COVID-19

in Behavioral Health & Addiction Treatment Programs

Staff Report Prepared for
Senator Elizabeth Warren
Representative Carolyn B. Maloney, Chairwoman,
House Committee on Oversight and Reform
Representative Katie Porter

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Executive Summary

As the novel coronavirus 2019 (SARS-CoV-2 or COVID-19) pandemic continues, mental health care needs are increasing, and people in need of behavioral health treatment are especially vulnerable. Isolation, job loss, reduced income, and anxiety about health risks are all associated with worsened mental health and substance use.

A recent poll found that 53% of adults in the United States reported that "their mental health has been negatively impacted due to worry and stress over the virus." Emergency calls related to drug overdoses have increased by as much as 50% since the same period last year in some parts of the country. The Centers for Disease Control and Prevention (CDC) has found that adults in the U.S. are experiencing "worse mental health outcomes, increased substance use, and elevated suicidal ideation" as a result of the pandemic. In addition, the National Institutes of Health (NIH) warns that people with a history of tobacco, marijuana, opioid, or methamphetamine use may be at higher risk for complications from COVID-19 due to the harm those substances can cause to respiratory health.

Although some states have begun to collect and report statistics on cases of COVID-19 within addiction and behavioral health treatment centers, there is currently no national requirement for these facilities to report infections or fatalities in these facilities. As a result, little is known about the extent of COVID-19 outbreaks in inpatient behavioral health facilities or the actions taken by providers to reduce the risk to patients and staff.

To address this gap, Senator Elizabeth Warren, House Oversight Committee Chairwoman Carolyn B. Maloney, and Representative Katie Porter wrote to ten large behavioral health treatment program operators on August 5, 2020, seeking information on the occurrence and prevention of COVID-19 in inpatient and residential behavioral health and addiction treatment facilities across the United States. Eight operators provided substantive responses, covering 376 facilities and more than 100,000 patients in 40 states and Puerto Rico.

This investigation, the first comprehensive review of COVID-19 in behavioral health programs, found:

- **Behavioral health facilities' crucial role in helping individuals in need of treatment for substance abuse disorders is particularly important during the COVID-19 pandemic.** At the same time that mental health and substance use disorder needs have increased, providers are operating with limited capacity and resources. Given these needs, federal, state, and local governments should provide all necessary assistance and ensure that these facilities have adequate testing, personal protective equipment (PPE), and other resources needed to prevent and control the disease.

- **More than half of behavioral health facilities covered by the survey had at least one case of COVID-19, and one in seven facilities had wider outbreaks.** 51% of the behavioral health facilities in the survey had at least one case of COVID-19, and 14% had larger outbreaks of ten or more cases. The surveyed providers indicated that, as of August 2020, 1,785 patients and 2,200 staff members had been diagnosed with COVID-

19. This represents an infection rate of 1.8% for patients and 3.3% for staff. While the infection rate for patients is in line with the incidence rate of COVID-19 for the general public, staff at the surveyed facilities were 83% more likely than the general public to be diagnosed with COVID-19 as of late August. These cases covered in the survey resulted in 21 total fatalities.

- **Limited testing capacity has led to a lack of testing and passive testing protocols in behavioral health facilities, which places workers and patients at risk.** Limited testing capacity is hampering providers' abilities to screen patients and workers for COVID-19. None of the behavioral health facility operators reported that they conduct routine daily or weekly testing of staff or patients at all their facilities. When tests are conducted, most facilities report experiencing turnaround times of a week or more for test results.

- **Behavioral health facilities are not reporting cases and fatalities to the federal government.** Most of the large behavioral health providers indicated that they do not systematically report any COVID-19 case information to the federal government, explaining, "Our facilities are not required to report COVID-19 cases to any federal agency." As a result, federal government officials, prospective patients, and the public do not have a full picture of COVID-19 occurrence and fatality rates in behavioral health facilities.

