

Impact of COVID-19 on State Mental Health Services



NRI's 2020 State Profiles

October 16, 2020

HIGHLIGHTS BASED ON 41 STATES RESPONDING

State Mental Health Agencies (SMHAs) are the critical safety net providing evidence-based mental health services to individuals in need in every state. Each year over 8 million individuals (2.5% of the U.S. population) receive mental health services and supports from SMHA systems. The COVID-19 pandemic has highlighted and exacerbated existing challenges in the state systems that expend over \$40 billion annually to provide mental health services. COVID-19 affects all aspects of state behavioral health systems, including inpatient care in state hospitals, crisis services, community-based treatment services, and services to school aged children.

State Psychiatric Hospital Impacts Since March 2020

- Patient treatment capacity in many State Psychiatric Hospitals has decreased due to admission limits (21 states), social distancing requirements (18 states), closing of units (8 states), and other reasons identified by 11 states (e.g., hospital personnel needing to isolate or quarantine due to COVID-19 exposure). Fifteen states reported a total of 1,666 fewer state hospital beds.
- State psychiatric hospitals in 9 states have experienced a decrease in demand for psychiatric beds, but in 7 states, demand for these beds increased (due to closure of general hospital or private psychiatric hospital beds). One state reported civil bed demand increased while forensic bed demand decreased.
- Twenty-eight of 41 (68%) SMHAs experienced workforce shortages due to the pandemic.
- SMHAs are managing to obtain necessary Personal Protective Equipment (PPE), but obtaining necessary PPE has strained budgets and required extra work of managers and administrators.

Community Mental Health Impacts Since March 2020

- 88% (36) of 41 responding SMHAs reported their community providers experienced a decrease in in-person, face-to-face encounters since March 2020 (3 reported no decrease, and 2 had insufficient data to respond). 71% (29) of responding SMHAs reported the decrease has been significantly offset by an increase in telehealth visits, while 15% (6) of SMHAs reported that telehealth has not significantly replaced face-to-face visits.
- As community providers experienced a reduction in clients coming in for services in response to COVID-19, 71% of responding SMHAs (29) provided supportive funds to providers.
- 73% (30) of 41 responding SMHAs reported that community providers have reduced staff or services.
- 20% of responding states (8) have had community mental health providers close.

68%

of SMHAs have experienced a workforce shortage since March 2020 due to the COVID-19 pandemic.

88%

of SMHAs reported their community providers experienced a decrease in face-to-face encounters since March 2020.

100%

of SMHAs found the increased flexibility in telehealth rules helpful, and would like these flexibilities be made permanent.

State Behavioral Health Crisis Systems Impacts Since March 2020

- Thirty-one SMHAs (76%) developed a new hotline or warmline system in response to COVID-19.
- Twelve SMHAs (29%) have experienced a decrease in behavioral health clients presenting at crisis stabilization programs (a face-to-face service), and 10 SMHAs (24%) have documented a reduction in mobile crisis visits since March 2020.

Use of Telehealth During COVID-19

- Each of the 41 responding SMHAs have found increased flexibility in rules using telehealth to provide behavioral health services during the pandemic helpful, and most states are requesting that these federal and state flexibilities be continued permanently.

INTRODUCTION

The COVID-19 pandemic has greatly impacted many aspects of life in America. COVID-19 has affected public mental health systems as they work to provide critical treatment services to individuals with serious mental illnesses (SMI). COVID-19 has resulted in reductions in services as mental health providers implement infection control protocols and deal with COVID-19 infections and exposures by doctors, nurses, psychologists, social workers, and other key members of the behavioral health workforce.

In addition to the stresses that dealing with COVID-19 has placed on existing mental health clients and the state mental health service systems treating them, research has identified that the increase in stress and anxiety due to COVID-19 has increased the number of individuals with mental health or substance use issues. A recent Centers for Disease Control (CDC) report found that "symptoms of anxiety disorder and depressive disorder increased considerably in the United States during April-June 2020, compared with the same period in 2019." [1] This same CDC report also noted a marked increase in the number of individuals experiencing suicidal ideation during the pandemic.

Little has been known about how the COVID-19 pandemic has impacted the mental health services provided and supported by SMHAs. As early as March 2020, SMHAs began reporting that the pandemic negatively affected their ability to provide comprehensive mental health services due to 1) potential and confirmed exposure to staff and patients to the virus; 2) the necessity to implement new infection protocols across mental health providers; and 3) the need to obtain and train staff in using PPE.

To understand and assess the magnitude of the COVID-19 impact on state mental health systems, and how these systems have adapted to challenges presented by COVID-19, NRI, in collaboration with the National Association of State Mental Health Program Directors (NASMHPD), surveyed the SMHAs during the summer of 2020. This report represents the results of this survey.

[1] Czeisler, MÉ, Lane, RI, Petrosky, E., et al. Mental health, substance use, and suicidal ideation during the COVID-19 pandemic. United States, June 24-30, 2020. *MMWR Morb Mortal Wkly Rep*, 2020;69:1049-1057. DOI: <http://dx.doi.org/10.15585/mmwr.mm6932a1>.

IMPACT OF COVID-19 ON STATE PSYCHIATRIC HOSPITALS

Eighty-five percent of the 41 responding SMHAs reported that COVID-19 has affected the number of clients they are serving at their state psychiatric hospitals. Over half of the states (21) reported decreased capacity due to limiting admissions, while 18 states (44%) reported reduced capacity due to social distancing requirements (such as reducing patients in a room). Eleven states (27%) described other reasons for decreased capacity, including establishing special units for patients quarantining or isolating due to COVID-19 exposure or diagnosis.

