Public health recommendations for community behavioral health services

Risk benefit assessment of in-person mental health, problem gambling, and substance use disorder care

Introduction

Until the COVID-19 pandemic, in-person visits were the predominant method of health care delivery for behavioral health services. Since COVID-19 is thought to spread between people who are in close contact with one another, face-to-face behavioral health services put both the patient and the provider at risk for exposure. This risk can be mitigated by wearing face coverings or masks, eye protection, maintaining physical distance whenever possible, and optimizing ventilation. After routinely practicing in these high-risk environments, mental health, problem gambling, and substance use disorder providers have made dramatic and rapid shifts in how they deliver services by transitioning from in-person care to using technology such as phones or computers to conduct healthcare appointments, a practice commonly referred to as telehealth.

Advantages of telehealth

Telehealth can be an effective option for many clients and providers when technological equity is achieved[1,2,3,4,5,6]. Some families may have circumstances that make an in-person trip to an appointment challenging. For example, a family with a child who has ADHD or autism and may have difficulties with the transition from home to the office can attend a telehealth appointment without as many large transitions[7]. Telehealth also appears to be effective and sometimes preferred for many aspects of substance use disorder (SUD) treatment including group-based therapies[8,9,10].

Using telehealth also eliminates the need to wear a face covering, face shield, or mask. While covering your face remains an important way to help decrease the spread of COVID-19, doing so may also decrease people's ability to communicate effectively. This effect can be especially acute for those with cultural differences, those with a history of adverse childhood experiences (ACEs), and those who otherwise have been impacted by health and social inequities. In cases like these, telehealth visits may be more effective than in-person visits with masks, or face coverings.

During this pandemic, telehealth is recommended for most community behavioral health delivery.

In-person visits

The benefits of having face-to-face care include the use of interpersonal signals for effective communication and the ability to create meaningful connection. Providers' effectiveness depends on their capacity to convey caring and safety, and to support the process of provider and client co-regulation of emotion.

Some people may be particularly sensitive to the nuances of interpersonal communication, including but not limited to those with learning and sensory differences (e.g., learning or language disabilities, autism, hearing or visual impairments), histories of traumatic life experiences, and histories of adverse childhood experiences (ACEs).

Telehealth may not be effective for some individuals experiencing a mental health emergency, including people in crisis, some individuals experiencing the acute impact of substance use disorders, and/or clients exhibiting psychotic disorders. In these circumstances, both people in crisis and the behavioral health providers who seek to help them may find that in-person care offers significant and irreplaceable advantages over the use of telehealth.

There are barriers to telehealth related to access to technology and cultural differences that create further health disparities for underserved populations. In person outreach and engagement are necessary practices for many of our most vulnerable individuals and communities.

This pandemic is likely to last months-to-years with varying severity. While telehealth is the recommended approach during this pandemic, this guidance offers a set of considerations to use when weighing the importance of person-centered clinical care and the risk of infection to themselves and others. **This content is not a mandate. It is intended to be a tool to help with decision-making.**

Client risk stratification assessment

Clinical Presentation	In-person needed	In-person strongly considered	In-person beneficial	Telehealth preferred (in-person optional)
High risk of acute adverse outcome ▪ Acute suicidal crises ▪ Psychosis ▪ Acute intoxication ▪ Delirium ▪ Drug withdrawal ▪ Aggression towards others ▪ Moderate-severe eating disorders	☑			
Moderate risk of acute adverse outcome ▪ Recent (within one month) crises with recent suicidal ideation ▪ Recent discharge from inpatient/residential psychiatric care or substance use disorder program ▪ Chronic suicidal ideation ▪ Non-acute mental health with significant behavioral challenges in developmental delay where behavioral or non-verbal intervention is most effective ▪ Need for intensive in-home services including therapeutic and peer support or community health worker support ▪ Domestic violence where privacy / safety is not possible at home ▪ Moderate or severe active substance misuse		☑		**For some clients**

