Calendar No. 336

111TH CONGRESS
2d Session

SENATE

REPORT
111–166

ESTABLISHING AN INDIAN YOUTH TELEMENTAL HEALTH DEMONSTRATION PROJECT, TO ENHANCE THE PROVISION OF MENTAL HEALTH CARE SERVICES TO INDIAN YOUTH, TO ENCOURAGE INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND OTHER MENTAL HEALTH CARE PROVIDERS SERVING RESIDENTS OF INDIAN COUNTRY TO OBTAIN THE SERVICES OF PREDOCTORAL PSYCHOLOGY AND PSYCHIATRY INTERNS, AND FOR OTHER PURPOSES

MARCH 25, 2010.—Ordered to be printed

Mr. DORGAN, from the Committee on Indian Affairs, submitted the following

R E P O R T

[To accompany S. 1635]

The Committee on Indian Affairs, to which was referred the bill, S. 1635 to establish an Indian Youth telemental health demonstration project, to enhance the provision of mental health care services to Indian youth, to encourage Indian tribes, tribal organizations, and other mental health care providers serving residents of Indian country to obtain the services of predoctoral psychology and psychiatry interns, and for other purposes, having considered the same, reports favorably thereon with amendment(s) and an amendment to the title and recommends that the bill (as amended) do pass.

PURPOSE

The purpose of S. 1635 is to give Indian youth suicide prevention programs greater authorization to meet the federal government's trust responsibility to provide health care to Native Americans. This is accomplished by streamlining the Substance Abuse and Mental Health Services Administration (SAMHSA) grants for Indian youth suicide prevention; authorizing tribal use of predoctoral psychology and psychiatry interns for health care services to increase the availability of mental health services and to recruit mental health providers to Indian Country; authorizing an Indian youth telemental health demonstration project for Native American communities to increase the use of technology to enhance mental health and prevent youth suicides; and authorizing a demonstra-

tion project for youth suicide prevention curriculum programs in schools serving Indian youth.

BACKGROUND

The incidence of suicide among Native Americans is 1.9 times higher than the national average and even higher among Native American youth. Native American youth experience the highest rate of suicide of any population group in the U.S. Between the ages of 15 and 24, Native American youth have a suicide rate 3.5 times higher than their peers of other races. The incidence of suicide for Native American male youth is especially extreme, with a rate four times higher than males in other racial groups and up to eleven times higher than females in other racial groups. Suicide is the second leading cause of death among Native American youth.

According to testimony received by the Committee, there are many risk behaviors and contributing factors for youth suicide. The Centers for Disease Control and Prevention (CDC) lists the following risk factors for youth suicide: history of previous suicide attempts, family history of suicide, symptoms of depression or other mental illness, alcohol or drug abuse, stressful life event or loss, easy access to lethal methods, exposure to the suicidal behavior of others, and incarceration. Several of these factors are overrepresented among Native American communities and, according to testimony received by the Committee, may contribute to the high rate of suicide in these communities.

These issues are further compounded by a lack of mental health services available to Native American youth. According to research reported by the National Strategy for Suicide Prevention, in the United States, ninety percent of all teens who die of suicide suffer from a diagnosable mental illness at the time of death and over half are never seen by a mental health provider. The lack of access to mental health professionals is especially problematic for Native American youth. The Indian Health Service (IHS) experiences severe mental health professional shortages.

Furthermore, the Committee has been informed that when Indian tribes seek federal assistance for suicide prevention programs, such as grants, they often lack the resources and infrastructure necessary to successfully access federal funding. The remote nature of reservations may hinder the Indian tribe's ability to develop the telecommunication and epidemiological infrastructure necessary to effectively compete for a federal grant. For example, a tribe may be unable to track, record, and evaluate the incidences and trends in youth suicide over a number of years. Additionally, the Committee received several complaints from tribes about the new federal requirements for grants that required the applications be submitted electronically and that hard copy or facsimile applications were not acceptable. While the federal grant process advanced with technology, the technological capabilities on some remote Indian reservations were still developing. Ultimately, this lack of administrative and technological infrastructure impairs a tribe's ability to apply and obtain federal funding for suicide prevention programs.

