Serious Mental Illness and Substance Use Disorders During the Pandemic

National Dialogue on Behavioral Health

BEHAVIORAL HEALTH IN THE 21ST CENTURY: FAST FORWARD AFTER THE PANDEMIC

Kevin Martone, Executive Director
TAC

October 14, 2021

COVID-19 Pandemic Considerations for People with Serious Mental Illness

- Impact of COVID-19 itself – people with SMI contracting the virus
- Social isolation
- Economic impact

Mental Illness and Substance Use During the Pandemic

- June 2020 – 40% of adults reported struggling with mental health or substance use (CDC 2020)
- These findings are generally sustained into February 2021 with an increase in those reporting an unmet mental health need.
- Mental health conditions are disproportionately affecting specific populations, especially young adults, Hispanic persons, black persons, essential workers, unpaid caregivers for adults, and those receiving treatment for preexisting psychiatric conditions.
- Overall, those with a psychiatric disorder reported more frequent mental distress and more recent missed medical visits and medications than did those with no psychiatric disorder. However, participants with serious mental illness did not report a higher rate of suicidal thoughts compared with their pre-pandemic responses.
- Suicidal ideation has increased, yet, suicides declined or stayed the same during the COVID-19 pandemic.
- However, some preliminary data indicates that the number of African-Americans dying by suicide increased.

Mental Health and Substance Use cont.

- Beginning in April 2020, the proportion of children's mental health–related ED visits among all pediatric ED visits increased and remained elevated through October.
- Some data indicates that people with SMI are more likely to contract COVID-19
- Drug overdose deaths rose by close to 30% in the United States in 2020
- 20% increased their substance use since the start of the pandemic
- 34% experienced changes in treatment or recovery support services for SUDs due to the COVID-19 pandemic.
- 14% were unable to access needed services due to COVID-19

Access and Workforce

- Providers are strained and drained. Access to PPE was a major challenge early on.
- Access to care was inequitable prior to pandemic, and became more difficult
- Workforce shortages existed pre-pandemic and were exacerbated during it. Sudden withdrawal of already limited mental health and primary care workforce in rural communities reduced access during COVID-19.
- COVID-19 led to a massive natural experiment in the rapid and widespread implementation of tele-behavioral health care.
- Medication Assisted Treatment for SUDS – regulatory flexibility

Inpatient and Residential Settings

- Individuals with SMI who were living in inpatient and other congregate residential (e.g. nursing homes, group homes, board and care homes) were significantly impacted by COVID-19 (e.g. high infection and mortality rate)
- Individuals in these settings were less likely to transition back to community-based settings. Two reasons include the belief by professionals that they would be safer in the facilities and that the community provider system was too compromised to facilitate transitions.
- About 8% of people who live in US long-term-care facilities have died of COVID-19—nearly 1 in 12. For nursing homes alone, the figure is nearly 1 in 10.
- Grabowski et al cite a range of 65 to 91% of nursing home residents with a significant mental disorder, namely mood disorders, psychotic disorders, anxiety disorders and other mental illness.
- Early in pandemic, many local acute care hospitals converted acute psychiatric units from doubles to single rooms reducing capacity. Concerns about accepting patients exposed to COVID-19, whether symptomatic or not, and access to PPE, have created further challenges to emergency department boarding.

Community-based Services

- Many day treatment and psychosocial rehab programs had to close or dramatically downsize capacity for extended period of time.
- Outreach and mobile-based services like ACT and PSH also had to scale back face to face. Many shifted to virtual, with limited face to face as PPE became available.
- As most employers went remote for periods of time, supported employment was also scaled back.
- Mobile crisis response teams initially scaled back, struggled with workforce and PPE issues.

Telehealth

- Responding to the need to provide socially-distanced services, health systems rapidly shifted to telehealth service
- Temporary legal and regulatory flexibilities were enacted to enable the provision of telehealth services
- A study that analyzed half of all private insurance claims in the United States from February of 2020 to April of 2020 found a 2900% increase in mental health telehealth claims
- Another study that examined a national sample of commercial and Medicare advantage claims from January to June 2020 found that telehealth accounted for 56.8% of total psychiatry visits, 50.8% of social work visits, and 49.1% of psychology visits during this period
- In general, and in rural areas specifically, it offers a more convenient way for people to access many mental health services. In addition to direct service delivery, telehealth may be used to support consultation with other providers, such as primary care providers or less specialized behavioral health care providers, so may be a way of bolstering the capacity of the existing workforce in rural and remote areas.

