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INDIAN YOUTH TELEMENTAL HEALTH DEMONSTRATION PROJECT ACT OF 2006

APRIL 24, 2006.—Ordered to be printed

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

R E P O R T

[To accompany S. 2245]

The Committee on Indian Affairs, to which was referred the bill (S. 2245) to establish an Indian youth telemental health demonstration project, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

PURPOSE

S. 2245 would authorize the Indian Youth Telemental Health Demonstration Project, under which the Secretary of Health and Human Services would award grants to five tribes and tribal organizations with telehealth capabilities to use in youth suicide prevention, intervention and treatment. The demonstration project authorized under S. 2245 would permit the use of telemental health for psychotherapy, psychiatric assessments and diagnostic interviews of Indian youth; the provision of clinical expertise and other medical advice to frontline health care providers working with Indian youth; training and related support for community leaders, family members and health and education workers who work with Indian youth; the development of culturally-relevant educational materials on suicide prevention and intervention; and data collection and reporting.

BACKGROUND

Several American Indian and Alaska Native communities around the country have experienced clusters of youth suicide completions and suicide attempts in recent years, including the Standing Rock Sioux Tribe in North and South Dakota, the Confederated Tribes

of Grand Ronde of Oregon, the Cheyenne River Sioux Tribe of South Dakota, the White Mountain Apache Tribe of Arizona, the Jicarilla Apache Tribe of New Mexico, and Native villages in western Alaska.

According to statistics collected by the Substance Abuse and Mental Health Services Administration, suicide is the second leading cause of death for American Indian and Alaska Native youth between the ages of 15 and 24, following unintentional injury and accidents. The rate of Indian youth suicide on reservations is two and a half times higher than for the rest of the country, with a rate that is 10 times higher than the national average in the Northern Great Plains. More than one-half of all persons who commit suicide in Indian Country have never been seen by a mental health services provider. In addition to the risk factors for completed suicide of substance abuse and mental health disorders is the economic depression and poverty of many reservation communities, the lack of education and other opportunity, and the breakdown of traditional family and community structures.

The Committee held two hearings on Indian youth suicide in 2005, including a field hearing in Bismarck, ND, and received testimony from the Surgeon General of the United States, the Director of the Indian Health Service, tribal elected officials, Indian psychologists and health professionals, and Indian parents and students, among others. The issue of Indian youth suicide has also been discussed at Committee hearings on Indian health services, child abuse prevention, and methamphetamine use, production and distribution in Indian Country. The suggested use of telecommunications technologies to support such possible services as psychotherapy and diagnostic interviews of Indian youth, and medical advice to frontline health care providers working with Indian youth was one of the several recommendations that came out of these hearings.

LEGISLATIVE HISTORY

S. 2245 was introduced on February 6, 2006, by Senators Dorgan, Conrad, Bingaman, Murkowski, McCain, Johnson and Smith, and was referred to the Committee on Indian Affairs. On March 29, 2006, the Committee on Indian Affairs Committee convened a business meeting to consider S. 2245 and other measures that had been referred to it, and on that date ordered the bill favorably reported.

SECTION-BY-SECTION ANALYSIS

Section 1. Short title

Section 1 states that the Act may be cited as the "Indian Youth Telemental Health Demonstration Project Act of 2006."

Section 2. Findings and purpose

Section 2 sets forth seven findings about youth suicide for Indians and Alaska Natives and its impact on tribal communities which provide the reasons for this legislation. This section also states that the purpose of this Act is to authorize the Secretary to carry out a demonstration project to test the use of telemental health services in suicide prevention, intervention, and treatment of Indian youth.

Section 3. Definitions

Section 3 provides definitions for various terms used in the Act.

Section 4. Indian Youth Telemental Health Demonstration Project

Section 4 authorizes the Secretary of Health and Human Services to carry out a demonstration project to award grants for the provision of telemental health services to Indian youth who have expressed suicidal ideas; have attempted suicide; or have mental health conditions that increase or could increase the risk of suicide.

Subsection (a) provides that grants are to be awarded to Indian tribes and tribal organizations that operate one or more facilities located in Alaska and part of the Alaska Federal Health Care Access Network; that report active clinical telehealth capabilities; or that offer school-based telemental health services relating to psychiatry to Indian youth.

