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Supporting Mental Health Policies and Practices through the American Rescue Plan

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Introduction

The pandemic exacerbated an already untenable mental health crisis, which continues to worsen by the week. To ensure that people have adequate and complete service coverage and supports, members of the public and private sectors, including policymakers, must make major systemic and policy changes. In March 2021, Congress passed the American Rescue Plan Act (ARPA) which included much-needed federal investments and opportunities to advance mental health policies and resources at the state and local level. However, these investments are timebound and insufficient to fully address the structural, systemic, and policy changes required to ensure appropriate and effective mental health services are equitably available to all individuals and communities.

This brief offers a set of principles policymakers and other stakeholders can consider as they implement ARPA's mental health provisions. It provides an overview of opportunities within the law to address mental health needs, and suggests immediate and longer-term policy recommendations that help to lift the longstanding barriers people of color and other historically disenfranchised populations face in accessing mental health services.

Background: America's Mental Health Crisis and Racial Inequities

Deaths or sickness of loved ones, job or housing losses/insecurity, and isolation due to COVID-19 have made conditions worse. According to recent Census Bureau Household Pulse Survey data (Phase 3.2, August 18-August 30), which collects data on how households are experiencing the pandemic, 32.1 percent of those surveyed showed symptoms of anxiety or depression over the last seven days, increasing as the weeks progress. The highest rates of anxiety or depression symptoms for this phase were shown in 18 to 29-year-olds (46.7 percent), transgender individuals (61.9 percent), bisexual people (59.7 percent), and disabled people (62.9 percent).[1]

COVID-19 has also exposed and deepened existing health inequities. Communities of color (including people who are Black, Indigenous, Latino, Asian American, Native Hawaiian, and Pacific Islander) experience barriers in the health care system due to racism and discrimination. Systemic barriers are also caused by limited transportation, broadband access, and health insurance coverage; occupations that do not provide paid leave or adequate insurance coverage; and a lack of trust in providers and the system. As of July 2021, American Indians[2]/Alaska Natives (AI/AN) died at 2.4 times the rate of white people. Other communities of color face similar disparities in death rates: Hispanic/Latinos have died at 2.3 times the rate of white Americans, and Black or African Americans have died at 2.0 times the rate. Hospitalization disparities are even more stark. For example, AI/AN communities are hospitalized 3.4 times more than white Americans. Black/African American and Hispanic/Latino people are hospitalized at 2.8 times the rate of white people.[3]

Because of limited sample sizes and limited disaggregated data collection among state and local entities, disparities in the Asian American, Native Hawaiian, and Pacific Islander (AA and NHPI) communities are often masked. NHPIs have been particularly hit hard by COVID-19. For example, the NHPI death rates in California are much higher (123 per 100,000) than the average state estimates (84 per 100,000).[4] Furthermore, racism and hate crimes associated with false representations of how COVID-19 spread have adversely affected the mental health of Asian Americans.[5]

ARPA relief funds and the mental health response

To have an impact, state and local policymakers must remove barriers to accessing appropriate mental health services faced by Black, Indigenous, Latino, and Asian American, Native Hawaiian, and Pacific Islander communities by engaging meaningfully with communities and using funds intentionally to alleviate those barriers.

Framing the response

Both mental health and addiction service policies are rooted in punitive measures, from institutionalizing people with serious mental illness (SMIs) in the 19th and early 20th centuries,[6] to criminalizing people in possession of or using substances.[7] Institutionalizing those considered mentally ill and imposing aggressive treatments or punitive acts on patients inside often made mental health conditions worse. At the same time, the separation of individuals from society at large exacerbated the stigma of mental health and substance use overall. We see the effects of stigma today, from the lack of comprehensive mental health policies, to criminalization due to substance use. There also remains a complete lack of compassion for those living in poverty who are unable to access benefits because of mental health concerns.

The Center for Law and Social Policy (CLASP), as an anti-poverty organization, understands the importance of addressing mental health and wellbeing for people to live full and healthy lives, as well as how mental health can impede access to other needed social supports. CLASP's Core Principles to Reframe Mental and Behavioral Health Policy speak to this, explaining why people impacted must be at the table to not only inform, but also direct policies to improve mental and behavioral health services and supports, by helping identify barriers and potential solutions.[8] Additionally, policymakers must be in partnership with individuals, families, and communities facing barriers to high-quality mental health care. They must listen to people impacted by these policy barriers; recognize the impacts of historical, cultural, and intergenerational trauma inflicted by harmful policies; and create healing spaces when needed, without retraumatizing people.

