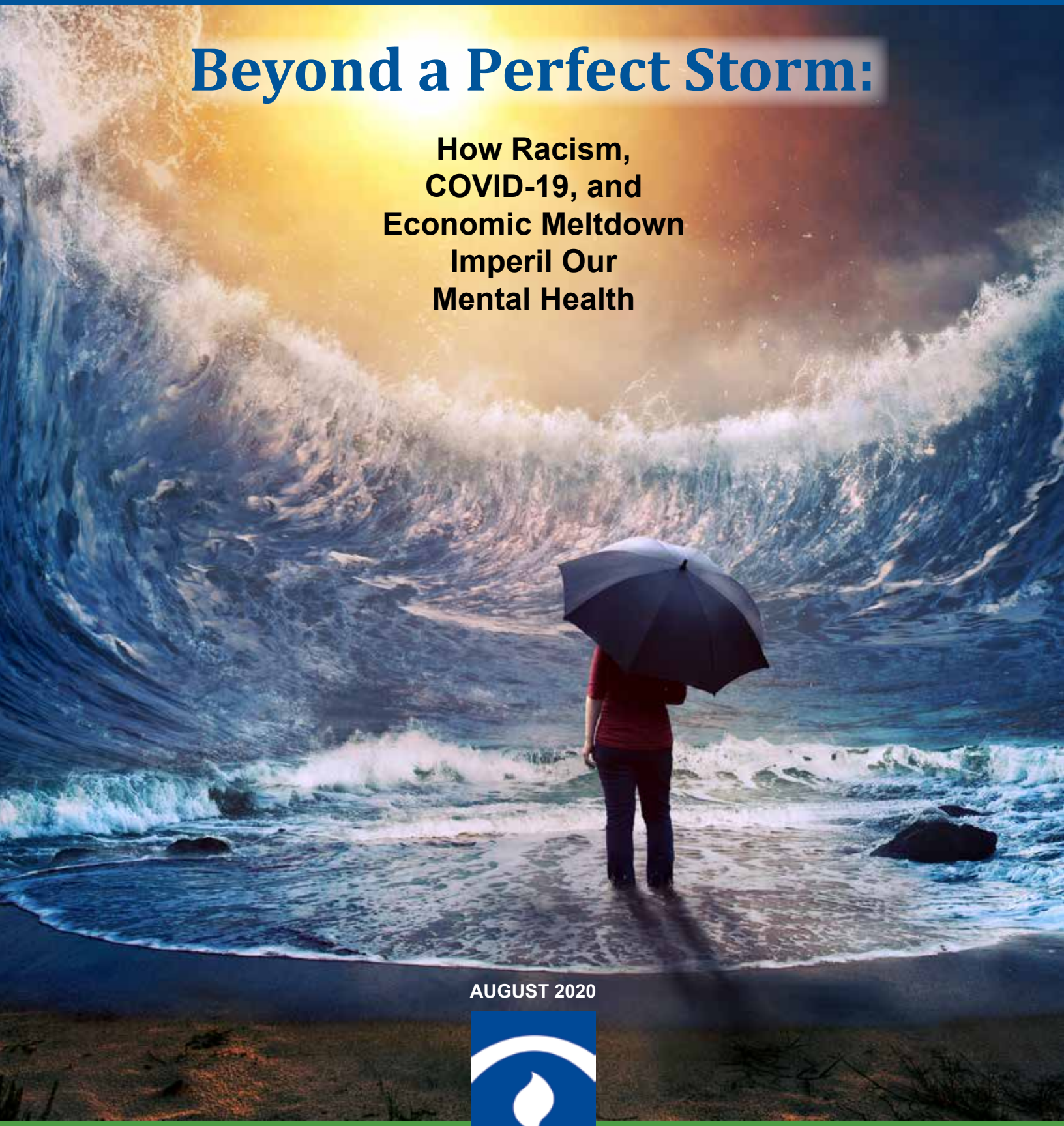
Beyond a Perfect Storm:

How Racism, COVID-19, and Economic Meltdown Imperil Our Mental Health



AUGUST 2020

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AMERICAN MENTAL HEALTH COUNSELORS ASSOCIATION

Beyond a Perfect Storm:

How Racism, COVID-19, and Economic Meltdown Imperil Our Mental Health

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Acknowledgments

The authors of the this report
recognize the following people
for their contributions to this American Mental Health
Counselors Association (AMHCA) report:

Tabular Data Analysis:
Rebecca Woodson
Director of the Office of Credentialing and Continuing Education
American Mental Health Counselors Association

Proofreader:
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1 Executive Summary

The long historical storm of racism and oppression in the United States has converged with the current storm of health care and economic crises brought about by the COVID-19 pandemic. These cataclysmic events have caused significant increases in mental health and substance related disorders in the United States in 2020. We are now witnessing a tsunami of mental health needs that will create massive suffering if not addressed on a widespread scale.

The confluence of these events has created a "perfect storm" that demands policy changes for the mental health system and well-being of all people. This has been especially true for those who identify as Black Americans.

Systemic racism: Systemic racism persists in our schools, offices, court system, police departments, and health care system. Racism and discrimination have adversely affected health outcomes particularly for Blacks and other people of color. They experience health disparities and they are at higher risk for chronic illness, including mental health disorders such as depression and anxiety.

COVID-19 health crisis: All Americans have been facing a major health crisis due to the coronavirus pandemic over the last several months. In addition, Americans are reporting high levels of emotional distress from the COVID-19 pandemic—levels that the authors of this report believe will lead to a national mental health crisis, if Congress and the states do not take action. Although, our U.S. society is in a shared state of traumatic distress, new data about COVID-19 has revealed an alarming trend: Black families face a much higher risk of contracting and dying from the virus. Residents of majority-Black counties have three times the rate of infection and almost six times the rate of death as residents of majority-white counties.

Economic meltdown: Economic downturns are usually associated with higher rates of depression and anxiety disorders as well as increased suicides. The financial strain resulting from income loss and unemployment has already been identified as a major driver of adverse mental health outcomes including depressive disorders, anxiety disorders, addiction disorders, and suicide. Extensive evidence supports the link between unemployment and devalued well-being.

Blacks and other racial groups have higher unemployment during good economic times and are even more disproportionately unemployed during recessions and downturns.

The COVID-19 pandemic and resulting economic downturn have negatively affected many people's mental health. They have also created new barriers for people already suffering from mental illness and substance use disorders.

Respondent Characteristics and Prevalence of Adverse Mental Health Outcomes, Increased Substance Use to Cope With Stress or Emotions Related to COVID-19 Pandemic, and Suicidal Ideation—United States, June 24–30, 2020

Characteristics	All respondents who completed surveys during June 24–30, 2020 weighted* no. (%)	WEIGHTED %* CONDITIONS: Anxiety disorders†	Depressive disorders†	Anxiety or Depressive disorders†	COVID-19–related TSRD (trauma- & stressor-related disorders)§	Started or increased substance use to cope with pandemic-related stress or emotions¶	Seriously considered suicide in past 30 days	1 or more adverse mental or behavioral health symptom
All respondents	5,470 (100)	25.5	24.3	30.9	26.3	13.3	10.7	40.9

To see a breakdown of the data by characteristics such as age, gender, race, education, etc., see the full Table 1 on page 24.

Due to the confluence of these three storms, **the American Mental Health Counselors Association (AMHCA) projects that more than 103 million adults in the United States—about 4 in 10—will experience a negative mental health or behavioral health condition, and/or will develop a co-occurring substance use disorder in 2020. AMHCA also estimates that 8 million to 24 million children ages 5–17 will suffer from a mental health condition this year.**

AMHCA's estimates are based on the reports of the National Center for Health Statistics and the U.S. Census Bureau, as well as other historical projections of the impact that disasters have had on mental health. See abbreviated versions of the three tables that support AMHCA's estimates, beginning with Table 1 above.

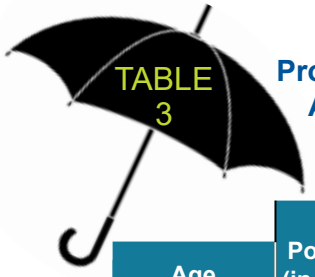
Based on these findings, it is estimated that 41 percent Americans are experiencing a mental illness such as generalized anxiety disorder or a major depressive disorder. Compared to a similar period in 2019, only 8.2 percent of adults aged 18 and over had symptoms of anxiety disorder and 6.6 percent had symptoms of a depressive disorder. College students and workers between the ages of 18 and 29 are experiencing the most prevalent indications.

Indicators of Anxiety or Depression Based on Reported Frequency of Symptoms During Last 7 Days

(Table 2 compares April 23–May 5 with July 16–21)

Week Label Group	Symptoms of Anxiety Disorder or Depressive Disorder: April 23–May 5 Percent	April 23–May 5 95% CI	July 16–July 21 Percent	July 16–July 21 95% CI
National Estimate: United States	35.9	35.0–36.8	40.9	40.1–41.8

For a breakdown of the data by characteristics such as age, gender, race, education, etc., see the full Table 2 on page 25.



Projected Number of Americans With a Mental Health Condition in 2020

Age	Population (in millions)	Number of Mental Health Disorders (in millions)
5–9	24.0	9.8*
10–17	32.9	13.5*
18–29	53.4	28.3
30–39	44.4	20.9
40–49	40.5	17.8
50–59	42.8	17.1
60–69	37.4	11.9
70–79	22.7	5.4
80+	12.9	2.2
Adults	**254.1**	**103.6**
TOTAL	**311.0**	**126.9**

The table includes the latest data for July 16–21. See the full Table 3 on page 26.

Nearly 40 percent (39.1) of Americans in this age bracket have reported symptoms correlated with diagnoses of generalized anxiety and major depressive disorders.

