

**Executive Order *Saving Lives Through Increased Support
for Mental and Behavioral Health Needs* Report**

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SAMHSA
Substance Abuse and Mental Health
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I. Executive Order Summary

On October 5, 2020, President Trump signed Executive Order (EO) 13594, *Saving Lives Through Increased Support for Mental and Behavioral Health Needs*. It reflects the Administration's dedication to preventing the tragedy of suicide, ending the opioid crisis, and improving mental and behavioral health. As such, the Administration has placed a great emphasis on helping those individuals who are most susceptible, from a mental health standpoint, to prolonged state and local COVID-19 restrictions. Since mental illnesses and substance use disorders (SUDs) can be a risk for all Americans equally, helping people with these vulnerabilities has broad bipartisan support. The EO highlights the exacerbation of emotional needs stemming from interpersonal and environmental stressors caused by the COVID-19 pandemic and the subsequent disruption of services, and provides a blueprint to alleviate these ongoing challenges.

The goal is to reduce the number of immediate life-threatening situations related to mental illness and SUDs through increased education, crisis intervention, follow-up and support services, and increased telehealth and online behavioral health services (i.e. services for a broad range of supports for people with mental illness, SUDs, and other conditions and across the age spectrum from youth to older adults), while utilizing both public and private resources. The EO orders the creation of a Coronavirus Mental Health Working Group (Working Group) to examine existing protocols and programs, and outline a plan for improving mental health functioning by assisting public and private stakeholders and agencies to maximize therapeutic support, including face-to-face in-person services, to reduce the negative impact of COVID-19. This Report sets forth actions to date, as well as recommendations for future activity to address these critical issues.

II. Introduction

The COVID-19 pandemic is first a physical health crisis, but it is also fueling a major mental and behavioral health crisis that is having a significant impact on the well-being of our citizens. Sixty-two percent of Americans have reported feeling more anxious this year compared with last year, according to a [public opinion poll](#) released recently by the American Psychiatric Association.¹ This is compared to data over the past three years, which demonstrates that between 32% and 39% of Americans report feeling more anxious compared with prior years. In fact, according to the Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report, at the end of June 2020, 40% of Americans reported experiencing significant emotional upheaval with anxiety, depression, trauma-related symptoms, increased use of substances and even suicidal ideation (11% reported seriously considering suicide), which was a higher percentage than in the previous year.² Further, extensive research exists that shows the toll exacted on mental health resulting from the isolation imposed by lockdowns and extended stay-at-home orders. Mental illness can develop in as little as 9 days of quarantine and these disorders can

¹ <https://alert.psychnews.org/2020/10/americans-report-increasing-rates-of.html>

² <https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6932a1-H.pdf>

last for years.³ What is not known is the magnitude of mental illness that will be experienced by the American people as a result of subjecting them to lockdowns of the extended durations seen during this pandemic. However, based on the existing scientific literature, we can expect that millions of Americans will need mental health and substance use disorder treatment and recovery services for years to come.

In order to address this, it is critical to focus on emergent and acute mental and behavioral health needs, as well as to take preventative action to avert future human suffering. Psychological distress in populations has been linked to both, and is widespread due to the immediate health impacts of the virus and the consequences of physical isolation. Many people have been distanced from loved ones due to the risk of infection, and are fearful of contagion, death, and losing family and friends. As state and local governments mandated prolonged stay-at-home orders and forced non-essential businesses to close, the economy was put into decline, and millions of people also have been faced with the loss of their jobs, income, and homes. The impacts of these actions have been far reaching and had varying effects on vulnerable populations, including minorities, seniors, veterans, small business owners, children, and individuals potentially affected by domestic violence or physical abuse, those living with disabilities, and those with a SUD.

The health of racial and ethnic minority groups and economically disadvantaged persons have been disproportionately impacted by this pandemic. Individuals in these communities remain at higher risk for COVID-19 infection, death and increased psychological distress. Frontline healthcare workers and first responders have also been exposed to numerous stressors, such as exhaustion, patient illness and death, risk of infection, and separation from loved ones. Ensuring and maintaining the mental health of healthcare workers is a critical factor in sustaining COVID-19 preparedness, response and recovery. Our seniors and people with pre-existing health conditions have been infected at higher rates, experience greater risks of fatality, and are often left afraid and alone. Children and adolescents feel the stress in the family and are impacted by social isolation, some facing increased abuse and disrupted education, putting them at risk for emotional problems and behavioral disorders. Women, particularly single mothers, are being affected disproportionately which further exacerbates the negative emotional impact on their children.

As a result of the isolation caused by social restrictions and the inability to access treatment and community recovery supports, people with SUDs are placed at significantly higher risk for relapse and subsequent fatal overdose. Further, CDC recently reported that one in ten individuals responding to a recent survey indicated that they had initiated substance misuse as a means of coping with stress induced by COVID-19. These individuals are at increased risk for developing alcohol and other SUDs, experiencing overdose and other substance-related adverse events. It is critical to move quickly, building on the infrastructure in place and using best practices to lead to a sustained, efficient, and equitable delivery of behavioral health services tailored to the needs of each group to help us through the pandemic and beyond.

³ Brooks SK, Webster RK, Smith LE, et al. The psychological impact of quarantine and how to reduce it: rapid review of the evidence. *Lancet* 395: 912-920, 2020.

III. Building on System Strengths

We are in the midst of a mental and behavioral health crisis exacerbated by the COVID-19 pandemic that is anticipated to continue worsening and have a long-term impact on the entire population. As outlined below, the Administration has engaged the resources and expertise of multiple agencies with a critical and simultaneous focus on prevention and early identification of these matters, including increased public education, more referrals to treatment, and the removal of barriers to increase access to care and further enhance capabilities for immediate crisis resolution and ongoing care as needed. This section will highlight the strengths of the current system including COVID-19 adaptations as a foundation for the recommendations offered in the following section.

A. Prevention

In an emergency situation prevention often takes a backseat to crisis services. In anticipation of the increased needs in the future, however, we must avoid losing sight of prevention planning. Utilizing certain surveillance data systems will aid in the provision of timely interventions by proactively targeting the needs of various populations and locations. Regularly reported data will enhance surveillance which increases the timeliness of aggregate reporting of nonfatal suicide-related outcomes (e.g. suicide ideation, attempts), and findings can be disseminated to stakeholders to inform prevention strategies. There are a number of agency and non-profit programs that focus in this area.

CDC deploys Epidemic Intelligence Service officers and Self-Management Education staff to provide epidemiological assistance and support partners in identifying factors that increase and decrease the risk for specific public health problems. State-Level Children’s Mental Health Champions (CMHC) address the mental health needs of children and families by supporting the implementation of effective strategies for mental health promotion, prevention supports, and early identification and referral networks based on state needs assessments. “Creating Safer States” addresses COVID-19 related injury and violence prevention activities, including suicide and Adverse Childhood Events (ACEs), providing leadership, support, and coordination to enhance and amplify treatment and prevention strategies to reduce suicides and ACEs in diverse partners and audiences.

In addition, “Preventing Suicide: A Technical Package of Policy, Programs, and Practices”⁴ supports implementation of suicide prevention strategies during times of infrastructure disruption. Special populations are being addressed in Tribal nations through the prevention of suicide, intimate partner violence, and ACEs, building public health capacity in 12 Tribal health-serving organizations. CDC is also assisting Veterans Serving Organizations (VSOs) in their evaluation of evidence surrounding capacity building for existing programmatic models to decrease veteran suicide. Additionally, the Substance Abuse and Mental Health Services Administration’s (SAMHSA) Garrett Lee Smith Campus Suicide Prevention Program grants facilitate a comprehensive public health approach to prevent suicide in institutions of higher

⁴ <https://www.cdc.gov/violenceprevention/pdf/suicidetechnicalpackage.pdf>

education by building essential capacity and infrastructure to support expanded efforts to promote wellness and help-seeking behaviors of all students, including those experiencing substance use and mental health problems who are at greater risk for suicide and suicidal attempts.

