State of Oregon
Addictions and Mental Health Division
Oregon Department of Human Services

Behavioral Health Emergency Response Field Guide

August 2007

[**NOTE: Readers with an imminent need to initiate a behavioral health response should turn to turn to *Attachments 4H, 4I,* and *4L* for an overview of the most essential material.]**

ACKNOWLEDGEMENTS

The *Behavioral Health Emergency Response Field Guide* represents culmination of the fruits and labors of several years of planning and discussion among numerous stakeholders. Their assistance has been critical to the success of this document. Thank you to the dozens of professional colleagues who have participated in the *Behavioral Health All-Hazards Workgroup,* for their dedication and commitment to looking out for the disaster behavioral health interests of the citizens of Oregon.

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FORWARD

This field guide is an attachment to *Attachment F – Behavioral Health* of the *Oregon Public Health Emergency Response Base Plan*. Its content provides guidance for local implementation, addressing the preparedness, activation, response, and recovery phases of behavioral health emergency management. Other than those aspects of local plans that relate to direct mandates, the actual final products developed by counties and regions are expected to differ based on local needs, resources, mutual aid agreements, and stakeholder infrastructures.

The scope of the *Behavioral Health Emergency Response Field Guide* is limited to presenting the basic overview of considerations critical to setting up and maintaining a behavioral health emergency response. References are provided for planners and responders seeking greater detail. Forms, handouts, and other tools intended to help facilitate disaster preparedness and response are attached to this document. Some material already appears in *Attachment F - Behavioral Health*, but is duplicated here for ease of implementation. In terms of preparedness use this document as a reference tool, becoming familiar with the general idea, the types of information the field guide holds, and being oriented to navigate through it and seek guidance during times of need rather than as material that must be committed to memory.

This field guide also serves as the primary participant handout for the Addictions and Mental Health Division (AMH)-developed behavioral health emergency response trainings: overview, leadership, and just-in-time/employment. The most updated versions of these trainings can be obtained by contacting the current AMH emergency response coordinator.

Health Preparedness Program (HPP) (formerly HRSA) regions 1 and 2 have developed umbrella plans for their counties that provide additional material and creative tools for preparedness and response. These materials can be accessed by contacting the relevant regional coordinator.

As with all state emergency response plan materials, the *Behavioral Health Emergency Response Field Guide* is an evolving document. It will continue to be revised as new guidelines become available and new findings in the field of disaster mental health emerge. When applying the field guide users should use the most current version, which can be accessed on the Preparedness Health Network website and the AMH website [under development].

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SECTION 1: INTRODUCTION

The nature of emergency situations is unique and diverse, and the impact on those who experience them can be considerable. The task of meeting disaster-caused needs requires community application of alternative practices and procedures to be able to successfully provide services, no less so for meeting needs relating to behavioral health. Mediating the behavioral health impact of disaster requires advance development of intervention plans and service delivery strategies falling outside of usual Community Mental Health Program (CMHP) and Addiction Services (AS) agency practices, due to multiple circumstances. The level of need following a major incident can exceed local capacity and capability for county behavioral health agencies to adequately respond, requiring assistance from other agencies or perhaps even from outside the impacted area. Effective intervention during a disaster and its aftermath differs from usual clinical intervention, and is primarily based more on a preventive emphasis. Those who would benefit from such services typically do not seek them or otherwise self-refer, which requires alternative strategies for getting the services to those who need them. Disasters are often sudden and the need for services immediate. Addressing the immediacy requires advance planning for supporting behavioral health emergency response, in terms of organizational structure, intervention practices, and functional interrelationships with the overall community's emergency response.

The field of disaster mental health is a relatively new professional endeavor, in itself requiring some explanation for those who will practice or coordinate with it due to its differences from usual clinical practice. Investigations of the impact of trauma and how it can be mediated began with the military, the American Red Cross, and the National Organization for Victims Assistance. As new mental health strategies and practitioner responder numbers increased, so did application of empirical investigation, professional networking and efforts to develop disaster mental health as an independent field of professional inquiry and practice. These developments have resulted in a better understanding of the inner experience of trauma survivors and how the immediate presence of behavioral health professionals might best address their needs.

As with all disaster scenarios, the relevance of the local context comes into play. Oregon does not routinely experience major disasters, and those that have occurred are relatively minor by national standards. However this reinforces Oregon's need for preparedness activity. We are less likely to remain

up to date based on practical experience. Historically Federal funds for disaster preparedness and response have been more generously allocated to states that experience disasters regularly, which requires that states with lesser funding resource seek creative means to implement meaningful and effective plans. In terms of acquiring out-of-state support during disaster, volunteers and to some extent the relief agencies themselves tend to focus more intensely on whoever has received the most media coverage, consequences that are most dramatic, and places with larger population centers. In the event of a widespread West-coast disaster such as a catastrophic earthquake, past experiences suggest that human resources will flow much more easily into Seattle, San Francisco, and Los Angeles than into Oregon. In view of these considerations, we need to take care and be prepared to make best use of our own internal resources.

SECTION 2: THE ADMINISTRATIVE PERSPECTIVE

Purpose and Goals

The purpose of behavioral health emergency response planning is to create a system for providing behavioral health support for those impacted by disaster – including victims, their families, responders, and the greater community. The goal of the system is to mediate the behavioral health impact of disaster, minimizing consequences such as development or exacerbation of behavioral health conditions and decreasing likelihood of need for traditional longer-term interventions during later phases of recovery.

Behavioral health emergency response accomplishes the desired final outcomes by employing a flexible basic framework. In order to address the surge in need the response incorporates the services of both professional and certain unlicensed behavioral health volunteers, who work side by side with CMHP and AS agency professionals. All responders receive training – either in advance or through just-in-time or mobilization trainings – in order to be more knowledgeable of intervention practices consistent with those found to be beneficial to survivors following exposure to trauma. The responders provide services by locating themselves wherever those impacted typically gather, such as shelters, reception centers, safe rooms, emergency response staff headquarters, and disaster sites; and respond to specific emergency response referrals as needed. Psychoeducation is provided for the greater community by means of presentations at community meetings and helping develop appropriate

risk communication and informational, prevention, and referral material for the media.

The success of these coordinated efforts depends largely on the extent of local- and state-level advance planning. Local behavioral health plans need to be sufficiently structurally consistent for coordination with local emergency management, state-level behavioral health response, and other agency/organization response leadership. As strategies are developed for emergency response plans, planners also need to consider other necessary disaster plans that impact post-disaster activity, such as those related to business continuity and disaster preparedness. *Table 1* briefly compares the three different types of disaster plans. They are listed in an order that mirrors relative priorities: first considering issues of safety and security, life and limb; next ensuring that critical usual ongoing services can continue to be provided by the agency or facility; and then investing focus and resources into ESF #8 response.

TYPES OF DISASTER PLANS:

Disaster Preparedness Plans

- Focus on keeping individuals physically safe and secure during immediate disaster impact.
- Implemented by individuals, families, and facilities for the purpose of self- and other-care.
- Include practices such as smoke alarms, evacuation and relocation plans, and preparing kits for 72-hour post-disaster survival needs.

Business Continuity Plans

- Focus on maintaining regular services and operations.
- Also known as "Continuity of Operations" plans.
- Typically activated and administrated by the agency's usual personnel.

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- Usually able to accommodate smaller surges in need by means of internal arrangements.

***ESF #8 Health and Medical* Emergency Response Plans**

- Focus on meeting needs beyond those met by of usual and/or business continuity practices designed to focus purely on surge need.
- Activated and administrated by Emergency Management procedures.
- Orchestrated as an integral part of the overall community emergency response.
- Typically implement outside human and material resource assistance, and expanded or alternative service delivery sites.

Table 1: Disaster Preparedness, Business Continuity, and Emergency Response plans.

Overview of Responsibilities and Authorities

The *National Response Plan* (NRP) (2004, see http://www.dhs.gov) is a Federal document describing who at the Federal level is assigned related authorities for coordinating or providing specific domains of service following a disaster or major emergency incident. Under Emergency Support Function (ESF) #8, the *NRP* designates the Department of Health and Human Services as the coordinating agency responsible for providing services for disaster-caused health and medical needs, including behavioral health needs. Coordination of such service delivery is assigned to the Centers for Disease Control (CDC).

The CMHP system is designated as responsible for preparing for, coordinating and providing the behavioral health component of emergency response. The Federal requirement indicating that states are to provide crisis counseling and intervention for those impacted by disaster is reiterated within the *Public Health Security and Bioterrorism Preparedness and Response Act* (2002) (http://www.fda.gov/oc/bioterrorism/bioact.html). In practice, the process of meeting these mandates is facilitated by specific role definitions and responsibilities at county, regional, state, and Federal levels.

On the county level, CMHPs are responsible for developing their local method of response. They network with local emergency management and other local partners in disaster and behavioral health, deciding together how they will provide a coordinated response. They develop teams of CMHP and local

volunteer behavioral health professionals who can join the local call-down roster for response. For incidents involving major surge need they prepare local behavioral health leadership to be able to screen, train, orient and assign spontaneous volunteer behavioral health professionals; as well as other- and non-licensed volunteers deemed appropriate to assist.

Regionally, counties prepare by assessing and planning for how they can support one another when individual county needs exceed local capacity and/or capability. Such planning may occur by means of mutual agreements within HPP (formerly HRSA) regions, regions representing counties typically covered by a common emergency management office, or geographic regions consisting of counties likely to be similarly impacted and/or are in the best position to be able to support one another.

On the state level, the Addictions and Mental Health Division (AMH) is responsible for providing technical guidance and support for local behavioral health emergency response. This field guide is one such form of technical guidance. AMH also develops related trainings for local presentation, trains state-level behavioral health emergency response leadership, and monitors the status of local readiness around the state. During a disaster AMH provides technical guidance and support by establishing behavioral health staff to serve as liaisons and consultants for such support within the overall Public Health emergency response operations.

Federal agencies provide technical support by means of various guideline publications available through the Federal Emergency Management Agency (FEMA) and Substance Abuse and Mental Health Services Administration (SAMHSA), some of which are referenced in this document. During catastrophic incidents such as Hurricane Katrina and other major large-scale disasters, federal agencies may provide direct on-site assistance. Also, the *Robert T. Stafford Event Relief and Emergency Assistance Act* stipulates the possibility of funds becoming available for providing financial assistance to counties during the aftermath of Federally-declared disasters.

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Structure and Organization of Emergency Response

Addressing the complexity and chaos of a disaster aftermath is a process of aligning the unique operative variables into an organizational framework, or "grid." A standard process for emergency response organization known as the incident command system (ICS) is employed to effectively coordinate the many agencies and organizations into a functioning whole. Establishing this structure is the responsibility of emergency management.

Oregon Office of Emergency Management

As prescribed by ORS 401, the Office of Emergency Management (OEM) is responsible for maintaining an emergency services system that plans, prepares, and provides for the prevention, mitigation and management of emergencies in Oregon. The OEM located in Salem serves as the Emergency Coordinating Center (ECC) during a disaster. When activated the ECC facilitates procurement and allocation of resources requested by agencies and organizations participating in the disaster response. *Table 2* lists ways in which OEM coordinates and facilitates such activities with the state and local emergency services agencies and organizations. In Oregon, the activities are called State Support Functions (SSF), which mirrors the ESF system described in the NRP.

OEM COORDINATES AND FACILITATES EMERGENCY RESPONSE: (See http://egov.oregon.gov/OOHS/OEM/)

- Makes appropriate and necessary rules for the administration of ORS 401.
- Coordinates the activities of all public and private organizations specifically related to providing emergency services.
- Develops and maintains the State of Oregon Emergency Management plan.
- Maintains a cooperative liaison with emergency management agencies and organization of local governments, other states, and the Federal Government.
- May have additional related authority, duties and responsibilities as

directed by the Governor.

- Administers grants relating to emergency program management and emergency services for the state.
- Establishes and maintains a State Emergency Operations (Coordination) Center for the purpose of facilitating performance of disaster-related duties.
- Serves as the Governor's authorized representative for coordination of certain response activities and management of the recovery process.
- Establishes training and professional standards for local emergency program management personnel.
- Establishes task forces and advisory groups to assist the office in achieving mandated responsibilities.
- Enforces compliance requirements of federal and state agencies for receiving fund and conducting designated emergency functions.

Table 2: Duties of the Oregon Office of Emergency Management

All disasters are local, and all emergency response begins as local response. A local office of Emergency Management is established for every county. Local departments of public health, in some cases including behavioral health, perform most SSF #8 duties by means of planning and cooperative relationships developed with local emergency management. During larger-scale emergencies the local office typically activates its emergency operation center (EOC). The EOC serves as a coordination point for emergency managers, public health and behavioral health, law enforcement, and all the other agencies and organizations that become active during the response. Having a central meeting site facilitates development of a unified command structure. It also provides a means for tracking and sharing information, such as indicating where certain kinds of response may be needed or facilitating public information efforts, and serves as the body that can request resources from the ECC when local resources are insufficient.

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When the SSF #8 Health and Medical component of an emergency incident becomes sufficiently large the Agency Operation Center (AOC) is activated. The AOC, located at the Portland State Office Building, provides technical support and guidance for those delivering SSF #8 services in the field, including support for behavioral health services. In addition to providing direct support for field responders and fellow AOC staff, AOC leadership provides consultation for the ECC when SSF #8-related resources are requested and when procurement and allocation decisions must be made, thus helping facilitate the process.

Within AMH, the behavioral health emergency response team (BHERT) is responsible for ensuring the availability of behavioral health technical guidance and support during preparedness and response phases. The BHERT is comprised of individuals who have state-level decision-making authority, including AMH staff such as the assistant director, deputy assistant director, emergency response coordinator, medical director, PHEP behavioral health liaison officer, and others who may be designated or requested during a specific incident. The BHERT provides oversight for behavioral health emergency response planning, and during preparedness and planning the BHERT members oversee activities and responsibilities of the AMH emergency response coordinator. During response the BHERT designates and oversees a specific individual to provide behavioral health technical guidance and support for those in the field, regardless of whether the incident is sufficiently large to activate the AOC.

The Incident Command System

Emergency responders organize their staff and activities using a required standard response system called the National Incident Management System (NIMS) (2004). It provides a consistent nationwide template that enables federal, state, local and tribal governments and private-sector and nongovernmental organizations to work together effectively during emergency response (see http://www.fema.gov/pdf/emergency/nims/nims_doc_full.pdf). The individual holding overall responsibility for management of incident organization is called the incident commander (IC).

Figure 1 illustrates the usual basic structure of incident command organization. The IC assigns the staff resources to the positions and duties that make the most sense for managing the incident at hand. Behavioral health leadership typically works under the Operations Section as a Branch Director. When behavioral health response activities are functioning relatively independently, a behavioral health liaison is more likely to be the official behavioral health leadership position within the overall response. However, individuals working as behavioral health resources could be assigned anywhere in the structure, based on the needs of the particular emergency response efforts. Additional information on these roles and their activities can be found in the NIMS manual and trainings.

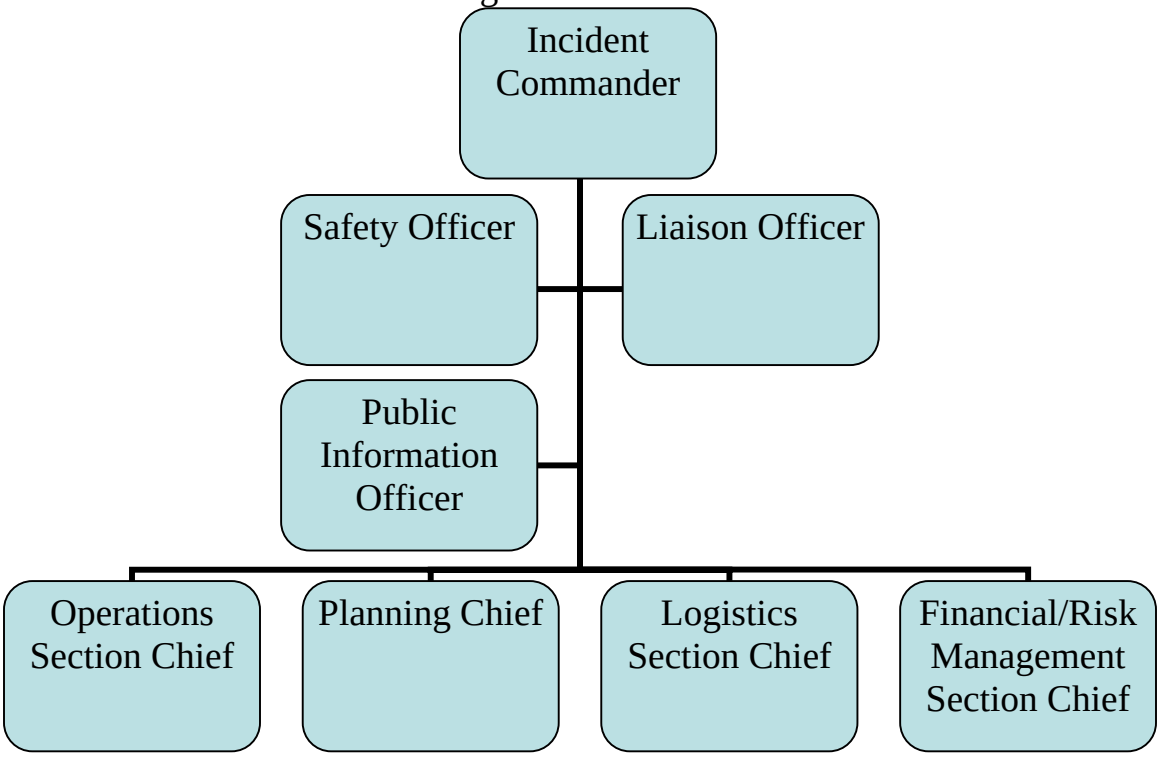

Figure 1: Typical Incident Command Organization Chart

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This structure may be implemented individually at each operation center – the AOC, ECC, and each county EOC. Local areas each have their own response organization and command structure specific to their emergency incident, focusing on the impact, needs, and resources within their own jurisdictions. The "incident" to be commanded at the AOC and ECC is that of managing resources and providing emergency-related support above and beyond what can be handled locally, including issues related to statewide communication and coordination, human and material resource procurement and allocation, and technical guidance.

