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Mental Health Care Was Severely Inequitable, Then Came the Coronavirus Crisis

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Introduction and summary

People with mental health disabilities, like other historically oppressed communities, are experiencing compounded harms due to the COVID-19 pandemic. This is because sanism—oppression that has systematically disadvantaged people perceived or determined to be mentally ill—pervades public policy and life in the United States.[1] People with mental health disabilities face disproportionately high rates of poverty,[2] housing and employment discrimination,[3] and criminalization.[4] The economic and social upheaval caused by the coronavirus outbreak has merely exacerbated these disparities for those who were disabled prior to the crisis, while also exposing scores more people to individual and communal trauma, loss, and uncertainty.

As the coronavirus crisis continues to wreak havoc on communities, the need for accessible, culturally affirming mental health support services has never been more acute. However, even before the pandemic, the U.S. mental health care system was already failing to meet people's needs. In particular, for people of color and people with marginalized gender identities, the system too often operates in oppressive ways.[5] The psychiatric establishment, whose leadership is overwhelmingly white and male,[6] has historically denied communities facing various forms of oppression any control over their mental health care. Today, treatment is often cost-prohibitive, scarce, and coercive.

This report lays out the existing barriers to accessing affordable and affirming mental health services and considers the impact of COVID-19 on an already strained and inequitable mental health system. It also recommends that local, state, and federal governments take the following actions:

- Provide an immediate increase in funding to Medicaid providers and in-need communities.
- Increase funding for peer support and community-based services.
- Address the social determinants of mental health.
- Commit to permanently funding these policies.

Dangers of institutionalization

While the focus of this report is on noninstitutionalized populations, it is critical to note that people institutionalized within psychiatric facilities throughout the United States are acutely vulnerable to infection and death during the pandemic.[7] Confining people within congregate settings is inherently dangerous to their health and well-being, and people with mental illness are disproportionately represented in carceral facilities, institutions, and similar environments.[8] Indeed, with the coronavirus spreading unabated in jails, prisons, veterans' hospitals, nursing homes, and psychiatric facilities, large-scale investment in community-based services and supports could not be more urgent.[9] Furthermore, states must reduce the populations of psychiatric hospitals and other congregate care facilities by scaling back admissions and expediting discharges.[10]

Analysis of disparities

Preexisting barriers to mental health care access

For many Americans, mental health care has been unaffordable and inaccessible well before the coronavirus pandemic. A national shortage of mental health providers, the high price of care, and a lack of insurance coverage for mental health services all make it difficult for people with mental health disabilities to access care. In 2016, 11.8 million Americans had a need for mental health services that went unmet; of these, nearly 38 percent could not afford the cost of treatment.[11] Moreover, only about 1 in 5 people with a substance use disorder received treatment in 2016, and only slightly more than 40 percent of adults with any mental illness received treatment in 2017.[12]

Critically, the intersection of systemic sanism and racism fuels the many disparities laid bare by the COVID-19 pandemic. Racial groups that have historically been discriminated against—such as African Americans, American Indians, and Alaska Natives—use mental health services at substantially lower rates than white Americans.[13] There are myriad reasons for this, including geographic inaccessibility, economic disenfranchisement, lower rates of insurance coverage, and mistrust of the health care system due to years of abuse, neglect, and coercive treatment.[14] For example, the coronavirus has been especially devastating in Native communities, with the Navajo Nation reporting among the highest per-capita infection rates in the country for several months.[15] Unmet treaty obligations by the federal government resulting in chronic underfunding of critical services, paired with colonialism and ecological devastation, have contributed to the high infection and mortality rates in Indian Country.[16] As COVID-19 continues to infect and kill Black, Native, and Latinx people at rates that far outpace those of white people, equitable access to affirming mental health supports has become increasingly imperative.[17]

Survey data collected by the U.S. Census Bureau show that clinically significant symptoms of depression and anxiety have more than tripled since the coronavirus pandemic began, with people of color disproportionately affected.[18] Recent data also show that following the release of video footage of George Floyd's murder at the hands of Minneapolis police officers, the share of Black people suffering from

psychological distress symptoms associated with depression and anxiety—such as feelings of hopelessness or uncontrollable worry—jumped from 36 percent to 41 percent.[19] This has grave implications, as the communities bearing the heaviest mental health burdens are the communities that face the steepest barriers to accessing equitable mental health treatment and support.