- **Paid sick leave policies do not provide appropriate coverage for many workers at behavioral health facilities.** While most of the surveyed providers have adapted their paid sick leave policies to accommodate workers diagnosed with COVID-19, only one makes paid sick leave accessible to 100% of employees. Two providers offer only six days of paid sick leave per year, far short of the recommended two-week quarantine period. Several do not offer coverage to part-time workers, leaving 10%-30% of workers with no paid sick leave at all. Every not-for-profit provider surveyed reported providing two weeks of paid leave to employees diagnosed with COVID-19, whereas some for-profit providers failed to offer their employees this comprehensive paid leave protection.

- **Fewer patients have been able to receive inpatient care, despite an increased need for services.** Several providers reported that operational changes to prevent the spread of COVID-19 have limited admissions to their inpatient programs, despite increases in inquiries and other evidence that the pandemic has intensified the need for mental and behavioral health care. Providers have shifted to telehealth to meet patients' needs. This decline in the number of patients receiving inpatient treatment may represent a potential public health problem on top of the ongoing COVID-19 pandemic—underscoring the need to provide inpatient facilities with the testing, equipment, and resources needed to respond to the pandemic.

I. Introduction and Methodology

On August 5, 2020, Senator Elizabeth Warren, House Oversight Committee Chairwoman Carolyn B. Maloney, and Representative Katie Porter wrote to ten large operators of behavioral health and addiction treatment facilities. The letters sought information on COVID-19 outbreaks in the residential and inpatient programs operated by these providers, and steps taken to prevent them.[1]

The members opened their inquiry because of the lack of comprehensive information available on the impact of COVID-19 in residential behavioral health facilities and because of alarming trends apparent in other congregate care facilities.

These trends showed that residents in congregate care facilities have died or been infected from COVID-19 at significantly higher rates than the general population. Senators Warren and Markey and Chairwoman Maloney's recent investigation of assisted living facilities found that clients of these facilities have tested positive for COVID-19 at more than five times the national average rate and that approximately 7,000 assisted living facility residents may have died from COVID-19 through May 2020.[2] Serious outbreaks have also been reported in prisons, jails, and group homes serving people with disabilities.[3]

Mental and behavioral health services have become increasingly important to the well-being of individuals struggling with substance use disorder or other behavioral health conditions during the ongoing pandemic. Isolation, job loss, reduced income, and anxiety about health risks are all associated with worsened mental health and substance use. A recent poll found that 53% of adults in the United States reported that "their mental health has been negatively impacted due to worry and stress over the virus."[4] Emergency calls related to drug overdoses have increased by as much as 50% since the same period last year in some parts of the country.[5] In addition, the NIH warns that people with a history of tobacco, marijuana, opioid, or methamphetamine use may be at higher risk for complications from COVID-19 due to the damage those substances can cause to respiratory health.[6]

Although some states have begun to collect and report statistics on cases of COVID-19 within addiction and behavioral health treatment centers, there is currently no national reporting requirement on cases or fatalities in these facilities.[7] As a result, little is known about the extent of COVID-19 outbreaks in inpatient behavioral health facilities or the actions taken by providers to reduce the risk to patients and staff. Without more information, it is impossible for public health authorities to appropriately direct resources to protect the health and safety of people who may be at heightened risk.

To answer these questions, this staff report presents an early analysis of the scope of COVID-19 outbreaks in behavioral health facilities and the actions taken by their operators to prevent and mitigate these outbreaks. It reflects responses from eight large operators of behavioral health and addiction treatment facilities, covering 376 inpatient or residential facilities in 40 states and Puerto Rico, approximately 101,000 patients, and 65,906 workers.[8]

II. Findings

1. Prevalence of COVID-19 in Behavioral Health Facilities

a. More than Half of Surveyed Facilities Have Had at Least One COVID-19 Case

The eight operators that provided data on their inpatient and residential facilities operate a total of 376 facilities. Of these, 191 facilities, or 51%, have had at least one case of COVID-19, and 54 facilities, or 14%, had a more widespread outbreak with at least ten or more cases.

