

Policy for Mental Health Support for Healthcare Disaster Responders

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Under the Supervision of

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A DNP Project Manuscript
Submitted in Partial Fulfillment of the Requirements for the
Doctor of Nursing Practice Degree

School of Nursing, University of Maryland at Baltimore
May 2025

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We have no conflicts of interest to disclose.

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Abstract

Problem: Organizations for disaster response require policy analysis regarding support for the mental health of operational and deployment forces to ensure the safety, resilience, and retention of those forces. The gap between forces and mental health support can result in decreased recruitment, increased attrition, and sudden, expensive deployment team changes. Evidence exists demonstrating that repeated deployments are correlated with psychiatric consequences.

Purpose: The purpose of this quality improvement project is to conduct a policy analysis of current mental health provisions among deployed disaster responders following the CDC Policy Process framework. **Methods:** This project gathered an environmental scan of experts in support for disaster response to obtain policy advice for disaster relief organizations. This project assembled the responses of 11 stakeholders in the mental health field who are responsible for force protection. Experts were identified in disaster response organizations, and interview questions were developed based on existing evidence. Interviews were conducted via video, and Research Electronic Data Capture (REDCap) was used to store the answers anonymously and securely. Data was collected on current mental health support policies and analyzed using the CDC Policy Analysis Tool to identify direction and common themes. **Results:** Data indicates a diversity of approaches between organizations on best practices for mental health support. The themes identified included embedded mental health care in disaster teams and response to the individual needs of team members on the ground. **Conclusions:** Experts across disaster relief organizations indicate that modifying current policies or creating new policies is the correct direction for disaster relief organizations and that the current policy is not sustainable.

Keywords: force health protection, disaster response, healthcare workers, resilience, mental health, policy analysis

Policy for Mental Health Support for Federal Healthcare Disaster Responders

Introduction

Mental health issues such as depression, anxiety, and PTSD that healthcare providers face as a result of deployments for disasters impact the workforce, their families, and the ability of an agency to fulfill its mission (Palm et al., 2004; Arceneaux et al., 2020). Frontline workers in disasters have an increased exposure to morally injurious events associated with increased psychological distress (Ehman et al., 2023). Adverse events that can result from a lack of support for disaster responders include an impact on decision-making and performance, professional burnout, an impact on systems outside the workplace, and mental and physical health implications (Jacobowitz et al., 2024; Siviy, 2022). Further, workforce retention and recruitment among public health workers have been negatively impacted by the COVID-19 pandemic, which threatens the sustainability of disaster healthcare response (Stone et al., 2021). Agencies deploying healthcare workers to disasters need a baseline policy for mental health support.

The gaps in the need for mental health support for disaster healthcare responders are addressed in the themes of Stigma, Logistical and Resource, and Systemic and Cultural (Khoo et al. 2021; Chen et al., 2023; Kaplan and Smith, 2022; Arceneaux, 2020; Ma et al., 2020; Russell et al., 2022). These interwoven causes create a fear of judgment for seeking help, a “toughness” narrative, concerns about privacy, and a sense that there is not enough time or that the workload must be placed at a higher priority than mental healthcare for the responder (Wright et al, 2022; Jones et al., 2020). These themes were accumulated into a Fishbone diagram (Appendix A) illustrating the disconnect between responders seeking help and the available solutions, and indicating that a policy is needed to bridge the gap between responders and services.

Available Knowledge and Specific Aims

This project aimed to ensure disaster relief workers can access mental health services by generating policy guidance. To ensure an evidence-based foundation, studies were identified by searching databases using the University of Maryland OneSearch tool, which includes PubMed.gov, CINAHL, Micromedex, PsycINFO, and Google Scholar, as well as others listed in “What’s Included in OneSearch?” (2024). The search proceeded as follows: the search terms used were “deployment,” “disaster,” and “healthcare OR health care OR hospital OR health services OR health facilities.” The results were limited to peer-reviewed studies, and the studies were limited to the years 2018 to the present, as well as only English language. The search path is documented in PRISMA format in Appendix B. After eliminating articles that were not related to healthcare or did not have comparable populations, thirteen sources were located with pertinent studies addressing this population and issue. Eleven of these studies were assessed using the Johns Hopkins Evidence-Based Practice model and were considered level III, while one was level II, and one was level IV (See Citation Appraisal, Appendix C) (Dang et al., 2022). The specific aim of this search was to demonstrate that evidence-based solutions exist on which to build policies.

Rationale

Themes were identified from the research to guide policy creation. These themes include deployment environment, moral distress, peer support, number of deployments, length of deployment, personal relationship to the disaster, and family communication (Arceneaux et al., 2020; Chen et al., 2023; Khoo et al., 2021; Nagamine et al., 2018). Strong evidence for the issue of family communication was provided by Arceneaux et al. (2020), supplementing the clear statement of the problem of mental health consequences by Chen et al. (2023). Feasibility and

effectiveness of peer interventions were the focus of Albott et al. (2020), which also demonstrates evidence-based interventions undertaken by the military. This evidence is echoed by Brace and Kennis (2023). Evidence of the problem of mental health, burnout, and moral distress is available in the aftermath of the many deployments during the COVID-19 pandemic (Khoo et al., 2021; Kaplan et al., 2022; Morganstein & Flynn, 2021). The themes and evidence are summarized in the evidence synthesis table in Appendix D. The literature located through this search offered evidence that solutions a) are needed for the problem addressed by this project and b) are emerging through disaster response research, indicating there are solutions around which to develop policy.

Theoretical Framework

The Centers for Disease Control (CDC) Policy Process was chosen as the theoretical base for the investigation of this policy problem. At the center of the framework is Stakeholder Engagement and Education; this embodies the goals of a scholarly policy project through an emphasis on stakeholders as the internal motivators for change as well as the experts in the context of disaster response (See Appendix E). The CDC policy process provides robust guidelines for evaluation, including utility, feasibility, propriety, and accuracy, ensuring that policies in development meet the needs of the organization while still being within the bounds of implementation. This framework will provide a path toward policy enactment and implementation beyond the scope of this project (CDC, 2019). A key step within the CDC Policy Process is the environmental scan (“A proactive, systematic collection of information about events, trends, and expectations”), which this project addresses (CDC, 2019). The environmental scan was used to accumulate the evidence needed to inform policy direction and guide decisions (Charlton et al., 2021). Once the environmental scan was completed, the CDC Policy Analysis

Table, a set of questions for assessing policy options, or a Policy Audit Tool (Appendix F) was used to interpret the answers provided (CDC, 2019). This tool categorizes questions into framing questions, public health impact, feasibility, and economic and budgetary impacts. The CDC Policy framework worked for this project because it provides a systematic process for policy analysis described in domain 2 of the process (CDC, 2024b).

Methods

Context

The selected site for project implementation was a Disaster Response Stakeholder Group (DRSG), which provides public health resources and medical support during disaster events via specialized deployment teams. Federal disaster response agencies were identified by the Government Accountability Office (GAO) as being at a high risk of inability to perform based on bureaucracy and regulatory requirement issues (GAO, 2023). The criteria for organizational health are demonstrated in The National Academy of Public Administration's white paper "Strengthening Organizational Health and Performance in Government" (2018). This also indicates agencies' challenges in diagnosing performance and using data to encourage innovative solutions. Current processes are hampered by several barriers, including procedural, logistical, and fitness for duty concerns. (See Appendix G, Current Process.)

The structural goal was to address the resources required for ensuring mental health needs are met, and the process goal was to identify the correct interventions and recommend, through policy, appropriate minimums for intervention. (See Appendix H, Desired Process). Using the Competing Values Framework, four constructs of organizational culture were identified based on internal vs external focus and flexibility vs stability. The four constructs are Hierarchy, Market, Adhocracy, and Clan (Goodman et al., 2001; Boyd & Larson, 2023). Based

on the Competing Values Framework, this DSRG is in the “Hierarchy” quadrant based on the values of emphasis on order, procedures, and structure. The “Hierarchy” construct represents bureaucracy, structure, and efficiency; it lacks the nimbleness of the Market and the freedom of the Adhocracy (Quinn & Rohrbaugh, 1983).

The intervention of this project was to apply the CDC Policy Process to provide policy guidance for the DRSR. An environmental scan was conducted via interviews with key stakeholders who are also experts in the field of disaster response, using a series of questions designed to elicit the best practices for the problem of lack of support for mental health in the population of healthcare disaster responders. Twenty organizations were identified as having compatible staff and goals with the DRSR or having experts in the field of mental health in disaster response. By June 2024, at least one expert from each organization was identified, and the site CSR and DNP Project Lead (PL) initiated contact. By July 2024, the PL established relationships with these interviewees with a timeline to complete the environmental scan; this was attainable with the assistance of site personnel. The necessary IRB inquiry and site ethical review board processes occurred between May and July 2024. Interviews were completed, and the data were entered into REDCap by the PL by December 2024.

Measures

The intervention included measurement of the project’s progress and steps toward completion in line with the CDC’s Policy Process Step 2: Policy Analysis, which defines an environmental scan as a process in which the policymaker proactively collects information about the intended policy goal systematically (CDC, 2019). Ten experts participated in the analysis interview. Key questions used in stakeholder interviews are located in Appendix I. The interview questions were reviewed with the site stakeholders to ensure comprehensiveness. The interview

questions were derived by the project lead from the evidence reviewed and stakeholder input and covered all phases of deployment and multiple approaches tested to solve the problem (Albott et al., 2020; Chen et al., 2023; Kaplan & Smith, 2022; Khoo et al., 2021). The interviews were not recorded and remain anonymized, and the PL acknowledges the inherent limitations in non-recorded interviews. Several strategies were used to prevent the loss of information and retain the integrity of the gathered data; the PL took comprehensive notes and confirmed the information collected with the interviewee. The PL entered the stakeholder interview data as recorded and approved by the interviewee into REDCap. The Project Lead (PL) synthesized the information gained from this body of experts and generated a cohesive priority list that aligns the DRSG with best practices as used and envisioned in the field of disaster management. Using the answers to these questions as guidance alongside the body of evidence for best practices, an analysis of policy recommendations was generated.

