

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

“(2) Over 4,000 children and young adults tragically take their lives every year, making suicide the third overall cause of death between the ages of 10 and 24. According to the Centers for Disease Control and Prevention, suicide is the third overall cause of death among college-age students.

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

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

“(5) From 1980 to 1997, the rate of suicide among young adults ages 15 to 19 increased 11 percent.

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

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

“(8) Congress has recognized that youth suicide is a public health tragedy linked to underlying mental health problems and that youth suicide early intervention and prevention activities are national priorities.

“(9) Youth suicide early intervention and prevention have been listed as urgent public health priorities by the President’s New Freedom Commission in [probably should be “on”] Mental Health (2002), the Institute of Medicine’s Reducing Suicide: A National Imperative (2002), the National Strategy for Suicide Prevention: Goals and Objectives for Action (2001), and the Surgeon General’s Call to Action To Prevent Suicide (1999).

“(10) Many States have already developed comprehensive statewide youth suicide early intervention and prevention strategies that seek to provide effective early intervention and prevention services.

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

“(12) There is clear evidence of an increased incidence of depression among college students. According to a survey described in the Chronicle of Higher Education (February 1, 2002), depression among freshmen has nearly doubled (from 8.2 percent to 16.3 percent). Without treatment, researchers recently noted that ‘depressed adolescents are at risk for school failure, social isolation, promiscuity, self-medication with drugs and alcohol, and suicide—now the third leading cause of death among 10–24 year olds.’

“(13) Researchers who conducted the study ‘Changes in Counseling Center Client Problems Across 13 Years’ (1989–2001) at Kansas State University stated that ‘students are experiencing more stress, more anxiety, more depression than they were a decade ago.’ (The Chronicle of Higher Education, February 14, 2003).

“(14) According to the 2001 National Household Survey on Drug Abuse, 20 percent of full-time undergraduate college students use illicit drugs.

“(15) The 2001 National Household Survey on Drug Abuse also reported that 18.4 percent of adults aged 18 to 24 are dependent on or abusing illicit drugs or alcohol. In addition, the study found that ‘serious mental illness is highly correlated with substance dependence or abuse. Among adults with serious mental illness in 2001, 20.3 percent were dependent on or abused alcohol or illicit drugs, while the rate among adults without serious mental illness was only 6.3 percent.’

“(16) A 2003 Gallagher’s Survey of Counseling Center Directors found that 81 percent were concerned about the increasing number of students with more serious psychological problems, 67 percent reported a need for more psychiatric services, and 63 percent reported problems with growing demand for services without an appropriate increase in resources.

“(17) The International Association of Counseling Services accreditation standards recommend 1 counselor per 1,000 to 1,500 students. According to the 2003 Gallagher’s Survey of Counseling Center Directors, the ratio of counselors to students is as high as 1 counselor per 2,400 students at institutions of higher education with more than 15,000 students.”

§ 290bb-36a. Suicide prevention for youth

(a) In general

The Secretary shall award grants or cooperative agreements to public organizations, private nonprofit organizations, political subdivisions, consortia of political subdivisions, consortia of States, or Federally recognized Indian tribes or tribal organizations to design early intervention and prevention strategies that will complement the State-sponsored statewide or tribal youth suicide early intervention and prevention strategies developed pursuant to section 290bb-36 of this title.

(b) Collaboration

In carrying out subsection (a) of this section, the Secretary shall ensure that activities under this section are coordinated with the relevant Department of Health and Human Services agencies and suicide working groups.

