Impact of COVID-19 Mitigation Efforts on Adults With Serious Mental Illness

A Patient-Centered Perspective

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Abstract: In response to COVID-19 mitigation policies, mental health and social service agencies have had to rapidly change their operations, creating challenges for patients with serious mental illness (SMI). This study aimed to explore the experiences of adults with SMI navigating these altered systems during the pandemic. In-depth interviews were conducted with 20 hospitalized adults with SMI in the fall of 2020; they were coded using thematic analysis. Most participants found the new systems effective at meeting their essential needs. However, several reported significant unmet needs, including inability to access mental health care and public benefits. These participants lacked identification documents, housing, and/or a personal device. Although none of the participants used telemedicine before COVID-19, most reported no or minimal problems with telemental health. Those reporting difficulties did not have personal devices, were receiving audio-only services, or viewed telemedicine as less personal or too distracting.

Key Words: COVID-19, care coordination, telemedicine, homelessness, serious mental illness

(*J Nerv Ment Dis* 2021;209: 892–898)

Individuals with serious mental illness (SMI) often require a broad network of health and social services to live independently in the community (Mechanic and Bilder, 2004). Before the COVID-19 pandemic, mental health and social service agencies that support this population relied heavily on in-person contacts (Bromley et al., 2013; Talley et al., 2021). COVID-19 fundamentally altered the operations of these services overnight, creating unprecedented challenges for patients with SMI and their care teams. The impact of these service delivery changes on individuals with SMI is unknown. To improve service provision during the remainder of the COVID-19 pandemic and potential future pandemics, we must understand how these systems have adapted to comply with physical distancing policies and how well these redesigned systems are meeting the needs of individuals with SMI.

Physical distancing policies have had significant impacts on our society, and this may be especially true for individuals with SMI. Many services on which individuals with SMI rely, including soup kitchens and clothing donation services, were either unable to operate or limited their operations during the pandemic (Willis, 2020). Libraries, which often act as unofficial day shelters and provide internet access for persons with SMI experiencing homelessness, have also been closed (Ashworth, 2020). Many supportive employment and group day programs have been canceled or have converted to a web-based format (SAMHSA, 2020). Government agencies that administer entitlement programs have stopped or limited in-person operations (Social Security Administration, 2020).

Access, quality, and satisfaction with outpatient mental health services may have all been impacted by COVID-19 mitigation efforts. Of all health services, outpatient mental health care has seen the greatest shift to telemedicine during the pandemic (Verma, 2020; Yellowlees et al., 2020). Although this transition to telemental health has resulted in numerous benefits, including flexible scheduling and increased convenience, nearly 40% of individuals with mental illness reported being concerned about losing access to mental health services during the pandemic (Avalone et al., 2021; Costa et al., 2020; Steidtmann et al., 2021). Individuals with SMI have lower rates of personal device ownership and internet access than the general population, which may impede their ability to access care (Augenstein, 2020; Interian et al., 2018; Young et al., 2020). In addition, although telemental health has been found to be successful at improving clinical outcomes, it is not clear whether it is as effective as in-person care for individuals with SMI (Talley et al., 2021).

Individuals with SMI are not well represented in general population surveys, and they are at especially high risk for negative impacts from the COVID-19 mitigation strategies, so there is a great need to conduct focused qualitative research with this population (Slade et al., 2015; Vindrola-Padros et al., 2020). The patient population is heterogeneous: patients vary in socioeconomics, disease characteristics, family support, and connectedness with health care providers. Hence, this study aims to begin answering the following questions: a) What are the attitudes of individuals with SMI toward COVID-19–related distancing measures? b) What are their experiences obtaining outpatient mental health care during the pandemic? c) What are their experiences navigating the health and social service systems? To our knowledge, this is the first study to use a patient-centered approach to explore how the COVID-19 pandemic has impacted access to and quality of mental health and social services for persons with SMI.

METHODS

Participants

After obtaining approval from the University of Maryland and George Washington University Institutional Review Boards, we recruited 20 adult patients hospitalized on a voluntary inpatient psychiatric unit in Washington, DC, during the COVID-19 pandemic between September and November 2020. The patients on the unit are predominantly African-American, have Medicaid, and receive outpatient care through the public mental health system. The Washington, DC, region has had some of the strictest COVID-19 restrictions in the country: many nonessential businesses have been required to telework, and public libraries ceased indoor operations for extended periods (McCann, 2020). Because of the urgent need for preliminary data, we enrolled patients from an inpatient psychiatric unit as part of a purposive sampling strategy (Palinkas et al., 2015; Vindrola-Padros et al., 2020). Individuals

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ISSN: 0022-3018/21/20912–0892
DOI: 10.1097/NMD.0000000000001389

hospitalized on inpatient psychiatric units typically have higher levels of unmet needs than those who do not require hospitalization (Ådnanes et al., 2020).

