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TrendWatch: The impacts of the COVID-19 pandemic on behavioral health

Key Findings

The COVID-19 pandemic has resulted in significant impacts to behavioral health access and services in the U.S.:

- In-person, outpatient professional behavioral health visits have declined heavily throughout the pandemic, falling by as much as 75% for consumers with commercial insurance, 56% for Medicare beneficiaries and 25% for Medicaid beneficiaries.
- Overall, utilization of behavioral health disorder services for all ages from birth to 64 dropped substantially in April 2020 and continued to decline through October 2020 in nearly all states.
- Preliminary evidence from the Centers for Disease Control and Prevention (CDC) suggests a sharp increase in the number of adults reporting adverse behavioral health conditions during the pandemic, compared to prior years.
- The pandemic exacerbated pre-existing strains in the nation's behavioral health services, especially among communities facing sustained hardship, including, young people, the LGBTQ+ population and historically underrepresented populations.
- Health professional shortages have long impeded behavioral health care access, and are largely attributable to low reimbursement/provider payment, as well as the recent and imminent retirement of more than half of the current workforce.
- As restrictions on telehealth loosened, including HIPAA requirements for video-conferencing software and geographic requirements, providers conducted 75% of behavioral health visits via telehealth in May and June 2020 for patients with commercial insurance.
- Lower overall adoption rates of telehealth for Medicaid beneficiaries highlight potential challenges with access to technology, computers or tablets.

As America confronts a health care landscape deeply – and likely permanently – altered by the COVID-19 pandemic, behavioral health care access has emerged as both a challenge and opportunity. The pandemic exacerbated the need for behavioral health services while individuals with existing disorders faced additional barriers to care. However, the pandemic also inspired innovation, including escalated tele-behavioral health services and other digital solutions. There are many current topics of interest in behavioral health care, and this report focuses on COVID-19's impact on behavioral health.

Definition: Behavioral Health Disorders and Services

In this report, we define behavioral health disorders as both mental illness and substance use disorders. Mental illnesses are specific, diagnosable disorders characterized by intense alterations of thought, mood and/or behavior. Substance use disorders involve the recurrent use of alcohol and/or drugs, including medications, which cause clinically significant impairment. Persons with behavioral health care needs may experience one or both conditions, as well as physical co-morbidities.

In 2019, the American Hospital Association (AHA) published a TrendWatch[1] report and Market Insights Report[2] that provided background on behavioral health care access, utilization and payment. This report builds on that foundation to describe COVID-19's impact on behavioral health care.

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Even before the COVID-19 public health emergency, the demand for behavioral health services was on the rise.[3] An estimated 52 million adults in 2019, or approximately 21% of the U.S. adult population, reported having mental, behavioral or emotional disorders. Additionally, 20 million people aged 12 or older attested to having substance use disorders, which are characterized by alcohol abuse, illicit drug abuse, or both.[4]

Patients exhibit behavioral health care needs in almost every care setting, including emergency departments and acute inpatient units such as oncology, cardiology and orthopedics, as well as in specialized psychiatric and behavioral health units such as substance use disorder, geriatric, eating disorder and medical/psychiatric disorder units. According to a 2015 report from the Agency for Healthcare Research and Quality, one of every four patients admitted to a general hospital is diagnosed with a behavioral health disorder.[5]

This prevalence of behavioral health issues and their interactions with – and impact on – physical health pressures caregivers. This demand is exacerbated by an ongoing national shortage of behavioral health providers, due in part to inadequate reimbursement rates. For example, Medicaid is the single largest payer for behavioral health services, with nearly a quarter of adult Medicaid and Children's Health Insurance Program (CHIP) beneficiaries receiving mental health or substance use disorder services. The Medicaid program also reimburses at the lowest rates of any payer.[6,7] Patients sometimes decline or delay treatment due to lack of insurance coverage and/or high out-of-pocket costs. The inadequate enforcement of mental health parity laws, high prescription costs and shortages of in-network providers all contribute to these high costs.[8]

The AHA and Behavioral Health

The AHA remains committed to improving a diverse array of behavioral health issues impacting hospitals and patients across the country. Behavioral health is one of the AHA's key strategic focus areas (along with workforce and health equity) for planning what health care should look like in a post-pandemic world. Objectives include further integrating physical and behavioral health services across hospital and other acute care settings; building community partnerships between hospitals and social service agencies; reducing the stigma surrounding behavioral health; and preventing suicide through targeted behavioral health initiatives.

