Committee on Natural Resources of the House of Representatives a report that describes the means and extent to which the Secretary has carried out paragraph (1).

(d) Coordination

(1) In general

The Secretary, in coordination with the Attorney General, Federal and tribal law enforcement agencies, Indian health programs, and domestic violence or sexual assault victim organizations, shall develop appropriate victim services and victim advocate training programs—

(A) to improve domestic violence or sexual abuse responses;

(B) to improve forensic examinations and collection;

(C) to identify problems or obstacles in the prosecution of domestic violence or sexual abuse; and

(D) to meet other needs or carry out other activities required to prevent, treat, and improve prosecutions of domestic violence and sexual abuse.

(2) Report

Not later than 2 years after March 23, 2010, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources of the House of Representatives a report that describes, with respect to the matters described in paragraph (1), the improvements made and needed, problems or obstacles identified, and costs necessary to address the problems or obstacles, and any other recommendations that the Secretary determines to be appropriate.

(Pub. L. 94–437, title VII, §714, as added Pub. L. 111–148, title X, §10221(a), Mar. 23, 2010, 124 Stat. 935.)

CODIFICATION

Section 714 of Pub. L. 94–437 is based on section 181 of title I of S. 1790, One Hundred Eleventh Congress, as reported by the Committee on Indian Affairs of the Senate in Dec. 2009, which was enacted into law by section 10221(a) of Pub. L. 111–148.

PRIOR PROVISIONS

A prior section 1665m, Pub. L. 94–437, title VII, §714, as added Pub. L. 102–573, title VII, §702(a), Oct. 29, 1992, 106 Stat. 4581, authorized appropriations through fiscal year 2000 to carry out this subchapter, prior to the general amendment of this subchapter by Pub. L. 111–148.

§ 1665n. Behavioral health research

(a) In general

The Secretary, in consultation with appropriate Federal agencies, shall make grants to, or enter into contracts with, Indian tribes, tribal organizations, and urban Indian organizations or enter into contracts with, or make grants to appropriate institutions for, the conduct of research on the incidence and prevalence of behavioral health problems among Indians served by the Service, Indian tribes, or tribal organizations and among Indians in urban areas. Research priorities under this section shall include—

(1) the multifactorial causes of Indian youth suicide, including—

(A) protective and risk factors and scientific data that identifies those factors; and

(B) the effects of loss of cultural identity and the development of scientific data on those effects;

(2) the interrelationship and interdependence of behavioral health problems with alcoholism and other substance abuse, suicide, homicides, other injuries, and the incidence of family violence; and

(3) the development of models of prevention techniques.

(b) Emphasis

The effect of the interrelationships and interdependencies referred to in subsection (a)(2) on children, and the development of prevention techniques under subsection (a)(3) applicable to children, shall be emphasized.

(Pub. L. 94–437, title VII, §715, as added Pub. L. 111–148, title X, §10221(a), Mar. 23, 2010, 124 Stat. 935.)

CODIFICATION

Section 715 of Pub. L. 94–437 is based on section 181 of title I of S. 1790, One Hundred Eleventh Congress, as reported by the Committee on Indian Affairs of the Senate in Dec. 2009, which was enacted into law by section 10221(a) of Pub. L. 111–148.

PART B—INDIAN YOUTH SUICIDE PREVENTION

§ 1667. Findings and purpose

(a) Findings

Congress finds that—

(1)(A) the rate of suicide of American Indians and Alaska Natives is 1.9 times higher than the national average rate; and

(B) the rate of suicide of Indian and Alaska Native youth aged 15 through 24 is—

(i) 3.5 times the national average rate; and

(ii) the highest rate of any population group in the United States;

(2) many risk behaviors and contributing factors for suicide are more prevalent in Indian country than in other areas, including—

(A) history of previous suicide attempts;

(B) family history of suicide;

(C) history of depression or other mental illness;

(D) alcohol or drug abuse;

(E) health disparities;

(F) stressful life events and losses;

(G) easy access to lethal methods;

(H) exposure to the suicidal behavior of others;

(I) isolation; and

(J) incarceration;

(3) according to national data for 2005, suicide was the second-leading cause of death for Indians and Alaska Natives of both sexes aged 10 through 34;

