ATTACHMENT F: BEHAVIORAL HEALTH

Tabs

This attachment is part of Annex F of the State of Oregon Emergency Management Plan and should be used in conjunction with the rest of Annex F base plan and hazard specific appendices. It is not a stand-alone plan.

1 INTRODUCTION

This document describes how the Oregon Addiction and Mental Health Division (AMHD) of the Department of Human Services (DHS) will prepare for and respond to disasters and other emergencies requiring a behavioral health response.

2 PURPOSE AND AUTHORITIES

2.1 Purpose

The purpose of this document is to provide guidance for mediating the behavioral health impact of a disaster in Oregon. It specifies the roles, responsibilities, and relationships of AMHD for disaster planning, response, and recovery.

Wherever response is typical of the response to any public health emergency, this plan refers to the appropriate section of Annex F, ESF-8 Public Health and Medical Services in the *Oregon Emergency Operations Plan*. Annex F can be found on the Health Alert Network (HAN) Web site (*https://www.oregonhan.org*) or can be requested by contacting the Public Health Emergency Preparedness (PHEP) program (971-673-1308).

2.2 Authorities

Table 1: Legal Authorities

Oregon Rule or Statute	Title
430.630	Services to be provided by community mental health and developmental disabilities program; local mental health authorities; local mental health services plan.

3 SITUATION AND ASSUMPTIONS

3.1 Situation

Following a disaster, there will be a need for behavioral health services, which will increase as the severity of the incident increases. The response by AMHD will follow the National Response Plan tiers, moving from a local response to a need to access federal resources as described in Annex F – Base Plan.

There are three general areas of focus for Behavioral Health service delivery:

- Behavioral Health services for first responders
- Behavioral Health services for those in the community who have been or may become impacted by the incident
- Behavioral Health services for those with pervasive behavioral health conditions who have had their usual service delivery disrupted, and/or may be experiencing exacerbated symptoms as a result of the incident.

Additional guidance regarding provision of continuity of care for those currently receiving services can be found in the DHS Business Continuity Plan.

3.2 Assumptions

- The sudden and immediate need for behavioral health services following an incident necessitates advance planning for a response organizational structure, intervention practices, and functional interrelationships with other agencies and organizations.
- The breadth and depth of a response depends upon the severity of the incident and assessed need for behavioral health services.
- Most emotional reactions following traumatic incidents are common and predictable, and the majority of individuals impacted by such events manifest sufficient psychological resilience to recover adequately without receiving treatment. However, some reactions require professional intervention.
- Anxiety responses comprise the most common emotional reactions following an incident, but depression, physical symptoms, and increased substance use also occur.
- The entire community is affected by major traumatic incidents. Civilian survivors, responders, and the greater community at large may require debriefing, psycho-education, crisis counseling, and/or other behavioral health intervention.
- Some behavioral health reactions stem from problems created by or related to the incident, such as observing others' distress, living in a shelter, or the overall impact on the community. Other behavioral health reactions may occur as exacerbation of preexisting behavioral health conditions. In all instances, these behavioral health reactions may lead to significant distress and disturbances of functioning, requiring appropriate clinical interventions to reduce the risk of immediate or long-term health consequences.
- Individual impact depends in part on the degree of exposure to the incident. Specific reactions and long-term effects are influenced by each individual's unique combination of health, developmental level, and resources and experiences, including cultural considerations.
- Some impacted individuals will have special needs that require especially early candidacy for assistance or intervention.
- The stress of disaster circumstances is such that individuals who have ongoing or chronic mental health difficulties are vulnerable for experiencing exacerbated

symptoms. This can create disruptiveness within general community emergency services delivery, including public health service delivery sites.

- A ratio of at least 4:1 of psychogenic to physical health difficulties represents the individuals likely to present at hospitals and other medical service delivery sites following high health impact-related incidents.
- Most who would benefit from clinical and/or preventative intervention typically do not self-refer, requiring that services be delivered through nontraditional means such as outreach and other case-finding strategies.
- The behavioral health need can exceed local community mental health programs' (CMHP) capacity to respond, requiring assistance from other counties and coordination with other agencies and organizations associated with behavioral health services during times of disaster.
- CMHPs develop community-based Behavioral Health Emergency Response Rosters – trained pools of behavioral health providers and community volunteers – who agree to be ready to respond to local incidents. AMHD provides technical support and guidance for these local response teams.
- During a major incident, AMHD facilities in impacted areas reduce their day-to-day operations to the minimum necessary to maintain the health, safety, and basic needs and services for those whom they serve. All other available resources are diverted to the behavioral health response, as deemed appropriate and/or requested by relevant authorities. The immediate response continues until behavioral health needs appear to be met or long-term recovery services are established, generally no longer than six to eight weeks.