b. COVID-19 Infection Rates in Behavioral Health Facility Residents and Staff

The surveyed providers indicate that, as of August 2020, 1,785 patients and 2,200 staff members had been diagnosed with COVID-19. This represents an infection rate of 1.8% for patients and 3.3% for staff. While the infection rate for patients is in line with the incidence rate of COVID-19 for the general public, staff at the surveyed facilities were 83% more likely than the general public to be diagnosed with COVID-19 as of late August.[9]

These infection rates reflect individuals who were diagnosed with COVID-19 after developing symptoms. Because none of the operators surveyed report conducting regular testing for asymptomatic patients or staff, the reported number of cases are likely to undercount the total number who contracted the virus.

Overall, long-term care workers, including behavioral health workers, are disproportionately low-wage workers, Black, and female.[10] Only 56% have employer-sponsored health insurance.[11] These characteristics are likely to make infected staff at behavioral health facilities less able to access high quality medical care and to cushion the economic impact of missed work.

COVID-19 fatality rates among both patients and workers were lower than the national average, perhaps because of a relatively young patient population.[12] The surveyed operators report 11 fatalities from COVID-19 among patients and ten among workers. This represents a fatality rate of 0.6% among patients diagnosed with COVID-19 and 0.5% among staff diagnosed with COVID-19, compared with an overall national case fatality rate of 2.6% nationwide.[13] The surveyed providers report that 94 patients and 136 staff members had been hospitalized, in line with cumulative hospitalization rates in the population at large for the 18-49 age group.[14]

2. Lack of Testing and Inadequate Testing Protocols in Behavioral Health Facilities

Lack of available testing, which has plagued the national response since the first case of COVID-19 appeared in the United States, is having a significant impact on behavioral health facilities. Providers report that they are generally not able to perform routine testing of asymptomatic individuals to monitor their facilities for potential outbreaks, as the CDC recommends for congregate care facilities, and that test results are frequently not available for a week or more—hampering their ability to identify cases of COVID-19, prevent its spread , and provide effective treatment.[15]

a. Behavioral Health Facilities Are Not Able to Conduct Routine COVID-19 Testing Due to Limited Availability of Necessary Supplies and Capacity

Routine coronavirus testing helps to identify asymptomatic coronavirus carriers who are capable of transmitting the virus to others despite their lack of symptoms. Routine testing is particularly important for congregate living settings. The CDC recommends broad-based viral testing, including of asymptomatic individuals, in congregate living settings that have had a known COVID-19 case or when there is "moderate to substantial transmission" in the community where the facility is located.[16]

None of the behavioral health facility operators reported that they conduct routine daily or weekly testing of patients at all their facilities. Although all providers test patients or staff who are symptomatic or have been in close contact with a person diagnosed with COVID-19, only two providers reported that they have begun conducting weekly routine testing at a few of their locations, accounting for only four facilities out of the 376 in the sample, which are located in 40 states and Puerto Rico. During the August time period of the survey, many of these states were experiencing spikes in COVID-19 cases.[17] Under these circumstances, the CDC recommends surveillance testing of asymptomatic individuals in congregate care settings.[18] Nonetheless, only two providers stated that they test all new patients upon their admission. Two providers reported testing new patients at some locations or under some circumstances, while the others only screen new patients for symptoms. All providers stated that they are not conducting testing for visitors because they are no longer allowing visitors at their facilities, except in rare court-mandated situations.

Most providers cited difficulty obtaining testing supplies and timely results for their decision not to conduct routine screening of asymptomatic patients or staff. One provider wrote in its response:

> Due to the difficulty of obtaining testing supplies, our facilities have not been able to implement routine testing of asymptomatic patients or staff. Most testing has been conducted via the local health departments. We have attempted on numerous occasions to acquire rapid testing supplies with limited success.

