

JUNE 13, 2022

RULES COMMITTEE PRINT 117-51
TEXT OF H.R. 7666, THE RESTORING HOPE FOR
MENTAL HEALTH AND WELL-BEING ACT OF 2022

**[Showing the text of H.R. 7666, as ordered reported by the
Committee on Energy and Commerce.]**

1 SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

2 (a) SHORT TITLE.—This Act may be cited as the
3 “Restoring Hope for Mental Health and Well-Being Act
4 of 2022”.

5 (b) TABLE OF CONTENTS.—The table of contents for
6 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—MENTAL HEALTH AND CRISIS CARE NEEDS

Subtitle A—Crisis Care Services and 9-8-8 Implementation

Sec. 101. Behavioral Health Crisis Coordinating Office.

Sec. 102. Crisis response continuum of care.

Subtitle B—Into the Light for Maternal Mental Health and Substance Use
Disorders

Sec. 111. Screening and treatment for maternal mental health and substance
use disorders.

Sec. 112. Maternal mental health hotline.

Sec. 113. Task force on maternal mental health.

Subtitle C—Reaching Improved Mental Health Outcomes for Patients

Sec. 121. Innovation for mental health.

Sec. 122. Crisis care coordination.

Sec. 123. Treatment of serious mental illness.

Subtitle D—Anna Westin Legacy

Sec. 131. Maintaining education and training on eating disorders.

Subtitle E—Community Mental Health Services Block Grant Reauthorization

Sec. 141. Reauthorization of block grants for community mental health services.

Subtitle F—Peer-Supported Mental Health Services

Sec. 151. Peer-supported mental health services.

TITLE II—SUBSTANCE USE DISORDER PREVENTION,
TREATMENT, AND RECOVERY SERVICES

Subtitle A—Native Behavioral Health Access Improvement

Sec. 201. Behavioral health and substance use disorder services for Native Americans.

Subtitle B—Summer Barrow Prevention, Treatment, and Recovery

Sec. 211. Grants for the benefit of homeless individuals.

Sec. 212. Priority substance abuse treatment needs of regional and national significance.

Sec. 213. Evidence-based prescription opioid and heroin treatment and interventions demonstration.

Sec. 214. Priority substance use disorder prevention needs of regional and national significance.

Sec. 215. Sober Truth on Preventing (STOP) Underage Drinking Reauthorization.

Sec. 216. Grants for jail diversion programs.

Sec. 217. Formula grants to States.

Sec. 218. Projects for Assistance in Transition From Homelessness.

Sec. 219. Grants for reducing overdose deaths.

Sec. 220. Opioid overdose reversal medication access and education grant programs.

Sec. 221. State demonstration grants for comprehensive opioid abuse response.

Sec. 222. Emergency department alternatives to opioids.

Subtitle C—Excellence in Recovery Housing

Sec. 231. Clarifying the role of SAMHSA in promoting the availability of high-quality recovery housing.

Sec. 232. Developing guidelines for States to promote the availability of high-quality recovery housing.

Sec. 233. Coordination of Federal activities to promote the availability of recovery housing.

Sec. 234. NAS study and report.

Sec. 235. Grants for States to promote the availability of recovery housing and services.

Sec. 236. Funding.

Sec. 237. Technical correction.

Subtitle D—Substance Use Prevention, Treatment, and Recovery Services
Block Grant

Sec. 241. Eliminating stigmatizing language relating to substance use.

Sec. 242. Authorized activities.

Sec. 243. Requirements relating to certain infectious diseases and human immunodeficiency virus.

Sec. 244. State plan requirements.

Sec. 245. Updating certain language relating to Tribes.

- Sec. 246. Block grants for substance use prevention, treatment, and recovery services.
- Sec. 247. Requirement of reports and audits by States.
- Sec. 248. Study on assessment for use in distribution of limited State resources.

Subtitle E—Timely Treatment for Opioid Use Disorder

- Sec. 251. Study on exemptions for treatment of opioid use disorder through opioid treatment programs during the COVID-19 public health emergency.
- Sec. 252. Changes to Federal opioid treatment standards.

Subtitle F—Additional Provisions Relating to Addiction Treatment

- Sec. 261. Prohibition.
- Sec. 262. Eliminating additional requirements for dispensing narcotic drugs in schedule III, IV, and V for maintenance or detoxification treatment.
- Sec. 263. Requiring prescribers of controlled substances to complete training.

TITLE III—ACCESS TO MENTAL HEALTH CARE AND COVERAGE

Subtitle A—Collaborate in an Orderly and Cohesive Manner

- Sec. 301. Increasing uptake of the collaborative care model.

Subtitle B—Helping Enable Access to Lifesaving Services

- Sec. 311. Reauthorization and provision of certain programs to strengthen the health care workforce.

Subtitle C—Eliminating the Opt-Out for Nonfederal Governmental Health Plans

- Sec. 321. Eliminating the opt-out for nonfederal governmental health plans.

Subtitle D—Mental Health and Substance Use Disorder Parity Implementation

- Sec. 331. Grants to support mental health and substance use disorder parity implementation.

TITLE IV—CHILDREN AND YOUTH

Subtitle A—Supporting Children’s Mental Health Care Access

- Sec. 401. Pediatric mental health care access grants.
- Sec. 402. Infant and early childhood mental health promotion, intervention, and treatment.

Subtitle B—Continuing Systems of Care for Children

- Sec. 411. Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances.
- Sec. 412. Substance Use Disorder Treatment and Early Intervention Services for Children and Adolescents.

Subtitle C—Garrett Lee Smith Memorial Reauthorization

Sec. 421. Suicide prevention technical assistance center.

Sec. 422. Youth suicide early intervention and prevention strategies.

Sec. 423. Mental health and substance use disorder services for students in higher education.

Sec. 424. Mental and behavioral health outreach and education at institutions of higher education.

1 **TITLE I—MENTAL HEALTH AND**
2 **CRISIS CARE NEEDS**
3 **Subtitle A—Crisis Care Services**
4 **and 9–8–8 Implementation**

5 **SEC. 101. BEHAVIORAL HEALTH CRISIS COORDINATING OF-**
6 **FICE.**

7 Part A of title V of the Public Health Service Act
8 (42 U.S.C. 290aa et seq.) is amended by adding at the
9 end the following:

10 **“SEC. 506B. BEHAVIORAL HEALTH CRISIS COORDINATING**
11 **OFFICE.**

12 “(a) IN GENERAL.—The Secretary shall establish,
13 within the Substance Abuse and Mental Health Services
14 Administration, an office to coordinate work relating to
15 behavioral health crisis care across the operating divisions
16 and agencies of the Department of Health and Human
17 Services, including the Substance Abuse and Mental
18 Health Services Administration, the Centers for Medicare
19 & Medicaid Services, and the Health Resources and Serv-
20 ices Administration, and external stakeholders.

21 “(b) DUTY.—The office established under subsection
22 (a) shall—

1 “(1) convene Federal, State, Tribal, local, and
2 private partners;

3 “(2) launch and manage Federal workgroups
4 charged with making recommendations regarding be-
5 havioral health crisis issues, including with respect
6 to health care best practices, workforce development,
7 mental health disparities, data collection, technology,
8 program oversight, public awareness, and engage-
9 ment; and

10 “(3) support technical assistance, data analysis,
11 and evaluation functions in order to assist States, lo-
12 calities, Territories, Tribes, and Tribal communities
13 to develop crisis care systems and establish nation-
14 wide best practices with the objective of expanding
15 the capacity of, and access to, local crisis call cen-
16 ters, mobile crisis care, crisis stabilization, psy-
17 chiatric emergency services, and rapid post-crisis fol-
18 low-up care provided by—

19 “(A) the National Suicide Prevention and
20 Mental Health Crisis Hotline and Response
21 System;

22 “(B) community mental health centers (as
23 defined in section 1861(ff)(3)(B) of the Social
24 Security Act);

1 “(C) certified community behavioral health
2 clinics, as described in section 223 of the Pro-
3 tecting Access to Medicare Act of 2014; and

4 “(D) other community mental health and
5 substance use disorder providers.

6 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
7 is authorized to be appropriated to carry out this section
8 \$5,000,000 for each of fiscal years 2023 through 2027.”.

9 **SEC. 102. CRISIS RESPONSE CONTINUUM OF CARE.**

10 Subpart 3 of part B of title V of the Public Health
11 Service Act (42 U.S.C. 290bb–31 et seq.) is amended by
12 adding at the end the following:

13 **“SEC. 520N. CRISIS RESPONSE CONTINUUM OF CARE.**

14 “(a) IN GENERAL.—The Secretary shall publish best
15 practices for a crisis response continuum of care for use
16 by health care providers, crisis services administrators,
17 and crisis services providers in responding to individuals
18 (including children and adolescents) experiencing mental
19 health crises, substance-related crises, and crises arising
20 from co-occurring disorders.

21 “(b) BEST PRACTICES.—

22 “(1) SCOPE OF BEST PRACTICES.—The best
23 practices published under subsection (a) shall de-
24 fine—

1 “(A) a minimum set of core crisis response
2 services, as determined by the Secretary, for
3 each entity that furnishes such services, that—

4 “(i) do not require prior authorization
5 from an insurance provider or group health
6 plan nor a referral from a health care pro-
7 vider prior to the delivery of services;

8 “(ii) provide for serving all individuals
9 regardless of age or ability to pay;

10 “(iii) provide for operating 24 hours a
11 day, 7 days a week; and

12 “(iv) provide for care and support
13 through resources described in paragraph
14 (2)(A) until the individual has been sta-
15 bilized or transferred to the next level of
16 crisis care; and

17 “(B) psychiatric stabilization, including the
18 point at which a case may be closed for—

19 “(i) individuals screened over the
20 phone; and

21 “(ii) individuals stabilized on the
22 scene by mobile teams.

23 “(2) IDENTIFICATION OF ESSENTIAL FUNC-
24 TIONS.—The best practices published under sub-
25 section (a) shall identify the essential functions of

1 each service in the crisis response continuum, which
2 shall include at least the following:

3 “(A) Identification of resources for referral
4 and enrollment in continuing mental health,
5 substance use, or other human services relevant
6 for the individual in crisis where necessary.

7 “(B) Delineation of access and entry
8 points to services within the crisis response con-
9 tinuum.

10 “(C) Development of protocols and agree-
11 ments for the transfer and receipt of individuals
12 to and from other segments of the crisis re-
13 sponse continuum segments as needed, and
14 from outside referrals including health care pro-
15 viders, first responders including law enforce-
16 ment, paramedics, and firefighters, education
17 institutions, and community-based organiza-
18 tions.

19 “(D) Description of the qualifications of
20 crisis services staff, including roles for physi-
21 cians, licensed clinicians, case managers, and
22 peers (in accordance with State licensing re-
23 quirements or requirements applicable to Tribal
24 health professionals).

1 “(E) The convening of collaborative meet-
2 ings of crisis response service providers, first
3 responders including law enforcement, para-
4 medics, and firefighters, and community part-
5 ners (including National Suicide Prevention
6 Lifeline or 9–8–8 call centers, 9–1–1 public
7 service answering points, and local mental
8 health and substance use disorder treatment
9 providers) operating in a common region for the
10 discussion of case management, best practices,
11 and general performance improvement.

12 “(3) SERVICE CAPACITY AND QUALITY BEST
13 PRACTICES.—The best practices under subsection
14 (a) shall include recommendations on—

15 “(A) adequate volume of services to meet
16 population need;

17 “(B) appropriate timely response; and

18 “(C) capacity to meet the needs of dif-
19 ferent patient populations that may experience
20 a mental health or substance use crisis, includ-
21 ing children, families, and all age groups, cul-
22 tural and linguistic minorities, individuals with
23 co-occurring mental health and substance use
24 disorders, individuals with cognitive disabilities,
25 individuals with developmental delays, and indi-

1 viduals with chronic medical conditions and
2 physical disabilities.

3 “(4) IMPLEMENTATION TIMEFRAME.—The Sec-
4 retary shall—

5 “(A) not later than 1 year after the date
6 of enactment of this section, publish and main-
7 tain the best practices required by subsection
8 (a); and

9 “(B) every two years thereafter, publish
10 updates.

11 “(5) DATA COLLECTION AND EVALUATIONS.—
12 The Secretary, directly or through grants, contracts,
13 or interagency agreements, shall collect data and
14 conduct evaluations with respect to the provision of
15 services and programs offered on the crisis response
16 continuum for purposes of assessing the extent to
17 which the provision of such services and programs
18 meet certain objectives and outcomes measures as
19 determined by the Secretary. Such objectives shall
20 include—

21 “(A) a reduction in reliance on law en-
22 forcement response, as appropriate, to individ-
23 uals in crisis who would be more appropriately
24 served by a mobile crisis team capable of re-

1 sponding to mental health and substance-re-
2 lated crises;

3 “(B) a reduction in boarding or extended
4 holding of patients in emergency room facilities
5 who require further psychiatric care, including
6 care for substance use disorders;

7 “(C) evidence of adequate access to crisis
8 care centers and crisis bed services; and

9 “(D) evidence of adequate linkage to ap-
10 propriate post-crisis care and longitudinal treat-
11 ment for mental health or substance use dis-
12 order when relevant.”.

13 **Subtitle B—Into the Light for Ma-**
14 **ternal Mental Health and Sub-**
15 **stance Use Disorders**

16 **SEC. 111. SCREENING AND TREATMENT FOR MATERNAL**
17 **MENTAL HEALTH AND SUBSTANCE USE DIS-**
18 **ORDERS.**

19 (a) IN GENERAL.—Section 317L-1 of the Public
20 Health Service Act (42 U.S.C. 247b-13a) is amended—

21 (1) in the section heading, by striking “**MA-**
22 **TERNAL DEPRESSION**” and inserting “**MATER-**
23 **NAL MENTAL HEALTH AND SUBSTANCE USE**
24 **DISORDERS**”; and

25 (2) in subsection (a)—

1 (A) by inserting “, Indian Tribes and Trib-
2 al organizations (as such terms are defined in
3 section 4 of the Indian Self-Determination and
4 Education Assistance Act), and Urban Indian
5 organizations (as such term is defined under
6 the Federally Recognized Indian Tribe List Act
7 of 1994)” after “States”; and

8 (B) by striking “for women who are preg-
9 nant, or who have given birth within the pre-
10 ceeding 12 months, for maternal depression”
11 and inserting “for women who are postpartum,
12 pregnant, or have given birth within the pre-
13 ceeding 12 months, for maternal mental health
14 and substance use disorders”.

15 (b) APPLICATION.—Subsection (b) of section 317L–
16 1 of the Public Health Service Act (42 U.S.C. 247b–13a)
17 is amended—

18 (1) by striking “a State shall submit” and in-
19 serting “an entity listed in subsection (a) shall sub-
20 mit”; and

21 (2) in paragraphs (1) and (2), by striking “ma-
22 ternal depression” each place it appears and insert-
23 ing “maternal mental health and substance use dis-
24 orders”.

1 (c) PRIORITY.—Subsection (c) of section 317L–1 of
2 the Public Health Service Act (42 U.S.C. 247b–13a) is
3 amended—

4 (1) by striking “may give priority to States pro-
5 posing to improve or enhance access to screening”
6 and inserting the following: “shall give priority to
7 entities listed in subsection (a) that—

8 “(1) are proposing to create, improve, or en-
9 hance screening, prevention, and treatment”;

10 (2) by striking “maternal depression” and in-
11 sserting “maternal mental health and substance use
12 disorders”;

13 (3) by striking the period at the end of para-
14 graph (1), as so designated, and inserting a semi-
15 colon; and

16 (4) by inserting after such paragraph (1) the
17 following:

18 “(2) are currently partnered with, or will part-
19 ner with, a community-based organization to address
20 maternal mental health and substance use disorders;

21 “(3) are located in an area with high rates of
22 adverse maternal health outcomes or significant
23 health, economic, racial, or ethnic disparities in ma-
24 ternal health and substance use disorder outcomes;
25 and

1 “(4) operate in a health professional shortage
2 area designated under section 332.”.

3 (d) USE OF FUNDS.—Subsection (d) of section
4 317L–1 of the Public Health Service Act (42 U.S.C.
5 247b–13a) is amended—

6 (1) in paragraph (1)—

7 (A) in subparagraph (A), by striking “to
8 health care providers; and” and inserting “on
9 maternal mental health and substance use dis-
10 order screening, brief intervention, treatment
11 (as applicable for health care providers), and
12 referrals for treatment to health care providers
13 in the primary care setting and nonclinical
14 perinatal support workers;”;

15 (B) in subparagraph (B), by striking “to
16 health care providers, including information on
17 maternal depression screening, treatment, and
18 followup support services, and linkages to com-
19 munity-based resources; and” and inserting “on
20 maternal mental health and substance use dis-
21 order screening, brief intervention, treatment
22 (as applicable for health care providers) and re-
23 ferrals for treatment, follow-up support serv-
24 ices, and linkages to community-based resources
25 to health care providers in the primary care set-

1 ting and clinical perinatal support workers;
2 and”); and

3 (C) by adding at the end the following:

4 “(C) enabling health care providers (such
5 as obstetrician-gynecologists, nurse practi-
6 tioners, nurse midwives, pediatricians, psychia-
7 trists, mental and other behavioral health care
8 providers, and adult primary care clinicians) to
9 provide or receive real-time psychiatric con-
10 sultation (in-person or remotely), including
11 through the use of technology-enabled collabo-
12 rative learning and capacity building models (as
13 defined in section 330N), to aid in the treat-
14 ment of pregnant and postpartum women;
15 and”); and

16 (2) in paragraph (2)—

17 (A) by striking subparagraph (A) and re-
18 designating subparagraphs (B) and (C) as sub-
19 paragraphs (A) and (B), respectively;

20 (B) in subparagraph (A), as redesignated,
21 by striking “and” at the end;

22 (C) in subparagraph (B), as redesign-
23 nated—

24 (i) by inserting “, including” before
25 “for rural areas”; and

1 (ii) by striking the period at the end
2 and inserting a semicolon; and

3 (D) by inserting after subparagraph (B),
4 as redesignated, the following:

5 “(C) providing assistance to pregnant and
6 postpartum women to receive maternal mental
7 health and substance use disorder treatment,
8 including patient consultation, care coordina-
9 tion, and navigation for such treatment;

10 “(D) coordinating with maternal and child
11 health programs of the Federal Government
12 and State, local, and Tribal governments, in-
13 cluding child psychiatric access programs;

14 “(E) conducting public outreach and
15 awareness regarding grants under subsection
16 (a);

17 “(F) creating multistate consortia to carry
18 out the activities required or authorized under
19 this subsection; and

20 “(G) training health care providers in the
21 primary care setting and nonclinical perinatal
22 support workers on trauma-informed care, cul-
23 turally and linguistically appropriate services,
24 and best practices related to training to im-
25 prove the provision of maternal mental health

1 and substance use disorder care for racial and
2 ethnic minority populations, including with re-
3 spect to perceptions and biases that may affect
4 the approach to, and provision of, care.”.

5 (e) **ADDITIONAL PROVISIONS.**—Section 317L–1 of
6 the Public Health Service Act (42 U.S.C. 247b–13a) is
7 amended—

8 (1) by redesignating subsection (e) as sub-
9 section (h); and

10 (2) by inserting after subsection (d) the fol-
11 lowing:

12 “(e) **TECHNICAL ASSISTANCE.**—The Secretary shall
13 provide technical assistance to grantees and entities listed
14 in subsection (a) for carrying out activities pursuant to
15 this section.

16 “(f) **DISSEMINATION OF BEST PRACTICES.**—The
17 Secretary, based on evaluation of the activities funded
18 pursuant to this section, shall identify and disseminate
19 evidence-based or evidence-informed best practices for
20 screening, assessment, and treatment services for mater-
21 nal mental health and substance use disorders, including
22 culturally and linguistically appropriate services, for
23 women during pregnancy and 12 months following preg-
24 nancy.

1 “(g) MATCHING REQUIREMENT.—The Federal share
2 of the cost of the activities for which a grant is made to
3 an entity under subsection (a) shall not exceed 90 percent
4 of the total cost of such activities.”.

5 (f) AUTHORIZATION OF APPROPRIATIONS.—Sub-
6 section (h) of section 317L–1 (42 U.S.C. 247b–13a) of
7 the Public Health Service Act, as redesignated, is further
8 amended—

9 (1) by striking “\$5,000,000” and inserting
10 “\$24,000,000”; and

11 (2) by striking “2018 through 2022” and in-
12 serting “2023 through 2027”.

13 **SEC. 112. MATERNAL MENTAL HEALTH HOTLINE.**

14 Part P of title III of the Public Health Service Act
15 (42 U.S.C. 280g et seq.) is amended by adding at the end
16 the following:

17 **“SEC. 399V–7. MATERNAL MENTAL HEALTH HOTLINE.**

18 “(a) IN GENERAL.—The Secretary shall maintain, di-
19 rectly or by grant or contract, a national hotline to provide
20 emotional support, information, brief intervention, and
21 mental health and substance use disorder resources to
22 pregnant and postpartum women at risk of, or affected
23 by, maternal mental health and substance use disorders,
24 and to their families or household members.

1 “(b) REQUIREMENTS FOR HOTLINE.—The hotline
2 under subsection (a) shall—

3 “(1) be a 24/7 real-time hotline;

4 “(2) provide voice and text support;

5 “(3) be staffed by certified peer specialists, li-
6 censed health care professionals, or licensed mental
7 health professionals who are trained on—

8 “(A) maternal mental health and sub-
9 stance use disorder prevention, identification,
10 and intervention; and

11 “(B) providing culturally and linguistically
12 appropriate support; and

13 “(4) provide maternal mental health and sub-
14 stance use disorder assistance and referral services
15 to meet the needs of underserved populations, indi-
16 viduals with disabilities, and family and household
17 members of pregnant or postpartum women at risk
18 of experiencing maternal mental health and sub-
19 stance use disorders.

