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The Restoring Hope for Mental Health and Well-Being Act of 2022 (Division FF, Title I of P.L. 117-328, the Consolidated Appropriations Act, 2023): Section-by-Section Summary

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SUMMARY

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The Restoring Hope for Mental Health and Well-Being Act of 2022 (Division FF, Title I of P.L. 117-328, the Consolidated Appropriations Act, 2023): Section-by-Section Summary

The Restoring Hope for Mental Health and Well-Being Act was enacted on December 29, 2022, as Division FF, Title I of the Consolidated Appropriations Act, 2023 (P.L. 117-328). The act primarily reauthorized or amended behavioral health (i.e., mental health and substance use) program authorizations expiring in FY2023. The act reauthorized many behavioral health programs established or reauthorized in 2016 by the 21st Century Cures (P.L. 114-255) or the Comprehensive Addiction and Recovery Act (P.L. 114-198). The act also amended or reauthorized federal programs or regulations related to mental health (e.g., mental health crisis response, suicide prevention, children's mental health) and substance use (e.g., alcohol use, opioid use disorder, recovery housing). Most of the amended provisions authorize grant programs administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the Department of Health and Human Services (HHS).

The Restoring Hope for Mental Health and Well-Being Act is organized into five titles. Each title focuses on a different aspect of behavioral health:

- **Subtitle A ("Mental Health and Crisis Care Needs")** focuses on federal mental health program authorizations, including programs supporting specific services (e.g., crisis response, peer support) or targeting certain populations (e.g., pregnant and postpartum women, individuals with eating disorders or serious mental illness). A reauthorization for SAMHSA's mental health block grant is also included.
- **Subtitle B ("Substance Use Disorder Prevention, Treatment, and Recovery Services")** focuses on federal substance use program authorizations, including programs supporting specific services (e.g., medications for opioid use disorder, recovery housing) or targeting certain populations (e.g., homeless individuals, Indian Tribes or tribal organizations). A reauthorization for SAMHSA's substance use block grant is also included.
- **Subtitle C ("Access to Mental Health Care and Coverage")** focuses on federal authorizations related to the mental health care workforce, access to integrated care services, and private health insurance coverage of behavioral health services (i.e., mental health parity).
- **Subtitle D ("Children and Youth")** focuses on federal mental health program authorizations specifically addressing the mental health and well-being of children and youth. These authorizations address support for school-based programming, suicide prevention activities (e.g., Garrett Lee Smith program reauthorizations), and children with serious emotional disturbances, among others.
- **Subtitle E ("Miscellaneous Provisions")** prohibits the HHS Secretary from allocating funding to carry out any program authorized or amended by the Restoring Hope for Mental Health and Well-Being Act without considering the incidence, prevalence, or determinants of behavioral health issues.

This report provides a section-by-section summary of the Restoring Hope for Mental Health and Well-Being Act, organized by subtitle and chapter of the act. It includes relevant background information, followed by a summary of each provision.

Contents

Appendixes

Contacts

Introduction

The Restoring Hope for Mental Health and Well-Being Act was enacted on December 29, 2022, as Division FF, Title I of the Consolidated Appropriations Act, 2023 (P.L. 117-328). The act primarily reauthorized or amended behavioral health (i.e., mental health and substance use) program authorizations expiring in FY2023. The act reauthorized many programs established or reauthorized in 2016 by the 21st Century Cures Act (Cures Act; P.L. 114-255)[1] or the Comprehensive Addiction and Recovery Act (P.L. 114-198).[2] The act amended or reauthorized specific federal programs related to mental health (e.g., mental health crisis response, suicide prevention, children's mental health) and substance use (e.g., alcohol use, opioid use disorder, recovery housing).

Most of the amended provisions authorize grant programs administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) within the Department of Health and Human Services (HHS). SAMHSA is the federal agency primarily responsible for supporting community-based mental health and substance abuse treatment and prevention services. SAMHSA provides federal funding to states, local communities, and individual organizations through block grants and other formula and discretionary grants. Through such grants, SAMHSA supports activities that include education and training, prevention programs, early intervention activities, treatment services, and technical assistance. SAMHSA does not provide mental health or substance abuse treatment. Rather, the agency supports states' efforts in providing community-based behavioral health services. SAMHSA derives most of its statutory authority from the Public Health Service Act (PHSA). More specifically, Title V and Title XIX of the PHSA contain most authorities for SAMHSA programs and activities.[3]

The Restoring Hope for Mental Health and Well-Being Act (H.R. 7666) passed the House as a standalone bill in June 2022. After being received in the Senate and referred to the Committee on Health, Education, Labor, and Pensions, the bill was ultimately incorporated into the Consolidated Appropriations Act, 2023, and enacted on December 29, 2022, as Division FF, Title I of P.L. 117-328.

This report provides a section-by-section summary of the Restoring Hope for Mental Health and Well-Being Act, organized by subtitle and chapter of the act. It includes relevant background information, followed by a summary of each provision.

[1] The 21st Century Cures Act (P.L. 114-255) was signed into law on December 13, 2016. Division B, entitled "Helping Families in Mental Health Crisis," established or reauthorized many federal programs—and amended several regulations—related to mental health. For more information on the behavioral health authorizations in the 21st Century Cures Act, see CRS Report R44718, *The Helping Families in Mental Health Crisis Reform Act of 2016 (Division B of P.L. 114-255)*.

[2] In a couple of cases, the act reauthorized programs established or amended by the SUPPORT for Patients and Communities Act (SUPPORT Act; P.L. 115-271). For more information on the behavioral health authorizations in the SUPPORT Act, see CRS Report R45423, *Public Health and Other Related Provisions in P.L 115-271, the SUPPORT for Patients and Communities Act*.

[3] For more information on SAMHSA, see CRS Report R46426, *Substance Abuse and Mental Health Services Administration (SAMHSA): Overview of the Agency and Major Programs*.

The Restoring Hope for Mental Health and Well-Being Act: At a Glance

In summary, the subtitles of the Restoring Hope for Mental Health and Well-Being Act address the following:

- **Subtitle A ("Mental Health and Crisis Care Needs")** focuses on federal mental health program authorizations, including programs supporting specific services (e.g., crisis response, peer support) or targeting certain populations (e.g., pregnant and postpartum women, individuals with eating disorders or serious mental illness). A reauthorization for SAMHSA's mental health block grant is also included.
- **Subtitle B ("Substance Use Disorder Prevention, Treatment, and Recovery Services")** focuses on federal substance use program authorizations, including programs supporting specific services (e.g., medications for opioid use disorder, recovery housing) or targeting certain populations (e.g., homeless individuals, Indian Tribes or Tribal organizations). A reauthorization for SAMHSA's substance use block grant is also included.
- **Subtitle C ("Access to Mental Health Care and Coverage")** focuses on federal authorizations related to the mental health care workforce, access to integrated care services, and private health insurance coverage of behavioral health services (i.e., mental health parity).
- **Subtitle D ("Children and Youth")** focuses on federal mental health program authorizations specifically addressing the mental health and well-being of children and youth. These authorizations address support for school-based programming, suicide prevention activities (e.g., Garrett Lee Smith program reauthorizations), and children with serious emotional disturbances, among others.
- **Subtitle E ("Miscellaneous Provisions")** prohibits the HHS Secretary from allocating funding to carry out any program authorized or amended by the Restoring Hope for Mental Health and Well-Being Act without considering the incidence, prevalence, or determinants of behavioral health issues.

The Restoring Hope for Mental Health and Well-Being Act is an authorizing law; it does not appropriate any funds. Some of the programs amended or reauthorized by the law have not received explicit appropriations.

In this report, "Secretary" refers to the HHS Secretary unless otherwise noted.[4]

[4] A table of the abbreviations used in this report appears in the **Appendix**.

The Restoring Hope for Mental Health and Well-Being Act: Summary of Provisions[5]

Technical Edits in the Restoring Hope for Mental Health and Well-Being Act

Many of the provisions in the Restoring Hope for Mental Health and Well-Being Act make similar amendments to language throughout Title V of the Public Health Service Act (PHSA). For example, several provisions replace the terms "addiction" and "abuse" with "use disorders" to describe substance use. The changes align the legislative language with current clinical and diagnostic terminology related to substance use disorders. The Restoring Hope for Mental Health and Well-Being provisions also capitalize "Tribes" and "Tribal" in places the terms appear in Title V of the PHSA. When *technical edits* are referenced in the current report, it usually describes these changes.

Subtitle A—Mental Health and Crisis Care Needs

Chapter 1—Crisis Care Services and 9-8-8 Implementation

Section 1101. Behavioral Health Crisis Coordinating Office

Background

The Department of Health and Human Services (HHS)—primarily through the Substance Abuse and Mental Health Services Administration (SAMHSA)—supports state and local response efforts to individuals experiencing a mental health crisis. For example, SAMHSA supports the operation of the *988 Suicide & Crisis Lifeline* (Lifeline). In July 2022, the Lifeline transitioned from a 10-digit number (1-800-273-TALK) to a three-digit 9-8-8 hotline. In its published 988 appropriations report, SAMHSA articulated a long-term goal of situating the Lifeline in the center of a broader, more robust crisis response system capable of dispatching mobile response services and providing adequate follow-up care.[6] At the direction of Congress via report language accompanying annual appropriations, SAMHSA established the 988 Behavioral Health Crisis Coordinating Office in 2022 through their general authorities derived from Title V of the Public Health Service Act (PHSA).[7] The purpose of the office is to provide leadership and facilitate coordination of behavioral health crisis services across the nation.[8]

Provision

Section 1101 adds a new PHSA Section 501B establishing a behavioral health crisis coordinating office to "coordinate work relating to behavioral health crisis care" across HHS agencies and departments, including SAMHSA, the Centers for Medicare & Medicaid Services (CMS), and the Health Resources and Services Administration (HRSA). Specified duties of the office include (1)

[5] Section 1001 introduces Title I of Division FF as the "Restoring Hope for Mental Health and Well-Being Act of 2022."

[6] Substance Abuse and Mental Health Services Administration (SAMHSA), *988 Appropriations Report*, Rockville, MD, December 2021, https://www.samhsa.gov/sites/default/files/988-appropriations-report.pdf.

[7] H.Rept. 117-96; see also "Explanatory Statement Submitted by Ms. DeLauro, Chair of the House Committee on Appropriations, Regarding the House Amendment to the Senate Amendment to H.R. 2471, Consolidated Appropriated Act, 2022," *Congressional Record*, vol. 168, part 42, book IV (March 9, 2022), p. H2679.

[8] SAMHSA, *988 & Behavioral Health Crisis Coordinating Office*, https://www.samhsa.gov/about-us/who-we-are/offices-centers/988-behavioral-crisis-coordinating-office.

convening stakeholders, (2) operating federal workgroups to make best practices recommendations, and (3) supporting technical assistance, data analysis, and evaluation functions of behavioral health crisis providers, such as the *988 Suicide & Crisis Lifeline*, community mental health centers, Certified Community Behavioral Health Clinics (CCBHCs), and other community behavioral health providers. Section 1101 codifies SAMHSA's 988 Behavioral Health Crisis Coordinating Office, initially established in 2022 under SAMHSA's general authorities.[9]

New PHSA Section 501B authorizes $5 million to be appropriated for each of FY2023-FY2027.

Section 1102. Crisis Response Continuum of Care

Background

During the 2022 transition of the National Suicide Prevention Lifeline from the 10-digit number to the new three-digit *988 Suicide & Crisis Lifeline*, the Biden Administration, executive agencies overseeing the Lifeline, and mental health advocacy groups referred to an opportunity to leverage the launch of 988 to enhance the national mental health crisis response system more broadly.[10] In its National Guidelines for Behavioral Health Crisis Care for instance, SAMHSA described an effective mental health crisis system as a continuum of care that includes crisis contact centers ("someone to talk to"), mobile crisis services ("someone to respond"), and crisis stabilization facilities such as psychiatric receiving centers ("a safe place for help").[11] SAMHSA established the 988 Behavioral Health Crisis Coordinating Office in 2022 to provide leadership and technical assistance related to behavioral health crisis services.[12]

Provision

Section 1102 requires the Secretary, acting through the SAMHSA Assistant Secretary, to identify and publish best practices for a behavioral health crisis response continuum of care. These best practices are to consider (1) the range of service providers (i.e., those that do not require prior authorization from insurance, provide services regardless of ability to pay, operate 24/7, provide services through stabilization or transfer to the next level of care, or address psychiatric stabilization), (2) functions of services (i.e., referral and enrollment in behavioral health care, access points to services within the continuum of care, transfer and receipt of individuals throughout the continuum of care, workforce qualifications, and collaboration with community partners), and (3) service capacity and quality (i.e., volume of services to meet population need, timely responsiveness, capacity to serve different patient populations).

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[9] Ibid.

[10] See, for example, HHS, "HHS Awards More Than $130 Million in 988 Lifeline Grants From the Bipartisan Safer Communities Act to Address Nation's Ongoing Mental Health and Substance Use Crises," press release, December 16, 2022, https://www.hhs.gov/about/news/2022/12/16/hhs-awards-more-than-130-million-988-lifeline-grants-bipartisan-safer-communities-act-address-nations-ongoing-mental-health-substance-use-crises.html; and National Council for Mental Wellbeing, *Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response*, March 2021, https://www.thenationalcouncil.org/resources/roadmap-to-the-ideal-crisis-system/.

[11] SAMHSA, *National Guidelines for Behavioral Health Crisis Care*, Best Practice Toolkit, Rockville, MD, 2020, https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf. See also, SAMHSA, *988 Appropriations Report*, Rockville, MD, December 2021, https://www.samhsa.gov/sites/default/files/988-appropriations-report.pdf.

[12] SAMHSA, *988 & Behavioral Health Crisis Coordinating Office*, https://www.samhsa.gov/about-us/who-we-are/offices-centers/988-behavioral-crisis-coordinating-office. The authority for this office was codified in Section 1101 of the Restoring Hope for Mental Health and Well-Being Act, as described above.

The provision requires SAMHSA to publish the best practices no later than one year after enactment (i.e., December 29, 2023). The provision requires GAO to submit an assessment of behavioral health crisis programs to specified congressional committees no later than three years after enactment (i.e., December 29, 2025) to evaluate which programs meet objectives and performance metrics (with potential data metrics specified).

Section 1103. Suicide Prevention Lifeline Improvement

Background

PHSA Section 520E-3 ("The National Suicide Prevention Lifeline Program") authorizes the National Suicide Prevention Lifeline, a national hotline providing crisis counseling and referral services to individuals experiencing suicidal thoughts or other mental distress. The 21st Century Cures Act codified the program in PHSA Section 520E-3 in 2016, though the Lifeline had operated since 2005.[13] The authorization for the Lifeline specifies that SAMHSA coordinate a network of 24-hour crisis centers and maintain the suicide prevention hotline to connect callers with local emergency services. Lifeline services have consisted primarily of immediate crisis counseling through the hotline, along with referrals, as needed, to local follow-up services. In 2022, the Lifeline transitioned from a 10-digit phone number to a three-digit 9-8-8 hotline (and rebranded as the *988 Suicide & Crisis Lifeline*).[14] Many saw the launch of 988 as an opportunity to enhance SAMHSA's role in more broadly building and maintaining the national mental health crisis response system.[15]

Section 520E-3 previously authorized $7.2 million (rounded) to be appropriated for each of FY2018-FY2022.

Provision

Section 1103 amends PHSA Section 520E-3 by adding more requirements to the National Suicide Prevention Lifeline authorization.[16] Specifically, Section 1101 authorizes the Secretary, acting through the SAMHSA Assistant Secretary, to support and coordinate a national network of crisis centers for suicide prevention and "mental health crisis intervention services, including appropriate follow-up services."[17] The provision requires SAMHSA to develop and implement a plan to support crisis centers and maintain the Lifeline. Contents of the plan include (1) program evaluation using performance measures to assess progress and improve responsiveness of the Lifeline; (2) crisis center requirements related to participation, call responsiveness, and best practices; (3) recommendations on implementing evidence-based practices; and (4) criteria for periodic testing of the Lifeline. The provision requires SAMHSA to develop the initial plan no later than one year after enactment (i.e., December 29, 2023).

Section 1103 requires the Secretary to complete a study and issue a report on the implementation of the Lifeline plan (specified above), and options to improve data on the Lifeline, no later than

[13] Cures Act §9005.

[14] While the Lifeline is now known as the *988 Suicide & Crisis Lifeline*, the authorizing provision in Title V of the PHSA (§520E-3; 42 U.S.C. §290bb-36c) maintains the "National Suicide Prevention Lifeline Program" title.

[15] See SAMHSA, *988 Appropriations Report*, Rockville, MD, December 2021, https://www.samhsa.gov/sites/default/files/988-appropriations-report.pdf; and National Council for Mental Wellbeing, *Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response*, March 2021, https://www.thenationalcouncil.org/resources/roadmap-to-the-ideal-crisis-system/.

[16] §520E-3; 42 U.S.C. §290bb-36c.

[17] 42 U.S.C. §290bb-36c.

two years after development of the plan. The provision requires GAO to complete a study and submit a report to Congress with specified information on implementation of the Lifeline plan, recommendations for improving the Lifeline, and specified issues related to access to the Lifeline no later than two years after implementation of the plan begins.