Twenty-two percent of states (9 SMHAs) reported decreased demand for inpatient services as patients avoided state hospitals during the pandemic; however, seven states (18%) reported increased demand resulting from the closure of crisis beds and/or general psychiatric beds during the pandemic. One state reported a mixed response, with an increase in demand for beds for civil-status patients and a decrease in demand for forensic (criminal court); see Table 1.

Table 1: Number of States Experiencing Change in State Psychiatric Hospital Use due to COVID-19

<i>States Experiencing a Decrease in State Psychiatric Hospital Use</i>	Number of States	Percent of States
Decreased Capacity Due to Limited Admissions	21	51%
Decreased Capacity Due to Social Distancing (Limiting # of Patients/Room)	18	44%
Decreased Capacity Due to Closing Units or Wards	8	20%
Other Decreased Capacity Reasons	11	27%
Decreased Demand	9	22%
<i>States Experiencing an Increase in State Psychiatric Hospital Use</i>	Number of States	Percent of States
Increased Demand	7	17%
<i>Other Impacts on State Psychiatric Hospital Use</i>	Number of States	Percent of States
Other Impacts	6	15%

SMHAs describing other impacts of COVID-19 on state psychiatric hospitals explained:

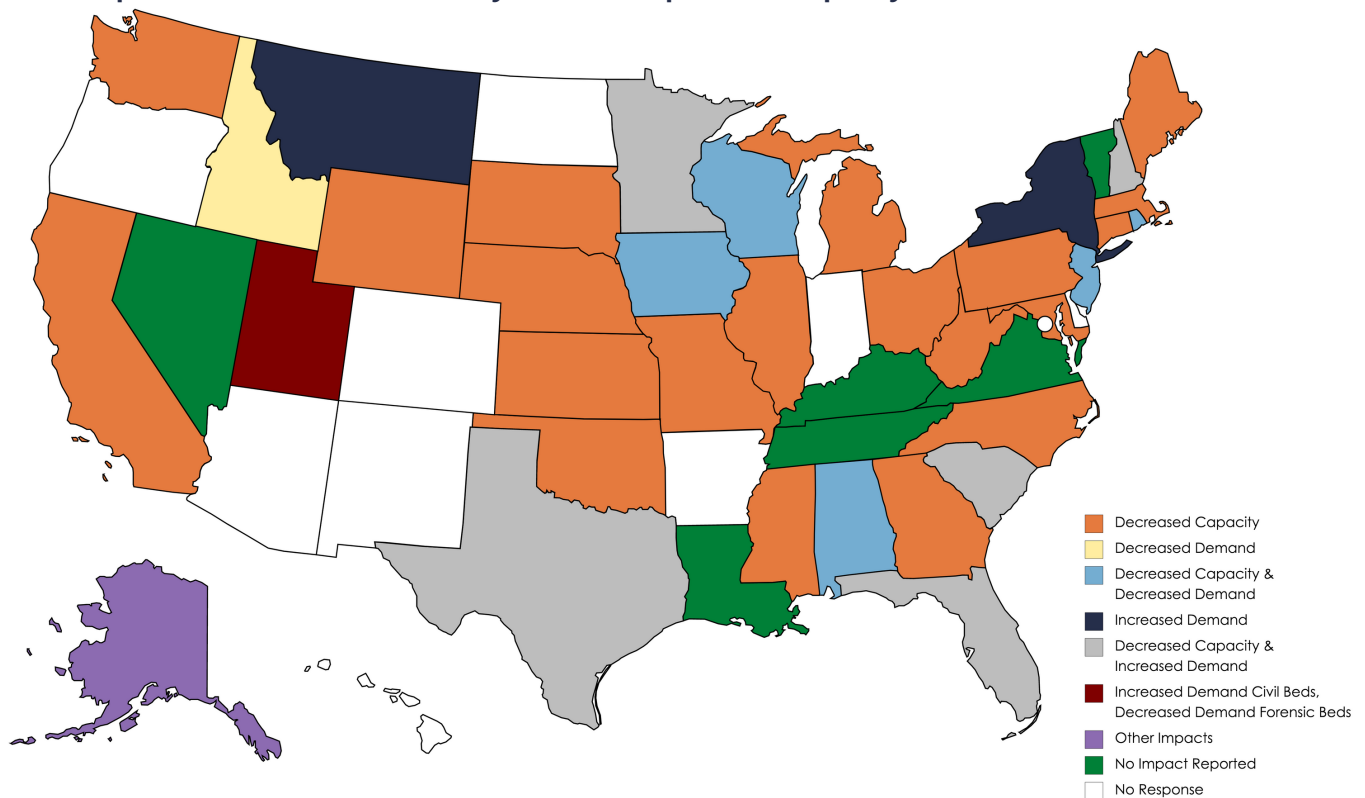
- Discharging and returning home hospital patients who live in remote areas was impacted by closure of airlines servicing remote communities and tribal villages.
- Demand for inpatient services remained unchanged. Inpatient capacity, however, was decreased due to outbreaks at several state hospitals which necessitated halting admissions at those facilities for a period of time.
- States reported experiencing increased difficulty discharging patients due to closed community programs and this resulted in reduced admissions due to lack of open beds.

