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Behavioral Health During the COVID-19 Pandemic: Overview and Issues for Congress

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Behavioral Health During the COVID-19 Pandemic: Overview and Issues for Congress

Circumstances surrounding the Coronavirus Disease 2019 (COVID-19) pandemic—including mitigation strategies to prevent spread of the virus—appear to have adversely affected the mental health of many Americans. According to some studies, Americans experienced elevated levels of emotional distress, anxiety, depression, substance use, and drug-related overdoses in 2020 and 2021 compared with the same time period in previous years. Various stressors related to the pandemic may have contributed to decreased mental well-being, such as fears about contracting the virus, anxiety about its health effects, social isolation due to physical distancing measures, financial stress due to the economic consequences of the pandemic, grief and bereavement due to the death of a loved one, exposure to pandemic-related media coverage, and interruptions to substance use treatment and mental health care.

The physical distancing measures and temporary stay-at-home orders used during the COVID-19 pandemic have changed service delivery for mental health and substance treatment. Such changes include relaxing privacy requirements required by the Health Insurance Portability and Accountability Act (HIPAA) rules and increasing the use of telehealth to deliver behavioral health treatment and services. Some states have employed other methods of service delivery (e.g., mobile units) for treatments that cannot be administered via telehealth, such as medication-assisted treatment (MAT) for opioid use disorder. Congress has appropriated additional funding for behavioral health-related activities during the pandemic in a series of supplemental funding measures—such as the Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136)—and the American Rescue Plan Act of 2021 (ARPA; P.L. 117-2) budget reconciliation measure.

Behavioral health changes during the COVID-19 pandemic pose a number of issues for Congress to consider. As the pandemic continues, the federal government may consider whether to extend—or make permanent—some of the regulatory changes to behavioral health treatment. In addition, Congress and other government institutions at the federal, state, and local levels may consider the potential mental health effects of COVID-related policies such as stay-at-home orders and asynchronous learning for students. Other considerations include oversight of the supplemental funding and of federally supported behavioral health activities during the pandemic and beyond.

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Johnathan H. Duff
Analyst in Health Policy

Amanda K. Sarata
Specialist in Health Policy

Paul D. Romero
Research Assistant

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Introduction

Circumstances surrounding the Coronavirus Disease 2019 (COVID-19) pandemic—including lifestyle changes instituted to prevent spread of the virus—appear to have adversely affected the mental health of many Americans. Some studies show that Americans experienced elevated levels of emotional distress, anxiety, depression, substance use, and drug-related overdoses in 2020 and 2021 compared with the same time periods in previous years. Various stressors related to the pandemic may have contributed to decreased mental well-being, such as fears about contracting the virus, anxiety about its health effects, social isolation due to physical distancing measures, financial stress due to the ensuing economic consequences of the pandemic, grief and bereavement due to the death of a loved one, exposure to pandemic-related media coverage, and interruptions to substance use treatment and mental health care.

Physical distancing measures and temporary stay-at-home orders associated with the COVID-19 pandemic have required changes in service delivery for mental health and substance use (collectively known as *behavioral health*) treatment. Such changes include relaxing privacy requirements required by the Health Insurance Portability and Accountability Act (HIPAA) rules and increasing the use of telehealth to deliver behavioral health treatment and services. Some states have employed other methods of service delivery (e.g., mobile units) for treatments that cannot be administered via telehealth, such as medication-assisted treatment (MAT) for opioid use disorder (OUD).

Congress has appropriated additional funding for behavioral health-related activities during the pandemic through several of the COVID-19-related supplemental funding measures. The third COVID-19 supplemental appropriations act enacted by Congress—the Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136)—appropriated \$425 million to the Substance Abuse and Mental Health Services Administration (SAMHSA) within the Department of Health and Human Services (HHS). The fifth COVID supplemental funding measure (Consolidated Appropriations Act, 2021; P.L. 116-260) appropriated \$4.25 billion to SAMHSA in supplemental COVID-related funding.¹ In March 2021, a budget reconciliation measure developed in response to the pandemic—the American Rescue Plan Act of 2021 (ARPA; P.L. 117-2)—appropriated \$3.64 billion to SAMHSA for behavioral health activities.²

As the COVID-19 pandemic continues, and eventually subsides, the federal government may consider whether to extend—or make permanent—some of the regulatory changes to behavioral health treatment delivery. In addition, Congress and other government institutions at the federal, state, and local level may consider the mental health consequences of COVID-related policies such as stay-at-home orders and school reopenings. Other considerations include determining allocation of the pandemic-related funding and oversight of federally supported behavioral health activities during the pandemic and beyond.

This report provides an overview of (1) mental health and substance use during the COVID-19 pandemic, (2) changes made to behavioral health services and related regulations, and (3) issues for Congress to consider.

¹ This amount was in addition to SAMHSA's annual FY2021 appropriations, which were also included in the law.

² See the House Budget Committee report (H.Rept. 117-7) for a discussion of the context surrounding the American Rescue Plan Act of 2021 (ARPA; P.L. 117-2).

Behavioral Health During the COVID-19 Pandemic

Data from multiple sources suggest that mental health symptoms and substance use have increased since the beginning of the COVID-19 pandemic. These symptoms include emotional distress and anxiety, depression, and trauma-related conditions. Substance use refers to the number of individuals using substances such as alcohol or illicit drugs, and the frequency and quantities of use.

Typically, comprehensive national morbidity and mortality data on mental health conditions, substance use, associated hospitalizations, and substance-related overdose deaths take months to compile and report.³ Comprehensive national data for 2020 are not yet available. Several organizations, including multiple federal agencies, have used short surveys and rapid data reporting to monitor mental health symptoms and substance use during the COVID-19 pandemic. Although the methodological differences between these surveys and perennial surveys make comparisons between years imperfect, most of the 2020 data suggest an increase in behavioral health morbidity in the United States over the course of the COVID-19 pandemic.

Mental Health

Data collected from multiple surveys during the COVID-19 pandemic suggest that Americans experienced increased stress and symptoms of mental health conditions. In a survey conducted in April 2020, the State Health Access Data Assistance Center (SHADAC)—a program of the Robert Wood Johnson Foundation—found that over 90% of U.S. adults reported experiencing additional levels of stress caused by the COVID-19 pandemic.⁴ In this context, stress refers to psychological stress, which occurs when individuals believe that the consequences of a situation outweigh their ability to adequately cope with it.⁵ Reactions to stressors may include fear and concern about the future, tension and irritability, sadness or depression, or feeling powerless or overwhelmed, among others.⁶

Without adequate coping strategies, stress can have detrimental effects on mental health. Coping strategies include any behavioral, social, or cognitive techniques used to mitigate the effects of stress. Coping strategies can be *adaptive*, meaning they promote better overall functioning (e.g., social connections, physical activities, hobbies, good sleep hygiene), or they can be *maladaptive*,

³ In the United States, national public health surveillance is conducted through multiple systems that typically involve partnerships between the federal government and other jurisdictions. Morbidity and mortality data, for instance, are collected from disparate and often private organizations, including laboratories, hospitals, and outpatient health care facilities. The Centers for Disease Control and Prevention (CDC) compiles and reports annual mortality data, but the timeliness and completeness of these data are affected by a number of variables. Often, comprehensive national data for a given year is not available until the following year. For more information, see CRS Report R46588, *Tracking COVID-19: U.S. Public Health Surveillance and Data*, by Kavya Sekar and Angela Napili.

⁴ Colin Planalp, Giovanni Alarcon, and Lynn Blewett, *90 Percent of U.S. Adults Reported Increased Stress due to the Coronavirus Pandemic*, State Health Access Data Assistance Center (SHADAC), SHADAC COVID-19 Survey Results, May 26, 2020, <https://www.shadac.org/publications/shadac-covid-19-survey-results>. The SHADAC COVID-19 Survey on the consequences of the coronavirus pandemic was conducted as part of the AmeriSpeak omnibus survey conducted by NORC at the University of Chicago. The survey was conducted using a mix of phone and online modes from April 24 and 26, 2020, among a nationally representative sample of 1,007 respondents age 18 and older. SHADAC is a partnership between the Robert Wood Johnson Foundation and the Health Policy and Management Division of the School of Public Health at the University of Minnesota.

⁵ Mental Health Foundation, *Stress*, United Kingdom, 2021, <https://www.mentalhealth.org.uk/a-to-z/s/stress>.

⁶ Centers for Disease Control and Prevention, *Injury Prevention & Control/Injury Center/Featured Topics/Dealing with Stress*, 2020, <https://www.cdc.gov/injury/features/dealing-with-stress/index.html>.

meaning they are more likely to result in worse overall functioning (e.g., substance use, excessive screen time, risky behaviors). Although maladaptive coping strategies may reduce stress in the moment, they may exacerbate problems in the long term.

Many individuals experiencing stress may have adequate coping strategies, meaning that stress is present but does not impair their daily functioning.⁷ For others, stress—and in particular stress caused by the pandemic—may have detrimental effects on their mental health. A nationally representative survey conducted by the Kaiser Family Foundation (KFF) throughout the pandemic found that an increasing number of Americans reported that pandemic-related stress was affecting their mental health.⁸ In March 2020, 32% of respondents felt that worry or stress related to coronavirus had a negative impact on their mental health. In April 2020 that number rose to 45%, and in July 2020, 53% reported that pandemic-related stress was affecting their mental health.⁹

Mental Health Disorders

In some cases, extreme or prolonged stress can lead to mental health disorders.¹⁰ According to data collected by the National Center for Health Statistics (NCHS), the percentage of Americans experiencing symptoms of a mental health disorder appears to have increased during the COVID-19 pandemic. NCHS—a research agency under the Centers for Disease Control and Prevention (CDC)—partnered with the U.S. Census Bureau on the Household Pulse Survey to monitor the social and economic effects of the pandemic on American households.¹¹ The nationally representative survey collected data on employment status, food security, housing, physical and mental health, access to health care (including mental health care), and education disruption during the coronavirus pandemic.¹² NCHS survey questions were designed to obtain information on the frequency of anxiety and depression symptoms.¹³

⁷ Stress and traumatic experiences—such as those affiliated with the COVID-19 pandemic—can also lead to positive psychological changes and improved mental health, commonly known as *posttraumatic growth*. See, for example, Kristine Olson, Tait Shanafelt, and Steve Southwick, “Pandemic-Driven Posttraumatic Growth for Organizations and Individuals,” *JAMA*, vol. 324, no. 18 (October 8, 2020), pp. 1829-1830.

⁸ Liz Hamel, Audrey Kearney, Ashley Kirzinger, et al., *KFF Health Tracking Poll - July 2020*, Kaiser Family Foundation, July 27, 2020, <https://www.kff.org/coronavirus-covid-19/report/kff-health-tracking-poll-july-2020/>.

⁹ See also Nirmita Panchal, Rabah Kamal, Cynthia Cox, et al., *The Implications of COVID-19 for Mental Health and Substance Use*, Kaiser Family Foundation, Issue Brief, February 10, 2021, <https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>.

¹⁰ See, for instance, Peggy Thoits, “Stress and Health: Major Findings and Policy Implications,” *Journal of Health and Social Behavior*, vol. 51, no. 1_suppl (March 1, 2010), pp. S41-S53; Marie-France Marin, Catherine Lord, Julie Andrews, et al., “Chronic Stress, Cognitive Functioning and Mental Health,” *Neurobiology of Learning and Memory*, vol. 96, no. 4 (November 2011), pp. 583-595; and George P. Chrousos, “Stress and Disorders of the Stress System,” *Nat Rev Endocrinol.*, vol. 5, no. 7 (July 2009), pp. 374-381.

¹¹ U.S. Census Bureau, *Measuring Household Experiences during the Coronavirus Pandemic*, Household Pulse Survey, <https://www.census.gov/data/experimental-data-products/household-pulse-survey.html>.

¹² Phase 1 of the Household Pulse Survey was conducted from April 23 through July 21, 2020. Phase 2 was conducted August 19 through October 26, 2020, and Phase 3 took place between October 28 and March 29, 2021. Phase 3.1 was scheduled to begin on April 14, 2021. The Household Pulse Survey is designed to be a short-turnaround instrument that provides data to aid in the pandemic recovery. It is part of the Census Bureau’s Experimental Data Series, and, as such, data products may not meet some of the Census Bureau’s typical statistical quality standards. The experimental data series is designed to be timely, and therefore may have less accuracy than perennial surveys such as NHIS or the National Survey on Drug Use and Health (NSDUH). Discretion should be used when comparing Household Pulse data with other annual federal surveys.

¹³ To capture symptoms of mental health disorders, the Household Pulse Survey used similar survey items as the annual

As shown in **Figure 1**, symptoms of anxiety disorder and depressive disorder were higher in the United States during April–June (Q2) of 2020, compared with the same period in 2019.¹⁴ More than one in three adults experienced symptoms of anxiety, depression, or both in 2020, compared with one in 10 in 2019.¹⁵ Subsequent data have shown that the 2020 second quarter rates increased through the final quarter of 2020.¹⁶ In February 2021, over 40% of U.S. adults had experienced symptoms of an anxiety or a depressive disorder during the past seven days.¹⁷ Some data from this survey suggests that as the number of COVID-19 cases has decreased nationally and pandemic-related restrictions have been lifted, symptoms of anxiety and depression have shown modest declines (see **Figure A-2**).

National Health Interview Survey—but amended them to be slightly shorter. The questions are a modified version of the two-item PHQ-2 and GAD-2 scale on the Household Pulse Survey, collecting information on symptoms over the past 7 days (rather than the typical 14 days). For more information, see <https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm>.

¹⁴ CDC, National Center for Health Statistics, *Anxiety and Depression*, Household Pulse Survey, 2021, <https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm>.