There have been few qualitative studies performed by conducting in-depth interviews on inpatient psychiatric units (Awenat et al., 2018); however, previous studies have found that patients hospitalized for acute psychiatric conditions are able to provide informed consent for research (Hickman et al., 2011). Patients were excluded if they lacked the capacity to consent for research or if their inpatient psychiatrist was concerned that a 1-hour interview on the subject matter would put them at risk for psychiatric deterioration. Given the vulnerability of the patient population, eligible participants were notified by the interviewer that enrollment in the study would not yield any preferential treatment or clinical advantages. Before providing written consent, patients were required to successfully complete a consent quiz to ensure that they understood the study procedures and potential risks and benefits. All participants were offered the option of having their interview transcript and study manuscript sent to them.

Data Collection

Minimally structured interviews were conducted in-person by a member of the research team (I. B.) who does not provide patient care on the psychiatric unit. Interviews ranged from 20 to 80 minutes. Participants were asked to describe their experiences living and obtaining health and social services during the COVID-19 pandemic. Because of the novel nature of the subject matter, the interview guide was crafted broadly to give participants the opportunity to decide what they were interested in discussing. The interviewer used prompts to help participants describe the pandemic's impact on their day-to-day activities, housing, access to food, employment, finances, transportation, childcare, mental health services, physical health services, and substance use services.

The interviews were conducted in-person on the inpatient psychiatric unit when there was a trough in new COVID-19 infections in the region. All patients on the psychiatric unit had a negative COVID-19 test before admission. During the interview, the interviewer and the interviewee both wore surgical masks and sat 6 ft apart. The interviewer also wore a face shield after a change in hospital policy.

All interviews were audio-recorded. All audio recordings were transcribed using Temi, an automated audio-to-text transcription program (Temi, 2020). The interviewer checked the transcripts for accuracy against the audio recordings before data analysis.

Data Analysis and Reporting

To develop the initial codebook, three members of the research team (I. B., N. D., and A. A.) reviewed five transcripts independently and then met to develop an initial coding structure using a thematic analysis approach (Braun and Clarke, 2006). This approach aims to bring meaning to qualitative data through the identification of summary themes and categories, and to emphasize the description of important themes over theory building (Thomas, 2006). After the initial codebook was developed, the three coders independently coded the remaining transcripts and met periodically via video conferencing to discuss newly coded transcripts. During each meeting, team members noted any new developments related to the themes and subthemes (Nowell et al., 2017). Inductive coding procedures were used to identify new themes (Fereday and Muir-Cochrane, 2006). Transcripts were reexamined iteratively in light of new and emerging themes, and differences were reconciled by consensus. Qualitative coding was tracked in Microsoft Excel.

We report the data using qualitative descriptors and numbers to illustrate the frequency of responses. As this study aims to provide an early understanding of the availability and quality of mental health and social services, we believe that numbers provide a helpful way to understand the diversity of experiences and opinions across this group and to highlight potential patterns (Maxwell, 2010). However, even if an experience has only been reported by a small number of participants, it does not mean that it is not important. Alternatively, if an experience is commonly reported by the study participants, it does not infer that similar frequencies would be seen in any group of individuals outside the participants of this study (Pyett, 2003).

RESULTS

Participant Demographics

The participants in the study ranged from 21 to 71 years of age (Table 1). The majority (75%) of participants self-identified as non-Hispanic Black. Fifty-five percent reported being disabled or retired, and 35% reported being unemployed. Seven participants reported experiencing homelessness; all experienced homelessness before the pandemic. Five participants reported not having a personal device.

The majority (13) of participants had at least one established outpatient mental health provider before hospitalization, typically through community mental health clinics. The remaining seven reported not being connected with a care team. Four reported a recent lapse in mental health care due to a lack of provider availability, lack of insurance, lack of identification, moving from another region in the country, and/or dropping out of treatment. The remaining three reported not receiving or not seeking recent outpatient mental health treatment.

Attitudes Toward Social Distancing Policies

The participants had three main reactions to physical distancing policies: no impact or improvement, sadness, and frustration, with some noting a combination of sadness and frustration.

