CHAMPAIGN COUNTY MENTAL HEALTH BOARD

CHAMPAIGN COUNTY BOARD FOR CARE AND TREATMENT OF PERSONS WITH A DEVELOPMENTAL DISABILITY

Study Session of the Champaign County Mental Health Board (CCMHB)

Wednesday, September 30, 2020
Brookens Administrative Center, Lyle Shields Room
1776 E. Washington St. Urbana, IL
5:30 p.m.

This Meeting will be Conducted Remotely at https://us02web.zoom.us/j/81393675682

1. Call to Order
2. Roll Call
3. Public Participation/Citizen Input
4. Approval of Agenda
5. President's Comments
6. Study Session: PY2022 Allocation Priority Criteria

   Board discussion of current priorities. Packet materials include Briefing Memorandum on current allocations by priority, various charts on past appropriations, and several pertinent articles on the impact of COVID-19.
7. Board Announcements
8. Adjournment

Instructions for participating in Zoom Conference Bridge for CCMHB Study Session September 30, 2020 at 5:45 p.m.

You will need a computer with a microphone and speakers to join the Zoom Conference Bridge; if you want your face broadcast you will need a webcam.

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Join with computer audio.

Once you are in the meeting, click on "participants" at the bottom of the screen.
Once you've clicked on participants you should see a list of participants with an option to "Raise Hand" at the bottom of the participants screen. **If you wish to speak, click "raise hand" and the Chair will call on you to speak.**

If you are not a member of the CCMHB or a staff person, **please sign in by writing your name and any agency affiliation in the Chat area.** This, like the recording of the meeting itself, is a public document. There are agenda items for Public Participation and for Agency Input, and we will monitor the 'raised hands' during those times.

If you have called in, please speak up during these portions of the meeting if you would like to make a contribution. If you have called in and therefore do not have access to the chat, there will be an opportunity for you to share your 'sign-in' information. If your name is not displayed in the participant list, we might ask that you change it, especially if many people join the call.

Members of the public should not write questions or comments in the Chat area, unless otherwise prompted by the Board, who may choose to record questions and answers there.

CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

BRIEFING MEMORANDUM

DATE: September 30, 2020
TO: Members, Champaign County Mental Health Board (CCMHB)
FROM: Lynn Canfield
SUBJECT: Review of Strategic Plan and Funding Priorities

Background

The purpose of this memorandum is to set the stage for evaluating and planning Champaign County's system of supports and services for its residents who have Mental Health conditions, Substance Use Disorders (SUD), or Intellectual and Developmental Disabilities (I/DD). Funding priorities and strategic plan are typically reviewed during the fall, as the Board establishes funding priorities for the next Program Year (July 1 to June 30) and Three-Year Plan Objectives for the next Fiscal Year (January 1 to December 31).

Board members have previously offered suggestions for strengthening the allocation process itself. In addition to the strategic plan and priorities documents under development, more work may be done in this area, as technical requirements are also a reflection of the values of Board, staff, and community.

Community Needs Assessment

In September and October 2018, the CCMHB reviewed and approved a community needs assessment, which is completed every three years as part of the strategic planning process. CCMHB staff currently work with the Regional Vermilion-Champaign Executive Committee, a group of representatives from health and behavioral health sectors which have similar requirements to complete community needs assessments and three-year plans. This partnership will result in a shared assessment, replacing or enhancing any developed by CCMHB staff. Committee meetings highlight member activities, report on subcommittee (iPlan workgroups) efforts, and are chaired by a coordinator who pulls together needs assessment activities. Consistent with CCMHB priority areas are: Mental Health First Aid training efforts for rural residents, crisis services, substance abuse prevention and suicide prevention education for youth, anti-violence and trauma-informed care initiatives, and resources such as 211-PATH and https://carle.org/about/serving-our-community/healthy-communities.

Program Year 2021 (Current) CCMHB Priorities

Based on these sources of information and other collaborations involving CCMHB members or staff, the Board approved the following priorities for funding for the Program Year 2021 and made awards to agencies offering services associated with each. For overviews of each funded program and related activities, please see the attached spreadsheet.

Behavioral Health Supports which Reduce Incarceration

Community-based behavioral health supports and other resources that lead to wellness should be available to people who have mental illness, substance use disorder, or disability support needs. These should reduce contact with the criminal justice system. Counties bear the cost of care for people who are incarcerated, whereas care provided in the community allows for payment by state, federal, and other funding sources. More importantly, people move toward wellness and away from 'criminalization'. Supports and services should: improve health and quality of life; connect and engage the most vulnerable people; increase access to effective treatments; reduce contact with law enforcement; 'divert' to services rather than arrest, booking, or charging; eliminate inappropriate incarceration; decrease the amount of time people spend in jail; and facilitate transition to the community from jail or prison.

Current collaborations of law enforcement, local government and funders, service providers, and stakeholders emphasize: data sharing analysis; Drug Court coordination; brief screening, case management, peer support, and benefits enrollment for people in jail; and coordinated supports for those in reentry. Recommendations from a previous project funded by US Department of Justice and the CCMHB are still relevant: strengthen the system; create a coordinating council; add case management for those served by the Public Defender's office; and explore feasibility of a 24 hour 'crisis center' or alternative, such as coordinated crisis interventions across the community. In collaborations which overlap with public safety or public health interests, co-funding by appropriate entities will reflect their commitment and ensure that we are not duplicating or interfering with similar efforts

6 agencies, 10 programs, totaling $1,030,812

- *CCRPC "Justice Diversion Program" $75,308*
- *CCRPC "Youth Assessment Center" $76,350*
- *CC CAC "Children's Advocacy Center" $52,754*
- *CC Health Care Cons "Justice Involved CHW Services & Benefits" $75,140*
- *Family Service "Counseling" $30,000*
- *First Followers "FirstSteps Community Re-entry House" NEW $39,600*
- *First Followers "Peer Mentoring for Re-entry" $95,000*
- *Rosecrance Central Illinois "Criminal Justice PSC" $304,350*
- *Rosecrance Central Illinois "Fresh Start" $79,310*
- *Rosecrance Central Illinois "Specialty Courts" $203,000*

Innovative Practices and Access to Behavioral Health Services

Insufficient behavioral healthcare and safety net systems not only lead to unnecessary incarcerations and hospitalizations but also to worsening of symptoms and loss of life; community awareness, system advocacy, and improved access to care and resources are all needed. Although Champaign County Jail's frequent visitors (5 or more bookings per year) decreased 54% between 2013 and 2018, high rates of housing instability, emergency department visits, and crisis intervention contacts continue. A strengthened partnership of providers could help secure housing and other basic needs for people with behavioral health conditions.

Barriers to appropriate community care include: siloed care and outdated regulations; insufficient provider capacity; difficulty securing insurance coverage for essential services; high costs of care even with coverage; stigma; and limited transportation or resources. The US Secretary of Health and Human Services acknowledges the value of the social determinants of health/behavioral health, e.g., access to food, healthcare, and housing. Illinois is testing promising practices through a new 1115 waiver. Because social determinants have not been the traditional purview of behavioral health systems, collaboration and co-funding by other appropriate entities will add value to an application and ensure that we are not duplicating or interfering with similar efforts. Locally we can improve access to care and support innovations not otherwise funded:

11 agencies, 14 programs, totaling $1,585,589

- *CCRPC "Homeless Services System Coordination" $51,906*
- *CC Christian Health Ctr "Mental Health Care at CCCHC" $13,000*
- *CC Health Care Consumers "CHW Outreach and Benefit Enrollment" $77,960*
- *CSCNCC "Resource Connection" $67,596*
- *Cunningham Children's Home "ECHO Housing/Employment Support" $101,604*
- *ECIRMAC (Refugee Center) "Family Support & Strengthening" $56,440*
- *Family Service "Self-Help Center" $28,930*
- *Family Service "Senior Counseling & Advocacy" $162,350*
- *GROW in Illinois "Peer-Support" $77,239*
- *Promise Healthcare "Mental Health Services with Promise" $350,117*
- *Promise Healthcare "Promise Healthcare Wellness" $107,987*
- *Rattle the Stars "Youth Suicide Prevention Education" $86,500*
- *Rosecrance Central Illinois "Crisis, Access, & Benefits" $203,960*
- *Rosecrance Central Illinois "Recovery Home" $200,000*

<u>System of Care for Children, Youth, Families</u>

Since 2001, the CCMHB has focused on ***youth*** with multi-system involvement, funding evidence-based programs to reduce juvenile justice system contact among those with serious emotional disturbance. Programs have been introduced which promote positive youth development. The System of Care for Youth and Families includes the Champaign County Community Coalition, with initiatives for summer youth programming and community crisis response to mitigate the harm caused by gun violence and other trauma. Where such community efforts overlap with public safety and public health interests, co-funding by appropriate entities will demonstrate their commitment and ensure that we are not duplicating or interfering with similar efforts.

The CCMHB has also funded programs for ***young children***, including perinatal supports, early identification, prevention, and treatment. Coordination of public and private early childhood provider organizations has resulted in a Home Visitors Consortium which aims to become a "no wrong door" System of Care for very young children and their families, building resilience and self-determination, with an understanding of the negative impacts of Adverse Childhood Experiences. Programs may also serve children who have an identified developmental delay or disability (DD) or risk, as well as offering supports for the families of these children, aligned with Collaboration with CCDDB priority below.

For best outcomes and to avoid criminalizing behavioral and developmental issues, Systems of Care should be strength-based, well-coordinated, family-driven, person-centered, trauma-informed, and culturally responsive. Early involvement has potential to improve individual and community health and disrupt poverty. Year-round, positive opportunities for all Champaign County children, from birth through young adulthood, should maximize social/emotional success and help them stay excited about learning. Success is sustainable when families and communities are resilient.

12 agencies, 17 programs, totaling $1,631,266

- *CCRPC Head Start/EHS "Early Childhood Mental Health Services" $209,906*
- *Courage Connection "Courage Connection" $127,000*
- *Crisis Nursery "Beyond Blue Champaign County" $75,000*
- *Cunningham Children's Home "Families Stronger Together" $403,107*
- *DREAAM House "DREAAM" $80,000*
- *Don Moyer Boys and Girls Club "C-U CHANGE" $100,000*
- *Don Moyer Boys and Girls Club "CUNC" $110,195*
- *Don Moyer Boys and Girls Club "Coalition Summer Initiatives" $107,000*
- *Don Moyer Boys and Girls Club "Youth and Family Services" $160,000*
- *Mahomet Area Youth Club "BLAST" $15,000*
- *Mahomet Area Youth Club "MAYC Members Matter!" $18,000*
- *NAMI Champaign County "NAMI Champaign County" $10,000*
- *RACES "Sexual Violence Counseling" NEW $35,790*
- *RACES "Sexual Violence Prevention Education" $63,000*
- *Rosecrance Central Illinois "Prevention Services" $60,000*
- *UP Center of Champaign Co. "Children, Youth, & Families Program" $31,768*
- *Urbana Neighborhood Connections "Community Study Center" $25,500*

Collaboration with the Champaign County Developmental Disabilities Board

The Intergovernmental Agreement (IGA) with the Champaign County Developmental Disabilities Board (CCDDB) requires integrated planning concerning Intellectual and Developmental Disabilities (I/DD) allocation decisions and includes a specific CCMHB set-aside, which for PY2021 will likely total $696,137 (PY2020 amount of $666,750 plus an increase equal to increase in the property tax levy extension). In addition to funding agency programs, the Boards share a Community Integrated Living Arrangement (CILA) Expansion project, which has enabled the purchase, improvement, and maintenance of two small group homes for people with I/DD who would otherwise be unable to live in this community. This effort aligns with the Ligas consent decree and Olmstead decision.

This commitment continues for PY2021, with a particular interest in programs focused on the developmental needs of very young children and support for their families. In recent years, the CCMHB has funded such efforts as they complement an array of approaches to behavioral health support for very young children and their families, and for which service providers collaborate toward a System of Care for children and families (see above). Services and supports not covered by Early Intervention or under the School Code, for young children with developmental and social-emotional concerns, might include: coordinated, home-based services addressing all areas of development and taking into consideration the needs of the family; early identification of delays through consultation with child care providers, pre-school educators, medical professionals, and other providers of service; education, coaching, and facilitation to focus on strengthening personal and family support networks; identification and mobilization of individual and family gifts and capacities, to access community associations and learning spaces.

Applications should explain how services, across levels of intensity of support, are as family driven, self-determined, and integrated as possible, consistent with state and federal standards.

2 agencies, 2 programs, plus CILA project, totaling $696,137

- *CILA Expansion CCMHB Commitment $ 0 for 2020, mortgage paid off in 2019*
- *Champaign Co. Head Start "Social Emotional Development Services" $99,615 (with $21,466 CCDDB)*
- *Developmental Services Center "Family Development" $596,522*

Overarching Priorities:

- Underserved/Underrepresented Populations and Countywide Access
- Inclusion and Anti-Stigma
- Outcomes
- Coordinated System
- Budget and Program Connectedness
- Added Value and Uniqueness

CCMHB Three Year Plan Goals, 2019-2021

1. Support a **continuum of services** to improve the quality of life experienced by individuals with mental or emotional disorders, substance use disorders, or intellectual and/or developmental disabilities and their families residing in Champaign County.
2. Sustain commitment to addressing health disparities experienced by **underrepresented and diverse populations.**
3. Improve **consumer access to and engagement** in services.
4. Continue the collaborative working relationship with the Champaign County Board for Care and Treatment of Persons with a Developmental Disability (CCDDB).

5. Building on progress achieved through the six Year Cooperative Agreement between the Federal Substance Abuse and Mental Health Services Administration (SAMHSA), the Illinois Department of Human Services (IDHS), and the Champaign County Mental Health Board (CCMHB), **sustain the SAMHSA/IDHS system of care** model.
6. **Divert from the criminal justice system**, as appropriate, persons with behavioral health needs or intellectual/developmental disabilities.
7. In conjunction with the Champaign County Sheriff's Office and other community stakeholders pursue a continuum of services as an **alternative to incarceration and/or overutilization of local Emergency Departments** for persons with behavioral health needs or developmental disabilities.
8. Support **interventions for youth** who have juvenile justice system involvement to reduce contact with law enforcement or prevent deeper penetration into the system.
9. Address the need for **acceptance, inclusion and respect** associated with a person's or family members' mental illness, substance use disorder, intellectual and/or developmental disability through broad based community education efforts to increase community acceptance and positive self-image.
10. Engage with other local, state, and federal stakeholders on **emerging issues**.