Section 1103 also adds requirements to the Lifeline authorization related to sharing data with the Centers for Disease Control and Prevention (CDC) and state and local agencies. More specifically, the provision requires the Secretary to formalize an arrangement between the Lifeline and CDC related to sharing de-identified epidemiological data. It also requires the Secretary to ensure that aggregated data are available to state and local agencies to inform suicide prevention activities.

The provision authorizes the Secretary to carry out a pilot program to research, analyze, and employ various technologies or communication platforms (e.g., social media, texting, and email) for suicide prevention, in addition to the Lifeline telephone and chat services. The Secretary is required to submit a report with specified information on the pilot program no later than 24 months after the pilot program commences.

Section 1103 reauthorizes the National Suicide Prevention Lifeline. PHSA Section 520E-3(f) now authorizes $101.6 million (rounded) to be appropriated for each of FY2023-FY2027.

Chapter 2—Into the Light for Maternal Mental Health and Substance Use Disorders

Section 1111. Screening and Treatment for Maternal Mental Health and Substance Use Disorders

Background

PHSA Section 317L-1 ("Screening and Treatment for Maternal Depression") authorizes a grant program to states for screening, assessment, and treatment of maternal depression. The Health Resources and Services Administration (HRSA) administers the Screening and Treatment for Maternal Depression and Related Behavioral Disorders grant program. HRSA provides grants to states for programs that expand the capacity to assess, treat, and refer pregnant and postpartum women for services for maternal depression and related behavioral health disorders. In FY2018, for example, HRSA funded seven states for programs training health care providers in assessing and treating maternal mental health conditions.[18]

Section 317L-1(e) previously authorized $5 million to be appropriated for each of FY2018-FY2022.

Provision

Section 1111 amends PHSA Section 317L-1 by changing the title to "Screening and Treatment for Maternal Mental Health and Substance Use Disorders." The provision adds Tribes and Tribal organizations as eligible grant recipients. It also expands the purpose of the grants (from "maternal depression" to "maternal mental health") and amends the definition of the population

[18] HRSA, *Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program (MDRBD)*, https://mchb.hrsa.gov/programs-impact/screening-treatment-maternal-depression-related-behavioral-disorders-program-mdrbd.

served. The provision makes similar conforming changes throughout Section 317L-1. It requires the Secretary to prioritize eligible entities providing screening and treatment for maternal behavioral health issues through partnerships with community-based organizations in areas with disproportionate need or in health professional shortage areas.

Section 1111 specifies training requirements and amends the types of professionals served through training and resources. It also expands the eligible uses of funds, adding several activities supported by the grant: (1) screening, brief intervention, and treatment; (2) psychiatric consultation; (3) coordination with maternal and child health programs, including child psychiatric access programs; (4) public outreach and awareness; (5) creation of a multistate consortia; and (6) training primary care providers on trauma-informed care, culturally appropriate services, and other best practices. Section 1111 also requires the Secretary to provide technical assistance to grantees and other states and Tribes, and to disseminate best practices based on program evaluation. The provision further adds a new subsection limiting the federal share of grant-supported activities to 90%.

Section 1111 reauthorizes the (renamed) Screening and Treatment for Maternal Mental Health and Substance Use Disorders grant program. PHSA Section 317L-1 now authorizes $24 million to be appropriated for each of FY2023-FY2027.

Section 1112. Maternal Mental Health Hotline

Background

In May 2022, HRSA launched a new *Maternal Mental Health Hotline* for expecting and new mothers experiencing mental health challenges.[19] The confidential, toll-free hotline connects callers with counselors available to provide mental health support. Individuals who contact the hotline receive brief interventions from trained counselors, or referrals to community-based and telehealth providers for further services. HRSA originally operated the hotline under its general authorities with an explicit appropriation from Congress.[20] PHSA Title III ("General Powers and Duties of the Public Health Service") contains many of the authorizations for HHS Public Health Service agency programs, including several HRSA maternal and child health initiatives.

Provision

Section 1112 amends PHSA Title III Part P ("Additional Programs") by adding a new Section 399V-7 ("Maternal Mental Health Hotline"), which requires the Secretary to maintain a national maternal mental health hotline. The new authorization requires that the hotline provide emotional support, information, brief intervention, and resources to pregnant and postpartum women with behavioral health needs (and to their families or household members). Section 1112 effectively codifies the *Maternal Mental Health Hotline* launched by HRSA in 2022.

Section 1112 specifies requirements for the hotline (e.g., hours of operation, staffing, services provided). It also requires the Secretary to conduct a public awareness campaign for the hotline and consult with state and local officials, federal agencies, and other related national hotlines,

[19] U.S. Department of Health and Human Services, "HHS Launches New Maternal Mental Health Hotline," press release, May 6, 2022, https://www.hhs.gov/about/news/2022/05/06/hhs-launches-new-maternal-mental-health-hotline.html.

[20] H.Rept. 116-450 and "Explanatory Statement Submitted by Mrs. Lowey, Chairwoman of the House Committee on Appropriations, Regarding the House Amendment to the Senate Amendment to H.R. 133, Consolidated Appropriations Act, 2021," *Congressional Record*, vol. 166, part 218, book IV (December 21, 2020), p. H8620.

such as the National Suicide Prevention Lifeline.[21] The provision requires the Secretary to submit an annual report to Congress that includes an evaluation of the effectiveness of the hotline and a directory of referral organizations.

New PHSA Section 399V-7 authorizes $10 million to be appropriated for each of FY2023-FY2027.

Section 1113. Task Force on Maternal Mental Health

Background

HHS—primarily through SAMHSA and HRSA—provides resources and administers grants related to maternal behavioral health. For example, HRSA operates the *Maternal Mental Health Hotline* for expecting and new mothers experiencing mental health challenges.[22] Similarly, SAMHSA offers clinical guidance for practitioners treating pregnant and parenting women,[23] toolkits and technical assistance related to maternal mental health,[24] and grant programs addressing health needs of pregnant women affected by substance use.[25] Prior to enactment of the Restoring Hope for Mental Health and Well-Being Act, no authorization for a maternal mental health task force existed.

Provision

Section 1113 requires the Secretary—no later than 180 days after enactment (i.e., June 30, 2023)—to establish a Task Force on Maternal Mental Health (or incorporate the duties specified in the provision into the responsibilities of an existing federal committee or working group). The provision specifies task force membership, which includes the heads of several HHS agencies and other nonfederal members representing various relevant organizations to be appointed by the Secretary. The provision requires designees to be appointed no later than 90 days after enactment (i.e., March 30, 2023).

Section 1113 specifies the duties of the task force, which include preparing and updating a report that evaluates federal maternal mental health programs and identifies best practices related to prevention, diagnosis, and treatment; referral to supports; and implementation of community-based or multigenerational support for maternal mental health conditions. The task force must also develop a national strategy for maternal mental health, which is to include how federal agencies coordinate efforts to address maternal mental health conditions. The task force is required to solicit public comments and consider the latest research in preparing the report and national strategy.

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[21] The statutory authorization for the National Suicide Prevention Lifeline uses that title; however, as of 2022, the program is more commonly referred to as the *988 Suicide & Crisis Lifeline*.

[22] HRSA, *National Maternal Mental Health Hotline*, May 2023, https://mchb.hrsa.gov/national-maternal-mental-health-hotline.

[23] SAMHSA, *Clinical Guidance for Treatment Pregnant and Parenting Women With Opioid Use Disorder and Their Infants*, SMA18-5054, January 2018, https://store.samhsa.gov/product/Clinical-Guidance-for-Treating-Pregnant-and-Parenting-Women-With-Opioid-Use-Disorder-and-Their-Infants/SMA18-5054.

[24] SAMHSA, *Depression in Mothers: More Than the Blues*, SMA14-4878, March 2016, https://store.samhsa.gov/product/Depression-in-Mothers-More-Than-the-Blues/sma14-4878.

[25] SAMHSA, "HHS Announces New Reports and Grant Programs Addressing the Health Needs of Pregnant Women and Children Affected by Substance Use," press release, February 3, 2022, https://www.samhsa.gov/newsroom/press-announcements/20220203/grants-pregnant-women.

The provision requires the task force to meet at least two times each year and convene public meetings, as appropriate. The provision also requires the task force to submit a report to specified entities, including federal agencies and certain congressional committees, no later than one year after the first task force meeting (and an updated report annually thereafter). It requires the task force to submit an initial national strategy no later than two years after the first task force meeting, and an updated national strategy annually thereafter. The provision requires the task force to submit a report to governors of all states describing opportunities for local and state partnerships.

Section 1113 requires the task force to terminate on September 30, 2027, and specifies that the task force may not duplicate others HHS efforts.

Section 1114. Residential Treatment Program for Pregnant and Postpartum Women Pilot Program Reauthorization

Background

PHSA Section 508 ("Residential Treatment Programs for Pregnant and Postpartum Women") authorizes SAMHSA's Pregnant and Postpartum Women (PPW) program, which supports residential substance use disorder treatment and recovery support services to pregnant and postpartum women, their children, and other family members.[26] In 2016, the Comprehensive Addiction and Recovery Act (CARA; P.L. 114-198) added an authorization for a pilot program for state substance abuse agencies to support new models of service delivery, family-based approaches, and activities addressing other gaps in care.[27] The new provision added by CARA included a five-year limit on the pilot program.

In 2018, the SUPPORT Act reauthorized PHSA Section 508, amending the authorization for appropriations to $29.9 million (rounded) for each of FY2019-FY2023.[28]

Provision

Section 1114 amends PHSA Section 508 to remove the five-year limit on the pilot program authorized in subsection (r). Additionally, the provision now requires that the pilot program report be submitted to specified congressional committees no later than September 30, 2026.

Chapter 3—Reaching Improved Mental Health Outcomes for Patients

Section 1121. Innovation for Mental Health

Background

In 2016, the 21st Century Cures Act created several new behavioral health authorizations, including for a new National Mental Health and Substance Use Policy Laboratory within SAMHSA, and an Interdepartmental Serious Mental Illness Coordinating Committee established by the Secretary.

[26] HHS, SAMHSA, *Justification of Estimates for Appropriations Committees, FY2024*.

[27] CARA §501; 42 U.S.C. §290bb-1(r).

[28] 42 U.S.C. §290bb-1(s).

Section 7001 of the Cures Act added a new PHSA Section 501A establishing within SAMHSA the National Mental Health Policy Laboratory. The Laboratory's responsibilities include coordinating the implementation of policy changes to improve certain behavioral health-related outcomes, identifying evidence-based practices, reviewing SAMHSA programs to identify duplicative programs or programs that are not evidence-based, and providing recommendations for improving SAMHSA programs. The provision authorized SAMHSA, via the Laboratory, to award grants for (1) evaluating promising service delivery models and (2) expanding the use of evidence-based programs. In 2018, the SUPPORT Act added another responsibility, requiring the Laboratory to provide information to SAMHSA grant applicants regarding the implementation of evidence-based practices and to provide technical assistance to applicants for funding. SAMHSA appointed its first Director of the National Mental Health and Substance Use Policy Laboratory in January 2018.[29] SAMHSA announced its third and most recent director in June 2023.[30]

PHSA Section 501A previously authorized $7 million to be appropriated for the period of FY2018-FY2020 to carry out each of the two grant programs (i.e., $14 million total).

Section 6031 of the Cures Act required the Secretary to establish an Interdepartmental Serious Mental Illness Coordinating Committee. The provision specified committee membership, membership terms, and the frequency of committee meetings. It required the committee to produce a report—no later than one year after enactment (i.e., December 2017) and again five years after enactment (i.e., December 2021)—summarizing advances, evaluating federal programs, and recommending services for individuals with serious mental illness (SMI). The Cures Act provision specified that the committee shall terminate six years after it is established; however, it also required the Secretary, upon submission of the committee's second report, to make a recommendation to Congress as to whether operation of the committee should be extended.

SAMHSA administers numerous grants and activities under authorities commonly known as Programs of Regional and National Significance (PRNS) in three areas: mental health, substance abuse treatment, and substance abuse prevention.[31] The mental health PRNS are authorized under PHSA Section 520A ("Priority Mental Health Needs of Regional and National Significance").

Previously, Section 520A authorized $395.6 million (rounded) to be appropriated for each of FY2018-FY2022 for the mental health PRNS.

Provision

Section 1121 amends PHSA Section 501A to reauthorize the National Mental Health and Substance Use Policy Laboratory. The provision requires GAO to prepare a report no later than 18 months after enactment (i.e., June 29, 2024) on the work of the Laboratory, including the extent to which it is meeting its statutory responsibilities and any recommendations for improvement. The provision makes other technical edits.

PHSA Section 501A(f) now authorizes $10 million to be appropriated for each of FY2023-FY2027 for all activities authorized under the section.

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[29] SAMHSA, *SAMHSA Blog*, Leadership Announcement, January 9, 2018, https://blog.samhsa.gov/tag/policy.

[30] SAMHSA, *About Us/Who We Are/Leadership/Brian Altman*, June 5, 2023, https://www.samhsa.gov/about-us/who-we-are/leadership/biographies/brian-altman.

[31] Under PHSA Title V Part B, the HHS Secretary is required to "address priority ... needs of regional and national significance" in mental health (PHSA §520A), substance abuse treatment (PHSA §509), and substance abuse prevention (PHSA §516); the HHS Secretary may do so "directly or through grants or cooperative agreements with States, political subdivisions of States, Indian tribes and tribal organizations, other public or private nonprofit entities."

Section 1121 adds a new PHSA Section 501C codifying in the PHSA an authorization for the Interdepartmental Serious Mental Illness Coordinating Committee (and reauthorizing the committee through 2027). The new PHSA provision specifies committee responsibilities and membership (including term duration). The provision requires the committee to produce reports no later than one year and five years after enactment (i.e., December 29, 2023, and December 29, 2027) summarizing research on the prevention, diagnosis, and treatment of SMI and evaluating federal programs for SMI (with specified information to include in the reports). New Section 501C specifies that the committee shall terminate on September 30, 2027. Section 1121 repeals the previous authorization for the committee included in the Cures Act.

Section 1121 reauthorizes SAMHSA's Priority Mental Health Needs of Regional and National Significance (PRNS). PHSA Section 520A now authorizes $599 million (rounded) to be appropriated for each of FY2023-FY2027.

Section 1122. Crisis Care Coordination

Background

Prior to being amended by the Restoring Hope for Mental Health and Well-Being Act, PHSA Section 520F ("Strengthening Community Crisis Response Systems") required the Secretary to award competitive grants (1) to states, localities, Indian Tribes, and Tribal Organizations to enhance community-based crisis response systems, or (2) to states to develop, maintain, or enhance a database of beds at specified inpatient behavioral health treatment facilities. It specified application procedures, defined the requirements of a database of inpatient beds, and required an evaluation. The provision required applicants to include a community-based crisis response plan (as defined) but did not explicitly require mobile crisis services.

In FY2022, SAMHSA established the Cooperative Agreements for Innovative Community Crisis Response Partnerships program under this authority.[32] The purpose of this program is to create or enhance existing mobile crisis response teams that divert individuals experiencing mental health crises from law enforcement in high-need communities. The program supports mobile crisis team services (including co-responder teams) that offer community-based intervention to individuals in need wherever they are located.[33]

PHSA Section 520F previously authorized $12.5 million to be appropriated for the period of FY2018-FY2022 to carry out the program.

PHSA Section 502J ("Mental Health Awareness Training Grants") authorizes a grant program to train teachers, emergency services personnel, law enforcement, and other individuals to identify and appropriately respond to children and adults with a mental disorder. Grants often support training through Mental Health First Aid, a formal eight-hour course on how to identify, understand, and respond to the signs of a crisis, mental health condition, or substance use issue.

Section 520J previously authorized $14.7 million (rounded) to be appropriated annually for each of FY2018-FY2022.

PHSA Section 520L ("Adult Suicide Prevention") authorizes the National Strategy for Suicide Prevention and the Zero Suicide grant programs. The National Strategy for Suicide Prevention grant program supports states and community partners in implementing the National Strategy for

[32] SAMHSA, *Justification of Estimates for Appropriations Committees, FY2024*, p. 80.

[33] For more information on co-responder teams, see CRS Report R47285, *Issues in Law Enforcement Reform: Responding to Mental Health Crises*.

Suicide Prevention—a coordinated guide to the nation's suicide prevention efforts.[34] The Zero Suicide program funds evidence-based suicide prevention interventions in health systems.

Section 520L previously authorized $30 million to be appropriated for the period of FY2018-FY2022.

Provision

Section 1122 replaces PHSA Section 520F with a new provision ("Mental Health Crisis Response Partnership Pilot Program") authorizing a pilot program requiring the Secretary to award grants to establish or enhance mobile crisis response teams. The provision effectively codifies SAMHSA's Cooperative Agreements for Innovative Community Crisis Response Partnerships program.[35]

Mobile crisis response teams are defined as a team of individuals available to respond to people in behavioral health crises and provide immediate stabilization, referrals to service, and triage to a higher level of care, if necessary. The provision requires the Secretary to submit a report to Congress no later than September 30, 2024, on previous steps taken by states and localities to strengthen partnerships among specified members of the behavioral health care community, including first responders, primary care providers, and law enforcement, among others. The provision requires the Secretary to submit annual progress reports with specified information on the grant program, including populations served and related outcomes.

