The Behavioral Health System and Its Response to COVID-19: A Snapshot Perspective

Debra A. Pinals, M.D., Brian Hepburn, M.D., Joseph Parks, M.D., Arlene H. Stephenson, M.A.S.

The global experience of the COVID-19 pandemic is unprecedented. The magnitude, pace, and uncertainty of the pandemic have taxed systems and catalyzed innovation in many fields, including behavioral health. Behavioral health leaders have absorbed changing information about regulations and laws, proper use of personal protective equipment, isolation and quarantine, telepsychiatry practices (broadly defined here as the use of virtual and telephonic means to provide behavioral health care), and financial opportunities and challenges while attending to the mental health needs of local populations. This Open Forum reviews many of the adaptations of the behavioral health system in response to COVID-19 on the basis of a point-in-time snapshot and describes needed multidimensional policy and practice considerations for the future.

Psychiatric Services 2020; 71:1070–1074; doi: 10.1176/appi.ps.202000264

Emergency plans are designed to provide guidance and an incident management structure in an emergency or a disaster. The Federal Emergency Management Agency (FEMA), which originated in 1803, is embedded in the U.S. Department of Homeland Security. Today, its structural framework for emergency preparedness, the National Incident Management System, offers direction for disaster response (1). With "preparedness and resilience" as an overarching goal, planning and preparedness encompass five key mission areas: prevention, protection, mitigation, response, and recovery (2). Continuity of Operations (COOP) plans provide direction on how an organization continues to perform essential functions during and after an emergency.

Even with the best COOP processes, the global experience of the COVID-19 pandemic is unprecedented. As with all systems, the behavioral health system has been overwhelmed by demands as the pandemic's consequences have unfolded. Even though the behavioral health system is well versed in the emergency response tenets noted above, the magnitude, pace, and uncertainty of this pandemic have both taxed systems and catalyzed innovation. Behavioral health leaders have absorbed changing information about regulations and laws, proper use of personal protective equipment (PPE), isolation and quarantine, telepsychiatry practices, and financial opportunities and challenges.

In the shifting landscape, behavioral health state leaders and local providers have been relying on federal entities such as the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Centers for Medicaid and Medicare Services (CMS) for guidance, support, and direction. Below, we describe some of the unique areas within behavioral health services that are shifting as the COVID-19 pandemic evolves. This Open Forum was written in early April 2020, less than 3 months after January 20, 2020, when the first case of COVID-19 illness was reported in the United States (3), and about 3 weeks after the World Health Organization declared the situation a pandemic.

State Hospitals

State hospitals began as and have continued to be a core component of the behavioral health response to COVID-19. Many began customizing their COVID-19 responses early, recognizing the vulnerability of patients within closed institutions, especially given patient populations that often have multiple medical and psychiatric comorbidities. Staff training practices on PPE and statewide policies were promulgated rapidly, with states sharing lessons learned as the situation evolved. Establishing provisions for screening visitors, staff, and others and taking inventory of supplies were early responses. As awareness of viral spread increased, heightened safety processes included limited entrance and exit points in buildings to allow for screening, elimination of visitors, establishment of quarantine processes, and establishment of isolation units. In many regions, complex admissions flow charts were created on the basis of exposure risks and symptomology and were used to either increase or decrease admissions depending on state needs and capacity. Staff and patient monitoring for emergence of fever and

other symptoms became routine in many hospitals, and hospital leaders enacted their coordinating and communicating command centers and continually kept staff informed.

Clinical services in state hospitals quickly shifted from minimizing to eliminating congregate programs on units, at mealtimes, and in treatment malls. Group therapy sizes were reduced throughout facilities, and individual contacts were reconsidered to maximize physical distancing, with the use of telepsychiatry when feasible. Protocols included opening individual room doors during the day and encouraging patients to remain in place, especially on units where quarantine or isolation procedures were in place. Infection control was prioritized to minimize viral spread and reduce mortality associated with COVID-19 among psychiatric state hospital populations, including patients and staff. From initial preparedness to action planning, state hospitals have had to be nimble and evolve practice and policy as vital parts of the continuum of care.

Preparedness for a Surge in the Need for Medical Beds and Its Impact on Psychiatric Beds

As state hospitals have become better equipped at managing COVID-19, the systems managing licensed private psychiatric beds have also adapted. The majority of psychiatric hospital beds in the country are on units within general hospitals (referred to by CMS as "distinct parts"). Using their all-hazards and COOP plans, these hospitals were preparing for a sudden overwhelming demand for bed space for patients on ventilators. Psychiatric units across the country anticipated a need to convert psychiatric beds to general medical use, which CMS facilitated by allowing such conversion during the COVID-19 pandemic (4). At the same time, the remaining acute psychiatric units rapidly evolved. With concerns about viral spread, many units converted double rooms to single rooms, thereby reducing capacity overall. Concerns about accepting patients exposed to COVID-19, whether symptomatic or not, and access to PPE, have created further challenges to emergency department boarding. The situation has continually changed, and states are examining strategies on the basis of their available infrastructure to best meet medical and psychiatric needs.