Clinical Presentation	In-person needed	In-person strongly considered	In-person beneficial	Telehealth preferred (in-person optional)
Low risk of acute adverse outcome; potential risk of poor long-term outcome ▪ Children under 8 who benefit from individual or parent-child therapies including child parent psychotherapy (CPP), parent child interactive therapy (PCIT) and parent management therapy (PMT) etc. ▪ Evidence-based strategies that rely on in-person care to be effective (e.g., trauma focused CBT and EMDR) ▪ Support groups and SUD treatment)				**For some clients**
Low Risk of acute adverse outcome; likely to benefit from either in-person or telehealth services: ▪ Treatment and monitoring of common psychiatric conditions in which a person is able to provide self-care (e.g., generalized anxiety, depression without significant suicidality, ADHD, OCD or stable SUD recovery)		**Factor patient preference when pandemic risk is diminished (as defined by the Local Public Health Authority)**		

Mitigating risk of infection

Risk of infection depends on the following factors: space, ventilation (no HVAC or windows is “poor”, HVAC is “standard” and outside air access is “well ventilated”), surface cleaning, sunlight, use of personal protective equipment, hand hygiene, duration of exposure, rates of community spread and individual health status.

This table describes decreasing levels of risk without consideration of rates of infection in the community or individual health factors.

Unacceptable risk without face mask and eye protection (face shield or goggles)
Indoors, less than six (6) feet apart
Higher risk for sessions over 15 minutes
• Indoors, 35 square feet per person, poorly-ventilated space*, six (6) feet apart, face coverings for client and face mask and eye protection for provider • Outdoors, less than six (6) feet apart, face mask or face covering for client and face mask and eye protection for provider
When in-person visits are “needed” or “strongly considered” (more time equals more risk)
• Indoors, 35 square feet per person, **poorly-ventilated** space*, six (6) feet apart, face covering or face mask for client and face mask and eye protection for provider for **less than** 15 minutes. • Indoors, more than 35 square feet per person, **well-ventilated** space*, six (6) feet apart, face covering or face mask for client and face mask and eye protection for provider for **any length of time**. • Indoors, large well-ventilated space (e.g., conference room, auditorium, basketball court), **more than** six (6) feet apart, face coverings or face mask for client, face covering or face mask for provider • Outdoors, six (6) feet distance, no face mask or face coverings for client, no face mask or face covering for provider • Outdoors, six (6) feet distance, face covering or face mask for client, face mask or face covering for provider

* An example of a poorly ventilated space is an 8x10 square foot office with no windows that open and no proper HVAC system or other adequate air flow mechanism. An example of a well-ventilated space is an office with windows that open and/or a well-maintained and operating HVAC system.

RELATED DEFINITIONS AND RESOURCES:

- **Face covering:** refers to a cloth, paper, or disposable face covering that covers the nose and mouth. It would also include a medical-grade face mask.
- **Face mask:** refers to a medical-grade face mask (either procedure mask with ear loops or surgical mask).
- **Eye protection:** refers to either goggles or face shield.

Face shield: refers to a clear plastic shield that covers the forehead, extends below the chin, and wraps around the sides of the face. *A face shield alone **without** a face mask is not recommended, as it may be less likely to protect from exhaling or inhaling infectious droplets or aerosols. Wearing eye protection in addition to a face mask ensures the eyes, nose, and mouth are all protected from exposure to respiratory secretions during face-to-face* care.