20 “(c) ADDITIONAL REQUIREMENTS.—In maintaining
21 the hotline under subsection (a), the Secretary shall—

22 “(1) consult with the Domestic Violence Hot-
23 line, National Suicide Prevention Lifeline, and Vet-
24 erans Crisis Line to ensure that pregnant and
25 postpartum women are connected in real-time to the

1 appropriate specialized hotline service, when applica-
2 ble;

3 “(2) conduct a public awareness campaign for
4 the hotline; and

5 “(3) consult with Federal departments and
6 agencies, including the Centers of Excellence of the
7 Substance Abuse and Mental Health Services Ad-
8 ministration and the Department of Veterans Af-
9 fairs, to increase awareness regarding the hotline.

10 “(d) ANNUAL REPORT.—The Secretary shall submit
11 an annual report to the Congress on the hotline under sub-
12 section (a) and implementation of this section, including—

13 “(1) an evaluation of the effectiveness of activi-
14 ties conducted or supported under subsection (a);

15 “(2) a directory of entities or organizations to
16 which staff maintaining the hotline funded under
17 this section may make referrals; and

18 “(3) such additional information as the Sec-
19 retary determines appropriate.

20 “(e) AUTHORIZATION OF APPROPRIATIONS.—To
21 carry out this section, there are authorized to be appro-
22 priated \$10,000,000 for each of fiscal years 2023 through
23 2027.”.

1 **SEC. 113. TASK FORCE ON MATERNAL MENTAL HEALTH.**

2 Part B of title III of the Public Health Service Act
3 (42 U.S.C. 243 et seq.) is amended by inserting after sec-
4 tion 317L-1 (42 U.S.C. 247b-13a) the following:

5 **“SEC. 317L-2. TASK FORCE ON MATERNAL MENTAL**
6 **HEALTH.**

7 “(a) ESTABLISHMENT.—Not later than 180 days
8 after the date of enactment of the Restoring Hope for the
9 Mental Health and Well-Being Act of 2022, the Secretary,
10 for purposes of identifying, evaluating, and making rec-
11 ommendations to coordinate and improve Federal re-
12 sponses to maternal mental health conditions, shall—

13 “(1) establish a task force to be known as the
14 Task Force on Maternal Mental Health (in this sec-
15 tion referred to as the ‘Task Force’); or

16 “(2) incorporate the duties, public meetings,
17 and reports specified in subsections (c) through (f)
18 into existing Federal policy forums, including the
19 Maternal Health Interagency Policy Committee and
20 the Maternal Health Working Group, as appro-
21 priate.

22 “(b) MEMBERSHIP.—

23 “(1) COMPOSITION.—The Task Force shall be
24 composed of—

25 “(A) the Federal members under para-
26 graph (2); and

1 “(B) the non-Federal members under
2 paragraph (3).

3 “(2) FEDERAL MEMBERS.—The Federal mem-
4 bers of the Task Force shall consist of the following
5 heads of Federal departments and agencies (or their
6 designees):

7 “(A) The Assistant Secretary for Health of
8 the Department of Health and Human Services,
9 who shall serve as Chair.

10 “(B) The Assistant Secretary for Planning
11 and Evaluation of the Department of Health
12 and Human Services.

13 “(C) The Assistant Secretary of the Ad-
14 ministration for Children and Families.

15 “(D) The Director of the Centers for Dis-
16 ease Control and Prevention.

17 “(E) The Administrator of the Centers for
18 Medicare & Medicaid Services.

19 “(F) The Administrator of the Health Re-
20 sources and Services Administration.

21 “(G) The Director of the Indian Health
22 Service.

23 “(H) The Assistant Secretary for Mental
24 Health and Substance Use.

1 “(I) Such other Federal departments and
2 agencies as the Secretary determines appro-
3 priate that serve individuals with maternal men-
4 tal health conditions.

5 “(3) NON-FEDERAL MEMBERS.—The non-Fed-
6 eral members of the Task Force shall—

7 “(A) compose not more than one-half, and
8 not less than one-third, of the total membership
9 of the Task Force;

10 “(B) be appointed by the Secretary; and

11 “(C) include—

12 “(i) representatives of medical soci-
13 eties with expertise in maternal or mental
14 health;

15 “(ii) representatives of nonprofit orga-
16 nizations with expertise in maternal or
17 mental health;

18 “(iii) relevant industry representa-
19 tives; and

20 “(iv) other representatives, as appro-
21 priate.

22 “(4) DEADLINE FOR DESIGNATING DES-
23 IGNEES.—If the Assistant Secretary for Health, or
24 the head of a Federal department or agency serving
25 as a member of the Task Force under paragraph

1 (2), chooses to be represented on the Task Force by
2 a designee, the Assistant Secretary or department or
3 agency head shall designate such designee not later
4 than 90 days after the date of the enactment of this
5 section.

6 “(c) DUTIES.—The Task Force shall—

7 “(1) prepare and regularly update a report that
8 analyzes and evaluates the state of national mater-
9 nal mental health policy and programs at the Fed-
10 eral, State, and local levels, and identifies best prac-
11 tices with respect to maternal mental health policy,
12 including—

13 “(A) a set of evidence-based, evidence-in-
14 formed, and promising practices with respect
15 to—

16 “(i) prevention strategies for individ-
17 uals at risk of experiencing a maternal
18 mental health condition, including strate-
19 gies and recommendations to address
20 health inequities;

21 “(ii) the identification, screening, di-
22 agnosis, intervention, and treatment of in-
23 dividuals and families affected by a mater-
24 nal mental health condition;

1 “(iii) the expeditious referral to, and
2 implementation of, practices and supports
3 that prevent and mitigate the effects of a
4 maternal mental health condition, includ-
5 ing strategies and recommendations to
6 eliminate the racial and ethnic disparities
7 that exist in maternal mental health; and

8 “(iv) community-based or
9 multigenerational practices that support
10 individuals and families affected by a ma-
11 ternal mental health condition; and

12 “(B) Federal and State programs and ac-
13 tivities to prevent, screen, diagnose, intervene,
14 and treat maternal mental health conditions;

15 “(2) develop and regularly update a national
16 strategy for maternal mental health, taking into con-
17 sideration the findings of the report under para-
18 graph (1), on how the Task Force and Federal de-
19 partments and agencies represented on the Task
20 Force may prioritize options for, and may implement
21 a coordinated approach to, addressing maternal
22 mental health conditions, including by—

23 “(A) increasing prevention, screening, di-
24 agnosis, intervention, treatment, and access to
25 care, including clinical and nonclinical care such

1 as peer-support and community health workers,
2 through the public and private sectors;

3 “(B) providing support for pregnant or
4 postpartum individuals who are at risk for or
5 experiencing a maternal mental health condi-
6 tion, and their families, as appropriate;

7 “(C) reducing racial, ethnic, geographic,
8 and other health disparities for prevention, di-
9 agnosis, intervention, treatment, and access to
10 care;

11 “(D) identifying options for modifying,
12 strengthening, and coordinating Federal pro-
13 grams and activities, such as the Medicaid pro-
14 gram under title XIX of the Social Security Act
15 and the State Children’s Health Insurance Pro-
16 gram under title XXI of such Act, including ex-
17 isting infant and maternity programs, in order
18 to increase research, prevention, identification,
19 intervention, and treatment with respect to ma-
20 ternal mental health; and

21 “(E) planning, data sharing, and commu-
22 nication within and across Federal depart-
23 ments, agencies, offices, and programs;

24 “(3) solicit public comments from stakeholders
25 for the report under paragraph (1) and the national

1 strategy under paragraph (2), including comments
2 from frontline service providers, mental health pro-
3 fessionals, researchers, experts in maternal mental
4 health, institutions of higher education, public health
5 agencies (including maternal and child health pro-
6 grams), and industry representatives, in order to in-
7 form the activities and reports of the Task Force;
8 and

9 “(4) disaggregate any data collected under this
10 section by race, ethnicity, geographical location, age,
11 marital status, socioeconomic level, and other fac-
12 tors, as the Secretary determines appropriate.

13 “(d) MEETINGS.—The Task Force shall—

14 “(1) meet not less than two times each year;
15 and

16 “(2) convene public meetings, as appropriate, to
17 fulfill its duties under this section.

18 “(e) REPORTS TO PUBLIC AND FEDERAL LEAD-
19 ERS.—The Task Force shall make publicly available and
20 submit to the heads of relevant Federal departments and
21 agencies, the Committee on Energy and Commerce of the
22 House of Representatives, the Committee on Health, Edu-
23 cation, Labor, and Pensions of the Senate, and other rel-
24 evant congressional committees, the following:

1 “(1) Not later than 1 year after the first meet-
2 ing of the Task Force, an initial report under sub-
3 section (c)(1).

4 “(2) Not later than 2 years after the first meet-
5 ing of the Task Force, an initial national strategy
6 under subsection (c)(2).

7 “(3) Each year thereafter—

8 “(A) an updated report under subsection
9 (c)(1);

10 “(B) an updated national strategy under
11 subsection (c)(2); or

12 “(C) if no update is made under subsection
13 (c)(1) or (c)(2), a report summarizing the ac-
14 tivities of the Task Force.

15 “(f) REPORTS TO GOVERNORS.—Upon finalizing the
16 initial national strategy under subsection (c)(2), and upon
17 making relevant updates to such strategy, the Task Force
18 shall submit a report to the Governors of all States de-
19 scribing opportunities for local- and State-level partner-
20 ships identified under subsection (c)(2)(D).

21 “(g) SUNSET.—The Task Force shall terminate on
22 September 30, 2027.

23 “(h) NONDUPLICATION OF FEDERAL EFFORTS.—
24 The Secretary may relieve the Task Force, in carrying out
25 subsections (c) through (f), from responsibility for car-

1 rying out such activities as may be specified by the Sec-
2 retary as duplicative with other activities carried out by
3 the Department of Health and Human Services.”.

4 **Subtitle C—Reaching Improved**
5 **Mental Health Outcomes for Pa-**
6 **tients**

7 **SEC. 121. INNOVATION FOR MENTAL HEALTH.**

8 (a) NATIONAL MENTAL HEALTH AND SUBSTANCE
9 USE POLICY LABORATORY.—Section 501A of the Public
10 Health Service Act (42 U.S.C. 290aa–0) is amended—

11 (1) in subsection (e)(1), by striking “Indian
12 tribes or tribal organizations” and inserting “Indian
13 Tribes or Tribal organizations”;

14 (2) by striking subsection (e)(3); and

15 (3) by adding at the end the following:

16 “(f) AUTHORIZATION OF APPROPRIATIONS.—To
17 carry out this section, there is authorized to be appro-
18 priated \$10,000,000 for each of fiscal years 2023 through
19 2027.”.

20 (b) INTERDEPARTMENTAL SERIOUS MENTAL ILL-
21 NESS COORDINATING COMMITTEE.—

22 (1) IN GENERAL.—Part A of title V of the Pub-
23 lic Health Service Act (42 U.S.C. 290aa et seq.) is
24 amended by inserting after section 501A (42 U.S.C.
25 290aa–0) the following:

1 **“SEC. 501B. INTERDEPARTMENTAL SERIOUS MENTAL ILL-**
2 **NESS COORDINATING COMMITTEE.**

3 “(a) ESTABLISHMENT.—

4 “(1) IN GENERAL.—The Secretary of Health
5 and Human Services, or the designee of the Sec-
6 retary, shall establish a committee to be known as
7 the Interdepartmental Serious Mental Illness Coordi-
8 nating Committee (in this section referred to as the
9 ‘Committee’).

10 “(2) FEDERAL ADVISORY COMMITTEE ACT.—

11 Except as provided in this section, the provisions of
12 the Federal Advisory Committee Act (5 U.S.C.
13 App.) shall apply to the Committee.

14 “(b) MEETINGS.—The Committee shall meet not
15 fewer than 2 times each year.

16 “(c) RESPONSIBILITIES.—The Committee shall sub-
17 mit, on a biannual basis, to Congress and any other rel-
18 evant Federal department or agency a report including—

19 “(1) a summary of advances in serious mental
20 illness and serious emotional disturbance research
21 related to the prevention of, diagnosis of, interven-
22 tion in, and treatment and recovery of serious men-
23 tal illnesses, serious emotional disturbances, and ad-
24 vances in access to services and support for adults
25 with a serious mental illness or children with a seri-
26 ous emotional disturbance;

1 “(2) an evaluation of the effect Federal pro-
2 grams related to serious mental illness have on pub-
3 lic health, including public health outcomes such
4 as—

5 “(A) rates of suicide, suicide attempts, in-
6 cidence and prevalence of serious mental ill-
7 nesses, serious emotional disturbances, and sub-
8 stance use disorders, overdose, overdose deaths,
9 emergency hospitalizations, emergency room
10 boarding, preventable emergency room visits,
11 interaction with the criminal justice system,
12 homelessness, and unemployment;

13 “(B) increased rates of employment and
14 enrollment in educational and vocational pro-
15 grams;

16 “(C) quality of mental and substance use
17 disorders treatment services; or

18 “(D) any other criteria as may be deter-
19 mined by the Secretary; and

20 “(3) specific recommendations for actions that
21 agencies can take to better coordinate the adminis-
22 tration of mental health services for adults with a
23 serious mental illness or children with a serious emo-
24 tional disturbance.

25 “(d) MEMBERSHIP.—

1 “(1) FEDERAL MEMBERS.—The Committee
2 shall be composed of the following Federal rep-
3 resentatives, or the designees of such representa-
4 tives—

5 “(A) the Secretary of Health and Human
6 Services, who shall serve as the Chair of the
7 Committee;

8 “(B) the Assistant Secretary for Mental
9 Health and Substance Use;

10 “(C) the Attorney General;

11 “(D) the Secretary of Veterans Affairs;

12 “(E) the Secretary of Defense;

13 “(F) the Secretary of Housing and Urban
14 Development;

15 “(G) the Secretary of Education;

16 “(H) the Secretary of Labor;

17 “(I) the Administrator of the Centers for
18 Medicare & Medicaid Services; and

19 “(J) the Commissioner of Social Security.

20 “(2) NON-FEDERAL MEMBERS.—The Com-
21 mittee shall also include not less than 14 non-Fed-
22 eral public members appointed by the Secretary of
23 Health and Human Services, of which—

1 “(A) at least 2 members shall be an indi-
2 vidual who has received treatment for a diag-
3 nosis of a serious mental illness;

4 “(B) at least 1 member shall be a parent
5 or legal guardian of an adult with a history of
6 a serious mental illness or a child with a history
7 of a serious emotional disturbance;

8 “(C) at least 1 member shall be a rep-
9 resentative of a leading research, advocacy, or
10 service organization for adults with a serious
11 mental illness;

12 “(D) at least 2 members shall be—

13 “(i) a licensed psychiatrist with expe-
14 rience in treating serious mental illnesses;

15 “(ii) a licensed psychologist with expe-
16 rience in treating serious mental illnesses
17 or serious emotional disturbances;

18 “(iii) a licensed clinical social worker
19 with experience treating serious mental ill-
20 nesses or serious emotional disturbances;
21 or

22 “(iv) a licensed psychiatric nurse,
23 nurse practitioner, or physician assistant
24 with experience in treating serious mental
25 illnesses or serious emotional disturbances;

1 “(E) at least 1 member shall be a licensed
2 mental health professional with a specialty in
3 treating children and adolescents with a serious
4 emotional disturbance;

5 “(F) at least 1 member shall be a mental
6 health professional who has research or clinical
7 mental health experience in working with mi-
8 norities;

9 “(G) at least 1 member shall be a mental
10 health professional who has research or clinical
11 mental health experience in working with medi-
12 cally underserved populations;

13 “(H) at least 1 member shall be a State
14 certified mental health peer support specialist;

15 “(I) at least 1 member shall be a judge
16 with experience in adjudicating cases related to
17 criminal justice or serious mental illness;

18 “(J) at least 1 member shall be a law en-
19 forcement officer or corrections officer with ex-
20 tensive experience in interfacing with adults
21 with a serious mental illness, children with a se-
22 rious emotional disturbance, or individuals in a
23 mental health crisis; and

24 “(K) at least 1 member shall have experi-
25 ence providing services for homeless individuals

1 and working with adults with a serious mental
2 illness, children with a serious emotional dis-
3 turbance, or individuals in a mental health cri-
4 sis.

5 “(3) TERMS.—A member of the Committee ap-
6 pointed under paragraph (2) shall serve for a term
7 of 3 years, and may be reappointed for 1 or more
8 additional 3-year terms. Any member appointed to
9 fill a vacancy for an unexpired term shall be ap-
10 pointed for the remainder of such term. A member
11 may serve after the expiration of the member’s term
12 until a successor has been appointed.

13 “(e) WORKING GROUPS.—In carrying out its func-
14 tions, the Committee may establish working groups. Such
15 working groups shall be composed of Committee members,
16 or their designees, and may hold such meetings as are nec-
17 essary.

18 “(f) SUNSET.—The Committee shall terminate on
19 September 30, 2027.”.

20 (2) CONFORMING AMENDMENTS.—

21 (A) Section 501(l)(2) of the Public Health
22 Service Act (42 U.S.C. 290aa(l)(2)) is amended
23 by striking “section 6031 of such Act” and in-
24 serting “section 501B of this Act”.

1 (B) Section 6031 of the Helping Families
2 in Mental Health Crisis Reform Act of 2016
3 (Division B of Public Law 114–255) is repealed
4 (and by conforming the item relating to such
5 section in the table of contents in section 1(b)).

6 (c) PRIORITY MENTAL HEALTH NEEDS OF RE-
7 GIONAL AND NATIONAL SIGNIFICANCE.—Section 520A of
8 the Public Health Service Act (42 U.S.C. 290bb–32) is
9 amended—

10 (1) in subsection (a), by striking “Indian tribes
11 or tribal organizations” and inserting “Indian Tribes
12 or Tribal organizations”; and

13 (2) in subsection (f), by striking “\$394,550,000
14 for each of fiscal years 2018 through 2022” and in-
15 serting “\$599,036,000 for each of fiscal years 2023
16 through 2027”.

17 **SEC. 122. CRISIS CARE COORDINATION.**

18 (a) STRENGTHENING COMMUNITY CRISIS RESPONSE
19 SYSTEMS.—Section 520F of the Public Health Service Act
20 (42 U.S.C. 290bb–37) is amended to read as follows:

21 **“SEC. 520F. MENTAL HEALTH CRISIS RESPONSE PARTNER-
22 SHIP PILOT PROGRAM.**

23 “(a) IN GENERAL.—The Secretary shall establish a
24 pilot program under which the Secretary will award com-
25 petitive grants to States, localities, territories, Indian

1 Tribes, and Tribal organizations to establish new, or en-
2 hance existing, mobile crisis response teams that divert the
3 response for mental health and substance use crises from
4 law enforcement to mobile crisis teams, as described in
5 subsection (b).

6 “(b) MOBILE CRISIS TEAMS DESCRIBED.—A mobile
7 crisis team described in this subsection is a team of indi-
8 viduals—

9 “(1) that is available to respond to individuals
10 in crisis and provide immediate stabilization, refer-
11 rals to community-based mental health and sub-
12 stance use disorder services and supports, and triage
13 to a higher level of care if medically necessary;

14 “(2) which may include licensed counselors,
15 clinical social workers, physicians, paramedics, crisis
16 workers, peer support specialists, or other qualified
17 individuals; and

18 “(3) which may provide support to divert be-
19 havioral health crisis calls from the 9–1–1 system to
20 the 9–8–8 system.

21 “(c) PRIORITY.—In awarding grants under this sec-
22 tion, the Secretary shall prioritize applications which ac-
23 count for the specific needs of the communities to be
24 served, including children and families, veterans, rural and

1 underserved populations, and other groups at increased
2 risk of death from suicide or overdose.

3 “(d) REPORT.—

4 “(1) INITIAL REPORT.—Not later than Sep-
5 tember 30, 2024, the Secretary shall submit to Con-
6 gress a report on steps taken by the entities speci-
7 fied in subsection (a) as of such date of enactment
8 to strengthen the partnerships among mental health
9 providers, substance use disorder treatment pro-
10 viders, primary care physicians, mental health and
11 substance use crisis teams, paramedics, law enforce-
12 ment officers, and other first responders.

13 “(2) PROGRESS REPORTS.—Not later than one
14 year after the date on which the first grant is
15 awarded to carry out this section, and for each year
16 thereafter, the Secretary shall submit to Congress a
17 report on the grants made during the year covered
18 by the report, which shall include—

19 “(A) impact data on the teams and people
20 served by such programs, including demo-
21 graphic information of individuals served, vol-
22 ume, and types of service utilization;

23 “(B) outcomes of the number of linkages
24 to community-based resources, short-term crisis
25 receiving and stabilization facilities, and diver-

1 sion from law enforcement or hospital emer-
2 gency department settings;

3 “(C) data consistent with the State block
4 grant requirements for continuous evaluation
5 and quality improvement, and other relevant
6 data as determined by the Secretary; and

7 “(D) the Secretary’s recommendations and
8 best practices for—

9 “(i) States and localities providing
10 mobile crisis response and stabilization
11 services for youth and adults; and

12 “(ii) improvements to the program es-
13 tablished under this section.

14 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
15 are authorized to be appropriated to carry out this section,
16 \$10,000,000 for each of fiscal years 2023 through 2027.”.

17 (b) MENTAL HEALTH AWARENESS TRAINING
18 GRANTS.—

19 (1) IN GENERAL.—Section 520J(b) of the Pub-
20 lic Health Service Act (42 U.S.C. 290bb–41(b)) is
21 amended—

22 (A) in paragraph (1), by striking “Indian
23 tribes, tribal organizations” and inserting “In-
24 dian Tribes, Tribal organizations”;

1 (B) in paragraph (4), by striking “Indian
2 tribe, tribal organization” and inserting “Indian
3 Tribe, Tribal organization”;

4 (C) in paragraph (5)—

5 (i) by striking “Indian tribe, tribal or-
6 ganization” and inserting “Indian Tribe,
7 Tribal organization”;

8 (ii) in subparagraph (A), by striking
9 “and” at the end;

10 (iii) in subparagraph (B)(ii), by strik-
11 ing the period at the end and inserting “;
12 and”; and

13 (iv) by adding at the end the fol-
14 lowing:

15 “(C) suicide intervention and prevention,
16 including recognizing warning signs and how to
17 refer someone for help.”;

18 (D) in paragraph (6), by striking “Indian
19 tribe, tribal organization” and inserting “Indian
20 Tribe, Tribal organization”; and

21 (E) in paragraph (7), by striking
22 “\$14,693,000 for each of fiscal years 2018
23 through 2022” and inserting “\$24,963,000 for
24 each of fiscal years 2023 through 2027”.