4 CONCEPT OF OPERATIONS

Behavioral health operations are integrated and coordinated with the greater ESF #8 Health and Medical and/or Emergency Management response. Operational structure is consistent with the *National Incident Management System* (NIMS) (*www.fema.gov/pdf/emergency/nims/nims_doc_full.pdf*). Typically, AMHD will integrate within the ICS as a branch under Operations in the Public Health Agency Operations Center (AOC). (See Tab F-1 for a position description of the Behavioral Health Branch Director.)

4.1 Notification

Notification of a large scale incident will likely come from the Oregon Emergency Response System (OERS) through the Public Health Duty Officer. The Public Health Duty Officer, in turn, would notify the AMHD Duty Officer, who will initiate the parts of this plan as needed. In smaller incidents, CMHPs and/or local hospitals may notify OERS, the Public Health Duty Officer, or other officials in an incident command position of the need to initiate a behavioral health response; or local public health authorities may initiate notification of CMHPs regarding such local incidents. (See Tab F-3 for the Behavioral

Health Duty Officer SOP and Tab F-4 for the Behavioral Health Statewide Activation SOP.)

4.2 Operational Priorities

To minimize the behavioral health impact of the disaster, AMHD will:

- Assess the risk of mental health effects from the incident and recommend intervention strategies.
- Prioritize and recommend priority groups for interventions.
- Coordinate with other behavioral health agencies and organizations active in disaster in order to establish role boundaries and a coordinated system of response.
- Provide technical support and guidance for county-level operations.

5 ROLES AND RESPONSIBILITIES

This section outlines the roles and responsibilities of the federal, state, and local agencies involved in the preparation for and response to an incident.

5.1 Federal

The Substance Abuse and Mental Health Services Administration (SAMHSA) of the U. S. Department of Human Services (HHS) provides guidance for behavioral health all-hazards disaster planning (see HHS publication No. SMA 3829: *Mental Health All-Hazards Disaster Planning Guidance*) and offers a variety of educational materials for responders and those impacted by disaster (see References).

- Federal Emergency Management Agency (FEMA) - In the event of a federally declared emergency (given by the President of the United States), grant funds are available by application for the development of a Crisis Counseling Program (CCP). The funds can provide services for up to 11 months. Activities most frequently funded include short-term individual and group crisis counseling, public education, and arranging referrals for longer-term needs. For more information on the CCP, see: *http://mentalhealth.samhsa.gov/cmhs/EmergencyServices/ccp_pg01.asp*.
- Disaster Medical Assistance Teams (DMAT) - DMAT behavioral medicine professionals (psychiatrists, psychiatric mental health nurse practitioners, and others) either as part of an overall DMAT deployment or as a specific deployment team, can:
  - Provide "surge behavioral medical capability" for individual hospitals and ambulatory treatment areas by assisting in the evaluation and treatment of ambulatory and hospitalized patients' behavioral health needs.
  - Assess and treat other first responders.
  - Provide consultation to and receive referrals from other mental health disaster response workers.

- Provide behavioral health expertise as part of a rapid medical assessment team that would assist in the assessment of the medical and public health needs of the affected communities.

5.2 State Agencies

This section outlines the roles and responsibilities of the state agencies involved in an emergency incident.

5.2.1 Department of Human Services (DHS)

5.2.1.1 Oregon Addiction and Mental Health Division (AMHD)

Preparedness

- Maintains a Behavioral Health Emergency Response Coordinating Team (BHERT) which provides oversight for the behavioral health all-hazards planning and response.
- Develops statewide plans, which address internal lines of authority, action for both preparedness and response, and communication with partner agencies.
- Coordinates plans with statewide and local emergency management authorities.
- Networks with other agencies and organizations that typically play behavioral health roles following emergency incidents.
- Participates in local, regional or statewide training and exercises that focus on behavioral health readiness.
- Oversees development of the clinical intervention standards. The Behavioral Health Emergency Response Field Guide, for additional discussion of typical intervention strategies and standards (See Tab F-5).
- Develops a list of state-level primary and backup staff contact information, designated as Clinical Staff or Administrative/Support Staff.
- Identifies, coordinates, and if necessary, develops emergency response training for behavioral health staff and volunteers.
- Establishes a list of appropriate individuals who could serve as Branch Director when the plan has been activated.
- Ensures that those who can take leadership roles are appropriately trained and/or informed regarding local plans for response.
- Provides planning guidance for CMHPs.
- Receives from CMHPs and stores local volunteer response team rosters, seeking updates every two years or as is feasible.
- Ensures that disaster preparedness educational material is available for those with psychiatric disabilities, including how to access behavioral health-related resources following an incident.

