Agenda: Together to Fight Suicide – Regional Coalition Webinar

1 p.m. – 2:30 p.m.

Please join my meeting from your computer, tablet or smartphone.

https://www.gotomeet.me/AnnetteMarcus/coalitionwebinar

You can also dial in using your phone.

United States: +1 (872) 240-3412

Access Code: 115-644-093

Time	Topic and Presenter
1:00 – 1:15	Welcome and Introductions (intro's on chat) and Alliance Update Suicide Prevention Month Messaging – Annette Marcus
1:15-1:20	Update Oregon Health Authority – Shanda Hochstetler
1:20 – 1:35	American Foundation to Prevent Suicide – National Approaches Suicide Prevention Week – Ryan Price,
1:35 – 1:45	Healthy Transitions-Stories of Hope, Help and Healing – Elliot Hinkle
1:45 – 1:55	Clackamas Suicide Prevention Coalition-Jennifer Fraga
1:55 – 2:30	Group Discussion and Reflections

Webinar Meeting Notes:

08.25.2020

Attendance:

- Amy Ruona – Portland Public Schools
- Charlette Lumby
- Doug Gouge – Lane County
- Elliott Hinkle – Healthy Transitions
- Emily Watson - OHA
- Fran Pearson – OHA School Based Mental Heatlh
- Gabi Colton – Youth Era, Coos County
- Gordon Clay
- Grace Bullock – Oregon Department of Education
- Jammie Gardner – Youth Era
- Jesus Nunez-Pineda – Youth Era
- John Seeley – U of O Lab
- Jonathan Hankins – Lines for Life
- Jon Rochelle – U of O Lab
- Joseph Stepanenko – Young Adult
- Justin Potts – Eugene 4j School District
- Kahae Rikeman – Lines for Life
- Kimberlee Jones – Jefferson County
- Kris Bifulco - AOCMHP
- Kristin Fettig
- Lev Schneidman
- Lon Staub – Loss Survivor
- Liz Thorne – Matchstick Consulting
- Meghan Crane - OHA
- Roxanne Wilson – Loss Survivor; Fifth Corner Academy; Yamhill COunty
- Ryan Price – American Foundation for Suicide Prevention
- Sarah Rea – Mental Health Promotion & Prevention Coordinator
- Sarah Trejo - Columbia County
- Shanda Hochstetler - OHA
- Shane Roberts – Young Adult
- Spencer Lewis – Oregon School Boards Association
- Stephanie Cisneros – Youth Era
- Sunshine Mason – Umatilla County Veteran Service Officer
- Tanya Pritt – YES House
- Timothy Glascock - AOCMHP

CDC Report: https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm

Lines for Life Regional Coordinator Job Postings: https://recruiting.paylocity.com/recruiting/jobs/All/c4d60954-95aa-4f33-a606-3062073468e8/Lines-For-Life

Schools can apply for up to $1,500 in mini-grant funding to help support Adi's Act implementation: https://oregonyouthline.org/school-suicide-prevention-plan-grant-application/

Don't Give Up Signs: https://www.dontgiveupsigns.com/

Button / Signs for those trained in Suicide Prevention / Intervention / Postvention / Management: https://www.eachmindmatters.org/product/know-the-signs-pin-button/

Suicide Prevention Month Ideas:

- Kimberlee Jones - Yard Campaign
    - Have signage printed and provided to those in the community that have been trained in the community
    - Signs like "You Can Talk to Me" "Our Community Can Prevent Suicide"
- Roxanne Wilson – "5 C's for Life"
    - https://docs.google.com/presentation/d/1rOdA89vbNWGjATCFc-tp4bGmWKf2olYCwkbc7rMwMWE/edit?usp=sharing
- Sarah Rea – "Getting people out of the house
    - Baker County
    - Drive-by candlelight vigil
    - You are not alone signs
    - National sober day awareness walk
- Gabi Colton – Youth Era
    - Having a stream on Twitch and Discord
        - Video gaming stream site that also allows people to chat

Oregon Alliance to Prevent Suicide
Hope • Help • Healing

Together We Can Prevent Suicide: Suicide Prevention Month

Regional Coalition Webinar Aug. 25, 2020

Please enter your name, pronouns, title, organization, email and coalition in the chat box

What if I stumble?
I will become resilient.
What if I break?
I will rebuild myself.
What if I fail?
I will have a story to tell.
I will have someone to inspire.
I will have someone to lead.

Najwa Zebian

Together Virtually: We Got This!

AGENDA 1:00 – 2:30 p.m.

- Welcome and Alliance Update – Annette Marcus
- Oregon Health Authority Update – Shanda Hochstetler
- AFSP – Suicide Prevention Month – Ryan Price
- Healthy Transitions-Stories of Hope, Help and Healing – Elliot Hinkle
- Clackamas Suicide Prevention Coalition Campaign – Jennifer Fraga
- Group Discussions and Reflections

- **September Quarterly Meeting**
- Focus on Next 5 Year Youth Suicide Intervention and Prevention Plan
  - Friday Sept. 11, 2020
  - Orientation 8:45 – 9:15 a.m.
  - Meeting 9:30 a.m. – 12:30 a.m.
  - Zoom Meeting Link to Follow

- Alliance Policy Priorities
  - Requiring Behavioral Health workforce to be trained in suicide prevention, intervention and management
  - Supporting continued investment in behavioral health system to prevent and treat suicide
  - Extending age of YSIPP from 10 -24, to Kindergarten – 24'
  - Supporting implementation of Adi's Act (SB52)
  - Supporting implementation of HB3090/3091 which require caring contact after emergency dept. visit for mental health crisi

Framework for Safe Messaging

- Safety – avoid content that increases risk for vulnerable individuals or is unhelpful by reinforcing problematic norms, conveying negative stereotypes or undermining prevention.
- Positive Narrative – promote the positive in some form, such as sharing resources, telling positive real stories, describing action steps, and featuring program success.
- Guidelines – use specific guidance or best practices that apply to messaging.
- Strategy – plan and focus messages so they are as effective as possible. This includes integrating communications with other efforts, defining clear, achievable and measurable goals, understanding the audiences, identifying a "call to action" and providing resources for taking action.

Framework for Successful Messaging

Framework - National Action Alliance for Suicide Prevention

Framing Messages

The Alliance supports youth and families and promotes public policy to:

- Promote a sense of **hope** and highlight resilience.
- Make sure the right **help** is available at the right time.
- Engage individuals and communities in the **healing** process after an attempt or suicide

Oregon Alliance to Prevent Suicide
Hope • Help • Healing

Some Key Resources

- CDC Report: Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic, June 24 – 30, 2020 - Link to CDC Report
- American Foundation for Suicide Prevention and Lines for Life social media campaigns
- Public Health Surveillance Update from Oregon Health Authority on Suicide-related visits to ED's, Urgent Care, Oregon Poison Center, and Lines for Life (Will attach report with materials after webinar)
- Sample press release language from the Alliance that can be adapted to highlight local activities (Contact Annette for sample)

Join Us in Recognizing September as Suicide Prevention Month

- In a time when issues of mental health and social isolation are on the front page, it's more important than ever that during suicide prevention month, we promote and recognize suicide prevention efforts and stories of hope, help, and healing. While the mental health challenges brought with COVID-19 are like none in our lifetime, there is much good work happening and many examples of Oregonian's resilience.
- The pandemic has resulted in an explosion in both formal and informal networks of digital yet emotional connections. Counselors are available widely via tele- health, while someone sitting alone at a table is now dining and playing games with friends through over online platforms like Zoom and Google Chat.
- Highlight local stories of hope, help and healing. Be realistic about the challenges and desperation many are experiencing Always include crisis and text line resources

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Weekly / Vol. 69 / No. 32
August 14, 2020

Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020

Mark É. Czeisler[1,2]; Rashon I. Lane MA[3]; Emiko Petrosky, MD[3]; Joshua F. Wiley, PhD[1]; Aleta Christensen, MPH[3]; Rashid Njai, PhD[3]; Matthew D. Weaver, PhD[1,4,5]; Rebecca Robbins, PhD[4,5]; Elise R. Facer-Childs, PhD[1]; Laura K. Barger, PhD[4,5]; Charles A. Czeisler, MD, PhD[1,4,5]; Mark E. Howard, MBBS, PhD[1,2,6]; Shantha M.W. Rajaratnam, PhD[1,4,5]

The coronavirus disease 2019 (COVID-19) pandemic has been associated with mental health challenges related to the morbidity and mortality caused by the disease and to mitigation activities, including the impact of physical distancing and stay-at-home orders.* Symptoms of anxiety disorder and depressive disorder increased considerably in the United States during April–June of 2020, compared with the same period in 2019 (*1*,*2*). To assess mental health, substance use, and suicidal ideation during the pandemic, representative panel surveys were conducted among adults aged ≥18 years across the United States during June 24–30, 2020. Overall, 40.9% of respondents reported at least one adverse mental or behavioral health condition, including symptoms of anxiety disorder or depressive disorder (30.9%), symptoms of a trauma- and stressor-related disorder (TSRD) related to the pandemic† (26.3%), and having started or increased substance use to cope with stress or emotions related to COVID-19 (13.3%). The percentage of respondents who reported having seriously considered suicide in the 30 days before completing the survey (10.7%) was significantly higher among respondents aged 18–24 years (25.5%), minority racial/ethnic groups (Hispanic respondents [18.6%], non-Hispanic black [black] respondents [15.1%]), self-reported unpaid caregivers for adults§ (30.7%), and essential workers¶ (21.7%).

* https://www.medrxiv.org/content/10.1101/2020.04.22.20076141v1.

† Disorders classified as TSRDs in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM–5) include posttraumatic stress disorder (PTSD), acute stress disorder (ASD), and adjustment disorders (ADs), among others.

§ Unpaid adult caregiver status was self-reported. The definition of an unpaid caregiver for adults was a person who had provided unpaid care to a relative or friend aged ≥18 years to help them take care of themselves at any time in the last 3 months. Examples provided included helping with personal needs, household chores, health care tasks, managing a person's finances, taking them to a doctor's appointment, arranging for outside services, and visiting regularly to see how they are doing.

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

INSIDE

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1103 Notes from the Field: Multidrug-Resistant Tuberculosis Among Workers at Two Food Processing Facilities — Ohio, 2018–2019
1106 QuickStats

Continuing Education examination available at https://www.cdc.gov/mmwr/mmwr_continuingEducation.html

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Community-level intervention and prevention efforts, including health communication strategies, designed to reach these groups could help address various mental health conditions associated with the COVID-19 pandemic.

During June 24–30, 2020, a total of 5,412 (54.7%) of 9,896 eligible invited adults** completed web-based surveys†† administered by Qualtrics.§§ The Monash University Human Research Ethics Committee of Monash University (Melbourne, Australia) reviewed and approved the study protocol on human subjects research. Respondents were informed of the study purposes and provided electronic consent before commencement, and investigators received anonymized responses. Participants included 3,683 (68.1%) first-time respondents and 1,729 (31.9%) respondents who had completed a related survey during April 2–8, May 5–12, 2020, or both intervals; 1,497 (27.7%) respondents participated during all three intervals (*2*,*3*). Quota sampling and survey weighting were employed to improve cohort representativeness of the U.S. population by gender, age, and race/ethnicity.¶¶ Symptoms of anxiety disorder and depressive disorder were assessed using the four-item Patient Health Questionnaire*** (*4*), and symptoms of a COVID-19–related TSRD were assessed using the six-item Impact of Event Scale††† (*5*). Respondents also reported

** A minimum age of 18 years and residence within the United States as of April 2–8, 2020, were required for eligibility for the longitudinal cohort to complete a survey during June 24–30, 2020. Residence was reassessed during June 24–30, 2020, and one respondent who had moved from the United States was excluded from the analysis. A minimum age of 18 years and residence within the United States were required for eligibility for newly recruited respondents included in the cross-sectional analysis. For both the longitudinal cohort and newly recruited respondents, respondents were required to provide informed consent before enrollment into the study. All surveys underwent data quality screening procedures including algorithmic and keystroke analysis for attention patterns, click-through behavior, duplicate responses, machine responses, and inattentiveness. Country-specific geolocation verification via IP address mapping was used to ensure respondents were from the United States. Respondents who failed an attention or speed check, along with any responses identified by the data-scrubbing algorithms, were excluded from analysis.

†† The surveys contained 101 items for first-time respondents and 86 items for respondents who also participated in later surveys, with the 15 additional items for first-time respondents consisting of questions on demographics. The survey instruments included a combination of individual questions, validated questionnaires, and COVID-19-specific questionnaires, which were used to assess respondent attitudes, behaviors, and beliefs related to COVID-19 and its mitigation, as well as the social and behavioral health impacts of the COVID-19 pandemic.

§§ https://www.qualtrics.com/.

¶¶ Survey weighting was implemented according to the 2010 U.S. Census with respondents who reported gender, age, and race/ethnicity. Respondents who reported a gender of "Other," or who did not report race/ethnicity were assigned a weight of one.

*** Symptoms of anxiety disorder and depressive disorder were assessed via the four-item Patient Health Questionnaire (PHQ-4). Those who scored ≥3 out of 6 on the Generalized Anxiety Disorder (GAD-2) and Patient Health Questionnaire (PHQ-2) subscales were considered symptomatic for these respective disorders. This instrument was included in the April, May, and June surveys.

††† Symptoms of a TSRD attributed to the COVID-19 pandemic were assessed via the six-item Impact of Event Scale (IES-6) to screen for overlapping symptoms of PTSD, ASD, and ADs. For this survey, the COVID-19 pandemic was specified as the traumatic exposure to record peri- and posttraumatic symptoms associated with the range of stressors introduced by the COVID-19 pandemic. Those who scored ≥1.75 out of 4 were considered symptomatic. This instrument was included in the May and June surveys only.

The *MMWR* series of publications is published by the Center for Surveillance, Epidemiology, and Laboratory Services, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30329-4027.

Suggested citation: [Author names; first three, then et al., if more than six.] [Report title]. MMWR Morb Mortal Wkly Rep 2020;69:[inclusive page numbers].

whether they had started or increased substance use to cope with stress or emotions related to COVID-19 or seriously considered suicide in the 30 days preceding the survey.[§§§]

Analyses were stratified by gender, age, race/ethnicity, employment status, essential worker status, unpaid adult caregiver status, rural-urban residence classification,[¶¶¶] whether the respondent knew someone who had positive test results for SARS-CoV-2, the virus that causes COVID-19, or who had died from COVID-19, and whether the respondent was receiving treatment for diagnosed anxiety, depression, or posttraumatic stress disorder (PTSD) at the time of the survey. Comparisons within subgroups were evaluated using Poisson regressions with robust standard errors to calculate prevalence ratios, 95% confidence intervals (CIs), and p-values to evaluate statistical significance ($\alpha = 0.005$ to account for multiple comparisons). Among the 1,497 respondents who completed all three surveys, longitudinal analyses of the odds of incidence[****] of symptoms of adverse mental or behavioral health conditions by essential worker and unpaid adult caregiver status were conducted on unweighted responses using logistic regressions to calculate unadjusted and adjusted[††††] odds ratios (ORs), 95% CI, and p-values ($\alpha = 0.05$). The statsmodels package in Python (version 3.7.8; Python Software Foundation) was used to conduct all analyses.

Overall, 40.9% of 5,470 respondents who completed surveys during June reported an adverse mental or behavioral health condition, including those who reported symptoms of anxiety disorder or depressive disorder (30.9%), those with TSRD symptoms related to COVID-19 (26.3%), those who reported having started or increased substance use to cope with stress or emotions related to COVID-19 (13.3%), and those who reported having seriously considered suicide in the preceding 30 days (10.7%) (Table 1). At least one adverse mental or behavioral health symptom was reported by more than one half of respondents who were aged 18–24 years (74.9%) and 25–44 years (51.9%), of Hispanic ethnicity (52.1%), and who held less than a high school diploma (66.2%), as well as those who were essential workers (54.0%), unpaid caregivers for adults (66.6%), and who reported treatment for diagnosed anxiety (72.7%), depression (68.8%), or PTSD (88.0%) at the time of the survey.