Within that broader framework, this paper focuses on issues that the COVID-19 pandemic has brought to light.

Behavioral health care's impact on in-person utilization during the pandemic

Since the onset of the pandemic, the number of individuals reporting symptoms of anxiety or depressive disorders has increased threefold. The number of individuals reporting suicidal ideation has increased at nearly the same rate, and annual drug overdose deaths have surged by 30%.[9] Yet, patients have utilized behavioral health services less, due to limited psychiatric inpatient bed capacity, a loss of health insurance coverage, a reduction in provider capacity, stay-at-home mandates, and a general avoidance of care tied to patients' COVID-19 concerns.[10,11]

In-person, outpatient professional behavioral health visits have declined heavily throughout the pandemic, falling by as much as 75% for consumers with commercial insurance, 56% for Medicare beneficiaries, and 25% for Medicaid beneficiaries. Behavioral health inpatient admissions dropped even more significantly over the same period before rebounding in August 2020, with many social distancing requirements limiting occupancy.[12]

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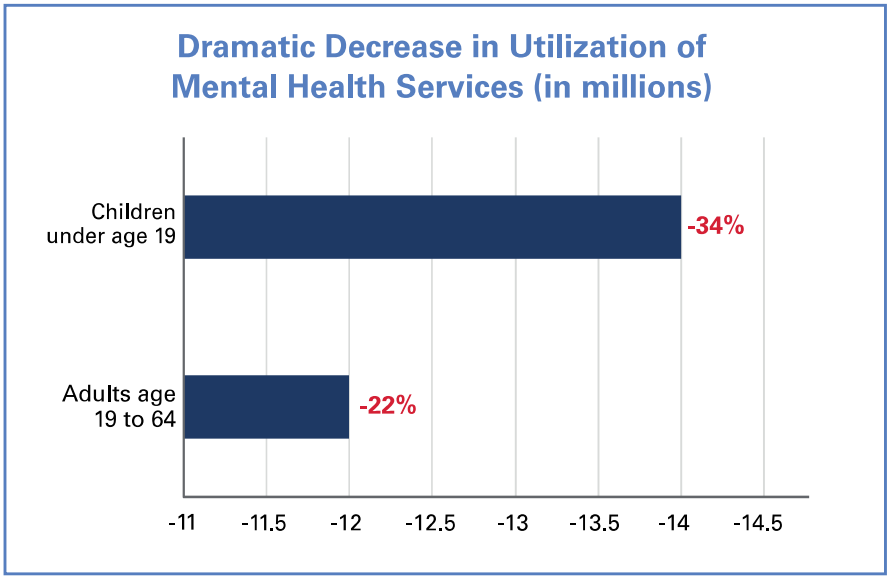
For people covered by Medicaid and CHIP, data from the Centers for Medicare & Medicaid Services (CMS) demonstrate a significant decline in behavioral health service use beginning in April 2020 and continuing until at least late that year.[13] Overall, utilization of behavioral health disorder services for all ages from birth to 64 dropped substantially in April 2020 and continued to decline through October 2020 in nearly all states. Among children under age 19 covered under Medicaid or CHIP, 14 million fewer mental health services, or a 34% reduction, were delivered from March through October 2020. Among adults age 19 through 64, mental health services decreased by 12 million, or 22% (see chart below).[14] Moreover, substance use disorder service utilization fell by 3.6 million services, a 13% decline, when compared to the same time period in 2019, even as the number of overdose-related deaths rose.[15,16] And while utilization rates for many types of care have rebounded to pre-pandemic levels, behavioral health services have been slower to rebound.[17]



Increased need for behavioral health services

As behavioral health utilization decreased, economic hardships, elevated stress, social isolation and growing behavioral health disorders contributed to greater treatment needs.[18,19]

Preliminary evidence from the Centers for Disease Control and Prevention (CDC) suggests a sharp increase in the number of adults reporting adverse behavioral health conditions during the pandemic, compared to prior years.

