



December 2021

BEHAVIORAL HEALTH AND COVID-19

Higher-Risk Populations and Related Federal Relief Funding



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GAO@100 Highlights

Highlights of [GAO-22-104437](#), a report to congressional committees

Why GAO Did This Study

The COVID-19 pandemic has had repercussions for the behavioral health of the nation. During the pandemic, U.S. adults have reported higher rates of anxiety and depression symptoms and substance use. To address related concerns, the CARES Act; the Consolidated Appropriations Act, 2021; and the American Rescue Plan Act of 2021 appropriated relief funds specifically for behavioral health.

The CARES Act includes a provision for GAO to report on its ongoing monitoring and oversight efforts related to the COVID-19 pandemic. This report describes (1) populations that may be at higher risk of behavioral health effects; (2) the amount and type of funding the federal government provided in COVID-19 relief to address behavioral health needs; and (3) whether COVID-19 relief funds for behavioral health could serve higher-risk populations, and how selected funding recipients plan to use these funds. GAO will continue to monitor behavioral health issues as part of ongoing COVID-19 related oversight.

To conduct this work, GAO reviewed selected research on COVID-19 and behavioral health, and relevant federal funding opportunity and awards documents. GAO also interviewed stakeholders, such as federal officials, researchers, and grantees. Grantees included state officials and providers in four states and Washington, D.C., selected based on state behavioral health metrics and CARES Act-funded grants received, among other factors.

GAO incorporated technical comments from the departments of Health and Human Services and Homeland Security, as appropriate.

View [GAO-22-104437](#). For more information, contact Alyssa M. Hundrup at (202) 512-7114 or hundrupa@gao.gov.

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What GAO Found

The effects of the COVID-19 pandemic and related economic crisis—such as increased social isolation, stress, and unemployment—have intensified concerns about the number of people in the U.S. affected by behavioral health conditions: mental health and substance use disorders. Based on 32 interviews with federal, state, and other stakeholders, and a review of selected research, GAO found that certain populations may be at higher risk of new or exacerbated behavioral health symptoms or conditions related to the pandemic. Six populations were cited by the most stakeholders as being at higher risk of such behavioral health effects for a range of reasons. Children and adolescents, for example, had rising rates of behavioral health conditions before the pandemic and then faced disruptions to school-based behavioral health services, stakeholders said. They also said that people may be part of multiple higher-risk populations, though not everyone at risk will develop symptoms or conditions. Stakeholders cautioned that with the COVID-19 pandemic ongoing, it will take time to determine how different populations may be affected in the long term.

Populations Cited by the Most Stakeholders as Being at Higher Risk of Behavioral Health Effects

 People from certain racial and ethnic groups	 Health care workers	 Children and adolescents
 People with pre-existing behavioral health conditions	 Young adults	 People facing financial distress

Source: GAO analysis of stakeholder input and selected research. | GAO-22-104437

As of November 2021, the federal government awarded over \$8 billion in COVID-19 relief funding for behavioral health. Over 97 percent of this funding was provided to states and other recipients through six programs: one Federal Emergency Management Agency program, and five Substance Abuse and Mental Health Services Administration (SAMHSA) programs. For example, SAMHSA awarded about \$5.3 billion to 50 states, Washington, D.C., eight U.S. territories and other jurisdictions, and one tribe through supplements to existing substance abuse and mental health block grants using standard statutory formulas. The Federal Emergency Management Agency also awarded about \$467 million to 46 states, Washington, D.C., and four U.S. territories via the Crisis Counseling Assistance and Training Program.

GAO's review of program documentation shows that the COVID-19 relief funds for behavioral health, as awarded through the six programs, could generally serve the six higher-risk populations identified by stakeholders. Selected funding recipients in four states and Washington, D.C., reported varying ways they were using, or planned to use, relief funds to reach higher-risk populations. For example, officials in one state said they planned to use some mental health block grant funds to assist children and adolescents in the child protective services system. SAMHSA officials said that it would take time to determine who was actually served by COVID-19 relief funded programs, but said that it was important to examine grantee data to determine whether target populations were reached and identify any gaps, and the agency planned to do so.

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Abbreviations

ARPA	American Rescue Plan Act of 2021
CAA	Consolidated Appropriations Act, 2021
CCBHC	Certified Community Behavioral Health Clinic
CCP	Crisis Counseling Assistance and Training Program
CDC	Centers for Disease Control and Prevention
COVID-19	Coronavirus Disease 2019
FEMA	Federal Emergency Management Agency
GPRA	Government Performance and Results Act
HHS	Department of Health and Human Services
MHBG	Community Mental Health Services Block Grant
SABG	Substance Abuse Prevention and Treatment Block Grant
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	serious emotional disturbance
SMI	serious mental illness
SUD	substance use disorder

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December 10, 2021

Congressional Committees

The effects of the Coronavirus Disease 2019 (COVID-19) pandemic and related economic crisis—such as increased social isolation, stress, and unemployment—have intensified concerns about the number of people in the United States affected by behavioral health conditions: mental health and substance use disorders.¹ Data collected during the COVID-19 pandemic suggest that the pandemic is potentially driving another national crisis related to its effects on behavioral health, with people experiencing new or exacerbated behavioral health symptoms or conditions.² For example, from April 2020 through September 2021, between 29 to 43 percent of U.S. adults reported symptoms of anxiety or depressive disorder, according to the Census Bureau’s Household Pulse Survey—percentages considerably higher than the percentage of adults (11 percent) reporting those symptoms in a similar survey in 2019.³

Additionally, data suggest that substance use—alcohol and drug use—has also increased during the pandemic. In particular, in August 2020, the Centers for Disease Control and Prevention (CDC) published the results of surveys that found that about 13 percent of overall adult respondents reported having started or increased substance use to cope with stress or

¹We define behavioral health conditions as all mental, emotional, and substance use disorders that are included in the Diagnostic and Statistical Manual of Mental Disorders. Examples of mental health conditions that are included are anxiety disorders; mood disorders, such as depression; post-traumatic stress disorder; and schizophrenia. Examples of substance use disorders are alcohol use disorder and opioid use disorder.

²In this report, we use the term behavioral health effects to include new or exacerbated behavioral health symptoms and conditions associated with the pandemic, such as those related to anxiety, depression, and substance use; behavioral health effects also include suicidal ideation, suicide attempts, and suicide deaths.

³The Household Pulse Survey, an experimental data product, is an interagency federal statistical rapid response survey to measure household experiences during the COVID-19 pandemic. The survey is conducted by the Census Bureau in partnership with seven other agencies from the Federal Statistical System. See appendix I for more information about the Household Pulse Survey methodology and limitations. Regarding the 2019 survey, see Centers for Disease Control and Prevention, National Center for Health Statistics, *Estimates of Mental Health Symptomatology, by Month of Interview: United States, 2019* (March 2021).

emotions related to COVID-19.⁴ Moreover, drug overdose deaths increased about 29 percent from April 2020 to April 2021, to a predicted record high of 100,306 lives lost, according to provisional data from CDC's National Center for Health Statistics.⁵

As demand for behavioral health treatment services was expected to increase as a result of the COVID-19 pandemic, access to treatment was also expected to worsen.⁶ Concerns about the availability of behavioral health treatment, particularly for low-income individuals, have been longstanding, as have been concerns about shortages of qualified behavioral health professionals, particularly in rural areas.⁷ The pandemic has exacerbated these concerns. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency within the Department of Health and Human Services (HHS), contributing factors include layoffs of behavioral health staff and the loss of providers without the financial reserves to survive long-term.⁸

⁴See M. É. Czeisler, R. I. Lane, E. Petrosky et al., *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020*, MMWR Morbidity and Mortality Weekly Report, vol. 69, no. 32 (2020): pp. 1049-1057 (Atlanta, Ga.: Centers for Disease Control and Prevention, Aug. 14, 2020).

⁵The CDC National Center for Health Statistics provisional counts are often incomplete and causes of death may be pending investigation resulting in an underestimate relative to final counts. To address this, CDC adjusted provisional counts for reporting delays by generating a set of predicted provisional counts.

⁶See GAO, *COVID-19: Urgent Actions Needed to Better Ensure an Effective Federal Response*, [GAO-21-191](#) (Washington, D.C.: Nov. 30, 2020); and *Behavioral Health: Patient Access, Provider Claims Payment, and the Effect of the COVID-19 Pandemic*, [GAO-21-437R](#) (Washington, D.C.: Mar. 31, 2021).

⁷See GAO, *Behavioral Health: Options for Low-Income Adults to Receive Treatment in Selected States*, [GAO-15-449](#) (Washington, D.C.: June 19, 2015); and Health Resources and Services Administration, National Center for Health Workforce Analysis, *National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025* (Rockville, Md.: November 2016). For example, before the COVID-19 pandemic, the Health Resources and Services Administration reported that by 2025 shortages of seven selected types of behavioral health providers were expected—with shortages of some provider types expected to exceed 10,000 full-time equivalents.

⁸As a result of the COVID-19 pandemic, behavioral health care providers, like other health care providers, may have experienced financial losses and changes in operating expenses due to factors such as decreased revenues from cancellations of in-person visits, limitations in services due to social distancing requirements, and increased expenses, such as for purchasing personal protective equipment.

Three COVID-19 relief acts—the CARES Act, the Consolidated Appropriations Act, 2021 (CAA), and the American Rescue Plan Act of 2021 (ARPA)—specifically appropriated funds for programs and activities to help address the nation’s behavioral health needs.⁹ Most of these funds were provided to SAMHSA for further distribution through various grant programs to states and other entities. In addition, on April 28, 2020, the President granted the Federal Emergency Management Agency (FEMA) authority to approve the Crisis Counseling Assistance and Training Program (CCP) for COVID-19 pandemic related disasters.¹⁰ Collectively, in this report we use the term “COVID-19 relief funds for behavioral health” to refer to funds appropriated to HHS agencies specifically for behavioral health through the three COVID-19 relief acts, as well as funds awarded through FEMA’s CCP.¹¹

The CARES Act includes a provision for GAO to report on its ongoing monitoring and oversight efforts related to the COVID-19 pandemic.¹² In this report, we describe

⁹Pub. L. No. 116-136, div. B., tit. VIII, 134 Stat. 281, 556 (2020); Pub. L. No. 116-260, div. M, tit. III, 134 Stat. 1182, 1913 (2020); Pub. L. No. 117-2, tit. II, subtit. H, 135 Stat. 4, 45-48. Unless otherwise stated, references to the CAA in this report refer to Division M of that act (Coronavirus Response and Relief Supplemental Appropriations Act, 2021). Behavioral health funds provided for in annual appropriations acts enacted as part of the CAA were outside the scope of our review.

¹⁰The CCP assists individuals and communities in recovering from the psychological effects of natural and human caused disasters through community-based outreach and educational services. FEMA awards CCP funding from its Disaster Relief Fund, which received \$97 billion in supplemental appropriations from the CARES Act, CAA, and ARPA.

¹¹In addition, federal agencies, state agencies, tribes, and other recipients of COVID-19 relief funds may have used funds available for a range of response activities to fund behavioral health activities. These funds were outside the scope of our review. Similarly, also outside of our scope were additional COVID-19 relief funds that behavioral health providers may have received, such as funds through HHS’s Provider Relief Fund, which reimburses eligible providers for health care-related expenses or lost revenues attributable to COVID-19. For more information about the Provider Relief Fund, see, for example, GAO, *COVID-19: Sustained Federal Action Is Crucial as Pandemic Enters Its Second Year*, [GAO-21-387](#) (Washington, D.C.: Mar. 31, 2021).

¹²Pub. L. No. 116-136, § 19010(b), 134 Stat. 281, 580 (2020). We have regularly issued government-wide reports on the federal response to COVID-19. For the latest report, see GAO, *COVID-19: Additional Actions Needed to Improve Accountability and Program Effectiveness of Federal Response*, [GAO-22-105051](#) (Washington, D.C.: Oct. 27, 2021). Our next government-wide report will be issued in January 2022 and will be available on GAO’s website at <https://www.gao.gov/coronavirus>. We will continue to monitor behavioral health funding as part of this ongoing COVID-19 related oversight.

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1. populations that may be at higher risk of behavioral health effects related to the COVID-19 pandemic;
 2. the amount and type of funding the federal government provided in COVID-19 relief to states, providers, and other organizations to address behavioral health needs; and
 3. whether COVID-19 relief funds for behavioral health could serve populations that may be at higher risk of behavioral health effects related to the pandemic, and how selected funding recipients plan on using relief funds to serve these populations.

To address all three objectives, we interviewed or obtained written responses from stakeholders representing a range of roles and perspectives with respect to behavioral health during the COVID-19 pandemic. These stakeholders include federal agency officials and researchers, as well as representatives from behavioral health care provider associations, consumer groups, and other organizations. Additionally, in four selected states (Colorado, Mississippi, New York, and West Virginia) and Washington, D.C., we interviewed state agencies and other selected recipients of COVID-19 relief funding for behavioral health. We selected these states and Washington, D.C., because of their ranking in behavioral health metrics, such as rates of serious mental illness, and to reflect variation in the number of COVID-19 cases and deaths as of February 2021, among other factors.

To identify populations that may be at higher risk of behavioral health effects related to the COVID-19 pandemic, we reviewed selected research by federal agencies and other organizations, such as CDC Morbidity and Mortality Weekly Reports and data from the Census Bureau's Household Pulse Survey. We also analyzed information stakeholders provided about at-risk populations. As part of our analysis, we considered how many of the stakeholders we interviewed or obtained written responses from identified various populations as potentially being at higher risk of experiencing behavioral health effects related to the COVID-19 pandemic. We also considered the results of selected research about populations at risk of such behavioral health effects.

To determine the amount and type of COVID-19 relief funding the federal government provided for behavioral health and whether the funding could serve higher-risk populations, we reviewed relevant federal laws, behavioral health related funding opportunity documents, and award data for COVID-19 relief funds for behavioral health awarded after the CARES Act was enacted in March 2020 through November 2021. We reviewed

these documents to determine such things as grant purposes, time frames, and populations of focus.

To determine the reliability of the data used for our objectives, we reviewed relevant documentation, requested written information from knowledgeable officials, and checked for obvious errors, when appropriate. We determined the data used in this report were sufficiently reliable for the purpose of addressing all three objectives above. (See app. I for additional information on our scope and methodology.)

We conducted this performance audit from July 2020 through December 2021 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Behavioral Health in the United States

Behavioral health conditions affect a substantial number of adults in the United States. In 2019, prior to the pandemic, an estimated 61.2 million adults (24.5 percent) in the United States had a behavioral health condition, according to SAMHSA.¹³ Behavioral health conditions can be grouped into mental illnesses and substance use disorders. Examples of mental illnesses are anxiety disorders; mood disorders, such as depression; post-traumatic stress disorder; and schizophrenia. Substance use disorders include alcohol use disorder and illicit drug use disorders, such as opioid use disorder. SAMHSA reported that in 2019, an estimated

- 42 million adults had a mental illness and no co-occurring substance use disorder;
- 9.7 million adults had substance use disorder and no mental illness;
- 9.5 million adults had both a mental illness and a substance use disorder; and

¹³See Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health*, (Rockville, Md.: September 2020).

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- 4.5 million adolescents aged 12 to 17 had either a substance use disorder or a major depressive episode.¹⁴

Behavioral health symptoms and conditions vary in terms of their severity. For example, people may have symptoms such as distress, anxiety, or sadness that do not meet the diagnostic criteria for anxiety disorder, depression, or other conditions. In contrast, SAMHSA estimated that in 2019, 13.1 million adults had a serious mental illness, which is defined as a mental, behavioral, or emotional disorder that substantially interfered with or limited one or more major life activities.¹⁵ Additionally, CDC estimated that in 2019, 2.8 percent of adults experienced severe symptoms of depression, 4.2 percent experienced moderate symptoms, and 11.5 percent experienced mild symptoms.¹⁶

Federal data indicate that before the COVID-19 pandemic, the extent of behavioral health conditions, symptoms, and outcomes varied across populations. For example, SAMHSA data show that in 2019, young adults age 18 to 25 reported higher rates of having any mental illness than adults in older age groups, and women were more likely than men to report anxiety and depression symptoms in 2019.¹⁷ Other federal data

¹⁴SAMHSA classified adults aged 18 or older as having any mental illness if they had any mental, behavioral, or emotional disorder in the past year of sufficient duration to meet criteria in the Diagnostic and Statistical Manual of Mental Disorders (excluding developmental disorders and substance use disorders). See SAMHSA, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health* (2020).

¹⁵See SAMHSA, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health* (2020).

¹⁶See M.A. Villarroel and E.P. Terlizzi, *Symptoms of Depression among Adults: United States, 2019*, NCHS Data Brief, no. 379 (Hyattsville, Md.: National Center for Health Statistics, September 2020).

¹⁷See SAMHSA, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health* (2020); Villarroel and Terlizzi, *Symptoms of Depression among Adults: United States, 2019* (2020); and E.P. Terlizzi and M.A. Villarroel, *Symptoms of Generalized Anxiety Disorder among Adults: United States, 2019*, NCHS Data Brief, no. 378 (Hyattsville, Md.: National Center for Health Statistics, September 2020).

show that from 1999 to 2019, the drug overdose death rate was consistently higher for men than women.¹⁸

Behavioral Health Risk and Protective Factors

Many factors can influence a person's likelihood of developing a behavioral health condition.¹⁹ Both the factors that place people at greater risk and those that act to protect them influence a person's likelihood of developing a condition, and people with risk factors will not necessarily develop a behavioral health condition (see text box).

Overview of Behavioral Health Risk and Protective Factors

What are they?

- Risk factors are characteristics associated with a higher likelihood of developing a behavioral health condition.
- Protective factors are characteristics associated with a lower likelihood of developing a behavioral health condition—or that reduce a risk factor's impact.

Key facts

Risk and protective factors can occur at different levels, such as the individual, community, and societal level.

- People can have multiple risk and protective factors, and both types of factors can have a cumulative effect.
- Risk and protective factors can have influence throughout a person's life; for example, childhood experiences can affect the likelihood of developing a condition later in life.

Source: GAO summary of Substance Abuse and Mental Health Services Administration information. | GAO-22-104437

The CDC and others have identified a range of behavioral health risk and protective factors. These include risk and protective factors for behavioral health conditions generally, as well as those related to specific populations, conditions, or outcomes. For example, poverty, unemployment, isolation and loneliness, lack of education or housing, racial discrimination, poor nutrition, bereavement, and trauma are all general behavioral health risk factors, while social support and community

¹⁸See H. Hedegaard, A.M. Miniño, and M. Warner, *Drug Overdose Deaths in the United States, 1999–2019*, NCHS Data Brief, no. 394 (Hyattsville, Md: National Center for Health Statistics, December 2020).

¹⁹See Substance Abuse and Mental Health Services Administration, *A Guide to SAMHSA's Strategic Prevention Framework* (Rockville, Md.: June 2019); and Substance Abuse and Mental Health Services Administration, *Risk and Protective Factors*, accessed August 12, 2021, <https://www.samhsa.gov/sites/default/files/20190718-samhsa-risk-protective-factors.pdf>.

networks are examples of protective factors.²⁰ For suicide specifically, mental illness, social isolation, financial problems, job loss, and barriers to health care are all risk factors, while available physical and mental health care and connections to family and friends are protective factors.²¹

Behavioral Health in Times of Disaster

According to SAMHSA, it is common for people to experience behavioral health effects related to disease outbreaks, natural disasters (e.g., hurricanes), and other types of disasters. For example, people may experience symptoms such as anxiety or sadness after such disasters.²² Not everyone with symptoms will go on to have a diagnosed condition. For many people, symptoms will resolve soon after a crisis. However, other people will have longer-term effects.²³ In addition, some people who have no symptoms right after a crisis may develop delayed symptoms later on.²⁴

Prior research also indicates that certain populations may be at increased risk for behavioral health effects in times of disasters. For example, health

²⁰See World Health Organization, *Prevention of Mental Disorders: Effective Interventions and Policy Options, Summary Report* (Geneva, Switz.: World Health Organization, 2004). The report noted that there are generic risk and protective factors that are common to several mental health problems and disorders. For example, poverty and child abuse are common to depression, anxiety, and substance abuse. In contrast, disease-specific risk and preventive factors are mainly related to a particular disorder. For example, negative thinking is specifically related to depression.

²¹See Centers for Disease Control and Prevention, *Suicide Prevention: Risk and Protective Factors*, accessed June 1, 2021, <https://www.cdc.gov/suicide/factors/index.html>.

²²See D. J. DeWolfe, *Training Manual for Mental Health and Human Service Workers in Major Disasters*, HHS Publication no. ADM 90-538, (2nd ed.) (Rockville, Md.: Substance Abuse and Mental Health Services Administration, 2000); Substance Abuse and Mental Health Services Administration, *Warning Signs and Risk Factors for Emotional Distress*, accessed September 23, 2021, <https://www.samhsa.gov/find-help/disaster-distress-helpline/warning-signs-risk-factors>; and Substance Abuse and Mental Health Services Administration, *Survivors of Disasters Resource Portal*, accessed September 23, 2021, <https://www.samhsa.gov/dtac/disaster-survivors>.