Prevalences of symptoms of adverse mental or behavioral health conditions varied significantly among subgroups (Table 2). Suicidal ideation was more prevalent among males than among females. Symptoms of anxiety disorder or depressive disorder, COVID-19–related TSRD, initiation of or increase in substance use to cope with COVID-19–associated stress, and serious suicidal ideation in the previous 30 days were most commonly reported by persons aged 18–24 years; prevalence decreased progressively with age. Hispanic respondents reported higher prevalences of symptoms of anxiety disorder or depressive disorder, COVID-19–related TSRD, increased substance use, and suicidal ideation than did non-Hispanic whites (whites) or non-Hispanic Asian (Asian) respondents. Black respondents reported increased substance use and past 30-day serious consideration of suicide in the previous 30 days more commonly than did white and Asian respondents. Respondents who reported treatment for diagnosed anxiety, depression, or PTSD at the time of the survey reported higher prevalences of symptoms of adverse mental and behavioral health conditions compared with those who did not. Symptoms of a COVID-19–related TSRD, increased substance use, and suicidal ideation were more prevalent among employed than unemployed respondents, and among essential workers than nonessential workers. Adverse conditions also were more prevalent among unpaid caregivers for adults than among those who were not, with particularly large differences in increased substance use (32.9% versus 6.3%) and suicidal ideation (30.7% versus 3.6%) in this group.

Longitudinal analysis of responses of 1,497 persons who completed all three surveys revealed that unpaid caregivers for adults had a significantly higher odds of incidence of adverse mental health conditions compared with others (Table 3). Among those who did not report having started or increased substance use to cope with stress or emotions related to COVID-19 in May, unpaid caregivers for adults had 3.33 times the odds of reporting this behavior in June (adjusted OR 95% CI = 1.75–6.31; p<0.001). Similarly, among those who did not report having seriously considered suicide in the previous 30 days in May, unpaid caregivers for adults had 3.03 times the odds of reporting suicidal ideation in June (adjusted OR 95% CI = 1.20–7.63; p = 0.019).

[§§§] For this survey, substance use was defined as use of "alcohol, legal or illegal drugs, or prescriptions drugs that are taken in a way not recommended by your doctor." Questions regarding substance use and suicidal ideation were included in the May and June surveys only. Participants were informed that responses were deidentified and that direct support could not be provided to those who reported substance use behavior or suicidal ideation. Regarding substance use, respondents were provided the following: "This survey is anonymous so we cannot provide direct support. If you would like crisis support please contact the Substance Abuse and Mental Health Services Administration National Helpline, 1-800-662-HELP (4357), (also known as the Treatment Referral Routing Service) or TTY: 1-800-487-4889. This is a confidential, free, 24-hour-a-day, 365-day-a-year, information service, in English and Spanish, for persons and family members facing mental and/or substance use disorders." Regarding suicidal ideation, respondents were provided the following: "This survey is anonymous so we cannot provide direct support. If you would like crisis support please contact the National Suicide Prevention Lifeline, 1-800-273-TALK (8255, or chat line) for help for themselves or others."

[¶¶¶] Rural-urban classification was determined by using self-reported ZIP codes according to the Federal Office of Rural Health Policy definition of rurality. https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html.

[****] Odds of incidence was defined as the odds of the presence of an adverse mental or behavioral health outcome reported during a later survey after previously having reported the absence of that outcome (e.g., having reported symptoms of anxiety disorder during June 24–30, 2020, after not having reported symptoms of anxiety disorder during April 2–8, 2020).

[††††] Adjusted for gender, employment status, and essential worker status or unpaid adult caregiver status.

TABLE 1. Respondent characteristics and prevalence of adverse mental health outcomes, increased substance use to cope with stress or emotions related to COVID-19 pandemic, and suicidal ideation — United States, June 24–30, 2020

Characteristic	All respondents who completed surveys during June 24–30, 2020 weighted* no. (%)	Weighted %*						
		Conditions				Started or increased substance use to cope with pandemic-related stress or emotions¶	Seriously considered suicide in past 30 days	≥1 adverse mental or behavioral health symptom
		Anxiety disorder†	Depressive disorder†	Anxiety or depressive disorder†	COVID-19–related TSRD§			
All respondents	**5,470 (100)**	**25.5**	**24.3**	**30.9**	**26.3**	**13.3**	**10.7**	**40.9**
Gender								
Female	2,784 (50.9)	26.3	23.9	31.5	24.7	12.2	8.9	41.4
Male	2,676 (48.9)	24.7	24.8	30.4	27.9	14.4	12.6	40.5
Other	10 (0.2)	20.0	30.0	30.0	30.0	10.0	0.0	30.0
Age group (yrs)								
18–24	731 (13.4)	49.1	52.3	62.9	46.0	24.7	25.5	74.9
25–44	1,911 (34.9)	35.3	32.5	40.4	36.0	19.5	16.0	51.9
45–64	1,895 (34.6)	16.1	14.4	20.3	17.2	7.7	3.8	29.5
≥65	933 (17.1)	6.2	5.8	8.1	9.2	3.0	2.0	15.1
Race/Ethnicity								
White, non-Hispanic	3,453 (63.1)	24.0	22.9	29.2	23.3	10.6	7.9	37.8
Black, non-Hispanic	663 (12.1)	23.4	24.6	30.2	30.4	18.4	15.1	44.2
Asian, non-Hispanic	256 (4.7)	14.1	14.2	18.0	22.1	6.7	6.6	31.9
Other race or multiple races, non-Hispanic**	164 (3.0)	27.8	29.3	33.2	28.3	11.0	9.8	43.8
Hispanic, any race(s)	885 (16.2)	35.5	31.3	40.8	35.1	21.9	18.6	52.1
Unknown	50 (0.9)	38.0	34.0	44.0	34.0	18.0	26.0	48.0
2019 Household income (USD)								
<25,000	741 (13.6)	30.6	30.8	36.6	29.9	12.5	9.9	45.4
25,000–49,999	1,123 (20.5)	26.0	25.6	33.2	27.2	13.5	10.1	43.9
50,999–99,999	1,775 (32.5)	27.1	24.8	31.6	26.4	12.6	11.4	40.3
100,999–199,999	1,301 (23.8)	23.1	20.8	27.7	24.2	15.5	11.7	37.8
≥200,000	282 (5.2)	17.4	17.0	20.6	23.1	14.8	11.6	35.1
Unknown	247 (4.5)	19.6	23.1	27.2	24.9	6.2	3.9	41.5
Education								
Less than high school diploma	78 (1.4)	44.5	51.4	57.5	44.5	22.1	30.0	66.2
High school diploma	943 (17.2)	31.5	32.8	38.4	32.1	15.3	13.1	48.0
Some college	1,455 (26.6)	25.2	23.4	31.7	22.8	10.9	8.6	39.9
Bachelor's degree	1,888 (34.5)	24.7	22.5	28.7	26.4	14.2	10.7	40.6
Professional degree	1,074 (19.6)	20.9	19.5	25.4	24.5	12.6	10.0	35.2
Unknown	33 (0.6)	25.2	23.2	28.2	23.2	10.5	5.5	28.2
Employment status††								
Employed	3,431 (62.7)	30.1	29.1	36.4	32.1	17.9	15.0	47.8
Essential	1,785 (32.6)	35.5	33.6	42.4	38.5	24.7	21.7	54.0
Nonessential	1,646 (30.1)	24.1	24.1	29.9	25.2	10.5	7.8	41.0
Unemployed	761 (13.9)	32.0	29.4	37.8	25.0	7.7	4.7	45.9
Retired	1,278 (23.4)	9.6	8.7	12.1	11.3	4.2	2.5	19.6
Unpaid adult caregiver status§§								
Yes	1,435 (26.2)	47.6	45.2	56.1	48.4	32.9	30.7	66.6
No	4,035 (73.8)	17.7	16.9	22.0	18.4	6.3	3.6	31.8
Region¶¶								
Northeast	1,193 (21.8)	23.9	23.9	29.9	22.8	12.8	10.2	37.1
Midwest	1,015 (18.6)	22.7	21.1	27.5	24.4	9.0	7.5	36.1
South	1,921 (35.1)	27.9	26.5	33.4	29.1	15.4	12.5	44.4
West	1,340 (24.5)	25.8	24.2	30.9	26.7	14.0	10.9	43
Rural-urban classification***								
Rural	599 (10.9)	26.0	22.5	29.3	25.4	11.5	10.2	38.3
Urban	4,871 (89.1)	25.5	24.6	31.1	26.4	13.5	10.7	41.2

See table footnotes on the next page.