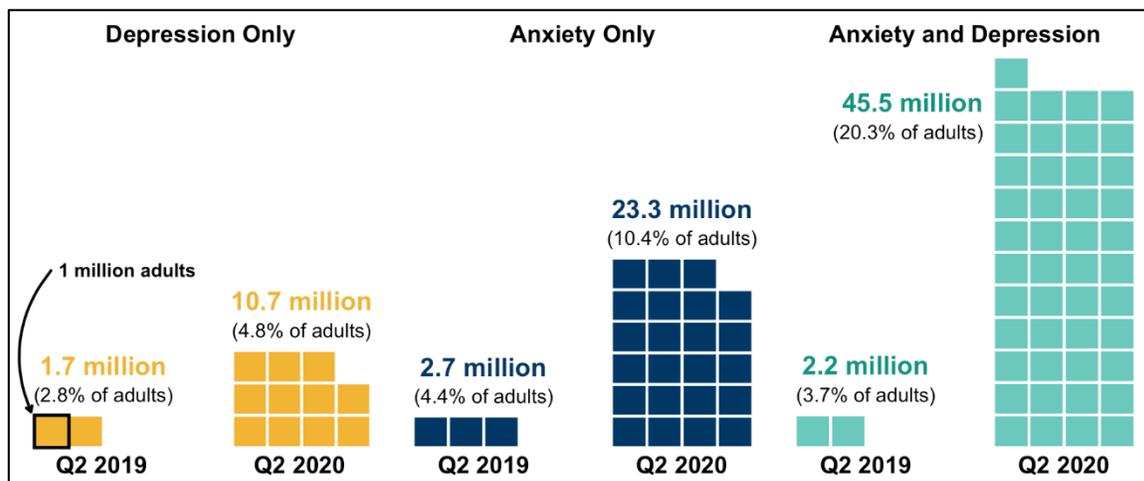
¹⁵ Data on symptoms of anxiety and depressive disorders in the Household Pulse Survey (2020) reflect similar findings from a single week survey conducted in June 2020. See Mark Czeisler, Rashon Lane, and Emiko Petrosky, *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic - United States, June 24-30, 2020*, Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report (MMWR)*, vol. 69, no. 32, Atlanta, GA, August 14, 2020.

¹⁶ Household Pulse data show 40% of adults exhibited symptoms of one or both disorders in Q4 of 2020, compared with 35% in Q2. More specifically, the “depression only” category increased from 4.8% to 5.1%, “anxiety only” increased from 10.4% to 12.6%, and concurrent symptoms of both disorders increased from 20.3% to 22.7% of adults. Some studies suggest that the mental health effects of the pandemic may be more acute in the United States compared with other high-income countries. An international survey showed that more U.S. adults reported experiencing stress, anxiety, and sadness than adults in other countries during the pandemic. In addition, fewer Americans reported the ability to receive help from a professional compared with Australia and Canada. See Reginald Williams, Arnav Shah, Roosa Tikkanen, et al., *Do Americans Face Greater Mental Health and Economic Consequences from COVID-19? Comparing the U.S. with Other High-Income Countries*, The Commonwealth Fund, Issue Brief, August 6, 2020, <https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/americans-mental-health-and-economic-consequences-COVID19>.

¹⁷ Anjel Vahratian, Stephen Blumberg, Emily Terlizzi, et al., *Symptoms of Anxiety or Depressive Disorder and Use of Mental Health Care Among Adults During the COVID-19 Pandemic - United States, August 2020-February 2021*, Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report (MMWR)*, vol. 70, March 26, 2021.

Figure 1. Mental Health Symptomology in the United States, 2019 and 2020

Symptoms of Anxiety and Depression in Adults, April-June (Q2)



Source: CRS analysis of Centers for Disease Control and Prevention, *2019 NHIS*, National Health Information, <https://www.cdc.gov/nchs/nhis/2019nhis.htm>, and U.S. Census Bureau, *Measuring Household Experiences during the Coronavirus Pandemic*, Household Pulse Survey, <https://www.census.gov/data/experimental-data-products/household-pulse-survey.html>.

Notes: Estimates show the percentage of adults in the United States who reported symptoms of anxiety or depression that have been shown to be associated with diagnoses of generalized anxiety disorder or major depressive disorder. These symptoms generally occur more than half the days or nearly every day. The first Household Pulse Survey was conducted starting on April 23, 2020, thus there are 22 days in the second quarter that are missing for 2020. Along with this limitation, the two surveys differ in that the NHIS asks respondents about the “last 2 weeks,” whereas the Household Pulse Survey asks about the “last 7 days.” See footnote 12 for more information.

Other indicators of psychological distress appear elevated during the first phases of the pandemic. For example, CDC analysis of national emergency department (ED) visits showed that socioeconomic and psychosocial-related visits increased during April 2020 (compared with April 2019), while total ED visits decreased over 40%.¹⁸ Socioeconomic or psychosocial factors were one of a few categories of ED visits that increased; most of the 200 common diagnostic causes of ED visits decreased during that same time. Other research suggests that ED visits for mental health conditions may have decreased during the first few months of the pandemic, to a lesser extent than overall ED visits.¹⁹

Psychiatric Symptoms of COVID-19

In addition to the more common symptoms of COVID-19, such as upper respiratory tract infections, fever, or acute respiratory distress, COVID-19 can also cause psychiatric symptoms.²⁰ Research and clinical case reports have described mental health symptoms of COVID-19 that include

¹⁸ Kathleen Hartnett, Aaron Kite-Powell, Jourdan DeVies, et al., *Impact of the COVID-19 Pandemic on Emergency Department Visits - United States, January 1, 2019 - March 30, 2020*, Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report (MMWR)* vol. 69, no. 23, June 12, 2020, pp. 699-704, <https://www.cdc.gov/mmwr/volumes/69/wr/mm6923e1.htm>.

¹⁹ See Kristin M. Holland, Christopher Jones, Alana M. Vivolo-Kantor, et al., “Trends in US Emergency Department Visits for Mental Health, Overdose, and Violence Outcomes Before and During the COVID-19 Pandemic,” *JAMA Psychiatry*, February 3, 2021.

²⁰ “COVID-19 and Mental Health,” *Lancet Psychiatry*, vol. 8 (February 2021), p. 87.

- anxiety²¹ and depression;
- altered mental status (e.g., confusion, delirium, agitation);
- psychosis (e.g., delusions, hallucinations, paranoia);
- post-traumatic stress;
- impaired memory; and
- insomnia.²²

Most individuals diagnosed with COVID-19 do not experience any mental health issues. However, for some (especially those with severe COVID-19 infections), psychiatric symptoms can appear during the acute illness or post-illness stages.²³ The causes of psychiatric symptoms of COVID-19 are unclear.²⁴ Some research suggests that the infection can have possible neurological effects and cause inflammation of the brain.²⁵ In addition, the experience of having COVID-19 may lead to altered mood, post-traumatic stress, or other mental health symptoms.²⁶ Studies report worsening of symptoms for COVID-19 patients with preexisting psychiatric disorders, though individuals with no history of mental illness have also displayed psychiatric symptoms during and after the illness.²⁷ An international study following 284 patients found that over a third (34.5%) reported clinically significant post-traumatic stress symptoms, anxiety, and/or depression nearly two months after a COVID-19 diagnosis.²⁸ The presence of psychiatric symptoms during COVID-19 is consistent with prior research on other coronavirus infections, which found that confusion, impaired memory, depressed mood, anxiety, and insomnia are common symptoms.²⁹

Suicide

Some evidence suggests that suicidal thoughts may have increased during the pandemic. One CDC analysis found that during the pandemic approximately twice as many U.S. adults reported serious consideration of suicide in the previous 30 days compared with 2018 (10.7% versus

²¹ Of note, CDC has reported some anxiety-related adverse events associated with COVID-19 vaccinations. See Anne M. Hause, Julianne Gee, Tara Johnson, et al., *Anxiety-Related Adverse Event Clusters After Janssen COVID-19 Vaccination - Five U.S. Mass Vaccination Sites, April 2021*, Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report (MMWR)* vol. 70, no. 18, May 7, 2021, pp. 685-688, <https://www.cdc.gov/mmwr/volumes/70/wr/mm7018e3.htm>.

²² See, for example, Maxime Taquet, John R. Geddes, Masud Husain, et al., “6-Month Neurological and Psychiatric Outcomes in 236,379 Survivors of COVID-19: A Retrospective Cohort Study Using Electronic Health Records,” *The Lancet Psychiatry*, vol. 8, no. 5 (May 1, 2021), pp. 416-427; and Aravinthan Varatharaj, Naomi Thomas, and Mark A. Ellul, “Neurological and Neuropsychiatric Complications of COVID-19 in 153 Patients: A UK-Wide Surveillance Study,” *The Lancet Psychiatry*, vol. 7, no. 10 (October 1, 2020), pp. 875-882.

²³ Jonathan P. Rogers, Edward Chesney, Dominic Oliver, et al., “Psychiatric and Neuropsychiatric Presentations Associated with Severe Coronavirus Infections: A Systematic Review and Meta-analysis with Comparison to the COVID-19 Pandemic,” *The Lancet Psychiatry*, vol. 7, no. 7 (July 2020), pp. 611-627.

²⁴ S. Al-Sarraj, C. Troakes, B. Hanley, et al., “Invited Review: The Spectrum of Neuropathology in COVID-19,” *Neuropathology and Applied Neurobiology*, vol. 47 (2021), pp. 3-16.

²⁵ Krishna Nalleballe, Sanjeeva Reddy Onteddu, Rohan Sharma, et al., “Spectrum of Neuropsychiatric Manifestations in COVID-19,” *Brain, Behavior, and Immunity*, vol. 88 (August 2020), pp. 71-74; and Jakob Matschke, Marc Lutgehetmann, Christian Hagel, et al., “Neuropathy of Patients with COVID-19 in Germany: A Post-Mortem Case Series,” *The Lancet Neurology*, vol. 19, no. 11 (November 1, 2020), pp. 919-929.

²⁶ Burc Cagri Poyraz, Cana Aksoy Poyraz, and Yesim Olgun, “Psychiatric Morbidity and Protracted Symptoms After COVID-19,” *Psychiatric Research*, vol. 295 (January 2021).

²⁷ Nina Vindegaard and Michael Eriksen Benros, “COVID-19 Pandemic and Mental Health Consequences: Systematic Review of the Current Evidence,” *Brain, Behavior, and Immunity*, vol. 89 (October 2020), pp. 531-542.

²⁸ Poyraz et al., “Psychiatric Morbidity and Protracted Symptoms After COVID-19,” 2021.

²⁹ Rogers et al., “Psychiatric and Neuropsychiatric Presentations Associated with Severe Coronavirus Infections,” 2020.

4.3%).³⁰ Although the National Suicide Prevention Lifeline did not report increases in call volume, the Disaster Distress Helpline (part of the Suicide Lifeline) experienced a 335% increase in calls during the first five months of the pandemic.³¹

The effects of the pandemic on suicide attempts and suicide deaths is unclear, though it appears that suicide mortality has decreased compared with previous years. An increase in suicidal thoughts does not necessarily equate to an increase in suicide attempts or suicide deaths.³² Research from CDC shows a decrease in emergency department (ED) visits for suicide attempts between March and October 2020 compared with the same period in 2019, but to a lesser extent than overall ED visits.³³ Preliminary national suicide mortality data in the United States for 2020 show that suicide deaths in the United States may have decreased in 2020 compared with the three previous years.³⁴ In addition, regional differences may account for changes in suicide mortality. For example, some individual states and municipalities have reported stable rates in suicide deaths during the pandemic, whereas others have reported decreased rates.³⁵ There may be demographic differences in suicide rates during the pandemic also. For example, CDC reported that in May, 2020 ED visits for suspected suicide attempts began to increase among adolescents, especially girls.³⁶ Researchers in Maryland found that suicide mortality rates increased for Black residents from March, 2020 to May, 2020, while decreasing for White residents over that same time.³⁷

³⁰ Mark Czeisler, Rashon Lane, and Emiko Petrosky, *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic - United States, June 24-30, 2020*, Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report (MMWR)*, vol. 69, no. 32, Atlanta, GA, August 14, 2020. Data were from the Household Pulse Survey. Researchers did not compare 2020 suicidal ideation data to 2019 data, nor did they explain their choice of 2018 as the comparison year.

³¹ Communications Daily, “Some Disaster Distress Helpline Call Traffic Jumps During COVID-19,” emailed press release, September 3, 2020, and Vibrant Emotional Health, “Help When it’s Needed Most: The National Disaster Distress Hotline,” press release, August 26, 2020, <https://www.vibrant.org/stories-from-the-disaster-distress-helpline/>.

³² For further discussion on suicide during the COVID-19 pandemic, see Christine Moutier, “Suicide Prevention in the COVID-19 Era: Transforming Threat into Opportunity,” *JAMA Psychiatry*, vol. 78, no. 4 (October 16, 2020), pp. 433-438.

³³ Kristin M. Holland, Christopher Jones, Alana Vivolo-Kantor, et al., “Trends in US Emergency Department Visits for Mental Health, Overdose, and Violence Outcomes Before and During the COVID-19 Pandemic,” *JAMA Psychiatry*, February 3, 2021.

³⁴ Farida B. Ahmad and Robert N. Anderson, “The Leading Causes of Death in the U.S. for 2020,” *JAMA*, March 31, 2021, <https://jamanetwork.com/journals/jama/fullarticle/2778234>.

³⁵ Reports from some individual states—such as Massachusetts and Utah, for example—suggest that suicide death rates during the pandemic may be stable compared with previous years. See Jeremy Samuel Faust, Sejal Shah, Chengan Du, et al., “Suicide Deaths During the COVID-19 Stay-at-Home Advisory in Massachusetts, March to May 2020,” *JAMA Network Open*, vol. 4, no. 1 (January 21, 2021); and Utah Department of Health, *Social and Behavioral Health During COVID-19*, February 2021, https://coronavirus-download.utah.gov/Health/COVID_Mental_Health_Report_.pdf. Other locations have reported decreases. See, for example, Jesse Bogan, “Fewer People Are Dying by Suicide in St. Louis During Pandemic,” *St. Louis Post-Dispatch*, October 29, 2020, https://www.stltoday.com/news/local/metro/fewer-people-are-dying-by-suicide-in-st-louis-during-pandemic/article_b4200ed7-4d00-5645-b7b7-961f4fb76c64.html.

³⁶ Ellen Yard, Lakshmi Radhakrishnan, and Michael Ballesteros, et al., *Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID-19 Pandemic—United States, January 2019–May 2021*, Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, vol. 70, Atlanta, GA, June 11, 2021, https://www.cdc.gov/mmwr/volumes/70/wr/mm7024e1.htm?s_cid=mm7024e1_w. Additionally, CDC reported that suspected suicide attempt ED visits were 50.6% higher among girls aged 12–17 years during February 21–March 20, 2021 compared to the same period in 2019.

³⁷ Michael Johnathan Charles Bray, Nicholas Omid Daneshvari, and Indu Radhakrishnan, et al., “Racial Differences in Statewide Suicide Mortality Trends in Maryland During the Coronavirus Disease 2019 (COVID-19) Pandemic,” *JAMA Psychiatry*, vol. 78, no. 4 (December 16, 2020). Suicide mortality rates for Black residents from May, 2020 to July,

Substance Use

Substance use rates appear to have increased during the COVID-19 pandemic. Certain consequences of the pandemic—such as increased stress and prolonged social isolation—have been linked with increased vulnerability to alcohol and drug use.³⁸ During the pandemic, Nora Volkow—Director of the National Institute on Drug Abuse (NIDA) at the National Institutes of Health (NIH)—stated:

All of these aspects [of the pandemic] are translating into much more stress. And stress, as we know, is one of the factors that leads people to relapse. Stress is also a factor that leads many to increase consumption of drugs.³⁹

In reporting data from the Household Pulse Survey, CDC indicated that 13% of U.S. adults started or increased substance use in the first few months of the pandemic to cope with stress related to COVID-19.⁴⁰ Increased substance use can lead to the development or exacerbation of substance use disorders, increased health conditions, or premature death.⁴¹ In addition, COVID-19 mitigation measures might lead persons using opioids or other substances to do so in higher-risk ways, such as alone or without access to overdose reversal medications such as naloxone.