Analysis

The environmental scan of the experts provided key themes and perspectives on the central problem. The PL reviewed each interview answer and analyzed the content using the Policy Audit Tool. The PL performed a thematic analysis, and the data were compared with evidence for Quality Improvement (QI) solutions. The PL used the experts' perspectives and recommendations and generated actionable policy direction for quality improvement. The resulting policy recommendation involved synthesizing findings that offer credible, transferable policy direction. The outcome of this project is a decision to create, adapt, or continue policy within the DRSG. This paper creates an evidence-based position for the DRSG director, after which, if no further information is required and support is found, the position statement will be elevated to the DRSG leadership team for consideration of formalizing into official policy.

Ethical Considerations

Those responding to disaster may have prior experiences of trauma, prior exposure to disaster, personal proximity to the event, and previously existing healthcare needs. Some populations may have a higher risk of mental health problems as a result of disaster response. Responders are also not immune to underlying equity and health disparity issues (Couig et al., 2021; Siviyy, 2022).

The author of this policy proposal is not employed by this agency and does not receive any financial compensation from the DRSG or any agency consulted. The author does not have any personal relationships with any members of the project team, which may influence objectivity. The author's participation in this project will not result in any financial benefit. Additionally, the author's current employment will not be affected by the outcome of this project. The project was conducted under a Non-human Subject's Research determination from the Human Research Protections Office (HRPO) of the University of Maryland School of Medicine (UMSOM) Institutional Review Board (IRB). The author received training in Good Clinical Research Practices (GCP) from the Collaborative Institute and Training Initiative (CITI) program and patient privacy regulations in the United States, such as the Healthcare Insurance Portability and Accountability Act (HIPAA). Any data collected for this project was maintained confidentially and handled following ethical and regulatory guidelines. No patient data was collected as part of this project.

Results

Twenty-four expert stakeholders received invitations to participate in the process of the environmental scan. The aim was to secure 10 participants; 12 participants' interviews were completed, and 10 participants' interviews were completed adequately to generate data for

analysis. Participants shared professional anecdotes about their experience with mental health support in disaster settings, as well as knowledge of the real-life application of mental health support as it occurred in their experience. The validity and reliability of the information given is demonstrated by the participants' significant practical experience. The data obtained from this environmental scan were analyzed by the PL to determine themes present in the responses contributing to decisions regarding the creation of policy (Appendix J).

Agreement among experts brought forward several themes. Organizations need robust strategies to prepare workers for potential mental health challenges before disaster deployment. This includes education on what to expect emotionally ("what's normal to experience"), recognizing early warning signs, and fostering awareness and acceptability of mental health care. In addition to preparation, support during deployment is crucial, including embedded mental health professionals to assist personnel with issues like long shifts, lack of sleep, and exposure to death. Following return from deployment, post-crisis recovery time and support for families are also demonstrated to enhance force health protection. Individualized support tailored to team members' needs is mentioned by nearly all experts, as well as the unique tendency of these workers to overextend. Organizations should actively explore and implement evidence-based concepts and interventions like Psychological First Aid (PFA), peer support training (e.g., "Battle Buddies"), and utilize evaluation tools such as the ProQol-5 and Maslach's Burnout Inventory (Hemsworth et al., 2018; Schutte et al., 2000). A proactive organizational culture that encourages seeking mental healthcare without fear of reprisal was also mentioned frequently in the environmental survey. This can be fostered through proactive efforts that normalize seeking help as a sign of strength and build trust in the organization. Embedded mental health support was mentioned during nine out of the ten interviews as the desired policy outcome.

Using the *CDC Policy Analysis: Key Questions* tool, the interview questions were tailored to the problem and classified as pertaining to framing, public health impact, feasibility, and economic or budgetary impacts (CDC, 2024a). These allowed for evaluation in each category to determine the best course of action as defined by continuation with current policy, modification of existing policy, or creation of new policy demonstrated in four graphs (Figures 1-4). The majority of experts agreed that continuing with the current policy was unfavorable in terms of public health impact, budget impact, and economic impact (Figure 2, Figure 3, Figure 4). Most stakeholders are future-oriented and look towards sustainability in these categories. The feasibility question remained less clear (Figure 1), reflecting the challenges that policy change faces in many complex organizations; modification was deemed the most likely to be enacted through this analysis.

Discussion

Deployed disaster response teams face mental health challenges unique to the field. This quality improvement project brings attention to the need for policy support for the mental health of the people performing these duties. The results of this project demonstrate that experts in the field, when asked about the impact of behavioral health conditions on this population and ultimately on public health, believe organizations must address this need. Multiple studies have established that first-response providers experience mental health conditions at a higher rate than the general population, as well as at a comparable rate to military populations (Arjmand et al., 2024). The themes of impact on families, challenges of long deployment, and the importance of support during and after deployment, which were demonstrated in the literature search, are replicated in the comments obtained during the environmental scan (Arceneaux et al., 2020; Chen et al., 2023; Brake & Kennis, 2023). Many studies executed throughout the COVID-19

epidemic provide evidence for the need for individualized intervention embedded within a disaster response; this is echoed by most of the experts surveyed for this project (Kaplan et al., 2022).

One challenge to gathering this information was the timing of the project, which aligned with the hurricane season. Due to the alignment with the hurricane season many disaster response organizations and their staff did not have time to contribute to the project. This is likely one of the reasons that only a portion of the 24 stakeholders contacted responded to the inquiry. Once interviews were initiated, there was one respondent who aborted the interview due to a perceived lack of knowledge of the topic. All other interviews were completed. Another limitation of this project is that organizations outside of the military have limited ability to track the attribution of cost and benefit to mental health interventions due to privacy issues.

Enactment of a new policy or modification of a current policy is favored for public health impact, budget, and economic impact, per the testimony of the experts in this project. Reporting or seeking mental health support can potentially affect a responder's job status, highlighting the need for policies that protect those seeking help (Russell et al., 2022; Wright et al., 2022).

Feasibly, peer support interventions are recognized as effective, although the economic value of embedded behavioral health remains debated; leaders often view it as unnecessary, while experts surveyed for this project see it as crucial (Khoo et al., 2021; Mäkinen et al., 2015). Preliminary findings include an emphasis on preparation, quality variability between personnel, the need for individualized care, the recent nature of attention to force health protection, and the need to support the responder as a whole person, including their family needs (Ein et al., 2024).

Policy development allows for the creation of a stable foundation for organizational and clinical practices; having no official policy or vague or out-of-date policies weakens the efforts

of organizations, including DRSGs (CDC, 2024a). The sustainability of this project is dependent on the drive for policy reform despite challenges. Well-crafted policy is a reflection of a high-quality organization, thus, it is imperative to use the information gathered in this policy improvement project to sustain the momentum for policy change. Using the identified themes of embedded support, family support, and preparation for deployment indicated by this project, continued policy projects can move toward codification of evidence-based solutions moving forward.

Conclusions

Disaster workforce mental health protection is evolving, with public health workers increasingly requiring access to mental health services as disasters rise (NCEI, 2025). Current DRSG practices lack uniform policy, with variations across organizations; solutions include embedded mental healthcare, peer support, family support for deployed workers, and preparatory education (Khoo et al., 2021; Kaplan et al., 2022). Telehealth's effectiveness remains unclear, but experts favor embedded behavioral health personnel (Gilder et al., 2023). Workforce challenges—such as reduced availability, staff shortages, and decreased volunteerism due to psychosocial factors—compromise disaster response capabilities and raise deployment costs when contract workers are needed (FEMA, 2023; Sivi, 2022). Allowing a gap to remain between the response force and access to mental health resources is unnecessary, and policy formation can assist leaders to ensure the continued ability to field strong and effective disaster response teams. The next step for DRSGs is to have a policy in place that reflects the current literature and ensures Force Health Protection is a required part of the deployment cycle.