Impact of COVID-19 on State Mental Health Services

- Another state found that psychiatric inpatient demand did not increase, but they noted that individual cases were dismissed in favor of a more expedient admission process.
- A state realized both a decrease in demand for civil state psychiatric hospital admissions, and a decrease in other state forensic hospital admissions due to the need to create space for social distancing.
- A state developed hospital capacity for specific isolation areas for new admissions and quarantine areas for symptomatic and COVID-19-positive cases. They created Care Coordination Teams to better identify civil and forensic cases that could be diverted to alternative services. They also created forensic pilot projects for jail and community-based competency programs for non-violent offenders.
- Admission policies were changed to limit to specific time frames so as to ensure 14-day quarantine before movement amongst the general population. This resulted in reduced admissions (both number and type, particularly children/adolescent) overall to ensure space for admission quarantine, but also for space to isolate suspected or positive patients.
- Several states reported increased difficulty in obtaining discharge placements due to community program closing or restrictions due to COVID-19.
- A state reported they prioritize admitting civilly committed persons currently located in a jail or home ahead of those already receiving treatment in a hospital psychiatric unit or a Crisis Stabilization Unit. They mitigate the negative effects of potential delays in admissions by coordinating the provision of psychiatric services to civilly committed persons who are awaiting admission in a county jail or at home through the local CMHC's Mobile Crisis Response Teams, ACT Programs, and/or Intensive Community Outreach and Recovery Teams.

Figure 2 shows which SMHAs reported impacts of COVID-19 on state psychiatric hospitals during the summer of 2020. As displayed in the map, several states realized multiple impacts on state hospitals (e.g., simultaneous increased demand for state hospital beds and decreased capacity).

Figure 2: Impact of COVID-19 on State Psychiatric Hospital Bed Capacity and Demand



Impact of COVID-19 on the Number of State Hospital Beds

The decreased capacity in state psychiatric hospitals has resulted in the temporary loss of 1,666 beds (15 states reporting 1,726 beds closed; one state opened 60 beds for a net loss of 1,666). Among the states that closed beds, they averaged closing 13% of their beds, with one SMHA reporting a high of more than 25% bed reduction. Overall, there was a 5% reduction in beds across responding states.

PPE for Staff and Patients

Most states (78%; 32 out of 41) reported they have been able to obtain sufficient PPE equipment. The SMHAs reported three methods for acquiring PPE: 1) the SMHA purchasing PPE directly, 2) the SMHA working with the State Health Department, and 3) the SMHA working with FEMA to obtain PPE. Several states highlighted that while they have been able to obtain PPE, the costs of purchasing PPE have stressed their hospitals' budgets and have required additional time by hospital administrators and state officials to obtain.

A few SMHAs described having to reuse PPE or use lower levels of PPE than preferred. One SMHA indicated that "early in the pandemic, the state psychiatric hospitals did not have adequate PPE and were required to use modified PPE-use criteria. For example, we issued five procedure masks and five paper bags to employees working on patient units. Each procedure mask was then used for one full shift each of five days, five days apart to allow the virus to die." Another SMHA described "the amount of appropriate PPE was not available. We had to use PPE that provided lower levels of protection due to shortages." SMHAs generally reported that shortages of PPE were most acute in the first 30 to 45 days of the COVID-19 crisis and since then, state hospitals have been more successful in obtaining needed PPE.

State Psychiatric Hospital Workforce Shortages Due to COVID-19

Twenty-nine SMHAs (71%) reported experiencing workforce shortages due to the pandemic. The SMHAs cited staff having to self isolate due to exposure to COVID-19 or needing to quarantine after testing positive for COVID-19. SMHAs also cited needing to mandate overtime in order to maintain sufficient staff, further stressing hospital budgets. Several SMHAs are concerned that the stresses of overtime and following COVID protocols are exhausting their workforce. SMHA comments about workforce challenges include:

- "It has been a challenge, especially when a significant number of staff are sent home to self quarantine. However, we have been able to manage with overtime and agency staff. The augmentation of staff resources from the state is invaluable."
- "Yes, staffing levels were impacted by COVID-19-related illnesses, which caused the need for temporary staffing, assistance from retirees who were still licensed, utilization of short-term contracts with external individual direct-care professionals, and detailing of internal employees to meet staffing shortages."
- "It is becoming increasingly difficult to incentivize the dedicated employees we have to continue coming to work. There was a shortage of filled PINs in our direct patient care positions prior to the COVID-19 pandemic, so the longer this health crisis continues, the more of a strain it becomes on our workforce. Several of our programs are only meeting coverage because they are requiring clinical support staff and administrative support staff (teachers, social workers, psychologists, administrative assistants) to work in direct patient care roles. Not only are these employees having to manage the already existing challenges of behavioral, mental, and physical health conditions, they

are now having to provide direct care to individuals who are COVID-19 positive."

- "Due to staff being COVID-19 positive, or a staff family member COVID-19 positive, we added an additional Alternate Care Site for COVID-19 positive patients, PUI patients. Factors impacting staffing included increased vacancies, substantially reduced number of persons applying, staff departing because of fear of virus, staff quarantined because of COVID-19."
- "Earlier in the pandemic (April/May) when our state's COVID-19 numbers were higher, there were direct-care staff members that were required to be at home quarantine for 14 days. However, since then, that has leveled out and does not seem to be a stressor on the system. One solution that was implemented for the state's hospitals is that hotel rooms near the hospital were secured such that staff members could work and then stay in the hotel, and then return to work in an effort to decrease the possibility of transferring infection back to staff's families."
- "We had significant difficulties with our psychiatric providers in the state psychiatric hospital. There was a time we had four practitioners (two NPs and two psychiatrists) for over 100 psychiatric patients, with 50 of those being forensic. We did better with medical providers. We did well with most ancillary staff and nursing. Almost all of our social workers went out of work on the same day (when our first staff member tested positive) and many psychologists. Our physicians and nurses filled the gaps, including communicating with patients about our procedures, the state of the hospital, the guidelines and restrictions we were implementing, etc. This continued for several weeks. After the first few weeks, most staffing, except psychiatric practitioners, was good."
- "There continues to be a continually increasing number of call-outs by nursing personnel due to various reasons related to the pandemic. Exposure or possible exposure to the virus; closing of schools, and lack of child care requiring staff to remain at home; staff who believe themselves to be at high risk declining to work. The longer the high prevalence of the virus in the community continues, the greater the adverse impact on hospital staffing, both due to more staff becoming exposed, and due to staff who have been working additional shifts becoming exhausted."