New PHSA Section 520F authorizes $10 million to be appropriated for each of FY2023-FY2027.

Section 1122 amends PHSA Section 502J by making several technical edits. It adds evidence-based training and education on suicide intervention and prevention to the list of allowable uses of funds. It also allows SAMHSA to provide technical assistance to grantees.

Section 1122 reauthorizes the mental health awareness training grant program. PHSA Section 502J now authorizes $25 million (rounded) to be appropriated for each of FY2023-FY2027.

Section 1122 amends PHSA Section 520L by making changes to the purpose of the suicide prevention grant programs. It expands the intended population served to all adults instead of those 25 years of age or older, further emphasizes suicide prevention in the purpose of the grant, and adds suicide prevention resources and the promotion of help seeking for those at risk for suicide as allowable components of activities. The provision adds a third technical assistance requirement, in which the Secretary is to identify best practices for referrals and coordination of follow-up care for individuals in the emergency department who are at risk for suicide, and coordination of care after discharge.

Section 1122 reauthorizes the adult suicide prevention grant programs in PHSA Section 520L. PHSA Section 520L now authorizes $30 million to be appropriated for each of FY2023-FY2027.

[34] U.S. Surgeon General and the National Action Alliance for Suicide Prevention, *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*, PEP12=NSSPGOALS, September 2012, https://www.hhs.gov/surgeongeneral/reports-and-publications/suicide-prevention/index.html.

[35] For more information on some mobile crisis response approaches, see CRS Report R47285, *Issues in Law Enforcement Reform: Responding to Mental Health Crises*.

Section 1123. Treatment of Serious Mental Illness

Background

PHSA Section 520M ("Assertive Community Treatment Grant Program") authorizes SAMHSA's Assertive Community Treatment (ACT) for Individuals with Serious Mental Illness (SMI) grant program.[36] Originally authorized by the Cures Act,[37] the ACT for SMI grant program supports a multidisciplinary intervention designed to reduce rehospitalization and improve outcomes in community settings for individuals with serious mental illness.[38]

PHSA Section 520M previously authorized $5 million to be appropriations for the period of FY2018-FY2022.

The Protecting Access to Medicare Act of 2014 (PAMA; P.L. 113-93) Section 224 ("Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness") authorized a four-year pilot program to award grants for Assisted Outpatient Treatment (AOT) programs for individuals with SMI. It limited grant amounts to not exceed $1 million in each year. It originally authorized $15 million to be appropriated annually for each of FY2015-FY2018. In 2018, the Cures Act extended the program's authorization through FY2022.[39]

The Cures Act amended PAMA Section 224 to authorize $15 million to be appropriated annually for each of FY2015-FY2017, $20 million for FY2018, $19 million annually for each of FY2019-FY2020, and $18 million annually for each of FY2021-FY2022.

Provision

Section 1123 amends PHSA Section 520M. The provision requires the Secretary to provide a report on the grant program to specified congressional committees no later than September 30, 2026.

Section 1123 reauthorizes the ACT for SMI grant program. PHSA Section 520M now authorizes $9 million to be appropriated for each of FY2023-FY2027.

Section 1123 amends PAMA Section 224 to remove the four-year pilot aspect of the program. It makes the annual report biennial, specifies to which congressional committees the report is due, and adds demographic information of the population served to the reporting requirements. Section 1123 requires GAO to provide a report to specified congressional committees on the efficacy of the assisted outpatient treatment programs funded under PAMA Section 224.

Section 1123 reauthorizes the AOT grant program. PAMA Section 224 now authorizes $22 million to be appropriated for each of FY2023-2027.[40]

[36] 42 U.S.C. §290bb-44.

[37] Cures Act §9015.

[38] SAMHSA, *Justification of Estimates for Appropriations Committees, FY2023.*

[39] Cures Act §9014.

[40] 42. U.S.C. §290aa-17. (Previously 42 U.S.C. §290aa note.)

Section 1124. Study on the Costs of Serious Mental Illness

Background

Serious mental illness (SMI) is defined as a mental, behavioral, or emotional disorder that substantially interferes with or limits one or more major life activities.[41] According to SAMHSA's National Survey on Drug Use and Health (NSDUH), an estimated 14 million adults in the United States had a serious mental illness in 2021. SMI causes significant functional impairment, often disrupting an individual's social functioning, capacity to participate in the labor force, and ability to maintain stable housing, among other areas of life. The estimated per individual economic burden from SMI can be substantial—comparable to other major health conditions such as cancer and diabetes.[42]

Provision

Section 1124 requires the Secretary, in consultation with SAMHSA, the HHS Assistant Secretary for Planning and Education (ASPE), the Department of Justice (DOJ), the Department of Labor (DOL), and the Department of Housing and Urban Development (HUD), to conduct a study on the costs of serious mental illness with respect to nongovernmental entities, the federal government, and state, local, and Tribal governments.

The provision specifies considerations for the study, which include costs (1) to the health care system for health services, (2) of homelessness, (3) of residential facilities and other supportive housing, (4) of law enforcement and criminal justice system encounters, (5) of serious mental illness on employment, (6) of caring for individual with SMI by family members and caregivers, and (7) any other relevant costs for programs. The provision specifies disaggregation of the data by costs to governments, types of medical and behavioral health conditions, demographic characteristics, prevalence of serious mental illness, and housing status. The Secretary is required to prepare a report on the study's results no later than two years after enactment of the Restoring Hope for Mental Health and Well-Being Act (i.e., December 29, 2024).

Chapter 4—Anna Westin Legacy

Section 1131. Maintaining Education and Training on Eating Disorders

Background

As part of its mission, SAMHSA supports health practitioners through technical assistance and training. Since 2018, SAMHSA has supported a National Center of Excellence for Eating Disorders (NCEED), located at the University of North Carolina at Chapel Hill.[43] The purpose of the program is to develop and disseminate training and technical assistance for health care

[41] Excluding developmental disorders and substance use disorders. Common SMI includes psychoses, major depressive disorder, and bipolar disorder. Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health*, HHS Publication No. PEP22-07-01-005, NSDUH Series H-57, Rockville, MD, December 2022.

[42] Seth A. Seabury, Sarah Axeen, Gwyn Pauley, et al., "Measuring the Lifetime Costs of Serious Mental Illness and the Mitigating Effects of Educational Attainment," *Health Affairs*, vol. 38, no. 4 (April 2019).

[43] National Center of Excellence for Eating Disorders, *National Center of Excellence for Eating Disorders: Our Mission*, https://www.nceedus.org/about/.

practitioners on issues related to addressing eating disorders.[44] This center for excellence facilitates the identification of model programs, develops and updates materials related to eating disorders, and ensures that high-quality training is provided to health professionals.

Provision

Section 1131 adds a new PHSA 520N entitled "Center for Excellence for Eating Disorders for Education and Training on Eating Disorders." The provision effectively codifies the NCEED program, requiring the Secretary acting through the SAMHSA Assistant Secretary, by grant or contract, to maintain a Center of Excellence for Eating Disorders to improve diagnosis and treatment of eating disorders.

The center's specified activities include (1) training and technical assistance for medical providers in screening and referral for treatment for individuals with eating disorders, and for other paraprofessionals in nonclinical community services; (2) developing and disseminating training materials to health care providers regarding effective treatments for eating disorders; (3) collaborating and coordinating with other SAMHSA entities regarding eating disorders; (4) coordinating with CDC, HRSA, and other federal agencies to disseminate training to primary care and mental health care providers; and (5) conducting other activities as determined by the Secretary. The provision also states that the Secretary may support the integration of eating disorder screening, brief intervention, and referral to treatment (SBIRT) with health information technology systems, provide resources to members of the military and veterans, and consult with DOD and VA on SBIRT for eating disorders.

The new PHSA Section 520N authorizes $1 million to be appropriated for each of FY2023-FY2027.

Chapter 5—Community Mental Health Services Block Grant Reauthorization

Section 1141. Reauthorization of Block Grants for Community Mental Health Services

Background

PHSA Title XIX Subpart I ("Block Grants for Community Mental Health Services") authorizes SAMHSA's Community Mental Health Services Block Grant (MHBG). The MHBG supports state efforts in providing community mental health services for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED).[45] SAMHSA distributes MHBG funds to states (including the District of Columbia and specified territories) according to a formula specified in Title XIX of the PHSA.[46] Each state may distribute MHBG funds to local government entities and nongovernmental organizations to provide community mental health services in accordance with the state's plan. States have flexibility in the use of MHBG funds

[44] SAMHSA, *National Center of Excellence for Eating Disorders (NCEED)*, November 2, 2022, https://www.samhsa.gov/national-center-excellence-eating-disorders-nceed. See also SAMHSA, "SAMHSA announces up to $3.75 million in funding to enhance training efforts to address eating disorders," press release, July 18, 2018, https://www.samhsa.gov/newsroom/press-announcements/20180718.

[45] SAMHSA's definitions of adults with SMI and children with SED were provided in a 1993 *Federal Register* notice (May 20, 1993; 58 *Federal Register* 29422).

[46] 42 U.S.C. §300x et seq.

within the framework of the state plan and federal requirements. The state must designate a Single State Agency responsible for administering the grant and submit the state plan to the Secretary every two years.[47] The statutory authorization for the MHBG contains funding set-asides, such as the requirement that a state must expend 10% of the funds to support early SMI.[48]

Beginning in FY2021, Congress has included a set-aside for "evidence-based crisis systems" in annual appropriations for the MHBG [49] This set-aside reflects Congress's recent intentions to support the development and maintenance of a robust mental health crisis response system.[50] The set-aside is intended to support core elements of crisis care programs, such as mobile crisis units, psychiatric stabilization beds, and crisis call centers.[51]

PHSA Section 1920 previously authorized $532.6 million (rounded) to be appropriated for each of FY2018-FY2022 for the MHBG.

Provision

Section 1141 adds a new subsection to PHSA Section 1920 to codify the 5% set-aside of the MHBG for "Evidence-Based Crisis Care Services."[52] Set-aside funding for crisis care services may be used to support crisis call centers, 24/7 mobile crisis services, or crisis stabilization programs.[53] Section 1141 requires the Secretary to provide a report to Congress no later than September 20, 2025 (and biennially thereafter), on the crisis care strategies and programs supported by the MHBG set-aside. The report must include a description of crisis care activities, populations served, and outcomes of activities, including the program's effects on hospitalization and hospital stays, onset of serious mental illness, and incidents of suicidal ideation and behaviors.

Section 1141 amends PHSA Section 1920 ("Funding") to reauthorize the Community Mental Health Services Block Grant program. PHSA Section 1920 now authorizes $857.6 million (rounded) to be appropriated for each of FY2023-FY2027.

Chapter 6—Peer-Supported Mental Health Services

Section 1151. Peer-Supported Mental Health Services

Background

Support services provided by individuals with lived experiences with mental health and substance use disorders have been recognized as an essential component of comprehensive behavioral

[47] For more information, see CRS Report R46426, *Substance Abuse and Mental Health Services Administration (SAMHSA): Overview of the Agency and Major Programs*.

[48] PHSA §1920(c); 42 U.S.C. §300x-9(c).

[49] Rep. Rosa DeLauro, "Explanatory Statement Submitted by Ms. DeLauro, Chair of the House Committee on Appropriations, Regarding the House Amendment to the Senate Amendment to H.R. 2471, Consolidated Appropriations Act, 2022," Proceedings and Debates of the 117th Congress, Second Session, *Congressional Record*, vol. 168, part No. 42, Book IV (March 9, 2022), pp. H2477-H3215.

[50] See, for example, H.Rept. 117-96 and SAMHSA, *Justification of Estimates for Appropriations Committees, FY2023*.

[51] Ibid.

[52] 42 U.S.C. §300x-9(d).

[53] According to the provision, a state may instead elect to expend not less than 10% of the MHBG funds over two fiscal years.

health care.[54] Although SAMHSA supports peer involvement in mental health care through activities such as its Consumer-Supporter Technical Assistance Centers, no explicit SAMHSA authority to fund peer-support services in mental health treatment existed prior to enactment of the Restoring Hope for Mental Health and Well-Being Act.[55]

Provision

Section 1151 adds a new PHSA Section 520H entitled "Peer-Supported Mental Health Services." The provision authorizes SAMHSA to administer a new grant program to develop, expand, and enhance access to peer-delivered mental health services.

Specified use of funds for the new grant program include (1) initiating workforce development activities to recruit and train peer-workforce providers; (2) building connections between various treatment programs; (3) reducing stigma associated with mental health disorders; (4) expanding virtual peer mental health support services; and (5) researching peer-support and mental illness. Eligible entities include consumer-run nonprofit organizations and Indian Tribes and Tribal organizations.

New PHSA Section 520H authorizes $13 million to be appropriated for each of FY2023-FY2027.

Subtitle B—Substance Use Disorder Prevention, Treatment, and Recovery Services

Chapter 1—Native Behavioral Health Resources

Section 1201. Behavioral Health and Substance Use Disorder Resources for Native Americans

Background

PHSA 506A ("Alcohol and Drug Prevention or Treatment Services for Indians and Native Alaskans") authorized a grant program for Native Alaskan entities and Indian Tribes and Tribal organizations for substance use prevention and treatment services. Originally added by the Children's Health Act of 2000 (P.L. 106-310), the program authorization never received an explicit appropriation. SAMHSA reported in its annual Congressional Budget Justification that the activities authorized in Section 506A may be supported with funding from other Programs of

[54] SAMHSA, for example, funds a Peer Support Technical Assistance Center and operates a Recovery Community Services Program to strengthen the infrastructure of recovery communities and provide peer recovery support services for individuals with substance use disorders and co-occurring mental health disorders. See SAMHSA, *Recovery Community Services Program*, 2023 Notice of Funding Opportunity, https://www.samhsa.gov/grants/grant-announcements/ti-23-018. See also SAMHSA, *Peer Support Services in Crisis Care*, SAMHSA Advisory, Rockville, MD, June 2022, https://store.samhsa.gov/sites/default/files/pep22-06-04-001.pdf; and SAMHSA, *Peers Supporting Recovery from Mental Health Conditions*, BRSS TACS Infographic, Rockville, MD, 2017, https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/peers-supporting-recovery-mental-health-conditions-2017.pdf.

[55] SAMHSA, *Justification of Estimates for Appropriations Committees, FY2024.*

Regional or National Significance (PRNS) or block grants.[56] SAMHSA also noted that the agency has the authority to carry out these programs in their general authorities.[57]

PHSA 506A previously authorized $15 million to be appropriated for FY2001, and such sums as necessary for FY2002 and FY2003.

Provision

Section 1201 replaces PHSA Section 506A with a new provision entitled "Behavioral Health and Substance Use Disorder Resources for Native Americans." The provision authorizes a grant program for services for mental health and substance use disorder prevention and treatment among American Indians, Alaska Natives, and Native Hawaiians.

The provision authorizes the Secretary, acting through the SAMHSA Assistant Secretary in coordination with the Indian Health Service (IHS) as appropriate, to administer grant funds through a contract or compact under Title I or V of the Indian Self-Determination and Education Assistance Act.[58] Award amounts are determined by a formula developed by HHS, with consultation from Indian Tribes and Tribal organizations. Eligible entities are required to apply for awards. The authorization requires the Secretary to provide technical assistance to grantees and to assist with program evaluation data and reporting requirements. The provision requires the Secretary to submit a report describing the services supported by the grant program to specified congressional committees no later than three years after enactment (i.e., December 29, 2025).

PHSA Section 506A now authorizes $80 million to be appropriated for each of FY2023-FY2027 for the grant program.

Chapter 2—Summer Barrow Prevention, Treatment, and Recovery Services

Section 1211. Grants for the Benefit of Homeless Individuals

Background

PHSA Section 506 ("Grants for the Benefit of Homeless Individuals") authorizes SAMHSA's Treatment Systems for Homeless program. Reauthorized in 2016 by the Cures Act,[59] PHSA Section 506 requires the Secretary to award grants, contracts, and cooperative agreements to eligible entities, as specified, to provide mental health and substance abuse services to homeless individuals. The section specifies granting preferences, conditions for services provided under the grant, and terms of awards, among other factors.

PHSA Section 506 previously authorized $41.3 million (rounded) to be appropriated for each of FY2018-FY2022.

[56] See, for example, SAMHSA, *Justification of Estimates for Appropriations Committees, FY2002*, pp. 37-39.

[57] See, for example, SAMHSA, *Justification of Estimates for Appropriations Committees, FY2005*, pp. 27-29.

[58] P.L. 93-638, as amended (25 U.S.C. Chapter 46 et seq.).

[59] Cures Act §9001.

Provision

Section 1211 amends PHSA Section 506 by reauthorizing $41.3 million for each of FY2023-FY2027 for the Treatment Systems for Homeless program.