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Stone, K. W., Kintziger, K. W., Jagger, M. A., & Horney, J. A. (2021). Public Health Workforce Burnout in the COVID-19 Response in the U.S. *International Journal of Environmental Research and Public Health, 18*(8), 4369-. <https://doi.org/10.3390/ijerph18084369>

What's Included in OneSearch?. (2024). Retrieved from University of Maryland

<https://www2.hshsl.umaryland.edu/hshsl/resources/onesearch.cfm>

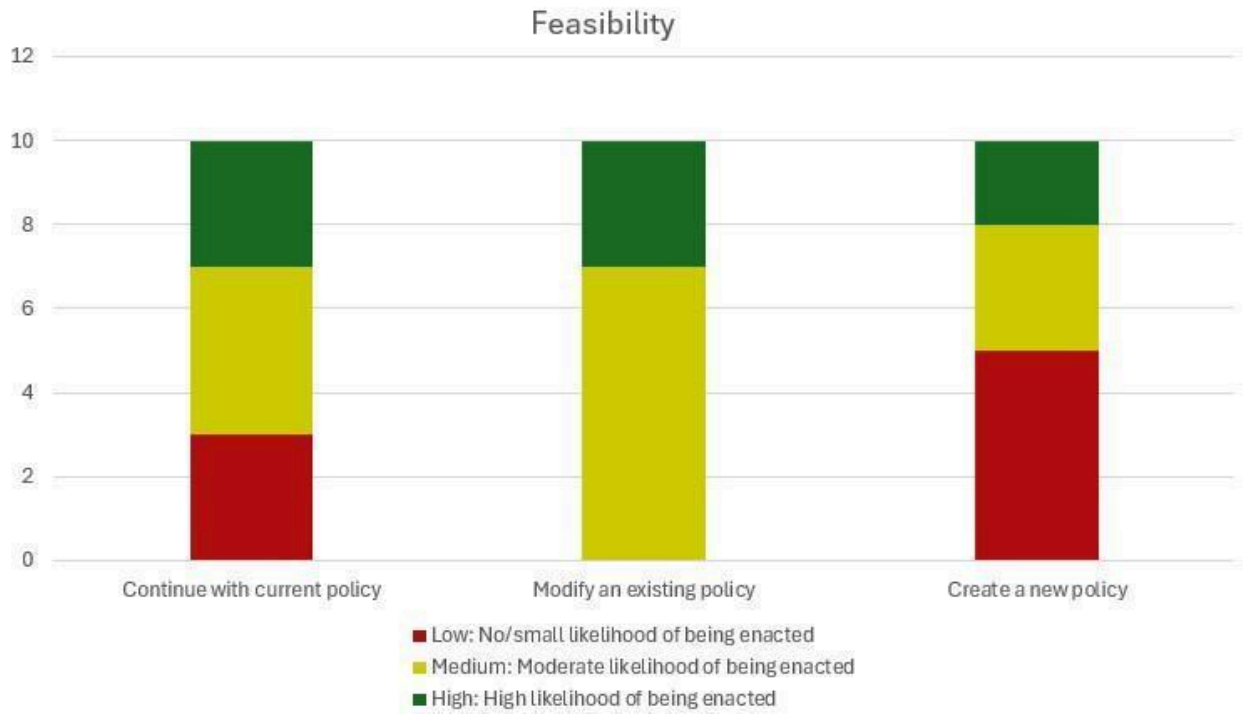
Wright, H. M., Fuessel-Hermann, D., Pazdera, M., Lee, S., Ridge, B., Kim, J. U., Konopacki, K., Hilton, L., Greensides, M., Langenecker, S. A., & Smith, A. J. (2022). Preventative Care in First Responder Mental Health: Focusing on Access and Utilization via Stepped

Telehealth Care. *Frontiers in Health Services*, 2, 848138.

<https://doi.org/10.3389/frhs.2022.848138>

Figure 1

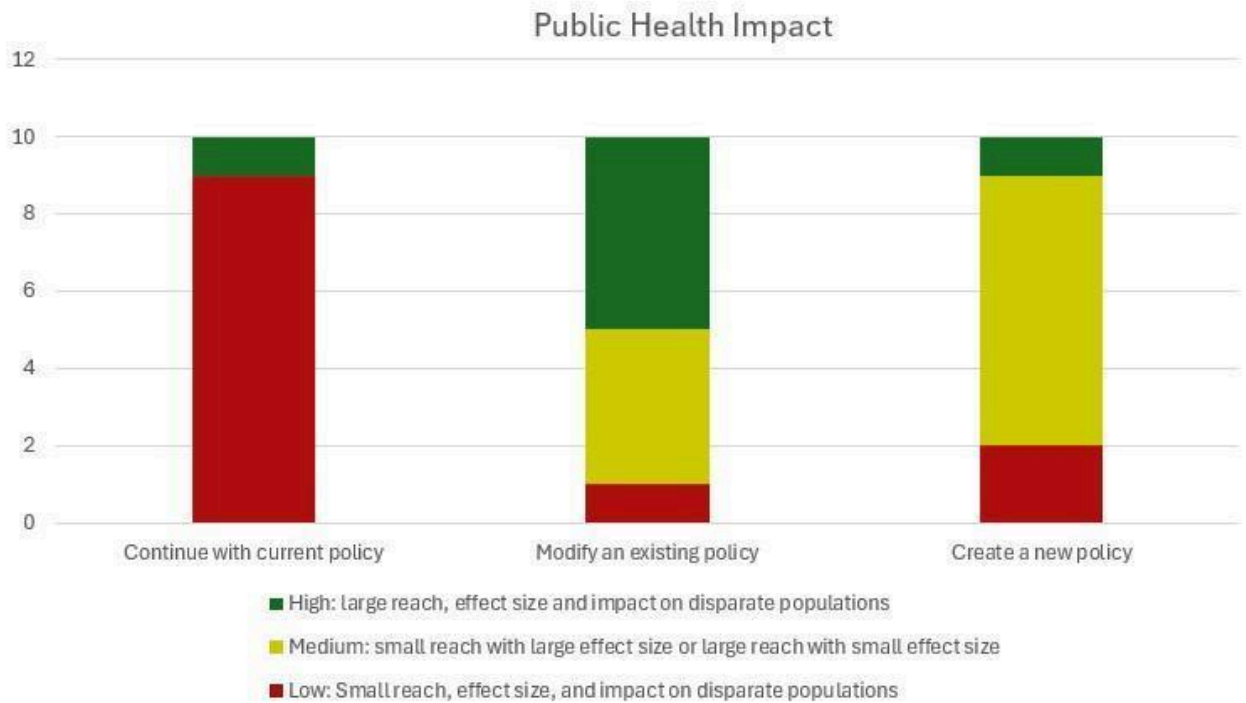
Feasibility of Policy Action



Note: The figure shows the number of answers from experts rated low, medium, or high.

Figure 2

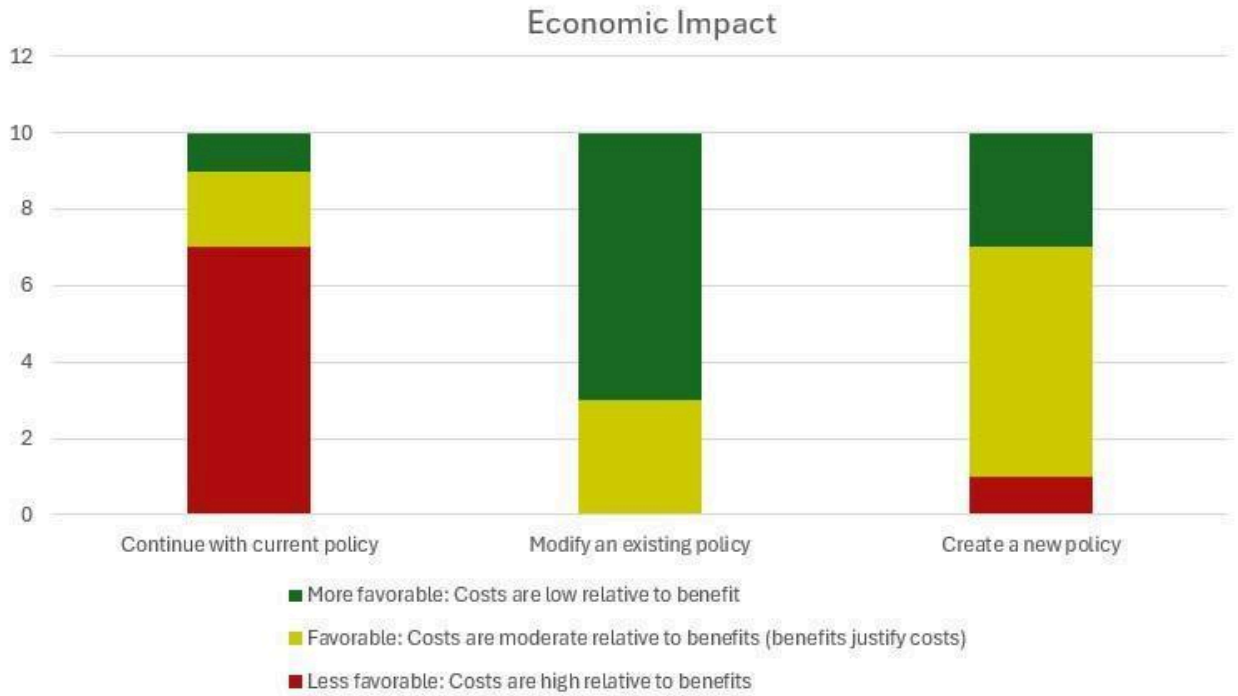
Public Health Impact of Policy Action



Note: The figure shows the number of answers from experts rated low, medium, or high.