(c) Requirements

A public organization, private nonprofit organization, political subdivision, consortium of political subdivisions, consortium of States, or federally recognized Indian tribe or tribal organization desiring a grant, contract, or cooperative agreement under this section shall demonstrate that the suicide prevention program such entity proposes will—

(1)(A) comply with the State-sponsored statewide early intervention and prevention strategy as developed under section 290bb-36 of this title; and

(B) in the case of a consortium of States, receive the support of all States involved;

(2) provide for the timely assessment, treatment, or referral for mental health or substance abuse services of youth at risk for suicide;

(3) be based on suicide prevention practices and strategies that are adapted to the local community;

(4) integrate its suicide prevention program into the existing health care system in the community including general, mental, and behavioral health services, and substance abuse services;

(5) be integrated into other systems in the community that address the needs of youth including the school systems, educational institutions, juvenile justice system, substance abuse programs, mental health programs, foster care systems, and community child and youth support organizations;

(6) use primary prevention methods to educate and raise awareness in the local community by disseminating evidence-based information about suicide prevention;

(7) include suicide prevention, mental health, and related information and services for the families and friends of those who completed suicide, as needed;

(8) offer access to services and care to youth with diverse linguistic and cultural backgrounds;

(9) conduct annual self-evaluations of outcomes and activities, including consulting with interested families and advocacy organizations;¹

(10) ensure that staff used in the program are trained in suicide prevention and that professionals involved in the system of care have received training in identifying persons at risk of suicide.

(d) Use of funds

Amounts provided under a grant or cooperative agreement under this section shall be used to supplement, and not supplant, Federal and non-Federal funds available for carrying out the activities described in this section. Applicants shall provide financial information to demonstrate compliance with this section.

(e) Condition

An applicant for a grant or cooperative agreement under subsection (a) of this section shall demonstrate to the Secretary that the application complies with the State-sponsored statewide early intervention and prevention strategy as developed under section 290bb-36 of this title and the applicant has the support of the local community and relevant public health officials.

(f) Special populations

In awarding grants and cooperative agreements under subsection (a) of this section, the Secretary shall ensure that such awards are made in a manner that will focus on the needs of communities or groups that experience high or rapidly rising rates of suicide.

(g) Application

A public organization, private nonprofit organization, political subdivision, consortium of political subdivisions, consortium of States, or Federally recognized Indian tribe or tribal organization receiving a grant or cooperative agreement under subsection (a) of this section shall prepare and submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may reasonably require. Such application shall include a plan for the rigorous evaluation of activities funded under the grant or cooperative agreement, including a process and outcome evaluation.

(h) Distribution of awards

In awarding grants and cooperative agreements under subsection (a) of this section, the Secretary shall ensure that such awards are distributed among the geographical regions of the United States and between urban and rural settings.

(i) Evaluation

A public organization, private nonprofit organization, political subdivision, consortium of po-

litical subdivisions, consortium of States, or Federally recognized Indian tribe or tribal organization receiving a grant or cooperative agreement under subsection (a) of this section shall prepare and submit to the Secretary at the end of the program period, an evaluation of all activities funded under this section.

(j) Dissemination and education

The Secretary shall ensure that findings derived from activities carried out under this section are disseminated to State, county and local governmental agencies and public and private nonprofit organizations active in promoting suicide prevention and family support activities.

(k) Duration of projects

With respect to a grant, contract, or cooperative agreement awarded under this section, the period during which payments under such award may be made to the recipient may not exceed 3 years.

(l) Study

Within 1 year after October 17, 2000, the Secretary shall, directly or by grant or contract, initiate a study to assemble and analyze data to identify—

- (1) unique profiles of children under 13 who attempt or complete suicide;
- (2) unique profiles of youths between ages 13 and 24 who attempt or complete suicide; and
- (3) a profile of services available to these groups and the use of these services by children and youths from paragraphs (1) and (2).

(m) Definitions

In this section, the terms “early intervention”, “educational institution”, “institution of higher education”, “prevention”, “school”, and “youth” have the meanings given to those terms in section 290bb-36 of this title.

(n) Authorization of appropriation

For purposes of carrying out this section, there is authorized to be appropriated \$75,000,000 for fiscal year 2001 and such sums as may be necessary for each of the fiscal years 2002 through 2003.

(July 1, 1944, ch. 373, title V, §520E-1, formerly §520E, as added Pub. L. 106-310, div. B, title XXXI, §3111, Oct. 17, 2000, 114 Stat. 1186; renumbered §520E-1 and amended Pub. L. 108-355, §3(b), Oct. 21, 2004, 118 Stat. 1407.)