TABLE 1. Characteristics of Study Participants

Characteristic	Categories	*n* (%)
Age	20–29	4 (20)
	30–39	3 (15)
	40–49	3 (15)
	50–59	5 (25)
	60–69	4 (20)
	70 and over	1 (5)
Sex	Male	11 (55)
	Female	9 (45)
Race	N.H. White	5 (25)
	N.H. Black	15 (75)
Housing	Homeless	7 (35)
Employment	Employed	2 (10)
	Unemployment unrelated to COVID-19 pandemic	4 (20)
	Unemployment related to COVID-19 pandemic	3 (15)
	Disabled/retired	11 (55)
Outpatient mental health providers	Has at least one active provider	13 (65)
	Recent lapse in treatment	4 (20)
	Has not received recent mental health treatment	3 (15)
Mental health diagnostic category	Mood disorder or trauma disorder	10 (50)
	Psychotic disorder	10 (50)
Substance use	Self-reported substance use disorder	4 (20)
COVID-19 concerns	Previously diagnosed with COVID-19	2 (10)
Personal device	Does not having a functioning personal device	5 (25)

N.H. indicates non-Hispanic.

Five participants described pandemic-related distancing policies as not affecting their lives in any way or potentially improving their lives. Those unaffected by physical distancing policies either already spent most of their time at home or were able to continue their regular activities with the addition of a mask. The one participant who described being positively impacted by physical distancing policies noted fewer opportunities to use substances.

Eight participants described sadness related to not seeing friends or loved ones. One participant reported losing touch with family members for multiple months due to library closures and losing their regular access to the internet. Eight described sadness related to not having meaningful daily activities, including going to mental health care appointments, support group meetings, stores, restaurants, gyms, and church services.

> "You can't do anything. It's affecting me going out and getting fresh air. Cause I'm sick. I'm not sick sick but you know what I mean? I try to call my friends here and there, but to get my mind to stop racing, you can't do anything. You're stuck in the house and you're just stuck."

> "I would go [to my mental health clinic] twice a week and sometimes three times…I liked getting dressed and I liked walking up there. I liked walking home. It was a routine. And, now that it's at home, you can be in your underwear and no one would know. It's just not the same thing. I like having things to do during the day."

Six participants reported frustration with increased difficulty accessing essential government services during the pandemic, including benefit offices and the courts. Four reported being unable to access an essential form of identification, which prevented them from receiving other necessary services, including housing, health insurance, outpatient mental health treatment, or unemployment assistance. The cessation of in-person operations at the social security office also impeded one participant's ability to apply for disability and another's termination of benefits appeal.

> "I know that it is hard to balance lives with the economy and moving on, but how are people going to live if they cannot get the resources that they need? People are going to start failing in other ways. They need to open government offices up. They need to start putting Plexiglass up and letting services resume… I can't see my kids because the supervised visitation center is closed because of COVID. Why can't I do supervised visits with a mask on? Why is the court closed, but we can all go to restaurants?"

Four participants reported frustration with the health care system for limiting their access to care, including reduced numbers of beds at substance use and eating disorder treatment facilities and no longer being able to self-present to freestanding psychiatric hospitals for inpatient admission due to the facility's inability to rapidly test for COVID-19. Another four participants reported frustration related to a decrease in quality and volume of homeless housing during the pandemic. Two participants reported previously staying at homeless shelters that closed as a result of COVID-19 outbreaks and inability to comply with physical distancing requirements.

> "All these places that homeless people and people in drug recovery depend on are closed. People in drug recovery cannot find a place to go. [The rehab unit] has been packed. There are no beds. More people are going into [rehab] because there are no other services available and they are there for longer because there is nowhere for them to go. Homeless people are really affected. There are more people on the street and there is no place to shower. Beds in shelters get booked up quick."

Attitudes Toward Mental Health Treatment During the Pandemic

Four participants reported continuing with one or more in-person outpatient mental health providers during the pandemic. These participants reported wearing masks and complying with social distancing requirements at their appointments.

Eleven participants reported that one or more of their established mental health providers transitioned exclusively to telemedicine during the pandemic. None of these participants reported receiving telemedicine before the pandemic. Of the 11 who reported a transition to telemedicine, 5 reported being able to transition to telemental health care without any significant difficulty.

> "They were shut down, so I would call my therapist, my psychiatrist, and talk to her over the phone. And then if I needed a refill, she would call into the pharmacy, put in a refill for me to go pick up the prescription. It's the same that it always is, just that we would only communicate on phone."

The other six reported significant difficulty with telemental health (Table 2). Two reported not having cell phones and thus not being able to connect with their providers. The other four described difficulty engaging with their providers. They described telemental health services as poorer quality (shorter appointments, less comprehensive assessments), less personal, and less productive due to more frequent distractions, including intrusions from family members and push notifications on cell phone devices. Some mental health clinics experienced changes in staffing, and two participants found it more difficult to create relationships with new providers through telemedicine. Although not identified as a major issue, three participants expressed difficulty finding a private place at their homes or jobs to participate in their telemedicine visits.

