associated with having an ED visit (AOR, 1.9; 95% CI, 1.1-3.2), alcohol dependence (AOR, 2.6; 95% CI, 1.4-4.9), receiving mental health care treatment (AOR, 2.5; 95% CI, 1.6-3.9), and having illicit drug use disorder (AOR, 2.8; 95% CI, 1.7-4.6).

Discussion | Although guidelines suggest that patients with AUD should be prescribed MAUD and brief counseling as initial therapy or referred for more intensive psychosocial interventions,3,4 we found that among an estimated 14.1 million adults with past-year AUD in 2019, only 1.6% (or 223,000 persons) used MAUD. Thus, despite the availability of medications with demonstrated efficacy, MAUDs are rarely prescribed to and used by adults with AUD.

Use of MAUD may be associated with greater AUD severity. Adults receiving MAUD were more likely to report receiving mental health care and having more frequent ED visits, consistent with the associations of cooccurring psychiatric and medical disorders with greater AUD severity.5,6 Adults with AUD who receive mental health care or ED services or who reside in large metropolitan areas may have greater access to MAUD. For those receiving nonmedication alcohol use treatment, using MAUD may improve treatment effectiveness. Although NSDUH is subject to recall and social-desirability biases, our results highlight the urgent need for improving access to and use of MAUD among adults with AUD.

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COMMENT & RESPONSE

Challenges to Behavioral Health and Injury Surveillance During the COVID-19 Pandemic

To the Editor The study by Holland et al1 reports trends in emergency department (ED) visits involving mental health and substance use, including deliberate self-harm, unintentional overdose and other injuries, and assault, before and during the COVID-19 pandemic. The authors report 2 metrics for each time period, using data from the National Syndromic Surveillance Program (NSSP) at the US Centers for Disease Control and Prevention (CDC): the absolute number of ED visits of a given type and the rate of ED visits of a given type per 100,000 ED visits of all types.

We share the authors’ interest in assessing the possible effects of the pandemic on behavioral health and injury outcomes. But we find it difficult to draw clear inferences from the present findings for 2 main reasons. First, as the authors mention briefly, the number of hospitals reporting to the NSSP rose across the study period. The study did not adjust for this by restricting to a common set of hospitals, as the authors suggest future research should do, or by standardizing for or at least reporting for readers the number of hospitals participating each month. This makes it difficult to interpret trends in absolute visit counts, particularly for outcomes such as deliberate self-harm, for which absolute counts remained below prepandemic levels for most or all of the study period (despite the number of hospitals reporting to NSSP rising).

Second, we see no clear way to draw inferences between the type of rate the study reports—for example, ED visits for self-harm per 100,000 total ED visits—and the rates of most immediate public health interest, that is, ED visits and events associated with self-harm per unit population. In particular, while it might have been plausible before March 2020 to assume that general patterns of ED care-seeking were mainly con-
The COVID-19 pandemic has simultaneously increased the importance of timely public health surveillance of behavioral health and made it more challenging. Retrospective surveys may ultimately help fill gaps in our understanding of outcomes in 2020. Additional innovation may be needed to enhance relevant surveillance approaches during future emergencies.

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In Reply Schoenbaum and Colpe identify important limitations to our study1 on trends in emergency department (ED) visits for mental health, overdose, and violence before and during the COVID-19 pandemic. Specifically, they highlight 3 aspects of the data from the National Syndromic Surveillance Program (NSSP) at the US Centers for Disease Control and Prevention (CDC) that affected the interpretation of reported trends, including the expanded coverage of the NSSP over time, that analyses were not limited to EDs with consistent participation, and that rates per population were not reported.

NSSP coverage expanded from 62.4% of ED visits in the US in 2019 to 70.7% in 2020. While this growth can affect interpretability of trends, particularly following substantial declines in the overall number of ED visits, NSSP’s expansion has resulted in additional resources that have improved data quality and system functionality, including recent advances in the ability to limit analyses to facilities with consistently high discharge diagnosis code completeness and consistent reporting over time. Recently, NSSP used this methodology to characterize the effect of COVID-19 on ED visits from December 2018 to January 2021 and found results consistent with our study,1 with more individuals seeking emergency care for mental or behavioral health and socioeconomic (eg, threats of job loss) and psychosocial concerns during the pandemic period compared with the prepandemic period.2 Therefore, NSSP’s growth actually reflects a system strength, as it facilitates subset analyses that can confirm and bolster confidence in national-level study results.

While calculating rates per population is challenging because of varying NSSP coverage by state, robust population-based estimates can be determined on finer geographic scales by limiting analyses to counties with participating facilities. County-level analyses historically required state permission, but this requirement has been lifted for COVID-19 response activities to improve understanding of the effect of the pandemic on the US health care system. Recent initiatives—including the CDC’s Drug Overdose Surveillance and Epidemiology,3 Emergency Department Surveillance of Nonfatal Suicide Related Outcomes,4 and Firearm Injury Surveillance Through Emergency departments5—provide funding for state and territorial health departments to share local data with the CDC for routine monitoring of overdose, violence, and injury outcomes. These initiatives require recipients to collect at least 75% of state-level ED visits and encourage recipients to onboard new facilities, thus increasing NSSP coverage and improving opportunities to calculate rates per population at granular levels.

All data sources have strengths and limitations that affect their ability to address epidemiologic questions. Current time lags for mortality and survey data using rigorous sampling methods limit our understanding of the immediate challenges that communities face. NSSP data uniquely offer near real-time insights into nationwide ED visit trends. While the pandemic has raised awareness of existing public health data system limitations, it has also greatly increased the visibility and highlighted the value of timely syndromic surveillance data to inform public health activities. Further, novel methodologic tools within the NSSP platform enable these data to better contribute to our understanding of important public health threats over time. Future studies of ED visits for mental health, overdose, and violence will use these methods to improve interpretability of results.

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**CORRECTION**

Errors in Statistical Results: The Original Investigation "Sustained Care Smoking Cessation Intervention for Individuals Hospitalized for Psychiatric Disorders: The Helping HAND 3 Randomized Clinical Trial," published online May 5, 2021, contained errors in the statistical results. In the Sensitivity Analyses subsection, the adjusted odds ratio and 95% CI labeled "model 1," 2.14 (95% CI, 1.11-4.11), should have been 2.22 (95% CI, 1.14-4.31). This error also appears in the Visual Abstract. Additionally, for the sensitivity analysis including unit as a covariate, the P value of .02 for the adjusted odds ratio 2.95 (95% CI, 1.26-6.91) should have instead been P = .01. Finally, in Table 2, in the section labeled "Missing equated to smoking," the values for smoking biochemically verified or verified by a significant other were incorrect. The adjusted odds ratio was presented as 2.14 (95% CI, 1.11-4.11) but should have been 2.22 (95% CI, 1.14-4.31). The errors have been corrected online.