²³See D. J. DeWolfe, *Training Manual for Mental Health and Human Service Workers in Major Disasters* (2000); Substance Abuse and Mental Health Services Administration, *Tips for Survivors of a Disaster or Other Traumatic Event: Managing Stress*, HHS Publication No. SMA-13-4776, (Rockville, Md.: SAMHSA, January 2013); and SAMHSA, *Warning Signs and Risk Factors for Emotional Distress*.

²⁴See E. Goldmann and S. Galea, "Mental Health Consequences of Disasters," *Annual Review of Public Health*, vol. 35 (2014).

care workers and surviving patients are at increased risk of behavioral health effects related to disease outbreaks.²⁵ Children and adolescents, older adults, and people with pre-existing behavioral health conditions are among those generally at risk after disasters, according to SAMHSA.²⁶ Also, according to a review of disaster mental health research, people with certain pre-disaster risk factors—such as having a prior mental illness or being a woman or a child—are at increased risk for behavioral health effects; post-disaster risk factors include life stressors such as job loss and disaster-related health concerns, and low social support.²⁷ A person’s degree of exposure to a disaster is the most predictive factor overall, according to the review; exposure to a disaster includes factors such as experiencing life threats or the death of loved ones, or responding to emergency situations.

Federal Agencies that Address Behavioral Health

Various federal agencies within HHS regularly conduct behavioral health-related work. In particular, SAMHSA leads federal public health efforts to advance the behavioral health of the nation. SAMHSA is responsible for, among other things, providing federal funding through grants to states, local communities, and private entities to support community-based mental health and substance abuse treatment and prevention services. For example, SAMHSA’s two largest grant programs supporting these treatment and prevention services are the Community Mental Health Services Block Grant and the Substance Abuse Treatment and Prevention Block Grant. SAMHSA also conducts surveillance and data

²⁵See G. Salazar de Pablo, J. Vaquerizo-Serrano, A. Catalan et al., “Impact of Coronavirus Syndromes on Physical and Mental Health of Health Care Workers: Systematic Review and Meta-Analysis,” *Journal of Affective Disorders*, vol. 275 (Oct. 1, 2020); S. W. H. Chau, O. W. H. Wong, R. Ramakrishnan et al., “History for Some or Lesson for All? A Systematic Review and Meta-analysis on the Immediate and Long-Term Mental Health Impact of the 2002–2003 Severe Acute Respiratory Syndrome (SARS) Outbreak,” *BMC Public Health*, vol. 21, no. 1 (April 7, 2021); and J. M. Cénata, N. Felix, C. Blais-Rochette et al., “Prevalence of Mental Health Problems in Populations Affected by the Ebola Virus Disease: A Systematic Review and Meta-Analysis,” *Psychiatry Research*, vol. 289 (July 2020).

²⁶Examples of other at-risk groups include women, people who are homeless, and first responders and recovery workers who respond to crisis situations. See SAMHSA, *Warning Signs and Risk Factors for Emotional Distress*.

²⁷See E. Goldmann and S. Galea, “Mental Health Consequences of Disasters,” *Annual Review of Public Health*, vol. 35 (2014). According to this review, pre-disaster mental illness is consistently associated with post-disaster depression, post-traumatic stress disorder, and substance use disorders. Children exposed to disasters are particularly vulnerable to psychological problems, which are most commonly symptoms of anxiety (for example, panic and phobias) and depression.

collection of national behavioral health issues and provides statistical and analytic support to grantees.

Other HHS agencies are regularly involved in behavioral health-related work. Some of these agencies and selected behavioral health-related activities include:

- CDC, which conducts surveillance and nationwide data collection of behavioral health-related deaths (such as suicide deaths and drug overdose deaths);
- National Institutes of Health, which provides funding for and conducts research on behavioral health topics, such as mental health disorders and substance use and addiction; and
- Health Resources and Services Administration, which collects data on behavioral health workforce shortage areas and provides funding to support behavioral health workforce training.

Further, in times of disasters or emergencies, such as the COVID-19 pandemic, additional federal agencies may take on roles to help address behavioral health issues. This includes FEMA, within the Department of Homeland Security, which funds and implements the CCP. When states, territories, or tribal governments request major disaster declarations from the President, they may request assistance under this program. Likewise, when the President declares a major disaster, the declaration may authorize FEMA's Individual Assistance programs, which may include the CCP.²⁸

²⁸FEMA's Individual Assistance mission is to ensure disaster survivors have timely access to a full range of authorized programs and services to maximize recovery.

Certain Populations, Such As People from Certain Racial and Ethnic Groups, May Be at Higher Risk of Behavioral Health Effects; Pandemic's Long-Term Effects Are Uncertain







People from Certain Racial and Ethnic Groups, Children and Adolescents, and Others May Be At Higher Risk of New or Worsening Behavioral Health Conditions or Symptoms

COVID-19 has had widespread repercussions for the behavioral health of the nation as a whole, but certain populations may be at higher risk of behavioral health effects, according to 32 stakeholders we interviewed and our review of selected research.²⁹ We found that the populations identified by stakeholders and research as potentially at higher risk generally fell into two groups: (1) six populations most frequently identified by stakeholders, and (2) 11 other populations stakeholders identified.³⁰ (See fig. 1.)

²⁹In this report, we use the term behavioral health effects to refer to new or exacerbated behavioral health symptoms and conditions associated with the pandemic, such as those related to anxiety, depression, and substance use; behavioral health effects also include suicidal ideation, suicide attempts, and suicide deaths. This analysis was based on 32 of the stakeholders we interviewed or obtained written responses from. We did not include responses from officials of two federal agencies, because they did not provide input on populations at higher risk of behavioral health effects. We also did not include responses from the recipients of federal COVID-19 behavioral health relief funding that were not state agencies.

³⁰We considered how many of the stakeholders identified various populations as potentially being at higher risk of experiencing behavioral health effects related to the COVID-19 pandemic. The six populations stakeholders identified most frequently included four populations identified by more than half of the 32 stakeholders, and two populations identified by about half (15 or 16) of stakeholders. A smaller share of stakeholders (three to nine) also identified 11 additional populations as potentially at higher risk.

Figure 1: Populations That May Be At Higher Risk of Behavioral Health Effects Related to the COVID-19 Pandemic

Populations Most Frequently Identified by Stakeholders (6)			
 People from certain racial and ethnic groups	 Health care workers	 Children and adolescents	
 People with pre-existing behavioral health conditions	 Young adults	 People facing financial distress	

Other Populations Stakeholders Identified (11)			
Women	Older adults	Parents of young or school-aged children	People who were diagnosed with COVID-19
Essential workers	Individuals who are lesbian, gay, bisexual, or transgender	People with fewer social supports	People experiencing domestic violence
	People living in rural areas	Unpaid caregivers of adults	People with limited education

Source: GAO analysis of stakeholder input and selected research. | GAO-22-104437

Note: We use the term behavioral health effects to refer to new or exacerbated behavioral health symptoms and conditions associated with the pandemic, such as those related to anxiety, depression, and substance use; behavioral health effects also include suicidal ideation, suicide attempts, and suicide deaths. People in one or more higher-risk populations will not necessarily develop behavioral health symptoms or conditions. Our analysis was based on interviews and written responses from 32 stakeholders, including federal officials, state officials, researchers, and others. We considered how many of these stakeholders identified populations as potentially being at higher risk of behavioral health effects.

There are a range of reasons why these populations might be at higher risk, according to stakeholders and research. For example, the pandemic disrupted access to school-based behavioral health supports for children and adolescents, and people with pre-existing behavioral health conditions faced reduced access to residential programs and other forms of in-person care, some stakeholders said. Some stakeholders also noted that health care workers have faced heightened health risks and stress due to the pandemic. Also, several populations, such as adolescents and young adults, had increasing or relatively higher rates of behavioral health conditions prior to the pandemic.³¹

³¹See SAMHSA, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health* (2020); and Centers for Disease Control and Prevention, *Youth Risk Behavior Survey Data Summary & Trends Report 2009-2019* (Atlanta, Ga.: 2021).

People from certain racial and ethnic groups. Twenty-two stakeholders shared concerns about the pandemic’s potential impact on the behavioral health of people from certain racial and ethnic groups.³² Some stakeholders cited the pandemic’s disproportionate effect on certain racial and ethnic groups with respect to illness and death.³³ Between March 2020 and August 2021, for example, available CDC data indicate that non-Hispanic American Indian/Alaska Native individuals were hospitalized due to COVID-19 at a rate 3.5 times that of non-Hispanic White individuals, after adjusting for age; Hispanic or Latino and non-Hispanic Black individuals were hospitalized at a rate 2.8 times that of non-Hispanic White individuals.³⁴ Some stakeholders said that disparities in access to behavioral health care could contribute to higher risk for people from certain racial and ethnic groups, as could the pandemic’s impact on employment. We have reported that during the pandemic, labor market conditions weakened more for Hispanic or Latino, Black, and Asian individuals as compared to White individuals.³⁵ See figure 2 for examples of information from stakeholders and research.


³²For the purposes of this report, “people from certain racial and ethnic groups” refers to people of races and ethnicities other than non-Hispanic White, including people who identify as multiracial. People of races and ethnicities other than non-Hispanic White have a wide variety of backgrounds and experiences.

³³We have reported on the racial and ethnic disparities in COVID-19 cases, hospitalizations, and deaths, as well as vaccination rates. See GAO, *Health Care Capsule: Racial and Ethnic Disparities*, [GAO-21-105354](#) (Washington, D.C.: Sept. 23, 2021); and [GAO-21-387](#).

³⁴During that time frame, non-Hispanic American Indian/Alaska Native individuals died of COVID-19 at a rate 2.4 times that of non-Hispanic White individuals; Hispanic or Latino individuals died of COVID-19 at a rate 2.3 times that of non-Hispanic White individuals; and non-Hispanic Black individuals died at a rate two times that of non-Hispanic White individuals, after adjusting for age. Hospitalization rates are based on COVID-NET, a CDC surveillance system that collects data on COVID-19-associated hospitalizations confirmed by laboratory testing, in select counties in 14 states representing about 10 percent of the U.S. population. See Centers for Disease Control and Prevention, *Risk for COVID-19 Infection, Hospitalization, and Death By Race/Ethnicity*, accessed October 4, 2021, <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html#print>.

³⁵See [GAO-21-387](#).

Figure 2: People from Certain Racial and Ethnic Groups: Examples of Information about Behavioral Health Risks

<p>PEOPLE FROM CERTAIN RACIAL AND ETHNIC GROUPS</p> 	<p>Before the COVID-19 pandemic</p>
	<ul style="list-style-type: none"> Hispanic or Latino and Black individuals' rates of behavioral health disorders did not significantly differ from the general population, but they have had substantially less access to behavioral health treatment, according to a Substance Abuse and Mental Health Services Administration (SAMHSA) report. The report noted that in 2018, 69.4 percent of Black adults and 67.1 percent of Hispanic or Latino adults with any mental illness said they did not receive treatment, as compared to 56.7 percent of all U.S. adults with any mental illness, according to SAMHSA data.^a Non-Hispanic American Indian/Alaska Native individuals had substantial rates of serious mental illness (6.7 percent), alcohol use disorder (6.4 percent) and substance use disorder (10.1 percent) in 2019, according to SAMHSA data.^b
	<p>During the COVID-19 pandemic</p>
	<ul style="list-style-type: none"> The Census Bureau's Household Pulse Survey has found that Hispanic or Latino, non-Hispanic Black adults, and non-Hispanic adults of other races or multiple races generally were more likely than non-Hispanic White and Asian adults to report symptoms of an anxiety disorder or a depressive disorder. From August 18 – August 30, 2021, 39.9 percent of non-Hispanic adults of other races or multiple races, 35.2 percent of Hispanic or Latino adults, and 33.4 percent of non-Hispanic Black adults reported such symptoms, as compared to 31.3 percent of non-Hispanic White and 24.2 percent of non-Hispanic Asian adults.^c Between 2018 and 2020—the first year of the pandemic—drug overdose death rates increased for all racial and ethnic groups, but non-Hispanic American Indian/Alaska Native and Black individuals experienced the largest increases, according to an analysis of overdose deaths during the first 9 months of both years. In 2020, estimated drug overdose death rates were highest among non-Hispanic American Indian/Alaska Native individuals (29.8 per 100,000), followed by non-Hispanic Black individuals (27.3 per 100,000) and White individuals (23.6 per 100,000).^d National Institutes of Health officials told us in April 2021 that while provisional data showed the national rate of suicide had not been substantially affected by the pandemic, early data in one state from March to May 2020 suggested “there was a disproportionate impact on racial minorities;” non-White individuals experienced a 62 percent increase in their suicide rate compared with the previous year.^e Officials in one state said they were working to address an increase in suicidal ideation, depression, and anxiety among Hispanic or Latino adolescents, among other things. They also said primary care providers had informed them of increased depression and anxiety in members of Asian communities as a result of violence against those communities during the pandemic.

Source: GAO summary of stakeholder input and selected research. | GAO-22-104437

^aSubstance Abuse and Mental Health Services Administration, *Double Jeopardy: COVID-19 and Behavioral Health Disparities for Black and Latino Communities in the U.S.* (Rockville, Md.: 2020).

^bSubstance Abuse and Mental Health Services Administration, *Behavioral Health Barometer: United States, Volume 6: Indicators as Measured Through the 2019 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services*, HHS Publication no. PEP20-07-02-001 (Rockville, Md.: 2020).


^cThe Household Pulse Survey, an experimental data product, is an interagency federal statistical rapid response survey to measure household experiences during the COVID-19 pandemic. These estimates are based on responses to two questions about symptoms of depressive disorder and two questions about symptoms of anxiety disorder in the prior 7 days. The percentage of adults include those who reported symptoms that generally occurred more than half the days or nearly every day. The margin of error for these estimates varied, but ranged from about ± 1 to 4 percentage points at the 95 percent confidence level. See appendix I for details on the Household Pulse Survey and these estimates, including response rates and nonresponse bias analysis.

^dN. Panchal, R. Garfield, C. Cox et al. *Substance Use Issues Are Worsening Alongside Access to Care* (San Francisco, Ca.: Kaiser Family Foundation, Aug. 12, 2021), accessed October 5, 2021, <https://www.kff.org/policy-watch/substance-use-issues-are-worsening-alongside-access-to-care>. The analysis was based on Centers for Disease Control and Prevention drug overdose death data, including provisional data for 2020, and Census Bureau population estimates.

^eNational Institutes of Health officials cited T. O. Mitchell and L. Li, "State-Level Data on Suicide Mortality During COVID-19 Quarantine: Early Evidence of a Disproportionate Impact on Racial Minorities," *Psychiatry Research*, vol. 295 (2021).

Health care workers. Twenty-two stakeholders raised concerns about behavioral health risks to health care workers. Multiple stakeholders cited a range of factors that could adversely affect these workers' behavioral health, such as the fear of contracting COVID-19 or transmitting it to family members, exhaustion, burnout, and losing patients due to COVID-19. See figure 3 for examples of information from stakeholders and research.

Figure 3: Health Care Workers: Examples of Information about Behavioral Health Risks

 <p>HEALTH CARE WORKERS</p>	<p>Before the COVID-19 pandemic</p> <ul style="list-style-type: none"> Behavioral health risks among health care workers were already high, according to a National Academies of Science, Engineering, and Medicine report.^a The report cited studies showing that women in the health care workforce were especially at risk of death by suicide, and 44 percent of physicians reported symptoms of burnout. During prior disease outbreaks, such as the Severe Acute Respiratory Syndrome outbreak in 2002-2003, health care workers have experienced symptoms of behavioral health effects such as anxiety, depression, and post-traumatic stress disorder, according to researchers.^b
	<p>During the COVID-19 pandemic</p> <ul style="list-style-type: none"> Working in health care settings has had a significant negative impact on emotional well-being, according to a National Academies report on COVID-19 and behavioral health.^c The report noted that health care workers "have felt anger, frustration, anguish, grief, fear, and anxiety for themselves and their families"—and that in the longer term, "worsening mental health conditions (e.g., insomnia, burnout, and post-traumatic stress disorder) are emerging." U.S. health care workers were struggling more with behavioral health issues, according to a May 2021 Substance Abuse and Mental Health Services Administration (SAMHSA) bulletin. For example, SAMHSA cited a Yale University study that found that among about 1,100 health workers from a non-representative sample of 25 academic medical centers surveyed early in the pandemic in May 2020, there was a rate of probable major depression of 14.0 percent, probable generalized anxiety disorder of 15.8 percent, and probable post-traumatic stress disorder of 23.1 percent.^d Representatives from a psychiatric nurses' association told us the results of a December 2020 American Nurses Foundation survey of nurses' mental health and wellness found that members had reported exhaustion, isolation, sadness, and sleep issues related to anxiety, as well as overeating and drinking too much alcohol. Representatives from a hospital association said in October 2020 that COVID-related burnout was affecting hospital staff at all levels, including clinicians, administrative staff, food service staff, and security guards. Representatives from a consumer group told us that medical professionals were experiencing tremendous burnout as well as post-traumatic stress disorder, but that they might not seek help due to concerns about being stigmatized, isolated, or penalized in their workplace as a result.

Source: GAO summary of stakeholder input and selected research. | GAO-22-104437

^aNational Academies of Sciences, Engineering, and Medicine, *Rapid Expert Consultation on Understanding Causes of Health Care Worker Deaths Due to the COVID-19 Pandemic (December 10, 2020)* (Washington, D.C.: The National Academies Press, 2020).

^bS. W. H. Chau, O. W. H. Wong, R. Ramakrishnan et al., "History for Some or Lesson for All? A Systematic Review and Meta-analysis on the Immediate and Long-Term Mental Health Impact of the 2002–2003 Severe Acute Respiratory Syndrome (SARS) Outbreak," *BMC Public Health*, vol. 21, no. 1 (April 7, 2021); J. M. Cénata, N. Felix, C. Blais-Rochette et al., "Prevalence of Mental Health Problems in Populations Affected by the Ebola Virus Disease: A Systematic Review and Meta-

Analysis," *Psychiatry Research*, vol. 289 (July 2020); and G. Salazar de Pablo, J. Vaquerizo-Serrano, A. Catalan et al. "Impact of Coronavirus Syndromes on Physical and Mental Health of Health Care Workers: Systematic Review and Meta-Analysis," *Journal of Affective Disorders*, vol. 275 (Oct. 1, 2020).

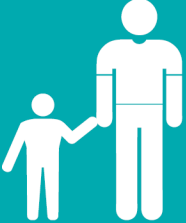
^cAttributed to Dr. Albert Wu, Johns Hopkins University. See National Academies of Sciences, Engineering, and Medicine, *Mental Health and Substance Use Disorders in the Era of COVID-19: The Impact of the Pandemic on Communities of Color: Proceedings of a Workshop in Brief* (Washington, D.C.: The National Academies Press, March 2021).

^dSubstance Abuse and Mental Health Services Administration, *Disaster Technical Assistance Center Supplemental Research Bulletin: A Preliminary Look at the Mental Health and Substance Use-related Effects of the COVID-19 Pandemic*, (Rockville, Md.: May 2021); and R. Hennein and S. Lowe, "A Hybrid Inductive-Abductive Analysis of Health Workers' Experiences and Wellbeing During the COVID-19 Pandemic in the United States," *PLoS ONE*, vol. 15, no. 10 (2020).

Children and adolescents. Nineteen stakeholders raised concerns about the pandemic's effects on children and adolescents. Their concerns stemmed from a range of factors. For example, some stakeholders noted that school closures had adversely affected children's and adolescents' ability to connect with their peers, as well as their access to school-based supports, such as behavioral health screening and services and adults who could identify potential abuse and neglect. Some stakeholders noted that children's and adolescents' well-being can be affected by their homes and communities. Negative experiences that may occur due to the pandemic, such as parental substance use, financial hardship, and food insecurity, can put them at risk for behavioral health conditions in the short-term and into adulthood.³⁶ See figure 4 for examples of information from stakeholders and research.

³⁶See CDC, *Adverse Childhood Experiences Prevention Strategy* (Atlanta, Ga.: 2021).

Figure 4: Children and Adolescents: Examples of Information about Behavioral Health Risks

<p>CHILDREN AND ADOLESCENTS</p> 	<p>Before the COVID-19 pandemic</p> <ul style="list-style-type: none"> Increasing numbers of U.S. high school students reported persistent feelings of sadness or hopelessness, serious contemplation of suicide, and suicide attempts from 2009 to 2019, according to the Centers for Disease Control and Prevention (CDC).^a The percentage of adolescents age 12 to 17 who had a major depressive episode increased from 2004 to 2019, and the rate of suicide among girls age 10 to 14 also increased during that time period.^b
	<p>During the COVID-19 pandemic</p> <ul style="list-style-type: none"> In October and November 2020, 22 percent of parents of children aged 5–12 years in public or private schools reported that their child’s mental or emotional health was worse than before the pandemic, according to a survey conducted by CDC.^c Early in the pandemic, in May 2020, a set of emergency departments reporting visits for suspected suicide attempts showed an increase in those visits among adolescents aged 12 to 17 years, especially girls. About one year into the pandemic, from February 21–March 20, 2021, suspected suicide attempt visits were about 51 percent higher among girls that age than during the same period in 2019; among boys that age, suspected suicide attempt visits increased about 4 percent.^d As of April 2021, just under 105,000 U.S. children had lost a parent due to COVID-19, according to estimates from a global study led by CDC.^e Officials in one jurisdiction told us that with fewer eyes on children during the pandemic, children with behavioral health needs or experiencing abuse at home might not be identified by teachers or other school staff. These officials stated that the city’s child protective agency had received fewer calls during the pandemic, but the calls received involved more serious cases of abuse, injury, and neglect. Local children’s hospital staff had reported more cases of violence in the home during the pandemic, these officials said. Behavioral health clinic staff in one state told us they had lost contact with many children because they were not in school: “Some of our youth clients have simply almost dropped out of sight with respect to services. There is tremendous risk. It is very scary.”