CODIFICATION

Section was formerly classified to section 290bb-36 of this title prior to renumbering by Pub. L. 108-355.

AMENDMENTS

2004—Pub. L. 108-355, §3(b)(1)(A), substituted “youth” for “children and adolescents” in section catchline.

Subsec. (a). Pub. L. 108-355, §3(b)(1)(B), added subsec. (a) and struck out heading and text of former subsec. (a). Text read as follows: “The Secretary shall award grants, contracts, or cooperative agreements to States, political subdivisions of States, Indian tribes, tribal organizations, public organizations, or private nonprofit organizations to establish programs to reduce suicide deaths in the United States among children and adolescents.”

Subsec. (b). Pub. L. 108-355, §3(b)(1)(C), substituted “with the relevant Department of Health and Human Services agencies and suicide working groups.” for

¹ So in original. Probably should be followed by “and”.

“among the Substance Abuse and Mental Health Services Administration, the relevant institutes at the National Institutes of Health, the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the Administration on Children and Families.”

Subsec. (c). Pub. L. 108-355, §3(b)(1)(D)(i), substituted “A public organization, private nonprofit organization, political subdivision, consortium of political subdivisions, consortium of States, or federally recognized Indian tribe or tribal organization desiring” for “A State, political subdivision of a State, Indian tribe, tribal organization, public organization, or private nonprofit organization desiring” in introductory provisions.

Subsec. (c)(1). Pub. L. 108-355, §3(b)(1)(D)(iii), added par. (1). Former par. (1) redesignated (2).

Subsec. (c)(2). Pub. L. 108-355, §3(b)(1)(D)(ii), (iv), redesignated par. (1) as (2) and substituted “youth” for “children and adolescents”. Former par. (2) redesignated (3).

Subsec. (c)(3). Pub. L. 108-355, §3(b)(1)(D)(ii), (v), redesignated par. (2) as (3) and struck out “best evidence-based,” after “based on”. Former par. (3) redesignated (4).

Subsec. (c)(4). Pub. L. 108-355, §3(b)(1)(D)(ii), (vi), redesignated par. (3) as (4) and substituted “general, mental, and behavioral health services, and substance abuse services;” for “primary health care, mental health services, and substance abuse services;”. Former par. (4) redesignated (5).

Subsec. (c)(5). Pub. L. 108-355, §3(b)(1)(D)(ii), (vii), redesignated par. (4) as (5) and substituted “youth including the school systems, educational institutions, juvenile justice system, substance abuse programs, mental health programs, foster care systems, and community child and youth support organizations;” for “children and adolescents including the educational system, juvenile justice system, welfare and child protection systems, and community youth support organizations;”. Former par. (5) redesignated (6).

Subsec. (c)(6), (7). Pub. L. 108-355, §3(b)(1)(D)(ii), redesignated pars. (5) and (6) as (6) and (7), respectively. Former par. (7) redesignated (8).

Subsec. (c)(8). Pub. L. 108-355, §3(b)(1)(D)(viii), added par. (8) and struck out former par. (8) which read as follows: “provide linguistically appropriate and culturally competent services, as needed;”.

Pub. L. 108-355, §3(b)(1)(D)(ii), redesignated par. (7) as (8). Former par. (8) redesignated (9).

Subsec. (c)(9). Pub. L. 108-355, §3(b)(1)(D)(ix), added par. (9) and struck out former par. (9) which read as follows: “provide a plan for the evaluation of outcomes and activities at the local level, according to standards established by the Secretary, and agree to participate in a national evaluation; and”.

Pub. L. 108-355, §3(b)(1)(D)(ii), redesignated par. (8) as (9). Former par. (9) redesignated (10).

Subsec. (c)(10). Pub. L. 108-355, §3(b)(1)(D)(ii), redesignated par. (9) as (10).

Subsec. (d). Pub. L. 108-355, §3(b)(1)(E), added subsec. (d) and struck out heading and text of former subsec. (d). Text read as follows: “Amounts provided under grants, contracts, or cooperative agreements under subsection (a) of this section shall be used to supplement and not supplant other Federal, State, and local public funds that are expended to provide services for eligible individuals.”