- Ensures plans for the State Hospitals are in place for the evacuation of patients and for receiving inpatients from hospitals in affected areas if needed, including:
  - Addressing how the State Hospital Inpatient Program relates to and works with the local CMHP and/or state BHERT.
  - Ensuring that adequate staffing exists to continue the day-to-day operations, especially if staff are called to the field during an emergency.

Response

The Behavioral Health Branch Director, in consultation with other AMHD staff if needed:

- Maintains communication for the purposes of technical/clinical guidance, sharing information related to behavioral health issues, and discussion of issues requiring confidential peer consultation.
- Performs outreach activity, including provision of relevant and accurate information to the Public Information Officer (PIO), promoting case finding activities, and promotion of individual and community resilience.
- Ensures that State-employed health care workers who become responders during an incident know that they can access behavioral health assistance by means of the Employee Assistance Program: *http://www.oregon.gov/DAS/PEBB/EAP.shtml*
- When necessary recruits a Behavioral Health Liaison Officer to coordinate response with volunteer services, including mental health associations, American Red Cross, National Organization for Victims Assistance, the faith community, Volunteer Agencies Active in Disaster, consumer/advocacy organizations, and others as appropriate. (See Tab F-2 for a position description for the Behavioral Health Liaison Officer.)
- Implements its call-down procedure for notifying staff, centers, hospitals, offices, and other units, including methods for recruiting additional behavioral health professionals as volunteers if the response capacity is at risk of being exceeded.
- Inventories available supplies and equipment.
- Develops and shares with relevant parties a state-level service delivery plan that considers and indicates opportunities and possible strategies for delivering services related to:
  - Triage (e.g., cases requiring immediate treatment, less urgent referral, or watchful waiting).
  - Direct care of persons affected by the incident.
  - Counseling services and medications.
  - Care/support/surveillance of responders.
- Considers sites and settings where behavioral health needs may be addressed, including, but not limited to:
  - Sites where the actual incident/damage has occurred.
  - Locations where impacted individuals are gathering.
  - Shelters.

  - Disaster Resources Centers.
  - Medical settings, including temporary sites set up by the ESF #8 Health and Medical response.
  - Morgues.
  - Response sites set up by other agencies and organizations.
  - Schools, churches, town meetings, community centers, media events, and other community gatherings that may involve impacted individuals.
  - Responder or emergency management settings, such as the EOC, AOC, ECC, and organizational sites for emergency responders or medical personnel.
- Identifies sites and settings the general service delivery plan will aim to cover, considering:
  - Where the damage is most severe.
  - Where the greatest number of impacted individuals could be accessed.
  - Where the behavioral health impact seems to be greatest.
  - Needs that are being met by other agencies and organizations.
  - Anything specifically requested by the ECC, AOC, or an EOC.
- Determines the intervention standards or expected protocol.
- Ensures development of a system of appropriate intervention or post-response action for behavioral health staff and other Department of Human Services responders.
- Communicates directly with the BHERT as often as deemed necessary.

Recovery

- Develops and implements a plan for addressing ongoing and/or long-term behavioral health needs, including those specifically defined by FEMA, SAMHSA, or other granting organizations, and addressing considerations such as:
  - Likely long-term behavioral health impact on both individuals and the community.
  - Level of behavioral health impact observed during the immediate response phase.
  - Available CMHP and other behavioral health resources in the impacted areas.
  - Special population needs.
  - Business continuity needs.
  - Any unique behavioral health factors relevant to the specific incident.

5.2.2 Department of Justice (DOJ) and the National Organization for Victims Assistance (NOVA)

As part of a statewide network that provides assistance on a daily basis to crime victims, the DOJ Crime Victims Assistance Section (CVAS) can provide specialized assistance in the event of a criminal incident.

- CVAS maintains familiarity with every aspect of the criminal justice response system (death notification, support in times of personal crisis through sentencing of defendants,

information and support by experienced criminal justice advocates, etc.). Planning for future assistance for victims of crime is also available.