IMPACT OF COVID-19 ON COMMUNITY MENTAL HEALTH SERVICES

COVID-19 has had a major impact on community mental health providers, as 36 of 41 SMHAs (88%) reported their community providers are experiencing a decrease in in-person, face-to-face encounters since March 2020 (only three states reported they have not had a reported decrease, and two states reported the impact on face-to-face visits was unknown at this time). Of the 36 SMHAs reporting a decrease, 29 reported the decrease has been significantly offset by an increase in telehealth visits being provided, while six SMHAs reported telehealth has not significantly replaced face-to-face visits.

SMHAs reported that generally individual services were easier to transition to telehealth, while group services were less frequently maintained. One SMHA indicated that, "in short, individualized services tend to fair better than group-setting programs at this moment in time. While telehealth offers some offset, it is not sufficient to address current fiscal shortages." Several states provided examples of major increases in telehealth visits:

- "Telephone encounters have increased by 365% from January to June 2020. Video-conferencing encounters increased by 137% from January to June 2020."
- "State telehealth claims went from 1,500 per month to 4,500 per month, with half for mental health."

Financial Supports for Community Mental Health Providers

As community providers experienced a reduction in clients coming in for services, 29 states have provided funds to support community providers in response to COVID-19.

- Eleven SMHAs increased state funds to community providers.
- Six states increased Medicaid direct payments to providers.
- Twenty-three states provided other types of interim payments to community providers, such as discretion to bill more services to telehealth, SAMHSA grants, provision of PPE or funds to purchase PPE, and funds to purchase telehealth equipment.

Closure of Community Mental Health Providers

Eight SMHAs reported they have had community mental health providers close since March 2020. In five of these states, the closure was described as temporary during the pandemic; however, three states reported providers have closed permanently.

Thirty SMHAs reported that community providers have reduced staff or services since March 2020. SMHAs reported providers were experiencing insufficient demand to maintain staff, or had to close some residential programs due to COVID-19 concerns.

Sixteen SMHAs reported they have **reduced the use of congregate living situations** (e.g., group homes) due to concerns of COVID-19 exposure. Examples provided by SMHAs to address these concerns include:

- "There have been COVID-19 exposures in group home/residential settings. The agency notifies us through a reporting mechanism that has been implemented by our SMHA. Coordination for appropriate testing is in place via our partners at Public Health. We stay in communication with the provider until no residents or staff show as being positive. The facilities go back to accepting new clients as needed once it is safe to do so. We have not shut down any residential programs at this time."
- "Reduced occupancy to provide for social distancing and reduced staffing."
- "Providers of residential treatment for substance use disorders (detox and residential treatment) have had to reduce capacity to maintain safety protocols."
- "A number of behavioral health assisted living facilities are not accepting new admissions, as many are impacted by cases of positive residents and staff, and are experiencing staff shortages. The impact is felt in hospitals having fewer available appropriate options for discharging patients in need of assisted living level of care, increasing lengths of stay, and further reducing the capacity of state hospitals to accept new admissions."
- "Various providers needed to reduce capacity due to COVID-19 infection-control measures. Therefore, if the capacity was reduced, then their utilization was temporarily reduced as well."

USE OF TELEHEALTH DURING COVID-19

Every responding SMHA has found increased flexibility in rules using telehealth to provide behavioral health services during the pandemic to be helpful, and most SMHAs are requesting these federal and state flexibilities to be continued permanently. As Table 2 shows, every SMHA has found the ability to provide audio-only telehealth to be helpful, and 35 SMHAs are recommending continuing this service. The expansion of available services and locations where telehealth can be provided, the removal of barriers for remote prescribing, the flexibility for providers to work across state lines, and the relaxation of federal privacy rules were all found to be beneficial by 32 SMHAs.

Table 2: State Experiences with Increased Telehealth Flexibility Options During the COVID-19 Pandemic

Change has been Helpful			State Activities to Address Impact of COVID-19 on State Psychiatric Hospitals	Should be Continued After COVID-19 Flexibility Expires		
Yes	No	N/A		Yes	No	N/A
40	0	1	Expansion of services that may be delivered via telehealth.	38	1	2
41	0	0	Expansion of telehealth services that may be delivered via audio-only communication.	35	2	4
39	0	2	Expansion of allowable patient locations for telehealth (e.g., allowing telehealth to be delivered in patient's home).	38	0	3
35	0	6	Expansion of types of professionals who may conduct telehealth visits.	34	0	7
20	5	16	Increased reimbursements for telehealth services.	21	5	15
36	2	3	Removal of regulatory barriers for remote prescribing of controlled substances.	28	7	5
34	1	6	Flexibility in licensure requirements for the practice of telemedicine across state lines.	27	7	7
33	2	6	Relaxation of federal privacy and confidentiality standards.	23	10	8
27	5	9	Funding for purchase of telehealth equipment.	31	1	9

Several states remarked on the importance of paying for telehealth services on parity with face-to-face encounters. One SMHA indicated, "it is crucial that we are paying at parity with in-person healthcare for telehealth. This parity has allowed us to expand telehealth dramatically and have it embraced by the provider community."

SMHAs identified an additional area where telehealth could be useful for behavioral health systems: court telehealth for clients with commitment or competency hearings.

