Disaster Behavioral Health Through the Lens of COVID-19

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Disaster Behavioral Health through the Lens of COVID-19

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Abstract:

Disaster planning and response in the U.S. is structured by the National Incident Management System (NIMS) that focuses on the safety and protection of life, assets, and the environment. Additionally, the Federal Emergency Management Agency (FEMA) issues specific guidance related to such planning and response. Part of this planning includes the need to attend to the emotional well-being of those impacted by disasters, as well as the need to ensure continuity of operations and access to behavioral health care during emergencies. COVID-19 resulted in a declaration of emergency and by early 2020 was codified as a global pandemic. Unlike a more common, local, or sudden disaster emergency such as a tornado or an explosion, COVID-19 was global and long-term. It overwhelmed health care systems, caused the death of millions, created economic and social disruption around the world, and dramatically changed life as we knew it. From this experience, health disparities and the unique needs of public behavioral health populations became increasingly apparent. Additionally, the human toll from COVID-19 and the resultant need for expanded behavioral health crisis response suggests there are lessons to be learned from the widespread loss, quarantine, and social shifts to connections via technology. The pandemic also highlighted some of the progress that has occurred over the last several decades related to incorporating behavioral health responses into overall emergency preparedness. This paper reviews the history and framework of emergency planning and response and addresses aspects related to COVID-19. Recommendations for how best to incorporate behavioral health responses into future disaster emergency planning are offered.

Highlights:

- Emergency preparedness continues to evolve, integrating disaster behavioral health planning into overall preparedness.
- COVID-19 highlighted gaps in planning for epidemics and pandemics, including disaster behavioral health.
- Disparities in outcomes from COVID-19 and its impact on minority populations requires an intentional focus on health equity in emergency management.

Recommendations for the post-COVID-19 future:

1. Bolster the integration of disaster behavioral health into public health emergency preparedness and response.
2. Attend to health equity with specific efforts focused on the needs of high-risk populations.
3. Conduct mass psychological distress screenings and opportunities to provide emotional support.
4. Continue to promote behavioral health surveillance and research.
5. Foster communications focused on behavioral health needs.
6. Attend to the mental health of health care workers and responders.
7. Continue to build telehealth capacity.
8. Continue to foster training on aspects of disaster behavioral health.
9. Maximize continuity and access to treatment for behavioral health populations.
10. Continue efforts to expand and develop a robust crisis care system.

E mergency planning and response in the U.S. is structured by the National Incident Management System (NIMS), which focuses on the safety and protection of life, assets, and the environment. Guidance for this structure was established first in 2004 by the Federal Emergency Management Agency (FEMA) within the U.S. Department of Homeland Security.[1] The COVID-19 pandemic presented new challenges in all areas related to emergency planning and response. Unlike a more common, local, or sudden disaster emergency such as a tornado or an explosion, COVID-19 ultimately resulted in a declaration of emergency in all states and territories and by early 2020 was codified as a global pandemic. It overwhelmed health care systems, caused the death of millions and

> Coronavirus disease 2019 (COVID-19) is an infectious disease caused by the novel coronavirus SARS-CoV-2. The initial lack of immunity caused it to spread rapidly throughout the world causing millions to become ill and die.

economic and social disruption around the world, and dramatically changed life as we knew it. Behavioral health systems were not spared. Public behavioral health systems, which not only serve the public behavioral health needs, but as state mental health authorities must attend to the emotional needs of the entire population, were especially impacted. This technical assistance paper focuses on Disaster Behavioral Health through this newly emerged COVID-19 lens and with thoughts for future planning and preparedness.

Overview of Disaster Preparedness

Three major components of emergency management are: an **Emergency Operations Plan (EOP)** that is utilized to prepare for and respond to an emergency; an **Incident Command System** (ICS) which is a management structure that defines who is in charge (Incident Commander), who reports to whom and who has responsibility for overseeing duties related to Operations, Planning, Logistics, and Administration/Finance; and a **Continuity of Operation Plan (COOP)** that is typically activated in order to assist the agency with reconstituting or continuing regular operations. All federal and state agencies are required to develop EOPs using an "all-hazards" approach, meaning they are sufficiently flexible to address a full spectrum of emergencies or disasters, including man-made emergencies (e.g. chemical spills, explosions, chemical or biological attacks, nuclear blasts, plane crashes) and naturally occurring disasters/emergencies (e.g. tornadoes, hurricanes, floods, viruses, toxins). EOPs must also include planning for pandemic influenza, given the experience of the 1918 Pandemic and the expectation that one would emerge. An EOP is a requirement for government agencies but should also be a practice for all other organizations and businesses. It should be noted that much of the initial response is at the local level.