Crisis Services

Crisis services include crisis call lines, mobile crisis services, crisis stabilization, and short-term crisis residential services. COVID-19 has made it increasingly important to screen individuals' physical health symptoms prior to community outreach in order to reduce the risk that the mobile crisis team will be exposed to an individual who has the virus. If an individual needs additional stabilization, he or she may need to enter a short-term crisis stabilization or residential program. Because of limits to PPE access, especially early on in the pandemic, and because viral testing and medical providers are generally not part of behavioral health crisis services, providers have expressed concern about potential exposure to the virus. That said, if an individual is at risk to harm themselves or others due to a behavioral health need, a dilemma emerges regarding which risk to address and how best to do so to minimize harm related to COVID-19 and sequelae of mental illness or substance use disorders. The expansion of telehealth, which includes telephonic and video platforms, has reached unparalleled levels in order to address these challenges. Although the National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit (5) became available prior to the expanded demand for telehealth, its guidance is useful as system administrators begin to consider whether these crisis telepsychiatry practices will have advantages even after the COVID-19 crisis.

Residential Treatment Services

Residential treatment services outside of crisis responses include respite, step-down from hospitalization, and long-term residential treatment. These programs have faced the same challenges and implemented many of the same solutions as the psychiatric units in state general hospitals, in terms of managing COVID-19 among persons living in smaller facilities and with organizations with lower staffing ratios. Most had no or limited prior experience or training in infection control or quarantine and have faced greater challenges in accessing PPE and virus testing in comparison with hospitals and nursing homes. This lack of experience has raised particular challenges in implementing CDC recommendations to mitigate viral spread.

Community Treatment Services

Community treatment services include partial hospitalization programs (PHPs), intensive outpatient programs, psychosocial rehabilitation day treatment programs, and therapy and medication services. Treatment settings range from comprehensive organizations to individual practitioners. Given limitations on PPE and the directives of many governors' executive orders, many behavioral health state leaders, providers, and systems dramatically downsized community-based face-to-face services, shifting to two-way video and telephonic care and restricting in-person contacts to only services determined to be essential for life and safety. Decisions on how to enact guidelines for who needs a face-to-face service are generally made locally on the basis of clinical judgment and capacity and an evolving understanding of how to address patient needs. Some states have organized centralized hot spots for communities with Internet limitations, and various issues with video connection have created more reliance on telephone contacts, a striking change for behavioral health treatment. Intensive services, such as PHPs, and intensive outpatient services have been particularly challenged but many started to shift approaches such as group therapy and complex day activities and supports to services offered remotely. Some providers have

found increased ability to connect with patients via telepsychiatry, with fewer no-show rates, leaving open the question of whether these shifting approaches to community service delivery will be sustained.

Criminal Justice Interface

Given the critical surge of COVID-19 cases at the height of the crisis, all branches of government have stepped in to effectuate proportional responses. Court activities have typically shifted to video, with only serious cases proceeding. Treatment courts have changed to avoid congregate meetings. Jails and prisons, as closed institutions, are at risk for viral spread throughout the facility. These entities are well versed in infection control, but given the severity and acuity of the respiratory symptoms of COVID-19, there is increasing worry about how to meet the medical needs of those who are incarcerated. In addition, to minimize the risk of spread, many jurisdictions have shifted forensic evaluation, civil commitment, and guardianship activities to video-based assessments and video or telephonic testimony. Several states have given directives to release low-level offenders and those with special needs. Whether these approaches will lead to a sustained change in practice for detention decisions remains to be seen.

Financial Viability of Community Providers

Community providers of treatment for mental illness and substance use disorders nationwide have been operating on thin financial margins. Billing code adjustments to telephone and video services have been granted, but implementing these changes has taken time, leaving providers without reimbursement between service implementation and the coding changes. Many providers started issuing furloughs and have been anticipating layoffs unless they receive retainer payments sufficient to keep employees on payroll. Other financial strains relate to shifts in staffing. Reasons for staff absences have included development of COVID-19 symptoms, fear of risk of exposure, discomfort with the rapidly changing environment, family demands with school closures and other home constraints, and opportunities to file for unemployment that might yield greater income. In some states, hazard pay is being sought to keep people at work in behavioral health contexts. On March 26, 2020, nine national hospital and physician organizations called on CMS to begin making periodic interim payments to providers to offset revenue losses from delayed procedures during the COVID-19 pandemic and to ask that states do the same under Medicaid (6).

