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Commentary:
COVID-19

# Mental Health Community and Health System Issues in COVID-19: Lessons from Academic, Community, Provider and Policy Stakeholders

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The coronavirus pandemic of 2019 (COVID-19) has created unprecedented changes to everyday life for millions of Americans due to job loss, school closures, stay-at-home orders and health and mortality consequences. In turn, physicians, academics, and policymakers have turned their attention to the public mental health toll of COVID-19.

This commentary reporting from the field integrates perceptions of academic, community, health system, and policy leaders from state, county, and local levels in commenting on community mental health needs in the COVID-19 pandemic. Stakeholders noted the broad public health scope of mental health challenges while expressing concern about exacerbation of existing disparities in access and adverse social determinants, including for communities with high COVID-19 infection rates, such as African Americans and Latinos. They noted rapid changes toward telehealth and remote care, and the importance of understanding impacts of changes, including who may benefit or have limited access, with implications for future services delivery. Needs for expanded workforce and training in mental health were noted, as well as potential public health value of expanding digital resources tailored to local populations for enhancing resilience to stressors.

The COVID-19 pandemic has led to changes in delivery of health care services across populations and systems. Concerns over the mental health impact of COVID-19 has enhanced interest in remote mental care delivery and preventive services, while being mindful of potential for enhanced disparities and needs to address social determinants of health. Ongoing quality improvement across systems can integrate lessons learned to enhance a public mental well-being. *Ethn Dis*. 2020;30(4):695-700; doi:10.18865/ed.30.4.695

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## Introduction

The COVID-19 pandemic has raised awareness of mental health as a primary public health concern. Physical distancing, business and school closures, grief, and stress are aspects of the pandemic with significant mental health consequences.[1-6] In addition to individual stressors, effects on communities include worsening disparities and concerns of widespread health and economic consequences. Communities are also impacted by system-level changes, such as the rapid expansion of telehealth,[6] which will likely have implications beyond the pandemic, shaping the future of health care. Similarly, emergent needs for emotional resilience tools under a prevention-based approach

to mental health, while common in some countries, has not been as developed in the United States.[1,7,8]

This commentary from the field describes issues related to mental health and the COVID-19 pandemic occurring at local health system, county, and state levels; the issues were discussed with the authors representing community, academic, health care, and policy stakeholders in California and Louisiana. Conversations focused on ongoing efforts, potential new programs within systems, and experiences of community and academic partners related to the mental health consequences of COVID-19. Notes were compiled from more than two dozen discussions involving varied stakeholders. Key principles, examples, and strategies were iteratively reviewed across stakeholders for accuracy and consistency, similar to approaches for Rapid Assessment Procedures with participatory features.[9]

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## Findings/Key Themes

### Mental Health Priorities

*Community Context*

Community stakeholders expressed concerns about universal stress, social isolation, loss, and grief. They also voiced concerns about the mental health impact of abrupt changes in routine, job loss, and school closures. Specific concerns were changes in socioeconomic status due to job loss, family stress in the context of governmental orders to stay at home, and other losses suffered. They identified a need for support in coping with personal stress, in parallel with help for issues such as finances and housing. Emphasis was placed on a strength-based approach to wellness.

Discussants expressed concerns about increased mental health symptoms within communities, such as anxiety, depression, suicidal ideation, and grief, particularly in communities with high infection and death rates (such as African American, Asian and Pacific Islander, Indigenous, and Latino populations).[10,11] They noted that these concerns are particularly burdensome in under-resourced communities, which have reduced access to services and higher rates of job loss. These communities also have fewer technology resources, which were identified as important for supporting children in distance learning. Concerns were raised in policy sectors about reported increases in domestic violence and child abuse, with limited options for individuals and families to leave potentially dangerous situations.

Stakeholders suggested a call for rapid implementation of internet-based preventive mental health resources. They prioritized tailoring engagement to diverse communities to encourage uptake and develop trust. Stakeholders emphasized the importance of free, accessible evidence-based tools with tailoring as feasible to specific populations, such as including narratives from members of the community and translating to diverse languages. Stakeholders recognized that engagement and tailoring must be accomplished rapidly, under an iterative and transparent process.