Of the nine that had their outpatient mental health appointments via telehealth (excluding the two participants who could no longer access mental health care due to lack of a personal device), only three reported receiving their care through video conferencing. The other six reported phone appointments without a video component. One participant described using a telephone because they could not correctly set up the video conferencing software. The other five said video conferencing had not been offered. All six reported having video conferencing capabilities (*e.g.*, smartphones or computers). Of note, many study participants reported video conferencing with their non–mental health providers (*e.g.*, primary care physician) without technological difficulties during the pandemic.

Care and Social Service Coordination

A majority of participants described being able to navigate the new health and social service systems that have rapidly arisen during the pandemic; some did this independently (using their skills to navigate new/existing challenges), and others had support from family and/or providers. A proportion of participants did not experience any pandemic challenges that required navigation; their disability checks are automatically deposited in their bank account, their Supplemental Nutritional Assistance Program benefits automatically load on to a card, and their mental health clinic continued in-person operations. Most participants reported no difficulty shopping online, filling out applications online, or scheduling appointments online. One participant described reaching out to their local councilmember to find out what services were available for seniors during the pandemic, and they were provided with a gamut.

Many described health and social service providers quickly adapting services to meet the needs of their clients. Those who rely on soup kitchens described operations seamlessly moving outside without any service gaps. Those who sought services through the municipality's department of health services described short wait times on the phone and receiving in-person support. A number of participants reported that their health care providers implemented new care coordination strategies to bridge potential gaps caused by the pandemic, including weekly phone calls, medication delivery, and mask delivery.

However, five participants described significant difficulty obtaining health care and other necessary services during the pandemic and not having any or sufficient assistance from care providers or family members to bridge this gap (Table 3). Four of these participants reported experiencing

TABLE 2. Barriers to Engagement With Telemedicine

Less personal	"You're not having no face-to-face, no visual with them. No looking at them eye-to-eye. You can learn a lot about a person from the way they sit in a chair or talk or look at you eye-to-eye."
Poorer quality	"If you are looking at a person, you have a tendency to be more honest with them, then over the phone, you know what I'm saying? I'm speaking for myself. I cannot speak for everybody else. When you can see a person's demeanor, look at it the way they sitting or whatever, you can tell something's going on with them, compared to just talking to the telephone."
Too many distractions	"I was doing therapy and we were seeing each other, but then we got to COVID and we had to do virtual. And when I was going virtual with her, she was talking to her family in the background, arguing with her [partner]. And I'm this cannot be real, no way. How are you going back and forth with him. Tell him to leave. You're at work. So, I just hung up and stopped going. So that interrupted a lot…I do not like the zoom thing. I really do not. It does not benefit me. I'd rather be close contact with somebody, but I know we cannot do that in a lot of places...During the Zoom, I'll probably be on my phone. When notifications pop, I'm paying attention to that."
Difficulty establishing new relationships	"My psychiatrist left in January, which was really hard for me. It was before we knew about COVID, but COVID was sort of happening. He left in January and I got a new psychiatrist. I have a meeting with her on the phone once a month for med management…I've never met her…She keeps asking what's your social security number? How old are you? What's your date of birth? And she does not know very much about me."
Lack of privacy	"Oftentimes I would have to wake up my partner and be like, 'Hey, I have an appointment in like 5 minutes. Can you skedaddle?'…When you are in a doctor's office, like with your psychiatrist or something, and it's very clear that this is us and it's not anyone else listening in on us. And to have the possibility of someone could be like sitting in the other room and like listening to your conversation, it's like very weird to have that like element to a doctor's appointment."
Provider uses telephone	"[The attending physician] asked the question to the resident. 'You mean to tell me you have been treating her all this time and you have never seen her face.' So, [the attending physician] was a little perturbed by that. And she said, next time it has to be tele, because you have to be able to see a person to read their face and their body language. And that's when I said no more of that. Let me go to [another mental health clinic]."

homelessness and not having a cell phone. Before the pandemic, this group described either showing up in-person to social service agencies to complete applications or using library computers. One participant described walking into mental health clinics for medication refills. Although these participants all reported struggling to meet their needs before the pandemic, they all described increased difficulty as a result of the pandemic. In addition, four of the five participants reported not having a necessary form of identification and needing new social services that require identification.