A number of provisions in the EO are consistent with ongoing efforts to implement The President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS). Executive Order 13861, signed on March 5, 2019, created PREVENTS to implement an "all of nation" approach to prevent suicide and created an interagency task force to focus on this effort. It resulted in the development of a comprehensive plan, or Roadmap, to empower Veterans, and to end suicide for all Americans through culture change, seamless access to care, a connected research ecosystem, and robust community engagement. Many of the [Roadmap Recommendations](#) are already being expanded to reflect the ongoing impact of the pandemic on all Americans, and PREVENTS is focused on tracking Federal grants that provide a number of critical mental health and suicide prevention services, including crisis-intervention services, to at-risk populations. PREVENTS has developed numerous formal partnerships with national healthcare associations and academic institutions to prioritize expanding lifesaving suicide prevention programs and trainings. The effort has also engaged faith-based and other nonprofit efforts across Federal agencies, as well as at the state and local level to facilitate the provision of social and community services.

PREVENTS launched the first of its kind, national public health campaign (REACH.gov) created to encourage a culture of openness, support, and belonging surrounding the topic of suicide specifically and mental health more broadly. Through REACH, the Federal government is capable of engaging Americans nearly a billion times per month to engage those who are struggling with mental health challenges, substance misuse and addiction, and self-destructive/suicidal thoughts and behaviors. REACH delivers critical information about risk and protective factors, as well as actions that all Americans can take to reach those who are struggling. Moving forward, through its public health lens, the PREVENTS Roadmap and the REACH campaign will continue to elevate the national conversation on mental health and suicide, to convene communities, and to expand on the research, policies, and programs underway in our nation as we respond proactively to the impact of COVID-19.

Finally, many individuals are experiencing stressors of life-threatening illnesses in addition to COVID-19. For example, CDC's series of trainings for providers, caregivers, and survivors includes "Coping with Cancer and Mental Health: Personal Perspectives on Cancer Survivorship," and can be used as models to reach those who are navigating these and other potentially catastrophic illnesses during the pandemic.

B. Being Prepared

Preparing Individual and Communities. Prevention also incorporates being prepared. Having a fully functioning mental health infrastructure involves both training providers and preparing patients to access help when they need it. The SAMHSA [SMI Adviser](#) is a web-based national technical assistance and training support system aimed at increasing knowledge and skills of healthcare providers with the goal of expanding access to care and treatment for those with serious mental illnesses (SMI), and in transforming care for these individuals so they can live their

best lives. Because no one knows when a flare up of a mental disorder might strike, it is important for people living with SMI to be prepared in the same way that a person living with a chronic illness would prepare for a physical health crisis. To support person-centered crisis care planning, the SMI Adviser recently launched a psychiatric advance directive (PAD) app -*My Mental Health Crisis Plan*- to empower individuals living with an SMI to guide their treatment decision preferences when they experience a mental health crisis that impairs their decision-making capacity. *My Mental Health Crisis Plan* is a free and secure mobile app with simple, step-by-step instructions for individuals to create their own PAD. It also includes state-specific statutes to ensure the PAD is a legal document. Users decide on what emergency treatments are acceptable and preferred, medications that work the best, their preference of a clinical mental health team, and the facilities they choose for treatment. The app also gives users the opportunity to designate a "healthcare agent" or "health care power of attorney" to make healthcare decisions on the individual's behalf when in a mental health crisis. Individuals can also identify emergency contacts to call when experiencing a mental health crisis.

Opioids Overdose Crisis Prevention Intervention Funding. Funding through the State Opioid Response grants has provided resources to individual states to assist in expanding a multitude of evidence-based preventions, treatments and community recovery support efforts for persons with Opioid Use Disorder (OUD). These funds must be used to provide the gold standard of care for OUD, including medications approved by the Federal Drug Administration (FDA) to specifically prevent overdose death. Since 2017, there has been an increase in the number of individuals receiving these medications from less than 1 million to over 1.46 million in 2019. Prevention of opioid overdose death in the form of first responder training and funding for the opioid overdose antidote, naloxone, has also saved tens of thousands of lives. In fact, the Department of Health and Human Services (HHS) and the Office of National Drug Control Policy (ONDCP) staff recently collaborated to develop a one page document for first responders on how naloxone may be used safely as an antidote during the COVID-19 pandemic.⁵ In the latest round of funding, the State Opioid Response grant program has also included attention to the growing challenges of methamphetamine and other stimulant use disorders. The SAMHSA Opioid Response Network (ORN) provides ongoing educational resources and outreach to healthcare providers, with technical assistance and other benefits to communities, healthcare organizations, and others interested in providing resources to address the opioids crisis.

C. Crisis Services

Prevention has immediate and long-term benefits, but during COVID-19, acute crises are a priority. Published in 2020, SAMHSA advances national guidelines in crisis care within the toolkit, "The National Guidelines for Behavioral Health Crisis Care –A Best Practice Toolkit" (National Guidelines) to support program design, development, implementation, and continuous quality improvement efforts of crisis services. Crisis services are for anyone, anywhere, at anytime.⁶ Importantly, the National Guidelines outline how to implement a "no-wrong door"

⁵ <https://www.hhs.gov/opioids/sites/default/files/2020-09/opioids-naloxone-one-pager.pdf>

⁶ <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

comprehensive crisis system which has been a top priority at SAMHSA for the last three years, and helps reduce police contact with individuals experiencing a crisis related to mental health, substance use and/or homelessness. Based on these National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective: (1) Regional Crisis Call Centers; (2) Crisis Mobile Team Response; and (3) Crisis Receiving and Stabilization Facilities. The details of these components are outlined below.

In times of a behavioral health crisis, bystanders or healthcare providers can call 911, which results in police dispatch. A *regional crisis call* center provides an alternative to an automatic police response, thereby averting possible injury of an individual experiencing a crisis by a police officer who is unfamiliar with, or not trained to, respond to an individual displaying psychiatric symptoms. This may also reduce the risk of injury to law enforcement personnel and relieve an overburdened law enforcement system. Regional crisis call centers would ideally be made available statewide, provide real-time access to a live mental health professional on a 24/7 basis, meet National Suicide Prevention Lifeline (NSPL or Lifeline) operational guidelines, and serve as “Air Traffic Control” to assess and determine the appropriate response to a mental health crisis. These services would integrate and collaborate with existing 911 and 211 emergency/crisis centers, which serve as an entry point to crisis services and/or provide information and referrals to callers on where to obtain assistance.

Once a crisis line has been called, a *mobile crisis team* response is required if the crisis cannot be deescalated by phone. In the current system, police are often dispatched to the location of the individual in crisis. Rather, in an effective crisis system, two-person behavioral health teams, including a clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be transported to the appropriate level of care, if needed, as determined by the clinician and response team. Unfortunately, in most parts of the country, the individual is transported either to an Emergency Department (ED) or to a jail (which are not optimal and are expensive) because it is a police response and/or there are no service alternatives.

Crisis receiving and stabilization facilities provide a quality and cost-effective alternative to EDs and jails. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a no-rejection policy. These facilities are efficient and provide a welcoming environment, as well as behavioral health assessment and treatment. The multi-disciplinary team, including peers at the facility, can work with the individual to coordinate next steps in care in order to help prevent future mental health crises and repeat contacts with the system.