> *The authors of this technical assistance paper have a combined 40 plus years of experience in state government and disaster preparedness and response. Much of the content of this report is drawn from this experience in the field.*

The COVID-19 pandemic is a unique type of emergency because it necessitated all five phases of the emergency management planning cycle to be addressed virtually simultaneously rather than one phase at a time. **Table 1 depicts these five phases and how they took place during COVID-19.**

Table 1: Five phases of emergency management planning cycle and COVID-19 response

Phase	Description	Sample COVID-19 response
1. Preparedness	Includes emergency preparedness plans to save lives and minimize damage that can occur during a disaster.	• Developed knowledge base of COVID-19 symptoms; • Acquired supplies and pharmaceuticals.
2. Prevention	Activities to increase the community's ability to respond when a disaster occurs. This can include: • deterrence operations and surveillance, • assessing the hazards, risks and vulnerabilities, • backing up information, • developing mutual aid agreements, • training for both response personnel and concerned citizens, • conducting disaster exercises to reinforce training and test capabilities, and • presenting all-hazards education campaigns.	• Developed pandemic influenza plans; • Moved vaccines through the approval process; • Current vaccination efforts.
3. Mitigation	Putting in place measures that prevent an emergency, reduce the chance of an emergency happening, or reduce the damaging effects of unavoidable emergencies. This phase involves developing policies to reduce risks to people and property during a disaster and determining which groups are most at risk and what resources are needed.	• Emphasis and orders for consistent and correct use of masks, physical distancing and procedures for infection control; • Contact tracing in combination with isolation and quarantine; • Identification of seniors and some minority populations as being at greater risk.
4. Response	Activating the emergency operations plans and taking actions aimed at saving lives, reducing economic losses, and alleviating suffering.	• Deployment of personnel, information, protective equipment; • Activation of the Strategic National Stockpile; • COVID-19 vaccinations messaging regarding its efficacy and safety, distribution and administration.
5. Recovery	Actions taken to return a community to normal or near-normal conditions.	• Returning to the workplace; • Relaxation of mask mandates.

Activating an **Incident Command System (ICS)** provides a flexible, yet standardized core mechanism for coordinated and collaborative incident management internally, and particularly when multiple agencies,

organizations or jurisdictions are involved thus requiring cross-jurisdictional coordination. The ICS is designed to enable effective, efficient incident management by integrating a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure. ICS enables incident managers to identify key concerns associated with the incident—often under urgent conditions—without sacrificing attention to any component of the command system or the response. It represents organizational "best practices" and, as an element of the Command and Management Component of NIMS, has become the standard for emergency management across the country.[2]

A **Continuity of Operations Plan** (COOP) is a companion plan to an EOP. It establishes policy and guidance ensuring that an organization can continue critical functions in the event of a disaster. In order to achieve that goal, the organizations begin plan development by identifying their essential functions and further developing it ensure that those functions can be continued throughout, or resumed rapidly after, a disruption of normal activities. The overarching continuity requirements include:

1. Orders of succession – who takes over if leadership are unavailable or unable to execute their duties;
2. Delegations of authority – identification, by position, of the authorities for making policy determinations and decisions at all levels and at all other organizational locations;
3. Continuity facilities – if necessary, personnel and resources are relocated to an alternate location until operations return to normal or are directed to work from home**;**
4. Continuity communications – keep communications systems operational and provide the capability to perform essential functions internally and remotely as needed;
5. Vital records management – identification, protection and ready availability of electronic and hard copy documents as well as hardware, software and equipment needed to support essential functions during a continuity situation;
6. Human capital – ICS and/or COOP assigned employees and other special categories of employees who are activated to perform assigned response duties;
7. Tests, training, and exercises (TT&E) – drills or exercises conducted to ensure that plans can support the continued execution of essential functions throughout the duration of a continuity event;
8. Devolution of control and direction – capability to transfer authority for essential functions from primary operating staff and facilities to other employees and facilities; and
9. Reconstitution – the process by which surviving and/or replacement personnel resume normal organization operations from the original or replacement primary operating facility.