Figure 3

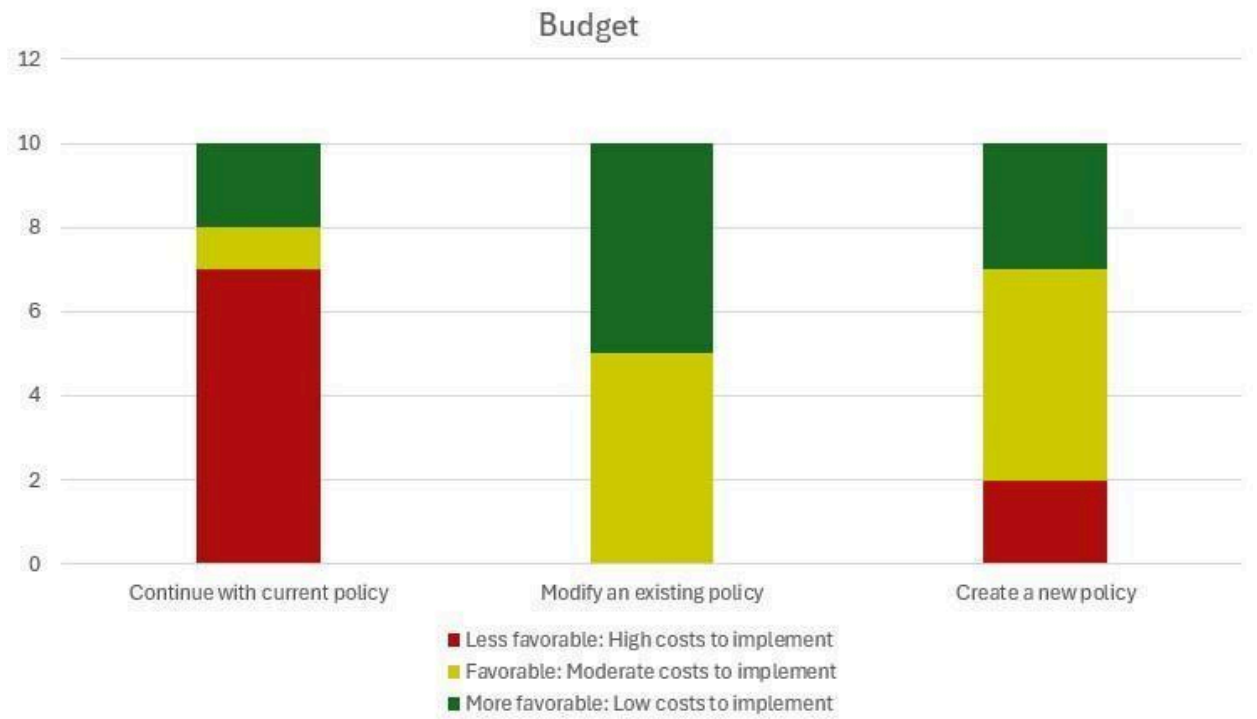
Economic Impact of Policy Action



Note: The figure shows the number of answers from experts rated more or less favorable.

Figure 4

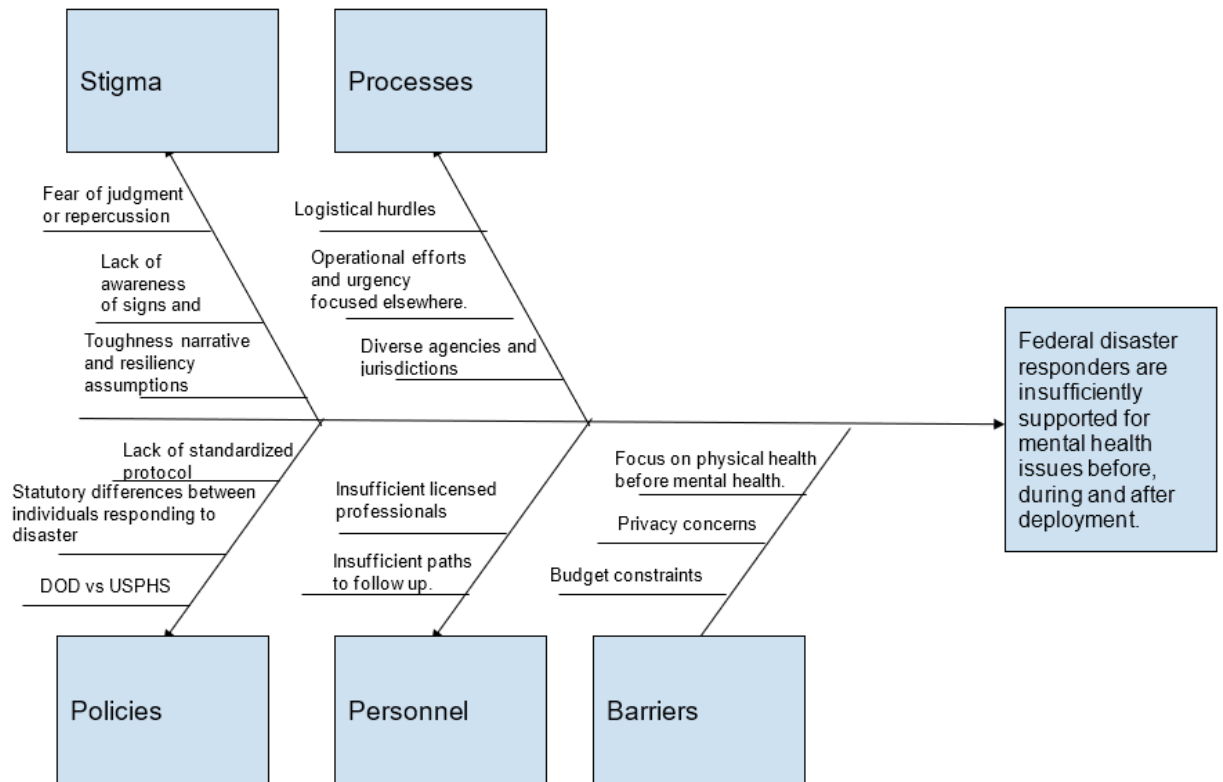
Budget Impact of Policy Action



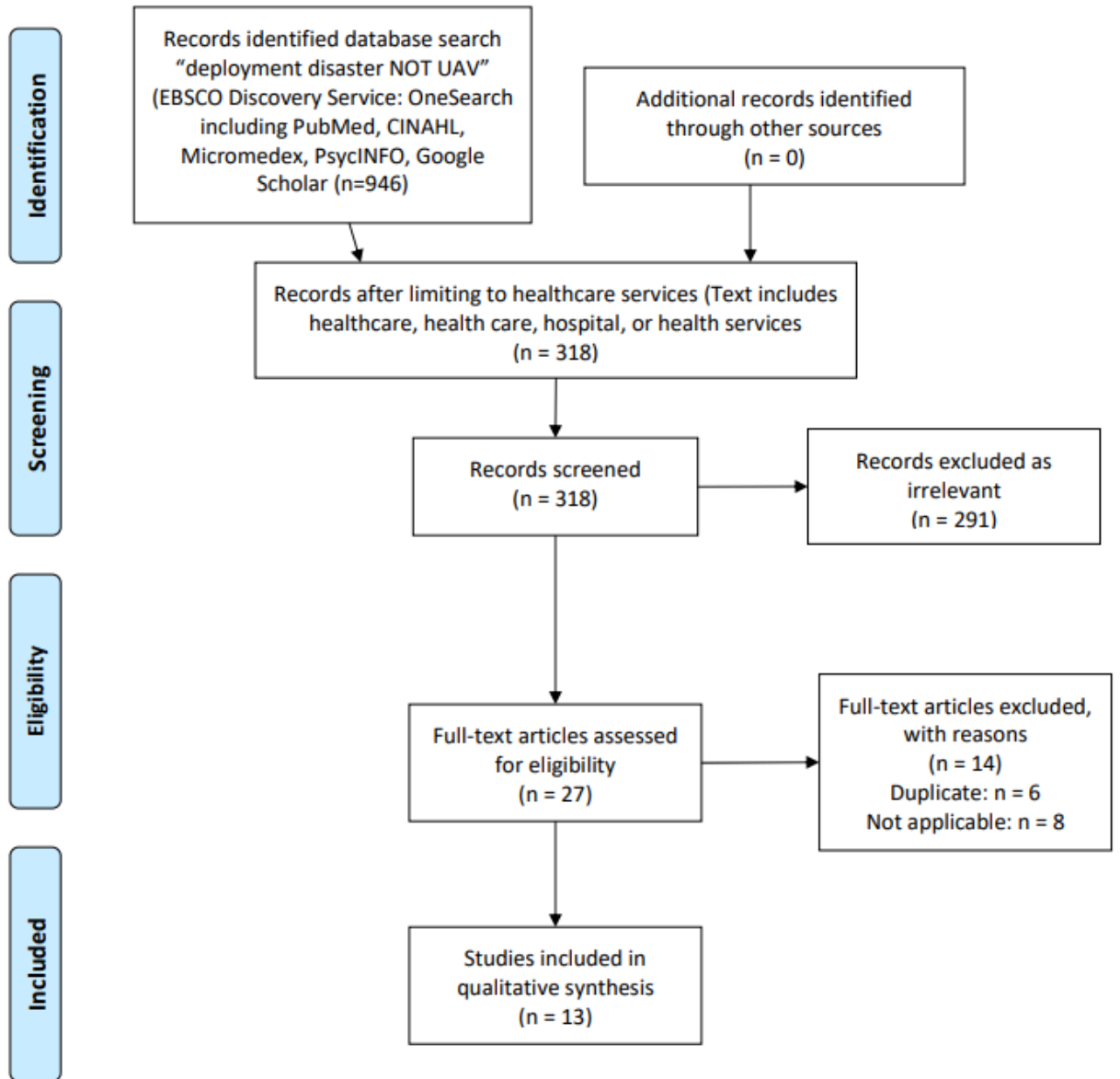
Note: The figure shows the number of answers from experts rated more or less favorable.