- Many CVAS individuals, as well as a broader group of clergy, teachers, health care professionals, firefighters, etc., are trained to provide short-term interventions based on the NOVA crisis response model.
- Following major events, NOVA can provide trained volunteers to provide initial emotional support to victims and witnesses, as well as assistance to the public, planners, victims, and witnesses.
- Coordinates efforts with the ICS by means of a DOJ representative at the ECC.

5.3 Local Health Departments

5.3.1 Preparedness

During the preparedness phase, the local health department is responsible for:

- Ensuring the existence of a local behavioral health response plan.
- Establishing with their CMHP the means by which notification and activation will take place during an incident, including how and when to consult with one another when activation needs to be considered.
- Networking with those who are developing the local behavioral health response plan, including establishing how they will work together during response and when possible inviting the behavioral health team to participate in local health department trainings, drills and exercises.

5.3.2 Response

During the response phase, the local health department:

- Follows through on the locally-established procedure for notification and activation.
- Coordinating with the Emergency Operation Center and the behavioral health operation, establishes the means by which behavioral health leadership will receive and be able to provide ongoing communication regarding what is happening in the field.
- Keeps the behavioral health operation informed regarding LHD response activities, so that services may be coordinated.
- Consult the Behavioral Health Emergency Response Field Guide (see Tab F-5) for additional specific information on coordination of integration between Behavioral Health and Public Health emergency response.

5.3.3 Recovery

During the recovery phase, local health departments:

- When needed, help coordinate and facilitate referral processes.

- Ensure that their LHD responders are aware of how they might receive behavioral health services after the response phase has ended.

5.4 Private Sector

5.4.1 Private Agencies Contracting as CMHP

The roles of private mental health agencies that contract or subcontract for some or all of the CMHP functions for the county are consistent with roles defined within their respective local health departments.

5.4.2 American Red Cross

The American Red Cross is congressionally mandated to respond to both natural and human-caused incidences of all sizes. Red Cross Disaster Mental Health (DMH) responders are typically present at all large emergencies.

- The Red Cross fills the gaps between the disaster-related needs following an incident and the services and resources available within the impacted community.
- Red Cross DMH responders are mental health professionals who have completed the required Red Cross coursework and have licenses or certifications that allow for independent practice.
- Mental health services provided are short-term and rely upon local referral resources for addressing the needs of those who require on-going care.
- The Red Cross may also provide deployment training for additional mental health volunteers if and when the circumstances require it, and may be able to provide other relevant trainings and resources as is feasible.
- DMH provides or endeavors to arrange for mental health coverage for all Red Cross sites and operations, addressing the needs of clients, all Red Cross staff, and other impacted individuals when the need for assistance is identified and/or requested.
- When possible, the Red Cross provides DMH staff when services are requested by other agencies or organizations.
- If the behavioral health need exceeds the capacity of the local chapter to respond, the Red Cross typically recruits additional DMH staff from neighboring chapters, the relevant Red Cross Service Area and/or nationally.
- Once the community is able to address the surge in behavioral health needs on its own, the Red Cross transitions their operation back to the local chapter, and continues to provide post-incident mental health intervention for Red Cross staff as is necessary.

6 VULNERABLE POPULATIONS

Many individual conditions can result in certain people being more vulnerable than others to significant behavioral health impact during times of disaster, such as, but not limited to:

- Those with pre-existing or chronic mental health or addiction conditions.
- Those who are frail elderly, who have disabilities, or for other reasons may need regular special care or assistance.
- Those who may encounter obstacles to receiving services due to issues related to culture or language.

AMHD works closely with the Seniors and People with Disabilities Division in order to coordinate planning, response, and recovery efforts in ways that consider such special needs.

7 PLAN MAINTENANCE

This document was developed and will be maintained by AMHD of DHS. It will be reviewed every year, and will be updated as necessary.

8 TRAINING AND EXERCISES

Recommended trainings include:

- Introduction to Behavioral Health Emergency Response - under development
- Leading Behavioral Health Emergency Response – under development
- Psychological First Aid:
  - *Psychological First Aid,* offered by the American Red Cross, is a 3-4 hour training designed for the lay audience, or
  - A ½ hour web-based training intended for the professional behavioral health audience is provided by SAMHSA at *http://www.shs.net/samhsadr/contents.htm*.

9 WEB SITES

Oregon Public Employees Benefit Board: Provides crisis counseling for state employees. *http://www.oregon.gov/DAS/PEBB/EAP.shtml*.

National Center for PTSD: *http://www.ncptsd.org*.

