

SUICIDE PREVENTION ACT

SEPTEMBER 18, 2020.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. PALLONE, from the Committee on Energy and Commerce, submitted the following

R E P O R T

[To accompany H.R. 5619]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 5619) to authorize a pilot program to expand and intensify surveillance of self-harm in partnership with State and local public health departments, to establish a grant program to provide self-harm and suicide prevention services in hospital emergency departments, and for other purposes, having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

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The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the “Suicide Prevention Act”.

SEC. 2. SYNDROMIC SURVEILLANCE OF SELF-HARM BEHAVIORS PROGRAM.

Title III of the Public Health Service Act is amended by inserting after section 317U of such Act (42 U.S.C. 247b–23) the following:

“SEC. 317V. SYNDROMIC SURVEILLANCE OF SELF-HARM BEHAVIORS PROGRAM.

“(a) **IN GENERAL.**—The Secretary shall award grants to State, local, Tribal, and territorial public health departments for the expansion of surveillance of self-harm.

“(b) **DATA SHARING BY GRANTEES.**—As a condition of receipt of such grant under subsection (a), each grantee shall agree to share with the Centers for Disease Control and Prevention in real time, to the extent feasible and as specified in the grant agreement, data on suicides and self-harm for purposes of—

“(1) tracking and monitoring self-harm to inform response activities to suicide clusters;

“(2) informing prevention programming for identified at-risk populations; and

“(3) conducting or supporting research.

“(c) **DISAGGREGATION OF DATA.**—The Secretary shall provide for the data collected through surveillance of self-harm under subsection (b) to be disaggregated by the following categories:

“(1) Nonfatal self-harm data of any intent.

“(2) Data on suicidal ideation.

“(3) Data on self-harm where there is no evidence, whether implicit or explicit, of suicidal intent.

“(4) Data on self-harm where there is evidence, whether implicit or explicit, of suicidal intent.

“(5) Data on self-harm where suicidal intent is unclear based on the available evidence.

“(d) **PRIORITY.**—In making awards under subsection (a), the Secretary shall give priority to eligible entities that are—

“(1) located in a State with an age-adjusted rate of nonfatal suicidal behavior that is above the national rate of nonfatal suicidal behavior, as determined by the Director of the Centers for Disease Control and Prevention;

“(2) serving an Indian Tribe (as defined in section 4 of the Indian Self-Determination and Education Assistance Act) with an age-adjusted rate of nonfatal suicidal behavior that is above the national rate of nonfatal suicidal behavior, as determined through appropriate mechanisms determined by the Secretary in consultation with Indian Tribes; or

“(3) located in a State with a high rate of coverage of statewide (or Tribal) emergency department visits, as determined by the Director of the Centers for Disease Control and Prevention.

“(e) **GEOGRAPHIC DISTRIBUTION.**—In making grants under this section, the Secretary shall make an effort to ensure geographic distribution, taking into account the unique needs of rural communities, including—

“(1) communities with an incidence of individuals with serious mental illness, demonstrated suicidal ideation or behavior, or suicide rates that are above the national average, as determined by the Assistant Secretary for Mental Health and Substance Use;

“(2) communities with a shortage of prevention and treatment services, as determined by the Assistant Secretary for Mental Health and Substance Use and the Administrator of the Health Resources and Services Administration; and

“(3) other appropriate community-level factors and social determinants of health such as income, employment, and education.

“(f) **PERIOD OF PARTICIPATION.**—To be selected as a grant recipient under this section, a State, local, Tribal, or territorial public health department shall agree to participate in the program for a period of not less than 4 years.

“(g) **TECHNICAL ASSISTANCE.**—The Secretary shall provide technical assistance and training to grantees for collecting and sharing the data under subsection (b).

“(h) **DATA SHARING BY HHS.**—Subject to subsection (b), the Secretary shall, with respect to data on self-harm that is collected pursuant to this section, share and integrate such data through—

“(1) the National Syndromic Surveillance Program’s Early Notification of Community Epidemics (ESSENCE) platform (or any successor platform);

“(2) the National Violent Death Reporting System, as appropriate; or

“(3) another appropriate surveillance program, including such a program that collects data on suicides and self-harm among special populations, such as members of the military and veterans.

