Behavioral Health Providers' Experience with Changes in Services for People Experiencing Homelessness During COVID-19, USA, August–October 2020

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Abstract

The COVID-19 pandemic caused disruptions in behavioral health services (BHS), essential for people experiencing homelessness (PEH). BHS changes created barriers to care and opportunities for innovative strategies for reaching PEH. The authors conducted 50 qualitative interviews with behavioral health providers in the USA during August–October 2020 to explore their observations of BHS changes for PEH. Interviews were transcribed and entered into MAXQDA for analysis and to identify salient themes. The largest impact from COVID-19 was the closure or limited hours for BHS and homeless shelters due to mandated "stay-at-home" orders or staff working remotely leading to a disconnection in services and housing linkages. Most providers initiated telehealth services for clients, yielding positive outcomes. Implications for BHS are the need for long-term strategies, such as advances in communication technology to support BHS and homeless services and to ensure the needs of underserved populations are met during public health emergencies.

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Introduction

Behavioral health services (BHS) are integral to the overall health of underserved populations and particularly people experiencing homelessness (PEH).[1] In the USA in 2020, there were 580,466 PEH counted on a single night in January — these individuals or families lacked a fixed, regular, and adequate nighttime residence, and can be sheltered or unsheltered.[2] PEH have higher rates of mortality, chronic health conditions (e.g., asthma, heart disease, and chronic obstructive lung disease), infectious diseases, disabilities, and behavioral health conditions, such as substance use disorders (SUD) and mental illness, than people who are stably housed.[3–6] Additionally, because they often live in congregate settings such as shelters or encampments where they are often unable to physically distance, PEH are at increased risk of acquiring COVID-19.[7] They also have more severe COVID-19 outcomes due to older age, predisposing medical conditions, health disparities due to racial inequities, and barriers to accessing care.[8–17]

BHS provided to PEH are especially crucial during the COVID-19 pandemic as the co-occurrence of COVID-19 and behavioral health conditions, such as depression, anxiety, and SUDs, can reciprocally exacerbate each other.[5,18–20] It is estimated that over half of PEH identify as ever having depression.[3,21] According to Finnigan,[22] approximately one-half of PEH studied reported ever being diagnosed with a work-limiting physical or mental disability (53%) or a severe mental health condition (e.g., major depression, bipolar disorder, schizophrenia) (46%). Furthermore, substance use is higher among PEH than among the general population.[23,24] SUD is among the underlying medical conditions that increase the risk of more severe COVID-19 illness.[25]

The COVID-19 pandemic also has increased reports of behavioral health conditions, including depression, substance use, and suicidal ideation, potentially resulting in increased risk of death from suicide or drug overdose.[26] Furthermore, persons with COVID-19 were more likely to receive a first-time psychiatric diagnosis in the 14 to 90 days after COVID-19 diagnosis compared to people with other health conditions,[20] which may be associated with increased need for long-term psychiatric services. PEH who also have mental illness and SUD may be adversely affected by changes in normal routines, social isolation, lapses in appointments with behavioral health care providers, changes in ability to access medications, and/or substance use withdrawal symptoms. Additionally, people who inject drugs face acute risk of overdose and poor health outcomes, especially during infectious disease outbreaks.[27] Emerging adults, aged 18–25, experiencing homelessness are particularly affected by systems of care that are not designed to meet their needs, resulting in disruptions to BHS and causing increased use of substances and worse mental health conditions during the COVID-19 pandemic.[23,28]

COVID-19 community mitigation measures have impacted the locations, operations, and consistency of behavioral health care provision. Physical distancing requirements have reduced capacity in behavioral health residential mental health and SUD programs so that the waitlists are exceedingly long and have resulted in the suspension of group sessions (e.g., SUD groups). These disruptions impact all BHS, yet less is known about the effect of these changes for PEH. Though disruptions to BHS during the COVID-19 pandemic may have created barriers to the provision and receipt of care, these changes may have also led to adopting innovative strategies for reaching these populations.

The purpose of this qualitative study was to examine behavioral health providers' perceptions and observations of the impact of disruptions to BHS for PEH at the beginning of the COVID-19 pandemic. The extended duration of the pandemic makes the need to understand the impact of changes in BHS for PEH even more critical. Furthermore, exploring BHS providers' understanding of both their clients' behavioral issues and institutional changes in service provision due to the COVID-19 pandemic can help inform effective long-term strategies for caring for underserved populations, especially PEH, during future pandemics.

