

April 23, 2020

Mayor Muriel Bowser
District of Columbia

Chairman Phil Mendelson
Council of the District of Columbia

By Electronic Transmittal

Behavioral Health in the District of Columbia During Covid-19

Madam Mayor and Mr. Chairman,

Thank you for your leadership in the District's response to the onset of covid-19. Years of thoughtful planning, careful stewardship of the District's financial resources, and dedicated work by elected leaders, appointed officials, and civil servants prepared the District to meet the challenges of covid-19 with resiliency and resolve. To maximize the effectiveness of the District's response, behavioral health must be incorporated alongside physical health as the emergency continues.

The District's public health and safety needs are not and will not be adequately met without addressing this emergency's behavioral health dimensions.

Summary of Actions Needed

The District must take action now to address core behavioral health needs in response to covid-19:

- **District officials must communicate clearly with residents about the emotional effects of covid-19 and of the policies in effect to stop its spread.**
 - Use all means of public communication to share information about stress and emotional distress from covid-19 and from social distancing.
 - Actively promote the DBH Access Helpline and 'Warm Line' for those experiencing emotional distress.
 - Share behavioral health information with anyone tested for covid-19.
- **The behavioral healthcare delivery system must be strengthened and marshalled to meet escalated ongoing needs and increasing emotional distress.**
 - Provide immediate financial relief for behavioral health provider organizations.
 - Anticipate and prepare to respond to higher incidence of self-harm, suicide, and overdose, as anxiety, social isolation, and grief rise, including through continuing, safe use of inpatient and residential care.
 - Support behavioral health provider adaptations to covid-19, through reimbursement and policy changes.
 - Address behavioral health issues of the healthcare workforce, including personal loss and vicarious trauma.

- **Residents and providers must have access to the tools and support they need to use telehealth to meet as many of these needs as possible.**
 - Enforce the federal Mental Health Parity and Addiction Equity Act and District of Columbia Behavioral Health Parity Act.
 - Provide necessary technology, cellular service, and broadband internet connection for participation in telehealth services.
- **The front-line workforce that continues to deliver care in person must have the support and equipment to do so as safely as possible.**
 - Improve access to PPE and covid-19 testing for the behavioral healthcare workforce.
 - Increase capacity for offsite locations for the workforce and those who live in behavioral health group homes to undergo quarantine if they become ill with covid-19 or are exposed.
 - Set the foundations for a next generation behavioral health workforce that robustly incorporates non-licensed workforce extenders, including paraprofessionals, peers, navigators, community health workers, and family support organizations.
- **Special attention must be dedicated to meeting needs of aging adults, people with disabilities, children and families, and of adults isolated or quarantined during covid-19.**
 - Help aging adults, especially those aging alone, maintain connections to friends, families, and the broader community through phone and video contact.
 - Ensure that people with disabilities have means to make choices to contribute to covid-19 response, and prepare to support them if their caregivers become ill with covid-19.
 - Provide financial and technical support for children and families to successfully use telehealth for behavioral health intake and ongoing care, and support pediatricians, obstetricians, and other primary care providers to incorporate behavioral health considerations into their contact with families.
 - Provide anyone in isolation or quarantine choices, structured activities, access to information about their own condition, and contact with those outside the isolation or quarantine environment, including maintaining evidence-based critical care practices to mitigate negative brain health consequences for people who are intubated.

As the District responds to these needs, evidence of long-standing racial inequities brought into new light by covid-19 must not be ignored. Resources should be deployed equitably and in response to evident inequities leading to higher incidence of covid-19 illness and death, especially among the District's African American population.

Details Regarding Actions Needed

More comprehensive behavioral health communications are needed. The District has created strong public messages about coronavirus and symptoms of covid-19 and the Mayor's stay at home order. While maintaining a healthy lifestyle has received consistent attention, other public messages about stress and emotional distress from covid-19 and from social distancing either are not highlighted or

appear to be missing.^{1,2} Basic promotion of DBH's Access HelpLine and its current 'Warm Line' functions should be highlighted through media channels, including the Mayor's press briefings, District websites and social media, and TV commercials, as an essential element of the response, and not merely among an extensive list of government operations statuses on coronavirus.dc.gov. Information about behavioral health resources should be given to anyone who is tested for covid-19, as additional behavioral health supports may be particularly needed by individuals who are tested.

