

108TH CONGRESS
2D SESSION

S. 2634

To amend the Public Health Service Act to support the planning, implementation, and evaluation of organized activities involving statewide youth suicide early intervention and prevention strategies, to provide funds for campus mental and behavioral health service centers, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JULY 8, 2004

Mr. DODD (for himself, Mr. DEWINE, Mr. REED, Mr. SMITH, Mr. REID, Mr. DASCHLE, Mr. FRIST, Mr. KENNEDY, Mrs. CLINTON, Mr. LAUTENBERG, Mr. LEVIN, Mr. KOHL, Ms. STABENOW, Mr. PRYOR, Mrs. HUTCHISON, Mr. DOMENICI, Mr. WARNER, Mr. MCCONNELL, Mr. GRAHAM of South Carolina, Mr. AKAKA, Mr. ROBERTS, Mr. LEAHY, Ms. MURKOWSKI, Mr. HARKIN, Mr. JOHNSON, Mr. BINGAMAN, Mr. JEFFORDS, Mr. LIEBERMAN, Mrs. MURRAY, Mr. DORGAN, Ms. SNOWE, Mr. NICKLES, Mr. CORZINE, Mr. HATCH, Mr. WYDEN, and Mr. DURBIN) introduced the following bill; which was read twice, considered, read the third time, and passed

A BILL

To amend the Public Health Service Act to support the planning, implementation, and evaluation of organized activities involving statewide youth suicide early intervention and prevention strategies, to provide funds for campus mental and behavioral health service centers, and for other purposes.

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 “Garrett Lee Smith Me-
3 morial Act”.

4 **SEC. 2. FINDINGS.**

5 Congress makes the following findings:

6 (1) More children and young adults die from
7 suicide each year than from cancer, heart disease,
8 AIDS, birth defects, stroke, and chronic lung disease
9 combined.

10 (2) Over 4,000 children and young adults trag-
11 ically take their lives every year, making suicide the
12 third overall cause of death between the ages of 10
13 and 24. According to the Centers for Disease Con-
14 trol and Prevention suicide is the third overall cause
15 of death among college-age students.

16 (3) According to the National Center for Injury
17 Prevention and Control of the Centers for Disease
18 Control and Prevention, children and young adults
19 accounted for 15 percent of all suicides completed in
20 2000.

21 (4) From 1952 to 1995, the rate of suicide in
22 children and young adults has tripled.

23 (5) From 1980 to 1997, the rate of suicide
24 among young adults ages 15 to 19 increased 11 per-
25 cent.

1 (6) From 1980 to 1997, the rate of suicide
2 among children ages 10 to 14 increased 109 percent.

3 (7) According to the National Center of Health
4 Statistics, suicide rates among Native Americans
5 range from 1.5 to 3 times the national average for
6 other groups, with young people ages 15 to 34 mak-
7 ing up 64 percent of all suicides.

8 (8) Congress has recognized that youth suicide
9 is a public health tragedy linked to underlying men-
10 tal health problems and that youth suicide early
11 intervention and prevention activities are national
12 priorities.

13 (9) Youth suicide early intervention and preven-
14 tion have been listed as urgent public health prior-
15 ities by the President's New Freedom Commission in
16 Mental Health (2002), the Institute of Medicine's
17 Reducing Suicide: A National Imperative (2002), the
18 National Strategy for Suicide Prevention: Goals and
19 Objectives for Action (2001), and the Surgeon Gen-
20 eral's Call to Action To Prevent Suicide (1999).

21 (10) Many States have already developed com-
22 prehensive Statewide youth suicide early intervention
23 and prevention strategies that seek to provide effec-
24 tive early intervention and prevention services.

1 (11) In a recent report, a startling 85 percent
2 of college counseling centers revealed an increase in
3 the number of students they see with psychological
4 problems. Furthermore, the American College
5 Health Association found that 61 percent of college
6 students reported feeling hopeless, 45 percent said
7 they felt so depressed they could barely function,
8 and 9 percent felt suicidal.

9 (12) There is clear evidence of an increased in-
10 cidence of depression among college students. Ac-
11 cording to a survey described in the Chronicle of
12 Higher Education (February 1, 2002), depression
13 among freshmen has nearly doubled (from 8.2 per-
14 cent to 16.3 percent). Without treatment, research-
15 ers recently noted that “depressed adolescents are at
16 risk for school failure, social isolation, promiscuity,
17 self medication with drugs and alcohol, and sui-
18 cide—now the third leading cause of death among
19 10–24 year olds.”.