Individual Roles within Behavioral Health Response

AMH has established roles and corresponding responsibilities relating to emergency response. Some roles are ongoing, with responsibilities that will vary based on whether the role activities are occurring within a framework of preparedness or responding to an emergency incident. Other roles are incident-limited, activated and assigned during an emergency or when an incident appears imminent. *Table 3* and *Table 4* provide the general descriptions of state-level and recommended county-level behavioral health emergency response roles. More specific role responsibilities are described in the sections on preparedness, activation, response, and recovery.

Note that since the allocation and assignment of behavioral health response within the overall emergency response varies, the position title held by those holding leadership can vary as well. In spite of the potential variation in behavioral health title, the leadership functions of behavioral health response are described here in terms of the branch director role, since this is the most usual position for such leadership.

STATE-LEVEL BEHAVIORAL HEALTH EMERGENCY RESPONSE ROLES

Ongoing Roles:

AMH Emergency Response Coordinator: The AMH emergency response coordinator holds primary responsibility for developing and implementing an effective statewide plan for behavioral health all-hazards preparedness and response, providing technical guidance and resources for regional and county all-hazards leadership as needed.

Behavioral Health State/Regional Planner: Behavioral health planners, in conjunction with the AMH emergency response coordinator and HPP coordinators, assist with and are a source of guidance during preparedness and response activities.

Incident-limited Roles:

AOC Behavioral Health Branch Director: This individual holds state-level responsibility to support, coordinate, and manage resources for the overall behavioral health response, acting as primary behavioral health consultant for the ECC, AOC and those working in the field.

Behavioral Health Liaison Officer: The liaison officer acts as an information and communication conduit for coordination and cooperation between the behavioral health response and other emergency response entities, such as the Joint Information Center, the ECC, local EOCs, special needs relief efforts, and any others as needed.

Table 3: State-level behavioral health emergency response roles

RECOMMENDED COUNTY-LEVEL BEHAVIORAL HEALTH EMERGENCY RESPONSE ROLES

Ongoing Roles:

Behavioral Health Branch Director – Planning: This individual is responsible for developing and implementing the county's behavioral health emergency response plan and, during an incident, is responsible for either adopting or assigning the role of EOC behavioral health branch director. The CMHP director is responsible for performing these duties unless another individual has been assigned to do so.

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Behavioral Health Response Teams: These county-based teams consist of rosters of individuals who have received appropriate training and are potentially available to join behavioral health response teams during and/or following an event. They include CMHP professional employees, volunteer licensed or certified behavioral health professionals, and non-licensed/non-certified community volunteers.

Incident-limited Roles:

EOC Behavioral Health Branch Director: During county-level incidents this individual serves as local manager of the behavioral health response, receiving technical guidance and support from the BHERT as needed. During larger events this position coordinates with the AOC behavioral health branch director and state-level behavioral health service delivery planning.

Behavioral Health Response Team – CMHP: These behavioral health responders are qualified employees of behavioral health agencies within their geographic regions, having at least one of the following designations:

- Licensed Medical Professionals: Psychiatrist, Psychiatric Physician Assistant or Psychiatric Nurse Practitioner
- Psychiatric Registered Nurse
- Psychologist
- Qualified Mental Health Professional
- Qualified Mental Health Associate
- Certified Alcohol and Drug Counselor

Behavioral Health Response Team – Community Volunteers:
Behavioral health responders may also be behavioral health volunteers from the community licensed as:

- Licensed Medical Professionals: Psychiatrist, Psychiatric Physician Assistant or Psychiatric Nurse Practitioner
- Psychiatric Registered Nurse
- Psychologist
- Licensed Clinical Social Worker

- Licensed Professional Counselor
- Licensed Marriage and Family Therapist

Non-licensed Community Volunteer Response Team: During response non-licensed community responders who have received training in psychological first aid and other related topics can also serve, and are supervised by the licensed or certified behavioral health professionals within their crew. They can be drawn from any appropriate group of helpers based on availability within the particular community, such as pastors, school counselors, chaplains, behavioral health consumer advocates and service group members.

Crew Leader: As the IC assigns and organizes groups of responders an individual on each crew is assigned the role of crew leader. The crew leader provides leadership and supervision of crewmembers; and as a behavioral health crew leader is responsible for maintaining contact with the EOC behavioral health branch director for any needed technical guidance, and reporting to administrative supervision while in the field.

Table 4: Recommended county-level behavioral health emergency response roles

Partnering Agencies

Behavioral health response is coordinated with efforts of other agencies and organizations that provide similar services following emergency incidents, or are directly connected with behavioral health response in some other manner. Duplicating behavioral health efforts can be just as detrimental for impacted individuals as leaving gaps, in that clients who are repeatedly approached can become retraumatized, or may lose confidence in the efficiency and competence of responders. This section outlines the activation and response expectations for some of the major relevant response organizations active during disasters.

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Counties may wish to outline and establish expectations in a similar manner as they network with additional local community organizations and agencies. When feasible, networking benefits if partnering agencies and organizations can be invited to participate during behavioral health drills and exercises.

Table 5 provides a recommended list of organizations and agencies with which local behavioral health emergency response planners may wish to have established relationships. Given that resources and community structures and practices vary among locales, the list of available or appropriate networking resources may be briefer or more extensive than those listed.

RECOMMENDED LOCAL AGENCIES AND ORGANIZATIONS FOR EMERGENCY RESPONSE NETWORKING

- Emergency Management
- Public Health
- Seniors and People with Disabilities
- Oregon Disaster Medical Assistance Teams
- Department of Justice – Crime Victims Advocacy Program, National Organization for Victims Assistance
- American Red Cross
- Salvation Army
- Volunteer Organizations Active in Disaster
- Emergency Response
- First Responders
- Hospitals
- Behavioral Health Professional Organizations
- Schools
- Organizations of Clergy
- Behavioral Health Consumer Advocates
- Peer Support Groups
- Cultural Groups

Table 5: List of recommended agencies and organizations for networking.

Attachment 5 and *Attachment 6* are tables from the HPP (formerly HRSA) Region 1 plan that describe suggested roles and responsibilities of community partners, and a breakdown of behavioral health activities that can

prove useful when explaining the behavioral health emergency response to such partners. Following are descriptions of the activities of some of the major organizations and agencies.

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

Description. As part of a statewide network of individuals that provide 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 of these individuals as well as a broader group of clergy, teachers, health care professionals, firefighters, etc., have been trained to provide short-term interventions based on the NOVA crisis response model. These individuals would also be available for criminal incidents. Following major events NOVA can provide trained volunteers who can provide initial emotional support to victims and witnesses, as well as assistance to the public, planners, victims, and witnesses.

Compensation programs assist victims with out-of-pocket costs incurred as a result of being an innocent victim of crime. This includes costs of counseling, funeral expenses, loss of earnings, and medical costs.

Activation. A request for assistance may come directly from OEM, through the Event Preparedness Coordinator, or by a request of a local public official for a NOVA response. Contact for deployment of NOVA teams is the Director of Crime Victims Assistance Section, Oregon Department of Justice (CVAS). When appropriate the administrator of CVAS will contact NOVA to activate both in-state and out-of-state response.

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Response and Recovery. CVAS engages in planning assistance to victims/witnesses of any criminal act and, as appropriate, promotes direct assistance to victims of crime. They assist with obtaining funding and administering the federal Antiterrorism and Emergency Assistance Program Grants through the office for Victims of Crime. In response to an incident of mass violence, they initiate an Emergency Crime Victims Compensation Program. This is part of the ongoing authority of CVAS to administer such a program to eligible victims of crime. In the event of an incident of mass violence, this process can be facilitated by use of an onsite location and additional staff to expedite the application and payment process for victims of crime. Efforts are coordinated efforts with the ICS by means of a DOJ representative at the ECC. CVAS and NOVA may continue to provide services during the recovery phase.

Oregon Disaster Medical Assistance Teams (ODMAT)

Description. ODMAT is an independent non-profit organization of volunteer healthcare professionals who provide services when local, county, and mutual aid reserves are inadequate due to a mass casualty or other disaster-related incident. ODMAT members are also members of the nationally deployable, Department of Homeland Security's National Disaster Medical System's Disaster Medical Assistance Teams (OR-2 DMAT).

ODMAT behavioral medicine professionals (psychiatrists, psychiatric mental health nurse practitioners, and others), either as part of an overall ODMAT 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. They can also assess and treat other first responders, provide consultation to and receive referrals from other mental health disaster response workers, and provide Oregon Health Services (OHS) and its partners with 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.

*Activation***.** The ODMAT behavioral health professional complement is activated through the general ODMAT activation process as described in the Concepts of Operation section of the Oregon Emergency Management Plan, Annex F. After consultation with the BHERT, ESF #8 Health and Medical response leadership may request ODMAT behavioral health professional involvement via a call to the Oregon Emergency Response System (OERS 1-

800-452-0311) or the ECC if it has been activated. OEM will subsequently consult OHS (Oregon State Health Officer or designee).

If the request is approved, OEM - in conjunction with OHS, BHERT, and ODMAT Team Leaders - will determine the exact mission as well as other operational details of the ODMAT behavioral health response. If the potential mission will likely require a full 35-member federal National Disaster Medical System (NDMS) team or multiple teams for a duration of longer than 72 hours, then a simultaneous and parallel request, FEMA NDMS DMAT-OR2 will be made through normal established channels.

Response and Recovery. The exact mission and other operational details of the ODMAT behavioral health response will be determined by OEM in conjunction with OHS, the BHERT, and ODMAT leaders.

American Red Cross

Description. The American Red Cross (ARC) is Congressionally mandated to respond to both natural and human-caused incidents of all sizes. ARC is organized as local chapters, designated to cover specific jurisdictions. ARC Disaster Mental Health (DMH) is typically present at all large emergency incidents. ARC DMH responders are mental health professionals who carry licenses or certifications that allow for independent practice, and have completed the required ARC coursework. Mental health services provided are short-term in nature and rely upon local referral resources for addressing the needs of those who require ongoing care. ARC may be able to provide deployment training for additional mental health volunteers when warranted.

ARC DMH is additionally charged by the National Transportation and Safety Board (NTSB) with primary responsibility for the mental health response following major transportation incidents. On a national level, ARC Crisis Response Teams (CRTs) are specially trained and on-call for immediate deployment to NTSB-activated transportation incidents, as well as for weapons of mass destruction or other mass casualty incidents.

Activation. ARC Disaster Services may be activated by a request from emergency management, or by the local chapter choosing to self-activate when

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an incident appears imminent. While activation is most typically based on observed or anticipated needs for emergency housing or feeding, activation of DMH services is usually automatically included, based on indications and decisions made by ARC leadership. Activation status can be ascertained by means of the EOC for the incident, or by contacting the local ARC chapter.

Response. ARC Disaster Services is charged with endeavoring to fill gaps between level of disaster-related needs following an incident and the services and resources available within the impacted community to apply to these needs. An ARC liaison is typically assigned to EOCs for the purposes of communicating and coordinating with the ICS. During major transportation incidents such as aviation accidents, ARC works with the NTSB as ARC DMH develops and implements the overall mental health service delivery plan for the incident. During a response ARC DMH provides or endeavors to arrange for mental health coverage for all ARC sites and operations, addressing the needs of clients, all ARC staff, and other impacted individuals when the need for assistance is identified and/or requested. When possible they endeavor to provide DMH staff when services are requested by other agencies or organizations. If the DMH need exceeds the capacity of the local ARC chapter to respond, ARC typically recruits additional staff from neighboring chapters, the relevant ARC Service Area and/or nationally.

Recovery. Once the community is able to address the surge in behavioral health needs on its own, ARC DMH transitions its operations back to the local chapter and continues to provide post-incident mental health intervention for ARC staff as is necessary. Local ARC DMH also continues to provide short-term limited services to meet newly-emerging incident-related needs among other impacted individuals. When needs for longer-term or more extensive intervention are identified, ARC makes referrals to local behavioral health resources.

County Emergency Management/Federal Emergency Management Agency (FEMA)

In the event of a Presidentially-declared emergency, grant funds are made available by application for funding the development of a Crisis Counseling Program. Depending upon eligibility criteria, funds are available for providing an Immediate Services Program, covering needed services from the onset of the precipitating incident up to a period of 60 days after the incident. Subsequent application can be made to continue provision of services under a Regular Services Program that can fund services for an additional nine months. County

public health departments are encouraged to work with the local staff of the three medical centers of the Veterans Administration Healthcare System and their eight community-based outpatient clinics, given that all facilities have mental health staff trained in emergency response and post-traumatic stress.

Oregon Department of Education

Description. On a state level, the Oregon Department of Education (ODE) and AMH can support one another's plans with top-down sharing of developments among their constituencies as appropriate during preparedness, response, and recovery. Since each school district develops its own plans for managing emergencies and other crisis situations, specific details of coordination with behavioral health emergency response needs to be arranged locally. Following are some suggestions for how school districts and county-level behavioral health response plans can support one another.

Preparedness. School districts and CMHP can support one another by collaborating with relevant trainings. The school district may be able to provide training for behavioral health personnel regarding how crises are handled within their districts. The CMHP may be able to provide training in psychological first aid or on other topics relevant to emergency response.

Immediate and Long-term Recovery. Following emergencies and other crisis situations that typically result in surges in child trauma reactions, schools typically set up "safe rooms." Safe rooms provide a place for children to go when they are feeling overwhelmed, and are staffed by school personnel. At times safe rooms may benefit from CMHP support such as consultation, guidance, or having a CMHP worker present. Depending upon the EAP services available, CMHP support may be needed for post-incident interventions for school personnel who became involved as responders.

Schools can serve as an avenue for behavioral health information to be shared with the public, as they serve a major role in a community's internal support network. Information can be shared by newsletters, the ODE website, school meetings and events, and other regular public announcements.

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Oregon Psychiatric Association/Oregon Health and Science University Department of Psychiatry

*Description***.** Many psychiatric providers in the general community may be available and capable of participating in an expanded response, especially if they receive just-in-time orientation and training. The Oregon Psychiatric Association and Oregon Health and Science University Department of Psychiatry are able to quickly contact their constituencies with a request for volunteers.

Activation. In the event that incident command and behavioral health leadership concur that additional psychiatric provider response is necessary, behavioral health leadership will initiate the psychiatric call-down system. [under development]

Response and Recovery. Psychiatric volunteers work side by side with other behavioral health volunteers, reporting within the same orientation and assignment process and command structure. In addition to engaging in usual behavioral health response, duties will likely include medication evaluation and facilitation, psychiatric screening and triage, and psychiatric consultation with other health providers and incident command staff. During the recovery phase most psychiatric services will transfer to the local behavioral health providers. If continued psychiatric practitioner resources are deemed necessary, arrangements can be negotiated with individual providers.

Peer Support Network

[under development]

Alcoholics Anonymous, Narcotics Anonymous, Dual Diagnosis Anonymous

[under development]

SECTION 3: THE INTERVENTION PERSPECTIVE

The Field Work Model

The behavioral health emergency response roles are designed to fit together and support a field work model approach to providing effective interventions. Behavioral health emergency response typically does not take place in an office or clinic. It is a case-finding model, where the therapist goes to the client rather than the client seeking the therapist. Following disaster many of those impacted can be expected to scatter to the four winds. The only way to get the services to them may be to go to where they are, before relocation efforts nullify most possibilities. Furthermore those first few days following the disaster are among the most critical for behavioral health intervention to have its most beneficial effect. Disaster responders benefit from an immediate presence of behavioral health support in that problems can be taken care of while they are still small, nor will responders be required to take time away from operations to make an appointment. Hooking up with clients and successfully offering services requires flexibility, creativity, and immediacy.

Numerous other factors contribute to the appropriateness of adopting a field work rather than clinic-based model. True to Maslow's motivation hierarchy, during the immediate aftermath of response disaster survivors focus on primary needs such as food, shelter, and physical safety and well-being. Secondary needs such as cognitive, behavioral, and emotional well-being are much further down on their list of motivational priorities. Furthermore the early phases of disaster recovery produce a personal "high" of adrenalin and community bonding that can mask issues brewing beneath the surface of an individual's behavioral health status.

Often disaster survivors do not acknowledge or even recognize when their emotional state has begun to interfere with their effectiveness at disaster recovery. When direct referrals take place they are more typically the result of family members recognizing that their loved one is becoming impaired than the loved one spontaneously self-referring. Individuals who are usually high-functioning often see themselves as normal, and may recognize or hear through

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the media that symptoms they are experiencing are normal reactions following disaster. They may not realize that behavioral health intervention would be useful for preventive purposes. Even when those impacted do recognize they would receive benefit, the concrete tasks facing them may overwhelm them and prevent them from making an appointment or going to where services are offered. Additionally, the cultural stigma attached to seeking mental health services is alive and well within disaster settings. Mental health intervention is seen as something for "crazy" people, and therefore not something "normal" people should seek out.

Finding the Clientele

Behavioral health emergency response therefore wraps itself around the rest of emergency response and the disaster scenario itself, positioning responders wherever opportunities may await. Following is a description of many ways in which behavioral health emergency response can seek the clients the responders will serve.

*Disaster sites***.** Following incidents such as tornadoes, floods, hurricanes, and wildfires, there are varying degrees of loss. Some areas may be completely razed, with little or no evidence of previous habitation. Other homes may show partial damage or be reduced to a pile of debris. During the days immediately following the incident even those whose homes are a total loss will return, hoping to salvage at least something. Those with substantial debris may salvage for days or even weeks. Those whose homes sustained damage but can become livable again will be involved with clean-up and repair for weeks or months to come. The emotional impact of this assessment and salvaging process can be profound, and presents ideal opportunities for responders to offer behavioral health support.

Shelters. A number of charitable organizations set up shelters for those whose homes have been destroyed, or who have been cut off from their homes by the impact of the incident. Spontaneous shelters also evolve at churches and other types of community centers. Shelters are a primary gathering place for those impacted following major disaster. Screening and triage efforts are especially fruitful at shelters because their populations often more heavily represent those who do not have financial or relationship resources for more comfortable relocation, which is also often characteristic of those with pre-existing behavioral health conditions. Pet shelters can provide an opportunity to meet with owners who come to visit. Special needs shelters may be set up,

including for those who may have been living in residential facilities that had been evacuated, and may need more extensive behavioral health support.

Campgrounds/tent cities. During evacuations or following disasters that impact residences, evacuees often spontaneously gather at nearby campgrounds or parks. When relocation resources are slim and the need is great, government agencies sometimes set up "tent cities" to house large numbers of individuals. Both provide opportunities for behavioral health responders to circulate, assess, and provide intervention and information.