Section 1212. Priority Substance Use Disorder Treatment Needs of Regional and National Significance

Background

PHSA Section 509 ("Priority Substance Abuse Treatment Needs of Regional and National Significance") provides the authorities for SAMHSA's substance abuse treatment grants and activities commonly known as Programs of Regional and National Significance (PRNS).[60] Reauthorized in 2016 by the Cures Act,[61] the substance abuse treatment PRNS includes grant program authorizations, technical assistance, and other activities supporting treatment for substance use disorders. Some PRNS are explicitly authorized in statute; others are carried out under the general authorities included in PHSA Section 509.

PHSA Section 509 previously authorized $333.8 million (rounded) for each of FY2018-FY2022.

Provision

Section 1212 amends PHSA Section 509 by replacing the term "abuse" with "substance use disorder" wherever it appears.[62] The provision makes other technical edits.

Section 1212 reauthorizes SAMHSA's substance use disorder treatment PRNS. PHSA Section 509 now authorizes $521.5 million (rounded) to be appropriated for each of FY2023-FY2027.

Section 1213. Evidence-Based Prescription Opioid and Heroin Treatment and Interventions Demonstration

Background

PHSA Section 514B ("Evidence-Based Prescription Opioid and Heroin Treatment and Interventions Demonstration") authorizes a competitive grant program to expand treatment of substance use disorders in geographic areas with a high rate or rapid increase of heroin and other opioid use.[63] The provision was originally added by CARA in 2016.[64] The program authorized under PHSA 514B has never received an explicit appropriation.[65]

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[60] Under PHSA Title V Part B, Section 509, the HHS Secretary is required to "address priority substance use disorder treatment needs of regional and national significance"; the Secretary may do so "directly or through grants or cooperative agreements with States, political subdivisions of States, Indian tribes or tribal organizations, … or other public or private nonprofit entities" (42 U.S.C. §290bb-2). PRNS authorizations exist for mental health (PHSA §520A) and substance abuse prevention (PHSA §516) also.

[61] Cures Act §7004.

[62] For example, the provision changes the section title to "Priority Substance Use Disorder Treatment Needs of Regional and National Significance."

[63] 42 U.S.C. §290bb-10.

[64] CARA §301.

[65] Through FY2023.

PHSA Section 514B previously authorized $25 million to be appropriated for each of FY2017-FY2021.

Provision

Section 1213 amends PHSA Section 514B by replacing the terms "substance abuse" and "addiction" with "substance use disorder." The provision makes other technical edits.

Section 1213 amends PHSA Section 514B by reauthorizing $25 million to be appropriated for each of FY2023-FY2027.

Section 1214. Priority Substance Use Disorder Prevention Needs of Regional and National Significance

Background

PHSA Section 516 ("Priority Substance Use Disorder Prevention Needs of Regional and National Significance") provides the authorities for SAMHSA's substance use disorder prevention grants and activities, commonly known as Programs of Regional and National Significance (PRNS).[66] Reauthorized in 2016 by the Cures Act,[67] the substance use disorder treatment PRNS includes grant program authorizations, technical assistance, and other activities supporting prevention of substance use disorders. Some PRNS are explicitly authorized in statute; others are carried out under the general authorities included in PHSA Section 516.

Provision

Section 1214 amends PHSA Section 516 by making technical edits.

Section 1214 reauthorizes SAMHSA's substance use disorder prevention PRNS. PHSA Section 516 now authorizes $218.2 million (rounded) to be appropriated for each of FY2023-FY2027.

Section 1215. Sober Truth on Preventing (STOP) Underage Drinking Authorization

Background

PHSA Section 519B ("Programs to Reduce Underage Drinking") authorizes SAMHSA's Sober Truth on Preventing Underage Drinking Act (STOP Act) programs. Originally added by the STOP Act of 2006 (P.L. 109-422) and reauthorized in 2016 by the Cures Act,[68] PHSA Section 519B authorizes a range of activities aimed at reducing underage drinking. The provision provides separate authorizations of appropriations for each specified activity.

PHSA Section 519B previously authorized the following amounts for each of FY2018-FY2022:

[66] Under PHSA Title V Part B, Section 516, the HHS Secretary is required to "address priority substance use disorder prevention needs of regional and national significance"; the Secretary may do so "directly or through grants or cooperative agreements with States, political subdivisions of States, Indian tribes or tribal organizations, … or other public or private nonprofit entities" (42 U.S.C. §290bb-22). PRNS authorizations exist for substance use disorder treatment (PHSA §509) and mental health (PHSA §520A) also.

[67] Cures Act §7005.

[68] Cures Act §9016.

- $1 million to support an Interagency Coordinating Committee on the Prevention of Underage Drinking and an annual report on state underage drinking prevention and enforcement activities;
- $1 million for a national media campaign to prevent underage drinking;
- $5 million for "enhancement grants" aimed at maximizing the effectiveness of community-wide approaches to preventing and reducing underage drinking; and
- $6 million for research on underage drinking.

There was no explicit authorization of appropriations for grants to pediatric health care providers for screening and brief intervention to reduce underage drinking.

Provision

Section 1215 amends PHSA Section 519B by:

- amending the definitions subsection and removing a reference to a 2003 report by the former Institute of Medicine. The provision now requires the National Academies of Sciences, Engineering, and Medicine (NASEM)[69] to report to Congress with the results of a review on research related to underage alcohol use no later than 12 months after enactment (i.e., December 29, 2023);
- replacing subsection (c) to add a new authorization for the interagency coordinating committee on the prevention of underage drinking and adding specified information to the Secretary's annual report to Congress on state underage drinking prevention and enforcement activities, including certain specified surveillance data. New subsection (c) adds further direction for the Secretary's annual collaborative report on each state's performance preventing or reducing underage drinking. The new provision clarifies the contents of the report including performance measures developed by the Secretary and other specified details;
- replacing subsection (d) with a new authority for the national media campaign to prevent underage drinking. The provision requires the Secretary in consultation with the National Highway Traffic Safety Administration to continue a media campaign aimed at adults to reduce underage drinking. The provision specifies the purpose of the campaign, describes campaign components, and requires the Secretary to consult with various specified stakeholders. It requires the Secretary to produce an annual report on the media campaign. The provision also provides the Secretary with the authority, based on the availability of funds, to support research on the potential for a youth-oriented national media campaign, with requirements to share such information with Congress;
- replacing subsection (e) with a new authorization for the community-based coalition enhancement grants to prevent underage drinking. The provision increases the maximum amount of each grant, for example, from $50,000 (the previous amount) to $60,000. It removes the authorization for grants directed at preventing and reducing alcohol abuse at institutions of higher education;

[69] The National Academies of Sciences, Engineering, and Medicine (NASEM) is a private, nonprofit organization that provides "independent, objective advice to inform policy with evidence, spark progress and innovation, and confront challenging issues for the benefit of society." For more information, see https://www.nationalacademies.org/about.

- replacing subsection (f) to include an authorization for grants to pediatric health care providers to reduce underage drinking through screening and brief intervention. The provision amends the previous authorization by narrowing the intended population served to adolescents (removing "children"). The provision adds a definition for the term "screening"; and
- replacing subsection (g) to include the authority to collect data and conduct or support research on underage drinking. The provision amends the specified characteristics of the authorized research and includes (1) evaluation of the effectiveness of community-based programs and statewide systems, (2) the reporting of more precise information on the scope of underage drinking and patterns of underage alcohol consumption, (3) development and identification of evidence-based strategies to reduce underage drinking, and (4) improvement of public health data collection on alcohol use and alcohol-related conditions.

Section 1215 reauthorizes the STOP Act programs. PHSA Section 519B now authorizes the following amounts to be appropriated for each subsection:

- subsection (c): $1 million for each of FY2023-FY2027 to support the Interagency Coordinating Committee on the Prevention of Underage Drinking and an annual report on state underage drinking prevention and enforcement activities;
- subsection (d): $2.5 million for each of FY2023-FY2027 for a national media campaign to prevent underage drinking;
- subsection (e): $11.5 million for each of FY2023-FY2027 for community-based coalition enhancement grants to prevent underage drinking;
- subsection (f): $3 million for each of FY2023-FY2027 for grants to pediatric health care providers to reduce underage drinking through screening and brief intervention;
- subsection (g): $5 million for each of FY2023-FY2027 for research on underage drinking; and $500,000 for FY2023 to contract with NASEM regarding a report on underage drinking.

Section 1216. Grants for Jail Diversion Programs

Background

PHSA Section 520G ("Grants for Jail Diversion Programs") authorizes SAMHSA's Criminal and Juvenile Justice Programs. Reauthorized in 2016 by the Cures Act,[70] PHSA Section 520G requires the Secretary to make grants to states, political subdivisions of states, Indian Tribes, and Tribal organizations, directly or through agreements, for jail diversion programs (i.e., programs to divert individuals with mental illness from the criminal justice system to community-based services).

Section 520G previously authorized $4.3 million (rounded) to be appropriated annually for each of FY2018-FY2022.

[70] Cures Act §9002.

Provision

Section 1216 amends PHSA 520G by removing the cap on the number of grants administered, allowing eligible health facilities or nonprofit entities to apply for the grants directly, ensuring peer recovery support services are mentioned in the application, and adding paraprofessional training to the allowable uses of funds. The provision makes other technical edits to the grant authorization.

Section 1216 reauthorizes the Criminal and Juvenile Justice Programs. PHSA Section 520G now authorizes $14 million to be appropriated for each of FY2023-FY2027.

Section 1217. Formula Grants to States

Background

PHSA Section 521 ("Formula Grants to States") authorizes SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) grant program.[71] Reauthorized in 2016 by the Cures Act,[72] the PATH program is a formula grant program that distributes funds to states to support local organizations providing services for people with serious mental illness (including those with co-occurring substance use disorders) who are homeless or at imminent risk of becoming homeless.[73] Up to 20% of the federal payments may be used for housing-related assistance. Other services include (but are not limited to) outreach, mental health and substance use disorder treatment, case management, and job training.[74]

Provision

Section 1217 amends PHSA Section 521 by reauthorizing the PATH formula grant program for FY2023 through FY2027.

Section 1218. Projects for Assistance in Transition from Homelessness

Background

PHSA Section 535 ("Funding") authorizes the appropriations for the PATH program. PHSA Section 535 previously authorized to be appropriated $64.6 million (rounded) for each of FY2018-FY2022 for the PATH program.

Provision

Section 1218 amends PHSA Section 535 by reauthorizing $64.6 million (rounded) to be appropriated for each of FY2023-FY2024.

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[71] Authorizations for various aspects of the PATH program are included in PHSA Sections 521-535 (42 U.S.C. §290cc-21 through §290cc-35).

[72] Cures Act §9004.

[73] The minimum allotment is $300,000 for each of the 50 states, the District of Columbia, and Puerto Rico, and $50,000 for each of Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands. Funds are distributed to states in amounts proportional to their populations living in urbanized areas. The formula to determine allotments is included in PHSA Section 524 (42 U.S.C. §290cc-24).

[74] For more about PATH, see http://www.samhsa.gov/homelessness-programs-resources/grant-programs-services/path.

Section 1219. Grants for Reducing Overdose Deaths

Background

PHSA Section 544 ("Grants for Reducing Overdose Deaths") authorizes SAMHSA's Improving Access to Overdose Treatment grant program. Originally added by CARA in 2016,[75] PHSA Section 544 authorizes a grant program to expand access to FDA-approved drugs for emergency treatment of opioid overdoses. Grants provided a maximum amount of $200,000 per grant year to federally qualified health centers (FQHCs)[76] and federally certified opioid treatment programs (OTPs)[77] for prescribing, purchasing, or training health care providers in the use of FDA-approved overdose reversal medications such as naloxone.[78]

PHSA Section 544 previously authorized $5 million to be appropriated for the period of FY2017-FY2021.

Provision

Section 1219 amends PHSA Section 544 by repealing the $200,000 maximum amount for each grant and changing eligibility for the grant program from FQHCs and OTPs to states, territories, localities, and Tribes. The provision adds an authority for grantees to award subgrants to FQHCs, OTPs, and other practitioners using medications for opioid use disorder. The provision adds individuals co-prescribed benzodiazepines to the specified populations served, includes connecting patients to overdose reversal medications in the use of funds, and makes other technical edits. The provision also adds authorities to PHSA Section 544 for the Secretary to provide best practices to specified stakeholders (including prescribers within the VA and DOD) for prescribing FDA-approved drugs for opioid overdoses.

Section 1219 amends PHSA Section 544 to reauthorize $5 million to be appropriated for the period of FY2023-FY2027 for the Improving Access to Overdose program.

Section 1220. Opioid Overdose Reversal Medication Access and Education Grant Programs

Background

PHSA Section 545 ("Opioid Overdose Reversal Medication Access and Education Grant Programs") authorizes a grant program to implement strategies to dispense FDA-approved drugs for emergency treatment of opioid overdose. Originally added by CARA,[79] PHSA Section 545 authorized grants to states to encourage pharmacies to dispense opioid overdose reversal medications, such as naloxone, pursuant to a standing order.[80] The program authorized under PHSA 545 has never received an explicit appropriation as of FY2023.

[75] CARA §107 (42 U.S.C. §290dd-3).

[76] For more information on FQHCs, see CRS Report R43937, *Federal Health Centers: An Overview*.

[77] For more information on OTPs, see CRS In Focus IF12348, *Medications for Opioid Use Disorder*.

[78] For more information on naloxone, see CRS In Focus IF12490, *Naloxone for Opioid Overdose: Considerations for Congress*.

[79] CARA §110 "Opioid Overdose Reversal Medication Access and Education Grant Program" (42 U.S.C. §290ee).

[80] For more information on FDA-approved opioid overdose reversal medications and standing orders, see CRS In Focus IF12490, *Naloxone for Opioid Overdose: Considerations for Congress*.

PHSA Section 545 previously authorized $5 million to be appropriated for the period of FY2017-FY2019.

Provision

Section 1220 amends PHSA Section 545 by amending the title to include "Co-Prescribing" and adding localities and Tribes to the list of eligible grantees.[81] The provision adds co-prescribing FDA-approved medications for opioid overdose to the list of required grant activities and removes the specification for pharmacists to be the dispensers of such drugs.[82] The provision also expands the time period for the grant from three years to five years. It amends the limit for using grant funds for public education from 20% to 10% and requires that not less than 20% of the grant be used to offset cost sharing for emergency overdose reversal medications. The provision makes other technical edits regarding language describing FDA approval of opioid overdose reversal medications.

Section 1220 amends PHSA Section 545 to reauthorize $5 million to be appropriated for the period of FY2023-FY2027.

Section 1221. Emergency Department Alternatives to Opioids

Background

SUPPORT for Patients and Communities Act Section 7091 ("Emergency Department Alternatives to Opioids Demonstration Program") authorized SAMHSA's Emergency Department Alternatives to Opioids program. Through this program, SAMHSA provides grants to hospitals and emergency departments to develop, implement, or study alternatives to opioids for pain management in hospital or emergency department settings. The authorizing provision requires SAMHSA to facilitate the development of best practices on opioid alternatives and to provide technical assistance to hospitals and other acute care settings. It also requires the Secretary to submit a report to Congress on the results of the program one year after the completion of the demonstration program.

SUPPORT Act Section 7091 previously authorized $10 million to be appropriated for each of FY2019-FY2021.

Provision

Section 1221 amends SUPPORT Act Section 7091 by removing the demonstration label and making the required report to specified congressional committees annual, due at the end of each year from FY2024 through FY2028.

Section 1221 amends SUPPORT Act Section 7091 by reauthorizing $10 million to be appropriated for each of FY2023-FY2027 for the Emergency Department Alternatives to Opioids program.

[81] The title for PHSA Section 545 is now "Opioid Overdose Reversal Medication Access, Education, and Co-Prescribing Grant Program."

[82] The provision describes "drugs or devices approved, cleared, or otherwise legally marketed under the Federal Food, Drug, and Cosmetic Act for emergency treatment of known or suspected opioid overdose" (42 U.S.C. §290ee). For more information, see CRS Report R41983, *How FDA Approves Drugs and Regulates Their Safety and Effectiveness*.

Chapter 3—Excellence in Recovery Housing

Background

PHSA Section 550 ("National Recovery Housing Best Practices)" requires the Secretary to develop best practices for operating substance use recovery housing. Originally added by the SUPPORT Act in 2018,[83] PHSA Section 550 defines recovery housing to mean a "shared living environment free from alcohol and illicit drug use and centered on peer support and connection to services that promote sustained recovery from substance use disorders."[84] In identifying these best practices, the Secretary is required to consult with other entities such as SAMHSA, CMS, the HUD Secretary, state health commissioners, health insurers, and individuals with a history of substance use disorder (SUD), among others. The provision requires the Secretary, in consultation with the same specified entities and the Attorney General, to identify common indicators that could be used to identify potentially fraudulent recovery housing operators, as described.

The Secretary is required to disseminate the best practices and common indicators to specified entities, which include state agencies, Tribal organizations, the Attorney General, recovery housing entities, and the public, among others. In carrying out these activities, the Secretary is required to consult with specified entities and to consider how recovery housing supports recovery, prevents relapse and overdose, and improves access to treatment such as medications for opioid use disorder. This provision does not give the Secretary the authority to require states to adhere to minimum standards, though the best practices may include model laws for states to implement suggested minimum standards. SAMHSA published recovery housing best practices in 2019.[85]

PHSA Section 550 previously authorized $3 million to be appropriated for the period of FY2019-FY2021.