20 (13) Researchers who conducted the study
21 “Changes in Counseling Center Client Problems
22 Across 13 Years” (1989–2001) at Kansas State
23 University stated that “students are experiencing
24 more stress, more anxiety, more depression than

1 they were a decade ago.” (The Chronicle of Higher
2 Education, February 14, 2003).

3 (14) According to the 2001 National Household
4 Survey on Drug Abuse, 20 percent of full-time un-
5 dergraduate college students use illicit drugs.

6 (15) The 2001 National Household Survey on
7 Drug Abuse also reported that 18.4 percent of
8 adults aged 18 to 24 are dependent on or abusing
9 illicit drugs or alcohol. In addition, the study found
10 that “serious mental illness is highly correlated with
11 substance dependence or abuse. Among adults with
12 serious mental illness in 2001, 20.3 percent were de-
13 pendent on or abused alcohol or illicit drugs, while
14 the rate among adults without serious mental illness
15 was only 6.3 percent.”.

16 (16) A 2003 Gallagher’s Survey of Counseling
17 Center Directors found that 81 percent were con-
18 cerned about the increasing number of students with
19 more serious psychological problems, 67 percent re-
20 ported a need for more psychiatric services, and 63
21 percent reported problems with growing demand for
22 services without an appropriate increase in re-
23 sources.

24 (17) The International Association of Coun-
25 seling Services accreditation standards recommend 1

1 counselor per 1,000 to 1,500 students. According to
 2 the 2003 Gallagher’s Survey of Counseling Center
 3 Directors, the ratio of counselors to students is as
 4 high as 1 counselor per 2,400 students at institu-
 5 tions of higher education with more than 15,000
 6 students.

7 **SEC. 3. AMENDMENT TO THE PUBLIC HEALTH SERVICES**

8 **ACT.**

9 Title V of the Public Health Service Act (42 U.S.C.
 10 290aa et seq) is amended—

11 (1) in section 520E (42 U.S.C. 290bb–36)—

12 (A) in the section heading by striking
 13 “CHILDREN AND ADOLESCENTS” and in-
 14 serting “YOUTH”;

15 (B) by striking subsection (a) and insert-
 16 ing the following:

17 “(a) IN GENERAL.—The Secretary shall award
 18 grants or cooperative agreements to public organizations,
 19 private nonprofit organizations, political subdivisions, and
 20 Federally recognized Indian tribes or tribal organizations
 21 to implement the State-sponsored statewide or tribal youth
 22 suicide early intervention and prevention strategy as devel-
 23 oped under section 596A.”;

24 (C) in subsection (b), by striking all after
 25 “coordinated” and inserting “with the Strategy

1 for Suicide Prevention Federal Steering Group
2 and the suicide prevention resource center pro-
3 vided for under section 596B.”;

4 (D) in subsection (c)—

5 (i) in the matter preceding paragraph
6 (1), by striking “A State” and all that fol-
7 lows through “desiring” and inserting “A
8 public organization, private nonprofit orga-
9 nization, political subdivision, and Feder-
10 ally recognized Indian tribes or tribal orga-
11 nization desiring”;

12 (ii) by redesignating paragraphs (1)
13 through (9) as paragraphs (2) through
14 (10), respectively;

15 (iii) by inserting before paragraph (2)
16 (as so redesignated), the following:

17 “(1) comply with the State-sponsored statewide
18 early intervention and prevention strategy as devel-
19 oped under section 596A;”;

20 (iv) in paragraph (2) (as so redesign-
21 ated), by striking “children and adoles-
22 cents” and inserting “youth”;

23 (v) in paragraph (3) (as so redesign-
24 ated), by striking “best evidence-based,”;

1 (vi) in paragraph (4) (as so redesignig-
2 nated), by striking “primary” and all that
3 follows and inserting “general, mental, and
4 behavioral health services, and substance
5 abuse services;”;

6 (vii) in paragraph (5) (as so redesignig-
7 nated), by striking “children and” and all
8 that follows and inserting “youth including
9 the school systems, educational institu-
10 tions, juvenile justice system, substance
11 abuse programs, mental health programs,
12 foster care systems, and community child
13 and youth support organizations;”;