1 (2) TECHNICAL CORRECTIONS.—Section
2 520J(b) of the Public Health Service Act (42 U.S.C.
3 290bb–41(b)) is amended—

4 (A) in the heading of paragraph (2), by
5 striking “EMERGENCY SERVICES PERSONNEL”
6 and inserting “EMERGENCY SERVICES PER-
7 SONNEL”; and

8 (B) in the heading of paragraph (3), by
9 striking “DISTRIBUTION OF AWARDS” and in-
10 serting “DISTRIBUTION OF AWARDS”.

11 (c) ADULT SUICIDE PREVENTION.—Section 520L of
12 the Public Health Service Act (42 U.S.C. 290bb–43) is
13 amended—

14 (1) in subsection (a)—

15 (A) in paragraph (2)—

16 (i) by striking “Indian tribe” each
17 place it appears and inserting “Indian
18 Tribe”; and

19 (ii) by striking “tribal organization”
20 each place it appears and inserting “Tribal
21 organization”; and

22 (B) by amending paragraph (3)(C) to read
23 as follows:

1 “(C) Raising awareness of suicide preven-
2 tion resources, promoting help seeking among
3 those at risk for suicide.”; and

4 (2) in subsection (d), by striking “\$30,000,000
5 for the period of fiscal years 2018 through 2022”
6 and inserting “\$30,000,000 for each of fiscal years
7 2023 through 2027”.

8 **SEC. 123. TREATMENT OF SERIOUS MENTAL ILLNESS.**

9 (a) **ASSERTIVE COMMUNITY TREATMENT GRANT**
10 **PROGRAM.—**

11 (1) **TECHNICAL AMENDMENT.—**Section
12 520M(b) of the Public Health Service Act (42
13 U.S.C. 290bb–44(b)) is amended by striking “Indian
14 tribe or tribal organization” and inserting “Indian
15 Tribe or Tribal organization”.

16 (2) **REPORT TO CONGRESS.—**Section
17 520M(d)(1) of the Public Health Service Act (42
18 U.S.C. 290bb–44(d)(1)) is amended by striking “not
19 later than the end of fiscal year 2021” and inserting
20 “not later than the end of fiscal year 2026”.

21 (3) **AUTHORIZATION OF APPROPRIATIONS.—**
22 Section 520M(e)(1) of the Public Health Service Act
23 (42 U.S.C. 290bb–44(d)(1)) is amended by striking
24 “\$5,000,000 for the period of fiscal years 2018

1 through 2022” and inserting “\$9,000,000 for each
2 of fiscal years 2023 through 2027”.

3 (b) ASSISTED OUTPATIENT TREATMENT.—Section
4 224 of the Protecting Access to Medicare Act of 2014 (42
5 U.S.C. 290aa note) is amended to read as follows:

6 **“SEC. 224. ASSISTED OUTPATIENT TREATMENT GRANT**
7 **PROGRAM FOR INDIVIDUALS WITH SERIOUS**
8 **MENTAL ILLNESS.**

9 “(a) IN GENERAL.—The Secretary shall carry out a
10 program to award grants to eligible entities for assisted
11 outpatient treatment programs for individuals with serious
12 mental illness.

13 “(b) CONSULTATION.—The Secretary shall carry out
14 this section in consultation with the Director of the Na-
15 tional Institute of Mental Health, the Attorney General
16 of the United States, the Administrator of the Administra-
17 tion for Community Living, and the Assistant Secretary
18 for Mental Health and Substance Use.

19 “(c) SELECTING AMONG APPLICANTS.—In awarding
20 grants under this section, the Secretary—

21 “(1) may give preference to applicants that
22 have not previously implemented an assisted out-
23 patient treatment program; and

24 “(2) shall evaluate applicants based on their po-
25 tential to reduce hospitalization, homelessness, incar-

1 ceration, and interaction with the criminal justice
2 system while improving the health and social out-
3 comes of the patient.

4 “(d) PROGRAM REQUIREMENTS.—An assisted out-
5 patient treatment program funded with a grant awarded
6 under this section shall include—

7 “(1) evaluating the medical and social needs of
8 the patients who are participating in the program;

9 “(2) preparing and executing treatment plans
10 for such patients that—

11 “(A) include criteria for completion of
12 court-ordered treatment if applicable; and

13 “(B) provide for monitoring of the pa-
14 tient’s compliance with the treatment plan, in-
15 cluding compliance with medication and other
16 treatment regimens;

17 “(3) providing for case management services
18 that support the treatment plan;

19 “(4) ensuring appropriate referrals to medical
20 and social services providers;

21 “(5) evaluating the process for implementing
22 the program to ensure consistency with the patient’s
23 needs and State law; and

1 “(6) measuring treatment outcomes, including
2 health and social outcomes such as rates of incarcer-
3 ation, health care utilization, and homelessness.

4 “(e) REPORT.—Not later than the end of fiscal year
5 2027, the Secretary shall submit a report to the appro-
6 priate congressional committees on the grant program
7 under this section. Such report shall include an evaluation
8 of the following:

9 “(1) Cost savings and public health outcomes
10 such as mortality, suicide, substance abuse, hos-
11 pitalization, and use of services.

12 “(2) Rates of incarceration of patients.

13 “(3) Rates of homelessness of patients.

14 “(4) Patient and family satisfaction with pro-
15 gram participation.

16 “(5) Demographic information regarding par-
17 ticipation of those served by the grant compared to
18 demographic information in the population of the
19 grant recipient.

20 “(f) DEFINITIONS.—In this section:

21 “(1) The term ‘assisted outpatient treatment’
22 means medically prescribed mental health treatment
23 that a patient receives while living in a community
24 under the terms of a law authorizing a State or local
25 civil court to order such treatment.

1 “(2) The term ‘eligible entity’ means a county,
2 city, mental health system, mental health court, or
3 any other entity with authority under the law of the
4 State in which the entity is located to implement,
5 monitor, and oversee an assisted outpatient treat-
6 ment program.

7 “(g) FUNDING.—

8 “(1) AMOUNT OF GRANTS.—

9 “(A) MAXIMUM AMOUNT.—The amount of
10 a grant under this section shall not exceed
11 \$1,000,000 for any fiscal year.

12 “(B) DETERMINATION.—Subject to sub-
13 paragraph (A), the Secretary shall determine
14 the amount of each grant under this section
15 based on the population of the area to be served
16 through the grant and an estimate of the num-
17 ber of patients to be served.

18 “(2) AUTHORIZATION OF APPROPRIATIONS.—

19 There is authorized to be appropriated to carry out
20 this section \$22,000,000 for each of fiscal years
21 2023 through 2027.”.

1 **Subtitle D—Anna Westin Legacy**

2 **SEC. 131. MAINTAINING EDUCATION AND TRAINING ON**
3 **EATING DISORDERS.**

4 Subpart 3 of part B of title V of the Public Health
5 Service Act (42 U.S.C. 290bb–31 et seq.), as amended by
6 section 102, is further amended by adding at the end the
7 following:

8 **“SEC. 5200. CENTER OF EXCELLENCE FOR EATING DIS-**
9 **ORDERS FOR EDUCATION AND TRAINING ON**
10 **EATING DISORDERS.**

11 “(a) IN GENERAL.—The Secretary, acting through
12 the Assistant Secretary, shall maintain, by competitive
13 grant or contract, a Center of Excellence for Eating Dis-
14 orders (referred to in this section as the ‘Center’) to im-
15 prove the identification of, interventions for, and treat-
16 ment of eating disorders in a manner that is develop-
17 mentally, culturally, and linguistically appropriate.

18 “(b) SUBGRANTS AND SUBCONTRACTS.—The Center
19 shall coordinate and implement the activities under sub-
20 section (c), in whole or in part, by awarding competitive
21 subgrants or subcontracts—

22 “(1) across geographical regions; and

23 “(2) in a manner that is not duplicative.

24 “(c) ACTIVITIES.—The Center—

25 “(1) shall—

1 “(A) provide training and technical assist-
2 ance for—

3 “(i) primary care and behavioral
4 health care providers to carry out screen-
5 ing, brief intervention, and referral to
6 treatment for individuals experiencing, or
7 at risk for, eating disorders; and

8 “(ii) nonclinical community support
9 workers to identify and support individuals
10 with, or at disproportionate risk for, eating
11 disorders;

12 “(B) develop and provide training mate-
13 rials to health care providers, including primary
14 care and behavioral health care providers, in
15 the effective treatment and ongoing support of
16 individuals with eating disorders, including chil-
17 dren and marginalized populations at dispropor-
18 tionate risk for eating disorders;

19 “(C) provide collaboration and coordina-
20 tion to other centers of excellence, technical as-
21 sistance centers, and psychiatric consultation
22 lines of the Substance Abuse and Mental
23 Health Services Administration and the Health
24 Resources and Services Administration on the
25 identification, effective treatment, and ongoing

1 support of individuals with eating disorders;
2 and

3 “(D) coordinate with the Director of the
4 Centers for Disease Control and Prevention and
5 the Administrator of the Health Resources and
6 Services Administration to disseminate training
7 to primary care and behavioral health care pro-
8 viders; and

9 “(2) may—

10 “(A) coordinate with electronic health
11 record systems for the integration of protocols
12 pertaining to screening, brief intervention, and
13 referral to treatment for individuals experi-
14 encing, or at risk for, eating disorders;

15 “(B) develop and provide training mate-
16 rials to health care providers, including primary
17 care and behavioral health care providers, in
18 the effective treatment and ongoing support for
19 members of the Armed Forces and veterans ex-
20 perencing, or at risk for, eating disorders; and

21 “(C) consult with the Secretary of Defense
22 and the Secretary of Veterans Affairs on pre-
23 vention, identification, intervention for, and
24 treatment of eating disorders.

1 “(d) AUTHORIZATION OF APPROPRIATIONS.—To
2 carry out this section, there is authorized to be appro-
3 priated \$1,000,000 for each of fiscal years 2023 through
4 2027.”.

5 **Subtitle E—Community Mental**
6 **Health Services Block Grant Re-**
7 **authorization**

8 **SEC. 141. REAUTHORIZATION OF BLOCK GRANTS FOR COM-**
9 **MUNITY MENTAL HEALTH SERVICES.**

10 (a) FUNDING.—Section 1920(a) of the Public Health
11 Service Act (42 U.S.C. 300x–9(a)) is amended by striking
12 “\$532,571,000 for each of fiscal years 2018 through
13 2022” and inserting “\$857,571,000 for each of fiscal
14 years 2023 through 2027”.

15 (b) SET-ASIDE FOR EVIDENCE-BASED CRISIS CARE
16 SERVICES.—Section 1920 of the Public Health Service
17 Act (42 U.S.C. 300x–9) is amended by adding at the end
18 the following:

19 “(d) CRISIS CARE.—

20 “(1) IN GENERAL.—Except as provided in para-
21 graph (3), a State shall expend at least 5 percent of
22 the amount the State receives pursuant to section
23 1911 for each fiscal year to support evidenced-based
24 programs that address the crisis care needs of—

1 “(A) individuals, including children and
2 adolescents, experiencing mental health crises,
3 substance-related crises, or crises arising from
4 co-occurring disorders; and

5 “(B) persons with intellectual and develop-
6 mental disabilities.

7 “(2) CORE ELEMENTS.—At the discretion of
8 the single State agency responsible for the adminis-
9 tration of the program of the State under a grant
10 under section 1911, funds expended pursuant to
11 paragraph (1) may be used to fund some or all of
12 the core crisis care service components, delivered ac-
13 cording to evidence-based principles, including the
14 following:

15 “(A) Crisis call centers.

16 “(B) 24/7 mobile crisis services.

17 “(C) Crisis stabilization programs offering
18 acute care or subacute care in a hospital or ap-
19 propriately licensed facility, as determined by
20 the Substance Abuse and Mental Health Serv-
21 ices Administration, with referrals to inpatient
22 or outpatient care.

23 “(3) STATE FLEXIBILITY.—In lieu of expending
24 5 percent of the amount the State receives pursuant
25 to section 1911 for a fiscal year to support evidence-

1 based programs as required by paragraph (1), a
2 State may elect to expend not less than 10 percent
3 of such amount to support such programs by the
4 end of two consecutive fiscal years.

5 “(4) RULE OF CONSTRUCTION.—With respect
6 to funds expended pursuant to the set-aside in para-
7 graph (1), section 1912(b)(1)(A)(vi) shall not
8 apply.”

9 (c) EARLY INTERVENTION.—

10 (1) STATE PLAN OPTION.—Section
11 1912(b)(1)(A)(vii) of the Public Health Service Act
12 (42 U.S.C. 300x-1(b)(1)(A)(vii)) is amended—

13 (A) in subclause (III), by striking “and” at
14 the end;

15 (B) in subclause (IV), by striking the pe-
16 riod at the end and inserting “; and”; and

17 (C) by adding at the end the following:

18 “(V) a description of any evi-
19 dence-based early intervention strate-
20 gies and programs the State provides
21 to prevent, delay, or reduce the sever-
22 ity and onset of mental illness and be-
23 havioral problems, including for chil-
24 dren and adolescents, irrespective of
25 experiencing a serious mental illness

1 or serious emotional disturbance, as
2 defined under subsection (c)(1).”.

3 (2) ALLOCATION ALLOWANCE; REPORTS.—Sec-
4 tion 1920 of the Public Health Service Act (42
5 U.S.C. 300x–9), as amended by subsection (c), is
6 further amended by adding at the end the following:
7 “(e) EARLY INTERVENTION SERVICES.—In the case
8 of a State with a State plan that provides for strategies
9 and programs specified in section 1912(b)(1)(A)(vii)(VI),
10 such State may expend not more than 5 percent of the
11 amount of the allotment of the State pursuant to a fund-
12 ing agreement under section 1911 for each fiscal year to
13 support such strategies and programs.

14 “(f) REPORTS TO CONGRESS.—Not later than Sep-
15 tember 30, 2025, and biennially thereafter, the Secretary
16 shall provide a report to the Congress on the crisis care
17 and early intervention strategies and programs pursued by
18 States pursuant to subsections (d) and (e). Each such re-
19 port shall include—

20 “(1) a description of the each State’s crisis care
21 and early intervention activities;

22 “(2) the population served, including informa-
23 tion on demographics, including age;

24 “(3) the outcomes of such activities, includ-
25 ing—

1 “(A) how such activities reduced hos-
2 pitalizations and hospital stays;

3 “(B) how such activities reduced incidents
4 of suicidal ideation and behaviors; and

5 “(C) how such activities reduced the sever-
6 ity of onset of serious mental illness and serious
7 emotional disturbance; and

8 “(4) any other relevant information the Sec-
9 retary deems necessary.”.

10 **Subtitle F—Peer-Supported Mental** 11 **Health Services**

12 **SEC. 151. PEER-SUPPORTED MENTAL HEALTH SERVICES.**

13 Subpart 3 of part B of title V of the Public Health
14 Service Act (42 U.S.C. 290bb—31 et seq.) is amended by
15 inserting after section 520G (42 U.S.C. 290bb—38) the
16 following:

17 **“SEC. 520H. PEER-SUPPORTED MENTAL HEALTH SERVICES.**

18 “(a) GRANTS AUTHORIZED.—The Secretary, acting
19 through the Director of the Center for Mental Health
20 Services, shall award grants to eligible entities to enable
21 such entities to develop, expand, and enhance access to
22 mental health peer-delivered services.

23 “(b) USE OF FUNDS.—Grants awarded under sub-
24 section (a) shall be used to develop, expand, and enhance
25 national, statewide, or community-focused programs, in-

1 cluding virtual peer-support services and infrastructure,
2 including by—

3 “(1) carrying out workforce development, re-
4 cruitment, and retention activities, to train, recruit,
5 and retain peer-support providers;

6 “(2) building connections between mental
7 health treatment programs, including between com-
8 munity organizations and peer-support networks, in-
9 cluding virtual peer-support networks, and with
10 other mental health support services;

11 “(3) reducing stigma associated with mental
12 health disorders;

13 “(4) expanding and improving virtual peer men-
14 tal health support services, including adoption of
15 technologies to expand access to virtual peer mental
16 health support services, including by acquiring—

17 “(A) appropriate physical hardware for
18 such virtual services;

19 “(B) software and programs to efficiently
20 run peer-support services virtually; and

21 “(C) other technology for establishing vir-
22 tual waiting rooms and virtual video platforms
23 for meetings; and

1 “(5) conducting research on issues relating to
2 mental illness and the impact peer-support has on
3 resiliency, including identifying—

4 “(A) the signs of mental illness;

5 “(B) the resources available to individuals
6 with mental illness and to their families; and

7 “(C) the resources available to help sup-
8 port individuals living with mental illness.

9 “(c) SPECIAL CONSIDERATION.—In carrying out this
10 section, the Secretary shall give special consideration to
11 the unique needs of rural areas.

12 “(d) DEFINITION.—In this section, the term ‘eligible
13 entity’ means—

14 “(1) a nonprofit consumer-run organization
15 that—

16 “(A) is principally governed by people liv-
17 ing with a mental health condition; and

18 “(B) mobilizes resources within and out-
19 side of the mental health community, which
20 may include through peer-support networks, to
21 increase the prevalence and quality of long-term
22 wellness of individuals living with a mental
23 health condition, including those with a co-oc-
24 curring substance use disorder; or

1 “(2) a Federally recognized Tribe, Tribal orga-
2 nization, Urban Indian organization, or consortium
3 of Tribes or Tribal organizations.

4 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
5 is authorized to be appropriated to carry out this section
6 \$13,000,000 for each of fiscal years 2023 through 2027.”.

7 **TITLE II—SUBSTANCE USE DIS-**
8 **ORDER PREVENTION, TREAT-**
9 **MENT, AND RECOVERY SERV-**
10 **ICES**

11 **Subtitle A—Native Behavioral**
12 **Health Access Improvement**

13 **SEC. 201. BEHAVIORAL HEALTH AND SUBSTANCE USE DIS-**
14 **ORDER SERVICES FOR NATIVE AMERICANS.**

15 Section 506A of the Public Health Service Act (42
16 U.S.C. 290aa–5a) is amended to read as follows:

17 **“SEC. 506A. BEHAVIORAL HEALTH AND SUBSTANCE USE**
18 **DISORDER SERVICES FOR NATIVE AMERI-**
19 **CANS.**

20 “(a) DEFINITIONS.—In this section:

21 “(1) The term ‘eligible entity’ means an Indian
22 Tribe, a Tribal organization, an Urban Indian orga-
23 nization, and a Native Hawaiian health organization.

24 “(2) The terms ‘Indian Tribe’, ‘Tribal organiza-
25 tion’, and ‘Urban Indian organization’ have the

1 meanings given to the terms ‘Indian tribe’, ‘tribal
2 organization’, and ‘Urban Indian organization’ in
3 section 4 of the Indian Health Care Improvement
4 Act.

5 “(3) The term ‘Native Hawaiian health organi-
6 zation’ means ‘Papa Ola Lokahi’ as defined in sec-
7 tion 12 of the Native Hawaiian Health Care Im-
8 provement Act.

9 “(b) FORMULA FUNDS.—

10 “(1) IN GENERAL.—The Secretary, in consulta-
11 tion with the Director of the Indian Health Service,
12 as appropriate, shall award funds to eligible entities,
13 in amounts determined pursuant to the formula de-
14 scribed in paragraph (2), to be used by the eligible
15 entity to provide culturally appropriate mental
16 health and substance use disorder prevention, treat-
17 ment, and recovery services to American Indians,
18 Alaska Natives, and Native Hawaiians.

19 “(2) FORMULA.—The Secretary, using the
20 process described in subsection (d), shall develop a
21 formula to determine the amount of an award under
22 paragraph (1). Such formula shall take into account
23 the populations of eligible entities whose rates of
24 overdose deaths or suicide are substantially higher
25 relative to the populations of other Indian Tribes,

1 Tribal organizations, Urban Indian organizations, or
2 Native Hawaiian health organizations, as applicable.

3 “(c) TECHNICAL ASSISTANCE AND PROGRAM EVAL-
4 UATION.—

5 “(1) IN GENERAL.—The Secretary shall—

6 “(A) provide technical assistance to appli-
7 cants and awardees under this section; and

8 “(B) collect and evaluate information on
9 the program carried out under this section.

10 “(2) CONSULTATION ON EVALUATION MEAS-
11 URES, AND DATA SUBMISSION AND REPORTING RE-
12 QUIREMENTS.—The Secretary shall, using the proc-
13 ess described in subsection (d), develop evaluation
14 measures and data submission and reporting re-
15 quirements for purposes of the collection and evalua-
16 tion of information.

17 “(3) DATA SUBMISSION AND REPORTING.—As a
18 condition on receipt of funds under this section, an
19 applicant shall agree to submit data and reports in
20 a timely manner consistent with the evaluation
21 measures and data submission and reporting re-
22 quirements developed under subsection (d).

23 “(d) REGULATIONS.—

24 “(1) PROMULGATION.—Not later than 180 days
25 after the date of enactment of the Restoring Hope

1 for Mental Health and Well-Being Act of 2022, the
2 Secretary shall initiate procedures under subchapter
3 III of chapter 5 of title 5, United States Code, to
4 negotiate and promulgate such regulations as are
5 necessary to carry out this section, including devel-
6 opment of the funding formula described in sub-
7 section (b) and the program evaluation and report-
8 ing requirements under subsection (c).

9 “(2) PUBLICATION.—Not later than 18 months
10 after the date of enactment of the Restoring Hope
11 for Mental Health and Well-Being Act of 2022, the
12 Secretary shall publish in the Federal Register pro-
13 posed regulations to implement this section.