Evacuation centers. When a release of hazardous material or an explosion has occurred, the arrival of a hurricane or wildfire is predicted to be imminent, or some other circumstance arises that requires people to quickly leave their homes or workplaces, evacuation centers are typically established. These provide temporary comfort areas in which impacted individuals can gather, or perhaps be sheltered while waiting to be allowed to return home.

Feeding stations and distribution sites. Many charitable agencies and community organizations set up feeding stations where individuals impacted by disaster are served regular meals; as well as sites for distributing goods, such as clothing, perishables, and cleaning and salvaging supplies. These and other sites that have fleeting contact with disaster survivors present opportunities for responders to touch bases with those who are more difficult to find, due to their not using mass care sheltering arrangements or having already permanently relocated.

Decontamination operations, points of distribution/dispensing (PODS), hospital emergency rooms, and other public health-oriented operations. As Public Health performs its health and medical support duties, operational sites are established for delivering specific needed services relevant to the particular emergency. Behavioral health response can provide support for emotional reactions of those receiving services or in some cases of those who may wish to receive services but do not qualify. They can also help facilitate the operational process itself by advocating for or assisting those who may be confused, distraught, or otherwise impaired in their ability to proceed.

Disaster Resource Centers (DRCs). When a disaster receives a Federal declaration FEMA sets up DRCs, where those who qualify can apply for or

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learn about various forms of assistance. Traditionally these sites are among the first to be staffed with the newly-hired CMHP workers funded by the Federal grants.

*Responder deployment/administrative sites***.** Responder needs can assessed as they engage in the inprocessing, outprocessing, and other administrative procedures.

Hotlines. Hotlines are often set up for those seeking information or services. Behavioral health responders are often assigned to call centers to facilitate immediate referrals for those callers who are observed to need such services, or are specifically requesting them.

Community meetings/gatherings. Community meetings occur for many reasons following disasters, such as public announcements related to when residents are likely to be able to return to damaged or isolated homes, long-term repair plans, schools assessing/meeting children's needs post-disaster or educating families regarding the emotional impact on children, and political discussions about priorities. Informal gatherings of individuals can happen anywhere for any reason, such as people gathering to hold a vigil. In addition to consideration as an opportunity for screening and triage, emotions can run high at such gatherings. The presence of behavioral health responders can prove useful in mediating any personal or public problems that may escalate because of such reactions.

Linking with volunteer agencies. Establishing working relationships with the many volunteer agencies providing assistance following disaster not only keeps the behavioral health response apprised of factors suggesting where there may be behavioral health need, but may also open opportunities for collaborative efforts. For example, following disaster ARC often establishes service centers where caseworkers help clients apply for various forms of support. While ARC usually supplies its own behavioral health staff, when resources are slim they may turn to CMHP resources for additional assistance.

Direct referrals. Another disaster relief agency or someone in the community may inform behavioral health responders of specific individuals who appear to be in need of behavioral health support.

Approaching Clients

During usual clinical practice clients are connected with behavioral health professionals because they have actively sought their services. They come ready for the process of establishing a working/therapeutic relationship, and are able to discuss issues such as informed consent. During emergency

response these expectations typically do not apply. The responders approach potential clients, usually no formal request for services is in place, and informed consent is much more informally established, in some circumstances perhaps not established at all. Disaster mental health ethics have only begun to be explored in the professional literature, mainly in the form of stating that such investigation is needed. HIPAA regulations do relax a few of the informed consent and confidentiality considerations during times of emergency. However, regardless of current professional standards and federal positions, offering services still requires sensitivity and awareness of boundaries between what is helpful and/or desired and what is intrusive.

The means by and manner in which responders and clients will connect should first be established through the administrative leadership at the site or setting. Agreements could include arrangements such as clients and responders connecting spontaneously and at will after being referred or introduced by someone on site, following an open announcement of the responder's presence, with disaster victims only and not staff, or vice versa. The specific arrangement will dictate some of the approach. Especially before engaging in anything resembling formal behavioral health intervention, responders need to formally introduce themselves and identify themselves as behavioral health professionals, since distressed individuals may not notice responder identification tags or consider their implications. Additionally explaining their presence as serving the purposes of providing stress management or behavioral health transition services helps responders appear more benign for those inclined toward stigma-oriented reactions.

Clients who are obviously distressed typically recognize why the responders are approaching them and offering help. Others who simply look lost, bewildered, or extraordinarily detached can be approached with an offering of a cup of coffee or engaging in casual conversation. When children are involved responders can offer to help entertain them while parents are busy arranging for services or loading goods. Asking parents about how their children are doing can lead to opportunities for psychoeducation, as well as a lead-in to parents discussing how they themselves are doing. Forming strong collegial relationships with the other disaster relief staff on site is essential.

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Once they know their behavioral health responders and become familiar with what they do, they are more likely to point out individuals who appear to be struggling.

Providing behavioral health support for other disaster relief responders can be as simple as the mere presence of a behavioral health responder on site. The knowledge that behavioral health support is available should circumstances become either personally or situationally difficult can be comforting in itself. A strong reassuring presence is both healing and preventive, even when the activity of the behavioral health responders is not typically thought of as behavioral health intervention. Pitching in with some of the grunt work at a site can help workers feel more comfortable speaking with behavioral health responders, as they begin to recognize them as one of the gang rather than "the shrink."

Behavioral Health Impact

The behavioral health impact of disaster and emergency situations is well-established. The entire community is affected when there is a major traumatic incident. Individual, community, and incident-specific factors are all associated with type and intensity of behavioral health reaction. Level of exposure often plays a major role in the degree of individual impact. Some behavioral health reactions stem from dealing with problems created by or related to the incident, or exacerbation of pre-existing behavioral health conditions, rather than the direct impact of experiencing the incident. However all who are exposed to disaster are in some way impacted - survivors, responders, and the greater community at large. 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.

Most emotional reactions following traumatic incidents are common and expectable. The majority of individuals successfully apply the same coping skills and strategies they use for their usual life trials and tribulations, and by way of this natural psychological resilience recover adequately without receiving any form of treatment or intervention. Some individuals will require a little assistance in accessing and applying their psychological resilience.

However some reactions are sufficiently severe to require professional intervention. In addition to exacerbation of pre-existing conditions, trauma, stress, and grief reactions are common. The two most frequently newly-diagnosed psychiatric conditions following disaster are post-traumatic stress

disorder and major depression. Staff members and volunteers who are interested in the field of disaster mental health benefit from including seminars and workshops covering these topics when they sign up for coursework intended to accrue continuing education credits.

Grief reactions require some special considerations during a disaster aftermath. People experience grief reactions not only as a result of having lost loved ones but also due to the many other losses that occur following disaster, such as homes, personal possessions, family heirlooms and photographs, relationships amidst communities or neighborhoods that have been razed and are permanently disrupted, and employment situations. Loss of pets can result in grief reactions every bit as powerful as having lost a significant person. The Oregon Animal-Disaster Response Plan identifies AMH as responsible for providing grief-related services, as a component of the behavioral health emergency response services.

The Psychological First Aid Intervention Model

Psychological first aid is currently the professionally-recognized intervention of choice for helping individuals deal with the immediate aftermath of disaster and emergency incidents. It can be applied to responders and disaster survivors of all types, and can take place in most any setting. In-depth discussion of psychological first aid and other useful related handouts and resources can be found in the *Psychological First Aid Field Operations Guide* (2006) sponsored by SAMHSA. It can be accessed at http://www.nctsn.org/nctsn_assets/pdfs/pfa/2/psyfirstaid.pdf.

Most psychological first aid interventions can be performed by any caring person; but sometimes ultimately require clinical expertise. If unlicensed or other-licensed responders are being used to provide behavioral health services it is essential that a licensed/certified behavioral health professional is also on site or easily accessible so that triage, treatment and/or referral can be facilitated. Because of this possible outcome, it is critical that all behavioral health responders go into the field armed with a list of local resources and referral procedures for behavioral health assistance.

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Screening tools have been developed that can assist with the triage and referral process. *Attachment 4M* describes circumstances that warrant referral to a behavioral health professional for screening and intervention, and could be used by any emergency responder for the purpose of guiding such referral decisions. Attached to the *Psychological First Aid Field Operations Guide* are two worksheets for provider use. The first is a checklist health care providers can use for establishing a survivor's current behavioral health needs (another version of an initial primary care device for behavioral health screening can be found at http://www.centerforthestudyoftraumaticstress.org/factsheets.shtml). The second reflects more in-depth evaluation and is oriented toward establishing a behavioral health record, indicating psychological first aid components provided and further referrals made when such documentation is needed.

In general, psychological first aid helps by promoting and sustaining an atmosphere of safety, calm and stabilization, connectedness to others, self-efficacy or empowerment, and hopefulness. Two factors account for psychological first aid's success in helping disaster survivors. First, it is oriented toward where the clients are: physically, pragmatically, and existentially. Second, it is designed to work hand in hand with natural psychological resilience - the unique collection of coping skills each individual already uses.

Located at the conclusion of this behavioral health field guide are three attachments containing brief discussions of psychological first aid. *Attachment 4 L* is a one page handout that, during crisis, can be used by those who are about to engage in immediate response and do not have time to go over longer documents reminding them of how they would best focus. *Attachments 4K and 4M* are additional overview-type documents that provide additional excellent overview synopses.

It is important to note that this relatively new intervention concept as a complete model has not yet gone through the rigors of empirical outcome investigation. The professional field has accepted it as the new standard on the strength of empirical support for its component parts, as well as the many anecdotal experiences of those who respond to disaster and have noted what seems to be most helpful in alleviating distress and reducing incidence of longer-term impact.

The Treatment Plan

From a pragmatic perspective, the overall intervention plan for meeting behavioral health needs related to the incident would best reflect the sorts of activities that funding grants are likely to cover. During federally-declared disasters, FEMA Crisis Counseling Training and Assistance Program (CCP) grants can be applied for to finance services. Activities most frequently funded include short-term individual and group crisis counseling, public education, and arranging referrals for longer-term needs. Additional information concerning CCP and grant application can be found at: http://mentalhealth.samhsa.gov/cmhs/EmergencyServices/ccp_pg01.asp.

Activities of behavioral health responders vary some based on the phase of the disaster and the qualifications of the responders. During the response phase licensed/certified responders provide services such as screening, triage, referral, and crisis counseling, and may initiate some forms of short-term counseling. During this phase the unlicensed or other-licensed responders provide non-clinical psychological first aid services only. During the recovery phase licensed/certified responders offer services within the CMHP system in accordance with current requirements for crisis counseling grants. Unlicensed and other-licensed responders may continue to provide outreach support and dissemination of informational materials during the recovery phase.

Psychoeducational materials serve as a pivotal means of preventive care through all phases of disaster. References for recommended handouts covering a variety of relevant topics can be found in the back of this field guide. Downloading and printing those preferred ahead of time and storing them with other response materials can prove prudent, given that power lines and communication systems are notorious for becoming disrupted during the immediate aftermath of disaster. The material covered by these handouts can also be useful for developing community or media presentations.

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Psychiatric Protocol

Psychiatric and addiction-related medical services are also coordinated with ESF #8 Health and Medical emergency response activities. A psychiatric consultant, preferably an associate having appropriate state or local behavioral health authority and previous disaster response experience, may be invited to participate in immediate planning and consultation with public health regarding the coordination and delivery of services in various event scenarios. These psychiatric oversight and consultation practices should be as consistent as possible with those generally provided for local mental health crisis teams or emergency facilities. Likewise, specific logistic and service expectations for brief psychiatric assessments and medication management in disaster response settings should be as consistent as possible with those provided by local CMHP settings.

Most disaster aftermaths will not require immediate participation by psychiatric providers beyond the usual cohort identified and provided through local community behavioral health provider organizations. At times additional support will be needed, which can be sought through the psychiatric planning and consultation component of state or local disaster response authorities, or the ODMAT psychiatric resources. However in some larger scale events the behavioral health challenges may exceed the capacity of the existing crisis response teams or other similar resources. This is particularly true when there is a need for assessing mental health conditions having ambiguous presentations that could be confused for other medical problems and/or disaster-related medical consequences, or a need for skillful use of psychiatric medications for persons affected by the emergency incident.

In terms of behavioral health services psychiatric-oriented needs often require the most specialized and urgent services, yet personnel available to provide such behavioral health services are typically the most limited. While it is preferable to draw upon psychiatric staff associated with the local mental health authorities or their subcontract provider agencies, local limitations, disruptions and casualties caused by the disaster itself can nullify this possibility. Volunteer psychiatric assistance may be recruited by means of the OPA and OHSU Department of Psychiatry (see the Partnering Agencies section).

Responder Care

Disaster mental health work can be extremely rewarding, especially when responders can stay involved long enough to observe client recovery and know they played a role in it. However disaster work is not for everybody. Hardship variables abound, such as long hours, repeated exposure to people in extreme distress, and difficult working environments. Those who have pre-existing health or behavioral health conditions should be especially careful to consider what they are getting themselves into. Sometimes a potential responder's family or employment situation is not conducive to taking off into disaster world. Before becoming involved, potential workers – both behavioral health and others – benefit from engaging in some self-assessment.

Responder Self-evaluation

A pre-assignment self-assessment inventory, *Psychological First Aid Provider Care,* can be found as an appendix of the *Psychological First Aid Field Operations Guide*. The inventory provides lists of questions responders can ask themselves that will help them consider whether they are ready to meet the challenge for the particular incident at hand, or perhaps whether they are appropriate for disaster work in general. The inventory also describes common stress reactions, uncommon stress reactions, and how behavioral health care providers or any responders can engage in self-care during emergency response.

The questions actually apply for almost any volunteer responder, thus sharing the inventory with other response agencies to use with their responders could serve as a preemptive strike against later behavioral or physical health difficulties. Even seasoned behavioral health professionals may find the challenge to be too overwhelming, or that their current life situation simply does not support involvement. Those within the CMHP system who draw such conclusions are still of tremendous value, however, as they can keep the home fires burning while other agency personnel are participating in emergency response.

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Management Practices and Stress

One of the most commonly-encountered sources of stress reported by emergency responders is "system stress" – specifically, issues arising due to work relationships and management policies and practices. Behavioral Health responders cannot do much about the level of trauma and stress already produced by the disaster itself, nor can they reduce system stress that arises because of what an agency actually can or cannot do to help, including dealing with resource limitations. However in their role as advocates they can, in fact, impact responder stress levels by working with management to minimize stress stemming from administration and work setting procedures. System stress can be minimized by finding appropriate ways to educate managers and encourage them to apply the following elements: [Shultz, J. M. et al (2007). *Disaster behavioral health: All-Hazards Training.* Miller School of Medicine, University of Miami.]

- *Set up an effective management structure and leadership.* Establish clear chain of command and reporting relationships. Managers and clinical supervisors should be available and accessible and, whenever possible such duty should be assigned to those who have had some experience in emergency response.
- *Establish clear purpose, goals and training.* All responders should receive an orientation before going into the field, including just-in-time training when possible, that outlines clearly defined intervention goals and appropriate strategies.
- *Ensure that roles are clear and functionally defined.* Responders can only be expected to jump through the hoop if they have been shown where it is. Not knowing if what they are doing is what is expected is stressful. They need to be oriented and trained to understand the role description for wherever they have been assigned. This is especially true when working within a partnership relationship with another agency or organization.
- *Implement realistic shift practices.* Shifts should be no longer than 12 hours, with at least 12 hours off between shifts. Taking breaks during shifts should be enforced. Tasks assigned should be rotated between high-, mid-, and low-stress tasks. Usual workload should be delegated elsewhere so that workers are not expected to do both disaster response and their regular job.

- *Provide workers with appropriate tools.* Workers need the tools of the trade in order to succeed, such as office supplies, handouts, professional resource materials, and communication equipment.
- *Promote an atmosphere of teamwork and team support.* Behavioral health responders are especially in need of a buddy system, for peer support purposes. Practicing mutual support and tolerance and providing clinical support and consultation are essential to workers maintaining self-confidence and self-esteem as they engage in practices that are brand new for most.

Psychological Debriefing

The last few decades of emergency response have included the evolution of an intervention practice called "debriefing." Originally it entailed immediately applying a set of post-incident self-evaluation questions related to participants' experiences and psychological processing of an incident, typically discussed in groups made up of others who had also been involved. Numerous emergency response agencies and organizations have adopted the use of this practice. Over time, adjustments to the process were made, incorporating findings of outcome studies investigating the effects of psychological debriefing. In its current updated form the intervention appears to provide benefit for many who have been emergency responders at traumatic incidents. However practitioners who have not remained current with debriefing practice have the potential for doing more harm than good. Behavioral health responders engaged for debriefing purposes are best queried regarding the currency of their training.

Additional information about psychological debriefing can be found at http://www.icisf.org. The most important adjustment factors with which debriefers should be familiar:

- Participation in debriefing is always voluntary.
- It should be limited to responders; the effectiveness of its use with survivors does not have significant empirical support.

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- Ongoing intervention within a system of critical incident stress management is more beneficial than one-time meetings.
- Individual debriefings are generally preferable to group debriefings.
- Group debriefings are most useful for individuals who experienced the same incident, are already well familiar with one another – such as a group of firefighters from the same station, and are generally homogeneous in terms of level and type of exposure to the incident.
- When performing group debriefings participants need to be screened ahead of time for risk factors related to development of PTSD. Such responders are better served by individual interventions, so they do not become retraumatized by listening to others' stories.
- As with all mental health interventions, debriefings need to proceed at the rate that appears appropriate to wherever the specific individual is, rather than according to a set agenda.
- Not everyone needs debriefing. Responder self-care practices, application of natural resilience, and traditional behavioral health interventions may be sufficient and/or more appropriate.
- Since experienced emergency responders may be functioning off of earlier understandings of debriefing, and assume that they are required to participate in it regardless of whether they want to or feel as if they need or are ready for it, debriefers need to ensure that responders are aware of their rights before they proceed.

Employee Assistance Programs

Provided the telephone system is functioning, the most immediately available services for state-employed health care workers who have become responders are most likely provided by their Employee Assistance Program (EAP). Such responders can access crisis counseling assistance at http://www.oregon.gov/DAS/PEBB/EAP.shtml, or 1-800-433-2320. Establishing an early connection with their own behavioral health resources better serves the needs of any responder who experiences more significant forms of impact, given that EAPs can provide ongoing treatment if needed and the temporarily-present behavioral health responders can not.