14 (viii) by striking paragraph (8) (as so
15 redesignated), and inserting the following:

16 “(8) offer access to services and care to youth
17 with diverse linguistic and cultural backgrounds;”;
18 and

19 (ix) by striking paragraph (9) (as so
20 redesignated), and inserting the following:

21 “(9) conduct annual self-evaluations of out-
22 comes and activities, including consulting with inter-
23 ested families and advocacy organizations;”;

24 (E) by striking subsection (d) and insert-
25 ing the following:

1 “(d) USE OF FUNDS.—Amounts provided under a
 2 grant or cooperative agreement under this section shall be
 3 used to supplement, and not supplant, Federal and non-
 4 Federal funds available for carrying out the activities de-
 5 scribed in this section. Applicants shall provide financial
 6 information to demonstrate compliance with this section.”;

7 (F) in subsection (e)—

8 (i) by striking “contract,”; and

9 (ii) by inserting after “Secretary that
 10 the” the following: “application complies
 11 with the State-sponsored statewide early
 12 intervention and prevention strategy as de-
 13 veloped under section 596A and”;

14 (G) in subsection (f), by striking “con-
 15 tracts,”;

16 (H) in subsection (g)—

17 (i) by striking “A State” and all that
 18 follows through “organization receiving”
 19 and inserting “A public organization, pri-
 20 vate nonprofit organization, political sub-
 21 division, and Federally recognized Indian
 22 tribes or tribal organization receiving”;
 23 and

24 (ii) by striking “contract,” each place
 25 that such appears;

1 (I) in subsection (h), by striking “con-
2 tracts,”;

3 (J) in subsection (i)—

4 (i) by striking “A State” and all that
5 follows through “organization receiving”
6 and inserting “A public organization, pri-
7 vate nonprofit organization, political sub-
8 division, and Federally recognized Indian
9 tribes or tribal organization receiving”;
10 and

11 (ii) by striking “contract,”;

12 (K) in subsection (k), by striking “5
13 years” and inserting “3 years”;

14 (L) in subsection (l)(2), by striking “21”
15 and inserting “24”; and

16 (M) in subsection (m)—

17 (i) by striking “APPROPRIATION.—”
18 and all that follows through “For” in
19 paragraph (1) and inserting “APPROPRIA-
20 TION.—For”; and

21 (ii) by striking paragraph (2);

22 (2) by inserting after part I (42 U.S.C. 290jj
23 et seq), the following:

1 **“PART J—SUICIDE EARLY INTERVENTION AND**
 2 **PREVENTION”;**

3 (3) by redesignating section 520E (42 U.S.C.
 4 290bb–36), as amended by paragraph (1), as section
 5 596 and transferring such section to part J (as
 6 added by paragraph (2)); and

7 (4) by adding at the end of part J (as added
 8 by paragraph (2) and amended by paragraph (3)),
 9 the following:

10 **“SEC. 596A. YOUTH SUICIDE EARLY INTERVENTION AND**
 11 **PREVENTION STRATEGIES, TRAINING, AND**
 12 **TECHNICAL ASSISTANCE.**

13 “(a) YOUTH SUICIDE EARLY INTERVENTION AND
 14 PREVENTION STRATEGIES.—

15 “(1) IN GENERAL.—The Secretary acting
 16 through the Administrator of the Substance Abuse
 17 and Mental Health Services Administration, shall
 18 award grants or cooperative agreements to eligible
 19 entities to—

20 “(A) develop and implement State-spon-
 21 sored statewide or tribal youth suicide early
 22 intervention and prevention strategies in
 23 schools, educational institutions, juvenile justice
 24 systems, substance abuse programs, mental
 25 health programs, foster care systems, and other
 26 child and youth support organizations;

1 “(B) support public organizations and pri-
2 vate nonprofit organizations actively involved in
3 State-sponsored statewide or tribal youth sui-
4 cide early intervention and prevention strategies
5 and in the development and continuation of
6 State-sponsored statewide youth suicide early
7 intervention and prevention strategies;

8 “(C) collect and analyze data on State-
9 sponsored statewide or tribal youth suicide early
10 intervention and prevention services that can be
11 used to monitor the effectiveness of such serv-
12 ices and for research, technical assistance, and
13 policy development; and

14 “(D) assist eligible entities, through State-
15 sponsored statewide or tribal youth suicide early
16 intervention and prevention strategies, in
17 achieving targets for youth suicide reductions
18 under title V of the Social Security Act (42
19 U.S.C. 701 et seq.).