14 “(3) COMMITTEE.—A negotiated rulemaking
15 committee established pursuant to section 565 of
16 title 5, United States Code, to carry out this sub-
17 section shall have as its members only representa-
18 tives of the Federal Government, Tribal Govern-
19 ments, and Urban Indian organizations. For pur-
20 poses of such rulemaking, the Indian Health Service
21 shall be the lead agency for the Department.

22 “(4) ADAPTATION OF PROCEDURES.—In car-
23 rying out this subsection, the Secretary shall adapt
24 any negotiated rulemaking procedures to the unique

1 context of the government-to-government relation-
2 ship between the United States and Indian Tribes.

3 “(5) EFFECT.—The lack of promulgated regu-
4 lations under this subsection shall not limit the ef-
5 fect or implementation of this section.

6 “(e) APPLICATION.—An entity desiring an award
7 under subsection (b) shall submit an application to the
8 Secretary at such time, in such manner, and accompanied
9 by such information as the Secretary may reasonably re-
10 quire.

11 “(f) REPORT.—Not later than 3 years after the date
12 of the enactment of the Restoring Hope for Mental Health
13 and Well-Being Act of 2022, and annually thereafter, the
14 Secretary shall prepare and submit, to the Committee on
15 Health, Education, Labor, and Pensions of the Senate,
16 and the Committee on Energy and Commerce of the
17 House of Representatives, a report describing the services
18 provided pursuant to this section.

19 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
20 are authorized to be appropriated to carry out this section,
21 \$40,000,000 for each of fiscal years 2023 through 2027.”.

1 **Subtitle B—Summer Barrow Pre-**
2 **vention, Treatment, and Recov-**
3 **ery**

4 **SEC. 211. GRANTS FOR THE BENEFIT OF HOMELESS INDI-**
5 **VIDUALS.**

6 Section 506(e) of the Public Health Service Act (42
7 U.S.C. 290aa–5(e)) is amended by striking “2018 through
8 2022” and inserting “2023 through 2027”.

9 **SEC. 212. PRIORITY SUBSTANCE ABUSE TREATMENT NEEDS**
10 **OF REGIONAL AND NATIONAL SIGNIFICANCE.**

11 Section 509 of the Public Health Service Act (42
12 U.S.C. 290bb–2) is amended—

13 (1) in the section heading, by striking
14 “**ABUSE**” and inserting “**USE DISORDER**”;

15 (2) in subsection (a)—

16 (A) by striking “tribes and tribal organiza-
17 tions (as the terms ‘Indian tribes’ and ‘tribal
18 organizations’ are defined” and inserting
19 “Tribes and Tribal organizations (as such
20 terms are defined”; and

21 (B) in paragraph (3), by striking “in sub-
22 stance abuse”;

23 (3) in subsection (b), in the subsection heading,
24 by striking “**ABUSE**” and inserting “**USE DIS-**
25 **ORDER**”; and

1 (4) in subsection (f), by striking “\$333,806,000
2 for each of fiscal years 2018 through 2022” and in-
3 serting “\$521,517,000 for each of fiscal years 2023
4 through 2027”.

5 **SEC. 213. EVIDENCE-BASED PRESCRIPTION OPIOID AND**
6 **HEROIN TREATMENT AND INTERVENTIONS**
7 **DEMONSTRATION.**

8 Section 514B of the Public Health Service Act (42
9 U.S.C. 290bb–10) is amended—

10 (1) in subsection (a)(1)—

11 (A) by striking “substance abuse” and in-
12 serting “substance use disorder”;

13 (B) by striking “tribes and tribal organiza-
14 tions” and inserting “Tribes and Tribal organi-
15 zations”; and

16 (C) by striking “addiction” and inserting
17 “substance use disorders”;

18 (2) in subsection (e)(3), by striking “tribes and
19 tribal organizations” and inserting “Tribes and
20 Tribal organizations”; and

21 (3) in subsection (f), by striking “2017 through
22 2021” and inserting “2023 through 2027”.

1 **SEC. 214. PRIORITY SUBSTANCE USE DISORDER PREVEN-**
2 **TION NEEDS OF REGIONAL AND NATIONAL**
3 **SIGNIFICANCE.**

4 Section 516 of the Public Health Service Act (42
5 U.S.C. 290bb–22) is amended—

6 (1) in subsection (a)—

7 (A) in paragraph (3), by striking “abuse”
8 and inserting “use”; and

9 (B) in the matter following paragraph (3),
10 by striking “tribes or tribal organizations” and
11 inserting “Tribes or Tribal organizations”;

12 (2) in subsection (b), in the subsection heading,
13 by striking “ABUSE” and inserting “USE DIS-
14 ORDER”; and

15 (3) in subsection (f), by striking “\$211,148,000
16 for each of fiscal years 2018 through 2022” and in-
17 serting “\$218,219,000 for each of fiscal years 2023
18 through 2027”.

19 **SEC. 215. SOBER TRUTH ON PREVENTING (STOP) UNDER-**
20 **AGE DRINKING REAUTHORIZATION.**

21 Section 519B of the Public Health Service Act (42
22 U.S.C. 290bb–25b) is amended—

23 (1) by amending subsection (a) to read as fol-
24 lows:

25 “(a) DEFINITIONS.—For purposes of this section:

1 “(1) The term ‘alcohol beverage industry’
2 means the brewers, vintners, distillers, importers,
3 distributors, and retail or online outlets that sell or
4 serve beer, wine, and distilled spirits.

5 “(2) The term ‘school-based prevention’ means
6 programs, which are institutionalized, and run by
7 staff members or school-designated persons or orga-
8 nizations in any grade of school, kindergarten
9 through 12th grade.

10 “(3) The term ‘youth’ means persons under the
11 age of 21.”; and

12 (2) by striking subsections (e) through (g) and
13 inserting the following:

14 “(c) INTERAGENCY COORDINATING COMMITTEE; AN-
15 NUAL REPORT ON STATE UNDERAGE DRINKING PREVEN-
16 TION AND ENFORCEMENT ACTIVITIES.—

17 “(1) INTERAGENCY COORDINATING COMMITTEE
18 ON THE PREVENTION OF UNDERAGE DRINKING.—

19 “(A) IN GENERAL.—The Secretary, in col-
20 laboration with the Federal officials specified in
21 subparagraph (B), shall continue to support
22 and enhance the efforts of the interagency co-
23 ordinating committee, that began operating in
24 2004, focusing on underage drinking (referred
25 to in this subsection as the ‘Committee’).

1 “(B) OTHER AGENCIES.—The officials re-
2 ferred to in subparagraph (A) are the Secretary
3 of Education, the Attorney General, the Sec-
4 retary of Transportation, the Secretary of the
5 Treasury, the Secretary of Defense, the Sur-
6 geon General, the Director of the Centers for
7 Disease Control and Prevention, the Director of
8 the National Institute on Alcohol Abuse and Al-
9 coholism, the Assistant Secretary for Mental
10 Health and Substance Use, the Director of the
11 National Institute on Drug Abuse, the Assist-
12 ant Secretary for Children and Families, the
13 Director of the Office of National Drug Control
14 Policy, the Administrator of the National High-
15 way Traffic Safety Administration, the Admin-
16 istrator of the Office of Juvenile Justice and
17 Delinquency Prevention, the Chairman of the
18 Federal Trade Commission, and such other
19 Federal officials as the Secretary of Health and
20 Human Services determines to be appropriate.

21 “(C) CHAIR.—The Secretary of Health
22 and Human Services shall serve as the chair of
23 the Committee.

24 “(D) DUTIES.—The Committee shall guide
25 policy and program development across the

1 Federal Government with respect to underage
2 drinking, provided, however, that nothing in
3 this section shall be construed as transferring
4 regulatory or program authority from an Agen-
5 cy to the Coordinating Committee.

6 “(E) CONSULTATIONS.—The Committee
7 shall actively seek the input of and shall consult
8 with all appropriate and interested parties, in-
9 cluding States, public health research and inter-
10 est groups, foundations, and alcohol beverage
11 industry trade associations and companies.

12 “(F) ANNUAL REPORT.—

13 “(i) IN GENERAL.—The Secretary, on
14 behalf of the Committee, shall annually
15 submit to the Congress a report that sum-
16 marizes—

17 “(I) all programs and policies of
18 Federal agencies designed to prevent
19 and reduce underage drinking, focus-
20 ing particularly on programs and poli-
21 cies that support the adoption and en-
22 forcement of State policies designed to
23 prevent and reduce underage drinking
24 as specified in paragraph (2);

1 “(II) the extent of progress in
2 preventing and reducing underage
3 drinking at State and national levels;

4 “(III) data that the Secretary
5 shall collect with respect to the infor-
6 mation specified in clause (ii); and

7 “(IV) such other information re-
8 garding underage drinking as the Sec-
9 retary determines to be appropriate.

10 “(ii) CERTAIN INFORMATION.—The
11 report under clause (i) shall include infor-
12 mation on the following:

13 “(I) Patterns and consequences
14 of underage drinking as reported in
15 research and surveys such as, but not
16 limited to, Monitoring the Future,
17 Youth Risk Behavior Surveillance
18 System, the National Survey on Drug
19 Use and Health, and the Fatality
20 Analysis Reporting System.

21 “(II) Measures of the availability
22 of alcohol from commercial and non-
23 commercial sources to underage popu-
24 lations.

1 “(III) Measures of the exposure
2 of underage populations to messages
3 regarding alcohol in advertising, social
4 media, and the entertainment media.

5 “(IV) Surveillance data, includ-
6 ing information on the onset and
7 prevalence of underage drinking, con-
8 sumption patterns, beverage pref-
9 erences, prevalence of drinking among
10 students at institutions of higher edu-
11 cation, correlations between adult and
12 youth drinking, and the means of un-
13 derage access, including trends over
14 time for these surveillance data. The
15 Secretary shall develop a plan to im-
16 prove the collection, measurement,
17 and consistency of reporting Federal
18 underage alcohol data.

19 “(V) Any additional findings re-
20 sulting from research conducted or
21 supported under subsection (f).

22 “(VI) Evidence-based best prac-
23 tices to prevent and reduce underage
24 drinking including a review of the re-
25 search literature related to State laws,

1 regulations, and policies designed to
2 prevent and reduce underage drink-
3 ing, as described in paragraph
4 (2)(B)(i).

5 “(2) ANNUAL REPORT ON STATE UNDERAGE
6 DRINKING PREVENTION AND ENFORCEMENT ACTIVI-
7 TIES.—

8 “(A) IN GENERAL.—The Secretary shall,
9 with input and collaboration from other appro-
10 priate Federal agencies, States, Indian Tribes,
11 territories, and public health, consumer, and al-
12 cohol beverage industry groups, annually issue
13 a report on each State’s performance in enact-
14 ing, enforcing, and creating laws, regulations,
15 and policies to prevent or reduce underage
16 drinking based on an assessment of best prac-
17 tices developed pursuant to paragraph
18 (1)(F)(ii)(VI) and subparagraph (B)(i). For
19 purposes of this paragraph, each such report,
20 with respect to a year, shall be referred to as
21 the ‘State Report’. Each State Report shall be
22 designed as a resource tool for Federal agencies
23 assisting States in the their underage drinking
24 prevention efforts, State public health and law
25 enforcement agencies, State and local policy-

1 makers, and underage drinking prevention coa-
2 litions including those receiving grants pursuant
3 to subsection (e).

4 “(B) STATE PERFORMANCE MEASURES.—

5 “(i) IN GENERAL.—The Secretary
6 shall develop, in consultation with the
7 Committee, a set of measures to be used in
8 preparing the State Report on best prac-
9 tices as they relate to State laws, regula-
10 tions, policies, and enforcement practices.

11 “(ii) STATE REPORT CONTENT.—The
12 State Report shall include updates on
13 State laws, regulations, and policies in-
14 cluded in previous reports to Congress, in-
15 cluding with respect to the following:

16 “(I) Whether or not the State
17 has comprehensive anti-underage
18 drinking laws such as for the illegal
19 sale, purchase, attempt to purchase,
20 consumption, or possession of alcohol;
21 illegal use of fraudulent ID; illegal
22 furnishing or obtaining of alcohol for
23 an individual under 21 years; the de-
24 gree of strictness of the penalties for
25 such offenses; and the prevalence of

1 the enforcement of each of these in-
2 fractions.

3 “(II) Whether or not the State
4 has comprehensive liability statutes
5 pertaining to underage access to alco-
6 hol such as dram shop, social host,
7 and house party laws, and the preva-
8 lence of enforcement of each of these
9 laws.

10 “(III) Whether or not the State
11 encourages and conducts comprehen-
12 sive enforcement efforts to prevent
13 underage access to alcohol at retail
14 outlets, such as random compliance
15 checks and shoulder tap programs,
16 and the number of compliance checks
17 within alcohol retail outlets measured
18 against the number of total alcohol re-
19 tail outlets in each State, and the re-
20 sult of such checks.

21 “(IV) Whether or not the State
22 encourages training on the proper
23 selling and serving of alcohol for all
24 sellers and servers of alcohol as a con-
25 dition of employment.

1 “(V) Whether or not the State
2 has policies and regulations with re-
3 gard to direct sales to consumers and
4 home delivery of alcoholic beverages.

5 “(VI) Whether or not the State
6 has programs or laws to deter adults
7 from purchasing alcohol for minors;
8 and the number of adults targeted by
9 these programs.

10 “(VII) Whether or not the State
11 has enacted graduated drivers licenses
12 and the extent of those provisions.

13 “(iii) ADDITIONAL CATEGORIES.—In
14 addition to the updates on State laws, reg-
15 ulations, and policies listed in clause (ii),
16 the Secretary shall consider the following:

17 “(I) Whether or not States have
18 adopted laws, regulations, and policies
19 that deter underage alcohol use, as
20 described in ‘The Surgeon General’s
21 Call to Action to Prevent and Reduce
22 Underage Drinking’ issued in 2007
23 and ‘Facing Addiction in America:
24 The Surgeon General’s Report on Al-
25 cohol, Drugs and Health’ issued in

1 2016, including restrictions on low-
2 price, high-volume drink specials, and
3 wholesaler pricing provisions.

4 “(II) Whether or not States have
5 adopted laws, regulations, and policies
6 designed to reduce alcohol advertising
7 messages attractive to youth and
8 youth exposure to alcohol advertising
9 and marketing in measured and
10 unmeasured media and digital and so-
11 cial media.

12 “(III) Whether or not States
13 have laws and policies that promote
14 underage drinking prevention policy
15 development by local jurisdictions.

16 “(IV) Whether or not States
17 have adopted laws, regulations, and
18 policies to restrict youth access to al-
19 coholic beverages that may pose spe-
20 cial risks to youth, including but not
21 limited to alcoholic mists, gelatins,
22 freezer pops, premixed caffeinated al-
23 coholic beverages, and flavored malt
24 beverages.

1 “(V) Whether or not States have
2 adopted uniform best practices proto-
3 cols for conducting compliance checks
4 and shoulder tap programs.

5 “(VI) Whether or not States
6 have adopted uniform best practices
7 penalty protocols for violations of laws
8 prohibiting retail licensees from sell-
9 ing or furnishing of alcohol to minors.

10 “(iv) UNIFORM DATA SYSTEM.—For
11 performance measures related to enforce-
12 ment of underage drinking laws as speci-
13 fied in clauses (ii) and (iii), the Secretary
14 shall develop and test a uniform data sys-
15 tem for reporting State enforcement data,
16 including the development of a pilot pro-
17 gram for this purpose. The pilot program
18 shall include procedures for collecting en-
19 forcement data from both State and local
20 law enforcement jurisdictions.

21 “(3) AUTHORIZATION OF APPROPRIATIONS.—
22 There is authorized to be appropriated to carry out
23 this subsection \$1,000,000 for each of fiscal years
24 2023 through 2027.

1 “(d) NATIONAL MEDIA CAMPAIGN TO PREVENT UN-
2 DERAGE DRINKING.—

3 “(1) IN GENERAL.—The Secretary, in consulta-
4 tion with the National Highway Traffic Safety Ad-
5 ministration, shall develop an intensive, multifaceted,
6 adult-oriented national media campaign to reduce
7 underage drinking by influencing attitudes regarding
8 underage drinking, increasing the willingness of
9 adults to take actions to reduce underage drinking,
10 and encouraging public policy changes known to de-
11 crease underage drinking rates.

12 “(2) PURPOSE.—The purpose of the national
13 media campaign described in this section shall be to
14 achieve the following objectives:

15 “(A) Instill a broad societal commitment to
16 reduce underage drinking.

17 “(B) Increase specific actions by adults
18 that are meant to discourage or inhibit under-
19 age drinking.

20 “(C) Decrease adult conduct that tends to
21 facilitate or condone underage drinking.

22 “(3) COMPONENTS.—When implementing the
23 national media campaign described in this section,
24 the Secretary shall—

1 “(A) educate the public about the public
2 health and safety benefits of evidence-based
3 policies to reduce underage drinking, including
4 minimum legal drinking age laws, and build
5 public and parental support for and cooperation
6 with enforcement of such policies;

7 “(B) educate the public about the negative
8 consequences of underage drinking;

9 “(C) promote specific actions by adults
10 that are meant to discourage or inhibit under-
11 age drinking, including positive behavior mod-
12 eling, general parental monitoring, and con-
13 sistent and appropriate discipline;

14 “(D) discourage adult conduct that tends
15 to facilitate underage drinking, including the
16 hosting of underage parties with alcohol and
17 the purchasing of alcoholic beverages on behalf
18 of underage youth;

19 “(E) establish collaborative relationships
20 with local and national organizations and insti-
21 tutions to further the goals of the campaign
22 and assure that the messages of the campaign
23 are disseminated from a variety of sources;

24 “(F) conduct the campaign through multi-
25 media sources; and

1 “(G) conduct the campaign with regard to
2 changing demographics and cultural and lin-
3 guistic factors.

4 “(4) CONSULTATION REQUIREMENT.—In devel-
5 oping and implementing the national media cam-
6 paign described in this section, the Secretary shall
7 consult recommendations for reducing underage
8 drinking published by the National Academy of
9 Sciences and the Surgeon General. The Secretary
10 shall also consult with interested parties including
11 medical, public health, and consumer and parent
12 groups, law enforcement, institutions of higher edu-
13 cation, community organizations and coalitions, and
14 other stakeholders supportive of the goals of the
15 campaign.

16 “(5) ANNUAL REPORT.—The Secretary shall
17 produce an annual report on the progress of the de-
18 velopment or implementation of the media campaign
19 described in this subsection, including expenses and
20 projected costs, and, as such information is avail-
21 able, report on the effectiveness of such campaign in
22 affecting adult attitudes toward underage drinking
23 and adult willingness to take actions to decrease un-
24 derage drinking.

1 “(6) RESEARCH ON YOUTH-ORIENTED CAM-
2 PAIGN.—The Secretary may, based on the avail-
3 ability of funds, conduct research on the potential
4 success of a youth-oriented national media campaign
5 to reduce underage drinking. The Secretary shall re-
6 port any such results to Congress with policy rec-
7 ommendations on establishing such a campaign.

8 “(7) ADMINISTRATION.—The Secretary may
9 enter into a subcontract with another Federal agen-
10 cy to delegate the authority for execution and ad-
11 ministration of the adult-oriented national media
12 campaign.

13 “(8) AUTHORIZATION OF APPROPRIATIONS.—
14 There is authorized to be appropriated to carry out
15 this section \$2,500,000 for each of fiscal years 2023
16 through 2027.

17 “(e) COMMUNITY-BASED COALITION ENHANCEMENT
18 GRANTS TO PREVENT UNDERAGE DRINKING.—

19 “(1) AUTHORIZATION OF PROGRAM.—The As-
20 sistant Secretary for Mental Health and Substance
21 Use, in consultation with the Director of the Office
22 of National Drug Control Policy, shall award en-
23 hancement grants to eligible entities to design, im-
24 plement, evaluate, and disseminate comprehensive
25 strategies to maximize the effectiveness of commu-

1 nity-wide approaches to preventing and reducing un-
2 derage drinking. This subsection is subject to the
3 availability of appropriations.

4 “(2) PURPOSES.—The purposes of this sub-
5 section are to—

6 “(A) prevent and reduce alcohol use among
7 youth in communities throughout the United
8 States;

9 “(B) strengthen collaboration among com-
10 munities, the Federal Government, Tribal Gov-
11 ernments, and State and local governments;

12 “(C) enhance intergovernmental coopera-
13 tion and coordination on the issue of alcohol
14 use among youth;

15 “(D) serve as a catalyst for increased cit-
16 izen participation and greater collaboration
17 among all sectors and organizations of a com-
18 munity that first demonstrates a long-term
19 commitment to reducing alcohol use among
20 youth;

21 “(E) implement state-of-the-art science-
22 based strategies to prevent and reduce underage
23 drinking by changing local conditions in com-
24 munities; and

1 “(F) enhance, not supplant, effective local
2 community initiatives for preventing and reduc-
3 ing alcohol use among youth.

4 “(3) APPLICATION.—An eligible entity desiring
5 an enhancement grant under this subsection shall
6 submit an application to the Assistant Secretary at
7 such time, and in such manner, and accompanied by
8 such information and assurances, as the Assistant
9 Secretary may require. Each application shall in-
10 clude—

11 “(A) a complete description of the entity’s
12 current underage alcohol use prevention initia-
13 tives and how the grant will appropriately en-
14 hance the focus on underage drinking issues; or

15 “(B) a complete description of the entity’s
16 current initiatives, and how it will use this
17 grant to enhance those initiatives by adding a
18 focus on underage drinking prevention.

19 “(4) USES OF FUNDS.—Each eligible entity
20 that receives a grant under this subsection shall use
21 the grant funds to carry out the activities described
22 in such entity’s application submitted pursuant to
23 paragraph (3) and obtain specialized training and
24 technical assistance by the entity funded under sec-
25 tion 4 of Public Law 107–82, as amended (21

1 U.S.C. 1521 note). Grants under this subsection
2 shall not exceed \$60,000 per year and may not ex-
3 ceed four years.

4 “(5) SUPPLEMENT NOT SUPPLANT.—Grant
5 funds provided under this subsection shall be used to
6 supplement, not supplant, Federal and non-Federal
7 funds available for carrying out the activities de-
8 scribed in this subsection.