Seven participants reported experiencing homelessness. All were working with the housing office to obtain long-term housing and reported frustration with how long the process was taking. Their struggle

TABLE 3. Unmet Needs During the COVID-19 Pandemic

Mental health care	"I'm really just trying to get my doctors and stuff, but everybody wants to do Zoom or on phone meetings and it's making it more of a pain for me, because I do not have a phone right now and i'm trying to get one, but I cannot without identification."
Medication	"I went there one day and they said, 'you do not have your ID, you do not have your birth certificate, so we cannot help you out.' I begged him. I was like, 'man, I really need my medication. You know me. I've been here numerous times.' They just do not want to help you."
Cellphone	"Assurance Wireless has taken me through the ringer because one case worker applied for one at one shelter. Then I got moved to another shelter. So, they are telling me I already have a phone and I never received the first phone. I'm just through with the phone calls, the interviews, I'm just, I'm done. You know, it's been real difficult."
Internet	"I used to be able to sit on the computer [at the library] for 5 hours a day. Now, I cannot even get a computer for 15 minutes. I'm pretty sure it messes up my family. I cannot check in with them and see how they are doing."
Food	"It is hard. I get food stamps, but a lot of places that used to serve do not even serve anymore…Even the shelter van, does not come around as often anymore…You have to pick up the phone and actually call them before they would come pick you up. Normally, they would just drive around the city and if they see you. They do not even do that anymore…Before this started, you had people coming down to [the] park on Saturdays and Sundays. They would come down there, set up a tent, and pass out food. You had different people coming all day long with food, clothes, shoes, whatever. They barely do that anymore…There are still some places that still do things. You just gotta be there, and if you do not, you are just gonna miss out. You just got to have more of a plan. If you do not, then you are going to miss out."
Housing	"I was supposed to go to transitional housing. That is how it usually works after you are discharged from rehab, but because of COVID, there are no beds. They are only allowing one patient to a room and they only allow a new person in every 14 days because of quarantine. So, I left rehab and went back to looking for different places to stay and I was on a waiting list for a bed. I wound up missing my move-in date, because they emailed me and I do not have a phone or a computer. I had someone from [a soup kitchen] call for me the next day and they said that they already gave away my bed."
Financial assistance	"I cannot do nothing without my social…[I tried to get unemployment] and they were like, you have to send your social. I was like, I do not have it. They were like, oh we cannot, and they closed [my unemployment claim]. Yeah. I was just putting in the little times. I thought they would at least come through, but nope, it ain't work. I could not get food stamps. I tried to go to [a program] for the family, to help you get your own apartment. I could not do that."

to obtain stable housing began before the pandemic, but many voiced an intensified need for housing as a result of COVID. They described the difficulties of being homeless during a pandemic as the patchwork of formal and informal services that support individuals experiencing homelessness has eroded. All of these participants identified the mayor's most important task to improve lives during the second surge of the pandemic as housing the homeless. Two homeless participants spent 2 weeks in quarantine hotels; they spoke highly of their experiences and wished a similar program could be established for long-term housing. Four participants noted that one positive impact of the pandemic has been the suspension of city bus riding fees, which has made it easier to obtain resources.

DISCUSSION

We believe this is the first study aiming to capture the experiences of individuals with SMI living in the United States during the COVID-19 pandemic, navigating the markedly altered health and social services systems. Among individuals hospitalized due to a deterioration of their mental health during the pandemic, most have had limited to no difficulty in meeting their basic needs. They described health and social service agencies that quickly adapted their services to meet the needs of their clients and bridge gaps during the pandemic. Most of the participants who used telemental health did not report any difficulties engaging with their providers, which is in alignment with experiences during natural disasters: mental health systems that care for individuals with SMI have been found to be able to quickly adapt to meet the needs of their clients with little service disruption (Fried et al., 2005; Tally et al., 2013; Tofighi et al., 2015).

Six participants in our study reported significant difficulty with telemental health; most of these individuals were not given the option of video conferencing, but audio-only appointments instead. As video telemental health has high acceptability by patients, all providers should consider offering such visits, with audio-only conferencing reserved for patients who do not have video access. Video telemedicine became easier at the start of the pandemic, with the Department of Health and Human Services' relaxation of Health Insurance Portability and Accountability Act (HIPAA) rules around use of non–HIPAA-compliant video conferencing modalities (Office for Civil Right, 2020). Administrative staff can help teach patients how to use video conferencing software in advance of the visit (Medalia et al., 2020). In addition, mental health clinics should consider bringing back limited in-person operations to meet the needs of patients who do not have personal devices or who require a higher level of monitoring. Inpatient providers may be struggling to develop safe discharge plans due to the sizable number of patients without personal devices and the small number of mental health providers that are providing in-person services. The benefits of in-person appointments should, of course, be balanced with potential exposure risks to the patient and provider.

Five participants in this study described not being able to meet certain basic needs during the pandemic. Two of these participants separately described being disheartened as they watched restaurants operate at nearly full capacity, whereas they could not meet their basic needs as a result of limited in-person operations at certain government agencies. These individuals had a number of commonalities. They either did not have an essential form of identification, housing, a cell phone, or a combination of the three. These all play critical roles in remaining safe and healthy during COVID-19.

