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Untapped Potential: Local Health Departments' Involvement in Behavioral Health Preparedness Planning and Recovery through a Population Behavioral Health Framework

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Abstract

Due to the COVID-19 pandemic, there is an increased demand for behavioral health services in an already strained public health system. Thus, there is a critical need to shift to a population behavioral health framework to address the scope and magnitude of the behavioral health crisis. Local health departments (LHDs) are positioned and purposed to assist in this work by implementing behavioral health surveillance, prevention, and early intervention strategies. Two surveys conducted by the National Association of County and City Health Officials (NACCHO) were used for this analysis, the 2018 *Preparedness Profile* survey and the 2020 *Forces of Change* survey. In 2018, a little over half of LHDs involved behavioral health groups in their planning coalitions, and three-quarters of LHDs addressed behavioral health in preparedness planning. However, in 2020, LHDs implementing a behavioral health response during COVID-19 was substantially lower than the planning phases: strategy to support the public health system, including behavioral health (20%); specific initiative for individuals with behavioral health needs (48%); or targeted messaging for people with behavioral health needs (25%). The findings of this analysis indicate that as of 2020, LHDs' involvement in behavioral health is still minimal and the potential for LHDs to reduce burden on the public health system is not being maximized. For LHDs to provide more behavioral health services they will require support in the form of funds, technical assistance, education on best practices, and the support and authority to expand services in behavioral health.

Introduction

Behavioral health is not only critical in the planning phase for emergencies but also crucial for successful recovery strategies.[1] Prior research on natural disasters and pandemics emphasizes the need to prioritize behavioral health in response efforts,[2] which is applicable given the current and ongoing COVID-19 response. In 2011, the Centers for Disease Control and Prevention (CDC) released the *Public Health Preparedness Capabilities: National Standards for State and Local Planning*[3] and in 2018 these preparedness capabilities were

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updated.[4] Of the 15 standards for emergency preparedness, 11 mention behavioral health; indicating the significance and overlap between the two fields.

There is an ongoing discussion regarding behavioral health as a public health concern concomitant to the work concerning behavioral health in the context of emergency preparedness. Researchers[5,6] and professionals, such as the American Psychological Association,[7] emphasize the need to implement a population behavioral health framework. A public health approach to behavioral health, henceforth referred to as a population behavioral health framework, shifts the focus from an individualized clinical response to an up-stream approach, with prevention, early identification, and system-wide solutions. The framework does not intend to replace crisis care, but rather reduce the number of individuals requiring that level of care by prevention and early mitigation.

Many communities have local behavioral health departments, which are government entities tasked with providing behavioral health services to community members. Purtle and colleagues[8] point out that these entities do not have the capacity or power to implement population-based interventions. Concurrently, local health departments (LHDs) are designed to promote health and wellbeing at the community level. Thus, LHDs are purposed and positioned to effectively perform population behavioral health strategies. However, LHDs have expressed concern over infringing on the local behavioral health entities' territory when providing behavioral health services.[9] Other barriers cited by LHDs regarding a provision of behavioral health services include limited resources and a lack of knowledge and data.[7] Behavioral health integration in LHDs is uncommon; the nationally representative 2019 *National Profile of Local Health Departments*[10] found that only 17% of LHDs directly provide population-based programs and services in mental health.

The COVID-19 pandemic has resulted in numerous impacts to behavioral health, including but not limited to financial distress, isolation, illness, staffing shortages, and negative consequences to well-being. Now more than ever the demand for behavioral health services is overwhelming a strained system.[11] The current method of a clinical, individualized approach will leave many community members without care. Thus, a population behavioral health approach needs to be implemented without delay due to the scope of the problem.[12] LHDs are positioned and designed to successfully assist with the implementation if given the correct support. As Levy and colleagues write about uniting to improve behavioral healthcare, "there is more than enough work to go around, and without teamwork, integration will flounder. We need each other…".[6]

Methods

This analysis relies on two surveys conducted by the National Association of County and City Health Officials (NACCHO). The first is the 2018 biennial *Preparedness Profile* survey conducted with a sample of LHDs. The *Preparedness Profile* survey offers a snapshot of the LHD environment and status prior to the COVID-19 pandemic. Additionally, data from the 2020 *Forces of Change* survey, which focused on the LHD's COVID-19 response and recovery, provides a more recent and specific assessment around COVID-19.

Surveys and Sampling

Data from two surveys (NACCHO 2018 *Preparedness Profile* and NACCHO 2020 *Forces of Change*) were examined for the present analysis. Each survey was administered electronically through Qualtrics. The *Preparedness Profile* survey was distributed to a stratified random sample of 910 preparedness coordinators or top executives, with strata defined by the size of population served by the LHD. Data was collected from January to March 2018 (n = 387; response rate = 43%). The *Forces of Change* survey was distributed to a population of 2,392 LHDs. All LHDs in the study population received a common core set of questions from November to 2020 to March 2021 (n = 583; response rate = 24%). In addition to the core questionnaire sent to the population of LHDs, a stratified random sample of 905 LHDs were invited to complete a module questionnaire on topics such as pandemic preparedness, recovery, and equity, with strata defined by the size of the population served by the LHD (n = 237; 31% response rate).

Survey Weights

Statistics were computed using survey weights to adjust for oversampling and non-responses; for the *Forces of Change* survey, separate weights were computed for core questions and the module questionnaire. By using these survey weights based on size of population served, the present analysis provides national estimates for all LHDs in the United States.