Additionally, bed or services registries provide particularly helpful information for call centers and responders in areas with or without crisis receiving and stabilization centers. Recently, such information was collected and compiled in a National Association of State Mental Health Program Directors (NASMHPD) Resource Institute (NRI) report from the 24 states that received funding through the SAMHSA Center for Mental Health Services (CMHS) Transformation

Transfer Initiative (TTI) to expand or create a service registry system in their state.⁷ A few states piloted the project in a region of the state with strong stakeholder support, while other states have tapped into existing state advisory committees, established new advisories or engaged existing state provider associations to gather consistent input. Some states were surveyed for broader input through focus groups or presentations at statewide conferences. The most common stakeholders engaged in planning were hospitals and hospital associations, followed by local behavioral health authorities and consumer and family advocacy organizations. These resources have led to the establishment of inpatient/residential bed and behavioral health services registries in states which are now able to offer enhanced crisis intervention services and assure necessary follow-up for individuals in need.

Outside of the National Guidelines model, crisis call centers generally are the entry point to crisis dispatch and services, but they also serve in a prevention, identification and referral capacity. They automatically perform a safety check for every call and if an imminent risk exists, and if that risk cannot be deescalated over the phone, they forward the call to either 911 or to a local mobile crisis response team. However, if there is no imminent risk or if imminent risk has been deescalated over the phone, the call center will continue to work with the individual (or the person calling on their behalf) for as long as needed to prevent a serious crisis. Currently, the NSPL oversees more than 170 local call centers throughout the United States. Call center staff is comprised of professionals and volunteers who are trained to utilize best practices in handling distress calls. Recently, the National Suicide Hotline Designation Act of 2020 (S.2661) was signed into law, requiring that the current NSPL's 10-digit number be replaced by a new three-digit dialing code -988- for suicide prevention and mental health crisis services. The 988 code, an easier number to remember, will be available nationally by July 16, 2022, but SAMHSA is already working with states to establish 988 system in their jurisdictions; this number may be available in some areas sooner than 2022. It will also reduce the social and public health stigma of mental illness. SAMHSA will continue its federal resource provision to the Lifeline networks across the nation, and it will be vitally important to ensure Lifeline-member call centers have consistent funding to meet both the operational needs during the pandemic and the implementation of 988 as call volume is anticipated to grow substantially.

Crisis calls centers have been expanded by states in recent years through the aforementioned State Opioid Response (SOR) grants, to serve as an entry point for individuals with an OUD and now, as mentioned, methamphetamine and other stimulant use disorders. During 2020, states expanded capacity to call centers for individuals, including frontline health workers, experiencing a range of concerns including anxiety, behavioral health crises and suicidal ideation. The Disaster Distress Helpline, a sub-network of the NSPL that offers emotional support to people in need after natural and human-caused disasters, saw a 1000% spike in call volume in April 2020 compared with April 2019. The Crisis Text Line, which provides round-the-clock support by text messages with a trained crisis counselor, had 9,854 counselors active during a 28-day period

⁷ Improving Access to Behavioral Health Crisis Services with Electronic Bed Registries; TTI State Project Profiles (NASMHPD Research Institute, Inc., 2020)

ending May 29 – more than double the number that were active in the 28 days before the pandemic.⁸

D. Competency to Stand Trial (CST), Assisted Outpatient Treatment (AOT), Assertive Community Treatment (ACT), and IMD Exclusions

Competency to Stand Trial (CST). The pandemic is causing and exacerbating mental health issues, but of course containing and stopping the spread of COVID-19 is also a priority. Some states have placed additional restrictions on movement and admissions between jails and hospitals, and as a result, backlogs for Competency to Stand Trial (CST) services have grown in some locations.⁹ As a result, people are being held longer in jails, hospitals, and state psychiatric hospitals, while they wait to stand trial. This is problematic because people with SMI, who are often among those referred for competency evaluations, are at increased risk of complications from COVID-19 due to chronic medical conditions,¹⁰ as well as the presence of metabolic syndromes including cardiovascular disease and diabetes in some receiving treatment with antipsychotic medications. CST services are generally narrowly focused on stabilization, symptom management, and legal education. These services do not take the place of fully developed treatment planning and services with the goal of long-term recovery and a positive return to the community. States are examining pathways to divert individuals out of the criminal legal system even if found incompetent to stand trial by expanding community-based restoration services and developing strategies for alternative pathways, especially for misdemeanor defendants. SAMHSA has funded three years of “Communities of Practice” to help states gain momentum in reforming the system that has traditionally left those with SMI in state hospitals or awaiting services from jails. With COVID-19 impacting the risks to persons held in jail, it is more important than ever to identify these alternative pathways especially when the underlying criminal offense is minor.¹¹

Assisted Outpatient Treatment (AOT). AOT is a form of civil commitment, and it requires a court order under which the judicial system can commit specific eligible individuals, who have severe mental disorders and a history of poor outcomes and have refused treatment to mental health intervention in the community. The mental health intervention may vary, but often involves intensive case management and Assertive Community Treatment (ACT). If a respondent meets the criteria, they are committed to the care of a specific provider with specific clinical directives which may include that the individual be compliant in taking prescribed medications to address symptoms of mental illness. Enriched AOT services include housing assistance, community supports, and

⁸ <https://www.usatoday.com/story/news/2020/06/15/crisis-hotline-call-volume-spikes-straining-social-workers/5266072002/>

⁹ “State Hospital Curtails Admissions as Concerns over COVID-19 Grow,” Portland Tribune, March 31, 2020, accessed May 6, 2020, <https://pamplinmedia.com/pt/9-news/460144-374371-state-hospital-curtails-admissions-as-concerns-over-covid-19-grow-pwoff>.

¹⁰ “Mental Disorders and Medical Comorbidity,” Robert Wood Johnson Foundation, February 1, 2011, accessed July 27, 2020, <https://www.rwjf.org/en/library/research/2011/02/mental-disorders-and-medical-comorbidity.html>; Benjamin G. Druss, “Addressing the COVID-19 Pandemic in Populations with Serious Mental Illness,” *Journal of the American Academy of Psychiatry and the Law* (2020), doi:10.1001/jamapsychiatry.2020.0894.

¹¹ Pinals DA, Callahan L. Evaluation and Restoration of Competence to Stand Trial: Intercepting the Forensic System Using the Sequential Intercept Model. *Psychiatr Serv.* 2020 Jul 1;71(7):698-705.

vocational rehabilitation services. These enriched services for individuals under AOT orders for 6 months or longer have shown lower rates of re-hospitalization, arrest, re-arrest, incarceration, homelessness, violence, and suicide. When adequately funded, AOT has been found in some studies to reduce system treatment costs and improve participants' quality of life. AOT provides an opportunity to help prevent episodes of deterioration and negative outcomes, such as arrest.¹² Although voluntary mental health services and person-centered care is the default and preferred approach to treatment of mental illness, one study suggested that AOT may help people with SMI to remain in treatment in the community. These effects were found to hold beyond the conclusion of the original AOT order, and that those who need fewer intensive services under an AOT order may not require Assertive Community Treatment (ACT).¹³

Assertive Community Treatment (ACT). ACT is an evidence-based¹⁴ service delivery model that does *not* require a court order, with the primary goal of recovery through community treatment and habilitation and has historically been referred to as “the hospital without walls.” It is intended for consumers with SMI who have needs that have not been effectively met by traditional approaches,¹⁵ and prioritizes engaging and retaining participants in a way that is comfortable and tailored to each individual.¹⁶ ACT is characterized by a team of 10-12 practitioners who provide services to about 100 people through direct delivery, rather than through a wide array of agencies and providers. ACT services are highly integrated and individualized, time-unlimited, and with 24/7 crisis availability.¹⁷ ACT also integrates principles of cultural competence and linguistic preference, addresses the impact of discrimination and stigma, and recognizes the importance of family, community, and faith-based support.¹⁸ ACT programs have been implemented in 35 states, and research demonstrates that when effectively implemented, these programs significantly reduce psychiatric hospitalization, as well as lead to greater housing stability, better quality of life, reduced symptoms of mental illness, and improved social functioning. Increasingly, governmental and professional groups see ACT as a fundamental tool in a mental health service system, and accessibility to ACT has been identified as one of three best-practice measures of the quality of a state's mental health system, according to SAMHSA.¹⁹