9 “(6) EVALUATION.—Grants under this sub-
10 section shall be subject to the same evaluation re-
11 quirements and procedures as the evaluation re-
12 quirements and procedures imposed on recipients of
13 drug-free community grants.

14 “(7) DEFINITIONS.—For purposes of this sub-
15 section, the term ‘eligible entity’ means an organiza-
16 tion that is currently receiving or has received grant
17 funds under the Drug-Free Communities Act of
18 1997.

19 “(8) ADMINISTRATIVE EXPENSES.—Not more
20 than 6 percent of a grant under this subsection may
21 be expended for administrative expenses.

22 “(9) AUTHORIZATION OF APPROPRIATIONS.—
23 There is authorized to be appropriated to carry out
24 this subsection \$11,500,000 for each of fiscal years
25 2023 through 2027.

1 “(f) GRANTS TO PROFESSIONAL PEDIATRIC PRO-
2 VIDER ORGANIZATIONS TO REDUCE UNDERAGE DRINK-
3 ING THROUGH SCREENING AND BRIEF INTERVEN-
4 TIONS.—

5 “(1) IN GENERAL.—The Secretary, acting
6 through the Assistant Secretary for Mental Health
7 and Substance Use, shall make one or more grants
8 to professional pediatric provider organizations to in-
9 crease among the members of such organizations ef-
10 fective practices to reduce the prevalence of alcohol
11 use among individuals under the age of 21, including
12 college students.

13 “(2) PURPOSES.—Grants under this subsection
14 shall be made to promote the practices of—

15 “(A) screening adolescents for alcohol use;

16 “(B) offering brief interventions to adoles-
17 cents to discourage such use;

18 “(C) educating parents about the dangers
19 of and methods of discouraging such use;

20 “(D) diagnosing and treating alcohol use
21 disorders; and

22 “(E) referring patients, when necessary, to
23 other appropriate care.

24 “(3) USE OF FUNDS.—A professional pediatric
25 provider organization receiving a grant under this

1 section may use the grant funding to promote the
2 practices specified in paragraph (2) among its mem-
3 bers by—

4 “(A) providing training to health care pro-
5 viders;

6 “(B) disseminating best practices, includ-
7 ing culturally and linguistically appropriate best
8 practices, and developing, printing, and distrib-
9 uting materials; and

10 “(C) supporting other activities approved
11 by the Assistant Secretary.

12 “(4) APPLICATION.—To be eligible to receive a
13 grant under this subsection, a professional pediatric
14 provider organization shall submit an application to
15 the Assistant Secretary at such time, and in such
16 manner, and accompanied by such information and
17 assurances as the Secretary may require. Each ap-
18 plication shall include—

19 “(A) a description of the pediatric provider
20 organization;

21 “(B) a description of the activities to be
22 completed that will promote the practices speci-
23 fied in paragraph (2);

1 “(C) a description of the organization’s
2 qualifications for performing such practices;
3 and

4 “(D) a timeline for the completion of such
5 activities.

6 “(5) DEFINITIONS.—For the purpose of this
7 subsection:

8 “(A) BRIEF INTERVENTION.—The term
9 ‘brief intervention’ means, after screening a pa-
10 tient, providing the patient with brief advice
11 and other brief motivational enhancement tech-
12 niques designed to increase the insight of the
13 patient regarding the patient’s alcohol use, and
14 any realized or potential consequences of such
15 use to effect the desired related behavioral
16 change.

17 “(B) ADOLESCENTS.—The term ‘adoles-
18 cents’ means individuals under 21 years of age.

19 “(C) PROFESSIONAL PEDIATRIC PROVIDER
20 ORGANIZATION.—The term ‘professional pedi-
21 atric provider organization’ means an organiza-
22 tion or association that—

23 “(i) consists of or represents pediatric
24 health care providers; and

1 “(ii) is qualified to promote the prac-
2 tices specified in paragraph (2).

3 “(D) SCREENING.—The term ‘screening’
4 means using validated patient interview tech-
5 niques to identify and assess the existence and
6 extent of alcohol use in a patient.

7 “(6) AUTHORIZATION OF APPROPRIATIONS.—
8 There is authorized to be appropriated to carry out
9 this subsection \$3,000,000 for each of fiscal years
10 2023 through 2027.

11 “(g) DATA COLLECTION AND RESEARCH.—

12 “(1) ADDITIONAL RESEARCH ON UNDERAGE
13 DRINKING.—

14 “(A) IN GENERAL.—The Secretary shall,
15 subject to the availability of appropriations, col-
16 lect data, and conduct or support research that
17 is not duplicative of research currently being
18 conducted or supported by the Department of
19 Health and Human Services, on underage
20 drinking, with respect to the following:

21 “(i) Improve data collection in sup-
22 port of evaluation of the effectiveness of
23 comprehensive community-based programs
24 or strategies and statewide systems to pre-
25 vent and reduce underage drinking, across

1 the underage years from early childhood to
2 age 21, such as programs funded and im-
3 plemented by governmental entities, public
4 health interest groups and foundations,
5 and alcohol beverage companies and trade
6 associations, through the development of
7 models of State-level epidemiological sur-
8 veillance of underage drinking by funding
9 in States or large metropolitan areas new
10 epidemiologists focused on excessive drink-
11 ing including underage alcohol use.

12 “(ii) Obtain and report more precise
13 information than is currently collected on
14 the scope of the underage drinking prob-
15 lem and patterns of underage alcohol con-
16 sumption, including improved knowledge
17 about the problem and progress in pre-
18 venting, reducing, and treating underage
19 drinking, as well as information on the
20 rate of exposure of youth to advertising
21 and other media messages encouraging and
22 discouraging alcohol consumption.

23 “(iii) Synthesize, expand on, and
24 widely disseminate existing research on ef-
25 fective strategies for reducing underage

1 drinking, including translational research,
2 and make this research easily accessible to
3 the general public.

4 “(iv) Improve and conduct public
5 health surveillance on alcohol use and alco-
6 hol-related conditions in States by increas-
7 ing the use of surveys, such as the Behav-
8 ioral Risk Factor Surveillance System, to
9 monitor binge and excessive drinking and
10 related harms among individuals who are
11 at least 18 years of age, but not more than
12 20 years of age, including harm caused to
13 self or others as a result of alcohol use
14 that is not duplicative of research currently
15 being conducted or supported by the De-
16 partment of Health and Human Services.

17 “(B) AUTHORIZATION OF APPROPRIA-
18 TIONS.—There is authorized to be appropriated
19 to carry out this paragraph \$5,000,000 for each
20 of fiscal years 2023 through 2027.

21 “(2) NATIONAL ACADEMY OF SCIENCES
22 STUDY.—

23 “(A) IN GENERAL.—Not later than 12
24 months after the enactment of the Restoring

1 Hope for Mental Health and Well-Being Act of
2 2022, the Secretary shall—

3 “(i) contract with the National Acad-
4 emy of Sciences to study developments in
5 research on underage drinking and the
6 public policy implications of these develop-
7 ments; and

8 “(ii) report to the Congress on the re-
9 sults of such review.

10 “(B) AUTHORIZATION OF APPROPRIA-
11 TIONS.—There is authorized to be appropriated
12 to carry out this paragraph \$500,000 for fiscal
13 year 2023.”.

14 **SEC. 216. GRANTS FOR JAIL DIVERSION PROGRAMS.**

15 Section 520G of the Public Health Service Act (42
16 U.S.C. 290bb–38) is amended—

17 (1) in subsection (a)—

18 (A) by striking “up to 125”; and

19 (B) by striking “tribes and tribal organiza-
20 tions” and inserting “Tribes and Tribal organi-
21 zations”;

22 (2) in subsection (b)(2), by striking “tribes, and
23 tribal organizations” and inserting “Tribes, and
24 Tribal organizations”;

25 (3) in subsection (c)—

1 (A) in paragraph (1), by striking “tribe or
2 tribal organization” and inserting “Tribe or
3 Tribal organization, health facility or program
4 described in subsection (a), or public or non-
5 profit entity referred to in subsection (a)”; and

6 (B) in paragraph (2)(A)(iii), by striking
7 “tribe, or tribal organization” and inserting
8 “Tribe, or Tribal organization”;

9 (4) in subsection (e)—

10 (A) in the matter preceding paragraph (1),
11 by striking “tribe, or tribal organization” and
12 inserting “Tribe, or Tribal organization”; and

13 (B) in paragraph (5), by striking “or ar-
14 rest” and inserting “, arrest, or release”;

15 (5) in subsection (f), by striking “tribe, or trib-
16 al organization” each place it appears and inserting
17 “Tribe, or Tribal organization”;

18 (6) in subsection (h), by striking “tribe, or trib-
19 al organization” and inserting “Tribe, or Tribal or-
20 ganization”; and

21 (7) in subsection (j), by striking “\$4,269,000
22 for each of fiscal years 2018 through 2022” and in-
23 serting “\$14,000,000 for each of fiscal years 2023
24 through 2027”.

1 **SEC. 217. FORMULA GRANTS TO STATES.**

2 Section 521 of the Public Health Service Act (42
3 U.S.C. 290cc–21) is amended by striking “2018 through
4 2022” and inserting “2023 through 2027”.

5 **SEC. 218. PROJECTS FOR ASSISTANCE IN TRANSITION**
6 **FROM HOMELESSNESS.**

7 Section 535(a) of the Public Health Service Act (42
8 U.S.C. 290cc–35(a)) is amended by striking “2018
9 through 2022” and inserting “2023 through 2027”.

10 **SEC. 219. GRANTS FOR REDUCING OVERDOSE DEATHS.**

11 (a) GRANTS.—

12 (1) REPEAL OF MAXIMUM GRANT AMOUNT.—

13 Paragraph (2) of section 544(a) of the Public
14 Health Service Act (42 U.S.C. 290dd–3(a)) is here-
15 by repealed.

16 (2) ELIGIBLE ENTITY; SUBGRANTS.—Section
17 544(a) of the Public Health Service Act (42 U.S.C.
18 290dd–3(a)) is amended by striking paragraph (3)
19 and inserting the following:

20 “(2) ELIGIBLE ENTITY.—For purposes of this
21 section, the term ‘eligible entity’ means a State, Ter-
22 ritory, locality, Indian Tribe (as defined in the Fed-
23 erally Recognized Indian Tribe List Act of 1994),
24 Tribal organization, or Urban Indian organization
25 (as those terms are defined in section 4 of the In-
26 dian Health Care Improvement Act).

1 “(3) SUBGRANTS.—For the purposes for which
2 a grant is awarded under this section, the eligible
3 entity receiving the grant may award subgrants to a
4 Federally qualified health center (as defined in sec-
5 tion 1861(aa) of the Social Security Act), an opioid
6 treatment program (as defined in section 8.2 of title
7 42, Code of Federal Regulations (or any successor
8 regulations)), any practitioner dispensing narcotic
9 drugs pursuant to section 303(g) of the Controlled
10 Substances Act, or any nonprofit organization that
11 the Secretary deems appropriate.”.

12 (3) PRESCRIBING.—Section 544(a)(4) of the
13 Public Health Service Act (42 U.S.C. 290dd-
14 3(a)(4)) is amended—

15 (A) in subparagraph (A), by inserting “,
16 including patients prescribed with both an
17 opioid and a benzodiazepine” before the semi-
18 colon at the end; and

19 (B) in subparagraph (D), by striking
20 “drug overdose” and inserting “substance over-
21 dose”.

22 (4) USE OF FUNDS.—Paragraph (5) of section
23 544(c) of the Public Health Service Act (42 U.S.C.
24 290dd-3(c)) is amended to read as follows:

1 “(5) To establish protocols to connect patients
2 who have experienced an overdose with appropriate
3 treatment, including overdose reversal medications,
4 medication assisted treatment, and appropriate
5 counseling and behavioral therapies.”.

6 (5) IMPROVING ACCESS TO OVERDOSE TREAT-
7 MENT.—Section 544 of the Public Health Service
8 Act (42 U.S.C. 290dd–3) is amended—

9 (A) by redesignating subsections (d)
10 through (f) as subsections (e) through (g), re-
11 spectively;

12 (B) in subsection (f), as so redesignated,
13 by striking “subsection (d)” and inserting “sub-
14 section (e)”; and

15 (C) by inserting after subsection (c) the
16 following:

17 “(d) IMPROVING ACCESS TO OVERDOSE TREAT-
18 MENT.—

19 “(1) INFORMATION ON BEST PRACTICES.—

20 “(A) HEALTH AND HUMAN SERVICES.—

21 The Secretary of Health and Human Services
22 may provide information to States, localities,
23 Indian Tribes, Tribal organizations, and Urban
24 Indian organizations on best practices for pre-
25 scribing or co-prescribing a drug or device ap-

1 proved, cleared, or otherwise authorized under
2 the Federal Food, Drug, and Cosmetic Act for
3 emergency treatment of known or suspected
4 opioid overdose, including for patients receiving
5 chronic opioid therapy and patients being treat-
6 ed for opioid use disorders.

7 “(B) DEFENSE.—The Secretary of De-
8 fense may provide information to prescribers
9 within Department of Defense medical facilities
10 on best practices for prescribing or co-pre-
11 scribing a drug or device approved, cleared, or
12 otherwise authorized under the Federal Food,
13 Drug, and Cosmetic Act for emergency treat-
14 ment of known or suspected opioid overdose, in-
15 cluding for patients receiving chronic opioid
16 therapy and patients being treated for opioid
17 use disorders.

18 “(C) VETERANS AFFAIRS.—The Secretary
19 of Veterans Affairs may provide information to
20 prescribers within Department of Veterans Af-
21 fairs medical facilities on best practices for pre-
22 scribing or co-prescribing a drug or device ap-
23 proved, cleared, or otherwise authorized under
24 the Federal Food, Drug, and Cosmetic Act for
25 emergency treatment of known or suspected

1 opioid overdose, including for patients receiving
2 chronic opioid therapy and patients being treat-
3 ed for opioid use disorders.

4 “(2) RULE OF CONSTRUCTION.—Nothing in
5 this subsection shall be construed as establishing or
6 contributing to a medical standard of care.”.

7 (6) AUTHORIZATION OF APPROPRIATIONS.—
8 Section 544(g) of the Public Health Service Act (42
9 U.S.C. 290dd–3), as redesignated, is amended by
10 striking “fiscal years 2017 through 2021” and in-
11 serting “fiscal years 2023 through 2027”.

12 (7) TECHNICAL AMENDMENTS.—

13 (A) Section 544 of the Public Health Serv-
14 ice Act (42 U.S.C. 290dd–3), as amended, is
15 further amended by striking “approved or
16 cleared” each place it appears and inserting
17 “approved, cleared, or otherwise authorized”.

18 (B) Section 107 of the Comprehensive Ad-
19 diction and Recovery Act of 2016 (Public Law
20 114–198) is amended by striking subsection
21 (b).

22 **SEC. 220. OPIOID OVERDOSE REVERSAL MEDICATION AC-**
23 **CESS AND EDUCATION GRANT PROGRAMS.**

24 (a) GRANTS.—Section 545 of the Public Health Serv-
25 ice Act (42 U.S.C. 290ee) is amended—

1 (1) in the section heading, by striking “**AC-**
2 **CESS AND EDUCATION GRANT PROGRAMS**” and
3 inserting “**ACCESS, EDUCATION, AND CO-PRE-**
4 **SCRIBING GRANT PROGRAMS**”;

5 (2) in the heading of subsection (a), by striking
6 “GRANTS TO STATES” and inserting “GRANTS”;

7 (3) in subsection (a), by striking “shall make
8 grants to States” and inserting “shall make grants
9 to States, localities, Indian Tribes (as defined by the
10 Federally Recognized Indian Tribe List Act of
11 1994), Tribal organizations, and Urban Indian orga-
12 nizations (as those terms are defined in section 4 of
13 the Indian Health Care Improvement Act)”;

14 (4) in subsection (a)(1), by striking “implement
15 strategies for pharmacists to dispense a drug or de-
16 vice” and inserting “implement strategies that in-
17 crease access to drugs or devices”;

18 (5) by redesignating paragraphs (3) and (4) as
19 paragraphs (4) and (5), respectively; and

20 (6) by inserting after paragraph (2) the fol-
21 lowing:

22 “(3) encourage health care providers to co-pre-
23 scribe, as appropriate, drugs or devices approved,
24 cleared, or otherwise authorized under the Federal

1 Food, Drug, and Cosmetic Act for emergency treat-
2 ment of known or suspected opioid overdose;”.

3 (b) GRANT PERIOD.—Section 545(d)(2) of the Public
4 Health Service Act (42 U.S.C. 290ee(d)(2)) is amended
5 by striking “3 years” and inserting “5 years”.

6 (c) LIMITATION.—Paragraph (3) of section 545(d) of
7 the Public Health Service Act (42 U.S.C. 290ee(d)) is
8 amended to read as follows:

9 “(3) LIMITATIONS.—A State may—

10 “(A) use not more than 10 percent of a
11 grant under this section for educating the pub-
12 lic pursuant to subsection (a)(5); and

13 “(B) use not less than 20 percent of a
14 grant under this section to offset cost-sharing
15 for distribution and dispensing of drugs or de-
16 vices approved, cleared, or otherwise authorized
17 under the Federal Food, Drug, and Cosmetic
18 Act for emergency treatment of known or sus-
19 pected opioid overdose.”.

20 (d) AUTHORIZATION OF APPROPRIATIONS.—Section
21 545(h)(1) of the Public Health Service Act, is amended
22 by striking “fiscal years 2017 through 2019” and insert-
23 ing “fiscal years 2023 through 2027”.

24 (e) TECHNICAL AMENDMENT.—Section 545 of the
25 Public Health Service Act (42 U.S.C. 290ee), as amended,

1 is further amended by striking “approved or cleared” each
2 place it appears and inserting “approved, cleared, or oth-
3 erwise authorized”.

4 **SEC. 221. STATE DEMONSTRATION GRANTS FOR COM-**
5 **PREHENSIVE OPIOID ABUSE RESPONSE.**

6 Section 548 of the Public Health Service Act (42
7 U.S.C. 290ee-3) is amended—

8 (1) in the section heading, by striking
9 “**ABUSE**” and inserting “**USE DISORDER**”;

10 (2) in subsection (b)—

11 (A) in the subsection heading, by striking
12 “**ABUSE**” and inserting “**USE DISORDER**”;

13 (B) in paragraph (1), by striking “abuse”
14 and inserting “use disorder”;

15 (C) in paragraph (2)—

16 (i) in the matter preceding subpara-
17 graph (A), by striking “abuse” and insert-
18 ing “use disorder”;

19 (ii) in subparagraph (A), by striking
20 “opioid use, treatment, and addiction re-
21 covery” and inserting “opioid use dis-
22 orders, and treatment for, and recovery
23 from opioid use disorders”;

1 (iii) in subparagraph (C), by striking
2 “addiction” each place it appears and in-
3 sserting “use disorder”;

4 (iv) by amending subparagraph (D) to
5 read as follows:

6 “(D) developing, implementing, and ex-
7 panding efforts to prevent overdose death from
8 opioid or other prescription medication use dis-
9 orders; and”; and

10 (v) in subparagraph (E), by striking
11 “abuse” and inserting “use disorders”;
12 and

13 (D) in paragraph (4), by striking “abuse”
14 each place it appears and inserting “use dis-
15 orders”; and

16 (3) by striking “2017 through 2021” and in-
17 sserting “2023 through 2027”.

18 **SEC. 222. EMERGENCY DEPARTMENT ALTERNATIVES TO**
19 **OPIOIDS.**

20 Section 7091 of the SUPPORT for Patients and
21 Communities Act (Public Law 115–271) is amended—

22 (1) in the section heading, by striking “**DEM-**
23 **ONSTRATION**” (and by conforming the item relat-
24 ing to such section in the table of contents in section
25 1(b));

1 (2) in subsection (a)—

2 (A) by amending the subsection heading to
3 read as follows: “GRANT PROGRAM”; and

4 (B) in paragraph (1), by striking “dem-
5 onstration”;

6 (3) in subsection (b), in the subsection heading,
7 by striking “DEMONSTRATION”;

8 (4) in subsection (d)(4), by striking “tribal”
9 and inserting “Tribal”;

10 (5) in subsection (f), by striking “Not later
11 than 1 year after completion of the demonstration
12 program under this section, the Secretary shall sub-
13 mit a report to the Congress on the results of the
14 demonstration program” and inserting “Not later
15 than the end of each of fiscal years 2024 and 2027,
16 the Secretary shall submit to the Congress a report
17 on the results of the program”; and

18 (6) in subsection (g), by striking “2019 through
19 2021” and inserting “2023 through 2027”.

1 **Subtitle C—Excellence in Recovery**
2 **Housing**

3 **SEC. 231. CLARIFYING THE ROLE OF SAMHSA IN PRO-**
4 **MOTING THE AVAILABILITY OF HIGH-QUAL-**
5 **ITY RECOVERY HOUSING.**

6 Section 501(d) of the Public Health Service Act (42
7 U.S.C. 290aa) is amended—

8 (1) in paragraph (24)(E), by striking “and” at
9 the end;

10 (2) in paragraph (25), by striking the period at
11 the end and inserting “; and”; and

12 (3) by adding at the end the following:

13 “(26) collaborate with national accrediting enti-
14 ties, reputable providers, organizations or individuals
15 with established expertise in delivery of recovery
16 housing services, States, Federal agencies (including
17 the Department of Health and Human Services, the
18 Department of Housing and Urban Development,
19 and the agencies listed in section 550(e)(2)(B)), and
20 other relevant stakeholders, to promote the avail-
21 ability of high-quality recovery housing and services
22 for individuals with a substance use disorder.”.