20 “(2) ELIGIBLE ENTITY.—

21 “(A) DEFINITION.—In this subsection, the
22 term ‘eligible entity’ means—

23 “(i) a State;

24 “(ii) a public organization or private
25 nonprofit organization designated by a

1 State to develop or direct the State-spon-
2 sored statewide youth suicide early inter-
3 vention and prevention strategy; and

4 “(iii) a Federally-recognized Indian
5 tribe or tribal organization (as defined in
6 the Indian Self-Determination and Edu-
7 cation Assistance Act) or an urban Indian
8 organization (as defined in the Indian
9 Health Care Improvement Act) that is ac-
10 tively involved in the development and con-
11 tinuation of a tribal youth suicide early
12 intervention and prevention strategy.

13 “(B) PREFERENCE.—In awarding grants
14 and cooperative agreements under this section,
15 the Secretary shall give preference to States
16 that have rates of youth suicide that signifi-
17 cantly exceed the national average as deter-
18 mined by the Centers for Disease Control and
19 Prevention.

20 “(C) LIMITATION.—In carrying out this
21 section, the Secretary shall ensure that each
22 State is awarded only one grant or cooperative
23 agreement under this section. For purposes of
24 the preceding sentence, a State shall be consid-
25 ered to have been awarded a grant or coopera-

1 tive agreement if the eligible entity involved is
2 the State or an entity designated by the State
3 under subparagraph (A)(ii). Nothing in this
4 subparagraph shall be construed to apply to en-
5 tities described in subparagraph (A)(iii).

6 “(3) PREFERENCE.—In providing assistance
7 under a grant or cooperative agreement under this
8 subsection, an eligible entity shall give preference to
9 public organizations, private nonprofit organizations,
10 political subdivisions, and tribal organizations ac-
11 tively involved with the State-sponsored statewide or
12 tribal youth suicide early intervention and prevention
13 strategy that—

14 “(A) provide early intervention and assess-
15 ment services, including screening programs, to
16 youth who are at risk for mental or emotional
17 disorders that may lead to a suicide attempt,
18 and that are integrated with, school systems,
19 educational institutions, juvenile justice sys-
20 tems, substance abuse programs, mental health
21 programs, foster care systems, and other child
22 and youth support organizations;

23 “(B) demonstrate collaboration among
24 early intervention and prevention services or

1 certify that entities will engage in future col-
2 laboration;

3 “(C) employ or include in their applica-
4 tions a commitment to evaluate youth suicide
5 early intervention and prevention practices and
6 strategies adapted to the local community;

7 “(D) provide timely referrals for appro-
8 priate community-based mental health care and
9 treatment of youth who are at risk for suicide
10 in child-serving settings and agencies;

11 “(E) provide immediate support and infor-
12 mation resources to families of youth who are
13 at risk for suicide;

14 “(F) offer access to services and care to
15 youth with diverse linguistic and cultural back-
16 grounds;

17 “(G) offer appropriate post-suicide inter-
18 vention services, care, and information to fami-
19 lies, friends, schools, educational institutions,
20 juvenile justice systems, substance abuse pro-
21 grams, mental health programs, foster care sys-
22 tems, and other child and youth support organi-
23 zations of youth who recently completed suicide;

24 “(H) offer continuous and up-to-date in-
25 formation and awareness campaigns that target

1 parents, family members, child care profes-
2 sionals, community care providers, and the gen-
3 eral public and highlight the risk factors associ-
4 ated with youth suicide and the life-saving help
5 and care available from early intervention and
6 prevention services;

7 “(I) ensure that information and aware-
8 ness campaigns on youth suicide risk factors,
9 and early intervention and prevention services,
10 use effective communication mechanisms that
11 are targeted to and reach youth, families,
12 schools, educational institutions, and youth or-
13 ganizations;

14 “(J) provide a timely response system to
15 ensure that child-serving professionals and pro-
16 viders are properly trained in youth suicide
17 early intervention and prevention strategies and
18 that child-serving professionals and providers
19 involved in early intervention and prevention
20 services are properly trained in effectively iden-
21 tifying youth who are at risk for suicide;

22 “(K) provide continuous training activities
23 for child care professionals and community care
24 providers on the latest youth suicide early inter-

1 vention and prevention services practices and
2 strategies;

3 “(L) conduct annual self-evaluations of
4 outcomes and activities, including consulting
5 with interested families and advocacy organiza-
6 tions; and

7 “(M) provide services in areas or regions
8 with rates of youth suicide that exceed the na-
9 tional average as determined by the Centers for
10 Disease Control and Prevention.