¹² Draine, J., “Conceptualizing Services Research on Outpatient Commitment,” *Journal of Mental Health Administration* 24 (1997): 306–15

¹³ Munetz, M. R., Ritter, C., Teller, J. L., & Bonfine, N. (2019). Association Between Hospitalization and Delivery of Assisted Outpatient Treatment With and Without Assertive Community Treatment. *Psychiatric Services*, 70(9), 833-836. doi:10.1176/appi.ps.201800375

¹⁴ NY Office of Mental Health. (2007). ACT Program Guidelines. Retrieved from https://omh.ny.gov/omhweb/act/program_guidelines.html

¹⁵ [SAMHSA's ACT Toolkit](#): Building your Program

¹⁶ NY Office of Mental Health. (2007). ACT Program Guidelines. Retrieved from https://omh.ny.gov/omhweb/act/program_guidelines.html

¹⁷ [SAMHSA's ACT Toolkit](#): Building your Program

¹⁸ NY Office of Mental Health. (2007). ACT Program Guidelines. Retrieved from https://omh.ny.gov/omhweb/act/program_guidelines.html

¹⁹ [SAMHSA's ACT Toolkit](#): Building your Program

Institutes of Mental Disease (IMD) Exclusions. Those who are not detained in jails or referred to intensive community-based services, such as ACT, are frequently sent to state psychiatric hospitals. Increasingly, this population includes those that are sent for restoration of their competence to stand trial. As a result, access to civil state hospital inpatient beds have become limited, creating a cascade of patients into inappropriate levels of care.²⁰ State hospitals are defined as Institutes of Mental Disease (IMD), and as such, state hospitals provide services to Medicaid-eligible individuals for whom they cannot bill Medicaid, as outlined in Section 1905a of the Social Security Act. This prohibition is known as the “IMD Exclusion.” An IMD is “a hospital, nursing facility, or other institution that is primarily engaged in providing diagnosis, treatment, or care for persons with mental or substance use disorders, including medical attention, nursing care, and related services.” An IMD maintains more than 16 beds dedicated to diagnosis, care and treatment of those with mental illness and/or SUDs, or facilities that serve a variety of medical needs but have 51% or more of its beds dedicated to serving those with mental illness and/or SUDs. The IMD exclusion does not apply to individuals over 65 or under 21 years of age. However, through a Medicaid 1115 waiver, it may be possible to bill Medicaid for services provided at these facilities. The 1115 Waiver is a key strategy to explore facilitating access to needed inpatient mental health care in these settings for individuals with SMI.

E. Certified Community Behavioral Health Clinics (CCBHCs)

Individuals at risk of experiencing behavioral health crises, and those recovering from such events, benefit from having a comprehensive array of behavioral health services available. This assists in the prevention of future crises thus averting jail time, hospitalizations and general disruptions to daily living. Certified Community Behavioral Health Clinics (CCBHCs) provide comprehensive, integrated mental health and SUDs services to individuals in need. CCBHCs participating in the Section 223 Demonstration Program to Improve Community Mental Health Services receive an enhanced reimbursement rate in order to cover the cost of expanding resources to serve clients with complex needs.²¹ CCBHCs provide or contract nine types of services, including 24/7 crisis care, evidence-based practices in the treatment of mental and SUDs, and coordinated care between primary care, hospital facilities, and physical health integration. Guiding principles of these clinics include a focus on recovery, wellness, and trauma-informed care. With the goal of delivering comprehensive care, CCBHCs select services designed to facilitate access, crisis stabilization, and treatment for individuals with serious and complex mental illnesses and SUDs.²² Since the Section 223 Demonstration Program to Improve Community Mental Health Services pilot was launched in 2014, CCBHCs have dramatically increased access to treatment for mental illness and SUDs, expanded capacity to address the opioid crisis, and established innovative partnerships with law enforcement and hospitals to improve care and reduce recidivism and readmissions. In exchange, CCBHCs in the eight states participating in the CCBHC Demonstration

²⁰ When patients, whether forensic or not, cannot access the appropriate level of care, their health suffers. See Debra A. Pinals and Doris A. Fuller, *Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care* (Alexandria, VA: National Association of State Mental Health Program Directors, 2017), https://www.nasmhpd.org/sites/default/files/TAC.Paper_.1Beyond_Beds.pdf)

²¹ CCBHC National Council

²² CCBHC National Council

Program receive enhanced Medicaid reimbursement rates for these comprehensive services. Missouri demonstrated CCBHC's financial benefits by saving \$31 million through their Community Mental Health Center Healthcare Homes (CMHCs), with \$98 per member per month (PMPM) cost saving. Its disease management cohort enrolled in CMHC Health Homes saved \$22.8 million. This finding illustrates the potential for CCBHCs to be financially beneficial for states and localities.²³ In this past year (2020), two new states (Kentucky and Michigan) were selected as CCBHC Demonstration Program expansion states, joining CCBHCs in the original eight states. In addition to the CCBHC Demonstration Program, entities across the nation that meet CCBHC requirements are eligible to receive CCBHC Expansion grant funding from SAMHSA.

F. Services to those in the Criminal Justice System with Serious Mental Illness and/or Substance Use Disorders

It is a national tragedy that jails and prisons have become de facto mental institutions in the United States, and it is a situation which the Federal and state governments must work to reverse. The issue is being addressed through greater availability of integrated care services as described above, but criminal justice resources and reform are also necessary. For a number of years, efforts have been undertaken to try to address this situation and to find evidence-based alternatives for those with significant behavioral health challenges who too often are met with criminal sanctions for infractions of the law that occur as a result of untreated mental health illnesses and SUDs. Some of these resources are described further below and represent significant resource allocation from the Departments of Justice (DOJ).

Diversion Programs for the Seriously Mentally Ill. SAMHSA has invested in a program that diverts, from jail to mental health treatment, individuals with SMI who commit minor infractions of the law. This approach is important in a number of ways. First, it reduces the stigmatization to the individual of legal charges and a criminal record that can make it much more difficult for them to obtain basic life needs such as housing and employment in the future. Second, it reduces burden on the jails and the criminal justice system so that their limited resources can be put to more appropriate use. Key to this is that in recent years this small diversion program has had the added resource of the CCBHC system. As noted, CCBHCs are required to provide 24/7 crisis intervention services, and as such, these services often intervene to provide crisis services and ongoing behavioral health services for an identified individual. This, again, is important to individuals with SMI and, in addition, reduces the burden on law enforcement officers who too often intervene, sometimes with tragic results, in incidents involving those who need mental health care and not incarceration.

Use of Mental Health Block Grants to Provide Treatment of Mental Illness During Incarceration. It is an unfortunate fact that approximately 356,000 individuals who are currently incarcerated also have SMI and/or SUDs. Criminal justice personnel do not commonly maintain sufficient behavioral health expertise to treat these individuals. States are now able to use Mental Health Block Grant funds to support their unfunded needs for those with SMI, including to provide treatment services to incarcerated individuals with SMI. Use of Mental Health Block Grant funds

²³ CCBHC PowerPoint

in jail or prison settings requires that community-based service providers come into these facilities to provide needed mental health services which makes it more likely that relationships formed between inmates and the mental health providers will continue upon release to better assure ongoing care and reduce the risk for recidivism.