Provider Access to Telehealth Equipment

Sixty-one percent of SMHAs (25) reported that community mental health providers did not have necessary equipment to provide as much telehealth services as needed. In 11 states, the SMHA helped support the acquisition of telehealth equipment by behavioral health community providers. For example, one state explained, "we utilized CMP monies flexibility to support nursing facilities in their purchase of technology for telehealth. Some providers have also utilized CARES Act funding to help support increased costs related to telehealth. Removal of the site-of-service differential also supported providers in funding for telehealth expenses."

Several states mentioned that SAMHSA's Mental Health Block Grant (MHBG) funds were used to pay for telehealth services, but it would have been helpful if they were permitted to use MHBG funds to purchase telehealth equipment for providers.

Impact of Telehealth on No-Shows for Services

Most SMHAs (85%) reported that a positive impact of increasing the use of telehealth was a reduction in no-shows at community mental health providers. SMHAs indicated that:

- "Kept appointments have increased significantly, from approximately 60% to 90% based on provider feedback."
- "Significant improvement in the number of individuals keeping appointments, especially in rural and impoverished areas."
- "Coordinated specialty care (CSC) programs have reported increases in kept appointments. The CSC programs have also had the flexibility to have additional appointments with individuals to check in on those that need additional support."
- "Providers and consumers reported transportation issues prior to COVID-19; however, with the move to telehealth, the issues of transportation have decreased significantly."

However, one SMHA noted that while "some providers have reported a decrease in no-shows due to telehealth, some have reported difficulties in connecting with clients via telehealth due to clients' difficulty accessing and using technology."

Telehealth Practice Guidelines

Seventeen SMHAs have developed practice standards to assure high-quality behavioral telehealth services are provided. SMHAs report these practice guidelines were generally developed years prior to the current COVID-19 pandemic; however, SMHAs are updating them based on CDC, HRSA, and other federal guidance, and are providing webinars and other trainings to providers. Examples of SMHA work to help providers with telehealth include:

- An SMHA required providers to submit staff supervision plans for telehealth to continue our compliance with SPA requirements. The state Health Care Authority (HCA) posted an FAQ on the SMHAs' website for optimal delivery of telehealth. HCA hosted weekly provider conference calls to discuss issues and concerns related to the delivery of telehealth services. HCA partnered with the university to develop and host telehealth training for providers.
- An SMHA reported "We have been working with the HRSA-funded Northeast Telehealth Resource Center (NETRC) to provide high-quality training and technical assistance to licensed behavioral health providers on national best practices for behavioral health telemedicine. We have also provided SAMHSA grant funding to assist our providers in successfully acquiring HIPAA-compliant telemedicine platforms...In addition, we are working with our local non-profit trade association to conduct an environmental scan on current telemedicine practices and intend to support their work in implementing client feedback surveys at behavioral health providers, to be offered after each virtual session."

IMPACT OF COVID-19 ON STATE BEHAVIORAL HEALTH CRISIS SYSTEMS

Creation of State Hotlines Specific to COVID-19

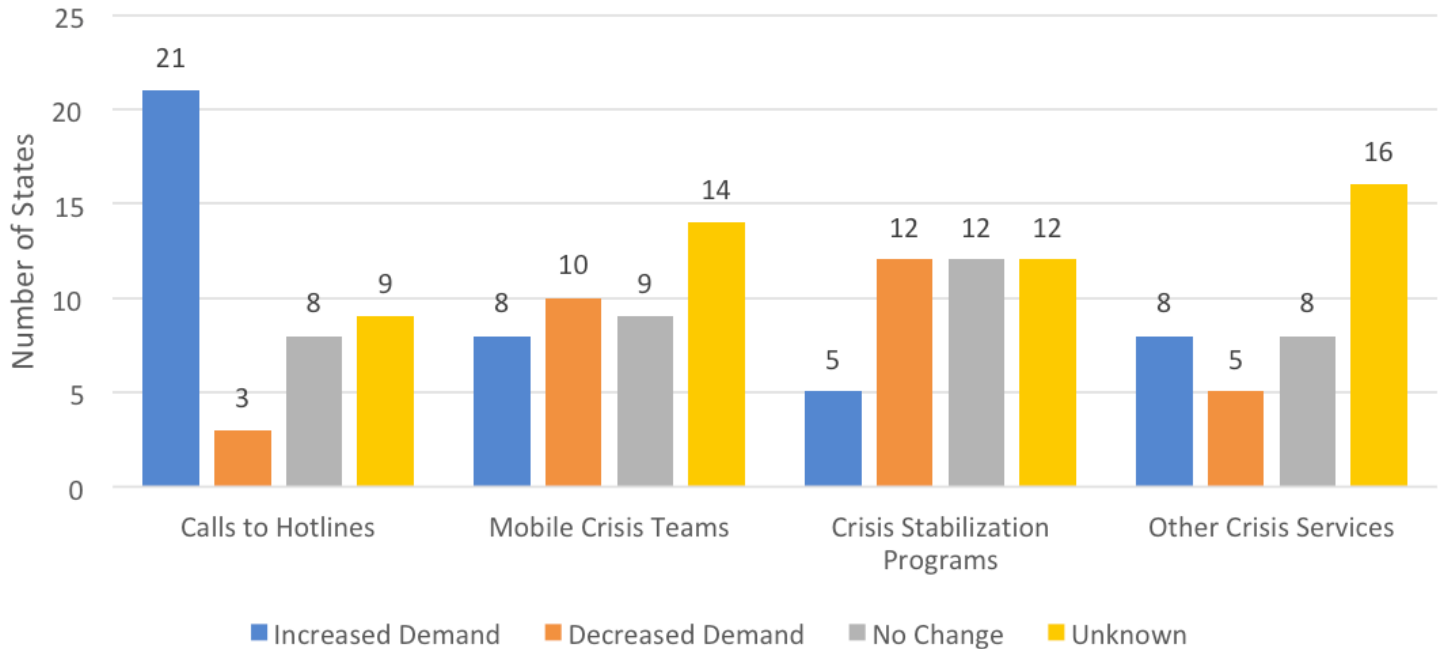
Thirty-one SMHAs (76%) have implemented a new hotline or warmline system in response to COVID-19. These new hotlines are focused on either the general public with behavioral health concerns related to COVID-19, or to provide behavioral health supports to medical personnel and first responders working with potential COVID-19 patients. These hotlines were developed by the SMHA in 19 states, and were jointly organized by the SMHA and another agency (e.g., the Governor's Office or the Health Department) in 12 states.