- *FDA has not approved any hand sanitizers that are not alcohol based. Some chemicals such as benzalkonium chloride are eligible as active ingredients for manufacturing non-alcohol based sanitizers. However, the efficacy of such market products has not been validated by FDA or other regulatory agencies. We recommend soap and water for hand cleaning when possible. Some products such as this (http://www.kutol.com/non-alcohol-hand-sanitizer/) claim to eliminate 99.99% of common germs. You might consider their use, and while benzalkonium chloride is used for disinfection purposes, including against coronaviruses, OHA does not have enough information to endorse similar products as hand sanitizers.*

RESOURCES:

- **How to make a face covering**: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-to-make-cloth-face-covering.html
- **How to wear a face covering**: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-to-wear-cloth-face-coverings.html
- **Do's and Don't's of wearing face coverings and masks**. https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/fs-facemask-dos-donts.pdf

Suggested additional practices to lower risk for face-to-face meetings

- Use trauma-informed communication at all practice levels as you adapt.
- Make sure that the client knows what to expect
  - Will the appointment be office-based or community outreach?

    - Describe the plan including
        - What the provider and others will be wearing and doing
        - Changes to the physical environment (plexiglass, markings on the floor indicating six feet, removal of public water cooler, etc.)
        - What they might do or wear to decrease risk of exposure
    - Ask for and listen to their recommendations and concerns
- Begin every encounter by acknowledging the realities of communication in the age of face coverings. Acknowledgement can lower emotional response to adversity by helping the patient feel prepared.

Here are some sample scenarios in order of *increasing* risk. In all of these scenarios, the client has had COVID-19 screening questions completed prior to making the trip to an office or prior to the provider meeting the client in the community, and other practices are in place. (See check list below):

- Meet outdoors, maintain physical distancing of more than six feet, while apart remove mask for brief greeting and then client and provider place face covering / face mask on. Consider privacy challenges in open air settings.
- With both provider and client wearing face mask / face covering, invite the client(s) into one room and the provider in another room where the technology is set up and ready to go. Both parties may then remove their face mask /face coverings and then replace when the visit is complete.
- With both provider and client wearing face coverings or face masks, invite the client(s) into one side of a mirrored room and provider on the other side. Conduct session via audio through the mirror without face-to-face engagement.
- Meet outdoors, briefly, without face coverings or face masks but while maintaining physical distancing of more than six feet, for the purpose of greeting each other, then put on face coverings and move to a large indoor space that is well-ventilated, remaining more than 6 feet apart and keeping face coverings or face masks in place (set up seats ahead of time and use this plan for a group treatment such as DBT or high-risk SUD).

- Meet in a is well-ventilated room with 35 sq ft per person, face covering for client and face mask and eye protection for provider, briefly closer than six feet and total time together less than 15 minutes. This approach could be used for vital sign checks, Abnormal Involuntary Movement Scale (AIMS) evaluations, providing injections for long-acting antipsychotics, arranging urine screens for clients in monitoring programs (reserved for clients for whom this practice is deemed effective and necessary in spite of the risk of travel and attendance for collection).

For further information on clinical care and infectious disease guidance see the OHA COVID-19 webpage.

Additional check list for decision making and preparation

- **Communication**
  - Plan for how you will communicate your decision making with clients who:
    - May not have a good understanding of infectious disease but express their preference for in-person visits.
    - Communicate in a language other than English
    - Have a disability that impacts their communication
- **Health status of client and provider**

  Factors that place individuals at increased risk of severe illness from COVID-19 include the following:

  - Age (i.e. people over 60 years of age)
  - People of any age with the following conditions:
    - Cancer
    - Chronic kidney disease
    - COPD (chronic obstructive pulmonary disease)
    - Immunocompromised state (weakened immune system) from solid organ transplant
    - Obesity (body mass index [BMI] of 30 or higher)

    - » Serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
    - » Sickle cell disease
    - » Type 2 diabetes mellitus
- Children who are:
    - » Medically complex
    - » Who have neurologic, genetic, metabolic conditions
    - » Who have congenital heart disease

COVID-19 is a new disease. Currently there are limited data and information about the impact of underlying medical conditions and whether they increase the risk for severe illness from COVID-19.