Suggested Actions

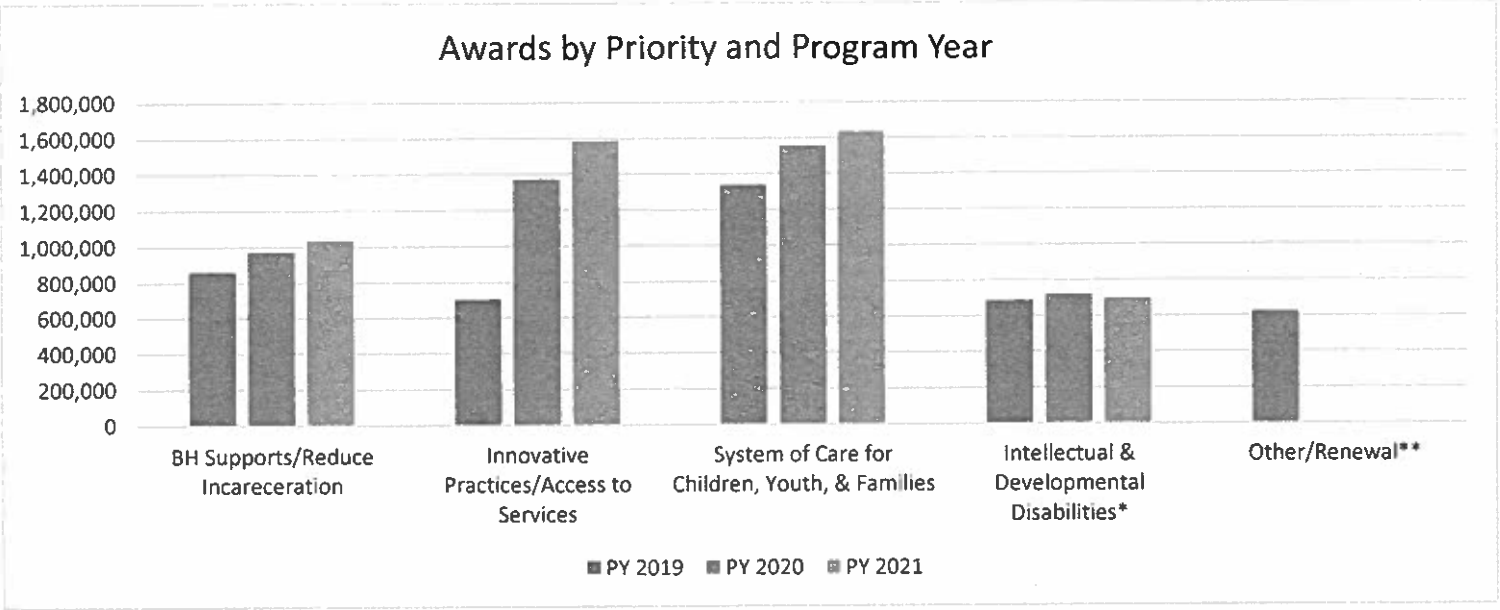
As in previous years, the September board meeting packet includes the current Three Year Plan with draft objectives for the coming year. This document is distributed to providers, and stakeholders for input and a final draft presented in November for board consideration. No change is suggested to this process.

A draft document of priorities for funding for the next cycle (in this case, Program Year 2022) is scheduled for presentation to the board in October, to be finalized in November or December. The COVID-19 pandemic and related epidemics has revealed weaknesses in our healthcare and service systems by making them far more deadly. Board members may desire to discuss priorities more deeply as well as with the events of 2020 in mind. The study session scheduled for September 30 at 5:45pm offers an initial opportunity. Additional time may be needed, possibly at the October 21, 5:45PM board meeting or October 28, 5:45PM study session, or special meeting called for this purpose.

If Board discussions would be enhanced by panelists/presenters from relevant agency programs or stakeholders with a relationship to the priority category, these could be scheduled. In addition, CCDDB and CCMHB members are welcome to join each other's meetings and may be especially interested in priorities discussions.

CCMHB Appropriations (contract awards) by Priority and Program Year

Priority	PY 2019	PY 2020	PY 2021
BH Supports/Reduce Incareceration	857,377	$970,847	$1,030,812
Innovative Practices/Access to Services	$703,599	$1,371,244	$1,585,589
System of Care for Children, Youth, & Families	$1,335,789	$1,553,310	$1,631,266
Intellectual & Developmental Disabilities*	$685,885	$716,750	$696,137
Other/Renewal**	$619,279	$0	$0
Total	$4,201,929	$4,612,151	$4,943,804



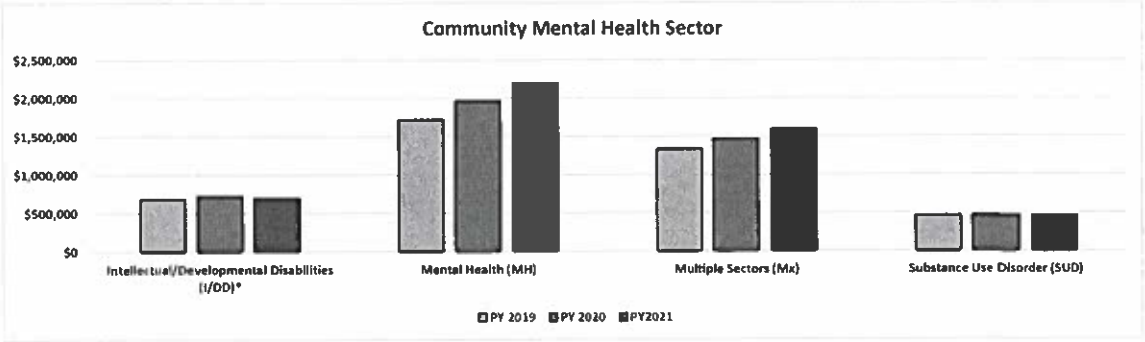
* PY19 and PY20 amounts include $50,000 allocated to CILA mortgage. CCMHB paid off mortgage later in PY20, eliminating expense in PY21.

**Applications submitted under the Other category in PY19 were submitted under different priorities in PY20. Funds awarded in PY19 to Crisis Nursery Beyond Blue and RACES Sexual Violence Prevention Education appear in the System of Care priority total for PY20 and 21. ECIRMAC Family Support and Stengthening, Promise Healthcare Mental Health Services, and Rosecrance Crisis, Access, and Benefits appear in the Innovative Practices/Access to Services priority total for PY20 and 21.

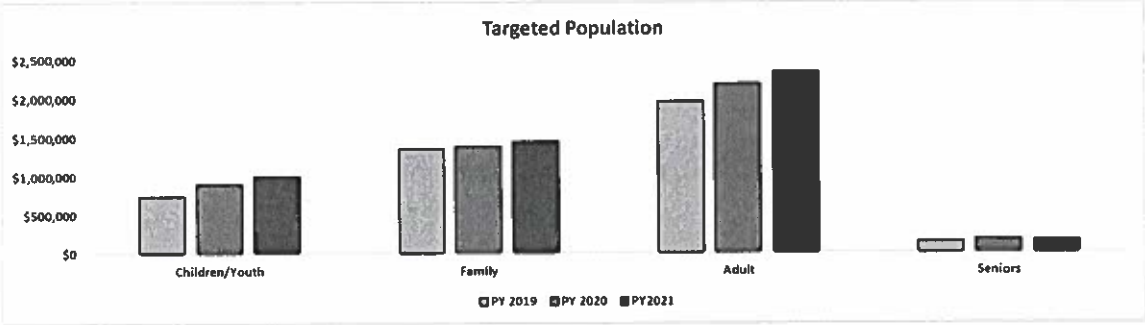
CCMHB Appropriations by Sector, Population, and Service for Program Year 2019, 2020, and 2021

Community Mental Health Sector	PY 2019	PY 2020	PY2021
Intellectual/Developmental Disabilities (I/DD)*	$685,885	$716,750	$696,137
Mental Health (MH)	$1,719,653	$1,964,896	$2,191,609
Multiple Sectors (Mx)	$1,333,391	$1,467,505	$1,593,058
Substance Use Disorder (SUD)	$463,000	$463,000	$463,000
Total	$4,201,929	$4,612,151	$4,943,804

* CILA mortgage paid off in PY20.

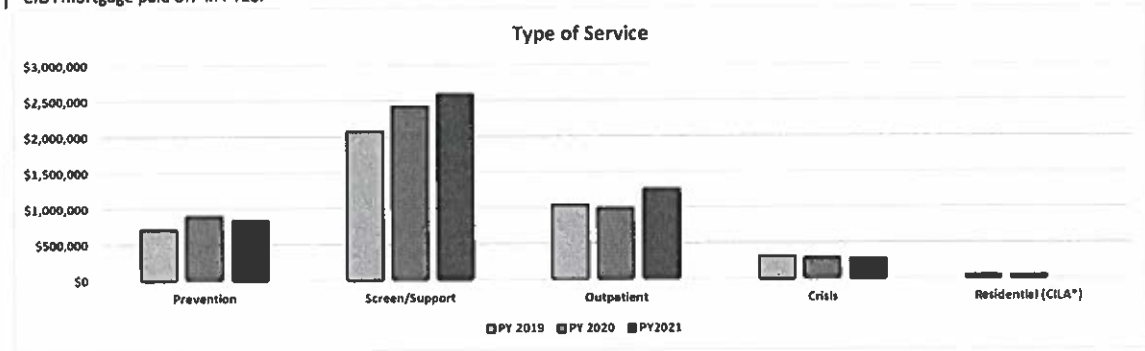


Targeted Population Group	PY 2019	PY 2020	PY2021
Children/Youth	$741,829	$891,874	$993,625
Family	$1,356,934	$1,378,730	$1,443,032
Adult	$1,960,829	$2,179,197	$2,344,797
Seniors	$142,337	$162,350	$162,350
Total	$4,201,929	$4,612,151	$4,943,804



Type of Service	PY 2019	PY 2020	PY2021
Prevention	$714,262	$882,127	$838,403
Screen/Support	$2,081,024	$2,418,401	$2,577,969
Outpatient	$1,036,129	$982,355	$1,248,164
Crisis	$320,514	$279,268	$279,268
Residential (CILA*)	$50,000	$50,000	$0
Total	$4,201,929	$4,612,151	$4,943,804

* CILA mortgage paid off in PY20.



HealthyPeople.gov

Mental Health

Mental Health Across the Life Stages

Mental health disorders are a concern for people of all ages, from early childhood through old age.

Children and Adolescents

- Approximately 20% of U.S. children and adolescents are affected by mental health disorders during their lifetime. Often, symptoms of anxiety disorders emerge by age 6, behavior disorders by age 11, mood disorders by age 13, and substance use disorders by age 15.[6]
- 15% of high school students have seriously considered suicide, and 7% have attempted to take their own life.[7]
- Mental health disorders among children and adolescents can lead to school failure, alcohol or other drug abuse, family discord, violence, and suicide.[8]

Adults

- It is estimated that only about 17% of U.S. adults are considered to be in a state of optimal mental health.[1]
- An estimated 26% of Americans age 18 and older are living with a mental health disorder in any given year, and 46% will have a mental health disorder over the course of their lifetime.[1]
- Almost 15% of women who recently gave birth reported symptoms of postpartum depression.[1]

Older Adults

- Alzheimer's disease is among the 10 leading causes of death in the United States. It is the 6th leading cause of death among American adults and the 5th leading cause of death for adults age 65 years and older.[9]
- Among nursing home residents, 18.7% of people age 65 to 74, and 23.5% of people age 85 and older have reported mental illness.[1]

Determinants of Mental Health

Several factors have been linked to mental health, including race and ethnicity, gender, age, income level, education level, sexual orientation, and geographic location. Other social conditions—such as interpersonal, family, and community dynamics, housing quality, social support, employment opportunities, and work and school conditions—can also influence mental health risk and outcomes, both positively and negatively. For example, safe shared places for people to interact, such as parks and churches, can support positive mental health. A better understanding of these factors, how they interact, and their impact is key to improving and maintaining the mental health of all Americans.

References

[1]Reeves WC, Strine TW, Pratt LA, et al. Mental illness surveillance among adults in the United States. MMWR. 2011;60(3):1–32. Atlanta, GA: Centers for Disease Control and Prevention. Available from http://www.cdc.gov/mmwr/preview/mmwrhtml/su6003a1.htm?s_cid=su6003a1_w

[6]Merikangas KR, He J, Burstein M, et al. Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Study–Adolescent Supplement (NCS-A). J Am Acad Child Adolesc Psychiatry. 2010;49(10):980–989.

[7]Eaton DK, Kann L, Kinchen S, et al. Youth risk behavior surveillance—United States, 2007. Surveillance summaries, June 6. MMWR. 2008;57(SS-4):1–131. Atlanta, GA: Centers for Disease Control and Prevention. Available from http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5704a1.htm

[8]MedlinePlus, National Library of Medicine, National Institutes of Health. Child Mental Health. Bethesda, MD: 2011. Available from http://www.nlm.nih.gov/medlineplus/childmentalhealth.html

[9]Healthy Aging Program, Centers for Disease Control and Prevention. Alzheimer's Disease. Atlanta, GA: 2011. Available from http://www.cdc.gov/aging/aginginfo/alzheimers.htm

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Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Weekly / Vol. 69 / No. 32
August 14, 2020

Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020

Mark É. Czeisler[1,2]; Rashon I. Lane MA[3]; Emiko Petrosky, MD[3]; Joshua F. Wiley, PhD[1]; Aleta Christensen, MPH[3]; Rashid Njai, PhD[3]; Matthew D. Weaver, PhD[1,4,5]; Rebecca Robbins, PhD[4,5]; Elise R. Facer-Childs, PhD[1]; Laura K. Barger, PhD[4,5]; Charles A. Czeisler, MD, PhD[1,4,5]; Mark E. Howard, MBBS, PhD[1,2,6]; Shantha M.W. Rajaratnam, PhD[1,4,5]

The coronavirus disease 2019 (COVID-19) pandemic has been associated with mental health challenges related to the morbidity and mortality caused by the disease and to mitigation activities, including the impact of physical distancing and stay-at-home orders.* Symptoms of anxiety disorder and depressive disorder increased considerably in the United States during April–June of 2020, compared with the same period in 2019 (*1*,*2*). To assess mental health, substance use, and suicidal ideation during the pandemic, representative panel surveys were conducted among adults aged ≥18 years across the United States during June 24–30, 2020. Overall, 40.9% of respondents reported at least one adverse mental or behavioral health condition, including symptoms of anxiety disorder or depressive disorder (30.9%), symptoms of a trauma- and stressor-related disorder (TSRD) related to the pandemic† (26.3%), and having started or increased substance use to cope with stress or emotions related to COVID-19 (13.3%). The percentage of respondents who reported having seriously considered suicide in the 30 days before completing the survey (10.7%) was significantly higher among respondents aged 18–24 years (25.5%), minority racial/ethnic groups (Hispanic respondents [18.6%], non-Hispanic black [black] respondents [15.1%]), self-reported unpaid caregivers for adults§ (30.7%), and essential workers¶ (21.7%).