Subsec. (e). Pub. L. 108-355, §3(b)(1)(F), struck out “, contract,” after “grant” and inserted “application complies with the State-sponsored statewide early intervention and prevention strategy as developed under section 290bb-36 of this title and the” after “Secretary that the”.

Subsec. (f). Pub. L. 108-355, §3(b)(1)(G), struck out “, contracts,” after “grants”.

Subsec. (g). Pub. L. 108-355, §3(b)(1)(H), substituted “A public organization, private nonprofit organization, political subdivision, consortium of political subdivisions, consortium of States, or Federally recognized Indian tribe or tribal organization receiving” for “A

State, political subdivision of a State, Indian tribe, tribal organization, public organization, or private nonprofit organization receiving” and struck out “, contract,” after “grant” in two places.

Subsec. (h). Pub. L. 108-355, §3(b)(1)(I), struck out “, contracts,” after “grants”.

Subsec. (i). Pub. L. 108-355, §3(b)(1)(J), substituted “A public organization, private nonprofit organization, political subdivision, consortium of political subdivisions, consortium of States, or Federally recognized Indian tribe or tribal organization receiving” for “A State, political subdivision of a State, Indian tribe, tribal organization, public organization, or private nonprofit organization receiving” and struck out “, contract,” after “grant”.

Subsec. (k). Pub. L. 108-355, §3(b)(1)(K), substituted “3 years” for “5 years”.

Subsec. (l)(2). Pub. L. 108-355, §3(b)(1)(L)(i), substituted “24” for “21”.

Subsec. (l)(3). Pub. L. 108-355, §3(b)(1)(L)(ii), struck out “which might have been” after “profile of services”.

Subsec. (m). Pub. L. 108-355, §3(b)(1)(O), added subsec. (m). Former subsec. (m) redesignated (n).

Pub. L. 108-355, §3(b)(1)(M), struck out par. (1) designation and heading and struck out heading and text of par. (2). Text read as follows: “In carrying out this section, the Secretary shall use 1 percent of the amount appropriated under paragraph (1) for each fiscal year for managing programs under this section.”

Subsec. (n). Pub. L. 108-355, §3(b)(1)(N), redesignated subsec. (m) as (n).

TEEN SUICIDE PREVENTION STUDY

Pub. L. 106-386, div. B, title VI, §1602, Oct. 28, 2000, 114 Stat. 1538, provided that:

“(a) SHORT TITLE.—This section may be cited as the ‘Teen Suicide Prevention Act of 2000’.

“(b) FINDINGS.—Congress finds that—

“(1) measures that increase public awareness of suicide as a preventable public health problem, and target parents and youth so that suicide risks and warning signs can be recognized, will help to eliminate the ignorance and stigma of suicide as barriers to youth and families seeking preventive care;

“(2) suicide prevention efforts in the year 2000 should—

“(A) target at-risk youth, particularly youth with mental health problems, substance abuse problems, or contact with the juvenile justice system;

“(B) involve—

“(i) the identification of the characteristics of the at-risk youth and other youth who are contemplating suicide, and barriers to treatment of the youth; and

“(ii) the development of model treatment programs for the youth;

“(C) include a pilot study of the outcomes of treatment for juvenile delinquents with mental health or substance abuse problems;

“(D) include a public education approach to combat the negative effects of the stigma of, and discrimination against individuals with, mental health and substance abuse problems; and

“(E) include a nationwide effort to develop, implement, and evaluate a mental health awareness program for schools, communities, and families;

“(3) although numerous symptoms, diagnoses, traits, characteristics, and psychosocial stressors of suicide have been investigated, no single factor or set of factors has ever come close to predicting suicide with accuracy;

“(4) research of United States youth, such as a 1994 study by Lewinsohn, Rohde, and Seeley, has shown predictors of suicide, such as a history of suicide attempts, current suicidal ideation and depression, a recent attempt or completed suicide by a friend, and low self-esteem; and

“(5) epidemiological data illustrate—

“(A) the trend of suicide at younger ages as well as increases in suicidal ideation among youth in the United States; and

“(B) distinct differences in approaches to suicide by gender, with—

“(i) 3 to 5 times as many females as males attempting suicide; and

“(ii) 3 to 5 times as many males as females completing suicide.

