation of the Secretary or requirement of State law will not on account of such report be discharged or discriminated against with respect to the employee's compensation or the terms, conditions, or privileges of the employee's employment;

(6) satisfactory assurances that each facility to be used in the provision of health or support services to be supported by the grant applied for meets the requirements of applicable fire and safety codes imposed by State law;

Page 35, line 3, strike out "(5)" and insert in lieu thereof "(7)".

Page 35, line 5, strike out "(6)" and insert in lieu thereof "(8)".

Page 35, line 14, strike out "(7)" and insert in lieu thereof "(9)".

Page 35, line 20, strike out "(8)" and insert in lieu thereof "(10)".

Page 35, line 23, strike out "(9)" and insert in lieu thereof "(11)".

Page 36, line 4, strike out "under this Act" and insert in lieu thereof "under titles I and II".

Page 38, line 20, strike out "this Act" and insert in lieu thereof "section 102".

Page 39, line 10, strike out "to" and insert in lieu thereof "of".

Page 40, line 15, strike out "providing" and insert in lieu thereof "the center shall have".

Page 45, line 16, strike out "this title" and insert in lieu thereof "this Act".

Page 45, insert after line 16 the following:

(1) The term "Secretary" means the Secretary of Health and Human Services.

Page 45, line 19, strike out "(1)" and insert in lieu thereof "(2)".

Page 46, line 1, strike out "(2)" and insert in lieu thereof "(3)".

Page 46, line 4, strike out "(3)" and insert in lieu thereof "(4)".

Page 47, line 13, strike out "of Health and Human Services".

Page 49, line 19, strike out "payments under".

Page 52, line 5, strike out "$40,000,000" and insert in lieu thereof "$4,000,000".

Page 54, beginning in line 1 strike out "which the length of the service so performed is of the length of the service so required to be performed" and insert in lieu thereof "of the length of the service so required to be performed which has not been performed".

Mr. WAXMAN. Mr. Chairman, the amendments before us were adopted by the subcommittee and the full committee and we submit them for the favorable consideration of the House.

The CHAIRMAN. The question is on the committee amendments.

The committee amendments were agreed to.

AMENDMENTS OFFERED BY MR. WAXMAN

Mr. WAXMAN. Mr. Chairman, I offer five amendments, and I ask unanimous consent that they be considered en bloc.

The CHAIRMAN. Is there objection to the request of the gentleman from California?

There was no objection.

Mr. WAXMAN. Mr. Chairman, I ask unanimous consent that the amendments be considered as read and printed in the RECORD.

The CHAIRMAN. Is there objection to the request of the gentleman from California?

There was no objection.

The amendments are as follows:

Amendments offered by Mr. WAXMAN: Page 11, insert before the period in line 4 the following: "(including community residential treatment system)".

Page 21, line 5, insert before the period a comma and the following: "except that, in the case of a grant under section 101, 102, 105, or 106, approval by a State mental health authority shall not be required".

Page 47, line 11, strike out "There shall be" and insert in lieu thereof "Effective October 1, 1980, there shall be".

Page 50, strike out line 11 and all that follows through "was obtained" in line 14 and insert in lieu thereof the following: "may use or disclose any personally identifiable information obtained, in carrying out an activity assisted by such grant or contract, by the recipient from a rape victim or a rape victim's immediate family unless such use or disclosure is necessary to carry out the activity or is made with the consent of the person who supplied the information".

Page 52, insert after line 6 the following:

(f) Section 206(e)(2)(B) of such Act (42 U.S.C. 2689e(e)(2)(B)) is amended by striking out "the fiscal year ending September 30, 1979, and during the fiscal year ending September 30, 1980" and inserting in lieu thereof "the fiscal years ending September 30, 1979, September 30, 1980, and September 30, 1981".

Mr. WAXMAN. Mr. Chairman, these amendments are either technical in nature or are minor and pursuant to the purposes of the act.

The first amendment is a technical amendment which would provide an effective date for title V for the Associate Director for Minority Affairs.

The second amendment is a conforming amendment to extend the waiver period for CMHC's which do not meet certain governing board requirements. Present law allows such an exemption through fiscal year 1980. The Systems Act does not include the requirements. We must continue to waive them through the period of the simple extension.

The third amendment is a clarifying amendment to include community treatment systems as entities eligible for grants for services to the chronically mentally ill.

The fourth amendment is a clarifying amendment to limit information and records provisions of title VI to information from victims and victims' families.

The fifth amendment is to exempt the Federal Indian Health Service from preliminary State grant reviews.

I know of no opposition to these amendments. As I mentioned, they are clarifying or technical in nature.

Mr. MARRIOTT. Mr. Chairman, will the gentleman yield?

Mr. WAXMAN. I yield to the gentleman.

Mr. MARRIOTT. Would the gentleman explain once again what he is doing with the Indians?

Mr. WAXMAN. This amendment, the fifth amendment, which deals with the Indian Health Service, is to provide for Indian groups to go directly to the Indian Health Services for grants rather than go through the procedure which is set out for other CMHC's.

Mr. MARRIOTT. I thank the gentleman.

The CHAIRMAN. The question is on the amendments offered by the gentleman from California (Mr. WAXMAN).

The amendments were agreed to.

AMENDMENT IN THE NATURE OF A SUBSTITUTE OFFERED BY MR. DANNEMEYER

Mr. DANNEMEYER. Mr. Chairman, I offer an amendment in the nature of a substitute.

The Clerk read as follows:

Amendment in the nature of a substitute offered by Mr. DANNEMEYER: Strike out all after the enacting clause and insert in lieu thereof the following:

That (a) subsection (d) of section 202 of the Community Mental Health Centers Act (42 U.S.C. 2689a(d)) (relating to grants for planning) is amended by striking out "for the fiscal year ending September 30, 1980" and inserting in lieu thereof "each for the fiscal year ending September 30, 1980, and the next two fiscal years".

(b) Subsection (d) of section 203 of such Act (42 U.S.C. 2689b(d)) (relating to grants for initial operation) is amended—

(1) in paragraph (1), by (A) striking out "and" after "1979,", and (B) inserting before the period a comma and the following: "$37,000,000 for the fiscal year ending September 30, 1981, and $40,700,000 for the fiscal year ending September 30, 1982"; and

(2) effective October 1, 1981, by striking out "(1)" and paragraph (2).

(c) Subsection (c) of section 204 of such Act (42 U.S.C. 2389c(c)) (relating to grants for consultation and education services) is amended (1) by striking out "and" after "1979,", and (2) by inserting before the period a comma and the following: "$15,000,000 for the fiscal year ending September 30, 1981, and $16,500,000 for the fiscal year ending September 30, 1982".

(d) Section 213 of such Act (42 U.S.C. 2689h) (relating to financial distress grants) is amended (1) by striking out "and" after "1978,", and (2) by inserting after "1979," the following: "$15,000,000 for the fiscal year ending September 30, 1981, and $16,500,000 for the fiscal year ending September 30, 1982,".

(e) Subsection (d) of section 231 of such Act (42 U.S.C. 2689q) (relating to rape prevention and control) is amended (1) by striking out "and" after "1979;", and (2) by inserting before the period a comma and the following: "$4,400,000 for the fiscal year ending September 30, 1981, and $4,160,000 for the fiscal year ending September 30, 1982".

Mr. DANNEMEYER (during the reading). Mr. Chairman, I ask unanimous consent that the amendment in the nature of a substitute be considered as read and printed in the RECORD.

The CHAIRMAN. Is there objection to the request of the gentleman from California?

There was no objection.

Mr. DANNEMEYER. Mr. Chairman, the amendment being offered here is as straightforward as it is essential. Simply put, it would extend the current community health or mental health services program for 2 years with a 10-percent increase in funding the second year instead of extending it for 1 year and extending it in the next 3 at authorization levels double and then nearly triple those contemplated for fiscal 1981.

□ 1400

As currently drafted, H.R. 7299 would authorize the expenditure of $607.5 million for community mental health center services over the next 4 years—$78 million in 1981, $152 million in 1982, $177.5 million in 1983, and $200 million in 1984. When we compare these figures to the $66.4 million appropriated in 1980 for the community mental health centers programs, the need for this amendment becomes abundantly apparent. At a time when the inflation rate is still in the double digits and the producer price index suggests it is about to take another jump upward, it would be highly irresponsible to authorize spending levels that would double in 2 years and triple in 4.

The issue here is not the concept behind the Community Mental Health Centers Act, which would offer formula grants to the States so that they could replace the traditional and inadequate institutions with smaller community-based facilities. No one is arguing that treatment of mental disorders cannot be more effectively handled in a hometown setting. What is at stake is the mental health of the American taxpayer and consumer. How long can he and she stand the cumulative effects of deficit spending?

The history of mental health programs illustrates the problem. Initially, mental health grants were to last for 4 years on a descending scale and terminate, but then some of the grants were extended for up to 8 years and expanded to include much more than professional staffing. Now the bill before us contemplates a geometric expansion of the program. Of course, the intentions are good, but I need not remind Members where roads paved with good intentions can lead.

Suffice it to say, we cannot afford such a rapid increase in expenditures for this or any other program until such time as we have reduced the budget deficit and put our financial house in order. To approve such an increase would run the risk of forcing more people to seek mental health care than this bill could possibly help.

In fact, there have been several newspaper articles in recent months to the effect that inflation is already driving more and more people to seek psychiatric and/or psychological care.

Mr. Chairman, passage of this amendment would not mean that we would be turning our backs on those suffering from mental depression and other mental illnesses. Rather, it would provide for a continuation of existing programs while recognizing that financial depression can result from excessive Federal spending. Perhaps in 2 years we will not be facing the prospect of $60 to $65 billion in budget deficits, and we can look at the possibility of expanding our mental health care programs, but for now I urge adoption of this amendment. The way to cut spending is not to double and triple authorization levels.

Lest anyone in this Chamber believe that this amendment in the nature of a substitute lacks compassion for those in need of these services, let us reflect on the fact that this bill does not deal with continuing authorizations in other programs now in existence and which will be continued unhampered by anything we do in this bill. The total in this current fiscal year is some $229 million. Since this program was started, the Federal Government has expended some $2 29 billion in 13 years. The States have matched that by another $4.5 billion in the same period.

In this year when this House under its current leadership has said, by the Speaker, that we are going to violate the law, which we are required to do, namely, to adopt a spending resolution or a budget resolution by September 15, we are going to violate that law. Why? Because the leadership in this House does not want to admit to the American public that there is a deficit in fiscal year 1981 of someplace in the magnitude of some $65 billion. This would constitute a reversal of the representations that were made in the spring of this year when we were talking to the American people.

The CHAIRMAN. The time of the gentleman has expired.

(By unanimous consent, Mr. DANNEMEYER was allowed to proceed for 1 additional minute.)

Mr. DANNEMEYER. In the spring of this year we citizens were told by our leaders in the Congress that we would have a balanced budget by this year for next year, fiscal year 1981. The main reason that we are avoiding the necessity of passing that budget resolution in the middle of next month is because the leadership in this House does not want to admit, as I said before, that that budget for next year is out of balance. It also exacerbates the promise by our President in 1976 when he campaigned that he would present a balanced budget to the American people by 1981.

This is not the time in this program to expand this mental health services program in 1983 and 1984 by another $400 million. That is what this amendment in the nature of a substitute is all about. It continues the existing program adjusted for inflation, which I think is a reasonable approach, and I ask support for it.

Mr. WAXMAN. Mr. Chairman, I rise in opposition to the amendment.

Mr. Chairman, this amendment would destroy all the work of the subcommittee and all of the improvements that we made in this mental health systems proposal and take the present program, as flawed as it is, and extend it for 2 years with a smaller amount of funding for that program by the end of the second year. One of the most important features of the bill that is before us is the provision that brings the States to be more involved in the mental health program so that the States will play an active role and take over the mental health program of the community mental health centers in the program at the end of the seed period in which the Government gives them money to get started. By merely extending the act, we continue the inability of the States to take an active interest that they would otherwise have in the planning process and otherwise in taking the CMHC program and in making it a very integral part of the mental health program for the State.

With the uncertainty of Federal support and uncertainty as to what the program will hold for the future, CMHC's have great difficulty in recruiting and retaining personnel. Institutions are discharging an increasing number of patients. Programs for the chronically mentally ill are needed now. This substitute has no provision for aiding severely disturbed children. It has no provision for flexibility to deal with priority populations. It is, I think, an inadequate way to deal with the problem. I feel that the work of the subcommittee ought to be adopted, and I would hope that the House would refuse to accept the amendment being offered.

Mr. CARTER. Mr. Chairman, I move to strike the necessary number of words, and I rise reluctantly in opposition to the amendment of my good friend, the gentleman from California (Mr. DANNEMEYER), who is really a tremendously able man. However, in this case I must say that the amendment would cut short this legislation from the year 1981 forward, as I see it.

Our legislation has been greatly improved, as the chairman said. It provides that most requests for funding of mental health and mental retardation grants must be approved by the State mental health authority and thus tightens things up a great deal. Priority population grants could be awarded only in areas which did not have a CMHC, and only two such grants may be awarded per year in a catchment area, although each project could receive five grants in total. This legislation is directed toward priority populations to help those who have never been helped previously, including the older people who are mentally ill, the chronically mentally ill, and severely mentally disturbed children. That in itself says, I think, enough that we should oppose this amendment and support the bill.

Mrs. SPELLMAN. Mr. Chairman, I move to strike the requisite number of words.

Mr. Chairman, I must rise in opposition to this amendment. There are so many people who have been looking forward to the legislation being discussed here today: Disturbed children, older citizens, people who have not been touched before. The direction in which this legislation goes is one that has been needed for such a long, long time. It is a step taking the work of mental health to relate to the communities to work with these States. It is so very important.

Mr. Chairman, a little while ago my colleague, the gentlewoman from Maryland (Ms. MIKULSKI) indicated that for the first time we were going to stop studying rape victims, for the first time the Federal Government was now going to reach out a hand to help rape victims. That is not in any of the programs that we have today. It is important that we do move ahead.

I am going to dwell on that for just a moment, although I feel I must say I am even more concerned about the children that our colleague discussed just awhile ago, the youngsters with the handicaps in reading, the autistic children, the disturbed children.

Let us go back to the rape victims. Perhaps during the last recess my colleagues may have missed an article in the Wednesday, August 6, Washington Star. That article listed more statistical information about the frequency of events in any typical day than many of us would probably care to know. I learned when I read the article that every day in America 10,930,000 cows are milked. That is an interesting statistic. I do not know how to work it into the conversation. Three million people go to the movies. One hundred and eighty women are raped. Let me repeat. There are 180 rapes in this country every single day and, if for no one else, but for the victims of these rapes, we need to have this legislation.

Mr. Chairman, we are now planning to have a program which would provide authorization for grants and contracts with local rape crisis centers. At the time of extreme trauma these centers help to meet the needs of both rape victims and their families by providing counseling, medical care, legal services. Through the counseling for rape victims and their immediate families as well, providing medical and legal assistance, rape crisis centers provide indispensable services for many of the 250,000 women raped in this country every year. I am sorry to say that figure continues to rise.

The funding provided by this legislation would help to alleviate one of the persistent problems of the staffs of rape crisis centers and that is that today they are spending most of their time, about 50 percent of their time, trying to raise money when they ought to be spending 100 percent of their time trying to help victims.

Therefore I say, Mr. Chairman, do not hold us back. Let us move ahead. Let us provide assistance for youngsters who have such exciting futures ahead of them if only they can learn to read. The kind of help we provide here reaches out to those kinds of children. Let us help all of the people that this committee has been working on, leading us toward providing help for these people. Let us now talk in terms of numbers. If we are talking only about numbers and saying that what we have had thus far has been a perfect solution to the problems, we are just going to remain in the dark ages.

Mr. Chairman, I implore my colleagues to vote against this amendment.

The CHAIRMAN. The question is on the amendment in the nature of a substitute offered by the gentleman from California (Mr. DANNEMEYER).

The question was taken; and the Chairman announced that the noes appeared to have it.

Mr. DANNEMEYER. Mr. Chairman, I demand a recorded vote, and pending that I make the point of order that a quorum is not present.

The CHAIRMAN. Evidently a quorum is not present. Pursuant to the provisions of clause 2 of rule XXIII, the Chair announces that he will reduce to a minimum of 5 minutes the period of time within which a vote by electronic device, if ordered, will be taken on the pending question following the quorum call. Members will record their presence by electronic device.

The call was taken by electronic device.

The following Members responded to their names:

[Roll No. 481]

Akaka	Benjamin	Carney
Albosta	Bennett	Carr
Ambro	Bereuter	Carter
Anderson, Calif.	Bethune	Cavanaugh
	Bingham	Clausen
Andrews, N Dak	Blanchard	Clay
	Boner	Clinger
Annunzio	Bonker	Coelho
Ashbrook	Bowen	Coleman
Aspin	Brademas	Conable
Atkinson	Brinkley	Conyers
AuCoin	Brodhead	Corcoran
Badham	Brooks	Corman
Bafalis	Broomfield	Coughlin
Bailey	Buchanan	Courter
Baldus	Burgener	Crane, Daniel
Barnard	Burton, John	D'Amours
Barnes	Burton, Phillip	Daniel, R. W.
Bauman	Butler	Daniel son
Beard, Tenn.	Byron	Dannemeyer
Beilenson	Campbell	Daschle
Davis, Mich.	Johnson, Calif.	Pritchard
Davis, S.C.	Jones, Okla.	Pursell
Deckard	Jones, Tenn.	Rahall
Derrick	Kastenmeier	Rangel
Dickinson	Kazen	Ratchford
Dixon	Kelly	Regula
Dornan	Kemp	Reuss
Dougherty	Kildee	Rhodes
Drinan	Kindness	Richmond
Duncan, Oreg.	Kostmayer	Rinaldo
Duncan, Tenn.	Kramer	Ritter
Edwards, Calif.	LaFalce	Roberts
English	Lagomarsino	Robinson
Erdahl	Latta	Roe
Erlenborn	Leach, Iowa	Rosenthal
Ertel	Leath, Tex.	Royer
Evans, Ga.	Lederer	Sabo
Evans, Ind.	Lee	Satterfield
Fary	Lehman	Sawyer
Fascell	Leland	Schroeder
Fazio	Lent	Schulze
Fenwick	Levitas	Sebelius
Ferraro	Lewis	Sensenbrenner
Findley	Lloyd	Sharp
Fisher	Loeffler	Shelby
Fithian	Long, La.	Shumway
Florio	Long, Md.	Shuster
Foley	Lowry	Simon
Ford, Tenn.	Luken	Skelton
Forsythe	Lungren	Smith, Nebr.
Fountain	McCloskey	Snowe
Frenzel	McCormack	Snyder
Garcia	McHugh	Solarz
Gaydos	Madigan	Solomon
Gephardt	Maguire	Spellman
Gilman	Marks	Spence
Ginn	Marlenee	Stack
Glickman	Marriott	Stangeland
Goldwater	Martin	Steed
Gonzalez	Mavroules	Stenholm
Goodling	Mazzoli	Stewart
Gore	Mica	Stockman
Gradison	Mikulski	Stokes
Gramm	Miller, Ohio	Stratton
Gray	Mineta	Studds
Green	Minish	Stump
Grisham	Mitchell, Md.	Swift
Guarini	Montgomery	Tauke
Guyer	Moore	Taylor
Hagedorn	Moorhead, Calif.	Thomas
Hall, Ohio		Thompson
Hall, Tex.	Murphy, Pa.	Traxler
Hamilton	Musto	Ullman
Hammer-schmidt	Myers, Ind.	Van Deerlin
	Natcher	Vanik
Hance	Neal	Vento
Harkin	Nelson	Volkmer
Harris	Nowak	Walgren
Hawkins	O'Brien	Walker
Heckler	Oakar	Waxman
Heftel	Oberstar	Weaver
Hillis	Obey	White
Hinson	Ottinger	Whitehurst
Holt	Panetta	Whittaker
Hopkins	Pashayan	Whitten
Howard	Patten	Wilson, Tex.
Hubbard	Patterson	Winn
Huckaby	Paul	Wirth
Hughes	Pease	Wolff
Hutchinson	Perkins	Wolpe
Jacobs	Petri	Wyatt
Jeffords	Peyser	Wylie
Jeffries	Porter	Yates
Jenkins	Preyer	Young, Mo.
Jenrette	Price	Zablocki

□ 1430

The CHAIRMAN. Two hundred eighty-four Members have answered to their names, a quorum is present, and the Committee will resume its business.

The pending business is the demand of the gentleman from California (Mr. DANNEMEYER) for a recorded vote.

A recorded vote was refused.

So the amendment in the nature of the substitute was rejected.

The CHAIRMAN. Are there further amendments to the bill?

If not, under the rule, the Committee rises.

Accordingly the Committee rose; and the Speaker pro tempore (Mr. BRADEMAS) having assumed the chair, Mr. BEILENSON, Chairman of the Committee of the Whole House on the State of the Union, reported that that Committee, having

had under consideration the bill (H.R. 7299) to revise and improve the Federal programs of assistance for the provision of mental health services, and for other purposes, pursuant to House Resolution 751, he reported the bill back to the House with sundry amendments adopted by the Committee of the Whole.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

Is a separate vote demanded on any amendment? If not, the Chair will put them en gros.

The amendments were agreed to.

The SPEAKER pro tempore. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT OFFERED BY MR. DANNEMEYER

Mr. DANNEMEYER. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. DANNEMEYER. I am opposed to the bill, Mr. Speaker.

The SPEAKER pro tempore. The gentleman qualifies.

The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. DANNEMEYER moves to recommit the bill, H.R. 7299, to the Committee on Interstate and Foreign Commerce, with instructions to report the same back forthwith with the following amendment:

Strike out all after the enacting clause and insert in lieu thereof the following:

That (a) subsection (d) of section 202 of the Community Mental Health Centers Act (42 U.S.C. 2689a(d)) (relating to grants for planning) is amended by striking out "for the fiscal year ending September 30, 1980" and inserting in lieu thereof "each for the fiscal year ending September 30, 1980, and the next two fiscal years".

(b) Subsection (d) of section 203 of such Act (42 U.S.C. 2689b(d)) (relating to grants for initial operation) is amended—

(1) in paragraph (1), by (A) striking out "and" after "1979,", and (B) inserting before the period a comma and the following: "$37,000,000 for the fiscal year ending September 30, 1981, and $40,700,000 for the fiscal year ending September 30, 1982"; and

(2) effective October 1, 1981, by striking out "(1)" and paragraph (2).

(c) Subsection (c) of section 204 of such Act (42 U.S.C. 2689c(c)) (relating to grants for consultation and education services) is amended (1) by striking out "and" after "1979,", and (2) by inserting before the period a comma and the following: "$15,000,000 for the fiscal year ending September 30, 1981, and $16,500,000 for the fiscal year ending September 30, 1982".

(d) Section 213 of such Act (42 U.S.C. 2689h) (relating to financial distress grants) is amended (1) by striking out "and" after "1978,", and (2) by inserting after "1979," the following: "$15,000,000 for the fiscal year ending September 30, 1981, and $16,500,000 for the fiscal year ending September 30, 1982,".

(e) Subsection (d) of section 231 of such Act (42 U.S.C. 2689q) (relating to rape prevention and control) is amended (1) by striking out "and" after "1979;", and (2) by inserting before the period a comma and the following: "$4,400,000 for the fiscal year ending September 30, 1981, and $4,160,000 for the fiscal year ending September 30, 1982".

Mr. JOHN L. BURTON (during the reading). Mr. Speaker, I ask unanimous consent that the motion to recommit be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

The SPEAKER pro tempore. The gentleman from California (Mr. DANNEMEYER) is recognized for 5 minutes in support of his motion to recommit.

Mr. DANNEMEYER. Mr. Speaker, this motion to recommit is very simple. It continues the existing programs in fiscal years 1981 and 1982, with an authorized 10-percent growth in each of those years for the impact of inflation.

It discontinues or does not authorize expansion by striking out the expansion of this program in 1983 and 1984.

The expansion for 1983 will take the program from $79.1 million to $177.5 million, and in 1984 it goes up to $200 million. This is not the time for that.

That is the thrust of this motion to recommit. This is not the time, in 1980, to be authorizing expansion of a program, irrespective of its merits, in 1983 and 1984. We will have plenty of time to do that in 1981 and 1982. if it is necessary to do it.

Mr. Speaker, that is what the motion to recommit is all about, and I ask for an aye vote.