We ask local, state, and federal policymakers to draw from the following principles, further detailed in the Core Principles brief:[9]

1) **Redefining Mental Health:** Mental health systems and other systems that affect one's wellbeing should focus on assets-based framing, on wellness and prevention at both the structural and individual levels, rather than diagnosis and deficit-based framing.

2) **Expanding Access to Care:** To achieve comprehensive mental health care, we need to expand the current mental health system. We must establish universal health care, and implement and enforce mental health parity, at least equivalent to what is needed for physical health services.

3) **Enhancing Culturally Responsive Services:** Changes to our mental health system must explicitly promote equity and address health inequities. Policymakers must acknowledge and remove structural barriers impacting mental health and mental health access. These barriers include historical trauma and systemic racism, which have resulted in mistrust of providers, services, and systems.

4) **Addressing Social Needs:** Public health recommendations highlight the importance of addressing the root causes of community health challenges. This includes focusing on the social determinants of health, such as housing and education. Mental and behavioral health policy solutions must follow suit. They must address the underlying social and economic conditions in communities that limit or foster good mental health, as well as address individuals' basic needs.

5) **Strengthening Quality Infrastructure:** A proper data surveillance system and care management infrastructure must be in place to improve care provision. Data needs to be disaggregated by race/ethnicity and age, in addition to being continuously collected in youth-friendly and culturally responsive spaces. Providers must be appropriately trained in the above principles, including offering culturally responsive care, receiving implicit bias trainings, and understanding and dismantling societal and structural racism.

6) **Building a Robust and Diverse Workforce:** Meeting communities' mental and behavioral health needs calls for more providers across different areas of expertise, coming from many racial/ethnic backgrounds. Policymakers must create a pipeline to bring more providers of color into the workforce who represent and understand the communities they are working with.

   Through our work with states and localities over the years, we have recognized the benefit of cross-agency collaboration to address mental health, combining resources and encouraging collaboration. This can prevent overlapping efforts and ensure that funding, like that from the American Rescue Plan Act, is being used as best as possible.

ARPA mental health provisions

The funding and policy provisions of ARPA are insufficient to counter deep systemic and historic inequities. However, when approached in combination with the principles laid out above, they offer an opportunity to provide those communities most impacted with some immediate relief. This includes funds and policies that can help extend mental health services to children, youth, and families.

Mental health resources and opportunities presented in ARPA include: Supplemental Substance Abuse and Mental Health Services Administration block grants, Child Care Stabilization grants, state and local relief funds, Elementary and Secondary School Emergency Relief (ESSER) Funds, and expanded Medicaid provisions.

I. Supplemental Substance Abuse and Mental Health Services Administration (SAMHSA) grants

ARPA makes investments totaling $3.56 billion directly into existing mental health grants and programs. These include:

- Certified Community Behavioral Health Clinics Expansion Grants (CCBHC Expansion Grants), which provide 24-hour and crisis physical, mental, and substance use disorder (SUD) care to individuals and families;
- National Child Traumatic Stress Initiative (NCTSI), Category III, Community Service Treatment (CTS) Centers grants, to expand access to trauma treatment and care for children, youth, and their families;
- Garrett Lee Smith (GLS) Campus Suicide Prevention grants, which fund mental health and SUD treatment and prevention activities for students in postsecondary education settings; and
- Supplements to the Community Mental Health Services Block Grant (MHBG) which provides comprehensive, community based mental health services to children and adults; and the Substance Abuse Prevention and Treatment Block Grant (SABG), which funds substance abuse prevention, treatment, and recovery support activities at the community level. Both grants are administered by states, and can be spent through FY 2025.

States can use the MHBG and SABG to pay for comprehensive services that aren't covered by Medicare, Medicaid or private insurance.[10] The SAMHSA guidance for ARPA funds encourages a wide variety of strategies to expand access to effective mental health services, particularly for underserved communities and individuals. For example, the guidance encourages expanding technology and access to telehealth services; community-based partnerships with key stakeholders; and strategies that support a

continuum of crisis care for children, which includes screening, mobile crisis response, and home and community-based services. SAMHSA requires that 10 percent of MHBG grants are allocated to first-episode psychosis or early serious mental illness (SMI) programs. At least 20 percent of the SABG funds must be used for primary prevention services for people who do not need treatment for substance use; SAMHSA also encourages states to provide services related to adverse childhood experiences (ACEs), particularly among young adults, as well as promote health equity within the state.[11]

Current (fiscal year 2021) grants for these categories of ARPA relief funds can be found on the SAMHSA website, and is referenced below.[12]

II. Child care stabilization grants

ARPA included a total of $39 billion in relief funds for child care and early education. The centerpiece of those investments was the $24 billion in child care stabilization grants, funding that states must regrant to providers by September 2022. ARPA language and the federal guidance that followed outlined mental health services for the child care workforce and for children in child care settings as allowable uses for these funds.