PHSA Section 501 ("Substance Abuse and Mental Health Services Administration") provides SAMHSA's general authorities, including those related to the Assistant Secretary and the agency organization.

Section 1231. Clarifying the Role of SAMHSA in Promoting the Availability of High-Quality Recovery Housing

Section 1231 amends PHSA Section 501 by adding a new authority requiring the SAMHSA Assistant Secretary to collaborate with states, federal agencies, and other specified stakeholders with expertise in recovery housing to promote the availability of recovery housing for individuals with substance use disorders.

Section 1232. Developing Guidelines for States to Promote the Availability of High-Quality Recovery Housing

Section 1232 amends PHSA Section 550 by requiring the Secretary to continue to identify, develop, and periodically update best practices for operating recovery housing. The provision

[83] SUPPORT Act §7031.

[84] 42 U.S.C. §290ee-5.

[85] Substance Abuse and Mental Health Services Administration (SAMHSA), *Recovery Housing: Best Practices and Suggested Guidelines*, 2019. SAMHSA updated these best practices in 2023 subsequent to P.L. 117-328. See SAMHSA, *Best Practices for Recovery Housing*, PEP23-10-00-002, Rockville, MD, 2023, https://www.samhsa.gov/resource/ebp/best-practices-recovery-housing.

adds specifics regarding whom the Secretary must consult with for the best practices. It adds a requirement that the best practices be made publicly available and published on SAMHSA's website. Lastly, it prohibits the Secretary from including best practices for substance use disorder treatment services in the recovery housing best practices.

Section 1233. Coordination of Federal Activities to Promote the Availability of Recovery Housing

Section 1233 amends PHSA Section 550 by adding a new subsection (e) requiring the Secretary, acting through the SAMHSA Assistant Secretary and HUD Secretary, to convene an interagency working group to increase collaboration among federal agencies regarding the promotion of recovery housing for individuals in need.

The new subsection tasks the working group with aligning efforts of federal agencies and avoiding duplication. It also requires the working group to develop a long-term plan for supporting state and local efforts to operate recovery housing consistent with the best practices. The provision specifies the composition of the interagency working group. The working group is required to meet on a quarterly basis and submit a report to specified congressional committees on the work of the group and any recommendations no later than four years after enactment (i.e., December 30, 2026). The provision makes other technical edits.

Section 1234. National Academies of Sciences, Engineering, and Medicine Study and Report

Section 1234 requires the Secretary, acting through the SAMHSA Assistant Secretary, to contract with the National Academies of Sciences, Engineering, and Medicine (NASEM) to study the quality and effectiveness of recovery housing in the United States. The provision tasks NASEM with determining whether the availability of recovery housing meets demand and providing recommendations to promote the availability of recovery housing. It requires the Secretary to contract with NASEM no later than 60 days after enactment (i.e., February 27, 2023) and report to Congress on the results of the review.

Section 1234 authorizes $1.5 million to be appropriated for FY2023.

Section 1235. Grants for States to Promote the Availability of Recovery Housing and Services

Section 1235 amends PHSA Section 550 by authorizing a grant program to support implementation of the national recovery housing best practices.

The provision authorizes the Secretary to award grants to states, Tribes, and territories for technical assistance to implement the national recovery housing best practices and to promote the availability of recovery housing. States receiving such grants are required to submit to SAMHSA, and publish on their state website, a state plan for promotion of recovery housing.

Section 1236. Funding

Section 1235 amends PHSA Section 550 by reauthorizing funding for National Recovery Housing Best Practices activities. PHSA Section 550 now authorizes $5 million to be appropriated for the period of FY2023-FY2027.

Section 1237. Technical Corrections

Section 1237 makes technical corrections to PHSA Title V by redesignating the second PHSA Section 550 (entitled "Sobriety Treatment and Recovery Teams"[86]) as Section 550A and locating it after Section 550.

Chapter 4—Substance Use Prevention, Treatment, and Recovery Services Block Grant

Background

PHSA Title XIX Subpart II ("Block Grants for Prevention and Treatment of Substance Abuse") authorizes SAMHSA's Substance Abuse Prevention and Treatment Block Grant (referred to as the SABG, or sometimes SAPT).[87] The SABG supports state efforts in providing community-based services to prevent and treat substance use disorders. SAMHSA distributes SABG funds to states (including the District of Columbia and specified territories) and one Tribal entity according to a formula specified in Title XIX of the PHSA.[88] Each state may distribute SABG funds to local government entities, administrative service organizations, and prevention and treatment service providers (among others) in accordance with the state's plan.[89] States must designate a Single State Agency responsible for administering the grant and submit an application containing the state plan to the HHS Secretary by the first of October preceding the fiscal year.[90] States have flexibility in the use of SABG funds within the framework of the state plan and federal requirements. While the use of funds is generally determined by states, each SABG grantee must expend at least 20% of its SABG allotment on primary prevention strategies.[91]

PHSA Section 1935 authorizes $1.86 billion (rounded) to be appropriated annually for each of FY2018-FY2022 for the SABG.

Section 1241. Eliminating Stigmatizing Language Relating to Substance Use

Section 1241 amends PHSA Title XIX Subpart II (Sections 1921-1935) by replacing the terms "substance abuse" with "substance use disorders." The provision amends the subpart heading to read "Block Grants for Substance Use Prevention, Treatment, and Recovery Services," effectively renaming it the Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) block

[86] The SUPPORT Act Section 8214 inserted a second PHSA Section 550 at the end of title V.

[87] PHSA §§1921-1935. Some provisions in PHSA Title XIX, Part B, Subpart III, also apply to the substance use block grant.

[88] 42 U.S.C. §300x et seq.

[89] PHSA §1932(b) (42 U.S.C. §300x-32(b)).

[90] PHSA §1932 (42 U.S.C. §300x-32). Of note, PHSA Section 1958 allows the Assistant Secretary to permit a joint application for the MHBG and SABG.

[91] PHSA §1922(a)(1) (42 U.S.C. §300x-22(a)(1)). Primary prevention strategies refer to interventions designed to avoid manifestations of a disease before the health condition occurs or, in the case of the SABG authorization, "for individuals who do not require treatment for substance abuse." For more information, see CRS Report R46426, *Substance Abuse and Mental Health Services Administration (SAMHSA): Overview of the Agency and Major Programs*.

grant program.[92] It amends PHSA Section 1934 ("Definitions") to define substance use disorder to mean the recurrent use of alcohol or other drugs that causes clinically significant impairment.[93]

Section 1242. Authorizes Activities

Section 1242 amends PHSA Section 1921 ("Formula Grants to States") by adding "recovery support services" to the authorized grant activities stated in subsection (b).

Section 1243. State Plan Requirements

Section 1243 amends PHSA Section 1932 ("Application for Grant; Approval of State Plan") by requiring states submitting a plan for the block grants to describe the state's recovery support services and the amount of block grant funds expended for these activities. The provision also makes a conforming edit.

Section 1244. Updating Certain Language Relating to Tribes

Section 1244 amends PHSA Section 1933 ("Determination of Amount of Allotment") by making technical edits, including several related to language pertaining to Tribes.

Section 1245. Block Grants for Substance Use Prevention, Treatment, and Recovery Services

Section 1245 amends PHSA Section 1935 ("Funding") by reauthorizing funding for the substance use block grant. The provision also makes a technical correction.

PHSA Section 1935 now authorizes $1.9 billion (rounded) to be appropriated for each of FY2023-FY2027.

Section 1246. Requirements of Reports and Audits by States

Section 1246 amends PHSA Section 1942 ("Requirement of Reports and Audits by States") by requiring states to include in the report to the Secretary the amount provided to recipients of block grant funds in the state in the previous fiscal year.

Section 1247. Study on Assessment for Use of State Resources

Section 1247 requires the Secretary, acting through the SAMHSA Assistant Secretary and in consultation with states and local service providers, to conduct a study on strategies to assess community needs related to substance use prevention, treatment, and recovery support services. The study is to facilitate state use of the substance use block grant. The provision requires the Secretary to submit results of the study to specified congressional committees no later than two years after enactment (i.e., December 29, 2024).

[92] Now referred to by SAMHSA as the SUPTRS block grant, or sometimes SUBG for short. See SAMHSA, *Substance Use Prevention, Treatment, and Recovery Services Block Grant*, updated April, 2023, available at https://www.samhsa.gov/grants/block-grants/subg.

[93] 42 U.S.C. §300x-34.

Chapter 5—Timely Treatment for Opioid Use Disorder

Section 1251. Study on Exemptions for Treatment of Opioid Use Disorder Through Opioid Treatment Programs During the COVID-19 Public Health Emergency

Background

Social distancing measures and temporary stay-at-home orders associated with the COVID-19 pandemic influenced changes in service delivery for substance use treatment. For substance use treatment that uses certain medications for opioid use disorder (MOUD)—specifically opioid agonist treatments such as methadone and buprenorphine—patients are required by law to attend in person for at least the initial visit for buprenorphine, and daily for methadone.[94] Methadone is typically administered on a daily basis onsite at federally certified opioid treatment programs (OTPs, sometimes known as methadone clinics), with some short-term take-home doses allowed for stable patients.[95]

During the pandemic, SAMHSA and DEA allowed stable patients to receive up to 28 days of take-home medication.[96] DEA also allowed alternative methods for the delivery of methadone to patients under stay-at-home orders,[97] as well as interstate prescribing privileges for providers.[98] Other changes included relaxing privacy requirements mandated by the Health Insurance Portability and Accountability Act (HIPAA) rules and increasing the use of telehealth to deliver substance use treatment services. In addition, some states employed other methods of service delivery (e.g., mobile units) for treatments that cannot be administered via telehealth, such as MOUD.

In addition to these flexibilities allowed by DEA and SAMHSA during the public health emergency, CFR Title 42 Part 8 allows OTPs to apply for exceptions to certain regulations, including during the COVID-19 pandemic.[99] The public health emergency declaration for the COVID-19 pandemic expired on May 11, 2023.[100]

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[94] See CRS In Focus IF12348, *Medications for Opioid Use Disorder*.

[95] As outlined in 42 CFR §8.12. See also Drug Enforcement Administration, *Use of Telemedicine While Providing Medication Assisted Treatment (MAT)*, Diversion Control, May 15, 2018, https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/telemedicine-dea-guidance.pdf.

[96] Substance Abuse and Mental Health Services Administration, *Opioid Treatment Program (OTP) Guidance*, Rockville, MD, March 16, 2020, https://www.samhsa.gov/sites/default/files/otp-guidance-20200316.pdf. See also CRS Report R46831, *Behavioral Health During the COVID-19 Pandemic: Overview and Issues for Congress*.

[97] Letter from Thomas Prevoznik, Deputy Assistant Administrator, Drug Enforcement Administration, to Registered Narcotic Treatment Program, April 7, 2020, https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-025)(DEA078)_Off-site_OTP_delivery_method_(Final)+_esign.pdf.

[98] Letter from William McDermott, Assistant Administrator, Drug Enforcement Administration, to DEA Registrants, March 25, 2020, https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-018)(DEA067)%20DEA%20state%20reciprocity%20(final)(Signed).pdf. For more information and resources related to the COVID-19 pandemic from the Drug Enforcement Administration, see "COVID-19 Information Page," https://www.deadiversion.usdoj.gov/coronavirus.html.

[99] 42 C.F.R. §8.11(h).

[100] See CRS Insight IN12088, *Effects of Terminating the Coronavirus Disease 2019 (COVID-19) PHE and NEA Declarations*; and Press Release, U.S. Department of Health and Human Services, Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap, February 9, 2023, at https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html.

Provision

Section 1251 requires the SAMHSA Assistant Secretary—in consultation with patients and other stakeholders—to conduct a study on activities carried out pursuant to exemptions granted to states or OTPs during the COVID-19 public health emergency. The provision requires SAMHSA to gather feedback from states and OTPs regarding their experiences implementing exemptions. It also requires that SAMHSA publish a report on the results of the study no later than 180 days after the termination of the COVID-19 public health emergency or at the end of calendar year 2022, whichever is sooner.[101]

Section 1252. Changes to Federal Opioid Treatment Standards

Background

Section 302 of the Controlled Substance Act (CSA; "Persons Required to Register") requires every person who manufactures or distributes controlled substances to register with the Attorney General (via DEA).[102] Section 302(e) requires a separate DEA registration for each principal place of business or professional practice where the applicant distributes or dispenses controlled substances.

Federally certified opioid treatment programs (OTPs) generally administer methadone (a schedule II controlled substance) to patients on a daily basis, with staff observing as a patient takes an oral dose of liquid methadone. Some OTPs have operated mobile medication units, in which methadone is dispensed at a remote location to individuals receiving treatment from the OTP.[103] DEA has approved mobile medication units in the past, but it ceased registering these mobile units beginning in 2007.[104] DEA announced in 2021 that it would lift the 14-year moratorium on mobile methadone units, removing the requirement that mobile components of OTPs receive a separate registration.[105]

Title 42, Part 8, of the *Code of Federal Regulations*, which includes most of the regulations for OTPs, specified that patients admitted to OTPs must "be addicted to opioids for at least one year", prohibiting individuals with opioid use disorder for less than a year from receiving treatment at an OTP.[106]

Provision

Section 1252 amends CSA Section 302(e) by making an exception to the separate registration for OTPs operating mobile methadone units, so long as the mobile unit meets such standards as the Attorney General may establish, effectively codifying in statute DEA's 2021 rule.

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[101] As declared under PHSA §319 (42 U.S.C. §247d). The public health emergency declaration for the COVID-19 pandemic expired on May 11, 2023.

[102] 21 U.S.C. §822(e).

[103] Brian Chan, Kim Hoffman, Christina Bougatsos, et al., "Mobile Methadone Medication Units: A Brief History, Scoping Review, and Research Opportunity," *Journal of Substance Abuse Treatment*, October 2021.

[104] U.S. Department of Justice, Bureau of Justice Assistance, "DEA Expands Access to Mobile Narcotic Treatment Programs," press release, August 2021, https://bja.ojp.gov/library/publications/dea-expands-access-mobile-narcotic-treatment-programs.

[105] Drug Enforcement Administration, "Registration Requirements for Narcotic Treatment Programs With Mobile Components," 86 *Federal Register* 33861, June 28, 2021. DEA refers to OTPs as "narcotic treatment programs."

[106] 42 C.F.R. §8.12(e).

Section 1252 also requires the Secretary to revise the *Code of Federal Regulations* (42 C.F.R. 8.12(e)(1)) to eliminate the requirement that OTPs admit an individual for treatment only if the individual became "addicted to opioids" at least one year before admission for treatment.

Chapter 6—Additional Provisions Relating to Addiction Treatment

Section 1261. Prohibition

Background

The federal government supports certain harm reduction strategies that emphasize prevention of adverse events associated with substance use, such as overdose and disease transmission. For example, the American Rescue Plan Act (P.L. 117-2) appropriated $30 million for grants to support "community-based overdose prevention programs, syringe services programs, and other harm reduction services."[107] The provision required grants be used for preventing and controlling the spread of infectious diseases, distributing opioid overdose reversal medications, connecting individuals with education and services, and encouraging individuals with substance use disorders to reduce the negative health impacts of substance use. SAMHSA announced the grant program in December 2021.[108]

Provision

Section 1261 prohibits funding from any provision in the Restoring Hope for Mental Health and Well-Being Act from being used to purchase or distribute "pipes or cylindrical objects" intended to be used to smoke or inhale illegal drugs.

Section 1262. Eliminating Additional Requirements for Dispensing Narcotic Drugs in Schedule III, IV, and V for Maintenance or Detoxification Treatment

Background

CSA Section 303 ("Registration Requirements") specifies the requirements for practitioners registering with DEA to dispense (i.e., prescribe or administer) controlled substances.[109]

The Drug Addiction Treatment Act of 2000 (DATA 2000; P.L. 106-310) amended the CSA to allow qualifying practitioners to dispense schedule III-V narcotic drugs for the purposes of maintenance or detoxification treatment for opioid use disorder (i.e., buprenorphine) outside of federally certified OTPs if they obtained a separate waiver from DEA and SAMHSA (known as a DATA waiver or X waiver).[110] Practitioners with DATA waivers treating opioid use disorder using

[107] ARPA §2706.

[108] Substance Abuse and Mental Health Services Administration, "SAMHSA Announced Unprecedented $30 Million Harm Reduction Grant Funding Opportunity to Help Address the Nation's Substance Use and Overdose Epidemic," press release, December 8, 2021, https://www.samhsa.gov/newsroom/press-announcements/202112081000. The HHS Secretary and ONDCP Director released a subsequent statement indicating that no federal funding would be used directly to put pipes in safe smoking kits distributed as part of harm reduction efforts. See U.S. Department of Health and Human Services, "Statement by HHS Secretary Xavier Becerra and ONDCP Director Rahul Gupta," press release, February 9, 2022, https://www.hhs.gov/about/news/2022/02/09/statement-hhs-secretary-xavier-becerra-and-ondcp-director-rahul-gupta.html.