Drug Courts. DOJ and SAMHSA maintain significant investments in drug courts throughout the nation. These programs serve adults, juveniles, and families, and have been associated with increased abstinence and lower rates of re-arrest, as well as higher rates of employment. With a focus on addressing an individual's drug and/or alcohol-related disorder that contributes to infractions of the law, these programs use the authority of the court to compel treatment for SUDs and provide an opportunity for effective treatment and access to services to assist in re-establishing a healthy and productive life in the community. Importantly, in the recent past, SAMHSA has made it possible for funds to be used to purchase FDA-approved medication therapies for the treatment of SUDs with a focus on addressing OUDs.

Offender Re-Entry Programs. For those who have been incarcerated and who have SUDs, this program provides services prior to and upon release to connect a person with needed ongoing treatment services. Two important changes have been made in recent years. These funds can now be used to pay for medication treatments for SUDs, particularly OUD. This is especially consequential because it is an all too common occurrence that release from jail or prison is often a trigger for relapse to drug use. The use of potent opioids, such as fentanyl, is particularly deadly for those released from custody due to their loss of tolerance to opioids while incarcerated. This Administration has also made it possible for funds to be used to provide treatment services in the months leading up to release from incarceration. This is important because it is difficult to locate and connect people to appropriate care once released. Engaging individuals in needed treatment services for a significant duration prior to release helps to assure that they will transition into ongoing care following release.

G. Programs to Address Homelessness

The Departments of Housing and Urban Development (HUD), Veterans Affairs (VA) and HHS maintain programs to provide support to those with housing insecurity and/or who are homeless. While HUD provides direct funding for housing resources in communities nationwide, SAMHSA/HHS has a program that provides behavioral health supports to those with housing needs and SMI and/or SUDs. HUD and SAMHSA work collaboratively to try to make the maximum positive use of their respective funds by pairing housing and behavioral health resources in communities where possible.

H. School-Based Mental Health Programs

Investing in interventions that prevent development of mental health and substance use challenges in youth and adolescence is a priority for the Federal government. SAMHSA provides funding to states and communities to address infrastructure needs to support school-based mental health services, funding to school staff, community members, families, and student/peer-based efforts that provide training in recognition of mental health problems and supportive interventions. These programs support the placement of positive environments in school settings to help students

to engage in prosocial interactions and positive approaches to problem solving. These funds also provide resources to schools to employ behavioral health staff in school settings who can help to address the mental health needs of students, as well as offer direct services for mental health concerns in school settings. SAMHSA and its Center for Mental Health Services recently published a document outlining the mechanisms for payment of school-based mental health services provided by community providers either face-to-face or by innovative approaches, such as telehealth. Early identification of, and intervention with, those at risk can significantly decrease the severity of mental illness in vulnerable children. In addition, these programs increase the likelihood that vulnerable children learn positive coping strategies that give them the greatest opportunity to live healthy, productive and meaningful lives in their communities.

I. Quality Care for Mental and Substance Use Disorders

The ongoing ability to provide the services discussed in this Report will ultimately depend on the ongoing collaborative relationships between communities, states, service providers, and payers, including Federal and state governments, private insurers and employers. These entities must rely on the use of evidence-based, best practices by providers, many of which have been described herein, but which will continue to evolve with time. A primary principle must be the recognition that mental illness and SUDs are chronic, relapsing illnesses and, for those with more severe conditions, will require ongoing care. For many, this will take the form of ongoing case management and long-term care, while for many others, this care will be episodic. However, there are guiding parameters that must be followed. There must be a broad array of both clinical services and settings, as well as easily accessible and available community recovery supports. These services can be managed using case management services and care coordination. Clinical and community supports are key to recovery, and must be covered by the payers as part of the health care coverage they provide, consistent with legal requirements. Programs described in this Report, specifically CCBHCs that have demonstrated partnerships with community-based recovery supports, school-based services, and services to the justice involved population, show the benefit of making an array of services available to those with SMI and SUDs. Results observed in these integrated care and recovery support programs provide the foundational evidence to support widespread, permanent establishment of and ongoing payment for such resources. Providers must work with those receiving behavioral health services to establish a treatment plan that addresses all of the individual's behavioral health needs, including the recognition that mental illnesses and SUDs frequently co-occur. Therefore, all persons with behavioral health needs must receive comprehensive assessment, a plan that addresses all behavioral health issues, and a plan that is regularly updated to address changing needs.

One model that addresses the array of service needs that individuals may have is the Addiction Recovery Medical Home Model.²¹ This model describes principles which are relevant to the care needs of those with mental health illnesses and/or SUDs, and it also directly addresses payment for bundled services and episodes of care related to recovery and utilizes linked quality and process measures emphasizing the importance of personalized and integrated care. To best implement systems of care for persons with mental illnesses and/or SUDs, a network that includes acute inpatient, outpatient, telehealth, and community recovery support services is needed. The care recovery team is an essential component which should focus on long-term, holistic recovery, bringing together essential elements of quality care that include the patient, involved family

members, and peer support in the context of developing a personalized plan of care. This plan of care must take into account the clinical, community and other environmental elements specific to an individual's needs that help to assure the best possible recovery.²⁴

J. Training and Technical Assistance

A recent HHS Inspector General report shows that COVID-19 brought specific challenges to opioid treatment programs chiefly related to providing face-to-face services while meeting guidelines concerning COVID-19 precaution protocols.²⁵ These issues, along with increased demand for services and closures of agencies providing services due to the pandemic, has resulted in a tremendous need for training and technical assistance for individuals, states and community-based organizations for the purpose of developing an adequate supply of services, quality improvement and the growth of the behavioral health workforce. It is critical to move quickly, be innovative, trauma-informed, and maximize resources to adapt the delivery of mental health care to the demands created by the COVID-19 pandemic.

Sustainable adaptations of delivery systems for behavioral health care should be developed and specifically designed to mitigate disparities in the provision of health care. This will require efforts from the Federal and state governments, local behavioral health authorities, colleges and universities, community organizations, employers, and others. Employers, the faith community, volunteers, behavioral health organizations and many others have stepped up to initiate efforts to provide training on resiliency and to support those in need. The Administration for Community Living (ACL) funded Mental Health and Developmental Disabilities (MHDD) National Training Center is working to improve mental health services and supports for people with developmental disabilities by serving as a national clearinghouse for practices that address the mental health needs of individuals with developmental disabilities.

The Suicide Prevention Resource Center (SPRC) is building national capacity for preventing suicide by providing technical assistance, training, and resources to assist states, tribes, organizations, and SAMHSA grantees to develop suicide prevention strategies. Project AWARE (Advancing Wellness and Resiliency in Education) builds and expands the capacity of state educational agencies to (1) increase awareness of mental health issues among school-aged youth; (2) provide training for school personnel and other adults who interact with school-age youth to detect and respond to mental health issues in children and youth; and (3) ensure that children, youth, and families who may have behavioral health issues have access to appropriate treatment services. The purpose of the SAMHSA-funded Technology Transfer Centers (TTC) (www.techtransfercenters.org) is to develop and strengthen the specialized behavioral healthcare and primary healthcare workforce that provides prevention, treatment, and recovery support services for mental illness and SUDs. The TTC program is comprised of three networks: the Addiction Technology Transfer Centers (ATTC), the Mental Health Technology Transfer Centers

²⁴ Alliance for Addiction Payment Reform. Addiction recovery medical home alternative payment model. IncentivizeRecovery.org, 2019.