Substance Use-Related Overdoses

Comprehensive national data on drug-related overdoses and overdose deaths during the pandemic are not yet available. Preliminary data from the Office of National Drug Control Policy (ONDCP) suggest increases in drug-related overdoses during the first few months of the pandemic. The Overdose Detection Mapping Application Program (ODMAP), an ONDCP surveillance system that tracks suspected overdose data nationally in near real-time, reported an increase of 11% in fatal overdoses and a 19% increase in nonfatal overdoses from March through May 2020 compared with the same months in 2019.⁴² Nearly 62% of participating counties reported increases from March to May 2020.⁴³ Other areas have reported stable rates of overdose deaths.⁴⁴ Notably, ODMAP overdose submissions appeared to be trending upward prior to the onset of the pandemic, making it difficult to determine the effects of the pandemic and mitigation measures

2020 remained higher than their pre-pandemic levels, while rates continued to decrease for White Maryland residents during that same time period.

³⁸ Primavera Spagnolo, Chiara Montemitro, and Lorenzo Leggio, “New Challenges in Addiction Medicine: COVID-10 Infection in Patients with Alcohol and Substance Use Disorders—The Perfect Storm,” *The American Journal of Psychiatry*, July 14, 2020.

³⁹ Francis Collins, Nora Volkow - *Addressing the Twin Challenges of Substance Use Disorders and COVID-19*, National Institutes of Health, NIH Director’s Blog, August 11, 2020, <https://directorsblog.nih.gov/tag/nora-volkow/>.

⁴⁰ Czeisler et al., *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic—United States, June 24–30, 2020*. 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.”

⁴¹ See, for instance, Marya T. Schulte and Yih-Ing Hser, “Substance Use and Associated Health Conditions Throughout the Lifespan,” *Public Health Reviews*, vol. 35, no. 2 (2013).

⁴² Aliese Alter and Christopher Yeager, *The Consequences of COVID-19 on the Overdose Epidemic: Overdoses are Increasing*, ODMAP Overdose Detection Mapping Application Program, ODMAP Report, May 2020, <http://odmap.org/Content/docs/news/2020/ODMAP-Report-May-2020.pdf>; and Aliese Alter and Christopher Yeager, *COVID-19 Impact on US National Overdose Crisis*, ODMAP Overdose Detection Mapping Application Program, ODMAP Report, June 2020, <http://www.odmap.org/Content/docs/news/2020/ODMAP-Report-June-2020.pdf>.

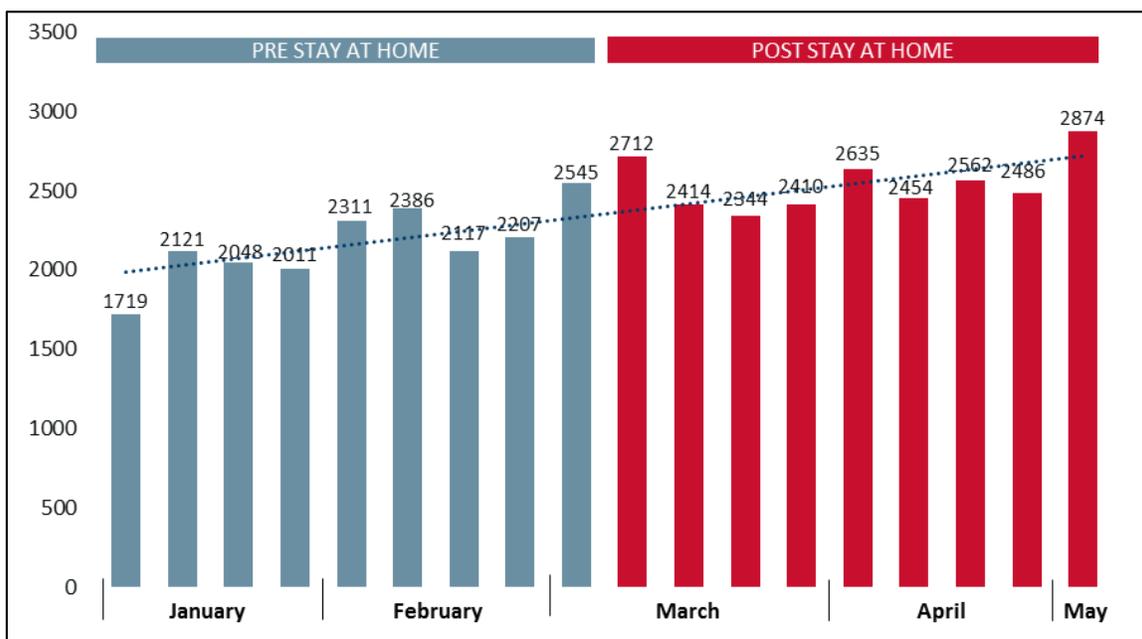
⁴³ Alter and Yeager, *The Consequences of COVID-19 on the Overdose Epidemic*, 2021.

⁴⁴ Utah, for instance, reported no significant change in drug-related overdose deaths from 2019 through 2020. See Utah Department of Health, *Social and Behavioral Health During COVID-19*, January 2021, https://coronavirus-download.utah.gov/Health/COVID_Mental_Health_Report_.pdf.

using these data. **Figure 2** shows weekly ODMAP-suspected overdose submissions for the first few months of 2020.

Figure 2. Weekly Suspected Overdose Submissions

ODMAP Submissions January 1, 2020, to March 18, 2020 Compared with March 19, 2020 to May 19, 2020



Source: Aliese Alter and Christopher Yeager, *COVID-19 Impact on US National Overdose Crisis*, ODMAP Overdose Detection Mapping Application Program, ODMAP Report, June 2020, <http://www.odmap.org/Content/docs/news/2020/ODMAP-Report-June-2020.pdf>.

Notes: For the purposes of its analysis, ODMAP considered the pre-stay-at-home period as January 1, 2020, through March 18, 2020, and the post-stay-at-home period as March 19, 2020, through May 19, 2020. Implementation date of mandated stay-at-home orders varied by state. Most states instituted mandated orders between March 19, 2020 and April 3, 2020.

CDC also noted an increase in drug-related overdose deaths in the beginning of the COVID-19 pandemic.⁴⁵ Similar to the ODMAP data, the CDC data showed that overdose deaths were already increasing in the months preceding the pandemic. However, CDC data showed the rate of overdose deaths accelerating after the pandemic began (see **Figure 3**).⁴⁶ In an analysis of provisional CDC mortality data, the National Institute for Health Care Management⁴⁷ found that

⁴⁵ Centers for Disease Control and Prevention, “Overdose Deaths Accelerating During COVID-19,” press release, December 18, 2020, <https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html>.

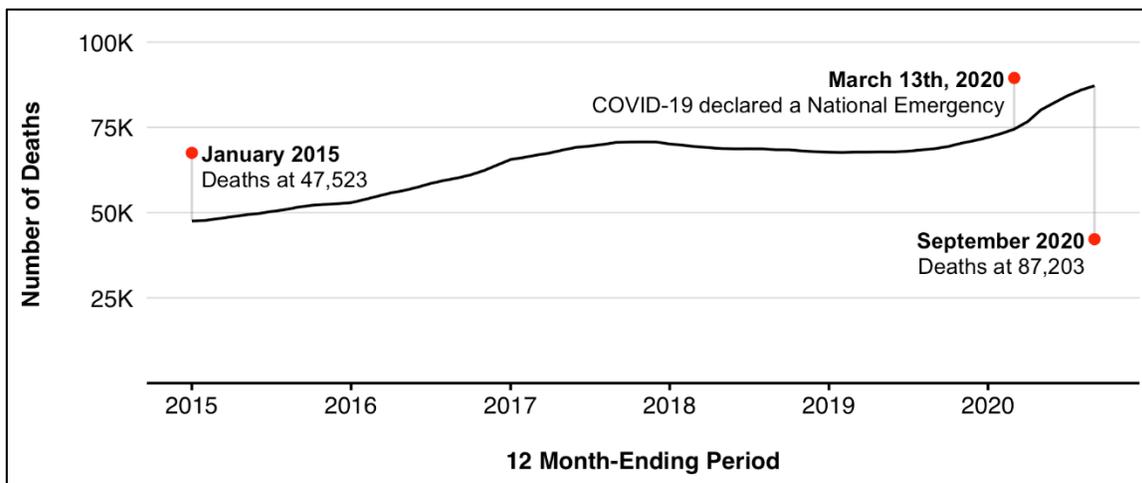
⁴⁶ Centers for Disease Control and Prevention, National Center for Health Statistics, *Provisional Drug Overdose Death Counts*, Vital Statistics Rapid Release, 2021, <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>. These CDC data reflect similar findings from drug overdose data on the local level for some states and municipalities. For example, in Cook County, Illinois, opioid-related overdose deaths were increasing prior to the pandemic, but showed a more pronounced increase during the 11-week stay-at-home orders. See Maryann Mason, Ponni Arukumar, and Joe Feinglass, “The Pandemic Stay-at-Home Order and Opioid Involved Overdose Fatalities,” *JAMA Insights*, vol. 325, no. 24 (April 23, 2021), pp. 2495-2496.

⁴⁷ The National Institute for Health Care Management (NIHCM) Foundation is a nongovernmental, nonpartisan organization “dedicated to transforming health care through evidence and collaboration.” The NIHCM Foundation frequently publishes data reports and infographics using federal data sources such as CDC mortality data. More

the rise is particularly notable for deaths involving synthetic opioids. In addition, the institute reported increases in deaths involving commonly prescribed opioids and heroin—both of which had been declining in recent years.⁴⁸

Figure 3. Drug-Related Overdose Deaths in the United States

January 2015–September 2020



Source: CRS analysis of data from Centers for Disease Control and Prevention, National Center for Health Statistics, *Provisional Drug Overdose Death Counts*, Vital Statistics Rapid Release, 2021, <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.

When examining emergency department (ED) visits, CDC found a higher number of drug overdoses—including opioid overdoses—between March and October 2020 compared with the same period in 2019.⁴⁹ Put together, the ODMAP and CDC data suggest that drug-related overdoses and overdose deaths have increased during the COVID-19 pandemic.

Individuals with substance use disorders may be at higher risk of contracting SARS-CoV-2 due to unstable housing situations, high incarceration rates, or the inability to physically distance themselves.⁵⁰ In addition, those with substance use disorders may be at higher risk for complications of COVID-19 because substance use can often suppress the immune system or inhibit respiratory functioning.⁵¹

information is available at <https://nihcm.org/about-us>.

⁴⁸ National Institute for Health Care Management (NIHCM) Foundation, *Synthetic Opioid Driving a Worsening Crisis of Overdose Deaths*, Infographics, Washington, DC, April 2, 2021, <https://nihcm.org/publications/synthetic-opioids-driving-a-worsening-crisis-of-overdose-deaths>.

⁴⁹ Holland et al., “Trends in US Emergency Department Visits,” 2021.

⁵⁰ SARS-CoV-2 is the name for the coronavirus that causes coronavirus disease (COVID-19). QuanQiu Wang, Rong Xu, and Nora D. Volkow, “Increased Risk of COVID-19 Infection and Mortality in People with Mental Disorders: Analysis from Electronic Health Records in the United States,” *World Psychiatry*, vol. 20, no. 1 (February 2021); and Osnat Melamed, Tanya Hauck, Leslie Buckley, et al., “COVID-19 and Persons with Substance Use Disorders: Inequities and Mitigation Strategies,” *Substance Abuse*, vol. 41, no. 3 (July 22, 2020), pp. 286-291.

⁵¹ Quan Qui Wang, David Kaelber, and Rong Xu, “COVID Risks and Outcomes in Patients with Substance Use Disorders: Analyses from Electronic Health Records in the United States,” *Molecular Psychiatry*, vol. 26 (September 14, 2020), pp. 30-39; and Jacques Baillargeon, Efstathia Polychronopoulou, Yong-Fang Kuo, et al., “The Impact of Substance Use Disorder on COVID-19 Outcomes,” *Psychiatry Online*, November 3, 2020.

Substance Use Disorder Services

Pandemic-related physical distancing measures may prevent individuals in need of substance use disorder treatment from accessing services. Lack of access to effective treatment may lead to relapse and increase the risk of overdose and death. During the pandemic, many harm reduction and overdose prevention and response activities have been suspended or are operating at a reduced capacity.⁵²

Substance use disorder treatment services involving physical interactions have been most affected by the pandemic. For example, it has been difficult for individuals to access peer-led programs such as Alcoholics Anonymous and Narcotics Anonymous.⁵³ These programs provide individuals with substance use disorders with certain supports—such as mentoring and a social support system—that are considered fundamental for recovery.⁵⁴ The National Association of County and City Health Officials (NACCHO) identified the following disruptions to overdose prevention services:

- reduced harm reduction programs, such as syringe service programs;
- greater difficulties connecting to individuals who have experienced overdose, including through peer recovery specialist programs and warm handoffs in the emergency department;
- challenges sharing best practices information with providers and disseminating provider education;
- barriers to accessing medication-assisted treatment; and
- complications in overdose prevention messaging.⁵⁵

A National Council for Behavioral Health survey of 3,400 behavioral health provider organizations reported that although 52% of facilities reported an increase in demand for services during the first six months of the pandemic, over 54% had cut back their programs.⁵⁶ In a follow-up survey in January 2021, 45% of organizations reported closing programs due to COVID-19, while the percentage reporting a demand for services increased to 67%.⁵⁷

While the use of telehealth services has increased throughout the pandemic, an analysis by the Commonwealth Fund showed that weekly visits to behavioral health providers remain below their baseline prepandemic levels.⁵⁸ Although certain services can be effectively provided through

⁵² National Association of County and City Health Officials (NACCHO), “Report from the Field: COVID-19 Impact on Overdose Response Activities at Local Health Departments,” press release, August 3, 2020, <https://www.naccho.org/blog/articles/press-release-report-from-the-field-covid-19-impact-on-overdose-response-activities-at-local-health-departments>.

⁵³ Collins, *Nora Volkow - Addressing the Twin Challenges of Substance Use Disorders and COVID-19*, 2020.

⁵⁴ *Ibid.*

⁵⁵ NACCHO, “Report from the Field: COVID-19 Impact on Overdose Response Activities at Local Health Departments,” 2020.