Appendices

Appendix A: Fishbone Diagram



Appendix B: PRISMA Diagram



Appendix C: Evidence Review Table, Appraisal

<p>Citation #1 Arceneaux, J. M., Dickens, J. L., & Bacon, W. (2020). Commissioned Corps Deployments & Family Resiliency. <i>Online Journal of Issues in Nursing</i>, 25(1), N.PAG. https://doi-org.proxy-hs.researchport.umd.edu/10.3912/OJIN.Vol25No01PPT70</p> <p>Level: III</p>					
Purpose or Hypothesis	Type of Evidence and Research Design	Sample (population, size, setting)	Intervention Procedures	Primary Outcome/Measures	Results Conclusions
<p>USPHS Commissioned Corps members face similar impacts to their families as do members of the military; Deployments contribute negatively and positively to the psychological health of deployed people and their families.</p>	<p>Literature review of research on military deployment's effect on families.</p>	<p>Deployed service members and their families.</p>	<p>The paper does not focus on intervention but examines relationships between different factors and the resilience of families.</p>		<p>“Deployments have noteworthy implications for parents and children in the uniformed services... To mitigate the impact of deployments on families, systems must be in place to prepare the entire family... and ensure effective communication”</p>
<p>Citation #2 Albott, C. S., Wozniak, J. R., McGlinch, B. P., Wall, M. H., Gold, B. S., & Vinogradov, S. (2020). Battle Buddies: Rapid Deployment of a Psychological Resilience Intervention for Health Care Workers During the COVID-19 Pandemic. <i>Anesthesia and Analgesia</i>, 131(1), 43–54. https://doi-org.proxy-hs.researchport.umd.edu/10.1213/ANE.0000000000004912</p> <p>Level: III</p>					
Purpose or Hypothesis	Type of Evidence and Research Design	Sample (population, size, setting)	Intervention Procedures	Primary Outcome/Measures	Results Conclusions

<p>The Battle Buddy and Anticipate-Plan-Deter (APD) system used for army servicemembers will increase the resilience of medical providers in the COVID-19 pandemic.</p>	<p>Non-experimental rapid deployment of intervention including observational study using surveys in a stratified delayed-start design.</p>	<p>Nurses and physicians within the University of Minnesota Medical Center.</p>	<p>Phase I: Battle Buddy system matching peers together for frequent ten-minute check-ins. Phase II: ADP to identify stressors and escalations and refer to a mental health consultant if necessary.</p>	<p>Levels of burnout measured by survey – not specified</p>	<p>“Level 1 of the program—the Battle Buddy system— is highly scalable, has no cost, and requires very few resources apart from endorsement on the part of unit and department leaders. Early anecdotal evidence (including the experience of the authors) suggests that it is easy to implement and very beneficial.”</p>
<p>Citation #3 Chen, J., Li, F., Hu, X., Yang, P., & He, Y. (2023). A scoping review of the moral distress of military nurses in crisis military deployment. <i>Nursing Ethics</i>, 30(7–8), 922–938. https://doi-org.proxy-hs.researchport.umd.edu/10.1177/09697330231189033 Level: III</p>					
<p>Purpose or Hypothesis</p>	<p>Type of Evidence and Research Design</p>	<p>Sample (population, size, setting)</p>	<p>Intervention Procedures</p>	<p>Primary Outcome/Measures</p>	<p>Results Conclusions</p>

<p>Define the current state of research and measurement tools on moral distress during the “crisis military deployment” of nurses.</p>	<p>Scoping Review</p>	<p>21 articles were included in the review: “Employing the framework developed by Arksey and O’Malley,30 operational steps for a scoping review are now widely used in the field of care, including defining research questions, identifying relevant studies, sifting through literature, extracting data, and summarizing results.”</p>	<p>“Literature research was conducted on PubMed, CINAHL, Cochrane Library, Web of Science, Embase, CNKI, and CBMDisc from initiation to January 20, 2023. The English databases were searched using a combination of MeSH and free terms”</p> <p>Inclusion Criteria: English or Chinese language, qualitative and quantitative and reviews, study participants were active duty military nurses who had been deployed, and the subjects experienced moral distress.</p>	<p>Definitions of moral distress in the military health care context, identification of differences between civilian and military nurse circumstances, identification of tools and methods to assess moral distress.</p>	<p>Identified themes include the deployment environment, limited patient rights, third-party intervention, military triage, resource allocation, futile care, caring for the enemy, and return to deployment.</p>
<p>Citation #4 Christensen, S. E., & Wagner, L. (2022). Disaster Relief Nurses: Exploring the Impetus to Respond to Multiple Efforts. <i>Nursing Science Quarterly</i>, 35(2), 244–255. https://doi-org.proxy-hs.researchport.umd.edu/10.1177/08943184211070575 Level: III</p>					
<p>Purpose or Hypothesis</p>	<p>Type of Evidence and Research Design</p>	<p>Sample (population, size, setting)</p>	<p>Intervention Procedures</p>	<p>Primary Outcome/Measures</p>	<p>Results Conclusions</p>

<p>Description and documentation of the experience of nurse volunteers who have experienced disaster assistance.</p>	<p>Qualitative study using grounded theory methodology.</p>	<p>20 English-speaking nurses who had volunteered to respond to more than one disaster event.</p>	<p>Semi-structured interview; Data analysis occurred simultaneously with data collection.</p>	<p>Categorization of themes and concepts applicable to the experience of nurses to better understand willingness to volunteer and the likeliness of repeated disaster volunteerism</p>	<p>Disaster volunteerism has the effect of shoring up the identity of nurses whose capacity can be expanded via providing care.</p>
<p>Citation #5 Brake, H. T., & Kennis, M. (2023). Returning to Normal Life after Deployment: What Can Emergency Response Organizations Learn from the Military? <i>Prehospital & Disaster Medicine</i>, 38, s115. https://doi-org.proxy-hs.researchport.umd.edu/10.1017/S1049023X23003096</p> <p>Level: III</p>					
<p>Purpose or Hypothesis</p>	<p>Type of Evidence and Research Design</p>	<p>Sample (population, size, setting)</p>	<p>Intervention Procedures</p>	<p>Primary Outcome/Measures</p>	<p>Results Conclusions</p>

<p>Provide a structured analysis of the military interventions that occur under the umbrella of post-deployment adaptation programs (PDAPs).</p>	<p>Systematic review of peer-reviewed studies</p>	<p>Out of 1535 unique records 16 articles were selected.</p>	<p>Studies were located on six databases (MEDLINE, Embase, PsycINFO, Cochrane, PTSDPubs, and OpenGrey) and the risk of bias was assessed using GRADE guidelines.</p>	<p>Interventions identified included third-location decompression, adaptation of skills, and cognitions after deployment.</p>	<p>“Empirical, high-quality evidence for PDAP is scarce. In addition, the existing literature reveals a lack of systematic method in describing the goals of PDAP and the ways of achieving these.”</p>
<p>Citation #6 Kaplan, A., & Smith, C. M. (2022). Mental Health Support of Frontline Medical Personnel in the Javits New York Medical Station Federal COVID-19 Treatment Center. <i>Federal Practitioner: For the Health Care Professionals of the VA, DoD, and PHS</i>, 39(5), 202–206. https://doi-org.proxy-hs.researchport.umd.edu/10.12788/fp.0261 Level: III</p>					
<p>Purpose or Hypothesis</p>	<p>Type of Evidence and Research Design</p>	<p>Sample (population, size, setting)</p>	<p>Intervention Procedures</p>	<p>Primary Outcome/Measures</p>	<p>Results Conclusions</p>

<p>Details the establishment of preventative and responsive mental health services for frontline workers at the Javits New York Medical Station Federal COVID-19 Treatment Center.</p>	<p>Observational documentation of the deployment of emergency mental health services to support federal health care workers staffing the JNYMS.</p>	<p>More than 600 uniformed and other federal personnel were deployed to the JNYMS site.</p>	<p>Multiple interventions were documented as part of this paper: A resiliency center where staff enter and leave, 24-hour availability of licensed clinicians (LCSW), daytime psychiatrist access for staff, reading materials provided, and real-time interventions for staff crisis.</p>	<p>Documentation of the efforts to maintain a mental health point of care provision within a disaster relief site.</p>	<p>Suggestions include securing a safe therapeutic space, developing relationships with leaders and frontline workers in their work environments, and placing services in high-traffic areas to normalize the use of services.</p>
<p>Citation #7 Gustavsson, M.E., Juth, N., Arnberg, F.K., & von Schreeb, J.. (2022). Dealing with difficult choices: a qualitative study of experiences and consequences of moral challenges among disaster healthcare responders. <i>Conflict and Health</i>, 16(1), 1–19. https://doi-org.proxy-hs.researchport.umd.edu/10.1186/s13031-022-00456-y Level: III</p>					
<p>Purpose or Hypothesis</p>	<p>Type of Evidence and Research Design</p>	<p>Sample (population, size, setting)</p>	<p>Intervention Procedures</p>	<p>Primary Outcome/Measures</p>	<p>Results Conclusions</p>

<p>Exploration of how deployed international disaster healthcare responders perceive, manage, and are affected by moral challenges.</p>	<p>Focus group discussions were transcribed and analyzed using content analysis.</p>	<p>12 nurses and physicians with disaster healthcare experience from three different agencies.</p>	<p>Focus group discussions with stimulated interactions by the researcher. The sessions were audio recorded. Each group lasted approximately 2 hours.</p>	<p>Identification of subcategories using qualitative content analysis as described by Graneheim and Lundman.</p>	<p>Five themes with 16 categories were identified; the themes were “type of difficult situation”, “managing difficult situations”, “tools and support”, “engagement as a protective factor” and “work environment stressors as a risk factor.”</p>
<p>Citation #8 Ma, H., Huang, J., Deng, Y., Zhang, Y., Lu, F., Yang, Y., & Luo, Y. (2021). Deployment experiences of military nurses: A systematic review and qualitative meta-synthesis. <i>Journal of Nursing Management</i>, 29(5), 869–877. https://doi-org.proxy-hs.researchport.umd.edu/10.1111/jonm.13201</p> <p>Level: III</p>					
<p>Purpose or Hypothesis</p>	<p>Type of Evidence and Research Design</p>	<p>Sample (population, size, setting)</p>	<p>Intervention Procedures</p>	<p>Primary Outcome/Measures</p>	<p>Results Conclusions</p>