National Child Traumatic Stress Network: *http://www.nctsnet.org*.

Substance Abuse and Mental Health Services Administration, Department of Health and Human Services:

Fundamentals of Disaster Planning and Response: *http://www.shs.net/samhsadr/*

Disaster Recovery Resources for Substance Abuse Treatment Providers:
http://www.samhsa.gov/csatdisasterrecovery/index.html

Disaster Readiness and Response Information:
http://www.samhsa.gov/Matrix/matrix_disaster.aspx

Additional relevant websites can be found in the Behavioral Health Emergency Response Field Guide (See Tab F-5).

10 REFERENCES

Centers for Disease Control and Prevention, Department of Health and Human Services. Public Health Emergency Response Guide for State, Local and Tribal Public Health Directors. *http://www.bt.cdc.gov/planning/*.

National Center for Child Traumatic Stress (NCCTS) and National Center for PTSD (PCPTSD) (2005). Psychological First Aid: Field Operations Guide. *http://ncptsd.va.gov/pfa/PFA_9_6_05_Final.pdf*.

Substance Abuse and Mental Health Services Administration, Department of Health and Human Services (2003). Mental Health All-Hazards Disaster Planning Guidance. HHS Publication No. SMA 3829.

Substance Abuse and Mental Health Services Administration, Department of Health and Human Services (2001). Emergency Mental Health and Traumatic Stress: An Overview of the Crisis Counseling Assistance and Training Program. Explains the CCP program. *http://mentalhealth.samhsa.gov/cmhs/EmergencyServices/ccp_pg01.asp*

Additional references can be found within the Behavioral Health Emergency Response Field Guide (See Tab F-5).

11 ACRONYMS

ACDP	Acute and Communicable Disease Prevention
AMHD	Addiction and Mental Health Division
AOC	Agency Operations Center
BHERT	Behavioral Health Emergency Response Coordinating Team
CCP	Crisis Counseling Program
CDC	Centers for Disease Control and Prevention
CMHP	community mental health program
CVAS	Crime Victims Assistance Section
DHS	Department of Human Services (Oregon)

DMAT	Disaster Medical Assistance Team
DMH	Disaster Mental Health (American Red Cross)
DOJ	Department of Justice
ECC	Emergency Coordination Center
EOC	Emergency Operations Center
ESF	Emergency Support Functions
FEMA	Federal Emergency Management Agency
HAN	Health Alert Network
HHS	Department of Health & Human Services (Federal)
ICS	Incident Command System
LHD	Local Health Department
LRN	Laboratory Response Network
NIMS	National Incident Management System
NOVA	National Organization for Victims Assistance
OAR	Oregon Administrative Rules
OEM	Office of Emergency Management
OERS	Oregon Emergency Response System
OPHD	Oregon Public Health Division
ORS	Oregon Revised Statutes
OSPHL	Oregon State Public Health Laboratory
PHEP	Public Health Emergency Preparedness
PIO	Public Information Officer
SAMHSA	Substance Abuse and Mental Health Services Administration

TAB F-1
AOC BEHAVIORAL HEALTH BRANCH DIRECTOR POSITION DESCRIPTION

DHS
Oregon Department of Human Services

ICS Section: Operations
Behavioral Health Branch
Reports to: Operations Section Chief
Location: DHS AOC

AOC Behavioral Health Branch Director

******Read This Entire Position Checklist Before Taking Action******

REMEMBER – SAFETY FIRST

Job Description

The AOC Behavioral Health Branch Director coordinates behavioral health services for the health care, public health, and first response workforce, as well as services to the public. The AOC Behavioral Health branch is responsible for ensuring that requests for behavioral health resources from the state Emergency Coordination Center in Salem are routed through to the appropriate behavioral health agency to be filled. Fulfillment of resource requests will need concurrence with the Emergency Support Function 8 Operations Chief in the state public health Agency Operations Center (AOC) in Portland for appropriate allocation and distribution. In most incidents, the Behavioral Health Branch will operate from the AOC. The AOC Behavioral Health Branch Director also provides technical guidance and support for behavioral health operations in the field.

Responsibilities

- Holds primary responsibility for management of the Behavioral Health response for the incident.
- During smaller or less complex responses, may also assume Behavioral Health Liaison Officer duties.
- During larger and more complex responses, may enlist the aid of an administrative assistant.
- In consultation with the Behavioral Health Emergency Response Team (BHERT) and the county Behavioral Health Branch Directors, develops and provides facilitation and support for a Behavioral Health service delivery plan.