TABLE 1. (*Continued*) Respondent characteristics and prevalence of adverse mental health outcomes, increased substance use to cope with stress or emotions related to COVID-19 pandemic, and suicidal ideation — United States, June 24–30, 2020

Characteristic	All respondents who completed surveys during June 24–30, 2020 weighted* no. (%)	Weighted %*						
		Conditions				Started or increased substance use to cope with pandemic-related stress or emotions¶	Seriously considered suicide in past 30 days	≥1 adverse mental or behavioral health symptom
		Anxiety disorder†	Depressive disorder†	Anxiety or depressive disorder†	COVID-19–related TSRD§			
Know someone who had positive test results for SARS-CoV-2								
Yes	1,109 (20.3)	23.8	21.9	29.6	21.5	12.9	7.5	39.2
No	4,361 (79.7)	26.0	25.0	31.3	27.5	13.4	11.5	41.3
Knew someone who died from COVID-19								
Yes	428 (7.8)	25.8	20.6	30.6	28.1	11.3	7.6	40.1
No	5,042 (92.2)	25.5	24.7	31.0.	26.1	13.4	10.9	41
Receiving treatment for previously diagnosed condition								
Anxiety								
Yes	536 (9.8)	59.6	52.0	66.0	51.9	26.6	23.6	72.7
No	4,934 (90.2)	21.8	21.3	27.1	23.5	11.8	9.3	37.5
Depression								
Yes	540 (9.9)	52.5	50.6	60.8	45.5	25.2	22.1	68.8
No	4,930 (90.1)	22.6	21.5	27.7	24.2	12.0	9.4	37.9
Posttraumatic stress disorder								
Yes	251 (4.6)	72.3	69.1	78.7	69.4	43.8	44.8	88
No	5,219 (95.4)	23.3	22.2	28.6	24.2	11.8	9.0	38.7

Abbreviations: COVID-19 = coronavirus disease 2019; TSRD = trauma- or stress-related disorder.

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

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

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

¶ 104 respondents selected "Prefer not to answer."

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

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

§§ Unpaid adult caregiver status was self-reported. The definition of an unpaid caregiver for adults was a person who had provided unpaid care to a relative or friend aged ≥18 years to help them take care of themselves at any time in the last three months. Examples provided included helping with personal needs, household chores, health care tasks, managing a person's finances, taking them to a doctor's appointment, arranging for outside services, and visiting regularly to see how they are doing.

¶¶ Region classification was determined by using the U.S. Census Bureau's Census Regions and Divisions of the United States. https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf.

*** Rural-urban classification was determined by using self-reported ZIP codes according to the Federal Office of Rural Health Policy definition of rurality. https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html.

Discussion

Elevated levels of adverse mental health conditions, substance use, and suicidal ideation were reported by adults in the United States in June 2020. The prevalence of symptoms of anxiety disorder was approximately three times those reported in the second quarter of 2019 (25.5% versus 8.1%), and prevalence of depressive disorder was approximately four times that reported in the second quarter of 2019 (24.3% versus 6.5%) (*2*). However, given the methodological differences and potential unknown biases in survey designs, this analysis might not be directly comparable with data reported on anxiety and depression disorders in 2019 (*2*). Approximately one quarter of respondents reported symptoms of a TSRD related to the pandemic, and approximately one in 10 reported that they started or increased substance use because of COVID-19. Suicidal ideation was also elevated; approximately twice as many respondents reported serious consideration of suicide in the previous 30 days than did adults in the United States in 2018, referring to the previous 12 months (10.7% versus 4.3%) (*6*).

Mental health conditions are disproportionately affecting specific populations, especially young adults, Hispanic persons, black persons, essential workers, unpaid caregivers for adults, and those receiving treatment for preexisting psychiatric conditions. Unpaid caregivers for adults, many of whom are currently providing critical aid to persons at increased risk

TABLE 2. Comparison of symptoms of adverse mental health outcomes among all respondents who completed surveys (N = 5,470), by respondent characteristic* — United States, June 24–30, 2020

Characteristic	Prevalence ratio[¶] (95% CI[¶])			
	Symptoms of anxiety disorder or depressive disorder[†]	Symptoms of a TSRD related to COVID-19[§]	Started or increased substance use to cope with stress or emotions related to COVID-19	Serious consideration of suicide in past 30 days
Gender				
Female vs. male	1.04 (0.96–1.12)	0.88 (0.81–0.97)	0.85 (0.75–0.98)	0.70 (0.60–0.82)**
Age group (yrs)				
18–24 vs. 25–44	1.56 (1.44–1.68)**	1.28 (1.16–1.41)**	1.31 (1.12–1.53)**	1.59 (1.35–1.87)**
18–24 vs. 45–64	3.10 (2.79–3.44)**	2.67 (2.35–3.03)**	3.35 (2.75–4.10)**	6.66 (5.15–8.61)**
18–24 vs. ≥65	7.73 (6.19–9.66)**	5.01 (4.04–6.22)**	8.77 (5.95–12.93)**	12.51 (7.88–19.86)**
25–44 vs. 45–64	1.99 (1.79–2.21)**	2.09 (1.86–2.35)**	2.56 (2.14–3.07)**	4.18 (3.26–5.36)**
25–44 vs. ≥65	4.96 (3.97–6.20)**	3.93 (3.18–4.85)**	6.70 (4.59–9.78)**	7.86 (4.98–12.41)**
45–64 vs. ≥65	2.49 (1.98–3.15)**	1.88 (1.50–2.35)**	2.62 (1.76–3.9)**	1.88 (1.14–3.10)
Race/Ethnicity[††]				
Hispanic vs. non-Hispanic black	1.35 (1.18–1.56)**	1.15 (1.00–1.33)	1.19 (0.97–1.46)	1.23 (0.98–1.55)
Hispanic vs. non-Hispanic Asian	2.27 (1.73–2.98)**	1.59 (1.24–2.04)**	3.29 (2.05–5.28)**	2.82 (1.74–4.57)**
Hispanic vs. non-Hispanic other race or multiple races	1.23 (0.98–1.55)	1.24 (0.96–1.61)	1.99 (1.27–3.13)**	1.89 (1.16–3.06)
Hispanic vs. non-Hispanic white	1.40 (1.27–1.54)**	1.50 (1.35–1.68)**	2.09 (1.79–2.45)**	2.35 (1.96–2.80)**
Non-Hispanic black vs. non-Hispanic Asian	1.68 (1.26–2.23)**	1.38 (1.07–1.78)	2.75 (1.70–4.47)**	2.29 (1.39–3.76)**
Non-Hispanic black vs. non-Hispanic other race or multiple races	0.91 (0.71–1.16)	1.08 (0.82–1.41)	1.67 (1.05–2.65)	1.53 (0.93–2.52)
Non-Hispanic black vs. non-Hispanic white	1.03 (0.91–1.17)	1.30 (1.14–1.48)**	1.75 (1.45–2.11)**	1.90 (1.54–2.36)**
Non-Hispanic Asian vs. non-Hispanic other race or multiple races	0.54 (0.39–0.76)**	0.78 (0.56–1.09)	0.61 (0.32–1.14)	0.67 (0.35–1.29)
Non-Hispanic Asian vs. non-Hispanic white	0.62 (0.47–0.80)**	0.95 (0.74–1.20)	0.64 (0.40–1.02)	0.83 (0.52–1.34)
Non-Hispanic other race or multiple races vs. non-Hispanic white	1.14 (0.91–1.42)	1.21 (0.94–1.56)	1.05 (0.67–1.64)	1.24 (0.77–2)

See table footnotes on the next page.

for severe illness from COVID-19, had a higher incidence of adverse mental and behavioral health conditions compared with others. Although unpaid caregivers of children were not evaluated in this study, approximately 39% of unpaid caregivers for adults shared a household with children (compared with 27% of other respondents). Caregiver workload, especially in multigenerational caregivers, should be considered for future assessment of mental health, given the findings of this report and hardships potentially faced by caregivers.