For people without insurance coverage, out-of-pocket costs to mental health coverage are far from affordable. Notably, people of color are more likely than non-Hispanic whites to be uninsured, with Hispanic or Latinx Americans, American Indians, and Alaska Natives all being more than 2 1/2 times more likely than non-Hispanic whites to be uninsured.[20] Even those with insurance coverage often experience difficulties accessing mental health services. More than half of U.S. counties have no practicing psychiatrists, 37 percent of counties have no psychologists, and two-thirds of counties have no psychiatric nurse practitioners; nonmetropolitan counties have an even higher likelihood of having no accessible providers.[21] Moreover, psychiatrists are far less likely than other providers to accept any type of insurance: While 73 percent of other providers accept Medicaid, only 43 percent of psychiatrists accept Medicaid.[22] And slightly more than half of psychiatrists accept Medicare and private insurance, compared with more than 86 percent of other providers.

While federal parity regulations prohibit insurers from restricting mental health coverage any more than they limit coverage for other medical services, these policies largely do not require insurers to be transparent and accountable with beneficiaries.[23] To increase parity, it is essential that there are network adequacy provisions ensuring that mental health coverage includes a sufficient number of providers that are both accessible and taking new patients; yet unfortunately, these regulations are often left out of parity enforcement. Subsequently, many insured patients with mental health disabilities are unable to find an in-network provider that is willing to see them, even though their insurer, by law, must cover mental health services. Although a limited number of plans offer some out-of-network coverage, many people who are insured may have to pay the full out-of-pocket costs of services or forgo care when they cannot find in-network providers.

Impact of social isolation and economic uncertainty

Social distancing requirements, including stay-at-home orders, are undoubtedly important tools to slow the spread of the coronavirus. However, social isolation can also be detrimental to many people's mental health, exacerbating preexisting conditions and adding to newfound mental health concerns. It is therefore essential to provide support for people struggling with several weeks or months of social isolation during the pandemic.

Around the world, prolonged social isolation is exacerbating many individuals' psychiatric symptoms and increasing incidence of psychiatric disability. For example, a survey of quarantined children in Hubei, China, found that 1 in 5 children reported experiencing depressive symptoms—a rate that is significantly higher than it was before the pandemic.[24] Among U.S. adults surveyed, nearly half of those sheltering in place reported negative mental health effects, compared with 37 percent of those not under stay-at-home orders.[25] Moreover, an analysis featured in the medical journal *The Lancet* found that people who have been asked to isolate at home or in quarantine facilities reported high levels of "negative psychological effects including post-traumatic stress symptoms, confusion, and anger."[26] And another survey found that about one-third of adults in the United States have felt lonelier than usual during the coronavirus pandemic.[27] Notably, chronic loneliness is associated with numerous adverse mental and physical health outcomes.[28]

The COVID-19 pandemic has also sparked an unprecedented economic crisis, with the United States entering what is likely to be an extended and deep recession. This downturn is disproportionately burdening people with disabilities, communities of color, people with marginalized gender identities, and those at the intersection of these identities, while also exposing them to trauma, stress, and uncertainty.[29] A systematic review of the impact of the 2008 Great Recession on health found that an increase in distress symptoms and mental illness coincided with the economic crisis.[30] Given that socioeconomic status is an important social determinant of mental health, the COVID-19-induced recession—as well as economic uncertainty and job loss at all income levels—is likely to exacerbate or trigger new incidences of psychiatric disability.[31]

Furthermore, the economic fallout of the pandemic is disproportionately burdening Black, Native, and Latinx communities. People of color are more likely to work in essential jobs that put them on the frontlines of the pandemic.[32] Essential workers—particularly women and people of color—are also nearly twice as likely to use the Supplemental Nutrition Assistance Program (SNAP), may struggle to afford child care amid closures of schools and their regular child care arrangements, and may have to pay for personal protective equipment (PPE) out of pocket.[33] Additionally, the racial wealth gap may preclude people of color from taking unpaid time away from work since they often lack the personal savings necessary to do so.[34] Making matters worse, occupational segregation and racism in the labor market mean that Black and Latinx people are less likely to have access to paid family or medical leave if they or a family member needs care for mental or physical illnesses.[35] As such, these communities face compounded harms and bear an outsize share of the mental health and economic fallout of the coronavirus crisis.[36]

Frontline health care workers and emergency medical services workers are also facing unprecedented burdens as a result of the pandemic. The World Health Organization recently released a policy brief on the need for proactive mental health action during the pandemic, with specific attention given to health care workers treating patients with COVID-19.[37] Frontline health workers experience elevated levels of stress, anxiety, insomnia, and depression. And preliminary research in the United States shows high levels of psychological and emotional distress among health care workers directly treating coronavirus-infected patients. In a May survey, nearly 3 in 5 health care workers said that their mental health has worsened due to the coronavirus pandemic.[38] Continued PPE shortages, long and physically demanding shifts, the emotional burden of treating and sometimes losing colleagues to the illness, and the ever-present fear of spreading COVID-19 to loved ones are causing severe emotional and mental strain for frontline health providers.[39]