[109] 21 U.S.C. §823.

[110] Buprenorphine was (and remains) the only schedule III controlled substance meeting the conditions for the waiver.

buprenorphine were subject to certain training requirements and limits on the number of patients they could treat at any time. Most requirements for DATA waivers were outlined in regulations pursuant to the Secretary's rulemaking authority. In 2018, the SUPPORT Act amended the CSA, codifying several DATA waiver policies in CSA Section 303(g).[111]

Provision

Section 1262 amends CSA Section 303 by exempting practitioners who dispense schedule III-V narcotic drugs (i.e., buprenorphine) from obtaining a separate DEA registration.[112] Subsequently, it removes the waiver initially required by the DATA 2000 Act for practitioners using schedule III-IV drugs for maintenance or detoxification treatment for opioid use disorder outside of an OTP, striking all of the specified requirements for obtaining such waiver.

Thus, under current law, any practitioner registered with DEA to dispense (i.e., prescribe or administer) controlled substances is authorized to use buprenorphine to treat OUD outside of an OTP, subject to state laws. Section 1262 makes other technical and conforming edits.

Section 1263. Requiring Prescribers of Controlled Substances to Complete Training

Background

CSA Section 303 ("Registration Requirements") specifies the requirements for practitioners registering with DEA to dispense (i.e., prescribe or administer) controlled substances.[113] Prior to enactment of the Restoring Hope for Mental Health and Well-Being Act, only practitioners who dispensed narcotic drugs to individuals for maintenance or detoxification treatment (e.g., medications for opioid use disorder) had specific qualification or training requirements related to treating individuals with substance use disorders. For instance, one of the conditions for certain physicians included completing an eight-hour training on treatment and management of patients with opioid use disorder (OUD).[114] Section 1262 removed the requirements for practitioners dispensing schedule III-V narcotics in detoxification or maintenance treatment of OUD. The act thus allows any practitioner registered with DEA to treat OUD using buprenorphine, subject to state laws, and removes the previous additional training requirements for treating individuals with OUD.

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[111] SUPPORT Act §§3201-3203. For more information, see CRS Report R45405, *The SUPPORT for Patients and Communities Act (P.L. 115-271): Food and Drug Administration and Controlled Substance Provisions*.

[112] Section 1262 amends CSA Section 303(g) (21 U.S.C. §823(g)), where the requirements for a separate registration for OTPs and the description of waiver requirements for the use of schedule III-V drugs in the treatment of opioid use disorder (the DATA waiver) had existed. More specifically, the provision removes CSA Section 303(g)(2), which specified the requirements to obtain a waiver. However, Section 103 of P.L. 117-215, enacted on December 2, 2022, several weeks before the Restoring Hope for Mental Health and Well-Being Act was signed into law (but after the bill had initially passed the House), redesignated CSA Section 303 subsection (f) as (g) and subsection (g) as (h). Restoring Hope for Mental Health and Well-Being Act Section 1262 did not reflect these changes. DEA and SAMHSA have interpreted the act to eliminate the DATA waiver requirement. In codifying the amendment, the Office of Law Revision Counsel also executed the revisions in the act to Title 21, Section 823(h), of the *U.S. Code*, noting that this was the "probable intent of Congress."

[113] 21 U.S.C. §823.

[114] Prior to enactment of the Restoring Hope for Mental Health and Well-Being Act, requirements for DATA waivers were outlined in CSA Section 303(g)(2)(G); 21 U.S.C. §823(g)(2)(G). Between enactment of P.L. 117-215 on December 2, 2022 and enactment of P.L. 117-328 on December 29, 2022, DATA waiver requirements were organized under CSA Section 303(h)(2)(G) (21 U.S.C. §823(h)(2)(G)).

Provision

Section 1263 amends CSA Section 303 by adding a requirement for practitioners registering with DEA to prescribe controlled substances to complete a one-time training on treatment and management of patients with opioid or other substance use disorders.[115] The provision specifies time requirements (no less than eight hours) and allowable training providers. The provision exempts physicians and other practitioners who meet certain specified requirements from the training.

Section 1263 requires the Secretary, in consultation with the Attorney General, to submit a report to specified congressional committees on the effects of the elimination of the DATA waiver (from Section 1262) no later than five years after enactment (i.e., December 29, 2027).

Section 1264. Increase in Number of Days Before Which Certain Controlled Substances Must Be Administered

Background

CSA Section 309A ("Delivery of a Controlled Substance by a Pharmacy to an Administering Practitioner") specifies the conditions for which a pharmacy may deliver a controlled substance to a practitioner for administration. Prior to the enactment of the Restoring Hope for Mental Health and Well-Being Act, a controlled substance had to be administered to a patient no later than 14 days after a practitioner had received it.

Provision

Section 1264 amends CSA Section 309A by extending the allowable timeline between delivery of a controlled substance by a pharmacy to a prescribing practitioner and its administration to a patient, from 14 days to 45 days.

Chapter 7—Opioid Crisis Response

Section 1271. Opioid Prescription Verification

Background

SUPPORT Act Section 3212 ("Programs and Materials for Training on Certain Circumstances Under Which a Pharmacist May Decline to Fill a Prescription") required the Secretary, in consultation with the DEA Administrator, the FDA Commissioner, the CDC Director, and the SAMHSA Assistant Secretary, and with input from relevant stakeholders, to develop and disseminate materials for pharmacists, health care providers, and patients. The purpose of these materials is to describe (1) the circumstances under which a pharmacist may deny filling a prescription for a controlled substance because the pharmacist suspects the prescription is fraudulent, forged, or suspicious, and (2) other federal requirements pertaining to declining a prescription for a controlled substance. The Secretary is required to include instructions for the

[115] The safe management of dental pain and screening, brief intervention, and referral for treatment for patients with opioid and other substance use disorders is also included in the training. The provision exempts veterinarians from the training requirement.

pharmacist on how to decline to fill a prescription, as well as information for health care practitioners and the public on the pharmacist's ability to decline to fill a prescription.

PHSA Section 392A authorizes the CDC Director to award grants and provide training and technical assistance to states, localities, and Indian Tribes to carry out and expand evidence-based prevention activities, which may include (1) improving the efficiency and use of a prescription drug monitoring program (PDMP); (2) promoting community or health system interventions; (3) evaluating interventions to prevent controlled substance overdoses; and (4) implementing projects to advance an innovative prevention approach with respect to new and emerging public health crises. Originally added by the SUPPORT Act,[116] PHSA Section 392A also authorizes the CDC Director to conduct controlled substance overdose data collection activities, and to assist states and localities in doing so through grants, training, and technical assistance.

Provision

Section 1271 amends SUPPORT Act Section 3212 by requiring the Secretary—in consultation with specified federal agencies—to update and disseminate the materials for pharmacists, health care providers, and patients related to the circumstances under which a pharmacist may deny filling a prescription for a controlled substance no later than one year after enactment (i.e., December 29, 2023), and periodically thereafter. The provision specifies that this includes updating and disseminating materials with information for pharmacists on how to verify the identity of the patient.

Section 1271 amends PHSA Section 392A by adding a new subsection (c) that allows the CDC Director to prioritize jurisdictions with a disproportionately high rate of drug overdoses or overdose deaths in awarding the opioid overdose prevention and data collection grants authorized in PHSA Section 392A subsections (a) and (b). The provision also makes a technical edit.

Section 1272. Synthetic Opioid and Emerging Drug Misuse Danger Awareness

Background

Led by fentanyl, a synthetic opioid 50-100 times more potent than morphine, synthetic opioids emerged as the leading cause of opioid-related overdose deaths in the United States beginning in 2016.[117] Although the Secretary—and SAMHSA Assistant Secretary and CDC Director—can conduct public awareness campaigns on various issues of public health through general and other specific authorities, no explicit authorization to conduct a campaign for synthetic opioids existed prior to enactment of the Restoring Hope for Mental Health and Well-Being Act.

Provision

Section 1272 requires the Secretary to plan and implement a public education campaign to raise awareness of synthetic opioids, such as fentanyl and fentanyl analogues. That campaign must include disseminating information on the potency of fentanyl and on the services provided by SAMHSA and CDC related to opioid misuse. The provision also requires the campaign to include

[116] SUPPORT Act §7161.

[117] Merianne Rose Spencer, Arialdi M. Minino, and Margaret Warner, *Drug Overdose Deaths in the United States, 2001-2021*, Centers for Disease Control and Prevention, National Center for Health Statistics, NCHS Data Brief No. 457, December 2022, https://www.cdc.gov/nchs/products/databriefs/db457.htm. Fentanyl, heroin, and some prescription pain medications (such as morphine and oxycodone) belong to the class of drugs known as opioids, which act on receptors in the brain that regulate pain and emotion.

information on nonopioid pain management treatments. The campaign must be carried out no later than one year after enactment (i.e., December 29, 2023) and be updated as needed to address emerging drug misuse issues. The provision requires an independent evaluation and accompanying report to Congress regarding the effectiveness of the campaign beginning two years after enactment (i.e., December 2024) and two years thereafter (i.e., December 2026).

Section 1272 also requires the Secretary, no later than 18 months after enactment (i.e., June 2024), to disseminate information related to synthetic opioids to health care providers participating in federal programs, publish a training guide for first responders detailing measures to prevent exposure to synthetic opioids, and conduct outreach to first responders about the availability of the training guide.

Section 1273. Grant Program for State and Tribal Response to Opioid Use Disorders

Background

Section 1003 of the 21st Century Cures Act established the "Account for the State Response to the Opioid Abuse Crisis" in the Treasury, to which $500 million was transferred and deposited for each of FY2017 and FY2018. The resulting grant—the State Targeted Response (STR) to the Opioid Crisis grant program—supplemented state activities related to the opioid crisis. The purpose of the grant program was to increase access to treatment, decrease unmet treatment need, and reduce overdose deaths through prevention, treatment, and recovery activities.

In FY2018, Congress provided $1 billion for similar activities through a new State Opioid Response (SOR) grant program. The appropriation, located in the annual Departments of Labor, Health and Human Services, and Education and Related Agencies (Labor-HHS-ED) Appropriations Act, included a $50 million set-aside for Indian Tribes and an additional 15% set-aside for states with the highest opioid-related mortality rates. Program goals were similar to the STR grants with an emphasis on expanding access to medications for opioid use disorder.

The STR grant authorization expired in FY2018, and the program did not receive any further funding. Rather, Congress increased the SOR grant appropriation by $500 million—the same amount as the STR grants—for a total of $1.5 billion for FY2019.[118] Prior to the Restoring Hope for Mental Health and Well-Being Act, the SOR grants did not have a statutory authorization; grants were authorized annually through that Labor-HHS-ED Appropriations Act.[119]

Provision

Section 1273 replaces Section 1003 of the Cures Act with a new provision authorizing the State Opioid Response grants, effectively codifying the SOR grant program and removing the authorization for the STR grants.

Section 1273 authorizes grants to address opioid and stimulant misuse for states and Tribes.[120] Grants are awarded to the Single State Agency responsible for administering SAMHSA's annual

[118] Subsequent annual appropriations for the SOR grants maintained this increase.

[119] For more information on the history of the STR and SOR grants, see CRS In Focus IF12116, *Opioid Block Grants*.

[120] The SOR grant appropriation has included set-aside for Indian Tribes and Tribal organizations—known as the TOR grants. TOR grants are not distributed by a formula. Instead, Tribes and Tribal organizations apply individually, as a consortia, or in partnership with an urban Indian organization. Funds are distributed noncompetitively based on Tribal population. Other grant requirements are similar to the SOR grant program. Section 1273 codifies authority for the TOR grants.

substance use block grant.[121] The provision codifies minimum amounts of $4 million for states and $250,000 for territories. It specifies that the Secretary shall develop a formula for funding allocations and submit it to specified congressional committees. The formula methodology must provide preference to states with a higher relative prevalence of opioid use disorders and overdose deaths. It should include performance assessments for continuation awards and avoid "a funding cliff between States with similar overdose mortality rates to prevent funding reductions when compared to prior year allocations."[122] The authorization codifies the 15% set-aside for states with the highest age-adjusted rate of drug overdose deaths. It caps the amount for Tribes at 5%.

The new statutory authorization for the SOR grants provides more specified uses of funds. According to the provision, SOR-supported activities may include the following:

- Implementing substance use disorder prevention activities (including primary prevention).
- Improving prescription drug monitoring programs (PDMPs).
- Training health care practitioners in pain management, best practices for prescribing opioids, identification of SUDs, referral to treatment programs, preventing diversion, and overdose prevention.
- Supporting access to SUD services, including those provided at opioid treatment programs (OTPs) or other outpatient or residential facilities providing MOUD,[123] or in integrated care settings.
- Recovery support services, including peer support, mutual aid programs, housing services, and family support.
- Other public health-related activities addressing substance misuse and use disorders.

Section 1273 specifies reporting requirements for grantees and the Secretary. States receiving funds must report a description of the activities supported by the grant and the population served. The Secretary must submit a report to specified congressional committees no later than September 30, 2024, that summarizes the information provided by the states. The authorization also requires the Secretary to provide technical assistance, including regarding grant applications, to grantees. The provision requires GAO to submit a report to specified congressional committees no later than two years after enactment (i.e., December 29, 2024) that assesses funding allocations and use of funds.

Cures Act Section 1003 now authorizes $1.75 billion to be appropriated for each of FY2023-FY2027.

[121] Authorized in Title XIX of the PHSA (42 U.S.C. 300x-21 et seq.). Section 1241 of the Restoring Hope for Mental Health and Well-Being Act renamed this grant the Substance Use Prevention, Treatment, and Recovery (SUPTRS) block grant.

[122] Report language accompanying appropriations laws authorizing the SOR grant included similar language. Initially, states receiving additional funding through the 15% set-aside for states with the highest overdose mortality could receive significant reductions in funds in subsequent years if they significantly reduced (or slowed) mortality relative to other states.

[123] For more information, see CRS In Focus IF12348, *Medications for Opioid Use Disorder*.

Subtitle C—Access to Mental Health Care and Coverage

Chapter 1—Improving Uptake and Patient Access to Integrated Care Services

Section 1301. Improving Uptake and Patient Access to Integrated Care Services

Background

PHSA Section 520K ("Integration Incentive Grants and Cooperative Agreements") authorizes SAMHSA's Primary and Behavioral Health Care Integration program. Amended in 2016 by the Cures Act,[124] the provision authorizes the Secretary to fund demonstration projects that provide coordinated and integrated mental health and primary care services. The program provides grants to states and community mental health centers to engage in collaboration, expand infrastructure, and increase the availability of primary health care and wellness services for individuals with serious mental illness or co-occurring mental illness and substance use disorders.[125]

PHSA Section 520K previously authorized $51.9 million (rounded) to be appropriated for each of FY2018-FY2022.

Provision

Section 1301 replaces PHSA Section 520K with a new provision authorizing similar activities, entitled "Improving Uptake and Patient Access to Integrated Care Services." The new authorization makes the following changes:

- Expands eligible entities to include rural health clinics, FQHCs, or primary care practices.
- Amends the definition of integrated care to include the psychiatric collaborative care model and other evidence-based or evidence-informed models, and specifies that integrated care includes coordinating and jointly delivering behavioral and physical health services.
- Adds a definition of the psychiatric collaborative care model.
- Adds a definition for bidirectional integrated care, which means integration of behavioral health care and specialty health care, or primary care into specialty behavioral health settings.
- Adds to the definition of "special population" adults with co-occurring mental health and substance use disorders.
- Changes "Purposes" of the program to "Use of Funds" and expands the use of funds beyond primary care and for all special populations (as now defined). It specifies that the grants support evidence-based or evidence-informed activities; adds recovery services; adds bidirectional integrated care services; adds greater

[124] Cures Act §9003.

[125] SAMHSA, *Justification of Estimates for Appropriations Committees, FY2023*.

specifications for use of funds (hiring staff, formalizing contractual relationships, purchasing software and other resources, etc.).

- Specifies greater detail regarding the application and partnerships with Tribal, rural, or medically underserved communities, and a description of evidence-based integrated care models other than the psychiatric care model.
- Further specifies that awards are for no more than $2 million (as opposed to exactly $2 million previously), with adjustments by the Secretary permitted.
- Broadens the information included in annual grantee reports and removes requirements to report certain specific outcomes.
- Adds training and information on the psychiatric collaborative care model to the technical assistance authorization for grantees.

The new authorization requires a report to specified congressional committees no later than 18 months after enactment (i.e., June 29, 2024), and annually thereafter, summarizing the annual grantee reports and including other specified information on outcomes. The provision specifies no less than 10% of funds are for implementing the psychiatric collaborative care model (provided the annual appropriation is not less than the FY2022 level).

PHSA Section 520K now authorizes $60 million to be appropriated for each of FY2023-FY2027.