Policy Implications

In March 2020, Medicare and many state Medicaid programs began reimbursing mental health providers for audio-only mental health appointments at the same rate as in-person visits. Although this policy may have expanded access to telemental health to individuals without smart phones or other personal devices with cameras, it may have also hindered the dissemination of audio-visual telemental health care (Center for Medicare and Medicaid Services, 2020). Policymakers should consider how to encourage providers to adopt video telemedicine technologies while also considering strategies to expand digital technologies to low-income Americans.

A valid form of identification is a prerequisite for obtaining a job, housing, or benefits. The Social Security Administration and the Department of Motor Vehicles have both significantly reduced in-person operations (Social Security Administration, 2020; Washington D.C. Department of Motor Vehicles, 2020). New strategies need to be adopted to reduce barriers to obtaining identification while mitigating the spread of COVID-19. These may include phone appointments or use of drive-thru or walk-up windows.

Housing is a critical component of mental health management (O'Campo et al., 2016). With travel restrictions in place, hotel rooms are often empty (Krishnan et al., 2020). The pandemic has also prompted many people to move out of high-cost living in cities, leading to high apartment vacancy rates (Warnock, 2020). The pandemic is presenting cities with unique opportunities to reimagine low-income housing and identify permanent housing for individuals with SMI. States and local municipalities may be able to buy vacant hotels and convert them into long-term homeless housing (Bolstad, 2020).

This study highlights that internet and (especially smart) cell phone access is an essential requirement for accessing health care and other social services and should thus be considered a human right (Howell and West, 2016). The federal Lifeline program, a program administered by the Federal Communications Commission to help low-income Americans obtain free or low-cost cell phones, is an absolutely critical public service (Lifeline Program for Low-Income Consumers, 2012). Although a number of study participants reported obtaining cell phones through this program, others reported losing government-provided phones or not being able to obtain them due to lack of stable address or identification. Additional efforts must be made to expand this program and ensure that outreach efforts are successful at identifying those with greatest need. Efforts must also be made to expand public Wi-Fi via outdoor hotspots.

Limitations

This is a single-site study with a small sample size, and the findings are not generalizable. In addition, the research team was not able to use any data collection methods to triangulate the findings (Nowell et al., 2017). This study was designed to rapidly generate preliminary evidence that can be used to design larger-scale inquiries into service gaps that have occurred for individuals with SMI during the COVID-19 pandemic (Vindrola-Padros et al., 2020). This study encourages more targeted research on the impact of pandemics on individuals with SMI; important issues include the effectiveness of audio-only telemental health, navigating the transition from inpatient psychiatry to outpatient telemental health, and cellphone ownership, internet access, and identification among individuals with SMI.

A few participants had active psychosis, had disorganized thought processes, or were poor historians. For them, the prompts were used to guide them back to describing how the COVID-19 pandemic has impacted their ability to receive mental health and other social services. Although the questions were not always fully answered or addressed, all of these participants shared important aspects of their experiences during the pandemic.

Lastly, we did not validate any of the information provided by study participants by checking their medical records or speaking with people who know them closely, such as their friends, families, or health care providers. It is possible that study participants minimized hardships they have endured and barriers in obtaining services during the pandemic because of lack of trust with the interviewer, feeling that the interviewer could not provide any assistance, or disorganized thoughts (Bixo et al., 2019).

CONCLUSION

The COVID-19 pandemic is expected to continue for at least the next few months, and new pandemics may occur in the near future. This study found that most people with SMI have been able to meet their needs during the pandemic, but those without access to housing, internet, cell phones, and identification face additional barriers and are less likely to have their basic social and mental health care needs met. The COVID-19 pandemic has caused shifts in our basic needs; access to cell phones and internet has become vital. Policymakers must work to expand programs that address needs made unduly important by the pandemic and deliver these programs in ways that do not exclude those without access to technology, stable housing, or the ability to coordinate their own health care or social services. As we move into the second wave of the pandemic, feedback from people with mental illnesses is critical to improving access to and the quality of the newly derived "socially distant" mental health and social service systems.

DISCLOSURE

Dr Chen is supported by a grant from the National Institute on Minority Health and Health Disparities (R01MD011523). She is also supported by 1R01AG062315-01A1 from the National Institute of Aging.

This study has not previously been submitted to any journals.

This study went through rigorous institutional review board approval processes at the University of Maryland College Park and George Washington University. All participants signed written informed consent after being determined to have capacity to consent to participate by an attending psychiatrist and passing a consent quiz.

The authors declare no conflict of interest.