Source: GAO summary of stakeholder input and selected research. | GAO-22-104437

^aCenters for Disease Control and Prevention, *Youth Risk Behavior Survey Data Summary & Trends Report 2009-2019*, accessed October 25, 2021, <http://www.cdc.gov/YRBSS>.

^bSubstance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health*, (Rockville, Md.: September 2020); and H. Hedegaard, S.C. Curtin, and M. Warner, *Suicide Mortality in the United States, 1999–2019*, NCHS Data Brief, no 398 (Hyattsville, Md.: National Center for Health Statistics, February 2021).


^cJ. V. Verlenden, S. Pampati, C.N. Rasberry et al., *Association of Children’s Mode of School Instruction with Child and Parent Experiences and Well-Being During the COVID-19 Pandemic—COVID Experiences Survey, United States, October 8–November 13, 2020*, MMWR Morbidity and Mortality Weekly Report, vol.70, no.11 (Atlanta, Ga.: Centers for Disease Control and Prevention, Mar. 19, 2021).

^dE. Yard, L. Radhakrishnan, M. F. Ballesteros et al., *Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID-19 Pandemic — United States, January 2019–May 2021*, MMWR Morbidity and Mortality Weekly Report, vol. 70, no. 24 (2021) (Atlanta, Ga: Centers for Disease Control and Prevention, June 18, 2021).

^eS.D. Hillis, H.J.T. Unwin, Y. Chen et al., “Global Minimum Estimates of Children Affected by COVID-19-Associated Orphanhood and Deaths of Caregivers: A Modelling Study,” *The Lancet*, vol. 398 (2021).

People with pre-existing behavioral health conditions. Nineteen stakeholders identified people with substance use disorder, serious mental illness, or other pre-existing behavioral health conditions as potentially at higher risk of behavioral health effects due to the pandemic. Pandemic-related factors, such as social isolation, increased stress, and unemployment, can worsen existing behavioral health conditions or lead to relapse among people in recovery for alcohol use disorder and other substance use disorders, according to stakeholders. In addition, the pandemic created challenges accessing care, such as the inability to have in-person contact with groups or treatment providers, and reduced access to residential programs due to social distancing measures, some stakeholders said. Further, telehealth—services provided remotely via technology—might not be a viable or preferred option for some people with pre-existing conditions, some stakeholders said. See figure 5 for examples of information from stakeholders and research.

Figure 5: People with Pre-Existing Behavioral Health Conditions: Examples of Information about Behavioral Health Risks

<p>PEOPLE WITH PRE-EXISTING BEHAVIORAL HEALTH CONDITIONS</p> 	<p><i>Before the COVID-19 pandemic</i></p> <ul style="list-style-type: none"> • In 2019, adults who had a serious mental illness were more likely to have misused opioids (e.g. used heroin or misused prescription pain relievers) in the past year than those who did not have any mental illness (13.8 percent vs 2.5 percent), according to data from the Substance Abuse and Mental Health Services Administration.^a • Mental illness is a risk factor that increases a person’s likelihood of suicide, according to the Centers for Disease Control and Prevention (CDC).^b
	<p><i>During the COVID-19 pandemic</i></p> <ul style="list-style-type: none"> • CDC reported that, among adults responding to a June 2020 survey, those who reported receiving treatment for previously diagnosed anxiety, depression, or post-traumatic stress disorder reported higher rates of suicidal ideation than those who did not. Twenty-two percent of people receiving treatment for prior depression reported seriously considering suicide in the past 30 days, compared to 9 percent of people not being treated for depression. Respondents receiving treatment for these conditions also were more likely to report initiating or increasing substance use to cope with pandemic-related stress or emotions.^c • Representatives from a behavioral health association told us that the pandemic is a “perfect bad storm” with anxiety, isolation, and other issues leading to increases in substance use. The COVID-19 pandemic created an environment of isolation and social distancing, both of which are antithetical to addiction treatment, association officials said. They noted that people were also afraid to go to treatment. • Officials in one state told us that their primary behavioral health concern during the pandemic was substance use disorder relapse and nonfatal and fatal overdoses. The head of a behavioral health clinic in that same state said she was most concerned about people with severe and persistent mental illness who are isolated and do not have social support. She also noted concerns about people with a history of trauma who self-medicate through substance use. • Officials in another state described concerns about people with serious mental illness, especially those with complex needs, who had lost connections to outpatient care settings when facilities shut down due to the pandemic. As of May 2021, officials said it was unclear whether there are people who were not able to access telehealth services or for whom telehealth services do not meet their needs. (Telehealth services are services provided remotely via technology.)

Source: GAO summary of stakeholder input and selected research. | GAO-22-104437


^aSubstance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health*, (Rockville, Md.: September 2020).

^bCenters for Disease Control and Prevention, *Suicide Prevention: Risk and Protective Factors*, accessed June 1, 2021, <https://www.cdc.gov/suicide/factors/index.html>.

^cM. É. Czeisler, R. I. Lane, E. Petrosky et al., *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020*, MMWR Morbidity and Mortality Weekly Report, vol. 69, no. 32 (2020): pp. 1049-1057 (Atlanta, Ga.: Centers for Disease Control and Prevention, Aug. 14, 2020).

Young adults. Sixteen stakeholders raised concerns about young adults. Some stakeholders cited factors such as young adults’ relatively higher rates of social isolation and loneliness before the pandemic, as well as the increases in social isolation and employment challenges due to the pandemic. See figure 6 for examples of information from stakeholders and research.

Figure 6: Young Adults: Examples of Information about Behavioral Health Risks

<p>YOUNG ADULTS</p> 	Before the COVID-19 pandemic
	<ul style="list-style-type: none"> From 2015 to 2019, young adults age 18 to 25 reported the highest rates of having any mental illness and having serious thoughts of suicide, followed by adults aged 26-49 and those age 50 and over, according to Substance Abuse and Mental Health Services Administration (SAMHSA) data.^a A study based on surveys of a non-representative sample of people in the U.S. found that young adults reported higher rates of loneliness than other adults; loneliness and social isolation are associated with poorer mental health.^b
	During the COVID-19 pandemic
	<ul style="list-style-type: none"> The Census Bureau’s Household Pulse Survey found that people age 18 to 29 have consistently reported the highest rates of symptoms of anxiety disorder or depressive disorder, across all age groups. From August 18 – August 30, 2021, 46.7 percent of these young adults reported such symptoms, as compared to 40.7 percent of adults age 30-39, who had the next highest rate.^c In a separate survey in June 2020, people age 18 to 24 reported the highest rates of symptoms of various behavioral health conditions, suicidal ideation, and initiating or increasing substance use to cope with pandemic-related stress or emotions, across all age groups. For example, 25.5 percent reported seriously considering suicide in the prior 30 days, compared with 16.0 percent of people age 25 to 44 and 3.8 percent of people age 45 to 64, according to the Centers for Disease Control and Prevention’s report on this survey.^d A May 2021 SAMHSA research bulletin said researchers have found higher rates of anxiety, depression, traumatic stress, and other issues among young adults (ages 18 to 35) than older age groups. Noting that there are exceptions, SAMHSA wrote “young people seem to be a uniquely vulnerable population in the current pandemic.”^e Officials in one jurisdiction said youth transitioning out of high school and into adulthood were one population particularly at risk. Officials cited the importance of friends and social interactions during this phase of life and noted that youth were confined to home at times during the pandemic. One researcher told us that past economic downturns and crises were linked to poor behavioral health outcomes. He was concerned that for young adults entering the job market, the economic situation due to the pandemic could have a negative impact on their behavioral health.

Source: GAO summary of stakeholder input and selected research. | GAO-22-104437

Note: The different young adult age ranges shown above reflect the varying age categories cited in selected research.

^aSubstance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2019 National Survey on Drug Use and Health*, (Rockville, Md.: September 2020).

^bB. Shovestul, J. Han, L. Germine et al. "Risk Factors for Loneliness: The High Relative Importance of Age Versus Other Factors," *PLoS ONE*, vol.15, no. 2 (2020); N. Leigh-Hunt N, D. Bagguley, K. Bash et al. "An Overview of Systematic Reviews on the Public Health Consequences of Social Isolation and Loneliness," *Public Health*, vol. 152 (2017); and National Academies of Sciences, Engineering, and Medicine, *Social Isolation and Loneliness in Older Adults: Opportunities for the Health Care System*, (The National Academies Press; Washington, D.C.: 2020).


^cThe Household Pulse Survey, an experimental data product, is an interagency federal statistical rapid response survey to measure household experiences during the COVID-19 pandemic. These estimates are based on responses to two questions about symptoms of depressive disorder and two questions about symptoms of anxiety disorder in the prior 7 days. The percentage of adults include those who reported symptoms that generally occurred more than half the days or nearly every day. These estimates have a margin of error of about ± 2 percentage points at the 95 percent confidence level. See appendix I for details on the Household Pulse Survey and these estimates, including response rates and nonresponse bias analysis.

^dM. É. Czeisler, R. I. Lane, E. Petrosky et al., *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020, MMWR Morbidity and Mortality Weekly Report*, vol. 69, no. 32 (2020): p. 1049-1057 (Atlanta, Ga.: Centers for Disease Control and Prevention, Aug. 14, 2020).

^eSubstance Abuse and Mental Health Services Administration, *Disaster Technical Assistance Center Supplemental Research Bulletin: A Preliminary Look at the Mental Health and Substance Use-related Effects of the COVID-19 Pandemic*, (Rockville, Md.: May 2021).

People facing financial distress. Fourteen stakeholders identified people experiencing financial distress as potentially at higher risk. We include in this population people experiencing unemployment, housing or food insecurity, low incomes, or other situations related to financial distress. Some stakeholders noted that job loss, being homeless, not having enough food, and other financial difficulties can adversely affect behavioral health. See figure 7 for examples of information from stakeholders and research.

Figure 7: People Facing Financial Distress: Examples of Information about Behavioral Health Risks

<p>PEOPLE FACING FINANCIAL DISTRESS</p> 	Before the COVID-19 pandemic
	<ul style="list-style-type: none"> • Job loss and financial problems are risk factors that increase the possibility of suicide, according to the Centers for Disease Control and Prevention.^a
	During the COVID-19 pandemic
	<ul style="list-style-type: none"> • A study examining rates of depression pre-pandemic and in March-April 2020 found that adults were more likely to experience depression symptoms early in the pandemic if their incomes were lower than \$20,000 or they had less than \$5,000 in savings, after controlling for other factors. The prevalence of depression symptoms in the U.S. was more than three-fold higher early in the pandemic than before the pandemic.^b • A nationally representative survey in July 2020 found that 21.2 percent of adults with household incomes of less than \$35,000 reported symptoms of serious psychological distress, as compared with about 7 percent of adults with household incomes of \$75,000 or more.^c • Federal officials from the Administration for Children and Families, within the Department of Health and Human Services, told us that communities with concentrated poverty face significant barriers to accessing high-quality mental health support. As a result, officials said, people in these communities may be at greatest risk for behavioral health effects due to the pandemic, in both the short term and long term. • Officials in one state told us that one of their most pressing behavioral health concerns was people experiencing housing and food insecurities, as well as economic impacts, sometimes for the first time. Officials said these individuals may not know what support is available to them or how to access it. • Representatives from a psychiatric nurses' association told us that losing a job can worsen the behavioral health of people without a pre-existing condition and exacerbate the conditions of those who have a pre-existing condition.

Source: GAO summary of stakeholder input and selected research. | GAO-22-104437

^aCenters for Disease Control and Prevention, *Suicide Prevention: Risk and Protective Factors*, accessed June 1, 2021, <https://www.cdc.gov/suicide/factors/index.html>.

^bC. K. Ettman, S. M. Abdalla, G. H. Cohen et al., "Prevalence of Depression Symptoms in US Adults Before and During the COVID-19 Pandemic," *JAMA Network Open*, vol. 3, no. 9 (2020).

^cE. E. McGinty, R. Presskreischer, K.E. Anderson et al. "Psychological Distress and COVID-19-Related Stressors Reported in a Longitudinal Cohort of U.S. Adults in April and July 2020," *JAMA*, vol. 324 no. 24 (2020).

Other Populations Stakeholders Identified As At Risk for Behavioral Health Effects

- Women
- Older adults
- Parents of young or school-aged children
- People who were diagnosed with COVID-19
- Essential workers
- Individuals who are lesbian, gay, bisexual, or transgender
- People with fewer social supports
- People experiencing domestic violence
- People living in rural areas
- Unpaid caregivers of adults
- People with limited education

Source: GAO analysis of stakeholder input and selected research. | GAO-22-104437

A smaller share of stakeholders we interviewed, and selected research, identified other populations that may also be at higher risk of behavioral health effects due to the pandemic.³⁷ These 11 populations could be at higher risk for a range of reasons, according to stakeholders. For example, some populations' occupations or roles put them at risk, such as essential workers and parents of young or school-aged children. Other populations—such as people with fewer social supports and people experiencing domestic violence—were at higher risk of behavioral health conditions prior to the pandemic and could experience exacerbated conditions, according to some stakeholders. People diagnosed with COVID-19 might be at higher risk, according to multiple stakeholders; however, some stakeholders said it was too early to know what the implications of a COVID-19 diagnosis were for behavioral health. See appendix II for information about behavioral health risks for these populations.

Observations From a Physician Who Treats Hospitalized Patients

We spoke with a physician-researcher who was concerned about the behavioral health of people of races and ethnicities other than White, particularly in communities with many COVID-19 deaths. He said the pandemic has combined economic uncertainty; grief and loss; and health-related fears—and he sees patients “who are facing all of these issues at once.” He described, for example, a 23-year-old patient who was hospitalized for a chronic medical condition. The patient had lost multiple family members due to COVID-19, including his mother and uncle. The patient's two self-reported symptoms were pain and depression.

Source: GAO summary of stakeholder input. | GAO-22-104437

Some people's characteristics or circumstances may include them in more than one of the higher-risk populations described above, which may lead to compounding behavioral health risks for them. For example, people from certain racial and ethnic groups are more likely than non-Hispanic White individuals to work in industries that have been particularly at risk for loss of income during the pandemic, such as retail and hospitality; this places some individuals in two higher-risk groups: people from certain racial and ethnic groups, and people facing financial distress.³⁸ Health care workers may be at higher risk due not only to their profession, but also if they are in other higher-risk groups, such as parents of young or school-aged children, women, or people from certain racial and ethnic groups. Members of American Indian/Alaska Native communities may also be at higher risk due to a combination of factors (see text box). Nonetheless, people in one or more higher-risk population will not necessarily develop behavioral health symptoms or conditions, as protective factors can mitigate the behavioral health risks they face.

³⁷These populations are not meant to be exhaustive of all other populations potentially at higher risk of behavioral health effects due to the pandemic, but reflect stakeholder input we received and selected research we reviewed. There may be other populations also at higher risk that our stakeholders did not identify.

³⁸See Substance Abuse and Mental Health Services Administration, *Double Jeopardy: COVID-19 and Behavioral Health Disparities for Black and Latino Communities in the U.S.* (Rockville, Md.: 2020).

American Indians/Alaska Natives: Observations on Pandemic-Related Behavioral Health Risks

We spoke with some tribal organizations about the experiences of American Indians/Alaska Natives during the pandemic and factors that may put them at higher risk of behavioral health effects. An official from one tribe explained the multiple risk factors converging for that tribe:

The tribal official told us that financial stability decreased, the removal of free and reduced cost school lunch most children received led to food insecurity, and social networks were removed as people were remanded to their homes. He also noted that the tribe's reservation is rural and remote, with limited telephone and internet services, creating challenges for implementing telehealth during the pandemic. He said that these challenges made it difficult for tribal members to work from home, saying that many were sent home to do nothing—due to lack of equipment or broadband internet access—which led to major depressive episodes and increased substance use. He expressed concern that lifetime mental health and substance use disorder problems could result from the pandemic—noting that the tribe already had substance use problems and COVID-19 only made things worse.

Source: GAO summary of stakeholder input. | GAO-22-104437

Pandemic's Long-Term Effects on Various Populations' Behavioral Health Are Unknown

Social Isolation and Behavioral Health

A researcher who studies social isolation and loneliness told us that prior to the COVID-19 pandemic, social isolation and loneliness were linked to poorer behavioral health outcomes, such as depression and anxiety, as well as dementia and other types of cognitive decline.

Pre-pandemic, certain populations reported relatively higher rates of social isolation and loneliness, this researcher said. These populations included, for example, young adults; people with mental or physical conditions; people with lower income, less education, or who were unemployed; and people with disabilities.

Social connection, on the other hand, can serve as a protective factor that protects against poor behavioral health outcomes.

Source: GAO summary of stakeholder input. | GAO-22-104437

The COVID-19 pandemic is ongoing as of this report and it will take time to determine how different populations may be affected in the long-term, multiple stakeholders said. Some stakeholders noted that emerging COVID-19 variants, such as Delta, and changes in COVID-19 case numbers, vaccination rates, and the job market create a dynamic situation.³⁹ Multiple stakeholders said there is uncertainty about how different populations may fare and whether new higher-risk populations might emerge over time. Officials from one state, for example, said that new populations of people who had not previously sought behavioral health services might find they need help due to anxiety, depression, mood disorders, or post-traumatic stress disorder. Some stakeholders noted that the pandemic is unprecedented due to its duration, widespread economic impact, periods of isolation, and other factors. Social isolation on such a large scale was an unprecedented aspect of the pandemic and questions remain about its long-term implications for behavioral health, according to some stakeholders. In addition, some stakeholders noted that as with prior crises, they expect some people will see their behavioral health symptoms resolve, others will have persistent effects, and still others will find that new symptoms or conditions manifest over time. As a result, it will take time to determine the long-term behavioral health effects resulting from the pandemic.

³⁹As of November 30, 2021, the Department of Health and Human Services had characterized two of the COVID-19 variants—Delta and Omicron—as public health concerns. As of the week ending November 13, 2021, the proportion of current cases attributed to the Delta variant was estimated to be greater than 99 percent nationally, according to CDC. CDC reported that the Delta variant is more than twice as contagious as previous variants.

Multiple stakeholders also said they did not have a complete picture of how different populations have been affected during the pandemic. They cited a range of data gaps and other limitations that led to challenges in assessing the pandemic's effects on behavioral health. Some challenges, such as pandemic-driven changes in data collection methods, stemmed from the pandemic itself. Other challenges pertained more broadly to assessments of behavioral health, regardless of the pandemic. For example, National Institutes of Health officials said a key challenge during the pandemic stemmed from studies having to pivot to collect data in ways that were in line with public health mitigation efforts. They stated that researchers moved from collecting data in-person to collecting it remotely, typically through online platforms. This presented a new challenge in reaching people with little or no internet access. SAMHSA has noted that studies based on surveys of self-reported symptoms do not reflect whether a respondent meets the diagnostic criteria for a behavioral health condition, which requires a more thorough assessment. In addition, National Institutes of Health officials told us that data on suicides often lag due to the time needed to adjudicate cause of death, and that those data lags had been exacerbated by competing demands for medical examiners to determine COVID-19 related deaths. Also, some stakeholders noted that during the pandemic there have been additional factors that have potentially affected peoples' behavioral health, such as wildfires and the political climate; this makes it difficult to distinguish the pandemic's impact from the impact of other factors, according to some researchers.

Moving forward, multiple stakeholders emphasized the importance of data collection and research to assess the pandemic's ongoing effects on behavioral health. CDC officials, for example, added questions to the National Health Interview Survey in 2020 to identify people who had been diagnosed with COVID-19; the survey would help provide information related to the behavioral health of those diagnosed with COVID-19, officials said. The National Institutes of Health has funded a range of efforts to determine how the pandemic is affecting behavioral health. SAMHSA officials told us that they plan to publish additional information in 2022 to help inform mental health professionals about what new research is finding about the pandemic's effect on behavioral health.

As of November 2021, HHS and FEMA Awarded Over \$8 Billion in COVID-19 Relief Funding for Behavioral Health Mainly through Existing Programs, Such As Block Grants

Most COVID-19 Relief Funding for Behavioral Health Was Awarded to States and Community-Based Providers through Four Existing and Two New Programs

Based on our review of the three relevant COVID-19 relief acts, funding documentation, and award data, as of November 2021, the federal government awarded over \$8 billion in COVID-19 relief funding for behavioral health. The three relief acts appropriated about \$8.56 billion to HHS agencies for behavioral health related grant programs or activities specified in the acts; of that amount, about \$8.24 billion was appropriated to SAMHSA.⁴⁰ (See table 1.) This funding was in addition to regular annual appropriations for SAMHSA in fiscal years 2020 and 2021, which were about \$5.74 billion and \$5.87 billion, respectively.