²⁵ Opioid Treatment Programs Reported Challenges Encountered During the COVID-19 Pandemic and Actions Taken To Address Them, A-09-20-01001 (hhs.gov)

(MHTTC), and the Prevention Technology Transfer Centers (PTTC), the latter two developed and launched by SAMHSA in 2018. The U.S. Department of Labor's Office of Disability Employment Policy's (ODEP) Employer Assistance and Resource Network on Disability Inclusion (EARN) created the Mental Health Toolkit for Employers, an online gateway to background, tools, and resources for employers. It provides valuable information and guidance for employers seeking to offer a mental health-friendly workplace. The Toolkit also provides summaries of research on workplace mental health, descriptions of mental health initiatives implemented by companies of varying sizes and industries, and links to ready-to-use resources employers can use to start their own. Additional workforce development initiatives include a guidance document created by the National Association of State Mental Health Program Directors that addresses key workforce development issues and challenges, including core competencies, recruitment, selection and retention of staff, and training and professional development.²⁶

The MHTTC Network (www.mhttcnetwork.org) is a group that includes 10 Regional Centers, a National American Indian and Alaska Native Center, a National Hispanic and Latino Center, and a Network Coordinating Office. This collaborative network supports resource development and dissemination, training and technical assistance, and workforce development for the mental health field. This resource also includes supplemental funding to specifically address school-based mental health needs and, in January 2021, will launch resources directed at the mental health needs of healthcare practitioners who have experienced significant stress and mental health issues related to their experiences in patient care during COVID-19. The PTTC Network (www.pttcnetwork.org), is designed to improve implementation and delivery of effective substance abuse prevention interventions, and to provide training and technical assistance services to the substance abuse prevention field. It does this by: developing and disseminating tools and strategies needed to improve the quality of substance abuse prevention efforts; providing intensive technical assistance and learning resources to prevention professionals in order to improve their understanding of prevention science, epidemiological data, and implementation of evidence-based and promising practices; and developing tools and resources to engage the next generation of prevention professionals.

K. Assistance with Emerging Needs Related to COVID-19

There are new and expanding demands for mental and behavioral health services that require unique and thoughtful approaches. As an example, SAMHSA temporarily created the opportunity for healthcare providers to [prescribe buprenorphine for new patients via telephone](#). [Further, as a result of the national emergency for COVID-19, the Drug Enforcement Agency \(DEA\) was able to offer providers certain flexibilities](#), including allowing healthcare providers to prescribe after [audio only](#) assessments, provided that the telephone call aligns with adequate levels of care. The Centers for Medicaid & Medicare Services (CMS) also was able to allow additional flexibilities in terms of services Medicaid and Medicare may reimburse, such as Tennessee now [permitting telephonic](#) sessions to occur in a TennCare (Medicaid) enrollee's home if that member has concerns about COVID-19.

²⁶ https://www.nasmhpd.org/sites/default/files/DH-Workforce_Development_reference_doc_1.pdf.

Similarly, the HHS Center for Faith Based and Neighborhood Partnerships (Partnership Center) has been preparing faith leaders to address mental health during the COVID-19 pandemic. Recognizing that many individuals turn to their faith tradition in a time of crisis, the Partnership Center created the [Considering Faith, Community, and Mental Health During the COVID-19 Crisis](#) resource, highlighting the response of various faith traditions to mental health challenges related to COVID-19. In conjunction with this resource, the Partnership Center also hosted a four-part webinar series engaging more than 8,000 participants. This webinar series, [available on the HHS YouTube channel](#), helped faith and community leaders consider and prepare for the mental health challenges occurring during the COVID-19 pandemic. It included information and education about mental health challenges, as well as strategies to address the increasing mental health needs in the community. All of the education and technical assistance programs encourage private stakeholder participation. These available resources span HHS from SAMHSA's Technology Transfer Center Network to the work on behavioral health integration occurring through the Health Resources and Services Administration (HRSA) funded Federally Qualified Health Centers as well as the technical assistance and training resources that address mental health and wellness across the lifespan from the Administration for Children and Families and the Administration for Community Living.

Finally, it is important to recognize that the COVID-19 pandemic has complicated the continuous administration of Medication Assisted Treatment for SUDs to individuals with OUD. Necessary flexibilities have been put in place by SAMHSA and other Federal entities to help ameliorate these challenges during this public health emergency. These actions include ongoing work with the DEA to ensure consensus around prescribing/dispensing opioid therapies, telehealth flexibilities, and mid-level practitioner clinical responsibilities. The COVID-19 pandemic has also highlighted the need for all Americans to have a reliable internet connection. Large parts of rural America are "digital deserts," where high-speed internet access is inconsistent or unavailable.²⁷ Internet access in Tribal nations is also low. According to the FCC, only 46.6 percent of homes on rural tribal lands have access to broadband networks.²⁸ This understandably complicates the delivery of mental health services to rural and tribal communities during the pandemic.²⁹

²⁷ The Real Digital Divide? Advertised vs. Actual Internet Speeds Purdue University Center for Regional Development [Purdue Center for Regional Development https://pcrd.purdue.edu/the-real-digital-divide-advertised-vs-actual-internet-speeds/](https://pcrd.purdue.edu/the-real-digital-divide-advertised-vs-actual-internet-speeds/)

²⁸ FCC Report on Broadband Deployment in Indian Country, Pursuant to the Repack Airwaves yielding Better Access for Users of Modern Services Act of 2018 <https://www.fcc.gov/document/report-broadband-deployment-indian-country>

²⁹ <https://www.whitehouse.gov/presidential-actions/presidential-executive-order-streamlining-expediting-requests-locate-broadband-facilities-rural-america/>

IV. Recommendations

During times of crisis we become even more determined, and with that more creative and innovative when designing programs and policies that meet ever-changing needs. As part of the coordination amongst the members of this Working Group, this Report presents information from Federal agencies to best utilize their knowledge of systems and services that can be adapted to address these important issues.

A. Agency Recommendations

The recommendations that follow are those provided by the departments and agencies noted.

The President's Commission on Law Enforcement and the Administration of Justice. Social problems impacting public safety should be a key area of study. Moving forward, there will continue to be a significant emphasis on the challenges for law enforcement and community responses to individuals who have mental illness, SUD, or other challenges. Increasingly, efforts are being envisioned and developed for diversion and deflection of individuals with mental illness who encounter law enforcement. In addition, it is imperative that we look to expand models of community-based crisis intervention that rely on law enforcement only when necessary. Further, the recognition that those who serve in law enforcement have high rates of trauma and suicide is also relevant to any reform strategies to help communities respond better. It is, therefore, critical that behavioral health expertise is included in the development of any new strategies.

Collaboration Between Behavioral Health Agencies, Housing Agencies, CMS and SAMHSA to address Supportive Housing. Combining health care and support services with non-time-limited housing is an evidence-based practice that is effective in improving health, reducing total costs of care, and decreasing the use of inpatient psychiatric hospitals.^{30,31} Federal agencies should support states in their efforts to integrate supportive housing into community-based services, and encourage local agencies and provider organizations to partner with housing providers/developers to match high-need individuals with housing. For example, contractual requirements can stipulate how this should happen in addition to the performance measures to collect and report, as well as the evaluations to conduct in order to ensure these partnerships are effective.

Office of National Drug Control Policy. ONDCP develops and publishes the President's National Drug Control Strategy and oversees its implementation. Additionally, it publishes policy plans like the 2019 National Treatment Plan, and helps to coordinate work between Federal departments with equities in addressing SUD needs. Areas of emphasis should include the

³⁰ A wealth of studies have been conducted on supportive housing. Numerous literature reviews on various aspects of study results are available at <http://www.csh.org/supportive-housingfacts/evidence/>.