* https://www.medrxiv.org/content/10.1101/2020.04.22.20076141v1.

† Disorders classified as TSRDs in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM–5) include posttraumatic stress disorder (PTSD), acute stress disorder (ASD), and adjustment disorders (ADs), among others.

§ Unpaid adult caregiver status was self-reported. The definition of an unpaid caregiver for adults was a person who had provided unpaid care to a relative or friend aged ≥18 years to help them take care of themselves at any time in the last 3 months. Examples provided included helping with personal needs, household chores, health care tasks, managing a person's finances, taking them to a doctor's appointment, arranging for outside services, and visiting regularly to see how they are doing.

¶ Essential worker status was self-reported. The comparison was between employed respondents (n = 3,431) who identified as essential versus nonessential. For this analysis, students who were not separately employed as essential workers were considered nonessential workers.

INSIDE

Continuing Education examination available at https://www.cdc.gov/mmwr/mmwr_continuingEducation.html

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

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Community-level intervention and prevention efforts, including health communication strategies, designed to reach these groups could help address various mental health conditions associated with the COVID-19 pandemic.

During June 24–30, 2020, a total of 5,412 (54.7%) of 9,896 eligible invited adults** completed web-based surveys†† administered by Qualtrics.§§ The Monash University Human Research Ethics Committee of Monash University (Melbourne, Australia) reviewed and approved the study protocol on human subjects research. Respondents were informed of the study purposes and provided electronic consent before commencement, and investigators received anonymized responses. Participants included 3,683 (68.1%) first-time respondents and 1,729 (31.9%) respondents who had completed a related survey during April 2–8, May 5–12, 2020, or both intervals; 1,497 (27.7%) respondents participated during all three intervals (*2*,*3*). Quota sampling and survey weighting were employed to improve cohort representativeness of the U.S. population by gender, age, and race/ethnicity.¶¶ Symptoms of anxiety disorder and depressive disorder were assessed using the four-item Patient Health Questionnaire*** (*4*), and symptoms of a COVID-19–related TSRD were assessed using the six-item Impact of Event Scale††† (*5*). Respondents also reported

** A minimum age of 18 years and residence within the United States as of April 2–8, 2020, were required for eligibility for the longitudinal cohort to complete a survey during June 24–30, 2020. Residence was reassessed during June 24–30, 2020, and one respondent who had moved from the United States was excluded from the analysis. A minimum age of 18 years and residence within the United States were required for eligibility for newly recruited respondents included in the cross-sectional analysis. For both the longitudinal cohort and newly recruited respondents, respondents were required to provide informed consent before enrollment into the study. All surveys underwent data quality screening procedures including algorithmic and keystroke analysis for attention patterns, click-through behavior, duplicate responses, machine responses, and inattentiveness. Country-specific geolocation verification via IP address mapping was used to ensure respondents were from the United States. Respondents who failed an attention or speed check, along with any responses identified by the data-scrubbing algorithms, were excluded from analysis.

†† The surveys contained 101 items for first-time respondents and 86 items for respondents who also participated in later surveys, with the 15 additional items for first-time respondents consisting of questions on demographics. The survey instruments included a combination of individual questions, validated questionnaires, and COVID-19-specific questionnaires, which were used to assess respondent attitudes, behaviors, and beliefs related to COVID-19 and its mitigation, as well as the social and behavioral health impacts of the COVID-19 pandemic.

§§ https://www.qualtrics.com/.

¶¶ Survey weighting was implemented according to the 2010 U.S. Census with respondents who reported gender, age, and race/ethnicity. Respondents who reported a gender of "Other," or who did not report race/ethnicity were assigned a weight of one.

*** Symptoms of anxiety disorder and depressive disorder were assessed via the four-item Patient Health Questionnaire (PHQ-4). Those who scored ≥3 out of 6 on the Generalized Anxiety Disorder (GAD-2) and Patient Health Questionnaire (PHQ-2) subscales were considered symptomatic for these respective disorders. This instrument was included in the April, May, and June surveys.

††† Symptoms of a TSRD attributed to the COVID-19 pandemic were assessed via the six-item Impact of Event Scale (IES-6) to screen for overlapping symptoms of PTSD, ASD, and ADs. For this survey, the COVID-19 pandemic was specified as the traumatic exposure to record peri- and posttraumatic symptoms associated with the range of stressors introduced by the COVID-19 pandemic. Those who scored ≥1.75 out of 4 were considered symptomatic. This instrument was included in the May and June surveys only.

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whether they had started or increased substance use to cope with stress or emotions related to COVID-19 or seriously considered suicide in the 30 days preceding the survey.§§§

Analyses were stratified by gender, age, race/ethnicity, employment status, essential worker status, unpaid adult caregiver status, rural-urban residence classification,¶¶¶ whether the respondent knew someone who had positive test results for SARS-CoV-2, the virus that causes COVID-19, or who had died from COVID-19, and whether the respondent was receiving treatment for diagnosed anxiety, depression, or posttraumatic stress disorder (PTSD) at the time of the survey. Comparisons within subgroups were evaluated using Poisson regressions with robust standard errors to calculate prevalence ratios, 95% confidence intervals (CIs), and p-values to evaluate statistical significance ($\alpha = 0.005$ to account for multiple comparisons). Among the 1,497 respondents who completed all three surveys, longitudinal analyses of the odds of incidence**** of symptoms of adverse mental or behavioral health conditions by essential worker and unpaid adult caregiver status were conducted on unweighted responses using logistic regressions to calculate unadjusted and adjusted†††† odds ratios (ORs), 95% CI, and p-values ($\alpha = 0.05$). The statsmodels package in Python (version 3.7.8; Python Software Foundation) was used to conduct all analyses.

Overall, 40.9% of 5,470 respondents who completed surveys during June reported an adverse mental or behavioral health condition, including those who reported symptoms of anxiety disorder or depressive disorder (30.9%), those with TSRD symptoms related to COVID-19 (26.3%), those who reported having started or increased substance use to cope with stress or emotions related to COVID-19 (13.3%), and those who reported having seriously considered suicide in the preceding 30 days (10.7%) (Table 1). At least one adverse mental or behavioral health symptom was reported by more than one half of respondents who were aged 18–24 years (74.9%) and 25–44 years (51.9%), of Hispanic ethnicity (52.1%), and who held less than a high school diploma (66.2%), as well as those who were essential workers (54.0%), unpaid caregivers for adults (66.6%), and who reported treatment for diagnosed anxiety (72.7%), depression (68.8%), or PTSD (88.0%) at the time of the survey.

Prevalences of symptoms of adverse mental or behavioral health conditions varied significantly among subgroups (Table 2). Suicidal ideation was more prevalent among males than among females. Symptoms of anxiety disorder or depressive disorder, COVID-19–related TSRD, initiation of or increase in substance use to cope with COVID-19–associated stress, and serious suicidal ideation in the previous 30 days were most commonly reported by persons aged 18–24 years; prevalence decreased progressively with age. Hispanic respondents reported higher prevalences of symptoms of anxiety disorder or depressive disorder, COVID-19–related TSRD, increased substance use, and suicidal ideation than did non-Hispanic whites (whites) or non-Hispanic Asian (Asian) respondents. Black respondents reported increased substance use and past 30-day serious consideration of suicide in the previous 30 days more commonly than did white and Asian respondents. Respondents who reported treatment for diagnosed anxiety, depression, or PTSD at the time of the survey reported higher prevalences of symptoms of adverse mental and behavioral health conditions compared with those who did not. Symptoms of a COVID-19–related TSRD, increased substance use, and suicidal ideation were more prevalent among employed than unemployed respondents, and among essential workers than nonessential workers. Adverse conditions also were more prevalent among unpaid caregivers for adults than among those who were not, with particularly large differences in increased substance use (32.9% versus 6.3%) and suicidal ideation (30.7% versus 3.6%) in this group.

Longitudinal analysis of responses of 1,497 persons who completed all three surveys revealed that unpaid caregivers for adults had a significantly higher odds of incidence of adverse mental health conditions compared with others (Table 3). Among those who did not report having started or increased substance use to cope with stress or emotions related to COVID-19 in May, unpaid caregivers for adults had 3.33 times the odds of reporting this behavior in June (adjusted OR 95% CI = 1.75–6.31; p<0.001). Similarly, among those who did not report having seriously considered suicide in the previous 30 days in May, unpaid caregivers for adults had 3.03 times the odds of reporting suicidal ideation in June (adjusted OR 95% CI = 1.20–7.63; p = 0.019).

§§§ For this survey, substance use was defined as use of "alcohol, legal or illegal drugs, or prescriptions drugs that are taken in a way not recommended by your doctor." Questions regarding substance use and suicidal ideation were included in the May and June surveys only. Participants were informed that responses were deidentified and that direct support could not be provided to those who reported substance use behavior or suicidal ideation. Regarding substance use, respondents were provided the following: "This survey is anonymous so we cannot provide direct support. If you would like crisis support please contact the Substance Abuse and Mental Health Services Administration National Helpline, 1-800-662-HELP (4357), (also known as the Treatment Referral Routing Service) or TTY: 1-800-487-4889. This is a confidential, free, 24-hour-a-day, 365-day-a-year, information service, in English and Spanish, for persons and family members facing mental and/or substance use disorders." Regarding suicidal ideation, respondents were provided the following: "This survey is anonymous so we cannot provide direct support. If you would like crisis support please contact the National Suicide Prevention Lifeline, 1-800-273-TALK (8255, or chat line) for help for themselves or others."

¶¶¶ Rural-urban classification was determined by using self-reported ZIP codes according to the Federal Office of Rural Health Policy definition of rurality. https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html.

**** Odds of incidence was defined as the odds of the presence of an adverse mental or behavioral health outcome reported during a later survey after previously having reported the absence of that outcome (e.g., having reported symptoms of anxiety disorder during June 24–30, 2020, after not having reported symptoms of anxiety disorder during April 2–8, 2020).

†††† Adjusted for gender, employment status, and essential worker status or unpaid adult caregiver status.

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TABLE 1. Respondent characteristics and prevalence of adverse mental health outcomes, increased substance use to cope with stress or emotions related to COVID-19 pandemic, and suicidal ideation — United States, June 24–30, 2020

Characteristic	All respondents who completed surveys during June 24–30, 2020 weighted* no. (%)	Weighted %*						
		Conditions				Started or increased substance use to cope with pandemic-related stress or emotions¶	Seriously considered suicide in past 30 days	≥1 adverse mental or behavioral health symptom
		Anxiety disorder†	Depressive disorder†	Anxiety or depressive disorder†	COVID-19–related TSRD§			
All respondents	5,470 (100)	25.5	24.3	30.9	26.3	13.3	10.7	40.9
Gender								
Female	2,784 (50.9)	26.3	23.9	31.5	24.7	12.2	8.9	41.4
Male	2,676 (48.9)	24.7	24.8	30.4	27.9	14.4	12.6	40.5
Other	10 (0.2)	20.0	30.0	30.0	30.0	10.0	0.0	30.0
Age group (yrs)								
18–24	731 (13.4)	49.1	52.3	62.9	46.0	24.7	25.5	74.9
25–44	1,911 (34.9)	35.3	32.5	40.4	36.0	19.5	16.0	51.9
45–64	1,895 (34.6)	16.1	14.4	20.3	17.2	7.7	3.8	29.5
≥65	933 (17.1)	6.2	5.8	8.1	9.2	3.0	2.0	15.1
Race/Ethnicity								
White, non-Hispanic	3,453 (63.1)	24.0	22.9	29.2	23.3	10.6	7.9	37.8
Black, non-Hispanic	663 (12.1)	23.4	24.6	30.2	30.4	18.4	15.1	44.2
Asian, non-Hispanic	256 (4.7)	14.1	14.2	18.0	22.1	6.7	6.6	31.9
Other race or multiple races, non-Hispanic**	164 (3.0)	27.8	29.3	33.2	28.3	11.0	9.8	43.8
Hispanic, any race(s)	885 (16.2)	35.5	31.3	40.8	35.1	21.9	18.6	52.1
Unknown	50 (0.9)	38.0	34.0	44.0	34.0	18.0	26.0	48.0
2019 Household income (USD)								
<25,000	741 (13.6)	30.6	30.8	36.6	29.9	12.5	9.9	45.4
25,000–49,999	1,123 (20.5)	26.0	25.6	33.2	27.2	13.5	10.1	43.9
50,999–99,999	1,775 (32.5)	27.1	24.8	31.6	26.4	12.6	11.4	40.3
100,999–199,999	1,301 (23.8)	23.1	20.8	27.7	24.2	15.5	11.7	37.8
≥200,000	282 (5.2)	17.4	17.0	20.6	23.1	14.8	11.6	35.1
Unknown	247 (4.5)	19.6	23.1	27.2	24.9	6.2	3.9	41.5
Education								
Less than high school diploma	78 (1.4)	44.5	51.4	57.5	44.5	22.1	30.0	66.2
High school diploma	943 (17.2)	31.5	32.8	38.4	32.1	15.3	13.1	48.0
Some college	1,455 (26.6)	25.2	23.4	31.7	22.8	10.9	8.6	39.9
Bachelor's degree	1,888 (34.5)	24.7	22.5	28.7	26.4	14.2	10.7	40.6
Professional degree	1,074 (19.6)	20.9	19.5	25.4	24.5	12.6	10.0	35.2
Unknown	33 (0.6)	25.2	23.2	28.2	23.2	10.5	5.5	28.2
Employment status††								
Employed	3,431 (62.7)	30.1	29.1	36.4	32.1	17.9	15.0	47.8
Essential	1,785 (32.6)	35.5	33.6	42.4	38.5	24.7	21.7	54.0
Nonessential	1,646 (30.1)	24.1	24.1	29.9	25.2	10.5	7.8	41.0
Unemployed	761 (13.9)	32.0	29.4	37.8	25.0	7.7	4.7	45.9
Retired	1,278 (23.4)	9.6	8.7	12.1	11.3	4.2	2.5	19.6
Unpaid adult caregiver status§§								
Yes	1,435 (26.2)	47.6	45.2	56.1	48.4	32.9	30.7	66.6
No	4,035 (73.8)	17.7	16.9	22.0	18.4	6.3	3.6	31.8
Region¶¶								
Northeast	1,193 (21.8)	23.9	23.9	29.9	22.8	12.8	10.2	37.1
Midwest	1,015 (18.6)	22.7	21.1	27.5	24.4	9.0	7.5	36.1
South	1,921 (35.1)	27.9	26.5	33.4	29.1	15.4	12.5	44.4
West	1,340 (24.5)	25.8	24.2	30.9	26.7	14.0	10.9	43
Rural-urban classification***								
Rural	599 (10.9)	26.0	22.5	29.3	25.4	11.5	10.2	38.3
Urban	4,871 (89.1)	25.5	24.6	31.1	26.4	13.5	10.7	41.2

See table footnotes on the next page.