⁴⁰SAMHSA officials said that oversight of COVID-19 relief funds for behavioral health would be conducted in the same way SAMHSA oversees its other grant programs, including activities such as onsite and virtual financial and compliance reviews, required annual financial reporting, and submission of periodic performance and progress reports. SAMHSA's oversight of COVID-19 relief funds was outside the scope of this review.

Table 1: Department of Health and Human Services Programs or Activities Related to Behavioral Health Funded Through the COVID-19 Relief Acts

Appropriations dollars in millions

Program or activity	CARES Act^a (enacted March 27, 2020)	Consolidated Appropriations Act, 2021 (CAA)^b (enacted December 27, 2020)	American Rescue Plan Act of 2021 (ARPA)^c (enacted March 11, 2021)	Total appropriated by program or activity
Substance Abuse Prevention and Treatment Block Grant	—	1,650	1,500	3,150
Community Mental Health Services Block Grant	—	1,650 ^d	1,500	3,150
Certified Community Behavioral Health Clinic Expansion Grants program	250 ^e	600 ^f	420	1,270
Grants to address emergency substance abuse or mental health needs in local communities ^g	100 ^e	240 ^f	—	340
Suicide prevention programs	50 ^e	50 ^f	20 ^h	120
Behavioral health workforce education and training grants	—	—	100	100
Project AWARE ⁱ	—	50	30	80
Mental and substance use disorder training for health care professionals, paraprofessionals, and public safety officers	—	—	80	80
Pediatric mental health care access grants	—	—	80	80
Community-based funding for local behavioral health needs	—	—	50	50
Grants for health care providers to promote mental health among their health professional workforce	—	—	40	40
Community-based funding for local substance use disorder services	—	—	30	30
National Child Traumatic Stress Network	—	10	10	20
Education and awareness campaign encouraging healthy work conditions and use of mental health and substance use disorder services by health care professionals	—	—	20	20
Tribes, tribal organizations, urban Indian health organizations, or health or behavioral health service providers to tribes	15	—	—	15
Totals	425^j	4,250	3,880	8,555^j

Source: GAO analysis of the CARES Act, CAA, and ARPA. | GAO-22-104437

Notes: A dash (—) reflects that no funding was appropriated for this program or activity in the relevant COVID-19 relief act. In addition to the funds noted in this table, federal agencies may have used COVID-19 relief funds available for a range of response activities to fund behavioral health activities.

^aPub. L. No. 116-136, div. B., tit. VIII, 134 Stat. 281, 556 (2020).

^bPub. L. No. 116-260, div. M, tit. III, 134 Stat. 1182, 1913 (2020). This table includes relevant appropriations from Division M of the CAA (Coronavirus Response and Relief Supplemental Appropriations Act, 2021) and does not include behavioral health funds provided for in annual appropriations acts enacted as part of the CAA. The CAA specified that from the amounts noted in this table, a total of not less than \$125 million shall be allocated to tribes, tribal organizations, urban Indian health organizations, or health or behavioral health service providers to tribes. The act also noted that the Substance Abuse and Mental Health Services Administration (SAMHSA) shall maintain the 20 percent set-aside for prevention, but may waive requirements with respect to allowable activities, timelines, or reporting requirements for the Substance Abuse Prevention and Treatment Block Grant and the Community Mental Health Services Block Grant as deemed necessary to facilitate a grantee's response to coronavirus.

^cPub. L. No. 117-2, tit. II, subtit. H, 135 Stat. 4, 45-48.

^dThe CAA specified, that of this amount, SAMHSA was to provide no less than 50 percent directly to community mental health centers.

^eThe CARES Act specified that at least the amount noted be available for this purpose.

^fThe CAA specified that at least the amount noted be available for this purpose.

^gAppropriations are for activities under section 501(o) of the Public Health Service Act, which authorizes noncompetitive grants, contracts, or cooperative agreements to public entities to address emergency substance abuse or mental health needs in local communities.

^hARPA funding related to suicide prevention was designated specifically for youth suicide prevention.

ⁱThe full name of this program is Project AWARE (Advancing Wellness and Resiliency in Education).

^jTotal does not equal the sum of the numbers listed above, because \$10 million of the \$425 million in funding appropriated to SAMHSA in the CARES Act was not designated for a specific program or activity.

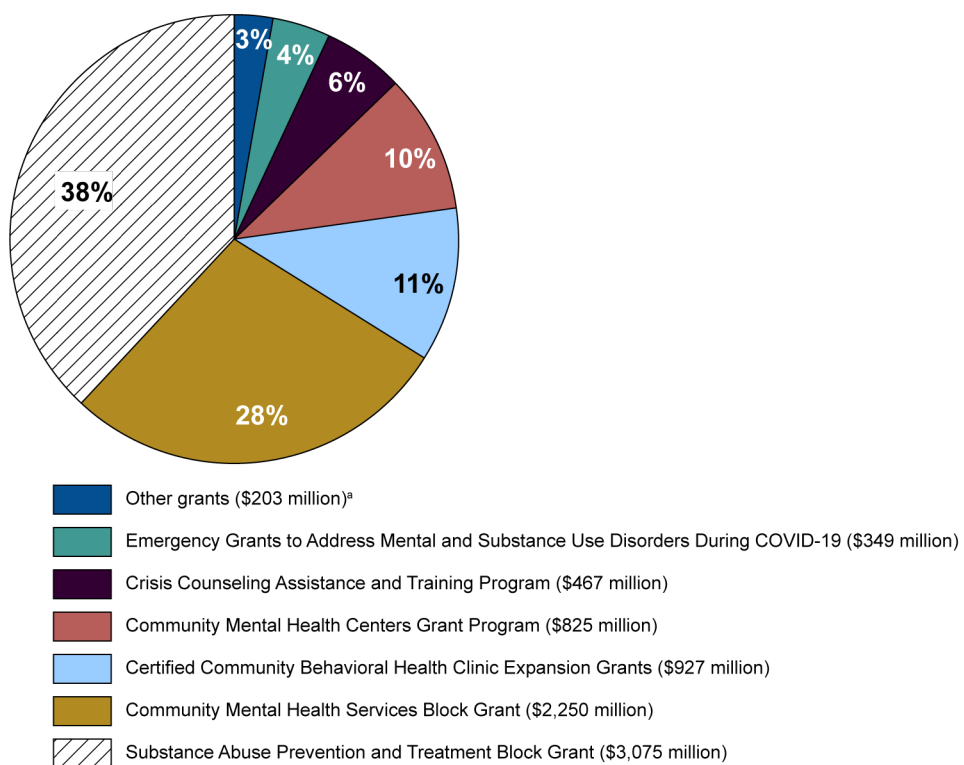
In addition to the \$8.56 billion appropriated to SAMHSA and other HHS agencies, as of November 2021, FEMA has awarded approximately \$467 million in COVID-19 relief funding for behavioral health through its CCP.

Of the over \$8 billion of the COVID-19 relief funding for behavioral health that had been awarded as of November 2021, we found that the majority (over 97 percent) was awarded through six programs, as shown in figure 8:

- the Community Mental Health Services Block Grant,
- the Substance Abuse Prevention and Treatment Block Grant,
- the Certified Community Behavioral Health Clinic (CCBHC) Expansion Grants program,
- FEMA's CCP,
- the Community Mental Health Centers Grant Program, and
- the Emergency Grants to Address Mental and Substance Use Disorders During COVID-19.

Two of these six programs—the Community Mental Health Centers Grant Program, and the Emergency Grants to Address Mental and Substance Use Disorders During COVID-19—were created specifically to respond to the pandemic, while the other four programs pre-dated the pandemic. The six programs provide funding to entities such as state agencies and community behavioral health and mental health centers to, for example, provide behavioral health services directly to persons in need.

Figure 8: Over \$8 Billion in COVID-19 Relief Funding Awarded for Behavioral Health as of November 2021, by Program



Source: GAO analysis of Department of Health and Human Services and Federal Emergency Management Agency award documentation. | GAO-22-104437

^aThis total includes \$4 million that the Centers for Disease Control and Prevention obligated for a national evidence-based campaign related to the prevention of mental health conditions and substance use disorders.

SAMHSA administers five of these six programs; FEMA administers the sixth—the CCP—in partnership with SAMHSA. Specific characteristics of the programs, including eligible funding recipients, award amounts, and

the ways in which SAMHSA and FEMA awarded funds, varied by program, as described below.

Community mental health and substance abuse block grant supplements. The COVID-19 relief acts appropriated about \$5.5 billion as supplemental funding to the existing Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant. As of November 2021, SAMHSA had awarded \$5.325 billion through both block grants to states, Washington, D.C., U.S. territories, and other jurisdictions using an existing formula specified in statute to distribute funding to grantees.⁴¹ These grantees may, in turn, distribute funds to local government entities and nonprofit organizations in accordance with a plan submitted to SAMHSA. See table 2 for summary information about awards made through the two grant programs; see appendix IV for a complete list of award amounts, including per capita amounts, by grantee.

⁴¹SAMHSA also awarded the substance abuse block grant to one tribe. The formula takes into account three measures: (1) the population in need of services (adults aged 18-64 in the state), (2) costs of services in the state, and (3) fiscal capacity of the state. All states, Washington, D.C., and U.S. territories have minimum allotments.

Table 2: Behavioral Health Block Grant Supplemental Funding from COVID-19 Relief Acts as of November 2021

	Community Mental Health Services Block Grant	Substance Abuse Prevention and Treatment Block Grant
Purpose	To allow states, U.S. territories, and other jurisdictions to provide comprehensive community mental health services, and address needs and gaps in existing treatment services for those with severe mental health conditions.	To allow states, U.S. territories, and other jurisdictions to plan, implement, and evaluate activities to prevent and treat substance use disorder. This funding also is intended to allow recipients to maximize efficiency in the existing treatment and recovery infrastructure, promote support for providers, and address unique local needs to deliver substance use disorder prevention.
Amount	<p>Total amount awarded: \$2.25 billion</p> <p>Consolidated Appropriations Act, 2021 (CAA) appropriated \$825 million in December 2020 for states, territories, and other jurisdictions; the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded \$825 million in March 2021.^a</p> <p>American Rescue Plan Act of 2021 (ARPA) appropriated \$1.5 billion in March 2021; SAMHSA awarded \$1.425 billion in May 2021</p> <p>Award amounts ranged from a total of \$187,492 to Palau to about \$295 million to California. Per capita, amounts ranged from about \$5 per capita in Wyoming to \$9.55 per capita in American Samoa.</p>	<p>Total amount awarded: \$3.075 billion</p> <p>CAA appropriated \$1.65 billion in December 2020; SAMHSA awarded \$1.65 billion in March 2021.</p> <p>ARPA appropriated \$1.5 billion in March 2021; SAMHSA awarded \$1.425 billion in May 2021.</p> <p>Award amounts ranged from \$256,239 to Palau to about \$444 million to California. Per capita, amounts ranged from about \$7 per capita in Nebraska to \$18 per capita in Vermont.</p>
Grantees	50 states, Washington, D.C., American Samoa, Guam, Northern Mariana Islands, Puerto Rico, the U.S. Virgin Islands, Federated States of Micronesia, Palau, and Republic of Marshall Islands.	50 states, Washington, D.C., American Samoa, Guam, Northern Mariana Islands, Puerto Rico, the U.S. Virgin Islands, Federated States of Micronesia, Palau, Republic of Marshall Islands, and the Red Lake Band of Chippewa Indians.
Time frames	Grantees have until March 14, 2023, to expend block grant funds from the CAA, and until September 30, 2025, to expend block grant funds from ARPA.	

Source: GAO analysis of COVID-19 relief acts and Substance Abuse and Mental Health Services Administration documentation. | GAO-22-104437

^aAppropriations from the CAA for the Community Mental Health Services Block Grant totaled \$1.65 billion, however, the CAA specified that, of this amount, SAMHSA was to provide no less than 50 percent directly to community mental health centers. Therefore, SAMHSA awarded \$825 million through the Community Mental Health Services Block Grant and \$825 million through the Community Mental Health Centers Grant Program.

CCBHC Expansion Grants program. The COVID-19 relief acts appropriated about \$1.27 billion to the existing CCBHC Expansion Grants program to expand the program's reach.⁴² CCBHCs are to provide a comprehensive collection of services intended to create access, stabilize people in crisis, and provide treatment and recovery support services for those with the most serious and complex mental and substance use disorders. As of November 2021, SAMHSA had awarded about \$927 million of the total appropriated to 267 CCBHCs in 41 states and Guam.⁴³ (See fig. 9.) Grants were concentrated among several states; for example, over 38 percent of the total number of CCBHC Expansion Grants went to CCBHCs in five states.⁴⁴ Clinics in New York—one of the five states—received almost 11 percent of the total grants, the largest percentage of any state.

⁴²The CCBHC Expansion Grants program funds must be used to provide access to services including 24/7 crisis intervention services for individuals with serious mental illness or substance use disorders, including opioid use disorders; children and adolescents with serious emotional disturbance; and individuals with co-occurring mental and substance disorders. SAMHSA expects that this program will provide comprehensive 24/7 access to community-based mental and substance use disorder services; treatment of co-occurring disorders; and physical health care in one single location. CCBHCs cannot be private, for profit organizations, and cannot refuse service to any individual on the basis of ability to pay or place of residence.

Applicants were required to be community-based behavioral health clinics that either currently met the certification criteria, or could be certified within four months. Extensive CCBHC certification criteria fall into six areas: (1) staffing; (2) availability and accessibility of services; (3) care coordination; (4) scope of services; (5) quality and other reporting; and (6) organizational authority, governance, and accreditation.

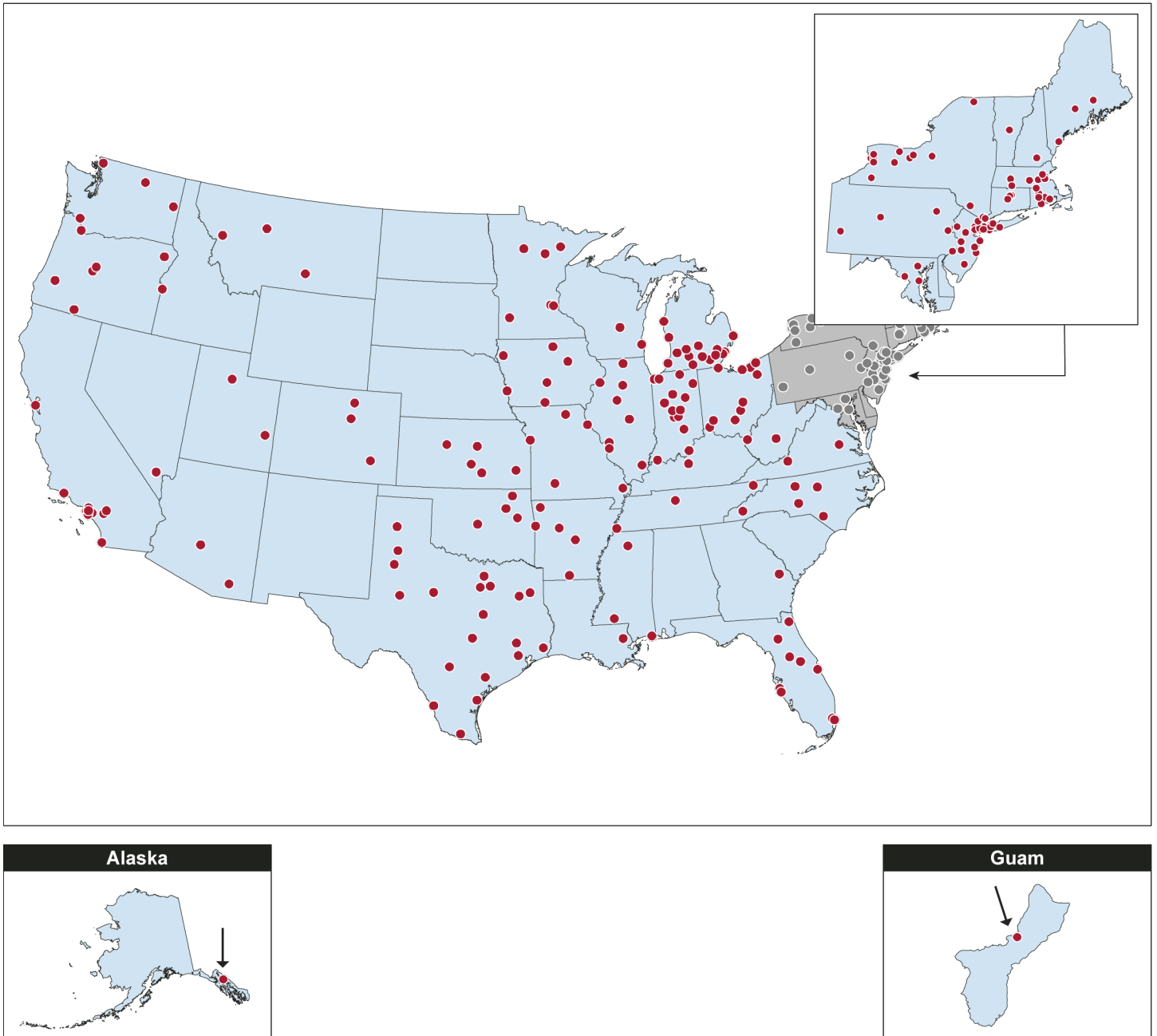
The CCBHC Expansion Grants program received regular appropriations in addition to appropriations from the COVID-19 relief acts.

⁴³The CARES Act and CAA appropriated \$250 million and \$600 million, respectively, all of which was awarded in fiscal years 2020 and 2021. ARPA appropriated \$420 million, of which about \$77 million had been awarded as of November 2021.

A CCBHC Expansion Grants program grantee in Washington, D.C., was not able to use the grant funds it was initially awarded, and according to SAMHSA officials, voluntarily relinquished its award of about \$4 million in April 2021. This award amount is therefore not included in the total.

⁴⁴These states are five of the 25 that participated in SAMHSA's 2016 Planning Grant program, which among other things, supported states' ability to certify clinics as CCBHCs. While CCBHC Expansion Grants from COVID-19 relief acts were available to entities that met the CCBHC certification criteria and could be certified within 4 months of award, SAMHSA gave priority to clinics in the 25 states that were awarded a planning grant.

Figure 9: Location of the Certified Community Behavioral Health Clinic Expansion Grants Program Grantees Awarded Funding Provided by the COVID-19 Relief Acts as of November 2021



Source: GAO analysis of Substance Abuse and Mental Health Services Administration award documentation. | GAO-22-104437

Notes: Clinics in Hawaii and the other U.S. territories besides Guam did not receive grants from the Certified Community Behavioral Health Clinic (CCBHC) Expansion Grants program, and are therefore not pictured above. The CCBHC Expansion Grants program is an existing grant program that has received regular appropriations in addition to appropriations from the three COVID-19 relief acts. The clinics above are only those that received funding from the COVID-19 relief acts.

Award amounts for funds provided by the CARES Act and CAA were up to \$4 million per CCBHC, with a project period of 2 years, while award amounts for funds provided from ARPA were up to \$2 million per CCBHC per year for 2 years.⁴⁵

As of November 2021, most (about 74 percent) of the CCBHCs that received grants from COVID-19 relief funds applied for funding prior to the onset of the pandemic, according to SAMHSA officials. The officials explained that rather than issue a new, COVID-19 specific fiscal year 2020 funding announcement, SAMHSA awarded the supplemental funding provided through the CARES Act and CAA to CCBHCs that had already applied for a grant, but had lower priority scores and had not received funding from regular appropriations under an existing, fiscal year 2020 funding announcement.⁴⁶ Subsequently, SAMHSA issued an additional fiscal year 2021 CCBHC Expansion Grants program funding announcement, through which some clinics have been awarded grants using remaining CAA funds and a portion of ARPA funds. According to SAMHSA officials, the agency plans to issue another funding announcement in fiscal year 2022 through which the remaining expansion grant program funding provided under ARPA will be awarded to additional clinics.

CCP. As of November 2021, FEMA awarded approximately \$467 million to 46 states, Washington, D.C., and four U.S. territories.⁴⁷ Award amounts varied widely, and ranged from a total of \$333,770 to New Hampshire to

⁴⁵SAMHSA officials told us that unlike the CCBHC Expansion Grants program funds provided under the CARES Act and CAA, which were available only through fiscal year 2021, the funds provided under ARPA do not expire and, therefore, awards can be made across more than one fiscal year. As of November 2021, SAMHSA had obligated \$77 million from ARPA for the second year of the project period.

⁴⁶SAMHSA uses peer reviewers who are subject matter experts and generally not SAMHSA employees to evaluate discretionary grant applications. Peer reviewers score applications on a scale of 0-100. The priority score for each application is the mean of the committee members' total scores.