<p>Explore military nurses' preparation, deployment, and reintegration experiences and provide recommendations for sufficient support.</p>	<p>A systematic review and qualitative meta-synthesis of studies studies.</p>	<p>Initial search in CINAHL followed by textual analysis, then using identified keywords search was undertaken across five databases; only studies in English were included. From 562 studies, 16 were included.</p>	<p>Literature Search</p>	<p>Five synthesized findings were identified: 1. Pre-deployment preparing and sharing 2. Transition from civilian to emergency 3. Teamwork and bonding during deployment 4. Devotion to the profession of nursing 5. Necessity of external support during reintegration</p>	<p>“Regular and formal training can boost the confidence and the capacity of nurses. Managers should also acknowledge that the deployment experience is a challenge for nurses, and they should provide sufficient support in each stage of deployment.”</p>
<p>Citation #9 Khoo, V. P. H., Ting, R. S.-K., Wang, X., Luo, Y., Seeley, J., Ong, J. J., Zhao, M., Morsillo, J., Su, C., Fu, X., & Zhang, L. (2021). Risk and Protective Factors for the Mental Wellbeing of Deployed Healthcare Workers During the COVID-19 Pandemic in China: A Qualitative Study. <i>Frontiers in Psychology</i>, 12, 1–16. https://doi-org.proxy-hs.researchport.umd.edu/10.3389/fpsyg.2021.773510</p> <p>Level: III</p>					
<p>Purpose or Hypothesis</p>	<p>Type of Evidence and Research Design</p>	<p>Sample (population, size, setting)</p>	<p>Intervention Procedures</p>	<p>Primary Outcome/Measures</p>	<p>Results Conclusions</p>

<p>Using a systematic approach study health care workers deployed to care in the COVID-19 crisis.</p>	<p>Semi-structured interviews</p>	<p>25 deployed healthcare workers in the H province of China who had been deployed for a minimum of 3 months</p>	<p>Inductive-deductive thematic coding of interview contents</p>	<p>Weaknesses identified: intensive schedule, high-risk environment, unfamiliar work setting and colleagues, isolation. Strengths identified: reciprocal relationships, and organizational support to the workers and their families.</p>	<p>Five supportive guidelines were identified: Cultivating resilience through peer support, safe space, and mentoring; Cultivating reciprocal relationships consistent with values of reciprocity and relational cognition; Attending to the welfare of the deployed workers' dependents and family; Culturally sensitive mental health interventions; and adequate workplace training.</p>
<p>Citation #10 Mao, X., Loke, A.Y., & Hu, X.. (2020). Developing a tool for measuring the disaster resilience of healthcare rescuers: a modified Delphi study. <i>Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine</i>, 28(1), 1–12. https://doi-org.proxy-hs.researchport.umd.edu/10.1186/s13049-020-0700-9</p> <p>Level: IV</p>					
<p>Purpose or Hypothesis</p>	<p>Type of Evidence and Research Design</p>	<p>Sample (population, size, setting)</p>	<p>Intervention Procedures</p>	<p>Primary Outcome/Measures</p>	<p>Results Conclusions</p>

<p>Establish the content validity of a tool for measuring the disaster resilience of disaster rescue workers.</p>	<p>A modified Delphi method required the participation of 21 experts.</p>	<p>A panel of 21 experts was contacted virtually.</p>	<p>Several rounds of Delphi survey were used depending on the level of consensus and the data were analyzed using the Statistical Package for Social Services (SPSS)</p>	<p>A final version of a measuring tool with 27 items was established for assessing disaster resilience among healthcare rescuers</p>	<p>The next necessary step is a study to establish the psychometric properties of the established scale</p>
<p>Citation #11 Nagamine, M., Yamamoto, T., Shigemura, J., Tanichi, M., Yoshino, A., Suzuki, G., Takahashi, Y., Miyazaki, M., Uwabe, Y., Harada, N., & Shimizu, K. (2018). The psychological impact of the Great East Japan Earthquake on Japan Ground Self-Defense Force personnel: A three-wave, one-year longitudinal study. <i>Psychiatry: Interpersonal and Biological Processes</i>, 81(3), 288–296. https://doi-org.proxy-hs.researchport.umd.edu/10.1080/00332747.2017.1333340 Level: II</p>					
<p>Purpose or Hypothesis</p>	<p>Type of Evidence and Research Design</p>	<p>Sample (population, size, setting)</p>	<p>Intervention Procedures</p>	<p>Primary Outcome/Measures</p>	<p>Results Conclusions</p>

<p>It is important to understand the trajectory of psychological health in disaster workers. (This study is included in the evidence review due to the implications of the psychological effects of real-life disaster response on government workers being measured.)</p>	<p>Self-report questionnaires were sent to members of the Japan Ground Self-Defense Force who responded to emergencies related to the Great East Japan Earthquake.</p>	<p>70,000 questionnaires were sent out and data were retrieved from 56,753 individuals who completed the three waves of the study.</p>	<p>The Impact of Event Scale-Revised (IES-R) and Kessler Psychological Distress Scale (K10) were used to evaluate Post-Traumatic Stress Responses.</p>	<p>Various factors were compared with the scoring of PTSD and General Psychological Distress (GPD) including length of deployment, timing of leave related to deployment, and nature of work performed.</p>	<p>Factors identified as high risk included deployments of greater than three months, personal effects of the disaster, and post-deployment overwork.</p>
<p>Citation #12 Russell, D. W., Russell, C. A., & Hill, R. P. (2022). Mental health service utilization after military missions: The double-edged consequences of unit-level organizational support. <i>Psychological Services</i>, 19(Suppl 2), 113–125. https://doi-org.proxy-hs.researchport.umd.edu/10.1037/ser0000542</p> <p>Level: III</p>					
<p>Purpose or Hypothesis</p>	<p>Type of Evidence and Research Design</p>	<p>Sample (population, size, setting)</p>	<p>Intervention Procedures</p>	<p>Primary Outcome/Measures</p>	<p>Results Conclusions</p>

<p>Examines mental health service utilization among U.S. servicemembers following deployment to a combat zone (study 1) and domestic civil support to an environmental disaster (Study 2).</p> <p>“RQ1: Are the servicemembers exhibiting high MH symptomology and positive MH screening seeking care? RQ2: How do perceived stigma, barriers to care, cost of care, and (dis) belief in treatment correspond to the utilization of professional MH services? RQ3: Do perceptions of social support in the group setting (unit-level) where the MH issues developed moderate the relationship between MH symptoms and utilization of MH services?”</p>	<p>A two-pronged approach was used to assess recently deployed vs. non-recently deployed national guard units.</p>	<p>Study 1: 472/202 Study 2: National Guard deployed and non-deployed service members</p>	<p>Pre-, Inter, and Post-Deployment surveys</p>	<p>Number of visits to a professional mental health service facility (military or civilian), scores on validated psychological tools (PTSD-MC, GAD-7, PHQ-9), Perceived Organizational Support measure, Perceived care-seeking deterrents, and Deployment stressors.</p>	<p>Negative mental health outcomes are a common occurrence in serving one’s society. MH services are not used due to the stigma associated with their use despite multiple efforts to counter the stigma. Organizational support for servicemembers which is not designed as a mental health intervention may be a source of comradery but may reduce the likelihood of seeking treatment.</p>
<p>Citation #13 Schreiber, M., Cates, D. S., Formanski, S., & King, M. (2019). Maximizing the Resilience of Healthcare Workers in Multi-hazard Events: Lessons from the 2014–2015 Ebola Response in Africa. <i>Military Medicine</i>, 184, 114–120. https://doi-org.proxy-hs.researchport.umd.edu/10.1093/milmed/usy400</p> <p>Level: III</p>					

Purpose or Hypothesis	Type of Evidence and Research Design	Sample (population, size, setting)	Intervention Procedures	Primary Outcome/Measures	Results Conclusions
<p>“The Anticipate, Plan, and Deter (APD) Responder Risk and Resilience Model ...enables the first known evidence-driven “targeted action” plan to address responder risk early before Post Traumatic Stress Disorder and impairment become established.”</p>	<p>A retrospective, qualitative, and completely de-identified analysis of self-triage encounters.</p>	<p>186 healthcare workers deployed to Africa to assist with Ebola</p>	<p>“APD focuses on operational actions to enhance worker resilience by offering “hazard-specific stress inoculation” training in the pre-incident period that requires participants to create individualized resilience plans before deployment. The APD model also integrates the Psychological Simple Triage and Rapid Treatment – Responder (PsySTART-R) self-triage tool.”</p>	<p>Situational real-time awareness on factors in the PsySTART-R tool available to leaders...</p>	<p>Recommends a proactive approach to the mental health burden on HCWs using the APD model.</p>

Appendix D: Evidence Review Table, Synthesis

Project Title: Recommendations for Mental Health Support of Non-Military Disaster Responders			
PICOT: Federal non-military disaster responders are insufficiently supported and monitored for mental health issues during and after deployment causing the potential for early demobilization.			
JHNEBP Model Level	Total Number of Sources	Author and Quality Rating of each study	Synthesis of Findings
<p>Level 1</p> <p>Experimental study · Randomized Controlled Trial (RCT) · Systematic review of RCTs with or without meta-analysis</p>			
<p>Level II</p> <p>Quasi-experimental studies · Systematic review of a combination of RCTs and quasi-experimental studies, or quasi-experimental studies only, with or without meta-analysis</p>	1	Nagamine (strong)	This study provided evidence of government workers' psychological effects identifying length of deployment, personal relation to the disaster, and post-deployment overwork.