1 **SEC. 232. DEVELOPING GUIDELINES FOR STATES TO PRO-**
2 **MOTE THE AVAILABILITY OF HIGH-QUALITY**
3 **RECOVERY HOUSING.**

4 Section 550(a) of the Public Health Service Act (42
5 U.S.C. 290ee-5(a)) (relating to national recovery housing
6 best practices) is amended—

7 (1) by amending paragraph (1) to read as fol-
8 lows:

9 “(1) IN GENERAL.—The Secretary, in consulta-
10 tion with the individuals and entities specified in
11 paragraph (2), shall build on existing best practices
12 and previously developed guidelines to develop and
13 periodically update consensus-based best practices,
14 which may include model laws for implementing sug-
15 gested minimum standards for operating, and pro-
16 moting the availability of, high-quality recovery
17 housing.”;

18 (2) in paragraph (2)—

19 (A) by striking subparagraphs (A) and (B)
20 and inserting the following:

21 “(A) Officials representing the agencies de-
22 scribed in subsection (e)(2).”; and

23 (B) by redesignating subparagraphs (C)
24 through (G) as subparagraphs (B) through (F),
25 respectively; and

26 (3) by adding at the end the following:

1 “(3) AVAILABILITY.—The best practices re-
2 ferred to in paragraph (1) shall be—

3 “(A) made publicly available; and

4 “(B) published on the public website of the
5 Substance Abuse and Mental Health Services
6 Administration.

7 “(4) EXCLUSION OF GUIDELINE ON TREAT-
8 MENT SERVICES.—In developing the guidelines
9 under paragraph (1), the Secretary may not include
10 any guidelines with respect to substance use disorder
11 treatment services.”.

12 **SEC. 233. COORDINATION OF FEDERAL ACTIVITIES TO PRO-**
13 **MOTE THE AVAILABILITY OF RECOVERY**
14 **HOUSING.**

15 Section 550 of the Public Health Service Act (42
16 U.S.C. 290ee–5) (relating to national recovery housing
17 best practices) is amended—

18 (1) by redesignating subsections (e), (f), and
19 (g) as subsections (g), (h), and (i), respectively; and

20 (2) by inserting after subsection (d) the fol-
21 lowing:

22 “(e) COORDINATION OF FEDERAL ACTIVITIES TO
23 PROMOTE THE AVAILABILITY OF HOUSING FOR INDIVID-
24 UALS EXPERIENCING HOMELESSNESS, INDIVIDUALS

1 WITH A MENTAL ILLNESS, AND INDIVIDUALS WITH A
2 SUBSTANCE USE DISORDER.—

3 “(1) IN GENERAL.—The Secretary, acting
4 through the Assistant Secretary, and the Secretary
5 of Housing and Urban Development shall convene
6 an interagency working group for the following pur-
7 poses:

8 “(A) To increase collaboration, coopera-
9 tion, and consultation among the Department
10 of Health and Human Services, the Department
11 of Housing and Urban Development, and the
12 Federal agencies listed in paragraph (2)(B),
13 with respect to promoting the availability of
14 housing, including recovery housing, for individ-
15 uals experiencing homelessness, individuals with
16 mental illnesses, and individuals with substance
17 use disorder.

18 “(B) To align the efforts of such agencies
19 and avoid duplication of such efforts by such
20 agencies.

21 “(C) To develop objectives, priorities, and
22 a long-term plan for supporting State, Tribal,
23 and local efforts with respect to the operation
24 of recovery housing that is consistent with the
25 best practices developed under this section.

1 “(D) To coordinate enforcement of fair
2 housing practices, as appropriate, among Fed-
3 eral and State agencies.

4 “(E) To coordinate data collection on the
5 quality of recovery housing.

6 “(2) COMPOSITION.—The interagency working
7 group under paragraph (1) shall be composed of—

8 “(A) the Secretary, acting through the As-
9 sistant Secretary, and the Secretary of Housing
10 and Urban Development, who shall serve as the
11 co-chairs; and

12 “(B) representatives of each of the fol-
13 lowing Federal agencies:

14 “(i) The Centers for Medicare & Med-
15 icaid Services.

16 “(ii) The Substance Abuse and Men-
17 tal Health Services Administration.

18 “(iii) The Health Resources and Serv-
19 ices Administration.

20 “(iv) The Office of Inspector General.

21 “(v) The Indian Health Service.

22 “(vi) The Department of Agriculture.

23 “(vii) The Department of Justice.

24 “(viii) The Office of National Drug
25 Control Policy.

1 “(ix) The Bureau of Indian Affairs.

2 “(x) The Department of Labor.

3 “(xi) The Department of Veterans Af-
4 fairs.

5 “(xii) Any other Federal agency as
6 the co-chairs determine appropriate.

7 “(3) MEETINGS.—The working group shall
8 meet on a quarterly basis.

9 “(4) REPORTS TO CONGRESS.—Not later than
10 4 years after the date of the enactment of this sec-
11 tion, the working group shall submit to the Com-
12 mittee on Energy and Commerce, the Committee on
13 Ways and Means, the Committee on Agriculture,
14 and the Committee on Financial Services of the
15 House of Representatives and the Committee on
16 Health, Education, Labor, and Pensions, the Com-
17 mittee on Agriculture, Nutrition, and Forestry, and
18 the Committee on Finance of the Senate a report
19 describing the work of the working group and any
20 recommendations of the working group to improve
21 Federal, State, and local coordination with respect
22 to recovery housing and other housing resources and
23 operations for individuals experiencing homelessness,
24 individuals with a mental illness, and individuals
25 with a substance use disorder.”.

1 **SEC. 234. NAS STUDY AND REPORT.**

2 (a) IN GENERAL.—Not later than 60 days after the
3 date of enactment of this Act, the Secretary of Health and
4 Human Services, acting through the Assistant Secretary
5 for Mental Health and Substance Use shall—

6 (1) contract with the National Academies of
7 Sciences, Engineering, and Medicine—

8 (A) to study the quality and effectiveness
9 of recovery housing in the United States and
10 whether the availability of such housing meets
11 demand; and

12 (B) to identify recommendations to pro-
13 mote the availability of high-quality recovery
14 housing; and

15 (2) report to the Congress on the results of
16 such review.

17 (b) AUTHORIZATION OF APPROPRIATIONS.—To carry
18 out this section there is authorized to be appropriated
19 \$1,500,000 for fiscal year 2023.

20 **SEC. 235. GRANTS FOR STATES TO PROMOTE THE AVAIL-**
21 **ABILITY OF RECOVERY HOUSING AND SERV-**
22 **ICES.**

23 Section 550 of the Public Health Service Act (42
24 U.S.C. 290ee–5) (relating to national recovery housing
25 best practices), as amended by sections 232 and 233, is

1 further amended by inserting after subsection (e) (as in-
2 serted by section 233) the following:

3 “(f) GRANTS FOR IMPLEMENTING NATIONAL RECOV-
4 ERY HOUSING BEST PRACTICES.—

5 “(1) IN GENERAL.—The Secretary shall award
6 grants to States (and political subdivisions thereof),
7 Tribes, and territories—

8 “(A) for the provision of technical assist-
9 ance to implement the guidelines and rec-
10 ommendations developed under subsection (a);
11 and

12 “(B) to promote—

13 “(i) the availability of recovery hous-
14 ing for individuals with a substance use
15 disorder; and

16 “(ii) the maintenance of recovery
17 housing in accordance with best practices
18 developed under this section.

19 “(2) STATE PROMOTION PLANS.—Not later
20 than 90 days after receipt of a grant under para-
21 graph (1), and every 2 years thereafter, each State
22 (or political subdivisions thereof,) Tribe, or territory
23 receiving a grant under paragraph (1) shall submit
24 to the Secretary, and publish on a publicly accessible

1 internet website of the State (or political subdivi-
2 sions thereof), Tribe, or territory—

3 “(A) the plan of the State (or political sub-
4 divisions thereof), Tribe, or territory, with re-
5 spect to the promotion of recovery housing for
6 individuals with a substance use disorder lo-
7 cated within the jurisdiction of such State (or
8 political subdivisions thereof), Tribe, or terri-
9 tory; and

10 “(B) a description of how such plan is con-
11 sistent with the best practices developed under
12 this section.”.

13 **SEC. 236. FUNDING.**

14 Subsection (i) of section 550 of the Public Health
15 Service Act (42 U.S.C. 290ee–5) (relating to national re-
16 covery housing best practices), as redesignated by section
17 233, is amended by striking “\$3,000,000 for the period
18 of fiscal years 2019 through 2021” and inserting
19 “\$5,000,000 for the period of fiscal years 2023 through
20 2027”.

21 **SEC. 237. TECHNICAL CORRECTION.**

22 Title V of the Public Health Service Act (42 U.S.C.
23 290aa et seq.) is amended—

24 (1) by redesignating section 550 (relating to
25 Sobriety Treatment and Recovery Teams) (42

1 U.S.C. 290ee–10), as added by section 8214 of Pub-
2 lic Law 115–271, as section 550A; and

3 (2) by moving such section so it appears after
4 section 550 (relating to national recovery housing
5 best practices).

6 **Subtitle D—Substance Use Preven-**
7 **tion, Treatment, and Recovery**
8 **Services Block Grant**

9 **SEC. 241. ELIMINATING STIGMATIZING LANGUAGE RELAT-**
10 **ING TO SUBSTANCE USE.**

11 (a) **BLOCK GRANTS FOR PREVENTION AND TREAT-**
12 **MENT OF SUBSTANCE USE.**—Part B of title XIX of the
13 Public Health Service Act (42 U.S.C. 300x et seq.) is
14 amended—

15 (1) in the part heading, by striking “**SUB-**
16 **STANCE ABUSE**” and inserting “**SUBSTANCE**
17 **USE**”;

18 (2) in subpart II, by amending the subpart
19 heading to read as follows: “**Block Grants for**
20 **Substance Use Prevention, Treatment,**
21 **and Recovery Services**”;

22 (3) in section 1922(a) (42 U.S.C. 300x–
23 22(a))—

24 (A) in paragraph (1), in the matter pre-
25 ceding subparagraph (A), by striking “sub-

1 stance abuse” and inserting “substance use dis-
2 orders”; and

3 (B) by striking “such abuse” each place it
4 appears in paragraphs (1) and (2) and insert-
5 ing “such disorders”;

6 (4) in section 1923 (42 U.S.C. 300x-23)—

7 (A) in the section heading, by striking
8 “**SUBSTANCE ABUSE**” and inserting “**SUB-**
9 **STANCE USE**”; and

10 (B) in subsection (a), by striking “drug
11 abuse” and inserting “substance use disorders”;

12 (5) in section 1925(a)(1) (42 U.S.C. 300x-
13 25(a)(1)), by striking “alcohol or drug abuse” and
14 inserting “alcohol or other substance use disorders”;

15 (6) in section 1926(b)(2)(B) (42 U.S.C. 300x-
16 26(b)(2)(B)), by striking “substance abuse”;

17 (7) in section 1931(b)(2) (42 U.S.C. 300x-
18 31(b)(2)), by striking “substance abuse” and insert-
19 ing “substance use disorders”;

20 (8) in section 1933(d)(1) (42 U.S.C. 300x-
21 33(d)), in the matter following subparagraph (B), by
22 striking “abuse of alcohol and other drugs” and in-
23 serting “use of substances”;

24 (9) by amending paragraph (4) of section 1934
25 (42 U.S.C. 300x-34) to read as follows:

1 “(4) The term ‘substance use disorder’ means
2 the recurrent use of alcohol or other drugs that
3 causes clinically significant impairment.”;

4 (10) in section 1935 (42 U.S.C. 300x–35)—

5 (A) in subsection (a), by striking “sub-
6 stance abuse” and inserting “substance use dis-
7 orders”; and

8 (B) in subsection (b)(1), by striking “sub-
9 stance abuse” each place it appears and insert-
10 ing “substance use disorders”;

11 (11) in section 1949 (42 U.S.C. 300x–59), by
12 striking “substance abuse” each place it appears in
13 subsections (a) and (d) and inserting “substance use
14 disorders”;

15 (12) in section 1954(b)(4) (42 U.S.C. 300x–
16 64(b)(4))—

17 (A) by striking “substance abuse” and in-
18 serting “substance use disorders”; and

19 (B) by striking “such abuse” and inserting
20 “such disorders”;

21 (13) in section 1955 (42 U.S.C. 300x–65), by
22 striking “substance abuse” each place it appears
23 and inserting “substance use disorder”; and

1 (14) in section 1956 (42 U.S.C. 300x–66), by
2 striking “substance abuse” and inserting “substance
3 use disorders”.

4 (b) CERTAIN PROGRAMS REGARDING MENTAL
5 HEALTH AND SUBSTANCE ABUSE.—Part C of title XIX
6 of the Public Health Service Act (42 U.S.C. 300y et seq.)
7 is amended—

8 (1) in the part heading, by striking “**SUB-**
9 **STANCE ABUSE**” and inserting “**SUBSTANCE**
10 **USE**”;

11 (2) in section 1971 (42 U.S.C. 300y), by strik-
12 ing “substance abuse” each place it appears in sub-
13 sections (a), (b), and (f) and inserting “substance
14 use”; and

15 (3) in section 1976 (42 U.S.C. 300y–11), by
16 striking “intravenous abuse” each place it appears
17 and inserting “intravenous use”.

18 **SEC. 242. AUTHORIZED ACTIVITIES.**

19 Section 1921(b) of the Public Health Service Act (42
20 U.S.C. 300x–21(b)) is amended by striking “prevent and
21 treat substance use disorders” and inserting “prevent,
22 treat, and provide recovery support services for substance
23 use disorders”.

1 **SEC. 243. REQUIREMENTS RELATING TO CERTAIN INFEC-**
2 **TIOUS DISEASES AND HUMAN IMMUNO-**
3 **DEFICIENCY VIRUS.**

4 Section 1924 of the Public Health Service Act (42
5 U.S.C. 300x-24) is amended—

6 (1) in the section heading, by striking “**TUBER-**
7 **CULOSIS AND HUMAN IMMUNODEFICIENCY**
8 **VIRUS**” and inserting “**TUBERCULOSIS, VIRAL**
9 **HEPATITIS, AND HUMAN IMMUNODEFICIENCY**
10 **VIRUS**”;

11 (2) by amending subsection (a)(2) to read as
12 follows:

13 “(2) DESIGNATED STATES.—

14 “(A) FISCAL YEARS THROUGH FISCAL
15 YEAR 2024.—For purposes of this subsection,
16 through September 30, 2024, a State described
17 in this paragraph is any State whose rate of
18 cases of acquired immune deficiency syndrome
19 is 10 or more such cases per 100,000 individ-
20 uals (as indicated by the number of such cases
21 reported to and confirmed by the Director of
22 the Centers for Disease Control and Prevention
23 for the most recent calendar year for which
24 such data are available).

25 “(B) FISCAL YEAR 2025 AND SUCCEEDING
26 FISCAL YEARS.—

1 “(i) IN GENERAL.—Beginning with
2 fiscal year 2025, for purposes of this sub-
3 section, a State described in this para-
4 graph is any State whose rate of cases of
5 human immunodeficiency virus is 10 or
6 more such cases per 100,000 individuals
7 (as indicated by the number of such cases
8 newly reported to and confirmed by the Di-
9 rector of the Centers for Disease Control
10 and Prevention for the most recent cal-
11 endar year for which such data are avail-
12 able).

13 “(ii) CONTINUATION OF DESIGNATED
14 STATE STATUS.—In the case of a State
15 whose rate of cases of human immuno-
16 deficiency virus falls below the threshold
17 specified in clause (i) for a calendar year,
18 such State shall, notwithstanding clause
19 (i), continue to be described in this para-
20 graph unless the rate of cases falls below
21 such threshold for three consecutive cal-
22 endar years.”.

23 (3) by redesignating subsections (c) and (d) as
24 subsections (d) and (e), respectively; and

1 (4) by inserting after subsection (b) the fol-
2 lowing:

3 “(c) VIRAL HEPATITIS.—

4 “(1) IN GENERAL.—A funding agreement for a
5 grant under section 1921 is that the State involved
6 will require that any entity receiving amounts from
7 the grant for operating a program of treatment for
8 substance use disorders—

9 “(A) will, directly or through arrangements
10 with other public or nonprofit private entities,
11 routinely make available viral hepatitis services
12 to each individual receiving treatment for such
13 disorders; and

14 “(B) in the case of an individual in need
15 of such treatment who is denied admission to
16 the program on the basis of the lack of the ca-
17 pacity of the program to admit the individual,
18 will refer the individual to another provider of
19 viral hepatitis services.

20 “(2) VIRAL HEPATITIS SERVICES.—For pur-
21 poses of paragraph (1), the term ‘viral hepatitis
22 services’, with respect to an individual, means—

23 “(A) screening the individual for viral hep-
24 atitis; and

1 “(B) referring the individual to a provider
2 whose practice includes viral hepatitis vaccina-
3 tion and treatment.”.

4 **SEC. 244. STATE PLAN REQUIREMENTS.**

5 Section 1932(b)(1)(A) of the Public Health Service
6 Act (42 U.S.C. 300x-32(b)(1)(A)) is amended—

7 (1) by redesignating clauses (vi) through (ix) as
8 clauses (vii) through (x), respectively; and

9 (2) by inserting after clause (v) the following:

10 “(vi) provides a description of—

11 “(I) the State’s comprehensive
12 statewide recovery support services ac-
13 tivities, including the number of indi-
14 viduals being served, target popu-
15 lations, and priority needs; and

16 “(II) the amount of funds re-
17 ceived under this subpart expended on
18 recovery support services,
19 disaggregated by the amount ex-
20 pended for type of service activity;”.

21 **SEC. 245. UPDATING CERTAIN LANGUAGE RELATING TO**
22 **TRIBES.**

23 Section 1933(d) of the Public Health Service Act (42
24 U.S.C. 300x-33(d)) is amended—

25 (1) in paragraph (1)—

1 (A) in subparagraph (A)—

2 (i) by striking “of an Indian tribe or
3 tribal organization” and inserting “of an
4 Indian Tribe or Tribal organization”; and

5 (ii) by striking “such tribe” and in-
6 sserting “such Tribe”;

7 (B) in subparagraph (B)—

8 (i) by striking “tribe or tribal organi-
9 zation” and inserting “Tribe or Tribal or-
10 ganization”; and

11 (ii) by striking “Secretary under this”
12 and inserting “Secretary under this sub-
13 part”; and

14 (C) in the matter following subparagraph
15 (B), by striking “tribe or tribal organization”
16 and inserting “Tribe or Tribal organization”;

17 (2) by amending paragraph (2) to read as fol-
18 lows:

19 “(2) INDIAN TRIBE OR TRIBAL ORGANIZATION
20 AS GRANTEE.—The amount reserved by the Sec-
21 retary on the basis of a determination under this
22 subsection shall be granted to the Indian Tribe or
23 Tribal organization serving the individuals for whom
24 such a determination has been made.”;

1 (3) in paragraph (3), by striking “tribe or trib-
2 al organization” and inserting “Tribe or Tribal or-
3 ganization”; and

4 (4) in paragraph (4)—

5 (A) in the paragraph heading, by striking
6 “DEFINITION” and inserting “DEFINITIONS”;
7 and

8 (B) by striking “The terms” and all that
9 follows through “given such terms” and insert-
10 ing the following: “The terms ‘Indian Tribe’
11 and ‘Tribal organization’ have the meanings
12 given the terms ‘Indian tribe’ and ‘tribal orga-
13 nization’”.

14 **SEC. 246. BLOCK GRANTS FOR SUBSTANCE USE PREVEN-**
15 **TION, TREATMENT, AND RECOVERY SERV-**
16 **ICES.**

17 (a) **IN GENERAL.**—Section 1935(a) of the Public
18 Health Service Act (42 U.S.C. 300x–35(a)), as amended
19 by section 241, is further amended by striking “appro-
20 priated” and all that follows through “2022..” and insert-
21 ing the following: “appropriated \$1,908,079,000 for each
22 of fiscal years 2023 through 2027.”.

23 (b) **TECHNICAL CORRECTIONS.**—Section
24 1935(b)(1)(B) of the Public Health Service Act (42

1 U.S.C. 300x–35(b)(1)(B)) is amended by striking “the
2 collection of data in this paragraph is”.

3 **SEC. 247. REQUIREMENT OF REPORTS AND AUDITS BY**
4 **STATES.**

5 Section 1942(a) of the Public Health Service Act (42
6 U.S.C. 300x–52(a)) is amended—

7 (1) in paragraph (1), by striking “and” at the
8 end;

9 (2) in paragraph (2), by striking the period at
10 the end and inserting “; and”; and

11 (3) by adding at the end the following:

12 “(3) the amount provided to each recipient in
13 the previous fiscal year.”.

14 **SEC. 248. STUDY ON ASSESSMENT FOR USE IN DISTRIBUTION**
15 **OF LIMITED STATE RESOURCES.**

16 (a) IN GENERAL.—The Secretary of Health and
17 Human Services, acting through the Assistant Secretary
18 for Mental Health and Substance Use (in this section re-
19 ferred to as the “Secretary”), shall, in consultation with
20 States and other local entities providing prevention, treat-
21 ment, or recovery support services related to substance
22 use, conduct a study to develop a model needs assessment
23 process for States to consider to help determine how best
24 to allocate block grant funding received under subpart II
25 of part B of title XIX of the Public Health Service Act

1 (42 U.S.C. 300x–21) to provide services to substance use
2 disorder prevention, treatment, and recovery support. The
3 study shall include cost estimates with each model needs
4 assessment process.

5 (b) REPORT.—Not later than 2 years after the date
6 of the enactment of this Act, the Secretary shall submit
7 to the Committee on Energy and Commerce of the House
8 of Representatives and the Committee on Health, Edu-
9 cation, Labor, and Pensions of the Senate a report on the
10 results of the study conducted under paragraph (1).

11 **Subtitle E—Timely Treatment for**
12 **Opioid Use Disorder**

13 **SEC. 251. STUDY ON EXEMPTIONS FOR TREATMENT OF**
14 **OPIOID USE DISORDER THROUGH OPIOID**
15 **TREATMENT PROGRAMS DURING THE COVID-**
16 **19 PUBLIC HEALTH EMERGENCY.**

17 (a) STUDY.—The Assistant Secretary for Mental
18 Health and Substance Use shall conduct a study, in con-
19 sultation with patients and other stakeholders, on activi-
20 ties carried out pursuant to exemptions granted—

21 (1) to a State (including the District of Colum-
22 bia or any territory of the United States) or an
23 opioid treatment program;

24 (2) pursuant to section 8.11(h) of title 42, Code
25 of Federal Regulations; and

1 (3) during the period—

2 (A) beginning on the declaration of the
3 public health emergency for the COVID–19
4 pandemic under section 319 of the Public
5 Health Service Act (42 U.S.C. 247d); and

6 (B) ending on the earlier of—

7 (i) the termination of such public
8 health emergency, including extensions
9 thereof pursuant to such section 319; and

10 (ii) the end of calendar year 2022.