The SPEAKER pro tempore. The gentleman from California (Mr. WAXMAN) is recognized for 5 minutes in opposition to the motion to recommit.

Mr. WAXMAN. Mr. Speaker, I will not take the 5 minutes. I rise in opposition to the motion to recommit.

The legislation from the subcommittee and the full committee that is before the House will have us focus on mental health services for those population groups that are unserved or underserved, and, secondly, will give the States a far greater role in the mental health programs than they now have.

Mr. Speaker, I urge defeat of the motion for recommittal and I urge adoption of the bill before us.

Mr. CARTER. Mr. Speaker, will the distinguished subcommittee chairman yield?

Mr. WAXMAN. I am pleased to yield to the distinguished ranking minority member.

Mr. CARTER. Mr. Speaker, I, too, am opposed to the motion to recommit and the amendment, and I support the legislation.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

The question was taken, and the Speaker pro tempore announced that the noes appeared to have it.

RECORDED VOTE

Mr. DANNEMEYER. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. Pursuant to the provisions of clause 5, rule XV, the Chair announces that he will reduce to a minimum of 5 minutes the period of time within which a vote by electronic device, if ordered, will be taken on the question of the passage of the bill.

The vote was taken by electronic device, and there were—ayes 75, noes 223, not voting 134, as follows:

[Roll No. 482]

AYES—75

Archer	Gramm	Paul
Ashbrook	Grisham	Rhodes
Badham	Hagedorn	Ritter
Bauman	Hall, Tex.	Robinson
Beard, Tenn.	Holt	Satterfield
Bennett	Jeffries	Sawyer
Bereuter	Jenkins	Schulze
Bethune	Kelly	Sensenbrenner
Campbell	Kemp	Shumway
Carney	Kindness	Shuster
Clinger	Lagomarsino	Smith, Nebr.
Conable	Latta	Solomon
Corcoran	Leath, Tex.	Spence
Crane, Daniel	Lee	Stangeland
Daniel, R. W.	Loeffler	Stenholm
Dannemeyer	Lungren	Stockman
Dickinson	McDonald	Stratton
Dornan	Madigan	Stump
Erdahl	Martin	Taylor
Erlenborn	Miller, Ohio	Thomas
Fenwick	Montgomery	Walker
Fountain	Moore	Whitehurst
Frenzel	Moorhead, Calif.	Whittaker
Gephardt	O'Brien	Wylie
Goldwater	Pashayan	
Goodling		

NOES—223

Akaka	Ertel	Long, La.
Albosta	Evans, Ga.	Long, Md.
Ambro	Evans, Ind.	Lowry
Anderson, Calif.	Fary	Luken
Andrews, N.Dak.	Fascell	McCloskey
Annunzio	Fazio	McCormack
Aspin	Findley	McHugh
Atkinson	Fithian	Maguire
AuCoin	Florio	Markey
Bafalis	Foley	Marlenee
Bailey	Ford, Tenn.	Marriott
Baldus	Forsythe	Mathis
Barnard	Garcia	Mavroules
Barnes	Gaydos	Mazzoli
Beard, R.I.	Gilman	Mica
Bellenson	Ginn	Mikulski
Benjamin	Glickman	Mineta
Bingham	Gonzalez	Minish
Blanchard	Gore	Mitchell, Md.
Bolling	Gradison	Moffett
Boner	Gray	Murphy, Pa.
Bonker	Green	Murtha
Bowen	Guarini	Myers, Ind.
Brademas	Guyer	Natcher
Brinkley	Hall, Ohio	Neal
Brodhead	Hamilton	Nelson
Brooks	Hammerschmidt	Nowak
Broomfield	Hance	Oakar
Buchanan	Harkin	Oberstar
Burlison	Harris	Obey
Burton, John	Harsha	Ottinger
Burton, Phillip	Hawkins	Panetta
Byron	Heckler	Patten
Carr	Heftel	Patterson
Carter	Hillis	Pease
Cavanaugh	Hinson	Perkins
Chisholm	Hopkins	Petri
Clausen	Howard	Peyser
Clay	Hubbard	Porter
Coelho	Huckaby	Preyer
Coleman	Hughes	Price
Conyers	Hutchinson	Pritchard
Corman	Jacobs	Pursell
Coughlin	Jeffords	Rahall
D'Amours	Jenrette	Rangel
Daniel, Dan	Johnson, Calif.	Ratchford
Daschle	Jones, Okla.	Regula
Davis, Mich.	Jones, Tenn.	Reuss
Davis, S.C.	Kastenmeier	Richmond
Deckard	Kazen	Rinaldo
Derrick	Kildee	Roberts
Dingell	Kostmayer	Roe
Dixon	LaFalce	Rosenthal
Dougherty	Leach, Iowa	Royer
Drinan	Lederer	Sabo
Duncan, Oreg.	Lehman	Santini
Duncan, Tenn.	Leland	Scheuer
Eckhardt	Lent	Schroeder
Edwards, Ala.	Levitas	Sebelius
Edwards, Calif.	Lewis	Seiberling
English	Lloyd	Sharp
		Shelby

Simon	Thompson	Williams, Mont.
Skelton	Traxler	Wilson, Tex.
Snowe	Udall	Winn
Snyder	Ullman	Wirth
Solarz	Van Deerlin	Wolff
Spellman	Vanik	Wolpe
Stack	Vento	Wright
Steed	Volkmer	Wyatt
Stewart	Walgren	Yates
Stokes	Waxman	Young, Mo.
Studds	Weaver	Zablocki
Swift	White	
Tauke	Whitten	

NOT VOTING—134

Abdnor	Fish	Mottl
Addabbo	Flippo	Murphy, Ill.
Alexander	Ford, Mich.	Murphy, N.Y.
Anderson, Ill.	Fowler	Murtha
Andrews, N.C.	Frost	Myers, Pa.
Anthony	Fuqua	Nedzi
Applegate	Giaimo	Nichols
Ashley	Gibbons	Nolan
Bedell	Gingrich	Pepper
Bevill	Grassley	Pickle
Biaggi	Gudger	Quayle
Boggs	Hanley	Quillen
Boland	Hansen	Railsback
Bonior	Hefner	Rodino
Bouquard	Hightower	Rose
Breaux	Holland	Rostenkowski
Brown, Calif.	Hollenbeck	Roth
Brown, Ohio	Holtzman	Rousselot
Broyhill	Horton	Roybal
Burgener	Hutto	Rudd
Butler	Hyde	Russo
Chappell	Ichord	Shannon
Cheney	Ireland	Smith, Iowa
Cleveland	Johnson, Colo.	St Germain
Collins, Ill.	Jones, N.C.	Staggers
Collins, Tex.	Kogovsek	Stanton
Conte	Kramer	Stark
Cotter	Leach, La.	Symms
Courter	Livingston	Synar
Crane, Philip	Lott	Tauzin
Daniel, Dan	Lujan	Trible
de la Garza	Lundine	Vander Jagt
Dellums	McClory	Wampler
Derwinski	McDade	Watkins
Devine	McEwen	Weiss
Dicks	McKay	Whitley
Dodd	McKinney	Williams, Ohio
Donnelly	Matsui	Wilson, Bob
Downey	Mattox	Wilson, C. H.
Early	Michel	Wydler
Edgar	Miller, Calif.	Yatron
Edwards, Okla.	Mitchell, N.Y.	Young, Alaska
Emery	Moakley	Young, Fla.
Evans, Del.	Mollohan	Zeferetti
Ferraro	Moorhead, Pa.	

□ 1450

The Clerk announced the following pairs:

Ms. Ferraro with Mr. Abdnor.
Mr. Addabbo with Mr. Emery.
Mr. Boland with Mr. McDade.
Mrs. Boggs with Mr. Vander Jagt.
Mr. Biaggi with Mr. McClory.
Mr. Downey with Mr. Young of Florida.
Mr. Breaux with Mr. Brown of Ohio.
Mrs. Bouquard with Mr. Evans of Delaware.
Mr. Hanley with Mr. McEwen.
Mr. Moakley with Mr. Trible.
Mr. Mollohan with Mr. Lujan.
Mr. Murphy of New York with Mr. Lott.
Mr. Rodino with Mr. Young of Alaska.
Mr. Nichols with Mr. Wydler.
Mr. Bevill with Mr. Broyhill.
Mr. Dodd with Mr. Burgener.
Mr. de la Garza with Mr. Fish.
Mr. Cotter with Mr. Gingrich.
Mr. Chappell with Mr. McKinney.
Mr. Fuqua with Mr. Michel.
Mr. Giaimo with Mr. Mitchell of New York.
Mr. Ireland with Mr. Symms.
Mr. Jones of North Carolina with Mr. Stanton.
Mr. Stark with Mr. Livingston.
Mr. Tauzin with Mr. Kramer.
Mr. Whitley with Mr. Williams of Ohio.
Mr. Zeferetti with Mr. Wampler.
Mr. Yatron with Mr. Butler.
Mr. Charles H. Wilson of California with Mr. Cheney.
Mr. Rostenkowski with Mr. Grassley.
Mr. Russo with Mr. Hansen.
Mr. St Germain with Mr. Quayle.
Mr. Staggers with Mr. Quillen.
Mr. Moorhead of Pennsylvania with Mr. Rudd.
Mr. Murtha with Mr. Rousselot.
Mr. Nolan with Mr. Hyde.
Mr. Bonior of Michigan with Mr. Cleveland.
Mr. Anthony with Mr. Collins of Texas.
Mr. Dellums with Mr. Hollenbeck.
Mr. Dicks with Mr. Horton.
Mr. Fowler with Mr. Railsback.
Mr. Frost with Mr. Roth.
Mr. Gibbons with Mr. Conte.
Mr. Gudger with Mr. Courter.
Mr. Alexander with Mr. Philip M. Crane.
Mr. Andrews of North Carolina with Mr. Derwinski.
Mr. Dan Daniel with Mr. Devine.
Mr. Hefner with Mr. Edwards of Oklahoma.
Mr. Hightower with Mr. Leach of Louisiana.
Mr. Donnelly with Mr. Mattox.
Mr. Applegate with Mr. McKay.
Mr. Ashley with Mr. Shannon.
Mr. Bedell with Mr. Smith of Iowa.
Mr. Brown of California with Mr. Weiss.
Mr. Kogovsek with Mr. Watkins.
Mr. Flippo with Mr. Synar.
Mr. Early with Mr. Ichord.
Mr. Edgar with Mr. Hutto.
Mr. Lundine wtih Ms. Holtzman.
Mr. Matsui with Mr. Holland.
Mr. Myers of Pennsylvania with Mr. Mottl.
Mr. Ford of Michigan with Mr. Pepper.
Mr. Nedzi with Mr. Roybal.
Mr. Pickle with Mrs. Collins of Illinois.
Mr. Rose with Mr. Miller of California.
Mr. Murphy of Illinois with Mr. Johnson of Colorado.

So the motion to recominit was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the passage of the bill.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. CARTER. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The vote was taken by electronic device, and there were—yeas 277, nays 15, not voting 140, as follows:

[Roll No. 483]

YEAS—277

Akaka	Burton, Phillip	Erlenborn
Albosta	Byron	Evans, Ga.
Ambro	Campbell	Evans, Ind.
Anderson, Calif.	Carney	Fary
	Carr	Fascell
Andrews, N. Dak.	Carter	Fazio
	Chisholm	Fenwick
Annunzio	Clausen	Findley
Archer	Clay	Fisher
Ashley	Clinger	Fithian
Atkinson	Coelho	Foley
AuCoin	Coleman	Ford, Tenn.
Bafalis	Conable	Forsythe
Bailey	Convers	Fountain
Baldus	Corcoran	Frenzel
Barnard	Corman	Garcia
Barnes	Coughlin	Gaydos
Bauman	D'Amours	Gephardt
Beard, R.I.	Daniel, R. W.	Gilman
Beard, Tenn.	Danielson	Ginn
Bellenson	Daschle	Glickman
Benjamin	Davis, Mich.	Goldwater
Bennett	Davis, S.C.	Gonzalez
Bereuter	Deckard	Goodling
Bingham	Derrick	Gore
Blanchard	Dickinson	Gradison
Bolling	Dingell	Gramm
Boner	Dixon	Gray
Bonker	Dornan	Green
Bowen	Dougherty	Grisham
Brademas	Drinan	Guarini
Brinkley	Duncan, Oreg.	Guyer
Brodhead	Duncan, Tenn.	Hagedorn
Brooks	Eckhardt	Hall, Ohio
Broomfield	Edwards, Ala.	Hall, Tex.
Buchanan	Edwards, Calif.	Hamilton
Burlison	English	Hammer-schmidt
Burton, John	Erdahl	
Hance	Mavroules	Schroeder
Harkin	Mazzoli	Schulze
Harris	Mica	Sebelius
Harsha	Mikulski	Seiberling
Hawkins	Mineta	Sharp
Heckler	Minish	Shelby
Heftel	Mitchell, Md	Shumway
Hillis	Moffett	Shuster
Hinson	Montgomery	Simon
Holt	Moore	Skelton
Hopkins	Moorhead, Calif.	Smith, Nebr.
Howard		Snowe
Hubbard	Murphy, Pa.	Snyder
Huckaby	Musto	Solarz
Hughes	Myers, Ind.	Solomon
Hutchinson	Natcher	Spellman
Jacobs	Neal	Spence
Jeffords	Nedzi	Stack
Jeffries	Nelson	Stangeland
Jenkins	Nowak	Steed
Jenrette	O'Brien	Stewart
Johnson, Calif.	Oakar	Stockman
Jones, Okla.	Oberstar	Stokes
Jones, Tenn.	Obey	Stratton
Kastenmeier	Ottinger	Studds
Kazen	Panetta	Swift
Kemp	Pashayan	Tauke
Kildee	Patten	Taylor
Kindness	Patterson	Thomas
Kostmayer	Pease	Thompson
LaFalce	Perkins	Traxler
Lagomarsino	Petri	Udall
Latta	Peyser	Ullman
Leach, Iowa	Porter	Van Deerlin
Lederer	Preyer	Vanik
Lee	Price	Vento
Lehman	Pritchard	Walgren
Leland	Pursell	Walker
Lent	Rahall	Waxman
Levitas	Rangel	Weaver
Lloyd	Ratchford	White
Loeffler	Regula	Whitehurst
Long, La.	Reuss	Whittaker
Long, Md.	Rhodes	Whitten
Lowry	Richmond	Williams, Mont
Luken	Rinaldo	Wilson, Tex.
McCloskey	Roberts	Winn
McCormack	Robinson	Wolff
McHugh	Roe	Wolpe
Madigan	Rosenthal	Wright
Maguire	Royer	Wyatt
Marks	Sabo	Wylie
Marlenee	Santini	Yates
Marriott	Satterfield	Young, Mo.
Martin	Sawyer	Zablocki
Mathis	Scheuer	

NAYS—15

Ashbrook	Leath, Tex.	Paul
Badham	Lewis	Sensenbrenner
Crane, Daniel	Lungren	Stenholm
Dannemeyer	McDonald	Stump
Kelly	Miller, Ohio	Volkmer

NOT VOTING—140

Abdnor	Donnelly	Lott
Addabbo	Downey	Lujan
Alexander	Early	Lundine
Anderson, Ill.	Edgar	McClory
Andrews, N.C.	Edwards, Okla.	McDade
Anthony	Emery	McEwen
Applegate	Ertel	McKay
Aspin	Evans, Del.	McKinney
Bedell	Ferraro	Markey
Bethune	Fish	Matsui
Bevill	Flippo	Mattox
Biaggi	Florio	Michel
Boggs	Ford, Mich.	Miller, Calif.
Boland	Fowler	Mitchell, N.Y.
Bonior	Frost	Moakley
Bouquard	Fuqua	Mollohan
Breaux	Giaimo	Moorhead, Pa.
Brown, Calif.	Gibbons	Mottl
Brown, Ohio	Gingrich	Murphy, Ill.
Broyhill	Grassley	Murphy, N.Y.
Burgener	Gudger	Murtha
Butler	Hanley	Myers, Pa.
Cavanaugh	Hansen	Nichols
Chappell	Hefner	Nolan
Cheney	Hightower	Pepper
Cleveland	Holland	Pickle
Collins, Ill.	Hollenbeck	Quayle
Collins, Tex.	Holtzman	Quillen
Conte	Horton	Railsback
Cotter	Hutto	Ritter
Courter	Hyde	Rodino
Crane, Philip	Ichord	Rose
Daniel, Dan	Ireland	Rostenkowski
de la Garza	Johnson, Colo.	Roth
Dellums	Jones, N.C.	Rousselot
Derwinski	Kogovsek	Roybal
Devine	Kramer	Rudd
Dicks	Leach, La.	Russo
Dodd	Livingston	Shannon

Smith, Iowa	Trible	Wilson, C. H.
St Germain	Vander Jagt	Wirth
Staggers	Wampler	Wydler
Stanton	Watkins	Yatron
Stark	Weiss	Young, Alaska
Symms	Whitley	Young, Fla.
Synar	Williams, Ohio	Zeferetti
Tauzin	Wilson, Bob	

□ 1500

The Clerk announced the following pairs:

Mr. Addabbo with Mr. Abdnor.
Ms. Ferraro with Mr. McClory.
Mr. Boland with Mr. Railsback.
Mrs. Boggs with Mr. Rousselot.
Mr. Moakley with Mr. Wydler.
Mr. Murphy of New York with Mr. Bob Wilson.
Mr. Chappell with Mr. Derwinski.
Mr. Flippo with Mr. Conte.
Mr. Hanley with Mr. Cleveland.
Mr. Tauzin with Mr. Broyhill.
Mr. Pepper with Mr. Fish.
Mr. Anthony with Mr. Emery.
Mr. Alexander with Mr. Edwards of Oklahoma.
Mr. Cotter with Mr. Devine.
Mr. de la Garza with Mr. Philip M. Crane.
Mr. Giaimo with Mr. Kramer.
Mr. Fuqua with Mr. Lott.
Mr. Biaggi with Mr. Lujan
Mr. Bevill with Mr. Hansen.
Mr. Nichols with Mr. Grassley.
Mr. Matsui with Mr Evans of Delaware.
Mr. Mollohan with Mr. McEwen.
Mr Russo with Mr. Michel.
Mr. Zeferetti with Mr. Mitchell of New York.
Mr. Whitley with Mr. McDade.
Mr. Dodd with Mr. Quayle.
Mr. Applegate with Mr. Gingrich.
Mr Breaux with Mr. Hollenbeck.
Mrs. Bouquard with Mr. Burgener.
Mr. Ireland with Mr. Brown of Ohio.
Mr. Jones of North Carolina with Mr. Bethune.
Mr. Kogovsek with Mr. Cheney.
Mr. Rodino with Mr. Butler.
Mr. Pickle with Mr. Collins of Texas.
Mr. Staggers with Mr. Horton.
Mr. St Germain with Mr. Hyde
Mr. Andrews of North Carolina with Mr. Symms.
Mr. Aspin with Mr. Young of Florida.
Mr. Cavanaugh with Mr. Livingston.
Mrs. Collins of Illinois with Mr. Rudd.
Mr. Florio with Mr. Ritter.
Mr. Ford of Michigan with Mr. Quillen.
Mr. Bedell with Mr. McKinney.
Mr. Dan Daniel with Mr. Roth.
Mr. Fowler with Mr. Stanton.
Mr. Frost with Mr. Williams of Ohio.
Mr. Bonior of Michigan with Mr. Young of Alaska.
Mr. Brown of California with Mr. Wampler.
Mr. De'lums with Mr. Vander Jagt.
Mr. Gibbons with Mr. Trible.
Mr. Gudger with Mr. Courter.
Mr. Dicks with Mr. Donnelly.
Mr. Hefner with Mr. Holland.
Mr. Hightower with Ms. Holtzman.
Mr. Downey with Mr. Edgar.
Mr. Early with Mr. Leach of Louisiana.
Mr. Lundine with Mr. Mattox.
Mr. Markey with Mr. Moorhead of Pennsylvania.
Mr. McKay with Mr. Mottl.
Mr. Miller of California with Mr. Nolan.
Mr. Murtha with Mr. Rose.
Mr. Murphy of Illinois with Mr. Smith of Iowa.
Mr. Stark with Mr. Synar.
Mr. Weiss with Mr. Watkins.
Mr. Yatron with Mr. Wirth.
Mr. Rostenkowski with Mr. Roybal.
Mr. Charles H. Wilson of California with Mr. Shannon.
Mr. Ichord with Mr. Ertel.
Mr. Myers of Pennsylvania with Mr. Hutto.

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Mr. WAXMAN. Mr. Speaker, I ask unanimous consent to take from the Speaker's table the Senate bill (S. 1177) to improve the provision of mental health services and otherwise promote mental health throughout the United States, and for other purposes, and ask for its immediate consideration.

The Clerk read the title of the Senate bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

The Clerk read the Senate bill, as follows:

S. 1177

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

SHORT TITLE

SECTION 1. That so much of this Act as precedes title VII, along with the following table of contents, may be cited as the "Mental Health Systems Act".

TABLE OF CONTENTS

FINDINGS AND PURPOSE

SEC. 2. (a) The Congress hereby finds—

(1) despite significant progress that has been made in making community mental health services available and improving residential mental health facilities since the original community mental health centers legislation was enacted in 1963, unserved and underserved populations remain and certain groups in the population in particular, such as chronically mentally ill individuals, children and youth, elderly individuals, racial or ethnic minorities, women, poor persons, and persons in rural areas, often lack access to adequate private and public sector mental health services and support services;

(2) the process of transferring or diverting chronically mentally ill persons from unwarranted or inappropriate institutionalized settings to their home communities has frequently not been accompanied by a process of providing those persons with the mental health and support services they need in community-based settings or a process of affording training, retraining, and job placement for employees affected by institutional closure and conversion and the establishment of community-based programs.

(3) the delivery of mental health and support services is typically uncoordinated at the individual, local, State, and Federal level, and among concerned local, State, and Federal entities and agencies of government;

(4) mentally ill persons are often inadequately served by programs of the Department of Health and Human Services such as medicare, medicaid, supplemental security income, and social services (under title XX of the Social Security Act), and the programs of the Department of Housing and Urban Development, the Department of Labor, and other Federal agencies;

(5) health care systems often lack general health care personnel with adequate mental health training and often lack mental health care personnel, resulting in millions of persons with some level of mental disorder not receiving appropriate mental health care;

(6) present efforts to prevent mental illness through discovery and elimination of its causes and through early detection and treatment are far too limited;

(7) a comprehensive and coordinated array of appropriate private and public sector mental health and support services for all people in need within a specific geographic area, based upon a cooperative local-State-Federal partnership, remains the most effective and humane way to provide a majority of mentally ill individuals with mental health care and needed support; and

(8) because of the rising demand for mental health services and wide disparities in the distribution of psychiatrists, clinical psychologists, psychiatric nurses, and psychiatric social workers, psychiatry is a medical shortage specialty, and there are distinct needs for the other health professionals.

(b) It is, therefore, the purpose of this Act to—

(1) provide and assure an appropriate, coordinated, and accountable network of comprehensive community-based mental health services through the private and public sector for all persons in need of such services, which is sufficiently flexible to respond to changing community circumstances, to the diverse cultural and ethnic backgrounds of individuals, and to differences in race, sex, and age among individuals;

(2) improve and initiate mental health and support services for unserved and underserved populations, particularly chronically mentally ill individuals, children and youth, elderly individuals, racial and ethnic minorities, women, poor persons, persons in rural areas, and any other group with special need;

(3) encourage innovative programs for preventing mental illness and promoting mental health and provide for a specific administrative structure within the Federal Government to direct such efforts;

(4) provide more flexibility in the funding of mental health services and encourage development of a partnership in the delivery of mental health services and related support services among private providers and local, State, and Federal governments;

(5) facilitate State efforts to carry out the State responsibility for—

(A) providing or arranging for the provision of appropriate care for those adults and children whose mental illnesses are so severe that they require inpatient care on a short-term or long-term basis;

(B) bringing about the transition from an institution-based service system (including skilled nursing and intermediate care facilities) to a community-based service system by providing those discharged or diverted from institutions, or who might otherwise be sent there, with the opportunity for appropriate mental health and support services through a comprehensive system of community mental health and support services and by providing training, retraining, and job placement for personnel displaced by institutional closures and conversions and the development of community-based services;

(C) coordinating the mental health services provided in the State with related support services provided in the State;

(D) ensuring the adequacy and fiscal soundness of all mental health and support services within the State through the mental health planning process; and

(E) fostering the most effective use of private, local, State and Federal resources (including private and public forms of health insurance) by promoting the coordinated delivery of, and planning for, mental health and support services at and among all levels of activity and government; and

(6) promote evaluation of the mental health delivery system, particularly with regard to its effectiveness in meeting the needs of priority population groups.

