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108TH CONGRESS
1ST SESSION

H. R. 3063

To authorize the Secretary of Health and Human Services, the Secretary of Education, and the Attorney General to make 10 grants to demonstration facilities to implement evidence-based preventive-screening tools to detect mental illness and suicidal tendencies in school-age youth at selected facilities.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 10, 2003

Ms. DELAURO (for herself, Mr. WAXMAN, Mr. SERRANO, Mr. TOWNS, Mr. GRIJALVA, Mrs. CHRISTENSEN, and Mr. ACEVEDO-VILÁ) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To authorize the Secretary of Health and Human Services, the Secretary of Education, and the Attorney General to make 10 grants to demonstration facilities to implement evidence-based preventive-screening tools to detect mental illness and suicidal tendencies in school-age youth at selected facilities.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the ''Children's Mental
3 Health Screening and Prevention Act of 2003''.

4 **SEC. 2. FINDINGS.**

5 The Congress finds as follows:

6 (1) Over the past 20 years, advances in sci-
7 entific research have changed the way of thinking
8 about children's mental health and proven that the
9 same mental disorders that afflict adults can also
10 occur in children and adolescents.

11 (2) In January 2001, the Report of the Sur-
12 geon General's Conference on Children's Mental
13 Health noted that 74 percent of individuals age 21
14 with mental disorders had prior problems, indicating
15 that children's mental disorders often persist into
16 adulthood.

17 (3) Scientific research has demonstrated that
18 early identification and treatment of mental dis-
19 orders in youth greatly improves a child or adoles-
20 cent's prognosis throughout his or her lifetime.

21 (4) In January 2001, the Surgeon General
22 noted that, while 1 in 10 children and adolescents in
23 the United States suffers from mental illness severe
24 enough to cause some level of impairment, only 1 in
25 5 of such children and adolescents receives needed
26 mental health treatment.

1 (5) According to an interim report by the Presi-
2 dent's New Freedom Commission on Mental Health,
3 about 7 to 9 percent of all children who are 9 to 17
4 years of age (about 1 or 2 in every classroom) have
5 a serious emotional disturbance.
6 (6) In September 2002, the National Council
7 on Disability noted that between 60 and 70 percent
8 of youth in the juvenile justice system have an emo-
9 tional disturbance and almost 50 percent have co-oc-
10 curring disabilities.
11 (7) The World Health Organization has re-
12 ported that youth neuropsychiatric disorders will rise
13 by over 50 percent by 2020, making such disorders
14 1 of the top 5 causes of disability, morbidity, and
15 mortality among children and adolescents.
16 (8) Psychological autopsy studies have found
17 that 90 percent of youths who end their own lives
18 have depression or another diagnosable mental or
19 substance abuse disorder at the time of their deaths,
20 verifying a link between mental illness and suicide.
21 (9) According to an interim report by the Presi-
22 dent's New Freedom Commission on Mental Health,
23 more than 30,000 lives are lost every year to suicide,
24 which is a largely preventable public health problem.

1 (10) In 1999, the Surgeon General recognized
2 that mental illness and substance abuse disorders
3 are, in fact, the greatest risk factors for suicidal be-
4 havior, and that properly identifying and treating
5 mental illness and substance abuse disorders are an
6 important part of suicide prevention activities.
7 (11) The National Council on Disability has
8 also stated that ''the failure to identify and treat
9 mental disabilities between children and youth has
10 serious consequences, including school failure, in-
11 volvement with the justice system and other tragic
12 outcomes,'' including ''the growing problem of teen
13 suicides and/or suicide attempts''.
14 (12) The Centers for Disease Control and Pre-
15 vention reported that in 2000 suicide was the 3rd
16 leading cause of death among youth 15 to 24 years
17 of age.
18 (13) The Substance Abuse and Mental Health
19 Services Administration reported that in 1999 al-
20 most 3,000,000 youth were at risk for suicide, but
21 only 36 percent received mental health treatment.
22 (14) According to the Youth Risk Behavior
23 Surveillance System of the Centers for Disease Con-
24 trol and Prevention, among high school students
25 surveyed in 2001, 19 percent had seriously consid-

1 ered attempting suicide, almost 15 percent had
2 made a specific plan to attempt suicide, almost 9
3 percent had attempted suicide, and almost 3 percent
4 had made an attempt at suicide that required med-
5 ical attention.

6 (15) The Centers for Disease Control and Pre-
7 vention reported that each year in the United States,
8 almost as many adolescents and young adults com-
9 mit suicide as die from all natural causes combined,
10 including leukemia, birth defects, pneumonia, influ-
11 enza, and AIDS.