“(i) **RULE OF CONSTRUCTION REGARDING APPLICABILITY OF PRIVACY PROTECTIONS.**—Nothing in this section shall be construed to limit or alter the application of Federal or State law relating to the privacy of information to data or information that is collected or created under this section.

“(j) REPORT.—

“(1) SUBMISSION.—Not later than 3 years after the date of enactment of this Act, the Secretary shall evaluate the suicide and self-harm syndromic surveillance systems at the Federal, State, and local levels and submit a report to Congress on the data collected under subsections (b) and (c) in a manner that prevents the disclosure of individually identifiable information, at a minimum, consistent with all applicable privacy laws and regulations.

“(2) CONTENTS.—In addition to the data collected under subsections (b) and (c), the report under paragraph (1) shall include—

“(A) challenges and gaps in data collection and reporting;

“(B) recommendations to address such gaps and challenges; and

“(C) a description of any public health responses initiated at the Federal, State, or local level in response to the data collected.

“(k) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated \$20,000,000 for each of fiscal years 2021 through 2025.”.

SEC. 3. GRANTS TO PROVIDE SELF-HARM AND SUICIDE PREVENTION SERVICES.

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

“SEC. 520N. GRANTS TO PROVIDE SELF-HARM AND SUICIDE PREVENTION SERVICES.

“(a) IN GENERAL.—The Secretary of Health and Human Services shall award grants to hospital emergency departments to provide self-harm and suicide prevention services.

“(b) ACTIVITIES SUPPORTED.—

“(1) IN GENERAL.—A hospital emergency department awarded a grant under subsection (a) shall use amounts under the grant to implement a program or protocol to better prevent suicide attempts among hospital patients after discharge, which may include—

“(A) screening patients for self-harm and suicide in accordance with the standards of practice described in subsection (e)(1) and standards of care established by appropriate medical and advocacy organizations;

“(B) providing patients short-term self-harm and suicide prevention services in accordance with the results of the screenings described in subparagraph (A); and

“(C) referring patients, as appropriate, to a health care facility or provider for purposes of receiving long-term self-harm and suicide prevention services, and providing any additional follow up services and care identified as appropriate as a result of the screenings and short-term self-harm and suicide prevention services described in subparagraphs (A) and (B).

“(2) USE OF FUNDS TO HIRE AND TRAIN STAFF.—Amounts awarded under subsection (a) may be used to hire clinical social workers, mental and behavioral health care professionals, and support staff as appropriate, and to train existing staff and newly hired staff to carry out the activities described in paragraph (1).

“(c) GRANT TERMS.—A grant awarded under subsection (a)—

“(1) shall be for a period of 3 years; and

“(2) may be renewed subject to the requirements of this section.

“(d) APPLICATIONS.—A hospital emergency department seeking a grant under subsection (a) shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require.

“(e) STANDARDS OF PRACTICE.—

“(1) IN GENERAL.—Not later than 180 days after the date of the enactment of this section, the Secretary shall develop standards of practice for screening patients for self-harm and suicide for purposes of carrying out subsection (b)(1)(C).

“(2) CONSULTATION.—The Secretary shall develop the standards of practice described in paragraph (1) in consultation with individuals and entities with expertise in self-harm and suicide prevention, including public, private, and non-profit entities.

“(f) REPORTING.—

“(1) REPORTS TO THE SECRETARY.—

“(A) IN GENERAL.—A hospital emergency department awarded a grant under subsection (a) shall, at least quarterly for the duration of the grant, submit to the Secretary a report evaluating the activities supported by the grant.

“(B) MATTERS TO BE INCLUDED.—The report required under subparagraph (A) shall include—

“(i) the number of patients receiving—

“(I) screenings carried out at the hospital emergency department;

“(II) short-term self-harm and suicide prevention services at the hospital emergency department; and

“(III) referrals to health care facilities for the purposes of receiving long-term self-harm and suicide prevention;

“(ii) information on the adherence of the hospital emergency department to the standards of practice described in subsection (f)(1); and

“(iii) other information as the Secretary determines appropriate to evaluate the use of grant funds.

“(2) REPORTS TO CONGRESS.—Not later than 2 years after the date of the enactment of the Suicide Prevention Act, and biennially thereafter, the Secretary shall submit to the Committee on Health, Education, Labor and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on the grant program under this section, including—

“(A) a summary of reports received by the Secretary under paragraph (1);

and

“(B) an evaluation of the program by the Secretary.