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TABLE 1. (*Continued*) Respondent characteristics and prevalence of adverse mental health outcomes, increased substance use to cope with stress or emotions related to COVID-19 pandemic, and suicidal ideation — United States, June 24–30, 2020

Characteristic	All respondents who completed surveys during June 24–30, 2020 weighted* no. (%)	Weighted %*						
		Conditions						
		Anxiety disorder†	Depressive disorder†	Anxiety or depressive disorder†	COVID-19–related TSRD§	Started or increased substance use to cope with pandemic-related stress or emotions¶	Seriously considered suicide in past 30 days	≥1 adverse mental or behavioral health symptom
Know someone who had positive test results for SARS-CoV-2								
Yes	1,109 (20.3)	23.8	21.9	29.6	21.5	12.9	7.5	39.2
No	4,361 (79.7)	26.0	25.0	31.3	27.5	13.4	11.5	41.3
Knew someone who died from COVID-19								
Yes	428 (7.8)	25.8	20.6	30.6	28.1	11.3	7.6	40.1
No	5,042 (92.2)	25.5	24.7	31.0.	26.1	13.4	10.9	41
Receiving treatment for previously diagnosed condition								
Anxiety								
Yes	536 (9.8)	59.6	52.0	66.0	51.9	26.6	23.6	72.7
No	4,934 (90.2)	21.8	21.3	27.1	23.5	11.8	9.3	37.5
Depression								
Yes	540 (9.9)	52.5	50.6	60.8	45.5	25.2	22.1	68.8
No	4,930 (90.1)	22.6	21.5	27.7	24.2	12.0	9.4	37.9
Posttraumatic stress disorder								
Yes	251 (4.6)	72.3	69.1	78.7	69.4	43.8	44.8	88
No	5,219 (95.4)	23.3	22.2	28.6	24.2	11.8	9.0	38.7

Abbreviations: COVID-19 = coronavirus disease 2019; TSRD = trauma- or stress-related disorder.

* Survey weighting was employed to improve the cross-sectional June cohort representativeness of the U.S. population by gender, age, and race/ethnicity according to the 2010 U.S. Census with respondents in which gender, age, and race/ethnicity were reported. Respondents who reported a gender of "Other" or who did not report race/ethnicity were assigned a weight of one.

† Symptoms of anxiety disorder and depressive disorder were assessed via the four-item Patient Health Questionnaire (PHQ-4). Those who scored ≥3 out of 6 on the Generalized Anxiety Disorder (GAD-2) and Patient Health Questionnaire (PHQ-2) subscales were considered symptomatic for each disorder, respectively.

§ Disorders classified as TSRDs in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM–5) include posttraumatic stress disorder (PTSD), acute stress disorder (ASD), and adjustment disorders (ADs), among others. Symptoms of a TSRD precipitated by the COVID-19 pandemic were assessed via the six-item Impact of Event Scale (IES-6) to screen for overlapping symptoms of PTSD, ASD, and ADs. For this survey, the COVID-19 pandemic was specified as the traumatic exposure to record peri- and posttraumatic symptoms associated with the range of stressors introduced by the COVID-19 pandemic. Those who scored ≥1.75 out of 4 were considered symptomatic.

¶ 104 respondents selected "Prefer not to answer."

** The Other race or multiple races, non-Hispanic category includes respondents who identified as not being Hispanic and as more than one race or as American Indian or Alaska Native, Native Hawaiian or Pacific Islander, or "Other."

†† Essential worker status was self-reported. The comparison was between employed respondents (n = 3,431) who identified as essential vs. nonessential. For this analysis, students who were not separately employed as essential workers were considered nonessential workers.

§§ Unpaid adult caregiver status was self-reported. The definition of an unpaid caregiver for adults was a person who had provided unpaid care to a relative or friend aged ≥18 years to help them take care of themselves at any time in the last three months. Examples provided included helping with personal needs, household chores, health care tasks, managing a person's finances, taking them to a doctor's appointment, arranging for outside services, and visiting regularly to see how they are doing.

¶¶ Region classification was determined by using the U.S. Census Bureau's Census Regions and Divisions of the United States. https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf.

*** Rural-urban classification was determined by using self-reported ZIP codes according to the Federal Office of Rural Health Policy definition of rurality. https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html.

Discussion

Elevated levels of adverse mental health conditions, substance use, and suicidal ideation were reported by adults in the United States in June 2020. The prevalence of symptoms of anxiety disorder was approximately three times those reported in the second quarter of 2019 (25.5% versus 8.1%), and prevalence of depressive disorder was approximately four times that reported in the second quarter of 2019 (24.3% versus 6.5%) (*2*). However, given the methodological differences and potential unknown biases in survey designs, this analysis might not be directly comparable with data reported on anxiety and depression disorders in 2019 (*2*). Approximately one quarter of respondents reported symptoms of a TSRD related to the pandemic, and approximately one in 10 reported that they started or increased substance use because of COVID-19. Suicidal ideation was also elevated; approximately twice as many respondents reported serious consideration of suicide in the previous 30 days than did adults in the United States in 2018, referring to the previous 12 months (10.7% versus 4.3%) (*6*).

Mental health conditions are disproportionately affecting specific populations, especially young adults, Hispanic persons, black persons, essential workers, unpaid caregivers for adults, and those receiving treatment for preexisting psychiatric conditions. Unpaid caregivers for adults, many of whom are currently providing critical aid to persons at increased risk

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TABLE 2. Comparison of symptoms of adverse mental health outcomes among all respondents who completed surveys (N = 5,470), by respondent characteristic* — United States, June 24–30, 2020

Characteristic	Prevalence ratio[¶] (95% CI[**])			
	Symptoms of anxiety disorder or depressive disorder[†]	Symptoms of a TSRD related to COVID-19[§]	Started or increased substance use to cope with stress or emotions related to COVID-19	Serious consideration of suicide in past 30 days
Gender				
Female vs. male	1.04 (0.96–1.12)	0.88 (0.81–0.97)	0.85 (0.75–0.98)	0.70 (0.60–0.82)**
Age group (yrs)				
18–24 vs. 25–44	1.56 (1.44–1.68)**	1.28 (1.16–1.41)**	1.31 (1.12–1.53)**	1.59 (1.35–1.87)**
18–24 vs. 45–64	3.10 (2.79–3.44)**	2.67 (2.35–3.03)**	3.35 (2.75–4.10)**	6.66 (5.15–8.61)**
18–24 vs. ≥65	7.73 (6.19–9.66)**	5.01 (4.04–6.22)**	8.77 (5.95–12.93)**	12.51 (7.88–19.86)**
25–44 vs. 45–64	1.99 (1.79–2.21)**	2.09 (1.86–2.35)**	2.56 (2.14–3.07)**	4.18 (3.26–5.36)**
25–44 vs. ≥65	4.96 (3.97–6.20)**	3.93 (3.18–4.85)**	6.70 (4.59–9.78)**	7.86 (4.98–12.41)**
45–64 vs. ≥65	2.49 (1.98–3.15)**	1.88 (1.50–2.35)**	2.62 (1.76–3.9)**	1.88 (1.14–3.10)
Race/Ethnicity[††]				
Hispanic vs. non-Hispanic black	1.35 (1.18–1.56)**	1.15 (1.00–1.33)	1.19 (0.97–1.46)	1.23 (0.98–1.55)
Hispanic vs. non-Hispanic Asian	2.27 (1.73–2.98)**	1.59 (1.24–2.04)**	3.29 (2.05–5.28)**	2.82 (1.74–4.57)**
Hispanic vs. non-Hispanic other race or multiple races	1.23 (0.98–1.55)	1.24 (0.96–1.61)	1.99 (1.27–3.13)**	1.89 (1.16–3.06)
Hispanic vs. non-Hispanic white	1.40 (1.27–1.54)**	1.50 (1.35–1.68)**	2.09 (1.79–2.45)**	2.35 (1.96–2.80)**
Non-Hispanic black vs. non-Hispanic Asian	1.68 (1.26–2.23)**	1.38 (1.07–1.78)	2.75 (1.70–4.47)**	2.29 (1.39–3.76)**
Non-Hispanic black vs. non-Hispanic other race or multiple races	0.91 (0.71–1.16)	1.08 (0.82–1.41)	1.67 (1.05–2.65)	1.53 (0.93–2.52)
Non-Hispanic black vs. non-Hispanic white	1.03 (0.91–1.17)	1.30 (1.14–1.48)**	1.75 (1.45–2.11)**	1.90 (1.54–2.36)**
Non-Hispanic Asian vs. non-Hispanic other race or multiple races	0.54 (0.39–0.76)**	0.78 (0.56–1.09)	0.61 (0.32–1.14)	0.67 (0.35–1.29)
Non-Hispanic Asian vs. non-Hispanic white	0.62 (0.47–0.80)**	0.95 (0.74–1.20)	0.64 (0.40–1.02)	0.83 (0.52–1.34)
Non-Hispanic other race or multiple races vs. non-Hispanic white	1.14 (0.91–1.42)	1.21 (0.94–1.56)	1.05 (0.67–1.64)	1.24 (0.77–2)

See table footnotes on the next page.

for severe illness from COVID-19, had a higher incidence of adverse mental and behavioral health conditions compared with others. Although unpaid caregivers of children were not evaluated in this study, approximately 39% of unpaid caregivers for adults shared a household with children (compared with 27% of other respondents). Caregiver workload, especially in multigenerational caregivers, should be considered for future assessment of mental health, given the findings of this report and hardships potentially faced by caregivers.

The findings in this report are subject to at least four limitations. First, a diagnostic evaluation for anxiety disorder or depressive disorder was not conducted; however, clinically validated screening instruments were used to assess symptoms. Second, the trauma- and stressor-related symptoms assessed were common to multiple TSRDs, precluding distinction among them; however, the findings highlight the importance of including COVID-19–specific trauma measures to gain insights into peri- and posttraumatic impacts of the COVID-19 pandemic (*7*). Third, substance use behavior was self-reported; therefore, responses might be subject to recall, response, and social desirability biases. Finally, given that the web-based survey might not be fully representative of the United States population, findings might have limited generalizability. However, standardized quality and data inclusion screening procedures, including algorithmic analysis of click-through behavior, removal of duplicate responses and scrubbing methods for web-based panel quality were applied. Further the prevalence of symptoms of anxiety disorder and depressive disorder were largely consistent with findings from the Household Pulse Survey during June (*1*).

Markedly elevated prevalences of reported adverse mental and behavioral health conditions associated with the COVID-19 pandemic highlight the broad impact of the pandemic and the need to prevent and treat these conditions. Identification of populations at increased risk for psychological distress and unhealthy coping can inform policies to address health inequity, including increasing access to resources for clinical diagnoses and treatment options. Expanded use of telehealth, an effective means of delivering treatment for mental health conditions, including depression, substance use disorder, and suicidal ideation (*8*), might reduce COVID-19-related mental health consequences. Future studies should identify drivers of adverse mental and behavioral health during the COVID-19 pandemic and whether factors such as social isolation, absence of school structure, unemployment and other financial worries, and various forms of violence (e.g., physical,

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TABLE 2. (*Continued*) Comparison of symptoms of adverse mental health outcomes among all respondents who completed surveys (N = 5,470), by respondent characteristic* — United States, June 24–30, 2020

Characteristic	Prevalence ratio[¶] (95% CI[¶])			
	Symptoms of anxiety disorder or depressive disorder[†]	Symptoms of a TSRD related to COVID-19[§]	Started or increased substance use to cope with stress or emotions related to COVID-19	Serious consideration of suicide in past 30 days
Employment status				
Employed vs. unemployed	0.96 (0.87–1.07)	1.28 (1.12–1.46)**	2.30 (1.78–2.98)**	3.21 (2.31–4.47)**
Employed vs. retired	3.01 (2.58–3.51)**	2.84 (2.42–3.34)**	4.30 (3.28–5.63)**	5.97 (4.20–8.47)**
Unemployed vs. retired	3.12 (2.63–3.71)**	2.21 (1.82–2.69)**	1.87 (1.30–2.67)**	1.86 (1.16–2.96)
Essential vs. nonessential worker[§§]	1.42 (1.30–1.56)**	1.52 (1.38–1.69)**	2.36 (2.00–2.77)**	2.76 (2.29–3.33)**
Unpaid caregiver for adults vs. not[¶¶]	2.55 (2.37–2.75)**	2.63 (2.42–2.86)**	5.28 (4.59–6.07)**	8.64 (7.23–10.33)**
Rural vs. urban residence***	0.94 (0.82–1.07)	0.96 (0.83–1.11)	0.84 (0.67–1.06)	0.95 (0.74–1.22)
Knows someone with positive SARS-CoV-2 test result vs. not	0.95 (0.86–1.05)	0.78 (0.69–0.88)**	0.96 (0.81–1.14)	0.65 (0.52–0.81)**
Knew someone who died from COVID-19 vs. not	0.99 (0.85–1.15)	1.08 (0.92–1.26)	0.84 (0.64–1.11)	0.69 (0.49–0.97)
Receiving treatment for anxiety vs. not	2.43 (2.26–2.63)**	2.21 (2.01–2.43)**	2.27 (1.94–2.66)**	2.54 (2.13–3.03)**
Receiving treatment for depression vs. not	2.20 (2.03–2.39)**	1.88 (1.70–2.09)**	2.13 (1.81–2.51)**	2.35 (1.96–2.82)**
Receiving treatment for PTSD vs. not	2.75 (2.55–2.97)**	2.87 (2.61–3.16)**	3.78 (3.23–4.42)**	4.95 (4.21–5.83)**

Abbreviations: CI = confidence interval; COVID-19 = coronavirus disease 2019; PTSD = posttraumatic stress disorder; TSRD = trauma- or stress-related disorder.

* Number of respondents for characteristics: gender (female = 2,784, male = 2,676), age group in years (18–24 = 731; 25–44 = 1,911; 45–64 = 1,895; ≥65 = 933), race/ethnicity (non-Hispanic white = 3453, non-Hispanic black = 663, non-Hispanic Asian = 256, non-Hispanic other race or multiple races = 164, Hispanic = 885).

† Symptoms of anxiety disorder and depressive disorder were assessed via the four-item Patient Health Questionnaire (PHQ-4). Those who scored ≥3 out of 6 on the Generalized Anxiety Disorder (GAD-2) and Patient Health Questionnaire (PHQ-2) subscales were considered to have symptoms of these disorders.