The findings in this report are subject to at least four limitations. First, a diagnostic evaluation for anxiety disorder or depressive disorder was not conducted; however, clinically validated screening instruments were used to assess symptoms. Second, the trauma- and stressor-related symptoms assessed were common to multiple TSRDs, precluding distinction among them; however, the findings highlight the importance of including COVID-19–specific trauma measures to gain insights into peri- and posttraumatic impacts of the COVID-19 pandemic (*7*). Third, substance use behavior was self-reported; therefore, responses might be subject to recall, response, and social desirability biases. Finally, given that the web-based survey might not be fully representative of the United States population, findings might have limited generalizability. However, standardized quality and data inclusion screening procedures, including algorithmic analysis of click-through behavior, removal of duplicate responses and scrubbing methods for web-based panel quality were applied. Further the prevalence of symptoms of anxiety disorder and depressive disorder were largely consistent with findings from the Household Pulse Survey during June (*1*).

Markedly elevated prevalences of reported adverse mental and behavioral health conditions associated with the COVID-19 pandemic highlight the broad impact of the pandemic and the need to prevent and treat these conditions. Identification of populations at increased risk for psychological distress and unhealthy coping can inform policies to address health inequity, including increasing access to resources for clinical diagnoses and treatment options. Expanded use of telehealth, an effective means of delivering treatment for mental health conditions, including depression, substance use disorder, and suicidal ideation (*8*), might reduce COVID-19-related mental health consequences. Future studies should identify drivers of adverse mental and behavioral health during the COVID-19 pandemic and whether factors such as social isolation, absence of school structure, unemployment and other financial worries, and various forms of violence (e.g., physical,

TABLE 2. (*Continued*) Comparison of symptoms of adverse mental health outcomes among all respondents who completed surveys (N = 5,470), by respondent characteristic* — United States, June 24–30, 2020

Characteristic	Prevalence ratio¶ (95% CI¶)			
	Symptoms of anxiety disorder or depressive disorder†	Symptoms of a TSRD related to COVID-19§	Started or increased substance use to cope with stress or emotions related to COVID-19	Serious consideration of suicide in past 30 days
Employment status				
Employed vs. unemployed	0.96 (0.87–1.07)	1.28 (1.12–1.46)**	2.30 (1.78–2.98)**	3.21 (2.31–4.47)**
Employed vs. retired	3.01 (2.58–3.51)**	2.84 (2.42–3.34)**	4.30 (3.28–5.63)**	5.97 (4.20–8.47)**
Unemployed vs. retired	3.12 (2.63–3.71)**	2.21 (1.82–2.69)**	1.87 (1.30–2.67)**	1.86 (1.16–2.96)
Essential vs. nonessential worker§§	1.42 (1.30–1.56)**	1.52 (1.38–1.69)**	2.36 (2.00–2.77)**	2.76 (2.29–3.33)**
Unpaid caregiver for adults vs. not¶¶	2.55 (2.37–2.75)**	2.63 (2.42–2.86)**	5.28 (4.59–6.07)**	8.64 (7.23–10.33)**
Rural vs. urban residence***	0.94 (0.82–1.07)	0.96 (0.83–1.11)	0.84 (0.67–1.06)	0.95 (0.74–1.22)
Knows someone with positive SARS-CoV-2 test result vs. not	0.95 (0.86–1.05)	0.78 (0.69–0.88)**	0.96 (0.81–1.14)	0.65 (0.52–0.81)**
Knew someone who died from COVID-19 vs. not	0.99 (0.85–1.15)	1.08 (0.92–1.26)	0.84 (0.64–1.11)	0.69 (0.49–0.97)
Receiving treatment for anxiety vs. not	2.43 (2.26–2.63)**	2.21 (2.01–2.43)**	2.27 (1.94–2.66)**	2.54 (2.13–3.03)**
Receiving treatment for depression vs. not	2.20 (2.03–2.39)**	1.88 (1.70–2.09)**	2.13 (1.81–2.51)**	2.35 (1.96–2.82)**
Receiving treatment for PTSD vs. not	2.75 (2.55–2.97)**	2.87 (2.61–3.16)**	3.78 (3.23–4.42)**	4.95 (4.21–5.83)**

Abbreviations: CI = confidence interval; COVID-19 = coronavirus disease 2019; PTSD = posttraumatic stress disorder; TSRD = trauma- or stress-related disorder.

* Number of respondents for characteristics: gender (female = 2,784, male = 2,676), age group in years (18–24 = 731; 25–44 = 1,911; 45–64 = 1,895; ≥65 = 933), race/ethnicity (non-Hispanic white = 3453, non-Hispanic black = 663, non-Hispanic Asian = 256, non-Hispanic other race or multiple races = 164, Hispanic = 885).

† Symptoms of anxiety disorder and depressive disorder were assessed via the four-item Patient Health Questionnaire (PHQ-4). Those who scored ≥3 out of 6 on the Generalized Anxiety Disorder (GAD-2) and Patient Health Questionnaire (PHQ-2) subscales were considered to have symptoms of these disorders.

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

¶ Comparisons within subgroups were evaluated on weighted responses via Poisson regressions used to calculate a prevalence ratio, 95% CI, and p-value (not shown). Statistical significance was evaluated at a threshold of a = 0.005 to account for multiple comparisons. In the calculation of prevalence ratios for started or increased substance use, respondents who selected "Prefer not to answer" (n = 104) were excluded.

** P-value is statistically significant (p<0.005).

†† Respondents identified as a single race unless otherwise specified. The non-Hispanic, other race or multiple races category includes respondents who identified as not Hispanic and as more than one race or as American Indian or Alaska Native, Native Hawaiian or Pacific Islander, or 'Other'.

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

¶¶ Unpaid adult caregiver status was self-reported. The definition of an unpaid caregiver for adults was having provided unpaid care to a relative or friend aged ≥18 years to help them take care of themselves at any time in the last three months. Examples provided included helping with personal needs, household chores, health care tasks, managing a person's finances, taking them to a doctor's appointment, arranging for outside services, and visiting regularly to see how they are doing.

*** Rural-urban classification was determined by using self-reported ZIP codes according to the Federal Office of Rural Health Policy definition of rurality. https://www.hrsa.gov/rural-health/about-us/definition/datafiles.html.

emotional, mental, or sexual abuse) serve as additional stressors. Community-level intervention and prevention efforts should include strengthening economic supports to reduce financial strain, addressing stress from experienced racial discrimination, promoting social connectedness, and supporting persons at risk for suicide (*9*). Communication strategies should focus on promotion of health services§§§§,¶¶¶¶,***** and culturally and linguistically tailored prevention messaging regarding practices to improve emotional well-being. Development and implementation of COVID-19–specific screening instruments for early identification of COVID-19–related TSRD symptoms would allow for early clinical interventions that might prevent progression from acute to chronic TSRDs. To reduce potential harms of increased substance use related to COVID-19, resources, including social support, comprehensive treatment options, and harm reduction services, are essential and should remain accessible. Periodic assessment of mental health, substance use, and suicidal ideation should evaluate the prevalence of psychological distress over time. Addressing mental health disparities and preparing support systems to mitigate mental health consequences as the pandemic evolves will continue to be needed urgently.