11 (b) PRIVACY.—The section does not authorize the
12 disclosure by the Department of Health and Human Serv-
13 ices of individually identifiable information about patients.

14 (c) FEEDBACK.—In conducting the study under sub-
15 section (a), the Assistant Secretary for Mental Health and
16 Substance Use shall gather feedback from the States and
17 opioid treatment programs on their experiences in imple-
18 menting exemptions described in subsection (a).

19 (d) REPORT.—Not later than 180 days after the end
20 of the period described in subsection (a)(3)(B), and sub-
21 ject to subsection (c), the Assistant Secretary for Mental
22 Health and Substance Use shall publish a report on the
23 results of the study under this section.

1 **SEC. 252. CHANGES TO FEDERAL OPIOID TREATMENT**
2 **STANDARDS.**

3 (a) **MOBILE MEDICATION UNITS.**—Section 302(e) of
4 the Controlled Substances Act (21 U.S.C. 822(e)) is
5 amended by adding at the end the following:

6 “(3) Notwithstanding paragraph (1), a registrant
7 that is dispensing pursuant to section 303(g) narcotic
8 drugs to individuals for maintenance treatment or detoxi-
9 fication treatment shall not be required to have a separate
10 registration to incorporate one or more mobile medication
11 units into the registrant’s practice to dispense such nar-
12 cotics at locations other than the registrant’s principal
13 place of business or professional practice described in
14 paragraph (1), so long as the registrant meets such stand-
15 ards for operation of a mobile medication unit as the At-
16 torney General may establish.”

17 (b) **REVISE OPIOID TREATMENT PROGRAM ADMIS-**
18 **SION CRITERIA TO ELIMINATE REQUIREMENT THAT PA-**
19 **TIENTS HAVE AN OPIOID USE DISORDER FOR AT LEAST**
20 **1 YEAR.**—Not later than 18 months after the date of en-
21 actment of this Act, the Secretary of Health and Human
22 Services shall revise section 8.12(e)(1) of title 42, Code
23 of Federal Regulations (or successor regulations), to elimi-
24 nate the requirement that an opioid treatment program
25 only admit an individual for treatment under the program

1 if the individual has been addicted to opioids for at least
2 1 year before being so admitted for treatment.

3 (c) FINAL REGULATION ON PERIODS FOR TAKE-
4 HOME SUPPLY REQUIREMENTS.—

5 (1) IN GENERAL.—Not later than 18 months
6 after the date of enactment of this Act, the Sec-
7 retary of Health and Human Services shall promul-
8 gate a final regulation amending paragraphs (i)(3)(i)
9 through (i)(3)(vi) of section 8.12 of title 42, Code of
10 Federal Regulations, as appropriate based on the
11 findings of the study under section 251 of this Act.

12 (2) CRITERIA.—The regulation under para-
13 graph (1) shall establish relevant criteria for the
14 medical director or an appropriately licensed practi-
15 tioner of an opioid treatment program, to determine
16 whether a patient is stable and may qualify for un-
17 supervised use, which criteria may allow for consid-
18 eration of each of the following:

19 (A) Whether the benefits of providing un-
20 supervised doses to a patient outweigh the
21 risks.

22 (B) The patient's demonstrated adherence
23 to their treatment plan.

24 (C) The patient's history of negative tox-
25 icology tests.

1 (D) Whether there is an absence of serious
2 behavioral problems.

3 (E) The patient's stability in living ar-
4 rangements and social relationships.

5 (F) Whether there is an absence of sub-
6 stance misuse-related behaviors.

7 (G) Whether there is an absence of recent
8 diversion activity.

9 (H) Whether there is an assurance that
10 the medication can be safely stored by the pa-
11 tient.

12 (I) Any other criterion the Secretary of
13 Health and Human Services determines appro-
14 priate.

15 (3) PROHIBITED SOLE CONSIDERATION.—The
16 regulation under paragraph (1) shall prohibit the
17 medical director of an opioid treatment program
18 from considering, as the sole consideration in deter-
19 mining whether a patient is sufficiently responsible
20 in handling opioid drugs for unsupervised use,
21 whether the patient has an absence of recent misuse
22 of drugs (whether narcotic or nonnarcotic), including
23 alcohol.

1 **Subtitle F—Additional Provisions**
2 **Relating to Addiction Treatment**

3 **SEC. 261. PROHIBITION.**

4 Notwithstanding any provision of this Act and the
5 amendments made by this Act, no funds made available
6 to carry out this Act or any amendment made by this Act
7 shall be used to purchase, procure, or distribute pipes or
8 cylindrical objects intended to be used to smoke or inhale
9 illegal scheduled substances.

10 **SEC. 262. ELIMINATING ADDITIONAL REQUIREMENTS FOR**
11 **DISPENSING NARCOTIC DRUGS IN SCHEDULE**
12 **III, IV, AND V FOR MAINTENANCE OR DETOXI-**
13 **FICATION TREATMENT.**

14 (a) IN GENERAL.—Section 303(g) of the Controlled
15 Substances Act (21 U.S.C. 823(g)) is amended—

16 (1) by striking paragraph (2);

17 (2) by striking “(g)(1) Except as provided in
18 paragraph (2), practitioners who dispense narcotic
19 drugs to individuals for maintenance treatment or
20 detoxification treatment” and inserting “(g) Practi-
21 tioners who dispense narcotic drugs (other than nar-
22 cotic drugs in schedule III, IV, or V) to individuals
23 for maintenance treatment or detoxification treat-
24 ment”;

1 (3) by redesignating subparagraphs (A), (B),
2 and (C) as paragraphs (1), (2), and (3), respectively;
3 and

4 (4) in paragraph (2), as so redesignated—

5 (A) by striking “(i) security of stocks” and
6 inserting “(A) security of stocks”; and

7 (B) by striking “(ii) the maintenance of
8 records” and inserting “(B) the maintenance of
9 records”.

10 (b) CONFORMING CHANGES.—

11 (1) Subsections (a) and (d)(1) of section 304 of
12 the Controlled Substances Act (21 U.S.C. 824) are
13 each amended by striking “303(g)(1)” each place it
14 appears and inserting “303(g)”.

15 (2) Section 309A(a)(2) of the Controlled Sub-
16 stances Act (21 U.S.C. 829a) is amended—

17 (A) in the matter preceding subparagraph
18 (A), by striking “the controlled substance is to
19 be administered for the purpose of maintenance
20 or detoxification treatment under section
21 303(g)(2)” and inserting “the controlled sub-
22 stance is a narcotic drug in schedule III, IV, or
23 V to be administered for the purpose of mainte-
24 nance or detoxification treatment”; and

1 (B) by striking “and—” and all that fol-
2 lows through “is to be administered by injection
3 or implantation;” and inserting “and is to be
4 administered by injection or implantation;”.

5 (3) Section 520E–4(c) of the Public Health
6 Service Act (42 U.S.C. 290bb–36d(c)) is amended
7 by striking “information on any qualified practi-
8 tioner that is certified to prescribe medication for
9 opioid dependency under section 303(g)(2)(B) of the
10 Controlled Substances Act” and inserting “informa-
11 tion on any practitioner who prescribes narcotic
12 drugs in schedule III, IV, or V of section 202 of the
13 Controlled Substances Act for the purpose of main-
14 tenance or detoxification treatment”.

15 (4) Section 544(a)(3) of the Public Health
16 Service Act (42 U.S.C. 290dd–3), as added by sec-
17 tion 219(a)(2), is amended by striking “any practi-
18 tioner dispensing narcotic drugs pursuant to section
19 303(g) of the Controlled Substances Act” and in-
20 sserting “any practitioner dispensing narcotic drugs
21 for the purpose of maintenance or detoxification
22 treatment”.

23 (5) Section 1833(bb)(3)(B) of the Social Secu-
24 rity Act (42 U.S.C. 1395l(bb)(3)(B)) is amended by
25 striking “first receives a waiver under section 303(g)

1 of the Controlled Substances Act on or after Janu-
2 ary 1, 2019” and inserting “first begins prescribing
3 narcotic drugs in schedule III, IV, or V of section
4 202 of the Controlled Substances Act for the pur-
5 pose of maintenance or detoxification treatment on
6 or after January 1, 2021”.

7 (6) Section 1834(o)(3)(C)(ii) of the Social Se-
8 curity Act (42 U.S.C. 1395m(o)(3)(C)(ii)) is amend-
9 ed by striking “first receives a waiver under section
10 303(g) of the Controlled Substances Act on or after
11 January 1, 2019” and inserting “first begins pre-
12 scribing narcotic drugs in schedule III, IV, or V of
13 section 202 of the Controlled Substances Act for the
14 purpose of maintenance or detoxification treatment
15 on or after January 1, 2021”.

16 (7) Section 1866F(c)(3) of the Social Security
17 Act (42 U.S.C. 1395cc-6(c)(3)) is amended—

18 (A) in subparagraph (A), by adding “and”
19 at the end;

20 (B) in subparagraph (B), by striking “;
21 and” and inserting a period; and

22 (C) by striking subparagraph (C).

23 (8) Section 1903(aa)(2)(C) of the Social Secu-
24 rity Act (42 U.S.C. 1396b(aa)(2)(C)) is amended—

- 1 (A) in clause (i), by adding “and” at the
2 end;
3 (B) by striking clause (ii); and
4 (C) by redesignating clause (iii) as clause
5 (ii).

6 **SEC. 263. REQUIRING PRESCRIBERS OF CONTROLLED SUB-**
7 **STANCES TO COMPLETE TRAINING.**

8 Section 303 of the Controlled Substances Act (21
9 U.S.C. 823) is amended by adding at the end the fol-
10 lowing:

11 “(1) REQUIRED TRAINING FOR PRESCRIBERS.—

12 “(1) TRAINING REQUIRED.—As a condition on
13 registration under this section to dispense controlled
14 substances in schedule II, III, IV, or V, the Attorney
15 General shall require any qualified practitioner, be-
16 ginning with the first applicable registration for the
17 practitioner, to meet the following:

18 “(A) If the practitioner is a physician, the
19 practitioner meets one or more of the following
20 conditions:

21 “(i) The physician holds a board cer-
22 tification in addiction psychiatry or addic-
23 tion medicine from the American Board of
24 Medical Specialties.

1 “(ii) The physician holds a board cer-
2 tification from the American Board of Ad-
3 diction Medicine.

4 “(iii) The physician holds a board cer-
5 tification in addiction medicine from the
6 American Osteopathic Association.

7 “(iv) The physician has, with respect
8 to the treatment and management of pa-
9 tients with opioid or other substance use
10 disorders, completed not less than 8 hours
11 of training (through classroom situations,
12 seminars at professional society meetings,
13 electronic communications, or otherwise)
14 that is provided by—

15 “(I) the American Society of Ad-
16 diction Medicine, the American Acad-
17 emy of Addiction Psychiatry, the
18 American Medical Association, the
19 American Osteopathic Association, the
20 American Psychiatric Association, or
21 any other organization accredited by
22 the Accreditation Council for Con-
23 tinuing Medical Education (commonly
24 known as the ‘ACCME’);

1 “(II) any organization accredited
2 by a State medical society accreditor
3 that is recognized by the ACCME;

4 “(III) any organization accred-
5 ited by the American Osteopathic As-
6 sociation to provide continuing med-
7 ical education; or

8 “(IV) any organization approved
9 by the Assistant Secretary for Mental
10 Health and Substance Abuse or the
11 ACCME.

12 “(v) The physician graduated in good
13 standing from an accredited school of
14 allopathic medicine or osteopathic medicine
15 in the United States during the 5-year pe-
16 riod immediately preceding the date on
17 which the physician first registers or re-
18 news under this section and has success-
19 fully completed a comprehensive allopathic
20 or osteopathic medicine curriculum or ac-
21 credited medical residency that included
22 not less than 8 hours of training on treat-
23 ing and managing patients with opioid and
24 other substance use disorders, including
25 the appropriate clinical use of all drugs ap-

1 proved by the Food and Drug Administra-
2 tion for the treatment of a substance use
3 disorder.

4 “(B) If the practitioner is not a physician,
5 the practitioner meets one or more of the fol-
6 lowing conditions:

7 “(i) The practitioner has completed
8 not fewer than 8 hours of training with re-
9 spect to the treatment and management of
10 patients with opioid or other substance use
11 disorders (through classroom situations,
12 seminars at professional society meetings,
13 electronic communications, or otherwise)
14 provided by the American Society of Addic-
15 tion Medicine, the American Academy of
16 Addiction Psychiatry, the American Med-
17 ical Association, the American Osteopathic
18 Association, the American Nurses
19 Credentialing Center, the American Psy-
20 chiatric Association, the American Associa-
21 tion of Nurse Practitioners, the American
22 Academy of Physician Associates, or any
23 other organization approved or accredited
24 by the Assistant Secretary for Mental
25 Health and Substance Abuse or the or the

1 Accreditation Council for Continuing Med-
2 ical Education.

3 “(ii) The practitioner has graduated
4 in good standing from an accredited physi-
5 cian assistant school or accredited school
6 of advanced practice nursing in the United
7 States during the 5-year period imme-
8 diately preceding the date on which the
9 practitioner first registers or renews under
10 this section and has successfully completed
11 a comprehensive physician assistant or ad-
12 vanced practice nursing curriculum that
13 included not fewer than 8 hours of training
14 on treating and managing patients with
15 opioid and other substance use disorders,
16 including the appropriate clinical use of all
17 drugs approved by the Food and Drug Ad-
18 ministration for the treatment of a sub-
19 stance use disorder.

20 “(2) ONE-TIME TRAINING.—The Attorney Gen-
21 eral shall not require any qualified practitioner to
22 complete the training described in clause (iv) or (v)
23 of paragraph (1)(A) or clause (i) or (ii) of para-
24 graph (1)(B) more than once.

1 “(3) RULE OF CONSTRUCTION.—Nothing in
2 this subsection shall be construed to preclude the
3 use, by a qualified practitioner, of training received
4 pursuant to this subsection to satisfy registration re-
5 quirements of a State or for some other lawful pur-
6 pose.

7 “(4) DEFINITIONS.—In this section:

8 “(A) FIRST APPLICABLE REGISTRATION.—
9 The term ‘first applicable registration’ means
10 the first registration or renewal of registration
11 by a qualified practitioner under this section
12 that occurs on or after the date that is 180
13 days after the date of enactment of the Restor-
14 ing Hope for Mental Health and Well-Being
15 Act of 2022.

16 “(B) QUALIFIED PRACTITIONER.—In this
17 subsection, the term ‘qualified practitioner’
18 means a practitioner who—

19 “(i) is licensed under State law to pre-
20 scribe controlled substances; and

21 “(ii) is not solely a veterinarian.”.

1 **TITLE III—ACCESS TO MENTAL**
2 **HEALTH CARE AND COVERAGE**
3 **Subtitle A—Collaborate in an**
4 **Orderly and Cohesive Manner**

5 **SEC. 301. INCREASING UPTAKE OF THE COLLABORATIVE**
6 **CARE MODEL.**

7 Section 520K of the Public Health Service Act (42
8 U.S.C. 290bb–42) is amended to read as follows:

9 **“SEC. 520K. INTEGRATION INCENTIVE GRANTS AND COOP-**
10 **ERATIVE AGREEMENTS.**

11 “(a) **DEFINITIONS.**—In this section:

12 “(1) **COLLABORATIVE CARE MODEL.**—The term
13 ‘collaborative care model’ means the evidence-based,
14 integrated behavioral health service delivery method
15 that includes—

16 “(A) care directed by the primary care
17 team;

18 “(B) structured care management;

19 “(C) regular assessments of clinical status
20 using developmentally appropriate, validated
21 tools; and

22 “(D) modification of treatment as appro-
23 priate.

1 “(2) ELIGIBLE ENTITY.—The term ‘eligible en-
2 tity’ means a State, or an appropriate State agency,
3 in collaboration with—

4 “(A) 1 or more qualified community pro-
5 grams as described in section 1913(b)(1);

6 “(B) 1 or more health centers (as defined
7 in section 330(a)), a rural health clinic (as de-
8 fined in section 1961(aa) of the Social Security
9 Act), or a Federally qualified health center (as
10 defined in such section); or

11 “(C) 1 or more primary health care prac-
12 tices.

13 “(3) INTEGRATED CARE; BIDIRECTIONAL INTE-
14 GRATED CARE.—

15 “(A) The term ‘integrated care’ means
16 models or practices for coordinating and jointly
17 delivering behavioral and physical health serv-
18 ices, which may include practices that share the
19 same space in the same facility.

20 “(B) The term ‘bidirectional integrated
21 care’ means the integration of behavioral health
22 care and specialty physical health care, as well
23 as the integration of primary and physical
24 health care with specialty behavioral health set-

1 tings, including within primary health care set-
2 tings.

3 “(4) PRIMARY HEALTH CARE PROVIDER.—The
4 term ‘primary health care provider’ means a pro-
5 vider who—

6 “(A) provides health services related to
7 family medicine, internal medicine, pediatrics,
8 obstetrics, gynecology, or geriatrics; or

9 “(B) is a doctor of medicine or osteopathy,
10 physician assistant, or nurse practitioner, who
11 is licensed to practice medicine by the State in
12 which such physician, assistant, or practitioner
13 primarily practices, including within primary
14 health care settings.

15 “(5) PRIMARY HEALTH CARE PRACTICE.—The
16 term ‘primary health care practice’ means a medical
17 practice of primary health care providers, including
18 a practice within a larger health care system.

19 “(6) SPECIAL POPULATION.—The term ‘special
20 population’, for an eligible entity that is collabo-
21 rating with an entity described in subparagraph (A)
22 or (B) of paragraph (3), means—

23 “(A) adults with a serious mental illness
24 who have a co-occurring physical health condi-
25 tion or chronic disease;

1 “(B) children and adolescents with a men-
2 tal illness who have a co-occurring physical
3 health condition or chronic disease;

4 “(C) individuals with a substance use dis-
5 order; or

6 “(D) individuals with a mental illness who
7 have a co-occurring substance use disorder.

8 “(b) GRANTS AND COOPERATIVE AGREEMENTS.—

9 “(1) IN GENERAL.—The Secretary may award
10 grants and cooperative agreements to eligible entities
11 to support the improvement of integrated care for
12 physical and behavioral health care in accordance
13 with paragraph (2).

14 “(2) USE OF FUNDS.—A grant or cooperative
15 agreement awarded under this section shall be
16 used—

17 “(A) in the case of an eligible entity that
18 is collaborating with an entity described in sub-
19 paragraph (A) or (B) of subsection (a)(2)—

20 “(i) to promote full integration and
21 collaboration in clinical practices between
22 physical and behavioral health care for spe-
23 cial populations including each population
24 listed in subsection (a)(7);

1 “(ii) to support the improvement of
2 integrated care models for physical and be-
3 havioral health care to improve the overall
4 wellness and physical health status of—

5 “(I) adults with a serious mental
6 illness or children with a serious emo-
7 tional disturbance; and

8 “(II) individuals with a substance
9 use disorder; and

10 “(iii) to promote bidirectional inte-
11 grated care services including screening,
12 diagnosis, prevention, treatment, and re-
13 covery of mental and substance use dis-
14 orders, and co-occurring physical health
15 conditions and chronic diseases; and

16 “(B) in the case of an eligible entity that
17 is collaborating with a primary health care
18 practice, to support the uptake of the collabo-
19 rative care model, including by—

20 “(i) hiring staff;

21 “(ii) identifying and formalizing con-
22 tractual relationships with other health
23 care providers, including providers who will
24 function as psychiatric consultants and be-
25 havioral health care managers in providing

1 behavioral health integration services
2 through the collaborative care model;

3 “(iii) purchasing or upgrading soft-
4 ware and other resources needed to appro-
5 priately provide behavioral health integra-
6 tion services through the collaborative care
7 model, including resources needed to estab-
8 lish a patient registry and implement
9 measurement-based care; and

10 “(iv) for such other purposes as the
11 Secretary determines to be necessary.

12 “(c) APPLICATIONS.—

13 “(1) IN GENERAL.—An eligible entity that is
14 collaborating with an entity described in subpara-
15 graph (A) or (B) of subsection (a)(2) seeking a
16 grant or cooperative agreement under subsection
17 (b)(2)(A) shall submit an application to the Sec-
18 retary at such time, in such manner, and accom-
19 panied by such information as the Secretary may re-
20 quire, including the contents described in paragraph
21 (2).

22 “(2) CONTENTS.—Any such application of an
23 eligible entity described in subparagraph (A) or (B)
24 of subsection (a)(2) shall include—

1 “(A) a description of a plan to achieve
2 fully collaborative agreements to provide
3 bidirectional integrated care to special popu-
4 lations;

5 “(B) a document that summarizes the poli-
6 cies, if any, that are barriers to the provision of
7 integrated care, and the specific steps, if appli-
8 cable, that will be taken to address such bar-
9 riers;

10 “(C) a description of partnerships or other
11 arrangements with local health care providers
12 to provide services to special populations;

13 “(D) an agreement and plan to report to
14 the Secretary performance measures necessary
15 to evaluate patient outcomes and facilitate eval-
16 uations across participating projects;

17 “(E) a description of how validated rating
18 scales will be implemented to support the im-
19 provement of patient outcomes using measure-
20 ment-based care, including those related to de-
21 pression screening, patient follow-up, and symp-
22 tom remission; and

23 “(F) a plan for sustainability beyond the
24 grant or cooperative agreement period under
25 subsection (e).

1 “(3) COLLABORATIVE CARE MODEL GRANTS.—
2 An eligible entity that is collaborating with a pri-
3 mary health care practice seeking a grant pursuant
4 to subsection (b)(2)(B) shall submit an application
5 to the Secretary at such time, in such manner, and
6 accompanied by such information as the Secretary
7 may require.