CMS has offered emergency 1135 waivers and 1915(c) Appendix K waivers under the Social Security Act to allow more flexibility in the provision of services. Although many states have submitted such waivers in an attempt to implement interim retainer payments, as of the date of this writing, CMS has approved only interim retainer payments using section 1915(c) waivers. We have not yet seen CMS approval of portions of section 1135 waivers proposing interim retainer payments nor CMS decisions regarding interim retainer payments made under section 1115 demonstrations. State leadership has taken on major activities to help realize these opportunities to assist behavioral health providers in obtaining immediate financial relief, but complete CMS guidance had not yet been issued as of the time of this writing.

Medication

Traditionally, several behavioral health contexts, including laboratory testing for clozapine, testing for medication blood levels, and administration of medications such as long-acting injectable antipsychotic medications or methadone require providers to be in close contact with clients, according to the CDC's definition of "close contact" with regard to COVID-19 infection control. Clinics where these services are offered are balancing how to continue these treatments while minimizing risk of viral transmission for staff and patients, and some clinical providers have begun changing medications to avoid close contact. Fortunately, regulatory agencies have offered discretionary flexibility for some of these activities. For example, the U.S. Food and Drug Administration has updated guidance for patients receiving medications covered by Risk Evaluation and Mitigation Strategy protections, including clozapine (7). In addition, the Drug Enforcement Administration (DEA) has been flexible regarding medication-assisted treatment with buprenorphine and take-home doses of methadone but continues to prohibit initiating new persons on methadone without face-to-face service (8). The impact of these regulatory changes on long-term care remains to be seen.

Communication and Coordination

Changes to requirements under HIPAA and Title 42 of the Code of Federal Regulations (CFR), part 2, include broadening the range of video platforms allowable for treatment. Behavioral health leadership has worked with state leaders as well as local emergency teams and health departments. Targeted and increased communication has been key, internally and externally, to keep staff and the community informed. In addition to risk and crisis communication, many behavioral health systems, as part of COOP responses, have created behavioral health COVID-19 response teams that use regular huddles, conference calls, and video conferencing to communicate, share ideas, coordinate, and triage responsibilities. Behavioral health responses have included efforts to provide emotional support and education related to physical distancing and COVID-19 illness and its collateral consequences.

Telehealth, Telemedicine, and Telepsychiatry

Providers have ramped up telehealth capabilities and adopted widespread use of telepsychiatry as an excellent option to continue treating patients. This option has been permissible due to relaxed rules for licensure from CMS and reduced

restrictions under HIPAA and 42 CFR part 2. These modalities have been effective for telecourt, forensic evaluations, attorney visits, prescribing of controlled substances, recovery support, and group therapy. The U.S. Department of Health and Human Services has a special website on COVID-19 and HIPAA (9). Updates regarding prescribing, the national drug supply, electronic prescribing of controlled substances, telemedicine, medication-assisted treatment, and DEA contacts are also available to the public (8). Resources to assist in the practice of telepsychiatry and related services have been an asset to practitioners setting up these new ways of doing business (10).

Special Populations

Homeless consumers have presented nuanced challenges for communities in managing COVID-19 outbreaks. Although many efforts have been made during the pandemic to provide safe housing options, such as isolation or quarantine sites, homelessness continues, and reaching this population has been difficult because homeless individuals may lack access to cell phones. Also, as alcohol has become less available to these individuals, concerns about withdrawal have arisen. "Wet shelters" and recovery homes are being explored as options. Other populations of concern are children, individuals with intellectual and developmental disabilities, and older adults. Issues related to COVID-19 in nursing homes have received national attention, given early outbreaks in those facilities and the vulnerability of the population they serve. In addition, growing attention has centered on health care workers, first responders, racial-ethnic minority populations, and those who have experienced losses of family or supports due to COVID-19. Community providers have been increasing efforts to provide emotional supports for these populations and have worked to develop messaging directed to them.

Experiences in the Field and Potential Policy Direction

State behavioral health directors have faced inordinate challenges in facilitating responsive approaches to the COVID-19 crisis and have dealt with them only with the help of local and federal partners such as SAMHSA, the CDC, and CMS. Preparedness with regard to prevention through PPE, testing capabilities, and even vaccination development for novel viruses will undoubtedly be priorities going forward, and advocacy for the behavioral health population's access to these facets of care will remain important. Local responses may demonstrate the ability to provide services in new ways even after the COVID-19 crisis, and barriers to accessing care during the pandemic may expose regulatory burdens, outdated rules, and inadequate payment methodologies. As the situation continues to unfold, additional solutions will be needed in the realm of policy, technical, and financial relief for populations of all types and at all ages, regardless of race or ethnicity. Such solutions will also need to be developed for individuals with behavioral health needs who also disproportionately face unique challenges related to issues such as child welfare, forensic or justice involvement, and homelessness.