Compared to all racial groups, Black Americans are experiencing the worst effects of the overall crisis, exacerbated by the police killing of George Floyd on May 25, 2020 and other incidents of police violence. Nearly 35 percent of Blacks are screening positive for anxiety and/or depression. Hispanics are experiencing similarly frightening numbers. Asian-Americans have seen marked increases in their mental health. Just 3 percent of Asian-Americans had screened positive for depression in 2019; now that rate is 22 percent, and 28 percent are experiencing anxiety disorders, up from 4 percent in 2019.

We need to act to take the following actions:

- Promote health equity by adequately addressing racism, bias, discrimination, and other systemic barriers within the health care system.
- Support the development of a robust, diverse, and culturally competent health care workforce by facilitating diversity throughout the health care system and by adequately training all staff to be culturally sensitive.
- Ensure federal and state mental health parity laws are enforced.
- Expand mental health accessibility through telemental health and make temporary crisis-enacted accessibility policies permanent.
- Integrate our nation's mental health care system, including substance use disorder services and medical health care so that health delivery services focus on the "whole person."
- Deliver health and mental health insurance coverage for millions of Americans through comprehensive Medicaid expansion.
- Promote access to licensed mental health therapists by encouraging federal and state agencies to provide up-to-date information to the public about therapists and mental health resources.
- Increase the public's access to licensed mental health care providers, including Clinical Mental Health Counselors, through Medicare reimbursement for older adults and disabled individuals—legislation that has been stalled in Congress for more than 20 years.

Representatives in our states and in Congress must take these actions now to prevent the devastation that will follow in the wake of this mental health tsunami.

2
Beyond a Perfect Storm:
The Wave of Institutional Racism and Discrimination

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The Wave of Institutional Racism and Discrimination

Since 1619 and the first introduction of slavery into Virginia, racist policies and practices were intended to subjugate Black Americans and afford dominance to white people. Many experts assert that these policies led to the systemic barriers that created racial injustice and bigotry. Each period of racial progress has been followed by a backlash of racist policies and practices.

For example, the racial progress that bloomed in the immediate aftermath of the abolition of slavery and the Civil War were followed by racial segregation enforced by laws and regulations, white mob violence, and lynchings. The civil rights movement and legislation were succeeded by tax cuts—primarily benefiting the wealthy—federal assistance programs, and the initiation of mass incarceration.

Some of the hope for increased egalitarianism raised by the 2008 election of the first Black president has been followed by a sharp setback. Since the 2016 election, regulations and policies that enforce fair housing, reduce inequities in the criminal justice system, and protect consumers from racial targeting by predatory lenders have all been curtailed.

The Affordable Care Act (ACA) helped ensure health coverage for millions of Americans. Passed in 2010, the ACA created new health coverage options that provided an opportunity to narrow long-standing racial and ethnic disparities in health coverage. The failure of several states to implement Medicaid Expansion under the Affordable Care Act continues to increase inequities in health care, including mental health care, and health insurance. This history of discriminatory policies and institutional practices has created deep inequities across social and economic domains.

The police killing of George Floyd has catalyzed awareness of the 400-year-long history of systemic racism and oppression in the United States, which has converged with an existing storm of health and economic crises brought about by the COVID-19 pandemic. The confluence of events has created a "perfect storm" for the mental health and well-being of all people, especially those who identify as Black Americans. In fact, the "perfect storm" evokes the consciousness of historical trauma, racial trauma, and the cognizance of the Post Traumatic Slave Syndrome linked to the mental health of Black Americans.

The resulting tidal wave of mental health concerns requires a comprehensive and integrated policy response. Intentional and culturally responsive changes to policy and practices have become crucial in order to reduce the negative impacts of racial trauma, discrimination, and oppression while promoting short and long-term mental health and well-being.

The American Mental Health Counselors Association foresees a more equitable future in which the policies, programs, and institutional practices that produced inequitable outcomes are corrected and the effects are reversed. Achieving that vision requires closing five cavernous equity gaps that Black Americans face:

- health care disparities
- wealth inequalities
- inequities in public school quality
- employment and earnings imbalances
- punitive policing

These gaps are wide and deeply entrenched in U.S. society today, and are a direct result of structural racism—the historical and contemporary policies, practices, and norms of white privilege.

RACIAL UNFAIRNESS IN THE U.S. CRIMINAL JUSTICE SYSTEM PERSISTS

The ongoing examples of police shootings of citizens, along with recent shootings of police in the line of duty, raise the question, "How can we stop the bloodshed?"

Answering that question must begin by acknowledging the systemic racism in many police departments and the culture of brutality and tolerance of brutality embedded among a great number of police officers. We must also address the militarization of police departments, because the combat-style equipment designed for battlefields and heedlessly deployed in American streets reinforces the culture of unconscionable violence against Black citizens and of a siege mentality in our communities.

The pervasiveness and frequency of police killings of Black Americans is also a public health crisis. The racial disparity in the victims of police violence is stark. In Minneapolis, where George Floyd was horrifically killed by law enforcement, police officers use force against Blacks seven times more often than against whites. Studies show that Black Americans are up to 3.5 times more likely than whites to be killed by law enforcement; one in every 1,000 Black men will die at the hands of police [1].

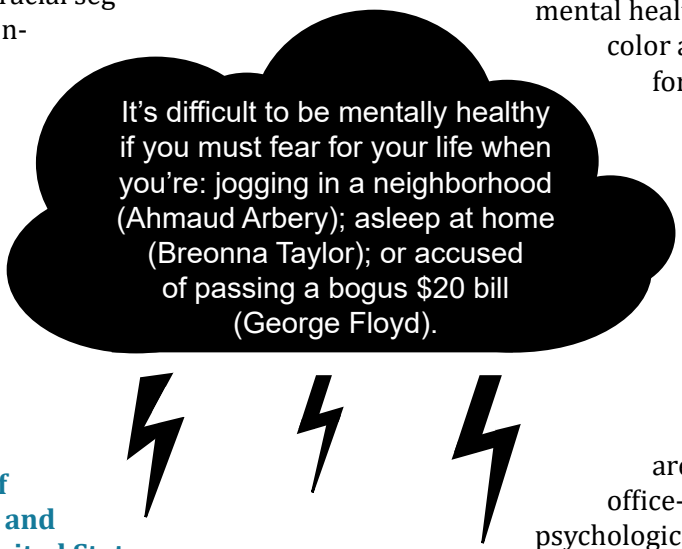
In addition, completely unwarranted confrontations between law enforcement and Black Americans creates a climate of fear for each person when pulled over by a police officer. There is no question that Black and Brown American citizens are disproportionately singled out for police stops, investigations, and harassment with little or no accountability by police departments. Blacks, and all of those whose lives have been marginalized by those in power, experience life differently from those whose lives have not been devalued. They experience overt and subtle racism and bigotry, and as a result, they experience a higher degree of fear. A recent study by American University found that more than half of all African Americans surveyed fear interactions with police [2].

INSTITUTIONAL RACISM AFFECTS PHYSICAL HEALTH

Institutional racism impacts health care accessibility within Black communities by creating health disparities. Racism correlates with disproportionate rates of diseases among Black communities. For example, the federal government responded slowly to the

AIDS epidemic in Black communities. And, even when the federal government has responded to health concerns in Black communities, it has been insensitive to ethnic diversity in preventive medicine, community health maintenance, and AIDS treatment services [3].

Institutional racism has directly affected health-related policies as well as indirectly through other factors. For example, underprivileged Blacks are more likely to be uninsured. This significantly impedes them from accessing preventive, diagnostic, or therapeutic health services. Also, racial segregation disproportionately subjects Black communities to crowding, litter, noise, chemical substances such as lead paint, and respiratory irritants such as diesel fumes.



The **enforcement of environmental laws and regulations in the United States has exposed Blacks to greater health and environmental risks** than the general population.

The fact that Blacks in the United States are exposed to greater health and environmental risks than the general population is not surprising since research shows that racial discrimination exists in the enforcement of environmental laws and regulations. Blacks are more likely to live, work, and play in America's most polluted environments and they tend to be disproportionately exposed to lead, pesticides, and petrochemical plants.

Unfortunately, race and class is a reliable indicator of where industrial plants and waste facilities are located. Institutional environmental racism encompasses these land-use decisions, which contribute to health issues such as asthma, obesity, and diabetes [4]. The pervasive impact of racism must be changed in health reform efforts.

BLACK AMERICANS BEAR A DISPROPORTIONATE MENTAL HEALTH BURDEN

Racism and discrimination are stressful events that can adversely affect physical health and mental health, placing people of color at risk for mental health disorders such as depression and anxiety.

Blacks have higher rates of severe depression and yet lower rates of treatment compared to white populations. Blacks are less likely to receive office-based counseling for psychological stressors and are more likely to be seen in emergency rooms. Blacks endure more intense and frequent mental and behavioral health issues than other Americans. This is in a large part related to poverty and exposure to racism and discrimination, both of which disproportionally affect people of color.

Among Black Americans who have at least one everyday discrimination experience there is a greater likelihood of meeting criteria for at least one lifetime anxiety disorder, or a lifetime depressive or mood disorder [5].

Furthermore, Black Americans shoulder a complex and more profound mental health burden than others. It's difficult to be mentally healthy if you must fear for your life when you're: jogging in a neighborhood (Ahmaud Arbery), asleep at

home (Breonna Taylor), or accused of passing a bogus $20 bill (George Floyd).

The landmark 2001 Surgeon General's report, Mental Health: Culture, Race, and Ethnicity, underscored significant disparities in the initiation of and engagement in mental health care among people from racial and ethnic groups. Now, almost 20 years later, these disparities persist, with higher rates of death because of less access to high-quality mental health care, including use of evidence-based medications and mental health therapies [6].