Methods

From August 20 through October 14, 2020, the authors conducted in-depth qualitative interviews with 50 behavioral health providers who serve PEH across the USA. Behavioral health providers over 18 years of age who provide direct patient care (e.g., physicians, nurse practitioners, physician assistants, nurses, substance use counselors, psychologists, case managers, social workers, or outreach workers) were eligible for interview. Providers were identified and recruited in coordination with the National Healthcare for the Homeless Council (NHCHC), using purposive sampling through partnerships with state and local health departments, behavioral health care providers, and community organizations providing shelter/housing or health services to PEH.

Interviews were conducted by phone using a standardized, semi-structured interview guide developed by the Centers for Disease Control and Prevention (CDC) with input from behavioral health providers in the USA. The interview guide included discussions about changes to BHS provided and challenges and unexpected benefits of these service changes during the COVID-19 pandemic. Because the providers were recruited through the NHCHC, they primarily provided services to PEH; however, the authors asked about unique experiences providing services for PEH with SUDs and serious mental illness (SMI). People who use drugs were defined as using, for example, marijuana (legal or illicit), cocaine, heroin or other opioids (including misuse of prescription opioids), or methamphetamine; people with SMI were defined as people whose illness interferes with their ability to perform basic activities of daily living without medication or additional support. Some providers noted distinctions about services provided to specific client populations.

Providers also completed a brief quantitative survey created in a Research Electronic Data Capture (REDCap) database[29] either prior to or during the phone interview. The survey included questions about provider demographics, including job title, the facility type where they work, client characteristics, and types of BHS offered at their facility.

Interviewers and notetakers included CDC COVID-19 Response Team members and members of CDC's Homelessness and Public Health Working Group, who were provided standardized training on interview guide use. Interviews were voluntary and providers gave verbal consent to participate and have their interviews audio-recorded. Interviews were approximately 60 to 90 min in length. Each provider was assigned a unique code, and no names or personal identifiers were recorded. Providers received a $100 gift card in appreciation for their time.

Data analysis

The interviews were transcribed verbatim using CaptionSync transcription service and entered into MAXQDA 2020 (VERBI Software, 2019; version 20.0.7) for analysis. Codes were developed a priori using the interview guide and overall research questions. As additional themes emerged in the transcripts, codes were modified, and new codes were added to ensure all thematic areas were captured. Coding of the 50 transcripts was completed by three individuals (AAM, AJ, JB) trained in qualitative research. One transcript was selected at random for each of the coders to code independently to ensure understanding and consistent code application. Then, each transcript was coded by two independent coders; differences were reconciled by discussion. Coders met regularly to address additional themes as they emerged in the transcripts, to discuss and modify codes, if needed, and to add new codes to ensure all thematic areas were captured. This activity was reviewed by the CDC and was conducted consistent with applicable federal law and CDC policy.[1]

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[1] See, e.g., 45 C.F.R. part 46, 21 C.F.R. part 56; 42 U.S.C. §241(d); 5 U.S.C. §552a; 44 U.S.C. §3501 et seq.

Results

Behavioral health providers

The 50 participating providers were predominantly female (84%), 45 years old or younger (68%), and non-Hispanic White (74%) (Table 1). They were primarily case managers, social workers, or therapists/counselors practicing throughout the USA. Almost all behavioral health providers provided case management/social services and referrals (92%), outreach and education (86%), mental health counseling (80%), or substance use treatment services (76%).

Changes in services

Providers described unexpected changes in service delivery experienced during the COVID-19 pandemic, many with negative consequences that required adjustment by both the providers and the clients. When stay-at-home orders were implemented, offices closed or limited the number of clients who could be seen in-person. Although some providers continued to see clients on an individual basis while adhering to strict infection control practices, none was able to hold in-person group sessions. If an office remained open, the number of people who could be in waiting rooms at any one time was limited. Not only were the providers' offices closed or operating with limited capacity, but other clinical services, such as mobile medical clinics, drop-in centers, intensive out-patient programs, and in-patient and out-patient mental health or SUD treatment programs were also affected. Some out-patient drug treatment programs continued to provide services, particularly medication for opioid use disorder or syringe services programs, but many limited their hours or services.