- Over 40% of respondents to a CDC survey reported at least one adverse behavioral condition related to the pandemic, including symptoms of anxiety, depression, trauma, or stress-related disorders, or having started or increased substance use to cope with stress or emotions related to COVID-19.[20,21]
- Emergency department visits for overdoses rose 26% over 2019, and suicide attempts from mid-March to mid-October 2020 rose 26%.[22,23]
- Shelter-in-place orders increased rates of suicidal ideation.[24]

In addition, the Kaiser Family Foundation reported a 12% increase in alcohol consumption or substance use to cope with stress and worry.[25,26] Every state has reported a spike or increase in overdose deaths or other substance use disorder issues during the pandemic.[27]

As of March 31, 2022, HRSA has designated more than 6,000 mental health provider shortage areas, which collectively contain more than one-third of Americans, or 135 million people. In these areas, the number of mental health providers available were adequate to meet only about 28% of the estimated need.[28]

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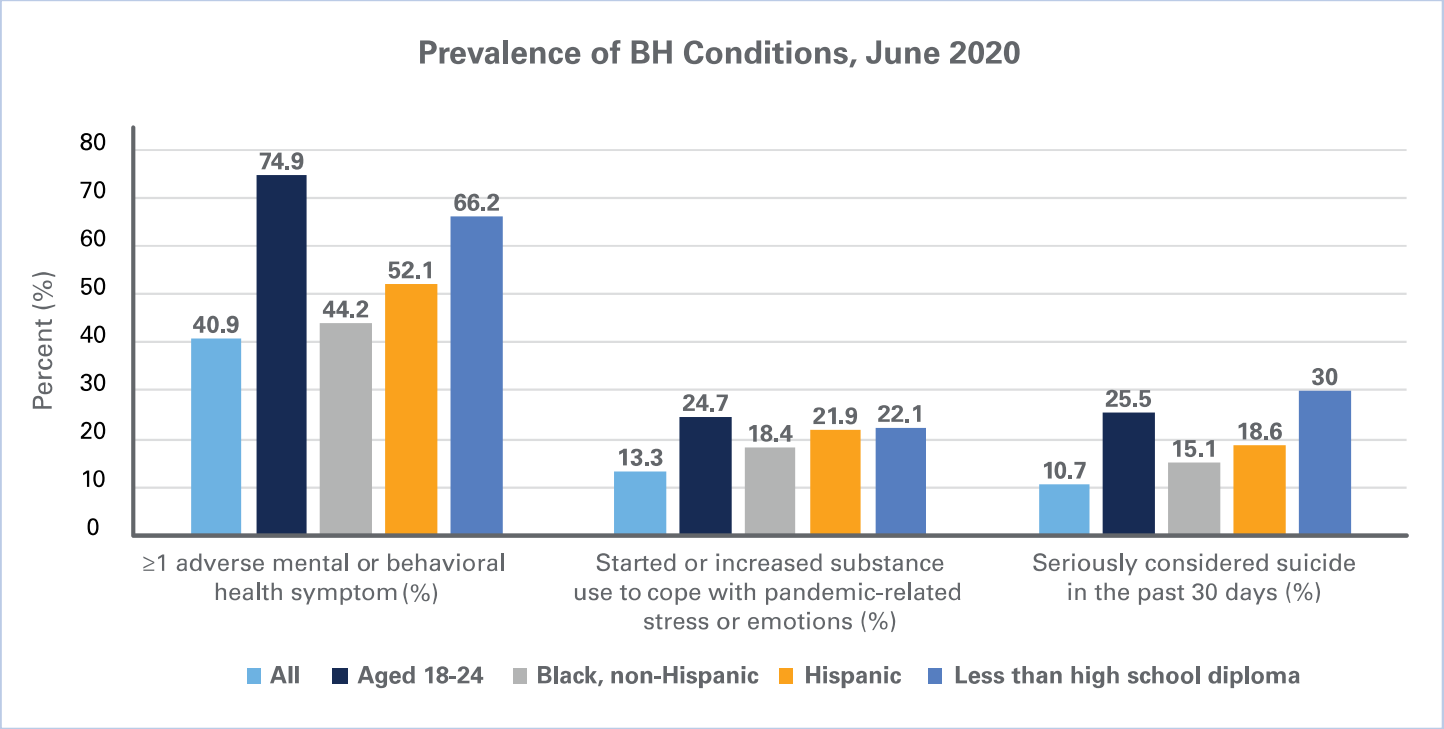
Impact on specific populations

The pandemic exacerbated pre-existing strains in the nation's behavioral health services, especially among communities facing sustained hardship. These communities include:

1. Young people: The pandemic has had a significant impact on the nation's youth, creating major disruptions in their daily lives. For example, school closures and transitions to online learning changed their routines and support structures.[29] The pandemic may be linked with higher youth suicidal ideation and attempt rates, as demonstrated by increased rates of positive suicide-risk screen results from January to July 2020, compared with January to July 2019.[30] Just as the pandemic impacted utilization among adults, young people utilized outpatient behavioral health services significantly less. This lowered utilization heightened the need for emergent care when behavioral health needs went unaddressed.
    - Utilization of mental health services among youth under age 19 plunged by 34%, compared to the same period in 2019.[31]
    - Mental health visits to emergency departments increased among pediatric patients during the first few months of the pandemic. Patients with mental health issues frequently required inpatient admission. [32]
    - The overall amount of pediatric mental health visits dropped between March and December 2020, strongly suggesting unmet pediatric mental health service needs. [33]
2. LGBTQ+ populations: The pandemic led to a slowdown in health care services for LGBTQ+ populations, which not only impacts their physical needs but increases the likelihood that their behavioral health needs will go unmet. A Columbia University paper notes that this population has been uniquely affected by the pandemic, due to heightened risk of exposure, delays in access to gender-affirming care and diminished social support.[34] LGBTQ+ youth also experienced higher rates of mental health issues during COVID-19. For example, one survey conducted in fall 2020 found that 73% of LGBTQ+ respondents between ages 13-17 reported symptoms of anxiety disorder, while 67% reported depressive disorder over the prior two weeks. Almost 50% seriously considered attempting suicide over the past year. The data represent a significant increase over 2019 rates.[34]
3. Historically underrepresented populations: Communities facing sustained hardship have historically experienced higher rates of behavioral health conditions matched with greater barriers to care.[36] This trend has only continued during the pandemic, with historically underrepresented groups experiencing higher rates of depression, substance use disorders and self-reported suicidal thoughts.[37] For example:
    - Hispanic adults reported significantly higher rates of depression, suicidal ideation and substance use disorders compared to Black and white Americans.
    - More Hispanic and Black Americans have gone without behavioral health treatment than the general population.
    - Black Americans reported increased substance use and serious considerations of suicide in the previous 30 days more frequently than white and Asian respondents have.[38]
    - Black and Hispanic adults experienced higher rates of illness and death from COVID-19, negative financial impacts, and poor mental health outcomes, which may also hurt their children's' mental health.[39]

Black, Hispanic and Asian American children also experienced higher rates of behavioral health issues during the pandemic. They also faced additional impediments to accessing care because of reduced school services. For example, because of anti-Asian racism that spiked during the pandemic, Asian American children are experiencing higher risk of negative behavioral health outcomes.[40]



Impact on the health care workforce

Health care workers suffer additional emotional and physical strain from treating COVID-19 patients.[41] Not only did health care workers on the front lines of the pandemic risk exposure to the coronavirus daily, but the crisis also hurt their mental health, contributing to anxiety, stress, depression and loneliness.[42] One recent study found that 93% of health care workers during the pandemic reported stress, 86% reported anxiety, 77% reported frustration, 76% reported exhaustion and burnout, and 75% said they were overwhelmed.[43] Worry and stress lead to sleep disturbances, headaches or stomachaches, and increased alcohol or drug use.[44] Yet just 13% of front-line health care workers received behavioral health services due to worry and stress.

New ways of providing behavioral health services

The increased need for behavioral health services, combined with regulatory flexibilities granted through the declaration of COVID-19 as a public health emergency, has led to the growing use of new and previously underutilized tools for providing care.

Many hospitals, health systems and physician organizations created new initiatives aimed at increasing access to behavioral health services. The Behavioral Health Integration Collaborative, for example, incorporates behavioral health into overall health care by providing clinicians the support tools – including a compendium of resources from several physician organizations, webinar programming, and training opportunities – to deliver these services in a primary care setting.[45]

Prior to COVID-19, behavioral health providers led outpatient care via telemedicine, with more than twice as many using telemedicine compared to other types of clinicians.[46] Nonetheless, less than 1% of pre-

pandemic behavioral health visits were provided via telehealth. The pandemic spurred the removal of regulatory barriers, such as restrictions on eligible patient location or mobile platform, pushing behavioral telehealth to new heights.