The limited availability of testing supplies and capacity for processing has prevented many facilities from implementing routine testing of asymptomatic patients and staff, despite its importance for identifying and containing outbreaks.

b. Testing Results Are Delayed

Rapid return of test results is crucial for timely and accurate isolation of infected individuals. But only two of the eight providers reported that they are able to obtain test results within 24 hours. Both of these providers use their own laboratories to process results, allowing them to bypass longer processing times at local health departments and commercial labs.

The other providers reported turnaround times for test results ranging from 48 hours to 14 days. These delays can prevent needed care and consume costly resources as patients and staff are required to quarantine and use PPE while waiting for results. One provider wrote:

> It could take 7-14 days to obtain test results; during this time, the individual could die from an overdose if he/she is not able to admit into treatment. If a patient is experiencing symptoms while in treatment, but hasn't received COVID-19 test results yet, patient is isolated until results are available. Most local department of health agencies have limited rapid test supplies and feel they are not reliable. All have told us to monitor for symptoms and treat the bigger issue of potential overdose/death. We are treating an epidemic within a pandemic environment.

The lack of a robust and widely available infrastructure for COVID-19 testing continues to impede providers' ability to protect the health and safety of their patients and staff, with potentially deadly consequences.

3. Lack of Federal Reporting of COVID-19 Cases in Behavioral Health Facilities

All of the large behavioral health facility operators were asked whether they inform residents and their families, local and state governments, and the federal government about cases in their facilities. The responses revealed a significant gap in federal reporting requirements.

All operators reported that they inform state and local health departments as required and appropriate in their locality. However, only one provider reported directly submitting information to the federal government. The other providers noted that they were not required to provide data to federal agencies, writing, "None of the facilities is currently required to conduct federal reporting of COVID cases," and "Our facilities are not required to report COVID-19 cases to any federal agency." This lack of reporting at the federal level creates a significant gap in the national understanding of risks to patients in behavioral health settings.

There was wide variation in how providers inform staff, patients, and their families about confirmed positive cases of COVID-19. Some providers reported that they disclose positive cases to all staff and residents within the same facility, through in-person meetings, electronic or written communication, and/or phone outreach to discharged patients. Other providers inform patients and staff only if they potentially have been exposed to the person diagnosed with COVID-19. Although there are federal guidelines for other congregate care settings, such as nursing homes, for disclosing COVID-19 cases to residents, their loved ones, and the general public in a timely manner, there are no such federal guidelines or standard practices in place for behavioral health facilities.[19]

4. Inadequate Paid Sick Leave Policies

Providing staff with adequate leave policies is one key to helping reduce the transmission of COVID-19 in congregate care settings. For this reason, the CDC recommends that residential facilities "[i]mplement sick leave policies that are flexible and non-punitive" in order to ensure

that employees who have or may have COVID-19 do not come into work and interact with residents and co-workers when they are ill.[20]

Most of the surveyed providers reported having made changes to their policies to allow employees to take paid sick leave when they are diagnosed with COVID-19 or advised to quarantine. Two providers reported that they are waiving 90-day waiting periods for new employees to allow them to access paid sick leave immediately, and two other providers reported that workers may borrow against future accrued leave if they are diagnosed with COVID-19 or advised to quarantine. Another provider directs employees who have insufficient accrued leave to apply for Family and Medical Leave, but it has committed to supplementing their pay so that they will continue to receive their full salary while recovering from COVID-19.

However, two providers reported that they continue to limit their workers to only six days of paid sick leave per year—far fewer days than the recommended two-week quarantine period. An additional four providers combined sick leave with other types of paid time off for at least some of their workers. In effect, many of these companies are forcing employees who may have or fear they have COVID-19 to use vacation or personal leave to mitigate the risk to the facility.