³¹ Kerman, N, et al. (March 2018). The Effects of Housing Stability on Service Use Among Homeless Adults with Mental Illness in a Randomized Controlled Trial of Housing First. *BMC Health Serv Res* 18 (1): 190. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/29558927>

integration of screening and referral to care for SUD/Mental Health/Suicide into COVID-19 testing protocols to promote public safety/public health partnerships and to build, co-locate, or partner behavioral health crisis response units with first responders. Additional important areas include: providing information on Mental Health/SUD resources where risk factors are triggered, e.g., loss of employment, COVID-19 related death of a spouse, parent or others, closing of a business, etc.; developing/promoting tailored mental healthcare models that take into account the challenges of delivering services in rural communities; addressing stigma as an important barrier in rural communities; examining the factors that impact mental and behavioral health in rural communities, such as the social determinants of mental health; and presenting possible mitigation strategies for in-person participation in group therapy and support, as well as syringe service continuity of operations.

Department of Defense (DOD). DOD recommends the development of an environmental scan of current relationships within the public and private sectors to determine where potential opportunities exist for additional collaboration. Oftentimes, non-profit organizations or corporations may enter into a partnership with one Federal agency that may actually serve to benefit multiple agencies. It is important that there is a listing of these partnerships, so there can be an understanding of where these partnerships and collaborations currently exist in order to allow a whole of government approach around crisis intervention and support.

Department of Labor, Employee Benefits Security Administration. The correction of Mental Health Parity and Addiction Equity Act (MHPAEA) violations removes barriers to mental health and SUD treatment and impacts hundreds of thousands of health plans and millions of participants. It is recommended that EBSA should continue to implement parity compliance and enforcement programs, and coordinate with other agencies as appropriate.

Department of Labor, Office of Disability Employment Policy. The Advancing State Policy Integration for Recovery and Employment (ASPIRE) initiative will help selected states create and implement strategic plans that engage multiple state systems in order to better integrate funding, policy, and programs to support evidence-based supported employment models, such as Individual Placement and Support (IPS). It is recommended that ODEP and a team of nationally recognized experts work with states to advance policy in this area, including greater consideration and adoption of EARN's Mental Health Toolkit for employers. States will have an opportunity to learn from one another, and state challenges and solutions will inform federal policy development.

Department of Veterans Affairs. Analytics to better understand current mental health and suicide prevention efforts, gaps, and needs, with the goal of shaping future funding efforts should be prioritized. Therefore, there should be increased opportunities to coordinate with VA, HHS, and the White House to establish the PREVENTS National Grant Program, which will facilitate collaboration and coordination among community-based efforts to ensure that organizations are working more closely with each other, as well as with their Federal, state and local government partners. These efforts also depend on the successful outreach to, and education of, the American people to ensure that they are aware of risk factors that can affect them during this pandemic, as well as protective factors that are available to help at-risk groups through this crisis. The REACH public health campaign should be expanded to include focus on and attention to the at-risk groups included in the EO 13954. In addition to the activities of PREVENTS and the REACH public

health campaign, there are a number of VA programs that focus on these important issues, including the National Strategy for Preventing Veteran Suicide, the Veteran Crisis Line (www.veteranscrisisline.net), the Veterans Justice Outreach (VJO) programs to support homeless Veterans (www.va.gov/homeless/vjo), as well as VA's ongoing partnership with CDC to publish data and surveillance statistics on Veteran suicides.

Housing and Urban Development. HUD's EnVision Center program expands opportunities for low-income Americans by coordinating the delivery of programs across multiple departments and agencies and integrating those programs with local government and private resources at centralized locations. HUD's Continuum of Care (CoC) Program and Emergency Solutions Grants recipients partner with community-based providers that serve those at-risk of homelessness or those experiencing homelessness. These services include case management, and other specialized services for those with serious mental illness and SUDs who are at-risk of homelessness or are experiencing homelessness. Participants of both CoC and Emergency Solutions Grants (ESG) programs are evaluated to match their needs with available services. Increasing or focusing case management services to address early signs of mental illness or other mental health challenges could provide a means for service providers to engage participants with prevention and early treatment of mental illness and SUDs.

Department of Health and Human Services, Centers for Medicare & Medicaid Services. CMS, together with the Labor and Treasury Departments, should continue to work with SAMHSA and the ONDCP to improve compliance and enforcement of MHPAEA. Through rule-making, the agency has already added more than 60 services to the Medicare telehealth list that will continue to be covered beyond the end of the PHE. The agency should also continue to gather more data and evaluate whether more services should be added in the future.

Department of Health and Human Services, Centers for Disease Control and Prevention. The development of an interagency working group to evaluate and assess what emergency authorities, such as expansion of telehealth services, is recommended. Findings from CDC research on national and jurisdictional disaster and emergency preparedness planning for people with SMI and/or intellectual disability/developmental disability (ID/DD) could inform a potential interagency agreement between CDC, SAMHSA, the HHS Assistant Secretary for Preparedness and Response (ASPR), and the Federal Emergency Management Administration (FEMA) to address the gaps and deficiencies identified for people with SMI and ID/DD.

Department of Health and Human Services, Administration for Community Living. Recommendations from ACL include: further scaling of Chronic Disease Self-Management Education (CDSME) programs by encouraging substantive partnerships between State Units on Aging, State Mental Health Authorities, and Single State Agencies for Substance Abuse, as well as community-level partnerships between Area Agencies on Aging, clinicians and specialty behavioral health providers; encouraging connections with SAMHSA's Center of Excellence for Behavioral Health Disparities in Older Adults to ensure that ACL and SAMHSA are leveraging efforts to the greatest benefit; supporting community level partnerships between the Nutrition Innovation grantees, clinicians and, specialty behavioral health providers to ensure the social determinants of health of older adults are being addressed, including nutrition and mental well-being; expanding upon NCAAPS to more fully coordinate SAMHSA efforts to improve person-

centered systems; expanding upon existing ACL and SAMHSA funding of University Centers for Excellence in Developmental Disabilities' (UCEDD) mental health activities; further dissemination of existing technical assistance products such as trainings/toolkits, publications, and behavioral health profiles; supporting further state adoption of effective evidence-based interventions will be important to helping communities to address mental health needs; and using block grant and discretionary funding to further address the impact of the [opioid crisis](#) among older adults and individuals with disabilities and their families, including addressing gaps in knowledge and developing evidence based practices.

Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. SAMHSA recommends increased funding for the Mental Health Block Grant as proposed in the 2021 Budget to promote and develop crisis services across all states addressing the needs of individuals with SMI and serious emotional disturbances (SED). It is also recommended that the set-aside fund some or all of a set of core crisis care elements including centrally deployed 24/7 mobile crisis units, short-term residential crisis stabilization beds, evidence-based protocols for delivering services to individuals with suicide risk, and real time regional or State-wide crisis call centers coordination. States can also use block grant funds to help convert community mental health centers (CMHCs) into CCBHCs to better meet the needs of those with SMI, as well as to provide for community resource needs related to behavioral health. In addition, states should consider using block grant funds for care transitions for youth in child welfare and juvenile justice settings, as well as for treatment services for mental health for juveniles and adults in jails and prisons.

For those involved in the criminal justice system, maximizing re-entry coordination and treatment will expand access to pharmacotherapy for OUD, continuity of treatment for SMI and intensive care coordination of youth and adults with SED, IDD/DD and SUD. SAMHSA also recommends consideration of the expansion of buprenorphine products for pharmacotherapy for OUD by removing the patient limits on any DATA-waived practitioner working in a SUD specialty treatment setting. This action would provide a means of safely and effectively expanding needed treatment to Americans experiencing the challenges of OUD. An additional recommendation includes educational and clinical training on screening, diagnosis, and treatment of SUDs including OUD in all healthcare practitioner undergraduate training programs. The high prevalence of these disorders make this modification to the education of healthcare practitioners an essential part of their training.