<p>Level III</p> <p>Non-experimental study · Systematic review of a combination of RCTs, quasi-experimental, and non-experimental studies, or non-experimental studies only, with or without meta-analysis · Qualitative study or systematic review of qualitative studies with or without meta-synthesis</p>	<p>11</p>	<p>Arceneaux (Moderate), Albott (Strong), Brake (Low), Chen (Moderate), Christensen (Low), Gustavsson (Low), Kaplan (Strong), Khoo (Strong), Ma (Strong), Russell (moderate), Schreiber (strong)</p>	<p>Themes that emerged from the data search which support policy recommendations are: Robust tools for deployed workers to communicate with families (Arceneaux et al., 2020; Khoo et al., 2021); structured peer support (Albott et al., 2020; Khoo et al., 2021); addressing moral insult or distress (Chen et al., 2023), deployment environment (Chen et al., 2023, Kaplan & Smith, 2022, Gustavsson et al., 2022; Khoo et al., 2021); safe therapeutic space (Kaplan & Smith, 2022; Khoo et al, 2021); training, tools and support (Chen, Gustavsson, Khoo)</p> <p>Support for limitation on multiple deployments was mixed; evidence shows that identity can be reinforced (Christensen & Wagner, 2022; Ma et al., 2021)) however a risk for psychiatric consequences comes with repeated deployments (Chen et al., 2023)</p> <p>Brake & Kennis endeavors to show evidence for Post-deployment adaptation programs but admits weak evidence for the PDAP (2023) which itself represents multiple modalities. Russell et al., 2022 established evidence that organizational support can provide help but discourage psychiatric treatment-seeking. Pre-deployment preparation and teamwork/bonding are demonstrated as effective (Ma et al., 2021; Schreiber et al., 2019).</p>
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<p>Level IV</p> <p>Opinion of respected authorities and/or reports of nationally recognized expert committees/consensus panels based on scientific evidence</p>	<p>1</p>	<p>Mao (Moderate)</p>	<p>This study used expert consensus to develop a content-valid tool for measuring disaster resilience.</p>
<p>Level V</p> <p>Evidence obtained from literature reviews, quality improvement, program evaluation, financial evaluation, or case reports · Opinion of nationally recognized expert(s) based on experiential evidence</p>			

Appendix E: CDC Policy Framework Diagram



Appendix F: Policy Audit Tool

Policy Audit Tool

Page 1

Record ID _____

Public Health Impact

Scoring Definitions:

Low: Small reach, effect size, and impact on disparate populations

Medium: small reach with large effect size or large reach with small effect size

High: large reach, effect size and impact on disparate populations

Policy 1: Keep current work flow

- Low
- Medium
- High

Policy 2: Adjust current policy

- Low
- Medium
- High

Policy 3: New Policy

- Low
- Medium
- High

Feasibility

Scoring definitions:

Low: No/small likelihood of being enacted

Medium: Moderate likelihood of being enacted

High: High likelihood of being enacted

Policy 1: Keep current work flow

- Low
- Medium
- High

Policy 2: Adjust current policy

- Low
- Medium
- High

Policy 3: New policy

- Low
- Medium
- High

Economic Impact

Scoring Definitions:

Less favorable: High costs to implement

Favorable: Moderate costs to implement

More favorable: Low costs to implement

Policy 1: Keep current work flow

- Less favorable
- Favorable
- More favorable

Policy 2: Adjust current policy

- Less favorable
- Favorable
- More favorable

Policy 3: New policy

Less favorable
 Favorable
 More favorable

Budgetary impact
Scoring definitions:
Less favorable: Costs are high relative to benefits
Favorable: Costs are moderate relative to benefits (benefits justify costs)
More favorable: Costs are low relative to benefits

Policy 1: Keep current work flow

Less favorable
 Favorable
 More favorable

Policy 2: Adjust current policy

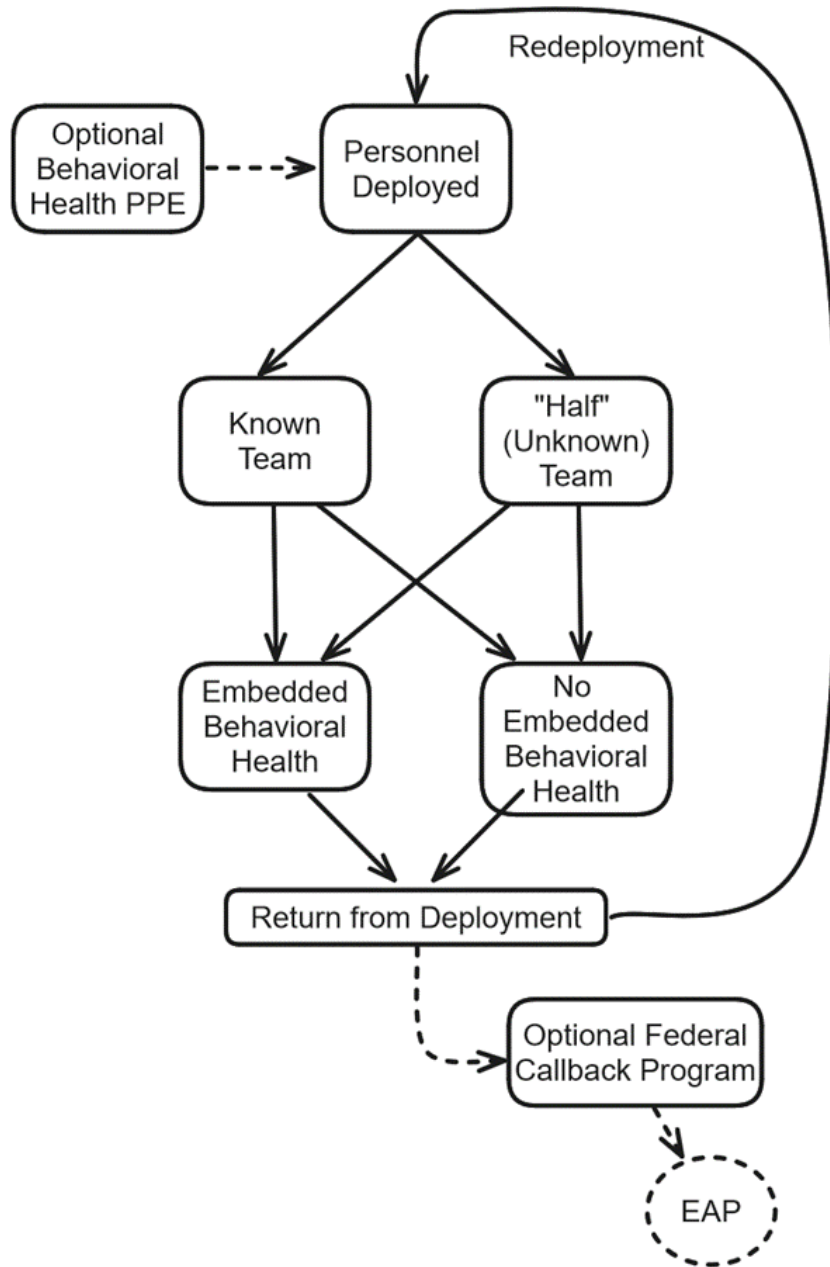
Less favorable
 Favorable
 More favorable