(4)(A) the suicide rates of Indian and Alaska Native males aged 15 through 24 are—

(i) as compared to suicide rates of males of any other racial group, up to 4 times greater; and

(ii) as compared to suicide rates of females of any other racial group, up to 11 times greater; and

(B) data demonstrates that, over their lifetimes, females attempt suicide 2 to 3 times more often than males;

(5)(A) Indian tribes, especially Indian tribes located in the Great Plains, have experienced epidemic levels of suicide, up to 10 times the national average; and

(B) suicide clustering in Indian country affects entire tribal communities;

(6) death rates for Indians and Alaska Natives are statistically underestimated because many areas of Indian country lack the proper resources to identify and monitor the presence of disease;

(7)(A) the Indian Health Service experiences health professional shortages, with physician vacancy rates of approximately 17 percent, and nursing vacancy rates of approximately 18 percent, in 2007;

(B) 90 percent of all teens who die by suicide suffer from a diagnosable mental illness at time of death;

(C) more than ½ of teens who die by suicide have never been seen by a mental health provider; and

(D) ⅓ of health needs in Indian country relate to mental health;

(8) often, the lack of resources of Indian tribes and the remote nature of Indian reservations make it difficult to meet the requirements necessary to access Federal assistance, including grants;

(9) the Substance Abuse and Mental Health Services Administration and the Service have established specific initiatives to combat youth suicide in Indian country and among Indians and Alaska Natives throughout the United States, including the National Suicide Prevention Initiative of the Service, which has worked with Service, tribal, and urban Indian health programs since 2003;

(10) the National Strategy for Suicide Prevention was established in 2001 through a Department of Health and Human Services collaboration among—

(A) the Substance Abuse and Mental Health Services Administration;

(B) the Service;

(C) the Centers for Disease Control and Prevention;

(D) the National Institutes of Health; and

(E) the Health Resources and Services Administration; and

(11) the Service and other agencies of the Department of Health and Human Services use information technology and other programs to address the suicide prevention and mental health needs of Indians and Alaska Natives.

(b) Purposes

The purposes of this part are—

(1) 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, including through—

(A) the use of psychotherapy, psychiatric assessments, diagnostic interviews, therapies for mental health conditions predisposing to suicide, and alcohol and substance abuse treatment;

(B) the provision of clinical expertise to, consultation services with, and medical advice and training for frontline health care providers working with Indian youth;

(C) training and related support for community leaders, family members, and health and education workers who work with Indian youth;

(D) the development of culturally relevant educational materials on suicide; and

(E) data collection and reporting;

(2) 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

(3) to enhance the provision of mental health care services to Indian youth through existing grant programs of the Substance Abuse and Mental Health Services Administration.

(Pub. L. 94–437, title VII, § 721, as added Pub. L. 111–148, title X, § 10221(a), Mar. 23, 2010, 124 Stat. 935.)

CODIFICATION

Section 721 of Pub. L. 94–437 is based on section 181 of title I of S. 1790, One Hundred Eleventh Congress, as reported by the Committee on Indian Affairs of the Senate in Dec. 2009, which was enacted into law by section 10221(a) of Pub. L. 111–148.

§ 1667a. Definitions

In this part:

(1) Administration

The term ''Administration'' means the Substance Abuse and Mental Health Services Administration.

(2) Demonstration project

The term ''demonstration project'' means the Indian youth telemental health demonstration project authorized under section 1667b(a) of this title.

(3) Telemental health

The term ''telemental health'' means the use of electronic information and telecommunications technologies to support long-distance mental health care, patient and professional-related education, public health, and health administration.

(Pub. L. 94–437, title VII, § 722, as added Pub. L. 111–148, title X, § 10221(a), Mar. 23, 2010, 124 Stat. 935.)

CODIFICATION

Section 722 of Pub. L. 94–437 is based on section 181 of title I of S. 1790, One Hundred Eleventh Congress, as reported by the Committee on Indian Affairs of the Senate in Dec. 2009, which was enacted into law by section 10221(a) of Pub. L. 111–148.

§ 1667b. Indian youth telemental health demonstration project

(a) Authorization

(1) In general

The Secretary, acting through the Service, is authorized to carry out a demonstration project to award grants for the provision of