The pandemic has been so disruptive to most government agencies and businesses for such a prolonged period that they have been utilizing both their EOPs and their COOPs simultaneously throughout the pandemic.[3]

Functions of Government Agencies in Disaster Response

During an emergency FEMA's function is to serve in a support role to other federal and state government agencies overwhelmed by disaster. For a biological emergency FEMA would support the Department of Health and Human Services (DHHS) and, if needed, state health departments. However,

on March 19, 2020, FEMA's role in the pandemic response was changed by the White House Coronavirus Task Force from supporting DHHS, which was designated as the initial lead federal agency for the COVID-19 pandemic response, to coordinating the Whole-of-Government response to the pandemic. In his testimony to Congress on July 24, 2020, the FEMA Administrator, Peter Gaynor, explained that for the first time in U.S. history the entire nation was in a state of emergency. There were 114 concurrent Major Disaster Declarations —one or more in every state and the District of Columbia, five territories and the Seminole Tribe of Florida. The scale of this historic event required FEMA to adapt its response practices and workforce posture to both respond to COVID-19 and simultaneously maintain readiness for more common disasters such as hurricanes, earthquakes, floods, or wildfires. The agency became responsible for building "surge capacity" (ability to manage a high volume of patients), managing critical shortages of health supplies, distributing DHHS' Strategic National Stockpile (SNS), overseeing the Supply Chain Stabilization Task Force and Project Airbridge which increased manufacturing and expedited shipping of consumer goods, and assumed authority for The Defense Production Act, Next-Generation SNS, and deployment of over 50,000 federal personnel.[4]

The Substance Abuse and Mental Health Services Administration (SAMHSA) is an agency within DHHS whose emergency planning role is to provide states, communities and responders with behavioral health resources that help them prepare, respond, and recover from disasters. SAMHSA has assisted in the response to COVID-19 by making available products and resources in various media that can be useful when coping with the effects of widespread public health crises for individuals, employers and populations at increased risk. They emphasized the immediate and potential long-term effects of the pandemic on the public and health care providers and responders and the importance for self-care and seeking help if needed. SAMHSA issued alerts providing guidance for many services such as opioid treatment programs, vaccine usage and continued to promote best practices for crisis counseling through their Disaster Behavioral Health relief efforts. Due to the pandemic and its associated economic stressors, SAMHSA has been assisting state behavioral health and Medicaid agencies with the financial challenges to meet both existing needs as well as an increase in demand, by issuing grants to address service demands and easing regulations to make telehealth more readily available. The Centers for Disease Control and Prevention's (CDC) issued a report showing the immense and growing need for behavioral health services – four out of 10 individuals struggling with mental health and/or substance use and 11% having considered suicide.[5] A blog published in *Health Affairs* aptly described the pandemic as the "perfect storm for psychological stress … long-lasting storm will widen already massive mental health disparities among marginalized populations."[6]

The Evolution of Disaster Behavioral Health

Disaster behavioral health is defined as the provision of mental health, substance abuse, and stress management services to disaster survivors and responders.[7] Disaster Behavioral Health as a field was first established in the wake of the terrorist attacks on September 11, 2001, natural disasters, and other emergencies of the last several years. Research and studies have highlighted the close interplay between behavioral health and physical health and the importance of integrating them both into all

aspects of public health and medical disaster management.[8] However, disaster behavioral health as we know it today became an integral part of emergency management when the Disaster Mental Health Subcommittee of the National Biodefense Science Board (NBSB). The Board was created by President George W. Bush in October 2007 through the Homeland Security Presidential Directive 21, paragraph 31 and was charged with submitting recommendations to the NBSB for protecting, preserving, and restoring individual and community mental health in catastrophic health event settings.[9] In its report, the NBSB Subcommittee on Disaster Mental Health conceptualized "disaster mental and behavioral health" as including "the interconnected psychological, emotional, cognitive, developmental, and social influences on behavior and mental health and the impact of those factors on preparedness, response, and recovery from disasters or traumatic events."[10] The recommendations were presented to the NBSB in November 2008 and the NBSB sent its recommendations to the Secretary of DHHS describing the importance and context of the integration and provided details of the subcommittee's assessment and recommendations regarding integration.