⁴⁷The four U.S. territories receiving funding are Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

about \$110 million to California.⁴⁸ Alaska, Kentucky, and Mississippi, Wyoming either withdrew their application or did not apply for funding. (See app. V.) Recipients can use the funds to assist individuals and communities in recovering from the effects of natural and human-caused disasters through the provision of community-based outreach and psychoeducational services. Historically, the CCP has been a program through which states, Washington, D.C., U.S. territories, and tribes affected by a major disaster can apply for and may receive funding. Such funding typically has been used for disasters that covered a more limited geographic area, such as natural disasters like hurricanes and wildfires. However, in the case of COVID-19, CCP awards span the nation.

COVID-19 specific discretionary grant programs. The COVID-19 relief acts appropriated almost \$1.2 billion to be used for grants to address emergency substance abuse or mental health needs in local communities and grants for community mental health centers. In response, SAMHSA created the Emergency Grants to Address Mental Health and Substance Use Disorders During COVID-19 program and the Community Mental Health Centers Grant Program. As of November 2021, SAMHSA had awarded approximately \$349 million in funding through the Emergency Grants to Address Mental Health and Substance Use Disorders During COVID-19 to 126 grantees, including state agencies, U.S. territories, and tribal entities; and \$825 million in Community Mental Health Centers grant funding to 231 non-profit Community Mental Health Centers. (See table 3.)

⁴⁸According to FEMA officials, recipients requested a specific amount of funding to address their disaster specific needs and provided a written narrative and a budget to justify that amount. The amount of funding FEMA awarded to recipients was based on several factors including: (1) the amount of funding requested; (2) the justification provided; (3) the demonstrated need for the services; and (4) the recipient's capability to provide services.

Table 3: COVID-19 Specific Discretionary Grant Programs from COVID-19 Relief Funding as of November 2021

	Emergency Grants to Address Mental Health and Substance Use Disorder During COVID-19	Community Mental Health Centers Grant Program
Purpose	To provide crisis intervention services, mental and substance use disorder treatment, and other related recovery supports for children and adults affected by the COVID-19 pandemic.	To enable community mental health centers to support and restore the delivery of clinical services that were impacted by the COVID-19 pandemic and address the needs of individuals with serious emotional disturbance (SED), serious mental illness (SMI), and individuals with SMI or SED and substance use disorders, referred to as co-occurring disorder.
Amount	<p>Total amount awarded: \$349 million</p> <p>CARES Act: appropriated \$100 million in March 2020; the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded about \$110 million in April 2020.^a</p> <p>Consolidated Appropriations Act, 2021 (CAA): appropriated \$240 million in December 2020; SAMHSA awarded about \$239 million in March 2021.</p> <p>Base awards: State agencies and Washington, D.C., received funding amounts of up to \$2 million, and territories and tribal entities received up to \$500,000.^b</p> <p>Supplements: According to SAMHSA officials, tribal entities received supplements of about 217 percent of their base award, while states received 143 percent of their base awards. State agencies generally received about \$2.86 million.</p>	<p>Total amount awarded: \$825 million</p> <p>CAA: appropriated \$825 million in December 2020;^c SAMHSA awarded \$825 million in September 2021.</p> <p>Award amounts ranged from \$221,747 to \$5 million depending on the minimum number of unduplicated individuals with SMI, SED, and co-occurring disorder the community mental health center planned to serve per year with grant funds.</p>
Grantees	<p>126 total including 50 state agencies, Washington, D.C., four U.S. territories, and 71 tribal entities.</p> <p>According to SAMHSA, all applicants that applied received base funding in fiscal year 2020 or 2021 unless they declined it or did not respond to inquiries from SAMHSA. All grantees that received base funding received supplemental funding in fiscal year 2021 unless they declined it.</p>	<p>231 non-profit community mental health centers including state and local government-operated centers.</p> <p>Grantees had to meet two additional requirements related to the provision of services: a community mental health center must be the applicant organization, and must have at least 2 years of experience providing relevant services.</p>
Time frames	Project period of up to 16 months.	Project period of up to 2 years.

Source: GAO analysis of COVID-19 relief acts and SAMHSA documentation. | GAO-22-104437

^aTen million dollars of the \$425 million in funding appropriated to SAMHSA in the CARES Act was not designated for a specific program or activity. According to SAMHSA officials, the agency used this \$10 million to award additional grants through the Emergency Grants to Address Mental Health and Substance Use Disorder During COVID-19 program.

^bNinety-six grantees were selected for base funding from the fiscal year 2020 funding opportunity announcement funding, which resulted in 32 unfunded applicants. SAMHSA officials said they awarded grants starting at the highest score until the money was expended. In fiscal year 2021, 30 previously unfunded applicants were awarded base funding. Two tribal entities were not awarded base funding, because, according to SAMHSA officials, one applicant never responded to an inquiry after SAMHSA reached out multiple times, and one declined the funding.

^cThese funds were part of \$1.65 billion in total appropriations from the CAA to the Community Mental Health Services Block Grant. The CAA specified that, of this amount, SAMHSA was to provide no less than 50 percent directly to community mental health centers. Therefore, SAMHSA awarded \$825

million through the Community Mental Health Services Block Grant and \$825 million through the Community Mental Health Centers Grant Program.

Remaining COVID-19 Relief Funding for Behavioral Health Provided Through Multiple HHS Programs, Including Four Suicide Prevention Grant Programs

Our review of COVID-19 relief laws, award documentation, and data shows that the remaining approximately \$635 million of the nearly \$8.56 billion in total appropriated funding for HHS agencies from the three COVID-19 relief acts is being provided through multiple HHS programs, including four suicide prevention grant programs.

Suicide prevention programs. As of November 2021, SAMHSA had awarded almost \$100.5 million of \$120 million appropriated in the three relief acts for suicide prevention through four grant programs. One of these programs—the COVID-19 Emergency Response for Suicide Prevention Grant Program—was created to respond to the pandemic. The other three programs—the Suicide Prevention Lifeline Crisis Center Follow-Up Expansion Grant Program, the National Suicide Lifeline and Disaster Distress Helpline Cooperative Agreement, and the Garrett Lee Smith Campus Suicide Prevention Grant Program—were previously funded with annual appropriations; SAMHSA used relief funds to expand the reach of these programs. (See table 4.)

Table 4: COVID-19 Relief Funding for Suicide Prevention Programs as of November 2021

COVID-19 relief grant program	Purpose	Information about award amounts and types of grantees
Funded through the CARES Act		
Suicide Prevention Lifeline Crisis Center Follow-Up Expansion Grant Program	To provide an integrated hub that (1) ensures systematic follow-up of suicidal persons who contact a National Suicide Lifeline Crisis Center; (2) provides enhanced coordination of crisis stabilization, crisis respite, and hospital emergency department services; and (3) enhances coordination with mobile on-site crisis response.	Substance Abuse and Mental Health Services Administration (SAMHSA) awarded about \$3 million to three National Suicide Prevention Lifeline crisis centers. ^a Grantees applied for this grant program before the onset of the pandemic. SAMHSA awarded these funds in fiscal year 2020 to the three highest scoring non-funded applications from a fiscal year 2019 funding opportunity announcement.
Funded through the CARES Act and Consolidated Appropriations Act, 2021 (CAA)		
COVID-19 Emergency Response for Suicide Prevention Grant Program	To support states and communities during the COVID-19 pandemic in advancing efforts to prevent suicide and suicide attempts among adults age 25 and older in order to reduce the overall suicide rate and number of suicides in the U.S. SAMHSA required that a minimum of 25 percent of direct services funding be used to support victims of domestic violence. According to the funding opportunity announcement, domestic violence can lead to situations of increased stress, anxiety, depression, and trauma, which are risk factors for suicide if left unaddressed. Current conditions exacerbate this situation for domestic violence victims.	SAMHSA awarded about \$40 million from the CARES Act to 50 grantees in fiscal year 2020, and \$17.8 million from the CAA to 26 grantees in fiscal year 2021. ^b Grantees received requested funding amounts up to \$800,000 for a 16 month project period. Grantees included states, Washington, D.C., and U.S. territories; community-based behavioral healthcare organizations; public health agencies; and federally recognized American Indian/Alaskan Native tribes, among others.
Cooperative Agreement for National Suicide Prevention Lifeline and Disaster Distress Helpline	To manage, enhance, and strengthen the National Suicide Lifeline that routes individuals in the U.S. to a network of certified crisis centers that links to local emergency, mental health, and social services resources; and support the Disaster Distress Helpline to assist residents in the U.S. and its territories who are experiencing emotional distress resulting from disasters and traumatic events. ^c This grant funding will be used to support the nation's call centers' capacity and technological readiness as the National Suicide Lifeline's shift to 988 becomes operational. ^d	SAMHSA awarded over \$7 million in CARES Act funding in fiscal year 2020, and \$32 million in CAA funding in fiscal year 2021 to Vibrant Emotional Health. ^e According to SAMHSA officials, the over \$7 million from the CARES Act was used to ensure that Vibrant Emotional Health was prepared for potential increases in calls, online chats, and text message support to the lifelines.
Funded through the American Rescue Plan Act of 2021		
Garrett Lee Smith Campus Suicide Prevention	To develop a comprehensive, collaborative, well-coordinated, and evidence-based approach to (1) enhance mental health services for all college students; (2) prevent mental and substance use disorders; (3) promote help-seeking behavior and reduce negative public attitudes; and (4) improve the identification and treatment of at-risk college students so they can successfully complete their studies.	SAMHSA awarded \$741,252 to eight colleges and universities in fiscal year 2021. ^f Grantees received up to \$102,000, and will each year for 3 years. SAMHSA will continue to fund these grants annually during a 3-year project period for a total of \$2.2 million. Grantees included private and public non-profit institutions of higher education, including tribal colleges and universities.

Source: GAO analysis of SAMHSA award documentation. | GAO-22-104437

^aThe National Suicide Prevention Lifeline is a 24/7 confidential suicide prevention hotline and chat network for anyone in the United States experiencing a suicidal crisis or emotional distress. Callers can dial a single toll-free number to be routed to the closest certified crisis center within the National Suicide Prevention Lifeline network. The network includes over 170 local- and state-funded crisis centers located across the United States.

^bAccording to SAMHSA officials, the agency was not able to fund all the applicants that applied to the funding opportunity announcement in fiscal year 2020. Later, using CAA funds, SAMHSA awarded funding to 26 previously unfunded applicants from the 2020 funding opportunity announcement.

^cThe Disaster Distress Helpline is a confidential 24/7 crisis support service that connects anyone in the United States experiencing distress as a result of a disaster and/or traumatic event with a crisis center responder through a sub-network of the National Suicide Lifeline crisis centers.

^dIn 2020, the Federal Communications Commission and The National Suicide Hotline Designation Act of 2020 designated 988 as the new three-digit number for the National Suicide Prevention Lifeline.

^eVibrant Emotional Health will be the administrator of the 988 dialing code for the National Suicide Prevention Lifeline.

^fIn addition, 25 colleges received the Garrett Lee Smith Campus Suicide Prevention awards through SAMHSA's annual appropriation totaling \$2.5 million.

Other programs. Behavioral health-related funding provided under the COVID-19 relief acts also was used to support several additional programs. For example, the CARES Act appropriated \$15 million to support tribal entities, and according to SAMHSA, the agency chose to award these funds as supplements to the existing Tribal Behavioral Health Grant Program based on tribal consultation.⁴⁹ As of November 2021, SAMHSA had awarded the \$15 million to 154 current Tribal Behavioral Health grantees for a total of \$97,402 each. Additionally, the CAA and ARPA appropriated a total of \$100 million to expand the reach of the Project AWARE (Advancing Wellness and Resilience in Education) State Education Agency Grants program, and the National Child Traumatic Stress Network. As of November 2021, SAMHSA had awarded

⁴⁹Specifically, the CARES Act required that not less than \$15 million of SAMHSA's appropriations be allocated to tribes, tribal organizations, urban Indian health organizations, or health or behavioral health service providers to tribes.

about \$61 million of this funding to, for example, state education agencies and tribal entities.⁵⁰

Additionally, ARPA appropriated \$100 million to the Health Resources and Services Administration for the Behavioral Health Workforce Education and Training Program for Professionals; the agency had awarded about \$22 million of this funding to 56 grantees as of November 2021.⁵¹ ARPA also appropriated \$20 million to CDC to use for an education and awareness campaign encouraging healthy work conditions, and use of mental health and substance use disorder services by health care professionals. According to CDC, as of November 2021, the agency had obligated \$4 million of this funding.

HHS agencies, including SAMHSA, the Health Resources and Services Administration, and CDC, had yet to obligate the remaining \$296 million of ARPA funds as of November 2021. These include funds to be used to provide support for pediatric mental health care access, local behavioral health needs and substance use disorder services, and mental health and substance use disorder awareness and training for health care professionals.

⁵⁰The CAA and ARPA appropriated a total of \$80 million to Project AWARE, and as of November 2021, SAMHSA had awarded about \$50 million of this funding to 10 grantees. Funding is intended to build or expand the capacity of state education agencies in partnership with state mental health agencies and three local education agencies to increase awareness of mental health issues among school-aged youth, provide training for those who interact with school-aged youth to detect and respond to mental health issues, and connect school-aged youth who may have behavioral health issues, and their families, to needed services.

The CAA and ARPA appropriated a total of \$20 million to the National Child Traumatic Stress Network, and as of November 2021, SAMHSA had awarded almost \$11 million of this funding to nine grantees. Grants were awarded through two related programs under this initiative with the purposes of (1) providing national expertise on specific types of traumatic events, population groups, and service systems; and (2) providing and increasing access to effective trauma-focused treatment and services systems in communities for children and adolescents, and their families.

⁵¹Grantees included accredited doctoral, internship, and post-doctoral residency programs of health service psychology (including clinical psychology, counseling, and school psychology), among others. Recipients of the Behavioral Health Workforce Education and Training Program for Professionals are to train graduate level students of social work, psychology, and other behavioral and mental health disciplines to work with vulnerable populations, particularly children, adolescents and transitional-aged youth at risk for behavioral health disorders. According to the Health Resources and Services Administration, this is a multi-year award; the remaining \$80 million will be awarded in future fiscal years in installments for a 5-year period.

**COVID-19 Relief
Funds for Behavioral
Health Could
Generally Serve
Populations at Higher
Risk; Selected
Funding Recipients’
Plans for Serving
These Populations
Varied**

**COVID-19 Relief Funds
for Behavioral Health
Generally Allow Funding
Recipients to Serve
Populations that May be At
Higher Risk**

Our review of program documentation shows that the majority of COVID-19 relief funds for behavioral health, as represented by the six largest behavioral health programs noted previously and listed in table 5, could generally serve all six populations stakeholders most frequently identified as being at higher risk of behavioral health effects related to the pandemic, as we describe in this report.⁵² Each of the six of the largest behavioral health programs have specific requirements or recommendations regarding any target populations for each program. Some of the six higher-risk populations are specifically identified in these requirements, as shown in table 5.

⁵²For the remaining COVID-19 behavioral health relief programs and activities—with appropriated funding totaling about \$635 million—the primary populations of focus varied, but a number of the identified higher-risk populations are specifically targeted. For example, about \$215 million of this funding is for programs focusing on children, adolescents, and young adults, including American Indian and Alaska Native youth. Another \$140 million is for programs focusing on health care workers, while \$180 million is for programs with a more general population focus like the National Suicide Prevention Lifeline.

Table 5: Target Population Requirements for Each of the Six Largest Behavioral Health Programs that Provided COVID-19 Relief Funding

Program	Requirements
Community Mental Health Services Block Grant (MHBG)^a	<p>The target populations for the MHBG are adults with serious mental illness (SMI) and children with serious emotional disturbance (SED).</p> <p>Each grantee must expend at least 10 percent of its block grant funds each fiscal year (or at least 20 percent by the end of the succeeding fiscal year) to support evidence-based programs to address early serious mental illness.</p> <p>Further, the MHBG has a set-aside requirement for children with SED—each year the state shall expend not less than the amount expended in fiscal year 1994.</p> <p>MHBG funds cannot be used for primary prevention activities. Grantees cannot use MHBG funds for those who are not diagnosed with a SMI.</p>
Substance Abuse Prevention and Treatment Block Grant (SABG)^a	<p>The SABG population focus is at-risk individuals or persons in need of substance use disorder (SUD) treatment. The SABG program targets five priority populations and service areas: (1) pregnant women and women with dependent children; (2) persons who inject drugs; (3) tuberculosis services; (4) early intervention services for HIV/AIDS; and (5) primary prevention services.</p> <p>Grantees must spend no less than 20 percent of their allotment on substance abuse primary prevention strategies directed at individuals not identified to be in need of treatment.</p>
Emergency Grants to Address Mental and Substance Use Disorders During COVID-19	<p>The target populations for the emergency COVID-19 grants were individuals with SMI, SUD, and co-occurring SMI and SUD, although language in the grant announcement also notes that they are generally to serve children and adults impacted by the COVID-19 pandemic, including those with mental disorders less severe than SMI.</p> <p>Specifically, at least 80 percent of the grant funds must be used for direct services. Of that amount</p> <ul style="list-style-type: none"> • 70 percent must go to the target populations, • 10 percent must go to health care practitioners with mental disorders (less severe than SMI), and • 20 percent can be used for all other individuals with mental disorders less severe than SMI.
Community Mental Health Centers Grant Program	<p>The populations of focus for the Community Mental Health Centers Grant Program include individuals with SMI, SED, and individuals with co-occurring SUDs. Further, developing and providing resources to address the mental health needs of community mental health center staff is a required grant activity.</p> <p>The funding announcement also lists among its allowable activities those activities serving the following populations: school age youth at risk for SED; children and youth at risk for maltreatment; vulnerable populations, such as minority populations and individuals residing in economically disadvantaged communities; and incarcerated persons.</p>
Certified Community Behavioral Health Clinics (CCBHC) Expansion Grants	<p>The CCBHC Expansion Grants program participating clinics must provide services to any individual (regardless of their ability to pay or place of residence), and do not have specific population requirements. Nonetheless, according to program documentation, CCBHCs are expected to serve individuals with SMI, those with severe SUD, children and adolescents with SED, and those with co-occurring mental, substance use, or physical health disorders.</p>
The Federal Emergency Management Agency (FEMA) Crisis Counseling Assistance and Training Program	<p>FEMA’s Crisis Counseling Assistance and Training Program is intended to provide services to any affected disaster survivor who may need assistance in coping with the effects of the disaster, such as those who were in the impacted area at the time of the incident or live in the impacted area. Its funding recipients conduct a needs assessment that identifies the most vulnerable populations that would benefit from receiving crisis counseling services. FEMA notes that in most disaster situations, children, adolescents, older adults, underserved populations, individuals with disabilities, and individuals with access or functional needs may benefit from program services, but the needs assessment may reveal additional groups who are vulnerable to disaster effects or who have been particularly affected by the disaster.</p>

^aFiscal year 2020-2021 block grant guidance also notes that in addition to the required target populations for each block grant, grantees are encouraged to consider the following populations: persons experiencing homelessness; individuals involved in the criminal or juvenile justice systems; persons living in rural areas; underserved racial and ethnic populations; individuals who are lesbian, gay, bisexual, transgender, or queer/questioning; and persons with disabilities.

In addition to the requirements described in table 5, our review of program documentation for the six largest behavioral health programs determined the following additional information specific to the ways these programs can serve the higher-risk populations identified by stakeholders:

People from certain racial and ethnic groups. People from various racial and ethnic groups can be served by all six of the largest behavioral health programs, and funding recipients are specifically prohibited from discriminating on the basis of race, color, nationality, or English proficiency, among other factors. Additionally, most of the programs specifically recommend that people from certain racial and ethnic groups be target populations. For example, block grant guidance for fiscal years 2020-2021 notes that in addition to required target populations, states are encouraged to consider targeting, among others, underserved racial and ethnic groups. SAMHSA also requires that recipients of the CCBHC Expansion Grants and Community Mental Health Centers grants submit disparity impact statements, which include identifying racial, ethnic, sexual, and gender groups vulnerable to behavioral health disparities, and plans for addressing identified differences in access to and use of services. CCP recipients are directed to adapt the program to the needs of local populations, including racial, ethnic, and cultural groups. However, none of the six programs have specific funding set-asides for certain racial and ethnic groups, although funding recipients that are tribes or tribal organizations would generally serve American Indians/Alaska Natives.

Health care workers. As noted in table 5, two of the six largest behavioral health programs—the emergency COVID-19 grants, and Community Mental Health Centers Grant Program—require that services be provided to health care workers. Health care workers could also receive services through the other four programs if they meet those programs' requirements.

However, some barriers could exist in serving certain health care workers who do not meet any existing requirements related to income limits or insurance. For example, officials from one state said that they had to lift a state financial screening requirement for health care workers to be able to

provide more services to this population with the emergency COVID-19 grant. They said many health care workers were not otherwise eligible for services, because their incomes were more than 200 percent above the poverty level—a state financial screening requirement.