The Secretary shall award grants under this section for a period of up to 4 years, and not more than 5 grants shall be provided. Priority consideration shall be given in the awarding of grants to Indian tribes and tribal organizations that serve a particular community or geographic area in which there is a demonstrated need to address Indian youth suicide; enter into collaborative partnerships with Indian Health Service (IHS) or other tribal health programs or facilities to provide services under this demonstration project; serve an isolated community or geographic area which has limited or no access to behavioral health services; or operate a detention facility at which Indian youth are detained.

The bill is intended to provide services for counseling, medical advice and training, and educational materials under this new demonstration project to Indian youth living on reservations and in Native villages, which are generally in remote locations and quite isolated, and which experience much more limited access to mental health services than are available in the nation's cities.

Subsection (b) authorizes the specific use of funds. An Indian tribe or tribal organization may use a grant to (1) provide telemental health services to Indian youth, including the provision of psychotherapy; psychiatric assessments and diagnostic interviews, therapies for mental health conditions predisposing to suicide, and treatment; and alcohol and substance abuse treatment; (2) provide clinician-interactive medical advice, guidance and training, assistance in diagnosis and interpretation, crisis counseling and intervention, and related assistance to IHS or tribal clinicians and health services providers working with youth being served under the demonstration project; (3) assist, educate, and train community leaders, health education professionals and paraprofessionals, tribal outreach workers, and family members who work with the youth receiving telemental health services under the demonstration project, including with identification of suicidal tendencies, crisis intervention and suicide prevention, emergency skill development, and building and expanding networks among those individuals and with state and local health services providers; (4) develop and distribute culturally-appropriate community educational materials on suicide prevention, suicide education, suicide screening, suicide intervention, and ways to mobilize communities with respect to the identification of risk factors for suicide; or (5) conduct data collec-

tion and reporting relating to Indian youth suicide prevention efforts.

Subsection (c) sets forth the application requirements and information which must be submitted in order for an Indian tribe or tribal organization to be eligible to receive a grant.

Subsection (d) requires the Secretary to ensure that the demonstration project involves the use and promotion of the traditional health care practices of the Indian tribes of the youth to be served.

Subsection (e) directs the Secretary to encourage grantee Indian tribes and tribal organizations to collaborate to enable comparisons about best practices across projects.

Subsection (f) directs each grant recipient to submit to the Secretary an annual report that describes the number of telemental health services provided, and includes any other information that the Secretary may require.

Subsection (g) directs the Secretary to submit a final report to Congress not later than 270 days after the date of termination of the demonstration project. That report will describe the results of the projects funded by grants awarded under this section, including any data available that indicate the number of attempted suicides; evaluate the impact of the telemental health services funded by the grants in reducing the number of completed suicides among Indian youth; evaluate whether the demonstration project should be expanded to provide more than five grants and made a permanent program; and evaluate the benefits of expanding the demonstration project to include urban Indian health organizations.

Subsection (h) authorizes $1.5 million for each of fiscal years 2007 through 2010 for the demonstration program.

COST AND BUDGETARY CONSIDERATIONS

The following cost estimate, as provided by the Congressional Budget Office, dated April 18, 2006, was prepared for S. 2245:

S. 2245—Indian Youth Telemental Health Demonstration Project Act of 2006

S. 2245 would direct the Indian Health Service to conduct a demonstration project to examine the feasibility of using information and communications technology to improve the provision of suicide prevention services to Indian youths. As many as five tribes or tribal organizations would be able to participate in the project, with priority given to those tribes or tribal organizations that have a demonstrated need to address youth suicide or are located in remote areas. The bill would authorize the appropriation of $1.5 million annually for fiscal years 2007 through 2010 for the project.

CBO estimates that implementing S. 2245 would cost less than $500,000 in 2007 and about $6 million over the 2007–2011 period, assuming the appropriation of the authorized amounts. Enacting this bill would have no effect on direct spending or revenues.

This legislation contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act and would impose no costs on State, local, or tribal governments.

The CBO staff contact for this estimate is Eric Rollins. This estimate was approved by Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

EXECUTIVE COMMUNICATIONS

The Committee has not received any executive communications on S. 2245.

REGULATORY AND PAPERWORK IMPACT STATEMENT

Paragraph 11(b) of rule XXVI of the Standing Rules of the Senate requires each report accompanying a bill to evaluate the regulatory and paperwork impact that would be incurred in carrying out the bill. The Committee believes that S. 2245 will have a minimal impact on regulatory or paperwork requirements.

CHANGES IN EXISTING LAW

In compliance with subsection 12 of rule XXVI of the Standing Rules of the Senate, the Committee states that the enactment of S. 2245 will not result in changes in existing law.

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