§ Disorders classified as TSRDs in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM–5) include PTSD, acute stress disorder (ASD), and adjustment disorders (ADs), among others. Symptoms of a TSRD precipitated by the COVID-19 pandemic were assessed via the six-item Impact of Event Scale (IES-6) to screen for overlapping symptoms of PTSD, ASD, and ADs. For this survey, the COVID-19 pandemic was specified as the traumatic exposure to record peri- and posttraumatic symptoms associated with the range of stressors introduced by the COVID-19 pandemic. Persons who scored ≥1.75 out of 4 were considered to be symptomatic.

¶ Comparisons within subgroups were evaluated on weighted responses via Poisson regressions used to calculate a prevalence ratio, 95% CI, and p-value (not shown). Statistical significance was evaluated at a threshold of a = 0.005 to account for multiple comparisons. In the calculation of prevalence ratios for started or increased substance use, respondents who selected "Prefer not to answer" (n = 104) were excluded.

** P-value is statistically significant (p<0.005).

†† Respondents identified as a single race unless otherwise specified. The non-Hispanic, other race or multiple races category includes respondents who identified as not Hispanic and as more than one race or as American Indian or Alaska Native, Native Hawaiian or Pacific Islander, or 'Other'.

§§ Essential worker status was self-reported. The comparison was between employed respondents (n = 3,431) who identified as essential vs. nonessential. For this analysis, students who were not separately employed as essential workers were considered nonessential workers.

¶¶ Unpaid adult caregiver status was self-reported. The definition of an unpaid caregiver for adults was having provided unpaid care to a relative or friend aged ≥18 years to help them take care of themselves at any time in the last three months. Examples provided included helping with personal needs, household chores, health care tasks, managing a person's finances, taking them to a doctor's appointment, arranging for outside services, and visiting regularly to see how they are doing.

*** Rural-urban classification was determined by using self-reported ZIP codes according to the Federal Office of Rural Health Policy definition of rurality. https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html.

emotional, mental, or sexual abuse) serve as additional stressors. Community-level intervention and prevention efforts should include strengthening economic supports to reduce financial strain, addressing stress from experienced racial discrimination, promoting social connectedness, and supporting persons at risk for suicide (*9*). Communication strategies should focus on promotion of health services[§§§§,¶¶¶¶,*****] and culturally and linguistically tailored prevention messaging regarding practices to improve emotional well-being. Development and implementation of COVID-19–specific screening instruments for early identification of COVID-19–related TSRD symptoms would allow for early clinical interventions that might prevent progression from acute to chronic TSRDs. To reduce potential harms of increased substance use related to COVID-19, resources, including social support, comprehensive treatment options, and harm reduction services, are essential and should remain accessible. Periodic assessment of mental health, substance use, and suicidal ideation should evaluate the prevalence of psychological distress over time. Addressing mental health disparities and preparing support systems to mitigate mental health consequences as the pandemic evolves will continue to be needed urgently.

[§§§§] Disaster Distress Helpline (https://www.samhsa.gov/disaster-preparedness): 1-800-985-5990 (press 2 for Spanish), or text TalkWithUs for English or Hablanos for Spanish to 66746. Spanish speakers from Puerto Rico can text Hablanos to 1-787-339-2663.

[¶¶¶¶] Substance Abuse and Mental Health Services Administration National Helpline (also known as the Treatment Referral Routing Service) for persons and families facing mental disorders, substance use disorders, or both: https://www.samhsa.gov/find-help/national-helpline, 1-800-662-HELP, or TTY 1-800-487-4889.

[*****] National Suicide Prevention Lifeline (https://suicidepreventionlifeline.org/): 1-800-273-TALK for English, 1-888-628-9454 for Spanish, or Lifeline Crisis Chat (https://suicidepreventionlifeline.org/chat/).

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TABLE 3. Odds of incidence* of symptoms of adverse mental health, substance use to cope with stress or emotions related to COVID-19 pandemic, and suicidal ideation in the third survey wave, by essential worker status and unpaid adult caregiver status among respondents who completed monthly surveys from April through June (N = 1,497) — United States, April 2–8, May 5–12, and June 24–30, 2020

	Essential worker† vs. all other employment statuses (nonessential worker, unemployed, retired)				Unpaid caregiver for adults§ vs. not unpaid caregiver			
	Unadjusted		Adjusted¶		Unadjusted		Adjusted**	
Symptom or behavior	OR (95% CI)††	p-value††	OR (95% CI)††	p-value††	OR (95% CI)††	p-value††	OR (95% CI)††	p-value††
Symptoms of anxiety disorder§§	1.92 (1.29–2.87)	0.001	1.63 (0.99–2.69)	0.056	1.97 (1.25–3.11)	0.004	1.81 (1.14–2.87)	0.012
Symptoms of depressive disorder§§	1.49 (1.00–2.22)	0.052	1.13 (0.70–1.82)	0.606	2.29 (1.50–3.50)	<0.001	2.22 (1.45–3.41)	<0.001
Symptoms of anxiety disorder or depressive disorder§§	1.67 (1.14–2.46)	0.008	1.26 (0.79–2.00)	0.326	1.84 (1.19–2.85)	0.006	1.73 (1.11–2.70)	0.015
Symptoms of a TSRD related to COVID-19¶¶	1.55 (0.86–2.81)	0.146	1.27 (0.63–2.56)	0.512	1.88 (0.99–3.56)	0.054	1.79 (0.94–3.42)	0.076
Started or increased substance use to cope with stress or emotions related to COVID-19	2.36 (1.26–4.42)	0.007	2.04 (0.92–4.48)	0.078	3.51 (1.86–6.61)	<0.001	3.33 (1.75–6.31)	<0.001
Serious consideration of suicide in previous 30 days	0.93 (0.31–2.78)	0.895	0.53 (0.16–1.70)	0.285	3.00 (1.20–7.52)	0.019	3.03 (1.20–7.63)	0.019

Abbreviations: CI = confidence interval, COVID-19 = coronavirus disease 2019, OR = odds ratio, TSRD = trauma- and stressor-related disorder.

* For outcomes assessed via the four-item Patient Health Questionnaire (PHQ-4), odds of incidence were marked by the presence of symptoms during May 5–12 or June 24–30, 2020, after the absence of symptoms during April 2–8, 2020. Respondent pools for prospective analysis of odds of incidence (did not screen positive for symptoms during April 2–8): anxiety disorder (n = 1,236), depressive disorder (n = 1,301) and anxiety disorder or depressive disorder (n = 1,190). For symptoms of a TSRD precipitated by COVID-19, started or increased substance use to cope with stress or emotions related to COVID-19, and serious suicidal ideation in the previous 30 days, odds of incidence were marked by the presence of an outcome during June 24–30, 2020, after the absence of that outcome during May 5–12, 2020. Respondent pools for prospective analysis of odds of incidence (did not report symptoms or behavior during May 5–12): symptoms of a TSRD (n = 1,206), started or increased substance use (n = 1,408), and suicidal ideation (n = 1,456).

† Essential worker status was self-reported. For Table 3, essential worker status was determined by identification as an essential worker during the June 24–30 survey. Essential workers were compared with all other respondents, not just employed respondents (i.e., essential workers vs. all other employment statuses [nonessential worker, unemployed, and retired], not essential vs. nonessential workers).

§ Unpaid adult caregiver status was self-reported. The definition of an unpaid caregiver for adults was having provided unpaid care to a relative or friend 18 years or older to help them take care of themselves at any time in the last three months. Examples provided included helping with personal needs, household chores, health care tasks, managing a person's finances, taking them to a doctor's appointment, arranging for outside services, and visiting regularly to see how they are doing.

¶ Adjusted for gender, employment status, and unpaid adult caregiver status.

** Adjusted for gender, employment status, and essential worker status.

†† Respondents who completed surveys from all three waves (April, May, June) were eligible to be included in an unweighted longitudinal analysis. Comparisons within subgroups were evaluated via logit-linked binomial regressions used to calculate unadjusted and adjusted odds ratios, 95% confidence intervals, and p-values. Statistical significance was evaluated at a threshold of $\alpha = 0.05$. In the calculation of odds ratios for started or increased substance use, respondents who selected "Prefer not to answer" (n = 11) were excluded.

§§ Symptoms of anxiety disorder and depressive disorder were assessed via the PHQ-4. Those who scored ≥3 out of 6 on the two-item Generalized Anxiety Disorder (GAD-2) and two-item Patient Health Questionnaire (PHQ-2) subscales were considered symptomatic for each disorder, respectively.

¶¶ Disorders classified as TSRDs in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) include posttraumatic stress disorder (PTSD), acute stress disorder (ASD), and adjustment disorders (ADs), among others. Symptoms of a TSRD precipitated by the COVID-19 pandemic were assessed via the six-item Impact of Event Scale (IES-6) to screen for overlapping symptoms of PTSD, ASD, and ADs. For this survey, the COVID-19 pandemic was specified as the traumatic exposure to record peri- and posttraumatic symptoms associated with the range of potential stressors introduced by the COVID-19 pandemic. Those who scored ≥1.75 out of 4 were considered symptomatic.

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Summary

What is already known about this topic?

Communities have faced mental health challenges related to COVID-19–associated morbidity, mortality, and mitigation activities.

What is added by this report?

During June 24–30, 2020, U.S. adults reported considerably elevated adverse mental health conditions associated with COVID-19. Younger adults, racial/ethnic minorities, essential workers, and unpaid adult caregivers reported having experienced disproportionately worse mental health outcomes, increased substance use, and elevated suicidal ideation.

What are the implications for public health practice?

The public health response to the COVID-19 pandemic should increase intervention and prevention efforts to address associated mental health conditions. Community-level efforts, including health communication strategies, should prioritize young adults, racial/ethnic minorities, essential workers, and unpaid adult caregivers.

administration of the survey in June. No other potential conflicts of interest were disclosed.

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NACBHDD National Association of County Behavioral Health & Developmental Disability Directors
The voice of local authorities in the nation's capital

National Association of County Behavioral Health and Developmental Disability Directors

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NEWSLETTER

AUGUST 24, 2020

IMMEDIATE ACTION: CONTACT YOUR REPRESENTATIVE AND SENATORS

Neither the House nor the Senate technically has adjourned for the traditional August recess. Rather, members are subject to recall by House and Senate leadership, primarily to respond to the growing crisis around the Postal Service and mail-in/absentee voting and, as critically, to consider the now stalemated COVID-19 stimulus measure.

We must now step up our advocacy on both of these issues. Postal Service slowdowns aren't just about the election; the slowdown also affects the health of individuals who depend on mail-order prescription medication for behavioral disorders and other chronic conditions. A new, robust stimulus bill can give hope to millions whose health and livelihoods have been upended by the pandemic. A new, robust stimulus bill with funding to hard-pressed counties can help preserve the social, economic and healthcare safety net programs counties provide to millions. Let's step up and take action now. Taking action changes minds, particularly in an election cycle.

COVID-19: WHERE WE STAND TODAY; WHAT'S NEXT.

As we write, worldwide cases of COVID-19 total nearly 23 million, with over 800,000 deaths. In the US, the global coronavirus hotspot, 5,626,284 million cases have been reported; deaths have reached 175,429 souls. Because US testing remains limited and results delayed, the CDC estimates the actual number of US cases to be 23 million or more.

THE BEHAVIORAL HEALTH IMPACT. Beyond the mortality of the COVID-19 pandemic, it also has had a pernicious effect on behavioral health. Each of us has been confronted not only by the threat of a lethal, new viral disease, but also by the isolation resulting from stay-at-home orders, social distancing and reduced access to community resources. Not surprisingly, according to the CDC's new survey, *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic, US, June 24-30, 2020,* symptoms of anxiety and depressive disorders increased considerably in the US from April through June 2020 compared with the same period in 2019. Over 40% of those surveyed said they experienced a mental or behavioral health condition connected to the COVID-19 emergency. Young adults, Black and Hispanic people, essential workers and adult caregivers reported worse mental health outcomes, increased substance abuse or suicidal thoughts over the past year. The number of Americans reporting anxiety symptoms is 3 times the number at the same time last year. Over the same year, suicidal ideation has risen among young people; as many as 1 in 4 of those ages 18 through 24 seriously considered suicide in the prior 30 days. Eleven percent of

ALSO IN THIS ISSUE

Teddi Fine, MA, Editor

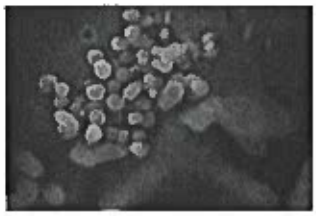
adults had seriously considered suicide in the past 30 days. The numbers were worse among people identifying as Black or Hispanic: 19% of Hispanics reported suicidal ideation and 15% of Blacks reported suicidal thoughts.

Concomitant with a growing need for services, behavioral health services themselves are becoming increasingly scarce at the community level, as the pandemic forces counties and states to cut services and supports to the bone. As a result, millions of people—among them many who we serve—are caught up short, caught without medical treatment and medications, without stable housing and employment, without help or hope. To make matters worse, many of the lifelines provided to millions of Americans under the March CARES act are about to expire or have already expired.

NEEDED HELP ISN'T COMING...YET. As the situation for millions in the US continues to spiral downward in both health and economic terms, the HEROES Act, the critically needed further stimulus package passed by the House over two months ago, remains stalled in the Senate. The $600 federal add-on to state unemployment benefits has expired. Rent and foreclosure forgiveness has lapsed and PPP funds remain elusive for many mom-and-pop businesses, from storefront shops to artists' studios. We have experienced weeks of stalemate during which Democratic House and Senate leaders have offered multiple compromises; each was rejected by the White House, sometimes without actually hearing the offer. In the meantime, Senate Majority Leader McConnell sat on the sidelines, playing no part in the negotiations.

That gave the President an opportunity to appear to play the hero. On August 8, after disregarding the HEROES Act and excoriating House and Senate Democrats for inaction, he signed an Executive Order and three memoranda designed to provide assistance for those adversely affected by the COVID-19 pandemic. While nice words, these executive actions so far have had little impact on those most in need of help

- √ The EO intended to prevent *rental evictions and mortgage foreclosures* doesn't extend the federal eviction moratorium that expired at the end of July. It simply directs federal agencies to examine resources that could be used to provide assistance for renters and homeowners—that's no assistance at all.
- √ One memorandum *cuts the $600 weekly federal unemployment insurance add-on to $400*, of which the federal government would pay $300. To make the federal payment, the Administration would redirect up to $44 billion (of the $70 billion available) from the FEMA disaster relief fund. States would be required to provide the remaining $100 per beneficiary each week as a match for the federal FEMA funds. So not only would States have to find the funds to cover the so-called match, but also they would need to create a new mechanism to disseminate these funds, something done by the federal government under the CARES act.