⁵⁶ National Council for Behavioral Health, *Member Survey*, National Council for Behavioral Health Polling Presentation, Washington, DC, September 2020, https://www.thenationalcouncil.org/wp-content/uploads/2020/09/NCBH_Member_Survey_Sept_2020_CTD2.pdf.

⁵⁷ National Council for Behavioral Health, *Member Survey*, National Council for Behavioral Health Polling Presentation, Washington, DC, February 2021, <https://www.thenationalcouncil.org/wp-content/uploads/2021/03/NCBH-Member-Survey-Feb-2021.pdf>.

⁵⁸ <https://www.commonwealthfund.org/publications/2020/oct/impact-covid-19-pandemic-outpatient-care-visits-return-prepandemic-levels>.

virtual telehealth platforms, some patients and providers have questioned whether virtual sessions can impart the same benefits of in-person services—particularly group therapy and peer-led programs.⁵⁹ Moreover, scientific research on telehealth is nascent, and questions remain regarding the effectiveness of telehealth modalities for certain populations and mental health conditions.⁶⁰

In April 2021, Government Accountability Office (GAO) published a report on the effects of the COVID-19 pandemic on patient access to behavioral health services. GAO found that long-standing unmet needs for behavioral health services persisted and were often worsened by new challenges associated with the pandemic.⁶¹

Differences Between Groups

Certain groups appear to be disproportionately affected by increases in behavioral health issues associated with the COVID-19 pandemic. The 2020 Household Pulse data showed differences in symptoms of anxiety and depression by education level, income level, age, ethnicity, and household job loss. For example, 45% of individuals in a household that experienced job loss had symptoms of anxiety or depressive disorder compared with 27% of those in households without job loss (**Figure 4**).⁶² Mental health symptoms appear particularly stratified by education level and income. For instance, 44% of individuals with less than a high school education exhibited symptoms of an anxiety or depressive disorder compared with 29% of individuals with a bachelor's degree or higher (**Figure 5**). Over 50% of individuals making less than \$25,000 annually exhibited symptoms of one or both mental health conditions compared with 35% of those making \$50,000-\$75,000 and 23% of those with an income above \$150,000 (**Figure A-1**).

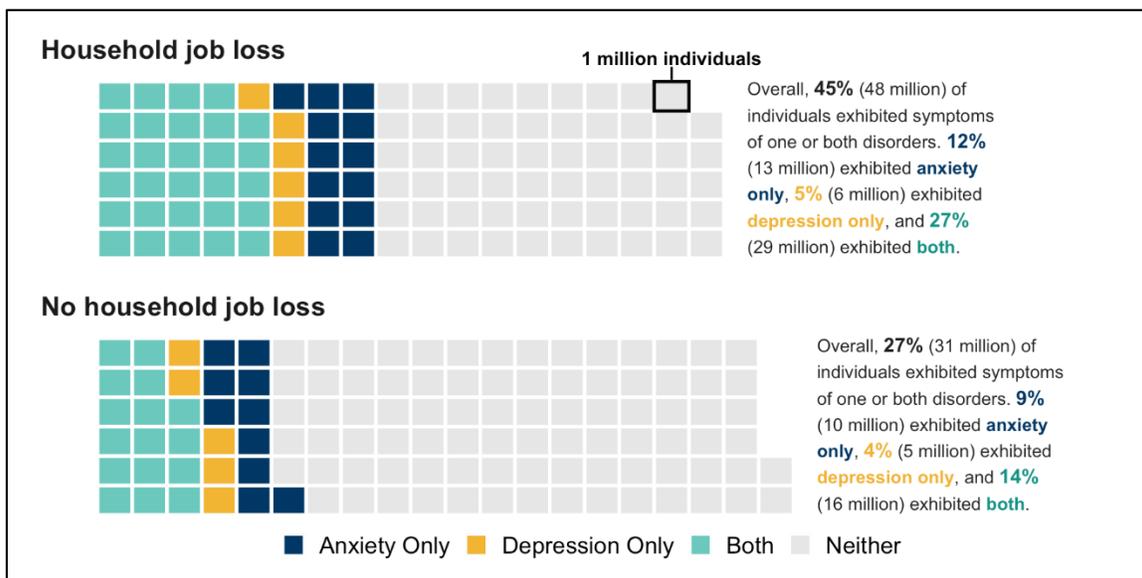
⁵⁹ Haim Weinberg, "Online Group Psychotherapy: Challenges and Possibilities During COVID-19—A Practice Review," *Group Dynamics: Theory, Research, and Practice*, vol. 24, no. 3 (2020), pp. 201-211.

⁶⁰ See, for example, David Hailey, Risto Roine, and Arto Ohinmaa, "The Effectiveness of Telemental Health Applications: A Review," *The Canadian Journal of Psychiatry*, November 1, 2008; and Donald M. Hilty, Daphne C. Ferrer, Michele Burke Parish, et al., "The Effectiveness of Telemental Health: A 2013 Review," *Telemedicine Journal and e-Health*, vol. 19, no. 6 (2013), pp. 444-454.

⁶¹ U.S. Government Accountability Office, *Behavioral Health: Patient Access, Provider Claims Payment, and the Effects of the COVID-19 Pandemic*, GAO-21-437R, April 30, 2021, <https://www.gao.gov/products/gao-21-437r>.

⁶² Findings from the December KFF Health Tracking Poll also indicated that households experiencing income or job loss were significantly more likely to report that worry or stress over the coronavirus outbreak has negatively affected their mental health (KFF 2021).

Figure 4. Mental Health Symptomology, by Household Job Loss in the United States
Symptoms of Anxiety and Depression, April 2020–June 2020



Source: CRS Analysis of U.S. Census Bureau, *Measuring Household Experiences during the Coronavirus Pandemic*, Household Pulse Survey, <https://www.census.gov/data/experimental-data-products/household-pulse-survey.html>.

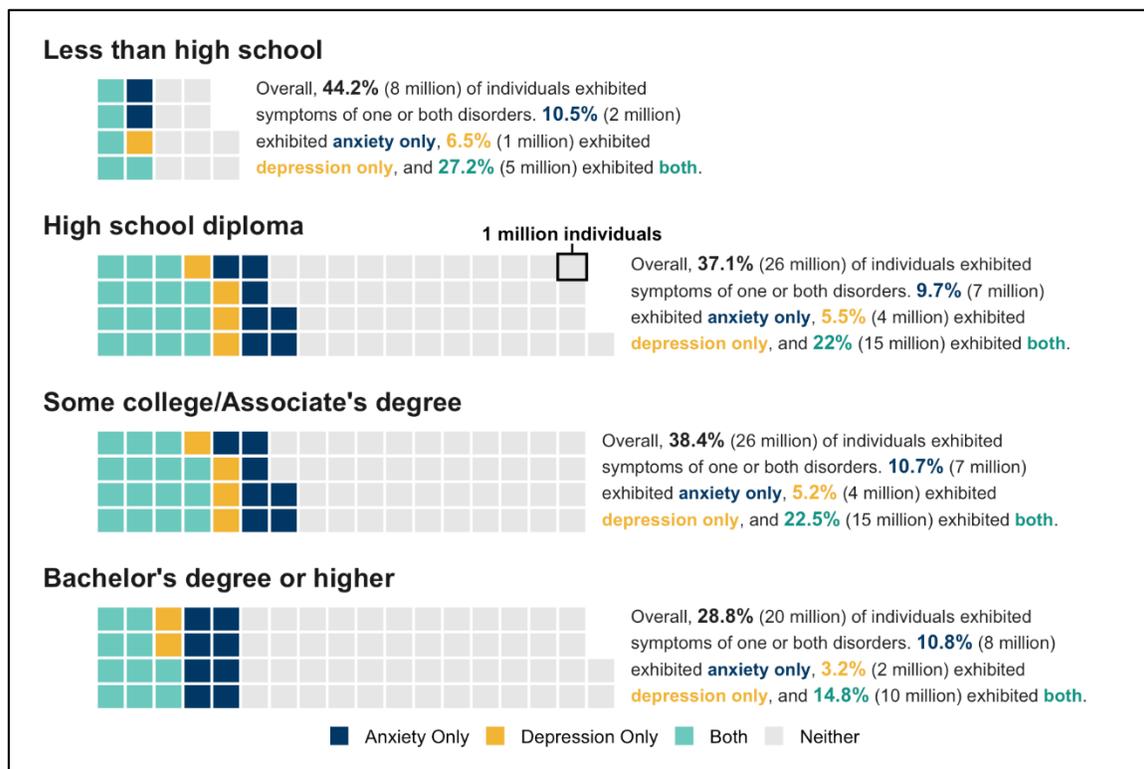
Notes: Estimates show the percentage of adults who reported symptoms of anxiety or depression that have been shown to be associated with diagnoses of generalized anxiety disorder or major depressive disorder. These symptoms generally occur more than half the days or nearly every day. Percentages may not add to totals due to rounding.

Another CDC survey conducted in June 2020 reflected similar mental health differences by age, caregiver status, and employment status and type. For example, at least one adverse mental or behavioral health symptom was reported by more than half of respondents who were aged 18–24 (74.9%) and 25–44 (51.9%), as well as those who were essential workers (54.0%) or unpaid caregivers for adults (66.6%).⁶³ In this survey, the percentage of respondents who reported having seriously considered suicide in the past 30 days (10.7%) was significantly higher among respondents aged 18–24 (25.5%), certain minority racial/ethnic groups, unpaid caregivers for adults (30.7%), and essential workers (21.7%).⁶⁴

⁶³ Mark Czeisler, Rashon Lane, and Emiko Petrosky, *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic—United States, June 24–30, 2020*, Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report (MMWR)*, vol. 69, no. 32, Atlanta, GA, August 14, 2020.

⁶⁴ *Ibid.* Prevalence decreased progressively with age.

Figure 5. Mental Health Symptomatology, by Education Level in the United States
Symptoms of Anxiety and Depression, April 2020 – June 2020



Source: CRS analysis from U.S. Census Bureau, *Measuring Household Experiences during the Coronavirus Pandemic*, Household Pulse Survey, <https://www.census.gov/data/experimental-data-products/household-pulse-survey.html>.

Notes: Estimates show the percentage of adults who reported symptoms of anxiety or depression that have been shown to be associated with diagnoses of generalized anxiety disorder or major depressive disorder. These symptoms generally occur more than half the days or nearly every day. Percentages may not add to totals due to rounding.

Overall, data from CDC has indicated that mental health symptoms associated with the early phases of the COVID-19 pandemic may have disproportionately affected those who are

- young adults (aged 18-24),
- Black or Latino/Hispanic,
- essential workers,
- unpaid caregivers for adults,
- unemployed,
- individuals with low income levels, or
- individuals with less than high school diploma.⁶⁵

⁶⁵ Mark Czeisler, Rashon Lane, and Emiko Petrosky, *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic—United States, June 24-30, 2020*, Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report (MMWR)*, vol. 69, no. 32, Atlanta, GA, August 14, 2020; and Lela R. McKnight-Eily, Catherine A. Okoro, and Tara W. Strine, *Racial and Ethnic Disparities in the Prevalence of Stress and Worry, Mental Health Conditions, and Increased Substance Use Among Adults During the COVID-19 Pandemic - United States, April and May 2020*, Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report (MMWR)*, vol. 70, no. 5, February 5, 2021, pp. 162-166, <https://www.cdc.gov/mmwr/volumes/70/wr/mm7005a3.htm>. See **Figure A-1**.

The disproportionate stress—and subsequent behavioral health issues—for some groups could be influenced by several factors.

The economic consequences of the pandemic have resulted in significant financial strain for many individuals. The KFF July 2020 Health Tracking Poll revealed that of the people who indicated that pandemic-related stress had caused adverse effects on their mental health, 75% reported difficulties affording household expenses. This correlation between financial strain and mental health differed between groups. For example, roughly 7 in 10 Black adults and individuals who had difficulty paying household bills in the past three months due to the financial impact of the coronavirus said that stress and worry related to the pandemic had a negative impact on their mental health.⁶⁶

Fears of contracting the virus, especially for those at high risk, could increase stress and symptoms of anxiety and depression. Essential workers, for instance, are generally required to work outside of their home and may be unable to practice physical distancing. Consequently, they are at increased risk of contracting coronavirus and exposing other members of their household to it.⁶⁷ According to a KFF June 2020 analysis, essential workers were more likely than nonessential workers to report symptoms of anxiety or depressive disorder (42% vs. 30%, respectively), to start or increase substance use (25% vs. 11%), or to consider suicide in the past 30 days (22% vs. 8%).⁶⁸

Other factors contribute to the differences in behavioral health issues between groups, such as the amount of COVID-19-related stressors experienced and access to effective resources for coping with pandemic-related stress. For example, one study found that U.S. adults who experienced more COVID-19-related stressors than other adults had a greater incidence of depressive symptoms.⁶⁹ Additionally, groups differ in their use of adaptive and maladaptive coping strategies. The SHADAC survey found variations in coping responses by age, sex, education, health status, and income.⁷⁰ Groups with higher risks for pandemic-related stressors also reported coping responses associated with greater health risks. The survey found higher alcohol consumption among younger adults, more unhealthy eating habits among women, and higher tobacco use among individuals with less education. Conversely, people with higher incomes were more likely to report healthier coping strategies, such as increased exercise. Such variations can compound behavioral health disparities among groups, in that groups with fewer stressors may employ healthy coping strategies, whereas groups at higher risk for pandemic-related mental health symptoms may use coping mechanisms that further jeopardize their health.

⁶⁶ Liz Hamel, Audrey Kearney, Ashley Kirzinger, et al., *KFF Health Tracking Poll - July 2020*, Kaiser Family Foundation, July 27, 2020, <https://www.kff.org/coronavirus-covid-19/report/kff-health-tracking-poll-july-2020/>.

⁶⁷ Nirmita Panchal, Rabah Kamal, Cynthia Cox, et al., *The Implications of COVID-19 for Mental Health and Substance Use*, Kaiser Family Foundation, Issue Brief, February 10, 2021, <https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>.

⁶⁸ *Ibid.*, and Czeisler et al., *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic—United States, June 24–30, 2020*.

⁶⁹ Catherine Ettman, Salma Abdalla, Gregory Cohen, et al., “Prevalence of Depression Symptoms in US Adults Before and During the COVID-19 Pandemic,” *JAMA Network Open*, vol. 3, no. 9 (September 2, 2020).

⁷⁰ Planalp et al., *90 Percent of U.S. Adults Reported Increased Stress due to the Coronavirus Pandemic*, 2020.

Summary of Behavioral Health Data During the COVID-19 Pandemic

Data from multiple sources suggest that mental health issues and substance use rates have increased during the COVID-19 pandemic. A greater number of Americans are experiencing stress and symptoms of mental health conditions than in previous years. Mental health conditions are disproportionately affecting specific populations, especially young adults, Black and Hispanic persons, essential workers, unpaid caregivers for adults, and households that have experienced job loss, among others.