Additionally, homeless shelters were either closed or had limited capacity, which decreased case management services and provided "less opportunity to check-in and share information" with clients and other staff. Providers were accustomed to connecting with clients to ensure they were taking their medications and able to access mental health and SUD services. Providers mentioned that they previously assisted with transportation services for clients and having the ability to interact and communicate while driving was no longer possible with physical distancing. Clients often relied upon public transportation to access appointments, and in some locations, public transportation was provided free of charge, which facilitated access to pharmacies to receive medications or to attend medical appointments, if available in-person. However, public transportation was one essential service that many providers described as no longer available in all locations or that clients were no longer comfortable using. In addition, closure of various social services was problematic.

Providers described mixed experiences with providing outreach services. Some providers expanded services outdoors, whereas others curtailed community outreach activities. Reaching people was considered one of the most difficult challenges according to one provider:

> I think the limited ability to do outreach and to visit people where they are, has been one of the biggest challenges. For behavioral health services and then also for medical, the team that I work on, we also do outreach and home visits, and that has also stopped. So, yes, I think our ability to meet people where they are has been the biggest challenge. (Peer specialist)

Telehealth

Telehealth, or telemedicine, became the norm during the pandemic, even though most providers had not previously used telehealth to provide services for reasons that included the following: lack of insurance inclusion/ability to bill for services, preconceived ideas of the effect of phone or video on the counseling experience, and concern about providing their personal phone number to clients because they did not have a work phone. Providers found converting to telehealth was a "big

Table 1

Demographics of behavioral health service providers participating in interviews regarding impacts of COVID-19 on service provision for people experiencing homelessness, USA, August–October 2020

	All providers ($n = 50$) n (%)
Gender	
Female	42 (84%)
Male	8 (16%)
Age	
18–34 years	18 (36%)
35–45 years	16 (32%)
46–59 years	11 (22%)
60 + years	5 (10%)
Race/ethnicity[a]	
White, not Hispanic/Latino	31 (62%)
Black or African American, not Hispanic/Latino	10 (20%)
Hispanic/Latino, White race	6 (12%)
American Indian or Alaska Native, not Hispanic/Latino	4 (8%)
Other race/Missing[b]	3 (6%)
Job Title	
Case Manager	10 (20%)
Social Worker	8 (16%)
Therapist or Counselor	7 (14%)
Nurse or Nurse Practitioner	6 (12%)
Outreach Staff	5 (10%)
General/Unspecified Behavioral Health Provider	5 (10%)
Director, Associate Director, or CEO	2 (4%)
Peer Specialist	3 (6%)
Psychiatrist or Psychologist	1 (2%)
Type of facility or organization[c]	
Community health center	32 (64%)
Street team	17 (34%)
Other[d]	12 (24%)
Out-patient psychiatric service provider	11 (22%)
Emergency care provider	7 (14%)
Homeless shelter	7 (14%)
Intensive outpatient program	3 (6%)
In-patient psychiatric facility	2 (4%)
Types of services provided[c]	
Case management/social service care and referrals	46 (92%)
Outreach and education	43 (86%)
Mental health counseling	40 (80%)
Substance use treatment services	38 (76%)

Table 1
(continued)

	All providers ($n=50$) n (%)
Primary care	37 (74%)
Evaluations and care planning	34 (68%)
Pharmacotherapies/medication renewal	34 (68%)
Medication for opioid use disorder (e.g., methadone, buprenorphine, vivit-rol)	33 (66%)
Rehabilitation or support services (e.g., recovery support groups, AA, NA)	16 (32%)
Other[e]	12 (24%)
Clients served[f]	
People with a behavioral health-related diagnosis	50 (100%)
People experiencing homelessness	49 (98%)
People who use drugs	49 (98%)
People who have experienced or are currently experiencing trauma or violence	48 (96%)
People with serious mental illness that interferes with their ability to perform basic activities of daily living without medication or additional support	44 (88%)

[a]Providers could select multiple races, so *n* may not add up to 50. The denominator is 50 because that is the total number of people who answered this question

[b]Other race/Missing includes providers who reported "Hispanic/Latino, other race" "Other race, not Hispanic/Latino," or data were "Missing"

[c]Some providers and programs have multiple facility types that provide multiple different services as part of larger care networks, so providers could select more than one facility type and service provided

[d]Other facility types included facilities that specifically provide intensive opioid and other substance use treatment services, dental clinics, and harm reduction facilities

[e]Other service types provided included dental, optometry, and podiatry services, specialized care for people living with HIV or AIDS, recreational therapy, and any youth-focused services needed for individuals under age 18 years (pediatrics)