8 “(d) GRANT AND COOPERATIVE AGREEMENT
9 AMOUNTS.—

10 “(1) TARGET AMOUNT.—The target amount
11 that an eligible entity may receive for a year through
12 a grant or cooperative agreement under this section
13 shall be—

14 “(A) \$2,000,000 for an eligible entity de-
15 scribed in subparagraph (A) or (B) of sub-
16 section (a)(2); or

17 “(B) \$100,000 or less for an eligible entity
18 described in subparagraph (C) of subsection
19 (a)(2).

20 “(2) ADJUSTMENT PERMITTED.—The Sec-
21 retary, taking into consideration the quality of an el-
22 igible entity’s application and the number of eligible
23 entities that received grants under this section prior
24 to the date of enactment of the Restoring Hope for
25 Mental Health and Well-Being Act of 2022, may ad-

1 just the target amount that an eligible entity may
2 receive for a year through a grant or cooperative
3 agreement under this section.

4 “(3) LIMITATION.—An eligible entity that is
5 collaborating with an entity described in subpara-
6 graph (A) or (B) of subsection (a)(2) receiving fund-
7 ing under this section—

8 “(A) may not allocate more than 20 per-
9 cent of the funds awarded to such eligible entity
10 under this section to administrative functions;
11 and

12 “(B) shall allocate the remainder of such
13 funding to health facilities that provide inte-
14 grated care.

15 “(e) DURATION.—A grant or cooperative agreement
16 under this section shall be for a period not to exceed 5
17 years.

18 “(f) REPORT ON PROGRAM OUTCOMES.—An eligible
19 entity receiving a grant or cooperative agreement under
20 this section—

21 “(1) that is collaborating with an entity de-
22 scribed in subparagraph (A) or (B) of subsection
23 (a)(2) shall submit an annual report to the Sec-
24 retary that includes—

1 “(A) the progress made to reduce barriers
2 to integrated care as described in the entity’s
3 application under subsection (c); and

4 “(B) a description of outcomes with re-
5 spect to each special population listed in sub-
6 section (a)(7), including outcomes related to
7 education, employment, and housing; or

8 “(2) that is collaborating with a primary health
9 care practice shall submit an annual report to the
10 Secretary that includes—

11 “(A) the progress made to improve access;

12 “(B) the progress made to improve patient
13 outcomes; and

14 “(C) the progress made to reduce referrals
15 to specialty care.

16 “(g) TECHNICAL ASSISTANCE FOR PRIMARY-BEHAV-
17 IORAL HEALTH CARE INTEGRATION.—

18 “(1) CERTAIN RECIPIENTS.—The Secretary
19 may provide appropriate information, training, and
20 technical assistance to eligible entities that are col-
21 laborating with an entity described in subparagraph
22 (A) or (B) of subsection (a)(2) that receive a grant
23 or cooperative agreement under this section, in order
24 to help such entities meet the requirements of this
25 section, including assistance with—

1 “(A) development and selection of inte-
2 grated care models;

3 “(B) dissemination of evidence-based inter-
4 ventions in integrated care;

5 “(C) establishment of organizational prac-
6 tices to support operational and administrative
7 success; and

8 “(D) other activities, as the Secretary de-
9 termines appropriate.

10 “(2) COLLABORATIVE CARE MODEL RECIPI-
11 ENTS.—The Secretary shall provide appropriate in-
12 formation, training, and technical assistance to eligi-
13 ble entities that are collaborating with primary
14 health care practices that receive funds under this
15 section to help such entities implement the collabo-
16 rative care model, including—

17 “(A) developing financial models and budg-
18 ets for implementing and maintaining a collabo-
19 rative care model, based on practice size;

20 “(B) developing staffing models for essen-
21 tial staff roles;

22 “(C) providing strategic advice to assist
23 practices seeking to utilize other clinicians for
24 additional psychotherapeutic interventions;

1 “(D) providing information technology ex-
2 pertise to assist with building the collaborative
3 care model into electronic health records, in-
4 cluding assistance with care manager tools, pa-
5 tient registry, ongoing patient monitoring, and
6 patient records;

7 “(E) training support for all key staff and
8 operational consultation to develop practice
9 workflows;

10 “(F) establishing methods to ensure the
11 sharing of best practices and operational knowl-
12 edge among primary health care physicians and
13 primary health care practices that provide be-
14 havioral health integration services through the
15 collaborative care model; and

16 “(G) providing guidance and instruction to
17 primary health care physicians and primary
18 health care practices on developing and main-
19 taining relationships with community-based
20 mental health and substance use disorder facili-
21 ties for referral and treatment of patients
22 whose clinical presentation or diagnosis is best
23 suited for treatment at such facilities.

24 “(3) ADDITIONAL DISSEMINATION OF TECH-
25 NICAL INFORMATION.—In addition to providing the

1 assistance described in paragraphs (1) and (2) to re-
2 cipients of a grant or cooperative agreement under
3 this section, the Secretary may also provide such as-
4 sistance to other States and political subdivisions of
5 States, Indian Tribes and Tribal organizations (as
6 defined under the Federally Recognized Indian Tribe
7 List Act of 1994), outpatient mental health and ad-
8 diction treatment centers, community mental health
9 centers that meet the criteria under section 1913(e),
10 certified community behavioral health clinics de-
11 scribed in section 223 of the Protecting Access to
12 Medicare Act of 2014, primary care organizations
13 such as Federally qualified health centers or rural
14 health clinics as defined in section 1861(aa) of the
15 Social Security Act, primary health care practices,
16 other community-based organizations, and other en-
17 tities engaging in integrated care activities, as the
18 Secretary determines appropriate.

19 “(h) AUTHORIZATION OF APPROPRIATIONS.—To
20 carry out this section, there is authorized to be appro-
21 priated \$60,000,000 for each of fiscal years 2023 through
22 2027.”.

1 **Subtitle B—Helping Enable Access**
2 **to Lifesaving Services**

3 **SEC. 311. REAUTHORIZATION AND PROVISION OF CERTAIN**
4 **PROGRAMS TO STRENGTHEN THE HEALTH**
5 **CARE WORKFORCE.**

6 (a) LIABILITY PROTECTIONS FOR HEALTH PROFES-
7 SIONAL VOLUNTEERS.—Section 224(q)(6) of the Public
8 Health Service Act (42 U.S.C. 233(q)(6)) is amended by
9 striking “October 1, 2022” and inserting “October 1,
10 2027”.

11 (b) MINORITY FELLOWSHIPS IN CRISIS CARE MAN-
12 AGEMENT.—Section 597(b) of the Public Health Service
13 Act (42 U.S.C. 290ll(b)) is amended by striking “in the
14 fields of psychiatry,” and inserting “in the fields of crisis
15 care management, psychiatry,”.

16 (c) MENTAL AND BEHAVIORAL HEALTH EDUCATION
17 AND TRAINING GRANTS.—Section 756 of the Public
18 Health Service Act (42 U.S.C. 294e–1) is amended—

19 (1) in subsection (a)(1), by inserting “(which
20 may include master’s and doctoral level programs)”
21 after “occupational therapy”; and

22 (2) in subsection (f), by striking “For each of
23 fiscal years 2019 through 2023” and inserting “For
24 each of fiscal years 2023 through 2027”.

1 (d) TRAINING DEMONSTRATION PROGRAM.—Section
2 760(g) of the Public Health Service Act (42 U.S.C.
3 294k(g)) is amended by inserting “and \$31,700,000 for
4 each of fiscal years 2023 through 2027” before the period
5 at the end.

6 **Subtitle C—Eliminating the Opt-**
7 **Out for Nonfederal Govern-**
8 **mental Health Plans**

9 **SEC. 321. ELIMINATING THE OPT-OUT FOR NONFEDERAL**
10 **GOVERNMENTAL HEALTH PLANS.**

11 Section 2722(a)(2) of the Public Health Service Act
12 (42 U.S.C. 300gg–21(a)(2)) is amended by adding at the
13 end the following new subparagraph:

14 “(F) SUNSET OF ELECTION OPTION.—

15 “(i) IN GENERAL.—Notwithstanding
16 the preceding provisions of this para-
17 graph—

18 “(I) no election described in sub-
19 paragraph (A) with respect to section
20 2726 may be made on or after the
21 date of the enactment of this subpara-
22 graph; and

23 “(II) except as provided in clause
24 (ii), no such election with respect to
25 section 2726 expiring on or after the

1 date that is 180 days after the date of
2 such enactment may be renewed.

3 “(ii) EXCEPTION FOR CERTAIN COL-
4 LECTIVELY BARGAINED PLANS.—Notwith-
5 standing clause (i)(II), a plan described in
6 subparagraph (B)(ii) that is subject to
7 multiple agreements described in such sub-
8 paragraph of varying lengths and that has
9 an election described in subparagraph (A)
10 with respect to section 2726 in effect as of
11 the date of the enactment of this subpara-
12 graph that expires on or after the date
13 that is 180 days after the date of such en-
14 actment may extend such election until the
15 date on which the term of the last such
16 agreement expires.”.

17 **Subtitle D—Mental Health and**
18 **Substance Use Disorder Parity**
19 **Implementation**

20 **SEC. 331. GRANTS TO SUPPORT MENTAL HEALTH AND SUB-**
21 **STANCE USE DISORDER PARITY IMPLEMEN-**
22 **TATION.**

23 (a) IN GENERAL.—Section 2794(c) of the Public
24 Health Service Act (42 U.S.C. 300gg–94(c)) (as added by
25 section 1003 of the Patient Protection and Affordable

1 Care Act (Public Law 111–148)) is amended by adding
2 at the end the following:

3 “(3) PARITY IMPLEMENTATION.—

4 “(A) IN GENERAL.—Beginning during the
5 first fiscal year that begins after the date of en-
6 actment of this paragraph, the Secretary shall,
7 out of funds made available pursuant to sub-
8 paragraph (C), award grants to eligible States
9 to enforce and ensure compliance with the men-
10 tal health and substance use disorder parity
11 provisions of section 2726.

12 “(B) ELIGIBLE STATE.—A State shall be
13 eligible for a grant awarded under this para-
14 graph only if such State—

15 “(i) submits to the Secretary an appli-
16 cation for such grant at such time, in such
17 manner, and containing such information
18 as specified by the Secretary; and

19 “(ii) agrees to request and review
20 from health insurance issuers offering
21 group or individual health insurance cov-
22 erage the comparative analyses and other
23 information required of such health insur-
24 ance issuers under subsection (a)(8)(A) of
25 section 2726 relating to the design and ap-

1 plication of nonquantitative treatment limi-
2 tations imposed on mental health or sub-
3 stance use disorder benefits.

4 “(C) AUTHORIZATION OF APPROPRIA-
5 TIONS.—There are authorized to be appro-
6 priated \$10,000,000 for each of the first five
7 fiscal years beginning after the date of the en-
8 actment of this paragraph, to remain available
9 until expended, for purposes of awarding grants
10 under subparagraph (A).”.

11 (b) TECHNICAL AMENDMENT.—Section 2794 of the
12 Public Health Service Act (42 U.S.C. 300gg–95), as
13 added by section 6603 of the Patient Protection and Af-
14 fordable Care Act (Public Law 111–148) is redesignated
15 as section 2795.

16 **TITLE IV—CHILDREN AND**
17 **YOUTH**
18 **Subtitle A—Supporting Children’s**
19 **Mental Health Care Access**

20 **SEC. 401. PEDIATRIC MENTAL HEALTH CARE ACCESS**
21 **GRANTS.**

22 Section 330M of the Public Health Service Act (42
23 U.S.C. 254c–19) is amended—

24 (1) in the section enumerator, by striking
25 “**330M**” and inserting “**330M.**”;

1 (2) in subsection (a)—

2 (A) by striking “Indian tribes and tribal
3 organizations” and inserting “Indian Tribes
4 and Tribal organizations”; and

5 (B) by inserting “or, in the case of a State
6 that does not submit an application, a nonprofit
7 entity that has the support of the State” after
8 “450b))”;

9 (3) in subsection (b)—

10 (A) in paragraph (1)—

11 (i) in subparagraph (G), by inserting
12 “developmental-behavioral pediatricians,”
13 after “adolescent psychiatrists,”;

14 (ii) in subparagraph (H), by striking
15 “; and” at the end and inserting a semi-
16 colon;

17 (iii) by redesignating subparagraph
18 (I) as subparagraph (J); and

19 (iv) by inserting after subparagraph
20 (H) the following:

21 “(I) maintain an up-to-date list of commu-
22 nity-based supports for children with mental
23 health problems; and”;

24 (B) by redesignating paragraph (2) as
25 paragraph (4);

1 (C) by inserting after paragraph (1) the
2 following:

3 “(2) SUPPORT TO SCHOOLS AND EMERGENCY
4 DEPARTMENTS.—In addition to the activities re-
5 quired by paragraph (1), a pediatric mental health
6 care telehealth access program referred to in sub-
7 section (a), with respect to which a grant under such
8 subsection may be used, may provide support to
9 schools and emergency departments.

10 “(3) PRIORITY.—In awarding grants under this
11 section, the Secretary shall give priority to appli-
12 cants proposing to—

13 “(A) continue existing programs that meet
14 the requirements of paragraph (1);

15 “(B) establish a pediatric mental health
16 care telehealth access program in the jurisdic-
17 tion of a State, Territory, Indian Tribe, or
18 Tribal organization that does not yet have such
19 a program; or

20 “(C) expand a pediatric mental health care
21 telehealth access program to include one or
22 more new sites of care, such as a school or
23 emergency department.”; and

24 (D) in paragraph (4), as redesignated by
25 subparagraph (B), by inserting “Such a team

1 may include a developmental-behavioral pedia-
2 trician.” after “mental health counselor.”;

3 (4) in subsections (c), (d), and (f), by striking
4 “Indian tribe, or tribal organization” each place it
5 appears and inserting “Indian Tribe, Tribal organi-
6 zation, or nonprofit entity”; and

7 (5) by striking subsection (g) and inserting the
8 following:

9 “(g) TECHNICAL ASSISTANCE.—The Secretary shall
10 award grants or contracts to one or more eligible entities
11 (as defined by the Secretary) for the purposes of providing
12 technical assistance and evaluation support to grantees
13 under subsection (a).

14 “(h) AUTHORIZATION OF APPROPRIATIONS.—To
15 carry out this section, there are authorized to be appro-
16 priated—

17 “(1) \$14,000,000 for each of fiscal years 2023
18 through 2025; and

19 “(2) \$30,000,000 for each of fiscal years 2026
20 through 2027.”.

21 **SEC. 402. INFANT AND EARLY CHILDHOOD MENTAL**
22 **HEALTH PROMOTION, INTERVENTION, AND**
23 **TREATMENT.**

24 Section 399Z–2(f) of the Public Health Service Act
25 (42 U.S.C. 280h–6(f)) is amended by striking

1 “\$20,000,000 for the period of fiscal years 2018 through
2 2022” and inserting “\$50,000,000 for the period of fiscal
3 years 2023 through 2027”.

4 **Subtitle B—Continuing Systems of**
5 **Care for Children**

6 **SEC. 411. COMPREHENSIVE COMMUNITY MENTAL HEALTH**
7 **SERVICES FOR CHILDREN WITH SERIOUS**
8 **EMOTIONAL DISTURBANCES.**

9 (a) DEFINITION OF FAMILY.—Section 565(d)(2)(B)
10 of the Public Health Service Act (42 U.S.C. 290ff–
11 4(d)(2)(B)) is amended by striking “as appropriate re-
12 garding mental health services for the child, the parents
13 of the child (biological or adoptive, as the case may be)
14 and any foster parents of the child” and inserting “as ap-
15 propriate regarding mental health services for the child
16 and the parents or kinship caregivers of the child”.

17 (b) AUTHORIZATION OF APPROPRIATIONS.—Para-
18 graph (1) of section 565(f) of the Public Health Service
19 Act (42 U.S.C. 290ff–4(f)) is amended—

20 (1) by moving the margin of such paragraph 2
21 ems to the right; and

22 (2) by striking “\$119,026,000 for each of fiscal
23 years 2018 through 2022” and inserting
24 “\$125,000,000 for each of fiscal years 2023 through
25 2027”.

1 **SEC. 412. SUBSTANCE USE DISORDER TREATMENT AND**
2 **EARLY INTERVENTION SERVICES FOR CHIL-**
3 **DREN AND ADOLESCENTS.**

4 Section 514 of the Public Health Service Act (42
5 U.S.C. 290bb-7) is amended—

6 (1) in subsection (a), by striking “Indian tribes
7 or tribal organizations” and inserting “Indian Tribes
8 or Tribal organizations”; and

9 (2) in subsection (f), by striking “2018 through
10 2022” and inserting “2023 through 2027”.

11 **Subtitle C—Garrett Lee Smith**
12 **Memorial Reauthorization**

13 **SEC. 421. SUICIDE PREVENTION TECHNICAL ASSISTANCE**
14 **CENTER.**

15 (a) TECHNICAL AMENDMENT.—Section 520C of the
16 Public Health Service Act (42 U.S.C. 290bb-34) is
17 amended—

18 (1) by striking “tribes” and inserting “Tribes”;
19 and

20 (2) by striking “tribal” each place it appears
21 and inserting “Tribal”.

22 (b) AUTHORIZATION OF APPROPRIATIONS.—Section
23 520C(c) of the Public Health Service Act (42 U.S.C.
24 290bb-34(e)) is amended by striking “\$5,988,000 for
25 each of fiscal years 2018 through 2022” and inserting
26 “\$9,000,000 for each of fiscal years 2023 through 2027”.

1 (c) ANNUAL REPORT.—Section 520C(d) of the Public
2 Health Service Act (42 U.S.C. 290bb–34(d)) is amended
3 by striking “Not later than 2 years after the date of enact-
4 ment of this subsection” and inserting “Not later than
5 2 years after the date of enactment of the Restoring Hope
6 for Mental Health and Well-Being Act of 2022”.

7 **SEC. 422. YOUTH SUICIDE EARLY INTERVENTION AND PRE-**
8 **VENTION STRATEGIES.**

9 Section 520E of the Public Health Service Act (42
10 U.S.C. 290bb–36) is amended—

11 (1) by striking “tribe” and inserting “Tribe”;

12 (2) by striking “tribal” each place it appears
13 and inserting “Tribal”;

14 (3) in subsection (a)(1), by inserting “pediatric
15 health programs,” after “foster care systems,”;

16 (4) by amending subsection (b)(1)(B) to read
17 as follows:

18 “(B) a public organization or private non-
19 profit organization designated by a State or In-
20 dian Tribe (as defined under the Federally Rec-
21 ognized Indian Tribe List Act of 1994) to de-
22 velop or direct the State-sponsored statewide or
23 Tribal youth suicide early intervention and pre-
24 vention strategy; or”;

25 (5) in subsection (c)—

1 (A) in paragraph (1), by inserting “pedi-
2 atric health programs,” after “foster care sys-
3 tems,”;

4 (B) in paragraph (7), by inserting “pedi-
5 atric health programs,” after “foster care sys-
6 tems,”;

7 (C) in paragraph (9), by inserting “pedi-
8 atric health programs,” after “educational insti-
9 tutions,”;

10 (D) in paragraph (13), by striking “and”
11 at the end;

12 (E) in paragraph (14), by striking the pe-
13 riod at the end and inserting “; and”; and

14 (F) by adding at the end the following:

15 “(15) provide to parents, legal guardians, and
16 family members of youth, supplies to securely store
17 means commonly used in suicide, if applicable, with-
18 in the household.”;

19 (6) in subsection (d)—

20 (A) in the heading, by striking “DIRECT
21 SERVICES” and inserting “SUICIDE PREVEN-
22 TION ACTIVITIES”; and

23 (B) by striking “direct services, of which
24 not less than 5 percent shall be used for activi-

1 ties authorized under subsection (a)(3)” and in-
2 serting “suicide prevention activities”;

3 (7) in subsection (e)(3)(A), by inserting “and
4 Department of Education” after “Department of
5 Health and Human Services”;

6 (8) in subsection (g)—

7 (A) in paragraph (1), by striking “18” and
8 inserting “24”; and

9 (B) in paragraph (2), by striking “2 years
10 after the date of enactment of Helping Families
11 in Mental Health Crisis Reform Act of 2016”
12 and inserting “3 years after December 31,
13 2022”;

14 (9) in subsection (l)(4), by striking “between 10
15 and 24 years of age” and inserting “up to 24 years
16 of age”; and

17 (10) in subsection (m), by striking
18 “\$30,000,000 for each of fiscal years 2018 through
19 2022” and inserting “\$40,000,000 for each of fiscal
20 years 2023 through 2027”.

21 **SEC. 423. MENTAL HEALTH AND SUBSTANCE USE DIS-**
22 **ORDER SERVICES FOR STUDENTS IN HIGHER**
23 **EDUCATION.**

24 Section 520E–2 of the Public Health Service Act (42
25 U.S.C. 290bb–36b) is amended—

1 (1) in the heading, by striking “**ON CAMPUS**”
2 and inserting “**FOR STUDENTS IN HIGHER EDU-**
3 **CATION**”; and

4 (2) in subsection (i), by striking “2018 through
5 2022” and inserting “2023 through 2027”.

6 **SEC. 424. MENTAL AND BEHAVIORAL HEALTH OUTREACH**
7 **AND EDUCATION AT INSTITUTIONS OF HIGH-**
8 **ER EDUCATION.**

9 Section 549 of the Public Health Service Act (42
10 U.S.C. 290ee-4) is amended—

11 (1) in the heading, by striking “**ON COLLEGE**
12 **CAMPUSES**” and inserting “**AT INSTITUTIONS OF**
13 **HIGHER EDUCATION**”;

14 (2) in subsection (c)(2), by inserting “, includ-
15 ing minority-serving institutions as described in sec-
16 tion 371(a) of the Higher Education Act of 1965
17 (20 U.S.C. 1067q) and community colleges” after
18 “higher education”; and

19 (3) in subsection (f), by striking “2018 through
20 2022” and inserting “2023 through 2027”.