- √ Another memorandum directs the Secretary of the Treasury to *defer federal payroll taxes* for those earning less than roughly $100,000 beginning September 1, through December 31, 2020. The deferment only applies to the employee share normally collected and submitted by employers; the President says that, if reelected, he will forgive the deferred taxes. BUT remember, these payroll taxes are paid into the Social Security and Medicare trust funds on which *current* eligible individuals often depend, trust funds that need these tax dollars now more than ever before.
- √ The last memorandum, focused on student loan relief, directs the Secretary of Education to extend student loan repayment relief on loans held by the Department until December 31, 2020, just 3 months longer than in the CARES Act. This notwithstanding the fact that many schools will not be convening with on-campus education for the rest of the year, Moreover, This memorandum does not address student loan debt held by private lenders.

While these actions sound good, they are more word than deed. Some question whether reprogramming funds in this manner is legal. As we point out above, the memoranda and EO primarily move dollars from one funding silo to another, shortchanging both and imposing added costs on already overburdened and underfunded state and county coffers. They shift FEMA dollars at the height of more dangerous than ever hurricane and fire seasons. They waive Social Security and Medicare payroll taxes, harming the solvency of the trust funds at a critical moment in time.

Critically, too, none of these actions recognize or respond to the fiscal hardships faced by counties and states whose governments have had to absorb the lost income and vast majority of human and economic costs associated with the pandemic. Other items that lawmakers and the White House have considered including coronavirus relief legislation were not addressed in Trump's orders, among them, more funding for the Paycheck Protection Program, funding for schools and additional money for coronavirus testing.

As we go to press, behind the scenes negotiations appear to be continuing. Speaker Pelosi has made yet another offer: to cut the HEROES bill costs in half, from $3 trillion to $1.5 trillion as a short-term response through the end of 2020. The chasm between the sides remains steep. The White house continues to reject funding for states and counties; continues to insist on his payroll tax vacation; and wants to zero out funds for COVID-19 testing, contact tracing, and vaccine development.

TIME TO ACT. Whatever the outcome of the legislative package, now caught up in both election-year politics and battling Republican and Democratic policy, it likely will be the last major coronavirus relief legislation that Congress will consider before the November election. We can only hope the final version of this legislation emphasizes the social and economic wellbeing of millions of Americans rather than crass, political gameplay.

We can waste no time. We must convince Congress do no less than what is required to meet the social, health and services crisis caused by COVID-19. We must convince Congress of the full scope and range of funding, programs and policies demanded by smart public policy and real human need. We can't stop pressing our legislators in Washington, DC, to include the critically needed funding for states and counties to stand up key resources for their populations. We can't stop pressing our legislators to extend the waivers and policy changes that make health coverage—including coverage for behavioral health issues—available to those struggling without employment and without health care. It is time indeed for us to "make good trouble." It is time for us to help build back and unify in the battle against COVID-19 and it effects, rather than engage in magical thinking. It is time for us to step up because, indeed, our actions may spell the difference between life and death for millions around our country.

Full report can be found at: https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm

BITS FROM DC

Dear Colleagues:

I am very pleased to report that our virtual NACBHDD Summer Board Meeting events held on July 20-22 were very successful. Many members participated and the content was excellent. A special thanks to all who spoke at these events and to those members who joined us.

We are in the early steps of beginning to prepare for our NACBHDD Fall Board Meeting. This will be a more traditional Board Meeting, and it will be conducted virtually. Because it will be a virtual event, those who are not Board members also will have the opportunity to participate. I will be sending a calendar invite for this event within the next few weeks.

It also is not too early to begin thinking about our 2021 NACBHDD Legislative and Policy Conference. Initial planning suggests that this will be a virtual event, and that it will be timed to coincide with the NACo Legislative Conference. Thus, our Spring Board Meeting and Conference likely will be held on or about February 22-24.

I hope that you and your family are safe, healthy, and together at this difficult time. I also hope that you are able to enjoy the waning days of summer, even if you are doing a stay-cation.

Ron Manderscheid, PhD
Executive Director, NACBHDD and NARMH

FEDERAL PROVIDER RELIEF FUND OPPORTUNITY OPENS AGAIN

HHS has opened up a second opportunity for Medicare, Medicaid and CHIP service providers who didn't receive an initial payment under Phase 1 of the Provider Relief Fund for a variety of reasons to apply for funding. Eligible providers could receive funding of up to 2% of their reported total patient care revenue. In addition, certain providers who experienced a change in ownership, making them previously ineligible for Phase 1 funding, are also eligible to apply for financial relief. **Starting August 10th, eligible providers may submit their applications for possible funds by August 28, 2020.** Applications and details about who may apply and how to apply are found at: https://cares.linkhealth.com/

NEWS AND NOTES

- **SCOTUS and the ACA.** The US Supreme Court will hear arguments on the Administration-backed lawsuit (Texas v. HHS) to strike down the Affordable Care Act on November 10, 2020, a week following the election. Nonetheless, healthcare remains a significant campaign issue, particularly during the COVID-19 crisis. The Court will not render a decision until sometime in the spring.
- **NEW CCBHCS CHOSEN.** CMS and SAMHSA have selected *Kentucky* and *Michigan* as the latest participants in the Certified Community Behavioral Health Clinic (CCBHC) demonstration program. Initially created under the Protecting Access to Medicare act of 2014, the demonstration CCBHC program has been extended several times. Since it began, the program has focused on integrating behavioral health with physical health care, increasing consistent use of evidence-based practices, and improving access to high quality care for people with mental health and substance use disorders. Kentucky and Michigan join the original 8 programs (MN, MO, NY, NJ, NV,OK, OR, and PA).
- **CORRECTIONS AND MEDICAID.** NACBHDD has joined 125 organizations in a letter to the House and Senate leaders urging Congress to include the substance of the bipartisan *Medicaid Reentry Act* in the COVID-19 response package now being negotiated. This bill would make essential Medicaid-supported health care during 30 days before release and upon reentry for individuals incarcerated in jails and prisons. Such coverage would help ensure more coordinated care for people in correctional settings and for those reentering the community. Access to and coordination of physical, mental health and substance use disorder care is especially important during this pandemic. Providing Medicaid coverage pre-release can help reduce later hospitalizations, use of emergency departments, and other medical expenses upon reentry, resulting in lower health care costs.
- **ONDCP'S LOSS IS PURDUE'S GAIN.** After a number of years working on rural health issues at the federal level, Anne Hazlett, who we know best as ONDCP's senior advisor for rural affairs, has headed back home again to Indiana. She will take her significant knowledge of things rural, behavioral health and advocacy to her new position as senior director of government relations and public affairs for Purdue University. We wish her the best of luck in these new endeavors.
- **GEORGIA ON MY MIND.** Georgia Democrats on Monday chose *Nikema Williams*, a state senator and chairwoman of the state party, to replace the late congressman John Lewis (D) on the November ballot. Lewis won the June primary for the 5th Congressional District seat in his bid for an 18th term. Under state law, the Georgia Democratic Party was required to choose a replacement on the first business day following a nominee's death.

- **HELP COUNT OUR NATION'S NOSES.** The US Census Bureau abruptly said it will stop this decade's data collection and self-response on September 30. The census is the linchpin on which federal funding for social programs as well as political representation is based. Counties could gain or lose billions based on a census over- or undercount. We must step up to help get an accurate count for our own communities. Learn about and share innovative strategies to ensure a complete count during a pandemic at: naco.org/census-2020.
- **ADMINISTRATION COMINGS AND GOINGS.** Two senior Administration political appointees have left CDC. Both *Kyle McGowan*, the first politically appointed chief-of-staff, and *Amanda Campbell*, the deputy chief-of-staff, resigned to start a consulting firm. They had been criticized by the White House for not being sufficiently loyal. After over a year, *Russ Vought* was confirmed by the Senate to head the Office of Management and Budget, but not without controversy. He defied a congressional subpoena after refusing to answer questions about freezing hundreds of millions of dollars in military aid to Ukraine.
- **NEW COVID-19 RESOURCE CENTER.** The Network of Care serves behavioral health communities nationwide, providing advanced online solutions for behavioral-health information; helping consumers better engage in their own health and wellbeing; supporting frontline workers; and assisting administrators and officials to advance their programs and initiatives. The coronavirus pandemic has amplified need to ensure our communities have access to crisis information, telehealth, support groups and information to help stay healthy. Thus, in partnership with the Network of Care, NACBHDD wants to let you know of a locally customized, no-cost online *Coronavirus (COVID-19) Resource Center*. A sample version of the page is at: https://alameda.nocbeta.org/mh/coronavirus/ . To use the Resource Center, contact Pam Frank with Network of Care at pam@trilogyir.com or (415) 257-2407.

AT THE WHITE HOUSE

Because our lead story discusses the 4 orders the President signed as a response to the current stalemate over the next stimulus bill, we don't discuss it here. However, other executive orders were signed that could have an impact on the work we do and the people we serve.

- **TELEHEALTH.** An August 3 Executive Order outlined 4 policy proposals to enhance rural healthcare services: (1) continuing current temporary COVID-19 related telehealth flexibilities; (2) creating new Medicare payment models for rural hospitals; (3) investing in rural telehealth infrastructure; and (4) reducing regulatory burdens for rural healthcare providers. In and of itself, the EO simply is a list of items for HHS (and the Department of Agriculture) to undertake within 30 days (items 2-4). Within 60 days, HHS is directed to review emergency telehealth flexibilities and to "propose a regulation to extend these measures, *as appropriate*," beyond the public health emergency. The EO does not mention anything about extending audio-only telehealth, a critical need for many rural residents who do not have broadband access. The majority of the changes require action by the House and Senate. Any other Administration would be collaborating with Hill leadership to that end.
- **DRUG PRICING.** As we go to press, only 3 of 4 drug pricing Executive Orders issued in late July have been published in the Federal Register. Those EOs allow certain drugs to be imported from Canada and change how pharmacy benefit manager-negotiated discounts are passed on to Medicare patients. The fourth and most controversial order, *Lowering Drug Prices by Putting American First,* would require Medicare to pay the same price for medications received in the hospital under Medicare Part B as are paid by other countries. The status of this unpublished EO remains unclear, though when first announced, the President said it would go into effect on August 25, absent a "deal" with pharmaceutical companies. Is the EO is being used as a cudgel? Stay tuned.

HILL HAPPENINGS

Neither the House nor the Senate technically has adjourned for the traditional August recess that, this year, includes the Democratic and Republican conventions. On August 13, the Senate was dismissed from Washington, subject to the call of the Majority Leader McConnell, until sometime in September. House Speaker Nancy Pelosi has already called the House back due to the Postal Service crisis related to the upcoming election. However, floor votes aren't on the current docket until September 14, UNLESS there is a hoped-for breakthrough on the stimulus bill.

- **APPROPRIATIONS 2021 MOVING AHEAD.** Late last month by a 224-189 vote, the House approved a $259.5 billion package of FY 2021 funding for foreign operations; agriculture; interior and environment; and military construction and veterans' affairs. The bill includes over $1 billion to expand rural broadband, funds a slew of nutritional assistance programs and would give the Federal Drug Administration mandatory recall authority for prescription and over-the-counter drugs. The very next week, in a 217-197 vote, the same body approved a $1.3 trillion FY 2021 appropriations package, spanning the departments of defense; labor, health and human services, and education; commerce, justice and science; energy and water; financial services and general government; and transportation and housing and urban development. HHS appropriations included a total of $96.4 billion, including significant spending on COVID-19-related issues. It also includes $6 billion for SAMHSA programs (over $100 million more than the previous fiscal year); $8 billion for the CDC; an increase of over 40% in funding for the loan repayment program for HRSA's Substance Use Disorder Treatment Workforce Program. The House has now approved all but two spending bills (homeland security and the legislative branch). In contrast, the Senate Appropriations Committee has not released a single spending bill for 2021. As a result, Congress is likely to approve yet another stopgap measure to keep the government funded and prevent a shutdown before the November elections. The election results may determine whether the spending bills progress or are tossed aside until next year, when different actors may be in charge of the Senate and White House.
- **MOVEMENT ON VETERANS' BEHAVIORAL HEALTH.** By voice vote, the Senate has adopted the Commander Jojjnm Scott Hannon Veterans Mental Healthcare Improvement Act (S 785). While initially Introduced by Senator John Tester (D-MT), the full Senate actually adopted a "substitute" measure offered by the Veterans Affairs Committee Chair, Senator Jerry Moran (R-KS). It aims to improve the quality of mental health care provided by the VA. The bill would provide about $174 million over 5 years for VA mental health care services, including a grant program for local organizations that work to assist veterans. The measure also would expand care to veterans with other-than-honorable discharges; help with transitions from military to civilian life; and place greater emphasis on suicide prevention. Whether the House has the time to consider ways to reconcile this measure with one already adopted by the House during the few legislative days remaining remains to be seen.
- **SUPPORTING FOSTER YOUTH**. The Chair and ranking member of the House Ways and Means Subcommittee on Worker and Family Support, Representatives Danny Davis (D-IL.) and Jackie Walorski (R-IN.), have introduced a proposal to support the child welfare system as the COVID-19 pandemic continues. The *Supporting Foster Youth and Families through the Pandemic Act* (HR 7947) would increase funding and create temporary flexibilities for programs targeting older foster youth, child abuse prevention, and kinship care providers. To that end, the measure would authorize a $400 million increase for programs supporting older foster youth, temporarily increasing the eligibility age to 26. The bill would require states to allow youth who would "age out" of foster care during the pandemic to remain in care and to ease education and work requirements for them to do so. The legislation also provides more options and an additional $75 million in funding for states and counties to provide services that support family preservation, family reunification, adoption, and other supportive services.
- **SCHOOLS AND BEHAVIORAL SUPPORTS.** The *Strengthening Behavioral Health Supports for Schools Act* (HR 7859), introduced by Representative Tony Cardenas (D-CA), would authorize annual funding of $25 million through FY 2025 for SAMHSA to operate a technical assistance and training center to provide schools and school systems with mental health and substance use disorder support and services for students during the COVID-19 pandemic and beyond. Original cosponsors of the bill include Earl Leroy "Buddy" Carter (R-GA), Joe Kennedy III (D-MA), Brian Fitzpatrick (R-PA), Grace Napolitano (D-CA), Gus Bilirakis (R-FL), David Trone (D-MD), and John Joyce, MD (R-PA).