[f]Providers were asked, "What percent of your clients are experiencing homelessness?" "What percent of your clients use drugs?" etc. Providers that listed a percentage greater than 0 were counted as serving that clientele

adjustment," but they quickly shifted to "doing everything over the phone," even if that involved having the client in the office while the provider was working remotely from home:

Yeah, really big changes. I mean most of our behavioral health work is done over the phone now, you know for clients who are able to do that. A lot of the behavioral health providers are teleworking. I mean we all telework different days… So, even if the client doesn't have a phone, like we have a room set up here at the clinic, a clean room that is just like a chair, a desk, and a phone. So, a client without a phone could come to the clinic and be in this room by themselves and could talk to their provider over the phone, who's at home. You know clients who do have phones, we're able to talk to them that way. But I think telehealth has really changed a lot for our clients. It's really changed like a lot of the way that we work. I mean there's some clients in some situations that are just, are never different, [they] just don't

really buy into the 'it's not safe to go outside thing.' So they, you know, will still come to the clinic for their appointments. And we would encourage them to stay home, but you know if they want to come in, and that's what they need, then we would let them. (Case manager, including health and housing)

Challenges of telehealth

Some of the challenges of telehealth centered around the use of technology for both the clients and providers. Clients often had no access to phones, or no remaining minutes left on their pre-paid mobile phone plan, or they lost or sold their phones. This provider explained:

Challenges were some of our clients just don't do phones. They don't know how to use phones, or they don't have phones; or they have the government phone and if they run out of minutes then when it's time for their appointment, they have no minutes. Or they lose their phone, or their phone gets stolen if they're outside, or their phone is broke, those are definitely challenges; or they can't charge their phone. (Social worker)

Clients also often had no available computer to use and the provider and their colleagues "would go out and set up [their] computer for them to [use]."

Providers also found the sudden use of computers and new technology, such as video- or audio-conferencing, challenging. Several mentioned they were counselors or social workers who lacked technological skills. Training for providers, especially on the use of new technology, was essential. One provider described:

So we've not converted over to visual yet, and so, my behavioral health staff like to look at people, and they like to pick up, you know, cues, and clues, and, you know, affect, and how -- you know, so they're learning new, different ways to ask instead of just assume by look. You know, they weren't trained [in] telehealth, which now, I have to tell you -- we train a lot of people in health care, from internal medicine to family medicine residents, to social workers and nurse practitioners. And we're teaching them to use telehealth, because you have to have new tools in your toolbox, so to speak. Your cadence, your voice, how to ask questions, how to be with a person over the phone, and then, like I said, you know, still moving towards being able to do visual. (CEO/Executive director/Leadership)

Providers described additional challenges that included examples such as the following: they often did not want to provide clients with their personal phone number, sometimes cellular service providers blocked phone calls from unknown numbers, and sometimes providers or clients did not want to respond to an unfamiliar phone number. Providers mentioned that they often needed to be creative to receive or to make phone calls, for example, some signed up for a Google Voice number or they forwarded their office phone calls to a private home or mobile number to enable communication. Providers working remotely had challenges of sharing computer access or quality internet (i.e., bandwidth) with family members who also were working or learning from home.

Confidentiality and privacy were among the other concerns expressed by providers. Providers described that clients would use phones in public places, including "walking down the street" or on public transportation or in other locations where privacy was compromised. They also found it difficult to ensure client confidentiality when using a phone in their own home where family members were present. Some facilities did not allow providers to use web conferencing platforms, such as Zoom, to conduct videoconferences with clients because it did not meet their HIPAA firewall standards.

An additional challenge to the remote nature of telehealth visits was that electronic patient medical records were not always available for providers to access. As the ability to bill for telehealth visits became more widespread, providers had to learn to chart telehealth client visits, sometimes using a new or different electronic medical record system. With staff working from home, they often did not have access to electronic medical records, which caused delays in getting records and communicating with clients and other health care professionals.

Another challenge was the effect of telehealth on the provider–client relationship. Providers expressed feeling that it was more difficult to establish rapport using a phone, especially for new clients. They struggled with establishing or regaining trust with their clients using a new means of communication.