The behavioral healthcare delivery system must be strengthened so it can address new challenges being experienced by those developing or already diagnosed with mental illnesses or substance use disorders. Covid-19 and the policies in effect to stop its spread exacerbate severity and increase incidence of behavioral health conditions. Social distancing has been adopted as the primary method for reducing spread of covid-19. Residents who already had histories of trauma, toxic stress, adverse childhood experiences and adverse community environments are now joined by residents facing new social isolation, domestic violence, child abuse, and rising anxiety, depression, and grief facing illness and death from covid-19. Alongside sickness and deaths officially assigned due to covid-19, the District faces a meaningful risk of extraordinarily high rates of self-harm, overdose, and suicide, even compared to a baseline before covid-19 that included opioid overdoses alone causing more deaths than homicides in the District during several recent years.

The District must provide immediate additional financial relief to behavioral health provider organizations, or the District faces a loss of critical behavioral health capacity, even while Medicaid enrollment and behavioral conditions are both on the rise and expected to continue to grow in response to covid-19. Data from the District of Columbia Behavioral Health Association paint a bleak picture for the behavioral health provider network. Thirty-two members of the District of Columbia Behavioral Health Association, organizations that collectively provide behavioral health care for over 35,000 District residents, participated in an early April survey that found that projected revenue losses under current conditions will leave those organizations with over \$11M in losses, and hundreds of thousands of dollars in new expenses, from early April 2020 to June 30, 2020. Twenty-five of those organizations (75.5%) had twelve or fewer weeks of cash on hand, including eight with three to four weeks of cash on hand and six with only one or two weeks of cash on hand.

The fourteen organizations that reported one to four weeks of cash on hand report providing behavioral health services to 8,663 District residents, including 3,320 District residents enrolled in DBH mental health rehabilitation services, 460 of who are currently receiving Assertive Community Treatment (ACT) services, the highest level of behavioral health care provided outside a hospital. All thirty-two organizations were asked: "If another organization that provides services similar to those offered by your organization closes its program(s) within the next 90 days, how many people would your organization be willing to take on, by program(s)? If your organization would be unprepared to take on

¹ See, for example, WHO. *Coping with Stress During the 2019-nCoV Outbreak*. Available April 10, 2020 at https://www.who.int/docs/default-source/coronaviruse/coping-with-stress.pdf?sfvrsn=9845bc3a_2

² WHO also issued a more comprehensive *Mental health and psychosocial considerations during the COVID-19 outbreak*, which includes focused messages for different groups. Available April 10, 2020 at <https://www.who.int/docs/default-source/coronaviruse/mental-health-considerations.pdf>

additional people within the next 90 days, respond zero.” Including the fourteen organizations with four or fewer weeks of cash on hand (!), organizations that responded to the survey indicated they could accept reassignment of no more than 1,238 individuals into mental health rehabilitation services programs over the period from April 2020 to June 30, 2020. Only two organizations believed they could accept reassignment of additional individuals for ACT, with capacity for up to 100, plus the possibility to accept some additional individuals if able to hire the entire staff of the program closing. In 2017, when Green Door closed, 1,700 consumers lost the organization that provided their care, and even with another provider organization taking on Green Door’s lease and much of its staff, the disruption of that closure reverberated through the District’s entire safety net of healthcare and social service providers. While cash on hand is not synonymous with a plan by any provider organization to close any or all of its programs, the District cannot afford – and provider organizations confirm they are unable to replace the loss of capacity – to repeat an experience similar to the closure of Green Door during covid-19, and certainly not a twofold loss for the mental health rehabilitation services provider network or fourfold loss across the overall behavioral health provider network.

Behavioral health provider organizations must also receive additional support for different ways of responding to behavioral health needs during covid-19. Reimbursement must be made available for brief phone contacts and wellness checks, in addition to more formal rehabilitative and psychotherapeutic interventions. Payments must be made available for new expenses, including hazard pay, overtime, and use of temporary staffing firms to address workforce shortages, sickness, and family care during covid-19. Behavioral health provider organizations should also be provided with reimbursement for staff time devoted to addressing increasing unmet basic needs, including shopping for and delivering groceries, medications, and needed household supplies, or other community resources must be mobilized to fill those needs on a rapid delivery basis, since many of the people who need these supplies wait until their needs are urgent before communicating those needs. New support may also be needed to help ‘unfreeze’ the continuum of care, where both reasonable precautions and unreasonable concerns are leading to delayed or foregone care seeking, reluctance to make referrals to inpatient or residential level of behavioral health care, and reluctance by provider organizations to accept referrals to inpatient or residential levels of care without certainty that people who are referred to that level of care do not have covid-19.