> Residents and responders who experience a new disaster are at greater risk for adverse stress reactions. People may display symptoms and reactions such as:
>
> - Emotional symptoms including as irritability or excessive sadness;
>
> - cognitive dysfunction such as difficulty making decisions or following directions;
>
> - physical symptoms such as headache, stomach pain, or difficulty breathing;
>
> - behavioral reactions such as consuming more alcohol or interpersonal conflict; and
>
> - failure to adhere to needed physical or psychiatric medication needs.[8]

Since that time, the need for behavioral health disaster capabilities has been demonstrated by research that has linked the exposure to trauma and the onset of other health care needs immediately following an emergency event.[11] For example, research suggests that after a traumatic event, individuals could later present with cardiovascular, musculoskeletal, and neurological illness, as well as psychiatric diagnoses such as post-traumatic stress disorder (PTSD), anxiety, depression, and substance use disorders, even years after the event occurred. There is also data demonstrating that costs associated with the treatment of these conditions also increase.[12]

It is now considered a best practice to integrate behavioral health into disaster EOPs and into elements of disaster response education and training and based on and advanced through research. However, in practice this integration is not be as robust across all jurisdictions. An important factor for integration is that it must be supported in underlying policies with clear lines of responsibility for implementing policy in practice.[13] Just as emergency planners develop EOPs that incorporate a component for pandemics, they must also incorporate a behavioral health component.

SAMHSA has taken a comprehensive approach to providing guidance to states that simplifies the task of developing an emergency plan for disaster behavioral health. *TAP 34: Disaster Planning Handbook for Behavioral Health Service Programs* is SAMHSA's most recent technical assistance publication, updated in 2021.[14] It provides guidance for mental health and substance use disorder treatment programs wanting to develop or update a comprehensive, scalable, and flexible disaster plan. It addresses planning needs specific to programs that offer prevention services, outpatient or residential treatment, medically supervised withdrawal, and pharmacotherapy. In addition, SAMHSA developed a disaster kit to arm disaster recovery workers with materials that aid in responding effectively to the public during and after a disaster, and in dealing with any accompanying workplace stress. Other materials include supporting seniors, tips for healthcare professionals, trauma-informed care materials, and a disaster smart phone app. Finally, SAMHSA provides free disaster technical assistance, training, and consultation

efforts to help states, territories, tribes, and other disaster behavioral health providers plan for and respond effectively to mental health and substance use needs related to disaster events.[15]

COVID-19 Challenges for Behavioral Health and Future Directions

In conventional natural disasters, technological accidents, and intentional acts of mass destruction, a primary mental health concern is PTSD arising from exposure to trauma. Experiencing a pandemic was not contemplated to meet the current criteria for trauma required for a diagnosis of PTSD in the most formal sense, even though the experience of the pandemic can be considered traumatic in a general sense. However, one would expect other psychopathology, such as depressive and anxiety disorders, which have been fairly common sequelae.[16] Unlike an acute traumatic stressor that has a discrete beginning and end, the COVID-19 pandemic is an ongoing event that has the potential to cause chronic stress. Chronic stress causes the body to stay in a constant state of alertness, despite being in no immediate danger. Prolonged chronic stress can disturb all major systems in the body (e.g., immune, digestive, cardiovascular, sleep) and can increase risk for psychiatric disorders and some physical disorders such as cardiovascular diseases and diabetes.[17] Widespread trauma-informed care, which involves first recognizing that trauma is common among individuals, serves both in the immediate crisis and as a preventative measure against unforeseen future traumatic contexts.[18]

In its analysis of the current COVID-19 pandemic, UNICEF identified several potential negative consequences for children and adolescents, including the increased risk of child maltreatment and exposure to violence.[19] The necessary public health strategies employed, including confinement and school closures, have underlined the hurdles of current protective systems to offer services to support vulnerable families and provide targeted and effective services to meet their needs. Leaders have already and will continue to make efforts to assist children and families by understanding what puts individuals at higher risk for traumatic stress, as well as adopting stress mediation strategies.[20] A trauma informed approach may never have been so important as during a pandemic to promote the health and well-being of all and to protect our marginalized populations at greatest risk.

Despite efforts that have been made in behavioral health emergency planning and integration into all hazards planning, many challenges remain in order to achieve the best possible responses. Additionally, many new lessons have emerged after the COVID-19 experience that can inform future disaster preparedness. These include the following:

1. **Safety as a primary concern of providers.** Staff and client safety related to infection control were critical to the ability to provide behavioral health treatment. Initially, safety guidance for protocols, social distancing and COVID-19 testing was not widely available or accessible. Personal protective equipment shortages and shortages of cleaning and sanitizing products added to cases and exacerbated fear. Testing supplies and strategies took time to become widely available. A well-operating manufacturing and supply chain would prevent these shortages in the future.