Substance use rates appear to have increased during the COVID-19 pandemic. More than 1 in 10 adults started or increased substance use to cope with stress related to COVID-19. National drug-related overdose data remain limited, and some overdose metrics—such as emergency department visits and ODMAP-suspected overdose submissions—appeared to be increasing before the COVID-19 pandemic.⁷¹ As a result, determining the effects of the pandemic and related mitigation efforts on drug-related overdose rates is difficult. Regardless of the underlying causes, the data suggest that substance use rates and drug-related overdoses increased during the pandemic in 2020.

For individuals in need of mental health or substance use disorder treatment, pandemic-related physical distancing measures may have made it difficult to access such services. An estimated 10%-20% of individuals in need of mental health services during the pandemic did not receive them.⁷²

The behavioral health consequences of the COVID-19 pandemic may extend beyond the public health emergency itself. Many individuals experiencing pandemic-related stress may readjust when the event is over, while others may be left with mental health conditions and substance use disorders that outlast the pandemic.⁷³ Substance use disorders and mental health conditions spurred by the pandemic could have lasting effects on morbidity and mortality. A projected analysis by the Wellbeing Trust estimated that the pandemic could influence between 27,644 and 154,037 additional behavioral health-related deaths over the next decade.⁷⁴

⁷¹ National Center for Health Statistics, *Provisional Drug Overdose Death Counts*, Vital Statistics Rapid Release, Hyattsville, MD, 2021, <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.

⁷² Vahratian et al., *Symptoms of Anxiety or Depressive Disorder and Use of Mental Health Care Among Adults During the COVID-19 Pandemic*, 2021; and Kaiser Family Foundation, *Unmet Need for Counseling or Therapy Among Adults Reporting Symptoms of Anxiety and/or Depressive Disorder During the COVID-19 Pandemic*, State Health Facts, February 2021, <https://www.kff.org/other/state-indicator/unmet-need-for-counseling-or-therapy-among-adults-reporting-symptoms-of-anxiety-and-or-depressive-disorder-during-the-covid-19-pandemic/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

⁷³ Antonis Kousoulis, Tine Van Bortel, Priscila Hernandez, et al., *The Long Term Mental Health Impact of COVID-19 Must Not Be Ignored*, BMJ, The BMJ Opinion, May 5, 2021, <https://blogs.bmj.com/bmj/2020/05/05/the-long-term-mental-health-impact-of-covid-19-must-not-be-ignored/>.

⁷⁴ Stephen Petterson, John M. Westfall, and Benjamin F. Miller, *Projected Deaths of Despair from COVID-19*, Well Being Trust, May 8, 2020, https://wellbeingtrust.org/wp-content/uploads/2020/05/WBT_Deaths-of-Despair_COVID-19-FINAL-FINAL.pdf.

Changes to Behavioral Health Services During the COVID-19 Pandemic

Except for during the COVID-19 pandemic, most mental health treatment is typically administered in outpatient settings where patients visit providers in brick-and-mortar offices, clinics, hospitals, or specialty facilities. Treatment visits may occur on a regular basis (e.g., weekly, monthly); as a single, one-time visit (such as for an evaluation); or in discrete episodes as full-day or overnight visits as part of more intensive service like intensive outpatient, residential, or partial hospitalization programs. As technology has advanced, some behavioral health treatment providers have used *telehealth* (or *telemedicine*) modalities such as video conferencing to deliver services. Behavioral health services via telehealth (known as *telebehavioral health*) are provided through live video and mobile telephone calls or applications.

Substance use disorder treatment works similarly in most instances, with exceptions for interventions using frequent administration of medications, such as medication-assisted treatment (MAT) for opioid use disorder (OUD).⁷⁵ For MAT that uses opioid agonist treatments such as methadone and buprenorphine, patients are required by law to attend in person for at least the initial visit for buprenorphine, and daily for methadone.⁷⁶ Methadone is administered on a daily basis in federally certified opioid treatment programs (OTPs; also known as methadone clinics), with some short-term take-home doses allowed for stable patients.⁷⁷

Physical distancing measures and temporary stay-at-home orders associated with the COVID-19 pandemic have required changes in service delivery for mental health and substance use treatment. Such changes include relaxing privacy requirements required by the Health Insurance Portability and Accountability Act (HIPAA) rules and increasing the use of telehealth to deliver behavioral health treatment and services. In addition, some states have employed other methods of service delivery (e.g., mobile units) for treatments that cannot be administered via telehealth, such as MAT for OUD.

Changes to Telehealth

On March 13, 2020, the HHS Secretary implemented the Section 1135 waiver authority from the Social Security Act in an effort to ensure that sufficient health care services are available to individuals enrolled in Medicare, Medicaid and Children's Health Insurance Program (CHIP).⁷⁸ Using this new authority, which was authorized by the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (P.L. 116-123), and other COVID-19 related acts, the HHS Secretary waived or modified telebehavioral health-related participation requirements under

⁷⁵ CRS In Focus IF10219, *Opioid Treatment Programs and Related Federal Regulations*.

⁷⁶ CRS Report R45279, *Buprenorphine and the Opioid Crisis: A Primer for Congress*.

⁷⁷ Drug Enforcement Administration, *Use of Telemedicine While Providing Medication Assisted Treatment (MAT)*, Diversion Control, May 15, 2018, https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/telemedicine-dea-guidance.pdf.

⁷⁸ Alex Azar II, Secretary of Health and Human Services, *Waiver or Modification of Requirements Under Section 1135 of the Social Security Act*, U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, March 13, 2020, <https://www.phe.gov/emergency/news/healthactions/section1135/Pages/covid19-13March20.aspx>. For more information, see CRS Legal Sidebar LSB10430, *Section 1135 Waivers and COVID-19: An Overview*.

programs administered by the Centers for Medicare & Medicaid Services (CMS).⁷⁹ For instance, CMS announced that it would now reimburse for audio-only behavioral health telephone visits.

Other federal agencies have also addressed telebehavioral health services relative to their missions. For example, the Health Resources and Services Administration (HRSA) of HHS continued to administer demonstration programs aimed at assessing whether telehealth networks can improve access to behavioral health in rural and frontier communities under the Substance Abuse Treatment Network Grant Program and Evidence-Based Tele-Behavioral Health Network Grant Program.⁸⁰ The Department of Veterans Affairs expanded telebehavioral health care services to veterans by entering into short-term agreements with telecommunications companies and through mobile applications such as COVID Coach and Mindfulness Coach.⁸¹

In conjunction with the federal government, some states have waived or modified laws and reimbursement policies on telebehavioral health during the COVID-19 pandemic.⁸² Since the pandemic began, behavioral health service providers have substantially increased the use of telehealth.⁸³ However, the increase in telehealth use does not appear to have offset clinic closures or other reductions to treatment service capacity enough to adequately meet the demand for services during the pandemic.⁸⁴ AKFF poll found that nearly a quarter of adults with symptoms of anxiety or depressive disorders reported an unmet need for counseling or therapy throughout the pandemic.⁸⁵

Changes to Substance Use Disorder Treatment

The Controlled Substances Act includes limits on prescribing controlled substances over the internet.⁸⁶ For example, patients initiating MAT with buprenorphine for opioid use disorder

⁷⁹ Centers for Medicare and Medicaid Services, “Trump Administration Issues Second Round of Sweeping Changes to Support U.S. Healthcare System During COVID-19 Pandemic,” press release, April 30, 2020, <https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid>.

⁸⁰ See Health Resources and Services Administration (HRSA), *Evidence Based Telehealth Network Program*, <https://www.hrsa.gov/grants/find-funding/hrsa-21-082>.

⁸¹ See, for example, U.S. Department of Veteran’s Affairs, *VAMobile/COVID Coach*, <https://mobile.va.gov/app/covid-coach>.

⁸² See, for instance, The National Telehealth Policy Resource Center, Center for Connected Health Policy, *Current State Laws and Reimbursement Policies*, September 2020, <https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies>.

⁸³ Ateev Mehrotra, Michael Chernew, and David Linesky, *The Impact of the COVID-19 Pandemic on Outpatient Care: Visits Return to Prepandemic Levels, but Not for All Providers and Patients*, The Commonwealth Fund, New York, NY, October 15, 2020, <https://www.commonwealthfund.org/publications/2020/oct/impact-covid-19-pandemic-outpatient-care-visits-return-prepandemic-levels>.

⁸⁴ The National Council for Behavioral Health, *Demand for Mental Health and Addiction Services Increasing as COVID-19 Pandemic Continues to Threaten Availability of Treatment Options*, National Council for Behavioral Health Member Survey Polling Presentation, Washington, DC, September 2020, <https://www.thenationalcouncil.org/press-releases/demand-for-mental-health-and-addiction-services-increasing-as-covid-19-pandemic-continues-to-threaten-availability-of-treatment-options/>.

⁸⁵ Kaiser Family Foundation, *Unmet Need for Counseling or Therapy Among Adults Reporting Symptoms of Anxiety and/or Depressive Disorder During the COVID-19 Pandemic*, State Health Facts, February 2021, <https://www.kff.org/other/state-indicator/unmet-need-for-counseling-or-therapy-among-adults-reporting-symptoms-of-anxiety-and-or-depressive-disorder-during-the-covid-19-pandemic/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

⁸⁶ Controlled Substances Act §309(e) and 21 C.F.R. §1300 et seq.

(OUD) are typically required to attend an initial examination in person.⁸⁷ For the duration of the public health emergency, SAMHSA and the Drug Enforcement Administration (DEA) are allowing prescriptions for buprenorphine for OUD to a new patient via telemedicine (including telephone) without an initial in-person examination.⁸⁸ In April 2021, HHS published practice guidelines for administering buprenorphine for OUD.⁸⁹ These new guidelines exempt eligible practitioners from certification prerequisites previously required to treat patients with buprenorphine.⁹⁰ According to HHS, this exemption addresses reported barriers to expanding access to buprenorphine treatment.⁹¹ The exemptions in these guidelines are not subject to the public health emergency declaration.

Typically, most individuals receiving methadone treatment must travel to brick-and-mortar OTPs on a daily basis to receive their dose (with some exceptions for stable and long-term patients).⁹² During the pandemic, SAMHSA and DEA are allowing stable patients to receive up to 28 days of take-home medication.⁹³ DEA is also allowing alternative methods for delivery of methadone to patients under stay-at-home orders,⁹⁴ and interstate prescribing privileges for providers.⁹⁵ DEA—the agency that provides registrations to operate OTPs—had previously published a proposed rule allowing these facilities to operate a mobile component to administer methadone.⁹⁶

Changes to Privacy Requirements

Given the large number of people seeking COVID-19 treatment, testing, and vaccination, individuals' interactions with the health care and public health system have increased, both virtually and in person, during the COVID-19 pandemic. As a result, a significant amount of clinical and related demographic and other data have been generated. A coordinated response to the pandemic has, in many cases, relied on efforts to share health care and public health information in new ways and more readily, and to overcome the barriers associated with doing

⁸⁷ Controlled Substances Act §309(e); 21 U.S.C. §829(e).

⁸⁸ Letter from Thomas Prevoznik, Deputy Assistant Administrator, Diversion Control Center, to DEA Qualifying Practitioners and DEA Qualifying Other Practitioners, DEA Registrants, March 31, 2020, [https://www.dea diversion.usdoj.gov/GDP/\(DEA-DC-022\)\(DEA068\)%20DEA%20SAMHSA%20buprenorphine%20telemedicine%20%20\(Final\)%20+Esign.pdf](https://www.dea diversion.usdoj.gov/GDP/(DEA-DC-022)(DEA068)%20DEA%20SAMHSA%20buprenorphine%20telemedicine%20%20(Final)%20+Esign.pdf).

⁸⁹ Department of Health and Human Services, “Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder,” 86 *Federal Register* 22439-22440, April 28, 2021.

⁹⁰ For more information, see CRS Report R45279, *Buprenorphine and the Opioid Crisis: A Primer for Congress*.

⁹¹ 86 *Federal Register* 22439.

⁹² As outlined in 42 CFR §8.12.

⁹³ Substance Abuse and Mental Health Services Administration, *Opioid Treatment Program (OTP) Guidance*, Rockville, MD, March 16, 2020, <https://www.samhsa.gov/sites/default/files/otp-guidance-20200316.pdf>.

⁹⁴ Letter from Thomas Prevoznik, Deputy Assistant Administrator, Drug Enforcement Administration, to Registered Narcotic Treatment Program, April 7, 2020, [https://www.dea diversion.usdoj.gov/GDP/\(DEA-DC-025\)\(DEA078\)_Off-site_OTP_delivery_method_\(Final\)+_esign.pdf](https://www.dea diversion.usdoj.gov/GDP/(DEA-DC-025)(DEA078)_Off-site_OTP_delivery_method_(Final)+_esign.pdf).

⁹⁵ Letter from William McDermott, Assistant Administrator, Drug Enforcement Administration, to DEA Registrants, March 25, 2020, [https://www.dea diversion.usdoj.gov/GDP/\(DEA-DC-018\)\(DEA067\)%20DEA%20state%20reciprocity%20\(final\)\(Signed\).pdf](https://www.dea diversion.usdoj.gov/GDP/(DEA-DC-018)(DEA067)%20DEA%20state%20reciprocity%20(final)(Signed).pdf). DEA operates a webpage with more information and resources related to the COVID-19 pandemic. See Drug Enforcement Administration, “COVID-19 Information Page,” <https://www.dea diversion.usdoj.gov/coronavirus.html>.

⁹⁶ Drug Enforcement Administration, “Registration Requirements for Narcotic Treatment Programs With Mobile Components,” 85 *Federal Register* 11008-11020, February 26, 2020. DEA refers to OTPs as “narcotic treatment programs.”

so.⁹⁷ Such efforts have resulted in certain changes to how existing privacy requirements are enforced and highlighted other potential changes.

In response to the COVID-19 pandemic, the Office for Civil Rights (OCR) in the Department of Health and Human Services (HHS), the agency responsible for administering and enforcing the HIPAA rules, released numerous guidance documents and published notices of enforcement discretion to support the sharing of health information or to clarify how such information may be shared per the requirements of the rules. These actions are generally linked and limited to the COVID-19 pandemic. Some of these announcements, such as those involving requirements related to the sharing of health information in the context of telehealth, may be particularly relevant for individuals with behavioral health conditions.