Despite these challenges, there are few accessible options for tailored mental health supports for these frontline workers. Volunteer trauma crisis response groups, peer support networks, and specialists in trauma-informed therapy have mobilized to reach health care workers, but the need outpaces the availability.[40] Furthermore, many physicians delay or forego needed mental health treatment because they could face steep repercussions from state licensing boards, 90 percent of which still require physicians to disclose details of their mental health history.[41] While symptoms of distress will abate for many once the crisis is under control, others may develop trauma-related psychiatric disabilities requiring long-term support.

This underscores the need for long-term investment in mental health services for populations experiencing higher rates of trauma exposure. Moreover, those seeking out and receiving treatment should not face professional barriers.

A rise in abuse

Panic, uncertainty, social isolation, and economic devastation can, in turn, exacerbate or trigger new forms of child abuse and intimate partner violence.[42] Alcohol abuse, controlling behaviors, unemployment, and limited access to social support systems are factors associated with family violence that have become more common during this crisis.[43] Globally, reports of domestic violence have tripled in China and risen by 30 percent in France and by 40 to 50 percent in Brazil, indicating broader global patterns of rising rates of domestic violence during the pandemic.[44] While data on domestic violence in the United States are limited,[45] several agencies have reported increased rates of physical and emotional abuse during the pandemic and new forms of pandemic-related manipulation.[46] As such, it is essential to provide ongoing tailored support for survivors of intimate partner violence and child abuse both during and following this crisis.

Disruption of services

Physical distancing policies, including stay-at-home orders, have also made it difficult for people with mental health concerns to access in-person psychiatric and peer support services. Peer support refers to the guidance, care, and nonclinical support services provided by people with lived experience of mental health disability, trauma, and/or substance use disorders; this model of care emerges from the self-advocacy and organizing of psychiatric service users and survivors.[47] Extensive research has demonstrated its efficacy in reducing hospitalization and symptoms associated with severe emotional distress.[48] Furthermore, peer support promotes an affirming and equitable model of healing that equalizes the inherent power imbalance in traditional clinical relationships.[49] There are several types of peer support programs and modalities, including peer-led respite crisis centers, one-on-one recovery and virtual meal support for people with eating disorders, and the Alternatives to Suicide approach, which creates spaces for people to safely share their experiences with suicidality and acute emotional distress.[50] However, program disruptions caused by the pandemic have threatened the continuity of some of these services.

While some peer support services have managed to ensure continuity of care by transitioning online, pandemic-related movement restrictions have disrupted most in-person mental health outreach in underserved communities. These services, performed by peer workers, community health workers, violence disruptors, and others are critical to expanding service utilization for people living in communities wracked by high rates of violence, displacement, economic disinvestment, ecological destruction, and other forms of oppression.[51] The cessation of such in-person outreach is likely to cause adverse mental health outcomes. According to a recent survey of 880 community behavioral health care organizations, 61 percent have shuttered at least one program due to the pandemic; and nearly all of organizations surveyed have reduced their operations.[52]

As pandemic-related closures and distancing policies continue, many people have turned to telehealth platforms and mental health apps as an alternative. Telehealth can be an important option for patients who cannot access in-person services. However, policymakers must consider privacy concerns and disparate access to broadband, as well as adequately regulate telehealth services as more Americans use virtual options. While detailed recommendations on telehealth are outside the scope of this report, further research is needed.

Recommendations

In order to sufficiently meet people's needs, it is essential that all funding and reforms put in place during this pandemic remain in place after the emergency declaration expires. Responses to trauma are often delayed, and it is likely that individuals' psychiatric symptoms will continue long after the initial spread of the coronavirus is contained. As such, funding to adapt to the current situation, as well as long-term, sustained efforts to offer supports and access to services, will be needed in order to properly address pandemic-related psychological and emotional distress.

Expand access to health care coverage

There are several important, immediate steps that can be taken to expand health care coverage. Amid rampant job loss,[53] risk of infection and hospitalization,[54] and increased need for mental health services,[55] universal health coverage has never been more important. However, the current administration in the White House is committed to undermining health insurance coverage through its attacks on the Affordable Care Act (ACA) and Medicaid, making this approach unattainable for the time being.[56] As an intermediate step, federal and state governments can and should make every effort to offer affordable coverage to the uninsured within the existing ACA and Medicaid infrastructure.