Position Checklist

Activation Phase

- ❑ Sign in upon arrival at the AOC.
- ❑ Report to the Operations Section Chief and receive or confirm position and duties.

- ❑ Set up a workstation and review position responsibilities.
- ❑ Establish and maintain an individual log that chronologically describes actions taken during each shift.
- ❑ Determine resource needs, such as a computer, phone, plan copies, and other reference documents.
- ❑ During state-level activation, establish with OPHD the method by which behavioral health leadership in impacted counties will be alerted and proceed as indicated.
- ❑ If AOC interactions appear to require more extensive time and involvement than the AOC Behavioral Health Branch Director can provide, and the Incident Commander so requests or concurs, recruit and assign Behavioral Health Liaison officers as appropriate and arrange plans for regular communication with such liaison officers.
- ❑ Obtain information about the incident from:
  - ❑ The BHERT
  - ❑ The ICS sections, including the ICS Operations Chief
  - ❑ OPHD
  - ❑ The county-level Behavioral Health Branch Directors in the impacted counties
  - ❑ The media
- ❑ Identify the nature, scope, severity, and type of incident. Note information such as:
  - ❑ Extent of physical damage and/or other types of impact on individuals and the community.
  - ❑ Location of different types of impact from the incident.
  - ❑ Diverse populations and special needs involved.
  - ❑ Response sites being set up and services planned by other organizations and agencies.
  - ❑ Assistance requested by other organizations and agencies.
  - ❑ Availability of behavioral health and community volunteer responders in the impacted counties.
  - ❑ Availability of staff and resources in non-impacted counties.
- ❑ Determine sites and settings where behavioral health needs may need to be addressed, including but not limited to:
  - ❑ Sites where the actual incident/damage has occurred
  - ❑ Locations where impacted individuals are gathering
  - ❑ Shelters
  - ❑ Disaster Resources Centers
  - ❑ Medical settings, including response sites set up by Public Health

- ❑ Morgues
- ❑ Response sites set up by other agencies and organizations
- ❑ Schools, churches, town meetings, community centers, media events, and other community gatherings that may involve impacted individuals
- ❑ Responder or emergency management settings, such as the ECC, and organizational sites for emergency responders or medical personnel

❑ Develop a general Behavioral Health service delivery plan and share it with activated counties, which considers:

- ❑ Where the damage is most severe
- ❑ Where the greatest number of impacted individuals could be accessed
- ❑ Where the behavioral health impact seems to be greatest
- ❑ Needs that are being met by other agencies and organizations
- ❑ Anything specifically requested by the ECC, AOC, or an EOC

Operational Phase

❑ Establish with public health leadership whether impacted-county behavioral health leadership will initially be alerted by local public health, or by the behavioral health branch director, and proceed as indicated.

❑ Establish contact with the Agency Operation Center (AOC):

- ❑ Identify the nature, scope, severity, and type of impact of the incident.
- ❑ Monitor all incident and response activities reported to the AOC, with an eye to where behavioral health support may be needed, introduced, and/or requested.
- ❑ Identify other agencies or organizations activated to provide disaster mental health services, what their contributions entail, and how coordination and cooperation might be established.
- ❑ Establish any hazards and restricted-access areas in the field.
- ❑ If Agency Operation Center interactions appear to require more extensive time and involvement than the Behavioral Health Branch Director can provide, and the Incident Commander so requests, recruit and assign a Behavioral Health Liaison and arrange a plan for regular communication with the Behavioral Health Liaison.

❑ Perform an inventory of available supplies and equipment that may be necessary for the response.

❑ Establish contact with the Behavioral Health leadership for all impacted counties:

- ❑ Remind them to review their local plan, even if all they have is the default plan.
- ❑ Share information gathered at the AOC that is relevant to their particular county.

- ❑ Inform them of resources that are available or are expected to become available, and facilitate getting resources into the field.
- ❑ Establish contact information and a means of regular communication, gathering information from the field that may be useful to share at the AOC.
- ❑ Develop and share a template for an orientation presentation that county behavioral health leadership can use to prepare their workers.
- ❑ Supply just-in-time training materials.