Conditions of Vulnerability

Some people have intermittent or ongoing personal issues associated with demographic or functional factors that can result in increased vulnerability

during a disaster and its aftermath. Individuals with serious and persistent behavioral health conditions are the highest priority of focus for AMH and the community-based mental health and addiction services systems. Local agencies should ensure that the persons they serve know how to access services in the event of a disaster that disrupts communication or physical access to a facility or service, or that may require a facility to move to an alternative site. The field work model of service delivery following disaster facilitates case finding, including locating those with behavioral health vulnerabilities who may not have been sufficiently able and/or informed to find behavioral health assistance while the community is in a state of chaos or disruption.

Some individuals are associated with other group demographic or functional characteristics that can put them at greater behavioral health risk due to conditions or circumstances that may interfere with taking care of themselves during a disaster. For example older persons, those who are medically fragile, and those who have physical, cognitive, or developmental disabilities may need assistance with evacuation, relocation, or accessing disaster-related services. Due to issues of language or other cultural barriers, those from non-dominant ethnic or other cultural groups may not access or receive effective communication about impending emergencies or how to obtain services,. Children are at risk not only because of compromised or insufficiently developed abilities to understand or cope with crisis situations, but also because the parents and other caregivers they depend upon for their resilience may be experiencing challenges with the disaster themselves. Persons with the additional disadvantages of poverty, unemployment, homelessness, or similar severe life challenges are at risk as more stressors occur. In so far as these demographic and functional factors contribute to greater stress or trauma, they increase risk for behavioral health impact.

Various agencies and organizations currently have or are expected to assume formal or informal responsibility for addressing needs of certain populations. Local behavioral health emergency response planners benefit from identifying populations with conditions of vulnerability within their jurisdictions. Such groups will be a concern during a disaster, so it is essential to network with the entities likely to serve them. Such anticipatory and in-time

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collaboration should include discussion of plans to access and meet needs of their respective populations during disasters in a manner that addresses their specific vulnerabilities. These efforts should also include how behavioral health and social support needs are typically met for their respective populations, and establish how behavioral health emergency response might coordinate with them to ensure that those with behavioral health need are identified and referred for appropriate and culturally relevant services.

CDC-sponsored guidance for considerations of those with medical and other risk-related conditions can be found at http://www.bt.gov/workbook/. SAMHSA-sponsored guidance discussing cultural competence and disaster can be found at http://mentalheatlh.samhsa.gov/publications/allpubs/SMA03-3828/default.asp.

SECTION 4: PHASES OF DISASTER RESPONSE

The immediate responsibilities, tasks, and activities within specific behavioral health emergency response roles vary according to whether those filling the roles are addressing preparedness, activation, response, or recovery. Following are descriptions of the four phases, and the typical activities of those holding roles when implementing each phase of the plan.

The Preparedness Phase

The preparedness phase concerns specific duties and activities during the time period before disaster strikes, which promotes readiness to respond. As can be surmised by the preceding sections, the uniqueness and complexities of behavioral health emergency response require considerable advance strategizing. Generally speaking, the preparedness phase focuses on establishing and implementing response-related structures and developing advance expectations and understandings among disaster partners.

Establishing both state and local plans, and ensuring that they are consistent with one another, is pivotal to their ultimate success. However it is also important to note that all involved must recognize that having a written plan in and of itself does not constitute preparedness. Preparedness means readiness to respond. To be prepared, those who would play roles must be familiar with what is in their written plan or what has been internally agreed upon, and have had the necessary strategizing conversations with their appropriate disaster partners.

Response plans of all types need to address internal lines of authority, identify appropriate actions for preparedness and response, and how these actions will fit in with the activities of emergency management and other agencies and organizations following emergency incidents. Appropriate qualifications and the trainings for behavioral health personnel need to be identified. Exercises and drills serve as a means of practicing plans and identifying the holes in them in advance. Annual updates can incorporate new planning that addresses holes identified by exercises and drills or by regular comprehensive review.

However the world does not revolve around disaster preparedness, especially within overtaxed systems with very limited or nonexistent funding. Day-to-day priorities cannot and should not relinquish their emphases in pursuit of behavioral health response planning. Planning and preparedness on a shoestring requires creativity and flexibility, considering what is needed but also what is both realistic and fiscally responsible. Following are suggestions for some strategies that can limit the extent to which preparedness efforts become a drain on the system:

- Assign preparedness leadership responsibility to a staff member who already has an interest or background in disaster and/or trauma.
- When meeting with staff to discuss preparedness, incorporate information-sharing and planning into a regular meeting or extend some other meeting already scheduled, rather than set up separate preparedness meetings.
- Provide training within the context of regular in-service practices.
- When setting up trainings first focus tightly on the critical nuts and bolts of what people are supposed to do during the incident, rather than philosophical and clinical issues, and expand into additional areas as time and interest permit.
- Arrange for continuing education credits for trainings, since licensed and certified practitioners already set aside a certain amount of time for such activity. Free CEUs also provide a draw for the volunteer practitioner pool.

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- Encourage interested staff to seek other outside trainings in trauma and crisis response when in pursuit of their continuing education credits. Staff whose trainings lead them to become involved with other organizations active during disaster can become a wealth of information, and their new knowledge base can rub off by means of informal day-to-day conversation.
- In the break room or somewhere else regularly frequented by staff, post a summary of the nuts and bolts of disaster response, such as the overview summary provided as *Attachment 4H*.
- Participate in drills and exercises by joining those already occurring within emergency management and other agencies and organizations, rather than building your own from scratch.
- Set limited, precise objectives for drill and exercise participation that focus on what is most critical, such as testing the ability to successfully activate.

In practice, preparedness is never truly finished. There is no end to how much state and local behavioral health response personnel can do improve their preparedness status. Furthermore, during an actual incident certain portions of advance planning may well be discarded as irrelevant or conflicting with the needs, resources, and scenario at hand. This is the nature of working with the unpredictability of disaster. However there are certain things that are critical to be able to proceed when disaster strikes. Following are more specific activities and responsibilities during the preparedness phase as they pertain to positions that play roles within the plan.

State-level Positions

*AMH assistant director***.** The AMH assistant director is ultimately responsible for ensuring the response readiness of state and local entities. Doing so requires having a solid understanding of the Behavioral Health Emergency Response Plan, and ensuring that the readiness status of both state and local response plans is regularly monitored.

AMH medical director or equivalent state-employed qualified psychiatrist. This individual oversees development of response clinical intervention standards and typically participates in state-level administrative meetings addressing behavioral health disaster response, such as the AMH Behavioral Health All-Hazards Workgroup.

AMH emergency response coordinator. This position holds primary responsibility for providing planning guidance to local entities and implementing behavioral health emergency response preparedness plans on the state level.

Typical activities include:

- Encouraging and monitoring CMHP emergency response plan development, including providing guidance.
- Chairing the state-level Behavioral Health All-Hazards Workgroup, which is responsible for continued development of the state-level plan.
- Maintaining a call-down list with current contact information for AMH staff expected to hold designated roles during emergency response, and those that are trained to be available to fill leadership roles at the AOC.
- Typically serving as the behavioral health duty officer, the first point of contact for state-level activation of the Behavioral Health Emergency Response Plan.
- Ensuring participation by state-level personnel in behavioral health plan drills, and when possible facilitating local participation in drills and exercises.
- Providing support for recruitment and training of local response teams.
- Maintaining records of local volunteer response team members submitted by CMHPs.
- Identifying and coordinating appropriate trainings for behavioral health staff and volunteers.
- Developing and maintaining a library of public informational brochures and educational materials related to behavioral health, including how to access behavioral health-related resources following an incident.
- As needed, representing AMH at other state-level committees for developing statewide health services emergency response plans.
- Consulting with inpatient treatment facilities regarding planning and management of their response to local incidents.

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- Providing state-level liaison with volunteer services that relate to behavioral health emergency response, including mental health associations, ARC, NOVA, the faith community, Volunteer Agencies Active in Disaster (VOAD), consumer/advocacy organizations, and others as appropriate.

County-level Positions

*Behavioral health branch director – planning***.** Given that all disasters are local, local CMHP leadership is the kingpin for preparedness and response. Solid preparedness requires that a specific individual be assigned this duty, and that all within the agency framework are aware of his/her identity and planning strategy – not to mention where said individual stores the local disaster response plans and materials! Duties during preparedness fall under the general areas of training and recruitment, materials management, and community networking.

Planning leaders facilitate and participate in the AMH trainings for responders, supervisors, and coordinators. They are responsible for developing a pool of potential behavioral health and community volunteer responders by means of local recruitment, offering trainings, and encouraging volunteer responders to join the roster. Status of volunteers is best reviewed at least every two years, verifying continued interest and currency of licensure/certification, and at which time responders can also be informed of program updates.

Rather than having local planning leaders hold permanent disaster on-call status such duty is better rotated, when possible within the context of on-call duty for the agency in general. Also when possible, having a rotating designation of a couple of CMHP responders who will be available for immediate crisis deployment can help eliminate some of the chaos of coming up with staff at the time of initial activation. To facilitate such a possibility, planning leaders need to help agencies prepare for the potential of needing to rearrange workers' schedules to accommodate involvement with the response. Regardless, planning leaders need to develop a call-down procedure for contacting those on their responder rosters during times of crisis. They also need to establish a list of appropriate individuals to serve as branch director or as crew leader when the plan has been activated, and ensure they too are appropriately trained and informed regarding local plans for response.

Planning leaders maintain a ready supply of disaster-related behavioral health response tools and materials. They make sure they have on hand an easily accessible and updated copy of their Behavioral Health Operations

Record, or whatever other tracking and organizing system they intend to use during response. They establish the identification to be used by potential responders, and make sure that identification tags or their possibility exists for all potential responders. A supply of disaster-related behavioral health educational materials also should be kept on hand, or at the very least identified and referenced as to where they can be found. Materials for both professional understanding and for use as handouts to those impacted should be included.

Planner networking activity includes both internal and external stakeholders. On the administrative level they interface with the AMH emergency response coordinator and HPP (formerly HRSA) regional boards, and ensure that AMH has a current copy of their plans and rosters. Locally they maintain familiarity with other agencies and organizations that provide mental health services, and ensure that up-to-date clinical and social service referral resource lists are maintained. They attend or arrange representation for community-level emergency management planning meetings, and endeavor to establish with local emergency management an explicit understanding of roles and responsibilities within written local disaster plans.

Behavioral health responders. Those on the responder rosters attend the AMH-arranged trainings or other similar training as required by the CMHP administrator. When feasible they participate in drills and exercises as is appropriate. They enter contact information into whatever volunteer registry system is being utilized, and provide updates as needed.

The Activation Phase

Activation is the sequence of steps that results in the behavioral health emergency response plan being put into motion. From a planning and administrative perspective, activation considerations are among the most critical elements of response. No matter how sophisticated the local plan structure or how well the responders are trained, without a solidly established activation sequence response quality is likely to suffer, or may not even occur until after critical intervention points have passed. Testing the ability to successfully activate should be included in every emergency response drill and exercise.

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Activation of the behavioral health response can be achieved by means of multiple avenues; a local plan may self-activate. For example, during a school crisis school officials may call the CMHP directly and ask for their assistance. Based on the circumstances the CMHP may elect to respond to the crisis by activating its emergency response plan. Activation may also be initiated by means of a call from local emergency management or public health officials, as would occur if a flash flood had just inundated a local neighborhood or a hazardous material had spilled onto the highway. Statewide activation could be requested or recommended as well, as might occur during a pandemic influenza incident. Most important of all is the local connection: establishing how word of the incident and/or need to activate will get from emergency management or Public Health to the appropriate local behavioral health representative.

In general the activation process involves establishing that the plan will be implemented, identifying a behavioral health branch director, notifying CMHP agencies, agencies performing a call-down of potential responders, and generating a list of those who will be able to respond. Following are more specific activities and position responsibilities as they pertain to the activation phase.

State-level Positions

The BHERT. During smaller or more localized responses the BHERT arranges to provide technical support and guidance as requested or appropriate, a duty typically assigned to the behavioral health emergency response coordinator. During more intense or widespread response the AMH assistant director (or assigned staff in his/her absence) is authorized to activate the state-level behavioral health emergency response plan. *Attachment 3* more specifically details the steps that would be taken by the BHERT as it activates the plan.

Behavioral health liaison. During more complex responses the BHERT or the behavioral health branch director may need a liaison or two to be able to stay on top of quickly developing scenarios. Once chosen and assigned, the liaison reports to the AOC or designated alternative site assignment, and begins collecting and sharing incident-related information between behavioral health leadership and the agency, operation center, or other setting for which the liaison activity is needed.

County-level Positions

Behavioral health branch director – planning. The local individual responsible for response planning and preparedness either adopts or assigns the role of EOC behavioral health branch director, and ensures that the identity of and contact information for this individual is passed on to the BHERT or behavioral health branch director. The planner also initiates the county's call-down procedure, notifying potential local responders and beginning the process of establishing their availability. If not assuming EOC behavioral health branch director duties, the planner briefs the individual assigned to the role regarding the status of the incident and any networking or other developments that impact response plan duties, and briefly reviews the local response plan.

If the incident is sufficiently large or complex, the need for behavioral health resources may be more than the impacted jurisdictions can meet on their own. Thus, behavioral health branch directors for planning in the non-impacted counties can be proactive by preparing to assist in various support functions such as calling in staff for potential response team involvement, or assisting in locating and deploying other logistical supports.

Behavioral health and community volunteer responders. When contacted, responders inform the EOC behavioral health branch director of their immediate and future availability to respond. Once they are recruited, they stay informed and in touch with the status of the response by means of the communication method established for the local county.

The Response Phase

The response phase represents incident-related behavioral health services provided during the time span between activation and final transition into the long-term recovery plan. Response phase activities generally last no more than six to eight weeks. Behavioral health system resources are dedicated to the affected areas until either the crisis has been resolved, or federally supported crisis counselors are hired to meet continuing incident-related needs. The primary goals of the response plan are to assist with restoring community

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behavioral health program operations following the surge in needs, and to address emerging incident-related behavioral health needs by stationing staff in settings where those impacted by the incident are likely to gather. Activities typically include:

- Implementing the preparedness plan for reducing ongoing business to the extent possible and releasing resources for the response.
- Collaborating efforts with local behavioral health staff, local and state OEM, and other response personnel.
- Developing a needs assessment/proposed behavioral health service delivery plan, including a system of outreach.
- Providing intervention for those impacted by the incident, including those directly affected, individuals whose ongoing treatment may have become disrupted, responders, and the community at large.
- Identifying those in need of more than immediate crisis counseling and arranging appropriate referrals and/or resources for longer-term assistance.

Following are more specific activities and role responsibilities as they pertain to the response phase of the plan. In addition to those listed, it is important to note that during response all behavioral health responders are responsible for monitoring their assignment situation for behavioral health need. Whether the responder is located at the disaster site, an EOC, the AOC, or with an outside agency, behavioral health responders screen, triage and intervene as is deemed appropriate.

State-level Positions

AMH assistant director. When the scope of the incident exceeds the capability or capacity of local behavioral health programs to manage locally, the AMH assistant director is ultimately responsible for ascertaining and ensuring that the administrative responsibility to respond has been established and that AMH staff have been or are being assigned to do so.

AMH medical director or equivalent qualified state-appointed psychiatrist. The AMH medical director coordinates and supervises the clinical aspects of the division's overall response to the incident. This includes providing clinical supervision for the implementation and maintenance of incident-related crisis counseling/intervention programs, and providing oversight ensuring that clinical staff is sufficiently oriented and that debriefing

processes are available and appropriate for both state employee and volunteer responders.

The BHERT. The BHERT is responsible for providing a system for oversight of and technical guidance provision for the behavioral health branch director(s). During larger-scale incidents they ensure that the AOC behavioral health branch director position remains filled and that a system is in place to provide oversight and technical guidance for the individuals holding this position. They arrange to physically meet daily or stay in contact by means of electronic communications, reviewing regular reports from the AOC behavioral health branch director or by whatever means best ensures regular communication and oversight. Oversight includes consultation and approval of clinical aspects of plans developed and proposed by the AOC behavioral health branch director. However at times during or directly following the incident, some aspects of the plan are necessarily implemented before the service delivery plan is likely to be fully developed and reviewed by the BHERT.

AOC behavioral health branch director. A more complete listing of tasks and responsibilities of the AOC behavioral health branch director are detailed on *Attachment 1*, which also appears in Attachment F – Behavioral Health of the Public Health Base Plan. As a summary, during the response phase the AOC behavioral health branch director follows up and ensures that all impacted counties have successfully activated, maintains a connection with the overall response management, and provides technical guidance and support as the response scenario evolves. Technical guidance and support activities include:

- Consultation regarding how to implement the local plan, or fill in holes discovered in local plans.
- Discussion involving altered standards of care, and subject matter expertise.
- Providing guidance to the ECC when counties request outside behavioral health resources, and helping identify where the need is greatest and/or where and how additional resources may be sought.
- Guidance and assistance for application for crisis counseling program grants.

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- Providing an avenue for professional communication. This serves as a back-up for regular channels that at times will fail, and a means for informal communications when situations would benefit from off-line discussion among peers.
- Seeking and sharing information regarding how behavioral health response is being handled in various parts of the state.
- Providing a shoulder to cry on.

These activities are elaborated upon in the next section, which describes how to organize and lead response.

*Behavioral health liaison officer***.** Behavioral health liaisons may be established at any time, based on need. Based on the situation and/or in consultation with behavioral health leadership, the IC may request a behavioral health liaison officer to serve in a command staff position within the ICS. Or, the AOC behavioral health branch director may choose to assign responders to the liaison position for the purpose of facilitating activity within the overall behavioral health response. *Attachment 2,* which appears in the State Behavioral Health Emergency Response Plan, provides more specific detail.

County-level Positions

EOC behavioral health branch director. During response, local behavioral health leadership is responsible for coordinating local behavioral health efforts. Coordination evolves among working relationships established with the local behavioral health agencies, the local EOC, the other agencies and organizations providing behavioral health services during the incident, and state-level leadership. *Attachment 4I* describes in more detail the duties of the EOC behavioral health branch director. In summary, main areas of responsibility include:

- Developing an internal administrative structure that will facilitate response organization and tracking.
- Establishing a local behavioral health service delivery plan.
- Maintaining connections within the working relationships.
- Recruiting, orienting, and recommending assignments for staff as needed, and monitoring their ongoing assignments.
- Providing technical guidance and support to the EOC and responders in the field; if necessary, consulting with state behavioral health leadership for clarifications.