B. Service and Funding Recommendations

Data Collection and Analysis. Across agencies, data collection and analysis should be prioritized as it can examine prevalence rates, outcomes and retention in various programs and inform future decision-making. Further, program adaptations made during the COVID-19 pandemic should be evaluated for effectiveness to determine if the changes should be made permanent after the public health emergency.

Needs of Special Populations. Targeting special populations can be effective in both prevention and treatment. Programs such as the Indian Country initiative, Suicide Prevention Strategies, ASOs, Campus Suicide Prevention Grants, and PREVENTS should be promoted and

expanded. Specifically, PREVENTS should leverage ongoing interagency relationships, the National PREVENTS Ambassador program, and non-governmental partnerships to amplify and elevate suicide prevention messaging and education targeting specific at-risk populations through the REACH Public Health Campaign.

Certified Community Behavioral Health Centers. The development and expansion of CCBHCs should be incentivized. These programs offer a full range of services including crisis services that provide the variety of services needed by individuals during the pandemic and beyond.

Telehealth. It is recommended that the CMS gather more data and evaluate whether more services should be added to the Medicare telehealth services list beyond what was already added through rule-making, and that all payers are encouraged to evaluate covering behavioral health services delivered through telehealth. Lessons learned from the COVID-19 pandemic have proven this technology as beneficial for individuals with behavioral health problems, and additional amendments should be considered as needed based on data. Stakeholders should be fully engaged in advocating for these services, and educational institutions should include training on provision of telehealth services as a routine component of healthcare practitioner training.

The National Guidelines for Behavioral Health Crisis Care –A Best Practice Toolkit. It is recommended that the National Guidelines supporting program design, development, implementation, and continuous quality improvement efforts continue to be publicly promoted. The provision of financial incentives for states/regions to create crisis services systems by putting in place call centers, mobile crisis response teams and crisis receiving and stabilization centers is important to addressing the mental health and SUDs issues that so often result in a need for crisis services.

National Suicide Prevention Lifeline: 988 implementation and operation. The NSPL should continue its support of regional or statewide crisis call center hubs staffed by mental health professionals that meet Lifeline standards for imminent risk assessment. These crisis call centers should coordinate crisis care in real-time, including having the ability to dispatch mobile crisis teams and monitoring the availability of crisis receiving and stabilization centers and inpatient psychiatric beds; operate uniform platforms for uniformity and backup systems; and collect and analyze data for the purpose of quality monitoring and improvement. Lifeline-member call centers need consistent funding to meet the operational needs of 988 as call volume is anticipated to grow. Americans calling such lifelines are often in imminent danger of self-harm or death. The establishment of this crisis hotline number will save thousands of lives.

IMD Exclusion and Waiver. In order for states to bill Medicaid for services provided in hospital acute care psychiatric facilities and state psychiatric hospitals during COVID-19 and beyond, consider ways the 1115 waiver application processes can be simplified in accordance with state consultation. Also, it is encouraged that action be taken on the President's FY 2021 Budget proposal, which modifies the Medicaid IMD exclusion to provide targeted flexibility to states to provide inpatient mental health services to Medicaid beneficiaries with SMI as part of a comprehensive strategy that includes improvements to community-based treatment.

Psychiatric Advance Directives. PAD is a useful and self-directed tool that should be promoted and encouraged throughout behavioral health programming. Associated services and funding should be prioritized in order to maximize patient engagement. PAD development should become a standard of care on which quality of service provision in the behavioral health system both at inpatient and outpatient facilities is evaluated.

Assisted Outpatient Treatment. The continuation of education and technical assistance to communities related to AOT potential and limitations would be impactful, as well as the utilization of technical assistance and training resources, such as the SMI Adviser, to continually update knowledge domains related to AOT practices.

Community-Based Competency to Stand Trial Restoration Services. The promotion of alternatives to state hospital-based CST restoration is recommended. Providing technical assistance to help in the development of community-based outpatient restoration, as well as alternatives such as jail diversion to route individuals out of the criminal justice system altogether, should be considered. While traditional CST restoration does not provide the full range of treatment planning and services needed by individuals, particularly if they are being detained for long periods of time, developing program elements to assess the underlying issues and need for services for persons found incompetent to stand trial should be reviewed (e.g. whether they have SMI or ID/DD).

Assertive Community Treatment. Promoting ACT as an evidence-based practice that can support individuals with SMI in their homes should be considered, including a multi-disciplinary treatment team that can interact with program participants wherever they are, with the goal of decreasing symptoms and repeated hospitalization, as well as maximizing quality of life.

Bed or Service Registries. Registries provide fast and useful information for call centers and responders in finding needed services during a crisis, particularly in areas without crisis receiving and stabilization centers. Federal financial incentives are already assisting many states with development of registries. These incentives should be considered for continuation or expansion.

Emerging Needs. Lessons learned and real-time tracking data will assist in identifying needs and trends during the pandemic as new and emerging issues arise. Surveillance data collected by CDC including information on emergency department utilization, suicide and overdose deaths should be collected, analyzed and made publicly available as soon as possible. SAMHSA has reinstated the Drug Abuse Warning Network (DAWN) which provides real-time data from emergency departments across the nation about trends in substance use that will help to direct federal resources to address emerging substance misuse issues. Promoting programs with community-based and faith-based organizations will assist in hearing from those most directly affected by COVID-19. In order to adjust federal assistance and services to incorporate new items or need for greater volumes of services, federal programs must be nimble and quick. An example of such an emerging need is the flexibility offered for MAT for OUD, prescribing buprenorphine by telephone, which was a rapid adjustment for a critically needed service. Developing tracking and evaluation tools to facilitate greater coordination and collaboration is critical and should be adopted to ensure effectiveness and efficiency.

V. Conclusion

The COVID-19 pandemic has already affected the mental health of millions of Americans, and it will continue to do so well beyond the end of the declared public health emergency. The psychological toll of the disease is already apparent both in the general population and specifically in people who are most vulnerable because of prior trauma, the experience of significant loss resulting from COVID-19, presence of mental illness (particularly SMI and cognitive impairment); prior substance use or addiction, and intellectual disability. Further, frontline healthcare workers who are shouldering the responsibility for providing physical and mental healthcare during this crisis are also at greater risk for mental health challenges as the ongoing stress, strain, fatigue and trauma compounds these circumstances. To their credit, mental health systems have rapidly adapted during the pandemic,³² especially during prolonged lock-down periods and economic uncertainty, but our nation would benefit from a sustained and coordinated response to the challenges we face. Communities offering assistance will need support to guide their energy where it is needed the most. Furthermore, we must develop new and innovative ways to deliver treatment services to disadvantaged populations and others disproportionately affected by COVID-19, who lack health insurance or other private resources. Frontline workers also need to be encouraged to seek help within a preventive self-care framework, or as ongoing therapeutic support for both their mental and physical health needs.

Now more than ever, we need to engage and educate all Americans to ensure that everyone understands that there is no shame in seeking care for mental health and SUDs. We will continue to screen and assess each person to determine their unique health needs, and use the acquired data to target areas of concern and reduce outcome disparities among all populations, especially the most vulnerable. An attempt to stretch existing resources will likely result in a weakened system and poorer long-term outcomes. Service design, accountability and evaluation are critical to using resources wisely. Mental health is public health. As such, our approach should begin with a foundation of prevention, early identification, and early intervention as we proceed through one of the most difficult periods in our history. We are suggesting that a more systemic effort that builds on the actions and recommendations described herein will benefit the desire we all share for a healthy and resilient nation.

³² Pinals DA, Hepburn B, Parks J, Stephenson A. Behavioral Health System Response to the COVID-19 Pandemic: A system response. Psychiatric Services 2020.