§§§§ Disaster Distress Helpline (https://www.samhsa.gov/disaster-preparedness): 1-800-985-5990 (press 2 for Spanish), or text TalkWithUs for English or Hablanos for Spanish to 66746. Spanish speakers from Puerto Rico can text Hablanos to 1-787-339-2663.

¶¶¶¶ Substance Abuse and Mental Health Services Administration National Helpline (also known as the Treatment Referral Routing Service) for persons and families facing mental disorders, substance use disorders, or both: https://www.samhsa.gov/find-help/national-helpline, 1-800-662-HELP, or TTY 1-800-487-4889.

***** National Suicide Prevention Lifeline (https://suicidepreventionlifeline.org/): 1-800-273-TALK for English, 1-888-628-9454 for Spanish, or Lifeline Crisis Chat (https://suicidepreventionlifeline.org/chat/).

TABLE 3. Odds of incidence* of symptoms of adverse mental health, substance use to cope with stress or emotions related to COVID–19 pandemic, and suicidal ideation in the third survey wave, by essential worker status and unpaid adult caregiver status among respondents who completed monthly surveys from April through June (N = 1,497) — United States, April 2–8, May 5–12, and June 24–30, 2020

	Essential worker† vs. all other employment statuses (nonessential worker, unemployed, retired)				Unpaid caregiver for adults§ vs. not unpaid caregiver			
	Unadjusted		Adjusted¶		Unadjusted		Adjusted**	
Symptom or behavior	OR (95% CI)††	p-value††	OR (95% CI)††	p-value††	OR (95% CI)††	p-value††	OR (95% CI)††	p-value††
Symptoms of anxiety disorder§§	1.92 (1.29–2.87)	0.001	1.63 (0.99–2.69)	0.056	1.97 (1.25–3.11)	0.004	1.81 (1.14–2.87)	0.012
Symptoms of depressive disorder§§	1.49 (1.00–2.22)	0.052	1.13 (0.70–1.82)	0.606	2.29 (1.50–3.50)	<0.001	2.22 (1.45–3.41)	<0.001
Symptoms of anxiety disorder or depressive disorder§§	1.67 (1.14–2.46)	0.008	1.26 (0.79–2.00)	0.326	1.84 (1.19–2.85)	0.006	1.73 (1.11–2.70)	0.015
Symptoms of a TSRD related to COVID–19¶¶	1.55 (0.86–2.81)	0.146	1.27 (0.63–2.56)	0.512	1.88 (0.99–3.56)	0.054	1.79 (0.94–3.42)	0.076
Started or increased substance use to cope with stress or emotions related to COVID–19	2.36 (1.26–4.42)	0.007	2.04 (0.92–4.48)	0.078	3.51 (1.86–6.61)	<0.001	3.33 (1.75–6.31)	<0.001
Serious consideration of suicide in previous 30 days	0.93 (0.31–2.78)	0.895	0.53 (0.16–1.70)	0.285	3.00 (1.20–7.52)	0.019	3.03 (1.20–7.63)	0.019

Abbreviations: CI = confidence interval, COVID–19 = coronavirus disease 2019, OR = odds ratio, TSRD = trauma– and stressor–related disorder.

* For outcomes assessed via the four-item Patient Health Questionnaire (PHQ–4), odds of incidence were marked by the presence of symptoms during May 5–12 or June 24–30, 2020, after the absence of symptoms during April 2–8, 2020. Respondent pools for prospective analysis of odds of incidence (did not screen positive for symptoms during April 2–8): anxiety disorder (n = 1,236), depressive disorder (n = 1,301) and anxiety disorder or depressive disorder (n = 1,190). For symptoms of a TSRD precipitated by COVID–19, started or increased substance use to cope with stress or emotions related to COVID–19, and serious suicidal ideation in the previous 30 days, odds of incidence were marked by the presence of an outcome during June 24–30, 2020, after the absence of that outcome during May 5–12, 2020. Respondent pools for prospective analysis of odds of incidence (did not report symptoms or behavior during May 5–12): symptoms of a TSRD (n = 1,206), started or increased substance use (n = 1,408), and suicidal ideation (n = 1,456).

† Essential worker status was self–reported. For Table 3, essential worker status was determined by identification as an essential worker during the June 24–30 survey. Essential workers were compared with all other respondents, not just employed respondents (i.e., essential workers vs. all other employment statuses [nonessential worker, unemployed, and retired], not essential vs. nonessential workers).

§ Unpaid adult caregiver status was self–reported. The definition of an unpaid caregiver for adults was having provided unpaid care to a relative or friend 18 years or older to help them take care of themselves at any time in the last three months. Examples provided included helping with personal needs, household chores, health care tasks, managing a person's finances, taking them to a doctor's appointment, arranging for outside services, and visiting regularly to see how they are doing.

¶ Adjusted for gender, employment status, and unpaid adult caregiver status.

** Adjusted for gender, employment status, and essential worker status.

†† Respondents who completed surveys from all three waves (April, May, June) were eligible to be included in an unweighted longitudinal analysis. Comparisons within subgroups were evaluated via logit–linked Binomial regressions used to calculate unadjusted and adjusted odds ratios, 95% confidence intervals, and p–values. Statistical significance was evaluated at a threshold of $\alpha = 0.05$. In the calculation of odds ratios for started or increased substance use, respondents who selected "Prefer not to answer" (n = 11) were excluded.

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

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

Acknowledgments

Survey respondents; Kristen Holland, Emily Kiernan, Meg Watson, CDC COVID-19 Response Team; Mallory Colys, Sneha Baste, Daniel Chong, Rebecca Toll, Qualtrics, LLC; Alexandra Drane, Sarah Stephens Winnay, Archangels; Emily Capodilupo, Whoop, Inc.; The Kinghorn Foundation; Australian-American Fulbright Commission.

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All authors have completed and submitted the International Committee of Medical Journal Editors form for disclosure of potential conflicts of interest. Charles A. Czeisler reports an endowed professorship provided to Harvard Medical School by Cephalon, Inc. for educational and research support to Harvard Medical School and Brigham and Women's Hospital from Philips Respironics, Inc, which supported in part the contract with Qualtrics LLC to administer the survey. Elise R. Facer-Childs reports a grant from the Science and Industry Endowment Fund Ross Metcalf STEM+ Business Fellowship, administered by the Commonwealth Scientific and Industrial Research Organisation. Mark É. Czeisler reports a grant from the Australian-American Fulbright Commission for a research project that was cancelled because of COVID-19. Mark E. Howard reports a grant from the Institute for Breathing and Sleep, Austin Health (Australia). Shantha M.W. Rajaratnam reports a grant from the Turner Institute for Brain and Mental Health, Monash University (Australia). Charles A. Czeisler, Elise R. Facer-Childs, Laura K. Barger, Joshua F. Wiley, Matthew D. Weaver, Mark É. Czeisler, Mark E. Howard, Rebecca Robbins, and Shantha M.W. Rajaratnam report contributions by Archangels for the screener used to determine unpaid caregiver status in the survey; and a grant from Whoop, Inc, for

Summary

What is already known about this topic?

Communities have faced mental health challenges related to COVID-19–associated morbidity, mortality, and mitigation activities.

What is added by this report?

During June 24–30, 2020, U.S. adults reported considerably elevated adverse mental health conditions associated with COVID-19. Younger adults, racial/ethnic minorities, essential workers, and unpaid adult caregivers reported having experienced disproportionately worse mental health outcomes, increased substance use, and elevated suicidal ideation.

What are the implications for public health practice?

The public health response to the COVID-19 pandemic should increase intervention and prevention efforts to address associated mental health conditions. Community-level efforts, including health communication strategies, should prioritize young adults, racial/ethnic minorities, essential workers, and unpaid adult caregivers.

administration of the survey in June. No other potential conflicts of interest were disclosed.

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National Suicide Prevention Week and Month

Samples, Ideas and Engagement opportunities.

afsp.org

American Foundation for Suicide Prevention

American Foundation for Suicide Prevention

afsp.org

American Foundation *for* Suicide Prevention

#Keep Going

- AFSP’s Theme for NSPM/NSPW
  - In the era of Covid-19, as we all try to protect our mental health and cope with uncertainty, it’s more important than ever that we be there for each other and take steps to prevent suicide.