- Arranging for or facilitating behavioral health-related material resources for distribution.
- Coordinating with the local public information officer in regard to public information announcements and media interviews.

Crew leaders. These individuals act as leaders and/or supervisors of response crews while in the field. They provide or ensure availability of clinical supervision for responders who are not qualified to practice independently, and also provide technical guidance to the extent to which they are qualified. From a technical guidance perspective, they seek assistance from their EOC behavioral health branch director. From an administrative perspective, they may answer directly to the EOC behavioral health branch director, or take their direction from incident command in the field, as determined within the particular manifestation of the ICS.

The crew leaders ensure that the team members cover the domain that has been assigned by the ICS, and that they have sufficient material resources and information to perform their duties. They track team member locations and activities and make adjustments as necessary. They maintain regular communication with the EOC behavioral health branch director in order to receive technically-related updates, and share information regarding behavioral health activity and developments encountered in the field.

Behavioral health responders and non-licensed community volunteer responders. Once responders have been recruited, they become part of the behavioral health response team. They report to behavioral health leadership as instructed following recruitment, and participate in orientation and any required just-in-time training activities. While in the field they address the behavioral health needs identified within their assignment setting by applying the intervention standards indicated within the local behavioral health plan. They maintain regular contact with their direct supervisor.

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The Recovery Phase

The recovery phase provides behavioral health services that address the needs of incident-impacted individuals during the nine-month period following the incident, and at times longer. Delivery of these services is in part based on funding and guidance from the Center for Mental Health Services (CMHS) of SAMHSA, and is typically coordinated and implemented by AMH or delegated specific community behavioral health service agencies.

The recovery phase involves addressing both continuing short-term needs and having provisions in place for longer-term needs. Following federally-declared disasters, counties or AMH can apply for long-term FEMA crisis counseling grants. To facilitate grant application a plan for addressing ongoing and/or long-term behavioral health needs is developed, consistent with specifications designated by FEMA, SAMHSA, or other granting organizations. A plan should also be in place for addressing any surge in longer-term intervention needs, which usually is not funded by traditional granting organizations.

State-level Positions

The BHERT. The BHERT holds responsibility for ensuring establishment of a long-term recovery plan. Typically this duty will be assigned to the AMH emergency response coordinator. Considerations to be addressed include level of impact observed during the response phase and expectable long-term impact, available CMHP and other behavioral health resources in the impacted areas, special population needs, business continuity needs, and any unique behavioral health factors relevant to the specific incident. When indicated, the BHERT facilitates applications for FEMA crisis counseling program or other appropriate grants. The BHERT can also help with establishing special considerations for those impacted by the incident and are seeking longer-term non-funded services, such as being moved to the top of waiting lists, waiving all fees or charging the lowest sliding scale fee.

AMH medical director or equivalent qualified state-appointed psychiatrist. The AMH medical director supervises grants earmarked for crisis counseling/intervention and trauma services, the implementation and maintenance of incident-related crisis counseling/intervention programs, and

the post-disaster intervention processes and procedures for state employees and volunteers who have been responders in the field.

County-level Positions

Community mental health programs. The CMHPs from impacted counties provide behavioral health intervention consistent with the recovery plan coordinated with the BHERT, which takes into account both grant-related and long-term non-funded intervention needs. VOAD or other organizations that had been active during the response may remain in affected areas to assist with ongoing recovery efforts, such as social, health, counseling, and rebuilding. Behavioral health components related to these efforts are best delivered with some ongoing coordination with the local behavioral health authorities. Consumer/advocacy organizations may be utilized to extend behavioral health case finding, personal support, and case management/monitoring assistance as appropriate.

SECTION 5: ORGANIZING AND LEADING RESPONSE

Episodes requiring full-fledged behavioral health emergency response plan implementation are few and far between, especially here in Oregon. Those who lead and organize response are therefore likely to do so as relative neophytes, implementing training that may have taken place some time before the incident or perhaps has not taken place at all. At times leadership falls into the hands of those who do not routinely hold any form of official leadership duty, perhaps finding themselves to be the "last crisis counselor standing" when usual leadership personnel are either cut off or have become casualties of the disaster. The following discussion aims to provide guidance for those who become responsible for leading or organizing response following an emergency incident.

The mission of behavioral health emergency response is to mediate the behavioral health impact of disaster, and the driving principle behind response leadership activity that will accomplish this mission is endeavoring to connect the services with the clients. While these two factors may seem obvious, simple

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principles can easily get lost in the cloud of dust raised by the chaos, trauma and multiple priorities swirling about during the aftermath of disaster. Reviewing *Attachment 4H*, the overview summary, is a good place for leaders to start as it quickly covers the main ideas and creates an immediate appropriate focus. As time permits, reviewing, the sections of this field guide describing the field work and clinical approaches and *Attachment 4I*, the EOC behavioral health branch director description, will help concretize specific tasks for facilitating the process of initiating and developing a response operation.

In a nutshell the job of behavioral health response operation leadership is to assess the damages, identify likely clients and potential responders, identify appropriate sites and settings for placing responders, orient/train responders available for assignment, and coordinate with emergency management to facilitate the process.

Elements of Behavioral Health Response Organization

As applies to any cognitively-driven endeavor, the complexity of factors involved with establishing and maintaining a response operation can be simplified by means of clustering and prioritizing. Effective response entails a gentle intertwining among several relevant elements: the local context, the intervention approach, the response resource management system, and behavioral health technical support and guidance. A visual analogy might be to view the local need and resource situation as a garden, the intervention approach as the water for nurturing it, the response resource management system as the watering can providing containment for the intervention approach and directing its flow, and the hands supporting the watering can as the technical guidance and support. Response leadership is the process of facilitating creation of this conceptual whole.

The Local Context

Connecting clients with services first requires identifying the clients and the resources. As stated earlier everyone who has experienced a disaster is touched by it in some way, which means that virtually everyone is at risk for experiencing adverse behavioral health impact. However some are found to be more at risk than others:

- Those who were most directly impacted, such as injuries to themselves or loved ones, loss of loved ones, witnessing major trauma occurring to others, and major damage to homes and/or loss of all belongings.
- Emergency responders of all types, especially those who are experiencing repeated and ongoing exposure to others' trauma.
- Vulnerable populations, such as seniors, children, those with disabilities or pre-existing behavioral health conditions, and those of diverse culture and language.

Major emergency response operations require a greater number of behavioral health responders than any CMHP system is likely to be able to provide, thus the importance of incorporating other behavioral health resources present in the community. This practice actually promotes bidirectional healing: not only do clients receive necessary services; satisfying the drive to help out during disaster promotes healing among those who provide them:

- CMHP employees.
- Local licensed volunteer behavioral health professionals.
- Local trained unlicensed/other-licensed volunteers.
- Other agencies that provide behavioral health services during disaster.
- Peer support groups.
- Other groups that support vulnerable populations.

The EOC behavioral health branch director position description describes tasks related to preparing and orienting staff. Often during major disasters – and always during catastrophic disasters such as the Events of September 11 and Hurricane Katrina – the majority of behavioral health responders are spontaneous volunteers with limited or no background in trauma. Whether leadership requires deployment training or a fuller complement of mobilization training is a judgment call, based upon the immediacy of the crisis at hand. When time permits requiring all responders to take the brief just-in-time training before being oriented and assigned not only ensures that the untrained understand the basic dos and don'ts, but also provides a good review for those

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whose training may have occurred some time ago. Those who do not have the recommended behavioral health licensures and certifications are best held back for more extensive psychological first aid training before being assigned, and are better used at sites or settings for which a licensed responder is also assigned. In determining where to send responders, reviewing the list of potential sites and settings on pages 22-25 is a good place to start.

The Intervention Approach and Goals

As described in earlier segments meeting the needs of those impacted by disaster requires utilizing a fieldwork approach, and applying a psychological first aid model of intervention. In the process of developing a service delivery plan the general goals of the clinical investment should be considered:

- Stabilizing distressed clients, and when needed helping them direct their focus toward recovery and providing any necessary referrals.
- Identifying vulnerable populations and severely-impacted individuals and addressing their disaster-related needs, including issues such as continuity of care and advocacy.
- Providing behavioral health support as needed to facilitate operations at medical care, such as PODs, emergency rooms, and decontamination centers.
- Providing stress management services for responders.
- Providing post-disaster behavioral health-oriented information for the general public.
- Endeavoring to provide support related to previous local agreements.

Response Resource Management System

Effective emergency response is a system of relationships; the quality of the relationships has a direct impact on the quality of the response. As described in earlier segments the ICS is the overall system for organizing and managing response. When disaster strikes, making a speedy connection with emergency management increases the chances for effective integration of the behavioral health response.

Integrating behavioral health with overall emergency response is something new. Depending upon how much networking has occurred during preparedness activities, incident commanders may need a little education and some suggestions regarding how behavioral health can be useful. Ongoing

communication, prior training, collaboration, and development of trust ensures that behavioral health leadership is aware of what is happening in the overall response, and can therefore employ appropriate creative process to meet the unique needs of the incident at hand.

Behavioral Health Technical Support and Guidance

Behavioral health technical guidance and support provides information, advocacy and other facilitation-related consultation by means of local leadership and AMH, and during major incidents by means of the AOC behavioral health branch director. The system for provision of technical guidance and support is not to be confused with the command structure. The AOC behavioral health branch director may have recommendations as far as what might be the best way to proceed. However when the local behavioral health leadership is working tightly within the EOC structure, it is local incident command's call to review and approve any course of action that may be decided upon as preferable by their local behavioral health leadership. Following are some examples of technical guidance and support.

*General plan implementation***.** Behavioral health branch directors may request clarifications about plans in general, or ideas how to implement the plan for the specific disaster at hand. In the course of trying to implement their local plan they may find too many previously undiscovered holes for the plan to be implementable, and therefore are seeking potential alternatives.

Altered standard of care and other clinical considerations. Usual clinical intervention practices differ during disaster, and standards of care may be altered. For example, under normal circumstances clinicians only practice in specialized fields if they have achieved levels of training and experience. While training responders to practice disaster mental health in advance is the most desirable scenario during a disaster the level of need and limits on resources are such that many of the clinicians who provide services have limited or no specialized training and experience in disaster mental health. Decisions related to how altered this standard of care may become, as well as other unique clinical issues that can arise during disaster, benefit from peer discussions.

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Subject matter discussion. Subject matter expertise can be provided either by means of the specific leadership individuals' knowledge bases, or by directing inquiries to where such information might be found.

Crisis counseling grant application. Counties may be seeking general information about applying for FEMA grant funds, or how the collective of impacted counties and/or state are going about applying for or distributing funds to cover the specific incident.

Professional/"back door" communication. Communication is one of the first things to be found deficient or fall apart during disaster. It requires back-ups on its back-ups. There is never too much redundancy, so long as all concerned remember who the official sources or recipients are for specific types of communications. For example, an EOC behavioral health branch director may want to discuss with the AOC behavioral health branch director a possible need for recruiting additional responders from outside the area. However if the EOC behavioral health branch director decides to request outside responders, this is processed through the chain of command at the county EOC. Pieces of communication that are especially critical within behavioral health response, such as establishing that notifications of activation have been successfully communicated, benefit from being sought in the form of direct communication between the AOC and EOC behavioral health branch directors.

Command/profession conflicts. Incident commanders usually are not behavioral health professionals and cannot be expected to be aware of all the "ins and outs" of ethical, legal, and clinical considerations related to service delivery. From time to time they may innocently recommend a course of action that violates such considerations, most typically related to confidentiality or informed consent. Upon receiving explanations they are likely to acquiesce, but then again, they may not. Support for sorting out such scenarios can be found at the AOC.

ECC resource procurement and allocation. The ECC is likely to consult with the AOC behavioral health branch director when additional behavioral health responders are being sought by specific localities. Just as AOC public health entities decide who will get the vaccine first during an influenza pandemic, so also does AOC behavioral health provide input regarding relative neediness in the field from a behavioral health perspective. Such decisions can only be made by means of discussions with local behavioral health leadership, at times of a clinical nature and therefore subject to confidentiality considerations, thus to be accomplished by conversations among behavioral health professionals.

Seeking/sharing information about other local behavioral health operations. Strategies working for one locale may well work for another. The AOC can serve as a clearinghouse for what is going on around the state, and share information among all the locales.

Emotional support. It can be lonely at the top. Others in the EOC tend to depend on whoever is serving as the lead behavioral health representative on site to provide the strong presence to be relied upon in times of personal crisis. Effectiveness in this regard can become diluted if the behavioral health branch director overuses EOC colleagues to unload his or her own frustrations, as it might in any multiple-relationship scenario. If no peers are available elsewhere for this type of peer support, it can be provided at the AOC.

The Behavioral Health Operations Record

Creating and utilizing an ongoing record of operations helps both as an administrative guide and as a method of tracking the history and organization of an operation. It can be handed off as replacement personnel take over behavioral health response leadership, which helps maintain operation consistency and integrity. *Attachments 4A* through *4G* are forms that facilitate record-keeping; *Attachments 4H* through *4M* are informational sheets that can be useful. Most of the form concepts are drawn from emergency management forms and practices, and some actually represent required forms for EOC activity. However, when working directly in the EOC, it is best to use the version of shared internal forms – such as those for messages or requests – that the EOC uses. Other forms and pieces of information can be incorporated into the operations record as well; the ones listed here represent basics that are most critical to tracking and organizing response.

Unit log. This simple form provides a place to write down significant happenings during the day and the actions taken to address them.

Individual log. Leadership may want responders to keep track of what they are doing as well. Such records can prove useful when gathering information about the behavioral health impact of the incident for CCP grant application purposes.

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Service delivery plans. Once or twice a day the EOC will produce and distribute an action plan, which describes overall emergency response goals and how the EOC plans on achieving them. Based on what behavioral health branch directors see going on in the field, developing a set of goals of their own to share with EOC leadership for planning purposes can be helpful.

Messages and requests. In the EOC all significant activity is recorded on message forms and passed on to EOC leadership, creating a paper trail to be followed as needed. Likewise, specific actions desired by branch directors require approval by incident command. This form can be used for either purpose until the official forms being used for the incident are identified and/or become available.

Staff assignment scheduling. This calendar-type form provides a simple way of recording who is working, as well as when and where they will be located. During larger operations a wall chart comprised of assignment sites and post-it notes containing responders' names and contact information may be more efficient for tracking and organizing. However rotating post-it notes presents the disadvantage of not creating a paper trail to show the history of such assignments, thus an alternative method for recording this information would be needed. One option would be to utilize a separate calendar form for each site or setting.

Behavioral health responder registration. This form is designed to help leadership establish basic information about those applying to respond, such as contact information, qualifications and experiences, and their availability schedule.

Disaster partner contact worksheet. These worksheets provide a means for recording information related to working relationships with and contact information for the most critical disaster partners. Additional working relationships with other disaster partners can be added as the response develops, such as with behavioral health organizations and VOAD groups.

Behavioral health response plan overview summary and EOC behavioral health branch director position description. Placing these documents in the operations record creates easy accessibility for those serving temporary shifts or taking over the behavioral health leadership position.

Orientation template. This template can be used to develop handouts for responders as when they receive orientations and assignments.

Psychological first aid synopsis. This one-page overview of the do's and don'ts of psychological first aid can be given to responders during orientation.

Overview of psychological first aid. This handout provides the best synopsis of the psychological first aid process for those implementing it in the field. It could be used in lieu of orientation and just-in-time training when getting responders on the road holds highest urgency.

Psychological first aid introduction and overview. When time allows this document can be used to provide a strong review of psychological first aid during orientation and just-in-time training.

When to refer for mental health services. Copies of this handout can be given to behavioral health responders for distribution to other emergency responders, for the purpose of helping them recognize when a referral to behavioral health responders is most critical.

SECTION 6: PANDEMIC, RADIATION, AND TERRORIST INCIDENTS

Public Health has developed addendum-like plans for addressing the unique health and procedural needs likely to arise during the aftermath of pandemic and radiation incidents, operations that are expected to be supported by behavioral health emergency response. There are some administrative differences for behavioral health emergency response during terrorist and public health emergencies. There are also special considerations for all of these particular types of incidents relating to behavioral health reactions and how to assist those who experience them.

Pandemic Influenza Incidents

Pandemic influenza occurs when a new strain of influenza virus enters a population. Because it is a new virus individuals have little or no immunity to it, and thus are more at risk for severe illness, complications, and fatalities. Large numbers of people become ill at once, and people of all ages, backgrounds and locations are at risk. However much of the behavioral health impact of pandemic influenza relates not so much to being ill but more to social and practical circumstances surrounding its presence. During an influenza pandemic:

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- Many people become ill at the same time, leaving social network holes regarding who will take care of ongoing business at home and in the community, and who will care for those who became ill.
- Those who have become infected by the virus may be isolated.
- Quarantine practices may be imposed on those who are not ill but have been exposed.
- Public transportation could be shut down, public gathering places and events cancelled, schools and businesses closed, and access to some areas restricted.
- Usual community services could be disrupted, due to worker illnesses or quarantine strategies.
- The ability to obtain food and other household goods may become limited.
- The health care services system may become overwhelmed.

The stress of these circumstances can be expected to result in behavioral health reactions; feeling frustrated or overwhelmed, the scariness of the invisible threat presented by an actively spreading virus, concerns over the health of loved ones and difficulties with accessing limited health care services, grief reactions when loved ones are lost, boredom and loneliness during isolation or quarantine, or development of a sense of disempowerment or faith in the ability to cope.

Much of the behavioral health response during an influenza pandemic involves providing good information: What is the actual risk? How can people protect themselves? What should they do to prepare for the potential of quarantine or isolation? Developing answers to these questions and distributing information is accomplished by working closely with Public Health, which typically holds incident command responsibility for such incidents. A good source for finding current information is a Web site sponsored by the Department of Health and Human Services: http://www.pandemicflu.gov.

As people find ways to take control and provide protection for themselves, psychological resilience strengthens. Further strengthening of psychological resilience can be encouraged by:

- Helping people identify goals of any sort and move toward them, no matter how small the steps or how far in the distance the light in the tunnel may appear to be.
- Encouraging them to take some form of decisive action aimed to address specific issues that concern them.