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*Social Determinants*

A key theme across stakeholders was the need to attend to the social context of the pandemic, including the impacts of physical distancing, loss of income, and decreased access to social services. It was suggested

that a public health approach would integrate basic support for coping with stress with policies responding to social and economic changes, such as rent freezes, eviction moratoriums, unemployment support, parental leave, and rapid access to permanent housing. Some communities were organizing efforts to promote these policy changes in California and Louisiana. Other consequences discussed were financial instability as well as rapid demand for services from community partners such as social services agencies and community-based organizations. In addition, there was a need to increase support to community members and to help stabilizing or expanding partnerships or workforce.

### *Higher Risk/Vulnerable Patient Populations*

Among providers, a central theme was reaching and supporting the most vulnerable: the elderly; homeless; children; pregnant women; and those with medical and psychiatric comorbidities or who have significant social isolation. Concerns included: the efficacy of remote services for serious mental illness; support for housing and shelter stability; safety and exposure in congregate shelters; availability of personal protective equipment for patients and providers; and stress levels of patients and providers. People experiencing homelessness are vulnerable to exposure to COVID-19 and worse health outcomes, with recent evidence of viral spread within congregate shelters. While guidelines from the National Alliance to End Homelessness support moving individuals to non-congregate settings, communities are struggling to accomplish this. Another concern was increased risk for incarcerated people. With the release of large numbers of incarcerated individuals to reduce danger of exposure, concerns remained of how to meet potential behavioral health, substance use, housing, and physical health needs during community re-entry.

### *Disparities*

All stakeholders voiced concerns about racial and ethnic disparities in COVID-19 outcomes. These disparities were noted to overlap with disparities in housing, physical health conditions, management and access to care and unmet mental health needs.[10-12] Discussions highlighted concerns about equitable allocation of resources.

## Systems Issues

### *Disaster Framework*

Discussants noted the need to expand integration and collaboration of mental health systems and community disaster resources. There was precedent in both Louisiana and California for integrating disaster preparedness and recovery with depression collaborative care.[9,13-15] Given the pandemic nature of COVID-19, a broader integration of approaches was noted as important. Approaches may include disaster training for mental health staff and implementation of mental health competencies for public health staff. Post-disaster mental health outcomes are known to be impacted by a history of post-traumatic stress disorder, underlying resource restriction, and historical trauma,[14] highlighting the need to understand mental health and pandemic contexts together.

### *Health Systems*

Important issues for health systems included rapid and nearly universal expansion of telehealth. It was noted that different systems used different technologies, and that mental health providers had been low adopters of remote care services pre-pandemic.[6] Pre-pandemic limiting factors included barriers to reimbursement and burdensome technological and compliance requirements from insurance companies; these barriers persisted as ongoing challenges during the pandemic. Stakeholder discussions focused on the process of the expansion and the consequences for patient and provider experiences in conducting mental health assessments, therapy, and medication management. Key issues raised included access and feasibility, effectiveness for persons with serious mental illness, population reach, and cost-effectiveness for systems. Describing massive loss of revenue coupled with apparent increase in need for mental health services, stakeholders expressed a need for payment reform to allow local health care systems to adapt to changing needs.

### *Rapidly Adaptable and Relevant Technologies*

Implications of the shift to telehealth and other technologies included a potential for widening of disparities for some populations as a result of differential comfort with

and access to technology. Specific populations of concern included the elderly, lower-income, and people experiencing homelessness. There was a need identified to determine approaches to rapidly create and implement new technologies that could be tailored to specific populations and support new system and community workflows. Policy changes to increase availability of devices such as cell phones or tablets, and access to cell service or Wi-Fi, were noted as key interventions, together with expanded insurance reimbursement.