While some behavioral health providers initially expressed concerns about the quality of telehealth encounters, the transition has been largely positive for both patients and clinicians.[47] Although there are some drawbacks to telehealth services, such as reduced ability to observe nonverbal cues to inform diagnosis and treatment and difficulty hearing patients clearly by phone or video, one study of psychiatrists found these were offset by several advantages, including seeing the patient's home environment and providing some patients with greater access to care.[48]

As restrictions on telehealth loosened, including HIPAA requirements for video-conferencing software and geographic requirements[49], providers conducted 75% of behavioral health visits via telehealth in May and June 2020 for patients with commercial insurance.[50] For Medicare beneficiaries, nearly half of behavioral health visits were provided via telehealth in April through July 2020. Adoption rates were lowest for Medicaid beneficiaries, where, at peak, 28% of behavioral health visits were provided via telehealth.[51]

The lower overall adoption rates for Medicaid beneficiaries highlight potential challenges with access to technology. For instance, people with fewer resources may not have reliable internet access or available computers or tablets.[52] This digital divide disproportionately affects women, the elderly, people with disabilities, people of low socioeconomic status, people of color, immigrants, and those in rural areas.[53] Overall, telemedicine use grew rapidly during the pandemic, but not enough to offset drops in in-person office visits.[54]

The Collaborative Assessment and Management of Suicidality (CAMS)

CAMS is an evidence based, suicide-focused assessment and treatment framework that reduces suicidal ideation and increases hope. CAMS is based on the belief that, beyond prevention, suicide risk is treatable by focusing on treating drivers that make someone want to die.

Providers have historically leveraged the CAMS to provide an effective clinical response to the challenges of suicide risk. In this time of increased suicidal ideation and attempts, providers have demonstrated the feasibility of remote, CAMS-guided treatment. Community mental health centers have reported that patients often do not need to be hospitalized, which, in turn, motivates patients to participate in outpatient suicide prevention in addition to telepsychotherapy use of CAMS.

Legislative Actions

Since the pandemic began, significant laws aimed at providing relief from the social and economic impacts of the pandemic have been enacted. Many provisions address the behavioral health-related issues raised in this brief, but gaps remain. These laws include:

1. The Families First Coronavirus Response Act[55]

   The Families First Coronavirus Response Act (P.L. 116-127) provides paid sick leave effective April 2020 for people who have COVID-19 symptoms, need to quarantine, or are caring for children or sick family members. Any employee can use these funds, including providers on the front lines.

2. The Coronavirus Aid, Relief, and Economic Security (CARES) Act[56]

   The CARES Act (P.L. 116-136) contains several important provisions of relevance to behavioral health providers. It includes $425 million for the Substance Abuse and Mental Health Services Administration (SAMHSA) to respond to the pandemic, with $250 million in new funding for Certified Community Behavioral Health Clinic (CCBHC) Expansion grants, $100 million for emergency response activities, and $50 million for suicide prevention. The CARES Act also partially aligns rules affecting the sharing of substance use disorder treatment information with HIPAA requirements.

3. Consolidated Appropriations Act, 2021 (CAA)[57]

   In the CAA (P.L. 116-260), Congress addressed shortages in access to behavioral health services by increasing funding for existing SAMHSA grants, CCBHCs and opioid use disorder treatment. The CAA also strengthened the Mental Health Parity and Addiction Equity Act of 2008, which requires that group health plans offering mental health and substance use disorder benefits provide those benefits on no less generous terms than for medical and surgical benefits. The CAA included requirements for health plans to document their coverage of these benefits to the appropriate regulatory authority facilitating oversight and improving transparency.[58]

4. American Rescue Plan Act[59] (ARPA)

   The American Rescue Plan Act (P.L. 117-2) includes $3 billion in funding for block grants to address mental health and substance use prevention, treatment and recovery services in addition to $1.4 billion to support the mental health needs of health care professionals and first responders, as well as funding specifically for pediatric mental health. Additionally, ARPA provides $140 million to establish programs to reduce suicide, burnout and substance use disorders among front-line workers. In addition, the law directs the Health Resources and Services Administration (HRSA) to develop mental health and substance use disorder training programs for the health care workforce. It also allocates funding for mental health and substance use disorder services, including $80 million for pediatric mental health care, $20 million for youth suicide prevention, and $10 million for the National Child Traumatic Stress Initiative.[60] ARPA also provides Medicaid funding for behavioral mobile crisis services and increases the federal matching rate for spending on Medicaid home and community-based services, including behavioral health, by 10 percentage points through March 2022.[61]

5. The Dr. Lorna Breen Health Care Provider Protection Act

   Named for a doctor who led the emergency department at New York-Presbyterian Allen Hospital, this bill authorizes grants for programs that offer behavioral health services for front-line health care workers. It also requires the Department of Health and Human Services to recommend strategies to facilitate health care provider well-being and launch a campaign encouraging health care workers to seek assistance when needed. It was signed into law by President Joseph Biden on March 18, 2022.