- Examining and addressing self-talk, guiding it toward supporting a positive self-view.
- Discussing how they have successfully coped with other crises in their lives, and how those coping skills might be applied to the crisis at hand.
- Encouraging them to stay connected with their social support network, to both talk and listen, both give and receive support. Our era of electronic communications makes staying in touch by means of telephone or Internet possible for most social support networks – a more appropriate means for social contact given communicable disease considerations.
- Encouraging them to stay informed.

A handout on the topic of emotional coping during an influenza pandemic can be obtained through ARC chapters, or be accessed on-line by anyone who subscribes to ARC *CrossNet* at https://crossnet.redcross.org/every/initiatives/flu_planning/pan_flu_coping_emotional_well-being.pdf.

As the health care system rallies to meet medical needs associated with a pandemic incident, significant behavioral health impact variables become apparent. There are limits to vital resources such as hospital beds and ventilators. When vaccine becomes available some populations will be given higher priority for receiving it than will others. Those who are being required to do without limited services will be understandably upset. Furthermore, hospital emergency rooms and clinics can be expected to collect large numbers of individuals – those who are truly ill and need services, those who fear they need services but are being overcautious, and loved ones of those who are being evaluated or have been admitted. Points of dispensing (PODs) may find themselves surrounded by gatherings of those who wish to obtain vaccine for themselves or their loved ones but are not yet eligible. Those with significant pervasive behavioral health or developmental conditions will have less patience and understanding with service delivery processes and may become disruptive.

Behavioral health emergency response aims to help minimize such distress and prevent or manage any disruptiveness by working closely with public health. Because of the need to keep people apart during a pandemic

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incident, hot lines or “warm lines” are the preferred means for offering crisis counseling and providing the information people will need to take control of their personal situations. However as outlined above, there will be need for in-person on the spot services as well. Behavioral health responders can be on site at the PODs to help with those who are upset or require information and/or advocacy to negotiate the system. Similar support can be arranged for those who gather at hospitals and clinics. Strategies for connecting with people in ways that will not promote spread of the disease are found by means of creativity, negotiating and coordinating solutions with Public Health emergency response.

Pandemic incidents are especially stressful for health care providers. Much medical need will be generated yet many of their health care colleagues will be out with the flu themselves. Others may elect not to come to work due to fears of contracting the disease and/or spreading it to their families. This scenario can easily stretch health care providers to their outer limits and beyond. Added to this circumstance will be the more frequent exposure to and trauma of watching people die, as well as the stress of not being able to provide needed critical health care services due to resource limitations.

Given that long-term stress impacts the immune system, the importance of health care provider stress management leaps to the forefront during a pandemic influenza incident. Behavioral health responders and leadership should work closely with Public Health leadership to find ways of minimizing system stress as much as possible, and educating health care providers regarding how they can manage their levels and experiencing of stress.

Fact sheets on the topic of behavioral health and pandemics and on stress management for health care responders can be found at http://www.centerforthestudyoftraumaticstress.org/factsheets.shtml.

Radiation Incidents

Radiation incidents also function under the incident command of Public Health, though if associated with terrorist involvement will require working closely with and under the direction of DOJ/FBI. Circumstances unique to radiation incidents extend significant impact throughout the general population. Radiation contamination is an invisible threat that is not well understood by the general population, thus is difficult to recognize, predict, and/or control – factors known to be especially likely to create distress and cause behavioral health problems for those impacted. Realistic concern regarding spread and pervasiveness of such agents creates more widespread behavioral health impact

than other disasters, as an entire population of an area can be at risk. Such reactions are likely to be further complicated for those of generations that had experienced World War II and/or the Cold War's home atom-bomb shelter era.

Human-caused disasters, which are typically the case for radiation incidents, typically result in a greater degree of anger among those they impact because they are perceived as circumstances that could have been prevented by someone. The resulting reactions of outrage, blaming, and vulnerability further complicate behavioral health well-being.

At emergency rooms and other medical facilities, individuals popularly labeled the "worried well" can be expected to vastly outnumber those who are legitimately at medical risk and/or have suffered some form of exposure or physical impact. Likewise, the two or three significant others who typically accompany loved ones to emergency rooms during times of urgency can be expected to gather at whatever facilities are set up for containing and treating medical impact following a radiation incident. Given that radiation impact is experienced as mysterious to the general public, and that symptoms may occur over time rather than immediately, repeat visits to emergency rooms can be expected. These individuals require interventions that will mediate their immediate behavioral health reactions and provide them with information to help them manage their behavioral and physical health risk, as well as reduce the chaos their reactions can create at medical facilities.

Decontamination processes themselves are traumatic. They can be especially so for those who have experienced sexual assault or child sexual abuse, a population currently estimated to include about one in four women and one in eight men. At any given time many of these individuals can be expected to be experiencing active behavioral health consequences as a reaction to such life experiences, and during decontamination procedures are unlikely to spontaneously volunteer their histories as they face this new form of personal assault and vulnerability. Exacerbation or recurrence of behavioral health conditions is likely for some of these individuals. Receiving news about one's level of exposure can also be expected to result in trauma reactions for some.

Whatever logistical structures are arranged for these and other medical facilities need to take into account space, supplies, and interagency working

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relationships necessary for the behavioral health response to be able to facilitate intervention for those who have been traumatized by a radiation disaster or its sequelae. Behavioral health responders will need to be educated regarding how to protect themselves and not get in the way of operations as they provide services at medical facilities. Health care providers may seek advice regarding how they might provide psychological first aid in the medical setting, and how best to engage in patient education about risks and protective measures.

A fact sheet on behavioral health issues and radiation disasters can be accessed at http://www.centerforthestudyoftraumaticstress.org/factsheets.shtml.

Terrorist Incidents

Terrorists do what they do for the purpose of creating terror. Thus in addition to cleaning up after the immediate physical and emotional carnage, an integral component of emergency response following a terrorist incident is to engage in interventions that help defend against the intended ongoing emotional impact – counterterrorism, so to speak. From this perspective the behavioral health component of emergency response is truly part of our national defense system.

Terrorist attacks serve as a massive reminder of our human fragility, which seeps into the effectiveness of the psychological structures that normally protect us from maladaptive levels of awareness of our own vulnerability. Terrorism undermines confidence and hope. Studies of those impacted by terrorist incidents have found that they become more negative toward those who are culturally and/or ideologically different and more drawn to those who are culturally/ideologically similar, perhaps developing a special attachment to concrete representative icons such as American flags or crucifixes. They show an increasing need for information and understanding about the event, increased desire for justice or punishment for those responsible, a shift toward placing higher value on security practices and lesser value on human rights, and an increased desire to help. [Greenberg, J., Solomon, S., & Pyszczynski, T. (1997). Terror management theory: Empirical assessments and conceptual refinements. In M. Zanna (Ed.), *Advances in experimental social psychology*.]

Counteracting the impact of terrorism is best pursued by maximizing upon the presence of usual and common adaptive reactions and minimizing impact of reactions that can become destructive, all the while moving toward the goal of pushing personal vulnerability concerns back down to adaptive levels:

- Encouraging individuals to focus upon and value the positive aspects of their cultures and ideologies, as such bonds result in strengths and promote self-esteem.
- Helping individuals develop and maintain close personal relationships with friends, family, loved ones, and those who share their personal beliefs.
- Providing accurate information about the incident itself and those who perpetrated it, and what people can do to help protect themselves from realistic risk.
- Finding ways for individuals to help with recovery efforts, and other altruistic activities that are likely to promote a sense of empowerment and good self-esteem.

From an emergency management perspective, terrorist incidents are also criminal incidents. Therefore DOJ and the FBI are typically in charge of incident command, at least during the initial phases of response. Following criminal incidents NOVA traditionally is designated as the behavioral health entity in charge of developing and orchestrating overall behavioral health emergency response, rather than the state CMHP system. This adds some administrative wrinkles. The AMH-oriented behavioral health response still needs to actively support the state public health response activity, such as decontamination centers, overloaded hospital emergency rooms, and public health responder support needs. However, broader community-wide efforts will need to be coordinated with NOVA administrators who will develop an overall program of behavioral health emergency response for the incident. Coordination not only minimizes duplication of efforts, conflicts, and gaps in coverage, but also helps facilitate the transition of behavioral health responsibility back to the state system.

A SAMHSA-sponsored training manual on the topic of behavioral health response following mass violence and terrorism can be accessed at http://mentalhealth.samhsa.gov/publications/allpubs/SMA-3959/default.asp.

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SECTION 7: PLAN MAINTENANCE

Plans are best reviewed and revised annually. The following review items represent elements considered to establish a plan's compliance with the ESF #8 response plan requirements within the current (2007-2009) Local Mental Health Authority (LMHA) contract:

- The specific individual designated to develop and maintain the emergency response plan, and to be first to be contacted in the event of a need to activate and/or implement the plan; and contact information for the responsible individual.
- The call-down roster of all current employees, and a phone-tree or other system for contacting staff.
- The call-down roster of all potential volunteer staff, and a phone-tree or other system for contacting them.
- The designated 24/7 telephone number for contacting the LMHA during an emergency incident that can be used by staff, volunteers, other agencies and health care providers, and the public.
- A roster of those who could serve in leadership roles.
- The system of identification for CMHP and volunteer responders.
- A listing of facilities/locations within the jurisdiction that are populated by vulnerable populations.
- A supply of disaster-related behavioral health education materials, or establishing and indicating where they will be readily accessed.
- An up-to-date clinical and social service referral resource list.
- Where emergency response materials will be stored, including an off-site location.
- The process for providing appropriate training and updates for LMHA staff, community volunteers, and those designated to serve in leadership.
- The plan for participating in annual drills or exercises.
- A description of mutual aid understandings with other LMHAs.
- A description of the networking understandings with local Public Health and emergency management, including local activation procedure expectations.
- A description of networking understandings established with ARC, the local DOJ Crime Victims Assistance Section, and other relevant local agencies or organizations that provide behavioral health services during times of disaster.

- A description of the annual plan review process.

SECTION 8: CLOSING

After reviewing this field guide, behavioral health emergency response may seem to be remarkably or even unbearably complex. Yet the focus is remarkably simple:

- Mediate the behavioral health impact of disaster;
- Connect the services with the clients; and
- Develop what is realistic for local resources and set up understandings and practices that pave the way for importing additional resources when circumstances of greater need arise.

Groundlessness abounds during disaster. Those of us who cope and function well within it will likely thrive during disaster response. Preparedness efforts serve as an anchor, providing the grid upon which the chaos can be aligned and serving as the concrete structure responders know they can rely upon. Flexibility helps. So does a sense of humor. And when all else fails, consider the oft-quoted observation of Eleanor Roosevelt that "This, too, will pass."

NOTES:

ACRONYMS LIST

AMH	Addictions and Mental Health Division
AS	Addiction Services
AOC	Agency Operation Center
ARC	American Red Cross
BHERT	Behavioral Health Emergency Response Team
CCP	FEMA Crisis Counseling Training and Assistance Program
CMHS	Center for Mental Health Services
CVAS	Crime Victims Assistance Section
CMHP	Community Mental Health Program
CRT	Crisis Response Teams
DOJ	Oregon Department of Justice
DRC	Disaster Resource Centers
DMH	Disaster Mental Health
ECC	Emergency Coordinating Center
EOC	Emergency Operation Center
ESF	Emergency Support Function
FEMA	Federal Emergency Management Agency
HRSA	Health Resource Service Area
ICS	Incident Command System
IC	Incident Commander
NDMS	National Disaster Medical System
NIMS	National Incident Management System
NOVA	National Organization for Victims Assistance
NRP	National Response Plan
NTSB	National Transportation and Safety Board
OEM	Office of Emergency Management
ODE	Oregon Department of Education
ODMAT	Oregon Disaster Medical Assistance Teams
POD	Point of Distribution/Dispensing
VOAD	Volunteer Agencies Active in Disaster
SAMHSA	Substance Abuse and Mental Health Services Administration

LISTING OF REFERENCED WEBSITES

Center for the Study of Traumatic Stress, numerous fact sheets:
http://www.centerforthestudyoftraumaticstress.org/factsheets.shtml

Cultural Competence and Disaster Mental Health:
http://mentalheatlh.samhsa.gov/publications/allpubs/SMA03-3828/default.asp

FEMA Crisis Counseling Program Grants:
http://mentalhealth.samhsa.gov/cmhs/EmergencyServices/ccp_pg01.asp

International Critical Incident Stress Foundation:
http://www.icisf.org.

Mental Health Impact of Mass Violence and Terrorism:
http://mentalhealth.samhsa.gov/publications/allpubs/SMA-3959/default.asp

National Incident Management System:
http://www.fema.gov/pdf/emergency/nims/nims_doc_full.pdf).

National Response Plan:
http://www.dhs.gov

Oregon Emergency Management:
http://egov.oregon.gov/OOHS/OEM/

Oregon Employee Assistance Program:
http://www.oregon.gov/DAS/PEBB/EAP.shtml

Pandemic Influenza Resources, DHHS-sponsored:
http://www.pandemicflu.gov.

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Psychological First Aid Field Operations Guide: http://www.nctsn.org/nctsn_assets/pdfs/pfa/2/psyfirstaid.pdf.

Public Health Security and Bioterrorism Preparedness and Response Act (2002): http://www.fda.gov/oc/bioterrorism/bioact.html

Vulnerable Populations: http://www.bt.gov/workbook/

PSYCHOEDUCATIONAL HANDOUTS

American Psychological Association

- The Road to Resilience
  http://www.apahelpcenter.org/featuredtopics/feature.php?id=6

American Red Cross

- Children and Disasters (available in multiple languages)
  http://www.redcross.org/services/disaster/0,1082,0_602_,00.html
- Disaster Preparedness for People with Disabilities
  http://www.redcross.org/services/disaster/0,1082,0_603_,00.html
- Emotional Coping during a Pandemic (on-line availability only through CrossNet)
  https://crossnet.redcross.org/every/initiatives/flu_planning/pan_flu_coping_emotional_well-being.pdf.

Delta Society http://www.deltasociety.org/PetLossArticles.htm

- The Human-Animal Bond
- Elders and Pet Loss
- Children and the Death of a Pet
- The Loss of a Service Dog

National Center for Child Traumatic Stress

- Psychological First Aid Manual – Handout Attachments

http://www.nctsn.org/nctsn_assets/pdfs/pfa/2/psyfirstaid.pdf.

  - Connecting with Others: Seeking Social Support (for adults and adolescents)
  - Connecting with Others: Giving Social Support (for adults and adolescents)
  - When Terrible Things Happen (for adults and adolescents)
  - Parent Tips for Helping Infants and Toddlers (for parents/caregivers)

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    - Parent Tips for Helping Preschool-Age Children (for parents/caregivers)
    - Parent Tips for Helping School-Age Children (for parents/caregivers)
    - Parent Tips for Helping Adolescents (for parents/caregivers)
    - Tips for Adults (for adult survivors)
    - Basic Relaxation Techniques (for adults, adolescents and children)
    - Alcohol and Drug Use after Disasters (for adults and adolescents)
- Reactions to a Major Disaster: A Fact Sheet http://www.ncptsd.va.gov/ncmain/ncdocs/handouts/Reactions_Survivors.pdf?opm=1&rr=rr1410&srt=d&echorr=true
- Self-care and Self-help Following Disasters http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_self_care_disaster.html

National Child Traumatic Stress Network: (under "For Parents and Caregivers") http://www.nctsn.org/

- What is Child Traumatic Stress?
- Understanding Child Traumatic Stress (also available in Spanish)
- Age-related Reactions to a Traumatic Event

United States Department of Health and Human Services (under "Mental Health & Traumatic Events", links to SAMHSA publications) http://www.os.dhhs.gov/emergency/index.shtml

Information for Parents and Families:

- How to Help Children After a Disaster
- Age-specific Interventions at Home for Children in Trauma: From Preschool to Adolescence
- After Disaster: What Teens Can Do
- After a Disaster: A Guide for Parents and Teachers
- How Families Can Help Children Cope with Fear and Anxiety
- Helping Children Cope with Fear and Anxiety
- Anxiety Disorders in Children and Adolescents
- Talking with Young Children about War and Terrorism
- Talking with School-Age Children about War and Terrorism
- Talking with Teenagers about War and Terrorism

Information for Adults:

- Mental Health Aspects of Terrorism
- Disaster Counseling
- After a Disaster: Self-Care Tips for Dealing with Stress
- How to Deal with Grief
- Recognizing and Reducing Anxiety in Times of Crisis
- The Long-term Impact of a Traumatic Event: What to Expect in Your Personal, Family, Work, and Financial Life

Information for Emergency & Disaster Response Workers:

- Self-Care Tips for Emergency and Disaster Response Workers
- Stress Prevention and Management Approaches for Rescue Workers in the Aftermath of Terrorist Acts

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PROFESSIONAL RESOURCES

American Psychological Association

- Fact sheets for working with a variety of populations http://www.apa.org/psychologist/resilience.html#factsheets

Center for Disease Control

- Traumatic Incident Stress: Information for Emergency Response Workers http://www.cdc.gov/niosh/unp-trinstrs.html
- Public Health Workbook to Define, Locate and Reach Special, Vulnerable, and At-Risk Populations in an Emergency http://www.bt.cdc.gov/workbook

Links provided at http://www.cdc.gov/mentalhealth/:

- Coping with a Traumatic Event: Information for the Public
- Disaster Mental Health Primer: Key Principles, Issues, and Questions
- Coping with a Traumatic Event – For Health Professionals

Center for the Study of Traumatic Stress

- Numerous fact sheets on topics related to disaster and terrorism http://www.centerforthestudyoftraumaticstress.org/factsheets.shtml

National Child Traumatic Stress Network

- Psychological First Aid Manual http://www.nctsn.org/nctsn_assets/pdfs/pfa/2/psyfirstaid.pdf. Listed at http://www.nctsnet.org/nccts/nav.do?pid=ctr_top_sp:
- Addressing the Trauma Treatment Needs of Children Who Are Deaf or Hard of Hearing and the Hearing Children of Deaf Parents
- Facts on Trauma and Deaf Children
- Facts on Trauma and Homeless Children
- Facts on Traumatic Stress and Children with Developmental Disabilities

Substance Abuse and Mental Health Service Administration

- Mental Health Response to Mass Violence and Terrorism http://mentalhealth.samhsa.gov/publications/allpubs/SMA-3959/default.asp

- Mental Health All-Hazard Planning Guidance http://mentalhealth.samhsa.gov/publications/allpubs/SMA03-3829/default.asp
- Mental Health Topics: Disaster/Trauma http://mentalhealth.samhsa.gov/topics/explore/disaster
- Developing Cultural Competence in Disaster Mental Health Programs: Guiding Principles and Recommendations http://mentalhealth.samhsa.gov/publications/allpubs/SMA03-3828/default.asp
- Crisis Counseling and Mental Health Treatment: Similarities and Differences http://www.fema.gov/pdf/media/2006/ccp_mh.pdf
- Field Manual for Mental Health and Human Services Workers in Major Disasters http://mentalhealth.samhsa.gov/publications/allpubs/ADM90-537/default.asp

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ATTACHMENTS

1. AOC Behavioral Health Branch Director Job 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 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.
- ❑ Diverse populations and special needs.
- ❑ 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.