> I think for the most part, the majority of my work has switched to telemedicine or tele therapy. And, again, the challenge is just really being able to establish rapport. It's much more difficult on the phone, and to really provide that -- that feeling of safety and relationship over the phone is really impacted. There are times when I work in the shelter where it is even a little bit of a challenge to encourage people. We have to social distance, we have to sit six feet away from each other and we both have to wear our masks, even that has a little bit of an impact on the ability to build a relationship right at the very beginning. So it has made it harder. (General/Unspecified behavioral health provider)

Benefits of telehealth

Despite the challenges with implementation, providers expressed surprise about the benefits of telehealth. They found they were often able to contact clients more easily and extend the length of their conversations. They had fewer missed appointments, less "loss-to-follow-up," ability for clients to connect with them more quickly, and ability to provide more services to more clients in a day. One provider shared that general accessibility was improved for all clients:

> But it also tells us that access for our clients may actually be increased by having those phone services for people who have trouble either due to physical limitations or even like some sort of mental health limitations like agoraphobia or a really severe PTSD or have trouble leaving their homes but still want to access services. That this opens up more opportunities for them to be able to seek care where they are, and for us to meet them where they are even if that's not in person. So, I feel like there's a balance of our need -- the need is greater and our ability to meet that need is in some ways greater as well, even though there's the changes of not having groups and those options to offer. (Therapist/Counselor)

Providers mentioned that more clients were seeking BHS during the COVID-19 pandemic for multiple reasons related to the stress and anxiety of the pandemic or changes in their routine. Some mentioned that the accessibility of services using telehealth led clients to access services more often. Behavioral health providers altered their services to accommodate the changes they were experiencing. As one provider explained,

> …because we have such a high number of people that are being referred to our behavioral health providers, what we're doing now is we're streamlining intakes for everybody, and then assigning patients so that they can, you know, at least have an intake right away and be able to get into our queue a lot faster and I think that's been really beneficial for our patients because it allows them to actually be contacted sooner and then at least know, you know, be able to

have someone engage with them right away versus having to wait four months to be assigned a therapist. (Psychologist)

Providers mentioned that with the change in services they were now able to bill insurance companies or clients for telehealth visits. As one pointed out, "now that we're all set up for it, we can do it through our [computer system]. It's actually great. We can see more people." Although providers mentioned that changes had been made to insurance company policies, they did not specify if they were now able to bill for all telehealth visits, including video and phone.

Impact of service changes on clients

While the use of technology, including phones and computers, was the key component of maintaining BHS during COVID-19, some clients continued to receive on-site services, while others were afraid to come to the office for fear of getting sick. Providers mentioned some of their clients were lost to care because it was difficult to contact them due to a lack of ability to communicate via phone, email, or other technology.

Providers also described the effect of changes in group sessions. For some patients, not having group counseling was detrimental for those who thrived on social support from peers.

However, clients received more individualized attention:

You know, now the doctors can see them in telehealth and maintain that relationship. That's been actually really neat. With Psych Day, we have our behavioral health, like our in-house behavioral health program, going down to one-on-one. So many patients have expressed how much they needed that one-on-one conversation. I think down here, a lot of times it's hard to get any sort of -- you just -- for our homeless patients -- or mentally ill patients is to sit down with a social worker every day, one-on-one, for an hour. It's been huge for them. I was kind of hoping we'd keep it one-on-one…. That's really big. (General/Unspecified behavioral health provider)

Providers also reported challenges delivering care to patients for whom English was not their primary language. Obtaining interpreters in the virtual environment often required a great deal of back and forth between parties and coordination to get the provider, the interpreter, and the patient on the phone at the same time. They often called several offices to get the proper interpreter and then contacted the client who needed to call back at a designated time and number. Appointments and services were often delayed or not provided.

Impact of service changes on staff

As staff pivoted to working remotely, they too needed to be cognizant of the effect of COVID-19 on their own mental health or that of their colleagues. Behavioral health providers described being concerned about the consequences of isolation, anxiety, and fear. They mentioned the effect of teleworking on staff morale:

I think the first thing that comes to my mind is because everything is virtual, all of our work meetings are virtual. We're not in an office together as much anymore. It has definitely affected our morale, I think. And I think that's something in social services that's really important is to feel the sense of being a team and, you know, team morale. And that helps us to give better services to our clients. So, that's definitely been a change. And then, yeah, just working from home so much, I mean, even if the drop-in center wasn't open, if you were working from an office and working at a drop-in center, you would be able to like -- if somebody came to the

door, give them a snack or a cup of coffee, or let them use the bathroom and stuff. And so, just not being able to do that and doing most things from home, I mean, I definitely think the services are just not as good as they were before. (Case manager, including health and housing)