DEFINITIONS

SEC. 3. For the purposes of this Act, unless the context otherwise requires, the term—

(1) "State" includes (in addition to the fifty States) the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Trust Territory of the Pacific Islands, and the Northern Mariana Islands;

(2) "Governor" means the chief executive officer of a State;

(3) "Secretary" means the Secretary of Health and Human Services;

(4) "nonprofit", as applied to any entity, means an entity which is owned and operated by one or more corporations or associations no part of the net earnings of which inures or may lawfully inure to the benefit of any private shareholder or person;

(5) "mental health service area" means a geographic area established for the purpose of planning and providing mental health services in accordance with section 103 of this Act;

(6) "State health plan" means the plan prepared in accordance with title XV of the Public Health Service Act;

(7) "mental Health services" means the treatment provided by the private or public sector which reasonably can be expected to ameliorate a nervous, mental, or emotional disorder, or which reasonably can be expected to prevent the decline of or improve a person's level of mental functioning;

(8) "support services" means health services (other than mental health services), and the educational, rehabilitation, vocational, housing, and social services, and other services specified by the Secretary;

(9) "priority population group" means any group which is determined by the Secretary to have special mental health needs and to be unserved or underserved by mental health service programs, such as but not limited to chronically mentally ill individuals, children and youth, elderly individuals, any racial or ethnic minority, women, Indians and urban Indians (as those terms are defined in the Indian Health Care Improvement Act), Native Hawaiians, the poor, rural residents, and victims of violence or disaster;

(10) "comprehensive mental health services" means the services described in section 201(b) of the Community Mental Health Centers Act (as amended by this Act);

(11) "community mental health center" means an entity which either through its staff and supporting resources or through contracts or cooperative arrangements with other public or private entities provides those services described in paragraph (10) of this section; and

(12) "contract" means a cooperative agreement as described in section 6 of the Federal Grant and Cooperative Agreement Act of 1977 and shall not be governed by the provisions of volume 41, chapters 1 and 3, of the Code of Federal Regulations.

TITLE I—STATE MENTAL HEALTH SYSTEM

CONDITION OF FEDERAL FUNDING

SEC. 101. In order for any entity in a State to receive funding under this Act, the State shall meet the requirements of this title.

DESIGNATION AND FUNCTIONS OF STATE AGENCIES

SEC. 102. Each State shall designate an agency or authority to act as the State administrative agency with regard to mental health services. Such agency shall be referred to in this Act as the "State Agency". The State Agency shall divide the State into, and designate, mental health service areas in accordance with section 103 and shall prepare, consistent with the mental health provisions of the State health plan described in section 104, a State mental health operations program which meets the requirements of section 105.

MENTAL HEALTH SERVICE AREAS

SEC. 103. (a) Within one year after the effective date of this Act, each State Agency shall divide the State into, and designate, mental health service areas. Each mental health service area shall be a geographic region appropriate for the effective development, delivery, and coordination of mental health services in such area. Prior to designating mental health service areas, the State Agency shall conduct hearings relating to the designation of such areas, and all interested persons shall be afforded an opportunity to participate in such hearings. In designating mental health service areas, the State Agency shall consider the following factors:

(1) the optimum number of persons to be served in each area;

(2) the accessibility of services to persons in each area;

(3) the cultural needs of the area;

(4) preexisting geographic boundaries related to the provision of mental health and other services; and

(5) the boundaries of the health service areas of the State established pursuant to title XV of the Public Health Service Act.

(b) The boundaries of each mental health service area shall be within or conform to the boundaries of a health service area established pursuant to title XV of the Public Health Service Act.

MENTAL HEALTH PROVISIONS OF THE STATE HEALTH PLAN

SEC. 104. Each State health plan prepared pursuant to title XV of the Public Health Service Act shall contain, in an identifiable place or places, provisions relating to—

(1) the need for mental health services in the State;

(2) the special mental health service needs in the State of chronically mentally ill individuals (including chronically mentally ill individuals who are multiply handicapped), emotionally disturbed children and adolescents, elderly individuals, and other priority population groups;

(3) the adequacy of public and private mental health facilities and services available in the State;

(4) mental health service priorities in the State;

(5) geographic, cultural, linguistic, and economic barriers with respect to the delivery of mental health services in the State;

(6) the coordination of mental health services with health and other services;

(7) the measures which need to be taken to assure that statistics and other information collected with regard to the provision of mental health services conform to such criteria, standards, and other requirements relating to form, method of collection, content, and confidentiality as have been prescribed by the Secretary; and

(8) such additional requirements as the Secretary may prescribe to carry out the provisions of title XV of the Public Health Service Act and this Act.

MENTAL HEALTH OPERATIONS PROGRAM

SEC. 705. (a) Each State Agency shall prepare, consistent with the mental health provisions of the State health plan described in section 104 and after consultation with the Statewide Health Coordinating Council established pursuant to title XV of the Public Health Service Act, a mental health operations program.

(b) The mental health operations program recuired under subsection (a) shall—

(1) identify the mental health service areas within the State;

(2) identify the need in each mental health service area of the State for mental health and related support services after consideration of—

(A) the demographic, economic, cultural, and social characteristics of the population of the area, and

(B) the services and activities needed in the area for the prevention of mental illness;

(3) identify the special mental health services needs in each mental health service area of chronically mentally ill individuals (including chronically mentally ill individuals who are multiply handicapped), emotionally disturbed children and adolescents, elderly individuals, and other priority population groups;

(4) identify and evaluate the public and private mental health facilities, the mental health personnel, and the mental health services available in each mental health service area, and determine the additional facilities, personnel, and services necessary to meet the mental health needs of each area;

(5) identify the methods used (A) to determine the mental health needs of each mental health service area, and (B) to evaluate the facilities, personnel, and services of each mental health service area;

(6) list the mental health service needs of each mental health service area in the order of priority that such needs should be addressed through the use of existing Federal, State, and local resources;

(7) identify measures which need to be taken to alleviate geographic, cultural, linguistic, and economic barriers with respect to the delivery of mental health services;

(8) identify measures which need to be taken to assure that mental health services will be provided in a manner respectful of each individual's human dignity, and with attention to continuity and quality of care;

(9) identify the legal rights of persons in the State who are mentally ill or otherwise mentally handicapped in addition to the rights provided under title III of this Act, and describe any measures which need to be taken to protect all such rights; and

(10) identify the measures which need to be taken to coordinate the provision of mental health services, including mental health services and support services for chronically mentally ill individuals and other priority population groups.

(c) The mental health operations program required under subsection (a) shall also describe in specific terms how the State agency will—

(1) ensure the continued provision of appropriate services which have been provided in the past by local entities in the State, which entities have received Federal funding under the Community Mental Health Centers Act and this Act, but which entities may in the future become ineligible for Federal funding under this Act;

(2) promote the development of comprehensive mental health services in each mental health service area where such services are currently unavailable;

(3) ensure, within a five-year period after the program is prepared (or within such other period as the State Agency justifies and the Secretary determines to be reasonable), that—

(A) residents of public inpatient psychiatric facilities who are inappropriately placed in such facilities are identified, discharged, and, to the extent appropriate, placed in the least-restrictive settings and provided mental health and support services appropriate to such persons' level of functioning;

(B) persons who need to be placed in mental health facilities are placed in least-restrictive settings and provided mental health and support services appropriate to such persons' level of functioning; and

(C) persons who are discharged from, or are in need of placement in, mental health facilities shall—

(i) upon discharge or prior to placement, be informed of available community-based facilities and programs providing mental health and related support services, and

(ii) have access to a sufficient number of adequately staffed and adequately funded community-based facilities and programs providing mental health and related support services;

(4) promote the development of adequate mental health services for chronically ill individuals and other priority population groups;

(5) promote the prevention of mental illness;

(6) assist the courts and other public agencies, and appropriate private agencies, in screening persons being considered for inpatient care in mental health facilities in the State in order to determine if such care is medically or psychologically indicated;

(7) comply with regulations prescribed by the Secretary of Labor pursuant to section 212(b) of this Act; and

(8) made adequate provisions for the development of planning and service delivery staffs with appropriate training and experience at both the local and State levels.

(d) The mental health operations programs required under subsection (a) shall—

(1) describe the financial commitment and ability of the State to implement the provisions of subsection (c);

(2) include an analysis of the services made available for mentally ill individuals in the State under titles IV(B), V, XVI, XVIII, XIX, and XX of the Social Security Act, the Education for All Handicapped Children Act, the Older Americans Act, the Developmental Disabilities Assistance and Bill of Rights Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1973, the Drug Abuse Office and Treatment Act, and other relevant Federal statutes; and

(3) describe the steps being taken in the State to coordinate the provision of services under this Act with the provision of services under the aforementioned Acts.

(e) In preparing the mental health operations program required under subsection (a), the State Agency shall consult with a State advisory council, which council shall include:

(1) representatives of consumers and providers of mental health services in the State who are familiar with the need for such services, and

(2) representatives of nongovernment organizations or groups, and of State Agencies, concerned with the planning, operation, or use of such services.

Such representatives of consumers shall constitute a majority of the members of such council.

ENFORCEMENT

SEC. 106. (a) Whenever the Secretary determines that there has been a substantial and persistent failure to comply with the requirements of this title, the Secretary shall notify the appropriate State Agency that further payments under this Act will not be made to any entity in the State, including the State Agency, until the Secretary is satisfied that such failure has been or will be corrected. After providing such notice and the opportunity for an informal hearing in the State, if the Secretary reaffirms the determination that there has been a substantial and persistent failure to comply with the requirements of this title, the Secretary shall make no further payments under this Act to any entity in the State, including the State Agency, until the Secretary is satisfied that such failure has been or will be corrected.

(b)(1) Notwithstanding the provisions of subsection (a), the Secretary may continue to make payments to any entity in a State, other than the State Agency, which received funding under the Community Mental Health Centers Act prior to October 1, 1979, if the Secretary determines that—

(A) such entity in no way contributed to the failure to comply with the requirements of this title which led to the termination of payments under subsection (a), and

(B) payments have been terminated under subsection (a) for at least one month.

(2) No entity receiving payments pursuant to paragraph (1) may receive such payments for more than eight years.

TITLE II—COMMUNITY SERVICES

PART A—CONTRACT AUTHORITY

CONTRACTS

SEC. 201. (a) The Secretary may enter into contracts with public and nonprofit private entities, including State Agencies, for the purpose of assisting such entities to provide the services described in part B of this title.

(b) No contract may be entered into under subsection (a) unless an application has been submitted to and selected by the Secretary in accordance with parts C, D, and E of this title.

(c) The Secretary shall determine the amount of any contract entered into under this title, but in no case may such amount be more than the amount permitted under section 223.

PART B—TYPES OF SERVICES

SERVICES FOR CHRONICALLY MENTALLY ILL INDIVIDUALS

SEC. 202. (a)(1) For purposes of this subsection, the Secretary may enter into contracts with public or nonprofit private entities other than a State Agency for the provision of mental health and related support services to chronically mentally ill individuals. A contract entered into under this subsection shall provide for at least the following:

(A) identifying and providing outreach to chronically mentally ill individuals located in inpatient facilities, boarding homes, nursing homes, intermediate care facilities, residential care facilities, group homes, and other community settings, and identifying the barriers preventing chronically mentally ill individuals from receiving needed services and devising and implementing measures to eliminate such barriers;

(B) making available to each chronically mentally ill individual a case manager to assume responsibility for coordinating the provision of mental health services and, as needed, related support services for such individual, and assuring the availability of outreach services, including information and counseling for the families and employers of chronically mentally ill individuals; and

(C) developing, in collaboration with other health, mental health, and human services agencies, community support services not otherwise available to chronically mentally ill individuals (such as screening and referral, followup care, alternatives to hospitalization, assistance in apply for entitlements, crisis stabilization, psychosocial rehabilitation, and supportive living and working arrangements) in order to reduce the dependency of, and increase the potential of, individuals receiving such services, and arranging for the provision of such services in cooperation with such other agencies or entities.

(2) In addition to the provisions of section 210(a) relating to omission of any service or other requirement from an application for a contract, the Secretary may permit the omission of services from an application for a contract to provide services under paragraph (1) if the entity applying for a contract demonstrates, to the satisfaction of the Secretary, that—

(A) the entity is incapable of providing all the services required under paragraph (1), and the chronically mentally ill individuals to be served would benefit from less than all the services being provided by such entity; or

(B) the services to be omitted are not

needed by the chronically mentally ill individuals to be served.

(b) For purposes of this subsection, the Secretary may enter into contracts with a State Agency for the provision of mental health and related support services to chronically mentally ill individuals. A contract entered into under this subsection shall provide for at least one of the following:

(1) assisting mental health service areas in the continuing process of identifying chronically mentally ill individuals in need of mental health and related support services, planning the provision of such services, and carrying out such plans;

(2) assessing the needs of chronically mentally ill individuals throughout the State, identifying local, State, and Federal barriers preventing chronically mentally ill individuals from receiving needed services, and devising and implementing measures to eliminate such barriers;

(3) improving the skills of personnel providing services to chronically mentally ill individuals by providing or arranging for the provision of inservice training, other training, or retraining for such personnel;

(4) providing or arranging for the provision of job placement for, and training and retraining of, employees of public inpatient psychiatric facilities at which there has been a reduction in the need for such employees in order to train and place such employees in settings where such employees can perform comparable work, including, but not limited to, work with priority population groups as defined by this Act; and

(5) coordinating the operations of State agencies or intrastate regional agencies responsible for mental health and related support services for chronically mentally ill individuals, and coordinating the provision of mental health and support services for chronically mentally ill individuals with the provision of services under titles IV(B), V, XVI, XVIII, XIX, and XX of the Social Security Act, the Rehabilitation Act of 1973, the United States Housing Act, the Comprehensive Employment and Training Act, the Developmental Disabilities Assistance and Bill of Rights Act, the Older Americans Act, and other Federal and State statutes.

SERVICES FOR SEVERELY DISTURBED CHILDREN AND ADOLESCENTS

SEC. 203. The Secretary may enter into contracts with public and nonprofit private entities for the provision of mental health and related support services to severely disturbed children and adolescents. A contract entered into under this section shall provide for at least one of the following:

(1) identifying and assessing the needs of severely disturbed children and adolescents, and providing needed services which are not provided by existing programs;

(2) assuring the availability of appropriate personnel responsible for providing, or arranging for the provision of, mental health and related support services needed by severely disturbed children and adolescents;

(3) coordinating the provision of mental health and related support services available to severely disturbed children and adolescents with the activities of community agencies and State agencies and with the provision of services available pursuant to titles IV(B), V, XVI, XIX, and XX of the Social Security Act, the Education for All Handicapped Children Act, the Developmental Disabilities Assistance and Bill of Rights Act, the Rehabilitation Act of 1973, and other Federal and State statutes;

(4) establishing cooperative arrangements with juvenile justice authorities, educational authorities, and other authorities and agencies that come in contact with severely disturbed children and adolescents to ensure referral of such children and adolescents to appropriate mental health and related support services;

(5) establishing self-help groups and crisis support programs for children and adolescents and their families; and

(6) providing auxiliary mental health services to handicapped children served under the Education for All Handicapped Children Act.

SERVICES FOR ELDERLY INDIVIDUALS

SEC. 204. (a) The Secretary may enter into contracts with public and nonprofit private entities for the provision of mental health and support services to elderly individuals. A contract entered into under this section shall provide for out-reach activities, medical differential diagnosis to distinguish between and establish the need for mental health services and other medical care prior to treatment, and for at least one of the following:

(1) identifying and assessing the mental health needs of elderly individuals and providing needed services which are not provided by existing programs; and

(2) providing mental health services to elderly individuals in, and staff training for employees of, nursing homes, intermediate care facilities, boarding homes, senior centers, and ongoing self-help groups and crisis support programs.

(b) With respect to geographic areas where the Secretary determines the services in subsection (a) are being provided, the Secretary may enter into contracts with public and nonprofit private entities for the provision of at least one of the following:

(1) assuring the availability of appropriate personnel responsible for providing, or arranging for the provision of, mental health and related support services needed by elderly individuals; and

(2) coordinating the provision of mental health and related support services available to elderly individuals with the area agency on aging (as defined in the Older Americans Act) and other community agencies providing mental health and related support services for elderly individuals and with the provision of services available pursuant to titles XVI, XVIII, XIX, and XX of the Social Security Act, the Older Americans Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act, the Drug Abuse Office and Treatment Act, the United States Housing Act, the Domestic Volunteer Service Act of 1973, and other Federal and State statutes.

SERVICES FOR PRIORITY POPULATION GROUPS

SEC. 205. The Secretary may enter into contracts with public and nonprofit private entities for the provision of mental health and support services to priority population groups other than chronically mentally ill individuals, severely disturbed children and adolescents, and elderly individuals. A contract under this section shall promote comprehensive mental health services, where appropriate, for such priority population group.

PREVENTION OF MENTAL ILLNESS AND PROMOTION OF MENTAL HEALTH

SEC. 206. (a) The Secretary may enter into contracts with public and nonprofit private entities for programs to prevent mental illness and promote mental health. A contract under this section shall focus upon population groups that have a higher incidence, or greater risk, of mental illness than other population groups. A contract entered into under this section may be for, but need not be limited to, a program to—

(1) educate the general public regarding mental health problems and mental illness, prevention of mental health problems and mental illness, and promotion of mental health;

(2) improve the ability of health, social service, and other human services personnel to identify mental illness in individuals and assure appropriate care;

(3) provide screening, consultation, referral, and education in public school systems and in the work place in order to detect early and prevent mental health problems and promote mental health;

(4) organize self-help groups for populations that have a higher incidence, or greater risk, of mental illness than other population groups; and

(5) promote measures to manage and reduce stress.

(b) Programs supported under this section shall be consistent with national goals and priorities regarding the prevention of mental illness and promotion of mental health determined by the Director of the National Institute of Mental Health pursuant to section 455 of the Public Health Service Act.

COMMUNITY MENTAL HEALTH CENTERS

SEC. 207. (a) The Secretary may enter into contracts with public and nonprofit private entities for the provision of comprehensive mental health services by a community mental health center.

(b) A community mental health center which provides services pursuant to this section shall comply with all applicable provisions of the Community Mental Health Centers Act and shall also establish, in accordance with regulations prescribed by the Secretary a quality assurance program which includes—

(1) multidisciplinary peer review and utilization evaluation;

(2) a secure system of recordkeeping that—

(A) integrates physical and mental health records, and

(B) is in accordance with applicable Federal and State laws respecting confidentiality of and access to such records;

(3) a multidisciplinary professional advisory board; and

(4) an identifiable administrative unit responsible for providing consultation and education services.

(c) The provision of services by a community mental health center in a mental health service area under this section shall be coordinated as appropriate with the provision of services by other mental health, health and social service programs and agencies (including public inpatient psychiatric facilities) serving residents of the mental health service area. Services may be provided under this section—

(1) at a community mental health center, or at a satellite facility, located in the mental health service area;

(2) by the staff of the community mental health center, or through appropriate arrangement with other health professionals and other providers located in the mental health service area; and

(3) in the case of inpatient, emergency, partial hospitalization services, or certain specialized services, by health professionals or agencies, pursuant to appropriate arrangements, in any location that is readily accessible to residents of the mental health service area.

(d) All services provided under this section shall be accessible and promptly available to residents of the mental health service area. Such services shall assure continuity and quality of care, and shall take into account the cultural, economic, and social characteristics of the population to be served.

NON-REVENUE-PRODUCING SERVICES

SEC. 208. (a) The Secretary may enter into contracts with public and nonprofit private entities for the provision of non-revenue-producing services. A contract entered into under this section shall require the provision of such services by an existing community mental health center, or, if no such center is providing services in a mental health service area, by any other entity providing mental health services in the mental health service area.

(b) Services provided under this section may include—

(1) consultation and education services (as described in section 201(b) of the Community Mental Health Centers Act);

(2) evaluation of the mental health services program of a community mental health center;

(3) case management; and

(4) any other nonrevenue producing service which has been determined to be appropriate by the Secretary.

LINKAGES BETWEEN HEALTH CARE SETTINGS AND MENTAL HEALTH SERVICES

SEC. 209. (a) The Secretary may enter into contracts with any public or nonprofit private entity providing mental health services, or having in effect a written agreement with another entity providing mental health services, for the purpose of ensuring linkages between (1) health facilities and programs, nursing homes, and intermediate care facilities and (2) mental health facilities and programs.

(b) A contract entered into under this section shall—

(1) identify individuals in need of mental health services in health care facilities, nursing homes, and intermediate care facilities, and

(2) provide, or arrange for the provision of, mental health and related support services for such individuals, including 24-hour emergency services, outpatient services, and consultation and education services (as described in section 201(b) of the Community Mental Health Centers Act).

PART C—APPLICATION REQUIREMENTS

SEC. 210. (a) An application for a contract under this title may omit any service or other requirement required to be provided or met under section 202 through 209 if the application demonstrates that the service or requirement is already being provided or met to such an extent that the allocation of additional resources to provide the service or to meet the requirement is unnecessary. Any application omitting a service or requirement under this subsection shall demonstrate to the satisfaction of the Secretary that the entity submitting the application has identified another entity providing the service or meeting the requirement and has established a cooperative working agreement with such entity.

(b) An application for a contract under this title shall be submitted in accordance with the provisions of this part and applicable regulations prescribed by the Secretary. Such application shall contain or be accompanied by—

(1) a statement of the objectives of the services to be provided;

(2) information regarding the organization and operation of the entity submitting the application;

(3) a financing plan and budget for the fiscal year for which funding is sought (and such additional period as the Secretary may require), indicating for each service to be provided the sources of funding for the service;

(4) the schedule of fees to be charged for services to be provided, and the discounts to be allowed (to individuals unable to pay in full) on the basis of relative inability to pay for a service, and satisfactory assurances that the entity submitting the application will make every reasonable effort to collect fees for such services;

(5) satisfactory assurances that funds made available under this Act will be used to supplement and, to the extent practicable, increase the level of non-Federal funding for the services provided, and that such Federal funds shall not supplant non-Federal funds except when necessary to carry out the purposes of this Act;

(6) satisfactory assurances that measures have been taken by the entity submitting the application to consult with members of the group or groups to be served, members of the public, and affected organizations and agencies during the development of the application, and to give reasonable opportunities to members of such groups, members of the public, and interested organizations and agencies to comment on the application;

(7) where substantial portions of the population to be served are of limited English-speaking ability, or bicultural, or both, a description of how the entity will provide services in appropriate languages and cultural contexts and the extent to which staff will be bilingual and bicultural;

(8) a description of the efforts made by the entity submitting the application, and the efforts to be made by such entity, to coordinate the services to be provided with other mental health and support services in the same area;

(9) such satisfactory assurances as are required as conditions of eligibility under part D of this title;

(10) information regarding the extent to which and manner in which the entity has served chronically mentally ill individuals in prior years (if such service has been provided) and proposes to serve chronically mentally ill individuals during the fiscal year in which funding is sought under this title (if such service is proposed);

(11) satisfactory assurances that the entity submitting the application shall submit such reports, at such times and containing such information, as the Secretary may request, maintain such records as the Secretary may find necessary for purposes of this Act, and afford the Secretary and the Comptroller General of the United States access to such records and other documents as may be necessary for an effective audit of each service or activity;

(12) statistics and other information requested by the Secretary necessary to evaluate the compliance of the application with the requirements of this Act; and

(13) such other information and material and such other assurances as the Secretary may prescribe in order to carry out the purposes of this Act.

PART D—APPLICANT ELIGIBILITY

ELIGIBILITY REQUIREMENTS: IN GENERAL

SEC. 211. (a)(1) In order to be eligible to enter into a contract under this title, an entity shall—

(A) in the case of an entity, other than a public entity or a hospital, which seeks to provide comprehensive services through a community mental health centers pursuant to section 207, or which has as its primary purpose the provisions of services which are funded under this Act, provide satisfactory assurances to the Secretray that it has a governing board which—

(i) is composed, where practicable, of individuals who reside in the entity's mental health service area and who, as a group, represent the residents of that area, taking into consideration their employment, age sex, and place of residence, and other demographic characteristics of the area, provided that at least one half of the members of such board shall be individuals who are not providers of health care, and

(ii) meets at least once a month, establishes general policies for the entity (including a schedule of hours during which services will be provided), approves the entity's annual budget, and approves the selection of a director for the entity; or

(B) in the case of any entity not described in subparagraph (A), provides satisfactory assurances to the Secretary that it has an advisory committee which—

(i) is composed of individuals who reside in the entity's mental health service area and are representative of the residents of the area as to employment, age, sex, place of residence, and other demographic characteristics of the area: *Provided*, That at least one half of the members of such committee shall be individuals who are not providers of health care, and

(ii) advises the entity with respect to the provision of services which are funded under this Act.