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), only one-third of Blacks who need mental health care services receive it [7]. Many factors account for the lower treatment rates, including a lack of culturally informed treatment options, absence of a diverse mental health workforce, racism, mistrust of health care systems (possibly stemming from the Tuskegee Experiment, which the U.S. Public Health Service conducted from 1932–1972), variance in the quality of mental health treatment offered, and lack of attention to the social determinants of health.

Discrimination in its multiple forms (e.g., discrimination based on color or race) **is a principal social determinant of mental health.** This correlates with to other determinants, including socioeconomic status and gender.

We need to address the severity of the problem among adults and children from racial and ethnic groups. We also must consider cultural issues related to higher attrition rates from mental health care and structural challenges associated with the limitations of access to care.

Moreover, we need to explore strategies for dismantling structural racism. This approach must incorporate criminal justice reform as well as true health reform—which would include public health interventions focused on Black American health crises, such as neighborhood violence.

THE IMPACT OF POLICE KILLINGS ON THE MENTAL HEALTH OF BLACK AMERICANS

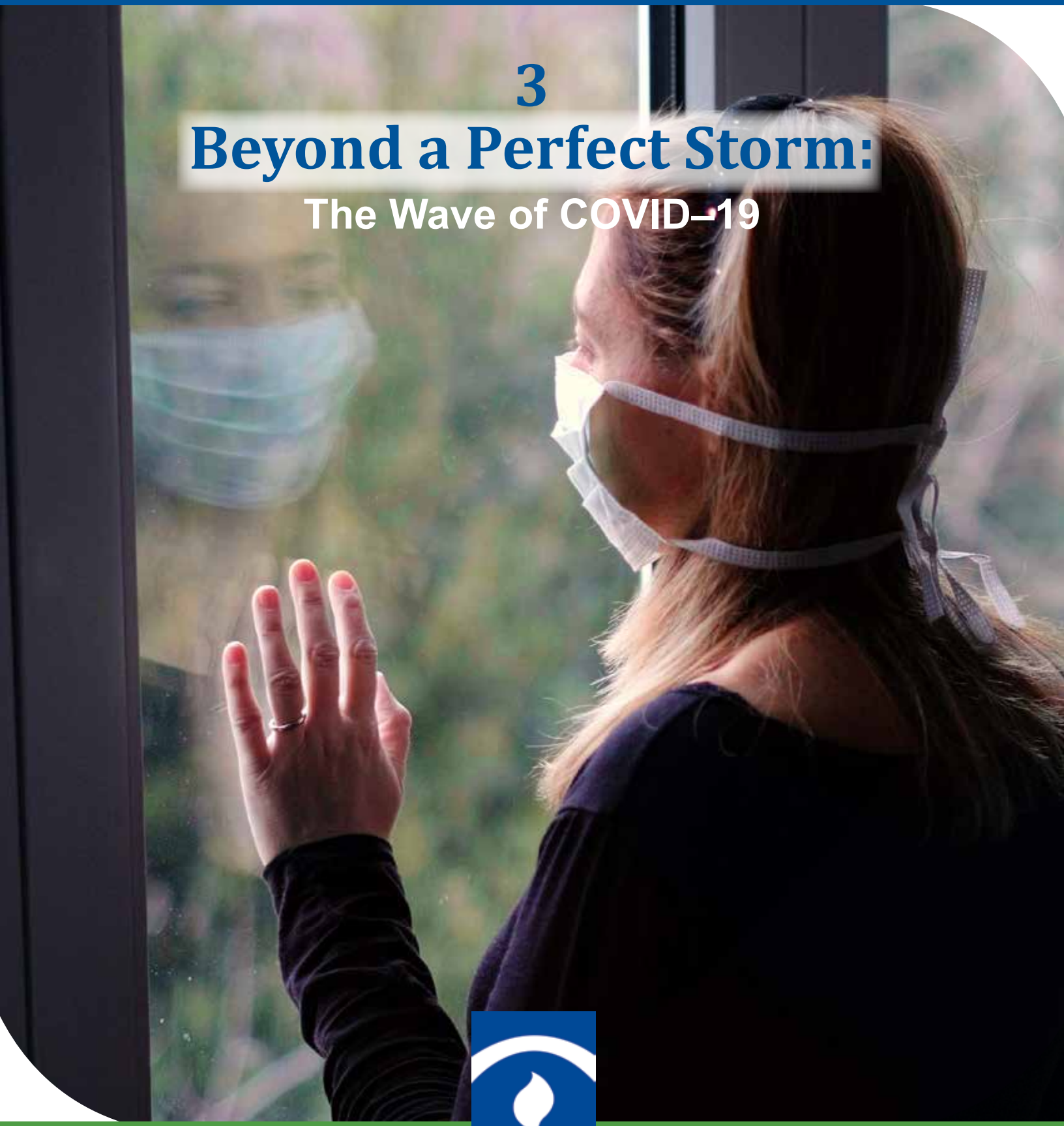
Black Americans are three times more likely to be killed by police than white Americans, and five times more likely to be killed unarmed.

In 2018, Dr. Jacob Bor and colleagues conducted a nationally representative study to measure the impact of these police shootings on the mental health of Black Americans. Bor and his team analyzed data from two sources: The Behavioral Risk Factor Surveillance System (BRFSS), a large, population-based survey conducted by the Centers for Disease Control. They also used data from the Mapping Police Violence research collaborative, which has collected and compiled the date and location of police killings since 2013 [8].

On average, Black Americans are exposed to four police killings of other unarmed Black Americans in the same state each year. Police killings affected mental health the most within the initial two months of the incident. The authors estimate that these killings cause an additional 1.7 poor mental health days per person every year. This equates to an additional 55 million poor mental health days per year in the general Black population.

The impact of mental health for Black Americans will vary between individuals within each state (from people who experienced a close exposure and were impacted directly to others who may not have heard of the event). The effects were estimated at a population-level [9].

Historical pain and trauma is something Blacks are all too familiar with, from the evils of the Middle Passage, to the tortures of slavery, lynching, medical experiments, and forced sterilizations. The recent videotapes of widespread police brutality are the most recent display of public lynching. Overt bigotry and microaggressions have a negative impact on mental health and increase the risk for a range of mental health conditions, such as anxiety, post-traumatic stress disorder, depression, and physical health conditions.



3
Beyond a Perfect Storm:
The Wave of COVID–19

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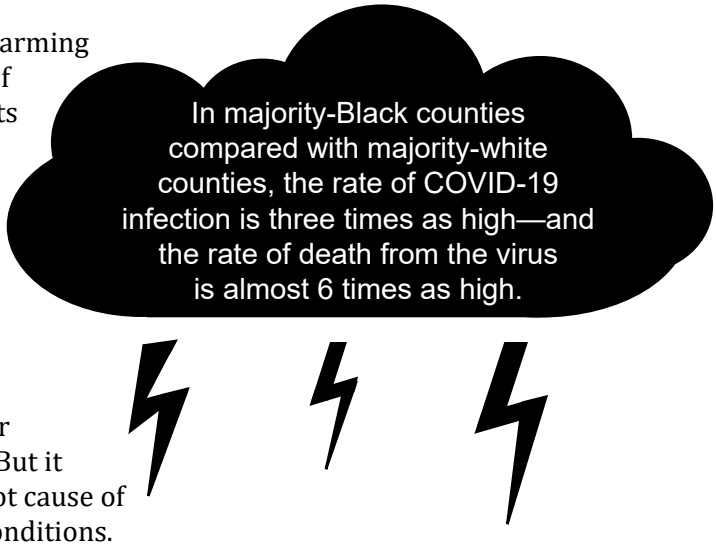
In direct response to the COVID-19 pandemic in early spring 2020, states and locales implemented physical distancing measures. These and other measures became increasingly comprehensive and prescriptive as COVID-19 infections continued to rise in April and May, and threatened to overwhelm health care systems.

New data about COVID-19 has revealed an alarming trend: Black families face a much higher risk of contracting and dying from the virus. Residents of majority-Black counties have three times the rate of infection and almost six times the rate of deaths as residents of majority-white counties [10].



Public officials have pointed out the underlying health issues that disproportionately affect Black Americans, such as diabetes and hypertension, as contributors to the larger impact of COVID-19 on the Black community. But it is important to go further and examine the root cause of these racial disparities in underlying health conditions.

Research has shown that differences in access to high-quality education, health care services, community resources, and jobs (and the economic stability that high-quality jobs lead to) contribute to racial inequities in health. Structural racism—the policies, programs, and institutional practices that favor white families while creating barriers to the well-being of Black families—results in unequal access to resources that promote health and opportunity. Structural racism drives the racial health inequities which have been laid bare by COVID-19 [11].

COVID-19 has given us even more clarity about our society's racial inequities. Now that our eyes are wide open, it is time to take steps to eliminate the structural racism that has produced these stark disparities.

THE CORONAVIRUS HAS TAKEN A TOLL ON MENTAL HEALTH

All Americans have been facing a major health crisis due to the coronavirus pandemic. The closed businesses and stay-at-home strategies embraced as a means of controlling the pandemic have led to an immediate recession and unprecedented economic turmoil—at a level we have not seen since the Great Depression of the 1930s. Yet the rate of confirmed new cases continues to grow. We now have a mental health tsunami that will create massive suffering if not addressed on a widespread scale.

In just a matter of weeks after the initial stay-at-home orders by states, an alarming 55 percent of adults interviewed said that the coronavirus has affected their mental health. It's hard to imagine dealing with something as unknown as coronavirus and not being distressed. However, as the coronavirus continues to spread and states begin to allow businesses to re-open, the multitude of stress-

ors many people face daily may be like pouring gasoline on top of an existing wildfire [12].