Policy 3: New policy

Less favorable
 Favorable
 More favorable

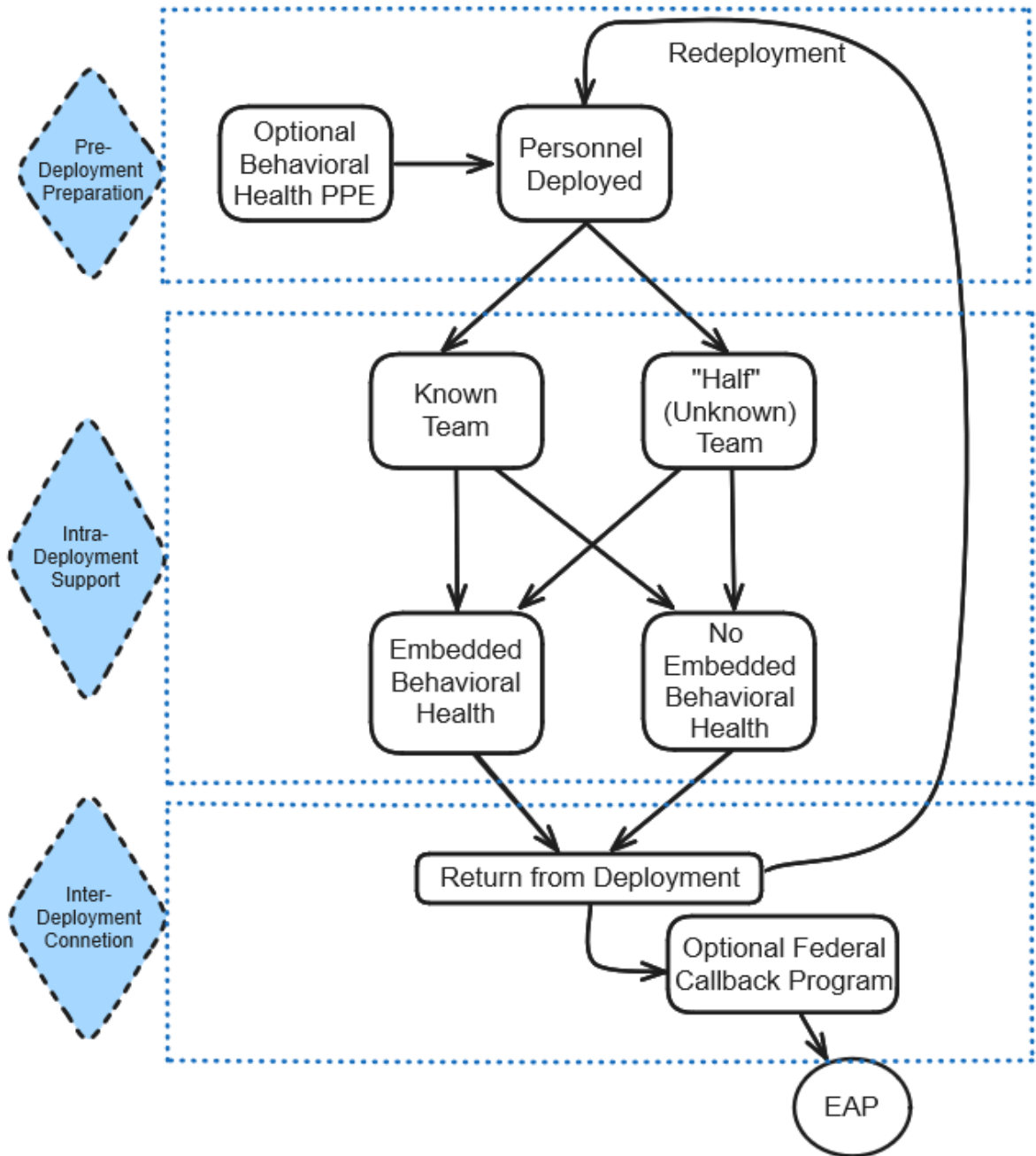
Appendix G: Current Process Map

CURRENT



Appendix H: Desired Process Map

POLICY: KEY POINTS FOR IMPROVEMENT



Appendix I: Interview Questions for Stakeholders

Page 1

Current Practices in Behavioral Health for Disaster Responders

Please complete the survey below.

Thank you!

How do you prepare your workers before deployment or operations for potential mental health challenges they may face during or after a disaster response?

Services Provided	Yes	No
Services are provided before deployment.	<input type="radio"/>	<input type="radio"/>
Services are provided during deployment.	<input type="radio"/>	<input type="radio"/>
Services are provided after deployment.	<input type="radio"/>	<input type="radio"/>
Is screening part of workforce protection?	<input type="radio"/>	<input type="radio"/>
Is assessment part of workforce protection?	<input type="radio"/>	<input type="radio"/>
Is check-in part of workforce protection?	<input type="radio"/>	<input type="radio"/>
Are peer services part of workforce protection?	<input type="radio"/>	<input type="radio"/>

Please describe the support provided for workers deployed during a disaster in your organization.

Does your organization provide training specifically regarding Post-Traumatic Stress Disorder (PTSD)? Yes No

Explain how the diagnosis/concept of PTSD is incorporated into force protection.

Does your organization use any of the following evidence-based concepts/interventions, or recognize them in official documents or policy:

- Psychological First Aid (also known as Stress First Aid or Behavioral Health First Aid)
- Compassion Fatigue
- Secondary Trauma, or Second Victims
- Moral Injury
- Peer Support interventions such as Caring for the Caregiver: Resilience in Stressful Events (RISE), Battle Buddies and Anticipate-Plan-Deter (APD)
- Post-deployment Adaptation Programs (PDAP)
- The Psychological Simple Triage and Rapid Treatment - Responder (PsySTART-R) Tool
- Other

Other Education Opportunities

Feedback on Mental Health Support from Operational Staff

	Yes	No
Do you receive formal feedback from operational staff?	<input type="radio"/>	<input type="radio"/>
Do you receive informal feedback from operational staff?	<input type="radio"/>	<input type="radio"/>

How do you receive feedback from deployed staff in a formal or measurable way?

Describe how informal feedback is relayed to leadership in your organization.

Based on feedback received, what is the experience of healthcare workers who have experienced deployment to or operations surrounding disasters, and how does that inform your approach?

Do you collect data or information on your team's mental health or well-being? Yes No

If so, how?

If not, what information do you desire to have?

Is there a cost to your organization from trauma and mental health effects experienced by operational/deployed healthcare workers?

What are the barriers you encounter in addressing the mental healthcare needs of healthcare workers, and if applicable, what approaches have been attempted to surmount these barriers?

Does the reporting of or seeking of mental health support in your organization affect responders' status on the job? Yes No

Describe the ways that mental health status can effect job status in your organization.

Have mental health concerns or PTSD affected your organization's ability to staff operations or provide public health services? Yes No I don't know

How have mental health concerns affected your organization's ability to staff operations or provide public health services?

How have health disparities affected workers deployed to disasters, either through observations of their effect on the population (secondary trauma) or directly affecting the personnel?

What kind of education do you recommend to generate awareness, acceptability, and use of mental health care among workers?

What do you see as the benefits of providing interventions for mental and behavioral healthcare to your workers?

What processes have you implemented or attempted to implement to support deployed healthcare workers, and what were the results?

Does your organizational culture proactively encourage seeking mental healthcare support when needed?

- Yes
- No

If so, what proactive efforts does your organization make to encourage seeking mental health care?

What do you find is the most important/highest priority factor in mental health support for your workers?

Appendix J: Summary of Themes

CDC Policy Analysis Questions	Thematic Analysis
<p>Framing Questions:</p> <ol style="list-style-type: none"> 1. How do you prepare your workers before deployment or operations for potential mental health challenges they may face during disasters? 2. Please describe the support provided for workers deployed during a disaster in your organization. 3. Explain how the diagnosis of PTSD is incorporated into force protection. 4. Does your organization use any of the following evidence-based concepts/interventions, or recognize them in official documents or policy? 5. Do you receive formal feedback from operational staff? 6. Based on the feedback received, what is the experience of healthcare workers who have experienced deployment to or operations surrounding disasters, and how does that inform your approach? 7. What kind of education do you recommend to generate awareness, acceptability, and use of mental health care among workers? 8. Does your organizational culture proactively encourage seeking mental healthcare support when needed? If so, what proactive efforts does your organization make to encourage seeking mental healthcare? 9. What do you find is the most important/highest priority factor in mental health support for your workers? 	<ul style="list-style-type: none"> ● Development of the evidence base has matured over the past 2-3 decades: “Nobody knew what disaster mental health was.” ● Industrial acceptance that clinicians who are not supported may “burn out” and leave the field ● The importance of trust in organizations and a culture that prevents a fear of reprisal for seeking care, as well as seeking help as a strength ● Need for support to include the families of deployed workers ● Prevention methods and preparation for fieldwork; post-crisis recovery time, i.e., “what’s normal to experience after a crisis/event” ● Knowledge and professional expertise unique to mental health care: “We made it clear that arousal, which precedes anxiety, is a normal human reaction and is adaptive ... when does it turn non-adaptive and start working against you?” ● Time spent in the field, overtime, long shifts, and lack of sleep are recurring problems, assisted by the presence of embedded support ● A need for individualized support focused on the needs of the team member ● Death exposure and post-mortem care should be made a priority in support of those involved ● The unique tendency of this population of workers to overextend due to the nature of the need
<p>Public Health Impact Questions</p> <ol style="list-style-type: none"> 1. Do you collect data or information on your team’s mental health or well-being? If so, how? If not, what information do you desire to have? 2. Have mental health concerns or PTSD affected your organization’s ability to staff operations or provide public health services? How? 3. How have health disparities affected workers deployed to disasters, either through observations of their effect on the 	<ul style="list-style-type: none"> ● Current perceptions that utilization rates of mental health care are increased in disaster organizations ● Difficulty of assessing the effectiveness of interventions; impact is hard to measure but is felt deeply, impacting the populations served in a disaster ● Healthcare disparities increase the level of moral injury felt by workers ● An increase in concurrent/consecutive disasters is placing a high burden on rescue workers ● Identifying and remedying worsening

<p>public (secondary trauma) or directly affecting the personnel?</p>	<p>mental health conditions prevents crisis-level events such as addiction, self-harm, or psychosis</p>
<p>Feasibility Questions</p> <ol style="list-style-type: none"> 1. What are the barriers you encounter in addressing the mental healthcare needs of healthcare workers, and if applicable, what approaches have been attempted to surmount these barriers? 2. Does the reporting of or seeking of mental health support in your organization affect responders ' status on the job? Describe the ways that mental health status can affect job status in your organization. 3. What processes have you implemented or attempted to implement to support deployed healthcare workers, and what were the results? 	<ul style="list-style-type: none"> ● Emergence of peer training for support, Psychological First Aid, and other efficient and effective tools ● Consistency between deployment teams and mental health care professionals' depth of integration in a given team ● High use of evidence-based programs piloted in the military, such as "Battle Buddies", has efficacy ● Evidence-based tools for evaluations include things like ProQol (Professional Quality of Life) and Maslach's Burnout Inventory; some of these are in the public domain
<p>Economic and Budgetary Impact Questions</p> <ol style="list-style-type: none"> 1. Is there a cost to your organization from trauma and mental health effects experienced by operational/deployed healthcare workers? 2. What do you see as the benefits of providing interventions for mental and behavioral healthcare to your workers? 	<ul style="list-style-type: none"> ● Determining the cost of Force Health Protection vs. not providing mental health support is challenging; "It is one of those things where people do not want to open the box." ● Evidence exists that the monetary cost of depression alone to the public is significant, indicating a similarly high cost across populations. ● The cost of inattention to mental health decreases capacity and volunteer rates, and creates the potential for "sick-out." "If you don't protect the force, you won't have a force." ● Knowledge of the cost of de-deployment exists, but it is difficult to tie it to a specific cause.