For the purposes of this paragraph, the term "provider of health care" shall have the same meaning as under section 201(c)(2) of the Community Mental Health Centers Act.

(2) Notwithstanding paragraph (1), any public or nonprofit private entity receiving a grant or entering into a contract under section 328 of the Public Health Service Act (relating to hospital-affiliated primary care centers), section 329 of the Public Health Service Act (relating to migrant health centers) or section 330 of the Public Health Service Act (relating to community health centers) shall be eligible for a contract under this title.

(b)(1) In order to be eligible to enter into a contract under this title to provide services pursuant to sections 202, 203, 204, 205, 206, or 209 in any mental health service area—

(A) in the case of an entity other than a State Agency, such entity shall provide satisfactory assurances to the Secretary that it has negotiated in good faith regarding, or secured, a contract or agreement with any entity providing comprehensive mental services through a community health center in the mental health service area concerning such entities mutual responsibilities, and

(B) in the case of a State Agency, such State Agency shall provide satisfactory assurances to the Secretary that it has made a good faith effort to coordinate, or has coordinated, with any entity providing comprehensive mental health services through a community mental health center in the mental health service area concerning such entities' mutual responsibilities.

(2) In order to be eligible to enter into a contract under this title to provide services pursuant to section 207 or 208 in any mental health service area—

(A) in the case of an entity other than a State Agency, such entity shall provide satisfactory assurances to the Secretary that it has negotiated in good faith regarding, or secured, a contract or agreement with any other entity providing mental health services in the mental health service area concerning such entities' mutual responsibilities, and

(B) in the case of a State Agency, such State Agency shall provide satisfactory assurances to the Secretary that it has made a good faith effort to coordinate, or has coordinated, with any other entity providing mental health services in the mental health service area concerning such entities' mutual responsibilities.

(c) In order to be eligible to enter into a contract under this title, an entity shall provide satisfactory assurances to the Secretary that any application for a contract submitted by such entity is consistent with the State health plan of the State.

ELIGIBILITY REQUIREMENTS FOR STATE AGENCIES

SEC. 212. (a) In order to be eligible to enter into a contract under this title, a State Agency shall provide satisfactory assurances to the Secretary that local public and nonprofit private entities have been included as providers of service to the maximum extent possible.

(b)(1) In order to be eligible to enter into a contract under this title, a State Agency shall be certified to be in compliance with the regulations established pursuant to paragraph (2).

(2) The Secretary of Labor, after publishing a notice in the Federal Register and pro-

viding an opportunity for consultation for the Governor of any State and the Secretary of Health and Human Services, shall establish regulations which require fair and equitable arrangements to protect the interests of employees adversely affected by actions taken to emphasize outpatient treatment of mentally ill individuals, against a worsening of such employees' positions with respect to their employment, including those arrangements that are required by section 1642(c)(1) of the Public Health Service Act. In applying this subsection the Secretary of Labor may, to the extent feasible consistent with the principal objective of protecting against a worsening of the positions of affected employees, take into account the State's financial circumstances and their legal requirements.

(3) The Secretary of Labor shall certify which States, which have applied for funding under this title, are in compliance with the regulations required by paragraph (2), and shall provide the Secretary of Health and Human Services with a list of States so certified.

ELIGIBILITY REQUIREMENTS FOR STATE AGENCIES SEEKING TO BE EXCLUSIVE CONTRACTORS

SEC. 213. (a)(1) A State Agency may be the exclusive contractor of services for a State under this title if—

(A) such State agency complies with the provisions of this section, and

(B) the Secretary enters into an exclusive contract with such State Agency under section 217.

(b) A State Agency, in order to be eligible to enter into a contract to be the exclusive contractor of services for a State under this title, shall demonstrate to the satisfaction of the Secretary that it is effectively implementing its mental health operations program prepared pursuant to section 105, and shall also demonstrate to the satisfaction of the Secretary that it, or another agency of the State, is making a good faith effort to establish and implement procedures for carrying out the requirements of subsection (c).

(c)(1) A State Agency, in order to be in compliance with this section, shall monitor the placement in the community of chronically mentally ill individuals discharged or diverted from mental health facilities, and shall prevent overconcentration of such individuals in any community or group of communities.

(2) A State Agency, in order to be in compliance with this section, shall administer a program of support and placement services for chronically mentally ill individuals in the State discharged or diverted from mental health facilities or who may be so discharged or diverted. Such program shall prescribe and enforce minimum standards for the provision of followup care for such individuals by community mental health centers and other appropriate entities. Such program shall include as a minimum the following:

(A) Timely notification by the mental health facility to the appropriate community mental health center or other entity concerning the discharge of each chronically mentally ill individual and the placement of such individual in the mental health service area in which the center or other entity is located.

(B) A prerelease consultation between the mental health facility and the appropriate community mental health center or other entity with respect to each chronically mentally ill individual to be discharged and placed in a community. Such consultation shall take place without delaying the discharge of such individual from the mental health facility. Such consultation shall include a preliminary evaluation of the physical, mental, social, and monetary needs of the individual to be discharged, and an identification of the services and programs for which such individual is eligible.

(C) Development by the mental health facility of a written treatment and services plan for each chronically mentally ill individual to be discharged, or already discharged, or diverted, in consultation with a case manager in the community mental health center or other appropriate entity in the mental health service area in which such individual will or does reside. Such plan shall—

(i) to the maximum extent feasible, be developed with the participation of the individual discharged or diverted and the family of such individual;

(ii) include appropriate living arrangements suited to the needs of the individual. If family or independent living is not possible and the individual resides in a multioccupant residence, the State Agency shall assure that such residence is subject to a program for regulation as described in paragraph (3) of this subsection;

(iii) describe appropriate mental health services and other needed services, such as medical and dental services, rehabilitation services, vocational training and placement, social services, and living skills training; and

(iv) identify specific programs and services for which the individual is eligible, including income support, and provide for a periodic reevaluation of the plan at least every one hundred and twenty days.

(D) Designation of a case manager responsible for the coordination of service for each chronically mentally ill individual discharged or diverted from a mental health facility and the implementation of the treatment and services plan for such individual.

(3) A State Agency, in order to be in compliance with this section, shall develop a program for regulating multioccupant residences (other than family residences in which all the residents are related by blood or marriage, and residences that the State Agency certifies to the Secretary's satisfaction are subject to and in compliance with section 1616(e) of the Social Security Act and which are located in a State in which the standards applicable to such residences pursuant to section 1616(e)(1) of such Act are comparable to the standards required by this paragraph) in which four or more chronically mentally ill individuals reside and for which room is charged, in accordance with guidelines established by the Secretary. Such program shall include the following:

(A) Minimum standards for approval of a residence, including referral to and assistance in reaching appropriate medical, dental, mental health, and other services not otherwise available at such residence, compliance with appropriate life safety, fire, and sanitation codes, and access for visitation during reasonable hours without prior notice by appropriate mental health and social service staff.

(B) Evaluation, inspection, and monitoring procedures.

(C) Remedies for noncompliance.

(4) A State Agency, in order to be in compliance with this section, shall provide educational or informational services to educate the population of the State regarding the problems of chronically mentally ill individuals, the need for community involvement in programs designed to resolve the problems of chronically mentally ill individuals outside institutional settings, and the resources available or needed to help such programs succeed.

(5) A State Agency, in order to be in compliance with this section, shall improve the skills of personnel involved in providing services for chronically mentally ill individuals through inservice training, retraining, or other training of such personnel.

(6) A State Agency, in order to be in compliance with this section, shall review State policies and programs to determine if such policies and programs discriminate against chronically mentally ill individuals, and the means by which such discrimination may be eliminated.

(d) A State Agency, in order to be eligible to enter into a contract to be the exclusive contractor of services for a State under this title, shall provide satisfactory assurances to the Secretary that it will submit an annual report to the Secretary regarding its efforts and progress under this section, including the manner in which the needs of chronically mentally ill individuals in each mental health services area in the State are being met within the community and the State's progress in implementing mechanisms to ensure that, as chronically mentally ill individuals are discharged from mental health facilities, State mental health funds are flowing from institution-based care to community-based care.

PROCESS FOR DETERMINING ELIGIBILITY OF STATE AGENCIES TO BE EXCLUSIVE CONTRACTORS

SEC. 214. No later than the date three hundreds and thirty days before the beginning of each fiscal year, the Secretary shall determine and announce which State Agencies have met the requirements of section 213 and are thereby eligible to be the exclusive contractors of services for their respective State under this title. Prior to such date the Secretary shall provide technical assistance to State Agencies which do not appear to have met requirements of section 213 but which seek to meet such requirements.

PART E—APPLICATION PROCEDURE, SELECTION OF APPLICATIONS, PERFORMANCE CONTRACTS

APPLICATION PROCEDURE

SEC. 215. (a) All applications by public and nonprofit private entities to enter into contracts under this title (except the applications of a State Agency) shall be submitted to the State Agency. Applications shall be submitted no later than the date two hundred and seventy days prior to the first day of the fiscal year for which funding is sought under this title. All such applications shall be submitted to the health systems agency prior to submission to the State Agency. The health systems agency may submit recommendations and comments regarding such applications to the State Agency at any time prior to the transmission of such applications to the Secretary:

(b)(1) A State Agency may—

(A) prepare one or more applications to enter into contracts under this title; or

(B) if the State Agency has been determined to be eligible to be the exclusive contractor of services for the State under this title pursuant to section 214, prepare an application to be the exclusive contractor of services for the State under this title

(c) Within forty-five days after the final date of submission applications under subsection (a), the State Agency shall—

(1) provide public notice of all applications submitted, under subsection (a), the comments and recommendations (if any) submitted by health systems agencies regarding such applications and the comments and recommendations (if any) of the State Agency regarding such applications; and

(2) provide public notice of all applications prepared by the State Agency itself under subsection (b)(1) and the comments and recommendations (if any) submitted by health systems agencies regarding such applications; and

(3) in the case of a State Agency that, pursuant to subsection (b)(2), has announced its decision to submit an application to the Secretary to be the exclusive contractor of mental health services for the State under this title, provide public notice of the ap-

plication to be submitted by the State Agency to the Secretary and the comments and recommendations (if any) submitted by the Statewide Health Coordinating Council regarding such application.

(2) If a State Agency prepares one or more applications to enter into contracts under this title pursuant to paragraph (1)(A), the State Agency shall submit such applications to the affected health systems agencies no later than the date two hundred and seventy days prior to the first day of the fiscal year for which funding is sought under this title. Such health systems agencies may submit comments and recommendations regarding such applications to the State Agency at any time prior to the transmission of such applications to the Secretary.

(3) If a State Agency which has been determined to be eligible to be the exclusive contractor of services for the State under this title decides that it will submit an application to the Secretary to be the exclusive contractor of services for the State under this title, such State Agency shall announce such decision no later than two hundred and seventy days prior to the first day of the fiscal year for which funding is sought under this title. The application to be the exclusive contractor of services for the State under this title, prepared pursuant to paragraph (1)(B), shall be submitted to the Statewide Health Coordinating Council of the State established pursuant to title XV of the Public Health Service Act no later than such date. The Statewide Health Coordinating Council may submit comments and recommendations regarding such application to the State Agency at any time prior to the transmission of such application to the Secretary.

(d) No sooner than twenty days but no later than thirty days after the date public notice is provided under subsection (c), the State Agency shall convene public hearings and receive public comment regarding such application or applications.

(e) After consideration of the public comments received pursuant to subsection (d), the State Agency, on the date one hundred and fifty days prior to the first day of the fiscal year for which funding is sought under this title, shall—

(1) transmit to the Secretary the applications to enter into contracts under this title submitted pursuant to subsection (a), or prepared pursuant to subsection (b)(1)(A), the comments and recommendations (if any) submitted by health systems agencies regarding such applications, the comments and recommendations (if any) of the State Agency regarding such applications and the comments and recommendations (if any) received by the State Agency pursuant to the public hearings held under subsection (d); or

(2) in the case of a State Agency that, pursuant to subsection (b)(1)(B), has prepared an application to the Secretary to be the exclusive contractor of mental health services for the State under this title, transmit to the Secretary such application, the comments and recommendations (if any) of the Statewide Health Coordinating Council regarding such application, and the comments and recommendations (if any) received by the State Agency pursuant to the public hearings held under subsection (d).

(f) An application transmitted by a State Agency to the Secretary to be the exclusive contractor of mental health services for the State under this title may omit applications submitted by other entities under subsection (a) and incorporate any one or more of the following:

(1) applications submitted by other entities under subsection (a), in substantially their original form;

(2) applications submitted by other entities under subsection (a), but substantially modified by the State Agency; and

(3) services under this title proposed only by the State Agency.

(g)(1) Whenever a State Agency transmits an application to the Secretary to be the exclusive contractor of mental health services for the State under this title, and such application omits an application submitted by an entity under subsection (a), or incorporates an application submitted under subsection (a) in a substantially modified form, the State Agency shall inform the entity that submitted such application under subsection (a) that such application has been so omitted or modified, make available the reasons for such omission or modification to the entity and any interested party, and inform the entity of the procedure described in paragraph (2).

(2)(A) If, in an application transmitted to the Secretary by a State Agency to be the exclusive contractor of mental health services for a State under this title, an application submitted by an entity under subsection (a) has been omitted by the State Agency, or has been substantially modified by the State Agency, the entity may, within thirty days after receipt of notice from the State Agency under paragraph (1), request that the application or modified portions thereof be considered in original form during the negotiations of the State Agency's application between the State Agency and the Secretary. Such a request shall be accompanied by written justifications for the incorporation of such application or portion thereof in the State Agency's application. If an entity makes such a request, the Secretary shall promptly determine if—

(i) the application or modified portions thereof are consistent with the State health plan of the State; and

(ii) the entity has sought to, or had an opportunity to, make a good faith effort to negotiate with the State Agency regarding the incorporation of the application or the modified portions thereof in the State Agency's application.

(B) If the Secretary determines that the requirements of subparagraph (A)(i) and (A)(ii) have been met, the Secretary shall review—

(i) the justifications submitted by the entity regarding incorporation of its application or modified portions thereof in the State Agency's application; and

(ii) the justifications of the State Agency regarding omission of such application or portions thereof in the State Agency's application.

(C) If the Secretary determines, upon review under subparagraph (B), that—

(i) an entity's justifications for incorporation of its application or portions thereof are as meritorious as the State Agency's justifications for omission or modification; or

(ii) the decision by the State Agency to omit or modify such application or portions thereof—

(I) is inconsistent with the provisions of this Act,

(II) is inconsistent with the provisions of the State health plan of the State, or

(III) was made in an arbitrary or capricious manner;

the entity's application or portions thereof shall be considered during the negotiation of the State Agency's application between the State Agency and the Secretary.

(h) The State Agency shall make available to any interested party, on the date one hundred and fifty days prior to the first day of the fiscal year for which funding is sought under this title, the materials transmitted to the Secretary under paragraph (e).

(i) In the event that the State Agency fails to transmit the appropriate material pursuant to subsection (e), any entity that submitted an application to enter into a contract under subsection (a) may transmit such application to the Secretary directly.

(j) If a State Agency transmits an application to the Secretary to be the exclusive contractor of services for the State under this title, there shall be selected, by the State Agency and the Secretary, two citizen representatives to provide advice during the negotiation of the State Agency's application between the State Agency and the Secretary. Organizations representing consumers of mental health services within a State, and organizations representing local providers of mental health services within a State, may recommend to the State Agency and the Secretary the names of individuals willing and able to serve as representatives of consumers or providers, respectively, during such negotiations. On the basis of such recommendations, the State Agency and the Secretary shall agree upon one representative of consumers and one representative of providers from the State to serve as advisors during such negotiations.

SELECTION OF APPLICATIONS

SEC. 216. (a) After conducting appropriate negotiations with the entities that submitted the applications transmitted under section 215(e)(1), or with the State Agency in the case of a State Agency that has transmitted under Section 215(e)(2) an application to be the exclusive contractor of mental health services for the State under this title, the Secretary shall select those applications that—

(1) are consistent with the State health plan;

(2) are consistent with the applicable provisions of this title; and

(3) are most likely, in the judgment of the Secretary, to—

(A) provide priority population groups with the most effective and broadest services,

(B) provide the general population with the most effective and broadest services,

(C) lead to the provision of comprehensive mental health services for all persons in every mental health service area,

(D) provide for the maximum feasible utilization of private and public non-Federal resources, including private and public forms of health insurance, and

(E) where substantial portions of the population to be served are of limited English-speaking ability, or bicultural, or both, provide services in appropriate languages and cultural contexts, and provide staff that is bilingual and bicultural.

(b) Upon selection of applications to enter into contracts to provide services under this title, the Secretary shall provide an explanation to each entity whose application was transmitted to the Secretary under section 215(e) of the reasons for acceptance or rejection of such entity's application. If the Secretary uses a formula to rank applications, the Secretary shall provide notice of the principles upon which such formula is based. The explanation provided to the entity under this subsection shall include an explanation of the designated rank of such entity's application.

PERFORMANCE CONTRACTS

SEC. 217. (a) Any entity whose application to provide services has been selected under section 216 shall be eligible to enter into an annual performance contract with the Secretary. In the case of a State Agency for which an application to be the exclusive contractor of mental health services for a State under this title has been selected, the performance contract shall be an exclusive statewide performance contract, and shall provide for the State Agency to enter into performance contracts with other entities providing services in the State as subcontractors.

(b) Each performance contract shall include agreements regarding—

(1) the establishment of citizen participation in the administration of services;

(2) the populations to be served, including

any priority populations, the settings in which services are to be delivered, the means by which such settings shall be the least restrictive and most accessible as possible, and the anticipated outcome and service impact on the populations to be served;

(3) the standards by which the performance of the entity will be monitored and evaluated, incentives for meeting such standards, the role of consumers and individuals representative of affected communities in any monitoring and evaluation, and the role of the Secretary in such monitoring and evaluation;

(4) the methods and format by which performance data shall be collected and transmitted to the Secretary;

(5) the qualifications and clinical and administrative functions and responsibilities of the personnel of the entity;

(6) the annual budget of the entity;

(7) the means by which the activities of the entity will be coordinated with the activities of other entities providing mental health services or related support services in any affected mental health service area;

(8) the allocation of responsibilities among local, State, and Federal entities for provision of mental health services and administration of such services;

(9) the means by which the entity shall decrease its reliance on Federal financial support under this Act;

(10) a schedule for the performance of all obligations arising under the performance contract;

(11) an expeditious and impartial method by which disputes arising under the performance contract may be resolved;

(12) appropriate and defined remedies available to each contracting party in the event that the other contracting party fails to carry out an obligation arising under the performance contract; and

(13) such other matters that the Secretary determines shall be negotiated and resolved to carry out the purposes of this Act.

(c) The Secretary shall promulgate regulations establishing criteria with respect to the evaluation of the performance of entities under this Act.

ENFORCEMENT

SEC. 218. (a) No entity may receive funds under this title unless it has entered into a performance contract which complies with the requirements of section 217.

(b) The extent to which an entity or State Agency has performed in accordance with the performance contract entered into under section 217 and the extent to which the entity has cooperated with other entities providing mental health or support services in the affected mental health service areas shall be periodically reviewed by the Secretary. Substantial and unreasonable failure to perform in accordance with such performance contract or to cooperate with other entities providing mental health or support services in the affected mental health service areas shall, after notice of such alleged failure and an opportunity for an informal hearing which results in a finding of such failure, be a reasonable justification for termination of funding under this title. The Secretary shall consider any such failure with regard to any subsequent application for funding under this title.

FUNDING FOR INNOVATIVE PROJECTS

SEC. 219. (a) Notwithstanding the provisions of this title relating to application procedures, a public entity, nonprofit private entity, or other private entity engaged solely in the provision of services related to mental health may submit directly to the Secretary an application to provide services under this title, or rights protection and advocacy services, if such entity demonstrates that the services to be provided are innovative and of national significance.

(b) The Secretary may accept such applications and enter into contracts for such services under this section if the Secretary determines that such services are innovative and of national significance, but no more than 5 percent of the funds available for allocation under this title may be used for such contracts.

(c) Any entity receiving Federal funding under this section shall be subject to the requirements of sections 217 and 218.

PART F—GENERAL PROVISIONS

DURATION OF CONTRACTS

SEC. 220. A contract under this title shall be for such period of time, not exceeding one year, as the Secretary may determine.

INDIRECT PROVISIONS OF SERVICES

SEC. 221. Any services for which a contract is entered into under this title may be provided directly by the contracting entity at its primary or satellite facilities, or by arrangements with other entities or health professionals.

PAYMENT PROCEDURES

SEC. 222. (a) Except as provided in subsection (b), the amount of payments under any contract for any fiscal year under this title may be reduced to the extent that—

(1) the sums paid to the entity under any prior contract under the same section of this title, or the sums paid to such entity under section 203(a), 203(e), or 211 of the Community Mental Health Centers Act, plus

(2) the funds available for the project, activity, or services for which the prior sums were paid, from State, local, or other sources (including collections),

exceed the total cost of the project, activity, or services for which the prior sums were paid, in lieu of such excess being repaid to the United States.

(b) In the case of any such excess under subsection (a)—

(1) a reduction under subsection (a) shall not be made to the extent adjustments regarding such excess were made previously, or were retained and excluded from repayment under clause (2) of this subsection, and

(2) such portion of an excess under subsection (a) for any year for any project, activity, or services for which sums were paid under this Act and the Community Mental Health Centers Act as the Secretary may determine, but not exceeding 5 per centum of the cost of operation of the recipient's mental health program, may be retained by the recipient for deposit in a reserve fund maintained for purposes approved by the Secretary, and shall not be counted as available funds for purposes of any subsequent contract under this title.

ALLOCATION OF FUNDS

SEC. 223. (a) Under this title, no single public or nonprofit private entity shall receive funding for more than eight fiscal years for the provision of the same mental health services in the same affected mental health service areas. For purposes of this subsection, one or more grants for a fiscal year under section 203(a) of the Community Mental Health Services Act (or section 220 of the Community Mental Health Centers Act as in effect before July 29, 1975, or as continued after such date by section 203(e) of that Act) shall be considered funding for a fiscal year under this subsection. No funding under a contract under this title may exceed the following percentages of the cost of the services with respect to which such contract is made:

(1) 90 per centum in the case of the first and second years of funding;

(2) 80 per centum in the case of the third year of funding;

(3) 70 per centum in the case of the fourth year of funding;

(4) 60 per centum in the case of the fifth year of funding;

(5) 50 per centum in the case of the sixth year of funding;

(6) 40 per centum in the case of the seventh year of funding; and

(7) 30 per centum in the case of the eighth year of funding.

(b) Notwithstanding the limitations described in subsection (a) on the number of years for which funding under this title may be received and the maximum amount of such funding, an entity that submits annual applications to provide services pursuant to section 208 may receive funding under this title for such longer periods and for such greater amounts as determined by the Secretary, but no such funding may exceed $1.50 per capita of the population of the affected area.

(c) Notwithstanding the limitations described in subsection (a), any entity that receives eight years of funding under section 202, 203, 204, 205, 206, 207, or 209 of this title and which thereafter continues to provide substantially the same level of services for the same population for which it received funding under such section, may receive funding to provide different services in the same mental health service area or areas under any other such section.

(d)(1) Outpatient treatment and care and related support services for chronically mentally ill individuals shall account for—

(A) no less than 5 per centum of the Federal funding allocated under this title within each State in the fiscal year ending September 30, 1982;

(B) no less than 10 per centum of the Federal funding allocated for services under this title within each State in the fiscal year ending September 30, 1983;

(C) no less than 15 per centum of Federal funding allocated for services under this title within each State in the fiscal year ending September 30, 1984; and

(D) no less than 20 per centum of Federal funding allocated for services under this title within each State in the fiscal year ending September 30, 1985.

