

(2) Consultation

In awarding grants under this subsection, the Assistant Secretary shall, as appropriate, consult with the Chief Medical Officer, appointed under section 290aa(g) of this title, the advisory councils described in section 290aa-1 of this title, the National Institute of Mental Health, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism, as appropriate.

(f) Authorization of appropriations

To carry out this section, there is authorized to be appropriated \$10,000,000 for each of fiscal years 2023 through 2027.

(July 1, 1944, ch. 373, title V, § 501A, as added Pub. L. 114-255, div. B, title VII, § 7001, Dec. 13, 2016, 130 Stat. 1220; amended Pub. L. 115-271, title VII, § 7111, Oct. 24, 2018, 132 Stat. 4042; Pub. L. 117-328, div. FF, title I, § 1121(a), Dec. 29, 2022, 136 Stat. 5647.)

Editorial Notes**AMENDMENTS**

2022—Subsec. (e)(1). Pub. L. 117-328, § 1121(a)(1), substituted “Indian Tribes or Tribal organizations” for “Indian tribes or tribal organizations” in introductory provisions.

Subsec. (e)(3). Pub. L. 117-328, § 1121(a)(2), struck out par. (3) which authorized appropriations for grants for fiscal years 2018 through 2020.

Subsec. (f). Pub. L. 117-328, § 1121(a)(3), added subsec. (f).

2018—Subsec. (b)(6), (7). Pub. L. 115-271 added par. (6) and redesignated former par. (6) as (7).

§ 290aa-0a. Behavioral health crisis coordinating office**(a) In general**

The Secretary shall establish, within the Substance Abuse and Mental Health Services Administration, an office to coordinate work relating to behavioral health crisis care across the operating divisions and agencies of the Department of Health and Human Services, including the Substance Abuse and Mental Health Services Administration, the Centers for Medicare & Medicaid Services, and the Health Resources and Services Administration, and external stakeholders.

(b) Duty

The office established under subsection (a) shall—

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

(2) launch and manage Federal workgroups charged with making recommendations regarding issues related to mental health and substance use disorder crises, including with respect to health care best practices, workforce development, health disparities, data collection, technology, program oversight, public awareness, and engagement; and

(3) support technical assistance, data analysis, and evaluation functions in order to assist States, localities, Territories, Indian Tribes, and Tribal organizations in developing crisis care systems and identifying best practices with the objective of expanding the ca-

capacity of, and access to, local crisis call centers, mobile crisis care, crisis stabilization, psychiatric emergency services, and rapid post-crisis follow-up care provided by—

(A) the National Suicide Prevention and Mental Health Crisis Hotline and Response System;

(B) the Veterans Crisis Line;

(C) community mental health centers (as defined in section 1395x(ff)(3)(B) of this title);

(D) certified community behavioral health clinics, as described in section 223 of the Protecting Access to Medicare Act of 2014; and

(E) other community mental health and substance use disorder providers.

(c) Authorization of appropriations

There is authorized to be appropriated to carry out this section \$5,000,000 for each of fiscal years 2023 through 2027.

(July 1, 1944, ch. 373, title V, § 501B, as added Pub. L. 117-328, div. FF, title I, § 1101, Dec. 29, 2022, 136 Stat. 5635.)

Editorial Notes**REFERENCES IN TEXT**

Section 223 of the Protecting Access to Medicare Act of 2014, referred to in subsec. (b)(3)(D), is section 223 of Pub. L. 113-93, which is set out as a note under section 1396a of this title.

Statutory Notes and Related Subsidiaries**CRISIS RESPONSE CONTINUUM OF CARE**

Pub. L. 117-328, div. FF, title I, § 1102, Dec. 29, 2022, 136 Stat. 5635, provided that:

“(a) IN GENERAL.—The Secretary, acting through the Assistant Secretary for Mental Health and Substance Use, shall facilitate the identification and publication of best practices for a crisis response continuum of care related to mental health and substance use disorders for use by health care providers, crisis services administrators, and crisis services providers in responding to individuals (including children and adolescents) experiencing mental health crises, substance-related crises, and crises arising from co-occurring disorders.