Behavioral health needs of the broader healthcare workforce will also need to be addressed. Personal loss and vicarious trauma are both escalated during covid-19. Behavioral health needs should be expected not only from medical and behavioral health clinicians, but also from other staff members that continue to support delivery of healthcare services, including building maintenance workers, janitorial and custodial staff, receptionists and phone operators, and emergency response dispatchers. Those who handle dead bodies, contact tracers who undertake surveillance for covid-19 patient contacts, and others must receive additional behavioral health support.

The District must ensure that telehealth technologies and services are readily available. Work by the DC Department of Health Care Finance has paved the way for rapid changes to delivery of behavioral health services for Medicaid beneficiaries, and the District must look to any means it has available to create similar expectations for commercial and private insurance carriers, including enforcement of non-

quantitative treatment limit provisions of the federal Mental Health Parity and Addiction Equity Act and District of Columbia Behavioral Health Parity Act. People who need hardware and software must also be provided with additional support to access cell phones with talk and data plans, wifi in homes, and internet broadband service capable to deliver tele-video for telehealth services. The District must identify resources to maintain language access for use of telehealth by people who speak first languages other than English. People who are experiencing homelessness must also have safe places made available that they can charge their phones and other devices, to ensure they are able to participate in scheduled telehealth services.

The District must include the behavioral healthcare workforce as it allocates access to publicly procured supplies, equipment, and resources. The financial challenges facing the behavioral health provider network precede a looming crisis in the workforce. Despite lack of adequate PPE, the behavioral healthcare workforce continues to deploy ACT teams to provide in-person care to individuals whose mental illness would dangerously deteriorate without such contact, to deliver care in residential treatment and housing for people with substance use disorders and serious mental illnesses, and to provide injections of medications that stabilize psychiatric and substance use disorders. Without adequate PPE, these members of the District's healthcare workforce will be among those more likely to be infected, more likely to contribute to community spread, and more likely to die. They already are. Colleagues who see this will also be among those more likely to quit, to the further detriment of people who need that care, and they will not reliably return to the behavioral health workforce even after covid-19 is successfully controlled. While DBH now has secured access to the District's drive-through testing site for members of the DBH contracted provider network who are experiencing covid-19 symptoms, any behavioral health organizations that continue to deliver in-person care should have the same access for their front-line staff members. Behavioral health provider organizations also should be included in the District's PPE Supply surveys directly, instead of only organizations that are contracted with DBH, and only through DBH indirectly passing information along. The District should review whether hotels can be more broadly made available to members of the behavioral health workforce or residents of behavioral health group homes if they need to undergo self-quarantine after exposure to someone covid-positive. Given the short-term and long-term need for increasing the District's behavioral health workforce, now is the time to set the foundations for a next generation behavioral health workforce that robustly incorporates non-licensed workforce extenders, including paraprofessionals, peers, navigators, and community health workers. Peer operated centers, family run organizations, and other natural and informal supports must be recognized for the vital contributions they already make to the lives of District residents with behavioral conditions and turned to as the necessary complement they already are to the behavioral health treatment workforce.

The District must support development of appropriately protective environments for its most vulnerable residents.³ Specific interventions and supports must be made available to address the needs

³ Having addressed general communications and interventions to support the workforce, we follow the United Nations Inter-Agency Standing Committee's IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings, *Interim Briefing Note ADDRESSING MENTAL HEALTH AND PSYCHOSOCIAL ASPECTS OF COVID-19 OUTBREAK Version 1.5*. February 2020. Available online April 13, 2020:

of older adults coping with stress during covid-19, of people with disabilities, of children and families, and of those in isolation or quarantine.

Aging adults, particularly those aging alone, need support to address stress from covid-19. The District should develop resources to ensure that older adults can access the communication technologies that can help keep them connected to families, friends, and other natural and informal supports. Without these connections, loneliness and depression will be more likely to set in, and others may not notice signs of degrading well-being that could merit more focused attention. Older adults with cognitive impairments due to their mental illness or substance use disorders may need additional support understanding the risk covid-19 has for them and more assistance than usual accessing basic resources for daily living.