Stabilization grants can include a number of strategies to support mental health services for the child care workforce and for children in their care:

- Incorporating the cost of comprehensive health coverage, including mental health care, in their estimates of the cost of care, which inform grant amounts made available;
- Encouraging programs and providers to use a portion of their general stabilization grants to offer expanded mental health services to child care workers, and to help them access professional development and training in trauma-informed care and child mental health;
- Administering separate subgrants specifically incentivizing providers to support mental health services for children in care or child care workers, and designed to connect them to and pay for mental health services beyond existing state consultation programs; or
- Incorporating existing state evidence-based infant and early childhood mental health consultation (IECMHC) programs into subgrants by offering applicants the option of directing a portion of their subgrant funds toward IECMHC services at the state or regional level.

The complete guidance on how states can use child care stabilization grants is published on the Administration for Children and Families website, and referenced below.[13]

III. State and Local Relief Funds

ARPA included over $350 billion in state and local relief funds for states and municipalities to address the impacts of the pandemic. State and local governments have until December 2024 to use the funds. Interim guidance on these relief funds identified approved uses that include mental health and substance abuse treatment.[14] In addition, the guidance specifies that in communities severely impacted by the pandemic—identified as Qualified Census Tracts (QCTs)—funds can be used to meet a wide array of community needs. For instance, funds can help facilitate access to health services, meet the mental health needs of students to mitigate the educational impact of the public health emergency, and support mental health recovery for families involved in the child welfare system.

IV. Elementary and Secondary School Emergency Relief (ESSER) Funds

ARPA awarded approximately $122 billion to State Education Agencies (SEAs) through the Elementary and Secondary School Emergency Relief (ESSER) to counter the negative effects of the pandemic on students in prekindergarten through secondary school settings. Among the approved uses for these funds, states have the option to support mental health services for students.[15]

In its reopening plans, the U.S. Department of Education required states to explain how they planned to address the social, emotional, and mental health needs of students. Of the 37 states that had submitted plans by July 5, 2021, 30 mentioned investments in social and emotional learning (SEL) as a key strategy to address the mental health needs of students. Among those states, some expanded existing SEL programs--including by developing new curricula, definitions, and frameworks--while others made initial investments in SEL, focusing on training educators. Some states also chose to invest in the behavioral health workforce, both by hiring direct service providers (e.g., counselors, mobile crisis teams, clinicians) and by hiring state-level coordinators to oversee mental health initiatives.

V. ARPA Medicaid Provisions

Finally, ARPA included a number of Medicaid provisions that can support equitable mental health services for individuals and communities. These include:

- A state option to extend Medicaid coverage of comprehensive postpartum health care from 60 days to 12 months, which can expand mothers' access to critical postpartum mental health care;
- An incentive for states to develop mobile response services that more effectively and humanely respond to mental health crises in communities. ARPA offers an enhanced federal matching rate of up to 85 percent for such services with a

Medicaid State Plan Amendment or waiver request, as well as state planning funds to develop mobile response systems. While mobile response services are generally needed in communities, they can be particularly effective in supporting the needs of youth;[16] and

- An incentive for states to offer enhanced home and community-based services (HCBS) through March 2024. With a temporary increase of 10 percent to the federal matching rate from April 1, 2021 to March 31, 2022, states can prioritize and expand access to HCBS, including mental and behavioral health services. This may create opportunities to improve services like case management, rehabilitative, or school-based services for targeted populations and reduce access barriers like transportation, linguistic, or cultural needs.