The staff also were worried about acquiring COVID-19 and becoming ill themselves or transmitting infection to their family and the ability to continue providing services for clients. One provider who continued with in-person work explained, "people see us as resources for them, but we're also in this pandemic." This provider went on to say,

We are also impacted by being at work, worried about those that we are responsible and accountable to, worried about the risk that we're taking on, worried about, you know, kind of the realities of if somebody comes in and they're COVID-positive, and somehow they get past the screening in that, am I now COVID-positive, then what happens to me? So I think one of the challenges has been kind of your own kind of self-care and your own kind of fears and triggers about risk in your life and your own safety. (Social worker)

Many providers were caregivers of children or older adults, and they were balancing these commitments with their work as behavioral health providers. Providers who were parents mentioned that their children were engaged in remote learning, which required extensive attention while simultaneously treating clients.

Staff shortages were also a common theme. Furthermore, fewer staff were available due to early retirement or "downsizing," leaving many providers to work longer hours and feeling the pressure and stress of more responsibility. The greatest difficulty was finding psychiatric providers, both physicians and nurse practitioners. However, providers described that expanding services brought advantages, such as providers who were newly eligible to provide care. For example, a provider mentioned that they "were able to bill for associate clinical social workers who are not yet licensed, as long as they're supervised by a licensed provider. And that's huge, too."

Changes in services affected the provider–client relationship. Overall, providers described compassion for their clients and commitment to their profession, but that COVID-19 strained their ability to maintain connections with clients. One provider explained,

That connection has been kind of lost, and it's kind of disappointing, you know, because I'm a human being. I'm into this work for helping people and whatnot, so making such good contact and making such good connection and then not being able to maintain it has created distance. And they don't reach out the way that they did before, so that's based off of COVID and social distancing and everything. (General/Unspecified behavioral health provider)

Overall, providers were encouraged knowing that the positive outcomes outweighed the negative. They expressed dedication and commitment to their clients and an ability to adjust to the changes in services. As one provider described:

I think the resilience is absolutely [an outcome]. So, you know one of the things that we have really enjoyed watching is our clients. They're more independent than maybe we gave them credit for or maybe they gave themselves credit for. You know some people have really struggled with the change, but some people have really sort of found their stride. So, when faced with the inability to do things, right. You know you no longer have the option for me to drive you to Social Security to your appointment and sit there all day. You know they kind of had to find like their own solutions. And it's been actually really fun, and really exciting to see clients sort of you know find new solutions independently. (Case manager, including health and housing)

One provider spoke for other colleagues validating the work of behavioral health providers during the COVID-19 pandemic:

So, well, the first thing I will say is-- like personally, I think clients are so grateful for the services overall…And that being said, at the same time, you know, there are certain emotions, especially from the behavioral health side, that you start to pull out or draw out of clients as you talk to them. The frustration with what's going on in the community and on the political level, and I mean like locally, like where it's going politically. Because a lot of things were happening, you know, as well, from a political stance too. So, that has an impact. So, you know, because of that, I think there were times and talking to the pharmacy, talking to providers, that they felt clients were a little bit ungrateful. Like they just had a sort of entitlement at times when it came to things. And it wasn't that the providers didn't want to provide or, you know, give services. They just felt that clients weren't like willing to listen. And almost like, man, maybe there was a breakdown in listening. I mean, it was so much to take in every day. Like, it was a lot to take in just for myself. So, I'm sure it was a lot for clients to take in. And maybe they were listening at the full capacity they could. And so, I think that was always my encouragement just to -- is just for providers to know that, hey, you know, like you all are doing the best you can. They're doing the best they can, and just kind of be aware of that -- at least just kind of be aware of that part. So, I mean, I think the providers did a great job. (Therapist/Counselor)

Changes that led to community-wide impact

Changes in BHS brought opportunities for improved coordination among service providers. The providers interviewed worked specifically with PEH, and they routinely collaborated with housing service providers, but the COVID-19 pandemic created new opportunities for interaction:

I've always tried to really interact with the shelters and our other community partners in the area, but I do think that we've all really had to collaborate in like a more urgent way. I think we've gotten to know each other better. Our whole homeless community kind of pulled together. I know, yeah, I know -- I've talked and texted, emailed more with people from other totally outside programs than I ever used to. That's been really neat. So, those are kind of some of the positive things. (General/Unspecified behavioral health provider)