In addition, OCR publicly released a notice of proposed rulemaking on the HHS website in December 2020 that would make numerous changes to the HIPAA Privacy Rule.⁹⁸ Several of these proposed changes—for example, modifying the standard for sharing information about individuals experiencing health emergencies, including substance use disorder crises—could directly affect individuals with behavioral health conditions. In addition, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act, P.L. 116-136) included a provision that amended confidentiality requirements for sharing certain substance use disorder patient information, requirements that are implemented by the Part 2 Rule and SAMHSA.⁹⁹ The goal of these changes was to better support care coordination and health care delivery by giving all providers involved in a patient’s care ready access to health information in a manner similar to the HIPAA Privacy Rule. These permanent changes are not limited to the COVID-19 pandemic; however, broader issues with data sharing during the pandemic accelerated these changes, which had been under debate for several years.

In general, such changes undertaken to relax or otherwise modify privacy requirements may be of consequence to individuals with behavioral health conditions. These individuals, in particular, may weigh the potential benefits of sharing their health data against the risks of having their personal information shared more broadly, including their behavioral health information. Conversely, having information more readily available in clinical care settings may provide a specific benefit to this population, possibly supporting and resulting in better health care outcomes, because the clinical information may be more complete and more easily integrated into an individual’s general medical care. Having health information readily available may be particularly important during health emergencies, for example, in cases involving opioid overdose.

HIPAA Privacy and Security Rule

The HIPAA Privacy Rule¹⁰⁰ governs covered entities’ (health care plans, providers, and clearinghouses) and their business associates’ *use and disclosure* of protected health information (PHI). PHI is generally defined as individually identifiable health information, in any form or format, including oral, paper-based, and electronic. Covered entities perform many different functions that involve PHI, and they often need to contract with outside entities to conduct their work. These contracted entities, or business associates, are defined as a person or organization

⁹⁷ For more information, see CRS Report R46588, *Tracking COVID-19: U.S. Public Health Surveillance and Data*.

⁹⁸ The NPRM was published in the *Federal Register* on January 21, 2021. See 86 *Federal Register* 6446, January 21, 2021.

⁹⁹ The Part 2 Rule is codified at 42 C.F.R. Part 2, “Confidentiality of Substance Use Disorder Patient Records.”

¹⁰⁰ 45 C.F.R. Part 164 Subpart E.

that performs certain functions or activities on behalf of, or provides certain services to, a covered entity that involve the use or disclosure of individually identifiable health information.¹⁰¹

The use and disclosure of PHI by a business associate is generally governed by the requirements of the HIPAA Privacy Rule, and more narrowly by specific parameters outlined in a Business Associate Agreement (BAA) between the covered entity and the business associate. The rule's requirements apply only to PHI, and they do not apply to data that have been de-identified pursuant to requirements in the rule. The rule delineates when and under what conditions covered entities may permissibly use or disclose PHI without written authorization. Uses and disclosures that are not expressly permitted under the rule require an individual's prior written authorization. Specifically, covered entities are permitted to disclose PHI to noncovered entities for several specific "priority purposes" that are not health care specific, without authorization from the individual.¹⁰² These include, for example, legally required disclosures for public health activities, for health oversight activity, and to avert a serious threat to health or safety, among others.

In addition, the HIPAA Security Rule¹⁰³ governs the security and integrity of electronic PHI (ePHI), and the Breach Notification Rule¹⁰⁴ requires notification to affected individuals and covered entities, the media, and the HHS Secretary in certain cases of breaches involving unsecured PHI.

These disclosures have taken on increased significance during the COVID-19 pandemic, because sharing large amounts of data for public health purposes has become key to monitoring and responding to the crisis.

As part of its response to the COVID-19 pandemic, OCR has not changed existing requirements in the HIPAA rules, but has instead modified the enforcement of specific requirements in certain cases. These changes will generally remain in effect until the end of the COVID-19 public health emergency.¹⁰⁵ For example, OCR issued guidance in March 2020 announcing that it will not penalize health care providers for noncompliance when they are providing telehealth services in good faith during the COVID-19 emergency.¹⁰⁶ Specifically, the notice explains that health care providers using certain common nonpublic facing applications (e.g., Apple FaceTime or Facebook Messenger video chat) in good faith for telehealth would not be penalized. Generally, for example, a BAA between a covered entity (health care provider) and the video communication vendor would be required prior to providing telehealth services. Under this OCR policy, a provider may use a video communication vendor to provide telehealth services in the absence of a BAA, although OCR recommends that providers advise patients of the potential privacy risks, and suggests that all available privacy and encryption modes be used when possible.

In addition, to facilitate its response to the COVID emergency in terms of both disclosures and the performance of certain data analytic functions, OCR published a notice of enforcement

¹⁰¹ 45 C.F.R. §160.103.

¹⁰² See 45 C.F.R. §164.512, generally.

¹⁰³ 45 C.F.R. Part 164, Subpart C.

¹⁰⁴ 45 C.F.R. Part 164, Subpart D.

¹⁰⁵ See, for example, [JD: Is something missing here?] the notice of enforcement discretion allowing business associates to share PHI for public health purposes, noting that the changes will "remain in effect until the Secretary of HHS declares that the public health emergency no longer exists, or upon the expiration date of the declared public health emergency (as determined by 42 U.S.C. 247d), whichever occurs first." 85 *Federal Register* 19392, April 7, 2020.

¹⁰⁶ 85 *Federal Register* 22024, April 21, 2020.

discretion allowing business associates to share PHI for public health purposes in a manner that might not be expressly permitted by their BAA.¹⁰⁷ Due to the requirements relating to the BAA in the Privacy Rule, certain entities serving as business associates were delayed or unable to respond to requests for certain public health data. This enforcement discretion aims to address that issue and to facilitate rapid public health monitoring during the pandemic. The scope of this policy is limited only to certain specified Privacy Rule provisions, and it does not extend to requirements under the Security or Breach Notification Rules.

In December 2020, OCR issued a public Notice of Proposed Rulemaking (NPRM) proposing several modifications to the HIPAA Privacy Rule to broadly facilitate care coordination and to reduce the burden of compliance on providers.¹⁰⁸ Several of these proposed changes, which had been under discussion since publication of a December 2018 Request for Information (RFI) soliciting comments on possible changes to the rule,¹⁰⁹ may be of special relevance to individuals with behavioral health conditions. Specifically, the proposed rule proposes modifying the language regarding the allowance for lawful disclosure when there is a “serious or imminent threat” to health or safety.¹¹⁰ This disclosure, which may be made by a covered entity to a noncovered entity without individual authorization, is significant because the information, once held by a noncovered entity, is no longer subject to the Privacy Rule’s requirements. The NPRM proposes to change this disclosure language from “serious or imminent threat to the health or safety” to “serious and reasonably *foreseeable*” harm. This change is meant to provide a less strict standard for disclosure, one that does not require a provider to determine if a threat is “imminent,” but rather only foreseeable. If finalized, this change may result in more disclosures of potentially sensitive information.

Many providers may be unaware that the Privacy Rule allows them to share PHI in certain cases when an individual is incapacitated. Providers may be unfamiliar with the rule’s specific requirements in these cases, or may be bound by potentially more stringent state laws or professional ethics. Currently, providers may share PHI with family and friends involved in an individual’s care if the individual is unable to agree or object to the disclosure, based on the providers’ professional judgment.¹¹¹ The December 2020 NPRM proposes to substitute the current phrase “exercise of professional judgement” with “good faith belief” in an effort to expand “the ability of covered entities to disclose PHI to family members and other caregivers when they believe it is in the best interests of the individual ... without the covered entity having undue fear of violating HIPAA.”¹¹² This change aims to help individuals experiencing a health crisis related to substance use disorder or serious mental illness, among others, by making it easier for family and friends to care for them, especially if they are incapacitated.

Together, these actions and proposed changes generally support expanding the timely sharing of information, in certain cases without explicit authorization. In certain cases, these changes may benefit patients (e.g., sharing information when an individual is incapacitated). In other cases, these changes may benefit the broader public (e.g., disclosures related to monitoring the pandemic or averting a serious threat to health or safety). However, these benefits are being

¹⁰⁷ 85 *Federal Register* 19392, April 7, 2020.

¹⁰⁸ The NPRM was published in the *Federal Register* in January 2021. See 86 *Federal Register* 6446, January 21, 2021. Comments are due by May 6, 2021.

¹⁰⁹ 83 *Federal Register* 64302, December 14, 2018.

¹¹⁰ 45 C.F.R. §164.512(j).

¹¹¹ 45 C.F.R. §164.510(b).

¹¹² Office for Civil Rights, “Office for Civil Rights (OCR) Proposes Modifications to the HIPAA Privacy Rule to Empower Individuals, Improve Coordinated Care, and Reduce Regulatory Burdens FACT SHEET,” December 10, 2020, <https://www.hhs.gov/sites/default/files/hipaa-nprm-fact-sheet.pdf>.

weighed against privacy concerns and the potential risk of sharing sensitive information too broadly, with individuals unable to specifically control what information is being shared and with whom. Although the issue of privacy is being debated both at the state and federal levels, it is unclear whether these temporary changes will be made permanent or finalized through rulemaking in the future.

CARES Act: Harmonizing the Part 2 Rule with the HIPAA Privacy Rule

Beyond the context of the COVID-19 pandemic, the CARES Act made changes, not limited to the emergency period, to requirements governing confidentiality of substance use disorder records. Promulgated in the “Part 2” Rule, these requirements apply to individually identifiable patient information received or acquired by federally assisted substance use disorder programs.¹¹³ The Part 2 Rule is generally considered to be one of the strictest privacy laws in effect, due in large part to the stigma associated with seeking treatment for substance use disorders.

The CARES Act allows covered information to be shared in a manner more aligned with HIPAA Privacy Rule requirements regarding treatment, payment, or health care operations information shared between and among covered entities without authorization. Although an initial consent will be required for such sharing of records to occur, once that consent is given, the records may be disclosed for PHI as they are under the Privacy Rule for the purposes of treatment, payment, and health care operations. The specifics of the consent requirement were not addressed by the CARES Act and could be included in promulgating regulations.

The changes made by the CARES Act seek to balance improved care coordination for individuals with substance use disorders with the heightened privacy interest around sensitive information, reflecting that the delivery of health care has changed significantly since the substance use disorder confidentiality requirements became law. Although the CARES Act requires the Secretary to revise Part 2 or other regulations as necessary with respect to uses and disclosures of covered records one year after enactment (i.e., March 27, 2021), HHS has not yet promulgated these regulations. SAMHSA recently noted that it expects to publish these regulations later in 2021, in conjunction with OCR. In the interim, the current Part 2 regulations will remain in effect.¹¹⁴

Changes to Mental Health Parity

Mental health parity refers to the requirement that health insurance issuers provide equivalent terms for the coverage of mental health services as provided for medical and surgical services.¹¹⁵ Mental health services include counseling, psychotherapy, and substance use treatment, among others. Federal parity law does not require private health insurance, Medicaid, or CHIP to offer mental health benefits (although other areas of federal law mandate such benefits in some cases). Rather, when both mental health benefits and medical/surgical benefits are offered, federal parity

¹¹³ PHSA §543 “Confidentiality of Records”; 42 U.S.C. § 290dd–2. The Part 2 Rule is codified at 42 C.F.R. Part 2, “Confidentiality of Substance Use Disorder Patient Records.”

¹¹⁴ SAMHSA, “Statement on 42 CFR Part 2 Amendments Process,” April 9, 2021, <https://www.samhsa.gov/newsroom/statements/2021/42-cfr-part-2-amendments-process>.

¹¹⁵ Federal parity law is explicitly directed at private health insurance. The law is applied to Medicaid and the Children’s Health Insurance Program through the statute governing private health insurance.

law generally prohibits the insurer from imposing more restrictive limits—including quantitative and nonquantitative treatment limitations—on the mental health benefits.¹¹⁶

A provision in the Consolidated Appropriations Act, 2021 (P.L. 116-260), attempts to strengthen federal oversight of insurers' compliance with mental health parity laws and regulations by requiring group health plans and health insurance issuers to perform and document comparative analyses of nonquantitative treatment limitations for mental health and substance use disorder benefits and medical and surgical benefits.¹¹⁷ The provision requires HHS and the Department of Labor to request and review at least 20 comparative analyses from group health plans and health insurance issuers that may involve a violation or a complaint regarding noncompliance with mental health parity requirements. The information in the comparative analyses is to be used to determine compliance, as well as develop guidance to help group health plans and health insurance issuers comply with mental health parity requirements.

Changes to Behavioral Health Funding

The COVID-19 pandemic has limited in-person health service visits and caused economic hardships, resulting in behavioral health clinic closures and other reductions to treatment service capacity.¹¹⁸ In response to this decreasing capacity, Congress sought to address the high demand for mental health and substance use disorder treatment services through emergency financial support for behavioral health activities provided in three of the supplemental COVID-19 funding laws.

The CARES Act appropriated \$425 million to SAMHSA to support behavioral health services during the pandemic. This amount included \$250 million for the Certified Community Behavioral Health Clinic (CCBHC) Expansion grant program and \$50 million for suicide prevention. Of the remaining total, \$110 million went to states in the form of emergency grants to provide crisis intervention services, mental and substance use disorder treatment, and other related recovery supports for children and adults affected by the COVID-19 pandemic.¹¹⁹ SAMHSA gave states significant flexibility in how to use these funds to support behavioral health-related activities.¹²⁰

In addition, Congress established the Provider Relief Fund (PRF) in the CARES Act. The measure appropriated \$100 billion “to reimburse, through grants or other mechanisms, eligible health care providers for health care related expenses or lost revenues that are attributable to

¹¹⁶ Quantitative treatment limitations include, but are not limited to, annual, episode, and lifetime day and visit limits. Nonquantitative treatment limitations include medical management standards limiting benefits based on medical necessity, prior authorization requirements, and treatment exclusions for certain conditions, among others. For the definition of “treatment limitations,” see 45 C.F.R. §146.136. For a list of quantitative and nonquantitative treatment limitations, see <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf>.

¹¹⁷ Division BB, Title II, §203 of P.L. 116-260, Consolidated Appropriations Act, 2021 (42 U.S.C. 300gg-26(a)).

¹¹⁸ The National Council for Behavioral Health, *Demand for Mental Health and Addiction Services Increasing as COVID-19 Pandemic Continues to Threaten Availability of Treatment Options*, National Council for Behavioral Health Member Survey Polling Presentation, Washington, DC, September 2020, <https://www.thenationalcouncil.org/press-releases/demand-for-mental-health-and-addiction-services-increasing-as-covid-19-pandemic-continues-to-threaten-availability-of-treatment-options/>.

¹¹⁹ Eligibility included territories and tribes/tribal organizations. See Substance Abuse and Mental Health Services Administration, *Emergency Grants to Address Mental Health and Substance Use Disorders during COVID-19*, Funding Opportunity Announcement FG-20-006, April 1, 2020, <https://www.samhsa.gov/grants/grant-announcements/fg-20-006>.