State Policy Recommendations for ARPA Implementation

ARPA presents many immediate opportunities for states to improve access to mental health prevention, assessment, and treatment. It also can support community-level efforts to ensure people who have been historically disenfranchised have equitable access to appropriate and effective services. State and community policymakers should act quickly to take these steps:

1. State and local policymakers should engage and consult with impacted people, service providers, and other stakeholders to better understand how the mental health resources provided through ARPA can most effectively be used to address the specific needs of children and adults. These discussions should focus on understanding the impact of the public health crisis and mental health needs in Black, Latino, Indigenous, Asian American, Native Hawaiian, and Pacific Islander (AA and NHPI) communities, as well as among individuals who are immigrants, LGBTQIA+, and/or living with disabilities;

2. State and local mental health agencies and service providers should pursue and coordinate use of the various SAMHSA supplemental grants available under ARPA to ensure they are being used effectively to equitably reach and respond to the needs of impacted communities;

3. States should keep in mind populations adversely impacted by the pandemic (e.g., youth and young adults, AA and NHPIs, disabled populations, and immigrants) and provide funding for services that offer appropriate, culturally responsive care and support;

4. State child care agencies should incorporate resources for mental health services for both children and the child care workforce into their ARPA-funded stabilization grants, and ensure they're designed to equitably reach families and providers.[17] Child care leaders at the state and community level should also consider collaborating with agencies funded through SAMHSA to ensure children, families, and the child care workforce are aware of the full range of available supports and facilitate their access to them;

5. State education agencies must collaborate with state Medicaid offices and/or state health departments to ensure on-campus providers are reimbursed; Tier 1 supports (like SEL) are available to all students and fully funded; all students receive care regardless of insurance coverage -- and that these mental health programs can sustain post-ESSER;

6. ESSER funding can best support anti-racist mental health policies if state and local education agencies ensure that all school-based mental health care is culturally responsive, equitably reaching children in communities most impacted by the pandemic. This includes prioritizing culturally affirming SEL that does not reinforce white values by ensuring anti-racist and anti-bias training for all school-based providers and hiring providers who are diverse in both identity and credentials;

7. State Medicaid offices should pursue the waiver and state plan options under ARPA to maximize access to effective mental health services for individuals and families, including expanding postpartum coverage, implementing mobile crisis response services, and enhancing home and community-based services;

8. State health departments must ensure that funding for a robust behavioral health workforce meets the needs of the current mental health crisis, including hiring providers across disciplines (e.g., peer-support providers, recovery specialists, doulas, and social workers, as well as psychologists and psychiatrists), and in different locations (e.g., schools, afterschool care, child care facilities, Federally Qualified Health Centers, clinics, workforce agencies, community-based organizations, etc.). They must also build future pipelines through loan repayment scholarship programs and strategies;

9. Through 9-8-8 (suicide prevention and mobile response) funding, state health and human service departments can ensure that mental health mobile response models are police-free, acknowledging mental health professionals beyond psychiatrists and psychologists (e.g., peer support specialists) are first responders. During implementation of mobile crisis response, states must ensure that everyone involved is trained in issues including crisis intervention, de-escalation, culturally responsive services, trauma-informed care, and disability awareness;

10. For non-clinical providers (e.g., peer support providers, recovery specialists, social workers, etc.) to feel valued and be adequately compensated, states must work to expand scope-of-practice laws to include provision of essential mental and behavioral health services by these professionals;

11. ARPA subgrants should be given to community providers and to non-health settings (e.g., afterschool centers, workforce agencies). As we mentioned above, stakeholder and community engagement is a key driver of effective policy development. Providing grants directly to community-based organizations that deliver services beyond mental health (e.g., job training, community support, housing, food banks) can help to address the

broader needs of people experiencing mental and behavioral health challenges and fill in gaps that community providers continually face to address the mental and behavioral health of their participants/clients; and

12. Regulations must ensure that telehealth can be used and reimbursed by multiple kinds of care and provider types. This may require relaxing licensing requirements and expanding access to reimbursement, particularly for non-traditional providers like peer-support specialists; easing rules about privacy standards; encouraging states to eliminate the origination site requirement; opening up reimbursement for telehealth by phone, text, and app; and ensuring both synchronous and asynchronous care, group, and individual care is permissible by telehealth.

Conclusion

We hope that the recommendations outlined above, along with CLASP's Core Principles to Reframe Mental and Behavioral Health Policy will provide guidance to local and state policymakers as they develop services and supports to meet the needs of their communities. Without comprehensive action across agencies to address the growing mental and behavioral health crises, adverse conditions will continue to rise. ARPA presents a unique and crucial opportunity to collaboratively support communities living in poverty, working across the child care, education, workforce, and health care systems. State policymakers and other stakeholders must fully utilize these resources to address the immediate and worsening crisis and make the case for long-term policy changes and investments that can address the racial inequities and other gaps in our mental and behavioral health systems.

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