2. **Increased recognition of the significant psychological impacts of disasters.** According to a recent study, the prevalence of PTSD six years after a disaster was 11.3%, and the previous baseline prevalence was 4.2%, with onset mainly within 1 month and remission within 3 years

post-disaster.[12] During COVID-19 providers identified major problems with business operations, service provision, telehealth, client concerns, staff concerns, supplies, technology, illness/grief/loss, and communications.[21] In addition, safety concerns surfaced related to child abuse, intimate partner violence, and substance abuse.[22]

3. **Need for integration of appropriate disaster behavioral health interventions and services into all phases of emergency management.** Some lessons learned from COVID-19 include the need for a cultural change for emergency planners from that of a medical response/public health response to one that fully appreciates and integrates behavioral health concepts. This includes responses to mitigate mental health impacts and incorporate planning for behavioral health populations. In short, acknowledging that behavioral health is part of public health.[23] However, this will need to be facilitated by national policy that establishes the joint roles and responsibilities between behavioral health and public health.

   Engaging all facets of the community from political leaders, faith-based institutions and community members would assist in addressing local concerns.[24]

4. **Limited access to providers, medication and other evidence-based therapies**. Existing problems with lack of access to care were exacerbated by pandemic-created demand. Behavioral health professional workforce shortages and geographic imbalances in available care became increasingly problematic as case counts and fear continued to rise. Access to effective medication and other evidence-based therapies for individuals was difficult due to manufacturing and shipping delays. There is a Strategic National Stockpile of medications to be used in emergencies. During the annual reviews of SNS formulary policy recommendations, it has been strongly suggested that psychotropic medications be included in the SNS.[25] To provide necessary access, it should incorporate a full range of psychoactive and SUD medications. Behavioral health issues related to the pandemic will continue into the future for those with behavioral health conditions or those whose conditions emerge during the disaster. Therefore, sustainable behavioral health treatment and simplified referral pathways must be available and continue beyond the emergencies.

5. **Telehealth and remote service provision.** Telehealth, which ultimately has included telephonic and video technology, was exceedingly helpful in solving many safety, access and workflow concerns. However, provider access was initially hampered by telehealth regulations. Access by clients was hampered by those who had limited access to technology and reliable internet services or had difficulty utilizing the technology. Utilization of the technology by staff without adequate training was also problematic. Other related problems that were reported included requirements for HIPAA compliant platforms and emergency exceptions to some of these restrictions and an inability to access electronic medical records. These created challenges to business operations and consumers initially, but regulation waivers and training eventually resolved these issues, and it quickly became invaluable. Actions taken now to unify regulations, simplify technology, expand internet access and provide training will serve us well in the future.

6. **Challenges in anticipating and meeting needs of priority populations.** Early determinations of populations anticipated to sustain the greatest negative impact, i.e. priority populations, and

how to reach out to them could have had the potential to reduce negative outcomes. As COVID-19 was increasing in prevalence, it was becoming clear that congregate living facilities were being impacted quickly, such as nursing homes, some state psychiatric hospitals, jails and prisons and others. Other priority populations often include individuals with existing mental health, developmental disabilities, and substance use disorders, as well as health care workers,[26] first responders, marginalized populations, older adults and children, among others. Preparedness that includes planning across settings for these populations is needed.

7. **Financial concerns of providers and consumers.** Financial relief for providers made available by various government agencies was helpful, but vehicles to make it available more quickly would also be beneficial. A survey conducted by The National Council for Mental Wellbeing reported that behavioral health providers on average lost 24.3% of revenue. Organizations with more diversified payment methodologies (e.g. Prospective Payment System) managed better financially.[27]

   Assistance with client loss of income that could have been used to pay for services also arrived slowly. The DHHS Office of the Inspector General's ability to reduce or waive beneficiary cost sharing for federal health care programs was impactful for Medicare and Medicaid beneficiaries.[28] However, some consumers faced unpaid insurance claims because their private or employer-based health insurance coverage violated the provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) by providing lesser coverage for behavioral health benefits than for physical health.[29] Parity compliance and enforcement programs should be supported and coordinated with state authorities as appropriate to avert this problem in the future.[30] Policy makers must take steps to improve access including the continuation of policies implemented during the pandemic, such as insurance coverage for telehealth, copayment waivers, and license reciprocity to enable telehealth across state lines.