The heightened incidence of youth suicides in Indian Country over the past few years led the Committee to examine the issue in an effort to help Native American communities deal with this epidemic. On February 26, 2009, the Committee held an oversight

hearing on youth suicide in Indian Country. The hearing was intended to follow-up on a series of hearings held on this topic since the 109th Congress. These hearings were held to address growing concerns about the incidence of suicide among Native American youth precipitated by the cluster of suicides that occurred at the Standing Rock Sioux Reservation in 2005.

On August 6, 2009, Chairman Dorgan along with Senators Johanns, Johnson, Tester, Udall, Baucus and Thune introduced S. 1635, the *7th Generation Promise: Indian Youth Suicide Prevention Act of 2009*. This legislation builds upon prior bills introduced to address Indian youth suicide prevention in the 109th Congress, S. 2245, the *Indian Youth Telemental Health Demonstration Project Act of 2006*, and 110th Congress, S. 322, the *Indian Youth Telemental Health Demonstration Project Act of 2007*. S. 322 authorized the Secretary of Health and Human Services to carry out a demonstration project to provide grants for telemental health services to Indian youth who have expressed suicidal ideas, have attempted suicide, or have mental health conditions that create a risk of suicide. The bill would have made telemental health service grants available to Indian tribes operating one or more facilities; reported active clinical telehealth capabilities; and offered school-based telemental health services relating to psychiatry for Indian youth.

The bill gets its name from the belief in Indian Country that you should consider the impact of your decisions on the seventh generation yet to come. As with prior bills, the goal of the 7th Generation Promise is to enhance the mental health services and suicide prevention resources available to Native Americans, particularly the youth. In addition to promoting innovative, new programs and building upon existing successful programs, S. 1635 also addresses barriers Native Americans face in accessing federal funding.

LEGISLATIVE HISTORY

The *Indian Youth Telemental Health Demonstration Project Act of 2006, S. 2245*, was introduced by Senator Dorgan during the 109th Congress. It was also incorporated into S. 1057, the *Indian Health Care Improvement Act Amendments of 2005* and H.R. 5312, the *Indian Health Care Improvement Act Amendments of 2006*. S. 2245 was co-sponsored by Senators McCain, Conrad, Johnson, Murkowski, Smith, and Bingaman. S. 2245 authorized the Secretary of Health and Human Services to carry out a demonstration project to provide grants for telemental health services to Indian youth who have expressed suicidal ideas, have attempted suicide, or have mental health conditions that create a risk of suicide. The bill would have made telemental health service grants available to Indian tribes operating one or more facilities; reported active clinical telehealth capabilities; and offered school-based telemental health services relating to psychiatry for Indian youth. The Committee favorably reported S. 2245 on April 24, 2006, and the Senate passed the bill by unaminous consent on May 11, 2006. The bill was referred to the House Resources and Energy and Commerce Committees but no further action was taken.

The *Indian Youth Telemental Health Demonstration Project Act of 2007*, S. 322, was introduced by Senator Dorgan during the 110th Congress. It was also incorporated into S. 1200, the *Indian Health Care Improvement Act Amendments of 2008*, and H.R. 1328,

the *Indian Health Care Improvement Act Amendments of 2007*, in that same Congress. S. 322 was cosponsored by Senators Thomas, Baucus, Bingaman, Conrad, Inouye, McCain, Murkowski, and Smith. On February 8, 2007, the Senate Committee on Indian Affairs favorably reported S. 322 to the full Senate by a voice vote. No further action was taken on S. 322.