Even when paid sick leave policies are flexible and allow for at least two weeks of paid leave, they are rarely available to all workers. Only one of the surveyed providers indicated that 100% of its employees are eligible for paid leave. For all of the other providers, between 10% and 30% of workers are ineligible for paid leave. These providers reported making paid leave available to only full-time employees, setting a minimum number of hours for part-time employees to access the benefit, or requiring a waiting period before paid leave can be used—a high barrier in an industry with high turnover rates.[21] Although some providers reported waiving this waiting period if the employee has been diagnosed with COVID-19 or instructed to quarantine, as discussed above, this allowed the employee to access only accrued leave, even though it would typically take the employee months to accumulate sufficient leave to complete a two-week quarantine. Among providers surveyed, those operating on a not-for-profit basis provide two weeks of paid leave to employees diagnosed with COVID-19, whereas some for-profit providers reported offering their employees this comprehensive paid leave protection.

5. Use of PPE in Behavioral Health Facilities

Proper use of readily available PPE is critical to preventing coronavirus spread in congregate care facilities, and the CDC recommends that all health care professionals use protective equipment such as eye protection and face masks.[22] Although all facility operators reported following state and federal guidelines for PPE use and providing PPE to employees at no cost, they also reported facing significant logistical difficulties obtaining adequate PPE for their staff.

Especially early in the pandemic, several behavioral health facility operators cited challenges obtaining adequate PPE for their staff and patients. Although addiction and behavioral health treatment were considered essential services that remained open throughout "shelter-in-place" orders, they were seldom prioritized for distribution of protective equipment and had to go to great lengths to procure PPE. One provider reported that although they are now able to obtain sufficient PPE for their staff and patients, this had not always been the case:

> At the height of the pandemic however, substance abuse treatment centers—though deemed essential—were overlooked, and had few resources to procure PPE, yet were held to the same strict standards as large hospital systems that had the benefit of group purchasing organization to place large supply orders.

Another provider wrote that, "as a sub-acute provider, our Company facilities and staff seemed to be near the bottom of the list to receive both assistance with emergency supplies or financial assistance." Several providers noted that they had secured their own supply chains for PPE, without the assistance of local health or emergency response officials.

Despite these challenges, all providers responded that their PPE policies comply with federal and state guidelines, including the CDC's guidance, and that PPE is provided free of charge to all employees. Most providers reported that both patients and staff are required to wear face masks in their facilities, with staff required to wear gloves during direct interactions with patients in some cases. Full PPE, including gowns, eye protection, and respirator masks, are typically reserved for staff interacting with patients who have suspected cases of COVID-19, have been exposed to COVID-19 in a close contact, or who are otherwise in isolation.

6. Fewer Patients Have Been Able to Receive Inpatient Care for Behavioral Health, Despite Increased Need for Support

Several providers reported that although they have observed increased need for behavioral health services during the pandemic, operational changes they implemented to prevent the spread of COVID-19 have limited admissions to their inpatient programs. Early evidence indicates that the pandemic has increased the need for substance use disorder, addiction, and mental health treatment. The CDC has found that adults in the U.S. are experiencing worse mental health outcomes, increased substance use, and elevated suicidal ideation during the pandemic.[23] Emergency calls related to drug overdoses are also up as much as 50% in some parts of the country.[24]

However, patients may be reluctant to enter inpatient treatment given the risk of infection in congregate living settings and the difficulty of travel, and infection control practices have limited providers' capacity. One provider reported a 10% increase in phone calls looking for assistance and a 20% increase in website inquiries during the pandemic, but it noted that its actual admissions remain flat. Another provider reported that its facilities are currently operating at 55%-58% capacity. A third provider reported a 20% decrease in new admissions during the national shutdown, although they experienced record levels of "calls for help" in May and June 2020. A fourth provider reported that they are no longer admitting new patients to programs for "high-risk" individuals, such as programs for pregnant/post-partum people and senior citizens.