8. **Vaccines and hesitancy/refusal among persons with mental illness**. Many organizations have spoken out on behalf of individuals with mental illness to encourage vaccination prioritization. The British Medical Journal suggested that extra support would be needed as individuals living with mental health challenges have a historically low uptake of preventive health programs, such as the influenza vaccine.[31] They expressed concerns that this population may simply get left behind because the nature of mental illness can stigmatize and impact sufferers' ability to speak and be heard. They suggest that prioritization is justified because within the larger population of those with serious mental illness there is considerable multimorbidity putting them at higher risk for COVID-19.[32] During the pandemic, then American Psychiatric Association called on state public health authorities to include people with serious mental illness and substance use disorders in the high-risk priority categories with individuals over 65 years-old and those with high-risk medical conditions ages 16-64.[33] Solutions offered to improve vaccination rates are to embed vaccination clinics within mental health services, provide direct access to existing immunization registries which assists in both monitoring and coordination and/or to develop emergency legislation to allow for a wider group of health care professionals to administer the vaccinations.[34]

State Behavioral Health System Leadership in Disaster Behavioral Health

Governors and their senior health and human services leadership play an essential role in incorporating a behavioral health strategy into the states' COVID-19 response and recovery approach. There are many key issues that are currently challenging state behavioral health systems. Some of these include challenges in maintaining access to treatment and services due to workforce shortages. Flow through systems is frequently impeded such as is seen with emergency department boarding, waitlists for admissions into state hospitals, waitlists for community placements and appointments for psychiatrists and other services. All of this is under the pressures of seemingly endless increasing demand for services. It will be critical to continue to advocate for flexibility of policies, program rules, and regulations, such as pursuing federal waivers for provider qualifications, telehealth coverage, prior authorization requirements, and where services can be delivered. Additionally, providing guidance, training, support, and resources (e.g., purchasing virtual meeting licenses and equipment) for behavioral health providers will be an ongoing need as the workforce shifts to flexibly modalities on a more long-term basis. Ongoing technical assistance for capacity building will be critical. There will be an ongoing need to continue to ensure that behavioral health system needs are among the priorities for federal funding and policy development. Many of the issues identified are still emerging and state and federal actions will require ongoing research to identify opportunities and follow up to determine outcomes.[35] To that end, it is critical for leadership within the behavioral health system to have a seat within policy conversations. COVID-19 has provided an increased opportunity for these partnerships to continue to forge a path forward.

Recommendations for the Post-COVID-19 future

1. **Bolster the integration of disaster behavioral health into public health emergency preparedness and response.**

   The strength of a public health system rests on its capacity to effectively deliver the 10 Essential Public Health Services specifically laid out by the CDC and revised again in September 2020 to more specifically aim to address the needs to "protect and promote health of *all people in all communities*," while removing structural barriers. The identified services include:

   1) Assess and monitor factors related to public health
   2) Investigate, diagnose and attend to population health problems
   3) Communication to inform and educate
   4) Strengthen, support and mobilize communities
   5) Create, champion and implement policies, plans and laws
   6) Utilize regulatory or legal actions to improve public health.
   7) Enable equitable access to services
   8) Enhance and sustain a diverse capable public health workforce
   9) Improve functioning through evaluation and research
   10) Build and maintain public health infrastructure.[36]

   The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities. Behavioral health system leaders, along with

public health leaders, are increasingly recognizing that behavioral health is a subset of public health and as such behavioral health should assess which of the 10 Essential Public Health Services may need strengthening to best serve individuals with behavioral health needs.

2. **Attend to health equity with specific efforts focused on the needs of high-risk populations**.

SAMHSA defines behavioral health equity as the right to access quality health care for all populations, regardless of the individual's race, ethnicity, gender, socioeconomic status, sexual orientation, or geographical location.[37] This includes access to prevention, treatment, and recovery services for mental and substance use disorders. In March 2021, the CDC announced a plan to invest $2.25 billion over two years to address COVID-19-related health disparities and advance health equity among populations that are at high-risk and underserved, including racial and ethnic minority groups and people living in rural areas. This funding represents CDC's largest investment to date to support health disparities in communities affected by COVID-19. Behavioral health services, both in-person and remote, are included in this funding as they are considered clinical care.[38] In addition to the CDC funding, the American Psychiatric Association (APA) has made specific recommendations advocating for more public health funding especially for vulnerable populations and eliminating racism in the justice system. In addition, the APA guidance called for education about intrinsic bias against persons with mental illness and minority populations, as well as reduced bureaucratic and logistical barriers to healthcare access including helplines, telehealth/Internet access, among others. served.[39] These tenets reflect important strategic direction to address the needs equitably for diverse populations.