REFERENCES

Ådnanes M, Cresswell-Smith J, Melby L, Westerlund H, Šprah L, Sfetcu R, Straßmayr C, Donisi V (2020) Discharge planning, self-management, and community support: Strategies to avoid psychiatric rehospitalisation from a service user perspective. *Patient Educ Couns*. 103:1033–1040.

Ashworth B (2020) The coronavirus' impact on libraries goes beyond books. *Wired*. Available at: https://www.wired.com/story/covid-19-libraries-impact-goes-beyond-books/. Accessed April 21, 2020.

Augenstein J (2020) Opportunities to expand telehealth use amid the coronavirus pandemic. *Health Affairs Blog*. Available at: http://www.healthaffairs.org/do/10.1377/hblog20200315.319008/full/. Accessed April 20, 2020.

Avalone L, Barron C, King C, Linn-Walton R, Lau J, McQuistion H, Popiel M, Balasubramaniam M, Freeman R, Fattal O (2021) Rapid telepsychiatry implementation during COVID-19: Increased attendance at the largest health system in the United States. *Psychiatr Serv.* 72:708–711.

Awenat YF, Peters S, Gooding PA, Pratt D, Shaw-Núñez E, Harris K, Haddock G (2018) A qualitative analysis of suicidal psychiatric inpatients views and expectations of psychological therapy to counter suicidal thoughts, acts and deaths. *BMC Psychiatry.* 18:334.

Bixo L, Cunningham JL, Ekselius L, Öster C, Ramklint M (2019) 'Sick and tired': Patients reported reasons for not participating in clinical psychiatric research. *Health Expect*. 24:20–29.

Bolstad E (2020) Prompted by pandemic, some states buy hotels for the homeless. Pew Trusts. Available at: https://pew.org/37zwE4s. Accessed December 20, 2020.

Braun V, Clarke V (2006) Using thematic analysis in psychology. *Qual Res Psychol*. 3:77–101.

Bromley E, Gabrielian S, Brekke B, Pahwa R, Daly KA, Brekke JS, Braslow JT (2013) Experiencing community: Perspectives of individuals diagnosed as having serious mental illness. *Psychiatr Serv.* 64:672–679.

Center for Medicare and Medicaid Services (2020) Trump administration issues second round of sweeping changes to support U.S. Healthcare system during COVID-19 pandemic. *Centers for Medicare and Medicaid Services*. Available at: https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid. Accessed January 15, 2021.

Costa M, Pavlo A, Reis G, Ponte K, Davidson L (2020) COVID-19 concerns among persons with mental illness. *Psychiatr Serv.* 71:1188–1190.

Fereday J, Muir-Cochrane E (2006) Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *Int J Qual Methods*. 5:80–92.

Fried BJ, Domino ME, Shadle J (2005) Use of mental health services after hurricane Floyd in North Carolina. *Psychiatr Serv.* 56:1367–1373.

Hickman NJ, Prochaska JJ, Dunn LB (2011) Screening for understanding of research in the inpatient psychiatry setting. *J Empir Res Hum Res Ethics*. 6:65–72.

Howell C, West D (2016) The internet as a human right. *Brookings*. Available at: https://www.brookings.edu/blog/techtank/2016/11/07/the-internet-as-a-human-right/. Accessed December 21, 2020.

Interian A, King AR, St. Hill LM, Robinson CH, Damschroder LJ (2018) Evaluating the implementation of home-based videoconferencing for providing mental health services. *Psychiatr Serv.* 69:69–75.

Krishnan V, Mann R, Seitzman N, Wittkamp N (2020) Hospitality and COVID-19: How long until 'no vacancy' for US hotels? *McKinsey and Company.* Available at: https://www.mckinsey.com/industries/travel-logistics-and-transport-infrastructure/our-insights/hospitality-and-covid-19-how-long-until-no-vacancy-for-us-hotels. Accessed December 20, 2020.

Lifeline Program for Low-Income Consumers (2012) *Federal Communications Commission*. Available at: https://www.fcc.gov/general/lifeline-program-low-income-consumers. Accessed December 21, 2020.

Maxwell JA (2010) Using numbers in qualitative research. *Qual Inq*. 16:475–482.

McCann A (2020) States with the fewest coronavirus restrictions. *WalletHub*. Available at: https://wallethub.com/edu/states-coronavirus-restrictions/73818. Accessed December 20, 2020.

Mechanic D, Bilder S (2004) Treatment of people with mental illness: A decade-long perspective. *Health Aff.* 23:84–95.

Medalia A, Lynch DA, Herlands T (2020) Telehealth conversion of serious mental illness recovery services during the COVID-19 crisis. *Psychiatr Serv.* 71:872–872.