Chapter 2—Helping Enable Access to Lifesaving Services

Section 1311. Reauthorization and Provision of Certain Programs to Strengthen the Health Care Workforce

Background

PHSA Section 756 ("Mental and Behavioral Health Education and Training Grants") authorizes the Behavioral Health Workforce Education and Training (BHWET) Program. Administered by HRSA, this program provides grants to support the training of the behavioral health workforce, including paraprofessionals. Grants are awarded to eligible institutions of higher education, training programs, and other organizations involved in training specified behavioral health service professionals in fields such as psychiatry, psychology, psychiatric nursing, social work, and occupational therapy, among others. Codified by the Cures Act in 2016,[126] the program authorization was subsequently amended by the SUPPORT Act in 2018,[127] which added language specifying that providers trained in trauma-informed care are eligible to participate.

PHSA Section 756 previously authorized $50 million to be appropriated for each of FY2019-FY2023

PHSA Section 760 ("Training Demonstration Program") requires the Secretary to establish a demonstration program that awards grants to eligible entities to (1) support training for psychiatry residents and fellows, nurse practitioners, physician assistants, and social workers in underserved community-based settings integrating primary care and mental and substance use disorder treatment, and (2) support academic units or programs that provide training for students or faculty in the ability to recognize, diagnose, and treat mental and substance use disorders or develop evidence-based practices or recommendations for curricula content standards. Originally added

[126] Cures Act §9021 (42 U.S.C. §294e-1).

[127] SUPPORT Act §7073.

by the Cures Act in 2016,[128] PHSA Section 760 specifies acceptable use of grant funds, eligible entities, granting priority, and required studies and reports.

PHSA Section 760 previously authorized $10 million to be appropriated annually for each of FY2018-FY2022.

Provision

Section 1311 amends PHSA Section 756 to specify that occupational therapy master's or doctoral level programs are grant eligible. The provision also adds trauma-informed training for paraprofessionals to allowable uses of funds.

Section 1311 extends the authorization of appropriations for the BHWET program. PHSA Section 756 now authorizes $50 million to be appropriated for each of FY2023-FY2027 (with specified allocations for each activity).

Section 1311 amends PHSA Section 760 by making technical corrections to language related to mental health disorders and by specifying that individuals completing clinical training requirements for licensure are eligible for training. It also adds counselors and nurses to the list of eligible professionals, as well as programs that focus on pediatric populations or trauma-informed care to the eligibility list. It adds health service psychologists, nurses, counselors, and physician assistants to the prioritized eligible grantees.

Section 1311 extends authorizations of appropriations for the Training Demonstration program, authorizing $31.7 million to be appropriated for each of FY2023-FY2027.

Section 1312. Reauthorization of Minority Fellowship Program

Background

PHSA Section 597 ("Fellowships") requires the Secretary to maintain a "Minority Fellowship Program" to award fellowships, which may include stipends, for post-baccalaureate training for mental health professionals in the fields of psychiatry, nursing, social work, marriage and family therapy, mental health counseling, and substance use disorder and addiction counseling. The SAMHSA-administered Minority Fellowship Program provides grants to professional associations (e.g., the American Psychiatric Association and the American Nurses Association) to offer stipends to minority doctoral students who are studying for degrees in a mental or behavioral health profession.[129]

PHSA Section 597 previously authorized $12.7 million (rounded) to be appropriated for each of FY2018-FY2022.[130]

Provision

Section 1312 amends PHSA Section 597 to reauthorize SAMHSA's Minority Fellowship Program. PHSA Section 597 now authorizes $25 million to be appropriated for each of FY2023-2027.

[128] Cures Act §9022 (42 U.S.C. §294k).

[129] Of note, the Health Resources and Services Administration (HRSA) within HHS also provides workforce development programming for behavioral health providers. See, for instance, *HRSA; Grants; Behavioral Health* at https://bhw.hrsa.gov/grants/behavioral-health.

[130] 42 U.S.C. §290ll(c).

Chapter 3—Eliminating the Opt-Out for Nonfederal Governmental Health Plans

Section 1321. Eliminating the Opt-Out for Nonfederal Governmental Health Plans

Background

Private health insurance—offered by private-sector insurance companies or sponsored by employers and other entities, such as unions—is the most common form of health coverage in the United States. Both private-sector employers and governmental employers may offer private health insurance to their employees and their dependents.

A *nonfederal governmental plan* is a governmental group health plan that is sponsored by entities such as states, counties, school districts, and municipalities.[131] Like private employers, sponsors of nonfederal governmental plans can choose to offer *self-insured* or *fully insured* plans.[132]

Per PHSA Section 2722, if a sponsor of a nonfederal governmental plan offers a self-insured plan, the sponsor may elect to exempt the plan from certain federal requirements that otherwise apply to self-insured group health plans. The exemption for self-insured, nonfederal governmental plans was established in the PHSA under the Health Insurance Portability and Accountability Act (HIPAA; P.L. 104-191) and later modified by the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended).[133] Per the ACA, self-insured, nonfederal plans may opt out of some or all of the following federal requirements:

- Coverage of Minimum Hospital Stay After Childbirth (42 U.S.C. §300gg-25);
- Mental Health Parity (42 U.S.C. §300gg-26);
- Coverage of Reconstruction After Mastectomy (42 U.S.C. §300gg-27); and
- Coverage for Students Who Take a Medically Necessary Leave of Absence (42 U.S.C. §300gg-28).[134]

Federal mental health parity law does not require applicable plans to cover mental health and substance use disorder (MH/SUD) benefits when such coverage is not otherwise required by federal or state law.[135] However, when a plan does cover both MH/SUD benefits and medical/surgical (M/S) benefits, parity law generally prohibits the imposition of more restrictive limitations on the MH/SUD as compared with the M/S benefits.

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[131] *Nonfederal governmental plan* is defined at 42 U.S.C. §300gg-91(d)(8)(C) and uses the definition of governmental plan at 29 U.S.C. §1002(32).

[132] When group plan sponsors purchase coverage from insurers and offer it to their employees or other groups, these plans are referred to as *fully insured*. When group plan sponsors provide health benefits directly (instead of purchasing coverage from an insurer), these plans are referred to as *self-insured* or self-funded. For more information, see "Federal and State Regulation of Private Health Insurance" in CRS Report R47507, *Private Health Insurance: A Primer*.

[133] For additional background on the exemption for self-insured, nonfederal governmental plans, see the relevant section in CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*.

[134] For discussions of these and other provisions, see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

[135] Federal mental health parity law includes the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA; P.L. 110-343), as it amended prior parity law and has since been amended. For more information, see CRS Report R47402, *Mental Health Parity and Coverage in Private Health Insurance: Federal Requirements*.

In 2021, approximately 13 million state and local government employees were enrolled through their employer's health plan (i.e., a nonfederal governmental plan).[136] Among those employees enrolled, 64.4% (or 8.4 million) were in a self-insured plan. For reference, 72.6 million private-sector employees were enrolled through their employer's health plan in 2021, and among those enrollees, an estimated 57.9% (or 42 million) were in a self-insured plan.

According to data published by the Center for Consumer Information & Insurance Oversight (CCIIO), as of June 2019, at least 174 nonfederal governmental entities across 35 states had elected to exempt at least one self-insured plan they offer from one or more of the four requirements above.[137] Nearly all of the 174 entities offered at least one plan that was exempt from the mental health parity requirement; significantly fewer entities offered plans that were exempt from each of the other three requirements. Overall, it is unclear how many nonfederal governmental entities offered plans that covered MH/SUD benefits at that time, nor is it clear how many such self-insured plans had *not* opted out of parity requirements.

Provision

Section 1321 amends PHSA Section 2722 to provide that self-insured, nonfederal governmental plans can no longer opt out of mental health parity requirements.[138] Such plans may not elect this exemption on or after the date of enactment (i.e., December 29, 2022), and they may not renew a mental health parity exemption that expires on or after 180 days after enactment (i.e., June 27, 2023).

There is an exception in Section 1321 for certain collectively bargained plans. As explained in subsequent guidance regarding this provision:

> Specifically, a self-funded, non-Federal governmental group health plan that is subject to multiple collective bargaining agreements (CBAs) of varying lengths and that has a MHPAEA opt-out election in effect on December 29, 2022, that expires on or after June 27, 2023, may extend such election until the date on which the term of the last collective bargaining agreement expires.[139]

Per CCIIO data updated as of July 2023 (i.e., after the enactment of this provision), at least 186 nonfederal governmental entities across 26 states had elected to exempt at least one self-insured plan they offer from one or more of the four requirements above—all but one of which included a

[136] Estimates in this paragraph are based on Congressional Research Service (CRS) analysis of Medical Expenditure Panel Survey (MEPS) Insurance Component (IC) data from the U.S. Agency for Healthcare Research and Quality (AHRQ). See "Employee" data in the "Public Sector" and "Private Sector – National" tabs at https://datatools.ahrq.gov/meps-ic/. The MEPS-IC public sector data (available through 2021 at the time of this report) include state and local governmental entities. The MEPS-IC private sector data (available through 2022, but 2021 data used for comparison) include nongovernmental employers, the self-employed with employees, and the incorporated, self-employed with no employees. While employers may offer coverage to employees and their dependents, the MEPS-IC enrollment data include covered *employees* only. See "covered persons" in the glossary at the MEPS-IC webpage linked in this footnote.

[137] Centers for Medicare & Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO), "List of HIPAA Opt-Out Elections for Self-Funded Non-Federal Governmental Plans," June 21, 2019, at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HIPAAOptOuts.pdf.

[138] 42 U.S.C. §300gg-21(a)(2)(F).

[139] CMS, CCIIO, "Insurance Standards Bulletin Series – Information: Sunset of MHPAEA opt-out provision for self-funded, non-Federal governmental group health plans," June 7, 2023, at https://www.cms.gov/files/document/hipaa-opt-out-bulletin.pdf. MHPAEA refers to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343).

parity exemption.[140] The details of all of these parity exemptions are not provided, but some of the plans were elected prior to December 29, 2022, and some are indicated as collectively bargained plans.[141]

Chapter 4—Mental Health and Substance Use Disorder Parity Implementation

Section 1331. Grants to Support Mental Health and Substance Use Disorder Parity Implementation

Background

Both the federal and state governments regulate private health insurance.[142] Federal health insurance requirements typically follow the model of federalism: federal law establishes standards, and states are primarily responsible for monitoring compliance with and enforcement of those standards. States may impose additional requirements on insurers and the plans they offer (i.e., fully insured group and nongroup plans), provided the state requirements neither conflict with federal law nor prevent the implementation of federal requirements. In general, self-insured group plans are regulated by the federal government but not by state governments.

Per federal mental health parity law, applicable plans are generally prohibited from imposing more restrictive coverage limits, including nonquantitative treatment limitations (NQTLs), on their mental health and substance use disorder (MH/SUD) benefits as compared with their medical/surgical (M/S) benefits.[143] NQTLs include nonnumeric coverage restrictions or plan attributes, such as prior authorization requirements.

Per mental health parity provisions in the Consolidated Appropriations Act, 2021 (CAA, 2021; P.L. 116-260), plans also are required to "perform and document comparative analyses of the design and application of NQTLs" and to make such analyses available to applicable federal agencies or state authority, upon request.[144] The Secretaries of HHS, Labor, and the Treasury must annually request and review at least 20 of the NQTL analyses described above from plans that "involve potential [parity] violations" or complaints of noncompliance, or in "any other instances in which the Secretary determines appropriate."[145] States are not required to request and review the NQTL analyses.

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[140] CMS, CCIIO, "HIPAA Opt-Out Elections for Self-Funded Non-Federal Governmental Plans," July 31, 2023, at https://www.cms.gov/files/document/hipaaoptouts03182021.pdf. (The document itself indicates it has been updated, but the URL retains a prior date.)

[141] In August 2023, a proposed federal rule on mental health parity topics included proposed amendments to existing regulations as related to implementation of Section 1321. See Internal Revenue Service (IRS), Department of the Treasury; Employee Benefits Security Administration (EBSA), Department of Labor (DOL); CMS, Department of Health and Human Services (HHS), "Requirements Related to the Mental Health Parity and Addiction Equity Act," August 3, 2023, at 88 *Federal Register* 51552.

[142] See "Federal and State Regulation of Private Health Insurance" in CRS Report R47507, *Private Health Insurance: A Primer*.

[143] See "Parity Requirements Related to Coverage Limits and Benefit Classifications" in CRS Report R47402, *Mental Health Parity and Coverage in Private Health Insurance: Federal Requirements*.

[144] Consolidated Appropriations Act, 2021 (CAA, 2021; P.L. 116-260), Division BB, Title II, Section 203. Also see "NQTL Comparative Analyses" in CRS Report R47402, *Mental Health Parity and Coverage in Private Health Insurance: Federal Requirements.*

[145] Ibid.

Separately, Section 1003 of the ACA added a new PHSA Section 2794 (42 U.S.C. §300gg-94), establishing a $250 million grant program, to be awarded during the five-year period beginning with FY2010, to assist states in carrying out premium rate review activities and related activities as specified.[146] ACA Section 1003 further specified that if there were remaining funds at the end of FY2014, those funds were available to the Secretary for additional grants to states for "planning and implementing the insurance reforms and consumer protections under part A" (of Title XXVII of the PHSA).

Separately, Section 6603 of the ACA also added PHSA Section 2794, "Uniform fraud and abuse referral format." It was codified at Title 42, Section 300gg-95, of the *U.S. Code*.

Provision

Section 1331 amends PHSA Section 2794 to establish new grants for states "to enforce and ensure compliance with" mental health parity requirements.[147] To be eligible for the grants, states must agree to request and review (an unspecified number of) the NQTL comparative analyses required of group and individual health insurance issuers. The Secretary is otherwise required to specify the timing, manner, and information requirements for state applications for the grants.

The amended PHSA Section 2794 authorizes $10 million to be appropriated for each of the first five fiscal years beginning after the date of enactment (i.e., December 29, 2022), to remain available until expended, for purposes of awarding these grants.

Section 1331 also includes a technical amendment regarding the PHSA Section 2794 that was added by ACA Section 6603. This provision is redesignated as PHSA Section 2795.[148]

Subtitle D—Children and Youth

Chapter 1—Supporting Children's Mental Health Care Access

Section 1401. Technical Assistance for School-Based Health Centers

Background

PHSA Section 399Z-1 ("School-Based Health Centers") requires the Secretary to award grants for the operating costs of school-based health centers (SBHCs). School-based health centers are health clinics located in schools that provide primary health services to children.[149] The section's authorization of appropriation was extended in P.L. 116-260 in 2020, which authorized to be appropriated such sums as necessary for each of FY2022-FY2026. Prior to the law's enactment in 2020, authorizations of appropriations had lapsed in FY2014.

Grants have never been explicitly awarded under the PHSA Section 399Z-1 authority since the section was enacted in 2010. Instead, HRSA has awarded grants to health centers authorized under PHSA Section 330 to establish school sites. Funding for this purpose has been made

[146] See 42 U.S.C. §300gg-94(c)(1-2) regarding the initial premium rate review grants and the additional grants. The premium rate review requirements are at 42 U.S.C. 300gg-94(a-b). Regarding premium rate review requirements, see "Rate Review" in CRS Report R45146, *Federal Requirements on Private Health Insurance Plans.*

[147] 42 U.S.C. §300gg-94(c)(3).

[148] 42 U.S.C. §300gg-95.

[149] For complete definition, see Social Security Act Section 2110(c)(9)(A) (42 U.S.C. 1397jj(c)(9)(A)).

available in annual appropriations act. For example, the part of this law—the Consolidated Appropriations Act, 2023 (P.L. 117-328)—that provided appropriations for HRSA (in Division H) included $55 million for school-based health centers as part of the funds made available for the general Health Center program.

Provision

Section 1401 amends PHSA Section 399Z-1 by adding a new subsection requiring the Secretary to provide technical assistance to SBHCs by grants or contracts to private, nonprofit entities with expertise in school-based health centers. New subsection (l) specifies the purpose and requirements for such technical assistance, including support for program operations and implementation of evidence-based or evidence-informed best practices.

Section 1402. Infant and Early Childhood Mental Health Promotion, Intervention, and Treatment

Background

PHSA Section 399Z-2 ("Infant and Early Childhood Mental Health Promotion, Intervention, and Treatment") authorizes SAMHSA's Infant Early Childhood Mental Health grant program. Originally added by the Cures Act,[150] PHSA Section 399Z-2 authorizes grants to support programs for infant and early childhood mental health promotion, intervention, and treatment. The program targets children up to age 12 who are at risk for, show early signs of, or have been diagnosed with a serious mental illness (including a serious emotional disturbance) and who would benefit from specified programs. Eligible entities are human services agencies or nonprofit institutions meeting specified criteria.

PHSA Section 399Z-2 previously authorized $20 million to be appropriated for the period FY2018-FY2022 to carry out the grant program.

Provision

Section 1402 amends PHSA Section 399Z-2 by adding a new subsection allowing the Secretary (directly or via grants or contracts) to provide technical assistance to eligible entities to provide mental health services for children, training for health care professionals, and consultation to early child care and education programs.

Section 1402 reauthorizes the Infant Early Childhood Mental Health grant program. PHSA Section 399Z-2 now authorizes $50 million to be appropriated for the period of FY2023-FY2027.