Children and adolescents. All six of the largest behavioral health programs may serve children and adolescents that meet the programs' other requirements, but only the Community Mental Health Services Block Grant has a related set-aside requirement (for children with serious emotional disturbance). Additionally, in documentation for the six programs, SAMHSA and FEMA note that these funds could be used for programs or services related to children. For example, in its May 2021 letter to states regarding ARPA funds, SAMHSA recommended using Community Mental Health Services Block Grant funds for services for children, such as screening and assessment within a crisis continuum, mobile crisis response and stabilization, residential crisis services, and ongoing care coordination.

People with pre-existing behavioral health conditions. As shown in table 5, people with certain pre-existing behavioral health conditions can be served by all six of the largest behavioral health programs, although all of these programs—other than the CCP—generally focus on those with more severe conditions, such as serious mental illness. For example, the target populations for the Community Mental Health Services Block Grant are adults with serious mental illness and children with serious emotional disturbance, as opposed to those with less severe, but pre-existing, behavioral health conditions.⁵³ FEMA's CCP does not specifically target services to individuals with pre-existing behavioral health conditions, but rather provides services to anyone, regardless of previous diagnosis or current symptoms, who may be experiencing disaster-related negative effects.⁵⁴

⁵³SAMHSA defines serious mental illness as someone over the age of 18 having (within the past year) a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. For people under the age of 18, the term "serious emotional disturbance" refers to a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.

⁵⁴FEMA officials said that the CCP provides coping mechanisms and psycho-educational support in one-time sessions, and can also provide those dealing with more severe behavioral health issues with referrals to existing resources better suited for long-term or continued support.

Young adults. All six of the largest behavioral health programs generally allow young adults to be served by these programs if they meet those programs' other requirements, although none of the programs specifically set-aside funds for this population. SAMHSA has, however, specifically recommended states consider using block grant funds for programs related to young adults. For example, in its May 2021 letter to states regarding ARPA funds, SAMHSA recommends using Substance Abuse Prevention and Treatment Block Grant funds for strategies to improve substance misuse outcomes, especially among young adults age 18-25 and those over 26 years of age.

People facing financial distress. All six of the largest behavioral health programs generally allow people facing financial distress to be served by these programs. Specifically, the five SAMHSA grant programs are generally intended to serve people with low incomes or without public or commercial insurance. For example, SAMHSA has indicated that the block grants may be used to fund priority treatment and support services for low-income individuals, and individuals without insurance or for whom coverage is terminated for short periods of time. The sixth program—FEMA's CCP—can generally serve any individual impacted by a disaster, such as the pandemic, but the program guidance specifically notes that people who have lost homes or jobs as a result of a disaster, among others, may benefit from crisis counseling services.

SAMHSA officials said that it will be some time before the agency is able to determine who was served by the COVID-19 relief-funded grants. When asked about potential analysis plans for data reported by grantees about populations served by the COVID-19 relief act-funded programs, SAMHSA officials said they are starting to look at data—examining demographics such as race, ethnicity, and gender of clients served through these programs.⁵⁵ SAMHSA officials told us that it was too early in the process to have a more specific data analysis plan, noting that officials wanted to review some of the data as it comes in to determine what additional analysis might be needed. Nonetheless, the SAMHSA officials said that it is important to examine populations served by programs receiving COVID-19 relief funds to determine whether target populations were reached, and whether there were any gaps in intended

⁵⁵Recipients of COVID-19 relief act SAMHSA grants are required to report a variety of information about the clients served by the grants, including their demographic characteristics, diagnoses, and treatment services provided.







populations served—and said that the agency planned to do so in the future.

Selected Funding Recipients Reported Various Ways They Intended to Use Relief Funds to Reach Higher-Risk Populations, but Noted Some Challenges in Using the Funds to Do So

Selected funding recipients we spoke with in Colorado, Mississippi, New York, Washington, D.C., and West Virginia reported varying ways they were using, or planned to use, awards from COVID-19 relief funds for behavioral health to reach the six populations stakeholders identified as at higher risk for behavioral health effects.⁵⁶ See figure 10 for examples of funding recipient efforts targeting these six populations.

⁵⁶Our interviews with funding recipients in our four selected states and Washington, D.C., were conducted from March through June 2021. At the time of our interviews, we were generally only able to speak with funding recipients about awards received from CARES Act and CAA funds, as ARPA funds had not yet been awarded.

Figure 10: Examples of How Selected Funding Recipients Have Used or Planned to Use COVID-19 Relief Funds for Behavioral Health to Reach Higher-Risk Populations

		EXAMPLES
POPULATIONS IDENTIFIED AS POTENTIALLY AT HIGHER RISK	 People from certain racial and ethnic groups	Substance Abuse Prevention and Treatment Block Grant: Officials in one state said that they planned to use some of these funds to look at disparities in populations and to strive to diversify the state’s behavioral health workforce. For example, officials are trying to increase the workforce for Hispanic or Latino behavioral health organizations, and said that supporting the Native American community with these funds is also key. Officials said that the pandemic had exacerbated existing vulnerabilities within the state’s behavioral health system, such as barriers to accessing culturally appropriate care for various racial and ethnic groups.
	 Health care workers	Emergency Grants to Address Mental Health and Substance Use Disorders During COVID-19: Officials in one state said that they used some of these funds to target health care workers as part of a public awareness campaign to raise awareness of care options, and link the workers to free mental health screenings.
	 Children and adolescents	Community Mental Health Services Block Grant: Officials in one state said that one of the ways they planned to use these funds to assist children and adolescents was to expand “safe home” services for children with serious emotional disturbance within the child protective services system.
	 People with pre-existing behavioral health conditions	Emergency Grants to Address Mental Health and Substance Use Disorders During COVID-19: Officials in another state that received this grant said that they used these funds to design a framework to reach individuals with serious mental illness and substance use disorder in several areas of the state that represented 75 percent of statewide COVID-19 cases.
	 Young adults	Federal Emergency Management Agency’s Crisis Counseling Assistance and Training Program: Officials in one state said that they used funds from this program to provide virtual counseling groups focusing on college aged youth and young adults.
	 People facing financial distress	Certified Community Behavioral Health Clinic Expansion Grant: One recipient of this grant said they planned to use the funds to hire staff to conduct outreach and provide therapy to people experiencing homelessness—noting that they are targeting vulnerable populations to bring people in for primary care and behavioral health services.

Source: GAO analysis of interviews with selected recipients of COVID-19 relief funds for behavioral health. | GAO-22-104437

Notes: We interviewed 18 funding recipients from four selected states and Washington, D.C. Specifically, we interviewed at least one recipient of each of the different types of Substance Abuse and Mental Health Services Administration grants that had been distributed as of March 2021, as well as recipients of Federal Emergency Management Agency Crisis Counseling Assistance and Training program funds.

Additionally, some funding recipients described programs that targeted multiple populations that stakeholders identified as being at higher risk. For example, using funds from FEMA’s CCP, officials in one state analyzed public health data to locate the counties with the highest COVID-19 infection and mortality rates, and higher unemployment rates.

They then focused their crisis counseling program on the 12 most affected counties. The officials noted that often people from certain racial and ethnic groups and people with poor financial status—either due to a previous history of poverty or to the pandemic—were those being served by this program. Officials told us in May 2021 that of all crisis contacts, communities served were 50 percent Black, 17 percent Hispanic or Latino, 25 percent White, and 3 percent Asian. Officials also noted that they are conducting outreach to children and school populations as part of their crisis counseling program.

Some of the selected funding recipients also described various program requirements and other features that they said can limit their ability to serve some of the higher-risk populations, such as people with less severe pre-existing behavioral health conditions and young adults. The challenges the funding recipients cited are, in general, long-standing grant rules or reporting requirements that pre-date the COVID-19 pandemic, and some are designed, in part, to help SAMHSA monitor progress toward program goals and help ensure accountability for the use of the federal funding. However, some of the funding recipients indicated these requirements posed a particular challenge in the context of the pandemic. SAMHSA officials described steps they have taken to help address some of the challenges cited by funding recipients, but also indicated that some grant requirements were beyond their authority to waive.

Grant requirements regarding populations served. Some block grant recipients and recipients of two types of COVID-19 specific emergency grants reported challenges related to grant target populations that could limit their ability to serve certain higher-risk populations.⁵⁷ For example, officials from one state said use of the funds from the Emergency Grants to Address Mental Health and Substance Use Disorders During COVID-19 program has been challenging given the requirement for 70 percent of funds to be used for populations meeting specific criteria for substance use disorder and serious mental illness. The officials added that during the pandemic there has been an increase in the volume of people needing crisis services, such as teachers, but not all of these people meet the criteria for substance use disorder and serious mental illness. Additionally, officials from a behavioral health clinic noted frustration related to the COVID-19 Emergency Response for Suicide Prevention

⁵⁷The two types of COVID-19 specific emergency grants we refer to in this section are the Emergency Grants to Address Mental Health and Substance Use Disorders During COVID-19 and the COVID-19 Emergency Response for Suicide Prevention Grant.

Grant, because they have to turn away young adults under age 25, because the organization is restricted from using these grant funds for individuals aged 18-24.

SAMHSA officials said the agency has determined that block grant requirements for populations served are beyond SAMHSA's authority to waive. However, they stated that they are not worried that grant requirements will limit any higher-risk populations from receiving services. Agency officials noted, for example, that the emergency COVID-19 grants allowed some funding to be used to serve persons with less severe mental illness. SAMHSA officials added that they had not been made aware of some grantees' concern regarding serving persons with mental disorders less severe than serious mental illness, but had heard concerns about serving health care workers.⁵⁸

Client data reporting requirements. Some recipients of block grants, two types of COVID-19 specific emergency grants, and the tribal behavioral health grant reported challenges related to client data reporting requirements, which could affect serving higher-risk populations. Specifically, SAMHSA requires grantees use a Government Performance and Results Act (GPRA) tool to collect and report data from clients at intake, follow-up, and discharge.⁵⁹ Officials in one state, for example, said that because of this GPRA tool, the state has declined to use Emergency Grants to Address Mental Health and Substance Use Disorders During COVID-19 funds for youth and adolescents accessing high intensity programs during the pandemic, because the tool would be too burdensome to complete for this population.

SAMHSA officials said that due to the pandemic, SAMHSA lessened a few GPRA-related data reporting requirements for grantees. For example,

⁵⁸SAMHSA officials said some emergency COVID-19 grantees reported difficulty identifying health care workers in need of services due to the stigma against receiving behavioral health services—noting that some health care workers may not want to receive behavioral health treatment out of fear that doing so could affect their certification or licensure.

⁵⁹The GPRA tool is a questionnaire that, according to SAMHSA officials, the agency developed to help HHS meet requirements of the Government Performance and Results Act of 1993 and the GPRA Modernization Act of 2010. The questionnaire is administered by providers at client intake, 6-month follow-up, and discharge from a SAMHSA funded treatment program to collect data about each individual served. Information collected about the individuals served includes their demographic characteristics, diagnoses, and treatment services provided. SAMHSA officials said that all recipients of COVID-19 relief act funds are required to use this data collection tool with most clients, except, for example, clients who receive one time services.

instead of requiring data collection to be done face-to-face with clients, SAMHSA allows information to be collected via telehealth, email, or through paper reporting. Also, officials said that data collection is not required for all clients, such as people receiving virtual education or people receiving one-time services. SAMHSA officials said that these flexibilities had been communicated during webinars or calls with grantees.

Limitations in how the funds can be spent. Some recipients of block grants, two types of COVID-19 specific emergency grants, the tribal behavioral health grant, and CCP funds reported challenges related to prohibitions on using funds for certain purposes, such as building construction, or purchasing technology equipment. An official in one state said that not being able to spend block grant funds on capital investment is a challenge, noting that a lack of residential services due to facility limitations are a barrier to care in the state, and that services can only be provided if there are locations to provide them. Officials in another state said the federal government should consider allowing for the purchase of equipment and supplies for clients with relief grant funds. They said that providers were using telehealth as a major tool for ensuring access and continuity of care during the pandemic, and because clients have few resources, it is challenging to ensure these clients have full access to telehealth.

SAMHSA officials told us that they have allowed for some flexibilities with block grant relief act funding; for example, allowing for the operation of crisis lines, which agency officials indicated are not generally allowed under regular grant rules. Officials said that they would consider requests to waive block grant requirements other than flexibilities specifically referenced in guidance letters to grantees on a case by case basis—to the extent it is within their authority to do so. For example, the agency has determined that block grant rules related to spending on capital infrastructure are beyond SAMHSA's authority to waive. Regarding spending funds on equipment for clients, SAMHSA officials said the agency allows grantees to use funding for technology for grantee staff, but not their clients. Officials said this is related to audit requirements and a need for the grantee to maintain custody and accountability of such supplies purchased with federal dollars.

Program project periods. Some of the funding recipients that received the two types of COVID-19 specific emergency grants, the CCBHC Expansion Grants, and CCP funds reported challenges related to

program project period lengths.⁶⁰ For example, officials in one state said it is hard to get a program initiated and operating—and to get any meaningful outcomes—in such a short time period. They added that grant timelines also affect staffing, as staff will begin looking for new jobs before the grant ends if there is not a guarantee that the grant will be renewed. SAMHSA officials said that grantees have some flexibilities related to the grant project periods, such as requesting no-cost extensions to the project time period, and that the agency attempts to be flexible to help ensure grantees can spend their funds to provide services. FEMA officials also provided us with documentation showing that they have allowed for and said they will continue to allow for additional extensions to CCP project time periods.

Workforce challenges. Funding recipients—particularly tribal grantees and grantees in two states—reported workforce concerns that could affect their ability to use COVID-19 relief funds for behavioral health.⁶¹ For example, one state CCBHC Expansion Grants recipient said that while she did not see any limitations or challenges with the grant itself, she was concerned that it could be a challenge to fill all of the positions for the extra employees her clinic wants to hire. She said that due to low reimbursement rates, the salaries her clinic can offer are not as competitive as those other clinics can offer.

Agency Comments

We provided a draft of this report to HHS and FEMA for review and comment. HHS and the Department of Homeland Security provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Secretary of Health and Human Services, the Secretary of Homeland Security, the FEMA Administrator, appropriate congressional committees, and other interested parties. The report is also available at no charge on the GAO website at <http://www.gao.gov>.

⁶⁰The two types of COVID-19 specific emergency grants have a project period of up to 16 months, and CCBHC Expansion Grants have a project period of up to 2 years. The two programs within the CCP (Immediate Services Program, and Regular Services Program) have different project periods, and while extensions can be requested as long as needed, justified, and in the best interest of the public, funds are generally intended to be used within a little over a year of a major disaster declaration, according to FEMA officials.

⁶¹ARPA appropriated \$100 million for behavioral health workforce education and training. However, because this funding is generally for student recruitment or training, it may not address the more short-term behavioral health workforce hiring challenges grantees described, such as less competitive salary rates.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at HundrupA@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix VI.



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The Honorable Richard Shelby
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The Honorable Ron Wyden
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The Honorable Richard Neal
Chairman

The Honorable Kevin Brady
Republican Leader
Committee on Ways and Means
House of Representatives

Appendix I: Objectives, Scope, and Methodology

The CARES Act includes a provision for GAO to report on its ongoing monitoring and oversight efforts related to the COVID-19 pandemic.¹ In this report, we describe

1. populations that may be at higher risk of behavioral health effects related to the COVID-19 pandemic;
2. the amount and type of funding the federal government provided in COVID-19 relief to states, providers, and other organizations to address behavioral health needs; and
3. whether COVID-19 relief funds for behavioral health could serve identified populations that may be at higher risk of behavioral health effects related to the COVID-19 pandemic, and how selected funding recipients plan on using relief funds to serve these populations.

To address all three objectives, we interviewed or obtained written responses from a range of stakeholders, and interviewed recipients of COVID-19 relief funds for behavioral health relief in four states and Washington, D.C. We also analyzed additional information that pertained to each of the objectives, such as selected behavioral health research, documents from stakeholder organizations, federal agencies, and others; and examined relevant laws.

Stakeholder Interviews

We interviewed or obtained written responses from stakeholders that represented a range of roles and perspectives with respect to behavioral health during the COVID-19 pandemic. In particular, we obtained information from relevant federal agencies; behavioral health provider associations; other health care provider associations; consumer groups; and national associations representing state behavioral health agencies and American Indian/Alaska Native health organizations. (See table 6.) In addition to these organizations, we spoke with four university-affiliated researchers and one university-based research working group with knowledge about topics such as behavioral health risk and protective factors; behavioral health during the pandemic; and the impact of disasters, recessions, and social isolation on behavioral health. We selected national organizations we identified as representing behavioral

¹Pub. L. No. 116-136, § 19010(b), 134 Stat. 281, 580 (2020). We have regularly issued government-wide reports on the federal response to COVID-19. For the latest report, see GAO, *COVID-19: Additional Actions Needed to Improve Accountability and Program Effectiveness of Federal Response*, [GAO-22-105051](https://www.gao.gov/products/GAO-22-105051) (Washington, D.C.: Oct. 27, 2021). Our next government-wide report will be issued in January 2022 and will be available on GAO's website at <https://www.gao.gov/coronavirus>. We will continue to monitor behavioral health funding as part of this ongoing COVID-19 related oversight.

health care providers, other health care providers, and individuals with behavioral health conditions. We also selected researchers we identified as having relevant knowledge based on their published work. We identified some organizations and researchers based on the recommendations of other stakeholders. We also reviewed reports, research, and other documentation provided by these stakeholders that pertained to our objectives.

Table 6: Federal Agencies, Health Care Provider Associations, and Other Organizations That Provided Information about Behavioral Health during the COVID-19 Pandemic

Type of stakeholder	Organization
Federal agencies	<ul style="list-style-type: none"> Administration for Children and Families Centers for Disease Control and Prevention Federal Emergency Management Agency Health Resources and Services Administration National Institutes of Health Substance Abuse and Mental Health Services Administration
Behavioral health provider associations	<ul style="list-style-type: none"> American Association for Geriatric Psychiatry American Psychiatric Association American Psychiatric Nurses Association American Psychological Association American Society of Addiction Medicine NAADAC, the Association for Addiction Professionals National Association of Addiction Treatment Providers National Council for Mental Wellbeing (formerly National Council for Behavioral Health)
Other health care provider associations	<ul style="list-style-type: none"> American Academy of Family Physicians American Association of Critical-Care Nurses American Medical Association America’s Essential Hospitals National Association of Community Health Centers
Consumer groups	<ul style="list-style-type: none"> Mental Health America National Alliance on Mental Illness
National associations representing state behavioral health agencies and American Indian/Alaska Native health organizations	<ul style="list-style-type: none"> National Association of State Alcohol and Drug Abuse Directors National Association of State Mental Health Program Directors National Indian Health Board

Source: GAO. | GAO-22-104437

As part of our stakeholder interviews, in a sample of four states—Colorado, Mississippi, New York, and West Virginia—and Washington, D.C., we interviewed state agencies and other selected organizations within those states that received federal COVID-19 relief funding for behavioral health. These states and Washington, D.C., were selected based on consideration of a number of different criteria including (1) the extent to which they were ranked in the top 10 across seven behavioral health metrics, including rates of self-reported serious mental illness, rates of any substance use disorder, and rates of suicide deaths and drug overdose deaths; (2) variation in the number and type of Substance Abuse and Mental Health Services Administration (SAMHSA) CARES Act-funded grants received; (3) variation in per capita funding ranking for CARES Act-funded SAMHSA grants and Federal Emergency Management Agency (FEMA) Crisis Counseling Assistance and Training Program (CCP) funding; and (4) whether the state had expanded Medicaid.² We also selected our sample based on overall variation in geographic region, number of COVID-19 cases and deaths as of February 2021, racial/ethnic group percentages, and percentage of the population in poverty.

Specifically, we interviewed selected recipients of the different types of SAMHSA grants specified in the CARES Act and Consolidated Appropriations Act, 2021 that had been distributed as of March 2021, as well as recipients of FEMA CCP funds. (See table 7 for more information on funding recipients interviewed, including the types of funding discussed.)

²Under the Patient Protection and Affordable Care Act, states have the option to expand their Medicaid programs to cover nearly all adults with incomes at or below 133 percent of the federal poverty level. States that choose to expand their programs receive a higher federal matching rate for the Medicaid expansion enrollees.