OVER THE FENCE: IT'S A SMALL WORLD

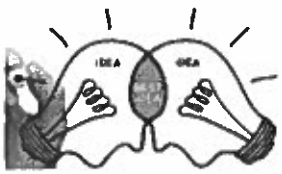
DAVID WEDEN, NARMH PRESIDENT
INTEGRAL CARE, AUSTIN, TX

As we see the headlines over the past months, we see similar struggles with COVID-19 and dealing with the health, mental health and economic impact throughout all the countries of the world. The similarity in our situations shines light on the fact that we are all facing the same struggles and challenges and should pause to learn from each other on best practices in order to advance the overall care for individuals with mental and behavioral health issues.

On August 17th, the National Association for Rural Mental Health (NARMH) hosted a webinar featuring Fran Silvestri, President and CEO of the International Initiative for Mental Health Leadership (IIMHL) and International Initiative for Disability Leadership (IIDL). The IIMHL is focused on exchange of information and best practices learned by other organizations and having organizations with similar interest share what has and has not worked in order to help advance the overall system of care. One of the methods utilized by IIMHL is the I-Circle which is established based on the following principles:

1. **Change the culture**
   - 1.1 Make mental health everyone's business
   - 1.2 Promote environments that support and respect resilience, recovery, self-determination and mutual aid
   - 1.3 Attend to the needs of all, but maintain our collective commitment especially to those most vulnerable and excluded
2. **Use data better**
   - 2.1 Build new ways to get the kind of information needed for a public health approach
   - 2.2 Share and use information to drive improvement, equity, and change
3. **Act early**
   - 3.1 Invest in prevention and reach people early
   - 3.2 Equip people with what they need to promote their mental health
   - 3.3 Pay close attention to early childhood and support new parents
4. **Close treatment gaps**
   - 4.1 Close gaps in access, quality, equity, cultural competence, and the impact of treatment on population health and prevention
   - 4.2 Multiply options for getting care with workforce and information innovation
   - 4.3 Support person-centered, holistic care
   - 4.4 Enhance treatment quality and value
5. **Partner with communities**
   - 5.1 Build on and foster personal, family and community assets for communities and workplace to be sources of mental health and resources for those with mental illness
   - 5.2 Equip communities to be their own problem solvers and innovators of solutions
   - 5.3 Address individual and collective trauma and its structural root causes
6. **Position government to lead**
   - 6.1 Be transparent
   - 6.2 Create opportunities to lead and coordinate scaled action for mental health
   - 6.3 Change structures to involve all of government and mental health in all policies
   - 6.4 Advocate for public policies and actions that promote and protect mental health and wellbeing
   - 6.5 Engage media, including social marketing and social media
   - 6.6 Innovate! Evaluate! Share! Create HOPE!

The I-CIRCLEs promote these principles in collaborative work and assist engaged cities across the globe in incorporating them into their own public health approach to mental health, while building a growing network.



While this model has been utilized very effectively by IIMHL in urban areas, an initiative is beginning to apply the same principles in rural areas, bringing sharing of knowledge and practices regarding rural mental health care across continents and the world to your hometown. In the initial phases of incorporating rural communities, we are currently looking for rural mental health providers who have interest in topics such as crisis services, addressing social determinants of health, food deserts, racial equity, youth suicide, and any other topic impacting mental health care for individuals in rural areas. We will then work to connect you with one or more international communities with interest in similar areas so best practices can be discussed and models may be seen in an effort to advance rural mental health care. Ideally the sharing of information would be at each site so each could share their models in action, but with the pandemic, we can take initial steps to connect via video and begin the process and building of the relationships. If you are interested in being paired with other entities, please email either Ron Manderscheid, rmanderscheid@nacbhd.org, or myself, david.weden@integralcare.org, with contact information and focus areas of interest. If you would like more information on IIMHL, please visit https://www.iimhl.com/

Take collaboration to the next level by sharing thoughts and ideas with other rural communities across the globe.

SOCIAL DETERMINANTS OF HEALTH AND THE INTERSECTION OF COVID: A WEBINAR

LINDA NAKAGAWA, POLICY ANALYST
MEDISKED

MedSked is thrilled to join NACBHDD as a Silver Partner and to join in offering a special training opportunity for NACBHDD members. To that end, please join us on **Wednesday, September 23, 2020, from 3:00-4:00 pm, EDT,** for the webinar, *Level Up: Using Data to Improve Social Determinants of Health Before, During, and After COVID-19*. Social determinants of health (SDoH) are conditions in a person's life that directly impact their holistic outcomes. The services you deliver and methods for service delivery have a large capacity to directly impact a person's SDoH - with that comes great responsibility. During the current age of COVID-19, SDoH become even more critical since we know that factors like where people live, relationships, and health conditions can affect a person's vulnerability and recovery from the disease. This session provides a case study from Partners Health Plan, a provider-led managed care organization for individuals with developmental disabilities whose coverage area is in the heart of the original outbreak in New York City, that utilizes many techniques, including telehealth, and data to identify opportunities to improve SDoH and increase quality and outcomes. Session presenters include JoAnn Lamphere, Dr. P.H., Former Deputy Commissioner, Person Centered Supports, New York State Office of People with Developmental Disabilities; Karleen Haines, Chief of Care Coordination, Partners Health Plan; and Doug Golub, President, MediSked.

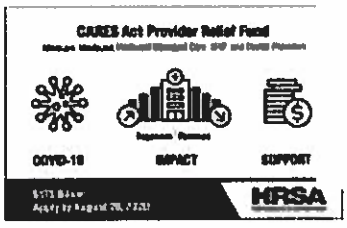
Since 2003, MediSked has been a technology partner to human services organizations nationwide that improves lives, drives efficiencies and generates innovations for the human services organizations that support our community. MediSked offers a full-featured software ecosystem of platforms specific to the HCBS industry, including I/DD, behavioral health, aging and other LTSS focus to support providers, state and county oversight agencies, care coordination entities, and payers to use data to streamline processes, reduce costs, and improve care.

AROUND THE DEPARTMENTS AND AGENCIES

- **MEDICARE TELEHEALTH EXPANSION PROPOSED.** In its draft 2021 Physician Fee Schedule rule, CMS includes provisions to permanently extend elements of telehealth flexibilities temporarily set in place during the COVID-19 pandemic. The proposed rule was issued concurrent with a telehealth Presidential Executive Order, noted earlier in this Newsletter. Some of the telehealth services added to the payment roster during the pandemic emergency would be made permanent, including home visits for patient evaluation and management, and certain visits for patients with cognitive impairments. To that end, 9 new telehealth billing codes have been added, among them: 99347 and 99348 (Home Visits), 99483 (Care Planning for Patients with Cognitive Impairment), 96121 (Neurobehavioral Status Exam), 90853 (Group Psychotherapy), 99XXX (Prolonged Services) and GPC1X (Visit Complexity Associated with Certain Office/Outpatient E/Ms). *CMS hopes the public will suggest other services to permanently add to the telehealth list beyond the public health emergency.* The draft rule also would temporarily extend payment for other telehealth services, such as emergency department visits, through the calendar year in which the emergency ends. It includes provisions that grant clinician reimbursement for time spent with patients, particularly for patient evaluation and management. *Public comments are due by October 5, 2020.* Read about the proposed rule at: telehealth and physician fee schedule draft rule . Be aware, however, some telehealth coverage changes require new legislation. As described over the year in this Newsletter, some measures are already under consideration in the House and Senate, but, caveat emptor, the Republican-touted telehealth provisions in its stimulus package [HEALS Act] only continue broadened Medicare telehealth coverage through the end of 2021and extend telehealth flexibilities for FQHCs and rural health centers for 5 years.

HHS.gov
U.S. Department of Health & Human Services

- **PROVIDER RELIEF FUND APPLICATION DEADLINE EXTENDED.** HHS has extended the application deadline for a second "General Distribution" under the COVID-19-related Provider Relief Fund *to Friday, August 28, 2020*, for providers under Medicaid, Medicaid managed care, and the Children's Health Insurance Program (CHIP). Phase 2 of the General Distribution provides funding of up to 2% of reported revenue from patient care for providers participating in state Medicaid and CHIP programs who did not receive funding in the Phase 1. The initial July 20, 2020, deadline was extended to August 3, 2020, and now is extended to August 28, 2020, to apply. HHS also is providing a more simplified application form in response to ongoing



dialogue focused on improving the provider experience. Further, HHS is working to make relief payments available to providers who joined the programs in 2020 along with those who have yet to receive any funding for a variety of reasons. Stay tuned for future announcements from CMS. For updated information and data on the Provider Relief Fund, visit: hhs.gov/providerrelief.

- **MORE ABOUT REVISED SUD CONFIDENTIALITY RULE.** SAMHSA issued a final rule updating the confidentiality requirements for substance use disorder (SUD) patient records under 42 C.F.R. Part 2, with an effective date of August 14, 2020. The final rule aims to improve care coordination by more closely aligning Part 2 with the HIPAA privacy rule, while maintaining certain privacy protections specific to Part 2. The revisions maintain the basic framework for SUD patient record confidentiality protection and maintain the restriction on disclosure of SUD treatment records without patient consent, with a few specific exceptions (e.g., court order, medical emergency, research, audit, program evaluation). *All of the regulatory changes are temporary*. The CARES Act, enacted into law in March, modifies the authorizing statute underlying Part 2. HHS must write a new proposed rule that is consistent with the CARES Act. The current regulations will serve as transitional standards. A SAMHSA fact sheet explains these now-interim changes to Part 2. Check out the fact sheet at: Health Privacy Rule 42 CFR Part 2 Is Revised .
- **PREMIUM REDUCTION OPTION OFFERED.** In response to the COVID-19 crisis, through the end of 2020, HealthCare.gov insurers may offer temporary premium reductions for individuals who are covered in the individual and small group markets. CMS says the aim is to help consumers struggling to pay their premiums. However, the communique to insurers is strictly *optional*, not required. It lifts the requirement that otherwise prohibits insurers from changing premiums offered in those markets after the start of the year. Insurers need not drop premiums; it is unclear if they actually could raise them under the same relaxed requirement. Read the guidance at: Premium reduction option .
- **PSYCHIATRIC HOSPITAL PAYMENTS RULE.** A final CMS rule bearing on Medicare payments for services in inpatient psychiatric facilities adopts both a 2.2% payment rate update and revised OMB statistical area delineations with wage index values more representative of the actual regional costs of labor. The rule also allows advanced practice providers (physician assistants, nurse practitioners, psychologists, and clinical nurse specialists) to operate within the scope of practice allowed by state law by documenting progress notes in the medical record of patients in psychiatric hospitals, for whom they are responsible. Read about the rule at – https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2021-final-medicare-payment-and-policy-changes-inpatient-psychiatric-facilities-cms-1731
- **RURAL HEALTH IMPROVEMENT.** CMS has a new funding opportunity to increase access to and improve the quality of care in rural America through the *Community Health Access and Rural Transformation* (CHART) Model. According to CMS, the model enables communities to develop a system of care to deliver high quality care to patients by providing support through new seed funding and payment structures, operational and regulatory flexibilities and technical and learning support. Further, the model ties payment to value, increases choice and lowers costs for patients. Providers can apply to participate in one of two CHART options
  - √ *Community Transformation Track* ($75 million in seed money) will allow up to 15 communities to implement care delivery reform, provide capitated payments, and offer other flexibilities (e.g., telehealth). In September, CMS will select the communities to participate in this track. Winners will be announced in early 2021; the model will begin in Summer 2021.
  - √ *Accountable Care Organization (ACO) Transformation Track* builds on the ACO Investment Model. Providers will enter into 2-sided risk arrangements as part of the Medicare Shared Savings Program (MSSP) and may use all waivers available in the MSSP program. CMS anticipates a Request for Applications in the Spring 2021 and selection of up to 20 rural ACOs to participate in this track starting in January 2022.

  For more information, visit: https://innovation.cms.gov/initiatives/chart-model/
- **GETTING DOWN TO GET A GRANT.** SAMHSA's Office of Financial Resources is conducting a webinar on how to develop a competitive grant application. It will address: (a) four registration processes that need to be completed; (b) preparing to apply for a grant; (c) key components of the grant announcement; (d) responding effectively to evaluation criteria; and (e) available resources and technical assistance. *The webinar will be offered on August 27, September 17, and October 22 at 2 pm (ET).* Learn more at: https://www.samhsa.gov/grants/grants-training-materials
- **RURAL HEALTH SERVICE GRANT OPPORTUNITY.** The Health Resources and Services Administration (HRSA) is making grants available under the Rural Network Development Planning Program to bring together key parts of a rural health delivery system, including entities that may not have collaborated in the past, to establish or improve an integrated health care network. Approximately $2 million will be available to support up to 20 grants. Applications

are due by November 16, 2020. For more information, go to: https://www.grants.gov/web/grants/search-grants.html?keywords=HRSA-21-021%20%20

- **THROWING DOWN THE GAUNTLET.** A challenge competition by Agency for Healthcare Research and Quality (AHRQ) will amplify current innovative programs that rural communities are implementing to address challenges to postpartum mental health diagnosis and treatment, and to elicit new solutions. AHRQ is interested both in success stories that highlight community achievements and new program proposals that demonstrate innovative planning for community action to improve postpartum mental health. A broad range of organizations that serve rural communities are eligible to submit proposals that highlight successful or promising programmatic interventions to improve rural postpartum mental health. AHRQ plans to share the information with rural communities, healthcare systems, healthcare professionals, local and state policy makers, federal partners, and the public. Submissions, which are due in September, must be in one of two categories: success stories and proposals. For more information, go to:*AHRQ Cross-Sectional Innovation to Improve Rural Postpartum Mental Health Challenge* website.

TAKING STOCK OF COVID-FUELED TRENDS THAT ARE SHAPING BEHAVIORAL HEALTH

RONALD MANDERSCHEID, PHD

Reprinted with permission, from Behavioral Healthcare at: COVID and behavioral health trends

As mid-summer rapidly approaches, it is important to take stock of where behavioral healthcare currently stands on our COVID-19 response, as well as how the field is likely to change during the next several months.

The current context is quite relevant. The early summer rush to "reopen" now is bearing fruit in terms of COVID-19 spikes in a majority of states, especially those that did not fully embrace social distancing or mask use. This has necessitated step-backs by governors, including mandated mask use, virtual school openings in the fall, and re-closure of restaurants and bars. Clearly, these developments have major implications for behavioral healthcare.

It also is very clear that COVID-19 and related abatement procedures have had a very significant impact upon the psychological health of all Americans. Stress, anxiety, depression and outreach for behavioral health services have all increased during the past three months. These trends also can be expected to continue and even accelerate in succeeding months.

Here are a few key areas where related developments are occurring in behavioral healthcare:

In-person reopening. Many behavioral healthcare entities are on the cusp of reopening their in-person practices. Pressure to do so comes from the recognition that some persons with more severe behavioral health disorders are doing more poorly in virtual care. A second factor is revenue; many of our providers have experienced significant revenue reductions with the conversion to virtual care. Overall, that loss may be as much as one-quarter since the end of March.