OperationalPhase

- ❑ 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.
  - ❑ Supply deployment-training materials when available.
- ❑ Assess the need for and availability of behavioral health and community volunteer responders in each of the impacted counties.
- ❑ 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 AMH 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 AMH 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.

❑ Coordinate with the AOC, and behavioral health liaison 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.

- ❑ Encourage appropriate members of local and state-level behavioral health agencies to join the Health Alert Network (HAN) as a means of facilitating communications within the behavioral health response community.
- ❑ When being replaced:
  - o Remain at the assignment position until the arrival of qualified relief staff and release by the AOC manager.
  - o Thoroughly brief replacement staff regarding developments and status of AOC behavioral health branch director activities to date before leaving the workstation.
  - o Ensure that all logs, lists, and paper work are complete and passed on.

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.

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:
  - o Remain at the assignment position until the arrival of qualified relief staff and release by the AOC manager and/or assignment site leadership.
  - o Thoroughly brief replacement staff regarding developments and status of behavioral health liaison officer activities to date before leaving the workstation.
  - o 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.

3. State-Level Behavioral Health Response Plan Activation – Standard Operating Procedure

Step	Responsible Party	Action
1.	Behavioral health duty officer/ emergency response coordinator	• Receives the initial call from the public health duty officer • Coordinating with the AMH assistant director and/or AMH deputy director, establishes the individual who will provide leadership for the response as AOC behavioral health branch director (or liaison). potential candidates include: o AMH assistant director o AMH deputy assistant director o Superintendent, Blue Mountain Recovery Center o Superintendent, Oregon State Hospital o Members of the AMH AOC leadership roster
2.	AOC behavioral health branch director	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.
3.	AOC behavioral health branch director	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.
4.	AOC behavioral health branch director	Perform an inventory of available supplies and equipment that may be necessary for the response.
5.	AOC behavioral health branch director	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.
6.	AOC behavioral health branch director	Arrange that all hospitals, care centers, and other facilities in the impacted areas are contacted and monitored regarding incident-related needs.
7.	AOC behavioral health branch director	Review the state behavioral health emergency response plan, and be prepared to provide technical guidance to counties and the AOC regarding its implementation.
8.	AOC behavioral health branch director	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 assistant director, 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.

4. Behavioral Health Operations Record Materials

The following list of materials is recommended for inclusion in the behavioral health operations records:

- Unit Log
- Individual Log
- Behavioral Health Service Delivery Plan
- Behavioral Health Message/request
- Staff Assignment Scheduling
- Behavioral Health Responder Registration
- Disaster Partner Contact Worksheet
- Behavioral Health Emergency Response Plan Overview
- EOC Behavioral Health Branch Director Position Description
- Orientation Outline
- Psychological First Aid Synopsis
- Overview of Psychological First Aid Response
- Psychological First Aid Introduction and Overview
- When to Refer to Mental Health Services

4A: UNIT ACTIVITY LOG

Incident name:	Branch director:	Page _____ of _____

Date	Time	Incident/problem situation	Action taken

4B. INDIVIDUAL ACTIVITY LOG

Incident name:	Date:	Page _____ of _____
This log belongs to:	Assignment site/setting:	Branch leader:

Time	Event

4C. BEHAVIORAL HEALTH SERVICE DELIVERY PLAN

Date:	Name:	Position:
Goal #1:		
Objectives (to meet goal):		
Resources needed:		
Action taken:		
Status:		
Goal #2:		
Objectives (to meet goal):		
Resources needed:		
Action taken:		
Status:		
Goal #2:		
Objectives (to meet goal):		
Resources needed:		
Action taken:		
Status:		

4D. BEHAVIORAL HEALTH MESSAGE/REQUEST

To:	Position:
From:	Position:
Date:	Time:
Message/request:	
Signature:	Position:
Reply:	

Date:	Time:	Signature/position:

4E. STAFF ASSIGNMENT SCHEDULING

Indicate assigned responder(s), site or setting, and hours.

Sun	Mon	Tue	Wed	Thu	Fri	Sat
Sun	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**

4F. BEHAVIORAL HEALTH RESPONDER REGISTRATION

Name:	Incident Name:	
Address:	Date:	
Professional License/Certification? Yes___ No____	Type:	#:
	State:	#:
	Type:	#:
Phone:	State:	#:

For the following, please check those items that describe areas in which you have had training and/or experience:

	State Behavioral Health All-Hazards Plan		Trauma Intervention
	Psychological First Aid		Rapid Triage/Emergency Room
	Stress Management		Other Disaster Response Assignments
	Debriefing		Hospice
	CISM		Grief Counseling

Comments regarding your disaster training and experience: _____

_____

Can you speak a language(s) other than English? Yes _____ No _____

If yes, please indicate: _____

Which of the following items describe populations with which you have had work experience or special training:

	Native American		Children
	African American		Seniors/Elderly
	Hispanic		Developmental Disabilities
	Asian		Other Disabilities:
	Other:		Homeless

Please list dates for which you can be available for assignment during the next two weeks:

_____

Responder signature: _____

First Assignment: _____ Date: _____

4G. COUNTY BEHAVIORAL HEALTH ALL-HAZARDS RESPONSE PLAN DISASTER PARTNER CONTACT WORKSHEET

Last Updated: _____

EMERGENCY MANAGEMENT

State: 800-452-0311 or 503-378-OERS (staffed 24/7)

County: _____

Local coordination/contact plan:

PUBLIC HEALTH

State Pager: 503-938-6790 (preferred); 971-246-1789 (staffed 24/7)

County: _____

Local coordination/contact plan:

BEHAVIORAL HEALTH

State behavioral health emergency response team (BHERT): 503-945-2800

Bob Furlow, state behavioral health emergency response: 503-545-3164

County behavioral health preparedness coordinator:

Name: _____

Phone: _____

AMERICAN RED CROSS

Regional chapter:

Emergency services director: _____

Phone: _____

County volunteer contact:

_____

_____

_____

Local coordination/contact plan:

OTHER AGENCY/ORGANIZATION PARTNERSHIPS AND COORDINATION:

4H. BEHAVIORAL HEALTH EMERGENCY RESPONSE PLAN OVERVIEW

This document provides a summarization of behavioral health response, serving as a quick review when the need to activate is immediate, or when usual behavioral health leadership is unavailable and those unfamiliar with the plan need to step in. Note that some local information will need to be attached in order for this review document to be most useful.

Goals of the response plan:

To provide immediate behavioral health support to those impacted by disaster, including victims, their families, responders, and the greater community; that is sufficiently structurally consistent for coordination with a state-level response.

Who responds:

- Licensed behavioral health professionals who provide assessment and triage, crisis counseling, emotional support, responder debriefing and support, and referrals. (Appropriate licensures: psychiatrist, psychiatric nurse/nurse practitioner, psychologist, social worker, marriage and family therapist, counselor, qualified mental health practitioner, qualified mental health associate, certified alcohol and drug counselor)
- Community responders who do not have the referenced licenses but would be appropriate for providing psychological first aid, and are drawn from helper populations such as chaplains, pastors, school counselors, advocates for victims of crime, and peer support groups. They are supervised by the licensed behavioral health responders.
- The County Mental Health Program (CMHP) director leads the response until he/she designates someone else to serve as leader of the behavioral health response, or unless someone else previously had been designated for this duty.

How behavioral health workers respond:

During the immediate aftermath local behavioral health leadership coordinates with local emergency response leadership in a manner consistent

with any pre-established strategies or priorities. Responders are assigned to where those impacted typically gather, such as shelters, reception centers, safe rooms, emergency response staff headquarters, and the disaster site itself; and respond to specific emergency response referrals as needed.

Activating behavioral health:

Behavioral health resources may be activated by city, county or state emergency management depending on the extent and duration of the event. A state level response, usually required when local resources are (or are expected to be) exceeded, will involve coordination with and through Oregon Emergency Management (OEM). OEM will, in turn, coordinate with Public Health Emergency Preparedness on the request for public health and medical resources, to include behavioral health. Public Health Emergency Preparedness will alert the state Addictions and Mental Health (AMH) behavioral health duty officer. Word of activation may come by means of either local Public Health or state AMH. However during the early stages of an incident behavioral health personnel may learn of the situation by other means. Under these circumstances the following contacts may help ascertain the status of activation:

Local Public Health contact: _____

State behavioral health emergency response team/duty officer:
503-945-2800 (Salem).

State Public Health duty officer:
Pager: 503-938-6790 (preferred); 971-246-1789 (staffed 24/7)

Oregon emergency response system:
800-452-0311 or 1-503-378-OERS (6377) (staffed 24/7)

After activation:

The individual assuming leadership at the time of activation should:

- Contact state AMH to report that the behavioral health response plan has been activated (unless activation occurred by means of AMH), and arrange for ongoing clinical/technical guidance and support for the

behavioral health response. State AMH support includes sending or helping locate the local behavioral health plan and filling related knowledge gaps, helping facilitate behavioral health support from outside the county if needed, providing a connection with the expected standard of care and thus protecting liability coverage, consultation regarding difficult cases and handling professional ethical/legal issues that may arise, and other types of peer support.

- If the CMHP director will not be leading the response, contact and recruit someone to do so. A list of CMHP leadership personnel who would be considered appropriate to step into this duty will help facilitate this process.
- Establish contact with local health departments/county emergency management – the incident commander, either directly or by means of the operations chief – in order to determine others who are responding (especially other mental health responders), how to coordinate efforts, appropriate sites for positioning behavioral health responders, and hazardous and/or restricted-access areas.

  Local emergency management: _____

- Initiate a call-down of local CMHP licensed/certified personnel and establish who can respond. A phone-tree system can be used by contacting agency administrators, who intern contact their personnel. Attaching a list of agency contact information to this document.
- If there is a pre-established understanding with non-CMHP responders, initiate a call-down of these volunteers as has been arranged with responder group leadership. Attach the local list of volunteers and their contact information to this document.

How to organize:

- Record names, licenses and contact information for recruited workers; Ensure they are carrying appropriate ID.
- Assign responders into teams for identified sites, assuring that those who require supervision receive it.
- Assign a leader for each team, who tracks and directs location and activity of other team members and maintains contact with the behavioral health response leader.

- Brief responders regarding current understanding of the situation, how behavioral health will assist, and appropriate interventions and referral practices and resources.
- Coordinate with emergency management to assign workers to appropriate locations.
- Maintain regular communication with team leaders, emergency management, and AMH leadership.

As soon as time permits:

- Review the local, Regional and/or State Behavioral Health Emergency Response Plan.
- Arrange for deployment trainings for spontaneous volunteers.
- Evaluate the need for seeking additional workers from outside of the county.

4I. EOC BEHAVORAL HEALTH BRANCH DIRECTOR POSITION DESCRIPTION

DHS Oregon Department of Human Services

ICS Section: Operations
Behavioral Health Branch
Reports to: Operations Section Chief
Location: Local EOC

EOC Behavioral Health Branch Director

******Read this entire position checklist before taking action******

REMEMBER – SAFETY FIRST

Job Description

The EOC behavioral health branch director manages local behavioral health services for the health care, public health, and first response workforce, as well as services to the public. The EOC 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 local behavioral health response for the incident.
- During smaller or less complex responses, may also assume the duties of the behavioral health liaison duties.
- In consultation with the ICS and AOC behavioral health branch director, develops and facilitates 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.
- ❑ Establish contact with AMH technical guidance and support.
- ❑ Set up a workstation and review position responsibilities.
- ❑ Establish and maintain an individual log that chronologically describes actions taken during each shift.
- ❑ Determine material resource needs, such as a computer, phone, plan copies, and other reference documents.
- ❑ Determine the status of the responder call-down procedure.
- ❑ If early interactions appear to require more extensive time and involvement than the EOC behavioral health branch director can provide, and the incident commander so requests or concurs, recruit and assign behavioral health liaison officer as appropriate and arrange plans for regular communication with such liaison officers.
- ❑ May also assume the duties of the crew leader during smaller responses.

Operational Phase

Administration:

- ❑ Establish the physical location from which the county's disaster response can be directed, including orienting, organizing, assigning, and meeting regularly with staff.
- ❑ Obtain information about the incident from:
  - ❑ The BHERT;
  - ❑ The ICS sections, including the ICS operations chief;
  - ❑ The local public health department;
  - ❑ 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.
- ❑ If relevant, 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 set up by FEMA;
- ❑ 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, and organizational sites for emergency responders or medical personnel.

❑ Establish the sites and settings the proposed behavioral health 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.

❑ Discuss and seek approval of the proposed plan with the ICS.

- ❑ When possible, check potential service delivery sites in advance to determine relative need and desire for a Behavioral Health Response.
- ❑ Establish community sites or locations where psychoeducational information could be distributed.
- ❑ Adjust the behavioral health service delivery plan as appropriate.
- ❑ Provide regular written or oral situation reports as is deemed necessary by leadership.
- ❑ When being replaced:
  - o Remain at the assignment position until the arrival of qualified relief staff and being released by the AOC manager.
  - o Thoroughly brief replacement staff regarding developments and status of AOC behavioral health branch director activities to date before leaving the workstation.
  - o Ensure that all logs, lists, and paper work are complete and passed on.

Staff Management:

- ❑ Assess the need for and availability of behavioral health and community volunteer responders in each of the impacted counties.
- ❑ Provide planning and technical guidance for responders within the county or counties of jurisdiction.
- ❑ Establish the safety of potential response sites, so as not to send responders into biohazards and other risky situations.
- ❑ Keep a record of responders who arrive at the operations site, checking for a current licensure/certification/qualification, making sure they have their disaster ID, and recording time/date/place of assignment.
- ❑ Provide incoming staff with an orientation. If using a template produced by the AOC behavioral health branch director, add in any local considerations responders may need. The orientation should provide 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.

- ❑ Provide personnel for the appropriate settings, in accordance with the incident action plan and incident command approval.
- ❑ When necessary, assign or arrange for crew leaders to provide technical/clinical guidance and supervision for teams of responders in the field.
- ❑ Provide responders with useful information obtained from agencies, organizations, and state-level AMHD leadership.
- ❑ Provide responders with new resource information as it becomes available.
- ❑ Monitor ongoing need for additional and/or replacement staff.
- ❑ When behavioral health staff numbers are insufficient, ensure that incident command is aware of all local and regional agreements, and how to recruit staff.
- ❑ Arranges for appropriate intervention or post-response action for behavioral health staff and other responders, given the unique stressors and vulnerabilities relevant to working in disaster settings.

Material Resource Management:

- ❑ Assess the need for materials for responders and those impacted within the county of his/her jurisdiction.
- ❑ Check on need for and availability of rental cars, cell phones, and/or other equipment that may become necessary for behavioral health response purposes.
- ❑ Request materials from the AOC behavioral health branch director or logistics, as appropriate.

- ❑ Arrange or ensure that material resources get to where they are needed in the field.
- ❑ Monitor need for additional materials.

Communication:

- ❑ 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.
- ❑ As appropriate, set up systems or methods by which response-related information is daily or regularly collected from and disseminated to the AOC behavioral health branch director, county-level behavioral health liaisons/ICS centers, and crews.
- ❑ Coordinate with the AOC, EOC, and behavioral health liaison 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.
- ❑ 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.

Demobilization Phase

- ❑ Deactivate the EOC behavioral health branch director position and close out logs when authorized by the incident Commander.
- ❑ Complete all required forms, reports, and other documentation. All forms should be submitted through the EOC 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.

4J. BEHAVIORAL HEALTH EMERGENCY RESPONSE DEPLOYMENT ORIENTATION INFORMATION

SITUATION TO DATE: [Nature and extent of the disaster, including safety issues]

STATE OF THE RESPONSE: [Behavioral health services delivered thus far]

SPECIFIC CONCERNS AND NEEDS: [Known vulnerable populations; specific issues likely to impact behavioral health]

LIKELY ASSIGNMENT SITES: [Current sites and settings where behavioral health services could potentially be delivered]

MATERIALS AND REFERRAL RESOURCES AVAILABLE: [Psychoeducational handouts, disaster-oriented services activated]

CONTACT INFORMATION:

My assignment site/setting: _____

Site/setting manager _____ Phone _____

My direct supervisor _____ Phone_____

I stay in touch with my supervisor daily, by the following means:

_____

_____

EOC BH branch director: _____

AOC BH branch director: _____

Behavioral health crisis hotline: _____

Behavioral health referral: _____

Child/disabled/elder abuse hotline: _____

Nearest emergency room: _____

Chaplain/ecumenical services: _____

REMEMBER!

- We are not here to do formal therapy and assessments.
- We are here to perform psychological first aid: Ensure safety and security, promote stabilization, and focus on reasonable action plans.
- Review the *Overview of Psychological First Aid Response* handout and/or other handouts as time permits.
- Facilitate referral for those who need more extensive services than those provided by psychological first aid.
- Do not leave your assignment without consulting with your direct supervisor.
- Get to know your fellow emergency responders, so they will know what you have to offer.
- Serve as the calm, confident presence.
- Maintain confidentiality to the extent possible.
- Stay out of hazardous areas.
- Take care of yourself!

4K. PSYCHOLOGICAL FIRST AID SYNOPSIS

HOW YOU CAN SUPPORT WELL-BEING IN DISASTER VICTIMS

Center for the Study of Traumatic Stress
http://www.centerforthestudyoftraumaticstress.org/factsheets.shtml

People often experience strong and unpleasant emotional and physical responses to disasters. Reactions may include combinations of confusion, fear, hopelessness, helplessness, sleeplessness, physical pain, anxiety, anger, grief, shock, aggressiveness, mistrustfulness, guilt, shame, shaken religious faith, and loss of confidence in self or others. There is a consensus among international disaster experts and researchers that psychological first aid can help alleviate painful emotions and reduce further harm from initial reactions to disasters.