(2) Funds for contracts to provide mental health services to chronically mentally ill individuals under section 202 shall account for—

(A) no less than 10 per centum and nor more than 20 per centum of all available funding under this title in the fiscal year ending September 30, 1982;

(B) no less than 10 per centum and no more than 20 per centum of all available funding under this title in the fiscal year ending September 30, 1983;

(C) no less than 15 per centum and no more than 25 per centum of all available funding under this title in the fiscal year September 30, 1984; and

(D) no less than 20 per centum and nor more than 30 per centum of all available funding under this title in the fiscal year ending September 30, 1985.

(3) Treatment and care and related support services for chronically mentally ill individuals shall account for no less than 20 per centum of the Federal funds allocated under section 207 of this title.

(e) Not more than 5 per centum of the funds allocated under section 207 shall be allocated to entities which do not meet the governing board requirements of section 211(a)(1)(A).

(f) Not less than 90 per centum of the Federal funds for each contract under this title shall be used to provide services at the local level.

(g) The Secretary, after allocating funds under this title, shall submit an annual report to the Committee on Labor and Human Resources of the United States Senate and the Committee on Interstate and Foreign Commerce of the United States House of

Representatives detailing the extent to which—

(1) each community mental health center funded under section 207 of this title is directing its resources towards the treatment and care of chronically mentally ill individuals, and

(2) the requirements of subsection (d)(1), (2) and (3) are being met.

The report required by this subsection shall be submitted to the committees described in this subsection no later than January 1 of each year.

EVALUATION AND TECHNICAL ASSISTANCE

SEC. 224. (a) With the approval of the Secretary, any entity entering into a contract under this Act may use a portion of such contract funds for evaluation of the projects or activities the entity conducts.

(b) The Secretary shall set aside from appropriations for contracts under this title such sums as are determined to be appropriate for the evaluation of the performance of entities under this title. Such evaluation shall determine the extent to which entities have complied with applicable requirements and the extent to which entities have advanced the objectives for which funding was provided.

(c) A portion of the funding available under this title for any fiscal year, as determined by the Secretary, but not to exceed 2 per centum, shall be available to the Secretary to provide technical assistance, including but not limited to the technical assistance described in section 214 and short-term training of personnel responsible for the implementation of contracts under this title. Such amounts shall be available to assist in the improvement of the management and administration of services provided pursuant to this title.

CONFORMING AMENDMENTS

SEC. 225. (a) The second sentence of section 455(a) of the Public Health Service Act (relating to the National Institute of Mental Health) is amended—

(1) by striking out "and" after "sections 301 and 303 of this Act" and inserting in lieu thereof a comma; and

(2) by inserting ", and the Mental Health Systems Act" after "Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (other than part C of title II)".

(b) Section 507 of the Public Health Service Act (relating to grants to Federal institutions) is amended—

(1) by striking out "and" after "drug dependence,"; and

(2) by inserting ", and appropriations under title VI of the Mental Health Systems Act" before "shall also be available".

(c) Section 513 of the Public Health Service Act (relating to evaluation of programs) is amended by inserting "the Mental Health Systems Act," after "Community Mental Health Centers Act,".

(d) Section 1513(e)(1)(A)(i) of the Public Health Service Act (relating to functions of health systems agencies) is amended by inserting "the Mental Health Systems Act," after "Community Mental Health Centers Act,".

(e) Section 201(b)(1)(A)(iii) of the Community Mental Health Centers Act is amended by adding after "facility" the following: ", including—

"(I) designation of a case manager responsible for the coordination of services for each resident discharged from a public inpatient psychiatric facility and for the development of an individual treatment and services plan for such individual;

"(II) pre-release consultation with respect to such individual; and

"(III) preparation and submission of an annual report to the State Agency designated under section 102 of the Mental Health Systems Act describing the manner in which the needs of chronically mentally ill individuals in the catchment area are being met.".

CONTRACTS FOR INDIAN TRIBES

SEC. 226. (a)(1) An Indian tribe (as defined in the Indian Self-Determination Act) or intertribal organization may submit an application directly to the Secretary to provide services eligible for funding under this title if such services will be available within or will specifically serve—

(A) a federally recognized Indian reservation,

(B) any land area in Oklahoma that is held in trust by the United States for Indians or that is a restricted Indian-owned land area,

(C) a native village in Alaska (as defined in section 3(c) of the Alaska Native Claims Settlement Act), or

(D) an Indian community the members of which are recognized as eligible for services under the Indian Health Care Improvement Act.

Each application shall demonstrate the manner in which the proposed services will be consistent with the Tribal Specific Health Plan of the tribe or tribes to be served A copy of the application shall be provided to the appropriate Health Systems Agency or Agencies established under title XV of the Public Health Service Act and to the appropriate State Agency for review and comment. Upon receipt of an application under this subsection, the Secretary shall review, rank, select, and fund the application according to the same criteria used to review, rank, select, and fund applications under this title.

(2) A tribe or intertribal organization receiving Federal funds under this title shall, prior to receiving such funds, enter into an annual performance contract with the Secretary pursuant to section 217, and shall receive payment directly from the Secretary (except as provided in subsection (b) of this section). Each performance contract shall conform with the provisions of section 217, and the provisions of section 218 shall also be applicable, to the extent that such provisions are not inconsistent with the purposes of this section.

(b) At the request of any Indian tribe or intertribal organization or any urban Indian organization (as defined in the Indian Care Improvement Act), the Secretary may enter into a contract with the Indian Health Service or any institution, clinic, or other unit thereof, for the purpose of serving the members of such tribe or organization, on the same terms and conditions as under subsection (a).

(c) Any contract under subsection (a) or (b) may be made for a project serving members of an Indian tribe, intertribal organization, or urban Indian organization even though the area in which the members of such tribe or organization reside is included in two or more mental health services areas of a State.

OBLIGATED SERVICE FOR MENTAL HEALTH TRAINEESHIPS

SEC. 227. Section 303 of the Public Health Service Act is amended by adding at the end thereof the following new subsection:

"(d)(1) Any individual who, after the date of enactment of the Mental Health System Act, has been informed in writing of the requirements and other provisions of this subsection and thereafter accepts a clinical traineeship in psychology, psychiatry, nursing, or social work, under subsection (a)(1) that is not of a limited duration or experimental nature (as determined by the Secretary) is obligated to serve, in service determined by the Secretary to be appropriate in the light of the individual's training and experience, at the rate of one year for each year (or academic year, whichever the Secretary determines to be appropriate) of the traineeship.

"(2) The service required under paragraph (1) shall be in a public inpatient psychiatric facility institution, or for any entity eligible for a contract under title II of the Mental Health Systems Act, or in a health manpower shortage area (as determined under subpart II of part D of title III of the Public Health Service Act), or to serve any priority population group as defined by this Act, or in any other area or for any other entity designated by the Secretary, and shall begin within such period after the termination of the traineeship as the Secretary may determine In developing criteria for determining for which institutions or entities or in which areas, referred to in the preceding sentence, individuals must perform service under this paragraph, the Secretary shall give preference to institutions, entities, or areas which in the Secretary's judgment have the greatest need for personnel to perform that service unless, for good cause shown to the Secretary, the individual requests performance of other service under this paragraph.

"(3) Any individual who fails to perform the service required of the individual under this subsection within the period prescribed by the Secretary is obligated to repay to the United States an amount equal to three times the cost of the traineeship (including stipends and allowances) plus interest at the maximum legal rate at the time of payment of the traineeship, multiplied, in any case in which the service so required has been performed in part, by the percentage which the length of the service so performed is of the length of the service so required to be performed.

"(4)(A) In the case of any individual any part of whose obligation to perform service under this subsection exists at the same time as any part of the individual's obligation to perform service under section 752 or 753 (because of receipt of a scholarship under subpart IV of part C of title VII) or the individual's obligation to perform service under section 472 (because of receipt of a National Research Service Award thereunder), or both, the same service may not be used to any extent to meet more than one of those obligations.

"(B) In any case to which subparagraph (A) is applicable and in which one of the obligations is to perform service under section 752 or 753, the obligation to perform service under that section must be met (by performance of the required service or payment of damages) before the obligation to perform service under this subsection or under section 472.

"(C) In any case to which subparagraphs (A) is applicable, if any part of the obligation to perform service under section 472 exists at the same time as any part of the obligation to perform service under this subsection, the manner and time of meeting each obligation shall be prescribed by the Secretary."

TITLE III—MENTAL HEALTH RIGHTS AND ADVOCACY

BILL OF RIGHTS

SEC. 301. It is the sense of the Congress that each State should review and revise, if necessary, its laws to insure that mental health patients receive the protection and services they require It is further the sense of the Congress that each State should take into account the recommendations of the President's Commission on Mental Health and the following provisions:

(a) A person admitted to a program or facility for the purpose of receiving mental health services has the following rights:

(1) The right to appropriate treatment and related services in a setting and under conditions that—

(A) are most supportive of such person's personal liberty; and

(B) restrict such liberty only to the extent necessary consistent with such person's treatment needs, applicable requirements of law, and applicable judicial orders.

(2) The right to an individualized, written, treatment or service plan (such plan to be developed promptly after admission of such person), the right to treatment based on such plan, the right to periodic review and reassessment of treatment and related service needs, and the right to appropriate revision of such plan, including any revision necessary to provide a description of mental health services that may be needed after such person is discharged from such program or facility.

(3) The right to ongoing participation, in a manner appropriate to such person's capabilities, in the planning of mental health services to be provided such person (including the right to participate in the development and periodic revision of the plan described in paragraph (2)), and, in connection with such participation, the right to be provided with a reasonable explanation, in terms and language appropriate to such person's condition and ability to understand, of—

(A) such person's general mental condition and, if such program or facility has provided a physical examination, such person's general physical condition;

(B) the objectives of treatment;

(C) the nature and significant possible adverse effects of recommended treatments;

(D) the reasons why a particular treatment is considered appropriate;

(E) the reasons why access to certain visitors may not be appropriate; and

(F) any appropriate and available alternative treatments, services, and types of providers of mental health services.

(4) The right not to receive a mode or course of treatment, established pursuant to the treatment plan, in the absence of such person's informed, voluntary, written consent to such mode or course of treatment, except that treatment may be provided without such consent—

(A) during an emergency situation if such treatment is pursuant to or documented contemporaneously by the written order of a responsible mental health professional; or

(B) as permitted under applicable law in the case of a person committed by a court to a treatment program or facility.

(5) The right not to participate in experimentation in the absence of such person's informed, voluntary, written consent, the right to appropriate protections in connection with such participation, including the right to a reasonable explanation of the procedure to be followed, the benefits to be expected, the relative advantages of alternative treatments, and the potential discomforts and risks, and the right and opportunity to revoke such consent.

(6) The right to freedom from restraint or seclusion, other than as a mode or course of treatment, except that restraint or seclusion may be used during an emergency situation if such restraint or seclusion is pursuant to or documented contemporaneously by the written order of a responsible mental health professional.

(7) The right to a humane treatment environment that affords reasonable protection from harm and appropriate privacy to such person with regard to personal needs.

(8) The right to confidentiality of such person's records, including confidentiality of information pertaining to such person's identity, diagnosis, prognosis, and treatment, under the same terms and conditions applicable to patients under section 515 of the Public Health Service Act.

(9) The right to access, upon request, to such person's mental health care records, except that such person may be refused access to—

(A) information in such records provided by a third party under assurance that such information shall remain confidential; and

(B) specific material in such records if the health professional responsible for the mental health services concerned has made a determination in writing that such access would be detrimental to such person's health, except that such material shall be made available to a similarly licensed health professional selected by such person and such health professional may, in the exercise of professional judgment, provide such person with access to any or all parts of such material or otherwise disclosure the information contained in such material to such person.

(10) The right, in the case of a person admitted on a residential or inpatient care basis, to converse with others privately, to have convenient and reasonable access to the telephone and mails, and to see visitors during regularly scheduled hours, except that, if a mental health professional treating such person determines that denial of access to a particular visitor is necessary for treatment purposes, such mental health professional may, for a specific, limited, and reasonable period of time, deny such access if such mental health professional has ordered such denial in writing and such order has been incorporated in the treatment plan for such person. An order denying such access shall include the reasons for such denial.

(11) The right to be informed promptly at the time of admission and periodically thereafter, in language and terms appropriate to such person's condition and ability to understand, of the rights under this part.

(12) The right to assert grievances with respect to infringement of such person's rights under this part, including the right to have such grievances considered in a fair, timely, and impartial grievance procedure provided for or by the program or facility.

(13) Notwithstanding paragraph (10), the right of access to (including the opportunities and facilities for private communicaties with) any available—

(A) rights protection service within the program or facility;

(B) rights protection service within the State mental health system designed to be available to such person; and

(C) qualified advocate;

for the purpose of receiving assistance to understand, exercise, and protect such person's rights under this part and other provisions of law.

(14) The right to exercise such person's rights under this part without reprisal, including reprisal in the form of denial of any appropriate, available treatment.

(15) The right to referral as appropriate to other providers of mental health services upon discharge.

(b)(1) The rights provided in this section are in addition to and not in derogation of any other statutory or constitutional rights otherwise afforded to all persons, handicapped persons, or recipients of health care services.

(2) The rights to confidentiality of and access to records as provided in paragraphs (8) and (9) of subsection (a) shall remain applicable to records pertaining to a person after such person's discharge from the program or facility.

(c)(1) No otherwise eligible person shall be denied admission to a program or facility for mental health services as a reprisal for the exercise of the rights provided in this section.

(2) Nothing in this section shall—

(A) obligate an individual mental health or health professional to administer treatment contrary to such professional's clinical judgment;

(B) prevent any program or facility from discharging any person for whom the provision of appropriate treatment, consistent with the clinical judgment of the mental health professional primarily responsible for such person's treatment, is or has become impossible as a result of such person's refusal to consent to such treatment;

(C) require a program or facility to admit any person who, while admitted on prior occasions to such program or facility, has repeatedly frustrated the purposes of such admissions by withholding consent to proposed treatment; or

(D) obligate a program or facility to provide treatment services to any person who is admitted to such program or facility solely for diagnostic or evaluative purposes.

(3) In order to assist a person admitted to a program or facility in the exercise or protection of such person's rights, such person's attorney or legal representatives shall have reasonable access to—

(A) such person;

(B) the areas of the program or facility where such person has received treatment, resided, or had access; and

(C) pursuant to the written authorization of such person, the records and information pertaining to such person's diagnosis, treatment, and related services to which such person has a right of access under subsection (a)(9).

(4) Each program and facility shall post a notice listing and describing, in language and terms appropriate to the ability of the persons to whom such notice is addressed to understand, the rights under this title of all persons admitted to such program or facility. Each such notice shall conform to the format and content for such notices, and shall be posted in all appropriate locations.

(d)(1) In the case of a person adjudicated by a court of competent jurisdiction as being incompetent to exercise the right to consent to treatment or experimentation under paragraph (4) or (5) of subsection (a), or the right to confidentiality of or access to records under paragraph (8) or (9) of such subsection, or to provide authorization pursuant to subsection (c)(3)(C), such right may be exercised or such authorization may be provided by the individual appointed by such court as such person's guardian or representative for the purpose of exercising such right or such authorization.

(2) In the case of a person who lacks capacity to exercise the right to consent to treatment or experimentation under paragraph (4) or (5) of subsection (a), or the right to confidentiality of or access to records under paragraph (8) or (9) of such subsection, or to provide authorization pursuant to subsection (c)(3)(C), because such person has not attained an age considered sufficiently advanced under State law to permit the exercise of such right or such authorization to be legally binding, such right may be exercised or such authorization may be provided on behalf of such person by a parent or legal guardian of such person.

(3) Notwithstanding paragraphs (1) and (2), in the case of a person admitted to a program or facility for the purpose of receiving mental health services, no individual employed by or receiving any remuneration from such program or facility may act as such person's guardian or representative under this subsection.

REPORT ON ADVOCACY

SEC. 302. (a) The Comptroller General shall conduct a study to examine the performance of advocacy programs that represent—

(1) persons admitted to programs and facilities for the purpose of receiving mental health services;

(2) persons who are developmentally disabled or severely disabled; and

(3) youth, racial and ethnic minorities, women, and other appropriate groups with respect to the constitutional and statutory rights of such persons.

(b) No later than the date eighteen

months after the effective date of this title, the Comptroller General shall submit to the President and the Congress a comprehensive report of such study, and shall include in such report any legislative recommendations that the Comptroller General considers appropriate.

(c) The report shall assess the performance of advocacy programs established by Congress or undertaken as demonstration projects within executive agencies designed to protect the constitutional and statutory rights of priority population groups. The report shall, at a minimum—

(1) summarize the advocacy activities and evaluate the performance of advocacy efforts authorized by the Developmental Disabilities Assistance and Bill of Rights Act and the Rehabilitation Act;

(2) describe and assess the role of the Legal Services Corporation in providing legal services to such priority population groups;

(3) describe and assess the role of the various volunteer agencies and other institutions and professions in providing advocacy services;

(4) assess the need for advocacy services currently not being provided;

(5) make recommendations regarding the efficient provision of advocacy services;

(6) make recommendations regarding measures to improve the Federal advocacy effort on behalf of youth, racial and ethnic minorities, and women; and

(7) assess the impact of advocacy programs upon the cost and quality of care and treatment in programs and facilities.

PROTECTION AND ADVOCACY OF INDIVIDUAL RIGHTS

SEC. 303. (a) In order for a State to receive funds under title II, the State shall have in effect a system to protect and advocate the rights of mentally ill individuals. Such system shall have the authority to pursure legal, administrative, and other appropriate remedies to insure the protection of the rights of such persons who are receiving treatment, services, or habilitation within the State, and be independent of any agency which provides treatment, services, or rehabilitation to mentally ill individuals. The State shall submit to the Secretary in a form prescribed by the Secretary in regulations—

(1) a report, not less often than once every three years, describing the system; and

(2) an annual report describing the activities carried out under the system and any changes made in the system during the previous year.

(b) (1) (A) To assist States in meeting the requirements of subsection (a), the Secretary shall allot to the States the sums appropriated under section 602(c). Allotments and reallotments of such sums shall be made in accordance with subparagraph (B), except that no State (other than Guam, the Northern Mariana Islands, American Samoa, the Virgin Islands, and the Trust Territory of the Pacific Islands) in any fiscal year shall be allotted an amount under this paragraph which is less than the greater of $50,000 or the amount of the allotment to the State under this subsection for the previous fiscal year.

(B) Is each fiscal year, the Secretary shall, in accordance with regulations, allot the sums appropriated for such year under sections 602(c) among the States on the basis of—

(i) the population;

(ii) the extent of need for services for the chronically mentally ill; and

(iii) the financial need,

of the respective States. The amount of an allotment to a State for a fiscal year, which the Secretary determines will not be required by the State during the period for which it is available for the purpose for which allotted shall be available for reallotment by the Secretary from time to time, on such date or dates as the Secretary may fix (but not earlier than thirty days after the Secretary has published notice of the intention to make such reallotment in the Federal Register), to other States with respect to which such a determination has not been made, in proportion to the original allotments of such States for such fiscal year, but with such proportionate amount for any of such other States being reduced to the extent it exceeds the sum the Secretary estimates such State needs and will be able to use during such periods; and the total of such reductions shall be similarly reallotted among the States whose proportionate amounts were not so reduced. Any amount so reallotted to a State for a fiscal year shall be deemed to be a part of its allotment under this paragraph for such fiscal year.

(2) (A) Notwithstanding paragraph (1), if the aggregate of the amounts of the allotments for grants to be made in accordance with paragraph (1) for any fiscal year exceeds the total of the amounts appropriated for such allotments under section 602(c), the amount of a State's allotment for such fiscal year shall bear the same ratio to the amount otherwise determined under such paragraph as the total of the amounts appropriated for that year under section 602(c) bears to the aggregate amount required to make an allotment to each of the States in accordance with paragraph (1).

(B) The provisions of section 1913 of title 18, United States Code, shall be applicable to all moneys authorized under the provisions of this section.

(3) The Secretary shall set aside up to 10 percent but not less than 5 percent of funds available for grants and contracts under this section for the provision of technical assistance, training, and backup support by entities concerned with advocacy.

EFFECTIVE DATE

SEC. 304. This title shall become effective on the date of the enactment of this Act.

TITLE IV—ASSOCIATE DIRECTOR FOR MINORITY CONCERNS

ASSOCIATE DIRECTOR OF MINORITY CONCERNS

SEC. 401. Section 455 of the Public Health Service Act is amended by adding at the end thereof the following new subsection:

"(d)(1) The Director shall designate an Associate Director for Minority Concerns to develop and coordinate prevention, treatment, research, and administrative policies and programs to assure increased focus on minority populations.

"(2) The Associate Director for Minority Concerns shall assist the Director in assuring that the Institute—

"(A) supports programs with regard to the delivery of mental health services to minority populations, including demonstration projects;

"(B) develops a plan to increase the representation of minority populations in mental health service delivery and manpower programs with an emphasis on developing bilingual and bicultural programs;

"(C) supports programs of basic and applied social and behavioral research on minority mental health;

"(D) studies the effects of racial, age, and sexual discrimination on institutions and individuals, including majority institutions and individuals;

"(E) develops systems to assist minority populations in adapting to, and coping with, the effects of racial, age, and sexual discrimination;

"(F) supports and develops research, demonstration, and training programs aimed at eliminating institutional racial, age, and sexual discrimination; and

"(G) provides for increased emphasis on the concerns of minority populations in training programs, service delivery programs, and research endeavors.

"(3) The Secretary shall report to Congress every 3 years on the Institute's activities in carrying out the provisions of this subsection.

"(4) Nothing contained in this subsection shall be construed to prevent or impair the administration or enforcement of any other provision of Federal law, nor shall the Associate Director for Minority Concerns be deemed to have exclusive jurisdiction of the Institute's responsibility to develop effective policies and programs for minority populations.".

TITLE V—PREVENTION

PREVENTION UNIT

SEC. 501. Section 455 of the Public Health Service Act is amended by adding at the end thereof the following new subsection:

"(e)(1) The Director shall designate an administrative unit for prevention of mental illness and the promotion of mental health. The purpose of such unit shall be to—

"(A) design national goals and establish national priorities related to the prevention of mental illness;

"(B) design national goals and establish national priorities related to the promotion of mental health; and

"(C) encourage and assist local entities and State agencies to achieve the goals and priorities described in this paragraph.

"(2) The Director shall designate an individual to develop and coordinate prevention policies and programs and to assure increased focus on the prevention of mental illness and the promotion of mental health. This individual shall assist the Director in assuring that the Institute—

"(A) enhances, focuses, and coordinates the research and training activities being carried out under existing legislative authorities which are aimed at preventing mental illness and promoting mental health;

"(B) encourages and assists local, State, and Federal efforts to prevent mental illness and promote mental health, particularly efforts relating to children and adolescents; and

"(C) emphasizes and strengthens orderly planning, implementation, and evaluation of the activities described in this paragraph.

"(3) The Secretary shall report to the Congress every three years on the Institute's activities in carrying out the provisions of this subsection.".

TITLE VI—MISCELLANEOUS

COMMUNITY MENTAL HEALTH CENTERS ACT APPROPRIATIONS

SEC. 601. (a) Section 202(d) of the Community Mental Health Centers Act is amended by deleting "and" after "1979", deleting the period at the end of such subsection, substituting a comma, and adding "and $1,000,000 for the fiscal year ending September 30, 1981.".

(b) Section 203(d)(1) of the Community Mental Health Centers Act is amended by deleting "and" after "1979", deleting the period at the end of such paragraph, substituting a comma, and adding "and $42,000,000 for the fiscal year ending September 30, 1981.".

(c) Section 204(c) of the Community Mental Health Centers Act is amended by deleting "and" after "1979", deleting the period at the end of such subsection, substituting a comma and adding "and $19,000,000 for the fiscal year ending September 30, 1981.".

(d) Section 213 of the Community Mental Health Centers Act is amended by deleting "and" after "1979", and adding after "1979," the phrase "and $25,000,000 for the fiscal year ending September 30, 1981,".

(e) No funds may be appropriated under the Community Mental Health Centers Act for any year period after September 30, 1982.

AUTHORIZATION OF APPROPRIATIONS

SEC. 602. (a) There are authorized to be appropriated, for funding under title II, $400,000,000 for the fiscal year ending September 30, 1982, $450,000,000 for the fiscal year ending September 30, 1983, $500,000,000 for the fiscal year ending September 30, 1984, and $550,000,000 for the fiscal year ending September 30, 1985.