Primary consideration in reopening ought to be given to the current status of the pandemic in the surrounding community. Almost as important are the fall opening plans of local school systems, as they juggle virtuality against in-person classes. The activities of the schools are a very good bellwether regarding the safety of in-person operations in the local area.

Insurance dynamics. The dramatic dislocations in the labor force related to business closures as a result of the pandemic are now beginning to cause major changes in health insurance coverage. Of specific interest to behavioral healthcare, the Medicaid program is growing rapidly. These new enrollees can be expected to have a very different understanding of care access and acceptability. Further, they will have very little knowledge of how the public behavioral healthcare system actually operates.

It will be important to monitor these insurance dynamics in the local community. States will have a vested interest in reducing Medicaid benefits or provider reimbursements as the rolls continue to row. Further, better outreach likely will be required to help new enrollees understand the importance of behavioral healthcare and how to access it. The stress of the pandemic, coupled with stay-at-home orders and increased social isolation and loneliness, has led many persons to develop new cases of behavioral healthcare conditions not present earlier.

Staff turnover. The pandemic has accentuated human resource trends and problems already present six months to one year ago. These include retirement of the baby boomers, accession of the Gen Xers into leadership positions, and continuing churn of the millennials. The net result is that it now is more difficult to hire. Fewer candidates are willing to leave their current positions; many have fear of exposure to the virus; and, in some local areas, no candidates are available.

Factors to consider in recruiting include promotion from within, especially based upon performance in the COVID-19 period, job sharing of staff with other local organizations, and much more effective use of peers. Moreover, beyond traditional telehealth care, which involves a provider and consumer in synchronous interaction, new virtual tools and apps are available, which can be used asynchronously by consumers to reduce demand upon staff time. Hence, it also will be important to develop a digital formulary of these tools to ease current staff shortages. Overall, some have estimated behavioral healthcare staff shortages as large as 90,000 to 150,000 over the next two to three years.

Behavioral healthcare will survive the COVID-19 pandemic. The success with which this will be done will depend upon our capacity to continue to be adaptable to a rapidly changing environment, while also remaining true to the major values and human goals that motivate entire behavioral healthcare endeavor.

OVERDOSE DEATH ON THE RISE

Drug overdose deaths climbed to a record high in 2019, reversing a historic decline in 2018 data, according to a National Center for Health Statistics/CDC interim report. In 2019, 70,980 overdose deaths were reported, surpassing the peak of 70,699 deaths in 2017. The 2019 data represent a near-5% increase over 2018. The upward trend continues as overdose deaths spike amid a pandemic that's taken a toll on America's mental health. Read the full preliminary set of findings at: https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.html

MEDICAID AND THE COLLABORATIVE CARE MODEL FOR SUD AND MENTAL HEALTH

COURTNEY GALLO HUNTER, VICE PRESIDENT, STATE POLICY
SHATTERPROOF: STRONGER THAN ADDICTION

The following brief introduction to the Collaborative Care Model (CoCM) is provided here as an introduction to a ***webinar being planned with NACBHDD to focus on the issues of integrated care, Medicaid and other financing models. The webinar will take place on Thursday, September 24, at 2:30 pm EDT.*** *Invitations and registration will be forwarded closer to the event date. Watch your in-boxes.*

We know that it is challenging to find evidence-based treatment for substance use disorder and that families struggle immensely to navigate the treatment and insurance processes. There are a multitude of reasons why this is the case, and tremendous barriers that individuals face when seeking treatment. One of these barriers is payment. Specialty care can be expensive, there might not be enough providers in the insurance network, and most people do not have disposable income to spend on specialists that are out-of-network.

In fact, approximately 80% of patients seeking behavioral health care do so in a primary care setting. Primary care settings have become the de facto behavioral health system for most adults. However, providers in these settings often lack behavioral health expertise or resources and diagnostic tracking tools specific to SUD.

The reality is that we are currently treating addiction in emergency rooms after acute episodes like an overdose occur. However, we know that treating a disease with an early diagnosis often results in better outcomes. So, in order to start treating addiction at stage 1 of the disease, we need tools for integration of behavioral health care within primary care.

States have gotten creative given the challenges with payment for specialty treatment and lack of accessible providers. For example, Vermont has implemented an innovative model called Hub and Spoke for opioid use disorder services. In the mental health community, they have been using the Collaborative Care Model (CoCM) to integrate behavioral health care into primary care settings. Through this approach, providers measure patient progress with a team of clinicians typically including a primary care physician, a behavioral health specialist and care coordinator. This approach has shown to be tremendously successfully in improving outcomes for patients.

Medicaid, which covers 17% of adults with a SUD and has a significant number of enrollees more likely to experience comorbid behavioral and chronic medical conditions, has a large role to play in adopting CoCM for substance use disorders. We need to integrate this model or the core elements of it into the standard practice for treating substance use disorder, so that we are identifying and treating addiction at Stage 1 of the

disease. This will not only improve outcomes for those getting treatment earlier, but it will preserve the limited intensive and specialty care for those who need it most.

AROUND THE STATES

- **ALABAMA.** If approved by CMS, the State Medicaid program's Section 1115/1915(c) waiver application would create a new, 5-year home and community-based services (HCBS) demonstration program for individuals with intellectual disabilities (IDs). The aim is to "maximize the capabilities of Alabamians with IDs; to support full community engagement, including employment; and to ensure supports to preserve community-based living." Initially, 500 individuals with IDs would be served, or approximately 25% of the current waiting list. By carefully leveraging existing resources through the waiver, the State expects to reduce the current services waiting list more rapidly than otherwise would be possible.

- **FLORIDA.** The State has submitted a request to CMS for a 2-year extension (through June 30, 2024) for its current section 1115 Managed Medical Assistance (MMA) waiver. This extension request does not include any amendments to the current waiver design.
- **MISSOURI.** In a recent referendum, State voters adopted Medicaid expansion through the Affordable Care Act (ACA) statewide. Because the referendum added Medicaid expansion to the State constitution, the Republican-controlled legislature may well be barred from imposing work requirements or premiums as conditions of enrollment. Missouri is the 38th state to expand this federally subsidized health program. Only 12 states—all Republican controlled—continue to resist Medicaid expansion (AL, FL, GA, KS, MS, NC. SC,SD, TM, TX, WI, WY).
- **NEW YORK.** The State budget director warned that the COVID-19-related budget shortfall this year could grow by as much as $1 billion. As a result, community services could be subject to new State withholds, further damaging local behavioral health services and programs already struggling under a third-quarter 20% withhold to which they were alerted in June. In response to the growing fiscal crisis for statewide behavioral healthcare, the *New York Association of Psychiatric Rehabilitation Services (NYASPRS)* and other health advocacy organizations have called for new state aid to prevent the collapse of community-based behavioral health services statewide. They argue that community-based behavioral health programs promote stable housing and support for individuals at a lower cost than other options and that funding them adequately saves money in the long run. Absent an infusion of federal funds to the State and communities, as proposed in the now-stalled, US House-passed HEROES Act, however, State budgeteers say they will have to raise added revenues to get the State through the pandemic and its attendant economic sequelae.
- **UTAH.** A Medicaid Section 1115 waiver application requests CMS approval to claim federal financial participation (FFP) for payment of services to Medicaid beneficiaries, ages 21 through 64, who receive inpatient psychiatric treatment or residential mental health treatment in an Institution for Mental Diseases (IMD) of greater than 16 beds. The application is a product of legislation directing this effort that cleared the State legislature during its 2020 session. The waiver request also would allow the State to make *capitation* payments to State-contracted managed care entities to pay for services to Medicaid beneficiaries regardless of the length of stay in an IMD, though the State assures that the average length of stay would be no more than 30 days. The waiver would also apply to Medicaid beneficiaries in the State's FFS service delivery systems. Stay tuned.

ON THE BOOKSHELF

- **MILLIMAN.** *How Do Individuals with Behavioral Health Conditions Contribute to Physical and Total Healthcare Spending?* details the characteristics of total healthcare costs for individuals with diagnoses of behavioral health conditions and/or receipt of behavioral- specific treatment, including services or prescriptions for behavioral drugs. Among other key findings, the analysis found that a small minority of high-cost individuals drive a significant majority of total healthcare costs. A majority of those high-cost patients either have a behavioral health problem or received treatment for one. Yet, in most cases, costs for behavioral health-specific treatment represented a small fraction of total healthcare costs for these individuals, and many had no or minimal spending on behavioral health-specific services. Read the full report at: https://www.milliman.com/en/insight/How-do-individuals-with-behavioral-health-conditions-contribute-to-physical

- **COMMOMWEALTH FUND.** A recent report, *Do Americans Face Greater Mental Health and Economic Consequences from COVID-19? Comparing the US with Other High-Income Countries,* details that, between March and May 2020,

1/3 of US adults reported experiencing stress, anxiety and sadness that were unable to cope with alone, a proportion significantly higher than found in other countries. Worse, only one in three was able to get help for these problems. Read more on these and other findings at: COVID and mental health-US and other countries

- **CENTER FOR MEDICARE AND MEDICAID SERVICES.** A new final Report to Congress, *Reducing Barriers to Using Telehealth and Remote Patient Monitoring for Pediatric Populations under Medicaid* has been released, as required by section 1009(d) of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act). The report identifies best practices and potential solutions for reducing barriers to using services delivered via telehealth for the treatment of substance use disorders (SUDs) among pediatric populations under Medicaid. Read the report at: https://www.medicaid.gov/medicaid/benefits/downloads/rtc-reducing-barriers-may-2020.pdf
- **NATIONAL ASSOCIATION OF COUNTIES.** NACo has released a new report, *Comprehensive Analysis of COVID-19's Impact on County Finances and Implications for the US Economy* that explains the financial situation of and impact of the pandemic on American's county governments, the funding cuts counties are being forced to make and the fallout for the overall national economy. Download the analysis at: COVID and the counties .
- **COMMONWEALTH FUND.** *The Crises—and Opportunities—of the COVID-19 Pandemic* discusses the current four interconnected crises arising from the COVID-19 pandemic that reveal underlying systemic problems in our health care system. It further identifies opportunities to revise and reform the system by addressing those flaws. Read the commentary (which also appears in the *New England Journal of Medicine*) at: the pandemic reveals health system failings .
- **MILBANK MEMORIAL FUND.** A pre-released article, *Situating the Continuum of Overdose Risk in the Social Determinants of Health: A New Conceptual Framework,* focuses on the social roots of the opioid epidemic and proposes 6 strategies addressing those social roots. Read the new article at: Social roots of opioid abuse
- **SAMHSA.** A new publication, *The Opioid Crisis and the Hispanic/Latino Population: An Urgent Issue,* presents data on prevalence of opioid misuse and death rates in the Hispanic/Latino population; contextual factors and challenges to prevention and treatment; innovative outreach and engagement strategies to connect people to evidence-based treatment; and the importance of community voice. Download the report at: Opioids and the Latinx Community
- **ADDICTION POLICY FORUM.** The Addiction Policy Forum has released both a *COVID-19 Health Advisory* and a survey, *COVID-19 Affecting Access to Addiction Treatment and Key Services.* The former details steps that people with substance use disorders should take to protect themselves against the novel coronavirus (What to know about COVID-19). The latter delineates some of the adverse effects COVID-19 is having on access to and continuity of services for SUD treatment (COVID-19 and care access).
- **MILBANK MEMORIAL FUND.** A special, virtual issue of the Milbank Memorial Quarterly focuses on *State Health Policy Innovations.* This open-access volume includes research articles, perspectives and opinion pieces on state health innovations that have been published in the journal over the past 2 years. Some articles focus on Medicaid reforms, such as efforts to integrate behavioral health and primary care, or to provide housing support services. Others consider statewide policies and programs intended to prevent opioid misuse or reduce disproportionately high maternal mortality among Black mothers, for example. Read or download the issue at: Health Policy Innovations .

MARK YOUR CALENDAR

- **NATIONAL ACADEMIES OF SCIENCES, ENGINEERING AND MEDICINE.** *Caring for People with Mental Health and Substance Use Disorders in Primary Care Settings: A Three-part Webinar* will examine ways to facilitate the delivery of essential elements of care for people with mental health and substance use disorders in primary care settings. The first online session was held on June 3, 2020; the second on July 29, 2020. The *third and final webinar will convene on August 26, 2020.* Learn more or register at: behavioral health in primary care settings webinar
- **NARMH.** Save the dates for the NARMH 2020 annual meeting, *Beyond Treatment: Tackling the Social Determinants to Improve Rural Mental Health,* August 7-20, 2020, Portland, OR. Consider submitting a paper or other presentation. For more information, go to: https://www.narmh.com .
- **PSYCHIATRY AND BEHAVIORAL HEALTH LEARNING NETWORK.** The Network will convene the *2021 Rx Drug Abuse and Heroin Summit* on April 5-8, 2021, Gaylord Opryland Resort and Convention Center, Nashville, TN. A call for

presentations is open until August 28, 2020. For more information, or to submit a proposal, go to: https://www.rx-summit.com/agenda .

- **NACBHDD AND SHATTERPROOF.** The organizations will convene a webinar focused on *integrated—coordinated—care to integrate behavioral health into primary care*. It will also explore Medicaid and other financing models. The webinar will take place on Wednesday, September 23, at 3 pm, EDT. Stay tuned to NACBHDD email for information on how to participate.
- **NEW JERSEY ASSOCIATION OF MENTAL HEALTH AND ADDICTION AGENCIES.** As the coronavirus crisis is expected to last several months, NJAMHAA is postponing a number of conferences:
- The Information Technology (IT) Conference, *No Fooling - IT is Critical,* originally scheduled for April 1, 2020, is now planned for October 21, 2020, at the Pines Manor in Edison, NJ.
- The Annual Conference, *Reimagining Health Care*, originally scheduled for April 23-24, 2020, is now planned for October 29-30, 2020, in Iselin, NJ.
- **ANXIETY AND DEPRESSION ASSOCIATION OF AMERICA.** The 41st annual ADAA *Conference Resilience and Recovery: From Research to Practice* will convene on March 18-21, 2021, in Boston, MA. This multidimensional conference spanning behavioral health professions, focuses exclusively on science and treatment of anxiety and depressive disorders and related disorders in children and adults. ADAA currently seeks submissions on practice topics related to these disorders. Learn more and submit presentation applications at: ADAA 2021 .
- **THE KENNEDY FORUM.** The October 6, 2020, annual meeting, *Our Words Matter: Harnessing the Power of Communications to Advance Mental Health Equity*, has been postponed until early 2021. Stay tuned for new details,

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