Improved collaboration involved agency-wide changes to improve community-level engagement and interaction. The benefit of a more integrated and coordinated system was discussed by this provider:

Zoom meetings and other sorts of online platforms has given us an opportunity to bring together organizations that had not always worked together in the past and increased significantly the number of meetings that I facilitate and are part of. Which I think has trickled down later in COVID times to a little bit of a more coordinated system, which I think will bring some direct client benefit, although I think we're -- you know, that's further downstream. And I do think it'll impact clients, but, I mean, I think that -- I think really is more of an impact for staff, and for organizations with the hopeful outcome of us being able to provide a more coordinated service to the folks that we're all engaging with, and trying to provide service to. (Case manager, including health and housing)

Opportunities for innovation

Facilities that provide BHS were forced to assess their activities and pivot to new and innovative services. Several providers presented examples of the ways their agency tried new approaches to best meet their clients' needs.

Using COVID-19 relief funding, some agencies paid for phones or phone calling cards or rideshare services for clients. Others stood up medical respite care services for clients who were discharged from

the hospital or hotel rooms for clients who lost their housing. Many got creative with mobile clinics or outreach. Some developed programs, such as a women's group via Zoom, that allowed women to connect to one another without needing child care, or online financial classes for clients. Providers explained that these innovations improved clients' mental health. One provider gave an example of her co-worker, a psychiatrist, who devised a creative response to client needs by conducting telehealth calls and telepsychiatry in locations in the community with the assistance of a case manager or outreach worker. This provider also mentioned their community-based outreach team was a "collaboration between the homeless outreach team and our team, street medicine team and the fire department" that increased and expanded services with a nurse practitioner and social worker who provided "medication, consults, assessments and even long acting injectables on the street."

The future of behavioral health services

Providers described long-term solutions based on their experiences and evaluation of what worked and what did not work well during COVID-19. For example,

It [telehealth] improved the show rate, reduced the no-show rate, ended up reaching people that, for various reasons, we couldn't reach, and it pretty much put us through a paradigm shift that we've been evaluating kind of what the heck happened to us, what worked, what didn't work, almost like a critical incident debriefing. And what we're going to keep, and what we're going to move on from. (CEO/Executive director/Leadership)

Some expressed their desire to continue telehealth, or to create a hybrid model involving both in-person services and telehealth in the future. One provider described their process:

One of the unexpected benefits has definitely been that we're able to, one, see more people, so doing more of a hybrid. So, one of the things we've already decided as a program is that once all the-- you know, once we're able to get ahold of the spread of COVID, there's a vaccine, etc., I think we're going to keep some of that. So, we want to try to do a hybrid of in-person and tele-health to be able to provide that service for our patients. So, that's definitely increased the number of patients who are seen is to be able to have phone visits available. So that's something we're going to already keep that's been a huge benefit… and that's for all modalities; even our pharmacists are able to do that now. Our community outreach workers are able to do that now with limited physical interaction. So, I think that's been a big-- that's been a huge benefit that has come out of it. (Psychologist)

Discussion

The authors interviewed front-line behavioral health service providers throughout the USA with lived experience of providing BHS to PEH while coping with changes that were occurring during the COVID-19 pandemic. This study details the most common themes from the interviews, where providers described their perceptions and experiences and challenges while highlighting effective interventions and suggesting areas for improvement. Some of the changes included limited in-person services, ancillary services, and outreach to the community; nevertheless, opportunities, such as telehealth, offered an expansion of services.

In 2020, the Centers for Medicare and Medicaid (CMS) expanded the use of telehealth under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act.[30] The services covered by the CMS waiver included office, hospital, and other visits, including home care. The expansion also covered additional types of providers, such as licensed clinical social workers, nurse practitioners,

and clinical psychologists. Though this measure was temporary, our findings support the benefits of the waiver for both providers and clients if similar approaches were available over the longer term.[31]

Ojha and colleagues[32] reviewed the technological challenges faced by mental health service providers and patients during the COVID-19 pandemic. These authors also described benefits of using telehealth, specifically telepsychiatry (telemedicine interventions for psychiatry), for clients with mental illness.[32] Others[33] provide guidance on the essential features of integrating telehealth into routine clinical care during emergencies. They emphasized the need for proper staff training, mechanisms for reimbursement, and improved acceptance of the technology by providers. The use of telehealth in rural areas is also mentioned by these authors as a challenge for patients and providers who may not have access to internet or technology,[32,33] making expansions to broadband telecommunications especially important. This current study supports the need for flexible funding to purchase phones, phone cards, minutes, or Wi-Fi hotspots to expand telehealth accessibility for clients' BHS. Although the providers in this study represented all regions of the USA, none specifically mentions practicing in a rural area; therefore, the challenges of telehealth where access is limited were not discussed. Use of telehealth for adolescents and young adults also can introduce options and improved access to care, and this population should be included in design of services that meet their specific needs for BHS.[34]