11 “(4) REQUIREMENT FOR DIRECT SERVICES.—
12 Not less than 85 percent of grant funds received
13 under this subsection shall be used to provide direct
14 services.

15 “(b) SUICIDE PREVENTION RESOURCE CENTER;
16 TRAINING AND TECHNICAL ASSISTANCE.—

17 “(1) OPERATION OF CENTER.—The Secretary,
18 acting through the Administrator of the Substance
19 Abuse and Mental Health Services Administration
20 and in consultation with the National Strategy for
21 Suicide Prevention Federal Steering Group, shall
22 award a competitive grant or contract to a public or
23 private nonprofit entity for the establishment of a
24 Suicide Prevention Resource Center to carry out the
25 activities described in paragraph (3).

1 “(2) APPLICATION.—To be eligible for a grant
2 or contract under paragraph (1), an entity shall pre-
3 pare and submit to the Secretary an application at
4 such time, in such manner, and containing such in-
5 formation as the Secretary may require.

6 “(3) AUTHORIZED ACTIVITIES.—The Suicide
7 Prevention Resource Center shall provide appro-
8 priate information, training, and technical assistance
9 to States, political subdivisions of a State, Federally
10 recognized Indian tribes, tribal organizations, public
11 organizations, or private nonprofit organizations
12 for—

13 “(A) the development or continuation of
14 statewide or tribal youth suicide early interven-
15 tion and prevention strategies;

16 “(B) ensuring the surveillance of youth
17 suicide early intervention and prevention strate-
18 gies;

19 “(C) studying the costs and effectiveness
20 of statewide youth suicide early intervention
21 and prevention strategies in order to provide in-
22 formation concerning relevant issues of impor-
23 tance to State, tribal, and national policy-
24 makers;

1 “(D) further identifying and understanding
2 causes and associated risk factors for youth sui-
3 cide;

4 “(E) analyzing the efficacy of new and ex-
5 isting youth suicide early intervention tech-
6 niques and technology;

7 “(F) ensuring the surveillance of suicidal
8 behaviors and nonfatal suicidal attempts;

9 “(G) studying the effectiveness of State-
10 sponsored statewide and tribal youth suicide
11 early intervention and prevention strategies on
12 the overall wellness and health promotion strat-
13 egies related to suicide attempts;

14 “(H) promoting the sharing of data re-
15 garding youth suicide with Federal agencies in-
16 volved with youth suicide early intervention and
17 prevention, and State-sponsored statewide or
18 tribal youth suicide early intervention and pre-
19 vention strategies for the purpose of identifying
20 previously unknown mental health causes and
21 associated risk-factors for suicide in youth; and

22 “(I) other activities determined appropriate
23 by the Secretary.

24 “(4) AUTHORIZATION OF APPROPRIATIONS.—

25 There is authorized to be appropriated to carry out

1 this subsection, \$3,000,000 for fiscal year 2005,
2 \$4,000,000 for fiscal year 2006, and \$5,000,000 for
3 fiscal year 2007.

4 “(c) COORDINATION AND COLLABORATION.—

5 “(1) IN GENERAL.—In carrying out this sec-
6 tion, the Secretary shall collaborate with the Na-
7 tional Strategy for Suicide Prevention Federal Steer-
8 ing Group and other Federal agencies responsible
9 for early intervention and prevention services relat-
10 ing to youth suicide.

11 “(2) CONSULTATION.—In carrying out this sec-
12 tion, the Secretary shall consult with—

13 “(A) State and local agencies, including
14 agencies responsible for early intervention and
15 prevention services under title XIX of the So-
16 cial Security Act (42 U.S.C. 1396 et seq.), the
17 State Children’s Health Insurance Program
18 under title XXI of the Social Security Act (42
19 U.S.C. 1397aa et seq.), programs funded by
20 grants under title V of the Social Security Act
21 (42 U.S.C. 701 et seq.), and programs under
22 part C of the Individuals with Disabilities Edu-
23 cation Act (20 U.S.C. 1431 et seq.);