While the national conversation has rightly focused on the importance of physical distancing to stop the spread of coronavirus, 71 percent of those surveyed are worried this isolation will have a negative impact on Americans' mental health. Data support that worry. Another survey showed that we are anxious not just about getting sick ourselves with coronavirus, but also about our loved ones getting COVID-19, the disease caused by the coronavirus [13].

Americans are reporting high levels of emotional distress from the COVID-19 pandemic—levels that some experts warn may lead to a national mental health crisis. U.S. society is in a collective state of traumatic distress.

Unlike PTSD (post-traumatic stress disorder) which surfaces after a trauma has ended, the country is only starting to grapple with the continuing psychological fallout from this ongoing pandemic.

Surveys show that Americans' outbreak-related worries have led to one or more negative mental health effects. These include, among other health problems, trouble eating or sleeping, a tendency to drink more alcohol, the misuse of other substances or medications, frequent headaches or stomachaches, and shorter tempers. Among frontline health care workers and their families, 64 percent report deteriorated mental health, as did 65 percent of those who had lost income [14].

Another recent study, from the Well Being Trust, found that the pandemic could lead to 75,000 additional "deaths of despair" from drug and alcohol misuse and from suicide due to unemployment, social isolation, and fears about the virus. A recent poll of 3,100 WebMD readers found that 26 percent said they felt a sense of trauma from COVID-19 [15, 16].

Many crisis centers are reporting 30 percent to 40 percent increases in the number of people seeking help. Many who are calling helplines sound panicked, and more callers are expressing fear—fear of catching the virus, fear of the future, fear of the unknown, and fear of not knowing how to cope with their feelings. And now mental health call-in centers are seeing more texts and emails about people who are fearful of their isolation and depression [17].

THE IMPACT OF THE CORONAVIRUS WILL BE FAR-REACHING

The mental health crisis we are experiencing will worsen over the next few years due to the lingering effects of the coronavirus, including:

- Wage earners who are not going to be hired back
- Health-compromised individuals who have a pre-existing condition
- Social drinkers who are now consuming more and more alcohol
- Parents of school-age children and disabled children who worry and agonize about their future

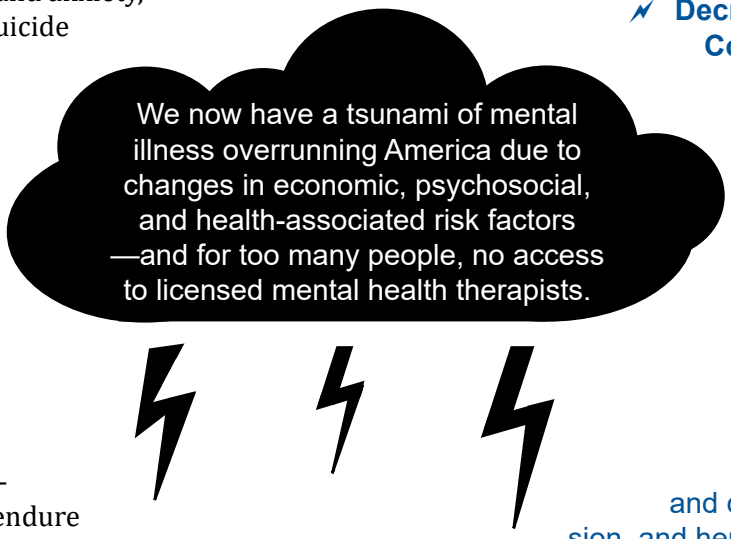
- Uninsured Americans who will develop chronic anxiety and depression

Far too many people for whom the pandemic increases their susceptibility to drugs and alcohol, depression and anxiety, and self-harm and suicide will have no access to licensed mental health therapists.

Moreover, because the United States was not sufficiently prepared for COVID-19, individuals will suffer needlessly. Families will endure hardships and divorces. The shock waves will be felt in communities across the nation, and everyone will feel the devastating forces of chronic traumatic distress.

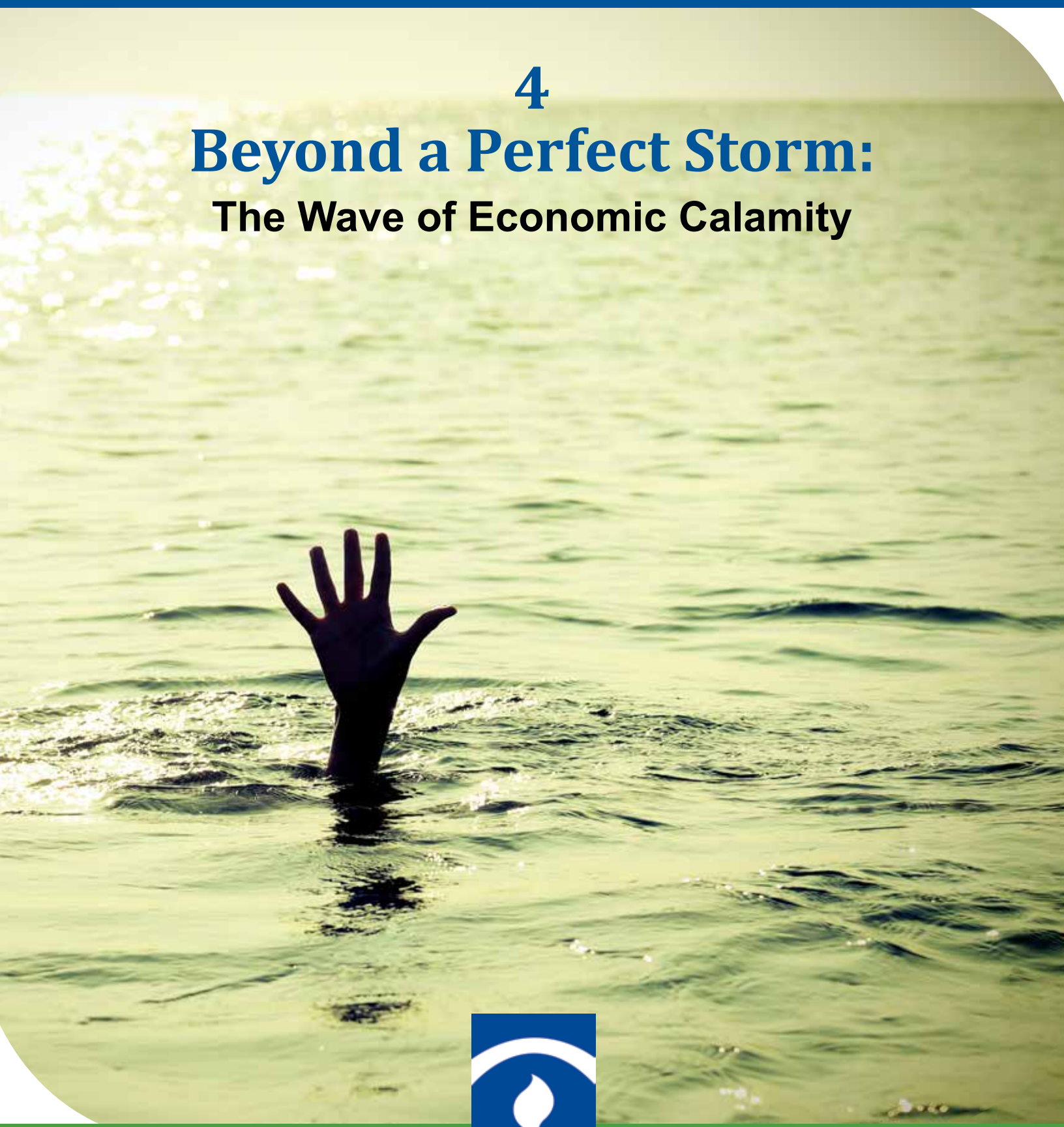
We all know the shattering impact that PTSD has on individuals and families. Like PTSD, chronic distress has lasting effects. Worries turn into anxiety and depression. Healthy individuals begin to question who they are. Diagnosable mental health disorders often multiply. Suicide, self-harm, interpersonal partner violence, addiction, and assaults surge. For example, law enforcement agencies are responding to escalating numbers of violent incidents.

We now have a tsunami of mental illness overrunning America due to changes in a variety of economic, psychosocial, and health-associated risk factors:



- **Social Isolation:** Increased social isolation and loneliness will increase the number of Americans with a mental illness, alcohol and drug use, and suicides.
- **Decreased Access to Community and Religious Support:** The effects of closing churches and community centers will further contribute to social isolation, anxiety, alcohol and drug use, depression, and hence suicide.
- **Barriers to Mental Health Treatment:** Health care facilities are adding COVID-19 screening questions at entry points and these actions will create barriers to mental health treatment (e.g., canceled appointments).
- **Illness and Medical Problems:** Exacerbated physical health problems will increase the risk of medical and mental health disorders for countless patients, especially among older adults.
- **Economic Stress:** Economic downturns are associated with higher rates of mental illness and suicide compared with periods of relative prosperity.

4
Beyond a Perfect Storm:
The Wave of Economic Calamity



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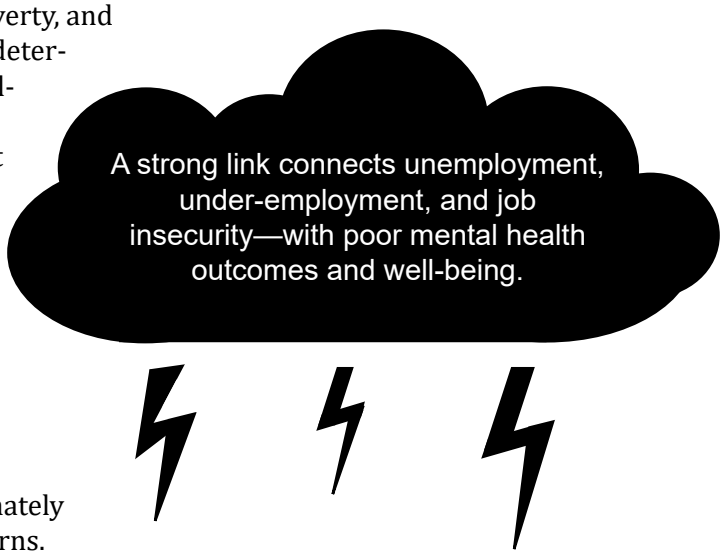
The unemployment rate in the United States in May 2020 was at 16 percent due to the shutdown of wide swaths of the economy in response to the coronavirus pandemic. But the unemployment rate could actually be as high as 20 percent, based on other economic models. The combinations of canceled public events, closed businesses, and stay-at-home strategies have led to an economic recession [18].