These reductions in the number of patients entering treatment facilities—even as there appears to be an increased need—represents a potential public health problem on top of the COVID-19 pandemic. Even before the pandemic, only about 12.2% of adults who need treatment for a substance use disorder received any type of specialty treatment.[25] Most providers reported shifting care into telehealth formats and using technology to arrange virtual visits and group

meetings. However, at least one provider reported difficulty obtaining reimbursement from commercial insurers for services provided by telehealth.

III. Conclusion and Recommendations

Behavioral health facilities and their patients and workers are facing significant challenges during the COVID-19 pandemic. More than half of facilities surveyed have had at least one case of COVID-19, and one in seven facilities had larger outbreaks of at least ten cases. Staff at behavioral health facilities were more likely than the general population to contract COVID-19.

At the same time, the need for behavioral health services is on the rise. Providers have taken some steps to protect workers and patients in their facilities, including implementing more generous paid sick leave policies and providing PPE at no cost to employees. However, they have not taken other steps recommended by experts, such as routine testing of asymptomatic patients. There is also no federal reporting system that would allow the public and patients to fully understand the extent of COVID-19 outbreaks in behavioral health facilities.

To address these challenges, we recommend:

- Enhanced federal data collection requirements for behavioral health providers that receive federal funding, including regular reporting of data on COVID-19 testing and cases for both patients and staff, which is shared transparently with the public.

- Federal funding and use of the Defense Production Act to increase availability of PPE, testing supplies, and test processing capacity, in order to support safe operation of behavioral health programs.

- Additional federal funding for behavioral health providers, including inpatient programs, to address the increased costs of providing essential care.

- Universal paid sick leave of at least two weeks for all behavioral health staff, including part time workers.

Greater transparency, additional resources, and fair paid sick leave policies are essential to supporting behavioral health providers and staff as they address the COVID-19 pandemic within their facilities and provide life-saving care to people in need.

[1] Letters from Sen. Warren, Chairwoman Maloney, and Rep. Porter to Behavioral Health Providers, August 5, 2020, https://www.warren.senate.gov/oversight/letters/warren-maloney-porter-ask-behavioral-health-and-addiction-treatment-facilities-what-actions-they-are-taking-to-protect-residents-from-covid-19-outbreaks. The information request was sent to American Addiction Centers, Acadia Healthcare, Universal Health Services, Alita Care,

BayMark Health Services, Gaudenzia Inc., BayCare Health, Promises Behavioral Health, LifeStream Behavioral Center, and Pinnacle Treatment Centers.

[2] "COVID-19 in Assisted Living Facilities," Staff Report Prepared for Senator Elizabeth Warren, Senator Edward J. Markey, and Rep. Carolyn B. Maloney, July 2020, https://www.warren.senate.gov/imo/media/doc/Assisted%20Living%20Facilities%20Staff%20Report.pdf.

[3] New York Times, "Chicago's Jail Is Top U.S. Hot Spot as Virus Spreads Behind Bars," Timothy Williams and Danielle Ivory, April 8, 2020, https://www.nytimes.com/2020/04/08/us/coronavirus-cook-county-jail-chicago.html; Associated Press, "Thousands sick from COVID-19 in homes for the disabled," Holbrook Mohr, Mitch Weiss, and Reese Dunklin, June 11, 2020, https://apnews.com/bdc1a68bcf73a79e0b6e96f7085ddd34.

[4] Kaiser Family Foundation, "The Implications of COVID-19 for Mental Health and Substance Use," Nirmita Panchal, Rabah Kamal, Kendal Orgera, Cynthia Cox, Rachel Garfield, Liz Hamel, Cailey Muñana, and Priya Chidambaram, August 21, 2020, https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/.

[5] Washington Post, "'Cries for help': Drug overdoses are soaring during the coronavirus pandemic," William Wan and Heather Long, July 1, 2020, https://www.washingtonpost.com/health/2020/07/01/coronavirus-drug-overdose/.

[6] National Institute on Drug Abuse, "COVID-19: Potential Implications for Individuals with Substance Use Disorders," Nora Volkow, April 6, 2020, https://www.drugabuse.gov/about-nida/noras-blog/2020/04/covid-19-potential-implications-individuals-substance-use-disorders.