1 “(B) local and national organizations that
2 serve youth at risk for suicide and their fami-
3 lies;

4 “(C) relevant national medical and other
5 health and education specialty organizations;

6 “(D) youth who are at risk for suicide,
7 who have survived suicide attempts, or who are
8 currently receiving care from early intervention
9 services;

10 “(E) families and friends of youth who are
11 at risk for suicide, who have survived suicide at-
12 tempts, who are currently receiving care from
13 early intervention and prevention services, or
14 who have completed suicide;

15 “(F) qualified professionals who possess
16 the specialized knowledge, skills, experience,
17 and relevant attributes needed to serve youth at
18 risk for suicide and their families; and

19 “(G) third-party payers, managed care or-
20 ganizations, and related commercial industries.

21 “(3) POLICY DEVELOPMENT.—The Secretary
22 shall—

23 “(A) coordinate and collaborate on policy
24 development at the Federal level with the Na-

1 tional Strategy for Suicide Prevention Federal
2 Steering Group; and

3 “(B) consult on policy development at the
4 Federal level with the private sector, including
5 consumer, medical, suicide prevention advocacy
6 groups, and other health and education profes-
7 sional-based organizations, with respect to
8 State-sponsored statewide or tribal youth sui-
9 cide early intervention and prevention strate-
10 gies.

11 “(d) RULE OF CONSTRUCTION; RELIGIOUS ACCOM-
12 MODATION.—Nothing in this section shall be construed to
13 preempt any State law, including any State law that does
14 not require the suicide early intervention for youth whose
15 parents or legal guardians object to such early interven-
16 tion based on the parents’ or legal guardians’ religious be-
17 liefs.

18 “(e) EVALUATIONS AND REPORT.—

19 “(1) EVALUATIONS BY ELIGIBLE ENTITIES.—
20 Not later than 18 months after receiving a grant or
21 cooperative agreement under subsection (a), an eligi-
22 ble entity shall submit to the Secretary the results
23 of an evaluation to be conducted by the entity con-
24 cerning the effectiveness of the activities carried out
25 under the grant or agreement.

1 “(b) PROGRAM AUTHORIZED.—From funds appro-
2 priated under subsection (j), the Secretary shall award
3 competitive grants to institutions of higher education to
4 create or expand mental and behavioral health services to
5 students at such institutions, to provide such services, and
6 to develop best practices for the delivery of such services.
7 Such grants shall, subject to the availability of such appro-
8 priations, be for a period of 3 years.

9 “(c) ELIGIBLE GRANT RECIPIENTS.—Any institution
10 of higher education that seeks to provide, or provides,
11 mental and behavioral health services to students is eligi-
12 ble to apply for a grant under this section. Services may
13 be provided at—

14 “(1) college counseling centers;

15 “(2) college and university psychological service
16 centers;

17 “(3) mental health centers;

18 “(4) psychology training clinics; and

19 “(5) institution of higher education supported,
20 evidence-based, mental health and substance abuse
21 screening programs.

22 “(d) APPLICATIONS.—Each institution of higher edu-
23 cation seeking to obtain a grant under this section shall
24 submit an application to the Secretary. Each such applica-
25 tion shall include—

1 “(1) a description of identified mental and be-
2 havioral health needs of students at the institution
3 of higher education;

4 “(2) a description of currently available Fed-
5 eral, State, local, private, and institutional resources
6 to address the needs described in paragraph (1) at
7 the institution of higher education;

8 “(3) an outline of program objectives and an-
9 ticipated program outcomes, including an expla-
10 nation of how the treatment provider at the institu-
11 tion of higher education will coordinate activities
12 under this section with existing programs and serv-
13 ices;

14 “(4) the anticipated impact of funds provided
15 under this section in improving the mental and be-
16 havioral health of students attending the institution
17 of higher education;

18 “(5) outreach strategies, including ways in
19 which the treatment provider at the institution of
20 higher education proposes to reach students, pro-
21 mote access to services, and address the range of
22 needs of students;

23 “(6) a proposed plan for reaching those stu-
24 dents most in need of services;

1 “(7) a plan to evaluate program outcomes and
2 assess the services provided with funds under this
3 section;

4 “(8) financial information concerning the appli-
5 cant to demonstrate compliance with subsection (h);
6 and

7 “(9) such additional information as is required
8 by the Secretary.