Based on what we know at this time, people with the following conditions **might be at an increased risk** for severe illness from COVID-19:

- Asthma (moderate-to-severe)
- Cerebrovascular disease (affects blood vessels and blood supply to the brain)
- Cystic fibrosis
- Hypertension or high blood pressure
- Immunocompromised state (weakened immune system) from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or use of other immune weakening medicines
- Neurologic conditions, such as dementia
- Liver disease
- Pregnancy
- Pulmonary fibrosis (having damaged or scarred lung tissues)
- Smoking

- Thalassemia
- Type 1 diabetes mellitus

- **Screening**

  Plan for how clients will be screened (and providers will self-screen) before arrival or be screened by a designated employee.

  - For information about screening in the community visit the CDC website.
  - Screening prior to office visits: People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear **2-14 days after exposure to the virus.** Ask the client if they have had a known exposure to someone with COVID, symptoms of COVID or have themselves had the following symptoms in the last 14 days:
    - Fever or chills
    - Cough
    - Shortness of breath or difficulty breathing
    - Fatigue
    - Muscle or body aches
    - Headache
    - New loss of taste or smell
    - Sore throat
    - Congestion or runny nose
    - Nausea or vomiting
    - Diarrhea

  This list does not include all possible symptoms. CDC will continue to update this list as we learn more about COVID-19.

- **Health Equity**

  Incorporate culturally and linguistically appropriate practices and health equity considerations and concerns in all aspects of decision-making and care delivery:

  - Particularly for underserved minority populations
  - Especially in instances where the client is a member of a community that has been most impacted by health disparities, social inequities, and systemic discrimination
  - Including how to support effective peer support and community health worker (CHW) participation while protecting the CHW's safety by providing PPE and training

- **Scheduling and Patient Flow**
  - Safe waiting room experiences may include limiting client-to-client and client-staff interaction, cleanable seating, and altered traffic flow. Waiting room time should be eliminated if possible.
  - Escort patients to the space rather than use a waiting room and receptionist.
  - If possible, create a one-way route using signs into the building and out after visits to decrease contact.
  - Consider how long it will take to disinfect frequently touched surfaces between clients.
  - Ventilate room with outside air for a few minutes or wait at least two hours before another client enters a small (exam/office) room prior to cleaning and entering.
  - Consider using text messaging, phone calling or other communication as appropriate for the client's communication ability, such as a sign in the window of the clinic for communication upon arrival.

- **Telehealth Technology**
  - Effectiveness of telehealth in your organization (technology and provider training) is the foundation for successful experiences for your clients. The biggest barrier may be the provider's own comfort with technology.
  - Your client's access to technology (bandwidth, equipment and knowledge) are also key to effective care and equity.

- Develop rooms for tele-health in your agency (quick start technology, easy clean surfaces and ventilation) for drop-in clients and those unable to access technology in their homes.
- Plan for walk-in clients and those who do not have technology access:
  - » Offer a face covering, complete screening questions with protection behind a glass partition. Remember patients must be symptom-free for 72 hours prior to encounter. Any patients with COVID-19 need to observe isolation per the recommendations of the local public health authority.
  - » If negative screen, invite into a room prepared for telehealth visit while provider starts visit in another room or use a larger space indoors or outdoors for an initial intake
  - » Disinfect room after completion of visit

- **Cleaning and disinfecting**

  General Guidance for cleaning during COVID can be found here and here.

  Guidance for cleaning after a COVID-19 infected person has been in an indoor space can be found here. https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html

Summary: While we cope with the unprecedented circumstances that adversely impact care for clients, and create significant stress for providers, decision-making should be led by an overall risk-benefit approach. Strive to implement effective services in all aspects of behavioral health care while balancing the realities that we must do things differently to stay safe and stop the spread of COVID-19. Telehealth can be the primary method of care delivery for most health services during this pandemic. It is an effective approach for most situations when technological barriers are overcome and cultural, linguistic and individual realities are considered. When in-person visits or community outreach are necessary, there are practical ways to improve interpersonal experience and reduce risk to everyone involved by understanding how COVID-19 spreads and taking appropriate risk mitigation strategies.

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