Nowell LS, Norris JM, White DE, Moules NJ (2017) Thematic analysis: Striving to meet the trustworthiness criteria. *Int J Qual Methods*. 16:1609406917733847.

O'Campo P, Stergiopoulos V, Nir P, Levy M, Misir V, Chum A, Arbach B, Nisenbaum R, To MJ, Hwang SW (2016) How did a housing First intervention improve health and social outcomes among homeless adults with mental illness in Toronto? Two-year outcomes from a randomised trial. *BMJ Open*. 6:e010581.

Office for Civil Right (2020) Notification of enforcement discretion for telehealth remote communications during the COVID-19 nationwide public health emergency. *Department of Health and Human Services*. Available at: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html. Accessed January 15, 2021.

Palinkas LA, Horwitz SM, Green CA, Wisdom JP, Duan N, Hoagwood K (2015) Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Adm Policy Ment Health*. 42:533–544.

Pyett PM (2003) Validation of qualitative research in the "real world." *Qual Health Res*. 13:1170–1179.

SAMHSA (2020) Considerations for the care and treatment of mental and substance use disorders in the COVID-19 epidemic. *Substance Abuse and Mental Health Data Archive*. Available at: https://www.samhsa.gov/sites/default/files/considerations-care-treatment-mental-substance-use-disorders-covid19.pdf. Accessed December 20, 2020.

Slade EP, Goldman HH, Dixon LB, Gibbons B, Stuart EA (2015) Assessing the representativeness of medical expenditure panel survey inpatient utilization data for individuals with psychiatric and nonpsychiatric conditions. *Med Care Res Rev.* 72:736–755.

Social Security Administration (2020) Available at: https://www.ssa.gov/agency/emergency/. Accessed December 20, 2020.

Steidtmann D, McBride S, Mishkind MC (2021) Experiences of mental health clinicians and staff in rapidly converting to full-time telemental health and work from home during the COVID-19 pandemic. *Telemed J E Health*. 27:785–791.

Talley RM, Brunette MF, Adler DA, Dixon LB, Berlant J, Erlich MD, Goldman B, First MB, Koh S, Oslin DW, Siris SG (2021) Telehealth and the community SMI population: Reflections on the disrupter experience of COVID-19. *J Nerv Ment Dis*. 209:49–53.

Tally S, Levack A, Sarkin AJ, Gilmer T, Groessl EJ (2013) The impact of the San Diego wildfires on a general mental health population residing in evacuation areas. *Adm Policy Ment Health*. 40:348–354.

Temi (2020) *Temi*. Available at: https://www.temi.com/. Accessed May 13, 2020.

Thomas DR (2006) A general inductive approach for analyzing qualitative evaluation data. *Am J Eval*. 27:237–246.

Tofighi B, Grossman E, Goldfeld KS, Williams AR, Rotrosen J, Lee JD (2015) Psychiatric comorbidity and substance use outcomes in an office-based buprenorphine program six months following hurricane Sandy. *Subst Use Misuse*. 50:1571–1578.

Verma S (2020) Early impact of CMS expansion of medicare telehealth during COVID-19. *Health Affairs Blog*. Available at: https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/full/. Accessed July 17, 2020.

Vindrola-Padros C, Chisnall G, Cooper S, Dowrick A, Djellouli N, Symmons SM, Martin S, Singleton G, Vanderslott S, Vera N, Johnson GA (2020) Carrying out rapid qualitative research during a pandemic: Emerging lessons from COVID-19. *Qual Health Res*. 30:2192–2204.

Warnock R (2020) Apartment vacancies are peaking in expensive markets. *Apartment List*. Available at: https://public.tableau.com/views/vacancies_v_rents/Dashboard1?:display_count=yes:showVizHome=no&:embed=true. Accessed December 20, 2020.

Washington D.C. Department of Motor Vehicles (2020) DMV appointment details. *Washington DC Department of Motor Vehicles*. Available at: https://dmv.dc.gov/page/dmv-appointment-details. Accessed January 15, 2021.

Willis J (2020) Who will run the soup kitchens? *The Atlantic*. Available at: https://www.theatlantic.com/family/archive/2020/03/the-coronaviruss-impact-on-homeless-services/608467/. Accessed April 20, 2020.

Yellowlees P, Nakagawa K, Pakyurek M, Hanson A, Elder J, Kales HC (2020) Rapid conversion of an outpatient psychiatric clinic to a 100% virtual telepsychiatry clinic in response to COVID-19. *Psychiatr Serv*. 71:749–752.

Young AS, Cohen AN, Niv N, Nowlin-Finch N, Oberman RS, Olmos-Ochoa TT, Goldberg RW, Whelan F (2020) Mobile phone and smartphone use by people with serious mental illness. *Psychiatr Serv*. 71:280–283.