9 “(e) PEER REVIEW OF APPLICATIONS.—The Sec-
10 retary, in consultation with the Secretary of Education,
11 shall provide the applications submitted under this section
12 to a peer review panel for evaluation. With respect to each
13 application, the peer review panel shall recommend the ap-
14 plication for funding or for disapproval.

15 “(f) USE OF FUNDS.—Funds provided by a grant
16 under this section may be used for 1 or more of the fol-
17 lowing activities:

18 “(1) Prevention, screening, early intervention,
19 assessment, treatment, management, and education
20 of mental and behavioral health problems that can
21 lead to school failure, such as depression, substance
22 abuse, and suicide attempts by students enrolled at
23 the institution of higher education.

24 “(2) Education of families to increase aware-
25 ness of potential mental and behavioral health issues

1 of students enrolled at the institution of higher edu-
2 cation.

3 “(3) Hiring staff trained to identify and treat
4 mental and behavioral health problems, including
5 residents and interns such as those in psychological
6 doctoral and post doctoral programs.

7 “(4) Evaluating and disseminating outcomes
8 and best practices of mental and behavioral health
9 services.

10 “(g) ADDITIONAL REQUIRED ELEMENTS.—Each in-
11 stitution of higher education that receives a grant under
12 this section shall—

13 “(1) provide annual reports to the Secretary de-
14 scribing the use of funds, the program’s objectives,
15 and how the objectives were met, including a descrip-
16 tion of program outcomes;

17 “(2) perform such additional evaluations as the
18 Secretary may require, which may include—

19 “(A) increases in range of services pro-
20 vided;

21 “(B) increases in the quality of services
22 provided;

23 “(C) increases in access to services;

24 “(D) college continuation rates;

25 “(E) decreases in college dropout rates;

1 “(F) increases in college graduation rates;
2 and

3 “(G) accepted and valid measurements and
4 assessments of improved mental health
5 functionality; and

6 “(3) coordinate such institution’s program
7 under this section with other related efforts on cam-
8 pus by entities concerned with the general mental
9 and behavioral health needs of students.

10 “(h) SUPPLEMENT NOT SUPPLANT.—Grant funds
11 provided under this section shall be used to supplement,
12 and not supplant, Federal and non-Federal funds available
13 for carrying out the activities described in this section.
14 Grantees shall provide financial information to dem-
15 onstrate compliance with this subsection.

16 “(i) REQUIREMENT FOR DIRECT SERVICES AND LIM-
17 ITATIONS.—

18 “(1) DIRECT SERVICES.—Not less than 75 per-
19 cent of grant funds received under this section shall
20 be used to provide direct services.

21 “(2) ADMINISTRATIVE COSTS.—Not more than
22 5 percent of grant funds received under this section
23 shall be used for administrative costs.

24 “(3) PROHIBITION ON USE FOR CONSTRUCTION
25 OR RENOVATION.—Grant funds received under this

1 section shall not be used for construction or renova-
2 tion of facilities or buildings.

3 “(j) AUTHORIZATION OF APPROPRIATIONS.—There
4 are authorized to be appropriated for grants under this
5 section, \$5,000,000 for fiscal year 2005, \$7,000,000 for
6 fiscal year 2006, \$10,000,000 for fiscal year 2007, and
7 such sums as may be necessary for each fiscal years 2008
8 and 2009.

9 **“SEC. 596C. DEFINITIONS.**

10 “In this part:

11 “(1) EARLY INTERVENTION.—The term ‘early
12 intervention’ means a strategy or approach that is
13 intended to prevent an outcome or to alter the
14 course of an existing condition.

15 “(2) EDUCATIONAL INSTITUTION; INSTITUTION
16 OF HIGHER EDUCATION; SCHOOL.—The term—

17 “(A) ‘educational institution’ means a
18 school or institution of higher education;

19 “(B) ‘institution of higher education’ has
20 the meaning given such term in section 101 of
21 the Higher Education Act of 1965; and

22 “(C) ‘school’ means an elementary or sec-
23 ondary school (as such terms are defined in sec-
24 tion 901 of the Elementary and Secondary
25 Education Act of 1965).

1 “(3) PREVENTION.—The term ‘prevention’
2 means a strategy or approach that reduces the likeli-
3 hood or risk of onset, or delays the onset, of adverse
4 health problems.

5 “(4) YOUTH.—The term ‘youth’ means individ-
6 uals who are between 6 and 24 years of age.”.

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