Section 1403. Co-Occurring Chronic Conditions and Mental Health in Youth Study

Background

Research has found that children with chronic health conditions exhibit symptoms of mental health disorders at higher rates than their healthier peers.[151] Previous HHS studies investigating

[150] Cures Act §10006.

[151] See Ann Marie Brady, Jessica Deighton, and Stephen Stansfeld, "Chronic Illness in Childhood and Early (continued...)

mental and physical health issues, such as suicidal ideation in medical populations, have focused primarily on adults.[152]

Provision

Section 1403 requires the Secretary to complete a study on the rates of suicidal behaviors among youth with chronic medical illnesses no later than 12 months after enactment (i.e., December 29, 2023). The provision requires the Secretary to submit a report to Congress on the results of the study, including recommendations for early intervention, dissemination of best practices, and strategies to reduce suicidal behaviors.

Section 1404. Best Practices for Behavioral and Mental Health Intervention Teams

Background

The federal government supports state and local efforts in promoting school safety and security.[153] For example, the U.S. Secret Service National Threat Assessment Center (NTAC) published an operational guide identifying how schools can enhance their safety using a threat assessment model.[154] School threat assessment interventions seek to identify students at risk of violence to self or others, assess their risk for engaging in violence or other harmful activities, and identify strategies to manage that risk.[155] According to NTAC, the first step in a targeted violence prevention plan is establishing a threat assessment team, sometimes referred to as a *behavioral intervention team*.[156] Composed of personnel in a variety of disciplines—including mental health professionals—behavioral intervention teams receive reports about students of concern, gather additional information, assess the risk posed to the school community, and develop strategies to mitigate any risk of harm.

Provision

Section 1404 adds a new PHSA Section 520H-1 ("Best Practices for Behavioral and Mental Health Intervention Teams") that requires the SAMHSA Assistant Secretary, in consultation with the U.S. Department of Education (ED), DOJ, and the Director of the NTAC, to submit to specified congressional committees a report on best practices for using school-based behavioral and mental health intervention teams. The provision defines a behavioral and mental health intervention team as a multidisciplinary team of trained individuals who can assess the behavioral

Adolescence: A Longitudinal Exploration of Co-Occurring Mental Illness," *Development and Psychopathology*, vol. 33, no. 3 (May 4, 2020), pp. 885-898; and Andrew J. Barnes, Marla E. Eisenberg, and Michaal Resnick, "Suicide and Self-Injury Among Children and Youth With Chronic Health Conditions," *Pediatrics*, vol. 124, no. 5 (May 2010), pp. 889-895.

[152] For example, Pamela L. Owens, Kevin Heslin, Kathryn Fingar, et al., "Co-occurrence of Physical Health Conditions and Mental Health and Substance Use Conditions Among Adult Inpatient Stays, 2010 Versus 2014," Agency for Healthcare Research and Quality, Statistical Brief #240, Rockville, MD, June 2018, https://hcup-us.ahrq.gov/reports/statbriefs/sb240-Co-occurring-Physical-Mental-Substance-Conditions-Hospital-Stays.jsp.

[153] For more information, see CRS Report R46872, *Federal Support for School Safety and Security*.

[154] U.S. Department of Homeland Security, United States Secret Service, National Threat Assessment Center, *Enhancing School Safety Using a Threat Assessment Model: An Operational Guide for* , July 2018, https://www.cisa.gov/sites/default/files/publications/18_0711_USSS_NTAC-Enhancing-School-Safety-Guide.pdf.

[155] Ibid., p. 1.

[156] Ibid., p. 3.

health needs of youth, connect at-risk youth with appropriate services, and implement evidence-based interventions to mitigate threats of harm and support safe, supportive learning environments in K-12 and higher education settings.

Chapter 2—Continuing Systems of Care for Children

Section 1411. Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances

Background

PHSA Title V, Part E (Sections 561-565), authorizes SAMHSA's Children's Mental Health Services. PHSA Title V, Part E, requires the Secretary to award grants to support "comprehensive community mental health services for children with a serious emotional disturbance." [157] Reauthorized by the Cures Act,[158] the authorization specifies reporting requirements, technical assistance requirements, and the ages of children to be served, among other things. PHSA Section 565 ("General Provisions") provides definitions for terms used in the Title V, Part E, authorizations and includes the authorization of appropriations, among other things.

PHSA Section 565 previously authorized $119 million (rounded) to be appropriated for each of FY2018-FY2022.

Provision

Section 1411 amends PHSA Section by adding "kinship caregivers" to the definition of "family" and reauthorizing SAMHSA's Children's Mental Health Services.

PHSA Section 565 now authorizes $125 million to be appropriated for each of FY2023-FY2027.

Section. 1412. Substance Use Disorder Treatment and Early Intervention Services for Children and Adolescents

Background

PHSA Section 514 ("Substance Use Disorder Treatment and Early Intervention Services for Children, Adolescents, and Young Adults") authorizes SAMHSA's Children and Families program. PHSA Section 514 requires the Secretary to award grants, contracts, or cooperative agreements to support substance use disorder services for children and adolescents. Eligible entities include public and private nonprofit entities, including Native Alaskan entities and Indian Tribes and Tribal organizations. PHSA Section 514 requires the Secretary to give priority to applicants meeting specified criteria (e.g., providing gender-specific and culturally appropriate treatment). The Cures Act reauthorized the activities in this provision in 2016, further specifying definitions for Indian Tribes or Tribal Organizations and Indian Health Service facilities, among other things. [159]

[157] 42 U.S.C. §290ff.

[158] Cures Act §10001.

[159] Cures Act §10003.

PHSA Section 514 previously authorized $29.6 million (rounded) to be appropriated for each of FY2018-FY2022.

Provision

Section 1412 amends PHSA Section 514 by making technical edits to Tribal terms and reauthorizing $29.6 million (rounded) for each of FY2023-2027 for SAMHSA's Children and Families program.

Chapter 3—Garrett Lee Smith Memorial Reauthorization

Sections 1421-1424

Background

SAMHSA supports several suicide prevention initiatives, including the National Strategy for Suicide Prevention, a suicide prevention technical assistance center, and the Garrett Lee Smith (GLS) State and Campus suicide grant programs, among others. In 2004, the Garrett Lee Smith Memorial Act (P.L. 108-355) explicitly authorized three of these suicide prevention programs in PHSA Title V.

PHSA Section 520C ("Suicide Prevention Technical Assistance Center") authorizes the Garrett Lee Smith (GLS) Suicide Prevention Resource Center. Amended by the Cures Act,[160] PHSA Section 520C requires the Secretary, acting through the SAMHSA Assistant Secretary, to operate a technical assistance center focused on suicide prevention. The provision specifies the program's focus on suicide prevention across the lifespan and requires the Secretary to submit to Congress a report on the activities carried out by the center.

PHSA Section 520C previously authorized $6 million (rounded) to be appropriated annually for each of FY2018-FY2022 for the center.

PHSA Sections 520E ("Youth Suicide Early Intervention and Prevention Strategies") and 520E-2 ("Mental Health and Substance Use Disorder Services on Campus") authorize the Garrett Lee Smith (GLS) State and Campus suicide grant programs. The GLS State grant program—entitled the GLS State/Tribal Youth Suicide Prevention and Early Intervention grant program—awards grants to states to support comprehensive statewide youth suicide prevention and early intervention strategies. The GLS Campus Suicide Prevention grant program provides institutions of higher education with grants to implement an array of suicide prevention initiatives on campus.[161] Both authorizing provisions were previously amended by the Cures Act in 2016.[162]

PHSA Section 520E previously authorized $30 million for each of FY2018-FY2022.

PHSA Section 520E-2 previously authorized $7 million for each of FY2018-FY2022.

Section 1421. Suicide Prevention Technical Assistance Center

Section 1421 amends PHSA Section 520C by making technical edits to Tribal terms and by requiring the Secretary to collaborate with DOD and VA when providing technical assistance to entities serving members of the Armed Forces and veterans. The provision amends the

[160] Cures Act §9008.

[161] SAMHSA *Justification of Estimates for Appropriations Committees, FY2024*.

[162] Cures Act §9008 and §9031.

authorization for an annual report, requiring the Secretary to submit to Congress a report on the activities carried out by the center no later than two years after enactment (i.e., December 29, 2024).

Section 1421 reauthorizes the Suicide Prevention Technical Assistance Center. PHSA Section 520C now authorizes $9 million to be appropriated for each of FY2023-FY2027.

Section 1422. Youth Suicide Early Intervention and Prevention Strategies

Section 1422 amends PHSA Section 520E by adding pediatric health programs to the list of applicable service-delivery settings and adding Tribe-designated organizations to the list of eligible grantees. The provision adds pediatric health programs that provide families with supplies to securely store means commonly used in suicide to the list of service delivery settings receiving preference.

Section 1422 amends the requirement in PHSA Section 520E that no less than 85% of funds be used for "direct services," instead requiring no less than that amount to be used for "suicide prevention activities."[163] It also adds the Department of Education to the list of entities the Secretary is required to consult with in carrying out this program. It extends the deadline for grantees to submit an evaluation of grant-funded activities to 24 months (from 18 months). It amends the date the Secretary must submit a report to congressional committees on the effectiveness of program activities to December 31, 2025. The provision makes technical edits to Tribal terms and amends the definition of "youth" to include individuals younger than 10 years old and up to 24 years old.

Section 1422 reauthorizes the GLS State/Tribal Youth Suicide Prevention and Early Intervention Grant Program. PHSA Section 520E now authorizes $40 million to be appropriated for each of FY2023-2027.

Section 1423. Mental Health and Substance Use Disorder Services for Students in Higher Education

Section 1423 amends PHSA Section 520E-2 by changing the title to "Mental Health and Substance Use Disorder Services for Students in Higher Education." The provision adds promoting resiliency to the goals of the program and adds providing resources (in addition to services) to allowable uses of funds. The provision makes other technical changes to language related to mental health promotion and service provision. It also specifies the congressional committees to receive the program's annual report to Congress, and requires the report to include a needs assessment of the population served by grant recipients.

Section 1423 amends PHSA Section 520E-2 by reauthorizing $7 million for each of FY2023-FY2027 for the GLS Campus Suicide Prevention grant program.

Section 1424. Mental and Behavioral Health Outreach and Education at Institutions of Higher Education

Background

PHSA Section 549 ("Mental and Behavioral Health Outreach and Education on College Campuses") requires the Secretary, acting through the SAMHSA Assistant Secretary in

[163] 42 U.S.C. §290bb-36(d).

collaboration with the CDC Director, to convene an interagency, public-private sector working group composed of representatives of certain specified groups. The working group is required to plan, establish, and coordinate a public education campaign, as specified, focused on mental and behavioral health on the campuses of institutions of higher education, as defined. Originally added by the Cures Act in 2016,[164] PHSA Section 549 specifies the elements required in the working group's plan.

PHSA Section 549 previously authorized $1 million to be appropriated for the period of FY2018-FY2022.

Provision

Section 1424 amends PHSA Section 549 by changing the heading to "Mental and Behavioral Health Outreach and Education at Institutions of Higher Education" and adding representatives of minority-serving institutions and community colleges to the working group authorized in the section.[165]

Section 1424 amends PHSA Section 549 by reauthorizing $1 million for the period of FY2023-FY2027 for the national public education campaign.

Chapter 4—Media and Mental Health

Background

Emerging research suggests that smartphone and social media use may pose risks of harm to youth and adolescents.[166] For example, some studies have shown smartphone and social media use is associated with increases in depression, anxiety, and suicidality (among other mental and behavioral issues) for youth and adolescents, particularly girls.[167] Other studies suggest only moderate negative effects,[168] or even possible benefits of social media use.[169] A greater understanding of the range of possible health effects of smartphone and social media on youth and adolescents awaits further research.

[164] Cures Act §9033.

[165] For more information on minority-serving institutions, see CRS Report R43237, *Programs for Minority-Serving Institutions Under the Higher Education Act*.

[166] See, for example, Kira E. Riehm, Kenneth A. Feder, and Kayla N. Tormohlen, et al., "Associations Between Time Spent Using Social Media and Internalizing and Externalizing Problems Among US," *JAMA Psychiatry*, vol. 76, no. 12 (September 11, 2019), pp. 1266-1273; and Chirag Gupta, Sangita Jogdand, and Mayank Kumar, "Reviewing the Impact of Social Media on the Mental Health of Adolescents and Youth Adults," *Cureus*, vol. 14, no. 10 (October 2022), p. e30143.

[167] See, for example, Yvonne Kelly, Afshin Zilanawala, and Cara Booker, et al., "Social Media Use and Adolescent Mental Health: Findings from the UK Millenium Cohort Study," *eClinicalMedicine*, vol. 6 (2018), pp. 59-68; and Jean M. Twenge and Eric Farley, "Not All Screen Time Is Created Equal: Associations with Mental Health Vary by Activity and Gender," *Social Psychiatry and Psychiatric Epidemiology*, vol. 56 (2021), pp. 207-217.

[168] See, for example, Amy Orben and Andrew K. Przybylski, "The Association Between Adolescent Well-Being and Digital Technology Use," *Nature Human Behavior*, vol. 3 (2019), pp. 173-182.

[169] See, for instance, Yalda T. Uhls, Nicole B. Ellison, and Kavri Subrahmanyam, "Benefits and Costs of Social Media in Adolescence," *Pediatrics*, vol. 140 (November 1, 2017).

Section 1431. Study on the Effects of Smartphone and Social Media Use on Adolescents

Section 1431 allows the Secretary to conduct or support research on smartphone and social media use by adolescents and the effects of use on emotional, behavioral, and physical health and development, and mental health disparities. The provision requires the Secretary to submit a report to Congress on the findings of the research no later than five years after enactment (i.e., December 29, 2027).

Section 1432. Research on the Health and Development Effects of Media and Related Technology on Infants, Children, and Adolescents

Section 1432 requires the Secretary to conduct or support research related to the health and developmental effects of specified media and technology use on infant, children, and adolescents. The provision requires the Secretary, acting through Director of the National Institutes of Health (NIH), to develop a research agenda assessing the effects of media and technology use on the cognitive development, physical health, and mental health of infants, children, and adolescents. The provision requires the NIH Director to submit a report to specific congressional committees no later than two years after enactment (i.e., December 29, 2024) on the progress made on this research program and a summary of research projects funded under this section.

Subtitle E—Miscellaneous Provisions

Section 1501. Limitations on Authority

Section 1501 prohibits the Secretary from allocating funding to any program authorized or amended by the Restoring Hope for Mental Health and Well-Being Act without considering the incidence, prevalence, or determinants of behavioral health issues (unless otherwise required by law).

Appendix. Abbreviations Used in This Report

Abbreviation	Definition
ACA	Patient Protection and Affordable Care Act (P.L. 111-148)
ACT	Assertive Community Treatment
AOT	Assisted Outpatient Treatment
ASPE	Assistant Secretary for Planning and Evaluation
BHWET	Behavioral Health Workforce Education and Training
CAA	Consolidated Appropriations Act
CARA	Comprehensive Addiction and Recovery Act of 2016 (P.L. 114-198)
CBAs	Collective Bargaining Agreements
CCBHC	Certified Community Behavioral Health Clinic
CCIIO	Center for Consumer Information & Insurance Oversight
CDC	Centers for Disease Control and Prevention
C.F.R.	*Code of Federal Regulations*
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
CSA	Controlled Substances Act
Cures Act	21st Century Cures Act of 2016 (P.L. 114-244)
DATA	Drug Addiction Treatment Act of 2000 (P.L. 106-310)
DEA	Drug Enforcement Administration
DOJ	U.S. Department of Justice
DOL	U.S. Department of Labor
ED	U.S. Department of Education
FDA	U.S. Food and Drug Administration
FQHC	Federally Qualified Health Centers
GAO	Government Accountability Office
GLS	Garrett Lee Smith
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act (P.L. 104-191)
HRSA	Health Resources and Services Administration
HUD	U.S. Department of Housing and Urban Development
IHS	Indian Health Service
MHBG	Community Mental Health Services Block Grant
MHPAEA	Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (P.L. 110-343)
MH/SUD	Mental Health/Substance Use Disorder
MOUD	Medications for Opioid Use Disorder
M/S	Medical/Surgical

Abbreviation	Definition
NASEM	National Academies of Sciences, Engineering, and Medicine
NCEED	National Center of Excellence for Eating Disorders
NIH	National Institutes of Health
NQTLs	Non-Quantitative Treatment Limitations
NTAC	National Threat Assessment Center
OTPs	Opioid Treatment Program
PATH	Projects for Assistance in Transition from Homelessness
PHSA	Public Health Service Act
PRNS	Programs of Regional and National Significance
SABG	Substance Use Prevention and Treatment Block Grant
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SED	Serious Emotional Disturbance
SMI	Serious Mental Illness
SOR	State Opioid Response
STOP Act	Sober Truth on Preventing Underage Drinking Act (P.L. 109-422)
SUD	Substance Use Disorders
SUPPORT Act	Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (P.L. 115-271)
SUPTRS	Substance Use Prevention, Treatment, and Recovery Services
ONDCP	Office of National Drug Control Policy
OUD	Opioid Use Disorder
U.S.C.	*U.S. Code*
VA	U.S. Department for Veterans Affairs

Source: CRS.

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