The COVID-19 pandemic provided creative and innovative opportunities for delivery of BHS. The providers interviewed gave examples of street outreach services that were expanded, use of rideshare services to provide transportation, opportunities for post-hospital respite care, and opening hotels for housing PEH. Other examples of innovative programs initiated throughout the USA include one in Los Angeles, CA, Homeless Health Care Los Angeles (HHCLA) that set up "telephone booths" for syringe services and a "coordinated pharmacy" model for dispensing medication for opioid use disorders.[35] Other agencies created response teams using street outreach.[36] In Boston, MA, the Boston Hope Field Hospital created 500 beds specifically for PEH using a mental health disaster response team.[24] Medical students, whose clinical rotations were hampered by the pandemic, provided telehealth to PEH in some areas.[37]

The NHCHC issued a brief providing a framework for continuing access to BHS for PEH.[31] This document outlines strategies to maintain high levels of services for PEH, low levels of missed appointments, and continuity of accessible services through telehealth. The brief includes recommended policy changes, such as retaining: (1) authorization and reimbursement for audio-only telehealth visits; (2) flexibility in originating (i.e., location of the patient) and distant (i.e., location of the provider) sites; (3) waiver of pre-existing patient-provider relationships; (4) keeping the ability to obtain patient verbal consent to care; (5) ensuring payment parity regardless of the visit type; (6) eliminating prior authorizations for insurance companies to pay for telehealth; and (7) facilitating patient access to phones, data, and broadband.[31] These actions could directly impact the behavioral health of PEH and provide long-term solutions for improving services disrupted during the COVID-19 pandemic.

This study is not without limitations. One, the authors interviewed providers and not PEH; therefore, the findings are limited to their perspective. The providers worked with PEH but they could not speak for them; ascertaining the perspective of PEH would provide important information about the effect of COVID-19 on their receipt of BHS. The providers were not demographically diverse, but they are similar to people working in the field of BHS. The interview guide was not designed to capture all the nuances of telehealth specifically to a point of saturation, which is an opportunity for further study. Two, the interview guide did not ascertain information about local jurisdiction changes that occurred because of the COVID-19 pandemic, but regional differences were evident in the resources that were available, staff shortages, and policies related to stay-at-home or other pandemic mitigation strategies. Three, because the authors used purposive sampling, the findings may be subject to selection bias;

however, providers were recruited by a national organization and represented a geographically diverse sample. Nevertheless, this study focused on first-hand experiences of behavioral health providers working in the field with PEH during a pandemic. Their perspective was key to identifying pandemic-related challenges and opportunities in providing BHS for PEH, and people with SUDS and SMI.

Conclusion

The COVID-19 pandemic has caused numerous disruptions to daily life for PEH. Through interviews with behavioral health care providers for PEH and/or those with mental health conditions or SUDs, the authors found that despite the multiple changes in routine and disruptions to services, new opportunities to connect with clients and provide essential services arose. Telehealth, in particular, was a successful avenue for provision of BHS to clients during an ongoing pandemic. Continued advances in communication technology could support the stability of behavioral health and homeless services and ensure that these needs are met among PEH during public health emergencies.

Implications for Behavioral Health

Behavioral health providers have a unique perspective on the needs of their clients who are experiencing homelessness, and those with SUDs and SMI. BHS providers are dedicated to their clients and they demonstrated resilience and flexibility in continuing to provide BHS. Expanding and supporting the behavioral health workforce with adequate and appropriate training to alleviate staff shortages are needed. Providers expressed a willingness to learn new technologies and communication skills that would benefit their clients, especially telehealth services. The shift toward use of telehealth services would be beneficial to behavioral health clients and staff even after in-person services resume. Continuity of services is crucial during public health emergencies, especially for PEH, people with SUDs, and people with SMI, whose lives are disproportionately affected by these emergencies.

Declarations

Conflict of Interest The authors declare no competing interests.

Disclaimer The findings and conclusions in this report are those of the author(s) and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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