“(c) PURPOSE.—The purpose of this section is to provide for a study of predictors of suicide among at-risk and other youth, and barriers that prevent the youth from receiving treatment, to facilitate the development of model treatment programs and public education and awareness efforts.

“(d) STUDY.—Not later than 1 year after the date of the enactment of this Act [Oct. 28, 2000], the Secretary of Health and Human Services shall carry out, directly or by grant or contract, a study that is designed to identify—

“(1) the characteristics of at-risk and other youth age 13 through 21 who are contemplating suicide;

“(2) the characteristics of at-risk and other youth who are younger than age 13 and are contemplating suicide; and

“(3) the barriers that prevent youth described in paragraphs (1) and (2) from receiving treatment.

“(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary.”

[For definition of “youth” as used in section 1602 of Pub. L. 106-386, set out above, see section 1002 of Pub. L. 106-386, set out as a note under section 3796gg-2 of this title.]

§ 290bb-36b. Mental and behavioral health services on campus

(a) In general

The Secretary, acting through the Director of the Center for Mental Health Services, in consultation with the Secretary of Education, may award grants on a competitive basis to institutions of higher education to enhance services for students with mental and behavioral health problems that can lead to school failure, such as depression, substance abuse, and suicide attempts, so that students will successfully complete their studies.

(b) Use of funds

The Secretary may not make a grant to an institution of higher education under this section unless the institution agrees to use the grant only for—

(1) educational seminars;

(2) the operation of hot lines;

(3) preparation of informational material;

(4) preparation of educational materials for families of students to increase awareness of potential mental and behavioral health issues of students enrolled at the institution of higher education;

(5) training programs for students and campus personnel to respond effectively to students with mental and behavioral health problems that can lead to school failure, such as depression, substance abuse, and suicide attempts; or

(6) the creation of a networking infrastructure to link colleges and universities that do not have mental health services with health care providers who can treat mental and behavioral health problems.

(c) Eligible grant recipients

Any institution of higher education receiving a grant under this section may carry out activities under the grant through—

(1) college counseling centers;

(2) college and university psychological service centers;

(3) mental health centers;

(4) psychology training clinics; or

(5) institution of higher education supported, evidence-based, mental health and substance abuse programs.

(d) Application

An institution of higher education desiring a grant under this section shall prepare and submit an application to the Secretary at such time and in such manner as the Secretary may require. At a minimum, the application shall include the following:

(1) A description of identified mental and behavioral health needs of students at the institution of higher education.

(2) A description of Federal, State, local, private, and institutional resources currently available to address the needs described in paragraph (1) at the institution of higher education.

(3) A description of the outreach strategies of the institution of higher education for promoting access to services, including a proposed plan for reaching those students most in need of mental health services.

(4) A plan to evaluate program outcomes, including a description of the proposed use of funds, the program objectives, and how the objectives will be met.

(5) An assurance that the institution will submit a report to the Secretary each fiscal year on the activities carried out with the grant and the results achieved through those activities.

(e) Requirement of matching funds

(1) In general

The Secretary may make a grant under this section to an institution of higher education only if the institution agrees to make available (directly or through donations from public or private entities) non-Federal contributions in an amount that is not less than \$1 for each \$1 of Federal funds provided in the grant, toward the costs of activities carried out with the grant (as described in subsection (b) of this section) and other activities by the institution to reduce student mental and behavioral health problems.

(2) Determination of amount contributed

Non-Federal contributions required under paragraph (1) may be in cash or in kind. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

(3) Waiver

The Secretary may waive the requirement established in paragraph (1) with respect to an institution of higher education if the Secretary determines that extraordinary need at the institution justifies the waiver.

(f) Reports

For each fiscal year that grants are awarded under this section, the Secretary shall conduct a