Impact on Behavioral Health Crisis Services

COVID-19 has affected state behavioral health crisis systems at several levels. While many SMHAs report an increase in calls to their Suicide and Crisis Hotlines, most SMHAs have experienced a decrease in behavioral health clients going to crisis stabilization programs (a face-to-face service), and have also realized a reduction in mobile crisis visits; see Figure 3 on the following page.

One SMHA explained that "even for some of the 'familiar faces,' COVID-19 has now become wrapped into their delusional system or suicidal thought processes. These cases have also been more complex in nature. Crisis stabilization has been more difficult, as housing is less stable for many people, and for a variety of other reasons due to COVID-19. We are spending more time with cases due to the pandemic."

Figure 3: Impact of COVID-19 on State Behavioral Health Crisis Services



Examples of other crisis services impacted by COVID-19 include:

- Peer-operated respite has shut down due to the staff being medically at risk and not enough PPE to ensure staff remain safe.
- Crisis residential services have decreased by 15% from January to June 2020.
- Crisis diversion residential services were suspended at the onset of the pandemic.
- Housing issues and need for alternatives, funding for basic necessities for people out of work, access to telepsychiatry with clients not having internet or cell phones that can accomplish this.

WORKFORCE EXPANSION: USE OF ADVANCED PRACTICE NURSES & PHYSICIAN ASSISTANTS

Thirteen states have changed licensure rules or regulations during the pandemic to expand the use of advanced practice nurses (APNs) or physician assistants (PAs). Examples include:

- Emergency licensure procedures for nurses were enacted as well as other temporary regulatory changes, such as allowing nurses licensed in other states to practice in our state without a state license, waiving continuing education requirements, and allowing nurses with expired licenses of less than five years to practice.
- An Executive Order was issued to facilitate out-of-state and allow recently retired providers to be granted emergency temporary licensure.
- The Board of Physicians has relaxed rules governing out-of-state providers, and the number of PAs a physician may supervise. The Board of Nursing relaxed rules related to permitting out-of-state practitioners to practice nursing in our state, and relaxed delegation of nursing duties regulations.
- The state temporarily waived certain scope-of-practice restrictions on APNs related to physician collaboration, including a rule requiring that an APN enter into a joint protocol with a collaborating physician in order to dispense narcotic drugs. The state also temporarily waived certain scope-of-practice restrictions on PAs related to physician supervision, including a rule requiring PAs to obtain authorization prior to prescribing a controlled dangerous substance.
- Board of Nursing waiver allows, under specific circumstances, for an NP to be reassigned to another practice area within the same facility without updating supervisory arrangements. No other changes or waivers to collaborative/supervision/protocol agreements were made. NPs must maintain other elements of collaborative agreements, supervision, or protocol in existing law/regulation. Executive Order waives limitation on the number of NPs a physician may supervise.
- State Nursing Board now allows out-of-state licenses to be utilized in our state provided they follow certain regulations.

CHILD BEHAVIORAL HEALTH SERVICES

Addressing Mental Health Gaps in School-Based Services During School Closures

With many school systems across the country shifting to remote learning, the ability of students with behavioral health needs to receive services while in school has been impacted. SMHAs described a number of initiatives to meet the behavioral health needs of school-aged children while school-based services are not available due to school closings and remote learning. States are using telemedicine and coordinating with state and local Departments of Education to develop resources for teachers and school systems and help behavioral health providers continue to assure children receive services while out of school. Some of the state examples below highlight difficulties reaching all children while they are out of school.

- A state provided guidance to providers on maintaining connectivity to students that were receiving school-based mental health services. The state expects this work to continue, just in non-traditional ways. Telehealth has been a helpful factor for this work as well.
- Individual CMHCs in one state are reaching out to schools they serve. This continues to be an area of grave concern as they have been unable to reach 10% to 20% of kids.