*Walk-ins*

Stakeholders noted that, despite expansion of telehealth, patients continued to present for walk-in clinic visits. Some populations may have limited access to technology, while simultaneously struggling with physical distancing or acute symptoms; others needed to receive injectable medications (eg, antipsychotics or vivitrol) at times when in-person provider coverage was limited. This raised questions about the limitations of remote care. For clinics remaining open for walk-ins, safety concerns included availability of protective equipment and development of policies regarding their use, for patients and providers alike. Particular concerns were noted for groups such as elderly patients experiencing homelessness, with significant medical comorbidities placing them at high risk of COVID-related complications. Clinics and systems were required to rapidly develop policies to ensure a safe environment of care, while attempting to not hamper access or effectiveness of treatment.

*Emergency Rooms*

Similarly, while systems-initiated telehealth modalities for emergency room psychiatric assessments, stakeholders shared that use of such technology was at times limited by patient uncooperativeness and limited access to family members or other sources of collateral data. Stakeholders noted a reduction in psychiatric emergency room visits, including for substance use problems. Stakeholders noted that it was not yet clear what happened to individuals experiencing mental health or substance emergencies who would have typically presented to emergency rooms; they may have received care remotely, through urgent care clinics, or not at all. Finally, stakeholders raised the question of whether patients who require psychiatric hospitalization should be routinely tested for COVID-19, given the congregate nature of inpatient units and potential for significant transmission.

*Primary Care and Provider Capacity*

Some stakeholders noted increases in primary care visits for anxiety, voicing the need for rapid deployment of mental health trainings for primary care providers. Additional needs included training in trauma-informed services and supports for providers working with people experiencing homelessness.

*Mental Health Capacity*

As one example of capacity change, Los Angeles County Department of Mental Health noted its rapid capacity development to provide clinicians and administrative staff with the resources necessary to do their jobs remotely. HIPAA-compliant electronic platforms to deliver secure mental health services were identified and a Tele-Work Tool Kit published and updated daily, enhancing the Department's ability to conduct its work remotely. Concurrently, the Quality Assurance unit published a Bulletin on Tele-Mental Health billing that provided claims codes and guidance on documentation. The Department notes its ongoing process of establishing metrics to track such changes in real time, to better understand system response to COVID-19. Other system partners noted similar processes, but with different technologies and specific products, suggesting there is an important opportunity over time for cross-system learning.

*Bed Capacity*

Health care systems expressed concerns about needing to increase availability of inpatient beds for COVID-19 cases. This was a concern in areas that pre-COVID-19 estimated shortages in psychiatric inpatient beds and post-acute rehabilitation facilities, making rapid discharges difficult. Enhancement of rehabilitation beds was noted as one strategy when planning had been initiated pre-pandemic, but likely not sufficient to meet new needs.

*Provider Support*

Administrative and logistical issues included changes in billing, use of new technologies, and reliance on virtual meetings. Stakeholders raised issues of ensuring availability of rapid IT support to assist provid-

ers with transitions. Beyond technological issues, additional challenges for providers included shifting roles, depending on evolving needs, and new challenges, such as how to effectively conduct telehealth visits with difficult-to-reach patients, such as those with serious mental illness. Stakeholders were concerned about impacts on provider well-being.

*Systems Learning*

Systems learning and quality improvement via ongoing evaluation were noted as important in responding to a changing pandemic and to inform future services. Questions raised by stakeholders included: What are best strategies for providing mental health supports as needs change over time? What can be learned about online supports for wellness to reduce need for direct services, or reliance on remote care? What are implications for addressing disparities and for diverse populations? What strategies increase the success of remote services? What are implications for systems, providers, patients, families and communities?

Stakeholders expressed the need for a systems-learning approach for real-time quality improvement, evaluation and research on fundamental questions. At the same time, they acknowledged challenges in "bandwidth" and resources for quality improvement, given the demands posed by the rapidly changing pandemic. This challenge raised questions of how to efficiently expand capacity for quality improvement. Stakeholders raised the idea of "learning collaboratives" in which groups partner across sectors (such as technology, academia, and community) to build capacity. Initially, learning collaboratives may be mobilized remotely, emphasizing secure data sharing, and interfaces needed among systems managers, data infrastructure, and stakeholders knowledgeable of changes and community priorities. The need to include voices from historically marginalized and underrepresented groups was prioritized.