Sustained economic stress will increase mental health conditions. As expected, the financial strain resulting from income loss and unemployment has already been identified as a major driver of adverse mental health outcomes. Furthermore, loss of employment can lead to loss of employer-based health insurance benefits, which limits people's access to care and the ability to afford it, especially for people with existing mental illnesses. New studies also show a connection between increased alcohol consumption and unemployment and under-employment.

Additional studies consistently find that unemployment has a profound impact on Black Americans and other racial groups in the form of poorer mental health [19]. Moreover, long-term economic factors—including inequality, poverty, and neighborhood deprivation—are key social determinants of mental health. Economic inequality and poverty have been increasing in the United States for several decades as a direct result of many governmental policies and programs [20].



Extensive evidence supports the link between unemployment, under-employment, and job insecurity with poor mental health outcomes and well-being. Historically, Blacks and other racial groups have higher unemployment during good economic times and are disproportionately unemployed during recessions and downturns.

From mid-March through mid-May 2020, unemployment claims jumped to a shocking 40 million. Should unemployment continue towards 20 percent, as some forecasts indicate, additional tens of millions of Americans could be out of work [21].

Studies show historical and structural injustices in the labor market. The ability to work remotely also differs starkly by race and ethnicity. Those who cannot work remotely include a disparate number of Blacks and Hispanic/Latino Americans with whites twice as likely to be able to telework than are other racial groups [22]. The upshot is that unemployment due to physical distancing, in addition to being vast in scope, will likely exacerbate existing inequities.

The resulting loss of income will most affect those Americans least able to afford it. Data from the Federal Reserve highlights that 10 percent of U.S. adults already struggle with monthly bills [23], and if faced with an unexpected bill of just $400, nearly 3 in 10 Americans would need to borrow or sell something to pay for the expense (not including use of credit cards) [24].

Black Americans face endless inequities. Studies have repeatedly shown that Blacks are more likely to face discrimination in the workplace and in having loan applications not approved, making it harder to get ahead. Median weekly pay for Black men is only 75 percent the $1,096 that white men earn, according to the latest Labor Department data. Even among workers with similar resumes, studies have found that Black workers are far less likely to get called for an interview if a hiring manager can tell the applicant is Black [25].

Racial prejudices play out in a number of ways in U.S. society. Only 44 percent of Black households own their own homes compared with nearly 74 percent of whites. The Black homeownership rate is little changed from the late 1960s, while whites have made steady gains over time [26].

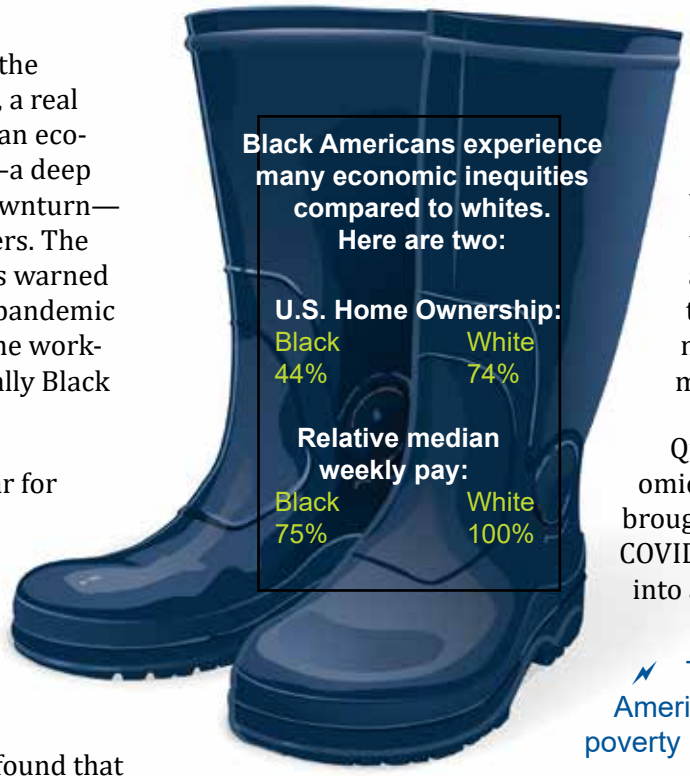
Many welcomed the news that middle-class income had hit an all-time high in 2018, but that was not true for Black Americans. They are still earning less than they did in 2000, according to inflation-adjusted figures from the Census Bureau.

Even if the rest of the economy rebounds, a real potential exists for an economic depression—a deep and long-lasting downturn—among Black workers. The Federal Reserve has warned that the COVID-19 pandemic is hitting low-income workers hardest, especially Black women [27].

The story is similar for Black businesses. An analysis of Labor Department data from the University of California at Santa Cruz (UCSC) found that more than 40 percent of Black small businesses and self-employed workers have been forced to shutter during the pandemic—well over twice the rate of other businesses. Many could close permanently.

It should not be surprising then, that most Black workers report that they have lost income since the COVID-19 crisis began. According to the Census Bureau, more than one in five Black families now report they often or sometimes do not have enough food—more than three times the rate for other families. Black families are almost four times as likely to report they missed a mortgage payment during the crisis, which does not bode well for already low Black homeownership rates. With far less savings or wealth to draw on, Blacks are especially vulnerable to the downturn [28].

On top of significant job losses is the compounding effect of school closures. School systems provide significant social support, particularly for single-parent households. Black households are now facing the double burden of job insecurity and lack of childcare options [29].

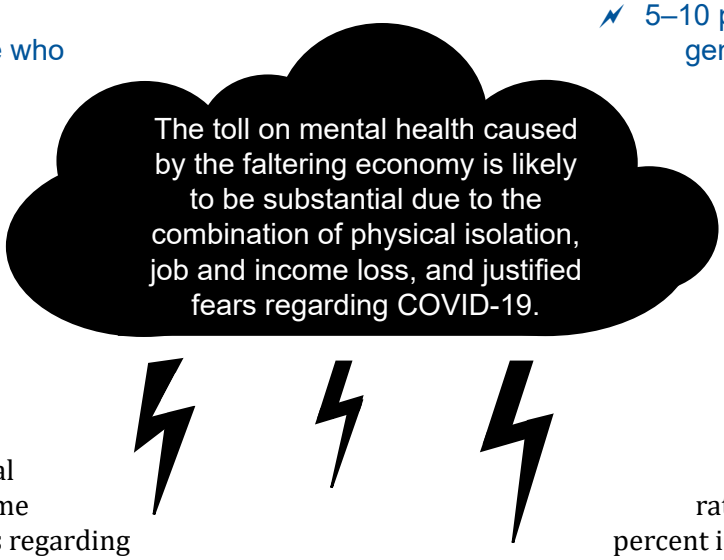


Young workers also bear a significant burden in times of economic downturns, both in terms of higher unemployment rates and lower salaries. This tends to fall the most on new entrants to the job market.

Quantifying the economic damage that has been brought about as a result of COVID-19 will require taking into account:

- The 38.1 million Americans already in poverty

- The 4 million college graduates in 2019–2020;
- The 42 million Americans who filed for unemployment since mid-March; and
- The many more who may lose their jobs this year [30].



The toll on mental health caused by the faltering economy is also likely to be substantial. This is due to the combination of physical isolation, job and income loss, and justified fears regarding COVID-19.