(b)(1) Sections 237 of the Community Mental Health Centers Act and 314(g) of the Public Health Service Act are repealed as of September 30, 1981.

(2) For the purpose of assisting States in carrying out their responsibilities under this Act for—

(A) planning and program design,

(B) data collection,

(C) data analysis,

(D) research,

(E) evaluation,

(F) setting and enforcing regulatory and other standards,

(G) reporting to the Secretary, and

(H) establishing, expanding, or operating internal rights protection programs,

the Secretary shall, in each fiscal year and in accordance with regulations, allot the sums appropriated for such year under paragraph (3) on the basis of the population and the financial need of the respective States. The populations of the States shall be determined on the basis of the latest figures for the populations of the States available from the Department of Commerce.

(3) There are authorized to be appropriated, for the purpose of assisting the States in carrying out their responsibilities under paragraph (2), $20,000,000 for the fiscal year ending September 30, 1982, and such sums as may be necessary for each of the next three fiscal years.

(4) No funds shall be made available to a State under this subsection unless the provisions of section 307 of this Act are being carried out in such State.

(c) There are authorized to be appropriated, for funding under title III, $10,000,000 for the fiscal year ending September 30, 1982, and such sums as may be necessary for each of the next three fiscal years.

REPORT ON SHELTER AND BASIC LIVING NEEDS OF CHRONICALLY MENTALLY ILL INDIVIDUALS

SEC. 603. (a) The Secretary of Health and Human Services and the Secretary of Housing and Urban Development shall jointly submit a report to the Committees on Labor and Human Resources and Banking, Housing, and Urban Affairs of the United States Senate, and the Committees on Interstate and Foreign Commerce and Banking, Finance, and Urban Affairs of the United States House of Representatives, relating to Federal efforts to respond to the shelter and basic living needs of chronically mentally ill individuals.

(b) The report required by subsection (a) shall include—

(1) an analysis of the extent to which chronically mentally ill individuals remain inappropriately housed in institutional facilities or have otherwise inadequate or inappropriate housing arrangements;

(2) an analysis of available permanent noninstitutional housing arrangements for the chronically mentally ill;

(3) an evaluation of ongoing permanent and demonstration programs, funded in whole or in part by Federal funds, which are designed to provide noninstitutional shelter and basic living services for the chronically mentally ill, including—

(A) a description of each program;

(B) the total number of individuals estimated to be eligible to participate in each program, the number of individuals served by each program, and an estimate of the total population each program expects to serve; and

(C) an assessment of the effectiveness of each program in the provision of shelter and basic living services;

(4) recommendations of measures to encourage States to coordinate and link the provisions in State health plans which relate to mental health and, in particular, the shelter and basic living needs of chronically mentally ill individuals, with local and State housing plans;

(5) recommendations for Federal legislation relating to the provision of permanent residential noninstitutional housing arrangements and basic living services for chronically mentally ill individuals, including an estimate of the cost of such recommendations; and

(6) any other recommendations for Federal initiatives which, in the judgment of the Secretary of Health and Human Services and the Secretary of Housing and Urban Development, will lead to improved shelter and basic living services for chronically mentally ill individuals.

(c) The report required by subsection (a) shall be submitted to the committee described in subsection (a) no later than January 1, 1981.

REPORT ON THE IMPLEMENTATION OF THE MENTAL HEALTH SYSTEMS ACT

SEC. 604. (a) The Secretary shall submit a report to the Committee on Labor and Human Resources of the United States Senate and the Committee on Interstate and Foreign Commerce of the United States House of Representatives regarding the implementation of the Mental Health Systems Act.

(b) The report required by subsection (a) shall include—

(1) a description of the number and types of proposals which have been funded, the populations served, and the kinds of services provided under the Act;

(2) an analysis of the extent to which the purposes of the Act have been achieved, are being achieved, and are likely to be achieved if the Act is continued;

(3) an analysis of the major problems, if any, which have arisen at the local, State, and Federal levels in implementing the Act; and

(4) recommendations regarding possible changes in the basic policy, design, requirements, criteria, and technical features of the Act which, in the judgment of the Secretary, would improve the provision of mental health care, further the prevention of mental illness, and promote mental health in the United States.

(c) The report required by subsection (a) shall be submitted to the committees described in subsection (a) no later than January 1, 1985.

CONFIDENTIALITY OF MENTAL HEALTH RECORDS

SEC. 605. The Public Health Service Act is amended by adding, at the end of title V of such Act, the following new section:

"CONFIDENTIALITY OF MENTAL HEALTH RECORDS

"SEC. 515. (a) Records of the identity, diagnosis, prognosis, or treatment of any patient pertaining to such person's mental health which are maintained in connection with the performance of any program or activity relating to mental health or health education, training, treatment, services, rehabilitation, or research which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e), be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section.

"(b)(1) The content of any record referred to in subsection (a) may be disclosed in accordance with the prior written consent of the patient with respect to whom such record is maintained, but only to such extent, under such circumstances, and for such purposes as may be allowed under regulations prescribed pursuant to subsection (h).

"(2) Whether or not the patient, with respect to whom any given record referred to in subsection (a) of this section is maintained, gives his written consent, the content of such record may be disclosed as follows:

"(A) To medical personnel to the extent necessary to meet a bona fide medical emergency.

"(B) To qualified personnel for the purpose of conducting scientific research, management audits, financial audits, program evaluation or eligibility determination, but such personnel may not identify, directly or indirectly, any individual patient in any report of such research, audit, or evaluation, or otherwise disclose patient identities in any manner.

"(C) If authorized by an appropriate order of a court of competent jurisdiction granted after application showing good cause therefor. In assessing good cause the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the therapist-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

"(D) Where the patient is admitted on an inpatient basis, to any person upon reasonable determinations by the individual responsible for the patient's diagnostic or treatment services that (i) such person is a close friend or family member of the patient and is concerned about the patient's welfare as the result of being unable to locate the patient, (ii) the patient is incapable of making an informed decision as to whether to provide consent to disclosure, and (iii) disclosure would not be inconsistent with any arrangement that has been made for the provision of the services involved. Disclosures under this subparagraph shall be limited to the location of the patient and the patient's general physical condition.

"(E) Where the patient is admitted on an inpatient basis, to a person who is a close friend or family member of a patient who is suffering from a serious physical condition involving the possibility of the patient's death if the individual responsible for the patient's diagnostic or treatment services reasonably determines that the patient is incapable of making an informed decision as to whether to provide consent to disclosure. Disclosures under this subparagraph shall be limited to the patient's location and information pertaining to such physical condition.

"(F) To such persons as the individual responsible for the patient's diagnostic or treatment services reasonably considers necessary to protect against a clear and substantial risk of imminent, serious bodily harm to the patient or others. Nothing in this subparagraph shall make such individual civilly or criminally liable for failing or refusing to make any disclosure under this subparagraph.

"(G) By a department or agency of the Federal Government that has provided care and treatment services to the patient, as necessary for the purposes of the United States' obtaining, from a third party, payment for the costs of the patient's care and treatment if the United States has the right under Public Law 87-693 or other applicable law to recover such costs in the absence of an assignment from the patient and there are reasonable grounds to believe that such third party is liable for such costs.

"(c) Except as authorized by a court order

granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.

"(d) The prohibitions of this section shall continue to apply to records concerning any individual who has been a patient, irrespective of whether or when he or she ceases to be a patient. For purposes of section 303 of this Act, persons who maintain records referred to in subsection (a) are deemed to be authorized by the Secretary to protect the privacy of individuals.

"(e) The prohibitions of this section do not apply to any interchange of records—

"(1) within the Armed Forces or within those components of the Veterans' Administration furnishing health care or determining eligibility for benefits or services under title 38, United States Code; or

"(2) between such components and the Armed Forces.

"(f) Any person who obtains a patient's consent to disclosure of a record referred to in subsection (a) of this section shall assure that such consent is informed and voluntary.

"(g) Any person who violates any provision of this section or any regulation issued pursuant to this section shall be fined not more than $500 in the case of a first offense, and not more than $5,000 in the case of each subsequent offense.

"(h) Except as provided in subsection (i) of this section, the Secretary shall prescribe regulations to carry out the purposes of this section. The regulations may contain such definitions, and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of orders under subsection (b)(2)(C), as in the judgment of the Secretary are necessary or proper to effectuate the purposes of this section, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

"(i) The Administrator of Veterans' Affairs, through the Chief Medical Director, shall, to the maximum feasible extent consistent with their responsibilities under title 38, United States Code, prescribe regulations making applicable the regulations prescribed by the Secretary under subsection (h) of this section to records referred to in subsection (a) of this section that are maintained in connection with the provision of hospital care, nursing home care, domiciliary care, and medical services under such title 38. In prescribing and implementing regulations pursuant to the subsection, the Administrator shall, from time to time, consult with the Secretary in order to achieve the maximum possible coordination of the regulations, and the implementation thereof, which they each prescribe.

"(j) For purposes of this section—

"(1) The term 'identity' means—

"(A) the patient's name or other data from which it could be reasonably anticipated that a person could—

"(i) identify such patient, or

"(ii) ascertain other data from which such patient might be identified; or

"(B) a code, number, or other means used to identify the patient in relation to a record regarding him.

"(2) The term 'record' means data or information in any recorded medium created or maintained that—

"(A) reveals or contains a patient's identity; or

"(B) relates to the physical or mental health history, diagnosis, condition, treatment, or rehabilitation of a patient.

"(3) The term 'patient' includes a mental health research subject.".

TITLE VII—RAPE PREVENTION AND CONTROL

RAPE PREVENTION AND CONTROL

SEC. 701. (a) Part D of title II of the Community Mental Health Centers Act (42 U.S.C. 2681) is amended by adding at the end thereof the following new section:

"RAPE SERVICES DEVELOPMENT AND DEMONSTRATION PROJECTS

"SEC. 232. (a) The Secretary, acting through the National Center for the Prevention and Control of Rape, shall make grants to, and enter into contracts with, public and private entities to develop or demonstrate new and innovative methods to provide rape services.

"(b) The Secretary may award grants and contracts under subsection (a) for development or demonstration projects for any one or more of the following—

"(1) training programs (including counseling techniques for the victim or the offender) for professional, paraprofessional, and volunteer personnel in the fields of law, social service, mental health, and other related fields in which personnel are or will become engaged in areas relating to the problems of rape;

"(2) treatment programs providing—

"(A) counseling for the victim, the victim's immediate family, or the offender;

"(B) information about or referral to medical, mental health, social, or legal services including necessary transportation costs and accompaniment to such services;

"(C) consultation with allied professionals; or

"(D) followup counseling for the victim, the victim's immediate family, or the offender;

"(3) community education;

"(4) offender rehabilitation and counseling;

"(5) self-help programs for victims, as well as potential victims;

"(6) telephone systems to provide assistance to the victim;

"(7) emergency shelter programs; or

"(8) projects which are likely to result in the development and demonstration of methods of preventing rape, or which address social problems related to rape.

"(c)(1) No grant may be made or contract entered into under this section unless an application therefor is submitted to, and approved by, the Secretary. Such an application shall be submitted in such form and manner and shall contain such information as the Secretary shall prescribe.

"(2) The amount of any grant or contract under this section shall be determined by the Secretary.

"(3) The Secretary may make payments under this section in advance or by way of reimbursement, and at such intervals and on such conditions as the Secretary may find necessary.

"(d) Each entity participating in a program under this section shall—

"(1) establish a recordkeeping system to insure the protection of the privacy of the victim, as well as of other individuals involved in accordance with subsection (f); and

"(2) establish internal procedures to measure progress in achieving the goals stated by the grantee or contractor in its application.

"(e) The Secretary shall develop standards and outcome criteria by which the effectiveness of this program shall be measured. Such standards and criteria shall be developed in consultation with the National Rape Prevention and Control Advisory Committee and established within ninety days after the date of the enactment of this section. The Secretary shall review the effectiveness of the development and demonstration projects caried out pursuant to this section.

"(f) Except as provided by Federal law other than this section, no officer or employee of the Federal Government, nor any recipient of assistance under the provisions of this section shall use or reveal any information furnished by or on behalf of a victim and identifiable to any specific private person for any purpose other than the purpose for which it was obtained in accordance with this section. Such information and copies thereof, when supplied to, or gathered by, such officer or employee of the Federal Government, or any recipient of asistance under the provisions of this section, shall be immune from legal process, and shall not, without the consent of the person furnishing such information, be admitted as evidence or used for any purpose in any action, suit, or other judicial, legislative, or administrative proceedings.

"(g) The annual submission to Congress under section 231(b)(1)(B) shall be submitted not later than March 1 of each year and shall include, in addition to the requirements of section 231—

"(1) a summary of the activities funded pursuant to this section; and

"(2) a review of the effectiveness of the activities carried out pursuant to this section.

"(h) Not more than 5 percent of any funds appropriated to cary out the provisions of this section for any fiscal year may be used by the Secretary to provide technical assistance to any public or private entity which desires to submit an application under this section. The Secretary may provide such assistance, upon request, if the Secretary determines that the entity does not possess the resources or expertise necessary to develop and submit an application without such assistance.

"(i) The Secretary shall, to the extent feasible, coordinate development and demonstration projects carried out under this section with other activities relating to rape carried out by the Secretary and the heads of other Federal agencies.

"(j) Not more than 90 percent of the costs of any project shall be funded by a grant or contract under this section.

"(k) There are authorized to be appropriated to cary out the provisions of this section $6,000,000 for the fiscal year ending September 30, 1981, $9,000,000 for the fiscal year ending September 30, 1982, and $12,000,000 for the fiscal year ending September 30, 1983.

"(l) The Secretary, notwithstanding the provisions of section 311 of the Civil Service Act of 1978 (Public Law 95-454, 92 Stat. 1111), in carrying out his functions and administering the provisions of this section and without regard to any other provision of this Act, is authorized to obtain the services of not more than ten full-time staff members to assist in carrying out the functions of the National Center for the Prevention and Control of Rape There are authorized to be appropriated to carry out the provisions of this subsection $200,000 for the fiscal year ending September 30, 1981, $212,000 for the fiscal year ending September 30, 1982, and $224,000 for the fiscal year ending September 30, 1983.".

(b) Section 231(d) of the Community Mental Health Centers Act is amended—

(1) by striking out "and" before "$9,000,000"; and

(2) by inserting the following after "1980": ", $10,200,000 for the fiscal year ending September 30, 1981, $11,500,000 for the fiscal year ending September 30, 1982, and $13,000,000 for the fiscal year ending September 30, 1983."

(c) Sections 231 and 232 of the Community Mental Health Centers Act shall be moved and redesignated as sections 456 and 457 of the Public Health Service Act.

TITLE VIII—MECHANIZED CLAIMS PROCESS'NG AND INFORMATION RETRIEVAL SYSTEMS

MECHANIZED CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS

SEC. 801. Section 1903 of the Social Security Act is amended by adding at the end thereof the following new subsection:

"(r)(1)(A) In order to receive payments

under subsection (a) without being subject to the penalties set forth in subparagraph (C) of this paragraph, a State must provide that mechanized claims processing and information retrieval systems of the type described in subsection (a)(3)(B) and detailed in an advance planning document approved by the Secretary be operational on or prior to the deadline established under subparagraph (B).

"(B) The deadline for operation of such systems for a State shall be the earlier of (i) September 30, 1982, or (ii) the last day of the sixth month following the date specified for operation of such systems in the State's most recently approved advance planning document submitted prior to the date of enactment of this subsection.

"(C) If a State fails to meet the deadline established under subparagraph (B), the Federal matching percentages, with respect to the next two fiscal quarters beginning on or after such deadline, for purposes of paragraphs (2) and (7) of subsection (a) shall be reduced by 5 percentage points. Such Federal matching percentages shall be further reduced by an additional 5 percentage points after each period consisting of two fiscal quarters during which the Secretary determines the State fails to meet the requirements of subparagraph (A); except that neither such Federal matching percentage may be reduced by more than 25 percentage points by reason of this paragraph.

"(D) The Federal matching percentages for a State under paragraphs (2) and (7) of subsection (a) shall be restored to the full percentage as provided in such paragraphs for quarters following the quarter during which such State meets the requirements of subparagraph (A).

"(2)(A) In order to receive payments under subsection (a) without being subject to the penalties set forth in subparagraph (C) of this paragraph, a State must have its mechanized claims processing and information retrieval systems, of the type required to be operational under paragraph (1), initially approved by the Secretary as meeting the requirements of subsection (a)(3)(B) and the requirements of this subsection relating to initial approvals, on or prior to the deadline established under subparagraph (B).

"(B) The deadline or approval of such systems for a State shall be the last day of the fourth fiscal quarter that begins after the date on which the Secretary determines that such systems became operational as required under paragraph (1).

"(C) If a State fails to meet the deadline established under subparagraph (B), the Federal matching percentages, with respect to the two fiscal quarters next following such deadline, for purposes of paragraphs (2) and (7) of subsection (a) shall be reduced by 5 percentage points. Such Federal matching percentages shall be further reduced by an additional 5 percentage points at the end of each period consisting of two fiscal quarters during which the State fails to meet the requirements of subparagraph (A); except that neither such Federal matching percentage may be reduced by more than 25 percentage points by reason of this paragraph.

"(D) The Federal matching percentages for a State under paragraphs (2) and (7) of subsection (a) shall be restored to the full percentage as provided in such paragraphs for quarters following the quarter during which such State's systems are approved by the Secretary as provided in subparagraph (A).

"(E) Any State's systems which are approved by the Secretary for purposes of subsection (a)(3)(B) on or before the date of the enactment of this subsection shall be deemed to be initially approved for purposes of this subsection.

"(3)(A) When a State's systems are initially approved, the 75 percent Federal matching provided in subsection (a)(3)(B) shall become effective with respect to such systems, retroactive to the first quarter beginning after the date on which such systems became operational as required under paragraph (1), except as provided in subparagraph (B).

"(B) In the case of any State which was subject to a penalty under paragraph (2), the Federal matching percentage under subsection (a)(3)(B) shall be reduced by 5 percentage points with respect to the two fiscal quarters next following the approval deadline date under paragraph (2)(B), and shall be further reduced by an additional 5 percentage points at the end of each period consisting of two fiscal quarters beginning after such deadline date and before the date on which such systems are initially approved.

"(C) The Federal matching percentage for a State under subsection (a)(3)(B) shall be 75 percent for quarters beginning after the date on which such systems are initially approved.

"(4)(A) The Secretary shall review all approved systems not less often than once each fiscal year, and shall reapprove or disapprove any such systems. Systems which fail to meet the current performance standards, system requirements, and any other conditions for approval developed by the Secretary under paragraph (6) shall be disapproved. Any State having systems which are so disapproved shall be subject to a penalty under subparagraph (B). The Secretary shall make the determination of reapproval or disapproval and so notify the States not later than the end of the first quarter following the review board.

"(B) If the Secretary disapproves a State's systems under subparagraph (A), the Secretary shall, with respect to quarters beginning after the determination of disapproval and prior to the first quarter beginning after such systems are reapproved, reduce the Federal matching percentage for such State under subsection (a)(3)(B) to a percentage of not less than 50 percent and not more than 70 percent as the Secretary determines to be appropriate and commensurate with the nature of noncompliance by such State; except that such Federal matching percentage may not be reduced by more than 10 percentage points in any 12-month period by reason of this subparagraph. No State shall be subject to the penalty for noncompliance under this paragraph prior to the fifth quarter beginning after initial approval.

"(C) The Secretary may remit any penalty levied under subparagraph (B), if the Secretary determines that the State's systems meet all current performance standards and other requirements for reapproval and that such action would improve the administration of the State's plan under this title; except that no such remission may extend beyond the four quarters immediately prior to the quarter in which Federal matching under subsection (a)(3)(B) resumes.

"(5)(A) In order to be initially approved by the Secretary, mechanized claims processing and information retrieval systems must be of the type described in subsection (a)(3)(B) and must meet the following requirements:

"(i) The systems must be capable of developing provider, physician, and patient profiles which are sufficient to provide specific information as to the use of covered types of services and items, including prescribed drugs.

"(ii) The State must provide that information on probable fraud or abuse which is obtained from, or developed by, the systems, is made available to the State's medicaid fraud control unit (if any) certified under subsection (q) of this section.

"(iii) The systems must meet all performance standards and other requirements for initial approval developed by the Secretary under paragraph (6).

"(B) In order to be reapproved by the Secretary, mechanized claims processing and information retrieval systems must meet the requirements of subparagraphs (A)(i) and (A)(ii) and performance standards and other requirements for reapproval developed by the Secretary under paragraph (6).

"(6) The Secretary, with respect to State systems, shall—

"(A) develop performance standards, system requirements, and other conditions for approval for initially approving such State systems, and shall further develop written approval procedures for conducting such initial reviews, including specific criteria for assessing systems in operation to insure that all such performance standards and other requirement are met;

"(B) by not later than October 1, 1980, develop an initial set of performance standards, system requirements, and other conditions for reapproval for use in reapproving or disapproving State systems, and shall further develop written reapproval procedures for conducting such reapproval reviews including specific criteria for reassessing systems operations over a period of at least six months during each fiscal year to insure that all such performance standards and other requirements are met on a continuous basis;

"(C) provide that reapproval reviews conducted prior to October 1, 1981, shall be for the purpose of developing a systems performance data base and assisting States to improve their systems, and that no reduction in Federal matching percentage under paragraph (4) shall be made on the basis of such a review;

"(D) insure that review procedures, performance standards and other requirements developed under subparagraph (B) are sufficiently flexible to allow for differing administrative needs among the States, and that such procedures, standards, and requirements are of a nature which will permit their use by the States for self-evaluation;

"(E) notify all States of proposed procedures, standards, and other requirements at least one quarter prior to the fiscal year in which such procedures, standards and other requirements will be used for conducting reapproval reviews;

"(F) periodically update the systems performance standards, system requirements, review criteria, objectives, regulations, and guides as the Secretary shall from time to time deem appropriate;

"(G) provide technical assistance to States in the development and improvement of the systems so as to continually improve the capacity of such systems to effectively detect cases of fraud or abuse;

"(H) for the purpose of insuring compatibility between the State systems and the systems utilized in the administration of title XVIII—

"(i) develop a uniform identification coding system (to the extent feasible) for providers, other persons receiving payments under the State plans (approved under this title) or under title XVIII, and beneficiaries of medical services under the State plans (approved under this title) or under title XVIII;

"(ii) provide liaison between States and carriers and intermediaries having agreements under title XVIII to facilitate timely exchange of appropriate data; and

"(iii) improve the exchange of data between the States and the Secretary with respect to providers and other persons who have been terminated, suspended, or other-

wise sanctioned under a State plan (approved under this title) or under title XVIII;

"(I) develop and disseminate clear definitions of those types of reasonable costs relating to the State systems which are reimbursable under the provisions of subsection (a)(3) of this section; and

"(J) report on or before October 1, 1981, to the Congress on the extent to which States have developed and operated effective mechanized claims processing and information retrieval systems.

"(7)(A) The Secretary shall waive the provisions of this subsection with respect to initial operation and approval of mechanized claims processing and information retrieval systems with respect to any State which had a 1976 population (as reported by the Bureau of the Census) of less than 1,000,000 and which made total expenditures (including Federal reimbursement) for which Federal financial participation is authorized under this title of less than $100,000,000 in fiscal year 1976 (as reported by such State for such year), and with respect to any State other than the 50 States and the District of Columbia, if such State reasonably demonstrates, and the Secretary does not formally disagree, that the application of such provisions would not significantly improve the efficiency of the administration of such State's plan under this title.

"(B) If a waiver granted to a State under subparagraph (A) is subsequently withdrawn, the Secretary shall impose a timetable for such State with respect to compliance with the provisions of this subsection and the imposition of penalties. Such timetable shall be comparable to the timetable established under this subsection as to the amount of time allowed such State to comply and the timing of penalty assessments.

"(8)(A) The reductions in payments to States required under this subsection shall not apply to a State for any quarter with respect to which the Secretary determines that such State is unable to comply with the revelant requirements of this subsection—

"(i) for good cause (but such a waiver may not be for a period in excess of 6 months), or

"(ii) due to circumstances beyond the control of such State.

"(B) If the Secretary determines under subparagraph (A) that a State is not subject to such reductions, the Secretary shall report to the Congress on the basis for each such determination and on the modification of all deadlines and penalties as described in subparagraph (C).