3. **Conduct mass psychological distress screenings and opportunities to provide emotional support.**

In addition to providing medical care, already stretched health care providers have an important role in monitoring psychosocial needs and delivering psychosocial support to their patients, other health care providers, and the public. These activities should be integrated into general pandemic health and there should be widespread information sharing about emotional responses to disaster and supports available. Efforts by SAMHSA, through its Disaster Technical Assistance Center, in partnership with FEMA have helped infuse these types of resources and supports through a variety of grant mechanisms, including the Crisis Counseling Program grants.[40] These funding streams have provided tremendous opportunities for states to help support their communities through the emotional challenges with the pandemic. As these supports are available, following psychological distress screenings, support opportunities could be and have been offered at vaccine sites, in offices upon return to work and school and with special emphasis on high-risk groups, and as a sustainable model. This would create easy accessibility and maximize the number of individuals who could benefit. Providers conducting the screenings can offer suggestions for stress management and coping (such as structuring activities and maintaining routines), link patients to social and mental health services, and counsel patients to seek professional mental health assistance when needed.[41]

4. **Continue to promote behavioral health surveillance and research**.

Prioritization of behavioral health surveillance and research through monitoring and collection of quality longitudinal data will inform public health policies and disaster planning for the future. Although standard surveillance techniques such as daily and cumulative infections and deaths from

COVID-19 have been helpful, they provide a static view of what has already occurred. Trends in clinical outcomes will provide a look into how effectively care has been provided. Deaths by suicide, hospital admissions and readmissions, COVID-19 infections, improved symptom management, reduction in symptoms and critical incident reports, each yield data that can lead to ongoing policy and programmatic activity for improvement.[42] The U.S. Census Bureau Pulse Household Survey had been conducted weekly or every two weeks and throughout the pandemic findings have been available on mental health symptoms, services and vaccination behaviors. It provides a point in time view but knowledge such as reasons for "not receiving the vaccine or not planning to" and "prevention actions among the vaccinated" are examples of data that would be helpful in planning as they explain thought processes and point us to barriers. Collection of varying levels of local and national data can help inform areas where mitigation measures may be most impactful.[43]

Although most people with COVID-19 recover, another lesson learned leading to considered thought for the future relates to the" COVID long-haulers" experiences with COVID-19 Syndrome. This condition is associated with longer duration and lingering symptoms that look different from acute COVID-19 and can include persistent somatic symptoms including brain fog, fatigue, headaches, dizziness and shortness of breath, among others. Individuals with this syndrome can experience mental health symptoms such as anxiety, depression and PTSD. Ongoing surveillance and research will be needed to understand these types of long-term impacts.

5. **Foster communications focused on behavioral health needs.**

    After action reports are generated by emergency managers following every emergency event to analyze how well an emergency was handled and to use feedback to improve future responses. These reports often reveal that roles, responsibilities and problematic communication can be common sources of confusion.[44] The efficacy of the response to COVID-19 has in part depended on the speed, scale and consistency of governmental intervention and communication, but also how communities have received, perceived, and acted on the information provided by governments and other agencies. The communication of information by government and receipt of information by the public has been complicated by the ever-changing nature of a pandemic, where new scientific information becomes available and the variability and trustworthiness of information sources. Government agencies must coordinate messaging to remove ambiguity.

    Pandemic risk communication requires ongoing engagement with communities as effective communications and leadership are crucial to the management of pandemics and the rapidly changing societal and economic landscape. It takes transparency, civic engagement and development of trust in order to effectively communicate. Engaging in clear communication is essential to provide specific information on what to do and what to avoid, which can reduce anxiety and maintain order.

    Leaders should also listen to the community's needs and concerns. Communication should be adjusted to consider variations in health literacy and understanding of numbers across audiences, It is vital to recognize that communities may not be affected by a pandemic in the same way and to the same degree. For example, people with disabilities have specific and varied needs and others may have linguistic needs. Because the pandemic has also seen a surge in misinformation and confusing messages, transparently providing factual and current information prevents subsequent susceptibility to emerging misinformation and conspiracy theories.[45] At the same time as

information about public health issues is shared, there should be ongoing attention to communicating about resources to help alleviate anxiety, answer questions and point people to distress supports. This became evident with the increased volume of activity for the Disaster Distress Helpline when the pandemic was emerging.[46]

6. **Attend to the mental health of health care workers**.