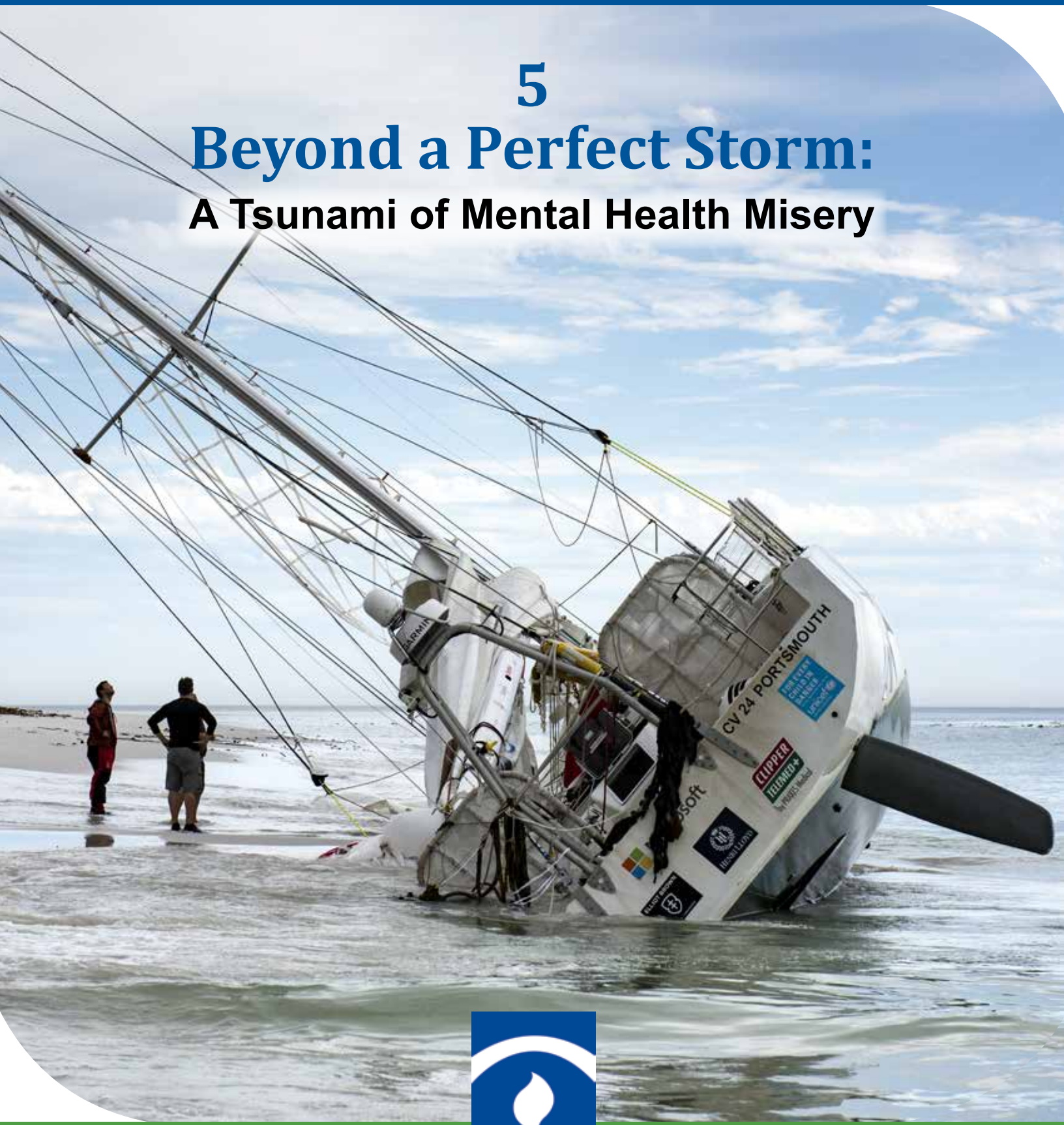
Economic recession is a traumatic event, particularly when combined with pandemic and physical distancing measures. Following other natural or human-made disasters, the prevalence of PTSD has been reported as:

- 30–40 percent among those immediately affected,
- 10–20 percent among rescue workers, and
- 5–10 percent in the general public.

Following the September 11 terrorist attacks, almost 10 percent of New Yorkers increased their smoking rates, and nearly 25 percent increased their alcohol intake [31].

The health problems associated with job loss, declining income, and the broad impact on mental health and physical isolation give us a sense of what is ahead. These traumatic circumstances will create a tidal wave of demands for mental health services which are already inadequate because of antiquated federal, as well as state laws and policies.

5
Beyond a Perfect Storm:
A Tsunami of Mental Health Misery



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5 A Tsunami of Mental Health Misery

Even before the pandemic reared its ugly head in the United States in the spring of 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that nearly 48 million American adults ages 18 to 64 experienced a mental health condition in 2018 [32]. Another 9 million to 10 million Americans over the age of 65 were living with a mental illness [33], and 8 million children (under the age of 18) had a diagnosable serious emotional disorder [34].

Due to the convergence of the three major forces discussed in the previous sections of this report—systemic racism, COVID-19, and economic calamity—a tsunami of mental health conditions has swamped millions more Americans. The recent statistics on suffering are staggering: "Overall, 40.9 percent of 5,470 respondents who completed surveys during June reported an adverse mental or behavioral health condition," the Centers for Disease Control and Prevention says in its *Morbidity and Mortality Weekly Report (MMWR)* for June 24–30, 2020 [35]. These include respondents who:

- Reported symptoms of anxiety disorder or depressive disorder (30.9%),
- Had trauma- and stressor-related disorder (TSRD) symptoms related to COVID-19 (26.3%),
- Reported having started or increased substance use to cope with stress or emotions related to COVID-19 (13.3%), and
- Reported having seriously considered suicide in the preceding 30 days (10.7%) (see Table 1 on the following page).

The *MMWR* goes on to say that "At least one adverse mental or behavioral health symptom was reported by more than one half of respondents," including:

- Those ages 18–24 years (74.9%)
- Those ages 25–44 years (51.9%),
- Those of Hispanic ethnicity (52.1%),
- Those who held less than a high school diploma (66.2%),
- Those who were essential workers (54.0%),
- Those who were unpaid caregivers for adults (66.6%), and
- Those who reported treatment, at the time of the survey, for the following diagnosed conditions:
  - anxiety (72.7%),
  - depression (68.8%), or
  - PTSD (88.0%).

Respondent Characteristics and Prevalence of Adverse Mental Health Outcomes, Increased Substance Use to Cope With Stress or Emotions Related to COVID-19 Pandemic, and Suicidal Ideation— United States, June 24–30, 2020

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

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

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

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

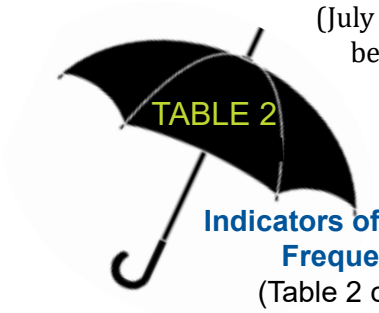
¶ 104 respondents selected "Prefer not to answer."

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

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

"Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic—United States, June 24–30, 2020": *https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm*

In addition to the *MMWR* report by the CDC, the National Center for Health Statistics and the U.S. Census Bureau have released a new data-reporting system—the Household Pulse Survey. This new online survey is tracking the change in American's mental health during the pandemic. In just three months, the percentage of those with symptoms of anxiety or depressive disoder jumped from 35.9 percent earlier in the pandemic (April 23–May 5) to 40.9 percent (July 16–21) [36]. (See Table 2 below.)



Indicators of Anxiety or Depression Based on Reported Frequency of Symptoms During Last 7 Days

(Table 2 compares April 23–May 5 with July 16–21)

Symptoms of Anxiety Disorder or Depressive Disorder				
Week Label	April 23–May 5		July 16–July 21	
Group	Percent	95% CI	Percent	95% CI
National Estimate				
United States	35.9	35.0–36.8	40.9	40.1–41.8
By Age				
18–29 years	46.8	44.3–49.3	53.4	51.3–55.6
30–39 years	39.6	37.7–41.5	47.1	45.2–48.9
40–49 years	38.9	37.2–40.7	44.5	42.4–46.5
50–59 years	35.8	34.0–37.7	40.0	38.2–41.9
60–69 years	28.9	27.6–30.3	32.1	30.3–34.0
70–79 years	21.5	19.3–23.7	24.3	21.9–26.8
80 years and above	21.1	15.6–27.5	17.5	14.3–21.0
By Gender				
Female	40.7	39.7–41.6	44.6	43.5–45.7
Male	31.0	29.6–32.3	37.0	35.7–38.4
By Race/Hispanic ethnicity				
Hispanic or Latino	42.7	39.7–45.7	46.3	43.7–48.9
Non-Hispanic Asian, single race	31.9	28.5–35.4	40.3	36.6–44.0
Non-Hispanic Black, single race	38.9	36.4–41.4	42.6	40.3–44.9
Non-Hispanic white, single race	33.6	32.7–34.4	38.8	38.0–39.7
Non-Hispanic, other races and multiple races	43.9	39.8–48.1	48.8	44.8–52.8
By Education				
Less than a high school diploma	45.4	40.3–50.5	47.3	43.3–51.4
High school diploma or GED	36.7	35.2–38.2	42.2	40.3–44.2
Some college/Associate's degree	38.5	36.9–40.0	43.3	42.0–44.5
Bachelor's degree or higher	30.7	29.8–31.5	35.7	34.6–36.8

U.S. Census Bureau, Household Pulse Survey, 2020:
www.cdc.gov/nchs/covid19/pulse/mental-health.htm

This finding—that more than 4 in 10 Americans, about 41 percent, are experiencing a mental illness—is striking. Compared to a similar period in 2019, only 8.2 percent of adults aged 18 and over had symptoms of anxiety disorder, and 6.6 percent had symptoms of a depressive disorder [37].

In addition, the Household Pulse Survey report highlights what many experts predicted: College students and workers between the ages of 18 and 29 are experiencing the worst indications. More than 50 percent of Americans in this age bracket (53.4%) have reported symptoms of diagnosable anxiety and depression disorders [38], which does not include *all* behavioral health disorders.

(See Table 3 on page 25, for data on the projected total number of Americans with a mental health condition in 2020.)

Black Americans are experiencing the worst effects of the overall crisis. This has been intensified by the police killing misconduct of George Floyd and other reported incidents of police violence.

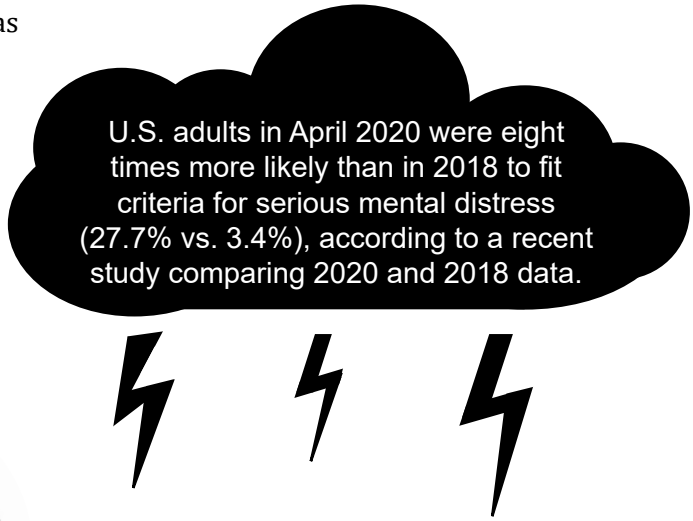
Nearly 35 percent of Black Americans are showing increased rates of anxiety and/or depression. Hispanics are experiencing similarly frightening numbers. Asian-Americans have seen marked

increases in anxiety and depression, as well as seen the largest changes in their mental health.