“(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated \$30,000,000 for each of fiscal years 2021 through 2025.”.

I. PURPOSE AND SUMMARY

H.R. 5619, the “Suicide Prevention Act”, was introduced on January 15, 2020, by Representatives Chris Stewart (R–UT) and Doris O. Matsui (D–CA). H.R. 5619 establishes two grant programs to help prevent self-harm and suicide. The bill requires the Secretary of Health and Human Services (the Secretary) to award grants to State, local, Tribal, and territorial health departments to expand surveillance of self-harm. The bill also requires the Secretary to award grants to hospital emergency departments for programs to prevent self-harm and suicide attempts among patients after discharge.

II. BACKGROUND AND NEED FOR LEGISLATION

The United States does not currently have a complete count of suicide attempts.¹ It is, however, estimated that 0.5 percent of the adults aged 18 or older (1.4 million adults) made at least one suicide attempt.² According to recent data, suicide is also among the leading causes of death in the Nation.³ In 2018, 10.7 million adults seriously contemplated suicide, 3.3 million of whom made suicide plans, and 1.4 million made a nonfatal suicide attempt.⁴ Available data suggest that adult females reported a suicide attempt 1.5 times as often as males; further breakdown by gender and race are not available.⁵ H.R. 5619 would enhance data collection for State, local, Tribal, and territorial health departments and community organizations in order to help recognize suicide trends, intervene earlier, and save lives.

According to the American Foundation for Suicide Prevention, emergency departments present a key opportunity to identify and treat the individuals at the highest and most immediate risk for suicide because 39 percent of people who die by suicide make an emergency department visit in the year prior to their deaths.⁶ Fur-

¹ <https://afsp.org/suicide-statistics/>

² <https://www.samhsa.gov/data/release/2018-national-survey-drug-use-and-health-nsduh-releases>

³ National Center for Health Statistics, Leading Causes of Death (www.cdc.gov/nchs/fastats/leading-causes-of-death.htm) (accessed June 5, 2020).

⁴ U.S. Department of Health and Human Services, Mental Health Myths and Fact (www.mentalhealth.gov) (accessed June 6, 2020).

⁵ *Id.*

⁶ <https://project2025.afsp.org/>

ther, studies indicate that the risk of a suicide attempt or death is highest within the first 30 days after discharge from an emergency department or inpatient psychiatric unit.⁷ Yet for many reasons, up to 70 percent of patients who leave the emergency department after a suicide attempt never attend their first outpatient follow-up appointment.⁸ H.R. 5619 would provide grants to emergency departments to establish or enhance their self-harm and suicide prevention services.

III. COMMITTEE HEARINGS

For the purposes of section 103(i) of H. Res. 6 of the 116th Congress, the following hearing was used to develop or consider H.R. 5619:

The Subcommittee on Health held a legislative hearing on June 30, 2020, entitled, “High Anxiety and Stress: Legislation to Improve Mental Health During Crisis” to consider H.R. 5619, the “Suicide Prevention Act”. The Subcommittee received testimony from the following witnesses:

- The Honorable Patrick J. Kennedy, Founder of the Kennedy Forum and former Member of Congress;
- Arthur C. Evans, Jr. Ph.D., Chief Executive Officer, American Psychological Association;
- Jeffrey L. Geller, M.D., M.P.H., President, American Psychiatric Association; and
- Ms. Arriana Gross, National Youth Advisory Board Member, Sandy Hook Promise Students Against Violence Everywhere (SAVE) Promise Club.

IV. COMMITTEE CONSIDERATION

H.R. 5619, the “Suicide Prevention Act”, was introduced by Representative Stewart (R–UT) and Matsui (D–CA) on January 15, 2020 and was referred to the Committee on Energy and Commerce. The bill was then referred to the Subcommittee on Health on January 16, 2020. On June 30, 2020, the Subcommittee held a legislative hearing on the bill.