¹²⁰ SAMHSA operates a webpage dedicated to other initiatives and information related to the novel coronavirus pandemic, including a webpage specific to MAT. The webpage can be found at <https://www.samhsa.gov/coronavirus>.

coronavirus.” The PRF provides grants to eligible health care providers. Funds do not have to be repaid as long as the provider meets the PRF’s terms and conditions.¹²¹ The Paycheck Protection Program and Health Care Enhancement Act (PPPHEA, P.L. 116-139)—the fourth COVID-19 supplemental measure—added an additional \$75 billion to the PRF.

Certified Community Behavioral Health Clinics

The Protecting Access to Medicare Act of 2014 (P.L. 113-193) created a program to improve community-based behavioral health services through a demonstration program. Certified community behavioral health clinics (CCBHCs) are facilities operated by nonprofit organizations and governmental or tribal entities that offer a comprehensive range of services, including risk assessment, outpatient mental health and substance use treatment, case management, psychiatric rehabilitation services, peer and family supports, 24-hour crisis management, and primary care medical services, among others.¹²² Federal funding provided through the CCBHC program helps community behavioral health clinics provide the services required for certification. To be certified, CCBHCs are required to maintain partnerships with other health and social service providers.

In 2015, 24 states received planning grants, and in 2016, 8 states were selected to participate in the initial demonstration program. These states receive an enhanced Medicaid federal medical assistance percentage (FMAP; i.e., federal matching) rate for CCBHC services, and the CCBHCs in these states received an enhanced payment rate through a prospective payment system methodology.¹²³ Two additional states were added to the demonstration program in 2020.¹²⁴

In 2019, the Further Consolidated Appropriations Act, 2020 (P.L. 116-94), authorized a CCBHC Expansion grant program. CCBHC Expansion Grants provided up to \$2 million to facilities that met the certification criteria to increase access and improve the quality of their behavioral health services. (Only CCBHCs in the Demonstration program receive the enhanced Medicaid rate.) In 2020, 33 states were participating in the CCBHC Demonstration and Expansion grant programs.¹²⁵

The fifth COVID-19 supplemental funding measure (P.L. 116-260) appropriated \$4.25 billion to SAMHSA in supplemental COVID-related funding.¹²⁶ Of this amount, \$1.65 billion was designated for each of SAMHSA’s two main block grants: the Substance Abuse Prevention and Treatment Block Grant (SABG) and the Community Mental Health Services Block Grant (MHBG). The SABG and MHBG are SAMHSA’s two largest grant programs.¹²⁷ Both block grant programs distribute funds to states (including the District of Columbia and territories) according to a formula specified in statute.¹²⁸ The states, in turn, may distribute funds to local government entities and nonprofit organizations for behavioral health-related treatment and prevention activities in accordance with a plan the state submits to SAMHSA. The provision in P.L. 116-260 maintained a 20% set-aside for prevention-related activities.

¹²¹ For more information, see CRS Insight IN11438, *The COVID-19 Health Care Provider Relief Fund*.

¹²² §223 of P.L. 113-93, Protecting Access to Medicare Act of 2014.

¹²³ SAMHSA, *Section 223 Demonstration Program for Certified Community Behavioral Health Clinics*, last updated October 11, 2018, <https://www.samhsa.gov/section-223>.

¹²⁴ §3814 of P.L. 116-136, the Coronavirus Aid, Relief, and Economic Security Act.

¹²⁵ The National Council for Behavioral Health, *CCBHCs: A New Model for Behavioral Health Gaining Momentum in States*, Events, Washington, DC, January 29, 2021, <https://www.thenationalcouncil.org/?api&do=attachment&name=ccbhc-a-new-model-for-behavioral-health-gaining-momentum-in-states>.

¹²⁶ This amount was in addition to SAMHSA’s annual FY2021 appropriations, which were also included in the law.

¹²⁷ For more information, see CRS Report R46426, *Substance Abuse and Mental Health Services Administration (SAMHSA): Overview of the Agency and Major Programs*.

¹²⁸ PHS Title XIX. For more information, see CRS Report R46426, *Substance Abuse and Mental Health Services Administration (SAMHSA): Overview of the Agency and Major Programs*.

Of the total appropriated to SAMHSA in P.L. 116-260, not less than \$240 million was reserved for emergency response activities.¹²⁹ The law designated \$600 million to the CCBHC Expansion grant program and \$50 million for suicide prevention. The law also designated \$50 million to SAMHSA's Project AWARE program, which supports school-based mental health training and referral services in elementary and secondary education. Another \$10 million was designated for the National Child Traumatic Stress Initiative (NCTSI).¹³⁰

In March 2021, a budget reconciliation measure developed in response to the pandemic—the American Rescue Plan Act (ARPA; P.L. 117-2)—provided another \$1.5 billion to each of SAMHSA's main block grant programs: the MHBG and SABG.¹³¹ The measure provided \$50 million to “address increased community behavioral health needs worsened by the COVID-19 public health emergency”¹³² and another \$30 million to support “community-based overdose prevention programs, syringe services programs, and other harm reduction services.”¹³³ The CCBHC Expansion grant program received \$420 million, Project AWARE received \$30 million, NCTSI received \$10 million, and \$20 million was provided for youth suicide prevention activities.

In addition to SAMHSA appropriations, ARPA provided \$80 million to HRSA for pediatric mental health care, which includes expansion of telehealth services. HRSA received \$120 million to promote mental health among health professionals and to reduce suicide, burnout, and mental health conditions among the health care workforce. CDC received \$20 million for a behavioral health education and awareness campaign directed at health care professionals and first responders.¹³⁴

Other Federal Efforts

During the COVID-19 pandemic, Congress has periodically requested that the Comptroller General of the Government Accountability Office (GAO) monitor and report on federal efforts related to the pandemic.¹³⁵ In November 2020, GAO published a report summarizing federal efforts during the pandemic and provided recommendations for federal action.¹³⁶ GAO reported the following behavioral health-related federal activities during the COVID-19 pandemic:

- CDC, in addition collecting data, has operated websites promoting strategies for good mental well-being during the COVID-19 pandemic.

¹²⁹ As authorized in PHS Act §501(o).

¹³⁰ The National Child Traumatic Stress Initiative aims to improve behavioral health services for children exposed to traumatic events. Grant funding supports development and promotion of effective community practices, mostly through information and trainings by a network of centers known as the National Child Traumatic Stress Network.

¹³¹ See the House Budget Committee report (H.Rept. 117-7) for a discussion of the context surrounding the American Rescue Plan Act of 2021 (ARPA; P.L. 117-2).

¹³² ARPA §2707.

¹³³ ARPA §2706.

¹³⁴ Some studies have shown increased anxiety, depression, sleep problems, and distress among health care workers during the COVID-19 pandemic. See, for example, Ashley E. Muller, Elisabet V. Hafstad, Jan P. W. Himmels, et al., “The Mental Health Impact of the COVID-19 Pandemic on Healthcare Workers, and Interventions to Help Them: A Rapid Systematic Review,” *Psychiatry Research*, vol. 293 (November 2020).

¹³⁵ See, for instance, several provisions in P.L. 116-136, the CARES Act.

¹³⁶ U.S. Government Accountability Office, *COVID-19 Urgent Actions Needed to Better Ensure an Effective Federal Response*, 21-191, November 2020, <https://www.gao.gov/assets/gao-21-191.pdf>.

- HRSA has supported grantees in their efforts to provide or expand access to behavioral health services. The agency has also focused on increasing access to telebehavioral health services and supported providers through its administration of the Provider Relief Fund.
- NIH has granted COVID-19 specific research awards for behavioral health research and internally conducted research related to the behavioral health impacts of the COVID-19 pandemic.
- The HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) deployed 20 National Disaster Medical System mental health specialists, both in-person and virtually, to help address behavioral health needs related to the COVID-19 pandemic.
- The Commissioned Corps deployed behavioral health officers in support of the COVID-19 pandemic response.
- The Federal Emergency Management Agency (FEMA) and SAMHSA awarded grants to 48 states through its Crisis Counseling Assistance and Training Program (CCP).¹³⁷

On October 3, 2020, President Trump signed an executive order creating a Coronavirus Mental Health Working Group to outline a plan for improving the federal mental health response.¹³⁸

Issues for Congress

Congress and the executive branch of the federal government—in addition to state and local governments—continue to face decisions related to the COVID-19 pandemic, including those affecting behavioral health treatment and prevention. Below are select behavioral health-related issues Congress may consider during the pandemic and beyond.

Extending Changes to Mental Health and Substance Use Disorder Treatment

One issue for Congress and the executive branch is how long to maintain changes to substance use disorder (SUD) service delivery after the pandemic. For the most part, the federal government defers to states and lets them regulate the practice of medicine. One exception pertains to using the controlled substances methadone and buprenorphine in medication-assisted treatment (MAT) for opioid use disorder. Regulations on methadone and buprenorphine—such the use of telehealth in MAT—are rooted in concerns about diversion of these substances.¹³⁹ Some public health experts and policymakers have advocated for permanently allowing the telehealth and substance use disorder treatment exceptions instituted during the pandemic.¹⁴⁰ Some have argued that the

¹³⁷ *Ibid.*, pp. 151-164.

¹³⁸ Executive Order 13954, “Saving Lives Through Increased Support for Mental- and Behavioral-Health Needs,” 85 *Federal Register* 63977-63979, October 3, 2020. For more information, see <https://www.samhsa.gov/sites/default/files/saving-lives-mental-behavioral-health-needs.pdf>.

¹³⁹ For more information, see CRS Report R45279, *Buprenorphine and the Opioid Crisis: A Primer for Congress*.

¹⁴⁰ Bridget C.E. Dooling and Laura Stanley, *Extending Pandemic Flexibilities for Opioid Use Disorder Treatment: Telemedicine & Initiating Buprenorphine Treatment*, The George Washington University Regulatory Studies Center, Report I of the Extending Pandemic Flexibilities for Opioid Use Disorder Treatment Project, Washington, DC, February 23, 2021, <https://regulatorystudies.columbian.gwu.edu/telemedicine-initiating-buprenorphine-treatment>.

pre-pandemic regulations are overly restrictive and inhibit access to SUD treatment such as MAT.¹⁴¹ Others have claimed that making medications such as buprenorphine and methadone more accessible will increase the diversion of these substances and lead to adverse consequences.¹⁴² DEA has stated that without congressional action, the exceptions that DEA has issued during the pandemic related to telemedicine and substance use disorder treatment through MAT will expire at the end of the public health emergency declarations.¹⁴³

In May 2020, a group of Members of the House of Representatives encouraged greater data collection to inform decisions regarding which, if any, of the pandemic flexibilities should be made permanent.¹⁴⁴ Exceptions to SUD treatment provision during the pandemic could create a naturalistic experiment on the effects of these temporary policies. Research could provide insights on possible consequences to providing greater flexibilities, such as increased accessibility to MAT, increased diversion, or both. In April 2021, the Office of National Drug Control Policy (ONDCP) released its annual drug policy priorities, stating it would “evaluate and explore making permanent the emergency provisions” implemented during the pandemic.¹⁴⁵ Executive agencies may have the authority to make certain changes permanent, while others would require statutory changes made by Congress.¹⁴⁶

In its brief report on behavioral health services during the pandemic, GAO noted that most of the stakeholder groups it interviewed (composed mostly of hospital system associations) reported positive effects of the increased use of and payment for telehealth.¹⁴⁷ The stakeholders believed that these changes improved access to behavioral health services for many patients not requiring

¹⁴¹ Ibid., and Corey S. Davis and Elizabeth A. Samuels, “Continuing Increased Access to Buprenorphine in the United States via Telemedicine after COVID-19,” *The International Journal on Drug Policy*, August 15, 2020.

¹⁴² For more information, see CRS Report R45279, *Buprenorphine and the Opioid Crisis: A Primer for Congress*. Some studies have suggested that buprenorphine diversion in the United States stems from difficulties in accessing the medication legally, and that removing some of the regulations to increase access may actually reduce diversion. See, for example, Howard D. Chilcoat, Halle R. Amick, Molly R. Sherwood, et al., “Buprenorphine in the United States: Motives for Abuse, Misuse, and Diversion,” *Journal of Substance Abuse Treatment*, vol. 104 (September 2019), pp. 148-157; Michelle R. Lofwall and Sharon Walsh, “A Review of Buprenorphine Diversion and Misuse: The Current Evidence Base and Experiences from Around the World,” *Journal of Addiction Medicine*, vol. 8, no. 5 (Sept.-Oct. 2014); and Theodore J. Cicero, Matthew S. Ellis, Howard D. Chilcoat, et al., “Understanding the Use of Diverted Buprenorphine,” *Drug and Alcohol Dependence*, vol. 193 (December 2018), pp. 117-123.

¹⁴³ Scott Brink, Section Chief, Drug Enforcement Administration, remarks at the American College of Medical Toxicology, *Mitigating the Intersection of COVID-19 and Opioid Use Disorder*, COVID-19 webinar, May 21, 2020, 43:06, https://www.youtube.com/watch?v=t_Iu9t-AJug. Section Chief Brink stated, “Once the declared public health emergency expires all these exceptions to regulations and guidance documents that DEA issued, they will expire when the public health emergency expires. Telemedicine will also return to how it was before the COVID-19 public health emergency. Telemedicine or the Ryan Haight Act are law. They are in statute and they can only be changed by Congress. DEA does not have the ability to change those.”

¹⁴⁴ Letter from Tom Emmer, Member of Congress, Paul Tonko, Member of Congress, and Tony Cardenas, Member of Congress, et al. to Nancy Pelosi, Speaker of the House, and Mitch McConnell, Senate Majority Leader, May 21, 2020, https://emmer.house.gov/_cache/files/e/7/e71a1dae-7716-4a4f-ac7a-ab339fc71f8e/CC1592FCF331D833D6EA42B18EEBBA68.telehealth-letter.pdf.

¹⁴⁵ Executive Office of the President Office of National Drug Control Policy, “The Biden-Harris Administration’s Statement of Drug Policy Priorities for Year One,” press release, April 1, 2021.

¹⁴⁶ See, for example, Bridget C.E. Dooling and Laura Stanley, *Extending Pandemic Flexibilities for Opioid Use Disorder Treatment: Telemedicine & Initiating Buprenorphine Treatment*, The George Washington University Regulatory Studies Center, Report I of the Extending Pandemic Flexibilities for Opioid Use Disorder Treatment Project, Washington, DC, February 23, 2021, <https://regulatorystudies.columbian.gwu.edu/telemedicine-initiating-buprenorphine-treatment>.