    Health care workers including first responders were particularly vulnerable to emotional distress during the pandemic given their risk of exposure to the virus, concern about infecting and caring for their loved ones, initial shortages of personal protective equipment, longer work hours, and involvement in emotionally and ethically fraught resource-allocation decisions. Prevention efforts such as screening for mental health problems, psychoeducation, and psychosocial support should focus on health care workers and first responders at risk for adverse psychological outcomes. Previous research suggests that health care workers suffer from mental distress during and even years after previous epidemics.[47] Therefore, attending to the mental health of health care workers during epidemics should include universal screenings, early interventions, long term follow up, support groups, expansion of resources and employer programs that teach coping strategies.

7. **Continue to build telehealth capacity**.

    Behavioral health professionals were thrust into telehealth as a matter of safety and necessity as the pandemic grew. Many embarked enthusiastically on this adventure but with little experience. A telehealth resource center in Minnesota cleverly developed "Telehealth in a Public Health Emergency: A Quick-Start Guide" with topics covering definitions, modalities, and basics of delivering psychotherapy and other specialty mental health services.[48] As telehealth will continue and expand, and with the knowledge and confidence that providers have obtained thus far, telehealth policy should be reformed. Utilization of telehealth necessitates a thorough review to identify obstacles (e.g. regulations, insurance) and opportunities (e.g. license reciprocity across state lines, expansion of coverage and amending beneficiary cost sharing).

8. **Continue to foster training on aspects of disaster behavioral health**.

    Mitigation works best when behavioral health care training is consistent with critical importance of disaster behavioral health themes and efforts in the overall response**.** Standardized training based on core curricula will prepare a cadre of qualified, trained professional counselors and paraprofessional outreach workers to respond to the psychosocial needs of impacted individuals and communities.[49] The SAMHSA Disaster Technical Assistance Center, for example, created the Just in Time training to provide training about emotional responses and how to address them (https://www.samhsa.gov/dtac/ccp-toolkit/just-time-web-based-training). Since the populations with the greatest need for services are people of color and other marginalized populations, it is time to add cultural and linguistic needs to the training curricula. It will also open the door to a larger workforce with more relevant and improved skills to care for a population that has been underserved.

9. **Maximize continuity and access to treatment for behavioral health populations**.

    The COVID-19 pandemic has complicated the continuous administration of individuals with behavioral health disorders with medication needs. This includes medication assisted treatment for

substance use disorders to individuals with opioid use disorders. and needed laboratory analyses for individuals on medications such as Clozapine or Lithium. Given the need for face to face visits for blood draws and other assessments, providing these medications became challenging. However, necessary flexibilities have been put in place by SAMHSA and other Federal entities to help ameliorate these challenges during this public health emergency. For medication assisted treatment, these actions include ongoing work with the Drug Enforcement Agency to ensure consensus around prescribing/dispensing opioid therapies, telehealth flexibilities, and mid-level practitioner clinical responsibilities.

10. **Continue efforts to expand and develop a robust crisis care system.**

COVID-19 has stretched the behavioral health crisis response system beyond what was ever imagined. Since it is anticipated that the pandemic will continue for some time, even in an attenuated state, a good preventive measure would be to improve the structure and capacity of our crisis services and crisis systems of care. This would include more and better linkages to the soon to emerge 988, re-routing of behavioral health calls from 911. A sea change is on the horizon with countless communities around the country working toward shifting crisis responders from police officers to behavioral health professionals, re-routing of individuals experiencing a crisis away from emergency departments to crisis stabilization centers, and improving community capacity to avert or lessen the number of crises through prevention efforts.[50] Whether in the context of COVID-19 or beyond, it is now clear that the role of crisis services must include operations to provide support in the context of a disaster. Planning these services with disaster behavioral health elements in mind will set the stage for much needed preparedness.

Conclusion

The spread of COVID-19 highlighted the importance of transforming behavioral health care. This unique virus presented a unique threat, and its aftermath will be just as unique and is still unfolding. The importance of immediate efforts focused on prevention and direct intervention continue to be needed to address the impact of the pandemic on individual and population level behavioral health. The pressing question is what have we really learned from this experience? Will we continue taking actions from lessons learned? Who is planning for the next pandemic so that our response is nimble, very well communicated, better coordinated and overall more effective? This paper in part aimed to document some of the lessons learned and potential avenues for future direction. We owe it to those we lost, to those who are currently ill or dying, and to those who could become victims of the next pandemic to take stock and keep improving in the field of disaster behavioral health.

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