In 2019, just 3 percent of Asian-Americans screened positive for depression; now that rate has jumped to 22 percent, and the rate of Asian-Americans experiencing anxiety disorders is now 28 percent, up from 4 percent [39].

Based on this data, the American Mental Health Counselors Association estimates that **more than 103 million adults in the United States will suffer from a mental health or behavioral health condition in 2020. AMHCA also estimates that 8 million to 24 million children ages 5–17 will suffer from a mental health condition this year.**

AMHCA's estimates are based on the reports of the National Center for Health Statistics and the U.S. Census Bureau as well as other historical projections of the impact of disasters on mental health. As high as these estimates are, they are likely very low because many people do not like to admit to mental health problems.



Projected Number of Americans With a Mental Health Condition in 2020

Age	Population (in millions)	Number of Mental Health Disorders (in millions)
5–9	24.0	9.8*
10–17	32.9	13.5*
18–29	53.4	28.3
30–39	44.4	20.9
40–49	40.5	17.8
50–59	42.8	17.1
60–69	37.4	11.9
70–79	22.7	5.4
80+	12.9	2.2
Adults	**254.1**	**103.6**
TOTAL	**311.0**	**126.9**

Notes:

- The data here are based on U.S. Census Bureau Population Data and the Household Pulse Survey *"Indicators of Anxiety or Depression Based on Reported Frequency of Symptoms."*
- The table includes the latest data on adults over age 18 for July 16–21. The table does not include data on ages 0–4.

Sources:

- "Indicators of Anxiety or Depression Based on Reported Frequency of Symptoms": *www.cdc.gov/nchs/covid19/pulse/mental-health.htm*
- "Data and Statistics on Chidren's Mental Health": *www.cdc.gov/childrensmental-health/data.html*

* *Authors' estimates based on U.S. Census and CDC data*

The pandemic, combined with social distancing, the economic recession, and public concern about racial injustice will have a significant negative impact on Americans' mental health. In a recent study comparing 2018 data to 2020 data, in April 2020, adults in the United States were eight times more likely to fit criteria for serious mental distress (3.4% vs. 27.7%).

Americans in 2020 were also three times more likely to fit criteria for moderate or serious mental distress (22.0% vs. 70.4%). The sizeable differences between the 2018 and 2020 data appeared across all demographic and age groups, with larger differences among younger adults and those with children in the household [40].

We cannot accurately predict the increases in mental disorders that we will yet face because of these ongoing tsunamis.

CO-OCCURRING MENTAL HEALTH ISSUES AND SUBSTANCE USE DISORDERS AMONG ADULTS

Adults aged 18 or older who had both a mental disorder and a Substance Use Disorder (SUD) in the past year are referred to as having co-occurring disorders. In the 2018 National Survey on Drug Use and Health (NSDUH), the presence of mental disorders is defined as having either Any Mental Illness (AMI) or Serious Mental Illness (SMI), and SUDs refer to the presence of either alcohol use disorder or illicit drug use disorder.

This section presents findings on co-occurring disorders among adults in the United States. As described previously for adolescents aged 12–17, however, it cannot be established in the NSDUH data for adults whether the onset of SUDs preceded the onset of symptoms of mental disorders, or vice versa).

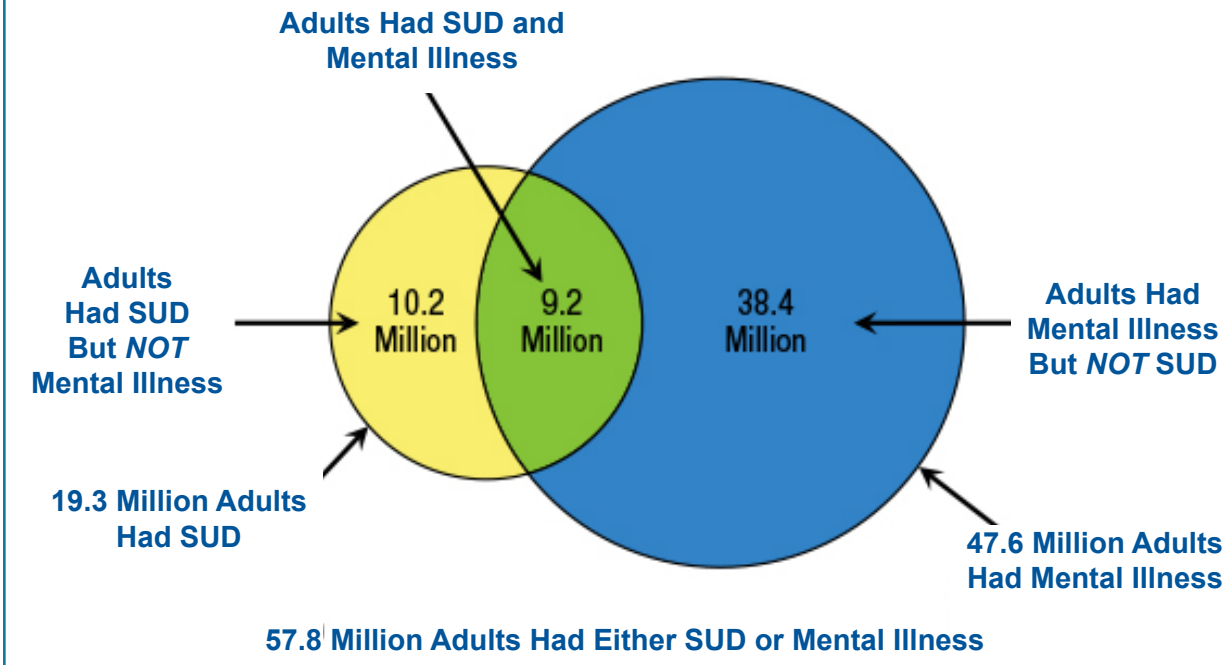
Co-Occurring Mental Health Issues and Substance Use Disorders

As noted previously, 47.6 million adults aged 18 or older in 2018 had AMI in the past year. In addition, 19.3 million adults had a past-year SUD. About 9.2 million adults had both AMI and an SUD (which corresponds to 3.7 percent of adults).

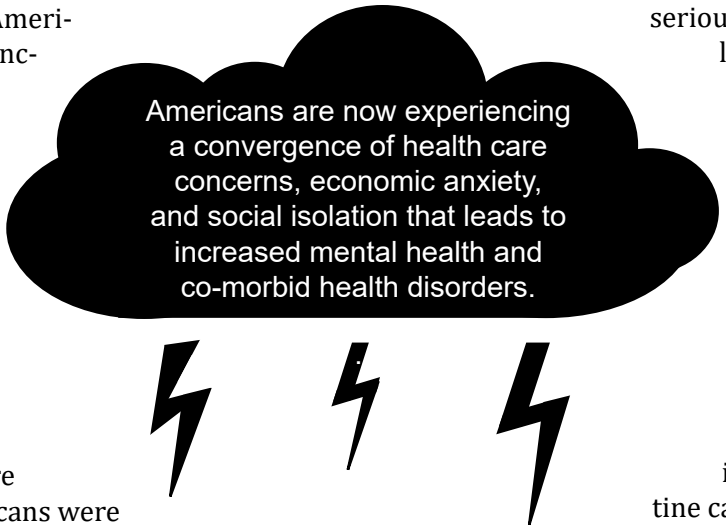
The 2018 percentage of adults with both AMI and an SUD was higher than the percentages in 2015 and 2016, but it was similar to the percentage in 2017. (See Figure 1 below.)

FIGURE 1

Co-Occurring Mental Health Issues and Substance Use Disorders Among Adults



2018 National Survey on Drug Use and Health:
www.samhsa.gov/data/report/2018-nsduh-annual-national-report



Based on the data, Americans are now experiencing a convergence of health care concerns, economic anxiety, and social isolation that leads to increased incidence of mental health and co-morbid health disorders. Even before the pandemic, Americans were experiencing high rates of depression, non-suicidal self-injury, and suicide. The COVID-19 pandemic has only intensified this urgency.

Prior to the pandemic, about 75 million American suffered from a mental illness, which includes substance use disorders. We estimate based on the CDC and Census Bureau Pulse data that upwards of 103.6 million adults in the United States are suffering from mental health conditions such as generalized anxiety and depressive conditions based on the CDC and Census Bureau Pulse Survey data, which does not include Americans who are suffering from serious mental illnesses line schizophrenia and bipolar disorders.

The evidence from a meta-study of health-related disasters found that isolation or quarantine can be traumatizing. Criteria for post-traumatic stress disorder (PTSD) was met in 30 percent of isolated or quarantined children based on parental reports, with 25 percent of isolated adults experiencing PTSD.

Natural disasters can lead to long-term mental health problems. Following Hurricane Katrina in 2005, for example, nearly 50 percent of the parents surveyed reported an increase in their child's behavioral difficulties. As the intensity of exposure to the hurricane increased, PTSD symptoms worsened. Three years later, researchers found that 28 percent still exhibited chronic dysfunction [41].