People with disabilities need support to continue to access necessary care during covid-19. The District deserves credit for ensuring the Mayor's press conferences have real-time sign interpretation for people who are Deaf or hard of hearing. People who are deaf, especially those with behavioral conditions, will also need specialized support during covid-19, particularly if they have to interact with people using PPE: masks remove lip reading, and gloves can make signs hard to understand, even when appropriate sign language is used. Children and adults with all kinds of disabilities who rely on caretakers will need care planning and additional support, which may include alternative living arrangements, if their caretakers become ill with covid-19, particularly if caregivers must be hospitalized or quarantined for a prolonged period. People with disabilities also cannot be deprived of their own ability to make informed decisions about their care, to be expected to participate in covid-19 response, and to make contributions to the community as they are able, including if they become ill with covid-19.

Children and their families need special support responding to behavioral conditions during covid-19. The shift to telehealth has not been smooth for children enrolled in behavioral health services, intake for those developing need for services has been interrupted, and crisis services have been disrupted. These specific behavioral health access challenges amplify the distress resulting from lost jobs, disrupted school, contact with people ill with covid-19 – including illnesses within their families, and increased housing and food insecurity. Children and families who become homeless will need special support, as will children whose parents are unable to care for them due to covid-19 illness or death. Pediatricians should receive additional messages about how to address through telehealth milder behavioral conditions likely to arise as some children struggle to cope with covid-19, and obstetricians should be provided with support to address additional anxiety that may arise for pregnant women or new mothers as they consider becoming parents during covid-19. The District should be prepared to consider supplementing its work to provide technology to support telehealth, as families may need multiple devices to keep up with remote work, appointments, school, and helpful social contacts. Addressing behavioral health needs for children, especially those trying to continue to participate in school, must continue to include activities to strengthen social and emotional wellness, promote effective coping

with difficult circumstances, and prevent destabilization. The District must also take special action to ensure that children and families have access to behavioral health services if they are removed or flee from their homes due to child abuse or interpersonal violence in the home, given anecdotal reports of increased incidence of child abuse and domestic violence and given the particularly disruptive and insecure feelings likely to arise in a relocation during covid-19.

People in isolation or quarantine due to covid-19 need support addressing the distinct emotional toll of undergoing the experience. Solitary isolation may be necessary for some medical care during covid-19, including at higher levels of acute hospitalization as well as quarantine during convalescence. People should not only be provided with appropriate medical care, but also with appropriate behavioral health care to combat social isolation and loneliness. For those who are intubated, critical care medicine best practices should be continued to the greatest degree possible, to help prevent cognitive impairment and to reduce or alleviate feelings of helplessness caused by loss of communication abilities and reaction to strong sedative medications. To the extent possible, anyone in isolation or quarantine should be provided with choices, structured activities, access to information about their own condition, and contact with those outside the isolation or quarantine environment.

Ensuring the availability of high-quality, whole-person care for District residents with mental illness or substance use disorders, and those at new risk of developing such conditions during covid-19, must be considered foundational to the District's short-term and long-term ability to respond to and to emerge from covid-19 with the resiliency and resolve that has characterized its early response. The District's tasks must include elevating behavioral health public communications, strengthening the behavioral health provider network, improving access to telehealth technologies, including the behavioral health workforce in the District's resource allocation, and addressing the behavioral health needs of especially vulnerable District residents. We⁴ eagerly await adoption of these recommendations.

Sincerely,

Organizations

District of Columbia Behavioral Health Association

Children's Law Center

Early Childhood Innovation Network

Health Alliance Network

Parent Watch, Inc.

⁴ Development of this letter incorporates thinking and information from the District of Columbia Behavioral Health Association and its members, Children's Law Center, Children's National Hospital, the Early Childhood Innovation Network, the Health Alliance Network, Parent Watch, and the Total Family Care Coalition. Additional recommendations were developed with contributions from the Consumer Action Network, DC Fiscal Policy Institute, the Depression and Bipolar Support Alliance, Disability Rights DC – University Legal Services, Education Reform Now DC, Georgetown Law Juvenile Justice Initiative, NAMI DC, and PAVE.

Total Family Care Coalition

Consumer Action Network

DC Fiscal Policy Institute

Depression and Bipolar Support Alliance National Capital Area Chapter

Disability Rights DC at University Legal Services

Education Reform Now DC

PAVE

Advisory Neighborhood Commission 7F

Advocates for Justice and Education

Black Swan Academy

Bread for the City

Bridging Resources in Communities, Inc.

Community of Hope

DC Action for Children

DC Alliance of Youth Advocates

DC Coalition on Long Term Care

DC Chapter of the American Academy of Pediatrics

England Family Foundation

Enyia Strategies, LLC

Equity Matters

Focused Vision Consulting

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