Executive and Other Regulatory Actions

The Trump and Biden Administrations have used their executive branch authority to provide additional relief from the pandemic. In January 2020, the U.S. Department of Health and Human Services declared COVID-19 to be a public health emergency (PHE) and has since issued several regulations that link it to health care flexibilities and mandates. While a PHE expires after 90 days, the current PHE has been extended multiple times by the Biden Administration.

Some PHE-related regulations aim to reduce requirements for face-to-face contact between patients and providers. CMS has lifted originating site and rural restrictions on telehealth services. It has also allowed certain behavioral health services, such as those conducted over both video and audio, to be reimbursed. SAMHSA expanded maximum take-home methadone doses for patients with opioid use disorder enrolled in opioid treatment programs and implemented a temporary exemption of the requirement for in-person evaluations for new prescriptions of buprenorphine.

Other regulatory changes have helped behavioral health providers remain financially viable during the COVID-19 crisis. CMS issued an 1135 blanket waiver to allow for greater flexibility in Medicare and Medicaid reimbursements, reduce prior authorizations and facilitate the transfer of patients between facilities — all of which will support behavioral health care delivery.[62] The provision regarding patient transfers is particularly relevant to hospitalized psychiatric patients, who may need to be safely transferred from facilities overwhelmed by COVID-19. More than 30 states have been approved for participation in this 1135 waiver opportunity. CMS has approved reimbursements for telehealth appointments that are equivalent to reimbursements for in-person appointments for most Medicare-financed services. [63]

CMS is further supporting behavioral health care through its recently launched Connecting Kids to Coverage National Campaign, a national outreach and enrollment initiative funded by the Children's Health Insurance Program Reauthorization Act and the Affordable Care Act. The campaign supports outreach to families with children and adolescents eligible for Medicaid and CHIP by letting families know who is eligible, what benefits are available, and how to apply for coverage.[64]

Policy Recommendations

Behavioral health care has long been underfunded, underappreciated and stigmatized. The AHA has prioritized advocacy around behavioral health in general, and many of the advocacy strategies in which the organization has engaged prior to the onset of the COVID-19 pandemic would address many of the issues raised in this brief. For example, investments in the behavioral health workforce, the integration of behavioral health into physical health care, the enforcement of federal and state parity laws, and improvements in reimbursement rates for behavioral health providers would help fill the critical gaps in access worsened by the pandemic. You can read more about AHA's behavioral health advocacy strategy here: *www.aha.org/behavioralhealth/advocacy-and-regulatory-resources*

To directly address the issues brought about or intensified by the COVID-19 pandemic explained in this brief, the AHA recommends the following policy actions:

Problem identified/Gap	Description	Solution and Policy Recommendation	Legislation that would Support Policy Recommendations
Workforce shortages	Existing shortages have been exacerbated by layoffs and termination of behavioral health programs.	Create new graduate medical education slots for physicians specializing in SUD treatment. Encourage team-based approaches. Enable providers to work at the top of their licenses.	Substance Use Disorder Workforce Act[65] Resident Physician Shortage Reduction Act[66]