[7] California Department of Health Care Services, "COVID-19 Cases Reported in Behavioral Health Facilities," Updated July 10,2020, https://www.dhcs.ca.gov/dataandstats/Pages/COVID-19-DHCS-BH-Certified-Facilities.aspx.

[8] BayMark's response indicated that they do not directly operate any inpatient or residential facilities, so their response is excluded from the analysis. Alita Care did not provide a response.

[9] As of August 27, 2020, the CDC reported 5.8 million COVID-19 cases, out of a population of 328.2 million, for a incidence rate in the general public of 1.8%. Centers for Disease Control and Prevention, "United States COVID-19 Cases and Deaths by State," updated August 27, 2020, https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/previouscases.html.

[10] Kaiser Family Foundation, "COVID-19 and Workers at Risk: Examining the Long-Term Care Workforce," April 23, 2020, https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-and-workers-at-risk-examining-the-long-term-care-workforce/.

[11] *Id.*

[12] Clin. Med., "Mental health in young adults and adolescents – supporting general physicians to provide holistic care," Izabela Jurewicz, April 2015, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4953734/.

[13] Fatality rate is calculated by dividing the number of deaths by the total number of cases. Centers for Disease Control and Prevention, "United States COVID-19 Cases and Deaths by State," updated October 27, 2020, https://covid.cdc.gov/covid-data-tracker/#cases_totalcases.

[14] The hospitalization rate for people ages 18-49 was 113.8 people per 100,000 at the time of the survey. The hospitalization rate among patients and staff in our survey was 137.6 per 100,000. Centers for Disease Control and Prevention, "COVIDView," Updated September 11, 2020, https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html.

[15] Centers for Disease Control and Prevention, "Performing Broad-Based Testing for SARS-CoV-2 in Congregate Settings," Updated June 27, 2020, https://www.cdc.gov/coronavirus/2019-ncov/hcp/broad-based-testing.html.

[16] *Id.*

[17] Washington Post, "Where states reopened and cases spiked after the U.S. shutdown," updated September 11, 2020, https://www.washingtonpost.com/graphics/2020/national/states-reopening-coronavirus-map/?itid=lk_inline_manual_15.

[18] Centers for Disease Control and Prevention, "Performing Broad-Based Testing for SARS-CoV-2 in Congregate Settings," Updated June 27, 2020, https://www.cdc.gov/coronavirus/2019-ncov/hcp/broad-based-testing.html.

[19] Centers for Medicare & Medicaid Services, "Upcoming Requirements for Notification of Confirmed COVID-19 (or COVID-19 Persons Under Investigation) Among Residents and Staff in Nursing Homes," April 19, 2020, https://www.cms.gov/files/document/qso-20-26-nh.pdf.

[20] Centers for Disease Control and Prevention, "Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities," May 29, 2020, https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html.

[21] Administration and Policy in Mental Health, "A prospective examination of clinician and supervisor turnover within the context of implementation of evidence-based practices in a publicly-funded mental health system" Rinad S. Beidas et al., September 1, 2017, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4715798/.

[22] Centers for Disease Control and Prevention, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," Updated July 15, 2020, https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html.
[23] Centers for Disease Control and Prevention, "Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic—United States, June 24-30, 2020," Mark Czeisler et al., August 14, 2020, https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm.
[24] Washington Post, "'Cries for help': Drug overdoses are soaring during the coronavirus pandemic," William Wan and Heather Long, July 1, 2020, https://www.washingtonpost.com/health/2020/07/01/coronavirus-drug-overdose/.
[25] U.S. Department of Health and Human Services, Office of the Surgeon General, "Facing Addiction In America: The Surgeon General's Spotlight on Opioids," September 2018, https://addiction.surgeongeneral.gov/sites/default/files/OC_SpotlightOnOpioids.pdf.