“(b) BEST PRACTICES.—

“(1) IN GENERAL.—The best practices published under subsection (a) shall, as appropriate, address best practices related to crisis response services for the range of entities that furnish such services, taking into consideration such services that—

“(A) do not require prior authorization from an insurance provider or group health plan nor a referral from a health care provider prior to the delivery of services;

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

“(C) provide for operating 24 hours a day, 7 days a week;

“(D) provide for care and support through resources described in paragraph (2)(A) until the individual has been stabilized or transferred to the next level of crisis care; and

“(E) address psychiatric stabilization, including for—

“(i) individuals screened over the phone, text, and chat; and

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

“(2) IDENTIFICATION OF FUNCTIONS.—The best practices published under subsection (a) shall consider the functions of the range of services in the crisis response continuum, including the following:

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

“(B) A description of access and entry points to services within the crisis response continuum.

“(C) Identification, as appropriate and consistent with State laws, of any protocols and agreements for the transfer and receipt of individuals to and from other segments of the crisis response continuum segments as needed, and from outside referrals, including health care providers, first responders (including law enforcement, paramedics, and firefighters), education institutions, and community-based organizations.

“(D) Description of the qualifications of the range of crisis services staff, including roles for physicians, licensed clinicians, case managers, and peers (in accordance with State licensing requirements or requirements applicable to Tribal health professionals).

“(E) The convening of collaborative meetings of relevant crisis response system partners, such as crisis response service providers, first responders (including law enforcement, paramedics, and firefighters), and community partners (including the National Suicide Prevention Lifeline or 9-8-8 call centers, 9-1-1 public service answering points, and local mental health and substance use disorder treatment providers), operating in a common region for the discussion of case management, best practices, and general performance improvement.

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

“(A) the volume of services to meet population need;

“(B) appropriate timely response; and

“(C) capacity to meet the needs of different patient populations that may experience a mental health or substance use crisis, including children, families, and all age groups, racial and ethnic minorities, veterans, individuals with co-occurring mental health and substance use disorders, individuals with disabilities, and individuals with chronic illness.

“(4) IMPLEMENTATION TIMEFRAME.—The Secretary shall—

“(A) not later than 1 year after the date of enactment of this section [Dec. 29, 2022], publish and maintain the best practices required by subsection (a); and

“(B) after 3 years, facilitate the identification of any updates to such best practices, as appropriate.

“(5) EVALUATIONS.—Not later than 3 years after the date of enactment of this Act, the Comptroller General of the United States 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, an assessment of relevant programs related to mental health and substance use disorder crises authorized under title V of the Public Health Service Act (42 U.S.C. 290aa et seq.) in order to assess the extent to which such programs meet objectives and performance metrics, as determined by the Secretary. Such evaluation may, as appropriate, include data on—

“(A) the type and variety of services provided when responding to mental health and substance use-related crises;

“(B) the impact on emergency department facility use and length of stay, including for patients who require further psychiatric care;

“(C) the impact on access to crisis care centers and crisis bed services;

“(D) the impact on linkage to appropriate post-crisis care; and

“(E) the use of best practices and recommendations identified under this section.”

§ 290aa-0b. Interdepartmental Serious Mental Illness Coordinating Committee

(a) Establishment

(1) In general

The Secretary, or the designee of the Secretary, shall establish a committee to be known as the Interdepartmental Serious Mental Illness Coordinating Committee (in this section referred to as the “Committee”).

(2) Federal Advisory Committee Act

Except as provided in this section, the provisions of the Federal Advisory Committee Act (5 U.S.C. App.)¹ shall apply to the Committee.

(b) Meetings

The Committee shall meet not fewer than 2 times each year.

(c) Responsibilities

Not later than each of 1 year and 5 years after December 29, 2022, the Committee shall submit to Congress and any other relevant Federal department or agency a report including—

(1) a summary of advances in serious mental illness and serious emotional disturbance research related to the prevention of, diagnosis of, intervention in, and treatment and recovery of serious mental illnesses, serious emotional disturbances, and advances in access to services and support for adults with a serious mental illness or children with a serious emotional disturbance;

(2) an evaluation of the effect Federal programs related to serious mental illness have on public health, including outcomes such as—

(A) rates of suicide, suicide attempts, incidence and prevalence of serious mental illnesses, serious emotional disturbances, and substance use disorders, overdose, overdose deaths, emergency hospitalizations, emergency department boarding, preventable emergency department visits, interaction with the criminal justice system, homelessness, and unemployment;

(B) increased rates of employment and enrollment in educational and vocational programs;

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

(D) any other criteria as may be determined by the Secretary; and

(3) specific recommendations for actions that agencies can take to better coordinate the administration of mental health services for adults with a serious mental illness or children with a serious emotional disturbance.

(d) Membership

(1) Federal members

The Committee shall be composed of the following Federal representatives, or the designees of such representatives—

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

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

¹ See References in Text note below.