Telehealth Challenges

- Because many of these changes designed to respond to the pandemic are temporary, mental health systems and providers face a lot of uncertainty and may have to adapt to a new regulatory and policy environment as COVID-19 rates decline
- Whereas there was a general acceptance of telehealth prior to COVID-19, rural communities had a harder time rapidly expanding use due to technology barriers, such as:
  - Lack of access to broadband or limited bandwidth
  - Poor cellular coverage
  - Limitations in individuals' phone plans that limit the number of minutes or amount of data that they can use; and
  - Lack of access to necessary technology
- Will a Congressional infrastructure bill help increase access to broadband and technology?

Opioid Treatment Program Flexibilities During COVID-19

- In March 2020, SAMHSA granted States and OTPs the flexibility to provide patients with more take-home doses than Federal regulations allow.
  - Decreased daily dosing lines and risk of COVID 19 exposure
  - Decreased barrier of daily dosing requirements

- SAMHSA and DEA provided guidance on implementing flexibilities affecting the delivery of medications to patients who were quarantined with COVID-19.

- June 2021, DEA authorizes OTPs to add mobile component to dispense methadone
  - Requires no additional registration by an OTP for a mobile van
  - Increases access for rural communities
  - Provides opportunity to engage hard-to-reach populations
  - Can be used to increase access to MAT for jails/prisons

Increasing Access to Buprenorphine

DEA & SAMHSA worked to ensure authorized practitioners may admit and treat new patients with OUD during the public health emergency. These flexibilities allow for the use of audio-only telehealth encounters for buprenorphine induction without requiring an in-person evaluation or video interface.

State Examples

- Rhode Island created a 24/7 buprenorphine hotline which offers access for people seeking initiation of buprenorphine treatment.
- Pennsylvania lifted requirement for Prior Authorization for Sublocade.
- Other states such as Virginia, Massachusetts and California extended the length of prescriptions and authorize automatic re-fills for medications.
- States such as West Virginia suspended their detailed requirements that people participate in counseling as a condition of receiving MAT.

State Strategies for Supporting SUD Providers – Strategies for Reducing Barriers to Care for People with SUD

- States can adopt regulatory and policy strategies to reduce barriers to treatment for people with SUD
  - Allowing **initiation of buprenorphine** without an in-person visit
  - Promoting alternative dispensing of **methadone**
  - Eliminating or suspending **counseling requirements** for **MAT**
  - Using long-standing options to **eliminate prior authorization** and other barriers to treatment for MAT
  - Using Medicaid to support **virtual counseling and peer support** through telehealth and telephone

Homeless System Response

- Delta variant may be resulting in sustained impact to homeless population, especially where vaccination rates are low.
- Closed shelters and/or established shelters for people with COVID vs some without COVID
- Hotels enabled a non-congregate approach to get people off street and out of congregate shelters
- Service availability has been a challenge and mixed
- Significant federal housing assistance resources are and will benefit people with MI and SUDS, but there is a housing supply/vacancy problem

Considerations for the Future

- COVID is here and we need an epidemic approach
- Encourage people with MI/SUDs to get vaccinated; especially important due to co-occurring chronic health conditions
- Telehealth
- Alternatives to site-based services
- Consider urban/suburban/rural service delivery
- Continue to think about congregate residential settings toward more integrated approaches.
- Workforce – planning re: first responders/frontline. Case to ensure treated as such, access to PPE, etc.

Takeaway Points

- At the time of this paper, much information is anecdotal.
- Emergence of Delta variant is prolonging affects of pandemic in communities, especially in states with low vaccination rates/low use of masks.
- Sudden withdrawal of already limited mental health and primary care workforce in communities reduced access during COVID-19, especially face to face.
- COVID-19 led to a massive natural experiment in the rapid and widespread implementation of tele-behavioral health care.
- Whereas there was a general acceptance of telehealth prior to COVID-19, rural communities had a harder time rapidly expanding use due to technology barriers

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