#Keep Going

- Social Media chats with experts.
    - **You can ask questions and join the conversation.**
- Town hall discussions.
    - **September 17th 12:00PM pacific time.** “Preventing Suicide in BIPOC Communities: Ways Forward,”

Social Shareables

Mental Health and COVID-19

- Dedicated landing page with shareable resources including.
  - **Talking Points**
  - **Images for social media**
  - **Workplace resources**
  - **Education Programs offered virtually.**

National Suicide Prevention Week and Month from the AFSP Oregon Chapter

American Foundation for Suicide Prevention

NSPW

- 3 livestreamed webinars.
  - **Loss and Healing**
  - **Research (a free registration is required.)**
    - Recording sent to registered participants.
  - **Advocacy**

Loss and Healing – September 1st

- Livestreamed on facebook, a panel facilitated by nationally recognized expert in childhood grief and suicide loss survivor.
    - **Featuring diverse group of suicide loss survivors.**
    - **Discussing themes related to grieving a suicide loss, things that might help, what to expect…etc.**

Research – September 8th

- Hear from AFSP funded researcher **Dr. Marisa Marraccini** give a talk titled “Supporting Adolescents Hospitalized for Suicide Risk in School Settings”
  - **Free but registration is required.**
    - orch-research.attendease.com/
  - **Alignment with the Alliance**

Advocacy – September 11th

- Learn about the importance of advocating for suicide prevention.
- Hear from elected officials.
- Learn from other people in Oregon who have used their voice to save lives through advocacy.
- Strong alignment with the Alliance.

Out of the Darkness Experience
September 26th

- Free virtual experience that will feature volunteer submissions from across the state.
  - **Memorial Wall**
  - **Strength and Resilience**
  - **My Why**
  - **Wall of Hope.**

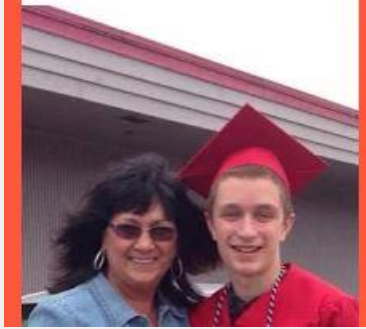
www.afsp.org/OregonOOTDExperience

AFSP Oregon Chapter + 1 • 3d

Memorial Wall

Remembering Those We've Lost

Tucker will be forever missed, by so many. Be aware of the help that's in your community. Ask questions. And remember you are never, ever alone.



Danielle, you will never be forgotten.

Remembering my son, Rigdon.

To my brother Charlie, you will always be in my heart.

Everyone should have a stand-in big brother growing up, Ryan was mine. Forever 22.

Dad, I wish there were more time. I love and miss you.

Jean, how grateful I am for the special bond we shared, I know that wherever life takes me your love is something that will always be there.

In honor of my incredibly giving and talented brother JP. Life isn't the same without your wit and charm. Thank you for being the best big brother!

Other examples and shareables.

National Suicide Prevention Lifeline

- Downloadable logos and ribbons to use.
- Sample messaging for social media and/or newsletters
- https://suicidepreventionlifeline.org/promote-national-suicide-prevention-month/

American Association of Suicidology: AAS

- www.aas365.org/tools
- Tools, Templates and Events
- Suggested activities and guides.

The National Action Alliance

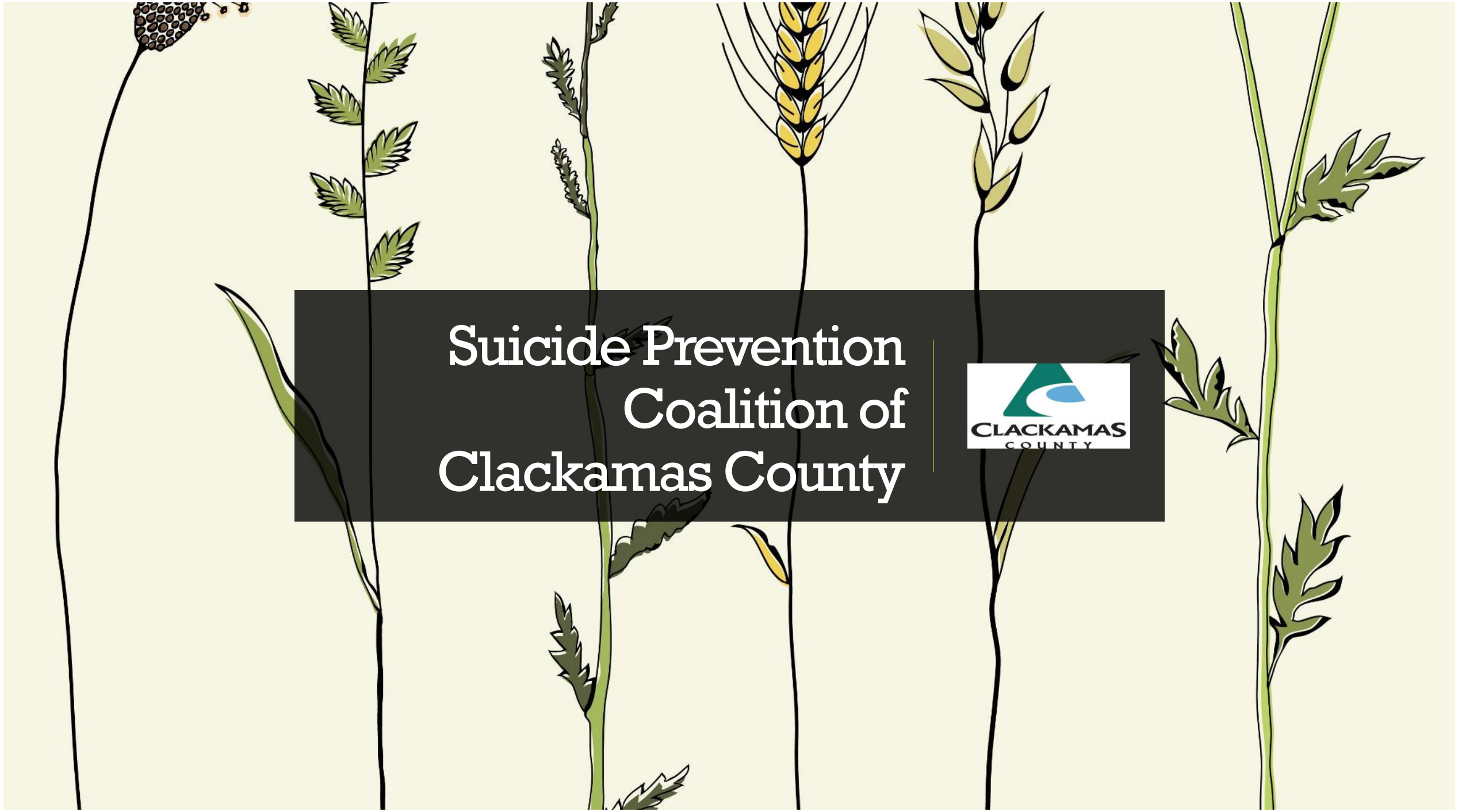
- theactionalliance.org/
- Tools, Templates and Event ideas.
- Webinars for a wide range of topics.
- Suggested activities and guides.

Thank you!

