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.

Emergency 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 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.

> 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.

Overview of Disaster Preparedness

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Table 1: Five phases of emergency management planning cycle and 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,0aqse0de

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

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 headac

efforts to help states, territories, tribes, and other disaster behavioral health providers plan for and

post-disaster.[12] During COVID-19 providers identified major problems with business operations, service provision, telehealth, client concerns, staff concerns, supplies, technology,

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

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.

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SAMHS

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]

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]

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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.

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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).

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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 an(s)-1.3 (e)-3c 6 (t)-61.859 0 Td(-)Tj7i1 Tw 0.304e 0 Td(an)2.Tw 11.hb(web).3 (.io)1.3 (m)-9.2T

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