Under the ACA, people who face certain life events—such as the loss of employer-sponsored health insurance, moving, marriage, or the birth or adoption of a child—qualify for a special enrollment period (SEP), during which they can sign up for marketplace coverage outside of the yearly open enrollment period.[57] Twelve states that operate their own state-facilitated marketplaces have opened a COVID-19-specific SEP that allows currently uninsured individuals to obtain individual market coverage, regardless of whether they qualify for a traditional SEP.[58] According to estimates by health care analyst Charles Gaba, in the eight states that have opened COVID-19 SEPs and are reporting data, at least 240,000 people already have enrolled in coverage using this pathway.[59]

The Trump administration, however, has refused to implement an SEP for the federally facilitated marketplace in response to the COVID-19 pandemic. Gaba estimates that approximately 920,000 people nationally would enroll in ACA coverage if the federal government opened a national COVID-19 SEP.[60] Allowing more people to enroll in coverage would not only alleviate some of the financial concerns associated with fears of getting sick contributing to individuals' psychological distress, it would also allow more people to access mental health services.

The Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act, which passed the U.S. House of Representatives in mid-May but has stalled in the Senate, establishes an SEP for the ACA marketplaces.[61] It is essential that this provision be included in the final package that passes Congress. In addition to establishing an SEP, policymakers must fund culturally appropriate outreach and enrollment efforts to allow people experiencing job loss to access health care coverage.

Millions of low-income Americans would not have access to coronavirus testing and treatment or mental health care services without the Medicaid program. As the Center for American Progress detailed in June, to streamline Medicaid enrollment for millions of unemployed folks who may have lost their employer-sponsored insurance, states should offer automatic enrollment into Medicaid expansion for the unemployed and receive 100 percent federal funding through the federal matching assistance percentage (FMAP).[62] Moreover, states that have not expanded Medicaid must do so to cover individuals who fall into the coverage gap. More than two million Americans currently do not qualify for traditional Medicaid in their states but also do not have high enough incomes to qualify for financial assistance on the individual market.[63] In states that refuse to expand Medicaid, the federal government should offer a Medicaid option for the unemployed that mimics the state-based option.[64]

To further support low-income individuals, presumptive eligibility is another important provision to allow uninsured and low-income people to access care. Presumptive eligibility allows certain health care providers to enroll patients who would likely qualify for Medicaid into the program for a limited amount of time, typically no more than two months.[65] Thirty-one states currently offer presumptive eligibility in certain settings, but most limit qualification to pregnant women and children; and all but eight states exclude childless adults.[66] Furthermore, hospitals are one of the few entities qualified to use presumptive eligibility.[67] Therefore, many uninsured people may need to seek mental health care in a hospital setting, which could risk their exposure to the coronavirus.

Based on recommendations from the Center for Law and Social Policy (CLASP), there are several steps that states can take to make presumptive eligibility more effective.[68] States can expand qualified entities that are able to screen for eligibility to include "urgent-care facilities, child care facilities, youth serving agencies, testing sites, and virtual options."[69] As CLASP suggests: "Just as pregnant women are allowed one period of presumptive eligibility per pregnancy, individuals exposed to COVID-19 should be allowed one period of eligibility per COVID-19 exposure. Multiple periods are especially critical for essential workers without insurance who risk multiple exposures throughout the pandemic."[70] Lastly, presumptive eligibility should be available to all potentially Medicaid-eligible individuals.

States should encourage presumptive eligibility providers to assist their patients with submitting a full Medicaid application when using presumptive eligibility in order to gain longer-term Medicaid coverage.[71] This would also allow people to keep their presumptive eligibility coverage until a decision on a full application is made. Additionally, states can apply for Section 1115 waivers to extend presumptive eligibility for a longer period.[72]

Provide immediate funding to key providers and in-need communities

While previous stimulus packages have included important supports for providers, clinics, and hospitals, additional funding is urgently needed to address the needs of mental health patients and providers. For instance, the Coronavirus Aid, Relief, and Economic Security (CARES) Act, passed by Congress and signed into law by the president at the end of March, allocated $250 million to certified community behavioral health centers as well as funding for state and local aid.[73] Meanwhile, the Families First Coronavirus Response Act increased the share of Medicaid payments covered by the federal government—the FMAP—by 6.2 percentage points through the end of the quarter in which the public health emergency ends. And if it passes the Senate, the HEROES Act would raise the FMAP by 14 percentage points through June 30, 2021; if the public health emergency extends beyond that, the FMAP would return to its original increase of 6.2 percentage points.[74] However, the definition of eligible services for the FMAP bump excludes most community mental health services.[75] Furthermore, community-based behavioral health providers have received little of the CARES Act funding intended to keep providers in business.[76] For these reasons, the Senate must pass the FMAP increase, and Congress as a whole must ensure that critical community mental health services are eligible for the FMAP increase, while also being mindful that federal Medicaid assistance may need to extend beyond the scope of the public health emergency as communities continue to face the repercussions of the pandemic.[77]