American Foundation for Suicide Prevention

Links mentioned:

- AFSP's NSPW/NSPM Landing Page: www.afsp.org/KeepGoing
- AFSP's COVID19 Landing Page: www.afsp.org/COVID19
- Register for the free Research Connection "Supporting Adolescents Hospitalized for Suicide Risk in School Settings": orch-research.attendease.com/
- Out of the Darkness Experience: **www.afsp.org/OregonOOTDExperience**
- National Suicide Prevention Lifeline materials https://suicidepreventionlifeline.org/promote-national-suicide-prevention-month/
- AAS Tools and Resources www.aas365.org/tools
- National Action Alliance Tools, resources and programs: theactionalliance.org/



Suicide Prevention Coalition of Clackamas County

CLACKAMAS COUNTY

What We're Up To

Online Coalition Meetings with Speakers

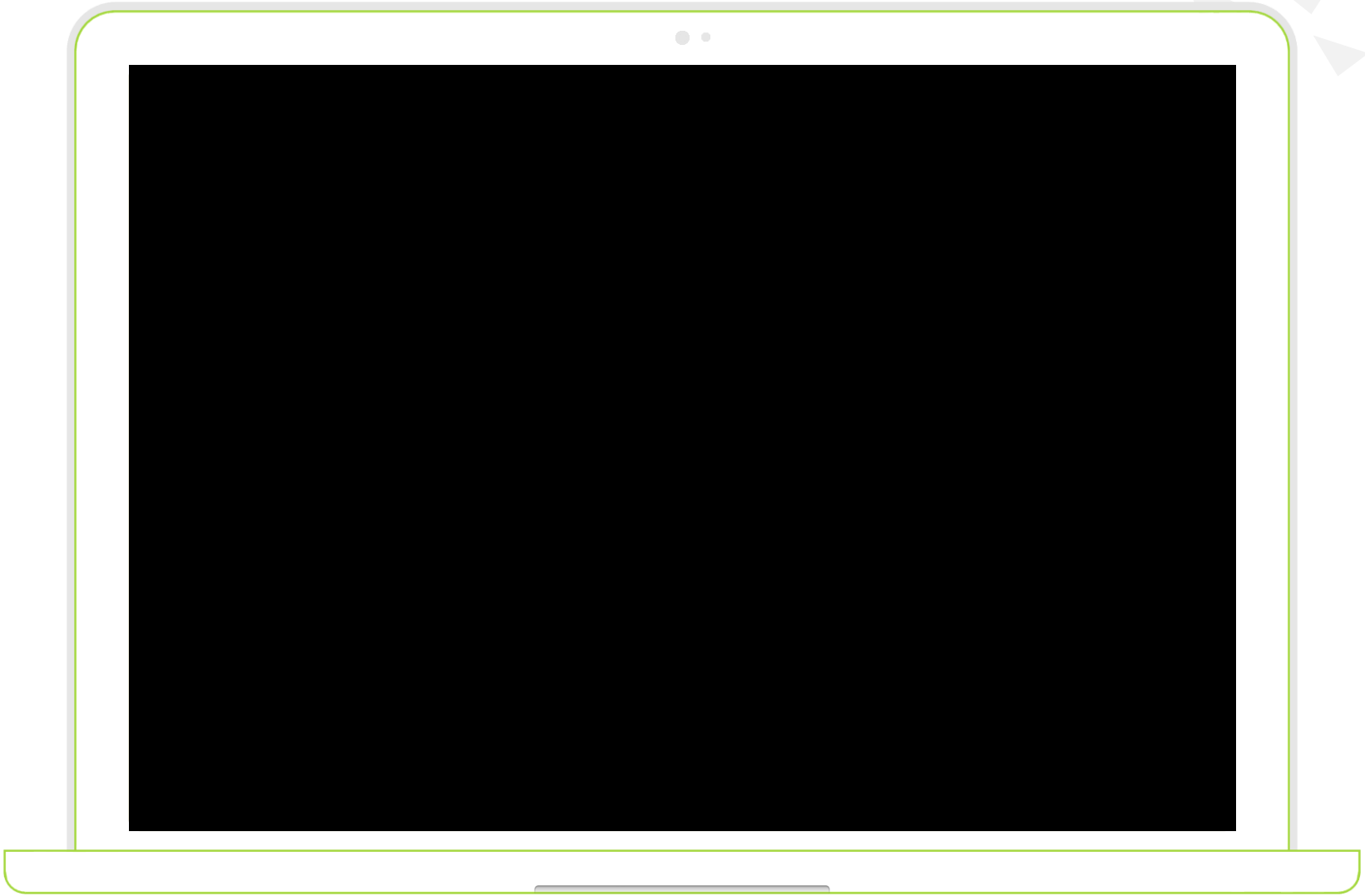
Strategic Planning

Suicide Prevention in September

2019 Efforts

Sign Rally

- Research was done to see the busiest intersections in Clackamas County
- People signed up to hold You Matter Signs; we had two shifts per day for about 2 weeks
- Received great feedback about this



2020 Efforts

Sign Rally COVID Edition

This year, we will be limiting the number of people, have everyone 6-feet apart, wearing masks

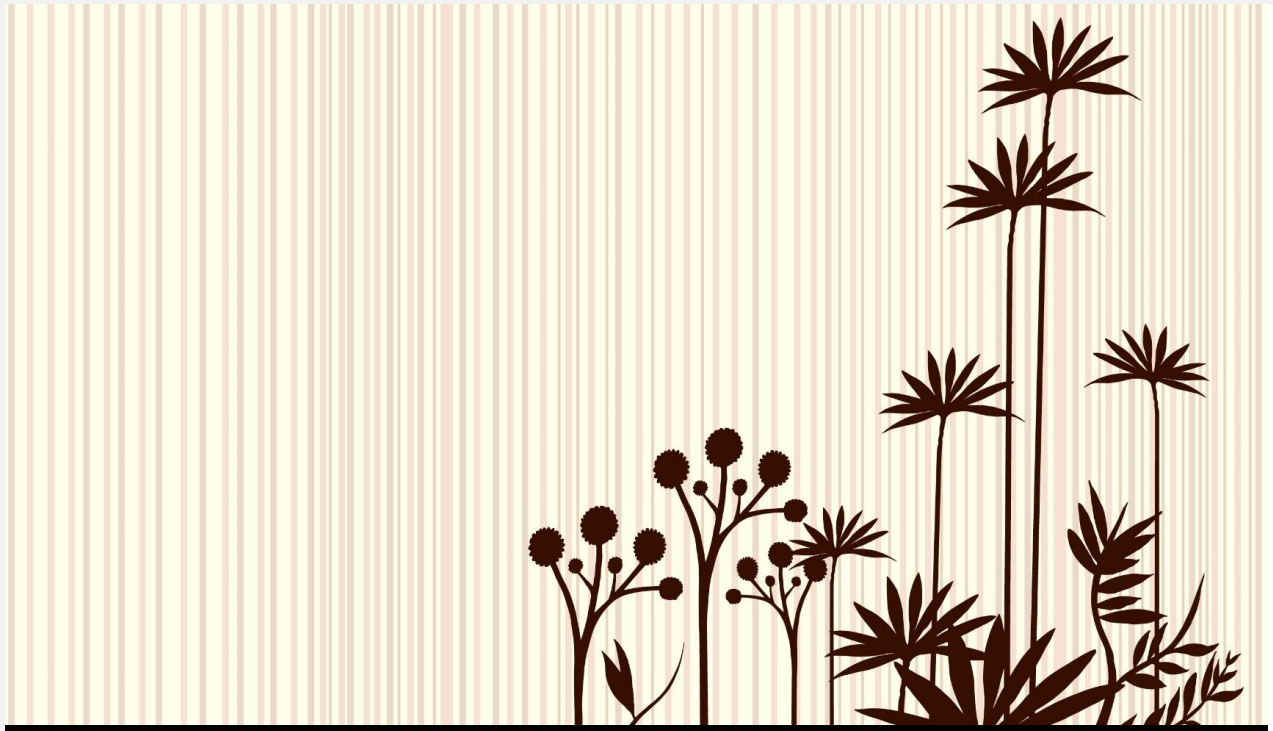
Other Ideas

Car Rally with “You Matter” Bracelets to toss to bystanders, taking part in Healthy Transitions Project

Considerations

“You Matter” Messaging. This is still an important message to pass on to those struggling AND we don’t want to interrupt or pull attention away from what is going on BLM. Looking at “Together we Can” messaging.

Your Logo or Name Here



Questions?

Email jfraga@aocmhp.org for more info on the Suicide Prevention Coalition of Clackamas County.

- What have you been thinking of doing in your area for Suicide Prevention Awareness Month in September?
- Is there anything you have thought about that we haven't mentioned?