- ❑ Assess the need for and availability of behavioral health and community volunteer responders in each of the impacted counties.
- ❑ Arrange that all hospitals, care centers, and other facilities in the impacted areas are contacted and monitored regarding incident-related needs.
- ❑ As needed, work with county Behavioral Health Branch Directors to establish staff needs and support or facilitate recruitment of staff from contiguous counties.
- ❑ Monitor ongoing needs for staff, assisting with recruitment as necessary.
- ❑ In consultation with the AMHD Medical Director, develop an orientation for county Behavioral Health Branch Directors to share with their incoming staff, which provides a brief review of:
  - ❑ The nature and state of the response, including its breadth and the activities of other behavioral health agencies and organizations.
  - ❑ Incident-specific concerns and needs.
  - ❑ The response organizational structure, including where the responders themselves fall with the structure and who their direct supervisor will be.
  - ❑ The intervention standards or expected protocol.
  - ❑ Materials and referral resources available.
  - ❑ Important contact numbers, such as their direct supervisor, the county Behavioral Health Branch Director, and referral resources.
- ❑ Ensure that county Behavioral Health Branch Directors are systematically tracking and recording staff assignments, including day-to-day assignment locations.
- ❑ Establish the safety of potential response sites, so as not to send responders into biohazards and other risky situations, and ensure that this information has been communicated to local Behavioral Health leadership.
- ❑ Provide consultation for the county Behavioral Health Branch Directors in regard to personnel issues that may arise.
- ❑ Develop a system of appropriate intervention or post-response action for Behavioral Health staff and other responders.
- ❑ Consult with the AMHD Emergency Response Coordinator regarding educational materials and human resources available.
- ❑ Check on need for and availability of rental cars, cell phones, and/or other equipment that may become necessary for behavioral health response purposes.

- ❑ Arrange or ensure that material resources get to where they are needed in the field.
- ❑ Provide regular written or oral situation reports for the BHERT. Communicate directly with the BHERT as often as deemed necessary.
- ❑ Adjust the Behavioral Health service delivery plan as appropriate, incorporating information gleaned from the ECC, AOC, EOCs, and Behavioral Health Liaison Officers as relevant.
- ❑ Respond to requests from the media for presentations regarding behavioral health issues, in consultation with the Public Information Officer, and the Behavioral Health Liaison when relevant.
- ❑ Review the state behavioral health emergency response plan, and be prepared to provide technical guidance to counties and the AOC regarding its implementation.
- ❑ Coordinate with the AOC, and Behavioral Health Liaison Officers when relevant, to disseminate information and guidelines to the public, such as:
  - ❑ Where and how to access behavioral health care.
  - ❑ How to cope with emotional reactions to the incident.
  - ❑ Issues related to children, their families, and teachers.
  - ❑ Issues related to special needs.
  - ❑ Dispelling rumors.
- ❑ Develop an initial general service delivery plan in consultation with the AOC, public health, county behavioral health, other relevant behavioral health units, and the behavioral health emergency response team (BHERT). (The BHERT is comprised of individuals who have state-level decision-making authority, including the AMH administrator, the AMH emergency response coordinator, the AMH medical director, the PHP behavioral health liaison officer, and others as designated or requested. The BHERT provides oversight for the behavioral health emergency response plan and during responses oversees activities and responsibilities of the behavioral health branch director assigned to AOC.)(
- ❑ When relevant, encourage appropriate members of local and state-level behavioral health agencies to join the Health Alert Network, as a means of facilitating communications within the behavioral health response community.
- ❑ When being replaced:
  - □ Remain at the assignment position until the arrival of qualified relief staff and being released by the AOC Manager.
  - □ Thoroughly brief replacement staff regarding developments and status of AOC Behavioral Health Branch Director activities to date before leaving the workstation.
  - □ Ensure that all logs, lists, and paper work are complete and passed on.

Forms for this Position

- ❒ AOC Sign In Sheet

- ❒ ICS 204 Division Assignment List (Review and modify for Divisions within the Branch)
- ❒ ICS 214 Unit/Activity Log
- ❒ ICS 214a Individual Log

Demobilization Phase

- ❑ Deactivate the AOC Behavioral Health Branch Director position and close out logs when authorized by the AOC Manager.
- ❑ Complete all required forms, reports, and other documentation. All forms should be submitted through the AOC Operations Chief to the Planning/Intelligence Section, as appropriate, prior to your departure.
- ❑ Be prepared to provide input to the after-action report.
- ❑ Clean up and ensure appropriate disposition of materials and equipment used at the workstation before leaving.
- ❑ Leave a forwarding phone number where you can be reached.