"(C) For purposes of determining all time limitations and deadlines imposed under this subsection, any time period during which a State was found under subparagraph (A) to be unable to comply with requirements of this subsection due to circumstances beyond its control shall not be taken into account, and the Secretary shall modify all such time limitations and deadlines with respect to such State accordingly.".

MOTION OFFERED BY MR. WAXMAN

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

The Clerk read as follows:

Mr. WAXMAN moves to strike out all after the enacting clause of the Senate bill, S. 1177, and to insert in lieu thereof the provisions of the bill H.R. 7299, as passed, as follows:

SHORT TITLE AND TABLE OF CONTENTS

SECTION 1. This Act may be cited as the "Mental Health Systems Act".

TABLE OF CONTENTS

TITLE I—COMMUNITY MENTAL HEALTH SERVICES

PREPARATION GRANTS

SEC. 101. (a) For the purpose of assisting public or nonprofit private entities to prepare for providing mental health services in a mental health service area, the Secretary may make grants to such entities for projects to—

(1) assess the needs of mental health service areas for mental health services;

(2) design mental health services programs for such areas based on such assessment;

(3) obtain financial and professional assistance and support for such programs; and

(4) initiate and encourage continuing community involvement in the development and operation of such programs.

(b) The amount of any grant under subsection (a) may not exceed $75,000.

(c)(1) Only one grant may be made under subsection (a) with respect to a mental health service area.

(2) No grant may be made under subsection (a) with respect to any mental health service area if a grant has previously been made under section 202 of the Community Mental Health Centers Act with respect to (A) the same area, or (B) any other area any substantial part of which (as determined by the Secretary) is included in that mental health service area.

(3) No application for a grant under subsection (a) for a project may be approved unless the State mental health authority for the State in which the project is to be located has recommended that the Secretary approve the application.

(d) For the purpose of making grants under subsection (a) there are authorized to be appropriated $1,000,000 for the fiscal year ending September 30, 1982, $1,000,000 for the fiscal year ending September 30, 1983, and $1,000,000 for the fiscal year ending September 30, 1984.

GRANTS FOR COMMUNITY MENTAL HEALTH CENTERS

SEC. 102. (a)(1) Subject to section 406, the Secretary may make grants to public and nonprofit private community mental health centers to assist them in meeting their costs of operation (other than costs related to construction).

(2) No application for a grant under paragraph (1) for a community mental health center which has not received a grant for its operation under the Community Mental Health Centers Act may be approved unless—

(A)(i) the community mental health center for which the application is submitted is operated by a State, or

(ii) in the case of any other center, the application has been recommended for approval by the State mental health authority for the State in which the center is located; and

(B) in the case of an application for a grant to be determined under subsection (c)(1)(B), the application is accompanied by assurances, provided by the State mental health authority for the State in which the center is located and satisfactory to the Secretary, that the grant applied for and the State, local, and other funds and the fees, premiums, and third-party reimbursements which the applicant may reasonably be expected to collect in the year for which the grant would be made are sufficient to meet the projected costs of operation for that year.

(3) Grants under paragraph (1) may only be made for a grantee's costs of operation during the first eight years after its establishment. In the case of a community mental health center which received a grant under section 220 of the Community Mental Health Centers Act (as in effect before the date of enactment of the Community Mental Health Centers Amendments of 1975) or section 203(a) of such Act, such center shall, for purposes of grants under paragraph (1), be considered as having been in operation for a number of years equal to the sum of the number of grants in the first series of grants it received under such section and the number of grants it has received under paragraph (1).

(b)(1) Each grant under subsection (a) to a community mental health center shall be made for the costs of its operation for the one-year period beginning on the first day of the month in which such grant is made, except that if at the end of such period a center has not obligated all the funds received by it under a grant, the center may use the unobligated funds under the grant in the succeeding year for the same purposes for which such grant was made but only if the center is eligible to receive a grant under subsection (a) for such succeeding year.

(2) No community mental health center may receive more than eight grants under subsection (a).

(c)(1) The amount of a grant for any year made under subsection (a) shall be

the lesser of the amounts computed under subparagraph (A) or (B) as follows:

(A) An amount equal to the amount by which the grantee's projected costs of operation for that year exceed the total of State, local, and other funds and of the fees, premiums, and third-party reimbursements which the grantee may reasonably be expected to collect in that year.

(B)(i) Except as provided in clause (ii), an amount equal to the following percentages of the grantee's projected costs of operation: 80 per centum of such costs for the first year of its operation, 65 per centum of such costs for the second year of its operation, 50 per centum of such costs for the third year of its operation, 35 per centum of such costs for the fourth year of its operation, 30 per centum of such costs for the fifth and sixth years of its operation, and 25 per centum of such costs for the seventh and eighth years of its operation.

(ii) In the case of a grantee providing services for persons in an area designated by the Secretary as an urban or rural poverty area, an amount equal to the following percentages of the grantee's projected costs of operation: 90 per centum of such costs for the first two years of its operation, 80 per centum of such costs for the third year of its operation, 70 per centum of such costs for the fourth year of its operation, 60 per centum of such costs for the fifth year of its operation, 50 per centum of such costs for the sixth year of its operation, 40 per centum of such costs for the seventh year of its operation, and 30 per centum of such costs for the eighth year of its operation.

(2)(A) The amount of a grant prescribed by paragraph (1) for a community mental health center for any year shall be reduced by the amount of unobligated funds from the preceding year which the center is authorized, under subsection (b)(1), to use in that year.

(B) If in a fiscal year the sum of—

(i) the total of State, local, and other funds, and of the fees, premiums, and third-party reimbursements collected in that year, and

(ii) the amount of the grant received under this section by a center or entity,

exceeds its costs of operation for that year because the amount collected was greater than expected, and if the center is eligible to receive a grant under subsection (a) in the succeeding year, an adjustment in the amount of that grant shall be made in such a manner that the center may retain such an amount (not to exceed 5 per centum of the amount by which such sum exceeded such costs) as the center can demonstrate to the satisfaction of the Secretary will be used to enable the center (I) to expand and improve its services, (II) to increase the number of persons (eligible to receive services from such a center) it is able to serve, (III) to modernize its facilities, (IV) to improve the administration of its service programs, and (V) to establish a financial reserve for the purpose of offsetting the decrease in the percentage of Federal participation in program operations in future years.

(d)(1) For the purpose of making initial grants under subsection (a) there are authorized to be appropriated $24,000,000 for the fiscal year ending September 30, 1982, $27,000,000 for the fiscal year ending September 30, 1983, and $30,000,000 for the fiscal year ending September 30, 1984.

(2) There are authorized to be appropriated for the fiscal year ending September 30, 1982, and for each of the next nine fiscal years such sums as may be necessary for continuation grants under subsection (a) to community mental health centers.

GRANTS FOR SERVICES FOR THE CHRONICALLY MENTALLY ILL

SEC. 103. (a) The Secretary may make grants to State mental health authorities, community mental health centers, and other public and nonprofit private entities for the provision of services, including case management, designed to assist the chronically mentally ill in gaining access to essential mental health services, medical and dental care, rehabilitation services, and employment, housing, and other support services to enable the chronically mentally ill to function to the maximum extent of their capabilities. No grant may be made under this subsection to a public entity (other than a State mental health authority) or a nonprofit private entity for the provision of services in a mental health service area served by a community mental health center.

(b) An application for a grant under subsection (a) shall contain a plan for the provision of the mental health and support services to be provided with the grant and describing the priorities to be applied by the applicant in determining which services to offer. Such a plan shall be in accordance with the State health plan in effect under section 1524 of the Public Health Service Act in the State of the applicant.

(c) In considering applications for grants under subsection (a) the Secretary shall give special consideration to applications for projects designed to supplement and strengthen existing community support services (including community residential treatment systems). The Secretary shall give priority to approved applications for such grants in the following order:

(1) Applications of State mental health authorities to provide mental health and support services in a State (A) through community mental health centers, and (B) in areas where centers do not exist, directly or through public or nonprofit private entities.

(2) Applications of community mental health centers.

(3) Applications of other public and nonprofit private entities for the provision of services in areas where community mental health centers do not exist.

(d) For the purpose of making grants under subsection (a) there are authorized to be appropriated $32,600,000 for the fiscal year ending September 30, 1982, $38,000,000 for the fiscal year ending September 30, 1983, and $43,000,000 for the fiscal year ending September 30, 1984.

GRANTS FOR SERVICES FOR SEVERELY MENTALLY DISTURBED CHILDREN AND ADOLESCENTS

SEC. 104. (a) The Secretary may make grants to State mental health authorities, community mental health centers, and other public and nonprofit private entities for the provision of mental health and support services for severely mentally disturbed children and adolescents and for members of their families. No grant may be made under this subsection to a public entity (other than a State mental health authority) or a nonprofit private entity for the provision of services in a mental health service area served by a community mental health center.

(b) An application for a grant under subsection (a) shall contain a plan for the provision of the mental health and support services to be provided with the grant and describing the priorities to be applied by the applicant in determining which services to offer. Such a plan shall be in accordance with the State health plan in effect under section 1524 of the Public Health Service Act in the State of the applicant.

(c) In making grants under subsection (a), the Secretary shall give priority to approved applications for such grants in the following order:

(1) Applications of State mental health authorities to provide mental health and support services in a State (A) through community mental health centers, and (B) in areas where centers do not exist, directly or through public or nonprofit private entities.

(2) Applications of community mental health centers.

(3) Applications of other public and nonprofit private entities for the provision of services in areas where community mental health centers do not exist.

(d) For the purpose of making grants under subsection (a) there are authorized to be appropriated $7,000,000 for the fiscal year ending September 30, 1982, $8,000,000 for the fiscal year ending September 30, 1983, and $9,000,000 for the fiscal year ending September 30, 1984.

GRANTS FOR MENTAL HEALTH SERVICES FOR PRIORITY POPULATIONS

SEC. 105. (a) Subject to section 406, the Secretary may make grants to any public or nonprofit private entity for any project for mental health services which—

(1) are designed to serve principally one or more priority population groups in a mental health service area,

(2) are available to all residents of the area, and

(3) are provided in a mental health service area not served by a community mental health center.

(b) An application for a grant under subsection (a) may be approved only if—

(1) the State mental health authority for the State in which the project to be assisted by the grant is located has recommended that the Secretary approve the application;

(2) the application contains satisfactory assurances that the project for which the application is made will lead to increased or more appropriate mental health services for a priority population group or to the development of mental health services for such a group;

(3) the application contains satisfactory assurances that members of the priority population group or groups to be served by the project have had a reasonable opportunity to comment on the proposed project during its preparation and satisfactory assurances that members of the group or groups will be afforded reasonable opportunity to comment on performance under the project; and

(4) the applicant (A) will during the first three years that it receives a grant under subsection (a) provide outpatient mental health services and any two of the following mental health services determined to be of the greatest need for the priority population to be served by the applicant: inpatient services, screening, followup, consultation and education, and emergency, and (B) has a plan satisfactory to the Secretary for the provision of all the mental health services described in clause (A) upon the expiration of the first three years that it receives a grant under subsection (a).

The Secretary may not approve an application of an entity which has received a grant for three years under subsection (a) unless the applicant is providing all the mental health services described in paragraph (4)(A).

(c) In any fiscal year not more than two grants may be made under subsection (a) for one mental health service area and the total number of grants that may be made to such an area under subsection (a) may not exceed ten. Not more than five grants may be made under subsection (a) to the same entity for mental health services for the same priority population group or groups. The amount of any grant under subsection (a) shall be determined by the Secretary, except that the fourth and fifth such grants may

not exceed 60 per centum and 30 per centum, respectively, of the costs of the project for which the grants are made.

(d) For the purpose of making grants under subsection (a) there are authorized to be appropriated $16,000,000 for the fiscal year ending September 30, 1982, $18,000,000 for the fiscal year ending September 30, 1983, and $20,000,000 for the fiscal year ending September 30, 1984.

(e) For purposes of this section, the term "priority population group" means an identifiable population group in a mental health service area which is unserved or underserved by mental health programs in such area as determined under a health systems plan or a State health plan in effect under section 1513 or 1524 of the Public Health Service Act.

GRANTS FOR NON-REVENUE-PRODUCING ACTIVITIES

SEC. 106. (a)(1) The Secretary may make grants to public and nonprofit private community mental health centers to assist in meeting the costs (as defined by the Secretary by regulation) of—

(A) providing the consultation and education services described in clause (iv) of section 409(b)(1)(A),

(B) providing the followup services described in clause (iii) of such section, and

(C) administering the mental health service programs of the entities.

(2) To be eligible for a grant under paragraph (1) a community mental health center must be a public or nonprofit private center which—

(A) has received a grant under section 203(a) of the Community Mental Health Centers Act, under section 220 of such Act as in effect before July 29, 1975, or under section 102 of this Act; and

(B) because of the limitations on the period for which a center may receive such a grant or on the number of such grants the center may receive, is no longer eligible to receive such a grant.

(3) No application for a grant under paragraph (1) for a fiscal year beginning after September 30, 1983, for a community mental health center may be approved unless—

(A) the community mental health center for which the application is submitted is operated by a State, or

(B) in the case of any other center, the application has been recommended for approval by the State mental health authority for the State in which the center is located.

(b) An application for a grant under subsection (a) shall contain assurances satisfactory to the Secretary that the applicant will, during the period which it receives a grant under subsection (a), provide, at a minimum, the comprehensive mental health services described in clauses (i) through (iv) of section 409(b)(1)(A).

(c)(1) No community mental health center may receive more than five grants under subsection (a).

(2) Each grant under subsection (a) shall be made for the one-year period beginning on the first day of the first month beginning after the date the grant is made.

(3) The amount of a grant under subsection (a) shall be determined by the Secretary, except that no grant may exceed the product of $1.00 and the population of the mental health service area of the community mental health center receiving the grant. The population of a mental health service area shall be determined on the basis of the latest figures for the populations of the States available from the Department of Commerce.

(d) For the purpose of making grants under subsection (a) there are authorized to be appropriated $35,000,000 for the fiscal year ending September 30, 1982, $40,000,000 for the fiscal year ending September 30, 1983, and $45,000,000 for the fiscal year ending September 30, 1984.

GRANTS FOR MENTAL HEALTH SERVICES IN AMBULATORY HEALTH CARE CENTERS

SEC. 107. (a)(1) For the purpose of assisting ambulatory health care centers to participate appropriately in the provision of mental health services to their patients, the Secretary may make grants to—

(A) any public or nonprofit private entity which provides mental health services that include at least twenty-four-hour emergency services, outpatient services, and consultation and education services (as described in section 409(b)(1)(A)(iv)) and has in effect an agreement of affiliation, described in paragraph (2), with an entity which is an ambulatory health care center; or

(B) any public or nonprofit private ambulatory health care center which has in effect an agreement of affiliation, described in paragraph (2), with an entity described in subpargraph (A).

(2) An agreement of affiliation referred to in paragraph (1) in an agreement between a mental health services entity described in paragraph (1)(A) and an ambulatory health care center which agreement—

(A) describes the geographical area the residents of which will be served by the mental health services to be provided under the agreement;

(B) provides for the employment of at least one mental health professional to serve as a liaison between the parties to the agreement and includes a description of the qualifications to be required of that person and of any other professional mental health personnel to be employed under the agreement;

(C) provides satisfactory assurances that the mental health services entity will make mental health services available to patients of the center referred to it by the liaison or other mental health professionals; and

(D) includes transportation arrangements and other arrangements for effecting referral from the center to the mental health services entity of patients needing the services of such entity.

(b) Any grant under subsection (a) may be made for a project for any one or more of the following:

(1) The costs of liaison or other mental health professionals providing services in the ambulatory health care center in accordance with an agreement of affiliation.

(2) Mental health services provided by other personnel of the center which the mental health services entity determines can be appropriately provided by such personnel.

(3) Consultation and inservice training on mental health provided to personnel of the ambulatory health care center by the mental health services entity.

(4) Establishing liaison between the center and other providers of mental health services or support services.

(c) For the purpose of making grants under subsection (a) there are authorized to be appropriated $15,000,000 for the fiscal year ending September 30, 1982, $17,500,000 for the fiscal year ending September 30, 1983, and $20,000,000 for the fiscal year ending September 30, 1984.

GRANTS FOR MEMBERS OF INDIAN TRIBES OR ORGANIZATIONS

SEC. 108. (a) Upon request of any Indian tribe or any urban Indian organization the Indian Health Service may apply to the Secretary for a grant under this title to be made to the Indian Health Service or any entity of the Service for the provision of mental health services to members of such tribe or organization. Such a grant shall be made on the same terms and conditions as apply to non-Federal entities, except that, in the case of a grant under section 101, 102, 105, or 106, approval by a State mental health authority shall not be required.

(b) Any grant under subsection (a) may be made for a project serving members of an Indian tribe or an urban Indian organization even though the area in which those members reside is included in two or more mental health service areas of a State.

(c) For purposes of this section, the terms "Indian tribe" and "urban Indian organization" have the same meaning as is prescribed for them in section 4 of the Indian Health Improvement Act (25 U.S.C. 1603(4)).

GRANTS FOR INNOVATIVE PROJECTS

SEC. 109. (a) The Secretary may make grants to public and nonprofit private entities for—

(1) projects for the training and retraining of employees adversely affected by changes in the delivery of mental health services and providing assistance in securing employment;

(2) projects for the innovative use of personnel in the management and delivery of mental health services; and

(3) any other innovative project of national significance respecting mental health services and mental health services personnel.

(b) The Secretary may set dates by which applications for grants under subsection (a) must be submitted.

(c) In any fiscal year, 5 per centum of the total amount appropriated for such fiscal year under sections 101 through 107 shall be available to the Secretary for grants under subsection (a). Of the funds obligated by the Secretary for such grants, not less than 50 per centum shall be obligated for approvable projects described in subsection (a)(1).

TITLE II—STATE PROGRAMS

GRANTS TO IMPROVE THE ADMINISTRATION OF STATE MENTAL HEALTH PROGRAMS

SEC. 201. (a) For the purpose of assisting States to improve the administration of State mental health programs, the Secretary may make grants to State mental health authorities for any project for any one or more of the following:

(1) Improving the capacity of the State mental health authority to collect and analyze statistics and other data and to otherwise meet the monitoring or reporting requirements under this Act.

(2) Improving the planning and other administrative functions of the State mental health authority.

(3) Improving the ability of the State mental health authority (A) to set performance standards for mental health service projects and programs, (B) to enfore those standards, and (C) to evaluate performance under such projects and programs through data analysis, studies, and other means.

(4) Any other activity designed to improve the provision of mental health services in the State or the administration of State or local mental health programs.

(b) For the purpose of making grants under subsection (a) there are authorized to be appropriated $3,000,000 for the fiscal year ending September 30, 1982, $4,000,000 for the fiscal year ending September 30, 1983, and $5,000,000 for the fiscal year ending September 30, 1984.

PILOT PROJECTS FOR STATE ADMINISTRATION OF GRANTS

SEC. 202. (a) For the purpose of demonstrating the improvement in administration and in the provision of mental health services that can be made by State mental health authorities participating in the administration of the grant programs under this Act, the Secretary may enter into agreements with State mental health authorities under which the authorities will, on behalf of the Secretary—

(1) disburse Federal funds under grants under this Act;

(2) review performance under projects and programs funded by grants under this Act and report to the Secretary the extent to which such performance complies with applicable requirements; and

(3) perform such other functions of the Secretary under the grant programs as the State mental health authority and the Secretary may agree upon.

As determined in the agreements entered into under this subsection, the Secretary shall make grants to State mental health authorities to meet their costs in carrying out the agreements.

(b) For the purpose of making grants under subsection (a) there are authorized to be appropriaed $3,000,000 for the fiscal year ending September 30, 1982, $4,000,000 for the fiscal year ending September 30, 1983, and $5,000,000 for the fiscal year ending September 30, 1984.

TITLE III—PREVENTION

DEMONSTRATION PROJECTS

SEC. 301. (a) The Secretary may make grants to public and nonprofit private entities to demonstrate the effectiveness of intervention techniques and mental health promotion activities in the—

(1) maintenance and improvement of the mental health of individuals and groups of individuals particularly susceptible to mental illness,

(2) prevention of the onset of mental illness in such individuals and groups, and

(3) prevention of the deterioration of the mental health of such individuals and groups.

(b) An application for a grant under subsection (a) shall—

(1) define the intervention techniques and mental health promotion activities to be funded by the grant;

(2) define the individuals or groups of individuals to be served by such techniques and activities; and

(3) provide for the evaluation of the effectiveness of such techniques and activities and describe the methodology to be used in making such evaluation.

(c) For the purpose of making grants under subsection (a) there are authorized to be appropriated $6,000,000 for the fiscal year ending September 30, 1982, $8,000,000 for the fiscal year ending September 30, 1983, and $10,000,000 for the fiscal year ending September 30, 1984.

TITLE IV—GENERAL PROVISIONS

PART A—STATE PLANS

STATE MENTAL HEALTH SERVICES PLANS

SEC. 401. (a) In order for the State mental health authority of or any entity in a State to be eligible to receive a grant under this Act for any fiscal year, such State must have in effect a State mental health services plan which—

(1) has been prepared by an agency of the State designated by the Governor (hereinafter in this Act referred to as the "State agency") and submitted to the Secretary through the Governor,

(2) is consistent with the provisions, relating to mental health services, of the State health plan prepared in accordance with section 1524(c)(2) of the Public Health Service Act, and

(3) has been approved by the Secretary as meeting the requirements of section 402.

(b) The Secretary may not finally disapprove a State mental health services plan (or any modification thereof) unless the State agency has been provided reasonable notice and opportunity for a hearing.

(c) Whenever the Secretary, after reasonable notice and opportunity for a hearing to the State agency of a State, finds that the State plan approved under this Act has been so changed that it no longer complies with section 402, or that in the administration of the plan there is a failure to comply substantially with any provision of such section, the Secretary—

(1) may, until the Secretary is satisfied that there will no longer be any such failure, discontinue payments under grants under this Act to the State mental health authority and any other entity in the State receiving such grants or to each program or project (or part of a program or project) affected by such failure, and

(2) shall notify the State agency of the action taken under paragraph (1).

CONTENTS OF PLANS

SEC. 402. To be approved under section 401 a State mental health services plan must be submitted in such form and manner as the Secretary prescribes. The plan shall consist of an administrative part and a services part as follows:

(1) The administrative part shall—

(A) provide that the State agency will assume responsibility for administration of the plan and the other aspects of the State's mental health services program;

(B) provide for the designation of a State advisory council to consult with the State agency in administering the plan, which council shall include (i) representatives of nongovernmental organizations or groups, and of State agencies, concerned with the planning, operation, or use of facilities for the provision of mental health services, and (ii) representatives of consumers and providers of such services who are familiar with the need for such services;

(C) provide that the State agency will make such reports in such form and containing such information as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports;

(D) provide that any statistics or other data included in the State mental health services plan or on which the State plan is based will conform to such criteria, standards, and other requirements relating to their form, method of collection, content, or other aspects as the Secretary may prescribe;

(E) provide that the State agency will from time to time, but not less often than annually, review the State plan and submit to the Secretary appropriate modifications thereof which it considers necessary; and

(F) include provisions, meeting such requirements as the Office of Personnel Management may prescribe, relating to the establishment and maintenance of personnel standards on a merit basis.

(2) The services part shall—

(A) identify the mental health service areas within the State;

(B) set forth (i) the need of each mental health service area in the State for mental health services, (ii) the public or private facilities, mental health personnel, and services which are available, and the additional facilities, personnel, and services required, to meet that need, (iii) the methods used to determine that need and to determine if the facilities, personnel, and services meet that need, (iv) the way in which and the order in which that need will be met through use of existing Federal, State, or local resources and otherwise, and (v) similar information for the State not included under clause (i), (ii), (iii), or (iv) which is of significance for more than a single mental health service area;

(C) describe the steps that are proposed to be taken at the State level and the local level in an effort to coordinate the provision of mental health and support services;

(D) describe the legal rights of persons in the State who are mentally ill or otherwise mentally handicapped and what is being done in the State to protect those rights;

(E) provide for emphasizing outpatient mental health services wherever appropriate and include fair and equitable arrangements (as determined by the Secretary after consultation with the Secretary of Labor) to protect the interests of employees affected adversely by actions taken to emphasize such outpatient treatment, including arrangements designed to preserve employee rights and benefits and to provide training and retraining of such employees, where necessary, for work in mental health or other fields and including arrangements under which maximum effort will be made to place such employees in employment; and

(F) contain or be accompanied by such additional information or assurances and meet such other requirements as the Secretary prescribes in order to achieve the purposes of this Act.