Impact of COVID-19 on State Mental Health Services

- A state's Medicaid-funded, school-based behavioral health services continue to be available primarily through telehealth, at the direction of service providers and local school districts. The use of telehealth to engage students in school-based behavioral health services has varied widely across the state.
- In a state, local school behavioral health staff are continuing to outreach to youth who have been under their care. Anecdotal reports are that school staff have been prioritizing outreach to those students who were of greatest concern. Private providers who were contracted by some school districts for these services have also attempted to maintain contact with youth. Both have taken full advantage of the relaxed telehealth regulations during this time. Many high-risk youth have also been served by school lunch programs, and there has been an informal connection through these robust services, although not formal behavioral health services.
- A state's Community Mental Health Centers (CMHCs) worked in partnership with the local school districts to continue behavioral health services for children being served. The SMHA is working to provide mental health resources to share with the Department of Education that will be provided to teachers and parents for the new school year. They are exploring providing teachers with a quick mental health screener to determine when children/youth may need mental health interventions. The state is working with the children's coordinators at the CMHCs to encourage them to continue to provide the services that they have always provided, as well as enhanced services to assist with the additional complications and challenges brought on by the pandemic.
- On the prevention side of the continuum of care, a state's school districts are contracting with certified community prevention agencies, school educators, and educational services centers to provide prevention education to maintain social and emotional learning skills during COVID-19. Certified prevention professionals and educators are holding virtual meetings of youth-led and youth-mentoring middle and high school groups. Prevention professionals are providing education and resources to youth and parents/caregivers in the Grab & Go meals being delivered or picked up by families. Some evidence-based prevention model programs are being (or will soon be) delivered remotely, such as Life Skills and Strengthening Families.
- A State's mental health providers deliver rural professional development to school districts upon request on topics, including trauma-informed schools, Return to Learn COVID-19 resources, social-emotional learning, and connecting school districts to their local community mental health providers. The SMHA and the Department of Education collaboration at the state level are offering virtual trauma-informed schools training available for school districts and behavioral health service providers.
- A state's School-Based Youth Services are providing services remotely. All programs in the Office of Family Support Services, including School-Based Youth Services, are required to conduct wellness checks with families. Activities such as groups to foster social and emotional needs of participants are held remotely. The school-based programs have also participated with students in virtual graduations and prepared goodie bags for students that include snacks, games, and gift cards. Many school-based programs are relying on social media platforms to stay connected with students and to share ideas to engage students and families over the summer. Providers have been utilizing various platforms, such as Google Classroom, Remind, Facebook, Zoom, etc., to remain connected to students and to conduct outreach to students outside of the School-Based Youth Services Program. Programs have also held virtual college campus tours and virtual freshman orientation for new students entering high school.

Impact of COVID-19 on State Mental Health Services

- The SMHA has focused efforts on reaching patients who have not received a service since the pandemic began in March 2020 by finding telehealth solutions or serving patients in-person with protective measures. School mental health clinicians provide services over the phone and via video conferencing services, when clients have the technology available. To aid in this process, over 500 computer tablets were purchased and distributed across the state to clinicians to facilitate the delivery of telehealth services. In addition, the SMHA worked with the state university to survey the parents of patients to gauge the ability for their child to continue to participate in clinical services over the summer. Most parents also said that their child would be able to continue to participate in a variety of services (e.g., individual therapy, family therapy, small group activities, and social/emotional skill development) whether it was available in-person following CDC guidelines, or over the internet using telehealth. A majority (86.3%) of parents indicated that they had the technology needed in order for their child to participate services provided via telehealth. When unavailable, audio-only was used.
- With the recent COVID-19 crisis, the state has worked with Kids' Link, a 24/7 pediatric behavioral health triage and referral hotline operated by Lifespan, to become a central referral hub for children's behavioral health referrals for the state. DCYF has reached out to the five geographic superintendent groups in the state, and have held a series of zoom meetings with additional key staff from the schools (social workers, psychologists, etc.) to discuss the resources available.
- Some SMHA supported programs set up Facebook pages as an informational portal for students and parents right after the school buildings closed and homeschooling began in April, and they have used these pages to post everything from age-appropriate meditation and yoga exercises, to healthy versus unhealthy coping skills, to ideas for fun, at-home games and activities to relive stress, such as nature scavenger hunts. They also list local resources and educational articles for parents on mental health related topics. Several programs have also helped with food distribution, handed out mental health packets for parents to take home, made phone calls to stressed-out parents and teachers, and held online video sessions with students identified as Tier II, meaning they may benefit from early intervention for mental health issues. And, some have helped families with physical needs and provided support for overwhelmed teachers through email and phone calls.
- A SMHA is continuing to partner with the Office of the Superintendent of Public Instruction and each of the state's Educational Services Districts (ESD) to provide a minimum of one full-time Student Assistance Professional (SAP) in over 80 Community Prevention and Wellness Initiative (CPWI) sites across the state. The SAPs have shifted their services to provide virtual offerings, including group sessions, individual sessions, and providing much-needed behavioral health and prevention-related messages to children, youth, and families, as well as to school employees themselves. The ESDs who are licensed behavioral health providers continued to provide services to youth first transitioned home, then a few weeks later added more telehealth options. Our family and youth peers had weekly calls during which families could share resources and support each other. Two ESDs have behavioral health system navigators to assist in coordinating services. We have a team working with school districts and their local providers to ensure there are supports in place, not only for youth and their families, but also for teachers when the next school year starts.

Addressing Mental Health Service Needs of Children in Foster Care

Thirty-one SMHAs (76%) reported on activities to support the provision of services to children in foster care, particularly provision of services remotely. While states are using telemedicine to continue providing services to children in foster care, several SMHAs expressed a concern that children in foster care settings may not have enough privacy to use telehealth equipment confidentially. In addition, at least one state reported there have been some difficulties for children attempting to transition between levels of care. In this case, the SMHA is meeting weekly with relevant state and local partners to monitor and brainstorm system-level solutions. Examples of state activities to support mental health services for children in foster care include:

- "Providers of behavioral health services across the state, including those who serve children in Treatment foster care, have rapidly adopted telehealth to continue services during COVID-19. However, telehealth services have not been universally available or accepted by all providers or youth/families, with approximately 30% of families declining telehealth services in preference of waiting until in-person services could resume. Children in out-of-home placements have experienced service interruptions due to delays in individual provider adoption of telehealth and/or lack of telehealth technology. Access to high-speed internet and technology varies widely across our state. Children in very rural and remote areas often lack access to reliable internet, making telehealth services an unrealistic option."
- "Some behavioral health services are provided to youth in foster care through Medicaid-billable services. These services have been impacted to the same extent that all Medicaid services have been. Providers have worked to be accessible via telehealth portals, or to remain open and providing necessary services under safe social distancing guidelines. Group homes and residential services (sub-PRTF) are not funded by the SMHA, but we are aware that admissions to these facilities have been slowed due to COVID-19 and COVID-19-related restrictions in capacity. Some crisis services are contracted by select local DHS agencies to behavioral health providers, and these were initially challenges by COVID-19 impacted, but have accommodated. Psychiatric RTCs (PRTFs) also had some initial delays and limitations on admissions, but these have mostly returned to normal capacity."
- "Face-to-face visits have been restricted by child welfare agency to the homes/facilities where these children reside. Telehealth services and phone calls have been the primary medium of communication with the children and child welfare agency."
- "The SMHA is supporting behavioral health services to foster care youth peripherally, in that many children and youth in foster care are served by the CMHCs, with the exclusion of children and youth in residential treatment. Residential treatment services have had difficulties with staffing capacity and admissions/discharges. This is due to the issue of trying to mitigate the exposure to the population at any given facility, and lack of capacity to cohort or quarantine large number of children at any one time."
- "We established dedicated sites available in the event that an out-of-home program would be unable to operate and/or offsite quarantine for youth would be required. Since reopening admissions in early May, admissions have been expedited for high-risk youth and program census is close to pre-COVID-19 levels. Throughout this period, no out-of-home programs have ceased operations."

USE OF STATE DISASTER PLANS DURING COVID-19

Most SMHAs (35 of 41; 85%) reported their state had an existing behavioral health disaster plan and the state was able to use this plan during the pandemic. SMHAs report using their behavioral health disaster plans to:

- Provide behavioral health supports to people impacted by COVID-19
- Implement crisis call centers and support crisis counselors
- Define essential and non-essential staff for determining who needed to work from home or at offices/service sites

Twenty-nine (71%) SMHAs indicated that they are updating existing behavioral health disaster plans to address the unique needs of the pandemic. One SMHA explained, "additional statewide workgroups were developed and implemented (such as infection control, training, PPE, etc.) to ensure COVID-19-related protocols were consistently applied at each hospital. The Division has also contracted with an epidemiologist who is participating in the Infection Control Work Group." Another SMHA had similar comments, indicating "our plan did not address the type of situation in which we now find ourselves, and did not consider the same variables, so it will be updated to include new scenarios to prepare for."

Obtaining Needed Personal Protective Equipment (PPE)

SMHAs reported that they have been successfully working in partnership with their state health departments, state emergency management agencies, and with FEMA to receive needed PPE. However, a few SMHAs report continuing difficulties receiving PPE, and that they were on their own in finding needed PPE for their behavioral health providers:

- "We were eventually deemed essential healthcare and received very limited PPE. We finally found some appropriate vendors and were able to procure limited amounts - still utilizing contingency PPE procedures, and have not received any reimbursement from CARES."
- "We have mostly had to purchase our own as they were not able to meet our needs."
- "We had no direct relationship with FEMA. All state agencies were to work through our Department of General Services to request PPE, and then as inventory came in the Department of Health determined where the supplies would go. The PPE inventory did not come in, in the ordered quantities so certain areas were prioritized. Recently, the inventory pipeline has stalled completely, and it was suggested that we order our own PPE supplies through any channels we have connections with."

SUMMARY

The COVID-19 pandemic has severely stressed SMHA systems through 1) increasing costs of providing services due to the necessary implementation of new infection protocols; 2) the need to procure PPE and train staff and patients on its proper use; 3) reducing the availability of state psychiatric hospital beds; 4) reducing community-based mental health services; and 5) strains on the mental health crisis systems through increased calls to hotlines, and the need to protect patients and staff from possible exposure to the virus when receiving and providing face-to-face services.

SMHAs reported significant increases in the provision of telehealth services since the beginning of the pandemic. SMHAs have found the increased flexibility and funding in state and federal policies for telehealth services during the pandemic to be very helpful, and have allowed them to continue to offer services safely while maintaining and increasing accessibility for all individuals. The use of voice-only telehealth was identified as very useful in rural areas. SMHAs strongly recommend that the time-limited flexibilities in telehealth policies and regulations allowed during the COVID-19 crisis be extended to permit continued use of telehealth services to individuals with behavioral health needs.

While the increased use of telehealth has permitted SMHAs to continue providing behavioral health services during the pandemic, the reduction in face-to-face services, especially group and team-based services, has impacted the behavioral health workforce and financial status of behavioral health providers. States reported reductions in workforce and closures of some behavioral health providers due to the stresses of the pandemic. It is unclear if or when these services will be restored.

Despite the stresses of the COVID-19 pandemic on their systems, SMHAs are adapting and working to provide high-quality evidence-based services to individuals in need. After the initial difficulties of securing PPE and implementing appropriate protocols to protect patients and staff from COVID-19 exposure, SMHAs reported that services are being provided and issues of workforce shortages are being addressed. The costs of providing services have increased, and future budget shortfalls are looming challenges facing SMHAs and their service providers, but the nation's behavioral health service system is running.

This report is based on information reported by States between June to September 2020. During that time, many states hadn't yet seen what, to them, was a significant number of cases, and so the effects of the pandemic may not yet have been fully recognized. Follow-up research to assess the impact of the disruptions in the SMHA service systems on client outcomes and future service provision will be important.

This 2020 State Mental Health Agency Profiles report on the Impact of COVID-19 on State Mental Health Systems is the first of a series of 2020 State Profiles reports on the organization, services, and financing of SMHAs that NRI will releasing over the next few months.

**For Additional Information About this Report, or the SMHA Profiles Project,
Please Contact: Ted Luttermann**

Senior Director of Government and Commercial Research
National Association of State Mental Health Program Directors Research Institute (NRI)
ted.luttermann@nri-inc.org / 703-738-8164