TAB F-2
AOC BEHAVIORAL HEALTH LIAISON OFFICER POSITION DESCRIPTION

DHS
Oregon Department of Human Services

ICS Section: Operations
Behavioral Health Branch
Reports to: Behavioral Health Branch Director
Location: DHS AOC or ECC

Behavioral Health Liaison Officer

******Read This Entire Position Checklist Before Taking Action******

REMEMBER – SAFETY FIRST

Job Description

The Behavioral Health Liaison Officer coordinates response activity between the AOC and the ECC, JIC, and/or other volunteer agencies involved with the provision of behavioral health services following disaster, such as:

- Mental health associations
- American Red Cross
- National Organization for Victims' Assistance
- Faith-based organizations
- Volunteer Agencies Active in Disaster
- Consumer/advocacy organizations

The BH Liaison Officer is typically located at the OPHD AOC. If an incident requires managing a large number of resources, a Behavioral Health Liaison Officer may be assigned to the state Emergency Coordination Center (ECC).

Responsibilities

- Acts as an information and communication conduit for coordination and cooperation between the behavioral health response and other agencies.
- When coordinating with a JIC, facilitates risk communication guidance as appropriate or requested; and provides guidance for fielding incoming calls that would benefit from referral to Behavioral Health.
- Monitors the ECC and/or other relevant work assignment settings for signs of behavioral health impact on responders, and provides or arranges for intervention as appropriate.

Position Checklist

Activation Phase

- ❑ Sign in upon arrival at the AOC, JIC or ECC, as appropriate.
- ❑ Report to the AOC Behavioral Health Branch Director, and when relevant the JIC or ECC Manager, and receive or confirm position and duties.
- ❑ Set up a workstation and review position responsibilities.
- ❑ Establish and maintain an individual log that chronologically describes actions taken during each shift.
- ❑ Determine resource needs, such as a computer, phone, plan copies, and other reference documents.

Operational Phase

- ❑ Meet with representatives of those entities for which the liaison officer has been assigned, and determine and address communication and coordination needs.
- ❑ Consult regularly with the Behavioral Health Branch Director, keeping him/her informed of developments; especially those that require consultation before proceeding or may result in the need for service delivery plan modification.
- ❑ When being replaced:
    - □ Remain at the assignment position until the arrival of qualified relief staff and being released by the AOC Manager and/or assignment site leadership.
    - □ Thoroughly brief replacement staff regarding developments and status of Behavioral Health Liaison Officer activities to date before leaving the workstation.
    - □ Ensure that all logs, lists, and paper work are complete and passed on.

Demobilization Phase

- ❑ Deactivate the Behavioral Health Liaison Officer position and close out logs when authorized to do so by the AOC Manager.
- ❑ Complete all required forms, reports, and other documentation. Before departing all forms should be submitted through the AOC Behavioral Health Branch Director to the Planning/Intelligence Section, as appropriate.
- ❑ Be prepared to provide input for the after-action report.
- ❑ Clean up and ensure appropriate disposition of materials and equipment used at the workstation before leaving.
- ❑ Leave a forwarding phone number where you can be reached.

TAB F-3
SOP: BEHAVIORAL HEALTH DUTY OFFICER

Standard Operating Procedures (SOP)

Section	Title
Attachment F – Behavioral Health	Behavioral Health Duty Officer

Number	Approved By	Revision Date
F-3	*DRAFT*	8/21/2007

Purpose	This SOP provides guidelines for the behavioral health duty officer.
Responsibility and Scope	The behavioral health duty officer is responsible for facilitating: • Initial state-level activation of a behavioral health emergency response. • Any necessary AOC behavioral health branch director activity, until establishing another individual in that position. • Technical guidance and support during county-level incidents or other circumstances resulting in such services being requested.

Procedures	The behavioral health duty officer: • Carries the pager for AMH, or arranges for another individual to carry it. • Receives the initial call from the public health duty officer. • Coordinating with the AMH assistant director and/or AMH deputy director, finds and assigns an individual who will provide leadership for the response as behavioral health branch director (or liaison) by proceeding through the following call-down order: o AMH assistant director o AMH deputy assistant director o Superintendent, Blue Mountain Recovery Center o Superintendent, Oregon State Hospital o AMH staff that have been trained to perform this duty • When contacted by counties seeking technical guidance or support, addresses the expressed need or arranges for the need to be met by someone on the behavioral health leadership roster. • Alerts the Behavioral Health Emergency Response Team (BHERT) when a county or counties report having activated their local plans.
Revision History	

TAB F-4
BEHAVIORAL HEALTH EMERGENCY RESPONSE FIELD GUIDE – UNDER SEPARATE COVER

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