PART B—APPLICATIONS AND RELATED PROVISIONS

APPLICATIONS

SEC. 403. (a) No grant may be made under this Act unless an application therefor is submitted to and approved by the Secretary. The application shall be in such form, submitted in such manner, and contain such information, as the Secretary may require.

(b) An application for a grant for any project must, in addition to the application requirements prescribed in the section under which the grant is to be made, contain or be accompanied by—

(1) a budget covering the year for which the grant is sought (and such additional period as the Secretary may require) showing the sources of funding for the project and allocating the funds available for the project among the various types of services to be provided or assisted or the various types of activities to be conducted or assisted and among the various population groups to which the project is directed;

(2) a statement of the objectives of the project;

(3) in the case of any project, to be assisted by a grant under title I, under which health services are to be provided, assurances satisfactory to the Secretary that—

(A) the applicant (i) has prepared a schedule of fees or payments for the provision of its services designed to cover its reasonable costs of operation and a corresponding schedule of discounts to be applied to the payment of such fees or payments which discounts are adjusted on the basis of the patient's ability to pay; (ii) has made and will continue to make every reasonable effort (I) to secure from patients payment for services in accordance with such approved schedules, and (II) to collect reimbursement for health services to persons described in subparagraph (B) on the basis of the full amount of fees and payments for such services without application of any discount, and (iii) has submitted to the Secretary such reports as he may require to determine compliance with this subparagraph; and

(B) the applicant has made or will make and will continue to make every reasonable effort to collect appropriate reimbursement for its costs in providing services to persons who are entitled to insurance benefits under title XVIII of the Social Security Act, to medical assistance under a State plan approved under title XIX of such Act, or to assistance for medical expenses under any other public assistance program or private health insurance program;

(C) the applicant will adopt and enforce a policy (i) under which fees for the provision of mental health services through the center will be paid to the center, and (ii) which prohibits health professionals who provide such services to patients through the center from providing such services to such patients except through the center; and

(D) has (i) established a requirement that the mental health care of every patient must

be under the supervision of a member of the professional staff, and (ii) provided for having a member of the professional staff available to furnish necessary mental health care in case of an emergency;

(4) in the case of a project which will serve a population which includes a substantial proportion of individuals of limited English-speaking ability, assurances satisfactory to the Secretary that the applicant has (A) developed a plan and made arrangements responsive to the needs of such population for providing services to the extent practicable in the language and cultural context most appropriate to such individuals, and (B) identified an individual on its staff who is fluent in both that language and English and whose responsibilities shall include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitiveness and bridging linguistic and cultural differences;

(5) satisfactory assurances that the applicant has in effect a system, satisfactory to the Secretary, to assure that an employee of the applicant who reports to any officer or employee of the Department of Health and Human Services or appropriate State authority any failure on the part of the applicant to comply with an applicable requirement of this Act or regulation of the Secretary or requirement of State law will not on account of such report be discharged or discriminated against with respect to the employee's compensation or the terms, conditions, or privileges of the employee's employment;

(6) satisfactory assurances that each facility to be used in the provision of health or support services to be supported by the grant applied for meets the requirements of applicable fire and safety codes imposed by State law;

(7) information on the organization and operation of the applicant;

(8) satisfactory assurances that the applicant will submit such reports, at such times and containing such information, as the Secretary may request and maintain such records as the Secretary may find necessary for purposes of this Act, and afford the Secretary and the Comptroller General of the United States such access to such records and other documents as may be necessary for an effective audit of the project or activity;

(9) satisfactory assurances that funds made available under this Act will be used to supplement and, to the extent practical, increase the level of non-Federal funds that would, in the absence of those Federal funds, be made available for the purpose, and will in no event supplant such non-Federal funds;

(10) satisfactory assurance that the project is consistent with the State mental health services plan; and

(11) such other information and material and such other assurances as the Secretary may prescribe.

TECHNICAL ASSISTANCE

SEC. 404. Such portion as the Secretary may determine, but not more than 2 per centum, of the total amount appropriated under titles I and II for any fiscal year is available for technical assistance, including short-term training, by the Secretary to any State mental health authority or other entity which is or has been a recipient of a grant under this Act, to assist it in developing, or in better administering, the mental health services program or programs for which it is responsible.

PART C—GRANT LIMITS

LIMITS ON GRANTS

SEC. 406. In any mental health service area the total number of grants under—

(1) section 220 of the Community Mental Health Centers Act (as in effect before the date of the enactment of the Community Mental Health Centers Amendments of 1975),

(2) section 203 of such Act,

(3) section 102 of this Act, and

(4) section 105 of this Act,

may not exceed ten.

PART D—PERFORMANCE

PERFORMANCE STANDARDS

SEC. 407. (a) The Secretary shall prescribe standard measures of performance designed to test the quality and extent of performance by grantees under this Act and the extent to which such performance has helped to achieve the national or other objectives for which the grants were made.

(b) In determining whether or not to approve an application for a grant under this Act, the Secretary shall consider the performance by the applicant under any prior grant under this Act as measured under subsection (a).

EVALUATION AND MONITORING

SEC. 408. (a) With the approval of the Secretary, any recipient of a grant under this Act may use a portion of that grant for evaluation of the project or activity involved and of the recipient's program of which the project or activity is a part.

(b) Not more than 1 per centum of the total amount appropriated under this Act for any fiscal year shall be used by the Secretary, directly or through contracts with State mental health authorities, to monitor activities of grantees under this Act to determine if the requirements of this Act applicable to the receipt of such grants are being met.

PART E—DEFINITIONS

DEFINITION OF COMMUNITY MENTAL HEALTH CENTER

SEC. 409. (a) For purposes of this Act, the term "community mental health center" means a legal entity (1) through which comprehensive mental health services are provided—

(A) principally to individuals residing in a mental health service area,

(B) within the limits of its capacity, to any individual residing or employed in such area regardless of his ability to pay for such services, his current or past health condition, or any other factor, and

(C) in the manner prescribed by subsection (b), and (2) which is organized in the manner prescribed by subsections (c) and (d).

(b)(1) The comprehensive mental health services which shall be provided through a community mental health center are as follows:

(A) Beginning on the date the community mental health center is established for purposes of section 102, the services provided through the center shall include—

(i) inpatient services, emergency services, and outpatient services;

(ii) assistance to courts and other public agencies in screening residents of the center's mental health service area who are being considered for referral to a State mental health facility for inpatient treatment to determine if they should be so referred and provision, where appropriate, of treatment for such persons through the center as an alternative to inpatient treatment at such a facility;

(iii) provision of followup care for residents of its mental health service area who have been discharged from inpatient treatment at a mental health facility;

(iv) consultation and education services which—

(I) are for a wide range of individuals and entities involved with mental health services, including health professionals, schools, courts, State and local law enforcement and correctional agencies, members of the clergy, public welfare agencies, health services delivery agencies, and other appropriate entities; and

(II) include a wide range of activities (other than the provision of direct clinical services) designed to develop effective mental health programs in the center's mental health service area, promote the coordination of the provision of mental health services among various entities serving the center's mental health service area, increase the awareness of the residents of the center's mental health service area of the nature of mental health problems and the types of mental health services available, and promote the prevention and control of rape and the proper treatment of the victims of rape; and

(v) the services described in subparagraph (B) or, in lieu of such services, the center shall have a plan approved by the Secretary under which the center will, during the three-year period beginning on such establishment date, assume in increments the provision of the services described in subparagraph (B) and will upon the expiration of such three-year period provide all the services described in subparagraph (B).

(B) After the expiration of such three-year period, a community mental health center shall provide, in addition to the services required by subparagraph (A), services which include—

(i) day care and other partial hospitalization services;

(ii) a program of specialized services for the mental health of children, including a full range of diagnostic, treatment, liaison, and followup services (as prescribed by the Secretary);

(iii) a program of specialized services for the mental health of the elderly, including a full range of diagnostic, treatment, liaison, and followup services (as prescribed by the Secretary);

(iv) a program of transitional half-way house services for mentally ill individuals who are residents of its mental health service area and who have been discharged from inpatient treatment in a mental health facility or would without such services require inpatient treatment in such a facility; and

(v) provision of each of the following service programs (other than a service program for which there is not sufficient need (as determined by the Secretary) in the center's mental health service area, or the need for which in the center's mental health service area the Secretary determines is currently being met):

(I) A program for the prevention and treatment of alcoholism and alcohol abuse and for the rehabilitation of alcohol abusers and alcoholics.

(II) A program for the prevention and treatment of drug addiction and abuse and for the rehabilitation of drug addicts, drug abusers, and other persons with drug dependency problems.

(2) The provision of comprehensive mental health services through a center shall be coordinated with the provision of services by other health and social service agencies (including State mental health facilities) in or serving residents of the center's mental health service area to insure that persons receiving services through the center have access to all such health and social services as they may require. The center's services (A) may be provided at the center or satellite centers through the staff of the center or through appropriate arrangements with health professionals and others in the center's mental health service area, or, with the approval of the Secretary, in the case of inpatient services, emergency services, and transitional half-way house services, through

appropriate arrangements with health professionals and others serving the residents of the mental health service area, (B) shall be available and accessible to the residents of the area promptly, as appropriate, and in a manner which preserves human dignity and assures continuity and high quality care and which overcomes geographic, cultural, linguistic, and economic barriers to the receipt of services, and (C) when medically necessary, shall be available and accessible twenty-four hours a day and seven days a week.

(3) Consistent with the requirements of State law, the medical services provided by a center to individual patients shall be under the direction and supervision of a physician Whenever possible, the physician providing such direction and supervision shall be a psychiatrist.

(c)(1) Except as provided in paragraph (2), the governing board of a community mental health center shall (A) be composed, where practicable, of individuals who reside in the center's mental health service area and who, as a group, represent the residents of that area taking into consideration their employment, age, sex, and place of residence, and other demographic characteristics of the area, and (B) meet at least once a month, establish general policies for the center (including a schedule of hours during which services will be provided), approve the center's annual budget, and approve the selection of a director for the center. At least one-half of the members of such body shall be individuals who are not providers of health care.

(2) In the case of a community mental health center which is operated by a governmental agency or a hospital, such center may, in lieu of meeting the requirements of paragraph (1), appoint a committee which advises it with respect to the operations of the center and which is composed of individuals who reside in the center's mental health service area, who are representative of the residents of the area as to employment, age, sex, place of residence, and other demographic characteristics, and at least one-half of whom are not providers of health care. A center to which this paragraph applies shall submit to such a committee for its review any application for a grant under section 102.

(3) For purposes of paragraphs (1) and (2), the term "provider of health care" has the same meaning as is prescribed for that term by section 1531(3) of the Public Health Service Act.

(d) A center shall, in accordance with regulations prescribed by the Secretary, have (1) an ongoing quality assurance program (including utilization and peer review systems) respecting the center's services, (2) an integrated medical records system (including a drug use profile) which, in accordance with applicable Federal and State laws respecting confidentiality, is designed to provide access to all past and current information regarding the health status of each patient and to maintain safeguards to preserve confidentiality and to protect the rights of the patient, (3) a professional advisory board, which is composed of members of the center's professional staff, to advise the governing board in establishing policies governing medical and other services provided by such staff on behalf of the center, and (4) an identifiable administrative unit which shall be responsible for providing the consultation and education services described in subsection (b)(1)(A)(iv) The Secretary may waive the requirements of clause (4) with respect to any center if he determines that because of the size of such center or because of other relevant factors the establishment of the administrative unit described in such clause is not warranted.

OTHER DEFINITIONS

SEC. 410. For purposes of this Act:

(1) The term "Secretary" means the Secretary of Health and Human Services.

(2) The term "ambulatory health care center" may include an outpatient facility operated in connection with a hospital, a community health center, a migrant health center, a clinic of the Indian Health Service, a skilled nursing home, an intermediate care facility, and an outpatient health care facility of a medical group practice, a public health department, or a health maintenance organization.

(3) The term "State mental health authority" means the agency of a State to which has been delegated the responsibility for the mental health programs of the State.

(4) A mental health service area shall, except to the extent permitted under regulations of the Secretary, have boundaries which conform to or are within the boundaries of a health service area established under title XV of the Public Health Service Act and, to the extent practicable, conform to boundaries of one or more school districts or political or other subdivisions in the State. Each State shall be covered by one or more mental health service areas.

PART F—MISCELLANEOUS

INDIRECT PROVISION OF SERVICES

SEC. 411. Except as provided in section 409(b)(2), any mental health service for the provision of which an entity is responsible for purposes of a grant under this Act may be provided by it directly at its primary or satellite facilities or through arrangements with other entities or health professionals and others in, or serving residents of, the same mental health service area.

COOPERATIVE AGREEMENTS

SEC. 412. In lieu of providing funds under a grant under this Act, the Secretary may provide such funds under a cooperative agreement, and all requirements which would apply with respect to such a grant shall apply to the cooperative agreement.

CONTRACT AUTHORITY

SEC. 413. The authority of the Secretary to enter into contracts under this Act shall be effective for any fiscal year only to such extent or in such amounts as are provided in advance by appropriation Acts.

TITLE V—MINORITY CONCERNS

ASSOCIATE DIRECTOR OF NATIONAL INSTITUTE OF MENTAL HEALTH

SEC. 501. (a) Effective October 1, 1980, there shall be in the National Institute of Mental Health an Associate Director for Minority Concerns.

(b) The Secretary, acting through the Associate Director for Minority Concerns, shall—

(1) support programs for the delivery of mental health services to minority populations;

(2) support programs of basic and applied social and behavioral research on the mental health problems of minority populations.

(3) develop a plan to increase the representation of minority populations in the delivery of mental health services and in mental health research;

(4) support programs to develop in individuals providing mental health services and conducting mental health research an understanding of the needs of minority populations;

(5) study the effect of discrimination on institutions and individuals; and

(6) support and develop research, demonstration, and training programs aimed at eliminating institutional discrimination.

Support of programs under this subsection shall be made by grants to and contracts with public and nonprofit private entities.

TITLE VI—RAPE SERVICES SUPPORT PROGRAM

GRANTS FOR SERVICES FOR RAPE VICTIMS

SEC. 601. (a) The Secretary may make grants to and enter into contracts with public and nonprofit private entities to asisst in meeting the cost of—

(1) providing counseling and followup counseling for rape victims and the immediate family of rape victims;

(2) providing assistance in securing mental health, social, medical, and legal services for rape victims;

(3) demonstration projects to develop and implement methods of preventing rape and assisting rape victims.

(b)(1) An application for a grant or contract under subsection (a) shall contain such assurances as the Secretary may require that the applicant will comply with the requirements of subsection (e).

(2) The amount of any grant or contract under this section shall be determined by the Secretary, except that the amount may not exceed 90 per centum of the cost of the project (as determined by the Secretary) with respect to which the grant or contract is made or entered into.

(c)(1) In carrying out this section, the Secretary shall coordinate with other activities related to rape carried out by the Secretary and the heads of other Federal departments and agencies.

(2) The Secretary shall establish a grant review panel to make recommendations to the Secretary with respect to the approval of applications for grants and contracts under subsection (a). The Secretary shall appoint individuals to the panel who are or have been engaged in the provisions of services to rape victims.

(d)(1) There are authorized to be appropriated to make grants and contracts under subsection (a) $6,000,000 for the fiscal year ending September 30, 1981, $9,000,000 for the fiscal year ending September 30, 1982, $12,000,000 for the fiscal year ending September 30, 1983, and $12.000,000 for the fiscal year ending September 30, 1984.

(2) The Secretary may in a fiscal year obligate not more than 10 per centum of the funds appropriated for that fiscal year under paragraph (1) to provide, upon request, technical assistance in the development and submission of applications for a grant or contract under subsection (a). Such assistance shall be provided only to those entities which the Secretary determines do not possess the resources or expertise necessary to develop and submit such an application.

(e) No officer or employee of the Federal Government or of any recipient of a grant or contract under subsection (a) may use or disclose any personally identifiable information obtained, in carrying out an activity assisted by such grant or contract, by the recipient from a rape victim or a rape victim's immediate family unless such use or disclosure is necessary to carry out the activity or is made with the consent of the person who supplied the information. Such information shall be immune from legal process and may not, without the consent of the person furnishing the information, be admitted as evidence or otherwise used in any civil or criminal action or other judicial or administrative proceeding.

TITLE VII—EXTENSION OF COMMUNITY MENTAL HEALTH CENTERS ACT

ONE-YEAR EXTENSION OF COMMUNITY MENTAL HEALTH CENTERS ACT

SEC. 701. (a) Subsection (d) of section 202 of the Community Mental Health Centers Act (42 U.S.C. 2689a(d)) (relating to grants for planning) is amended by striking out "for the fiscal year ending September 30, 1980" and inserting in lieu thereof "each for the fiscal year ending September 30, 1980, and the next fiscal year".

(b) Subsection (d) of section 203 of such Act (relating to grants for initial operation) is amended—

(1) in paragraph (1), by (A) striking out "and" after "1979,", and (B) inserting before the period a comma and the following: "and $37,000,000 for the fiscal year ending September 30, 1981"; and

(2) effective October 1, 1981, by striking out "(1)" and paragraph (2).

(c) Subsection (c) of section 204 of such Act (42 U S C. 2689c(c)) (relating to grants for consultation and education services) is amended (1) by striking out "and" after "1979,", and (2) by inserting before the period a comma and the following: "and $15,000,000 for the fiscal year ending September 30, 1981".

(d)(1) Section 213 of such Act (42 U S C 2689h) (relating to financial distress grants) is amended (1) by striking out "and" after "1978,", and (B) by inserting after "1979," the following: "and $15,000,000 for the fiscal year ending September 30, 1981,".

(2) Section 212(c) of such Act (42 U S C. 2689g(c)) of such Act is amended by striking out "five" and inserting in lieu thereof "six".

(e) Subsection (d) of section 231 of such Act (42 U S C. 2689q) (relating to rape prevention and control) is amended (1) by striking out "and" after "1979,", and (2) by inserting before the period a comma and the following: "and $4,000,000 for the fiscal year ending September 30, 1981".

(f) Section 206(e)(2)(B) of such Act (42 U S C 2689e(e)(2)(B)) is amended by striking out "the fiscal year ending September 30, 1979, and during the fiscal year ending September 30, 1980" and inserting in lieu thereof "the fiscal years ending September 30, 1979, September 30, 1980, and September 30, 1981".

TITLE VIII—MISCELLANEOUS

OBLIGATED SERVICE FOR MENTAL HEALTH TRAINEESHIPS

SEC. 801. (a) Section 303 of the Public Health Service Act is amended by adding at the end thereof the following new subsection:

"(d)(1) Any individual who has received a clinical traineeship, in psychology, psychiatry, nursing, or social work, under subsection (a)(1) that was not of a limited duration or experimental nature (as determined by the Secretary) is obligated to serve, in service determined by the Secretary to be appropriate in the light of the individual's training and experience, at the rate of one year for each year (or academic year, whichever the Secretary determines to be appropriate) of the traineeship.

"(2) The service required under paragraph (1) shall be performed—

"(A) for a State mental institution providing inpatient care or any entity receiving a grant under the Mental Health Systems Act,

"(B) in a health manpower shortage area (as determined under subpart II of part D of this title), or

"(C) in any other area or for any other entity designated by the Secretary,

and shall begin within such period after the termination of the traineeship as the Secretary may determine. In developing criteria for determining for which institutions or entities or in which areas, referred to in the preceding sentence, individuals must perform service under paragraph (1), the Secretary shall give preference to institutions, entities, or areas which in his judgment have the greatest need for personnel to perform that service. The Secretary may permit service for or in other institutions, entities, or areas if the Secretary determines that the request for such service is supported by good cause.

"(3) Any individual who fails to perform the service required under this subsection within the period prescribed by the Secretary is obligated to repay to the United States an amount equal to three times the cost of the traineeship (including stipends and allowances) plus interest at the maximum legal rate at the time of payment of the traineeship, multiplied, in any case in which the service so required has been performed in part, by the percentage of the length of the service so required to be performed which has not been performed.

"(4)(A) In the case of any individual any part of whose obligation to perform service under this subsection exists at the same time as any part of his obligation to perform service under section 752 or 753 (because of receipt of a scholarship under subpart IV of part C of title VII) or his obligation to perform service under section 472 (because of receipt of a National Research Service Award), or both, the same service may not be used to any extent to meet more than one of those obligations.

"(B) In any case to which subparagraph (A) is applicable and in which one of the obligations is to perform service under section 752 or 753, the obligation to perform service under that section must be met (by performance of the required service or payment of damages) before the obligation to perform service under this subsection or under section 472

"(C) In any case to which subparagraph (A) is applicable, if any part of the obligation to perform service under section 472 exists at the same time as any part of the obligation to perform service under this subsection, the manner and time of meeting each obligation shall be prescribed by the Secretary.".

(b) The amendment made by subsection (a) applies in the case of any academic year (of any traineeship awarded under section 303(a)(1) of the Public Health Service Act) beginning after the date of the enactment of this Act if the award for such academic year is made after such date.

CONFORMING AMENDMENTS

SEC. 802. (a) Section 507 of the Public Health Service Act (relating to grants to Federal institutions) is amended by inserting ", and appropriations under the Mental Health Systems Act," before "shall also be available".

(b) Section 513 of such Act (relating to evaluation of programs by the Secretary) is amended by inserting "the Mental Health Systems Act," after "Community Mental Health Centers Act,".

(c) Sections 1513(e)(1)(A)(i) and 1524(c)(6) of such Act (relating to review of proposed use of Federal funds) are each amended by inserting "the Mental Health Systems Act," after "Community Mental Health Centers Act,".

SPECIAL PAY FOR PUBLIC HEALTH SERVICE PHYSICIANS AND DENTISTS

SEC. 803. Section 208(a) of the Public Health Service Act (42 U.S.C. 210(a)) is amended (1) by inserting "(1)" after "(a)", and (2) by adding at the end the following:

"(2) Commissioned medical and dental officers in the Regular and Reserve Corps shall while on active duty be paid special pay in the same amounts as, and under the same terms and conditions which apply to, the special pay now or hereafter paid to commissioned medical and dental officers of the Armed Forces under chapter 5 of title 37, United States Code.".

MENTAL HEALTH PERSONNEL

SEC. 804. Section 303 of the Public Health Service Act (42 U.S.C. 242a) (as amended by section 801) is amended by adding at the end the following:

"(e) Because of the rising demands for mental health services and the wide disparity in the distribution of psychiatrists, clinical psychologists, social workers, and psychiatric nurses, there is a shortage in the medical specialty of psychiatry and there are also shortages among the other health personnel who provide mental health services.".

Amend the title so as to read: "An Act to revise and improve the Federal programs of assistance for the provision of mental health services, and for other purposes.".

The motion was agreed to.

The Senate bill was ordered to be read a third time, was read the third time, and passed, and a motion to reconsider was laid on the table.

A similar House bill (H.R. 7299) was laid on the table.

GENERAL LEAVE

Mr. WAXMAN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks on the bill, H.R. 7299, just passed.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

COMMEMORATING 75TH ANNIVERSARY OF FOREST SERVICE

Mr. FOLEY. Mr. Speaker, I ask unanimous consent for the immediate consideration of the concurrent resolution (H. Con. Res. 393) extending to the Forest Service, U.S. Department of Agriculture, the appreciation of the Congress on the 75th anniversary of the founding of the agency.

The Clerk read the title of the concurrent resolution.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Washington?

There was no objection.

The Clerk read the concurrent resolution, as follows:

H. CON RES 393

Whereas the forest resources of the United States are one of the Nation's most important assets; and

Whereas the management of those resources for the sustained production of goods and services for the benefit of the public is a declared policy of the Congress; and

Whereas the Forest Service, United States Department of Agriculture, is charged with providing national leadership in forestry and carries out this responsibility through the management of the national forest system, by cooperation with States and private landowners, and by conducting forestry research; and

Whereas the public interest has been well served by the Forest Service, United States Department of Agriculture, since its founding in 1905: Now, therefore, be it

Resolved by the House of Representatives (the Senate concurring), That the Congress recognizes the year 1980 as the seventy-fifth anniversary of the founding of the Forest Service, United States Department of Agriculture, and hereby extends to that agency its appreciation for service effectively rendered to the public over the past seventy-five years.

The concurrent resolution was agreed to.

A motion to reconsider was laid on the table.

GENERAL LEAVE

Mr. FOLEY. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to extend their remarks in the RECORD on the resolution just agreed to.