## Discussion

Stakeholders from community, academic, safety-net, policy, and clinical settings in California and Louisiana found that the COVID-19 pandemic led to an enhanced awareness of the relevance of public mental health. Issues like physical distancing, the shift to remote care, and exacerbation of preexisting racial/ethnic disparities were identified as major influences on mental health and resilience. The rapid shift to telehealth was noted as facilitating service delivery in the crisis, with potential for the future, but possibly amplifying some disparities. Stakeholders identified an important role for publicly accessible resources to support mental well-being for individuals, families, communities, and providers, with implications beyond the pandemic. By engaging diverse populations, accessible online resources could contribute to preventive mental health. Further, broadly aligning mental health system and public health disaster capacities may inform adaptation to a pandemic context and future services. Of note, this commentary was written prior to the death of George Floyd and the subsequent movement nationwide; while those events are not discussed here, they have significant implications for mental health both within and beyond the context of COVID-19 and are a crucial topic for further discussions.

Across different geographic areas of the United States and globally, a variety of strategies have been implemented in parallel within different systems, using different tools and datasets. Such strategies include online resources, changes in health care delivery and funding, and policies for social and economic sustainability and recovery. A fundamental question emerging across stakeholders was: What can be learned about the efficacy of strategies and differences in implementation and context to inform public health?

Addressing this set of issues raised by stakeholders will require efforts through policy initiatives, local evaluations, philanthropy, technology/industry support, and research initiatives. By using an integrated approach to identify community-specific priorities in the pandemic context, policy and services solutions at state and local levels could help support an effort to learn how to manage crises. Solutions could include lessons learned for improving services systematically, and for resilience and recovery in mental health/behavioral health, broadly. This should include attending to disparities and enhancing equity for diverse populations and include multiple types and consequences of stressors over time.[16] Achieving this will require a combi-

nation of attending to needs of systems and opportunities for funding – setting aside as feasible concerns about "looking bad" or expected gaps in what has been accomplished -- for broader learning for sustainable public welfare and equity.

## Conclusion

The COVID-19 pandemic created near-universal changes in delivery of services across populations and systems. These challenges provide learning opportunities as new programs are developed, with a focus on remote provision of mental health services. In addition, anticipation of a widespread surge in mental health need secondary to many personal, financial, and psychological stressors resulting from the COVID-19 pandemic, has enhanced interest in the potential for a new, prevention-oriented public mental health strategy. In discussions among stakeholders, a recurrent theme was the importance of monitoring impacts of these changes on high-risk and under-resourced populations, being mindful of the potential to widen disparities. Ongoing work will require a balance of attention to urgent, changing needs, while integrating lessons learned and striving toward collective learning to inform an innovative, robust public health approach to mental well-being.

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Conflict of Interest

ACA is founder of Chorus Innovations, Inc., Open Science Initiative, and Arevian Technologies, Inc.

Author Contributions

Research concept and design: Ewing, Lester, Cheung, Sugarman, Springgate, Sherin, Wells; Acquisition of data: Aguilar-Gaxiola, Cheung, Gabrielian, Sugarman, Bonds; Data analysis and interpretation: Ijadi-Maghsoodi, Sugarman, Innes-Gomberg, Wells; Manuscript draft: Arevian, Jones, Moore, Goodsmith, Aguilar-Gaxiola, Ewing, Siddiq, Lester, Cheung, Ijadi-Maghsoodi, Gabrielian, Sugarman, Bonds, Benitez, Innes-Gomberg, Springgate, Haywood, Meyers, Sherin, Wells; Acquisition of funding: Ewing, Cheung; Administrative: Lester, Ijadi-Maghsoodi, Gabrielian, Sugarman, Bonds, Innes-Gomberg, Sherin, Wells; Supervision: Springgate, Wells

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