Table 7: Federal COVID-19 Behavioral Health Relief Funding Recipients Interviewed

State	Agency or organization	Type of organization	COVID-19 relief funding discussed during interview
Colorado	Office of Behavioral Health	state agency	Community Mental Health Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SABG); Emergency Grants to Address Mental Health and Substance Use Disorders During COVID-19
	Department of Public Health & Environment Office of Suicide Prevention	state agency	COVID-19 Emergency Response for Suicide Prevention Grants
	Department of Public Health & Environment Emergency Preparedness	state agency	Crisis Counseling Assistance and Training Program
	Aurora Mental Health Center	Certified Community Behavioral Health Clinic (CCBHC)	CCBHC Expansion Grants program
	Ute Mountain Ute Tribe	tribal organization	Tribal Behavioral Health/Native Connections Grant supplement and COVID-19 Emergency Response for Suicide Prevention Grants
	Rocky Mountain Crisis Partners	crisis center	Suicide Prevention Lifeline Crisis Center Follow-Up Expansion Grant
Mississippi	Department of Mental Health	state agency	MHBG and SABG; Emergency Grants to Address Mental Health and Substance Use Disorders During COVID-19
	Southwest Mississippi Mental Health Complex	CCBHC	CCBHC Expansion Grants program
New York	Office of Mental Health	state agency	MHBG; Emergency Grants to Address Mental Health and Substance Use Disorders During COVID-19; Crisis Counseling Assistance and Training Program
	Office of Addiction Services and Supports	state agency	SABG
	Samaritan Daytop Village	CCBHC	CCBHC Expansion Grants program
	BestSelf Behavioral Health	CCBHC	COVID-19 Emergency Response for Suicide Prevention Grants and CCBHC Expansion Grants program
	Saint Regis Mohawk Tribe	tribal organization	Tribal Behavioral Health/Native Connections Grant supplement
Washington, D.C.	Department of Behavioral Health	state agency	MHBG and SABG; Emergency Grants to Address Mental Health and Substance Use Disorders During COVID-19; Crisis Counseling Assistance and Training Program
	Ivan Walks and Associates – Integrated Health Resources ^a	behavioral/mental health clinic	CCBHC Expansion Grants program
	National Council of Urban Indian Health	tribal organization	Tribal Behavioral Health/Native Connections Grant supplement

State	Agency or organization	Type of organization	COVID-19 relief funding discussed during interview
West Virginia	Department of Health and Human Resources	state agency	MHBG and SABG; Emergency Grants to Address Mental Health and Substance Use Disorders During COVID-19; Crisis Counseling Assistance and Training Program
	Prester Center	CCBHC	CCBHC Expansion Grants program

Source: GAO. | GAO-22-104437.

Note: At the time of our interviews, we were generally only able to speak with funding recipients about awards received from CARES Act and CAA funds, as ARPA funds had not yet been awarded.

^aIvan Walks and Associates – Integrated Health Resources received a CCBHC expansion grant, but was not able to use the grant funds. According to SAMHSA officials, this clinic voluntarily relinquished its award in April 2021, which was shortly after we interviewed them.

Identifying Populations at Potentially Higher Risk of Behavioral Health Effects Due to the Pandemic

To identify populations that may be at higher risk of behavioral health effects due to the COVID-19 pandemic, we analyzed selected research and information from federal and state officials and other stakeholders. We considered behavioral health effects related to the pandemic to include new or exacerbated behavioral health symptoms and conditions, such as those related to anxiety, depression, and substance use; behavioral health effects also include suicidal ideation, suicide attempts, and suicide deaths.

Selected research. We reviewed a range of reports, studies, resources, and data published by federal agencies and other organizations. For example, we reviewed Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Reports and other CDC publications about topics such as self-reported behavioral health symptoms and substance use, and emergency department visits for suspected suicide. We also reviewed SAMHSA research bulletins and other documents. In addition, we reviewed publications by the National Academies of Science, Engineering, and Medicine about behavioral health during the pandemic. We also reviewed selected journal articles that identified populations at risk of, or experiencing, behavioral health conditions or effects. We identified journal articles through our review of CDC and SAMHSA publications and other publications; input from federal officials,

researchers, and other stakeholders; and a targeted literature search.³ For each of the journal articles cited in this report, we reviewed the study methodologies and determined that they were suitable for identifying specific populations at higher risk of behavioral health effects due to the COVID-19 pandemic.

We also reviewed data from the Census Bureau's Household Pulse Survey on populations and the estimated percentage of U.S. adults reporting symptoms of anxiety disorder and depressive disorder during the COVID-19 pandemic.⁴ We assessed the reliability of these data by reviewing relevant agency documentation, requesting written information from agency officials, and checking for obvious errors. We determined that these data were sufficiently reliable for the purpose of describing what populations may be at higher risk of behavioral health effects related to the COVID-19 pandemic.

Information from selected stakeholders. We analyzed input from 32 of the stakeholders listed above who answered open-ended questions about

³For the targeted literature search, we conducted a search for relevant peer reviewed literature published between September 1, 2020, and June 1, 2021. We used bibliographic databases such as MEDLINE, APA PsycInfo, and SciSearch, and search terms such as "mental health," "anxiety," "depress*," "suicide*," "substance," "alcohol," "overdose," and "PTSD." Given the volume of literature being published on COVID-19 and behavioral health, we focused the search on terms in the title of journal articles and limited our review to articles about behavioral health in the United States. We selected articles that were most relevant to our analysis.

⁴The Household Pulse Survey, an experimental data product, is an interagency federal statistical rapid response survey to measure household experiences during the COVID-19 pandemic. The survey is conducted by the Census Bureau in partnership with seven other agencies from the Federal Statistical System. These estimates are based on responses to two questions about symptoms of depressive disorder and two questions about symptoms of anxiety disorder in the prior 7 days. The percentage of adults include those who reported symptoms that generally occurred more than half the days or nearly every day. Weighted response rates have ranged from 1.3-10.3 percent, and averaged about 5.8 percent. In March 2021, Census published the results of a nonresponse bias analysis that identified evidence of response patterns that could result in biased estimates. Census adjusted sampling weights, which can help but may not completely mitigate nonresponse bias. See <https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm>, accessed October 19, 2021; and <https://www.census.gov/programs-surveys/household-pulse-survey/technical-documentation.html>, accessed October 25, 2021, for more information about the mental health results and survey methodology.

the pandemic's effects on behavioral health.⁵ The questions were on topics such as stakeholders' most pressing behavioral health concerns during the pandemic; populations at higher risk, or of particular concern due to the pandemic, and why; the pandemic's impact on certain populations such as health care workers and people with prior behavioral health conditions; and populations at higher risk after disease outbreaks and other disasters. The questions varied somewhat depending on stakeholders' specific roles and the timing of our outreach to them. We analyzed stakeholders' responses across varying questions to determine whether they identified particular populations as being potentially at higher risk of behavioral health effects. We grouped certain populations together into broader populations. For example, we grouped people experiencing unemployment, housing or food insecurity, low incomes, or other situations related to financial distress into one broader population we referred to as "people facing financial distress." We also grouped people with serious mental illness, people with substance use disorders, and other people with behavioral health conditions into one broader population we referred to as "people with pre-existing behavioral health conditions."

Identifying populations that may be at higher risk of behavioral health effects. For the purpose of identifying populations that may be at higher risk of behavioral health effects related to COVID-19, we considered how many stakeholders identified various populations as potentially being at higher risk, as well as the results of selected research. We found that the populations identified by stakeholders and research generally fell into two groups based on the frequency with which particular populations were cited:

- Stakeholders identified six populations most frequently as potentially at higher risk. Specifically, four populations that more than half of the 32 stakeholders identified and two populations that were identified by

⁵These include officials from four of six federal agencies (Administration for Children and Families, CDC, SAMHSA, and the National Institutes of Health); representatives of the behavioral and other health care provider associations, consumer groups, and national associations representing state agencies and American Indian/Alaska Native health organizations; and researchers. We also included behavioral health agencies in four states and Washington, D.C. For this analysis, we considered each state to be a single stakeholder even when we spoke to multiple agencies in a state. We did not consider input from the other recipients of federal COVID-19 behavioral health relief funding that were not state agencies, though we include illustrative examples of their input as appropriate. Officials from two federal agencies—FEMA and the Health Resources and Services Administration—did not provide input on the populations at higher risk of behavioral health effects related to the pandemic.

about half (15 or 16) of stakeholders. Selected research we reviewed also cited all six populations as potentially at higher risk.

- A smaller share of stakeholders—three to nine—identified 11 other populations as potentially at higher risk. Selected research also cited these populations.

We did not include in those two groups—or describe in the report—populations that were identified by one or two stakeholders. Those populations included, for example, individuals who experienced the death of someone in their life due to COVID-19; individuals who are incarcerated or otherwise involved with the criminal justice system; and individuals with disabilities. The populations we describe in the report are not meant to be exhaustive of all populations at higher risk of behavioral health effects due to the pandemic, but rather reflect stakeholder input and selected research. There may be additional populations at higher risk.

Analysis of Federal Government COVID-19 Relief Funding for Behavioral Health

To further determine the amount and type of COVID-19 relief funding for behavioral health the federal government provided and whether the funding could serve higher-risk populations, we reviewed relevant federal laws and agency documents, COVID-19 funding opportunity documents for behavioral health, and award documentation for SAMHSA and FEMA program funds awarded after the CARES Act was enacted in March 2020 through November 2021. We reviewed funding opportunity documents to determine such things as grant purposes, time frames, and populations of focus. We also interviewed or obtained written responses from SAMHSA and FEMA about, among other things, how the agencies

- made funding decisions,
- communicated funding opportunities and any updates to programs, and
- responded to challenges reported by funding recipients related to using relief funds.

To determine the reliability of the data—SAMHSA and FEMA funding and award information—we interviewed agency officials, reviewed relevant documentation, and checked for obvious errors. We determined the data were sufficiently reliable for reporting on the amount and type of funding the federal government provided for COVID-19 relief funding for behavioral health to states, providers, and other organizations.

We conducted this performance audit from July 2020 through December 2021 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II: Other Populations Stakeholders Identified as Potentially Being at Higher Risk of Behavioral Health Effects

When identifying populations that may be at higher risk of behavioral health effects due to the Coronavirus Disease 2019 (COVID-19) pandemic, we identified two groups of populations: (1) six populations that stakeholders identified most frequently as potentially at higher risk, and (2) other populations that a small share of stakeholders (three to nine) identified as being potentially at higher risk.¹ This appendix provides information about the behavioral health risks for these other populations. The populations we describe in table 8 are not meant to be exhaustive of all other higher-risk populations, but rather reflect stakeholder input and selected research.

¹The six populations most frequently cited populations were people from certain racial and ethnic groups; health care workers; children and adolescents; people with pre-existing behavioral health conditions; young adults; and people facing financial distress. They included four populations that more than half of the 32 stakeholders included in this analysis identified, and two populations that were identified by about half (15 or 16) of those stakeholders. We did not include populations if they were identified by one or two stakeholders. Examples include individuals who experienced the death of someone in their life due to COVID-19; individuals who are incarcerated or otherwise involved with the criminal justice system; and individuals with disabilities.

Appendix II: Other Populations Stakeholders Identified as Potentially Being at Higher Risk of Behavioral Health Effects

Table 8: Other Populations Stakeholders Identified as Potentially Being at Higher Risk of Behavioral Health Effects Related to the COVID-19 Pandemic

Population	Examples of stakeholder input and research on behavioral health risks
Women	<p>Nine stakeholders identified women as potentially at higher risk of behavioral health effects due to the pandemic, citing factors such as increased childcare responsibilities and job loss. Pregnant women in particular were identified by some stakeholders as being at higher risk. A Substance Abuse and Mental Health Services Administration (SAMHSA) research bulletin reported that studies conducted in 2020 found higher levels of anxiety, depression, and traumatic stress among women than in men; studies also found that women’s consumption of alcohol increased during the pandemic.^a</p> <p>Centers for Disease Control and Prevention (CDC) officials cited findings from the Household Pulse Survey, which has consistently found that women report higher rates of symptoms of anxiety disorder or depressive disorder than men. From August 18 – August 30, 2021, 36 percent of women reported such symptoms, as compared with 28 percent of men.^b</p> <p>Members of a research group told us that women are generally more likely than men to experience anxiety and depression, and that women are more likely than men to experience those symptoms after a disaster or crisis. They said it can be difficult to distinguish the pandemic’s effect on women from pre-pandemic patterns.</p>
Older adults	<p>Nine stakeholders raised concerns about older adults, such as those with cognitive impairments or who live in a nursing home. Some stakeholders said that social isolation could be contributing to poor behavioral health effects in this population. For example, the head of a behavioral health clinic in one state said concerns regarding this group had not been discussed enough during the pandemic. The clinic’s elderly patients had to isolate during the pandemic, and some did not have good social supports; for example, their families had not been able to check on them. She expected that elderly patients would eventually return to the clinic with exacerbated psychiatric conditions.</p> <p>One researcher noted that while surveys conducted during the pandemic have found older adults to be faring less poorly than younger adults, those surveys may not be capturing certain older adults, such as those lacking access to technology. Further, there might be groups of older adults that are at higher risk of experiencing behavioral health problems, even though it is not apparent in aggregate survey data. A SAMHSA research bulletin stated that while older adults generally seemed to be faring better than other age groups, it was unclear whether this difference would hold over time.^a</p>
Parents of young or school-aged children	<p>Seven stakeholders identified this population as particularly at risk, in part, due to the stress parents experienced due to children learning from home during the pandemic. Officials in one jurisdiction said parents faced challenges managing work, family life, and being teachers for children learning from home. One researcher anticipated negative mental health outcomes for parents of small children, but said there was not robust data on the behavioral health of this population.</p> <p>A study examining the mental health of adult caregivers—specifically, parents of children under age 18 and unpaid caregivers of adults—found that parents reported significantly worse mental health than adults without any caregiving role. According to survey data from December 6–27, 2020, and February 16–March 8, 2021, parents were more likely than non-caregivers to report symptoms of anxiety or depression, or suicidal ideation.^c</p>
People who were diagnosed with COVID-19	<p>Seven stakeholders raised concerns about this population. National Institutes of Health officials and a SAMHSA research bulletin cited research that found individuals diagnosed with COVID-19 were more likely than individuals diagnosed with several other illnesses to develop a new psychiatric diagnosis. The most common new diagnoses were anxiety disorders, followed by mood disorders.^a Some stakeholders noted that it is still too early to tell what the implications of a COVID-19 diagnosis are for behavioral health.</p>

Appendix II: Other Populations Stakeholders Identified as Potentially Being at Higher Risk of Behavioral Health Effects

Population	Examples of stakeholder input and research on behavioral health risks
Essential workers	<p>Five stakeholders cited risks facing this population. Some stakeholders pointed to survey data from June 2020 that found self-reported essential workers reported higher rates of suicidal ideation, starting or increased substance use to cope with pandemic-related stress, and symptoms of anxiety disorder or depressive disorder than people who were not essential workers. CDC reported, for example, that the percentage of adults who reported having seriously considered suicide in the 30 days before completing the survey (10.7 percent overall) was significantly higher among essential workers (21.7 percent).^d</p> <p>Two stakeholders said grocery store workers and others who must be in public due to their jobs might be particularly at risk of behavioral health effects, because their jobs place them at increased exposure to COVID-19.</p>
Individuals who are lesbian, gay, bisexual, or transgender	<p>Five stakeholders raised concerns about this population. A psychiatric nurses' association said these individuals were at higher risk of depression and suicide before the pandemic and that pandemic-related isolation could have led to worsening depression and suicidal ideation. Officials in one state similarly said that these individuals could experience worsening behavioral health symptoms—and added that it can be difficult for them to access culturally competent behavioral health resources.</p>
People with fewer social supports	<p>Five stakeholders identified this population as particularly at risk, with some citing the potential impact of pandemic-driven social isolation. One researcher noted that before the pandemic, social isolation and loneliness were linked to poorer behavioral health outcomes, such as depression and anxiety, as well as cognitive decline. Members of a research group noted that in times of crisis a person's degree of social support affects their risk for behavioral health symptoms, and that social supports—which the pandemic undercut—serve as a protective factor. Officials in one state said they were worried about people who were living alone and experiencing extreme isolation and loneliness.</p>
People experiencing domestic violence	<p>Five stakeholders cited risks facing this population. According to SAMHSA, the economic stress, disconnection from community resources, and uncertainty stemming from the COVID-19 pandemic can lead to violence in families where it did not exist before—and worsen situations in homes where violence was already a problem.^e The pandemic also made it more difficult to seek help or leave a violent situation. Administration for Children and Families officials noted that shelters and other services had often been unavailable or significantly limited due to pandemic precautions, and that abusers consistently being at home led to fewer opportunities for people to leave the abusive situation. The head of a behavioral health clinic in one state said people were likely having to stay longer in very bad situations, because they could not find a safe time to leave their abuser, they had no safe place to go, or the people and places that would otherwise take them in would not do so due to the pandemic.</p>
People living in rural areas	<p>Three stakeholders raised concerns about this population, due, in part, to challenges rural populations face in accessing mental health care services. Members of a research group told us that the lack of mental health providers in rural areas can lead to months-long wait times for appointments and hinder individuals' ability to have their behavioral health conditions assessed, diagnosed, and treated.</p> <p>A 2020 study assessed the pandemic's impact on the well-being of individuals in the North American West, to help address a gap in knowledge about how diverse rural communities were faring during the pandemic. In particular, about 44 percent of respondents reported that the pandemic had some level of negative impact on their mental health, compared to 56 percent who reported no impact or a positive impact on their mental health.^f</p>
Unpaid caregivers of adults	<p>Three stakeholders identified this population, citing survey data from June 2020 that found self-reported unpaid caregivers of adults reported higher rates of increased substance use to cope with pandemic-related stress, suicidal ideation, and symptoms of anxiety disorder or depressive disorder than people who were not unpaid caregivers. CDC reported that among unpaid caregivers, 32.9 percent reported increased substance use and 30.7 percent reported suicidal ideation. Among adults who were not unpaid caregivers, 6.3 percent reported increased substance use and 3.6 percent reported suicidal ideation.^d</p> <p>A more recent study examining the mental health of adult caregivers—specifically, parents of children under age 18 and unpaid caregivers of adults—found that unpaid caregivers of adults reported significantly worse mental health than adults without any caregiving role. According to survey data from December 6–27, 2020, and February 16–March 8, 2021, unpaid caregivers of adults were more likely than non-caregivers to report symptoms of anxiety or depression, or suicidal ideation.^c</p>

Appendix II: Other Populations Stakeholders Identified as Potentially Being at Higher Risk of Behavioral Health Effects

Population	Examples of stakeholder input and research on behavioral health risks
People with limited education	Three stakeholders identified this population. CDC officials cited findings from the Census Bureau’s Household Pulse Survey, which has generally found that people with less than a high school education reported higher rates of symptoms of anxiety disorder or depressive disorder than people with higher levels of education. From August 18 – August 30, 2021, 36.3 percent of people with less than a high school diploma reported such symptoms, as compared with 27.1 percent of people with a Bachelor’s degree or higher. ^b

Source: GAO analysis of stakeholder input and selected research. | GAO-22-104437

^aSubstance Abuse and Mental Health Services Administration, *Disaster Technical Assistance Center Supplemental Research Bulletin: A Preliminary Look at the Mental Health and Substance Use-related Effects of the COVID-19 Pandemic*, (Rockville, Md.: May 2021).

^bThe Household Pulse Survey, an experimental data product, is an interagency federal statistical rapid response survey to measure household experiences during the COVID-19 pandemic. These estimates are based on responses to two questions about symptoms of depressive disorder and two questions about symptoms of anxiety disorder in the prior 7 days. The percentage of adults include those who reported symptoms that generally occurred more than half the days or nearly every day. The margin of error for these estimates varied, but ranged from about ± 1 to 4 percentage points at the 95 percent confidence level. See appendix I for details on the Household Pulse Survey and these estimates, including response rates and nonresponse bias analysis.

^cM. É. Czeisler, E.A.Rohan, S. Melillo et al., *Mental Health Among Parents of Children Aged <18 Years and Unpaid Caregivers of Adults During the COVID-19 Pandemic — United States, December 2020 and February–March 2021*, MMWR Morbidity and Mortality Weekly Report, vol. 70, no. 24 (2021) (Atlanta, Ga.: Centers for Disease Control and Prevention, June 18, 2021).

^dM. É. Czeisler, R. I. Lane, E. Petrosky et al., *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020*, MMWR Morbidity and Mortality Weekly Report, vol. 69, no. 32 (2020): p. 1049-1057 (Atlanta, Ga.: Centers for Disease Control and Prevention, Aug. 14, 2020).

^eSubstance Abuse and Mental Health Services Administration, *Intimate Partner Violence and Child Abuse Considerations During COVID-19*, (Rockville, Md.: April 2020).

^fJ. T. Mueller, K. McConnell, P.B. Burow et al., “*Impacts of the COVID-19 Pandemic on Rural America*,” Proceedings of the National Academy of Sciences, vol. 118, no. 1 (Jan. 5, 2021).

Appendix III: Challenges in Assessing the COVID-19 Pandemic’s Effects on Behavioral Health

This appendix provides information about the challenges assessing the COVID-19 pandemic’s effects on behavioral health in the United States, according to stakeholders and selected research. Some challenges, such as pandemic-driven changes in data collection methods, stemmed from the pandemic itself. Other challenges pertained more broadly to assessments of behavioral health, regardless of the pandemic. (See table 9.)