On July 15, 2020, the Subcommittee on Health was discharged from further consideration of H.R. 5619 as the bill was called up for markup, pursuant to notice, by the full Committee on Energy and Commerce. During consideration and markup an amendment in the nature of a substitute (AINS) was offered by Ms. Matsui of California. The Matsui AINS was agreed to by a voice vote. The full Committee subsequently agreed to a motion on final passage offered by Mr. Pallone, Chairman of the committee, to order H.R. 5619 reported favorably to the House, amended, by a voice vote, a quorum being present.

V. COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list each record vote on the motion to report legislation and amendments thereto. The Committee ad-

⁷Knesper, D.J. (2010). *Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatry inpatient unit*. Newton, MA: Suicide Prevention Resource Center.

⁸*Id.*

vises that there were no record votes taken on H.R. 5619, including the motion on final passage of the bill.

VI. OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the oversight findings and recommendations of the Committee are reflected in the descriptive portion of the report.

VII. NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

Pursuant to 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee adopts as its own the estimate of new budget authority, entitlement authority, or tax expenditures or revenues contained in the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

The Committee has requested but not received from the Director of the Congressional Budget Office a statement as to whether this bill contains any new budget authority, spending authority, credit authority, or an increase or decrease in revenues or tax expenditures.

VIII. FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

IX. STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

Pursuant to clause 3(c)(4) of rule XIII, the general performance goal or objective of this legislation is to expand and intensify surveillance of self-harm in partnership with State, local, Tribal, and territorial public health departments and to improve suicide prevention resources in hospital emergency departments.

X. DUPLICATION OF FEDERAL PROGRAMS

Pursuant to clause 3(c)(5) of rule XIII, no provision of H.R. 5619 is known to be duplicative of another Federal program, including any program that was included in a report to Congress pursuant to section 21 of Public Law 111-139 or the most recent Catalog of Federal Domestic Assistance.

XI. COMMITTEE COST ESTIMATE

Pursuant to clause 3(d)(1) of rule XIII, the Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

XII. EARMARKS, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

Pursuant to clause 9(e), 9(f), and 9(g) of rule XXI, the Committee finds that H.R. 5619 contains no earmarks, limited tax benefits, or limited tariff benefits.

XIII. ADVISORY COMMITTEE STATEMENT

No advisory committee within the meaning of section 5(b) of the Federal Advisory Committee Act was created by this legislation.

XIV. APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

XV. SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

Section 1 designates that the short title may be cited as the “Suicide Prevention Act”.

Sec. 2. Syndromic surveillance of self harm behaviors program

Section 2 amends the Public Health Service Act to direct the Secretary of Health and Human Services (the Secretary) to award grants to State, local, Tribal, and territorial public health departments for expansion of self-harm surveillance. Further, section 2 requires recipients of such grants to share these data with the Center for Disease Control and Prevention (CDC) for the purposes of nationwide tracking and monitoring on self-harm in order to inform prevention programming and research. These data shall be disaggregated by nonfatal self-harm data; data on suicidal ideation; and data on suicidal intent.

In awarding these grants, the Secretary shall give priority to eligible entities serving locations or populations with higher than national average rates of nonfatal suicidal behavior. The Secretary shall also try to ensure geographic distribution of funding is considered, including to communities with a shortage of prevention and treatment services. Grant recipients shall agree to participate in the program for no less than four years, and the Secretary shall provide technical assistance and training to grantees on collecting and sharing data. No later than 3 years after the date of enactment, the Secretary shall evaluate suicide and self-harm syndromic surveillance systems at the Federal, State, and local levels and submit a report to Congress on the data collected, any challenges and gaps in data collection and reporting, recommendations to address these challenges or gaps, and a description of public health responses initiated in response to the collected data.

There is authorized to be appropriated \$20 million for each of the fiscal years 2021 through 2025 to carry out section 2.

Sec. 3. Grants to provide self harm and suicide prevention services

Section 3 amends the Public Health Service Act to direct the Secretary to award grants to hospital emergency departments to pro-

vide self-harm and suicide prevention services. Such grants shall be used to implement suicide prevention programs or protocols for hospital patients after discharge. Activities may include increased screening, additional short-term services, targeted referral services. These funds may also be used to hire and train staff to carry out these activities.

Grants shall be for a period of three years, and grantees must report to the Secretary regarding the activities carried out with the grants. Not later than 180 days after the date of enactment, the Secretary shall, in consultation with individuals and entities with expertise in self-harm and suicide prevention, develop standards of practice for screening patients for self-harm and suicide. The Secretary must report to the relevant committees of jurisdiction a program evaluation no later than two years after enactment.