12 (16) In January 2001, the Surgeon General
13 issued a goal to ‘‘improve the assessment of and rec-
14 ognition of mental health needs in children’’ in part
15 by encouraging ‘‘early identification of mental health
16 needs in existing preschool, child care, education,
17 health, welfare, juvenile justice, and substance abuse
18 treatment systems’’.

19 (17) In May 2003, the National Council on
20 Disability noted that ‘‘despite calls for significant
21 prevention and early intervention efforts in schools
22 and the juvenile justice system, there is little evi-
23 dence that such efforts are widespread’’. The Coun-
24 cil also found that ‘‘the absence is notable because
25 research suggests that such programming may be

1 the only effective method for reducing the involve-
2 ment of youth with disabilities in the juvenile justice
3 system''.
4 (18) The April 2003 Outline of the Final Re-
5 port for the President's New Freedom Commission
6 on Mental Health states that ''evidence-based prac-
7 tice interventions should be tested in demonstration
8 projects with oversight by a public-private consor-
9 tium of stakeholders''.
10 (19) An interim report by the President's New
11 Freedom Commission on Mental Health concludes
12 that there is a range of effective treatments, serv-
13 ices, and supports to facilitate recovery from mental
14 illness, but the current system can not efficiently de-
15 liver them.
16 (20) The efforts, initiatives, and activities of
17 the Federal Government should be used to support
18 evidence-based preventive-screening tools to detect
19 mental illness and suicidal tendencies in school-age
20 youth.

21 **SEC. 3. MENTAL HEALTH SCREENING DEMONSTRATION**
22 **PROJECT.**

23 (a) IN GENERAL.—The Secretary of Health and
24 Human Services, the Secretary of Education, and the At-
25 torney General, acting jointly and in consultation with the

1 Directors (as that term is defined in subsection (k)), shall
2 make 10 grants to demonstration facilities to implement
3 evidence-based preventive-screening tools to detect mental
4 illness and suicidal tendencies in school-age youth and to
5 refer those youth in need of assessment or treatment.
6 (b) EQUITABLE GEOGRAPHIC DISTRIBUTION.—To
7 the extent practicable, the Secretaries shall ensure an eq-
8 uitable distribution of grants under this section among the
9 geographic regions of the United States.
10 (c) PERIOD OF GRANTS.—Each grant made under
11 subsection (a) shall be for a period of 3 years.
12 (d) APPLICATION REQUIREMENTS.—
13 (1) IN GENERAL.—To seek a grant under this
14 section, a demonstration facility shall submit an ap-
15 plication at such time and in such manner as the
16 Secretaries reasonably require.
17 (2) CONTENTS.—An application submitted by a
18 demonstration facility for a grant under subsection
19 (a) shall—
20 (A) demonstrate that the facility has
21 formed a multidisciplinary project implementa-
22 tion committee;
23 (B) specify an evidence-based preventive-
24 screening tool to be implemented with the
25 grant;

1 (C) demonstrate that the facility has the
2 means to obtain the necessary resources and
3 tools, other than personnel, to implement the
4 specified evidence-based preventive-screening
5 tool;
6 (D) demonstrate that the facility has exist-
7 ing staff, will hire new staff, or will partner
8 with staff from a local, licensed mental health
9 or medical organization, and has the ability to
10 train staff—
11 (i) to implement the specified evi-
12 dence-based screening tool;
13 (ii) to case manage youth with symp-
14 toms or indicators for mental illness, suici-
15 dal ideation, or suicide attempts; and
16 (iii) to work with the parents or
17 guardians of youth with symptoms or indi-
18 cators for mental illness, suicidal ideation,
19 or suicide attempts to help them under-
20 stand the youth's outcome and treatment
21 options;
22 (E) identify the location (which need not
23 be at the facility) where the specified evidence-
24 based preventive-screening tool will be imple-
25 mented;

1 (F) demonstrate that the facility has ob-
2 tained full approval to screen at such location;
3 (G) identify the sample of school-age youth
4 to be screened;
5 (H) identify a method for obtaining writ-
6 ten consent from the parent or legal guardian
7 of any minor participating in the demonstration
8 project;
9 (I) identify licensed mental health pro-
10 viders (including mental health professionals,
11 hospitals, residential treatment centers, or out-
12 patient clinics) in the community where the fa-
13 cility is located that will partner with the facil-
14 ity to provide further mental health assess-
15 ments and treatment for participating youth
16 with symptoms or indicators of mental illness,
17 and demonstrate the ability of those providers
18 to accept referrals; and
19 (J) contain such other information as the
20 Secretaries reasonably require.
21 (e) MULTIDISCIPLINARY PROJECT IMPLEMENTATION
22 COMMITTEE.—The Secretaries may not make a grant to
23 a demonstration facility under subsection (a) for a dem-
24 onstration project unless the facility agrees to the fol-
25 lowing:

1 (1) The multidisciplinary project implementa-
2 tion committee formed under subsection (d)(2)(A)
3 will consist of the following:
4 (A) Representatives of the facility.
5 (B) Representatives of the location where
6 the specified evidence-based preventive screen-
7 ing tool will be implemented (if that location is
8 other than the demonstration facility).
9 (C) A facility case manager (as that posi-
10 tion is described in subsection (d)(2)(D)(ii)).
11 (D) Mental health providers in the commu-
12 nity.
13 (E) Mental health consumers or family
14 members of mental health consumers.
15 (F) Parents or guardians of any school-
16 aged youth to be screened.
17 (2) When possible, the multidisciplinary project
18 implementation committee will follow the guidance of
19 any suicide prevention plan endorsed by State or
20 local government officials or local public health offi-
21 cials.
22 (3) The multidisciplinary project implementa-
23 tion committee will be responsible for ensuring com-
24 pliance with the representations made by the facility
25 in its grant application.

1 (4) The multidisciplinary project implementa-
2 tion committee will coordinate and collaborate with
3 mental health providers in the community, including
4 those identified in subsection (d)(2)(I), to guarantee
5 that all youth with symptoms or indicators for men-
6 tal illness, suicidal ideation, or suicide attempts re-
7 ceive appropriate and affordable treatment regard-
8 less of the financial or insurance status of the
9 youth's parent or guardian.

10 (f) INFORMATION COLLECTION.—The Secretaries
11 may not make a grant to an applicant under subsection
12 (a) for a demonstration project unless the applicant agrees
13 to collect the following:

14 (1) Information on the demographics of youth
15 participating in the project, including—

16 (A) the number of youth invited to partici-
17 pate in the project, including the number of
18 such youth disaggregated by age, gender, and
19 ethnicity; and

20 (B) the number of youth with symptoms or
21 indicators for mental illness requiring clinical
22 consultation or assessment, including such
23 number disaggregated by disorder.

24 (2) Information on the outcomes of evidence-
25 based preventive-screening tools, including—

(A) the number of screening refusals, due to lack of consent by a parent or legal guardian or refusal of the youth;

(B) the number of youth with symptoms or indicators for all mental illnesses, including such number disaggregated by disorder; and

(C) post assessment, the number of youth with positive outcomes for suicidal ideation or suicide attempts.

(3) Information on referrals based on outcomes, including—

(A) the number of youth referred for clinical interviews to determine the need for further evaluation or treatment;

(B) the number of youth referred for further evaluation or treatment, including such number disaggregated by type and location of treatment;

(C) the number of youth and their parents or legal guardians who accept referrals for further evaluation or treatment; and

(D) the number of youth and their parents or legal guardians who refuse referrals for further evaluation or treatment.

1 (4) To the extent practicable, information on
2 treatment based on referrals, including the number
3 of appointments kept by referred youth.
4 (5) To the extent practicable, information on
5 suicide attempts, suicide rates, and access to evi-
6 dence-based mental health screening and suicide pre-
7 vention programs among school-age youth in the
8 designated jurisdiction in which the grantee is lo-
9 cated for the 3 years preceding the commencement
10 of the project.
11 (6) To the extent practicable, data on barriers
12 to care encountered by referred youth, including but
13 not limited to linguistic barriers, transportation dif-
14 ficulties, lack of providers in the community, or lack
15 of insurance.
16 (7) Such additional information as the Secre-
17 taries reasonably require.
18 (g) INFORMATION REPORTING.—The Secretaries
19 may not make a grant to an applicant under subsection
20 (a) for a demonstration project unless the applicant agrees
21 to report information collected under subsection (f) to the
22 Secretaries as follows:
23 (1) Information collected under paragraphs (1),
24 (2), (3), (4), (6), (7), and (8) of subsection (f) shall
25 be reported—