Additionally, the $1 billion allocated in the CARES Act is woefully insufficient to meet the significant health needs of tribal nations during the pandemic and in its aftermath. Numerous short-term and long-term policy changes, as outlined in a recent CAP report, are needed to redress the federal government's broken treaty obligations, which have led to disproportionately high rates of COVID-19 infection and mortality in Native communities.[78]

Improve funding for peer support services and other community-based services

In times of crisis, peer support services are critical. Given the challenges faced by frontline health care workers, essential workers, survivors of COVID-19, the millions of people grieving loved ones, and communities—particularly Black, Latinx, and Native communities—disproportionately affected by the virus, increased access to affordable mental health services must be coupled with targeted funding for peer-to-peer supports.[79] Accordingly, the Substance Abuse and Mental Health Services Administration must provide grants to peer and mental health support groups by and for people affected by the coronavirus pandemic.

Reports suggest that this pandemic has caused a surge in the number of people with lived experience seeking to complete their peer support certifications.[80] Many peer-led support groups and services have transitioned to online models in order to maintain continuity of care. The CARES Act allocated $200 million to the Federal Communications Commission to disburse funds for telehealth and peer support services that fall within its purview.[81] However, this funding is woefully insufficient to meet the increased demand and to support the costs of rapidly training up people who can provide tailored and culturally affirming resources to those acutely in need.

Critically, peer support specialists and community health workers are developing innovative strategies to conduct outreach to underserved populations and provide tailored support. For example, the 30 million people with eating disorders in the United States are facing new pandemic-related stressors due to elevated concerns about food scarcity and the hoarding of groceries by shoppers, coupled with a surge in media content focused on food and weight.[82] Solutions such as online meal support groups can connect underserved populations with people who have a shared understanding of the unique challenges this pandemic poses.[83] Adequately funding such services through operational grants that extend beyond the duration of the pandemic is crucial to ensuring continuity of care. Furthermore, increased federal

funding for peer support training is essential to bolstering existing state and local peer certification programs and facilitating outreach efforts that target the most affected populations during and in the aftermath of the pandemic.

Invest in social determinants of mental health

While there clearly are protracted mental health impacts of the COVID-19 pandemic, the Trump administration's claim that lifting stay-at-home orders is necessary to curb suicide rates obscures the reality that much of this distress is due to the administration's failure to mobilize a pandemic response that meets people's basic needs.[84] Until the government adequately contains the coronavirus and provides economic and social support to those affected, Americans will continue to face increasing distress and trauma.[85]

Psychiatric service provision and the incidence of mental health disability are shaped by the oppressive and traumatizing social conditions many people navigate daily. Racism, sanism, and other structures of oppression produce social and institutional arrangements that put some groups at risk of poorer health outcomes and premature death while allocating life-sustaining resources to others.[86] Extreme social stratification and years of deliberate policy designed to unravel the social safety net have left huge swaths of the country—predominantly people of color, disabled people, and low-income people—unable to access life-sustaining resources.[87] As such, without full investment in permanent housing solutions,[88] expanded food assistance through the SNAP,[89] and the elimination of asset limits and other cumbersome barriers to public assistance, distress will only be elevated.[90] The behaviors that biomedical perspectives on psychiatry have defined as "disordered" are often the outcome of survival behaviors to cope with extreme and oppressive circumstances. Investing in the social determinants of mental health and redressing years of oppressive policymaking would ensure that the mental health interventions deployed in the wake of this crisis do not bolster the oppressive power structures that fomented such distress in the first place.[91]

Conclusion

The explosive spread of the novel coronavirus underscores the importance of transforming mental health care in the United States and redressing the structural inequities baked into the psychiatric establishment and mental health policy. Even prior to the COVID-19 pandemic, people with mental health disabilities faced numerous barriers in accessing competent, affordable and culturally affirming care; this crisis has merely exacerbated these inequities.

Local, state, and federal governments must address the new challenges this crisis poses for people experiencing acute psychological distress or trauma. Their actions must be swift, comprehensive, equitable, and sustainable through the long-lasting impact of the virus.

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