Problem identified/Gap	Description	Solution and Policy Recommendation	Legislation that would Support Policy Recommendations
Decreased utilization of behavioral health services	Even though prevalence of adverse behavioral health conditions increased during the pandemic, utilization decreased due to economic hardships and fear of exposure to the virus during in-person visits.	Expand use of tele-behavioral health by making PHE waivers of certain restrictions permanent. Improve reimbursement for in-person and tele-behavioral health services.	Ensuring Parity in MA and PACE for Audio-Only Telehealth Act[67]
Increase in substance use and overdose deaths	Surveys have shown increases in substance use to cope with stress and worry because of the pandemic. Every state reported a spike or increase in overdose deaths during the pandemic.	Improve access to life-saving treatments like naloxone, Medication-Assisted Treatment, and medications for Opioid Use Disorder, including flexibility in e-prescribing and longer-term prescriptions.	Opioid Treatment Access Act $102 million to the Food and Drug Administration to address the opioid crisis (Omnibus spending bill)
Increase in anxiety, depression, and suicidal ideation	Consequences from the pandemic, such as economic hardship, isolation, illness and personal loss, resulted in a sharp increase in adverse behavioral health conditions.	Improve access to outpatient services by ensuring coverage for intensive outpatient programs, partial hospitalization programs and outpatient psychotherapy. Increase funding for crisis intervention infrastructure based on crisis standards of care (such as 988) and encourage employer adoption of crisis resources for employees.	$75 million investment in National Suicide Prevention Lifeline programs in House Reconciliation bill $2.5 billion to support public health approaches to reduce community violence and trauma in House Reconciliation bill.
Unmet needs for child and adolescent behavioral health	School closures and disruptions of daily life led to exacerbation of behavioral health concerns.	Invest in youth-specific programs, like the optional Medicaid coverage of inpatient psychiatric care for persons under 21. Fund mental health workers in schools. Invest in pediatric-specific and trauma-informed care training.	Child Suicide Prevention and Lethal Means Safety Act[68,69]

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Problem identified/Gap	Description	Solution and Policy Recommendation	Legislation that would Support Policy Recommendations
Support for front-line workers	Health care workers suffer emotional and physical strain from treating COVID-19 patients.	Improve access to behavioral health services for clinicians by increasing funding to systems of care to provide support for their workers. Reduce regulatory and administrative burdens on clinicians. Streamline licensure and credentialing requirements. Implement emotional first-aid related to COVID-19 experiences.	Dr. Lorna Breen Health Care Provider Protection Act[70,71] Preventing and Assessing Trauma with Health Services (PATHS) Act
Unmet needs in LGBTQ+ population	This population has been uniquely affected by the pandemic in many ways, including risk of exposure to the virus and delays in access to tailored support.	Invest in clinician training on culturally competent care. Invest in the development of trauma-informed care. Encourage cultural respectfulness training and awareness for boards and other hospital/health system staff. Invest in peer and community health worker outreach.	
Unmet needs in historically underrepresented populations	These populations experienced exacerbation of existing disparities in behavioral health access and outcomes.	Invest in linguistically appropriate and culturally competent care. Strengthen community-level prevention efforts through partnerships. Improve data collection on Social Determinants of Health to better identify gaps in access. Invest in peer and community health worker outreach. Diversify behavioral health provider workforce.	$50 million investment in Minority Fellowship Program at SAMHSA in House Reconciliation bill $75 million in grants to grow and diversify the maternal mental health and SUD treatment workforce in House Reconciliation bill (from Momnibus) $100 million in grants to address maternal mental health and SUD for pregnant, lactating, and postpartum individuals (from Momnibus)

Problem identified/Gap	Description	Solution and Policy Recommendation	Legislation that would Support Policy Recommendations
Sustainability of alternative access strategies	Temporary waivers granted through the PHE authority will expire, rebuilding regulatory barriers to virtual care; conversely, the major shift to virtual care during the pandemic left those without reliable internet further lacking access to care.	Make waivers of originating site and eligible practitioner restrictions permanent, including access across state lines. Invest in broadband expansion. Fund end-user hardware for access to telehealth services.	Extension of telehealth flexibilities in Omnibus Spending Bill

These and future AHA policy recommendations aim to improve underlying or ongoing behavioral health issues, including: inadequate reimbursement; restrictions in services covered; inadequate coverage by private plans; high out-of-pocket costs; general behavioral health workforce shortages; and SUD-specific workforce shortages.

Conclusion

The COVID-19 pandemic response continues to be characterized by new challenges, variants and resurgences. Each resurgence impacts the daily lives of Americans, increasing the need for access to behavioral health services, many of which have been highlighted in recent reports by both the Senate Finance Committee and the Government Accountability Office.[72,73] However, hospitals and other providers of behavioral health services are leveraging new regulatory flexibilities to innovate and improve behavioral health. At the same time, additional policy changes, including policies that secure appropriate reimbursement, are necessary to meet the need and behavioral health demand.

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