There is authorized to be appropriated \$30 million for each of the fiscal years 2021 through 2025 to carry out section 3.

XVI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (new matter is printed in italics and existing law in which no change is proposed is shown in roman):

PUBLIC HEALTH SERVICE ACT

* * * * *

TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

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PART B—FEDERAL-STATE COOPERATION

* * * * *

SEC. 317V. SYNDROMIC SURVEILLANCE OF SELF-HARM BEHAVIORS PROGRAM.

(a) *IN GENERAL.*—The Secretary shall award grants to State, local, Tribal, and territorial public health departments for the expansion of surveillance of self-harm.

(b) *DATA SHARING BY GRANTEES.*—As a condition of receipt of such grant under subsection (a), each grantee shall agree to share with the Centers for Disease Control and Prevention in real time, to the extent feasible and as specified in the grant agreement, data on suicides and self-harm for purposes of—

(1) tracking and monitoring self-harm to inform response activities to suicide clusters;

(2) informing prevention programming for identified at-risk populations; and

(3) conducting or supporting research.

(c) *DISAGGREGATION OF DATA.*—The Secretary shall provide for the data collected through surveillance of self-harm under subsection (b) to be disaggregated by the following categories:

(1) Nonfatal self-harm data of any intent.

(2) Data on suicidal ideation.

(3) *Data on self-harm where there is no evidence, whether implicit or explicit, of suicidal intent.*

(4) *Data on self-harm where there is evidence, whether implicit or explicit, of suicidal intent.*

(5) *Data on self-harm where suicidal intent is unclear based on the available evidence.*

(d) *PRIORITY.—In making awards under subsection (a), the Secretary shall give priority to eligible entities that are—*

(1) *located in a State with an age-adjusted rate of nonfatal suicidal behavior that is above the national rate of nonfatal suicidal behavior, as determined by the Director of the Centers for Disease Control and Prevention;*

(2) *-serving an Indian Tribe (as defined in section 4 of the Indian Self-Determination and Education Assistance Act) with an age-adjusted rate of nonfatal suicidal behavior that is above the national rate of nonfatal suicidal behavior, as determined through appropriate mechanisms determined by the Secretary in consultation with Indian Tribes; or*

(3) *located in a State with a high rate of coverage of state-wide (or Tribal) emergency department visits, as determined by the Director of the Centers for Disease Control and Prevention.*

(e) *GEOGRAPHIC DISTRIBUTION.—In making grants under this section, the Secretary shall make an effort to ensure geographic distribution, taking into account the unique needs of rural communities, including—*

(1) *communities with an incidence of individuals with serious mental illness, demonstrated suicidal ideation or behavior, or suicide rates that are above the national average, as determined by the Assistant Secretary for Mental Health and Substance Use;*

(2) *communities with a shortage of prevention and treatment services, as determined by the Assistant Secretary for Mental Health and Substance Use and the Administrator of the Health Resources and Services Administration; and*

(3) *other appropriate community-level factors and social determinants of health such as income, employment, and education.*

(f) *PERIOD OF PARTICIPATION.—To be selected as a grant recipient under this section, a State, local, Tribal, or territorial public health department shall agree to participate in the program for a period of not less than 4 years.*

(g) *TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance and training to grantees for collecting and sharing the data under subsection (b).*

(h) *DATA SHARING BY HHS.—Subject to subsection (b), the Secretary shall, with respect to data on self-harm that is collected pursuant to this section, share and integrate such data through—*

(1) *the National Syndromic Surveillance Program's Early Notification of Community Epidemics (ESSENCE) platform (or any successor platform);*

(2) *the National Violent Death Reporting System, as appropriate; or*

(3) *another appropriate surveillance program, including such a program that collects data on suicides and self-harm among*

special populations, such as members of the military and veterans.

(i) RULE OF CONSTRUCTION REGARDING APPLICABILITY OF PRIVACY PROTECTIONS.—Nothing in this section shall be construed to limit or alter the application of Federal or State law relating to the privacy of information to data or information that is collected or created under this section.