On August 6, 2009, Chairman Dorgan, along with Senators Baucus, Begich, Conrad, Johanns, Johnson, Murkowski, Tester, and Thune introduced the *7th Generation Promise: Indian Youth Suicide Prevention Act of 2009*, S. 1635. On September 9, 2009, the Committee held a legislative hearing on the bill. On December 3, 2009, the Committee held a business meeting on S. 1635, and the bill was ordered to be reported favorably to the full Senate with amendments. In addition, the *Indian Health Care Improvement Reauthorization and Extension Act of 2009*, S. 1790, contains the text of S. 1635, as amended.

Indian Health Care Improvement Reauthorization and Extension Act of 2009, S. 1790, was included in H.R. 3590 which passed the Senate on December 24, 2009 and passed the House on March 21, 2010.

SUMMARY OF AMENDMENTS TO S. 1635

Four amendments were offered to S. 1635 at the Committee business meeting on December 3, 2009. All of the amendments were accepted by voice vote of the Committee. The four amendments are described below:

Chairman Dorgan offered a manager's amendment which made several technical changes and two substantive changes to S. 1635. The first substantive amendment addresses concerns raised by the SAMHSA regarding priority consideration required to be given to Indian tribes for youth suicide prevention grants. Instead, the manager's amendment requires SAMHSA to consider the needs of Indian tribes in the application process. The manager's amendment also includes a demonstration project, developed by Senator Udall of New Mexico, to provide tribes with grants for culturally compatible, school-based suicide prevention curriculum to strengthen Native American teen "life skills."

Senator Murkowski offered three amendments to S. 1635. The first amendment offered by Senator Murkowski clarified the definition of "Indian population" to ensure that eligible for services under the demonstration project was consistent with those eligible for health care services under the *Indian Health Care Improvement Act*, 25 U.S.C. 1601, *et seq*.

The second amendment offered by Senator Murkowski struck a mandate in S. 1635 requiring States to consult with all tribes in the jurisdiction when applying for a grant using any type of tribal data. Instead the amendment required States "to exercise reasonable effort to collaborate with each Indian tribe or tribal organization."

The third amendment offered by Senator Murkowski struck the definition of and one reference to the term "Indian Country." The amendment clarified that the Secretary shall encourage all federally recognized Indian tribes to use predoctoral psychology and psychiatry interns to increase access to mental health services.

SECTION-BY-SECTION OF S. 1635 AS AMENDED

Section 1. Short title

Section 1 provides the short title of S. 1635 as the *7th Generation Promise: Indian Youth Suicide Prevention Act of 2009.*

Section 2. Findings and purpose

Section 2 contains descriptions of current data, research, and ongoing federal youth suicide prevention programs for American Indians and Alaska Natives, conveying the purpose of this Act.

Section 3. Definitions

Section 3 includes definitions to be used for S. 1635. For the purposes of S. 1635, "Administration" means the Substance Abuse and Mental Health Services Administration; "Demonstration Project" means the Indian youth telemental health demonstration project authorized under section 4(a) of S. 1635; and "Indian" means any individual who is either a member of an Indian tribe or eligible for health services under the *Indian Health Care Improvement Act.* In addition, "Indian tribe" has the meaning given to the term in section 4 of the *Indian Self-Determination and Education Assistance Act*; "Secretary" means the Secretary of Health and Human Services; "Service" means the Indian Health Service; "Telemental Health" means the use of electronic information and telecommunication technologies to support long distance mental health care, patient and professional-related education, public health, and health administration; and "Tribal Organization" has the meaning given the term in section 4 of the *Indian Self-Determination and Education Assistance Act.*

Section 4. Indian Youth Telemental Health Demonstration Project

Section 4 authorizes the Secretary of the Department of Health and Human Services (HHS), through the IHS, to carry out a telemental health services demonstration project targeted to Indian youth suicide prevention. Telemental health services may include mental health services provided to remote locations through technological means; educational material distribution; and data collection. The demonstration project will award up to five, four-year grants to Indian tribes and tribal health organizations.