¹⁴⁷ U.S. Government Accountability Office, *Behavioral Health: Patient Access, Provider Claims Payment, and the Effects of the COVID-19 Pandemic*, GAO-21-437R, April 30, 2021, <https://www.gao.gov/products/gao-21-437r>.

in-person services and resulted in fewer missed appointments. In addition, some experts have lauded efforts to expand telehealth capacity, but warned that without proactive measures, expanding telehealth could increase disparities in health care access for vulnerable populations with limited digital literacy or access, such as rural residents, racial/ethnic minorities, older adults, and those with low income.¹⁴⁸

Mental Health Effects of Stay-at-Home Orders

Congress may play a role in influencing the timeline for reopening certain parts of the country and the mental health consequences of the COVID-19 pandemic. Although stay-at-home orders and other pandemic-related mitigation policies are determined at the state level, Congress could provide encouragement or incentives for maintaining or removing those policies. Decisions about maintaining or relaxing mitigation strategies could have implications for mental health and substance use. Determining the extent to which increased mental health symptoms have been caused by isolation related social distancing and stay-at-home orders rather than by anxieties about the coronavirus, economic consequences of the pandemic, or other reasons is difficult. As mentioned above, the data suggest that pandemic-related mitigation strategies have influenced mental distress and loneliness.¹⁴⁹ If stay-at-home orders are related to increased social isolation, anxiety, or depression, policymakers may take that correlation—and the tradeoffs it presents—into consideration when determining timelines for reopening. For example, the mental well-being of children and adolescents (and their parents) could be factored into decisions about returning to synchronous learning in schools.¹⁵⁰ On one hand, asynchronous learning at home may have increased stress for some students and parents.¹⁵¹ On the other hand, returning to in-classroom learning in schools could slow moderation of the pandemic, further exacerbating stress for many individuals.¹⁵²

Some mental health issues may have been caused by the COVID-19 pandemic itself, in which case, the mental distress it caused may dissipate for many individuals as the pandemic subsides. Given that concerns about the pandemic or fears of the virus have driven mental health issues during the pandemic, strategies to temper the pandemic as soon as possible—such as stay-at-home orders or vaccine distribution—may be prioritized. For individuals with mental health

¹⁴⁸ Sarah Nouri, Elaine C. Khoong, Courtney R. Lyles, et al., “Addressing Equity in Telemedicine for Chronic Disease Management During the COVID-19 Pandemic,” *NEJM Catalyst*, May 4, 2020, <https://catalyst.nejm.org/doi/pdf/10.1056/CAT.20.0123>.

¹⁴⁹ Emma McGinty, Rachel Presskreischer, Hahrie Han, et al., “Psychological Distress and Loneliness Reported by US Adults in 2018 and April 2020,” *JAMA*, vol. 324, no. 1 (June 3, 2020). See also N. Leigh-Hunt, D. Bagguley, K. Bash, et al., “An Overview of Systematic Reviews on the Public Health Consequences of Social Isolation and Loneliness,” *Public Health*, vol. 152 (November 2017), pp. 157-171.

¹⁵⁰ Little research exists on the mental health effects of the pandemic on children. Some data suggest that mental health issues have increased in this population, as illustrated by higher mental health-related emergency department visits throughout 2020. See Rebecca Leeb, Rebecca Bitsko, and Lakshmi Radhakrishnan, *Mental Health-Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic - United States January 1-October 17, 2020*, Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report (MMWR)*, vol. 69, no. 45, November 13, 2020, <https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm>.

¹⁵¹ See, for instance, Stephen W. Patrick, Laura E. Henkhaus, Joseph S. Zickafoose, et al., “Well-Being of Parents and Children During the COVID-19 Pandemic: A National Survey,” *Pediatrics*, vol. 146, no. 4 (October 2020); and Panchal et al., *The Implications of COVID-19 for Mental Health and Substance Use*, 2021.

¹⁵² The Biden Administration—through executive orders and other efforts—has indicated that it intends to support efforts to create the conditions necessary for safe, in-person learning as quickly as possible. See Executive Order 14000, “Supporting the Reopening and Continuing Operation of Schools and Early Childhood Education Providers,” 86 *Federal Register* 7215-7218, January 26, 2021.

issues that continue beyond the pandemic (or if the pandemic itself continues long-term), direct interventions may be necessary. Some public health experts have suggested that addressing the mental health impact of the pandemic on individuals and the general population will require, in particular, greater surveillance of problems, a more robust treatment delivery system, and strategies to combat loneliness.¹⁵³

Oversight of Funding and Federally Supported Activities

The COVID supplemental appropriations acts and ARPA together provided SAMHSA and other HHS agencies over \$8 billion to address behavioral health-related needs. Much of this funding was to be provided in the form of emergency grants or block grants to states, with substantial flexibility regarding the use of funds. Congress, in its oversight capacities, may choose to monitor how the funds are spent and which activities they support—a process that could occur over several years. (In some cases, the grant funding is available until expended. In other cases, the behavioral health funding is to be expended in FY2021.) Given the current behavioral health infrastructure, states may face challenges expending such a large influx of funding in a short amount of time. Such a funding influx may help states address the immediate behavioral health needs during the pandemic, but not the potential long-term behavioral health consequences associated with it.

In addition, without more sustainable supports, an infusion of funding in a single fiscal year could create a funding cliff for behavioral health activities initiated during the pandemic. Congress may consider providing more sustainable financial support for behavioral health-related activities instituted or expanded during the pandemic but needed beyond FY2021. Depending on the extent to which such funding is provided during the annual appropriations process, this financial support might require a more substantial funding allocation for the annual appropriations bill that funds SAMHSA, or reallocating funding for other purposes within that bill. The behavioral health funding that is available until expended may mitigate the threat of a fiscal cliff, as states and grantees can plan for expenditures beyond FY2021.

Congress, in its oversight capacity, may play an important role in monitoring how pandemic-related behavioral health funding is used. Much of the statutory language authorizing and appropriating funding for behavioral health-related activities allowed agencies and grantees to determine how the funds are spent. In addition, much of the funding is to be provided to states via block grants, which gives states significant flexibility regarding the use of funds. Congress may decide to monitor such spending to ensure that federal funds are supporting intended activities, such as evidence-based prevention and treatment interventions, for example. In addition, Congress may consider encouraging data collection on populations served and outcomes of federally supported mental health and substance use activities.

Behavioral Health Disparities

The consequences of the COVID-19 pandemic—including the behavioral health effects—have not been equally distributed among demographic groups. For example, CDC data show that mental distress and substance use have disproportionately affected younger individuals, individuals with lower educational attainment and income, essential workers and unemployed

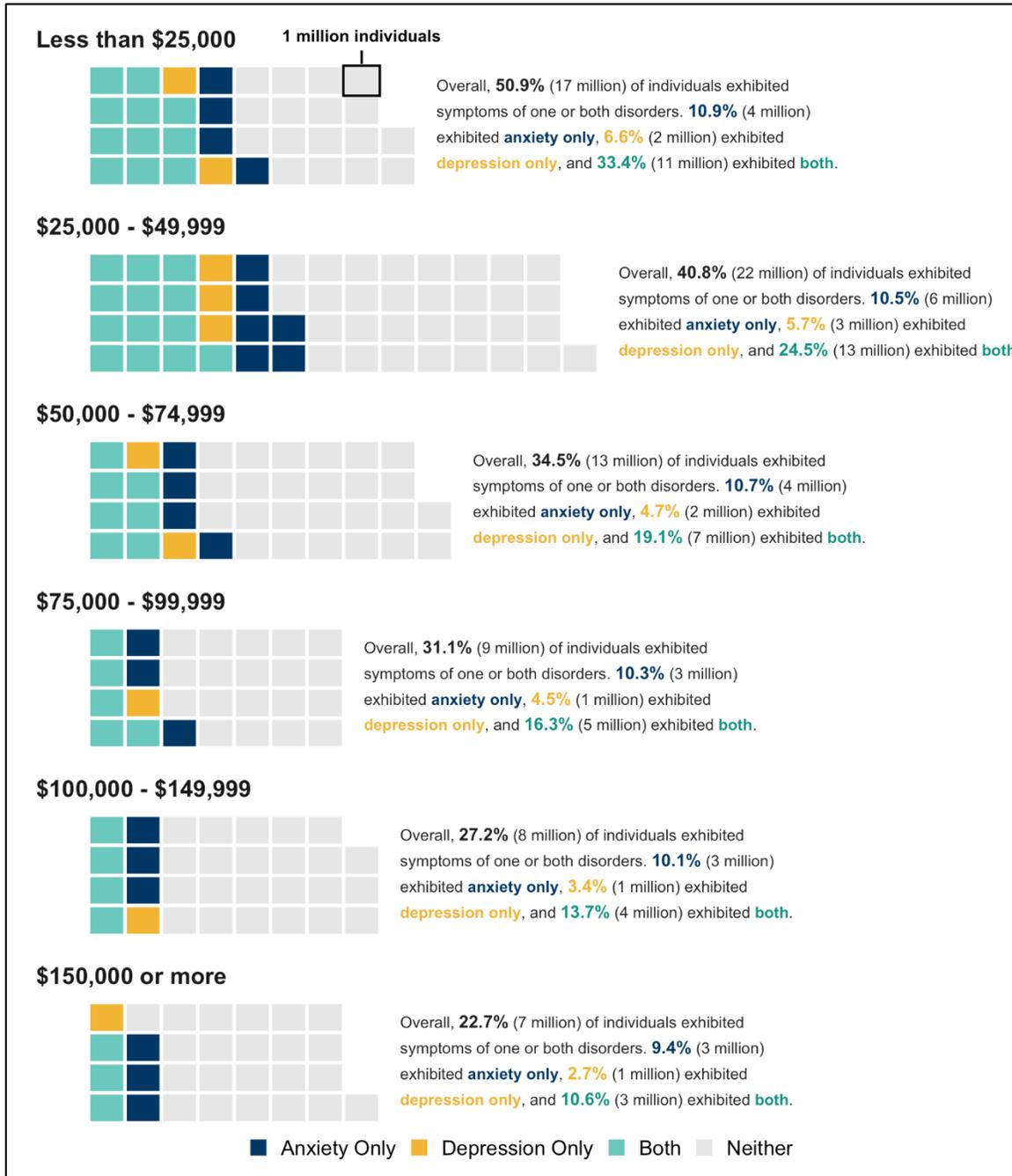
¹⁵³ Sandro Galea, Raina M. Merchant, and Nicole Lurie, “The Mental Health Consequences of COVID-19 and Physical Distancing: The Need for Prevention and Early Intervention,” *JAMA Internal Medicine*, vol. 180, no. 6 (June 2020), pp. 817-818.

individuals, and communities of color, among others. One analysis suggested that “the emotional costs of the pandemic are much higher for the poor and vulnerable than they are for the rich, heightening deep pre-existing inequities in well-being in the U.S and many other countries.”¹⁵⁴ Congress could consider the disproportionate impact of the pandemic on certain groups when directing behavioral health-related efforts during the pandemic. Reaching these groups may involve special consideration regarding availability of services, access to behavioral health resources, requirements for cultural competencies, and sustainability of benefits. As Congress conducts oversight on federal efforts to address mental health and substance use, it may consider the extent to which these endeavors reach the populations most in need.

¹⁵⁴ Carol Graham, *The Human Costs of the Pandemic: Is It Time to Prioritize Well-Being?*, Brookings Institution, Reimagining the Global Economy: Building Back Better in a Post-Covid-19 World, Washington, DC, November 17, 2020, <https://www.brookings.edu/research/the-human-costs-of-the-pandemic-is-it-time-to-prioritize-well-being/>.

Appendix. Mental Health Symptomology in the United States

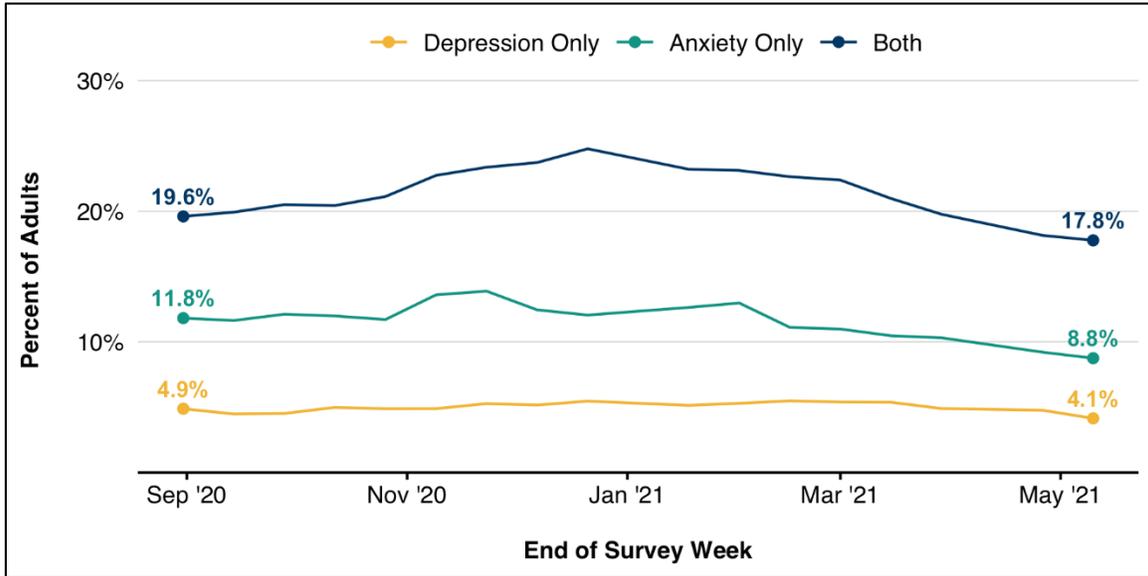
Figure A-1. Mental Health Symptomology in the United States, by Income
Symptoms of Anxiety and Depression, April 2020 – June 2020



Source: CRS analysis of U.S. Census Bureau, *Measuring Household Experiences during the Coronavirus Pandemic*, Household Pulse Survey, <https://www.census.gov/data/experimental-data-products/household-pulse-survey.html>.

Notes: Estimates show the percentage of adults who report symptoms of anxiety or depression that have been shown to be associated with diagnoses of generalized anxiety disorder or major depressive disorder. These symptoms generally occur more than half the days or nearly every day. Percentages may not add to totals due to rounding.

Figure A-2. Mental Health Symptomology in the United States over Time
Symptoms of Anxiety and Depression, September 2020 – May 2021



Source: CRS analysis of U.S. Census Bureau, *Measuring Household Experiences during the Coronavirus Pandemic*, Household Pulse Survey, <https://www.census.gov/data/experimental-data-products/household-pulse-survey.html>.

Notes: Estimates show the percentage of adults who report symptoms of anxiety or depression that have been shown to be associated with diagnoses of generalized anxiety disorder or major depressive disorder. These symptoms generally occur more than half the days or nearly every day. Percentages may not add to totals due to rounding.

Author Information

Johnathan H. Duff
Analyst in Health Policy

Paul D. Romero
Research Assistant

Amanda K. Sarata
Specialist in Health Policy

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