(j) REPORT.—

(1) SUBMISSION.—Not later than 3 years after the date of enactment of this Act, the Secretary shall evaluate the suicide and self-harm syndromic surveillance systems at the Federal, State, and local levels and submit a report to Congress on the data collected under subsections (b) and (c) in a manner that prevents the disclosure of individually identifiable information, at a minimum, consistent with all applicable privacy laws and regulations.

(2) CONTENTS.—In addition to the data collected under subsections (b) and (c), the report under paragraph (1) shall include—

- (A) challenges and gaps in data collection and reporting;*
- (B) recommendations to address such gaps and challenges; and*
- (C) a description of any public health responses initiated at the Federal, State, or local level in response to the data collected.*

(k) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated \$20,000,000 for each of fiscal years 2021 through 2025.

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TITLE V—SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

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PART B—CENTERS AND PROGRAMS

* * * * *

Subpart 3—Center for Mental Health Services

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SEC. 520N. GRANTS TO PROVIDE SELF-HARM AND SUICIDE PREVENTION SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall award grants to hospital emergency departments to provide self-harm and suicide prevention services.

(b) ACTIVITIES SUPPORTED.—

(1) IN GENERAL.—A hospital emergency department awarded a grant under subsection (a) shall use amounts under the grant to implement a program or protocol to better prevent suicide attempts among hospital patients after discharge, which may include—

- (A) screening patients for self-harm and suicide in accordance with the standards of practice described in sub-*

section (e)(1) and standards of care established by appropriate medical and advocacy organizations;

(B) providing patients short-term self-harm and suicide prevention services in accordance with the results of the screenings described in subparagraph (A); and

(C) referring patients, as appropriate, to a health care facility or provider for purposes of receiving long-term self-harm and suicide prevention services, and providing any additional follow up services and care identified as appropriate as a result of the screenings and short-term self-harm and suicide prevention services described in subparagraphs (A) and (B).

(2) *USE OF FUNDS TO HIRE AND TRAIN STAFF.*—Amounts awarded under subsection (a) may be used to hire clinical social workers, mental and behavioral health care professionals, and support staff as appropriate, and to train existing staff and newly hired staff to carry out the activities described in paragraph (1).

(c) *GRANT TERMS.*—A grant awarded under subsection (a)—

(1) shall be for a period of 3 years; and

(2) may be renewed subject to the requirements of this section.

(d) *APPLICATIONS.*—A hospital emergency department seeking a grant under subsection (a) shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require.

(e) *STANDARDS OF PRACTICE.*—

(1) *IN GENERAL.*—Not later than 180 days after the date of the enactment of this section, the Secretary shall develop standards of practice for screening patients for self-harm and suicide for purposes of carrying out subsection (b)(1)(C).

(2) *CONSULTATION.*—The Secretary shall develop the standards of practice described in paragraph (1) in consultation with individuals and entities with expertise in self-harm and suicide prevention, including public, private, and non-profit entities.

(f) *REPORTING.*—

(1) *REPORTS TO THE SECRETARY.*—

(A) *IN GENERAL.*—A hospital emergency department awarded a grant under subsection (a) shall, at least quarterly for the duration of the grant, submit to the Secretary a report evaluating the activities supported by the grant.

(B) *MATTERS TO BE INCLUDED.*—The report required under subparagraph (A) shall include—

(i) the number of patients receiving—

(I) screenings carried out at the hospital emergency department;

(II) short-term self-harm and suicide prevention services at the hospital emergency department; and

(III) referrals to health care facilities for the purposes of receiving long-term self-harm and suicide prevention;

(ii) information on the adherence of the hospital emergency department to the standards of practice described in subsection (f)(1); and

(iii) other information as the Secretary determines appropriate to evaluate the use of grant funds.

(2) *REPORTS TO CONGRESS.*—Not later than 2 years after the date of the enactment of the Suicide Prevention Act, and biennially thereafter, the Secretary shall submit to the Committee on Health, Education, Labor and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on the grant program under this section, including—

(A) a summary of reports received by the Secretary under paragraph (1); and

(B) an evaluation of the program by the Secretary.

(g) *AUTHORIZATION OF APPROPRIATIONS.*—To carry out this section, there are authorized to be appropriated \$30,000,000 for each of fiscal years 2021 through 2025.

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