Indian tribes and tribal organizations that operate one or more of the following facilities would be eligible for grants: (1) facilities located in IHS regions with documented disproportionately high rates of suicides; (2) facilities reporting active clinical telehealth capabilities; or (3) facilities offering school-based telemental health services relating to psychiatry to Indian youth.

There is an authorization of $1,500,000 for each of the fiscal years 2010 through 2013. The IHS is required to consult SAMHSA in the development and progress of this demonstration project.

Section 5. Substance Abuse and Mental Health Services Administration Grants

Section 5 is intended to enhance the provision of mental health care services for Indian youth provided through SAMHSA funding by decreasing the application barriers Indian tribes and tribal organizations face.

This section requires SAMHSA to maximize the efficiency of and streamline the process by which Indian tribes or tribal organizations may apply for grants. This includes accepting non-electronic grant applications from Indian tribes and tribal organizations and ensuring that tribes are not required to apply for grants through states.

In addition, this section asks that the unique needs of tribal communities with a high youth suicide rate, regardless of resources or infrastructure, be taken into consideration in the application and award process of SAMHSA grants.

This section also requires states that include tribal data in their grant applications to partner with tribes and tribal organizations within the state throughout the implementation of their programs. These states must provide a description of how they will use a portion of the funds within the Indian population and report on these efforts within a year.

A provision is included that prevents federal agencies from requiring Indian tribes or tribal organizations to provide matching funds in order to apply for a grant.

This section requires SAMHSA to monitor Indian Country suicide rates. However, any SAMHSA response or activities in Indian Country would require consultation with the respective tribe. The provision also allows for any disadvantaged Indian tribe (in terms of locality and/or resources) experiencing an unusually high rate of youth suicide to be eligible for assistance from SAMHSA. This provision includes an authorization for funding amounts as the Secretary of Health and Human Services deems necessary.

The last provision within this section requires that a SAMHSA grant recipient, serving an Indian youth population, provide training or education for individuals (including teachers, parents, coaches, and mentors) working with youth. The goal is to increase the early identification and intervention of at-risk Indian youth, while utilizing the already existing social network.

Section 6. Use of predoctoral psychology and psychiatry interns

Section 6 encourages Indian tribes, tribal organizations, and other mental health care providers serving Indian Country to utilize predoctoral psychology and psychiatry interns. Indian Country faces extreme shortages of mental health professionals and this provision will help increase the number of patients accessing care and serve as a recruitment tool for psychologists and psychiatrists.

Section 7. Indian Youth Life Skills Development Demonstration Program

Section 7 authorizes a demonstration grant program through the Substance Abuse and Mental Health Services Administration to provide grants to tribes and tribal organizations to provide culturally compatible, school-based suicide prevention curriculum to strengthen American Indian and Alaska Native teen "life skills". The section authorizes $4 million dollars for each fiscal year, 2010 through 2014.

COMMITTEE RECOMMENDATION AND TABULATION OF VOTE

In an open business meeting on December 3, 2009, the Committee on Indian Affairs, by voice vote, adopted S. 1635, as amend-

ed, and ordered the bill reported to the Senate, with the recommendation that the bill do pass.

COST AND BUDGETARY CONSIDERATIONS

To date, the Committee has not received a report on the cost or budget consideration from the Congressional Budget Office for S. 1635.

REGULATORY AND PAPERWORK IMPACT STATEMENT

Paragraph 11(b) of rule XXVI of the Standing Rules of the Senate requires that each report accompanying a bill evaluate the regulatory and paperwork impact that would be incurred in carrying out the bill. The Committee believes that the regulatory and paperwork impact of S. 1635 will be minimal.

CHANGES IN EXISTING LAW

In compliance with subsection 12 of rule XXVI of the Standing Rules of the Senate, the Committee finds that the enactment of S. 1635 will not make any changes in existing law.

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