Table 9: Challenges in Assessing the COVID-19 Pandemic’s Effect on Behavioral Health

Type of challenge	Examples
Gaps and limitations in data on certain populations	<p>Children and adolescents. There are fewer data and published studies on how they have fared than there are on adults, according to some stakeholders. Some national surveys, for example, have not included people under age 18.</p> <p>Older adults. Some stakeholders said that pandemic-era surveys that are done online or otherwise rely on technology are not capturing information from older adults who are unable or do not want to participate in those types of surveys. Representatives of a geriatric behavioral health association said some older adults, such as those with cognitive deficits, would not be “good reporters” of symptoms, particularly on surveys. They said older adults’ behavioral health is better assessed with caregiver input; clinician observations and interviews; and assessments of their ability to do activities of daily living, such as eat and dress.</p> <p>American Indian/Alaska Native individuals. Representatives of a national group representing American Indian/Alaska Native communities told us that there is a lack of data on American Indian/Alaska Native individuals’ behavioral health. They said, for example, that American Indian/Alaska Native individuals may be included in the category of “other” race and ethnicities, and that behavioral health data are not always reported separately for the American Indian/Alaska Native population.</p> <p>People without access to the internet or technology. National Institutes of Health officials said a key challenge stems from studies having to pivot to collect data in ways that are in line with public health mitigation efforts. For example, researchers moved from collecting data in-person to collecting it remotely, typically through online platforms. This presented a new challenge in reaching people with little or no internet access.</p> <p>Other populations. People with serious mental illness, who are homeless, or who are in nursing homes may be underrepresented in available survey data, according to stakeholders.</p>
Other data gaps and limitations	<p>Data lags. Data on suicides often lag due to the time needed to adjudicate cause of death, which has been exacerbated by competing demands for medical examiners to determine COVID-19 related deaths, according to National Institutes of Health officials. Data on drug overdose deaths also lag, as these deaths often require lengthy investigations and death certificates may be initially filed with a preliminary or unknown cause of death, according to the Centers for Disease Control and Prevention.^a</p> <p>Limits of self-reported symptoms. Substance Abuse and Mental Health Services Administration (SAMHSA) has noted that studies based on surveys of self-reported symptoms do not reflect whether a respondent meets the diagnostic criteria for a behavioral health condition, which requires a more thorough assessment.^b</p> <p>Limits of aggregate data. One researcher noted that aggregate data on populations may obscure the behavioral health of subgroups that are faring relatively poorly. This may be true, for example, for groups of older adults whose behavioral health is worse than what is apparent from looking at the data for older adults as a whole, the researcher said.</p> <p>Lack of information about people who are not seeking care. Some stakeholders said there have been gaps in information about children who became disconnected from school supports, people in domestic abuse situations who were isolated and had not sought assistance, people with new-onset symptoms who had not yet sought care, and people who stopped accessing care in person due to COVID-19 and had not yet returned to be seen.</p>

**Appendix III: Challenges in Assessing the
COVID-19 Pandemic's Effects on Behavioral
Health**

Additional challenges

State data issues. Officials with one state told us that fragmented behavioral health data created challenges in assessing behavioral health during the pandemic. Officials with another state told us that in addition to the inherent difficulty of doing behavioral health surveillance, state epidemiologists also had to work on COVID-19 issues instead of behavioral health.

Research lags. There are lags in published pandemic research due to the time required for data collection, analysis, reporting, review, and publishing, according to SAMHSA.^b

Limits of point-in-time studies. While useful, these types of studies cannot determine the extent to which the prevalence of behavioral health symptoms and conditions may reflect pre-pandemic rates and trends rather than the pandemic's impact, according to some stakeholders.

Concurrent national and regional factors. Some stakeholders noted that during the pandemic there have been additional factors that have potentially affected peoples' behavioral health, such as wildfires and the political climate; this makes it difficult to distinguish the pandemic's impact from the impact of other factors, according to some researchers.

Source: GAO analysis of stakeholder input and selected research. | GAO-22-104437

^aF.B. Ahmad, L.M. Rossen LM, and P. Sutton, National Center for Health Statistics, Centers for Disease Control and Prevention, *Provisional Drug Overdose Death Counts*, accessed August 24, 2021, <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.

^bSubstance Abuse and Mental Health Services Administration, *Disaster Technical Assistance Center Supplemental Research Bulletin: A Preliminary Look at the Mental Health and Substance Use-related Effects of the COVID-19 Pandemic*, (Rockville, Md.: May 2021).

Appendix IV: Block Grant Awards Provided from COVID-19 Relief Funds for Behavioral Health

This appendix presents supplemental grant amounts awarded from COVID-19 relief funds through the Substance Abuse and Mental Health Services Administration’s Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant.¹ (See tables 10 and 11, respectively.)

Table 10: Community Mental Health Services Block Grant (MHBG) Supplemental Award Amounts from COVID-19 Relief Funds by State, U.S. Territory, or Jurisdiction

Dollars

State, territory, or jurisdiction	Consolidated Appropriations Act, 2021	American Rescue Plan Act of 2021	Total	Per capita funding amount
Alabama	11,944,986	20,632,249	32,577,235	6.62
Alaska	1,869,289	3,228,772	5,098,061	6.97
American Samoa	162,398	280,505	442,903	9.55
Arizona	22,711,565	39,229,067	61,940,632	8.35
Arkansas	7,229,333	12,487,030	19,716,363	6.51
California	108,247,196	186,972,433	295,219,629	7.50
Colorado	16,240,446	28,051,679	44,292,125	7.63
Connecticut	8,012,502	13,839,776	21,852,278	6.14
Delaware	1,925,871	3,326,504	5,252,375	5.32
Federated States of Micronesia	331,157	571,998	903,155	8.88
Florida	54,888,469	94,807,356	149,695,825	6.89
Georgia	26,439,839	45,668,812	72,108,651	6.73
Guam	536,059	925,921	1,461,980	8.66
Hawaii	4,161,536	7,188,108	11,349,644	8.07
Idaho	4,873,385	8,417,665	13,291,050	7.28
Illinois	29,073,007	50,217,012	79,290,019	6.30
Indiana	14,807,647	25,576,844	40,384,491	5.98
Iowa	6,483,317	11,198,457	17,681,774	5.59
Kansas	6,035,542	10,425,027	16,460,569	5.65
Kentucky	10,734,798	18,541,924	29,276,722	6.54
Louisiana	11,975,406	20,684,792	32,660,198	7.03
Maine	3,241,688	5,599,279	8,840,967	6.55

¹CARES Act, Pub. L. No. 116-136, div. B., tit. VIII, 134 Stat. 281, 556 (2020); Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, div. M, tit. III, 134 Stat. 1182, 1913 (2020); American Rescue Plan Act of 2021, Pub. L. No. 117-2, tit. II, subtit. H, 135 Stat. 4, 45-48. Unless otherwise stated, references to the Consolidated Appropriations Act, 2021 in this report refer to Division M of that act (Coronavirus Response and Relief Supplemental Appropriations Act, 2021).

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State, territory, or jurisdiction	Consolidated Appropriations Act, 2021	American Rescue Plan Act of 2021	Total	Per capita funding amount
Maryland	16,100,385	27,809,755	43,910,140	7.25
Massachusetts	16,551,534	28,589,013	45,140,547	6.55
Michigan	24,265,829	41,913,705	66,179,534	6.64
Minnesota	12,518,067	21,622,115	34,140,182	6.03
Mississippi	7,556,583	13,052,279	20,608,862	6.95
Missouri	13,913,837	24,032,991	37,946,828	6.17
Montana	2,531,162	4,372,007	6,903,169	6.39
Nebraska	3,795,400	6,555,690	10,351,090	5.34
Nevada	8,743,742	15,102,828	23,846,570	7.60
New Hampshire	2,912,959	5,031,475	7,944,434	5.81
New Jersey	22,649,212	39,121,366	61,770,578	6.95
New Mexico	5,026,824	8,682,696	13,709,520	6.51
New York	46,339,285	80,040,583	126,379,868	6.54
North Carolina	24,046,721	41,535,246	65,581,967	6.19
North Dakota	1,435,102	2,478,813	3,913,915	5.11
Northern Mariana Islands	166,129	286,951	453,080	8.77
Ohio	25,773,140	44,517,241	70,290,381	6.01
Oklahoma	9,094,136	15,708,052	24,802,188	6.23
Oregon	13,107,788	22,640,725	35,748,513	8.43
Palau	68,747	118,745	187,492	8.67
Pennsylvania	27,119,409	46,842,615	73,962,024	5.79
Puerto Rico	10,526,878	18,182,788	28,709,666	9.09
Marshall Islands	241,823	417,694	659,517	8.37
Rhode Island	3,069,963	5,302,664	8,372,627	7.92
South Carolina	12,436,240	21,480,779	33,917,019	6.50
South Dakota	1,782,520	3,078,898	4,861,418	5.45
Tennessee	15,793,941	27,280,443	43,074,384	6.25
Texas	74,580,936	128,821,616	203,402,552	6.93
Utah	7,459,411	12,884,438	20,343,849	6.26
Vermont	1,415,844	2,445,549	3,861,393	6.19
Virgin Islands	341,809	590,398	932,207	8.81
Virginia	20,718,461	35,786,432	56,504,893	6.58
Washington	19,222,372	33,202,279	52,424,651	6.81
Washington, D.C.	1,956,394	3,379,225	5,335,619	7.49
West Virginia	4,503,493	7,778,761	12,282,254	6.88
Wisconsin	14,259,851	24,630,652	38,890,503	6.67

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State, territory, or jurisdiction	Consolidated Appropriations Act, 2021	American Rescue Plan Act of 2021	Total	Per capita funding amount
Wyoming	1,048,637	1,811,283	2,859,920	4.91
Total	825,000,000	1,425,000,000	2,250,000,000	

Source: GAO analysis of Substance Abuse and Mental Health Services Administration and U.S. Census Bureau documentation. | GAO-22-104437

Note: Per capita funding is based on U.S. Census Bureau July 2020 population estimates for states and Puerto Rico, and July 2021 estimates for U.S. territories and other jurisdictions.

Table 11: Substance Abuse Prevention and Treatment Block Grant (SABG) Supplemental Award Amounts from COVID-19 Relief Funds by State, U.S. Territory, Jurisdiction, or Tribe

Dollars

State, territory, jurisdiction or tribe	Consolidated Appropriations Act, 2021	American Rescue Plan Act of 2021	Total	Per capita amount
Alabama	21,641,962	18,690,785	40,332,747	8.20
Alaska	5,519,877	4,767,166	10,287,043	14.07
American Samoa	324,795	280,505	605,300	13.05
Arizona	37,892,228	32,725,106	70,617,334	9.52
Arkansas	12,676,621	10,947,991	23,624,612	7.80
California	238,465,012	205,947,056	444,412,068	11.29
Colorado	27,102,042	23,406,309	50,508,351	8.70
Connecticut	17,070,466	14,742,675	31,813,141	8.94
Delaware	6,530,972	5,640,385	12,171,357	12.33
Federated States of Micronesia	662,313	571,998	1,234,311	12.14
Florida	104,396,719	90,160,803	194,557,522	8.95
Georgia	53,569,236	46,264,340	99,833,576	9.32
Guam	1,072,119	925,921	1,998,040	11.84
Hawaii	8,044,183	6,947,249	14,991,432	10.65
Idaho	8,000,710	6,909,704	14,910,414	8.16
Illinois	63,404,936	54,758,808	118,163,744	9.39
Indiana	30,224,518	26,102,993	56,327,511	8.34
Iowa	12,272,501	10,598,978	22,871,479	7.23
Kansas	11,153,650	9,632,698	20,786,348	7.13
Kentucky	19,100,815	16,496,159	35,596,974	7.95
Louisiana	23,457,477	20,258,730	43,716,207	9.41
Maine	6,530,972	5,640,385	12,171,357	9.01
Maryland	31,943,446	27,587,522	59,530,968	9.83
Massachusetts	37,347,121	32,254,331	69,601,452	10.10
Michigan	52,538,794	45,374,413	97,913,207	9.82

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State, territory, jurisdiction or tribe	Consolidated Appropriations Act, 2021	American Rescue Plan Act of 2021	Total	Per capita amount
Minnesota	22,591,036	19,510,440	42,101,476	7.44
Mississippi	12,938,191	11,173,892	24,112,083	8.13
Missouri	24,884,101	21,490,814	46,374,915	7.54
Montana	6,530,972	5,640,385	12,171,357	11.26
Nebraska	7,162,196	6,185,533	13,347,729	6.89
Nevada	15,937,418	13,764,133	29,701,551	9.46
New Hampshire	6,530,972	5,640,385	12,171,357	8.91
New Jersey	45,050,958	38,907,646	83,958,604	9.45
New Mexico	8,965,458	7,742,896	16,708,354	7.93
New York	104,819,223	90,525,693	195,344,916	10.10
North Carolina	42,171,280	36,420,651	78,591,931	7.41
North Dakota	6,123,948	5,288,864	11,412,812	14.91
Northern Mariana Islands	332,259	286,951	619,210	11.99
Ohio	60,489,869	52,241,251	112,731,120	9.64
Oklahoma	16,074,216	13,882,277	29,956,493	7.53
Oregon	19,288,251	16,658,035	35,946,286	8.47
Palau	137,494	118,745	256,239	11.86
Pennsylvania	55,395,098	47,841,221	103,236,319	8.08
Puerto Rico	21,053,755	18,182,788	39,236,543	12.42
Red Lake Band of Chippewa Indians	556,786	480,861	1,037,647	N/A ^a
Marshall Islands	483,646	417,694	901,340	11.43
Rhode Island	7,122,113	6,150,916	13,273,029	12.56
South Carolina	22,230,862	19,199,380	41,430,242	7.94
South Dakota	5,662,944	4,890,725	10,553,669	11.82
Tennessee	29,973,471	25,886,179	55,859,650	8.11
Texas	135,636,613	117,140,711	252,777,324	8.61
Utah	15,548,611	13,428,346	28,976,957	8.92
Vermont	6,054,892	5,229,225	11,284,117	18.10
Virgin Islands	683,619	590,398	1,274,017	12.03
Virginia	39,348,104	33,982,454	73,330,558	8.54
Washington	35,415,872	30,586,435	66,002,307	8.58
Washington, D.C.	6,530,972	5,640,385	12,171,357	17.08
West Virginia	7,904,019	6,826,198	14,730,217	8.25
Wisconsin	25,492,891	22,016,587	47,509,478	8.15
Wyoming	3,934,405	3,397,896	7,332,301	12.59
Total	1,650,000,000	1,425,000,000	3,075,000,000	

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Source: GAO analysis of Substance Abuse and Mental Health Services Administration and U.S. Census Bureau documentation. | GAO-22-104437

Note: Per capita funding is based on U.S. Census Bureau July 2020 population estimates for states and Puerto Rico, and July 2021 estimates for U.S. territories and other jurisdictions.

^aA current population estimate for the Red Lake Band of Chippewa Indians was not available.

Appendix V: Crisis Counseling Assistance and Training Program Awards for COVID-19 Relief

This appendix presents the amounts awarded for COVID-19 relief through the Federal Emergency Management Agency’s Crisis Counseling Assistance and Training Program (CCP). (See table 12.) The CCP was available to states, Washington, D.C., U.S. territories, and tribes through two grant mechanisms: (1) the Immediate Services Program, which provides funds for up to 60 days of services immediately following a disaster declaration, with options for extensions; and (2) the Regular Services Program, which provides funds for up to 9 months following the date the recipients received the notice of award, with options for extensions.¹

Table 12: Crisis Counseling Assistance and Training Program Approved Award Amounts by State and Territory as of November 2021

Dollars

State	Immediate Services Program	Regular Services Program	Total	Per capita amount
Alabama	Did not apply	3,698,690	3,698,690	0.75
Alaska	Did not apply	Withdrew application	0.00	0.00
Arizona	976,751	3,333,221	4,309,972	0.58
Arkansas	961,620	4,523,036	5,484,656	1.81
California	3,755,732	106,204,594	109,960,326	2.79
Colorado	1,780,587	12,544,342	14,324,929	2.47
Connecticut	704,039	3,080,526	3,784,565	1.06
Delaware	281,651	1,229,750	1,511,401	1.53
Florida	Did not apply	4,994,530	4,994,530	0.23
Georgia	398,978	1,735,482	2,134,460	0.20
Guam	Did not apply	993,186	993,186	5.88
Hawaii	127,850	2,102,679	2,230,529	1.59
Idaho	382,643	1,798,634	2,181,277	1.19
Illinois	Did not apply	2,249,090	2,249,090	0.18
Indiana	986,244	3,862,696	4,848,940	0.72
Iowa	1,400,566	4,743,732	6,144,298	1.94
Kansas	217,825	2,202,452	2,420,277	0.83

¹States, U.S. territories, and tribes were eligible to apply for and receive funds if (1) the disaster crisis counseling needs for the COVID-19 pandemic were beyond the combined capabilities of the state, territorial, or tribal governments to address; (2) the total number of COVID-19 cases exceeded 5,000 within the state, territory or tribe, or the total of number of COVID-19 cases exceeded 1,000 per 1 million of the population; (3) the state, tribe, or territory had mandatory closure orders of schools, places of employment, and social service networks due to health and safety concerns of the population; and (4) data existed to demonstrate heightened need for emotional care.

Appendix V: Crisis Counseling Assistance and Training Program Awards for COVID-19 Relief

State	Immediate Services Program	Regular Services Program	Total	Per capita amount
Kentucky	Did not apply	Did not apply	0.00	0.00
Louisiana	1,997,742	7,722,778	9,720,520	2.09
Maine	989,045	3,789,247	4,778,292	3.54
Maryland	90,000	537,800	627,800	0.10
Massachusetts	707,507	3,780,904	4,488,411	0.65
Michigan	371,983	2,870,421	3,242,404	0.33
Minnesota	537,651	1,826,991	2,364,642	0.42
Mississippi	Did not apply	Did not apply	0.00	0.00
Missouri	2,277,507	12,920,042	15,197,549	2.47
Montana	Withdrew application	1,642,155	1,642,155	1.52
Navajo Nation	Did not apply	Application under review	0.00	0.00
Nebraska	1,461,165	5,326,327	6,787,492	3.50
Nevada	654,640	2,750,183	3,404,823	1.08
New Hampshire	120,925	212,845	333,770	0.24
New Jersey	1,308,969	11,628,711	12,937,680	1.46
New Mexico	798,899	3,625,473	4,424,372	2.10
New York	1,315,111	106,818,771	108,133,882	5.59
North Carolina	1,567,261	3,604,753	5,172,014	0.49
North Dakota	251,053	835,629	1,086,682	1.42
Northern Mariana Islands	113,854	986,443	1,100,297	21.30
Ohio	466,550	6,350,924	6,817,474	0.58
Oklahoma	521,685	5,701,193	6,222,878	1.56
Oregon	Withdrew application	10,344,256	10,344,256	2.44
Pennsylvania	754,391	1,126,157	1,880,548	0.15
Poarch Band Creek Indians	Did not apply	Did not apply	0.00	0.00
Puerto Rico	3,214,047	18,437,618	21,651,665	6.85
Rhode Island	209,979	1,455,469	1,665,448	1.58
South Carolina	311,588	3,599,354	3,910,942	0.75
South Dakota	210,723	681,872	892,595	1.00
Tennessee	966,380	3,494,302	4,460,682	0.65
Texas	5,862,529	20,686,221	26,548,750	0.90
Utah	1,419,476	3,277,676	4,697,152	1.45
Vermont	140,645	1,095,186	1,235,831	1.98
Virgin Islands	295,585	929,116	1,224,701	11.57
Virginia	391,655	996,016	1,387,671	0.16
Washington	2,194,956	6,065,389	8,260,345	1.07

Appendix V: Crisis Counseling Assistance and Training Program Awards for COVID-19 Relief

State	Immediate Services Program	Regular Services Program	Total	Per capita amount
Washington, D.C.	350,507	3,525,592	3,876,099	5.44
West Virginia	123,500	937,891	1,061,391	0.59
Wisconsin	675,526	3,931,117	4,606,643	0.79
Wyoming	Did not apply	Did not apply	0.00	0.00
Total	44,647,520	422,811,462	467,458,982	

Source: GAO analysis of Federal Emergency Management Agency (FEMA) and U.S. Census Bureau documentation. | GAO-22-104437

Notes: Per capita funding is based on U.S. Census Bureau July 2020 population estimates for states and Puerto Rico, and July 2021 estimates for U.S. territories and other jurisdictions.

According to FEMA officials, recipients requested a specific amount of funding to address their disaster specific needs and provided a written narrative and a budget to justify that amount. The amount of funding FEMA awarded to recipients was based on several factors including (1) the amount of funding requested; (2) the justification provided; (3) the demonstrated need for the services; and (4) the recipient's capability to provide services.

According to FEMA officials, states are not required to share their reasons for not applying for a program or for withdrawing an application. However, some reasons included declining to apply due to sufficient resources existing within the state or tribe to meet the need, or determining that the need is not great enough to require a FEMA program. Additionally, receiving Immediate Services Program funding is not a prerequisite for Regular Services Program funding, and some states, tribes, or territories may decide to apply just for the Regular Services Program and not the Immediate Services Program, or vice versa, based on the availability of resources or population need.

Appendix VI: GAO Contact and Staff Acknowledgements

GAO Contact

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Staff Acknowledgements

In addition to the contact named above, the following individuals made key contributions to this report: Karen Doran (Assistant Director), Christina Ritchie (Analyst-in-Charge), Robin Burke, and Kaitlin Dunn. Joycelyn Cudjoe, Drew Long, Eric Peterson, Vikki Porter, Patricia Powell, and Emily Wilson Schwark provided technical and other support.

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