Your actions and interactions with others can help provide psychosocial first aid to people in distress. Psychological first aid creates and sustains an environment of safety, calming, connectedness to others, self-efficacy, empowerment, and hopefulness.

DO:

- Do help people meet basic needs for food and shelter, and obtain emergency medical attention. Provide repeated, simple and accurate information on how to obtain these (safety).
- Do listen to people who wish to share their stories and emotions and remember there is no wrong or right way to feel (calming).
- Do be friendly and compassionate even if people are being difficult (calming).
- Do provide accurate information about the disaster or trauma and the relief efforts. This will help people to understand the situation (calming).
- Do help people contact friends or loved ones (connectedness).
- Do keep families together. Keep children with parents or other close relatives whenever possible (connectedness).
- Do give practical suggestions that steer people towards helping themselves (self-efficacy).
- Do engage people in meeting their own needs (self-efficacy)

- Do find out the types and locations of government and non-government services and direct people to services that are available (hopefulness).
- If you know that more help and services are on the way do remind people of this when they express fear or worry (hopefulness).

DON'T:

- Don't force people to share their stories with you, especially very personal details (this may decrease calmness in people not yet ready to share their experiences).
- Don't give simple reassurances like "everything will be ok" or "at least you survived" (statements like these tend to diminish calmness).
- Don't tell people what you think they should be feeling, thinking or doing now or how they should have acted earlier (this decreases self-efficacy).
- Don't tell people why you think they have suffered by giving reasons about their personal behaviors or beliefs (this also decreases self-efficacy).
- Don't make promises that may not be kept (un-kept promises decrease hope).
- Don't criticize existing services or relief activities in front of people in need of these services (this may decrease hopefulness or decrease calming).

4L. OVERVIEW OF PSYCHOLOGICAL FIRST AID RESPONSE

	Section Headers
Preparing to Deliver PFA	1. Entering the setting 2. Providing services 3. Maintain a calm presence 4. Be sensitive to culture and diversity 5. Be aware of at-risk populations
Contact and Engagement	1. Introduce yourself/ask about immediate needs
Safety and Comfort	1. Ensure immediate physical safety 2. Enhance sense of predictability, control, comfort, and safety 3. Provide simple information about disaster response activities and services 4. Attend to physical comfort 5. Promote social engagement 6. Attend to children who are separated from their parents 7. Protect from additional traumatic experiences and trauma reminders 8. Give special consideration for acutely bereaved individuals 9. Children and adolescents (bereavement)
Stabilization	1. Stabilize emotionally-overwhelmed survivors 2. Talking points for emotionally-overwhelmed survivors *Adults or caregivers* *Children and adolescents*
Information Gathering: Current Needs and Concerns	1. Nature and severity of experiences during the disaster 2. Death of a family member or close friend 3. Concerns about immediate post-disaster circumstances and ongoing threat 4. Separations from or concern about the safety of loved ones 5. Physical illness and need for medications 6. Losses incurred as a result of the disaster (home, school, neighborhood, business, personal property, or pets) 7. Extreme feelings of guilt or shame 8. Thoughts about causing harm to self or others 9. Lack of adequate supportive social network 10. Prior alcohol or drug use 11. Prior exposure to trauma and loss 12. Prior psychological problems 13. Specific youth, adult, and family concerns over developmental impact

Practical Assistance	1. Identify the most immediate need(s) 2. Clarify the need 3. Discuss an action plan 4. Act to address the need
Connection with Social Supports	1. Enhance access to primary support persons (family and significant others) 2. Encourage use of immediately-available support persons 3. Discuss support-seeking and giving 4. When social support is not working
Information on Coping	1. Provide basic information about stress reactions 2. Review common psychological reactions to traumatic experiences and losses *Intrusive reactions* *Avoidance and withdrawal reactions* *Physical arousal reactions* *Trauma reminders* *Loss reminders* *Change reminders* *Hardships* *Grief reactions* ***Traumatic grief*** *Depression* *Physical reactions* 3. Provide basic information on ways of coping 4. Demonstrate simple relaxation techniques 5. For parents or caregivers, review special considerations for children *Assist with developmental issues* 6. Assist with anger management 7. Address highly negative emotions 8. Help with sleep problems 9. Address substance abuse
Linkage with Collaborative Services	1. Provide direct link to additional needed services 2. Promote continuity in helping relationships

4M. PSYCHOLOGICAL FIRST AID INTRODUCTION AND OVERVIEW

From *Psychological First Aid: Field Operations Guide, 2nd ed.* (2006)
Complete materials can be accessed by means of their sponsors:
National Child Traumatic Stress Network www.nctsn.org
National Center for PTSD www.ncptsd.va.gov

What is Psychological First Aid?

Psychological first aid is an evidence-informed modular approach to help children, adolescents, adults, and families in the immediate aftermath of disaster and terrorism. Psychological first aid is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping. Principles and techniques of psychological first aid meet four basic standards. They are: (1) consistent with research evidence on risk and resilience following trauma; (2) applicable and practical in field settings; (3) appropriate for developmental levels across the lifespan; and (4) culturally informed and delivered in a flexible manner. psychological first aid does not assume that all survivors will develop severe mental health problems or long-term difficulties in recovery. Instead, it is based on an understanding that disaster survivors and others affected by such events will experience a broad range of early reactions (for example, physical, psychological, behavioral, spiritual). Some of these reactions will cause enough distress to interfere with adaptive coping, and recovery may be helped by support from compassionate and caring disaster responders.

Who is Psychological First Aid for?

Psychological first aid intervention strategies are intended for use with children, adolescents, parents/caretakers, families, and adults exposed to disaster or terrorism. Psychological first aid can also be provided to first responders and other disaster relief workers.

Who Delivers Psychological First Aid?

Psychological first aid is designed for delivery by mental health and other disaster response workers who provide early assistance to affected children,

families, and adults as part of an organized disaster response effort. These providers may be imbedded in a variety of response units, including first responder teams, incident command systems, primary and emergency health care, school crisis response teams, faith-based organizations, Community Emergency Response Teams (CERT), medical reserve corps, the citizens corps, and other disaster relief organizations.

When Should Psychological First Aid Be Used?

Psychological first aid is a supportive intervention for use in the immediate aftermath of disasters and terrorism.

Where Should Psychological First Aid Be Used?

Psychological First Aid is designed for delivery in diverse settings. Mental health and other disaster response workers may be called upon to provide psychological first aid in general population shelters, special needs shelters, field hospitals and medical triage areas, acute care facilities (for example, emergency departments), staging areas or respite centers for first responders or other relief workers, emergency operations centers, crisis hotlines or phone banks, feeding locations, disaster assistance service centers, family reception and assistance centers, homes, businesses, and other community settings. For more information on the challenges of providing psychological first aid in various settings, see Appendix B.

Strengths of Psychological First Aid

- Psychological first aid includes basic information-gathering techniques to help providers make rapid assessments of survivors' immediate concerns and needs, and to implement supportive activities in a flexible manner.
- Psychological first aid relies on field-tested, evidence-informed strategies that can be provided in a variety of disaster settings.
- Psychological first aid emphasizes developmentally and culturally appropriate interventions for survivors of various ages and backgrounds.
- Psychological first aid includes handouts that provide important information for youth, adults, and families for their use over the course of recovery.

Basic Objectives of Psychological First Aid

- Establish a human connection in a non-intrusive, compassionate manner.
- Enhance immediate and ongoing safety, and provide physical and emotional comfort.
- Calm and orient emotionally-overwhelmed or distraught survivors.
- Help survivors to tell you specifically what their immediate needs and concerns are, and gather additional information as appropriate.
- Offer practical assistance and information to help survivors address their immediate needs and concerns.
- Connect survivors as soon as possible to social support networks, including family members, friends, neighbors, and community helping resources.
- Support adaptive coping, acknowledge coping efforts and strengths, and empower survivors; encourage adults, children, and families to take an active role in their recovery.
- Provide information that may help survivors cope effectively with the psychological impact of disasters.
- Be clear about your availability, and (when appropriate) linking the survivor to another member of a disaster response team or to local recovery systems, mental health services, public-sector services, and organizations.

Delivering Psychological First Aid

Professional Behavior

- Operate only within the framework of an authorized disaster response system.
- Model healthy responses; be calm, courteous, organized, and helpful.
- Be visible and available.
- Maintain confidentiality as appropriate
- Remain within the scope of your expertise and your designated role
- Make appropriate referrals when additional expertise is needed or requested by the survivor.
- Be knowledgeable and sensitive to issues of culture and diversity.
- Pay attention to your own emotional and physical reactions, and practice self-care.

Guidelines for Delivering Psychological First Aid

- Politely observe first, don't intrude. Then ask simple respectful questions to determine how you may help.
- Often, the best way to make contact is to provide practical assistance (food, water, blankets).
- Initiate contact only after you have observed the situation and the person or family, and have determined that contact is not likely to be intrusive or disruptive.
- Be prepared that survivors will either avoid you or flood you with contact.
- Speak calmly. Be patient, responsive, and sensitive.
- Speak slowly, in simple concrete terms; don't use acronyms or jargon.
- If survivors want to talk, be prepared to listen. When you listen, focus on hearing what they want to tell you, and how you can be of help.
- Acknowledge the positive features of what the survivor has done to keep safe.
- Give information that directly addresses the survivor's immediate goals and clarify answers repeatedly as needed.
- Give information that directly addresses the survivor's immediate goals and clarify answers repeatedly as needed.
- Give information that is accurate and age-appropriate for your audience.
- When communicating through a translator or interpreter, look at the talk to the person you are addressing, not at the translator or interpreter.
- Remember that the goal of psychological first aid is to reduce distress, assist with current needs, and promote adaptive functioning, not to elicit details of traumatic experiences and losses.

Some Behaviors to Avoid

- Do not make assumptions about what survivors are experiencing or what they have been through.
- Do not assume that everyone exposed to a disaster will be traumatized.
- Do not pathologize. Most acute reactions are understandable and expectable given what people exposed to the disaster have experienced. Do not label reactions as "symptoms," or speak in terms of "diagnoses," "conditions," "pathologies," or "disorders."

- Do not talk down to or patronize the survivor, or focus on his/her helplessness, weaknesses, mistakes, or disability. Focus instead on what the person has done that is effective or may have contributed to helping others in need, both during the disaster and in the present setting.
- Do not assume that all survivors want to talk or need to talk to you. Often, being physically present in a supportive and calm way helps affected people feel safer and more able to cope.
- Do not "debrief" by asking for details of what happened.
- Do not speculate or offer possibly inaccurate information. If you cannot answer a survivor's question, do your best to learn the facts.

Working with Children and Adolescents

- For young children, sit or crouch at the child's eye level.
- Help school-age children verbalize their feelings, concerns and questions; provide simple labels for common emotional reactions (for example, mad, sad, scared, worried). Do not use extreme words like "terrified" or "horrified" because this may increase their distress.
- Listen carefully and check in with the child to make sure you understand him/her.
- Be aware that children may show developmental regression in their behavior and use of language.
- Match your language to the child's developmental level. Younger children typically have less understanding of abstract concepts like "death." Use direct and simple language as much as possible.
- Talk to adolescents "adult-to-adult," so you give the message that you respect their feelings, concerns, and questions.
- Reinforce these techniques with the child's parents/caregivers to help them provide appropriate emotional support to their child.

Working with Older Adults

- Older adults have strengths as well as vulnerabilities. Many older adults have acquired effective coping skills over a lifetime of dealing with adversities.
- For those who may have a hearing difficulty, speak clearly and in a low pitch.

- Don’t make assumptions based only on physical appearance or age, for example, that a confused elder has irreversible problems with memory, reasoning, or judgment. Reasons for apparent confusion may include: disaster-related disorientation due to change in surroundings; poor vision or hearing; poor nutrition or dehydration; sleep deprivation; a medical condition or problems with medications; social isolation; and feeling helpless or vulnerable.
- An older adult with a mental health disability may be more upset or confused in unfamiliar surroundings. If you identify such an individual, help to make arrangements for a mental health consultation or referral.

Working with Survivors with Disabilities

- When needed, try to provide assistance in an area with little noise or other stimulation.
- Address the person directly, rather than the caretaker, unless direct communications is difficult.
- If communication (hearing, memory, speech) seems impaired, speak simply and slowly.
- Take the word of a person who claims to have a disability – even if the disability is not obvious or familiar to you.
- When you are unsure of how to help, ask, “What can I do to help?” and trust what the person tells you.
- When possible, enable the person to be self-sufficient.
- Offer a blind or visually impaired person your arm to help him/her move about in unfamiliar surroundings.
- If needed, offer to write down information and make arrangements for the person to receive written announcements.
- Keep essential aids (such as medications, oxygen tank, respiratory equipment, and wheelchair) with the person.

4N. FOR MENTAL HEALTH AND HUMAN SERVICES WORKERS IN MAJOR DISASTERS

WHEN TO REFER TO MENTAL HEALTH SERVICES

SAMHSA's National Mental Health Information Center

http://mentalhealth.samhsa.gov/publications/allpubs/ADM90-537/fmrefer.asp

Referrals to mental health and other health care professionals are made as workers encounter survivors with severe disaster reactions or complicating conditions. The following reactions, behaviors, and symptoms signal a need for the worker to consult with the appropriate professional and, in most cases, to sensitively refer the survivor for further assistance.

Disorientation – dazed, memory loss, inability to give date or time, state where he or she is, recall events of the past 24 hours or understand what is happening

Depression – pervasive feelings of hopeless and despair, unshakable feelings of worthlessness and inadequacy, withdrawal from others, inability to engage in productive activity

Anxiety – constantly on edge, restless, agitated, inability to sleep, frequent frightening nightmares, flashbacks and intrusive thoughts, obsessive fears of another disaster, excessive ruminations about the disaster

Mental Illness – hearing voices, seeing visions, delusional thinking, excessive preoccupation with an idea or thought, pronounced pressure of speech (e.g., talking rapidly with limited content continuity)

Inability to care for self – not eating, bathing or changing clothes, inability to manage activities of daily living

Suicidal or homicidal thoughts or plans

Problematic use of alcohol or drugs

Domestic violence, child abuse, or elder abuse

5. Community Partner Activities by Phase

Table 2. Community Partners: Major Incident Roles and Responsibilities					
	Hospitals	**Interested Citizens/VOADS**	**Private Practice Professionals**	**Schools**	**Sample BH Intervention Sites**
Preparedness Phase	Training of emergency plans Build relationships between in-patient psych units and other relevant hospital departments. Surge response planning with behavioral health agencies. Identify alternative psychiatric care sites.	Build relationships with other VOADS to determine roles and responsibilities. Meet with hospitals, public and private sector agencies to outline roles and responsibilities. Conduct training and field exercises when possible.	Consider a list of preferred service sites. Participate in regional training. Join a regional response team; verify credentialing and register in a locally recognized disaster volunteer database.	Training of emergency plans. Train teams in disaster response and special issues dealing with children and trauma.	Response team training (throughout the community). Risk messaging development at local newspapers; television, radio, internet broadcast locations. Networking with public health and emergency management agencies.
Response Phase	Meet medical needs of community. Triage behavioral health patients with the help of community-based behavioral health response teams. Evaluate psychiatric holds; provide psychiatric in-patient services. Information and referral for behavioral health needs.	Follow organizational missions and goals. Activate and deploy as part of regional response teams or as members of a volunteer organization.	Assignment to regional response teams, agencies, or community organizations as needed.	Assignment to school, regional response teams or agency as needed.	Points of distribution (P.O.D.s). Shelters, feeding sites, disaster relief centers, hospitals, schools, survivor's homes, morgues, community clinics, red cross service centers. 1st responder workplace. On-scene (uncommon).
Recovery Phase	Meet medical needs of community and resume all services. Behavioral health information and referral.	Referrals to long-term behavioral health services.	Coordinate with local CMHPs to provide longer-term behavioral health services.	Coordinate with local CMHPs to provide longer-term behavioral health services.	Hospitals, private provider offices, CMHPs, health clinics; some volunteer organization headquarters.

6. Behavioral Health Operations Activities by Phase

Table 3. Behavioral Health Operations and Responder Resources					
	Comfort Care Operation	**Priority Populations Operation**	**Responder Care Operation**	**Triage/Assessment Operation**	**Psychiatric Medical Operation**
Preparedness Phase	• Relationship building with VOADS-Red Cross, NOVA, TIP, CBOs. • Agencies develop spontaneous volunteer policies and procedures. • Attend relevant trainings.	• Identify high risk or vulnerable populations. • Locate psych residential facilities. • Attend relevant trainings and exercises. • Identify risk messaging needs.	• Develop relationships with first responder groups, emergency managers and law enforcement unions. • Identify support service needs in hospitals and medical facilities. • Attend relevant trainings.	• Develop relationships with hospitals, safety net clinics, Red Cross (or other shelter operating agencies). • Review county protocols for involuntary psychiatric hospitalization. • Attend relevant trainings.	• Identify regional pharmaceutical outlets and suppliers. • Attend relevant trainings. • Identify risk messaging needs.
Response Phase	• Provide supervised psychological first aid. • Referrals to triage and assessment responders. • Disseminate risk messaging to the general public.	• Attend to needs of currently enrolled CMHP clients. • Identify and respond to needs of vulnerable groups. • Respond to referrals from triage/assessment responders. • Disseminate risk messaging.	• Crisis counseling with first responders, receivers, and their families. • Critical incident stress management with emergency workers. • Disseminate risk messaging.	• Provide crisis counseling. • Provide mental health triage and assessments. • Assess behavioral health needs in affected community. • Disseminate risk messaging.	• Prescribe and maintain access to behavioral health medications. • Support triage/assessment and other BH operations as needed. • Assess need and availability for tele-psychiatric systems.
Recovery Phase	• Work with existing community-based recovery agencies and VOADs (Red Cross, Salvation Army, etc). • Attend After Action debriefings (AADs).	• Maintain access to community-based behavioral health services. • Restore individuals to predisaster levels of functioning. • Agency AADs and assessments.	• Continue crisis counseling; development of peer support networks. • Referrals for ongoing behavioral health treatment.	• Continue triage and assessment for longer term mental health and addiction services needs. • Attend AADs.	• Treat behavioral health clients as needed in community and private health care settings. • Provide tele-psychiatric treatment per need.

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