1 (A) not later than the date that is 2
2 months after completion of the 1st year of the
3 project;
4 (B) not later than the date that is 2
5 months after completion of the 2nd year of the
6 project; and
7 (C) not later than the date that is 2
8 months after completion of the 3rd year of the
9 project.
10 (2) Any information collected under paragraph
11 (5) of subsection (f) shall be reported not later than
12 the date that is 6 months after commencement of
13 the demonstration project.
14 (h) FEASIBILITY OF COLLECTING INFORMATION ON
15 PRECEDING YEARS.—In making grants under subsection
16 (a), the Secretaries may not discriminate against an appli-
17 cant because it will not be practicable, owing to insuffi-
18 cient funds or otherwise, for the applicant to collect infor-
19 mation under subsection (f)(5).
20 (i) ADVISORY PANEL.—
21 (1) ESTABLISHMENT.—Not later than 14
22 months after making the first grant under sub-
23 section (a), the Secretaries shall convene an advisory
24 panel.
25 (2) DUTIES.—The advisory panel shall—

1 (A) assist in the review and evaluation of
2 the information collected and reported pursuant
3 to subsections (f) and (g), respectively; and
4 (B) submit recommendations to each of
5 the Secretaries on the use or improvement of
6 evidence-based preventive-screening tools to de-
7 tect mental illness and suicidal tendencies in
8 school-age youth.
9 (3) MEMBERSHIP.—The advisory panel shall
10 consist of not more than 20 members, and the mem-
11 bers shall represent the following:
12 (A) National or local organizations rep-
13 resenting for-profit and nonprofit mental health
14 care treatment facilities.
15 (B) National or local organizations rep-
16 resenting mental health care professionals.
17 (C) National or local organizations rep-
18 resenting mental health care consumers.
19 (D) National or local organizations rep-
20 resenting school-based mental health care pro-
21 fessionals.
22 (E) National or local organizations dedi-
23 cated to school-based health care.
24 (F) National or local organizations rep-
25 resenting school administrators.

(G) National or local organizations representing school boards and school board members.

(H) National or local organizations representing juvenile justice professionals.

(I) National or local organizations dedicated to juvenile justice.

(J) National or local organizations representing foster care professionals.

(K) National or local organizations dedicated to foster care.

(L) National or local organizations dedicated to child welfare.

(M) Accredited child and adolescent psychiatric programs at national medical colleges and universities.

(N) Any other entities or individuals that the Secretaries deem appropriate.

(j) REPORT.—Not later than 6 months after the end of the 3-year grant period for the last grant made under subsection (a), the Secretaries, in consultation with the Directors and the advisory panel, shall submit to the Congress a report on the grants made under this section. Such report shall be based on the information collected and reported under subsections (f) and (g), respectively, and

1 shall include the evaluation and recommendations of the
2 advisory panel.
3 (k) DEFINITIONS.—In this section:
4 (1) ADVISORY PANEL.—The term ‘‘advisory
5 panel’’ means the advisory panel convened under
6 subsection (i).
7 (2) DEMONSTRATION FACILITY.—The term
8 ‘‘demonstration facility’’ means a facility that serves
9 at-risk youth or performs outreach to school-age
10 youth, including any elementary school, secondary
11 school, school-based health center, juvenile justice
12 facility, foster care setting, homeless shelter, youth
13 drop-in center, youth outreach organization, youth
14 residential treatment center, or State or local mental
15 health organization.
16 (3) DIRECTORS.—The term ‘‘Directors’’ means
17 the Administrator of the Health Resources and Serv-
18 ices Administration, the Administrator of the Sub-
19 stance Abuse and Mental Health Services Adminis-
20 tration, the Director of the Centers for Disease Con-
21 trol and Prevention, the Director of the Indian
22 Health Service, and the Director of the National In-
23 stitute of Mental Health.
24 (4) ELEMENTARY SCHOOL; SECONDARY
25 SCHOOL.—The terms ‘‘elementary school’’ and ‘‘sec-

ondary school'' have the meanings given those terms in section 9101 of the Elementary and Secondary Education Act (20 U.S.C. 7801).

(5) EVIDENCE-BASED PREVENTIVE-SCREENING TOOL.—The term ''evidence-based preventive-screening tool'' means a preventive-screening tool that has been shown to be valid and effective through research that is conducted by independent scientific teams, is determined by well-regarded scientists to be of high quality, and meets the quality standards for publication in scientific peer-reviewed journals.

(6) SCHOOL-AGE YOUTH.—The term ''school-age youth'' means an individual who is 6 to 18 years of age, or who is enrolled in any elementary school or secondary school.

(7) SECRETARIES.—The term ''Secretaries'' means the Secretary of Health and Human Services, the Secretary of Education, and the Attorney General, acting jointly.

(l) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretaries to carry out this section $7,500,000 for each of fiscal years 2004 through 2006, and such sums as may be necessary thereafter, to remain available until expended.

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