Disaster preparedness for behavioral health has evolved to entail structure and planning, but the COVID-19 pandemic has exceeded the capacity of many behavioral health and other systems. The pandemic has created an expanded imperative to be nimble and responsive to growing demands, increasing stress, and rising numbers of deaths and individuals with illness. Given the growing recognition of the emotional sequelae of disasters, especially after 9/11, behavioral health has had a considerable role in addressing unique aspects of disaster response.

Much has been learned about preparedness and policy response. No doubt, more will be known in the days, weeks, and years to come. If anything can be gained to promote hope and community healing, the lessons learned from adapting to the COVID-19 crisis should be applied to maximize the potential for positive change toward sustainable, improved behavioral health services.

AUTHOR AND ARTICLE INFORMATION

Department of Psychiatry, University of Michigan Medical School, Ann Arbor (Pinals); National Association of State Mental Health Program Directors, Alexandria, Virginia (Hepburn); National Council for Behavioral Health, Washington, D.C. (Parks); private practice and consulting, Carolina Beach, North Carolina (Stephenson). Send correspondence to Dr. Pinals (dpinals@med.umich.edu).

The views expressed represent those of the authors and do not necessarily reflect the opinions, policies, or views of the academic, governmental, or other institutions or agencies with whom they are affiliated.

The authors report no financial relationships with commercial interests.

Received April 20, 2020; revision received April 25, 2020; accepted April 25, 2020; published online August 12, 2020.

REFERENCES

1. National Incident Management System. Washington, DC, U.S. Department of Homeland Security, FEMA, 2020. https://www.fema.gov/national-incident-management-system. Accessed March 28, 2020
2. National Incident Management (NIMS) 2017 Learning Materials. Emmitsburg, MD, FEMA Emergency Management Institute, 2017. https://training.fema.gov/nims/docs/nims.2017.instructor%20student%20learning%20materials.pdf
3. Holshue ML, DeBolt C, Lindquist S, et al: First case of 2019 novel coronavirus in the United States. N Engl J Med 2020; 382:929–936
4. Guidance for Infection Control and Prevention of Coronavirus Disease (COVID-19) in Hospitals, Psychiatric Hospitals, and Critical Access Hospitals (CAHs): FAQs, Considerations for Patient Triage, Placement, Limits to Visitation and Availability of 1135 Waivers. Baltimore, Department of Health and Human Services, Centers for Medicare and Medicaid Services, 2020. https://www.cms.gov/files/document/qso-20-13-hospitals-cahs-revised.pdf
5. National Guidelines for Behavioral Health Crisis Care—Best Practice Toolkit. Rockville, Maryland, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2020. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf
6. Romoser J: Providers ask CMS for interim payments during pandemic. Inside Health Policy, March 26, 2020. https://insidehealthpolicy.com/daily-news/providers-ask-cms-interim-payments-during-pandemic. Accessed April 7, 2020

7. Coronavirus (COVID-19) Update: FDA Provides Update on Patient Access to Certain REMS Drugs During COVID-19 Public Health Emergency. Silver Spring, Maryland, U.S. Food and Drug Administration, 2020. https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-provides-update-patient-access-certain-rems-drugs-during-covid-19. Accessed April 7, 2020
8. COVID-19 Information Page. Springfield, Virginia, U.S. Department of Justice, Drug Enforcement Administration, Diversion Control Division, 2020. https://www.deadiversion.usdoj.gov/coronavirus.html. Accessed April 7, 2020
9. Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency. Washington, DC, U.S. Department of Health and Human Services, 2020. https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html. Accessed April 7, 2020
10. Telepsychiatry Toolkit. Washington, DC, American Psychiatric Association, 2020. https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit. Accessed April 7, 2020

Call for Papers

Psychiatric Services welcomes high-quality submissions concerning the delivery and outcomes of mental health services to individuals experiencing mental illnesses of all types across the lifecycle. Submissions are especially welcome in the following topic areas:

- Integration of psychiatric and general medical care
- Criminal justice and psychiatric services
- Suicide prevention
- Effectiveness of peer support interventions (e.g., for substance abuse treatment or for serious mental illness)
- Impact of federal and state policies on the treatment of mental illness
- Cross-national comparisons of care for people with mental illness
- Opioids and mental illness, particularly in public sector populations
- Diversity and health equity
- Prevention of mental illness and early intervention

Submissions will undergo the journal's standard rigorous peer review.

To submit your paper, please visit https://ps.psychiatryonline.org/ and select Submit.