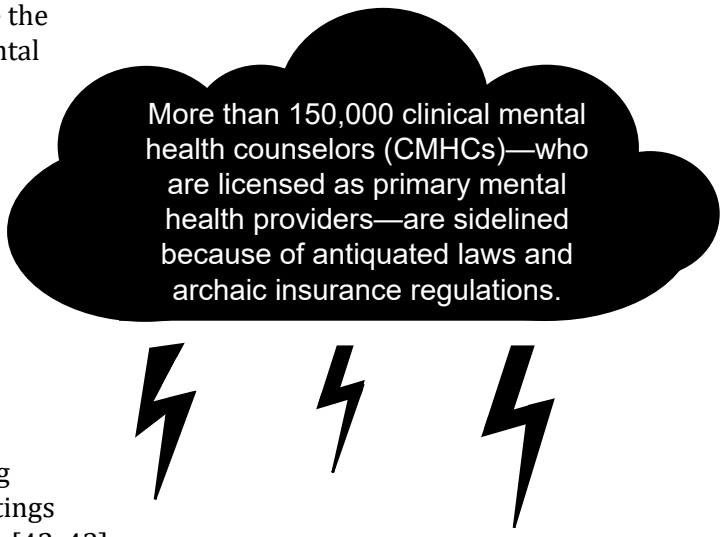
6
Beyond a Perfect Storm:
Opportunities to Transform The Mental Health System

AMHCA

AMERICAN MENTAL HEALTH COUNSELORS ASSOCIATION

The current pandemic is creating a cultural trauma. We need to respond now to the adverse mental health outcomes that are a result of the COVID-19 pandemic and the economic downturn, as well as the traumatic impact of structural racism. Immediate interventions need to be in place to ensure that the trauma does not last for years, let alone decades. We need policy changes for mental and behavioral health systems to help all communities thrive—now and beyond this public health crisis.

The current state of affairs could aggravate the conditions of those seeking or receiving mental health care. And, current regulations may further impede access to care. Right now, 119 million Americans live in areas where there are no licensed mental health professionals to meet the needs of the community (areas designated Mental Health Care Health Professional Shortage Areas). An estimated 50 percent of those who do receive care have to travel more than an hour round trip. Increasing the number of licensed mental health professionals, putting them in the right places, and in the right settings will be a challenge for the foreseeable future [42, 43].



More than 150,000 clinical mental health counselors (CMHCs), licensed as primary mental health providers, are sidelined because of antiquated laws and archaic insurance regulations. CMHCs are highly trained to diagnose and treat mental disorders including … anxiety, depression, trauma, PTSD, and co-occurring conditions. Yet decades-old federal laws and superfluous insurance requirements curtail what they can do and hinder their ability to help disadvantaged individuals and families.

Congress has acted to try to lessen the health and economic crisis. However, there has been nearly no effort to:

- **Promote health equity by adequately addressing racism, bias, discrimination, and other systemic barriers within the health care system.**

  To address these pernicious issues, policymakers must acknowledge the historical foundations of racism and ensure that health care providers, personnel, and staff are substantively trained to recognize and eliminate all forms of bias in the health care system. Accountability measures at both the individual and systems levels should be in place, including measures that link payment, professional certification, and licensure to quality of care.

- **Support the development of a robust, diverse, and culturally competent health care workforce by encouraging and facilitating diversity throughout the health care system, and adequately training all staff to be culturally sensitive.**

Payment rates and coverage guidelines for health care coverage should be developed to support fair, living wages and pay equity in the health care professions and jobs.

Expand access to mental health care through telemental health and make permanent the temporary federal and state policies enacted during the pandemic.

Telemental health (i.e., the provision of mental and behavioral health services via technology), has a robust evidence-base. Numerous studies have demonstrated its effectiveness across a range of modalities (e.g., telephone, videoconference) and mental health concerns (e.g., depression, anxiety, and substance use disorders). Telemental health offers a critical avenue not only to sustain mental and behavioral health services, but to expand them during the pandemic. Congress should mandate that all insurers expand coverage for telemental health, require reimbursement parity for all licensed mental health care providers, allow these providers to practice across state lines, eliminate geographic restrictions, and cover multiple modalities including telephone and videoconference.

Reduce the complicated insurance coverage procedures for mental health services that often result in denied claims and no reimbursement.

Many insurers still do not cover mental health services. Those that do are legally required to make benefits "comparable" to physical health coverage, but many insurers have found ways to circumvent that requirement. These tactics often include refusing to cover treatments like therapy on the grounds that they aren't "medically necessary." Often insurers are using the wrong criteria for what makes something medically necessary. For example, they pay enough only to stabilize a patient's condition, but not enough to improve their underlying illness.

Make sure federal and state mental health parity laws are enforced.

The 2008 Mental Health Parity and Addiction Equity Act required large group health plans that provide benefits for mental health problems to put that coverage on an equal footing with physical illness. Two years later, the Affordable Care Act required small-group and individual health plans sold in insurance marketplaces to cover mental health services and do so at levels comparable with medical services. In 2016, parity rules were also applied to Medicaid managed-care plans, which cover the majority of people in that federal-state health program for low-income residents.

Promote early diagnosis and intervention.

The majority of Americans living with a lifelong mental health condition show signs of distress at an early age and yet few are treated. We need to make the necessary investments and increase public awareness to address early mental health issues as well as trauma in children and young adults. This action is the right thing to do for our fellow citizens. It will also save taxpayer money over time, since it's more cost-effective to treat mental disorders proactively on an outpatient basis than on an inpatient one.

Integrate our nation's behavioral mental health care system with our physical health care system so that health care delivery focuses on the "whole person."

We need to foster improved integration of health care systems so that high-quality behavioral care for mental health conditions and addiction disorders is available

in general health care settings. This will decrease overall health care costs and promote better health for Americans.

- **Deliver health and mental health insurance coverage for millions of Americans through comprehensive Medicaid expansion, including the 14 states that have not taken advantage of the expansion program.**

Since main provisions of the of the Affordable Care Act (ACA) went into effect in 2014, the insurance coverage expansion and the Medicaid Expansion initiative have significantly increased Americans' ability to get needed health care. Research also indicates that the ACA's Medicaid Expansion program has narrowed racial and ethnic disparities in insurance coverage. This was a key objective of the law and one that enjoys substantial public support [44].

However, it is important to understand why getting covered through Medicaid is so much harder than Medicare. There are lots of superficial answers but the most significant reason is racism. Racism and classism which are worse now than at any time since its creation, also underlies the current threats to decrease Medicaid. These attacks threaten a valuable program and reinforce racial and class discrimination that was baked into Medicaid from the beginning. When it comes to expansion, we've reached the limit of what economics-based rational self-interest arguments can do, because the remaining opposition isn't rational, it's rooted in deeply held prejudices.

The Affordable Care Act sought to fix an unequal, unjust system in pre-ACA days by requiring states to participate in Medicaid and equalizing eligibility in all states. For the first time, lower-income American adults would be guaranteed access to health care coverage under the law no matter where they lived and states couldn't play games with their eligibility requirements to deny coverage to people of color. If a state denied someone coverage under the old rules, that individual would still qualify under the expansion.

It is time for the remaining 14 states to opt into the Medicaid Expansion program.

- **Promote the development of resources and up-to-date information by federal and state agencies to inform the public about access to licensed mental health therapists.**

Many individuals do not know what licensed mental health resources are available to them. Federal and state agencies need to create public sources of information so that Americans can make informed decisions when they or their family members need primary mental health care by a licensed professional.

- **Pass legislation for mental health Medicare reimbursement for older adults and disabled individuals that has been stalled in Congress for more than 20 years.**

The Mental Health Access Improvement Act would allow licensed mental health counselors and licensed marriage and family therapists to bill Medicare for medically necessary behavioral health services. Older people and individuals with Medicare approved disabilities cannot receive services by these primary mental health care providers. For 20 years, legislation has been stalled in Congress to authorized Medicare reimbursement only because of budget concerns. While seniors and disabled Americans suffer because there supposedly is a lack of licensed providers, Congress dithers even in the midst of the current health and economic calamity. Mental health and addiction issues have

been greatly exacerbated by this public health crisis. Now is the time to pass mental health Medicare reimbursement for older adults and disabled individuals.

The Bipartisan Policy Center's (BPC) Rural Health Task Force recently released a report recommending that licensed mental health counselors and marriage and family therapists be added to the list of Medicare providers as a method of increasing access to care. The BPC highlighted that the report's policy recommendations offer solutions to the challenges raised by the COVID-19 pandemic [45].

According to the National Academy of Medicine (formerly the Institute of Medicine), older adults are consistently underserved when it comes to behavioral health care [46]. During the COVID-19 pandemic, this is no different. The increased risk of hospitalization and death, coupled with the intense social isolation resulting from extended stay-at-home orders, are creating a behavioral health crisis among the Medicare population. Older Americans residing in assisted living facilities have been in almost a prison-like lock down in their rooms since the pandemic began.

Mental health counselors and marriage and family therapists comprise 40 percent of the mental health workforce and are licensed to provide medically necessary behavioral health services in every state [47]. They are serving clients via telehealth through Medicaid and other programs and they have the capacity to treat Medicare beneficiaries this way as well. Furthermore, they are often the only mental health professional available to underserved populations in many counties across the country. As telehealth and other solutions are considered in emergency response legislation, Congress must bolster the mental health workforce to deal with a coming surge in demand.

We must increase the capacity of our mental health system to address the oncoming tidal waves of mental illness. Otherwise, our public- and private-sector delivery systems will be overwhelmed. Millions will be denied the care they need from licensed CMHCs and other licensed professionals who are primary mental health care providers.

We must take actions now to prevent the devastation that will follow in the wake of the mental health tsunami.

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About the American Mental Health Counselors Association

Founded in 1976, the American Mental Health Counselors Association (AMHCA) works exclusively for the clinical mental health counseling profession. The AMHCA vision positions licensed clinical mental health counselors to meet the health care needs of those we serve while advancing the profession. Our mission is to advance the profession by setting the standard for: collaboration, advocacy, research, ethical practice, and education, training, and professional development.

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