Findings and Discussion

The 2018 *Preparedness Profile* survey inquired about partnerships with behavioral health providers and strategies to address behavioral health populations in preparedness planning. Table 1, below, summarizes the findings. Involvement of behavioral health groups in the LHD planning coalitions ranged from 55% to 64%, increasing by LHDs serving larger population sizes. Additionally, LHDs addressing behavioral health in preparedness planning ranged from 72% to 88% stratified along the size of the population served by the LHD.

As outlined by CDC's *Public Health Preparedness Capabilities*, behavioral health needs to be interwoven into preparedness response. Thus, the 2020 *Forces of Change* survey included questions specifically inquiring about the intersection of behavioral health and preparedness planning, recovery, and special populations considered for COVID-19 work. It is critical to note that 35% of LHDs did not have a recovery plan in place for COVID-19 at the time the survey was administered. Table 2 summarizes the three questions regarding behavioral health in the 2020 *Forces of Change* survey. All behavioral health activities remained below 50% except for large LHDs, a majority of which prioritized or developed targeted initiatives for behavioral health (61%).

In 2018, 58% of LHDs included behavioral health groups in their preparedness management coalitions. Yet in 2020, 20% of LHDs had a strategy to support community systems, including behavioral health, in their COVID-19 Recovery Plan. Additionally, three quarters of LHDs addressed behavioral health in preparedness efforts in 2018, but in 2020 less than

half of LHDs had developed initiatives to address behavioral health conditions and only one fourth implemented targeted messaging.

The juxtaposition between including groups within planning coalitions and implementing a strategy for behavioral health community systems likely reflects barriers in creating a recovery plan, collaborating with behavioral health groups, or creating solutions to improve and sustain behavioral health systems. The low percentage of LHDs implementing behavioral health initiatives or targeted messaging implies that LHDs encounter challenges when moving from the preparedness plan to developing initiatives to address behavioral health. These findings are important because excluding or passing over behavioral health within the preparedness response threatens the most vulnerable community members by not providing necessary care in the heightened time of need.

As indicated in Tables 1 and 2, fewer of the small population serving LHDs included behavioral health partners in preparedness planning or offered behavioral health initiatives. The least amount of variance was the involvement of behavioral health representatives on planning coalition (9% difference) and the greatest difference was the development or implementation of a strategy for health systems, including behavioral health (20% difference). The reduced consideration for behavioral health within preparedness planning and recovery increases the risk for possible negative implications for community members.

Public health has become increasingly politicized in the United States throughout the COVID-19 pandemic. LHDs face legal and political limits on expanding their scope of activities. The *New York Times*[13] reports that in 32 states new laws restrict the power of LHDs for COVID-19 responses in some capacity. As political powers aim to curb or reduce LHD's work this could inhibit LHDs from implementing a population behavioral health framework.

As aforementioned, in the 2019 *National Profile* survey, less than one fifth of LHDs provided behavioral health population services. The 2020 *Forces of Change* data shows that there has been a small increase of behavioral health strategies developed and implemented by LHDs; however, the percentage of LHDs remains far below 50%. As such, LHDs will require support in the form of funds, technical assistance, and share best practices to expand their behavioral health services more widely.

Limitations

While the survey datasets examined in the present study are unique sources of information on preparedness and public health practice at the local level, this study is not without limitations. First, the surveys were self-reported data from LHD staff and NACCHO did not independently verify the data provided. LHDs may have provided incomplete, imperfect, or inconsistent information for various reasons. Some of these reasons could include skipping questions due to time constraints, estimating responses to reduce burden, or interpreting undefined questions or response options differently.

Conclusion

Two major surveys conducted by NACCHO indicate that LHDs' involvement in behavioral health is still minimal and the potential of LHDs reducing the burden on the behavioral health system is not being maximized. Expanding services through a population behavioral health framework is more critical than ever before given the increase in demand for behavioral healthcare during the COVID-19 pandemic. A successful response will require a wholistic, community approach. LHDs are positioned and purposed to respond to this call through existing partnerships with community members and local organizations, as well as their prevailing community level work in public health.

For LHDs to reduce this burden, policies will need to be implemented that allow LHDs to develop and provide the needed behavioral health surveillance, prevention, and early intervention strategies. Moreover, support to aid LHDs in this work will be critical to the success—assistance such as disseminating best practices as well as funding to develop and sustain the work. Including behavioral health in the COVID-19 recovery is critical for public health and successful COVID-19 recovery.

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Table 1:

2018 Preparedness Profile Behavioral Health Planning Efforts

	All LHDs	Size of Population Served by LHDs		
		<50,000	50,000–499,000	500,000+
Behavioral/mental health groups are represented in the LHD preparedness planning healthcare coalition (n = 371)	58%	55%	62%	64%
LHD addressed people with behavioral/ mental health disorders in preparedness planning efforts (n = 378)	75%	72%	77%	88%

Table 2:

2020 Forces of Change Behavioral Health COVID-19 Planning, Recovery, and Health Equity

	All LHDs	Size of Population Served by LHDs		
		<50,000	50,000–499,000	500,000+
Developed or implemented in the COVID-19 recovery plan a strategy to support recovery operations of public health and related health systems in the community (i.e. hospitals, long-term care facilities, mental and behavioral health) (n = 203)	20%	14%	23%	34%
Prioritized or developed targeted initiatives to address anxiety, depression, or other behavioral and mental health conditions (n = 225)	48%	45%	48%	61%
Prioritized targeted, specific messaging for people with mental/behavioral disorders (n = 234)	25%	22%	27%	34%